MINISTRY OF HEALTH
MANATŪ HAUORA

National Patient Flow Phase 3

File Specification

Owner	Technology and Digital Services National Collections and Reporting
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1.1. Reproduction of material

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2. Introduction

2.1. Purpose of this document

This File Specification defines the file format and processes used to send batches of information to the Ministry for inclusion in the National Patient Flow Data Collection (NPF). The document includes the following information:

- An overview of batch processing
- Specification of the inputs and outputs of the NPF system
- Data definitions and formats
- Data code sets and code values
- Rules for data validation.

2.2. Authority for collection of health information

The Ministry of Health may collect health information where this is necessary to carry out lawful purposes connected with its functions and activities. These purposes, functions and activities may be set out in legislation, such as the Health Act 1956, or may be derived from lawful instructions from the Minister. The collection, storage and use of health information are also governed by the Privacy Act 1993 and the Health Information Privacy Code 1994.

2.3. Contact

If you have any queries regarding this file layout or the National Patient Flow load process, please email operations@moh.govt.nz.

3. Overview of the National Patient Flow Collection

3.1. Purpose

The National Patient Flow (NPF) Collection (the Collection) allows key points on the patient's journey through secondary and tertiary care to be tracked, compared and reported on. The Collection contains patient referrals to specialist services and records information about referral service activities to provide a complete view of the patient's secondary care pathway. The collection will provide comprehensive information on patients referred from primary care, the outcome of referrals, and the time it takes patients to access care.

The Collection will feed into a data warehouse environment to allow analytical reporting and comparison at both patient journey and activity level. As a consistent reporting dataset it will support operational practice and decision-making and enable local, regional and national access to service use and patient outcomes data.

3.2. Content

3.2.1 History and Development

The NPF Collection was developed between 2014 and 2017 across three phases.

NPF Phase 1 tracked referrals through to First Specialist Assessment (FSA).

NPF Phase 2 extended the data elements and services and service sub-types included in the Collection.

NPF Phase 3:

- Adds data elements
- Changes the obligation for some data elements
- Makes service sub-types that were optional in Phase 2 mandatory
- Adds service sub-types to the scope.

Refer to 'Section 4.5 Scope of the Collection' for more information.

3.2.2 Other Collections

The Collection will eventually replace the NBRS Collection, the current Faster Cancer Treatment reporting and Diagnostic Waiting Time reporting.

The National Booking Reporting System (NBRS) currently provides information to monitor wait times for first specialist assessment (at summary level) and for patients from when they are given certainty for inpatient treatment, or are placed in an Active Review status, until exit.

The Faster Cancer treatment reporting currently provides information used to monitor time taken from referral to first contact, diagnosis and treatment. It also provides summary data on waiting times from Referral to FSA.

Data collected currently in the National Non-admitted Patient Collection (NNPAC) and the National Minimum Dataset – Hospital Events (NMDS) Collection are also relevant to the patient journey because these collections record information about part of the journey.

3.3. Health Identity Data

The National Health Index (NHI), Date of Birth (DoB) and Domicile code are collected within the Referral and Activity Datasets. The NHI and DoB are used to ensure the Referral and Activity information captured by the Collection is for the same patient throughout the length of the patient journey. The Domicile Code assists in analysis of health needs of patients within a DHB and the delivery of services to the patient. The Domicile Code is collected at each Activity and Referral as it may change during the patient journey and the submitted data is considered to be more up to date than that held in NHI. The patient's ethnicity is captured in the Referral Dataset and is used to assist in analysis of health needs and the management of services provided across different ethnic groups.

The Health Care Provider Index (HPI) provides identification information regarding the providers of health care. The HPI Organisation Identifier is used to identify the organisations submitting data to NPF, providing services and managing the patient journey.

3.4. Start Date

Referrals within the Phase 3 scope (as set out in this document) that are received after 1 July 2016 and Activities related to these Referrals must be collected and submitted to the Collection to the requirements in this document.

Activities that occur after 1 July 2016 that relate to Referrals collected as part of the scope of Phase 1 and Phase 2 must be submitted to the Collection to the requirements in this document.

3.5. Frequency of Updates

Submitting Organisations are expected to provide NPF data to the Ministry on a weekly basis at a minimum.

3.6. Authorised Access

Authorised members of the Ministry will have access to the data for maintenance, data quality, analytical and audit purposes.

3.7. Privacy Issues

The Ministry of Health is required to ensure that the release of information recognises any legislation related to the privacy of health information, in particular the Official Information Act 1982, the Privacy Act 1993 and the Health Information Privacy Code 1994.

Information available to the general public is of a statistical and non-identifiable nature. Researchers requiring identifiable data will usually need approval from an Ethics Committee.

3.8. Purpose of Reports and Publications

The Collection will allow reports to be produced that support nominated health service performance indicators or targets e.g. Elective Services Patient Flow Indicators (ESPIs) and Faster Cancer Treatment (FCT) and other reports which monitor and assess the performance of the health system.

3.9. Data Provision

Customised datasets or summary reports are available on request, either electronically or on paper. Staff from the Ministry's Analytical Services team can help to define the specifications for a request and are familiar with the strengths and weaknesses of the data. Because some data elements are added or deleted as the Collection evolves, consistent time-series data may not be able to be provided.

The Ministry's Analytical Services team also offers a peer review service to ensure that Ministry of Health data is reported appropriately when published by other organisations.

Requestors outside the Ministry may be charged a fee for data extracts.

For further information about this collection or to request specific datasets or reports, contact the Ministry's Analytical Services team on (04) 816 2893 or email data-enquiries@moh.govt.nz.

4. NPF Collection Overview

This section describes the NPF core business concepts and provides an overview of the solution.

4.1. NPF Core Business Concepts

The following diagram illustrates the core business concepts and the relationships between the patient's referral and the points in time which are captured in the Collection following receipt of the Referral.

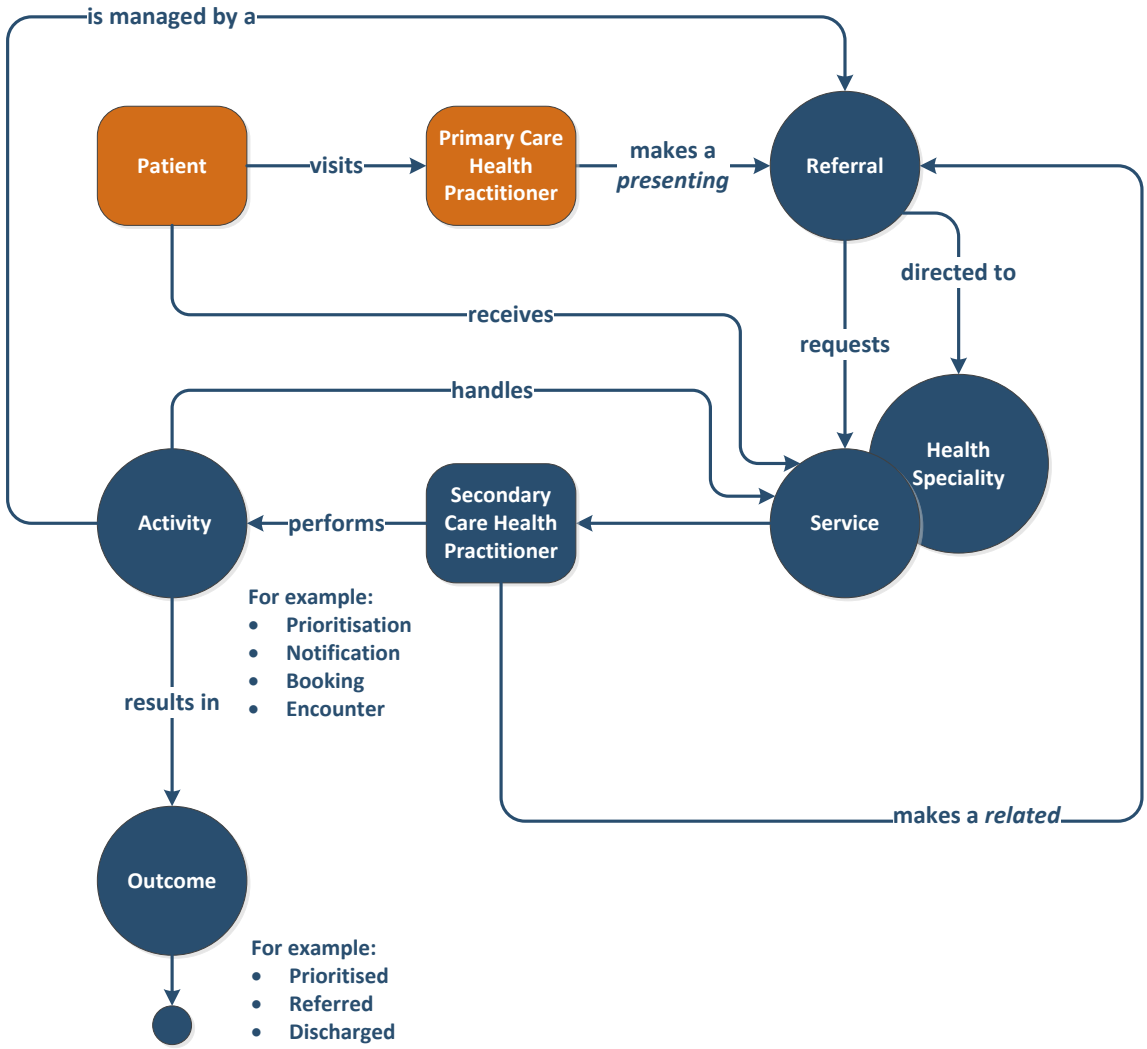


Figure 1 : NPF Core Business Concepts

Note: The NPF Core Business Concepts diagram is a subset of the overall Business Concept Model documented in the High Level Requirements. The diagram represents NPF business concepts, it does not cover all scenarios or represent all patient journeys.

