DSC Notice: 09/2006
Date of Issue: July 2006

NHS Information Standards Board

Sponsor:	Implementation Date: Immediate
Department of Health	**Subject:** **Measuring and recording of waiting times**

DATA SET CHANGE CONTROL PROCEDURE

This data set change notice updates the NHS data model and data dictionary to replace the previous waiting time forms with waiting times data flows.

Summary:

This data set change notice updates the NHS data model and data dictionary to replace the previous waiting time forms (including KH07 and QM08) with waiting times data flows.

For flexibility and for ease of maintenance and future changes, the new waiting times data flows are defined as datasets rather than central returns.

MAIN SPECIALTY CODE rather than TREATMENT FUNCTION CODE has been specified by the Department of Health for these data flows to maintain consistency with previous data collected via the central returns.

There should be minimal impact on system suppliers fulfilling the Department of Health's current requirements. This data set change notice updates the NHS Data Model and Dictionary following the previous mandatory data set change notice DSCN 01/2006 Amendment of inpatient and outpatient waiting times returns to collect data in weekly time bands

A separate DSCN 18/2006 will be published to provide details of data standards to support the measurement of 18 week referral to treatment periods. It is anticipated that the measurement of 18 week waits will not affect the collection of these datasets.

A separate DSCN will be issued to review the OPCS code lists once the maps from READ to OPCS 4.3 are available.

The NHS Information Standards Board (ISB) is responsible for approving information standards. The ISB output related to the assurance and sign-off of this standard can be found at http://www.isb.nhs.uk/docs/dscn09_2006output.pdf

More information about the ISB can be found at www.isb.nhs.uk
Dataset change notices can be found at www.connectingforhealth.nhs.uk/dscn

Change Request

NHS Connecting for Health

NHS Data Model and Dictionary Service

Reference:	Change Request 719
Version No:	1.0
Subject:	Waiting Times and Activity
Type of Change:	Change to NHS data standards
Effective Date:	1 April 2006
Reason for Change:	Replacement of the current waiting times central returns with new waiting times data flow datasets.

Background:

There are a number changes required to the returns to remove duplication and improve timetables. The main proposal is to switch to weekly timebands for outpatient and inpatient waiting times data from April 2006. This change paper defines the changes required to the NHS Data Dictionary.

These returns flow through Strategic Health Authorities, and require their sign off before they are accessed by the Department of Health.

ROCR

The following collections have been approved:-

- Quarterly In-patient waiting times return (stock) (day case admissions)-Commissioner and Provider-ROCR/OR/0149/FTSCH6
- Quarterly outpatient waiting times return (stock)-Commissioner and Provider-ROCR/OR/0150/FTSCH6
- Quarterly In-patient waiting times return (stock) (ordinary admissions)-Commissioner and Provider-ROCR/OR/0151/FTSCH6
- Quarterly In-patient Activity (Flow)-Commissioner and Provider-ROCR/OR/0152/FTSCH6
- Provider booking-ROCR/OR/0155/FTSCH6
- Monthly Activity (Flow) Provider-ROCR/OR/0156/FTSCH6
- Monthly In-patient waiting times return-Commissioner and Provider-ROCR/OR/0158/FTSCH6
- Quarterly outpatient waiting times return (stock) Commissioner and Provider-ROCR/OR/0160/FTSCH6

The above collections are valid for a period of 2 years.

As a consequence of the above approvals the following collections have been discontinued and can be removed from Schedule 6:-

- QM08-ROCR/OR/0004/001/FTSCH6
- KH06-ROCR/OR/0007/FTSCH6
- KH07A-ROCR/OR/0010/FTSCH6
- KH07-ROCR/OR/0011/001/FTSCH6
- Quarterly monitoring-ROCR/OR/0121/FTSCH6

Waiting Times Data Flow Datasets

For flexibility and for ease of maintenance and future changes, the new waiting times data flows are defined as datasets rather than central returns. This enables the dataset to be expressed as a series of data elements, each data element being separately defined and grouped appropriately. A data element may appear in more than one grouping within a dataset and within more than one dataset. The definition and any rules, calculations and guidance are provided for each data element. The REPORTING PERIOD for a data flow is specified by a REPORTING PERIOD START DATE and REPORTING PERIOD END DATE such that the same dataset can be used for any time period such as weekly, monthly or quarterly. This also enables any historic period to be re-calculated and analysed or any specific one off analyses to be provided.

In datasets where the data is required by MAIN SPECIALTY CODE then only where data is present for a MAIN SPECIALTY CODE should the specialty be included within the dataset e.g. if there is no data for 140 Oral Surgery then this specialty will be excluded from the data flow. This also applies where other groupings such as by specific intended procedures are defined within the datasets.

MAIN SPECIALTY CODE rather than TREATMENT FUNCTION CODE has been specified by the DH for these data flows to maintain consistency with previous data collected via the central returns.

New Waiting Times Data Flows Datasets

- Bookings Admitted Patient And Out-Patient Provider
- Choice At Six Months

- Choose And Book Utilisation Commissioner
- Admitted Patient Flows
- Admitted Patient Stocks
- Out-Patient Flows
- Out-Patient Stocks
- Summarised Activity Flows
- Summarised Stocks

Flows Datasets

Flows datasets show event activity that add to or remove patients from admitted patient stocks and outpatient stocks during the specified reporting period.

Stocks Datasets

Admitted patient stocks datasets show the number of patients still waiting to be admitted by the end of the specified reporting period. Outpatient stocks datasets show the number of patients where the first attendance has not yet taken place by the end of the specified reporting period.

Summary of changes:

Class Definitions	
APPOINTMENT	Change to Description
APPOINTMENT	Change to Attributes
APPOINTMENT	Change to Relationships
APPOINTMENT OR REQUEST INVITATION CLASSIFICATION	Deleted
APPOINTMENT REQUEST OR INVITATION	Change to Name
APPOINTMENT REQUEST OR INVITATION renamed APPOINTMENT OFFER	Change to Description
APPOINTMENT REQUEST OR INVITATION	Change to Attributes
APPOINTMENT REQUEST OR INVITATION	Change to Relationships
APPOINTMENT SLOT	Change to Description
APPOINTMENT SLOT	Change to Attributes
APPOINTMENT SLOT	Change to Relationships
APPOINTMENT WAITING LIST	New Class
CARE PROFESSIONAL	Change to Relationships
CARE PROFESSIONAL ORGANISATION	Change to Relationships
CLINIC OR FACILITY	Change to Description
CLINIC OR FACILITY	Change to Attributes
CLINIC OR FACILITY	Change to Relationships
CONSULTANT	Change to Relationships
DIAGNOSTIC TEST REQUEST	Change to Super Type
ELECTIVE ADMISSION LIST	Change to Description
ELECTIVE ADMISSION LIST ENTRY	Change to Description
ELECTIVE ADMISSION LIST ENTRY	Change to Attributes
HEALTH PROGRAMME	Change to Relationships
OFFER OF ADMISSION	Change to Description
OFFER OF ADMISSION	Change to Attributes
ORGANISATION	Change to Relationships
ORGANISATION SITE	Change to Attributes
PATIENT	Change to Relationships
REFERRAL REQUEST	Change to Super Type
REFERRAL REQUEST	Change to Attributes
REFERRAL REQUEST	Change to Relationships
SERVICE REQUEST	New Class
SERVICE REQUEST RELATIONSHIP	New Class
TREATMENT FUNCTION	Change to Relationships
WAITING LIST	New Class

Attribute Definitions	
ADMISSION OFFER OUTCOME	Change to Description
APPOINTMENT ACCEPTED DATE	New Attribute
APPOINTMENT BOOKING SYSTEM TYPE	Change to Description
APPOINTMENT CANCELLED DATE	New Attribute
APPOINTMENT ENTRY NUMBER	New Attribute

APPOINTMENT FIRST ATTENDANCE	New Attribute
APPOINTMENT OFFER ACCEPTED OR REFUSED	New Attribute
APPOINTMENT OFFER SLOT STATUS	New Attribute
APPOINTMENT OFFER VERBAL OR WRITTEN	New Attribute
APPOINTMENT OR REQUEST INVITATION CLASSIFICATION CODE	Change to Name
APPOINTMENT OR REQUEST INVITATION CLASSIFICATION CODE renamed APPOINTMENT CLASSIFICATION CODE	Change to Aliases
APPOINTMENT SLOT STATUS	Change to Description
APPOINTMENT SLOT TYPE	New Attribute
APPOINTMENT TIME OFFERED	New Attribute
ATTENDED OR DID NOT ATTEND	Change to Description
CLINIC OR FACILITY ADMINISTRATIVE TYPE	New Attribute
DECISION TO OFFER AN APPOINTMENT DATE	New Attribute
DEPARTMENT TYPE	Change to Description
ELECTIVE ADMISSION EFFECTIVE WAIT START DATE	New Attribute
FIRST ATTENDANCE	Change to Description
FIRST ATTENDANCE EFFECTIVE WAIT START DATE	New Attribute
INVITATION OFFER DATE SENT	New Attribute
MAIN SPECIALTY CODE	Change to Description
MEDICAL AND DENTAL POST SPECIALTY GROUP	Change to Description
OFFER OF ADMISSION ACCEPTED DATE	New Attribute
OFFER OF ADMISSION ACCEPTED OR REFUSED	New Attribute
OFFER OF ADMISSION GROUP IDENTIFIER	New Attribute
OFFER OF ADMISSION MADE DATE	New Attribute
OFFER OF ADMISSION MADE TIME	New Attribute
OFFER OF ADMISSION VERBAL OR WRITTEN	New Attribute
ORGANISATION SITE TREATMENT CENTRE	New Attribute
ORIGINAL REFERRAL REQUEST RECEIVED DATE	New Attribute
OUT-PATIENT CONVERTED UNIQUE BOOKING REFERENCE NUMBER	New Attribute
REFERRAL REQUEST RECEIVED TIME	New Attribute
REFERRAL REQUEST TYPE	Change to Description
REFERRAL TIME	New Attribute
REQUESTED OR INVITED DATE	Deleted
REQUESTED OR INVITED TIME	Deleted
REQUEST OR INVITATION FOR APPOINTMENT DATE	Change to Name
REQUEST OR INVITATION FOR APPOINTMENT DATE renamed APPOINTMENT DATE OFFERED	Change to Description
SERVICE REQUEST DATE	New Attribute
SERVICE REQUEST IDENTIFIER	New Attribute
SERVICE REQUEST RELATIONSHIP DESCRIPTION	New Attribute
SERVICE REQUEST TIME	New Attribute
WAITING LIST IDENTIFIER	New Attribute
WAITING LIST TYPE	New Attribute

Data Elements

ADMISSION INTENDED PROCEDURE	New Data Element
ADMITTED PATIENT ELECTIVE ADMISSIONS	New Data Element
ADMITTED PATIENT ELECTIVE ADMISSIONS (DAY CASE)	New Data Element
ADMITTED PATIENT ELECTIVE ADMISSIONS (IS TREATMENT CENTRES)	New Data Element
ADMITTED PATIENT ELECTIVE ADMISSIONS (NHS TREATMENT CENTRES)	New Data Element
ADMITTED PATIENT ELECTIVE ADMISSIONS (ORDINARY)	New Data Element
ADMITTED PATIENT ELECTIVE ADMISSIONS (PLANNED)	New Data Element
ADMITTED PATIENT NHS ADMISSIONS	New Data Element
ADMITTED PATIENT NON-NHS ADMISSIONS	New Data Element
ADMITTED PATIENT TOTAL NON-ELECTIVE ADMISSIONS	New Data Element
COMMISSIONER OR PROVIDER STATUS INDICATOR	New Data Element
DATASET PREPARATION DATE	New Data Element
DATASET PREPARATION TIME	New Data Element
DECISIONS TO ADMIT (BOOKED DAY CASE)	New Data Element
DECISIONS TO ADMIT (BOOKED ORDINARY)	New Data Element
DECISIONS TO ADMIT (DAY CASE)	New Data Element
DECISIONS TO ADMIT (ORDINARY)	New Data Element
DECISIONS TO ADMIT NUMBER	New Data Element

DEFERRED ADMISSIONS (DAY CASE)	New Data Element
DEFERRED ADMISSIONS (ORDINARY)	New Data Element
FIRST ATTENDANCE	Change to Description
GP WRITTEN REFERRALS	New Data Element
GP WRITTEN REFERRALS BOOKED	New Data Element
GP WRITTEN REFERRALS MADE	New Data Element
GP WRITTEN REFERRALS SEEN	New Data Element
LAST DNA OR PATIENT CANCELLED DATE	Change to Description
NUMBER OF OUT-PATIENT CONVERTED UNIQUE BOOKING REFERENCE NUMBERS	New Data Element
OTHER REFERRALS	New Data Element
OUT-PATIENT EFFECTIVE WAITS	New Data Element
OUT-PATIENT FIRST APPOINTMENTS DID NOT ATTEND	New Data Element
OUT-PATIENT FIRST APPOINTMENTS FIRST ATTENDANCES SEEN	New Data Element
OUT-PATIENT FOLLOW-UP APPOINTMENTS ATTENDANCES SEEN	New Data Element
OUT-PATIENT FOLLOW-UP APPOINTMENTS DID NOT ATTEND	New Data Element
OUT-PATIENTS WAITING	New Data Element
OUT-PATIENT WAITING TIME BAND	New Data Element
PATIENTS ADMITTED (DAY CASE)	New Data Element
PATIENTS ADMITTED (ORDINARY)	New Data Element
PATIENTS ADMITTED NUMBER	New Data Element
PATIENTS FAILED TO ATTEND	New Data Element
PATIENTS FAILED TO ATTEND (DAY CASE)	New Data Element
PATIENTS FAILED TO ATTEND (ORDINARY)	New Data Element
PATIENTS SUSPENDED (DAY CASE)	New Data Element
PATIENTS SUSPENDED (ORDINARY)	New Data Element
PATIENTS WAITING FOR ADMISSION	New Data Element
PATIENTS WAITING FOR ADMISSION TIME BAND	New Data Element
REMOVALS OTHER THAN ADMISSION	New Data Element
REMOVALS OTHER THAN ADMISSION (DAY CASE)	New Data Element
REMOVALS OTHER THAN ADMISSION (ORDINARY)	New Data Element
REPORTING PERIOD END DATE	New Data Element
REPORTING PERIOD START DATE	New Data Element
WAITING FOR ADMISSION INTENDED MANAGEMENT	New Data Element

Dataset

ADMITTED PATIENT FLOWS	New Dataset
ADMITTED PATIENT STOCKS	New Dataset
BOOKINGS ADMITTED PATIENT AND OUT-PATIENT PROVIDER	New Dataset
CHOOSE AND BOOK UTILISATION COMMISSIONER	New Dataset
OUT-PATIENT FLOWS	New Dataset
OUT-PATIENT STOCKS	New Dataset
SUMMARISED ACTIVITY FLOWS	New Dataset
SUMMARISED STOCKS	New Dataset

Central Return Forms

KC62 ANNEX 1	Change to Guidance Text
KC53 4	Change to Guidance Text
KC53 5	Change to Guidance Text
KC53 5	Unknown delta_is_information_centre_item
KC53 6	Change to Guidance Text
KC53 7	Change to Guidance Text
KC61 1	Change to Guidance Text
KC62 A 1	Change to Guidance Text
KC63 2	Change to Guidance Text
KH06 1	Deleted
KH06 2	Deleted
KH06 3	Deleted
KH06 4	Deleted
KH06 5	Deleted
KH06 6	Deleted
KH06R 1	Deleted
KH06R 2	Deleted

KH06R 3	Deleted
KH06R 4	Deleted
KH06R 5	Deleted
KH07 1	Deleted
KH07 2	Deleted
KH07 3	Deleted
KH07 4	Deleted
KH07 5	Deleted
KH07 6	Deleted
KH07 7	Deleted
KH07A 1	Deleted
KH07A 2	Deleted
KH07A 3	Deleted
KH07AR 1	Deleted
KH07AR 2	Deleted
KH07AR 3	Deleted
KH09 1	Deleted
KH09 2	Deleted
KH09 3	Deleted
QF01 1	Deleted
QF01 2	Deleted
QF01 3	Deleted
QF01 4	Deleted
QF01 5	Deleted
QF01 6	Deleted
QF01 7	Deleted
QF01 8	Deleted
QM08 1	Deleted
QM08 2	Deleted
QM08 3	Deleted
QM08 4	Deleted
QM08R 1	Deleted
QM08R 2	Deleted
QM08R 3	Deleted
QM08R 4	Deleted

Diagrams

ADDRESS, GEOGRAPHICAL AREA & COMMUNICATION	Change to Name
ADDRESS, GEOGRAPHICAL AREA & COMMUNICATION renamed ADDRESS, GEOGRAPHICAL AREA & COMMUNICATIO	Change to Aliases
ADDRESS, GEOGRAPHICAL AREA & COMMUNICATION renamed ADDRESS, GEOGRAPHICAL AREA & COMMUNICATIO	Change to Diagram Contents
APPOINTMENTS	Change to Diagram Contents
HEALTH PROGRAMME	Change to Diagram Contents
LISTS	Change to Diagram Contents
ORGANISATION	Change to Diagram Contents
REFERRAL REQUEST	Change to Diagram Contents

Supporting Information

ADMITTED PATIENT EFFECTIVE WAITING TIME CALCULATION	New Supporting Information
ADMITTED PATIENT FLOWS	New Supporting Information
ADMITTED PATIENT STOCKS	New Supporting Information
APPOINTMENT REQUEST	New Supporting Information
ATTENDANCE DATE	Change to Supporting Information
BOOKINGS ADMITTED PATIENT AND OUT-PATIENT PROVIDER	New Supporting Information
CENTRAL RETURN MENU	Change to Supporting Information
CHOOSE AND BOOK UTILISATION COMMISSIONER	New Supporting Information
CLINIC ATTENDANCE CONSULTANT	Change to Supporting Information
CLINIC ATTENDANCE FAMILY PLANNING	Change to Supporting Information
CLINIC ATTENDANCE MIDWIFE	Change to Supporting Information
CLINIC ATTENDANCE NON-CONSULTANT	Change to Supporting Information
CLINIC ATTENDANCE NURSE	Change to Supporting Information
CONSULTANT OUT-PATIENT EPISODE	Change to Supporting Information

DAY CARE ATTENDANCE	Change to Supporting Information
DIAGRAMS MENU	Change to Supporting Information
ELECTIVE ADMISSION LIST	New Supporting Information
GENITOURINARY CLINIC ATTENDANCE	Change to Supporting Information
GMP PRACTICE CONSULTATION	Change to Supporting Information
LISTS	Change to Supporting Information
MIDWIFE CLINIC	Change to Supporting Information
NURSE CLINIC	Change to Supporting Information
OPERATING THEATRE SESSION	Change to Supporting Information
OTHER APPOINTMENT	New Supporting Information
OUT-PATIENT APPOINTMENT	Change to Supporting Information
OUT-PATIENT APPOINTMENT CONSULTANT	Change to Supporting Information
OUT-PATIENT APPOINTMENT NON-CONSULTANT	Change to Supporting Information
OUT-PATIENT ATTENDANCE CONSULTANT	Change to Supporting Information
OUT-PATIENT CLINIC	Change to Supporting Information
OUT-PATIENT EFFECTIVE WAITING TIME CALCULATION	New Supporting Information
OUT-PATIENT FLOWS	New Supporting Information
OUT-PATIENT STOCKS	New Supporting Information
OUT-PATIENT WAITING LIST	New Supporting Information
QUARTERLY MONITORING	Deleted
SUMMARISED ACTIVITY FLOWS	New Supporting Information
SUMMARISED STOCKS	New Supporting Information

Packages

CLASSES	Change Diagram Contents
QUARTERLY MONITORING TOP INDEX	Change to Description

Date: 23 May 2006
Sponsor: Margaret Edwards

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

ADMITTED PATIENT FLOWS

Change to Dataset: New Dataset

ADMITTED PATIENT FLOWS

Admitted Patient Flows Dataset

Admitted Patient Flows

This replaces Korner Returns KH06 and KH07.

The Department and Strategic Health Authorities require summary details from care providers of admitted patient admission activity flows. This central information requirement provides performance management measures of waiting times and helps to identify those organisations failing to meet the standards of the NHS Plan.

The Admitted Patient Flows Dataset is provider or commissioner based depending upon the Organisation submitting the dataset. Providers are care Organisations providing admitted patient care and treatment for NHS patients. Commissioners are the Organisations commissioning admitted patient care for NHS patients

Data collection

The NHS report datasets to the Department of Health monthly and quarterly via Unify, an online data collection system. Trusts and PCTs can either enter data directly onto Unify, or upload from spreadsheets provided to ease data input.
These returns flow through Strategic Health Authorities, and require their sign off before they are accessed by the Department of Health.
Data providers are required to submit data by the 15th working day following the month end, with publication being on the Friday following the 20th working day after month end.

The Admitted Patient Flows Dataset contains the admission activity for the specified REPORTING PERIOD.

Dataset Data Elements
Organisation and Reporting Period
COMMISSIONER OR PROVIDER STATUS INDICATOR
ORGANISATION CODE (CODE OF COMMISSIONER)
ORGANISATION CODE (CODE OF PROVIDER)
REPORTING PERIOD START DATE
REPORTING PERIOD END DATE
DATASET PREPARATION DATE
DATASET PREPARATION TIME
Admitted Patient Flow Group by Main Specialty: To carry the flow details for the MAIN SPECIALTY CODE recorded. Where no flow activity for a MAIN SPECIALTY CODE has occurred within the Reporting Period then no Admitted Patient Flow group should be recorded for it. There should be only 1 occurrence of this sub group permitted per MAIN SPECIALTY CODE.
MAIN SPECIALTY CODE
DECISIONS TO ADMIT (DAY CASE)
PATIENTS ADMITTED (DAY CASE)
PATIENTS FAILED TO ATTEND (DAY CASE)
REMOVALS OTHER THAN ADMISSION (DAY CASE)
DECISIONS TO ADMIT (ORDINARY)
PATIENTS ADMITTED (ORDINARY)
PATIENTS FAILED TO ATTEND (ORDINARY)
REMOVALS OTHER THAN ADMISSION (ORDINARY)
DEFERRED ADMISSIONS (ORDINARY)
DEFERRED ADMISSIONS (DAY CASE)
PATIENTS SUSPENDED (ORDINARY)
PATIENTS SUSPENDED (DAY CASE)

ADMITTED PATIENT STOCKS

Change to Dataset: New Dataset

ADMITTED PATIENT STOCKS

Admitted Patient Stocks Dataset

Admitted Patient Stocks

This replaces the Korner Return KH07.

The Department and Strategic Health Authorities require summary details from care providers of admitted patient day case and ordinary admission stocks. This central information requirement provides performance management measures of waiting times and helps to identify those organisations failing to meet the standards of the NHS Plan.

The Admitted Patient Stocks Dataset is provider or commissioner based depending upon the Organisation submitting the dataset. Providers are care Organisations providing in-patient care and treatment for NHS patients. Commissioners are the Organisations commissioning in-patient care for NHS patients

Data collection

The NHS report datasets to the Department of Health monthly and quarterly via Unify, an online data collection system. Trusts and PCTs can either enter data directly onto Unify, or upload from spreadsheets provided to ease data input.
These returns flow through Strategic Health Authorities, and require their sign off before they are accessed by the Department of Health.
Data providers are required to submit data by the 15th working day following the month end, with publication being on the Friday following the 20th working day after month end.

The Admitted Patient Stocks Dataset contains the in-patient waiting to be admitted stocks as at the end of the specified REPORTING PERIOD.

Dataset Data Elements
Organisation and Reporting Period
COMMISSIONER OR PROVIDER STATUS INDICATOR

ORGANISATION CODE (CODE OF COMMISSIONER)
ORGANISATION CODE (CODE OF PROVIDER)
REPORTING PERIOD START DATE
REPORTING PERIOD END DATE
DATASET PREPARATION DATE
DATASET PREPARATION TIME
Admitted Patient Stock Group for Main Specialty **To carry the stock details for the Main Specialty Code and Intended Management recorded. Where there are no stocks present in the Reporting Period for all the sub-groups for the MAIN SPECIALTY CODE and the INTENDED MANAGEMENT then no Admitted Patient Stock Group should be recorded for it.**
MAIN SPECIALTY CODE
WAITING FOR ADMISSION INTENDED MANAGEMENT
Admitted Patient Stock Group **To carry the sub group stock details for ordinary or day case admissions for the MAIN SPECIALTY CODE recorded. Where no stocks are present in the Reporting Period then zero values should be recorded. There should be 1 occurrence of this sub group permitted for each PATIENTS WAITING FOR ADMISSION TIME BAND per MAIN SPECIALTY CODE .**
PATIENTS WAITING FOR ADMISSION TIME BAND
PATIENTS WAITING FOR ADMISSION
Admitted Patient Stock Group **To carry the sub group stock details for ordinary or day case admissions for the MAIN SPECIALTY CODE recorded. Where no stocks are present in the Reporting Period then zero values should be recorded. There should be 1 occurrence of this sub group permitted per MAIN SPECIALTY CODE .**
DEFERRED ADMISSIONS (ORDINARY)
PATIENTS SUSPENDED (ORDINARY)
Summarised Admitted Patient Intended Procedure Stock Group: **To carry the sub group stock details for waiting for admissions for the WAITING FOR ADMISSION INTENDED PROCEDURE. Where no stocks are present in the Reporting Period then zero values should be recorded. There should be 1 occurrence of this group permitted for ordinary admissions for each intended procedure and for each PATIENTS WAITING FOR ADMISSION TIME BAND.**
ADMISSION INTENDED PROCEDURE
PATIENTS WAITING FOR ADMISSION TIME BAND
PATIENTS WAITING FOR ADMISSION

BOOKINGS ADMITTED PATIENT AND OUT-PATIENT PROVIDER

Change to Dataset: New Dataset

BOOKINGS ADMITTED PATIENT AND OUT-PATIENT PROVIDER

Bookings Admitted Patient And Out-Patient Provider Dataset

Bookings Admitted Patient And Out-Patient Provider

The Department and Strategic Health Authorities requires information to help monitor national waiting list trends. These are used to develop policies and indicate changes which can enable waiting lists to be managed more effectively.

The Provider Admitted Patient and Out-Patient Bookings Dataset is provider based. Providers are care Organisations providing out-patient care and treatment for NHS patients.

The Provider Admitted Patient and Out-Patient Bookings Dataset contains the out-patient activity for the specified REPORTING PERIOD.

Dataset Data Elements
Organisation and Reporting Period
ORGANISATION CODE (CODE OF PROVIDER)
REPORTING PERIOD START DATE
REPORTING PERIOD END DATE
DATASET PREPARATION DATE
DATASET PREPARATION TIME
Admitted Patient Booking
DECISIONS TO ADMIT (DAY CASE)
DECISIONS TO ADMIT (ORDINARY)
DECISIONS TO ADMIT (BOOKED DAY CASE)
DECISIONS TO ADMIT (BOOKED ORDINARY)

Out-Patient Booking
GP WRITTEN REFERRALS BOOKED
GP WRITTEN REFERRALS MADE

CHOOSE AND BOOK UTILISATION COMMISSIONER

Change to Dataset: New Dataset

CHOOSE AND BOOK UTILISATION COMMISSIONER

Choose And Book Utlisation Commissioner Dataset

Choose And Book Utilisation Commissioner

The Department requires information to help monitor utlisation of the NHS Connecting for Health Choose and Book system.

The Choose and Book Utilisation Commissioner Dataset is commissioner based. Commissioners are the Organisations commissioning out-patient and in-patient care for NHS patients

The Choose and Book Utilisation Commissioner Dataset contains the out-patient booking activity for the specified REPORTING PERIOD.

Dataset Data Elements
Organisation and Reporting Period
ORGANISATION CODE (CODE OF COMMISSIONER)
REPORTING PERIOD START DATE
REPORTING PERIOD END DATE
DATASET PREPARATION DATE
DATASET PREPARATION TIME
Choose and Book Utilisation
NUMBER OF OUT-PATIENT CONVERTED UNIQUE BOOKING REFERENCE NUMBERS
GP WRITTEN REFERRALS MADE

OUT-PATIENT FLOWS

Change to Dataset: New Dataset

OUT-PATIENT FLOWS

Out-Patient Flows Dataset

Out-Patient Flows

This replaces the Korner Returns KH09, QM08 and QMOP.

The Department and Strategic Health Authorities require summary details from care providers of consultant out-patient activity flows. This central information requirement provides performance management measures of waiting times and helps to identify those organisations failing to meet the standards of the NHS Plan.

The Out-Patient Flows Dataset is provider or commissioner based depending upon the Organisation submitting the dataset. Providers are care Organisations providing out-patient care and treatment for NHS patients. Commissioners are the Organisations commissioning consultant out-patient care for NHS patients. For commissioner based datasets, the provider is required to supply data to the commissioner

Data collection

The NHS report datasets to the Department of Health monthly and quarterly via Unify, an online data collection system. Trusts and PCTs can either enter data directly onto Unify, or upload from spreadsheets provided to ease data input.
These returns flow through Strategic Health Authorities, and require their sign off before they are accessed by the Department of Health.
Data providers are required to submit data by the 15th working day following the month end, with publication being on the Friday following the 20th working day after month end.

The Out-Patient Flows Dataset contains the consultant out-patient activity for the specified REPORTING PERIOD.

Dataset Data Elements
Organisation and Reporting Period
COMMISSIONER OR PROVIDER STATUS INDICATOR
ORGANISATION CODE (CODE OF COMMISSIONER)
ORGANISATION CODE (CODE OF PROVIDER)
REPORTING PERIOD START DATE
REPORTING PERIOD END DATE
DATASET PREPARATION DATE
DATASET PREPARATION TIME
Out-Patient Flow Group by Main Specialty: **To carry the flow details for the MAIN SPECIALTY CODE recorded. Where no flow activity for a MAIN SPECIALTY CODE has occurred within the Reporting Period then no Out-Patient Flow group should be recorded for it. There should be only 1 occurrence of this sub group permitted per MAIN SPECIALTY CODE.**
MAIN SPECIALTY CODE
GP WRITTEN REFERRALS
OUT-PATIENT FIRST APPOINTMENTS FIRST ATTENDANCES SEEN
OUT-PATIENT FIRST APPOINTMENTS DID NOT ATTEND
OUT-PATIENT FOLLOW-UP APPOINTMENTS ATTENDANCES SEEN
OUT-PATIENT FOLLOW-UP APPOINTMENTS DID NOT ATTEND
OTHER REFERRALS
Out-Patient Effective Waits Group by Period within Main Specialty: **To carry the effective wait details for the MAIN SPECIALTY CODE recorded. There should be 1 occurrence of this sub group permitted for each Out-Patient waiting time band for each MAIN SPECIALTY CODE.**
MAIN SPECIALTY CODE
OUT-PATIENT WAITING TIME BAND
OUT-PATIENT EFFECTIVE WAITS

OUT-PATIENT STOCKS

Change to Dataset: New Dataset

OUT-PATIENT STOCKS

Out-Patient Stocks Dataset

Out-Patient Stocks

This replaces the Korner Returns QM08 Not Seens.

