

Type: Data Dictionary Change Notice
Reference: 1656
Version No: 1.0
Subject: NHS Data Model Update
Effective Date: Immediate
Reason for Change: Update of information
Publication Date: 24 September 2018

Background:

On reviewing various data sets it has been determined that a number of Attributes do not appropriately describe aspects of the Classes they were modelled on. As such, these incorrectly modelled Attributes have been identified and the correct Classes identified. Consideration was taken of the Class definitions, the associations between Classes in the logical model and the underpinning meta-model.

These changes do not affect Information Standards as they do not change the item definitions but result in changes to the NHS Data Model and Dictionary.

This Data Set Change Notice (DDCN) updates the NHS Data Model and Dictionary as follows:

- Moves Attributes to the correct Classes
- Retires Attributes to make the associated Data Element consistent with other similar items
- Retires Data Elements which are not used in any data set
- Retires unnecessary NHS Business Definitions and updates the linked Data Elements to associate them with the correct items
- Updates items to reflect the updated items
- Updates items with missing links
- Corrects html.

To view a demonstration on "How to Read an NHS Data Model and Dictionary Change Request", visit the NHS Data Model and Dictionary help pages at: http://www.datadictionary.nhs.uk/Flash_Files/changerequest.htm.

Note: if the web page does not open, please copy the link and paste into the web browser.

Summary of changes:

Diagrams

ACTIVITY DIAGRAM	Changed Diagram
CANCER OUTCOMES AND SERVICES DIAGRAM	Changed Diagram
COMMUNITY SERVICES DIAGRAM	Changed Diagram
DIAGNOSTIC IMAGING DIAGRAM	Changed Diagram
HIV AND AIDS DIAGRAM	Changed Diagram
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES DIAGRAM	Changed Diagram
MATERNITY SERVICES DIAGRAM	Changed Diagram
NATIONAL JOINT REGISTRY DIAGRAM	Changed Diagram
NATIONAL RENAL DIAGRAM	Changed Diagram
NATIONAL WORKFORCE DIAGRAM	Changed Diagram
PATIENT PATHWAY DIAGRAM	Changed Diagram
PERSON DIAGRAM	Changed Diagram
RADIOTHERAPY DIAGRAM	Changed Diagram
SERVICE REQUEST DIAGRAM	Changed Diagram
SYSTEMIC ANTI-CANCER THERAPY DIAGRAM	Changed Diagram

Central Return Forms

KC53 10	Changed Description
KC53 2	Changed Description
KC53 3	Changed Description
KC53 4	Changed Description
KC53 5	Changed Description
KC53 6	Changed Description
KC53 7	Changed Description
KC53 8	Changed Description
KC53 9	Changed Description
KC61 1	Changed Description
KC61 3	Changed Description
KC61 4	Changed Description
KC61 5	Changed Description

KC61 6	Changed Description
KC65 1	Changed Description
KC65 2	Changed Description
KC65 3	Changed Description
KC65 4	Changed Description
KC65 5	Changed Description
KC65 6	Changed Description
Supporting Information	
AMERICAN JOINT COMMITTEE ON CANCER STAGE DATE (RETIRED) renamed from AMERICAN JOINT COMMITTEE ON CANCER STAGE DATE	Changed Name, status to Retired, Description
ANN ARBOR STAGE DATE (RETIRED) renamed from ANN ARBOR STAGE DATE	Changed Name, status to Retired, Description
ANTENATAL BOOKING APPOINTMENT DATE (RETIRED) renamed from ANTENATAL BOOKING APPOINTMENT DATE	Changed Name, status to Retired, Description
APPOINTMENT DATE (RETIRED) renamed from APPOINTMENT DATE	Changed Name, status to Retired, Description
ARRIVAL DATE AND TIME AT ACCIDENT AND EMERGENCY DEPARTMENT (RETIRED) renamed from ARRIVAL DATE AND TIME AT ACCIDENT AND EMERGENCY DEPARTMENT	Changed Name, status to Retired, Description
ASSAULT DATE AND TIME (RETIRED) renamed from ASSAULT DATE AND TIME	Changed Name, status to Retired, Description
ATTENDANCE DATE (RETIRED) renamed from ATTENDANCE DATE	Changed Name, status to Retired, Description
BARCELONA CLINIC LIVER CANCER STAGE DATE (RETIRED) renamed from BARCELONA CLINIC LIVER CANCER STAGE DATE	Changed Name, status to Retired, Description
BINET STAGE DATE (RETIRED) renamed from BINET STAGE DATE	Changed Name, status to Retired, Description
CANCER CARE SPELL DELAY	Changed Description
CANCER DENTAL ASSESSMENT DATE (RETIRED) renamed from CANCER DENTAL ASSESSMENT DATE	Changed Name, status to Retired, Description
CANCER FASTER DIAGNOSIS PATHWAY END DATE (RETIRED) renamed from CANCER FASTER DIAGNOSIS PATHWAY END DATE	Changed Name, status to Retired, Description
CANCER REFERRAL TO TREATMENT PERIOD	Changed Description
CANCER REFERRAL TO TREATMENT PERIOD START DATE (RETIRED) renamed from CANCER REFERRAL TO TREATMENT PERIOD START DATE	Changed Name, status to Retired, Description
CANCER SYMPTOMS FIRST NOTED DATE (RETIRED) renamed from CANCER SYMPTOMS FIRST NOTED DATE	Changed Name, status to Retired, Description
CANCER TREATMENT PERIOD	Changed Description
CANCER TREATMENT PERIOD START DATE (RETIRED) renamed from CANCER TREATMENT PERIOD START DATE	Changed Name, status to Retired, Description
CARE PROGRAMME APPROACH REVIEW DATE (RETIRED) renamed from CARE PROGRAMME APPROACH REVIEW DATE	Changed Name, status to Retired, Description
CHANG STAGING SYSTEM STAGE DATE (RETIRED) renamed from CHANG STAGING SYSTEM STAGE DATE	Changed Name, status to Retired, Description
CHILD PROTECTION PLAN END DATE (RETIRED) renamed from CHILD PROTECTION PLAN END DATE	Changed Name, status to Retired, Description
CHILD PROTECTION PLAN START DATE (RETIRED) renamed from CHILD PROTECTION PLAN START DATE	Changed Name, status to Retired, Description
CLINICAL ASSESSMENT DATE (RETIRED) renamed from CLINICAL ASSESSMENT DATE	Changed Name, status to Retired, Description
CLINICAL STAGE DATE (PANCREATIC CANCER) (RETIRED) renamed from CLINICAL STAGE DATE (PANCREATIC CANCER)	Changed Name, status to Retired, Description
CLINICAL STATUS ASSESSMENT DATE (RETIRED) renamed from CLINICAL STATUS ASSESSMENT DATE	Changed Name, status to Retired, Description
CLINIC ATTENDANCE CONSULTANT	Changed Description
CONTACT DATE (RETIRED) renamed from CONTACT DATE	Changed Name, status to Retired, Description
CRITICAL CARE PERIOD DISCHARGE DATE AND TIME (RETIRED) renamed from CRITICAL CARE PERIOD DISCHARGE DATE AND TIME	Changed Name, status to Retired, Description
CRITICAL CARE PERIOD START DATE AND TIME (RETIRED) renamed from CRITICAL CARE PERIOD START DATE AND TIME	Changed Name, status to Retired, Description
DATE FIRST SEEN (RETIRED) renamed from DATE FIRST SEEN	Changed Name, status to Retired, Description
DECISION TO DELIVER	Changed Description
FINAL FIGO STAGE DATE (RETIRED) renamed from FINAL FIGO STAGE DATE	Changed Name, status to Retired, Description
FIVE FORENSIC PATHWAYS	Changed Description
FIVE FORENSIC PATHWAYS ASSESSMENT DATE (RETIRED) renamed from FIVE FORENSIC PATHWAYS ASSESSMENT DATE	Changed Name, status to Retired, Description
HEALTH VISITOR FIRST ANTENATAL VISIT DATE (RETIRED) renamed from HEALTH VISITOR FIRST ANTENATAL VISIT DATE	Changed Name, status to Retired, Description

HOLISTIC NEEDS ASSESSMENT COMPLETED DATE (RETIRED) renamed from HOLISTIC NEEDS ASSESSMENT COMPLETED DATE	Changed Name, status to Retired, Description
IMAGING OR RADIODIAGNOSTIC EVENT DATE (RETIRED) renamed from IMAGING OR RADIODIAGNOSTIC EVENT DATE	Changed Name, status to Retired, Description
IMMUNISATION DATE (RETIRED) renamed from IMMUNISATION DATE	Changed Name, status to Retired, Description
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES CONTACT	Changed Description
INFANT PHYSICAL EXAMINATION DATE (RETIRED) renamed from INFANT PHYSICAL EXAMINATION DATE	Changed Name, status to Retired, Description
INJURY DATE (RETIRED) renamed from INJURY DATE	Changed Name, status to Retired, Description
INJURY TIME (RETIRED) renamed from INJURY TIME	Changed Name, status to Retired, Description
INTENDED SMOKING QUIT DATE	Changed Description
INTERGROUP RHABDOMYOSARCOMA STUDY POST SURGICAL GROUP DATE (RETIRED) renamed from INTERGROUP RHABDOMYOSARCOMA STUDY POST SURGICAL GROUP DATE	Changed Name, status to Retired, Description
INTERNATIONAL NEUROBLASTOMA RISK GROUP STAGING SYSTEM STAGE DATE (RETIRED) renamed from INTERNATIONAL NEUROBLASTOMA RISK GROUP STAGING SYSTEM STAGE DATE	Changed Name, status to Retired, Description
MODIFIED DUKES STAGE DATE (RETIRED) renamed from MODIFIED DUKES STAGE DATE	Changed Name, status to Retired, Description
MURPHY ST JUDE STAGE DATE (RETIRED) renamed from MURPHY ST JUDE STAGE DATE	Changed Name, status to Retired, Description
MYELOMA INTERNATIONAL STAGING SYSTEM STAGE DATE (RETIRED) renamed from MYELOMA INTERNATIONAL STAGING SYSTEM STAGE DATE	Changed Name, status to Retired, Description
NATIONAL CANCER WAITING TIMES MONITORING DATA SET OVERVIEW	Changed Description
NATIONAL CANCER WAITING TIMES MONITORING DATA SET SCENARIOS	Changed Description
NHS BREAST SCREENING PROGRAMME CENTRAL RETURN DATA SET (KC62) OVERVIEW	Changed Description
NUTRITIONAL ASSESSMENT	Changed Description
OBSERVABLE ENTITY	New Supporting Information
OBSERVABLE ENTITY DATE	New Supporting Information
OBSERVABLE ENTITY TIME	New Supporting Information
ONWARD REFERRAL DATE (RETIRED) renamed from ONWARD REFERRAL DATE	Changed Name, status to Retired, Description
ONWARD REFERRAL TIME (RETIRED) renamed from ONWARD REFERRAL TIME	Changed Name, status to Retired, Description
PARENTS SEEN BY SENIOR STAFF MEMBER DATE AND TIME (RETIRED) renamed from PARENTS SEEN BY SENIOR STAFF MEMBER DATE AND TIME	Changed Name, status to Retired, Description
PRIMARY PROCEDURE DATE (RETIRED) renamed from PRIMARY PROCEDURE DATE	Changed Name, status to Retired, Description
PROCEDURE DATE	Changed Description
PROCEDURE DATE AND TIME (RETIRED) renamed from PROCEDURE DATE AND TIME	Changed Name, status to Retired, Description
REASONABLE OFFER	Changed Description
REFERRAL TO TREATMENT PERIOD INCLUDED IN REFERRAL TO TREATMENT CONSULTANT-LED WAITING TIMES MEASUREMENT	Changed Description
REFERRED TO SERVICE ASSESSMENT DATE (RETIRED) renamed from REFERRED TO SERVICE ASSESSMENT DATE	Changed Name, status to Retired, Description
REFERRED TO SERVICE ASSESSMENT TIME (RETIRED) renamed from REFERRED TO SERVICE ASSESSMENT TIME	Changed Name, status to Retired, Description
RESTRICTIVE INTERVENTION	Changed Description
RETINOBLASTOMA ASSESSMENT DATE (RETIRED) renamed from RETINOBLASTOMA ASSESSMENT DATE	Changed Name, status to Retired, Description
RUPTURE OF MEMBRANES DATE AND TIME (RETIRED) renamed from RUPTURE OF MEMBRANES DATE AND TIME	Changed Name, status to Retired, Description
SCREENING TEST DATE (RETIRED) renamed from SCREENING TEST DATE	Changed Name, status to Retired, Description
SERVICE DISCHARGE DATE (RETIRED) renamed from SERVICE DISCHARGE DATE	Changed Name, status to Retired, Description
SERVICE DISCHARGE TIME (RETIRED) renamed from SERVICE DISCHARGE TIME	Changed Name, status to Retired, Description
SPEECH AND LANGUAGE ASSESSMENT DATE (RETIRED) renamed from SPEECH AND LANGUAGE ASSESSMENT DATE	Changed Name, status to Retired, Description
STAGE GROUPING DATE (TESTICULAR CANCER) (RETIRED) renamed from STAGE GROUPING DATE (TESTICULAR CANCER)	Changed Name, status to Retired, Description
SYSTEMIC ANTI-CANCER THERAPY ADMINISTRATION DATE (RETIRED) renamed from SYSTEMIC ANTI-CANCER THERAPY ADMINISTRATION DATE	Changed Name, status to Retired, Description
TIME SEEN (RETIRED) renamed from TIME SEEN	Changed Name, status to Retired, Description
TNM STAGE GROUPING DATE (FINAL PRETREATMENT) (RETIRED) renamed from TNM STAGE GROUPING DATE (FINAL PRETREATMENT)	Changed Name, status to Retired, Description
TNM STAGE GROUPING DATE (INTEGRATED) (RETIRED) renamed from TNM STAGE GROUPING DATE (INTEGRATED)	Changed Name, status to Retired, Description

<u>TREATMENT START DATE (CANCER) (RETIRED)</u> renamed from <u>TREATMENT START DATE (CANCER)</u>	Changed Name, status to Retired, Description
<u>TWO YEAR NEONATAL OUTCOMES ASSESSMENT DATE (RETIRED)</u> renamed from <u>TWO YEAR NEONATAL OUTCOMES ASSESSMENT DATE</u>	Changed Name, status to Retired, Description
<u>WILMS TUMOUR STAGE DATE (RETIRED)</u> renamed from <u>WILMS TUMOUR STAGE DATE</u>	Changed Name, status to Retired, Description

Class Definitions

<u>ACTIVITY</u>	Changed Description
<u>ACTIVITY GROUP</u>	Changed Attributes, Description
<u>ACTIVITY OFFER</u>	Changed Attributes
<u>ADDRESS</u>	Changed Description
<u>ASSAULT</u>	New Class
<u>CARE ACTIVITY</u>	Changed Attributes, Description
<u>CARE CLUSTER</u>	Changed Attributes
<u>CARE CONTACT</u>	Changed Attributes
<u>CARE PLAN</u>	Changed Attributes
<u>CATEGORY VALUED PERSON OBSERVATION</u>	Changed Attributes, Description
<u>CLINICAL INTERVENTION</u>	Changed Attributes
<u>CLINICAL INVESTIGATION RESULT ITEM</u>	Changed Description
<u>DIAGNOSTIC TEST REQUEST</u>	Changed Description
<u>EMPLOYMENT</u>	Changed Attributes, Description
<u>LOCATION</u>	Changed Attributes
<u>MIDWIFE</u>	Changed Description
<u>ORGAN OR TISSUE DONOR</u>	Changed Description
<u>OTHER PERSON OBSERVATION</u>	Changed Description
<u>OVERSEAS VISITOR STATUS</u>	Changed Description
<u>PATIENT CLINICAL TRIAL STATUS</u>	Changed Attributes
<u>PATIENT DIAGNOSIS</u>	Changed Attributes
<u>PERFORMANCE STATUS</u>	Changed Attributes
<u>PERSON</u>	Changed Relationships
<u>PERSON NAME</u>	Changed Description
<u>PERSON PROPERTY</u>	Changed Attributes, Description
<u>PHARMACEUTICAL PRODUCT</u>	Changed Description
<u>PLANNED ACTIVITY</u>	Changed Attributes
<u>PRESCRIBED ITEM</u>	Changed Attributes
<u>REFERRAL REQUEST</u>	Changed Attributes, Description
<u>SAMPLE</u>	Changed Attributes
<u>TEXT VALUED PERSON OBSERVATION</u>	Changed Description

Attribute Definitions

<u>ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL</u>	Changed Description
<u>ACTIVITY DATE AND TIME TYPE</u>	Changed Description
<u>ACTIVITY DATE TYPE</u>	Changed Description
<u>ACTIVITY OFFER STATUS</u> renamed from <u>ACTIVITY OFFER STATUS CODE</u>	Changed Name
<u>ACTIVITY TIME TYPE</u>	Changed Description
<u>APPOINTMENT DATE</u>	Changed Description
<u>CANCER CARE SPELL DELAY REASON</u>	Changed Description
<u>CANCER CARE SPELL DELAY REASON COMMENT</u>	Changed Description
<u>CLINICAL INTERVENTION TEXT STRING</u>	New Attribute
<u>CRITICAL CARE LEVEL</u>	Changed Description
<u>CYTOMEGALOVIRUS MEDICATION TYPE</u> renamed from <u>CYTOMEGALOVIRUS MEDICATION TYPE CODE</u>	Changed Name
<u>DIAGNOSTIC TEST REQUEST TYPE</u>	Changed Description
<u>LAST MENSTRUAL PERIOD DATE (RETIRED)</u> renamed from <u>LAST MENSTRUAL PERIOD DATE</u>	Changed Name, status to Retired, Description
<u>PERFORMANCE STATUS FOR ADULTS</u> renamed from <u>PERFORMANCE STATUS CODE FOR ADULTS</u>	Changed Name
<u>PERFORMANCE STATUS FOR YOUNG PERSON</u> renamed from <u>PERFORMANCE STATUS CODE FOR YOUNG PERSON</u>	Changed Name
<u>PERSON PROPERTY EFFECTIVE END DATE</u>	Changed Description
<u>PERSON PROPERTY EFFECTIVE END TIME</u>	Changed Description
<u>PERSON PROPERTY EFFECTIVE START DATE</u> renamed from <u>PERSON PROPERTY EFFECTIVE DATE</u>	Changed Name, Description
<u>PERSON PROPERTY EFFECTIVE START TIME</u> renamed from <u>PERSON PROPERTY EFFECTIVE TIME</u>	Changed Name, Description

PERSON PROPERTY OBSERVED DATE	Changed Description
PERSON PROPERTY OBSERVED TIME	Changed Description
PERSON PROPERTY RECORDED DATE	Changed Description
PERSON PROPERTY RECORDED TIME	Changed Description
PLANNED ACTIVITY DATE TYPE	Changed Description
PREGNANCY PREVIOUS CAESAREAN SECTIONS (RETIRED) renamed from PREGNANCY PREVIOUS CAESAREAN SECTIONS	Changed Name, status to Retired, Description
PREGNANCY TOTAL LIVE BIRTHS (RETIRED) renamed from PREGNANCY TOTAL LIVE BIRTHS	Changed Name, status to Retired, Description
PREGNANCY TOTAL PREVIOUS LOSSES LESS THAN 24 WEEKS (RETIRED) renamed from PREGNANCY TOTAL PREVIOUS LOSSES LESS THAN 24 WEEKS	Changed Name, status to Retired, Description
PREGNANCY TOTAL PREVIOUS PREGNANCIES (RETIRED) renamed from PREGNANCY TOTAL PREVIOUS PREGNANCIES	Changed Name, status to Retired, Description
PREGNANCY TOTAL STILL BIRTHS (RETIRED) renamed from PREGNANCY TOTAL STILL BIRTHS	Changed Name, status to Retired, Description
SYSTEMIC ANTI-CANCER THERAPY REGIMEN MODIFICATION INDICATOR	Changed Description
TRAUMATIC LESION OF GENITAL TRACT TYPE renamed from TRAUMATIC LESION OF GENITAL TRACT TYPE CODE	Changed Name
TWO WEEK WAIT CANCER OR SYMPTOMATIC BREAST REFERRAL TYPE	Changed Description
VIABLE TUMOUR INDICATOR	Changed Description
Data Elements	
A AND E DEPARTURE TIME	Changed Description
A AND E INITIAL ASSESSMENT TIME	Changed Description
A AND E TIME SEEN FOR TREATMENT	Changed Description
ACTIVITY DATE (ANTENATAL APPOINTMENT)	Changed Description
AMERICAN JOINT COMMITTEE ON CANCER STAGE DATE	Changed linked Attribute, Description
ANN ARBOR STAGE DATE	Changed linked Attribute, Description
APPOINTMENT DATE (FORMAL ANTENATAL BOOKING)	Changed Description
ARRIVAL DATE AND TIME AT ACCIDENT AND EMERGENCY DEPARTMENT	Changed Description
ARRIVAL TIME AT ACCIDENT AND EMERGENCY DEPARTMENT	Changed Description
ASSAULT DATE AND TIME	Changed linked Attribute, Description
ATTENDANCE DATE	Changed Description
BABY FIRST FEED DATE TIME	Changed Description
BARCELONA CLINIC LIVER CANCER STAGE DATE	Changed linked Attribute, Description
BINET STAGE DATE	Changed linked Attribute, Description
CANCER CARE SPELL DELAY REASON (DECISION TO TREATMENT)	Changed Description
CANCER CARE SPELL DELAY REASON (FIRST SEEN)	Changed Description
CANCER CARE SPELL DELAY REASON (OUTCOME COMMUNICATION CANCER FASTER DIAGNOSIS PATHWAY)	Changed Description
CANCER CARE SPELL DELAY REASON (REFERRAL TO TREATMENT)	Changed Description
CANCER CARE SPELL DELAY REASON COMMENT (DECISION TO TREATMENT)	Changed Description
CANCER CARE SPELL DELAY REASON COMMENT (FIRST SEEN)	Changed Description
CANCER CARE SPELL DELAY REASON COMMENT (REFERRAL TO TREATMENT)	Changed Description
CANCER DENTAL ASSESSMENT DATE	Changed Description
CANCER FASTER DIAGNOSIS PATHWAY END DATE	Changed Description
CANCER PROGRESSION AGREED DATE (PRIMARY CANCER PATHWAY)	Changed Description
CANCER REFERRAL TO TREATMENT PERIOD START DATE	Changed Description
CANCER SYMPTOMS FIRST NOTED DATE	Changed linked Attribute, Description
CANCER TRANSFORMATION AGREED DATE (PRIMARY CANCER PATHWAY)	Changed Description
CANCER TREATMENT PERIOD START DATE	Changed Description
CARE CONTACT DATE (DIETITIAN INITIAL)	Changed Description
CARE CONTACT DATE (SPEECH AND LANGUAGE THERAPIST INITIAL)	Changed Description
CARE CONTACT TIME	Changed Description
CARE PROGRAMME APPROACH REVIEW DATE	Changed Description
CHANG STAGING SYSTEM STAGE DATE	Changed linked Attribute, Description
CHILD PROTECTION PLAN END DATE	Changed Description
CHILD PROTECTION PLAN START DATE	Changed Description
CLINICAL STAGE DATE (PANCREATIC CANCER)	Changed linked Attribute, Description
CLINICAL STATUS ASSESSMENT DATE (CANCER)	Changed Description
CRITICAL CARE DISCHARGE DATE AND TIME	Changed Description

CRITICAL CARE START DATE AND TIME	Changed Description
DATE FIRST SEEN	Changed Description
DATE FIRST SEEN (CANCER SPECIALIST)	Changed Description
DATE OF CLINICAL ASSESSMENT	Changed Description
DATE OF PREGNANCY OUTCOME (CURRENT FETUS)	Changed Description
DATE OF RESTRICTIVE INTERVENTION	Changed Description
DATE TIME OF DECISION TO DELIVER	Changed Description
DECISION TO TREAT DATE (RADIOTHERAPY TREATMENT EPISODE)	Changed Description
DISCHARGE DATE (MOTHER MATERNITY SERVICES)	Changed Description
DISCHARGE DATE TIME (HOSPITAL PROVIDER SPELL POSTPARTUM)	Changed Description
DISCHARGE DATE TIME (MOTHER POST DELIVERY HOSPITAL PROVIDER SPELL)	Changed Description
DISCHARGE LETTER ISSUED DATE (MENTAL HEALTH AND COMMUNITY CARE)	Changed Description
END DATE (CARE PROGRAMME APPROACH CARE)	Changed Description
END DATE (GMP PATIENT REGISTRATION)	Changed linked Attribute, Description
END DATE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)	Changed Description
END DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD)	Changed Description
END DATE (WARD STAY)	Changed Description
FINAL FIGO STAGE DATE	Changed linked Attribute, Description
FIVE FORENSIC PATHWAYS ASSESSMENT DATE	Changed Description
HEAD CIRCUMFERENCE IN CENTIMETRES (AT TWO YEAR NEONATAL OUTCOMES ASSESSMENT)	Changed Description
HEALTH VISITOR FIRST ANTENATAL VISIT DATE	Changed Description
HOLISTIC NEEDS ASSESSMENT COMPLETED DATE	Changed Description
IMMUNISATION DATE	Changed Description
INDIRECT ACTIVITY DATE	Changed Description
INDIRECT ACTIVITY TIME	Changed Description
INFANT PHYSICAL EXAMINATION DATE	Changed Description
INJURY DATE	Changed linked Attribute, Description
INJURY TIME	Changed linked Attribute, Description
INTERGROUP RHABDOMYOSARCOMA STUDY POST SURGICAL GROUP DATE	Changed linked Attribute, Description
INTERNATIONAL NEUROBLASTOMA RISK GROUP STAGING SYSTEM DATE	Changed linked Attribute, Description
LAST CONTACT DATE (LIVING DONOR)	Changed Description
LAST MENSTRUAL PERIOD DATE	Changed linked Attribute, Description
MATERNITY SCREENING TESTS BOOKLET GIVEN DATE	Changed Description
MODIFIED DUKES STAGE DATE	Changed linked Attribute, Description
MULTIDISCIPLINARY TEAM DISCUSSION DATE (CANCER)	Changed Description
MULTIDISCIPLINARY TEAM MEETING DATE (CANCER)	Changed Description
MURPHY ST JUDE STAGE DATE	Changed linked Attribute, Description
MYELOMA INTERNATIONAL STAGING SYSTEM STAGE DATE	Changed linked Attribute, Description
NUMBER OF HIV CONTACTS	Changed Description
OBSERVATION DATE	Changed Description
OBSERVATION DATE (BLOOD TEST) (RETIRED) renamed from OBSERVATION DATE (BLOOD TEST)	Changed Name, linked Attribute, status to Retired, Description
OBSERVATION DATE (HEAD CIRCUMFERENCE)	Changed Description
OBSERVATION DATE (HEIGHT)	Changed Description
OBSERVATION DATE (SUBSTANCE MISUSE EVIDENCE)	Changed Description
OBSERVATION DATE (WEIGHT)	Changed Description
OBSERVATION DATE AND TIME (SECOND BRAINSTEM DEATH TEST) (RETIRED) renamed from OBSERVATION DATE AND TIME (SECOND BRAINSTEM DEATH TEST)	Changed Name, linked Attribute, status to Retired, Description
OBSERVATION DATE AND TIME (TEMPERATURE)	Changed Description
ONWARD REFERRAL DATE	Changed linked Attribute, Description
ONWARD REFERRAL TIME	Changed linked Attribute, Description
OTHER GENE OR STRATIFICATION BIOMARKER TYPE ANALYSED COMMENT	Changed linked Attribute, Description
OTHER GERMLINE GENETIC TEST TYPE OFFERED COMMENT	Changed linked Attribute, Description
OXYTOCIN ADMINISTERED DATE TIME	Changed Description

PARENTS SEEN BY SENIOR STAFF MEMBER DATE AND TIME	Changed Description
PERSON HEIGHT IN CENTIMETRES (AT TWO YEAR NEONATAL OUTCOMES ASSESSMENT)	Changed Description
PERSON WEIGHT (AT TWO YEAR NEONATAL OUTCOMES ASSESSMENT)	Changed Description
PREGNANCY FIRST CONTACT DATE	Changed Description
PREGNANCY PREVIOUS CAESAREAN SECTIONS	Changed linked Attribute, Description
PREGNANCY TOTAL PREVIOUS LIVE BIRTHS	Changed linked Attribute, Description
PREGNANCY TOTAL PREVIOUS LOSSES LESS THAN 24 WEEKS	Changed linked Attribute, Description
PREGNANCY TOTAL PREVIOUS PREGNANCIES	Changed linked Attribute, Description
PREGNANCY TOTAL PREVIOUS STILLBIRTHS	Changed linked Attribute, Description
PRIMARY PROCEDURE DATE	Changed Description
PROCEDURE DATE (BRONCHOSCOPY)	Changed Description
PROCEDURE DATE (DATING ULTRASOUND SCAN)	Changed Description
PROCEDURE DATE (NEWBORN HEARING AUDIOLOGY)	Changed Description
PROCEDURE DATE (NEWBORN HEARING SCREENING)	Changed Description
PROCEDURE DATE AND TIME	Changed Description
PROCEDURE DATE AND TIME (ABDOMINAL X-RAY)	Changed Description
PROCEDURE DATE AND TIME (CESSATION OF RESUSCITATION UNCONTROLLED DONOR)	Changed Description
PROCEDURE DATE AND TIME (COLD PERFUSION)	Changed Description
PROCEDURE DATE AND TIME (CRANIAL ULTRASOUND SCAN)	Changed Description
PROCEDURE DATE AND TIME (DURING NEONATAL CRITICAL CARE PERIOD)	Changed Description
PROCEDURE DATE AND TIME (ESTIMATED DONOR RETRIEVAL)	Changed Description
PROCEDURE DATE AND TIME (NEWBORN HEARING SCREENING)	Changed Description
PROCEDURE DATE AND TIME (ORGAN OR TISSUE RETRIEVAL)	Changed Description
PROCEDURE DATE AND TIME (PLACED ON ICE LEFT KIDNEY)	Changed Description
PROCEDURE DATE AND TIME (PLACED ON ICE PANCREAS)	Changed Description
PROCEDURE DATE AND TIME (PLACED ON ICE RIGHT KIDNEY)	Changed Description
PROCEDURE DATE AND TIME (RETINOPATHY OF PREMATURITY SCREENING)	Changed Description
PROCEDURE DATE AND TIME (START RESUSCITATION UNCONTROLLED DONOR)	Changed Description
PROCEDURE DATE AND TIME (VENTILATION CEASED)	Changed Description
PROCEDURE DATE AND TIME (VENTILATION STARTED)	Changed Description
PROCEDURE DATE AND TIME (VENTILATION STOPPED)	Changed Description
PROCEDURE DATE TIME (CAESAREAN SECTION)	Changed Description
PROCEDURE DATE TIME (ULTRASOUND FETAL ANOMALY SCREENING)	Changed Description
REFERRED TO SERVICE ASSESSMENT DATE	Changed Description
REFERRED TO SERVICE ASSESSMENT TIME	Changed Description
RETINOBLASTOMA ASSESSMENT DATE	Changed linked Attribute, Description
RUPTURE OF MEMBRANES DATE TIME	Changed Description
SCREENING TEST DATE	New Data Element
SERVICE DISCHARGE DATE	Changed Description
SERVICE DISCHARGE TIME	Changed Description
SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL)	Changed Description
SPEECH AND LANGUAGE ASSESSMENT DATE	Changed Description
STAGE GROUPING DATE (TESTICULAR CANCER)	Changed linked Attribute, Description
START DATE	Changed Description
START DATE (ANTI-CANCER DRUG REGIMEN)	Changed Description
START DATE (ASSIGNMENT Payscale)	Changed Description
START DATE (CARE PROGRAMME APPROACH CARE)	Changed Description
START DATE (COMMISSIONER ASSIGNMENT PERIOD)	Changed Description
START DATE (EPISODE)	Changed Description
START DATE (ERYTHROPOIETIN EPISODE)	Changed Description
START DATE (FINAL SYSTEMIC ANTI-CANCER THERAPY)	Changed Description
START DATE (GMP PATIENT REGISTRATION)	Changed linked Attribute, Description
START DATE (HOSPITAL PROVIDER SPELL)	Changed Description
START DATE (KIDNEY PERFUSION LEFT KIDNEY)	Changed Description
START DATE (KIDNEY PERFUSION RIGHT KIDNEY)	Changed Description
START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)	Changed Description
START DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD)	Changed Description
START DATE (PERITONEAL DIALYSIS TREATMENT REGIME)	Changed Description
START DATE (RENAL PAEDIATRIC TRANSITION PROGRAMME)	Changed Description
START DATE (RENAL TREATMENT MODALITY)	Changed Description

START DATE (SYSTEMIC ANTI-CANCER DRUG CYCLE)	Changed Description
START DATE (TREATMENT FOR DIALYSIS RELATED INFECTION)	Changed Description
START DATE (WARD STAY)	Changed Description
START TIME (HOME LEAVE)	Changed Description
START TIME (HOSPITAL PROVIDER SPELL)	Changed Description
START TIME (KIDNEY PERFUSION LEFT KIDNEY)	Changed Description
START TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE)	Changed Description
START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)	Changed Description
START TIME (MENTAL HEALTH LEAVE OF ABSENCE)	Changed Description
START TIME (MENTAL HEALTH TRIAL LEAVE)	Changed Description
SYSTEMIC ANTI-CANCER THERAPY ADMINISTRATION DATE	Changed Description
SYSTEMIC ANTI-CANCER THERAPY REGIMEN MODIFICATION INDICATOR (TIME DELAY)	Changed Description
TNM STAGE GROUPING DATE (FINAL PRETREATMENT)	Changed linked Attribute, Description
TNM STAGE GROUPING DATE (INTEGRATED)	Changed linked Attribute, Description
TRANSFER START DATE TIME (NEONATAL UNIT)	Changed Description
TRANSPLANT PATIENT LAST CONTACT DATE	Changed Description
TREATMENT START DATE (CANCER)	Changed Description
TREATMENT START DATE (RADIOTHERAPY TREATMENT EPISODE)	Changed Description
TWO YEAR NEONATAL OUTCOMES ASSESSMENT DATE	Changed Description
WAITING TIME ADJUSTMENT (TREATMENT)	Changed Description
WILMS TUMOUR STAGE DATE	Changed linked Attribute, Description
WOMEN INVITED FOR SCREENING IN LAST THREE YEARS TOTAL (CALL AND RECALL)	Changed Description
WOMEN INVITED FOR SCREENING IN PERIOD TOTAL (CALL AND RECALL)	Changed Description
WOMEN INVITED TOTAL (OPEN BREAST SCREENING EPISODE)	Changed Description
WOMEN NOT INVITED TOTAL (OPEN BREAST SCREENING EPISODE)	Changed Description
WOMEN SCREENED IN LAST THREE YEARS TOTAL (CALL AND RECALL)	Changed Description
WOMEN SCREENED IN LAST THREE YEARS TOTAL (SELF AND GP REFERRALS)	Changed Description
WOMEN SCREENED IN PERIOD TOTAL (CALL AND RECALL)	Changed Description
WOMEN SCREENED IN PERIOD TOTAL (SELF AND GP REFERRALS)	Changed Description

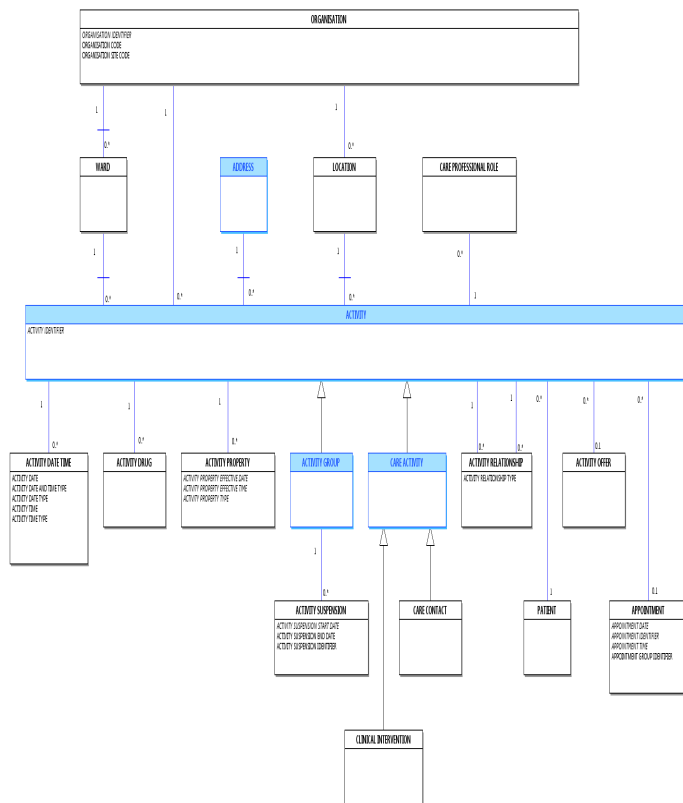
Date: 24 September 2018

Sponsor: Alex Elias, Information Representation Services Director, NHS Digital

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.

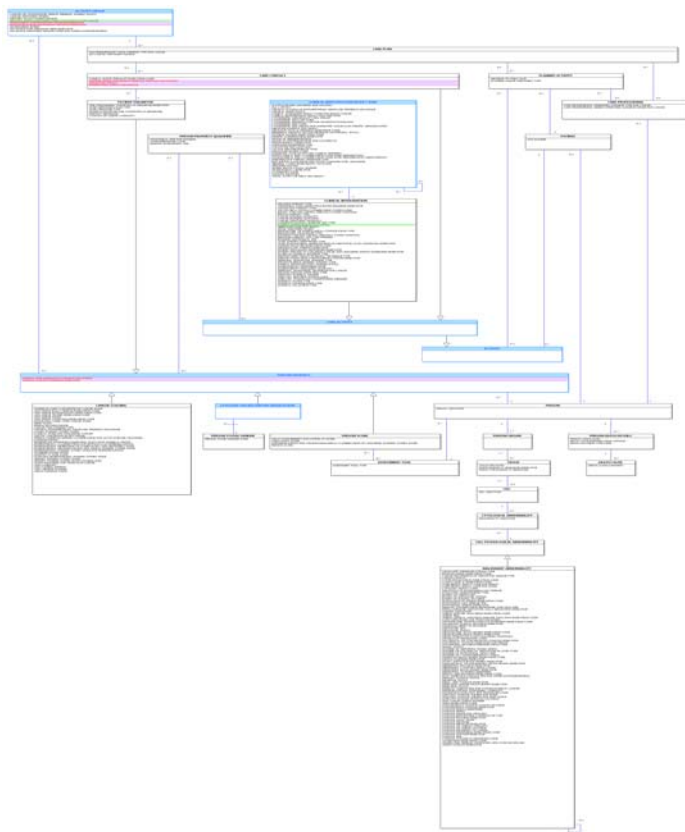
ACTIVITY DIAGRAM

Change to Diagram: Changed Diagram



CANCER OUTCOMES AND SERVICES DIAGRAM

Change to Diagram: Changed Diagram

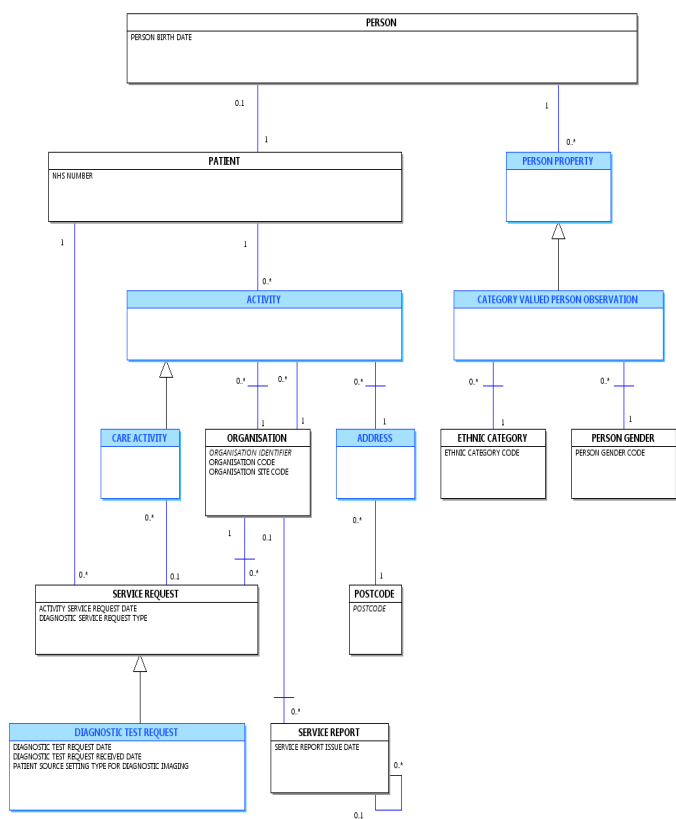


Change to Diagram: Changed Diagram



DIAGNOSTIC IMAGING DIAGRAM

Change to Diagram: Changed Diagram



Change to Diagram: Changed Diagram

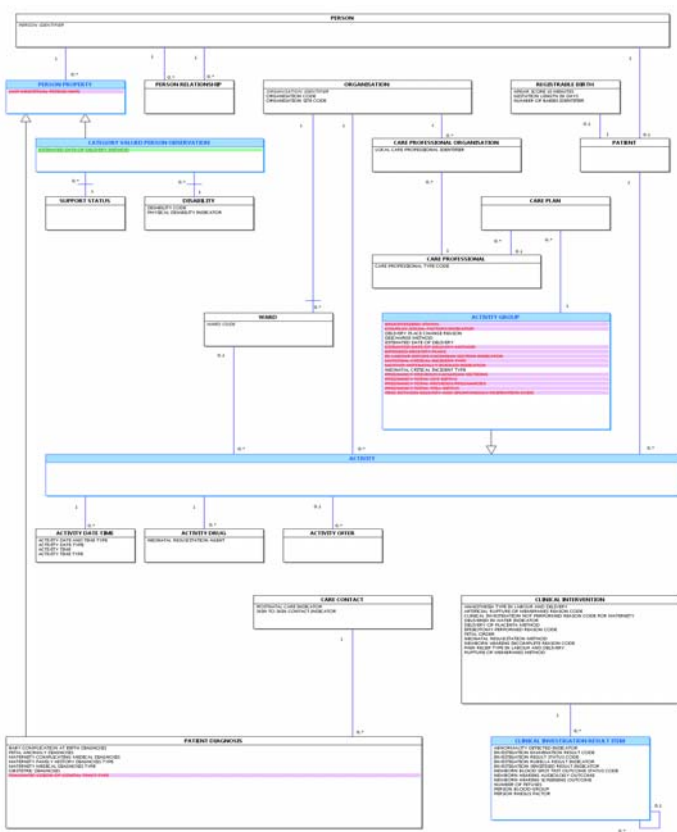


Change to Diagram: Changed Diagram



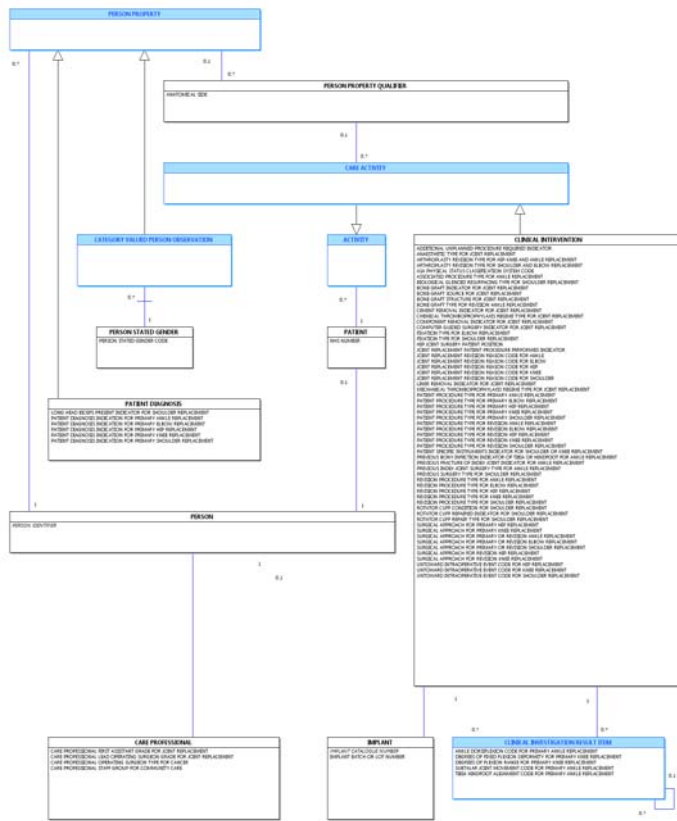
MATERNITY SERVICES DIAGRAM

Change to Diagram: Changed Diagram



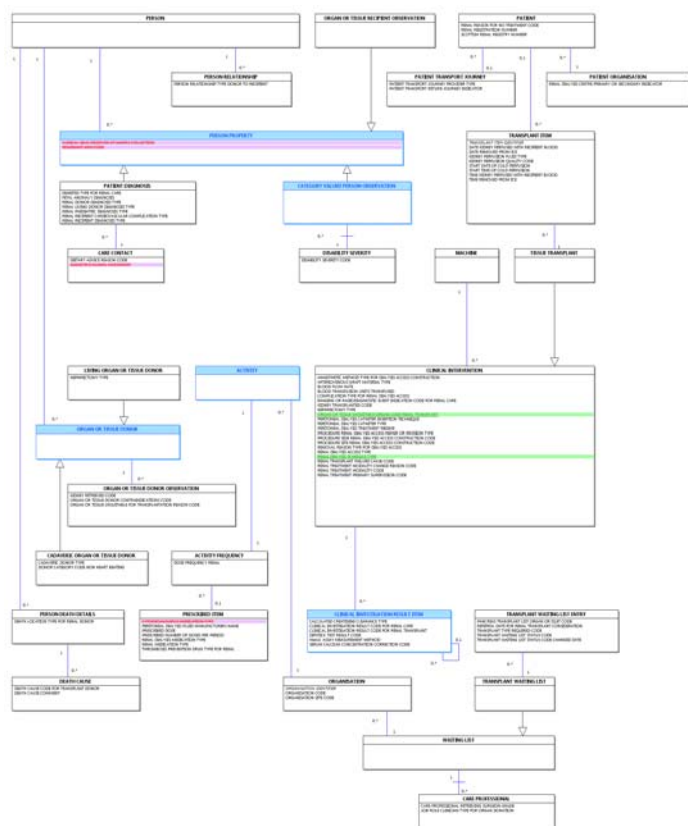
NATIONAL JOINT REGISTRY DIAGRAM

Change to Diagram: Changed Diagram

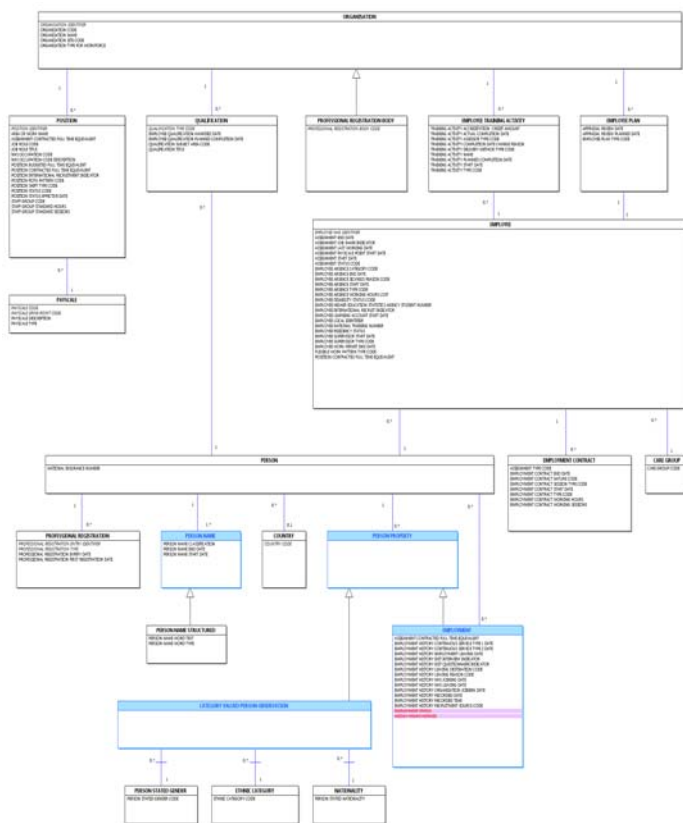


NATIONAL RENAL DIAGRAM

Change to Diagram: Changed Diagram

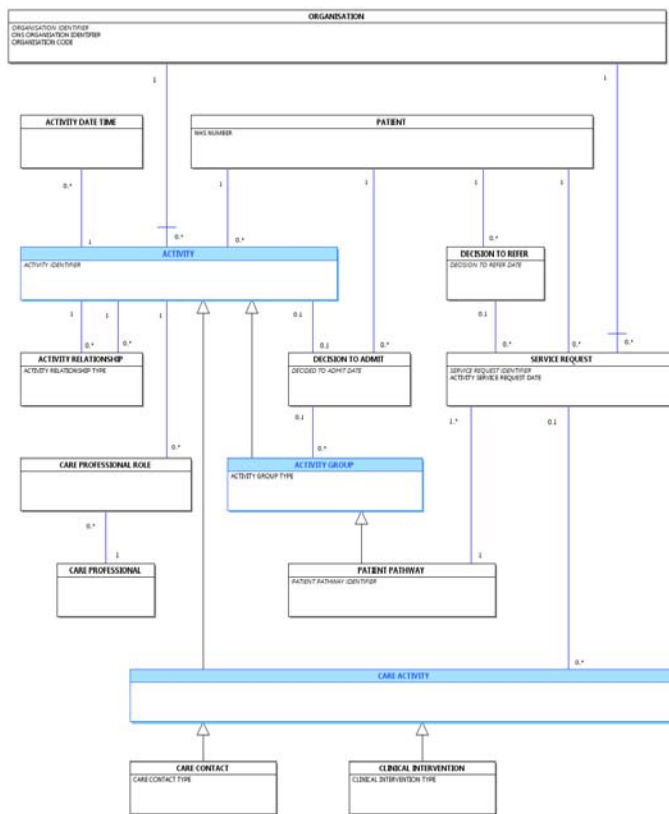


Change to Diagram: Changed Diagram



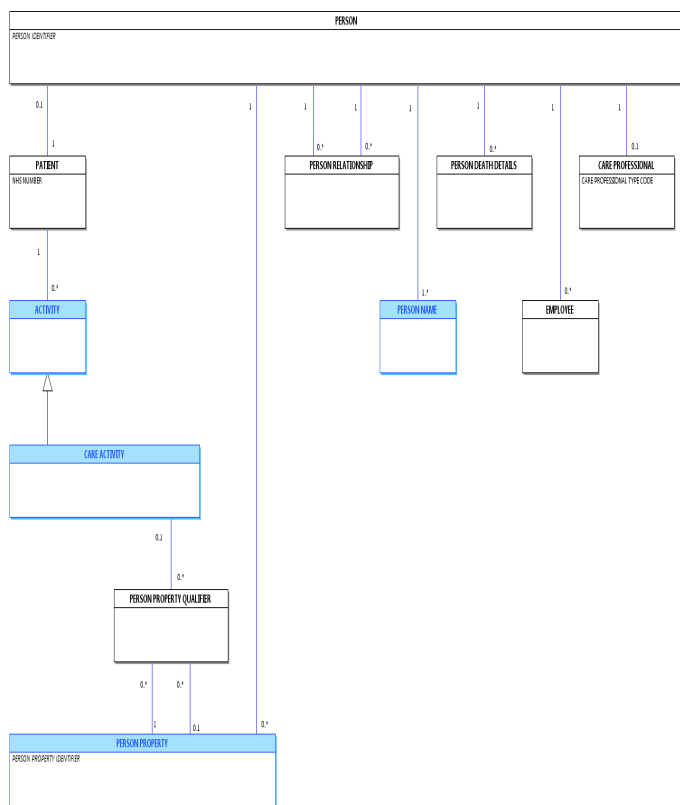
PATIENT PATHWAY DIAGRAM

Change to Diagram: Changed Diagram



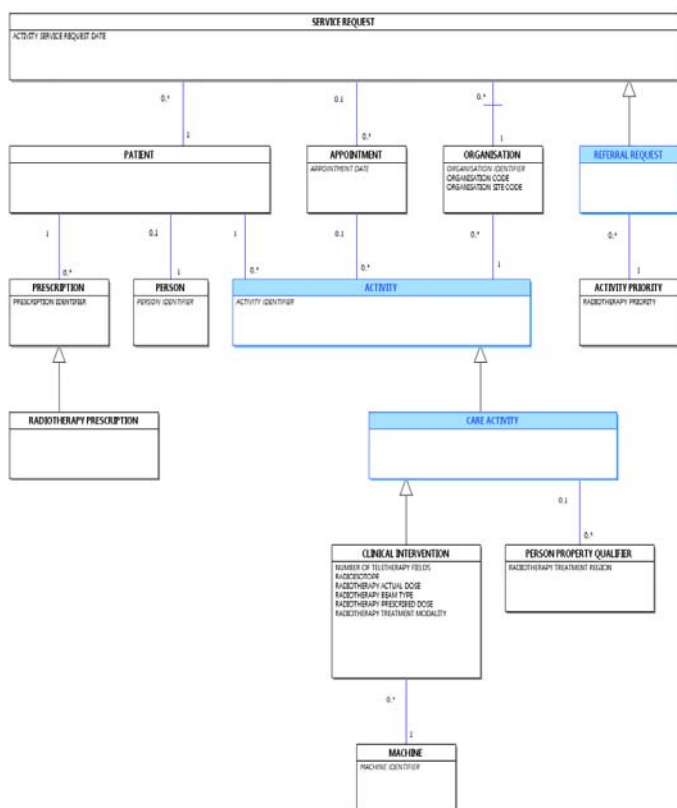
PERSON DIAGRAM

Change to Diagram: Changed Diagram



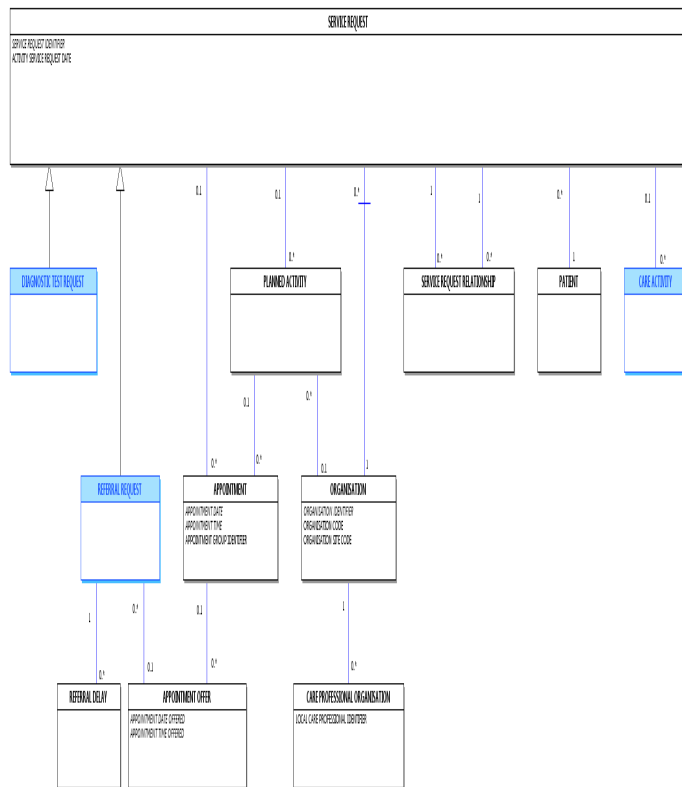
RADIOTHERAPY DIAGRAM

Change to Diagram: Changed Diagram



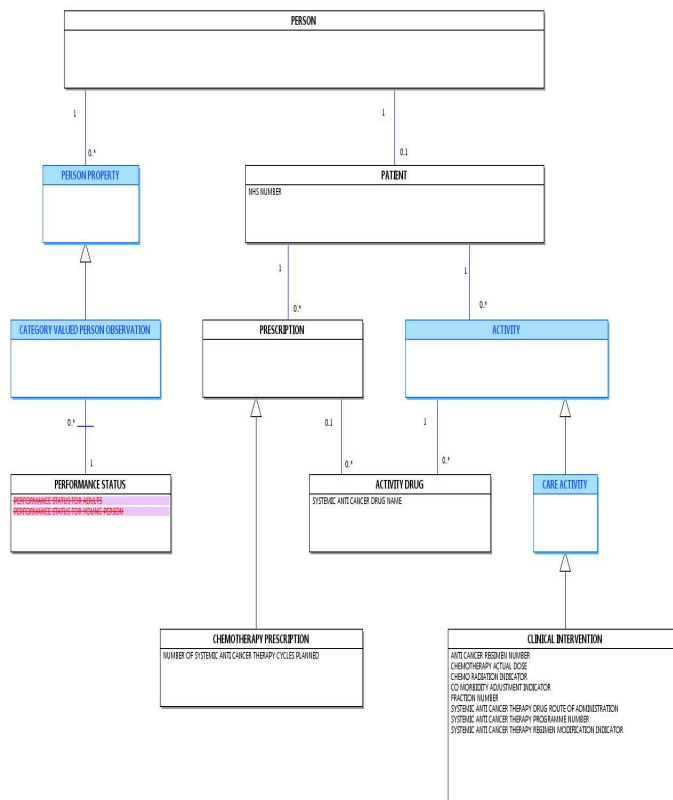
SERVICE REQUEST DIAGRAM

Change to Diagram: Changed Diagram



SYSTEMIC ANTI-CANCER THERAPY DIAGRAM

Change to Diagram: Changed Diagram



Change to Central Return Form: Changed Description

Central Return Form Guidance

[KC53: Adult Screening Programmes: Cervical Screening](#)

This return is in development by the NHS Cancer Screening Programme, therefore the information should not be used. For further information on National Cervical Screening, please see the [NHS Digital website](#).

Part F: Cervical Screening Programme - Test Recall/Status of women following most severe screening result in the year

- This part of the return collects information about the action taken following a woman's most severe test result in a year.
- The women included are those who have had a [Screening Test](#) and are aged 20 to 64. The age is derived from the [PERSON BIRTH DATE](#).