4.2. Structured Business Vocabulary

The Structured Business Vocabulary (SBV) is a set of terms and their definitions, along with all operational business concepts (also referred to as “business know how”) for the project. The SBV has been tailored specifically to the National Patient Flow; therefore some definitions may differ to those used for the same business concepts within the wider health sector. Below is a key subset of the terms. A full set of terms can be found in the Structured Business Vocabulary document.

Business Term	Definition
Activity	A reporting record that contains data elements that relate to an action of service that is provided as part of the Patient’s journey. Activities are component parts of a Service Sequence.
Encounter	The Activity that provides the Service to the Patient.
Health Practitioner	A practitioner of health as defined within the Health Practitioners Competence Assurance Act 2003. This term is synonymous with ‘Health Care Provider’.
Health Specialty	A classification describing the specialty or Service to which a healthcare user has been assigned, which reflects the nature of the Services being provided.
National Patient Flow (NPF)	The National Patient Flow (NPF) Collection is a Patient-centred Referral based reporting system, which connects related Patient Referrals and Activities to provide a complete view of the Patient’s secondary care pathway. The Collection will provide more comprehensive information on Patients referred from primary care, the outcome of Referrals, and the time it takes Patients to access care.
Outcome	Following completion of an Activity, the determination of next steps or the subsequent handling of a Referral. An Outcome is either an Activity Outcome or a Decision Outcome.
Patient	A person who receives attention, care or treatment health Services
Patient’s Journey	A journey of care, through the publicly funded Secondary Care Health Sector, for a Patient, which starts with a Presenting Referral with a Presenting Problem. This is reflected in National Patient Flow as all the Referrals and their associated Activities that relate to the handling of that particular Presenting Problem.
Presenting Referral	The first known Referral to the Secondary Care Health Sector for a particular Patient with a particular Presenting Problem requesting one or more Services.
Referral	A communication by one Health Practitioner to another Health Practitioner whose intent is the transfer of care, in part or in whole of a Patient in regards to a specific condition (e.g. if another specialty is asked to take over management of the Patient).

Business Term	Definition
Related Referral	A subsequent Referral related to the Presenting Referral, either across or within a specialty within secondary or tertiary care.
Service	The action a Health Practitioner within the specialty provides. The purpose of the Referral is normally to request a Service.
Service Sequence	The group of Activities that manage a Referral, with respect to a specific Service. In some cases, there may be additional related Services associated with the same Referral (e.g. Follow up Assessments which by nature follow other Encounters such as an FSA).

4.3. Business and Processing Rules

4.3.1 Rules validation approach

Rules will be validated as follows:

- Integrity rules are the rules defined in this File Specification and are applied at the point of file submission
- Consolidation rules are applied after submission and processing of files/records, but before or as part of running reports to allow for early corrective action. These rules are described in greater detail below.
- Reporting rules are applied in the production of reports, and are not elaborated in this File Specification.

The following diagram explains the various differences between the different types of rules:

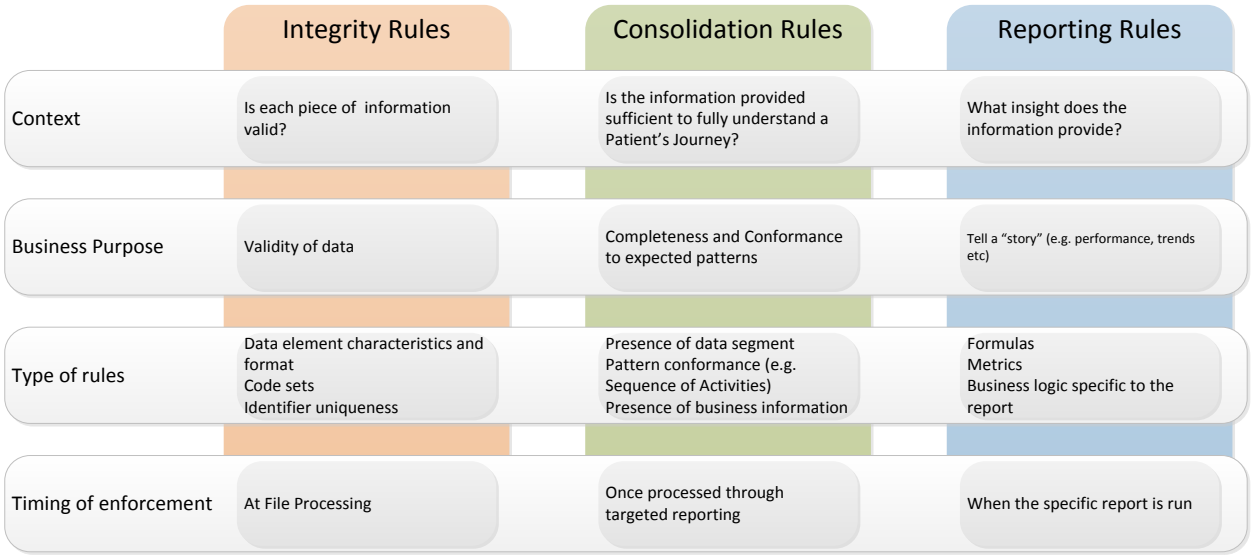


Figure 2 - Business Rules types

The Integrity Rules include the obligation rules (mandatory, conditionally mandatory or optional) (refer to 4.8.2 for definitions). Failing the obligation rules causes submitted files to be rejected.

The data elements that are required in Phase 3 are necessary to provide a richer data set for reporting and querying and to enable the connection of Referrals and Activities to form a Patient Journey.

Some of these data elements are considered essential (for example the Health Specialty) and therefore have been specified as 'Mandatory'. Others are necessary and important, but their enforcement at this stage could be premature. This File Specification will show these elements as 'Optional' but will strongly advise in the Data Guidance that DHBs provide them, and may be set as a

pre-requisite for achieving Compliance. These elements may also be more important in some cases than others. The checking for their presence/absence falls under the category of 'Presence of business information' within the Consolidation Rules. Their presence will provide a greater level of completeness, enabling in some cases, for example, a more explicit link to form a Patient Journey.

Reports to indicate the absence of these data elements are still to be specified.

4.3.2 Consolidation Rules overview

Consolidation rules will be applied to further refine data quality and the Collection content, for example linked Referrals and Activities form a complete and correct Service Sequence (i.e. the groups of Activities that manage a Referral for a specific Service exist and are complete). Only the Sequences that are considered "valid" will be used in Indicator reporting.

It is anticipated that "invalid" Sequences identified at this point will be of the following nature:

- An Activity that was expected in a Service Sequence is missing (for example a Referral and a related Encounter have been received by the Collection but the Prioritisation, Notification and Booking relating to that Referral and Encounter have not yet arrived)
- Activities related to a Service Sequence are in a different date order than expected (for example the Prioritisation date is later than the Encounter date)

Service Sequences that fail Consolidation rule validation will be highlighted and reported as issues that may need to be investigated and possibly resolved prior to the final production of that period's reporting.

This approach will highlight differences between the calculated indicators and the DHB's expectations of what those indicators should be.

As indicated in the previous section, Consolidation rules will also check for the presence of data elements that are mandated by the business but not enforced at the time of Submission.

4.4. What the Ministry of Health does with the NPF data

This diagram gives an overview of how the NPF data is updated, quality controlled and used.

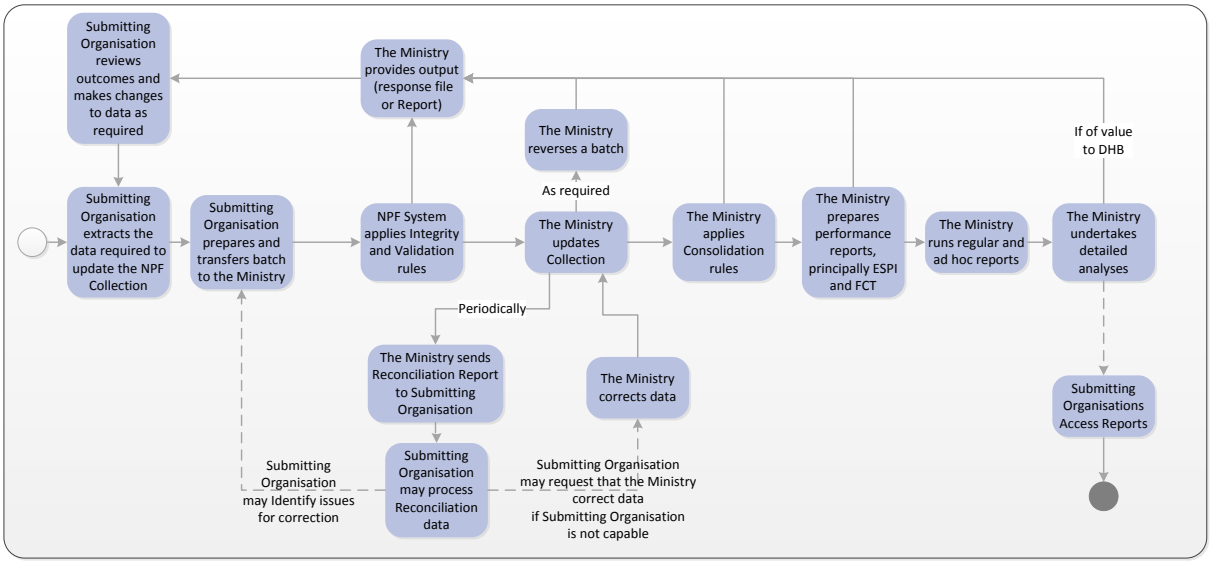


Figure 3: High Level Data Processing

The Submitting Organisation extracts the data relevant to the Collection from their patient administration and other related systems. The data is packaged in batches which are transferred by secure file transfer to the Ministry.

The Ministry applies the Integrity rules (see Appendix D: Business Rules and Error Messages) to the received batches to ensure that the mandatory data required in that file has been supplied and that the data structure relationships are correctly represented. The Ministry sends the Submitting Organisation a series of response files informing the Submitting Organisation of file processing outcomes.

Data that is rejected based on Integrity rules are not accepted into the Collection. Data is accepted, accepted with warning, or rejected. The Submitting Organisation may correct data that has not been accepted, or that has been accepted with a warning, and resubmit it.

