NHS Data Model and Dictionary

Type:	Data Dictionary Change Notice
Reference:	1934
Version No:	1.0
Subject:	Default Codes Description Updates
Effective Date:	Immediate
Reason for Change:	Updates to Default Code descriptions
Publication Date:	21 January 2025

Background:

As part of the migration to new software for the management of the NHS Data Model and Dictionary, it has been noted that there are slight amendments required to the wording of some Default Codes descriptions. This has been identified where there are multiple Data Elements which are associated with a single attribute, which use the same Default Code.

This Data Dictionary Change Notice (DDCN):

- Updates Default Code descriptions to make them consistent. Notes have been added to items where required. This includes removing extra HTML, which is not evident in the descriptions.
- Adds new Attributes where the default code description does not match any other linked to the existing Attribute.

A short demonstration is available which describes "How to Read an NHS Data Model and Dictionary Change Request", in an easy to understand screen capture including a voice over and readable captions. This demonstration can be viewed at: https://datadictionary.nhs.uk/elearning/change_request/index.html.

Note: if the web page does not open, please copy the link and paste into the web browser. A guide to how to use the demonstration can be found at: Demonstrations.

Summary of changes:

Class Definitions	
ACTIVITY	Changed Attributes
CLINICAL INVESTIGATION RESULT ITEM	Changed Attributes

Attribute Definitions

TEST OF RECENT INFECTION RESULT FOR HIV	New Attribute
TIME BETWEEN DELIVERY AND UMBILICAL CORD CLAMPING	New Attribute

Data Elements

ADVANCED CARDIOVASCULAR SUPPORT DAYS	Changed Description
ADVANCED RESPIRATORY SUPPORT DAYS	Changed Description
AGE AT ATTENDANCE DATE	Changed Description
BASE DEFICIT CONCENTRATION (WORST WITHIN 12 HOURS AFTER BIRTH)	Changed Description
BASIC CARDIOVASCULAR SUPPORT DAYS	Changed Description
BASIC RESPIRATORY SUPPORT DAYS	Changed Description
BIRTH HEAD CIRCUMFERENCE IN CENTIMETRES	Changed Description
BIRTH LENGTH IN CENTIMETRES	Changed Description
BLOOD GLUCOSE CONCENTRATION (ON ADMISSION TO NEONATAL CRITICAL CARE)	Changed Description
BLOOD GLUCOSE CONCENTRATION (ON NEONATAL CRITICAL CARE DAILY CARE DATE)	Changed Description
COUNTRY CODE (BIRTH)	Changed Description
COUNTRY CODE (FATHER BIRTH)	Changed Description
COUNTRY CODE (FATHER ORIGIN)	Changed Description
COUNTRY CODE (FEMALE GENITAL MUTILATION PERFORMED)	Changed Description
COUNTRY CODE (ORIGIN)	Changed Description
CRITICAL CARE LEVEL 2 DAYS	Changed Description
CRITICAL CARE LEVEL 3 DAYS	Changed Description
DERMATOLOGICAL SUPPORT DAYS	Changed Description
GASTRO-INTESTINAL SUPPORT DAYS	Changed Description
GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION)	Changed Description
GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION MOTHER)	Changed Description
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION (MOTHER))	Changed Description
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	Changed Description
HEAD CIRCUMFERENCE IN CENTIMETRES	Changed Description

HEART RATE (ON ADMISSION TO NEONATAL CRITICAL CARE)	Changed Description
LIVER SUPPORT DAYS	Changed Description
MEAN ARTERIAL BLOOD PRESSURE (ON ADMISSION TO NEONATAL CRITICAL CARE)	Changed Description
NEUROLOGICAL SUPPORT DAYS	Changed Description
ORGANISATION CODE (CODE OF COMMISSIONER)	Changed Description
ORGANISATION CODE (RESPONSIBLE PCT)	Changed Description
ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	Changed Description
ORGANISATION SITE IDENTIFIER (AT START OF INTRAPARTUM CARE)	Changed Description
ORGANISATION SITE IDENTIFIER (DISCHARGE FROM EMERGENCY CARE)	Changed Description
ORGANISATION SITE IDENTIFIER (DISCHARGE FROM URGENT AND EMERGENCY CARE)	Changed Description
ORGANISATION SITE IDENTIFIER (EMERGENCY CARE ATTENDANCE SOURCE)	Changed Description
ORGANISATION SITE IDENTIFIER (EMPLOYING ORGANISATION)	Changed Description
ORGANISATION SITE IDENTIFIER (OF ACUTE ONCOLOGY ASSESSMENT)	Changed Description
ORGANISATION SITE IDENTIFIER (OF ADMITTING NEONATAL UNIT)	Changed Description
ORGANISATION SITE IDENTIFIER (OF ANTENATAL BOOKING)	Changed Description
ORGANISATION SITE IDENTIFIER (OF CANCER FASTER DIAGNOSIS PATHWAY END DATE)	Changed Description
ORGANISATION SITE IDENTIFIER (OF CANCER SITE SPECIFIC STAGE)	Changed Description
ORGANISATION SITE IDENTIFIER (OF DIAGNOSIS)	Changed Description
ORGANISATION SITE IDENTIFIER (OF DIAGNOSTIC PROCEDURE)	Changed Description
ORGANISATION SITE IDENTIFIER (OF IMAGING)	Changed Description
ORGANISATION SITE IDENTIFIER (OF MULTIDISCIPLINARY TEAM MEETING)	Changed Description
ORGANISATION SITE IDENTIFIER (OF NEONATAL TREATMENT)	Changed Description
ORGANISATION SITE IDENTIFIER (OF PATHOLOGY TEST REQUEST)	Changed Description
ORGANISATION SITE IDENTIFIER (OF PLANNED DELIVERY)	Changed Description

ORGANISATION SITE IDENTIFIER (OF PROVIDER CANCER DECISION TO TREAT)	Changed Description
ORGANISATION SITE IDENTIFIER (OF PROVIDER CANCER TREATMENT START DATE)	Changed Description
ORGANISATION SITE IDENTIFIER (OF PROVIDER CONSULTANT UPGRADE)	Changed Description
ORGANISATION SITE IDENTIFIER (OF PROVIDER FIRST CANCER SPECIALIST)	Changed Description
ORGANISATION SITE IDENTIFIER (OF PROVIDER FIRST SEEN)	Changed Description
ORGANISATION SITE IDENTIFIER (OF PROVIDER FIRST SEEN NON PRIMARY CANCER PATHWAY)	Changed Description
ORGANISATION SITE IDENTIFIER (OF RETINOPATHY OF PREMATURITY SCREENING)	Changed Description
ORGANISATION SITE IDENTIFIER (OF TNM STAGE GROUPING FINAL PRETREATMENT)	Changed Description
ORGANISATION SITE IDENTIFIER (OF TNM STAGE GROUPING INTEGRATED)	Changed Description
ORGANISATION SITE IDENTIFIER (OF TREATMENT)	Changed Description
ORGANISATION SITE IDENTIFIER (OF TWO YEAR NEONATAL OUTCOMES ASSESSMENT)	Changed Description
ORGANISATION SITE IDENTIFIER (OF TWO YEAR NEONATAL OUTCOMES ASSESSMENT FOLLOWING DISCHARGE)	Changed Description
ORGANISATION SITE IDENTIFIER (OF WARD)	Changed Description
ORGANISATION SITE IDENTIFIER (RECEIVING POST DISCHARGE FROM NEONATAL CARE)	Changed Description
ORGANISATION SITE IDENTIFIER (URGENT AND EMERGENCY CARE ATTENDANCE SOURCE)	Changed Description
OXYGEN SATURATION (ON ADMISSION TO NEONATAL CRITICAL CARE)	Changed Description
PERSON LENGTH IN CENTIMETRES	Changed Description
PREGNANCY TOTAL PREVIOUS PREGNANCIES	Changed Description
RENAL SUPPORT DAYS	Changed Description
RESPIRATORY RATE (ON ADMISSION TO NEONATAL CRITICAL CARE)	Changed Description
TEST OF RECENT INFECTION RESULT (HIV)	Changed Description, linked Attribute
TIME BETWEEN DELIVERY AND UMBILICAL CORD CLAMPING	Changed Description, linked Attribute
	Changed Description

UMBILICAL CORD BLOOD PARTIAL PRESSURE CARBON DIOXIDE (ARTERIAL)	
UMBILICAL CORD BLOOD PARTIAL PRESSURE CARBON DIOXIDE (VENOUS)	Changed Description
UMBILICAL CORD BLOOD PH LEVEL (ARTERIAL)	Changed Description
UMBILICAL CORD BLOOD PH LEVEL (VENOUS)	Changed Description

Date: 21 January 2025

Sponsor: Tomas Sanchez Lopez, Director Technology and Data Integration, Data and Analytics, NHS England

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.

ACTIVITY

Change to Class: Changed Attributes

Attributes of this Class are:

K	ACTIVITY IDENTIFIER
	ACTIVITY COUNT
	ACTIVITY DURATION
	ACTIVITY PERCENTAGE
	CONTRACT MONITORING ACTUAL ACTIVITY
	GS1 SERVICE RELATION INSTANCE NUMBER
	INDIRECT ACTIVITY PERSON CONSULTED TYPE
	TIME BETWEEN DELIVERY AND UMBILICAL CORD CLAMPING
	URGENT AND EMERGENCY CARE ACTIVITY TYPE

CLINICAL INVESTIGATION RESULT ITEM

Change to Class: Changed Attributes

Attributes of this Class are:

