Health and Social Care Information Centre

NHS Data Model and Dictionary Service

Type:	Data Dictionary Change Notice
Reference:	1534
Version No:	1.0
Subject:	Retirement of Hospital Episode Statistics Cross Reference Tables
Effective Date:	Immediate
Reason for Change:	Retirement of Hospital Episode Statistics Cross Reference Tables
Publication Date:	26 October 2015

Background:

Hospital Episode Statistics (HES) is a data warehouse containing details of all Admitted Patient Care, Outpatient Attendances and Accident and Emergency attendances in England.

Within the NHS Data Model and Dictionary there are two tables that cross reference Commissioning Data Set (CDS) data elements with the HES name for Admitted Patient Care only. These tables have not been maintained in line with new CDS versions for some years and it has now been agreed to retire the cross reference tables.

This Data Dictionary Change Notice retires the HES - CDS data items cross reference tables and removes the HES name from the applicable data elements.

For further information regarding HES items please refer to the HES Data Dictionary, which is available on the Health Social Care Information Centre Website: http://www.hscic.gov.uk/hesdatadictionary

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

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

Summary of changes:

Data Set

HES - CDS DATA ITEMS CROSS REFERENCED BY HES ITEM - TABLE 2 (RETIRED) renamed from HES - CDS DATA ITEMS CROSS REFERENCED BY HES ITEM - TABLE 2	Changed Name, Description, status to Retired
HES - CDS DATA ITEMS CROSS REFERENCED BY HES NAME - TABLE 1 (RETIRED) renamed from HES - CDS DATA ITEMS CROSS REFERENCED BY HES NAME - TABLE 1	Changed Name, Description, status to Retired

Supporting Information

DATA ELEMENTS HELP	Changed Description
HES CROSS REFERENCE TABLES NAVIGATION (RETIRED) renamed from HES CROSS REFERENCE TABLES NAVIGATION	Changed Name, Description, status to Retired
HOSPITAL EPISODE STATISTICS	Changed Description

Data Elements

ACTIVITY TREATMENT FUNCTION CODE	Changed Description
ADMINISTRATIVE CATEGORY CODE	Changed Description
ADMINISTRATIVE CATEGORY CODE (ON ADMISSION)	Changed Description
ADMISSION METHOD CODE (HOSPITAL PROVIDER SPELL)	Changed Description
AGE AT CENSUS	Changed Description

ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY CODE	Changed Description
ANAESTHETIC GIVEN POST LABOUR OR DELIVERY CODE	Changed Description
BIRTH DATE	Changed Description
BIRTH ORDER	Changed Description
BIRTH WEIGHT	Changed Description
CARE PROFESSIONAL MAIN SPECIALTY CODE	Changed Description
CARER SUPPORT INDICATOR	Changed Description
COMMISSIONING SERIAL NUMBER	Changed Description
CONSULTANT CODE	Changed Description
DATE DETENTION COMMENCED	Changed Description
DECIDED TO ADMIT DATE	Changed Description
DELIVERY METHOD CODE	Changed Description
DELIVERY PLACE CHANGE REASON CODE	Changed Description
DELIVERY PLACE TYPE CODE (ACTUAL)	Changed Description
DELIVERY PLACE TYPE CODE (INTENDED)	Changed Description
DETAINED AND (OR) LONG TERM PSYCHIATRIC CENSUS DATE	Changed Description
DISCHARGE DATE (HOSPITAL PROVIDER SPELL)	Changed Description
DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL)	Changed Description
DISCHARGE METHOD (HOSPITAL PROVIDER SPELL)	Changed Description
DISCHARGE METHOD CODE (HOSPITAL PROVIDER SPELL)	Changed Description
DURATION OF CARE TO PSYCHIATRIC CENSUS DATE	Changed Description
DURATION OF DETENTION	Changed Description
DURATION OF ELECTIVE WAIT	Changed Description
END DATE (EPISODE)	Changed Description
EPISODE NUMBER	Changed Description
ETHNIC CATEGORY	Changed Description
FIRST ANTENATAL ASSESSMENT DATE	Changed Description
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	Changed Description
GENERAL MEDICAL PRACTITIONER (SPECIFIED)	Changed Description
GESTATION LENGTH	Changed Description
HOSPITAL PROVIDER SPELL NUMBER	Changed Description
INTENDED MANAGEMENT CODE	Changed Description
LABOUR OR DELIVERY ONSET METHOD CODE	Changed Description
LAST EPISODE IN SPELL INDICATOR CODE	Changed Description
LIVE OR STILL BIRTH CODE	Changed Description
LOCAL PATIENT IDENTIFIER	Changed Description
LOWER LAYER SUPER OUTPUT AREA (RESIDENCE)	Changed Description
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (AT CENSUS DATE)	Changed Description
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION)	Changed Description
NEONATAL LEVEL OF CARE CODE	Changed Description
NHS NUMBER	Changed Description
NUMBER OF BABIES INDICATION CODE	Changed Description
OPERATION STATUS CODE	Changed Description
ORGANISATION CODE (CODE OF COMMISSIONER)	Changed Description
ORGANISATION CODE (CODE OF PROVIDER)	Changed Description
ORGANISATION CODE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES STEPPED TO PROVIDER)	Changed Description
ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)	Changed Description
ORGANISATION CODE (STOP SMOKING SERVICE PROVIDER)	Changed Description
PATIENT CLASSIFICATION CODE	Changed Description
PERSON BIRTH DATE	Changed Description
PERSON BIRTH DATE (BABY)	Changed Description
PERSON BIRTH DATE (MOTHER)	Changed Description

[POSTCODE OF USUAL ADDRESS](#)	Changed Description
[PREGNANCY TOTAL PREVIOUS PREGNANCIES](#)	Changed Description
[PRIMARY PROCEDURE (OPCS)](#)	Changed Description
[PRIMARY PROCEDURE DATE](#)	Changed Description
[PSYCHIATRIC PATIENT STATUS CODE](#)	Changed Description
[REFERRER CODE](#)	Changed Description
[RESUSCITATION METHOD CODE](#)	Changed Description
[SEX](#)	Changed Description
[SITE CODE (OF TREATMENT)](#)	Changed Description
[SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL)](#)	Changed Description
[START DATE (CONSULTANT EPISODE)](#)	Changed Description
[START DATE (EPISODE)](#)	Changed Description
[START DATE (HOSPITAL PROVIDER SPELL)](#)	Changed Description
[STATUS OF PATIENT INCLUDED IN THE PSYCHIATRIC CENSUS CODE](#)	Changed Description
[STATUS OF PERSON CONDUCTING DELIVERY CODE](#)	Changed Description

Date: 26 October 2015
Sponsor: Peter Counter, Chief Technology Officer, Health and Social Care Information Centre

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

HES - CDS DATA ITEMS CROSS REFERENCED BY HES ITEM - TABLE 2 (RETIRED) renamed from HES - CDS DATA ITEMS CROSS REFERENCED BY HES ITEM - TABLE 2

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

~~HES / CDS Data Elements cross referenced by HES Item - Table 2~~
~~**CDS Type key**:~~

~~G = General Episode~~
~~D = Delivery Episode~~
~~B = Birth Episode~~
~~PC = Detained and or Long Term Psychiatric Census~~
~~OD = Other Delivery~~
~~OB = Other Birth~~**This item has been retired from the NHS Data Model and Dictionary.**

~~● = Mandatory for this CDS Type~~
~~O = Optional for this CDS Type~~**The last live version of this item is available in the September 2015 release of the NHS Data Model and Dictionary.**

HES Item	HES Name	CDS Data Element	CDS TYPE					
			G	D	B	PC	OD	OB
~~ADMINISTRATIVE CATEGORY (on admission)~~	~~**ADMINCAT**~~	~~ADMINISTRATIVE CATEGORY (on admission)~~	●	●	●	●		
~~ADMISSION METHOD (HOSPITAL PROVIDER SPELL)~~	~~**ADMIMETH**~~	~~ADMISSION METHOD (HOSPITAL PROVIDER SPELL)~~	●	●	●	●		
~~AGE AT CENSUS~~	~~**CENSAGE**~~	~~AGE AT CENSUS~~				●		
~~ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY~~	~~**DELPREAN**~~	~~ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY~~		●	●		●	●
~~ANAESTHETIC GIVEN POST LABOUR OR DELIVERY~~	~~**DELPOSAN**~~	~~ANAESTHETIC GIVEN POST LABOUR OR DELIVERY~~		●	●		●	●
~~AUGMENTED CARE LOCAL IDENTIFIER~~	~~**ACPLOCID**~~	~~AUGMENTED CARE PERIOD LOCAL IDENTIFIER~~	O	O	O			
~~AUGMENTED CARE LOCATION~~	~~**ACPLOC**~~	~~AUGMENTED CARE LOCATION~~	●	●	●			

Data Element	Abbr.	CDS Name						
AUGMENTED CARE OUTCOME INDICATOR	ACPOUT	AUGMENTED CARE OUTCOME INDICATOR	●	●	●			
AUGMENTED CARE PERIOD DISPOSAL	ACPDISP	AUGMENTED CARE PERIOD DISPOSAL	●	●	●			
AUGMENTED CARE PERIOD NUMBER	ACPN	AUGMENTED CARE PERIOD NUMBER	●	●	●			
AUGMENTED CARE PERIOD SOURCE	ACPSOUR	AUGMENTED CARE PERIOD SOURCE	●	●	●			
AUGMENTED CARE PLANNED INDICATOR	ACPPLAN	AUGMENTED CARE PLANNED INDICATOR	●	●	●			
BIRTH DATE	DOB	BIRTH DATE	●	●	●	●	●	●
BIRTH DATE (BABY)	DOBBABY	BIRTH DATE (BABY)		●			●	
BIRTH DATE (MOTHER)	MOTDOB	BIRTH DATE (MOTHER)			●			●
BIRTH ORDER	BIRORDER	BIRTH ORDER		●	●		●	●
BIRTH WEIGHT	BIRWEIT	BIRTH WEIGHT		●	●		●	●
CARER SUPPORT INDICATOR	CARERSI	CARER SUPPORT INDICATOR	O		O	O		
CATEGORY OF PATIENT	CATEGORY	Not in CDS						
CODE OF GP PRACTICE (REGISTERED GMP)	GPPRAC	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	O	O	O	O	O	O
COMMISSIONING SERIAL NUMBER	CSNUM	COMMISSIONING SERIAL NUMBER	●	●	●	●	●	●
CONSULTANT CODE	CONSULT	CONSULTANT CODE	●	●	●	●		
DATE DETENTION COMMENCED	DETNDATE	DATE DETENTION COMMENCED				●		
DECIDED TO ADMIT DATE	ELECDATE	DECIDED TO ADMIT DATE (for this provider)	●			●		
DELIVERY METHOD	DELMETH	DELIVERY METHOD		●	●		●	●
DELIVERY PLACE CHANGE REASON	DELCHANG	DELIVERY PLACE CHANGE REASON		●	●		●	●
DELIVERY PLACE TYPE (ACTUAL)	DELPLACE	DELIVERY PLACE TYPE (ACTUAL)		●	●		●	●
DELIVERY PLACE TYPE (INTENDED)	DELINTEN	DELIVERY PLACE TYPE (INTENDED)		●	●		●	●
DETAINED AND OR LONG TERM PSYCHIATRIC CENSUS DATE	CENDATE	DETAINED AND (OR) LONG TERM PSYCHIATRIC CENSUS DATE				●		
DISCHARGE DATE (HOSPITAL PROVIDER SPELL)	DISDATE	DISCHARGE DATE (HOSPITAL PROVIDER SPELL)	●	●	●			
DISCHARGE DESTINATION (HOSPITAL PROVIDER SPELL)	DISDEST	DISCHARGE DESTINATION (HOSPITAL PROVIDER SPELL)	●	●	●			
DISCHARGE METHOD (HOSPITAL PROVIDER SPELL)	DISMETH	DISCHARGE METHOD (HOSPITAL PROVIDER SPELL)	●	●	●			
DURATION OF CARE TO PSYCHIATRIC CENSUS DATE	CENDUR	DURATION OF CARE TO PSYCHIATRIC CENSUS DATE				●		
DURATION OF DETENTION	DETDUR	DURATION OF DETENTION				●		
DURATION OF ELECTIVE WAIT	ELECDUR	DURATION OF ELECTIVE WAIT	●			●		
END DATE (AUGMENTED CARE PERIOD)	ACPEND	END DATE (AUGMENTED CARE PERIOD)	●	●	●			
END DATE (CONSULTANT, NURSE OR MIDWIFE EPISODE)	EPIEND	END DATE (EPISODE)	●	●	●			
EPISODE NUMBER	EPIORDER	EPISODE NUMBER	●	●	●	●		
EPISODE STATUS	EPISTAT	Not in CDS						
EPISODE TYPE	EPITYPE	Not in CDS						
ETHNIC CATEGORY	ETHNOS	ETHNIC CATEGORY	●	●	O	●	●	O