The Ministry periodically queries the Collection to determine whether required Datasets in the Service Sequence have been received. The Ministry then sends the Submitting Organisation a reconciliation report listing the data that is invalid for the reporting period (this may be done as part of the regular reporting cycle). This report informs the Submitting Organisation what data does not meet usual patterns to facilitate data corrections. Performance Reports:

Summary NPF data is published on the elective services web site http://www.moh.govt.nz/electiveservices, and regular data quality reconciliation reports are available to DHBs.

The Ministry will prepare and send draft performance reports to the DHBs at agreed scheduled times. The DHB reviews the reports and may update the data based on their review. The Ministry prepares and sends the final performance reports to the DHBs at agreed scheduled times.

4.5. Scope of the Collection

The scope of the NPF Collection is determined by the:

- The Encounter Type (for example Inpatient or Outpatient)
- Specific Services and Service Sub-types – those that data **must** be provided for and those that it **should** be provided for, if it is available.
- Data element obligation – defines if provision of a data element is mandatory (i.e. will result in rejection if it is not provided), optional or conditionally mandatory.

Scope is described in this section using the Encounter Type and Services and Service Sub-Types. Data element obligation is included in section 10.

4.5.1 Services for which information must be provided:

- All intended Elective services (treatment, procedures, investigations and/or tests) to be provided to Inpatients and Day Patients where the intent is that the Patient be admitted**
- The following services to be provided to Outpatients:
  - First Specialist Assessment
  - Chemotherapy
  - Colonoscopy
  - Eye Injection
  - Flexible Sigmoidoscopy
  - Rigid Sigmoidoscopy
  - Palliative/best supportive care
  - Radiotherapy
  - Skin Lesion Removal
  - Targeted Therapy
  - Follow up – re-referral
  - Follow up – subsequent to FSA
  - Follow up – subsequent to procedure/treatment
  - Colonoscopy/gastroscopy
  - Gastroscopy
  - ERCP
  - Colposcopy
  - Hysteroscopy
  - Interventional radiology
  - Minor eye procedure
  - Eye laser
  - Bronchoscopy
  - Cystoscopy
  - Urodynamics

- Lithotripsy
- Dental treatment
- Minor operation
- CT scan
- CT angiography
- CT colonography
- MRI scan
- MRI angiography
- PET scan
- Ultrasound
- Mammogram
- Nuclear medicine
- Audiology
- ECG
- Echo cardiogram – transoesophogeal
- Echo cardiogram – transthoracic
- ETT
- Holter monitoring
- Lung function
- Sleep study
- EEG
- Nerve study
- All other Outpatient Treatment Services provided to patients that either have a high suspicion of cancer, or a confirmed cancer diagnosis (except for where a service is provided in Emergency or Acute situations as stated below.)

Services provided in Emergency and Acute situations (including Acute Admissions), Mental Health and Maternity are ***outside of scope.*** (e.g. A Colonoscopy provided as part of an Acute Admission is outside of scope.)

***** Booking Information regarding these services is currently collected by the NBRS Collection.***

4.5.2 Services for which information should be provided:

The following services provided to Outpatients:

- Nurse / midwife assessment
- Transplant/donor liaison coordinator assessment
- Dialysis education
- Anaesthetic assessment
- Multi-Disciplinary Meeting
- Botulinum toxin therapy
- X-ray (plain)

4.5.3 Accident Compensation Commission (ACC)

If an ACC funded journey is in the collection, a complete Service Sequence should be submitted. If a journey or Service Sequence is submitted to the collection and later changed to ACC, the Principal Health Service Purchaser should be updated to reflect that the service is ACC funded.

4.5.4 Description of Services

This section demonstrates how services are described for different Patients within the Collection. Please note that Cancer Patients will also fall under the Outpatient and Inpatient categories.

Service provided to:	**Service described in:**		
These descriptions of Services apply in particular to how Services are described within the Prioritisation Activity.			
	Service Type	**Service Sub type**	**Clinical Code**
Inpatients/Day patients	Treatment/Procedure or Investigation/Test	Specified or 'Intended Admitted Procedure'	Required
Outpatients	Dependent on type of Service as described in the code set	Specified	Not required
Patient Subset			
Cancer Patients	Are identified in the Collection as follows: • Using the Defined Suspicion of Cancer data element (collected within a Referral or Prioritisation Activity) • Using the 'Diagnosis Clinical Code' (collected within a Referral Diagnosis and a Diagnosis) if provided.		

4.5.5 Relationship between Services and Outcomes

The diagram on the following page shows the relationships between:

- Service Type
- Encounter Type
- Attendance Outcome
- Encounter Outcome Decision
- Encounter Outcome Reason
- Destination.

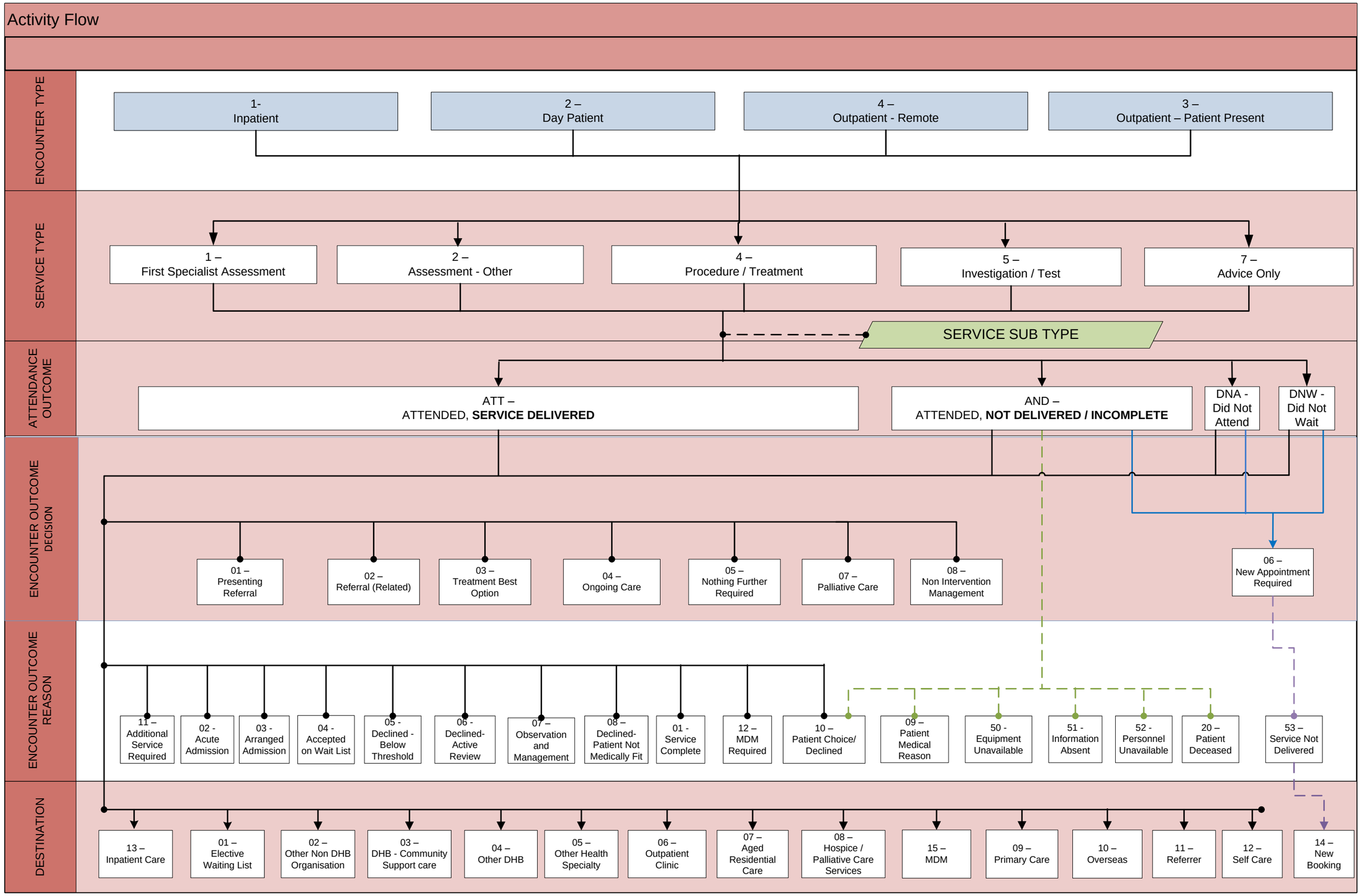


Figure 4: Relationship between Services and Outcomes

4.6. NPF Data Models

NPF can be represented by the following data models:

- The Collection model that represents the logical relationships of the data in the Collection
- The Submission model that represents the way the data is packaged and submitted for inclusion in the Collection. The Submission model can be further explained by the data file structure.

4.6.1 NPF Collection Model

The figure below shows the pattern of the NPF Collection.

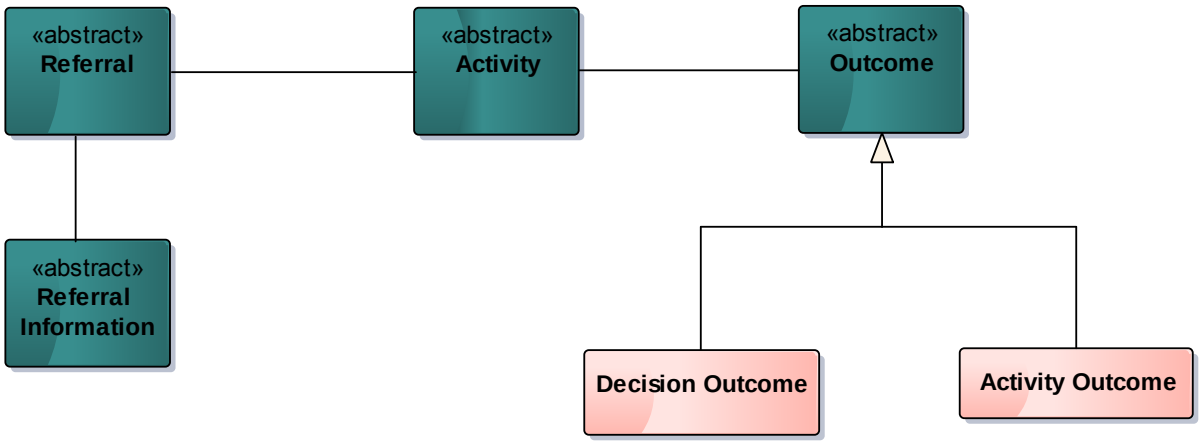


Figure 5: NPF Data Model Pattern

This model represents at an abstract level the concept of Referrals, Activities and Outcomes.