K	INVESTIGATION RESULT DATE
	ABNORMALITY DETECTED INDICATOR
	ACUTE MYELOID LEUKAEMIA RISK FACTORS
	AMNIONICITY STATUS

ANKLE DORSIFLEXION CODE FOR PRIMARY ANKLE REPLACEMENT

ANKLE PLANTARFLEXION CODE FOR PRIMARY ANKLE REPLACEMENT

BLOOD PRODUCTS REQUIRED FOLLOWING OESOPHAGECTOMY INDICATION CODE

BREAST BIOPSY REFERRAL OUTCOME

BREAST CANCER HISTOLOGICAL TYPE

BREAST PROGESTERONE RECEPTOR STATUS

BREAST SCREENING MAMMOGRAPHY OUTCOME CODE

CANCER SPECIMEN NATURE

CANCER SURGICAL ADMISSION TYPE

CANCER VASCULAR OR LYMPHATIC INVASION

CENTRAL TONE STATUS

CEREBRAL FUNCTION MONITORING BRAIN ACTIVITY RESULT CODE

CERVICAL GLANDULAR INTRAEPITHELIAL NEOPLASIA PRESENCE AND GRADE

CERVICAL GLANDULAR INTRAEPITHELIAL NEOPLASIA PRESENCE INDICATION CODE

CHLAMYDIA TEST RESULT

CHORIONICITY STATUS

CLINICAL FRAILTY SCALE POINT

CLINICAL INVESTIGATION RESULT ANALYSED DATE

CLINICAL INVESTIGATION RESULT RECEIVED DATE

CLINICAL INVESTIGATION RESULT VALUE

CONDITION SEEN IN ABDOMEN DURING XRAY

CYSTIC PERIVENTRICULAR LEUKOMALACIA OBSERVED DURING CRANIAL ULTRASOUND SCAN INDICATOR

CYTOGENETIC ABNORMALITY RISK GROUP

CYTOGENETIC RISK GROUP FOR PAEDIATRIC MOLECULAR GENETIC ABNORMALITIES

CYTOLOGY RESULT CODE FOR AXILLARY LYMPH NODE

CYTOLOGY RESULT CODE FOR BREAST

DEGREES OF FIXED FLEXION DEFORMITY FOR PRIMARY KNEE REPLACEMENT

DEGREES OF FLEXION RANGE FOR PRIMARY KNEE REPLACEMENT

DETRUSOR MUSCLE PRESENCE INDICATION CODE FOR BLADDER CANCER

ENDOMETRIAL OESTROGEN RECEPTOR STATUS

EPSTEIN BARR VIRUS IN SITU HYBRIDISATION TEST RESULT

EXCISION MARGIN INDICATION CODE

FINDING SCHEME IN USE

GENETIC CONFIRMATION INDICATOR

GRADE OF DIFFERENTIATION

GYNAECOLOGICIAL CANCER SITE OF PERITONEAL INVOLVEMENT

HAEMATOLOGICAL CENTRAL NERVOUS SYSTEM INVOLVEMENT STATUS

HAEMOGLOBINOPATHY INVESTIGATION RESULT CODE FOR NATIONAL NEONATAL DATA SET

HEPATITIS B INFECTION INDICATION CODE

HEPATITIS B STATUS

HEPATITIS C INFECTION INDICATION CODE

HEPATITIS C STATUS

HIV STATUS

HORMONE EXPRESSION TYPE

HUMAN EPIDERMAL GROWTH FACTOR IN SITU HYBRIDISATION RECEPTOR STATUS FOR BREAST CANCER

HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR 2 IMMUNOHISTOCHEMICAL SCORE

HUMAN PAPILLOMAVIRUS IN SITU HYBRIDISATION TEST RESULT

IMMUNOHISTOCHEMISTRY NUCLEAR EXPRESSION INTACT INDICATION CODE

INTRAVENTRICULAR HAEMORRHAGE GRADE

INVASIVE CANCER SPECIAL TYPE INDICATOR

INVESTIGATION EXAMINATION RESULT

INVESTIGATION RESULT CODE FOR MOTHER RUBELLA SCREENING

LEUKAEMIC CELLS PRESENT POST MINIMAL RESIDUAL DISEASE INDUCTION PERCENTAGE CODE

LYMPH NODE STATUS

MACROSCOPIC EXTRAGLANDULAR EXTENSION INDICATOR

METASTASIS EXTENT CODE

MICROSCOPIC INVOLVEMENT INDICATION CODE FOR FALLOPIAN TUBE OR OVARIAN CANCER

MICROSCOPIC INVOLVEMENT INDICATION CODE FOR UTERINE SEROSA

MICROSCOPIC INVOLVEMENT INDICATOR FOR PARAMETRIUM OR CERVICAL STROMA

MICROSCOPIC INVOLVEMENT INDICATOR FOR VAGINAL

NEWBORN BLOOD SPOT TEST OUTCOME STATUS

NEWBORN HEARING AUDIOLOGY OUTCOME

NEWBORN HEARING SCREENING OUTCOME

NEWBORN HEARING SCREENING OUTCOME FOR NATIONAL NEONATAL DATA SET

NUMBER OF FETUSES

OBSERVATION VALUE

OESOPHAGECTOMY OESOPHAGEAL CONDUIT NECROSIS FAILURE TYPE

OESOPHAGOENTERIC LEAK SEVERITY TYPE

OESTROGEN RECEPTOR STATUS

ORGAN SUPPORT MAXIMUM

OTHER NON BREAST LOCALLY ADVANCED METASTATIC MALIGNANCY INDICATOR

P16 IMMUNOHISTOCHEMISTRY TEST RESULT

P53 IMMUNOHISTOCHEMICAL TEST RESULT

PAEDIATRIC MYELODYSPLASIA CLINICAL FINDINGS

PATHOLOGICAL RISK CLASSIFICATION CODE AFTER NEPHRECTOMY

PATHOLOGICAL RISK CLASSIFICATION CODE AFTER PREOPERATIVE CHEMOTHERAPY

PERINEURAL INVASION PRESENCE INDICATION CODE

PERITONEAL INVOLVEMENT INDICATION CODE

PERSON BLOOD GROUP

PERSON GENOTYPIC SEX FOR NATIONAL NEONATAL DATA SET

PERSON RHESUS FACTOR

PORENCEPHALIC CYST VISIBLE DURING CRANIAL ULTRASOUND SCAN INDICATOR

PREOPERATIVE THERAPY RESPONSE TYPE

PRIMITIVE REFLEXES STATUS

RECURRENT LARYNGEAL NERVE INJURY INVOLVEMENT TYPE

RENAL VEIN TUMOUR INDICATOR FOR PAEDIATRIC KIDNEY

RENAL VEIN TUMOUR THROMBUS INDICATION CODE FOR UROLOGICAL

RETINOPATHY OF PREMATURITY CLOCK HOURS MAXIMUM STAGE

RETINOPATHY OF PREMATURITY MAXIMUM ZONE

RETINOPATHY OF PREMATURITY PLUS DISEASE STATUS

RETINOPATHY OF PREMATURITY STAGE

S CATEGORY CODE

SENTINEL LYMPH NODE BIOPSY OUTCOME

SITUATION SCHEME IN USE

SKIN CANCER PERINEURAL INVASION EXTENT

SKIN ULCERATION PRESENCE INDICATION CODE

SUBTALAR JOINT MOVEMENT CODE FOR PRIMARY ANKLE REPLACEMENT

SYPHILIS STATUS

TEST OF RECENT INFECTION RESULT FOR HIV

TIBIA HINDFOOT ALIGNMENT CODE FOR PRIMARY ANKLE REPLACEMENT

TUMOUR NECROSIS INDICATION CODE

VENTRICULAR DILATION DIAGNOSED DURING CRANIAL ULTRASOUND SCAN INDICATOR

VIABLE TUMOUR EVIDENCE AT RESECTION MARGIN

ZYGOSITY STATUS

TEST OF RECENT INFECTION RESULT FOR HIV

Change to Attribute: New Attribute

The result of the Clinical Investigation which measures the PATIENT's Avidity Score (a test used in conjunction with other information, to classify a newly diagnosed Human Immunodeficiency Virus (HIV) infection as recent or long standing), as recorded at the HIV Clinic Attendance.

This attribute is also known by these names:

Context	Alias
plural	TEST OF RECENT INFECTION RESULTS FOR HIV

TEST OF RECENT INFECTION RESULT FOR HIV

Change to Attribute: New Attribute

TEST OF RECENT INFECTION RESULT FOR HIV

Data Elements:

TEST OF RECENT INFECTION RESULT (HIV)

TIME BETWEEN DELIVERY AND UMBILICAL CORD CLAMPING

Change to Attribute: New Attribute

The amount of time in seconds between the Delivery of a baby and the Patient Procedure to clamp the umbilical cord.

TIME BETWEEN DELIVERY AND UMBILICAL CORD CLAMPING

Change to Attribute: New Attribute

TIME BETWEEN DELIVERY AND UMBILICAL CORD CLAMPING

Data Elements:

TIME BETWEEN DELIVERY AND UMBILICAL CORD CLAMPING

ADVANCED CARDIOVASCULAR SUPPORT DAYS

Change to Data Element: Changed Description

Format/Length:	max an3
National Codes:	
~~Default Codes:~~	~~998 - 998 or more days of advanced cardiovascular support~~
	~~999 - Occurred but day count not known~~
Default Codes:	998 - 998 or more days of critical care support
	999 - Occurred but critical care day count not known

Notes:
ADVANCED CARDIOVASCULAR SUPPORT DAYS is the same as attribute ACTIVITY DURATION.

ADVANCED CARDIOVASCULAR SUPPORT DAYS is the total number of days that the PATIENT received advanced cardiovascular support during a CRITICAL CARE PERIOD, ranging from 0 to 997 days.

ADVANCED CARDIOVASCULAR SUPPORT DAYS is derived from the difference between the ACTIVITY PROPERTY EFFECTIVE DATE and the ACTIVITY PROPERTY END DATE for all ACTIVITY PROPERTIES where the ORGAN SYSTEM SUPPORTED is National Code '*Advanced Cardiovascular Support*' within the CRITICAL CARE PERIOD.

ADVANCED CARDIOVASCULAR SUPPORT DAYS is used by the Secondary Uses Service to derive the **Healthcare Resource Group 4**. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS England website at: Payment by Results Guidance.

~~Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.~~Notes:

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Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

ADVANCED RESPIRATORY SUPPORT DAYS

Change to Data Element: Changed Description

Format/Length:	max an3
National Codes:	
~~Default Codes:~~	~~998 - 998 or more days of advanced respiratory support~~
	~~999 - Occurred but day count not known~~
Default Codes:	998 - 998 or more days of critical care support
	999 - Occurred but critical care day count not known

Notes:
ADVANCED RESPIRATORY SUPPORT DAYS is the same as attribute ACTIVITY DURATION.

ADVANCED RESPIRATORY SUPPORT DAYS is the total number of days that the PATIENT received advanced respiratory support during a CRITICAL CARE PERIOD, ranging from 0 to 997 days.

ADVANCED RESPIRATORY SUPPORT DAYS is derived from the difference between the ACTIVITY PROPERTY EFFECTIVE DATE and the ACTIVITY PROPERTY END DATE for all ACTIVITY PROPERTIES where the ORGAN SYSTEM SUPPORTED is National Code '*Advanced Respiratory Support*' within the CRITICAL CARE PERIOD.

ADVANCED RESPIRATORY SUPPORT DAYS is used by the Secondary Uses Service to derive the **Healthcare Resource Group 4**. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS England website at: Payment by Results Guidance.

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- Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

AGE AT ATTENDANCE DATE

Change to Data Element: Changed Description

Format/Length:	n3
National Codes:	
~~Default Codes:~~	~~999 - Not known i.e. date of birth not known and age cannot be estimated.~~
Default Codes:	999 - Not known i.e. date of birth not known and age cannot be estimated

Notes:
AGE AT ATTENDANCE DATE is the same as attribute PERSON AGE.

AGE AT ATTENDANCE DATE is derived as the number of completed years between the PERSON BIRTH DATE of the PATIENT and the ATTENDANCE DATE **or** the estimated age of the PATIENT.

