WELSH INFORMATION STANDARDS BOARD

DSC Notice:	DSCN 2015 / 03
Date of Issue:	4th February 2015

Ministerial / Official Letter: WHC 2015 / 006	**Subject:** Radiotherapy Data Set
Sponsor: Chris Dawson Head of Major Health Conditions Welsh Government	
Implementation Date: 1st October 2014 – 31st March 2014 Phased Implementation / Testing Data Set to be fully operational: 1st April 2015	

DATA SET CHANGE NOTICE

A Data Set Change Notice (DSCN) is an information mandate for a new or revised information standard.

This DSCN was approved by the Welsh Information Standards Board (WISB) at its meeting on the 18th September 2015

WISB Reference: ISRN 2013 / 001

Summary:

To introduce the Radiotherapy Data Set and associated data definitions.

Data sets / returns affected:

- Radiotherapy Data Set

Please address enquiries about this Data Set Change Notice to the Data Standards Team in NHS Wales Informatics Service

E-mail: data.standards@wales.nhs.uk / Tel: 029 2050 2539

The Welsh Information Standards Board is responsible for appraising information standards.

Submission documents and WISB Outcomes relating to the approval of this standard can be found at:

http://howis.wales.nhs.uk/sites3/page.cfm?orgid=742&pid=24632

DATA SET CHANGE NOTICE

Introduction

The 'National Radiotherapy Data Set' was developed to support consistent collection of a set of technical and clinical information on patients undergoing radiotherapy in England and was implemented on the 1st April 2009 via English DSCN 22/2008. The latest version of the Data Set (Version 4) was implemented in April 2014 via ISN Amd 26/2012.

The purpose of the data set is to improve availability and use (locally and centrally) of data already held about treatment given to patients by radiotherapy facilities and to direct the development of systems supporting data collection and use in the small number of facilities that do not yet hold such data.

The National Clinical Analysis and Specialised Applications Team (NATCANSAT) provide a Radiotherapy Data Set (RTDS) Management Service to England and Scotland.

The RTDS management service includes but is not limited to:

- Provision of NATCANSAT toolkits
- IT Support
- Helpdesk support for data collection, processing and submission.
- Secure transfer, receipt and quality assurance of submission.
- Validation reports via the RTDS microsite within 1 week.
- Benchmarked reports against UK providers via the microsite.
- Provision of monthly summary extracts to the Welsh Cancer Registry.
- Publication of catchment area mapping and populations per annum.

The NHS Wales Informatics Service (NWIS) committed to supporting the implementation of a Radiotherapy Data Set in Wales. It was agreed to proceed with provision of the RTDS Management Service from England. Subsequently NWIS entered in to an agreement with NATCANSAT to underpin this service provision.

This new standard will impact on three centres that deliver radiotherapy services in Wales:

- Velindre Cancer Centre, Cardiff
- Singleton Oncology Centre, Swansea
- North Wales Cancer Treatment Centre, Rhyl

The Welsh Data Set is a subset of the 'National Radiotherapy Data Set' focusing on the radiotherapy specific data items with a limited number of demographic data items.

The scope relates to every patient receiving the following types of radiotherapy:

- All Teletherapy
- All Brachytherapy given using automated remote afterloading machines
- All other Brachytherapy given for the treatment of Malignant Disease

The Radiotherapy Data Set is generated by Toolkits provided by the RTDS Management Service. These toolkits take local data from Oncology Management Systems and defined extracts from the Patient Administration System (PAS), converting the data into the output expected by RTDS. It is recognised that the codes and descriptions used locally may differ in format (e.g. defined field lengths at the point of user input) to what is required nationally in the RTDS. The data set and associated data definitions introduced in this DSCN are a reflection of how the data is ultimately stored and submitted to RTDS and not how the data is required to be captured and reported locally by the Cancer Centres.

Description of Change

To introduce the collection and submission of the Radiotherapy Data Set.

Data Dictionary Version

Where applicable, this DSCN reflects changes introduced by DSCN and/or DDCN since the release of version 4.6 of the NHS Wales Data Dictionary.

