DSC Notice: 11/2009
Date of Issue: June 2009

Information Standards Board for Health and Social Care
IMPLEMENTABILITY INTEROPERABILITY SAFETY

Sponsoring Organisation:	Implementation Date:	Immediate
NHS Connecting for Health	Subject: Data Standards: NHS Data Model and Dictionary Maintenance Update	

DATA SET CHANGE NOTICE

This DSCN informs users of changes to the NHS Data Model and Dictionary that have been approved by the Information Standards Board for Health and Social Care on 26 May 2009.

Summary:

This DSCN updates the NHS Data Model and Dictionary and includes the following changes:

1. The definition of "Hospital Bed" from the Class of "Ward Operational Plan" has been moved to a new NHS Business Definition.
2. The Attribute "NHS Number" has been updated to show the exceptions to when it is mandatory to record the NHS Number.
3. National Direct Access Audiology Patient Tracking List Data Set. The Data Element "Referral to Treatment Period Exceeds 18 Weeks Timeband" has been corrected to 1 to 7 days rather than 0 to 7 days for the 0-1 week timeband.
4. The Format / Length has been updated on the Data Elements "Delay Reason (Decision to Treatment)" and "Delay Reason Referral to Treatment (Cancer)" as they do not match the National Codes on the linked Attribute "Delay Reason to Treatment (Cancer)".
5. The Format/Length of the Data Element "DUN Number" has been amended to n9 to reflect the change in format. Systems that use this data element should be fully conformant with this change by 1 December 2009.
6. References to the purpose of the "Admitted Patient Stocks Data Set Overview" and Data Element "Patients Waiting For Admission" have been amended.
7. The Attributes of the Class "Patient Pathway" have been changed from "Secondary Care Patient Pathway Identifier" and "Secondary Care Patient Pathway Start Date" to "Patient Pathway Identifier" and "Patient Pathway Start Date" to match the Attribute names.
8. The pages describing the NHS Data Model and Dictionary Version 3 and its content have been updated.
9. Hyperlinks have been added to new/existing definitions as appropriate.
10. Unnecessary abbreviations and headings have been removed.

Any organisation or system supplier affected by the above changes may need to update their systems or processes.

Impact of Change:

Service: Minor **System Suppliers:** Minor

The Information Standards Board for Health and Social Care (ISB HaSC) is responsible for approving information standards.

Change Request

NHS Connecting for Health

NHS Data Model and Dictionary Service

Reference:	Change Request 1056
Version No:	1.0
Subject:	Updates to the NHS Data Model and Dictionary
Effective Date:	Immediate
Reason for Change:	Change to Data Standards
Publication Date:	3 June 2009

Background:

This Data Set Change Notice has been produced in response to queries raised with the NHS Data Model and Dictionary Service.

The NHS Data Model and Dictionary has been updated as follows:

- The NHS Data Model and Dictionary definitions have been restructured by moving the definition of "Hospital Bed" from the Class of "Ward Operational Plan" to a new NHS Business Definition.
- The Attribute "NHS Number" has been updated to show the exceptions to when it is mandatory to record the NHS Number. The Data Element "NHS Number" has been amended to remove the text as it is linked to the Attribute.
- Data Element "Referral to Treatment Period Exceeds 18 Weeks Timeband" has been amended as the Data Element gave the number of days in the 0-1 weeks time band, incorrectly as 0 to 7. It has been corrected to 1 to 7 days following confirmation of the correct information from the Department of Health. This Data Element is used in the National Direct Access Audiology Patient Tracking List Data Set.
- The Format/ Length has been updated on the Data Elements "Delay Reason (Decision to Treatment)" and "Delay Reason Referral to Treatment (Cancer)" as they do not match the National Codes on the linked Attribute "Delay Reason to Treatment (Cancer)".
- The Format/Length of the Data Element "DUN Number" has been amended to n9 to reflect the change in format. This has been confirmed by the NHS Purchasing and Supply Agency.
- The "Admitted Patient Stocks Data Set Overview" and Data Element "Patients Waiting For Admission" has been amended as it has been identified that references to what the collection is for were incorrect. The correct information has been confirmed by the Department of Health Waiting Times team
- The Attributes of the Class "Patient Pathway" are shown as "Secondary Care Patient Pathway Identifier" and "Secondary Care Patient Pathway Start Date". These have been renamed to "Patient Pathway Identifier" and "Patient Pathway Start Date" to match the Attribute names.
- Updates the pages describing the NHS Data Model and Dictionary Version 3 and the items it contains.
- Hyperlinks have been added to new/existing definitions as appropriate.
- Unnecessary abbreviations and headings have been removed.

Summary of changes:

Supporting Information	
ABOUT THE NHS DATA MODEL AND DICTIONARY VERSION 3	Changed Description
ACCIDENT AND EMERGENCY ATTENDANCE	Changed Description
ACCIDENT AND EMERGENCY DEPARTMENT	Changed Description
ADMITTED PATIENT STOCKS DATA SET OVERVIEW	Changed Description
ATTRIBUTE DEFINITIONS INTRO	Changed Description, Aliases
CENTRAL RETURN DATA SETS INTRODUCTION	Changed Aliases
CHANGES INTRODUCTION	Changed Description
CLASS DEFINITIONS INTRO	Changed Description, Aliases

COMMISSIONING DATA SET OVERVIEW	Changed Aliases
CONSULTANT OUT-PATIENT EPISODE	Changed Description
DATA ELEMENTS INTRO	Changed Description, Aliases
DAY CARE ATTENDANCE	Changed Description
DAY CARE FACILITY	Changed Description
DISCHARGE READY DATE	Changed Description
ELECTIVE ADMISSION	Changed Description
ELECTIVE ADMISSION LIST	Changed Description
GLOSSARY OF TERMS	Changed Description
HOME LEAVE	Changed Description
HOSPITAL BED	New Supporting Information
HOSPITAL PROVIDER	Changed Description
HOSPITAL PROVIDER SPELL	Changed Description
HOSPITAL SITE	Changed Description, Aliases
HOSPITAL STAY	Changed Description
META MODEL INTRODUCTION	Changed Description
MIDWIFE EPISODE	Changed Description
NHS BUSINESS DEFINITIONS	Changed Description, Aliases
OUT-PATIENT APPOINTMENT CONSULTANT	Changed Description
OUT-PATIENT ATTENDANCE CONSULTANT	Changed Description
PROFESSIONAL STAFF GROUP CONTACT	Changed Description
REGULAR ATTENDER EPISODE	Changed Description
SHELTERED WORK FACILITY	Changed Description
VASECTOMY PERFORMED	Changed Description
WARD STAY	Changed Description

Class Definitions

APPOINTMENT	Changed Description
CLINIC OR FACILITY	Changed Description
DAILY WARD LISTING	Changed Description
DIAGNOSTIC TEST REQUEST	Changed Description
ELECTIVE ADMISSION LIST	Changed Description
HEALTHY PERSON STAY	Changed Description
ORGANISATION SITE BED AVAILABILITY	Changed Description
ORGANISATION SITE BED OCCUPANCY	Changed Description
PATIENT	Changed Description
PATIENT PATHWAY	Changed Attributes
RIGHT OF ADMISSION	Changed Description
WARD	Changed Description
WARD BED AVAILABILITY	Changed Description
WARD OPERATIONAL PLAN	Changed Description

Attribute Definitions

A AND E ATTENDANCE DISPOSAL	Changed Description
ADMINISTRATIVE CATEGORY CODE	Changed Description
AVAILABLE BED DAYS NHS PATIENTS	Changed Description
BED AVAILABILITY END DATE	Changed Description
BED AVAILABILITY START DATE	Changed Description
CRITICAL CARE DISCHARGE READY DATE	Changed Description
CRITICAL CARE DISCHARGE READY TIME	Changed Description
DIAGNOSTIC SERVICE REQUEST TYPE	Changed Description
HEALTHY PERSON STAY NUMBER	Changed Description
INTENDED MANAGEMENT	Changed Description
INTENSIVE CARE OR HIGH DEPENDENCY BEDS INDICATOR renamed from IC OR HD BEDS INDICATOR	Changed Description, Name

LODGING END TIME	Changed Description
LODGING START TIME	Changed Description
NHS NUMBER	Changed Description
OPERATION CANCELLATION	Changed Description
PATIENT CLASSIFICATION	Changed Description
PATIENT FACILITY GROUP CODE	Changed Description
WARD AVAILABLE BED	Changed Description
WARD DAY NIGHT INDICATOR	Changed Description
WARD LISTING TOTAL BED OCCUPIED	Changed Description
WARD LISTING TOTAL BED RESERVED	Changed Description
WARD LISTING TOTAL BED UNAVAILABLE	Changed Description
WARD LISTING TOTAL BED UNOCCUPIED	Changed Description
WARD LISTING TOTAL WARD ATTENDER	Changed Description
WARD PLAN TOTAL BED CONSULTANT CARE	Changed Description
WARD PLAN TOTAL BED MIDWIFE ACCESS	Changed Description
WARD PLAN TOTAL BED NURSING CARE	Changed Description
WARD TOTAL BED INTENDED	Changed Description

Data Elements

DECIDED TO ADMIT DATE	Changed Description
DELAY REASON (DECISION TO TREATMENT)	Changed Description
DELAY REASON REFERRAL TO TREATMENT (CANCER)	Changed Description
DUN'S NUMBER	Changed Description
NHS NUMBER	Changed Description
PATIENTS WAITING FOR ADMISSION	Changed Description
REFERRAL TO TREATMENT PERIOD EXCEEDS 18 WEEKS TIME BAND	Changed Description

Date: 3 June 2009
Sponsor: Ken Lunn, NHS Connecting for Health

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

ABOUT THE NHS DATA MODEL AND DICTIONARY VERSION 3

Change to Supporting Information: Changed Description

~~**About the NHS Data Model and Dictionary Version 3**~~Following the issue of DSCN 07/2004 'Data Standards: Meta Model', the NHS Data Model and Dictionary was changed to reflect and be based upon a more generic logical data model which better supports the strategic way forward. This NHS Data Model and Dictionary was published as the NHS Data Model and Dictionary Version 3.

~~Following the issue of DSCN 07/2004 'Data Standards: Meta Model' the NHS Data Model and Dictionary has been changed to reflect and be based upon a more generic logical data model which will better support the strategic way forward. This NHS Data Model and Dictionary will be published as the NHS Data Model and Dictionary Version 3.~~There was extensive quality assurance of Version 3 including involvement of the Data Definition Group. All Version 3 contents were cross mapped and checked to ensure consistency with the Version 2 contents. Version 3 superseded Version 2 on 1st May 2005.

~~There has been extensive quality assurance of Version 3 including involvement of the Data Definition Group. All Version 3 contents have been cross mapped and checked to ensure consistency with the current Version 2 contents. With the completion of the final quality assurance, Version 3 is now ready for live publication and will completely supersede the current Version 2 on 1st May 2005.~~Version 3 supports all the messages, data sets and

central returns supported by Version 2 but the underlying structure was genericised. No changes were made to NHS Business Definitions.

~~Version 3 supports all the messages, data sets and central returns supported by Version 2 but the underlying structure has been genericised. No changes have been made to business definitions.~~

~~Version 3 introduces a new UML (Unified Modelling Language) Generic Model which is 'PERSON' based rather than 'ORGANISATION' based. The model has been developed around generic 'CARE ACTIVITY' for a PATIENT at 'SERVICE POINT' facility or location with each event transaction being recorded.~~Version 3 introduced a new UML (Unified Modelling Language) Generic Model which is 'PERSON based' rather than 'ORGANISATION based'. The model has been developed around generic 'CARE ACTIVITY' for a PATIENT at 'SERVICE POINT' facility or LOCATION with each event transaction being recorded. This has involved grouping many of the old classes into generic classes like ACTIVITY GROUP. ~~However, none of the detail or approved definitions or value sets in Version 2 has been lost although some of the old class definitions will now be found in the new 'NHS Business Definitions'.~~ However, none of the detail or approved definitions or value sets in Version 2 have been lost although some of the old class definitions will now be found in the new 'NHS Business Definitions'.

~~The NHS Data Dictionary Version 2 will be frozen and made available for archive information purposes only and will be watermarked accordingly. All future changes to NHS data standards and the supporting DSCNs will be made or be consistent only with Version 3.~~The NHS Data Dictionary Version 2 has been frozen and made available for archive information purposes only and has been watermarked accordingly. All changes to NHS data standards and the supporting Data Set Change Notices are now consistent only with Version 3.

Summary of main changes and enhancements incorporated within Version 3

- Introduction of the capability of holding Retired Items
- Introduction of NHS Business Definitions, which allow specific business areas to be defined in a more flexible manner
- New 'All Items Index' which lists all the contents held within the NHS Data Model and Dictionary
- Reduction in the number of data model diagrams making them more comprehensible
- Introduction of Domains, which are conceptual logical modelling objects which identify the logical format, length and value set attributable to one or more attribute(s)
- 'Where Used' list expanded to include a description of usage column
- Creation of a separate Meta Model area within the publication

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~~• Creation of a separate Meta Model area within the publication~~The introduction of Version 3 had no impact on current data standards or system suppliers.

~~The introduction of Version 3 has no impact on current data standards or system suppliers.~~**About the Generic Model**

~~**About the Generic Model**~~The Generic Model supports all the messages, data sets and central returns which the model supported but the underlying structure has been genericised. This involved grouping many of the old classes into generic classes like ACTIVITY GROUP. However, none of the detail was lost and most of the old class definitions can be found under 'NHS Business Definitions'. The number of diagrams has been greatly reduced and they now describe coherent areas of the model which is a far more useful approach for data modellers.

~~We have been working on supporting the principles of ReWBI (Review of Waiting and Booking Information), the~~

~~emerging Secondary Uses Service (SUS), the national data warehouse and the migration of the Commissioning Data Set messages. This has included rationalising the existing data standards so that the NHS Data Model and Dictionary can support both the 'legacy' systems and data needs, as well as new and emerging systems and data needs.~~This has led to the creation of a new UML (Unified Modelling Language) Generic Model which is 'PERSON based' rather than 'ORGANISATION based'. The model has been developed around generic 'CARE ACTIVITY' for a PATIENT at 'SERVICE POINT point' facility or location with each event transaction being recorded.

~~It supports all the messages, data sets and central returns which the current model supports but the underlying structure has been genericised. This has involved grouping many of the old classes into generic classes like ACTIVITY GROUP. However, none of the detail has been lost and most of the old class definitions can be found in the new 'NHS Business Definitions'. The number of diagrams has been greatly reduced and they now describe coherent areas of the model which is a far more useful approach for data modellers.~~The model is aimed at enabling all 'CARE ACTIVITIES' related to the same condition for the same PATIENT to be recorded and linked across ORGANISATIONS. The different states of the same 'CARE ACTIVITY' are recorded as event transactions e.g. requested, intended, scheduled, provided, cancelled, etc. These different state events also drive the scheduling and capacity planning of resources (people, equipment, facilities, etc.) to deliver the care.

~~This has led to the creation of a new UML (Unified Modelling Language) Generic Model which is 'PERSON' based rather than 'ORGANISATION' based. The model has been developed around generic 'CARE ACTIVITY' for a PATIENT at 'SERVICE POINT' facility or location with each event transaction being recorded.~~Although this may seem complicated, it is necessary both to form a coherent logical model and to relate physical information such as that which flows on the Data Sets to the logical model. Every physical item should be represented logically in the NHS Data Model and Dictionary. However, the scope of the logical model is greater than the physical information it holds and therefore not all logical information has a physical existence.

~~The Model will form the underpinning common structure which can be used by all future data sets related to patients and CARE ACTIVITY, whether they be 'administrative', 'clinical', 'management' etc. The data elements specified within the model and within attached data set modules will form the basis for XML message exchanges.~~The Classes, Attributes and Relationships are logical model components.

- A **Class** is something that you want to collect information about. Classes have four tabs:
  - Description: a description of the Class
  - Attributes: the Attributes which are associated with that Class
  - Relationships: the relationships associated with other Classes
  - Where Used: every item where the Class is referenced.

