Change Request

NHS Connecting for Health

NHS Data Model and Dictionary Service

Reference:	Change Request 921
Version No:	1.0
Subject:	Inclusion of page for the Department of Health
Type of Change:	Changes to NHS Data Standards
Effective Date:	Immediate
Reason for Change:	To include a NHS Business Definition for the Department of Health.

Background:

Organisations which are referenced in the NHS Data Model and Dictionary are being included in the NHS Data Model and Dictionary.

This Data Set Change Notice:

- adds a new NHS Business Definition for the Department of Health;
- adds links to existing references to the Department of Health in the NHS Data Model and Dictionary

This Data Set Change Notice also:

- add missing "links" to existing information where required
- removes all unnecessary abbreviations and
- corrects any spelling mistakes

Summary of changes:

Class Definitions	
OVERSEAS VISITOR STATUS	Change to Description
REFERRAL TO TREATMENT PERIOD	Change to Description
Attribute Definitions	
BODY IRRADIATION	Change to Description
CANCER REFERRAL PRIORITY TYPE	Change to Description
CANCER SPECIALIST REFERRAL DATE	Change to Description
CANCER STATUS	Change to Description
CRITICAL CARE LEVEL	Change to Description
CYTOLOGY SCREENING ACTION TYPE	Change to Description
DELAY REASON COMMENT	Change to Description
DELAY REASON REFERRAL TO FIRST SEEN (CANCER)	Change to Description
DELAY REASON TO TREATMENT (CANCER)	Change to Description
DEPARTMENT OF HEALTH ORGANISATION CODE	Change to Description
FIRST CANCER DIAGNOSTIC TEST	Change to Description
FIRST DEFINITIVE TREATMENT PLANNED	Change to Description
FIRST DEFINITIVE TREATMENT PROVIDED	Change to Description
MULTIDISCIPLINARY TEAM DISCUSSION DATE	Change to Description
ORGANISATION TYPE	Change to Description
PLANNED CANCER TREATMENT TYPE	Change to Description
PRIORITY TYPE	Change to Description
REFERRAL TO TREATMENT PERIOD END DATE	Change to Description

REFERRAL TO TREATMENT PERIOD START DATE	Change to Description
SAMPLE RECEIPT DATE	Change to Description
SERVICE TYPE	Change to Description
SOURCE OF REFERRAL FOR OUT-PATIENTS	Change to Description
SUPRA SERVICE INDICATOR	Change to Description
TWO WEEK WAIT EXCLUSION INDICATOR	Change to Description

Data Elements

DIAGNOSTIC TEST (ENDOSCOPY)	Change to Description
DIAGNOSTIC TEST (IMAGING)	Change to Description
DIAGNOSTIC TEST (PHYSIOLOGICAL MEASUREMENT)	Change to Description
FIRST SEEN BY SPECIALIST DATE (CANCER)	Change to Description
HEALTHCARE RESOURCE GROUP CODE	Change to Description
HEALTHCARE RESOURCE GROUP CODE-VERSION NUMBER	Change to Description
HRG DOMINANT GROUPING VARIABLE-PROCEDURE	Change to Description
NHS NUMBER	Change to Description
OVERSEAS VISITORS STATUS CLASSIFICATION	Change to Description

Dataset

CDS V6 TYPE 010	Change to Table

Central Return Forms

COVER 1	Change to Guidance Text
KA34 1	Change to Guidance Text
KC50 1	Change to Guidance Text
KC60 1A	Change to Guidance Text
KC60 1B	Change to Guidance Text
KC62 1	Change to Guidance Text
KH03A 1	Change to Guidance Text
KH12 2	Change to Guidance Text
KO41(A) 1	Change to Guidance Text
KO41(B) 1	Change to Guidance Text
KT31 1	Change to Guidance Text

Supporting Information

ACCIDENT & EMERGENCY QUARTERLY MONITORING DATA SET (QMAE) OVERVIEW	Change to Supporting Information
ADMINISTRATIVE CODES & CLASSIFICATIONS	Change to Supporting Information
ADMITTED PATIENT FLOWS DATA SET OVERVIEW	Change to Supporting Information
ADMITTED PATIENT STOCKS DATA SET OVERVIEW	Change to Supporting Information
BOOKINGS ADMITTED PATIENT AND OUT-PATIENT PROVIDER DATA SET OVERVIEW	Change to Supporting Information
CENTRAL RETURN DATA SETS INTRODUCTION	Change to Supporting Information
CHOOSE AND BOOK UTILISATION COMMISSIONER DATA SET OVERVIEW	Change to Supporting Information
COMMISSIONING DATA SET OVERVIEW	Change to Supporting Information
DEPARTMENT OF HEALTH	New Supporting Information
HES CROSS REFERENCE TABLES NAVIGATION	Change to Supporting Information
HOSPITAL EPISODE STATISTICS	Change to Supporting Information
MENTAL HEALTH MINIMUM DATA SET MESSAGE SCHEMA VERSIONS	Change to Supporting Information
MENTAL HEALTH MINIMUM DATA SET OVERVIEW	Change to Supporting Information
METADATA FILES	Change to Supporting Information
NATIONAL CANCER WAITING TIMES MONITORING DATA SET OVERVIEW	Change to Supporting Information
NEONATAL CRITICAL CARE MINIMUM DATA SET OVERVIEW	Change to Supporting Information
NHS POSTCODE DIRECTORY	Change to Supporting Information

ORGANISATIONS	Change to Supporting Information
OUT-PATIENT FLOWS DATA SET OVERVIEW	Change to Supporting Information
OUT-PATIENT STOCKS DATA SET OVERVIEW	Change to Supporting Information
PERSON SMOKING CESSATION EPISODE	Change to Supporting Information
PRIMARY CARE TRUST	Change to Supporting Information
SMOKING CESSATION SERVICE	Change to Supporting Information
SPECIALIST PALLIATIVE CARE DATE	Change to Supporting Information
SUMMARISED ACTIVITY FLOWS DATA SET OVERVIEW	Change to Supporting Information
SUMMARISED STOCKS DATA SET OVERVIEW	Change to Supporting Information
SUSPENDED PATIENT	Change to Supporting Information
THE NHS DATA MODEL & DICTIONARY ELEMENTS	Change to Supporting Information

Date: 4 January 2008
Sponsor:

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.

CDS V6 TYPE 010

Change to Dataset: Change to Table

CDS V6 TYPE 010 - ACCIDENT AND EMERGENCY CDS

~~**This CDS carries the data for an Accident and Emergency Attendance Episode and consists of the following CDS Data Groups:**~~

~~INTERCHANGE, MESSAGE and CDS TRANSACTION HEADERS and TRAILERS (defined independently)~~
~~PATIENT PATHWAY~~
~~PATIENT IDENTITY~~
~~PATIENT CHARACTERISTICS~~
~~GP REGISTRATION~~
~~ATTENDANCE OCCURRENCE - Activity Characteristics~~
~~ATTENDANCE OCCURRENCE - Service Agreement Details~~
~~ATTENDANCE OCCURRENCE - Person Group (A And E Consultant)~~
~~ATTENDANCE OCCURRENCE - Clinical Information (Diagnosis)~~
~~ATTENDANCE OCCURRENCE - Clinical Information (Investigation)~~
~~ATTENDANCE OCCURRENCE - Clinical Information (Treatment)~~
~~HEALTHCARE RESOURCE GROUP~~

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

This Commissioning Data Set carries the data for an Accident and Emergency Attendance Episode and consists of the following Commissioning Data Set Data Groups:

INTERCHANGE, MESSAGE and COMMISSIONING DATA SET TRANSACTION HEADERS and TRAILERS (defined independently)
PATIENT PATHWAY
PATIENT IDENTITY
PATIENT CHARACTERISTICS
GENERAL PRACTITIONER REGISTRATION

ATTENDANCE OCCURRENCE - Activity Characteristics
ATTENDANCE OCCURRENCE - Service Agreement Details
ATTENDANCE OCCURRENCE - Person Group (A And E Consultant)
ATTENDANCE OCCURRENCE - Clinical Information (Diagnosis)
ATTENDANCE OCCURRENCE - Clinical Information (Investigation)
ATTENDANCE OCCURRENCE - Clinical Information (Treatment)
HEALTHCARE RESOURCE GROUP

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

~~CDS V6 TYPE 010- THE ACCIDENT AND EMERGENCY ATTENDANCE CDS~~		
CDS V6 TYPE 010 - ACCIDENT AND EMERGENCY CDS		
~~CDS DATA GROUP: PATIENT PATHWAY:~~ ~~To carry the details of the Patient Pathway.~~ ~~One optional occurrence of this Group is permitted.~~		
COMMISSIONING DATA SET DATA GROUP: PATIENT PATHWAY: **To carry the details of the Patient Pathway.** **One optional occurrence of this Group is permitted.**		
Opt	**CDS Data Element**	
O	UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)	
O	PATIENT PATHWAY IDENTIFIER	
O	ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)	
O	REFERRAL TO TREATMENT STATUS	
O	REFERRAL TO TREATMENT PERIOD START DATE	
O	REFERRAL TO TREATMENT PERIOD END DATE	
*	LEAD CARE ACTIVITY INDICATOR (not defined or approved by the Information Standards Board)	
~~CDS DATA GROUP: PATIENT IDENTITY:~~ ~~To carry the identity of the Patient.~~ ~~One occurrence of this Group is permitted.~~		
COMMISSIONING DATA SET DATA GROUP: PATIENT IDENTITY: **To carry the identity of the Patient.** **One occurrence of this Group is permitted.**		
~~**Opt**~~	~~**CDS Data Element**~~	
Opt	**Commissioning Data Set Data Element**	
M	LOCAL PATIENT IDENTIFIER	
M	ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)	
O	NHS NUMBER	
M	NHS NUMBER STATUS INDICATOR	
O	PATIENT NAME	
O	PATIENT USUAL ADDRESS	
M	POSTCODE OF USUAL ADDRESS	
M	ORGANISATION CODE (PCT OF RESIDENCE)	

~~**Note:**~~
~~For reasons of confidentiality, the patient's preferred name and address (not including POSTCODE OF USUAL ADDRESS) must **not** be carried where a valid NHS Number is present. For patients with sensitive conditions (as defined in DSCN 41/98/P26), all patient identifiable information must be removed from Commissioning Data Set records. This includes LOCAL PATIENT IDENTIFIER, ORGANISATION CODE (LOCAL PATIENT IDENTIFIER), NHS NUMBER, PATIENT NAME, PATIENT USUAL ADDRESS, POSTCODE OF USUAL ADDRESS, ORGANISATION CODE (PCT OF RESIDENCE) and PERSON~~

~~BIRTH DATE (in Patient Characteristics data group below).~~

~~CDS DATA GROUP: PATIENT CHARACTERISTICS: To carry the characteristics of the Patient. One occurrence of this Group is permitted.~~	
	Note: For reasons of confidentiality, the PATIENT's preferred name and address (not including POSTCODE OF USUAL ADDRESS) must **not** be carried where a valid NHS Number is present. For patients with sensitive conditions (as defined in DSCN 41/98/P26), all PATIENT identifiable information must be removed from Commissioning Data Set records. This includes LOCAL PATIENT IDENTIFIER, ORGANISATION CODE (LOCAL PATIENT IDENTIFIER), NHS NUMBER, PATIENT NAME, PATIENT USUAL ADDRESS, POSTCODE OF USUAL ADDRESS, ORGANISATION CODE (PCT OF RESIDENCE) and PERSON BIRTH DATE (in PATIENT Characteristics data group below).

COMMISSIONING DATA SET DATA GROUP: PATIENT CHARACTERISTICS: To carry the characteristics of the Patient. One occurrence of this Group is permitted.		
~~Opt~~	~~CDS Data Element~~	
Opt	**Commissioning Data Set Data Element**	
M	PERSON BIRTH DATE	
M	PERSON GENDER CURRENT	
O	CARER SUPPORT INDICATOR	

~~CDS DATA GROUP: GP REGISTRATION: To carry the details of the Patient's Registered GMP. One occurrence of this Group is permitted.~~	
COMMISSIONING DATA SET DATA GROUP: GP REGISTRATION: To carry the details of the Patient's Registered General Medical Practioner. One occurrence of this Group is permitted.	
M	GMP (CODE OF REGISTERED OR REFERRING GMP)
O	CODE OF GP PRACTICE (REGISTERED GMP)

~~CDS DATA GROUP: ATTENDANCE OCCURRENCE - Activity Characteristics: To carry the details of the Accident and Emergency attendance.~~	
COMMISSIONING DATA SET DATA GROUP: ATTENDANCE OCCURRENCE - Activity Characteristics: To carry the details of the Accident and Emergency attendance.	
M	A+E ATTENDANCE NUMBER
M	A+E ARRIVAL MODE
M	A+E ATTENDANCE CATEGORY
M	A+E ATTENDANCE DISPOSAL
M	A+E INCIDENT LOCATION TYPE
M	A+E PATIENT GROUP
M	SOURCE OF REFERRAL FOR A+E
M	A+E DEPARTMENT TYPE
M	ARRIVAL DATE This is the ***mandatory*** date used to derive the ***mandatory*** CDS ACTIVITY DATE
M	ARRIVAL TIME
M	AGE AT CDS ACTIVITY DATE
M	A+E INITIAL ASSESSMENT TIME (first and unplanned follow-up attendances only)
M	A+E TIME SEEN FOR TREATMENT
M	A+E ATTENDANCE CONCLUSION TIME
M	A+E DEPARTURE TIME

~~CDS DATA GROUP: ATTENDANCE OCCURRENCE - Service Agreement Details: To carry the details of the Service Agreement for the Accident and Emergency Attendance. One occurrence of this Data Group is permitted.~~
COMMISSIONING DATA SET DATA GROUP: ATTENDANCE OCCURRENCE - Service Agreement Details:

To carry the details of the Service Agreement for the Accident and Emergency Attendance.
One occurrence of this Data Group is permitted.

M	COMMISSIONING SERIAL NUMBER	
O	NHS SERVICE AGREEMENT LINE NUMBER	
O	PROVIDER REFERENCE NUMBER	
O	COMMISSIONER REFERENCE NUMBER	
M	ORGANISATION CODE (CODE OF PROVIDER)	
M	ORGANISATION CODE (CODE OF COMMISSIONER)	

~~**CDS DATA GROUP: ATTENDANCE OCCURRENCE - Person Group (A + E Consultant):**~~
~~**To carry the details of the responsible Clinician.**~~
~~**One occurrence of this Group is permitted.**~~

COMMISSIONING DATA SET DATA GROUP: ATTENDANCE OCCURRENCE - Person Group (A + E Consultant):
To carry the details of the responsible Clinician.
One occurrence of this Group is permitted.

M	A+E STAFF MEMBER CODE	

~~**CDS DATA GROUP: ATTENDANCE OCCURRENCE -Clinical Diagnosis Details - ICD:**~~
~~**To carry the details of the Diagnosis Code Scheme and the Diagnoses.**~~
~~**One occurrence of this Group is permitted.**~~

COMMISSIONING DATA SET DATA GROUP: ATTENDANCE OCCURRENCE -Clinical Diagnosis Details - ICD:
To carry the details of the Diagnosis Code Scheme and the Diagnoses.
One occurrence of this Group is permitted.

O	DIAGNOSIS SCHEME IN USE	
O	PRIMARY DIAGNOSIS (ICD)	
O	SECONDARY DIAGNOSIS (ICD) Multiple Secondary Diagnoses may be recorded.	

~~**CDS DATA GROUP: ATTENDANCE OCCURRENCE - Clinical Diagnosis Details - READ:**~~
~~**To carry the details of the Diagnosis Code Scheme and the Diagnoses.**~~
~~**One occurrence of this Group is permitted.**~~

COMMISSIONING DATA SET DATA GROUP: ATTENDANCE OCCURRENCE - Clinical Diagnosis Details - READ:
To carry the details of the Diagnosis Code Scheme and the Diagnoses.
One occurrence of this Group is permitted.

O	DIAGNOSIS SCHEME IN USE	
O	PRIMARY DIAGNOSIS (READ)	
O	SECONDARY DIAGNOSIS (READ) Multiple Secondary Diagnoses may be recorded.	

~~**CDS DATA GROUP: ATTENDANCE OCCURRENCE - Clinical Diagnosis Details - A + E Coded:**~~
~~**To carry the details of the Diagnosis Code Scheme and the Diagnoses.**~~
~~**One occurrence of this Group is permitted.**~~

COMMISSIONING DATA SET DATA GROUP: ATTENDANCE OCCURRENCE - Clinical Diagnosis Details - A + E Coded:
To carry the details of the Diagnosis Code Scheme and the Diagnoses.
One occurrence of this Group is permitted.

M	DIAGNOSIS SCHEME IN USE	
M	ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST	
M	ACCIDENT AND EMERGENCY DIAGNOSIS - SECOND Multiple Secondary Diagnoses may be recorded.	

~~**CDS DATA GROUP: ATTENDANCE OCCURRENCE - Clinical Investigation Details - A + E:**~~
~~**To carry the details of the Investigation Code Scheme and the Investigations undertaken.**~~
~~**Multiple occurrences of this Group are permitted.**~~

COMMISSIONING DATA SET DATA GROUP: ATTENDANCE OCCURRENCE - Clinical Investigation Details - A + E:
To carry the details of the Investigation Code Scheme and the Investigations undertaken.

Multiple occurrences of this Group are permitted.		
M	INVESTIGATION SCHEME IN USE	
M	ACCIDENT AND EMERGENCY INVESTIGATION - FIRST	
M	ACCIDENT AND EMERGENCY INVESTIGATION - SECOND Multiple Secondary Investigations may be recorded.	
~~CDS DATA GROUP: ATTENDANCE OCCURRENCE - Clinical Activity / Treatment Group (OPCS): To carry the details of the OPCS coded Clinical Activities and Treatments undertaken. One occurrence of this Group is permitted.~~		
COMMISSIONING DATA SET DATA GROUP: ATTENDANCE OCCURRENCE - Clinical Activity / Treatment Group (OPCS): To carry the details of the OPCS coded Clinical Activities and Treatments undertaken. One occurrence of this Group is permitted.		
O	PROCEDURE SCHEME IN USE	
O O	PRIMARY PROCEDURE (OPCS) PROCEDURE DATE (of Primary Procedure)	
 O O	(Multiple occurrences of this sub-group may be recorded) PROCEDURE (OPCS) PROCEDURE DATE (of Secondary Procedure)	
~~CDS DATA GROUP: ATTENDANCE OCCURRENCE - Clinical Activity / Treatment Group (READ): To carry the details of the READ coded Clinical Activities and Treatments undertaken. One occurrence of this Group is permitted.~~		
COMMISSIONING DATA SET DATA GROUP: ATTENDANCE OCCURRENCE - Clinical Activity / Treatment Group (READ): To carry the details of the READ coded Clinical Activities and Treatments undertaken. One occurrence of this Group is permitted.		
O	PROCEDURE SCHEME IN USE	
O O	PRIMARY PROCEDURE (READ) PROCEDURE DATE (of Primary Procedure)	
 O O	(Multiple occurrences of this sub-group may be recorded) PROCEDURE (READ) PROCEDURE DATE (of Secondary Procedure)	
~~CDS DATA GROUP: ATTENDANCE OCCURRENCE - Clinical Activity / Treatment Group (A + E): To carry the details of the A + E coded Clinical Activities and Treatments undertaken. One occurrence of this Group is permitted.~~		
COMMISSIONING DATA SET DATA GROUP: ATTENDANCE OCCURRENCE - Clinical Activity / Treatment Group (A + E): To carry the details of the A + E coded Clinical Activities and Treatments undertaken. One occurrence of this Group is permitted.		
M	PROCEDURE SCHEME IN USE	
M M	ACCIDENT AND EMERGENCY TREATMENT - FIRST PROCEDURE DATE (of First Treatment)	
 M M	(Multiple occurrences of this sub-group may be recorded) ACCIDENT AND EMERGENCY TREATMENT - SECOND PROCEDURE DATE (of Subsequent Treatments)	
~~CDS DATA GROUP: CDS DATA GROUP: HEALTHCARE RESOURCE GROUP - Activity Characteristics: To carry the details of the Healthcare Resource Group.~~		
COMMISSIONING DATA SET DATA GROUP: HEALTHCARE RESOURCE GROUP - Activity Characteristics: To carry the details of the Healthcare Resource Group.		
M	HEALTHCARE RESOURCE GROUP CODE	
M	HEALTHCARE RESOURCE GROUP CODE-VERSION NUMBER	
~~CDS DATA GROUP: Healthcare Resource Group Activity - Clinical Activity Group: To carry the details of the HRG Dominant Grouping Variable - Procedure. Note that this will not apply when no operation was carried out. In this case, the segment referring to HRG Dominant Grouping Variable - Procedure should be omitted.~~		
COMMISSIONING DATA SET DATA GROUP: Healthcare Resource Group Activity - Clinical Activity Group:		

To carry the details of the Healthcare Resource Group Dominant Grouping Variable - Procedure. Note that this will not apply when no operation was carried out. In this case, the segment referring to Healthcare Resource Group Dominant Grouping Variable - Procedure should be omitted.		
O	PROCEDURE SCHEME IN USE	
O	HRG DOMINANT GROUPING VARIABLE-PROCEDURE	

Note:
~~In addition, Accident and Emergency reference costs are mandated and collected via a direct data flow between Providers and the Department of Health.~~In addition, Accident and Emergency reference costs are mandated and collected via a direct data flow between Providers and the Department of Health.

COVER 1

Change to Central Return Form: Change to Guidance Text

COVER - Request Parameters for Hepatitis B Vaccination data

Contextual Overview

1. ~~The Department of Health requires annual information on childhood immunisations to support performance indicators and benchmark indicators.~~

1. The Department of Health requires annual information on childhood immunisations to support performance indicators and benchmark indicators.

2. The performance indicators and benchmark indicators will be published routinely on the Department of Health Website - Statistics.

3. Information provided by COVER together with supplementary data collected on KC50 is published annually in the Health and Social Care Information Centre statistical bulletin: NHS Immunisation Statistics, England.

Completing the return COVER - Request Parameters for COVER data

4. The return is required from Primary Care Trusts for children in their responsible population, i.e.

   - all children registered with a GENERAL PRACTITIONER whose practice forms part of the Primary Care Trust, regardless of where the child is resident, plus
   - any children not registered with a GENERAL PRACTITIONER, who are resident within the Primary Care Trust's statutory geographical boundary.

   Children resident within the Primary Care Trust geographical area, who are registered with a GENERAL PRACTITIONER belonging to another Primary Care Trust, should be returned by that GENERAL PRACTITIONER's Primary Care Trust.

5. The return is required to be submitted quarterly to the Health Protection Agency Centre for Infections, who then forward annual data to the Department of Health.

6. The information necessary for COVER may be submitted as a computer output page containing the relevant data, which should be returned within two months of the end of the quarter to which it relates.

7. The COVER data provides the immunisation status of three cohorts of children, aged 12 months, 24 months, and 5 years.

Request 1: 12 MONTH COHORT

1. The total number of children for whom the Primary Care Trust is responsible on dd/mm/yyyy reaching their 1st birthday during the evaluation quarter.

8. This is the total number of children in the 12 month cohort, i.e. the number of children within the Primary Care Trust's responsible population at the REPORTING PERIOD END DATE who reached the age of one during the REPORTING PERIOD.

2. Total number included in line 1 completing a primary course at any time up to their 1st birthday for each of the listed diseases.

9. This is a count of the number of Immunisation Programmes For Person for children in the 12 month cohort, with an Immunisation Completion Date for an IMMUNISATION COURSE TYPE classification of primary up to the child's first birthday for particular VACCINE PREVENTABLE DISEASES. The VACCINE

PREVENTABLE DISEASES currently reported are Diphtheria, Pertussis, Tetanus, Polio, Haemophilus influenzae type b (Hib), Group C meningococcal disease (MenC), MMR and Pneumococcal (Pnc).

Immunisation Programme For Person is a PATIENT's involvement as a subject of a HEALTH PROGRAMME where the HEALTH PROGRAMME is a HEALTH PROGRAMME TYPE of National Code 08 '*Planned Immunisation Programme for neonates and schoolchildren*'. Immunisation Dose Given is a CLINICAL INTERVENTION where CLINICAL INTERVENTION TYPE is National Code 17 '*Immunisation Dose Given*'. Immunisation Completion Date is the same as attribute ACTIVITY DATE where ACTIVITY DATE TIME TYPE is National Code 35 '*Immunisation Completion Date*'.

Request 2: 24 MONTH COHORT

3. The total number of children for whom the Primary Care Trust is responsible on dd/mm/yyyy reaching their 2nd birthday during the evaluation quarter.

10. This is the total number of children in the 24 month cohort, i.e. the number of children within the Primary Care Trusts responsible population at the REPORTING PERIOD END DATE who reached the age of two during the REPORTING PERIOD.

4. Total number included in line 3 completing a primary course at any time up to their 2nd birthday for each of the listed diseases.

11. This is a count of the number of Immunisation Programmes For Person for children in the 24 month cohort, with an Immunisation Completion Date for an IMMUNISATION COURSE TYPE classification of *primary* up to the child's second birthday for particular VACCINE PREVENTABLE DISEASES. The VACCINE PREVENTABLE DISEASES currently reported are Diphtheria, Pertussis, Tetanus, Polio, Haemophilus influenzae type b (Hib), Group C meningococcal disease (MenC), MMR, Pneumococcal (Pnc) and Haemophilus influenzae type b/Group C meningococcal disease (Hib/MenC).

    Immunisation Programme For Person is a PATIENT's involvement as a subject of a HEALTH PROGRAMME where the HEALTH PROGRAMME is a HEALTH PROGRAMME TYPE of National Code 08 '*Planned Immunisation Programme for neonates and schoolchildren*'. Immunisation Dose Given is a CLINICAL INTERVENTION where CLINICAL INTERVENTION TYPE is National Code 17 '*Immunisation Dose Given*'. Immunisation Completion Date is the same as attribute ACTIVITY DATE where ACTIVITY DATE TIME TYPE is National Code 35 '*Immunisation Completion Date*'.

12. For booster courses this is a count of the number of Immunisation Programmes For Person for children in the 24 month cohort, with an Immunisation Completion Date for an IMMUNISATION COURSE TYPE classification of *booster* up to the PERSON's second birthday for particular VACCINE PREVENTABLE DISEASES. The VACCINE PREVENTABLE DISEASES currently reported are Pneumococcal (Pnc) and Haemophilus influenzae type b/Group C meningococcal disease (Hib/MenC).

Request 3: 5 YEAR COHORT

5. The total number of children for whom the Primary Care Trust is responsible on dd/mm/yyyy reaching their 5th birthday during the evaluation quarter.

13. This is the total number of children in the 5 year cohort, i.e. the number of children within the Primary Care Trust's responsible population at the REPORTING PERIOD END DATE who reached the age of five during the REPORTING PERIOD.

6. Total number included in line 5 completing a primary course at any time up to their 5th birthday and also total number included in line 5 receiving boosters for each of the listed diseases.

14. This is a count of the number of Immunisation Programmes For Person for children in the 5 year cohort, with an Immunisation Completion Date for an IMMUNISATION COURSE TYPE classification of primary up to the PERSON's fifth birthday for particular VACCINE PREVENTABLE DISEASES. The VACCINE

PREVENTABLE DISEASES currently reported are Diphtheria, Pertussis, Tetanus, Polio, Haemophilus influenzae type b (Hib), Group C meningococcal disease (MenC), and MMR, Pneumococcal (Pnc) and Haemophilus influenzae type b/Group C meningococcal disease (Hib/MenC).

15. For booster courses this is a count of the number of Immunisation Programmes For Person for children in the 5 year cohort, with an Immunisation Completion Date for an IMMUNISATION COURSE TYPE classification of booster up to the PERSON's fifth birthday for particular VACCINE PREVENTABLE DISEASES. The VACCINE PREVENTABLE DISEASES currently reported are Pneumococcal (Pnc) and Haemophilus influenzae type b/Group C meningococcal disease (Hib/MenC).

KA34 1

Change to Central Return Form: Change to Guidance Text

KA34: Ambulance Services

Contextual Overview

1. ~~The Department requires summary details from NHS Health Care Providers on ambulance activity. The return provides performance management measures of response time; these are also required by trusts for ambulance service internal monitoring and for defining service agreements.~~

1. The Department of Health requires summary details from NHS Health Care Providers on ambulance activity. The return provides performance management measures of response time; these are also required by trusts for ambulance service internal monitoring and for defining service agreements.

2. The information originally monitored: '*Your guide to the NHS*' targets and the standards introduced following a review of ambulance performance standards in 1996-97. The standards required that, by 2001, all ambulance services would be expected to reach 75% of immediately life-threatening calls within 8 minutes, with further progress thereafter.

