Health and Social Care Information Centre

NHS Data Model and Dictionary Service

Type:	Data Dictionary Change Notice
Reference:	1496
Version No:	1.0
Subject:	Clinical Coding
Effective Date:	Immediate
Reason for Change:	Updating of information
Publication Date:	26 January 2015

Background:

A review of Clinical Coding information in the NHS Data Model and Dictionary has been undertaken to better reflect current coding requirements and the distinction between clinical terminologies and clinical classifications.

- Background:
  - The NHS Data Model and Dictionary contains information relating to Clinical Classifications and Clinical Classification Codes which currently fails to make clear this necessary distinction in purpose and form between these two designations.
  - It has been identified that the information relating to Clinical Coding is inconsistent as there are no references to the representation of Clinical Terminology as distinct to that of Clinical Classification.
  - The specification of the format/length for classification and terminology Data Elements is inconsistent.

The information in this Data Dictionary Change Notice relates to the following Clinical Codes in the NHS Data Model and Dictionary:

- Clinical Classification Codes:
  - International Classification of Diseases (ICD) 10th Revision: Correct format min an4 max an6
  - International Classification of Diseases for Oncology (ICD-O): Correct format min an5 max an7
  - OPCS Classification of Interventions and Procedures (OPCS-4): Correct format an4
- Clinical Terminology Codes:
  - NHS dictionary of medicines and devices (dm+d): Correct format min n6 max n18
  - National Interim Clinical Imaging Procedure (NICIP) Code Set: Correct format: max an6
  - Read Coded Clinical Terms: Correct format an5 or an7
  - Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®): Correct format min n6 max n18

    It should be noted that the Read codes and NICIP are scheduled for a staged withdrawal from use commencing in April 2016.

Please note that the changes in this Data Dictionary Change Notice do not affect the current flow of data for any of the items listed.

Data Set developers affected by this change have been contacted to ensure the changes do not impact on their data set.

All data sets have been checked to establish if the data set specification formats are correct and:

- Where the data set specification matches the confirmed formats, the items have been checked to ensure they display the correct information.
- Where the XML Schema Constraints page matches the confirmed format, the items have been amended to show the correct information as they are correct in the XML Schema.

- In the following cases, the existing format has been retained and will be considered when the next version of the data set is developed:
  - There is currently no developer to contact to confirm the current validation rules, i.e. National Renal Data Set
  - The data set is out of date, i.e. Diabetes (Summary Core)
  - The current data set specification owned by the developer does not match the existing format/length in the NHS Data Model and Dictionary, i.e. Radiotherapy Data Set.
- Where the format/length of a Data Element is incorrect in the published Information Standard documents, the format/length will be updated in the next version of the data set under the usual maintenance programme. This has been agreed with the data set developers affected by the changes.

A separate Data Dictionary Change Notice will be published to update the DEATH CAUSE ICD CODE Data Elements to match the Office for National Statistics (ONS) information.

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

- Retires the following items:
  - Classes:
    - CLINICAL CLASSIFICATION
    - OPERATIVE PROCEDURE
  - Attributes:
    - DEATH CAUSE ICD CODE
    - PATIENT PROCEDURE CODING SIGNIFICANCE
  - Data Elements:
    - CLINICAL CLASSIFICATION SEQUENCE NUMBER
    - DIAGNOSTIC CODING
    - DIAGNOSTIC TEST
    - PRIMARY (ICD-10)
    - PROCEDURE CODING
- Adds the following items:
  - Classes:
    - CODED CLINICAL ENTRY
  - Attributes:
    - CLINICAL TERMINOLOGY CODE
    - EUROPEAN RENAL ASSOCIATION CODE
    - INTERNATIONAL FEDERATION OF GYNECOLOGY AND OBSTETRICS STAGE
    - UNION FOR INTERNATIONAL CANCER CONTROL CODE
  - Data Elements:
    - DM+D CODE
    - ICD-10 CODE
    - ICD-O CODE
    - NICIP CODE
    - OPCS-4 CODE
    - READ CODE
    - SNOMED CT CODE

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

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

Summary of changes:

Diagrams	
CANCER OUTCOMES AND SERVICES DIAGRAM	Changed Diagram
NATIONAL RENAL DIAGRAM	Changed Diagram
RADIOTHERAPY DIAGRAM	Changed Diagram

Supporting Information

ABO SYSTEM	Changed Description
ANATOMICAL SITE renamed from ANATOMICAL SITE	Changed Name, Description
CLINICAL CODING INTRODUCTION	Changed Description
EUROPEAN DIALYSIS AND TRANSPLANT ASSOCIATION CODING SCHEME	Changed Description
GLOSSARY OF TERMS	Changed Description
INTENDED PATIENT PROCEDURE	Changed Description
NHS DICTIONARY OF MEDICINES AND DEVICES	Changed Description
READ CODED CLINICAL TERMS	Changed Description
RH SYSTEM	Changed Description
SNOMED CT SUBSET	Changed Description
SYSTEMATIZED NOMENCLATURE OF MEDICINE CLINICAL TERMS	Changed Description
THEATRE CASE	Changed Description

Class Definitions

CANCER STAGING	Changed Attributes
CLINICAL CLASSIFICATION (RETIRED) renamed from CLINICAL CLASSIFICATION	Changed Relationships, Name, Attributes, Description, status to Retired
CODED CLINICAL ENTRY	New Class
DEATH CAUSE	Changed Attributes
OPERATING THEATRE	Changed Description
OPERATIVE PROCEDURE (RETIRED) renamed from OPERATIVE PROCEDURE	Changed Name, Description, Supertype, status to Retired
PATIENT DIAGNOSIS	Changed Description
PERSON PROPERTY QUALIFIER	Changed Attributes

Attribute Definitions

ACCIDENT AND EMERGENCY DIAGNOSIS	Changed Description
ACCIDENT AND EMERGENCY INVESTIGATION	Changed Description
ACCIDENT AND EMERGENCY TREATMENT	Changed Description
CLINICAL CLASSIFICATION CODE	Changed Description
CLINICAL TERMINOLOGY CODE	New Attribute
DEATH CAUSE ICD CODE (RETIRED) renamed from DEATH CAUSE ICD CODE	Changed Name, Description, status to Retired
EUROPEAN RENAL ASSOCIATION CODE	New Attribute
INTERNATIONAL FEDERATION OF GYNECOLOGY AND OBSTETRICS STAGE	New Attribute
PATIENT PROCEDURE CODING SIGNIFICANCE (RETIRED) renamed from PATIENT PROCEDURE CODING SIGNIFICANCE	Changed Name, Description, status to Retired
UNION FOR INTERNATIONAL CANCER CONTROL CODE	New Attribute

Data Elements

ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST	Changed Description
ACCIDENT AND EMERGENCY DIAGNOSIS - SECOND	Changed Description
ACCIDENT AND EMERGENCY INVESTIGATION - FIRST	Changed Description
ACCIDENT AND EMERGENCY INVESTIGATION - SECOND	Changed Description
ACCIDENT AND EMERGENCY TREATMENT - FIRST	Changed Description
ACCIDENT AND EMERGENCY TREATMENT - SECOND	Changed Description
CHLAMYDIA TEST RESULT (SNOMED CT)	Changed Description, linked Attribute
CLINICAL CLASSIFICATION SEQUENCE NUMBER (RETIRED) renamed from CLINICAL CLASSIFICATION SEQUENCE NUMBER	Changed Name, Description, status to Retired
DEATH CAUSE ICD CODE (CONDITION)	Changed Description, linked Attribute

DEATH CAUSE ICD CODE (DURING NEONATAL CRITICAL CARE PERIOD)	Changed Description, linked Attribute
DEATH CAUSE ICD CODE (IMMEDIATE)	Changed Description, linked Attribute
DEATH CAUSE ICD CODE (SIGNIFICANT)	Changed Description, linked Attribute
DEATH CAUSE ICD CODE (UNDERLYING)	Changed Description, linked Attribute
DIAGNOSIS (ICD NEUROLOGICAL)	Changed Description
DIAGNOSIS (ICD ON ADMISSION TO NEONATAL CRITICAL CARE)	Changed Description
DIAGNOSIS (ICD ON NEONATAL CRITICAL CARE DAILY CARE DATE)	Changed Description
DIAGNOSIS (ICD RECORDED ON DISCHARGE FROM NEONATAL CRITICAL CARE)	Changed Description
DIAGNOSIS (SNOMED CT ON ADMISSION TO NEONATAL CRITICAL CARE)	Changed Description, linked Attribute
DIAGNOSIS (SNOMED CT ON NEONATAL CRITICAL CARE DAILY CARE DATE)	Changed Description, linked Attribute
DIAGNOSIS (SNOMED CT RECORDED ON DISCHARGE FROM NEONATAL CRITICAL CARE)	Changed Description, linked Attribute
DIAGNOSTIC CODING (DIABETES RELEVANT ICD-10)	Changed Description
DIAGNOSTIC CODING (DIABETES RELEVANT READ CODES)	Changed Description, linked Attribute
DIAGNOSTIC CODING (RETIRED) renamed from DIAGNOSTIC CODING	Changed Name, Description, linked Attribute, status to Retired
DIAGNOSTIC OR PROCEDURE CODING (SEXUAL HEALTH AND HUMAN IMMUNODEFICIENCY VIRUS RELEVANT READ CODES)	Changed Description
DIAGNOSTIC TEST (ENDOSCOPY)	Changed Description
DIAGNOSTIC TEST (ENDOSCOPY CENSUS)	Changed Description
DIAGNOSTIC TEST (IMAGING)	Changed Description
DIAGNOSTIC TEST (IMAGING CENSUS)	Changed Description
DIAGNOSTIC TEST (PATHOLOGY CENSUS)	Changed Description
DIAGNOSTIC TEST (PHYSIOLOGICAL MEASUREMENT)	Changed Description
DIAGNOSTIC TEST (PHYSIOLOGICAL MEASUREMENT CENSUS)	Changed Description
DIAGNOSTIC TEST (RETIRED) renamed from DIAGNOSTIC TEST	Changed Name, Description, status to Retired
DIAGNOSTIC TESTS COMMISSIONED FROM INDEPENDENT SECTOR	Changed Description
DIAGNOSTIC TESTS DONE TOTAL	Changed Description
DM+D CODE	New Data Element
FINAL FIGO STAGE	Changed Description, linked Attribute
FORMULA MILK OR MILK FORTIFIER TYPE (SNOMED CT DM+D)	Changed Description, linked Attribute
HIGH COST DRUGS (OPCS)	Changed Description, linked Attribute
ICD-10 CODE	New Data Element
ICD-O CODE	New Data Element
IMAGING CODE (NICIP)	Changed Description, linked Attribute
IMAGING CODE (SNOMED-CT)	Changed Description, linked Attribute
INTENDED DIAGNOSTIC TEST	Changed Description
M CATEGORY (FINAL PRETREATMENT)	Changed Description, linked Attribute
M CATEGORY (INTEGRATED STAGE)	Changed Description, linked Attribute
M CATEGORY (PATHOLOGICAL)	Changed Description, linked Attribute
MEDICATION GIVEN DURING LABOUR (SNOMED CT DM+D)	Changed Description, linked Attribute

MEDICATION GIVEN DURING NEONATAL CRITICAL CARE DAILY CARE DATE (SNOMED CT DM+D)	Changed Description, linked Attribute
MORPHOLOGY (ICD-O)	Changed Description
MORPHOLOGY (ICD-O AT START SYSTEMIC ANTI-CANCER THERAPY)	Changed Description
MORPHOLOGY (SNOMED)	Changed Description, linked Attribute
MORPHOLOGY (SNOMED CT)	Changed Description, linked Attribute
N CATEGORY (FINAL PRETREATMENT)	Changed Description, linked Attribute
N CATEGORY (INTEGRATED STAGE)	Changed Description, linked Attribute
N CATEGORY (PATHOLOGICAL)	Changed Description, linked Attribute
NEONATAL RESUSCITATION DRUG (SNOMED CT DM+D)	Changed Description, linked Attribute
NICIP CODE	New Data Element
OCCUPATION MOTHER (SNOMED CT)	Changed Description, linked Attribute
OPCS-4 CODE	New Data Element
OPERATION STATUS CODE	Changed Description
PERITONITIS ORGANISM 1 (READ)	Changed Description, linked Attribute
PERITONITIS ORGANISM 2 (READ)	Changed Description, linked Attribute
PRIMARY (ICD-10) (RETIRED) renamed from PRIMARY (ICD-10)	Changed Name, Description, status to Retired
PRIMARY DIAGNOSIS (ICD)	Changed Description
PRIMARY DIAGNOSIS (ICD AT START SYSTEMIC ANTI-CANCER THERAPY)	Changed Description
PRIMARY DIAGNOSIS (ICD PATHOLOGICAL)	Changed Description
PRIMARY DIAGNOSIS (ICD RADIOLOGICAL)	Changed Description
PRIMARY DIAGNOSIS (READ)	Changed Description, linked Attribute
PRIMARY PROCEDURE (OPCS)	Changed Description
PRIMARY PROCEDURE (READ)	Changed Description, linked Attribute
PRIMARY PROCEDURE (SNOMED CT)	Changed Description, linked Attribute
PRIMARY RENAL DISEASE DIAGNOSIS	Changed Description, linked Attribute
PROCEDURE (OPCS)	Changed Description
PROCEDURE (OPCS ON NEONATAL CRITICAL CARE DAILY CARE DATE)	Changed Description
PROCEDURE (OPCS RECORDED ON DISCHARGE FROM NEONATAL CRITICAL CARE)	Changed Description
PROCEDURE (READ)	Changed Description, linked Attribute
PROCEDURE (SNOMED CT)	Changed Description, linked Attribute
PROCEDURE (SNOMED CT ON NEONATAL CRITICAL CARE DAILY CARE DATE)	Changed Description, linked Attribute
PROCEDURE (SNOMED CT RECORDED ON DISCHARGE FROM NEONATAL CRITICAL CARE)	Changed Description, linked Attribute
PROCEDURE CODING (DIABETES RELEVANT OPCS-4)	Changed Description
PROCEDURE CODING (DIABETES RELEVANT READ CODES)	Changed Description, linked Attribute
PROCEDURE CODING (RETIRED) renamed from PROCEDURE CODING	Changed Name, Description, linked Attribute, status to Retired
PROVISIONAL DIAGNOSIS (ICD)	Changed Description
RADIOTHERAPY ANATOMICAL TREATMENT SITE (OPCS)	

	Changed Description, linked Attribute
RADIOTHERAPY DIAGNOSIS (ICD)	Changed Description
READ CODE	New Data Element
SAMPLE ANTIBIOTIC SENSITIVITY RESULT (SNOMED CT DM+D)	Changed Description, linked Attribute
SAMPLE TEST RESULT ORGANISM TYPE (SNOMED CT)	Changed Description, linked Attribute
SARCOMA TUMOUR SITE (BONE)	Changed Description
SARCOMA TUMOUR SITE (SOFT TISSUE)	Changed Description
SECONDARY CAUSE OF END STAGE RENAL FAILURE	Changed Description, linked Attribute
SECONDARY DIAGNOSIS (ICD)	Changed Description, linked Attribute
SECONDARY DIAGNOSIS (READ)	Changed Description, linked Attribute
SKIN SPECIMEN SITE CODE	Changed Description
SNOMED CT CODE	New Data Element
SPECIMEN TYPE (CHLAMYDIA TESTING SNOMED CT)	Changed Description, linked Attribute
STEROID TYPE GIVEN TO MOTHER (SNOMED CT DM+D)	Changed Description, linked Attribute
T CATEGORY (FINAL PRETREATMENT)	Changed Description, linked Attribute
T CATEGORY (INTEGRATED STAGE)	Changed Description, linked Attribute
T CATEGORY (PATHOLOGICAL)	Changed Description, linked Attribute
TNM STAGE GROUPING (FINAL PRETREATMENT)	Changed Description, linked Attribute
TNM STAGE GROUPING (INTEGRATED)	Changed Description, linked Attribute
TNM STAGE GROUPING (PATHOLOGICAL)	Changed Description, linked Attribute
TOPOGRAPHY (ICD-O)	Changed Description
TOPOGRAPHY (SNOMED)	Changed Description, linked Attribute
TOPOGRAPHY (SNOMED CT)	Changed Description, linked Attribute
UNSCHEDULED DIAGNOSTIC TESTS DONE	Changed Description
WAITING LIST DIAGNOSTIC TESTS DONE	Changed Description

XML Schema Constraint

CANCER OUTCOMES AND SERVICES DATA SET XML SCHEMA CONSTRAINTS	Changed Description
COMMISSIONING DATA SET VERSION 6-2 XML SCHEMA CONSTRAINTS	Changed Description
HIV AND AIDS REPORTING DATA SET XML SCHEMA CONSTRAINTS	Changed Description

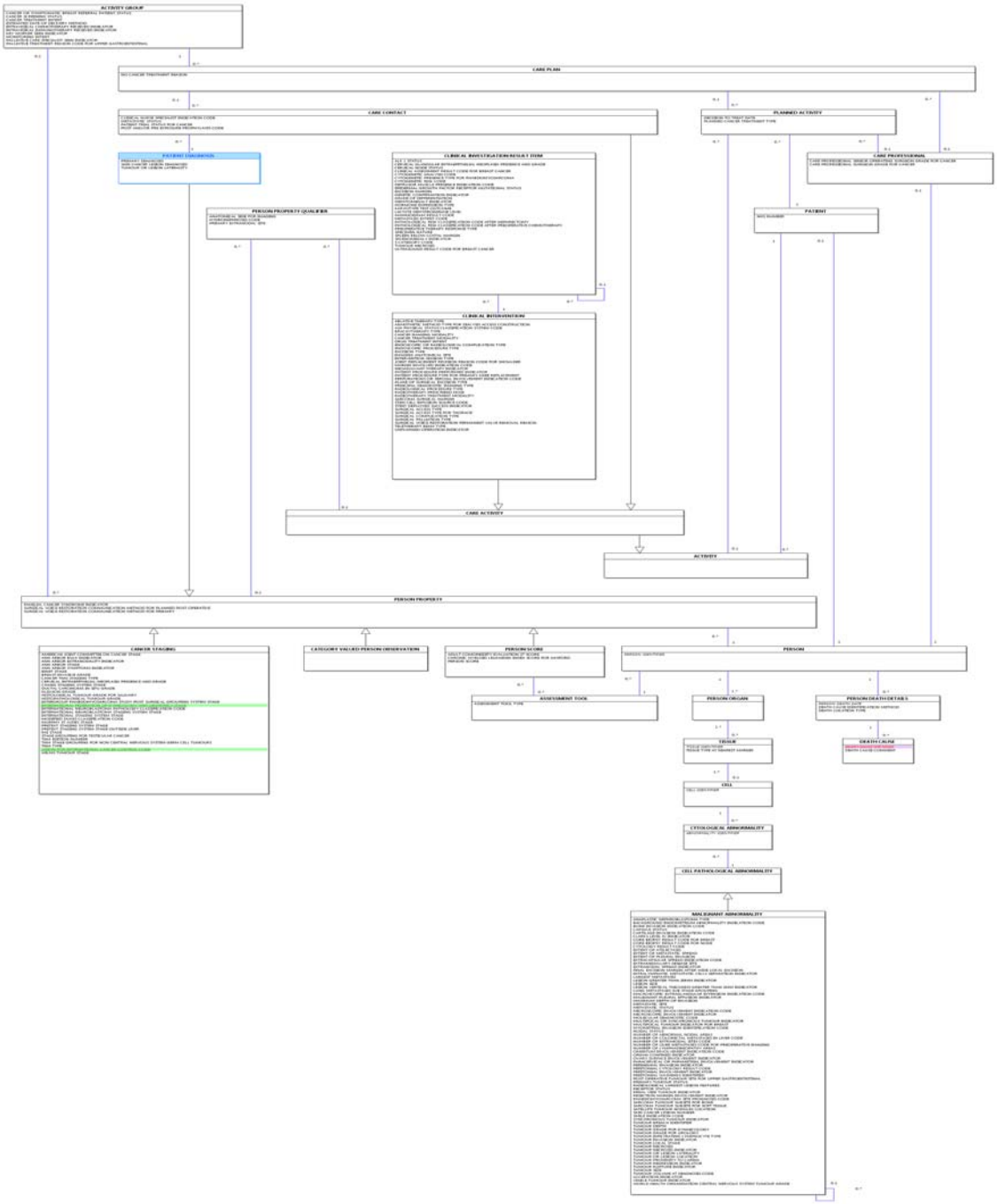
Date: 26 January 2015

Sponsor: Peter Counter, Chief Technology Officer, Health and Social Care Information Centre

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

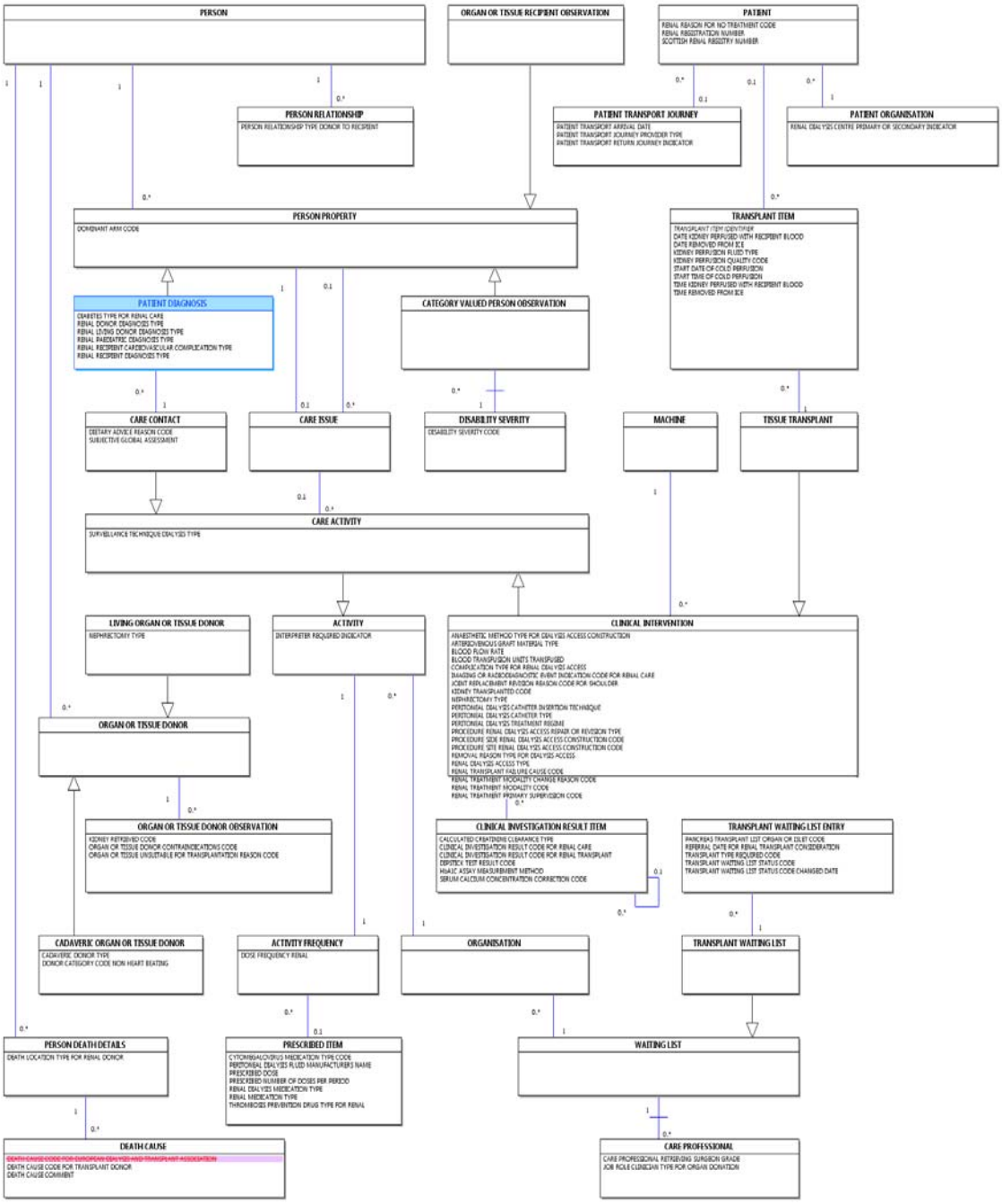
CANCER OUTCOMES AND SERVICES DIAGRAM

Change to Diagram: Changed Diagram



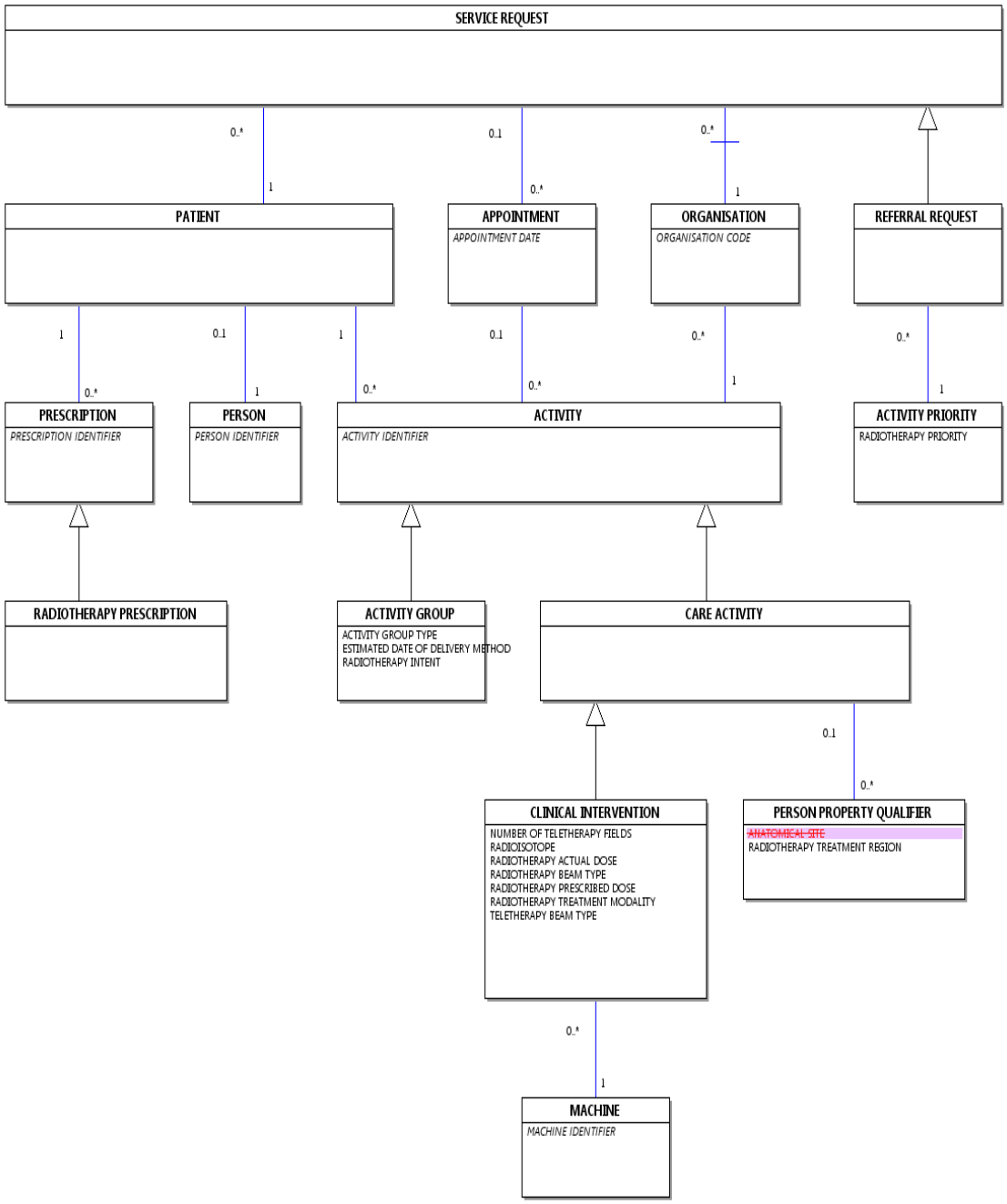
NATIONAL RENAL DIAGRAM

Change to Diagram: Changed Diagram



RADIOTHERAPY DIAGRAM

Change to Diagram: Changed Diagram



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ABO SYSTEM

Change to Supporting Information: Changed Description

~~The ABO System is a CLINICAL CLASSIFICATION.~~The ABO System is a CODED CLINICAL ENTRY.