- An **Attribute** is the information that is going to be collected. Attributes have three tabs:
  - Description: a description of the Attribute
  - Where Used: every item where the Attribute is referenced
  - Data Elements: the Data Elements based on the Attribute

~~The model is aimed at enabling all 'care activities' related to the same condition for the same patient to be recorded and linked across organisations. The different states of the same 'care activity' are recorded as event transactions e.g. requested, intended, scheduled, provided, cancelled, etc. These different state events also drive the scheduling and capacity planning of resources (people, equipment, facilities, etc.) to deliver the care.~~Data Elements are physical model components. They represent information on the Data Sets. Identifying how this information maps to the logical model is essential, if the information stored on the Attributes, Classes and Relationships is to be utilised with respect to the physical item.

- A **Data Element** is an instantiation of the logical Data Model. Data Elements have three tabs:
  - Description: a description of the Data Element
  - Where Used: every item where the Data Element is referenced
  - Attribute: the Attribute the Data Element is derived from

Each Attribute name, Class name or Data Element name is in uppercase, other items, such as NHS Business

Definitions etc will appear in Title Case. Where the name in text also appears in a colour other than black, this indicates that it is a clickable link and if clicked on will display the description for that item.

Contact us for more information: datastandards@nhs.net.

ACCIDENT AND EMERGENCY ATTENDANCE

Change to Supporting Information: Changed Description

Accident And Emergency Attendance is a CARE CONTACT.

An individual visit by one PATIENT to an Accident And Emergency Department to receive treatment from the accident and emergency service.

Note that the accident and emergency service may be provided by staff from other MAIN SPECIALTY.

During an Accident And Emergency Attendance the PATIENT may temporarily leave the Accident And Emergency Department, e.g. for an X-ray, whilst still under the responsibility of the Accident And Emergency Department.

An Accident And Emergency Attendance may be as a result of a request from a GENERAL PRACTITIONER for help with a diagnosis or treatment.

Attendances at Out-Patient Clinic run in the Accident And Emergency Department should not be recorded as Accident And Emergency Attendance but should be recorded as Out-Patient Attendance Consultant or Clinic Attendance Non-Consultant depending upon the type of Out-Patient Clinic attended.

Any facility set up to receive and treat emergency cases is regarded as an Accident And Emergency Department for this purpose.

Accident And Emergency Attendance include both first and follow-up attendances. A follow-up attendance is any subsequent Accident And Emergency Attendance at the same Accident And Emergency Department for the same incident. All attendances for the same incident will constitute an Accident And Emergency Episode.

Each Accident And Emergency Attendance, which is a first attendance or an unplanned follow-up attendance, should be assigned an A AND E STREAM.

~~Any patient diagnoses and interventions should be recorded using the A & E specific codes, see ACCIDENT AND EMERGENCY DIAGNOSIS, ACCIDENT AND EMERGENCY INVESTIGATION and ACCIDENT AND EMERGENCY TREATMENT.~~Any PATIENT diagnoses and interventions should be recorded using the A & E specific codes, see ACCIDENT AND EMERGENCY DIAGNOSIS, ACCIDENT AND EMERGENCY INVESTIGATION and ACCIDENT AND EMERGENCY TREATMENT.

For each Accident And Emergency Attendance the following times should be recorded: ARRIVAL TIME, A and E INITIAL ASSESSMENT TIME (first attendances and unplanned follow-up attendances), A and E TIME SEEN FOR TREATMENT, A and E ATTENDANCE CONCLUSION TIME and A and E DEPARTURE TIME.

~~For first attendances and unplanned follow-up attendances the A AND E INITIAL ASSESSMENT TRIAGE CATEGORY and A AND E STREAM need to be recorded.~~For first attendances and unplanned follow-up attendances the A AND E INITIAL ASSESSMENT TRIAGE CATEGORY and A AND E STREAM need to be recorded.

Information recorded for an Accident And Emergency Attendance includes:

- A and E ATTENDANCE NUMBER
- A AND E ARRIVAL MODE
- A AND E ATTENDANCE CATEGORY

A and E Attendance Conclusion Time
A AND E ATTENDANCE DISPOSAL
A and E Departure Time
~~A and E Initial Assessment Time~~ ~~(first attendances and unplanned follow-up attendances) O~~A and E Initial Assessment Time (first attendances and unplanned follow-up attendances)
~~A AND E INITIAL ASSESSMENT TRIAGE CATEGORY~~ ~~(first attendances and unplanned follow-up attendances) O~~A AND E INITIAL ASSESSMENT TRIAGE CATEGORY (first attendances and unplanned follow-up attendances)
~~A and E STAFF MEMBER CODE~~ ~~(person principally responsible for care)~~A and E STAFF MEMBER CODE (PERSON principally responsible for care)
~~A AND E STREAM~~ ~~(if first attendance or unplanned follow-up attendance) O~~A AND E STREAM (if FIRST ATTENDANCE or unplanned follow-up attendance)
~~A and E Time Seen For Treatment~~ ~~O~~A and E Time Seen For Treatment
ARRIVAL DATE
ARRIVAL TIME

ACCIDENT AND EMERGENCY DEPARTMENT

Change to Supporting Information: Changed Description

Accident And Emergency Department is a DEPARTMENT.

These may be either major units, providing a 24 hour service seven days a week to which the great majority of emergency ambulance cases are taken, or small units commonly called casualty departments, in which services are often only available for limited hours and which may not deal with emergency ambulance cases. ~~A casualty department is not always part of a Hospital Site. Additional activities may also take place such as: elective surgical work of a minor nature, observation and treatment of PATIENT in beds, and the holding of out-patient clinics. Beds either within or adjacent to a department will be counted as a WARD or part of a WARD.~~

A casualty department is not always part of a Hospital Site. Additional activities may also take place such as: elective surgical work of a minor nature, observation and treatment of PATIENTS in Hospital Beds and the holding of Out-Patient Clinics.

Hospital Beds either within or adjacent to a department will be counted as a WARD or part of a WARD. Work apart from the accident and emergency service should be recorded in the appropriate data system.

~~An accident and emergency service offers care to PATIENT who arrive with urgent problems and who have not usually been seen previously by a GENERAL PRACTITIONER.~~An accident and emergency service offers care to PATIENTS who arrive with urgent problems and who have not usually been seen previously by a GENERAL PRACTITIONER.

In the case of serious illness or accident, the treatment provided will be vital resuscitation only before the PATIENT is admitted to hospital.

ADMITTED PATIENT STOCKS DATA SET OVERVIEW

Change to Supporting Information: Changed Description

Admitted Patient Stocks at the end of the Reporting Period

- The Department of Health requires performance management information on ELECTIVE ADMISSION LIST

stocks at the end of a specified REPORTING PERIOD.

- The Department of Health uses the information to help monitor national WAITING LIST trends. These are used to develop policies and indicate changes which can enable the WAITING LISTS to be managed more effectively.

- This central information collection requirement is both:

  provider based and is submitted by provider NHS Trusts and provider Primary Care Trusts regardless of where PATIENTS live.

  and

  commissioner based and is the aggregation of commissioned PATIENT activity delivered by provider NHS Trusts and provider Primary Care Trusts.

- ~~Each submission will be from one ORGANISATION in the role of provider or commissioner and should only contain data appropriate to that role i.e. must not contain a mixture of commissioning and provider role data.~~

  ~~COMMISSIONER OR PROVIDER STATUS INDICATOR indicates whether it is a submission from the ORGANISATION in the role of commissioner of care or provider of care.~~

~~Admitted Patient Stock Group Main Specialty~~

- Each submission will be from one ORGANISATION in the role of provider or commissioner and should only contain data appropriate to that role i.e. must not contain a mixture of commissioning and provider role data.

  COMMISSIONER OR PROVIDER STATUS INDICATOR indicates whether it is a submission from the ORGANISATION in the role of commissioner of care or provider of care.

Admitted Patient Stock Group Main Specialty

- The collection data is grouped by MAIN SPECIALTY CODE. Where there are no stocks present for a MAIN SPECIALTY CODE within the REPORTING PERIOD then no admitted patient stocks group should be recorded for it. Only one sub group is permitted per MAIN SPECIALTY CODE.

Admitted Patient Stock Sub Group Ordinary Admissions and Day Case Admissions

- Within the MAIN SPECIALTY CODE grouping, the collection is further sub grouped by WAITING FOR ADMISSION INTENDED MANAGEMENT which indicates whether the sub group is for ordinary admissions or day case admissions
- ~~The collection is for:~~

  ~~all PATIENTS who have an OFFER OF ADMISSION MADE DATE before or on the REPORTING PERIOD END DATE and are waiting to be admitted from the Elective Admission List~~

  ~~and~~

  ~~all PATIENTS who have an OFFER OF ADMISSION MADE DATE before or on the REPORTING PERIOD END DATE and are waiting to be admitted by specified waiting time band from the Elective Admission List~~

  ~~and~~

~~all PATIENTS who have an OFFER OF ADMISSION MADE DATE before or on the REPORTING PERIOD END DATE and are waiting to be admitted from the Elective Admission List due to Self-Deferred Admission~~

~~and~~

~~all PATIENTS who have an OFFER OF ADMISSION MADE DATE before or on the REPORTING PERIOD END DATE and are waiting to be admitted from the Elective Admission List who at the REPORTING PERIOD END DATE are Suspended Patients~~

- ~~It includes those PATIENTS who are classified as a booked admissions and waiting list admissions; and is inclusive of private PATIENTS and PATIENTS from overseas.~~

  ~~It excludes those PATIENTS who are classified as a planned admissions and for the total number of PATIENTS waiting and waiting by time band also excludes Suspended Patients.~~

  ~~ELECTIVE ADMISSION TYPE records the classification of the admission.~~

- The collection is for:

  all PATIENTS who are waiting to be admitted from the ELECTIVE ADMISSION LIST on the REPORTING PERIOD END DATE. This includes PATIENTS with an OFFER OF ADMISSION MADE DATE before or on the REPORTING PERIOD END DATE.

  and

  all PATIENTS who are waiting to be admitted by specified waiting time band from the ELECTIVE ADMISSION LIST on the REPORTING PERIOD END DATE. This includes PATIENTS with an OFFER OF ADMISSION MADE DATE before or on the REPORTING PERIOD END DATE.

  and

  all PATIENTS who are waiting to be admitted from the ELECTIVE ADMISSION LIST on the REPORTING PERIOD END DATE due to Self-Deferred Admission. This includes PATIENTS with an OFFER OF ADMISSION MADE DATE before or on the REPORTING PERIOD END DATE.

  and

  all PATIENTS who are waiting to be admitted from the ELECTIVE ADMISSION LIST who at the REPORTING PERIOD END DATE are Suspended Patients. This includes PATIENTS with an OFFER OF ADMISSION MADE DATE before or on the REPORTING PERIOD END DATE.

- It includes those PATIENTS who are classified as booked admissions and waiting list admissions; and is inclusive of private PATIENTS and PATIENTS from overseas.

  It excludes those PATIENTS who are classified as planned admissions and for the total number of PATIENTS waiting and waiting by time band also excludes Suspended Patients.

  ELECTIVE ADMISSION TYPE records the classification of the admission.

- The collection is further sub grouped into a count of day case admissions and ordinary admissions .

  INTENDED MANAGEMENT records whether a PATIENT is intended as an ordinary admission or a day case admission and therefore which WAITING FOR ADMISSION INTENDED MANAGEMENT it is being sub grouped within.

Summarised Admitted Patient Stock Group Intended Procedures for Ordinary Admissions

- The collection data is grouped by ADMISSION INTENDED PROCEDURE which indicates the required range of OPERATIVE PROCEDURES. Where the are no stocks present for an ADMISSION INTENDED PROCEDURE within the REPORTING PERIOD then no in-patient stocks group should be recorded for it. Only one group is permitted per ADMISSION INTENDED PROCEDURE.
- The required grouping ranges of ADMISSION INTENDED PROCEDURE are:

  0001 CABG - K40-46 Coronary Artery Bypass Graft Code Range:
  or
  0002 PTCA - K49-50 Percutaneous Transluminal Operations Coding Range:
  or
  0003 Valves Coding Range K25-K35 & K38
  or
  0004 - Angiography Coding Range K63 & K65

- Within the ADMISSION INTENDED PROCEDURE the collection only applies to patients waiting for admission as ordinary admissions as indicated by WAITING FOR ADMISSION INTENDED MANAGEMENT.

- The collection is for:

  all PATIENTS for who have an OFFER OF ADMISSION MADE DATE before or on the REPORTING PERIOD and are waiting to be admitted from the Elective Admission List

  and

  all PATIENTS for who have an OFFER OF ADMISSION MADE DATE before or on the REPORTING PERIOD END DATE and are waiting to be admitted by specified waiting time band from the Elective Admission List

- It includes those PATIENTS who are classified as a booked admissions and waiting list admissions; and is inclusive of private PATIENTSs and PATIENTS from overseas.

  It excludes those PATIENTS who are classified as a planned admissions and Suspended Patients.

  ELECTIVE ADMISSION TYPE records the classification of the admission.

ATTRIBUTE DEFINITIONS INTRO

Change to Supporting Information: Changed Description, Aliases

~~The attributes of classes appearing in the NHS data standards logical data model are listed in alphabetical order. Click on a letter in the Attribute Bookmarks to display the list of attribute names for that letter.~~ ~~To display the definition for a specific attribute, click on the attribute name.~~Click on a letter in the Attribute menu to display the list of Attribute names for that letter. To display the definition for a specific Attribute, click on the Attribute name.

~~Each listed attribute contains its nationally agreed definition which may also include its agreed National Codes or classifications and a clickable link: 'data' tab, if a data element also exists that attribute.~~Each Attribute name is in uppercase. Where the name appears in text in **Purple**, it indicates that it is a hyperlink and if clicked on will display the definition for that Attribute.

~~Each attribute name or class name which appears in the definition text is in uppercase and each business definition name is in Title Case.~~ ~~Where the name appears in blue, this indicates that this is a clickable link and if clicked on will display the definition for that attribute, class or business definition.~~ ~~In the same way, if a data element link is present and clicked on, then the information for a data element will be displayed.~~The following

information is available on an Attribute:

- **"Description" tab**: a description of the Attribute
- **"Where Used" tab**: every item where the Attribute is used
- **"Data Elements" tab**: the Data Elements based on the Attribute
- Agreed National Codes or classifications.

~~Although this may seem complicated, it is necessary both to form a coherent logical model and to relate physical information such as that which flows on the messages (elements) to the logical model. Every physical item should be represented logically in the Dictionary. However, the scope of the logical model is greater than the physical information it holds and therefore not all logical information has a physical existence.~~For further information on Version 3 of the NHS Data Model and Dictionary, see About Version 3.

~~The classes, attributes and relationships are logical model components. The classes are comprised of attributes and the Attribute 'tab' is the way of displaying these. An attribute can only belong to one class (although the Where Used 'tab' will show every class or other object where it is referenced). The relationships identify any optional links or mandatory dependencies between classes. The relationship 'tab' is the way of displaying the relationships associated with a class.~~

~~Elements are physical model components. They represent information on the messages or in some cases Central Returns. Identifying how this information maps to the logical model is essential if the information stored on the attributes, classes and relationships is to be utilised with respect to the physical item.~~

ATTRIBUTE DEFINITIONS INTRO

Change to Supporting Information: Changed Description, Aliases

- Changed Description
- Alias Changes

Name	Old Value	New Value
alsoknownas		Attribute

CENTRAL RETURN DATA SETS INTRODUCTION

Change to Supporting Information: Changed Aliases

- Alias Changes

Name	Old Value	New Value
shortname		Central Return Data Sets

CHANGES INTRODUCTION

Change to Supporting Information: Changed Description

~~CHANGES INTRODUCTION~~

This area contains the Change Request log and the Deleted Items log. ~~These two sections list the changes that~~

~~have been made to the NHS Data Dictionary since December 2002.~~ These two sections list the changes that have been made to the NHS Data Model and Dictionary since December 2002.

CLASS DEFINITIONS INTRO

Change to Supporting Information: Changed Description, Aliases

~~The classes and their definitions appearing within the NHS data standards logical data model are listed in alphabetical order.~~Click on a letter in the Class menu to display the list of Classes for that letter. To display the definition for a specific Class, click on the Class name.

~~Each listed class contains a **'Description'** tab that link to its nationally agreed definition, an **'Attributes'** tab that links to a list of its attributes and a **'Relationship'** tab that links to a list of its relationships it has with other classes.~~Each Class name is in uppercase. Where the name appears in text in **Red**, it indicates that it is a hyperlink and if clicked on will display the definition for that Class.