3. The information is required to inform strategic policy development, to provide data to the Healthcare Commission for performance and activity assessment, to ensure that Spending Review bids reflect changes to overall demand and to inform the development of ambulance trust reference costs.

4. Information based on the return is published annually in the Department of Health Statistical Bulletin *'Ambulance services; England'*.

~~Completing Return ka34 1~~
Completing Return KA34: Ambulance Services

5. The central return KA34 is completed by NHS Health Care Providers - Trusts providing an Ambulance Service.

   An Ambulance Service is a type of ORGANISATION providing organisational arrangements for provision of PATIENT transport services.

6. The return KA34 relates to activity taking place over a 12 month period, between 1 April of one year and 31 March of the following year. The return is made annually and submitted within one month of the end of the year to which it relates. For the year 2004/05 changes were introduced mid-year; the first 6 months collect information on Emergency Calls Category B & C together while the second 6 months collect information on Category B & C separately. Subsequent years collect information on Emergency Calls Category B & C separately throughout the year.

7. The return requires the ORGANISATION CODE and ORGANISATION NAME of the NHS Ambulance Trust - the NHS Health Care Provider of the Ambulance Service.

8. The return requires information on:

   a. **Emergency Calls:**
      The following are subdivided by Category A, B & C.
      i. Total number of emergency calls received in the year;
      ii. The number of calls that resulted in an emergency response arriving at the scene of the incident;
      iii. The number of calls that resulted in an emergency response arriving at the scene of the

incident within 8 minutes (from 1 October 2004 this is no longer required for Category C calls);

iv. The number of calls where following the arrival of an emergency response no ambulance is required;

~~v. The number of calls that resulted in an ambulance able to transport a patient arriving at the scene of the incident (from 1 October 2004 this is no longer required for Category C calls);~~

v. The number of calls that resulted in an ambulance able to transport a PATIENT arriving at the scene of the incident (from 1 October 2004 this is no longer required for Category C calls);

~~vi. The number of calls that resulted in an ambulance able to transport a patient arriving at the scene of the incident within specified urban or rural target response times (from 1 October 2004 this is no longer required for Category C calls).~~

vi. The number of calls that resulted in an ambulance able to transport a PATIENT arriving at the scene of the incident within specified urban or rural target response times (from 1 October 2004 this is no longer required for Category C calls).

b. **Patient Journeys: Emergency:**

i. Total number of emergency PATIENT TRANSPORT JOURNEYS sub-divided by Categories A, B & C.

c. **Patient Journeys: Urgent:**

~~i. Total number of urgent patient journeys~~

i. Total number of urgent PATIENT journeys

ii. Arrival time in relation to requested arrival time: number not more than 15 minutes late

d. **Patient Journeys: Non-Urgent:**

i. Total number of special or planned journeys

KC50 1

Change to Central Return Form: Change to Guidance Text

KC50 - Immunisation Programmes Activity

Contextual Overview

1. ~~The Department and Regional Offices require summary details from NHS Health Care Providers to monitor Immunisation Programme activity in their areas. This information is normally available through the Child Health computer system.~~

1. The Department of Health and Regional Offices require summary details from NHS Health Care Providers to monitor Immunisation Programme activity in their areas. This information is normally available through the Child Health computer system.

2. Immunisation Programmes are programmes to deliver services within a 'structured framework' to a defined target population, planned by the Department of Health and implemented by Health Authorities which are aimed at maintaining an adequate level of immunisation in a population against a specific VACCINE PREVENTABLE DISEASE, such as diphtheria or tuberculosis, by a determined sequence of immunisation courses which can be primary, first booster, second booster, etc.

3. National targets for all vaccines in the recommended childhood schedule have been set at 95%, as detailed in the National Priorities Guidance Undercutting Health Inequalities. The KC50 return monitors progress of the childhood immunisation programme.

4. Information based on the return is also used in Public Expenditure Survey (PES) negotiations and resource allocation to the NHS.

5. Information about uptake of immunisation, formerly on the KC51 return, is collected through the `COVER' (cover of vaccination evaluated rapidly) returns made to the Communicable Disease Surveillance Centre (CDSC). From April 1999 uptake of all primary and booster pre-school immunisation is being monitored through COVER.

6. The KC50 return relates to school leaver immunisation and also to BCG testing and vaccination, as these aspects of the immunisation programme are not at present available through the COVER system.

7. Information based on the return will be published annually in a Department of Health Statistical Bulletin `*Vaccination and Immunisation Programmes; England'*.

Completing Return kc50 1

8. ~~The central return KC50 is completed by NHS Health Care Providers - NHS Trusts. These are asked to ensure that all immunisation activity in their area is recorded, including that provided by GP in addition to the NHS Trusts own provision of immunisation, if any. If problems are encountered in obtaining immunisation data from GP, this should be indicated on the return. The NHS Trust which manages the Child Health System should be responsible for liaising if necessary with neighbouring NHS Trust to ensure full coverage and avoid duplication. If full coverage cannot be provided, this should be indicated on the return.~~

8. The central return KC50 is completed by NHS Health Care Providers - NHS Trusts. These are asked to ensure that all immunisation activity in their area is recorded, including that provided by GENERAL PRACTITIONER in addition to the NHS Trusts own provision of immunisation, if any. If problems are encountered in obtaining immunisation data from GENERAL PRACTITIONER, this should be indicated on the return. The NHS Trust which manages the Child Health System should be responsible for liaising if

necessary with neighbouring NHS Trust to ensure full coverage and avoid duplication. If full coverage cannot be provided, this should be indicated on the return.

9. The KC50 return relates to activity taking place over a 12 month period, between 1 April of one year and 31 March of the following year. The return is made annually and submitted within two months of the end of the year to which it relates.

10. KC50 requires the ORGANISATION CODE and ORGANISATION NAME of the NHS Health Care Provider as well as the name of a contact and the contact telephone number on the front page. The ORGANISATION CODES is repeated at the bottom of each sheet.

KC60 1A

Change to Central Return Form: Change to Guidance Text

Contextual Overview

1. ~~The Department of Health (DH) requires information on services provided by Genitourinary Medicine Clinics (GUMs) and this information is collected on the DH central return form KC60.~~

1. The Department of Health requires information on services provided by Genitourinary Medicine Clinics and this information is collected on the Department of Health central return form KC60.

2. ~~The KC60 statistical return provides essential public health information about Sexually Transmitted Infection (STI) diagnoses and services provided by GUM clinics. The information provides key data to help monitor important standards in the Sexual Health and HIV Strategy.~~

2. The KC60 statistical return provides essential public health information about Sexually Transmitted Infection (STI) diagnoses and services provided by Genitourinary Medicine Clinics. The information provides key data to help monitor important standards in the Sexual Health and HIV Strategy.

3. The Minimum Data Set to support the monitoring and implementation of the Sexual Health and HIV Strategy, is currently being developed and a staged roll-out of this enhanced surveillance programme will commence during 2003; however, the dataset is not likely to be fully implemented across all GUM clinics before January 2005. The KC60 central return form collects information to allow for the interim monitoring of HIV testing standards and goals, and to allow for the collection of more precise information about individual infections and screening.

4. Summary information about Genitourinary Medicine Clinic services based on the KC60 return, is published by the Communicable Disease Surveillance Centre (CDSC) each year.

Completing the KC60 Central Return Form - Guidance
Part A - Initial contacts in the quarter - Lines: 01 - 44

5. This section of KC60 records the Initial Contacts in the quarter for the diagnosis and/or treatment of an infection or disease, during a Genitourinary Episode.

   Initial Contact is the first face to face CARE CONTACT occasion on which a PATIENT is seen. Genitourinary Episode is an ACTIVITY GROUP where the ACTIVITY GROUP TYPE is National Code 18 '*Genitourinary Episode*'.

6. A Genitourinary Episode being a period of time during which a PATIENT attends a Consultant Clinic or a Nurse Clinic for a Genitourinary problem.

   Consultant Clinic and Nurse Clinic are both types of a CLINIC OR FACILITY.

7. Each Genitourinary Episode is for **one** GENITOURINARY EPISODE TYPE, the type being the medical condition or reason for that Genitourinary Episode.

8. Collection of information on a male PATIENT SEXUAL ORIENTATION, is required information against specific conditions/episodes (within Part-A). SEXUAL ORIENTATION identifies those male PATIENTS who are homo/bisexual.

9. The following guidance note is from DSCN 05/2003 and explains why a change of wording was required leading to the replacement of "Of which were homosexually acquired" with "Of which were homo/bisexual": DSCN 05/2003: This change has been introduced because 'Of which were homosexually acquired' was inappropriate for codes referring to epidemiological treatment, HIV testing, hepatitis B

vaccination and sexual health screening. There was evidence that this field was poorly completed for these codes using the previous definition. It is recognised that the meaning of this field has been changed (as below).

10. *NB. If information is not available, please enter "Nil" in the appropriate boxes of the form.*

Part A - Services Provided - Lines: 45 - 51

11. The 'Services provided' section is to be used to code PATIENT receiving services or undergoing tests. For example, if a PATIENT is offered a sexual health screen he/she would be coded *S1* or *S2* in the 'Services provided' section (see lines 45 and 46 below). If, as a result of that screen, a chlamydial infection was found, he/she would also be coded C4A/C4C in the 'Diagnosis and/or treatment of infection or disease' section. If, following the screen, no infections were found, the PATIENT would be coded S1 or S2 and D3.

Diagnosis and/or treatment of infection or disease
Line 01: Primary and Secondary Infectious syphilis: A1 & A2

12. This refers to primary and secondary infectious syphilis.

13. *Male Total* column:* Record here the total number of males diagnosed/treated for A1, A2

14. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

15. *Female Total Column:* Record here the total number of females diagnosed/treated for A1, A2

Line 02: Early Latent Syphilis (first 2 years): A3

16. This refers to latent syphilis in the first two years of infection.

17. *Male Total* column:* Record here the total number of males diagnosed/treated for A3

18. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

19. *Female Total column:* Record here the total number of females diagnosed/treated for A3

Line 03: Other acquired syphilis: A4, A5 & A6

20. This refers to latent syphilis after the first two years of infection, cardiovascular syphilis, syphilis of the nervous system and all other latent syphilis. The PATIENT is only coded once in this category in the UK, i.e. the PATIENT is not given this code again unless after having been diagnosed as a case of late latent syphilis.
    Therefore, PATIENTS attending for routine follow up of say, latent syphilis, are not recorded in this category; and if they attend another clinic elsewhere in the country, they are not to be coded as A4, A5, A6.

21. *Male Total* column:* Record here the total number of males diagnosed/treated for A4, A5, A6

22. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

23. *Female Total column:* Record here the total number of females diagnosed/treated for A4, A5, A6

Line 04: Congenital syphilis, aged under 2: A7

24. *Male Total column:* Record here the total number of males diagnosed/treated for A7

25. *Female Total column:* Record here the total number of females diagnosed/treated for A7

Line 05: Congenital syphilis, aged 2 or over: A8

26. *Male Total column:* Record here the total number of males diagnosed/treated for A8

27. *Female Total column:* Record here the total number of females diagnosed/treated for A8

Line 06: Epidemiological treatment of suspected syphilis: A9

28. This should include **all** cases where syphilis has not been confirmed, but epidemiological treatment is prescribed because the index PATIENT (the partner) was found to be syphilis positive.

29. *Male Total* column:* Record here the total number of males diagnosed/treated for A9

30. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

31. *Female Total column:* Record here the total number of females diagnosed/treated for A9

Line 07: Uncomplicated gonorrhoea: B1, B2

32. This includes all cases of uncomplicated gonorrhoea of the lower genitourinary tract, anorectum, mouth, throat and adult conjunctivitis:

    Persistent/recurrent gonorrhoea:

    a) Treatment failures should not be given a new diagnosis
    b) PATIENTS who are thought to be re-infected should be regarded as new cases, and be investigated, treated and be diagnosed/coded accordingly.

33. *Male Total* column:* Record here the total number of males diagnosed/treated for B1, B2

34. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

35. *Female Total column:* Record here the total number of females diagnosed/treated for B1, B2

Line 08: Gonococcal ophthalmia neonatorum: B3

36. *Male Total column:* Record here the total number of males diagnosed/treated for B3

37. *Female Total column:* Record here the total number of females diagnosed/treated for B3

Line 09: Epidemiological treatment of suspected gonorrhoea: B4

38. This should include **all** cases where gonorrhoea has not been confirmed, but where epidemiological treatment has been prescribed because the index PATIENT (the partner) was found to be infected with gonorrhoea.

39. *Male Total* column:* Record here the total number of males diagnosed/treated for B4

40. **of which homo/bisexual column:* Record here the number of males from the male total column who are

homo/bisexual

41. *Female Total column:* Record here the total number of females diagnosed/treated for B4

Line 10: Complicated gonococcal infection - including PID and epididymitis: B5

42. This includes **all** cases of complicated gonorrhoea e.g. upper genitourinary tract complications (such as pelvic inflammatory disease and epididymitis), and systemic complications.

43. Where a PATIENT has complications that are associated with both gonococcal and chlamydial infections, the patient should be included in B5 (line 10) and in C4B (line 13).

44. *Male Total* column:* Record here the total number of males diagnosed/treated for B5

45. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

46. *Female Total column:* Record here the total number of females diagnosed/treated for B5

Line 11: Chancroid/LGV/Donovanosis: C1, C2 & C3

47. Specific confirmation is advisable for each of these conditions.

48. *Male Total column:* Record here the total number of males diagnosed/treated for C1, C2, C3

49. *Female Total column:* Record here the total number of females diagnosed/treated for C1, C2, C3

Line 12: Uncomplicated Chlamydial Infection: C4A & C4C

50. This includes **all** cases of uncomplicated chlamydial infections (diagnosed by culture or antigen detection) involving the lower genitourinary tract, and adult conjunctivitis.

51. Persistent/recurrent Chlamydia:

    a) Treatment failures should <u>not</u> be given a new diagnosis
    b) PATIENTS who are thought to be re-infected should be regarded as new cases, and be investigated, treated and diagnosed/coded accordingly.

52. *Male Total* column:* Record here the total number of males diagnosed/treated for C4A, C4C

53. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

54. *Female Total column:* Record here the total number of females diagnosed/treated for C4A, C4C

Line 13: Complicated Chlamydial infection - including PID and epididymitis: C4B

55. This includes **all** cases of complicated chlamydial infections, e.g. upper genitourinary tract complications (such as pelvic inflammatory disease and epididymitis), perihepatitis and arthritis. Diagnosis may be based on culture, antigen detection or high MIF titre.

56. Where a PATIENT has complications that are associated with both gonococcal and chlamydial infections, the PATIENT should be included in B5 (line 10) and in C4B (line 13).

57. *Male Total* column:* Record here the total number of males diagnosed/treated for C4B

58. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

59. *Female Total column:* Record here the total number of females diagnosed/treated for C4B

Line 14: Chlamydia ophthalmia neonatorum: C4D

60. *Male Total* column:* Record here the total number of males diagnosed/treated for C4D

61. *Female Total column:* Record here the total number of females diagnosed/treated for C4D

Line 15: Epidemiological treatment of suspected Chlamydia: C4E

62. This should include **all** cases where chlamydia has <u>not</u> been confirmed, but where epidemiological treatment has been prescribed because the index PATIENT (the partner) was found to be chlamydia positive. If a male partner presents as a contact of C4A (line 12) and has non-specific urethritis, he should be coded as C4H only and <u>not</u> C4E.

63. *Male Total* column:* Record here the total number of males diagnosed/treated for C4E

64. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

65. *Female Total column:* Record here the total number of females diagnosed/treated for C4E

Line 16: Uncomplicated non-gonococcal/non-specific urethritis in males or treatment of mucopurulent cervicitis in females: C4H

66. In males, this is diagnosed in the absence of gonorrhoea and laboratory confirmed chlamydia and the presence of polymorphononuclear leucocytes at >5 per high power field. Also, if a male partner presents as a contact of C4A (line 12) and has non-specific urethritis, he should be coded as C4H only and <u>not</u> C4E.

    Females being treated for non-specific mucopurulent cervicitis are also to be coded C4H.

67. Persistent/recurrent urethritis:

    a) Treatment failures should <u>not</u> be given a new diagnosis
    b) PATIENTS who are thought to be re-infected should be regarded as new cases, and be investigated, treated and diagnosed/coded accordingly

68. *Male Total* column:* Record here the total number of males diagnosed/treated for C4H

69. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

70. *Female Total column:* Record here the total number of females diagnosed/treated for C4H

Line 17: Epidemiological treatment of NSGI: C4I

71. This diagnosis is used for either males or females; e.g. the female would be diagnosed as C4I if she tested negative for gonorrhoea and chlamydia and is treated because her partner has been diagnosed with uncomplicated or complicated non-specific infection (C4H-line 16, or C5-line 18).

72. Similarly, the male partner is diagnosed as C4I if he tested negative for gonorrhoea and chlamydia, and is

treated because the female partner has been diagnosed as C4H (line 16) or C5 (line 18).

73. *Male Total* column:* Record here the total number of males diagnosed/treated for C4I

74. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

75. *Female Total column:* Record here the total number of females diagnosed/treated for C4I

Line 18: Complicated infection (non-chlamydial/non-gonococcal) - including PID and epididymitis: C5

76. This includes **all** cases of complicated non-specific infections requiring treatment and negative tests for gonorrhoea and chlamydia, e.g. upper genitourinary tract complications (such as pelvic inflammatory disease and epididymitis), prostatitic and arthritis.

77. *Male Total* column:* Record here the total number of males diagnosed/treated for C5

78. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

79. *Female Total column:* Record here the total number of females diagnosed/treated for C5

Line 19: Trichomoniasis: C6A

80. If associated with bacterial vaginosis, then code C6A only should be used.

81. *Male Total column:* Record here the total number of males diagnosed/treated for C6A

82. *Female Total column:* Record here the total number of females diagnosed/treated for C6A

Line 20: Anaerobic/Bacterial vaginosis & Anaerobic balanitis: C6B

83. Diagnosis of bacterial vaginosis is generally based on microscopy, pH vaginal fluid and the amine test. This diagnosis is very rarely appropriate in males and used only if the PATIENT has confirmed anaerobic balanitis. Other and non-confirmed and anaerboric balanitis, should be coded as C6C. Asymptomatic PATIENTS who do not require treatment should be coded C6B.

84. *Male Total column:* Record here the total number of males diagnosed/treated for C6B

85. *Female Total column:* Record here the total number of females diagnosed/treated for C6B

Line 21: Other vaginosis/vaginitis/balanitis: C6C

86. *Male Total column:* Record here the total number of males diagnosed/treated for C6C

87. *Female Total column:* Record here the total number of females diagnosed/treated for C6C

Line 22: Anogenital candidosis: C7A

88. This is diagnosed only when there is microscopic or culture evidence of Candida infection. Asymptomatic PATIENTS who do not require treatment should not be coded C7A.

89. *Male Total column:* Record here the total number of males diagnosed/treated for C7A

90. *Female Total column:* Record here the total number of females diagnosed/treated for C7A

Line 23: Epidemiological treatment of C6 & C7: C7B

91. This should include all cases where C6 and C7 have not been confirmed, but where epidemiological treatment has been prescribed.

92. *Male Total column:* Record here the total number of males diagnosed/treated for C6, C7, C7B

93. *Female Total column:* Record here the total number of females diagnosed/treated for C6, C7, C7B

Line 24: Scabies/pediculosis pubis: C8 & C9

94. This includes cases treated on either a clinical or epidemiological basis.

95. *Male Total* column:* Record here the total number of males diagnosed/treated for C8 & C9

96. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

97. *Female Total column:* Record here the total number of females diagnosed/treated for C8 & C9

Line 25: Anogenital herpes simplex: first attack: C10A

98. An episode should be recorded here only if the PATIENT has never (as far as can be ascertained) been previously diagnosed with anogenital herpes at any Genitourinary Medicine (GUM) clinic. Laboratory confirmation is essential.

99. *Male Total* column:* Record here the total number of males diagnosed/treated for C10A

100. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

101. *Female Total column:* Record here the total number of females diagnosed/treated for C10A

Line 26: Anogenital herpes simplex: recurrence: C10B

102. This should include **all** other episodes of anogenital herpes. If there has been previous confirmation, then clinical judgement is enough for this diagnosis.

103. *Male Total* column:* Record here the total number of males diagnosed/treated for C10B

104. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

105. *Female Total column:* Record here the total number of females diagnosed/treated for C10B

Line 27: Anogenital warts: first attack: C11A

106. An episode should be recorded here only if the PATIENT has never (as far as can be ascertained) been previously treated for anogenital warts at any GUM clinic.

107. C11A diagnosis refers to macroscopic warts, not acetowhite patches or abnormalities revealed by acetowhite staining, nor is the cytological finding of wart virus change sufficient to use this code.

108. *Male Total* column:* Record here the total number of males diagnosed/treated for C11A

109. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

110. *Female Total column:* Record here the total number of females diagnosed/treated for C11A

Line 28: Anogenital warts: recurrence: C11B

111. This should include PATIENTS in whom warts reappeared after a wart-free interval of at least 3 months.

112. C11B diagnosis refers to macroscopic warts, not acetowhite patches or abnormalities revealed by acetowhite staining, nor is the cytological finding of wart virus change sufficient to use this code.

113. *Male Total* column:* Record here the total number of males diagnosed/treated for C11B

114. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

115. *Female Total column:* Record here the total number of females diagnosed/treated for C11B

Line 29: Anogenital warts: re-registered cases: C11C

116. This is to be used for a PATIENT previously diagnosed as C11A or C11B in whom warts persist and treatment continues for longer than three months, or which recur within 3 months of apparent eradication. This code is not to be re-entered for the same patient more than once every 3 months.

117. C11C diagnosis refers to macroscopic warts, not acetowhite patches or abnormalities revealed by acetowhite staining, nor is the cytological finding of wart virus change sufficient to use this code.

118. *Male Total column:* Record here the total number of males diagnosed/treated for C11C

119. *Female Total column:* Record here the total number of females diagnosed/treated for C11C

Line 30: Molluscum contagiosum: C12

120. *Male Total* column:* Record here the total number of males diagnosed/treated for C12

121. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

122. *Female Total column:* Record here the total number of females diagnosed/treated for C12

Line 31: Viral hepatitis B (HbsAg positive): first diagnosis**: C13A

123. C13 has been divided into 3 codes: C13A, C13B and C13C.

124. C13A records a first diagnosis of antigen positive hepatitis B.

125. *Male Total* column:* Record here the total number of males diagnosed/treated for C13A

126. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

127. *Female Total column:* Record here the total number of females diagnosed/treated for C13A

Line 32: **number of which were acute viral hepatitis B: C13B

128. C13B is a subset of C13A, so that a PATIENT coded C13B **must** also be coded C13A.

129. C13B records the number of first diagnoses of hepatitis B infections that were acute, where this is known. The definition of acute hepatitis B is newly identified HBsAg positive with anti-HBc 1gM positive (>200 iu/1) (MR) *or* discrete onset of jaundice or anicteric illness accompanied by deranged LFTs (AST / ALT> 2x normal range) accompanied by HBsAg and anti-HBc IgM positive.

130. *Male Total* column:* Record here the total number of males diagnosed/treated for C13B

131. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

132. *Female Total column:* Record here the total number of females diagnosed/treated for C13B

Line 33: Viral hepatitis B: subsequent presentation: C13C

133. All subsequent presentations of hepatitis B that require management, or known carriers of hepatitis B who present at a clinic for the first time, are to be coded as C13C. *Subsequent attendances* by carriers that are unrelated to hepatitis B management should not be coded as C13C.

134. *Male Total* column:* Record here the total number of males diagnosed/treated for C13C

135. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

136. *Female Total column:* Record here the total number of females diagnosed/treated for C13C

Line 34: Viral hepatitis C: first diagnosis: C14

137. This code was changed from recording any other viral hepatitis to first diagnosis of hepatitis C only. The definition given in these guidelines are "Hepatitis C: anti-HCV positive or HRC RNA positive". All other hepatitis diagnoses are now coded as D2B/D3.

138. *Male Total* column:* Record here the total number of males diagnosed/treated for C14

139. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

140. *Female Total column:* Record here the total number of females diagnosed/treated for C14

Line 35: Urinary tract infection: D2A

141. *Male Total column:* Record here the total number of males diagnosed/treated for D2A

142. *Female Total column:* Record here the total number of females diagnosed/treated for D2A

Line 36: Other conditions requiring treatment at GUM clinic: D2B

143. *Male Total column:* Record here the total number of males diagnosed/treated for D2B

144. *Female Total column:* Record here the total number of females diagnosed/treated for D2B

Line 37: New HIV diagnosis: asymptomatic: E1A

145. This is a new HIV diagnosis in a PATIENT without symptoms who is not known to have been diagnosed at any GUM clinic. It **includes** PATIENTS with seroconversion illness. A PATIENT can receive this code only once and it is mutually **exclusive** of E2A (line 38) and E3A1 (line 40).

146. *Male Total* column:* Record here the total number of males diagnosed/treated for E1A

147. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

148. *Female Total column:* Record here the total number of females diagnosed/treated for E1A

Line 38: New HIV diagnosis: symptomatic (not AIDS): E2A

149. This is a new HIV diagnosis in a PATIENT with symptoms who is not known to have been diagnosed previously at any GUM clinic. It **excludes** PATIENTS with seroconversion illness (see code E1A). A PATIENT can receive E2A only once and it is mutually **exclusive** of E1A (line 37) and E3A1 (line 40).

150. *Male Total* column:* Record here the total number of males diagnosed/treated for E2A

151. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

152. *Female Total column:* Record here the total number of females diagnosed/treated for E2A

Line 39: Subsequent HIV presentation (not AIDS): E1B & E2B

153. Codes E1B and E2B have merged to become E1B/E2B (all subsequent presentations by a PATIENT who has been diagnosed with HIV previously). It **includes** asymptomatic (E1B) and symptomatic (E2B) PATIENTS, but **excludes** those with AIDS. The PATIENT should be given this code only once, during any quarterly period.

154. *Male Total column:* Record here the total number of males diagnosed/treated for E1B, E2B

155. *Female Total column:* Record here the total number of females diagnosed/treated for E1B, E2B

Line 40: AIDS: first presentation - new HIV diagnosis: E3A1

156. An AIDS diagnosis is used for HIV infected PATIENTS with one or more AIDS indicator diseases. It is necessary to discriminate between first AIDS presentations, that are also the first HIV diagnosis and those for which HIV was diagnosed previously. Therefore, E3A is divided into E3A1 and E3A2 (line 41).

157. E3A1 is a first presentation of AIDS, where HIV has not been diagnosed previously. The PATIENT (as far as can be ascertained) should not have been given an HIV or AIDS diagnosis at any clinic in the United Kingdom. This patient cannot be coded E1 or E2 ever again (E3A1 is mutually **exclusive** of E3A2).

158. *Male Total* column:* Record here the total number of males diagnosed/treated for E3A1

159. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

160. *Female Total column:* Record here the total number of females diagnosed/treated for E3A1

Line 41: AIDS: first presentation - HIV diagnosed previously: E3A2

161. E3A2 is a first presentation of AIDS where HIV has been diagnosed previously. The PATIENT (as far as can be ascertained) should not have been given an AIDS diagnoses at any clinic in the United Kingdom. This PATIENT cannot be coded E1 or E2 ever again. E3A2 is mutually **exclusive** of E3A1 (line 40).

162. *Male Total* column:* Record here the total number of males diagnosed/treated for E3A2

163. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

164. *Female Total column:* Record here the total number of females diagnosed/treated for E3A2

Line 42: AIDS: subsequent presentation: E3B

165. The PATIENT who has had an AIDS diagnosis at any time in the past, should be given this code only once during any quarterly period and cannot be coded E1, E2 or E3A ever again.

166. *Male Total* column:* Record here the total number of males diagnosed/treated for E3B

167. *Female Total column:* Record here the total number of females diagnosed/treated for E3B

Line 43: Cervical cytology: minor abnormality: P4A

168. This includes inflammatory smears, warts virus infection only, borderline changes and mild dyskaryosis.

169. *Female Total column:* Record here the total number of females diagnosed/treated for P4A

Line 44: Cervical cytology: major abnormality: P4B

170. This includes moderate or severe dyskaryosis, or worse.

171. *Female Total column:* Record here the total number of females diagnosed/treated for P4B

Services Provided

Line 45: Sexual health screen (no HIV antibody test): S1

172. S1 should only be used where a full sexual health screen is given (i.e. including gonorrhoea and chlamydia testing) and should not be used to record tests for recurrent candidosis/ bacterial vaginosis, etc. It will be used to count **all** PATIENTS who are given a sexual health screen **excluding** an HIV test. This may be because the PATIENT refuses or is not offered an HIV test. However, if the PATIENT is known to be HIV antibody positive, he/she can be coded S1 and one of E1B/E2B/E3A2/E3B - lines 39, 41, 42.