The ABO System is a system of 4 basic types into which human blood may be classified according to the presence or absence of particular antigens:

- A - Blood group A has A antigens in its red blood cells and anti-B antibodies in its plasma;
- B - Blood group B has B antigens and anti-A antibodies in its plasma;
- O - Blood group O blood has no antigens but both anti-A and anti-B antibodies

- AB - Blood group AB has both A and B antigens but no antibodies, as it would destroy itself.

For further information on the ABO System, see the NHS Choices website.

ANATOMICAL SITE renamed from ANATOMICAL SITE

Change to Supporting Information: Changed Name, Description

~~The classification of a structure of the human body.~~An Anatomical Site is a PERSON PROPERTY QUALIFIER.

~~The coding frame used is the OPCS Classification of Interventions and Procedures OPCS-4 'Z' coding.~~An Anatomical Site is a structure of the human body.

The coding frame used is the OPCS Classification of Interventions and Procedures (OPCS-4) 'Z' coding.

ANATOMICAL SITE renamed from ANATOMICAL SITE

Change to Supporting Information: Changed Name, Description

- Changed Name from Data_Dictionary.Attributes.A.Ana.ANATOMICAL_SITE to Data_Dictionary.NHS_Business_Definitions.A.Anatomical_Site
- Changed Description

CLINICAL CODING INTRODUCTION

Change to Supporting Information: Changed Description

- Accident and Emergency Coding Tables
- European Dialysis and Transplant Association Coding Scheme
- International Classification of Diseases (ICD)
- International Classification of Diseases for Oncology (ICD-O)
- ~~National Interim Clinical Imaging Procedure Code Set~~
- National Interim Clinical Imaging Procedure Code Set (NICIP Code Set)
- NHS dictionary of medicines and devices (dm+d)
- OPCS Classification of Interventions and Procedures
- Read Coded Clinical Terms
- ~~Systematized Nomenclature of Medicine Clinical Terms~~
- Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT)

EUROPEAN DIALYSIS AND TRANSPLANT ASSOCIATION CODING SCHEME

Change to Supporting Information: Changed Description

~~European Dialysis and Transplant Association Coding Scheme is a CLINICAL CLASSIFICATION.~~European Dialysis and Transplant Association Coding Scheme is a CODED CLINICAL ENTRY.

A coding scheme used by the European Renal Association (European Dialysis and Transplant Association) to record details of renal care and outcomes.

GLOSSARY OF TERMS

Change to Supporting Information: Changed Description

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

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

Class	Attribute
Admission	
Hospital Provider Spell	ACTIVITY DATE of the ACTIVITY DATE TYPE Start Date
Annual Census	
Hospital Provider Spell	ACTIVITY DATE of the ACTIVITY DATE TYPE Start Date
~~OPERATIVE PROCEDURE~~	
Mental Health Act Legal Status	MENTAL CATEGORY
Hospital Provider Spell	ACTIVITY DATE of the ACTIVITY DATE TYPE Discharge Date
PATIENT DIAGNOSIS	
Booked Admission	
ELECTIVE ADMISSION LIST ENTRY	ELECTIVE ADMISSION TYPE
Code of General Practitioner	
GENERAL MEDICAL PRACTITIONER	GENERAL MEDICAL PRACTITIONER PPD CODE
GENERAL DENTAL PRACTITIONER	GENERAL DENTAL PRACTITIONER CODE
Consultant Code	
CONSULTANT	CONSULTANT CODE
Consultant Name	
PERSON NAME	
Day Case Admission	
Hospital Provider Spell	PATIENT CLASSIFICATION
Diagnostic Services	
Pathology Department	
Radiology Department	
Isotope Procedure Department	
Physiological Measurement Department	
Discharge	
Hospital Provider Spell	ACTIVITY DATE of the ACTIVITY DATE TYPE Discharge Date
Drop-In Clinic	
REFERRAL REQUEST	OUT-PATIENT CLINIC REFERRING INDICATOR
Emergency Admission	
Hospital Provider Spell	ADMISSION METHOD
Emergency Journey	
Emergency Transport Request	
General Practitioner Name	
PERSON NAME	
GMC or GDC Reference Number	
CARE PROFESSIONAL	CARE PROFESSIONAL IDENTIFIER
Local Patient Identifier	
PATIENT ORGANISATION	LOCAL PATIENT IDENTIFIER

Maternity Admission	
Hospital Provider Spell	ADMISSION METHOD
Neonate	
PATIENT	
Nurse Identifier	
CARE PROFESSIONAL	CARE PROFESSIONAL IDENTIFIER
Nurse Name	
PERSON NAME	
Ordinary Admission	
Hospital Provider Spell	PATIENT CLASSIFICATION
Organisation Postcode	
ADDRESS	POSTCODE
ADDRESS ASSOCIATION	
Organisation Address	
ADDRESS ASSOCIATION	ADDRESS ASSOCIATION TYPE
Patient Name	
PERSON NAME	
Patients Usual Address	
ADDRESS ASSOCIATION	ADDRESS ASSOCIATION TYPE
Planned Admission	
ELECTIVE ADMISSION LIST ENTRY	ELECTIVE ADMISSION TYPE
Postcode of Usual Address	
ADDRESS	POSTCODE
Regular Day Admission	
Hospital Provider Spell	PATIENT CLASSIFICATION
Sex	
PERSON GENDER	PERSON GENDER CODE
PERSON GENDER CODE CURRENT	
PERSON GENDER CODE AT REGISTRATION	
Special/Planned Journey	
Special Transport Request	
Planned Transport Request	
Telephone Number	
COMMUNICATION CONTACT INFORMATION	COMMUNICATION CONTACT METHOD
	COMMUNICATION CONTACT STRING
TCI (To Come In Date)	
OFFER OF ADMISSION	OFFERED FOR ADMISSION DATE
Waiting List Admission	
ELECTIVE ADMISSION LIST ENTRY	ELECTIVE ADMISSION TYPE
Ward Transfer	
Ward Stay	ACTIVITY DATE of the ACTIVITY DATE TYPE End Date

INTENDED PATIENT PROCEDURE

Change to Supporting Information: Changed Description

An Intended Patient Procedure is PLANNED ACTIVITY.

~~An Intended Patient Procedure is a procedure intended to be performed on a PATIENT, recorded for an ELECTIVE ADMISSION LIST ENTRY, and classified by an OPERATIVE PROCEDURE or a Read Code.~~An Intended Patient Procedure is a procedure intended to be performed on a PATIENT, recorded for an ELECTIVE ADMISSION LIST ENTRY, and classified by a CODED CLINICAL ENTRY.

NHS DICTIONARY OF MEDICINES AND DEVICES

Change to Supporting Information: Changed Description

The NHS dictionary of medicines and devices (dm+d) is a dictionary containing unique identifiers and associated textual descriptions for medicines and medical devices. It has been developed for use throughout the NHS as a means of uniquely identifying the specific medicines and devices used in the diagnosis and treatment of PATIENTS.

Data within dm+d is also used to populate the UK Drug Extension; the drug extension then includes relationships into the full UK Edition of SNOMED CT to items such as products and substances. Further details on these two products can be found on the UK Terminology website.

The codes used to identify dm+d concepts are of the same form as those used in SNOMED CT and thus conform to the same specification.

For further information on the NHS dictionary of medicines and devices, see the NHS dictionary of medicines and devices website.

READ CODED CLINICAL TERMS

Change to Supporting Information: Changed Description

It should be noted that the Read Coded Clinical Terms are scheduled for a staged withdrawal commencing April 2016.

The Read Coded Clinical Terms are a comprehensive computerised coded thesaurus for use by clinicians. They are available in two main formats, known as Version 2 and Clinical Terms Version 3 (CTV3). They are designed for use in the electronic health care record. Clinical Terms Version 3 (CTV3) of the Read Codes is a "Superset" of all the codes from the earlier versions.

Read Coded Clinical Terms may be used for coding within local systems but are not acceptable directly for coding Hospital Episode Statistics which are extracted from the Admitted Patient Care Commissioning Data Sets. Version 2 and Clinical Terms Version 3 (CTV3) of the Read Codes contain mapping tables which can be used to generate ICD-10 and OPCS-4 codes.

~~For further information on Read Coded Clinical Terms, see Read Codes.~~For further information on Read Coded Clinical Terms, see Read Codes on the UK Terminology Centre website.

RH SYSTEM

Change to Supporting Information: Changed Description

~~The Rh System is a CLINICAL CLASSIFICATION.~~The Rh System is a CODED CLINICAL ENTRY.

In addition to the antigens present in the ABO System, red blood cells sometimes have another antigen, a protein called the Rh factor.

- If the Rh factor is present, the PERSON's blood group is RhD positive;
- If the Rh factor is absent, the PERSON is RhD negative.

This means that a PERSON can be one of eight blood groups:

- A RhD positive (A+)
- A RhD negative (A-)
- B RhD positive (B+)
- B RhD negative (B-)
- O RhD positive (O+)
- O RhD negative (O-)
- AB RhD positive (AB+)
- AB RhD negative (AB-).

For further information on the Rh System, see the NHS Choices website.

SNOMED CT SUBSET

Change to Supporting Information: Changed Description

A SNOMED CT Subset is a set of SNOMED CT® (Systematized Nomenclature of Medicine Clinical Terms) Concepts, Descriptions, or Relationships that is appropriate to deployment to support particular requirements of implementation.

SNOMED CT Subsets support user interface development through the organisation of clinical display, creation of menus and pick-lists, or support of knowledge structures.

SNOMED CT Subsets may be created as value sets for messaging or data entry or to provide pre-coordinated SNOMED CT® concepts for certain constrained use, or can inter-relate with qualifier value tables appropriate to the concept types.

SNOMED CT Subsets usually represent groups of concepts or objects (e.g. a specific clinical domain) which share specified characteristics.

Different types of Subsets are used to represent:

- Descriptions or concepts for particular realms or specialties
- Suitability of particular concepts for use in a particular context in a record
- Structure and ordering of hierarchies displaying concepts for user navigation

~~SNOMED CT Subsets can be registered or downloaded from the SNOMED CT Subset Registration page. This page is also used by the UK Terminology Centre to register SNOMED CT Subsets for distribution nationally in future releases.~~Information on the SNOMED CT Subsets within the UK Edition of SNOMED CT can be found on the SNOMED CT Subsets page of the UK Terminology Centre website.

For further information on SNOMED CT®, see SNOMED CT.

SYSTEMATIZED NOMENCLATURE OF MEDICINE CLINICAL TERMS

Change to Supporting Information: Changed Description

SNOMED CT®, the 'Systematized Nomenclature of Medicine Clinical Terms', is the clinical terminology approved as a Fundamental Standard by the Information Standards Board for Health and Social Care for use within the NHS in England. ~~SNOMED CT® is licensed for use in more than fifty countries and is free to use within the UK.~~

Requirements for utilising SNOMED CT® are stated within the National Information Board 'Framework for Action' with further details approved by the Standardisation Committee for Care Information (SCCI) in August

2014 (Item 9 on the agenda). SNOMED CT® is licensed for use in more than fifty countries and is free to deploy in systems used within the UK.

SNOMED CT® provides the clinical language that facilitates electronic communication between healthcare professionals in clear and unambiguous terms, and can be used to code, retrieve and analyse clinical data.

SNOMED CT® is very comprehensive and provides clinical terms for all healthcare professions. Applications thus often use subsets of SNOMED CT® that have been developed to support specific requirements. The NHS Data Model and Dictionary highlights where SNOMED CT Subsets exist to support data reporting for specific data items.

Note: Those using the Release Format 2 (RF2) of SNOMED CT® will be aware that SNOMED CT Subsets are implemented via the 'refset mechanism'. The UK RF2 release includes a file that provides the corresponding refset details for each SNOMED CT Subset. For further details please see the RF2 Overview.

SNOMED CT® is managed and maintained internationally by the International Health Terminology Standards Development Organisation (IHTSDO) and in the UK by the UK Terminology Centre (UKTC).

National and International arrangements have been established to ensure there is adequate and relevant governance of SNOMED CT®, to ensure it meets the needs of healthcare in the respective jurisdictions:

- UKTC - UK governance arrangements
- IHTSDO - International governance arrangements

THEATRE CASE

Change to Supporting Information: Changed Description

~~Theatre Case~~ ~~is a~~ ~~CARE CONTACT.~~A Theatre Case is a CARE CONTACT.

~~One visit of a~~ ~~PATIENT~~ ~~to an~~ ~~OPERATING THEATRE~~ ~~to undergo one or more~~ ~~OPERATIVE PROCEDURES.~~A Theatre Case is one visit of a PATIENT to an OPERATING THEATRE to undergo one or more operative procedures.

CANCER STAGING

Change to Class: Changed Attributes

Attributes of this Class are:

AMERICAN JOINT COMMITTEE ON CANCER STAGE
ANN ARBOR BULK INDICATOR
ANN ARBOR EXTRANODALITY INDICATOR
ANN ARBOR STAGE
ANN ARBOR SYMPTOMS INDICATOR
BINET STAGE
BREAST INVASIVE GRADE
CANCER TNM STAGING TYPE
CERVICAL INTRAEPITHELIAL NEOPLASIA PRESENCE AND GRADE
CHANG STAGING SYSTEM STAGE
DUCTAL CARCINOMA IN SITU GRADE
GLEASON GRADE
HISTOLOGICAL TUMOUR GRADE FOR SALIVARY
HISTOPATHOLOGICAL TUMOUR GRADE
INTERGROUP RHABDOMYOSARCOMA STUDY POST SURGICAL GROUPING SYSTEM STAGE
INTERNATIONAL FEDERATION OF GYNECOLOGY AND OBSTETRICS STAGE
INTERNATIONAL NEUROBLASTOMA PATHOLOGY CLASSIFICATION CODE

INTERNATIONAL NEUROBLASTOMA STAGING SYSTEM STAGE
INTERNATIONAL STAGING SYSTEM STAGE
MODIFIED DUKES CLASSIFICATION CODE
MURPHY ST JUDES STAGE
PRETEXT STAGING SYSTEM STAGE
PRETEXT STAGING SYSTEM STAGE OUTSIDE LIVER
RAI STAGE
STAGE GROUPING FOR TESTICULAR CANCER
TNM EDITION NUMBER
TNM STAGE GROUPING FOR NON CENTRAL NERVOUS SYSTEM GERM CELL TUMOURS
TNM TYPE
UNION FOR INTERNATIONAL CANCER CONTROL CODE
WILMS TUMOUR STAGE

CLINICAL CLASSIFICATION (RETIRED) renamed from CLINICAL CLASSIFICATION

Change to Class: Changed Relationships, Name, Attributes, Description, status to Retired

~~A classification for CLINICAL INTERVENTIONS and PERSON PROPERTIES.~~**This item has been retired from the NHS Data Model and Dictionary.**

~~Subtypes of CLINICAL CLASSIFICATION include:~~**The last live version of this item is available in the December 2014 release of the NHS Data Model and Dictionary.**

- ~~OPERATIVE PROCEDURE.~~

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

CLINICAL CLASSIFICATION (RETIRED) renamed from CLINICAL CLASSIFICATION

Change to Class: Changed Relationships, Name, Attributes, Description, status to Retired

~~*Attributes of this Class are:*~~

~~K~~ ~~CLINICAL CLASSIFICATION CODE~~
~~PATIENT PROCEDURE CODING SIGNIFICANCE~~

This class has no attributes.

CLINICAL CLASSIFICATION (RETIRED) renamed from CLINICAL CLASSIFICATION

Change to Class: Changed Relationships, Name, Attributes, Description, status to Retired

~~*Each CLINICAL CLASSIFICATION*~~
~~may be a clinical classification for one or more PERSON PROPERTY~~
~~may be an identifier for one or more PLANNED ACTIVITY~~

CLINICAL CLASSIFICATION (RETIRED) renamed from CLINICAL CLASSIFICATION

Change to Class: Changed Relationships, Name, Attributes, Description, status to Retired

- Changed Relationships
- Changed Name from Data_Dictionary.Classes.C.CLINICAL_CLASSIFICATION to Retired.Data_Dictionary.Classes.C.CLINICAL_CLASSIFICATION
- Changed Attributes

- Changed Description
- Retired CLINICAL CLASSIFICATION

CODED CLINICAL ENTRY

Change to Class: New Class

A CLINICAL TERMINOLOGY CODE or CLINICAL CLASSIFICATION CODE which may describe:

- CLINICAL INTERVENTIONS
- CLINICAL INVESTIGATION RESULT ITEMS
- PATIENT DIAGNOSES
- PERSON PROPERTIES
- PLANNED ACTIVITIES
- ACTIVITY DRUGS.

This class is also known by these names:

Context	Alias
plural	CODED CLINICAL ENTRIES

CODED CLINICAL ENTRY

Change to Class: New Class

Attributes of this Class are:

CLINICAL CLASSIFICATION CODE
CLINICAL TERMINOLOGY CODE
DEATH CAUSE CODE FOR EUROPEAN DIALYSIS AND TRANSPLANT ASSOCIATION
EUROPEAN RENAL ASSOCIATION CODE

CODED CLINICAL ENTRY

Change to Class: New Class

Each CODED CLINICAL ENTRY

may be a classification for one or more ACTIVITY DRUG
may be a classification for one or more CLINICAL INTERVENTION
may be a classification for one or more CLINICAL INVESTIGATION RESULT ITEM
may be a classification for one or more PATIENT DIAGNOSIS
may be a classification for one or more PERSON PROPERTY
may be a classification for one or more PLANNED ACTIVITY

DEATH CAUSE

Change to Class: Changed Attributes

Attributes of this Class are:

~~K~~ ~~DEATH CAUSE ICD CODE~~
~~DEATH CAUSE CODE FOR EUROPEAN DIALYSIS AND TRANSPLANT ASSOCIATION~~
DEATH CAUSE CODE FOR TRANSPLANT DONOR
DEATH CAUSE COMMENT

OPERATING THEATRE

Change to Class: Changed Description

A room in a Hospital Site of a provider registered with the Care Quality Commission, containing one or two operating tables or other similar devices. An OPERATING THEATRE accommodates one or two PATIENTS at a time during and only during the period in which, under the direct supervision of a registered medical practitioner, registered dental practitioner or other statutory registered practitioner (who are appropriately trained and qualified to carry out the regulated activity of performing surgical procedures), the PATIENT(s) can undergo operative treatment in pregnancy or childbirth or for the prevention, cure, relief or diagnosis of disease. The facilities needed for the bulk of the work and available for all PATIENTS shall permit:

a. Positioning the PATIENT(s) on the table(s) or the device(s) so as to render the operative treatment possible or convenient
b. Adjustable illumination of sufficient power to permit fine or delicate work
c. The operative treatment to take place in aseptic conditions which shall include the provision of sterile instruments and facilities for all staff to change clothing
d. The provision of pain relief during the operative treatment more elaborate than basal sedation administered in the ward, self administered inhalation or infiltration with local anaesthetic; for example general, spinal or epidural anaesthetic or nerve block with local anaesthetic.

The following are excluded from this description:

a. Obstetric delivery room containing a delivery bed
b. Dental treatment room or surgery containing a dental chair
c. X-Ray room, whether diagnostic or therapeutic
d. Room only used to carry out endoscopy

OPERATING THEATRES are staffed and available for only certain fixed periods of time. These can be divided into:

a. Operating Theatre Sessions
b. Time for which the OPERATING THEATRE is staffed and equipped to cope with emergency theatre cases
c. Time for maintenance and cleaning

~~It is not required to record details of operating theatres used under contractual arrangements, although details of the resulting operative procedures will be recorded.~~ ~~OPERATIVE PROCEDURES~~ ~~do not always take place in OPERATING THEATRES~~ ~~and some may be performed on a WARD~~ ~~or in an Accident and Emergency Department.~~It is not required to record details of OPERATING THEATRES used under contractual arrangements, although details of the resulting operative procedures will be recorded using the appropriate CODED CLINICAL ENTRIES.

OPERATIVE PROCEDURE (RETIRED) renamed from OPERATIVE PROCEDURE

Change to Class: Changed Name, Description, Supertype, status to Retired

~~A subtype of CLINICAL CLASSIFICATION.~~**This item has been retired from the NHS Data Model and Dictionary.**

~~A unique code identifying an operation which can be performed on a PATIENT. The coding structure is provided by the Office for National Statistics and defined in the OPCS Classification of Interventions and Procedures, 4th Revision.~~**The last live version of this item is available in the December 2014 release of the NHS Data Model and Dictionary.**

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

OPERATIVE PROCEDURE (RETIRED) renamed from OPERATIVE PROCEDURE

Change to Class: Changed Name, Description, Supertype, status to Retired

- Changed Name from Data_Dictionary.Classes.O.OPERATIVE_PROCEDURE to Retired.Data_Dictionary.Classes.O.OPERATIVE_PROCEDURE
- Changed Description
- Changed Supertype from Data_Dictionary.Classes.C.CLINICAL_CLASSIFICATION to null
- Retired OPERATIVE PROCEDURE

PATIENT DIAGNOSIS

Change to Class: Changed Description

A subtype of PERSON PROPERTY.

Diagnostic observations recorded about a PATIENT.