~~The **'Where Used'** tab provides a list of all the diagrams that the class is included in. Each diagram is a sub-set of the logical data model but does not contain an exclusive set of classes. Thus the same class can appear in more than one diagram.~~The following information is available on a Class:

- **"Description" tab**: a description of the Class
- **"Attributes" tab**: the Attributes which are associated with that Class
  - The unique identifier of a Class may include one or more Attributes. These are known as **KEY** attributes and are therefore shown with **'K'** before the Attribute name.
  - Attributes are sequenced with the key Attributes first.
- **"Relationships" tab**: the relationships between Classes
  - Description:
    - The nature of the relationship is indicated by: **'must be'** if the relationship is mandatory and **'may be'** if the relationship is optional.
    - Where relationships from one Class to others are mutually exclusive, then **'or'** appears at the beginning of the description between the second and subsequent exclusive relationships. Mutually exclusive relationships are shown on diagrams by a short straight line cutting across the relationship.
  - Keys:
    - The unique identifier of a Class may include one or more relationships to other Classes. These are indicated by **'K'** before the relationship description.
    - Relationships are sequenced with the key relationships first.
- "**Where Used" tab**: every item where the Class is used.

~~Each attribute name or class name which appears in the definition text, attribute list or relationships is in uppercase. Where the name also appears in blue indicates that it is clickable and if clicked on will display the definition for that class or attribute.~~For further information on Version 3 of the NHS Data Model and Dictionary, see About Version 3.

~~The following information may be shown against a class **attribute**:~~

~~**Keys**~~	~~The unique identifier of a class may include one or more attributes. These are known as key attributes and are shown with **'K'** before the attribute name. Attributes are sequenced with the key attributes first.~~

~~The following information is shown for each class **relationship**:~~

~~**Keys**~~	~~The unique identifier of a class may include one or more relationships to other classes.~~

	These are indicated by **'K'** before the relationship description. Relationships are sequenced with the key relationships first.
Description	The nature of the relationship is indicated by **'must be'** if the relationship is mandatory and by **'may be'** if the relationship is optional. Where relationships from one class to others are mutually exclusive, then **'or'** appears at the beginning of the description between the second and subsequent exclusive relationships. Mutually exclusive relationships are shown on diagrams by a short straight line cutting across the relationship.

Although this may seem complicated, it is necessary both to form a coherent logical model and to relate physical information such as that which flows on the messages (elements) to the logical model. Every physical item should be represented logically in the Dictionary. However, the scope of the logical model is greater than the physical information it holds and therefore not all logical information has a physical existence.

The classes, attributes and relationships are logical model components. The classes are comprised of attributes and the Attribute 'tab' is the way of displaying these. An attribute can only belong to one class (although the Where Used 'tab' will show every class or other object where it is referenced). The relationships identify any optional links or mandatory dependencies between classes. The relationship 'tab' is the way of displaying the relationships associated with a class.

Elements are physical model components. They represent information on the messages or in some cases Central Returns. Identifying how this information maps to the logical model is essential if the information stored on the attributes, classes and relationships is to be utilised with respect to the physical item.

CLASS DEFINITIONS INTRO

Change to Supporting Information: Changed Description, Aliases

- Changed Description
- Alias Changes

Name	Old Value	New Value
alsoknownas		Class

COMMISSIONING DATA SET OVERVIEW

Change to Supporting Information: Changed Aliases

- Alias Changes

Name	Old Value	New Value
plural	Commissioning Data Set Overview	
fullname	CDS Contextual Overview	
shortname		Commissioning Data Sets

CONSULTANT OUT-PATIENT EPISODE

Change to Supporting Information: Changed Description

Consultant Out-Patient Episode is an ACTIVITY GROUP.

An episode of care for a particular PATIENT comprising a series of Out-Patient Attendances Consultant, in respect of one referral, managed by the same CONSULTANT or, in the case of shared-care, by two or more

CONSULTANTS equally participating in care. Where care is provided by two or more CONSULTANTS within the same episode, one CONSULTANT will take overriding responsibility for the PATIENT and only one Consultant Out-Patient Episode is recorded. Additional CONSULTANTS participating in the care of a PATIENT are defined as Shared Care Out-Patient Consultants.

~~An out-patient episode can overlap with other Consultant Out-Patient Episodes or Consultant Episodes (Hospital Provider) for a PATIENT using a hospital bed.~~An out-patient episode can overlap with other Consultant Out-Patient Episodes or Consultant Episodes (Hospital Provider) for a PATIENT using a Hospital Bed.

A Consultant Out-Patient Episode starts on the date the PATIENT first sees or is in contact with the CONSULTANT at an Out-Patient Attendance Consultant. ~~The episode ends when the PATIENT is not given a further Out-Patient Appointment by the CONSULTANT or the PATIENT has not attended or been contacted for six months with no forthcoming appointment.~~ The episode ends when the PATIENT is not given a further Out-Patient Appointment by the CONSULTANT or the PATIENT has not attended or been contacted for six months with no forthcoming APPOINTMENT. If after discharge the condition deteriorates and the PATIENT returns to a clinic run by the same CONSULTANT, this is a new episode (referral).

During the Consultant Out-Patient Episode the PATIENT may be subject to more than one ADMINISTRATIVE CATEGORY PERIOD.

Notes:

~~Do not count the following attendances or contacts as part of a Consultant Out-Patient Episode:~~**Do not** count the following attendances or contacts as part of a Consultant Out-Patient Episode:

- ~~nurse clinic appointment/attendance;~~
- Nurse Clinic APPOINTMENT / attendance;
- face to face contacts with other health professionals;
- ~~contact with community nurses;~~
- contact with community NURSES;

~~If the treatment changes but the consultant stays the same, record it as the same out-patient episode; if the consultant changes but the treatment stays the same, record it as a new out-patient episode.~~If the treatment changes but the CONSULTANT stays the same, record it as the **same** Consultant Out-Patient Episode; if the CONSULTANT changes but the treatment stays the same, record it as a **new** Consultant Out-Patient Episode.

~~An out-patient episode would not necessarily terminate because a PATIENT was admitted into hospital or placed on an ELECTIVE ADMISSION LIST; if further appointments in respect of the same referral with the consultant are intended or expected, these would all be included in the same out-patient episode, with attendances after the end of a Hospital Provider Spell counting as follow-up attendances.~~A Consultant Out-Patient Episode would not necessarily terminate because a PATIENT was admitted into hospital or placed on an ELECTIVE ADMISSION LIST; if further APPOINTMENTS in respect of the same referral with the CONSULTANT are intended or expected, these would all be included in the same Consultant Out-Patient Episode, with attendances after the end of a Hospital Provider Spell counting as follow-up attendances.

Note that a PATIENT can have a concurrent Consultant Out-Patient Episode and Hospital Provider Spell. For example, a PATIENT in a long-stay WARD under the care of a psychiatrist might also be attending a general surgeon.

Information recorded for a Consultant Out-Patient Episode includes:

EPISODE NUMBER
End Date O
FUNCTIONAL DEFICIENCY O
FUNCTIONAL DEFICIENCY CAUSE O
Start Date

DATA ELEMENTS INTRO

Change to Supporting Information: Changed Description, Aliases

~~Data elements are used to identify or indicate the content of:~~Data Elements are used to identify or indicate the content of data sets. In addition, Data Elements can contain text providing guidance, support, values or other information concerning the Data Element and its usage.

~~i. the Commissioning Data Sets (CDS)~~
~~ii. the Hospital Episode Statistics (HES)~~
~~iii. the Central Returns~~

~~In addition, data elements can contain text providing guidance, support, values or other information concerning the data element and its use with the above.~~The Data Elements are listed in alphabetical order. Click on a letter in the Data Element menu to display the list of Data Element names for that letter. To display the definition for a specific Data Element, click on the Data Element name.

~~The data elements are listed in alphabetical order. Click on a letter in the Data Element Bookmarks to display the list of data element names for that letter in the right hand screen frame. To display the content of a specific data element, click on the data element name. The content of the data element replaces the list of data element names in the rightmost screen frame.~~Each Data Element name is in uppercase. Where the name appears in text in **Green**, it indicates that it is a hyperlink and if clicked on will display the definition for that Data Element.

~~Each attribute name, class name or data element name which appears in the data element content text is in uppercase, any business definition will appear in Title Case. Where the name also appears in blue, this indicates that it is a clickable link and if clicked on will display the definition for that class, attribute, business definition or the content of the data element. In the same way, if a 'definition' tab is present and clicked on, the attribute containing the definition of that data element will be displayed (this may contain National Codes relevant to that data element).~~The following information is available on a Data Element:

~~The following information may be shown within a data element:~~

- **"Description" tab**: a description of the a Data Element

~~**Attribute tab**~~ ~~An 'attribute' tab, indicates that an attribute definition exists with the same na Click on the tab to display the attribute, then click on the attribute name to ge it's definition.~~

~~When no tab is present, the data element itself is either a derived item which derivable from attributes or only exists as a data element.~~

~~**Format/length:**~~ ~~An entry in this field defines the format and length of the data element, the following conventions are used for format:~~

~~**a** – is alphabetic characters only~~
~~**n** – is numeric characters only~~
~~**an** is alphanumeric i.e. alphabetic and numeric characters allowed~~
~~The number following the format code indicates the field length of the data element, e.g. **an3** has a field length of three alphanumeric characters.~~

~~**HES item:**~~ ~~An entry in this field indicates that the data element is used by Hospital Episo Statistics and is identified by the entered name e.g. data element BIRTH DATE a Hospital Episode Statistics item name of DOB.~~

~~If the field is blank, the data element is not used by Hospital Episode Statistic~~

~~**National Codes:**~~ ~~An entry in this field indicates that the National Codes or classifications exist f data element (as an attribute) and describes how to view them e.g. 'Click on attribute tab to display the attribute that contains the National Codes' or 'Clic the attribute tab to display the attribute that contains the Classifications'.~~

~~If there are no agreed National Codes or classifications for the data element, field is blank.~~

~~A National Code has nationally agreed values for each code which must be us conjunction with the data element whereas for a classification, the classificati will be nationally agreed but will have no nationally agreed values assigned to them. Usually for classifications, the values to be used in conjunction with the element will be contained within **Notes:** content e.g. see AGE GROUP INTEND~~

~~**Default Codes:**~~ ~~An entry in this field indicates that in addition to the nationally agreed Nationa Codes or classifications, default codes may be used. These default codes only appear within data elements and are not nationally agreed data standards i.e. are not supported by an attribute definition. The following formats for default may be used:~~

~~*Not known* coded as 99 (2 digit codes) and 9 (1 digit code)~~
~~*Not applicable* coded as 98 (2 digit codes) and 8 (1 digit code)~~

~~This general rule however, is not totally consistent. For some data elements, has been assigned a meaning other than *Not applicable* e.g. DELIVERY PLACE (ACTUAL). Such exceptions are indicated within the **Notes:** content.~~

~~**Notes:**~~ ~~Provides guidance, support, values or other information concerning the data element and its usage. Any attribute name, class name or data element name which appears in the Notes text is in uppercase, any business definition appe Title Case. Where the name also appears in blue, this indicates that it is a clic link and if clicked on will display the definition for that class, attribute, busine definition or the content of the data element.~~

- **"Where Used" tab**: every item where the Data Element is used

- **"Attribute" tab**: the Attribute the Data Element is based on

- **Format/ Length**:
  - An entry in this field defines the format and length of the Data Element.
  - The character set used for Data Elements is the UTF-8 standard (Unicode Transformation Format-8).
  - The number indicates the field length of the Data Element.

- **HES Item**:
  - This is the Hospital Episode Statistics name for the Data Element, e.g. Data Element BIRTH DATE has a Hospital Episode Statistics item name of "DOB". For further information, see Hospital Episode Statistics Cross Reference Tables.

- **National Codes:**
  - An entry in this field indicates that the National Codes or classifications exist for the Data Element (as an Attribute) and describes how to view them e.g. 'Click on the attribute tab to display the attribute that contains the National Codes' or 'See *the relevant Attribute'*.
  - If there are no agreed National Codes or classifications for the Data Element, the field is blank.
  - A National Code has nationally agreed values for each code which must be used in conjunction with the Data Element whereas for a classification, the classifications will be nationally agreed but will have no nationally agreed values assigned to them. Usually for classifications, the values to be used in conjunction with the Data Element will be contained within **Notes:** content e.g. see AGE GROUP INTENDED.

- **Default Codes**:
  - An entry in this field indicates that in addition to the nationally agreed National Codes or classifications, default codes may be used. These default codes normally only appear within Data Elements.

- **Notes**:
  - Provides guidance, support, values or other information concerning the Data Element and its usage. Any Attribute name, Class name or Data Element name which appears in the Notes text is in uppercase, any NHS Business Definition appears in Title Case. Where the name also appears in text in a colour other than black, this indicates that it is a clickable link and if clicked on will display the definition for that item.

~~Although this may seem complicated, it is necessary both to form a coherent logical model and to relate physical information such as that which flows on the messages (elements) to the logical model. Every physical item should be represented logically in the Dictionary. However, the scope of the logical model is greater than the physical information it holds and therefore not all logical information has a physical existence.~~For further information on Version 3 of the NHS Data Model and Dictionary, see About Version 3.

~~The classes, attributes and relationships are logical model components. The classes are comprised of attributes and the Data Attribute 'tab' is the way of displaying these. An attribute can only belong to one class (although the Where Used 'tab' will show every class or other object where it is referenced). The relationships identify any optional links or mandatory dependencies between classes. The relationship 'tab' is the way of displaying the relationships associated with a class.~~

~~Elements are physical model components. They represent information on the messages or in some cases Central Returns. Identifying how this information maps to the logical model is essential if the information stored on the attributes, classes and relationships is to be utilised with respect to the physical item.~~

DATA ELEMENTS INTRO

Change to Supporting Information: Changed Description, Aliases

- Changed Description
- Alias Changes

Name	Old Value	New Value
alsoknownas		Data Element

DAY CARE ATTENDANCE

Change to Supporting Information: Changed Description

Day Care Attendance is a CARE CONTACT.

One attendance, or expected attendance, by a PATIENT at a particular Day Care Session. ~~This will either be by a regular attender or by a~~ PATIENT ~~currently using a hospital bed (including~~ Home Leave ~~and~~ Mental Health Leave Of Absence ~~for a period of 28 days or less).~~ This will either be by a regular attender or by a PATIENT currently using a Hospital Bed (including Home Leave and Mental Health Leave Of Absence for a period of 28 days or less).

If the PATIENT is currently subject to a Mental Health Care Spell and during attendance at the facility is in contact with the CARE PROFESSIONAL who is their allocated care programme approach care coordinator then a Face To Face Contact CPA Care Coordinator should also be recorded.

~~For Day Care Attendance, first attendance is the first of a series, or only attendance, at Day Care Facilities of an~~

~~ORGANISATION by either a PATIENT using a hospital bed or a regular day attender.~~For Day Care Attendance, first attendance is the first of a series, or only attendance, at Day Care Facilities of an ORGANISATION by either a PATIENT using a Hospital Bed or a regular day attender. A re-attendance is any subsequent attendance at a Day Care Session of the same Health Care Provider by a PATIENT whose attender status has not changed since the previous attendance.

Information recorded for a Day Care Attendance includes:

ATTENDED OR DID NOT ATTEND
FIRST ATTENDANCE

DAY CARE FACILITY

Change to Supporting Information: Changed Description

Day Care Facility is a CLINIC OR FACILITY.

A Day Care Facility provided for the clinical treatment, assessment and maintenance of function of PATIENTS, in particular, though not exclusively, those who are elderly, mentally ill or have learning difficulties. They may be called Day Hospitals, Centres, Facilities or Units.

~~Day Care Facilities may be financed, planned and run solely by NHS organisations or solely by non-NHS organisations or jointly between NHS and non-NHS organisations.~~Day Care Facilities may be financed, planned and run solely by NHS ORGANISATIONS or solely by non-NHS ORGANISATIONS or jointly between NHS and non-NHS organisations. Jointly run facilities should still be managed by only one ORGANISATION.

~~The facilities specifically do not have hospital beds and function separately from any WARD.~~The facilities specifically do not have Hospital Beds and function separately from any WARD.

Day Care Facilities are usually open during the five week days. In some places a service may be provided only once or twice a week and the service may take the form of evening or weekend Day Care Sessions.

DISCHARGE READY DATE

Change to Supporting Information: Changed Description

Discharge Ready Date is an ACTIVITY DATE TIME TYPE.