The changes introduced by such DSCNs will be published in version 4.7 of the NHS Wales Data Dictionary.

Actions Required

Actions for Local Health Boards

- Radiotherapy Centres to work with NATCANSAT on the installation of relevant toolkits to facilitate the submission of the radiotherapy data.
- The Radiotherapy Data Set is required to be submitted on a monthly basis by the 20th of each month. The extract should include all Radiotherapy Attendance records for the previous calendar month.
- All files should be sent in the format produced by the NATCANSAT toolkits via the N3 upload facility on http://www.natcansat.nhs.uk/rt/rtportal.aspx as an encrypted Microsoft Access file.

Actions for NHS Wales Informatics Service

- National Systems, Myrddin and CANISC will need to support the extract of demographic data to the toolkit to facilitate creation of the radiotherapy data set.

Appendix A: Table reflecting areas that are impacted as a result of this DSCN

The following table shows all applicable data sets, data items, terms and other associated areas that are linked with the changes documented within this DSCN.

Each data definition type is listed in alphabetical order and is shown in the sequence in which it appears in this DSCN.

Data Definition Type	Name	New/Retired/ Changed	Page Number
Data Sets & Aggregate Data Collections / Patient Level Data Sets	Radiotherapy Data Set	New	Page 4
Data Item	Birth Date	Changed	
Data Item	Code of Registered GP Practice	Changed	
Data Item	Consultant Code	Changed	
Data Item	Local Patient Identifier	Changed	
Data Item	NHS Number	Changed	
Data Item	Organisation Code (Code of Provider)	Changed	
Data Item	Patient's Name	Changed	
Data Item	Patients Usual Address	Changed	
Data Item	Postcode of Usual Address	Changed	
Data Item	Primary ICD Diagnostic Code	Changed	
Data Item	Primary OPCS Code	Changed	
Data Item	Procedure Date	Changed	
Data Item	Sex	Changed	
Data Item	Actual Fractions	New	
Data Item	Appointment Date	New	
Data Item	Decision to Treat Date (Radiotherapy Treatment Episode)	New	
Data Item	Earliest Clinically Appropriate Date	New	
Data Item	Machine Identifier	New	
Data Item	Number of Teletherapy Fields	New	
Data Item	Prescribed Fractions	New	
Data Item	Prescription Identifier	New	
Data Item	Radiotherapy Actual Dose	New	
Data Item	Radiotherapy Anatomical Treatment Site (OPCS)	New	
Data Item	Radiotherapy Attendance Identifier	New	
Data Item	Radiotherapy Beam Energy	New	
Data Item	Radiotherapy Beam Type	New	
Data Item	Radiotherapy Diagnosis (ICD10)	New	
Data Item	Radiotherapy Episode Identifier	New	
Data Item	Radiotherapy Field Identifier	New	
Data Item	Radiotherapy Intent	New	
Data Item	Radiotherapy Prescribed Dose	New	
Data Item	Radiotherapy Priority	New	
Data Item	Radiotherapy Treatment Modality	New	
Data Item	Radiotherapy Treatment Region	New	
Data Item	Referral Request Received Date	New	

Data Item	Time of Exposure	New	
Data Item	Treatment Start Date (Radiotherapy)	New	
Term	Fraction	New	
Term	Planned Cancer Treatment	New	
Term	Radiotherapy Episode	New	
Term	Radiotherapy Prescription	New	

Appendix B: Highlighted changes to be made to the NHS Wales Data Dictionary

Changes to the NHS Wales Data Dictionary are detailed below, with new text being highlighted in **blue** and deletions are shown with a ~~**strikethrough.**~~ The text shaded in **grey** shows existing text copied from the NHS Wales Data Dictionary.

a) New Section 'Patient Level Data Sets'

Radiotherapy Data Set

Return Submission Details

The Radiotherapy Data Set should be submitted to National Clinical Analysis and Specialised Applications Team (NATCANSAT) by the 20th of each month. The extracts should include all Radiotherapy Attendance records for the previous calendar month. Resubmissions can be made with prior agreement from NATCANSAT.