Note:

- A PATIENT DIAGNOSIS should be classified, where possible, using International Classification of Diseases (ICD) or other classification codes approved centrally for mapping to International Classification of Diseases (ICD) codes.
- Read Coded Clinical Terms or Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT) can be used in addition to International Classification of Diseases (ICD) codes for PATIENT DIAGNOSIS. However Read Coded Clinical Terms are not accepted for the purposes of central Hospital Episode Statistics data, where International Classification of Diseases (ICD) is mandatory.

PERSON PROPERTY QUALIFIER

Change to Class: Changed Attributes

Attributes of this Class are:

ANATOMICAL AREA
ANATOMICAL SIDE
ANATOMICAL SIDE FOR IMAGING
~~ANATOMICAL SITE~~
HANDEDNESS CODE
HYDRONEPHROSIS CODE
PRIMARY EXTRANODAL SITE
RADIOTHERAPY TREATMENT REGION

ACCIDENT AND EMERGENCY DIAGNOSIS

Change to Attribute: Changed Description

~~A broad coding of types of diagnoses which may be made as a result of Accident and Emergency Attendances.~~

~~*Classification:*~~A broad coding of types of diagnoses which may be made as a result of Accident and Emergency Attendances.

~~a. Laceration~~
~~b. Contusion/abrasion~~
~~i. contusion~~
~~ii. abrasion~~
~~c. Soft tissue inflammation~~

d. Head injury
    i. concussion
    ii. other head injury
e. Dislocation/ fracture/ joint injury/ amputation
    i. dislocation
    ii. open fracture
    iii. closed fracture
    iv. joint injury
    v. amputation
f. Sprain/ ligament injury
g. Muscle/ tendon injury
h. Nerve injury
i. Vascular injury
j. Burns and scalds
    i. electric
    ii. thermal
    iii. chemical
    iv. radiation
k. Electric shock
l. Foreign body
m. Bites/ stings
n. Poisoning (including overdose)
    i. prescriptive drug
    ii. proprietary drug
    iii. controlled drug
    iv. other, including alcohol
o. Near drowning
p. Visceral injury
q. Infectious disease
    i. notifiable disease
    ii. non-notifiable disease
r. Local infection
s. Septicaemia
t. Cardiac conditions
    i. myocardial ischaemia and infarction
    ii. other non-ischaemia
u. Cerebro-vascular conditions
v. Other vascular conditions
w. Haematological conditions
x. CNS conditions (excluding strokes)
    i. epilepsy
    ii. other non-epilepsy
y. Respiratory conditions
    i. bronchial asthma
    ii. other non-asthma
z. Gastrointestinal conditions
    i. haemorrhage
    ii. acute abdominal pain
    iii. other
aa. Urological conditions (including cystitis)
ab. Obstetric conditions
ac. Gynaecological conditions
ad. Diabetes and other endocrinological conditions
    i. diabetic
    ii. other non-diabetic
ae. Dermatological conditions
af. Allergy (including anaphylaxis)
ag. Facio-maxillary conditions

~~ah. ENT conditions~~
~~ai. Psychiatric conditions~~
~~aj. Ophthalmological conditions~~
~~ak. Social problem (includes chronic alcoholism and homelessness)~~
~~al. Diagnosis not classifiable~~
~~am. Nothing abnormal detected~~

~~Accident and Emergency Diagnosis Tables~~For further information, see the Accident and Emergency Diagnosis Tables.

ACCIDENT AND EMERGENCY INVESTIGATION

Change to Attribute: Changed Description

A broad coding of types of investigation which may be requested to assist with diagnosis as a result of Accident and Emergency Attendances.

~~See Accident and Emergency Investigation Table~~For further information, see the Accident and Emergency Investigation Table.

ACCIDENT AND EMERGENCY TREATMENT

Change to Attribute: Changed Description

A broad coding of types of treatment or guidance which may be provided to a PATIENT as a result of Accident and Emergency Attendances.

~~See Accident and Emergency Treatment Tables~~For further information, see the Accident and Emergency Treatment Tables.

CLINICAL CLASSIFICATION CODE

Change to Attribute: Changed Description

~~A unique identifier for a CLINICAL CLASSIFICATION, for example this could be an OPCS-4 code, Read code, SNOMED CT® concept, or defined in the National Interim Clinical Imaging Procedure Code Set.~~A unique clinical classification identifier for a CODED CLINICAL ENTRY.

~~This could also be a PATIENT DIAGNOSIS.~~This could be OPCS Classification of Interventions and Procedures (OPCS-4) codes or International Classification of Diseases (ICD) codes.

~~See Clinical Coding for further information about CLINICAL CLASSIFICATIONS.~~See Clinical Coding for further information about the types of CODED CLINICAL ENTRIES.

~~Notes:~~

- ~~Diagnoses should be classified where possible using ICD 10 or other classification codes approved centrally for mapping to ICD 10 codes. Clinical Terms (The Read Codes) can be used in addition to ICD 10 codes for PATIENT DIAGNOSIS. However Clinical Terms (The Read Codes) are not accepted for the purposes of central Hospital Episode Statistics data, where ICD 10 is mandatory.~~
- ~~ICD 10 diagnostic codes are at least four characters in length. The first character is always alphabetic. Where an undivided three character code is used, the fourth character must be filled with 'X'.~~

- ~~Fifth characters should be used in accordance with the guidance in International Classification of Diseases (ICD). Where they are not used the character must be filled with a ' '. The sixth character of the code is used to designate an asterisk or dagger indicator in ICD-10; it may be an 'A' or 'D'.~~

CLINICAL TERMINOLOGY CODE

Change to Attribute: New Attribute

A unique clinical terminology identifier for a CODED CLINICAL ENTRY.

This could be Read Coded Clinical Terms, Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT) concepts or defined in the National Interim Clinical Imaging Procedure Code Set.

See Clinical Coding for further information about the types of CODED CLINICAL ENTRIES.

Note: SNOMED CT is the current fundamental standard for clinical terminology for use within the NHS; it is planned that in time this will be the only terminology used by the NHS. For further information, see the Information Standards Board for Health and Social Care website at: ISB 0034 Amd 26/2006.

This attribute is also known by these names:

Context	Alias
plural	CLINICAL TERMINOLOGY CODES

CLINICAL TERMINOLOGY CODE

Change to Attribute: New Attribute

CLINICAL TERMINOLOGY CODE

Data Elements:

CHLAMYDIA TEST RESULT (SNOMED CT)
DIAGNOSIS (SNOMED CT ON ADMISSION TO NEONATAL CRITICAL CARE)
DIAGNOSIS (SNOMED CT ON NEONATAL CRITICAL CARE DAILY CARE DATE)
DIAGNOSIS (SNOMED CT RECORDED ON DISCHARGE FROM NEONATAL CRITICAL CARE)
DIAGNOSTIC CODING (DIABETES RELEVANT READ CODES)
DM+D CODE
FORMULA MILK OR MILK FORTIFIER TYPE (SNOMED CT DM+D)
IMAGING CODE (NICIP)
IMAGING CODE (SNOMED-CT)
MEDICATION GIVEN DURING LABOUR (SNOMED CT DM+D)
MEDICATION GIVEN DURING NEONATAL CRITICAL CARE DAILY CARE DATE (SNOMED CT DM+D)
MORPHOLOGY (SNOMED)
MORPHOLOGY (SNOMED CT)
NEONATAL RESUSCITATION DRUG (SNOMED CT DM+D)
NICIP CODE
OCCUPATION MOTHER (SNOMED CT)
PERITONITIS ORGANISM 1 (READ)
PERITONITIS ORGANISM 2 (READ)
PRIMARY DIAGNOSIS (READ)
PRIMARY PROCEDURE (READ)

PRIMARY PROCEDURE (SNOMED CT)
PROCEDURE (READ)
PROCEDURE (SNOMED CT)
PROCEDURE (SNOMED CT ON NEONATAL CRITICAL CARE DAILY CARE DATE)
PROCEDURE (SNOMED CT RECORDED ON DISCHARGE FROM NEONATAL CRITICAL CARE)
PROCEDURE CODING (DIABETES RELEVANT READ CODES)
READ CODE
SAMPLE ANTIBIOTIC SENSITIVITY RESULT (SNOMED CT DM+D)
SAMPLE TEST RESULT ORGANISM TYPE (SNOMED CT)
SECONDARY DIAGNOSIS (READ)
SNOMED CT CODE
SPECIMEN TYPE (CHLAMYDIA TESTING SNOMED CT)
STEROID TYPE GIVEN TO MOTHER (SNOMED CT DM+D)
TOPOGRAPHY (SNOMED)
TOPOGRAPHY (SNOMED CT)

DEATH CAUSE ICD CODE (RETIRED) renamed from DEATH CAUSE ICD CODE

Change to Attribute: Changed Name, Description, status to Retired

~~A code indicating a cause of death, classified using ICD.~~**This item has been retired from the NHS Data Model and Dictionary.**

The last live version of this item is available in the December 2014 release of the NHS Data Model and Dictionary.

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

DEATH CAUSE ICD CODE (RETIRED) renamed from DEATH CAUSE ICD CODE

Change to Attribute: Changed Name, Description, status to Retired

- Changed Name from Data_Dictionary.Attributes.D.DEATH_CAUSE_ICD_CODE to Retired.Data_Dictionary.Attributes.D.DEATH_CAUSE_ICD_CODE
- Changed Description
- Retired DEATH CAUSE ICD CODE

EUROPEAN RENAL ASSOCIATION CODE

Change to Attribute: New Attribute

A European Renal Association (European Dialysis and Transplant Association) code.

This attribute is also known by these names:

Context	Alias
plural	EUROPEAN RENAL ASSOCIATION CODES

EUROPEAN RENAL ASSOCIATION CODE

Change to Attribute: New Attribute

EUROPEAN RENAL ASSOCIATION CODE

Data Elements:

PRIMARY RENAL DISEASE DIAGNOSIS
SECONDARY CAUSE OF END STAGE RENAL FAILURE

INTERNATIONAL FEDERATION OF GYNECOLOGY AND OBSTETRICS STAGE

Change to Attribute: New Attribute

An International Federation of Gynecology and Obstetrics (FIGO) stage.

This attribute is also known by these names:

Context	Alias
plural	INTERNATIONAL FEDERATION OF GYNECOLOGY AND OBSTETRICS STAGES

INTERNATIONAL FEDERATION OF GYNECOLOGY AND OBSTETRICS STAGE

Change to Attribute: New Attribute

INTERNATIONAL FEDERATION OF GYNECOLOGY AND OBSTETRICS STAGE

Data Elements:

FINAL FIGO STAGE

PATIENT PROCEDURE CODING SIGNIFICANCE (RETIRED) renamed from PATIENT PROCEDURE CODING SIGNIFICANCE

Change to Attribute: Changed Name, Description, status to Retired

~~A classification of each Patient Procedure within each Consultant Episode (Hospital Provider) or Out Patient Attendance Consultant.~~**This item has been retired from the NHS Data Model and Dictionary.**

~~*Classification:*~~**The last live version of this item is available in the December 2014 release of the NHS Data Model and Dictionary.**

- ~~a. Primary~~
- ~~b. First secondary~~
- ~~c. Second secondary~~
- ~~d. Third secondary~~
- ~~e. Other~~

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

PATIENT PROCEDURE CODING SIGNIFICANCE (RETIRED) renamed from PATIENT PROCEDURE CODING SIGNIFICANCE

Change to Attribute: Changed Name, Description, status to Retired

- Changed Name from Data_Dictionary.Attributes.P.Pati.PATIENT_PROCEDURE_CODING_SIGNIFICANCE to Retired.Data_Dictionary.Attributes.P.PATIENT_PROCEDURE_CODING_SIGNIFICANCE
- Changed Description
- Retired PATIENT PROCEDURE CODING SIGNIFICANCE

UNION FOR INTERNATIONAL CANCER CONTROL CODE

Change to Attribute: New Attribute

The Union for International Cancer Control (UICC) code used during a Cancer Care Spell.

This attribute is also known by these names:

Context	Alias
plural	UNION FOR INTERNATIONAL CANCER CONTROL CODES

UNION FOR INTERNATIONAL CANCER CONTROL CODE

Change to Attribute: New Attribute

UNION FOR INTERNATIONAL CANCER CONTROL CODE

Data Elements:

M CATEGORY (FINAL PRETREATMENT)
M CATEGORY (INTEGRATED STAGE)
M CATEGORY (PATHOLOGICAL)
N CATEGORY (FINAL PRETREATMENT)
N CATEGORY (INTEGRATED STAGE)
N CATEGORY (PATHOLOGICAL)
T CATEGORY (FINAL PRETREATMENT)
T CATEGORY (INTEGRATED STAGE)
T CATEGORY (PATHOLOGICAL)
TNM STAGE GROUPING (FINAL PRETREATMENT)
TNM STAGE GROUPING (INTEGRATED)
TNM STAGE GROUPING (PATHOLOGICAL)

ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST

Change to Data Element: Changed Description

Format/Length:	an6
HES Item:	
~~National Codes:~~	
National Codes:	See Accident and Emergency Diagnosis Tables
Default Codes:	

Notes:

~~ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST is the first recorded ACCIDENT AND EMERGENCY DIAGNOSIS of PATIENT DIAGNOSIS for an Accident and Emergency Attendance. This is required for recording within an Accident and Emergency Attendance Commissioning Data Set.~~ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST is the same as attribute ACCIDENT AND EMERGENCY DIAGNOSIS.

~~See Accident and Emergency Diagnosis Tables for clinical coding and classification structure.~~ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST is the first recorded PATIENT DIAGNOSIS for an Accident and Emergency Attendance.

~~For Commissioning Data Set and XML schema version 6 onwards, ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST will be recognised as Primary Diagnosis (Accident and Emergency)~~ACCIDENT AND EMERGENCY

DIAGNOSIS - FIRST is required for recording within an Accident and Emergency Attendance Commissioning Data Set.

For Commissioning Data Set and XML schema version 6 onwards, ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST will be recognised as Primary Diagnosis (Accident and Emergency).

ACCIDENT AND EMERGENCY DIAGNOSIS - SECOND

Change to Data Element: Changed Description

Format/Length:	an6
HES Item:	
~~National Codes:~~	
National Codes:	See Accident and Emergency Diagnosis Tables
Default Codes:	

Notes:
~~ACCIDENT AND EMERGENCY DIAGNOSIS – SECOND is the second or subsequent recorded ACCIDENT AND EMERGENCY DIAGNOSIS of PATIENT DIAGNOSIS for an Accident and Emergency Attendance. This is required for recording within an Accident and Emergency Attendance Commissioning Data Set.~~ACCIDENT AND EMERGENCY DIAGNOSIS - SECOND is the same as attribute ACCIDENT AND EMERGENCY DIAGNOSIS.

~~See Accident and Emergency Diagnosis Tables for clinical coding and classification structure.~~ACCIDENT AND EMERGENCY DIAGNOSIS - SECOND is the second or subsequent recorded PATIENT DIAGNOSIS for an Accident and Emergency Attendance.

ACCIDENT AND EMERGENCY DIAGNOSIS - SECOND is required for recording within an Accident and Emergency Attendance Commissioning Data Set.

For Commissioning Data Set and XML Schema version 6 onwards, ACCIDENT AND EMERGENCY DIAGNOSIS - SECOND will be recognised as Secondary Diagnosis (Accident and Emergency).

For Commissioning Data Set version 6 onwards, there are no restrictions on the number of Secondary Diagnoses (Accident and Emergency) recorded.

ACCIDENT AND EMERGENCY INVESTIGATION - FIRST

Change to Data Element: Changed Description

Format/Length:	an6
HES Item:	
~~National Codes:~~	
National Codes:	See Accident and Emergency Investigation Table
Default Codes:	

Notes:
~~ACCIDENT AND EMERGENCY INVESTIGATION – FIRST is the first recorded ACCIDENT AND EMERGENCY INVESTIGATION of a CLINICAL INTERVENTION for an Accident and Emergency Attendance. This is required for recording within an Accident and Emergency Attendance Commissioning Data Set.~~ACCIDENT AND EMERGENCY INVESTIGATION - FIRST is the same as attribute ACCIDENT AND EMERGENCY INVESTIGATION.

~~See Accident and Emergency Investigation Table for clinical coding and classification structure.~~ACCIDENT AND EMERGENCY INVESTIGATION - FIRST is the first recorded CLINICAL INTERVENTION for an Accident and Emergency Attendance.

ACCIDENT AND EMERGENCY INVESTIGATION - FIRST is required for recording within an Accident and Emergency Attendance Commissioning Data Set.

For Commissioning Data Set and XML Schema version 6 onwards, ACCIDENT AND EMERGENCY INVESTIGATION - FIRST will be recognised as Primary Investigation (Accident and Emergency).

ACCIDENT AND EMERGENCY INVESTIGATION - SECOND

Change to Data Element: Changed Description

Format/Length:	an6
HES Item:	
~~National Codes:~~	
National Codes:	See Accident and Emergency Investigation Table
Default Codes:	

Notes:

~~ACCIDENT AND EMERGENCY INVESTIGATION - SECOND is the second or subsequent recorded ACCIDENT AND EMERGENCY INVESTIGATION of a CLINICAL INTERVENTION for an Accident and Emergency Attendance. This is required for recording within an Accident and Emergency Attendance Commissioning Data Set.~~ACCIDENT AND EMERGENCY INVESTIGATION - SECOND is the same as attribute ACCIDENT AND EMERGENCY INVESTIGATION.

~~See Accident and Emergency Investigation Table for clinical coding and classification structure.~~

ACCIDENT AND EMERGENCY INVESTIGATION - SECOND is the second or subsequent CLINICAL INTERVENTION for an Accident and Emergency Attendance.

ACCIDENT AND EMERGENCY INVESTIGATION - SECOND is required for recording within an Accident and Emergency Attendance Commissioning Data Set.

For Commissioning Data Set and Schema version 6 onwards, ACCIDENT AND EMERGENCY INVESTIGATION - SECOND will be recognised as Secondary Investigation (Accident and Emergency).

For Commissioning Data Set version 6 onwards there are no restrictions on the number of Secondary Investigations (Accident and Emergency) recorded.

ACCIDENT AND EMERGENCY TREATMENT - FIRST

Change to Data Element: Changed Description

Format/Length:	an6
HES Item:	
~~National Codes:~~	
National Codes:	See Accident and Emergency Treatment Tables
Default Codes:	

Notes:

~~ACCIDENT AND EMERGENCY TREATMENT - FIRST is the first recorded ACCIDENT AND EMERGENCY TREATMENT of a CLINICAL INTERVENTION for an Accident and Emergency Attendance. This is required for recording within~~

~~an Accident and Emergency Attendance Commissioning Data Set.~~ACCIDENT AND EMERGENCY TREATMENT - FIRST is the same as attribute ACCIDENT AND EMERGENCY TREATMENT.

~~See Accident and Emergency Treatment Tables for clinical coding and classification structure.~~ACCIDENT AND EMERGENCY TREATMENT - FIRST is the first recorded CLINICAL INTERVENTION for an Accident and Emergency Attendance.

ACCIDENT AND EMERGENCY TREATMENT - FIRST is required for recording within an Accident and Emergency Attendance Commissioning Data Set.

For Commissioning Data Set and XML Schema version 6 onwards, ACCIDENT AND EMERGENCY TREATMENT - FIRST will be recognised as Primary Treatment (Accident and Emergency).

ACCIDENT AND EMERGENCY TREATMENT - SECOND

Change to Data Element: Changed Description

Format/Length:	an6
HES Item:	
~~National Codes:~~	
National Codes:	See Accident and Emergency Treatment Tables
Default Codes:	

Notes:
~~ACCIDENT AND EMERGENCY TREATMENT - SECOND is the second or subsequent recorded ACCIDENT AND EMERGENCY TREATMENT of a CLINICAL INTERVENTION for an Accident and Emergency Attendance. This is required for recording within an Accident and Emergency Attendance Commissioning Data Set.~~ACCIDENT AND EMERGENCY TREATMENT - SECOND is the same as attribute ACCIDENT AND EMERGENCY TREATMENT.

~~See Accident and Emergency Treatment Tables for clinical coding and classification structure.~~ACCIDENT AND EMERGENCY TREATMENT - SECOND is the second or subsequent recorded CLINICAL INTERVENTION for an Accident and Emergency Attendance.

ACCIDENT AND EMERGENCY TREATMENT - SECOND is required for recording within an Accident and Emergency Attendance Commissioning Data Set.

For Commissioning Data Set and XML Schema version 6 onwards, ACCIDENT AND EMERGENCY TREATMENT - SECOND will be recognised as Secondary Treatment (Accident and Emergency).

For Commissioning Data Set version 6 onwards there are no restrictions on the number of Secondary Treatment (Accident and Emergency) recorded.

CHLAMYDIA TEST RESULT (SNOMED CT)

Change to Data Element: Changed Description, linked Attribute

Format/Length:	min n6 max n18
HES Item:	
National Codes:	
Default Codes:	

Notes:

~~CHLAMYDIA TEST RESULT (SNOMED CT) is the same as attribute CLINICAL CLASSIFICATION CODE.~~CHLAMYDIA TEST RESULT (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

CHLAMYDIA TEST RESULT (SNOMED CT) is the SNOMED CT concept ID which is used to identify the result of the Chlamydia test.

The SNOMED CT Subset:

- original ID is 58851000000137
- name is 'Chlamydia test result findings'.

CHLAMYDIA TEST RESULT (SNOMED CT)

Change to Data Element: Changed Description, linked Attribute

CHLAMYDIA TEST RESULT (SNOMED CT)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
CLINICAL TERMINOLOGY CODE

CLINICAL CLASSIFICATION SEQUENCE NUMBER (RETIRED) renamed from CLINICAL CLASSIFICATION SEQUENCE NUMBER

Change to Data Element: Changed Name, Description, status to Retired

~~Format/Length:~~	~~max n3~~
~~HES Item:~~	
~~National Codes:~~	
~~Default Codes:~~	

~~**Notes:**~~
~~CLINICAL CLASSIFICATION SEQUENCE NUMBER is used in the Commissioning Data Sets (version 6-2 onwards) to provide a sequence number for CLINICAL CLASSIFICATION CODES, to facilitate the correct processing of the codes within the Secondary Uses Service.~~

~~CLINICAL CLASSIFICATION SEQUENCE NUMBERS are applied to all secondary diagnoses (A&E, ICD and READ), procedures (OPCS and READ), and investigations and treatments (A&E).~~**This item has been retired from the NHS Data Model and Dictionary.**

~~The Secondary Uses Service will process the secondary CLINICAL CLASSIFICATION CODES in the order specified by the CLINICAL CLASSIFICATION SEQUENCE NUMBER through the Payment Grouper, therefore the eventual Healthcare Resource Group output will be determined by the order specified in the Commissioning Data Set submission.~~**The last live version of this item is available in the December 2014 release of the NHS Data Model and Dictionary.**

~~The CLINICAL CLASSIFICATION SEQUENCE NUMBER is an attribute of the applicable secondary procedure/diagnosis/investigation/treatment data groups in the CDS-XML schema (version 6-2 onwards), rather than a data element in its own right (each repeat of the secondary data group increments the attribute by 1). It must NOT be submitted as an individual data element.~~**Access to this version can be obtained by emailing information.standards@hscic.gov.uk with "NHS Data Model and Dictionary - Archive Request" in the email subject line.**

CLINICAL CLASSIFICATION SEQUENCE NUMBER (RETIRED) renamed from CLINICAL CLASSIFICATION SEQUENCE NUMBER

Change to Data Element: Changed Name, Description, status to Retired

- Changed Name from Data_Dictionary.Data_Field_Notes.C.Cl.CLINICAL_CLASSIFICATION_SEQUENCE_NUMBER to Retired.Data_Dictionary.Data_Field_Notes.C.CLINICAL_CLASSIFICATION_SEQUENCE_NUMBER
- Changed Description
- Retired CLINICAL CLASSIFICATION SEQUENCE NUMBER

DEATH CAUSE ICD CODE (CONDITION)

Change to Data Element: Changed Description, linked Attribute

~~Format/Length:~~	~~See DIAGNOSTIC CODING~~
Format/Length:	min an4 max an6
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~DEATH CAUSE ICD CODE (CONDITION) is the same as attribute DEATH CAUSE ICD CODE.~~DEATH CAUSE ICD CODE (CONDITION) is the same as attribute CLINICAL CLASSIFICATION CODE.

~~DEATH CAUSE ICD CODE (CONDITION) is the ICD code of the condition giving rise to death as recorded on the death certificate.~~DEATH CAUSE ICD CODE (CONDITION) is the International Classification of Diseases (ICD) code of the condition giving rise to death as recorded on the death certificate.

For the HIV and AIDS Reporting Data Set, if the PATIENT has not died, the field should be omitted.