			1	2	3	4	5	6
FIRST ANTENATAL ASSESSMENT DATE	**ANASDATE**	FIRST ANTENATAL ASSESSMENT DATE		●	●		●	●
FIRST REGULAR DAY OR NIGHT ADMISSION	**FIRSTREG**	FIRST REGULAR DAY OR NIGHT ADMISSION	●					
GESTATION LENGTH	**GESTAT**	GESTATION LENGTH		●	●		●	●
GMP (CODE OF REGISTERED OR REFERRING GMP)	**REGGMP**	GENERAL MEDICAL PRACTITIONER (SPECIFIED)	●	●	●	●		●
HEALTHCARE RESOURCE GROUP CODE	**HRGNHS**	HEALTHCARE RESOURCE GROUP CODE	●	●	●	●		
HEALTHCARE RESOURCE GROUP CODE – VERSION NUMBER	**HRGNHSVN**	HEALTHCARE RESOURCE GROUP CODE VERSION NUMBER	●	●	●	●		
HIGH DEPENDENCY CARE LEVEL DAYS	**DEPDAYS**	HIGH DEPENDENCY CARE LEVEL DAYS	●	●	●			
HOSPITAL PROVIDER SPELL NUMBER	**PROVSPNO**	HOSPITAL PROVIDER SPELL NUMBER	●	●	●	●		
HRG DOMINANT GROUPING VARIABLE – PROCEDURE	**DOMPROC**	HRG DOMINANT GROUPING VARIABLE PROCEDURE	○	○	○	○		
INTENDED MANAGEMENT	**INTMANIG**	INTENDED MANAGEMENT	●			●		
INTENSIVE CARE LEVEL DAYS	**INTDAYS**	INTENSIVE CARE LEVEL DAYS	●	●	●			
LABOUR OR DELIVERY ONSET METHOD	**DELONSET**	LABOUR OR DELIVERY ONSET METHOD		●	●		●	●
LAST EPISODE IN SPELL INDICATOR	**SPELEND**	LAST EPISODE IN SPELL INDICATOR	●	●	●			
LEGAL STATUS CLASSIFICATION CODE (AT CENSUS DATE)	**LEGLSTAT**	LEGAL STATUS CLASSIFICATION CODE (AT CENSUS DATE)				●		
LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION)	**LEGLCAT**	LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION)	●	●		●		
LIVE OR STILL BIRTH	**BIRSTAT**	LIVE OR STILL BIRTH		●	●		●	●
LOCAL PATIENT IDENTIFIER	**LOPATID**	LOCAL PATIENT IDENTIFIER	●	●	●	●	●	
MAIN SPECIALTY CODE	**MAINSPEF**	MAIN SPECIALTY CODE	●	●	●	●		
MAIN SPECIALTY CODE (AUGMENTED CARE PERIOD)	**ACPSPEF**	MAIN SPECIALTY CODE (AUGMENTED CARE PERIOD)	●	●	●			
MARITAL STATUS	**MARSTAT**	MARITAL STATUS	●	●			●	
MENTAL CATEGORY	**MENTCAT**	MENTAL CATEGORY				●		
NEONATAL LEVEL OF CARE	**NEOCARE**	NEONATAL LEVEL OF CARE	●		●			
NHS NUMBER	**NEWNHSNO**	NHS NUMBER	●	●	○	○	●	○
NHS NUMBER STATUS INDICATOR	**NHSNOIND**	NHS NUMBER STATUS INDICATOR	●	●	●	●	●	●
NUMBER OF AUGMENTED CARE PERIODS WITHIN EPISODE	**NUMACP**	NUMBER OF AUGMENTED CARE PERIODS WITHIN EPISODE	●	●	●			
NUMBER OF BABIES	**NUMBABY**	NUMBER OF BABIES		●	●		●	●
NUMBER OF ORGAN SYSTEMS SUPPORTED (for intensive care level only)	**ORGSUP**	NUMBER OF ORGAN SYSTEMS SUPPORTED	●	●	●			
OPERATION (OPCS-4)	**OPERTN2 - OPERTN12**	PROCEDURE (OPCS)	●	●	●			
OPERATION STATUS (per episode)	**OPERSTAT**	OPERATION STATUS (per episode)	●	●	●			
ORGANISATION CODE (CODE OF COMMISSIONER)	**PURCODE**	ORGANISATION CODE (CODE OF COMMISSIONER)	●	●	●	●	●	●
ORGANISATION CODE (CODE OF PROVIDER)	**PROCODE**	ORGANISATION CODE (CODE OF PROVIDER)	●	●	●	●	●	●
	PCTR		●	●	●	●	●	●

HES Item	Code	CDS Item						
~~ORGANISATION CODE (PCT OF RESIDENCE)~~		ORGANISATION CODE (PCT OF RESIDENCE)						
~~PATIENT CLASSIFICATION~~	**CLASSPAT**	PATIENT CLASSIFICATION	•	•	•	•		
~~POSTCODE OF USUAL ADDRESS~~	**HOMEADD**	POSTCODE OF USUAL ADDRESS	•	•	•	•	•	•
~~PREGNANCY TOTAL PREVIOUS PREGNANCIES~~	**NUMPREG**	PREGNANCY TOTAL PREVIOUS PREGNANCIES		•			•	
~~PRIMARY (ICD-10)~~	**CENDIAG1**	PRIMARY DIAGNOSIS (ICD)				•		
~~PRIMARY (ICD-10)~~	**DIAG_1**	PRIMARY DIAGNOSIS (ICD)	•	•	•			
~~PRIMARY OPERATION (OPCS-4)~~	**OPERTN1**	PRIMARY OPERATION (OPCS-4)	•	•	•			
~~PRIMARY PROCEDURE DATE~~	**OPDATE1**	PROCEDURE DATE	•	•	•			
~~PSYCHIATRIC PATIENT STATUS~~	**ADMISTAT**	PSYCHIATRIC PATIENT STATUS	•	•		•		
~~RECORD TYPE~~	**RECTYPE**	Not in CDS						
~~REFERRER CODE~~	**REFERRER**	REFERRER CODE	•	•	•	•		
~~REFERRING ORGANISATION CODE~~	**REFERORG**	REFERRING ORGANISATION CODE	•	•	•	•		
~~RESUSCITATION METHOD~~	**BIRRESUS**	RESUSCITATION METHOD		•	•		•	•
~~SECOND - TWELFTH OPERATION DATE~~	**OPDATE2 - OPDATE 12**	PROCEDURE DATE	•	•	•			
~~SECONDARY (ICD-10)~~	**CENDIAG3 - CENDIAG14**	SECONDARY DIAGNOSIS (ICD)				•		
~~SECONDARY (ICD-10)~~	**DIAG_3 - DIAG_14**	SECONDARY DIAGNOSIS (ICD)	•	•	•			
~~SEX~~	**SEX**	SEX	•	•	•	•	•	•
~~SEX (BABY)~~	**SEXBABY**	SEX (BABY)		•			•	
~~SITE CODE (OF TREATMENT) (at start of episode)~~	**SITETRET**	SITE CODE (OF TREATMENT)	•	•	•	•		
~~SOURCE OF ADMISSION (HOSPITAL PROVIDER SPELL)~~	**ADMISORC**	SOURCE OF ADMISSION (HOSPITAL PROVIDER SPELL)	•	•	•	•		
~~START DATE (AUGMENTED CARE PERIOD)~~	**ACPSTAR**	START DATE (AUGMENTED CARE PERIOD)	•	•	•			
~~START DATE (CONSULTANT, NURSE OR MIDWIFE EPISODE)~~	**EPISTART**	START DATE (EPISODE)	•	•	•	•		
~~START DATE (HOSPITAL PROVIDER SPELL)~~	**ADMIDATE**	START DATE (HOSPITAL PROVIDER SPELL)	•	•	•	•		
~~STATUS OF PATIENT INCLUDED IN THE PSYCHIATRIC CENSUS~~	**CENSAT**	STATUS OF PATIENT INCLUDED IN THE PSYCHIATRIC CENSUS				•		
~~STATUS OF PERSON CONDUCTING DELIVERY~~	**DELSTAT**	STATUS OF PERSON CONDUCTING DELIVERY		•	•		•	•
~~TREATMENT FUNCTION CODE~~	**TRETSPEF**	TREATMENT FUNCTION CODE	•	•	•	•		
~~WARD TYPE AT PSYCHIATRIC CENSUS DATE~~	**CENWARD**	Not in CDS						
~~WARD TYPE AT START OF EPISODE~~	**WARDSTRT**	Not in CDS						

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

HES - CDS DATA ITEMS CROSS REFERENCED BY HES ITEM - TABLE 2 (RETIRED)_ renamed from HES - CDS DATA ITEMS CROSS REFERENCED BY HES ITEM - TABLE 2

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

- Changed Name from Web_Site_Content.CDS_Supporting_Information.Hospital_Episode_Statistics.HES_-_CDS_Data_items_cros
to Retired.Web_Site_Content.CDS_Supporting_Information.HES_-_CDS_Data_items_cross_referenced_by_H
- Changed Description
- Retired HES - CDS Data items cross referenced by HES Item - Table 2

HES - CDS DATA ITEMS CROSS REFERENCED BY HES NAME - TABLE 1 (RETIRED)_ renamed from HES - CDS DATA ITEMS CROSS REFERENCED BY HES NAME - TABLE 1

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

HES / CDS Data Elements cross referenced by HES Name - Table 1

CDS Type key:

G = General Episode
D = Delivery Episode
B = Birth Episode
PC = Detained and or Long Term Psychiatric Census
OD = Other Delivery
OB = Other Birth**This item has been retired from the NHS Data Model and Dictionary.**

● = Mandatory for this CDS Type
O = Optional for this CDS Type**The last live version of this item is available in the September 2015 release of the NHS Data Model and Dictionary.**