All data should be submitted in a National Clinical Analysis and Specialised Applications Team approved format. Data should be submitted using the N3 upload facility on http://www.natcansat.nhs.uk/rt/rtportal.aspx as an encrypted Microsoft Access file.

The RTDS Data Manual and Implementation Guidance can be accessed via the NATCANSAT Website: http://www.natcansat.nhs.uk/dlhandler.ashx?d=natcansat&f=RTDS Data Manual and Implementation Guidance v4.0.8.doc

Further information can be found at:

- National Clinical Analysis and Specialised Applications Team website: http://www.natcansat.nhs.uk/rt/rtds.aspx

Scope

All facilities providing Radiotherapy Services are required to return data to the National Clinical Analysis and Specialised Applications Team (NATCANSAT) for all activity undertaken on Teletherapy and Brachytherapy machines, and activity to treat malignant disease with radioisotopes not contained within a Teletherapy or Brachytherapy machine.

Data Set

Data Item	**Format**
Patient Details	
NHS Number	n10
Birth Date	CCYY-MM-DD
Sex	n1
Code of Registered GP Practice	an6
Local Patient Identifier	an10
Patient's Name (s)	Unstructured an70 or structured with two an35 elements
Patient Usual Address	an175 (5 lines each an35)
Postcode of Usual Address	an8
Attendance Details	

Radiotherapy Attendance Identifier	an12
Organisation Code (Code of Provider)	an5
Appointment Date	CCYY-MM-DD
Consultant Code	an8
Referral Request Received Date	CCYY-MM-DD
Primary ICD Diagnostic Code	an6
Procedure Date	CCYY-MM-DD
Primary OPCS Code	an4
Radiotherapy Episode Details	
Radiotherapy Episode Identifier	an50 (max)
Decision to Treat Date (Radiotherapy Treatment Episode)	CCYY-MM-DD
Earliest Clinically Appropriate Date	CCYY-MM-DD
Radiotherapy Priority	an1
Treatment Start Date (Radiotherapy Treatment Episode)	CCYY-MM-DD
Radiotherapy Diagnosis (ICD)	an6
Radiotherapy Intent	an2
Radiotherapy Prescription	
Prescription Identifier	max an50
Radiotherapy Treatment Region	max an2
Radiotherapy Anatomical Treatment Site (OPCS)	an6
Number of Teletherapy Fields	max n2
Radiotherapy Prescribed Dose	maxn3.max n2
Prescribed Fractions	max n3
Radiotherapy Actual Dose	max n3.max n2
Actual Fractions	max n3
Radiotherapy Treatment Modality	an2
Radiotherapy Exposure	
Radiotherapy Field Identifier	max an50
Machine Identifier	max an12
Radiotherapy Beam Type	an2
Radiotherapy Beam Energy	max n3.max n3
Time of Exposure	HH:MM:SS

b) Changes to existing Data Items

Birth Date

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
APC ds99	1st April 1999	
EAL ds	1st April 1999	
OP ds	1st April 1999	
CC ds	1st April 2007	
OPR ds	1st July 2008	
EDDS	1st April 2009	
PAP ds	1st April 2013	
SM ds	1st April 2014	
RTDS	1st April 2014	

Date of birth of patient / client.

Format: 8 digit numeric, CCYYMMDD

For Radiotherapy Data Set;
Format: CCYY-MM-DD

If the Date of Birth is unknown; use the date '11/11/1811' (that is 18111111)

Birth Date Status is associated with this data item and should be used to indicate whether Birth Date is supplied or is not applicable.

See Date Format

Value	Meaning	Valid From	Valid To
00000000	*Date of Birth Unknown*	*1st March 2006*	*31st January 2007*
18111111	Date of Birth Unknown	1st February 2007	

Code of Registered GP Practice

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
APC ds	1st September 2012	
EAL ds	1st April 1999	21st November 2012
OP ds	1st April 1999	

CC ds	1st April 2007	
RTDS	1st April 2014	

This is the code of the patient's registered General Practitioner (GP) Practice. This allows the practice to be notified about treatment received by the patient. The registered GP Practice may or may not be the same as the referring GP Practice.