BASE DEFICIT CONCENTRATION (WORST WITHIN 12 HOURS AFTER BIRTH)

Change to Data Element: Changed Description

Format/Length:	max n2.n1
National Codes:	
~~Default Codes:~~	~~99.9 - Worst base deficit not known~~
Default Codes:	99.9 - CLINICAL INVESTIGATION RESULT VALUE not known

Notes:
BASE DEFICIT CONCENTRATION (WORST WITHIN 12 HOURS AFTER BIRTH) is the same as attribute CLINICAL INVESTIGATION RESULT VALUE.

BASE DEFICIT CONCENTRATION (WORST WITHIN 12 HOURS AFTER BIRTH) is the worst deficit result of any Clinical Investigation which measures the PERSON's base excess concentration, where the UNIT OF MEASUREMENT is '*Millimoles per litre (mmol/L)*', taken within twelve hours of the PERSON BIRTH DATE (BABY).

Note: Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

BASIC CARDIOVASCULAR SUPPORT DAYS

Change to Data Element: Changed Description

Format/Length:	max an3
National Codes:	
~~Default Codes:~~	~~998 - 998 or more days of basic cardiovascular support~~
	~~999 - Occurred but day count not known~~
Default Codes:	998 - 998 or more days of critical care support
	999 - Occurred but critical care day count not known

Notes:
BASIC CARDIOVASCULAR SUPPORT DAYS is the same as attribute ACTIVITY DURATION.

BASIC CARDIOVASCULAR SUPPORT DAYS is the total number of days that the PATIENT received basic cardiovascular support during a CRITICAL CARE PERIOD, ranging from 0 to 997 days.

BASIC CARDIOVASCULAR SUPPORT DAYS is derived from the difference between the ACTIVITY PROPERTY EFFECTIVE DATE and the ACTIVITY PROPERTY END DATE for all ACTIVITY PROPERTIES where the ORGAN SYSTEM SUPPORTED is National Code '*Basic Cardiovascular Support*' within the CRITICAL CARE PERIOD.

BASIC CARDIOVASCULAR SUPPORT DAYS is used by the Secondary Uses Service to derive the **Healthcare Resource Group 4**. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS England website at: Payment by Results Guidance.

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Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

BASIC RESPIRATORY SUPPORT DAYS

Change to Data Element: Changed Description

Format/Length:	max an3
National Codes:	
~~Default Codes:~~	~~998 - 998 or more days of basic respiratory support~~ ~~999 - Occurred but day count not known~~
Default Codes:	998 - 998 or more days of critical care support 999 - Occurred but critical care day count not known

Notes:
BASIC RESPIRATORY SUPPORT DAYS is the same as attribute ACTIVITY DURATION.

BASIC RESPIRATORY SUPPORT DAYS is the total number of days that the PATIENT received basic respiratory support during a CRITICAL CARE PERIOD, ranging from 0 to 997 days.

BASIC RESPIRATORY SUPPORT DAYS is derived from the difference between the ACTIVITY PROPERTY EFFECTIVE DATE and the ACTIVITY PROPERTY END DATE for all ACTIVITY PROPERTIES where the ORGAN SYSTEM SUPPORTED is National Code '*Basic Respiratory Support'* within the CRITICAL CARE PERIOD.

BASIC RESPIRATORY SUPPORT DAYS is used by the Secondary Uses Service to derive the **Healthcare Resource Group 4**. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS England website at: Payment by Results Guidance.

~~Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.~~Notes:

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Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

BIRTH HEAD CIRCUMFERENCE IN CENTIMETRES

Change to Data Element: Changed Description

Format/Length:	max n2.n1
National Codes:	
~~Default Codes:~~	~~99.9 - Baby's Head Circumference at birth unknown~~
Default Codes:	99.9 - CLINICAL INVESTIGATION RESULT VALUE not known

Notes:
BIRTH HEAD CIRCUMFERENCE IN CENTIMETRES is the same as attribute CLINICAL INVESTIGATION RESULT VALUE.

BIRTH HEAD CIRCUMFERENCE IN CENTIMETRES is result of the Clinical Investigation which measures the Birth Head Circumference, where the UNIT OF MEASUREMENT is *'Centimetres (cm)'*.

Note: Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

BIRTH LENGTH IN CENTIMETRES

Change to Data Element: Changed Description

Format/Length:	max n2.n1
National Codes:	
~~Default Codes:~~	~~99.9 - Baby's length at birth unknown~~
Default Codes:	99.9 - CLINICAL INVESTIGATION RESULT VALUE not known

Notes:
BIRTH LENGTH IN CENTIMETRES is the same as attribute CLINICAL INVESTIGATION RESULT VALUE.

BIRTH LENGTH IN CENTIMETRES is the result of the Clinical Investigation which measures the Birth Length, where the UNIT OF MEASUREMENT is *'Centimetres (cm)'*.

Note: Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

BLOOD GLUCOSE CONCENTRATION (ON ADMISSION TO NEONATAL CRITICAL CARE)

Change to Data Element: Changed Description

Format/Length:	max n2.max n1
National Codes:	
~~Default Codes:~~	~~99.9 – Blood Glucose Concentration unknown~~
Default Codes:	99.9 - CLINICAL INVESTIGATION RESULT VALUE not known

Notes:

BLOOD GLUCOSE CONCENTRATION (ON ADMISSION TO NEONATAL CRITICAL CARE) is the same as attribute CLINICAL INVESTIGATION RESULT VALUE.

BLOOD GLUCOSE CONCENTRATION (ON ADMISSION TO NEONATAL CRITICAL CARE) is the result of the Clinical Investigation which measures the baby's Blood Glucose Concentration, where the UNIT OF MEASUREMENT is *'Millimoles per litre (mmol/L)'*, on admission to Neonatal Critical Care.

The value is presented in the range 0.0 - 50.0.

Note: Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

BLOOD GLUCOSE CONCENTRATION (ON NEONATAL CRITICAL CARE DAILY CARE DATE)

Change to Data Element: Changed Description

Format/Length:	max n2.max n1
National Codes:	
~~Default Codes:~~	~~99.9 - Blood Glucose Concentration unknown~~
Default Codes:	99.9 - CLINICAL INVESTIGATION RESULT VALUE not known

Notes:
BLOOD GLUCOSE CONCENTRATION (ON NEONATAL CRITICAL CARE DAILY CARE DATE) is the same as attribute CLINICAL INVESTIGATION RESULT VALUE.

BLOOD GLUCOSE CONCENTRATION (ON NEONATAL CRITICAL CARE DAILY CARE DATE) is the result of the Clinical Investigation which measures the baby's lowest Blood Glucose Concentration on the Neonatal Critical Care Daily Care Date, where the UNIT OF MEASUREMENT is *'Millimoles per litre (mmol/L)'*.

The value is presented in the range 0.0 - 50.0.

Note: Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

COUNTRY CODE (BIRTH)

Change to Data Element: Changed Description

Format/Length:	a3
National Codes:	
~~Default Codes:~~	~~XXX - Unknown: only valid for use in the Female Genital Mutilation Data Set~~ ~~ZZZ - Not stated (PERSON asked but declined to provide a response): only valid for use in the GUMCAD Sexually Transmitted Infection Surveillance System Data Set and Female Genital Mutilation Data Set~~
Default Codes:	XXX - COUNTRY CODE not known ZZZ - Not stated (PERSON asked but declined to provide a response)

Notes:
COUNTRY CODE (BIRTH) is the same as attribute COUNTRY CODE.

COUNTRY CODE (BIRTH) is the country where the PERSON was born.

Notes:

- Default Code *"XXX - COUNTRY CODE not known"* is only valid for use in the Female Genital Mutilation Data Set
- Default Code *"ZZZ - Not stated (PERSON asked but declined to provide a response)"* is only valid for use in the GUMCAD Sexually Transmitted Infection Surveillance System Data Set and Female Genital Mutilation Data Set

Refer to the ISO 3166-1 standard for actual list of alphabetic codes and countries. The alphabetic code to be used is the 3-char alphabetic code available on the International Organisation for Standardisation website https://www.iso.org/obp/ui/#search. The 2-char alphabetic code **must not be used.**

Note: Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

COUNTRY CODE (FATHER BIRTH)

Change to Data Element: Changed Description

Format/Length:	a3
National Codes:	
~~Default Codes:~~	~~XXX - Unknown~~ ~~ZZZ - Not stated (PERSON asked but declined to provide a response)~~
Default Codes:	XXX - COUNTRY CODE not known ZZZ - Not stated (PERSON asked but declined to provide a response)

Notes:
COUNTRY CODE (FATHER BIRTH) is the same as attribute COUNTRY CODE.

COUNTRY CODE (FATHER BIRTH) is the country code of the father of a REGISTRABLE BIRTH.

Refer to the ISO 3166-1 standard for actual list of alphabetic codes and countries. The alphabetic code to be used is the 3-char alphabetic code available on the International Organisation for Standardisation website https://www.iso.org/obp/ui/#search. The 2-char alphabetic code **must not be used.**

Note: Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

COUNTRY CODE (FATHER ORIGIN)

Change to Data Element: Changed Description

Format/Length:	a3
National Codes:	
~~Default Codes:~~	~~XXX - Unknown~~ ~~ZZZ - Not stated (PERSON asked but declined to provide a response)~~
Default Codes:	XXX - COUNTRY CODE not known ZZZ - Not stated (PERSON asked but declined to provide a response)

Notes:
COUNTRY CODE (FATHER ORIGIN) is the same as attribute COUNTRY CODE.

COUNTRY CODE (FATHER ORIGIN) is the country code of origin of the father of a REGISTRABLE BIRTH.

Refer to the ISO 3166-1 standard for actual list of alphabetic codes and countries. The alphabetic code to be used is the 3-char alphabetic code available on the International Organisation for Standardisation website https://www.iso.org/obp/ui/#search. The 2-char alphabetic code **must not be used.**

For the Female Genital Mutilation Data Set, this is the country which the PERSON believes reflects their cultural heritage.

Note: Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

COUNTRY CODE (FEMALE GENITAL MUTILATION PERFORMED)

Change to Data Element: Changed Description

Format/Length:	a3
National Codes:	
~~Default Codes:~~	~~XXX - Unknown~~ ~~ZZZ - Not stated (PERSON asked bur declined to provide a response)~~
Default Codes:	XXX - COUNTRY CODE not known ZZZ - Not stated (PERSON asked bur declined to provide a response)

Notes:
COUNTRY CODE (FEMALE GENITAL MUTILATION PERFORMED) is the same as attribute COUNTRY CODE.

COUNTRY CODE (FEMALE GENITAL MUTILATION PERFORMED) is the country where female genital mutilation was performed.

Refer to the ISO 3166-1 standard for actual list of alphabetic codes and countries. The alphabetic code to be used is the 3-char alphabetic code available on the International Organisation for Standardisation website https://www.iso.org/obp/ui/#search. The 2-char alphabetic code **must not be used.**

Note: Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

COUNTRY CODE (ORIGIN)

Change to Data Element: Changed Description

Format/Length:	a3
National Codes:	
~~Default Codes:~~	~~XXX - Unknown~~ ~~ZZZ - Not stated (PERSON asked but declined to provide a response)~~
Default Codes:	XXX - COUNTRY CODE not known ZZZ - Not stated (PERSON asked but declined to provide a response)

Notes:
COUNTRY CODE (ORIGIN) is the same as attribute COUNTRY CODE.