HES Name	HES Item	CDS Data Element	CDS TYPE					
			G	D	B	PC	OD	OB
ACPDISP	AUGMENTED CARE PERIOD DISPOSAL	AUGMENTED CARE PERIOD DISPOSAL	●	●	●			
ACPEND	END DATE (AUGMENTED CARE PERIOD)	END DATE (AUGMENTED CARE PERIOD)	●	●	●			
ACPLOC	AUGMENTED CARE LOCATION	AUGMENTED CARE LOCATION	●	●	●			
ACPLOCID	AUGMENTED CARE LOCAL IDENTIFIER	AUGMENTED CARE PERIOD LOCAL IDENTIFIER	O	O	O			
ACPN	AUGMENTED CARE PERIOD NUMBER	AUGMENTED CARE PERIOD NUMBER	●	●	●			
ACPOUT	AUGMENTED CARE OUTCOME INDICATOR	AUGMENTED CARE OUTCOME INDICATOR	●	●	●			
ACPPLAN	AUGMENTED CARE PLANNED INDICATOR	AUGMENTED CARE PLANNED INDICATOR	●	●	●			
ACPSOUR	AUGMENTED CARE PERIOD SOURCE	AUGMENTED CARE PERIOD SOURCE	●	●	●			
ACPSPEF	MAIN SPECIALTY CODE (AUGMENTED CARE PERIOD)	MAIN SPECIALTY CODE (AUGMENTED CARE PERIOD)	●	●	●			
ACPSTAR	START DATE (AUGMENTED CARE PERIOD)	START DATE (AUGMENTED CARE PERIOD)	●	●	●			
ADMIDATE	START DATE (HOSPITAL PROVIDER SPELL)	START DATE (HOSPITAL PROVIDER SPELL)	●	●	●	●		
ADMIMETH	ADMISSION METHOD (HOSPITAL PROVIDER SPELL	ADMISSION METHOD (HOSPITAL PROVIDER SPELL)	●	●	●	●		
ADMINCAT	ADMINISTRATIVE CATEGORY (on admission)	ADMINISTRATIVE CATEGORY (on admission)	●	●	●	●		
ADMISORC	SOURCE OF ADMISSION (HOSPITAL PROVIDER SPELL)	SOURCE OF ADMISSION (HOSPITAL PROVIDER SPELL)	●	●	●	●		
ADMISTAT	PSYCHIATRIC PATIENT STATUS	PSYCHIATRIC PATIENT STATUS	●	●			●	

Element	Description	CDS Description	1	2	3	4	5	6
ANASDATE	FIRST ANTENATAL ASSESSMENT DATE	FIRST ANTENATAL ASSESSMENT DATE		•	•		•	•
BIRORDER	BIRTH ORDER	BIRTH ORDER		•	•		•	•
BIRRESUS	RESUSCITATION METHOD	RESUSCITATION METHOD		•	•		•	•
BIRSTAT	LIVE OR STILL BIRTH	LIVE OR STILL BIRTH		•	•		•	•
BIRWEIT	BIRTH WEIGHT	BIRTH WEIGHT		•	•		•	•
CATEGORY	CATEGORY OF PATIENT	Not in CDS						
CARERSI	CARER SUPPORT INDICATOR	CARER SUPPORT INDICATOR	o		o	o		
CENDATE	DETAINED AND OR LONG TERM PSYCHIATRIC CENSUS DATE	DETAINED AND (OR) LONG TERM PSYCHIATRIC CENSUS DATE					•	
CENDIAG1	PRIMARY (ICD-10)	PRIMARY DIAGNOSIS (ICD)					•	
CENDIAG3 – CENDIAG14	SECONDARY (ICD-10)	SECONDARY DIAGNOSIS (ICD)					•	
CENDUR	DURATION OF CARE TO PSYCHIATRIC CENSUS DATE	DURATION OF CARE TO PSYCHIATRIC CENSUS DATE					•	
CENSAGE	AGE AT CENSUS	AGE AT CENSUS					•	
CENSAT	STATUS OF PATIENT INCLUDED IN THE PSYCHIATRIC CENSUS	STATUS OF PATIENT INCLUDED IN THE PSYCHIATRIC CENSUS					•	
CENWARD	WARD TYPE AT PSYCHIATRIC CENSUS DATE	Not in CDS					•	
CLASSPAT	PATIENT CLASSIFICATION	PATIENT CLASSIFICATION	•	•	•	•		
CONSULT	CONSULTANT CODE	CONSULTANT CODE	•	•	•	•		
CSNUM	COMMISSIONING SERIAL NUMBER	COMMISSIONING SERIAL NUMBER	•	•	•	•	•	•
DELCHANG	DELIVERY PLACE CHANGE REASON	DELIVERY PLACE CHANGE REASON		•	•		•	•
DELINTEN	DELIVERY PLACE TYPE (INTENDED)	DELIVERY PLACE TYPE (INTENDED)		•	•		•	•
DELMETH	DELIVERY METHOD	DELIVERY METHOD		•	•		•	•
DELONSET	LABOUR OR DELIVERY ONSET METHOD	LABOUR OR DELIVERY ONSET METHOD		•	•		•	•
DELPLACE	DELIVERY PLACE TYPE (ACTUAL)	DELIVERY PLACE TYPE (ACTUAL)		•	•		•	•
DELPOSAN	ANAESTHETIC GIVEN POST LABOUR OR DELIVERY	ANAESTHETIC GIVEN POST LABOUR OR DELIVERY		•	•		•	•
DELSTAT	STATUS OF PERSON CONDUCTING DELIVERY	STATUS OF PERSON CONDUCTING DELIVERY		•	•		•	•
DEPDAYS	HIGH DEPENDENCY CARE LEVEL DAYS	HIGH DEPENDENCY CARE LEVEL DAYS	•	•	•			
DELPREAN	ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY	ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY		•	•		•	•
DETDUR	DURATION OF DETENTION	DURATION OF DETENTION					•	
DETNDATE	DATE DETENTION COMMENCED	DATE DETENTION COMMENCED					•	
DIAG_1	PRIMARY (ICD-10)	PRIMARY (ICD-10)	•	•	•			
DIAG_3 – DIAG_14	SECONDARY (ICD-10)	SECONDARY DIAGNOSIS (ICD)	•	•	•			
DISDATE	DISCHARGE DATE (HOSPITAL PROVIDER SPELL)	DISCHARGE DATE (HOSPITAL PROVIDER SPELL)	•	•	•			
DISDEST	DISCHARGE DESTINATION (HOSPITAL PROVIDER SPELL)	DISCHARGE DESTINATION (HOSPITAL PROVIDER SPELL)	•	•	•			
DISMETH	DISCHARGE METHOD (HOSPITAL PROVIDER SPELL)	DISCHARGE METHOD (HOSPITAL PROVIDER SPELL)	•	•	•			
DOB	BIRTH DATE	BIRTH DATE	•	•	•	•	•	•

Element	Description	Description (CDS)	1	2	3	4	5	6
DOBBABY	BIRTH DATE (BABY)	BIRTH DATE (BABY)		•			•	
DOMPROC	HRG DOMINANT GROUPING VARIABLE – PROCEDURE	HRG DOMINANT GROUPING VARIABLE PROCEDURE	○	○	○	○		
ELECDATE	DECIDED TO ADMIT DATE	DECIDED TO ADMIT DATE (for this provider)	•			•		
ELECDUR	DURATION OF ELECTIVE WAIT	DURATION OF ELECTIVE WAIT	•			•		
EPIEND	END DATE (CONSULTANT, NURSE OR MIDWIFE EPISODE)	END DATE (EPISODE)	•	•	•			
EPIORDER	EPISODE NUMBER	EPISODE NUMBER	•	•	•	•		
EPISTART	START DATE (CONSULTANT, NURSE OR MIDWIFE EPISODE)	START DATE (EPISODE),	•	•	•	•		
EPISTAT	EPISODE STATUS	Not in CDS						
EPITYPE	EPISODE TYPE	Not in CDS						
ETHNOS	ETHNIC CATEGORY	ETHNIC CATEGORY	•	•	○	•	•	○
FIRSTREG	FIRST REGULAR DAY OR NIGHT ADMISSION	FIRST REGULAR DAY OR NIGHT ADMISSION	•					
GESTAT	GESTATION LENGTH	GESTATION LENGTH		•	•		•	•
GPPRAC	CODE OF GP PRACTICE (REGISTERED GMP)	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	○	○	○	○	○	○
HOMEADD	POSTCODE OF USUAL ADDRESS	POSTCODE OF USUAL ADDRESS	•	•	•	•	•	
HRGNHS	HEALTHCARE RESOURCE GROUP CODE	HEALTHCARE RESOURCE GROUP CODE	•	•	•	•		
HRGNHSVN	HEALTHCARE RESOURCE GROUP CODE – VERSION NUMBER	HEALTHCARE RESOURCE GROUP CODE VERSION NUMBER	•	•	•	•		
INTDAYS	INTENSIVE CARE LEVEL DAYS	INTENSIVE CARE LEVEL DAYS	•	•	•			
INTMANIG	INTENDED MANAGEMENT	INTENDED MANAGEMENT	•			•		
LEGLCAT	LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION)	LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION)	•	•		•		
LEGLSTAT	LEGAL STATUS CLASSIFICATION CODE (AT CENSUS DATE)	LEGAL STATUS CLASSIFICATION CODE (AT CENSUS DATE)				•		
LOPATID	LOCAL PATIENT IDENTIFIER	LOCAL PATIENT IDENTIFIER	•	•	•	•	•	•
MAINSPEF	MAIN SPECIALTY CODE	MAIN SPECIALTY CODE	•	•	•	•		
MARSTAT	MARITAL STATUS	MARITAL STATUS	•	•		•	•	
MENTCAT	MENTAL CATEGORY	MENTAL CATEGORY				•		
MOTDOB	BIRTH DATE (MOTHER)	BIRTH DATE (MOTHER)			•			•
NEOCARE	NEONATAL LEVEL OF CARE	NEONATAL LEVEL OF CARE	•		•			
NEWNHSNO	NHS NUMBER	NHS NUMBER	•	•	○	•	○	○
NHSNOIND	NHS NUMBER STATUS INDICATOR	NHS NUMBER STATUS INDICATOR	•	•	•	•	•	•
NUMACP	NUMBER OF AUGMENTED CARE PERIODS WITHIN EPISODE	NUMBER OF AUGMENTED CARE PERIODS WITHIN EPISODE	•	•	•			
NUMBABY	NUMBER OF BABIES	NUMBER OF BABIES		•	•		•	•
NUMPREG	PREGNANCY TOTAL PREVIOUS PREGNANCIES	PREGNANCY TOTAL PREVIOUS PREGNANCIES		•			•	
OPDATE1	PRIMARY PROCEDURE DATE	PROCEDURE DATE	•	•	•			
OPDATE2 – OPDATE 12	SECOND – TWELFTH OPERATION DATE	PROCEDURE DATE	•	•	•			
OPERTN1	PRIMARY OPERATION (OPCS-4)	PRIMARY PROCEDURE (OPCS)	•	•	•			
	OPERATION (OPCS-4)	PROCEDURE (OPCS)	•	•	•			