A [Screening Test](#) is a [CLINICAL INTERVENTION](#) where the [CLINICAL INTERVENTION TYPE](#) is National Code 'Screening Test'.

- The data are based on the results of the woman's most severe test in the year and relate to [Screening Tests](#) with a [Screening Test Date](#) between 1 April - 31 March. Classifications are those of [CYTOLOGY RESULT TYPE](#) of a [Request for Pathology Investigation](#) and are in accordance with the categories shown in box 22 of HMR 101/5 Request/Report for Cervical or Vaginal Cytology.

[Screening Test Date](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code 'Screening Test Date'. A [Request for Pathology Investigation](#) is a [DIAGNOSTIC TEST REQUEST](#) where the [DIAGNOSTIC TEST REQUEST TYPE](#) is National Code 'Request for Pathology Investigation.'

Woman's most severe test result in the year

- The women included are those who have had a [Screening Test](#) and are aged 20 to 64. The age is derived from the [PERSON BIRTH DATE](#).
- The data are based on the results of the woman's most severe test in the year and relate to [Screening Tests](#) with a [SCREENING TEST DATE](#) between 1 April - 31 March. Classifications are those of [CYTOLOGY RESULT TYPE](#) of a [Request for Pathology Investigation](#) and are in accordance with the categories shown in box 22 of HMR 101/5 Request/Report for Cervical or Vaginal Cytology.

A [Request for Pathology Investigation](#) is a [DIAGNOSTIC TEST REQUEST](#) where the [DIAGNOSTIC TEST REQUEST TYPE](#) is National Code 'Request for Pathology Investigation.'

Woman's most severe test result in the year

- This is classified by the following [CYTOLOGY RESULT TYPES](#):

Inadequate (cat. 1)
Negative (cat. 2)
Mild dyskaryosis (cat. 3)
Severe dyskaryosis (cat. 4)
Severe dyskaryosis/?invasive carcinoma (cat. 5)
?Glandular neoplasia (cat. 6)
Moderate dyskaryosis (cat. 7)
Borderline changes (cat. 8)

- The return requires a count of the [CYTOLOGY SCREENING ACTION TYPE](#) against each [CYTOLOGY RESULT TYPE](#). The actions are classified into:

Normal (A) -	<i>Standard Primary Care Trust recall interval (Normal) (A)</i>
Suspend (S) -	<i>Refer for medical assessment or under medical treatment (Suspend) (S)</i>
Repeat (R) -	<i>Repeat at interval specified (R)</i>

- The actions are based on result codes 1 to 8 from HMR 101/5, the operational document used by most laboratories for coding the results of cervical smears.
- The actions are based on result codes 1 to 8 from HMR 101/5, the operational document used by most [Laboratories](#) for coding the results of cervical smears.

Change to Central Return Form: Changed Description

Central Return Form Guidance

[KC53: Adult Screening Programmes: Cervical Screening](#)

This return is in development by the NHS Cancer Screening Programme, therefore the information should not be used. For further information on National Cervical Screening, please see the [NHS Digital website](#).

Part A: Cervical Screening Programme - Status of PCT Responsible Population Part A1

- Part A1 of KC53 requires information on the routine recall interval in force in the [Primary Care Trust](#) for the [Screening Programme](#). This is the [CERVICAL SCREENING RECALL INTERVAL](#).

A [Screening Programme](#) is a [HEALTH PROGRAMME](#) where the [HEALTH PROGRAMME TYPE](#) is National Code 06 'Screening Programme'.

Part A2

- Part A2 of KC53 requires information on the [SCREENING STATUS](#) of the [Screening Population](#) - the number of women in [Primary Care Trusts](#) responsible population at 31 March.

[Screening Population](#) is a [HEALTH PROGRAMME POPULATION](#) where the [HEALTH PROGRAMME TYPE](#) is National Code 06 'Screening Programme'.

Age of woman at 31 March (column 4)

- Part A1 of KC53 requires information on the routine recall interval in force in the [Primary Care Trust](#) for the [Screening Programme](#). This is the [CERVICAL SCREENING RECALL INTERVAL](#).

A [Screening Programme](#) is a [HEALTH PROGRAMME](#) where the [HEALTH PROGRAMME TYPE](#) is National Code 'Screening Programme'.

Part A2

- Part A2 of KC53 requires information on the [SCREENING STATUS](#) of the [Screening Population](#) - the number of women in [Primary Care Trusts](#) responsible population at 31 March.

[Screening Population](#) is a [HEALTH PROGRAMME POPULATION](#) where the [HEALTH PROGRAMME TYPE](#) 06 'Screening Programme'.

Age of woman at 31 March (column 1)

- The age bands are derived from the [PERSON BIRTH DATE](#).

Under 20 (line 0001)
20-24 (line 0002)
25-29 (line 0003)
30-34 (line 0004)
35-39 (line 0005)
40-44 (line 0006)
45-49 (line 0007)
50-54 (line 0008)
55-59 (line 0009)
60-64 (line 0010)
65-69 (line 0011)
70-74 (line 0012)
75-79 (line 0013)
80 & over (line 0014)

Number of women resident in Primary Care Trust responsible population (column 2)

- This is the total number of women of all ages derived from the registers maintained by the [Primary Care Trust](#) to ensure compatibility with the other data recorded on the return.

The responsible population includes:

- all patients on the lists of the GPs in the [Primary Care Trust](#);
- and
- the unregistered population who live within the geographical area for which the [Primary Care Trust](#) is responsible.

Number of women recorded as having recall ceased (columns 3, 4 and 5)

- These columns do not include women with the [SCREENING STATUS](#) classification of *Recall suspended*.
- Column 3 counts women in the [Screening Programme](#) with the [SCREENING STATUS](#) classification of *Recall ceased - clinical reasons*. Women no longer eligible for screening due to removal of the cervix are included.

- Column 4 counts the number of women with the [SCREENING STATUS](#) classification of *Recall ceased - age reasons*, and column 5 counts those with the classification of *Recall ceased - other reasons*.

Eligible population (column 6)

- This is calculated by subtracting the number of women in column 3 (i.e. women with the [SCREENING STATUS](#) classification of *Recall ceased - clinical reasons*) from the number in column 2 (i.e. the [Primary Care Trust](#) responsible population).

Number of women whose most recent test was no more than 5 years ago (column 7)

- This is calculated from the addition of columns (2) to (5) in part A3.

Coverage (%) - less than 5 years since last adequate test (column 8)

- This is calculated from columns (6) and (7) in Part A2.

Target Age Group (25-64) (line 0015)

- This counts the number of women in the [Screening Programme](#) aged between 25 and 64 on 31 March (sum of lines 0003 to 0010). Coverage of the [Screening Programme](#) is based on women aged 25 to 64, and not on the NHS Cervical Screening Programme's target population of women aged 20 to 64 who are eligible to receive screening test invitations.

Total all ages (line 9999)

- This is the total for all age groups counted in lines 0001 to 0014 for each category of women.

Change to Central Return Form: Changed Description

Central Return Form Guidance

[KC53: Adult Screening Programmes: Cervical Screening](#)

This return is in development by the NHS Cancer Screening Programme, therefore the information should not be used. For further information on National Cervical Screening, please see the [NHS Digital website](#).

Part A3: Cervical Screening Programme - Screening Status of Eligible Women at 31 March YYYY

- This part of the return collects information specifically about the number of women screened by time since their last test. It includes all women who have had a [Screening Test](#) at any time during their life, even if the test was not part of a call and recall system, but was taken opportunistically. It does not include inadequate tests.

A [Screening Test](#) is a [CLINICAL INTERVENTION](#) where the [CLINICAL INTERVENTION TYPE](#) is National Code 'Screening Test'.

- This part of the return collects information specifically about the number of women screened by time since their last test. It includes all women who have had a [Screening Test](#) at any time during their life, even if the test was not part of a call and recall system, but was taken opportunistically. It does not include inadequate tests.

Age of women at 31 March (column 1)

- The age bands are derived from the [PERSON BIRTH DATE](#).

Under 20 (line 0001)
 20-24 (line 0002)
 25-29 (line 0003)
 30-34 (line 0004)
 35-39 (line 0005)
 40-44 (line 0006)
 45-49 (line 0007)
 50-54 (line 0008)
 55-59 (line 0009)
 60-64 (line 0010)
 65-69 (line 0011)
 70-74 (line 0012)
 75-79 (line 0013)
 80 & over (line 0014)

Number of women whose most recent adequate test was in last 1.5 years (column 2)

Number of women whose most recent adequate test was more than 1.5 years but no more than 3 years ago (column 3)

Number of women whose most recent adequate test was more than 3 years but no more than 3.5 years ago (column 4)

Number of women whose most recent adequate test was more than 3.5 years but no more than 5 years ago (column 5)

Number of women whose most recent adequate test was more than 5 years but no more than 10 years ago (column 6)

Number of women whose most recent adequate test was more than 10 years but no more than 15 years ago (column 7)

Number of women whose most recent adequate test was more than 15 years ago (column 8)

- The [Screening Test Date](#) should be used to derive the count of women tested in the time periods required by the return.

The [Screening Test Date](#) is the same as attribute [ACTIVITY DATE](#) where [ACTIVITY DATE TYPE](#) is National Code '[Screening Test Date](#)'.

- The [SCREENING TEST DATE](#) should be used to derive the count of women tested in the time periods required by the return.

Women called but no adequate smear (column 9)

- This is a count of the number of women who have been invited at any time in their lives but have no adequate smear.

Women called but never attended (column 10)

- This is a count of the number of women who have been invited at any time in their lives but have never attended.

Number of women with no cytology record (column 11)

- This is a count of women in the [Primary Care Trust](#) responsible population with no cervical screening history.

The responsible population includes:

- all patients on the lists of the GPs in the [Primary Care Trust](#);
- and
- the unregistered population who live within the geographical area for which the [Primary Care Trust](#) is responsible.

Target Age Group (25-64) (line 0015)

- This counts the number of women in the [Screening Programme](#) aged between 25 and 64 on 31 March (sum of lines 0003 to 0010). Coverage of the [Screening Programme](#) is based on women aged 25 to 64, and not on the NHS Cervical Screening Programme's target population of women aged 20 to 64 who are eligible to receive [Screening Test Invitations](#).

A [Screening Programme](#) is a [HEALTH PROGRAMME](#) where the [HEALTH PROGRAMME TYPE](#) is National Code 'Screening Programme'.

Total all ages (line 9999)

- This is the total for all age groups counted in lines 0001 to 0014 for each category of women.

Change to Central Return Form: Changed Description

Central Return Form Guidance

KC53: Adult Screening Programmes: Cervical Screening

This return is in development by the NHS Cancer Screening Programme, therefore the information should not be used. For further information on National Cervical Screening, please see the [NHS Digital website](#).

Part B: Cervical Screening Programme - Number of Women Invited

- Part B of KC53 requires age-banded data on the number of women invited for screening. The number invited relates to [Screening Test Invitations](#) with an [APPOINTMENT DATE OFFERED](#) between 1 April and 31 March. This date does not necessarily relate to a due date in the year – e.g. the [Screening Test](#) could be set to take place outside this period. Where a woman is invited on more than one occasion in the year, the last invitation is recorded on KC53.

A [Screening Test Invitation](#) is an [APPOINTMENT](#) associated with an [APPOINTMENT OFFER](#) for a [Screening Test](#).

A [Screening Test](#) is a [CLINICAL INTERVENTION](#) where [CLINICAL INTERVENTION TYPE](#) is National Code 28 'Screening Test'.
Age of woman at 31 March (column 1)

- Part B of KC53 requires age-banded data on the number of women invited for screening, the number invited relates to [Screening Test Invitations](#) with an [APPOINTMENT DATE OFFERED](#) between 1 April and 31 March. This date does not necessarily relate to a due date in the year - e.g. the [Screening Test](#) could be set to take place outside this period. Where a woman is invited on more than one occasion in the year, the last invitation is recorded on KC53.

A [Screening Test Invitation](#) is an [APPOINTMENT](#) associated with an [APPOINTMENT OFFER](#) for a [Screening Test](#).

Age of woman at 31 March (column 1)

- The age bands are derived from the [PERSON BIRTH DATE](#).

Under 20 (line 0001)
20-24 (line 0002)
25-29 (line 0003)
30-34 (line 0004)
35-39 (line 0005)
40-44 (line 0006)
45-49 (line 0007)
50-54 (line 0008)
55-59 (line 0009)
60-64 (line 0010)
65-69 (line 0011)
70-74 (line 0012)
75 & over (line 0013)

Call (column 2)

- A count of the number of women invited for their first screen i.e. those who have never been screened before. The [INVITATION TYPE](#) of the [Screening Test Invitation](#) will have the classification *First call*.

Routine recall (column 3)

- A count of the number of women invited for screening in the year as a result of a routine recall for screening. These women will have had a previous negative result and been recalled after the usual interval (3 to 5 years). The [INVITATION TYPE](#) of the [Screening Test Invitation](#) will have the classification *Routine recall*.

Surveillance (column 4)

- A count of the number of women invited for early screening because of a previous abnormal screening result or following treatment for cervical abnormalities. The [INVITATION TYPE](#) of the [Screening Test Invitation](#) will have the classification *Repeat in less than three years for surveillance*.

Abnormality (column 5)

- A count of the number of women invited for early screening because their last smear showed some abnormality and a repeat was advised. The [INVITATION TYPE](#) of the [Screening Test Invitation](#) will have the classification *Repeat in less than three years because of abnormality*.

Inadequate smear (column 6)

- A count of the number of women invited for screening because their last smear was inadequate. The [INVITATION TYPE](#) of the [Screening Test Invitation](#) will have either the classification *Repeat in less than three years because of inadequate smear*, or the classification *Technical recall (inadequate test)*.

Target age group (line 0014)

- This counts the number of women in the [Screening Programme](#) aged between 20 and 64 on 31 March (sum of lines 0002 to 0010).

A [Screening Programme](#) is a [HEALTH PROGRAMME](#) where the [HEALTH PROGRAMME TYPE](#) is National Code 06 'Screening Programme'.

Total all ages (line 9999)

- This counts the number of women in the [Screening Programme](#) aged between 20 and 64 on 31 March (sum of lines 0002 to 0010).

A [Screening Programme](#) is a [HEALTH PROGRAMME](#) where the [HEALTH PROGRAMME TYPE](#) is National Code 'Screening Programme'.

Total all ages (line 9999)

- This is the total for all age groups counted in lines 0001 to 0013 for each [INVITATION TYPE](#).

Change to Central Return Form: Changed Description

Central Return Form Guidance

KC53: Adult Screening Programmes: Cervical Screening

This return is in development by the NHS Cancer Screening Programme, therefore the information should not be used. For further information on National Cervical Screening, please see the [NHS Digital website](#).

Part C1: Cervical Screening Programme - Number of Women Tested - by Age

- Part C1 of KC53 requires data on the women screened in the year, by invitation or opportunistically. The number screened relates to [Screening Tests](#) with a [Screening Test Date](#) between 1 April and 31 March. Where a woman is screened more than once in the year, for whatever reason, her [INVITATION TYPE](#) at her first [Screening Test Date](#) in the review period is to be recorded.

A [Screening Test](#) is a [CLINICAL INTERVENTION](#) where the [CLINICAL INTERVENTION TYPE](#) is National Code 'Screening Test'. [Screening Test Date](#) is the same as attribute [ACTIVITY DATE](#) where [ACTIVITY DATE TYPE](#) is National Code 'Screening Test'.

Call (column 2)

- Part C1 of KC53 requires data on the women screened in the year, by invitation or opportunistically. The number screened relates to [Screening Tests](#) with a [SCREENING TEST DATE](#) between 1 April and 31 March. Where a woman is screened more than once in the year, for whatever reason, her [INVITATION TYPE](#) at her first [SCREENING TEST DATE](#) in the review period is to be recorded.

Call (column 2)

- A count of the number of women screened in the year as a result of a first call for screening within 12 months of the original invitation. These women will not have been screened before. The [INVITATION TYPE](#) of the [Screening Test Invitation](#) will have the classification *First call*.

A [Screening Test Invitation](#) is an [APPOINTMENT](#) associated with an [APPOINTMENT OFFER](#) for a [Screening Test](#).

Routine recall (column 3)

- A count of the number of women screened in the year as a result of a routine recall for screening within 12 months of the recall invitation. These women will have had a previous negative result and been recalled after the usual interval (3 to 5 years). The [INVITATION TYPE](#) of the [Screening Test Invitation](#) will have the classification *Routine recall*.

Surveillance (column 4)

- A count of the number of women screened in the year as a result of a non-routine recall for screening within 12 months of the recall invitation. The [INVITATION TYPE](#) of the [Screening Test Invitation](#) will have the classification *Repeat in less than 3 years for surveillance*.

Abnormality (column 5)

- A count of the number of women screened in the year as a result of a non-routine recall for screening within 12 months of the recall invitation. These women will usually have had a recent mildly abnormal smear. The [INVITATION TYPE](#) of the [Screening Test Invitation](#) will have the classification *Repeat in less than 3 years because of abnormality*.

Inadequate smear (column 6)

- Enter the number of women screened in the year as a result of a technical recall within 12 months of the recall invitation. The [INVITATION TYPE](#) of the [Screening Test Invitation](#) will have either the classification *Repeat in less than 3 years because of inadequate smear* or the classification *Technical recall (inadequate test)*.

While recall suspended (column 7)

- A count of the number of women screened in the year who were suspended from the call and recall system at the time of their [Screening Test Date](#). These women will have had a [Screening Test](#) with the [OPPORTUNISTIC SCREENING TYPE](#) classification of 'screened while recall suspended'.

A [Screening Test](#) is a [CLINICAL INTERVENTION](#) where the [CLINICAL INTERVENTION TYPE](#) is National Code 'Screening Test'.

While recall ceased (column 8)

- A count of the number of women screened opportunistically in the year who were ceased from the call and recall system at the time of their [Screening Test Date](#). These women will have had a [Screening Test](#) with the [OPPORTUNISTIC SCREENING TYPE](#) classification of 'screened while recall ceased'.

Not invited by Programme (column 9)

- A count of the number of women screened in the year who were suspended from the call and recall system at the time of their [SCREENING TEST DATE](#). These women will have had a [Screening Test](#) with the [OPPORTUNISTIC SCREENING TYPE](#) classification of 'screened while recall suspended'.

While recall ceased (column 8)

- A count of the number of women screened opportunistically in the year who were ceased from the call and recall system at the time of their SCREENING TEST DATE. These women will have had a Screening Test with the OPPORTUNISTIC SCREENING TYPE classification of *'screened while recall ceased'*.

Not Invited by Programme (column 9)

- A count of the number of women screened opportunistically during the year. This includes all women whose Recall Status was "No action", "GP not informed", "GP informed", "ZZZ GP" and those women whose Recall Status was "Final non-responder" where the initial invitation was generated more than 12 months ago. These women will have had a Screening Test with the OPPORTUNISTIC SCREENING TYPE classification of *'not invited by programme'*.

Target age group (line 0014)

- This counts the number of women in the Screening Programme aged between 20 and 64 on 31 March (sum of lines 0002 to 0010).

Total all women (line 9999)

- This is the total for all age groups counted in lines 0001 to 0013 for each INVITATION TYPE or women who have had a Screening Test with the OPPORTUNISTIC SCREENING TYPE recorded.

Change to Central Return Form: Changed Description

Central Return Form Guidance

KC53: Adult Screening Programmes: Cervical Screening

This return is in development by the NHS Cancer Screening Programme, therefore the information should not be used. For further information on National Cervical Screening, please see the [NHS Digital website](#).

Part C2: Cervical Screening Programme - Number of Women Tested - by Result

- Part C2 of KC53 requires data on the women aged 20 – 64 screened in the year, by invitation or opportunistically. The number screened relates to [Screening Tests](#) with a [Screening Test Date](#) between 1 April and 31 March. Where a woman is screened more than once in the year, for whatever reason, her [INVITATION TYPE](#) at her first [Screening Test Date](#) in the review period is to be recorded.

A [Screening Test](#) is a [CLINICAL INTERVENTION](#) where the [CLINICAL INTERVENTION TYPE](#) is National Code 'Screening Test'. [Screening Test Date](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code 'Screening Test Date'.

Call (column 2)

- Part C2 of KC53 requires data on the women aged 20 - 64 screened in the year, by invitation or opportunistically. The number screened relates to [Screening Tests](#) with a [SCREENING TEST DATE](#) between 1 April and 31 March. Where a woman is screened more than once in the year, for whatever reason, her [INVITATION TYPE](#) at her first [SCREENING TEST DATE](#) in the review period is to be recorded.

Call (column 2)

- A count of the number of women screened in the year as a result of a first call for screening within 12 months of the original invitation. These women will not have been screened before. The [INVITATION TYPE](#) of the [Screening Test Invitation](#) will have the classification *First call*.

A [Screening Test Invitation](#) is an [APPOINTMENT](#) associated with an [APPOINTMENT OFFER](#) for a [Screening Test](#).

Routine recall (column 3)

- A count of the number of women screened in the year as a result of a routine recall for screening within 12 months of the recall invitation. These women will have had a previous negative result and been recalled after the usual interval (3 to 5 years). The [INVITATION TYPE](#) of the [Screening Test Invitation](#) will have the classification *Routine recall*.

Surveillance (column 4)

- A count of the number of women screened in the year as a result of a non-routine recall for screening within 12 months of the recall invitation. The [INVITATION TYPE](#) of the [Screening Test Invitation](#) will have the classification *Repeat in less than 3 years for surveillance*.

Abnormality (column 5)

- A count of the number of women screened in the year as a result of a non-routine recall for screening within 12 months of the recall invitation. These women will usually have had a recent mildly abnormal smear. The [INVITATION TYPE](#) of the [Screening Test Invitation](#) will have the classification *Repeat in less than 3 years because of abnormality*.

Inadequate smear (column 6)

- Enter the number of women screened in the year as a result of a technical recall within 12 months of the recall invitation. The [INVITATION TYPE](#) of the [Screening Test Invitation](#) will have either the classification *Repeat in less than 3 years because of inadequate smear* or the classification *Technical recall (inadequate test)*.

While recall suspended (column 7)

- A count of the number of women screened in the year who were suspended from the call and recall system at the time of their [Screening Test Date](#). These women will have had a [Screening Test](#) with the [OPPORTUNISTIC SCREENING TYPE](#) classification of 'screened while recall suspended'.

A [Screening Test](#) is a [CLINICAL INTERVENTION](#) where the [CLINICAL INTERVENTION TYPE](#) is National Code 'Screening Test'.

While recall ceased (column 8)

- A count of the number of women screened opportunistically in the year who were ceased from the call and recall system at the time of their [Screening Test Date](#). These women will have had a [Screening Test](#) with the [OPPORTUNISTIC SCREENING TYPE](#) classification of 'screened while recall ceased'.

Not invited by Programme (column 9)

- A count of the number of women screened in the year who were suspended from the call and recall system at the time of their [SCREENING TEST DATE](#). These women will have had a [Screening Test](#) with the [OPPORTUNISTIC SCREENING TYPE](#) classification of 'screened while recall suspended'.

While recall ceased (column 8)

- A count of the number of women screened opportunistically in the year who were ceased from the call and recall system at the time of their SCREENING TEST DATE. These women will have had a Screening Test with the OPPORTUNISTIC SCREENING TYPE classification of *'screened while recall ceased'*.

Not Invited by Programme (column 9)

- A count of the number of women screened opportunistically during the year. This includes all women whose Recall Status was "No action", "GP not informed", "GP informed", "ZZZ GP" and those women whose Recall Status was "Final non-responder" where the initial invitation was generated more than 12 months ago. These women will have had a Screening Test with the OPPORTUNISTIC SCREENING TYPE classification of *'not invited by programme'*.

Result of test

- This is classified by the following CYTOLOGY RESULT TYPES:

Inadequate (cat. 1) (line 0001)

Negative (cat. 2) (line 0002)

Borderline changes (cat. 8) (line 0003)

Mild dyskaryosis (cat. 3) (line 0004)

Moderate dyskaryosis (cat. 7) (line 0005)

Severe dyskaryosis (cat. 4) (line 0006)

Severe dyskaryosis/?invasive carcinoma (cat. 5) (line 0007)

?Glandular neoplasia (cat. 6) (line 0008)

Total women tested aged 20-64 (line 9999)

- This counts the number of women in the Screening Programme aged between 20 and 64 on 31 March (sum of lines 0001 to 0008).

A Screening Programme is a HEALTH PROGRAMME where the HEALTH PROGRAMME TYPE is National Code 'Screening Programme'.

Change to Central Return Form: Changed Description

Central Return Form Guidance

KC53: Adult Screening Programmes: Cervical Screening

This return is in development by the NHS Cancer Screening Programme, therefore the information should not be used. For further information on National Cervical Screening, please see the [NHS Digital website](#).

Part C3: Cervical Screening Programme - Number of Tests - by Result

- Part C3 of KC53 requires data on all tests in the review period, not limited to the target age group 20 – 64, by invitation or opportunistically. The number screened relates to [Screening Tests](#) with a [Screening Test Date](#) between 1 April and 31 March. Where a woman is screened more than once in the year, for whatever reason, her [INVITATION TYPE](#) at her first [Screening Test Date](#) in the review period is to be recorded.

A [Screening Test](#) is a [CLINICAL INTERVENTION](#) where the [CLINICAL INTERVENTION TYPE](#) is National Code 'Screening Test'. [Screening Test Date](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Screening Test Date](#)'.

Call (column 2)

- Part C3 of KC53 requires data on all tests in the review period, not limited to the target age group 20 - 64, by invitation or opportunistically. The number screened relates to [Screening Tests](#) with a [SCREENING TEST DATE](#) between 1 April and 31 March. Where a woman is screened more than once in the year, for whatever reason, her [INVITATION TYPE](#) at her first [SCREENING TEST DATE](#) in the review period is to be recorded.

Call (column 2)

- A count of the number of tests in the year as a result of a first call for screening within 12 months of the original invitation. These women will not have been screened before. The [INVITATION TYPE](#) of the [Screening Test Invitation](#) will have the classification *First call*.

A [Screening Test Invitation](#) is an [APPOINTMENT](#) associated with an [APPOINTMENT OFFER](#) for a [Screening Test](#).

Routine recall (column 3)

- A count of the number of tests in the year as a result of a routine recall for screening within 12 months of the recall invitation. These women will have had a previous negative result and been recalled after the usual interval (3 to 5 years). The [INVITATION TYPE](#) of the [Screening Test Invitation](#) will have the classification *Routine recall*.

Surveillance (column 4)

- A count of the number of tests in the year as a result of a non-routine recall for screening within 12 months of the recall invitation. The [INVITATION TYPE](#) of the [Screening Test Invitation](#) will have the classification *Repeat in less than 3 years for surveillance*.

Abnormality (column 5)

- A count of the number of tests in the year as a result of a non-routine recall for screening within 12 months of the recall invitation. These women will usually have had a recent mildly abnormal smear. The [INVITATION TYPE](#) of the [Screening Test Invitation](#) will have the classification *Repeat in less than 3 years because of abnormality*.

Inadequate smear (column 6)

- Enter the number of tests in the year as a result of a technical recall within 12 months of the recall invitation. The [INVITATION TYPE](#) of the [Screening Test Invitation](#) will have either the classification *Repeat in less than 3 years because of inadequate smear* or the classification *Technical recall (inadequate test)*.

While recall suspended (column 7)

- A count of the number of tests in the year of women who were suspended from the call and recall system at the time of their [Screening Test Date](#). These women will have had a [Screening Test](#) with the [OPPORTUNISTIC SCREENING TYPE](#) classification of '*Screened while recall suspended*'.

A [Screening Test](#) is a [CLINICAL INTERVENTION](#) where the [CLINICAL INTERVENTION TYPE](#) is National Code 'Screening Test'.

While recall ceased (column 8)

- A count of the number of tests in the year of women who were ceased from the call and recall system at the time of their [Screening Test Date](#). These women will have had a [Screening Test](#) with the [OPPORTUNISTIC SCREENING TYPE](#) classification of '*screened while recall ceased*'.

Not invited by Programme (column 9)

- A count of the number of tests in the year of women who were suspended from the call and recall system at the time of their [SCREENING TEST DATE](#). These women will have had a [Screening Test](#) with the [OPPORTUNISTIC SCREENING TYPE](#) classification of '*Screened while recall suspended*'.

While recall ceased (column 8)

- A count of the number of tests in the year of women who were ceased from the call and recall system at the time of their [SCREENING TEST DATE](#). These women will have had a [Screening Test](#) with the [OPPORTUNISTIC SCREENING TYPE](#) classification of '*screened while recall ceased*'.

Not Invited by Programme (column 9)

- A count of the number of opportunistic tests during the year. This includes all women whose Recall Status was "No action", "GP not informed", "GP informed", "ZZZ GP" and those women whose Recall Status was "Final non-responder" where the initial invitation was generated more than 12 months ago. These women will have had a [Screening Test](#) with the [OPPORTUNISTIC SCREENING TYPE](#) classification '*not invited by programme*'.

Result of test

- This is classified by the following [CYTOLOGY RESULT TYPES](#):

Inadequate (cat. 1) (line 0001)

Negative (cat. 2) (line 0002)

Borderline changes (cat. 8) (line 0003)

Mild dyskaryosis (cat. 3) (line 0004)

Moderate dyskaryosis (cat. 7) (line 0005)

Severe dyskaryosis (cat. 4) (line 0006)

Severe dyskaryosis/?invasive carcinoma (cat. 5) (line 0007)

?Glandular neoplasia (cat. 6) line 0008)

Total all results (line 9999)

- This counts the number of tests in the [Screening Programme](#) for all age groups on 31 March (sum of lines 0001 to 0008).

A [Screening Programme](#) is a [HEALTH PROGRAMME](#) where the [HEALTH PROGRAMME TYPE](#) is National Code '*Screening Programme*'.

Change to Central Return Form: Changed Description

Central Return Form Guidance

KC53: Adult Screening Programmes: Cervical Screening

This return is in development by the NHS Cancer Screening Programme, therefore the information should not be used. For further information on National Cervical Screening, please see the [NHS Digital website](#).

Part D: Cervical Screening Programme - Result of Test

- Part D of KC53 requires age-banded data on the most severe results of cervical screening tests recorded during the year. It does not include inadequate tests. Where a woman has only one smear tested in the year which turns out to be inadequate, or more than one, all of which are inadequate, no entry is required.
- The data are based on the results of the woman's most severe test in the year and relate to [Screening Tests](#) with a [Screening Test Date](#) between 1 April - 31 March. Classifications are those of [CYTOLOGY RESULT TYPES](#) of a [Request for Pathology Investigation](#) and are in accordance with the categories shown in box 22 of HMR 101/5 Request/Report for Cervical or Vaginal Cytology.

A [Screening Test](#) is a [CLINICAL INTERVENTION](#) where the [CLINICAL INTERVENTION TYPE](#) is National Code 'Screening Test'. [Screening Test Date](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code 'Screening Test Date'.

A [Request for Pathology Investigation](#) is a [DIAGNOSTIC TEST REQUEST](#) where the [DIAGNOSTIC TEST REQUEST TYPE](#) is National Code 'Request for Pathology Investigation.'

Negative (column 2)

- The data are based on the results of the woman's most severe test in the year and relate to [Screening Tests](#) with a [SCREENING TEST DATE](#) between 1 April - 31 March. Classifications are those of [CYTOLOGY RESULT TYPES](#) of a [Request for Pathology Investigation](#) and are in accordance with the categories shown in box 22 of HMR 101/5 Request/Report for Cervical or Vaginal Cytology.

A [Request for Pathology Investigation](#) is a [DIAGNOSTIC TEST REQUEST](#) where the [DIAGNOSTIC TEST REQUEST TYPE](#) is National Code 'Request for Pathology Investigation.'

Negative (column 2)

- A count of the number of women with a [CYTOLOGY RESULT TYPE](#) classification of *Negative (cat. 2)*.

Borderline (column 3)

- A count of the number of women whose most severe [CYTOLOGY RESULT TYPE](#) classification was *Borderline changes (cat. 8)*.

Mild dyskaryosis (column 4)

- A count of the number of women whose most severe [CYTOLOGY RESULT TYPE](#) classification was *Mild dyskaryosis (column 4)*.

Moderate dyskaryosis (column 5)

- A count of the number of women whose most severe [CYTOLOGY RESULT TYPE](#) classification was *Moderate dyskaryosis (cat. 7)*.

Severe dyskaryosis (column 6)

- A count of the number of women whose most severe [CYTOLOGY RESULT TYPE](#) classification was *Severe dyskaryosis (cat. 4)*.

Severe dyskaryosis/?invasive carcinoma (column 7)

- A count of the number of women whose most severe [CYTOLOGY RESULT TYPE](#) classification was *Severe dyskaryosis/?invasive carcinoma (cat. 5)*.

?Glandular neoplasia (column 8)

- A count of the number of women whose most severe [CYTOLOGY RESULT TYPE](#) classification was *?Glandular neoplasia (cat. 6)*.

Target age group (line 0014)

- This counts the number of women in the [Screening Programme](#) aged between 20 and 64 on 31 March (sum of lines 0002 to 0010).

A [Screening Programme](#) is a [HEALTH PROGRAMME](#) where the [HEALTH PROGRAMME TYPE](#) is National Code 'Screening Programme'.

Total all ages (line 9999)

- This is the total for all age groups counted in lines 0001 to 0013 for each [CYTOLOGY RESULT TYPE](#) classification.

Change to Central Return Form: Changed Description

Central Return Form Guidance

KC53: Adult Screening Programmes: Cervical Screening

This return is in development by the NHS Cancer Screening Programme, therefore the information should not be used. For further information on National Cervical Screening, please see the [NHS Digital website](#).

Part E: Cervical Screening Programme - Notification of Result - Waiting Times

- This part of the return requires information on the length of time elapsing between a woman taking a smear test and when notification of the result is sent to her by the call and recall service. The national standard to be achieved is that women should be advised in writing of the result of their test four weeks from the date the test was taken. The information is used to monitor the performance of [Screening Programmes](#) and laboratories.

A [Screening Programme](#) is a [HEALTH PROGRAMME](#) where the [HEALTH PROGRAMME TYPE](#) is National Code 'Screening Programme'.

- The return also collects information on those instances where the letter is sent directly by the laboratory or by some other agency instead of by the call and recall service.
- This part of the return requires information on the length of time elapsing between a woman taking a smear test and when notification of the result is sent to her by the call and recall service. The national standard to be achieved is that women should be advised in writing of the result of their test four weeks from the date the test was taken. The information is used to monitor the performance of [Screening Programmes](#) and Laboratories.

A [Screening Programme](#) is a [HEALTH PROGRAMME](#) where the [HEALTH PROGRAMME TYPE](#) is National Code 'Screening Programme'.

- The return also collects information on those instances where the letter is sent directly by the [Laboratory](#) or by some other agency instead of by the call and recall service.
- The return counts all tests and not just those tests with the most severe result. It includes only smears taken as part of a NHS [Screening Programme](#).

Number of weeks between date smear is taken and date result is sent from the call and recall service

- This is the number of weeks between the [Screening Test Date](#) and the [Screening Result Sent Date](#) of the [Screening Test](#), where the [RESULT SENT DIRECT](#) indicator is Yes.

A [Screening Test](#) is a [CLINICAL INTERVENTION](#) where the [CLINICAL INTERVENTION TYPE](#) is National Code 'Screening Test'. [Screening Test Date](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code 'Screening Test Date'. [Screening Result Sent Date](#) is the same as attribute [ACTIVITY DATE](#) where [ACTIVITY DATE TYPE](#) is National Code 'Screening Result Sent Date'.

- This is the number of weeks between the [SCREENING TEST DATE](#) and the [Screening Result Sent Date](#) of the [Screening Test](#), where the [RESULT SENT DIRECT](#) indicator is Yes.

[Screening Result Sent Date](#) is the same as attribute [ACTIVITY DATE](#) where [ACTIVITY DATE TYPE](#) is National Code 'Screening Result Sent Date'.

- They are sub-divided into the following time periods:

- Less than or equal to four weeks (line 0001)
- > 4 weeks up to 6 weeks (line 0002)
- > 6 weeks up to 8 weeks (line 0003)
- > 8 weeks up to 10 weeks (line 0004)
- > 10 weeks up to 12 weeks (line 0005)
- > Over 12 weeks (line 0006)

Number of tests (column 2)

- This counts the number of [Screening Tests](#) where results were sent from the call and recall service for each time period.

Total (line 0007)

- This is the total of [Screening Tests](#) for all time periods counted in lines 0001 to 0006.

Letter not sent by the call and recall service (line 0008)

- This counts the number of [Screening Tests](#) where the [RESULT SENT DIRECT](#) indicator is No, indicating that the result was not sent by the call and recall service.

Change to Central Return Form: Changed Description

Central Return Form Guidance

KC61: Pathology Laboratories - Cervical Cytology and Outcome of Gynaecological Referrals

This return is in development by the NHS Cancer Screening Programme, therefore the information should not be used. For further information on National Cervical Screening, please see the [NHS Digital website](#).

Contextual Overview

- The [Department of Health and Social Care](#), NHS Cervical Screening Programme (NHSCSP), [Strategic Health Authorities](#) and trusts require information from [Pathology Laboratories](#) on cervical cytology and outcome of referrals.

A [Pathology Laboratory](#) is a [Laboratory](#).

- The information helps to monitor the process of achieving the Government's target to reduce the incidence of invasive cervical cancer and to ensure that the screening programme is managed effectively. The information is used to ensure that the [Laboratory](#) is achieving acceptable standards in examining smears in line with guidance provided by the NHS Cervical Screening Programme.
- The information helps to monitor the process of achieving the Government's target to reduce the incidence of invasive cervical cancer and to ensure that the screening programme is managed effectively. The information is used to ensure that the [Laboratory](#) is achieving acceptable standards in examining smears in line with guidance provided by the NHS Cervical Screening Programme.
- Information on the return is also used in Public Expenditure Survey (PES) negotiations, resource allocation to the NHS and Departmental accountability.
- Information based on the KC61 return is published annually by the Department in the Statistical Bulletin 'Cervical Screening Programme'.

Completing Return KC61: Pathology Laboratories - Cervical Cytology and Outcome of Referrals

- KC61 returns are required by all [Pathology Laboratories](#) carrying out cervical cytology within NHS [Health Care Providers](#). This applies to independently managed NHS laboratories, including cytopathology laboratories and also private laboratories if they are commissioned to report on smears for the NHS.

Each return requires the [ORGANISATION CODE](#) and [ORGANISATION NAME](#) of the [NHS Trust](#) and must be signed by a [CONSULTANT](#) in one of the Pathology [MAIN SPECIALTY CODES](#). It also requires the pathology [LABORATORY NAME](#) and pathology [LABORATORY CODE](#). Note that pathology [LABORATORY CODES](#) are maintained and issued by the [Organisation Data Service](#) on behalf of the NHS Cervical Screening Programme.

- A [Pathology Laboratory's](#) KC61 return should include all the original [Requests for Pathology Investigation](#) received by that laboratory. A [Request for Pathology Investigation](#) forwarded to another laboratory should only be included in the first laboratory's return (except Part A3).

A [Request for Pathology Investigation](#) is a [DIAGNOSTIC TEST REQUEST](#) where the [DIAGNOSTIC TEST REQUEST](#) is National Code 03 'Request for Pathology Investigation'.

- Smears re-screened within the same [Laboratory](#) as part of internal or external quality control or for any other reason should not be included in the KC61 return. The number of requests sent to or received from another [Laboratory](#) for primary screening or other reason should be recorded in Part A3.
- KC61 returns are required by all [Pathology Laboratories](#) carrying out cervical cytology within NHS [Health Care Providers](#). This applies to independently managed NHS [Laboratories](#), including cytopathology [Laboratories](#) and also private [Laboratories](#) if they are commissioned to report on smears for the NHS.

Each return requires the [ORGANISATION CODE](#) and [ORGANISATION NAME](#) of the [NHS Trust](#) and must be signed by a [CONSULTANT](#) in one of the Pathology [MAIN SPECIALTY CODES](#). It also requires the pathology [LABORATORY NAME](#) and pathology [LABORATORY CODE](#). Note that pathology [LABORATORY CODES](#) are maintained and issued by the [Organisation Data Service](#) on behalf of the NHS Cervical Screening Programme.

- A [Pathology Laboratory's](#) KC61 return should include all the original [Requests for Pathology Investigation](#) received by that laboratory. A [Request for Pathology Investigation](#) forwarded to another [Laboratory](#) should only be included in the first laboratory's return (except Part A3).

A [Request for Pathology Investigation](#) is a [DIAGNOSTIC TEST REQUEST](#) where the [DIAGNOSTIC TEST REQUEST](#) is National Code 'Request for Pathology Investigation'.

- Smears re-screened within the same [Laboratory](#) as part of internal or external quality control or for any other reason should not be included in the KC61 return. The number of requests sent to or received from another [Laboratory](#) for primary screening or other reason should be recorded in Part A3.
- Where more than one slide is associated with one [Request for Pathology Investigation](#), only the most significant [CYTOLOGY RESULT TYPES](#) may be counted for the KC61.
- The return KC61 is completed annually and submitted within two months of the end of the period.

- Parts A and B of the return relate to all smears reported by the laboratory where the smear was received and registered between 1 April of one year and 31 March of the following year. If this date is not recorded, the CERVICAL SMEAR EXAMINED DATE can be used as a proxy. Part C1 of the return relates to smears where the date of the smear which led to a referral fell in the first three months of the financial year (April, May and June). Part C2 is a duplicate of Part C1, but will collect data relating to gynaecological referrals from smears registered during the whole of the financial year *prior to* the current year.
- Parts A and B of the return relate to all smears reported by the Laboratory where the smear was received and registered between 1 April of one year and 31 March of the following year. If this date is not recorded, the CERVICAL SMEAR EXAMINED DATE can be used as a proxy. Part C1 of the return relates to smears where the date of the smear which led to a referral fell in the first three months of the financial year (April, May and June). Part C2 is a duplicate of Part C1, but will collect data relating to gynaecological referrals from smears registered during the whole of the financial year *prior to* the current year.

Change to Central Return Form: Changed Description

Central Return Form Guidance

KC61: Pathology Laboratories - Cervical Cytology and Outcome of Gynaecological Referrals

This return is in development by the NHS Cancer Screening Programme, therefore the information should not be used. For further information on National Cervical Screening, please see the [NHS Digital website](#).

Part A2: Laboratory Processing from Receipt of Smear to Authorisation of Report

- Part A2 collects information about the backlog of smears in laboratories. The laboratory which receives the original request should issue the report and include the information within this return.

Total number of smears registered

- This is the total number of [Pathology Laboratory Investigations](#) received and registered in:

Quarter 1 – As at 30 June yyyy (Line 0001)

Quarter 2 – As at 30 September yyyy (Line 0002)

Quarter 3 – As at 31 December yyyy (Line 0003)

Quarter 4 – As at 31 March yyyy (Line 0004)

A [Pathology Laboratory Investigation](#) is a [CLINICAL INTERVENTION](#) where [CLINICAL INTERVENTION TYPE](#) is National Code 24 'Pathology Laboratory Investigation'.

Number of results reported (to woman or PCT) within

- This is the total number of [Pathology Laboratory Investigations](#) received and registered in:

Quarter 1 - As at 30 June yyyy (Line 0001)

Quarter 2 - As at 30 September yyyy (Line 0002)

Quarter 3 - As at 31 December yyyy (Line 0003)

Quarter 4 - As at 31 March yyyy (Line 0004)

A [Pathology Laboratory Investigation](#) is a [CLINICAL INTERVENTION](#) where [CLINICAL INTERVENTION TYPE](#) is National Code 'Pathology Laboratory Investigation'.

Number of results reported (to woman or PCT) within

- The number of results reported are subdivided into the following time periods:

0-2 weeks 0-14 days (column 3)

3-4 weeks 15-28 days (column 4)

5-6 weeks 29-42 days (column 5)

7-8 weeks 43-56 days (column 6)

9-10 weeks 57-70 days (column 7)

More than 10 weeks over 70 days (column 8)

- The interval to be reported is from the date of receipt of the smear at the [Laboratory](#), the [SAMPLE RECEIPT DATE](#), and the date of authorisation of the final report, the [PATHOLOGY RESULT REPORTED DATE](#) (for the [SAMPLE](#) collected).

Total (line 0005)

- This is the total for all time periods counted in lines 0001 to 0004.

Part A3: Requests Screened for/by Another Laboratory

- Part A3 records information about which laboratories import and export smears.

Requests Sent To Another Laboratory For Screening (Line 0001)

- This requires the number of [Requests for Pathology Investigation](#) where the [DIAGNOSTIC TEST REQUEST](#) for the screening is to be sent to and carried out by another [Pathology Laboratory](#), sub-divided by details of Laboratory sent to and whether for primary screening or 'other'. 'Other' may include rapid review, checking, abnormal or clinical reporting etc.

A [Pathology Laboratory](#) is a [Laboratory](#). A [Request for Pathology Investigation](#) is a [DIAGNOSTIC TEST REQUEST](#) where the [DIAGNOSTIC TEST REQUEST](#) is National Code 03 'Request for Pathology Investigation'.

Requests Received From Another Laboratory For Screening (Line 0002)

- This requires the number of [Requests for Pathology Investigation](#) where the [DIAGNOSTIC TEST REQUEST](#) for the screening of the received smear has been sent from another [Pathology Laboratory](#), sub-divided by details of Laboratory received from and whether for primary screening or 'other'. 'Other' may include rapid review, checking, abnormal or clinical reporting etc.

Part A3: Where More Than One Smear is Taken

- This requires the number of [Requests for Pathology Investigation](#) where the [DIAGNOSTIC TEST REQUEST](#) for the screening is to be sent to and carried out by another [Pathology Laboratory](#), sub-divided by details of [Laboratory](#) sent to and whether for primary screening or 'other'. 'Other' may include rapid review, checking, abnormal or clinical reporting etc.

A [Pathology Laboratory](#) is a [Laboratory](#). A [Request for Pathology Investigation](#) is a [DIAGNOSTIC TEST REQUEST](#) where the [DIAGNOSTIC TEST REQUEST](#) is National Code '*Request for Pathology Investigation*'.

Requests Received From Another Laboratory For Screening (Line 0002)

- This requires the number of [Requests for Pathology Investigation](#) where the [DIAGNOSTIC TEST REQUEST](#) for the screening of the received smear has been sent from another [Pathology Laboratory](#), sub-divided by details of [Laboratory](#) received from and whether for primary screening or 'other'. 'Other' may include rapid review, checking, abnormal or clinical reporting etc.

Part A3: Where More Than One Smear is Taken

- Part A3 also requires the number of instances where a single report is derived from more than one sample.

Number of Instances Where a Single Report is Derived from More Than One Sample (Line 0003)

- This requires the number of [Requests for Pathology Investigation](#) where there is more than one [SAMPLE](#) collected. Full details should be available on request.

Change to Central Return Form: Changed Description

Central Return Form Guidance

KC61: Pathology Laboratories - Cervical Cytology and Outcome of Gynaecological Referrals

This return is in development by the NHS Cancer Screening Programme, therefore the information should not be used. For further information on National Cervical Screening, please see the [NHS Digital website](#).

Part B: Results of Smears from GP and NHS Community Clinics Only by Age Group of Women

- Part B requires the results of smears examined, but only those where the [SMEAR SOURCE TYPE](#) is classified as either '[GENERAL MEDICAL PRACTITIONER](#)' or '[NHS Community Clinic - this includes Sexual and Reproductive Health Clinics, well women clinics and young persons clinics, other than those run by GENERAL MEDICAL PRACTITIONERS](#)'.
- Columns 2 - 9 count the number of samples examined for each [CYTOLOGY RESULT TYPES](#) and are in accordance with the categories shown in box 22 of HMR 101/5 Request/Report for Cervical or Vaginal Cytology.
- These results are further broken down into age bands derived from the [PERSON BIRTH DATE](#) of the [PERSON](#) - the woman from whom the cervical smear was taken. This is the age of the woman at the date of the smear and not the woman's age on 31 March. The smears are the subject of the [Request for Pathology Investigation](#).

~~A [Request for Pathology Investigation](#) is a [DIAGNOSTIC TEST REQUEST](#) where the [DIAGNOSTIC TEST REQUEST](#) is National Code 03 'Request for Pathology Investigation'.~~

~~Total 20 - 64 (line 0014)~~

- These results are further broken down into age bands derived from the [PERSON BIRTH DATE](#) of the [PERSON](#) - the woman from whom the cervical smear was taken. This is the age of the woman at the date of the smear and not the woman's age on 31 March. The smears are the subject of the [Request for Pathology Investigation](#).

A [Request for Pathology Investigation](#) is a [DIAGNOSTIC TEST REQUEST](#) where the [DIAGNOSTIC TEST REQUEST](#) is National Code 'Request for Pathology Investigation'.

Total 20 - 64 (line 0014)

- This counts the number of women in NHS Cervical Screening Programme aged between 20 and 64 on 31 March (sum of lines 0002 to 0010).

Grand Total (line 0015)

- This is the total for all age groups examined in lines 0001 to 0013. This total should be the same as line 0007 in Part A1.

Change to Central Return Form: Changed Description

Central Return Form Guidance

KC61: Pathology Laboratories - Cervical Cytology and Outcome of Gynaecological Referrals

This return is in development by the NHS Cancer Screening Programme, therefore the information should not be used.
For further information on National Cervical Screening, please see the [NHS Digital website](#).

Part C1: Outcome by 31 March yyyy for Women Recommended for Gynaecological Referral where the Smear was Registered during April- June yyyy.

- Part C1 requires the analysis of the number of women subsequently referred for gynaecological investigation following a smear. This is where the CYTOTOLOGY SCREENING ACTION TYPE of a Screening Test has a classification of Refer for medical assessment or under medical treatment (Suspend) (S). The date of the smear must be between 1 April and 30 June of the current data year. The CYTOTOLOGY RESULT TYPES for each woman is used to allocate her to one of appropriate subdivisions of **Most significant result** in columns 3 to 9.

A Screening Test is a CLINICAL INTERVENTION where CLINICAL INTERVENTION TYPE is National Code 28 'Screening Test'.

- Part C1 requires the analysis of the number of women subsequently referred for gynaecological investigation following a smear. This is where the CYTOTOLOGY SCREENING ACTION TYPE of a Screening Test has a classification of Refer for medical assessment or under medical treatment (Suspend) (S). The date of the smear must be between 1 April and 30 June of the current data year. The CYTOTOLOGY RESULT TYPES for each woman is used to allocate her to one of appropriate subdivisions of **Most significant result** in columns 3 to 9.
- Note that CYTOTOLOGY RESULT TYPE classifications of *Severe dyskaryosis (cat. 4)*, *Severe dyskaryosis/invasive carcinoma (Cat. 5)* and *Glandular neoplasia (Cat. 6)* are recorded separately in columns 7, 8 and 9 respectively.
- CYTOTOLOGY RESULT TYPE with a classification of *Negative (cat. 2)* are not counted.
- The number of Most significant results in the CYTOTOLOGY RESULT TYPE columns (columns 3 - 9) are further analysed by the BIOPSY REFERRAL OUTCOME (lines 0001-0014). For cervical histology, biopsies are taken at colposcopy.
- Note that Cervical cancer is sub-divided into 'stage 1B or worse' (line 0001) and 'stage 1A' (line 0002) and that there are four options to describe results which are not applicable or not known: 'Seen in Colposcopy - NAD no biopsy taken' (line 0009), 'Outcome known - none of the above' (line 0010), 'Seen in Colposcopy - result not known' (line 0011) and 'No outcome available' (line 0012).
- ~~Part C1 also includes the formula to calculate the Positive Predictive Value (PPV) of smears reported as moderate dyskaryosis or worse to enable the laboratory to assess whether or not they are reaching an achievable standard.~~
- ~~Part C1 also includes the formula to calculate the Positive Predictive Value (PPV) of smears reported as moderate dyskaryosis or worse to enable the Laboratory to assess whether or not they are reaching an achievable standard.~~
- Part C1 includes the formula to calculate Lost to follow-up of smears reported as 'Seen in colposcopy - result not known' (line 0011) and 'No outcome available' (line 0012), as a percentage of the Total.
- Provision has been made to record details of non-cervical cancers at the bottom of Part C1.

Change to Central Return Form: Changed Description

Central Return Form Guidance

KC61: Pathology Laboratories - Cervical Cytology and Outcome of Gynaecological Referrals

This return is in development by the NHS Cancer Screening Programme, therefore the information should not be used. For further information on National Cervical Screening, please see the [NHS Digital website](#).

Part C2: Retrospective Collection

Outcome by 31 March yyyy for Women Recommended for Gynaecological Referral where the Smear was Registered during April yyyy - March yyyy.

- Part C2 is a duplicate of Part C1 but will collect data relating to gynaecological referrals from smears registered during the whole of the financial year prior to the current year. This is where the [CYTOLOGY SCREENING ACTION TYPE](#) of a [Screening Test](#) has a classification of *Refer for medical assessment or under medical treatment (Suspend) (S)*. The date of the smear must be between 1 April and 31 March of the previous data year. The [CYTOLOGY RESULT TYPES](#) for each woman is used to allocate her to one of appropriate subdivisions of **Most significant result** in columns 3 to 9.

A [Screening Test](#) is a [CLINICAL INTERVENTION](#) where [CLINICAL INTERVENTION TYPE](#) is National Code 28 'Screening Test'.

- Part C2 is a duplicate of Part C1 but will collect data relating to gynaecological referrals from smears registered during the whole of the financial year prior to the current year. This is where the [CYTOLOGY SCREENING ACTION TYPE](#) of a [Screening Test](#) has a classification of *Refer for medical assessment or under medical treatment (Suspend) (S)*. The date of the smear must be between 1 April and 31 March of the previous data year. The [CYTOLOGY RESULT TYPES](#) for each woman is used to allocate her to one of appropriate subdivisions of **Most significant result** in columns 3 to 9.
- Note that [CYTOLOGY RESULT TYPE](#) classifications of 'Severe dyskaryosis (cat. 4)', 'Severe dyskaryosis/invasive carcinoma (Cat. 5)' and 'Glandular neoplasia (Cat. 6)' are recorded separately in columns 7,8 and 9 respectively.
- [CYTOLOGY RESULT TYPES](#) with a classification of 'Negative (cat. 2)' are not counted.
- The number of Most significant results in the [CYTOLOGY RESULT TYPE](#) columns (columns 3 - 9) are further analysed by the [BIOPSY REFERRAL OUTCOME](#) (lines 0001-0014). For cervical histology, biopsies are taken at colposcopy.
- Note that Cervical cancer is sub-divided into 'stage 1B or worse' (line 0001) and 'stage 1A' (line 0002) and that there are four options to describe results which are not applicable or not known: 'Seen in Colposcopy - NAD no biopsy taken' (line 0009), 'Outcome known - none of the above' (line 0010), 'Seen in Colposcopy - result not known' (line 0011) and 'No outcome available' (line 0012).
- Part C2 also includes the formula to calculate the Positive Predictive Value (PPV) of smears reported as moderate dyskaryosis or worse to enable the laboratory to assess whether or not they are reaching an achievable standard.
- Part C2 also includes the formula to calculate the Positive Predictive Value (PPV) of smears reported as moderate dyskaryosis or worse to enable the Laboratory to assess whether or not they are reaching an achievable standard.
- Part C2 includes the formula to calculate Lost to follow-up of smears reported as 'Seen in colposcopy - result not known' (line 0011) and 'No outcome available' (line 0012), as a percentage of the Total.
- Provision has been made to record details of non-cervical cancers at the bottom of Part C2.

Change to Central Return Form: Changed Description

Central Return Form Guidance

[KC65: Colposcopy Clinics, Referrals, Treatments and Outcomes](#)

This return is in development by the NHS Cancer Screening Programme, therefore the information should not be used. For further information on National Cervical Screening, please see the [NHS Digital website](#).

Contextual Overview

- The [Department of Health and Social Care](#), NHS Cervical Screening Programme (NHSCSP) and Regional Offices require information from NHS [Health Care Providers](#) on colposcopy clinic activity.
- The KC65 forms part of the wider NHS Cancer Information Strategy which aims to improve the effectiveness and efficiency of care delivery for those with actual or suspected cancer, throughout the [PATIENT](#) journey.
- The information is used to monitor the process of achieving the Government's target to reduce the incidence of invasive cervical cancer and to monitor the performance of colposcopy clinics on local, regional and national levels.
- Information on the return is also used in Public Expenditure Survey (PES) negotiations, resource allocation to the NHS and Departmental accountability.
- Information based on the KC65 return is published annually by the Department in the Statistical Bulletin *Cervical Screening Programme*.

Completing Return KC65 - Colposcopy Clinics: Referrals, Treatments and Outcomes

- KC65 is a quarterly return with the first quarter starting on 1 April and the last quarter ending on 31 March. Returns must be submitted by the thirtieth working day after the end of the quarter.
- The KC65 return requires the [ORGANISATION CODE](#) and [ORGANISATION NAME](#) of the NHS [Health Care Provider](#) - NHS Trust or [Primary Care Trust](#) - as well as the name of a contact and the contact telephone number on the front page. It must be signed and dated by the person completing the return.
- The British Society for Colposcopy and Cervical Pathology has agreed a Minimum Data Set (MDS) for colposcopy services, currently being introduced into Colposcopy Clinics. The MDS meets professional requirements for audit and quality improvement as well as departmental needs, and provides the information needed to complete the KC65.

Colposcopy

- Colposcopy is a [Patient Procedure](#) carried out on a woman who has been referred to a Colposcopy Clinic following a [Screening Test](#) carried out either as part of a [Screening Programme](#) or opportunistically. Alternatively the woman may be referred as a result of clinical indications.

A [Screening Programme](#) is a [HEALTH PROGRAMME](#) where the [HEALTH PROGRAMME TYPE](#) is National Code 06 'Screening Programme'.

[Patient Procedure](#) and [Screening Test](#) are both a [CLINICAL INTERVENTION](#) where [CLINICAL INTERVENTION TYPE](#) is National Code 25 'Patient Procedure' and 28 'Screening Test' respectively.

- Colposcopy is a [Patient Procedure](#) carried out on a woman who has been referred to a Colposcopy Clinic following a [Screening Test](#) carried out either as part of a [Screening Programme](#) or opportunistically. Alternatively the woman may be referred as a result of clinical indications.