173. S1 is mutually exclusive of S2 (line 46) and P1A (line 47).

174. *Male Total* column:* Record here the total number of males seen by the *Service Provided*: S1

175. **of which homo/bisexual column:* Record here the number of males seen by the *Service Provided*: S1; who are homo/bisexual

176. *Female Total column:* Record here the total number of females seen by the *Service Provided*: S1

Line 46: HIV antibody test and sexual health screen: S2

177. This code will be used to count **all** PATIENTS who are given a sexual health screen **including** an HIV test. It should only be used where a full sexual health screen is given (i.e. including gonorrhoea and chlamydia testing) and should not be used to record tests for recurrent candidosis/ bacterial vaginosis, etc. If the patient tests positive for HIV antibody, then they would be coded S2, E1A (line 37).

178. S2 is mutually exclusive of S1 (line 45), P1A (line 47) and P1B (line 48).

179. *Male Total* column:* Record here the total number of males seen by the *Service Provided*: S2

180. **of which homo/bisexual column:* Record here the number of males seen by the *Service Provided*: S2; who are homo/bisexual

181. *Female Total column:* Record here the total number of females seen by the *Service Provided*: S2

Line 47: HIV antibody test (no sexual health screen): P1A

182. This code is re-defined to mean all HIV antibody testing done, regardless of whether counselling was given in PATIENTS who refuse or who are not offered a general sexual health screen. This code is mutually exclusive of S1 (line 45), S2 (line 46) and P1B (line 48).

183. *Male Total* column:* Record here the total number of males seen by the *Service Provided*: P1A

184. **of which homo/bisexual column:* Record here the number of males seen by the *Service Provided*: P1A; who are homo/bisexual

185. *Female Total column:* Record here the total number of females seen by the *Service Provided*: P1A

Line 48: HIV antibody test offered and refused: P1B

186. This code is redefined to mean all PATIENTS who are offered an HIV test, regardless of whether counselling was given, and who refuse the test. This code is mutually exclusive of S2 (line 46) and P1A (line 47).

187. *Male Total* column:* Record here the total number of males seen by the *Service Provided*: P1B

188. **of which homo/bisexual column:* Record here the number of males seen by the *Service Provided*: P1B; who are homo/bisexual

189. *Female Total:* Record here the total number of females seen by the *Service Provided*: P1B

Line 49: Hepatitis B vaccination (1st dose only): P2

190. Only the 1st dose of any new Hepatitis B vaccination course should be included. This would include those PATIENTS who have been vaccinated some time in the past, but who are now receiving the first dose of a new course of vaccination. Subsequent doses and boosters should be coded as D2B.

191. *Male Total* column:* Record here the total number of males seen by the *Service Provided*: P2

192. **of which homo/bisexual column:* Record here the number of males seen by the *Service Provided*: P2; who are homo/bisexual

193. *Female Total column:* Record here the total number of females seen by the *Service Provided*: P2

Line 50: Contraception (excluding condom provision): P3

194. This code will be used to record contraception (females only), including prescribing and family planning advice, and **excluding** condom provision. Condom provision should not be included on form KC60.

195. *Female Total:* Record here the total number of females seen by the *Service Provided*: P3

Line 51: Other Episodes:D3

196. D3 is used to code any new PATIENT episode where no treatment is given, whether or not a sexual health screen and/or an HIV test are/is performed. D3 can therefore be used to record an episode where a PATIENT tests negative for all tests done, or where testing the PATIENT is not indicated and otherwise no treatment is given. This code may also be used to record any other contact with a patient for clinical purposes, but which does not result in treatment. PATIENTS who do not attend appointments should not be coded D3, unless the PATIENT has been triaged and a set of new notes has been generated. D3 can be used only once per PATIENT episode.

197. *Male Total* column:* Record here the total number of males seen by the *Service Provided*: D3

198. *Female Total:* Record here the total number of females seen by the *Service Provided*: D3

Total Row: For all Conditions:

199. Male Total: Total for All Conditions: Record here the total initial contacts in the quarter for males, for **all** conditions

200. Of which homo/bisexual: Total for All Conditions: Record here the total males from the male total, who are homo/bisexual, for initial contacts in the quarter, for **all** conditions

201. Female Total: Total for All Conditions: Record here the total initial contacts in the quarter for females, for **all** conditions

KC60 1B

Change to Central Return Form: Change to Guidance Text

KC60 Central Return Form Guidance Text

Contextual Overview

1. ~~The Department of Health (DH) requires information on services provided by Genitourinary Medicine Clinics (GUMs) and this information is collected on the DH central return form KC60.~~

1. The Department of Health requires information on services provided by Genitourinary Medicine Clinics and this information is collected on the Department of Health central return form KC60.

2. ~~The KC60 statistical return provides essential public health information about Sexually Transmitted Infection (STI) diagnoses and services provided by GUM clinics. The information provides key data to help monitor important standards in the Sexual Health and HIV Strategy.~~

2. The KC60 statistical return provides essential public health information about Sexually Transmitted Infection (STI) diagnoses and services provided by Genitourinary Medicine Clinics. The information provides key data to help monitor important standards in the Sexual Health and HIV Strategy.

3. The Minimum Data Set to support the monitoring and implementation of the Sexual Health and HIV Strategy, is currently being developed and a staged roll-out of this enhanced surveillance programme will commence during 2003; however, the dataset is not likely to be fully implemented across all GUM clinics before January 2005. The KC60 central return form collects information to allow for the interim monitoring of HIV testing standards and goals, and to allow for the collection of more precise information about individual infections and screening.

4. Summary information about Genitourinary Medicine Clinic services based on the KC60 return, is published by the Communicable Disease Surveillance Centre (CDSC) each year.

Completing the KC60 Central Return Form - Guidance
Part A - Initial contacts in the quarter - Lines: 01 - 44

5. This section of KC60 records the Initial Contacts in the quarter for the diagnosis and/or treatment of an infection or disease, during a Genitourinary Episode.

   Initial Contact is the first face to face CARE CONTACT occasion on which a PATIENT is seen. Genitourinary Episode is an ACTIVITY GROUP where the ACTIVITY GROUP TYPE is National Code 18 '*Genitourinary Episode*'.

6. A Genitourinary Episode being a period of time during which a PATIENT attends a Consultant Clinic or a Nurse Clinic.

   Consultant Clinic and Nurse Clinic are both types of a CLINIC OR FACILITY.

7. Each Genitourinary Episode is for **one** GENITOURINARY EPISODE TYPE, the type being the medical condition or reason for that Genitourinary Episode.

8. Collection of information on a male PATIENTS SEXUAL ORIENTATION, is required information against specific conditions/episodes (within Part-A). SEXUAL ORIENTATION identifies those male PATIENTS who are homo/bisexual.

9. The following guidance note is from DSCN 05/2003 and explains why a change of wording was required

leading to the replacement of "Of which were homosexually acquired" with "Of which were homo/bisexual": DSCN 05/2003: This change has been introduced because 'Of which were homosexually acquired' was inappropriate for codes referring to epidemiological treatment, HIV testing, hepatitis B vaccination and sexual health screening. There was evidence that this field was poorly completed for these codes using the previous definition. It is recognised that the meaning of this field has been changed (as below).

10. *NB. If information is not available, please enter "Nil" in the appropriate boxes of the form.*

Part A - Services Provided - Lines: 45 - 51

11. The 'Services provided' section is to be used to code PATIENTS receiving services or undergoing tests. For example, if a PATIENT is offered a sexual health screen he/she would be coded *S1* or *S2* in the 'Services provided' section (see lines 45 and 46 below). If, as a result of that screen, a chlamydial infection was found, he/she would also be coded C4A/C4C in the 'Diagnosis and/or treatment of infection or disease' section. If, following the screen, no infections were found, the PATIENT would be coded S1 or S2 and D3.

Diagnosis and/or treatment of infection or disease
Line 01: Primary and Secondary Infectious syphilis: A1 & A2

12. This refers to primary and secondary infectious syphilis.

13. *Male Total* column:* Record here the total number of males diagnosed/treated for A1, A2

14. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

15. *Female Total Column:* Record here the total number of females diagnosed/treated for A1, A2

Line 02: Early Latent Syphilis (first 2 years): A3

16. This refers to latent syphilis in the first two years of infection.

17. *Male Total* column:* Record here the total number of males diagnosed/treated for A3

18. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

19. *Female Total column:* Record here the total number of females diagnosed/treated for A3

Line 03: Other acquired syphilis: A4, A5 & A6

20. This refers to latent syphilis after the first two years of infection, cardiovascular syphilis, syphilis of the nervous system and all other latent syphilis. The PATIENT is only coded once in this category in the UK, i.e. the PATIENT is not given this code again unless after having been diagnosed as a case of late latent syphilis.
    Therefore, PATIENTS attending for routine follow up of say, latent syphilis, are not recorded in this category; and if they attend another clinic elsewhere in the country, they are not to be coded as A4, A5, A6.

21. *Male Total* column:* Record here the total number of males diagnosed/treated for A4, A5, A6

22. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

23. *Female Total column:* Record here the total number of females diagnosed/treated for A4, A5, A6

Line 04: Congenital syphilis, aged under 2: A7

24. *Male Total column:* Record here the total number of males diagnosed/treated for A7

25. *Female Total column:* Record here the total number of females diagnosed/treated for A7

Line 05: Congenital syphilis, aged 2 or over: A8

26. *Male Total column:* Record here the total number of males diagnosed/treated for A8

27. *Female Total column:* Record here the total number of females diagnosed/treated for A8

Line 06: Epidemiological treatment of suspected syphilis: A9

28. This should include **all** cases where syphilis has not been confirmed, but epidemiological treatment is prescribed because the index PATIENT (the partner) was found to be syphilis positive.

29. *Male Total* column:* Record here the total number of males diagnosed/treated for A9

30. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

31. *Female Total column:* Record here the total number of females diagnosed/treated for A9

Line 07: Uncomplicated gonorrhoea: B1, B2

32. This includes all cases of uncomplicated gonorrhoea of the lower genitourinary tract, anorectum, mouth, throat and adult conjunctivitis:

    Persistent/recurrent gonorrhoea:

    a) Treatment failures should not be given a new diagnosis
    b) PATIENT who are thought to be re-infected should be regarded as new cases, and be investigated, treated and be diagnosed/coded accordingly.

33. *Male Total* column:* Record here the total number of males diagnosed/treated for B1, B2

34. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

35. *Female Total column:* Record here the total number of females diagnosed/treated for B1, B2

Line 08: Gonococcal ophthalmia neonatorum: B3

36. *Male Total column:* Record here the total number of males diagnosed/treated for B3

37. *Female Total column:* Record here the total number of females diagnosed/treated for B3

Line 09: Epidemiological treatment of suspected gonorrhoea: B4

38. This should include **all** cases where gonorrhoea has not been confirmed, but where epidemiological treatment has been prescribed because the index PATIENT (the partner) was found to be infected with gonorrhoea.

39. *Male Total* column:* Record here the total number of males diagnosed/treated for B4

40. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

41. *Female Total column:* Record here the total number of females diagnosed/treated for B4

Line 10: Complicated gonococcal infection - including PID and epididymitis: B5

42. This includes **all** cases of complicated gonorrhoea e.g. upper genitourinary tract complications (such as pelvic inflammatory disease and epididymitis), and systemic complications.

43. Where a PATIENT has complications that are associated with both gonococcal and chlamydial infections, the patient should be included in B5 (line 10) and in C4B (line 13).

44. *Male Total* column:* Record here the total number of males diagnosed/treated for B5

45. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

46. *Female Total column:* Record here the total number of females diagnosed/treated for B5

Line 11: Chancroid/LGV/Donovanosis: C1, C2 & C3

47. Specific confirmation is advisable for each of these conditions.

48. *Male Total column:* Record here the total number of males diagnosed/treated for C1, C2, C3

49. *Female Total column:* Record here the total number of females diagnosed/treated for C1, C2, C3

Line 12: Uncomplicated Chlamydial Infection: C4A & C4C

50. This includes **all** cases of uncomplicated chlamydial infections (diagnosed by culture or antigen detection) involving the lower genitourinary tract, and adult conjunctivitis.

51. Persistent/recurrent Chlamydia:

    a) Treatment failures should <u>not</u> be given a new diagnosis
    b) PATIENTS who are thought to be re-infected should be regarded as new cases, and be investigated, treated and diagnosed/coded accordingly.

52. *Male Total* column:* Record here the total number of males diagnosed/treated for C4A, C4C

53. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

54. *Female Total column:* Record here the total number of females diagnosed/treated for C4A, C4C

Line 13: Complicated Chlamydial infection - including PID and epididymitis: C4B

55. This includes **all** cases of complicated chlamydial infections, e.g. upper genitourinary tract complications (such as pelvic inflammatory disease and epididymitis), perihepatitis and arthritis. Diagnosis may be based on culture, antigen detection or high MIF titre.

56. Where a PATIENT has complications that are associated with both gonococcal and chlamydial infections, the PATIENT should be included in B5 (line 10) and in C4B (line 13).

57. *Male Total* column:* Record here the total number of males diagnosed/treated for C4B

58. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

59. *Female Total column:* Record here the total number of females diagnosed/treated for C4B

Line 14: Chlamydia ophthalmia neonatorum: C4D

60. *Male Total* column:* Record here the total number of males diagnosed/treated for C4D

61. *Female Total column:* Record here the total number of females diagnosed/treated for C4D

Line 15: Epidemiological treatment of suspected Chlamydia: C4E

62. This should include **all** cases where chlamydia has <u>not</u> been confirmed, but where epidemiological treatment has been prescribed because the index PATIENT (the partner) was found to be chlamydia positive. If a male partner presents as a contact of C4A (line 12) and has non-specific urethritis, he should be coded as C4H only and <u>not</u> C4E.

63. *Male Total* column:* Record here the total number of males diagnosed/treated for C4E

64. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

65. *Female Total column:* Record here the total number of females diagnosed/treated for C4E

Line 16: Uncomplicated non-gonococcal/non-specific urethritis in males or treatment of mucopurulent cervicitis in females: C4H

66. In males, this is diagnosed in the absence of gonorrhoea and laboratory confirmed chlamydia and the presence of polymorphononuclear leucocytes at >5 per high power field. Also, if a male partner presents as a contact of C4A (line 12) and has non-specific urethritis, he should be coded as C4H only and <u>not</u> C4E.

    Females being treated for non-specific mucopurulent cervicitis are also to be coded C4H.

67. Persistent/recurrent urethritis:

    a) Treatment failures should <u>not</u> be given a new diagnosis
    b) PATIENTS who are thought to be re-infected should be regarded as new cases, and be investigated, treated and diagnosed/coded accordingly

68. *Male Total* column:* Record here the total number of males diagnosed/treated for C4H

69. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

70. *Female Total column:* Record here the total number of females diagnosed/treated for C4H

Line 17: Epidemiological treatment of NSGI: C4I

71. This diagnosis is used for either males or females; e.g. the female would be diagnosed as C4I if she tested negative for gonorrhoea and chlamydia and is treated because her partner has been diagnosed with uncomplicated or complicated non-specific infection (C4H-line 16, or C5-line 18).

72. Similarly, the male partner is diagnosed as C4I if he tested negative for gonorrhoea and chlamydia, and is treated because the female partner has been diagnosed as C4H (line 16) or C5 (line 18).

73. *Male Total* column:* Record here the total number of males diagnosed/treated for C4I

74. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

75. *Female Total column:* Record here the total number of females diagnosed/treated for C4I

Line 18: Complicated infection (non-chlamydial/non-gonococcal) - including PID and epididymitis: C5

76. This includes **all** cases of complicated non-specific infections requiring treatment and negative tests for gonorrhoea and chlamydia, e.g. upper genitourinary tract complications (such as pelvic inflammatory disease and epididymitis), prostatitic and arthritis.

77. *Male Total* column:* Record here the total number of males diagnosed/treated for C5

78. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

79. *Female Total column:* Record here the total number of females diagnosed/treated for C5

Line 19: Trichomoniasis: C6A

80. If associated with bacterial vaginosis, then code C6A only should be used.

81. *Male Total column:* Record here the total number of males diagnosed/treated for C6A

82. *Female Total column:* Record here the total number of females diagnosed/treated for C6A

Line 20: Anaerobic/Bacterial vaginosis & Anaerobic balanitis: C6B

83. Diagnosis of bacterial vaginosis is generally based on microscopy, pH vaginal fluid and the amine test. This diagnosis is very rarely appropriate in males and used only if the PATIENT has confirmed anaerobic balanitis. Other and non-confirmed and anaerboric balanitis, should be coded as C6C. Asymptomatic PATIENTS who do not require treatment should be coded C6B.

84. *Male Total column:* Record here the total number of males diagnosed/treated for C6B

85. *Female Total column:* Record here the total number of females diagnosed/treated for C6B

Line 21: Other vaginosis/vaginitis/balanitis: C6C

86. *Male Total column:* Record here the total number of males diagnosed/treated for C6C

87. *Female Total column:* Record here the total number of females diagnosed/treated for C6C

Line 22: Anogenital candidosis: C7A

88. This is diagnosed only when there is microscopic or culture evidence of Candida infection. Asymptomatic PATIENTS who do not require treatment should not be coded C7A.

89. *Male Total column:* Record here the total number of males diagnosed/treated for C7A

90. *Female Total column:* Record here the total number of females diagnosed/treated for C7A

Line 23: Epidemiological treatment of C6 & C7: C7B

91. This should include all cases where C6 and C7 have not been confirmed, but where epidemiological treatment has been prescribed.

92. *Male Total column:* Record here the total number of males diagnosed/treated for C6, C7, C7B

93. *Female Total column:* Record here the total number of females diagnosed/treated for C6, C7, C7B

Line 24: Scabies/pediculosis pubis: C8 & C9

94. This includes cases treated on either a clinical or epidemiological basis.

95. *Male Total* column:* Record here the total number of males diagnosed/treated for C8 & C9

96. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

97. *Female Total column:* Record here the total number of females diagnosed/treated for C8 & C9

Line 25: Anogenital herpes simplex: first attack: C10A

98. An episode should be recorded here only if the patient has never (as far as can be ascertained) been previously diagnosed with anogenital herpes at any Genitourinary Medicine (GUM) clinic. Laboratory confirmation is essential.

99. *Male Total* column:* Record here the total number of males diagnosed/treated for C10A

100. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

101. *Female Total column:* Record here the total number of females diagnosed/treated for C10A

Line 26: Anogenital herpes simplex: recurrence: C10B

102. This should include **all** other episodes of anogenital herpes. If there has been previous confirmation, then clinical judgement is enough for this diagnosis.

103. *Male Total* column:* Record here the total number of males diagnosed/treated for C10B

104. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

105. *Female Total column:* Record here the total number of females diagnosed/treated for C10B

Line 27: Anogenital warts: first attack: C11A

106. An episode should be recorded here only if the PATIENT has never (as far as can be ascertained) been previously treated for anogenital warts at any GUM clinic.

107. C11A diagnosis refers to macroscopic warts, not acetowhite patches or abnormalities revealed by acetowhite staining, nor is the cytological finding of wart virus change sufficient to use this code.

108. *Male Total* column:* Record here the total number of males diagnosed/treated for C11A

109. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

110. *Female Total column:* Record here the total number of females diagnosed/treated for C11A

Line 28: Anogenital warts: recurrence: C11B

111. This should include PATIENTS in whom warts reappeared after a wart-free interval of at least 3 months.

112. C11B diagnosis refers to macroscopic warts, not acetowhite patches or abnormalities revealed by acetowhite staining, nor is the cytological finding of wart virus change sufficient to use this code.

113. *Male Total* column:* Record here the total number of males diagnosed/treated for C11B

114. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

115. *Female Total column:* Record here the total number of females diagnosed/treated for C11B

Line 29: Anogenital warts: re-registered cases: C11C

116. This is to be used for a PATIENT previously diagnosed as C11A or C11B in whom warts persist and treatment continues for longer than three months, or which recur within 3 months of apparent eradication. This code is not to be re-entered for the same patient more than once every 3 months.

117. C11C diagnosis refers to macroscopic warts, not acetowhite patches or abnormalities revealed by acetowhite staining, nor is the cytological finding of wart virus change sufficient to use this code.

118. *Male Total column:* Record here the total number of males diagnosed/treated for C11C

119. *Female Total column:* Record here the total number of females diagnosed/treated for C11C

Line 30: Molluscum contagiosum: C12

120. *Male Total* column:* Record here the total number of males diagnosed/treated for C12

121. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

122. *Female Total column:* Record here the total number of females diagnosed/treated for C12

Line 31: Viral hepatitis B (HbsAg positive): first diagnosis**: C13A

123. C13 has been divided into 3 codes: C13A, C13B and C13C.

124. C13A records a first diagnosis of antigen positive hepatitis B.

125. *Male Total* column:* Record here the total number of males diagnosed/treated for C13A

126. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

127. *Female Total column:* Record here the total number of females diagnosed/treated for C13A

Line 32: **number of which were acute viral hepatitis B: C13B

128. C13B is a subset of C13A, so that a PATIENT coded C13B **must** also be coded C13A.

129. C13B records the number of first diagnoses of hepatitis B infections that were acute, where this is known. The definition of acute hepatitis B is newly identified HBsAg positive with anti-HBc 1gM positive (>200 iu/1) (MR) *or* discrete onset of jaundice or anicteric illness accompanied by deranged LFTs (AST / ALT> 2x normal range) accompanied by HBsAg and anti-HBc IgM positive.

130. *Male Total* column:* Record here the total number of males diagnosed/treated for C13B

131. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

132. *Female Total column:* Record here the total number of females diagnosed/treated for C13B

Line 33: Viral hepatitis B: subsequent presentation: C13C

133. All subsequent presentations of hepatitis B that require management, or known carriers of hepatitis B who present at a clinic for the first time, are to be coded as C13C. *Subsequent attendances* by carriers that are unrelated to hepatitis B management should not be coded as C13C.

134. *Male Total* column:* Record here the total number of males diagnosed/treated for C13C

135. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

136. *Female Total column:* Record here the total number of females diagnosed/treated for C13C

Line 34: Viral hepatitis C: first diagnosis: C14

137. This code was changed from recording any other viral hepatitis to first diagnosis of hepatitis C only. The definition given in these guidelines are "Hepatitis C: anti-HCV positive or HRC RNA positive". All other hepatitis diagnoses are now coded as D2B/D3.

138. *Male Total* column:* Record here the total number of males diagnosed/treated for C14

139. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

140. *Female Total column:* Record here the total number of females diagnosed/treated for C14

Line 35: Urinary tract infection: D2A

141. *Male Total column:* Record here the total number of males diagnosed/treated for D2A

142. *Female Total column:* Record here the total number of females diagnosed/treated for D2A

Line 36: Other conditions requiring treatment at GUM clinic: D2B

143. *Male Total column:* Record here the total number of males diagnosed/treated for D2B

144. *Female Total column:* Record here the total number of females diagnosed/treated for D2B

Line 37: New HIV diagnosis: asymptomatic: E1A

145. This is a new HIV diagnosis in a PATIENT without symptoms who is not known to have been diagnosed at any GUM clinic. It **includes** PATIENTS with seroconversion illness. A PATIENT can receive this code only once and it is mutually **exclusive** of E2A (line 38) and E3A1 (line 40).

146. *Male Total* column:* Record here the total number of males diagnosed/treated for E1A

147. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

148. *Female Total column:* Record here the total number of females diagnosed/treated for E1A

Line 38: New HIV diagnosis: symptomatic (not AIDS): E2A

149. This is a new HIV diagnosis in a PATIENT with symptoms who is not known to have been diagnosed previously at any GUM clinic. It **excludes** PATIENTS with seroconversion illness (see code E1A). A PATIENT can receive E2A only once and it is mutually **exclusive** of E1A (line 37) and E3A1 (line 40).

150. *Male Total* column:* Record here the total number of males diagnosed/treated for E2A

151. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

152. *Female Total column:* Record here the total number of females diagnosed/treated for E2A

Line 39: Subsequent HIV presentation (not AIDS): E1B & E2B

153. Codes E1B and E2B have merged to become E1B/E2B (all subsequent presentations by a PATIENT who has been diagnosed with HIV previously). It **includes** asymptomatic (E1B) and symptomatic (E2B) PATIENTS, but **excludes** those with AIDS. The PATIENT should be given this code only once, during any quarterly period.

154. *Male Total column:* Record here the total number of males diagnosed/treated for E1B, E2B

155. *Female Total column:* Record here the total number of females diagnosed/treated for E1B, E2B

Line 40: AIDS: first presentation - new HIV diagnosis: E3A1

156. An AIDS diagnosis is used for HIV infected PATIENTS with one or more AIDS indicator diseases. It is necessary to discriminate between first AIDS presentations, that are also the first HIV diagnosis and those for which HIV was diagnosed previously. Therefore, E3A is divided into E3A1 and E3A2 (line 41).

157. E3A1 is a first presentation of AIDS, where HIV has not been diagnosed previously. The PATIENT (as far as can be ascertained) should not have been given an HIV or AIDS diagnosis at any clinic in the United Kingdom. This patient cannot be coded E1 or E2 ever again (E3A1 is mutually **exclusive** of E3A2).

158. *Male Total* column:* Record here the total number of males diagnosed/treated for E3A1

159. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

160. *Female Total column:* Record here the total number of females diagnosed/treated for E3A1

Line 41: AIDS: first presentation - HIV diagnosed previously: E3A2

161. E3A2 is a first presentation of AIDS where HIV has been diagnosed previously. The PATIENT (as far as can be ascertained) should not have been given an AIDS diagnoses at any clinic in the United Kingdom. This PATIENT cannot be coded E1 or E2 ever again. E3A2 is mutually **exclusive** of E3A1 (line 40).

162. *Male Total* column:* Record here the total number of males diagnosed/treated for E3A2

163. **of which homo/bisexual column:* Record here the number of males from the male total column who are homo/bisexual

164. *Female Total column:* Record here the total number of females diagnosed/treated for E3A2

Line 42: AIDS: subsequent presentation: E3B

165. The PATIENT who has had an AIDS diagnosis at any time in the past, should be given this code only once during any quarterly period and cannot be coded E1, E2 or E3A ever again.

166. *Male Total* column:* Record here the total number of males diagnosed/treated for E3B

167. *Female Total column:* Record here the total number of females diagnosed/treated for E3B

Line 43: Cervical cytology: minor abnormality: P4A

168. This includes inflammatory smears, warts virus infection only, borderline changes and mild dyskaryosis.

169. *Female Total column:* Record here the total number of females diagnosed/treated for P4A

Line 44: Cervical cytology: major abnormality: P4B

170. This includes moderate or severe dyskaryosis, or worse.

171. *Female Total column:* Record here the total number of females diagnosed/treated for P4B

Services Provided

Line 45: Sexual health screen (no HIV antibody test): S1

172. S1 should only be used where a full sexual health screen is given (i.e. including gonorrhoea and chlamydia testing) and should not be used to record tests for recurrent candidosis/ bacterial vaginosis, etc. It will be used to count **all** PATIENTS who are given a sexual health screen **excluding** an HIV test. This may be because the PATIENT refuses or is not offered an HIV test. However, if the PATIENT is known to be HIV antibody positive, he/she can be coded S1 and one of E1B/E2B/E3A2/E3B - lines 39, 41, 42.

173. S1 is mutually exclusive of S2 (line 46) and P1A (line 47).

174. *Male Total* column:* Record here the total number of males seen by the *Service Provided*: S1

175. **of which homo/bisexual column:* Record here the number of males seen by the *Service Provided*: S1;

who are homo/bisexual

176. *Female Total column:* Record here the total number of females seen by the *Service Provided*: S1

Line 46: HIV antibody test and sexual health screen: S2

177. This code will be used to count **all** PATIENTS who are given a sexual health screen **including** an HIV test. It should only be used where a full sexual health screen is given (i.e. including gonorrhoea and chlamydia testing) and should not be used to record tests for recurrent candidosis/ bacterial vaginosis, etc. If the patient tests positive for HIV antibody, then they would be coded S2, E1A (line 37).

178. S2 is mutually exclusive of S1 (line 45), P1A (line 47) and P1B (line 48).

179. *Male Total* column:* Record here the total number of males seen by the *Service Provided*: S2

180. **of which homo/bisexual column:* Record here the number of males seen by the *Service Provided*: S2; who are homo/bisexual

181. *Female Total column:* Record here the total number of females seen by the *Service Provided*: S2

Line 47: HIV antibody test (no sexual health screen): P1A

182. This code is re-defined to mean all HIV antibody testing done, regardless of whether counselling was given in PATIENTS who refuse or who are not offered a general sexual health screen. This code is mutually exclusive of S1 (line 45), S2 (line 46) and P1B (line 48).