Format: 6 character alpha-numeric

See Organisation Code

Consultant Code

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
APC	Pre 28th December 1995	
EAL	1st April 1999	21st November 2012
OP	1st April 1999	
EDDS	1st April 2009	31st March 2010
RTDS	1st April 2014	

Nationally agreed form for consultant code or Independent Nurse. It is the General Medical Council (GMC) code for the Consultant or the GP acting as a Consultant or locum Consultant, which is the unique identifier. The nurse's Registration Number will be used to identify the Independent Nurse.

Format: 8 character alpha-numeric

Value	Meaning	Valid From	Valid To
XXXXXXXX	Consultant code based upon General Medical Council registration number. The first character of the code is usually a 'C'. The 2nd to 8th characters are the GMC registration number.	Pre 28th December 1995	
LNNNNNNN	*Code for Limited Registered doctor. (Note: the first two digits will normally be the year in which limited registration was granted)*	*Pre 28th December 1995*	*28th February 2007*
DDNNNNNN DD/NNNNN	For Dental Consultants who have not been registered with the GMC the General Dental Council (GDC) number has to be used. (The slash character represents a space. The slash must not be used in data for central returns)	1st March 2007	
DD//NNNN	*For Dental Consultants who have not been registered with the GMC the General Dental Council (GDC) number has to be used. (The slash character represents a space. The slash must not be used in data for*	*Pre 28th December 1995*	*28th February 2007*

	central returns)		
C9999998	*Consultant code not known*	*1st May 1998*	*20th February 2002*
C9999998	For NHS patients treated overseas, if the overseas doctor does not have a GMC code.	21st June 2004	
D9999998	*Dentist Code not known*	*1st May 1998*	*20th February 2002*
M9999998	Midwife-led Activity If the patient episode is under the direct care of a Midwife the default Consultant Code must be M9999998 and the Treatment Function Code must be '560'.	1st April 2000 Amended 1st April 2006	
	For OP ds only:-		
YYYYYYYY	Independent Nurse The Nurse's Registration Number is used to record nurse-led activity in an Outpatients environment by an Independent Nurse	1st April 2006	

See GDC Registration Number
See GMC Registration Number

Local Patient Identifier

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
APC ds99	1st April 1999	
EAL ds	1st April 1999	21st November 2012
OP ds	1st April 1999	
OPR ds	1st July 2008	
EDDS	1st April 2009	
PAP ds	1st April 2013	
RTDS	1st April 2014	

This is the case record number. It is a unique identifier for a patient within a health care provider.

Format: 10 character alpha-numeric

See CASE RECORD NUMBER

Where care for NHS patients is sub-commissioned in the independent sector or overseas, the NHS commissioner local patient identifier should be used. If no NHS local patient identifier has been assigned the independent sector or overseas provider identifier should be used.

NHS Number

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
APC ds99	1st April 1999	
EAL ds	1st April 1999	
OP ds	1st April 1999	
OPR ds	1st July 2008	
EDDS	1st April 2009	
PAP ds	1st April 2013	
SM ds	1st April 2014	
RTDS	1st April 2014	

It is mandatory to record the NHS Number for each patient registered with a GP practice in England and Wales. The NHS number is allocated to an individual, to enable unique identification for NHS health care purposes.

This NHS Number format was mandated for use effective 1st November 1997. Prior to this, the NHS Number was an alphanumeric code which ranges in size from 10 – 17 characters. If known, the patient's Health and Care Number should be used to populate this field for patients resident in Northern Ireland.

If known, the patient's Community Health Index (CHI) Number should be used to populate this field for patients resident in Scotland.