A [Screening Programme](#) is a [HEALTH PROGRAMME](#) where the [HEALTH PROGRAMME TYPE](#) is National Code 'Screening Programme'.

Change to Central Return Form: Changed Description

Central Return Form Guidance

KC65 - Colposcopy Clinics: Referrals, Treatments and Outcomes

This return is in development by the NHS Cancer Screening Programme, therefore the information should not be used. For further information on National Cervical Screening, please see the [NHS Digital website](#).

Part A - Women referred to colposcopy by result of referral smear and time from referral to first appointment

- Part A of the KC65 return is a count of the number of women referred for colposcopy. This information is used to monitor referral patterns to ensure that guidelines on referral are being followed.
- A colposcopy is a [Patient Procedure](#) carried out during a [Clinic Attendance Consultant](#) or [Clinic Attendance Nurse](#). The [PATIENT](#) will have been referred to the Colposcopy Clinic:
 - following a [Screening Test](#) carried out either as part of a [Screening Programme](#) or opportunistically.
 or
 - as a result of clinical indication

A [Screening Programme](#) is a [HEALTH PROGRAMME](#) where the [HEALTH PROGRAMME TYPE](#) is National Code 06 'Screening Programme'.

[Patient Procedure](#) and [Screening Test](#) are both a [CLINICAL INTERVENTION](#) where [CLINICAL INTERVENTION TYPE](#) is National Code 25 'Patient Procedure' and 28 'Screening Test' respectively.

[Clinic Attendance Consultant](#) and [Clinic Attendance Nurse](#) are both a [CARE CONTACT](#) where [CARE CONTACT TYPE](#) is National Code 06 'Clinic Attendance Consultant' and 10 'Clinic Attendance Nurse' respectively.

In cases where there is both a clinical indication and a [Screening Test](#) referral smear, the referral should be treated as clinical indication.

- A colposcopy is a [Patient Procedure](#) carried out during a [Clinic Attendance Consultant](#) or [Clinic Attendance Nurse](#). The [PATIENT](#) will have been referred to the Colposcopy Clinic:
 - following a [Screening Test](#) carried out either as part of a [Screening Programme](#) or opportunistically.
 or
 - as a result of clinical indication

A [Screening Programme](#) is a [HEALTH PROGRAMME](#) where the [HEALTH PROGRAMME TYPE](#) is National Code 'Screening Programme'.

[Clinic Attendance Consultant](#) and [Clinic Attendance Nurse](#) are both a [CARE CONTACT](#) where [CARE CONTACT TYPE](#) is National Code 'Clinic Attendance Consultant' and 'Clinic Attendance Nurse' respectively.

In cases where there is both a clinical indication and a [Screening Test](#) referral smear, the referral should be treated as clinical indication.

- The data is based on the woman's first [Out-Patient Appointment](#) in the quarter regardless of whether she attended the clinic or not.

An [Out-Patient Appointment](#) is an [APPOINTMENT](#).

Time from referral to first appointment (lines 0001 to 0005)

- Lines 0001 to 0005 are counts of [REFERRAL REQUESTS](#) by the time from referral to first appointment. This should be measured from the [PATHOLOGY RESULT REPORTED DATE](#) for referrals following a screening test, and from the [SERVICE REQUEST DATE](#) for all other [REFERRAL REQUESTS](#), to the [APPOINTMENT DATE](#) of the first [Out-Patient Appointment](#).

For [PATIENTS](#) with a first [APPOINTMENT](#) which was cancelled by the clinic ([ATTENDED OR DID NOT ATTEND](#) was National Code 4 'Appointment cancelled or postponed by the [Health Care Provider](#)'), the time is measured from referral to the subsequent first [APPOINTMENT](#).

Referral Indication - Result of referral smear (columns 2 to 8)

- These columns count all the women with a [REFERRAL REQUEST](#) for colposcopy with a [COLPOSCOPY REFERRAL INDICATION](#) classification of 'Screening smear'. These are persons in a [Screening Programme](#) who have been given a [Screening Test](#) as part of a planned [Screening Programme](#). It also includes women screened opportunistically, these women have had a [Screening Test](#) with the [OPPORTUNISTIC SCREENING TYPE](#) recorded.

In addition, if a person in a [Screening Programme](#) has been suspended from the [Screening Programme](#) following colposcopy and is currently having surveillance smears as indicated by the [OPPORTUNISTIC SCREENING TYPE](#) classification of 'Screened while recall suspended', it may be that an abnormal smear will cause the woman to be re-referred to colposcopy. In this case the [COLPOSCOPY REFERRAL INDICATION](#) classification should be 'Screening smear', regardless of whether or not she has been discharged from colposcopy at this time.

- The information in columns 2-8 is based on the cervical screening test results, which led to the [REFERRAL REQUEST](#). Classifications are those of [CYTOLOGY RESULT TYPES](#) of a [Request for Pathology Investigation](#) and are in accordance with the categories shown in box 22 of HMP 101/6 Request/Report for Cervical or Vaginal Cytology.

Where the cervical screening test results which led to the [REFERRAL REQUEST](#) indicates more than one result type, the most severe result should recorded as the [CYTOLOGY RESULT TYPE](#).

A [Request for Pathology Investigation](#) is a [DIAGNOSTIC TEST REQUEST](#) where the [DIAGNOSTIC TEST REQUEST TYPE](#) is National Code 03 'Request for Pathology Investigation'.

Inadequate (column 2)

- The information in columns 2-8 is based on the cervical screening test results, which led to the [REFERRAL REQUEST](#). Classifications are those of [CYTOLOGY RESULT TYPES](#) of a [Request for Pathology Investigation](#) and are in accordance with the categories shown in box 22 of HMR 101/5 Request/Report for Cervical or Vaginal Cytology.

Where the cervical screening test results which led to the [REFERRAL REQUEST](#) indicates more than one result type, the most severe result should recorded as the [CYTOLOGY RESULT TYPE](#).

A [Request for Pathology Investigation](#) is a [DIAGNOSTIC TEST REQUEST](#) where the [DIAGNOSTIC TEST REQUEST TYPE](#) is National Code 'Request for Pathology Investigation'.

Inadequate (column 2)

- A count of the number of women with a [CYTOLOGY RESULT TYPE](#) classification of '*Inadequate sample (cat.1)*'.

NHS Cervical Screening Programme guidelines state the recording of three cervical screening tests with a [CYTOLOGY RESULT TYPE](#) classification of '*Inadequate sample (cat.1)*' indicates referral to colposcopy however, referral to colposcopy may occur following an inadequate smear for other reasons.

Borderline changes (column 3)

- A count of the number of women with a [CYTOLOGY RESULT TYPE](#) classification of '*Borderline changes (cat.8)*'.

NHS Cervical Screening Programme guidelines state the recording of three cervical screening tests with a [CYTOLOGY RESULT TYPE](#) classification of '*Borderline changes (cat.8)*' indicates referral to colposcopy however, referral to colposcopy may occur following a borderline smear for other reasons.

Mild dyskaryosis (column 4)

- A count of the number of women with a [CYTOLOGY RESULT TYPE](#) classification of '*Mild dyskaryosis (cat.3)*'.

Moderate dyskaryosis (column 5)

- A count of the number of women with a [CYTOLOGY RESULT TYPE](#) classification of '*Moderate dyskaryosis (cat. 7), including abnormal, unclassifiable and ungraded smears*'.

Severe dyskaryosis (column 6)

- A count of the number of women with a [CYTOLOGY RESULT TYPE](#) classification of '*Severe dyskaryosis (cat.4)*'.

Severe dyskaryosis/invasive carcinoma (column 7)

- A count of the number of women with a [CYTOLOGY RESULT TYPE](#) classification of '*Severe dyskaryosis/?invasive carcinoma (cat.5)*'.

Glandular neoplasia (column 8)

- A count of the number of women with a [CYTOLOGY RESULT TYPE](#) classification of '*?Glandular neoplasia (cat.6), including adenocarcinoma*'.

Referral Indication - Clinical indication (columns 9, 10)

- ~~These columns count women with a [REFERRAL REQUEST](#) for colposcopy with a [COLPOSCOPY REFERRAL INDICATION](#) classification of '*Clinical indication*'.~~

~~Where a woman is referred with symptoms and is given a [Screening Test](#) the [COLPOSCOPY REFERRAL INDICATION](#) should still be a classification of '*Clinical indication*' and not '*Screening smear*'. Where no symptoms are present the [COLPOSCOPY REFERRAL INDICATION](#) should not be a classification of '*Clinical indication*'.~~

~~A [Screening Test](#) is a [CLINICAL INTERVENTION](#) where [CLINICAL INTERVENTION TYPE](#) is National Code 28 '*Screening Test*'.~~

~~Clinical Indication Urgent (column 9)~~

- ~~These columns count women with a [REFERRAL REQUEST](#) for colposcopy with a [COLPOSCOPY REFERRAL INDICATION](#) classification of '*Clinical indication*'.~~

~~Where a woman is referred with symptoms and is given a [Screening Test](#) the [COLPOSCOPY REFERRAL INDICATION](#) should still be a classification of '*Clinical indication*' and not '*Screening smear*'. Where no symptoms are present the [COLPOSCOPY REFERRAL INDICATION](#) should not be a classification of '*Clinical indication*'.~~

~~A [Screening Test](#) is a [CLINICAL INTERVENTION](#) where [CLINICAL INTERVENTION TYPE](#) is National Code '*Screening Test*'.~~

~~Clinical Indication Urgent (column 9)~~

- A count of the number of women with a [COLPOSCOPY REFERRAL INDICATION](#) classification of '*urgent*'. This is restricted to cervical lesions suspicious of cancer, or post-coital bleeding of over four weeks where the patient is aged over 35.

Clinical Indication Non-Urgent (column 10)

- A count of the number of women with a [COLPOSCOPY REFERRAL INDICATION](#) classification of '*non-urgent*'. This includes all other symptomatic referrals for colposcopy.

Other (column 11)

- A count of the number of women with a [CYTOLOGY RESULT TYPE](#) classification of '*Other*' or with no [CYTOLOGY RESULT TYPE](#) and no [COLPOSCOPY REFERRAL INDICATION](#).

Entries for a [CYTOLOGY RESULT TYPE](#) classification of '*Other*' should only occur in exceptional circumstances. NHS Cervical Screening Programme (NHSCSP) guidelines state that all smears should be identified as belonging to one of the eight recognised category classifications of [CYTOLOGY RESULT TYPE](#). '*Other*' does not correspond to these recognised categories and should be used to record those rare cases in which a recognised category is not appropriate.

Otherwise this column should only be used in the rare situations where usual categorisation is not appropriate. Examples include women with incomplete or missing records and women who have moved from abroad.

Where an entry is present in column 11 supporting notes should be recorded in the available box on the first page of the KC65 form.

Total number referred (column 12)

- This is the total of women referred for colposcopy, broken down by time from referral to first appointment

Total (line 0006)

- This is the total for all women counted in columns 2 to 12.

Central Return Form Guidance

KC65 - Colposcopy Clinics: Referrals, Treatments and Outcomes

This return is in development by the NHS Cancer Screening Programme, therefore the information should not be used.
For further information on National Cervical Screening, please see the [NHS Digital website](#).

Part B - Appointments for Colposcopy

- Part B of the KC65 return is a breakdown of appointments by cancellation/non-attendance, and type of appointment. This information will allow monitoring of non-attendances, patient cancellations, and clinic cancellations.

It includes all [Out-Patient Appointments](#) with an [APPOINTMENT DATE](#) within the [REPORTING PERIOD](#).

An [Out-Patient Appointment](#) is an [APPOINTMENT](#).

Attendance Status

- The Attendance status is derived from the value of [ATTENDED OR DID NOT ATTEND](#) for the [Out-Patient Appointment](#).

Attended (line 0001)

- The number of appointments for which [ATTENDED OR DID NOT ATTEND](#) was either National Code 5 '*attended on time or, if late, before the relevant care professional was ready to see the patient*', or National Code 6 '*arrived late, after the relevant care professional was ready to see the patient, but was seen*'.

Cancelled by patient - in advance (line 0002)

- The number of appointments for which [ATTENDED OR DID NOT ATTEND](#) was National Code 2 '*appointment cancelled by, or on behalf of, the patient*' - before the appointment date.

Cancelled by patient - on the day (line 0003)

- The number of appointments for which [ATTENDED OR DID NOT ATTEND](#) was National Code 2 '*appointment cancelled by, or on behalf of, the patient*' - on the appointment day.

Cancelled by Clinic (line 0004)

- The number of appointments for which [ATTENDED OR DID NOT ATTEND](#) was National Code 4 '*appointment cancelled or postponed by the Health Care Provider*'.

DNA - no advance warning (line 0005)

- The number of appointments for which [ATTENDED OR DID NOT ATTEND](#) was National Code 3 '*did not attend - no advance warning given*'.

DNA - arrived late (line 0006)

- The number of appointments for which [ATTENDED OR DID NOT ATTEND](#) was National Code 7 '*patient arrived late and could not be seen*'.

DNA - left without being seen (line 0007)

- The number of appointments for which [ATTENDED OR DID NOT ATTEND](#) was national Code 3 '*did not attend - no advance warning given*' (arrived, but did not wait to be seen).

Total (line 0008)

- The number of appointments for which [ATTENDED OR DID NOT ATTEND](#) was either National Code '*attended on time or, if late, before the relevant care professional was ready to see the patient*', or National Code 6 '*arrived late, after the relevant care professional was ready to see the patient, but was seen*'.

Cancelled by patient - in advance (line 0002)

- The number of appointments for which [ATTENDED OR DID NOT ATTEND](#) was National Code '*appointment cancelled by, or on behalf of, the patient*' - before the appointment date.

Cancelled by patient - on the day (line 0003)

- The number of appointments for which [ATTENDED OR DID NOT ATTEND](#) was National Code '*appointment cancelled by, or on behalf of, the patient*' - on the appointment day.

Cancelled by Clinic (line 0004)

- The number of appointments for which [ATTENDED OR DID NOT ATTEND](#) was National Code '*appointment cancelled or postponed by the Health Care Provider*'.

DNA - no advance warning (line 0005)

- The number of appointments for which **ATTENDED OR DID NOT ATTEND** was National Code *'did not attend - no advance warning given'*.

DNA - arrived late (line 0006)

- The number of appointments for which **ATTENDED OR DID NOT ATTEND** was National Code *'patient arrived late and could not be seen'*.

DNA - left without being seen (line 0007)

- The number of appointments for which **ATTENDED OR DID NOT ATTEND** was national Code *'did not attend - no advance warning given'* (arrived, but did not wait to be seen).

Total (line 0008)

- This is the total of all women counted in lines 0001 to 0007.

Appointment Type

- Columns 2 to 4 require counts of colposcopy **Out-Patient Appointments** by **APPOINTMENT TYPE**.

An **Out-Patient Appointment** is an **APPOINTMENT**.

New (column 2)

- The number of colposcopy **Out-Patient Appointments** which are first **APPOINTMENTS**.

Return for Treatment (column 3)

- The number of colposcopy **Out-Patient Appointments** where the **APPOINTMENT TYPE** is National Code 01 *'Treatment: An appointment specifically for treatment'*.

Follow Up (column 4)

- The number of colposcopy **Out-Patient Appointments** which are follow-up **APPOINTMENTS** where the **APPOINTMENT TYPE** is National Code 02 *'Surveillance: All other appointments'*.

Total (column 5)

- The number of colposcopy **Out-Patient Appointments** where the **APPOINTMENT TYPE** is National Code *'Treatment: An appointment specifically for treatment'*.

Follow Up (column 4)

- The number of colposcopy **Out-Patient Appointments** which are follow-up **APPOINTMENTS** where the **APPOINTMENT TYPE** is National Code *'Surveillance: All other appointments'*.

Total (column 5)

- This is the total for all women in columns 3 to 5.

Change to Central Return Form: Changed Description

Central Return Form Guidance

KC65 - Colposcopy Clinics: Referrals, Treatments and Outcomes

This return is in development by the NHS Cancer Screening Programme, therefore the information should not be used. For further information on National Cervical Screening, please see the [NHS Digital website](#).

Part C1 - First attendances by type of procedure and result of referral

- Parts C1 and C2 of the KC65 return are counts of procedures undertaken at colposcopy clinics, showing the nature of treatment by result of referral. The information is used to monitor treatment patterns to ensure that treatment guidelines, such as on the number of biopsies taken, are met.

- Parts C1 and C2 are identical, except that Part C1 relates to initial treatment at first attendance, and Part C2 relates to all attendances. For part C1 data is collected on the woman's first [Clinic Attendance Consultant](#) or [Clinic Attendance Nurse](#) in the [REPORTING PERIOD](#).

Where a woman has a smear taken during the attendance the [COLPOSCOPY PRIME PROCEDURE TYPE](#) should be recorded as classification 'No treatment; no treatment received and no biopsy taken'.

[Clinic Attendance Consultant](#) and [Clinic Attendance Nurse](#) are both a [CARE CONTACT](#) where [CARE CONTACT TYPE](#) is National Code 06 'Clinic Attendance Consultant' and 10 'Clinic Attendance Nurse' respectively.

For [Clinic Attendance Consultant](#) and [Clinic Attendance Nurse](#), a first attendance is the first in a series of the only attendance at the clinic by a patient.

- The procedures undertaken in the colposcopy clinics are [Patient Procedure](#). Only one [Patient Procedure](#) should be counted for each woman's first attendance. If more than one procedure is carried out, the most severe should be recorded for KC65.

[Patient Procedure](#) is a [CLINICAL INTERVENTION](#) where [CLINICAL INTERVENTION TYPE](#) is National Code 25 'Patient Procedure'.

Result of referral smear

- Parts C1 and C2 are identical, except that Part C1 relates to initial treatment at first attendance, and Part C2 relates to all attendances. For part C1 data is collected on the woman's first [Clinic Attendance Consultant](#) or [Clinic Attendance Nurse](#) in the [REPORTING PERIOD](#).

Where a woman has a smear taken during the attendance the [COLPOSCOPY PRIME PROCEDURE TYPE](#) should be recorded as classification 'No treatment; no treatment received and no biopsy taken'.

[Clinic Attendance Consultant](#) and [Clinic Attendance Nurse](#) are both a [CARE CONTACT](#) where [CARE CONTACT TYPE](#) 06 'Clinic Attendance Consultant' and 10 'Clinic Attendance Nurse' respectively.

For [Clinic Attendance Consultant](#) and [Clinic Attendance Nurse](#), a first attendance is the first in a series of the only attendance at the clinic by a patient.

- The procedures undertaken in the colposcopy clinics are [Patient Procedure](#). Only one [Patient Procedure](#) should be counted for each woman's first attendance. If more than one procedure is carried out, the most severe should be recorded for KC65.

[Patient Procedure](#) is a [CLINICAL INTERVENTION](#) where [CLINICAL INTERVENTION TYPE](#) 25 'Patient Procedure'.

Result of referral smear

- Lines 0001 to 0008 require data on the number of women referred for colposcopy by [CYTOLOGY RESULT TYPES](#).

Inadequate (line 0001)

- A count of the number of women with a [CYTOLOGY RESULT TYPE](#) classification of 'Inadequate sample (cat. 1)'.

Borderline changes (line 0002)

- A count of the number of women with a [CYTOLOGY RESULT TYPE](#) classification of 'Borderline changes (cat. 8)'.

Mild dyskaryosis (line 0003)

- A count of the number of women with a [CYTOLOGY RESULT TYPE](#) classification of 'Mild dyskaryosis (cat. 3)'.

Moderate dyskaryosis (line 0004)

- A count of the number of women with a [CYTOLOGY RESULT TYPE](#) classification of 'Moderate dyskaryosis (cat. 7), including abnormal, unclassifiable and ungraded smears'.

Severe dyskaryosis (line 0005)

- A count of the number of women with a [CYTOLOGY RESULT TYPE](#) classification of 'Severe dyskaryosis (cat. 4)'.

Severe dyskaryosis/invasive carcinoma (line 0006)

- A count of the number of women with a [CYTOLOGY RESULT TYPE](#) classification of 'Severe dyskaryosis/invasive carcinoma (cat. 5)'.

Glandular neoplasia (line 0007)

- A count of the number of women with a [CYTOLOGY RESULT TYPE](#) classification of 'Glandular neoplasia (cat. 6), including adenocarcinoma'.

Referral Indication - Clinical indication (lines 0008, 0009)

- These columns count first attendances for women with a [REFERRAL REQUEST](#) for colposcopy with a [COLPOSCOPY REFERRAL INDICATION](#) classification of 'Clinical indication'.

Note all procedures carried out on women who have been referred to the colposcopy clinic with a [REFERRAL REQUEST](#) with a [COLPOSCOPY REFERRAL INDICATION](#) of classification *Clinical indication* should be recorded in this line regardless of the result of any smear taken after the referral.

Clinical Indication Urgent (line 0008)

- A count of the number of women with a [COLPOSCOPY REFERRAL INDICATION](#) of classification of 'urgent'. This is restricted to cervical lesions suspicious of cancer, or post-coital bleeding of over four weeks where the patient is aged over 35.

Clinical Indication Non-Urgent (line 0009)

- A count of the number of women with a [COLPOSCOPY REFERRAL INDICATION](#) classification of 'non-urgent'. This includes all other symptomatic referrals for colposcopy

Other (line 0010)

- A count of the number of women with a [COLPOSCOPY REFERRAL INDICATION](#) classification of 'Other'.

Entries recorded in Other (line 0010) should only occur in exceptional circumstances. NHS Cervical Screening Programme (NHSCSP) guidelines state that all smears should be identified as belonging to one of the eight recognised category classifications of [CYTOLOGY RESULT TYPE](#). Other (line 0010) does not correspond to these recognised categories and should be used to record those rare cases in which a recognised category is not appropriate. Where an entry is present in Other (line 0010) then supporting notes should be recorded in the available box on the first page of the KC65 form.

Total (line 0011)

- This is the total for all women counted in columns 2 to 8.

No treatment (column 2)

- This counts the number of women who received no treatment and for whom was recorded a [COLPOSCOPY PRIME PROCEDURE TYPE](#) classification of 'No treatment; no treatment received and no biopsy taken'.

Procedure Type

Diagnostic biopsy (punch) (column 3)

- This counts the number of women who received no treatment and for whom a [COLPOSCOPY PRIME PROCEDURE TYPE](#) classification of 'Diagnostic biopsy (punch); no treatment received and biopsy type recorded as directed biopsy or multiple directed biopsy, or any other biopsy taken for diagnostic purposes only' was recorded.

Treatment biopsy or treatment/diagnostic biopsy - Excision (column 4)

- This counts the number of women for whom was recorded a [COLPOSCOPY PRIME PROCEDURE TYPE](#) classification of 'Loop/laser excision or knife cone; treatment method recorded as loop/laser excision or knife cone and biopsy type recorded as other than no biopsy. This will include LLETZ and NEEP'.

Ablation + No Biopsy taken or biopsy result not yet known (column 5)

- This counts the number of women for whom was recorded a [COLPOSCOPY PRIME PROCEDURE TYPE](#) classification of 'Ablation; treatment method recorded as ablation. This will include cold coagulation, [Cryotherapy](#), cautery and diathermy. (ii) no biopsy taken, or biopsy result not known by clinic'.

Ablation + Biopsy (column 6)

- This counts the number of women for whom [COLPOSCOPY PRIME PROCEDURE TYPE](#) classification of 'Ablation; treatment method recorded as ablation. This will include cold coagulation, [Cryotherapy](#), cautery and diathermy. (i) biopsy result available' was recorded.

Other (column 7)

- This counts the number of women for whom [COLPOSCOPY PRIME PROCEDURE TYPE](#) classification of 'Other; treatment method recorded as other and biopsy type recorded as other than no biopsy. This will include polyp avulsion and treatment with silver nitrate' was recorded. It excludes any treatment that is not related to cervical abnormalities.

Number of first attendances (column 8)

- This is the total of all first attendances (see paragraph 2), subdivided by the [CYTOLOGY RESULT TYPE](#) classifications.

Change to Central Return Form: Changed Description

Central Return Form Guidance

KC65 - Colposcopy Clinics: Referrals, Treatments and Outcomes

This return is in development by the NHS Cancer Screening Programme, therefore the information should not be used. For further information on National Cervical Screening, please see the [NHS Digital website](#).

Part C2 - All attendances by type of procedure and result of referral

- Parts C1 and C2 of the KC65 return are counts of procedures undertaken at colposcopy clinics, showing the nature of treatment by result of referral. The information is used to monitor treatment patterns to ensure that treatment guidelines, such as on the number of biopsies taken, are met.
- Parts C1 and C2 are identical, except that Part C1 relates to initial treatment at first attendance, and Part C2 relates to all attendances. For part C2 data is collected on each [Clinic Attendance Consultant](#) or [Clinic Attendance Nurse](#) in the [REPORTING PERIOD](#).

Where a woman has a smear taken during the attendance the [COLPOSCOPY PRIME PROCEDURE TYPE](#) should be recorded as classification '[No treatment; no treatment received and no biopsy taken](#)'.

[Clinic Attendance Consultant](#) and [Clinic Attendance Nurse](#) are both a [CARE CONTACT](#) where [CARE CONTACT TYPE](#) is National Code 06 '[Clinic Attendance Consultant](#)' and 10 '[Clinic Attendance Nurse](#)' respectively.

For [Clinic Attendance Consultant](#) and [Clinic Attendance Nurse](#), a first attendance is the first in a series of the only attendance at the clinic by a patient.

- The procedures undertaken in the colposcopy clinics are [Patient Procedures](#). Only one [Patient Procedure](#) should be counted for each [Clinic Attendance Consultant](#) or [Clinic Attendance Nurse](#). If more than one procedure is carried out, the most severe should be recorded for KC65.

[Patient Procedure](#) is a [CLINICAL INTERVENTION](#) where [CLINICAL INTERVENTION TYPE](#) is National Code 25 '[Patient Procedure](#)'.

Result of referral smear

- Parts C1 and C2 are identical, except that Part C1 relates to initial treatment at first attendance, and Part C2 relates to all attendances. For part C2 data is collected on each [Clinic Attendance Consultant](#) or [Clinic Attendance Nurse](#) in the [REPORTING PERIOD](#).

Where a woman has a smear taken during the attendance the [COLPOSCOPY PRIME PROCEDURE TYPE](#) should be recorded as classification '[No treatment; no treatment received and no biopsy taken](#)'.

[Clinic Attendance Consultant](#) and [Clinic Attendance Nurse](#) are both a [CARE CONTACT](#) where [CARE CONTACT TYPE](#) is National Code '[Clinic Attendance Consultant](#)' and '[Clinic Attendance Nurse](#)' respectively.

For [Clinic Attendance Consultant](#) and [Clinic Attendance Nurse](#), a first attendance is the first in a series of the only attendance at the clinic by a patient.

- The procedures undertaken in the colposcopy clinics are [Patient Procedures](#). Only one [Patient Procedure](#) should be counted for each [Clinic Attendance Consultant](#) or [Clinic Attendance Nurse](#). If more than one procedure is carried out, the most severe should be recorded for KC65.

[Patient Procedure](#) is a [CLINICAL INTERVENTION](#) where [CLINICAL INTERVENTION TYPE](#) is National Code '[Patient Procedure](#)'.

Result of referral smear

- Lines 0001 to 0008 require data on the number of women referred for colposcopy by [CYTOLOGY RESULT TYPES](#).

Inadequate (line 0001)

- A count of the number of women with a [CYTOLOGY RESULT TYPE](#) classification of '[Inadequate sample \(cat. 1\)](#)'.

Borderline changes (line 0002)

- A count of the number of women with a [CYTOLOGY RESULT TYPE](#) classification of '[Borderline changes \(cat. 8\)](#)'.

Mild dyskaryosis (line 0003)

- A count of the number of women with a [CYTOLOGY RESULT TYPE](#) classification of '[Mild dyskaryosis \(cat. 3\)](#)'.

Moderate dyskaryosis (line 0004)

- A count of the number of women with a [CYTOLOGY RESULT TYPE](#) classification of '[Moderate dyskaryosis \(cat. 7\), including abnormal, unclassifiable and ungraded smears](#)'.

Severe dyskaryosis (line 0005)

- A count of the number of women with a [CYTOLOGY RESULT TYPE](#) classification of '[Severe dyskaryosis \(cat. 4\)](#)'.

Severe dyskaryosis/invasive carcinoma (line 0006)

- A count of the number of women with a [CYTOLOGY RESULT TYPE](#) classification of 'Severe dyskaryosis/invasive carcinoma (cat. 5)'.

Glandular neoplasia (line 0007)

- A count of the number of women with a [CYTOLOGY RESULT TYPE](#) classification of 'Glandular neoplasia (cat. 6), including adenocarcinoma'.

Referral Indication - Clinical indication (lines 0008, 0009)

- These columns count attendances for women with a [REFERRAL REQUEST](#) for colposcopy with a [COLPOSCOPY REFERRAL INDICATION](#) classification of 'Clinical indication'.

Note all procedures carried out on women who have been referred to the colposcopy clinic with a [REFERRAL REQUEST](#) with a [COLPOSCOPY REFERRAL INDICATION](#) classification of 'Clinical indication' should be recorded in this line regardless of the result of any smear taken after the referral.

Clinical Indication Urgent (line 0008)

- A count of the number of women with a [COLPOSCOPY REFERRAL INDICATION](#) classification of 'urgent'. This is restricted to cervical lesions suspicious of cancer, or post-coital bleeding of over four weeks where the patient is aged over 35.

Clinical Indication Non-Urgent (line 0009)

- A count of the number of women with a [COLPOSCOPY REFERRAL INDICATION](#) classification of 'non-urgent'. This includes all other symptomatic referrals for colposcopy

Other (line 0010)

- A count of the number of women with a [CYTOLOGY RESULT TYPE](#) classification of 'Other'.

Entries recorded in Other (line 0010) should only occur in exceptional circumstances. NHS Cervical Screening Programme (NHSCSP) guidelines state that all smears should be identified as belonging to one of the eight recognised category classifications of [CYTOLOGY RESULT TYPE](#). Other (line 0010) does not correspond to these recognised categories and should be used to record those rare cases in which a recognised category is not appropriate. Where an entry is present in Other (line 0010) then supporting notes should be recorded in the available box on the first page of the KC65 form.

Total (line 0011)

- This is the total for all women counted in columns 2 to 8.

No treatment (column 2)

- This counts the number of women who received no treatment and for whom was recorded a [COLPOSCOPY PRIME PROCEDURE TYPE](#) classification of 'No treatment; no treatment received and no biopsy taken'.

Procedure Type

Diagnostic biopsy (punch) (column 3)

- This counts the number of women who received no treatment and for whom a [COLPOSCOPY PRIME PROCEDURE TYPE](#) classification of 'Diagnostic biopsy (punch); no treatment received and biopsy type recorded as directed biopsy or multiple directed biopsy, or any other biopsy taken for diagnostic purposes only' was recorded.

Treatment biopsy or treatment/diagnostic biopsy - Excision (column 4)

- This counts the number of women who for whom was recorded a [COLPOSCOPY PRIME PROCEDURE TYPE](#) classification of 'Loop/laser excision or knife cone; treatment method recorded as loop/laser excision or knife cone and biopsy type recorded as other than no biopsy. This will include LLETZ and NEEP'.

Ablation + No Biopsy taken or biopsy result not yet known (column 5)

- This counts the number of women who for whom was recorded a [COLPOSCOPY PRIME PROCEDURE TYPE](#) classification of 'Ablation; treatment method recorded as ablation. This will include cold coagulation, [Cryotherapy](#), cautery and diathermy. (ii) no biopsy taken, or biopsy result not known by clinic'.

Ablation + Biopsy (column 6)

- This counts the number of women for whom [COLPOSCOPY PRIME PROCEDURE TYPE](#) classification of 'Ablation; treatment method recorded as ablation. This will include cold coagulation, [Cryotherapy](#), cautery and diathermy. (i) biopsy result available' was recorded.

Other (column 7)

- This counts the number of women for whom [COLPOSCOPY PRIME PROCEDURE TYPE](#) of 'Other; treatment method recorded as other and biopsy type recorded as other than no biopsy. This will include polyp avulsion and treatment with silver nitrate' was recorded. It excludes any treatment that is not related to cervical abnormalities.

Number of first attendances (column 8)

- This is the total of all first attendances (see paragraph 2), subdivided by the [CYTOLOGY RESULT TYPE](#) classifications.

Change to Central Return Form: Changed Description

Central Return Form Guidance

KC65 - Colposcopy Clinics: Referrals, Treatments and Outcomes

This return is in development by the NHS Cancer Screening Programme, therefore the information should not be used. For further information on National Cervical Screening, please see the [NHS Digital website](#).

Part D - Cervical Biopsies, by time from biopsy to informing patient of result in writing

- Part D of the KC65 return shows for each cervical biopsy the time elapsing before the woman is informed in writing of the result. The NHS Cervical Screening Programme (NHSCSP) has issued guidance on waiting times, and the information is used to monitor whether clinics are meeting these standards. The return is based upon those biopsies taken during the first month of the quarter.
- The time measured in this part of the return is the interval between the [PROCEDURE DATE](#) of the colposcopy [Patient Procedure](#) at which the biopsy was taken and the [Patient Informed Biopsy Result Date](#).

[Patient Procedure](#) is a [CLINICAL INTERVENTION](#) where [CLINICAL INTERVENTION TYPE](#) is National Code '[Patient Procedure](#)'- [PROCEDURE DATE](#) and [Patient Informed Biopsy Result Date](#) are both the same as attribute [ACTIVITY DATE](#) where [ACTIVITY DATE TYPE](#) is National Code '[Procedure Date](#)' and '[Patient Informed Biopsy Result Date](#)' respectively.

Total biopsies in first month of quarter

- The time measured in this part of the return is the interval between the [PROCEDURE DATE](#) of the colposcopy [Patient Procedure](#) at which the biopsy was taken and the [Patient Informed Biopsy Result Date](#).

Total biopsies in first month of quarter

- Column 2 counts the number of biopsies taken during the first month of the quarter. These are subdivided by the waiting times in lines 0001-0005.

Less than or equal to 2 weeks (line 0001)

- This counts the number of women whose waiting time was less than or equal to 14 days.

>2 weeks up to 4 weeks (line 0002)

- This counts the number of women whose waiting time was more than 14 days but less than or equal to 28 days.

>4 weeks up to 8 weeks (line 0003)

- This counts the number of women whose waiting time was more than 28 days but less than or equal to 56 days.

>8 weeks up to 12 weeks (line 0004)

- This counts the number of women whose waiting time was more than 56 days but less than or equal to 84 days.

>12 weeks (line 0005)

- This counts the number of women whose waiting time was more than 84 days.

Total (line 0006)

- This is the total for all women counted in column 2.

AMERICAN JOINT COMMITTEE ON CANCER STAGE DATE (RETIRED), renamed from AMERICAN JOINT COMMITTEE ON CANCER STAGE DATE

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

An [American Joint Committee on Cancer Stage Date \(AJCC Stage Date\)](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

An [American Joint Committee on Cancer Stage Date](#) is the date on which the [AMERICAN JOINT COMMITTEE ON CANCER STAGE](#) was recorded during a [Skin Cancer Care Spell](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

AMERICAN JOINT COMMITTEE ON CANCER STAGE DATE (RETIRED), renamed from AMERICAN JOINT COMMITTEE ON CANCER STAGE DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.A.American_Joint_Committee_on_Cancer_Stage_Date to Retired.Data_Dictionary.NHS_Business_Definitions.A.American_Joint_Committee_on_Cancer_Stage_Date
- Retired American Joint Committee on Cancer Stage Date
- Changed Description

ANN ARBOR STAGE DATE (RETIRED), renamed from ANN ARBOR STAGE DATE

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

An [Ann Arbor Stage Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

An [Ann Arbor Stage Date](#) is the date on which the [ANN ARBOR STAGE](#) was recorded during a [Haematological Cancer Care Spell](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

ANN ARBOR STAGE DATE (RETIRED), renamed from ANN ARBOR STAGE DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.A.Ann_Arbor_Stage_Date to Retired.Data_Dictionary.NHS_Business_Definitions.A.Ann_Arbor_Stage_Date
- Retired Ann Arbor Stage Date
- Changed Description

ANTENATAL BOOKING APPOINTMENT DATE (RETIRED), renamed from ANTENATAL BOOKING APPOINTMENT DATE

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

An [Antenatal Booking Appointment Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

An [Antenatal Booking Appointment Date](#) is the date the [Antenatal Booking Appointment](#) is completed. The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

ANTENATAL BOOKING APPOINTMENT DATE (RETIRED), renamed from ANTENATAL BOOKING APPOINTMENT DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.A.Antenatal_Booking_Appointment_Date to Retired.Data_Dictionary.NHS_Business_Definitions.A.Antenatal_Booking_Appointment_Date
- Retired Antenatal Booking Appointment Date
- Changed Description

APPOINTMENT DATE (RETIRED), renamed from APPOINTMENT DATE

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

An [Appointment Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

An [Appointment Date](#) is the [DATE](#) of an [APPOINTMENT](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

In the case of a [PATIENT](#) attending an [Out Patient Clinic](#) without prior notice or [APPOINTMENT](#), the [PATIENT](#) will be given an [Out Patient Appointment](#). Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

APPOINTMENT DATE (RETIRED), renamed from APPOINTMENT DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.A.Appointment_Date to Retired.Data_Dictionary.NHS_Business_Definitions.A.Appointment_Date
- Retired Appointment Date
- Changed Description

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

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

[Arrival Date and Time at Accident and Emergency Department](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

[Arrival Date and Time at Accident and Emergency Department](#) is the [DATE AND TIME](#) the [PATIENT](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

- self presented at the [Accident and Emergency Department](#) or
- arrived in an [Ambulance](#) at the [Accident and Emergency Department](#).

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

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

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.A.Arrival_Date_and_Time_at_Accident_and_Emergency_Department to Retired.Data_Dictionary.NHS_Business_Definitions.A.Arrival_Date_and_Time_at_Accident_and_Emergency_Department
- Retired Arrival Date and Time at Accident and Emergency Department
- Changed Description

ASSAULT DATE AND TIME (RETIRED) renamed from ASSAULT DATE AND TIME

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

[Assault Date and Time](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

[Assault Date and Time](#) is the [DATE AND TIME](#) the [PATIENT](#) was assaulted. The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

ASSAULT DATE AND TIME (RETIRED) renamed from ASSAULT DATE AND TIME

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.A.Assault_Date_and_Time to Retired.Data_Dictionary.NHS_Business_Definitions.A.Assault_Date_and_Time
- Retired Assault Date and Time
- Changed Description

ATTENDANCE DATE (RETIRED) renamed from ATTENDANCE DATE

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

An [Attendance Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

An [Attendance Date](#) is the date of an attendance or contact, for example at a [Consultant Clinic](#), [Nurse Clinic](#), [Accident and Emergency Department](#) or by a [Ward Attender](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

ATTENDANCE DATE (RETIRED) renamed from ATTENDANCE DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.A.Attendance_Date to Retired.Data_Dictionary.NHS_Business_Definitions.A.Attendance_Date
- Retired Attendance Date
- Changed Description

BARCELONA CLINIC LIVER CANCER STAGE DATE (RETIRED) renamed from BARCELONA CLINIC LIVER CANCER STAGE DATE

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

A [Barcelona Clinic Liver Cancer Stage Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

A [Barcelona Clinic Liver Cancer Stage Date](#) is the date on which the [BARCELONA CLINIC LIVER CANCER STAGE](#) was recorded during a [Liver Cancer Care Spell](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

BARCELONA CLINIC LIVER CANCER STAGE DATE (RETIRED), renamed from BARCELONA CLINIC LIVER CANCER STAGE DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.B.Barcelona_Clinic_Liver_Cancer_Stage_Date to Retired.Data_Dictionary.NHS_Business_Definitions.B.Barcelona_Clinic_Liver_Cancer_Stage_Date
- Retired Barcelona Clinic Liver Cancer Stage Date
- Changed Description

BINET STAGE DATE (RETIRED), renamed from BINET STAGE DATE

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

A [Binet Stage Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

A [Binet Stage Date](#) is the date on which the [BINET STAGE](#) was recorded during a [Haematological Cancer Care Spell](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

BINET STAGE DATE (RETIRED), renamed from BINET STAGE DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.B.Binet_Stage_Date to Retired.Data_Dictionary.NHS_Business_Definitions.B.Binet_Stage_Date
- Retired Binet Stage Date
- Changed Description

CANCER CARE SPELL DELAY

Change to Supporting Information: Changed Description

A [Cancer Care Spell Delay](#) is a [REFERRAL DELAY](#).

A [Cancer Care Spell Delay](#) is a delay experienced during a [Cancer Care Spell](#).

The [Cancer Care Spell Delays](#) for cancer waiting time service standards, as specified in the [National Cancer Waiting Times Monitoring Data Set](#) requirements are the delay between:

- [Cancer Referral To Treatment Period Start Date](#) and [DATE FIRST SEEN](#), where [PRIORITY TYPE](#) is National Code 'Two Week Wait'
- [Cancer Referral To Treatment Period Start Date](#) and [Treatment Start Date \(Cancer\)](#), where [PRIORITY TYPE](#) is National Code 'Two Week Wait' and [CANCER TREATMENT EVENT TYPE](#) is National Code 'First Definitive Treatment for a new Primary Cancer' or 'First treatment for metastatic disease following an unknown Primary Cancer'
- [Cancer Referral To Treatment Period Start Date](#) and [Treatment Start Date \(Cancer\)](#), where [PRIORITY TYPE](#) is National Code 'Urgent' and [SOURCE OF REFERRAL FOR OUT PATIENTS](#) is National Code 'Referral from a National Screening Programme' and [CANCER TREATMENT EVENT TYPE](#) is National Code 'First Definitive Treatment for a new Primary Cancer'
- [Cancer Treatment Period Start Date](#) and [Treatment Start Date \(Cancer\)](#), where [CANCER TREATMENT EVENT TYPE](#) is National Code 'First Definitive Treatment for a new Primary Cancer' or 'First treatment for metastatic disease following an unknown Primary Cancer'
- [Consultant Upgrade Date](#) and [Treatment Start Date \(Cancer\)](#), where [CANCER TREATMENT EVENT TYPE](#) is National Code 'First Definitive Treatment for a new Primary Cancer' or 'First treatment for metastatic disease following an unknown Primary Cancer'
- [Cancer Treatment Period Start Date](#) and [Treatment Start Date \(Cancer\)](#), where [CANCER TREATMENT EVENT TYPE](#) is NOT National Code 'First Definitive Treatment for a new Primary Cancer' OR 'First treatment for metastatic disease following an unknown Primary Cancer'
- [CANCER REFERRAL TO TREATMENT PERIOD START DATE](#) and [DATE FIRST SEEN](#), where [PRIORITY TYPE](#) is National Code 'Two Week Wait'
- [CANCER REFERRAL TO TREATMENT PERIOD START DATE](#) and [TREATMENT START DATE \(CANCER\)](#), where [PRIORITY TYPE](#) is National Code 'Two Week Wait' and [CANCER TREATMENT EVENT TYPE](#) is National Code 'First Definitive Treatment for a new Primary Cancer' or 'First treatment for metastatic disease following an unknown Primary Cancer'
- [CANCER REFERRAL TO TREATMENT PERIOD START DATE](#) and [TREATMENT START DATE \(CANCER\)](#), where [PRIORITY TYPE](#) is National Code 'Urgent' and [SOURCE OF REFERRAL FOR OUT-PATIENTS](#) is National Code 'Referral from a National Screening Programme' and [CANCER TREATMENT EVENT TYPE](#) is National Code 'First Definitive Treatment for a new Primary Cancer'

CANCER TREATMENT PERIOD START DATE and TREATMENT START DATE (CANCER), where CANCER TREATMENT EVENT TYPE is National Code 'First Definitive Treatment for a new Primary Cancer' or 'First treatment for metastatic disease following an unknown Primary Cancer'

- Consultant Upgrade Date and TREATMENT START DATE (CANCER), where CANCER TREATMENT EVENT TYPE is National Code 'First Definitive Treatment for a new Primary Cancer' or 'First treatment for metastatic disease following an unknown Primary Cancer'
- CANCER TREATMENT PERIOD START DATE and TREATMENT START DATE (CANCER), where CANCER TREATMENT EVENT TYPE is NOT National Code 'First Definitive Treatment for a new Primary Cancer' OR 'First treatment for metastatic disease following an unknown Primary Cancer'

CANCER DENTAL ASSESSMENT DATE (RETIRED), renamed from CANCER DENTAL ASSESSMENT DATE

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

A [Cancer Dental Assessment Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

A [Cancer Dental Assessment Date](#) is the date of the first dental assessment by a [GENERAL DENTAL PRACTITIONER](#), which contributes to preparation for treatment, during a [Head and Neck Cancer Care Spell](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

CANCER DENTAL ASSESSMENT DATE (RETIRED), renamed from CANCER DENTAL ASSESSMENT DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.C.Cancer_Dental_Assessment_Date to Retired.Data_Dictionary.NHS_Business_Definitions.C.Cancer_Dental_Assessment_Date
- Retired Cancer Dental Assessment Date
- Changed Description

CANCER FASTER DIAGNOSIS PATHWAY END DATE (RETIRED), renamed from CANCER FASTER DIAGNOSIS PATHWAY END DATE

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

A [Cancer Faster Diagnosis Pathway End Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

A [Cancer Faster Diagnosis Pathway End Date](#) is either the [DATE](#) when the [PATIENT](#): The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

- is informed of the [CANCER FASTER DIAGNOSIS PATHWAY END REASON](#), where the National Code is either 'Diagnosis of cancer' or 'Ruling out of cancer'
- is excluded from the [Cancer Faster Diagnosis Pathway](#), where the [CANCER FASTER DIAGNOSIS PATHWAY END REASON](#) National Code is 'Excluded from the Cancer Faster Diagnosis Pathway'

Note: where a [Decision To Treat](#) is made before the [CANCER FASTER DIAGNOSIS PATHWAY END REASON](#) is recorded, then the end of the [Cancer Faster Diagnosis Pathway](#) is the [DECISION TO TREAT DATE](#). Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

CANCER FASTER DIAGNOSIS PATHWAY END DATE (RETIRED), renamed from CANCER FASTER DIAGNOSIS PATHWAY END DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.C.Cancer_Faster_Diagnosis_Pathway_End_Date to Retired.Data_Dictionary.NHS_Business_Definitions.C.Cancer_Faster_Diagnosis_Pathway_End_Date
- Retired Cancer Faster Diagnosis Pathway End Date
- Changed Description

CANCER REFERRAL TO TREATMENT PERIOD

Change to Supporting Information: Changed Description

A [Cancer Referral To Treatment Period](#) is a [REFERRAL TO TREATMENT PERIOD](#).

The service standard for referral to treatment for cancer is that the [PATIENT](#) must receive [First Definitive Treatment](#) within 62 days (or 31 days for Acute Leukaemia, testicular, and children's cancers), rather than within [18 Weeks](#).

A [PATIENT](#) will have a [Cancer Referral To Treatment Period](#) in the following circumstances:

- The [PATIENT](#) was referred to secondary care with suspected cancer by a [GENERAL MEDICAL PRACTITIONER](#) or [GENERAL DENTAL PRACTITIONER](#), where the [PRIORITY TYPE](#) is National Code 'Two Week Wait'

- The [PATIENT](#) was referred to secondary care and cancer was not initially suspected, but was subsequently diagnosed, and the [PATIENT](#) was referred on to an appropriate specialist

A [Cancer Referral To Treatment Period](#) is the period of time between [Cancer Referral To Treatment Period Start Date](#) and either the [Cancer Referral To Treatment Period](#) is the period of time between [CANCER REFERRAL TO TREATMENT PERIOD START DATE](#) and either the:

- [Treatment Start Date \(Cancer\)](#), where a [PATIENT](#) diagnosed with a cancer condition receives [First Definitive Treatment](#)
- [TREATMENT START DATE \(CANCER\)](#), where a [PATIENT](#) diagnosed with a cancer condition receives [First Definitive Treatment](#)
- [CANCER FASTER DIAGNOSIS PATHWAY END DATE](#) where a [PATIENT](#) referred with suspected cancer by a [GENERAL MEDICAL PRACTITIONER](#) or [GENERAL DENTAL PRACTITIONER](#) has cancer ruled out
- [DATE](#) the [PATIENT](#) declines [First Definitive Treatment](#), or
- [DATE](#) that [Active Monitoring](#) (as a [First Definitive Treatment](#)) starts.

A [Cancer Referral To Treatment Period](#) does NOT complete automatically if the [PATIENT](#) does not attend the first [APPOINTMENT](#) during the [Cancer Referral To Treatment Period](#). [WAITING TIME ADJUSTMENT \(FIRST SEEN\)](#) is used to align waiting times monitoring with the service standard for [18 Weeks](#).

CANCER REFERRAL TO TREATMENT PERIOD START DATE (RETIRED), renamed from CANCER REFERRAL TO TREATMENT PERIOD START DATE

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

A [Cancer Referral To Treatment Period Start Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

A [Cancer Referral To Treatment Period Start Date](#) is the [Start Date](#) of a [Cancer Referral To Treatment Period](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

A [Cancer Referral To Treatment Period Start Date](#) will be one of the following: Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

- The [REFERRAL REQUEST RECEIVED DATE](#) of the [SERVICE REQUEST](#):
 - to secondary care by a [GENERAL MEDICAL PRACTITIONER](#) or [GENERAL DENTAL PRACTITIONER](#) where the [PRIORITY TYPE](#) is National Code 'Two Week Wait' *
 - to secondary care where the [PATIENT](#) was subsequently upgraded onto a [Cancer Pathway](#). The [CONSULTANT UPGRADE DATE](#) will also be recorded, as this is the [DATE](#) used to calculate the start of the two month (62 day) waiting time target for [PATIENTS](#) who have been upgraded to a [Cancer Pathway](#)
 - into secondary care when the [PATIENT](#) was referred urgently for 'breast symptoms', where the [PRIORITY TYPE](#) is National Code 'Two Week Wait' *
 - to an Assessment Clinic following the identification of an abnormality by an NHS Cancer [Screening Service](#), where the [PRIORITY TYPE](#) is National Code 'Urgent' *
- The [ORIGINAL REFERRAL REQUEST RECEIVED DATE](#) for the initial [SERVICE REQUEST](#) to secondary care by an NHS Cancer [Screening Service](#), where the [PRIORITY TYPE](#) is National Code 'Routine', and where the [PATIENT](#) was subsequently upgraded onto a [Cancer Pathway](#). The [CONSULTANT UPGRADE DATE](#) will also be recorded.

Notes:

- * The start of the [Cancer Faster Diagnosis Pathway](#) will be the [Cancer Referral To Treatment Period Start Date](#) for the items annotated.
- For a [SERVICE REQUEST](#) received from the [Choose and Book](#) system, the referral is received when the [PATIENT](#)'s Unique Booking Reference Number (UBRN) is used to book the first [Out Patient Appointment](#) slot (i.e. converted). See [REFERRAL REQUEST RECEIVED DATE](#).

CANCER REFERRAL TO TREATMENT PERIOD START DATE (RETIRED), renamed from CANCER REFERRAL TO TREATMENT PERIOD START DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.C.Cancer_Referral_To_Treatment_Period_Start_Date to Retired.Data_Dictionary.NHS_Business_Definitions.C.Cancer_Referral_To_Treatment_Period_Start_Date
- Retired Cancer Referral To Treatment Period Start Date
- Changed Description

CANCER SYMPTOMS FIRST NOTED DATE (RETIRED), renamed from CANCER SYMPTOMS FIRST NOTED DATE

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

A [Cancer Symptoms First Noted Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

A [Cancer Symptoms First Noted Date](#) is the date when the symptoms were first noted related to the cancer diagnosis as agreed between the [CONSULTANT](#) and the [PATIENT](#) during a [Cancer Care Spell](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

CANCER SYMPTOMS FIRST NOTED DATE (RETIRED), renamed from CANCER SYMPTOMS FIRST NOTED DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.C.Cancer_Symptoms_First_Noted_Date to Retired.Data_Dictionary.NHS_Business_Definitions.C.Cancer_Symptoms_First_Noted_Date
- Retired Cancer Symptoms First Noted Date
- Changed Description

CANCER TREATMENT PERIOD

Change to Supporting Information: Changed Description

A [Cancer Treatment Period](#) is an [ACTIVITY GROUP](#).

A [Cancer Treatment Period](#) is:

- initiated when a [Decision To Treat](#) for a cancer condition is made and
- ends when the [PATIENT](#) receives the [Planned Cancer Treatment](#) specified in the [Cancer Care Plan](#) covering the [PATIENTS](#) condition. This is the same as [Treatment Start Date \(Cancer\)](#).
- ends when the [PATIENT](#) receives the [Planned Cancer Treatment](#) specified in the [Cancer Care Plan](#) covering the [PATIENTS](#) condition. This is the same as [TREATMENT START DATE \(CANCER\)](#).

The full list of [International Classification of Diseases \(ICD\)](#) diagnosis codes is available on the [NHS Digital](#) website at: [Cancer Waiting Times](#).

If the [PATIENT](#) receives several different types of treatment within the same [Cancer Care Plan](#) (e.g. surgery, followed by [Chemotherapy](#), followed by [Radiotherapy](#)), then each stage has its own [Cancer Treatment Period](#) of 31 days between [DECISION TO TREAT DATE](#) (or [EARLIEST CLINICALLY APPROPRIATE DATE](#)) and [Treatment Start Date \(Cancer\)](#). If the [PATIENT](#) receives several different types of treatment within the same [Cancer Care Plan](#) (e.g. surgery, followed by [Chemotherapy](#), followed by [Radiotherapy](#)), then each stage has its own [Cancer Treatment Period](#) of 31 days between [DECISION TO TREAT DATE](#) (or [EARLIEST CLINICALLY APPROPRIATE DATE](#)) and [TREATMENT START DATE \(CANCER\)](#).

[CANCER CARE SETTING \(TREATMENT\)](#) is used to derive whether a waiting time adjustment between [Cancer Treatment Period Start Date](#) and [Treatment Start Date \(Cancer\)](#) may be recorded in [WAITING TIME ADJUSTMENT \(TREATMENT\)](#). [CANCER CARE SETTING \(TREATMENT\)](#) is used to derive whether a waiting time adjustment between [CANCER TREATMENT PERIOD START DATE](#) and [TREATMENT START DATE \(CANCER\)](#) may be recorded in [WAITING TIME ADJUSTMENT \(TREATMENT\)](#).

CANCER TREATMENT PERIOD START DATE (RETIRED), renamed from CANCER TREATMENT PERIOD START DATE

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

A [Cancer Treatment Period Start Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

A [Cancer Treatment Period Start Date](#) is the [Start Date](#) of a [Cancer Treatment Period](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

A [Cancer Treatment Period Start Date](#) will be either: Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

- the [DECISION TO TREAT DATE](#)
 - the [DATE](#) that a [PATIENT](#) agrees a treatment plan for either first or subsequent treatments within a [Cancer Care Plan](#). An individual [PATIENT](#) may have multiple [DECISION TO TREAT DATES](#) or
- the [EARLIEST CLINICALLY APPROPRIATE DATE](#)
 - where there is no new [DECISION TO TREAT DATE](#), but there has been a previously agreed and clinically appropriate period of delay. In this case the subsequent [ACTIVITY](#) may not be the final treatment, but could be the next [APPOINTMENT](#) which deals with the planning of subsequent treatments.

CANCER TREATMENT PERIOD START DATE (RETIRED), renamed from CANCER TREATMENT PERIOD START DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.C.Cancer_Treatment_Period_Start_Date to Retired.Data_Dictionary.NHS_Business_Definitions.C.Cancer_Treatment_Period_Start_Date
- Retired Cancer Treatment Period Start Date
- Changed Description

CARE PROGRAMME APPROACH REVIEW DATE (RETIRED), renamed from CARE PROGRAMME APPROACH REVIEW DATE

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

A [Care Programme Approach Review Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

A [Care Programme Approach Review Date](#) is the date of the [Care Programme Approach Review](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

CARE PROGRAMME APPROACH REVIEW DATE (RETIRED), renamed from CARE PROGRAMME APPROACH REVIEW DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.C.Care_Programme_Approach_Review_Date to Retired.Data_Dictionary.NHS_Business_Definitions.C.Care_Programme_Approach_Review_Date
- Retired Care Programme Approach Review Date
- Changed Description

CHANG STAGING SYSTEM STAGE DATE (RETIRED), renamed from CHANG STAGING SYSTEM STAGE DATE

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

A [Chang Staging System Stage Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

A [Chang Staging System Stage Date](#) is the date on which the [CHANG STAGING SYSTEM STAGE](#) was recorded during a [Central Nervous System Cancer Care Spell](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

CHANG STAGING SYSTEM STAGE DATE (RETIRED), renamed from CHANG STAGING SYSTEM STAGE DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.C.Chang_Staging_System_Stage_Date to Retired.Data_Dictionary.NHS_Business_Definitions.C.Chang_Staging_System_Stage_Date
- Retired Chang Staging System Stage Date
- Changed Description

CHILD PROTECTION PLAN END DATE (RETIRED), renamed from CHILD PROTECTION PLAN END DATE

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

A [Child Protection Plan End Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

A [Child Protection Plan End Date](#) is the date on which a [Child or Young Person](#) is removed from a [Child Protection Plan](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

CHILD PROTECTION PLAN END DATE (RETIRED), renamed from CHILD PROTECTION PLAN END DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.C.Child_Protection_Plan_End_Date to Retired.Data_Dictionary.NHS_Business_Definitions.C.Child_Protection_Plan_End_Date
- Retired Child Protection Plan End Date
- Changed Description

CHILD PROTECTION PLAN START DATE (RETIRED), renamed from CHILD PROTECTION PLAN START DATE

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

A [Child Protection Plan Start Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

A [Child Protection Plan Start Date](#) is the date on which a [Child or Young Person](#) is placed on a [Child Protection Plan](#).