DEATH CAUSE ICD CODE (CONDITION)

Change to Data Element: Changed Description, linked Attribute

DEATH CAUSE ICD CODE (CONDITION)

Attribute:

~~DEATH CAUSE ICD CODE~~
CLINICAL CLASSIFICATION CODE

DEATH CAUSE ICD CODE (DURING NEONATAL CRITICAL CARE PERIOD)

Change to Data Element: Changed Description, linked Attribute

~~Format/Length:~~	~~See DIAGNOSTIC CODING~~
Format/Length:	min an4 max an6
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~DEATH CAUSE ICD CODE (DURING NEONATAL CRITICAL CARE PERIOD) is the same as attribute DEATH CAUSE ICD CODE.~~DEATH CAUSE ICD CODE (DURING NEONATAL CRITICAL CARE PERIOD) is the same as attribute CLINICAL CLASSIFICATION CODE.

~~DEATH CAUSE ICD CODE (DURING NEONATAL CRITICAL CARE PERIOD) is the ICD code describing the reason for the death of a baby during a Neonatal CRITICAL CARE PERIOD.~~DEATH CAUSE ICD CODE (DURING NEONATAL CRITICAL CARE PERIOD) is the International Classification of Diseases (ICD) code describing the reason for the death of a baby during a Neonatal CRITICAL CARE PERIOD.

DEATH CAUSE ICD CODE (DURING NEONATAL CRITICAL CARE PERIOD)

Change to Data Element: Changed Description, linked Attribute

DEATH CAUSE ICD CODE (DURING NEONATAL CRITICAL CARE PERIOD)

Attribute:

~~DEATH CAUSE ICD CODE~~
CLINICAL CLASSIFICATION CODE

DEATH CAUSE ICD CODE (IMMEDIATE)

Change to Data Element: Changed Description, linked Attribute

~~Format/Length:~~	~~See DIAGNOSTIC CODING~~
Format/Length:	min an4 max an6
HES Item:	
National Codes:	
Default Codes:	

Notes:

~~DEATH CAUSE ICD CODE (IMMEDIATE) is the same as attribute DEATH CAUSE ICD CODE.~~DEATH CAUSE ICD CODE (IMMEDIATE) is the same as attribute CLINICAL CLASSIFICATION CODE.

~~DEATH CAUSE ICD CODE (IMMEDIATE) is the ICD code of the immediate cause of death as recorded on the death certificate.~~DEATH CAUSE ICD CODE (IMMEDIATE) is the International Classification of Diseases (ICD) code of the immediate cause of death as recorded on the death certificate.

DEATH CAUSE ICD CODE (IMMEDIATE)

Change to Data Element: Changed Description, linked Attribute

DEATH CAUSE ICD CODE (IMMEDIATE)

Attribute:

~~DEATH CAUSE ICD CODE~~
CLINICAL CLASSIFICATION CODE

DEATH CAUSE ICD CODE (SIGNIFICANT)

Change to Data Element: Changed Description, linked Attribute

~~Format/Length:~~	~~See DIAGNOSTIC CODING~~
Format/Length:	min an4 max an6
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~DEATH CAUSE ICD CODE (SIGNIFICANT) is the same as attribute DEATH CAUSE ICD CODE.~~DEATH CAUSE ICD CODE (SIGNIFICANT) is the same as attribute CLINICAL CLASSIFICATION CODE.

~~DEATH CAUSE ICD CODE (SIGNIFICANT) is the ICD code of a significant condition not directly related to death as recorded on the death certificate.~~DEATH CAUSE ICD CODE (SIGNIFICANT) is the International Classification of Diseases (ICD) code of a significant condition not directly related to death as recorded on the death certificate.

DEATH CAUSE ICD CODE (SIGNIFICANT)

Change to Data Element: Changed Description, linked Attribute

DEATH CAUSE ICD CODE (SIGNIFICANT)

Attribute:

~~DEATH CAUSE ICD CODE~~
CLINICAL CLASSIFICATION CODE

DEATH CAUSE ICD CODE (UNDERLYING)

Change to Data Element: Changed Description, linked Attribute

~~Format/Length:~~	~~See DIAGNOSTIC CODING~~
Format/Length:	min an4 max an6
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~DEATH CAUSE ICD CODE (UNDERLYING) is the same as attribute DEATH CAUSE ICD CODE.~~DEATH CAUSE ICD CODE (UNDERLYING) is the same as attribute CLINICAL CLASSIFICATION CODE.

~~DEATH CAUSE ICD CODE (UNDERLYING) is the ICD code of the underlying condition leading to death as recorded on the death certificate.~~DEATH CAUSE ICD CODE (UNDERLYING) is the International Classification of Diseases (ICD) code of the underlying condition leading to death as recorded on the death certificate.

DEATH CAUSE ICD CODE (UNDERLYING)

Change to Data Element: Changed Description, linked Attribute

DEATH CAUSE ICD CODE (UNDERLYING)

Attribute:

~~DEATH CAUSE ICD CODE~~
CLINICAL CLASSIFICATION CODE

DIAGNOSIS (ICD NEUROLOGICAL)

Change to Data Element: Changed Description

~~Format/Length:~~	~~an6~~
Format/Length:	See ICD-10 CODE

HES Item:
National Codes:
Default Codes:

Notes:
DIAGNOSIS (ICD NEUROLOGICAL) is the same as attribute CLINICAL CLASSIFICATION CODE.

DIAGNOSIS (ICD NEUROLOGICAL) is the ICD code describing a PATIENT DIAGNOSIS relating to a *Neurological Condition.*

For the National Neonatal Data Set - Two Year Neonatal Outcomes Assessment, DIAGNOSIS (ICD NEUROLOGICAL) may be recorded for the TPRG-SEND Two Year Corrected Age Outcome Assessment when *'Yes'* is recorded for any question (A-H) in the 'Neuromotor' section, or for question B in the 'Malformations' section.

DIAGNOSIS (ICD ON ADMISSION TO NEONATAL CRITICAL CARE)

Change to Data Element: Changed Description

~~Format/Length:~~	~~an6~~
Format/Length:	See ICD-10 CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:
DIAGNOSIS (ICD ON ADMISSION TO NEONATAL CRITICAL CARE) is the same as attribute CLINICAL CLASSIFICATION CODE.

DIAGNOSIS (ICD ON ADMISSION TO NEONATAL CRITICAL CARE) is the ICD code describing a PATIENT DIAGNOSIS for the baby on admission to neonatal critical care.

DIAGNOSIS (ICD ON NEONATAL CRITICAL CARE DAILY CARE DATE)

Change to Data Element: Changed Description

~~Format/Length:~~	~~an6~~
Format/Length:	See ICD-10 CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:
DIAGNOSIS (ICD ON NEONATAL CRITICAL CARE DAILY CARE DATE) is the same as attribute CLINICAL CLASSIFICATION CODE.

DIAGNOSIS (ICD ON NEONATAL CRITICAL CARE DAILY CARE DATE) is the ICD code describing a PATIENT DIAGNOSIS made on a Neonatal Critical Care Daily Care Date during a Neonatal CRITICAL CARE PERIOD.

DIAGNOSIS (ICD RECORDED ON DISCHARGE FROM NEONATAL CRITICAL CARE)

Change to Data Element: Changed Description

~~Format/Length:~~	~~an6~~
Format/Length:	See ICD-10 CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:
DIAGNOSIS (ICD RECORDED ON DISCHARGE FROM NEONATAL CRITICAL CARE) is the same as attribute CLINICAL CLASSIFICATION CODE.

DIAGNOSIS (ICD RECORDED ON DISCHARGE FROM NEONATAL CRITICAL CARE) is the ICD code describing a PATIENT DIAGNOSIS recorded when the PATIENT is discharged from neonatal critical care.

DIAGNOSIS (ICD RECORDED ON DISCHARGE FROM NEONATAL CRITICAL CARE) should include any PATIENT DIAGNOSES which were not recorded as expected on the applicable Neonatal Critical Care Daily Care Date during a Neonatal CRITICAL CARE PERIOD.

DIAGNOSIS (SNOMED CT ON ADMISSION TO NEONATAL CRITICAL CARE)

Change to Data Element: Changed Description, linked Attribute

~~Format/Length:~~	~~max n18~~
Format/Length:	See SNOMED CT CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~DIAGNOSIS (SNOMED CT ON ADMISSION TO NEONATAL CRITICAL CARE) is the same as attribute CLINICAL CLASSIFICATION CODE.~~DIAGNOSIS (SNOMED CT ON ADMISSION TO NEONATAL CRITICAL CARE) is the same as attribute CLINICAL TERMINOLOGY CODE.

DIAGNOSIS (SNOMED CT ON ADMISSION TO NEONATAL CRITICAL CARE) is the SNOMED CT concept ID describing a PATIENT DIAGNOSIS for the baby on admission to neonatal critical care.

DIAGNOSIS (SNOMED CT ON ADMISSION TO NEONATAL CRITICAL CARE)

Change to Data Element: Changed Description, linked Attribute

DIAGNOSIS (SNOMED CT ON ADMISSION TO NEONATAL CRITICAL CARE)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
CLINICAL TERMINOLOGY CODE

DIAGNOSIS (SNOMED CT ON NEONATAL CRITICAL CARE DAILY CARE DATE)

Change to Data Element: Changed Description, linked Attribute

~~Format/Length:~~	~~max n18~~
Format/Length:	See SNOMED CT CODE
HES Item:	
National Codes:	

Default Codes:

Notes:
~~DIAGNOSIS (SNOMED CT ON NEONATAL CRITICAL CARE DAILY CARE DATE) is the same as attribute CLINICAL CLASSIFICATION CODE.~~DIAGNOSIS (SNOMED CT ON NEONATAL CRITICAL CARE DAILY CARE DATE) is the same as attribute CLINICAL TERMINOLOGY CODE.

DIAGNOSIS (SNOMED CT ON NEONATAL CRITICAL CARE DAILY CARE DATE) is the SNOMED CT concept ID describing a PATIENT DIAGNOSIS made on a Neonatal Critical Care Daily Care Date during a Neonatal CRITICAL CARE PERIOD.

DIAGNOSIS (SNOMED CT ON NEONATAL CRITICAL CARE DAILY CARE DATE)

Change to Data Element: Changed Description, linked Attribute

DIAGNOSIS (SNOMED CT ON NEONATAL CRITICAL CARE DAILY CARE DATE)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
CLINICAL TERMINOLOGY CODE

DIAGNOSIS (SNOMED CT RECORDED ON DISCHARGE FROM NEONATAL CRITICAL CARE)

Change to Data Element: Changed Description, linked Attribute

~~Format/Length:~~	~~max n18~~
Format/Length:	See SNOMED CT CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~DIAGNOSIS (SNOMED CT ON NEONATAL CRITICAL CARE DAILY CARE DATE) is the same as attribute CLINICAL CLASSIFICATION CODE.~~DIAGNOSIS (SNOMED CT ON NEONATAL CRITICAL CARE DAILY CARE DATE) is the same as attribute CLINICAL TERMINOLOGY CODE.

DIAGNOSIS (SNOMED CT ON NEONATAL CRITICAL CARE DAILY CARE DATE) is the SNOMED CT concept ID describing a PATIENT DIAGNOSIS recorded when the PATIENT is discharged from neonatal critical care.

DIAGNOSIS (SNOMED CT RECORDED ON DISCHARGE FROM NEONATAL CRITICAL CARE) should include any PATIENT DIAGNOSES which were not recorded as expected on the applicable Neonatal Critical Care Daily Care Date during a Neonatal CRITICAL CARE PERIOD.

DIAGNOSIS (SNOMED CT RECORDED ON DISCHARGE FROM NEONATAL CRITICAL CARE)

Change to Data Element: Changed Description, linked Attribute

DIAGNOSIS (SNOMED CT RECORDED ON DISCHARGE FROM NEONATAL CRITICAL CARE)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~

CLINICAL TERMINOLOGY CODE

DIAGNOSTIC CODING (DIABETES RELEVANT ICD-10)

Change to Data Element: Changed Description

~~Format/Length:~~	~~See DIAGNOSTIC CODING~~
Format/Length:	an6
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~Records the DIAGNOSTIC CODING identified in the following relevant conditions and complications associated with the diabetic condition: The list shows those conditions and complications currently extracted by QUIDS using data linkage to Hospital Episode Statistics (HES).~~DIAGNOSTIC CODING (DIABETES RELEVANT ICD-10) is the International Classification of Diseases (ICD) code identified in the following relevant conditions and complications associated with the diabetic condition: The list shows those conditions and complications currently extracted by QUIDS using data linkage to Hospital Episode Statistics (HES).

~~ICD~~ ~~10Codes for relevant conditions and complications~~ICD-10 Codes for relevant conditions and complications

HYPERDKA (Hyperglycaemic emergencies)

E10.1	Insulin-dependent diabetes mellitus with ketoacidosis
E11.1	Non-insulin-dependent diabetes mellitus with ketoacidosis
E13.1	Other specified diabetes mellitus with ketoacidosis
E14.1	Unspecified diabetes mellitus with ketoacidosis
E10.0	Insulin-dependent diabetes mellitus with ketoacidosis and coma
E11.0	Non-insulin-dependent diabetes mellitus with ketoacidosis and coma
E13.0	Other specified diabetes mellitus with coma
E14.0	Unspecified diabetes mellitus with coma

ANGINA

I20.0	Unstable angina
I20.1	Angina pectoris with documented spasm
I20.8	Other forms of angina pectoris
I20.9	Angina pectoris

MI (Myocardial Infarction)

I21.0	Acute transmural myocardial infarction of anterior wall
I21.1	Acute transmural myocardial infarction of inferior wall
I21.2	Acute transmural myocardial infarction of other sites
I21.3	Acute transmural myocardial infarction of unspecified site
I21.4	Acute subendocardial myocardial infarction
I21.9	Acute myocardial infarction
I22.0	Subsequent myocardial infarction of anterior wall
I22.1	Subsequent myocardial infarction of inferior wall
I22.8	Subsequent myocardial infarction of other sites
I22.9	Subsequent myocardial infarction of unspecified site

CF (Cardiac Failure)

I50.0	Congestive heart failure.
I50.1	Left ventricular failure.
I50.9	Heart failure unspecified.

CVA (Stroke / Cerebro-Vascular Accident)

I61.0	Intracerebral haemorrhage in hemisphere, subcortical

I61.1	Intracerebral haemorrhage in hemisphere, cortical
I61.2	Intracerebral haemorrhage in hemisphere, unspecified
I61.3	Intracerebral haemorrhage in brain stem
I61.4	Intracerebral haemorrhage in cerebellum
I61.5	Intracerebral haemorrhage, intraventricular
I61.6	Intracerebral haemorrhage, multiple localised
I61.8	Other intracerebral haemorrhage
I61.9	Intracerebral haemorrhage, unspecified
I63.0	Cerebral infarct due to thrombosis of precerebral arteries
I63.1	Cerebral infarction due to embolism of precerebral arteries
I63.2	Cerebral infarct due to unspecified occlusion or stenos of precerebral arteries
I63.3	Cerebral infarction due to thrombosis of cerebral arteries
I63.4	Cerebral infarction due to embolism of cerebral arteries
I63.5	Cerebral infarction due to unspecified occlusion or stenosis of cerebral arteries
I63.6	Cerebral infarction due to cerebral venous thrombosis
I63.8	Other cerebral infarction
I63.9	Cerebral infarction, unspecified
I64.X	Stroke, unspecified

RRT (End stage renal failure requiring renal replacement therapy)

N18.0	End-stage renal disease
Z99.2	Dependence on renal dialysis
Z49.0	Preparatory care for dialysis
Z49.1	Extracorporeal dialysis
Z49.2	Other dialysis

DIAGNOSTIC CODING (DIABETES RELEVANT READ CODES)

Change to Data Element: Changed Description, linked Attribute

~~Format/length:~~	~~an7 for The Read Codes~~
~~HES item:~~	
Format/Length:	an7
HES Item:	
National Codes:	
Default Codes:	

Notes:

~~Records the DIAGNOSTIC CODING identified in the following relevant conditions and complication associated with the diabetic condition:~~

DIAGNOSTIC CODING (DIABETES RELEVANT READ CODES) is the Read Coded Clinical Terms identified in the following relevant conditions and complication associated with the diabetic condition:

Read Codes (diagnosis)

DKA (Hyperglycaemic emergencies)

4Byte Version (retired 1 October 2009)

C2..	Diabetes mellitus (retired 1 October 2009) Ketoacidosis - diabetic (synonym) (retired 1 October 2009)
C24.	Diabetes mellitus + ketoacidosis - no coma (retired 1 October 2009)
C25.	Diabetes with coma (retired 1 October 2009)

Version 2

C101.	Diabetes mellitus with ketoacidosis
C1010	Diabetes mellitus, juvenile type, with ketoacidosis
C1011	Diabetes mellitus, adult onset, with ketoacidosis

C101y Other specified diabetes mellitus with ketoacidosis
C101z Diabetes mellitus NOS with ketoacidosis

ANGINA
4Byte Version (retired 1 October 2009)
G44. Angina pectoris (retired 1 October 2009)
G440 Unstable angina (retired 1 October 2009)
G444 Stable angina (retired 1 October 2009)
Version 2
G3111 Unstable angina
G33.. Angina pectoris
G33z. Angina pectoris NOS
G33z7 Stable angina

MI (Myocardial Infarction)
4Byte Version (retired 1 October 2009)
G6A. Heart failure (preferred term) (retired 1 October 2009)
Cardiac failure (synonym) (retired 1 October 2009)
G6A1 Congestive cardiac failure (retired 1 October 2009)
Version 2
G58.. Heart failure (preferred term)
Cardiac failure (synonym)
G580. Congestive cardiac failure

CVA (Stroke/Cerebro-Vascular Accident)
4Byte Version (retired 1 October 2009)
G7.. Cerebrovascular disease (retired 1 October 2009)
G712 Intracerebral haemorrhage (retired 1 October 2009)
G73. Cerebral arterial occlusion (retired 1 October 2009)
G75. Stroke/CVA undefined (retired 1 October 2009)
Version 2
G6... Cerebrovascular disease
G61.. Intracerebral haemorrhage
G64.. Cerebral arterial occlusion
G66.. Stroke/CVA unspecified

RRT (End stage renal failure requiring renal replacement therapy)
4Byte Version (retired 1 October 2009)
J16. Chronic renal failure (preferred term) (retired 1 October 2009)
End stage renal failure (synonym) (retired 1 October 2009)
Version 2
K050. End stage renal failure

DIAGNOSTIC CODING (DIABETES RELEVANT READ CODES)

Change to Data Element: Changed Description, linked Attribute

DIAGNOSTIC CODING (DIABETES RELEVANT READ CODES)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
CLINICAL TERMINOLOGY CODE

DIAGNOSTIC CODING (RETIRED) renamed from DIAGNOSTIC CODING

Change to Data Element: Changed Name, Description, linked Attribute, status to Retired

~~Format/Length:~~

	an6 for ICD-10 (see ICD 10th Revision), an7 for Clinical Terms (The Read Codes)
HES Item:	DIAGNSIS
National Codes:	
Default Codes:	

Notes:
DIAGNOSTIC CODING is a CLINICAL CLASSIFICATION associated with PATIENT DIAGNOSIS.

See International Classification of Diseases (ICD) and Read Coded Clinical Terms.**This item has been retired from the NHS Data Model and Dictionary.**

The recording system will require you to classify diagnoses where possible using ICD 10 or other classification codes approved centrally for mapping to ICD 10 codes. Clinical Terms (The Read Codes) can be used in addition to ICD 10 codes for Patient Diagnosis. However Clinical Terms (The Read Codes) are not accepted for the purposes of central Hospital Episode Statistics data, where ICD 10 is mandatory.**The last live version of this item is available in the December 2014 release of the NHS Data Model and Dictionary.**

ICD 10 diagnostic codes are at least four characters in length. The first character is always alphabetic. Where an undivided three character code is used, the fourth character must be filled with 'X'.**Access to this version can be obtained by emailing information.standards@hscic.gov.uk with "NHS Data Model and Dictionary - Archive Request" in the email subject line.**

Fifth characters should be used in accordance with the guidance in International Classification of Diseases (ICD). Where they are not used the character must be filled with a '-'. The sixth character of the code is used to designate an asterisk or dagger indicator in ICD 10; it may be an 'A' or 'D'.

DIAGNOSTIC CODING (RETIRED) renamed from DIAGNOSTIC CODING

Change to Data Element: Changed Name, Description, linked Attribute, status to Retired

DIAGNOSTIC CODING

Attribute:

CLINICAL CLASSIFICATION CODE

DIAGNOSTIC CODING (RETIRED) renamed from DIAGNOSTIC CODING

Change to Data Element: Changed Name, Description, linked Attribute, status to Retired

- Changed Name from Data_Dictionary.Data_Field_Notes.D.Diag.DIAGNOSTIC_CODING to Retired.Data_Dictionary.Data_Field_Notes.D.DIAGNOSTIC_CODING
- Changed Description
- null
- Retired DIAGNOSTIC CODING

DIAGNOSTIC OR PROCEDURE CODING (SEXUAL HEALTH AND HUMAN IMMUNODEFICIENCY VIRUS RELEVANT READ CODES)

Change to Data Element: Changed Description

Format/Length:	an7
Format/Length:	See READ CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~DIAGNOSTIC OR PROCEDURE CODING (SEXUAL HEALTH AND HUMAN IMMUNODEFICIENCY VIRUS RELEVANT READ CODES) is either the DIAGNOSTIC CODING or PROCEDURE CODING using Read Coded Clinical Terms relevant to conditions associated with Sexual Health and Human Immunodeficiency Virus.~~DIAGNOSTIC OR PROCEDURE CODING (SEXUAL HEALTH AND HUMAN IMMUNODEFICIENCY VIRUS RELEVANT READ CODES) is the same as attribute CLINICAL TERMINOLOGY CODE.

DIAGNOSTIC OR PROCEDURE CODING (SEXUAL HEALTH AND HUMAN IMMUNODEFICIENCY VIRUS RELEVANT READ CODES) is the Read Coded Clinical Terms code relevant to conditions associated with Sexual Health and Human Immunodeficiency Virus.

The list of available sexual health Read Coded Clinical Terms are available at gumcad@hpa.org.uk.

DIAGNOSTIC TEST (ENDOSCOPY)

Change to Data Element: Changed Description

~~Format/length:~~	~~an5~~
~~HES item:~~	
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.~~

~~References:~~
~~Department of Health: Monthly and Quarterly/Biannual Diagnostics statistics~~

DIAGNOSTIC TEST (ENDOSCOPY) 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 OPCS-4 codes listed in the NHS England guidance at: Diagnostics Waiting Times and Activity.

DIAGNOSTIC TEST (ENDOSCOPY CENSUS)

Change to Data Element: Changed Description

~~Format/length:~~	~~an5~~
~~HES item:~~	
Format/Length:	an5
HES Item:	
National Codes:	
Default Codes:	

Notes:

~~This is the intended endoscopy DIAGNOSTIC TEST or procedure (CLINICAL INTERVENTION) split by test grouping of SERVICE REQUESTS derived from the CLINICAL CLASSIFICATION OPCS-4 codes listed in the~~

~~Department of Health document 'Diagnostics Census: Guidance on completing the "diagnostic waiting times" census.~~ DIAGNOSTIC TEST (ENDOSCOPY CENSUS) is the intended endoscopy diagnostic test or procedure (CLINICAL INTERVENTION) split by test grouping of SERVICE REQUESTS derived from the OPCS-4 codes listed in the NHS England guidance at: Diagnostics Waiting Times and Activity.

DIAGNOSTIC TEST (IMAGING)

Change to Data Element: Changed Description

Format/Length:	an5
HES Item:	
National Codes:	
Default Codes:	

Notes:
DIAGNOSTIC TEST (IMAGING) is the intended or actual Imaging Test or Procedure, for a SERVICE REQUEST, split by:

- Magnetic Resonance Imaging Scan (MRI Scan)
- Computerised Tomography Scan (CT Scan)
- Non-obstetric Ultrasound Scan
- Barium Enema and DEXA scan

~~It is 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'.~~DIAGNOSTIC TEST (IMAGING) is derived from the OPCS-4 codes listed in the NHS England guidance at: Diagnostics Waiting Times and Activity.

~~For further information, see the Department of Health: Diagnostics website.~~

DIAGNOSTIC TEST (IMAGING CENSUS)

Change to Data Element: Changed Description

~~Format/length:~~	~~an5~~
~~HES item:~~	
Format/Length:	an5
HES Item:	
National Codes:	
Default Codes:	

Notes:

~~This is the intended imaging DIAGNOSTIC TEST or procedure (CLINICAL INTERVENTION) split by test grouping of SERVICE REQUESTS derived from the CLINICAL CLASSIFICATION OPCS-4 codes listed in the Department of Health document 'Diagnostics Census: Guidance on completing the "diagnostic waiting times" census.~~ DIAGNOSTIC TEST (IMAGING CENSUS) is the intended imaging diagnostic test or procedure (CLINICAL INTERVENTION) split by test grouping of SERVICE REQUESTS derived from the OPCS-4 codes listed in the NHS England guidance at: Diagnostics Waiting Times and Activity.