~~The date that a PATIENT was medically ready for discharge from a hospital bed but could not be discharged, thereby qualifying for Delayed Discharge Payments under the provisions of the Community Care (Delayed Discharges etc) Act 2003.~~The date that a PATIENT was medically ready for discharge from a Hospital Bed but could not be discharged, thereby qualifying for Delayed Discharge Payments under the provisions of the Community Care (Delayed Discharges etc) Act 2003.

The settings from where the discharge may originate are a health service hospital or an independent hospital in pursuance of arrangements made by an NHS body.

Within the Act, the relevant community care services are defined under the National Health Service and Community Care Act 1990 section 46 (3). This in turn refers to provisions of other acts as follows:

"community care services" means services which a local authority may provide or arrange to be provided under any of the following provisions:

(a) Part III of the [1948 c. 29.] National Assistance Act 1948;

(b) section 45 of the [1968 c. 46.] Health Services and Public Health Act 1968;

(c) section 21 of and Schedule 8 to the [1977 c. 49.] National Health Service Act 1977; and

(d) section 117 of the [1983 c. 20.] Mental Health Act 1983

ELECTIVE ADMISSION

Change to Supporting Information: Changed Description

Elective Admission provides further guidance for classifying an admission to hospital via an ELECTIVE ADMISSION LIST.

An Elective Admission is one that has been arranged in advance. ~~It is not an emergency admission, a maternity admission or a transfer from a bed in another provider.~~ It is not an emergency admission, a maternity admission or a transfer from a Hospital Bed in another Health Care Provider. The period that the PATIENT has to wait for admission depends on the demand on hospital resources and the facilities available to meet this demand.

ELECTIVE ADMISSION LIST

Change to Supporting Information: Changed Description

Elective Admission List is a WAITING LIST.

A list of PATIENTS, for whom a DECISION TO ADMIT has been made, currently awaiting admission regardless of whether a date to admit has been given. This list may be maintained in several forms, including CONSULTANTS' diaries.

It does not include PATIENTS waiting for a first Out-Patient Attendance Consultant.

Lists can be maintained in several forms, using either computer or manual systems, including CONSULTANTS' diaries. They may be kept by TREATMENT FUNCTION CODE or for an individual CARE PROFESSIONAL. A PATIENT can be on more than one Elective Admission List. This may be because the PATIENT needs treatment for more than one condition or because the PATIENT has been placed on the list of more than one provider for the same condition.

It is also possible for a PATIENT to be entered on an Elective Admission List more than once, either for a different condition or for the same condition, where two or more admissions are required. For example, a PATIENT would have two ELECTIVE ADMISSION LIST ENTRIES on a list where the intention was to perform two or more operations requiring two or more admissions, such as repair of inguinal hernia and operation on varicose veins. Only one ELECTIVE ADMISSION LIST ENTRY should be made in the event of the intention to perform two or more procedures during one admission.

~~PATIENTS already in a hospital bed who are waiting for transfer in the same provider unit or to another provider unit cannot be included in an Elective Admission List. Elective Admission List is only for PATIENTS without a current provider spell, waiting for admission to hospital to start a Hospital Provider Spell.~~PATIENTS already in a Hospital Bed who are waiting for transfer in the same Health Care Provider unit or to another Health Care Provider unit cannot be included in an Elective Admission List. Elective Admission List is only for PATIENTS

without a current Hospital Provider Spell, waiting for admission to hospital to start a Hospital Provider Spell.

GLOSSARY OF TERMS

Change to Supporting Information: Changed Description

The Glossary lists commonly used terms in alphabetical order. These terms are not defined and therefore do not have a class or attribute. Each entry in the Glossary is shown with its related class and attribute where appropriate.

For example 'Booked Admission' is shown as relating to the class ELECTIVE ADMISSION LIST ENTRY. ELECTIVE ADMISSION LIST ENTRY has an attribute ELECTIVE ADMISSION TYPE and reference to the attribute definition will identify that 'Booked Admission' is one of the national code classifications of ELECTIVE ADMISSION TYPES.

Class	Attribute
Admission	
Hospital Provider Spell	ACTIVITY DATE of the ACTIVITY DATE TIME TYPE Start Date
Annual Census	
Hospital Provider Spell	ACTIVITY DATE of the ACTIVITY DATE TIME TYPE Start Date
OPERATIVE PROCEDURE	
Legal Status	MENTAL CATEGORY
Hospital Provider Spell	ACTIVITY DATE of the ACTIVITY DATE TIME TYPE Discharge Date
PATIENT DIAGNOSIS	
~~**Bed**~~	
~~WARD OPERATIONAL PLAN~~	
Booked Admission	
ELECTIVE ADMISSION LIST ENTRY	ELECTIVE ADMISSION TYPE
Code of General Practitioner	
GENERAL MEDICAL PRACTITIONER	GENERAL MEDICAL PRACTITIONER PPD CODE
GENERAL DENTAL PRACTITIONER	GENERAL DENTAL PRACTITIONER CODE
Consultant Code	
CONSULTANT	CONSULTANT CODE
Consultant Name	
PERSON NAME	
Day Case Admission	
Hospital Provider Spell	PATIENT CLASSIFICATION
Diagnostic Services	
Pathology Department	
Radiology Department	
Isotope Procedure Department	
Physiological Measurement Department	
Discharge	
Hospital Provider Spell	ACTIVITY DATE of the ACTIVITY DATE TIME TYPE Discharge Date
Drop-In Clinic	

REFERRAL REQUEST	OUT-PATIENT CLINIC REFERRING INDICATOR
Emergency Admission	
Hospital Provider Spell	ADMISSION METHOD
Emergency Journey	
Emergency Transport Request	
General Practitioner Name	
PERSON NAME	
GMC or GDC Reference Number	
CARE PROFESSIONAL	CARE PROFESSIONAL IDENTIFIER
Local Patient Identifier	
PATIENT ORGANISATION	LOCAL PATIENT IDENTIFIER
Maternity Admission	
Hospital Provider Spell	ADMISSION METHOD
Neonate	
PATIENT	
Nurse Identifier	
CARE PROFESSIONAL	CARE PROFESSIONAL IDENTIFIER
Nurse Name	
PERSON NAME	
Ordinary Admission	
Hospital Provider Spell	PATIENT CLASSIFICATION
Org**anisation Postcode**	
ADDRESS	POSTCODE
ADDRESS ASSOCIATION	
Organisation Address	
ADDRESS ASSOCIATION	ADDRESS ASSOCIATION TYPE
Patient Name	
PERSON NAME	
Patients Usual Address	
ADDRESS ASSOCIATION	ADDRESS ASSOCIATION TYPE
Planned Admission	
ELECTIVE ADMISSION LIST ENTRY	ELECTIVE ADMISSION TYPE
Postcode of Usual Address	
ADDRESS	POSTCODE
Regular Day Admission	
Hospital Provider Spell	PATIENT CLASSIFICATION
Sex	
PERSON GENDER	PERSON GENDER CODE
PERSON GENDER CURRENT	
PERSON GENDER AT REGISTRATION	
Special / Planned Journey	
Special Transport Request	
Planned Transport Request	
Telephone Number	
COMMUNICATION CONTACT INFORMATION	COMMUNICATION CONTACT METHOD
	COMMUNICATION CONTACT STRING

Two Man/One Man Crew	
TRANSPORT REQUIREMENT	TRANSPORT NEED
TCI (To Come In Date)	
OFFER OF ADMISSION	OFFERED FOR ADMISSION DATE
Urgent Journey	
Urgent Transport Request	
Waiting List Admission	
ELECTIVE ADMISSION LIST ENTRY	ELECTIVE ADMISSION TYPE
Ward Transfer	
Ward Stay	ACTIVITY DATE of the ACTIVITY DATE TIME TYPE End Date
	WARD STAY TERMINATION REASON

HOME LEAVE

Change to Supporting Information: Changed Description

Home Leave is a type of LEAVE.

~~Home Leave occurs when a PATIENT who is not liable to be detained under Part II of the Mental Health Act 1983 and who is using a bed in a WARD or care home spends a period of time outside hospital/care home, usually at home, with the intention of returning to the same type of WARD or care home to continue the same Consultant Episode (Hospital Provider), Midwife Episode or Nursing Episode.~~Home Leave occurs when a PATIENT who is not liable to be detained under Part II of the Mental Health Act 1983 and who is using a Hospital Bed in a WARD or a bed in a Care Home spends a period of time outside the hospital/Care Home, usually at home, with the intention of returning to the same type of WARD or Care Home to continue the same Consultant Episode (Hospital Provider), Midwife Episode or Nursing Episode.

A PATIENT liable to be detained in hospital under Part II of the Mental Health Act 1983 and as amended by the Mental Health (Patients in the Community) Act 1985, should be granted Mental Health Leave Of Absence instead of Home Leave.

For a PATIENT under a Nursing Episode or a Midwife Episode the period of time is at the discretion of the responsible NURSE OR MIDWIFE. The period of time for all other PATIENTS should be a maximum of Saturday, Sunday, NHS, bank and public holidays plus another three days. If a PATIENT does not return on the day specified and has failed to make alternative arrangements with hospital/care home staff, such a PATIENT should be considered discharged from that day. ~~The date on which a PATIENT leaves the WARD to go on Home Leave closes the preceding Ward Stay.~~ The date on which a PATIENT leaves the WARD to go on Home Leave closes the preceding Ward Stay.

Information recorded for a Home Leave includes:

- Start Date
- End Date

HOSPITAL BED

Change to Supporting Information: New Supporting Information

A Hospital Bed includes any device that may be used to permit a PATIENT to lie down when the need to do so is as a consequence of the PATIENT's condition rather than the need for active intervention such as examination,

diagnostic investigation, manipulation/treatment, or transport. Cots should be included in statistics about Hospital Beds where appropriate.

It should be noted that:

- A couch or trolley should be considered as a Hospital Bed provided it is used regularly to permit a PATIENT to lie down rather than for merely examination or transport. An example of such an arrangement is a day surgery ward furnished with trolleys
- A PATIENT may need to use a Hospital Bed, couch or trolley whilst attending for a specific short procedure taking an hour or less, such as an endoscopy. If such devices are being used only because of the active intervention and not because of the PATIENT's condition, they should NOT be counted as Hospital Beds for statistical purposes
- A PATIENT needing a lengthy procedure such as renal dialysis may use a Hospital Bed or other means of support such as a couch or special chair. Whatever the device used it should be counted as a Hospital Bed if used regularly for this purpose
- Some procedures require narcosis. If this necessitates the PATIENT to lie down, the Hospital Bed, couch or trolley can be counted as a Hospital Bed if used regularly for this purpose
- A device specifically and solely for the purpose of delivery should not be counted as a Hospital Bed if another device is normally reserved for antenatal and postnatal care. Details of the facilities available for delivery in a maternity ward should be included in a WARD inventory.

HOSPITAL PROVIDER

Change to Supporting Information: Changed Description

A Health Care Provider providing services from:-

a. Care Home

~~b. A separately managed NHS unit (including NHS Trusts) for PATIENTS using a hospital bed, or for PATIENTS using a Care Home bed under the care of a CONSULTANT~~

b. A separately managed NHS unit (including NHS Trusts) for PATIENTS using a Hospital Bed, or for PATIENTS CONSULTANT

HOSPITAL PROVIDER SPELL

Change to Supporting Information: Changed Description

Hospital Provider Spell is an ACTIVITY GROUP.

~~The total continuous stay of a PATIENT using a bed on premises controlled by a Health Care Provider during which medical care is the responsibility of one or more CONSULTANTS, or the PATIENT is receiving care under one or more Nursing Episodes or Midwife Episodes in a WARD.~~The total continuous stay of a PATIENT using a Hospital Bed on premises controlled by a Health Care Provider during which medical care is the responsibility of one or more CONSULTANTS, or the PATIENT is receiving care under one or more Nursing Episodes or Midwife Episodes in a WARD. During Nursing Episodes and Midwife Episodes general medical care is the responsibility of their own GENERAL MEDICAL PRACTITIONER, who is not acting as a CONSULTANT. The Hospital Provider Spell may be as a result of an ELECTIVE ADMISSION LIST ENTRY.

During the Hospital Provider Spell, the PATIENT may be subject to more than one ADMINISTRATIVE CATEGORY PERIODS. The PATIENT may be subject to one or more CRITICAL CARE PERIODS.

The Hospital Provider Spell starts when a CONSULTANT, NURSE or MIDWIFE assumes responsibility for care

following the decision to admit the PATIENT. This may be before formal admission procedures have been completed and the PATIENT transferred to a WARD. ~~For example, if a PATIENT is brought into hospital as an emergency and dies in the operating theatre before being transferred to a ward, the PATIENT would have started a Hospital Provider Spell.~~ For example, if a PATIENT is brought into hospital as an emergency and dies in the OPERATING THEATRE before being transferred to a WARD, the PATIENT would have started a Hospital Provider Spell.

In some circumstances a PATIENT may take Home Leave, or Mental Health Leave Of Absence for a period of 28 days or less, or have a current period of Mental Health Absence Without Leave of 28 days or less, which does not interrupt the Hospital Provider Spell, Consultant Episode (Hospital Provider), Nursing Episode, Midwife Episode or Hospital Stay.

Each admission as part of a series of regular day/night admissions generates a separate Hospital Provider Spell and Consultant Episode (Hospital Provider). An admission is the start of the PATIENT's Hospital Provider Spell and the first Consultant Episodes (Hospital Provider), Midwife Episode or Nursing Episode within the spell. If the PATIENT is on a Hospital Site the admission will also start the first Hospital Stay and, unless the PATIENT has to spend time as a LODGED PATIENT, the admission will also start the first Ward Stay within that Hospital Provider Spell. ~~If the PATIENT is in a care home the admission will start the first Care Home Stay (Consultant Care) within the Hospital Provider Spell. Any admission of a PERSON liable to be detained under the Mental Health Act 1983 cannot be in a care home and must be a Hospital Provider Spell.~~ If the PATIENT is in a Care Home the admission will start the first Care Home Stay (Consultant Care) within the Hospital Provider Spell. Any admission of a PERSON liable to be detained under the Mental Health Act 1983 cannot be in a Care Home and must be a Hospital Provider Spell.

A discharge will be the end of the last Consultant Episode (Hospital Provider), Midwife Episode or Nursing Episode, and the end of the last Care Home Stay (Consultant Care) or Hospital Stay and Ward Stay within that Hospital Provider Spell.

If there is any time spent as a LODGED PATIENT before transfer to a WARD this is included in the Hospital Provider Spell.

A Hospital Provider Spell starts with a Hospital Provider admission and ends with a Hospital Provider discharge.

HOSPITAL SITE

Change to Supporting Information: Changed Description, Aliases

Hospital Site is an ORGANISATION SITE.

A Hospital Site is an ORGANISATION SITE that is a hospital. ~~It should contain at least one bed routinely used by PATIENTS overnight. However, a dental hospital which does not have beds routinely used by PATIENTS overnight may be classified as a Hospital Site if it includes at least one bed routinely used by PATIENTS by day.~~ It should contain at least one Hospital Bed routinely used by PATIENTS overnight. However, a dental hospital which does not have Hospital Beds routinely used by PATIENTS overnight may be classified as a Hospital Site if it includes at least one Hospital Bed routinely used by PATIENTS by day. A hospital is an establishment for which the main purpose is to provide medical or psychiatric treatment for illness or mental disorder or palliative care. PATIENTS may have a Hospital Stay at a Hospital Site, as a result of one or more ELECTIVE ADMISSION LIST ENTRIES.

~~A hospital is run by a general manager and contracted staff within an organisational hierarchy of SERVICE POINTS.~~A hospital has an organisational hierarchy of SERVICE POINTS. Each SERVICE POINT serves a specific function and uses accommodation, equipment and money to provide residential care or allied and supporting services for PATIENTS.

~~A hospital which provides high security psychiatric services in high security accommodation for PATIENTS liable to be detained in hospital under provisions of the Mental Health Act 1983, who require treatment under conditions of special security on account of their dangerous, violent or criminal propensities, must be part of an NHS trust approved by the Secretary of State for the purpose of providing such services.~~A hospital which provides high security psychiatric services in high security accommodation for PATIENTS liable to be detained in hospital under provisions of the Mental Health Act 1983, who require treatment under conditions of special security on account of their dangerous, violent or criminal propensities, must be part of an NHS Trust approved by the Secretary of State for the purpose of providing such services.