The Department and Strategic Health Authorities require summary details from care providers of consultant out-patient activity flows. This central information requirement provides performance management measures of waiting times and helps to identify those organisations failing to meet the standards of the NHS Plan.

The Out-Patient Stocks Dataset is provider or commissioner based depending upon the Organisation submitting the dataset. Providers are care Organisations providing consultant out-patient care and treatment for NHS patients. Commissioners are the Organisations commissioning out-patient care for NHS patients. For commissioner based datasets, the provider is required to supply data to the commissioner

Data collection

The NHS report datasets to the Department of Health monthly and quarterly via Unify, an online data collection system. Trusts and PCTs can either enter data directly onto Unify, or upload from spreadsheets provided to ease data input.
These returns flow through Strategic Health Authorities, and require their sign off before they are accessed by the Department of Health.
Data providers are required to submit data by the 15th working day following the month end, with publication being on the Friday following the 20th working day after month end.

The Out-Patient Stocks Dataset contains the not yet seen consultant out-patient stocks as at the end of the specified REPORTING PERIOD.

Dataset Data Elements
Organisation and Reporting Period

COMMISSIONER OR PROVIDER STATUS INDICATOR
ORGANISATION CODE (CODE OF COMMISSIONER)
ORGANISATION CODE (CODE OF PROVIDER)
REPORTING PERIOD START DATE
REPORTING PERIOD END DATE
DATASET PREPARATION DATE
DATASET PREPARATION TIME
Out-Patient Stock Group by Main Specialty: **To carry the stock details for the MAIN SPECIALTY CODE recorded. Where there are no stocks present for a MAIN SPECIALTY CODE within the Reporting Period then no Out-Patient Stock group should be recorded for it. There should be 1 occurrence of this sub group permitted for each Out-Patients Waiting Time Band for each MAIN SPECIALTY CODE.**
MAIN SPECIALTY CODE
OUT-PATIENT WAITING TIME BAND
OUT-PATIENTS WAITING

SUMMARISED ACTIVITY FLOWS

Change to Dataset: New Dataset

SUMMARISED ACTIVITY FLOWS

Summarised Activity Flows Dataset

Summarised Activity Flows

The Department and Strategic Health Authorities require summary details from care providers of in-patient and out-patient activity flows. This central information requirement provides performance management measures of waiting times and helps to identify those organisations failing to meet the standards of the NHS Plan.

The Summarised Activity Flows Dataset is provider or commissioner based depending upon the Organisation submitting the dataset. Providers are care Organisations providing in-patient care and treatment for NHS patients. Commissioners are the Organisations commissioning in-patient care for NHS patients. For commissioner based datasets, the provider is required to supply data to the commissioner

The Summarised Activity Flows contains the in-patient and out-patient flow activity as at the end of the specified REPORTING PERIOD.

Dataset Data Elements
Organisation and Reporting Period
COMMISSIONER OR PROVIDER STATUS INDICATOR
ORGANISATION CODE (CODE OF COMMISSIONER)
ORGANISATION CODE (CODE OF PROVIDER)
REPORTING PERIOD START DATE
REPORTING PERIOD END DATE
DATASET PREPARATION DATE
DATASET PREPARATION TIME
Admitted Patient Flow All Elective Admissions: **To carry the flow details for admissions from the Elective Admission List.**
ADMITTED PATIENT ELECTIVE ADMISSIONS (ORDINARY)
ADMITTED PATIENT ELECTIVE ADMISSIONS (DAY CASE)
ADMITTED PATIENT ELECTIVE ADMISSIONS (PLANNED)
ADMITTED PATIENT ELECTIVE ADMISSIONS (NHS TREATMENT CENTRES)
ADMITTED PATIENT ELECTIVE ADMISSIONS (IS TREATMENT CENTRES)
Admitted Patient Flow for Trauma & Orthopaedics Elective Admissions Only: **To carry the in-patient flow details for all admissions from the Elective Admission List for MAIN SPECIALTY CODE 110 TRAUMA & ORTHOPAEDICS only. Where no stocks are are present, zero should be recorded.**
MAIN SPECIALTY CODE (Main Specialty Code 110)
ADMITTED PATIENT ELECTIVE ADMISSIONS (ORDINARY)
ADMITTED PATIENT ELECTIVE ADMISSIONS (DAY CASE)
ADMITTED PATIENT ELECTIVE ADMISSIONS (PLANNED)
ADMITTED PATIENT ELECTIVE ADMISSIONS (NHS TREATMENT CENTRES)
ADMITTED PATIENT ELECTIVE ADMISSIONS (IS TREATMENT CENTRES)

Admitted Patient Flows Admissions NHS Hospitals: To carry the flow details for admissions to a NHS Hospital
ADMITTED PATIENT TOTAL NON-ELECTIVE ADMISSIONS
Admitted Patient Flows Admissions NHS Hospitals: To carry the flow details for admissions to a NHS Hospital for particular intended procedures
ADMISSION INTENDED PROCEDURE
ADMITTED PATIENT NHS ADMISSIONS
Admitted Patient Flow Admissions non-NHS Hospitals: To carry the flow details for admissions for NHS patient admitted to a non-NHS Hospital.
ADMISSION INTENDED PROCEDURE
ADMITTED PATIENT NON-NHS ADMISSIONS
Out-Patient Flow GP Written Referrals: To carry the flow details for GP written referrals made and patients seen resulting from a GP written referral.
GP WRITTEN REFERRALS
GP WRITTEN REFERRALS SEEN
Out-Patient Flow GP Written Referrals Trauma & Orthopaedics: To carry the flow details for all GP written referrals made and patients seen resulting from a GP written referral to a CONSULTANT for MAIN SPECIALTY CODE 110 TRAUMA & ORTHOPAEDICS. Where no stocks are are present, zero should be recorded.
MAIN SPECIALTY CODE (Main Specialty Code 110)
GP WRITTEN REFERRALS
GP WRITTEN REFERRALS SEEN

SUMMARISED STOCKS

Change to Dataset: New Dataset

SUMMARISED STOCKS

Summarised Stocks Dataset

Summarised Stocks

The Department and Strategic Health Authorities require summary details from care providers of admitted patient and out-patient stocks for Trauma and Orthopaedics; and in-patient stocks for ordinary admissions for care procedures of CABG, PTCA, Valves and Angiography.

This central information requirement provides performance management measures of waiting times and helps to identify those organisations failing to meet the standards of the NHS Plan.

The Summarised Stocks Dataset is provider or commissioner based depending upon the Organisation submitting the dataset. Providers are care Organisations providing admitted patient care and treatment for NHS patients. Commissioners are the Organisations commissioning in-patient care for NHS patients. For commissioner based datasets, the provider is required to supply data to the commissioner.

The Summarised Stocks Dataset contains the admitted patient waiting to be admitted stocks as at the end of the specified REPORTING PERIOD.

Dataset Data Elements
Organisation and Reporting Period
COMMISSIONER OR PROVIDER STATUS INDICATOR
ORGANISATION CODE (CODE OF COMMISSIONER)
ORGANISATION CODE (CODE OF PROVIDER)
REPORTING PERIOD START DATE
REPORTING PERIOD END DATE
DATASET PREPARATION DATE
DATASET PREPARATION TIME
Admitted Patient Stock Group for Specialties To carry the in-patient stock details for a MAIN SPECIALTY CODE. Where no stocks are are present, zero should be recorded. There should be 1 occurence of this group for each PATIENTS WAITING FOR ADMISSION TIME BANDS for each MAIN SPECIALTY CODE
MAIN SPECIALTY CODE
WAITING FOR ADMISSION INTENDED MANAGEMENT

PATIENTS WAITING FOR ADMISSION TIME BAND
PATIENTS WAITING FOR ADMISSION
Summarised Admitted Patient Stock Group for particular intended procedures for ordinary admissions: To carry the sub group stock details for ordinary admissions for the INTENDED PROCEDURE. Where no stocks are present in the Reporting Period then zero values should be recorded. There should only be 1 occurrence of this group permitted for each PATIENTS WAITING FOR ADMISSION TIME BAND for ordinary admissions for each INTENDED PROCEDURE.
ADMISSION INTENDED PROCEDURE
WAITING FOR ADMISSION INTENDED MANAGEMENT
PATIENTS WAITING FOR ADMISSION TIME BAND
PATIENTS WAITING FOR ADMISSION
Out-Patient Stock Group To carry the out-patient stock details for MAIN SPECIALTY CODE. Where no stocks are present, zero should be recorded. There should be 1 occurrence of this sub group permitted for each OUT-PATIENT WAITING TIME BAND for each MAIN SPECIALTY CODE.
MAIN SPECIALTY CODE
OUT-PATIENT WAITING TIME BAND
OUT-PATIENTS WAITING

KC62 ANNEX 1

Change to Central Return Form: Change to Guidance Text

KC62: Adult Screening Programmes - Breast Screening

KC62 Annex: Adult Screening Programmes - Breast Screening

1. This is detailed information on each cancer detected for epidemiological comparisons to be made both within the Screening Programme and with data from other sources.

Line for each cancer detected (first column)

2. A separate line should be used for each PERSON with cancer detected.

Relevant tables (i.e. A, B, C1 etc.) (column 1)

3. The relevant table that the summary information has been included in for each PERSON with cancer detected.

KC62 Table A	First invitation for routine screening
KC62 Table B	Routine invitation to previous non-attenders
KC62 Table C1	Routine invitation to previous attenders (Last screen within 5 years)
KC62 Table C2	Routine invitation to previous attenders (Last screen more than 5 years)
KC62 Table D	Early Recalls
KC62 Table E	Self/GP referrals of women not screened previously
KC62 Table F1	Self/GP referrals of women screened previously (Last screen within 5 years)
KC62 Table F2	Self/GP referrals of women screened previously (Last screen more than 5 years previously)

Age at first offered appointment in this episode (years) (column 2)

4. ~~This is derived from the PERSON BIRTH DATE of the PERSON and is their age at the time of their first test date offered (see REQUEST OR INVITATION FOR APPOINTMENT DATE) for women invited as part of a Screening Programme or first test date offered (see REQUEST OR INVITATION FOR APPOINTMENT DATE) for women with a REFERRAL REQUEST for Screening Test.~~

4. This is derived from the PERSON BIRTH DATE of the PERSON and is their age at the time of their first test date offered (see APPOINTMENT DATE OFFERED) for women invited as part of a Screening Programme or first test date offered (see APPOINTMENT DATE OFFERED) for women with a REFERRAL REQUEST for Screening Test.

Type of cancer (invasive, non-invasive or micro-invasive) (column 3)

5. The BIOPSY REFERRAL OUTCOME from the Request for Pathology Investigation of the PERSON.
Invasive is BIOPSY REFERRAL OUTCOME of *Positive; i.e. cancer detected, invasive size not known* or *Positive; i.e. cancer detected, invasive size known* or *Positive; i.e. cancer detected, invasive status not known*. Non-invasive is BIOPSY REFERRAL OUTCOME of *Positive; i.e. cancer detected, non-invasive or possibly micro-invasive*. Micro-invasive is BIOPSY REFERRAL OUTCOME of *Positive; i.e. cancer detected, definitely micro-invasive*.

Size of tumour (mm) (column 4)

6. The INVASIVE LESION SIZE from the Request for Pathology Investigation of the PERSON.

Grade of tumour (I, II or III for invasive and high or low/intermediate for DCIS) (column 5)

7. The BIOPSY REFERRAL OUTCOME from the Request for Pathology Investigation of the PERSON.
Grade I is BIOPSY REFERRAL OUTCOME of *Positive; i.e. cancer detected, invasive size not known, Grade I or Positive; i.e. cancer detected, invasive size known, Grade I*. Grade II is BIOPSY REFERRAL OUTCOME of *Positive; i.e. cancer detected, invasive size not known, Grade II or Positive; i.e. cancer detected, invasive size known, Grade II*. Grade III is BIOPSY REFERRAL OUTCOME of *Positive; i.e. cancer detected, invasive size not known, Grade III or Positive; i.e. cancer detected, invasive size known, Grade III*. Low is BIOPSY REFERRAL OUTCOME of *Positive; i.e. cancer detected, non-invasive or possibly micro-invasive, low (DCIS only detected)* or *Positive; i.e. cancer detected, definitely micro-invasive, low (DCIS only detected)*. Intermediate is BIOPSY REFERRAL OUTCOME of *Positive; i.e. cancer detected, non-invasive or possibly micro-invasive, intermediate (DCIS only detected)*or *Positive; i.e. cancer detected, definitely micro-invasive, intermediate (DCIS only detected)*. High is BIOPSY REFERRAL OUTCOME of *Positive; i.e. cancer detected non-invasive or possibly micro-invasive high (DCIS only detected)* or *Positive; i.e. cancer detected definitely micro-invasive high (DCIS only detected)*.

Number of lymph nodes sampled (column 6)

8. The number of Requests for Pathology Investigation for the PERSON with a LYMPH NODE STATUS. Each lymph node sampled will be a different Request for Pathology Investigation. Where their have been no lymph nodes sampled enter zero. If any LYMPH NODE STATUSES are not yet available enter not known.

Number sampled positive (column 7)

9. The number of Requests for Pathology Investigation for the PERSON with a LYMPH NODE STATUS of lymph node positive.

Number sampled negative (column 8)

10. The number of Requests for Pathology Investigation for the PERSON with a LYMPH NODE STATUS of lymph node negative.

Histological type (column 9)

11. The CANCER HISTOLOGICAL TYPE from the Request for Pathology Investigation of the PERSON.

KC53 4

Change to Central Return Form: Change to Guidance Text

KC53: Adult Screening Programmes: Cervical Screening

Part B: Cervical Screening Programme - Number of Women Invited

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

   ~~A Screening Test Invitation is an APPOINTMENT associated with an APPOINTMENT REQUEST OR INVITATION and an APPOINTMENT OR REQUEST INVITATION CLASSIFICATION where the APPOINTMENT OR REQUEST INVITATION CLASSIFICATION CODE is National Code 06 *'Screening Test'*.~~

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

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

   A Screening Test Invitation is an APPOINTMENT associated with an APPOINTMENT OFFER and an APPOINTMENT OFFER where the APPOINTMENT CLASSIFICATION CODE is National Code 06 *'Screening Test'*.

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

Age of woman at 31 March (column 1)

2. The age bands are derived from the PERSON BIRTH DATE.

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

Call (column 2)

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

Routine recall (column 3)

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

Surveillance (column 4)

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

Abnormality (column 5)

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

Inadequate smear (column 6)

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

Target age group (line 0014)

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

   A Screening Programme is a HEALTH PROGRAMME where the HEALTH PROGRAMME TYPE is National Code 06 *'Screening Programme'.*

Total all ages (line 9999)

9. This is the total for all age groups counted in lines 0001 to 0013 for each INVITATION TYPE.

KC53 5

Change to Central Return Form: Change to Guidance Text

KC53: Adult Screening Programmes: Cervical Screening

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

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

   A Screening Test is a CLINICAL INTERVENTION where the CLINICAL INTERVENTION TYPE is National Code 28 *'Screening Test'.* Screening Test Date is the same as attribute ACTIVITY DATE where ACTIVITY DATE TIME TYPE is National Code 47 *'Screening Test'.*

Call (column 2)

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

   ~~A Screening Test Invitation is an APPOINTMENT associated with an APPOINTMENT REQUEST OR INVITATION and an APPOINTMENT OR REQUEST INVITATION CLASSIFICATION where the APPOINTMENT OR REQUEST INVITATION CLASSIFICATION CODE is National Code 06 *'Screening Test'.*~~

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

   A Screening Test Invitation is an APPOINTMENT associated with an APPOINTMENT OFFER where the APPOINTMENT CLASSIFICATION CODE is National Code 06 *'Screening Test'.*

Routine recall (column 3)

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

Surveillance (column 4)

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

Abnormality (column 5)

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

Inadequate smear (column 6)

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

While recall suspended (column 7)

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

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

While recall ceased (column 8)

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

Not Invited by Programme (column 9)

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

Target age group (line 0014)

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

Total all women (line 9999)

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

KC53 5

Change to Central Return Form: Unknown delta_is_information_centre_item

KC53 6

Change to Central Return Form: Change to Guidance Text

KC53: Adult Screening Programmes: Cervical Screening

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

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

   A Screening Test is a CLINICAL INTERVENTION where the CLINICAL INTERVENTION TYPE is National Code 28 *'Screening Test'*. Screening Test Date is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TIME TYPE is National Code 47 *'Screening Test Date'*.

Call (column 2)

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

   ~~A Screening Test Invitation is an APPOINTMENT associated with an APPOINTMENT REQUEST OR INVITATION and an APPOINTMENT OR REQUEST INVITATION CLASSIFICATION where the APPOINTMENT OR REQUEST INVITATION CLASSIFICATION CODE is National Code 06 *'Screening Test'*.~~

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

   A Screening Test Invitation is an APPOINTMENT associated with an APPOINTMENT OFFER and an APPOINTMENT CLASSIFICATION CODE where the APPOINTMENT CLASSIFICATION CODE is National Code 06 *'Screening Test'*.

Routine recall (column 3)

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

Surveillance (column 4)

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

Abnormality (column 5)

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

Inadequate smear (column 6)

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

While recall suspended (column 7)

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

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

While recall ceased (column 8)

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

Not Invited by Programme (column 9)

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

Result of test

10. This is classified by the following CYTOLOGY RESULT TYPES:
Inadequate (cat. 1) (line 0001)
Negative (cat. 2) (line 0002)
Borderline changes (cat. 8) (line 0003)
Mild dyskaryosis (cat. 3) (line 0004)
Moderate dyskaryosis (cat. 7) (line 0005)
Severe dyskaryosis (cat. 4) (line 0006)
Severe dyskaryosis/?invasive carcinoma (cat. 5) (line 0007)
?Glandular neoplasia (cat. 6) line 0008)

Total women tested aged 20-64 (line 9999)

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

    A Screening Programme is a HEALTH PROGRAMME where the HEALTH PROGRAMME TYPE is National Code 06 *'Screening Programme'*.

KC53 7

Change to Central Return Form: Change to Guidance Text

KC53: Adult Screening Programmes: Cervical Screening

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

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

   A Screening Test is a CLINICAL INTERVENTION where the CLINICAL INTERVENTION TYPE is National Code 28 *'Screening Test'*. Screening Test Date is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TIME TYPE is National Code 47 *'Screening Test Date'*.

Call (column 2)

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

   ~~A Screening Test Invitation is an APPOINTMENT associated with an APPOINTMENT REQUEST OR INVITATION and an APPOINTMENT OR REQUEST INVITATION CLASSIFICATION where the APPOINTMENT OR REQUEST INVITATION CLASSIFICATION CODE is National Code 06 *'Screening Test'*.~~

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

   A Screening Test Invitation is an APPOINTMENT associated with an APPOINTMENT OFFER where the APPOINTMENT CLASSIFICATION CODE is National Code 06 *'Screening Test'*.

Routine recall (column 3)

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

Surveillance (column 4)

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

Abnormality (column 5)

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

Inadequate smear (column 6)

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

While recall suspended (column 7)

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

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

While recall ceased (column 8)

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

Not Invited by Programme (column 9)

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

Result of test

10. This is classified by the following CYTOLOGY RESULT TYPES:
Inadequate (cat. 1) (line 0001)
Negative (cat. 2) (line 0002)
Borderline changes (cat. 8) (line 0003)
Mild dyskaryosis (cat. 3) (line 0004)
Moderate dyskaryosis (cat. 7) (line 0005)
Severe dyskaryosis (cat. 4) (line 0006)
Severe dyskaryosis/?invasive carcinoma (cat. 5) (line 0007)
?Glandular neoplasia (cat. 6) line 0008)

Total all results (line 9999)

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

    A Screening Programme is a HEALTH PROGRAMME where the HEALTH PROGRAMME TYPE is National Code 06 *'Screening Programme'*.

KC61 1

Change to Central Return Form: Change to Guidance Text

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

Contextual Overview

1. The Department, NHS Cervical Screening Programme (NHSCSP), Strategic Health Authorities and trusts require information from Pathology Laboratories on cervical cytology and outcome of referrals.
   A Pathology Laboratory is a LABORATORY where the LABORATORY TYPE is National Code 01 '*Pathology Laboratory*'.

2. The information helps to monitor the process of achieving the Government's target to reduce the incidence of invasive cervical cancer and to ensure that the screening programme is managed effectively. The information is used to ensure that the laboratory is achieving acceptable standards in examining smears in line with guidance provided by the NHS Cervical Screening Programme.

3. Information on the return is also used in Public Expenditure Survey (PES) negotiations, resource allocation to the NHS and Departmental accountability.

4. Information based on the KC61 return is published annually by the Department in the Statistical Bulletin `Cervical Screening Programme'.

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

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

   ~~Each return requires the ORGANISATION CODE and ORGANISATION NAME of the NHS Trust and must be signed by a CONSULTANT in one of the Pathology MAIN SPECIALTIES. It also requires the pathology LABORATORY NAME and pathology LABORATORY CODE. Note that pathology LABORATORY CODES are maintained and issued by the National Administrative Codes Service (NACS) on behalf of the NHS Cervical Screening Programme.~~

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

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

   For the NACS contact details, see Contact Details.

6. A Pathology Laboratory's KC61 return should include all the original Requests for Pathology Investigation received by that laboratory. A Request for Pathology Investigation forwarded to another laboratory should only be included in the first laboratory's return (except Part A3).
   A Request for Pathology Investigation is a DIAGNOSTIC TEST REQUEST where the DIAGNOSTIC TEST REQUEST is National Code 03 '*Request for Pathology Investigation*'.

7. Smears re-screened within the same Laboratory as part of internal or external quality control or for any other reason should not be included in the KC61 return. The number of requests sent to or received from another Laboratory for primary screening or other reason should be recorded in Part A3.

8. Where more than one slide is associated with one Request for Pathology Investigation, only the most significant CYTOLOGY RESULT TYPES may be counted for the KC61.

9. The return KC61 is completed annually and submitted within two months of the end of the period.

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

KC62 A 1

Change to Central Return Form: Change to Guidance Text

KC62: Adult Screening Programmes - Breast Screening

Table A: 1st Invitation for Routine Screening

This table reports the persons in a Screening Programme (see PERSON IN PROGRAMME) for Breast Screening whose SCREENING STATUS is *first call*.

Part A1: Invitations and Outcomes

1. This is a summary of the outcomes of screening and assessment of all women invited and/or screened.

Age at first offered appointment (first column)

2. This is derived from the BIRTH DATE of the PERSON. Line 01 includes all women who were aged 44 or less at the time of the date of their first offered appointment for screening in the period covered by the return. Lines 02 to 09 include women in specified age groups. Line 10 includes all women who were aged 75 or over. Line 11 gives the total of all women in lines 03 to 08, giving a summary of the women in the NHS Breast Screening Programme target age range of 50 to 70 - the Screening Population. Line 12 gives the total of all women in lines 01 to 10 regardless of age.

3. Lines 13 - 24 in Part A2 Assessment and lines 25 - 36 in Part A3 Cancer diagnosed follow the pattern described above.

Number of women invited (column 1)

4. ~~Count of Screening Test Invitations where the first Screening Test Invitation has a first test date offered (see REQUEST OR INVITATION FOR APPOINTMENT DATE) in the period covered by the return.~~

4. Count of Screening Test Invitations where the first Screening Test Invitation has a first test date offered (see APPOINTMENT DATE OFFERED) in the period covered by the return.

Lost to follow-up after technically inadequate screening mammogram (column 2)

5. Count of women whose SCREENING TEST RESULT classification was *Inadequate test*, and for whom no REFERRAL REQUEST for breast assessment was made.

Number screened (technically adequate) (column 3)

6. Count of women with a Screening Test Date in the period covered by the return whose SCREENING TEST RESULT classification was not *Inadequate test*.

Outcome of initial screen : Not known (column 4)

7. Count of women with a valid Screening Test Date but where no breast cancer screening test outcome (see BREAST ASSESSMENT OR TEST OUTCOME) has been recorded.

Outcome of initial screen: Routine recall (column 5)

8. Count of women with a breast cancer screening test outcome classification of *Routine recall*.

Outcome of initial screen: Early recall (column 6)

9. Count of women with a breast cancer screening test outcome classification of *Early recall* but without a REFERRAL REQUEST for breast assessment.

Outcome of initial screen: Referred for assessment (column 7)

10. Count of women with a REFERRAL REQUEST for breast assessment. This covers all the women reported in columns 8 to 12.

Final outcome of assessment: Failed to attend for assessment (column 8)

11. Count of women with a REFERRAL REQUEST for breast assessment who failed to attend for all required assessment appointments and for whom there is no breast assessment final outcome (see BREAST ASSESSMENT OR TEST OUTCOME).

Final outcome of assessment: Outcome of assessment not known (column 9)

12. Count of women with a breast assessment date (see ACTIVITY DATE) but where no breast assessment final outcome has been recorded.

Final outcome of assessment: Routine recall (column 10)

13. Count of women with a breast assessment date and a breast assessment final outcome classification of *Routine recall*.

Final outcome of assessment: Early recall (column 11)

14. Count of women with a breast assessment date and a breast assessment final outcome classification of *Early recall*.

Final outcome of assessment: Cancer (column 12)

15. Count of women with a breast assessment date and a breast assessment final outcome classification of *Cancer diagnosed*. The total recorded in this column will equal the total recorded in columns 13, 18 and 24.

Part A2: Assessment

16. This part breaks down the outcomes of assessment by the procedures involved for all women assessed as a result of screening.

Cancer diagnosed without cytology or histology (column 13)

17. Count of women with a breast assessment date and a breast assessment final outcome classification was *Cancer diagnosed*, but who had no REFERRAL REQUEST for biopsy or a REFERRAL REQUEST for biopsy where the PATHOLOGY INVESTIGATION TYPE CODE classification was not *Cytology* and the BIOPSY REFERRAL OUTCOME classification was *Inconclusive*.

Referred for cytology and/or core biopsy (column 14)

18. Count of women with a breast cancer screening test outcome classification of *Referred for assessment* and a subsequent REFERRAL REQUEST for biopsy with a PATHOLOGY INVESTIGATION TYPE CODE classification of *Cytology* or *Core biopsy*.

Not referred for open biopsy: No result recorded/inadequate result (column 15)

19. Count of women with a breast cancer screening test outcome classification of *Referred for assessment* and a subsequent REFERRAL REQUEST for biopsy with a PATHOLOGY INVESTIGATION TYPE CODE classification of *Cytology* or *Core biopsy* but without any PATHOLOGY INVESTIGATION TYPE CODE classification of *Histology (open biopsy)*. These women did not complete any or all procedures within 6 months of the date of the screen or had no breast assessment final outcome recorded.

Not referred for open biopsy: Routine recall (column 16)

20. Count of women with a breast cancer screening test outcome classification of *Referred for assessment*, a subsequent REFERRAL REQUEST for biopsy with a PATHOLOGY INVESTIGATION TYPE CODE classification of *Cytology* or *Core biopsy* but without any PATHOLOGY INVESTIGATION TYPE CODE classification of *Histology (open biopsy)*. These women have a breast assessment final outcome classification of *Routine recall*.

Not referred for open biopsy: Early recall (column 17)

21. Count of women with a breast cancer screening test outcome classification of *Referred for assessment*, a subsequent REFERRAL REQUEST for biopsy with a PATHOLOGY INVESTIGATION TYPE CODE classification of *Cytology* or *Core biopsy* but without any PATHOLOGY INVESTIGATION TYPE CODE classification of *Histology (open biopsy)*. These women have a breast assessment final outcome classification of *Early recall*.

Not referred for open biopsy: Cancer (column 18)

22. Count of women with a breast cancer screening test outcome classification of *Referred for assessment*, a subsequent REFERRAL REQUEST for biopsy with a PATHOLOGY INVESTIGATION TYPE CODE classification of *Cytology* or *Core biopsy* but without any PATHOLOGY INVESTIGATION TYPE CODE classification of *Histology (open biopsy)*. These women have a breast assessment final outcome classification of *Cancer diagnosed*.

Referred for open biopsy (column 19)

23. Count of women with a REFERRAL REQUEST for biopsy with a PATHOLOGY INVESTIGATION TYPE CODE classification of *Cytology* or *Core biopsy* followed by a REFERRAL REQUEST for biopsy with a PATHOLOGY INVESTIGATION TYPE CODE classification of *Histology (open biopsy)*.

Total referred for open biopsy (column 20)

24. Total count of women with a REFERRAL REQUEST for biopsy with a PATHOLOGY INVESTIGATION TYPE CODE classification of *Histology (open biopsy)*.

Up to and including open biopsy: No result/inadequate result (column 21)

25. Count of women with a REFERRAL REQUEST for biopsy with a PATHOLOGY INVESTIGATION TYPE CODE classification of *Histology (open biopsy)*. These women have a BIOPSY REFERRAL OUTCOME classification of *Inconclusive* or *Biopsy not done or result not yet known* or did not attend for the biopsy within 6 months of the date of the Screening Test having no recorded date biopsy taken (see ACTIVITY DATE) .

Up to and including open biopsy: Result: Benign/normal: Routine recall (column 22)

26. Count of women with a REFERRAL REQUEST for biopsy with a PATHOLOGY INVESTIGATION TYPE CODE classification of *Histology (open biopsy)*. The BIOPSY REFERRAL OUTCOME classification is *Benign or negative*. The breast assessment final outcome classification for these women is *Routine recall*.

Up to and including open biopsy: Result: Benign/normal: Early recall (column 23)

27. Count of women with a REFERRAL REQUEST for biopsy with a PATHOLOGY INVESTIGATION TYPE CODE classification of *Histology (open biopsy)*. The BIOPSY REFERRAL OUTCOME classification is *Benign or negative*. The breast assessment final outcome classification for these women is *Early recall*.

Up to and including open biopsy: Cancer (column 24)

28. Count of women with a REFERRAL REQUEST for biopsy with a PATHOLOGY INVESTIGATION TYPE CODE classification of *Histology (open biopsy)*. The BIOPSY REFERRAL OUTCOME classification is *Positive; i.e cancer diagnosed*. The breast assessment final outcome classification for these women is *Cancer diagnosed*.

KC63 2

Change to Central Return Form: Change to Guidance Text

KC63 - Adult Screening Programmes: Breast Screening

Breast Screening Programme

Part 1: Cross Section Analysis of Population Coverage within period 1/4/xxxx - 31/3/xxxx

1. KC63 requires information on the screening history of women who were resident in the Strategic Health Authority at 31 March.

2. ~~All types of screening episodes taking place within the stated period are counted. However, a woman will only be counted once in each screening category, regardless of how many of episodes she has. An `episode' may be the result of a Screening Test Invitation (within the programme) or a REFERRAL REQUEST for an APPOINTMENT associated with an APPOINTMENT REQUEST OR INVITATION and an APPOINTMENT OR REQUEST INVITATION CLASSIFICATION where the APPOINTMENT OR REQUEST INVITATION CLASSIFICATION CODE is National Code 06 '*Screening Test*' from outside the programme.~~

2. All types of screening episodes taking place within the stated period are counted. However, a woman will only be counted once in each screening category, regardless of how many of episodes she has. An `episode' may be the result of a Screening Test Invitation (within the programme) or a REFERRAL REQUEST for an APPOINTMENT associated with an APPOINTMENT OFFER where the APPOINTMENT CLASSIFICATION CODE is National Code 06 '*Screening Test*' from outside the programme.