COUNTRY CODE (ORIGIN) is the PERSON's country of origin.

Refer to the ISO 3166-1 standard for actual list of alphabetic codes and countries. The alphabetic code to be used is the 3-char alphabetic code available on the International Organisation for Standardisation website https://www.iso.org/obp/ui/#search. The 2-char alphabetic code **must not be used.**

For the Female Genital Mutilation Data Set, this is the country which the PATIENT believes reflects their cultural heritage.

Note: Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

CRITICAL CARE LEVEL 2 DAYS

Change to Data Element: Changed Description

Format/Length:	max an3
National Codes:	
~~Default Codes:~~	~~998 - 998 or more level 2 days~~ ~~999 - Level 2 days occurred but day count not known~~
Default Codes:	998 - 998 or more days of critical care support 999 - Occurred but critical care day count not known

Notes:
CRITICAL CARE LEVEL 2 DAYS is the same as attribute ACTIVITY DURATION.

CRITICAL CARE LEVEL 2 DAYS is the total number of days a PATIENT received level 2 care during a CRITICAL CARE PERIOD, ranging from 0 to 997 days.

CRITICAL CARE LEVEL 2 DAYS is derived from the difference between the ACTIVITY PROPERTY EFFECTIVE DATE and the ACTIVITY PROPERTY END DATE for all ACTIVITY PROPERTIES where the CRITICAL CARE LEVEL is National Code *'Level 2'* within the CRITICAL CARE PERIOD.

CRITICAL CARE LEVEL 2 DAYS is used by the Secondary Uses Service to derive the **Healthcare Resource Group 4**. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS England website at: Payment by Results Guidance.

~~Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.~~Notes:

- The Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.
- Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

CRITICAL CARE LEVEL 3 DAYS

Change to Data Element: Changed Description

Format/Length:	max an3
National Codes:	
~~Default Codes:~~	~~998 - 998 or more level 3 days~~
	~~999 - Level 3 days occurred but day count not known~~
Default Codes:	998 - 998 or more days of critical care support
	999 - Occurred but critical care day count not known

Notes:
CRITICAL CARE LEVEL 3 DAYS is the same as attribute ACTIVITY DURATION.

CRITICAL CARE LEVEL 3 DAYS is the total number of days a PATIENT received level 3 care during a CRITICAL CARE PERIOD, ranging from 0 to 997 days.

CRITICAL CARE LEVEL 3 DAYS is derived from the difference between the ACTIVITY PROPERTY EFFECTIVE DATE and the ACTIVITY PROPERTY END DATE for all ACTIVITY PROPERTIES where the CRITICAL CARE LEVEL is National Code *'Level 3'* within the CRITICAL CARE PERIOD.

CRITICAL CARE LEVEL 3 DAYS is used by the Secondary Uses Service to derive the **Healthcare Resource Group 4**. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS England website at: Payment by Results Guidance.

~~Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.~~Notes:

- The Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.
- Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

DERMATOLOGICAL SUPPORT DAYS

Change to Data Element: Changed Description

Format/Length:	max an3
National Codes:	
~~Default Codes:~~	~~998 - 998 or more days of dermatological support~~
	~~999 - Occurred but day count not known~~
Default Codes:	998 - 998 or more days of critical care support
	999 - Occurred but critical care day count not known

Notes:
DERMATOLOGICAL SUPPORT DAYS is the same as attribute ACTIVITY DURATION.

DERMATOLOGICAL SUPPORT DAYS is the total number of days that the PATIENT received dermatological system support during a CRITICAL CARE PERIOD, ranging from 0 to 997 days.

DERMATOLOGICAL SUPPORT DAYS is derived from the difference between the ACTIVITY PROPERTY EFFECTIVE DATE and the ACTIVITY PROPERTY END DATE for all ACTIVITY PROPERTIES where the ORGAN SYSTEM SUPPORTED is National Code '*Dermatological Support*' within the CRITICAL CARE PERIOD.

DERMATOLOGICAL SUPPORT DAYS is used by the Secondary Uses Service to derive the **Healthcare Resource Group 4**. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS England website at: Payment by Results Guidance.

~~Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.~~Notes:

- The Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.
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Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

GASTRO-INTESTINAL SUPPORT DAYS

Change to Data Element: Changed Description

Format/Length:	max an3
National Codes:	
~~Default Codes:~~	~~998 - 998 or more days of gastro-intestinal support~~ ~~999 - Occurred but day count not known~~
Default Codes:	998 - 998 or more days of critical care support 999 - Occurred but critical care day count not known

Notes:
GASTRO-INTESTINAL SUPPORT DAYS is the same as attribute ACTIVITY DURATION.

GASTRO-INTESTINAL SUPPORT DAYS is the total number of days that the PATIENT received gastro-intestinal system support during a CRITICAL CARE PERIOD, ranging from 0 to 997 days.

GASTRO-INTESTINAL SUPPORT DAYS is derived from the difference between the ACTIVITY PROPERTY EFFECTIVE DATE and the ACTIVITY PROPERTY END DATE for all ACTIVITY PROPERTIES where the ORGAN SYSTEM SUPPORTED is National Code '*Gastrointestinal Support*' within the CRITICAL CARE PERIOD.

~~Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.~~Notes:

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The Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.
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Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION)

Change to Data Element: Changed Description

Format/Length:	min an6 max an8
National Codes:	
Default Codes:	V81997 - No Registered GP Practice
	V81998 - GP Practice Code not applicable
	V81999 - GP Practice Code not known

Notes:
GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION) is the same as attribute ORGANISATION CODE.

GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION) is the ORGANISATION CODE of the GP Practice that the PATIENT is registered with.

The data for GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION) is supplied by the NHS Prescription Services.

Use of Organisation Data Service Default Codes

- **V81997** should be used when a PATIENT presents, who is not currently registered at a GP Practice, *but is eligible to be registered should they wish to.*
- **V81998** should be used where a PATIENT should not have a registered GP Practice.
- **V81999** should be used where it is not possible to determine a PATIENT's registered GP Practice code, but it is known that they should have one, or where it is impossible to determine whether they should or shouldn't have a registered practice (for instance the PATIENT cannot communicate and is unidentified).

GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION) will be replaced with GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION), which is the most recent approved national information standard to describe the required definition.

GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION MOTHER)

Change to Data Element: Changed Description

Format/Length:	min an6 max an8
National Codes:	
Default Codes:	V81997 - No Registered GP Practice
	V81998 - GP Practice Code not applicable
	V81999 - GP Practice Code not known

Notes:
GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION MOTHER) is the same as attribute ORGANISATION CODE.

GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION MOTHER) is the ORGANISATION CODE of the GP Practice that the mother of the PATIENT is registered with.

The data for GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION MOTHER) is supplied by the NHS Prescription Services.

GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION (MOTHER)) will be replaced with GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION MOTHER), which is the most recent approved national information standard to describe the required definition.

GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION (MOTHER))

Change to Data Element: Changed Description

Format/Length:	an6
National Codes:	
Default Codes:	V81997 - No Registered GP Practice
	V81998 - GP Practice Code not applicable
	V81999 - GP Practice Code not known

Notes:
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION (MOTHER)) is the same as the data element GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION) for the mother.

The data for GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION) is supplied by the NHS Prescription Services.

GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION (MOTHER)) will be replaced with GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION MOTHER), which is the most recent approved national information standard to describe the required definition.

GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)

Change to Data Element: Changed Description

Format/Length:	an6
National Codes:	
Default Codes:	V81997 - No Registered GP Practice
	V81998 - GP Practice Code not applicable
	V81999 - GP Practice Code not known

Notes:
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION) is the same as attribute ORGANISATION CODE.

The data for GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION) is supplied by the NHS Prescription Services.

GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION) is the ORGANISATION CODE of the GP Practice that the PATIENT is registered with.

Use of Organisation Data Service Default Codes

- **V81997** should be used when a PATIENT presents, who is not currently registered at a GP Practice, *but is eligible to be registered should they wish to.*
- **V81998** should be used where a PATIENT should not have a registered GP Practice.
- **V81999** should be used where it is not possible to determine a PATIENT's registered GP Practice code, but it is known that they should have one, or where it is impossible to determine whether they should or shouldn't have a registered practice (for instance the PATIENT cannot communicate and is unidentified).

GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION) will be replaced with GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION), which is the most recent approved national information standard to describe the required definition.

HEAD CIRCUMFERENCE IN CENTIMETRES

Change to Data Element: Changed Description

Format/Length:	max n2.n1
National Codes:	
~~Default Codes:~~	~~99.9 - Head Circumference not known~~
Default Codes:	99.9 - CLINICAL INVESTIGATION RESULT VALUE not known

Notes:
HEAD CIRCUMFERENCE IN CENTIMETRES is the same as attribute CLINICAL INVESTIGATION RESULT VALUE.

HEAD CIRCUMFERENCE IN CENTIMETRES is the result of the Clinical Investigation which measures the Head Circumference of a PERSON, where the UNIT OF MEASUREMENT is *'Centimetres'.*

For the National Neonatal Data Set - Episodic and Daily Care, HEAD CIRCUMFERENCE IN CENTIMETRES measures the Head Circumference of a baby on the Neonatal Critical Care Daily Care Date.

Note: Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

HEART RATE (ON ADMISSION TO NEONATAL CRITICAL CARE)

Change to Data Element: Changed Description

Format/Length:	max n3
National Codes:	
~~Default Codes:~~	~~999 - Heart Rate unknown~~
Default Codes:	999 - CLINICAL INVESTIGATION RESULT VALUE not known

Notes:
HEART RATE (ON ADMISSION TO NEONATAL CRITICAL CARE) is the same as attribute CLINICAL INVESTIGATION RESULT VALUE.

HEART RATE (ON ADMISSION TO NEONATAL CRITICAL CARE) is the result of the Clinical Investigation which measures the Heart Rate per minute of the baby on admission to Neonatal Critical Care.

The value is in the range of 50-350.

Note: Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

LIVER SUPPORT DAYS

Change to Data Element: Changed Description

Format/Length:	max an3
National Codes:	
~~Default Codes:~~	~~998 - 998 or more days of liver support~~
	~~999 - Occurred but day count not known~~
Default Codes:	998 - 998 or more days of critical care support
	999 - Occurred but critical care day count not known

Notes:
LIVER SUPPORT DAYS is the same as attribute ACTIVITY DURATION.

LIVER SUPPORT DAYS is the total number of days that the PATIENT received liver support during a CRITICAL CARE PERIOD, ranging from 0 to 997 days.

LIVER SUPPORT DAYS is derived from the difference between the ACTIVITY PROPERTY EFFECTIVE DATE and the ACTIVITY PROPERTY END DATE for all ACTIVITY PROPERTIES where the ORGAN SYSTEM SUPPORTED is National Code '*Liver Support*' within the CRITICAL CARE PERIOD.