DIAGNOSTIC TEST (PATHOLOGY CENSUS)

Change to Data Element: Changed Description

~~Format/length:~~	~~an5~~
~~HES item:~~	
Format/Length:	an5
HES Item:	
National Codes:	
Default Codes:	

Notes:

~~This is the intended pathology~~ DIAGNOSTIC TEST ~~or procedure (~~CLINICAL INTERVENTION~~) split by test grouping of~~ SERVICE REQUESTS ~~derived from the~~ CLINICAL CLASSIFICATION ~~OPCS-4 codes listed in the~~ Department of Health ~~document 'Diagnostics Census: Guidance on completing the "diagnostic waiting times" census.~~ DIAGNOSTIC TEST (PATHOLOGY CENSUS) is the intended pathology diagnostic test or procedure (CLINICAL INTERVENTION) split by test grouping of SERVICE REQUESTS derived from the OPCS-4 codes listed in the NHS England guidance at: Diagnostics Waiting Times and Activity.

DIAGNOSTIC TEST (PHYSIOLOGICAL MEASUREMENT)

Change to Data Element: Changed Description

~~Format/length:~~	~~an5~~
~~HES item:~~	
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.~~

~~References:~~
~~Department of Health: Monthly and Quarterly/Biannual Diagnostics statistics~~

DIAGNOSTIC TEST (PHYSIOLOGICAL MEASUREMENT) 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 OPCS-4 codes listed in the NHS England guidance at: Diagnostics Waiting Times and Activity.

DIAGNOSTIC TEST (PHYSIOLOGICAL MEASUREMENT CENSUS)

Change to Data Element: Changed Description

~~Format/length:~~	~~an5~~
~~HES item:~~	
Format/Length:	an5
HES Item:	
National Codes:	
Default Codes:	

Notes:

~~This is the intended physiological measurement~~ DIAGNOSTIC TEST ~~or procedure (~~CLINICAL INTERVENTION~~) split by test grouping of~~ SERVICE REQUESTS ~~derived from the~~ CLINICAL CLASSIFICATION ~~OPCS-4 codes listed in the~~ Department of Health ~~document 'Diagnostics Census: Guidance on completing the "diagnostic waiting times" census.~~ DIAGNOSTIC TEST (PHYSIOLOGICAL MEASUREMENT CENSUS) is the intended physiological measurement diagnostic test or procedure (CLINICAL INTERVENTION) split by test grouping of SERVICE REQUESTS derived from the OPCS-4 codes listed in the NHS England guidance at: Diagnostics Waiting Times and Activity.

DIAGNOSTIC TEST (RETIRED) renamed from DIAGNOSTIC TEST

Change to Data Element: Changed Name, Description, status to Retired

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

~~**Notes:**~~**This item has been retired from the NHS Data Model and Dictionary.**

~~This is a diagnostic test or procedure to be reported on derived from the CLINICAL CLASSIFICATION CODE OPCS4.3 code.~~

~~The list of diagnostic tests/procedures and their OPCS4.3 codes are listed in the Diagnostic Waiting Times and Activity Guidance.~~**The last live version of this item is available in the December 2014 release of the NHS Data Model and Dictionary.**

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

DIAGNOSTIC TEST (RETIRED) renamed from DIAGNOSTIC TEST

Change to Data Element: Changed Name, Description, status to Retired

- Changed Name from Data_Dictionary.Data_Field_Notes.D.Diag.DIAGNOSTIC_TEST to Retired.Data_Dictionary.Data_Field_Notes.D.DIAGNOSTIC_TEST
- Changed Description
- Retired DIAGNOSTIC TEST

DIAGNOSTIC TESTS COMMISSIONED FROM INDEPENDENT SECTOR

Change to Data Element: Changed Description

~~Format/length:~~	~~n6~~
~~HES item:~~	
Format/Length:	n6
HES Item:	
National Codes:	
Default Codes:	

Notes:

~~This is the number of CLINICAL INTERVENTION of a particular DIAGNOSTIC TEST done during the reporting period where the ORGANISATION commissioning the SERVICE REQUEST is from the Independent Sector.~~ DIAGNOSTIC TESTS COMMISSIONED FROM INDEPENDENT SECTOR is the number of CLINICAL INTERVENTIONS of a particular diagnostic test done during the reporting period where the ORGANISATION commissioning the SERVICE REQUEST is from the Independent Sector.

DIAGNOSTIC TESTS DONE TOTAL

Change to Data Element: Changed Description

~~Format/length:~~	~~n6~~
~~HES item:~~	
Format/Length:	n6
HES Item:	
National Codes:	
Default Codes:	

Notes:

~~This is the total number of CLINICAL INTERVENTIONS of a particular DIAGNOSTIC TEST done during the reporting period.~~ DIAGNOSTIC TESTS DONE TOTAL is the total number of CLINICAL INTERVENTIONS of a particular diagnostic test done during the reporting period.

DM+D CODE

Change to Data Element: New Data Element

Format/Length:	min n6 max n18
HES Item:	
National Codes:	
Default Codes:	

Notes:
DM+D CODE is the same as attribute CLINICAL TERMINOLOGY CODE.

DM+D CODE is the concept identifier from the NHS Dictionary of Medicines and Devices (dm+d) which is used to identify the CODED CLINICAL ENTRY.

This data element is also known by these names:

Context	Alias
plural	DM+D CODES

DM+D CODE

Change to Data Element: New Data Element

DM+D CODE

Attribute:

CLINICAL TERMINOLOGY CODE

FINAL FIGO STAGE

Change to Data Element: Changed Description, linked Attribute

Format/Length:	max an5
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~FINAL FIGO STAGE is the same as attribute CLINICAL CLASSIFICATION CODE.~~FINAL FIGO STAGE is the same as attribute INTERNATIONAL FEDERATION OF GYNECOLOGY AND OBSTETRICS STAGE.

FINAL FIGO STAGE is the final International Federation of Gynecology and Obstetrics (FIGO) stage as agreed by the Multidisciplinary Team at PATIENT DIAGNOSIS for a PATIENT during a Gynaecological Cancer Care Spell.

FINAL FIGO STAGE

Change to Data Element: Changed Description, linked Attribute

FINAL FIGO STAGE

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
INTERNATIONAL FEDERATION OF GYNECOLOGY AND OBSTETRICS STAGE

FORMULA MILK OR MILK FORTIFIER TYPE (SNOMED CT DM+D)

Change to Data Element: Changed Description, linked Attribute

~~Format/Length:~~	~~max n18~~
Format/Length:	See DM+D CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~FORMULA MILK OR MILK FORTIFIER TYPE (SNOMED CT DM+D) is the same as attribute CLINICAL CLASSIFICATION CODE.~~FORMULA MILK OR MILK FORTIFIER TYPE (SNOMED CT DM+D) is the same as attribute CLINICAL TERMINOLOGY CODE.

FORMULA MILK OR MILK FORTIFIER TYPE (SNOMED CT DM+D) is the SNOMED CT code from the NHS Dictionary of Medicines and Devices which is used to identify a type of formula milk or milk fortifier.

For the National Neonatal Data Set - Episodic and Daily Care, FORMULA MILK OR MILK FORTIFIER TYPE (SNOMED CT DM+D) indicates the type of formula milk or milk fortifier the baby received on the NEONATAL CRITICAL CARE DAILY CARE DATE.

FORMULA MILK OR MILK FORTIFIER TYPE (SNOMED CT DM+D)

Change to Data Element: Changed Description, linked Attribute

FORMULA MILK OR MILK FORTIFIER TYPE (SNOMED CT DM+D)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~

CLINICAL TERMINOLOGY CODE

HIGH COST DRUGS (OPCS)

Change to Data Element: Changed Description, linked Attribute

~~Format/Length:~~	~~an4~~
Format/Length:	See OPCS-4 CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~See PROCEDURE CODING for details on coding.~~HIGH COST DRUGS (OPCS) is the same as attribute CLINICAL CLASSIFICATION CODE.

~~This is the use of high cost drugs as per OPCS-4 definitions provided as a CARE ACTIVITY.~~HIGH COST DRUGS (OPCS) is the use of high cost drugs as per the OPCS-4 definitions provided as a CARE ACTIVITY.

Note that in the Commissioning Data Set version 6-1-1 schema, only OPCS-4 codes X81.0 - X97.9 are accepted. This constraint has been removed at Commissioning Data Set schema version 6-2.

HIGH COST DRUGS (OPCS)

Change to Data Element: Changed Description, linked Attribute

HIGH COST DRUGS (OPCS)

Attribute:

CLINICAL CLASSIFICATION CODE

ICD-10 CODE

Change to Data Element: New Data Element

Format/Length:	min an4 max an6
HES Item:	
National Codes:	
Default Codes:	

Notes:
ICD-10 CODE is the same as attribute CLINICAL CLASSIFICATION CODE.

ICD-10 CODE is the International Classification of Diseases (ICD) 10th Revision code which is used to identify the CODED CLINICAL ENTRY.

Note:

- ICD-10 diagnostic codes are at least four characters in length. The first character is always alphabetic. Where an undivided three character code is used, the fourth character must be filled with 'X'.
- Fifth characters should be used in accordance with the National Clinical Coding Standards for (ICD-10). Where they are not used the character must be filled with a '-'.
- The sixth character of the code is used to designate an asterisk or dagger indicator in ICD-10; it may be an 'A' or 'D'.

This data element is also known by these names:

Context	Alias
plural	ICD-10 CODES

ICD-10 CODE

Change to Data Element: New Data Element

ICD-10 CODE

Attribute:

CLINICAL CLASSIFICATION CODE

ICD-O CODE

Change to Data Element: New Data Element

Format/Length:	min an5 max an7
HES Item:	
National Codes:	
Default Codes:	

Notes:
ICD-O CODE is the same as attribute CLINICAL CLASSIFICATION CODE.

ICD-O CODE is the International Classification of Diseases for Oncology code which is used to identify the CODED CLINICAL ENTRY.

This data element is also known by these names:

Context	Alias
plural	ICD-O CODES

ICD-O CODE

Change to Data Element: New Data Element

ICD-O CODE

Attribute:

CLINICAL CLASSIFICATION CODE

IMAGING CODE (NICIP)

Change to Data Element: Changed Description, linked Attribute

~~Format/Length:~~	~~max an6~~
Format/Length:	See NICIP CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~IMAGING CODE (NICIP) is the same as attribute CLINICAL CLASSIFICATION CODE.~~IMAGING CODE (NICIP) is the same as attribute CLINICAL TERMINOLOGY CODE.

~~IMAGING CODE (NICIP) is the National Interim Clinical Imaging Procedure Code Set code which is used to identify both the test modality and body site of the test.~~IMAGING CODE (NICIP) is the National Interim Clinical Imaging Procedure Code Set code which is used to identify both the modality and body site of the test.

IMAGING CODE (NICIP)

Change to Data Element: Changed Description, linked Attribute

IMAGING CODE (NICIP)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
CLINICAL TERMINOLOGY CODE

IMAGING CODE (SNOMED-CT)

Change to Data Element: Changed Description, linked Attribute

Format/Length:	max n18
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~IMAGING CODE (SNOMED-CT) is the same as attribute CLINICAL CLASSIFICATION CODE.~~IMAGING CODE (SNOMED-CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

IMAGING CODE (SNOMED-CT) is the SNOMED CT concept ID which is used to identify the Diagnostic Imaging test.

The SNOMED CT Subset:

- original ID is 611000000135
- name is 'UK Diagnostic Imaging Procedure Concepts'.

IMAGING CODE (SNOMED-CT)

Change to Data Element: Changed Description, linked Attribute

IMAGING CODE (SNOMED-CT)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
CLINICAL TERMINOLOGY CODE

INTENDED DIAGNOSTIC TEST

Change to Data Element: Changed Description

Format/Length:	an4
HES Item:	
National Codes:	
Default Codes:	

~~**Notes:**~~Notes:
~~INTENDED DIAGNOSTIC TEST is the intended diagnostic test or procedure for a SERVICE REQUEST derived from the CLINICAL CLASSIFICATION OPCS4 code.~~

INTENDED DIAGNOSTIC TEST is the intended diagnostic test or procedure for a SERVICE REQUEST derived from the OPCS Classification of Interventions and Procedures code.

~~The list of diagnostic tests/procedures and their OPCS4.3 codes are listed in the Diagnostic Waiting Times and Activity Guidance.~~The list of diagnostic tests/procedures and their OPCS-4.4 codes are listed in the NHS England guidance at: Diagnostics Waiting Times and Activity.

M CATEGORY (FINAL PRETREATMENT)

Change to Data Element: Changed Description, linked Attribute

Format/Length:	max an5
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~M CATEGORY (FINAL PRETREATMENT) is the same as attribute CLINICAL CLASSIFICATION CODE.~~

~~M CATEGORY (FINAL PRETREATMENT) is the Union for International Cancer Control (UICC) code which classifies the absence or presence of distant metastases before treatment.~~

M CATEGORY (FINAL PRETREATMENT) is the same as attribute UNION FOR INTERNATIONAL CANCER CONTROL CODE which classifies the absence or presence of distant metastases before treatment.

M CATEGORY (FINAL PRETREATMENT)

Change to Data Element: Changed Description, linked Attribute

M CATEGORY (FINAL PRETREATMENT)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
UNION FOR INTERNATIONAL CANCER CONTROL CODE

M CATEGORY (INTEGRATED STAGE)

Change to Data Element: Changed Description, linked Attribute

Format/Length:	max an5
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~M CATEGORY (INTEGRATED STAGE) is the same as attribute CLINICAL CLASSIFICATION CODE.~~

~~M CATEGORY (INTEGRATED STAGE) is the Union for International Cancer Control (UICC) code which classifies the absence or presence of distant metastases after treatment and/or after all available evidence has been collected.~~

M CATEGORY (INTEGRATED STAGE) is the same as attribute UNION FOR INTERNATIONAL CANCER CONTROL CODE which classifies the absence or presence of distant metastases after treatment and/or after all available evidence has been collected.

M CATEGORY (INTEGRATED STAGE)

Change to Data Element: Changed Description, linked Attribute

M CATEGORY (INTEGRATED STAGE)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
UNION FOR INTERNATIONAL CANCER CONTROL CODE

M CATEGORY (PATHOLOGICAL)

Change to Data Element: Changed Description, linked Attribute

Format/Length:	max an5
HES Item:	
National Codes:	
Default Codes:	

Notes:

~~M CATEGORY (PATHOLOGICAL) is the same as attribute CLINICAL CLASSIFICATION CODE.~~

~~M CATEGORY (PATHOLOGICAL) is the Union for International Cancer Control (UICC) code which classifies the absence or presence of distant metastases based on the evidence from a pathological examination.~~

M CATEGORY (PATHOLOGICAL) is the same as attribute UNION FOR INTERNATIONAL CANCER CONTROL CODE which classifies the absence or presence of distant metastases based on the evidence from a pathological examination.

M CATEGORY (PATHOLOGICAL)

Change to Data Element: Changed Description, linked Attribute

M CATEGORY (PATHOLOGICAL)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
UNION FOR INTERNATIONAL CANCER CONTROL CODE

MEDICATION GIVEN DURING LABOUR (SNOMED CT DM+D)

Change to Data Element: Changed Description, linked Attribute

~~Format/Length:~~	~~max n18~~
Format/Length:	See DM+D CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:

~~MEDICATION GIVEN DURING LABOUR (SNOMED CT DM+D) is the same as attribute CLINICAL CLASSIFICATION CODE.~~MEDICATION GIVEN DURING LABOUR (SNOMED CT DM+D) is the same as attribute CLINICAL TERMINOLOGY CODE.

MEDICATION GIVEN DURING LABOUR (SNOMED CT DM+D) is the SNOMED CT concept ID from the NHS Dictionary of Medicines and Devices which is used to identify the type of medication given to the mother during Labour and Delivery.

Further details of the permitted SNOMED CT codes from the NHS Dictionary of Medicines and Devices can be found on the Neonatal Data Analysis Unit website.

MEDICATION GIVEN DURING LABOUR (SNOMED CT DM+D)

Change to Data Element: Changed Description, linked Attribute

MEDICATION GIVEN DURING LABOUR (SNOMED CT DM+D)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
CLINICAL TERMINOLOGY CODE

MEDICATION GIVEN DURING NEONATAL CRITICAL CARE DAILY CARE DATE (SNOMED CT DM+D)

Change to Data Element: Changed Description, linked Attribute

~~Format/Length:~~	~~max n18~~
Format/Length:	See DM+D CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:

~~MEDICATION GIVEN DURING NEONATAL CRITICAL CARE DAILY CARE DATE (SNOMED CT DM+D) is the same as attribute CLINICAL CLASSIFICATION CODE.~~MEDICATION GIVEN DURING NEONATAL CRITICAL CARE DAILY CARE DATE (SNOMED CT DM+D) is the same as attribute CLINICAL TERMINOLOGY CODE.

MEDICATION GIVEN DURING NEONATAL CRITICAL CARE DAILY CARE DATE (SNOMED CT DM+D) is the SNOMED CT concept ID from the NHS Dictionary of Medicines and Devices which is used to identify the type of medication given to the baby on a NEONATAL CRITICAL CARE DAILY CARE DATE.

Further details of the permitted SNOMED CT codes from the NHS Dictionary of Medicines and Devices can be found on the Neonatal Data Analysis Unit website.

MEDICATION GIVEN DURING NEONATAL CRITICAL CARE DAILY CARE DATE (SNOMED CT DM+D)

Change to Data Element: Changed Description, linked Attribute

MEDICATION GIVEN DURING NEONATAL CRITICAL CARE DAILY CARE DATE (SNOMED CT DM+D)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~

CLINICAL TERMINOLOGY CODE

MORPHOLOGY (ICD-O)

Change to Data Element: Changed Description

~~Format/Length:~~	~~min an5 max an7~~
Format/Length:	See ICD-O CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:
MORPHOLOGY (ICD-O) is the same as attribute CLINICAL CLASSIFICATION CODE.

MORPHOLOGY (ICD-O) is the PATIENT DIAGNOSIS using the International Classification of Diseases for Oncology (ICD-O) code.

For the Cancer Outcomes and Services Data Set, MORPHOLOGY (ICD-O) can be recorded as well as or instead of MORPHOLOGY (SNOMED).

MORPHOLOGY (ICD-O AT START SYSTEMIC ANTI-CANCER THERAPY)

Change to Data Element: Changed Description

~~Format/Length:~~	~~min an5 max an7~~
Format/Length:	See ICD-O CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:
MORPHOLOGY (ICD-O AT START SYSTEMIC ANTI-CANCER THERAPY) is the PATIENT DIAGNOSIS for the cell type at the start of a Systemic Anti-Cancer Drug Programme.

MORPHOLOGY (ICD-O AT START SYSTEMIC ANTI-CANCER THERAPY) is the PATIENT DIAGNOSIS using the International Classification of Diseases for Oncology (ICD-O) code.

MORPHOLOGY (SNOMED)

Change to Data Element: Changed Description, linked Attribute

Format/Length:	max an18
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~MORPHOLOGY (SNOMED) is the same as attribute CLINICAL CLASSIFICATION CODE.~~MORPHOLOGY (SNOMED) is the same as attribute CLINICAL TERMINOLOGY CODE.

MORPHOLOGY (SNOMED) is the PATIENT DIAGNOSIS using the SNOMED® (Systematised Nomenclature of Medicine) code for the CELL type of the malignant disease recorded as part of a Cancer Care Spell.

For the Cancer Outcomes and Services Data Set, MORPHOLOGY (SNOMED) can be recorded as well as or instead of MORPHOLOGY (ICD-O).

MORPHOLOGY (SNOMED)

Change to Data Element: Changed Description, linked Attribute

MORPHOLOGY (SNOMED)

Attribute:

CLINICAL TERMINOLOGY CODE

MORPHOLOGY (SNOMED CT)

Change to Data Element: Changed Description, linked Attribute

~~Format/Length:~~	~~max n18~~
Format/Length:	See SNOMED CT CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:
MORPHOLOGY (SNOMED CT) ~~is the same as attribute CLINICAL CLASSIFICATION CODE.~~MORPHOLOGY (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

MORPHOLOGY (SNOMED CT) is the SNOMED CT concept ID which is used to identify the type of disease.

For the Cancer Outcomes and Services Data Set, MORPHOLOGY (SNOMED CT) is used to identify the CELL type of the malignant disease recorded as part of a Cancer Care Spell.

MORPHOLOGY (SNOMED CT)

Change to Data Element: Changed Description, linked Attribute

MORPHOLOGY (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

N CATEGORY (FINAL PRETREATMENT)

Change to Data Element: Changed Description, linked Attribute

Format/Length:	max an5
HES Item:	
National Codes:	
Default Codes:	

Notes:

~~N CATEGORY (FINAL PRETREATMENT) is the same as attribute CLINICAL CLASSIFICATION CODE.~~

~~N CATEGORY (FINAL PRETREATMENT) is the Union for International Cancer Control (UICC) code which classifies the absence or presence and extent of regional lymph node metastases before treatment.~~

N CATEGORY (FINAL PRETREATMENT) is the same as attribute UNION FOR INTERNATIONAL CANCER CONTROL CODE which classifies the absence or presence and extent of regional lymph node metastases before treatment.

N CATEGORY (FINAL PRETREATMENT)

Change to Data Element: Changed Description, linked Attribute

N CATEGORY (FINAL PRETREATMENT)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
UNION FOR INTERNATIONAL CANCER CONTROL CODE

N CATEGORY (INTEGRATED STAGE)

Change to Data Element: Changed Description, linked Attribute

Format/Length:	max an5
HES Item:	
National Codes:	
Default Codes:	

Notes:

~~N CATEGORY (INTEGRATED STAGE) is the same as attribute CLINICAL CLASSIFICATION CODE.~~

~~N CATEGORY (INTEGRATED STAGE) is the Union for International Cancer Control (UICC) code which classifies the absence or presence and extent of regional lymph node metastases after treatment and/or after all available evidence has been collected.~~

N CATEGORY (INTEGRATED STAGE) is the same as attribute UNION FOR INTERNATIONAL CANCER CONTROL CODE which classifies the absence or presence and extent of regional lymph node metastases after treatment and/or after all available evidence has been collected.

N CATEGORY (INTEGRATED STAGE)

Change to Data Element: Changed Description, linked Attribute

N CATEGORY (INTEGRATED STAGE)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
UNION FOR INTERNATIONAL CANCER CONTROL CODE

N CATEGORY (PATHOLOGICAL)

Change to Data Element: Changed Description, linked Attribute

Format/Length:	max an5
HES Item:	
National Codes:	

Default Codes:

Notes:
~~N CATEGORY (PATHOLOGICAL) is the same as attribute CLINICAL CLASSIFICATION CODE.~~

~~N CATEGORY (PATHOLOGICAL) is the Union for International Cancer Control (UICC) code which classifies the absence or presence and extent of regional lymph node metastases based on the evidence from a pathological examination.~~

N CATEGORY (PATHOLOGICAL) is the same as attribute UNION FOR INTERNATIONAL CANCER CONTROL CODE which classifies the absence or presence and extent of regional lymph node metastases based on the evidence from a pathological examination.

N CATEGORY (PATHOLOGICAL)

Change to Data Element: Changed Description, linked Attribute

N CATEGORY (PATHOLOGICAL)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
UNION FOR INTERNATIONAL CANCER CONTROL CODE

NEONATAL RESUSCITATION DRUG (SNOMED CT DM+D)

Change to Data Element: Changed Description, linked Attribute

~~Format/Length:~~	~~max n18~~
Format/Length:	See DM+D CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~NEONATAL RESUSCITATION DRUG (SNOMED CT DM+D) is the same as attribute CLINICAL CLASSIFICATION CODE.~~NEONATAL RESUSCITATION DRUG (SNOMED CT DM+D) is the same as attribute CLINICAL TERMINOLOGY CODE.

NEONATAL RESUSCITATION DRUG (SNOMED CT DM+D) is the SNOMED CT concept ID from the NHS Dictionary of Medicines and Devices which is used to identify the drug given to resuscitate a Neonate.

Further details of the permitted SNOMED CT codes from the NHS Dictionary of Medicines and Devices can be found at the Neonatal Data Analysis Unit website.

NEONATAL RESUSCITATION DRUG (SNOMED CT DM+D)

Change to Data Element: Changed Description, linked Attribute

NEONATAL RESUSCITATION DRUG (SNOMED CT DM+D)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
CLINICAL TERMINOLOGY CODE

NICIP CODE

Change to Data Element: New Data Element

Format/Length:	max an6
HES Item:	
National Codes:	
Default Codes:	

Notes:
NICIP CODE is the same as attribute CLINICAL TERMINOLOGY CODE.

NICIP CODE is the National Interim Clinical Imaging Procedure Code Set which is used to identify the CODED CLINICAL ENTRY.