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

Age of Woman at 31 March (column 2)

3. The age bands are derived from the PERSON BIRTH DATE of the PERSON at 31 March.

   Under 45 (line 001)
   45-49 (line 002)
   50-52 (line 003)
   53-54 (line 004)
   55-59 (line 005)
   60-64 (line 006)
   65-69 (line 007)
   70 (line 008)
   71-74 (line 009)
   75 and over (line 010)
   Target Group 50-70 (line 11)
   Total all ages (line 999)

Number of women resident at 31 March xxxx (column 3)

4. This is derived from the registers maintained by the Strategic Health Authority to ensure compatibility with the other data recorded on the return.

Number of Ineligible Women (column 4)

5. A count of women with SCREENING STATUS classifications of '*Recall suspended*' or '*Recall ceased*'.

Never Screened: Number of women selected (column 5)

6. This counts the number of women (PERSONS IN PROGRAMME) who have been selected for screening, but have no Screening Test or with a current first Screening Test with no BREAST ASSESSMENT OR TEST OUTCOME.

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

Never Screened: Number never selected (column 6)

7. This counts the number of women who have no screening history at all.

Call/Recall Episodes: Number invited in period (column 7)

8. ~~The number invited relates to women with SCREENING STATUS classifications of '*First call*' or '*Routine recall*' who are sent Screening Test Invitations with first test date offered (the first REQUEST OR INVITATION FOR APPOINTMENT DATE) between 1 April and 31 March.~~

8. The number invited relates to women with SCREENING STATUS classifications of '*First call*' or '*Routine recall*' who are sent Screening Test Invitations with first test date offered (the first APPOINTMENT DATE OFFERED) between 1 April and 31 March.

~~A Screening Test Invitation is an APPOINTMENT associated with an APPOINTMENT REQUEST OR INVITATION and an APPOINTMENT OR REQUEST INVITATION CLASSIFICATION where the APPOINTMENT OR REQUEST INVITATION CLASSIFICATION CODE is National Code 06 'Screening Test'.~~ A Screening Test Invitation is an APPOINTMENT associated with an APPOINTMENT OFFER where the APPOINTMENT CLASSIFICATION CODE is National Code 06 'Screening Test'.

Call/Recall Episodes: Number screened in period (column 8)

9. The number screened relates to the women in column 7 who have a Screening Test with a SCREENING TEST RESULT.

Call/Recall Episodes: Number invited in last 3 years (column 9)

10. The number invited relates to women with SCREENING STATUS classifications of '*First call*' or '*Routine recall*' who are sent Screening Test Invitations with first test date offered within the last three years.

Call/Recall Episodes: Number screened in last 3 years (column 10)

11. The number screened relates to those women in column 9 who have a Screening Test with a SCREENING TEST RESULTS.

Self/GP Referral Episodes: Number screened in period (column 11)

12. The number screened relates to women with REFERRAL REQUEST for Screening Test with SCREENING REFERRAL SOURCE classifications of '*Self-referral*' or '*GP referral*' with a Screening Test Date between 1 April and 31 March and a SCREENING TEST RESULTS.

Screening Test Date is the same as attribute ACTIVITY DATE where ACTIVITY DATE TIME TYPE is National Code 47 '*Screening Test Date*'.

Self/GP Referral Episodes: Number screened in last three years (column 12)

13. The number screened relates to women with REFERRAL REQUEST for Screening Test classifications of '*Self-referral*' or '*GP referral*' with a Screening Test Date in the past three years and a SCREENING TEST RESULTS.

Women screened in period (column 13)

14. The number screened relates to women with a Screening Test Date between 1 April and 31 March who have a Screening Test with a SCREENING TEST RESULTS. This excludes the number invited with a SCREENING STATUS classification of '*Non-routine/Early recall advised*'.

Women screened in last three years (column 14)

15. The number screened relates to women with a Screening Test Date in the past three years who have a Screening Test with a SCREENING TEST RESULTS. This excludes the number invited with a SCREENING STATUS classification of '*Non-routine/Early recall advised*'.

Coverage: % Women screened in last 3 years (column 15)

16. This is the percentage of eligible women who have been screened in the last 3 years. It is derived from the number screened in last three years (column 14) divided by (the number of women resident as at 31 March xxxx (column 3) minus the number of ineligible women (column4)) multiplied by 100.

Part 2: Women with Open Episodes

17. This counts the number of women with open screening episodes. An open episode is incomplete; an invitation for Screening Test or REFERRAL REQUEST for Screening Test has not yet resulted in a SCREENING TEST RESULTS.

18. Line 001 counts the number of open episodes which were initiated by a REFERRAL REQUEST for Screening Test; Line 002 counts the number of open episodes which were initiated by an invitation for Screening Test.

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KH07 1

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ADDRESS, GEOGRAPHICAL AREA & COMMUNICATION

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~~Address, Geographical Area & Communication~~ Address, Geographical Area & Communicatio

ADDRESS, GEOGRAPHICAL AREA & COMMUNICATION_ renamed ADDRESS, GEOGRAPHICAL AREA & COMMUNICATIO

Change to Diagram: Change to Aliases

ADDRESS, GEOGRAPHICAL AREA & COMMUNICATION_ renamed ADDRESS, GEOGRAPHICAL AREA & COMMUNICATIO

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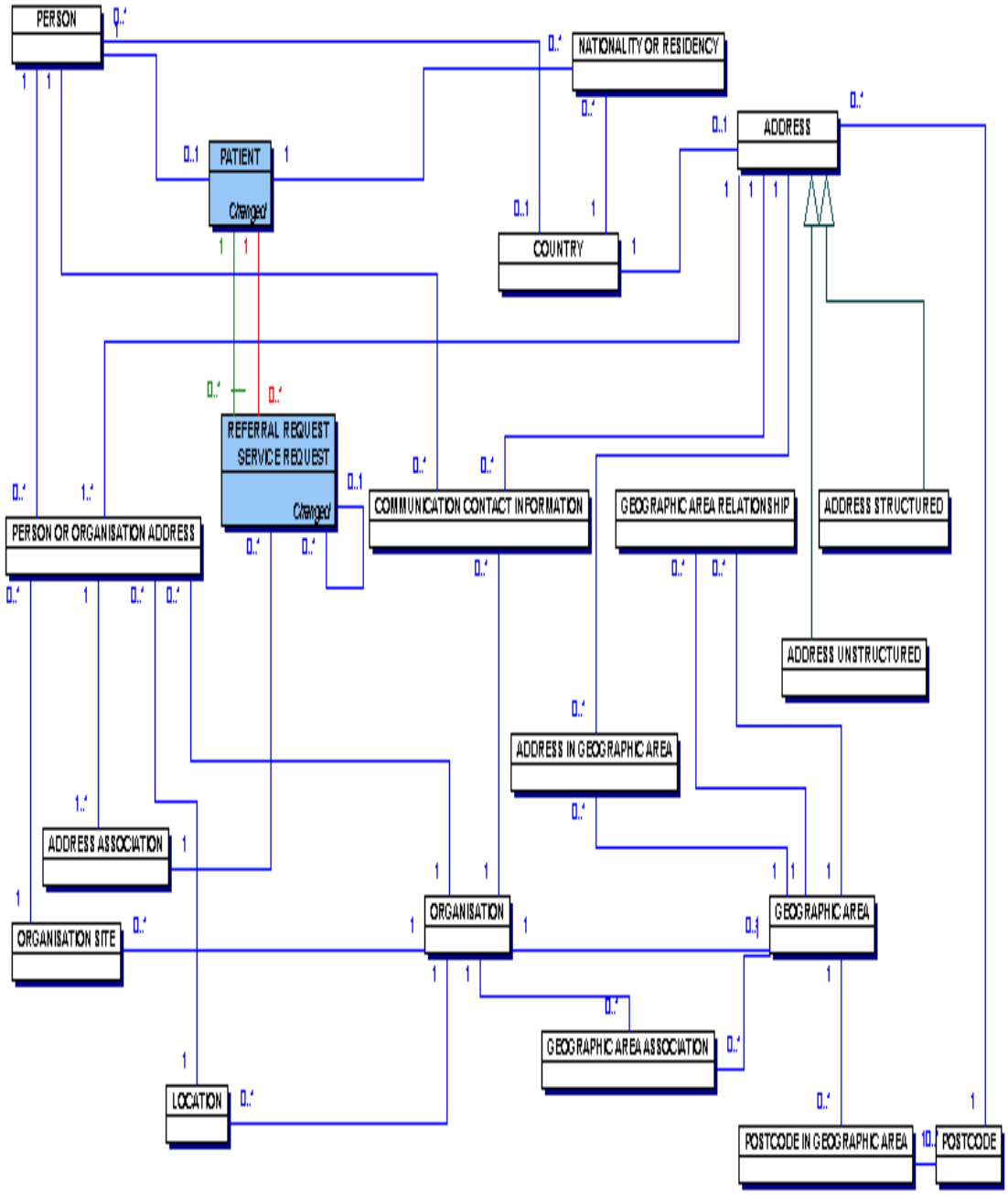

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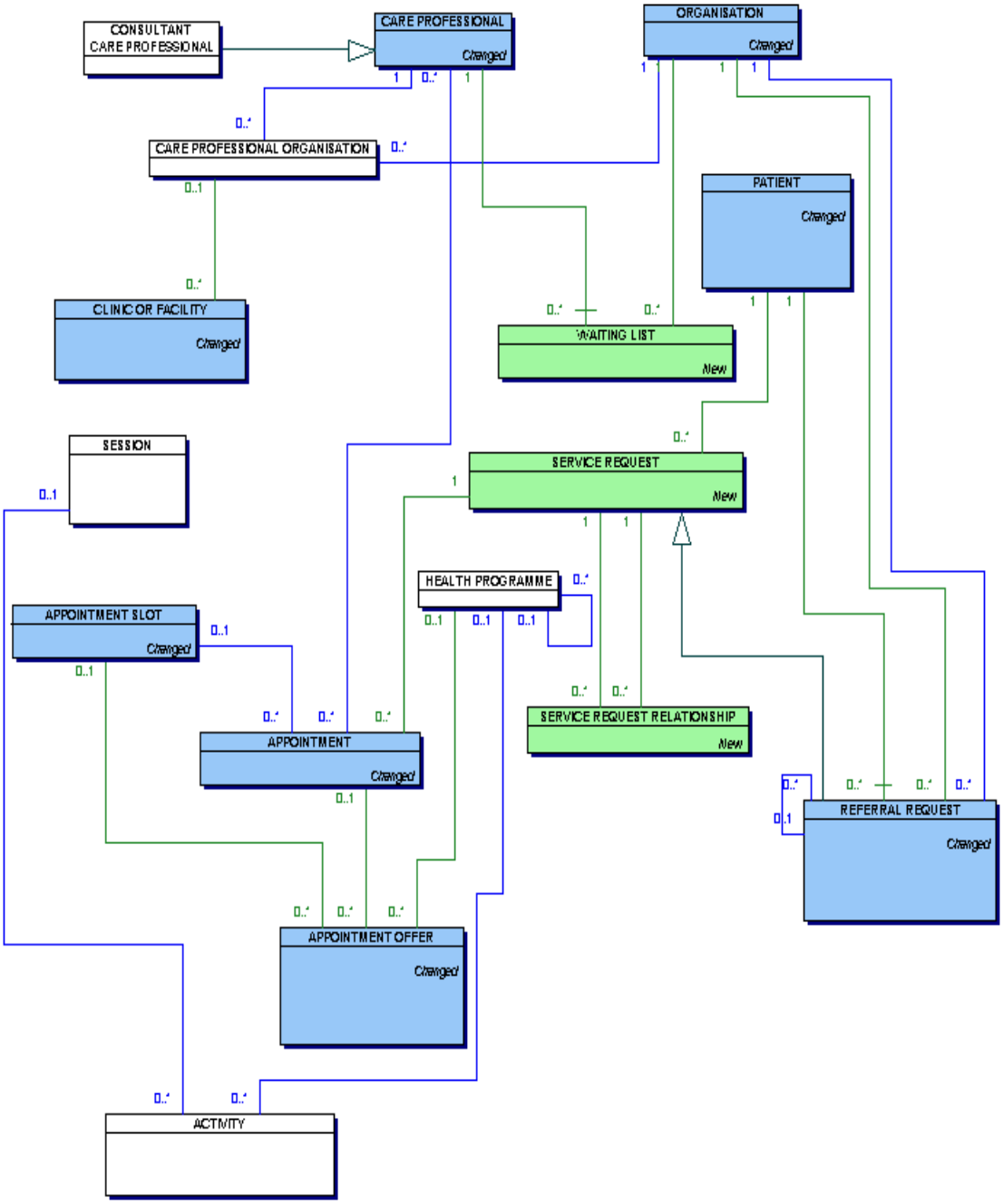

HEALTH PROGRAMME

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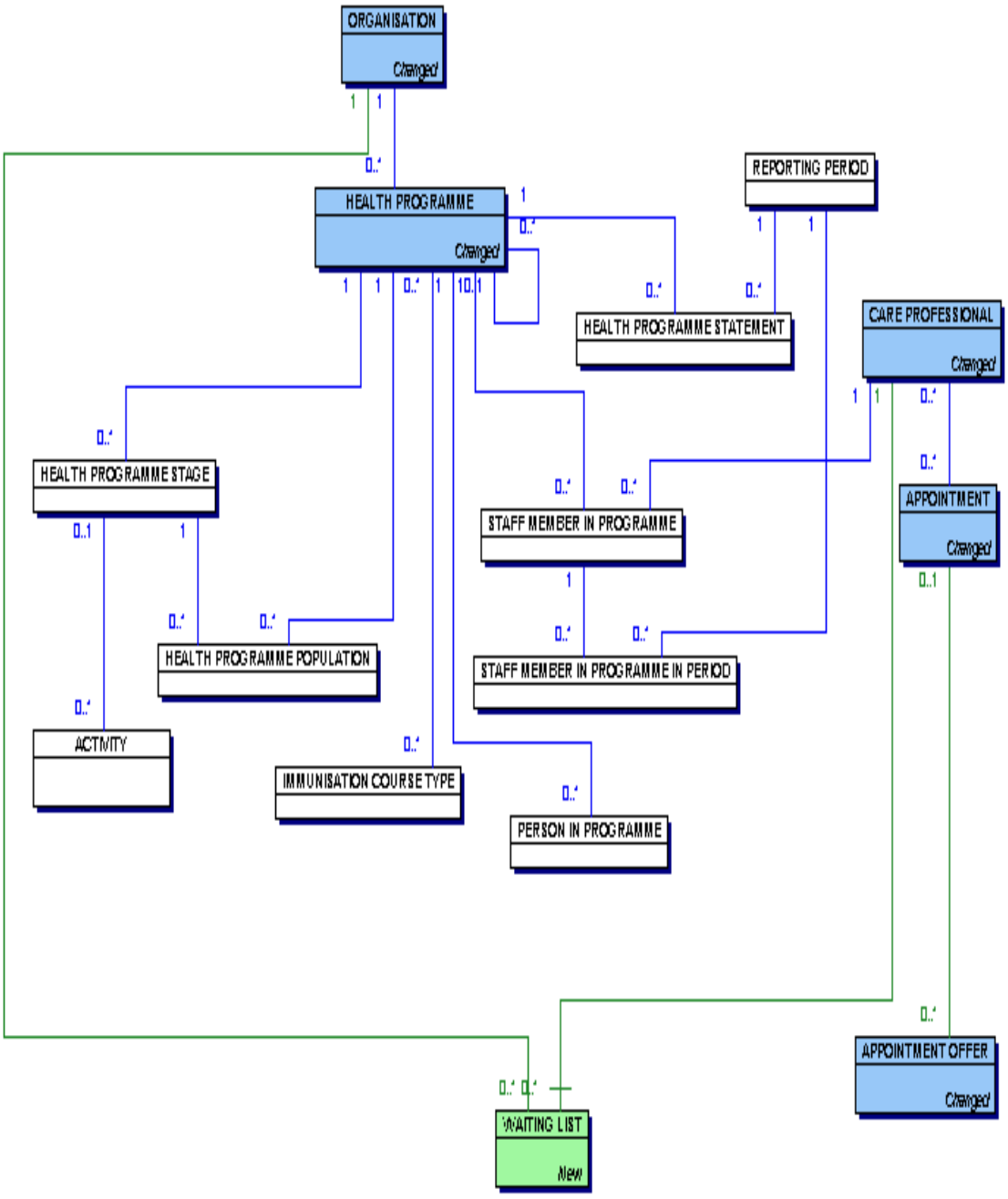

LISTS

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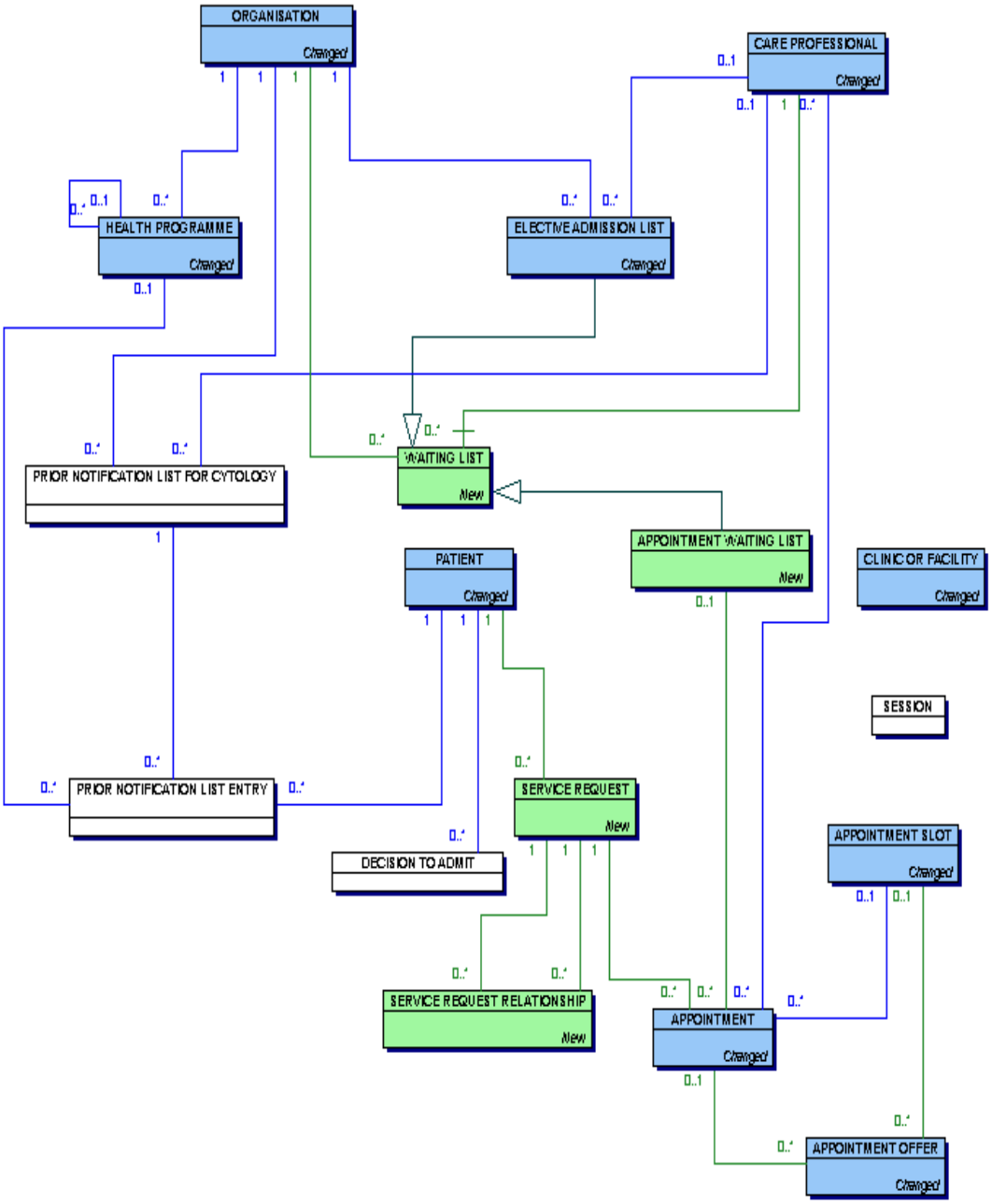

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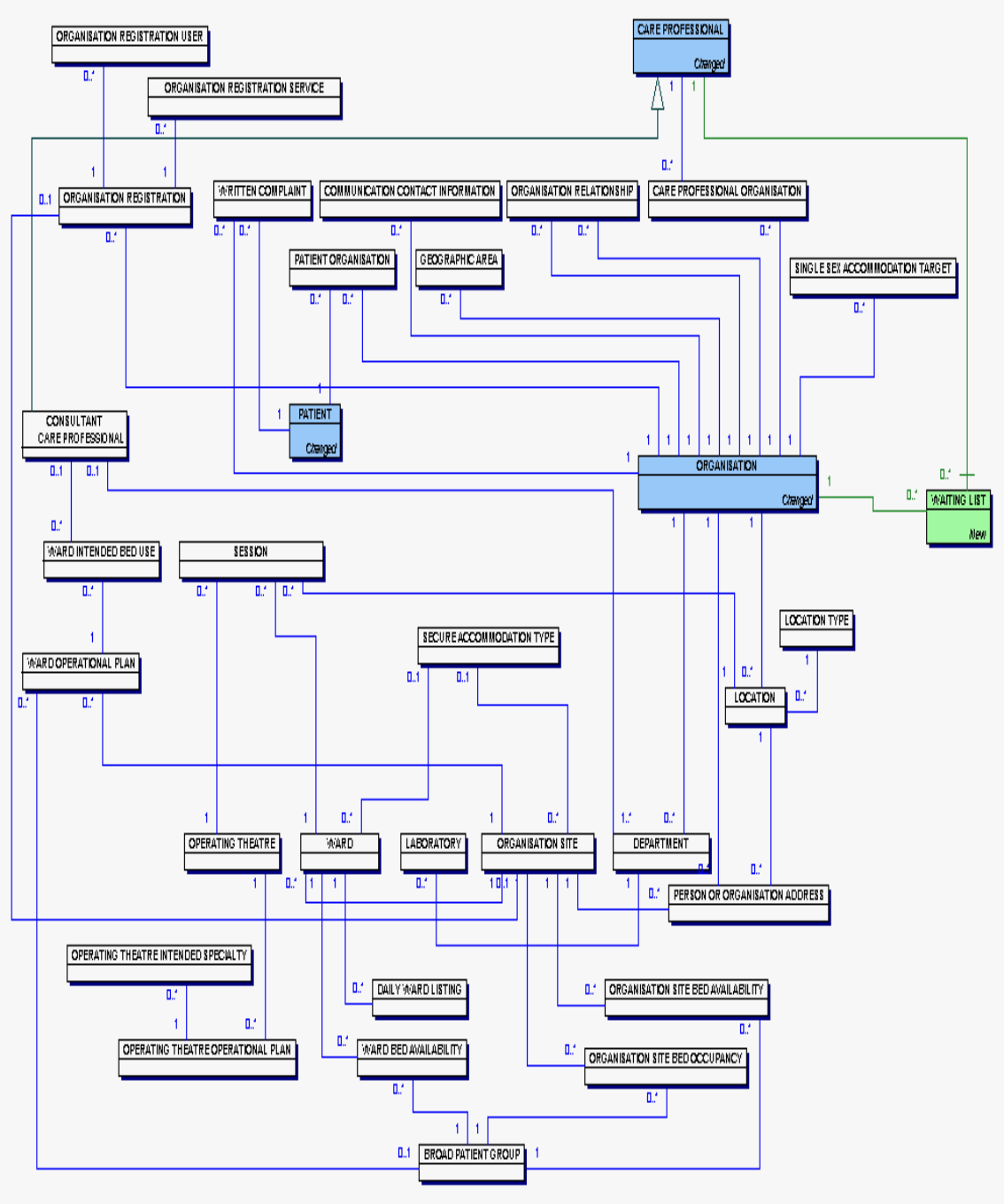

REFERRAL REQUEST

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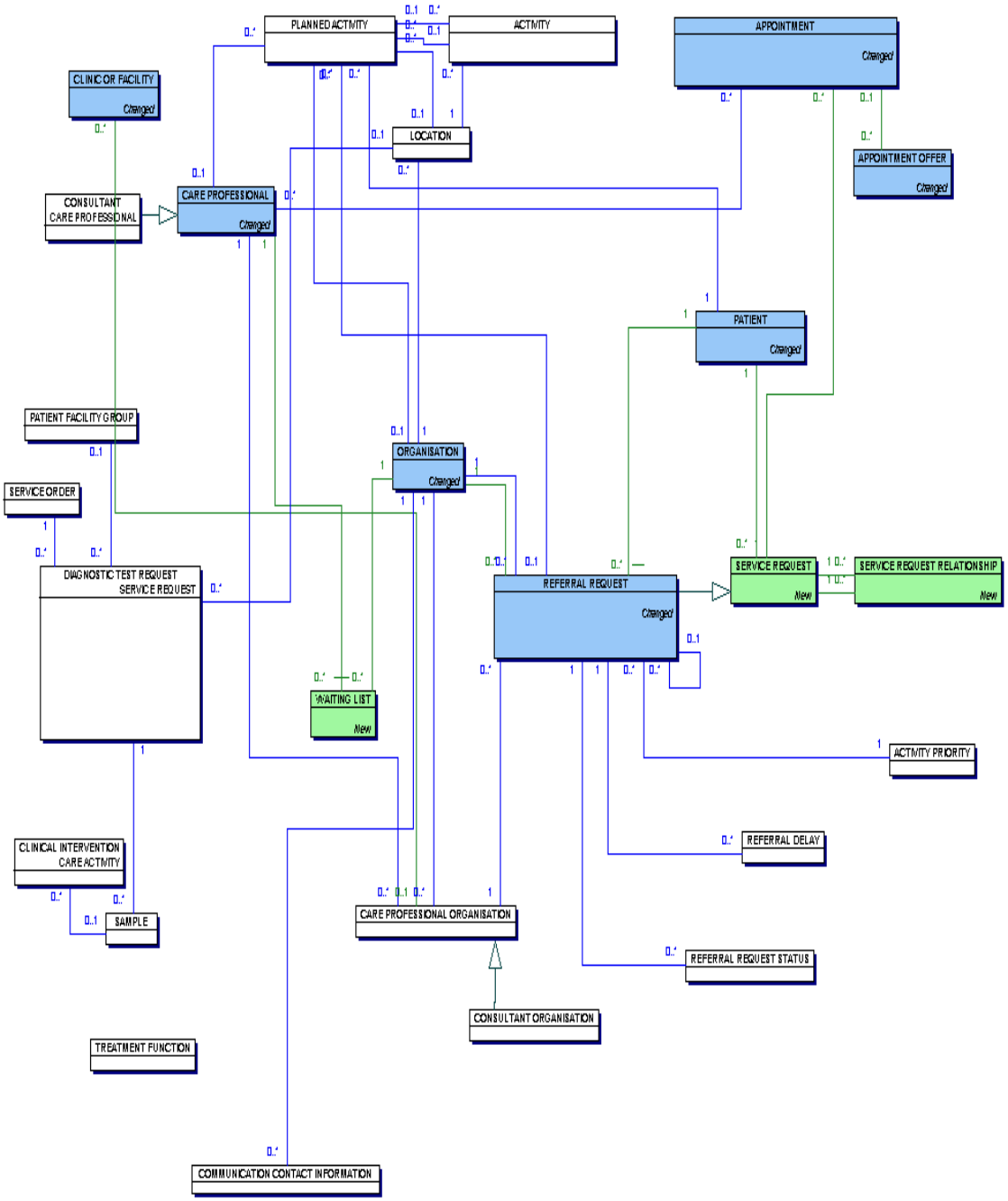

ADMITTED PATIENT EFFECTIVE WAITING TIME CALCULATION

Change to Supporting Information: New Supporting Information

Admitted Patient Effective Waiting Time Calculation

Admitted Patient Effective Waiting Time Calculation

For collection of information on Admitted Patient Waiting Times, the period of waiting for each PATIENT expressed as completed weeks

waiting is required to be calculated in order to determine the appropriate waiting time band the PATIENT should be counted within.

The start point of the waiting period calculation is the ELECTIVE ADMISSION EFFECTIVE WAIT START DATE which takes into consideration any PATIENT instigated resets. The end point is the REPORTING PERIOD END DATE. Once the period of wait has been calculated from these two dates in days, the result is also adjusted for any periods of suspension.

The collection of information may be retrospective and therefore any PATIENT where the ELECTIVE ADMISSION WAIT START DATE is after REPORTING PERIOD END DATE should be excluded from the count as they are outside the date boundaries of the collection.

Patients waiting for admission

When an ELECTIVE ADMISSION LIST ENTRY is made for a PATIENT following a DECISION TO ADMIT and the patient accepts an OFFERED FOR ADMISSION DATE of an OFFER OF ADMISSION, it is this offered date that the patient is expected to attend and be admitted. ADMISSION OFFER OUTCOME records whether or not the patient was admitted and the circumstances that applied.

The ELECTIVE ADMISSION LIST ENTRY is removed from the ELECTIVE ADMISSION LIST when the PATIENT is admitted or removed for other specified reasons. ELECTIVE ADMISSION LIST REMOVAL REASON records the method of removal from the list and ELECTIVE ADMISSION LIST REMOVAL DATE records the removal date.

Once removed from the ELECTIVE ADMISSION LIST, the PATIENT ceases to be waiting for admission and all associated OFFER OF ADMISSIONS become inactive.

The waiting time band the PATIENT is counted within is calculated from the ELECTIVE ADMISSION EFEECTIVE WAIT START DATE to the REPORTING PERIOD END DATE. The ELECTIVE ADMISSION EFFECTIVE WAIT START DATE is an adjusted date which takes into consideration the effect on waiting time calculations of Self-Deferred Admission.

Periods of suspension which are within the waiting period are also deducted to arrive at the appropriate waiting time band for the PATIENT to be counted within. See Suspended Patient.

ADMISSION OFFER OUTCOME records whether or not the patient was admitted and the circumstances that applied and for cancellations, the date of cancellation is recorded by the OFFER OF ADMISSION CANCELLATION DATE.

If the ELECTIVE ADMISSION EFFECTIVE WAIT START DATE is after the REPORTING PERIOD END DATE then no waiting time should be calculated and the PATIENT should be excluded from the count as they are outside the date boundaries of the collection.

Calculation of total suspension days

If the PATIENT has been suspended at all during the waiting time period, the period(s) of suspension should be calculated and summed to calculate the total suspension days which will then be deducted from the adjusted calculated days.

However, if the PATIENT is still suspended as at the REPORTING PERIOD END DATE they are excluded from Admitted Patient Stocks counts and no calculation of any periods of suspension is required.

Waiting time bands

The number of days waiting calculated excluding any suspension or self-deferred periods are divided by 7 to give the number of weeks waiting. Where the resultant number is less than 1, the Waiting Time Band is less than 1 week.