~~Any establishment in which treatment or nursing (or both) are provided for persons liable to be detained under the Mental Health Act 1983 is a Hospital Site.~~Any establishment in which treatment or nursing (or both) are provided for PERSONS liable to be detained under the Mental Health Act 1983 is a Hospital Site.

~~The site may or may not be classed as an NHS site.~~The Hospital Site may or may not be classed as an NHS site.

HOSPITAL SITE

Change to Supporting Information: Changed Description, Aliases

- Changed Description
- Alias Changes

Name	Old Value	New Value
shortname		Hospital

HOSPITAL STAY

Change to Supporting Information: Changed Description

Hospital Stay is an ACTIVITY GROUP.

~~The time a PATIENT using a bed stays on one Hospital Site during a Hospital Provider Spell.~~The time a PATIENT using a Hospital Bed stays on one Hospital Site during a Hospital Provider Spell. In some circumstances a PATIENT may take Home Leave, or Mental Health Leave Of Absence for 28 days or less, or have a current period of Mental Health Absence Without Leave of 28 days or less, which does not interrupt the Hospital Stay. If there is any time spent as a LODGED PATIENT before transfer to WARD this is included in the Hospital Stay.

META MODEL INTRODUCTION

Change to Supporting Information: Changed Description

~~The purpose of the meta model is to cohesively support the development and maintenance of NHS data standards in a consistent and integrated manner, that also supports the business process within and across the NHS, and with other non-NHS organisations involved with the care of patients.~~The purpose of the meta model is to cohesively support the development and maintenance of NHS data standards in a consistent and integrated manner, which also supports the business process within and across the NHS, and with other non-NHS ORGANISATIONS involved with the care of PATIENTS.

~~The meta data model will form the underpinning common structure which can be used by all future datasets~~

~~related to patients and care activity whether they be 'administrative', 'clinical', 'management' etc.~~The meta data model will form the underpinning common structure which can be used by all future data sets related to PATIENTS and CARE ACTIVITY whether they be 'administrative', 'clinical', 'management' etc.

~~A full review of the NHS Data Dictionary has been done in order to bring existing information into line with the Meta Data Model. This is to facilitate support of legacy data standards and alignment with NPfIT.~~A full review of the NHS Data Model and Dictionary has been done in order to bring existing information into line with the Meta Data Model. This is to facilitate support of legacy data standards and alignment with the National Programme for IT (NPfIT). This will therefore enable both legacy data standards and new data standards to be supported during the implementation of and migration to NPfIT. ~~There may be further pieces of work which follow to ensure consistency of the NHS Data Dictionary with the National Programme and other evolving data standards.~~ There may be further pieces of work which follow to ensure consistency of the NHS Data Model and Dictionary with the National Programme and other evolving data standards.

MIDWIFE EPISODE

Change to Supporting Information: Changed Description

Midwife Episode is an ACTIVITY GROUP.

~~A continuous period of time a client (PATIENT) uses a bed or delivery facility as part of a Hospital Provider Spell or Care Home Stay (Midwife Care), under the direct care of a MIDWIFE.~~A continuous period of time a PATIENT uses a Hospital Bed or delivery facility as part of a Hospital Provider Spell or Care Home Stay (Midwife Care), under the direct care of a MIDWIFE. This may be during a Pregnancy Episode or Labour And Delivery for the mother but may also be for a baby following a REGISTERABLE BIRTH.

The MIDWIFE with overall responsibility for a Midwife Episode must be identified. If the responsible MIDWIFE changes then a new Midwife Episode or Consultant Episode (Hospital Provider) begins.

General medical care during the Midwife Episode is the responsibility of the PATIENTS own GENERAL MEDICAL PRACTITIONER who is acting as a CONSULTANT.

Information recorded for a Midwife Episode includes:

- Start Date
- End Date O
- MIDWIFE EPISODE END REASON O

NHS BUSINESS DEFINITIONS

Change to Supporting Information: Changed Description, Aliases

Each NHS Business Definition consists of freestanding text which describes an aspect of NHS activity. The text starts by identifying which generic class encompasses the activity. This is followed by an outline of the business rules which should be applied to the activity.

The NHS Business Definitions are separate from the logical data model and allow specific business areas to be defined in greater detail. ~~The names of NHS Business Definitions are distinguished from the classes, attributes and data elements by appearing in Title Case rather than CAPITALS (see below).~~

The names of NHS Business Definitions are distinguished from the Classes, Attributes and Data Elements by appearing in Title Case rather than CAPITALS (see the example below).

Where the name appears in text in **Blue**, it indicates that it is a hyperlink and if clicked on will display the definition for that NHS Business Definition.

An example of an NHS Business Definition is a Hospital Provider Spell, which is related to the logical class ACTIVITY GROUP.

NHS BUSINESS DEFINITIONS

Change to Supporting Information: Changed Description, Aliases

- Changed Description
- Alias Changes

Name	Old Value	New Value
shortname		NHS Business Definition

OUT-PATIENT APPOINTMENT CONSULTANT

Change to Supporting Information: Changed Description

Out-Patient Appointment Consultant is an APPOINTMENT.

An Out-Patient Appointment.

An APPOINTMENT for a PATIENT to see or have contact with a CONSULTANT, or member of the CONSULTANT Firm, at a Consultant Clinic.

The APPOINTMENT may result in a Clinic Attendance Consultant as part of a Consultant Out-Patient Episode.

Information recorded for an Out-Patient Appointment Consultant includes:

~~ATTENDED OR DID NOT ATTEND~~ ~~O~~
ATTENDED OR DID NOT ATTEND

OUT-PATIENT ATTENDANCE CONSULTANT

Change to Supporting Information: Changed Description

Out-Patient Attendance Consultant is a CARE CONTACT.

An attendance at which a PATIENT is seen by or has contact with (face to face or via telephone/telemedicine) a CONSULTANT, in respect of one referral, that is not a visit to the home of a PATIENT for which a fee is payable under paragraph 140 of the Terms and Conditions of Service. For the purposes of this definition 'CONSULTANT' includes a member of the CONSULTANT's firm or locum for such a member. The attendance will be part of a Consultant Out-Patient Episode.

If a PATIENT is seen by a CONSULTANT at a Consultant Clinic then this will be a Clinic Attendance Consultant. ~~An attendance may involve more than one person (e.g. a family).~~ An attendance may involve more than one PERSON (e.g. a family). The number of attendances to be recorded should be the number of PATIENTS for whom the particular CONSULTANT has identifiable individual records and which will be maintained as a result of the attendance.

A visit to the home of a PATIENT made at the instance of a hospital or specialist to review the urgency of a proposed admission to hospital, or to continue to supervise treatment initiated or prescribed at a hospital or clinic is covered by this definition.

Out-Patient Attendance Consultant also includes a PATIENT being seen by a CONSULTANT from a different MAIN SPECIALTY CODE during a Consultant Episode (Hospital Provider) in circumstances where there is no transfer of responsibility for the care of the PATIENT.

If the PATIENT is currently subject to a Mental Health Care Spell and the CONSULTANT they are in contact with during attendance is their allocated Care Programme Approach care coordinator then a Face To Face Contact CPA Care Coordinator should also be recorded.

During the Out-Patient Attendance Consultant, a number of PATIENT DIAGNOSES and Patient Procedures may be recorded.

A series of Out-Patient Attendance Consultant will form a Consultant Out-Patient Episode, generated from a single referral. Note that it is possible to have two Consultant Out-Patient Episodes with the same CONSULTANT for different clinical conditions, if two referrals are made. An attendance may involve more than one PERSON - for example, a family. ~~The number of attendances to be recorded should be the number of PATIENTS for whom the CONSULTANT has identifiable individual records and which will be maintained as a result of the attendance. Note that Out-Patient Attendance Consultant can take place outside a clinic session, and can take place at the PATIENT's normal place of residence.~~ The number of attendances to be recorded should be the number of PATIENTS for whom the CONSULTANT Out-Patient Attendance Consultant can take place outside a clinic session, and can take place at the PATIENT's normal place of residence.

A PATIENT attending a WARD for examination or care will be counted as an Out-Patient Attendance Consultant if he/she is seen by a doctor. If they are only seen by a NURSE, they are a Ward Attendance.

An Out-Patient Attendance Consultant should also be recorded where a PATIENT is seen by a CONSULTANT from a different MAIN SPECIALTY CODE during a Consultant Episode (Hospital Provider) where there is no transfer of responsibility for the care of the PATIENT. For example, a PATIENT who is admitted to hospital under a Gastroenterology specialty following an overdose may be seen while still in hospital by a psychiatrist who has been asked to assess their mental condition. The assessment by the psychiatrist should be recorded as an Out-Patient Attendance Consultant.

Information recorded for an Out-Patient Attendance Consultant includes:

- ATTENDANCE DATE
- ATTENDANCE IDENTIFIER
- CONSULTATION MEDIUM USED
- FIRST ATTENDANCE
- LOCATION TYPE
- MEDICAL STAFF TYPE SEEING PATIENT O
- OUTCOME OF ATTENDANCE

PROFESSIONAL STAFF GROUP CONTACT

Change to Supporting Information: Changed Description

Professional Staff Group Contact is a CARE CONTACT.

A single occasion involving contact between a PATIENT or his/her proxy and one or more members of a professional staff group discipline from a Professional Staff Group Department, including paid support staff

working for a professional staff group discipline.

A Professional Staff Group Contact may follow from an Out-Patient Appointment Non-Consultant, in this event the time seen should be recorded.

A proxy contact is a single occasion involving contact between a client/PATIENT or his/her proxy, and one or more members of a professional staff group discipline or relevant staff group for community service. Contacts with proxies count as face-to-face contacts only if the contact is in lieu of the contact with the client, and the proxy is able more effectively than the client to ensure that specific professional advice devised for the client is followed. This is most likely to be the case where the client is unable to communicate effectively say for an infant, or for a PERSON who is mentally ill or learning disabilities.

For Professional Staff Group Services, face to face contacts comprise both:

a. Attendances lasting from the arrival to the departure of the PATIENT
b. Visits lasting from the arrival to the departure of professional staff group staff

One or more members of the professional staff group discipline may be in contact with one or more PATIENTS at the same time and PATIENTS may be seen in association with staff from other disciplines. Contacts should be recorded as follows:

a. If one or more staff of the same discipline are in contact with one PATIENT at the same time, this should be recorded as one face to face contact
b. If staff see a PATIENT with staff of other disciplines, this should be recorded as one face to face contact for each discipline involved
c. If one or more staff of one discipline are in contact with a group of PATIENTS at the same time, each PATIENT should be recorded as one face to face contact
d. If staff from different disciplines are in contact with a group of PATIENTS at the same time, each PATIENT should be recorded as one face to face contact for each discipline involved

For physiotherapy, it may not be practical to collect data about all face-to-face contacts; however as a minimum, initial contacts and first contacts in financial year should be recorded.

For occupational therapy, the contact duration should be recorded in half-hour units.

If the PATIENT is currently subject to a Mental Health Care Spell and the member of the professional staff group discipline in contact is also their allocated care programme approach care coordinator then a Face To Face Contact CPA Care Coordinator should also be recorded.

~~Note: When face-to-face contacts are used for attributing professional staff group costs to MAIN SPECIALTIES, it will be necessary to distinguish between those contacts by PATIENTS using a hospital bed, attenders at Consultant Clinics and attenders at Day Care Facilities.~~Note: When face-to-face contacts are used for attributing professional staff group costs to MAIN SPECIALTIES, it will be necessary to distinguish between those contacts by PATIENTS using a Hospital Bed, attenders at Consultant Clinics and attenders at Day Care Facilities.

Information recorded for a Professional Staff Group Contact includes:

Contact Date
First Contact In Financial Year
Initial Contact
LOCATION TYPE
PATIENT FACILITY GROUP
Time Seen O (if patient attends as a result of a clinic appointment)

REGULAR ATTENDER EPISODE

Change to Supporting Information: Changed Description

Regular Attender Episode is an ACTIVITY GROUP.

This is a period of care for a regular day attender attending one or more Day Care Facilities of a Health Care Provider within a particular day care function. ~~Regular day attenders are PATIENTS attending a Day Care Facility who are not currently using a hospital bed or on Home Leave or on Mental Health Leave Of Absence for a period of 28 days or less.~~ Regular day attenders are PATIENTS attending a Day Care Facility who are not currently using a Hospital Bed or on Home Leave or on Mental Health Leave Of Absence for a period of 28 days or less.

Regular Attender Episodes must be made up of one or more Day Care Attendances.

Information recorded for a Regular Attender Episode includes:

- EPISODE NUMBER
- DAY CARE FUNCTION
- End Date O
- Start Date

SHELTERED WORK FACILITY

Change to Supporting Information: Changed Description

Sheltered Work Facility is a CLINIC OR FACILITY.

A Sheltered Work Facility run specifically to provide work, usually during the day time, in sheltered surroundings for in particular, though not exclusively, those who are elderly, mentally ill or have learning difficulties.

~~The facilities specifically do not have hospital beds and function separately from any ward.~~The facilities specifically do not have Hospital Beds and function separately from any WARD.

Sheltered Work Facilities are usually open during the five week days. ~~In some places a service may be provided only once or twice a week and the service may take the form of evening or weekend sessions.~~ In some places a SERVICE may be provided only once or twice a week and the SERVICE may take the form of evening or weekend sessions.

VASECTOMY PERFORMED

Change to Supporting Information: Changed Description

Vasectomy Performed is a CLINICAL INTERVENTION.

~~A vasectomy operative procedure performed, excluding those vasectomies performed on NHS PATIENTS using a hospital bed.~~A vasectomy operative procedure performed, excluding those vasectomies performed on NHS PATIENTS using a Hospital Bed.

WARD STAY

Change to Supporting Information: Changed Description

Ward Stay is an ACTIVITY GROUP.

~~The time a PATIENT, using a bed and/or using a delivery facility, stays in one WARD.~~The time a PATIENT, using a Hospital Bed and/or using a delivery facility, stays in one WARD.

Each Ward Stay is within only one Hospital Provider Spell.

~~When a PATIENT takes Home Leave, Mental Health Leave Of Absence or has a current period of Mental Health Absence Without Leave, this should be recorded as a ward transfer to 'home leave', 'leave of absence' or 'absence without leave' and a new Ward Stay should begin on return.~~When a PATIENT takes Home Leave, Mental Health Leave Of Absence or has a current period of Mental Health Absence Without Leave, this should be recorded as a WARD transfer to 'Home Leave', 'leave of absence' or 'absence without leave' and a new Ward Stay should begin on return. In the case of Home Leave, the Nursing Episode, Midwife Episode or Consultant Episode (Hospital Provider), Hospital Stay or Hospital Provider Spell however remain uninterrupted. ~~In the case of Mental Health Leave Of Absence and Mental Health Absence Without Leave, the Nursing Episode, Midwife Episode or Consultant Episode (Hospital Provider) or Hospital Provider Spell however will only remain uninterrupted if the absence is for a period of 28 days or less.~~ In the case of Mental Health Leave Of Absence and Mental Health Absence Without Leave, the Nursing Episode, Midwife Episode, Consultant Episode (Hospital Provider) or Hospital Provider Spell however will only remain uninterrupted if the absence is for a period of 28 days or less.

~~In the case of PATIENTS using maternity wards of the same type on the same site, these should be recorded as one WARD.~~In the case of PATIENTS using maternity WARDS of the same type on the same site, these should be recorded as one WARD. There will therefore only be one Ward Stay rather than transfers between WARDS. For local purposes, however, such transfers may be identified.

For PATIENTS subject to a Mental Health Care Spell the end time of the Ward Stay should be recorded, as well as the start time if systems permit.

For each Ward Stay there should be a named NURSE or MIDWIFE who is responsible for the nursing or midwifery care of the PATIENT. If the named NURSE or MIDWIFE changes, the change is recorded.

APPOINTMENT

Change to Class: Changed Description

An arrangement for a PATIENT to be seen by or be in contact with one or more CARE PROFESSIONALS.

An APPOINTMENT becomes an entry on the APPOINTMENT WAITING LIST when it is decided that an offer of an APPOINTMENT should be made following a SERVICE REQUEST for an out-patient APPOINTMENT being received. The offer of an APPOINTMENT is made by one or more APPOINTMENT OFFERS

APPOINTMENTS include:

- Out-Patient Appointment Consultant
- Out-Patient Appointment Non-Consultant

APPOINTMENTS are also made for Home Help Visits, Registration Health Checks, Screening Tests, Day Care Attendances and GMP Practice Consultations.