This data element is also known by these names:

Context	Alias
plural	NICIP CODES

NICIP CODE

Change to Data Element: New Data Element

NICIP CODE

Attribute:

CLINICAL TERMINOLOGY CODE

OCCUPATION MOTHER (SNOMED CT)

Change to Data Element: Changed Description, linked Attribute

~~Format/Length:~~	~~max n18~~
Format/Length:	See SNOMED CT CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~OCCUPATION MOTHER (SNOMED CT) is the same as attribute CLINICAL CLASSIFICATION CODE.~~OCCUPATION MOTHER (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

OCCUPATION MOTHER (SNOMED CT) is the SNOMED CT concept ID describing the occupation of the mother in a Pregnancy Episode.

OCCUPATION MOTHER (SNOMED CT)

Change to Data Element: Changed Description, linked Attribute

OCCUPATION MOTHER (SNOMED CT)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~

CLINICAL TERMINOLOGY CODE

OPCS-4 CODE

Change to Data Element: New Data Element

Format/Length:	an4
HES Item:	
National Codes:	
Default Codes:	

Notes:
OPCS-4 CODE is the same as attribute CLINICAL CLASSIFICATION CODE.

OPCS-4 CODE is the OPCS Classification of Interventions and Procedures (OPCS-4) code which is used to identify the CODED CLINICAL ENTRY.

Notes:

- Where a procedure is carried out and required for reporting using the OPCS-4 classification, every effort must be made to report the appropriate OPCS-4 code in the Out-Patient Attendance Commissioning Data Set.
- Where providers locally use OPCS-4 codes with a fifth character added, this should be removed before inclusion in the Commissioning Data Set.

This data element is also known by these names:

Context	Alias
plural	OPCS-4 CODES

OPCS-4 CODE

Change to Data Element: New Data Element

OPCS-4 CODE

Attribute:

CLINICAL CLASSIFICATION CODE

OPERATION STATUS CODE

Change to Data Element: Changed Description

Format/Length:	an1
HES Item:	OPERSTAT
National Codes:	
Default Codes:	

Notes:
OPERATION STATUS CODES should be used once for each record to record states of knowledge regarding the operative procedure.

Permitted National Codes:

~~1~~ ~~One or more OPERATIVE PROCEDURE carried out~~

~~8~~ ~~Not applicable i.e. no OPERATIVE PROCEDURES performed or intended~~

1 One or more operative procedures carried out

8 Not applicable i.e. no operative procedure performed or intended

9 Not known i.e. finished episode/out-patient attendance but no data entered or the episode is unfinished and no data needs to be present. This would be a validation error only for a finished episode

Use in the Future Outpatient CDS:
If it is *not* intended to perform a procedure at the future attendance, use value 8. Otherwise this data element should be omitted.

OPERATION STATUS CODE replaces OPERATION STATUS and should be used for all new and developing data sets and for XML messages.

PERITONITIS ORGANISM 1 (READ)

Change to Data Element: Changed Description, linked Attribute

~~Format/Length:~~	~~See DIAGNOSTIC CODING~~
Format/Length:	an7
HES Item:	
National Codes:	
Default Codes:	

Notes:
PERITONITIS ORGANISM 1 (READ) is the same as attribute CLINICAL TERMINOLOGY CODE.

PERITONITIS ORGANISM 1 (READ) is the Read Code of the peritonitis organism with which the PATIENT is infected.

PERITONITIS ORGANISM 1 (READ)

Change to Data Element: Changed Description, linked Attribute

PERITONITIS ORGANISM 1 (READ)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
CLINICAL TERMINOLOGY CODE

PERITONITIS ORGANISM 2 (READ)

Change to Data Element: Changed Description, linked Attribute

~~Format/Length:~~	~~See DIAGNOSTIC CODING~~
Format/Length:	an7
HES Item:	
National Codes:	
Default Codes:	

Notes:
PERITONITIS ORGANISM 2 (READ) is the same as attribute CLINICAL TERMINOLOGY CODE.

PERITONITIS ORGANISM 2 (READ) is the Read Code of the peritonitis organism with which the PATIENT is infected.

PERITONITIS ORGANISM 2 (READ)

Change to Data Element: Changed Description, linked Attribute

PERITONITIS ORGANISM 2 (READ)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
CLINICAL TERMINOLOGY CODE

PRIMARY (ICD-10) (RETIRED) renamed from PRIMARY (ICD-10)

Change to Data Element: Changed Name, Description, status to Retired

~~Format/length:~~	~~See DIAGNOSTIC CODING~~
~~HES item:~~	~~DIAG_1 for Patient Diagnosis~~ ~~CENDIAG1 for Patient Diagnosis on Psychiatric Census Date for the Psychiatric Census Record: Additional Data Fields~~
~~National Codes:~~	
~~Default Codes:~~	

~~**Notes:**~~

~~See PRIMARY DIAGNOSES for the standardised definition of primary diagnosis.~~ **This item has been retired from the NHS Data Model and Dictionary.**

The last live version of this item is available in the December 2014 release of the NHS Data Model and Dictionary.

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

PRIMARY (ICD-10) (RETIRED) renamed from PRIMARY (ICD-10)

Change to Data Element: Changed Name, Description, status to Retired

- Changed Name from Data_Dictionary.Data_Field_Notes.P.Pri.PRIMARY_(ICD-10) to Retired.Data_Dictionary.Data_Field_Notes.P.PRIMARY_(ICD-10)
- Changed Description
- Retired PRIMARY (ICD-10)

PRIMARY DIAGNOSIS (ICD)

Change to Data Element: Changed Description

~~Format/Length:~~	~~an6~~
Format/Length:	See ICD-10 CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:

~~See DIAGNOSTIC CODING for details on coding and PRIMARY DIAGNOSES for the standardised definition of primary diagnosis.~~PRIMARY DIAGNOSIS (ICD) is the same as attribute CLINICAL CLASSIFICATION CODE. PRIMARY DIAGNOSIS (ICD) is the International Classification of Diseases (ICD) code used to identify the PRIMARY DIAGNOSIS.

Note:

- The format/length of this Data Element has been corrected as a result of the work undertaken for the development of the Coding Strategy.
- The data set specifications of the data sets that contain this Data Element will be updated in the next version of the information standard where it is not already correct.

PRIMARY DIAGNOSIS (ICD AT START SYSTEMIC ANTI-CANCER THERAPY)

Change to Data Element: Changed Description

~~Format/Length:~~	~~min an4 max an6~~
Format/Length:	See ICD-10 CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:

~~PRIMARY DIAGNOSIS (ICD AT START SYSTEMIC ANTI-CANCER THERAPY) is the same as data element PRIMARY DIAGNOSIS (ICD).~~PRIMARY DIAGNOSIS (ICD AT START SYSTEMIC ANTI-CANCER THERAPY) is the same as attribute CLINICAL CLASSIFICATION CODE.

~~For the Systemic Anti-Cancer Therapy Data Set, this is the PRIMARY DIAGNOSIS at the start of the Chemotherapy.~~For the Systemic Anti-Cancer Therapy Data Set, PRIMARY DIAGNOSIS (ICD AT START SYSTEMIC ANTI-CANCER THERAPY) is the PRIMARY DIAGNOSIS at the start of the Chemotherapy.

PRIMARY DIAGNOSIS (ICD PATHOLOGICAL)

Change to Data Element: Changed Description

~~Format/Length:~~	~~min an4 max an6~~
Format/Length:	See ICD-10 CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:

~~PRIMARY DIAGNOSIS (ICD PATHOLOGICAL) is the same as data element PRIMARY DIAGNOSIS (ICD).~~PRIMARY DIAGNOSIS (ICD PATHOLOGICAL) is the same as attribute CLINICAL CLASSIFICATION CODE.

PRIMARY DIAGNOSIS (ICD PATHOLOGICAL) is the PRIMARY DIAGNOSIS based on the evidence from a pathological examination.

PRIMARY DIAGNOSIS (ICD RADIOLOGICAL)

Change to Data Element: Changed Description

~~Format/Length:~~	~~min an4 max an6~~
Format/Length:	See ICD-10 CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~PRIMARY DIAGNOSIS (ICD RADIOLOGICAL) is the same as data element PRIMARY DIAGNOSIS (ICD).~~PRIMARY DIAGNOSIS (ICD RADIOLOGICAL) is the same as attribute CLINICAL CLASSIFICATION CODE.

PRIMARY DIAGNOSIS (ICD RADIOLOGICAL) is the PRIMARY DIAGNOSIS based on radiological examination.

For the Cancer Outcomes and Services Data Set:

- PRIMARY DIAGNOSIS (ICD RADIOLOGICAL) is recorded pre treatment
- In many cases this will be the definitive clinical diagnosis, but needs to be distinguished from the subsequent pathological diagnosis (if it becomes available).

PRIMARY DIAGNOSIS (READ)

Change to Data Element: Changed Description, linked Attribute

~~Format/length:~~	~~See DIAGNOSTIC CODING~~
~~HES item:~~	
Format/Length:	See READ CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~See PRIMARY DIAGNOSES for the standardised definition of primary diagnosis.~~PRIMARY DIAGNOSIS (READ) is the same as attribute CLINICAL TERMINOLOGY CODE. PRIMARY DIAGNOSIS (READ) is the Read Coded Clinical Terms code to identify the PRIMARY DIAGNOSIS.

Note: Read Coded Clinical Terms Version 3 (CTV3) with qualifiers is not supported in the Commissioning Data Sets. Therefore, the Commissioning Data Set Version 6-1 and 6-2 XML Schemas have the format of this Data Element constrained to max an5.

PRIMARY DIAGNOSIS (READ)

Change to Data Element: Changed Description, linked Attribute

PRIMARY DIAGNOSIS (READ)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
CLINICAL TERMINOLOGY CODE

PRIMARY PROCEDURE (OPCS)

Change to Data Element: Changed Description

~~Format/Length:~~	~~an4~~
Format/Length:	See OPCS-4 CODE
HES Item:	OPERTN1
National Codes:	
Default Codes:	

Notes:
~~See PROCEDURE CODING for details on coding.~~PRIMARY PROCEDURE (OPCS) is the same as attribute CLINICAL CLASSIFICATION CODE.

~~*'Primary'* is a classification of PATIENT PROCEDURE CODING SIGNIFICANCE for the OPCS 4 code of an OPERATIVE PROCEDURE.~~PRIMARY PROCEDURE (OPCS) is the OPCS Classification of Interventions and Procedures code which is used to identify the primary Patient Procedure carried out.

PRIMARY PROCEDURE (READ)

Change to Data Element: Changed Description, linked Attribute

~~Format/Length:~~	~~an7~~
Format/Length:	See READ CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~See PROCEDURE CODING for details on coding.~~PRIMARY PROCEDURE (READ) is the same as attribute CLINICAL TERMINOLOGY CODE.

~~*'Primary'* is a classification of PATIENT PROCEDURE CODING SIGNIFICANCE for the Read Coded Clinical Terms of an OPERATIVE PROCEDURE.~~PRIMARY PROCEDURE (READ) is the Read Coded Clinical Terms code which is used to identify the primary Patient Procedure carried out.

Note: Read Coded Clinical Terms Version 3 (CTV3) with qualifiers is not supported in the Commissioning Data Sets. Therefore, the Commissioning Data Set Version 6-1 and 6-2 XML Schemas have the format of this Data Element constrained to max an5.

PRIMARY PROCEDURE (READ)

Change to Data Element: Changed Description, linked Attribute

PRIMARY PROCEDURE (READ)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
CLINICAL TERMINOLOGY CODE

PRIMARY PROCEDURE (SNOMED CT)

Change to Data Element: Changed Description, linked Attribute

~~Format/Length:~~	~~max n18~~
Format/Length:	See SNOMED CT CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:

~~PRIMARY PROCEDURE (SNOMED CT) is the same as attribute CLINICAL CLASSIFICATION CODE.~~PRIMARY PROCEDURE (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

PRIMARY PROCEDURE (SNOMED CT) is the SNOMED CT concept ID which is used to identify the main Patient Procedure carried out.

PRIMARY PROCEDURE (SNOMED CT)

Change to Data Element: Changed Description, linked Attribute

PRIMARY PROCEDURE (SNOMED CT)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
CLINICAL TERMINOLOGY CODE

PRIMARY RENAL DISEASE DIAGNOSIS

Change to Data Element: Changed Description, linked Attribute

Format/Length:	an2
HES Item:	
National Codes:	
Default Codes:	

Notes:
PRIMARY RENAL DISEASE DIAGNOSIS is the same as attribute EUROPEAN RENAL ASSOCIATION CODE.

PRIMARY RENAL DISEASE DIAGNOSIS records the underlying aetiology of renal impairment using the European Dialysis and Transplant Association Coding Scheme.

PRIMARY RENAL DISEASE DIAGNOSIS

Change to Data Element: Changed Description, linked Attribute

PRIMARY RENAL DISEASE DIAGNOSIS

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
EUROPEAN RENAL ASSOCIATION CODE

PROCEDURE (OPCS)

Change to Data Element: Changed Description

~~Format/Length:~~	~~an4~~
Format/Length:	See OPCS-4 CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~PROCEDURE (OPCS) is a procedure other than the PRIMARY PROCEDURE (OPCS).~~PROCEDURE (OPCS) is the same as attribute CLINICAL CLASSIFICATION CODE.

~~See PROCEDURE CODING for details on coding.~~PROCEDURE (OPCS) is a procedure other than the PRIMARY PROCEDURE (OPCS).

For Commissioning Data Sets purposes it is recommended that multiple Procedures are recorded and the CDS-XML Message (CDS Version 6 onwards) has been designed to carry as many Procedures as required.

PROCEDURE (OPCS ON NEONATAL CRITICAL CARE DAILY CARE DATE)

Change to Data Element: Changed Description

~~Format/Length:~~	~~See PROCEDURE CODING~~
Format/Length:	See OPCS-4 CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:
PROCEDURE (OPCS ON NEONATAL CRITICAL CARE DAILY CARE DATE) is the same as attribute CLINICAL CLASSIFICATION CODE.

PROCEDURE (OPCS ON NEONATAL CRITICAL CARE DAILY CARE DATE) is the OPCS-4 code describing a Patient Procedure which occurred on a Neonatal Critical Care Daily Care Date during a Neonatal CRITICAL CARE PERIOD.

PROCEDURE (OPCS RECORDED ON DISCHARGE FROM NEONATAL CRITICAL CARE)

Change to Data Element: Changed Description

~~Format/Length:~~	~~See PROCEDURE CODING~~
Format/Length:	See OPCS-4 CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:
PROCEDURE (OPCS RECORDED ON DISCHARGE FROM NEONATAL CRITICAL CARE) is the same as attribute CLINICAL CLASSIFICATION CODE.

PROCEDURE (OPCS RECORDED ON DISCHARGE FROM NEONATAL CRITICAL CARE) is an OPCS-4 classification of a Patient Procedure recorded when the PATIENT is discharged from a neonatal critical care.

PROCEDURE (OPCS RECORDED ON DISCHARGE FROM NEONATAL CRITICAL CARE) should include any Patient Procedures which were not recorded as expected on the applicable Neonatal Critical Care Daily Care Date during a Neonatal CRITICAL CARE PERIOD.

PROCEDURE (READ)

Change to Data Element: Changed Description, linked Attribute

~~Format/Length:~~	~~an7~~
Format/Length:	See READ CODE
HES Item:	

National Codes:	
Default Codes:	

Notes:

~~PROCEDURE (READ) is a procedure other than the PRIMARY PROCEDURE (READ).~~PROCEDURE (READ) is the same as attribute CLINICAL TERMINOLOGY CODE.

~~See PROCEDURE CODING for details on coding.~~PROCEDURE (READ) is the Read Coded Clinical Terms for a procedure other than the PRIMARY PROCEDURE (READ).

For Commissioning Data Sets purposes it is recommended that multiple Procedures are recorded and the CDS-XML Message (CDS Version 6 onwards) has been designed to carry as many Procedures as required.

Note: Read Coded Clinical Terms Version 3 (CTV3) with qualifiers is not supported in the Commissioning Data Sets. Therefore, the Commissioning Data Set Version 6-1 and 6-2 XML Schemas have the format of this Data Element constrained to max an5.

PROCEDURE (READ)

Change to Data Element: Changed Description, linked Attribute

PROCEDURE (READ)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
CLINICAL TERMINOLOGY CODE

PROCEDURE (SNOMED CT)

Change to Data Element: Changed Description, linked Attribute

~~Format/Length:~~	~~max n18~~
Format/Length:	See SNOMED CT CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:

~~PROCEDURE (SNOMED CT) is the same as attribute CLINICAL CLASSIFICATION CODE.~~PROCEDURE (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

PROCEDURE (SNOMED CT) is the SNOMED CT concept ID which is used to identify the Patient Procedure carried out, other than the PRIMARY PROCEDURE (SNOMED CT).

PROCEDURE (SNOMED CT)

Change to Data Element: Changed Description, linked Attribute

PROCEDURE (SNOMED CT)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
CLINICAL TERMINOLOGY CODE

PROCEDURE (SNOMED CT ON NEONATAL CRITICAL CARE DAILY CARE DATE)

Change to Data Element: Changed Description, linked Attribute

~~Format/Length:~~	~~max n18~~
Format/Length:	See SNOMED CT CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:

~~PROCEDURE (SNOMED CT ON NEONATAL CRITICAL CARE DAILY CARE DATE) is the same as attribute CLINICAL CLASSIFICATION CODE.~~PROCEDURE (SNOMED CT ON NEONATAL CRITICAL CARE DAILY CARE DATE) is the same as attribute CLINICAL TERMINOLOGY CODE.

PROCEDURE (SNOMED CT ON NEONATAL CRITICAL CARE DAILY CARE DATE) is the SNOMED CT concept ID for a Patient Procedure carried out on a NEONATAL CRITICAL CARE DAILY CARE DATE during a neonatal CRITICAL CARE PERIOD.

PROCEDURE (SNOMED CT ON NEONATAL CRITICAL CARE DAILY CARE DATE)

Change to Data Element: Changed Description, linked Attribute

PROCEDURE (SNOMED CT ON NEONATAL CRITICAL CARE DAILY CARE DATE)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
CLINICAL TERMINOLOGY CODE

PROCEDURE (SNOMED CT RECORDED ON DISCHARGE FROM NEONATAL CRITICAL CARE)

Change to Data Element: Changed Description, linked Attribute

~~Format/Length:~~	~~max n18~~
Format/Length:	See SNOMED CT CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:

~~PROCEDURE (SNOMED CT RECORDED ON DISCHARGE FROM NEONATAL CRITICAL CARE) is the same as attribute CLINICAL CLASSIFICATION CODE.~~PROCEDURE (SNOMED CT RECORDED ON DISCHARGE FROM NEONATAL CRITICAL CARE) is the same as attribute CLINICAL TERMINOLOGY CODE.

PROCEDURE (SNOMED CT RECORDED ON DISCHARGE FROM NEONATAL CRITICAL CARE) is the SNOMED CT concept ID for a Patient Procedure recorded when the PATIENT is discharged from a Neonatal Intensive Care Unit.

PROCEDURE (SNOMED CT RECORDED ON DISCHARGE FROM NEONATAL CRITICAL CARE) should include any Patient Procedures which were not recorded as expected on the applicable Neonatal Critical Care Daily Care Date during a Neonatal CRITICAL CARE PERIOD.

PROCEDURE (SNOMED CT RECORDED ON DISCHARGE FROM NEONATAL CRITICAL CARE)

Change to Data Element: Changed Description, linked Attribute

PROCEDURE (SNOMED CT RECORDED ON DISCHARGE FROM NEONATAL CRITICAL CARE)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
CLINICAL TERMINOLOGY CODE

PROCEDURE CODING (DIABETES RELEVANT OPCS-4)

Change to Data Element: Changed Description

~~Format/length:~~	~~annn for OPCS-4~~
~~HES item:~~	
Format/Length:	See OPCS-4 CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:

~~Records the PROCEDURE CODING identified in the following relevant procedures associated with the diabetic condition.~~

PROCEDURE CODING (DIABETES RELEVANT OPCS-4) is the OPCS Classification of Interventions and Procedures code identified in the following relevant procedures associated with the diabetic condition.

OPCS-4 **Codes**

LASER (Ocular retinal photocoagulation)

C82.1 Cauterisation of lesion of retina
Includes: Photocoagulation of lesion of retina NEC; Electrocoagulation of lesion of retina NEC

Y08.4 Laser destruction of lesion of organ NOC (secondary procedure)

MINOR AMPUTATION (amputation toe or below ankle)

X11.1 Amputation of great toe
X11.2 Amputation of phalanx of toe
X11.8 Amputation of toe, other specified
X11.9 Amputation of toe, unspecified
X10.1 Amputation of foot through ankle
X10.8 Amputation of foot, other specified
X10.9 Amputation of foot, unspecified

MAJOR AMPUTATION (amputation leg, above or below knee)

X09.3 Amputation of leg above knee
X09.4 Amputation of leg through knee
X09.5 Amputation of leg below knee

RRT (End stage renal failure requiring renal replacement therapy)

X40.1 Compensation for renal failure, renal dialysis
X40.2 Compensation for renal failure, peritoneal dialysis NEC
X40.3 Compensation for renal failure, haemodialysis NEC
X40.8 Compensation for renal failure, other specified
X40.9 Compensation for renal failure, unspecified
M01.1 Transplantation of kidney autotransplantation of kidney
M01.2 Transplantation of kidney allotransplantation of kidney from live donor
M01.3 Transplantation of kidney allotransplantation of kidney from cadaver NEC

M01.8 Transplantation of kidney other specified
M01.9 Transplantation of kidney unspecified

PROCEDURE CODING (DIABETES RELEVANT READ CODES)

Change to Data Element: Changed Description, linked Attribute

~~Format/length:~~	~~an7 for the Read Codes~~
~~HES item:~~	
Format/Length:	an7
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~Records the PROCEDURE CODING identified in the following relevant procedures associated with the diabetic condition.~~

PROCEDURE CODING (DIABETES RELEVANT READ CODES) is the Read Coded Clinical Terms identified in the following relevant procedures associated with the diabetic condition.

Read Codes

LASER (Ocular retinal photocoagulation)
4Byte Version (retired 1 October 2009)
8633 Retinal photocoag. therapy (retired 1 October 2009)
Version 2
No equivalent term
AMPUTATION
4Byte Version (retired 1 October 2009)
7EU. Amputation - lower limb (retired 1 October 2009)
7EU1 Amputation of toes (retired 1 October 2009)
7EU2 Amputation foot: tarsal-metatar (retired 1 October 2009)
7EU3 Amputation foot: mid-tarsal (retired 1 October 2009)
7EU5 Supramalleolar ankle amptat (retired 1 October 2009)
7EU6 Below knee amputation (retired 1 October 2009)
7EU7 Above knee amputation (retired 1 October 2009)
Version 2
7L06. Amputation of leg
7L07. Amputation of foot
7L08. Amputation of toe
RRT (End stage renal failure requiring renal replacement therapy)
4Byte Version (retired 1 October 2009 - CP1016)
8874 Haemodialysis (preferred term) (retired 1 October 2009)
Dialysis - renal (synonym) (retired 1 October 2009)
7A4 Kidney Transplant (retired 1 October 2009)
Version 2
7L1A. Compensation for renal failure
7B00. Kidney Transplant

PROCEDURE CODING (DIABETES RELEVANT READ CODES)

Change to Data Element: Changed Description, linked Attribute

PROCEDURE CODING (DIABETES RELEVANT READ CODES)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
CLINICAL TERMINOLOGY CODE

PROCEDURE CODING (RETIRED) **renamed from PROCEDURE CODING**

Change to Data Element: Changed Name, Description, linked Attribute, status to Retired

~~Format/Length:~~	~~annn for OPCS-4, an7 for Clinical Terms (The Read Codes)~~
~~HES Item:~~	~~OPERTN~~
~~National Codes:~~	
~~Default Codes:~~	~~X998 - Out-patient procedure carried out but no appropriate OPCS-4 code available (Retired 01-10-2010)~~ ~~X999 - No out-patient procedure carried out (Retired 01-10-2010)~~

~~**Notes:**~~
~~PROCEDURE CODING is a CLINICAL CLASSIFICATION CODE.~~

~~See OPCS Classification of Interventions and Procedures for Classification of Surgical Operations and Procedures (OPCS-4) and Read Coded Clinical Terms.~~**This item has been retired from the NHS Data Model and Dictionary.**

~~Record any operative procedures carried out, such as an endoscopy or electro-convulsive therapy (ECT), as part of the current consultant episode.~~**The last live version of this item is available in the December 2014 release of the NHS Data Model and Dictionary.**

~~Clinical Terms (The Read Codes) (an7) may be used as an optional addition to OPCS-4.~~**Access to this version can be obtained by emailing information.standards@hscic.gov.uk with "NHS Data Model and Dictionary - Archive Request" in the email subject line.**

~~Where a procedure is carried out and required for reporting using the OPCS-4 classification every effort must be made to report the appropriate OPCS-4 code in the Out-Patient Attendance Commissioning Data Set.~~

~~Where providers locally use OPCS-4 codes with a fifth character added, this should be removed before inclusion in the Commissioning Data Set.~~

~~The default codes 'X998' and 'X999' and their descriptions have been retired as at 1st October 2010.~~ ~~Although these bespoke Data Set default codes do not currently exist in the OPCS Classification of Interventions and Procedures, it has been agreed that these codes will never be assigned within the OPCS Classification so as to avoid any confusion in the future.~~

PROCEDURE CODING (RETIRED) **renamed from PROCEDURE CODING**

Change to Data Element: Changed Name, Description, linked Attribute, status to Retired

~~PROCEDURE CODING~~

~~**Attribute:**~~

~~CLINICAL CLASSIFICATION CODE~~

PROCEDURE CODING (RETIRED) **renamed from PROCEDURE CODING**

Change to Data Element: Changed Name, Description, linked Attribute, status to Retired

- Changed Name from Data_Dictionary.Data_Field_Notes.P.Proc.PROCEDURE_CODING to Retired.Data_Dictionary.Data_Field_Notes.P.PROCEDURE_CODING
- Changed Description
- null
- Retired PROCEDURE CODING

PROVISIONAL DIAGNOSIS (ICD)

Change to Data Element: Changed Description

~~Format/Length:~~	~~See DIAGNOSTIC CODING~~
Format/Length:	See ICD-10 CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~See PROVISIONAL DIAGNOSIS for the standardised definition of PROVISIONAL DIAGNOSIS.~~PROVISIONAL DIAGNOSIS (ICD) is the same as attribute PROVISIONAL DIAGNOSIS.