Format: 10 digit numeric
See Health and Care Number
See Community Health Index (CHI) Number

Check Digit Algorithm

(This algorithm applies to the Welsh and English NHS Number and the Northern Ireland Health & Care Number. The check digit algorithm for the Scottish CHI Number is available on request.)

Step 1 Multiply each of the first nine digits by a weighting factor as follows:

Digit Position (starting from the left)	Factor
1	10
2	9
3	8
4	7
5	6
6	5

7	4
8	3
9	2

Step 2 Add the results of each multiplication together
Step 3 Divide the total by 11 and establish the remainder
Step 4 Subtract the remainder from 11 to give the check digit
Step 5 Check the remainder matches the check digit. If it does not, the number is invalid.
If the result of Step 4 is 11 then a check digit of 0 is used
If the result of Step 4 is 10 then the number is invalid and not used

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Organisation Code (Code of Provider)

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
APC ds99	1st April 1999	
EAL ds	1st April 1999	21st November 2012
OP ds	1st April 1999	
CC ds	1st April 2007	
OPR ds	1st July 2008	
DATS		
RTT	1st April 2007	31st August 2011
RTT-PTR	1st September 2008	30th September 2009
PP01W		
EDDS	1st April 2009	
RTT (Combined)	1st September 2011	
PAP ds	1st April 2013	
RTDS	1st April 2014	

This is the organisation code of the health care provider. The provider code identifies the health care provider who is responsible for managing the treatment of the patient.

Notes:

1. Healthcare providers may also act as commissioners when sub-contracting patient care services to other providers of health care.
2. Although the healthcare provider identified in this data item is responsible for managing the patient's treatment, it may not necessarily be where the treatment is actually conducted. For example, where the treatment has been sub-contracted to another healthcare provider.
3. For OPR ds, the Organisation Code (Code of Provider) is that of the organisation receiving the referral. If the provider is a Local Health Board/Trust, use the 3 character Local Health Board/Trust code with 2 zeros placed in the 4th and 5th character position.

4. For Referral to Treatment Times (Combined), use the 3 character Local Health Board/Trust code.

Format:

For Patient Level Data Sets *(APC, OP, CC, OPR, RTDS)*:-
5 character alpha-numeric Local Health Board/Trust Code with 2 zeros placed in the 4th and 5th character position.

For Aggregate Data Collections *(DATS, RTT (Combined) and PP01W)*:-
3 character alpha numeric Local Health Board/Trust Code

Value	Meaning
XAABB	The organisation code for the provider

Default codes:

Value	Meaning	Valid From	Valid To
89997	Non-UK provider where no organisation code has been issued	1st April 2004	
89999	Non-NHS UK provider where no organisation code has been requested and issued	1st April 2002	

See ORGANISATION CODE

Patient's Name

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
APC ds99	1st April 1999	
EAL ds	1st April 1999	21st November 2012
OP ds	1st April 1999	
CC ds	1st April 2007	
OPR ds	1st July 2008	
EDDS	1st April 2009	
RTDS	1st April 2014	

This will be the patients preferred name. The patient is the arbiter of his/her name.

Format: either structured with two 35 alpha character elements (forename followed by surname) or an unstructured string of 70 characters. Use block capitals, ignore apostrophes and insert space for hyphen. Enter surname first then as many letters of the first name as possible, leaving a blank box between each part of the name. Double-barrelled surnames

should be coded in the same order as in the hospital records. Name Format Code indicates which format is being used.

Patient's Usual Address

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
APC ds99	1st April 1999	
EAL ds	1st April 1999	21st November 2012
OP ds	1st April 1999	
CC ds	1st April 2007	
OPR ds	1st July 2008	
EDDS	1st April 2009	
RTDS	1st April 2014	

This is the usual address nominated by the patient at the time of admission or attendance. If patients usually reside elsewhere are staying in hotels, hostels or other residential establishments for a short term, say a week, they should be recorded as staying at their usual place of residence. However if long term, such as at boarding school, the school address must be recorded. University students may nominate either their home address or the address of their university accommodation. Where patients are not capable of supplying this information, because of age or mental illness, for example, then the person responsible for the patient, such as a parent or guardian, should nominate the usual address. Patients not able to provide an address should be asked for their most recent address. If this cannot be established then you should record the address as `No fixed abode' or `Address unknown'. These patients are regarded as resident in the local geographical district for contracting purposes. For birth episodes this should refer to the mother's usual place of residence.