183. *Male Total* column:* Record here the total number of males seen by the *Service Provided*: P1A

184. **of which homo/bisexual column:* Record here the number of males seen by the *Service Provided*: P1A; who are homo/bisexual

185. *Female Total column:* Record here the total number of females seen by the *Service Provided*: P1A

Line 48: HIV antibody test offered and refused: P1B

186. This code is redefined to mean all PATIENTS who are offered an HIV test, regardless of whether counselling was given, and who refuse the test. This code is mutually exclusive of S2 (line 46) and P1A (line 47).

187. *Male Total* column:* Record here the total number of males seen by the *Service Provided*: P1B

188. **of which homo/bisexual column:* Record here the number of males seen by the *Service Provided*: P1B; who are homo/bisexual

189. *Female Total:* Record here the total number of females seen by the *Service Provided*: P1B

Line 49: Hepatitis B vaccination (1st dose only): P2

190. Only the 1st dose of any new Hepatitis B vaccination course should be included. This would include those PATIENTS who have been vaccinated some time in the past, but who are now receiving the first dose of a new course of vaccination. Subsequent doses and boosters should be coded as D2B.

191. *Male Total* column:* Record here the total number of males seen by the *Service Provided*: P2

192. **of which homo/bisexual column:* Record here the number of males seen by the *Service Provided*: P2;

who are homo/bisexual

193. *Female Total column:* Record here the total number of females seen by the *Service Provided*: P2

Line 50: Contraception (excluding condom provision): P3

194. This code will be used to record contraception (females only), including prescribing and family planning advice, and **excluding** condom provision. Condom provision should not be included on form KC60.

195. *Female Total:* Record here the total number of females seen by the *Service Provided*: P3

Line 51: Other Episodes:D3

196. D3 is used to code any new PATIENT episode where no treatment is given, whether or not a sexual health screen and/or an HIV test are/is performed. D3 can therefore be used to record an episode where a PATIENT tests negative for all tests done, or where testing the PATIENT is not indicated and otherwise no treatment is given. This code may also be used to record any other contact with a patient for clinical purposes, but which does not result in treatment. PATIENTS who do not attend appointments should not be coded D3, unless the PATIENT has been triaged and a set of new notes has been generated. D3 can be used only once per PATIENT episode.

197. *Male Total* column:* Record here the total number of males seen by the *Service Provided*: D3

198. *Female Total:* Record here the total number of females seen by the *Service Provided*: D3

Total Row: For all Conditions:

199. Male Total: Total for All Conditions: Record here the total initial contacts in the quarter for males, for **all** conditions

200. Of which homo/bisexual: Total for All Conditions: Record here the total males from the male total, who are homo/bisexual, for initial contacts in the quarter, for **all** conditions

201. Female Total: Total for All Conditions: Record here the total initial contacts in the quarter for females, for **all** conditions

KC62 1

Change to Central Return Form: Change to Guidance Text

KC62 Adult Screening Programmes - Breast Screening

Contextual Overview

The KC62 form comprises eight main tables (Tables A - F2) to report separately on the eight cohorts of women considered to have different screening characteristics.
Totals Table (Table T) gives an overview of all screening carried out by the screening service.
The KC62 Annex provides further information on each cancer detected which allows epidemiological comparisons to be made both within the programme and with data from elsewhere.

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)
KC62 Table T	All invitations and screenings : Sum of Tables A - F2

**columns 49 to 51 are only appropriate for Tables A, B and C1*
The table below indicates which women are eligible for each Table on the KC62 return, based on their screening history and type.

Did Not Attend

Screening Type	No Previous Screen		Previous Screen	
	Not Previously Invited	Previously Invited ~~Did Not Attend~~	~~Previously Invited Attended~~	~~Attended Before as Self/Gp Referral~~
Previously Invited Attended	Attended Before as Self/GP Referral			
Invited	A	B	C1 or C2*	C1 or C2*
Recalled Early	n/a	n/a	D	D
Self/GP Referral	E	E	F1 or F2*	F1 or F2*

** Depending on the time since previous technically adequate screen*

1. ~~The Department, NHS Breast Screening Programme (NHSBSP) and Regional Offices require information from breast screening centres (see SERVICE POINT) on Breast Screening.~~

1. The Department of Health, NHS Breast Screening Programme (NHSBSP) and Regional Offices require information from breast screening centres (see SERVICE POINT) on Breast Screening.

2. The information is used to assess performance. Quality targets for breast screening are monitored and poor performances identified and followed up via performance management.

3. Information on screening is used to monitor progress towards achieving the Government's target of a reduction in the death rate in the population invited for screening.

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

5. ~~Information based on the KC62 return is published annually by the Department in the Statistical Bulletin "Breast Screening Programme".~~

5. Information based on the KC62 return is published annually by the Department of Health in the Statistical Bulletin "Breast Screening Programme".

Completing Return KC62: Adult Screening Programmes - Breast Screening

6. The Breast Screening Programme is a structured programme (see HEALTH PROGRAMME) planned by a Strategic Health Authority which is directed towards detecting specific diseases and conditions in a specific target group. The services provided to the population under this programme are carried out by a breast screening centre or Unit.

7. The KC62 return is completed by the breast screening centre and requires its ORGANISATION CODE and ORGANISATION NAME as well as the name of a contact and the contact telephone number.

Reading Type

8. A tick box for the BREAST SCREENING READING TYPE of the Screening Programme.

Number of Views

9. A tick box for the BREAST SCREENING PREVALENT VIEW NUMBER and the BREAST SCREENING INCIDENT VIEW NUMBER of the Screening Programme.

Round Length Indicator

10. The percentage of persons in a Screening Programme whose first offered Screening Test Invitation is within 36 months of their previous Screening Test.

Waiting time (percentage within 3 weeks)

11. The percentage of women screened within 3 weeks from the date of last Screening Test to the breast assessment first appointment date (derivable using ACTIVITY DATE) .

12. The Programme Manager/Clinical Director is required to sign the declaration at the front of the KC62 to confirm the accuracy of the return.

13. Information on Breast Screening should be readily available from the breast screening centre's computer system. Standards statistical routines should be provided by system suppliers.

14. The return is completed annually and must be submitted to the Department of Health via the Quality Assurance Reference Centre before 31 October following the year to which the return refers. The statistical routine to produce the return should not, however, be run before 1 October.

15. The KC62 return reports on a cohort of women (person in a Screening Programme - see PERSON IN PROGRAMME) who were either invited for screening (Screening Test Invitation) or who attended for screening as a result of a self or GP referral (REFERRAL REQUEST for Screening Test) within the review period defined as the twelve months between 1 April and 31 March inclusive.

16. Women are included in the KC62 return only if the test date offered (see ACTIVITY DATE) or the Screening Test Date was within the review period. All Screening Tests taking place within the stated period are counted. One woman may not have more than one outcome of cancer in the year. Women who are referred directly for a Screening Test (rather than an invitation as part of a Screening Programme)

are also included in KC62 return if the Screening Test Date is within the review period.

17. Each Table on the KC62 return consists of six parts:

    i. Invitations and Outcomes
    ii. Assessment
    iii. Cancers diagnosed
    iv. Outcomes measured
    v. Data completeness indicators
    vi. Status of cancer

18. There is also an Annex to provide further information on each woman who has cancer detected.

KH03A 1

Change to Central Return Form: Change to Guidance Text

KH03a - Adult Intensive Care and High Dependency Provision

Contextual Overview

1. ~~The Department of Health requires accurate information on adult intensive care beds and high dependency beds to support policy developments and to monitor provision.~~

1. The Department of Health requires accurate information on adult intensive care beds and high dependency beds to support policy developments and to monitor provision.

2. The KH03 return collects data by broad ward classification, and a ward classed as intensive care may have a mixture of intensive care, high dependency and other beds. The KH03a will provide more accurate information on the distribution, type and availability of adult intensive care and high dependency beds.

Completing Return kh03a 1

3. The return KH03a is a census of available adult intensive care and high dependency beds carried out on 15 January and 15 July. Returns are submitted within two weeks of the census dates - by 28 January and 28 July at the latest.

4. A return is required from each NHS Health Care Provider.

5. The return requires the ORGANISATION CODE and ORGANISATION NAME of the NHS Health Care Provider as well as the name of the contact and the contact telephone and fax number.

6. Beds should be counted as either intensive care or high dependency to avoid double counting of provision. The number of each type of bed in AUGMENTED CARE LOCATION CODE National Code 12 *'Combined High Dependency and Intensive Care Unit; the beds and staff for the two units are geographically in the same area'*, should be entered in the appropriate section of the return. If beds are available but unoccupied in a combined unit that offers this flexible provision, trusts should record the highest level of care they could provide based on the staff available.

7. The return requires information on the number of available adult intensive care and high dependency beds in each trust at the date of the census. Beds are classified as available if they are either occupied or ready to take a patient. Beds not currently funded or which are closed due to staff sickness or vacancies should be excluded. However, beds not officially funded but used for IC/HD care on the census day should be counted and an explanation given on the front of the form.

8. A note should be attached to the return if the number of beds has changed since the last return or if beds are funded but closed temporarily.

9. Beds in the following AUGMENTED CARE LOCATION CODES are excluded from this return:

09	*Cardiac Care Unit: otherwise referred to as a Coronary Care Unit*
13	*Post operative Recovery Unit: this includes a theatre recovery area* - (but note that longer term IC or HD recovery beds, separate to theatres, should be included in the relevant specialist or general lines)
16	*Renal Unit: this includes an in-patient kidney dialysis unit, but excludes general nephrology or urology wards*
17	*Not otherwise specified.*

10. Adult beds are WARD AVAILABLE BED in a WARD with a CLINICAL CARE INTENSITY of National Code 11

'for intensive therapy, including high dependency care', which is not a WARD assigned to an AGE GROUP INTENDED of National Code 1 *'Neonates'* or 2 *'Children and/or adolescents'*.

KH12 2

Change to Central Return Form: Change to Guidance Text

KH12 - Imaging and Radiological Examinations or Tests in any Part of a Hospital

Part 1: Total number of departments on 31 March

Radiology

1. Enter the total number of Radiology Department for the ORGANISATION as of 31 March.

   A Radiology Department is a DEPARTMENT where DEPARTMENT TYPE is National Code 04 *'Radiology Department'*.

Nuclear Medicine

2. Enter the total number of nuclear medicine Isotope Procedure Departments for the ORGANISATION as at 31 March.

   A nuclear medicine Isotope Procedure Department is a DEPARTMENT where DEPARTMENT TYPE is National Code 21 *'Isotope Procedure Department nuclear medicine'*.

Medical Physics

3. Enter the total number of medical physics Isotope Procedure Departments for the ORGANISATION as at 31 March.

   A medical physics Isotope Procedure Department is a DEPARTMENT where DEPARTMENT TYPE is National Code 22 *'Isotope Procedure Department medical physics'*.

4. Enter the total number of Isotope Procedure Department OF DEPARTMENT TYPE classification of *other* for the ORGANISATION as of 31 March.

Part 2: Number of imaging and radiodiagnostic examinations or tests

5. Part 2 of the form splits total Imaging Or Radiodiagnostic Event by IMAGING MODALITY and introduces the concept of events carried out 'Under auspices of' either an imaging department or other department.

   An Imaging Or Radiodiagnostic Event is a CLINICAL INTERVENTION where CLINICAL INTERVENTION TYPE is National Code 16 *'Imaging or Radiodiagnostic Event'*.

Imaging department

6. Enter the total number of other Isotope Procedure Departments for the ORGANISATION as at 31 March.

   An other Isotope Procedure Department is a DEPARTMENT where DEPARTMENT TYPE is National Code 23 *'Isotope Procedure Department other'*.

7. Any other department which is undertaking imaging or radiodiagnostic investigations.

Modality

8. The IMAGING MODALITY used during the Imaging Or Radiodiagnostic Event.

Part 2(a): Imaging and Radiodiagnostics without intervention

9. For each IMAGING MODALITY and Imaging Department enter the total number of Imaging Or Radiodiagnostic Event having an IMAGING INTERVENTION INDICATOR classification of *'No'*, that have taken place with ACTIVITY DATES within the period up to March 31.

Part 2(b): Imaging and Radiodiagnostics with intervention (successful or failed)

10. For each IMAGING MODALITY and Imaging Department, enter the total number of Imaging Or Radiodiagnostic Event having an IMAGING INTERVENTION INDICATOR classification of *'Yes'*, that have taken place with a Clinical Intervention Date within the period up to March 31.

    Clinical Intervention Date is the same as attribute ACTIVITY DATE where ACTIVITY DATE TIME TYPE is National Code 34 *'Clinical Intervention Date*'.

Consistency checks

11. Before returning the form to the Department of Health, please ensure that:

- Parts 2a and 2b - for all lines: columns (17) = total of columns (10) to (16);
- Parts 2a and 2b - for all columns: line 9 is the sum of lines 1 and 2.

KO41(A) 1

Change to Central Return Form: Change to Guidance Text

KO41 (A): Hospital and Community Health Service Complaints

Contextual Overview

1. ~~The Department requires information to monitor the number of written Hospital and Community Health Service (HCHS) complaints received by the NHS each year. The information allows analysis of complaints by subject, and helps the Department to monitor how well the NHS is meeting the performance targets of the complaints procedure.~~

1. The Department of Health requires information to monitor the number of written Hospital and Community Health Service (HCHS) complaints received by the NHS each year. The information allows analysis of complaints by subject, and helps the Department of Health to monitor how well the NHS is meeting the performance targets of the complaints procedure.

2. Information on the return is published in the booklet *'Written Complaints'* and on www.doh.gov.uk/nhscomplaints/.

~~Completing Return KO41(A) - HCHS Complaints~~
Completing Return KO41 (A): Hospital and Community Health Service Complaints

3. ~~KO41(A) is used for WRITTEN COMPLAINTS about Hospital and Community Health Services. For the purposes of this return a complaint that goes into writing at any stage, even if it is initiated orally, should be treated as a WRITTEN COMPLAINT. The return is subdivided into complaints by service areas, profession, subject of complaint and ethnic category of complainant (patient) and staff about whom the complaint is made.~~

3. KO41(A) is used for WRITTEN COMPLAINTS about Hospital and Community Health Services. For the purposes of this return a complaint that goes into writing at any stage, even if it is initiated orally, should be treated as a WRITTEN COMPLAINT. The return is subdivided into complaints by service areas, profession, subject of complaint and ethnic category of complainant (PATIENT) and staff about whom the complaint is made.

4. A KO41(A) return is required from each NHS Health Care Provider and Strategic Health Authority for complaints relating to Hospital and Community Health Services for which they are responsible. A 'NIL' return should be submitted where applicable.

5. The return KO41(A) relates to WRITTEN COMPLAINTS received over a 12 month period, between 1 April of one year and 31 March of the following year. The return is made annually and should be submitted within the timescale required by the Department of Health as stated on the notes for completion.

6. ~~Each WRITTEN COMPLAINT where the WRITTEN COMPLAINT TYPE is National Code 02 *'Hospital and Community Health Services (HCHS)'* should be recorded in parts 1, 2, 3 and 4 of the return according to COMPLAINT HCHS SERVICE AREA, COMPLAINT HCHS STAFF CATEGORY, COMPLAINT HCHS SUBJECT and ETHNIC CATEGORY of complainant (patient) and staff about whom the complaint is made.~~

6. Each WRITTEN COMPLAINT where the WRITTEN COMPLAINT TYPE is National Code 02 *'Hospital and Community Health Services (HCHS)'* should be recorded in parts 1, 2, 3 and 4 of the return according to COMPLAINT HCHS SERVICE AREA, COMPLAINT HCHS STAFF CATEGORY, COMPLAINT HCHS SUBJECT and ETHNIC CATEGORY of complainant (PATIENT) and staff about whom the complaint is made.

KO41(B) 1

Change to Central Return Form: Change to Guidance Text

KO41 (B): Family Health Services Complaints

Contextual Overview

1. ~~The Department requires information to monitor the number of written Family Health Services (FHS) complaints received by the NHS each year. The information allows analysis of complaints by subject, and helps the Department to monitor how well the NHS is meeting the performance targets of the complaints procedure.~~

1. The Department of Health requires information to monitor the number of written Family Health Services (FHS) complaints received by the NHS each year. The information allows analysis of complaints by subject, and helps the Department of Health to monitor how well the NHS is meeting the performance targets of the complaints procedure.

2. Information on the return is published in the booklet *'Written Complaints'* and on Department of Health Website - NHS Complaints.

~~Completing Return KO41(B) - FHS Complaints~~
Completing Return KO41 (B): Family Health Services Complaints

3. KO41 (B) is used for WRITTEN COMPLAINTS about Family Health Services. For the purposes of this return a complaint that goes into writing at any stage, even if it is initiated orally, should be treated as a WRITTEN COMPLAINT. The return is subdivided into complaints by service areas, complaint by subject of complaint, and ETHNIC CATEGORY of complainant (PATIENT) and staff about whom the complaint is made.

4. A KO41 (B) return is required from each Health Authority for complaints relating to Family Health Services for which they are responsible. A 'NIL' return should be submitted where applicable.

5. The return KO41 (B) relates to written complaints received over a 12 month period, between 1 April of one year and 31 March of the following year. The return is made annually and should be submitted within the timescale required by the Department of Health as stated on the notes for completion.

6. Each WRITTEN COMPLAINT on Family Health Services should be recorded in parts 1, 2 and 3 of the return according to COMPLAINT FHS SERVICE AREA, COMPLAINT FHS SUBJECT and ETHNIC CATEGORY of complainant (PATIENT) and staff about whom the complaint is made.

KT31 1

Change to Central Return Form: Change to Guidance Text

KT31 - Cross Sector Services

Contextual Overview

1. ~~The Department requires the collection of information about services provided by Family Planning Clinics, in order to monitor the implementation of the Government's strategy to reduce the number of teenage pregnancies.~~

1. The Department of Health requires the collection of information about services provided by Family Planning Clinics, in order to monitor the implementation of the Government's strategy to reduce the number of teenage pregnancies.

2. Improving contraception and sexual health services and encouraging young people to seek advice are important aspects of the Teenage Pregnancy Strategy. Best Practice Guidance on the provision of effective contraception and advice services for young people was issued in November 2000 and Local Teenage Pregnancy Strategies all include proposals to ensure that appropriate services are in place.

3. Monitoring of the Teenage Pregnancy Strategy is being undertaken partly through a National Indicator Set, which was issued in November 2001. This includes indicators on the provision of services in accordance with Best Practice Guidance and the uptake of services by under 18 year olds. The Central Return Form KT31 will provide data needed for these indicators.

4. The Best Practice Guidance on service provision is concerned with services for young people under 25, and this is reflected in KT31:
   (i) A key goal of the Teenage Pregnancy Strategy is to reduce the rate of conceptions for under 18s. The **AGE** group is split into 16-17 year olds and 18-19 year olds in parts B and C of the form.

   (ii) An important part of the Teenage Pregnancy Strategy is to increase the awareness and involvement of young men in sexual health matters. Data on males is to be collected for exactly the same **AGE** groups as for females.

   Completing the Central Return KT31 Family Planning Services

5. The coverage of the KT31 return includes services provided by NHS Trusts / Primary Care Trusts in Family Planning Clinics and at Family Planning Domiciliary Visits and also those provided by non-NHS clinics funded wholly or in part by the NHS. Not included are services provided by CONSULTANTS in Out-Patient Clinics or those provided by GENERAL MEDICAL PRACTITIONERS.

   Family Planning Clinic and Out-Patient Clinic are both types of a CLINIC OR FACILITY. A Family Planning Domiciliary Visit is a CARE CONTACT where the CARE CONTACT TYPE is National Code 21 *'Family Planning Domiciliary Visit'*.

6. A contact is a Clinic Attendance Family Planning or a Family Planning Domiciliary Visit, during which a PATIENT is seen by professional staff for counselling, or in order to be prescribed contraceptives.

   Clinic Attendance Family Planning and Family Planning Domiciliary Visit are both a CARE CONTACT where the CARE CONTACT TYPE is National Code 07 *'Clinic Attendance Family Planning'* and 21 *'Family Planning Domiciliary Visit'* respectively.

7. A first contact in financial year is the first time a PATIENT is seen in the year by the family planning service. A subsequent contact with the same service provider does not count as a first contact, so each

PATIENT is recorded only once in any year by any NHS Trust / Primary Care Trust.

8. Where a couple are seen together only one first contact is recorded; where either vasectomy or the male condom is the main method chosen, the first contact is recorded as one with a man; in all other cases, where any other method is chosen, the first contact is recorded as one with a woman.

9. The CONTRACEPTION METHOD MAIN for new PATIENTS is that chosen after counselling; for existing PATIENTS it is the principal method in use unless a change is advised. For new PATIENTS, the main method should be the substantive method chosen and not any interim method, even if the choice is not made until a subsequent attendance or visit. In particular, where vasectomy or female sterilisation is the method chosen after counselling, any interim methods used while waiting for an operation should not be recorded.

10. ~~The information in the KT31 Central Return form can now be submitted to the Department of Health via the Internet. If you would be interested in using this facility, please contact your Information Manager. Alternatively further information about this facility can be obtained from the Department of Health:~~

    ~~http://www.dh.gov.uk~~

10. The information in the KT31 Central Return form can now be submitted to the Department of Health via the Internet. If you would be interested in using this facility, please contact your Information Manager. Alternatively further information about this facility can be obtained from the Department of Health: http://www.dh.gov.uk

ACCIDENT & EMERGENCY QUARTERLY MONITORING DATA SET (QMAE) OVERVIEW

Change to Supporting Information: Change to Supporting Information

Contextual Overview

~~The Department of Health (DH) requires information on services provided by NHS providers of Accident and Emergency services and this information is collected on the DH central return form, Quarterly Monitoring Accident and Emergency (QMAE).~~ The Department of Health requires information on services provided by NHS providers of Accident and Emergency services and this information is collected on the Department of Health central return form, Quarterly Monitoring Accident and Emergency.

~~The QMAE central return provides essential information for monitoring key targets and standards in the Priorities and Planning Framework 2003-2006 for Accident And Emergency Departments, National Codes:~~ The Accident and Emergency Quarterly Monitoring Data Set (QMAE) provides essential information for monitoring key targets and standards in the Priorities and Planning Framework 2003-2006 for Accident And Emergency Departments, National Codes:

01 *Emergency departments are a consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency PATIENTS* ,

02 *Consultant led mono specialty accident and emergency service (e.g. ophthalmology, dental) with designated accommodation for the reception of PATIENTS,*

03 *Other type of A&E/minor injury ACTIVITY with designated accommodation for the reception of accident and emergency PATIENTS.* ~~*The department may be doctor led or nurse led and treats at least minor injuries and illnesses and can be routinely accessed without appointment. A service mainly or entirely appointment based (for example a GP practice or outpatient clinic) is excluded even though it may treat a number of patients with minor illness or injury.*~~ *The department may be doctor led or NURSE led and treats at least minor injuries and illnesses and can be routinely accessed without APPOINTMENT. A SERVICE mainly or entirely APPOINTMENT based (for*

example a GENERAL PRACTITIONER Practice or Out-Patient Clinic) is excluded even though it may treat a number of PATIENTS with minor illness or injury. Excludes NHS walk-in centres,

04 *NHS walk in centres*

Reporting

~~The QMAE is a quarterly return with the first quarter starting on 1 April and the last quarter ending on 31 March.~~ The Accident and Emergency Quarterly Monitoring Data Set (QMAE) is a quarterly return with the first quarter starting on 1 April and the last quarter ending on 31 March.

Returns must be submitted by 15 working days after the end of the quarter.

~~The QMAE is a provider based return not a commissioning return.~~ The Accident and Emergency Quarterly Monitoring Data Set (QMAE) is a provider based return not a commissioning return. A Primary Care Trust should only complete the return for the services it provides, not those it commissions from local NHS Trusts. Examples of services provided could be a minor injury unit or NHS walk-in centre managed by the Primary Care Trust.

~~Independent Sector organisations that provide NHS funded care are asked to provide the QMAE on a voluntary basis.~~ Independent Sector ORGANISATIONS that provide NHS funded care are asked to provide the Accident and Emergency Quarterly Monitoring Data Set (QMAE) on a voluntary basis.

The data is entered via Unify, an online data collection system. NHS providers enter their data onto Unify either directly or by uploading a spreadsheet.

~~**Quarterly Monitoring Accident & Emergency Services (QMAE) Central Return**~~ **Quarterly Monitoring Accident and Emergency Services Central Return**

~~The QMAE requires the REPORTING PERIOD START DATE, REPORTING PERIOD END DATE and the ORGANISATION CODE (CODE OF PROVIDER).~~ The Accident and Emergency Quarterly Monitoring Data Set (QMAE) requires the REPORTING PERIOD START DATE, REPORTING PERIOD END DATE and the ORGANISATION CODE (CODE OF PROVIDER).

- **Part 1:** Number of A+E DEPARTMENT TYPES.
- **Part 2:** Number of First and Follow-up Accident And Emergency Attendances per A+E DEPARTMENT TYPE.
- **Part 3:** ACCIDENT AND EMERGENCY ATTENDANCE TOTAL PER WAIT BAND per A+E DEPARTMENT TYPE.
- **Part 4:** ACCIDENT AND EMERGENCY ADMISSION TOTAL PER WAIT BAND per A+E DEPARTMENT TYPE.

ADMINISTRATIVE CODES & CLASSIFICATIONS

Change to Supporting Information: Change to Supporting Information

Administrative Codes and Classifications

1. Responsible Agencies:

   National Administrative Codes Service (NACS):

   NACS is responsible for allocating codes to the following ORGANISATIONS in England and Wales:

   Strategic Health Authorities (SHAs)
   NHS Trusts
   Primary Care Trusts (PCTs)
   Care Trusts (CTs)

Special Health Authorities (SpHAs)
Independent Providers (care homes, private hospitals etc.)
Pathology Laboratories
Cancer Registries
Other NHS Administration Units

2. Code allocation by other agencies

Several other UK agencies are responsible for issuing or publishing codes (to NHS standards) to the following healthcare ORGANISATION and maintaining their details. These details are made available on the NACS NHSnet website and on a quarterly CD-ROM, distributed by the NACS.

For the NACS contact details, see Contact Details.

NHS Business Services Authority (BSA):

Prescription Pricing Division (PPD):
GENERAL MEDICAL PRACTITIONERS in England, Wales, Isle of Man and Channel Islands
GENERAL PRACTITIONER Practices in England and Wales

Dental Practice Division (DPD):
GENERAL DENTAL PRACTITIONERS in England, Wales and Isle of Man
General Dental Practices in England, Wales and Isle of Man

Health Solutions Wales (HSW):
All secondary care organisations in Wales

NHS in Scotland:
All healthcare ORGANISATIONS and practitioners in Scotland

Department of Health, Social Services and Public Safety (DHSSPS), Northern Ireland:
All healthcare ORGANISATIONS and practitioners in Northern Ireland

Office for National Statistics (ONS):
Responsible for the formal definition of the geographical area covered by each Primary Care Trust and Strategic Health Authority (England), in terms of their component postcodes.

Source: Agencies responsible for allocation of codes on the NACS NHSnet site. For those without NHSnet access, visit the NACs www website for further information on the NACS or see Contact Details.

3. Administrative codes are used to identify:

Individual healthcare ORGANISATIONS including independent providers;
Independent Sector Healthcare Providers;
Dental and Medical Practices;
Practitioners, such as GENERAL PRACTITIONERS, and Hospital CONSULTANTS.

4. The codes allow for:

~~the identification of information returned to the Department of Health;~~
the identification of information returned to the Department of Health;
the identification of the ORGANISATIONS involved in the electronic exchange of information within the NHS;
the identification of the parties involved in the commissioning and administration of an episode of care.

5. The current coding standards were introduced in 1996 by the Organisation Codes Service (OCS), now the National Administrative Codes Service (NACS). Subsequent revisions to the structure and format of organisation codes have given these codes a consistent and stable format. This both reflects the organisational changes in the NHS and protects the codes against future changes to the structure of the NHS.

6. Codes used in England and Wales to identify organisations in Scotland and Northern Ireland are allocated by agencies working on behalf of the Information Standards Division (Scotland) and the Northern Ireland Department of Health, Social Services and Public Safety. These codes meet NHS coding standards and are

included on the NACS CD-ROM, issued quarterly to NHS users. Note, however, that different codes may be used locally e.g. in Scotland by Scottish users.