For example,

A PATIENT has an ORIGINAL DECIDED TO ADMIT DATE of 4/8/2005.

The hospital offers an admission for 5/9/2005 which the PATIENT accepts.

On the day of the admission the PATIENT has to cancel the admission and so his ELECTIVE ADMISSION EFFECTIVE WAIT START DATE is set to 5/9/2005 (the admission date that was cancelled).

The PATIENT then informs the hospital that he is on holiday for 3 weeks and so cannot come into hospital between 13/9/2005 and 3/10/2005 inclusive so the PATIENT is suspended for that period.

The PATIENT is given an OFFERED FOR ADMISSION DATE of 12/10/2005. This is accepted by the PATIENT and the PATIENT is admitted.

So the number of days the PATIENT was waiting is 37 days (from ELECTIVE ADMISSION EFFECTIVE WAIT DATE to the day before the OFFERED FOR ADMISSION DATE). The number of days in the suspended period (21 days) is then subtracted from waiting period of 37, which leaves 16 days. This is divided by 7 to give the actual period of weeks waiting as more than 2 weeks and less than 3 weeks.

ADMITTED PATIENT FLOWS

Central Information Requirement Guidance

Admitted Patient Flows: Events During the Reporting Period

Contextual Overviews

1. The Department requires performance management information on Elective Admission List events within a specified REPORTING PERIOD.

2. The Department 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.

3. 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.

4. 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 INDICATOR indicates whether it is a submission from the ORGANISATION in the role of commissioner of care or provider of care.

Admitted Patient Flow Events

5. The collection data is sub grouped by MAIN SPECIALTY CODE. Where no flow activity data for a MAIN SPECIALTY CODE has occurred within the REPORTING PERIOD then no admitted patient flow sub group should be recorded for it. Only one sub group is permitted per MAIN SPECIALTY CODE.

6. The collection is for:

   all patients for whom a DECISION TO ADMIT was taken during the REPORTING PERIOD to place the patients on the Elective Admission List.

   and

   all patients admitted during the REPORTING PERIOD from the Elective Admission List

   and

   all patients who giving no advance warning failed to attend for admission from the Elective Admission List during the REPORTING PERIOD

   and

   all patients who were removed from the Elective Admission List during the REPORTING PERIOD for reasons other than admission

7. 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 Suspended Patients.

   ELECTIVE ADMISSION TYPE records the classification of the admission.

8. The collection is sub-divided into a count of day case admissions and ordinary admissions.

   INTENDED MANAGEMENT records whether a patient is intended as as an ordinary admission (to stay overnight) or a day case

admission (not to stay overnight).

ADMITTED PATIENT STOCKS

Change to Supporting Information: New Supporting Information

Admitted Patient Stocks

Central Information Requirement Guidance

Admitted Patient Stocks at the end of the Reporting Period

Contextual Overviews

1. The Department requires performance management information on Elective Admission List stocks at the end of a specified REPORTING PERIOD.

2. The Department 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.

3. 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.

4. 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 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

5. The collection data is grouped by MAIN SPECIALTY CODE. Where the 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

6. 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

7. The collection is for:

   all patients for who have an OFFER OR 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 for who have an OFFER OR 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 for who have an OFFER OR 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 for who have an OFFER OR 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

8. 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.

9. 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

10. The collection data is grouped by ADMITTED PATIENT GROUPING INTENDED PROCEDURE which indicates the required range of OPERATIVE PROCEDURES. Where the are no stocks present for a ADMITTED PATIENT GROUPING INTENDED PROCEDURE within the REPORTING PERIOD then no in-patient stocks group should be recorded for it. Only one group is permitted per ADMITTED PATIENT GROUPING INTENDED PROCEDURE.

11. The required grouping ranges of ADMITTED PATIENT GROUPING 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

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

13. The collection is for:

    all patients for who have an OFFER OR 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 for who have an OFFER OR 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

14. 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 Suspended Patients.

    ELECTIVE ADMISSION TYPE records the classification of the admission.

APPOINTMENT REQUEST

Change to Supporting Information: New Supporting Information

Appointment Request

Appointment Request

Appointment Request is a type of SERVICE REQUEST for an APPOINTMENT.

Each originating request may result in one or more APPOINTMENT OFFER, the originating request may be from:

a. a PATIENT self-referral REFERRAL REQUEST

or

b. a REFERRAL REQUEST from one ORGANISATION or CARE PROFESSIONAL to another ORGANISATION or CARE PROFESSIONAL.

or

c. follow up to a previous APPOINTMENT at which attendance or contact has taken place related to the same REFERRAL REQUEST.

or

d. an APPOINTMENT at which attendance did not take place for whatever reason, requiring a new APPOINTMENT to be made

or

e. an invitation for an APPOINTMENT as part of a HEALTH PROGRAMME

or

f. an ACTIVITY which requires an APPOINTMENT to be made for further care or treatment

Each Appointment Request should be reviewed by the receiving CARE PROFESSIONAL, ORGANISATION or SERVICE POINT to decide whether an offer of an APPOINTMENT should be made. DECISION TO OFFER AN APPOINTMENT DATE records the date the decision was made to offer an APPOINTMENT.

It is on this date it is considered that the PATIENT has been added to the Out-Patient Waiting List for the APPOINTMENT with the expectation that it will take place.

When it is decided that an offer of an APPOINTMENT should be made then one or more APPOINTMENT OFFER should be offered each of which will record a separate and different APPOINTMENT DATE OFFERED and APPOINTMENT TIME OFFEREDto the PATIENT.

The APPOINTMENT DATE OFFERED and APPOINTMENT TIME OFFERED of the APPOINTMENT OFFER equate to the allocated APPOINTMENT SLOT.

When more than one date is offered for the same Appointment Request, the PATIENT can choose which date and time to accept. APPOINTMENT ACCEPTED DATE records whether or not the offer has been accepted. When multiple dates are offered, the PATIENT should only be allowed to select one of them.

The SERVICE REQUEST DATE and SERVICE REQUEST TIME will also be the default created and recorded date and time for each APPOINTMENT OFFER made for the Appointment Request.

ATTENDANCE DATE

Change to Supporting Information: Change to Supporting Information

Attendance Date

Attendance Date is an ACTIVITY DATE TIME TYPE.

~~The date of an attendance, for example at a Consultant Clinic, Nurse Clinic, Accident And Emergency Department or by a ward attender.~~ The date of an attendance or contact, for example at a Consultant Clinic, Nurse Clinic, Accident And Emergency Department or by a ward attender.

BOOKINGS ADMITTED PATIENT AND OUT-PATIENT PROVIDER

Change to Supporting Information: New Supporting Information

Bookings Admitted Patient And Out-Patient Provider

Central Information Requirement Guidance

Provider Admitted Patient and Out-Patient Bookings: Events During the Reporting Period

Contextual Overviews

1. The Department requires performance management information on ELECTIVE ADMISSION LIST and APPOINTMENT WAITING LIST booking events within a specified REPORTING PERIOD.

2. The Department 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.

3. This central information collection requirement is provider based and is submitted by provider NHS Trusts and provider Primary Care Trusts regardless of where PATIENTS live.

Admitted Patient Booking Events

4. The collection is for:

   all patients for whom a DECISION TO ADMIT was taken during the REPORTING PERIOD to place the patients on the ELECTIVE ADMISSION LIST for booked and waiting list admission

   and

   all patients for whom a DECISION TO ADMIT was taken during the REPORTING PERIOD to place the patients on the ELECTIVE ADMISSION LIST for booked admission only.

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

   ELECTIVE ADMISSION TYPE records the classification of the admission.

6. All PATIENTS waiting for admission to NHS hospitals should be included, i.e. include PATIENTS who are private patients and patients from overseas where they have an OVERSEAS VISITOR STATUS of OVERSEAS VISITOR EXEMPT CATEGORY).

7. The collection is sub-divided into a count of day case admissions and ordinary admissions.

   INTENDED MANAGEMENT records whether a patient is intended as an ordinary admission (to stay overnight) or a day case admission (not to stay overnight).

Out-Patient Booking Events

8. The collection is for:

   all patients referred within the REPORTING PERIOD for a first Out-Patient Appointment by GP written referral where a booking systems was used

   and

   all patients given a first APPOINTMENT and added to the Out-Patient Waiting List within the REPORTING PERIOD for a first Out-Patient Appointment arising from a GP written referral regardless of whether or not a booking systems was used.

9. The APPOINTMENT ACCEPTED DATE of the first APPOINTMENT indicates which REPORTING PERIOD the first APPOINTMENT was added to the Out-Patient Waiting List.

   A first APPOINTMENT is where APPOINTMENT FIRST ATTENDANCE is National Code 01 '*First appointment*' for a first appointment which has taken place.

   Where one or more APPOINTMENT is recorded for a PATIENT but none has as yet taken place, the notional 'first appointment' will be the APPOINTMENT with the earliest APPOINTMENT DATE. This excludes any APPOINTMENTS which have been cancelled as indicated by a recorded APPOINTMENT CANCELLED DATE.

CENTRAL RETURN MENU

Change to Supporting Information: Change to Supporting Information

- Central Returns Introduction and Contextual Overview
  ~~**Waiting Time Calculation Tables:**~~
- ~~KH07 and QF01~~
- ~~QM08 and QM08R~~
  ~~**Central Return Forms:**~~
- ~~Quarterly Monitoring~~ **Central Return Forms:**
- Hospital Aggregated Statistics
- Community
- Miscellaneous

CHOOSE AND BOOK UTILISATION COMMISSIONER

Change to Supporting Information: New Supporting Information

Choose And Book Utilisation Commissioner

Central Information Requirement Guidance

Choose and Book Utilisation Commissioner

Contextual Overviews

1. The Department requires performance management information on utilisation of the NHS Connecting for Health Choose and Book System.

2. This central information collection requirement is commissioner based and is the aggregation of commissioned PATIENT activity delivered by provider NHS Trusts and provider Primary Care Trusts.

3. The collection is for all patients given an APPOINTMENT and added to the Out-Patient Waiting List within the REPORTING PERIOD arising from a GP referral processed using the NHS Connecting for Health Choose and Book System.

4. The NHS Connecting for Health Choose and Book system during the booking process issues an unique booking reference number when a PATIENT is offered one or more APPOINTMENT DATE OFFERED of an APPOINTMENT OFFER.

   When the PATIENT accepts an APPOINTMENT DATE OFFERED, the unique booking reference number is considered to be 'converted' i.e. an APPOINTMENT is created and recorded; and the PATIENT is placed on an Out-Patient Waiting List even if susbsequently the PATIENT does not attend or cancels the APPOINTMENT.

   APPOINTMENT BOOKING SYSTEM TYPE of the APPOINTMENT records the type of booking system used and OUT-PATIENT CONVERTED UNIQUE BOOKING REFERENCE NUMBER the 'converted' reference number.

CLINIC ATTENDANCE CONSULTANT

Change to Supporting Information: Change to Supporting Information

Clinic Attendance Consultant

Clinic Attendance Consultant is a CARE CONTACT.

An Out-Patient Attendance Consultant.

~~An attendance at which a PATIENT is seen by a CONSULTANT, or member of the CONSULTANTS firm, at a Consultant Clinic.~~ An attendance or contact at which a PATIENT is seen by or in contact with a CONSULTANT, or member of the CONSULTANTS firm, at a Consultant Clinic.

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

If an appointment time was given, the time seen should be recorded.

Information recorded for a Clinic Attendance Consultant includes:

COLPOSCOPY PRIME PROCEDURE TYPE O (colposcopy only)
Time Seen

CLINIC ATTENDANCE FAMILY PLANNING

Change to Supporting Information: Change to Supporting Information

Clinic Attendance Family Planning

Clinic Attendance Family Planning is a CARE CONTACT.

A Clinic Attendance Non-Consultant.

~~An attendance by a PATIENT at a Family Planning Clinic.~~ An attendance or contact by a PATIENT at a Family Planning Clinic.

Information recorded for a Clinic Attendance Family Planning includes:

CONTRACEPTION METHOD MAIN O
CONTRACEPTION METHOD POST COITAL O
CONTRACEPTIVE ADVICE GIVEN
First Contact In Financial Year

CLINIC ATTENDANCE MIDWIFE

Change to Supporting Information: Change to Supporting Information

Clinic Attendance Midwife

Clinic Attendance Midwife is a CARE CONTACT.

A Clinic Attendance Non-Consultant.

~~An appointment and/or attendance at a Midwife Clinic.~~ An appointment and/or attendance at a Midwife Clinic or an appointment and/or contact with a Midwife Clinic.

~~The total number of attendances in a period is required for central returns.~~ The total number of attendances or contacts in a period is required for central returns.

Where both mother and baby attend a postnatal clinic together this is to count as one attendance.

Information recorded for a Clinic Attendance Midwife includes:

ANTENATAL OR POSTNATAL INDICATOR
CONSULTATION MEDIA USED
FIRST ATTENDANCE

CLINIC ATTENDANCE NON-CONSULTANT

Change to Supporting Information: Change to Supporting Information

Clinic Attendance Non-Consultant

Clinic Attendance Non-Consultant is a CARE CONTACT.

~~An attendance at a Nurse Clinic, Midwife Clinic or Family Planning Clinic.~~ An attendance at or contact with a Nurse Clinic, Midwife Clinic or Family Planning Clinic. This may have been as a result of an Out-Patient Appointment Non-Consultant.

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

~~Note: Attendances at clinics run by Paramedics are Professional Staff Group Contact.~~ Note: Attendances or contacts at clinics run by Paramedics are Professional Staff Group Contact.

If an appointment time was given, the time seen should be recorded.

Information recorded for a Clinic Attendance Non-Consultant includes:

ATTENDANCE DATE
ATTENDANCE IDENTIFIER
Time Seen O (if appointment time given)

CLINIC ATTENDANCE NURSE

Change to Supporting Information: Change to Supporting Information

Clinic Attendance Nurse

Clinic Attendance Nurse is a CARE CONTACT.

A Clinic Attendance Non-Consultant.

~~An attendance at a Nurse Clinic.~~ An attendance at or contact with a Nurse Clinic.

~~Note: Local arrangements for apportioning attendances to the relevant TREATMENT FUNCTION may be made instead of recording this for each attendance.~~ Note: Local arrangements for apportioning attendances or contacts to the relevant TREATMENT FUNCTION CODE may be made instead of recording this for each attendance.

Information recorded for a Clinic Attendance Nurse includes:

COLPOSCOPY PRIME PROCEDURE TYPE (colposcopy only)
CONSULTATION MEDIA USED
FIRST ATTENDANCE

CONSULTANT OUT-PATIENT EPISODE

Change to Supporting Information: Change to Supporting Information

Consultant Out-Patient Episode

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.

~~A Consultant Out-Patient Episode starts on the date the PATIENT first sees 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 for six months with no forthcoming appointment.~~ 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. 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:

- nurse clinic appointment/attendance;
- face to face contacts with other health professionals;
- 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.

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.

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

DAY CARE ATTENDANCE

Change to Supporting Information: Change to Supporting Information

Day Care Attendance

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 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. 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

DIAGRAMS MENU

Change to Supporting Information: Change to Supporting Information

- Diagramming Conventions
- Activity
- ~~Address, Geographical Area & Communication~~
- Address, Geographical Area & Communication
- Appointments
- Care Professional
- Category Valued Person Observation
- Health Programme
- Lists
- Organisation
- Person & Person Property
- Prescribing & Dispensing
- Referral Request

ELECTIVE ADMISSION LIST

Change to Supporting Information: New Supporting Information

Elective Admission List

Elective Admission List

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

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.

GENITOURINARY CLINIC ATTENDANCE

Change to Supporting Information: Change to Supporting Information

Genitourinary Clinic Attendance

Genitourinary Clinic Attendance is a CARE CONTACT.

~~An attendance of a PERSON at a Consultant Clinic as part of a Genitourinary Episode.~~ An attendance of a PERSON at or contact with a Consultant Clinic as part of a Genitourinary Episode.

Information recorded for a Genitourinary Clinic Attendance includes:

Attendance Date
ATTENDANCE IDENTIFIER
FIRST ATTENDANCE

GMP PRACTICE CONSULTATION

Change to Supporting Information: Change to Supporting Information

GMP Practice Consultation

GMP Practice Consultation is a CARE CONTACT.

A consultation by a CARE PROFESSIONAL to a PERSON for the provision of health care within a GENERAL MEDICAL PRACTITIONER practice.

~~The PATIENT should have a GMP Practice Consultation within 24 hours of a REQUESTED OR INVITED DATE and REQUESTED OR INVITED TIME if requesting to see a CARE PROFESSIONAL other than a GENERAL MEDICAL PRACTITIONER.~~ The PATIENT should be offered a GMP Practice Consultation within 24 hours of a REFERRAL DATE and REFERRAL TIME if requesting to see a CARE PROFESSIONAL other than a GENERAL MEDICAL PRACTITIONER. The PATIENT should have a GMP Practice Consultation to see a GENERAL MEDICAL PRACTITIONER within 48 hours of requesting an appointment.

LISTS

Change to Supporting Information: Change to Supporting Information

~~LISTS~~

Lists

~~This shows ELECTIVE ADMISSION LISTS and PRIOR NOTIFICATION LISTS FOR CYTOLOGIES and their relationships to ORGANISATIONS, PATIENTS and ACTIVITIES.~~ This shows WAITING LISTS and PRIOR NOTIFICATION LISTS FOR CYTOLOGIES and their relationships to ORGANISATIONS, PATIENTS and ACTIVITIES.

DIAGRAMMING CONVENTIONS

For information on how to read the diagrams the please click this link: Diagramming Conventions Middle Pane

MIDWIFE CLINIC

Change to Supporting Information: Change to Supporting Information

Midwife Clinic

Midwife Clinic is a CLINIC OR FACILITY.

An Out-Patient Clinic.

~~An administrative arrangement enabling PATIENTS to see a MIDWIFE for assessment, treatment, advice and/or counselling. Midwife Clinics include clinics where MIDWIVES have their own list of PATIENTS who are not expected to see a doctor, even though PATIENTS may be referred to a doctor by the MIDWIFE and seen during the same attendance.~~ An administrative arrangement enabling PATIENTS to see or be in contact with a MIDWIFE for assessment, treatment, advice and/or counselling. Midwife Clinics include clinics where MIDWIVES have their own list of PATIENTS who are not expected to see a doctor, even though PATIENTS may be referred to a doctor by the MIDWIFE and seen or be in contact during the same attendance or contact.

NURSE CLINIC

Change to Supporting Information: Change to Supporting Information

Nurse Clinic

Nurse Clinic is a CLINIC OR FACILITY.

An Out-Patient Clinic.

~~A Nurse Clinic is an administrative arrangement enabling PATIENTS to see a NURSE for assessment, treatment, advice and/or counselling. Nurse Clinics include clinics where NURSES have their own list of PATIENTS who are not expected to see a doctor even though PATIENTS may be referred to a doctor by the NURSE and seen during the same attendance. Note that this excludes PATIENTS attending a Consultant Clinic or a Midwife Clinic.~~ A Nurse Clinic is an administrative arrangement enabling PATIENTS to see or be in contact with a NURSE for assessment, treatment, advice and/or counselling. Nurse Clinics include clinics where NURSES have their own list of PATIENTS who are not expected to see or be in contact with a doctor even though PATIENTS may be referred to a doctor by the NURSE and seen or be in contact during the same attendance or contact. Note that this excludes PATIENTS attending or in contact with a Consultant Clinic or a Midwife Clinic. It also excludes Family Planning Clinics. Nurse Clinics may run in adjacent, concurrent sessions to Consultant Clinic Sessions.

OPERATING THEATRE SESSION

Change to Supporting Information: Change to Supporting Information

Operating Theatre Session

Operating Theatre Session is a SESSION.

A period of OPERATING THEATRE time allocated to one or more consultant firms (CONSULTANT).

A session is either scheduled or unscheduled.

A scheduled session is when the allocation of time is made to one CONSULTANT whose firm is responsible for the utilisation of this session. ~~It does not include time made available for an operation on a particular PATIENT unless the operation is included in a scheduled session as above and performed by a member of a consultant firm of the same TREATMENT FUNCTION as that allocated to the session.~~ It does not include time made available for an operation on a particular PATIENT unless the operation is included in a scheduled session as above and performed by a member of a consultant firm of the same TREATMENT FUNCTION CODE as that allocated to the session.

An unscheduled session is when an allocation of time is made available for one or more Theatre Cases in any circumstances outside a scheduled session as above. Theatre Cases in unscheduled sessions may be the responsibility of different CONSULTANTS.

An Operating Theatre Session may under/over-run the allocated time. The allocation, i.e. consultant firm, time and/or theatre may change by agreement any time before the session starts.

An Operating Theatre Session should be considered cancelled if the time slot allocation is not used to perform at least one operation.

OTHER APPOINTMENT

Change to Supporting Information: New Supporting Information

Other Appointment

Other Appointment

Other Appointment is an APPOINTMENT.

An appointment for a PATIENT to see a CARE PROFESSIONAL.

This general purpose type is used when a specific defined type of APPOINTMENT does not exist as a separate classification of APPOINTMENT CLASSIFICATION CODE. An example of a specific defined type of APPOINTMENT is Out-Patient Appointment Consultant.

Information recorded for an Other Appointment includes: APPOINTMENT DATE
APPOINTMENT TIME
APPOINTMENT BOOKING SYSTEM TYPE
APPOINTMENT TYPE (colposcopy appointments only)
ATTENDED OR DID NOT ATTEND

OUT-PATIENT APPOINTMENT

Change to Supporting Information: Change to Supporting Information

Out-Patient Appointment

Out-Patient Appointment is an APPOINTMENT.

~~An appointment for a PATIENT to see a health professional at an Out-Patient Clinic.~~ An appointment for a PATIENT to see or have contact with a care professional at an Out-Patient Clinic.

Each Out-Patient Appointment is either an Out-Patient Appointment Consultant or an Out-Patient Appointment Non-Consultant.

Information recorded for an Out-Patient Appointment includes:

APPOINTMENT DATE
APPOINTMENT TIME
APPOINTMENT BOOKING SYSTEM TYPE
APPOINTMENT TYPE (colposcopy appointments only)
ATTENDED OR DID NOT ATTEND

OUT-PATIENT APPOINTMENT CONSULTANT

Change to Supporting Information: Change to Supporting Information

Out-Patient Appointment Consultant

Out-Patient Appointment Consultant is an APPOINTMENT.

An Out-Patient Appointment.

~~An appointment for a PATIENT to see a CONSULTANT, or member of the CONSULTANT Firm, at a Consultant Clinic.~~ 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

OUT-PATIENT APPOINTMENT NON-CONSULTANT

Change to Supporting Information: Change to Supporting Information

Out-Patient Appointment Non-Consultant

Out-Patient Appointment Non-Consultant is a APPOINTMENT.

An Out-Patient Appointment.

~~An appointment for a PATIENT to see a health professional, other than a CONSULTANT or member of the CONSULTANT's firm, at an Out-Patient Clinic.~~ An appointment for a PATIENT to see or have contact with a care professional, other than a CONSULTANT or member of the CONSULTANT's firm, at an Out-Patient Clinic.

The appointment may result in a Clinic Attendance Non-Consultant or a Professional Staff Group Contact.

OUT-PATIENT ATTENDANCE CONSULTANT

Change to Supporting Information: Change to Supporting Information

Out-Patient Attendance Consultant

Out-Patient Attendance Consultant is a CARE CONTACT.

~~An attendance at which a PATIENT is seen (face to face or via telephone/telemedicine) by 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.~~ 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). 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 during a Consultant Episode (Hospital Provider) in circumstances where there is no transfer of responsibility for the care of the PATIENT.~~ 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.

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 during a Consultant Episode (Hospital Provider) where there is no transfer of responsibility for the care of the PATIENT.~~ 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 MEDIA USED
FIRST ATTENDANCE
LOCATION TYPE
MEDICAL STAFF TYPE SEEING PATIENT O
OUTCOME OF ATTENDANCE

OUT-PATIENT CLINIC

Change to Supporting Information: Change to Supporting Information

Out-Patient Clinic

Out-Patient Clinic is a CLINIC OR FACILITY.

~~An administrative arrangement enabling PATIENTS to see a CARE PROFESSIONAL at a Consultant Clinic, Nurse Clinic, Midwife Clinic, Family Planning Clinic, or at any other clinic.~~ An administrative arrangement enabling PATIENTS to see or be in contact with a CARE PROFESSIONAL at a Consultant Clinic, Nurse Clinic, Midwife Clinic, Family Planning Clinic, or at any other clinic.

OUT-PATIENT EFFECTIVE WAITING TIME CALCULATION

Change to Supporting Information: New Supporting Information

Out-Patient Effective Waiting Time Calculation

Out-Patient Effective Waiting Time Calculation

For collection of information on Out-Patient datasets, the period of waiting for each PATIENT expressed as weeks waiting is required to be calculated in order to determine the appropriate waiting time band the PATIENT should be counted within.

The start point of the waiting period calculation is either the ORIGINAL REFERRAL REQUEST RECEIVED DATE or the FIRST ATTENDANCE EFFECTIVE START DATE which takes into consideration any PATIENT instigated resets.

The end point is either the ACTIVITY DATE of the Out-Patient Attendance Consultant CARE CONTACT when an attendance has taken place or the REPORTING PERIOD END DATE depending upon the criteria of the waiting time being calculated.

Subtract the number of days of the FIRST ATTENDANCE EFFECTIVE DATE from the number of days of the ACTIVITY DATE or REPORTING PERIOD END DATE, this results in the number of days of the effective waiting time period.

The number of days is then divided by 7 to give the number of whole weeks. For example, if the number of days waiting is 49 then the number of weeks is 7 weeks, if the number of days waiting is 30 then the number of weeks is more than 4 weeks but less than 5 weeks time band.

OUT-PATIENT FLOWS

Change to Supporting Information: New Supporting Information

Out-Patient Flows

Central Information Requirement Guidance

Out-Patient Flows: Events During the Reporting Period

Contextual Overviews

1. The Department requires performance management information on Out-Patient Waiting List events within a specified REPORTING PERIOD.

2. The Department 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.

3. 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.

4. 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 INDICATOR indicates whether it is a submission from the ORGANISATION in the role of commissioner of care or provider of care.

Out-Patient Flow Events

5. The collection data is sub grouped by MAIN SPECIALTY CODE. Where no flow activity data for a MAIN SPECIALTY CODE has occurred within the REPORTING PERIOD then no out-patient flow sub group should be recorded for it. Only one sub group is permitted per MAIN SPECIALTY CODE.

6. The collection is for:

   all GP written referrals, whether from doctor or dentists, received within the REPORTING PERIOD for a first Out-Patient Appointment Consultant

   and

   all non-GP written referrals received within the REPORTING PERIOD for a first Out-Patient Appointment Consultant

   and

   all GP written referrals, whether from doctor or dentists, for a first Out-Patient Appointment Consultant where the first Out-Patient Attendance Consultant took place within the REPORTING PERIOD and the period between the receipt of the referral and the attendance by specified waiting time band

   and

   all GP written referrals, whether from doctor or dentists, for a first Out-Patient Appointment Consultant where the first Out-Patient Attendance Consultant has not yet taken place and the period between the receipt of the referral and the REPORTING PERIOD END DATE by specified waiting time band

   and

   all first attendance APPOINTMENTS where the first Out-Patient Attendance Consultant took place within the REPORTING PERIOD

   and

   all first attendance APPOINTMENTS where the first Out-Patient Attendance Consultant should have taken place within the REPORTING PERIOD did not take place due to the patient not attending or not attending on time

   and

   all follow-up attendance APPOINTMENTS where the Out-Patient Attendance Consultant took place within the REPORTING PERIOD

   and

   all follow-up attendance APPOINTMENTS where the follow-up Out-Patient Attendance Consultant should have taken place

within the REPORTING PERIOD did not take place due to the patient not attending or not attending on time

7. It includes private patients and patients from overseas.

OUT-PATIENT STOCKS

Change to Supporting Information: New Supporting Information

Out-Patient Stocks

Central Information Requirment Guidance

Out-Patient Stocks at the end of the Reporting Period

Contextual Overviews

1. The Department requires performance management information on Out-Patient Waiting List stocks within a specified REPORTING PERIOD.

2. The Department 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.

3. 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.

4. 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 INDICATOR indicates whether it is a submission from the ORGANISATION in the role of commissioner of care or provider of care.

Out-Patient Stocks

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

6. The collection is for all GP written referrals, whether from doctor or dentists, for a first Out-Patient Appointment Consultant where the first Out-Patient Attendance Consultant has not yet taken place and the period between the receipt of the referral and the REPORTING PERIOD END DATE by specified waiting time band.

7. It includes private patients and patients from overseas.

OUT-PATIENT WAITING LIST

Change to Supporting Information: New Supporting Information

Out-Patient Waiting List

Out-Patient Waiting List

Out-Patient Waiting List is a WAITING LIST.

A list of PATIENTS, for whom a decision to offer an APPOINTMENT for an Out-Patient Appointment has been made as recorded by DECISION TO OFFER AN APPOINTMENT DATE, currently awaiting to be seen or contacted regardless of whether a date for the appointment has been given. This usually involves the PATIENT attending an Out-Patient Clinic.

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 Out-Patient Waiting 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 Out-Patient Waiting List more than once, either for a different condition where it will be a different referral, or for the same condition, where two or more appointments are required.

QUARTERLY MONITORING

Change to Supporting Information: DeletedDeleted

SUMMARISED ACTIVITY FLOWS

Change to Supporting Information: New Supporting Information

Summarised Activity Flows

Central Information Requirement Guidance

Summarised Activity Flows: Events During the Reporting Period

Contextual Overviews

1. The Department requires performance management information on Elective Admission List and Out-Patient Waiting List events within a specified REPORTING PERIOD.

2. The Department 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.

3. 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.

4. 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 INDICATOR indicates whether it is a submission from the ORGANISATION in the role of commissioner of care or provider of care.

Admitted Patient Flow Events Elective Admission List

5. The collection data is sub grouped by totals for all MAIN SPECIALTY CODES and for MAIN SPECIALTY CODE 110 Trauma & Orthopaedics only.

6. The collection is for:

   all patients admitted during the REPORTING PERIOD from the Elective Admission List subdivided into count of day case admissions and ordinary admissions

   and

   all patients admitted during the REPORTING PERIOD from the Elective Admission List as planned admission during the REPORTING PERIOD

   and

   all patients admitted during the REPORTING PERIOD from the Elective Admission List to a NHS Treatment Centre and Independent Sector Treatment Centre during the REPORTING PERIOD

7. It includes private patients and patients from overseas.

It excludes Suspended Patients.

ELECTIVE ADMISSION TYPE records the classification of the admission.

8. The collection is sub-divided into a count of day case admissions and ordinary admissions.

   INTENDED MANAGEMENT records whether a patient is intended as an ordinary admission (to stay overnight) or a day case admission (not to stay overnight).

Admitted Patient Flow Events non-Elective Admissions

9. The collection data is grouped by totals for ADMITTED PATIENT GROUPING INTENDED PROCEDURE which indicates the required range of OPERATIVE PROCEDURES and by admission to NHS Hospitals and non-NHS Hospitals.