OPERTN2 - OPERTN12								
OPERSTAT	OPERATION STATUS (per episode)	OPERATION STATUS (per episode)	●	●	●			
ORGSUP	NUMBER OF ORGAN SYSTEMS SUPPORTED (for intensive care level only)	NUMBER OF ORGAN SYSTEMS SUPPORTED (for intensive care level only)	●	●	●			
PCTR	ORGANISATION CODE (PCT OF RESIDENCE)	ORGANISATION CODE (PCT OF RESIDENCE)	●	●	●	●	●	●
PROCODE	ORGANISATION CODE (CODE OF PROVIDER)	ORGANISATION CODE (CODE OF PROVIDER)	●	●	●	●	●	●
PROVSPNO	HOSPITAL PROVIDER SPELL NUMBER	HOSPITAL PROVIDER SPELL NUMBER	●	●	●	●		
PURCODE	ORGANISATION CODE (CODE OF COMMISSIONER)	ORGANISATION CODE (CODE OF COMMISSIONER)	●	●	●	●	●	●
RECTYPE	RECORD TYPE	Not in CDS						
REFERORG	REFERRING ORGANISATION CODE	REFERRING ORGANISATION CODE	●	●	●	●		
REFERRER	REFERRER CODE	REFERRER CODE	●	●	●	●		
REGGMP	GMP (CODE OF REGISTERED OR REFERRING GMP)	GENERAL MEDICAL PRACTITIONER (SPECIFIED)	●	●	●	●	●	●
SEX	SEX	SEX	●	●	●	●	●	●
SEXBABY	SEX (BABY)	SEX (BABY)		●			●	
SITETRET	SITE CODE (OF TREATMENT) (at start of episode)	SITE CODE (OF TREATMENT) (at start of episode)	●	●	●	●		
SPELEND	LAST EPISODE IN SPELL INDICATOR	LAST EPISODE IN SPELL INDICATOR	●	●	●			
TRETSPEF	TREATMENT FUNCTION CODE	TREATMENT FUNCTION CODE	●	●	●	●		
WARDSTRT	WARD TYPE AT START OF EPISODE	Not in CDS						

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

HES - CDS DATA ITEMS CROSS REFERENCED BY HES NAME - TABLE 1 (RETIRED)_ renamed from HES - CDS DATA ITEMS CROSS REFERENCED BY HES NAME - TABLE 1

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

- Changed Name from Web_Site_Content.CDS_Supporting_Information.Hospital_Episode_Statistics.HES_-_CDS_Data_items_cro to Retired.Web_Site_Content.CDS_Supporting_Information.HES_-_CDS_Data_items_cross_referenced_by_H
- Changed Description
- Retired HES - CDS Data items cross referenced by HES Name - Table 1

DATA ELEMENTS HELP

Change to Supporting Information: Changed Description

A Data Element is the definition of the information which is usually transmitted in a Data Set.

In addition, Data Elements can contain text providing guidance, support, values or other information concerning the Data Element and its usage.

Each Data Element:

- Has a Green Bar to signify that it is a Data Element;
- Name is in UPPERCASE and where the name appears in text in **GREEN**, it indicates that it is a hyperlink and if clicked on will display the definition for that Data Element.

The following information is available on an Data Element:

- **"Description" tab**: a definition of the Data Element which provides hyperlinks to other related definitions.

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

  - **HES Item**:
    - This is the Hospital Episode Statistics (HES) name for the Data Element, for example, Data Element PERSON BIRTH DATE has a Hospital Episode Statistics item name of "DOB".
    - Hospital Episode Statistics is a data warehouse containing details of all Accident and Emergency, admitted and outpatient activity reported in the Commissioning Data Sets, therefore, not all Data Elements have a HES Item name.
    - A list of HES names can be found in the Hospital Episode Statistics Cross Reference Tables.

  - **National Codes**:
    - An entry in this field indicates that National Codes or classifications exist for the Data Element (as an Attribute) and describes how to view them.
    - If there are no agreed National Codes or classifications for the Data Element, the field is blank.
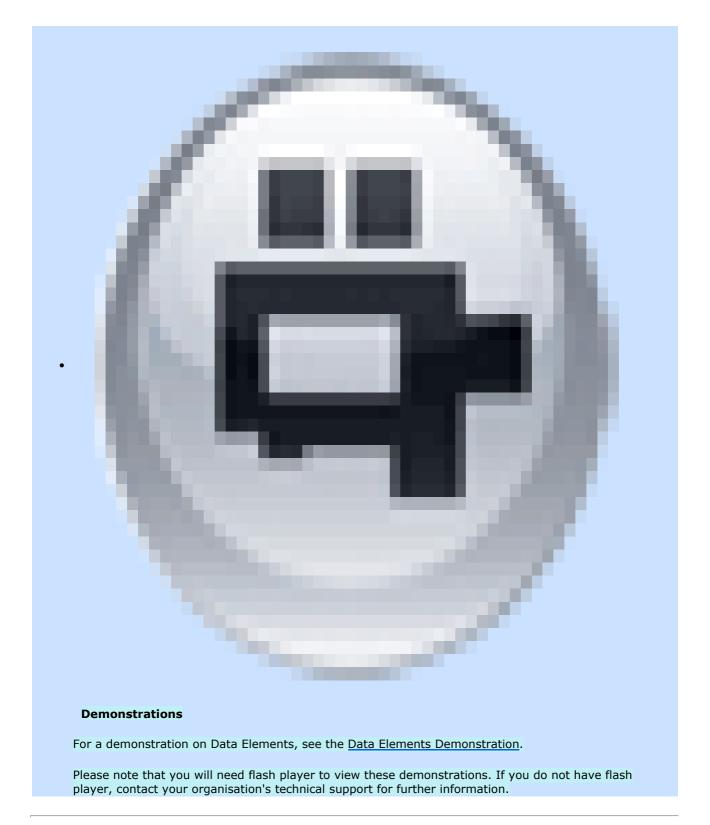
  - **Default Codes**:
    - An entry in this field indicates that in addition to the agreed National Codes for the Data Element, there are default codes applicable to that Data Element only.
    - If there are no Default Codes for the Data Element, the field is blank.

  - **Notes**:
    - The Notes section provides guidance or other information concerning the Data Element and its usage.
    - The table at the foot of the page shows if there is an alias for this Data Element, e.g. schema name etc.

- **"Where Used" tab**: every item where the Data Element is used within the NHS Data Model and Dictionary.

- **"Attribute" tab**: the Attribute the Data Element is based on.
  - Most Data Elements are linked to Attributes so they can share the common Attribute definition. For example, NHS NUMBER, NHS NUMBER (BABY) and NHS NUMBER (MOTHER) are based on the one Attribute of NHS NUMBER.
  - Not all Data Elements are based on an Attribute. Some Data Elements are derived from other items, for example, AGE ON ADMISSION is a derived item and is not linked to an Attribute.

What would you like to do next?

- **NHS**

Data Model and Dictionary Content

View Data Elements in the NHS Data Model and Dictionary.

-

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

  - **National Codes:**
    - An entry in this field indicates that National Codes or classifications exist for the Data Element (as an Attribute) and describes how to view them.
    - If there are no agreed National Codes or classifications for the Data Element, the field is blank.

  - **Default Codes**:
    - An entry in this field indicates that in addition to the agreed National Codes for the Data Element, there are default codes applicable to that Data Element only.
    - If there are no Default Codes for the Data Element, the field is blank.

  - **Notes**:
    - The Notes section provides guidance or other information concerning the Data Element and its usage.
    - The table at the foot of the page shows if there is an alias for this Data Element, e.g. schema name etc.

- **"Where Used" tab**: every item where the Data Element is used within the NHS Data Model and Dictionary.

- **"Attribute" tab**: the Attribute the Data Element is based on.
  - Most Data Elements are linked to Attributes so they can share the common Attribute definition. For example, NHS NUMBER, NHS NUMBER (BABY) and NHS NUMBER (MOTHER) are based on the one Attribute of NHS NUMBER.
  - Not all Data Elements are based on an Attribute. Some Data Elements are derived from other items, for example, AGE ON ADMISSION is a derived item and is not linked to an Attribute.

What would you like to do next?

- **NHS**

Data Model and Dictionary Content

View Data Elements in the NHS Data Model and Dictionary.

-

Demonstrations

For a demonstration on Data Elements, see the Data Elements Demonstration.

Please note that you will need flash player to view these demonstrations. If you do not have flash player, contact your organisation's technical support for further information.

HES CROSS REFERENCE TABLES NAVIGATION (RETIRED) renamed from HES CROSS REFERENCE TABLES NAVIGATION

Change to Supporting Information: Changed Name, Description, status to Retired

- **Commissioning Data Sets Menu**

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

HES CROSS REFERENCE TABLES NAVIGATION (RETIRED) renamed from HES CROSS REFERENCE TABLES NAVIGATION

Change to Supporting Information: Changed Name, Description, status to Retired

- Changed Name from Web_Site_Content.Navigation.HES_Cross_Reference_Tables_Navigation to Retired.Web_Site_Content.Navigation.HES_Cross_Reference_Tables_Navigation
- Changed Description
- Retired HES Cross Reference Tables Navigation

HOSPITAL EPISODE STATISTICS

Change to Supporting Information: Changed Description

~~Hospital Episode Statistics is a data warehouse containing details of all admissions to NHS hospitals in England. It includes private PATIENTS treated in NHS hospitals, PATIENTS who were resident outside of England and care delivered by treatment centres (including those in the independent sector) funded by the NHS. Hospital Episode Statistics also contain details of all NHS Out-Patient Appointments in England.~~

~~Hospital Episode Statistics is the data source for a wide range of healthcare analysis for the NHS, Government and many other ORGANISATIONS and individuals. It contains admitted patient care data from 1989 onwards, with more than 15 million new records added each year, and outpatient attendance data from 2003 onwards, with more than 60 million new records added each year.~~

~~The Secondary Uses Service is used to collect data for input to the Hospital Episode Statistics process.~~ Hospital Episode Statistics is a data warehouse containing details of all Admitted Patient Care, Outpatient Attendances and Accident and Emergency Attendances in England. It includes private PATIENTS treated by the NHS, PATIENTS who were resident outside of England and care delivered by treatment centres (including those in the independent sector) funded by the NHS.

For further information on Hospital Episode Statistics, see the Health and Social Care Information Centre website at: Hospital Episode Statistics.

ACTIVITY TREATMENT FUNCTION CODE

Change to Data Element: Changed Description

Format/Length:	an3
~~HES Item:~~	~~TRETSPEF~~
National Codes:	See TREATMENT FUNCTION CODE
Default codes:	199 - Non-UK provider; TREATMENT FUNCTION not known, treatment mainly surgical
	499 - Non-UK provider; TREATMENT FUNCTION not known, treatment mainly medical

Notes:
ACTIVITY TREATMENT FUNCTION CODE is the same as attribute TREATMENT FUNCTION CODE.

The default codes 199 and 499 are only applicable for overseas health care providers.

ACTIVITY TREATMENT FUNCTION CODE 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 Secondary Uses Service Guidance page.

ADMINISTRATIVE CATEGORY CODE

Change to Data Element: Changed Description

Format/Length:	an2
~~HES Item:~~	~~ADMINCAT~~
National Codes:	See ADMINISTRATIVE CATEGORY CODE
Default Codes:	98 - Not applicable
	99 - Not known: a validation error

Notes:
ADMINISTRATIVE CATEGORY CODE is the same as ADMINISTRATIVE CATEGORY CODE.