Format: 175 character alpha-numeric. This is based on 5 lines of 35 characters. This relates to the physical layout of the address, not the logical layout and does not require intelligent intervention when splitting the text string into lines.

Prior to April 1999 the PEDW Format: 100 character alpha-numeric. This is based on 4 lines of 25 characters. This relates to the physical layout of the address, not the logical layout.

Postcode of Usual Address

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
APC ds99	1st April 1999	
EAL ds	1st April 1999	21st November 2012
OP ds	1st April 1999	
CC ds	1st April 2007	
OPR ds	1st July 2008	
EDDS	1st April 2009	

RTDS	1st April 2014	

The postcode applied to the usual address nominated by the patient at the time of admission or attendance.

Format: 8 character alpha-numeric. This allows a space to be inserted to differentiate between the inward and outward segments of the code, enabling full use to be made of the Royal Mail postcode functionality.

Organisation Data Service rules apply.

If a patient has no fixed abode, this should be recorded with the appropriate code (ZZ99 3VZ).

For overseas visitors, the postcode field must show the relevant country pseudo postcode commencing ZZ99, plus spaces followed by a numeric, then an alpha character, then a Z. For example, ZZ99 6CZ is the pseudo-postcode for India. Pseudo-postcodes can be found in the NHS Postcode Directory.

See Postcode

(PEDW (Prior to April 1999), Psychiatric Census)
The postcode applied to the usual address nominated by the patient at the time of admission or attendance, using rules supplied above and those in the NHS Postcode User Directory.

Format: 8 character alpha-numeric. The 5th position is always blank (Δ) and possibly the 3rd and 4th characters may be blank also.

See Postcode

Primary ICD Diagnostic Code

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
APC ds99	1st April 1999	
OP ds	1st April 1999	
RTDS	1st April 2014	

This is the patient diagnosis for:

- the main condition treated or investigated during the relevant episode of healthcare and
- where there is no definitive diagnosis, the main symptom, abnormal findings or problem.

It is a classification of diseases, injuries and causes of death according to the 10th Revision of International Statistical Classification of Diseases and Health Related Problems (ICD10).

ICD Version	Valid From	Valid To
ICD-9		30th September 1994
ICD-10	1st August 1994	30th June 2012

ICD-10 4th Edition	1st July 2012	

Format: 6 character alpha-numeric

Value	Meaning
ANNXXX	ICD10 code
Spaces	Not applicable
Character position	Valid Values
1	A-Z
2-3	00-99
4	0-9, or 'X' if absent
5	0-9, or space if absent
6	A, D or space

Primary OPCS Code

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
APC ds99	1st April 1999	
OP ds	1st April 1999	
RTDS	1st April 2014	

The primary intervention / procedure performed on a patient at a particular time, during the relevant episode, as determined by the responsible Consultant or Independent Nurse.

Format: 4 character alpha-numeric

Value	Meaning
ANNN	See OPCS Classification of Interventions and Procedures, Fourth Revision (Version 4).
Spaces	No procedure performed or episode not coded.

Listing of all current OPCS codes and descriptions can be found from the Reference Data site via the following link:
http://howis.wales.nhs.uk/sitesplus/286/page/39262 **(NHS Wales Users Only)**

Procedure Date

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
APC ds99	1st April 1999	
PAP ds	1st April 2013	

RTDS	1st April 2014	

This is the date of the start of a patient procedure. Procedure Date Status is associated with this data item and should be used to indicate whether procedure date is supplied or is not applicable.

Format: 8 digit numeric, CCYYMMDD

For Radiotherapy Data Set
Format: CCYY-MM-DD

Sex

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
APC ds99	1st April 2009	
OP ds	1st April 1999	
OPR ds	1st July 2008	
EDDS	1st April 2009	
RTDS	1st April 2014	

This is the sex of person, employee or patient.