The data model on the following page represents the logical view of data elements in the Collection showing the data model entities and the relationships between those entities.

There are data elements for an Activity common to all Activities - Prioritisation, Notification, Booking, Encounter and Exception. This is represented in the diagram by a generalisation/specialisation association (closed arrowhead) between an Activity entity and its specialisations Prioritisation, Notification, Booking, Encounter and Exception.

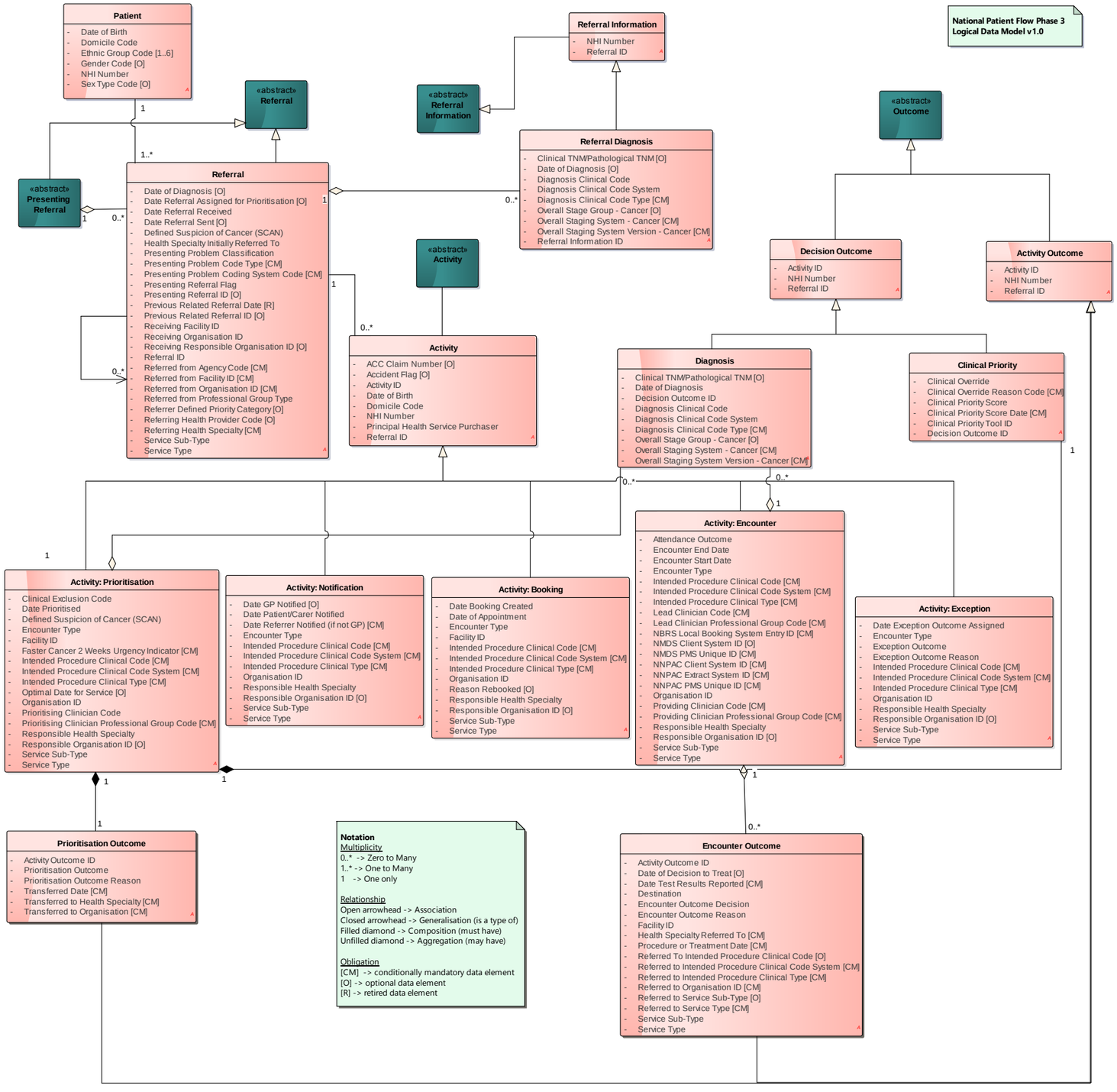


Figure 6: Logical Data Model for the NPF Collection

4.6.2 Relationships between entities in the data model

The table below expresses the relationships between entities.

An example of relationships is:

- A Patient can have one or more Referrals
- A Referral is related to one Patient

	Patient	Referral	Activity	Activity Outcome	Clinical Priority	Diagnosis
Patient	-	Can have one or more	-	-	-	-
Referral	Is related to one	Can have zero or more related referrals	Can have one or more	-	-	Can have zero or more referral diagnoses
Activity	-	Is related to one	-	A Prioritisation Activity can have only one Prioritisation Outcome An Encounter Activity can have zero or many Encounter Outcomes	A Prioritisation Activity can have only one Clinical Priority	Can have zero or more
Activity Outcome	-	-	Is related to one	-	-	-
Clinical Priority	-	-	Is related to one	-	-	-
Referral Diagnosis	-	Is related to one		-	-	-
Diagnosis	-	-	Is related to one	-	-	-

NOTE: An encounter outcome may be submitted with the encounter or at a later time. An encounter outcome is required to enable a complete view of a patient's pathway.

Refer to "Section 10 Data Element Definitions" for information about the data entities and their elements.

4.6.3 NPF Submission Model

4.6.3.1 Submission Structure

The figure below represents the structure of a submission of data to the Collection.

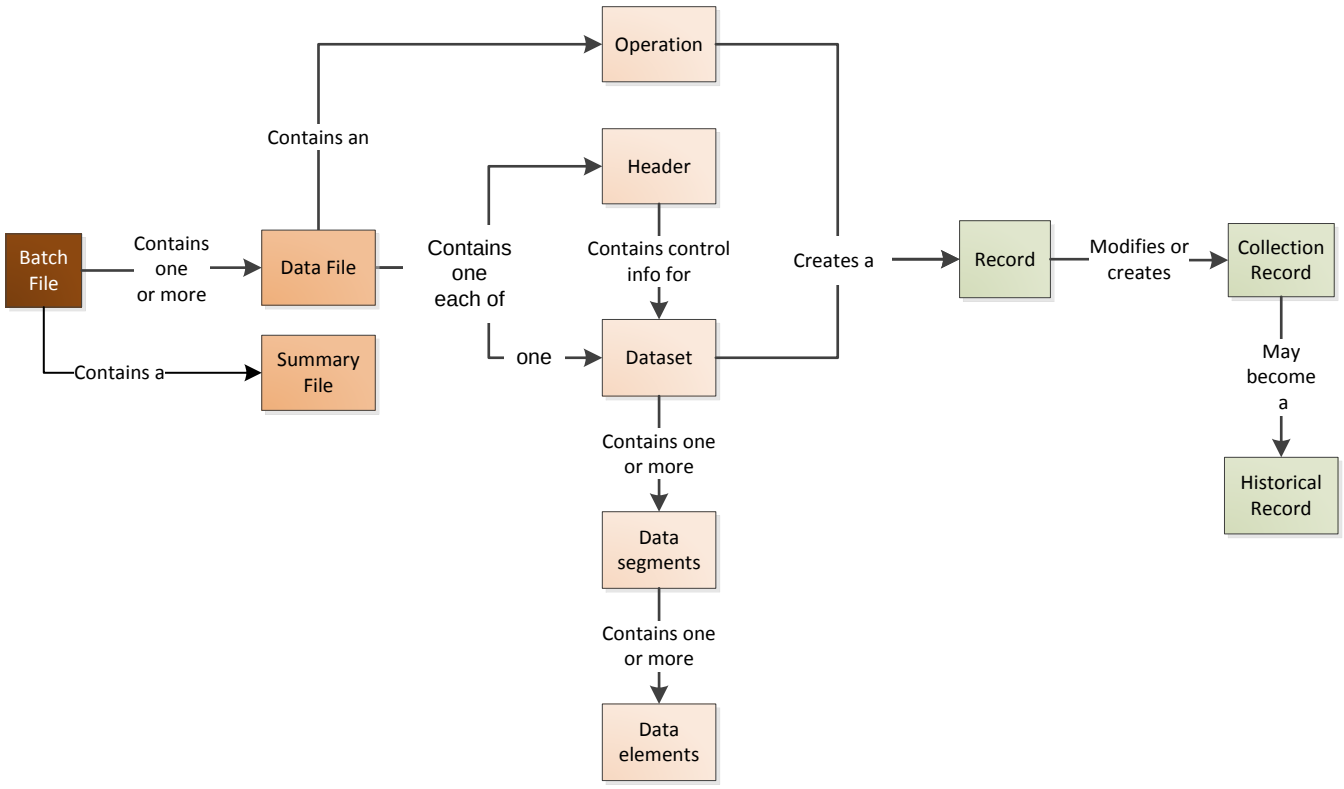


Figure 7: Submission Structure

- Batch File – A batch file is a compressed (zip) file containing one or more data files and one summary file.
- Data File – A file containing a single request to maintain the Collection. It contains an operation, a header and a dataset.
- Summary File - A file containing summary totals for batch. It also contains a header.
- Operation – The action to be effected on the record in the Collection - Add, Update, Remove.
- Header - A header contains control information for a data/summary file.
- Dataset – A dataset is made up of one or more data segments containing a collection of data that accompanies an operation in a file. The operation determines how the dataset will impact the Collection.
- Data segment – a subgroup of data within a dataset. A data segment allows common subgroups of data within multiple datasets to be easily defined and referred to.
- Data element –A data element supplied in a data segment is a unit of data required by the Collection - the actual data that is applied to the Collection.
- Collection record – A unit of information that reflects the Collection's current view of a point in the Patient's Journey. At the highest level records are Referrals or Activities. This is also known as the active record.
- Historical record – A past Collection record, a Collection record that has been superseded through the effect of an operation or a reversal.