7. Where treatment for a NHS PATIENT is sub-commissioned to a non-NHS UK provider healthcare ORGANISATION (independent provider and/or Independent Sector Healthcare Provider) but that non-NHS UK provider does not have an ORGANISATION CODE or sites registered with a responsible agency, the default value of 89999 should be used.

   For codes and format see:

   ORGANISATION CODE
   ORGANISATION DEPARTMENT CODE
   ORGANISATION SITE CODE
   CONSULTANT CODE
   DOCTOR INDEX NUMBER (DIN)
   GENERAL MEDICAL COUNCIL (GMC) NUMBER
   GENERAL MEDICAL PRACTITIONER (GMP) PPD CODE
   GENERAL DENTAL COUNCIL NUMBER
   GENERAL DENTAL PRACTITIONER CODE
   PRIVATE CONTROLLED DRUG PRESCRIBER

ADMITTED PATIENT FLOWS DATA SET OVERVIEW

Change to Supporting Information: Change to Supporting Information

Events During the Reporting Period

Contextual Overview

1. ~~The Department of Health requires performance management information on ELECTIVE ADMISSION LIST events within a specified REPORTING PERIOD.~~

2. The Department of Health requires performance management information on ELECTIVE ADMISSION LIST events within a specified REPORTING PERIOD.

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

4. This central information collection requirement is both:

   provider based and is submitted by provider NHS Trust 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.

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

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

Admitted Patient Flow Events

6. 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.
7. 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

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 Suspended Patients.

   ELECTIVE ADMISSION TYPE records the classification of the admission.

9. 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 STOCKS DATA SET OVERVIEW

Change to Supporting Information: Change to Supporting Information

Admitted Patient Stocks at the end of the Reporting Period

1. ~~The Department of Health requires performance management information on ELECTIVE ADMISSION LIST stocks at the end of a specified REPORTING PERIOD.~~

2. The Department of Health requires performance management information on ELECTIVE ADMISSION LIST stocks at the end of a specified REPORTING PERIOD.

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

4. 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.

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

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

Admitted Patient Stock Group Main Specialty

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

Admitted Patient Stock Sub Group Ordinary Admissions and Day Case Admissions

7. 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
8. The collection is for:

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

   and

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

   and

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

   and

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

9. 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.

10. 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

11. The collection data is grouped by ADMISSION INTENDED PROCEDURE which indicates the required range

of OPERATIVE PROCEDURES. Where the are no stocks present for an ADMISSION INTENDED PROCEDURE within the REPORTING PERIOD then no in-patient stocks group should be recorded for it. Only one group is permitted per ADMISSION INTENDED PROCEDURE.

12. The required grouping ranges of ADMISSION INTENDED PROCEDURE are:

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

13. Within the ADMISSION INTENDED PROCEDURE the collection only applies to patients waiting for admission as ordinary admissions as indicated by WAITING FOR ADMISSION INTENDED MANAGEMENT.
14. The collection is for:

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

    and

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

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

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

    ELECTIVE ADMISSION TYPE records the classification of the admission.

BOOKINGS ADMITTED PATIENT AND OUT-PATIENT PROVIDER DATA SET OVERVIEW

Change to Supporting Information: Change to Supporting Information

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

Contextual Overview

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

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

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

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~~ 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 GENERAL PRACTITIONER 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 GENERAL PRACTITIONER 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 DATA SETS INTRODUCTION

Change to Supporting Information: Change to Supporting Information

Introduction

The development of data sets supports:

- information requirements of national and local performance management, planning and clinical governance
- assurance of the quality of health and social care services

- the monitoring of National Service Frameworks (NSFs)

The information in the Central Return Data Sets is transmitted at aggregate level. Some of these Central Return Data Sets are transmitted to Unify.
~~Unify is the data collection system used by the Knowledge and Intelligence team in the Department of Health to collect a wide range of performance information.~~ Unify is the data collection system used by the Knowledge and Intelligence team in the Department of Health to collect a wide range of performance information. The Unify homepage can be found at the following address:
http://nww.unify.dh.nhs.uk/unify/interface/homepage.aspx.

Note: access to this address requires a Unify account and password. Any queries about the site can be addressed to the Unify helpdesk by emailing STEIS-Helpdesk@dh.gsi.gov.uk or calling 0113 254 5278

CHOOSE AND BOOK UTILISATION COMMISSIONER DATA SET OVERVIEW

Change to Supporting Information: Change to Supporting Information

~~**Contextual Overview**~~
Contextual Overview

- ~~The Department of Health requires performance management information on utilisation of the NHS Connecting for Health Choose and Book System.~~
    - The Department of Health requires performance management information on utilisation of the NHS Connecting for Health Choose and Book System.
    - 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
    - ~~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
    - The collection is for all PATIENTS given an APPOINTMENT and added to the Out-Patient Waiting List within the REPORTING PERIOD arising from a GENERAL PRACTITIONER referral processed using the NHS Connecting for Health Choose and Book System.
    - ~~The collection is for all PATIENTS given an APPOINTMENT and added to the Out-Patient Waiting List within the REPORTING PERIOD arising from a GENERAL PRACTITIONER referral processed using the NHS Connecting for Health Choose and Book System.~~
    - ~~The NHS Connecting for Health Choose and Book system during the booking process issues a unique booking reference number when a PATIENT is offered one or more APPOINTMENT DATE OFFERED of an APPOINTMENT OFFER.~~
    - The NHS Connecting for Health Choose and Book system during the booking process issues a 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 subsequently the PATIENT does not attend or cancels the APPOINTMENT.

      The APPOINTMENT BOOKING SYSTEM TYPE of the APPOINTMENT records the type of booking system used and UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) records the 'converted' reference number.

COMMISSIONING DATA SET OVERVIEW

Commissioning Data Set Overview

A. Information Requirements

1. ~~Information on care provided by NHS hospitals and Primary Care Trusts for all PATIENTS, and Independent Sector providers (for NHS patients only) is required to:~~

    - ~~monitor and manage Service Agreements;~~
    - ~~develop commissioning plans;~~
    - ~~monitor Health Improvement Programmes;~~
    - ~~underpin clinical governance;~~
    - ~~understand the health needs of the population.~~

    ~~Main commissioners need access to data to monitor Out Of Area Treatment activity as part of the management of their Service Agreements. Primary Care Trusts also need to monitor in-year referrals to investigate the sources and reasons for Out of Area Treatments.~~

    ~~Independent Sector Treatment Centres (TC) are responsible for providing Admitted Patient Care and Out-Patient Attendance CDS and may submit it on their own behalf or via a third party. Other Independent Sector activity for NHS patients is the responsibility of the NHS commissioning body for the provision of the appropriate central returns and data sets.~~

1. Information on care provided by NHS hospitals and Primary Care Trusts for all PATIENTS, and Independent Sector providers (for NHS PATIENTS only) is required to:
    - monitor and manage Service Agreements;
    - develop commissioning plans;
    - monitor Health Improvement Programmes;
    - underpin clinical governance;
    - understand the health needs of the population.

    Main commissioners need access to data to monitor Out Of Area Treatment activity as part of the management of their Service Agreements. Primary Care Trusts also need to monitor in-year referrals to investigate the sources and reasons for Out of Area Treatments.

    Independent Sector Treatment Centres are responsible for providing Admitted Patient Care and Out-Patient Attendance Commissioning Data Set and may submit it on their own behalf or via a third party. Other Independent Sector activity for NHS PATIENTS is the responsibility of the NHS Commissioning Body for the provision of the appropriate central returns and data sets.

2. ~~The **Department of Health** (DH) needs a complete record of all patients admitted to or treated as out-patients by NHS hospitals and Primary Care Trusts, including patients receiving private treatment. The record also includes NHS patients treated electively in the independent sector and overseas. Hospital Episode Statistics (HES) are derived from the Admitted Patient Care CDS Types, Out-Patient Attendance and Accident and Emergency Attendance CDS Types submitted via the NHS-wide Clearing Service (NWCS). These records provide information about hospital and patient management and epidemiological data on patient diagnoses and operative procedures. The HES data warehouse has already been used to support many aspects of the new Performance Framework.~~

2. The **Department of Health** needs a complete record of all PATIENTS admitted to or treated as out-patients by NHS hospitals and Primary Care Trusts, including patients receiving private treatment. The record also includes NHS PATIENTS treated electively in the independent sector and overseas. Hospital Episode Statistics are derived from the Admitted Patient Care Commissioning Data Set Types, Out-Patient Attendance and Accident and Emergency Attendance Commissioning Data Set Types submitted via the NHS-Wide Clearing Service. These records provide information about hospital and PATIENT management

and epidemiological data on PATIENT diagnoses and operative procedures. The Hospital Episode Statistics data warehouse has already been used to support many aspects of the new Performance Framework.

B. Data Flows

3. ~~HES records are extracted from the NWCS database quarterly. The timely provision of Admitted Patient Care (APC) records to the NWCS, complete with clinical information, is now a performance issue for Trusts.~~

3. Hospital Episode Statistics records are extracted from the NHS-Wide Clearing Service quarterly. The timely provision of Admitted Patient Care records to the NHS-Wide Clearing Service , complete with clinical information, is now a performance issue for Trusts.

4. The strategic direction set out within *Information for Health* is to develop comprehensive and consistent electronic health records for patients from clinical information flows. In the short term, access to and the analysis of Commissioning Data Set Types will remain important, and the exchange of these data sets should continue on at least a monthly basis.

5. To determine who receives Commissioning Data Set Types, NHS Trusts and Primary Care Trusts need to take **all** of the following factors into account, not necessarily in the order specified here:

    - identifying the PATIENT's registered GENERAL PRACTITIONER - to establish the responsible Primary Care Trust;

7. determining where the patient is resident - necessary when the patient is not registered with a GENERAL PRACTITIONER;

8. assigning the correct type of NHS Service Agreement for the treatment provided;

9. identifying an overseas visitor and whether the PATIENT is a private PATIENT.

10. ~~The strategic direction set out within *Information for Health* is to develop comprehensive and consistent electronic health records for patients from clinical information flows. In the short term, access to and the analysis of CDS Types will remain important, and the exchange of these data sets should continue on at least a monthly basis.~~

11. ~~To determine who receives CDS Types, NHS Trusts and Primary Care Trusts need to take **all** of the following factors into account, not necessarily in the order specified here:~~

    - ~~identifying the patient's registered GP – to establish the responsible Primary Care Trust;~~
    - ~~determining where the patient is resident – necessary when the patient is not registered with a GP;~~
    - ~~assigning the correct type of NHS Service Agreement for the treatment provided;~~
    - ~~identifying an overseas visitor and whether the patient is a private patient.~~

~~The information data flows are shown in the Tables below.~~

The information data flows are shown in the Tables below.

~~C. CDS Data Flow Definitions~~
C. Commissioning Data Set Data Flow Definitions

12. ~~The exchange of individual CDS Types may be mandatory or optional. All Admitted Patient Care, Out-Patient Attendance and Accident & Emergency Attendance CDS Type exchanges are mandatory, but exchanges of some individual CDS Types for Elective Admission List are not, and require local agreement between the parties concerned. Where CDS information is collected, it should always be exchanged via the NHS Wide Clearing Service.~~

10. The exchange of individual Commissioning Data Set Types may be mandatory or optional. All Admitted Patient Care, Out-Patient Attendance and Accident and Emergency Attendance Commissioning Data Set Type exchanges are mandatory, but exchanges of some individual Commissioning Data Set Types for Elective Admission List are not, and require local agreement between the parties concerned. Where Commissioning Data Set information is collected, it should always be exchanged via the NHS-Wide Clearing Service.

11. ~~Where CDS Types **are** exchanged, the data items within the CDS Type have a mandatory or optional status. A data item marked as mandatory (M) means that it must be included in the CDS Type; a data item marked as optional (O) means that the data item need only be included if both parties agree to its exchange. Although the exchange of the CDS Type may be optional, this does **not** apply to the status of the data items within this CDS Type.~~

11. Where Commissioning Data Set Types **are** exchanged, the data items within the Commissioning Data Set Type have a mandatory or optional status. A data item marked as mandatory (M) means that it must be included in the Commissioning Data Set Type; a data item marked as optional (O) means that the data item need only be included if both parties agree to its exchange. Although the exchange of the Commissioning Data Set Type may be optional, this does **not** apply to the status of the data items within this Commissioning Data Set Type.

12. ~~For records relating to CDS **activity from the 1st April 2005** see REVISED CDS INFORMATION FLOW ADDRESSING GRID – Activity from 1st April 2005 below. An additional Patient/Service Agreement row has been introduced to identify activity commissioned by the National Specialist Commissioning Advisory Group (NSCAG). The code YDD82 should be used as the ORGANISATION CODE (CODE OF COMMISSIONER) for NSCAG commissioned activity.~~

12. For records relating to Commissioning Data Set **activity from the 1st April 2005** see REVISED CDS INFORMATION FLOW ADDRESSING GRID - Activity from 1st April 2005 below. An additional Patient/Service Agreement row has been introduced to identify activity commissioned by the National Specialist Commissioning Advisory Group. The code YDD82 should be used as the ORGANISATION CODE (CODE OF COMMISSIONER) for National Specialist Commissioning Advisory Group commissioned activity.

13. For records relating to CDS **activity from 1st April 2002 to 31st March 2005**, see PREVIOUS CDS INFORMATION FLOW ADDRESSING GRID - Activity from 1st April 2002 to 31st March 2005 below.

REVISED CDS INFORMATION FLOW ADDRESSING GRID - Activity from 1st April 2005

	CDS PRIME RECIPIENT	-	-	-
Patient/Service Agreement	PCT OF RESIDENCE	PCT responsible	Main Commissioner	Organisation to which cos treatment accrue
Patient registered with GP with PCT Service Agreement	*	*		
Patient not registered with a GP but resident in an area covered by a PCT with a PCT Service Agreement	*	*		
Patient registered with a GP treated as an Out Of Area Treatment (OAT)	*	*	*	
Patient not registered with a GP treated as an Out Of Area Treatment (OAT)	*	*	*	
Overseas visitor exempt from charges and not registered with a GP	* **(TDH00)**		*	
Overseas visitor exempt from	*	*	*	

charges and registered with a GP	**(TDH00)**			
Overseas visitor liable for NHS charges and not registered with a GP	* **(VPP00)**			
Overseas visitor liable for NHS charges and registered with a GP	* **(VPP00)**	*		
Patient registered with GP with a Specialised Services & Other Commissioning Consortia Service Agreement	*	*		*
Patient not registered with GP with a Specialised Services & Other Commissioning Consortia Service Agreement	*	*		*
Private Patient	*	*		
NSCAG commissioned	*	*		**YDD82**

Notes:

a. Some flows will be sent for unfinished episodes. For example, a consultant episode may be in progress when a data flow is sent. In such cases the end date is not known and the patient has not been discharged. These data items will therefore not be included in that data flow.

b. ~~Note that if two recipients are identical (PCT of Residence is the same as the Main Commissioner) only **one** data set should be sent to that recipient.~~ Note that if two recipients are identical (Primary Care Trust of Residence is the same as the Main Commissioner) only **one** data set should be sent to that recipient.

c. For further information please refer to **DSCN 06/2005**.

PREVIOUS CDS INFORMATION FLOW ADDRESSING GRID - Activity from 1st April 2002 to 31st March 2005

	CDS PRIME RECIPIENT			
Patient/Service Agreement	PCT OF RESIDENCE	PCT responsible	Main Commissioner	Organi to whi costs c treatm accrue
Patient registered with GP with PCT Service Agreement	*	*		
Patient not registered with a GP but resident in an area covered by a PCT with a PCT Service Agreement	*	*		
Patient registered with a GP treated as an Out Of Area Treatment (OAT)	*	*	*	
Patient not registered with a GP treated as an Out Of Area Treatment (OAT)	*	*	*	
Overseas visitor exempt from charges and not registered with a GP	* **(TDH00)**		*	
Overseas visitor exempt from charges and registered with a GP	* **(TDH00)**	*	*	
Overseas visitor liable for NHS charges and not registered with a GP	* **(VPP00)**			
Overseas visitor liable for NHS charges and registered with a GP	* **(VPP00)**	*		
Patient registered with GP with a Specialised Services & Other Commissioning Consortia Service Agreement	*	*		*
Patient not registered with GP with a Specialised Services & Other Commissioning Consortia Service Agreement	*	*		*

Private Patient	*	*		

Notes:

a. Some flows will be sent for unfinished episodes. For example, a consultant episode may be in progress when a data flow is sent. In such cases the end date is not known and the patient has not been discharged. These data items will therefore not be included in that data flow.

b. Note that if two recipients are identical (PCT of Residence is the same as the Main Commissioner) only **one** data set should be sent to that recipient.

c. For further information please refer to **DSCN 46/2002**.

DEPARTMENT OF HEALTH

Change to Supporting Information: New Supporting Information

Department of Health

Aims

The aim of the Department of Health's is to improve the health and wellbeing of everyone in England by:

- ensuring the provision of care services (health and social care) and
- Promoting the health of the public.

Roles

The Department of Health's roles are to be:

- the effective national Headquarter for the NHS;
- a major Department of State for broad and complex range of governmental activity and
- responsible for setting health policy on public health, adult social care and related topics from genetics to international health

Responsibilities

The Department of Health is responsible for :

- developing strategy and direction for the health and social care system;
- providing the legislative framework;
- building capability and capacity;
- setting some standards and ensuring others are set;
- securing and allocating resources, and ensuring that their usage provides value for money and
- ensuring accountability to the public and Parliament.

For further information on the Department of Health, see the Department of Health website.

HES CROSS REFERENCE TABLES NAVIGATION

Change to Supporting Information: Change to Supporting Information

~~The tables in this section show the relationship between HES data items and APCCDS data items, indicating from~~

~~which CDS Type they are extracted.~~ The tables in this section show the relationship between HES data items and Admitted Patient Care Commissioning Data Set data items, indicating from which Commissioning Data Set Type they are extracted.

~~**HES Cross Reference Tables:**~~ **Hospital Episode Statistics Cross Reference Tables:**

- HES - CDS Data items cross referenced by HES Name - Table 1
- HES - CDS Data items cross referenced by HES Item - Table 2

~~**HES Contact Details:**~~ **Hospital Episode Statistics Contact Details:**
~~**HES Codes, Classifications & Definitions:**~~ **Hospital Episode Statistics Codes, Classifications and Definitions:**
Dept SD2HES
Room 430B
Department of Health
Skipton House
80 London Road
London
SE1 6LW
Tel: 020 7972 5563

~~**HES Processing Enquiries:**~~ **Hospital Episode Statistics Processing Enquiries:**
~~HES Help Desk~~ Hospital Episode Statistics Help Desk
IBM Global Services
Normandy House
Bunnian Place
Basingstoke
Hampshire
RG21 7EJ
Tel: 01256 344186

HES information and publications are available from:
~~The DH Website~~ The Department of Health Website

HOSPITAL EPISODE STATISTICS

Change to Supporting Information: Change to Supporting Information

HOSPITAL EPISODE STATISTICS (HES)

Introduction

~~The data for the Department of Health Hospital Episode Statistics (HES) data warehouse are extracted from the Commissioning Data Set at the NHS-wide Clearing Service (NWCS).~~ The data for the Department of Health Hospital Episode Statistics data warehouse are extracted from the Commissioning Data Set at the NHS-Wide Clearing Service (NWCS).

~~HES and what they are used for~~
Hospital Episode Statistics and what they are used for

~~The Hospital Episode Statistics (HES) required by the Department of Health cover every finished consultant, nurse and midwife episode in England (including regular day and night admissions) within the financial year, from 1 April to 31 March.~~ The Hospital Episode Statistics required by the Department of Health cover every finished CONSULTANT, NURSE and MIDWIFE episode in England (including regular day and night admissions) within the financial year, from 1 April to 31 March. Finished episodes must contain all the relevant clinical data. Hospital Episode Statistics also includes an Annual Census of episodes unfinished at midnight on 31 March, and

the Psychiatric Census, a subset of the Annual Census, which contains additional data items. Hospital Episode Statistics will also cover out-patient and accident and emergency data backdated to 1 April 2003, extracted from the Out-Patent Attendance and Accident and Emergency Attendance Commissioning Data Set Types. The data warehouse represents an invaluable national source of information about patterns of treatment in hospitals throughout England as well as providing epidemiological data about diseases and operative procedures.

Hospital Episode Statistics data are published annually and are also used to feed into other published statistics including the Compendium of Clinical and Health Indicators (formerly the Public Health Common Dataset) and the Performance Indicators. Within the Department of Health, the main uses of the data include policy development, resource allocation, performance management, accountability to public and parliament and monitoring of health and healthcare variations. In addition, Hospital Episode Statistics data are widely used by clinical and other researchers, both within and outside the Department of Health. There is pressure to increase both the timeliness and completeness of the Hospital Episode Statistics data set.

~~Further information can be obtained from the Hospital Episode Statistics (HES) website:~~ ~~http://www.~~ Further information can be obtained from the Hospital Episode Statistics website: http://www.dh.gov.uk/PublicationsAndStatistics/Statistics/HospitalEpisodeStatistics/fs/en

How Hospital Episode Statistics data are processed

~~Data records must be lodged with the NHS-wide Clearing Service regularly and routinely, preferably on a monthly basis.~~ Data records must be lodged with the NHS-Wide Clearing Service regularly and routinely, preferably on a monthly basis.

~~Extracts for the Hospital Episode Statistics data warehouse are taken at prearranged times each quarter and these dates are published on the ClearNET website and elsewhere.~~ Extracts for the Hospital Episode Statistics data warehouse are taken at prearranged times each quarter and these dates are published on the ClearNET website and elsewhere. http://clearnet.mhapp.nhs.uk/iclearnet.html

These quarterly extracts are generally taken one month apart in order to reduce the burden on the NHS. A&E data will be extracted to a similar timetable, initially six months in arrears but moving to quarterly extracts.

Data is extracted as cumulative quarters throughout the period 1 April - 31 March and the entire year's data is taken again - as an 'annual refresh' - approximately eight weeks after the end of the year for admitted patient data and 12 weeks after the end of the year for out-patient data.

It is expected that at each of the extract dates the records are as complete as possible both in terms of the overall activity and the completion of the relevant data items. Unfinished and psychiatric census episodes for the whole year, which form part of the admitted patient data, are taken at the same time as the annual refresh.

Before being incorporated into the main Hospital Episode Statistics data warehouse, all data are subject to a complex sequence of checks, as follows:

Verification

For finished admitted patient episodes, the NWCS service provider selects episodes that contain an end date within the data year. To be accepted for Hospital Episode Statistics, a record must contain an appropriate Hospital Provider Code relating to that data year. A record which fails this check will be rejected. ~~Similar criteria apply for the extraction of out-patient and A&E CDS data in that the event must have occured within the extract period.~~ Similar criteria apply for the extraction of out-patient and A&E Commissioning Data Set data in that the event must have occurred within the extract period.

Derivation

~~The data extracted is used singly or in combination to derive additional information, such as the patient's age group or the SHA of treatment to facilitate the interrogation and analysis of the data warehouse.~~ The data extracted is used singly or in combination to derive additional information, such as the PATIENT's age group or the Strategic Health Authority of treatment to facilitate the interrogation and analysis of the data warehouse.

Manual Cleaning (Annual Data Only)
Under exceptional circumstances, the processing of the annual data can be halted to make manual changes to the data. This is carried out on a Trust specific basis and requires the agreement of the Trust(s) concerned and the Hospital Episode Statistics section. Manual cleaning is extremely resource and time intensive and is only undertaken when there would otherwise be a significant impact on the integrity of the dataset. The details of the manual cleaning process are on the Hospital Episode Statistics website (see below for the website address).

Autocleaning
Various fields within the record are analysed to see whether the entries make sense on their own, and with reference to related fields. In some cases it is possible to overwrite incorrect entries by deriving the data from other fields within the record. If this cannot be done, the incorrect entry may be overwritten with the accepted code for `not known/not applicable'.

Further information

If you want to find out more on Hospital Episode Statistics processing, the Hospital Episode Statistics team at the Department of Health publish a number of documents, one of which details the autocleaning and derivation routines outlined above.

The Hospital Episode Statistics team can be contacted at:

~~Department of Health HES Service~~ Department of Health Hospital Episode Statistics Service
Skipton House - Room 430B
80, London Road
London
SE1 6LH
Tel: 020 7972 5529
Fax: 020 7972 5662
~~DH Website – HES~~ Department of Health Website - Hospital Episode Statistics.

MENTAL HEALTH MINIMUM DATA SET MESSAGE SCHEMA VERSIONS

Change to Supporting Information: Change to Supporting Information

~~The Mental Health Minimum Data Set will be collected from Health Care Providers via the Secondary Uses Service using the MHMDS XML Message. The Mental Health Minimum Data Set data will be stored in the Secondary Uses Service enabling the Department of Health to produce routine reports.~~ The Mental Health Minimum Data Set will be collected from Health Care Providers via the Secondary Uses Service using the Mental Health Minimum Data Set-XML Message. The Mental Health Minimum Data Set data will be stored in the Secondary Uses Service enabling the Department of Health to produce routine reports.

XML is a markup language for data flows containing structured information and will meet Government standards in line with the e-Government Interoperability Framework (e-gif) requirements.

The schemas are published as .xsd files and are in zipped format. These are best viewed using XMLSPY or an equivalent XML viewer. Schema documentation as generated by XMLSPY is also available for download, this documentation may be viewed in most browsers.

A Schema Version Release Note file (in MS Word) is also included with the schema.

The following table sets out the approved versions of the Mental Health Minimum Data Set Message. To download a schema and its associated documentation, follow the hyperlink for the specific Message Version.

MHMDS Version	Message Format	Message Version	Available From	Mandated From	Usable To
V 2.1	XML	MHMDS-XML_Schema-v3-3-2007-06-01 and MHMDS-	31 Dec	31 Dec	Current

	Schema	XML_Schema-v3-3-2007-06-01 Documentation	2007	2007	

~~Previous versions of the MHMDS-XML Schema which were used for development and testing of the Secondary Uses Service services are now obsolete.~~ Previous versions of the Mental Health Minimum Data Set-XML Schema which were used for development and testing of the Secondary Uses Service services are now obsolete.

MENTAL HEALTH MINIMUM DATA SET OVERVIEW

Change to Supporting Information: Change to Supporting Information

Mental Health Minimum Data Set Overview

~~The Mental Health Minimum Data Set (MHMDS) was introduced by DSCN20/19/P13 in April 2000 in response to the lack of national clinical data collection in the mental health arena, in line with the information requirements of the emerging National Service Framework for Mental Health.~~ The Mental Health Minimum Data Set was introduced by DSCN20/19/P13 in April 2000 in response to the lack of national clinical data collection in the mental health arena, in line with the information requirements of the emerging National Service Framework for Mental Health.

Since April 2003 (DSCN 49/2002) it has been a mandatory requirement that all Providers of specialist adult, including elderly, mental health services submit central Mental Health Minimum Data Set returns on a quarterly basis, with an additional annual submission.

The Mental Health Minimum Data Set facilitates the collection of person-focussed clinical data and the sharing of such data to underpin the delivery of mental health care. It is structured around the clinical process and includes an outcome assessment (Health of the Nation Outcome Scales, or HoNOS). It records the key role played by partner agencies, particularly social services.

The Mental Health Minimum Data Set describes Mental Health Care Spells. These comprise all interventions made for a PATIENT by a specialist Mental Health Care Team from initial REFERRAL REQUEST to final discharge. For some individuals the Mental Health Care Spell will comprise a short Out-Patient Episode; for others it may extend over many years and include hospital, community, out-patient and day care episodes.

Information is collected relating to various stages in the PATIENTS journey, including activity such as inpatients, out-patients, community care, and NHS day care episodes; mental health reviews and assessments including Care Programme Approach (CPA) and Health of the National Outcome Scales (HoNOS); contacts with mental health professionals such as care co-ordinators, psychiatric NURSES and CONSULTANTS; and also any diagnosis and treatment.

The prime purpose of the Mental Health Minimum Data Set is to provide local clinicians and managers with better quality information for clinical audit, and service planning and management.

Central collection provides improved national information, facilitating feedback to Trusts, and the setting of benchmarks. It will also allow the delivery of the National Service Framework for Mental Health priorities to be monitored.

~~The Mental Health Minimum Data Set data is collected from NHS Trusts and submitted via the Mental Health Minimum Data Set Assembler to the Secondary Uses Service for storage, analysis and reporting by a variety of stakeholders including the Department of Health, Healthcare Commission, and the Health and Social Care Information Centre.~~ The Mental Health Minimum Data Set data is collected from NHS Trusts and submitted via the Mental Health Minimum Data Set Assembler to the Secondary Uses Service for storage, analysis and reporting by a variety of stakeholders including the Department of Health, Healthcare Commission, and the Health and Social Care Information Centre.