The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

CHILD PROTECTION PLAN START DATE (RETIRED), renamed from CHILD PROTECTION PLAN START DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.C.Child_Protection_Plan_Start_Date to Retired.Data_Dictionary.NHS_Business_Definitions.C.Child_Protection_Plan_Start_Date
- Retired Child Protection Plan Start Date
- Changed Description

CLINICAL ASSESSMENT DATE (RETIRED), renamed from CLINICAL ASSESSMENT DATE

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

A [Clinical Assessment Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

A [Clinical Assessment Date](#) is the date a [CARE PROFESSIONAL](#) undertakes a physical examination and clinical history of the [PATIENT](#) during a [Care Spell](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

For the [Cancer Outcomes and Services Data Set](#), the [Clinical Assessment Date](#) is undertaken during a [Breast Cancer Care Spell](#). Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

CLINICAL ASSESSMENT DATE (RETIRED), renamed from CLINICAL ASSESSMENT DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.C.Clinical_Assessment_Date to Retired.Data_Dictionary.NHS_Business_Definitions.C.Clinical_Assessment_Date
- Retired Clinical Assessment Date
- Changed Description

CLINICAL STAGE DATE (PANCREATIC CANCER) (RETIRED), renamed from CLINICAL STAGE DATE (PANCREATIC CANCER)

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

A [Clinical Stage Date \(Pancreatic Cancer\)](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

A [Clinical Stage Date \(Pancreatic Cancer\)](#) is the date on which the [CLINICAL STAGE \(PANCREATIC CANCER\)](#) was recorded during an [Upper Gastrointestinal Cancer Care Spell](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

CLINICAL STAGE DATE (PANCREATIC CANCER) (RETIRED), renamed from CLINICAL STAGE DATE (PANCREATIC CANCER)

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.C.Clinical_Stage_Date_(Pancreatic_Cancer) to Retired.Data_Dictionary.NHS_Business_Definitions.C.Clinical_Stage_Date_(Pancreatic_Cancer)
- Retired Clinical Stage Date (Pancreatic Cancer)
- Changed Description

CLINICAL STATUS ASSESSMENT DATE (RETIRED), renamed from CLINICAL STATUS ASSESSMENT DATE

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

A [Clinical Status Assessment Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

A [Clinical Status Assessment Date](#) is the date on which a clinical status assessment was performed during a [Head and Neck Cancer Care Spell](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

CLINICAL STATUS ASSESSMENT DATE (RETIRED), renamed from CLINICAL STATUS ASSESSMENT DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.C.Clinical_Status_Assessment_Date to Retired.Data_Dictionary.NHS_Business_Definitions.C.Clinical_Status_Assessment_Date
- Retired Clinical Status Assessment Date
- Changed Description

CLINIC ATTENDANCE CONSULTANT

Change to Supporting Information: Changed Description

A [Clinic Attendance Consultant](#) is a [CARE CONTACT](#).

A [Clinic Attendance Consultant](#) is an [Out-Patient Attendance Consultant](#).

A [Clinic Attendance Consultant](#) is an attendance or contact at which a [PATIENT](#) is seen by or in contact with a [CONSULTANT](#), or member of the [CONSULTANTS](#) firm, at a [Consultant Clinic](#).

A [PATIENT](#) attending or being contacted by a clinic will always be given an [Out-Patient Appointment Consultant](#) (even when arriving with no prior notice), but [APPOINTMENTS](#) will not always result in an attendance or contact.

If an [APPOINTMENT TIME](#) was given, the time seen should be recorded.

Information recorded for a [Clinic Attendance Consultant](#) includes:

[COLPOSCOPY PRIME PROCEDURE TYPE](#) ☐ (colposcopy only)
[Time Seen](#)

CONTACT DATE (RETIRED), renamed from CONTACT DATE

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

A [Contact Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

A [Contact Date](#) is the date on which a face to face contact or telephone contact takes place. The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

CONTACT DATE (RETIRED), renamed from CONTACT DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.C.Contact_Date to Retired.Data_Dictionary.NHS_Business_Definitions.C.Contact_Date
- Retired Contact Date
- Changed Description

CRITICAL CARE PERIOD DISCHARGE DATE AND TIME (RETIRED), renamed from CRITICAL CARE PERIOD DISCHARGE DATE AND TIME

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

[Critical Care Period Discharge Date and Time](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

[Critical Care Period Discharge Date and Time](#) is the [End Date](#) and [End Time](#) of a [CRITICAL CARE PERIOD](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

CRITICAL CARE PERIOD DISCHARGE DATE AND TIME (RETIRED), renamed from CRITICAL CARE PERIOD DISCHARGE DATE AND TIME

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.C.Critical_Care_Period_Discharge_Date_and_Time to Retired.Data_Dictionary.NHS_Business_Definitions.C.Critical_Care_Period_Discharge_Date_and_Time
- Retired Critical Care Period Discharge Date and Time
- Changed Description

CRITICAL CARE PERIOD START DATE AND TIME (RETIRED), renamed from CRITICAL CARE PERIOD START DATE AND TIME

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

[Critical Care Period Start Date and Time](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

[Critical Care Period Start Date and Time](#) is the [Start Date](#) and [Start Time](#) of a [CRITICAL CARE PERIOD](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

CRITICAL CARE PERIOD START DATE AND TIME (RETIRED), renamed from CRITICAL CARE PERIOD START DATE AND TIME

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.C.Critical_Care_Period_Start_Date_and_Time to Retired.Data_Dictionary.NHS_Business_Definitions.C.Critical_Care_Period_Start_Date_and_Time
- Retired Critical Care Period Start Date and Time
- Changed Description

DATE FIRST SEEN (RETIRED), renamed from DATE FIRST SEEN

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

[Date First Seen](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

[Date First Seen](#) is the date that the [PATIENT](#) is first seen in the Trust that receives the first referral. The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

[Date First Seen](#) will be one of the following, whichever is the earliest [SERVICE](#) relating to the [REFERRAL REQUEST](#): Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

- first [Out Patient Appointment](#); this is the [Attendance Date](#) of the first [Out Patient Attendance Consultant](#)
- first diagnostic procedure if this precedes the first [Out Patient Appointment](#); this is the first [Clinical Intervention Date](#) of the [Imaging or Radiodiagnostic Event](#) or [CLINICAL INTERVENTION](#)
- first seen as an emergency; this is the [Start Date](#) of the [Hospital Provider Spell](#) or the [Arrival Date At Accident and Emergency Department](#) of the [Accident and Emergency Attendance](#)
- the date the [PATIENT](#) was first seen following referral (or recall) from (or by) a Screening Unit.

DATE FIRST SEEN (RETIRED), renamed from DATE FIRST SEEN

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.D.Date_First_Seen to Retired.Data_Dictionary.NHS_Business_Definitions.D.Date_First_Seen
- Retired Date First Seen
- Changed Description

DECISION TO DELIVER

Change to Supporting Information: Changed Description

A [Decision To Deliver](#) is a [CARE ACTIVITY](#).

A [Decision To Deliver](#) is the decision made to accelerate the delivery of the baby by caesarean section or instrumental birth.

FINAL FIGO STAGE DATE (RETIRED), renamed from FINAL FIGO STAGE DATE

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

A [Final Figo Stage Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

A [Final Figo Stage Date](#) is the date on which the [FINAL FIGO STAGE](#) was recorded during a [Gynaecological Cancer Care Spell](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

FINAL FIGO STAGE DATE (RETIRED), renamed from FINAL FIGO STAGE DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.F.Final_Figo_Stage_Date to Retired.Data_Dictionary.NHS_Business_Definitions.F.Final_Figo_Stage_Date
- Retired Final Figo Stage Date
- Changed Description

FIVE FORENSIC PATHWAYS

Change to Supporting Information: Changed Description

Five Forensic Pathways is a CARE CLUSTER.

Five Forensic Pathways (FFP) are part of a currency developed to support the National Tariff Payment System for Forensic Mental Health Services.

Five Forensic Pathways are 5 groupings of Forensic Mental Health Patients based on their presenting characteristics and projected care package needs.

Five Forensic Pathways are initially allocated on the basis of the pathway descriptors only. The allocation may be reviewed and adjusted if necessary on the basis of baseline measures.

FIVE FORENSIC PATHWAYS ASSESSMENT DATE (RETIRED), renamed from FIVE FORENSIC PATHWAYS ASSESSMENT DATE

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

A Five Forensic Pathways Assessment Date is an ACTIVITY DATE TIME. This item has been retired from the NHS Data Model and Dictionary.

A Five Forensic Pathways Assessment Date is the date on which a Five Forensic Pathways assessment was completed for a PATIENT. The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

FIVE FORENSIC PATHWAYS ASSESSMENT DATE (RETIRED), renamed from FIVE FORENSIC PATHWAYS ASSESSMENT DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.F.Five_Forensic_Pathways_Assessment_Date to Retired.Data_Dictionary.NHS_Business_Definitions.F.Five_Forensic_Pathways_Assessment_Date
- Retired Five Forensic Pathways Assessment Date
- Changed Description

HEALTH VISITOR FIRST ANTENATAL VISIT DATE (RETIRED), renamed from HEALTH VISITOR FIRST ANTENATAL VISIT DATE

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

A Health Visitor First Antenatal Visit Date is an ACTIVITY DATE TIME. This item has been retired from the NHS Data Model and Dictionary.

A Health Visitor First Antenatal Visit Date is the date of the first antenatal CARE CONTACT between the Health Visitor and the pregnant woman. The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

HEALTH VISITOR FIRST ANTENATAL VISIT DATE (RETIRED), renamed from HEALTH VISITOR FIRST ANTENATAL VISIT DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.H.Health_Visitor_First_Antenatal_Visit_Date to Retired.Data_Dictionary.NHS_Business_Definitions.H.Health_Visitor_First_Antenatal_Visit_Date
- Retired Health Visitor First Antenatal Visit Date
- Changed Description

HOLISTIC NEEDS ASSESSMENT COMPLETED DATE (RETIRED), renamed from HOLISTIC NEEDS ASSESSMENT COMPLETED DATE

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

A Holistic Needs Assessment Completed Date is an ACTIVITY DATE TIME. This item has been retired from the NHS Data Model and Dictionary.

A Holistic Needs Assessment Completed Date is the date a Holistic Needs Assessment is completed. The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

HOLISTIC NEEDS ASSESSMENT COMPLETED DATE (RETIRED), renamed from HOLISTIC NEEDS ASSESSMENT COMPLETED DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.H.Holistic_Needs_Assessment_Completed_Date to Retired.Data_Dictionary.NHS_Business_Definitions.H.Holistic_Needs_Assessment_Completed_Date
 - Retired Holistic Needs Assessment Completed Date
 - Changed Description
-

IMAGING OR RADIODIAGNOSTIC EVENT DATE (RETIRED), renamed from IMAGING OR RADIODIAGNOSTIC EVENT DATE

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

A [Imaging or Radiodiagnostic Event Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

A [Imaging or Radiodiagnostic Event Date](#) is the date on which the [Imaging or Radiodiagnostic Event](#) was performed. The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

IMAGING OR RADIODIAGNOSTIC EVENT DATE (RETIRED), renamed from IMAGING OR RADIODIAGNOSTIC EVENT DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.I.Imaging_or_Radiodiagnostic_Event_Date to Retired.Data_Dictionary.NHS_Business_Definitions.I.Imaging_or_Radiodiagnostic_Event_Date
 - Retired Imaging or Radiodiagnostic Event Date
 - Changed Description
-

IMMUNISATION DATE (RETIRED), renamed from IMMUNISATION DATE

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

An [Immunisation Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

An [Immunisation Date](#) is the date on which the immunisation was carried out. The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

IMMUNISATION DATE (RETIRED), renamed from IMMUNISATION DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.I.Immunisation_Date to Retired.Data_Dictionary.NHS_Business_Definitions.I.Immunisation_Date
 - Retired Immunisation Date
 - Changed Description
-

IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES CONTACT

Change to Supporting Information: Changed Description

An [Improving Access to Psychological Therapies Contact](#) is a [CARE CONTACT](#), where the [CARE CONTACT TYPE](#) is National Code '[Improving Access to Psychological Therapies Contact](#)'. An [Improving Access to Psychological Therapies Contact](#) is a [CARE CONTACT](#).

An [Improving Access to Psychological Therapies Contact](#) is an assessment or intervention provided by an [Improving Access to Psychological Therapies Service](#) offering a range of evidence based interventions in accordance with the [National Institute for Health and Care Excellence \(NICE\)](#) guidelines for people suffering from depression and anxiety disorders.

INFANT PHYSICAL EXAMINATION DATE (RETIRED), renamed from INFANT PHYSICAL EXAMINATION DATE

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

An [Infant Physical Examination Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

An [Infant Physical Examination](#) is the date of the [Infant Physical Examination](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

INFANT PHYSICAL EXAMINATION DATE (RETIRED), renamed from INFANT PHYSICAL EXAMINATION DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.I.Infant_Physical_Examination_Date to Retired.Data_Dictionary.NHS_Business_Definitions.I.Infant_Physical_Examination_Date
- Retired Infant Physical Examination Date
- Changed Description

INJURY DATE (RETIRED), renamed from INJURY DATE

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

An [Injury Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

[Injury Date](#) is the [DATE](#) the [PATIENT](#) was injured. Where this information cannot be obtained directly from the [PATIENT](#) (or [Patient Proxy](#)), the [Injury Date](#) should be estimated. The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

INJURY DATE (RETIRED), renamed from INJURY DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.I.Injury_Date to Retired.Data_Dictionary.NHS_Business_Definitions.I.Injury_Date
- Retired Injury Date
- Changed Description

INJURY TIME (RETIRED), renamed from INJURY TIME

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

An [Injury Time](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

[Injury Time](#) is the [TIME](#) the [PATIENT](#) was injured. Where this information cannot be obtained directly from the [PATIENT](#) (or [Patient Proxy](#)), the [Injury Time](#) should be estimated. The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

INJURY TIME (RETIRED), renamed from INJURY TIME

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.I.Injury_Time to Retired.Data_Dictionary.NHS_Business_Definitions.I.Injury_Time
- Retired Injury Time
- Changed Description

INTENDED SMOKING QUIT DATE

Change to Supporting Information: Changed Description

[Intended Smoking Quit Date](#) is an [ACTIVITY DATE TIME](#). [Intended Smoking Quit Date](#) is a [PLANNED ACTIVITY DATE TIME](#).

[Intended Smoking Quit Date](#) is the [DATE](#) set by a [PERSON](#) on which they intend to stop smoking.

For [PERSONS](#) using bupropion, it is recommended that an [Intended Smoking Quit Date](#) is set within the first 2 weeks of therapy, usually in the second week, e.g. day 8.

For [PERSONS](#) using varenicline, current license specification and preliminary guidance indicates that an [Intended Smoking Quit Date](#) should fall on the 8th day after commencement of dosing with varenicline.

INTERGROUP RHABDOMYOSARCOMA STUDY POST SURGICAL GROUP DATE (RETIRED)_ renamed from INTERGROUP RHABDOMYOSARCOMA STUDY POST SURGICAL GROUP DATE

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

An [Intergroup Rhabdomyosarcoma Study Post Surgical Group Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

An [Intergroup Rhabdomyosarcoma Study Post Surgical Group Date](#) is the date on which the [INTERGROUP RHABDOMYOSARCOMA STUDY POST SURGICAL GROUP](#) was recorded during a [Sarcoma Cancer Care Spell](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

INTERGROUP RHABDOMYOSARCOMA STUDY POST SURGICAL GROUP DATE (RETIRED)_ renamed from INTERGROUP RHABDOMYOSARCOMA STUDY POST SURGICAL GROUP DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.I.Intergroup_Rhabdomyosarcoma_Study_Post_Surgical_Group_Date to Retired.Data_Dictionary.NHS_Business_Definitions.I.Intergroup_Rhabdomyosarcoma_Study_Post_Surgical_Group_Date
- Retired Intergroup Rhabdomyosarcoma Study Post Surgical Group Date
- Changed Description

INTERNATIONAL NEUROBLASTOMA RISK GROUP STAGING SYSTEM STAGE DATE (RETIRED)_ renamed from INTERNATIONAL NEUROBLASTOMA RISK GROUP STAGING SYSTEM STAGE DATE

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

An [International Neuroblastoma Risk Group Staging System Stage Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

An [International Neuroblastoma Risk Group Staging System Stage Date](#) is the date on which the [INTERNATIONAL NEUROBLASTOMA RISK GROUP STAGING SYSTEM STAGE](#) was recorded during a [Children Teenagers and Young Adults Cancer Care Spell](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

INTERNATIONAL NEUROBLASTOMA RISK GROUP STAGING SYSTEM STAGE DATE (RETIRED)_ renamed from INTERNATIONAL NEUROBLASTOMA RISK GROUP STAGING SYSTEM STAGE DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.I.International_Neuroblastoma_Risk_Group_Staging_System_Stage_Date to Retired.Data_Dictionary.NHS_Business_Definitions.I.International_Neuroblastoma_Risk_Group_Staging_System_Stage_Date
- Retired International Neuroblastoma Risk Group Staging System Stage Date
- Changed Description

MODIFIED DUKES STAGE DATE (RETIRED)_ renamed from MODIFIED DUKES STAGE DATE

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

A [Modified Dukes Stage Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

A [Modified Dukes Stage Date](#) is the date on which the [MODIFIED DUKES STAGE](#) was recorded during a [Cancer Care Spell](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

MODIFIED DUKES STAGE DATE (RETIRED)_ renamed from MODIFIED DUKES STAGE DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.M.Modified_Dukes_Stage_Date to Retired.Data_Dictionary.NHS_Business_Definitions.M.Modified_Dukes_Stage_Date
- Retired Modified Dukes Stage Date
- Changed Description

MURPHY ST JUDE STAGE DATE (RETIRED), renamed from MURPHY ST JUDE STAGE DATE

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

A [Murphy \(St Jude\) Stage Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

A [Murphy \(St Jude\) Stage Date](#) is the date on which the [MURPHY ST JUDE STAGE](#) was recorded during a [Haematological Cancer Care Spell](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

MURPHY ST JUDE STAGE DATE (RETIRED), renamed from MURPHY ST JUDE STAGE DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.M.Murphy_St_Jude_Stage_Date to Retired.Data_Dictionary.NHS_Business_Definitions.M.Murphy_St_Jude_Stage_Date
- Retired Murphy St Jude Stage Date
- Changed Description

MYELOMA INTERNATIONAL STAGING SYSTEM STAGE DATE (RETIRED), renamed from MYELOMA INTERNATIONAL STAGING SYSTEM STAGE DATE

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

A [Myeloma International Staging System Stage Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

A [Myeloma International Staging System Stage Date](#) is the date on which the [MYELOMA INTERNATIONAL STAGING SYSTEM STAGE](#) was recorded during a [Haematological Cancer Care Spell](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

MYELOMA INTERNATIONAL STAGING SYSTEM STAGE DATE (RETIRED), renamed from MYELOMA INTERNATIONAL STAGING SYSTEM STAGE DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.M.Myeloma_International_Staging_System_Stage_Date to Retired.Data_Dictionary.NHS_Business_Definitions.M.Myeloma_International_Staging_System_Stage_Date
- Retired Myeloma International Staging System Stage Date
- Changed Description

NATIONAL CANCER WAITING TIMES MONITORING DATA SET OVERVIEW

Change to Supporting Information: Changed Description

Introduction:

The information in the [National Cancer Waiting Times Monitoring Data Set](#) is required to provide details on cancer [SERVICES](#) in England. This enables the performance monitoring of [Health Care Providers](#) and [Clinical Commissioning Groups](#) in order to maintain and increase standards across England.

Cancer Waiting Times data relates to:

- the waiting time requirements outlined in the '[NHS Cancer Plan \(2000\)](#)' and the '[Cancer Reform Strategy \(2007\)](#)' and
- a performance standard that [PATIENTS](#) should wait no longer than 28 days from initial referral by a [GENERAL PRACTITIONER](#) to diagnosis or ruling out of cancer (the 28 Day Faster Diagnosis Standard) introduced by the Independent Cancer Taskforce, '[Achieving World-Class Cancer Outcomes](#)'.

The '[Cancer Reform Strategy \(2007\)](#)' introduced new and changed commitments in terms of service standards for cancer [PATIENTS](#) that must be met. A Review of Cancer Waiting Times Standards was carried out by the [Department of Health and Social Care](#) and published alongside '[Improving Outcomes: A Strategy for Cancer \(2011\)](#)'.

The [National Cancer Waiting Times Monitoring Data Set](#) supports the continued management and monitoring of the following waiting times:

- A maximum two week wait from an urgent [GENERAL PRACTITIONER](#) referral for suspected cancer to [DATE FIRST SEEN](#) by a specialist for all suspected cancers
- A maximum 28 day wait from an urgent [GENERAL PRACTITIONER](#) referral for suspected cancer to having cancer either diagnosed or ruled out ([CANCER FASTER DIAGNOSIS PATHWAY END DATE](#)), or [DECISION TO TREAT DATE](#), whichever comes first, for all suspected cancers
- A maximum 28 day wait from referral for breast symptoms (where cancer is not initially suspected) to having cancer either diagnosed or ruled out ([CANCER FASTER DIAGNOSIS PATHWAY END DATE](#)), or [DECISION TO TREAT DATE](#), whichever comes first, for all suspected cancers

- A maximum 28 day wait from a referral to an Assessment [CLINIC OR FACILITY](#) following the identification of an abnormality by an NHS Cancer [Screening Service](#) to having cancer either diagnosed or ruled out ([CANCER FASTER DIAGNOSIS PATHWAY END DATE](#)), or [DECISION TO TREAT DATE](#), whichever comes first, for all suspected cancers
- A maximum one month (31-day) wait from diagnosis ([Cancer Treatment Period Start Date](#)) to [First Definitive Treatment](#) for all cancers
- A maximum one month (31-day) wait from diagnosis ([CANCER TREATMENT PERIOD START DATE](#)) to [First Definitive Treatment](#) for all cancers
- A maximum two month (62-day) wait from urgent [GENERAL PRACTITIONER](#) referral for suspected cancer to [First Definitive Treatment](#) for all cancers
- A maximum one month (31-day) wait from urgent [GENERAL PRACTITIONER](#) referral for suspected cancer to [First Definitive Treatment](#) for children's cancers, testicular cancers and acute leukaemia
- A maximum 62-day wait from referral from an NHS Cancer [Screening Programme](#) to [First Definitive Treatment](#) for all cancers
- A maximum 62-day wait from a [CONSULTANTS](#) decision to upgrade the urgency of a [PATIENT](#) they suspect to have cancer to [First Definitive Treatment](#) for all cancers
- A maximum 31-day wait for all subsequent treatments for new cases of primary and [Recurrent Cancer](#) where an [Anti-Cancer Drug Regimen](#), surgery or [Radiotherapy](#) is the chosen [CANCER TREATMENT MODALITY](#)
- A maximum two week wait from referral for breast symptoms (where cancer is not initially suspected) to [DATE FIRST SEEN](#).

Patient Pathway Scenarios:

The [Patient Pathway Scenarios](#) for the [National Cancer Waiting Times Monitoring Data Set](#) are to be used to manage the collection of data for all [PATIENTS](#) suspected of having, or diagnosed with cancer.

Transmission:

- Data can be transmitted to the Cancer Waiting Times System through any of three routes:
 - Bulk upload via an XML file
 - Bulk upload via a CSV file
 - Single record entry through the Cancer Waiting Times Submission portal
- The specification for CSV upload file is detailed in the '[National Cancer Waiting Times User Manual](#)' available on the [NHS Digital](#) website
- Data for XML submission will be formatted into an XML file as per [Technology Reference Data Update Distribution \(TRUD\)](#) at: [NHS Data Model and Dictionary: DD XML Schemas](#)
- Once data is transmitted to the Cancer Waiting Times system it will undergo further validation. Details of this validation is available on the [NHS Digital](#) website at: [Cancer Waiting Times](#).

Further guidance:

- Further guidance relating to the [National Cancer Waiting Times Monitoring Data Set](#) is available on the [NHS Digital](#) website at: [Cancer Waiting Times](#).
- Queries regarding the [National Cancer Waiting Times Monitoring Data Set](#) should be addressed to CANCER-WAITS@dh.gsi.gov.uk.

NATIONAL CANCER WAITING TIMES MONITORING DATA SET SCENARIOS

Change to Supporting Information: Changed Description

[National Cancer Waiting Times Monitoring Data Set](#)

Concept of Operation and Patient Pathway Scenarios:

The [National Cancer Waiting Times Monitoring Data Set](#) is a generic data set designed to support the monitoring of waiting times for a variety of different pathways of cancer care. For the purpose of this data collection cancer is defined using the [International Classification of Diseases \(ICD\)](#) codes. The full list of [International Classification of Diseases \(ICD\)](#) diagnosis codes is available on the [NHS Digital](#) website at: [Cancer Waiting Times](#).

Collection and submission of the [National Cancer Waiting Times Monitoring Data Set](#) is to be managed according to the maximum waiting time and information requirements of the pathway of care for each individual [PATIENT](#). These requirements for providers of cancer [SERVICES](#) to return data to the Cancer Waiting Times Database are defined using different scenarios.

- **Scenario 1a:**
The [Health Care Provider](#) where the [PATIENT](#) is first seen following a [REFERRAL REQUEST](#) with [PRIORITY TYPE](#) 'Two Week Wait', or where an urgent referral is from an NHS Cancer [Screening Programme](#), and where the [PATIENT](#) has not had a [Decision To Treat](#), has not had the diagnosis outcome communicated, and the [PATIENT](#) has not been excluded from the [Cancer Faster Diagnosis Pathway](#). No inter-provider transfers are in progress.
- **Scenario 1a:**
The [Health Care Provider](#) where the [PATIENT](#) is first seen following a [REFERRAL REQUEST](#) with [PRIORITY TYPE](#) 'Two Week Wait', or where an urgent referral is from an NHS Cancer [Screening Programme](#), and where the [PATIENT](#) has not had a [Decision To Treat](#), has not had the diagnosis outcome communicated, and the [PATIENT](#) has not been excluded from the [Cancer Faster Diagnosis Pathway](#). No inter-provider transfers are in progress.
- **Scenario 1b:**
The [Health Care Provider](#) where the [PATIENT](#) is first seen following a [REFERRAL REQUEST](#) with [PRIORITY TYPE](#) 'Two Week Wait', or where an urgent referral is from an NHS Cancer [Screening Programme](#), and where the [PATIENT](#) has not had a [Decision To Treat](#), has not had the diagnosis outcome communicated, and the [PATIENT](#) has not been excluded from the [Cancer Faster Diagnosis Pathway](#). No inter-provider transfers are in progress.
- **Scenario 1c:**
The [Health Care Provider](#) where the [PATIENT](#) receives [First Definitive Treatment](#) for cancer following a [REFERRAL REQUEST](#) with [PRIORITY TYPE](#) 'Two Week Wait', or where an urgent referral is from an NHS Cancer [Screening Programme](#)
- **Scenario 1d:**
The [Health Care Provider](#) where the [PATIENT](#) is first seen following a [REFERRAL REQUEST](#) with [PRIORITY TYPE](#) 'Two Week Wait', or where an urgent referral is from an NHS Cancer [Screening Programme](#), and where the [PATIENT](#) has had the [Decision To Treat](#), has had the diagnosis

outcome communicated, and the [PATIENT](#) has not been excluded from the [Cancer Faster Diagnosis Pathway](#). No inter-provider transfers are in progress.

• **Scenario 1e:**

The [Health Care Provider](#) where the [PATIENT](#) is first seen following a [REFERRAL REQUEST](#) with [PRIORITY TYPE](#) 'Two Week Wait', or where an urgent referral is from an NHS Cancer [Screening Programme](#), and where the [PATIENT](#) has not had a [Decision To Treat](#), has not had the diagnosis outcome communicated, and the [PATIENT](#) has not been excluded from the [Cancer Faster Diagnosis Pathway](#). The [Health Care Provider](#) sends the [PATIENT](#) to another [Health Care Provider](#), that is, makes an inter-provider transfer.

• **Scenario 1f:**

The [Health Care Provider](#) receiving an inter-provider transfer of a [PATIENT](#), where the [PATIENT](#) is first seen at a different [Health Care Provider](#), and where the [PATIENT](#) has not had a [Decision To Treat](#), has not had the diagnosis outcome communicated, and the [PATIENT](#) has not been excluded from the [Cancer Faster Diagnosis Pathway](#). The [Health Care Provider](#) then subsequently sends the [PATIENT](#) to another [Health Care Provider](#), that is, makes a further inter-provider transfer.

• **Scenario 1g:**

The [Health Care Provider](#) where the [PATIENT](#) is first seen following a [REFERRAL REQUEST](#) with [PRIORITY TYPE](#) 'Two Week Wait', or where an urgent referral is from an NHS Cancer [Screening Programme](#), and where the [PATIENT](#) has not had a [Decision To Treat](#), has not had the diagnosis outcome communicated, and the [PATIENT](#) has been excluded from the [Cancer Faster Diagnosis Pathway](#). No inter-provider transfers are in progress.

• **Scenario 2a:**

The [Health Care Provider](#) where the [PATIENT](#) receives [First Definitive Treatment](#) for cancer following a [REFERRAL REQUEST](#) with [PRIORITY TYPE](#) 'Two Week Wait', or where an urgent referral is from an NHS Cancer [Screening Programme](#), and where the [PATIENT](#) has had the [Decision To Treat](#), has had the diagnosis outcome communicated, and the [PATIENT](#) has not been excluded from the [Cancer Faster Diagnosis Pathway](#). No inter-provider transfers are in progress.

• **Scenario 2b:**

The [Health Care Provider](#) where the [PATIENT](#) receives [First Definitive Treatment](#) for cancer following an inter-provider transfer, and where the [PATIENT](#) has had the [Decision To Treat](#), and has had the diagnosis outcome communicated, and the [PATIENT](#) has not been excluded from the [Cancer Faster Diagnosis Pathway](#).

• **Scenario 2c:**

The [Health Care Provider](#) where the [PATIENT](#) receives [First Definitive Treatment](#) for cancer following an inter-provider transfer, and where the [PATIENT](#) has had the [Decision To Treat](#), and has not had the diagnosis outcome communicated, and the [PATIENT](#) has not been excluded from the [Cancer Faster Diagnosis Pathway](#).

• **Scenario 3:**

The [Health Care Provider](#) where the [PATIENT](#) receives second or subsequent treatment for cancer following a [REFERRAL REQUEST](#) with [PRIORITY TYPE](#) 'Two Week Wait', or where an urgent referral is from an NHS Cancer [Screening Programme](#). No inter-provider transfers are in progress.

• **Scenario 4:**

The [Health Care Provider](#) where the [PATIENT](#) receives [First Definitive Treatment](#) for cancer following a consultant upgrade onto a 62 day [PATIENT PATHWAY](#). No inter-provider transfers are in progress.

• **Scenario 5:**

The [Health Care Provider](#) where the [PATIENT](#) receives second or subsequent treatment for cancer following a consultant upgrade onto a 62 day [PATIENT PATHWAY](#). No inter-provider transfers are in progress.

• **Scenario 6:**

The [Health Care Provider](#) where the [PATIENT](#) receives [First Definitive Treatment](#) for cancer following a [REFERRAL REQUEST](#) from another [SOURCE OF REFERRAL FOR OUT-PATIENTS](#) or a different [PRIORITY TYPE](#). No inter-provider transfers are in progress.

• **Scenario 7:**

The [Health Care Provider](#) where the [PATIENT](#) receives second or subsequent treatment for cancer following a [REFERRAL REQUEST](#) from another [SOURCE OF REFERRAL FOR OUT-PATIENTS](#) or a different [PRIORITY TYPE](#). No inter-provider transfers are in progress.

The columns in the table below show which data items are required for a range of health care scenarios:

Data Set Notation:

- **M = Mandatory:** the Standard Contract Schedule 5 requires NHS provider [Organisations](#) to submit this information on a monthly basis. [NHS England](#) require the data to be submitted 25 working days after the end of each month or quarter.
- **M* = Mandatory if applicable:** the Standard Contract Schedule 5 requires NHS provider [Organisations](#) to submit this information on a monthly basis, where collection of the item was applicable to them. [NHS England](#) require the data to be submitted 25 working days after the end of each month or quarter.
- **O = Optional**
- **O* = Optional if applicable:** These optional fields should only be populated if they relate to the [PATIENT PATHWAY](#) identified in the scenarios and the conditions required for their use are met.
- **N/A = Not Applicable**

Note: Inter-Provider Transfers:

- # First transfer involving the [Health Care Provider](#)
- ## Second transfer involving the [Health Care Provider](#). There can be up to ten inter-provider transfers involving many [Organisations](#), but an individual [Organisation](#) can only be involved in two transfers of a [PATIENT](#).

Data-Item	Scenarios														
	Scenario 1a	Scenario 1b	Scenario 1c	Scenario 1d	Scenario 1e	Scenario 1f	Scenario 1g	Scenario 2a	Scenario 2b	Scenario 2c	Scenario 3	Scenario 4	Scenario 5	Scenario 6	Scenario 7
Data Item	Scenario 1a	Scenario 1b	Scenario 1c	Scenario 1d	Scenario 1e	Scenario 1f	Scenario 1g	Scenario 2a	Scenario 2b	Scenario 2c	Scenario 3	Scenario 4	Scenario 5	Scenario 6	Scenario 7
NHS NUMBER	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
NHS NUMBER STATUS INDICATOR CODE	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
PATIENT PATHWAY IDENTIFIER	M	M	M	M	M	M	M	M*	M*	M*	M*	M*	M*	M*	M*
	M	M	M	M	M	M	M	M*	M*	M*	M*	M*	M*	M*	M*

ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)																
SOURCE OF REFERRAL FOR OUT-PATIENTS	M	M	M	M	M	N/A	M	N/A	N/A	N/A	N/A	M	N/A	O	N/A	
PRIORITY TYPE CODE	M	M	M	M	M	N/A	M	N/A	N/A	N/A	N/A	M	N/A	O	N/A	
DECISION TO REFER DATE (CANCER OR BREAST SYMPTOMS)	M*	M*	M*	M*	M*	N/A	M*	N/A	N/A	N/A	N/A	N/A	N/A	O	N/A	
CANCER REFERRAL TO TREATMENT PERIOD START DATE	M	M	M	M	M	N/A	M	M	N/A	N/A	N/A	O	N/A	O	N/A	
TWO WEEK WAIT CANCER OR SYMPTOMATIC BREAST REFERRAL TYPE	M	M	M	M	M	N/A	M	N/A	N/A	N/A	N/A	N/A	N/A	O	N/A	
CONSULTANT UPGRADE DATE	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	M	N/A	O	N/A	
ORGANISATION SITE IDENTIFIER (OF PROVIDER CONSULTANT UPGRADE)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	M	N/A	O	N/A	
DATE FIRST SEEN	M	M	M	M	M	N/A	M	N/A	N/A	N/A	N/A	M	N/A	O	N/A	
ORGANISATION SITE IDENTIFIER (OF PROVIDER FIRST SEEN)	M	M	M	M	M	N/A	M	N/A	N/A	N/A	N/A	M	N/A	N/A	N/A	
WAITING TIME ADJUSTMENT (FIRST SEEN)	M*	M*	M*	M*	M*	N/A	M*	N/A	N/A	N/A	N/A	O*	N/A	N/A	N/A	
WAITING TIME ADJUSTMENT REASON (FIRST SEEN)	M*	M*	M*	M*	M*	N/A	M*	N/A	N/A	N/A	N/A	O*	N/A	N/A	N/A	
CANCER CARE SPELL DELAY REASON (FIRST SEEN)	M*	M*	M*	M*	M*	N/A	M*	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
CANCER CARE SPELL DELAY REASON COMMENT (FIRST SEEN)	O*	O*	O*	O*	O*	N/A	O*	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
MULTIDISCIPLINARY TEAM CANCER CARE PLAN DISCUSSED INDICATOR	M*	M*	M*	M*	M*	M*	M*	M*	M*	M*	M*	M*	M*	M*	M*	
MULTIDISCIPLINARY TEAM DISCUSSION DATE (CANCER)	M*	M*	M*	M*	M*	M*	M*	M*	M*	M*	M*	M*	M*	M*	M*	
CANCER OR SYMPTOMATIC BREAST REFERRAL PATIENT STATUS	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	
PRIMARY DIAGNOSIS (ICD)	N/A	M*	M*	M*	N/A	N/A	N/A	M	M	M	M	M	M	M	M	
TUMOUR LATERALITY	N/A	M*	M*	M*	N/A	N/A	N/A	M	M	M	M	M	M	M	M	
CANCER TREATMENT PERIOD START DATE	N/A	N/A	M	M	N/A	N/A	N/A	M	M	M	M	M	M	M	M	
ORGANISATION SITE IDENTIFIER (OF PROVIDER CANCER DECISION TO TREAT)	N/A	N/A	M	M	N/A	N/A	N/A	M	M	M	M	M	M	M	M	

SERVICE REQUESTED DATE (INTER-PROVIDER TRANSFER) #	N/A	N/A	N/A	N/A	M	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
REFERRAL REQUEST RECEIVED DATE (INTER-PROVIDER TRANSFER) #	N/A	N/A	N/A	N/A	N/A	M	N/A	N/A	M	M	N/A	N/A	N/A	N/A	N/A
ORGANISATION IDENTIFIER (REFERRING) #	N/A	N/A	N/A	N/A	M	M	N/A	N/A	M	M	N/A	N/A	N/A	N/A	N/A
ORGANISATION IDENTIFIER (RECEIVING) #	N/A	N/A	N/A	N/A	M	M	N/A	N/A	M	M	N/A	N/A	N/A	N/A	N/A
CANCER TRANSFER REFERRING REASON (INTER-PROVIDER TRANSFER) #	N/A	N/A	N/A	N/A	M	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
CANCER TRANSFER RECEIVING REASON (INTER-PROVIDER TRANSFER) #	N/A	N/A	N/A	N/A	N/A	M	N/A	N/A	M	M	N/A	N/A	N/A	N/A	N/A
SERVICE REQUESTED DATE (INTER-PROVIDER TRANSFER) ##	N/A	N/A	N/A	N/A	N/A	M	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
REFERRAL REQUEST RECEIVED DATE (INTER-PROVIDER TRANSFER) ##	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
ORGANISATION IDENTIFIER (REFERRING) ##	N/A	N/A	N/A	N/A	N/A	M	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
ORGANISATION IDENTIFIER (RECEIVING) ##	N/A	N/A	N/A	N/A	N/A	M	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
CANCER TRANSFER REFERRING REASON (INTER-PROVIDER TRANSFER) ##	N/A	N/A	N/A	N/A	N/A	M	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
CANCER TRANSFER RECEIVING REASON (INTER-PROVIDER TRANSFER) ##	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
CANCER FASTER DIAGNOSIS PATHWAY END REASON	N/A	M	N/A	M	N/A	N/A	M	M	M	N/A	M*	N/A	N/A	N/A	N/A
PRIMARY CANCER SITE (CANCER FASTER DIAGNOSIS PATHWAY)	N/A	M	N/A	M	N/A	N/A	N/A	M	M	N/A	N/A	N/A	N/A	N/A	N/A
CANCER FASTER DIAGNOSIS PATHWAY END DATE	N/A	M	N/A	M	N/A	N/A	M	M	M	N/A	M*	N/A	N/A	N/A	N/A
CANCER CARE SPELL DELAY REASON (OUTCOME COMMUNICATION CANCER FASTER DIAGNOSIS PATHWAY)	N/A	M*	N/A	M*	N/A	N/A	N/A	M*	M*	N/A	N/A	N/A	N/A	N/A	N/A
CANCER CARE SPELL DELAY REASON COMMENT (OUTCOME COMMUNICATION CANCER FASTER DIAGNOSIS PATHWAY)	N/A	O*	N/A	O*	N/A	N/A	N/A	O*	O*	N/A	N/A	N/A	N/A	N/A	N/A
	N/A	N/A	N/A	N/A	N/A	N/A	M	N/A	N/A	N/A	M*	N/A	N/A	N/A	N/A

CANCER FASTER DIAGNOSIS PATHWAY EXCLUSION REASON																
CARE PROFESSIONAL TYPE CODE (OUTCOME COMMUNICATION CANCER FASTER DIAGNOSIS PATHWAY)	N/A	O*	N/A	O*	N/A	N/A	N/A	O*	O*	N/A	N/A	N/A	N/A	N/A	N/A	N/A
METHOD OF COMMUNICATION (END OF CANCER FASTER DIAGNOSIS PATHWAY)	N/A	O*	N/A	O*	N/A	N/A	N/A	O*	O*	N/A	N/A	N/A	N/A	N/A	N/A	N/A
ORGANISATION SITE IDENTIFIER (OF CANCER FASTER DIAGNOSIS PATHWAY END DATE)	N/A	M	N/A	M	N/A	N/A	M	M	M	N/A	M*	N/A	N/A	N/A	N/A	N/A
TREATMENT START DATE (CANCER)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	M	M	M	M	M	M	M	M	M
ORGANISATION SITE IDENTIFIER (OF PROVIDER CANCER TREATMENT START DATE)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	M	M	M	M	M	M	M	M	M
CANCER TREATMENT EVENT TYPE	N/A	N/A	N/A	N/A	N/A	N/A	N/A	M	M	M	M	M	M	M	M	M
CANCER TREATMENT MODALITY	N/A	N/A	N/A	N/A	N/A	N/A	N/A	M	M	M	M	M	M	M	M	M
CLINICAL TRIAL INDICATOR	N/A	N/A	N/A	N/A	N/A	N/A	N/A	M	M	M	M	M	M	M	M	M
CANCER CARE SETTING (TREATMENT)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	M	M	M	M	M	M	M	M	M
RADIOTHERAPY PRIORITY	N/A	N/A	N/A	N/A	N/A	N/A	N/A	M*	M*	M*	M*	M*	M*	M*	M*	M*
CANCER CARE SPELL DELAY REASON (DECISION TO TREATMENT)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	M*	M*	M*	M*	M*	M*	M*	M*	M*
CANCER CARE SPELL DELAY REASON COMMENT (DECISION TO TREATMENT)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	O*	O*	O*	O*	O*	O*	O*	O*	O*
WAITING TIME ADJUSTMENT (TREATMENT)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	M*	M*	M*	M*	M*	M*	M*	M*	M*
WAITING TIME ADJUSTMENT REASON (TREATMENT)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	M*	M*	M*	M*	M*	M*	M*	M*	M*
CANCER CARE SPELL DELAY REASON (REFERRAL TO TREATMENT)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	M*	M*	M*	N/A	M*	N/A	O*	N/A	N/A
CANCER CARE SPELL DELAY REASON COMMENT (REFERRAL TO TREATMENT)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	O*	O*	O*	N/A	O*	O*	O*	N/A	N/A
CANCER CARE SPELL DELAY REASON (CONSULTANT UPGRADE)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	M*	N/A	O*	N/A	N/A
	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	O*	N/A	O*	N/A	N/A

Full details of the validation rules and processes are available on the [NHS Digital](#) website at: [Cancer Waiting Times](#).

Change to Supporting Information: Changed Description

The information is used:

- The [NHS Breast Screening Programme Central Return Data Set \(KC62\)](#) is analysed by [NHS Digital](#) and also used by the Public Health Research Unit to evaluate the effectiveness of [Breast Screening](#). It is also used by the Regional Breast Screening Quality Assurance Reference Centres as part of the quality assurance process, and enables on-going monitoring of their individual programmes and comparisons within their regions and with England overall.

The [NHS Breast Screening Programme Central Return Data Set \(KC62\)](#) requires information on women invited for [Breast Screening](#), the outcome of the [Breast Screening](#) and further information on each cancer detected. It is completed annually and submitted by the end of the October following the end of the [REPORTING PERIOD](#) to which the data relates.

Women are included in the [NHS Breast Screening Programme Central Return Data Set \(KC62\)](#) only if the test date offered or [SCREENING TEST DATE](#) was within the review period. All [Screening Tests](#) taking place within the [REPORTING PERIOD](#) are counted. One woman may not have more than one outcome of cancer in the [REPORTING PERIOD](#). Women who are referred directly for a [Screening Test](#) (rather than an invitation as part of a [Screening Programme](#)) are also included if the [Screening Test Date](#) is within the [REPORTING PERIOD](#). Women who are referred directly for a [Screening Test](#) (rather than an invitation as part of a [Screening Programme](#)) are also included if the [SCREENING TEST DATE](#) is within the [REPORTING PERIOD](#).

Parts One to Five of the [NHS Breast Screening Programme Central Return Data Set \(KC62\)](#) should be reported for Tables A to T.

* INVASIVE BREAST CANCER TOTAL OBSERVED, INVASIVE BREAST CANCER TOTAL EXPECTED and STANDARDISED DETECTION RATIO TOTAL are only appropriate for tables A, B and C1.

The [NHS Breast Screening Programme Central Return Data Set \(KC62\)](#) is submitted in csv file format.

Change to Supporting Information: Changed Description

A ~~Nutritional Assessment~~ is a ~~CARE CONTACT~~. A Nutritional Assessment is a CLINICAL INTERVENTION.

A **Nutritional Assessment** is a dietary and weight assessment. This may be a partial or full assessment.

Change to Supporting Information: New Supporting Information

An [Observable Entity](#) is a [CLINICAL INTERVENTION](#).

An [Observable Entity](#) represents a question or assessment which can produce an answer or result, for example, [SYSTOLIC BLOOD PRESSURE](#), color of iris etc.

For further information on [Observable Entities](#), see the [SNOMED CT](#) Concept Model at: [6. SNOMED CT Concept Model: Observable entity](#).

This supporting information is also known by these names:

Context	Alias
plural	Observable Entities

OBSERVABLE ENTITY DATE

Change to Supporting Information: New Supporting Information

An [Observable Entity Date](#) is an [ACTIVITY DATE TIME](#).

An [Observable Entity Date](#) is the [DATE](#) of the [Observable Entity](#).

This supporting information is also known by these names:

Context	Alias
plural	Observable Entity Dates

OBSERVABLE ENTITY TIME

Change to Supporting Information: New Supporting Information

An [Observable Entity Time](#) is an [ACTIVITY DATE TIME](#).

An [Observable Entity Time](#) is the [TIME](#) of the [Observable Entity](#).

This supporting information is also known by these names:

Context	Alias
plural	Observable Entity Times

ONWARD REFERRAL DATE (RETIRED), renamed from ONWARD REFERRAL DATE

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

An [Onward Referral Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

An [Onward Referral Date](#) is the date the [PATIENT](#) was referred from one [SERVICE](#) to another [SERVICE](#), which may be in the same or a different [Organisation](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

ONWARD REFERRAL DATE (RETIRED), renamed from ONWARD REFERRAL DATE

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

- Changed Name from [Data_Dictionary.NHS_Business_Definitions.O.Onward_Referral_Date](#) to [Retired.Data_Dictionary.NHS_Business_Definitions.O.Onward_Referral_Date](#)
- Retired Onward Referral Date
- Changed Description

ONWARD REFERRAL TIME (RETIRED), renamed from ONWARD REFERRAL TIME

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

An [Onward Referral Time](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

An [Onward Referral Time](#) is the time the [PATIENT](#) was referred from one [SERVICE](#) to another [SERVICE](#), which may be in the same or a different [Organisation](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

ONWARD REFERRAL TIME (RETIRED), renamed from **ONWARD REFERRAL TIME**

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.O.Onward_Referral_Time to Retired.Data_Dictionary.NHS_Business_Definitions.O.Onward_Referral_Time
- Retired Onward Referral Time
- Changed Description

PARENTS SEEN BY SENIOR STAFF MEMBER DATE AND TIME (RETIRED), renamed from **PARENTS SEEN BY SENIOR STAFF MEMBER DATE AND TIME**

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

[Parents Seen By Senior Staff Member Date and Time](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

[Parents Seen By Senior Staff Member Date and Time](#) is the [Start Date](#) and [Start Time](#) that the parents of a baby admitted to a Neonatal Intensive Care Unit, were seen by a senior staff member. The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

PARENTS SEEN BY SENIOR STAFF MEMBER DATE AND TIME (RETIRED), renamed from **PARENTS SEEN BY SENIOR STAFF MEMBER DATE AND TIME**

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.P.Parents_Seen_By_Senior_Staff_Member_Date_and_Time to Retired.Data_Dictionary.NHS_Business_Definitions.P.Parents_Seen_By_Senior_Staff_Member_Date_and_Time
- Retired Parents Seen By Senior Staff Member Date and Time
- Changed Description

PRIMARY PROCEDURE DATE (RETIRED), renamed from **PRIMARY PROCEDURE DATE**

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

A [Primary Procedure Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

A [Primary Procedure Date](#) is the [ACTIVITY DATE](#) of the primary [Patient Procedure](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

PRIMARY PROCEDURE DATE (RETIRED), renamed from **PRIMARY PROCEDURE DATE**

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.P.Primary_Procedure_Date to Retired.Data_Dictionary.NHS_Business_Definitions.P.Primary_Procedure_Date
- Retired Primary Procedure Date
- Changed Description

PROCEDURE DATE

Change to Supporting Information: Changed Description

[Procedure Date](#) is an [ACTIVITY DATE TIME](#).

[Procedure Date](#) is the date of the occurrence of the [CLINICAL INTERVENTION](#). Procedure Date is the DATE of the Patient Procedure.

PROCEDURE DATE AND TIME (RETIRED), renamed from **PROCEDURE DATE AND TIME**

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

[Procedure Date and Time](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

[Procedure Date and Time](#) is the [DATE AND TIME](#) of the [Patient Procedure](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

PROCEDURE DATE AND TIME (RETIRED), renamed from PROCEDURE DATE AND TIME

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

- Changed Name from [Data_Dictionary.NHS_Business_Definitions.P.Procedure_Date_and_Time](#) to [Retired.Data_Dictionary.NHS_Business_Definitions.P.Procedure_Date_and_Time](#)
- Retired Procedure Date and Time
- Changed Description

REASONABLE OFFER

Change to Supporting Information: Changed Description

A [Reasonable Offer](#) is an [APPOINTMENT OFFER](#) or [OFFER OF ADMISSION](#) where the [REASONABLE OFFER INDICATOR](#) is National Code 1. ~~'Reasonable Offer'~~ A Reasonable Offer is an [APPOINTMENT OFFER](#) or [OFFER OF ADMISSION](#).

A [Reasonable Offer](#) is where the [REASONABLE OFFER INDICATOR](#) is National Code '[Reasonable Offer](#)'.

An offer is reasonable where:

- the offer of an [Out-Patient Appointment](#) or an [OFFER OF ADMISSION](#) is for a time and date three or more weeks from the time that the offer was made
- or
- the [PATIENT](#) accepts the offer
- or
- the offer is for the first [Genitourinary Consultant Clinic Attendance](#) in a [Sexual Health and HIV Episode](#)
- or
- the offer is for any [APPOINTMENT](#) for treatment in a [Cancer Treatment Period](#)
- or
- the offer of an [APPOINTMENT](#) for a non-outpatient [CARE CONTACT](#) provided by a [Community Health Service](#) complies with local, publicly available/published policies for access to that [SERVICE](#). These local policies should be clearly defined and specifically protect the clinical interests of vulnerable [PATIENTS](#) (e.g. children) and must have been agreed with clinicians, commissioners, [PATIENTS](#) and other stakeholders.

REFERRAL TO TREATMENT PERIOD INCLUDED IN REFERRAL TO TREATMENT CONSULTANT-LED WAITING TIMES MEASUREMENT

Change to Supporting Information: Changed Description

[Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement](#) is any [REFERRAL TO TREATMENT PERIOD](#) included in the reporting for Referral To Treatment Consultant-Led Waiting Times Measurement.

It includes all [Cancer Referral To Treatment Periods](#).

It is all [Measured Referral to Treatment Periods](#) where the [SERVICE REQUEST](#) is to a [Consultant Led Service](#) or an [Interface Service](#) except:

- any [REFERRAL TO TREATMENT PERIODS](#) where the [PATIENT](#) did not attend their first [APPOINTMENT](#) during a [REFERRAL TO TREATMENT PERIOD](#) ([REFERRAL TO TREATMENT PERIOD STATUS](#) is National Code ~~33 Did not attend - the PATIENT did not attend the first CARE ACTIVITY after the referral~~)
- any [REFERRAL TO TREATMENT PERIODS](#) which are not commissioned by or on behalf of the English NHS
- any [REFERRAL TO TREATMENT PERIODS](#) where the [PATIENT](#) did not attend their first [APPOINTMENT](#) during a [REFERRAL TO TREATMENT PERIOD](#) ([REFERRAL TO TREATMENT PERIOD STATUS](#) is National Code '[Did not attend - the PATIENT did not attend the first CARE ACTIVITY after the referral](#)')
- any [REFERRAL TO TREATMENT PERIODS](#) which are not commissioned by or on behalf of the English NHS.

Two alternative approaches to calculating the duration of a [Measured Referral to Treatment Period](#) are defined in data elements [REFERRAL TO TREATMENT PERIOD DURATION \(UNADJUSTED\)](#) and [REFERRAL TO TREATMENT PERIOD DURATION \(ADJUSTED\)](#).

REFERRED TO SERVICE ASSESSMENT DATE (RETIRED), renamed from REFERRED TO SERVICE ASSESSMENT DATE

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

A [Referred To Service Assessment Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

A [Referred To Service Assessment Date](#) is the date that a [CARE PROFESSIONAL](#) from a [SERVICE](#) which a [PATIENT](#) has been referred to, assesses the [PATIENT](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

REFERRED TO SERVICE ASSESSMENT DATE (RETIRED), renamed from REFERRED TO SERVICE ASSESSMENT DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.R.Referred_To_Service_Assessment_Date to Retired.Data_Dictionary.NHS_Business_Definitions.R.Referred_To_Service_Assessment_Date
- Retired Referred To Service Assessment Date
- Changed Description

REFERRED TO SERVICE ASSESSMENT TIME (RETIRED), renamed from REFERRED TO SERVICE ASSESSMENT TIME

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

A [Referred To Service Assessment Time](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

A [Referred To Service Assessment Time](#) is the time that a [CARE PROFESSIONAL](#) from a [SERVICE](#) which a [PATIENT](#) has been referred to, assesses the [PATIENT](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

REFERRED TO SERVICE ASSESSMENT TIME (RETIRED), renamed from REFERRED TO SERVICE ASSESSMENT TIME

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.R.Referred_To_Service_Assessment_Time to Retired.Data_Dictionary.NHS_Business_Definitions.R.Referred_To_Service_Assessment_Time
- Retired Referred To Service Assessment Time
- Changed Description

RESTRICTIVE INTERVENTION

Change to Supporting Information: Changed Description

A [Restrictive Intervention](#) is a [CLINICAL INTERVENTION](#). A Restrictive Intervention is a CARE ACTIVITY.

[Restrictive Interventions](#) are defined by the [Department of Health and Social Care](#) as:

- Deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to:
 - take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and
 - end or reduce significantly the danger to the person or others; and
 - contain or limit the person's freedom for no longer than is necessary.

For further information on [Restrictive Interventions](#), see the [Department of Health and Social Care](#) part of the gov.uk website at: [Positive and Proactive Care: reducing the need for restrictive interventions](#).

RETINOBLASTOMA ASSESSMENT DATE (RETIRED), renamed from RETINOBLASTOMA ASSESSMENT DATE

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

A [Retinoblastoma Assessment Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

A [Retinoblastoma Assessment Date](#) is the date on which retinoblastoma details were recorded during a [Children Teenagers and Young Adults Cancer Care Spell](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

RETINOBLASTOMA ASSESSMENT DATE (RETIRED), renamed from RETINOBLASTOMA ASSESSMENT DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.R.Retinoblastoma_Assessment_Date to Retired.Data_Dictionary.NHS_Business_Definitions.R.Retinoblastoma_Assessment_Date
- Retired Retinoblastoma Assessment Date
- Changed Description

RUPTURE OF MEMBRANES DATE AND TIME (RETIRED), renamed from RUPTURE OF MEMBRANES DATE AND TIME

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

Rupture of Membranes Date and Time is an ACTIVITY DATE TIME. This item has been retired from the NHS Data Model and Dictionary.

Rupture of Membranes Date and Time is the Start Date and Start Time of the Rupture of Membranes during Labour and Delivery. The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

RUPTURE OF MEMBRANES DATE AND TIME (RETIRED), renamed from RUPTURE OF MEMBRANES DATE AND TIME

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.R.Rupture_of_Membranes_Date_and_Time to Retired.Data_Dictionary.NHS_Business_Definitions.R.Rupture_of_Membranes_Date_and_Time
- Retired Rupture of Membranes Date and Time
- Changed Description

SCREENING TEST DATE (RETIRED), renamed from SCREENING TEST DATE

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

Screening Test Date is an ACTIVITY DATE TIME. This item has been retired from the NHS Data Model and Dictionary.

The date on which the Screening Test was performed. In the case of cervical screening, this is the date the cervical smear was taken. The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

SCREENING TEST DATE (RETIRED), renamed from SCREENING TEST DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.S.Screening_Test_Date to Retired.Data_Dictionary.NHS_Business_Definitions.S.Screening_Test_Date
- Retired Screening Test Date
- Changed Description

SERVICE DISCHARGE DATE (RETIRED), renamed from SERVICE DISCHARGE DATE

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

A Service Discharge Date is an ACTIVITY DATE TIME. This item has been retired from the NHS Data Model and Dictionary.