PROVISIONAL DIAGNOSIS (ICD) is the International Classification of Diseases (ICD) code used to identify the PROVISIONAL DIAGNOSIS.

For the Cancer Outcomes and Services Data Set, PROVISIONAL DIAGNOSIS (ICD) is the working PATIENT DIAGNOSIS as defined at the Multidisciplinary Team Meeting where the First Definitive Treatment is agreed. This is the clinical opinion which may also be informed by Biopsy, radiological and/or other investigations.

Note:

- The format/length of this Data Element has been corrected as a result of the work undertaken for the development of the Coding Strategy.
- The data set specifications of the data sets that contain this Data Element will be updated in the next version of the information standard where it is not already correct.

RADIOTHERAPY ANATOMICAL TREATMENT SITE (OPCS)

Change to Data Element: Changed Description, linked Attribute

Format/Length:	an6
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~RADIOTHERAPY ANATOMICAL TREATMENT SITE (OPCS) is the same as attribute ANATOMICAL SITE.~~RADIOTHERAPY ANATOMICAL TREATMENT SITE (OPCS) is the same as attribute CLINICAL CLASSIFICATION CODE.

RADIOTHERAPY ANATOMICAL TREATMENT SITE (OPCS) is the part of the body to which the RADIOTHERAPY ACTUAL DOSE is administered.

For the Radiotherapy Data Set, see the Radiotherapy Data Set Manual on the National Clinical Analysis and Specialised Applications Team website for the OPCS Classification of Interventions and Procedures (OPCS-4) code to be used.

RADIOTHERAPY ANATOMICAL TREATMENT SITE (OPCS)

Change to Data Element: Changed Description, linked Attribute

RADIOTHERAPY ANATOMICAL TREATMENT SITE (OPCS)

Attribute:

~~ANATOMICAL SITE~~
CLINICAL CLASSIFICATION CODE

RADIOTHERAPY DIAGNOSIS (ICD)

Change to Data Element: Changed Description

Format/Length:	an6
HES Item:	
National Codes:	
Default Codes:	

Notes:
RADIOTHERAPY DIAGNOSIS (ICD) is the same as attribute CLINICAL CLASSIFICATION CODE.

RADIOTHERAPY DIAGNOSIS (ICD) is the International Classification of Diseases (ICD) code for PATIENT DIAGNOSIS for a PATIENT receiving Radiotherapy.

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

READ CODE

Change to Data Element: New Data Element

Format/Length:	an5 or an7
HES Item:	
National Codes:	
Default Codes:	

Notes:
READ CODE is the same as attribute CLINICAL TERMINOLOGY CODE.

READ CODE is the Read Coded Clinical Terms which is used to identify the CODED CLINICAL ENTRY.

This data element is also known by these names:

Context	Alias
plural	READ CODES

READ CODE

Change to Data Element: New Data Element

READ CODE

Attribute:

CLINICAL TERMINOLOGY CODE

SAMPLE ANTIBIOTIC SENSITIVITY RESULT (SNOMED CT DM+D)

Change to Data Element: Changed Description, linked Attribute

~~Format/Length:~~	~~max n18~~
Format/Length:	See DM+D CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~SAMPLE ANTIBIOTIC SENSITIVITY RESULT (SNOMED CT DM+D) is the same as attribute CLINICAL CLASSIFICATION CODE.~~SAMPLE ANTIBIOTIC SENSITIVITY RESULT (SNOMED CT DM+D) is the same as attribute CLINICAL TERMINOLOGY CODE.

SAMPLE ANTIBIOTIC SENSITIVITY RESULT (SNOMED CT DM+D) is the SNOMED CT concept ID from the NHS Dictionary of Medicines and Devices which is used to identify the antibiotics to which a culture SAMPLE is sensitive (i.e. which antibiotics are most likely to successfully treat a bacterial infection).

Further details of the permitted SNOMED CT codes from the NHS Dictionary of Medicines and Devices can be found on the Neonatal Data Analysis Unit website.

SAMPLE ANTIBIOTIC SENSITIVITY RESULT (SNOMED CT DM+D)

Change to Data Element: Changed Description, linked Attribute

SAMPLE ANTIBIOTIC SENSITIVITY RESULT (SNOMED CT DM+D)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
CLINICAL TERMINOLOGY CODE

SAMPLE TEST RESULT ORGANISM TYPE (SNOMED CT)

Change to Data Element: Changed Description, linked Attribute

~~Format/Length:~~	~~max n18~~
Format/Length:	See SNOMED CT CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~SAMPLE TEST RESULT ORGANISM TYPE (SNOMED CT) is the same as attribute CLINICAL CLASSIFICATION CODE.~~SAMPLE TEST RESULT ORGANISM TYPE (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

SAMPLE TEST RESULT ORGANISM TYPE (SNOMED CT) is the SNOMED CT concept ID describing the organism found in a culture SAMPLE.

SAMPLE TEST RESULT ORGANISM TYPE (SNOMED CT)

Change to Data Element: Changed Description, linked Attribute

SAMPLE TEST RESULT ORGANISM TYPE (SNOMED CT)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
CLINICAL TERMINOLOGY CODE

SARCOMA TUMOUR SITE (BONE)

Change to Data Element: Changed Description

~~Format/Length:~~	~~an4~~
Format/Length:	See OPCS-4 CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:
SARCOMA TUMOUR SITE (BONE) is the same as attribute CLINICAL CLASSIFICATION CODE

SARCOMA TUMOUR SITE (BONE) is the location of the bone sarcoma within the body using the OPCS-4 code, which is a at a more detailed level than the International Classification of Diseases (ICD) or International Classification of Diseases for Oncology (ICD-O) codes.

~~See PROCEDURE CODING for details on coding.~~

SARCOMA TUMOUR SITE (SOFT TISSUE)

Change to Data Element: Changed Description

~~Format/Length:~~	~~an4~~
Format/Length:	See OPCS-4 CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:
SARCOMA TUMOUR SITE (SOFT TISSUE) is the same as attribute CLINICAL CLASSIFICATION CODE

SARCOMA TUMOUR SITE (SOFT TISSUE) is the location of the soft tissue sarcoma within the body using the OPCS-4 code, which is a at a more detailed level than the International Classification of Diseases (ICD) or International Classification of Diseases for Oncology (ICD-O) codes.

~~See PROCEDURE CODING for details on coding.~~

SECONDARY CAUSE OF END STAGE RENAL FAILURE

Change to Data Element: Changed Description, linked Attribute

~~Format/Length:~~	~~an5 for DIAGNOSIS SCHEME IN USE (RENAL) of 02 (ICD-10)~~ ~~an2 for DIAGNOSIS SCHEME IN USE (RENAL) of 06 (European Renal Association (European Dialysis and Transplant Association)~~
Format/Length:	an5 for ICD-10 an2 for European Renal Association (European Dialysis and Transplant Association)
HES Item:	
National Codes:	
Default Codes:	

Notes:
SECONDARY CAUSE OF END STAGE RENAL FAILURE is the same as attribute CLINICAL CLASSIFICATION CODE or EUROPEAN RENAL ASSOCIATION CODE.

SECONDARY CAUSE OF END STAGE RENAL FAILURE is either:

- ~~an ICD-10 code or~~
- an ICD-10 code or
- European Renal Association (European Dialysis and Transplant Association) code

depending on the value in DIAGNOSIS SCHEME IN USE (RENAL) detailing a secondary cause for the PATIENT's end stage renal failure diagnosis.

SECONDARY CAUSE OF END STAGE RENAL FAILURE

Change to Data Element: Changed Description, linked Attribute

SECONDARY CAUSE OF END STAGE RENAL FAILURE

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
CLINICAL CLASSIFICATION CODE
EUROPEAN RENAL ASSOCIATION CODE

SECONDARY DIAGNOSIS (ICD)

Change to Data Element: Changed Description, linked Attribute

~~Format/Length:~~	~~See DIAGNOSTIC CODING~~
Format/Length:	See ICD-10 CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~SECONDARY DIAGNOSIS (ICD) is a classification of PATIENT DIAGNOSIS CODING SIGNIFICANCE.~~SECONDARY DIAGNOSIS (ICD) is the same as attribute CLINICAL CLASSIFICATION CODE.

SECONDARY DIAGNOSIS (ICD) is the International Classification of Diseases (ICD) code used to identify the secondary PATIENT DIAGNOSIS.

For Commissioning Data Sets (CDS) purposes it is recommended that multiple Diagnoses are recorded and the CDS-XML Message (CDS Version 6 onwards) has been designed to carry as many Diagnoses as required.

Note:

- The format/length of this Data Element has been corrected as a result of the work undertaken for the development of the Coding Strategy.
- The data set specifications of the data sets that contain this Data Element will be updated in the next version of the information standard where it is not already correct.

SECONDARY DIAGNOSIS (ICD)

Change to Data Element: Changed Description, linked Attribute

SECONDARY DIAGNOSIS (ICD)

Attribute:

~~PATIENT DIAGNOSIS CODING SIGNIFICANCE~~
CLINICAL CLASSIFICATION CODE

SECONDARY DIAGNOSIS (READ)

Change to Data Element: Changed Description, linked Attribute

~~Format/length:~~	~~See~~ DIAGNOSTIC CODING
~~HES item:~~	
Format/Length:	See READ CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:

~~See~~ ~~Read Coded Clinical Terms~~ ~~for their usage.~~SECONDARY DIAGNOSIS (READ) is the same as attribute CLINICAL TERMINOLOGY CODE.

~~Secondary is a classification of~~ ~~PATIENT DIAGNOSIS CODING SIGNIFICANCE~~.SECONDARY DIAGNOSIS (READ) is the Read Coded Clinical Terms used to identify the secondary PATIENT DIAGNOSIS.

For Commissioning Data Set (CDS) purposes it is recommended that multiple Diagnoses are recorded and the CDS-XML Message (CDS Version 6 onwards) has been designed to carry as many Diagnoses as required.

Note: Read Coded Clinical Terms Version 3 (CTV3) with qualifiers is not supported in the Commissioning Data Sets. Therefore, the Commissioning Data Set Version 6-1 and 6-2 XML Schemas have the format of this Data Element constrained to max an5.

SECONDARY DIAGNOSIS (READ)

Change to Data Element: Changed Description, linked Attribute

SECONDARY DIAGNOSIS (READ)

Attribute:

~~PATIENT DIAGNOSIS CODING SIGNIFICANCE~~
CLINICAL TERMINOLOGY CODE

SKIN SPECIMEN SITE CODE

Change to Data Element: Changed Description

~~Format/Length:~~	~~min an4 max an6~~
Format/Length:	See ICD-10 CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:
SKIN SPECIMEN SITE CODE is the same as attribute CLINICAL CLASSIFICATION CODE.

SKIN SPECIMEN SITE CODE is the site code of the skin specimen using the International Classification of Diseases (ICD) code.

SNOMED CT CODE

Change to Data Element: New Data Element

Format/Length:	min n6 max n18
HES Item:	
National Codes:	
Default Codes:	

Notes:
SNOMED CT CODE is the same as attribute CLINICAL TERMINOLOGY CODE.

SNOMED CT CODE is the Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT) concept ID which is used to identify the CODED CLINICAL ENTRY

This data element is also known by these names:

Context	Alias
plural	SNOMED CT CODES

SNOMED CT CODE

Change to Data Element: New Data Element

SNOMED CT CODE

Attribute:

CLINICAL TERMINOLOGY CODE

SPECIMEN TYPE (CHLAMYDIA TESTING SNOMED CT)

Change to Data Element: Changed Description, linked Attribute

Format/Length:	min n6 max n18
HES Item:	
National Codes:	
Default Codes:	

Notes:
SPECIMEN TYPE (CHLAMYDIA TESTING SNOMED CT) ~~is the same as attribute~~ CLINICAL CLASSIFICATION

~~CODE~~.~~SPECIMEN~~ TYPE (CHLAMYDIA TESTING SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

SPECIMEN TYPE (CHLAMYDIA TESTING SNOMED CT) is the SNOMED CT concept ID which is used to identify the type of specimen used for Chlamydia testing.

The SNOMED CT Subset:

- original ID is 58831000000130
- name is 'Chlamydia test procedures'.

SPECIMEN TYPE (CHLAMYDIA TESTING SNOMED CT)

Change to Data Element: Changed Description, linked Attribute

SPECIMEN TYPE (CHLAMYDIA TESTING SNOMED CT)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
CLINICAL TERMINOLOGY CODE

STEROID TYPE GIVEN TO MOTHER (SNOMED CT DM+D)

Change to Data Element: Changed Description, linked Attribute

~~Format/Length:~~	~~max n18~~
Format/Length:	See DM+D CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~STEROID TYPE GIVEN TO MOTHER (SNOMED CT DM+D) is the same as attribute CLINICAL CLASSIFICATION CODE~~.STEROID TYPE GIVEN TO MOTHER (SNOMED CT DM+D) is the same as attribute CLINICAL TERMINOLOGY CODE.

STEROID TYPE GIVEN TO MOTHER (SNOMED CT DM+D) is the SNOMED CT concept ID from the NHS Dictionary of Medicines and Devices which is used to identify the type of steroid given to the mother during a Pregnancy Episode in order to mature the fetal lungs.

Further details of the permitted SNOMED CT codes from the NHS Dictionary of Medicines and Devices can be found at the Neonatal Data Analysis Unit website.

STEROID TYPE GIVEN TO MOTHER (SNOMED CT DM+D)

Change to Data Element: Changed Description, linked Attribute

STEROID TYPE GIVEN TO MOTHER (SNOMED CT DM+D)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
CLINICAL TERMINOLOGY CODE

T CATEGORY (FINAL PRETREATMENT)

Change to Data Element: Changed Description, linked Attribute

Format/Length:	max an5
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~T CATEGORY (FINAL PRETREATMENT) is the same as attribute CLINICAL CLASSIFICATION CODE.~~

~~T CATEGORY (FINAL PRETREATMENT) is the Union for International Cancer Control (UICC) code which classifies the size and extent of the primary Tumour before treatment.~~

T CATEGORY (FINAL PRETREATMENT) is the same as attribute UNION FOR INTERNATIONAL CANCER CONTROL CODE which classifies the size and extent of the primary Tumour before treatment.

T CATEGORY (FINAL PRETREATMENT)

Change to Data Element: Changed Description, linked Attribute

T CATEGORY (FINAL PRETREATMENT)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
UNION FOR INTERNATIONAL CANCER CONTROL CODE

T CATEGORY (INTEGRATED STAGE)

Change to Data Element: Changed Description, linked Attribute

Format/Length:	max an5
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~T CATEGORY (INTEGRATED STAGE) is the same as attribute CLINICAL CLASSIFICATION CODE.~~

~~T CATEGORY (INTEGRATED STAGE) is the Union for International Cancer Control (UICC) code which classifies the size and extent of the primary Tumour after treatment and/or after all available evidence has been collected.~~

T CATEGORY (INTEGRATED STAGE) is the same as attribute UNION FOR INTERNATIONAL CANCER CONTROL CODE which classifies the size and extent of the primary Tumour after treatment and/or after all available evidence has been collected.

T CATEGORY (INTEGRATED STAGE)

Change to Data Element: Changed Description, linked Attribute

T CATEGORY (INTEGRATED STAGE)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
UNION FOR INTERNATIONAL CANCER CONTROL CODE

T CATEGORY (PATHOLOGICAL)

Change to Data Element: Changed Description, linked Attribute

Format/Length:	max an5
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~T CATEGORY (PATHOLOGICAL) is the same as attribute CLINICAL CLASSIFICATION CODE.~~

~~T CATEGORY (PATHOLOGICAL) is the Union for International Cancer Control (UICC) code which classifies the size and extent of the primary Tumour based on the evidence from a pathological examination.~~

T CATEGORY (PATHOLOGICAL) is the same as attribute UNION FOR INTERNATIONAL CANCER CONTROL CODE which classifies the size and extent of the primary Tumour based on the evidence from a pathological examination.

T CATEGORY (PATHOLOGICAL)

Change to Data Element: Changed Description, linked Attribute

T CATEGORY (PATHOLOGICAL)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
UNION FOR INTERNATIONAL CANCER CONTROL CODE

TNM STAGE GROUPING (FINAL PRETREATMENT)

Change to Data Element: Changed Description, linked Attribute

Format/Length:	max an5
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~TNM STAGE GROUPING (FINAL PRETREATMENT) is the same as attribute CLINICAL CLASSIFICATION CODE.~~

~~TNM STAGE GROUPING (FINAL PRETREATMENT) is the Union for International Cancer Control (UICC) code which classifies the combination of Tumour, node and metastases into stage groupings before treatment.~~

TNM STAGE GROUPING (FINAL PRETREATMENT) is the same as attribute UNION FOR INTERNATIONAL CANCER CONTROL CODE which classifies the combination of Tumour, node and metastases into stage groupings before treatment.

TNM STAGE GROUPING (FINAL PRETREATMENT)

Change to Data Element: Changed Description, linked Attribute

TNM STAGE GROUPING (FINAL PRETREATMENT)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
UNION FOR INTERNATIONAL CANCER CONTROL CODE

TNM STAGE GROUPING (FINAL PRETREATMENT)

Change to Data Element: Changed Description, linked Attribute

- Changed Description
- null

TNM STAGE GROUPING (INTEGRATED)

Change to Data Element: Changed Description, linked Attribute

Format/Length:	max an5
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~TNM STAGE GROUPING (INTEGRATED) is the same as attribute CLINICAL CLASSIFICATION CODE.~~

~~TNM STAGE GROUPING (INTEGRATED) is the Union for International Cancer Control (UICC) code which classifies the combination of Tumour, node and metastases into stage groupings after treatment and/or after all available evidence has been collected.~~

TNM STAGE GROUPING (INTEGRATED) is the same as attribute UNION FOR INTERNATIONAL CANCER CONTROL CODE which classifies the combination of Tumour, node and metastases into stage groupings after treatment and/or after all available evidence has been collected.

TNM STAGE GROUPING (INTEGRATED)

Change to Data Element: Changed Description, linked Attribute

TNM STAGE GROUPING (INTEGRATED)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
UNION FOR INTERNATIONAL CANCER CONTROL CODE

TNM STAGE GROUPING (PATHOLOGICAL)

Change to Data Element: Changed Description, linked Attribute

Format/Length:	max an5
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~TNM STAGE GROUPING (PATHOLOGICAL) is the same as attribute CLINICAL CLASSIFICATION CODE.~~

~~TNM STAGE GROUPING (PATHOLOGICAL) is the Union for International Cancer Control (UICC) code which classifies the combination of Tumour, node and metastases into stage groupings based on the evidence from a pathological examination.~~

TNM STAGE GROUPING (PATHOLOGICAL) is the same as attribute UNION FOR INTERNATIONAL CANCER CONTROL CODE which classifies the combination of Tumour, node and metastases into stage groupings based on the evidence from a pathological examination.

TNM STAGE GROUPING (PATHOLOGICAL)

Change to Data Element: Changed Description, linked Attribute

TNM STAGE GROUPING (PATHOLOGICAL)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
UNION FOR INTERNATIONAL CANCER CONTROL CODE

TOPOGRAPHY (ICD-O)

Change to Data Element: Changed Description

~~Format/Length:~~	~~min an5 max an7~~
Format/Length:	See ICD-O CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:
TOPOGRAPHY (ICD-O) is the same as attribute CLINICAL CLASSIFICATION CODE.

TOPOGRAPHY (ICD-O) is the topographical site of the Tumour using the International Classification of Diseases for Oncology (ICD-O) code.

TOPOGRAPHY (SNOMED)

Change to Data Element: Changed Description, linked Attribute

Format/Length:	max an18
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~TOPOGRAPHY (SNOMED) is the same as attribute CLINICAL CLASSIFICATION CODE.~~TOPOGRAPHY (SNOMED) is the same as attribute CLINICAL TERMINOLOGY CODE.

TOPOGRAPHY (SNOMED) is the topographical site of the Tumour using the SNOMED® (Systematised Nomenclature of Medicine) code as part of a Cancer Care Spell.

TOPOGRAPHY (SNOMED)

Change to Data Element: Changed Description, linked Attribute

TOPOGRAPHY (SNOMED)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
CLINICAL TERMINOLOGY CODE

TOPOGRAPHY (SNOMED CT)

Change to Data Element: Changed Description, linked Attribute

~~Format/Length:~~	~~max n18~~
Format/Length:	See SNOMED CT CODE
HES Item:	
National Codes:	
Default Codes:	

Notes:

~~TOPOGRAPHY (SNOMED CT) is the same as attribute CLINICAL CLASSIFICATION CODE.~~TOPOGRAPHY (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

TOPOGRAPHY (SNOMED CT) is the SNOMED CT concept ID which is used to identify a topographical site.

For the Cancer Outcomes and Services Data Set, TOPOGRAPHY (SNOMED CT) is used to identify the topographical site of the Tumour, recorded as part of a Cancer Care Spell.

TOPOGRAPHY (SNOMED CT)

Change to Data Element: Changed Description, linked Attribute

TOPOGRAPHY (SNOMED CT)

Attribute:

~~CLINICAL CLASSIFICATION CODE~~
CLINICAL TERMINOLOGY CODE

UNSCHEDULED DIAGNOSTIC TESTS DONE

Change to Data Element: Changed Description

Format/Length:	n6
HES Item:	
National Codes:	
Default Codes:	

Notes:

~~UNSCHEDULED DIAGNOSTIC TESTS DONE is the number of CLINICAL INTERVENTIONS of a particular DIAGNOSTIC TEST done during the REPORTING PERIOD where the DIAGNOSTIC SERVICE REQUEST TYPE of the SERVICE REQUEST is *'Emergency or unscheduled diagnostic test or procedure'*.~~UNSCHEDULED DIAGNOSTIC TESTS DONE is the number of CLINICAL INTERVENTIONS of a particular diagnostic test done during the REPORTING PERIOD where the DIAGNOSTIC SERVICE REQUEST TYPE of the SERVICE REQUEST is *'Emergency or unscheduled diagnostic test or procedure'*.

WAITING LIST DIAGNOSTIC TESTS DONE

Change to Data Element: Changed Description

Format/Length:	n6
HES Item:	
National Codes:	
Default Codes:	

Notes:
~~WAITING LIST DIAGNOSTIC TESTS DONE is the number of CLINICAL INTERVENTIONS of a particular DIAGNOSTIC TEST done during the REPORTING PERIOD where the DIAGNOSTIC SERVICE REQUEST TYPE of the SERVICE REQUESTS is *'Waiting list for test/procedure'*.~~WAITING LIST DIAGNOSTIC TESTS DONE is the number of CLINICAL INTERVENTIONS of a particular diagnostic test done during the REPORTING PERIOD where the DIAGNOSTIC SERVICE REQUEST TYPE of the SERVICE REQUESTS is *'Waiting list for test/procedure'*.

CANCER OUTCOMES AND SERVICES DATA SET XML SCHEMA CONSTRAINTS

Change to XML Schema Constraint: Changed Description

XML Schema constraints applied to the Cancer Outcomes and Services Data Set.

The "Allowed Values" column indicates the NHS Data Model and Dictionary National Codes and Default Codes present in the XML Schema:

- None = The National Codes and Default Codes are included in the XML Schema
- Removed = The National Codes and Default Codes are not included in the XML Schema.