The Mental Health Minimum Data Set is transmitted to the Secondary Uses Service using Mental Health Minimum Data Set Message Schema Versions

Please note that the collection of the Mental Health Minimum Data Set does not replace any other collection of mental health data such as the Admitted Patient Care Commissioning Data Set Type Detained and/or Long Term Psychiatric Census, which should continue to be collected.

For further information on the Mental Health Minimum Data Set, please view the following Health and Social Care Information Centre website:

http://www.ic.nhs.uk/mentalhealth/mhmds

Mental Health Minimum Data Set Version History

Version	Date Issued	Summary of Changes	DSCN	Implementation Date
1.0	November 1999	Introduction of Mental Health Minimum Data Set	DSCN 20/99/P13	April 2000
1.1	June 2002	Data Standards - Changes to Mental Health Minimum Data Set (MHMDS)	DSCN 27/2002	April 2003
1.2	September 2002	Data Standards - Changes to Mental Health Minimum Data Set (MHMDS)	DSCN 29/2002	April 2003
1.3	October 2002	Data Standards - Changes to Mental Health Minimum Data Set (MHMDS)	DSCN 48/2002	April 2003
2.0	October 2002	Mental Health Minimum Data Set - Mandatory Central returns. This version of the data set incorporates changes defined in DSCN 27/2002, 29/2002 and 48/2002.	DSCN 49/2002	April 2003
2.1	November 2007	Introduction of Mental Health Minimum Data Set Version 2.1	DSCN 37/2007	November 2007

METADATA FILES

Change to Supporting Information: Change to Supporting Information
~~Metadata Files~~

~~METADATA FILES~~

Metadata Files

METADATA FILES

Files Available

1. Metadata files are used by the NHS to validate data. The files facilitate data consistency and quality. The files are:

    - Diagnosis (ICD-10)
    - Operation (OPCS-4) Fourth Revision Consolidated Version
    - NHS Postcode Directory
    - Frozen Postcode Directory
    - Country Pseudo Postcodes.

2. ~~Metadata files are used by the NHS to validate data. The files facilitate data consistency and quality. The files are:~~

    - ~~Diagnosis (ICD-10)~~
    - ~~Operation (OPCS-4) Fourth Revision Consolidated Version~~

- ~~NHS Postcode Directory~~
- ~~Frozen Postcode Directory~~
- ~~Country Pseudo Postcodes.~~

2. The ICD-10 file is issued by NHS Connecting for Health, from whom a specification is available. It is intended to reissue this file in line with the ICD-10 updates.

3. ~~The Operation metadata file is also issued by the NHS Information Authority on request. No update of this file is currently envisaged.~~

3. The Operation metadata file is also issued by NHS Connecting for Health on request. No update of this file is currently envisaged.

4. ~~The NHS Postcode Directory (''Gridlink'' version) is maintained, on behalf of the Department of Health, by the Office for National Statistics (ONS). The full NHS Postcode Directory on CD-ROM and via the NHSnet is provided free to the NHS, every quarter, by the National Administrative Codes Service (NACS). A reduced version of the full NHS Postcode Directory, containing Postcode, Strategic Health Authority Code and Primary Care Group/Trust/Care Trust Code, is provided every quarter on CD-ROM and via ***NHSnet*** as part of the standard National Administrative Codes Service (NACS) data issue; see Contact Details.~~

4. The NHS Postcode Directory (''Gridlink'' version) is maintained, on behalf of the Department of Health, by the Office for National Statistics. The full NHS Postcode Directory on CD-ROM and via the NHSnet is provided free to the NHS, every quarter, by the National Administrative Codes Service (NACS). A reduced version of the full NHS Postcode Directory, containing Postcode, Strategic Health Authority Code and Primary Care Group/Trust/Care Trust Code, is provided every quarter on CD-ROM and via ***NHSnet*** as part of the standard National Administrative Codes Service (NACS) data issue; see Contact Details.

5. ~~A version of the Central Postcode Directory (CPD), the 91-based Frozen Postcode Directory, is produced by the ONS to provide a stable base to facilitate time source analysis. Full details are set out in the CPD User Guide available from ONS; see Contact Details.~~

5. A version of the Central Postcode Directory, the 91-based Frozen Postcode Directory, is produced by the ONS to provide a stable base to facilitate time source analysis. Full details are set out in the Central Postcode Directory User Guide available from Office for National Statistics; see Contact Details.

6. ~~Any area within the NHS taking advantage of the supply of metadata by ONS will be expected to abide by any rules and conditions imposed by the ONS Section supplying the metadata.~~

6. Any area within the NHS taking advantage of the supply of metadata by the Office for National Statistics will be expected to abide by any rules and conditions imposed by the Office for National Statistics Section supplying the metadata.

Media

7. NHS Connecting for Health Metadata files are normally supplied on disk. Potential users should contact the NHS Information Authority Coding and Classification Help Desk on 0121 333 0420 (direct line).

Format of Metadata Files

8. The following pages give the record layouts and data content for the Operation and Country Pseudo Postcode metadata files.

Operation File Data Content

9. This file consists of about 7,000 records, one record for each operation (OPCS-4) Fourth Revision Consolidated Version used in the HES processing system. The records are in operation code order. Each

record also contains editing parameters used in validation.

OPERATION FILE RECORD LAYOUT

Start Position	Size	Occurs	Field Description
1	11		selection indicators
12	1		operation prefix
13	4		operation code
17	8		filler
25	55		operation name (3 digit)
80	5		filler
85	60		operation name (4 digit)
145	43		filler
188	1		sex (absolute)
189	3		filler
192	1		sex (scrutiny)
193	1		filler
194	2		status of operation
196	23		filler
219	1	10	method of delivery
229	24		filler

OPERATION FILE FIELD CONTENTS

Field	Content
Operation Prefix	space
Operation Code	4 chars, 1 alphanumeric + 3 numeric
Sex (absolute)	space = accept any sex code 1 = males not accepted 2 = females not accepted
	1 = males not accepted
	2 = females not accepted
Sex (scrutiny)	space = accept any sex code
	1 = males not accepted
	2 = females not accepted
NB The following relate to primary operation only	
Status of Operation	if status not = 01, reject for scrutiny
Method of Delivery	10 one character codes representing the DELMETH code values 0 - 9. Check character position corresponding to DELMETH code value space = no check required 1 = reject for scrutiny

Country Pseudo Postcode File Data Content

10. ~~This file contains about 130 records. The usual country of residence for short term overseas visitors is derived from the country pseudo postcode, these can be found by browsing the NACS *NHSnet* website. The codes are also available in electronic format on the NHS Postcode Directory ("Gridlink version").~~

10. This file contains about 130 records. The usual country of residence for short term overseas visitors is derived from the country pseudo postcode, these can be found by browsing the National Administrative Codes Service *NHSnet* website. The codes are also available in electronic format on the NHS Postcode Directory ("Gridlink version").

~~For the NACS contact details, see~~ ~~Contact Details.~~ For the National Administrative Codes Service contact details, see Contact Details.

11. The expanded area code field contains the country of birth code in characters 1-4 (a repeat of the characters 3-6 in the pseudo postcode). The remainder of the expanded area code is blank except for codes 993C (UK nos) and 993V (no fixed abode) where characters 5-7 are 9space9.

COUNTRY PSEUDO FILE RECORD LAYOUT

Start Pos	Size	Data Type	Field Description
1	11	X	selection indicators
12	6	X	6 digit postcode (POSTSIX)
18	1	A	7th digit
19	6	X	filler
25	50	X	name of country
75	5	X	filler
80	19	X	area details
99	154	X	filler

NATIONAL CANCER WAITING TIMES MONITORING DATA SET OVERVIEW

Change to Supporting Information: Change to Supporting Information

Introduction

DSCN 22/2002 introduced a central electronic collection of patient level information to monitor waiting times in line with targets in the National Cancer Plan.

Reporting

QMCW

~~The existing QMCW will be phased out when data outlined in the DSCN is submitted via a central database and the data is of an acceptable quality.~~ ~~Until notification otherwise, the QMCW must be submitted to the Department.~~ The existing Quarterly Monitoring of Cancer Waits will be phased out when data outlined in the DSCN is submitted via a central database and the data is of an acceptable quality. Until notification otherwise, the Quarterly Monitoring of Cancer Waits must be submitted to the Department of Health.

Patient level information

~~Information is to be submitted onto a national database that has been developed and maintained by the NHS Information Authority.~~ ~~The Trust~~ first seeing ~~a patient in a particular month or quarter is responsible for ensuring that the mandated data fields, up to date first seen, are complete on the database by the national deadline.~~ ~~The Trust~~ first treating ~~a patient in a particular month or quarter is responsible for ensuring that the mandated data fields on that patient are complete on the database by the national deadline.~~ Information is to be submitted onto a national database that has been developed and maintained by NHS Connecting for Health. The Trust first seeing a PATIENT in a particular month or quarter is responsible for ensuring that the mandated data fields, up to date first seen, are complete on the database by the national deadline. The Trust first treating a patient in a particular month or quarter is responsible for ensuring that the mandated data fields on that PATIENT are complete on the database by the national deadline.

How the data set is transmitted

Information can be entered either manually through the Cancer Waiting Times Record screen or via the upload screen. The specification for the upload file is detailed in the 'National Cancer Waiting Times User Manual' available at Cancer Waiting Times - Useful Documentation and Links

Security and Confidentiality

Security and confidentiality information to accompany the collection of this information is available at Cancer Waiting Times - Useful Documentation and Link (Security Section)

~~**Further guidance** Further guidance has been produced by the Department of Health and is available at Cancer Waiting Times – Useful Documentation and Link (DoH Section)~~ **Further guidance** Further guidance has been produced by the Department of Health and is available at Cancer Waiting Times - Useful Documentation and Link (Department of Health Section)

NEONATAL CRITICAL CARE MINIMUM DATA SET OVERVIEW

Change to Supporting Information: Change to Supporting Information

Scope:

The definition of the Neonatal Critical Care is linked to the definition of Neonatal Critical Care Healthcare Resource Groups. ~~These closely follow the definitions contained in the 2003 Department of Health report 'Report of the Neonatal Intensive Care Services Review Group'.~~ These closely follow the definitions contained in the 2003 Department of Health report 'Report of the Neonatal Intensive Care Services Review Group'.

This takes account of related definitions which have been developed for the Maternity and Child Health data sets which are currently being drafted by the Health and Social Care Information Centre.

The scope of the Neonatal Critical Care Minimum Data Set is:

a) All PATIENTS on a WARD with a CRITICAL CARE UNIT FUNCTION *Neonatal Intensive Care Unit* regardless of care being delivered.

b) All PATIENTS (excluding Mothers) on a WARD with a CRITICAL CARE UNIT FUNCTION *Facility for Babies on a Neonatal Transitional Care Ward* or *Facility for Babies on a Maternity Ward* to whom one or more of the following CRITICAL CARE ACTIVITIES applies for a period greater than 4 hours:

01	Respiratory support via a tracheal tube
02	Nasal Continuous Positive Airway Pressure (nCPAP)
04	Exchange Transfusion
05	Peritoneal Dialysis
06	Continuous infusion of inotrope, pulmonary vasodilator or prostaglandin
07	Parentral Nutrition
08	Convulsions
09	Oxygen Therapy
10	Neonatal abstinence syndrome
11	Care of an intra-arterial catheter or chest drain
12	Dilution Exchange Transfusion
13	Tracheostomy cared for by nursing staff
14	Tracheostomy cared for by external carer
15	Recurrent apnoea
16	Haemofiltration
22	Continuous monitoring
23	Intravenous glucose and electrolyte solutions
24	Tube-fed
25	Barrier nursed
26	Phototherapy
27	Special monitoring
28	Observations at regular intervals

29 Intravenous medication

If one or more of these CRITICAL CARE ACTIVITIES apply to a PATIENT, then the PATIENT would be counted as receiving Neonatal Critical Care at the level of Intensive Care, High Dependency Care or Special Care depending on the CRITICAL CARE ACTIVITIES which apply.

Except in very exceptional circumstances, CRITICAL CARE ACTIVITIES 01 to 16 will only occur in a Neonatal Intensive Care Unit environment where all PATIENTS are covered by Neonatal Critical Care Minimum Data Set regardless of treatment. Care on WARDS with a CRITICAL CARE UNIT FUNCTION of 'Facility for Babies on a Neonatal Transitional Care Ward' or 'Facility for Babies on a Maternity Ward' will only be in respect of CRITICAL CARE ACTIVITIES 22 to 29 unless very exceptional circumstances apply. This does not prevent these WARDS recording CRITICAL CARE ACTIVITIES 01 to 16 on the Neonatal Critical Care Minimum Data Set if they occur. However, it does mean that such settings will in practice be dealing with a much shorter list of CRITICAL CARE ACTIVITIES which would determine whether the Neonatal Critical Care Minimum Data Set applied or not.

NHS POSTCODE DIRECTORY

Change to Supporting Information: Change to Supporting Information
~~NHS Postcode Directory~~

~~NHS POSTCODE DIRECTORY~~

NHS Postcode Directory

NHS POSTCODE DIRECTORY

1. ~~The NHS Postcode Directory is maintained, on behalf of the Department of Health, by the Office for National Statistics (ONS). It contains a record for every postcode in the UK, Channel Islands and the Isle of Man, and associates each postcode with a variety of geographic information, including grid references, Primary Care Trusts and Strategic Health Authority codes. The file also includes pseudo postcodes covering defaults and overseas countries.~~

1. The NHS Postcode Directory is maintained, on behalf of the Department of Health, by the Office for National Statistics. It contains a record for every postcode in the UK, Channel Islands and the Isle of Man, and associates each postcode with a variety of geographic information, including grid references, Primary Care Trust and Strategic Health Authority codes. The file also includes pseudo postcodes covering defaults and overseas countries.

2. ~~The full and reduced versions of the NHS Postcode Directory are issued every quarter by the National Administrative Codes Service (NACS). A CD-ROM is sent to named recipients both inside the NHS and to other recipients licensed to use this data in support of the NHS. Both versions of the NHS Postcode Directory are also available via the ***NHSnet***.~~

2. The full and reduced versions of the NHS Postcode Directory are issued every quarter by the National Administrative Codes Service. A CD-ROM is sent to named recipients both inside the NHS and to other recipients licensed to use this data in support of the NHS. Both versions of the NHS Postcode Directory are also available via the ***NHSnet***.

3. ~~A full description of the NHS Postcode Directory and the NACS reduced postcode data files, can be found by browsing the ONS Data website (this website is only available on *NHSnet*). See Publication Information Contact Details.~~

3. A full description of the NHS Postcode Directory and the National Administrative Codes Service reduced postcode data files, can be found by browsing the Office for National Statistics Data website (this website is only available on *NHSnet*). See Contact Details.

4. ~~The ONS will supply, on request and at a cost, copies of the NHS Postcode Directory, on different media, in different formats and for selected extracts. Contact the ONS for details and charges; See Publication Information Contact Details.~~

4. The Office for National Statistics will supply, on request and at a cost, copies of the NHS Postcode Directory, on different media, in different formats and for selected extracts. Contact the Office for National Statistics for details and charges; see Contact Details.

Postcodes

5. ~~All postcodes made available via NACS postcode files have been standardised to the eight character postcode format as used by the Royal Mail's Postal Address File (PAF). All NHS Organisations should ensure that they conform to the postcode format.~~

5. All postcodes made available via National Administrative Codes Service postcode files have been standardised to the eight character postcode format as used by the Royal Mail's Postal Address File (PAF). All NHS ORGANISATIONS should ensure that they conform to the postcode format.

6. Postcodes are of the general format :

Character Position	1	2	3	4	5	6	7	8
Format	a	a/n	a/n	a/n	space	n	a	a
Coding Frame	Outward Code				space	Inward Code		

7. The coding frame allows the use of digits 0 (zero) to 9 and the use of upper-case alpha characters; no special characters are allowed.

8. The fifth character of all standard format postcodes is always a space, and separates the outward and inward parts of the postcode. The outward part of the postcode is left-justified and can contain 2, 3 or 4 characters, and is space-filled in character positions 3 and 4 where required. The inward part of the postcode is always 3 characters.

   The following table gives examples of typical postcodes :

Character Position								Allocated by	Notes
1	2	3	4	5	6	7	8		
1	2	3	4	5	6	7	8		
W	9				3	X	X	Royal Mail	
D	A	1			5	P	L	Royal Mail	
M	K	4	5		1	T	E	Royal Mail	
Z	Z	9	9		4	L	Z	NACS	Pseudo Postcodes, Defaults and Overseas

9. The "Scottish split postcode indicator" field was discontinued from the 1996/1 version of the NHS Postcode Directory. This value used to appear in the 8th character position of the postcode (the postcode field was then only 7 characters in length). The ‘Alternative’ version of the NHS Postcode Directory, showing postcodes containing this field, is available from the ONS.

Strategic Health Authority / Local Health Board / Health Board Codes

10. ~~Strategic Health Authorities in England are indicated by their standard NACS codes (Q codes). Local Health Boards in Wales use five character codes commencing with a '6', and with the last two characters~~

~~'00'. Health Boards in Scotland use a three character version of the Health Board code (range SA9 – SZ9). The four Northern Ireland Health Boards are indicated by their standard codes – ZE0, ZN0, ZS0, ZW0.~~

10. Strategic Health Authority in England are indicated by their standard NACS codes (Q codes). Local Health Boards in Wales use five character codes commencing with a '6', and with the last two characters '00'. Health Boards in Scotland use a three character version of the Health Board code (range SA9 - SZ9). The four Northern Ireland Health Boards are indicated by their standard codes - ZE0, ZN0, ZS0, ZW0.

11. ~~No Strategic Health Authorities exist for the Channel Islands and the Isle of Man so notional (or dummy) Strategic Health Authority codes are used to identify postcodes from these locations. The default Pseudo health authority code of X98 is used to indicate pseudo postcodes (defaults and overseas).~~

11. No Strategic Health Authority exist for the Channel Islands and the Isle of Man so notional (or dummy) Strategic Health Authority codes are used to identify postcodes from these locations. The default Pseudo health authority code of X98 is used to indicate pseudo postcodes (defaults and overseas).

12. For further information on Strategic Health Authority, Local Health Board, and Health Board codes and their values, See ADMINISTRATIVE CODES.

Related Products

13. The ONS produce annually two related publications : ***ONS Geography User Guide 9 (The Area of Residence Classification)*** and ***ONS Geography User Guide 10 (The NHS Organisation Manual)***. These show a breakdown of Strategic Health Authorities by Local Government authorities and Electoral Wards. Copies are available from ONS. Electronic copies are also included in the full NHS Postcode Directory on CD-ROM as provided by NACS.

14. ~~ONS produce a version of the Postcode Directory that is based on a stable area base to facilitate time series analysis – the 1991-based Frozen Postcode Directory. This is available from the ONS.~~

14. The Office for National Statistics produce a version of the Postcode Directory that is based on a stable area base to facilitate time series analysis - the 1991-based Frozen Postcode Directory. This is available from the Office for National Statistics.

15. The NACS issues the full manuals on the CD-ROM each quarter. This ensures that any new customers receive the necessary information.

Changes

16. ~~The ONS should be notified of any queries relating to the allocation of postcodes to Strategic Health Authorities or Primary Care Trusts. All such queries are investigated by ONS, and any agreed changes are included in the following edition of the NHS Postcode Directory. The monthly postcode corrections are also included on the ***NHSnet***, See Publication Information Contact Details.~~

16. The Office for National Statistics should be notified of any queries relating to the allocation of postcodes to Strategic Health Authorities or Primary Care Trusts. All such queries are investigated by Office for National Statistics, and any agreed changes are included in the following edition of the NHS Postcode Directory. The monthly postcode corrections are also included on the ***NHSnet***, see Contact Details.

17. ~~Requests and suggestions for improvements to the NHS Postcode Directory or queries relating to its use should be directed to NACS, who are taking the lead on this product on behalf of the NHS; see Publication Information Contact Details.~~

17. Requests and suggestions for improvements to the NHS Postcode Directory or queries relating to its use should be directed to National Administrative Codes Service, who are taking the lead on this product on behalf of the NHS; see Contact Details.

ORGANISATIONS

Change to Supporting Information: Change to Supporting Information

~~**Referenced Organisations**~~
- ~~Health and Social Care Information Centre~~

- **Referenced Organisations:**
  - Department of Health

- **Regulatory Bodies:**

OUT-PATIENT FLOWS DATA SET OVERVIEW

Change to Supporting Information: Change to Supporting Information

Contextual Overview

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

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

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

- This central information collection requirement is both:

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

  and

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

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

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

Out-Patient Flow Events

- 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.
- The collection is for:

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

and

all GENERAL PRACTITIONER 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 GENERAL PRACTITIONER 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

- It includes private PATIENTS and PATIENTS from overseas.

OUT-PATIENT STOCKS DATA SET OVERVIEW

Change to Supporting Information: Change to Supporting Information

Contextual Overview

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

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

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

- This central information collection requirement is both:

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

  and

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

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

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

Out-Patient Stocks

- 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.
- The collection is for all GENERAL PRACTITIONER 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.
- It includes private PATIENTS and PATIENTS from overseas.

PERSON SMOKING CESSATION EPISODE

Change to Supporting Information: Change to Supporting Information

Person Smoking Cessation Episode is an ACTIVITY GROUP.

A period of time during which a PERSON attempts to stop smoking. During this time, it is expected that the PERSON will set a quit date. ~~The episode starts when the PERSON presents themselves to the Smoking Cessation Service and ends either when it is confirmed that the person has stopped smoking, or has ceased to attempt to give up smoking, whichever is the earlier.~~ The episode starts when the PERSON presents themselves to the Smoking Cessation Service and ends either when it is confirmed that the PERSON has stopped smoking, or has ceased to attempt to give up smoking, whichever is the earlier.

References: HSC 1999/087 New NHS Smoking Cessation Services, April 1999
~~Department of Health Monitoring Return: Smoking Cessation Services, April 2001~~ Department of Health Monitoring Return: Smoking Cessation Services, April 2001.

PRIMARY CARE TRUST

Change to Supporting Information: Change to Supporting Information

Primary Care Trust is an ORGANISATION.

A Primary Care Trust is a legal entity, set up by order of the Secretary of State. It is a free-standing NHS body, performance managed by a Strategic Health Authority.

The overall function of a Primary Care Trust is to improve the health of the responsible population, develop primary and community health services, and commission secondary care services. A Primary Care Trust will, if it so wishes and is capable of doing so, be able to provide directly a range of community health services, creating new opportunities to integrate primary and community health services as well as health and social care provision.

~~The PCT's responsible population comprises:~~ The Primary Care Trust's responsible population comprises:

~~- all persons registered with a GP whose practice forms part of the PCT, regardless of where the person is resident, plus~~
- all PERSONS registered with a GENERAL PRACTITIONER whose practice forms part of the Primary Care Trust, regardless of where the PERSON is resident, plus
~~- any persons not registered with a GP who are resident within the PCT's statutory geographical boundary~~
- any PERSONS not registered with a GENERAL PRACTITIONER who are resident within the Primary Care Trust's statutory geographical boundary

~~Note that persons resident within the PCT geographical area, but registered with a GP belonging to another PCT, are the responsibility of that other PCT.~~ Note that PERSONS resident within the Primary Care Trust geographical area, but registered with a GENERAL PRACTITIONER belonging to another Primary Care Trust, are the responsibility of that other Primary Care Trust.

With "Shifting the Balance of Power", Primary Care Trusts will be the leading NHS organisation for partnership with local authorities and a range of other partners, including NHS Trusts, Strategic Health Authorities and a range of other Primary Care Trusts and local communities to improve health and deliver wider objectives for social and economic regeneration.

Primary Care Trusts provide some services themselves and others through agreement with other organisations. Several Primary Care Trusts may decide to work together to provide certain services. In this case a lead Primary Care Trust will be identified for the group.

There may be occasions when relationships are formed on a larger scale. ~~For example the provision of a highly specialised service, such as specialist cancer or spinal injury services, may be done collaboratively across a population larger even than strategic health authority.~~ For example the provision of a highly specialised service, such as specialist cancer or spinal injury services, may be done collaboratively across a population larger even than Strategic Health Authority.

References:
~~Department of Health Booklet "Primary Care Trusts: Establishing Better Services" (Ref.~~ Department of Health Booklet "Primary Care Trusts: Establishing Better Services" (Ref. PCT1), issued April 1999. Shifting the Balance of Power publications.

SMOKING CESSATION SERVICE

Change to Supporting Information: Change to Supporting Information

Smoking Cessation Service is a SERVICE.

A service set up by a Primary Care Trust to help people give up smoking and to monitor the service.

To be designated as an NHS smoking cessation service requires that minimum quality standards should be met. To meet these minimum quality standards all advisers should:

- have received appropriate training for their role,
- carry out the 4 week follow-up promptly, in accordance with the current guidance,
~~- complete the minimum dataset (the individual client data monitoring forms) for each client,~~ - complete the minimum data set (the individual client data monitoring forms) for each client,
fully and accurately, and return the information required to the coordinator in good time,
- offer weekly support for at least the first four weeks of a quit attempt,
- attempt to confirm smoking status of all clients self-reporting as having quit at 4 week follow-up by use of a CO monitor, except where follow-up is carried out by telephone.

The majority of services will operate broadly on the 'Maudsley' model of a clinic providing intensive support, usually on a group therapy basis, to the most dependent smokers. The service should also continue to be supplemented by a range of services in various settings in primary care, secondary care and the community.

Central monitoring of data regarding 52 week follow-up is no longer required however, follow-up at 52 week stage is still recommended as good practice to establish long-term success rates and this information should still be collected locally.

References:
~~HSC 1999/087 New NHS Smoking Cessation Services, April 1999 Department of Health Monitoring Return: Smoking Cessation Services, April 2001~~ Health Service Circular 1999/087 New NHS Smoking Cessation Services, April 1999 Department of Health Monitoring Return: Smoking Cessation Services, April 2001.

SPECIALIST PALLIATIVE CARE DATE

Change to Supporting Information: Change to Supporting Information

Specialist Palliative Care Date is an ACTIVITY DATE TIME TYPE.

The date on which the first treatment or support from specialist palliative care was given to a PATIENT with diagnosed cancer.

References:
~~The NHS National Cancer Waiting Times, DH, DSCN 22/2002.~~ The NHS National Cancer Waiting Times, Department of Health, DSCN 22/2002.

SUMMARISED ACTIVITY FLOWS DATA SET OVERVIEW

Change to Supporting Information: Change to Supporting Information

Contextual Overview

- ~~The Department of Health requires performance management information on ELECTIVE ADMISSION LIST and Out-Patient Waiting List events within a specified REPORTING PERIOD.~~

- The Department of Health requires performance management information on ELECTIVE ADMISSION LIST and Out-Patient Waiting List events within a specified REPORTING PERIOD.

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

- This central information collection requirement is both:

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

and

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

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

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

Admitted Patient Flow Events Elective Admission List

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

- It includes private PATIENTS and PATIENTS from overseas.

  It excludes Suspended Patients.

  ELECTIVE ADMISSION TYPE records the classification of the admission.

- 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

- The collection data is grouped by totals for ADMISSION INTENDED PROCEDURE which indicates the required range of OPERATIVE PROCEDURES and by admission to NHS Hospitals and non-NHS Hospitals.
- The required grouping ranges of ADMISSION 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

- ORGANISATION TYPE of ORGANISATION records whether the hospital provider is an NHS or non-NHS organisation.
- The collection is for all PATIENTS admitted non-electively during the REPORTING PERIOD.

  a

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

- 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

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

  all GENERAL PRACTITIONER 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 GENERAL PRACTITIONER written referrals, whether from doctors or dentists, where the Out-Patient Attendance Consultant took place within the REPORTING PERIOD.

- It includes private PATIENTS and PATIENTS from overseas.

SUMMARISED STOCKS DATA SET OVERVIEW

Change to Supporting Information: Change to Supporting Information

Contextual Overview

- ~~The Department of Health requires performance management information on ELECTIVE ADMISSION LIST stocks at the end of a specified REPORTING PERIOD.~~

- The Department of Health requires performance management information on ELECTIVE ADMISSION LIST stocks at the end of a specified REPORTING PERIOD.

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

- This central information collection requirement is both:

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

  and

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

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

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

Admitted Patient Stock Group Main Specialty Code 110 Trauma & Orthopaedics

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

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

  and

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

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

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

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

- Within the ADMISSION INTENDED PROCEDURE the collection only applies to PATIENTS waiting for admission as ordinary admissions as indicated by INTENDED MANAGEMENT.
- The collection is for:

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

  and

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

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

- The collection data is for MAIN SPECIALTY CODE 110 Trauma & Orthopaedics only.
- The collection is for all PATIENTS referred by GENERAL PRACTITIONER 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.
- It includes private PATIENTS and PATIENTS from overseas.