LIVER SUPPORT DAYS is used by the Secondary Uses Service to derive the **Healthcare Resource Group 4**. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS England website at: Payment by Results Guidance.

~~Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.~~Notes:

- The Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.
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Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

MEAN ARTERIAL BLOOD PRESSURE (ON ADMISSION TO NEONATAL CRITICAL CARE)

Change to Data Element: Changed Description

Format/Length:	max n3
National Codes:	
~~Default Codes:~~	~~999 - Mean arterial Blood Pressure unknown~~
Default Codes:	999 - CLINICAL INVESTIGATION RESULT VALUE not known

Notes:
MEAN ARTERIAL BLOOD PRESSURE (ON ADMISSION TO NEONATAL CRITICAL CARE) is the same as attribute CLINICAL INVESTIGATION RESULT VALUE.

MEAN ARTERIAL BLOOD PRESSURE (ON ADMISSION TO NEONATAL CRITICAL CARE) is the result of the Clinical Investigation which measures the mean Arterial Blood Pressure of the baby, calculated using the Systolic Blood Pressure and Diastolic Blood Pressure, where the UNIT OF MEASUREMENT is *'Millimetres of mercury (mmHg)'*, on admission to Neonatal Critical Care.

The value is in the range of 10-150.

Note: Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

NEUROLOGICAL SUPPORT DAYS

Change to Data Element: Changed Description

Format/Length:	max an3
National Codes:	
~~Default Codes:~~	~~998 - 998 or more days of neurological support~~
	~~999 - Occurred but day count not known~~
Default Codes:	998 - 998 or more days of critical care support
	999 - Occurred but critical care day count not known

Notes:
NEUROLOGICAL SUPPORT DAYS is the same as attribute ACTIVITY DURATION.

NEUROLOGICAL SUPPORT DAYS is total number of days that the PATIENT received neurological system support during a CRITICAL CARE PERIOD, ranging from 0 to 997 days.

NEUROLOGICAL SUPPORT DAYS is derived from the difference between the ACTIVITY PROPERTY EFFECTIVE DATE and the ACTIVITY PROPERTY END DATE for all ACTIVITY PROPERTIES where the ORGAN SYSTEM SUPPORTED is National Code '*Neurological Support*' within the CRITICAL CARE PERIOD.

NEUROLOGICAL SUPPORT DAYS is used by the Secondary Uses Service to derive the **Healthcare Resource Group 4**. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS England website at: Payment by Results Guidance.

~~Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.~~Notes:

- The Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.
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Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

ORGANISATION CODE (CODE OF COMMISSIONER)

Change to Data Element: Changed Description

Format/Length:	an3 or an5
National Codes:	
~~Default Codes:~~	~~VPP00 - Private PATIENTS / Overseas Visitor liable for charge~~
Default Codes:	VPP00 - Private PATIENTS / Overseas Visitor liable for charges XMD00 - Commissioner Code for Ministry of Defence (MoD) Healthcare YDD82 - Episodes funded directly by the National Commissioning Group for England (Retired September 2018)

Notes:
ORGANISATION CODE (CODE OF COMMISSIONER) is the same as attribute ORGANISATION CODE.

ORGANISATION CODE (CODE OF COMMISSIONER) is the ORGANISATION CODE of the ORGANISATION commissioning health care.

For Commissioning Data Sets, the ORGANISATION CODE (CODE OF COMMISSIONER) should always be the ORGANISATION CODE of the original commissioner to support the National Tariff Payment System.

The NHS England document "Who Pays? Determining responsibility for NHS payments to providers" sets out a framework for establishing responsibility for commissioning and paying for a PATIENT's care within the NHS.

The document includes information on the following:

- General Rules
- Applying the rules to Integrated Care Board and NHS England commissioned SERVICES
- Exceptions to the general rules
- Examples to help clarify the boundaries of responsibility between commissioning ORGANISATIONS.

For further information on this document contact: england.responsiblecommissioner@nhs.net.

Where NHS England is the responsible commissioner for a specialised SERVICE, based on the NHS England Commissioner Assignment Method (CAM), one of the Specialised Commissioning Hub ORGANISATION CODES should be used depending on which Health Care Provider delivered the SERVICE, e.g. NHS Trust, Independent Sector Healthcare Provider.

The NHS England website provides a mapping list of which Health Care Providers map to which Specialised Commissioning Hub. The mapping can be found on the Organisation Data Service web pages at: Provider to commissioning hub mapping.

Note: Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

ORGANISATION CODE (CODE OF COMMISSIONER) will be replaced with ORGANISATION IDENTIFIER (CODE OF COMMISSIONER), which is the most recent approved national information standard to describe the required definition.

ORGANISATION CODE (RESPONSIBLE PCT)

Change to Data Element: Changed Description

Format/Length:	an3
National Codes:	
Default Codes:	Q99 - High Level Health Geography/Primary Care ORGANISATION of Residence Not Known ~~X98 - Primary Care ORGANISATION Not Applicable - (Overseas Visitors)~~ X98 - Primary Care ORGANISATION Not Applicable (Overseas Visitors)

Notes:
ORGANISATION CODE (RESPONSIBLE PCT) is the same as attribute ORGANISATION CODE.

ORGANISATION CODE (RESPONSIBLE PCT) is the ORGANISATION CODE of the Responsible Primary Care Trust.

Note: Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)

Change to Data Element: Changed Description

Format/Length:	min an3 max an5
National Codes:	
~~Default Codes:~~	~~VPP00 - Private PATIENTS / Overseas Visitor liable for charge~~
Default Codes:	VPP00 - Private PATIENTS / Overseas Visitor liable for charges XMD00 - Commissioner Code for Ministry of Defence (MoD) Healthcare YDD82 - Episodes funded directly by the National Commissioning Group for England (Retired September 2018)

Notes:
ORGANISATION IDENTIFIER (CODE OF COMMISSIONER) is the same as attribute ORGANISATION IDENTIFIER.

ORGANISATION IDENTIFIER (CODE OF COMMISSIONER) is the ORGANISATION IDENTIFIER of the ORGANISATION commissioning health care.

For Commissioning Data Sets, the ORGANISATION IDENTIFIER (CODE OF COMMISSIONER) should always be the ORGANISATION IDENTIFIER of the original commissioner to support the National Tariff Payment System.

The NHS England document "Who Pays? Determining responsibility for NHS payments to providers" sets out a framework for establishing responsibility for commissioning and paying for a PATIENT's care within the NHS.

The document includes information on the following:

- General Rules
- Applying the rules to Integrated Care Board and NHS England commissioned SERVICES
- Exceptions to the general rules
- Examples to help clarify the boundaries of responsibility between commissioning ORGANISATIONS.

For further information on this document contact: england.responsiblecommissioner@nhs.net.

Where NHS England is the responsible commissioner for a specialised SERVICE, based on the NHS England Commissioner Assignment Method (CAM), one of the Specialised Commissioning Hub ORGANISATION IDENTIFIERS should be used depending on which Health Care Provider delivered the SERVICE, e.g. NHS Trust, Independent Sector Healthcare Provider.

The NHS England website provides a mapping list of which Health Care Providers map to which Specialised Commissioning Hub. The mapping can be found on the Organisation Data Service web pages at: Provider to commissioning hub mapping.

Note: Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

ORGANISATION CODE (CODE OF COMMISSIONER) will be replaced with ORGANISATION IDENTIFIER (CODE OF COMMISSIONER), which is the most recent approved national information standard to describe the required definition.

ORGANISATION SITE IDENTIFIER (AT START OF INTRAPARTUM CARE)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
National Codes:	
Default Codes:	ZZ201 - Home
	ZZ888 - Non-NHS ORGANISATION
	ZZ203 - Not Known (Not Recorded)

Notes:
ORGANISATION SITE IDENTIFIER (AT START OF INTRAPARTUM CARE) is the same as attribute ORGANISATION SITE IDENTIFIER.

ORGANISATION SITE IDENTIFIER (AT START OF INTRAPARTUM CARE) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE where the mother started intrapartum care.

ORGANISATION SITE IDENTIFIER (DISCHARGE FROM EMERGENCY CARE)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
National Codes:	
Default Codes:	89999 - Non-NHS UK Provider where no ORGANISATION SITE IDENTIFIER has been issued 89997 - Non-UK Provider where no ORGANISATION SITE IDENTIFIER has been issued

Notes:
ORGANISATION SITE IDENTIFIER (DISCHARGE FROM EMERGENCY CARE) is the same as attribute ORGANISATION SITE IDENTIFIER.

ORGANISATION SITE IDENTIFIER (DISCHARGE FROM EMERGENCY CARE) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE to which a PATIENT is discharged following an Emergency Care Attendance.

This Data Element should only be completed in CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set / Emergency Care Data Set Version 4 where the PATIENT is discharged to continue treatment at another secondary care ORGANISATION SITE, which may be part of the same Health Care Provider or at a different NHS Foundation Trust or NHS Trust.

ORGANISATION SITE IDENTIFIER (DISCHARGE FROM URGENT AND EMERGENCY CARE)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
National Codes:	
Default Codes:	89999 - Non-NHS UK Provider where no ORGANISATION SITE IDENTIFIER has been issued 89997 - Non-UK Provider where no ORGANISATION SITE IDENTIFIER has been issued

Notes:
ORGANISATION SITE IDENTIFIER (DISCHARGE FROM URGENT AND EMERGENCY CARE) is the same as attribute ORGANISATION SITE IDENTIFIER.

ORGANISATION SITE IDENTIFIER (DISCHARGE FROM URGENT AND EMERGENCY CARE) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE to which a PATIENT is discharged following Urgent and Emergency Care Activity.

This Data Element should only be completed where the PATIENT is discharged to continue treatment at another secondary care ORGANISATION SITE, which may be part of the same Health Care Provider or at a different NHS Foundation Trust or NHS Trust.

ORGANISATION SITE IDENTIFIER (EMERGENCY CARE ATTENDANCE SOURCE)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
National Codes:	
Default Codes:	89999 - Non-NHS UK Provider where no ORGANISATION SITE IDENTIFIER has been issued 89997 - Non-UK Provider where no ORGANISATION SITE IDENTIFIER has been issued

Notes:
ORGANISATION SITE IDENTIFIER (EMERGENCY CARE ATTENDANCE SOURCE) is the same as attribute ORGANISATION SITE IDENTIFIER.

ORGANISATION SITE IDENTIFIER (EMERGENCY CARE ATTENDANCE SOURCE) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE from which a PATIENT arrived at an Emergency Care Department.

This Data Element should only be completed in CDS V6-2-3 Type 011 - Emergency Care Commissioning Data Set /Emergency Care Data Set Version 4 where the PATIENT has arrived from a different secondary care ORGANISATION SITE which may be part of the same Health Care Provider or a different NHS Foundation Trust or NHS Trust.