ADMINISTRATIVE CATEGORY CODE (ON ADMISSION)

Change to Data Element: Changed Description

Format/Length:	an2
~~HES Item:~~	~~ADMINCAT~~
National Codes:	See ADMINISTRATIVE CATEGORY CODE
Default Codes:	98 - Not applicable
	99 - Not known: a validation error

Notes:
ADMINISTRATIVE CATEGORY CODE (ON ADMISSION) is the same as attribute ADMINISTRATIVE CATEGORY CODE.

ADMINISTRATIVE CATEGORY CODE (ON ADMISSION) is used to record the ADMINISTRATIVE CATEGORY CODE at the start of the Hospital Provider Spell.

ADMISSION METHOD CODE (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Description

Format/Length:	an2
~~HES Item:~~	~~ADMIMETH~~
National Codes:	See ADMISSION METHOD
Default Codes:	98 - Not applicable
	99 - Not known: a validation error

Notes:
ADMISSION METHOD CODE (HOSPITAL PROVIDER SPELL) is the same as attribute ADMISSION METHOD.

ADMISSION METHOD CODE (HOSPITAL PROVIDER SPELL) 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 [Secondary Uses Service Guidance](#) page.

AGE AT CENSUS

Change to Data Element: Changed Description

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

Notes:

[AGE AT CENSUS](#) is the same as [AGE AT CDS ACTIVITY DATE](#) where the [CDS ACTIVITY DATE](#) is the date of the census.

ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY CODE

Change to Data Element: Changed Description

Format/Length:	an1
~~HES Item:~~	~~DELPREAN~~
National Codes:	See [ANAESTHETIC OR ANALGESIC CATEGORY](#)
Default Codes:	8 - Not applicable, i.e. no analgesic or anaesthetic administered
	9 - Not known: a validation error

Notes:

[ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY CODE](#) is derived from attribute [ANAESTHETIC OR ANALGESIC CATEGORY](#) and [PERIOD ADMINISTERED](#) which records whether anaesthetic was given during labour/delivery, and the type used.

ANAESTHETIC GIVEN POST LABOUR OR DELIVERY CODE

Change to Data Element: Changed Description

Format/Length:	an1
~~HES Item:~~	~~DELPOSAN~~
National Codes:	See [ANAESTHETIC OR ANALGESIC CATEGORY](#)
Default Codes:	8 - Not applicable, i.e. no analgesic or anaesthetic administered
	9 - Not known: a validation error

Notes:

[ANAESTHETIC GIVEN POST LABOUR OR DELIVERY CODE](#) is derived from attribute [ANAESTHETIC OR ANALGESIC CATEGORY](#) and [PERIOD ADMINISTERED](#) which records whether anaesthetic was given after delivery, and the type used.

BIRTH DATE

Change to Data Element: Changed Description

Format/Length:	n8 - ccyymmdd
~~HES Item:~~	~~DOB~~
National Codes:	
Default Codes:	

Notes:

BIRTH DATE is the date on which a PERSON was born.

BIRTH DATE will be replaced with PERSON BIRTH DATE which is the most recent approved national information standard to describe the required definition.

BIRTH ORDER

Change to Data Element: Changed Description

Format/Length:	n1
~~HES Item:~~	~~BIRORDER~~
National Codes:	
Default Codes:	8 - Not applicable
	9 - Not known: a validation error

Notes:

BIRTH ORDER is the same as attribute BIRTH ORDER.

BIRTH ORDER records the sequence in which the baby was born, with 1 indicating the first or only birth in the sequence (i.e. singleton), 2 indicating the second birth in the sequence, 3 indicating the third, and so on.

BIRTH WEIGHT

Change to Data Element: Changed Description

Format/Length:	n4
~~HES Item:~~	~~BIRWEIT~~
National Codes:	
Default Codes:	9999 - Not known

Notes:

BIRTH WEIGHT is the Birth Weight, where the UNIT OF MEASUREMENT is *'Grams (g)'*.

The range is 0001 to 9998.

CARE PROFESSIONAL MAIN SPECIALTY CODE

Change to Data Element: Changed Description

Format/Length:	an3
~~HES Item:~~	~~MAINSPEF~~
National Codes:	See MAIN SPECIALTY CODE
Default Codes:	199 - Non-UK provider; specialty function not known, treatment mainly surgical
	499 - Non-UK provider; specialty function not known, treatment mainly medical

Notes:

CARE PROFESSIONAL MAIN SPECIALTY CODE is the same as attribute MAIN SPECIALTY CODE.

CARE PROFESSIONAL MAIN SPECIALTY CODE is the specialty in which the CONSULTANT is contracted or recognised. MAIN SPECIALTY classifies clinical work divisions more precisely for a limited number of specialties.

All Non-Consultant Led Activity is identified by a pseudo CARE PROFESSIONAL MAIN SPECIALTY CODE of:

- 560 - Non-Consultant Led Activity - Midwife Episode
- 950 - Non-Consultant Led Activity - Nursing Episode
- 960 - Non-Consultant Led Activity - Allied Health Professional Episode.

The default codes 199 and 499 are only applicable for overseas providers.

For the purposes of the Quarterly Bed Availability and Occupancy Data Set (KH03), the applicable list of CARE PROFESSIONAL MAIN SPECIALTY CODES is available by emailing unify2@dh.gsi.gov.uk.

CARE PROFESSIONAL MAIN SPECIALTY CODE 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 Secondary Uses Service Guidance page.

CARER SUPPORT INDICATOR

Change to Data Element: Changed Description

Format/Length:	an2
HES Item:	CARERSI
National Codes:	See CARER SUPPORT INDICATOR
Default Codes:	

Notes:
CARER SUPPORT INDICATOR is the same as attribute CARER SUPPORT INDICATOR.

COMMISSIONING SERIAL NUMBER

Change to Data Element: Changed Description

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

Notes:
COMMISSIONING SERIAL NUMBER is the same as attribute NHS SERVICE AGREEMENT NUMBER.

From 01/04/2001 this data item will be used to identify PATIENTS treated under Non-Contract Activities. NHS Trusts and NHS Foundation Trusts are required to insert the letters 'OAT' (mandated input as capitals) in the first three characters of the COMMISSIONING SERIAL NUMBER field of the Admitted Patient Care Commissioning Data Set. The remaining three characters will continue to be defined locally, see DSCN 17/2000.

From 01/04/2005 an '=' (equals) as the last significant character in this six character field will indicate an episode that should be excluded from the National Tariff Payment System tariff.

The position of the last character depends on any preceding characters eg 1st character if field is otherwise blank, 4th character if following 'OAT', up to a maximum of 6th position. This provides a general exclusion facility

for unusual circumstances or where more specific rules regarding coding in other fields cannot be implemented due to local software restrictions.

CONSULTANT CODE

Change to Data Element: Changed Description

Format/Length:	an8
~~HES Item:~~	~~CONSULT~~
National Codes:	
ODS Default Codes:	C9999998 - CONSULTANT, GENERAL MEDICAL COUNCIL REFERENCE NUMBER not known
	CD999998 - Dental CONSULTANT: GENERAL MEDICAL COUNCIL REFERENCE NUMBER / GENERAL DENTAL COUNCIL REGISTRATION NUMBER not known
	D9999998 - Dentist, GENERAL DENTAL PRACTITIONER CODE not known
	M9999998 - MIDWIFE
	N9999998 - NURSE
	H9999998 - Other health care professional

Notes:
CONSULTANT CODE is the same as attribute CONSULTANT CODE.

All Midwife Episodes and attendances are identified in the Commissioning Data Sets and Hospital Episode Statistics by a pseudo CARE PROFESSIONAL MAIN SPECIALTY CODE, 560, see Main Specialty and Treatment Function Codes Table. An Organisation Data Service Default Code is used in the CONSULTANT CODE field to show that a MIDWIFE is the responsible CARE PROFESSIONAL. Note that the MIDWIFE's own Nursing and Midwifery Council code is not used.

All Nursing Episodes and attendances are identified in the Commissioning Data Sets and Hospital Episode Statistics by a pseudo CARE PROFESSIONAL MAIN SPECIALTY CODE, 950, see Main Specialty and Treatment Function Codes Table. An Organisation Data Service Default Code is used in the CONSULTANT CODE field to show that a NURSE is the responsible CARE PROFESSIONAL. Note that the NURSE's own Nursing and Midwifery Council code is not used.

DATE DETENTION COMMENCED

Change to Data Element: Changed Description

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

Notes:
DATE DETENTION COMMENCED is the same as the attribute PERSON PROPERTY EFFECTIVE DATE.

This is the PERSON PROPERTY EFFECTIVE DATE of the Mental Health Act Legal Status. It is the date on which the first order was made in this period of detention, even though the section of the Act under which the PATIENT is detained may have changed, the PATIENT may have been transferred to another provider or the PATIENT was detained under the Act after admission to the current provider. All changes in MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE should be recorded, and the continuous period of detention obtained by comparing the PERSON PROPERTY EFFECTIVE DATES for the historical Mental Health Act Legal Status records. (Act refers to the 1983 Mental Health Act).

Where the detention order is held by a hospital other than that where the PATIENT is present at the date of the census, the latter should ensure the information relating to this detention order is obtained from the former hospital. Only the hospital where the PATIENT is treated should submit the data.

Mental Health Act Legal Status is a CATEGORY VALUED PERSON OBSERVATION where CATEGORY VALUED PERSON OBSERVATION TYPE is National Code 07 '*Legal Status Classification*'.

DECIDED TO ADMIT DATE

Change to Data Element: Changed Description

Format/Length:	See DATE
~~HES Item:~~	~~ELECDATE~~
National Codes:	
Default Codes:	

Notes:

DECIDED TO ADMIT DATE is the same as attribute DECIDED TO ADMIT DATE.

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

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

DELIVERY METHOD CODE

Change to Data Element: Changed Description

Format/Length:	an1
~~HES Item:~~	~~DELMETH~~
National Codes:	See DELIVERY METHOD
Default Codes:	

Notes:

DELIVERY METHOD CODE is the same as attribute DELIVERY METHOD.

Additional National Code guidance not contained in the attribute definition is given below. It is shown in *italics*.

0	Spontaneous vertex *(normal vaginal delivery, occipitoanterior)*
1	Spontaneous other cephalic *(cephalic vaginal delivery with abnormal presentation of head at delivery, without instruments, with or without manipulation)*
2	Low forceps, not breech *(e.g. forceps, low application, without manipulation. Includes forceps delivery not otherwise specified)*
3	Other forceps, not breech *(e.g. forceps with manipulation. Includes high forceps and mid forceps)*
4	Ventouse, vacuum extraction
5	Breech *(spontaneous delivery assisted or unspecified. Includes partial breech extraction)*
6	Breech extraction *(not otherwise specified. Includes total breech extraction and version with breech extraction)*
7	Elective caesarean section *(caesarean section before, or at onset of, labour)*

8 Emergency caesarean section

9 Other than those specified above *(e.g. application of weight to leg in breech delivery. Includes destructive operation to facilitate delivery and other surgical or instrumental delivery)*

DELIVERY PLACE CHANGE REASON CODE

Change to Data Element: Changed Description

Format/Length:	an1
~~HES Item:~~	~~DELCHANG~~
National Codes:	See DELIVERY PLACE CHANGE REASON
Default Codes:	8 - Not applicable (i.e. no change)
	9 - Not known: a validation error

Notes:
DELIVERY PLACE CHANGE REASON CODE is the same as attribute DELIVERY PLACE CHANGE REASON.