A Service Discharge Date is the date a PATIENT was discharged from a SERVICE. The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

SERVICE DISCHARGE DATE (RETIRED), renamed from SERVICE DISCHARGE DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.S.Service_Discharge_Date to Retired.Data_Dictionary.NHS_Business_Definitions.S.Service_Discharge_Date
- Retired Service Discharge Date
- Changed Description

SERVICE DISCHARGE TIME (RETIRED) renamed from SERVICE DISCHARGE TIME

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

A [Service Discharge Time](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

A [Service Discharge Time](#) is the time a [PATIENT](#) was discharged from a [SERVICE](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

SERVICE DISCHARGE TIME (RETIRED) renamed from SERVICE DISCHARGE TIME

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.S.Service_Discharge_Time to Retired.Data_Dictionary.NHS_Business_Definitions.S.Service_Discharge_Time
- Retired Service Discharge Time
- Changed Description

SPEECH AND LANGUAGE ASSESSMENT DATE (RETIRED) renamed from SPEECH AND LANGUAGE ASSESSMENT DATE

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

A [Speech and Language Assessment Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

A [Speech and Language Assessment Date](#) is the [Contact Date](#) of a speech and language assessment following completion of treatment during a [Head and Neck Cancer Care Spell](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

SPEECH AND LANGUAGE ASSESSMENT DATE (RETIRED) renamed from SPEECH AND LANGUAGE ASSESSMENT DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.S.Speech_and_Language_Assessment_Date to Retired.Data_Dictionary.NHS_Business_Definitions.S.Speech_and_Language_Assessment_Date
- Retired Speech and Language Assessment Date
- Changed Description

STAGE GROUPING DATE (TESTICULAR CANCER) (RETIRED) renamed from STAGE GROUPING DATE (TESTICULAR CANCER)

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

A [Stage Grouping Date \(Testicular Cancer\)](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

A [Stage Grouping Date \(Testicular Cancer\)](#) is the date on which the [STAGE GROUPING \(TESTICULAR CANCER\)](#) was recorded during a [Urological Cancer Care Spell](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

STAGE GROUPING DATE (TESTICULAR CANCER) (RETIRED) renamed from STAGE GROUPING DATE (TESTICULAR CANCER)

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.S.Stage_Grouping_Date_(Testicular_Cancer) to Retired.Data_Dictionary.NHS_Business_Definitions.S.Stage_Grouping_Date_(Testicular_Cancer)
- Retired Stage Grouping Date (Testicular Cancer)
- Changed Description

SYSTEMIC ANTI-CANCER THERAPY ADMINISTRATION DATE (RETIRED) renamed from SYSTEMIC ANTI-CANCER THERAPY ADMINISTRATION DATE

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

[Systemic Anti-Cancer Therapy Administration Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

Systemic Anti-Cancer Therapy Administration Date identifies each contact between the PATIENT and the Chemotherapy CARE PROFESSIONAL TEAM when Chemotherapy is administered. The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

The Systemic Anti-Cancer Therapy Administration Date is recorded for admitted PATIENT treatment, Chemotherapy Out-Patient Clinic attendances, attendances in a primary care setting and domiciliary administration by a specialist team (i.e. oncology, haematology or paediatrics). Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

The Systemic Anti-Cancer Therapy Administration Date is recorded as follows:

- for infusions, the day the infusion was commenced and
- for continuous oral Chemotherapy, the first day of the nominal cycle i.e. one Systemic Anti-Cancer Therapy Administration Date per 28 days.

SYSTEMIC ANTI-CANCER THERAPY ADMINISTRATION DATE (RETIRED), renamed from SYSTEMIC ANTI-CANCER THERAPY ADMINISTRATION DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.S.Systemic_Anti-Cancer_Therapy_Administration_Date to Retired.Data_Dictionary.NHS_Business_Definitions.S.Systemic_Anti-Cancer_Therapy_Administration_Date
- Retired Systemic Anti-Cancer Therapy Administration Date
- Changed Description

TIME SEEN (RETIRED), renamed from TIME SEEN

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

Time Seen is an ACTIVITY DATE TIME. This item has been retired from the NHS Data Model and Dictionary.

The time, recorded using the 24 hour clock, that a PATIENT is seen by the relevant health professional. The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

TIME SEEN (RETIRED), renamed from TIME SEEN

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.T.Time_Seen to Retired.Data_Dictionary.NHS_Business_Definitions.T.Time_Seen
- Retired Time Seen
- Changed Description

TNM STAGE GROUPING DATE (FINAL PRETREATMENT) (RETIRED), renamed from TNM STAGE GROUPING DATE (FINAL PRETREATMENT)

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

A TNM Stage Grouping Date (Final Pretreatment) is an ACTIVITY DATE TIME. This item has been retired from the NHS Data Model and Dictionary.

A TNM Stage Grouping Date (Final Pretreatment) is the date on which the TNM STAGE GROUPING (FINAL PRETREATMENT) was recorded during a Cancer Care Spell. The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

TNM STAGE GROUPING DATE (FINAL PRETREATMENT) (RETIRED), renamed from TNM STAGE GROUPING DATE (FINAL PRETREATMENT)

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.T.TNM_Stage_Grouping_Date_(Final_Pretreatment) to Retired.Data_Dictionary.NHS_Business_Definitions.T.TNM_Stage_Grouping_Date_(Final_Pretreatment)
- Retired TNM Stage Grouping Date (Final Pretreatment)
- Changed Description

TNM STAGE GROUPING DATE (INTEGRATED) (RETIRED), renamed from TNM STAGE GROUPING DATE (INTEGRATED)

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

A TNM Stage Grouping Date (Integrated) is an ACTIVITY DATE TIME. This item has been retired from the NHS Data Model and Dictionary.

A [TNM Stage Grouping Date \(Integrated\)](#) is the date on which the [TNM STAGE GROUPING \(INTEGRATED\)](#) was recorded during a [Cancer Care Spell](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

TNM STAGE GROUPING DATE (INTEGRATED) (RETIRED), renamed from TNM STAGE GROUPING DATE (INTEGRATED)

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.T.TNM_Stage_Grouping_Date_(Integrated) to Retired.Data_Dictionary.NHS_Business_Definitions.T.TNM_Stage_Grouping_Date_(Integrated)
- Retired TNM Stage Grouping Date (Integrated)
- Changed Description

TREATMENT START DATE (CANCER) (RETIRED), renamed from TREATMENT START DATE (CANCER)

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

A [Treatment Start Date \(Cancer\)](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

A [Treatment Start Date \(Cancer\)](#) is the [Start Date](#) of the first, second or subsequent cancer treatment given to a [PATIENT](#) who is receiving care for a cancer condition. The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

If the [CANCER TREATMENT MODALITY](#) is recorded as National Code 'Surgery', the [Treatment Start Date \(Cancer\)](#) is the same as [START DATE \(HOSPITAL PROVIDER SPELL\)](#) of the related admission. Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

[Treatment Start Date \(Cancer\)](#) is also the [END DATE](#) of a [Cancer Referral To Treatment Period](#).

A [Cancer Referral To Treatment Period](#) will end on the same [DATE](#) as the [Treatment Start Date \(Cancer\)](#) where [First Definitive Treatment](#) is given, unless cancer was discounted when the [PATIENT](#) was first seen (in which case the [Cancer Referral To Treatment Period](#) is ended at [DATE FIRST SEEN](#)).

If a [PATIENT](#) declines all treatment and the [CANCER TREATMENT MODALITY](#) is recorded as National Code 'All treatment declined', then the [Treatment Start Date \(Cancer\)](#) should be recorded as the [DATE](#) upon which the [PATIENT](#) made this decision.

For the [National Cancer Waiting Times Monitoring Data Set](#), [Treatment Start Date \(Cancer\)](#) is for a cancer condition with a [PRIMARY DIAGNOSIS \(ICD\)](#) code defined by [NHS England](#). The full list of diagnosis codes can be found on the [NHS Digital](#) website at: [Cancer Waiting Times](#).

TREATMENT START DATE (CANCER) (RETIRED), renamed from TREATMENT START DATE (CANCER)

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.T.Treatment_Start_Date_(Cancer) to Retired.Data_Dictionary.NHS_Business_Definitions.T.Treatment_Start_Date_(Cancer)
- Retired Treatment Start Date (Cancer)
- Changed Description

TWO YEAR NEONATAL OUTCOMES ASSESSMENT DATE (RETIRED), renamed from TWO YEAR NEONATAL OUTCOMES ASSESSMENT DATE

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

A [Two Year Neonatal Outcomes Assessment Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

A [Two Year Neonatal Outcomes Assessment Date](#) is the date on which a [Two Year Neonatal Outcomes Assessment](#) was carried out. The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

TWO YEAR NEONATAL OUTCOMES ASSESSMENT DATE (RETIRED), renamed from TWO YEAR NEONATAL OUTCOMES ASSESSMENT DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.T.Two_Year_Neonatal_Outcomes_Assessment_Date to Retired.Data_Dictionary.NHS_Business_Definitions.T.Two_Year_Neonatal_Outcomes_Assessment_Date
- Retired Two Year Neonatal Outcomes Assessment Date
- Changed Description

WILMS TUMOUR STAGE DATE (RETIRED), renamed from WILMS TUMOUR STAGE DATE

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

A [Wilms Tumour Stage Date](#) is an [ACTIVITY DATE TIME](#). This item has been retired from the NHS Data Model and Dictionary.

A [Wilms Tumour Stage Date](#) is the date on which the [WILMS TUMOUR STAGE](#) was recorded during a [Children Teenagers and Young Adults Cancer Care Spell](#). The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

WILMS TUMOUR STAGE DATE (RETIRED), renamed from WILMS TUMOUR STAGE DATE

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

- Changed Name from Data_Dictionary.NHS_Business_Definitions.W.Wilms_Tumour_Stage_Date to Retired.Data_Dictionary.NHS_Business_Definitions.W.Wilms_Tumour_Stage_Date
- Retired Wilms Tumour Stage Date
- Changed Description

ACTIVITY

Change to Class: Changed Description

An [ACTIVITY](#) is a provision of [SERVICES](#) to a [PATIENT](#) by one or more [CARE PROFESSIONALS](#).

An [ACTIVITY](#) may be either an [ACTIVITY GROUP](#) or a [CARE ACTIVITY](#). An [ACTIVITY GROUP](#) may include a series of one or more [CARE ACTIVITIES](#).

Subtypes of [ACTIVITY](#) are:

[ACTIVITY GROUP](#)
[CARE ACTIVITY](#)

- [ACTIVITY GROUP](#)
- [CARE ACTIVITY](#)

ACTIVITY GROUP

Change to Class: Changed Attributes, Description

A subtype of [ACTIVITY](#).

An [ACTIVITY GROUP](#) is a continuous period of care or assessment for a [PATIENT](#) by one or more [CARE PROFESSIONALS](#). [ACTIVITY GROUPS](#) mainly consist of episodes, spells, stays or care periods.

An [ACTIVITY GROUP](#) may include one or more [CARE ACTIVITIES](#).

Subtypes of [ACTIVITY GROUP](#) are:

[CRITICAL CARE PERIOD](#)
[PATIENT PATHWAY](#)
[REFERRAL TO TREATMENT PERIOD](#)

- [CRITICAL CARE PERIOD](#)
- [PATIENT PATHWAY](#)
- [REFERRAL TO TREATMENT PERIOD](#)

[ACTIVITY GROUP TYPE](#) provides a list of [ACTIVITY GROUPS](#).

ACTIVITY GROUP

Change to Class: Changed Attributes, Description

Attributes of this Class are:

A and E INCIDENT LOCATION TYPE
A and E PATIENT GROUP
ACTIVITY GROUP TYPE
ADMISSION METHOD

ASSAULT METHOD
 BABY FIRST FEED BREAST MILK STATUS
 BREASTFEEDING STATUS
 CANCER OR SYMPTOMATIC BREAST REFERRAL PATIENT STATUS
 CANCER TRANSFER REASON FOR INTER PROVIDER TRANSFER
 CANCER TREATMENT INTENT
 CARE PROGRAMME APPROACH REVIEW ABUSE QUESTION ASKED INDICATOR
 CARER RESIDENT INDICATION CODE FOR NATIONAL NEONATAL DATA SET
 CHILDREN TEENAGERS AND YOUNG ADULTS AGE CATEGORY
 COMMUNITY TREATMENT ORDER END REASON
 COMPLEX SOCIAL FACTORS INDICATOR
 DAUGHTER BORN AT THIS ENCOUNTER INDICATOR
 DECISION TO UNDERTAKE FURTHER ASSESSMENT INDICATOR
 DELIVERY PLACE CHANGE REASON
 DISCHARGE DESTINATION
 DISCHARGED TO HOSPITAL AT HOME SERVICE INDICATOR
 DISCHARGE METHOD
 EMERGENCY CARE ATTENDANCE CATEGORY
 ESTIMATED DATE OF DELIVERY
 ESTIMATED DATE OF DELIVERY METHOD
 FEMALE GENITAL MUTILATION AGE CATEGORY
 FIRST REGULAR DAY OR NIGHT ADMISSION
 HEALTHCARE RESOURCE GROUP CODE
 HOLISTIC NEEDS ASSESSMENT POINT OF PATHWAY FOR CANCER
 IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES CARE SPELL END CODE
 IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES OPT IN DATE
 IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES STEPPED CARE INTENSITY DELIVERED
 IN LABOUR BEFORE CAESARIAN SECTION INDICATOR
 INTENDED DELIVERY PLACE
 INTRAVESICAL CHEMOTHERAPY RECEIVED INDICATOR
 INTRAVESICAL IMMUNOTHERAPY RECEIVED INDICATOR
 LENGTH OF STAY ADJUSTMENT
 LENGTH OF STAY ADJUSTMENT REASON
 MATERNAL CRITICAL INCIDENT TYPE
 MECONIUM PRESENT IN LIQUOR INDICATOR
 MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY
 MENTAL HEALTH CONDITIONAL DISCHARGE END REASON
 MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE
 MENTAL HEALTH DELAYED DISCHARGE REASON
 METHOD OF COMMUNICATION FOR END OF CANCER FASTER DIAGNOSIS PATHWAY
 MONITORING INTENT
 MOTHER ANTENATALLY BOOKED INDICATOR
 NEONATAL CRITICAL INCIDENT TYPE
 NEONATAL LEVEL OF CARE
 NON SMOKING CONFIRMATION STATUS AT 4 WEEKS
 ORGAN OR TISSUE UNSUITABLE ORGAN CODE RENAL TRANSPLANT
 OUTCOME AT 4 WEEK FOLLOW UP FOR STOP SMOKING
 PAEDIATRIC NEPHROLOGY REGISTRY STATUS CODE
 PALLIATIVE CARE SPECIALIST SEEN INDICATOR
 PALLIATIVE TREATMENT REASON CODE FOR UPPER GASTROINTESTINAL
 PATIENT CLASSIFICATION
 PATIENT RECEIVING ONE TO ONE NURSING CARE INDICATOR
 PHARMACOTHERAPY STOP SMOKING AID RECEIVED
 PREGNANCY OUTCOME CODE
 PREGNANCY PREVIOUS CAESAREAN SECTIONS
 PREGNANCY TOTAL LIVE BIRTHS
 PREGNANCY TOTAL PREVIOUS LOSSES LESS THAN 24 WEEKS
 PREGNANCY TOTAL PREVIOUS PREGNANCIES
 PREGNANCY TOTAL STILL BIRTHS
 PREVIOUS NEGATIVE HIV TEST INDICATOR
 RADIOTHERAPY INTENT
 RENAL DIALYSIS SCHEDULE TYPE
 SOURCE OF ADMISSION
 TIME BETWEEN DELIVERY AND SPONTANEOUS RESPIRATION CODE

ACTIVITY OFFER

Change to Class: Changed Attributes

Attributes of this Class are:

K ACTIVITY OFFER DATE
K ACTIVITY OFFER STATUS CODE
K ACTIVITY OFFER STATUS
ACTIVITY NOT OFFERED REASON CODE FOR MATERNITY

ADDRESS

Change to Class: Changed Description

The identification of a place of relevance to a:

- [PERSON](#)
- [Organisation](#)
- [Organisation Site](#) or
- [LOCATION](#).

The [ADDRESS](#) may have [COMMUNICATION CONTACT INFORMATION](#) associated with it and may be the location for an [ACTIVITY](#).

Subtypes of [ADDRESS](#) are:

[ADDRESS STRUCTURED](#)
[ADDRESS UNSTRUCTURED](#)

- [ADDRESS STRUCTURED](#)
- [ADDRESS UNSTRUCTURED](#).

ASSAULT

Change to Class: New Class

Observations regarding an assault on a [PERSON](#).

This class is also known by these names:

Context	Alias
plural	ASSAULTS

ASSAULT

Change to Class: New Class

Attributes of this Class are:

[ASSAULT METHOD](#)

ASSAULT

Change to Class: New Class

Each [ASSAULT](#)

may be carried out on one and only one [PERSON](#)

CARE ACTIVITY

Change to Class: Changed Attributes, Description

A subtype of [ACTIVITY](#)

A [CARE ACTIVITY](#) is the provision of an individual instance of care to a [PATIENT](#) given by one or more [CARE PROFESSIONALS](#).

Subtypes of [CARE ACTIVITY](#) are:

[CARE CONTACT](#)
[CLINICAL INTERVENTION](#)
[TISSUE CARE ACTIVITY](#)

- [CARE CONTACT](#)
- [CLINICAL INTERVENTION](#)

- [TISSUE CARE ACTIVITY](#).

[CARE ACTIVITIES](#) include:

- [Multidisciplinary Team Meeting](#)

CARE ACTIVITY

Change to Class: Changed Attributes, Description

Attributes of this Class are:

COMMUNITY CARE ACTIVITY TYPE CODE
~~GROUP THERAPY INDICATOR~~
[CONSULTATION MEDIUM USED](#)
[FEMALE GENITAL MUTILATION IDENTIFICATION METHOD CODE](#)
[METHOD OF COMMUNICATION FOR END OF CANCER FASTER DIAGNOSIS PATHWAY](#)
[MOTHER ANTENATALLY BOOKED INDICATOR](#)
[RESTRICTIVE INTERVENTION TYPE](#)
 SEXUAL AND REPRODUCTIVE HEALTH CARE ACTIVITY

CARE CLUSTER

Change to Class: Changed Attributes

Attributes of this Class are:

ADULT MENTAL HEALTH CARE CLUSTER CODE
 CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE
[FIVE FORENSIC PATHWAYS ASSESSMENT REASON](#)
[FIVE FORENSIC PATHWAYS CODE](#)
 FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE
 FORENSIC MENTAL HEALTH CARE CLUSTER CODE
 LEARNING DISABILITIES CARE CLUSTER CODE
 MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE

CARE CONTACT

Change to Class: Changed Attributes

Attributes of this Class are:

A and E ATTENDANCE CATEGORY
 A and E INITIAL ASSESSMENT TRIAGE CATEGORY
 A and E STREAM
 ACCIDENT AND EMERGENCY ARRIVAL MODE
 ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL
~~ANTIRETROVIRAL THERAPY DRUG REGIMEN GROUP CODE~~
~~ANTIRETROVIRAL THERAPY HOME DELIVERY INDICATOR~~
 BRIEF INTERVENTION PROVIDED INDICATOR
 BRIEF INTERVENTION TYPE FOR NHS HEALTH CHECK
 CARE CONTACT CANCELLATION REASON
 CARE CONTACT SUBJECT
 CARE CONTACT TYPE
[CARE PROGRAMME APPROACH REVIEW ABUSE QUESTION ASKED INDICATOR](#)
 CHILD DIFFICULT TO TEST REASON
 CLINICAL NURSE SPECIALIST INDICATION CODE
 CLINIC ATTENDANCE PURPOSE CODE FOR HIV
~~COLPOSCOPY PRIME PROCEDURE TYPE~~
~~CONSULTATION MEDIUM USED~~
 CONSULTATION TYPE
 CONTRACEPTIVE SERVICE TYPE
~~DECISION TO UNDERTAKE FURTHER ASSESSMENT INDICATOR~~
 DIETARY ADVICE REASON CODE
~~EMPLOYMENT SUPPORT SUITABILITY INDICATOR~~
[EMERGENCY CARE ATTENDANCE CATEGORY](#)
 FACE TO FACE COMMUNICATION MODE
~~FEMALE GENITAL MUTILATION IDENTIFICATION METHOD CODE~~
~~FIRST ANTIRETROVIRAL THERAPY IN THE UNITED KINGDOM INDICATOR~~
 FIRST ATTENDANCE

FIVE FORENSIC PATHWAYS ASSESSMENT REASON
 GROUP THERAPY INDICATOR
 FIVE FORENSIC PATHWAYS CODE
 FURTHER ASSESSMENT TYPE FOR NHS HEALTH CHECK
 HOLISTIC NEEDS ASSESSMENT POINT OF PATHWAY FOR CANCER
 INFORMATION AND ADVICE PROVIDED INDICATOR
 INFORMATION AND ADVICE TYPE PROVIDED FOR FEMALE GENITAL MUTILATION
 INFORMATION AND ADVICE TYPE PROVIDED FOR NHS HEALTH CHECK
 INITIAL CONTACT INDICATOR
 INITIAL DIAGNOSIS CARE SETTING OR SERVICE FOR HIV
 MEDICAL STAFF TYPE SEEING PATIENT
 MENTAL HEALTH PREDICTION AND DETECTION INDICATOR
 METASTATIC STATUS
 MULTIPROFESSIONAL OR MULTIDISCIPLINARY INDICATION CODE
 NEW HIV DIAGNOSIS IN UNITED KINGDOM INDICATOR
 OTHER PERSON IN ATTENDANCE AT CARE CONTACT
 OUTCOME OF ATTENDANCE
 PATIENT EXPOSURE TO HIV
 PATIENT HIV CARE STATUS
 PATIENT TRIAL STATUS FOR CANCER
 POST EXPOSURE PROPHYLAXIS INDICATOR
 POSTNATAL CARE INDICATOR
 PRE EXPOSURE PROPHYLAXIS INDICATOR
 PREGNANCY INDICATOR FOR HIV
 PSYCHIATRIC CARE INDICATOR FOR HIV
 SIGNPOSTING TO SERVICE INDICATOR
 SIGNPOSTING TO SERVICE TYPE FOR NHS HEALTH CHECK
 SKIN TO SKIN CONTACT INDICATOR
 SOCIAL WORKER CARE INDICATOR FOR HIV
 SUBJECTIVE GLOBAL ASSESSMENT
 THERAPY TYPE FOR IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES
 TWO YEAR NEONATAL OUTCOMES ASSESSMENT NOT CARRIED OUT REASON

CARE PLAN

Change to Class: Changed Attributes

Attributes of this Class are:

K CARE PLAN IDENTIFIER
 CANCER CARE PLAN INTENT
 CANCER RECURRENCE CARE PLAN INDICATOR
 CARE PLAN AGREED BY
 CARE PLAN TYPE
 CARE PLAN TYPE FOR MENTAL HEALTH
 CHILD PROTECTION PLAN INDICATION CODE
 CHILD PROTECTION PLAN REASON CODE
 DISCHARGE PLAN AGREED BY
 INTENDED DELIVERY PLACE
 MULTIDISCIPLINARY TEAM CANCER CARE PLAN DISCUSSED INDICATOR
 MULTIDISCIPLINARY TEAM MEETING TYPE FOR CANCER
 NO CANCER TREATMENT REASON

CATEGORY VALUED PERSON OBSERVATION

Change to Class: Changed Attributes, Description

A subtype of [PERSON PROPERTY](#).

Observations made regarding a [PERSON](#). ~~[CATEGORY VALUED PERSON OBSERVATIONS](#) do not include information about a treatment or intervention.~~

[CATEGORY VALUED PERSON OBSERVATIONS](#) do not include information about performing a treatment or intervention.

[CATEGORY VALUED PERSON OBSERVATION TYPE](#) provides coded classifications of observations about a [PERSON](#).

Note: [CLINICAL INVESTIGATION RESULT ITEM](#) captures measurements about a [PERSON](#) and [OTHER PERSON OBSERVATION](#) is where the [PERSON](#) states, for example, when they first experienced symptoms, the number of days on which alcohol has been consumed etc.

CATEGORY VALUED PERSON OBSERVATION

Change to Class: Changed Attributes, Description

Attributes of this Class are:

BABY FIRST FEED BREAST MILK STATUS
BREASTFEEDING STATUS
BREAST SCREENING HIGH RISK CATEGORY
CATEGORY VALUED PERSON OBSERVATION TYPE
COMPLEX SOCIAL FACTORS INDICATOR
DOMINANT ARM CODE
EMPLOYMENT STATUS
EMPLOYMENT SUPPORT SUITABILITY INDICATOR
ESTIMATED DATE OF DELIVERY METHOD
FAMILIAL CANCER SYNDROME INDICATOR
FEMALE GENITAL MUTILATION AGE CATEGORY
FREE PRESCRIPTIONS INDICATOR
IN LABOUR BEFORE CAESARIAN SECTION INDICATOR
MENTAL CATEGORY
MENTAL HEALTH ACT 2007 MENTAL CATEGORY
OFFENCE HISTORY INDICATION CODE
PAEDIATRIC NEPHROLOGY REGISTRY STATUS CODE
PATIENT EXPOSURE TO HIV
PREGNANCY INDICATOR FOR HIV
PREGNANCY STATUS
PREVIOUS NEGATIVE HIV TEST INDICATOR
SOCIAL WORKER CARE INDICATOR FOR HIV
SUBJECTIVE GLOBAL ASSESSMENT
TIME BETWEEN DELIVERY AND SPONTANEOUS RESPIRATION CODE
WEEKLY HOURS WORKED
YOUNG CARER INDICATOR

CLINICAL INTERVENTION

Change to Class: Changed Attributes

Attributes of this Class are:

ABDOMINAL XRAY PERFORMED REASON
ABDOMINAL XRAY PERFORMED TO INVESTIGATE ABDOMINAL SIGNS INDICATOR
ABLATIVE THERAPY TYPE
ACCIDENT AND EMERGENCY INVESTIGATION
ACCIDENT AND EMERGENCY TREATMENT
ADDITIONAL UNPLANNED PROCEDURE REQUIRED INDICATOR
ADJUNCTIVE THERAPY TYPE
ANAESTHESIA TYPE IN LABOUR AND DELIVERY
ANAESTHETIC METHOD TYPE FOR DIALYSIS ACCESS CONSTRUCTION
ANAESTHETIC TYPE FOR JOINT REPLACEMENT
ANTI CANCER REGIMEN NUMBER
ANTIRETROVIRAL THERAPY DRUG REGIMEN GROUP CODE
ANTIRETROVIRAL THERAPY HOME DELIVERY INDICATOR
ARTERIOVENOUS GRAFT MATERIAL TYPE
ARTHROPLASTY REVISION TYPE FOR HIP KNEE AND ANKLE REPLACEMENT
ARTHROPLASTY REVISION TYPE FOR SHOULDER AND ELBOW REPLACEMENT
ARTIFICIAL RUPTURE OF MEMBRANES REASON CODE
ASA PHYSICAL STATUS CLASSIFICATION SYSTEM CODE
ASSOCIATED PROCEDURE TYPE FOR ANKLE REPLACEMENT
BIOLOGICAL GLENOID RESURFACING TYPE FOR SHOULDER REPLACEMENT
BIOPSY TYPE FOR CENTRAL NERVOUS SYSTEM TUMOURS
BLOOD FLOW RATE
BLOOD TRANSFUSION PRODUCT TYPE
BLOOD TRANSFUSION TYPE
BLOOD TRANSFUSION UNITS TRANSFUSED
BONE GRAFT INDICATOR FOR JOINT REPLACEMENT
BONE GRAFT SOURCE FOR JOINT REPLACEMENT
BONE GRAFT STRUCTURE FOR JOINT REPLACEMENT

BONE GRAFT TYPE FOR REVISION ANKLE REPLACEMENT
 BRACHYTHERAPY TYPE
 BREAST ASSESSMENT OUTCOME
 BREAST SCREENING TEST OUTCOME
 CANCER IMAGING MODALITY
 CANCER IMAGING OUTCOME
 CANCER TREATMENT MODALITY
 CARDIOPULMONARY EXERCISE TEST TYPE
 CEMENT REMOVAL INDICATOR FOR JOINT REPLACEMENT
 CHEMICAL THROMBOPROPHYLAXIS REGIME TYPE FOR JOINT REPLACEMENT
 CHEMO RADIATION INDICATOR
 CHEMOTHERAPY ACTUAL DOSE
 CHEST DRAIN IN SITU INDICATOR
 CLINICAL INTERVENTION TEXT STRING
 CLINICAL INTERVENTION TYPE
 CLINICAL INVESTIGATION NOT PERFORMED REASON CODE FOR MATERNITY
 COLPOSCOPY PRIME PROCEDURE TYPE
 CO MORBIDITY ADJUSTMENT INDICATOR
 COMPLICATION TYPE FOR RENAL DIALYSIS ACCESS
 COMPONENT REMOVAL INDICATOR FOR JOINT REPLACEMENT
 COMPUTER GUIDED SURGERY INDICATOR FOR JOINT REPLACEMENT
 CONTINUOUS INFUSION OF PULMONARY VASODILATOR RECEIVED INDICATOR
 CONTINUOUS POSITIVE AIRWAY PRESSURE DELIVERY MODE
 CONTRACEPTION METHOD STATUS
 CYTOLOGY SCREENING ACTION TYPE
 DEINFIBULATION UNDERTAKEN REASON
 DELIVERED IN WATER INDICATOR
 DELIVERY INSTRUMENT TYPE
 DELIVERY OF PLACENTA METHOD
 DIEPOXYBUTANE TEST RESULT
 DRUG ADMINISTRATION DURATION
 DRUG ADMINISTRATION STATUS
 DRUG DAYS SUPPLY
 DRUG DOSAGE AND ADMIN SPECIFICATION
 DRUG IDENTIFICATION
 DRUG INFORMATION COMMENT
 DRUG INFORMATION TYPE
 DRUG QUANTITY SUPPLIED
 DRUG REGIMEN ACRONYM
 DRUG TREATMENT INTENT
 ENDOSCOPIC OR RADIOLOGICAL COMPLICATION TYPE
 ENDOSCOPIC PROCEDURE TYPE
 ENTERAL FEEDING METHOD
 ENTERAL FEED TYPE GIVEN
 EPISIOTOMY PERFORMED REASON CODE
 EXCISION TYPE FOR CENTRAL NERVOUS SYSTEM TUMOURS
 FETAL ORDER
 FIRST ANTIRETROVIRAL THERAPY IN THE UNITED KINGDOM INDICATOR
 FIRST DEFINITIVE TREATMENT PROVIDED
 FIXATION TYPE FOR ELBOW REPLACEMENT
 FIXATION TYPE FOR SHOULDER REPLACEMENT
 FORMULA MILK OR MILK FORTIFIER TYPE
 FRACTION NUMBER
 GERMLINE GENETIC TEST TYPE OFFERED
 HIP JOINT SURGERY PATIENT POSITION
 HUMAN PAPILLOMAVIRUS VACCINATION DOSE GIVEN
 IMAGE GUIDED SURGERY INDICATOR
 IMAGING ANATOMICAL SITE
 IMAGING INTERVENTION INDICATOR
 IMAGING MODALITY
 IMAGING OR RADIODIAGNOSTIC EVENT INDICATION CODE FOR RENAL CARE
 INFECTION CULTURE TEST INDICATOR
 INTERVENTION SESSION TYPE FOR STOP SMOKING
 INTERVENTION SETTING TYPE FOR STOP SMOKING
 INTRAPARTUM ANTIBIOTICS GIVEN INDICATOR
 INTRAVESICAL CHEMOTHERAPY RECEIVED INDICATOR
 INTRAVESICAL IMMUNOTHERAPY RECEIVED INDICATOR

JOINT REPLACEMENT PATIENT PROCEDURE PERFORMED INDICATOR
 JOINT REPLACEMENT REVISION REASON CODE FOR ANKLE
 JOINT REPLACEMENT REVISION REASON CODE FOR ELBOW
 JOINT REPLACEMENT REVISION REASON CODE FOR HIP
 JOINT REPLACEMENT REVISION REASON CODE FOR KNEE
 JOINT REPLACEMENT REVISION REASON CODE FOR SHOULDER
 KIDNEY TRANSPLANTED CODE
 LABOUR FIRST STAGE LENGTH
 LABOUR OR DELIVERY ONSET METHOD
 LABOUR SECOND STAGE LENGTH
 LAPAROTOMY FOR NECROTISING ENTEROCOLITIS INDICATION CODE
 LINER REMOVAL INDICATOR FOR JOINT REPLACEMENT
 LIVER CANCER SURVEILLANCE SCAN INDICATOR
 LIVER SURGERY PERFORMED TYPE
 LIVER TRANSARTERIAL EMBOLISATION MATERIAL INJECTION TYPE
 LIVER TRANSARTERIAL EMBOLISATION OF HEPATOCELLULAR CARCINOMA INDICATOR
 MARGIN INVOLVED INDICATION CODE
 MATERNAL CRITICAL INCIDENT TYPE
 MECHANICAL THROMBOPROPHYLAXIS REGIME TYPE FOR JOINT REPLACEMENT
 MECONIUM PRESENT IN LIQUOR INDICATOR
 MINIMALLY INVASIVE SURGERY INDICATOR FOR JOINT REPLACEMENT
 MORE THAN THREE RECTAL WASHOUTS RECEIVED INDICATOR
 NEOADJUVANT THERAPY INDICATOR
 NEONATAL RESUSCITATION METHOD
 NEONATAL RESUSCITATION METHOD FOR NATIONAL NEONATAL DATA SET
 NEPHRECTOMY TYPE
 NEURODEVELOPMENTAL ASSESSMENT ALREADY TAKEN INDICATOR
 NEWBORN HEARING INCOMPLETE REASON CODE
 NEWBORN HEARING SCREENING TEST TYPE
 NITRIC OXIDE GIVEN INDICATOR
 NUMBER OF THERAPY SESSIONS
 OBSERVATION SCHEME IN USE
 OPPORTUNISTIC SCREENING TYPE
 ORGAN OR TISSUE UNSUITABLE ORGAN CODE RENAL TRANSPLANT
 PAIN RELIEF TYPE IN LABOUR AND DELIVERY
 PARENTAL CONSENT TO ADMINISTER VITAMIN K INDICATOR
 PARENTAL CONSENT TO POST MORTEM INDICATOR
 PARENTERAL NUTRITION RECEIVED INDICATOR
 PATHOLOGY INVESTIGATION PRIORITY
 PATHOLOGY RESULT REPORTED DATE
 PATIENT PROCEDURE PERFORMED INDICATOR
 PATIENT PROCEDURE TYPE FOR PRIMARY ANKLE REPLACEMENT
 PATIENT PROCEDURE TYPE FOR PRIMARY ELBOW REPLACEMENT
 PATIENT PROCEDURE TYPE FOR PRIMARY HIP REPLACEMENT
 PATIENT PROCEDURE TYPE FOR PRIMARY KNEE REPLACEMENT
 PATIENT PROCEDURE TYPE FOR PRIMARY SHOULDER REPLACEMENT
 PATIENT PROCEDURE TYPE FOR REVISION ANKLE REPLACEMENT
 PATIENT PROCEDURE TYPE FOR REVISION ELBOW REPLACEMENT
 PATIENT PROCEDURE TYPE FOR REVISION HIP REPLACEMENT
 PATIENT PROCEDURE TYPE FOR REVISION KNEE REPLACEMENT
 PATIENT PROCEDURE TYPE FOR REVISION SHOULDER REPLACEMENT
 PATIENT SPECIFIC INSTRUMENTS INDICATOR FOR SHOULDER OR KNEE REPLACEMENT
 PATIENT TREATED TO CHILDRENS CANCER AND LEUKAEMIA GROUP GUIDELINES INDICATOR
 PERITONEAL DIALYSIS CATHETER INSERTION TECHNIQUE
 PERITONEAL DIALYSIS CATHETER TYPE
 PERITONEAL DIALYSIS TREATMENT REGIME
 PLANE OF SURGICAL EXCISION TYPE
 PLANNED TREATMENT CHANGE REASON
 POST MORTEM CARRIED OUT INDICATOR
 POST MORTEM CONFIRMED NECROTISING ENTEROCOLITIS DIAGNOSIS INDICATOR
 POST MORTEM TYPE
 PRETREATMENT PROSTATE BIOPSY TECHNIQUE TYPE
 PREVIOUS BONY INFECTION INDICATOR OF TIBIA OR HINDFOOT FOR ANKLE REPLACEMENT
 PREVIOUS FRACTURE OF INDEX JOINT INDICATOR FOR ANKLE REPLACEMENT
 PREVIOUS INDEX JOINT SURGERY TYPE FOR ANKLE REPLACEMENT
 PREVIOUS SURGERY TYPE FOR SHOULDER REPLACEMENT

PRIMARY INDUCTION CHEMOTHERAPY FAILURE INDICATOR
 PRINCIPAL DIAGNOSTIC IMAGING TYPE
 PROCEDURE RENAL DIALYSIS ACCESS REPAIR OR REVISION TYPE
 PROCEDURE SCHEME IN USE
 PROCEDURE SIDE RENAL DIALYSIS ACCESS CONSTRUCTION CODE
 PROCEDURE SITE RENAL DIALYSIS ACCESS CONSTRUCTION CODE
 PROSTATE NERVE SPARING SURGERY TYPE
 RADICAL PROSTATECTOMY MARGIN STATUS
 RADIOISOTOPE
 RADIOTHERAPY ACTUAL DOSE
 RADIOTHERAPY BEAM TYPE
 RADIOTHERAPY INTENT
 RADIOTHERAPY PRESCRIBED DOSE
 RADIOTHERAPY TREATMENT MODALITY
 REGIONAL ANAESTHETIC TECHNIQUE FOR CANCER
 RELAPSE METHOD DETECTION TYPE
 REMOVAL REASON TYPE FOR DIALYSIS ACCESS
 RENAL DIALYSIS ACCESS TYPE
 RENAL DIALYSIS SCHEDULE TYPE
 RENAL TRANSPLANT FAILURE CAUSE CODE
 RENAL TREATMENT MODALITY CHANGE REASON CODE
 RENAL TREATMENT MODALITY CODE
 RENAL TREATMENT PRIMARY SUPERVISION CODE
 REPROGLE TUBE IN SITU INDICATOR
 RESPIRATORY SUPPORT DEVICE TYPE FOR NATIONAL NEONATAL DATA SET
 RESPIRATORY SUPPORT MODE FOR NATIONAL NEONATAL DATA SET
~~RESTRICTIVE INTERVENTION TYPE~~
 RESULT SENT DIRECT
 RETINOPATHY OF PREMATURITY SCREENING OUTCOME STATUS CODE
 REVISION PROCEDURE TYPE FOR ANKLE REPLACEMENT
 REVISION PROCEDURE TYPE FOR ELBOW REPLACEMENT
 REVISION PROCEDURE TYPE FOR HIP REPLACEMENT
 REVISION PROCEDURE TYPE FOR KNEE REPLACEMENT
 REVISION PROCEDURE TYPE FOR SHOULDER REPLACEMENT
 ROTATOR CUFF CONDITION FOR SHOULDER REPLACEMENT
 ROTATOR CUFF REPAIRED INDICATOR FOR SHOULDER REPLACEMENT
 ROTATOR CUFF REPAIR TYPE FOR SHOULDER REPLACEMENT
 RUPTURE OF MEMBRANES METHOD
 SARCOMA SURGICAL MARGIN
 SENTINEL LYMPH NODE BIOPSY TYPE
 SIGNIFICANT MATERNAL PYREXIA IN LABOUR INDICATOR
 STEM CELL INFUSION DONOR TYPE
 STEM CELL INFUSION SOURCE CODE
 STEM CELL TRANSPLANT CONDITIONING REGIMEN
 STEROIDS GIVEN DURING PREGNANCY TO MATURE FETAL LUNGS INDICATOR
 STOMA PRESENT INDICATOR
 SURFACTANT GIVEN INDICATOR
 SURGICAL ACCESS TYPE
 SURGICAL APPROACH FOR PRIMARY HIP REPLACEMENT
 SURGICAL APPROACH FOR PRIMARY KNEE REPLACEMENT
 SURGICAL APPROACH FOR PRIMARY OR REVISION ANKLE REPLACEMENT
 SURGICAL APPROACH FOR PRIMARY OR REVISION ELBOW REPLACEMENT
 SURGICAL APPROACH FOR PRIMARY OR REVISION SHOULDER REPLACEMENT
 SURGICAL APPROACH FOR REVISION HIP REPLACEMENT
 SURGICAL APPROACH FOR REVISION KNEE REPLACEMENT
 SURGICAL COMPLICATION TYPE
 SURGICAL PALLIATION TYPE
 SYSTEMIC ANTI CANCER THERAPY DRUG ROUTE OF ADMINISTRATION
 SYSTEMIC ANTI CANCER THERAPY PROGRAMME NUMBER
 SYSTEMIC ANTI CANCER THERAPY REGIMEN MODIFICATION INDICATOR
 THERAPY TYPE FOR IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES
 TRACHEOSTOMY TUBE IN SITU INDICATOR
 TREATMENT TYPE FOR NECROTISING ENTEROCOLITIS
 TREATMENT TYPE FOR PATENT DUCTUS ARTERIOSUS
 UNTOWARD INTRAOPERATIVE EVENT CODE FOR ANKLE REPLACEMENT
 UNTOWARD INTRAOPERATIVE EVENT CODE FOR ELBOW REPLACEMENT
 UNTOWARD INTRAOPERATIVE EVENT CODE FOR HIP REPLACEMENT

UNTOWARD INTRAOPERATIVE EVENT CODE FOR KNEE REPLACEMENT
UNTOWARD INTRAOPERATIVE EVENT CODE FOR SHOULDER REPLACEMENT
VASCULAR LINE TYPE IN SITU
VISUAL INSPECTION CONFIRMED NECROTISING ENTEROCOLITIS DURING LAPAROTOMY INDICATOR
VITAMIN K ADMINISTERED INDICATOR
VITAMIN K ROUTE OF ADMINISTRATION

CLINICAL INVESTIGATION RESULT ITEM

Change to Class: Changed Description

The result of a [Clinical Investigation](#).

[CLINICAL INVESTIGATION RESULT ITEM TYPE](#) provides a list of [CLINICAL INVESTIGATION RESULT ITEMS](#).

References:

~~The Version 1.0 Trial NHS Standard EDIFACT Messages for Radiology Requests and Reports, 14.3.95~~
~~The Version 1.0 Trial NHS Standard EDIFACT Messages for GP Hospital Communications – 17.5.95~~

DIAGNOSTIC TEST REQUEST

Change to Class: Changed Description

A subtype of [SERVICE REQUEST](#).

~~A request for a single diagnostic investigation or procedure for an individual [PATIENT](#) or any human or, for pathology, non-human source.~~
~~A request for a single diagnostic investigation or diagnostic procedure for an individual [PATIENT](#) or any human or, for pathology, non-human source.~~

When a [DIAGNOSTIC TEST REQUEST](#) is used to apportion costs to [MAIN SPECIALTY](#), distinction should be made between those for [PATIENTS](#) using a [Hospital Bed](#), out-patients and attendees at [CLINICS OR FACILITIES](#).

[DIAGNOSTIC TEST REQUEST TYPE](#) provides a list of [DIAGNOSTIC TEST REQUESTS](#).

EMPLOYMENT

Change to Class: Changed Attributes, Description

A subtype of [PERSON PROPERTY](#).

[EMPLOYMENT](#) records observations regarding the employment of a [PERSON](#).

EMPLOYMENT

Change to Class: Changed Attributes, Description

Attributes of this Class are:

ASSIGNMENT CONTRACTED FULL TIME EQUIVALENT
EMPLOYMENT HISTORY CONTINUOUS SERVICE TYPE 1 DATE
EMPLOYMENT HISTORY CONTINUOUS SERVICE TYPE 2 DATE
EMPLOYMENT HISTORY EMPLOYMENT LEAVING DATE
EMPLOYMENT HISTORY EXIT INTERVIEW INDICATOR
EMPLOYMENT HISTORY EXIT QUESTIONNAIRE INDICATOR
EMPLOYMENT HISTORY LEAVING DESTINATION CODE
EMPLOYMENT HISTORY LEAVING REASON CODE
EMPLOYMENT HISTORY NHS JOINING DATE
EMPLOYMENT HISTORY NHS LEAVING DATE
EMPLOYMENT HISTORY ORGANISATION JOINING DATE
EMPLOYMENT HISTORY RECORDED DATE
EMPLOYMENT HISTORY RECORDED TIME
EMPLOYMENT HISTORY RECRUITMENT SOURCE CODE
~~EMPLOYMENT STATUS~~
~~WEEKLY HOURS WORKED~~

LOCATION

Change to Class: Changed Attributes

Attributes of this Class are:

[A and E INCIDENT LOCATION TYPE](#)
ACTIVITY LOCATION TYPE CODE
ASSAULT LOCATION TYPE
LOCATION IN HOSPITAL TYPE
LOCATION OF HIGHEST LEVEL OF CARE
PLACE OF SAFETY INDICATOR

MIDWIFE

Change to Class: Changed Description

A subtype of [CARE PROFESSIONAL](#).

A practising [MIDWIFE](#) means a registered [MIDWIFE](#).

A [PERSON](#) who has given notice of their intention to practise to the local supervising authority in every area that they intend to practise in and who has updated their practise in accordance with the standards published by the [Nursing and Midwifery Council](#) and who: A [MIDWIFE](#) is a [PERSON](#) who has given notice of their intention to practise to the local supervising authority in every area that they intend to practise in and who has updated their practise in accordance with the standards published by the [Nursing and Midwifery Council](#) and who:

- is in attendance upon a woman and baby during the [Antenatal](#), intranatal or [Postnatal](#) period; or
- holds a post for which a midwifery qualification is required.

To be eligible to practise as a [MIDWIFE](#) a [PERSON](#) must:

- hold a midwifery qualification;
- have current registration as a [MIDWIFE](#) with the [Nursing and Midwifery Council](#); and
- have met the [Nursing and Midwifery Council](#) standards for updating their midwifery practice.

ORGAN OR TISSUE DONOR

Change to Class: Changed Description

An [ORGAN OR TISSUE DONOR](#) is a [PERSON](#) whose tissue or organs may be used in an organ or [TISSUE](#) transplant operation.

Subtypes of [ORGAN OR TISSUE DONOR](#) include:

[CADAVERIC ORGAN OR TISSUE DONOR](#)
[LIVING ORGAN OR TISSUE DONOR](#)

- [CADAVERIC ORGAN OR TISSUE DONOR](#)
- [LIVING ORGAN OR TISSUE DONOR](#).

OTHER PERSON OBSERVATION

Change to Class: Changed Description

A subtype of [PERSON PROPERTY](#).

Observations made by a [PERSON](#) which are not coded or measured.

~~These observations do not include information about a treatment or intervention.~~ These observations do not include information about performing a treatment or intervention. These observations may be where the [PERSON](#) states, for example, when they first experienced symptoms, the number of days on which alcohol has been consumed etc.

Note: [CATEGORY VALUED PERSON OBSERVATION](#) allows coded classifications of observations about a [PERSON](#) and [CLINICAL INVESTIGATION RESULT ITEM](#) captures measurements about a [PERSON](#).

OVERSEAS VISITOR STATUS

Change to Class: Changed Description

The status of a [PATIENT](#) who is an [Overseas Visitor](#).

Notes:

- [PATIENTS](#) charged under the [National Health Service \(Overseas Visitors Hospital Charging Regulations\)](#) are NHS charged [PATIENTS](#) and should not be confused with private [PATIENTS](#). Unlike private [PATIENTS](#), NHS Charged [PATIENTS](#) are liable to pay for their healthcare even where an undertaking to pay has not been obtained. Alternatively, the [PATIENT](#) can opt to be treated as a private [PATIENT](#).
- Healthcare for [PATIENTS](#) who are [Overseas Visitors](#) should be reported to the [Department for Work and Pensions Overseas Healthcare Team](#) via the [Overseas Visitor Treatment Portal](#). This enables the [Department of Health and Social Care](#) and ultimately the NHS to be reimbursed for the cost of treatments of [Overseas Visitors](#) from the [European Economic Area \(EEA\)](#) and Switzerland under European Union regulations.
- Healthcare for [PATIENTS](#) who are [Overseas Visitors](#) should be reported to the [Department for Work and Pensions Overseas Healthcare Team](#) via the [Overseas Visitor Treatment Portal](#). This enables the [Department of Health and Social Care](#) and ultimately the NHS to be reimbursed for the cost of treatments of [Overseas Visitors](#) from the [European Economic Area \(EEA\)](#) and Switzerland under European Union regulations.
- The [OVERSEAS VISITOR STATUS](#) may change while the [PATIENT](#) is being treated. All such changes should be recorded so that charges for treatment can be revised accordingly.
- [Health Care Providers](#) should recover the full cost of the healthcare given to a [PATIENT](#) who is an [Overseas Visitor](#). To calculate the cost, trusts follow [Non-Contract Activity](#) guidance, which can be found on the [Department of Health and Social Care](#) part of the gov.uk website at: [Guidance on overseas visitors hospital charging regulations](#).

PATIENT CLINICAL TRIAL STATUS

Change to Class: Changed Attributes

Attributes of this Class are:

CLINICAL TRIAL INDICATOR
[PATIENT TRIAL STATUS FOR CANCER](#)

PATIENT DIAGNOSIS

Change to Class: Changed Attributes

Attributes of this Class are:

ACCIDENT AND EMERGENCY DIAGNOSIS
BABY COMPLICATION AT BIRTH DIAGNOSIS
BASIS OF DIAGNOSIS FOR CANCER
BREAST CANCER INVASIVE STATUS
CEREBRAL PALSY TYPE CODE FOR NATIONAL NEONATAL DATA SET
CYTOMEGALOVIRUS DISEASE CODE
DIABETES TYPE FOR RENAL CARE
DIAGNOSIS SCHEME IN USE
FEMALE GENITAL MUTILATION TYPE 4 CODE
FETAL ANOMALY DIAGNOSIS
HISTOLOGY CONFIRMED NECROTISING ENTEROCOLITIS FOLLOWING LAPAROTOMY INDICATOR
HISTORY OF FEMALE GENITAL MUTILATION INDICATOR
HYPOXIC ISCHEMIC ENCEPHALOTHAPY GRADE
LIFE THREATENING SYMPTOMS AT DIAGNOSIS INDICATOR
LIVER CIRRHOSIS CAUSE TYPE
LIVER CIRRHOSIS TYPE
LONG HEAD BICEPS PRESENT INDICATOR FOR SHOULDER REPLACEMENT
LONG TERM PHYSICAL HEALTH CONDITION INDICATOR FOR IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES
MATERNITY COMPLICATING MEDICAL DIAGNOSIS
MATERNITY FAMILY HISTORY DIAGNOSIS TYPE
MATERNITY MEDICAL DIAGNOSIS TYPE
NEONATAL ABSTINENCE SYNDROME OBSERVED INDICATOR
NEONATAL DIAGNOSIS
OBSTETRIC DIAGNOSIS
OTHER MYELODYSPLASIA SYMPTOMS AT DIAGNOSIS
PATIENT DIAGNOSIS CODING SIGNIFICANCE
PATIENT DIAGNOSIS INDICATION FOR PRIMARY ANKLE REPLACEMENT
PATIENT DIAGNOSIS INDICATION FOR PRIMARY ELBOW REPLACEMENT
PATIENT DIAGNOSIS INDICATION FOR PRIMARY HIP REPLACEMENT
PATIENT DIAGNOSIS INDICATION FOR PRIMARY KNEE REPLACEMENT
PATIENT DIAGNOSIS INDICATION FOR PRIMARY SHOULDER REPLACEMENT
PATIENT DIAGNOSIS INDICATOR
PATIENT DIAGNOSIS TYPE FOR NHS HEALTH CHECK
POST HAEMORRHAGIC HYDROCEPHALUS OBSERVED DURING CRANIAL ULTRASOUND SCAN INDICATOR

PRESENT ON ADMISSION INDICATOR
PRIMARY CANCER SITE FOR CANCER FASTER DIAGNOSIS PATHWAY
PRIMARY DIAGNOSIS
PROVISIONAL DIAGNOSIS
RENAL DONOR DIAGNOSIS TYPE
RENAL LIVING DONOR DIAGNOSIS TYPE
RENAL PAEDIATRIC DIAGNOSIS TYPE
RENAL RECIPIENT CARDIOVASCULAR COMPLICATION TYPE
RENAL RECIPIENT DIAGNOSIS TYPE
SEIZURE OCCURRED INDICATOR
SEPSIS SUSPECTED INDICATOR
~~TRAUMATIC LESION OF GENITAL TRACT TYPE CODE~~
[TRAUMATIC LESION OF GENITAL TRACT TYPE](#)
TUMOUR OR LESION LATERALITY

PERFORMANCE STATUS

Change to Class: Changed Attributes

Attributes of this Class are:

~~PERFORMANCE STATUS CODE FOR ADULTS~~
[PERFORMANCE STATUS FOR ADULTS](#)
~~PERFORMANCE STATUS CODE FOR YOUNG PERSON~~
[PERFORMANCE STATUS FOR YOUNG PERSON](#)

PERSON

Change to Class: Changed Relationships

Each PERSON

must be the user of one or more PERSON NAME
must be the owner of one or more PERSON ORGAN
[may be the subject of one or more ASSAULT](#)
may be required to complete one or more ASSESSMENT TOOL
may be registered as one and only one CARE PROFESSIONAL
may be contacted via one or more COMMUNICATION CONTACT INFORMATION
may be born in one and only one COUNTRY
may be classified by one or more EDUCATION
may be recorded as one or more EMPLOYEE
may be classified by one or more EMPLOYMENT
may be acting as one or more ORGAN OR TISSUE DONOR
may be registered as one and only one PATIENT
may be the subject of one or more PERSON DEATH DETAILS
may be the reporter of one or more PERSON PROPERTY
may be the recorder of one or more PERSON PROPERTY
may be the owner of one or more PERSON PROPERTY
may be the observer of one or more PERSON PROPERTY
may be the second party in one or more PERSON RELATIONSHIP
may be the first party in one or more PERSON RELATIONSHIP
may be holder of one or more PROFESSIONAL REGISTRATION
may be awarded one or more QUALIFICATION
may be the recipient of one or more TISSUE TRANSPLANT

PERSON NAME

Change to Class: Changed Description

The unique identifier for a specific and ordered combination of words and titles by which a [PERSON](#) may be known.

Subtypes of [PERSON NAME](#) are:

[PERSON NAME STRUCTURED](#)
~~[PERSON NAME UNSTRUCTURED](#)~~

- [PERSON NAME STRUCTURED](#)
- [PERSON NAME UNSTRUCTURED](#)

PERSON PROPERTY

Change to Class: Changed Attributes, Description

A [PERSON PROPERTY](#) is a condition or state associated with a [PERSON](#).

[PERSON PROPERTIES](#) are collected as a result of an [ACTIVITY](#).

[PERSON PROPERTIES](#) for a [PATIENT](#) do not include information about a treatment or intervention. [PERSON PROPERTIES](#) for a [PATIENT](#) do not include information about performing a treatment or intervention.

- The [PERSON PROPERTY](#) may be a clinical diagnosis
- The observer of a [PERSON PROPERTY](#) may be a related [PERSON](#) or a [CARE PROFESSIONAL](#)
- The observer of a [PERSON PROPERTY](#) may be any [PERSON](#)
- [PERSON PROPERTIES](#) may be recorded during, or as a result of, a course of treatment.

Subtypes of [PERSON PROPERTY](#) include:

- [ASSAULT](#)
- [CANCER STAGING](#)
- [CATEGORY VALUED PERSON OBSERVATION](#)
- [EDUCATION](#)
- [EDUCATIONAL ASSESSMENT](#)
- [EMPLOYMENT](#)
- [ORGAN OR TISSUE DONOR OBSERVATION](#)
- [OTHER PERSON OBSERVATION](#)
- [PATIENT DIAGNOSIS](#)
- [PERSON SCORE](#)
- [SAFEGUARDING CHILDREN OBSERVATION](#)
- [TEXT VALUED PERSON OBSERVATION](#)
- [TOBACCO USAGE](#)
- [TOBACCO USAGE](#)

PERSON PROPERTY

Change to Class: Changed Attributes, Description

Attributes of this Class are:

K ~~PERSON PROPERTY IDENTIFIER~~
 ~~CLINICAL SIGN OBSERVED AT SAMPLE COLLECTION~~
 ~~DOMINANT ARM CODE~~
 ~~FAMILIAL CANCER SYNDROME INDICATOR~~
 ~~FREE PRESCRIPTIONS INDICATOR~~
 ~~LAST MENSTRUAL PERIOD DATE~~
 ~~OFFENCE HISTORY INDICATION CODE~~
 ~~PERSON PROPERTY EFFECTIVE DATE~~
 ~~PERSON PROPERTY EFFECTIVE END DATE~~
 ~~PERSON PROPERTY EFFECTIVE END TIME~~
 ~~PERSON PROPERTY EFFECTIVE TIME~~
 [PERSON PROPERTY EFFECTIVE START DATE](#)
 [PERSON PROPERTY EFFECTIVE START TIME](#)
 ~~PERSON PROPERTY OBSERVED DATE~~
 ~~PERSON PROPERTY OBSERVED TIME~~
 ~~PERSON PROPERTY RECORDED DATE~~
 ~~PERSON PROPERTY RECORDED TIME~~
 ~~PREGNANCY STATUS~~
 ~~YOUNG CARER INDICATOR~~

PHARMACEUTICAL PRODUCT

Change to Class: Changed Description

Subtypes of [PHARMACEUTICAL PRODUCT](#) are:

[GENERIC PRESCRIBABLE ITEM](#)

[PROPRIETARY PRODUCT](#) A drug, appliance, dressing or reagent that can be prescribed as a [CLINICAL INTERVENTION](#).

A drug, appliance, dressing or reagent that can be prescribed as a [CLINICAL INTERVENTION](#). Subtypes of [PHARMACEUTICAL PRODUCT](#) are:

- [GENERIC PRESCRIBABLE ITEM](#)
- [PROPRIETARY PRODUCT](#)

PLANNED ACTIVITY

Change to Class: Changed Attributes

Attributes of this Class are:

K PLANNED ACTIVITY SEQUENCE NUMBER
 DECISION TO TREAT DATE
 FIRST DEFINITIVE TREATMENT PLANNED
 FURTHER ASSESSMENT TYPE FOR NHS HEALTH CHECK
 PLANNED CANCER TREATMENT TYPE
 PLANNED SERVICE DESCRIPTION
 RADIOLOGY INVESTIGATION PLAN STATUS
 RADIOLOGY INVESTIGATION STATUS REASON

PRESCRIBED ITEM

Change to Class: Changed Attributes

Attributes of this Class are:

K PRESCRIBED ITEM IDENTIFIER
 CYTOMEGALOVIRUS MEDICATION TYPE CODE
 CYTOMEGALOVIRUS MEDICATION TYPE
 PERITONEAL DIALYSIS FLUID MANUFACTURERS NAME
 PRESCRIBED DOSE
 PRESCRIBED ITEM QUANTITY
 PRESCRIBED NUMBER OF DOSES PER PERIOD
 RENAL DIALYSIS MEDICATION TYPE
 RENAL MEDICATION TYPE
 THROMBOSIS PREVENTION DRUG TYPE FOR RENAL

REFERRAL REQUEST

Change to Class: Changed Attributes, Description

A subtype of [SERVICE REQUEST](#).

~~This is a request for a care service, other than a specific diagnostic investigation or procedure, to be provided for a [PATIENT](#).~~ A REFERRAL REQUEST is a request for a care service, other than a specific diagnostic investigation or diagnostic procedure, to be provided for a [PATIENT](#). This includes [PATIENT](#) self-referrals for an [APPOINTMENT](#) to see or be in contact with a [CARE PROFESSIONAL](#) of an [Organisation](#).