Format: 1 digit numeric

Value	Meaning	Valid From	Valid To
0	*Not known*	*1st July 1997*	*20th January 2002*
1	Male	Pre 28th December 1995	
2	Female	Pre 28th December 1995	
3	*Indeterminate or anticipated sex change*	*Pre 28th December 1995*	*30th June 1997*
9	Not Specified	1st July 1997	

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c) New Data Items

Actual Fractions

The total number of fractions or hyper- fractions delivered as part of a Radiotherapy Prescription.

Format: max 3 digit numeric

Appointment Date

An arrangement for a patient to be seen by or be in contact with one or more care professionals i.e. Date of patients attendance for radiotherapy

Format: CCYY-MM-DD

Decision to Treat Date (Radiotherapy Treatment Episode)

The date that a decision was taken to treat a patient's condition with a radiotherapy treatment modality.

This is the date that the consultation between the patient and the clinician took place and a planned cancer treatment was agreed.

Format: CCYY-MM-DD

Earliest Clinically Appropriate Date

The earliest date that it was clinically appropriate to start radiotherapy treatment.

For the Radiotherapy Data Set, Earliest clinically appropriate data is the:

- first date that the patient would have been clinically fit to start radiotherapy and
- same as the decision to treat date unless there was an elective delay, i.e. a clinical reason, such as the patient was not fit.

Format: CCYY-MM-DD

Machine Identifier

A unique identifier for a Radiotherapy Machine.

Details of how this identifier is generated and used within the Radiotherapy Data Set can be found at the National Clinical Analysis and Specialised Applications Team website.

Format: max 12 character alpha numeric

Number of Teletherapy Fields

The actual number of fields used to deliver a fraction as part of the radiotherapy prescription.

Format: max 2 digit numeric

Prescribed Fractions

The prescribed number of fractions or hyper-fractions of a radiotherapy prescription.

Format: max 3 digit numeric

Prescription Identifier

An identifier that is unique for each radiotherapy prescription.

Format: max 50 character alpha-numeric

Radiotherapy Actual Dose

The total actual absorbed radiation dose received during a course of Radiotherapy Treatment, measured in Grays, given to the International Commission on Radiation Units (ICRU) Reference Point for the whole prescription. http://www.icru.org/home/reports/prescribing-recording-and-reporting-photon-beam-therapy-report-62

Format: max 3 digit numeric.max 2 digit numeric

Radiotherapy Anatomical Treatment Site (OPCS)

A classification of the part of the body to which the Radiotherapy Actual Dose is administered.

Note: Only complete where Radiotherapy Treatment Region = A, O or M.

Format: 4 character alpha numeric (OPCS 4 Z Codes)

Value	Meaning
ANNN	See OPCS Classification of Interventions and Procedures, Fourth Revision (Version 4).
Spaces	No procedure performed or episode not coded.

Recommended list of OPCS Codes for use in this field:

20140820-GEN-OPCS 4 6 Z codes-d0-2.dc

Radiotherapy Attendance Identifier

A sequential number or time of day used to enable an attendance or appointment to be uniquely identified.

Note: This data item is generated by the Radiotherapy Toolkits and is not required to be recorded or generated by the Radiotherapy Centres.

Format: 12 character alpha-numeric

Radiotherapy Beam Energy

The prescribed energy of a radiotherapy exposure, where the unit of measurement is 'megavolts (MV)'.

Format: maximum 3 digit numeric.maximum 3 digit numeric

Radiotherapy Beam Type

The prescribed type of beam for a Radiotherapy Exposure.

Format: 2 character alpha-numeric

Value	Meaning
T1	Photon
T2	Electron
T3	Other

Radiotherapy Diagnosis (ICD)

Radiotherapy Diagnosis (ICD) is the International Classification of Diseases (ICD) code for a patient receiving Radiotherapy.