The type of APPOINTMENT is classified by the APPOINTMENT CLASSIFICATION CODE.

~~When a PATIENT accepts an APPOINTMENT OFFER the APPOINTMENT DATE OFFERED and APPOINTMENT TIME~~

~~OFFERED of the offer become the APPOINTMENT DATE and APPOINTMENT TIME of the accepted APPOINTMENT.~~When a PATIENT accepts an APPOINTMENT OFFER the APPOINTMENT DATE OFFERED and APPOINTMENT TIME OFFERED of the offer become the APPOINTMENT DATE and APPOINTMENT TIME of the accepted APPOINTMENT.

Where more than one APPOINTMENT OFFER has been made for an APPOINTMENT and one has been accepted all the others for the same APPOINTMENT should be refused.

The APPOINTMENT should be removed from the APPOINTMENT WAITING LIST when the APPOINTMENT has taken place.

A series of APPOINTMENTS should relate to the same SERVICE REQUEST which initiated the series within the ORGANISATION. The SERVICE REQUEST may be related to a previous SERVICE REQUEST either from within the same or another ORGANISATION and be related to subsequent SERVICE REQUEST to the same or another ORGANISATION.

CLINIC OR FACILITY

Change to Class: Changed Description

An administrative arrangement enabling PATIENTS to see or be in contact with CARE PROFESSIONALS. The CLINIC OR FACILITY should always relate to an identified SERVICE POINT within an ORGANISATION.

~~CLINIC OR FACILITY ADMINISTRATIVE TYPE classifies the administrative arrangement for the clinic or facility and whether it is a physical or virtual SERVICE POINT or combination of both.~~CLINIC OR FACILITY ADMINISTRATIVE TYPE classifies the administrative arrangement for the CLINIC OR FACILITY and whether it is a physical or virtual SERVICE POINT or combination of both.

~~Clinics are mainly Out-Patient Clinics for PATIENTS to receive consultation, test, assessment, diagnosis, treatment or care without the need to be admitted.~~Clinics are mainly Out-Patient Clinics for PATIENTS to receive consultation, tests, assessment, diagnosis, treatment or care without the need to be admitted.

A Day Care Facility is provided for the clinical treatment, assessment and maintenance of function of PATIENTS, in particular, though not exclusively, those who are elderly, mentally ill or have learning difficulties. They may be called Day Hospitals, Centres, Facilities or Units.

~~A Day Care Facility may be financed, planned and run solely by NHS organisations or solely by non-NHS organisations or jointly between NHS and non-NHS organisations.~~A Day Care Facility may be financed, planned and run solely by NHS ORGANISATIONS or solely by non-NHS ORGANISATIONS or jointly between NHS and non-NHS ORGANISATIONS. Jointly run facilities should still be managed by only one ORGANISATION.

~~The facilities specifically do not have hospital beds and function separately from any WARD.~~The facilities specifically do not have Hospital Beds and function separately from any WARD.

A Day Care Facility is usually open during the five week days. ~~In some places a service may be provided only once or twice a week and the service may take the form of evening or weekend sessions.~~ In some places a service may be provided only once or twice a week and the SERVICE may take the form of evening or weekend sessions.

DAILY WARD LISTING

Change to Class: Changed Description

~~This records all the activity that has occurred in the WARD in the previous 24 hours and the bed availability status of the WARD. DAILY WARD LISTINGS should be completed at midnight, or during the working day in wards only open for limited periods.~~This records all the ACTIVITY that has occurred in the WARD in the previous 24 hours and the Hospital Bed availability status of the WARD. DAILY WARD LISTINGS should be completed at midnight, or during the working day in WARDS only open for limited periods.

~~Beds may be reserved and unavailable for a variety of reasons, including when they are vacated by PATIENTS who are on Home Leave.~~Hospital Beds may be reserved and unavailable for a variety of reasons, including when they are vacated by PATIENTS who are on Home Leave.

~~A bed vacated by a PATIENT while on Home Leave or Mental Health Leave Of Absence for 28 days or less, or with a current period of Absence Without Leave of 28 days or less, may be recorded on the DAILY WARD LISTING, if unoccupied, as reserved and not available because of Home Leave, Mental Health Leave Of Absence or Absence Without Leave.~~A Hospital Bed vacated by a PATIENT while on Home Leave or Mental Health Leave Of Absence for 28 days or less, or with a current period of Absence Without Leave of 28 days or less, may be recorded on the DAILY WARD LISTING, if unoccupied, as reserved and not available because of Home Leave, Mental Health Leave Of Absence or Absence Without Leave.

~~However, if a bed that is reserved for whatever reason is occupied by another PATIENT it should be recorded as available and occupied.~~However, if a Hospital Bed that is reserved for whatever reason is occupied by another PATIENT it should be recorded as available and occupied.

~~Beds may be used sometimes by healthy persons accompanying a PATIENT. When this occurs the bed should be recorded as unavailable because it is being used by a healthy person.~~Hospital Beds may be used sometimes by healthy PERSONS accompanying a PATIENT. When this occurs the Hospital Bed should be recorded as unavailable because it is being used by a healthy PERSON.

~~Bed availability should be measured in terms of bed days for all WARDS which are open overnight. WARDS open only during the day time or at night should be separately identified and the bed availability measured on the basis of the number of days or nights for which a service is being provided. For WARDS open overnight, bed availability should be measured as at midnight.~~Hospital Bed availability should be measured in terms of Hospital Bed days for all WARDS which are open overnight. WARDS open only during the day time or at night should be separately identified and the Hospital Bed availability measured on the basis of the number of days or nights for which a SERVICE is being provided. For WARDS open overnight, Hospital Bed availability should be measured as at midnight.

~~For WARDS only open during the day, bed availability should be measured in the morning. If a WARD is open for five days and four nights, the bed availability on the fifth day should be measured in the morning.~~For WARDS only open during the day, Hospital Bed availability should be measured in the morning. If a WARD is open for five days and four nights, the Hospital Bed availability on the fifth day should be measured in the morning.

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.

DIAGNOSTIC TEST REQUESTS include:

- Request for Isotope Procedure

- Request for Physiological Measurement
- Request for Pathology Investigation
- Request for Radiological Procedure
- Request for Diagnostic Endoscopy

~~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 .~~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 .

ELECTIVE ADMISSION LIST

Change to Class: Changed Description

A subtype of WAITING LIST.

A list of PATIENTS, for whom a DECISION TO ADMIT has been made, currently awaiting admission regardless of whether a date to admit has been given.

A PATIENT can be on more than one ELECTIVE ADMISSION LIST. This may be because the PATIENT needs treatment for more than one condition or because the PATIENT has been placed on the list of more than one provider for the same condition.

It is also possible for a PATIENT to be entered on an ELECTIVE ADMISSION LIST more than once, either for a different condition or for the same condition, where two or more admissions are required. For example, a PATIENT would have two ELECTIVE ADMISSION LIST ENTRIES on a list where the intention was to perform two or more operations requiring two or more admissions, such as repair of inguinal hernia and operation on varicose veins. Only one ELECTIVE ADMISSION LIST ENTRY should be made in the event of the intention to perform two or more procedures during one admission.

~~PATIENTS already in a hospital bed who are waiting for transfer in the same provider unit or to another provider unit should not be included in an ELECTIVE ADMISSION LIST for the condition being treated or for the treatment for which they are awaiting transfer. An ELECTIVE ADMISSION LIST is only for PATIENTS without a current provider spell, waiting for admission to hospital to start a Hospital Provider Spell and PATIENTS already admitted and waiting for a bed elsewhere should not be included.~~PATIENTS already in a Hospital Bed who are waiting for transfer in the same Health Care Provider unit or to another Health Care Provider unit should not be included in an ELECTIVE ADMISSION LIST for the condition being treated or for the treatment for which they are awaiting transfer. An ELECTIVE ADMISSION LIST is only for PATIENTS without a current Hospital Provider Spell, waiting for admission to hospital to start a Hospital Provider Spell and PATIENTS already admitted and waiting for a Hospital Bed elsewhere should not be included.

HEALTHY PERSON STAY

Change to Class: Changed Description

~~This is a record of all overnight stays by healthy PERSONS who use a hospital bed. The hospital bed allocated to the healthy PERSON may be drawn from the bed stock allocated to PATIENTS, thus the bed becomes unavailable, or from specially provided facilities.~~This is a record of all overnight stays by healthy PERSONS who use a Hospital Bed. The Hospital Bed allocated to the healthy PERSON may be drawn from the Hospital Bed stock allocated to PATIENTS, thus the Hospital Bed becomes unavailable, or from specially provided facilities.

ORGANISATION SITE BED AVAILABILITY

Change to Class: Changed Description

~~The number of bed days available in an ORGANISATION SITE during a period of time.~~The number of Hospital Bed days available in an ORGANISATION SITE during a period of time.

ORGANISATION SITE BED OCCUPANCY

Change to Class: Changed Description

~~The number of bed days occupied in an ORGANISATION SITE during a period of time.~~The number of Hospital Bed days occupied in an ORGANISATION SITE during a period of time.

PATIENT

Change to Class: Changed Description

A PERSON with a specific disease or condition who receives treatment from a Health Care Provider or any REGISTERABLE BIRTH.

It is an entry on the PATIENT master index. This will be a PERSON, which includes neonates (babies aged 28 days or less), who use a hospital bed in order to receive clinical care/treatment or someone attending a clinic, day care facility, etc. It will also include people in the community receiving care under a specific NHS Service Agreements forming part of 'nursing care in the community'. ~~This also includes PATIENTS on the ELECTIVE ADMISSION LIST who are awaiting Elective Admission.~~ This also includes PATIENTS on the ELECTIVE ADMISSION LIST who are awaiting elective admission.

PATIENT PATHWAY

Change to Class: Changed Attributes

Attributes of this Class are:

~~K~~	~~SECONDARY CARE PATIENT PATHWAY IDENTIFIER~~
K	PATIENT PATHWAY IDENTIFIER
	~~SECONDARY CARE PATIENT PATHWAY START DATE~~
	PATIENT PATHWAY START DATE

RIGHT OF ADMISSION

Change to Class: Changed Description

~~An arrangement by a Health Care Provider giving Medical or Nursing Staff the right to admit a PATIENT to a hospital bed or ORGANISATION SITE.~~An arrangement by a Health Care Provider giving Medical or Nursing Staff the right to admit a PATIENT to a Hospital Bed or ORGANISATION SITE.

WARD

Change to Class: Changed Description

~~A group of beds with associated treatment facilities managed as a single unit for the purposes of staffing and treatment responsibilities.~~A group of Hospital Beds with associated treatment facilities managed as a single unit for the purposes of staffing and treatment responsibilities. All the rooms in a small hospital may be managed by one senior NURSE and as a single unit and thus they would comprise one WARD. A WARD may be available all the time or for only limited time periods during the day or week.

~~A critical care unit will comprise one WARD if the beds and associated treatment facilities are managed as a single unit.~~A critical care unit will comprise one WARD if the Hospital Beds and associated treatment facilities are managed as a single unit.

Maternity wards of the same 'type' on the same site should for national purposes be treated as one WARD, so that a PATIENT moving between them is not counted as a transfer between WARDS. For local purposes it may be useful to identify separately such transfers. Facilities specifically used for delivery in maternity wards should be included as WARDS, or annexed to WARDS.

WARD BED AVAILABILITY

Change to Class: Changed Description

~~The total number of beds resourced and available for use on a WARD for a single CLINICAL CARE INTENSITY or AUGMENTED CARE LOCATION CODE. Availability of beds for a single AUGMENTED CARE LOCATION CODE will be separately recorded for intensive care and for high dependency.~~The total number of Hospital Beds resourced and available for use on a WARD for a single CLINICAL CARE INTENSITY or AUGMENTED CARE LOCATION CODE. Availability of Hospital Beds for a single AUGMENTED CARE LOCATION CODE will be separately recorded for intensive care and for high dependency.

~~Note: On the 31st March, the total numbers of cots resourced for the provision of intensive care to a neonate are to be recorded for KH03 purposes.~~Note: On the 31st March each year, the total numbers of cots resourced for the provision of intensive care to a neonate are to be recorded for KH03 purposes. This is regardless of actual utilisation.

WARD OPERATIONAL PLAN

Change to Class: Changed Description

~~This is a statement of the operational planning intent for a particular WARD, including intended time and bed availability, TREATMENT FUNCTION, BROAD PATIENT GROUP CODE and CLINICAL CARE INTENSITY.~~This is a statement of the operational planning intent for a particular WARD, including intended time and Hospital Bed availability, TREATMENT FUNCTION, BROAD PATIENT GROUP CODE and CLINICAL CARE INTENSITY.

~~Bed availability, in the above, is expressed as the WARD Total Beds Intended (Consultant Care, Nursing Care and Midwife Care) available for the use of PATIENTS. This should reflect the number of places available for patient care rather than just a count of physical devices that may be used as a bed.~~Hospital Bed availability, in the above, is expressed as the WARD Total Beds Intended (CONSULTANT Care, NURSE Care and MIDWIFE Care)

available for the use of PATIENTS. This should reflect the number of places available for PATIENT care rather than just a count of physical devices that may be used as a Hospital Bed.

~~A bed includes any device that may be used to permit a PATIENT to lie down when the need to do so is as a consequence of the PATIENT's condition rather than the need for active intervention such as examination, diagnostic investigation, manipulation/treatment, or transport. Cots should be included in statistics about beds where appropriate.~~

~~It should be noted that:~~

a. ~~A couch or trolley should be considered as a bed provided it is used regularly to permit a PATIENT to lie down rather than for merely examination or transport. An example of such an arrangement is a day surgery ward furnished with trolleys~~
b. ~~A PATIENT may need to use a bed, couch or trolley whilst attending for a specific short procedure taking an hour or less, such as an endoscopy. If such devices are being used only because of the active intervention and not because of the PATIENT's condition, they should NOT be counted as beds for statistical purposes~~
c. ~~A PATIENT needing a lengthy procedure such as renal dialysis may use a bed or other means of support such as a couch or special chair. Whatever the device used it should be counted as a bed if used regularly for this purpose~~
d. ~~Some procedures require narcosis. If this necessitates the PATIENT to lie down, the bed, couch or trolley can be counted as a hospital bed if used regularly for this purpose~~
e. ~~A device specifically and solely for the purpose of delivery should not be counted as a bed if another device is normally reserved for antenatal and postnatal care. Details of the facilities available for delivery in a maternity ward should be included in a ward inventory~~

A AND E ATTENDANCE DISPOSAL

Change to Attribute: Changed Description

A coding of the ways in which an Accident And Emergency Attendance might end.

National Codes:

~~01~~	~~Admitted to hospital bed/became a LODGED PATIENT of the same Health Care Provider~~
~~02~~	~~Discharged - follow up treatment to be provided by General Practitioner~~
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 treated~~
~~13~~	~~Left Department having refused treatment~~
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 treated
13	Left DEPARTMENT having refused treatment

14 Other

ADMINISTRATIVE CATEGORY CODE

Change to Attribute: Changed Description

This is recorded for PATIENT activity.

~~The category 'amenity patient' of the classification is only applicable to PATIENTS using a hospital bed.~~The category 'amenity patient' of the classification is only applicable to PATIENTS using a Hospital Bed.

National Codes:

~~01~~	~~NHS patient, including overseas visitors charged under Section 121 of the NHS Act 1977 as amended by Section 7(12) and (14) of the Health and Medicine Act 1988~~
01	NHS PATIENT, including overseas visitors charged under Section 121 of the NHS Act 1977 as amended by Section 7(12) and (14) of the Health and Medicine Act 1988
02	Private patient, one who uses accommodation or services authorised under section 65 and/or 66 of the NHS Act 1977 (Section 7(10) of Health and Medicine Act 1988 refers) as amended by Section 26 of the National Health Service and Community Care Act 1990
03	Amenity patient, one who pays for the use of a single room or small ward in accord with section 12 of the NHS Act 1977, as amended by section 7(12) and (14) of the Health and Medicine Act 1988
04	Category II patient, one for whom work is undertaken by hospital medical or dental staff within category II as defined in paragraph 37 of the Terms and Conditions of Service of Hospital Medical and Dental Staff.