ORGANISATION SITE IDENTIFIER (EMPLOYING ORGANISATION)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
NWDS ID:	ORST

NWDS Field Name:	Site Description (Location)
National Codes:	
Default Codes:	89999 - Non-NHS UK Provider where no ORGANISATION SITE IDENTIFIER has been issued 89997 - Non-UK Provider where no ORGANISATION SITE IDENTIFIER has been issued

Notes:
ORGANISATION SITE IDENTIFIER (EMPLOYING ORGANISATION) is the same as attribute ORGANISATION SITE IDENTIFIER.

ORGANISATION SITE IDENTIFIER (EMPLOYING ORGANISATION) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE of the employing ORGANISATION where the EMPLOYEE is employed or based from.

ORGANISATION SITE IDENTIFIER (OF ACUTE ONCOLOGY ASSESSMENT)

Change to Data Element: Changed Description

Format/Length:	an5
National Codes:	
Default Codes:	89999 - Non-NHS UK Provider where no ORGANISATION SITE IDENTIFIER has been issued 89997 - Non-UK Provider where no ORGANISATION SITE IDENTIFIER has been issued

Notes:
ORGANISATION SITE IDENTIFIER (OF ACUTE ONCOLOGY ASSESSMENT) is the same as attribute ORGANISATION SITE IDENTIFIER.

ORGANISATION SITE IDENTIFIER (OF ACUTE ONCOLOGY ASSESSMENT) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE where the Acute Oncology Assessment was carried out during a Cancer Care Spell.

ORGANISATION SITE IDENTIFIER (OF ADMITTING NEONATAL UNIT)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
National Codes:	
Default Codes:	ZZ888 - Non-NHS ORGANISATION ZZ203 - Not Known (Not Recorded)

Notes:
ORGANISATION SITE IDENTIFIER (OF ADMITTING NEONATAL UNIT) is the same as attribute ORGANISATION SITE IDENTIFIER.

ORGANISATION SITE IDENTIFIER (OF ADMITTING NEONATAL UNIT) is the ORGANISATION SITE IDENTIFIER of the Neonatal Unit where the Neonate was transferred to as part of a Maternity Episode.

Note: Default Codes ZZ888 and ZZ203 are for use in the National Neonatal Data Set - Episodic and Daily Care only.

ORGANISATION SITE IDENTIFIER (OF ANTENATAL BOOKING)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
National Codes:	
Default Codes:	ZZ201 - Home ZZ888 - Non-NHS ORGANISATION ZZ203 - Not Known (Not Recorded) ZZ999 - Other

Notes:
ORGANISATION SITE IDENTIFIER (OF ANTENATAL BOOKING) is the same as attribute ORGANISATION SITE IDENTIFIER.

ORGANISATION SITE IDENTIFIER (OF ANTENATAL BOOKING) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE of the Antenatal Booking Appointment.

ORGANISATION SITE IDENTIFIER (OF CANCER FASTER DIAGNOSIS PATHWAY END DATE)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
National Codes:	
Default Codes:	89999 - Non-NHS UK Provider where no ORGANISATION SITE IDENTIFIER has been issued 89997 - Non-UK Provider where no ORGANISATION SITE IDENTIFIER has been issued

Notes:
ORGANISATION SITE IDENTIFIER (OF CANCER FASTER DIAGNOSIS PATHWAY END DATE) is the same as attribute ORGANISATION SITE IDENTIFIER.

ORGANISATION SITE IDENTIFIER (OF CANCER FASTER DIAGNOSIS PATHWAY END DATE) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE acting as Health Care Provider where the CANCER FASTER DIAGNOSIS PATHWAY END DATE is recorded.

ORGANISATION SITE IDENTIFIER (OF CANCER SITE SPECIFIC STAGE)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
National Codes:	
Default Codes:	89999 - Non-NHS UK Provider where no ORGANISATION SITE IDENTIFIER has been issued 89997 - Non-UK Provider where no ORGANISATION SITE IDENTIFIER has been issued

Notes:
ORGANISATION SITE IDENTIFIER (OF CANCER SITE SPECIFIC STAGE) is the same as attribute ORGANISATION SITE IDENTIFIER.

ORGANISATION SITE IDENTIFIER (OF CANCER SITE SPECIFIC STAGE) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE of the Health Care Provider where the cancer site specific stage was carried out during a Cancer Care Spell.

ORGANISATION SITE IDENTIFIER (OF DIAGNOSIS)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
National Codes:	
Default Codes:	89999 - Non-NHS UK Provider where no ORGANISATION SITE IDENTIFIER has been issued 89997 - Non-UK Provider where no ORGANISATION SITE IDENTIFIER has been issued

Notes:
ORGANISATION SITE IDENTIFIER (OF DIAGNOSIS) is the same as attribute ORGANISATION SITE IDENTIFIER.

ORGANISATION SITE IDENTIFIER (OF DIAGNOSIS) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE where the PATIENT DIAGNOSIS took place.

ORGANISATION SITE IDENTIFIER (OF DIAGNOSTIC PROCEDURE)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
National Codes:	
Default Codes:	89999 - Non-NHS UK Provider where no ORGANISATION SITE IDENTIFIER has been issued 89997 - Non-UK Provider where no ORGANISATION SITE IDENTIFIER has been issued

Notes:
ORGANISATION SITE IDENTIFIER (OF DIAGNOSTIC PROCEDURE) is the same as attribute ORGANISATION SITE IDENTIFIER.

ORGANISATION SITE IDENTIFIER (OF DIAGNOSTIC PROCEDURE) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE where the Diagnostic Procedure took place.

ORGANISATION SITE IDENTIFIER (OF IMAGING)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9

National Codes:	
Default Codes:	89999 - Non-NHS UK Provider where no ORGANISATION SITE IDENTIFIER has been issued 89997 - Non-UK Provider where no ORGANISATION SITE IDENTIFIER has been issued

Notes:
ORGANISATION SITE IDENTIFIER (OF IMAGING) is the same as attribute ORGANISATION SITE IDENTIFIER.

ORGANISATION SITE IDENTIFIER (OF IMAGING) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE where the Diagnostic Imaging took place.

SITE CODE (OF IMAGING) will be replaced with ORGANISATION SITE IDENTIFIER (OF IMAGING), which is the most recent approved national information standard to describe the required definition.

ORGANISATION SITE IDENTIFIER (OF MULTIDISCIPLINARY TEAM MEETING)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
National Codes:	
Default Codes:	89999 - Non-NHS UK Provider where no ORGANISATION SITE IDENTIFIER has been issued 89997 - Non-UK Provider where no ORGANISATION SITE IDENTIFIER has been issued

Notes:
ORGANISATION SITE IDENTIFIER (OF MULTIDISCIPLINARY TEAM MEETING) is the same as attribute ORGANISATION SITE IDENTIFIER.

ORGANISATION SITE IDENTIFIER (OF MULTIDISCIPLINARY TEAM MEETING) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE where the Multidisciplinary Team Meeting took place.

ORGANISATION SITE IDENTIFIER (OF NEONATAL TREATMENT)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
National Codes:	
Default Codes:	ZZ203 - Not Known (Not Recorded)

Notes:
ORGANISATION SITE IDENTIFIER (OF NEONATAL TREATMENT) is the same as attribute ORGANISATION SITE IDENTIFIER.

ORGANISATION SITE IDENTIFIER (OF NEONATAL TREATMENT) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE where the baby was treated on the Neonatal Critical Care Daily Care Date.

ORGANISATION SITE IDENTIFIER (OF PATHOLOGY TEST REQUEST)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
National Codes:	
Default Codes:	89999 - Non-NHS UK Provider where no ORGANISATION SITE IDENTIFIER has been issued 89997 - Non-UK Provider where no ORGANISATION SITE IDENTIFIER has been issued

Notes:
ORGANISATION SITE IDENTIFIER (OF PATHOLOGY TEST REQUEST) is the same as attribute ORGANISATION SITE IDENTIFIER.

ORGANISATION SITE IDENTIFIER (OF PATHOLOGY TEST REQUEST) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE at which the CARE PROFESSIONAL who requested the DIAGNOSTIC TEST REQUEST for suspected cancer, is based during a Cancer Care Spell.

ORGANISATION SITE IDENTIFIER (OF PLANNED DELIVERY)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
National Codes:	
Default Codes:	ZZ201 - Home ZZ888 - Non-NHS ORGANISATION ZZ203 - Not Known (Not Recorded)

Notes:
ORGANISATION SITE IDENTIFIER (OF PLANNED DELIVERY) is the same as attribute ORGANISATION SITE IDENTIFIER.

ORGANISATION SITE IDENTIFIER (OF PLANNED DELIVERY) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE of the planned Delivery of the baby as part of a Maternity Episode.

ORGANISATION SITE IDENTIFIER (OF PROVIDER CANCER DECISION TO TREAT)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
National Codes:	
Default Codes:	89999 - Non-NHS UK Provider where no ORGANISATION SITE IDENTIFIER has been issued 89997 - Non-UK Provider where no ORGANISATION SITE IDENTIFIER has been issued

Notes:
ORGANISATION SITE IDENTIFIER (OF PROVIDER CANCER DECISION TO TREAT) is the same as attribute ORGANISATION SITE IDENTIFIER.

ORGANISATION SITE IDENTIFIER (OF PROVIDER CANCER DECISION TO TREAT) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE acting as Health Care Provider where the decision to treat the PATIENT was made which initiated a Cancer Care Plan with one or more Planned Cancer Treatments.

The Planned Cancer Treatment may be planned and provided by a different Health Care Provider.

ORGANISATION SITE IDENTIFIER (OF PROVIDER CANCER TREATMENT START DATE)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
National Codes:	
Default Codes:	89999 - Non-NHS UK Provider where no ORGANISATION SITE IDENTIFIER has been issued 89997 - Non-UK Provider where no ORGANISATION SITE IDENTIFIER has been issued

Notes:
ORGANISATION SITE IDENTIFIER (OF PROVIDER CANCER TREATMENT START DATE) is the same as attribute ORGANISATION SITE IDENTIFIER.

ORGANISATION SITE IDENTIFIER (OF PROVIDER CANCER TREATMENT START DATE) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE where the TREATMENT START DATE (CANCER) is recorded.

ORGANISATION SITE IDENTIFIER (OF PROVIDER CONSULTANT UPGRADE)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
National Codes:	
Default Codes:	89999 - Non-NHS UK Provider where no ORGANISATION SITE IDENTIFIER has been issued 89997 - Non-UK Provider where no ORGANISATION SITE IDENTIFIER has been issued

Notes:
ORGANISATION SITE IDENTIFIER (OF PROVIDER CONSULTANT UPGRADE) is the same as attribute ORGANISATION SITE IDENTIFIER.

ORGANISATION SITE IDENTIFIER (OF PROVIDER CONSULTANT UPGRADE) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE acting as Health Care Provider when a decision is made to upgrade the PATIENT to an urgent Cancer PATIENT PATHWAY.