Data Element	XML Schema Format/Length	Allowed Values	Range	Pattern Match	Reason / Comment / XML Choice
ALBUMIN LEVEL	None	None	10-80	None	Range 10-80
ALLRED SCORE (ESTROGEN RECEPTOR)	None	None	0 and 2-8	None	Range 0 and 2-8
ALLRED SCORE (PROGESTERONE RECEPTOR)	None	None	0 and 2-8	None	Range 0 and 2-8
BETA2 MICROGLOBULIN LEVEL	None	None	None	d{1,2}(.d){1}	Format pattern applied to allow correct reporting of BETA2 MICROGLOBULIN LEVEL
BLOOD BASOPHILS PERCENTAGE	None	None	0-100	None	Range 0-100
BLOOD EOSINOPHILS PERCENTAGE	None	None	0-100	None	~~Range 0-100~~
~~BLOOD MYELOBLASTS PERCENTAGE~~	~~None~~	~~None~~	Range 0-100		
BODY MASS INDEX	None	None	None	d{2}(.d){1}	Format pattern applied to allow correct reporting of BODY MASS INDEX
BLOOD MYELOBLASTS PERCENTAGE	None	None	0-100	None	~~Range 0-100~~
~~BONE MARROW BLAST CELLS PERCENTAGE~~	~~None~~	~~None~~	Range 0-100		
BLOOD LYMPHOCYTE COUNT	None	None	None	d{1,2}(.d){1}	Format pattern applied to allow correct reporting of BLOOD LYMPHOCYTE COUNT
BONE MARROW BLAST CELLS PERCENTAGE	None	None	0-20	None	~~Range 0-20~~

~~CANCER SYMPTOMS FIRST NOTED DATE~~	~~None~~	~~None~~	Range 0-20		
BRESLOW THICKNESS	None	None	None	d{1,2}(.)d{1,2}	Format pattern applied to allow correct reporting of BRESLOW THICKNESS
CANCER SYMPTOMS FIRST NOTED DATE	None	None	None	((19|20)dd-(0[1-9]|1[012])-(0[1-9]|[12][0-9]|3[01])|(19|20)dd-(0[1-9]|1[012])|(19|20)dd)	Format pattern applied to allow correct reporting of CANCER SYMPTOMS FIRST NOTED DATE
CARE PROFESSIONAL MAIN SPECIALTY CODE (CANCER REFERRAL)	None	Removed	None	None	National Codes and default codes not enumerated in the XML Schema
CARE PROFESSIONAL MAIN SPECIALTY CODE (DIAGNOSIS)	None	Removed	None	None	National Codes and default codes not enumerated in the XML Schema
CARE PROFESSIONAL MAIN SPECIALTY CODE (FIRST SEEN)	an3	Removed	None	None	National Codes and default codes not enumerated in the XML Schema
CARE PROFESSIONAL MAIN SPECIALTY CODE (TREATMENT)	an3	Removed	None	None	National Codes and default codes not enumerated in the XML Schema
CONSULTANT CODE (ENDOSCOPIC OR RADIOLOGICAL PROCEDURE)	None	Removed	None	None	Default codes not enumerated in the XML Schema
CONSULTANT CODE (FIRST SEEN)	None	Removed	None	None	Default codes not enumerated in the XML Schema
CONSULTANT CODE (PATHOLOGIST)	None	Removed	None	None	Default codes not enumerated in the XML Schema
CONSULTANT CODE (TREATMENT)	None	Removed	None	None	Default codes not enumerated in the XML Schema
COSDS SUBMISSION IDENTIFIER	None	None	None	[0-9A-F]{8}-[0-9A-F]{4}-[0-9A-F]{4}-[0-9A-F]{4}-[0-9A-F]{12}	Format pattern applied to allow correct reporting of COSDS SUBMISSION RECORD COUNT
COSDS UNIQUE IDENTIFIER	None	None	None	[0-9A-F]{8}-[0-9A-F]{4}-[0-9A-F]{4}	Format pattern applied to allow correct reporting of COSDS UNIQUE IDENTIFIER

				-[0-9A-F]{4}-[0-9A-F]{12}		
DISTANCE BEYOND MUSCULARIS PROPRIA	None	None	None	d{1,3}.d{1,2}	Format pattern applied to allow correct reporting of DISTANCE BEYOND MUSCULARIS PROPRIA	
DISTANCE FROM DENTATE LINE	None	None	None	d{1,3}.d{1,2}	~~Format pattern applied to allow correct reporting of DISTANCE FROM DENTATE LINE~~	
~~DISTANCE TO CIRCUMFERENTIAL EXCISION MARGIN~~	~~None~~	~~None~~	Format pattern applied to allow correct reporting of DISTANCE FROM DENTATE LINE			
DISTANCE TO CLOSEST NON PERITONEALISED RESECTION MARGIN	None	None	None	~~d{1,3}.~~	d{1,2}.d{1,2}	~~Format patte applied to all correct repor DISTANCE T(CIRCUMFERE EXCISION M~~
~~DISTANCE TO CLOSEST NON PERITONEALISED RESECTION MARGIN~~	~~None~~	~~None~~	Format pattern applied to allow correct reporting of DISTANCE TO CLOSEST NON PERITONEALISED RESECTION MARGIN			
DISTANCE TO DISTAL RESECTION MARGIN	None	None	None	~~d{1,2}.~~	d{1,4}.d{1,2}	~~Format patte applied to all correct repor DISTANCE T(CLOSEST NO PERITONEAL RESECTION I~~
~~DISTANCE TO DISTAL RESECTION MARGIN~~	~~None~~	~~None~~	Format pattern applied to allow correct reporting of DISTANCE TO DISTAL RESECTION MARGIN			
DISTANCE TO MARGIN	None	None	None	~~d{1,4}.d{1,2}~~	d{1,2}.d{1}	~~Format patte applied to all correct repor DISTANCE T(DISTAL RESI MARGIN~~
~~ETHNIC CATEGORY~~	~~max an2~~	~~None~~	Format pattern applied to allow correct reporting of DISTANCE TO MARGIN			
ETHNIC CATEGORY	max an2	None	None	None	Existing Format/Length means fixed length which is incorrect. Unable to change this as it is used in other data sets. Second character can	

					be for local use. XML Schema allows max an10
FOLLICULAR LYMPHOMA INTERNATIONAL PROGNOSTIC INDEX SCORE	None	None	0-5	None	Range 0-5
FORCED EXPIRATORY VOLUME IN 1 SECOND (ABSOLUTE AMOUNT)	None	None	0.10-9.99	(0.1[0-9]{1}|0.[2-9]{1}[0-9]{1}|[1-9].dd){1}	Range 0.10 to 9.99
FORCED EXPIRATORY VOLUME IN 1 SECOND (PERCENTAGE)	None	None	1-150	None	Range 1 to 150
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
GENERAL MEDICAL PRACTITIONER (SPECIFIED)	None	Removed	None	None	Default codes not enumerated in the XML Schema
GLEASON GRADE (PRIMARY)	None	None	1-5	None	Range 1-5
GLEASON GRADE (SECONDARY)	None	None	1-5	None	Range 1-5
GLEASON GRADE (TERTIARY)	None	None	1-5 and 8	None	Range 1-5 and 8
HAEMOGLOBIN CONCENTRATION (GRAMS PER LITRE)	None	None	10-250	None	Range 10-250
HASENCLEVER INDEX SCORE	None	None	0-7	None	Range 0-7
INTERNATIONAL PROGNOSTIC SCORING SYSTEM SCORE	None	None	0.0-3.0	([0-2]{1}.d{1}|3.0)	Range 0.0-3.0
LESION SIZE (PATHOLOGICAL)	None	None	None	d{1,3}.d{1,2}	~~Format pattern applied to allow correct reporting of LESION SIZE (PATHOLOGICAL)~~
~~LOCAL PATIENT IDENTIFIER~~	~~max an10~~	~~None~~	Format pattern applied to allow correct reporting of LESION SIZE (PATHOLOGICAL)		
LESION SIZE (RADIOLOGICAL)	None	None	None	d{1,3}.d{1,2}	Format pattern applied to allow correct reporting of LESION SIZE (RADIOLOGICAL)
LOCAL PATIENT IDENTIFIER	max an10	None	None	None	Existing format an10 should mean fixed length - however this is incorrect - cannot immediately change format/length in dictionary as used by other data sets. ~~XML~~

					~~Schema allows max an10~~
~~MORPHOLOGY (SNOMED)~~	~~None~~	~~None~~ XML Schema allows max an10			
MORPHOLOGY (SNOMED)	max an18	None	None	d{1,18}	~~Format pattern applied to allow correct reporting of MORPHOLOGY (SNOMED)~~
~~NUMBER OF LYMPHADENOPATHY AREAS~~	~~None~~	~~None~~	Format pattern applied to allow correct reporting of MORPHOLOGY (SNOMED) Current XML Schema format max an18 - to be amended in the next version		
MORPHOLOGY (SNOMED CT)	max n18	None	None	None	Current XML Schema format max n18 - to be amended in the next version
NEUTROPHIL COUNT	None	None	None	d{1,3}(.d){1}	Format pattern applied to allow correct reporting of NEUTROPHIL COUNT
NOTTINGHAM PROGNOSTIC INDEX SCORE	None	None	None	d{1,2}.d{1,2}	Format pattern applied to allow correct reporting of NOTTINGHAM PROGNOSTIC INDEX SCORE
NUMBER OF LYMPHADENOPATHY AREAS	None	None	0-3	None	Range 0-3
ORGANISATION CODE (CODE OF PROVIDER)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
ORGANISATION CODE (CODE OF SUBMITTING ORGANISATION)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
ORGANISATION CODE (OF REPORTING PATHOLOGIST)	min an3 max an12	None	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
PERSON HEIGHT IN METRES	None	None	None	d{1}(.d{1,2}){1}	Format pattern applied to allow correct reporting of PERSON HEIGHT IN METRES
PERSON WEIGHT	None	None	None	d{1,3}(.d{1,3}){1}	~~Format pattern applied to allow correct reporting of PERSON WEIGHT~~
~~PRIMARY DIAGNOSIS (ICD)~~	~~min an4 max an6~~	~~None~~	Format pattern applied to allow correct reporting of PERSON WEIGHT		

PRIMARY PROCEDURE (SNOMED CT)	max n18	None	None	None	~~Existing Format/Length allows for all clinical classifications - XML Schema allows min an4 max an6~~	
~~PROVISIONAL DIAGNOSIS (ICD)~~	~~min an4 max an6~~	~~None~~	Current XML Schema format max n18 - to be amended in the next version			
PROCEDURE (SNOMED CT)	max n18	None	None	None	~~Existing Format/Length allows for all clinical classifications -XML Schema allows min an4 max an6~~	
~~REVISED INTERNATIONAL PROGNOSTIC INDEX SCORE~~	~~None~~	~~None~~	Current XML Schema format max n18 - to be amended in the next version			
PROSTATE SPECIFIC ANTIGEN (DIAGNOSIS)	None	None	None	~~0-5~~	d{1,5}(.d){1}	~~None~~
REVISED INTERNATIONAL PROGNOSTIC INDEX SCORE	None	None	~~Range 0-5~~			
~~SECONDARY DIAGNOSIS (ICD)~~	~~min an4 max an6~~	~~None~~	~~None~~	0-5	None	~~Existing Format/Leng for all clinica classification Schema allo an4 max an6~~
~~SITE CODE (OF AXILLA ULTRASOUND)~~	~~min an3 max an12~~	~~Removed~~	Range 0-5			
SITE CODE (OF AXILLA ULTRASOUND)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes	
SITE CODE (OF BREAST ULTRASOUND)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes	
SITE CODE (OF CLINICAL ASSESSMENT)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes	
SITE CODE (OF IMAGING)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes	
SITE CODE (OF MAMMOGRAM)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes	
SITE CODE (OF PATHOLOGY TEST REQUEST)	min an3 max an12	Removed	None	None	Field size extended to future proof for	

					ODS ORGANISATION CODE changes
SITE CODE (OF PROVIDER CANCER TREATMENT START DATE)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
SITE CODE (OF PROVIDER ENDOSCOPIC OR RADIOLOGICAL PROCEDURE)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
SITE CODE (OF PROVIDER FIRST CANCER SPECIALIST)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
SITE CODE (OF PROVIDER FIRST SEEN)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
SPLEEN BELOW COSTAL MARGIN	None	None	0-50	None	~~Range 0-50~~
~~TOPOGRAPHY (SNOMED)~~	~~None~~	~~None~~	Range 0-50		
TOPOGRAPHY (SNOMED)	max an18	None	None	d{1,18}	~~Format pattern applied to allow correct reporting of TOPOGRAPHY (SNOMED)~~
~~TURP TUMOUR PERCENTAGE~~	~~None~~	~~None~~	Format pattern applied to allow correct reporting of TOPOGRAPHY (SNOMED) Current XML Schema format max an18 - to be amended in the next version		
TOPOGRAPHY (SNOMED CT)	max n18	None	None	None	Current XML Schema format max n18 - to be amended in the next version
TURP TUMOUR PERCENTAGE	None	None	0-100	None	Range 0-100
WHITE BLOOD CELL COUNT (HIGHEST PRETREATMENT)	None	None	None	d{1,3} (.d{1}) {1}	Format pattern applied to allow correct reporting of WHITE BLOOD CELL COUNT (HIGHEST PRETREATMENT)

The following Data Elements are not included in the Cancer Outcomes and Services Data Set Message.

Cancer Registries obtain the data from another source, or the item is submitted under another Standard and is included for reference only:

- RADIOTHERAPY ANATOMICAL TREATMENT SITE (OPCS)
- CANCER CARE SETTING (TREATMENT)
- CANCER REFERRAL TO TREATMENT PERIOD START DATE
- CANCER SCREENING STATUS
- CANCER TREATMENT PERIOD START DATE
- CLINICAL TRIAL INDICATOR
- CONSULTANT UPGRADE DATE
- DATE OF DIAGNOSIS (CANCER REGISTRATION)

- DATE OF RECURRENCE (CANCER REGISTRATION)
- DEATH CAUSE ICD CODE (CONDITION)
- DEATH CAUSE ICD CODE (IMMEDIATE)
- DEATH CAUSE ICD CODE (SIGNIFICANT)
- DEATH CAUSE ICD CODE (UNDERLYING)
- DEATH CAUSE IDENTIFICATION METHOD
- DECISION TO REFER DATE (CANCER OR BREAST SYMPTOMS)
- DELAY REASON (CONSULTANT UPGRADE)
- DELAY REASON (DECISION TO TREATMENT)
- DELAY REASON COMMENT (CONSULTANT UPGRADE)
- DELAY REASON COMMENT (DECISION TO TREATMENT)
- DELAY REASON COMMENT (FIRST SEEN)
- DELAY REASON COMMENT (REFERRAL TO TREATMENT)
- DELAY REASON REFERRAL TO FIRST SEEN (CANCER OR BREAST SYMPTOMS)
- DELAY REASON REFERRAL TO TREATMENT (CANCER)
- DRUG REGIMEN ACRONYM
- DRUG TREATMENT INTENT
- ORGANISATION CODE (GP PRACTICE RESPONSIBILITY)
- ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)
- ORGANISATION CODE (RESIDENCE RESPONSIBILITY)
- PATIENT PATHWAY IDENTIFIER
- PRIORITY TYPE CODE
- RADIOTHERAPY INTENT
- RADIOTHERAPY PRIORITY
- RADIOTHERAPY TOTAL DOSE
- RADIOTHERAPY TOTAL FRACTIONS
- SITE CODE (OF PROVIDER CANCER DECISION TO TREAT)
- SITE CODE (OF PROVIDER CONSULTANT UPGRADE)
- TWO WEEK WAIT CANCER OR SYMPTOMATIC BREAST REFERRAL TYPE
- WAITING TIME ADJUSTMENT (FIRST SEEN)
- WAITING TIME ADJUSTMENT (TREATMENT)
- WAITING TIME ADJUSTMENT REASON (FIRST SEEN)
- WAITING TIME ADJUSTMENT REASON (TREATMENT)

COMMISSIONING DATA SET VERSION 6-2 XML SCHEMA CONSTRAINTS

Change to XML Schema Constraint: Changed Description

XML Schema constraints applied to the Commissioning Data Sets.

The "Allowed Values" column indicates the NHS Data Model and Dictionary National Codes and Default Codes present in the XML Schema:

- None = The National Codes and Default Codes are included in the XML Schema
- Removed = The National Codes and Default Codes are not included in the XML Schema.

Data Element	XML Schema Format/Length	Allowed Values	Range
A and E ATTENDANCE NUMBER	max an12	None	None
ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST	min an2 max an6	None	None
ACCIDENT AND EMERGENCY	min an2 max an6	None	None

DIAGNOSIS - SECOND			
ACCIDENT AND EMERGENCY INVESTIGATION - FIRST	min an2 max an6	None	None
ACCIDENT AND EMERGENCY INVESTIGATION - SECOND	min an2 max an6	None	None
ACCIDENT AND EMERGENCY TREATMENT - FIRST	min an2 max an6	None	None
ACCIDENT AND EMERGENCY TREATMENT - SECOND	min an2 max an6	None	None
ADVANCED CARDIOVASCULAR SUPPORT DAYS	max n3	None	None
ADVANCED RESPIRATORY SUPPORT DAYS	max n3	None	None
AGE AT CDS ACTIVITY DATE	max n3	None	None
AGE AT CENSUS	max n3	None	None
AGE ON ADMISSION	max n3	None	None
ATTENDANCE IDENTIFIER	max an12	None	None
BASIC CARDIOVASCULAR SUPPORT DAYS	max n3	None	None
BASIC RESPIRATORY SUPPORT DAYS	max n3	None	None
BIRTH WEIGHT	max n4	None	None
CARE PROFESSIONAL MAIN SPECIALTY CODE	None	100,101,110,120,130,140,141,142,143,145,146,147,148,149,150,160,170,171,180,190,192,300,301,302,303,304,305,310,311,312,313,314,315,320,321,325,326,330,340,350,352,360,361,370,371,400,401,410,420,421,430,450,451,460,501,502,504,560,600,601,700,710,711,712,713,715,800,810,820,821,822,823,824,830,831,833,834,900,901,902,903,904,950,960,199,499	None
CDS COPY RECIPIENT IDENTITY	min an3 max an12	Removed	None
CDS MESSAGE REFERENCE	max n7	None	None
CDS MESSAGE VERSION NUMBER	None	CDS062	None
		Removed	None

CDS PRIME RECIPIENT IDENTITY	min an3 max an12		
CDS SENDER IDENTITY	min an3 max an12	None	None
CDS UNIQUE IDENTIFIER	max an35	None	None
COMMISSIONER REFERENCE NUMBER	max an17	None	None
COMMISSIONING SERIAL NUMBER	max an6	None	None
CONSULTATION MEDIUM USED	None	01,02,03,04	None
COUNT OF DAYS SUSPENDED	max n4	None	None
CRITICAL CARE LEVEL 2 DAYS	max n3	None	None
CRITICAL CARE LEVEL 3 DAYS	max n3	None	None
CRITICAL CARE LOCAL IDENTIFIER	max an8	None	None
DERMATOLOGICAL SUPPORT DAYS	max n3	None	None
DURATION OF CARE TO PSYCHIATRIC CENSUS DATE	max n5	None	None
DURATION OF DETENTION	max n5	None	None
DURATION OF ELECTIVE WAIT	max n4	None	None
ELECTIVE ADMISSION LIST ENTRY NUMBER	max an12	None	None
EPISODE NUMBER	max an2	None	None
ETHNIC CATEGORY	max an2	None	None
	max n3	None	None

GASTRO-INTESTINAL SUPPORT DAYS			
GENERAL MEDICAL PRACTITIONER PRACTICE (ANTENATAL CARE)	min an3 max an12	Removed	None
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	min an3 max an12	Removed	None
GENERAL MEDICAL PRACTITIONER (ANTENATAL CARE)	None	Removed	None
GENERAL MEDICAL PRACTITIONER (SPECIFIED)	None	Removed	None
HOSPITAL PROVIDER SPELL NUMBER	max an12	None	None
INTENDED SITE CODE (OF TREATMENT)	min an3 max an12	Removed	None
LIVER SUPPORT DAYS	max n3	None	None
LOCAL PATIENT IDENTIFIER	max an10	None	None
LOCAL PATIENT IDENTIFIER (BABY)	max an10	None	None
LOCAL PATIENT IDENTIFIER (MOTHER)	max an10	None	None
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (AT CENSUS DATE)	None	01,02,03,04,05,06,07,08,09,10,11,12,13,14, 15,16,17,18,19,20,31,32,34,35,36,37,38	None
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION)	None	01,02,03,04,05,06,07,08,09,10,11,12,13,14, 15,16,17,18,19,20,31,32,34,35,36,37,38	None
NEUROLOGICAL SUPPORT DAYS	max n3	None	None
NHS SERVICE AGREEMENT LINE NUMBER	max an10	None	None
	None	None	00-06

ORGAN SUPPORT MAXIMUM			
ORGANISATION CODE (CODE OF COMMISSIONER)	min an3 max an12	Removed	None
ORGANISATION CODE (CODE OF PROVIDER)	min an3 max an12	Removed	None
ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)	min an3 max an12	None	None
ORGANISATION CODE (LOCAL PATIENT IDENTIFIER (BABY))	min an3 max an12	None	None
ORGANISATION CODE (LOCAL PATIENT IDENTIFIER (MOTHER))	min an3 max an12	None	None
ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)	min an3 max an12	None	None
ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	min an3 max an12	Removed	None
PERSON WEIGHT	n3.n3	None	None
~~PRIMARY DIAGNOSIS (ICD)~~	~~min an4 max an6~~	~~None~~max n3 - XML Schema enforces 3 digits before and after the decimal point - max removed	
PRIMARY DIAGNOSIS (READ)	max an5	None	None
~~PRIMARY DIAGNOSIS (READ)~~	~~max an5~~	~~None~~	~~None~~
PROVIDER REFERENCE NUMBER	max an17	None	None
REFERRER CODE	None	Removed	None
REFERRING ORGANISATION CODE	min an3 max an12	Removed	None
RENAL SUPPORT DAYS	max n3	None	None

~~SECONDARY DIAGNOSIS (ICD)~~	~~min an4 max an6~~	~~None~~	Existing Format/Leng states n3 - XML Schema allows max
SECONDARY DIAGNOSIS (READ)	max an5	None	None
~~SECONDARY DIAGNOSIS (READ)~~	~~max an5~~	~~None~~	~~None~~
SITE CODE (OF TREATMENT)	min an3 max an12	Removed	None

HIV AND AIDS REPORTING DATA SET XML SCHEMA CONSTRAINTS

Change to XML Schema Constraint: Changed Description

XML Schema constraints applied to the HIV and AIDS Reporting Data Set.

The "Allowed Values" column indicates the NHS Data Model and Dictionary National Codes and Default Codes present in the XML Schema:

- None = The National Codes and Default Codes are included in the XML Schema
- Removed = The National Codes and Default Codes are not included in the XML Schema.

Data Element	XML Schema Format/Length	Allowed Values	Range	Pattern Match	Reason / Comment / XML Choice
CLINICAL TRIAL INDICATOR	an1	01,02	None	None	~~Default Code 99 is not valid for the HIV and AIDS Reporting Data Set~~
~~DEATH CAUSE ICD CODE (CONDITION)~~	~~min an4 max an6~~	~~None~~	Default Code 99 is not valid for the HIV and AIDS Reporting Data Set		
ETHNIC CATEGORY	max an2	None	None	None	~~Existing Format/Length allows for all clinical classifications - XML Schema allows min an4 max an6~~
~~ETHNIC CATEGORY~~	~~max an2~~	~~None~~	~~None~~	~~None~~	Existing Format/Length means fixed length which is incorrect. Unable to change this as it is used in other data sets. Second character can be for local use. Format/Length amended to max an2.
GENERAL MEDICAL PRACTICE CODE	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes

(PATIENT REGISTRATION)					
LOWER LAYER SUPER OUTPUT AREA (RESIDENCE)	an9	Removed	None	None	Existing Format/Length annnnnnnn - XML Schema format an9
ORGANISATION CODE (CODE OF PROVIDER)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION SITE CODE changes
ORGANISATION CODE (CODE OF SUBMITTING ORGANISATION)	min an3 max an12	None	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
SITE CODE (OF PREVIOUS HIV CARE)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION SITE CODE changes
SITE CODE (OF TREATMENT)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION SITE CODE changes
SITE CODE (REFERRED TO FOR HIV CARE)	min an3 max an12	None	None	None	Field size extended to future proof for ODS ORGANISATION SITE CODE changes
TEST OF RECENT INFECTION RESULT (HIV)	None	None	1-120	None	Range 1-120 plus default code 999

For enquiries about this Change Request, please email information.standards@hscic.gov.uk