AVAILABLE BED DAYS NHS PATIENTS

Change to Attribute: Changed Description

~~The number of beds available for NHS PATIENTS during the period of an ORGANISATION SITE BED AVAILABILITY.~~The number of Hospital Beds available for NHS PATIENTS during the period of an ORGANISATION SITE BED AVAILABILITY.

BED AVAILABILITY END DATE

Change to Attribute: Changed Description

~~The date that the total number of beds resourced and available for use on a WARD for a single CLINICAL CARE INTENSITY or AUGMENTED CARE LOCATION CODE ceases to be applicable.~~The date that the total number of Hospital Beds resourced and available for use on a WARD for a single CLINICAL CARE INTENSITY or AUGMENTED CARE LOCATION CODE ceases to be applicable.

BED AVAILABILITY START DATE

Change to Attribute: Changed Description

~~The date that the total number of beds resourced and available for use on a WARD for a single CLINICAL CARE~~

~~INTENSITY or AUGMENTED CARE LOCATION CODE becomes applicable.~~The date that the total number of Hospital Beds resourced and available for use on a WARD for a single CLINICAL CARE INTENSITY or AUGMENTED CARE LOCATION CODE becomes applicable.

CRITICAL CARE DISCHARGE READY DATE

Change to Attribute: Changed Description

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

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

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

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

CRITICAL CARE DISCHARGE READY TIME

Change to Attribute: Changed Description

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

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

DIAGNOSTIC SERVICE REQUEST TYPE

Change to Attribute: Changed Description

~~The type of service requested for a diagnostic test/procedure.~~The type of SERVICE requested for a diagnostic test/procedure.

~~Waiting list tests/procedures are those for which the PATIENT needs to wait on a waiting list for an~~

~~APPOINTMENT. If the PATIENT is waiting for a first diagnostic test/procedure as part of a planned series of treatments, these should be included as waiting list request types unless the procedure or test has to be carried out at a specific time for clinical reasons. Waiting list tests/procedures should not include any tests or procedures for PATIENTS who have a current Hospital Provider Spell and require an emergency or unscheduled diagnostic test/procedure as part of their inpatient treatment. Also excluded are any SERVICE REQUESTS for PATIENTS who are waiting for a therapeutic operation on the ELECTIVE ADMISSION LIST who may require these routine diagnostic tests/procedures following admission.~~WAITING LIST tests/procedures are those for which the PATIENT needs to wait on a WAITING LIST for an APPOINTMENT. If the PATIENT is waiting for a first diagnostic test/procedure as part of a planned series of treatments, these should be included as WAITING LIST request types unless the procedure or test has to be carried out at a specific time for clinical reasons. WAITING LIST tests/procedures should not include any tests or procedures for PATIENTS who have a current Hospital Provider Spell and require an emergency or unscheduled diagnostic test/procedure as part of their inpatient treatment. Also excluded are any SERVICE REQUESTS for PATIENTS who are waiting for a therapeutic operation on the ELECTIVE ADMISSION LIST who may require these routine diagnostic tests/procedures following admission. This is only SERVICE REQUESTS where the prime purpose of the wait is for the diagnostic test/procedure.

A planned diagnostic test/procedure or series of procedures are those that are carried out as part of a treatment plan which are required for clinical reasons to be carried out at a specific time or repeated at a specific frequency. Examples include 6 month check cystoscopy or regular blood tests.

~~Unscheduled diagnostic tests/procedures are tests carried out following an emergency admission, as well as any diagnostic tests/procedures carried out on PATIENTS in Accident and Emergency.~~Unscheduled diagnostic tests/procedures are tests carried out following an emergency admission, as well as any diagnostic tests/procedures carried out on PATIENTS in Accident and Emergency.

~~A test/procedure done following an Elective Admission includes any PATIENTS who have a current Hospital Provider Spell and are waiting for an emergency or unscheduled diagnostic test/procedure as part of their inpatient treatment and any SERVICE REQUEST for PATIENTS who are waiting for a therapeutic operation on the ELECTIVE ADMISSION LIST who may require these routine diagnostic tests/procedures following admission.~~A test/procedure done following an Elective Admission includes any PATIENTS who have a current Hospital Provider Spell and are waiting for an emergency or unscheduled diagnostic test/procedure as part of their inpatient treatment and any SERVICE REQUEST for PATIENTS who are waiting for a therapeutic operation on the ELECTIVE ADMISSION LIST who may require these routine diagnostic tests/procedures following admission.

~~This classification should be recorded for all relevant tests/procedures irrespective of the referral route (i.e. whether the SERVICE REQUEST was from a GP or a hospital-based CARE PROFESSIONAL or other route) and also irrespective of the setting they are to be carried out in (e.g. inpatient ward, x-ray department etc.).~~This classification should be recorded for all relevant tests/procedures irrespective of the referral route (i.e. whether the SERVICE REQUEST was from a GENERAL MEDICAL PRACTITIONER or a hospital-based CARE PROFESSIONAL or other route) and also irrespective of the setting they are to be carried out in (e.g. inpatient ward, x-ray department etc.).

National Codes:

01	Waiting list for test/procedure
02	Planned test required
03	Emergency or unscheduled diagnostic test or procedure
04	Test/procedure following elective admission

HEALTHY PERSON STAY NUMBER

Change to Attribute: Changed Description

~~The unique sequence number given to a healthy PERSON who lodges overnight and uses the hospital's PATIENT bed stock or other special facilities.~~The unique sequence number given to a healthy PERSON who lodges

overnight and uses a Hospital Bed from the hospital's PATIENT bed stock or other special facilities.

INTENDED MANAGEMENT

Change to Attribute: Changed Description

~~This is the intended pattern of bed use for a PATIENT, decided when the decision is made to admit.~~This is the intended pattern of Hospital Bed use for a PATIENT, decided when the decision is made to admit. This only applies to PATIENTS on the ELECTIVE ADMISSION LIST. It is not necessary to collect this information for maternity PATIENTS or for babies admitted to hospital shortly after birth.

National Codes:

- ~~1 Patient to stay in hospital for at least one night~~
- ~~2 Patient not to stay in hospital overnight~~
- ~~3 Patient to be admitted for a planned sequence of admissions each involving at least one overnight stay~~
- ~~4 Patient to be admitted for a planned sequence of admissions which do not involve an overnight stay~~
- ~~5 Patient to be admitted regularly for a planned sequence of nights who returns home for the remainder of the 24 hour period~~
- 1 PATIENT to stay in hospital for at least one night
- 2 PATIENT not to stay in hospital overnight
- 3 PATIENT to be admitted for a planned sequence of admissions each involving at least one overnight stay
- 4 PATIENT to be admitted for a planned sequence of admissions which do not involve an overnight stay
- 5 PATIENT to be admitted regularly for a planned sequence of nights who returns home for the remainder of the 24 hour period

INTENSIVE CARE OR HIGH DEPENDENCY BEDS INDICATOR renamed from IC OR HD BEDS INDICATOR

Change to Attribute: Changed Description, Name

~~An indicator which identifies whether the total number of beds resourced and available for use recorded by a WARD BED AVAILABILITY is for intensive care beds or high dependency beds.~~An indicator which identifies whether the total number of Hospital Beds resourced and available for use recorded by a WARD BED AVAILABILITY is for intensive care Hospital Beds or high dependency Hospital Beds.

Classification:

- ~~a. Intensive care beds~~
- ~~b. High dependency beds~~
- a. Intensive care Hospital Beds
- b. High dependency Hospital Beds

LODGING END TIME

Change to Attribute: Changed Description

The time that the responsibility for nursing care is transferred from an Accident And Emergency Attendance to a WARD thus ending the period as a LODGED PATIENT. ~~This will be the same as ACTIVITY TIME of type 'A+E Departure Time' if the PATIENT was lodged as a result of an Accident And Emergency Attendance.~~ This will be

the same as ACTIVITY TIME of type 'A and E DEPARTURE TIME' if the PATIENT was lodged as a result of an Accident And Emergency Attendance.

~~The transfer of responsibility may occur when the PATIENT is received into a bed in an appropriate WARD, an OPERATING THEATRE or another setting for immediate treatment (e.g. an X-ray Department) before being received into a bed in an appropriate WARD. A bed in an A&E observation and assessment WARD may be a transfer of responsibility but a trolley, bed or chair in a corridor would not.~~The transfer of responsibility may occur when the PATIENT is received into a Hospital Bed in an appropriate WARD, an OPERATING THEATRE or another setting for immediate treatment (e.g. an X-ray Department) before being received into a Hospital Bed in an appropriate WARD.

A Hospital Bed in an Accident and Emergency observation and assessment WARD may be a transfer of responsibility but a trolley, bed or chair in a corridor would not.

LODGING START TIME

Change to Attribute: Changed Description

~~The time when medical staff with RIGHTS OF ADMISSION to hospital beds take clinical responsibility for a PATIENT, but the PATIENT has to remain waiting in the nursing care of an Accident And Emergency Department until they can be transferred to a WARD.~~The time when medical staff with RIGHTS OF ADMISSION to Hospital Beds take clinical responsibility for a PATIENT, but the PATIENT has to remain waiting in the nursing care of an Accident And Emergency Department until they can be transferred to a WARD. This starts a period of time as a LODGED PATIENT.

NHS NUMBER

Change to Attribute: Changed Description

~~A number used to identify a PATIENT uniquely within the NHS in England and Wales.~~The NHS NUMBER, the primary identifier of a PERSON, is a unique identifier for a PATIENT within the NHS in England and Wales.

~~References:~~
~~UK Government Data Standards Catalogue (GDSC), Version 2.0, Agreed 01.01.02. GDSC: http://www.govtalk.gov.uk/gdsc/html/default.htm.~~

This will not vary by any ORGANISATION of which a PERSON is a PATIENT.

~~It is mandatory to record the NHS NUMBER for each PATIENT. The exception to this rule is A&E care. The NHS NUMBER, the primary identifier of a PERSON, is a unique identifier for the PATIENT.~~It is mandatory to record the NHS NUMBER. There are exceptions, such as A&E care, sexual health and major incidents, as defined in existing national policies.

The NHS NUMBER is 10 numeric digits in length. The tenth digit is a check digit used to confirm its validity. The check digit is validated using the Modulus 11 algorithm and the use of this algorithm is mandatory. There are 5 steps in the validation of the check digit:

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

If the result is 11 then a check digit of 0 is used. If the result is 10 then the NHS NUMBER is invalid and not used.

Step 5 Check the remainder matches the check digit. If it does not, the NHS NUMBER is invalid.

References:
~~NHS Strategic Tracing Service: http://www.connectingforhealth.nhs.uk/nsts/faqs~~

- UK Government Data Standards Catalogue (GDSC), Version 2.0, Agreed 01.01.02. GDSC: http://www.govtalk.gov.uk/gdsc/html/default.htm.
- Further guidance is available from the NHS Number Programme website.

OPERATION CANCELLATION

Change to Attribute: Changed Description

An indicator of whether the operation that the PATIENT is being admitted for, was cancelled for non-clinical reasons on or after the day that the PATIENT was due to arrive in hospital (cancelled at the 'last minute' or 'at short notice'). This includes telephone cancellations made to PATIENTS on the day of their operation or day of admission.

An operation which is rescheduled to a time within 24 hours of the original scheduled operation should be recorded as a postponement and not as a cancellation. ~~Some common non-clinical reasons for cancellations by the hospital include: WARD beds unavailable; surgeon unavailable; emergency case needing theatre; theatre list over-ran; equipment failure; admin error; anaesthetist unavailable; theatre staff unavailable; and critical care bed unavailable. These examples are based on information from the Modernisation Agency's Theatres Project and do not necessarily cover all non-clinical reasons.~~ Some common non-clinical reasons for cancellations by the hospital include:

- Hospital Beds unavailable;

- surgeon unavailable;
- emergency case needing theatre;
- theatre list over-ran;
- equipment failure;
- administrative error;
- anaesthetist unavailable;
- theatre staff unavailable and critical care Hospital Bed unavailable

These examples are based on information from the Modernisation Agency's Theatres Project and do not necessarily cover all non-clinical reasons.

National Codes:

1	Operation cancelled for non-clinical reasons on the day of surgery
2	Operation cancelled at short notice for non-clinical reasons although not on the day of surgery
8	Not applicable - Operation cancelled for clinical reasons or not cancelled

PATIENT CLASSIFICATION

Change to Attribute: Changed Description

A coded classification of PATIENTS who have been admitted to a Hospital Provider Spell.

National Codes:

~~1~~ ~~Ordinary admission.~~
~~A patient not admitted electively, and any patient admitted electively with the expectation that they will remain in hospital for at least one night, including a patient admitted with this intention who leaves hospital for any reason without staying overnight. A patient admitted electively with the intent of not staying overnight, but who does not return home as scheduled, should be counted as an ordinary admission~~

~~2~~ ~~Day case admission.~~
~~A patient admitted electively during the course of a day with the intention of receiving care who does not require the use of a hospital bed overnight and who returns home as scheduled. If this original intention is not fulfilled and the patient stays overnight, such a patient should be counted as an ordinary admission~~

~~3~~ ~~Regular day admission.~~
~~A patient admitted electively during the day, as part of a planned series of regular admissions for an on-going regime of broadly similar treatment and who is discharged the same day. If the intention is not fulfilled and one of these admissions should involve a stay of at least 24 hours, such an admission should be classified as an ordinary admission. The series of regular admissions ends when the patient no longer requires frequent admissions~~

~~4~~ ~~Regular night admission.~~
~~A patient admitted electively for the night, as part of a planned series of regular admissions for an on-going regime of broadly similar treatment and who is discharged in the morning. If the intention is not fulfilled and one of these admissions should involve a stay of at least 24 hours, such an admission should be classified as an ordinary admission. The series of regular admissions ends when the patient no longer requires frequent admissions~~

~~5~~ ~~Mother and baby using delivery facilities only.~~
~~Mother and baby using delivery facilities only and not using a bed in the antenatal or postnatal wards during the stay in hospital~~

1 Ordinary admission.
A PATIENT not admitted electively, and any PATIENT admitted electively with the expectation that they will remain in hospital for at least one night, including a PATIENT admitted with this intention who leaves hospital for any reason without staying overnight. A PATIENT admitted electively with the intent of not staying overnight, but who does not return home as scheduled, should be counted as an ordinary admission

2 Day case admission.
A PATIENT admitted electively during the course of a day with the intention of receiving care who does not require the use of a Hospital Bed overnight and who returns home as scheduled. If this

original intention is not fulfilled and the PATIENT stays overnight, such a PATIENT should be counted as an ordinary admission

3 Regular day admission.
A PATIENT admitted electively during the day, as part of a planned series of regular admissions for an on-going regime of broadly similar treatment and who is discharged the same day. If the intention is not fulfilled and one of these admissions should involve a stay of at least 24 hours, such an admission should be classified as an ordinary admission. The series of regular admissions ends when the PATIENT no longer requires frequent admissions

4 Regular night admission.
A PATIENT admitted electively for the night, as part of a planned series of regular admissions for an on-going regime of broadly similar treatment and who is discharged in the morning. If the intention is not fulfilled and one of these admissions should involve a stay of at least 24 hours, such an admission should be classified as an ordinary admission. The series of regular admissions ends when the patient no longer requires frequent admissions

5 Mother and baby using delivery facilities only.
Mother and baby using delivery facilities only and not using a Hospital Bed in the antenatal or postnatal WARDS during the stay in hospital

PATIENT FACILITY GROUP CODE

Change to Attribute: Changed Description

A classification of PATIENT FACILITY GROUPS.

Classification:

~~a.~~ ~~Patient using a hospital bed~~
a. PATIENT using a Hospital Bed
b. Out-patient
~~c.~~ ~~Patient attending day care facilities~~
c. PATIENT attending day care facilities
d. Accident and Emergency facility attender
~~e.~~ ~~Patient receiving care in the community~~
e. PATIENT receiving care in the community

WARD AVAILABLE BED

Change to Attribute: Changed Description

~~The count of the total number of beds resourced and available for use on a WARD for a single CLINICAL CARE INTENSITY or AUGMENTED CARE LOCATION CODE.~~The count of the total number of Hospital Beds resourced and available for use on a WARD for a single CLINICAL CARE INTENSITY or AUGMENTED CARE LOCATION CODE.