The decision to upgrade must be made by a CONSULTANT or an authorised member of the CONSULTANTS team (subject to local agreement).

ORGANISATION SITE IDENTIFIER (OF PROVIDER FIRST CANCER SPECIALIST)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
National Codes:	
Default Codes:	89999 - Non-NHS UK Provider where no ORGANISATION SITE IDENTIFIER has been issued 89997 - Non-UK Provider where no ORGANISATION SITE IDENTIFIER has been issued

Notes:
ORGANISATION SITE IDENTIFIER (OF PROVIDER FIRST CANCER SPECIALIST) is the same as attribute ORGANISATION SITE IDENTIFIER.

ORGANISATION SITE IDENTIFIER (OF PROVIDER FIRST CANCER SPECIALIST) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE where the PATIENT is first seen by an appropriate cancer specialist on the DATE FIRST SEEN (CANCER SPECIALIST).

ORGANISATION SITE IDENTIFIER (OF PROVIDER FIRST SEEN)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
National Codes:	
Default Codes:	89999 - Non-NHS UK Provider where no ORGANISATION SITE IDENTIFIER has been issued 89997 - Non-UK Provider where no ORGANISATION SITE IDENTIFIER has been issued

Notes:
ORGANISATION SITE IDENTIFIER (OF PROVIDER FIRST SEEN) is the same as attribute ORGANISATION SITE IDENTIFIER.

ORGANISATION SITE IDENTIFIER (OF PROVIDER FIRST SEEN) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE of the Health Care Provider at the first contact with the PATIENT.

For the National Cancer Waiting Times Monitoring Data Set this may be the:

- Out-Patient Attendance Consultant
- Imaging or Radiodiagnostic Event
- CLINICAL INTERVENTION
- Hospital Provider Spell
- Emergency Care Attendance or
- Screening Test

whichever is the earlier SERVICE related to the initial REFERRAL REQUEST.

ORGANISATION SITE IDENTIFIER (OF PROVIDER FIRST SEEN) may be the same Health Care Provider as for ORGANISATION SITE IDENTIFIER (OF PROVIDER FIRST CANCER SPECIALIST) if the PATIENT was first seen by the appropriate specialist for cancer.

ORGANISATION SITE IDENTIFIER (OF PROVIDER FIRST SEEN NON PRIMARY CANCER PATHWAY)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
National Codes:	
Default Codes:	89999 - Non-NHS UK Provider where no ORGANISATION SITE IDENTIFIER has been issued 89997 - Non-UK Provider where no ORGANISATION SITE IDENTIFIER has been issued

Notes:
ORGANISATION SITE IDENTIFIER (OF PROVIDER FIRST SEEN NON PRIMARY CANCER PATHWAY) is the same as attribute ORGANISATION SITE IDENTIFIER.

ORGANISATION SITE IDENTIFIER (OF PROVIDER FIRST SEEN NON PRIMARY CANCER PATHWAY) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE of the Health Care Provider at the first contact with the PATIENT during a Non Primary Cancer Pathway.

ORGANISATION SITE IDENTIFIER (OF RETINOPATHY OF PREMATURITY SCREENING)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
National Codes:	
Default Codes:	ZZZ203 - Not Known (Not Recorded)

Notes:
ORGANISATION SITE IDENTIFIER (OF RETINOPATHY OF PREMATURITY SCREENING) is the same as attribute ORGANISATION SITE IDENTIFIER.

ORGANISATION SITE IDENTIFIER (OF RETINOPATHY OF PREMATURITY SCREENING) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE where the Retinopathy of Prematurity Screening was performed.

ORGANISATION SITE IDENTIFIER (OF TNM STAGE GROUPING FINAL PRETREATMENT)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
National Codes:	
Default Codes:	89999 - Non-NHS UK Provider where no ORGANISATION SITE IDENTIFIER has been issued 89997 - Non-UK Provider where no ORGANISATION SITE IDENTIFIER has been issued

Notes:
ORGANISATION SITE IDENTIFIER (OF TNM STAGE GROUPING FINAL PRETREATMENT) is the same as attribute ORGANISATION SITE IDENTIFIER.

ORGANISATION SITE IDENTIFIER (OF TNM STAGE GROUPING FINAL PRETREATMENT) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE of the Multidisciplinary Team who agreed the TNM STAGE GROUPING (FINAL PRETREATMENT) for a cancer PATIENT.

ORGANISATION SITE IDENTIFIER (OF TNM STAGE GROUPING INTEGRATED)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
National Codes:	
Default Codes:	89999 - Non-NHS UK Provider where no ORGANISATION SITE IDENTIFIER has been issued 89997 - Non-UK Provider where no ORGANISATION SITE IDENTIFIER has been issued

Notes:
ORGANISATION SITE IDENTIFIER (OF TNM STAGE GROUPING INTEGRATED) is the same as attribute ORGANISATION SITE IDENTIFIER.

ORGANISATION SITE IDENTIFIER (OF TNM STAGE GROUPING INTEGRATED) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE of the Multidisciplinary Team treating the PATIENT post surgery, where the surgery was the first treatment agreed for TNM STAGE GROUPING (INTEGRATED).

ORGANISATION SITE IDENTIFIER (OF TREATMENT)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
National Codes:	
Default Codes:	R9998 - Not a hospital site 89999 - Non-NHS UK Provider where no ORGANISATION SITE IDENTIFIER has been issued 89997 - Non-UK Provider where no ORGANISATION SITE IDENTIFIER has been issued

Notes:
ORGANISATION SITE IDENTIFIER (OF TREATMENT) is the same as attribute ORGANISATION SITE IDENTIFIER.

ORGANISATION SITE IDENTIFIER (OF TREATMENT) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE where the PATIENT was treated, i.e. it should enable the treating ORGANISATION to be identified.

ORGANISATION SITE IDENTIFIER (OF TREATMENT) identifies the ORGANISATION SITE within the ORGANISATION on which the PATIENT was treated, since facilities may vary on different hospital sites.

The code recorded should always be the national code; if the treatment is sub-commissioned to another NHS Health Care Provider or an Independent Sector Healthcare Provider, the ORGANISATION SITE IDENTIFIER (OF TREATMENT) used should be the ORGANISATION SITE IDENTIFIER of the Health Care Provider actually carrying out the work.

Where treatment is sub-commissioned to an overseas provider the Organisation Data Service Default Code 89997 *'Non-UK Provider where no ORGANISATION SITE IDENTIFIER has been issued'* is applicable.

Each ORGANISATION has a unique ORGANISATION SITE IDENTIFIER. However, where an ORGANISATION has more than one site from which it provides SERVICES, then each site is uniquely identified. These sites are ORGANISATION SITES and are uniquely identified by an ORGANISATION SITE IDENTIFIER.

For out-patients, ACTIVITY may take place outside the hospital, such as in the PATIENT'S home; in such cases, raising a site code is impractical. Therefore, code R9998 *'Not a hospital site'* would be used in these circumstances.
Note: LOCATION CLASS is used in the Commissioning Data Set (CDS) message to indicate the physical LOCATION within which the ACTIVITY occurred.

Use in the Future Outpatient CDS:
If the INTENDED SITE CODE (OF TREATMENT) is not known, this data element should be omitted.

SITE CODE (OF TREATMENT) will be replaced with ORGANISATION SITE IDENTIFIER (OF TREATMENT), which is the most recent approved national information standard to describe the required definition.

ORGANISATION SITE IDENTIFIER (OF TWO YEAR NEONATAL OUTCOMES ASSESSMENT)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
National Codes:	
Default Codes:	ZZ203 - Not Known (Not Recorded)

Notes:

ORGANISATION SITE IDENTIFIER (OF TWO YEAR NEONATAL OUTCOMES ASSESSMENT) is the same as attribute ORGANISATION SITE IDENTIFIER.

ORGANISATION SITE IDENTIFIER (OF TWO YEAR NEONATAL OUTCOMES ASSESSMENT) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE that carries out the Two Year Neonatal Outcomes Assessment.

ORGANISATION SITE IDENTIFIER (OF TWO YEAR NEONATAL OUTCOMES ASSESSMENT FOLLOWING DISCHARGE)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
National Codes:	
Default Codes:	ZZ888 - Non-NHS ORGANISATION ZZ203 - Not Known (Not Recorded)

Notes:
ORGANISATION SITE IDENTIFIER (OF TWO YEAR NEONATAL OUTCOMES ASSESSMENT FOLLOWING DISCHARGE) is the same as attribute ORGANISATION SITE IDENTIFIER.

ORGANISATION SITE IDENTIFIER (OF TWO YEAR NEONATAL OUTCOMES ASSESSMENT FOLLOWING DISCHARGE) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE that is responsible for undertaking the Two Year Neonatal Outcomes Assessment following discharge from Neonatal Critical Care.

ORGANISATION SITE IDENTIFIER (OF WARD)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
National Codes:	
Default Codes:	R9998 - Not a hospital site 89999 - Non-NHS UK Provider where no ORGANISATION SITE IDENTIFIER has been issued 89997 - Non-UK Provider where no ORGANISATION SITE IDENTIFIER has been issued

Notes:
ORGANISATION SITE IDENTIFIER (OF WARD) is the same as attribute ORGANISATION SITE IDENTIFIER.

ORGANISATION SITE IDENTIFIER (OF WARD) is the ORGANISATION SITE IDENTIFIER of the WARD where the PATIENT was treated.

ORGANISATION SITE IDENTIFIER (RECEIVING POST DISCHARGE FROM NEONATAL CARE)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
National Codes:	
Default Codes:	ZZ888 - Non-NHS ORGANISATION ZZ203 - Not Known (Not Recorded)

Notes:
ORGANISATION SITE IDENTIFIER (RECEIVING POST DISCHARGE FROM NEONATAL CARE) is the same as the attribute ORGANISATION IDENTIFIER for the purposes of the National Neonatal Data Set - Episodic and Daily Care.

ORGANISATION SITE IDENTIFIER (RECEIVING POST DISCHARGE FROM NEONATAL CARE) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE where a baby is transferred to on discharge from Neonatal Critical Care.

ORGANISATION SITE IDENTIFIER (URGENT AND EMERGENCY CARE ATTENDANCE SOURCE)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
National Codes:	
Default Codes:	89999 - Non-NHS UK Provider where no ORGANISATION SITE IDENTIFIER has been issued 89997 - Non-UK Provider where no ORGANISATION SITE IDENTIFIER has been issued

Notes:

ORGANISATION SITE IDENTIFIER (URGENT AND EMERGENCY CARE ATTENDANCE SOURCE) is the same as attribute ORGANISATION SITE IDENTIFIER.

ORGANISATION SITE IDENTIFIER (URGENT AND EMERGENCY CARE ATTENDANCE SOURCE) is the ORGANISATION SITE IDENTIFIER of the ORGANISATION SITE from which a PATIENT arrived at an Urgent and Emergency Care Service.

This Data Element should only be completed where the PATIENT has arrived from a different secondary care ORGANISATION SITE which may be part of the same Health Care Provider or a different NHS Foundation Trust or NHS Trust.