4.6.3.2 Data File Structure

The figure below illustrates the data file structure.

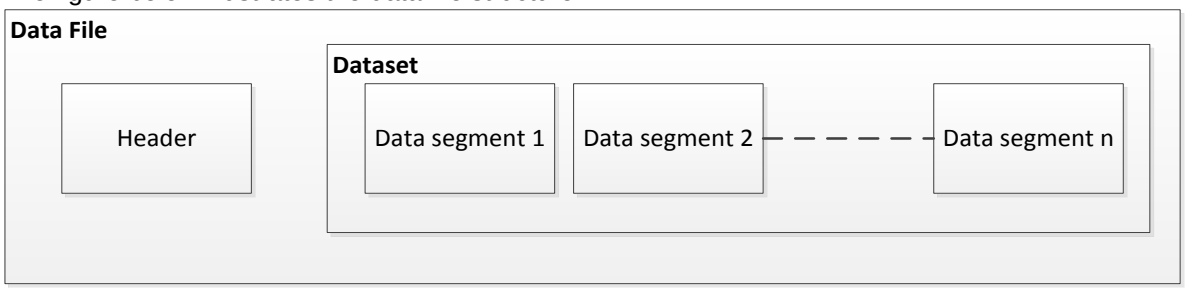


Figure 8: Data File Structure

Each data file contains:

- The operation
- A header containing control information
- A dataset containing one or more data segments.

Within a dataset there are mandatory segments and there may be optional segments.

A data segment contains data elements.

Mandatory/Optional Segments

Mandatory data segments must be supplied in the file. Optional data segments may be absent.

Mandatory/Optional Elements

Mandatory data elements must be populated. Optional data elements may be null.

Within the context of a dataset some data elements are *conditionally mandatory*. Depending on the data elements being provided in a dataset other data elements will also need to be provided.

Note:

- if a data segment contains mandatory elements it does not imply that the data segment is mandatory
- data segments may be optional for submission but mandatory for reporting requirements

4.6.3.3 Dataset combinations

The following diagram shows all the combinations of data segments that are permitted for each dataset as a way of providing examples for the above explanation. This diagram is a summary of the details set out in section 7.

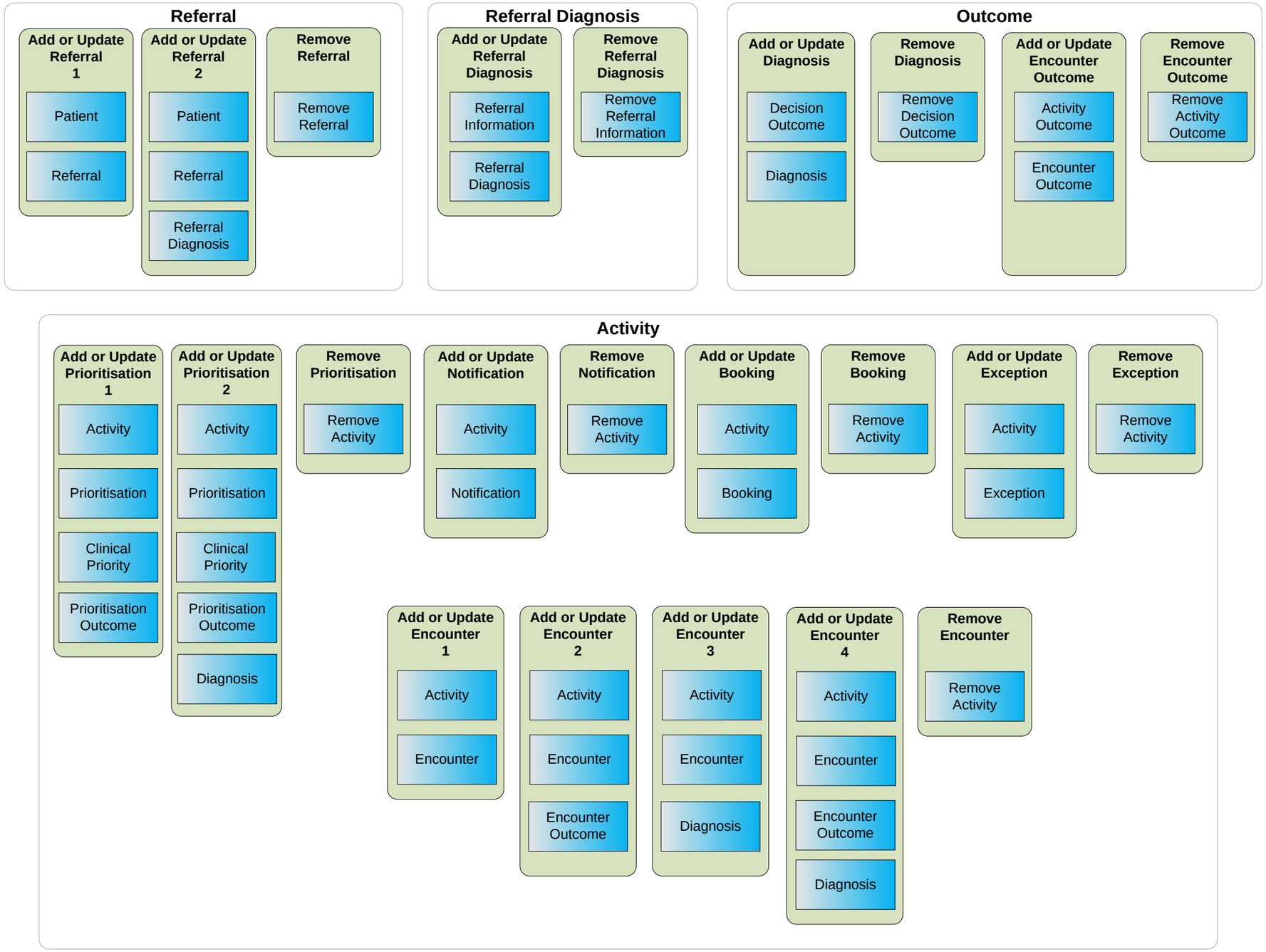


Figure 9: Allowable Dataset Combinations

4.6.4 NPF Response Model

4.6.4.1 Response Structure

The figure below represents the structure of a response to a submission of data to the Collection.

Refer to section “5.2 Batch Processing Overview” for a description of pre-processing and processing.

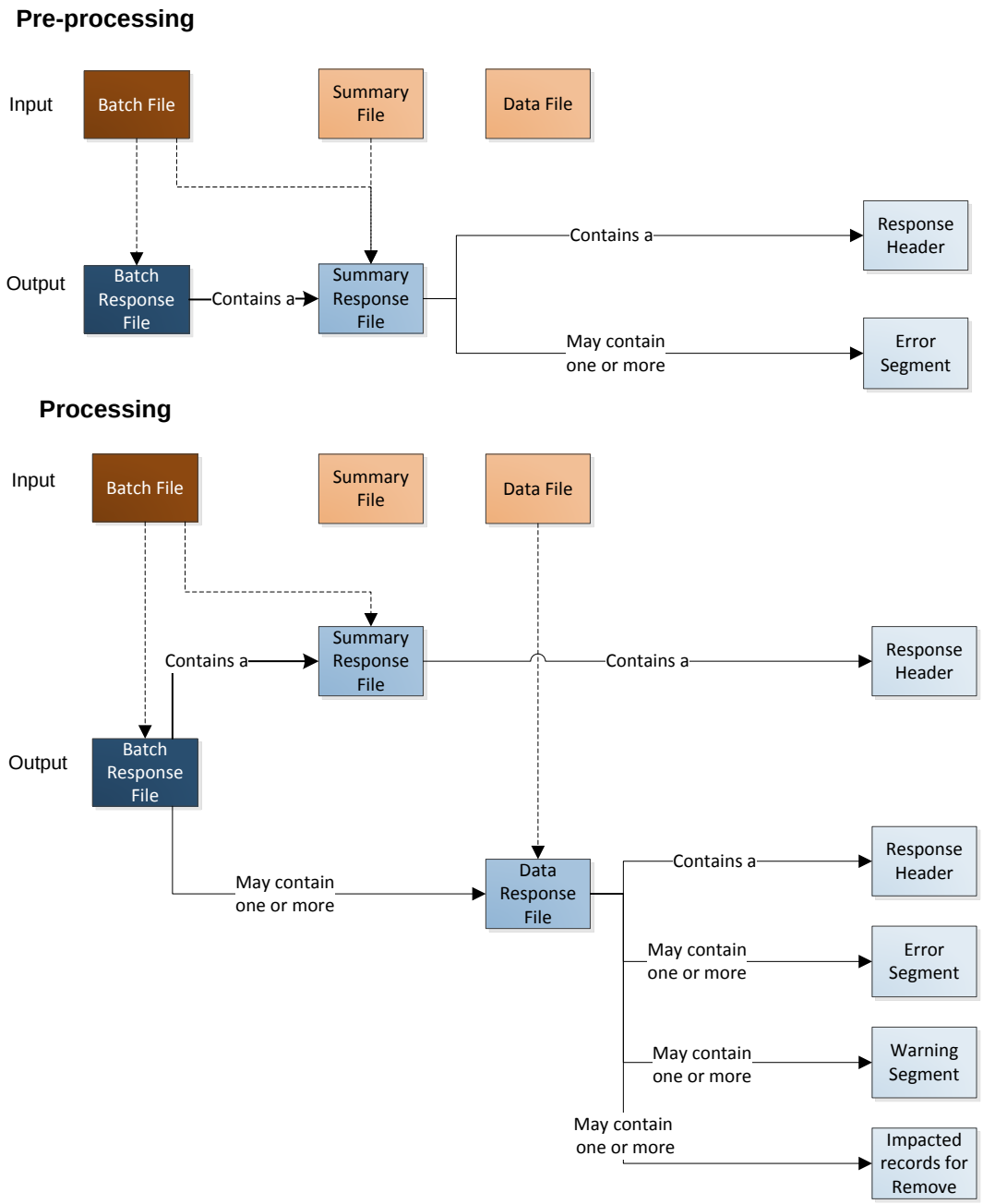


Figure 10: Response Structure

- Batch Response File - A compressed (zip) file containing one or more response files
- Summary Response File - A Summary Response File relates to a batch.
  There is always a Summary Response File for a batch. The Summary Response File contains the result of processing a batch, including the summary file. It may contain one or more errors related to batch or summary file validation.
  The Summary Response File is an XML file.