- For patients with cancer, Radiotherapy Diagnosis (ICD) is the primary tumour diagnosis code
- For non-cancer diagnoses, Radiotherapy Diagnosis is the main condition being treated during the Radiotherapy Episode.

NOTE: The definition of this data item is different from that of the Primary Diagnosis in this data set.

Format: 6 character alpha-numeric

Recommended list of ICD Codes for use in this field:

20140820-GEN-Selected ICD 10 codes for

Radiotherapy Episode Identifier

A unique identifier for each radiotherapy episode

Format: max 50 character alpha-numeric

Radiotherapy Field Identifier

A unique identifier for each radiotherapy field.

Details of how this identifier is generated and used with the Radiotherapy Data Set can be found at the National Clinical Analysis and Specialised Applications Team website.

Format: max 50 character alpha-numeric

Radiotherapy Intent

The intent of the delivered beam radiation.

Format: 2 character alpha-numeric

Value	Meaning
01	Palliative
02	*Anti Cancer (Radical)*
03	Other
99	Unknown (Not Recorded)

Radiotherapy Prescribed Dose

The total prescribed absorbed radiation dose for radiotherapy treatment.

Measured in Grays, given to the ICRU Reference Point for the whole prescription. http://www.icru.org/home/reports/prescribing-recording-and-reporting-photon-beam-therapy-report-62

Format: max 3 digit numeric.max 2 digit numeric

Radiotherapy Priority

This is the priority for the radiotherapy treatment course as classified by the requesting clinician.

Format: 1 character alpha-numeric

Value	Meaning
E	*Emergency (treatment required within*

	24hrs)
U	*Urgent (to include the Royal College of Radiologist Category I)*
R	*Routine (to include the Royal College of Radiologist Category II)*
D	*Elective delay (Treatment delayed for reason)*

For further information on the Royal College of Radiologists Categories see the Royal College of Radiologists website.

Radiotherapy Treatment Modality

The type of treatment delivered during a radiotherapy prescription.

Format: 2 character alpha-numeric

Value	Meaning
05	Teletherapy
06	Brachytherapy

Radiotherapy Treatment Region

The specific region of the body being treated with Radiotherapy.

Format: max 2 character alpha-numeric

Value	Meaning
P	Primary
R	Regional Nodes
PR	Primary & Regional Nodes
A	Non-anatomically specific primary site
O	Prophylactic (to non-primary site)
M	Metastasis

Referral Request Received Date

Date of referral request from the clinical oncologist to radiotherapy radiographer.

Format: CCYY-MM-DD

Time of Exposure

The time when the radiotherapy exposure was first initiated at the radiotherapy attendance.

Format: HH:MM:SS

Treatment Start Date (Radiotherapy Treatment Episode)

The date that treatment for a patient's condition using a radiotherapy treatment modality started.

Format: CCYY-MM-DD

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d) New Terms

Fraction

A Fraction is a set of exposures delivered or intended to be delivered to a patient in the course of one visit to a Radiotherapy room

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Radiotherapy Prescription

A request for the administration of Radiotherapy to a patient

A radiotherapy prescription relates to a series of identical treatments to a single anatomical site.

Planned Cancer Treatment

Planned Cancer Treatment is the proposed treatment(s) agreed at a Multidisciplinary Team Meeting.

Note: this may not be the same as later agreed between the patient and the clinician. There may be more than one PLANNED CANCER TREATMENT TYPE proposed within a Cancer Care Plan.

Radiotherapy Episode

A Radiotherapy Episode is a continuous period of care for Radiotherapy including all preparation, planning and delivery of Radiotherapy.

Treatment given concurrently or consecutively to multiple anatomical sites associated with the same primary tumour will form part of the same Radiotherapy Episode.

If the treatment plan changes during treatment (e.g. because a new symptom arises which also requires Radiotherapy) then all of the treatment delivered concurrently or consecutively will form part of the same Radiotherapy Episode.

Treatment given to separate unrelated primary tumour sites will form separate Radiotherapy Episodes.