DELIVERY PLACE TYPE CODE (ACTUAL)

Change to Data Element: Changed Description

Format/Length:	an1
~~HES Item:~~	~~DELPLACE~~
National Codes:	See ACTUAL DELIVERY PLACE
Default Codes:	

Notes:
DELIVERY PLACE TYPE CODE (ACTUAL) is the same as attribute ACTUAL DELIVERY PLACE.

DELIVERY PLACE TYPE CODE (INTENDED)

Change to Data Element: Changed Description

Format/Length:	an1
~~HES Item:~~	~~DELINTEN~~
National Codes:	See INTENDED DELIVERY PLACE
Default Codes:	

Notes:
DELIVERY PLACE TYPE CODE (INTENDED) is the same as attribute INTENDED DELIVERY PLACE.

DETAINED AND (OR) LONG TERM PSYCHIATRIC CENSUS DATE

Change to Data Element: Changed Description

Format/Length:	See DATE
~~HES Item:~~	~~CENDATE~~
National Codes:	
Default Codes:	

Notes:
DETAINED AND (OR) LONG TERM PSYCHIATRIC CENSUS DATE is the date at which the Psychiatric Census of Detained and/or Long-Term PATIENTS is held.

CDS V6-2 Type 170 - Admitted Patient Care - Detained and or Long Term Psychiatric Census Commissioning Data Set must be submitted annually to the Secondary Uses Service using a date of 31 March for the year of the census.

See the Commissioning Data Set Mandated Data Flows for further information.

By local agreement, other submissions may be made and where this is undertaken, the date chosen must also be compatible with the Commissioning Data Set Submission Protocol used.

DISCHARGE DATE (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Description

Format/Length:	See DATE
HES Item:	~~DISDATE~~
National Codes:	
Default Codes:	

Notes:
DISCHARGE DATE (HOSPITAL PROVIDER SPELL) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Discharge Date*'.

DISCHARGE DATE (HOSPITAL PROVIDER SPELL) is the date a PATIENT was discharged from a Hospital Provider Spell.

DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Description

Format/Length:	an2
HES Item:	~~DISDEST~~
National Codes:	See DISCHARGE DESTINATION
Default Codes:	98 - Not applicable - Hospital Provider Spell not finished at episode end (i.e. not discharged) or current episode unfinished
	99 - Not known: a validation error

Notes:
DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL) is the same as attribute DISCHARGE DESTINATION.

DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL) 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 Secondary Uses Service Guidance page.

DISCHARGE METHOD (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Description

| Format/Length: | n1 |

HES Item:	~~DISMETH~~
National Codes:	See DISCHARGE METHOD
Default Codes:	8 - Not applicable - Hospital Provider Spell not finished at episode end (i.e. not discharged) or current episode unfinished
	9 - Not known: a validation error

Notes:

DISCHARGE METHOD (HOSPITAL PROVIDER SPELL) is the same as attribute DISCHARGE METHOD.

DISCHARGE METHOD (HOSPITAL PROVIDER SPELL) will be replaced with DISCHARGE METHOD CODE (HOSPITAL PROVIDER SPELL), which is the most recent approved national information standard to describe the required definition.

DISCHARGE METHOD CODE (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Description

Format/Length:	an1
HES Item:	~~DISMETH~~
National Codes:	See DISCHARGE METHOD
Default Codes:	8 - Not applicable - Hospital Provider Spell not finished at episode end (i.e. not discharged) or current episode unfinished
	9 - Not known: a validation error

Notes:

DISCHARGE METHOD CODE (HOSPITAL PROVIDER SPELL) is the same as attribute DISCHARGE METHOD.

DISCHARGE METHOD CODE (HOSPITAL PROVIDER SPELL) 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 Secondary Uses Service Guidance page.

DISCHARGE METHOD (HOSPITAL PROVIDER SPELL) will be replaced with DISCHARGE METHOD CODE (HOSPITAL PROVIDER SPELL), which is the most recent approved national information standard to describe the required definition.

DURATION OF CARE TO PSYCHIATRIC CENSUS DATE

Change to Data Element: Changed Description

Format/Length:	n5
HES Item:	~~CENDUR~~
National Codes:	
Default Codes:	99999 - Not known (i.e. cannot be derived because one or more dates are unavailable): a validation error

Notes:

~~The duration is derived from the Start Date of the Hospital Provider Spell. Enter 00000-29200 in days (approximately 80 years), right justified with preceding zeros.~~DURATION OF CARE TO PSYCHIATRIC CENSUS DATE is the duration derived from the Start Date of the Hospital Provider Spell. Enter 00000-29200 in days (approximately 80 years), right justified with preceding zeros.

DURATION OF DETENTION

Change to Data Element: Changed Description

Format/length:	n5
~~HES item:~~	~~DETDUR~~
National Codes:	
Default Codes:	99998 - Not applicable (i.e. psychiatric patient not detained, included in census only because of long stay status)
	99999 - Not known (i.e. cannot be derived because one or more dates are unavailable): a validation error

Notes:

~~The duration is derived from the DATE DETENTION COMMENCED and the date of the census. Enter 00000-29200 in days (approximately 80 years), right justified with preceding zeros.~~DURATION OF DETENTION is the duration derived from the DATE DETENTION COMMENCED and the date of the census. Enter 00000-29200 in days (approximately 80 years), right justified with preceding zeros.

DURATION OF ELECTIVE WAIT

Change to Data Element: Changed Description

Format/length:	n4
~~HES item:~~	~~ELECDUR~~
National Codes:	
Default Codes:	9998 - Not applicable
	9999 - Not known (i.e. no date known for decision to admit): a validation error

Notes:

~~This derived item records the waiting time from the ORIGINAL DECIDED TO ADMIT DATE to the admission date at the provider where the treatment actually takes place.~~DURATION OF ELECTIVE WAIT is a derived item that records the waiting time from the ORIGINAL DECIDED TO ADMIT DATE to the admission date at the provider where the treatment actually takes place.

Enter 0000-8887 in days, right justified with preceding zeros.

A waiting time of 0 (zero) days is only to be entered after careful scrutiny.

Please note that the PATIENT's WAITING PERIOD EXCLUSIONS (their aggregate suspended and/or self-deferred periods) should be subtracted from the DURATION OF ELECTIVE WAIT.

END DATE (EPISODE)

Change to Data Element: Changed Description

Format/Length:	See DATE
~~HES Item:~~	~~EPIEND~~
National Codes:	
Default Codes:	

Notes:

END DATE (EPISODE) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '_End Date_' of an Episode.

END DATE (EPISODE) 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 Secondary Uses Service Guidance page.

EPISODE NUMBER

Change to Data Element: Changed Description

Format/length:	n2
~~HES item:~~	~~EPIORDER~~
National Codes:	
Default Codes:	98 - Not applicable
	99 - Not known: a validation error

Notes:
EPISODE NUMBER is the same as attribute ACTIVITY IDENTIFIER and is used to uniquely identify episodes, and is a sequence number for each Consultant Episode (Hospital Provider) in a Hospital Provider Spell. The first episode of each new Hospital Provider Spell (including re-admitted PATIENTS) commences at 01.

A known EPISODE NUMBER can be between 01 to 87.

For other Health Care Provider episodes, it is a sequence number for a CONSULTANT/PATIENT combination; or it is a sequence number for each Sexual Health and HIV Episode; or it is a sequence number for each Community Episode in a Nursing In The Community Programme.

EPISODE NUMBER 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 Secondary Uses Service Guidance page.

ETHNIC CATEGORY

Change to Data Element: Changed Description

Format/Length:	an2
~~HES Item:~~	~~ETHNOS~~
NWDS ID:	PETH
NWDS Field Name:	Ethnic Category
ESR Field Name:	Ethnic Origin
National Codes:	See ETHNIC CATEGORY CODE
Default Codes:	99 - Not known

Notes:
ETHNIC CATEGORY is the same as attribute ETHNIC CATEGORY CODE.

The 16+1 ethnic data categories defined in the 2001 census is the national mandatory standard for the collection and analysis of ethnicity.

The national code must be transmitted as the first character in the 2 character field. The second character is optional for use locally. It must, however, be able to be grouped consistently with the 16 main categories.

The information recorded about ETHNIC CATEGORIES must be obtained by asking the PATIENT.

National code Z should be used where the PERSON has been given the opportunity to state their ETHNIC CATEGORY but chose not to. Default code 99 should be used where the PERSON's ETHNIC CATEGORY is not known.

FIRST ANTENATAL ASSESSMENT DATE

Change to Data Element: Changed Description

Format/Length:	See DATE
~~HES Item:~~	~~ANASDATE~~
National Codes:	
Default Codes:	

Notes:
FIRST ANTENATAL ASSESSMENT DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National code '*First Antenatal Assessment Date*'.

GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)

Change to Data Element: Changed Description

Format/Length:	an6
~~HES Item:~~	~~GPPRAC~~
National Codes:	
ODS 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.

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, due for instance to them having only recently entered the country.

- **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 PRACTITIONER (SPECIFIED)

Change to Data Element: Changed Description

Format/Length:	an8
~~HES Item:~~	~~REGGMP~~
National Codes:	
ODS Default Codes:	G9999998 - GENERAL MEDICAL PRACTITIONER PPD CODE not known
	G9999981 - GENERAL MEDICAL PRACTITIONER PPD CODE not applicable

Notes:
GENERAL MEDICAL PRACTITIONER (SPECIFIED) is the GENERAL MEDICAL PRACTITIONER PPD CODE of the GENERAL MEDICAL PRACTITIONER specified by the PATIENT.

This GENERAL MEDICAL PRACTITIONER works within the General Medical Practitioner Practice with which the PATIENT is registered.

A GENERAL MEDICAL PRACTITIONER will have at least one of the following:

- GENERAL MEDICAL COUNCIL REFERENCE NUMBER
- DOCTOR INDEX NUMBER
- GENERAL MEDICAL PRACTITIONER PPD CODE.

Ministry of Defence Doctors:

- If a Ministry of Defence Doctor **has** a GENERAL MEDICAL PRACTITIONER PPD CODE, the GENERAL MEDICAL PRACTITIONER PPD CODE should be used
- If a Ministry of Defence Doctor **does not have** a GENERAL MEDICAL PRACTITIONER PPD CODE, Organisation Data Service Default Code G9999981 '*GENERAL MEDICAL PRACTITIONER PPD CODE not applicable*' should be used.

GESTATION LENGTH

Change to Data Element: Changed Description

Format/Length:	n2
~~HES Item:~~	~~GESTAT~~
National Codes:	
Default Codes:	99 - Not known

Notes:
GESTATION LENGTH is the same as attribute GESTATION LENGTH IN WEEKS and records a period (if known) of between 10 to 49 weeks in completed weeks.

HOSPITAL PROVIDER SPELL NUMBER

Change to Data Element: Changed Description

Format/Length:	an12
~~HES Item:~~	~~PROVSPNO~~
National Codes:	
Default Codes:	

Notes:
HOSPITAL PROVIDER SPELL NUMBER is the same as attribute ACTIVITY IDENTIFIER.

A HOSPITAL PROVIDER SPELL NUMBER is a unique identifier for each Hospital Provider Spell for a Health Care Provider.

HOSPITAL PROVIDER SPELL NUMBER 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 Secondary Uses Service Guidance page.

INTENDED MANAGEMENT CODE

Change to Data Element: Changed Description

Format/Length:	an1
~~HES Item:~~	~~INTMANIG~~
National Codes:	See INTENDED MANAGEMENT
Default Codes:	8 - Not applicable
	9 - Not known: a validation error

Notes:
INTENDED MANAGEMENT CODE is the same as attribute INTENDED MANAGEMENT.