SUSPENDED PATIENT

Change to Supporting Information: Change to Supporting Information

Suspended Patient provides further guidance for suspending a PATIENT on a hospital ELECTIVE ADMISSION LIST.

A PATIENT is suspended from the ELECTIVE ADMISSION LIST for medical reasons or is unavailable for admission for a specified period because of family commitments, holidays or other reasons. During this period of suspension, a PATIENT on an ELECTIVE ADMISSION LIST is unavailable for admission and therefore should not be given an OFFER OF ADMISSION for this interval. Note that a PATIENT cannot be suspended from the elective waiting list after an OFFER OF ADMISSION has been made.

Periods of suspension are normally deducted from the waiting time from the OFFER OF ADMISSION. However if the PATIENT has self-deferred, the period of suspension will be deducted from the date offered for admission which was refused.

In some instances, a PATIENT who is medically unfit for treatment could be removed from the waiting list altogether, but it should be stressed that this would need to be a clinical judgement made locally. PATIENTS on an ELECTIVE ADMISSION LIST should be those who need treatment and who are likely to be fit for surgery when offered admission. ~~The Waiting List Action Team Handbook: Getting Patients Treated (August 1999) issued by the DH states that only PATIENTS who are clinically ready to undergo surgery should be placed on a waiting list for surgery.~~ The Waiting List Action Team Handbook: Getting Patients Treated (August 1999) issued by the Department of Health states that only PATIENTS who are clinically ready to undergo surgery should be placed on a waiting list for surgery. However, PATIENTS can become medically unfit for treatment while already on an ELECTIVE ADMISSION LIST. They may develop conditions, such as diabetes or obesity, that need to be treated before surgery can take place.

Once the period of suspension has passed, the PATIENT is restored to valid membership of an ELECTIVE ADMISSION LIST.

Each period of suspension for a PATIENT from an ELECTIVE ADMISSION LIST ENTRY is recorded by an ELECTIVE ADMISSION SUSPENSION DETAIL with the LIST SUSPENSION START DATE and LIST SUSPENSION END DATE recording the start and end points of the period. Where no LIST SUSPENSION END DATE is present then the period of suspension is still ongoing.

THE NHS DATA MODEL & DICTIONARY ELEMENTS

Change to Supporting Information: Change to Supporting Information

The NHS Data Model and Dictionary Elements

The NHS Data Dictionary and the NHS Data Manual were originally published separately. The elements of both these publications have been consolidated into one browsable integrated publication called the NHS Data Model and Dictionary.

NHS Data Standards

The NHS Data Model and Dictionary gives common definitions and guidance to support the sharing, exchange and comparison of information across the NHS. ~~The common definitions, known as data standards, are used in commissioning and make up the base currency of Commissioning Data Sets (CDS). On the monitoring side, they support comparative data analysis, preparation of performance tables, and data returned to the Department of Health.~~ The common definitions, known as data standards, are used in commissioning and make up the base

currency of Commissioning Data Sets. On the monitoring side, they support comparative data analysis, preparation of performance tables, and data returned to the Department of Health. NHS data standards also support clinical messages, such as those used for pathology and radiology. NHS data standards are presented as a logical data model, ensuring that the standards are consistent and integrated across all NHS business areas.

NHS data standards should not just be seen as supporting the collection of data on a consistent basis throughout the NHS. They also have an important role in supporting the flow and quality of information used in different parts of the NHS so that health care professionals are presented with the relevant information where and when it is required. An example of this is the linking of all records about a patient collected in different parts of the NHS, to be available to a health care professional wherever the patient attends to be seen for treatment, thus facilitating the Electronic Patient Record. ~~Changes to NHS data standards are still being published as Data Set Change Notices (DSCNs) at the time of publication.~~ Changes to NHS data standards are still being published as Data Set Change Notices at the time of publication. The NHS Information Standards Board may eventually use a different form of change notification, but the principles of regulated changes will still apply.

See the **NHS Information Standards Boards website** for the latest information relating to the NHS Information Standards Boards.

The NHS Data Model and Dictionary Elements

Class Definitions	All the classes that appear within the NHS data standards logical data model. Each class contains its nationally agreed definition, all of its attributes, all relationships it has with other classes. Class Definitions Intro
Attribute Definitions	All the attributes of the classes that appear within the NHS data standards logical data model. Each attribute contains its nationally agreed definition which may also include its agreed National Codes or classifications and a clickable 'data' tab if a data element also exists for it. Attribute Definitions Intro
Data Elements	Data elements which may be supported by an attribute definition i.e. the data element has the same name as an attribute, be a derived item which is derivable from attributes or only exists as a data element. Where a data element is supported by an attribute definition, such as the national codes to be used in that data element exist in an attribute, then there will be a link to that attribute through a 'definition' tab. Data elements are used in the completion of Data Sets, Commissioning Data Sets, Hospital Episode Statistics and Central Returns. The data element information comprises format and field length, Hospital Episode Statistics name if applicable, National Codes or classifications and useful notes clarifying the selected data element. Data Elements Intro
NHS Business Definitions	These contain the business rules for recording NHS activity and will be of particular relevance to NHS Information Professionals. NHS Business Definitions
~~**CDS and HES**~~	~~Guidance on completion of Commissioning Data Sets (CDS) is not yet consolidated within CDS.~~ ~~Hospital Episode Statistics (HES) for information purposes (HES is now extracted automatically from the NHS-wide Clearing Service database).~~ ~~Commissioning Data Set Overview~~
CDS and HES	Guidance on completion of Commissioning Data Sets is not yet consolidated within the Commissioning Data Sets. Hospital Episode Statistics for information purposes (Hospital Episode Statistics is now extracted automatically from the NHS-Wide Clearing Service database). Commissioning Data Set Overview
Data Sets	The primary purpose of national data sets is to enable the same health information to be generated across the country independent of the organisation or system that captures it. Data Sets Contextual Overview
Central Return Forms	Guidance on completion of Central Returns for hospital activity, complaints management process, cervical and breast screening activity, patient transport and some community activity. Central Returns Introduction

Diagrams	The new generic dictionary is based on a small set of rationalised diagrams. Diagrams Menu
~~**Supporting Information**~~	~~Supporting information such as clinical coding etc, is provided to help users understand the CDS and Central Returns.~~ ~~Supporting Information Introduction~~
Supporting Information	Supporting information such as clinical coding etc, is provided to help users understand the Commissioning Data Sets and Central Returns. Supporting Information Introduction

OVERSEAS VISITOR STATUS

Change to Class: Change to Description

The status of an overseas visitor for a particular ACTIVITY, where an overseas visitor is a PERSON not ordinarily resident in the UK, with respect to charging rates. ~~The algorithm for determining whether the PATIENT is exempt from charges or not is complex, but laid down in the Department of Health's Manual of Guidance for charging rates for overseas visitors.~~ The algorithm for determining whether the PATIENT is exempt from charges or not is complex, but laid down in the Department of Health's Manual of Guidance for charging rates for overseas visitors. A PERSON not exempt under the NHS Charges to Overseas Visitors Regulations will be treated as a 'charged NHS patient'; however such PATIENTS may pay hotel fees only, or pay all fees. Alternatively, the PATIENT can opt to be treated as a private PATIENT.

Although there is a central list of set charges, Health Care Providers can set their own charges on what they consider to be an appropriate commercial basis.

This class is also known by these names:

Context	Alias
plural	OVERSEAS VISITOR STATUSES

REFERRAL TO TREATMENT PERIOD

Change to Class: Change to Description
A subtype of ACTIVITY GROUP.

This is the part of a PATIENT PATHWAY covered by the 18 week referral to treatment target.

~~It is the period from referral to the start of the first treatment that is intended to manage a person's disease, condition or injury as described by REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD END DATE.~~ It is the period from referral to the start of the first treatment that is intended to manage a PERSON's disease, condition or injury as described by REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD END DATE.

If the PATIENT is referred from one Health Care Provider to another during the REFERRAL TO TREATMENT PERIOD, the REFERRAL TO TREATMENT PERIOD continues with the original REFERRAL TO TREATMENT PERIOD START DATE and the related PATIENT PATHWAY IDENTIFIER being part of the onward referral information. The REFERRAL TO TREATMENT PERIOD continues until there is a REFERRAL TO TREATMENT PERIOD END DATE in the other ORGANISATION.

~~For PATIENTS who have not attended an appointment or admission:~~ For PATIENTS who have not attended an APPOINTMENT or admission:

- DNA for first out-patient appointment or direct access admissions. This will complete the REFERRAL TO TREATMENT PERIOD (REFERRAL TO TREATMENT PERIOD STATUS code 33 for the ACTIVITY with

DNA) and a new REFERRAL TO TREATMENT PERIOD will commence at the point when the PATIENT rebooks if this occurs (REFERRAL TO TREATMENT PERIOD STATUS code 10 on the ACTIVITY).

- ~~DNA for follow-up or out-patient/diagnostic appointments. The REFERRAL TO TREATMENT PERIOD will continue. The potential effect of this will be factored into the tolerances set, taken together with Department of Health rules to cover patients who are appropriately returned to the care of their GP, and thereby complete the REFERRAL TO TREATMENT PERIOD.~~
- DNA for follow-up or out-patient/diagnostic appointments. The REFERRAL TO TREATMENT PERIOD will continue. The potential effect of this will be factored into the tolerances set, taken together with Department of Health rules to cover PATIENTS who are appropriately returned to the care of their GENERAL PRACTITIONER, and thereby complete the REFERRAL TO TREATMENT PERIOD.
- ~~DNA for an admission (except direct access admissions). The REFERRAL TO TREATMENT PERIOD will continue. The effect of DNAs for admission will be allowed for in the system of 18 week measurement that will replace the current in-patient suspension and self-deferral systems. Similarly, there will be a set of rules to cover patients who are appropriately returned to the care of the GP, thereby complete the REFERRAL TO TREATMENT PERIOD.~~
- DNA for an admission (except direct access admissions). The REFERRAL TO TREATMENT PERIOD will continue. The effect of DNAs for admission will be allowed for in the system of 18 week measurement that will replace the current in-patient suspension and self-deferral systems. Similarly, there will be a set of rules to cover patients who are appropriately returned to the care of the GENERAL PRACTITIONER, thereby complete the REFERRAL TO TREATMENT PERIOD.

At this stage, referrals to non-consultant clinicians, nurse consultants and allied health professionals are excluded from REFERRAL TO TREATMENT PERIODS.

References:
Tackling hospital waiting: the 18 week patient pathway. An implementation framework, May 2006. Author - 18 Week Pathway Programme, Department of Health.

This class is also known by these names:

Context	Alias
plural	REFERRAL TO TREATMENT PERIODS

BODY IRRADIATION

Change to Attribute: Change to Description

~~This identifies whether or not the radiotherapy procedure is a total body irradiation.~~ This identifies whether or not the radiotherapy procedure is a total BODY IRRADIATION. The number of hours devoted to such radiation should be recorded. ~~In returns to the DH it should be counted as 20 EXPOSURES for each hour the procedure took.~~ In returns to the Department of Health it should be counted as 20 EXPOSURES for each hour the procedure took.

This attribute is also known by these names:

Context	Alias
plural	BODY IRRADIATIONS

CANCER REFERRAL PRIORITY TYPE

Change to Attribute: Change to Description

A classification of the urgency of a referral of a PATIENT to see a cancer specialist, determined by the CARE PROFESSIONAL making the referral.

National Codes:

~~01~~ ~~Urgent referral for suspected cancer from a General Medical Practitioner or General Dental Practitioner~~

01 Urgent referral for suspected cancer from a GENERAL MEDICAL PRACTITIONER or GENERAL DENTAL PRACTITIONER

02 Other referral source or urgency

References:
~~The NHS National Cancer Waiting Times, DH, DSCN 22/2002~~ The NHS National Cancer Waiting Times, Department of Health, DSCN 22/2002

This attribute is also known by these names:

Context	Alias
plural	CANCER REFERRAL PRIORITY TYPES

CANCER SPECIALIST REFERRAL DATE

Change to Attribute: Change to Description

The date on which the decision was made to refer a PATIENT with suspected cancer to an appropriate cancer specialist. An appropriate specialist is the PERSON or PERSONS who are most able to progress the diagnosis of the primary tumour. This date will be one of the following:

- The date on which the referral was made
- ~~The date of the letter or fax from General Practitioner or other hospital department~~
- The date of the letter or fax from GENERAL PRACTITIONER or other hospital department
- ~~The date of phone call from referring General Practitioner or other hospital department~~
- The date of phone call from referring GENERAL PRACTITIONER or other hospital department
- The date of cross-referral where the patient is already in hospital.

References:
~~The NHS National Cancer Waiting Times, DH, DSCN 22/2002.~~ The NHS National Cancer Waiting Times, Department of Health, DSCN 22/2002.

This attribute is also known by these names:

Context	Alias
plural	CANCER SPECIALIST REFERRAL DATES

CANCER STATUS

Change to Attribute: Change to Description

This is to identify urgent REFERRAL REQUESTS from GENERAL PRACTITIONERS for suspected cancer who are subsequently diagnosed with cancer.

National Codes:

1 suspected cancer

3 no new cancer diagnosis identified by the Trust
5 diagnosis of new cancer confirmed - treatment not yet planned
7 diagnosis of new cancer confirmed - no NHS treatment planned
8 first treatment commenced (NHS only)

References:
~~The NHS National Cancer Waiting Times, DH, DSCN 22/2002.~~ The NHS National Cancer Waiting Times, Department of Health, DSCN 22/2002.

This attribute is also known by these names:

Context	Alias
plural	CANCER STATUSES

CRITICAL CARE LEVEL

Change to Attribute: Change to Description
The levels of care provided during a Hospital Provider Spell. A Hospital Provider Spell is an ACTIVITY GROUP where the ACTIVITY GROUP TYPE is National Code 21 *'Hospital Provider Spell'*.

National Codes:

00 Level 0 (Patients whose needs can be met through normal ward care in an acute hospital)
~~01 Level 1 (Patients at risk of their condition deteriorating, or those recently relocated from higher levels of care, whose needs can be met on an acute ward with additional advice and support from the critical care team.)~~
01 Level 1 (PATIENTS at risk of their condition deteriorating, or those recently relocated from higher levels of care, whose needs can be met on an acute ward with additional advice and support from the critical care team.)
~~02 Level 2 (Patients requiring more detailed observation or intervention including support for a single failing organ system or post-operative care and those 'stepping down' from higher levels of care.)~~
02 Level 2 (PATIENTS requiring more detailed observation or intervention including support for a single failing organ system or post-operative care and those 'stepping down' from higher levels of care.)
~~03 Level 3 (Patients requiring advanced respiratory support alone or monitoring and support for two or more organ systems. This level includes all complex patients requiring support for multi-organ failure.)~~
03 Level 3 (PATIENTS requiring advanced respiratory support alone or monitoring and support for two or more organ systems. This level includes all complex PATIENTS requiring support for multi-organ failure.)

References:
~~Comprehensive Critical Care: a review of adult critical care services, Department of Health May 2000 and Levels of critical care for adult patients, Intensive Care Society 2002.~~ Comprehensive Critical Care: a review of adult critical care services, Department of Health May 2000 and Levels of critical care for adult PATIENTS, Intensive Care Society 2002.

This attribute is also known by these names:

Context	Alias
plural	CRITICAL CARE LEVELS

CYTOLOGY SCREENING ACTION TYPE

Change to Attribute: Change to Description

The action recommended as a consequence of a Cytology Screening Test.

Classification:

~~a.~~ ~~Standard Primary Care Trust recall interval (Normal) (A)~~
a. Standard Primary Care Trust recall interval (Normal) (A)
b. Repeat at interval specified (R)
c. Refer for medical assessment or under medical treatment (Suspend) (S)
d. Make no change to recall date (H)

References:
GP - Health Authority Information Flows 1996.
~~Department of Health Form KC53: Adult Screening Programmes: Cervical Screening~~ Department of Health Form KC53: Adult Screening Programmes: Cervical Screening

This attribute is also known by these names:

Context	Alias
plural	CYTOLOGY SCREENING ACTION TYPES

DELAY REASON COMMENT

Change to Attribute: Change to Description

A comment on the reason why a Cancer Care Spell Delay was experienced with regard to a Cancer Care Spell. This must be recorded for each breach of existing standards after any adjustments have been made.

The standards which will be in place at the end of 2002 are:

- ~~maximum two week wait for an urgent GP referral for suspected cancer to date first seen for all suspected cancers~~
- maximum two week wait for an urgent GENERAL PRACTITIONER referral for suspected cancer to date first seen for all suspected cancers
- ~~maximum one month wait from urgent GP referral for suspected cancer to first definitive treatment for testicular cancer (ICD code C62), acute leukaemia (ICD codes C91.0, C92.0, C92.4, C92.5, C93.0, C94.2, C95.0) and children's cancer (under 16 years of age at date of first definitive treatment)~~
- maximum one month wait from urgent GENERAL PRACTITIONER referral for suspected cancer to first definitive treatment for testicular cancer (ICD code C62), acute leukaemia (ICD codes C91.0, C92.0, C92.4, C92.5, C93.0, C94.2, C95.0) and children's cancer (under 16 years of age at date of first definitive treatment)
- ~~maximum two month wait from urgent GP referral for suspected cancer to first definitive treatment for breast cancer (ICD codes C50 and D05)~~
- maximum two month wait from urgent GENERAL PRACTITIONER referral for suspected cancer to first definitive treatment for breast cancer (ICD codes C50 and D05)
- maximum one month wait from decision to treat to first definitive treatment for breast cancer (ICD codes C50 and D05)

References:
~~The NHS National Cancer Waiting Times, DH, DSCN 22/2002.~~ The NHS National Cancer Waiting Times, Department of Health, DSCN 22/2002.

This attribute is also known by these names:

Context	Alias

plural	DELAY REASON COMMENTS

DELAY REASON REFERRAL TO FIRST SEEN (CANCER)

Change to Attribute: Change to Description

A classification of the reason why a Cancer Care Spell Delay was experienced with regard to a Cancer Care Spell if the delay occurred between referral and when the PATIENT was first seen and where the referral was an urgent REFERRAL REQUEST for suspected cancer.

This is the reason why the Provider was unable to offer a date within the target time.

National Codes:

01 Clinic cancellation
02 Out-patient capacity inadequate (i.e. no cancelled clinic, but not enough slots for this PATIENT
03 Administrative delay (e.g. failed to be rebooked after Did Not Attend, lost referral)
04 Referral not received within 24 hours
99 Other

References:
~~The NHS National Cancer Waiting Times, DH, DSCN 22/2002.~~ The NHS National Cancer Waiting Times, Department of Health, DSCN 22/2002.

This attribute is also known by these names:

Context	Alias
plural	DELAY REASONS REFERRAL TO FIRST SEEN (CANCER)

DELAY REASON TO TREATMENT (CANCER)

Change to Attribute: Change to Description

A classification of the reason why a Cancer Care Spell Delay was experienced with regard to a Cancer Care Spell. The National Codes to be used are the same for both the delay between referral and treatment for cancer and the delay between the decision to treat and treatment for cancer.

This is the reason why the Provider was unable to offer a date within the target time.

National Codes:

1 Clinic cancellation
2 Out-patient capacity inadequate (i.e. no cancelled clinic, but not enough slots for this PATIENT
3 Administrative delay (e.g. failed to be rebooked after Did Not Attend, lost referral)
4 Elective cancellation (for non-medical reason)
5 Elective capacity inadequate (patient unable to be scheduled for treatment within target time)
6 Delay in diagnostic test(s) (delay caused by wait for diagnostic test(s))
7 Complex diagnostic pathway (many, or complex, diagnostic tests required)
8 Delay due to referral between Trusts

References:
~~The NHS National Cancer Waiting Times, DH, DSCN 22/2002~~ The NHS National Cancer Waiting Times,

Department of Health, DSCN 22/2002

This attribute is also known by these names:

Context	Alias
plural	DELAY REASONS TO TREATMENT (CANCER)

DEPARTMENT OF HEALTH ORGANISATION CODE

Change to Attribute: Change to Description

~~A code which the Department of Health use to identify an ORGANISATION.~~ A code which the Department of Health use to identify an ORGANISATION.

This attribute is also known by these names:

Context	Alias
plural	DEPARTMENT OF HEALTH ORGANISATION CODES

FIRST CANCER DIAGNOSTIC TEST

Change to Attribute: Change to Description

An indicator of the first major CLINICAL INTERVENTION for the diagnosis of cancer. This is the test that moves the level of suspicion of cancer from "possible or probable (based on history, clinical examination or blood count) to "highly probable or certain". It does not refer to the first intervention undergone, prior to referral to hospital, such as a blood count, chest x-ray or blood tests of liver function.

Classification:

a. first diagnostic test
b. not first diagnostic test

References:
~~The NHS National Cancer Waiting Times, DH, DSCN 22/2002.~~ The NHS National Cancer Waiting Times, Department of Health, DSCN 22/2002.

This attribute is also known by these names:

Context	Alias
plural	FIRST CANCER DIAGNOSTIC TESTS

FIRST DEFINITIVE TREATMENT PLANNED

Change to Attribute: Change to Description

This is an indicator that the Planned Cancer Treatment is the planned first definitive treatment or intervention to be given which is intended to remove or shrink a cancer tumour, to enable an anti-cancer treatment and/or to

palliate the effects of the cancer.

Classification:

a. first definitive treatment planned
b. not first definitive treatment planned

References:
~~The NHS National Cancer Waiting Times, DH, DSCN 22/2002.~~ The NHS National Cancer Waiting Times, Department of Health, DSCN 22/2002.

This attribute is also known by these names:

Context	Alias
plural	FIRST DEFINITIVE TREATMENTS PLANNED

FIRST DEFINITIVE TREATMENT PROVIDED

Change to Attribute: Change to Description

This is an indicator that the Planned Cancer Treatment was provided as the first definitive treatment or intervention which was intended to remove or shrink a cancer tumour, to enable an anti-cancer treatment and/or to palliate the effects of the cancer.

Classification:

a. first definitive treatment provided
b. not first definitive treatment provided

~~References: The NHS National Cancer Waiting Times, DH, DSCN 22/2002.~~ References: The NHS National Cancer Waiting Times, Department of Health, DSCN 22/2002.

This attribute is also known by these names:

Context	Alias
plural	FIRST DEFINITIVE TREATMENT PROVIDED

MULTIDISCIPLINARY TEAM DISCUSSION DATE

Change to Attribute: Change to Description

The date on which a PATIENT's Cancer Care Plan was discussed by a multidisciplinary team specialising in cancer. The Cancer Care Plan may be drawn up at the meeting or the meeting may discuss a plan drawn up prior to the meeting. ~~A multidisciplinary team meeting is a regularly held meeting of the group of professionals who together make decisions regarding recommended treatment of individual patients, which can therefore be regarded as multidisciplinary.~~ A multidisciplinary team meeting is a regularly held meeting of the group of professionals who together make decisions regarding recommended treatment of individual PATIENTS, which can therefore be regarded as multidisciplinary.

References:
~~The NHS Cancer Plan, DH, published September 2000.~~ The NHS Cancer Plan, Department of Health, published

September 2000.

This attribute is also known by these names:

Context	Alias
plural	MULTIDISCIPLINARY TEAM DISCUSSION DATES

ORGANISATION TYPE

Change to Attribute: Change to Description

A list of ORGANISATION TYPES of ORGANISATIONS according to the nature of the ORGANISATION (eg. 'NHS Trust', 'Strategic Health Authority').

Organisation Type Code	Organisation Type Name	Description
AR	APPLICATION SERVICE PROVIDER	
BM	BMS CALL CENTRE ESTABLISHMENT	Booking Management System (BMS) Call Centre Establishment
CN	CANCER NETWORK	
CR	CANCER REGISTRY	
CT	CARE TRUST	
DD	DENTAL PRACTICE	
ED	EDUCATION - DEANERY	
EA	EXECUTIVE AGENCY	
AP	EXECUTIVE AGENCY PROGRAMME	
GD	GOVERNMENT DEPARTMENT	
GO	GOVERNMENT OFFICE REGION	
PR	GP PRACTICE	A single GP practising otherwise than in a partnership or two or more GPs practising in partnership. Includes all Practices in England and Wales.
HA	HEALTH AUTHORITY (HA)	A body corporate with succession and common seal established by the National Health Service Reform and Health Care Professions Bill 2002
IP	INDEPENDENT PROVIDER	
PH	INDEPENDENT SECTOR HEALTHCARE PROVIDER	
IM	ISLE OF MAN GOVERNMENT DEPARTMENT	
ID	ISLE OF MAN GOVERNMENT DIRECTORATE	
EL	LOCAL AUTHORITY	
LO	LOCAL SERVICE PROVIDER (LSP)	
NP	NATIONAL APPLICATION SERVICE PROVIDER (NPFIT PROJECTS)	
NS	NHS SUPPORT AGENCY	

TR	NHS TRUST	A legal entity set up by order of the Secretary of State under Section 5 of 'The National Health Service and Community Care Act 1990'. NHS Trusts may act as Health Care Providers and provide hospital services, community services and/or other aspects of patient care, such as patient care, such as patient transport facilities. They may also act as commissioner when sub contracting patient care to other providers of health care.
NN	NON-NHS ORGANISATION	
OA	OTHER STATUTORY AUTHORITY (OSA)	An Authority set up within the NHS to provide specific health care related services and support to the NHS
OU	OTHER UNIT (IN SUPPORT OF NHS BUSINESSES)	
PX	PHARMACY HEADQUARTER	
PT	PRIMARY CARE TRUST	
~~RO~~	~~IT CLUSTER~~	~~The regional outposts of the Department of Health Tasked with performance managing Strategic Health Authority~~
RO	IT CLUSTER	The regional outposts of the Department of Health Tasked with performance managing Strategic Health Authority
SA	SPECIAL HEALTH AUTHORITY (SHA)	
TC	TRANSPLANT CONSORTIUM (TC)	
UN	EDUCATION - UNIVERSITY	A University involve in Medical Training
WA	WELSH ASSEMBLY	
WH	WELSH HEALTH COMMISSION	
LH	WELSH LOCAL HEALTH BOARD	
WR	WELSH REGIONAL OFFICE	
WC	WORKFORCE CONFEDERATION	

This attribute is also known by these names:

Context	Alias
plural	ORGANISATION TYPES

PLANNED CANCER TREATMENT TYPE

Change to Attribute: Change to Description

A classification of a type of treatment or care which may be planned to be provided within a Planned Cancer Treatment.

National Codes:

01 Surgery
02 Teletherapy
03 Chemotherapy
04 Hormone therapy

05 Specialist palliative care
06 Brachytherapy
07 Biological
08 Other
09 Active monitoring

~~References: The NHS National Cancer Waiting Times, DH, DSCN 22/2002~~ References: The NHS National Cancer Waiting Times, Department of Health, DSCN 22/2002

This attribute is also known by these names:

Context	Alias
plural	PLANNED CANCER TREATMENT TYPES

PRIORITY TYPE

Change to Attribute: Change to Description

This is the priority of a request for services; in the case of services to be provided by a CONSULTANT, it is as assessed by or on behalf of the CONSULTANT.

Priority Type 'Urgent' should be used where the request for services is defined as clinically urgent, but it does not fall under the criteria for Two Week Wait GP referrals for suspected cancer.

~~Priority Type 'Two Week Wait' should only be used where the request for services meets the criteria for an urgent GP referral for suspected cancer. These are defined in Department of Health Guidance 'Cancer Waiting Targets - A Guide (version 4)'.~~ Priority Type 'Two Week Wait' should only be used where the request for services meets the criteria for an urgent GENERAL PRACTITIONER referral for suspected cancer. These are defined in Department of Health Guidance 'Cancer Waiting Targets - A Guide (version 4)'.

National Codes:

1 Routine
2 Urgent
3 Two Week Wait

This attribute is also known by these names:

Context	Alias
plural	PRIORITY TYPES

REFERRAL TO TREATMENT PERIOD END DATE

Change to Attribute: Change to Description
The end date of a REFERRAL TO TREATMENT PERIOD.

This is a specific type of the attribute ACTIVITY DATE.