10. The required grouping ranges of ADMITTED PATIENT GROUPING INTENDED PROCEDURE are:

    0001 CABG - Coronary Artery Bypass Graft Code Range:
    or
    0002 PTCA - Percutaneous Transluminal Operations Coding Range:
    or
    0005 CHD - Coronary Heart Disease Coding Range

11. ORGANISATION TYPE of ORGANISATION records whether the hospital provider is an NHS or non-NHS organisation.

12. The collection is for all patients admitted non-electively during the REPORTING PERIOD.

    and

    all patients admitted during the REPORTING PERIOD from the Elective Admission List to a NHS Treatment Centre and Independent Sector during the REPORTING PERIOD

13. For NHS hospital providers it includes private patients and patients from overseas.

    It excludes Suspended Patients.

    ELECTIVE ADMISSION TYPE records the classification of the admission.

Out-Patient Referral Flow Events

14. The collection data is sub grouped by totals for all MAIN SPECIALTY CODES and for MAIN SPECIALTY CODE 110 Trauma & Orthopaedics only.

15. The collection is for:

    all GP written referrals, whether from doctor or dentists, received within the REPORTING PERIOD for a first Out-Patient Appointment Consultant

    and

    all first attendance APPOINTMENTS arising from GP written referrals, whether from doctors or dentists, where the Out-Patient Attendance Consultant took place within the REPORTING PERIOD.

16. It includes private patients and patients from overseas.

SUMMARISED STOCKS

Change to Supporting Information: New Supporting Information

Summarised Stocks

Central Information Requirement Guidance

Summarised Admitted Patient and Out-Patient Stocks at the end of the Reporting Period

Contextual Overviews

1. The Department requires performance management information on Elective Admission List stocks at the end of a specified REPORTING PERIOD.

2. The Department 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.

3. 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.

4. 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 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 Code 110 Trauma & Orthopaedics

5. The collection data is grouped by ordinary admissions and day case admissions for MAIN SPECIALTY CODE 110 Trauma & Orthopaedics only.

6. The collection is for:

   all patients for who have an OFFER OR 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 for who have an OFFER OR 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

7. 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 Suspended Patients.

   ELECTIVE ADMISSION TYPE records the classification of the admission.

Summarised Admitted Patient Stock Group Intended Procedures for Ordinary Admissions

8. The collection data is grouped by ADMITTED PATIENT GROUPING INTENDED PROCEDURE which indicates the required range of OPERATIVE PROCEDURES. Where the are no stocks present for a ADMITTED PATIENT GROUPING INTENDED PROCEDURE within the REPORTING PERIOD then no in-patient stocks group should be recorded for it. Only one group is permitted per ADMITTED PATIENT GROUPING INTENDED PROCEDURE.

9. The required grouping ranges of ADMITTED PATIENT GROUPING INTENDED PROCEDURE are:

   0001 CABG - Coronary Artery Bypass Graft Code Range:
   or
   0002 PTCA - Percutaneous Transluminal Operations Coding Range:
   or
   0003 Valves Coding Range
   or
   0004 - Angiography Coding Range

10. Within the ADMITTED PATIENT GROUPING INTENDED PROCEDURE the collection only applies to patients waiting for admission as ordinary admissions as indicated by INTENDED MANAGEMENT.

11. The collection is for:

    all patients for who have an OFFER OR 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 for who have an OFFER OR 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

12. 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 Suspended Patients.

    ELECTIVE ADMISSION TYPE records the classification of the admission.

Out-Patient Stock Group Main Specialty Code 110 Trauma & Orthopaedics

13. The collection data is for MAIN SPECIALTY CODE 110 Trauma & Orthopaedics only.

14. The collection is for all patients referred by GP written referral for a first Out-Patient Appointment Consultant where the appointment has not taken place by the REPORTING PERIOD END DATE by specified waiting time band.

15. It includes private patients and patients from overseas.

CLASSES

Change to Package: Change Diagram Contents

QUARTERLY MONITORING TOP INDEX

Change to Package: Change to Description
Note, this package has a fully qualified name of: Web_Site_Content.Pages.Central_Return_Indices.Quarterly_Monitoring_Top_Index.Quarterly_Monitoring_Top_Index

APPOINTMENT

Change to Class: Change to Description

~~An arrangement for a PATIENT to be seen by one or more CARE PROFESSIONALS.~~ 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~~
  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.

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.

This class is also known by these names:

Context	Alias
plural	APPOINTMENTS

APPOINTMENT

Change to Class: Change to Attributes

Attributes of this Class are:

~~K~~	~~APPOINTMENT DATE~~
~~K~~	~~APPOINTMENT TIME~~
	~~APPOINTMENT BOOKING SYSTEM TYPE~~
K	APPOINTMENT ENTRY NUMBER
	APPOINTMENT CANCELLED DATE
	APPOINTMENT CLASSIFICATION CODE
	APPOINTMENT DATE
	APPOINTMENT FIRST ATTENDANCE
	APPOINTMENT GROUP IDENTIFIER
	APPOINTMENT TIME
	APPOINTMENT TYPE
	ATTENDED OR DID NOT ATTEND
	DID NOT ATTEND REASON
	OUT-PATIENT CONVERTED UNIQUE BOOKING REFERENCE NUMBER

APPOINTMENT

Change to Class: Change to Relationships

Each APPOINTMENT

~~K~~	~~must be for one and only one PATIENT~~
K	must be a result of one and only one SERVICE REQUEST
	must be grouped by one and only one APPOINTMENT OR REQUEST INVITATION CLASSIFICATION
	may be resultant in one or more ACTIVITY
	~~may be a result of one and only one APPOINTMENT REQUEST OR INVITATION~~
	may be resultant in one or more APPOINTMENT OFFER
	may be within one and only one APPOINTMENT SLOT
	may be an entry on one and only one APPOINTMENT WAITING LIST
	may be to see one or more CARE PROFESSIONAL
	may be for one or more PLANNED ACTIVITY

APPOINTMENT OR REQUEST INVITATION CLASSIFICATION

Change to Class: DeletedDeleted

APPOINTMENT REQUEST OR INVITATION

Change to Class: Change to Name

~~APPOINTMENT REQUEST OR INVITATION~~ APPOINTMENT OFFER

APPOINTMENT REQUEST OR INVITATION_ renamed APPOINTMENT OFFER

Change to Class: Change to Description

A record of the APPOINTMENT DATE offered to a PATIENT and the date and time that the offer or request was made.

For a Screening Test the INVITATION TYPE should be recorded.

~~For a GMP Practice Consultation the PATIENT should have the Consultation within 24 hours of the REQUESTED OR INVITED DATE and REQUESTED OR INVITED TIME if requesting to see a CARE PROFESSIONAL other than a GENERAL MEDICAL PRACTITIONER.~~ For a GMP Practice Consultation the PATIENT should have the Consultation within 24 hours of the REFERRAL REQUEST RECEIVED DATE and REFERRAL REQUEST RECEIVED TIME if requesting to see a CARE PROFESSIONAL other than a GENERAL MEDICAL PRACTITIONER. The PATIENT should have a GMP Practice Consultation to see a GENERAL MEDICAL PRACTITIONER within 48 hours of requesting an APPOINTMENT.

This class is also known by these names:

Context	Alias
plural	APPOINTMENT OFFERS

APPOINTMENT REQUEST OR INVITATION

Change to Class: Change to Attributes

Attributes of this Class are:

~~K~~	~~REQUEST OR INVITATION FOR APPOINTMENT DATE~~
K	APPOINTMENT DATE OFFERED
K	APPOINTMENT TIME OFFERED
	APPOINTMENT ACCEPTED DATE
	APPOINTMENT CLASSIFICATION CODE
	APPOINTMENT OFFER ACCEPTED OR REFUSED
	APPOINTMENT OFFER SLOT STATUS
	INVITATION OFFER DATE SENT
	INVITATION TYPE
	~~REQUESTED OR INVITED DATE~~
	~~REQUESTED OR INVITED TIME~~
	REQUEST OR INVITATION

APPOINTMENT REQUEST OR INVITATION

Change to Class: Change to Relationships

~~*Each APPOINTMENT REQUEST OR INVITATION*~~*Each APPOINTMENT OFFER*

K	must be offered to one and only one PATIENT
	must be grouped by one and only one APPOINTMENT OR REQUEST INVITATION CLASSIFICATION
	~~may be resultant in one and only one APPOINTMENT~~
	may be an offer of one and only one APPOINTMENT
	may be allocated to one and only one APPOINTMENT SLOT
	may be within one and only one HEALTH PROGRAMME
	~~may be booked with one and only one ORGANISATION~~
	~~may be a result of one and only one REFERRAL REQUEST~~

APPOINTMENT SLOT

Change to Class: Change to Description

A period of time within a SESSION for one or more APPOINTMENTS with a CARE PROFESSIONAL.

APPOINTMENT SLOTS may be of variable length e.g. to accommodate new PATIENTS, and may be allocated more than once, if the original APPOINTMENT is cancelled.

An APPOINTMENT SLOT can be allocated to one or more APPOINTMENT OFFER until an offer is accepted by, or on behalf of a PATIENT.

When an APPOINTMENT OFFER is accepted by, or on behalf of a PATIENT the APPOINTMENT SLOT becomes booked and may become unavailable for any other offered appointment to which it was allocated depending upon the APPOINTMENT SLOT TYPE.

APPOINTMENT SLOT STATUS should be used in conjuction with APPOINTMENT SLOT TYPE and APPOINTMENT OFFER SLOT STATUS to

ensure correct allocation and booking of APPOINTMENTS.

This class is also known by these names:

Context	Alias
plural	APPOINTMENT SLOTS

APPOINTMENT SLOT

Change to Class: Change to Attributes

Attributes of this Class are:

K APPOINTMENT SLOT NUMBER
APPOINTMENT SLOT STATUS
APPOINTMENT SLOT TYPE

APPOINTMENT SLOT

Change to Class: Change to Relationships

Each APPOINTMENT SLOT

K must be within one and only one SESSION
may be filled by one or more APPOINTMENT
may be allocated one or more APPOINTMENT OFFER

APPOINTMENT WAITING LIST

Change to Class: New Class

APPOINTMENT WAITING LIST

A subtype of WAITING LIST.

A list of APPOINTMENTS to be made for PATIENTS waiting for an APPOINTMENT SLOT to be confirmed and then to take place.

This class is also known by these names:

Context	Alias
plural	APPOINTMENT WAITING LISTS

This class has no attributes.

Each APPOINTMENT WAITING LIST

may be made up of one or more APPOINTMENT

CARE PROFESSIONAL

Change to Class: Change to Relationships

Each CARE PROFESSIONAL

must be recorded as one and only one PERSON
may be the subject of one or more APPOINTMENT
may be a member of one or more CARE PROFESSIONAL GROUP
may be employed by one or more CARE PROFESSIONAL ORGANISATION
may be playing one or more CARE PROFESSIONAL ROLE
may be member of one or more CARE PROFESSIONAL TEAM MEMBER
may be related to one or more CLINICAL INVESTIGATION SERVICE PROVIDER
may be the dispenser of one or more DISPENSED ITEM
may be responsible for one or more ELECTIVE ADMISSION LIST
may be sharing care for one or more ELECTIVE ADMISSION LIST ENTRY

may be instigator of one or more PLANNED ACTIVITY
may be the prescriber of one or more PRESCRIPTION
may be responsible for one or more PRIOR NOTIFICATION LIST FOR CYTOLOGY
may be requestor of one or more SERVICE REPORT
may be receive a copy of one or more SERVICE REPORT
may be issue one or more SERVICE REPORT
may be related to one or more STAFF MEMBER IN PERIOD
may be related to one or more STAFF MEMBER IN PROGRAMME
may be responsible for one or more WAITING LIST

CARE PROFESSIONAL ORGANISATION

Change to Class: Change to Relationships

Each CARE PROFESSIONAL ORGANISATION

K must be related to one and only one CARE PROFESSIONAL
K must be related to one and only one ORGANISATION
may be responsible for one or more CLINIC OR FACILITY
may be the originator of one or more REFERRAL REQUEST
may be the originator of one or more SERVICE REQUEST
may be responsible for one or more WAITING LIST

CLINIC OR FACILITY

Change to Class: Change to Description

~~Either a clinic (e.g. Out-Patient Clinic) or a facility (e.g. Drug Misuse Facility).~~ 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.

~~An Out-Patient Clinic is an administrative arrangement enabling PATIENTS to see a health professional at a Consultant Clinic, Nurse Clinic, Midwife Clinic, Family Planning Clinic, or at any other clinic.~~ Clinics are mainly Out-Patient Clinics for PATIENTS to receive consultation, test, 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.~~ 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.

This class is also known by these names:

Context	Alias
plural	CLINICS OR FACILITIES

CLINIC OR FACILITY

Change to Class: Change to Attributes

Attributes of this Class are:

K	CLINIC OR FACILITY CODE
	CLINIC OR FACILITY ADMINISTRATIVE TYPE
	CLINIC OR FACILITY FREQUENCY
	CLINIC OR FACILITY NAME
	CLINIC OR FACILITY PURPOSE CODE
	FACILITY TYPE
	JOINT CONSULTANT CLINIC FLAG
	NUMBER OF SESSIONS INTENDED
	PRIOR APPOINTMENT INDICATOR
	SELF-REFERRAL OR OPEN ACCESS
	YOUNG PERSONS CLINIC INDICATOR

CLINIC OR FACILITY

Change to Class: Change to Relationships

Each CLINIC OR FACILITY

~~must be provided by one and only one ORGANISATION~~
~~or must be provided at one and only one SERVICE POINT~~
must be provided at one and only one SERVICE POINT
must be a type of one and only one SERVICE
may be resultant in one or more ACTIVITY
~~may be the responsibility of one and only one CONSULTANT~~
may be the responsibility of one and only one CARE PROFESSIONAL ORGANISATION
may be conducted by one or more CONSULTANT
may be the subject of one or more DAY CARE OPERATIONAL PLAN
may be related to one or more PATIENT CLINIC
may be provided during one or more SESSION

CONSULTANT

Change to Class: Change to Relationships

Each CONSULTANT

must be responsible for one or more DEPARTMENT
may be sharing conduction of one or more CLINIC OR FACILITY
~~may be responsible for one or more CLINIC OR FACILITY~~
may be responsible for one or more WARD INTENDED BED USE

DIAGNOSTIC TEST REQUEST

Change to Class: Change to Super Type

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 .

This class is also known by these names:

Context	Alias

plural	DIAGNOSTIC TEST REQUESTS

ELECTIVE ADMISSION LIST

Change to Class: Change to Description

~~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.~~

A subtype of WAITING LIST.

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

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.

~~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.~~ 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 LISTS. 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 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.

This class is also known by these names:

Context	Alias
plural	ELECTIVE ADMISSION LISTS

ELECTIVE ADMISSION LIST ENTRY

Change to Class: Change to Description

An entry on an ELECTIVE ADMISSION LIST denoting a PATIENT for whom the DECISION TO ADMIT has been made.

Being placed on the ELECTIVE ADMISSION LIST will result in an ELECTIVE ADMISSION LIST ENTRY. When the ELECTIVE ADMISSION LIST ENTRY is first recorded, the ORIGINAL DECIDED TO ADMIT DATE should be recorded as the same as the DECIDED TO ADMIT DATE of the first DECISION TO ADMIT.

It is possible for a PATIENT to have more than one ELECTIVE ADMISSION LIST ENTRY, either for a different condition or for the same condition where two or more admissions are required.

Only one ELECTIVE ADMISSION LIST ENTRY should be made in the event of the intention to perform two or more procedures during one admission.

To monitor key targets it is necessary for the Health Care Provider responsible for the ELECTIVE ADMISSION LIST, to record the date of any previous OFFERS OF ADMISSION for the same condition, which was made by a previous Health Care Provider and then cancelled by them on the day of or after admission for non-medical reasons.

The ELECTIVE ADMISSION LIST ENTRY is removed from the WAITING LIST when the PATIENT is admitted or removed for other specified reasons. ELECTIVE ADMISSION LIST REMOVAL REASON records the method of removal from the list and ELECTIVE

ADMISSION LIST REMOVAL DATE records the removal date.

Once removed from the Elective Admission List, the PATIENT ceases to be waiting for admission and all associated OFFER OF ADMISSIONS become inactive.

Note: An ELECTIVE ADMISSION LIST ENTRY must be related to a DECISION TO ADMIT.

This class is also known by these names:

Context	Alias
plural	ELECTIVE ADMISSION LIST ENTRIES

ELECTIVE ADMISSION LIST ENTRY

Change to Class: Change to Attributes

Attributes of this Class are:

K ELECTIVE ADMISSION LIST ENTRY NUMBER
ADMISSION BOOKING SYSTEM TYPE
ELECTIVE ADMISSION EFFECTIVE WAIT START DATE
ELECTIVE ADMISSION LAST REVIEWED DATE
~~ELECTIVE ADMISSION LIST ENTRY NUMBER~~
ELECTIVE ADMISSION LIST REMOVAL DATE
ELECTIVE ADMISSION LIST REMOVAL REASON
ELECTIVE ADMISSION TYPE
GUARANTEED ADMISSION DATE
INTENDED MANAGEMENT
ORIGINAL DECIDED TO ADMIT DATE
PREVIOUS PROVIDER OFFERED ADMISSION DATE
WAITING PERIOD EXCLUSION

HEALTH PROGRAMME

Change to Class: Change to Relationships

Each HEALTH PROGRAMME

K must be led by one and only one ORGANISATION
may be resultant in one or more ACTIVITY
~~may be resultant in one or more APPOINTMENT REQUEST OR INVITATION~~
may be resultant in one or more APPOINTMENT OFFER
may be subdivided into one or more HEALTH PROGRAMME
may be a subdivision of one HEALTH PROGRAMME
may be targeting one or more HEALTH PROGRAMME POPULATION
may be broken into one or more HEALTH PROGRAMME STAGE
may be reported as one or more HEALTH PROGRAMME STATEMENT
may be the supplier of one or more IMMUNISATION COURSE TYPE
may be related to one or more PERSON IN PROGRAMME
may be resultant in one or more PRIOR NOTIFICATION LIST ENTRY
may be offering one or more SERVICE REQUEST
may be related to one or more STAFF MEMBER IN PROGRAMME

OFFER OF ADMISSION

Change to Class: Change to Description

This records each OFFER OF ADMISSION made to a PATIENT on the ELECTIVE ADMISSION LIST.

When a PATIENT is given a set of more than one OFFERED FOR ADMISSION DATES, each OFFER OF ADMISSION in the set should record the same OFFER OF ADMISSION GROUP IDENTIFIER.

When the PATIENT accepts an OFFERED FOR ADMISSION DATE, it is this offered date that the PATIENT is expected to attend and be

admitted. ADMISSION OFFER OUTCOME records whether or not the PATIENT was admitted and the circumstances that applied.

This class is also known by these names:

Context	Alias
plural	OFFERS OF ADMISSION

OFFER OF ADMISSION

Change to Class: Change to Attributes

Attributes of this Class are:

~~K~~ ~~OFFERED FOR ADMISSION DATE~~
K OFFER OF ADMISSION MADE DATE
K OFFER OF ADMISSION MADE TIME
ADMISSION OFFER OUTCOME
OFFER OF ADMISSION ACCEPTED DATE
OFFER OF ADMISSION ACCEPTED OR REFUSED
OFFER OF ADMISSION GROUP IDENTIFIER
OFFER OF ADMISSION VERBAL OR WRITTEN
OPERATION CANCELLATION
OPERATION CANCELLATION PATIENT CHOICE

ORGANISATION

Change to Class: Change to Relationships

Each ORGANISATION

may be a supplier of one or more ACTIVITY
~~may be responsible for one or more APPOINTMENT REQUEST OR INVITATION~~
may be the originator of one or more CARE PLAN
may be the employer of one or more CARE PROFESSIONAL ORGANISATION
may be related to one or more CLINICAL INVESTIGATION SERVICE PROVIDER
~~may be the provider of one or more CLINIC OR FACILITY~~
may be contacted by one or more COMMUNICATION CONTACT INFORMATION
may be the operator and manager of one or more DEPARTMENT
may be the subject of one or more ELECTIVE ADMISSION LIST
may be the employer of one or more EMPLOYEE IN ORGANISATION
may be the resident in one or more GEOGRAPHIC AREA
may be related to one or more GEOGRAPHIC AREA ASSOCIATION
may be the subject of one or more GMP CLAIM FOR PAYMENT OR REIMBURSEMENT
may be the recipient of one or more GMP CLAIM FOR PAYMENT OR REIMBURSEMENT
may be the payee of one or more GMP PAYMENT OR REIMBURSEMENT
may be the lead for one or more HEALTH PROGRAMME
may be the creator and updater of one or more LOCATION
may be commissioner of one or more NHS SERVICE AGREEMENT
may be playing one or more ORGANISATION ACTIVITY ROLE
may be recorded as one or more ORGANISATION REGISTRATION
may be the second party in one or more ORGANISATION RELATIONSHIP
may be the first party in one or more ORGANISATION RELATIONSHIP
may be related to one or more ORGANISATION REPORTING PERIOD
may be operator or manager of one or more ORGANISATION SITE
may be the registered organisation for one or more PATIENT ORGANISATION
may be related to one or more PERSON OR ORGANISATION ADDRESS
may be intending to provide one or more PLANNED ACTIVITY
may be the place of treatment for one or more PRIOR NOTIFICATION LIST ENTRY
may be the subject of one or more PRIOR NOTIFICATION LIST FOR CYTOLOGY
may be play a role within one or more PROVIDER IN SERVICE AGREEMENT
may be the originator of one or more REFERRAL REQUEST
may be give one or more RIGHT OF ADMISSION
may be request one or more SERVICE REPORT

may be receive a copy of one or more SERVICE REPORT
may be issue one or more SERVICE REPORT
may be the originator of one or more SERVICE REQUEST
may be the subject of one or more SINGLE SEX ACCOMMODATION TARGET
may be the recipient of one or more TRANSPORT REQUEST
may be the responsible owner organisation of one or more WAITING LIST
may be the receiver of one or more WRITTEN COMPLAINT

ORGANISATION SITE

Change to Class: Change to Attributes

Attributes of this Class are:

K ORGANISATION SITE CODE
ACCREDITED DATE
CCAD HOSPITAL IDENTIFIER
COMMUNITY PHARMACY SITE CLOSED DATE
COMMUNITY PHARMACY SITE OPENED DATE
DECOMMISSIONED DATE
DELIVERY FACILITIES AVAILABLE
DISTANCE TO NEXT AVAILABLE PHARMACY
ESSENTIAL SMALL PHARMACY INDICATOR
GMP PREMISES COST RENT SUB STANDARD
GMP PREMISES SUB STANDARD
HIGH SECURITY PSYCHIATRIC ACCOMMODATION
INDEPENDENT HEALTH CARE FACILITY TYPE
OPTICIAN PREMISES TYPE
ORGANISATION SITE CLASSIFICATION
ORGANISATION SITE END DATE
ORGANISATION SITE NAME
ORGANISATION SITE START DATE
ORGANISATION SITE TREATMENT CENTRE
ORIGIN
OXYGEN SERVICE SUPPLIER INDICATOR
PROVIDING CARE TO CHILDREN
UNWANTED MEDICINE SCHEME INDICATOR

PATIENT

Change to Class: Change to Relationships

Each PATIENT

must be recorded as one and only one PERSON
may be the subject of one or more ACTIVITY
~~may be the requiree of one or more APPOINTMENT~~
~~may be offered one or more APPOINTMENT REQUEST OR INVITATION~~
may be offered one or more APPOINTMENT OFFER
may be the subject of one or more DECISION TO ADMIT
may be the subject of one or more ELECTIVE ADMISSION LIST ENTRY
may be the subject of one or more LEAVE
may be classified by one or more NATIONALITY OR RESIDENCY
may be treated out of area under one or more NHS SERVICE AGREEMENT
may be related to one or more PATIENT CLINIC
may be related to one or more PATIENT IN PROGRAMME STAGE
may be the registered patient of one or more PATIENT ORGANISATION
may be related to one or more PERSON IN PROGRAMME
may be the subject of one or more PLANNED ACTIVITY
may be the recipient of one or more PRESCRIPTION
may be the subject of one or more PRIOR NOTIFICATION LIST ENTRY
may be the self-referral request for one or more REFERRAL REQUEST
may be born as one and only one REGISTERABLE BIRTH

may be the victim of one or more ROAD TRAFFIC ACCIDENT

may be subject of one or more SERVICE REQUEST
may be the reporter of one or more WRITTEN COMPLAINT

REFERRAL REQUEST

Change to Class: Change to Super Type

~~A subtype of SERVICE REQUEST.~~

~~This is a request for a health care service, other than a specific diagnostic investigation or procedure, to be provided for a PATIENT. If there is a verbal request this would normally be confirmed by a written request, and these should be processed as one referral.~~ A subtype of SERVICE REQUEST.

This is a request for a care service to be provided for a PATIENT. This includes PATIENT self-referrals for an APPOINTMENT to see or be in contact with a CARE PROFESSIONAL of an ORGANISATION.

If there is a verbal request this would normally be confirmed by written request, and these should be processed as one referral. An electronic message is treated as a written referral.

~~Where the REFERRAL REQUEST relates to a booking system, the PATIENT is given the choice of when to attend. For full booking the PATIENT is offered a date within one working day of the referral or DECISION TO ADMIT.~~ Where the REFERRAL REQUEST relates to a booking system, the PATIENT is given the choice of when to attend or be in contact. For full booking, the PATIENT is offered a date within one working day of the referral or DECISION TO ADMIT.

This class is also known by these names:

Context	Alias
plural	REFERRAL REQUESTS

REFERRAL REQUEST

Change to Class: Change to Attributes

Attributes of this Class are:

APPOINTMENT BOOKING SYSTEM TYPE
BENIGN THERAPEUTIC OPERATION
CANCER DETECTED BY SURGERY
CANCER REFERRAL DECISION DATE
CANCER REFERRAL PRIORITY TYPE
CANCER SPECIALIST REFERRAL DATE
COLPOSCOPY REFERRAL INDICATION
COMMISSIONER REFERENCE NUMBER
FIRST ATTENDANCE EFFECTIVE WAIT START DATE
ORIGINAL REFERRAL REQUEST RECEIVED DATE
OTHER REFERRER CODE
OUT-PATIENT CLINIC REFERRING INDICATOR
OUT-PATIENT REFERRAL INDICATOR
REFERRAL DATE
REFERRAL REQUEST CANCELLED DATE
REFERRAL REQUEST RECEIVED DATE
REFERRAL REQUEST RECEIVED TIME
REFERRAL REQUEST TYPE
REFERRAL TIME
SCREENING REFERRAL SOURCE
SERVICE TYPE REQUESTED
SOURCE OF REFERRAL FOR A+E
SOURCE OF REFERRAL FOR CANCER
SOURCE OF REFERRAL FOR COMMUNITY
SOURCE OF REFERRAL FOR COMMUNITY DENTAL
SOURCE OF REFERRAL FOR DRUG MISUSE

SOURCE OF REFERRAL FOR MENTAL HEALTH
SOURCE OF REFERRAL FOR OUT-PATIENTS
SOURCE OF REFERRAL FOR PROF STAFF GROUP
TWO WEEK WAIT EXCLUSION INDICATOR
URGENT CANCER REFERRAL TYPE
WRITTEN REFERRAL REQUEST INDICATOR

REFERRAL REQUEST

Change to Class: Change to Relationships

Each REFERRAL REQUEST
must be made by one and only one CARE PROFESSIONAL ORGANISATION
or must be made by one and only one ORGANISATION
or must be made by one and only one PATIENT
must be given one and only one ACTIVITY PRIORITY
must be a request with a correspondence address at one and only one ADDRESS ASSOCIATION
~~may be resultant in one or more APPOINTMENT REQUEST OR INVITATION~~
must be categorised by one and only one TREATMENT FUNCTION
may be classified by one and only one LOCAL SUB-SPECIALTY
may be classified by one and only one PATHOLOGY INVESTIGATION TYPE
may be the reason for one or more PLANNED ACTIVITY
may be subject to one or more REFERRAL DELAY
may be subsequent to one and only one REFERRAL REQUEST
may be followed by one or more REFERRAL REQUEST
may be passing through one or more REFERRAL REQUEST STATUS
may be the reason for one or more TRANSPORT REQUIREMENT

SERVICE REQUEST

Change to Class: New Class

SERVICE REQUEST

Subtypes of SERVICE REQUEST are:

REFERRAL REQUEST
DIAGNOSTIC TEST REQUEST

A request for the the provision of care services to a PATIENT.

This class is also known by these names:

Context	Alias
plural	SERVICE REQUESTS

Attributes of this Class are:

K SERVICE REQUEST IDENTIFIER
APPOINTMENT CLASSIFICATION CODE
APPOINTMENT OFFER VERBAL OR WRITTEN
DECISION TO OFFER AN APPOINTMENT DATE
SERVICE REQUEST DATE
SERVICE REQUEST TIME

Each SERVICE REQUEST
K must be a request for one and only one PATIENT
may be resultant in one or more APPOINTMENT
may be within one and only one HEALTH PROGRAMME
may be related to one or more SERVICE REQUEST RELATIONSHIP
may be related to one or more SERVICE REQUEST RELATIONSHIP

SERVICE REQUEST RELATIONSHIP

Change to Class: New Class

SERVICE REQUEST RELATIONSHIP

This identifies a relationship between one SERVICE REQUEST and another.

For example, a SERVICE REQUEST for an APPOINTMENT may be related to a previous Appointment Request where the PATIENT refused all the offered dates for the APPOINTMENT. Another example may be where one SERVICE REQUEST is subdivided into further SERVICE REQUEST each for a specific and different treatment all related back to the originating SERVICE REQUEST.

This class is also known by these names:

Context	Alias
plural	SERVICE REQUEST RELATIONSHIPS

Attributes of this Class are:

SERVICE REQUEST RELATIONSHIP DESCRIPTION

Each SERVICE REQUEST RELATIONSHIP

K must be connected to the secondary one and only one SERVICE REQUEST

K must be connected to the main one and only one SERVICE REQUEST

TREATMENT FUNCTION

Change to Class: Change to Relationships

Each TREATMENT FUNCTION

may be the classification for one or more CARE ACTIVITY
may be the classifier for one or more ELECTIVE ADMISSION LIST
may be the identifier for one or more OPERATING THEATRE INTENDED SPECIALTY
may be the classifier for one or more REFERRAL REQUEST
may be a constraint on one or more RIGHT OF ADMISSION
may be the category for one or more SERVICE REQUEST
may be a classifier for one or more SESSION
may be the classifier of one or more WAITING LIST
may be a classifier for one or more WARD INTENDED BED USE

WAITING LIST

Change to Class: New Class

WAITING LIST

A list of PATIENTS waiting to receive a consultative, assessment, diagnosis, care or treatment ACTIVITY from an ORGANISATION. The list is maintained for an identified CARE PROFESSIONAL or SERVICE POINT within an ORGANISATION.

The subtypes of WAITING LIST are:

ELECTIVE ADMISSION LIST
APPOINTMENT WAITING LIST

Lists can be maintained in several forms, using either computer or manual systems, including CONSULTANT' diaries. They may be kept by TREATMENT FUNCTION CODE or for an individual CARE PROFESSIONAL.