- Data Response File - A response file that relates to a data file.
  If a batch is accepted for processing there is a response file per each processed data file within the batch. The Data Response File contains the result of processing a data file.

4.7. NPF Data Identifiers

One of the aims of the Collection is to understand the Patient Journey. To achieve this, the Collection will be able to connect various Service Sequences (groups made up of a Referral and the Activities that handle it) with the Presenting Referral that initiated the Journey.

The diagram below indicates how the Collection will view the entire Journey:

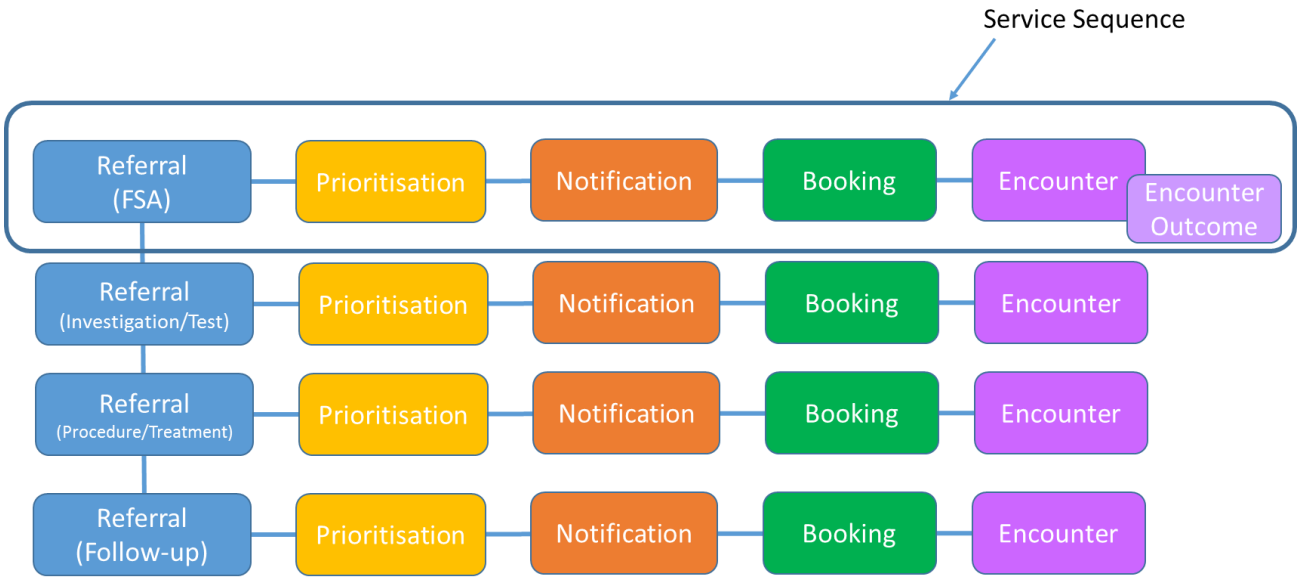


Figure 11: Patient Journey

In order to achieve this, rules need to be established. Among those rules is the need to ensure the unique identification of each piece of the Journey. This is achieved through the use of identifiers as follows:

1. Each Referral (Presenting or Related) must be uniquely identified within the Submitting Organisation.
2. Each Referral Diagnosis must be uniquely identified within the Referral it is associated with.
3. Each Activity must be uniquely identified within the Referral it is associated with.
4. Each Outcome (Activity and Decision) must be uniquely identified within the Activity it is associated with.

The six key identifiers for Collection data are:

- Referral Identifier
- Presenting Referral Identifier
- Previous Related Referral Identifier
- Activity Identifier
- Outcome Identifier
- Referral Information Identifier (for Referral Diagnosis)

Refer to the data model diagram in section “4.6.1 NPF Collection Model” for a graphical view of the relationship of the identifiers listed above.

The uniqueness rules are summarised below

Entity	Identifier	Unique to
Referral	Referral ID	The Submitting Organisation. The Referral is made unique to the Collection by the Ministry taking into account both the Submitting Organisation ID and Referral ID.
Referral	Presenting Referral identifier	The Submitting Organisation that raised the Presenting Referral. The Collection will use the Patient (the live NHI Number) to uniquely identify the Presenting Referral. See Note below table for an explanation of why this has been done.
Referral	Related Referral identifier	The Submitting Organisation that raised the Related Referral This ID is the unique ID for the Referral that preceded the Referral in question. The Collection will use the Patient to uniquely identify the Related Referral.
Referral Diagnosis	Referral Information identifier	The Referral it is associated with.
Activity	Activity ID	The Referral it is associated with.
Outcome	Outcome ID	The Activity it is associated with.

Note: No identifier must intentionally in part or as a whole include a National Health Index number

Note: The Patient is used to uniquely identify Presenting and Related Referrals because:

- Doing so does not require additional data to be supplied (Submitting Organisation ID) to create the required uniqueness when the Presenting or Previous Related Referral is unique within another organisation.
- The risk of a Patient having two Referrals with the same Referral ID in two different Submitting Organisations is so small that it can be ignored for practical purposes.

There are two identifiers related to file processing:

- the batch identifier - Business Transaction ID
- the data/summary file identifier - Correlation ID

The uniqueness rules for these identifiers are summarised below.

Entity	Identifier	Unique to
Batch File	Business Transaction ID	The Submitting Organisation.

Data/Summary File	Correlation ID	The Submitting Organisation.

4.7.1 Connecting the Patient Journey

Phase 3 builds on the frameworks introduced in Phase 2. The purpose of these enhancements is to enable the connection of the Referrals and associated Activities to form an understanding of the Journeys that a Patient participates in.

A Patient Journey is defined in the National Patient Flow Structured Business Vocabulary as: "A journey of care for a Patient which starts with a Presenting Problem and ends with a discharge from treatment and rehabilitation." This definition describes what could be termed as a complete Journey where Treatment is provided. There will be Journeys that are either not complete (due to for example exceptions or service being declined) or that will end with Services other than Treatment.

NPF collects and reports on the Information about a Patient Flow, accordingly NPF identifies a ***Patient Journey*** from an information perspective ***as the Services that are requested, prioritised and provided to a Patient with a Health Condition.***

This means that a Patient with several Health Conditions will be on several Journeys. The challenge for NPF is to identify which Activity pertains to which Journey

NPF will view the Information about a Patient's Journey from two major perspectives:

- A Health Sector's (District Health Boards) perspective and
- A Patient's perspective

See the diagram below for a view of how these two perspectives are formed.

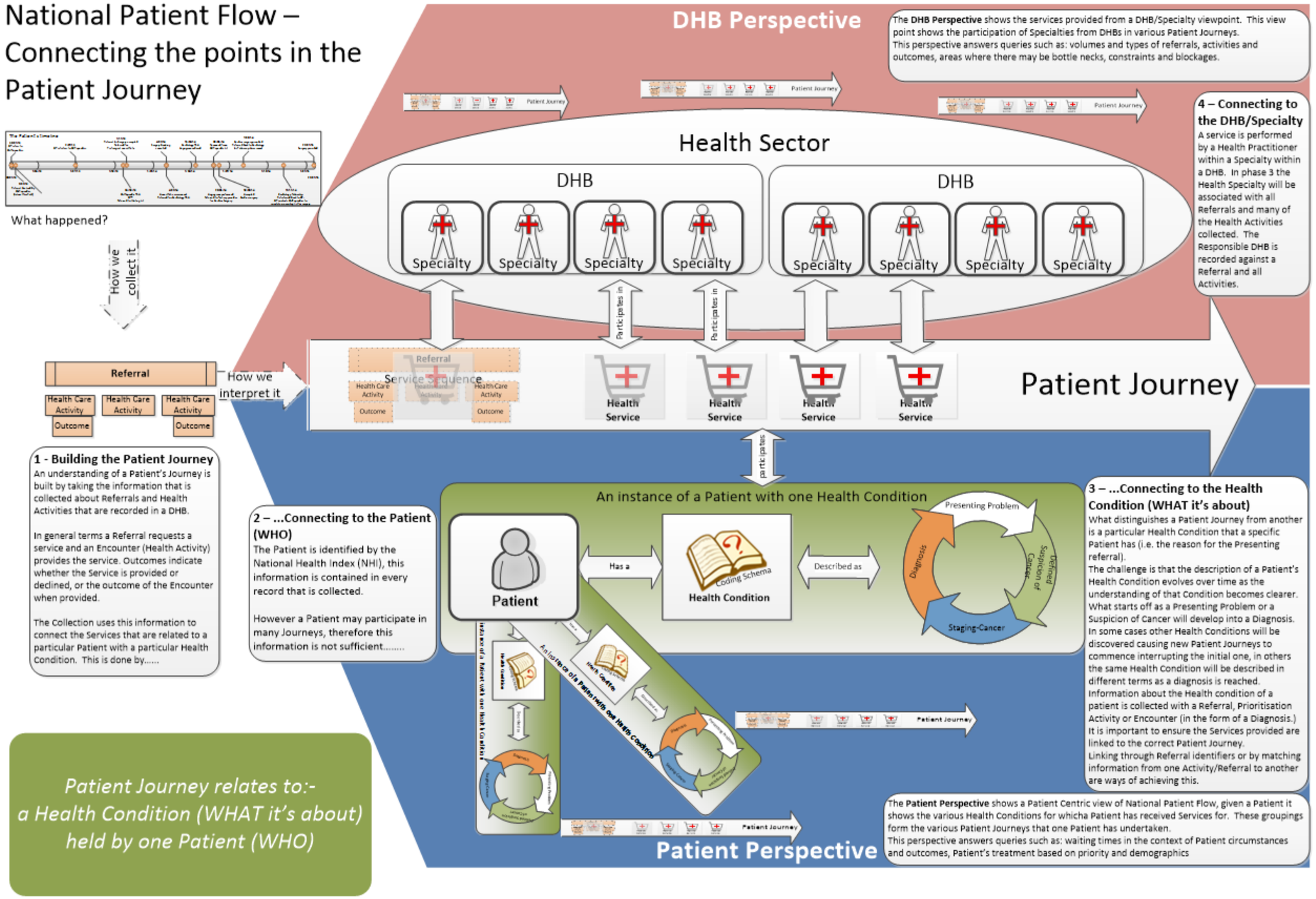


Figure 12 - Connecting the points in the Patient Journey - the different perspectives

The ability to connect and link the various points to the correct Patient and the correct Health Condition is fundamental to the Collection providing a clear understanding of Patients' Journeys.