If there is a verbal request this would normally be confirmed by written request, and these should be processed as one referral. An electronic message is treated as a written referral.

Where the [REFERRAL REQUEST](#) relates to a booking system, the [PATIENT](#) is given the choice of when to attend or be in contact. For full booking, the [PATIENT](#) is offered a date within one working day of the referral or [DECISION TO ADMIT](#).

REFERRAL REQUEST

Change to Class: Changed Attributes, Description

Attributes of this Class are:

BENIGN THERAPEUTIC OPERATION INDICATOR
COLPOSCOPY REFERRAL INDICATION
COMMISSIONER REFERENCE NUMBER
REASON FOR REFERRAL TO COMMUNITY CARE
REASON FOR REFERRAL TO MENTAL HEALTH
REFERRAL CLOSURE REASON
REFERRAL REJECTION REASON
REFERRAL REQUEST ACCEPTANCE INDICATOR
REFERRAL REQUEST RECEIVED DATE
REFERRAL REQUEST RECEIVED TIME
REFERRAL REQUEST SERVICE TYPE FOR NHS HEALTH CHECK
SCREENING REFERRAL SOURCE
SERVICE TYPE REQUESTED
SOURCE OF REFERRAL FOR A and E

SOURCE OF REFERRAL FOR COMMUNITY
SOURCE OF REFERRAL FOR FEMALE GENITAL MUTILATION
SOURCE OF REFERRAL FOR MENTAL HEALTH
SOURCE OF REFERRAL FOR OUT-PATIENTS
TWO WEEK WAIT CANCER OR SYMPTOMATIC BREAST REFERRAL TYPE

SAMPLE

Change to Class: Changed Attributes

Attributes of this Class are:

K SAMPLE COLLECTION DATE
K SAMPLE COLLECTION TIME
AMOUNT OF SAMPLE COLLECTED
ANATOMICAL ORIGIN OF SAMPLE
CLINICAL SIGN OBSERVED AT SAMPLE COLLECTION
SAMPLE COLLECTION PERIOD END DATE
SAMPLE COLLECTION PERIOD END TIME
SAMPLE COLLECTION PROCEDURE
SAMPLE HANDLING WARNING
SAMPLE IDENTIFIER FOR PROVIDER
SAMPLE IDENTIFIER FOR REQUESTER
SAMPLE RECEIPT DATE
SAMPLE RECEIPT TIME
SAMPLE TYPE
SAMPLE TYPE FOR NATIONAL NEONATAL DATA SET
SAMPLE UNIT OF MEASURE
SPECIMEN TYPE FOR CHLAMYDIA TESTING
TRANSPORT TYPE FOR SAMPLE COLLECTED

TEXT VALUED PERSON OBSERVATION

Change to Class: Changed Description

A type of [PERSON PROPERTY](#).

A [PERSON PROPERTY](#) having a value expressed by a text string. Automated analysis of text entries is difficult.

ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL

Change to Attribute: Changed Description

A code to identify how an [Accident and Emergency Attendance](#) might end. A code to identify how an [Accident and Emergency Attendance](#) concluded.

National Codes:

- 01 Admitted to a [Hospital Bed](#) /became a [LODGED PATIENT](#) of the same [Health Care Provider](#)
- 02 Discharged - follow up treatment to be provided by [GENERAL PRACTITIONER](#)
- 03 Discharged - did not require any follow up treatment
- 04 Referred to A&E Clinic
- 05 Referred to Fracture Clinic
- 06 Referred to other [Out-Patient Clinic](#)
- 07 Transferred to other [Health Care Provider](#)
- 10 Died in [Department](#)
- 11 Referred to other health [CARE PROFESSIONAL](#)
- 12 Left [Department](#) before being seen for treatment
- 13 Left [Department](#) having refused treatment
- 14 Other

For the Accident and Emergency Clinical Quality Indicators, further guidance on National Code 'Left [Department](#) before being seen for treatment' is available on the [Department of Health and Social Care](#) National Archives at: [A&E clinical quality indicators: Implementation guidance and data definitions](#).

ACTIVITY DATE AND TIME TYPE

Change to Attribute: Changed Description

The type of [DATE AND TIME](#) that defines the usage with regard to the [ACTIVITY](#).

An [ACTIVITY](#) may have many [DATES AND TIMES](#) associated with it but may only have one [DATE AND TIME](#) of a particular type.

National Codes:

300	Maternal Critical Incident Date and Time
301	Procedure Date and Time
301	Procedure Date and Time (Retired September 2018)
302	Baby First Feed Date and Time
303	Date and Time of Decision to Deliver
304	Discharge Date and Time (Hospital Provider Spell Postpartum)
305	Oxytocin Administered Date and Time
306	Rupture of Membranes Date and Time
306	Rupture of Membranes Date and Time (Retired September 2018)
307	Transfer Start Date and Time (Neonatal Unit)
308	Urgent Care Service Accessed Date and Time (Retired 01 September 2015)
309	Clinical Intervention Date and Time
310	Critical Care Period Start Date and Time
311	Parents Seen By Senior Staff Member Date and Time
312	Critical Care Period Discharge Date and Time
313	Arrival Date and Time at Accident and Emergency Department
314	Assault Date and Time
309	Clinical Intervention Date and Time (Retired September 2018)
310	Critical Care Period Start Date and Time (Retired September 2018)
311	Parents Seen By Senior Staff Member Date and Time (Retired September 2018)
312	Critical Care Period Discharge Date and Time (Retired September 2018)
313	Arrival Date and Time at Accident and Emergency Department (Retired September 2018)
314	Assault Date and Time (Retired September 2018)

Note: This list is not in alphabetical order.

ACTIVITY DATE TYPE

Change to Attribute: Changed Description

The type of date that defines the usage with regard to the [ACTIVITY](#).

An [ACTIVITY](#) may have many dates associated with it but may only have one date of a particular type.

National Codes:

001	Angiogram Date (Retired July 2012)
002	Arrival Date At Accident and Emergency Department
003	Breast Assessment Date (Retired 1 January 2013)
004	Cancer Dental Assessment Date
004	Cancer Dental Assessment Date (Retired September 2018)
005	Colorectal or Stoma Nurse Seen Date (Retired 1 January 2013)
006	Coronary Angiography Date (Retired July 2012)
007	Care Programme Approach Review Date
007	Care Programme Approach Review Date (Retired September 2018)
008	Date Biopsy Taken (Retired 01 April 2014)
009	Discharge Date
010	Discharge Ready Date
011	End Date
012	Event Date (Retired July 2012)
013	Expected Delivery Date (Retired September 2012)
014	First Antenatal Assessment Date
015	Full Postnatal Examination Date (Retired September 2012)
016	Initial Patient Contact Date (Retired July 2012)
017	Investigation Transfer Date (Retired July 2012)
018	Intrauterine Device Application Date (Retired September 2012)
019	Intrauterine Device Fitted Date (Retired September 2012)
020	Last Dosage Date
021	Mental Health Care Assessment Date (Retired September 2012)
022	Miscarriage Date (Retired September 2012)
023	Pathology Result Due Date
024	Patient Informed Biopsy Result Date
025	Patient Informed Of Outcome Date (Retired September 2012)

026 [Smoking Quit Date](#) (Retired October 2017)
 026 **Smoking Quit Date (Retired October 2017)**
 027 Review Planned Date (Retired 01 April 2014)
 028 Screening Result Date (Retired 01 April 2014)
 029 [Screening Result Sent Date](#)
 030 Specialist Palliative Care Date (Retired 01 April 2014)
 031 [Start Date](#)
 032 [Cancer Symptoms First Noted Date](#)
 033 [Attendance Date](#)
 032 **Cancer Symptoms First Noted Date (Retired September 2018)**
 033 **Attendance Date (Retired September 2018)**
 034 [Clinical Intervention Date](#)
 035 Immunisation Completion Date (Retired 01 September 2015)
 036 [Clinical Status Assessment Date](#)
 036 **Clinical Status Assessment Date (Retired September 2018)**
 037 Dose Given Date (Retired September 2012)
 038 Test Date (Retired September 2012)
 039 [Contact Date](#)
 040 [Appointment Date](#)
 041 [Primary Procedure Date](#)
 039 **Contact Date (Retired September 2018)**
 040 **Appointment Date (Retired September 2018)**
 041 **Primary Procedure Date (Retired September 2018)**
 042 Second Operation Date (Retired 01 April 2014)
 043 [Speech and Language Assessment Date](#)
 043 **Speech and Language Assessment Date (Retired September 2018)**
 044 Third Operation Date (Retired 01 April 2014)
 045 [Date First Seen](#)
 045 **Date First Seen (Retired September 2018)**
 046 Statutory Assessment Date (Retired 01 January 2016)
 047 [Screening Test Date](#)
 047 **Screening Test Date (Retired September 2018)**
 048 Genitourinary Care Contact Date (Retired January 2014)
 049 [Consultant Upgrade Date](#)
 101 Referral Closure Date (Community Care) (Retired 01 September 2015)
 102 Discharge Letter Issued Date (Community Care) (Retired 01 September 2015)
 403 [Systemic Anti-Cancer Therapy Administration Date](#)
 103 **Systemic Anti-Cancer Therapy Administration Date (Retired September 2018)**
 104 [Procedure Date](#)
 406 [Immunisation Date](#)
 105 **Immunisation Date (Retired September 2018)**
 106 [Antenatal Appointment Date](#)
 407 [Antenatal Booking Appointment Date](#)
 107 **Antenatal Booking Appointment Date (Retired September 2018)**
 108 [Pregnancy First Contact Date](#)
 109 [Screening Test Information Given Date](#)
 110 [Assessment Date For Transplant Suitability](#)
 111 [Accident and Emergency Initial Assessment Date](#)
 112 [Accident and Emergency Date Seen For Treatment](#)
 113 [Accident and Emergency Attendance Conclusion Date](#)
 114 [Accident and Emergency Departure Date](#)
 446 [Clinical Assessment Date](#)
 446 [Imaging or Radiodiagnostic Event Date](#)
 115 **Clinical Assessment Date (Retired September 2018)**
 116 **Imaging or Radiodiagnostic Event Date (Retired September 2018)**
 117 [Neonatal Critical Care Daily Care Date](#)
 448 [Two Year Neonatal Outcomes Assessment Date](#)
 118 **Two Year Neonatal Outcomes Assessment Date (Retired September 2018)**
 119 [Date of Pregnancy Outcome \(Current Fetus\)](#)
 120 [Neonatal Critical Incident Date](#)
 424 [American Joint Committee on Cancer Stage Date](#)
 422 [Ann Arbor Stage Date](#)
 423 [Barcelona Clinic Liver Cancer Stage Date](#)
 424 [Binet Stage Date](#)
 425 [Chang Staging System Stage Date](#)
 426 [Clinical Stage Date \(Pancreatic Cancer\)](#)
 427 [Final Figo Stage Date](#)
 428 [Holistic Needs Assessment Completed Date](#)
 429 [Intergroup Rhabdomyosarcoma Study Post Surgical Group Date](#)

121	American Joint Committee on Cancer Stage Date (Retired September 2018)
122	Ann Arbor Stage Date (Retired September 2018)
123	Barcelona Clinic Liver Cancer Stage Date (Retired September 2018)
124	Binet Stage Date (Retired September 2018)
125	Chang Staging System Stage Date (Retired September 2018)
126	Clinical Stage Date (Pancreatic Cancer) (Retired September 2018)
127	Final Figo Stage Date (Retired September 2018)
128	Holistic Needs Assessment Completed Date (Retired September 2018)
129	Intergroup Rhabdomyosarcoma Study Post Surgical Group Date (Retired September 2018)
130	International Neuroblastoma Staging System Date (Retired 01 April 2017)
131	Myeloma International Staging System Stage Date
132	Modified Dukes Stage Date
133	Myeloma International Staging System Stage Date (Retired September 2018)
134	Modified Dukes Stage Date (Retired September 2018)
135	Multidisciplinary Team Discussion Date (Cancer)
136	Multidisciplinary Team Meeting Date (Cancer)
137	Murphy St Jude Stage Date
138	Murphy St Jude Stage Date (Retired September 2018)
139	Rai Stage Date (Retired 01 April 2017)
140	Retinoblastoma Assessment Date
141	TNM Stage Grouping Date (Final Pretreatment)
142	TNM Stage Grouping Date (Integrated)
143	Wilms Tumour Stage Date
144	Retinoblastoma Assessment Date (Retired September 2018)
145	TNM Stage Grouping Date (Final Pretreatment) (Retired September 2018)
146	TNM Stage Grouping Date (Integrated) (Retired September 2018)
147	Wilms Tumour Stage Date (Retired September 2018)
148	Care Contact Cancellation Date
149	Care Contact Date
150	Child Protection Plan End Date
151	Child Protection Plan Start Date
152	Child Protection Plan End Date (Retired September 2018)
153	Child Protection Plan Start Date (Retired September 2018)
154	Discharge Letter Issued Date (Mental Health and Community Care)
155	Health Visitor First Antenatal Visit Date
156	Infant Physical Examination Date
157	Onward Referral Date
158	Health Visitor First Antenatal Visit Date (Retired September 2018)
159	Infant Physical Examination Date (Retired September 2018)
160	Onward Referral Date (Retired September 2018)
161	Referral Closure Date
162	Referral Rejection Date
163	Replacement Appointment Booked Date
164	Replacement Appointment Date Offered
165	Service Discharge Date
166	Service Discharge Date (Retired September 2018)
167	Date of Restrictive Intervention
168	Indirect Activity Date
169	Mental Health Crisis Plan Creation Date (Retired 01 April 2017)
170	Mental Health Crisis Plan Last Updated Date (Retired 01 April 2017)
171	Care Plan Agreed Date
172	Care Plan Creation Date
173	Care Plan Implementation Date
174	Care Plan Last Updated Date
175	Five Forensic Pathways Assessment Date
176	International Neuroblastoma Risk Group Staging System Stage Date
177	Stage Grouping Date (Testicular Cancer)
178	Five Forensic Pathways Assessment Date (Retired September 2018)
179	International Neuroblastoma Risk Group Staging System Stage Date (Retired September 2018)
180	Stage Grouping Date (Testicular Cancer) (Retired September 2018)
181	Emergency Care Arrival Date
182	Emergency Care Initial Assessment Date
183	Emergency Care Date Seen For Treatment
184	Emergency Care Attendance Conclusion Date
185	Emergency Care Departure Date
186	Injury Date
187	Referred To Service Assessment Date
188	Intended Smoking Quit Date
189	Injury Date (Retired September 2018)

171	Referred To Service Assessment Date (Retired September 2018)
172	Intended Smoking Quit Date (Moved to PLANNED ACTIVITY DATE TYPE ## 2018)
173	Cancer Transformation Agreed Date (Primary Cancer Pathway)
174	Cancer Progression Agreed Date (Primary Cancer Pathway)
175	Clinical Trial Decision Date
176	Treatment Start Date (Cancer)
177	Cancer Faster Diagnosis Pathway End Date
178	Cancer Referral To Treatment Period Start Date
179	Cancer Treatment Period Start Date
176	Treatment Start Date (Cancer) (Retired September 2018)
177	Cancer Faster Diagnosis Pathway End Date (Retired September 2018)
178	Cancer Referral To Treatment Period Start Date (Retired September 2018)
179	Cancer Treatment Period Start Date (Retired September 2018)
180	Observable Entity Date

Note: This list is not in alphabetical order.

ACTIVITY OFFER STATUS_ renamed from ACTIVITY OFFER STATUS CODE

Change to Attribute: Changed Name

- Changed Name from Data_Dictionary.Attributes.A.Acc.ACTIVITY_OFFER_STATUS_CODE to Data_Dictionary.Attributes.A.Acc.ACTIVITY_OFFER_STATUS

ACTIVITY TIME TYPE

Change to Attribute: Changed Description

The type of [TIME](#) that defines the usage with regard to the [ACTIVITY](#).

An [ACTIVITY](#) may have many [TIMES](#) associated with it but may only have one [TIME](#) of a particular type.

National Codes:

50	Accident and Emergency Attendance Conclusion Time
51	Accident and Emergency Departure Time
52	Accident and Emergency Initial Assessment Time
53	Accident and Emergency Time Seen For Treatment
54	Arrival At Hospital Time (Retired April 2012)
55	ARRIVAL TIME (Retired April 2012)
56	End Time
57	Event Time (Retired July 2012)
58	Initial Patient Contact Time (Retired July 2012)
59	Last Dosage Time
60	Pathology Result Due Time
61	Start Time
62	Theatre Case Time In To Theatre Suite (Retired September 2012)
63	Theatre Case Time Out Of Theatre (Retired September 2012)
64	Theatre Case Time Out Of Theatre Suite (Retired September 2012)
65	Time Seen
65	Time Seen (Retired September 2018)
66	Discharge Ready Time (Retired April 2012)
67	Arrival Time At Accident and Emergency Department
68	Arrival Time For Transport Requests (Retired September 2015)
69	Discharge Time
70	Clinical Intervention Time
71	Care Contact Time
72	Indirect Activity Time
73	Service Discharge Time
73	Service Discharge Time (Retired September 2018)
74	Referral Closure Time
75	Onward Referral Time
75	Onward Referral Time (Retired September 2018)
76	Emergency Care Arrival Time
77	Emergency Care Initial Assessment Time
78	Emergency Care Time Seen For Treatment
79	Emergency Care Attendance Conclusion Time
80	Emergency Care Departure Time
84	Injury Time

82	Referred To Service Assessment Time
81	Injury Time (Retired September 2018)
82	Referred To Service Assessment Time (Retired September 2018)
83	Procedure Time
84	Care Plan Agreed Time
85	Care Plan Creation Time
86	Care Plan Last Updated Time
87	Referral Rejection Time
88	Observable Entity Time

Note: This list is not in alphabetical order.

APPOINTMENT DATE

Change to Attribute: Changed Description

The date of an [APPOINTMENT](#). The DATE of an [APPOINTMENT](#).

In the case of a [PATIENT](#) attending an [Out-Patient Clinic](#) without prior notice or [APPOINTMENT](#), the [PATIENT](#) will be given an [Out-Patient Appointment](#).

CANCER CARE SPELL DELAY REASON

Change to Attribute: Changed Description

The reason why a [Cancer Care Spell Delay](#) occurred.

This could be the delay between the:

- [Cancer Referral To Treatment Period Start Date](#) and [Treatment Start Date \(Cancer\)](#)
- [DECISION TO TREAT DATE](#) and [Treatment Start Date \(Cancer\)](#)
- [Consultant Upgrade Date](#) and [Treatment Start Date \(Cancer\)](#)
- [Cancer Referral To Treatment Period Start Date](#) and the [Date First Seen](#), where the [PRIORITY TYPE](#) is National Code 'Two Week Wait'
- [Cancer Faster Diagnosis Pathway End Date](#) and the [PATIENT](#) being advised of the [CANCER FASTER DIAGNOSIS PATHWAY END REASON](#).
- [CANCER REFERRAL TO TREATMENT PERIOD START DATE](#) and [TREATMENT START DATE \(CANCER\)](#)
- [DECISION TO TREAT DATE](#) and [TREATMENT START DATE \(CANCER\)](#)
- [Consultant Upgrade Date](#) and [TREATMENT START DATE \(CANCER\)](#)
- [CANCER REFERRAL TO TREATMENT PERIOD START DATE](#) and the [DATE FIRST SEEN](#), where the [PRIORITY TYPE](#) is National Code 'Two Week Wait'
- [CANCER FASTER DIAGNOSIS PATHWAY END DATE](#) and the [PATIENT](#) being advised of the [CANCER FASTER DIAGNOSIS PATHWAY END REASON](#).

National Codes:

01	Clinic cancellation
02	Out-patient capacity inadequate (i.e. no cancelled clinic, but not enough slots for this PATIENT)
03	Administrative delay
04	Elective cancellation (for non-medical reason) for treatment in an admitted care setting
05	Elective capacity inadequate (PATIENT unable to be scheduled for treatment within standard time) for treatment in an admitted care setting
06	Delay to diagnostic test or treatment planning (Retired 1 July 2012)
07	Complex diagnostic pathway (many, or complex, diagnostic tests required)
08	Delay due to referral between Trusts (Retired 1 July 2012)
10	Treatment delayed for medical reasons (PATIENT unfit for treatment episode, excluding planned recovery period following diagnostic test) in an admitted care setting
11	Diagnosis delayed for medical reasons (PATIENT unfit for diagnostic episode, excluding planned recovery period following diagnostic test)
13	Delay due to recovery after an invasive test (PATIENT DIAGNOSIS or treatment delayed due to planned recovery period following an invasive diagnostic test)
14	PATIENT Did Not Attend treatment APPOINTMENT
16	PATIENT Choice (PATIENT declined or cancelled an offered Appointment Date for treatment)
16	PATIENT Choice (PATIENT declined or cancelled an offered APPOINTMENT DATE for treatment)
17	PATIENT choice delay relating to first Out-Patient Appointment
18	Health Care Provider initiated delay to diagnostic test or treatment planning
19	PATIENT initiated (choice) delay to diagnostic test or treatment planning, advance notice given
20	PATIENT Did Not Attend an APPOINTMENT for a diagnostic test or treatment planning event (no advance notice)
21	PATIENT failed to present for elective treatment (choice) in an admitted care setting
22	PATIENT care not commissioned by the NHS in England (waiting time standard does not apply) for treatment in an admitted care setting
23	Equipment breakdown

- 24 Inconclusive diagnostic result
- 25 [Health Care Provider](#) unable to make contact with [PATIENT](#) by telephone
- 26 [PATIENT](#) choice ([PATIENT](#) declined or cancelled an offered [Appointment Date](#) for follow up [APPOINTMENT](#))
- 26 [PATIENT](#) choice ([PATIENT](#) declined or cancelled an offered [APPOINTMENT DATE](#) for follow up [APPOINTMENT](#))
- 97 Other reason (not listed)
- 98 Other reason (Retired 1 April 2018)
- 99 Other reason (Retired 1 July 2012)

CANCER CARE SPELL DELAY REASON COMMENT

Change to Attribute: Changed Description

A comment why a [CANCER CARE SPELL DELAY REASON](#) was experienced.

This can be recorded for:

- each breach of existing service standards (introduced by the '[NHS Cancer Plan \(2000\)](#)')
- the extended service standards (as specified within the '[Cancer Reform Strategy \(2007\)](#)') and
- the 28 Day Faster Diagnosis Standard (introduced by the independent Cancer Taskforce '[Achieving World-Class Cancer Outcomes](#)')

after any patient pauses have been taken into account.

The standards for which a [CANCER CARE SPELL DELAY REASON COMMENT](#) can be given are:

- maximum two week wait** for an urgent [GENERAL PRACTITIONER](#) referral for suspected cancer to [Date First Seen](#) for all suspected cancers
- maximum two week wait** for an urgent [GENERAL PRACTITIONER](#) referral for suspected cancer to [DATE FIRST SEEN](#) for all suspected cancers
- maximum 28 day wait for an urgent [GENERAL PRACTITIONER](#) referral or referral for suspected cancer from an NHS Cancer [Screening Programme](#) for suspected cancer, where the [CANCER FASTER DIAGNOSIS PATHWAY END REASON](#) is National Code '[Diagnosis of cancer](#)' or '[Ruling out of cancer](#)'
- maximum 28 day wait for an urgent [GENERAL PRACTITIONER](#) referral, referral for breast symptoms (where cancer is not initially suspected) or referral for suspected cancer from an NHS Cancer [Screening Programme](#) for suspected cancer, where the [CANCER FASTER DIAGNOSIS PATHWAY END REASON](#) is National Code '[Diagnosis of cancer](#)' or '[Ruling out of cancer](#)'
- maximum one month** wait from urgent [GENERAL PRACTITIONER](#) referral for suspected cancer to [First Definitive Treatment](#) for testicular cancer, acute leukaemia and children's cancer (under 16 years of age at date of [First Definitive Treatment](#))*
- maximum two month wait** from urgent [GENERAL PRACTITIONER](#) referral for suspected cancer to [First Definitive Treatment](#) for all cancers
- maximum one month wait** from [Cancer Treatment Period Start Date \(DECISION TO TREAT DATE\)](#) to [First Definitive Treatment](#) for all cancers
- maximum 31 day wait from [Cancer Treatment Period Start Date \(DECISION TO TREAT DATE\)](#) or [EARLIEST CLINICALLY APPROPRIATE DATE](#) to the start of second or subsequent treatment for all cancers, where the [CANCER TREATMENT MODALITY](#) is National Code '[Chemoradiotherapy](#)', '[Teletherapy \(Beam Radiation excluding Proton Therapy\)](#)', '[Brachytherapy](#)' or '[Proton Therapy](#)'
- maximum 31 day wait from [Cancer Treatment Period Start Date \(DECISION TO TREAT DATE\)](#) or [EARLIEST CLINICALLY APPROPRIATE DATE](#) to start of second or subsequent treatment for all cancers where the [CANCER TREATMENT MODALITY](#) is '[Surgery](#)'
- maximum 31 day wait from [Cancer Treatment Period Start Date \(DECISION TO TREAT DATE\)](#) or [EARLIEST CLINICALLY APPROPRIATE DATE](#) to start of second or subsequent treatment for all cancers where the [CANCER TREATMENT MODALITY](#) is National Code '[Anti-Cancer Drug Regimen \(Cytotoxic Chemotherapy\)](#)', '[Anti-Cancer Drug Regimen \(Hormone Therapy\)](#)', '[Anti-Cancer Drug Regimen \(Immunotherapy\)](#)' or '[Anti-Cancer Drug Regimen \(other\)](#)'
- maximum 31 day wait from [Cancer Treatment Period Start Date \(DECISION TO TREAT DATE\)](#) or [EARLIEST CLINICALLY APPROPRIATE DATE](#) to start of second or subsequent treatment for all cancers where the [CANCER TREATMENT MODALITY](#) is other than '[Surgery](#)', '[Anti-Cancer Drug Regimen \(Cytotoxic Chemotherapy\)](#)', '[Anti-Cancer Drug Regimen \(Hormone Therapy\)](#)', '[Anti-Cancer Drug Regimen \(Immunotherapy\)](#)' or '[Anti-Cancer Drug Regimen \(other\)](#)'
- maximum 31-day wait from [CANCER TREATMENT PERIOD START DATE \(DECISION TO TREAT DATE\)](#) or [EARLIEST CLINICALLY APPROPRIATE DATE](#) to the start of second or subsequent treatment for all cancers, where the [CANCER TREATMENT MODALITY](#) is National Code '[Chemoradiotherapy](#)', '[Teletherapy \(Beam Radiation excluding Proton Therapy\)](#)', '[Brachytherapy](#)' or '[Proton Therapy](#)'
- maximum 31-day wait from [CANCER TREATMENT PERIOD START DATE \(DECISION TO TREAT DATE\)](#) or [EARLIEST CLINICALLY APPROPRIATE DATE](#) to start of second or subsequent treatment for all cancers where the [CANCER TREATMENT MODALITY](#) is National Code '[Surgery](#)'
- maximum 31-day wait from [CANCER TREATMENT PERIOD START DATE \(DECISION TO TREAT DATE\)](#) or [EARLIEST CLINICALLY APPROPRIATE DATE](#) to start of second or subsequent treatment for all cancers where the [CANCER TREATMENT MODALITY](#) is National Code '[Anti-Cancer Drug Regimen \(Cytotoxic Chemotherapy\)](#)', '[Anti-Cancer Drug Regimen \(Hormone Therapy\)](#)', '[Anti-Cancer Drug Regimen \(Immunotherapy\)](#)' or '[Anti-Cancer Drug Regimen \(other\)](#)'
- maximum 31-day wait from [CANCER TREATMENT PERIOD START DATE \(DECISION TO TREAT DATE\)](#) or [EARLIEST CLINICALLY APPROPRIATE DATE](#) to start of second or subsequent treatment for all cancers where the [CANCER TREATMENT MODALITY](#) is other than National Code '[Surgery](#)', '[Anti-Cancer Drug Regimen \(Cytotoxic Chemotherapy\)](#)', '[Anti-Cancer Drug Regimen \(Hormone Therapy\)](#)', '[Anti-Cancer Drug Regimen \(Immunotherapy\)](#)' or '[Anti-Cancer Drug Regimen \(other\)](#)'
- maximum 62-day wait from referral for suspected cancer from an NHS Cancer [Screening Programme](#) to [First Definitive Treatment](#) for breast, bowel and cervical cancers*
- maximum 62-day wait from a decision to upgrade the priority of a [PATIENT](#) by a [CONSULTANT](#) (or authorised member of a [CONSULTANT](#) team) to [First Definitive Treatment](#)
- maximum two week wait** for an urgent referral for breast symptoms (where cancer is not initially suspected) to [DATE FIRST SEEN](#).

Notes:

* Breast, bowel, cervical and testicular cancer and acute leukaemia are defined by [International Classification of Diseases \(ICD\)](#) diagnosis codes. The full list of diagnosis codes can be found on the [NHS Digital](#) website at: [Cancer Waiting Times](#).

** For the performance management and the requirement to record a [CANCER CARE SPELL DELAY REASON COMMENT](#) for the above service standards, the following standardised time periods have been identified:

Time Period	Number of Calendar Days
Two Weeks	14
Twenty Eight Days	28
One Month	31
Two Months	62

CLINICAL INTERVENTION TEXT STRING

Change to Attribute: New Attribute

A free text string to record information relating to a [CLINICAL INTERVENTION](#).

This attribute is also known by these names:

Context	Alias
plural	CLINICAL INTERVENTION TEXT STRINGS

CLINICAL INTERVENTION TEXT STRING

Change to Attribute: New Attribute

CLINICAL INTERVENTION TEXT STRING

Data Elements:

OTHER GENE OR STRATIFICATION BIOMARKER TYPE ANALYSED COMMENT
OTHER GERMLINE GENETIC TEST TYPE OFFERED COMMENT

CRITICAL CARE LEVEL

Change to Attribute: Changed Description

The levels of care provided during a [Hospital Provider Spell](#): A [Hospital Provider Spell](#) is an [ACTIVITY GROUP](#) where the [ACTIVITY GROUP TYPE](#) is National Code 21 [Hospital Provider Spell](#).

The level of critical care provided during a [Hospital Provider Spell](#).

National Codes:

- 00 Level 0 (Patients whose needs can be met through normal ward care in an acute hospital)
- 01 Level 1 ([PATIENTS](#) at risk of their condition deteriorating, or those recently relocated from higher levels of care, whose needs can be met on an acute ward with additional advice and support from the critical care team.)
- 02 Level 2 ([PATIENTS](#) requiring more detailed observation or intervention including support for a single failing organ system or post-operative care and those 'stepping down' from higher levels of care.)
- 03 Level 3 ([PATIENTS](#) requiring advanced respiratory support alone or monitoring and support for two or more organ systems. This level includes all complex [PATIENTS](#) requiring support for multi-organ failure.)

References:

Comprehensive Critical Care: a review of adult critical care services, [Department of Health and Social Care](#) May 2000 and Levels of critical care for adult [PATIENTS](#), Intensive Care Society 2002.

CYTOMEGALOVIRUS MEDICATION TYPE renamed from CYTOMEGALOVIRUS MEDICATION TYPE CODE

Change to Attribute: Changed Name

- Changed Name from Data_Dictionary.Attributes.C.Cy.CYTOMEGALOVIRUS_MEDICATION_TYPE_CODE to Data_Dictionary.Attributes.C.Cy.CYTOMEGALOVIRUS_MEDICATION_TYPE

DIAGNOSTIC TEST REQUEST TYPE

Change to Attribute: Changed Description

One of the business definitions listed in the [DIAGNOSTIC TEST REQUEST](#) class as a type of this class: The type of [DIAGNOSTIC TEST REQUEST](#).

National Codes:

- 01 [Request for Isotope Procedure](#)
- 02 [Request for Physiological Measurement](#)

- 03 [Request for Pathology Investigation](#)
- 04 [Request for Radiological Procedure](#)

LAST MENSTRUAL PERIOD DATE (RETIRED), renamed from LAST MENSTRUAL PERIOD DATE

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

The date of the first day of the last menstrual period for a female [PERSON](#). This item has been retired from the NHS Data Model and Dictionary.

The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

LAST MENSTRUAL PERIOD DATE (RETIRED), renamed from LAST MENSTRUAL PERIOD DATE

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

- Changed Name from Data_Dictionary.Attributes.L.LAST_MENSTRUAL_PERIOD_DATE to Retired.Data_Dictionary.Attributes.L.LAST_MENSTRUAL_PERIOD_DATE
- Retired LAST MENSTRUAL PERIOD DATE
- Changed Description

PERFORMANCE STATUS FOR ADULTS, renamed from PERFORMANCE STATUS CODE FOR ADULTS

Change to Attribute: Changed Name

- Changed Name from Data_Dictionary.Attributes.P.Paya.PERFORMANCE_STATUS_CODE_FOR_ADULTS to Data_Dictionary.Attributes.P.Paya.PERFORMANCE_STATUS_FOR_ADULTS

PERFORMANCE STATUS FOR YOUNG PERSON, renamed from PERFORMANCE STATUS CODE FOR YOUNG PERSON

Change to Attribute: Changed Name

- Changed Name from Data_Dictionary.Attributes.P.Paya.PERFORMANCE_STATUS_CODE_FOR_YOUNG_PERSON to Data_Dictionary.Attributes.P.Paya.PERFORMANCE_STATUS_FOR_YOUNG_PERSON

PERSON PROPERTY EFFECTIVE END DATE

Change to Attribute: Changed Description

The date when a [PERSON PROPERTY](#) is no longer applicable to the [PATIENT](#). The DATE when a [PERSON PROPERTY](#) is no longer applicable to the [PATIENT](#).

PERSON PROPERTY EFFECTIVE END TIME

Change to Attribute: Changed Description

The time when a [PERSON PROPERTY](#) is no longer applicable to the [PATIENT](#). The TIME when a [PERSON PROPERTY](#) is no longer applicable to the [PATIENT](#).

PERSON PROPERTY EFFECTIVE START DATE, renamed from PERSON PROPERTY EFFECTIVE DATE

Change to Attribute: Changed Name, Description

The date when a [PERSON PROPERTY](#) became effective for a [PATIENT](#). The DATE when a [PERSON PROPERTY](#) became effective for a [PATIENT](#).

Examples may be the date when the [PATIENT](#) experienced a symptom or gave up smoking. Examples may be the DATE when the [PATIENT](#) experienced a symptom or gave up smoking.

PERSON PROPERTY EFFECTIVE START DATE, renamed from PERSON PROPERTY EFFECTIVE DATE

Change to Attribute: Changed Name, Description

- Changed Name from Data_Dictionary.Attributes.P.Person.PERSON_PROPERTY_EFFECTIVE_DATE to Data_Dictionary.Attributes.P.Person.PERSON_PROPERTY_EFFECTIVE_START_DATE
 - Changed Description
-

PERSON PROPERTY EFFECTIVE START TIME_ renamed from PERSON PROPERTY EFFECTIVE TIME

Change to Attribute: Changed Name, Description

~~The time when a [PERSON PROPERTY](#) became effective for a [PATIENT](#).~~ The [TIME](#) when a [PERSON PROPERTY](#) became effective for a [PATIENT](#).

PERSON PROPERTY EFFECTIVE START TIME_ renamed from PERSON PROPERTY EFFECTIVE TIME

Change to Attribute: Changed Name, Description

- Changed Name from Data_Dictionary.Attributes.P.Person.PERSON_PROPERTY_EFFECTIVE_TIME to Data_Dictionary.Attributes.P.Person.PERSON_PROPERTY_EFFECTIVE_START_TIME
- Changed Description

PERSON PROPERTY OBSERVED DATE

Change to Attribute: Changed Description

~~The date when the [PERSON PROPERTY](#) was observed by a [PERSON](#).~~ The [DATE](#) when the [PERSON PROPERTY](#) was observed by a [PERSON](#).

PERSON PROPERTY OBSERVED TIME

Change to Attribute: Changed Description

~~The time when the [PERSON PROPERTY](#) was observed by a [PERSON](#).~~ The [TIME](#) when the [PERSON PROPERTY](#) was observed by a [PERSON](#).

PERSON PROPERTY RECORDED DATE

Change to Attribute: Changed Description

~~The date when the [PERSON PROPERTY](#) was recorded by a [PERSON](#).~~ The [DATE](#) when the [PERSON PROPERTY](#) was recorded by a [PERSON](#).

~~For the [National Renal Data Set](#), in a computerised system this data would be derived from the time the information was entered.~~ For the [National Renal Data Set](#), in a computerised system this data would be derived from the [DATE](#) the information was entered.

PERSON PROPERTY RECORDED TIME

Change to Attribute: Changed Description

~~The time when the [PERSON PROPERTY](#) was recorded by a [PERSON](#). In a computerised system this data would be derived from the time the information was entered.~~ The [TIME](#) when the [PERSON PROPERTY](#) was recorded by a [PERSON](#).

In a computerised system this data would be derived from the [TIME](#) the information was entered.

PLANNED ACTIVITY DATE TYPE

Change to Attribute: Changed Description

The type of date that defines the usage with regard to the [PLANNED ACTIVITY](#).

A [PLANNED ACTIVITY](#) may have many dates associated with it but may only have one date of a particular type.

National Codes:

- 01 [Planned Discharge Date \(Hospital Provider Spell\)](#)
- 02 [Estimated Discharge Date \(Hospital Provider Spell\)](#)
- 03 [Intended Smoking Quit Date](#)

Note: This list is not in alphabetical order.

PREGNANCY PREVIOUS CAESAREAN SECTIONS (RETIRED)_ renamed from PREGNANCY PREVIOUS CAESAREAN SECTIONS

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

The number of previous caesarean sections performed. This is part of the data recorded about the fetal outcome of previous pregnancies and forms part of the maternity clinical option. This item has been retired from the NHS Data Model and Dictionary.

The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

PREGNANCY PREVIOUS CAESAREAN SECTIONS (RETIRED), renamed from PREGNANCY PREVIOUS CAESAREAN SECTIONS

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

- Changed Name from Data_Dictionary.Attributes.P.Pow.PREGNANCY_PREVIOUS_CAESAREAN_SECTIONS to Retired.Data_Dictionary.Attributes.P.PREGNANCY_PREVIOUS_CAESAREAN_SECTIONS
- Retired PREGNANCY PREVIOUS CAESAREAN SECTIONS
- Changed Description

PREGNANCY TOTAL LIVE BIRTHS (RETIRED), renamed from PREGNANCY TOTAL LIVE BIRTHS

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

The number of registrable live births by the mother. This is part of the data recorded about the fetal outcome of previous pregnancies and forms part of the maternity clinical option. This item has been retired from the NHS Data Model and Dictionary.

The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

PREGNANCY TOTAL LIVE BIRTHS (RETIRED), renamed from PREGNANCY TOTAL LIVE BIRTHS

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

- Changed Name from Data_Dictionary.Attributes.P.Pow.PREGNANCY_TOTAL_LIVE_BIRTHS to Retired.Data_Dictionary.Attributes.P.PREGNANCY_TOTAL_LIVE_BIRTHS
- Retired PREGNANCY TOTAL LIVE BIRTHS
- Changed Description

PREGNANCY TOTAL PREVIOUS LOSSES LESS THAN 24 WEEKS (RETIRED), renamed from PREGNANCY TOTAL PREVIOUS LOSSES LESS THAN 24 WEEKS

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

The recorded number of terminations and previous losses before 24 weeks of pregnancy (i.e. less than 23 weeks and 6 days) for a woman. This item has been retired from the NHS Data Model and Dictionary.

The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

PREGNANCY TOTAL PREVIOUS LOSSES LESS THAN 24 WEEKS (RETIRED), renamed from PREGNANCY TOTAL PREVIOUS LOSSES LESS THAN 24 WEEKS

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

- Changed Name from Data_Dictionary.Attributes.P.Pow.PREGNANCY_TOTAL_PREVIOUS_LOSSES_LESS_THAN_24_WEEKS to Retired.Data_Dictionary.Attributes.P.PREGNANCY_TOTAL_PREVIOUS_LOSSES_LESS_THAN_24_WEEKS
- Retired PREGNANCY TOTAL PREVIOUS LOSSES LESS THAN 24 WEEKS
- Changed Description

PREGNANCY TOTAL PREVIOUS PREGNANCIES (RETIRED), renamed from PREGNANCY TOTAL PREVIOUS PREGNANCIES

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

The number of previous pregnancies resulting in one or more [REGISTRABLE BIRTHS](#). This item has been retired from the NHS Data Model and Dictionary.

The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

PREGNANCY TOTAL PREVIOUS PREGNANCIES (RETIRED), renamed from PREGNANCY TOTAL PREVIOUS PREGNANCIES

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

- Changed Name from Data_Dictionary.Attributes.P.Pow.PREGNANCY_TOTAL_PREVIOUS_PREGNANCIES to Retired.Data_Dictionary.Attributes.P.PREGNANCY_TOTAL_PREVIOUS_PREGNANCIES
- Retired PREGNANCY TOTAL PREVIOUS PREGNANCIES
- Changed Description

PREGNANCY TOTAL STILL BIRTHS (RETIRED), renamed from PREGNANCY TOTAL STILL BIRTHS

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

~~The number of registrable still births by the mother i.e. a birth after a gestation of 24 weeks (168 days), or more, where a baby shows no identifiable signs of life at delivery. This is part of the data recorded about the fetal outcome of previous pregnancies and forms part of the maternity clinical option.~~ **This item has been retired from the NHS Data Model and Dictionary.**

~~Note: Up to, and including, 30/9/02 the criteria was 28 weeks and not 24 weeks as above.~~ **The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.**

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

PREGNANCY TOTAL STILL BIRTHS (RETIRED), renamed from PREGNANCY TOTAL STILL BIRTHS

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

- Changed Name from Data_Dictionary.Attributes.P.Pow.PREGNANCY_TOTAL_STILL_BIRTHS to Retired.Data_Dictionary.Attributes.P.PREGNANCY_TOTAL_STILL_BIRTHS
- Retired PREGNANCY TOTAL STILL BIRTHS
- Changed Description

SYSTEMIC ANTI-CANCER THERAPY REGIMEN MODIFICATION INDICATOR

Change to Attribute: Changed Description

An indication of whether a [Systemic Anti-Cancer Drug Regimen](#) was modified.

This could be by:

- reducing the administration days below the number planned
- reducing the dose administered or
- ~~extending the time between [Systemic Anti-Cancer Therapy Administration Dates](#).~~
- extending the time between [SYSTEMIC ANTI-CANCER THERAPY ADMINISTRATION DATES](#).

National Codes:

Y	Yes
N	No
Y	Yes - a Systemic Anti-Cancer Drug Regimen was modified
N	No - a Systemic Anti-Cancer Drug Regimen was not modified

TRAUMATIC LESION OF GENITAL TRACT TYPE, renamed from TRAUMATIC LESION OF GENITAL TRACT TYPE CODE

Change to Attribute: Changed Name

- Changed Name from Data_Dictionary.Attributes.T.Tran.TRAUMATIC_LESION_OF_GENITAL_TRACT_TYPE_CODE to Data_Dictionary.Attributes.T.Tran.TRAUMATIC_LESION_OF_GENITAL_TRACT_TYPE

TWO WEEK WAIT CANCER OR SYMPTOMATIC BREAST REFERRAL TYPE

Change to Attribute: Changed Description

The site where cancer is suspected:

- by the [GENERAL MEDICAL PRACTITIONER](#), [GENERAL DENTAL PRACTITIONER](#) or [OPTOMETRIST](#) referring the [PATIENT](#) where the [PRIORITY TYPE](#) is National Code "Two Week Wait".
- which is used to identify [PATIENTS](#) being referred on the basis of exhibited (non-cancer) breast symptoms from any [CARE PROFESSIONAL](#).

National Codes:

01	Suspected breast cancer
02	Suspected children's cancer *

- 03 Suspected lung cancer
- 04 Suspected haematological malignancies excluding acute leukaemia
- 05 Suspected acute leukaemia
- 06 Suspected upper gastrointestinal cancers
- 07 Suspected lower gastrointestinal cancers
- 08 Suspected skin cancers
- 09 Suspected gynaecological cancers
- 10 Suspected brain or central nervous system tumours
- 11 Suspected urological cancers (excluding testicular)
- 12 Suspected testicular cancer
- 13 Suspected head and neck cancers
- 14 Suspected sarcomas
- 15 Other suspected cancer (not listed)
- 16 Exhibited (non-cancer) breast symptoms - cancer not initially suspected **

Notes:

- ~~* For monitoring of the cancer Two Week Wait and 28 Day Faster Diagnosis standards, a child is defined as under the age of 16 years at the [Cancer Referral To Treatment Period Start Date](#)~~
- * For monitoring of the cancer Two Week Wait and 28 Day Faster Diagnosis standards, a child is defined as under the age of 16 years at the [CANCER REFERRAL TO TREATMENT PERIOD START DATE](#)
- ** National Code *Exhibited (non-cancer) breast symptoms - cancer not initially suspected* is only to be used where a [PATIENT](#) has been referred on the basis of exhibited breast symptoms, but those symptoms do not place the [PATIENT](#) within the scope of the referral guidelines that specify that an urgent referral for suspected cancer from a [GENERAL MEDICAL PRACTITIONER](#) or [GENERAL DENTAL PRACTITIONER](#) must be made.

VIABLE TUMOUR INDICATOR

Change to Attribute: Changed Description

An indication of whether there is evidence of a viable [Tumour](#) in the renal sinus.

National Codes:

- Y Yes - there is evidence of a viable [Tumour](#)
- N No - there is no evidence of a viable [Tumour](#)

A AND E DEPARTURE TIME

Change to Data Element: Changed Description

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:

~~[A and E DEPARTURE TIME](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Accident and Emergency Departure Time](#)'.~~ [A and E DEPARTURE TIME](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Accident and Emergency Departure Time](#)'.

A AND E INITIAL ASSESSMENT TIME

Change to Data Element: Changed Description

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:

~~[A and E INITIAL ASSESSMENT TIME](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Accident and Emergency Initial Assessment Time](#)'.~~ [A and E INITIAL ASSESSMENT TIME](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Accident and Emergency Initial Assessment Time](#)'.

A AND E TIME SEEN FOR TREATMENT

Change to Data Element: Changed Description

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:

A and E TIME SEEN FOR TREATMENT is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code 'Accident and Emergency Time Seen For Treatment'. A and E TIME SEEN FOR TREATMENT is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code 'Accident and Emergency Time Seen For Treatment'.

ACTIVITY DATE (ANTENATAL APPOINTMENT)

Change to Data Element: Changed Description

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

ACTIVITY DATE (ANTENATAL APPOINTMENT) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Antenatal Appointment Date'. ACTIVITY DATE (ANTENATAL APPOINTMENT) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Antenatal Appointment Date'.

For the Maternity Services Data Set ACTIVITY DATE (ANTENATAL APPOINTMENT) does not include the ACTIVITY DATE for a 'Pregnancy First Contact Date' or 'Antenatal Booking Appointment Date'. For the Maternity Services Data Set ACTIVITY DATE (ANTENATAL APPOINTMENT) does not include the ACTIVITY DATE for a 'Pregnancy First Contact Date' or APPOINTMENT DATE (FORMAL ANTENATAL BOOKING).

AMERICAN JOINT COMMITTEE ON CANCER STAGE DATE

Change to Data Element: Changed linked Attribute, Description

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

AMERICAN JOINT COMMITTEE ON CANCER STAGE DATE is the same as attribute ACTIVITY DATE, where the ACTIVITY DATE TYPE is National Code 'American Joint Committee on Cancer Stage Date'. AMERICAN JOINT COMMITTEE ON CANCER STAGE DATE is the same as attribute PERSON PROPERTY RECORDED DATE. AMERICAN JOINT COMMITTEE ON CANCER STAGE DATE is the DATE on which AMERICAN JOINT COMMITTEE ON CANCER STAGE was recorded during a Skin Cancer Care Spell.

AMERICAN JOINT COMMITTEE ON CANCER STAGE DATE

Change to Data Element: Changed linked Attribute, Description

AMERICAN JOINT COMMITTEE ON CANCER STAGE DATE

Attribute:

[ACTIVITY DATE](#)
[PERSON PROPERTY RECORDED DATE](#)

ANN ARBOR STAGE DATE

Change to Data Element: Changed linked Attribute, Description

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

ANN ARBOR STAGE DATE is the same as attribute ACTIVITY DATE, where the ACTIVITY DATE TYPE is National Code 'Ann Arbor Stage Date'. ANN ARBOR STAGE DATE is the same as attribute PERSON PROPERTY RECORDED DATE.

ANN ARBOR STAGE DATE is the DATE on which ANN ARBOR STAGE was recorded during a Haematological Cancer Care Spell.

ANN ARBOR STAGE DATE

Change to Data Element: Changed linked Attribute, Description

ANN ARBOR STAGE DATE

Attribute:

[ACTIVITY DATE](#)

[PERSON PROPERTY RECORDED DATE](#)

APPOINTMENT DATE (FORMAL ANTENATAL BOOKING)

Change to Data Element: Changed Description

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[APPOINTMENT DATE \(FORMAL ANTENATAL BOOKING\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Antenatal Booking Appointment Date](#)'. [APPOINTMENT DATE \(FORMAL ANTENATAL BOOKING\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) National Code '[Care Contact Date](#)'. [APPOINTMENT DATE \(FORMAL ANTENATAL BOOKING\)](#) is the [DATE](#) of the Formal [Antenatal Booking Appointment](#), i.e. the [DATE](#) of the first official [Antenatal Booking Appointment](#) at which the assessment for health and social care needs is carried out and [Antenatal](#) care arrangements for the [Pregnancy Episode](#) are made.

ARRIVAL DATE AND TIME AT ACCIDENT AND EMERGENCY DEPARTMENT

Change to Data Element: Changed Description

Format/Length: See [DATE AND TIME](#)
National Codes:
Default Codes:

Notes:

[ARRIVAL DATE AND TIME AT ACCIDENT AND EMERGENCY DEPARTMENT](#) is the same as attribute [ACTIVITY DATE](#) and [ACTIVITY TIME](#) where the [ACTIVITY DATE AND TIME TYPE](#) is National Code '[Arrival Date and Time at Accident and Emergency Department](#)'. [ARRIVAL DATE AND TIME AT ACCIDENT AND EMERGENCY DEPARTMENT](#) is the same as attribute [ACTIVITY DATE](#) and [ACTIVITY TIME](#) where the [ACTIVITY DATE TYPE](#) and [ACTIVITY TIME TYPE](#) is National Code '[Arrival Date At Accident and Emergency Department](#)' and '[Arrival Time At Accident and Emergency Department](#)'.

ARRIVAL TIME AT ACCIDENT AND EMERGENCY DEPARTMENT

Change to Data Element: Changed Description

Format/Length: See [TIME](#)
National Codes:
Default Codes:

Notes:

[ARRIVAL TIME AT ACCIDENT AND EMERGENCY DEPARTMENT](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Arrival Time At Accident and Emergency Department](#)'. [ARRIVAL TIME AT ACCIDENT AND EMERGENCY DEPARTMENT](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Arrival Time At Accident and Emergency Department](#)'.

ASSAULT DATE AND TIME

Change to Data Element: Changed linked Attribute, Description

Format/Length: See [DATE AND TIME](#)
National Codes:
Default Codes:

Notes:

[ASSAULT DATE AND TIME](#) is the same as attribute [ACTIVITY DATE](#) and [ACTIVITY TIME](#) where the [ACTIVITY DATE AND TIME TYPE](#) is National Code '[Assault Date and Time](#)'. [ASSAULT DATE AND TIME](#) is the same as attribute [PERSON PROPERTY EFFECTIVE START DATE](#) and [PERSON PROPERTY EFFECTIVE START TIME](#). [ASSAULT DATE AND TIME](#) is the [DATE AND TIME](#) the [PATIENT](#) was assaulted.

ASSAULT DATE AND TIME

Change to Data Element: Changed linked Attribute, Description

ASSAULT DATE AND TIME

Attribute:

[ACTIVITY DATE](#)
[ACTIVITY TIME](#)

PERSON PROPERTY EFFECTIVE START DATE

PERSON PROPERTY EFFECTIVE START TIME

ATTENDANCE DATE

Change to Data Element: Changed Description

Format/Length: See [DATE](#)

National Codes:

Default Codes:

Notes:

[ATTENDANCE DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Attendance Date](#)'. [ATTENDANCE DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Care Contact Date](#)'. [ATTENDANCE DATE](#) is the [DATE](#) of an attendance or contact, for example at a [Consultant Clinic](#), [Nurse Clinic](#), [Accident and Emergency Department](#) or by a [Ward Attender](#).

BABY FIRST FEED DATE TIME

Change to Data Element: Changed Description

Format/Length: See [DATE AND TIME](#)

National Codes:

Default Codes:

Notes:

[BABY FIRST FEED DATE TIME](#) is the same as attribute [ACTIVITY DATE](#) and [ACTIVITY TIME](#) where the [ACTIVITY DATE AND TIME TYPE](#) is National Code '[Baby First Feed Date and Time](#)'. [BABY FIRST FEED DATE TIME](#) is the same as attribute [ACTIVITY DATE](#) and [ACTIVITY TIME](#) where the [ACTIVITY DATE AND TIME TYPE](#) is National Code '[Baby First Feed Date and Time](#)'.

BARCELONA CLINIC LIVER CANCER STAGE DATE

Change to Data Element: Changed linked Attribute, Description

Format/Length: See [DATE](#)

National Codes:

Default Codes:

Notes:

[BARCELONA CLINIC LIVER CANCER STAGE DATE](#) is the same as attribute [ACTIVITY DATE](#), where the [ACTIVITY DATE TYPE](#) is National Code '[Barcelona Clinic Liver Cancer Stage Date](#)'. [BARCELONA CLINIC LIVER CANCER STAGE DATE](#) is the same as attribute [PERSON PROPERTY RECORDED DATE](#).

[BARCELONA CLINIC LIVER CANCER STAGE DATE](#) is the [DATE](#) on which [BARCELONA CLINIC LIVER CANCER STAGE](#) was recorded during a [Liver Cancer Care Spell](#).

BARCELONA CLINIC LIVER CANCER STAGE DATE

Change to Data Element: Changed linked Attribute, Description

BARCELONA CLINIC LIVER CANCER STAGE DATE

Attribute:

[ACTIVITY DATE](#)

[PERSON PROPERTY RECORDED DATE](#)

BINET STAGE DATE

Change to Data Element: Changed linked Attribute, Description

Format/Length: See [DATE](#)

National Codes:

Default Codes:

Notes:

[BINET STAGE DATE](#) is the same as attribute [ACTIVITY DATE](#), where the [ACTIVITY DATE TYPE](#) is National Code '[Binet Stage Date](#)'. [BINET STAGE DATE](#) is the same as attribute [PERSON PROPERTY RECORDED DATE](#).

[BINET STAGE DATE](#) is the [DATE](#) on which [BINET STAGE](#) was recorded during a [Haematological Cancer Care Spell](#).

BINET STAGE DATE

Change to Data Element: Changed linked Attribute, Description

BINET STAGE DATE

Attribute:

[ACTIVITY DATE](#)

[PERSON PROPERTY RECORDED DATE](#)

CANCER CARE SPELL DELAY REASON (DECISION TO TREATMENT)

Change to Data Element: Changed Description

Format/Length:	an2
National Codes:	See CANCER CARE SPELL DELAY REASON
Default Codes:	

Notes:

[CANCER CARE SPELL DELAY REASON \(DECISION TO TREATMENT\)](#) is the same as attribute [CANCER CARE SPELL DELAY REASON](#).

~~[CANCER CARE SPELL DELAY REASON \(DECISION TO TREATMENT\)](#) is the reason why a [Cancer Care Spell Delay](#) occurred between the [DECISION TO TREAT DATE](#) and [Treatment Start Date \(Cancer\)](#).~~ [CANCER CARE SPELL DELAY REASON \(DECISION TO TREATMENT\)](#) is the reason why a [Cancer Care Spell Delay](#) occurred between the [DECISION TO TREAT DATE](#) and [TREATMENT START DATE \(CANCER\)](#).

CANCER CARE SPELL DELAY REASON (FIRST SEEN)

Change to Data Element: Changed Description

Format/Length:	an2
National Codes:	
Default Codes:	

Notes:

[CANCER CARE SPELL DELAY REASON \(FIRST SEEN\)](#) is the same as attribute [CANCER CARE SPELL DELAY REASON](#).

~~[CANCER CARE SPELL DELAY REASON](#) is the reason why a [Cancer Care Spell Delay](#) occurred between the [Cancer Referral To Treatment Period Start Date](#) and the [Date First Seen](#), when the [PRIORITY TYPE](#) is National Code 'Two Week Wait'.~~ [CANCER CARE SPELL DELAY REASON](#) is the reason why a [Cancer Care Spell Delay](#) occurred between the [CANCER REFERRAL TO TREATMENT PERIOD START DATE](#) and the [DATE FIRST SEEN](#), when the [PRIORITY TYPE](#) is National Code 'Two Week Wait'.

Permitted National Codes:

- 01 Clinic cancellation
- 02 Out-patient capacity inadequate (i.e. no cancelled clinic, but not enough slots for this [PATIENT](#))
- 03 Administrative delay
- 17 [PATIENT](#) choice delay relating to first [Out-Patient Appointment](#)
- 22 [PATIENT](#) care not commissioned by the NHS in England (waiting time standard does not apply) for treatment in an admitted care setting
- 97 Other reason (not listed)

CANCER CARE SPELL DELAY REASON (OUTCOME COMMUNICATION CANCER FASTER DIAGNOSIS PATHWAY)

Change to Data Element: Changed Description

Format/Length:	an2
National Codes:	
Default Codes:	

Notes:

[CANCER CARE SPELL DELAY REASON \(OUTCOME COMMUNICATION CANCER FASTER DIAGNOSIS PATHWAY\)](#) is the same as attribute [CANCER CARE SPELL DELAY REASON](#).

[CANCER CARE SPELL DELAY REASON \(OUTCOME COMMUNICATION CANCER FASTER DIAGNOSIS PATHWAY\)](#) is the reason why a [Cancer Care Spell Delay](#) occurred, where the [Health Care Provider](#) was unable to communicate the outcome of the [Cancer Faster Diagnosis Pathway](#) to the [PATIENT](#) within the service standard of 28 days.