PATIENTS may appear on more than one list for the same ORGANISATION or other ORGANISATIONS at the same time unless otherwise specifed.

This class is also known by these names:

Context	Alias

plural	WAITING LISTS

Attributes of this Class are:

K WAITING LIST IDENTIFIER
WAITING LIST TYPE

Each WAITING LIST

K must be a waiting list for one and only one ORGANISATION
K must be classified by one and only one TREATMENT FUNCTION
must be a waiting list of one and only one CARE PROFESSIONAL
or must be a waiting list of one and only one CARE PROFESSIONAL ORGANISATION

ADMISSION OFFER OUTCOME

Change to Attribute: Change to Description

A code which indicates the outcome of an OFFER OF ADMISSION to a PATIENT on an ELECTIVE ADMISSION LIST.

National Codes:

8	Patient admitted - treatment commenced
1	Patient admitted - treatment completed
2	Admission cancelled by, or on behalf of, the patient
6	Admission cancelled by hospital before day offered for admission
7	Admission cancelled by hospital on day offered for admission
4	Patient failed to arrive
5	Patient admitted - treatment deferred

Note: The classification has been listed in logical sequence rather than alphanumeric order.

This attribute is also known by these names:

Context	Alias
plural	ADMISSION OFFER OUTCOMES

APPOINTMENT ACCEPTED DATE

Change to Attribute: New Attribute

APPOINTMENT ACCEPTED DATE

The date on which an APPOINTMENT DATE OFFERED of an APPOINTMENT OFFER is accepted by, or on behalf of a PATIENT.

This attribute is also known by these names:

Context	Alias
plural	APPOINTMENT ACCEPTED DATES

APPOINTMENT BOOKING SYSTEM TYPE

Change to Attribute: Change to Description

An indication of the type of booking system used for allocating the Out-Patient Appointment. ~~In any booked system (partial or full), the PATIENT is given the choice of when to attend.~~

In any booked system in use, the PATIENT is given the choice of when to attend. In a partial booking system the PATIENT is given an indication of how long the wait should be and is contacted by the Health Care Provider at some point after the referral is made to be given a choice of dates for the appointment. In a full booking system the PATIENT should be given the opportunity to book an appointment within one working day of the request.

Classification:

a. No PATIENT choice of dates offered for the Out-Patient Appointment
~~b. Partial booking system~~
b. Partial booking system - non-Choose and Book system
~~c. Full booking system~~
c. Full booking system - non-Choose and Book system
d. Full booking system - Choose and Book system

This attribute is also known by these names:

Context	Alias
plural	APPOINTMENT BOOKING SYSTEM TYPES

APPOINTMENT CANCELLED DATE

Change to Attribute: New Attribute

APPOINTMENT CANCELLED DATE

The date an APPOINTMENT was cancelled.

This attribute is also known by these names:

Context	Alias
plural	APPOINTMENT CANCELLED DATES

APPOINTMENT ENTRY NUMBER

Change to Attribute: New Attribute

APPOINTMENT ENTRY NUMBER

A number to provide a unique identifier for each APPOINTMENT.

This attribute is also known by these names:

Context	Alias
plural	APPOINTMENT ENTRY NUMBERS

APPOINTMENT FIRST ATTENDANCE

Change to Attribute: New Attribute

APPOINTMENT FIRST ATTENDANCE

This indicates, when an attendance or contact is to take place as an APPOINTMENT, whether it is a first attendance appointment or a follow-up attendance appointment.

If the PATIENT does not attend the first APPOINTMENT, another first attendance appointment should be made.

An APPOINTMENT FIRST ATTENDANCE may be the first in a series such as an Consultant Out-Patient Episode, or only appointment which took place regardless of how many previous APPOINTMENTS were made which did not take place for whatever reason. All subsequent appointments in the series which take place should be recorded as follow-up.

Where one or more APPOINTMENT is recorded for a PATIENT but none has as yet taken place, the notional 'appointment first attendance' will be the APPOINTMENT with the earliest APPOINTMENT DATE. This excludes any APPOINTMENTS which have been cancelled as indicated by a recorded APPOINTMENT CANCELLED DATE.

National Codes:

01 Appointment first attendance
02 Appointment follow-up attendance

This attribute is also known by these names:

Context	Alias
plural	APPOINTMENTS FIRST ATTENDANCE

APPOINTMENT OFFER ACCEPTED OR REFUSED

Change to Attribute: New Attribute

APPOINTMENT OFFER ACCEPTED OR REFUSED

A record of whether or not the APPOINTMENT DATE OFFERED and APPOINTMENT TIME OFFERED of an APPOINTMENT OFFER was accepted by, or on behalf of the PATIENT.

The date on which APPOINTMENT OFFER was accepted by, or on behalf of the PATIENT should be recorded by the APPOINTMENT ACCEPTED DATE.

When the PATIENT accepts an APPOINTMENT OFFER, the APPOINTMENT OFFER SLOT STATUS and the APPOINTMENT SLOT STATUS should be recorded as booked.

National Codes:

1 Accepted
2 Refused

This attribute is also known by these names:

Context	Alias
plural	APPOINTMENT OFFERS ACCEPTED OR REFUSED

APPOINTMENT OFFER SLOT STATUS

Change to Attribute: New Attribute

APPOINTMENT OFFER SLOT STATUS

The status of the APPOINTMENT SLOT for the APPOINTMENT OFFER.

An APPOINTMENT SLOT can be allocated to one or more APPOINTMENT OFFER until an offer is accepted by, or on behalf of a PATIENT. During this period the APPOINTMENT OFFERS SLOT STATUS of all the APPOINTMENT OFFERS allocated to the same APPOINTMENT SLOT should be recorded as *'Allocated'*.

When an APPOINTMENT OFFER is accepted by, or on behalf of, a PATIENT the APPOINTMENT SLOT becomes booked and will become unavailable for any other offered appointment to which it was allocated unless the APPOINTMENT SLOT TYPE is *'Multiple appointment booking for the slot'*.

For the APPOINTMENT OFFER which was accepted, the APPOINTMENT OFFER SLOT STATUS should be updated and recorded as *'Booked'* .

An APPOINTMENT OFFER for an APPOINTMENT SLOT may need to be withdrawn. In these circumstances the APPOINTMENT OFFER SLOT STATUS should be updated and recorded as *'Withdrawn'* and if necessary new offers made.

The status of an APPOINTMENT OFFER should correspond to the status of the APPOINTMENT SLOT STATUS and be used in conjunction with APPOINTMENT SLOT TYPE.

National Codes:

1 Allocated
2 Booked

3 Withdrawn

This attribute is also known by these names:

Context	Alias
plural	APPOINTMENT OFFERS SLOT STATUS

APPOINTMENT OFFER VERBAL OR WRITTEN

Change to Attribute: New Attribute

APPOINTMENT OFFER VERBAL OR WRITTEN

This records whether the APPOINTMENT OFFER for an SERVICE REQUEST was made verbally or in writing to the PATIENT.

When there is more than one APPOINTMENT OFFER for the same SERVICE REQUEST, they should all be the same form of offer i.e all verbal or all written.

Verbal includes any form of voice communication whether face to face via telephone or other communication media.

Written includes any notifcation in writing whether communicated electronically, by post or by hand.

National Codes:

01 Verbal offer
02 Written offer

This attribute is also known by these names:

Context	Alias
plural	APPOINTMENT OFFERS VERBAL OR WRITTEN

APPOINTMENT OR REQUEST INVITATION CLASSIFICATION CODE

Change to Attribute: Change to Name

~~APPOINTMENT OR REQUEST INVITATION CLASSIFICATION CODE~~ APPOINTMENT CLASSIFICATION CODE

APPOINTMENT OR REQUEST INVITATION CLASSIFICATION CODE__ renamed APPOINTMENT CLASSIFICATION CODE

Change to Attribute: Change to Aliases, Change to Description

~~This is the list of the sort of APPOINTMENTS and APPOINTMENT REQUESTS OR INVITATIONS.~~ The classification of an APPOINTMENT and a SERVICE REQUEST.

National Codes:

01 Home Help Visit
~~02 Out-Patient Appointments with Consultants~~
02 Out-Patient Appointment Consultant
~~03 Out-Patient Appointments with Non-Consultants~~
03 Out-Patient Appointments Non-Consultant
04 GMP Practice Consultation
05 Registration Health Check
06 Screening Test
07 Day Care Attendance
97 Other Appointment

This attribute is also known by these names:

Context	Alias

~~plural~~	~~APPOINTMENT OR REQUEST INVITATION CLASSIFICATION CODES~~
plural	APPOINTMENT CLASSIFICATION CODES

APPOINTMENT SLOT STATUS

Change to Attribute: Change to Description

~~The booking status of an APPOINTMENT SLOT.~~ The status of an APPOINTMENT SLOT.

~~*Classification:*~~
An APPOINTMENT SLOT can be booked to one APPOINTMENT or to more than one APPOINTMENT but it should be of one type only. The APPOINTMENT SLOT TYPE indicates the type of slot. This is to allow for a group of PATIENTS to share the same APPOINTMENT SLOT for group related care or therapy.

For a slot which can be booked to more than one APPOINTMENT, the APPOINTMENT SLOT can be allocated to one or more APPOINTMENT OFFER. When an offer is accepted by, or on behalf of a PATIENT the slot becomes booked but still available for booking and allocation for any other offered appointment.

APPOINTMENT SLOT STATUS should be used in conjuction with APPOINTMENT SLOT TYPE and APPOINTMENT OFFER SLOT STATUS to ensure correct allocation and booking of APPOINTMENTS.
Any cancelled APPOINTMENT SLOTS, the APPOINTMENT SLOT STATUS should revert to not booked or no longer available.

National Codes:

- ~~a. Booked~~
- ~~b. Not booked – still available~~
- ~~c. Was booked – now available due to cancellation by patient~~
- ~~d. Was booked – now available due to cancellation by hospital~~
- ~~e. No longer available~~
- ~~f. Reserved (eg for follow up appointments or urgent referrals)~~
- 01 Booked - single appointment only
- 02 Booked - multiple appointments
- 03 Not booked - unallocated still available
- 04 No longer available
- 05 Reserved (eg for follow up appointments or urgent referrals)
- 06 Allocated to one or more offered appointments but none yet confirmed as booked

This attribute is also known by these names:

Context	Alias
plural	APPOINTMENT SLOT STATUSES

APPOINTMENT SLOT TYPE

Change to Attribute: New Attribute

APPOINTMENT SLOT TYPE

The type of an APPOINTMENT SLOT.

APPOINTMENT SLOT TYPE should be used in conjuction with APPOINTMENT SLOT STATUS and APPOINTMENT OFFER SLOT STATUS to ensure correct allocation and booking of APPOINTMENTS.

National Codes:

- 01 Single appointment booking for the slot only
- 02 Multiple appointment booking for the slot

This attribute is also known by these names:

Context	Alias
plural	APPOINTMENT SLOT TYPES

APPOINTMENT TIME OFFERED

Change to Attribute: New Attribute

APPOINTMENT TIME OFFERED

The actual time offered to a PATIENT for an APPOINTMENT by an APPOINTMENT OFFER in response to a SERVICE REQUEST.

This attribute is also known by these names:

Context	Alias
plural	APPOINTMENT TIMES OFFERED

ATTENDED OR DID NOT ATTEND

Change to Attribute: Change to Description

~~This indicates whether or not a PATIENT attended for an appointment. If the PATIENT did not attend it also indicates whether or not advanced warning was given.~~This indicates whether or not an APPOINTMENT for a CARE CONTACT took place. If the APPOINTMENT did not take place it also indicates whether or not advanced warning was given.

~~For colposcopy appointments only, code 2 is subdivided into:~~
~~(i) before the appointment date~~
~~(ii) on the appointment day~~
~~and code 3 is subdivided into:~~
~~(i) arrived, but did not wait to be seen~~
~~(ii) other~~ When an APPOINTMENT is cancelled the APPOINTMENT CANCELLED DATE should also be recorded.

National Codes:

~~5~~	~~Attended on time or, if late, before the relevant CARE PROFESSIONAL was ready to see the PATIENT~~
5	Attended on time or, if late, before the relevant CARE PROFESSIONAL was ready to see the PATIENT
6	Arrived late, after the relevant CARE PROFESSIONAL was ready to see the PATIENT, but was seen
7	PATIENT arrived late and could not be seen
2	Appointment cancelled by, or on behalf of, the PATIENT
3	Did not attend - no advance warning given
~~4~~	~~Appointment cancelled or postponed by the Health Care Provider~~
4	Appointment cancelled or postponed by the Health Care Provider

Note: The classification has been listed in logical sequence rather than alphanumeric order.

This attribute is also known by these names:

Context	Alias
plural	ATTENDED OR DID NOT ATTEND

CLINIC OR FACILITY ADMINISTRATIVE TYPE

Change to Attribute: New Attribute

CLINIC OR FACILITY ADMINISTRATIVE TYPE

A coded classification of a CLINIC OR FACILITY administrative arrangement within an ORGANISATION.

The adminstrative arrangement identifies whether for the organised SESSIONS, the PATIENTS attend and are seen in a clinic or facility which is a physical SERVICE POINT of an ORGANISATION or not.

A facility unlike a clinic, should only be classified as a static or mobile physical SERVICE POINT as patients will need to attend the facility.

National Codes:

01	**Static physical service point**. The clinic or facility is a static physical SERVICE POINT site of an Organisation where patient appointments are made and

patients attend the site for the appointment to be seen by the appropriate care professionals.

In exceptional circumstances the care professional may journey to where the patient is currently located due to the patient not being able to attend the physical site but this must be the exception and not the general rule.

02 **Mobile physical service point**.
The clinic or facility is a mobile physical SERVICE POINT unit of an Organisation where patient appointments are made and patients attend the mobile unit for the appointment to be seen by the appropriate care professionals.

A mobile unit may travel to different geographical areas but will be static for the period of the organised clinic or facility SESSIONS.

03 **Combined static and mobile physical service point**.
The clinic or facility is a SERVICE POINT which combines a static and mobile physical sites of an Organisation where patient appointments are made and patients attend the static site or mobile unit for the appointment to be seen by the appropriate care professionals.

04 **Virtual clinic service point**.
The clinic does not physically exist but is an administrative SERVICE POINT. This is to enable contact with patients to be made without need for the patient to attend a physical static or mobile site.

This includes care activities which are normally delivered by the care professionals by telephone or other form of remote contact and where the care professionals normally visit patients for a face to face contact care delivery.

This type of clinic allows lists, sessions, appointments, consultations and contacts etc., to be set up, managed and administered in exactly the same way as for physical clinics.

05 **Combined static physical and virtual clinic service point**.
The clinic is a SERVICE POINT which combines a static physical site where patient appointments are made and patients attend the site for the appointment to be seen by the appropriate care professionals and virtual clinic capabilities where care activities can be delivered by the care professionals by telephone or other form of remote contact and where the care professionals normally visit patients for a face to face contact care delivery .

To qualify as this type of clinic the combination of the physical and virtual capabilities must be normal practice and not that one or other can occur under exceptional circumstances

This type of clinic allows lists, sessions, appointments, consultations and contacts etc., to be set up, managed and administered in exactly the same way for both the physical and virtual care contact activities.

06 **Combined mobile physical and virtual clinic service point**.
The clinic is a SERVICE POINT which combines a mobile physical site where patient appointments are made and patients attend the site for the appointment to be seen by the appropriate care professionals and virtual clinic capabilities where care activities can be delivered by the care professionals by telephone or other form of remote contact and where the care professionals normally visit patients for a face to face contact care delivery .

To qualify as this type of clinic the combination of the physical and virtual capabilities must be normal practice and not that one or other can occur under exceptional circumstances

This type of clinic allows lists, sessions, appointments, consultations and contacts etc., to be set up, managed and administered in exactly the same way for both the physical and virtual care contact activities.

07 **Combined static physical and mobile physical and virtual clinic service point**.
The clinic is a SERVICE POINT which combines a static physical and mobile physical site where patient appointments are made and patients attend the site for the appointment to be seen by the appropriate care professionals and virtual clinic capabilities where care activities can be delivered by the care professionals by telephone or other form of remote contact and where the care professionals normally visit patients for a face to face contact care delivery .

To qualify as this type of clinic the combination of the physical, mobile and virtual capabilities must be normal practice and not that one or other can occur under exceptional circumstances

This type of clinic allows lists, sessions, appointments, consultations and contacts etc., to be set up, managed and administered in exactly the same way for both the physical and virtual care contact activities.

This attribute is also known by these names:

Context	Alias
plural	CLINIC OR FACILITY ADMINISTRATIVE TYPE

DECISION TO OFFER AN APPOINTMENT DATE

Change to Attribute: New Attribute

DECISION TO OFFER AN APPOINTMENT DATE

The date the decison was made to offer an APPOINTMENT to a PATIENT following the receipt of an Appointment Request. It is on this date it is considered that the PATIENT has been added to the APPOINTMENT WAITING LIST for the APPOINTMENT with the expectation that it will take place.

One or more APPOINTMENT OFFERS with different dates should then be offered to the PATIENT for the APPOINTMENT.

This attribute is also known by these names:

Context	Alias
plural	DECISION TO OFFER AN APPOINTMENT DATES

DEPARTMENT TYPE

Change to Attribute: Change to Description

~~This is used to record the type of Isotope Procedure Department, based on the MAIN SPECIALTY of the head of the DEPARTMENT, or the type of Physiological Measurement Department.~~ This is used to record the type of Isotope Procedure Department, based on the MAIN SPECIALTY CODE of the head of the DEPARTMENT, or the type of Physiological Measurement Department.

National Codes:

- 01 Accident And Emergency Department
- 02 Pathology Department
- 03 Professional Staff Group Department
- 04 Radiology Department
- 05 Radiotherapy Department
- 20 Isotope Procedure Department
  - 21 nuclear medicine
  - 22 medical physics
  - 23 other
- 30 Physiological Measurement Department
  - 31 electrocardiography
  - 32 electroencephalography
  - 33 respiratory function

This attribute is also known by these names:

Context	Alias
plural	DEPARTMENT TYPES

ELECTIVE ADMISSION EFFECTIVE WAIT START DATE

Change to Attribute: New Attribute

ELECTIVE ADMISSION EFFECTIVE WAIT START DATE

The ORIGINAL DECIDED TO ADMIT DATE should normally be the date used as the start point from which an effective waiting time for admission from an ELECTIVE ADMISSION LIST to a Hospital Provider Spell is calculated. However, when a PATIENT refuses a reasonable OFFERED FOR ADMISSION DATE or cancels the admission or fails to arrive for admission, the point from which the effective waiting time is calculated changes.

To take account of PATIENT instigated resets, the ELECTIVE ADMISSION EFFECTIVE WAIT START DATE should be used as the start point from which the effective waiting time is calculated.

When an ELECTIVE ADMISSION LIST ENTRY is created and recorded, the ELECTIVE ADMISSION EFFECTIVE WAIT START DATE should be initialised with the same date used to record the ORIGINAL DECIDED TO ADMIT DATE. Thereafter it should only change if and due to a PATIENT action which instigates a change to the point from which the effective waiting time should be re-calculated or a change to the ORIGINAL DECIDED TO ADMIT DATE.

ELECTIVE ADMISSION EFFECTIVE WAIT START DATE should be changed only when:

a. the PATIENT refuses a reasonable admission date offer, this is a Self-Deferred Admission. The ELECTIVE ADMISSION EFFECTIVE WAIT START DATE should be updated with the earliest OFFERED FOR ADMISSION DATE.

   For a verbal admission offer, as indicated by OFFER OF ADMISSION VERBAL OR WRITTEN, to be deemed reasonable, the PATIENT should be offered a minimum of two OFFERED FOR ADMISSION DATES on different days with at least three weeks notice before the first OFFERED FOR ADMISSION DATE. OFFER OF ADMISSION GROUP

IDENTIFIER should be the same for each individual OFFER OF ADMISSION within the set of the two or more offered dates.

For a written appointment offer, as indicated by OFFER OF ADMISSION VERBAL OR WRITTEN, to be deemed reasonable, the PATIENT should be offered an OFFERED FOR ADMISSION DATE with a minimum of three weeks notice before admission. A written offer may comprise of only one offered date or a set of offered date

or

b. the PATIENT failed to arrive for admission, this is a Self-Deferred Admission. The ELECTIVE ADMISSION EFFECTIVE WAIT START DATE should be updated with the OFFERED FOR ADMISSION DATE the patient did not arrive to attend

ADMISSION OFFER OUTCOME records records whether the PATIENT failed to arrive on the OFFERED FOR ADMISSION DATE

or

c. the admission was cancelled, by or on behalf of, the patient; this is a Self-Deferred Admission. The ELECTIVE ADMISSION EFFECTIVE WAIT START DATE should be updated with the OFFERED FOR ADMISSION DATE after that date has passed i.e. the next day

ADMISSION OFFER OUTCOME records records whether the PATIENT cancelled and APPOINTMENT CANCELLED DATE records the date of cancellation

or

d. the PATIENT initiates transfer themselves to another Health Care Provider and remove themselves from the waiting list of their current provider then the waiting period will reset. The DECIDED TO ADMIT DATE of the new provider will be used to record the ORIGINAL DECIDED TO ADMIT DATE and re-initialise ELECTIVE ADMISSION EFFECTIVE WAIT START DATE accordingly.

Where two Health Care Providers agree to the transfer of a PATIENT for example to speed up treatment or provide continuity of care then this should not be treated as a PATIENT initiated transfer.

In these cases the ORIGINAL DECIDED TO ADMIT DATE and the ELECTIVE ADMISSION EFFECTIVE WAIT START DATE of the transferring provider will also become the initialised ORIGINAL DECIDED TO ADMIT DATE and the ELECTIVE ADMISSION EFFECTIVE WAIT START DATE of the new provider.

In addition, the WAITING PERIOD EXCLUSION will also be transferred to the new provider.

When two Health Care Providers merge the PATIENT elective admission details are retained and waiting times are unaffected.

This attribute is also known by these names:

Context	Alias
plural	ELECTIVE ADMISSION EFFECTIVE WAIT START DATES

FIRST ATTENDANCE

Change to Attribute: Change to Description

~~This indicates whether a patient is making a first or follow-up attendance. For Day Care Attendances, FIRST ATTENDANCE is the first of a series, or only attendance, within one DAY CARE FUNCTION 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 DAY CARE FUNCTION and same Health Care Provider by a PATIENT whose attender status has not changed since the previous attendance.~~ This indicates whether a PATIENT is making a first attendance or contact; or a follow-up attendance or contact.

~~It should be noted that:~~

- ~~a. If a PATIENT attends a ORGANISATION of the same DAY CARE FUNCTION at another site of the ORGANISATION, the initial attendance at the second facility is a re-attendance~~
- ~~b. If a PATIENT attends a Day Care Session which is not of the same DAY CARE FUNCTION as one previously attended within the ORGANISATION, the initial attendance at the second facility is a FIRST ATTENDANCE~~
- ~~c. If a PATIENT changes attender status from hospital bed to regular attender or vice versa, the initial attendance after the change is a FIRST ATTENDANCE~~

~~For Out-Patient Attendances Consultant the first attendance (face to face or telephone/telemedicine) is the start of the Consultant Out-Patient Episode and is the first attendance in a series with the same CONSULTANT following a referral.~~

~~For Clinic Attendances Nurse a FIRST ATTENDANCE is the first in a series, or the only attendance (face to face or telephone/telemedicine), at a Nurse Clinic by a PATIENT.~~

~~For Clinic Attendances Midwife a FIRST ATTENDANCE is the first in a series, or the only attendance (face to face or~~

~~telephone/telemedicine), at a Midwife Clinic by a PATIENT. For Ward Attendances a FIRST ATTENDANCE is the first in a series, or the only attendance by a PATIENT at a WARD.~~

~~For Genitourinary Clinic Attendances a FIRST ATTENDANCE is the first in a series, or the only attendance by a PERSON at a Consultant Clinic.~~

~~Each of the above attendances is a CARE CONTACT where the CARE CONTACT TYPE identifies the specific attendance type. ACTIVITY DATE of ACTIVITY DATE TIME where the ACTIVITY DATE TIME TYPE is National Code 33 '*Attendance Date*' records the date of each attendance. FIRST ATTENDANCE is the first i.e. the only attendance or the earliest dated attendance in the series of attendances.~~

~~When FIRST ATTENDANCE is present within a message it should have one of the following National Code values.~~

National Codes:

1 First attendance face to face
2 Follow-up attendance face to face
3 First telephone or telemedicine consultation
4 Follow-up telephone or telemedicine consultation

This attribute is also known by these names:

Context	Alias
plural	FIRST ATTENDANCES

FIRST ATTENDANCE EFFECTIVE WAIT START DATE

Change to Attribute: New Attribute

FIRST ATTENDANCE EFFECTIVE WAIT START DATE

The ORIGINAL REFERRAL REQUEST RECEIVED DATE should normally be the date used as the start point from which an effective waiting time for a first Out-Patient Appointment is calculated. However, when a PATIENT refuses a reasonable APPOINTMENT DATE OFFERED for a first APPOINTMENT or did not attend a first APPOINTMENT, the point from which the effective waiting time is calculated changes.

To take account of a PATIENT instigated resets, the FIRST ATTENDANCE EFFECTIVE WAIT START DATE should be used as the start point from which the effective waiting time is calculated.

When a REFERRAL REQUEST is created and recorded, FIRST ATTENDANCE EFFECTIVE WAIT START DATE should be initialised with the same date used to record the ORIGINAL REFERRAL REQUEST RECEIVED DATE. Thereafter it should only change if and due to a PATIENT action which instigates a change to the point from which the effective waiting time should be calculated or a change to the ORIGINAL REFERRAL REQUEST RECEIVED DATE.

FIRST ATTENDANCE EFFECTIVE WAIT START DATE should be updated when:

a. the PATIENT refuses a reasonable appointment offer. The FIRST ATTENDANCE EFFECTIVE WAIT START DATE should be updated with the earliest APPOINTMENT DATE OFFERED of the APPOINTMENT OFFERS for the SERVICE REQUEST.

   For a verbal appointment offer, as indicated by APPOINTMENT OFFER VERBAL OR WRITTEN, to be deemed reasonable, the PATIENT should be offered a minimum of two APPOINTMENT DATES OFFERED on different days with at least three weeks notice before the first APPOINTMENT DATE OFFERED.

   For a written appointment offer, as indicated by APPOINTMENT OFFER VERBAL OR WRITTEN, to be deemed reasonable, the PATIENT should be offered an APPOINTMENT DATE OFFERED with a minimum of three weeks notice before the first APPOINTMENT DATE OFFERED

or

b. the PATIENT failed to attend the APPOINTMENT, whether giving advance notice or not, the FIRST ATTENDANCE EFFECTIVE WAIT START DATE should be updated with the APPOINTMENT DATE of the APPOINTMENT not attended

   ATTENDED OR DID NOT ATTEND records whether the PATIENT failed to attend

or

c. the PATIENT initiates transfer themselves to another Health Care Provider and remove themselves from the waiting list of their current provider then the waiting period will reset. The REFERRAL REQUEST RECEIVED DATE of the new provider will be used to record the ORIGINAL REFERRAL REQUEST RECEIVED DATE. This will exclude any period of wait before the transfer took place and re-initialise the FIRST ATTENDANCE EFFECTIVE WAIT START DATE accordingly.

This attribute is also known by these names:

Context	Alias
plural	FIRST ATTENDANCE EFFECTIVE WAIT START DATES

INVITATION OFFER DATE SENT

Change to Attribute: New Attribute

INVITATION OFFER DATE SENT

The date on which an APPOINTMENT OFFER was sent out.

This attribute is also known by these names:

Context	Alias
plural	INVITATION OFFERS DATE SENT

MAIN SPECIALTY CODE

Change to Attribute: Change to Description

~~A unique code identifying each MAIN SPECIALTY designated by Royal Colleges.~~ A unique code identifying each main specialty designated by Royal Colleges. This is the same as the occupation codes describing specialties.

Specialties are divisions of clinical work which may be defined by body systems (dermatology), age (paediatrics), clinical technology (nuclear medicine), clinical function (rheumatology), group of diseases (oncology) or combinations of these factors. Only Specialty titles recognised by the Royal Colleges and Faculties should be used. This list is maintained by the European Specialist Medical Qualifications Order 1995 and European Primary and Specialist Dental Qualifications Regulations 1998.

Each CONSULTANT should be assigned a main specialty by the ORGANISATION to which the CONSULTANT is contracted. For physicians and surgeons with a generalist component to their work, the main specialty should be general medicine or general surgery. The hallmark of a general physician or general surgeon is the continued care of unselected emergency referrals. The main specialty is specific to a Health Care Provider. If, for example, a CONSULTANT physician working in two Health Care Providers has a generalist component to the work in one and not the other, general medicine is only assigned as the main specialty in the former case. CONSULTANTS in general medicine or general surgery may also have specialist interests and these should be recorded as well as the main specialty.

The initial source of the information should be the designation on the CONSULTANT's contract. This should be checked periodically against the work a CONSULTANT is actually doing so that the statistics can relate to a CONSULTANT's current type of work.

The main specialty only should be used for the purpose of producing Specialty costing statistics and for Workforce statistics where links with activity and finance are required. Other specialist interests of CONSULTANTS may be recorded for workforce planning purposes.

This will be used to indicate the skill level of medical and dental employees.

This attribute is also known by these names:

Context	Alias
plural	MAIN SPECIALTY CODES

MEDICAL AND DENTAL POST SPECIALTY GROUP

Change to Attribute: Change to Description

~~A grouping of MAIN SPECIALTIES used to classify Medical and Dental posts.~~ A grouping of MAIN SPECIALTY CODES used to classify Medical and Dental posts.

Classification:

a. Medicine
b. Surgery

c. Obstetrics and Gynaecology
d. Pathology
e. Anaesthetics
f. Paediatrics
g. Accident and Emergency
h. Radiology
i. Psychiatry
j. Dentistry

This attribute is also known by these names:

Context	Alias
plural	MEDICAL AND DENTAL POST SPECIALTY GROUPS

OFFER OF ADMISSION ACCEPTED DATE

Change to Attribute: New Attribute

OFFER OF ADMISSION ACCEPTED DATE

The date on which an OFFERED FOR ADMISSION DATE of an OFFER OF ADMISSION is accepted by, or on behalf of a PATIENT.

ADMISSION OFFER OUTCOME records whether or not the admission took place on the OFFERED FOR ADMISSION DATE.

This attribute is also known by these names:

Context	Alias
plural	OFFER OF ADMISSION ACCEPTED DATES

OFFER OF ADMISSION ACCEPTED OR REFUSED

Change to Attribute: New Attribute

OFFER OF ADMISSION ACCEPTED OR REFUSED

A record of whether or not the OFFERED FOR ADMISSION DATE of an OFFER OF ADMISSION was accepted by, or on behalf of the PATIENT.

The date on which OFFER OF ADMISSION was accepted by, or on behalf of the PATIENT should be recorded by the OFFER OF ADMISSION ACCEPTED DATE.