WARD DAY NIGHT INDICATOR

Change to Attribute: Changed Description

~~A ward is classified as a day WARD or as a night WARD in its operational plan.~~A WARD is classified as a day WARD or as a night WARD in its WARD OPERATIONAL PLAN. It should be noted that WARDS may be open for 24 hours (both overnight and during the day), open overnight only, or open during the day only.

Classification:

a. Open 24 hours
b. Only open overnight
c. Open only during the day

WARD LISTING TOTAL BED OCCUPIED

Change to Attribute: Changed Description

~~This records the total number of beds available, adequately resourced and occupied by PATIENTS at the time the DAILY WARD LISTING is prepared or, if a WARD open for day cases only, the number of beds occupied by at least one PATIENT during the day.~~This records the total number of Hospital Beds available, adequately resourced and occupied by PATIENTS at the time the DAILY WARD LISTING is prepared or, if a WARD open for day cases only, the number of Hospital Beds occupied by at least one PATIENT during the day.

WARD LISTING TOTAL BED RESERVED

Change to Attribute: Changed Description

~~This records the total number of beds, which are unavailable, because they have been reserved. The beds remain unavailable for as long as a management decision to reserve them is in force.~~This records the total number of Hospital Beds, which are unavailable, because they have been reserved. The Hospital Beds remain unavailable for as long as a management decision to reserve them is in force.

WARD LISTING TOTAL BED UNAVAILABLE

Change to Attribute: Changed Description

~~This is the total number of beds which are unavailable for reasons other than being reserved for PATIENTS, e.g. the use of a bed by a healthy PERSON, inadequate staffing.~~This is the total number of Hospital Beds which are unavailable for reasons other than being reserved for PATIENTS, e.g. the use of a Hospital Bed by a healthy PERSON, inadequate staffing.

WARD LISTING TOTAL BED UNOCCUPIED

Change to Attribute: Changed Description

~~This records the total number of beds available, adequately resourced but unoccupied at the time the DAILY WARD LISTING is prepared or, if a WARD open for day cases only, the number of available and adequately resourced beds not occupied by at least one PATIENT during the day.~~This records the total number of Hospital Beds available, adequately resourced but unoccupied at the time the DAILY WARD LISTING is prepared or, if a WARD open for day cases only, the number of available and adequately resourced Hospital Beds not occupied by at least one PATIENT during the day.

WARD LISTING TOTAL WARD ATTENDER

Change to Attribute: Changed Description

~~The number of ward attenders (i.e. PATIENTS attending a WARD for care but not requiring beds) should be recorded for the WARD each day. This should not form part of the patient administration system.~~The number of ward attenders (i.e. PATIENTS attending a WARD for care but not requiring Hospital Beds) should be recorded for the WARD each day. This should not form part of the Patient Administration System.

WARD PLAN TOTAL BED CONSULTANT CARE

Change to Attribute: Changed Description

~~This records the number of beds intended to be available in a WARD which are allocated for use by PATIENTS under the care of a CONSULTANT.~~This records the number of Hospital Beds intended to be available in a WARD which are allocated for use by PATIENTS under the care of a CONSULTANT.

WARD PLAN TOTAL BED MIDWIFE ACCESS

Change to Attribute: Changed Description

~~The number of beds to be available in a WARD for MIDWIFE led delivery episodes during the period of a WARD OPERATIONAL PLAN.~~The number of Hospital Beds to be available in a WARD for MIDWIFE led delivery episodes during the period of a WARD OPERATIONAL PLAN.

WARD PLAN TOTAL BED NURSING CARE

Change to Attribute: Changed Description

~~This records the number of beds intended to be available in a WARD which are allocated for use by PATIENTS under the care of a NURSE.~~This records the number of Hospital Beds intended to be available in a WARD which are allocated for use by PATIENTS under the care of a NURSE.

WARD TOTAL BED INTENDED

Change to Attribute: Changed Description

~~This records the number of beds intended to be available in a WARD.~~This records the number of Hospital Beds intended to be available in a WARD.

DECIDED TO ADMIT DATE

Change to Data Element: Changed Description

Format/length:	see DATE

HES item:	ELECDATE
National Codes:	
Default Codes:	

Notes:
This date may be the same as the date of admission (e.g. most emergency admissions). Alternatively, a decision can be made to admit at a future date. ~~This decision denotes that the PATIENT is intended to be admitted to a hospital bed, either immediately or subsequently in the future. It records the event that a clinical decision to admit a PATIENT to a hospital bed has been made by or on behalf of someone, who has the right of admission to a hospital provider.~~ This decision denotes that the PATIENT is intended to be admitted to a Hospital Bed, either immediately or subsequently in the future. It records the event that a clinical DECISION TO ADMIT a PATIENT to a Hospital Bed has been made by or on behalf of someone, who has the right of admission to a Hospital Provider.

The date will be different from the ORIGINAL DECIDED TO ADMIT DATE when the PATIENT has been transferred from another provider's list, or when the PATIENT has been admitted to hospital, discharged but not treated and is again placed on an ELECTIVE ADMISSION LIST with a new DECISION TO ADMIT.

DELAY REASON (DECISION TO TREATMENT)

Change to Data Element: Changed Description

~~Format/length:~~	~~n1~~
Format/length:	n2
HES item:	
National codes	Click on the attribute tab to show the attribute that contains the National Codes
Default codes	

Notes:
This is the same as the attribute DELAY REASON TO TREATMENT (CANCER).

A DELAY REASON (DECISION TO TREATMENT) must be present in the National Cancer Waiting Times Monitoring Data Set where a Cancer Care Spell Delay with a DELAY REASON TO TREATMENT (CANCER) exists.

This data can also be recorded locally for prospective PATIENTS where a full histological diagnosis confirming cancer is not yet available.

DELAY REASON REFERRAL TO TREATMENT (CANCER)

Change to Data Element: Changed Description

~~Format/length:~~	~~n1~~
Format/length:	n2
HES item:	
National codes	
Default codes	

Notes:
See attribute DELAY REASON TO TREATMENT (CANCER) for the National Codes used for recording the DELAY REASON REFERRAL TO TREATMENT (CANCER).

It is an optional data element and should only be present if a Cancer Care Spell Delay with a DELAY REASON TO

TREATMENT (CANCER) has been recorded where the DELAY REASON INDICATOR is classification b. *'delay between urgent GP referral and date of first definitive treatment'*.

Cancer Care Spell Delay is a REFERRAL DELAY where REFERRAL DELAY TYPE is National Code 01 '*Cancer Care Spell Delay*'.

DUN'S NUMBER

Change to Data Element: Changed Description

~~Format/length:~~	~~11 characters~~
Format/length:	n9
HES item:	
National Codes:	
Default Codes:	

Notes:
The reference assigned to a company in Dun and Bradstreet's Company Register.

References:
UK Government Data Standards Catalogue (GDSC), Version 2.0, Agreed 01.01.02. GDSC:
http://www.govtalk.gov.uk/gdsc/html/default.htm

~~UK Government Data Standards Catalogue~~

~~**Data Element**~~	~~**Dun's Number**~~
~~*Is Part Of*~~	~~**Financial**~~
~~*Has Parts*~~	
~~*Version*~~	~~**2.0**~~
~~*Status*~~	~~**Release**~~
~~*Previous Versions*~~	
~~*Later Versions*~~	
~~*Date Agreed*~~	~~**1 January 2002**~~

~~**Meta Data**~~	~~**Value**~~
~~*Name*~~	~~**Dun's Number**~~
~~*Description*~~	~~The reference assigned to a company in Dun & Bradstreet's Company Register~~
~~*Business Format*~~	~~11 Characters~~
~~*Element Type*~~	~~Data Item~~
~~*Validation*~~	~~Must be 11 numeric characters~~
~~*Value*~~	
~~*Default Value*~~	
~~*Owner*~~	~~Dun & Bradstreet~~
~~*Based On*~~	~~Dun & Bradstreet~~
~~*Verification*~~	
~~*Comment*~~	

NHS NUMBER

Change to Data Element: Changed Description

Format/length:	n10
HES item:	NEWNHSNO
National Codes:	
Default Codes:	

Notes:

~~References:~~

~~UK Government Data Standards Catalogue (GDSC), Version 2.0, Agreed 01.01.02.~~ ~~GDSC:~~ ~~http://www.govtalk.gov.uk/gdsc/html/default.htm~~

NHS NUMBER is the same as attribute NHS NUMBER.

~~It is mandatory to record the NHS NUMBER for each PATIENT. The exception to this rule is A&E care. The NHS NUMBER is the unique identifier for the PATIENT.~~

~~The NHS NUMBER is 10 numeric digits in length. The tenth digit is a check digit used to confirm its validity. The check digit is validated using the Modulus 11 algorithm and the use of this algorithm is mandatory. There are 5 steps in the validation of the check digit:~~

~~**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.~~

~~If the result is **11** then a check digit of **0** is used.~~
~~If the result is **10** then the NHS NUMBER is invalid and not used.~~

~~**Step 5** Check the remainder matches the check digit. If it does not, the NHS NUMBER is invalid.~~

References:

~~NHS Strategic Tracing Service:~~ ~~http://www.connectingforhealth.nhs.uk/nsts/faqs~~

~~UK Government Data Standards Catalogue~~

~~**Data Element**~~	~~**NHS Number**~~
~~*Is Part Of*~~	~~**Person Identifiers**~~
~~*Has Parts*~~	
~~*Version*~~	~~**2.0**~~
~~*Status*~~	~~**Release**~~
~~*Previous Versions*~~	
~~*Later Versions*~~	

Date Agreed	**1 January 2002**

Meta Data	**Value**
Name	**NHS Number**
Description	A number used to identify a person uniquely within the NHS in England and Wales.
Business Format	10 numeric
Element Type	Data Item
Validation	The tenth digit of the NHS Number is a check digit used to confirm its validity. The check digit is validated using the Modulus 11 algorithm and the use of this algorithm is mandatory. There are 5 steps in the validation of the check digit:

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. If the result is 11 then a check digit of 0 is used. If the result is 10 then the NHS NUMBER is invalid and not used.

Step 5 Check the remainder matches the check digit. If it does not, the NHS NUMBER is invalid.

Value	
Default Value	
Owner	Department of Health
Based On	Department of Health
Verification	
Comment	

- UK Government Data Standards Catalogue (GDSC), Version 2.0, Agreed 01.01.02. GDSC: http://www.govtalk.gov.uk/gdsc/html/default.htm.
- Further guidance is available from the NHS Number Programme website.

PATIENTS WAITING FOR ADMISSION

Change to Data Element: Changed Description

Format/length:	n10
HES item:	
National Codes:	
Default Codes:	

Notes:

~~The number of PATIENTS classified as booked admissions or WAITING LIST admissions, who have an OFFER OF ADMISSION MADE DATE recorded before or on the REPORTING PERIOD END DATE and are waiting to be admitted from an ELECTIVE ADMISSION LIST to a Hospital Provider Spell for the specified WAITING FOR ADMISSION INTENDED MANAGEMENT.~~The number of PATIENTS classified as booked admissions or WAITING LIST admissions, who are waiting to be admitted from an ELECTIVE ADMISSION LIST to a Hospital Provider Spell for the specified WAITING FOR ADMISSION INTENDED MANAGEMENT on the REPORTING PERIOD END DATE.

This includes PATIENTS with an OFFER OF ADMISSION MADE DATE recorded before or on the REPORTING PERIOD END DATE.

PATIENTS WAITING FOR ADMISSION will be further categorised by MAIN SPECIALTY CODE of the ELECTIVE ADMISSION LIST or ADMISSION INTENDED PROCEDURE.

This includes Self-Deferred Admission PATIENTS where a further OFFERED FOR ADMISSION DATE has been made on or before the end of the REPORTING PERIOD.

It excludes Self-Deferred Admission PATIENTS where no further OFFERED FOR ADMISSION DATE has been made as at the end of the REPORTING PERIOD, private PATIENTS, PATIENTS from overseas, elective planned admissions and Suspended Patients.

It is the total of number of PATIENTS waiting Elective Admission where:

a. no ELECTIVE ADMISSION LIST REMOVAL REASON and ELECTIVE ADMISSION LIST REMOVAL DATE is recorded i.e. the PATIENT is still waiting for admission on the WAITING LIST

   or

   if recorded, ELECTIVE ADMISSION LIST REMOVAL DATE is after the REPORTING PERIOD END DATE i.e. the PATIENTS was waiting for admission on the WAITING LIST as at the end of the REPORTING PERIOD and should therefore be included in the count

and

b. an OFFERED FOR ADMISSION DATE of an OFFER OF ADMISSION is recorded where the OFFER OF ADMISSION MADE DATE is before or on the REPORTING PERIOD END DATE

   Where more than one OFFER OF ADMISSION is recorded (due to Self-Deferred Admission), at least one should have an OFFER OF ADMISSION MADE DATE before or on the REPORTING PERIOD END DATE and the latest OFFER OF ADMISSION MADE DATE is before or on the REPORTING PERIOD END DATE i.e exclude from the count if the latest offer was made after the end of the REPORTING PERIOD

and

c. the ADMINISTRATIVE CATEGORY CODE of the ADMINISTRATIVE CATEGORY for the ELECTIVE ADMISSION LIST ENTRY is National Code 01 *'NHS patient, including overseas visitors charged under Section 121 of the NHS Act 1977 as amended by Section 7(12) and (14) of the Health and Medicine Act 1988'*

   and

   no OVERSEAS VISITOR STATUS is recorded for the ELECTIVE ADMISSION LIST ENTRY

and

d. no ELECTIVE ADMISSION SUSPENSION DETAIL has been recorded

   or

   if recorded, the LIST SUSPENSION START DATE is before the REPORTING PERIOD END DATE and the LIST SUSPENSION END DATE is before the REPORTING PERIOD END DATE i.e. no period of suspension is still on-going as at the end of the REPORTING PERIOD.

   Where no LIST SUSPENSION END DATE has been recorded or where the LIST SUSPENSION END DATE is on or after the REPORTING PERIOD END DATE then the period of suspension is still active and the PATIENT should be excluded from the count

and

e. the ELECTIVE ADMISSION TYPE is National Code 11 *'Waiting list admission'* or 12 *'Booked admission'*

Hospital Provider Spell is an ACTIVITY GROUP where ACTIVITY GROUP TYPE is National Code 21 *'Hospital Provider Spell'*.

REFERRAL TO TREATMENT PERIOD EXCEEDS 18 WEEKS TIME BAND

Change to Data Element: Changed Description

Format/length:	an7
HES item:	
National Codes:	
Default Codes:	

Notes:

These are the time bands of the number of weeks until a PATIENT's wait for treatment would exceed 18 weeks.

This is expressed as below:

unknown	Patients with unknown REFERRAL TO TREATMENT PERIOD START DATE
>6-8	Patients whose wait for treatment will exceed 18 weeks in more than 6 and up to and including 8 weeks
>4-6	Patients whose wait for treatment will exceed 18 weeks in more than 4 and up to and including 6 weeks
>2-4	Patients whose wait for treatment will exceed 18 weeks in more than 2 and up to and including 4 weeks
>1-2	Patients whose wait for treatment will exceed 18 weeks in more than 1 and up to and including 2 weeks
0-1	Patients whose wait for treatment will exceed 18 weeks in 0 and up to and including 1 week

Guidance for calculating days until 18 weeks wait for treatment is exceeded:

The REFERRAL REQUEST RECEIVED DATE is day zero in the REFERRAL TO TREATMENT PERIOD. Therefore:

PATIENTS who are reported in the >6-8 weeks time band are those who have 43 to 56 days until 18 weeks wait for treatment is exceeded at the REPORTING PERIOD END DATE

PATIENTS who are reported in the >4-6 weeks time band are those who have 29 to 42 days until 18 weeks wait for treatment is exceeded at the REPORTING PERIOD END DATE

PATIENTS who are reported in the >2-4 weeks time band are those who have 15 to 28 days until 18 weeks wait for treatment is exceeded at the REPORTING PERIOD END DATE

PATIENTS who are reported in the >1-2 weeks time band are those who have 8 to 14 days until 18 weeks wait for treatment is exceeded at the REPORTING PERIOD END DATE

~~PATIENTS who are reported in the 0-1 weeks time band are those who have 0 to 7 days until 18 weeks wait for treatment is exceeded at the REPORTING PERIOD END DATE~~PATIENTS who are reported in the 0-1 weeks time band are those who have 1 to 7 days until 18 weeks wait for treatment is exceeded at the REPORTING PERIOD END DATE

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