This categorisation describes what is intended to happen to the PATIENT. Occasionally the PATIENT's treatment does not go exactly to plan. For example, a PATIENT admitted as a day case may develop complications and have to be kept in overnight. Therefore another data item, PATIENT CLASSIFICATION, is used to describe what actually happens to the PATIENT. In this example, the PATIENT CLASSIFICATION would be 'Ordinary admission' and not 'Day case admission'.

LABOUR OR DELIVERY ONSET METHOD CODE

Change to Data Element: Changed Description

Format/Length:	an1
~~HES Item:~~	~~DELONSET~~
National Codes:	See LABOUR OR DELIVERY ONSET METHOD
Default Codes:	9 - Not known: a validation error

Notes:
LABOUR OR DELIVERY ONSET METHOD CODE is the same as attribute LABOUR OR DELIVERY ONSET METHOD.

Only those methods that are used to induce labour, such as surgical induction, medical induction or a combination of the two, should be recorded. Methods that are used to accelerate labour should not be recorded.

LAST EPISODE IN SPELL INDICATOR CODE

Change to Data Element: Changed Description

Format/Length:	an1
~~HES Item:~~	~~SPELEND~~
National Codes:	
Default Codes:	9 - Not known

Notes:
LAST EPISODE IN SPELL INDICATOR CODE is a derived data element which identifies whether the consultant episode is the final episode in the Hospital Provider Spell.

Permitted National Codes:

1	This episode is the last episode in the Hospital Provider Spell
2	The episode is not the last episode in the Hospital Provider Spell

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LIVE OR STILL BIRTH CODE

Change to Data Element: Changed Description

Format/Length:	an1
~~HES Item:~~	~~BIRSTAT~~
National Codes:	See LIVE OR STILL BIRTH
Default Codes:	

Notes:
LIVE OR STILL BIRTH CODE is the same as attribute LIVE OR STILL BIRTH.

If born dead before 24 weeks, it would be a spontaneous abortion.

LOCAL PATIENT IDENTIFIER

Change to Data Element: Changed Description

Format/Length:	an10
~~HES Item:~~	~~LOPATID~~
National Codes:	
Default Codes:	

Notes:
LOCAL PATIENT IDENTIFIER is the same as attribute LOCAL PATIENT IDENTIFIER.

LOWER LAYER SUPER OUTPUT AREA (RESIDENCE)

Change to Data Element: Changed Description

Format/Length:	annnnnnnn
~~HES Item:~~	~~SOAL~~
National Codes:	
Default Codes:	Z99999999 - Scotland, Northern Ireland, Channel Islands, Isle of Man
	X99999998 - Not Applicable (outside the United Kingdom)
	X99999999 - Not Known

Notes:
LOWER LAYER SUPER OUTPUT AREA (RESIDENCE) is the Lower Layer Super Output Area for where the PATIENT is resident

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MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (AT CENSUS DATE)

Change to Data Element: Changed Description

Format/Length:	an2
~~HES Item:~~	~~LEGLSTAT~~
National Codes:	See MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE
Default Codes:	

Notes:

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (AT CENSUS DATE) is the same as attribute MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE at the census date.

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (AT CENSUS DATE) is only required for the Admitted Patient Care CDS - Detained and/or Long Term Psychiatric Census.

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION)

Change to Data Element: Changed Description

Format/Length:	an2
~~HES Item:~~	~~LEGLCAT~~
National Codes:	See MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE
Default Codes:	

Notes:

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION) is the same as attribute MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE on admission.

NEONATAL LEVEL OF CARE CODE

Change to Data Element: Changed Description

Format/Length:	an1
~~HES Item:~~	~~NEOCARE~~
National Codes:	See NEONATAL LEVEL OF CARE
Default Codes:	8 - Not applicable: a still birth or the episode of care does not involve a neonate during all, or part, of the duration of the episode
	9 - Not known: the episode of care involves a neonate and is finished but no data has been entered, or the episode involves a neonate and is unfinished therefore no data needs to be present. This would constitute a validation error only for a finished episode

Notes:

NEONATAL LEVEL OF CARE CODE is the same as attribute NEONATAL LEVEL OF CARE.

The value recorded must be the highest level of care given during a Hospital Provider Spell with Neonatal Level Of Care Periods.

NEONATAL LEVEL OF CARE CODE 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 Secondary Uses Service Guidance page.

NHS NUMBER

Change to Data Element: Changed Description

Format/Length:	n10
~~HES Item:~~	~~NEWNHSNO~~
National Codes:	See NHS NUMBER
Default Codes:	

Notes:

NHS NUMBER is the same as attribute NHS NUMBER.

For the AIDC for Patient Identification Data Set, NHS NUMBER must be displayed in accordance with the NHS Common User Interface Information Standard - NHS Number Input and Display (ISB 1504).

NUMBER OF BABIES INDICATION CODE

Change to Data Element: Changed Description

Format/Length:	an1
~~HES Item:~~	~~NUMBBABY~~
National Codes:	
Default Codes:	9 - Not known: a validation error

Notes:

NUMBER OF BABIES INDICATION CODE is a derived data element that records the number of REGISTRABLE BIRTHS (live or still born at a particular delivery).

Permitted National Codes:

1	One
2	Two
3	Three
4	Four
5	Five
6	Six or more

OPERATION STATUS CODE

Change to Data Element: Changed Description

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

Notes:

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

Permitted National Codes:

1	One or more operative procedures carried out
8	Not applicable i.e. no operative procedure performed or intended
9	

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

Use in the Future Outpatient CDS:

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

ORGANISATION CODE (CODE OF COMMISSIONER)

Change to Data Element: Changed Description

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

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 payments to providers" sets out a framework for establishing responsibility for commissioning an individual's care within the NHS, (i.e. determining who pays for a PATIENT's care.)

The document includes information on the following:

- General Rules
- Applying the rules to Clinical Commissioning Group 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 NHS England at "Contact us".

ORGANISATION CODE (CODE OF PROVIDER)

Change to Data Element: Changed Description

Format/Length:	an3, an5 or an6
~~HES Item:~~	~~PROCODE~~
National Codes:	
ODS Default Codes:	89997 - Non-UK provider where no ORGANISATION CODE has been issued
	89999 - Non-NHS UK provider where no ORGANISATION CODE has been issued

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

ORGANISATION CODE (CODE OF PROVIDER) is the ORGANISATION CODE of the ORGANISATION acting as a Health Care Provider.

For Commissioning Data Sets, the ORGANISATION CODE (CODE OF PROVIDER) should always be the ORGANISATION CODE of the Health Care Provider receiving the National Tariff Payment System income.

ORGANISATION CODE (CODE OF PROVIDER) 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 Secondary Uses Service Guidance page.

ORGANISATION CODE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES STEPPED TO PROVIDER)

Change to Data Element: Changed Description

Format/Length:	an3, an5 or an6
~~HES Item:~~	~~PROCODE~~
National Codes:	
ODS Default Codes:	89997 - Non-UK provider where no ORGANISATION CODE has been issued
	89999 - Non-NHS UK provider where no ORGANISATION CODE has been issued

Notes:
ORGANISATION CODE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES STEPPED TO PROVIDER) is the same as the attribute ORGANISATION CODE.

ORGANISATION CODE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES STEPPED TO PROVIDER) is the ORGANISATION CODE (CODE OF PROVIDER) of the ORGANISATION stepped to during an Improving Access to Psychological Therapies Care Spell.

ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)

Change to Data Element: Changed Description

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

Notes:
ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER) is the same as attribute ORGANISATION CODE.

ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER) is the ORGANISATION CODE of the ORGANISATION issuing the PATIENT PATHWAY IDENTIFIER.

Where Choose and Book has been used, the ORGANISATION CODE X09 should be used.

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement, and is of the following Commissioning Data Set Types:

- CDS V6-2 Type 020 - Outpatient Commissioning Data Set
- CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set
- CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set
- CDS V6-2 Type 030 - Elective Admission List - End of Period Census (Standard) Commissioning Data Set
- CDS V6-2 Type 060 - Elective Admission List - Event During Period (Add) Commissioning Data Set
- CDS V6-2 Type 070 - Elective Admission List - Event During Period (Remove) Commissioning Data Set
- CDS V6-2 Type 080 - Elective Admission List - Event During Period (Offer) Commissioning Data Set

then ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER) must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.

ORGANISATION CODE (STOP SMOKING SERVICE PROVIDER)

Change to Data Element: Changed Description

Format/Length:	See ORGANISATION CODE
HES Item:	PROCODE
National Codes:	
ODS Default Codes:	89997 - Non-UK provider where no ORGANISATION CODE has been issued
	89999 - Non-NHS UK provider where no ORGANISATION CODE has been issued

Notes:
ORGANISATION CODE (STOP SMOKING SERVICE PROVIDER) is the same as attribute ORGANISATION CODE.

ORGANISATION CODE (STOP SMOKING SERVICE PROVIDER) is the same as data element ORGANISATION CODE (RESPONSIBLE PCT) with the exception of PERSONS receiving a Stop Smoking Service at or near their workplace, which may be some distance from their home.

For example, a Stop Smoking Service might be provided for commuters at their workplace in a large city. In such circumstances it is likely that PERSONS will be drawn from a range of places in the surrounding area e.g. commuters to London who live all around the south-east of England.

Where a SERVICE is judged to meet these criteria, the Primary Care Trust providing the SERVICE is the Responsible Primary Care Trust.

PATIENT CLASSIFICATION CODE

Change to Data Element: Changed Description

Format/Length:	an1
HES Item:	CLASSPAT
National Codes:	See PATIENT CLASSIFICATION
Default Codes:	8 - Not applicable

Notes:
PATIENT CLASSIFICATION CODE is derived from the ADMISSION METHOD, INTENDED MANAGEMENT and the duration of stay of the PATIENT.

The duration of stay is derived by subtracting the date of admission from the date of discharge.

In the case of maternity PATIENTS, the use being made of the delivery facilities is also used in this derivation.

PATIENT CLASSIFICATION CODE 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 Secondary Uses Service Guidance page.

PERSON BIRTH DATE

Change to Data Element: Changed Description

Format/Length:	See DATE
~~HES Item:~~	~~DOB~~
NWDS ID:	PEBD
NWDS Field Name:	Date of Birth
National Codes:	
Default Codes:	

Notes:
PERSON BIRTH DATE is the same as attribute PERSON BIRTH DATE.

BIRTH DATE will be replaced with PERSON BIRTH DATE which is the most recent approved national information standard to describe the required definition.

PERSON BIRTH DATE (BABY)

Change to Data Element: Changed Description

Format/Length:	See PERSON BIRTH DATE
~~HES Item:~~	~~DOBBABY~~
National Codes:	
Default Codes:	

Notes:
PERSON BIRTH DATE (BABY) is the same as data element PERSON BIRTH DATE for the baby.

PERSON BIRTH DATE (MOTHER)

Change to Data Element: Changed Description

Format/Length:	See PERSON BIRTH DATE
~~HES Item:~~	~~MOTDOB~~
National Codes:	
Default Codes:	

Notes:
PERSON BIRTH DATE (MOTHER) is the same as data element PERSON BIRTH DATE for the mother.

POSTCODE OF USUAL ADDRESS

Change to Data Element: Changed Description

Format/Length:	See POSTCODE
~~HES Item:~~	~~HOMEADD~~
National Codes:	
Default Codes:	

Notes:

POSTCODE OF USUAL ADDRESS is the same as data element POSTCODE.