National Codes:
1 Accepted
2 Refused

OFFER OF ADMISSION GROUP IDENTIFIER

Change to Attribute: New Attribute

OFFER OF ADMISSION GROUP IDENTIFIER

A unique number which associates a set of OFFERS OF ADMISSION for the same ELECTIVE ADMISSION LIST ENTRY.

This attribute is also known by these names:

Context	Alias
plural	OFFER OF ADMISSION GROUP IDENTIFIERS

OFFER OF ADMISSION MADE DATE

Change to Attribute: New Attribute

OFFER OF ADMISSION MADE DATE

The date an OFFER OF ADMISSION was made and recorded.

This attribute is also known by these names:

Context	Alias
plural	OFFER OF ADMISSION MADE DATES

OFFER OF ADMISSION MADE TIME

Change to Attribute: New Attribute

OFFER OF ADMISSION MADE TIME

The time an OFFER OF ADMISSION was made and recorded.

This attribute is also known by these names:

Context	Alias
plural	OFFER OF ADMISSION MADE TIME

OFFER OF ADMISSION VERBAL OR WRITTEN

Change to Attribute: New Attribute

OFFER OF ADMISSION VERBAL OR WRITTEN

This records whether the OFFER OF ADMISSION for an ELECTIVE ADMISSION LIST ENTRY was made verbally or in writing to the PATIENT.

When there is more than one OFFER OF ADMISSION with the same OFFER OF ADMISSION GROUP IDENTIFIER for the same ELECTIVE ADMISSION LIST ENTRY, they should all be the same form of offer i.e. all verbal or all written.

Verbal includes any form of voice communication whether face to face via telephone or other communication media.

Written includes any notification in writing whether communicated electronically, by post or by hand.

National Codes:

01 Verbal offer
02 Written offer

This attribute is also known by these names:

Context	Alias
plural	OFFERS OF ADMISSION VERBAL OR WRITTEN

ORGANISATION SITE TREATMENT CENTRE

Change to Attribute: New Attribute

ORGANISATION SITE TREATMENT CENTRE

This indicates whether or not an ORGANISATION SITE is a Treatment Centre.

It is necessary to monitor care delivered by the NHS and Independent Sector Treatment Centres and be able to differentiate it from other care activity provided to NHS patients. Treatment Centres whether NHS or Independent Sector, should be registered as individual ORGANISATION SITES with the National Administrative Codes Service (NACS).

National Codes:

1 Not a Treatment Centre
2 NHS Treatment Centre
3 Independent Sector Treatment Centre

This attribute is also known by these names:

Context	Alias
plural	ORGANISATION SITE TREATMENT CENTRES

ORIGINAL REFERRAL REQUEST RECEIVED DATE

Change to Attribute: New Attribute

ORIGINAL REFERRAL REQUEST RECEIVED DATE

This records the first REFERRAL REQUEST RECEIVED DATE for a specific health care service to be provided, which was received. This date should be recorded on any subsequent REFERRAL REQUESTS for the same health care service and should never be altered or removed, even if the Health Care Provider changes, until the specific health care service is provided for the PATIENT, or is no longer required or the PATIENT initiates a reset of the waiting period.

In cases where a PATIENT is transferred to another Health Care Provider as initiated by the transferring provider; and the receiving provider and the PATIENT both agree to the transfer, the ORIGINAL REFERRAL REQUEST RECEIVED DATE should also be transferred and retained as the ORIGINAL REFERRAL REQUEST RECEIVED DATE of the receiving provider. This is due to the receiving provider becoming responsible for PATIENT waiting time including the period of wait before the transfer.

In cases where a PATIENT initiates transfer themselves to another Health Care Provider and remove themselves from the waiting list of their current provider then the waiting period will reset. The REFERRAL REQUEST RECEIVED DATE of the new provider will be used to record the ORIGINAL REFERRAL REQUEST RECEIVED DATE. This will exclude any period of wait before the transfer took place.

This attribute is also known by these names:

Context	Alias
plural	ORIGINAL REFERRAL REQUEST RECEIVED DATE

OUT-PATIENT CONVERTED UNIQUE BOOKING REFERENCE NUMBER

Change to Attribute: New Attribute

OUT-PATIENT CONVERTED UNIQUE BOOKING REFERENCE NUMBER

The unique booking reference number assigned by the NHS Connecting for Health Choose and Book system when a PATIENT accepts an APPOINTMENT DATE OFFERED of an APPOINTMENT OFFER where the offer was made via the NHS Connecting for Health Choose and Book system.

When a PATIENT accepts an APPOINTMENT DATE OFFERED, the unique booking reference number issued and used during the booking process is considered to be 'converted' i.e. an APPOINTMENT has been created and recorded; and the PATIENT has been placed on an Out-Patient Waiting List even if susbsequently the PATIENT does not attend or cancels the APPOINTMENT.

APPOINTMENT BOOKING SYSTEM TYPE of the APPOINTMENT records the type of booking system used and OUT-PATIENT CONVERTED UNIQUE BOOKING REFERENCE NUMBER should only be recorded where the type of booking system is the NHS Connecting for Health Choose and Book system.

This attribute is also known by these names:

Context	Alias
plural	OUT-PATIENT CONVERTED UNIQUE BOOKING REFERENCE NUMBERS

REFERRAL REQUEST RECEIVED TIME

Change to Attribute: New Attribute

REFERRAL REQUEST RECEIVED TIME

This records the time the REFERRAL REQUEST was received.

This attribute is also known by these names:

Context	Alias
plural	REFERRAL REQUEST RECEIVED TIMES

REFERRAL REQUEST TYPE

Change to Attribute: Change to Description

Identifies the originating source of a REFERRAL REQUEST.

National Codes:

01 GP referral request
02 Consultant referral request
~~03~~ ~~Other~~
03 Other - **Retired April 2006**
04 Patient self-referral request
97 Other

This attribute is also known by these names:

Context	Alias
plural	REFERRAL REQUEST TYPES

REFERRAL TIME

Change to Attribute: New Attribute

REFERRAL TIME

The time a REFERRAL REQUEST was made.

This attribute is also known by these names:

Context	Alias
plural	REFERRAL TIMES

REQUESTED OR INVITED DATE

Change to Attribute: DeletedDeleted

REQUESTED OR INVITED TIME

Change to Attribute: DeletedDeleted

REQUEST OR INVITATION FOR APPOINTMENT DATE

Change to Attribute: Change to Name

~~REQUEST OR INVITATION FOR APPOINTMENT DATE~~ APPOINTMENT DATE OFFERED

REQUEST OR INVITATION FOR APPOINTMENT DATE renamed APPOINTMENT DATE OFFERED

Change to Attribute: Change to Description

~~The actual date offered for the APPOINTMENT in response to the request or the APPOINTMENT DATE offered on the invitation.~~ The actual date offered for an APPOINTMENT in response to an SERVICE REQUEST or an invitaion as part of a HEALTH PROGRAMME.

This attribute is also known by these names:

Context	Alias
~~plural~~	~~REQUEST OR INVITATION FOR APPOINTMENT DATES~~
plural	APPOINTMENT DATES OFFERED

SERVICE REQUEST DATE

Change to Attribute: New Attribute

SERVICE REQUEST DATE

The date a SERVICE REQUEST for an APPOINTMENT was made and recorded.

This attribute is also known by these names:

Context	Alias
plural	SERVICE REQUEST DATES

SERVICE REQUEST IDENTIFIER

Change to Attribute: New Attribute

SERVICE REQUEST IDENTIFIER

The unique identifier of an SERVICE REQUEST.

This attribute is also known by these names:

Context	Alias
plural	SERVICE REQUEST IDENTIFIERS

SERVICE REQUEST RELATIONSHIP DESCRIPTION

Change to Attribute: New Attribute

SERVICE REQUEST RELATIONSHIP DESCRIPTION

Describes how one SERVICE REQUEST relates to another.

This attribute is also known by these names:

Context	Alias
plural	SERVICE REQUEST RELATIONSHIP DESCRIPTION

SERVICE REQUEST TIME

Change to Attribute: New Attribute

SERVICE REQUEST TIME

The time a SERVICE REQUEST for an APPOINTMENT was made and recorded.

This attribute is also known by these names:

Context	Alias
plural	SERVICE REQUEST TIMES

WAITING LIST IDENTIFIER

Change to Attribute: New Attribute

WAITING LIST IDENTIFIER

A unique identifier of a WAITING LIST.

This attribute is also known by these names:

Context	Alias
plural	WAITING LISTS IDENTIFIER

WAITING LIST TYPE

Change to Attribute: New Attribute

WAITING LIST TYPE

Identifies the type of WAITING LIST.

National Codes:

01 Elective Admission List
02 Out-Patient Waiting List

This attribute is also known by these names:

Context	Alias
plural	WAITING LIST TYPES

ADMISSION INTENDED PROCEDURE

Change to Data Element: New Data Element

ADMISSION INTENDED PROCEDURE

Format/length: an4
HES item:
National Codes:
Default Codes:

Notes:
This is the grouping code for the specified Intended Patient Procedure for summarising in-patient stocks.

The grouping is based upon specified OPCS-4 codes as recorded by the CLINICAL CLASSIFICATION CODE of the CLINICAL CLASSIFICATION which is an OPERATIVE PROCEDURE for the PLANNED ACTIVITY of an ELECTIVE ADMISSION LIST ENTRY for a PATIENT being admitted electively.

When the OPCS-4 code of the OPERATIVE PROCEDURE is within the range of the specified ADMISSION INTENDED PROCEDURE for the sub group within the dataset, the PATIENT should be included in the count providing all the other criteria of the count are also met.

An Intended Patient Procedure is a PLANNED ACTIVITY where PLANNED ACTIVITY TYPE is National Code 04 'Intended Patient Procedure'.

One of the following values can be set:

OPCS-4.2 codes

0001	CABG - Coronary Artery Bypass Graft Code Range: K40.- Saphenous vein graft replacement of coronary artery K41.- Other autograft replacement of coronary artery K42.- Allograft replacement of coronary artery K43.- Prosthetic replacement of coronary artery K44.- Other replacement of coronary artery K45.- Connection of thoracic artery to coronary artery K46.- Other bypass of coronary artery
0002	PTCA - Percutaneous Transluminal Operations Coding Range: *Therapeutic* K49.- Transluminal balloon angioplasty of coronary artery K50.- Other therapeutic transluminal operations on coronary artery *Diagnostic* K51.- Diagnostic transluminal operations on coronary artery
0003	Valves Coding Range *Open* K25.- Plastic repair of mitral valve K26.- Plastic repair of aortic valve K27.- Plastic repair of tricuspid valve K28.- Plastic repair of pulmonary valve K29.- Plastic repair of unspecified valve of heart K30.- Revision of plastic repair of heart K31.- Open incision of valve of heart K34.- Other open operations on valve of heart *Closed* K32.- Closed incision of valve of heart *Therapeutic transluminal* K35.- Therapeutic transluminal operations on valve of heart
0004	Angiography Coding Range K63.- Contrast radiology of heart K65.- Catheterisation of heart
0005	CHD - Coronary Heart Disease Coding Range

This data element is also known by these names:

Context	Alias
plural	ADMISSION INTENDED PROCEDURES

ADMITTED PATIENT ELECTIVE ADMISSIONS

Change to Data Element: New Data Element

ADMITTED PATIENT ELECTIVE ADMISSIONS

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

Notes:
The total number of finished Consultant Episode (Hospital Provider) where the PATIENT was admitted from an ELECTIVE ADMISSION LIST to a Hospital Provider Spell within the REPORTING PERIOD. This includes patients who have been admitted and then are subsequently sent home without treatment.

It includes private patients and patients from overseas.

It is the total of number of elective admissions for PATIENTS where:

a. the ADMISSION OFFER OUTCOME of the OFFER OF ADMISSION is National Code 1 *'Patient admitted - treatment commenced'* or 5 *'Patient admitted - treatment deferred'*

and

b. the ADMISSION METHOD of the Hospital Provider Spell ACTIVITY GROUP is National Code 11 *'Waiting list'* or 12 *'Booked'* or 13 *'Planned'*

and

c. the ACTIVITY DATE of the Consultant Episode (Hospital Provider) ACTIVITY GROUP recording the End Date is within the period of the REPORTING PERIOD START DATE and the REPORTING PERIOD END DATE.

Within the reporting period includes where the date is the same as the start date or end date.

ADMITTED PATIENT ELECTIVE ADMISSIONS (DAY CASE)

Change to Data Element: New Data Element

ADMITTED PATIENT ELECTIVE ADMISSIONS (DAY CASE)

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

Notes:
This is a subset of ADMITTED PATIENT ELECTIVE ADMISSIONS of all the day case admissions within the REPORTING PERIOD. That is where the PATIENT CLASSIFICATION for the Hospital Provider Spell ACTIVITY GROUP is National Code 2 'Day case admission'.

This data element is also known by these names:

Context	Alias
plural	ADMITTED PATIENT ELECTIVE ADMISSIONS (DAY CASE)

ADMITTED PATIENT ELECTIVE ADMISSIONS (IS TREATMENT CENTRES)

Change to Data Element: New Data Element

ADMITTED PATIENT ELECTIVE ADMISSIONS (IS TREATMENT CENTRES)

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

Notes:
This is a subset of ADMITTED PATIENT ELECTIVE ADMISSIONS of all the admissions to an Independent Sector Treatment Centre as day case admissions or ordinary admissions within the REPORTING PERIOD. That is where the ADMINSTRATIVE CATEGORY CODE current at the Start Date of the Hospital Provider Spell is National Code 01 *'NHS patient'* and the ORGANISATION SITE TREATMENT CENTRE of ORGANISATION SITE is National Code 3 *'Independent Sector Treatment Centre'*.

This data element is also known by these names:

Context	Alias
plural	ADMITTED PATIENT ELECTIVE ADMISSIONS (IS TREATMENT CENTRES)

ADMITTED PATIENT ELECTIVE ADMISSIONS (NHS TREATMENT CENTRES)

Change to Data Element: New Data Element

ADMITTED PATIENT ELECTIVE ADMISSIONS (NHS TREATMENT CENTRES)

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

Notes:
This is a subset of ADMITTED PATIENT ELECTIVE ADMISSIONS of all the admissions in an NHS Treatment Centre as day case admissions or ordinary admissions within the REPORTING PERIOD where the ORGANISATION SITE TREATMENT CENTRE of ORGANISATION SITE is National Code 2 *'NHS Treatment Centre'*.

This data element is also known by these names:

Context	Alias
plural	ADMITTED PATIENT ELECTIVE ADMISSIONS (NHS TREATMENT CENTRES)

ADMITTED PATIENT ELECTIVE ADMISSIONS (ORDINARY)

Change to Data Element: New Data Element

ADMITTED PATIENT ELECTIVE ADMISSIONS (ORDINARY)

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

Notes:
This is a subset of ADMITTED PATIENT ELECTIVE ADMISSIONS of all the ordinary admissions within the REPORTING PERIOD. That is where the PATIENT CLASSIFICATION for the Hospital Provider Spell ACTIVITY GROUP is National Code 1 'Ordinary admission'.

This data element is also known by these names:

Context	Alias
plural	ADMITTED PATIENT ELECTIVE ADMISSIONS (ORDINARY)

ADMITTED PATIENT ELECTIVE ADMISSIONS (PLANNED)

Change to Data Element: New Data Element

ADMITTED PATIENT ELECTIVE ADMISSIONS (PLANNED)

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

Notes:
This is a subset of ADMITTED PATIENT ELECTIVE ADMISSIONS of all the planned admissions within the REPORTING PERIOD. That is where the ADMISSION METHOD of the Hospital Provider Spell ACTIVITY GROUP is National Code 13 *'Planned*'.

This data element is also known by these names:

Context	Alias
plural	ADMITTED PATIENT ELECTIVE ADMISSIONS (PLANNED)

ADMITTED PATIENT NHS ADMISSIONS

Change to Data Element: New Data Element

ADMITTED PATIENT NHS ADMISSIONS

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

Notes:
This is the number of NHS PATIENTS admitted to a Hospital Provider Spell of an NHS provider within the REPORTING PERIOD for planned treatment activity for a particular ADMISSION INTENDED PROCEDURE.

That is where the ORGANISATION TYPE of the Health Care Provider ORGANISATION is classification c *'NHS Trust'* or x *'Primary Care Trust'* and the OPCS-4 code as recorded by the CLINICAL CLASSIFICATION CODE of the OPERATIVE PROCEDURE is within the group range of ADMITTED PATIENT GROUPING INTENDED PROCEDURE.

This data element is also known by these names:

Context	Alias
plural	ADMITTED PATIENT NHS ADMISSIONS

ADMITTED PATIENT NON-NHS ADMISSIONS

Change to Data Element: New Data Element

ADMITTED PATIENT NON-NHS ADMISSIONS

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

Notes:
This is the number of NHS PATIENTS admitted to a Hospital Provider Spell of a registered or unregistered non-NHS provider ORGANISATION within the REPORTING PERIOD for planned treatment activity for a particular ADMITTED PATIENT GROUPING INTENDED PROCEDURE.

That is where the ORGANISATION TYPE of the Health Care Provider ORGANISATION is classification q. *'Registered non-NHS Provider'* or r. *'Unregistered non-NHS Provider (except Local Authority)'* and the ADMINISTRATIVE CATEGORY CODE current at the Start Date of the Hospital Provider Spell is National Code 01 *'NHS patient'* and the OPCS-4 code as recorded by the CLINICAL CLASSIFICATION CODE of the OPERATIVE PROCEDURE is within the group range of ADMITTED PATIENT GROUPING INTENDED PROCEDURE.

This data element is also known by these names:

Context	Alias
plural	ADMITTED PATIENT NON-NHS ADMISSIONS

ADMITTED PATIENT TOTAL NON-ELECTIVE ADMISSIONS

Change to Data Element: New Data Element

ADMITTED PATIENT TOTAL NON-ELECTIVE ADMISSIONS

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

Notes:
The total number of PATIENTS admitted non-electively to a Hospital Provider Spell of a NHS provider within the REPORTING PERIOD. This includes patients who have been admitted and then are subsequently sent home without treatment.

It includes private patients and patients from overseas.

It is the total of number of non-elective admissions for PATIENTS where:

a. the ORGANISATION TYPE of the Health Care Provider ORGANISATION is classification c *'NHS Trust'* or x *'Primary Care Trust'*

and

b. the ADMISSION METHOD of the Hospital Provider Spell ACTIVITY GROUP is National Code:

21, 22, 23 24 or 28 *'Emergency admission, when admission is unpredictable and at short notice because of clinical need'* see ADMISSION METHOD for definition of each code within this grouping

or 31 or 32 *'Maternity admission, of a pregnant or recently pregnant woman to a maternity ward (including delivery facilities) except when the intention is to terminate the pregnancy'* see ADMISSION METHOD for definition of each code within this grouping

or 81, 82 or 83*'Other admission* see ADMISSION METHOD for definition of each code within this grouping

and

c. the ACTIVITY DATE of the Hospital Provider Spell ACTIVITY GROUP recording the Start Date of the Hospital Provider Spell is within the period of the REPORTING PERIOD START DATE and the REPORTING PERIOD END DATE.

Within the reporting period includes where the date is the same as the start date or end date

This data element is also known by these names:

Context	Alias
plural	ADMITTED PATIENT TOTAL NON-ELECTIVE ADMISSIONS

COMMISSIONER OR PROVIDER STATUS INDICATOR

Change to Data Element: New Data Element

COMMISSIONER OR PROVIDER STATUS INDICATOR

Format/length:	n2
HES item:	
National Codes:	
Default Codes:	

Notes:
This indicates whether a Central Information Requirement Dataset and the data it contains is a submission from the ORGANISATION in the role of commissioner of care or provider of care.

One of the following values can be used:
- 01 Commissioner submission
- 02 Provider submission

This data element is also known by these names:

Context	Alias
plural	COMMISSIONER OR PROVIDER STATUS INDICATOR

DATASET PREPARATION DATE

Change to Data Element: New Data Element

DATASET PREPARATION DATE

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

Notes:
DATASET PREPARATION DATE in conjunction with DATASET PREPARATION TIME date and time stamps when the data reported within the dataset was extracted, prepared and recorded within the dataset.

This date may be different to the actual submission date of the dataset.

This data element is also known by these names:

Context	Alias
plural	DATASET PREPARATION DATES

DATASET PREPARATION TIME

Change to Data Element: New Data Element

DATASET PREPARATION TIME

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

Notes:
DATASET PREPARATION TIME in conjunction with DATASET PREPARATION DATE date and time stamps when the data reported within the dataset was extracted, prepared and recorded within the dataset.

This date may be different to the actual submission date of the dataset.

This data element is also known by these names:

Context	Alias
plural	DATASET PREPARATION TIMES

DECISIONS TO ADMIT (BOOKED DAY CASE)

Change to Data Element: New Data Element

DECISIONS TO ADMIT (BOOKED DAY CASE)

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

Notes:
The DECISIONS TO ADMIT NUMBER where the ELECTIVE ADMISSION TYPE is National Code 12 *'Booked admission*' and the PATIENT CLASSIFICATION for the ELECTIVE ADMISSION LIST ENTRY is National Code 2 *'Day case admission'*.

It excludes DECISIONS TO ADMIT for planned and waiting list admissions.

This data element is also known by these names:

Context	Alias
plural	DECISIONS TO ADMIT (BOOKED DAY CASE)

DECISIONS TO ADMIT (BOOKED ORDINARY)

Change to Data Element: New Data Element

DECISIONS TO ADMIT (BOOKED ORDINARY)

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

Notes:
The DECISIONS TO ADMIT NUMBER ELECTIVE ADMISSION TYPE is National Code 12 *'Booked admission*' and the PATIENT CLASSIFICATION for the ELECTIVE ADMISSION LIST ENTRY is National Code 1 *'Ordinary admission'*.

It excludes DECISIONS TO ADMIT for planned and waiting list admissions.

This data element is also known by these names:

Context	Alias
plural	DECISIONS TO ADMIT (BOOKED ORDINARY)

DECISIONS TO ADMIT (DAY CASE)

Change to Data Element: New Data Element

DECISIONS TO ADMIT (DAY CASE)

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

Notes:
The DECISIONS TO ADMIT NUMBER where the ELECTIVE ADMISSION TYPE is National Code 11 *'Waiting list admission'* or 12 *'Booked admission*' and the PATIENT CLASSIFICATION for the ELECTIVE ADMISSION LIST ENTRY is National Code 2 *'Day case admission'*.

It excludes DECISIONS TO ADMIT for planned admissions.

This data element is also known by these names:

Context	Alias
plural	DECISIONS TO ADMIT (DAY CASE)

DECISIONS TO ADMIT (ORDINARY)

Change to Data Element: New Data Element

DECISIONS TO ADMIT (ORDINARY)

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

Notes:
The DECISIONS TO ADMIT NUMBER where the ELECTIVE ADMISSION TYPE is National Code 11 *'Waiting list admission'* or 12 *'Booked admission*' and the PATIENT CLASSIFICATION for the ELECTIVE ADMISSION LIST ENTRY is National Code 1 *'Ordinary admission'*.

It excludes DECISIONS TO ADMIT for planned admissions.

This data element is also known by these names:

Context	Alias
plural	DECISIONS TO ADMIT (ORDINARY)

DECISIONS TO ADMIT NUMBER

Change to Data Element: New Data Element

DECISIONS TO ADMIT NUMBER

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

Notes:
The total number of DECISIONS TO ADMIT taken within the REPORTING PERIOD for PATIENTS to be placed on ELECTIVE ADMISSION LIST for admission to a Hospital Provider Spell. It includes private patients and patients from overseas.

It is the total of number of such DECISIONS TO ADMIT where:

a. the DECIDED TO ADMIT DATE of the ELECTIVE ADMISSION LIST ENTRIES is within the period of the REPORTING PERIOD START DATE and the REPORTING PERIOD END DATE.
Within the reporting period includes where the date is the same as the start date or end date

This data element is also known by these names:

Context	Alias
plural	DECISIONS TO ADMIT NUMBERS

DEFERRED ADMISSIONS (DAY CASE)

Change to Data Element: New Data Element

DEFERRED ADMISSIONS (DAY CASE)

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

Notes:
This is the same as DEFERRED ADMISSIONS (ORDINARY) except that the specified PATIENT CLASSIFICATION is 'day case'.

This data element is also known by these names:

Context	Alias
plural	DEFERRED ADMISSIONS (DAY CASE)

DEFERRED ADMISSIONS (ORDINARY)

Change to Data Element: New Data Element

DEFERRED ADMISSIONS (ORDINARY)

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

Notes:
The total 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 still waiting to be admitted from an ELECTIVE ADMISSION LIST to a Hospital Provider Spell for the specified PATIENT CLASSIFICATION of 'ordinary admission' due to Self-Deferred Admission.

This includes Self-Deferred Admission patients where the OFFERED FOR ADMISSION DATE has passed by the end of the REPORTING PERIOD.

It excludes Self-Deferred Admission patients where the OFFERED FOR ADMISSION DATE has not passed by the end of the REPORTING PERIOD, private patients, patients from overseas, elective planned admissions and Suspended Patients.

It is the total of number of Self-Deferred Admission PATIENTS with an offer of admission date still waiting 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 patient 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 patient Self-Deferred Admission, at least one should have an OFFER OF ADMISSION MADE DATE before or on the REPORTING PERIOD END DATE even if it is not the latest offer made

and

the latest OFFER OF ADMISSION made, the one with 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. 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

d. 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

e. the ADMISSION LIST EFFECTIVE WAIT START DATE is different to the ORIGINAL DECIDED TO ADMIT DATE
and
the ADMISSION LIST EFFECTIVE WAIT START DATE is before or on the REPORTING PERIOD END DATE

and

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

and

g. the PATIENT CLASSIFICATION is National Code 1 *'Ordinary admission"*

Where no Self-Deferred Admission PATIENTS waiting for admissions match the above criteria, a zero value should be recorded.

This data element is also known by these names:

Context	Alias
plural	DEFERRED ADMISSIONS (ORDINARY)

FIRST ATTENDANCE

Change to Data Element: Change to Description

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

Notes:
~~This indicates whether a PATIENT is making a FIRST ATTENDANCE or follow-up attendance and whether the CONSULTATION MEDIA USED was a face to face contact or telephone/telemedicine consultation.~~ This indicates whether a PATIENT is making a FIRST ATTENDANCE or follow-up attendance or contact and whether the CONSULTATION MEDIA USED was a face to face contact or telephone/telemedicine consultation. A first attendance is the first in a series, or only attendance of an appointment which took place regardless of how many previous APPOINTMENTS were made which did not take place for whatever reason. All subsequent attendances in the series which take place should be recorded as follow-up.

This data element is also known by these names:

Context	Alias
plural	FIRST ATTENDANCES

GP WRITTEN REFERRALS

Change to Data Element: New Data Element

GP WRITTEN REFERRALS

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

Notes:
The total number of GENERAL PRACTITIONER written referrals, whether from doctors or dentists, received within the REPORTING PERIOD for a first Out-Patient Appointment Consultant regardless of whether or not they resulted in an Out-Patient Attendance Consultant.

It is the total number of GP written referrals where:

a. the REFERRAL REQUEST TYPE of the REFERRAL REQUEST is National Code 01 '*GP referral request*'

and

b. the WRITTEN REFERRAL REQUEST INDICATOR of the REFERRAL REQUEST is classification 'Yes'

and

c. the REFERRAL REQUEST is for an Out-Patient Appointment Consultant whether directed to a specific CONSULTANT or not

and

d. the ORIGINAL REFERRAL REQUEST RECEIVED DATE of the REFERRAL REQUEST is within the period of the REPORTING PERIOD START DATE and the REPORTING PERIOD END DATE.

Within the reporting period includes where the date is the same as the start date or end date

This data element is also known by these names:

Context	Alias
plural	GP WRITTEN REFERRALS

GP WRITTEN REFERRALS BOOKED

Change to Data Element: New Data Element

GP WRITTEN REFERRALS BOOKED

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

Notes:
The total number of GENERAL PRACTITIONER written referrals, whether from doctors or dentists, received within the REPORTING PERIOD for a first Out-Patient Appointment Consultant where a booking system was used. This is regardless of whether or not they resulted in an Out-Patient Attendance Consultant.

Currently this count only includes GP written referrals to a named CONSULTANT and excludes any other form of REFERRAL REQUEST whether to a named CONSULTANT or not.

It is the total number of GP written referrals where:

a. the REFERRAL REQUEST TYPE of the REFERRAL REQUEST is National Code 01 '*GP referral request*'

and

b. the WRITTEN REFERRAL REQUEST INDICATOR of the REFERRAL REQUEST is classification 'Yes'

and

c. the REFERRAL REQUEST is to a CONSULTANT for an Out-Patient Appointment Consultant

and

d. the ORIGINAL REFERRAL REQUEST RECEIVED DATE of the REFERRAL REQUEST is within the period of the REPORTING PERIOD START DATE and the REPORTING PERIOD END DATE

Within the reporting period includes where the date is the same as the start date or end date

and

e. the APPOINTMENT BOOKING SYSTEM TYPE of the REFERRAL REQUEST is classification b. '*Partial booking system non-Choose and Book system*' or c. '*Full booking system - non Choose and Book system*' or d. '*Choose and Book system*'

Out-Patient Appointment Consultant is an SERVICE REQUEST for an APPOINTMENT where APPOINTMENT CLASSIFICATION CODE is National Code 02 *'Out-Patient Appointment Consultant'*.

This data element is also known by these names:

Context	Alias
plural	GP WRITTEN REFERRALS BOOKED

GP WRITTEN REFERRALS MADE

Change to Data Element: New Data Element

GP WRITTEN REFERRALS MADE

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

Notes:
The total number of APPOINTMENTS resulting from GENERAL PRACTITIONER written referrals, whether from doctors or dentists, where PATIENTS have been added to an Out-Patient Waiting List within the REPORTING PERIOD for a first Out-Patient Appointment Consultant.

Currently this count only includes GP written referrals to a named CONSULTANT and excludes any other form of REFERRAL REQUEST whether to a named CONSULTANT or not.

The DECISION TO OFFER AN APPOINTMENT DATE of a SERVICE REQUEST indicates in which REPORTING PERIOD the PATIENT was added to an Out-Patient Waiting List as a result of the REFERRAL REQUEST received. Note there may be a period of time between when the referral was recieved and when the decision to offer an appointment was made and recorded depending upon referral process and whether and what type of booking systems was used.

It is the total number of APPOINTMENTS arising from GP written referrals where:

a. the REFERRAL REQUEST TYPE of the REFERRAL REQUEST is National Code 01 '*GP referral request*'

and

b. the WRITTEN REFERRAL REQUEST INDICATOR of the REFERRAL REQUEST is classification 'Yes'

and

c. the REFERRAL REQUEST is to a CONSULTANT for an Out-Patient Appointment Consultant

and

d. the DECISION TO OFFER AN APPOINTMENT DATE of the SERVICE REQUEST is within the period of the REPORTING PERIOD START DATE and the REPORTING PERIOD END DATE.