Permitted National Codes:

- 01 Clinic cancellation
- 02 Out-patient capacity inadequate (i.e. no cancelled clinic, but not enough slots for this [PATIENT](#))
- 03 Administrative delay
- 04 Elective cancellation (for non-medical reason) for treatment in an admitted care setting
- 05 Elective capacity inadequate ([PATIENT](#) unable to be scheduled for treatment within standard time) for treatment in an admitted care setting
- 07 Complex diagnostic pathway (many, or complex, diagnostic tests required)
- 11 Diagnosis delayed for medical reasons ([PATIENT](#) unfit for diagnostic episode, excluding planned recovery period following diagnostic test)
- 13 Delay due to recovery after an invasive test ([PATIENT DIAGNOSIS](#) or treatment delayed due to planned recovery period following an invasive diagnostic test)
- 14 [PATIENT](#) Did Not Attend treatment [APPOINTMENT](#)
- 17 [PATIENT](#) choice delay relating to first [Out-Patient Appointment](#)
- 18 [Health Care Provider](#) initiated delay to diagnostic test or treatment planning
- 19 [PATIENT](#) initiated (choice) delay to diagnostic test or treatment planning, advance notice given
- 20 [PATIENT](#) Did Not Attend an [APPOINTMENT](#) for a diagnostic test or treatment planning event (no advance notice)
- 22 [PATIENT](#) care not commissioned by the NHS in England (waiting time standard does not apply) for treatment in an admitted care setting
- 23 Equipment breakdown
- 24 Inconclusive diagnostic result
- 25 [Health Care Provider](#) unable to make contact with [PATIENT](#) by telephone
- 26 [PATIENT](#) choice ([PATIENT](#) declined or cancelled an offered [Appointment Date](#) for follow up [APPOINTMENT](#))
- 26 [PATIENT](#) choice ([PATIENT](#) declined or cancelled an offered [APPOINTMENT DATE](#) for follow up [APPOINTMENT](#))
- 97 Other reason (not listed)

CANCER CARE SPELL DELAY REASON (REFERRAL TO TREATMENT)

Change to Data Element: Changed Description

Format/Length:	an2
National Codes:	See CANCER CARE SPELL DELAY REASON
Default Codes:	

Notes:

[CANCER CARE SPELL DELAY REASON \(REFERRAL TO TREATMENT\)](#) is the same as attribute [CANCER CARE SPELL DELAY REASON](#).

~~[CANCER CARE SPELL DELAY REASON \(REFERRAL TO TREATMENT\)](#) is the reason why a [Cancer Care Spell Delay](#) occurred between the [Cancer Referral To Treatment Period Start Date](#) and [Treatment Start Date \(Cancer\)](#), less any adjustments recorded by [WAITING TIME ADJUSTMENT \(FIRST SEEN\)](#) and [WAITING TIME ADJUSTMENT \(TREATMENT\)](#).~~ [CANCER CARE SPELL DELAY REASON \(REFERRAL TO TREATMENT\)](#) is the reason why a Cancer Care Spell Delay occurred between the [CANCER REFERRAL TO TREATMENT PERIOD START DATE](#) and [TREATMENT START DATE \(CANCER\)](#), less any adjustments recorded by [WAITING TIME ADJUSTMENT \(FIRST SEEN\)](#) and [WAITING TIME ADJUSTMENT \(TREATMENT\)](#).

CANCER CARE SPELL DELAY REASON COMMENT (DECISION TO TREATMENT)

Change to Data Element: Changed Description

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

Notes:

[CANCER CARE SPELL DELAY REASON COMMENT \(DECISION TO TREATMENT\)](#) is the same as attribute [CANCER CARE SPELL DELAY REASON COMMENT](#).

[CANCER CARE SPELL DELAY REASON COMMENT \(DECISION TO TREATMENT\)](#) is the free text comment that describes why a [Cancer Care Spell Delay](#) occurred:

- between the [DECISION TO TREAT DATE](#) and [Treatment Start Date \(Cancer\)](#) and
- between the [DECISION TO TREAT DATE](#) and [TREATMENT START DATE \(CANCER\)](#) and
- where the [CANCER CARE SPELL DELAY REASON](#) is National Code 'Other reason (not listed)' or any additional supporting information is required.

CANCER CARE SPELL DELAY REASON COMMENT (FIRST SEEN)

Change to Data Element: Changed Description

Format/Length:	max an255
----------------	-----------

National Codes:
Default Codes:

Notes:

CANCER CARE SPELL DELAY REASON COMMENT (FIRST SEEN) is the same as attribute CANCER CARE SPELL DELAY REASON COMMENT.

CANCER CARE SPELL DELAY REASON COMMENT (FIRST SEEN) is the free text comment field to describe why a Cancer Care Spell Delay occurred:

- between the Cancer Referral To Treatment Period Start Date and the Date First Seen and
- between the CANCER REFERRAL TO TREATMENT PERIOD START DATE and the DATE FIRST SEEN and
- where the:
 - PRIORITY TYPE is National Code 'Two Week Wait' and
 - CANCER CARE SPELL DELAY REASON is National Code 'Other reason (not listed)' or any additional supporting information is required .

CANCER CARE SPELL DELAY REASON COMMENT (REFERRAL TO TREATMENT)

Change to Data Element: Changed Description

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

Notes:

CANCER CARE SPELL DELAY REASON COMMENT (REFERRAL TO TREATMENT) is the same as attribute CANCER CARE SPELL DELAY REASON COMMENT.

CANCER CARE SPELL DELAY REASON COMMENT (REFERRAL TO TREATMENT) is the free text comment field to describe why a Cancer Care Spell Delay occurred:

- between the Cancer Referral To Treatment Period Start Date and Treatment Start Date (Cancer) and
- between the CANCER REFERRAL TO TREATMENT PERIOD START DATE and TREATMENT START DATE (CANCER) and
- less any adjustments recorded by WAITING TIME ADJUSTMENT (FIRST SEEN) and WAITING TIME ADJUSTMENT (TREATMENT) and
- where the CANCER CARE SPELL DELAY REASON is National Code 'Other reason (not listed)' or any additional supporting information is required.

CANCER DENTAL ASSESSMENT DATE

Change to Data Element: Changed Description

Format/Length: See DATE
National Codes:
Default Codes:

Notes:

CANCER DENTAL ASSESSMENT DATE is the same as attribute ACTIVITY DATE, where the ACTIVITY DATE TYPE is National Code 'Cancer Dental Assessment Date'. CANCER DENTAL ASSESSMENT DATE is the same as attribute ACTIVITY DATE, where the ACTIVITY DATE TYPE is National Code 'Clinical Intervention Date'.

CANCER DENTAL ASSESSMENT DATE is the DATE of the first dental assessment by a GENERAL DENTAL PRACTITIONER, which contributes to preparation for treatment, during a Head and Neck Cancer Care Spell.

CANCER FASTER DIAGNOSIS PATHWAY END DATE

Change to Data Element: Changed Description

Format/Length: See DATE
National Codes:
Default Codes:

Notes:

CANCER FASTER DIAGNOSIS PATHWAY END DATE is the same as ACTIVITY DATE, where the ACTIVITY DATE TYPE is National Code 'Cancer Faster Diagnosis Pathway End Date'. CANCER FASTER DIAGNOSIS PATHWAY END DATE is the same as ACTIVITY DATE, where the ACTIVITY DATE TYPE is National Code 'End Date'.

CANCER FASTER DIAGNOSIS PATHWAY END DATE is either the DATE when the PATIENT:

- is informed of the CANCER FASTER DIAGNOSIS PATHWAY END REASON, where the National Code is either 'Diagnosis of cancer' or 'Ruling out of cancer'

- is excluded from the [Cancer Faster Diagnosis Pathway](#), where the [CANCER FASTER DIAGNOSIS PATHWAY END REASON](#) is National Code is 'Excluded from the [Cancer Faster Diagnosis Pathway](#)'.

Note: where a [Decision To Treat](#) is made before the [CANCER FASTER DIAGNOSIS PATHWAY END REASON](#) is recorded, then the end of the [Cancer Faster Diagnosis Pathway](#) is the [DECISION TO TREAT DATE](#).

CANCER PROGRESSION AGREED DATE (PRIMARY CANCER PATHWAY)

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

[CANCER PROGRESSION AGREED DATE \(PRIMARY CANCER PATHWAY\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Cancer Progression Agreed Date \(Primary Cancer Pathway\)](#)'. [CANCER PROGRESSION AGREED DATE \(PRIMARY CANCER PATHWAY\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Cancer Progression Agreed Date \(Primary Cancer Pathway\)](#)'.

CANCER REFERRAL TO TREATMENT PERIOD START DATE

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

[CANCER REFERRAL TO TREATMENT PERIOD START DATE](#) is the same as attribute [ACTIVITY DATE](#), where the [ACTIVITY DATE TYPE](#) is National Code '[Cancer Referral To Treatment Period Start Date](#)'. [CANCER REFERRAL TO TREATMENT PERIOD START DATE](#) is the same as attribute [ACTIVITY DATE](#), where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Cancer Referral To Treatment Period](#). A [CANCER REFERRAL TO TREATMENT PERIOD START DATE](#) will be one of the following:

- The [REFERRAL REQUEST RECEIVED DATE](#) of the [SERVICE REQUEST](#):
 - to secondary care by a [GENERAL MEDICAL PRACTITIONER](#) or [GENERAL DENTAL PRACTITIONER](#) where the [PRIORITY TYPE](#) is National Code '[Two Week Wait](#)' *
 - to secondary care where the [PATIENT](#) was subsequently upgraded onto a [Cancer Pathway](#). The [CONSULTANT UPGRADE DATE](#) will also be recorded, as this is the [DATE](#) used to calculate the start of the two month (62 day) waiting time target for [PATIENTS](#) who have been upgraded to a [Cancer Pathway](#)
 - into secondary care when the [PATIENT](#) was referred urgently for 'breast symptoms', where the [PRIORITY TYPE](#) is National Code '[Two Week Wait](#)' *
 - to an Assessment Clinic following the identification of an abnormality by an NHS Cancer [Screening Service](#), where the [PRIORITY TYPE](#) is National Code '[Urgent](#)' *
- The [ORIGINAL REFERRAL REQUEST RECEIVED DATE](#) for the initial [SERVICE REQUEST](#) to secondary care by an NHS Cancer [Screening Service](#), where the [PRIORITY TYPE](#) is National Code '[Routine](#)', and where the [PATIENT](#) was subsequently upgraded onto a [Cancer Pathway](#). The [CONSULTANT UPGRADE DATE](#) will also be recorded.

Notes:

- * The start of the [Cancer Faster Diagnosis Pathway](#) will be the [CANCER REFERRAL TO TREATMENT PERIOD START DATE](#) for the items annotated.
- For a [SERVICE REQUEST](#) received from the [Choose and Book](#) system, the referral is received when the [PATIENT](#)'s Unique Booking Reference Number (UBRN) is used to book the first [Out-Patient Appointment](#) slot (i.e. converted). See [REFERRAL REQUEST RECEIVED DATE](#).

CANCER SYMPTOMS FIRST NOTED DATE

Change to Data Element: Changed linked Attribute, Description

Format/Length:	max an10
National Codes:	
Default Codes:	

Notes:

[CANCER SYMPTOMS FIRST NOTED DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Cancer Symptoms First Noted Date](#)'. [CANCER SYMPTOMS FIRST NOTED DATE](#) is the same as attribute [PERSON PROPERTY EFFECTIVE START DATE](#).

[CANCER SYMPTOMS FIRST NOTED DATE](#) is the [DATE](#) when the symptoms were first noted related to the cancer diagnosis as agreed between the [CONSULTANT](#) and the [PATIENT](#) during a [Cancer Care Spell](#).

Note:

- Depending on the length of time this should normally include at least the month and year. The day should also be included if known. If the symptoms have been present for a long time then it may only be possible to record the year.
- In these circumstances the Format/Length will be:
 - [DATE](#) (including year, month and day): CCYY-MM-DD
 - [YEAR AND MONTH](#): YYYY-MM
 - Year only: YYYY.

CANCER SYMPTOMS FIRST NOTED DATE

Change to Data Element: Changed linked Attribute, Description

CANCER SYMPTOMS FIRST NOTED DATE

Attribute:

ACTIVITY DATE
PERSON PROPERTY EFFECTIVE START DATE

CANCER TRANSFORMATION AGREED DATE (PRIMARY CANCER PATHWAY)

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

[CANCER TRANSFORMATION AGREED DATE \(PRIMARY CANCER PATHWAY\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Cancer Transformation Agreed Date \(Primary Cancer Pathway\)](#)'. [CANCER TRANSFORMATION AGREED DATE \(PRIMARY CANCER PATHWAY\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) '[Cancer Transformation Agreed Date \(Primary Cancer Pathway\)](#)'.

CANCER TREATMENT PERIOD START DATE

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

[CANCER TREATMENT PERIOD START DATE](#) is the same as attribute [ACTIVITY DATE](#), where the [ACTIVITY DATE TYPE](#) is National Code '[Cancer Treatment Period Start Date](#)'. [CANCER TREATMENT PERIOD START DATE](#) is the same as attribute [ACTIVITY DATE](#), where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the Cancer Treatment Period. A [CANCER TREATMENT PERIOD START DATE](#) will be either:

- the [DECISION TO TREAT DATE](#)
 - the [DATE](#) that a [PATIENT](#) agrees a treatment plan for either first or subsequent treatments within a [Cancer Care Plan](#). An individual [PATIENT](#) may have multiple [DECISION TO TREAT DATES](#) or
- the [EARLIEST CLINICALLY APPROPRIATE DATE](#)
 - where there is no new [DECISION TO TREAT DATE](#), but there has been a previously agreed and clinically appropriate period of delay. In this case the subsequent [ACTIVITY](#) may not be the final treatment, but could be the next [APPOINTMENT](#) which deals with the planning of subsequent treatments.

CARE CONTACT DATE (DIETITIAN INITIAL)

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

[CARE CONTACT DATE \(DIETITIAN INITIAL\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Care Contact Date](#)'. [CARE CONTACT DATE \(DIETITIAN INITIAL\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Care Contact Date](#)'.

[CARE CONTACT DATE \(DIETITIAN INITIAL\)](#) is the [Contact Date](#) of the [Initial Contact](#) with a [Dietitian](#). [CARE CONTACT DATE \(DIETITIAN INITIAL\)](#) is the [DATE](#) of the [Initial Contact](#) with a [Dietitian](#).

CARE CONTACT DATE (SPEECH AND LANGUAGE THERAPIST INITIAL)

Change to Data Element: Changed Description

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[CARE CONTACT DATE \(SPEECH AND LANGUAGE THERAPIST INITIAL\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Care Contact Date](#)'. -

[CARE CONTACT DATE \(SPEECH AND LANGUAGE THERAPIST INITIAL\)](#) is the [Contact Date](#) of the [Initial Contact](#) with a [Speech and Language Therapist](#). [CARE CONTACT DATE \(SPEECH AND LANGUAGE THERAPIST INITIAL\)](#) is the [DATE](#) of the [Initial Contact](#) with a [Speech and Language Therapist](#).

CARE CONTACT TIME

Change to Data Element: Changed Description

Format/Length: See [TIME](#)
National Codes:
Default Codes:

Notes:

[CARE CONTACT TIME](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Care Contact Time](#)'. [CARE CONTACT TIME](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Care Contact Time](#)'.

CARE PROGRAMME APPROACH REVIEW DATE

Change to Data Element: Changed Description

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[CARE PROGRAMME APPROACH REVIEW DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Care Programme Approach Review Date](#)'. [CARE PROGRAMME APPROACH REVIEW DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Care Contact Date](#)'. [CARE PROGRAMME APPROACH REVIEW DATE](#) is the [DATE](#) of the [Care Programme Approach Review](#).

CHANG STAGING SYSTEM STAGE DATE

Change to Data Element: Changed linked Attribute, Description

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[CHANG STAGING SYSTEM STAGE DATE](#) is the same as attribute [ACTIVITY DATE](#), where the [ACTIVITY DATE TYPE](#) is National Code '[Chang Staging System Stage Date](#)'. [CHANG STAGING SYSTEM STAGE DATE](#) is the same as attribute [PERSON PROPERTY RECORDED DATE](#).

[CHANG STAGING SYSTEM STAGE DATE](#) is the [DATE](#) on which [CHANG STAGING SYSTEM STAGE](#) was recorded during a [Central Nervous System Cancer Care Spell](#).

CHANG STAGING SYSTEM STAGE DATE

Change to Data Element: Changed linked Attribute, Description

CHANG STAGING SYSTEM STAGE DATE

Attribute:

[ACTIVITY DATE](#)

[PERSON PROPERTY RECORDED DATE](#)

CHILD PROTECTION PLAN END DATE

Change to Data Element: Changed Description

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

~~CHILD PROTECTION PLAN END DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Child Protection Plan End Date'.~~ CHILD PROTECTION PLAN END DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'End Date'.

CHILD PROTECTION PLAN END DATE is the DATE on which a Child or Young Person is removed from a Child Protection Plan.

CHILD PROTECTION PLAN START DATE

Change to Data Element: Changed Description

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

~~CHILD PROTECTION PLAN START DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Child Protection Plan Start Date'.~~ CHILD PROTECTION PLAN START DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Start Date'. CHILD PROTECTION PLAN START DATE is the DATE on which a Child or Young Person is placed on a Child Protection Plan.

CLINICAL STAGE DATE (PANCREATIC CANCER)

Change to Data Element: Changed linked Attribute, Description

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

~~CLINICAL STAGE DATE (PANCREATIC CANCER) is the same as attribute ACTIVITY DATE, where the ACTIVITY DATE TYPE is National Code 'Clinical Stage Date (Pancreatic Cancer)'.~~ CLINICAL STAGE DATE (PANCREATIC CANCER) is the same as attribute PERSON PROPERTY RECORDED DATE.

CLINICAL STAGE DATE (PANCREATIC CANCER) is the DATE on which CLINICAL STAGE (PANCREATIC CANCER) was recorded during a Upper Gastrointestinal Cancer Care Spell.

CLINICAL STAGE DATE (PANCREATIC CANCER)

Change to Data Element: Changed linked Attribute, Description

CLINICAL STAGE DATE (PANCREATIC CANCER)

Attribute:

[ACTIVITY DATE](#)

[PERSON PROPERTY RECORDED DATE](#)

CLINICAL STATUS ASSESSMENT DATE (CANCER)

Change to Data Element: Changed Description

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

~~CLINICAL STATUS ASSESSMENT DATE (CANCER) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Clinical Status Assessment Date'.~~ CLINICAL STATUS ASSESSMENT DATE (CANCER) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Clinical Intervention Date'. CLINICAL STATUS ASSESSMENT DATE (CANCER) is the DATE on which a clinical status assessment was performed during a Head and Neck Cancer Care Spell.

CRITICAL CARE DISCHARGE DATE AND TIME

Change to Data Element: Changed Description

Format/Length:	See DATE AND TIME
National Codes:	
Default Codes:	

Notes:

[CRITICAL CARE DISCHARGE DATE AND TIME](#) is the same as attribute [ACTIVITY DATE](#) and [ACTIVITY TIME](#) where the [ACTIVITY DATE AND TIME TYPE](#) is National Code '[Critical Care Period Discharge Date and Time](#)' of the [CRITICAL CARE PERIOD](#). CRITICAL CARE DISCHARGE DATE AND TIME is the same as attribute [ACTIVITY DATE](#) and [ACTIVITY TIME](#) where the [ACTIVITY DATE AND TIME TYPE](#) is National Code '[End Date](#)' and '[End Time](#)' of a [CRITICAL CARE PERIOD](#).

CRITICAL CARE START DATE AND TIME

Change to Data Element: Changed Description

Format/Length:	See DATE AND TIME
National Codes:	
Default Codes:	

Notes:

[CRITICAL CARE START DATE AND TIME](#) is the same as attribute [ACTIVITY DATE](#) and [ACTIVITY TIME](#) where the [ACTIVITY DATE AND TIME TYPE](#) is National Code '[Critical Care Period Start Date and Time](#)' of the [CRITICAL CARE PERIOD](#). CRITICAL CARE START DATE AND TIME is the same as attribute [ACTIVITY DATE](#) and [ACTIVITY TIME](#) where the [ACTIVITY DATE AND TIME TYPE](#) is National Code '[Start Date](#)' and '[Start Time](#)' of the [CRITICAL CARE PERIOD](#).

DATE FIRST SEEN

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

[DATE FIRST SEEN](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Date First Seen](#)'. [DATE FIRST SEEN](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Care Contact Date](#)'.

[DATE FIRST SEEN](#) is the [DATE](#) that the [PATIENT](#) is first seen in the Trust that receives the first referral.

[DATE FIRST SEEN](#) will be one of the following, whichever is the earliest [SERVICE](#) relating to the [REFERRAL REQUEST](#):

- first Out-Patient Appointment; this is the [ATTENDANCE DATE](#) of the first Out-Patient Attendance Consultant
- first diagnostic procedure if this precedes the first Out-Patient Appointment; this is the first [Clinical Intervention Date](#) of the [Imaging or Radiodiagnostic Event](#) or [CLINICAL INTERVENTION](#)
- first seen as an emergency; this is the [Start Date](#) of the [Hospital Provider Spell](#) or the [Arrival Date At Accident and Emergency Department](#) of the Accident and Emergency Attendance
- the date the [PATIENT](#) was first seen following referral (or recall) from (or by) a Screening Unit.

[DATE FIRST SEEN](#) for the:

- [National Cancer Waiting Times Monitoring Data Set](#) is:
 - the [DATE](#) when the [PATIENT](#) is seen for the first time by a [CONSULTANT](#) (or member of their team) or in a clinic following receipt of the [REFERRAL REQUEST](#).
- [HIV and AIDS Reporting Data Set](#) is:
 - the [DATE](#) the [PATIENT](#) was first seen for Human Immunodeficiency Virus (HIV) care at a [HIV Clinic Attendance](#) at the current [Health Care Provider](#).

DATE FIRST SEEN (CANCER SPECIALIST)

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

DATE FIRST SEEN (CANCER SPECIALIST) is the DATE that the PATIENT is first seen by the appropriate specialist for cancer care within a Cancer Care Spell. This is the PERSON or PERSONS who are most able to progress the diagnosis of the primary Tumour.

This is the PERSON or PERSONS who are most able to progress the diagnosis of the primary Tumour.

DATE FIRST SEEN (CANCER SPECIALIST) will be one of the following, whichever is the earlier ACTIVITY related to the Cancer Care Spell where the PATIENT saw an appropriate specialist for cancer care:

- first Out-Patient Appointment with an appropriate cancer specialist; this is the first attendance of the Out-Patient Attendance Consultant
- first diagnostic procedure if this precedes the first Out-Patient Appointment; this is the first Imaging or Radiodiagnostic Event Date or Clinical Intervention Date
- first diagnostic procedure if this precedes the first Out-Patient Appointment; this is the first Clinical Intervention Date (i.e. DATE of the Imaging or Radiodiagnostic Event)
- first seen as an emergency; this is the START DATE (HOSPITAL PROVIDER SPELL) or EMERGENCY CARE ARRIVAL DATE
- first seen following recall by screening unit; this is the Screening Test Date.
- first seen following recall by screening unit; this is the SCREENING TEST DATE.

DATE FIRST SEEN (CANCER SPECIALIST) may be the same as DATE FIRST SEEN if the initial consultation was with an appropriate cancer specialist in the Trust that receives the first referral.

DATE OF CLINICAL ASSESSMENT

Change to Data Element: Changed Description

Format/Length:	See <u>DATE</u>
National Codes:	
Default Codes:	

Notes:

DATE OF CLINICAL ASSESSMENT is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Clinical Assessment Date'. DATE OF CLINICAL ASSESSMENT is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Clinical Intervention Date'.

DATE OF CLINICAL ASSESSMENT is the date a CARE PROFESSIONAL undertakes a physical examination and clinical history of the PATIENT during a Breast Cancer Care Spell.

For the Cancer Outcomes and Services Data Set:

- DATE OF CLINICAL ASSESSMENT is based on clinical history and physical examination and will normally be the DATE of the first Out-Patient Appointment at the breast clinic.
- If the PATIENT attends more than one breast clinic, the DATE of each clinical assessment undertaken should be recorded.

DATE OF PREGNANCY OUTCOME (CURRENT FETUS)

Change to Data Element: Changed Description

Format/Length:	See <u>DATE</u>
National Codes:	
Default Codes:	

Notes:

DATE OF PREGNANCY OUTCOME (CURRENT FETUS) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Date of Pregnancy Outcome (Current Fetus)'. DATE OF PREGNANCY OUTCOME (CURRENT FETUS) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Date of Pregnancy Outcome (Current Fetus)'.

DATE OF RESTRICTIVE INTERVENTION

Change to Data Element: Changed Description

Format/Length:	See <u>DATE</u>
National Codes:	
Default Codes:	

Notes:

DATE OF RESTRICTIVE INTERVENTION is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Date of Restrictive Intervention'. DATE OF RESTRICTIVE INTERVENTION is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Date of Restrictive Intervention'.

DATE TIME OF DECISION TO DELIVER

Change to Data Element: Changed Description

Format/Length:	See DATE AND TIME
National Codes:	
Default Codes:	

Notes:

~~DATE TIME OF DECISION TO DELIVER is the same as attribute [ACTIVITY DATE](#) and [ACTIVITY TIME](#) where the [ACTIVITY DATE AND TIME TYPE](#) is National Code '[Date and Time of Decision to Deliver](#)'. DATE TIME OF DECISION TO DELIVER is the same as attribute [ACTIVITY DATE](#) and [ACTIVITY TIME](#) where the [ACTIVITY DATE AND TIME TYPE](#) is National Code '[Date and Time of Decision to Deliver](#)'.~~

DECISION TO TREAT DATE (RADIOTHERAPY TREATMENT EPISODE)

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

[DECISION TO TREAT DATE \(RADIOTHERAPY TREATMENT EPISODE\)](#) is the same as attribute [DECISION TO TREAT DATE](#).

[DECISION TO TREAT DATE \(RADIOTHERAPY TREATMENT EPISODE\)](#) is the [DATE](#) that a decision was taken to treat a [PATIENT](#)'s condition with a [RADIOTHERAPY TREATMENT MODALITY](#).

~~Where the treatment is being undertaken as part of a [Cancer Treatment Period](#) and the [CANCER TREATMENT MODALITY](#) is National Code '[Teletherapy](#)' or '[Brachytherapy](#)', the [DECISION TO TREAT DATE \(RADIOTHERAPY TREATMENT EPISODE\)](#) is the same as the [Cancer Treatment Period Start Date](#). Where the treatment is being undertaken as part of a Cancer Treatment Period and the [CANCER TREATMENT MODALITY](#) is National Code '[Teletherapy](#)' or '[Brachytherapy](#)', the [DECISION TO TREAT DATE \(RADIOTHERAPY TREATMENT EPISODE\)](#) is the same as the [CANCER TREATMENT PERIOD START DATE](#).~~

DISCHARGE DATE (MOTHER MATERNITY SERVICES)

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

~~[DISCHARGE DATE \(MOTHER MATERNITY SERVICES\)](#) is the [End Date](#) of the [Maternity Episode](#). [DISCHARGE DATE \(MOTHER MATERNITY SERVICES\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Discharge Date](#)'.~~

[DISCHARGE DATE \(MOTHER MATERNITY SERVICES\)](#) is the [DATE](#) on which the mother ceased to be cared for in a [Maternity Episode](#). This will be the last [Contact Date](#) with a [MIDWIFE](#) when care is then continued by a [Specialist Community Public Health Nurse: Health Visitor](#). [DISCHARGE DATE \(MOTHER MATERNITY SERVICES\)](#) is the [DATE](#) on which the mother ceased to be cared for in a Maternity Service.

DISCHARGE DATE TIME (HOSPITAL PROVIDER SPELL POSTPARTUM)

Change to Data Element: Changed Description

Format/Length:	See DATE AND TIME
National Codes:	
Default Codes:	

Notes:

~~[DISCHARGE DATE TIME \(HOSPITAL PROVIDER SPELL POSTPARTUM\)](#) is the same as attribute [ACTIVITY DATE](#) and [ACTIVITY TIME](#) where the [ACTIVITY DATE AND TIME TYPE](#) is National Code '[Discharge Date and Time \(Hospital Provider Spell Postpartum\)](#)'. [DISCHARGE DATE TIME \(HOSPITAL PROVIDER SPELL POSTPARTUM\)](#) is the same as attribute [ACTIVITY DATE](#) and [ACTIVITY TIME](#) where the [ACTIVITY DATE AND TIME TYPE](#) is National Code '[Discharge Date and Time \(Hospital Provider Spell Postpartum\)](#)'.~~

DISCHARGE DATE TIME (MOTHER POST DELIVERY HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Description

Format/Length:	See DATE AND TIME
National Codes:	
Default Codes:	

Notes:

~~[DISCHARGE DATE TIME \(MOTHER POST DELIVERY HOSPITAL PROVIDER SPELL\)](#) is the same as attribute [ACTIVITY DATE](#) and [ACTIVITY](#)~~

TIME where the ACTIVITY DATE AND TIME TYPE is National Code 'Discharge Date and Time (Hospital Provider Spell Postpartum)'. DISCHARGE DATE TIME (MOTHER POST DELIVERY HOSPITAL PROVIDER SPELL) is the same as attribute ACTIVITY DATE and ACTIVITY TIME where the ACTIVITY DATE AND TIME TYPE is National Code 'Discharge Date and Time (Hospital Provider Spell Postpartum)'.

DISCHARGE LETTER ISSUED DATE (MENTAL HEALTH AND COMMUNITY CARE)

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

DISCHARGE LETTER ISSUED DATE (MENTAL HEALTH AND COMMUNITY CARE) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Discharge Letter Issued Date (Mental Health and Community Care)'. DISCHARGE LETTER ISSUED DATE (MENTAL HEALTH AND COMMUNITY CARE) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Discharge Letter Issued Date (Mental Health and Community Care)'.

END DATE (CARE PROGRAMME APPROACH CARE)

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

END DATE (CARE PROGRAMME APPROACH CARE) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'End Date' of the Care Programme Approach care for the PATIENT. END DATE (CARE PROGRAMME APPROACH CARE) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'End Date' of the Care Programme Approach care for the PATIENT.

END DATE (GMP PATIENT REGISTRATION)

Change to Data Element: Changed linked Attribute, Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

END DATE (GMP PATIENT REGISTRATION) is the same as END DATE. END DATE (GMP PATIENT REGISTRATION) is the same as attribute PERSON PROPERTY EFFECTIVE END DATE.

END DATE (GMP PATIENT REGISTRATION) is the DATE on which the PERSON ceased to be registered with a General Medical Practitioner Practice.

END DATE (GMP PATIENT REGISTRATION)

Change to Data Element: Changed linked Attribute, Description

END DATE (GMP PATIENT REGISTRATION)

Attribute:

ACTIVITY DATE

PERSON PROPERTY EFFECTIVE END DATE
--

END DATE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

END DATE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'End Date'. END DATE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'End Date'.

END DATE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES) is the date the PATIENT is deemed by the CARE PROFESSIONAL to have completed treatment and discharged from the Improving Access to Psychological Therapies Service.

END DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD)

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

~~[END DATE \(MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[End Date](#)' of the [Mental Health Responsible Clinician Assignment Period](#).~~ [END DATE \(MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[End Date](#)' of the [Mental Health Responsible Clinician Assignment Period](#).

END DATE (WARD STAY)

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

~~[END DATE \(WARD STAY\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[End Date](#)' of the [Ward Stay](#).~~ [END DATE \(WARD STAY\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[End Date](#)' of the [Ward Stay](#).

FINAL FIGO STAGE DATE

Change to Data Element: Changed linked Attribute, Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

~~[FINAL FIGO STAGE DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Final Figo Stage Date](#)'.~~ [FINAL FIGO STAGE DATE](#) is the same as attribute [PERSON PROPERTY RECORDED DATE](#).

[FINAL FIGO STAGE DATE](#) is the [DATE](#) on which [FINAL FIGO STAGE](#) was recorded during a [Gynaecological Cancer Care Spell](#).

FINAL FIGO STAGE DATE

Change to Data Element: Changed linked Attribute, Description

FINAL FIGO STAGE DATE**Attribute:**

ACTIVITY DATE
PERSON PROPERTY RECORDED DATE

FIVE FORENSIC PATHWAYS ASSESSMENT DATE

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

~~[FIVE FORENSIC PATHWAYS ASSESSMENT DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Five Forensic Pathways Assessment Date](#)'.~~ [FIVE FORENSIC PATHWAYS ASSESSMENT DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Clinical Intervention Date](#)'. [FIVE FORENSIC PATHWAYS ASSESSMENT DATE](#) is the [DATE](#) on which a [Five Forensic Pathways](#) assessment was completed for a [PATIENT](#).

HEAD CIRCUMFERENCE IN CENTIMETRES (AT TWO YEAR NEONATAL OUTCOMES ASSESSMENT)

Change to Data Element: Changed Description

Format/Length:	max n2.n1
National Codes:	
Default Codes:	

Notes:

HEAD CIRCUMFERENCE IN CENTIMETRES records the Head Circumference of the PATIENT (child) as recorded at a Two Year Neonatal Outcomes Assessment, where the UNIT OF MEASUREMENT is 'Centimetres'.

~~For the National Neonatal Data Set - Two Year Neonatal Outcomes Assessment, where the Head Circumference measurement was not taken on the Two Year Neonatal Outcomes Assessment Date, the actual OBSERVATION DATE (HEAD CIRCUMFERENCE) should be recorded.~~ For the National Neonatal Data Set - Two Year Neonatal Outcomes Assessment, where the Head Circumference measurement was not taken on the TWO YEAR NEONATAL OUTCOMES ASSESSMENT DATE, the actual OBSERVATION DATE (HEAD CIRCUMFERENCE) should be recorded.

HEALTH VISITOR FIRST ANTENATAL VISIT DATE

Change to Data Element: Changed Description

Format/Length:	See <u>DATE</u>
National Codes:	
Default Codes:	

Notes:

HEALTH VISITOR FIRST ANTENATAL VISIT DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Health Visitor First Antenatal Visit Date'. HEALTH VISITOR FIRST ANTENATAL VISIT DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Care Contact Date'. HEALTH VISITOR FIRST ANTENATAL VISIT DATE is the DATE of the first antenatal CARE CONTACT between the Health Visitor and the pregnant woman.

HOLISTIC NEEDS ASSESSMENT COMPLETED DATE

Change to Data Element: Changed Description

Format/Length:	See <u>DATE</u>
National Codes:	
Default Codes:	

Notes:

HOLISTIC NEEDS ASSESSMENT COMPLETED DATE is the same as attribute ACTIVITY DATE, where the ACTIVITY DATE TYPE is National Code 'Holistic Needs Assessment Completed Date'. HOLISTIC NEEDS ASSESSMENT COMPLETED DATE is the same as attribute ACTIVITY DATE, where the ACTIVITY DATE TYPE is National Code 'Care Contact Date'. HOLISTIC NEEDS ASSESSMENT COMPLETED DATE is the DATE a Holistic Needs Assessment is completed.

IMMUNISATION DATE

Change to Data Element: Changed Description

Format/Length:	See <u>DATE</u>
National Codes:	
Default Codes:	

Notes:

IMMUNISATION DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Immunisation Date'. IMMUNISATION DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Clinical Intervention Date'. IMMUNISATION DATE is the DATE on which the immunisation was carried out.

INDIRECT ACTIVITY DATE

Change to Data Element: Changed Description

Format/Length:	See <u>DATE</u>
National Codes:	
Default Codes:	

Notes:

~~INDIRECT ACTIVITY DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Indirect Activity Date'.~~ INDIRECT ACTIVITY DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Indirect Activity Date'.

INDIRECT ACTIVITY TIME

Change to Data Element: Changed Description

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:

~~INDIRECT ACTIVITY TIME is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code 'Indirect Activity Time'.~~ INDIRECT ACTIVITY TIME is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code 'Indirect Activity Time'.

INFANT PHYSICAL EXAMINATION DATE

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

~~INFANT PHYSICAL EXAMINATION DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Infant Physical Examination Date'.~~ INFANT PHYSICAL EXAMINATION DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Clinical Intervention Date'. INFANT PHYSICAL EXAMINATION DATE is the DATE of the Infant Physical Examination.

INJURY DATE

Change to Data Element: Changed linked Attribute, Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

~~INJURY DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Injury Date'.~~ INJURY DATE is the same as attribute PERSON PROPERTY EFFECTIVE START DATE.

INJURY DATE is the DATE the PATIENT was injured.

Where this information cannot be obtained directly from the PATIENT (or Patient Proxy), the INJURY DATE should be estimated.

INJURY DATE

Change to Data Element: Changed linked Attribute, Description

INJURY DATE

Attribute:

ACTIVITY DATE
PERSON PROPERTY EFFECTIVE START DATE

INJURY TIME

Change to Data Element: Changed linked Attribute, Description

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:

~~INJURY TIME is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code 'Injury Time'.~~ INJURY TIME is the same as attribute PERSON PROPERTY EFFECTIVE START TIME.

INJURY TIME is the TIME the PATIENT was injured.

Where this information cannot be obtained directly from the PATIENT (or Patient Proxy), the INJURY TIME should be estimated.

INJURY TIME

Change to Data Element: Changed linked Attribute, Description

INJURY TIME

Attribute:

ACTIVITY TIME

PERSON PROPERTY EFFECTIVE START TIME

INTERGROUP RHABDOMYOSARCOMA STUDY POST SURGICAL GROUP DATE

Change to Data Element: Changed linked Attribute, Description

Format/Length: See DATE
National Codes:
Default Codes:

Notes:

INTERGROUP RHABDOMYOSARCOMA STUDY POST SURGICAL GROUP DATE is the same as attribute ACTIVITY DATE, where the ACTIVITY DATE TYPE is National Code 'Intergroup Rhabdomyosarcoma Study Post Surgical Group Date'. INTERGROUP RHABDOMYOSARCOMA STUDY POST SURGICAL GROUP DATE is the same as attribute PERSON PROPERTY RECORDED DATE.

INTERGROUP RHABDOMYOSARCOMA STUDY POST SURGICAL GROUP DATE is the DATE on which INTERGROUP RHABDOMYOSARCOMA STUDY POST SURGICAL GROUP was recorded during a Sarcoma Cancer Care Spell.

INTERGROUP RHABDOMYOSARCOMA STUDY POST SURGICAL GROUP DATE

Change to Data Element: Changed linked Attribute, Description

INTERGROUP RHABDOMYOSARCOMA STUDY POST SURGICAL GROUP DATE

Attribute:

ACTIVITY DATE

PERSON PROPERTY RECORDED DATE

INTERNATIONAL NEUROBLASTOMA RISK GROUP STAGING SYSTEM DATE

Change to Data Element: Changed linked Attribute, Description

Format/Length: See DATE
National Codes:
Default Codes:

Notes:

INTERNATIONAL NEUROBLASTOMA RISK GROUP STAGING SYSTEM DATE is the same as attribute ACTIVITY DATE, where the ACTIVITY DATE TYPE is National Code 'International Neuroblastoma Risk Group Staging System Stage Date'. INTERNATIONAL NEUROBLASTOMA RISK GROUP STAGING SYSTEM DATE is the same as attribute PERSON PROPERTY RECORDED DATE. INTERNATIONAL NEUROBLASTOMA RISK GROUP STAGING SYSTEM DATE is the DATE on which INTERNATIONAL NEUROBLASTOMA RISK GROUP STAGING SYSTEM STAGE was recorded during a Children Teenagers and Young Adults Cancer Care Spell.

INTERNATIONAL NEUROBLASTOMA RISK GROUP STAGING SYSTEM DATE

Change to Data Element: Changed linked Attribute, Description

INTERNATIONAL NEUROBLASTOMA RISK GROUP STAGING SYSTEM DATE

Attribute:

ACTIVITY DATE

PERSON PROPERTY RECORDED DATE

LAST CONTACT DATE (LIVING DONOR)

Change to Data Element: Changed Description

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[LAST CONTACT DATE \(LIVING DONOR\)](#) is the last [Contact Date](#) with the [LIVING ORGAN OR TISSUE DONOR](#). [LAST CONTACT DATE \(LIVING DONOR\)](#) is the last [Care Contact Date](#) with the [LIVING ORGAN OR TISSUE DONOR](#).

LAST MENSTRUAL PERIOD DATE

Change to Data Element: Changed linked Attribute, Description

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[LAST MENSTRUAL PERIOD DATE](#) is the same as attribute [LAST MENSTRUAL PERIOD DATE](#). [LAST MENSTRUAL PERIOD DATE](#) is the same as attribute [PERSON PROPERTY EFFECTIVE START DATE](#). The [LAST MENSTRUAL PERIOD DATE](#) is the [DATE](#) of the first day of the last menstrual period for a [PERSON](#).

LAST MENSTRUAL PERIOD DATE

Change to Data Element: Changed linked Attribute, Description

LAST MENSTRUAL PERIOD DATE

Attribute:

[LAST MENSTRUAL PERIOD DATE](#)
[PERSON PROPERTY EFFECTIVE START DATE](#)

MATERNITY SCREENING TESTS BOOKLET GIVEN DATE

Change to Data Element: Changed Description

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[MATERNITY SCREENING TESTS BOOKLET GIVEN DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Screening Test Information Given Date](#)'. [MATERNITY SCREENING TESTS BOOKLET GIVEN DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Screening Test Information Given Date](#)'.

MODIFIED DUKES STAGE DATE

Change to Data Element: Changed linked Attribute, Description

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[MODIFIED DUKES STAGE DATE](#) is the same as attribute [ACTIVITY DATE](#), where the [ACTIVITY DATE TYPE](#) is National Code '[Modified Dukes Stage Date](#)'. [MODIFIED DUKES STAGE DATE](#) is the same as attribute [PERSON PROPERTY RECORDED DATE](#). [MODIFIED DUKES STAGE DATE](#) is the [DATE](#) on which [MODIFIED DUKES STAGE](#) was recorded during a [Cancer Care Spell](#).

MODIFIED DUKES STAGE DATE

Change to Data Element: Changed linked Attribute, Description

MODIFIED DUKES STAGE DATE

Attribute:

[ACTIVITY DATE](#)
[PERSON PROPERTY RECORDED DATE](#)

MULTIDISCIPLINARY TEAM DISCUSSION DATE (CANCER)

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

[MULTIDISCIPLINARY TEAM DISCUSSION DATE \(CANCER\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code ['Multidisciplinary Team Discussion Date \(Cancer\)'](#). [MULTIDISCIPLINARY TEAM DISCUSSION DATE \(CANCER\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code ['Multidisciplinary Team Discussion Date \(Cancer\)'](#).

MULTIDISCIPLINARY TEAM MEETING DATE (CANCER)

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

[MULTIDISCIPLINARY TEAM MEETING DATE \(CANCER\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code ['Multidisciplinary Team Meeting Date \(Cancer\)'](#). [MULTIDISCIPLINARY TEAM MEETING DATE \(CANCER\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code ['Multidisciplinary Team Meeting Date \(Cancer\)'](#).

MURPHY ST JUDE STAGE DATE

Change to Data Element: Changed linked Attribute, Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

[MURPHY ST JUDE STAGE DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code ['Murphy St Jude Stage Date'](#). [MURPHY ST JUDE STAGE DATE](#) is the same as attribute [PERSON PROPERTY RECORDED DATE](#).

[MURPHY ST JUDE STAGE DATE](#) is the [DATE](#) on which [MURPHY ST JUDE STAGE](#) was recorded during a [Haematological Cancer Care Spell](#).

MURPHY ST JUDE STAGE DATE

Change to Data Element: Changed linked Attribute, Description

MURPHY ST JUDE STAGE DATE

Attribute:

ACTIVITY DATE

PERSON PROPERTY RECORDED DATE

MYELOMA INTERNATIONAL STAGING SYSTEM STAGE DATE

Change to Data Element: Changed linked Attribute, Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

[MYELOMA INTERNATIONAL STAGING SYSTEM STAGE DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code ['Myeloma International Staging System Stage Date'](#). [MYELOMA INTERNATIONAL STAGING SYSTEM STAGE DATE](#) is the same as attribute [PERSON PROPERTY RECORDED DATE](#).

[MYELOMA INTERNATIONAL STAGING SYSTEM STAGE DATE](#) is the [DATE](#) on which [MYELOMA INTERNATIONAL STAGING SYSTEM STAGE](#) was recorded during a [Haematological Cancer Care Spell](#).

MYELOMA INTERNATIONAL STAGING SYSTEM STAGE DATE

Change to Data Element: Changed linked Attribute, Description

MYELOMA INTERNATIONAL STAGING SYSTEM STAGE DATE

Attribute:

ACTIVITY DATE

PERSON PROPERTY RECORDED DATE

NUMBER OF HIV CONTACTS

Change to Data Element: Changed Description

Format/Length: max n3

National Codes:

Default Codes:

Notes:

NUMBER OF HIV CONTACTS is the number of the PATIENT's Human Immunodeficiency Virus (HIV) contacts as stated by the PATIENT at the Attendance Date. NUMBER OF HIV CONTACTS is the number of the PATIENT's Human Immunodeficiency Virus (HIV) contacts as stated by the PATIENT at the ATTENDANCE DATE.

NUMBER OF HIV CONTACTS is assessed for PATIENTS who are newly diagnosed with Human Immunodeficiency Virus (HIV).

Guidance for recording HIV partner contacts can be downloaded from the [British HIV Association](#) website at: [HIV partner notification for adults: definitions, outcomes and standards](#).

OBSERVATION DATE

Change to Data Element: Changed Description

Format/Length: See DATE

National Codes:

Default Codes:

Notes:

OBSERVATION DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Clinical Intervention Date'. OBSERVATION DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Observable Entity Date'.

OBSERVATION DATE (BLOOD TEST) (RETIRED), renamed from OBSERVATION DATE (BLOOD TEST)

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

Format/Length: See DATE

National Codes:

Default Codes:

Notes:

OBSERVATION DATE (BLOOD TEST) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Clinical Intervention Date'.

OBSERVATION DATE (BLOOD TEST) is the date when the PATIENT's blood test was taken. This item has been retired from the NHS Data Model and Dictionary.

The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

OBSERVATION DATE (BLOOD TEST) (RETIRED), renamed from OBSERVATION DATE (BLOOD TEST)

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

OBSERVATION DATE (BLOOD TEST)

Attribute:

ACTIVITY DATE

OBSERVATION DATE (BLOOD TEST) (RETIRED), renamed from OBSERVATION DATE (BLOOD TEST)

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

- Changed Name from Data_Dictionary.Data_Field_Notes.O.OBSERVATION_DATE_(BLOOD_TEST) to Retired.Data_Dictionary.Data_Field_Notes.O.OBSERVATION_DATE_(BLOOD_TEST)
- null
- Retired OBSERVATION DATE (BLOOD TEST)
- Changed Description

OBSERVATION DATE (HEAD CIRCUMFERENCE)

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

~~[OBSERVATION DATE \(HEAD CIRCUMFERENCE\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Clinical Intervention Date](#)'.~~ [OBSERVATION DATE \(HEAD CIRCUMFERENCE\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Observable Entity Date](#)'.

~~[OBSERVATION DATE \(HEAD CIRCUMFERENCE\)](#) is the date when the [PATIENT's Head Circumference](#) was measured.~~ [OBSERVATION DATE \(HEAD CIRCUMFERENCE\)](#) is the [DATE](#) when the [PATIENT's Head Circumference](#) was measured.

OBSERVATION DATE (HEIGHT)

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

~~[OBSERVATION DATE \(HEIGHT\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Clinical Intervention Date](#)'.~~ [OBSERVATION DATE \(HEIGHT\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Observable Entity Date](#)'.

~~[OBSERVATION DATE \(HEIGHT\)](#) is the date when the [PATIENT's Height](#) was measured.~~ [OBSERVATION DATE \(HEIGHT\)](#) is the [DATE](#) when the [PATIENT's Height](#) was measured.

OBSERVATION DATE (SUBSTANCE MISUSE EVIDENCE)

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

[OBSERVATION DATE \(SUBSTANCE MISUSE EVIDENCE\)](#) is the same as attribute [PERSON PROPERTY OBSERVED DATE](#).

~~[OBSERVATION DATE \(SUBSTANCE MISUSE EVIDENCE\)](#) is the date that evidence of current substance misuse by a [PATIENT](#) was observed by a [CARE PROFESSIONAL](#).~~ [OBSERVATION DATE \(SUBSTANCE MISUSE EVIDENCE\)](#) is the [DATE](#) that evidence of current substance misuse by a [PATIENT](#) was observed by a [CARE PROFESSIONAL](#).

For the [Mental Health Services Data Set](#), [OBSERVATION DATE \(SUBSTANCE MISUSE EVIDENCE\)](#) is recorded within a [Ward Stay](#).

OBSERVATION DATE (WEIGHT)

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

~~[OBSERVATION DATE \(WEIGHT\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Clinical Intervention Date](#)'.~~ [OBSERVATION DATE \(WEIGHT\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Observable Entity Date](#)'.

OBSERVATION DATE (WEIGHT) is the date when the PATIENT's Weight was measured. OBSERVATION DATE (WEIGHT) is the DATE when the PATIENT's Weight was measured.

OBSERVATION DATE AND TIME (SECOND BRAINSTEM DEATH TEST) (RETIRED), renamed from OBSERVATION DATE AND TIME (SECOND BRAINSTEM DEATH TEST)

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

Format/Length:	See <u>DATE AND TIME</u>
National Codes:	
Default Codes:	

Notes:

OBSERVATION DATE AND TIME (SECOND BRAINSTEM DEATH TEST) is the same as attribute ACTIVITY DATE and ACTIVITY TIME where the ACTIVITY DATE AND TIME TYPE is National Code 'Clinical Intervention Date and Time'.

OBSERVATION DATE AND TIME (SECOND BRAINSTEM DEATH TEST) is the date and time of the second brainstem death test. **This item has been retired from the NHS Data Model and Dictionary.**

The last live version of this item is available in the July 2018 release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

OBSERVATION DATE AND TIME (SECOND BRAINSTEM DEATH TEST) (RETIRED), renamed from OBSERVATION DATE AND TIME (SECOND BRAINSTEM DEATH TEST)

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

OBSERVATION DATE AND TIME (SECOND BRAINSTEM DEATH TEST)

Attribute:

<u>ACTIVITY DATE</u>
<u>ACTIVITY TIME</u>

OBSERVATION DATE AND TIME (SECOND BRAINSTEM DEATH TEST) (RETIRED), renamed from OBSERVATION DATE AND TIME (SECOND BRAINSTEM DEATH TEST)

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

- Changed Name from Data_Dictionary.Data_Field_Notes.O.OBSERVATION_DATE_AND_TIME_(SECOND_BRAINSTEM_DEATH_TEST) to Retired.Data_Dictionary.Data_Field_Notes.O.OBSERVATION_DATE_AND_TIME_(SECOND_BRAINSTEM_DEATH_TEST)
- null
- Retired OBSERVATION DATE AND TIME (SECOND BRAINSTEM DEATH TEST)
- Changed Description

OBSERVATION DATE AND TIME (TEMPERATURE)

Change to Data Element: Changed Description

Format/Length:	See <u>DATE AND TIME</u>
National Codes:	
Default Codes:	

Notes:

OBSERVATION DATE AND TIME (TEMPERATURE) is the same as attribute ACTIVITY DATE and ACTIVITY TIME where the ACTIVITY DATE AND TIME TYPE is National Code 'Clinical Intervention Date and Time'. OBSERVATION DATE AND TIME (TEMPERATURE) is the same as attribute ACTIVITY DATE and ACTIVITY TIME where the ACTIVITY DATE TYPE and ACTIVITY TIME TYPE is National Code 'Observable Entity Date' and 'Observable Entity Time'.

OBSERVATION DATE AND TIME (TEMPERATURE) is the date and time when the PERSON's Temperature was taken. OBSERVATION DATE AND TIME (TEMPERATURE) is the DATE AND TIME when the PERSON's Temperature was taken.

ONWARD REFERRAL DATE

Change to Data Element: Changed linked Attribute, Description

Format/Length:	See <u>DATE</u>
National Codes:	
Default Codes:	

Notes:

ONWARD_REFERRAL_DATE is the same as attribute ACTIVITY_DATE where the ACTIVITY_DATE_TYPE is National Code 'Onward Referral Date'. ONWARD_REFERRAL_DATE is the same as attribute ACTIVITY_SERVICE_REQUEST_DATE. ONWARD_REFERRAL_DATE is the DATE the PATIENT was referred from one SERVICE to another SERVICE, which may be in the same or a different Organisation.

ONWARD REFERRAL DATE

Change to Data Element: Changed linked Attribute, Description

ONWARD REFERRAL DATE

Attribute:

ACTIVITY_DATE

ACTIVITY_SERVICE_REQUEST_DATE

ONWARD REFERRAL TIME

Change to Data Element: Changed linked Attribute, Description

Format/Length: See TIME

National Codes:

Default Codes:

Notes:

ONWARD_REFERRAL_TIME is the same as attribute ACTIVITY_TIME where the ACTIVITY_TIME_TYPE is National Code 'Onward Referral Time'. ONWARD_REFERRAL_TIME is the same as attribute ACTIVITY_SERVICE_REQUEST_TIME. ONWARD_REFERRAL_DATE is the TIME the PATIENT was referred from one SERVICE to another SERVICE, which may be in the same or a different Organisation.

ONWARD REFERRAL TIME

Change to Data Element: Changed linked Attribute, Description

ONWARD REFERRAL TIME

Attribute:

ACTIVITY_TIME

ACTIVITY_SERVICE_REQUEST_TIME

OTHER GENE OR STRATIFICATION BIOMARKER TYPE ANALYSED COMMENT

Change to Data Element: Changed linked Attribute, Description

Format/Length: max an30

National Codes:

Default Codes:

Notes:

OTHER_GENE_OR_STRATIFICATION_BIOMARKER_TYPE_ANALYSED_COMMENT is the same as attribute PERSON_OBSERVATION_TEXT_STRING. OTHER_GENE_OR_STRATIFICATION_BIOMARKER_TYPE_ANALYSED_COMMENT is the same as attribute CLINICAL_INTERVENTION_TEXT_STRING.

OTHER_GENE_OR_STRATIFICATION_BIOMARKER_TYPE_ANALYSED_COMMENT is free text to specify the Gene or Stratification Biomarker that was analysed, where GENE_OR_STRATIFICATION_BIOMARKER_TYPE_ANALYSED is National Code 'Other (not listed)'.

OTHER GENE OR STRATIFICATION BIOMARKER TYPE ANALYSED COMMENT

Change to Data Element: Changed linked Attribute, Description

OTHER GENE OR STRATIFICATION BIOMARKER TYPE ANALYSED COMMENT

Attribute:

CLINICAL_INTERVENTION_TEXT_STRING

OTHER GERMLINE GENETIC TEST TYPE OFFERED COMMENT

Change to Data Element: Changed linked Attribute, Description

Format/Length: max an30

National Codes:
Default Codes:

Notes:

~~[OTHER GERMLINE GENETIC TEST TYPE OFFERED COMMENT](#) is the same as attribute [PERSON OBSERVATION TEXT STRING](#).~~
[OTHER GERMLINE GENETIC TEST TYPE OFFERED COMMENT](#) is the same as attribute [CLINICAL INTERVENTION TEXT STRING](#).

[OTHER GERMLINE GENETIC TEST TYPE OFFERED COMMENT](#) is free text to specify the Germline Genetic Test that was offered to the [PATIENT](#), where [GERMLINE GENETIC TEST TYPE OFFERED](#) is National Code 'Other (not listed)'.

OTHER GERMLINE GENETIC TEST TYPE OFFERED COMMENT

Change to Data Element: Changed linked Attribute, Description

OTHER GERMLINE GENETIC TEST TYPE OFFERED COMMENT

Attribute:

[CLINICAL INTERVENTION TEXT STRING](#)

OXYTOCIN ADMINISTERED DATE TIME

Change to Data Element: Changed Description

Format/Length: See [DATE AND TIME](#)
National Codes:
Default Codes:

Notes:

~~[OXYTOCIN ADMINISTERED DATE TIME](#) is the same as attribute [ACTIVITY DATE](#) and [ACTIVITY TIME](#) where the [ACTIVITY DATE AND TIME TYPE](#) is National Code 'Oxytocin Administered Date and Time'.~~
[OXYTOCIN ADMINISTERED DATE TIME](#) is the same as attribute [ACTIVITY DATE](#) and [ACTIVITY TIME](#) where the [ACTIVITY DATE AND TIME TYPE](#) is National Code 'Oxytocin Administered Date and Time'.

PARENTS SEEN BY SENIOR STAFF MEMBER DATE AND TIME

Change to Data Element: Changed Description

Format/Length: See [DATE AND TIME](#)
National Codes:
Default Codes:

Notes:

~~[PARENTS SEEN BY SENIOR STAFF MEMBER DATE AND TIME](#) is the same as attribute [ACTIVITY DATE](#) and [ACTIVITY TIME](#) where the [ACTIVITY DATE AND TIME TYPE](#) is National Code 'Parents Seen By Senior Staff Member Date and Time'.~~
[PARENTS SEEN BY SENIOR STAFF MEMBER DATE AND TIME](#) is the same as attribute [ACTIVITY DATE](#) and [ACTIVITY TIME](#) where the [ACTIVITY DATE AND TIME TYPE](#) is National Code 'Start Date' and 'Start Time' that the parents of a baby admitted to a Neonatal Intensive Care Unit, were seen by a senior staff member.

PERSON HEIGHT IN CENTIMETRES (AT TWO YEAR NEONATAL OUTCOMES ASSESSMENT)

Change to Data Element: Changed Description

Format/Length: max n2.max n2
National Codes:
Default Codes:

Notes:

[PERSON HEIGHT IN CENTIMETRES \(AT TWO YEAR NEONATAL OUTCOMES ASSESSMENT\)](#) records the [Height](#) of the [PATIENT](#) (child) as recorded at a [Two Year Neonatal Outcomes Assessment](#), where the [UNIT OF MEASUREMENT](#) is 'Centimetres'.

~~For the [National Neonatal Data Set - Two Year Neonatal Outcomes Assessment](#), where the [Height](#) measurement was not taken on the [Two Year Neonatal Outcomes Assessment Date](#), the actual [OBSERVATION DATE \(HEIGHT\)](#) should be recorded.~~
For the [National Neonatal Data Set - Two Year Neonatal Outcomes Assessment](#), where the [Height](#) measurement was not taken on the [TWO YEAR NEONATAL OUTCOMES ASSESSMENT DATE](#), the actual [OBSERVATION DATE \(HEIGHT\)](#) should be recorded.