OXYGEN SATURATION (ON ADMISSION TO NEONATAL CRITICAL CARE)

Change to Data Element: Changed Description

Format/Length:	max n3
National Codes:	
~~Default Codes:~~	~~999 - Oxygen Saturation unknown~~
Default Codes:	999 - CLINICAL INVESTIGATION RESULT VALUE not known

Notes:
OXYGEN SATURATION (ON ADMISSION TO NEONATAL CRITICAL CARE) is the same as attribute CLINICAL INVESTIGATION RESULT VALUE.

OXYGEN SATURATION (ON ADMISSION TO NEONATAL CRITICAL CARE) is the result of the Clinical Investigation which measures the baby's Oxygen Saturation percentage, on admission to Neonatal Critical Care.

The value is in the range of 10-100.

Note: Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

PERSON LENGTH IN CENTIMETRES

Change to Data Element: Changed Description

Format/Length:	max n2.n1
National Codes:	
~~Default Codes:~~	~~99.9 - Length unknown~~
Default Codes:	99.9 - CLINICAL INVESTIGATION RESULT VALUE not known

Notes:
PERSON LENGTH IN CENTIMETRES is the same as attribute CLINICAL INVESTIGATION RESULT VALUE.

PERSON LENGTH IN CENTIMETRES is the result of the Clinical Investigation which measures the Length of a baby, where the UNIT OF MEASUREMENT is *'Centimetres (cm)'*.

For the National Neonatal Data Set - Episodic and Daily Care, PERSON LENGTH IN CENTIMETRES measures the Length of a baby on the Neonatal Critical Care Daily Care Date.

Note: Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

PREGNANCY TOTAL PREVIOUS PREGNANCIES

Change to Data Element: Changed Description

Format/Length:	n2
National Codes:	
~~Default Codes:~~	~~99 - Not known~~
Default Codes:	99 - Number of previous pregnancies resulting in a REGISTRABLE BIRTH not known

Notes:
PREGNANCY TOTAL PREVIOUS PREGNANCIES is the same as attribute ACTIVITY COUNT.

PREGNANCY TOTAL PREVIOUS PREGNANCIES is the number of previous pregnancies resulting in one or more REGISTRABLE BIRTHS.

The following values with the addition of the Default Code, can be used:

00 No previous pregnancy resulting in a REGISTRABLE BIRTH
01 One previous pregnancy resulting in a REGISTRABLE BIRTH

02 Two previous pregnancies resulting in a REGISTRABLE BIRTH
03 Three previous pregnancies resulting in a REGISTRABLE BIRTH

etc. until

29 Twenty nine previous pregnancies resulting in a REGISTRABLE BIRTH

Note: Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

PREGNANCY TOTAL PREVIOUS PREGNANCIES will be replaced with NUMBER OF PREVIOUS PREGNANCIES RESULTING IN REGISTRABLE BIRTH, which is the most recent approved national information standard to describe the required definition.

RENAL SUPPORT DAYS

Change to Data Element: Changed Description

Format/Length:	max an3
National Codes:	
~~Default Codes:~~	~~998 - 998 or more days of renal support~~
	~~999 - Occurred but day count not known~~
Default Codes:	998 - 998 or more days of critical care support
	999 - Occurred but critical care day count not known

Notes:
RENAL SUPPORT DAYS is the same as attribute ACTIVITY DURATION.

RENAL SUPPORT DAYS is the total number of days that the PATIENT received renal system support during a CRITICAL CARE PERIOD, ranging from 0 to 997 days.

RENAL SUPPORT DAYS is derived from the difference between the ACTIVITY PROPERTY EFFECTIVE DATE and the ACTIVITY PROPERTY END DATE for all ACTIVITY PROPERTIES where the ORGAN SYSTEM SUPPORTED is National Code '*Renal Support*' within the CRITICAL CARE PERIOD.

RENAL SUPPORT DAYS is used by the Secondary Uses Service to derive the **Healthcare Resource Group 4**. Failure to correctly populate this data element is likely to result in an

incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS England website at: Payment by Results Guidance.

~~Note: the Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.~~Notes:

- The Format/Length has been updated in Data Dictionary Change Notice 1808 "Correction of Format/Length Data Elements". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.
- Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

RESPIRATORY RATE (ON ADMISSION TO NEONATAL CRITICAL CARE)

Change to Data Element: Changed Description

Format/Length:	min n2 max n3
National Codes:	
~~Default Codes:~~	~~999 - Respiratory Rate unknown~~
Default Codes:	999 - CLINICAL INVESTIGATION RESULT VALUE not known

Notes:
RESPIRATORY RATE (ON ADMISSION TO NEONATAL CRITICAL CARE) is the same as attribute CLINICAL INVESTIGATION RESULT VALUE.

RESPIRATORY RATE (ON ADMISSION TO NEONATAL CRITICAL CARE) is the result of the Clinical Investigation which measures the Respiratory Rate per minute of the baby on admission to Neonatal Critical Care.

The value is in the range of 10-200.

Note: Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

TEST OF RECENT INFECTION RESULT (HIV)

Change to Data Element: Changed Description, linked Attribute

Format/Length:	maxn3.n1
National Codes:	
Default Codes:	99.9 - Test is invalid or the sample is insufficient

Notes:
~~TEST OF RECENT INFECTION RESULT (HIV) is the same as attribute CLINICAL INVESTIGATION RESULT VALUE.~~

~~TEST OF RECENT INFECTION RESULT (HIV) is the result of the Clinical Investigation which measures the PATIENT's Avidity Score (a test used in conjunction with other information, to classify a newly diagnosed Human Immunodeficiency Virus (HIV) infection as recent or long standing), as recorded at the HIV Clinic Attendance.~~

TEST OF RECENT INFECTION RESULT (HIV) is the same as attribute TEST OF RECENT INFECTION RESULT FOR HIV.

TEST OF RECENT INFECTION RESULT (HIV)

Change to Data Element: Changed Description, linked Attribute

TEST OF RECENT INFECTION RESULT (HIV)

Attribute:

~~CLINICAL INVESTIGATION RESULT VALUE~~
TEST OF RECENT INFECTION RESULT FOR HIV

TIME BETWEEN DELIVERY AND UMBILICAL CORD CLAMPING

Change to Data Element: Changed Description, linked Attribute

Format/Length:	max an4
National Codes:	
Default Codes:	9999 - Time between delivery and the clamping of the umbilical cord not known

Notes:
~~TIME BETWEEN DELIVERY AND UMBILICAL CORD CLAMPING is the same as attribute ACTIVITY DURATION.~~TIME BETWEEN DELIVERY AND UMBILICAL CORD CLAMPING is the same as attribute TIME BETWEEN DELIVERY AND UMBILICAL CORD CLAMPING.

~~TIME BETWEEN DELIVERY AND UMBILICAL CORD CLAMPING is the amount of time in seconds between the Delivery of a baby and the Patient Procedure to clamp the umbilical cord.~~

For the National Neonatal Data Set - Episodic and Daily Care, TIME BETWEEN DELIVERY AND UMBILICAL CORD CLAMPING is measured in seconds.

The value is presented in the range 0-3600.

TIME BETWEEN DELIVERY AND UMBILICAL CORD CLAMPING

Change to Data Element: Changed Description, linked Attribute

TIME BETWEEN DELIVERY AND UMBILICAL CORD CLAMPING

Attribute:

~~ACTIVITY DURATION~~
TIME BETWEEN DELIVERY AND UMBILICAL CORD CLAMPING

UMBILICAL CORD BLOOD PARTIAL PRESSURE CARBON DIOXIDE (ARTERIAL)

Change to Data Element: Changed Description

Format/Length:	max n1.max n2
National Codes:	
~~Default Codes:~~	~~9.99 - Partial pressure CO2 unknown~~
Default Codes:	9.99 - CLINICAL INVESTIGATION RESULT VALUE not known

Notes:
UMBILICAL CORD BLOOD PARTIAL PRESSURE CARBON DIOXIDE (ARTERIAL) is the same as attribute CLINICAL INVESTIGATION RESULT VALUE.

UMBILICAL CORD BLOOD PARTIAL PRESSURE CARBON DIOXIDE (ARTERIAL) is the PARTIAL PRESSURE CARBON DIOXIDE of arterial blood taken from the umbilical cord after Delivery of the baby.

The value is presented in the range 5.00 - 8.50.

Note: Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

UMBILICAL CORD BLOOD PARTIAL PRESSURE CARBON DIOXIDE (VENOUS)

Change to Data Element: Changed Description

Format/Length:	max n1.max n2
National Codes:	
~~Default Codes:~~	~~9.99 - Partial pressure CO2 unknown~~
Default Codes:	9.99 - CLINICAL INVESTIGATION RESULT VALUE not known

Notes:
UMBILICAL CORD BLOOD PARTIAL PRESSURE CARBON DIOXIDE (VENOUS) is the same as attribute CLINICAL INVESTIGATION RESULT VALUE.

UMBILICAL CORD BLOOD PARTIAL PRESSURE CARBON DIOXIDE (VENOUS) is the PARTIAL PRESSURE CARBON DIOXIDE of venous blood taken from the umbilical cord after Delivery of the baby.

The value is presented in the range 5.00 - 8.50.

Note: Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

UMBILICAL CORD BLOOD PH LEVEL (ARTERIAL)

Change to Data Element: Changed Description

Format/Length:	max n1.max n2

National Codes:	
~~Default Codes:~~	~~9.99 - Arterial pH level unknown~~
Default Codes:	9.99 - CLINICAL INVESTIGATION RESULT VALUE not known

Notes:
UMBILICAL CORD BLOOD PH LEVEL (ARTERIAL) is the same as attribute CLINICAL INVESTIGATION RESULT VALUE.

UMBILICAL CORD BLOOD PH LEVEL (ARTERIAL) is the PH LEVEL of arterial blood taken from the umbilical cord after Delivery of the baby.

The value is presented in the range 6.00 - 8.00.

Note: Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

UMBILICAL CORD BLOOD PH LEVEL (VENOUS)

Change to Data Element: Changed Description

Format/Length:	max n1.max n2
National Codes:	
~~Default Codes:~~	~~9.99 - Venous pH level unknown~~
Default Codes:	9.99 - CLINICAL INVESTIGATION RESULT VALUE not known

Notes:
UMBILICAL CORD BLOOD PH LEVEL (VENOUS) is the same as attribute CLINICAL INVESTIGATION RESULT VALUE.

UMBILICAL CORD BLOOD PH LEVEL (VENOUS) is the PH LEVEL of venous blood taken from the umbilical cord after Delivery of the baby.

The value is presented in the range 6.00 - 8.00.

Note: Default Code descriptions have been updated in Data Dictionary Change Notice 1934 "Default Codes Description Updates". The Data Set specifications that contain this item will be updated in the next version of the Information Standard where it is not already correct.

For enquiries about this Change Request, please email information.standards@nhs.net