POSTCODE OF USUAL ADDRESS is the POSTCODE of the ADDRESS nominated by the PATIENT where the ADDRESS ASSOCIATION TYPE is *'Main Permanent Residence'* or *'Other Permanent Residence'.*

PREGNANCY TOTAL PREVIOUS PREGNANCIES

Change to Data Element: Changed Description

Format/Length:	n2
~~HES Item:~~	~~NUMPREG~~
National Codes:	
Default Codes:	99 - Not known

Notes:

PREGNANCY TOTAL PREVIOUS PREGNANCIES is the same as attribute PREGNANCY TOTAL PREVIOUS PREGNANCIES.

A live birth is always registrable, no matter how short the gestation. Still births and abortions are registrable only if they occur after a gestation of 24 weeks or more, see REGISTRABLE BIRTH.

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

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PRIMARY PROCEDURE (OPCS)

Change to Data Element: Changed Description

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

Notes:

PRIMARY PROCEDURE (OPCS) is the same as attribute CLINICAL CLASSIFICATION CODE.

PRIMARY PROCEDURE (OPCS) is the OPCS Classification of Interventions and Procedures code which is used to identify the primary Patient Procedure carried out.

PRIMARY PROCEDURE DATE

Change to Data Element: Changed Description

Format/Length:	See DATE
~~HES Item:~~	~~OPDATE1~~
National Codes:	
Default Codes:	

Notes:
PRIMARY PROCEDURE DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Primary Procedure Date*'.

PSYCHIATRIC PATIENT STATUS CODE

Change to Data Element: Changed Description

Format/Length:	an1
~~HES Item:~~	~~ADMISTAT~~
National Codes:	
Default Codes:	

Notes:
~~Where a PATIENT has a history of admissions to several Hospital Provider, then priority between National Codes 1 and 2 should be given to the current Hospital Provider, and National Code 1 selected, irrespective of whether or not the last admission was to the same Hospital Provider.~~

~~This data item applies only to PATIENTS admitted or transferred to a CONSULTANT in one of the psychiatric specialties within a Hospital Provider Spell.~~ The PSYCHIATRIC PATIENT STATUS CODE applies only to PATIENTS admitted or transferred to a CONSULTANT in one of the psychiatric specialties within a Hospital Provider Spell. Record this against the first consultant episode under a CONSULTANT in one of the psychiatric specialties but not for subsequent psychiatric consultant episodes or for any non-psychiatric episodes. This information is used to indicate the turnover period within the service and identify, where possible, all first time psychiatric admissions and re-admissions.

Where a PATIENT has a history of admissions to several Hospital Provider, then priority between National Codes 1 and 2 should be given to the current Hospital Provider, and National Code 1 selected, irrespective of whether or not the last admission was to the same Hospital Provider.

Permitted National Codes:

0   No known previous Hospital Provider Spells with a Consultant Episode (Hospital Provider) within a psychiatric speciality within any Health Care Provider.
1   One or more previous Hospital Provider Spells involving a Consultant Episode (Hospital Provider) within a psychiatric specialty with this Health Care Provider.
2   One or more previous Hospital Provider Spells involving a Consultant Episode (Hospital Provider) within a psychiatric specialty with another Health Care Provider, but none with this Health Care Provider.
8   Not applicable: the PATIENT is not receiving admitted patient care under a CONSULTANT in a psychiatric specialty.
9   Not known: the PATIENT is receiving admitted patient care under a CONSULTANT in a psychiatric specialty, but the information is not available. This constitutes a validation error

REFERRER CODE

Change to Data Element: Changed Description

Format/Length:	an8
~~HES Item:~~	~~REFERRER~~
National Codes:	
ODS Default Codes:	A9999998 - Ministry of Defence Doctor
	C9999998 - CONSULTANT GENERAL MEDICAL COUNCIL REFERENCE NUMBER not known
	CD999998 - Dental CONSULTANT: GENERAL MEDICAL COUNCIL REFERENCE NUMBER / GENERAL DENTAL COUNCIL REGISTRATION NUMBER not known
	D9999998 - Dentist, GENERAL DENTAL PRACTITIONER CODE not known
	R9999981 - Referrer other than GENERAL MEDICAL PRACTITIONER, GENERAL DENTAL PRACTITIONER or CONSULTANT
	X9999998 - Not applicable, e.g. PATIENT has self-presented or not known

Notes:

REFERRER CODE is the code of the PERSON making the REFERRAL REQUEST. This will normally be a CARE PROFESSIONAL, GENERAL MEDICAL PRACTITIONER or CONSULTANT.

The intention is for this item to reflect the actual (true) referrer. For example, following a GENERAL MEDICAL PRACTITIONER referral, a CONSULTANT may subsequently refer the PATIENT to another CONSULTANT within the Hospital Provider Spell. The code of the CONSULTANT making the referral and the CONSULTANTS ORGANISATION should be recorded in the Commissioning Data Set (CDS) rather than the code of the GENERAL MEDICAL PRACTITIONER referrer. This also applies where a CONSULTANT refers an NHS PATIENT to another doctor for NHS-commissioned treatment at another NHS / non-NHS provider, or an overseas provider. Where the CONSULTANT CODE is not known, the Organisation Data Service Default Code C9999998 should be used.

In all other cases, the code of the referring GENERAL MEDICAL PRACTITIONER should be recorded, if applicable. When a locum refers, use the GENERAL MEDICAL PRACTITIONER PPD CODE of the GENERAL PRACTITIONER for whom the locum is acting.

See CONSULTANT CODE and GENERAL MEDICAL PRACTITIONER (SPECIFIED) for the codes available for CONSULTANTS and GENERAL MEDICAL PRACTITIONERS and GENERAL DENTAL PRACTITIONERS.

If the REFERRER CODE is not known or not applicable e.g. the PATIENT has self-presented, the Organisation Data Service Default Code (X9999998) should be used.

RESUSCITATION METHOD CODE

Change to Data Element: Changed Description

Format/Length:	an1
~~HES Item:~~	~~BIRRESUS~~
National Codes:	
Default Codes:	8 - Not applicable (e.g. stillborn, where no method of resuscitation was attempted)
	9 - Not known: a validation error

Notes:

RESUSCITATION METHOD CODE is derived from RESUSCITATION METHOD POSITIVE PRESSURE and RESUSCITATION METHOD DRUGS.

RESUSCITATION METHOD CODE records the means by which regular respiration of the baby was attempted. This is not recorded for stillbirths. For local purposes, the actual drugs administered should be specified.

Permitted National Codes:

1   Positive pressure nil, drugs nil

2	Positive pressure nil, drugs administered
3	Positive pressure by mask, drugs nil
4	Positive pressure by mask, drugs administered
5	Positive pressure by endotracheal tube, drugs nil
6	Positive pressure by endotracheal tube, drugs administered

SEX

Change to Data Element: Changed Description

Format/Length:	n1
~~HES Item:~~	~~SEX~~
National Codes:	See PERSON GENDER CODE
Default Codes:	

Notes:

SEX is the same as the attribute PERSON GENDER CODE.

SEX will be replaced with PERSON STATED GENDER CODE or PERSON PHENOTYPIC SEX, which is the most recent approved national information standard to describe the required definition.

SITE CODE (OF TREATMENT)

Change to Data Element: Changed Description

Format/Length:	min an5 max an9
~~HES Item:~~	~~SITETRET~~
National Codes:	
ODS Default Codes:	R9998 - Not a hospital site (for use on Out-Patient CDS)
	89999 - Non-NHS UK Provider where no ORGANISATION SITE CODE has been issued
	89997 - Non-UK Provider where no ORGANISATION SITE CODE has been issued

Notes:

SITE CODE (OF TREATMENT) is the same as attribute ORGANISATION SITE CODE.

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

This 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 UK provider, the SITE CODE (OF TREATMENT) used should be the ORGANISATION SITE CODE 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 CODE has been issued'* is applicable.

Each ORGANISATION has a unique ORGANISATION CODE. 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 ORGANISATION SITE CODE. The ORGANISATION SITE CODE contains the first 3 digits of the ORGANISATION CODE with the last two digits being the site identifier.

Example:

   RA700   ORGANISATION CODE of the ORGANISATION
   RA701   ORGANISATION SITE CODE of the first identified ORGANISATION SITE within the ORGANISATION
   RA702   ORGANISATION SITE CODE of the second identified ORGANISATION SITE within the ORGANISATION

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 (for use on Out-Patient CDS)'* would be used in these circumstances.
Note: LOCATION CLASS is used in the Commissioning Data Set (CDS) message to indicate the classification of 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.

SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Description

Format/Length:	an2
~~HES Item:~~	~~ADMISORC~~
National Codes:	See SOURCE OF ADMISSION
Default Codes:	98 - Not applicable
	99 - Not known: a validation error

Notes:
SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL) is the same as attribute SOURCE OF ADMISSION.

SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL) 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 Secondary Uses Service Guidance page.

START DATE (CONSULTANT EPISODE)

Change to Data Element: Changed Description

Format/Length:	See DATE
~~HES Item:~~	~~EPISTART~~
National Codes:	
Default Codes:	

Notes:
START DATE (CONSULTANT EPISODE) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Start Date*' of the consultant episode.

START DATE (EPISODE)

Change to Data Element: Changed Description

Format/Length:	See DATE

HES Item:	~~EPISTART~~
National Codes:	
Default Codes:	

Notes:

START DATE (EPISODE) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Start Date*' of the episode.

START DATE (EPISODE) 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 Secondary Uses Service Guidance page.

START DATE (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Description

Format/Length:	See DATE
~~HES Item:~~	~~ADMIDATE~~
National Codes:	
Default Codes:	

Notes:

START DATE (HOSPITAL PROVIDER SPELL) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Start Date*' of the Hospital Provider Spell.

The Start Date of the Hospital Provider Spell is the date of admission: the CONSULTANT or MIDWIFE has assumed responsibility for care following the DECISION TO ADMIT the PATIENT.

START DATE (HOSPITAL PROVIDER SPELL) 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 Secondary Uses Service Guidance page.

STATUS OF PATIENT INCLUDED IN THE PSYCHIATRIC CENSUS CODE

Change to Data Element: Changed Description

Format/Length:	an1
~~HES Item:~~	~~CENSAT~~
National Codes:	
Default Codes:	

Notes:

~~The information about the current detained status is derived from MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (AT CENSUS DATE) and the length of stay in hospital derived from details held about the current Hospital Provider Spell.~~

STATUS OF PATIENT INCLUDED IN THE PSYCHIATRIC CENSUS CODE is derived from MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (AT CENSUS DATE) and the length of stay in hospital derived from details held about the current Hospital Provider Spell.

See Mental Health Act Table for details of how this data item relates to Parts and Sections of the Act.

Permitted National Codes:

1	Detained PATIENT
2	Long term PATIENT
3	Detained and long term PATIENT

STATUS OF PERSON CONDUCTING DELIVERY CODE

Change to Data Element: Changed Description

Format/Length:	an1
~~HES Item:~~	~~DELSTAT~~
National Codes:	See STATUS OF PERSON CONDUCTING DELIVERY
Default Codes:	9 - Not known: a validation error

Notes:

STATUS OF PERSON CONDUCTING DELIVERY CODE is the same as attribute STATUS OF PERSON CONDUCTING DELIVERY.

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