PERSON WEIGHT (AT TWO YEAR NEONATAL OUTCOMES ASSESSMENT)

Change to Data Element: Changed Description

Format/Length: max n2.max n2
National Codes:

Default Codes:

Notes:

[PERSON WEIGHT \(AT TWO YEAR NEONATAL OUTCOMES ASSESSMENT\)](#) records the [Weight](#) of the [PATIENT](#) (child) as recorded at a [Two Year Neonatal Outcomes Assessment](#), where the [UNIT OF MEASUREMENT](#) is 'Kilograms'.

~~For the [National Neonatal Data Set - Two Year Neonatal Outcomes Assessment](#), where the [Weight](#) measurement was not taken on the [Two Year Neonatal Outcomes Assessment Date](#), the actual [OBSERVATION DATE \(WEIGHT\)](#) should be recorded.~~ For the [National Neonatal Data Set - Two Year Neonatal Outcomes Assessment](#), where the [Weight](#) measurement was not taken on the [Two Year Neonatal Outcomes Assessment Date](#), the actual [OBSERVATION DATE \(WEIGHT\)](#) should be recorded.

PREGNANCY FIRST CONTACT DATE

Change to Data Element: Changed Description

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[PREGNANCY FIRST CONTACT DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Pregnancy First Contact Date](#)'. [PREGNANCY FIRST CONTACT DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Pregnancy First Contact Date](#)'.

PREGNANCY PREVIOUS CAESAREAN SECTIONS

Change to Data Element: Changed linked Attribute, Description

Format/Length: max n2
National Codes:
Default Codes:

Notes:

[PREGNANCY PREVIOUS CAESAREAN SECTIONS](#) is the same as attribute [PREGNANCY PREVIOUS CAESAREAN SECTIONS](#). [PREGNANCY PREVIOUS CAESAREAN SECTIONS](#) is the number of previous pregnancies where a baby was delivered via a caesarean section.

PREGNANCY PREVIOUS CAESAREAN SECTIONS

Change to Data Element: Changed linked Attribute, Description

PREGNANCY PREVIOUS CAESAREAN SECTIONS

Attribute:

[PREGNANCY PREVIOUS CAESAREAN SECTIONS](#)

PREGNANCY TOTAL PREVIOUS LIVE BIRTHS

Change to Data Element: Changed linked Attribute, Description

Format/Length: max n2
National Codes:
Default Codes:

Notes:

[PREGNANCY TOTAL PREVIOUS LIVE BIRTHS](#) is the same as attribute [PREGNANCY TOTAL LIVE BIRTHS](#). [PREGNANCY TOTAL PREVIOUS LIVE BIRTHS](#) is the number of live [REGISTRABLE BIRTHS](#) from previous pregnancies.

PREGNANCY TOTAL PREVIOUS LIVE BIRTHS

Change to Data Element: Changed linked Attribute, Description

PREGNANCY TOTAL PREVIOUS LIVE BIRTHS

Attribute:

[PREGNANCY TOTAL LIVE BIRTHS](#)

PREGNANCY TOTAL PREVIOUS LOSSES LESS THAN 24 WEEKS

Change to Data Element: Changed linked Attribute, Description

Format/Length: max n2

National Codes:

Default Codes:

Notes:

~~PREGNANCY TOTAL PREVIOUS LOSSES LESS THAN 24 WEEKS~~ is the same as attribute ~~PREGNANCY TOTAL PREVIOUS LOSSES LESS THAN 24 WEEKS~~. ~~PREGNANCY TOTAL PREVIOUS LOSSES LESS THAN 24 WEEKS~~ is the number of previous terminations and losses before 24 weeks of pregnancy (i.e. less than 23 weeks and 6 days).

PREGNANCY TOTAL PREVIOUS LOSSES LESS THAN 24 WEEKS

Change to Data Element: Changed linked Attribute, Description

PREGNANCY TOTAL PREVIOUS LOSSES LESS THAN 24 WEEKS

Attribute:

PREGNANCY TOTAL PREVIOUS LOSSES LESS THAN 24 WEEKS

PREGNANCY TOTAL PREVIOUS PREGNANCIES

Change to Data Element: Changed linked Attribute, Description

Format/Length:	n2
National Codes:	
Default Codes:	99 - Not known

Notes:

~~PREGNANCY TOTAL PREVIOUS PREGNANCIES~~ is the same as attribute ~~PREGNANCY TOTAL PREVIOUS PREGNANCIES~~. ~~PREGNANCY TOTAL PREVIOUS PREGNANCIES~~ is the number of previous pregnancies resulting in one or more REGISTRABLE BIRTHS.

- A live birth is always registrable, no matter how short the gestation.
- Still births and abortions are registrable only if they occur after a gestation of 24 weeks or more.

~~A live birth is always registrable, no matter how short the gestation. Still births and abortions are registrable only if they occur after a gestation of 24 weeks or more, see REGISTRABLE BIRTH.~~

The following values with the addition of the Default Code, can be used:

00	No previous pregnancy resulting in a registrable birth
01	One previous pregnancy resulting in a registrable birth
02	Two previous pregnancies resulting in a registrable birth
03	Three previous pregnancies resulting in a registrable birth
00	No previous pregnancy resulting in a <u>REGISTRABLE BIRTH</u>
01	One previous pregnancy resulting in a <u>REGISTRABLE BIRTH</u>
02	Two previous pregnancies resulting in a <u>REGISTRABLE BIRTH</u>
03	Three previous pregnancies resulting in a <u>REGISTRABLE BIRTH</u>

etc. until

20	Twenty nine previous pregnancies resulting in a registrable birth
29	Twenty nine previous pregnancies resulting in a <u>REGISTRABLE BIRTH</u>

PREGNANCY TOTAL PREVIOUS PREGNANCIES

Change to Data Element: Changed linked Attribute, Description

PREGNANCY TOTAL PREVIOUS PREGNANCIES

Attribute:

PREGNANCY TOTAL PREVIOUS PREGNANCIES

PREGNANCY TOTAL PREVIOUS STILLBIRTHS

Change to Data Element: Changed linked Attribute, Description

Format/Length:	max n2
National Codes:	
Default Codes:	

Notes:

~~PREGNANCY TOTAL PREVIOUS STILLBIRTHS~~ is the same as attribute ~~PREGNANCY TOTAL STILL BIRTHS~~. ~~PREGNANCY TOTAL PREVIOUS STILLBIRTHS~~ is the number of still REGISTRABLE BIRTHS from previous pregnancies, i.e. a birth after a gestation of 24 weeks (168 days), or more, where a baby shows no identifiable signs of life at delivery.

PREGNANCY TOTAL PREVIOUS STILLBIRTHS

Change to Data Element: Changed linked Attribute, Description

PREGNANCY TOTAL PREVIOUS STILLBIRTHS

Attribute:

PREGNANCY TOTAL STILL BIRTHS

PRIMARY PROCEDURE DATE

Change to Data Element: Changed Description

Format/Length: See [DATE](#)

National Codes:

Default Codes:

Notes:

[PRIMARY PROCEDURE DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Primary Procedure Date](#)'. PRIMARY PROCEDURE DATE is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) '[Clinical Intervention Date](#)'. PRIMARY PROCEDURE DATE is the [DATE](#) of the primary Patient Procedure. Primary Pat

PROCEDURE DATE (BRONCHOSCOPY)

Change to Data Element: Changed Description

Format/Length: See [DATE](#)

National Codes:

Default Codes:

Notes:

[PROCEDURE DATE \(BRONCHOSCOPY\)](#) is the same as data element [PROCEDURE DATE](#).

[PROCEDURE DATE \(BRONCHOSCOPY\)](#) is the [DATE](#) the [Bronchoscopy](#) was performed.

[PROCEDURE DATE \(BRONCHOSCOPY\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Procedure Date](#)' of the [Bronchoscopy](#).

PROCEDURE DATE (DATING ULTRASOUND SCAN)

Change to Data Element: Changed Description

Format/Length: See [DATE](#)

National Codes:

Default Codes:

Notes:

[PROCEDURE DATE \(DATING ULTRASOUND SCAN\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Procedure Date](#)' for the [Clinical Investigation of Dating Ultrasound Scan](#). PROCEDURE DATE (DATING ULTRASOUND SCAN) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Procedure Date](#)' of the [Dating Ultrasound Scan](#).

PROCEDURE DATE (NEWBORN HEARING AUDIOLOGY)

Change to Data Element: Changed Description

Format/Length: See [DATE](#)

National Codes:

Default Codes:

Notes:

[PROCEDURE DATE \(NEWBORN HEARING AUDIOLOGY\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Procedure Date](#)' for the [Newborn Hearing Audiology Test](#). PROCEDURE DATE (NEWBORN HEARING AUDIOLOGY) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Procedure Date](#)' of the [Newborn Hearing Audiology Test](#).

PROCEDURE DATE (NEWBORN HEARING SCREENING)

Change to Data Element: Changed Description

Format/Length: See [DATE](#)

National Codes:

Default Codes:

Notes:

PROCEDURE DATE (NEWBORN HEARING SCREENING) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Procedure Date' for the Newborn Hearing Screening. PROCEDURE DATE (NEWBORN HEARING SCREENING) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Procedure Date' of the Newborn Hearing Screening.

PROCEDURE DATE AND TIME

Change to Data Element: Changed Description

Format/Length:	See <u>DATE AND TIME</u>
National Codes:	
Default Codes:	

Notes:

PROCEDURE DATE AND TIME is the same as data element DATE AND TIME.

PROCEDURE DATE AND TIME is the Procedure Date and Time of a Patient Procedure.

PROCEDURE DATE AND TIME is the same as attribute ACTIVITY DATE and ACTIVITY TIME where the ACTIVITY DATE TYPE and ACTIVITY TIME TYPE is National Code 'Procedure Date' and 'Procedure Time'.

PROCEDURE DATE AND TIME (ABDOMINAL X-RAY)

Change to Data Element: Changed Description

Format/Length:	See <u>DATE AND TIME</u>
National Codes:	
Default Codes:	

Notes:

PROCEDURE DATE AND TIME (ABDOMINAL X-RAY) is the same as data element PROCEDURE DATE AND TIME.

PROCEDURE DATE AND TIME (ABDOMINAL X-RAY) is the date and time an Abdominal X-Ray was performed. PROCEDURE DATE AND TIME (ABDOMINAL X-RAY) is the Procedure Date and Procedure Time an Abdominal X-Ray was performed.

PROCEDURE DATE AND TIME (CESSATION OF RESUSCITATION UNCONTROLLED DONOR)

Change to Data Element: Changed Description

Format/Length:	See <u>DATE AND TIME</u>
National Codes:	
Default Codes:	

Notes:

PROCEDURE DATE AND TIME (CESSATION OF RESUSCITATION UNCONTROLLED DONOR) is the same as data element DATE AND TIME at the end of the CARE ACTIVITY procedure to resuscitate the uncontrolled ORGAN OR TISSUE DONOR. PROCEDURE DATE AND TIME (CESSATION OF RESUSCITATION UNCONTROLLED DONOR) is the same as data element PROCEDURE DATE AND TIME. PROCEDURE DATE AND TIME (CESSATION OF RESUSCITATION UNCONTROLLED DONOR) is the Procedure Date and Procedure Time of the CARE ACTIVITY procedure to resuscitate the uncontrolled ORGAN OR TISSUE DONOR.

PROCEDURE DATE AND TIME (COLD PERFUSION)

Change to Data Element: Changed Description

Format/Length:	See <u>DATE AND TIME</u>
National Codes:	
Default Codes:	

Notes:

PROCEDURE DATE AND TIME (COLD PERFUSION) is the same as data element DATE AND TIME of the start of cold perfusion for all ORGAN OR TISSUE DONORS. PROCEDURE DATE AND TIME (COLD PERFUSION) is the same as data element PROCEDURE DATE AND TIME.

PROCEDURE DATE AND TIME (COLD PERFUSION) is the Procedure Date and Procedure Time of the start of cold perfusion for all ORGAN OR TISSUE DONORS.

PROCEDURE DATE AND TIME (CRANIAL ULTRASOUND SCAN)

Change to Data Element: Changed Description

Format/Length:	See DATE AND TIME
National Codes:	
Default Codes:	

Notes:

[PROCEDURE DATE AND TIME \(CRANIAL ULTRASOUND SCAN\)](#) is the same as data element [PROCEDURE DATE AND TIME](#).

~~[PROCEDURE DATE AND TIME \(CRANIAL ULTRASOUND SCAN\)](#) is the date and time a cranial [Ultrasound Scan](#) was performed.~~
[PROCEDURE DATE AND TIME \(CRANIAL ULTRASOUND SCAN\)](#) is the [Procedure Date](#) and [Procedure Time](#) a cranial [Ultrasound Scan](#) was performed.

PROCEDURE DATE AND TIME (DURING NEONATAL CRITICAL CARE PERIOD)

Change to Data Element: Changed Description

Format/Length:	See DATE AND TIME
National Codes:	
Default Codes:	

Notes:

~~[PROCEDURE DATE AND TIME \(DURING NEONATAL CRITICAL CARE PERIOD\)](#) is the same as [Procedure Date and Time](#) for a [Patient Procedure](#) performed during a neonatal [CRITICAL CARE PERIOD](#).~~
[PROCEDURE DATE AND TIME \(DURING NEONATAL CRITICAL CARE PERIOD\)](#) is the same as data element [PROCEDURE DATE AND TIME](#). [PROCEDURE DATE AND TIME \(DURING NEONATAL CRITICAL CARE PERIOD\)](#) is the [Procedure Date](#) and [Procedure Time](#) during a neonatal [CRITICAL CARE PERIOD](#).

PROCEDURE DATE AND TIME (ESTIMATED DONOR RETRIEVAL)

Change to Data Element: Changed Description

Format/Length:	See DATE AND TIME
National Codes:	
Default Codes:	

Notes:

~~[PROCEDURE DATE AND TIME \(ESTIMATED DONOR RETRIEVAL\)](#) is the same as data element [DATE AND TIME](#) of the [CARE ACTIVITY](#) for the estimated date and time of the retrieval of the kidney.~~
[PROCEDURE DATE AND TIME \(ESTIMATED DONOR RETRIEVAL\)](#) is the same as data element [PROCEDURE DATE AND TIME](#). [PROCEDURE DATE AND TIME \(ESTIMATED DONOR RETRIEVAL\)](#) is the [Procedure Date](#) and [Procedure Time](#) of the [CARE ACTIVITY](#) for the estimated date and time of the retrieval of the kidney.

PROCEDURE DATE AND TIME (NEWBORN HEARING SCREENING)

Change to Data Element: Changed Description

Format/Length:	See DATE AND TIME
National Codes:	
Default Codes:	

Notes:

~~[PROCEDURE DATE AND TIME \(NEWBORN HEARING SCREENING\)](#) is the same as [Procedure Date and Time](#) for [Newborn Hearing Screening](#).~~
[PROCEDURE DATE AND TIME \(NEWBORN HEARING SCREENING\)](#) is the same as data element [PROCEDURE DATE AND TIME](#). [PROCEDURE DATE AND TIME \(NEWBORN HEARING SCREENING\)](#) is the [Procedure Date](#) and [Procedure Time](#) of the [Newborn Hearing Screening](#).

PROCEDURE DATE AND TIME (ORGAN OR TISSUE RETRIEVAL)

Change to Data Element: Changed Description

Format/Length:	See DATE AND TIME
National Codes:	
Default Codes:	

Notes:

~~[PROCEDURE DATE AND TIME \(ORGAN OR TISSUE RETRIEVAL\)](#) is the same as data element [DATE AND TIME](#) for the start of the [CARE ACTIVITY](#) where the whole retrieval operation started, not just the retrieval of the kidney.~~
[PROCEDURE DATE AND TIME \(ORGAN OR TISSUE](#)

RETRIEVAL is the same as data element PROCEDURE DATE AND TIME. PROCEDURE DATE AND TIME (ORGAN OR TISSUE RETRIEVAL) is the Procedure Date and Procedure Time for the start of the CARE ACTIVITY where the whole retrieval operation started, not just the retrieval of the kidney.

PROCEDURE DATE AND TIME (PLACED ON ICE LEFT KIDNEY)

Change to Data Element: Changed Description

Format/Length:	See DATE AND TIME
National Codes:	
Default Codes:	

Notes:

~~PROCEDURE DATE AND TIME (PLACED ON ICE LEFT KIDNEY) is the same as data element DATE AND TIME of when the ORGAN OR TISSUE DONOR's left kidney was placed on ice.~~ PROCEDURE DATE AND TIME (PLACED ON ICE LEFT KIDNEY) is the same as data element PROCEDURE DATE AND TIME.

PROCEDURE DATE AND TIME (PLACED ON ICE LEFT KIDNEY) is the Procedure Date and Procedure Time of when the ORGAN OR TISSUE DONOR's left kidney was placed on ice.

PROCEDURE DATE AND TIME (PLACED ON ICE PANCREAS)

Change to Data Element: Changed Description

Format/Length:	See DATE AND TIME
National Codes:	
Default Codes:	

Notes:

~~PROCEDURE DATE AND TIME (PLACED ON ICE PANCREAS) is the same as data element DATE AND TIME of when the ORGAN OR TISSUE DONOR's pancreas was placed on ice.~~ PROCEDURE DATE AND TIME (PLACED ON ICE PANCREAS) is the same as data element PROCEDURE DATE AND TIME.

PROCEDURE DATE AND TIME (PLACED ON ICE PANCREAS) is the Procedure Date and Procedure Time of when the ORGAN OR TISSUE DONOR's pancreas was placed on ice.

PROCEDURE DATE AND TIME (PLACED ON ICE RIGHT KIDNEY)

Change to Data Element: Changed Description

Format/Length:	See DATE AND TIME
National Codes:	
Default Codes:	

Notes:

~~PROCEDURE DATE AND TIME (PLACED ON ICE RIGHT KIDNEY) is the same as data element DATE AND TIME of when the ORGAN OR TISSUE DONOR's right kidney was placed on ice.~~ PROCEDURE DATE AND TIME (PLACED ON ICE RIGHT KIDNEY) is the same as data element PROCEDURE DATE AND TIME.

PROCEDURE DATE AND TIME (PLACED ON ICE RIGHT KIDNEY) is the Procedure Date and Procedure Time of when the ORGAN OR TISSUE DONOR's right kidney was placed on ice.

PROCEDURE DATE AND TIME (RETINOPATHY OF PREMATURITY SCREENING)

Change to Data Element: Changed Description

Format/Length:	See DATE AND TIME
National Codes:	
Default Codes:	

Notes:

~~PROCEDURE DATE AND TIME (RETINOPATHY OF PREMATURITY SCREENING) is the same as Procedure Date and Time for Retinopathy of Prematurity Screening.~~ PROCEDURE DATE AND TIME (RETINOPATHY OF PREMATURITY SCREENING) is the same as data element PROCEDURE DATE AND TIME. PROCEDURE DATE AND TIME (RETINOPATHY OF PREMATURITY SCREENING) is the Procedure Date and Procedure Time for Retinopathy of Prematurity Screening.

PROCEDURE DATE AND TIME (START RESUSCITATION UNCONTROLLED DONOR)

Change to Data Element: Changed Description

Format/Length:	See DATE AND TIME
National Codes:	
Default Codes:	

Notes:

~~PROCEDURE DATE AND TIME (START RESUSCITATION UNCONTROLLED DONOR) is the same as data element DATE AND TIME of the start of the CARE ACTIVITY procedure to resuscitate the uncontrolled ORGAN OR TISSUE DONOR.~~ PROCEDURE DATE AND TIME (START RESUSCITATION UNCONTROLLED DONOR) is the same as data element PROCEDURE DATE AND TIME. PROCEDURE DATE AND TIME (START RESUSCITATION UNCONTROLLED DONOR) is the Procedure Date and Procedure Time of the start of the CARE ACTIVITY procedure to resuscitate the uncontrolled ORGAN OR TISSUE DONOR.

PROCEDURE DATE AND TIME (VENTILATION CEASED)

Change to Data Element: Changed Description

Format/Length:	See DATE AND TIME
National Codes:	
Default Codes:	

Notes:

~~PROCEDURE DATE AND TIME (VENTILATION CEASED) is the same as data element DATE AND TIME of the end of the CARE ACTIVITY procedure to ventilate an ORGAN OR TISSUE DONOR.~~ PROCEDURE DATE AND TIME (VENTILATION CEASED) is the same as data element PROCEDURE DATE AND TIME. PROCEDURE DATE AND TIME (VENTILATION CEASED) is the Procedure Date and Procedure Time of the end of the CARE ACTIVITY procedure to ventilate an ORGAN OR TISSUE DONOR.

PROCEDURE DATE AND TIME (VENTILATION STARTED)

Change to Data Element: Changed Description

Format/Length:	See DATE AND TIME
National Codes:	
Default Codes:	

Notes:

~~PROCEDURE DATE AND TIME (VENTILATION STARTED) is the same as data element DATE AND TIME of the start of the CARE ACTIVITY procedure to ventilate the transplant recipient.~~ PROCEDURE DATE AND TIME (VENTILATION STARTED) is the same as data element PROCEDURE DATE AND TIME. PROCEDURE DATE AND TIME (VENTILATION STARTED) is the Procedure Date and Procedure Time of the start of the CARE ACTIVITY procedure to ventilate the transplant recipient.

PROCEDURE DATE AND TIME (VENTILATION STOPPED)

Change to Data Element: Changed Description

Format/Length:	See DATE AND TIME
National Codes:	
Default Codes:	

Notes:

~~PROCEDURE DATE AND TIME (VENTILATION STOPPED) is the same as data element DATE AND TIME of the end of the CARE ACTIVITY procedure to ventilate the transplant recipient.~~ PROCEDURE DATE AND TIME (VENTILATION STOPPED) is the same as data element PROCEDURE DATE AND TIME. PROCEDURE DATE AND TIME (VENTILATION STOPPED) is the Procedure Date and Procedure Time of the end of the CARE ACTIVITY procedure to ventilate the transplant recipient.

PROCEDURE DATE TIME (CAESAREAN SECTION)

Change to Data Element: Changed Description

Format/Length:	See DATE AND TIME
----------------	-----------------------------------

National Codes:

Default Codes:

Notes:

~~PROCEDURE DATE TIME (CAESAREAN SECTION) is the same as Procedure Date and Time when the Caesarean Section took place during Labour and Delivery.~~ PROCEDURE DATE TIME (CAESAREAN SECTION) is the same as data element PROCEDURE DATE AND TIME. PROCEDURE DATE TIME (CAESAREAN SECTION) is the Procedure Date and Procedure Time of when the Caesarean Section took place during Labour and Delivery.

PROCEDURE DATE TIME (ULTRASOUND FETAL ANOMALY SCREENING)

Change to Data Element: Changed Description

Format/Length:

See [DATE AND TIME](#)

National Codes:

Default Codes:

Notes:

~~PROCEDURE DATE TIME (ULTRASOUND FETAL ANOMALY SCREENING) is the same as Procedure Date and Time for the Clinical Investigation of a fetal anomaly.~~ PROCEDURE DATE TIME (ULTRASOUND FETAL ANOMALY SCREENING) is the same as data element PROCEDURE DATE AND TIME. PROCEDURE DATE TIME (ULTRASOUND FETAL ANOMALY SCREENING) is the Procedure Date and Procedure Time of the fetal anomaly Ultrasound Scan In Pregnancy.

REFERRED TO SERVICE ASSESSMENT DATE

Change to Data Element: Changed Description

Format/Length:

See [DATE](#)

National Codes:

Default Codes:

Notes:

~~REFERRED TO SERVICE ASSESSMENT DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Referred To Service Assessment Date'.~~ REFERRED TO SERVICE ASSESSMENT DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is *Clinical Intervention Date*.

REFERRED TO SERVICE ASSESSMENT DATE is the DATE a PATIENT was assessed by a CARE PROFESSIONAL from a SERVICE which a PATIENT has been referred to.

REFERRED TO SERVICE ASSESSMENT TIME

Change to Data Element: Changed Description

Format/Length:

See [TIME](#)

National Codes:

Default Codes:

Notes:

~~REFERRED TO SERVICE ASSESSMENT TIME is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code 'Referred To Service Assessment Time'.~~ REFERRED TO SERVICE ASSESSMENT TIME is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is *Clinical Intervention Time*.

REFERRED TO SERVICE ASSESSMENT TIME is the TIME a PATIENT was assessed by a CARE PROFESSIONAL from a SERVICE which a PATIENT has been referred to.

RETINOBLASTOMA ASSESSMENT DATE

Change to Data Element: Changed linked Attribute, Description

Format/Length:

See [DATE](#)

National Codes:

Default Codes:

Notes:

RETINOBLASTOMA ASSESSMENT DATE is the same as attribute ACTIVITY DATE, where the ACTIVITY DATE TYPE is National Code 'Retinoblastoma Assessment Date'. RETINOBLASTOMA ASSESSMENT DATE is the same as attribute PERSON PROPERTY RECORDED DATE.

RETINOBLASTOMA ASSESSMENT DATE is the DATE on which retinoblastoma details were recorded during a Children Teenagers and Young Adults Cancer Care Spell.

RETINOBLASTOMA ASSESSMENT DATE

Change to Data Element: Changed linked Attribute, Description

RETINOBLASTOMA ASSESSMENT DATE**Attribute:**

ACTIVITY DATE

PERSON PROPERTY RECORDED DATE

RUPTURE OF MEMBRANES DATE TIME

Change to Data Element: Changed Description

Format/Length: See DATE AND TIME

National Codes:

Default Codes:

Notes:

RUPTURE OF MEMBRANES DATE TIME is the same as attribute ACTIVITY DATE and ACTIVITY TIME where the ACTIVITY DATE AND TIME TYPE is National Code 'Rupture of Membranes Date and Time'. RUPTURE OF MEMBRANES DATE TIME is the same as attribute ACTIVITY DATE and ACTIVITY TIME where the ACTIVITY DATE AND TIME TYPE is National Code 'Start Date' and 'Start Time' of the Rupture of Membranes during Labour and Delivery.

SCREENING TEST DATE

Change to Data Element: New Data Element

Format/Length: See DATE

National Codes:

Default Codes:

Notes:

SCREENING TEST DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Clinical Intervention Date'.

SCREENING TEST DATE is the DATE on which the Screening Test was performed.

In the case of cervical screening, this is the DATE the cervical smear was taken.

This data element is also known by these names:

Context	Alias
plural	SCREENING TEST DATES

SCREENING TEST DATE

Change to Data Element: New Data Element

SCREENING TEST DATE**Attribute:**

ACTIVITY DATE

SERVICE DISCHARGE DATE

Change to Data Element: Changed Description

Format/Length: See DATE

National Codes:

Default Codes:

Notes:

SERVICE DISCHARGE DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Service Discharge Date'. SERVICE DISCHARGE DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Discharge Date'. SERVICE DISCHARGE DATE is the DATE a PATIENT was discharged from a SERVICE.

SERVICE DISCHARGE TIME

Change to Data Element: Changed Description

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:

SERVICE DISCHARGE TIME is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code 'Service Discharge Time'. SERVICE DISCHARGE TIME is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code 'Discharge Time'. SERVICE DISCHARGE TIME is the TIME a PATIENT was discharged from a SERVICE.

SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Description

Format/Length:	an2
National Codes:	See SOURCE OF ADMISSION
Default Codes:	98 - Not applicable 99 - Not known: a validation error

Notes:

SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL) is the same as attribute SOURCE OF ADMISSION.

SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL) is the source of admission to a Hospital Provider Spell in a Hospital Site.

SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL) is used by the [Secondary Uses Service](#) to derive the [Healthcare Resource Group](#) 4. Failure to correctly populate this data element is likely to result in an incorrect [Healthcare Resource Group](#), usually associated with lower levels of Healthcare resource.

For further information, please refer to the [NHS Digital](#) website at: [Payment by Results Guidance](#).

SPEECH AND LANGUAGE ASSESSMENT DATE

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

SPEECH AND LANGUAGE ASSESSMENT DATE is the same as the attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Speech and Language Assessment Date'. SPEECH AND LANGUAGE ASSESSMENT DATE is the same as the attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Care Contact Date'. SPEECH AND LANGUAGE ASSESSMENT DATE is the DATE of a speech and language assessment following completion of treatment during a Head and Neck Cancer Care Spell.

STAGE GROUPING DATE (TESTICULAR CANCER)

Change to Data Element: Changed linked Attribute, Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

STAGE GROUPING DATE (TESTICULAR CANCER) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Stage Grouping Date (Testicular Cancer)'. STAGE GROUPING DATE (TESTICULAR CANCER) is the same as attribute PERSON PROPERTY

RECORDED DATE, STAGE GROUPING DATE (TESTICULAR CANCER) is the DATE on which STAGE GROUPING (TESTICULAR CANCER) was recorded during a Urological Cancer Care Spell.

STAGE GROUPING DATE (TESTICULAR CANCER)

Change to Data Element: Changed linked Attribute, Description

STAGE GROUPING DATE (TESTICULAR CANCER)

Attribute:

ACTIVITY DATE

PERSON PROPERTY RECORDED DATE

STAGE GROUPING DATE (TESTICULAR CANCER)

Change to Data Element: Changed linked Attribute, Description

- null
- Changed Description

START DATE

Change to Data Element: Changed Description

Format/Length:	See <u>DATE</u>
National Codes:	
Default Codes:	

Notes:

START DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Start Date'.

START DATE (ANTI-CANCER DRUG REGIMEN)

Change to Data Element: Changed Description

Format/Length:	See <u>DATE</u>
National Codes:	
Default Codes:	

Notes:

START DATE (ANTI-CANCER DRUG REGIMEN) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Start Date' of the Anti-Cancer Drug Regimen.

This should be recorded if the First Definitive Treatment is Chemotherapy and/or other anti-cancer drug treatments.

START DATE (ANTI-CANCER DRUG REGIMEN) is the ACTIVITY DATE of the Anti-Cancer Drug Programme where the Planned Cancer Treatment is for PLANNED CANCER TREATMENT TYPE National Code 'Chemotherapy' or 'Hormone Therapy' and FIRST DEFINITIVE TREATMENT PROVIDED is classification 'First Definitive Treatment planned'.

START DATE (ASSIGNMENT PAYSACLE)

Change to Data Element: Changed Description

Format/Length:	See <u>DATE</u>
<u>NWDS</u> ID:	SGSD
<u>NWDS</u> Field Name:	Start Date in Grade
National Codes:	
Default Codes:	

Notes:

START DATE (ASSIGNMENT PAYSACLE) is the same as attribute ASSIGNMENT PAYSACLE POINT START DATE.

START DATE (CARE PROGRAMME APPROACH CARE)

Change to Data Element: Changed Description

Format/Length:	See <u>DATE</u>
National Codes:	
Default Codes:	

Notes:

[START DATE \(CARE PROGRAMME APPROACH CARE\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Care Programme Approach](#) care for the [PATIENT](#).

START DATE (COMMISSIONER ASSIGNMENT PERIOD)

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

[START DATE \(COMMISSIONER ASSIGNMENT PERIOD\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Commissioner Assignment Period](#). [START DATE \(COMMISSIONER ASSIGNMENT PERIOD\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Commissioner Assignment Period](#).

START DATE (EPISODE)

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

[START DATE \(EPISODE\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the episode.

[START DATE \(EPISODE\)](#) is used by the [Secondary Uses Service](#) to derive the [Healthcare Resource Group 4](#). Failure to correctly populate this data element is likely to result in an incorrect [Healthcare Resource Group](#), usually associated with lower levels of healthcare resource.

For further information, please refer to the [NHS Digital](#) website at: [Payment by Results Guidance](#).

START DATE (ERYTHROPOIETIN EPISODE)

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

[START DATE \(ERYTHROPOIETIN EPISODE\)](#) is the same as the attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' for the start of a course of treatment with Erythropoietin Stimulating Agents.

START DATE (FINAL SYSTEMIC ANTI-CANCER THERAPY)

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

[START DATE \(FINAL SYSTEMIC ANTI-CANCER THERAPY\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Systemic Anti-Cancer Drug Regimen](#).

[START DATE \(FINAL SYSTEMIC ANTI-CANCER THERAPY\)](#) is the [Start Date](#) of the final cycle of [Chemotherapy](#) within a [Systemic Anti-Cancer Drug Regimen](#), which is the [End Date](#) of the [Chemotherapy](#) treatment.

START DATE (GMP PATIENT REGISTRATION)

Change to Data Element: Changed linked Attribute, Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

START DATE (GMP PATIENT REGISTRATION) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Start Date' on which the PERSON registered with a General Medical Practitioner Practice. START DATE (GMP PATIENT REGISTRATION) is the same as attribute PERSON PROPERTY EFFECTIVE START DATE. START DATE (GMP PATIENT REGISTRATION) is the DATE on which the PERSON registered with a General Medical Practitioner Practice.

START DATE (GMP PATIENT REGISTRATION)

Change to Data Element: Changed linked Attribute, Description

START DATE (GMP PATIENT REGISTRATION)

Attribute:

ACTIVITY DATE

PERSON PROPERTY EFFECTIVE START DATE

START DATE (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Description

Format/Length: See DATE

National Codes:

Default Codes:

Notes:

START DATE (HOSPITAL PROVIDER SPELL) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Start Date' of the Hospital Provider Spell.

The Start Date of the Hospital Provider Spell is the date of admission: the CONSULTANT or MIDWIFE has assumed responsibility for care following the DECISION TO ADMIT the PATIENT. The Start Date of the Hospital Provider Spell is the DATE of admission: the CONSULTANT or MIDWIFE has assumed responsibility for care following the DECISION TO ADMIT the PATIENT.

START DATE (HOSPITAL PROVIDER SPELL) is used by the Secondary Uses Service to derive the Healthcare Resource Group 4. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

START DATE (KIDNEY PERFUSION LEFT KIDNEY)

Change to Data Element: Changed Description

Format/Length: See DATE

National Codes:

Default Codes:

Notes:

START DATE (KIDNEY PERFUSION LEFT KIDNEY) is the same as the attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Start Date' for the commencement of left kidney cold perfusion. START DATE (KIDNEY PERFUSION LEFT KIDNEY) is the same as the attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Start Date' for the commencement of left kidney cold perfusion.

START DATE (KIDNEY PERFUSION RIGHT KIDNEY)

Change to Data Element: Changed Description

Format/Length: See DATE

National Codes:

Default Codes:

Notes:

START DATE (KIDNEY PERFUSION RIGHT KIDNEY) is the same as the attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Start Date' for the commencement of right kidney cold perfusion. START DATE (KIDNEY PERFUSION RIGHT KIDNEY) is the same as the attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Start Date' for the commencement of right kidney cold perfusion.

START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)

Change to Data Element: Changed Description

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

~~[START DATE \(MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Mental Health Act Legal Status Classification Assignment Period](#).~~ [START DATE \(MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Mental Health Act Legal Status Classification Assignment Period](#).

START DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD)

Change to Data Element: Changed Description

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

~~[START DATE \(MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Mental Health Responsible Clinician Assignment Period](#).~~ [START DATE \(MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Mental Health Responsible Clinician Assignment Period](#).

START DATE (PERITONEAL DIALYSIS TREATMENT REGIME)

Change to Data Element: Changed Description

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[START DATE \(PERITONEAL DIALYSIS TREATMENT REGIME\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)'.

[START DATE \(PERITONEAL DIALYSIS TREATMENT REGIME\)](#) is the [START DATE](#) of the [PATIENT](#)'s [PERITONEAL DIALYSIS TREATMENT REGIME](#).

START DATE (RENAL PAEDIATRIC TRANSITION PROGRAMME)

Change to Data Element: Changed Description

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

~~[START DATE \(RENAL PAEDIATRIC TRANSITION PROGRAMME\)](#) is the same as attribute [ACTIVITY DATE](#) where [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)'.~~ [START DATE \(RENAL PAEDIATRIC TRANSITION PROGRAMME\)](#) is the same as attribute [ACTIVITY DATE](#) where [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)'.

[START DATE \(RENAL PAEDIATRIC TRANSITION PROGRAMME\)](#) is the [DATE](#) when a referral to adult renal services is made.

START DATE (RENAL TREATMENT MODALITY)

Change to Data Element: Changed Description

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

~~[START DATE \(RENAL TREATMENT MODALITY\)](#) is the same as attribute [ACTIVITY DATE](#) where [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' for the renal treatment modality.~~ [START DATE \(RENAL TREATMENT MODALITY\)](#) is the same as attribute [ACTIVITY DATE](#) where [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' for the renal treatment modality.

START DATE (SYSTEMIC ANTI-CANCER DRUG CYCLE)

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

[START DATE \(FINAL SYSTEMIC ANTI-CANCER THERAPY\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Systemic Anti-Cancer Drug Cycle](#).

[START DATE \(SYSTEMIC ANTI-CANCER DRUG CYCLE\)](#) is the date of the first drug administration in each [Systemic Anti-Cancer Drug Cycle](#).

START DATE (TREATMENT FOR DIALYSIS RELATED INFECTION)

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

[START DATE \(TREATMENT FOR DIALYSIS RELATED INFECTION\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is '[Start Date](#)' for the start of a course of treatment for an infection caused by a prior [CARE ACTIVITY](#) for peritoneal dialysis. [START DATE \(TREATMENT FOR DIALYSIS RELATED INFECTION\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' for the start of a course of treatment for an infection caused by a prior [CARE ACTIVITY](#) for peritoneal dialysis.

START DATE (WARD STAY)

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

[START DATE \(WARD STAY\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Ward Stay](#).

START TIME (HOME LEAVE)

Change to Data Element: Changed Description

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:

[START TIME \(HOME LEAVE\)](#) is the same as the attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Start Time](#)' of the [Home Leave](#).

START TIME (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Description

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:

[START TIME \(HOSPITAL PROVIDER SPELL\)](#) is the same as the attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Start Time](#)' of the [Hospital Provider Spell](#).

START TIME (KIDNEY PERFUSION LEFT KIDNEY)

Change to Data Element: Changed Description

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:

[START TIME \(KIDNEY PERFUSION LEFT KIDNEY\)](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Start Time](#)' for the commencement of left kidney cold perfusion.

START TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE)

Change to Data Element: Changed Description

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:

[START TIME \(MENTAL HEALTH ABSENCE WITHOUT LEAVE\)](#) is the same as the attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Start Time](#)' of the [Mental Health Absence Without Leave](#).

START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)

Change to Data Element: Changed Description

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:

[START TIME \(MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD\)](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Start Time](#)' of the [Mental Health Act Legal Status Classification Assignment Period](#).

START TIME (MENTAL HEALTH LEAVE OF ABSENCE)

Change to Data Element: Changed Description

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:

[START TIME \(MENTAL HEALTH LEAVE OF ABSENCE\)](#) is the same as the attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Start Time](#)' of the [Mental Health Leave of Absence](#).

START TIME (MENTAL HEALTH TRIAL LEAVE)

Change to Data Element: Changed Description

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:

[START TIME \(MENTAL HEALTH TRIAL LEAVE\)](#) is the same as the attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Start Time](#)' of the [Mental Health Trial Leave](#).

SYSTEMIC ANTI-CANCER THERAPY ADMINISTRATION DATE

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

[SYSTEMIC ANTI-CANCER THERAPY ADMINISTRATION DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Systemic Anti-Cancer Therapy Administration Date](#)'. [SYSTEMIC ANTI-CANCER THERAPY ADMINISTRATION DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Care Contact Date](#)'.

[SYSTEMIC ANTI-CANCER THERAPY ADMINISTRATION DATE](#) is the date on which the [Chemotherapy](#) was administered to a [PATIENT](#), an infusion commenced, or an oral drug was initially dispensed to the [PATIENT](#). [SYSTEMIC ANTI-CANCER THERAPY ADMINISTRATION DATE](#) is the [DATE](#) on which the [Chemotherapy](#) was administered to a [PATIENT](#), an infusion commenced, or an oral drug was initially dispensed to the [PATIENT](#).

[SYSTEMIC ANTI-CANCER THERAPY ADMINISTRATION DATE](#):

- Identifies each contact between the [PATIENT](#) and the [Chemotherapy](#) [CARE PROFESSIONAL TEAM](#) when [Chemotherapy](#) is administered

- Is recorded for:
 - Admitted PATIENT treatment, Chemotherapy Out-Patient Clinic attendances, attendances in a primary care setting and domiciliary administration by a specialist team (i.e. oncology, haematology or paediatrics)
 - Infusions, the day the infusion was commenced and
 - Continuous oral Chemotherapy, the first day of the nominal cycle i.e. one Systemic Anti-Cancer Therapy Administration Date per 28 days.

SYSTEMIC ANTI-CANCER THERAPY REGIMEN MODIFICATION INDICATOR (TIME DELAY)

Change to Data Element: Changed Description

Format/Length:	an1
National Codes:	See SYSTEMIC ANTI-CANCER THERAPY REGIMEN MODIFICATION INDICATOR
Default Codes:	

Notes:

[SYSTEMIC ANTI-CANCER THERAPY REGIMEN MODIFICATION INDICATOR \(TIME DELAY\)](#) is the same as attribute [SYSTEMIC ANTI-CANCER THERAPY REGIMEN MODIFICATION INDICATOR](#).

An indication of whether a [Systemic Anti Cancer Drug Regimen](#) was modified by extending the time between [Systemic Anti Cancer Therapy Administration Dates](#). An indication of whether a [Systemic Anti-Cancer Drug Regimen](#) was modified by extending the time between [SYSTEMIC ANTI-CANCER THERAPY ADMINISTRATION DATES](#).

Note: Time delays of 5 days or fewer are discounted to allow for bank holidays or other incidental interruptions not related to drug tolerance.

TNM STAGE GROUPING DATE (FINAL PRETREATMENT)

Change to Data Element: Changed linked Attribute, Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

[TNM STAGE GROUPING DATE \(FINAL PRETREATMENT\)](#) is the same as attribute [ACTIVITY DATE](#), where the [ACTIVITY DATE TYPE](#) is National Code [TNM Stage Grouping Date \(Final Pretreatment\)](#). [TNM STAGE GROUPING DATE \(FINAL PRETREATMENT\)](#) is the same as attribute [PERSON PROPERTY RECORDED DATE](#).

[TNM STAGE GROUPING DATE \(FINAL PRETREATMENT\)](#) is the [DATE](#) on which [TNM STAGE GROUPING \(FINAL PRETREATMENT\)](#) was recorded during a [Cancer Care Spell](#).

TNM STAGE GROUPING DATE (FINAL PRETREATMENT)

Change to Data Element: Changed linked Attribute, Description

TNM STAGE GROUPING DATE (FINAL PRETREATMENT)

Attribute:

ACTIVITY DATE
PERSON PROPERTY RECORDED DATE

TNM STAGE GROUPING DATE (INTEGRATED)

Change to Data Element: Changed linked Attribute, Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

[TNM STAGE GROUPING DATE \(INTEGRATED\)](#) is the same as attribute [ACTIVITY DATE](#), where the [ACTIVITY DATE TYPE](#) is National Code [TNM Stage Grouping Date \(Integrated\)](#). [TNM STAGE GROUPING DATE \(INTEGRATED\)](#) is the same as attribute [PERSON PROPERTY RECORDED DATE](#).

[TNM STAGE GROUPING DATE \(INTEGRATED\)](#) is the [DATE](#) on which [TNM STAGE GROUPING \(INTEGRATED\)](#) was recorded during a [Cancer Care Spell](#).

TNM STAGE GROUPING DATE (INTEGRATED)

Change to Data Element: Changed linked Attribute, Description

TNM STAGE GROUPING DATE (INTEGRATED)

Attribute:

[ACTIVITY DATE](#)

[PERSON PROPERTY RECORDED DATE](#)

TRANSFER START DATE TIME (NEONATAL UNIT)

Change to Data Element: Changed Description

Format/Length: See [DATE AND TIME](#)
National Codes:
Default Codes:

Notes:

[TRANSFER START DATE TIME \(NEONATAL UNIT\)](#) is the same as attribute [ACTIVITY DATE](#) and [ACTIVITY TIME](#) where the [ACTIVITY DATE AND TIME TYPE](#) is National Code '[Transfer Start Date and Time \(Neonatal Unit\)](#)'. [TRANSFER START DATE TIME \(NEONATAL UNIT\)](#) is the same as attribute [ACTIVITY DATE](#) and [ACTIVITY TIME](#) where the [ACTIVITY DATE AND TIME TYPE](#) is National Code '[Transfer Start Date and Time \(Neonatal Unit\)](#)'.

For the [Neonatal Critical Care Minimum Data Set](#), [TRANSFER START DATE TIME \(NEONATAL UNIT\)](#) is equivalent to the [CRITICAL CARE START DATE](#) and [CRITICAL CARE START TIME](#) when the [CRITICAL CARE PERIOD](#) for a [Neonate](#) begins.

TRANSPLANT PATIENT LAST CONTACT DATE

Change to Data Element: Changed Description

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[TRANSPLANT PATIENT LAST CONTACT DATE](#) is derived from the last [Contact Date](#) for the [PATIENT](#). [TRANSPLANT PATIENT LAST CONTACT DATE](#) is derived from the last [Care Contact Date](#) for the [PATIENT](#).

TREATMENT START DATE (CANCER)

Change to Data Element: Changed Description

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[TREATMENT START DATE \(CANCER\)](#) is the same as attribute [ACTIVITY DATE](#), where the [ACTIVITY DATE TYPE](#) is National Code '[Treatment Start Date \(Cancer\)](#)'. [TREATMENT START DATE \(CANCER\)](#) is the same as attribute [ACTIVITY DATE](#), where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of a CLINICAL INTERVENTION. [TREATMENT START DATE \(CANCER\)](#) is the [Start Date](#) of the first, second or subsequent cancer treatment given to a [PATIENT](#) who is receiving care for a cancer condition.

If the [CANCER TREATMENT MODALITY](#) is recorded as National Code '[Surgery](#)', the [TREATMENT START DATE \(CANCER\)](#) is the same as [START DATE \(HOSPITAL PROVIDER SPELL\)](#) of the related admission.

[TREATMENT START DATE \(CANCER\)](#) is also the [END DATE](#) of a [Cancer Referral To Treatment Period](#).

A [Cancer Referral To Treatment Period](#) will end on the same [DATE](#) as the [TREATMENT START DATE \(CANCER\)](#) where [First Definitive Treatment](#) is given, unless cancer was discounted when the [PATIENT](#) was first seen (in which case the [Cancer Referral To Treatment Period](#) is ended at [DATE FIRST SEEN](#)).

If a [PATIENT](#) declines all treatment and the [CANCER TREATMENT MODALITY](#) is recorded as National Code '[All treatment declined](#)', then the [TREATMENT START DATE \(CANCER\)](#) should be recorded as the [DATE](#) upon which the [PATIENT](#) made this decision.

For the [National Cancer Waiting Times Monitoring Data Set](#), [TREATMENT START DATE \(CANCER\)](#) is for a cancer condition with a [PRIMARY DIAGNOSIS \(ICD\)](#) code defined by [NHS England](#). The full list of diagnosis codes can be found on the [NHS Digital](#) website at: [Cancer Waiting Times](#).

TREATMENT START DATE (RADIO THERAPY TREATMENT EPISODE)

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

~~[TREATMENT START DATE \(RADIOTHERAPY TREATMENT EPISODE\)](#) is the same as attribute [ACTIVITY DATE](#), where the [ACTIVITY DATE TYPE](#) is National Code '[Treatment Start Date \(Cancer\)](#)'.~~ [TREATMENT START DATE \(RADIOTHERAPY TREATMENT EPISODE\)](#) is the same as data element [TREATMENT START DATE \(CANCER\)](#).

~~[TREATMENT START DATE \(RADIOTHERAPY TREATMENT EPISODE\)](#) is the [Treatment Start Date \(Cancer\)](#) where the treatment is being undertaken as part of a [Cancer Treatment Period](#) and where the [CANCER TREATMENT MODALITY](#) is National Code '[Teletherapy](#)' or '[Brachytherapy](#)'.~~ [TREATMENT START DATE \(RADIOTHERAPY TREATMENT EPISODE\)](#) is the [TREATMENT START DATE \(CANCER\)](#) where the treatment is being undertaken as part of a [Cancer Treatment Period](#) and where the [CANCER TREATMENT MODALITY](#) is National Code '[Teletherapy](#)' or '[Brachytherapy](#)'.

[TREATMENT START DATE \(RADIOTHERAPY TREATMENT EPISODE\)](#) is the [DATE](#) that treatment for a [PATIENT](#)'s condition using a [RADIOTHERAPY TREATMENT MODALITY](#) started.

For the [Radiotherapy Data Set](#), [TREATMENT START DATE \(RADIOTHERAPY TREATMENT EPISODE\)](#) is the [DATE](#) the first [Fraction](#) of [Radiotherapy](#) was given to the [PATIENT](#) in the [Radiotherapy Episode](#).

TWO YEAR NEONATAL OUTCOMES ASSESSMENT DATE

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

~~[TWO YEAR NEONATAL OUTCOMES ASSESSMENT DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is '[Two Year Neonatal Outcomes Assessment Date](#)'.~~ [TWO YEAR NEONATAL OUTCOMES ASSESSMENT DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is '[Care Contact Date](#)'.

[TWO YEAR NEONATAL OUTCOMES ASSESSMENT DATE](#) is the [DATE](#) on which a [Two Year Neonatal Outcomes Assessment](#) was carried out.

WAITING TIME ADJUSTMENT (TREATMENT)

Change to Data Element: Changed Description

Format/Length:	max n3
National Codes:	
Default Codes:	

Notes:

~~[WAITING TIME ADJUSTMENT \(TREATMENT\)](#) records the number of days that should be removed from the derived waiting time between [Cancer Treatment Period Start Date](#) and [Treatment Start Date \(Cancer\)](#).~~ [WAITING TIME ADJUSTMENT \(TREATMENT\)](#) records the number of days that should be removed from the derived waiting time between [CANCER TREATMENT PERIOD START DATE](#) and [TREATMENT START DATE \(CANCER\)](#).

The recording of this data item is mandatory for all [Tumours](#), regardless of whether a national service standard is in place.

Adjustments are allowed in the following circumstances:

- When a patient pause is initiated because the [PATIENT](#) is unavailable for treatment for a specified period because of family commitments, holidays, or other (non-clinical) reasons

[WAITING TIME ADJUSTMENT \(TREATMENT\)](#) should only be recorded where [CANCER CARE SETTING \(TREATMENT\)](#) is:

- National Code '[Cancer treatment delivered as part of a Hospital Provider Spell](#)' (where [PATIENT CLASSIFICATION](#) is National Code '[Ordinary admission](#)') or
- National Code '[Cancer treatment delivered as part of a Hospital Provider Spell](#)' (where [PATIENT CLASSIFICATION](#) is National Code '[Day case admission](#)').

Guidance on calculating the number of days which may be removed from the waiting time is available on the [NHS Digital](#) website at: [Cancer Waiting Times](#).

WILMS TUMOUR STAGE DATE

Change to Data Element: Changed linked Attribute, Description

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[WILMS TUMOUR STAGE DATE](#) is the same as attribute [ACTIVITY DATE](#), where the [ACTIVITY DATE TYPE](#) is National Code [Wilms Tumour Stage Date](#). [WILMS TUMOUR STAGE DATE](#) is the same as attribute [PERSON PROPERTY RECORDED DATE](#).

[WILMS TUMOUR STAGE DATE](#) is the [DATE](#) on which [WILMS TUMOUR STAGE](#) was recorded during a [Children Teenagers and Young Adults Cancer Care Spell](#).

WILMS TUMOUR STAGE DATE

Change to Data Element: Changed linked Attribute, Description

WILMS TUMOUR STAGE DATE

Attribute:

[ACTIVITY DATE](#)

[PERSON PROPERTY RECORDED DATE](#)

WOMEN INVITED FOR SCREENING IN LAST THREE YEARS TOTAL (CALL AND RECALL)

Change to Data Element: Changed Description

Format/Length: max n7
National Codes:
Default Codes:

Notes:

[WOMEN INVITED FOR SCREENING IN LAST THREE YEARS TOTAL \(CALL AND RECALL\)](#) is the total number of women:

- with a [BREAST SCREENING CALL STATUS](#) recorded as National Code 'Call', 'Routine Call' or 'Early/short term recall'
- who are sent a [Breast Screening](#) test invitation by the [NHS Breast Screening Programme](#)
- and have a first [Screening Test Date](#) offered in the 36 months up to the [REPORTING PERIOD END DATE](#).
- and have a first [SCREENING TEST DATE](#) offered in the 36 months up to the [REPORTING PERIOD END DATE](#).

WOMEN INVITED FOR SCREENING IN PERIOD TOTAL (CALL AND RECALL)

Change to Data Element: Changed Description

Format/Length: max n7
National Codes:
Default Codes:

Notes:

[WOMEN INVITED FOR SCREENING IN PERIOD TOTAL \(CALL AND RECALL\)](#) is the total number of women:

- with a [BREAST SCREENING CALL STATUS](#) recorded as National Code 'Call', 'Routine Call' or 'Early/short term recall'
- who are sent a [Breast Screening](#) test invitation by the [NHS Breast Screening Programme](#)
- and have a first [Screening Test Date](#) offered between the [REPORTING PERIOD START DATE](#) and the [REPORTING PERIOD END DATE](#).
- and have a first [SCREENING TEST DATE](#) offered between the [REPORTING PERIOD START DATE](#) and the [REPORTING PERIOD END DATE](#).

WOMEN INVITED TOTAL (OPEN BREAST SCREENING EPISODE)

Change to Data Element: Changed Description

Format/Length: max n3
National Codes:
Default Codes:

Notes:

[WOMEN INVITED TOTAL \(OPEN BREAST SCREENING EPISODE\)](#) is the total number of women with an [Open Breast Screening Episode](#) with a first offered [Appointment Date](#) resulting from either an invitation for a [Breast Screening](#) test or a [REFERRAL REQUEST](#). [WOMEN INVITED TOTAL](#)

([OPEN BREAST SCREENING EPISODE](#)) is the total number of women with an [Open Breast Screening Episode](#) with a first offered [APPOINTMENT DATE](#) resulting from either an invitation for a [Breast Screening](#) test or a [REFERRAL REQUEST](#).

WOMEN NOT INVITED TOTAL (OPEN BREAST SCREENING EPISODE)

Change to Data Element: Changed Description

Format/Length:	max n4
National Codes:	
Default Codes:	

Notes:

~~[WOMEN NOT INVITED TOTAL \(OPEN BREAST SCREENING EPISODE\)](#) is the total number of women with an [Open Breast Screening Episode](#) without a first offered [Appointment Date](#).~~ [WOMEN NOT INVITED TOTAL \(OPEN BREAST SCREENING EPISODE\)](#) is the total number of women with an [Open Breast Screening Episode](#) without a first offered [APPOINTMENT DATE](#). The women may have been selected for [Breast Screening](#) but have not yet been sent an invitation for a [Mammogram](#).

WOMEN SCREENED IN LAST THREE YEARS TOTAL (CALL AND RECALL)

Change to Data Element: Changed Description

Format/Length:	max n7
National Codes:	
Default Codes:	

Notes:

[WOMEN SCREENED IN LAST THREE YEARS TOTAL \(CALL AND RECALL\)](#) is the total number of women who have a:

- [BREAST SCREENING CALL STATUS](#) recorded as National Code 'Call', 'Routine Call' or 'Early/short term recall'
- [Mammogram](#) invitation by the [NHS Breast Screening Programme](#)
- first [Screening Test Date](#) offered in the 36 months up to the [REPORTING PERIOD END DATE](#)
- First [SCREENING TEST DATE](#) offered in the 36 months up to the [REPORTING PERIOD END DATE](#)
- [BREAST SCREENING MAMMOGRAPHY OUTCOME CODE](#).

WOMEN SCREENED IN LAST THREE YEARS TOTAL (SELF AND GP REFERRALS)

Change to Data Element: Changed Description

Format/Length:	max n6
National Codes:	
Default Codes:	

Notes:

[WOMEN SCREENED IN LAST THREE YEARS TOTAL \(SELF AND GP REFERRALS\)](#) is the total number of women with a:

- [REFERRAL REQUEST](#) for a [Mammogram](#)
- [SCREENING REFERRAL SOURCE](#) recorded as National Code 'Self-referral' or 'General Medical Practitioner'
- [Screening Test Date](#) in 36 months up to the [REPORTING PERIOD END DATE](#)
- [SCREENING TEST DATE](#) in 36 months up to the [REPORTING PERIOD END DATE](#)
- [BREAST SCREENING MAMMOGRAPHY OUTCOME CODE](#).

WOMEN SCREENED IN PERIOD TOTAL (CALL AND RECALL)

Change to Data Element: Changed Description

Format/Length:	max n7
National Codes:	
Default Codes:	

Notes:

[WOMEN SCREENED IN PERIOD TOTAL \(CALL AND RECALL\)](#) is the total number of women with a:

- [BREAST SCREENING CALL STATUS](#) recorded as National Code 'Call', 'Routine Call' or 'Early/short term recall'
- [Screening Test](#) invitation by the [NHS Breast Screening Programme](#)
- first [Screening Test Date](#) offered between the [REPORTING PERIOD START DATE](#) and the [REPORTING PERIOD END DATE](#)
- First [SCREENING TEST DATE](#) offered between the [REPORTING PERIOD START DATE](#) and the [REPORTING PERIOD END DATE](#)
- [BREAST SCREENING MAMMOGRAPHY OUTCOME CODE](#).

WOMEN SCREENED IN PERIOD TOTAL (SELF AND GP REFERRALS)

Change to Data Element: Changed Description

Format/Length:	max n6
National Codes:	
Default Codes:	

Notes:

WOMEN SCREENED IN PERIOD TOTAL (SELF AND GP REFERRALS) is the total number of women with a:

- REFERRAL REQUEST for a Screening Test
- SCREENING REFERRAL SOURCE recorded as National Code 'Self-referral' or 'General Medical Practitioner'
- Screening Test Date between the REPORTING PERIOD START DATE and the REPORTING PERIOD END DATE
- SCREENING TEST DATE between the REPORTING PERIOD START DATE and the REPORTING PERIOD END DATE
- BREAST SCREENING MAMMOGRAPHY OUTCOME CODE.

For enquiries about this Change Request, please email information.standards@nhs.net