REFERRAL TO TREATMENT PERIOD END DATE will be one of the following:

- ~~the ACTIVITY DATE when the PATIENT is admitted for the first treatment intended to manage the~~

~~PATIENT's disease, condition or injury.~~
~~If the start of a patient's treatment is cancelled after admission, the REFERRAL TO TREATMENT PERIOD will continue.~~

~~**or**~~

- ~~the ACTIVITY DATE for treatment undertaken in an outpatient setting, where no Hospital Provider Spell is expected.~~

- the ACTIVITY DATE when the PATIENT is admitted for the first treatment intended to manage the PATIENT's disease, condition or injury.
  If the start of a PATIENT's treatment is cancelled after admission, the REFERRAL TO TREATMENT PERIOD will continue.

  or

- the ACTIVITY DATE for treatment undertaken in an outpatient setting, where no Hospital Provider Spell is expected.

  or

- the ACTIVITY DATE when the decision not to treat is made, with no further action at this time communicated to the PATIENT.

  or

- the ACTIVITY DATE when the PATIENT declines offered treatment.

  or

- the ACTIVITY DATE when the PATIENT does not attend for the first ACTIVITY following referral. See REFERRAL TO TREATMENT PERIOD for guidance on DNA.

  or

- the ACTIVITY DATE the clinical decision is made (and agreed with the PATIENT) that a period of active monitoring will begin. If a PATIENT subsequently requires further treatment this decision would start a new REFERRAL TO TREATMENT PERIOD. This includes any treatment that is planned for a specific date in the future as ongoing monitoring.

  or

- the PERSON DEATH DATE.

In the unfortunate event that a PATIENT is booked into the wrong clinic and needs to be re-referred to the right one, this will not end the REFERRAL TO TREATMENT PERIOD or restart it. The start of the REFERRAL TO TREATMENT PERIOD is still the original REFERRAL REQUEST RECEIVED DATE.

Further guidance on ending REFERRAL TO TREATMENT PERIODS and first treatments.

Undertaking a procedure is not necessarily in itself the end of a REFERRAL TO TREATMENT PERIOD. For example, outpatient or day case diagnostic CARE ACTIVITIES prior to admission for treatment do not represent the end of the period and, in these cases, are part of the diagnostic process rather than the start of treatment.

Commencement of medication as an outpatient can be the end of a REFERRAL TO TREATMENT PERIOD, if it is intended as the first treatment to manage the PATIENT's disease, condition or injury. ~~However, clinicians often begin to manage a patient's condition in advance of the first actual treatment taking place, for example by giving pain relief before a surgical procedure takes place.~~ However, clinicians often begin to manage a PATIENT's condition in advance of the first actual treatment taking place, for example by giving pain relief before a surgical

procedure takes place. In these cases, the REFERRAL TO TREATMENT PERIOD END DATE is when the first actual treatment (in this example, surgery) has started.

Other CARE ACTIVITIES that may end a REFERRAL TO TREATMENT PERIOD as the start of first treatment that is intended to manage the PATIENT 's disease, condition or injury include:

- ~~the fitting of a medical device where a consultant decides that treatment consists of fitting a medical device. This is the date of the actual fitting of the device rather than the point at which the patient is measured for the device.~~
- the fitting of a medical device where a CONSULTANT decides that treatment consists of fitting a medical device. This is the date of the actual fitting of the device rather than the point at which the PATIENT is measured for the device.
- the date of a therapeutic procedure where it is intended as diagnostic but the CARE PROFESSIONAL makes a decision to undertake a therapeutic procedure at the same time. In this example, it may count as a start of treatment and as such, the period will end.
- ~~the date for less intensive treatment and medical management such as palliative care which may be attempted before moving on to invasive procedures and treatment or may be the only treatment. In such cases, the first treatment that is intended to manage a person's disease,condition or injury will end that particular REFERRAL TO TREATMENT PERIOD. Should the patient at some later stage require more 'aggressive' treatment then the decision to treat would start a new REFERRAL TO TREATMENT PERIOD.~~
- the date for less intensive treatment and medical management such as palliative care which may be attempted before moving on to invasive procedures and treatment or may be the only treatment. In such cases, the first treatment that is intended to manage a PERSON's disease, condition or injury will end that particular REFERRAL TO TREATMENT PERIOD. Should the PATIENT at some later stage require more 'aggressive' treatment then the decision to treat would start a new REFERRAL TO TREATMENT PERIOD.

References:
Tackling hospital waiting: the 18 week patient pathway. An implementation framework, May 2006. ~~Author - 18 Week Pathway Programme, Department of Health~~ Author - 18 Week Pathway Programme, Department of Health.

This attribute is also known by these names:

Context	Alias
plural	REFERRAL TO TREATMENT PERIOD END DATES

REFERRAL TO TREATMENT PERIOD START DATE

Change to Attribute: Change to Description
The start date of a REFERRAL TO TREATMENT PERIOD.

This is a specific type of the attribute ACTIVITY DATE.

A REFERRAL TO TREATMENT PERIOD START DATE will be one of the following:

- ~~the REFERRAL REQUEST RECEIVED DATE of a SERVICE REQUEST for a particular condition~~

  ~~**or**~~

- ~~the ACTIVITY DATE of ACTIVITY when a PATIENT has rebooked following the PATIENT not attending an appointment or admission. See REFERRAL TO TREATMENT PERIOD for guidance on DNA.~~

  ~~**or**~~

- ~~the ACTIVITY DATE of a CARE ACTIVITY when a decision to treat or refer for diagnostic tests was made following a period of active monitoring and the REFERRAL TO TREATMENT PERIOD STATUS is '*active monitoring end*'~~

~~or~~

- ~~the REFERRAL REQUEST RECEIVED DATE of a SERVICE REQUEST when a decision has been made to refer the PATIENT directly to another consultant for a separate condition (the REFERRAL TO TREATMENT PERIOD STATUS for the first CARE ACTIVITY with the other CONSULTANT is '*consultant referral*').~~
- the REFERRAL REQUEST RECEIVED DATE of a SERVICE REQUEST for a particular condition

or

- the ACTIVITY DATE of ACTIVITY when a PATIENT has rebooked following the PATIENT not attending an APPOINTMENT or admission. See REFERRAL TO TREATMENT PERIOD for guidance on DNA.

or

- the ACTIVITY DATE of a CARE ACTIVITY when a decision to treat or refer for diagnostic tests was made following a period of active monitoring and the REFERRAL TO TREATMENT PERIOD STATUS is '*active monitoring end*'

or

- the REFERRAL REQUEST RECEIVED DATE of a SERVICE REQUEST when a decision has been made to refer the PATIENT directly to another CONSULTANT for a separate condition (the REFERRAL TO TREATMENT PERIOD STATUS for the first CARE ACTIVITY with the other CONSULTANT is '*consultant referral*').

For most PATIENTS, the start of the REFERRAL TO TREATMENT PERIOD begins with a SERVICE REQUEST from a GENERAL MEDICAL PRACTITIONER to a CONSULTANT.

SERVICE REQUESTS to CONSULTANTS who provide care services in community settings (for example in outreach clinics, directly employed by a Primary Care Trust or working in a community hospital) also start REFERRAL TO TREATMENT PERIODS and the REFERRAL REQUEST RECEIVED DATE will be the start of the REFERRAL TO TREATMENT PERIOD.

~~A REFERRAL TO TREATMENT PERIOD may also start from SERVICE REQUESTS to CONSULTANTS from GENERAL DENTAL PRACTITIONER, GENERAL MEDICAL PRACTITIONER with a Special Interest(GPwSIs), Optometrists and Orthoptists, Genito-urinary medicine clinics, National Screening Programmes (for non-malignant conditions) and Specialist nurses or allied CARE PROFESSIONALS where Primary Care Trusts have approved these mechanisms locally.~~ A REFERRAL TO TREATMENT PERIOD may also start from SERVICE REQUESTS to CONSULTANTS from GENERAL DENTAL PRACTITIONER, GENERAL MEDICAL PRACTITIONER with a Special Interest(GPwSIs), Optometrists and Orthoptists, Genito-urinary medicine clinics, National Screening Programmes (for non-malignant conditions) and Specialist nurses or allied CARE PROFESSIONAL where Primary Care Trusts have approved these mechanisms locally.

~~Where PATIENTS are transferred to an elective pathway, SERVICE REQUESTS from A&E, Minor injuries units and Walk In Centres to CONSULTANTS will also start a REFERRAL TO TREATMENT PERIOD.~~ Where PATIENTS are transferred to an elective pathway, SERVICE REQUESTS from A&E, Minor injuries units and Walk In Centres to CONSULTANTS will also start a REFERRAL TO TREATMENT PERIOD.

References:
Tackling hospital waiting: the 18 week patient pathway. An implementation framework, May 2006. ~~Author - 18 Week Pathway Programme, Department of Health.~~ Author - 18 Week Pathway Programme, Department of Health.

This attribute is also known by these names:

Context	Alias
plural	REFERRAL TO TREATMENT PERIOD START DATES

SAMPLE RECEIPT DATE

Change to Attribute: Change to Description

Date of receipt of a SAMPLE by a LABORATORY.

References:
The Version 1.1 NHS Standard EDIFACT Messages for Pathology Requests and Reports, 2001
~~DH Form KC61 Pathology Laboratories – Cervical Cytology and Outcome of Gynaecological Referrals.~~ Department of Health Form KC61 Pathology Laboratories - Cervical Cytology and Outcome of Gynaecological Referrals.

This attribute is also known by these names:

Context	Alias
plural	SAMPLE RECEIPT DATES

SERVICE TYPE

Change to Attribute: Change to Description

~~The NHS has a concept that there is a type of service which may be provided within activities and may be planned for. A definitive classification is at present lacking, although in some areas such as GP Practices, Professional Staff Groups and Specialist Services there are examples.~~ The NHS has a concept that there is a type of SERVICE which may be provided within ACTIVITIES and may be planned for. A definitive classification is at present lacking, although in some areas such as GENERAL PRACTITIONER Practices, Professional Staff Groups and Specialist Services there are examples. These are shown below.

Classification:

GP Practice

a. General Medical Services
b. Community Dentist Services
c. General Dental Practitioner Services
d. Maternity Services
e. Acupuncture
f. Contraceptive services to any patient
g. Contraceptive services to GMS-registered patients only

Professional Staff Group

a. Chiropody
b. Clinical Psychology
c. Dietetics
d. Occupational Therapy
e. Physiotherapy
f. Speech and Language Therapy

Specialised Service

A specialised service is defined in the National Specialised Services Definition Set. The definitions identify the activity that should be regarded as specialised and therefore subject to any arrangements that are in place for the commissioning of specialised services. The definitions provide a helpful basis for service reviews and strategic planning and enable commissioners to establish a broad base-line position and make initial comparisons on activity and spend. The definition set can be found on the Department of Health (DH) website.

References:
~~National Specialised Services Definition Set, Department of Health~~ National Specialised Services Definition Set, Department of Health

This attribute is also known by these names:

Context	Alias
plural	SERVICE TYPES

SOURCE OF REFERRAL FOR OUT-PATIENTS

Change to Attribute: Change to Description

A CLASSIFICATION which is used to identify the source of referral of each Consultant Out-Patient Episode.

National Codes:
The codes 01, 02, 10, 11 and 05 below in italics are not to be used in reporting National Cancer Waiting Times.

Initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode

- *01* *following an emergency admission*
- *02* *following a Domiciliary Consultation*
- *10* *following an Accident And Emergency Attendance (including Minor Injuries Units and Walk In Centres)*
- *11* *other - initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode*

Not initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode

- 03 referral from a GENERAL MEDICAL PRACTITIONER
- 92 referral from a GENERAL DENTAL PRACTITIONER
- 12 referral from a GENERAL PRACTITIONER with Special Interest
- 04 referral from an Accident And Emergency Department (including Minor Injuries Units and Walk In Centres)
- *05* *referral from a CONSULTANT, other than in an Accident And Emergency Department*
- 06 self-referral
- 07 referral from a Prosthetist
- 13 referral from a Specialist Nurse (Secondary Care)
- 14 referral from an Allied Health Professional
- 15 referral from an Optometrist
- 16 referral from an Orthoptist
- 17 referral from a National Screening Programme
- 93 referral from a Community Dental Service
- 97 other - not initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode

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

~~Where a patient is referred by a GENERAL PRACTITIONER acting in the capacity of GP with Special Interest, code 12 should be used.~~ ~~Where a patient is referred by that GP acting in their capacity as an ordinary GENERAL MEDICAL PRACTITIONER, or as an ordinary GENERAL DENTAL PRACTITIONER, code 03 or code 92 should be used as appropriate.~~ Where a PATIENT is referred by a GENERAL PRACTITIONER acting in the capacity of GENERAL PRACTITIONER with Special Interest, code 12 should be used. Where a PATIENT is referred by that GENERAL PRACTITIONER acting in their capacity as an ordinary GENERAL MEDICAL PRACTITIONER, or as an ordinary GENERAL DENTAL PRACTITIONER, code 03 or code 92 should be used as appropriate.

~~Two Week Wait Referrals made by Specialist Nurses in Primary Care, under the authority of the GENERAL MEDICAL PRACTITIONER leading their team, should continue to be classified as referrals from the GP (code 03).~~

Two Week Wait Referrals made by Specialist Nurses in Primary Care, under the authority of the GENERAL MEDICAL PRACTITIONER leading their team, should continue to be classified as referrals from the GENERAL PRACTITIONER (code 03). Referrals from Specialist Nurses in Secondary Care should be classified as code 13.

References:
~~The NHS National Cancer Waiting times, DH, DSCN 22/2002~~ The NHS National Cancer Waiting times, Department of Health, DSCN 22/2002

This attribute is also known by these names:

Context	Alias
plural	SOURCES OF REFERRALS FOR OUT-PATIENTS

SUPRA SERVICE INDICATOR

Change to Attribute: Change to Description

~~A designated services for which national commissioning arrangements exist.~~ A designated SERVICE for which national commissioning arrangements exist. These arrangements are made for reasons of clinical effectiveness, equity of access and/or economic viability. The services are identified by the National Specialist Commissioning Advisory Group (NSCAG).

Classification:

a. Yes
b. No

References:
~~National Specialist Commissioning Advisory Group, Department of Health~~National Specialist Commissioning Advisory Group, Department of Health

This attribute is also known by these names:

Context	Alias
plural	SUPRA SERVICE INDICATORS

TWO WEEK WAIT EXCLUSION INDICATOR

Change to Attribute: Change to Description

~~An indicator that the PATIENT will be excluded from two week wait monitoring of Out-Patient Appointment for cancer care as the PATIENT refused an appointment within two weeks before being offered an appointment.~~ An indicator that the PATIENT will be excluded from two week wait monitoring of Out-Patient Appointment for cancer care as the PATIENT refused an APPOINTMENT within two weeks before being offered an APPOINTMENT. These PATIENTS will still be included in monitoring of the treatment targets for cancer care.

Classification:

a. Not excluded
~~b. Excluded – PATIENT refused an appointment within 2 weeks before being offered an appointment~~
b. Excluded - PATIENT refused an APPOINTMENT within 2 weeks before being offered an APPOINTMENT

References:
~~The NHS National Cancer Waiting Times, DH, DSCN 22/2002~~ The NHS National Cancer Waiting Times, Department of Health, DSCN 22/2002

This attribute is also known by these names:

Context	Alias
plural	TWO WEEK WAIT EXCLUSION INDICATORS

DIAGNOSTIC TEST (ENDOSCOPY)

Change to Data Element: Change to Description

Format/length:	an5
HES item:	
National Codes:	
Default Codes:	

Notes:

~~This is the intended or actual endoscopy diagnostic test or procedure split by Colonoscopy, Flexi sigmoidoscopy, Cystoscopy and Gastroscopy for a SERVICE REQUEST derived from the CLINICAL CLASSIFICATION OPCS 4 codes listed in the Department of Health document 'Diagnostics waiting times and activity: Guidance on completing the "diagnostic waiting times & activity" monthly data collection.~~ This is the intended or actual endoscopy diagnostic test or procedure split by Colonoscopy, Flexi sigmoidoscopy, Cystoscopy and Gastroscopy for a SERVICE REQUEST derived from the CLINICAL CLASSIFICATION OPCS 4 codes listed in the Department of Health document 'Diagnostics waiting times and activity: Guidance on completing the "diagnostic waiting times & activity" monthly data collection.

References:
Department of Health: Monthly and Quarterly/Biannual Diagnostics statistics

This data element is also known by these names:

Context	Alias
plural	DIAGNOSTIC TESTS (ENDOSCOPY)

DIAGNOSTIC TEST (IMAGING)

Change to Data Element: Change to Description

Format/length:	an5
HES item:	
National Codes:	
Default Codes:	

Notes:

~~This is the intended or actual Imaging Test or Procedure split by Magnetic Resonance Imaging (MRI), Computed Tomography (CT) scan, Non-obstetric ultrasound, Barium Enema and DEXA scan for a SERVICE REQUEST derived from the CLINICAL CLASSIFICATION OPCS 4 codes listed in the Department of Health document 'Diagnostics waiting times and activity: Guidance on completing the "diagnostic waiting times & activity" monthly~~

~~data collection.~~ This is the intended or actual Imaging Test or Procedure split by Magnetic Resonance Imaging (MRI), Computed Tomography (CT) scan, Non-obstetric ultrasound, Barium Enema and DEXA scan for a SERVICE REQUEST derived from the CLINICAL CLASSIFICATION OPCS 4 codes listed in the Department of Health document 'Diagnostics waiting times and activity: Guidance on completing the "diagnostic waiting times & activity" monthly data collection.

References:
Department of Health: Monthly and Quarterly/Biannual Diagnostics statistics

This data element is also known by these names:

Context	Alias
plural	DIAGNOSTIC TESTS (IMAGING)

DIAGNOSTIC TEST (PHYSIOLOGICAL MEASUREMENT)

Change to Data Element: Change to Description

Format/length:	an5
HES item:	
National Codes:	
Default Codes:	

Notes:

~~This is the intended or actual physiological measurement diagnostic test or procedure split by Audiology - audiological assessments, Cardiology - echocardiography and electrophysiology, Neurophysiology - peripheral neurophysiology, Respiratory physiology - sleep studies, Urodynamics - pressures and flows for a SERVICE REQUEST derived from the CLINICAL CLASSIFICATION OPCS 4 codes listed in the Department of Health document 'Diagnostics waiting times and activity: Guidance on completing the "diagnostic waiting times & activity" monthly data collection.~~ This is the intended or actual physiological measurement diagnostic test or procedure split by Audiology - audiological assessments, Cardiology - echocardiography and electrophysiology, Neurophysiology - peripheral neurophysiology, Respiratory physiology - sleep studies, Urodynamics - pressures and flows for a SERVICE REQUEST derived from the CLINICAL CLASSIFICATION OPCS 4 codes listed in the Department of Health document 'Diagnostics waiting times and activity: Guidance on completing the "diagnostic waiting times & activity" monthly data collection.

References:
Department of Health: Monthly and Quarterly/Biannual Diagnostics statistics

This data element is also known by these names:

Context	Alias
plural	DIAGNOSTIC TESTS (PHYSIOLOGICAL MEASUREMENT)

FIRST SEEN BY SPECIALIST DATE (CANCER)

Change to Data Element: Change to Description

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

Notes:
~~This is the date that the PATIENT is first seen by the appropriate specialist for cancer care within a Cancer Care Spell. This is the PERSON or PERSONS who are most able to progress the diagnosis of the primary tumour. The date will be one of the following, whichever is the earlier ACTIVITY related to the Cancer Care Spell where the PATIENT saw an appropriate specialist for cancer care:~~ This is the date that the PATIENT is first seen by the appropriate specialist for cancer care within a Cancer Care Spell. This is the PERSON or PERSONS who are most able to progress the diagnosis of the primary tumour. The date will be one of the following, whichever is the earlier ACTIVITY related to the Cancer Care Spell where the PATIENT saw an appropriate specialist for cancer care:

- ~~first out-patient appointment with appropriate cancer specialist; this is the first attendance of the Out-Patient Attendance Consultant~~
- first Out-Patient Appointmentwith appropriate cancer specialist; this is the first attendance of the Out-Patient Attendance Consultant
- ~~first diagnostic procedure if this precedes the first out-patient appointment; this is the first ACTIVITY DATE of the Imaging Or Radiodiagnostic Event or the CLINICAL INTERVENTION.~~
- first diagnostic procedure if this precedes the first Out-Patient Appointment; this is the first ACTIVITY DATE of the Imaging Or Radiodiagnostic Event or the CLINICAL INTERVENTION.
- ~~first seen as an emergency; this is the ACTIVITY DATE (start date) of the Hospital Provider Spell or the ACTIVITY DATE (arrival date) of the Accident And Emergency Attendance.~~
- first seen as an emergency; this is the ACTIVITY DATE (start date) of the Hospital Provider Spell or the ACTIVITY DATE (arrival date) of the Accident And Emergency Attendance.
- ~~first seen following recall by screening unit; this is the ACTIVITY DATE of the Screening Test.~~
- first seen following recall by screening unit; this is the ACTIVITY DATE of the Screening Test.

This date may be the same as DATE FIRST SEEN if the initial consultation was with an appropriate cancer specialist in the Trust that receives the first referral.

~~References:~~
~~The NHS National Cancer Waiting Times, DH, DSCN 22/2002.~~ References:
The NHS National Cancer Waiting Times, Department of Health, DSCN 22/2002.

This data element is also known by these names:

Context	Alias
plural	FIRST SEEN BY SPECIALIST DATES (CANCER)

HEALTHCARE RESOURCE GROUP CODE

Change to Data Element: Change to Description

Format/length:	an3
HES item:	HRGNHS
National Codes:	
Default Codes:	

Notes:
~~The National Schedule of Reference Costs, developed by the Department of Health, uses Healthcare Resource Groups (HRGs) as the basis for costing inpatient and daycase services.~~ The National Schedule of Reference Costs, developed by the Department of Health, uses Healthcare Resource Groups as the basis for costing inpatient and daycase services.

~~Healthcare Resource Groups (HRGs) for Admitted Patient Care are derived from existing CDS data items.~~ Healthcare Resource Groups for Admitted Patient Care are derived from existing Commissioning Data Set data items.

~~HRGs for Out-Patient Attendances are directly assigned and cannot be derived from the Out-Patient Attendance CDS data items.~~ Healthcare Resource Groups for Out-Patient Attendances are directly assigned and cannot be derived from the Out-Patient Attendance Commissioning Data Set data items.

HEALTHCARE RESOURCE GROUP CODES identify the HRGs.

~~DSCN 08/2000 includes HEALTHCARE RESOURCE GROUP CODES in the core CDS to standardise the handling of this data item within the CDS, the NHS CDS EDIFACT message and the NWCS database.~~ DSCN 08/2000 includes HEALTHCARE RESOURCE GROUP CODES in the core Commissioning Data Set to standardise the handling of this data item within the Commissioning Data Set, the NHS Commissioning Data Set EDIFACT message and the NHS-Wide Clearing Service database. It is mandatory from 01/10/2001.

This data element is also known by these names:

Context	Alias
plural	HEALTHCARE RESOURCE GROUP CODES

HEALTHCARE RESOURCE GROUP CODE-VERSION NUMBER

Change to Data Element: Change to Description

Format/length:	an3
HES item:	HRGNHSVN
National Codes:	OP (applies to out-patient HRGs only)
Default Codes:	

Notes:

~~The version number should be 'OP' when designating an out-patient Healthcare Resource Group (HRG) code, rather than a numeric value.~~ The version number should be 'OP' when designating an out-patient Healthcare Resource Group code, rather than a numeric value.

~~The National Schedule of Reference Costs, developed by the Department of Health, uses Healthcare Resource Groups as the basis for costing inpatient and day case services.~~ The National Schedule of Reference Costs, developed by the Department of Health, uses Healthcare Resource Groups as the basis for costing inpatient and day case services.

Healthcare Resource Groups are derived for Admitted Patient Care from existing Commissioning Data Set data items.

Healthcare Resource Groups for Out-Patient Attendances are directly assigned and cannot be derived from the Out-Patient Attendance Commissioning Data Set data items.

HEALTHCARE RESOURCE GROUP CODE-VERSION NUMBERS identify which version of the Healthcare Resource Group has been used to identify the Healthcare Resource Group.

This will facilitate the management of regular Healthcare Resource Group updates issued by the Health and Social Care Information Centre.

This data element is also known by these names:

Context	Alias
plural	HEALTHCARE RESOURCE GROUP CODE-VERSION NUMBERS

HRG DOMINANT GROUPING VARIABLE-PROCEDURE

Change to Data Element: Change to Description

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

Notes:

~~The National Schedule of Reference Costs, developed by the Department of Health, uses Healthcare Resource Groups as the basis for costing inpatient and day case services.~~ The National Schedule of Reference Costs, developed by the Department of Health, uses Healthcare Resource Groups as the basis for costing inpatient and day case services. Healthcare Resource Groups are derived from existing Commissioning Data Set data items using an algorithm and a software package developed by the Health and Social Care Information Centre Casemix Service.

HRG DOMINANT GROUPING VARIABLE-PROCEDURES is a field derived by the Healthcare Resource Group Acute Inpatient Grouper. It represents the procedure that the Healthcare Resource Group grouping algorithm has identified as having the greatest effect upon the resources consumed by a PATIENT. It is required for the production of the National Schedule of Reference Costs reports.

The HRG DOMINANT GROUPING VARIABLE-PROCEDURE has the same data format, rules and attributes as OPCS-4 codes for Patient Procedure, see also PROCEDURE CODING.

~~DSCN 08/2000 includes HRG DOMINANT GROUPING VARIABLE PROCEDURES in the core Commissioning Data Set to standardise the handling of this data item within the Commissioning Data Set, the NHS Commissioning Data Set EDIFACT message and the NWCS database.~~ DSCN 08/2000 includes HRG DOMINANT GROUPING VARIABLE-PROCEDURES in the core Commissioning Data Set to standardise the handling of this data item within the Commissioning Data Set, the NHS Commissioning Data Set EDIFACT message and the NHS-Wide Clearing Service database. It is mandatory from 01/10/2001.

Patient Procedure is a CLINICAL INTERVENTION where CLINICAL INTERVENTION TYPE is National Code 25 *'Patient Procedure'*.

This data element is also known by these names:

Context	Alias
plural	HRG DOMINANT GROUPING VARIABLE-PROCEDURES

NHS NUMBER

Change to Data Element: Change to Description

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

Notes:

References:

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

NHS NUMBER is the same as attribute NHS NUMBER.

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

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

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

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

Step 2 Add the results of each multiplication together.

Step 3 Divide the total by 11 and establish the remainder.

Step 4 Subtract the remainder from 11 to give the check digit.
If the result is **11** then a check digit of **0** is used.
If the result is **10** then the NHS NUMBER is invalid and not used.

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

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

UK Government Data Standards Catalogue

Data Element	**NHS Number**
Is Part Of	**Person Identifiers**
Has Parts	
Version	**2.0**
Status	**Release**
Previous Versions	
Later Versions	
Date Agreed	**1 January 2002**

Meta Data	**Value**
Name	**NHS Number**
Description	A number used to identify a person uniquely within the NHS in England and Wales.
Business Format	10 numeric
Element Type	Data Item

Validation

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

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

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

Step 2 Add the results of each multiplication together.

Step 3 Divide the total by 11 and establish the remainder.

Step 4 Subtract the remainder from 11 to give the check digit. If the result is 11 then a check digit of 0 is used. If the result is 10 then the NHS NUMBER is invalid and not used.

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

Value

Default Value

~~*Owner*~~ ~~Department of Health~~

Owner Department of Health

Based On Department of Health

Verification

Comment

This data element is also known by these names:

Context	Alias
plural	NHS NUMBERS

OVERSEAS VISITORS STATUS CLASSIFICATION

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:	8 - Not applicable (not an overseas visitor) 9 - Charging rate not known

Notes:

~~IGA forms for overseas visitors should be sent to North East Leeds PCT, the agency acting on behalf of the~~

~~Department of Health.~~ Income Generation Audit (IGA) forms for overseas visitors should be sent to North East Leeds Primary Care Trust, the agency acting on behalf of the Department of Health. This enables the financial side of reciprocal and international agreements to be supported. It also helps to monitor the treatment of overseas visitors and associated levels of expenditure.

~~Where the transmission of Commissioning Data Sets identifies reciprocal agreement overseas patients by the use of TDH00 in the ORGANISATION CODE (CODE OF COMMISSIONER), the Secondary Uses Service (SUS) will send the activity to the provider's host commissioner to pay and copy it to North East Leeds PCT - alleviating the need to send a separate IGA form.~~ Where the transmission of Commissioning Data Sets identifies reciprocal agreement overseas PATIENTS by the use of TDH00 in the ORGANISATION CODE (CODE OF COMMISSIONER), the Secondary Uses Service will send the activity to the provider's host commissioner to pay and copy it to North East Leeds Primary Care Trust - alleviating the need to send a separate Income Generation Audit form.

The OVERSEAS VISITOR STATUS may change while the PATIENT is being treated. All such changes should be recorded so that charges for treatment can be revised accordingly

This data element is also known by these names:

Context	Alias
plural	OVERSEAS VISITORS STATUS CLASSIFICATIONS

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