Within the reporting period includes where the date is the same as the start date or end date

and

e. the APPOINTMENT FIRST ATTENDANCE of the APPOINTMENT is National Code 01 *'First appointment'*

or

where there is one or more APPOINTMENT recorded for a PATIENT but none has as yet taken place, the notional 'first appointment' included in the count will be the APPOINTMENT with the earliest APPOINTMENT DATE. This excludes any APPOINTMENTS which have been cancelled as indicated by a recorded APPOINTMENT CANCELLED DATE.

Out-Patient Appointment Consultant is an SERVICE REQUEST for an APPOINTMENT where APPOINTMENT CLASSIFICATION CODE is National Code 02 *'Out-Patient Appointment Consultant'*.

This data element is also known by these names:

Context	Alias
plural	GP WRITTEN REFERRALS MADE

GP WRITTEN REFERRALS SEEN

Change to Data Element: New Data Element

GP WRITTEN REFERRALS SEEN

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

Notes:
The total number of first attendance APPOINTMENTS resulting from GENERAL PRACTITIONER written referrals, whether from doctors or dentists, where the Out-Patient Attendance Consultant took place within the REPORTING PERIOD. This includes private patient attendances.

Currently this count only includes GP written referrals to a CONSULTANT and excludes any other form of REFERRAL REQUEST whether to a CONSULTANT or not.

When an Out-Patient Appointment Consultant APPOINTMENT takes place an Out-Patient Attendance Consultant CARE CONTACT

records the attendance with FIRST ATTENDANCE recording whether it is a first attendance or a follow-up attendance and ACTVITY DATE recording the the Attendance Date.

The ADMINISTRATIVE CATEGORY records whether a PATIENT is a private or NHS patient and should be the ADMINISTRATIVE CATEGORY which is current at the date of the attendance ACTIVITY DATE.

It is the total number of GP written referrals first attendance APPOINTMENTS where:

a. the REFERRAL REQUEST TYPE of the REFERRAL REQUEST is National Code 01 '*GP referral request*'

and

b. the WRITTEN REFERRAL REQUEST INDICATOR of the REFERRAL REQUEST is classification 'Yes'

and

c. the REFERRAL REQUEST is to a CONSULTANT for an Out-Patient Appointment Consultant

and

d. the FIRST ATTENDANCE of the Out-Patient Attendance Consultant CARE CONTACT is National Code 1 *'First attendance face to face'* or 3 *'First telephone or telemedicine consultation'*

and

e. the ACTIVITY DATE of the Out-Patient Attendance Consultant CARE CONTACT is within the period of the REPORTING PERIOD START DATE and the REPORTING PERIOD END DATE

Within the reporting period includes where the date is the same as the start date or end date

Out-Patient Appointment Consultant is an Appointment Request for an APPOINTMENT where APPOINTMENT CLASSIFICATION CODE is National Code 02 *'Out-Patient Appointment Consultant'*.

Out-Patient Attendance Consultant is a CARE CONTACT where CARE CONTACT TYPE is is National Code 30 *'Out-Patient Attendance Consultant'*.

This data element is also known by these names:

Context	Alias
plural	GP WRITTEN REFERRALS SEEN

LAST DNA OR PATIENT CANCELLED DATE

Change to Data Element: Change to Description

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

Notes:
For the Elective Admission List CDS types, this date is derived from OFFERED FOR ADMISSION DATE and ADMISSION OFFER OUTCOME and is needed to meet central requirements. It is recorded when PATIENTS who have been offered a date for admission have missed this admission date with or without advance notice.

For Out-Patient Attendance CDS, the four dates, REFERRAL REQUEST RECEIVED DATE, APPOINTMENT DATE, Attendance Date and LAST DNA OR PATIENT CANCELLED DATE, together provide all the information needed to derive the out-patient waiting time for the QM08 central return form. Both APPOINTMENT DATE and Attendance Date may be required to calculate waiting times if the PATIENT cancels an appointment or did not attend and then subsequently attended at a future date.

Attendance Date is an ACTIVITY DATE where ACTIVITY DATE TIME TYPE is National Code 33 '*Attendance Date*'.

This data element is also known by these names:

Context	Alias
plural	LAST DNA OR PATIENT CANCELLED DATES

NUMBER OF OUT-PATIENT CONVERTED UNIQUE BOOKING REFERENCE NUMBERS

Change to Data Element: New Data Element

NUMBER OF OUT-PATIENT CONVERTED UNIQUE BOOKING REFERENCE NUMBERS

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

Notes:
The total number of APPOINTMENTS where the APPOINTMENT ACCEPTED DATE is within the REPORTING PERIOD for an Out-Patient Appointment Consultant and where the NHS Connecting for Health Choose and Book system was used.

Currently this count only includes requests to a named CONSULTANT for an Out-Patient Appointment Consultant and excludes any other form of request.

The APPOINTMENT ACCEPTED DATE of an APPOINTMENT indicates in which REPORTING PERIOD the APPOINTMENT DATE OFFERED of an APPOINTMENT OFFER was accepted by, or on behalf of the PATIENT this is regardless of the APPOINTMENT DATE which may be within a different period.

When an APPOINTMENT is created and recorded, the unique booking reference used by the NHS Connecting for Health Choose and Book system is recorded by OUT-PATIENT CONVERTED UNIQUE BOOKING REFERENCE NUMBER.

It is the total of number of APPOINTMENTS where:

a. the REFERRAL REQUEST TYPE of the REFERRAL REQUEST is National Code 01 '*GP referral request*'

and

b. the REFERRAL REQUEST is to a CONSULTANT for an Out-Patient Appointment Consultant

and

c. the APPOINTMENT ACCEPTED DATE is within the period of the REPORTING PERIOD START DATE and the REPORTING PERIOD END DATE.
Within the reporting period includes where the date is the same as the start date or end date

and

d. the APPOINTMENT BOOKING SYSTEM TYPE of the APPOINTMENT is classification d. '*Choose and Book system*'

Out-Patient Appointment Consultant is an SERVICE REQUEST for an APPOINTMENT where APPOINTMENT CLASSIFICATION CODE is National Code 02 *'Out-Patient Appointment Consultant'*.

This data element is also known by these names:

Context	Alias
plural	NUMBER OF OUT-PATIENT CONVERTED UNIQUE BOOKING REFERENCE NUMBERS

OTHER REFERRALS

Change to Data Element: New Data Element

OTHER REFERRALS

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

Notes:
The total number of non-GP written REFERRAL REQUESTS received within the REPORTING PERIOD for a first Out-Patient Appointment Consultant regardless of whether or not they resulted in an Out-Patient Attendance Consultant.

It is the total number of REFERRAL REQUESTS where:

a. the REFERRAL REQUEST is to a CONSULTANT for a first Out-Patient Appointment Consultant

and

b. the ORIGINAL REFERRAL REQUEST RECEIVED DATE of the REFERRAL REQUEST is within the period of the REPORTING PERIOD START DATE and the REPORTING PERIOD END DATE.
Within the reporting period includes where the date is the same as the start date or end date

However, this total number should exclude the following types of REFERRAL REQUESTS:

a. GP written referrals; these are where the REFERRAL REQUEST TYPE of the REFERRAL REQUEST is National Code 01 '*GP referral request*'

and

the WRITTEN REFERRAL REQUEST INDICATOR of the REFERRAL REQUEST is classification 'Yes'

b. Self-referrals; these are where the REFERRAL REQUEST TYPE of the REFERRAL REQUEST is National Code 04 '*Patient self-referral request*'

c. Initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode referrals; these are where the SOURCE OF REFERRAL FOR OUT-PATIENTS of the REFERRAL REQUEST is National Code 01 *'following an emergency admission'* or 02 *'following a domiciliary visit'* or 10 *'following an Accident And Emergency Attendance'* or 11 *'other'*

d. Referrals initiated by attendance at drop-in clinic without prior appointment; these are where the OUT-PATIENT CLINIC REFERRING INDICATOR of the REFERRAL REQUEST is classification '*Attended referring Out-Patient Clinic without prior appointment*'

This data element is also known by these names:

Context	Alias
plural	OTHER REFERRALS

OUT-PATIENT EFFECTIVE WAITS

Change to Data Element: New Data Element

OUT-PATIENT EFFECTIVE WAITS

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

Notes:
The total number of GENERAL PRACTITIONER written referrals with a particular effective waiting time band, whether from doctors or dentists, measured from receipt of the referral and the first Out-Patient Attendance Consultant.

The effective waiting time band should be calculated from the FIRST ATTENDANCE EFFECTIVE START DATE which takes into account any waiting time resets instigated by the PATIENT.

It is the total number of GP written referrals where:

a. the REFERRAL REQUEST TYPE of the REFERRAL REQUEST is National Code 01 '*GP referral request*'

and

b. the WRITTEN REFERRAL REQUEST INDICATOR of the REFERRAL REQUEST is classification *'Yes'*

and

c. the REFERRAL REQUEST is to a CONSULTANT for an Out-Patient Appointment Consultant

and

d. the FIRST ATTENDANCE of the Out-Patient Attendance Consultant CARE CONTACT is National Code 1 *'First attendance face to face'* or 3 *'First telephone or telemedicine consultation'*

and

the ACTIVITY DATE of the Out-Patient Attendance Consultant CARE CONTACT is within the period of the REPORTING PERIOD START DATE and the REPORTING PERIOD END DATE

Within the reporting period includes where the date is the same as the start date or end date.

or

e. no first Out-Patient Attendance Consultant CARE CONTACT has been recorded

and

the calculated waiting time between the FIRST ATTENDANCE EFFECTIVE START DATE and the REPORTING PERIOD END DATE.

Out-Patient Effective Waiting Time Calculation provides full details on calculating the waiting time band.

This data element is also known by these names:

Context	Alias
plural	OUT-PATIENT EFFECTIVE WAITS

OUT-PATIENT FIRST APPOINTMENTS DID NOT ATTEND

Change to Data Element: New Data Element

OUT-PATIENT FIRST APPOINTMENTS DID NOT ATTEND

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

Notes:
The total number of accepted APPOINTMENTS which should have resulted in a first Out-Patient Attendance Consultant within the REPORTING PERIOD which did not take place due to the PATIENT not attending the APPOINTMENT. This includes private patient non-attendances.

Until a first attendance actually takes place, any APPOINTMENT which did not take place due to the PATIENT not attending and which has an earlier APPOINTMENT DATE to that of the actual first attendance APPOINTMENT should be classified as should have resulted in a first Out-Patient Attendance Consultant.

It is the total number of APPOINTMENTS where:

a. the ATTENDED OR DID NOT ATTEND of the Out-Patient Appointment Consultant APPOINTMENT is National Code 3 *'Did not attend - no advance warning given'* or 7 *'PATIENT arrived late and could not be seen'*

and

b. the APPOINTMENT DATE is within the period of the REPORTING PERIOD START DATE and the REPORTING PERIOD END DATE

Within the reporting period includes where the date is the same as the start date or end date

and

c. no first Out-Patient Attendance Consultant CARE CONTACT has yet been been recorded for the PATIENT

or

a first attendance Out-Patient Attendance Consultant CARE CONTACT has been recorded for the PATIENT but the ACTIVITY DATE is after (or on the same day) as the APPOINTMENT DATE of the non-attended APPOINTMENT

OUT-PATIENT FIRST APPOINTMENTS FIRST ATTENDANCES SEEN

Change to Data Element: New Data Element

OUT-PATIENT FIRST APPOINTMENTS FIRST ATTENDANCES SEEN

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

Notes:
The total number of first attendance APPOINTMENTS, where the Out-Patient Attendance Consultant took place within the REPORTING PERIOD. This includes private patient attendances.

It is the total number of first attendance APPOINTMENTS where:

a. the FIRST ATTENDANCE of the Out-Patient Attendance Consultant CARE CONTACT is National Code 1 *'First attendance face to face'* or 3 *'First telephone or telemedicine consultation'*

and

b. the ACTIVITY DATE of the Out-Patient Attendance Consultant CARE CONTACT is within the period of the REPORTING PERIOD START DATE and the REPORTING PERIOD END DATE

Within the reporting period includes where the date is the same as the start date or end date

OUT-PATIENT FOLLOW-UP APPOINTMENTS ATTENDANCES SEEN

Change to Data Element: New Data Element

OUT-PATIENT FOLLOW-UP APPOINTMENTS ATTENDANCES SEEN

Format/length:	n10
HES item:	
National Codes:	

Default Codes:

Notes:
The total number of follow-up attendance APPOINTMENTS, where the Out-Patient Attendance Consultant took place within the REPORTING PERIOD. This includes private patient attendances.

When an Out-Patient Appointment Consultant APPOINTMENT takes place an Out-Patient Attendance Consultant CARE CONTACT records the attendance with FIRST ATTENDANCE recording whether it is a first attendance or a follow-up attendance and ACTVITY DATE recording the the Attendance Date.

The ADMINISTRATIVE CATEGORY records whether a PATIENT is a private or NHS patient and should be the ADMINISTRATIVE CATEGORY which is current at the date of the attendance ACTIVITY DATE.

It is the total number of follow-up attendance APPOINTMENTS where:

a. the FIRST ATTENDANCE of the Out-Patient Attendance Consultant CARE CONTACT is National Code 2 *'Follow-up attendance face to face'* or 4 *'Follow-up telephone or telemedicine consultation'*

and

b. the ACTIVITY DATE of the Out-Patient Attendance Consultant CARE CONTACT is within the period of the REPORTING PERIOD START DATE and the REPORTING PERIOD END DATE
Within the reporting period includes where the date is the same as the start date or end date

This data element is also known by these names:

Context	Alias
plural	OUT-PATIENT FOLLOW-UP APPOINTMENTS ATTENDANCES SEEN

OUT-PATIENT FOLLOW-UP APPOINTMENTS DID NOT ATTEND

Change to Data Element: New Data Element

OUT-PATIENT FOLLOW-UP APPOINTMENTS DID NOT ATTEND

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

Notes:
The total number of accepted APPOINTMENTS which should have resulted in a follow-up Out-Patient Attendance Consultant within the REPORTING PERIOD which did not take place due to the PATIENT not attending the APPOINTMENT. This includes private patient non-attendances.

When an Out-Patient Attendance Consultant actually takes place, any APPOINTMENT which did not take place due to the PATIENT not attending and which has a later APPOINTMENT DATE to that of the actual first attendance APPOINTMENT should be classified as should have resulted in a follow-up Out-Patient Attendance Consultant

It is the total number of APPOINTMENTS where:

a. the ATTENDED OR DID NOT ATTEND of the Out-Patient Appointment Consultant APPOINTMENT is National Code 3 *'Did not attend - no advance warning given'* or 7 *'PATIENT arrived late and could not be seen'*

and

b. the APPOINTMENT DATE is within the period of the REPORTING PERIOD START DATE and the REPORTING PERIOD END DATE
Within the reporting period includes where the date is the same as the start date or end date

and

c. a first Out-Patient Attendance Consultant CARE CONTACT has been been recorded for the PATIENT
and
the ACTIVITY DATE is before (or on the same day) as the APPOINTMENT DATE of the non-attended APPOINTMENT

This data element is also known by these names:

Context	Alias
plural	OUT-PATIENT FOLLOW-UP APPOINTMENTS DID NOT ATTENDS

OUT-PATIENTS WAITING

Change to Data Element: New Data Element

OUT-PATIENTS WAITING

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

Notes:
The total number of GENERAL PRACTITIONER written referrals, whether from doctors or dentists, where the first Out-Patient Attendance Consultant has not yet taken place.

When an Out-Patient Appointment Consultant APPOINTMENT takes place an Out-Patient Attendance Consultant CARE CONTACT records the attendance with FIRST ATTENDANCE recording whether it is a first attendance or a follow-up attendance and ACTVITY DATE recording the the Attendance Date.

The effective waiting period should be calculated from the FIRST ATTENDANCE EFFECTIVE START DATE which takes into account any waiting time resets instigated by the PATIENT.

It is the total number of GP written referrals where:

a. the REFERRAL REQUEST TYPE of the REFERRAL REQUEST is National Code 01 '*GP referral request*'

and

b. the WRITTEN REFERRAL REQUEST INDICATOR of the REFERRAL REQUEST is classification *'Yes'*

and

c. the REFERRAL REQUEST is to a CONSULTANT for an Out-Patient Appointment Consultant

and

d. no first Out-Patient Attendance Consultant CARE CONTACT has been recorded

and

e. the calculated waiting time between the FIRST ATTENDANCE EFFECTIVE START DATE and the REPORTING PERIOD END DATE.

Out-Patient Effective Waiting Time Calculation provides full details on calculating the waiting time band

This data element is also known by these names:

Context	Alias
plural	OUT-PATIENTS WAITING

OUT-PATIENT WAITING TIME BAND

Change to Data Element: New Data Element

OUT-PATIENT WAITING TIME BAND

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

Notes:
The time band for OUT-PATIENTS WAITING or OUT-PATIENT EFFECTIVE WAITS for the period between receipt of the referral and the end of the REPORTING PERIOD.

The timebands are as follows:

0	less than 1 week
01-02	1 to less than 2 weeks
02-03	at least 2 weeks to less than 3 weeks
03-04	at least 3 weeks to less than 4 weeks
04-05	at least 4 weeks to less than 5 weeks
05-06	at least 5 weeks to less than 6 weeks
06-07	at least 6 weeks to less than 7 weeks

07-08	at least 7 weeks to less than 8 weeks
08-09	at least 8 weeks to less than 9 weeks
09-10	at least 9 weeks to less than 10 weeks
10-11	at least 10 weeks to less than 11 weeks
11-12	at least 11 weeks to less than 12 weeks
12-13	at least 12 weeks to less than 13 weeks
13-14	at least 13 weeks to less than 14 weeks
14-15	at least 14 weeks to less than 15 weeks
15-16	at least 15 weeks to less than 16 weeks
16-17	at least 16 weeks to less than 17 weeks
17+	more than 17 weeks

This data element is also known by these names:

Context	Alias
plural	OUT-PATIENT WAITING TIME BANDS

PATIENTS ADMITTED (DAY CASE)

Change to Data Element: New Data Element

PATIENTS ADMITTED (DAY CASE)

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

Notes:
The total PATIENTS ADMITTED NUMBER where the PATIENT CLASSIFICATION of the Hospital Provider Spell ACTIVITY GROUP is National Code 2 *'Day case admission'*.

This data element is also known by these names:

Context	Alias
plural	PATIENTS ADMITTED (DAY CASE)

PATIENTS ADMITTED (ORDINARY)

Change to Data Element: New Data Element

PATIENTS ADMITTED (ORDINARY)

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

Notes:
The total PATIENTS ADMITTED NUMBER where the PATIENT CLASSIFICATION of the Hospital Provider Spell ACTIVITY GROUP is National Code 1 *'Ordinary admission'*.

This data element is also known by these names:

Context	Alias
plural	PATIENTS ADMITTED (ORDINARY)

PATIENTS ADMITTED NUMBER

Change to Data Element: New Data Element

PATIENTS ADMITTED NUMBER

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

Notes:
The total number of PATIENTS classified as booked admissions or waiting list admissions, admitted from an ELECTIVE ADMISSION LIST to a Hospital Provider Spell as day case admissions within the REPORTING PERIOD. This includes patients who have been admitted and then are subsequently sent home without treatment.

It includes private patients and patients from overseas, it excludes elective planned admissions.

It is the total of number of elective admissions for PATIENTS where:

a. the ADMISSION OFFER OUTCOME of the OFFER OF ADMISSION is National Code 1 *'Patient admitted - treatment commenced'* or 5 *'Patient admitted - treatment deferred'*

and

b. the ADMISSION METHOD of the Hospital Provider Spell ACTIVITY GROUP is National Code 11 *'Waiting list'* or 12 *'Booked'*

and

c. the ACTIVITY DATE of the Hospital Provider Spell ACTIVITY GROUP recording the Start Date of the Hospital Provider Spell is within the period of the REPORTING PERIOD START DATE and the REPORTING PERIOD END DATE.

Within the reporting period includes where the date is the same as the start date or end date

and

d. the PATIENT CLASSIFICATION of the Hospital Provider Spell ACTIVITY GROUP is National Code 2 *'Day case admission'*

Start Date of a Hospital Provider Spell is an ACTIVITY DATE where ACTIVITY DATE TIME TYPE is National Code 31 *'Start Date'*.

This data element is also known by these names:

Context	Alias
plural	PATIENTS ADMITTED NUMBERS

PATIENTS FAILED TO ATTEND

Change to Data Element: New Data Element

PATIENTS FAILED TO ATTEND

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

Notes:
The total number of PATIENTS classified as booked admissions or waiting list admissions, who giving no advanced warning failed to attend for admission from an ELECTIVE ADMISSION LIST to a Hospital Provider Spell within the REPORTING PERIOD.

It includes private patients and patients from overseas, it excludes elective planned admissions, Self Deferred Admission by the patient and Suspended Patients.

It is the total of number of failed to attend for elective admission for PATIENTS where:

a. the ADMISSION OFFER OUTCOME of the OFFER OF ADMISSION is National Code 4 *'Patient failed to arrive'*

and

b. the OFFERED FOR ADMISSION DATE of the OFFER OF ADMISSION for the ELECTIVE ADMISSION LIST ENTRY is within the period of the REPORTING PERIOD START DATE and the REPORTING PERIOD END DATE

Within the reporting period includes where the date is the same as the start date or end date

and

c. no ELECTIVE ADMISSION SUSPENSION DETAIL has been recorded

or

if recorded, the LIST SUSPENSION END DATE is before the OFFERED FOR ADMISSION DATE i.e. no period of suspension is still on-going at the date failed to attend. Where no LIST SUSPENSION END DATE has been recorded then the period of suspension is still active and should be excluded from the count

and

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

This data element is also known by these names:

Context	Alias
plural	PATIENTS FAILED TO ATTEND

PATIENTS FAILED TO ATTEND (DAY CASE)

Change to Data Element: New Data Element

PATIENTS FAILED TO ATTEND (DAY CASE)

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

Notes:
The total PATIENTS FAILED TO ATTEND where the PATIENT CLASSIFICATION for the ELECTIVE ADMISSION LIST ENTRY is National Code 2 *'Day case admission'*.

This data element is also known by these names:

Context	Alias
plural	PATIENTS FAILED TO ATTEND (DAY CASE)

PATIENTS FAILED TO ATTEND (ORDINARY)

Change to Data Element: New Data Element

PATIENTS FAILED TO ATTEND (ORDINARY)

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

Notes:
The total PATIENTS FAILED TO ATTEND where the PATIENT CLASSIFICATION for the ELECTIVE ADMISSION LIST ENTRY is National Code 1 *'Ordinary admission'*.

This data element is also known by these names:

Context	Alias
plural	PATIENTS FAILED TO ATTEND (ORDINARY)

PATIENTS SUSPENDED (DAY CASE)

Change to Data Element: New Data Element

PATIENTS SUSPENDED (DAY CASE)

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

Notes:
This is the same as PATIENTS SUSPENDED (ORDINARY) except that the specified PATIENT CLASSIFICATION is 'day case'.

This data element is also known by these names:

Context	Alias
plural	PATIENTS SUSPENDED (DAY CASE)

PATIENTS SUSPENDED (ORDINARY)

Change to Data Element: New Data Element

PATIENTS SUSPENDED (ORDINARY)

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

Notes:
The total number of PATIENTS classified as booked admissions or waiting list admissions, who are still waiting to be admitted from an Elective Admission List to a Hospital Provider Spell for the specified PATIENT CLASSIFICATION of 'Ordinary Admission' who at the REPORTING PERIOD END DATE are Suspended Patients.

It excludes private patients, patients from overseas and elective planned admissions.

It is the total of number of Suspended Patients on the Elective Admission List 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 patient 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 ELECTIVE ADMISSION SUSPENSION DETAIL is recorded where the LIST SUSPENSION START DATE is before or on the REPORTING PERIOD END DATE
and
the LIST SUSPENSION END DATE is on or after the REPORTING PERIOD END DATE
or
no LIST SUSPENSION END DATE is recorded i.e. it is still active and on-going

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

and

e. PATIENT CLASSIFICATION is 'Ordinary Admission'

This data element is also known by these names:

Context	Alias
plural	PATIENTS SUSPENDED (ORDINARY)

PATIENTS WAITING FOR ADMISSION

Change to Data Element: New Data Element

PATIENTS WAITING FOR ADMISSION

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.

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 patient 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'*.

This data element is also known by these names:

Context	Alias
plural	PATIENTS WAITING FOR ADMISSION

PATIENTS WAITING FOR ADMISSION TIME BAND

Change to Data Element: New Data Element

PATIENTS WAITING FOR ADMISSION TIME BAND

Format/length: 5 character
HES item:
National Codes:

Default Codes:

Notes:
The time band for PATIENTS WAITING FOR ADMISSION.

These are as follows:

0	less than 1 week
01-02	1 to less than 2 weeks
02-03	at least 2 weeks to less than 3 weeks
03-04	at least 3 weeks to less than 4 weeks
04-05	at least 4 weeks to less than 5 weeks
05-06	at least 5 weeks to less than 6 weeks
06-07	at least 6 weeks to less than 7 weeks
07-08	at least 7 weeks to less than 8 weeks
08-09	at least 8 weeks to less than 9 weeks
09-10	at least 9 weeks to less than 10 weeks
10-11	at least 10 weeks to less than 11 weeks
11-12	at least 11 weeks to less than 12 weeks
12-13	at least 12 weeks to less than 13 weeks
13-14	at least 13 weeks to less than 14 weeks
14-15	at least 14 weeks to less than 15 weeks
15-16	at least 15 weeks to less than 16 weeks
16-17	at least 16 weeks to less than 17 weeks
17-18	at least 17 weeks to less than 18 weeks
18-19	at least 18 weeks to less than 19 weeks
19-20	at least 19 weeks to less than 20 weeks
20-21	at least 20 weeks to less than 21 weeks
21-22	at least 21 weeks to less than 22 weeks
22-23	at least 22 weeks to less than 23 weeks
23-24	at least 23 weeks to less than 24 weeks
24-25	at least 24 weeks to less than 25 weeks
25-26	at least 25 weeks to less than 26 weeks
26-27	at least 26 weeks to less than 27 weeks
27-28	at least 27 weeks to less than 28 weeks
28-29	at least 28 weeks to less than 29 weeks
29-30	at least 29 weeks to less than 30 weeks
30+	more than 30 weeks

Some time bands are cumulative which means that all PATIENTS who have been waiting within the time band or more should be included in the count.

For example, a PATIENT who has been waiting 35 weeks should be included in the count for 26 plus weeks, 31 plus weeks and 35 plus weeks time bands.

If the count is cumulative it is expressed as below:

26+	26 weeks or more
31+	31 weeks or more
35+	35 weeks or more

This data element is also known by these names:

Context	Alias
plural	PATIENTS WAITING FOR ADMISSION TIME BANDS

REMOVALS OTHER THAN ADMISSION

Change to Data Element: New Data Element

REMOVALS OTHER THAN ADMISSION

Format/length: n10
HES item:
National Codes:

Default Codes:

Notes:
The total number of PATIENTS classified as booked admissions or waiting list admissions to be admitted to a Hospital Provider Spell, who were removed from an ELECTIVE ADMISSION LIST within the REPORTING PERIOD for reasons other than admission.

It includes private patients and patients from overseas, it excludes elective planned admissions and Suspended Patients.

It is the total of number of removals from elective admission for PATIENTS where:

a. the ELECTIVE ADMISSION LIST REMOVAL REASON is National Code 2 *'Patient admitted as an emergency for the same condition'* or 3 *'Patient died'* or 4 *'Patient removed for other reasons'*

and

b. the ELECTIVE ADMISSION LIST REMOVAL DATE is within the period of the REPORTING PERIOD START DATE and the REPORTING PERIOD END DATE

Within the reporting period includes where the date is the same as the start date or end date

and

c. no ELECTIVE ADMISSION SUSPENSION DETAIL has been recorded

or

if recorded, the LIST SUSPENSION END DATE is before the ELECTIVE ADMISSION LIST REMOVAL DATE i.e. no period of suspension is still on-going at the date of removal. Where no LIST SUSPENSION END DATE has been recorded then the period of suspension is still active and should be excluded from the count

and

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

This data element is also known by these names:

Context	Alias
plural	REMOVALS OTHER THAN ADMISSIONS

REMOVALS OTHER THAN ADMISSION (DAY CASE)

Change to Data Element: New Data Element

REMOVALS OTHER THAN ADMISSION (DAY CASE)

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

Notes:
The total REMOVALS OTHER THAN ADMISSION where the INTENDED MANAGEMENT for the ELECTIVE ADMISSION LIST ENTRY is *'Patient not to stay in hospital over night'*.

This data element is also known by these names:

Context	Alias
plural	REMOVALS OTHER THAN ADMISSIONS (DAY CASE)

REMOVALS OTHER THAN ADMISSION (ORDINARY)

Change to Data Element: New Data Element

REMOVALS OTHER THAN ADMISSION (ORDINARY)

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

Notes:
The total REMOVALS OTHER THAN ADMISSION where the INTENDED MANAGEMENT for the ELECTIVE ADMISSION LIST ENTRY is

'Patient to stay in hospital for at least one night'.

This data element is also known by these names:

Context	Alias
plural	REMOVALS OTHER THAN ADMISSIONS (ORDINARY)

REPORTING PERIOD END DATE

Change to Data Element: New Data Element

REPORTING PERIOD END DATE

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

Notes:
This is the same as attribute REPORTING PERIOD END DATE.

This is the end date of the REPORTING PERIOD and is used in conjunction with REPORTING PERIOD START DATE to specify the actual period the reported information relates to.

The date should not be before the REPORTING PERIOD START DATE although it can be the same if the period being reported only covers 1 day.

This data element is also known by these names:

Context	Alias
plural	REPORTING PERIODS END DATE

REPORTING PERIOD START DATE

Change to Data Element: New Data Element

REPORTING PERIOD START DATE

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

Notes:
This is the same as attribute REPORTING PERIOD START DATE.

This is the start date of the REPORTING PERIOD and is used in conjunction with REPORTING PERIOD END DATE to specify the actual period the reported information relates to.

The date should not be after the REPORTING PERIOD END DATE although it can be the same if the period being reported only covers 1 day.

This data element is also known by these names:

Context	Alias
plural	REPORTING PERIODS START DATE

WAITING FOR ADMISSION INTENDED MANAGEMENT

Change to Data Element: New Data Element

WAITING FOR ADMISSION INTENDED MANAGEMENT

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

Notes:
This is a grouping for specified INTENDED MANAGEMENT for in-patient stocks datsets.

When the INTENDED MANAGEMENT matches the requirements of the specified WAITING FOR ADMISSION INTENDED MANAGEMENT for the sub group within the dataset, the PATIENT should be included in the count providing all the other criteria of the count are also met.

One of the following values can be set:

1	Ordinary admission equivalent to INTENDED MANAGEMENT '*Patient to stay in hospital at least one night*'
2	Day case admission equivalent to INTENDED MANAGEMENT ''*Patient not to stay in hospital overnight*'. '
6	Ordinary admission and day case admission equivalent to INTENDED MANAGEMENT '*Patient to stay in hospital at least one night*' or '*Patient not to stay in hospital overnight*'

This data element is also known by these names:

Context	Alias
plural	WAITING FOR ADMISSION INTENDED MANAGEMENTS

For further information contact datastandards@cfh.nhs.uk