A Health Condition's description evolves in the Collection by collecting the:

- Presenting Problem
- Diagnosis Codes

Linking Referrals into a Patient Journey is achieved through identifiers and codes, and also interpretation rules. These identifiers and data elements were introduced in Phase 2, they are:

- Presenting Referral ID
- Previous Related Referral ID
- Presenting Referral Flag

Other data elements that provide information that could be used to interpret a link are:

- Presenting Problem Classification
- Health Specialty
- Diagnosis Clinical Codes
- Service Type and Service Subtype
- Intended Procedure Clinical Codes
- Destination
- Encounter Outcome Decision
- Encounter Outcome Reason
- Health Specialty Referred To
- Referred to Organisation

4.7.2 National Patient Flow standard patterns

The NPF Collection expects the following standard patterns to enable linking of Referrals and Activities:

1. Referral Information:
   - Each Referral will include a Presenting Referral ID.
   - In the absence of a Presenting Referral ID a Related Referral will include a Previous Related Referral ID.
   - A Referral may include both a Presenting Referral ID and a Previous Related Referral ID when it is a Related Referral.
2. Service Sequence:
   - Each Service Sequence is initiated by a Referral.

The following sections explain the elements of the above patterns and what will happen when these patterns are not followed.

4.7.2.1 Referral Information

A Referral is defined in the National Patient Flow Structured Business Vocabulary as: "A communication by one health practitioner to another health practitioner whose intent is the transfer of care, in part or in whole of a patient in regards to a specific condition (e.g. if another specialty is asked to take over management of the patient)."

In NPF a Referral reflects a request for a Service. A Service Sequence is defined as "The group of activities that manage a referral for a specific service." Grouping Activities into Service Sequences is useful to enable the Collection to answer questions such as "How long do people wait at points across the pathway and between process outcomes?" or "Where are the constraints or blockages that impact on patient access?" and "What are the 'legitimate delays' in the patient journey, e.g. clinical reasons or patient preference?"

Using the original request (i.e. a Referral) as a linking mechanism is an approach that enables this. Not all Submitting Organisations use a Referral as the initiation of the request. In some cases, it may

be a note, a letter or a booking. NPF requires that the request for a Service be recorded as a Referral even though the Submitting Organisation may not treat it as such.

When a Submitting Organisation does not follow the practice of raising a Referral for each request and records several Services against the same Referral, that Referral is, in effect, linking many Service Sequences together in a similar way a Presenting Referral does. Thus the ability to distinguish each Service is diminished. (See the section: 'Activities and Outcomes within a Service Sequence".)

The following table describes how the Collection will handle the various combinations of the presence or absence within a Referral data set of:

- Presenting Referral ID
- Previous Related Referral ID
- Presenting Referral Flag

The above fields are considered mandatory. However, if any of the two IDs are not present the Collection will not reject the Referral data set. The Presenting Referral Flag is a mandatory data element and must be present in all cases. The table below shows how the Collection will process and interpret the various combinations of values in these fields. The list is displayed in preference order, with the preferred combinations at the top and the not acceptable options at the end of the end of the list:

	Presenting Referral Flag	Presenting Referral ID	Previous Related Referral ID	Handling
1	Yes	Provided	Empty	This is the ideal format for a Presenting Referral. This Referral will be considered the Presenting Referral when the Presenting Referral ID equals the Referral ID.
2	No	Provided	Provided	This is the ideal format for a Related Referral. This Referral will be considered a Related Referral to the stated Presenting Referral and a subsequent Referral to the stated Previous Related Referral when neither the Presenting Referral ID nor the Previous Related Referral ID equal the Referral ID.
3	No	Provided	Empty	This Referral will be considered a Related Referral to the stated Presenting Referral when the Presenting Referral ID does not equal the Referral ID. This Referral will be included in a Patient Journey when the Presenting Referral ID equals a Referral ID of a Referral that is an existing Collection record.
4	No	Empty	Empty	No extra validation performed. Some grouping based on data provided may be possible.

	Presenting Referral Flag	Presenting Referral ID	Previous Related Referral ID	Handling
5	Yes	Empty	Empty	This Referral will be considered a Presenting Referral.
6	No	Empty	Provided	The Previous Related Referral ID must not equal the Referral ID and it must equal a Referral ID of a Referral that is an existing Collection record. This Referral will be considered a Related Referral when the Previous Related Referral ID does not equal the Referral ID. This Referral will be included in a Patient Journey when the Previous Related Referral ID equals a Referral ID of a Referral that is an existing Collection record. Identifying the Presenting Referral that it is related to will be determined by interpreting the data available as required. The absence of a Presenting Referral ID could have an impact on accurate reporting as the derived link will not be explicit.
7	Yes	Provided	Provided	This is not a valid combination for the Collection. A Presenting Referral must not have a Previous Related Referral. This will be rejected at File submission time.
8	Yes	Empty	Provided	This is not a valid combination for the Collection. A Presenting Referral must not have a Previous Related Referral. This will be rejected at File submission time.

NOTE: Only scenarios 7 and 8 will cause a file to be rejected on submission. Data that does not conform to the rules set out in the other scenarios will be brought to the Submitting Organisation's attention through reporting.

It is assumed that a Previous Related Referral is a Related Referral that precedes the Referral and belongs to the same Patient Journey. A Presenting Referral is considered the first Referral in a Patient's Journey therefore a Presenting Referral does not have a Previous Related Referral.

Journeys that are about the same Health Condition but are a significant amount of time apart will be treated as separate Journeys but they could be associated through the Presenting Problem or Diagnosis Codes.

The above table is represented as a decision tree, when the Presenting Referral ID set to “Yes”, as:

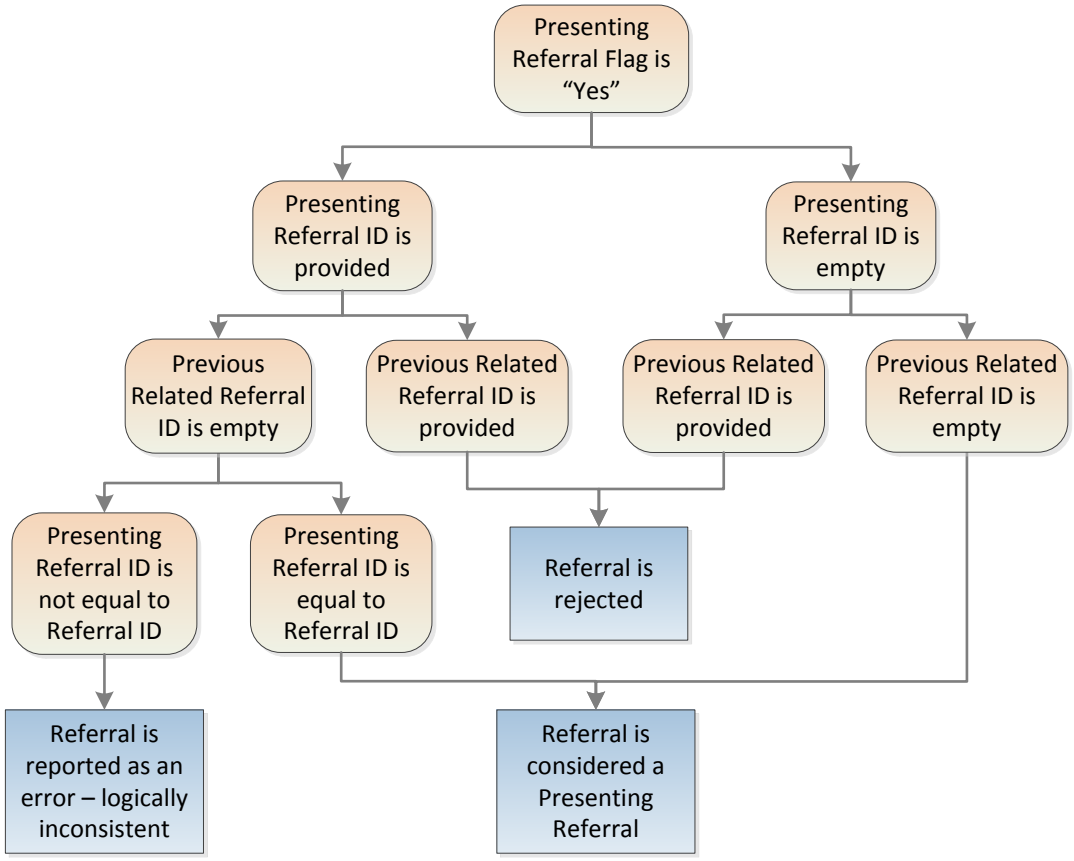


Figure 13 – Presenting Referral Flag set to “Yes” decision tree

For Referrals that have the Presenting Referral ID set to “No”, the decision tree is:

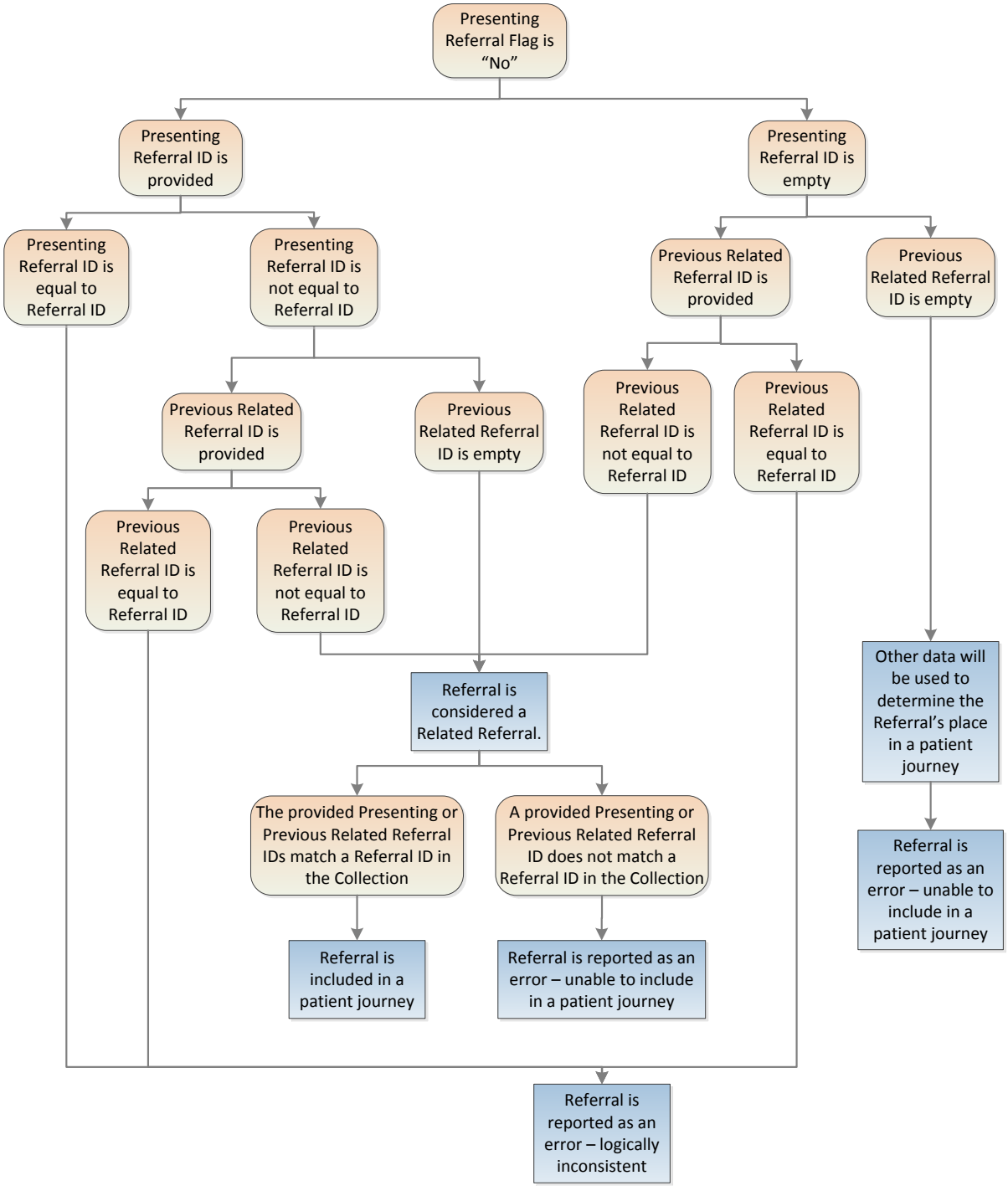


Figure 14 – Presenting Referral Flag set to “No” decision tree

Handling Referrals that don’t have any linking IDs

When a Referral does not include a Presenting Referral ID nor a Previous Related Referral ID, the Presenting Referral Flag will continue to determine whether it is a Presenting Referral.

When the Presenting Referral ID and Previous Related ID are not present and the Presenting Referral Flag identifies it as a Presenting Referral the Referral is a Presenting Referral to which other Related Referrals could be connected to.

When the Presenting Referral ID and a Previous Related ID are not present and the Presenting Referral Flag indicates that it is not a Presenting Referral the Referral will be treated as a Related

Referral that may be connected to a Presenting Referral. In this case the Collection knows what Patient the Referral relates to and will make assumptions about connections and links based on the information available. If the Collection is unable to derive the links, Referrals will be considered as not connected. Unconnected Referrals or Referrals not connected to a Presenting Referral will be considered when Reports are run but various degrees of interpretation rules will be applied within the context of the report.

Specific variance reports may be developed to assist the Ministry and Submitting Organisations to more explicitly connect Referrals to the correct Journeys.

Handling Referrals that have other issues

There are additional scenarios to those above that require handling:

- A Presenting or Related Referral ID may match a Referral for another patient
- Referrals may appear to be in a patient journey but there are only Related Referrals, with no declared Presenting Referral in the Collection
- Where a Submitting Organisation uses only Previous Related Referral IDs to identify a patient journey, a missing Referral will break the chain.

The first scenario, where the supplied ID links to a referral for another patient, will result in the Referral being reported as of unknown status. The other scenarios will be interpreted using all data supplied as appropriate for the context in which it is being reported.

4.7.2.2 Service Sequence

A Service Sequence is the group of Activities that manage a Referral, with respect to a specific Service. In some cases, there may be additional related Services associated with the same Referral. For example, if a patient is referred for two different tests, this should be recorded as either two separate Referrals or two separate Services Sequences, linked to the same Referral ID. Having a complete Service Sequence for every Service is required to ensure a complete view of the Patient Journey.

Included within the data elements for all Activities are the Service Type, Service Sub Type, and Intended Procedure Code. It is these three data elements that are considered in the concept of a Service Sequence. Where the Service Type, Service Sub Type, and Intended Procedure Code match between activities associated with a referral ID the matching activities are grouped into the same Service Sequence. The concept of Service Sequence will be used in the development of reporting from NPF for parts of the patient pathway, and as a check on data completeness.

The mandated pattern for a Service Sequence is for it to start with a Referral, be for a single Service and end with:

- An Encounter Outcome where the Outcome Decision is not New Appointment Required or,
- A Prioritisation Outcome that is Declined and Notified or
- An Exception Activity that is Closes the Service Sequence.

It is anticipated that this mandate will not be possible for those Submitting Organisations that associate more than one Service to the same Referral. It is therefore necessary that the Collection is able to interpret, at the very least, what Service Sequences Activities are linked to.

Activities are connected in the same Service Sequence when they contain the same:

- Referral ID,
- Service Type,
- Service Sub-type. and
- Intended Procedure Clinical Code (where supplied).

4.8. Moving from Phase 2 to Phase 3 and handling of data element validation

4.8.1 Approach

To enable the movement of Submitting Organisations from a Phase 2 collection to a Phase 3 one, and to avoid the need for a full migration, the following transition approach has been adopted:

- The Phase 3 file format will be implemented at the same time for all Submitting Organisations.
- Phase 3 business rules will apply to all submissions made from this date onwards, this includes submissions of files representing records collected prior to Phase 3.
- Where a Submitting Organisation is unable to submit values for any new mandatory data by the Phase 3 start date, a remediation plan will need to be agreed with the Ministry. Default values will be provided for Submitting Organisations for use during the period covered by the plan, after which point valid values will need to be submitted.
- Updates and additions to records collected under Phase 2 but submitted after the transition date will need to be submitted in the Phase 3 file format. To avoid rejections due to the absence of values for "new" data elements placeholder values will be supplied to fill in the gap, where required.

The implementation of the approach is set out in Appendix F: Moving from Phase 2 to Phase 3.

4.8.2 Different types of obligation

In implementing Phase 3 the treatment of data elements, whilst remaining the same at a technical level, varies in treatment at a business level as follows:

Mandate	Technical Obligation	Business handling
Optional	**Optional** The file will still be processed if the data element is absent.	This element is important to the Collection but not considered critical.
Conditionally Mandatory	**Conditionally Mandatory** Validated against a Condition; if the Condition is met then the file will reject if the data element is absent.	Given a condition, this element is considered critical to the Collection.
Mandatory	**Mandatory** The file will reject if the data element is absent.	This element is considered critical to the Collection in all cases.
Business Mandatory / Conditionally Mandatory	**Optional** The file will still be processed if the data element is absent. These elements are described as 'mandatory for business purposes' in the Guide for Use sections	This element is considered essential for the Collection. *Reports will be produced for Submitting Organisations to indicate when these elements are missing with the expectation that the omission will be fixed.* *Examples of these include Identifiers that will connect the Patient Journey such as Presenting Referral ID*
Mandatory / Conditionally Mandatory (with default codes)	**Mandatory /** **Conditionally Mandatory** The file will reject if the data element is absent, but the use of a default code will circumvent this.	When default codes are used this will be reported to the Submitting Organisation (either through warning codes or a summary report), indicating that the expectation is that a valid value for this data element is expected to be provided for files in the 'near future'.
Retired	**Optional** The file will still be processed if the data element is absent. These elements are clearly identified in	This element is no longer required, but is retained so that data collected in Phase 2 can updated.

	the data dictionary as no longer required to be collected.	

4.9. Exceptions

Exception Activities are required when a Service Sequence does not proceed as expected, for example, the Encounter does not occur for reasons other than the Referral was declined at Prioritisation.

The inclusion of an Exception activity in a Referral will affect the way in which the Service Sequence and Patient Journey are measured in performance reports and in clinical and administrative analyses. The guidance provided for using Exceptions is mostly general in nature as the range of scenarios in which Exceptions can be applied is extensive. The Ministry expects to add to the specific guidance as the Collection matures.

Performance reports will treat Exceptions within the context of the report, and this will be set out in detail in the report specifications as they are delivered.

“12.13 - EXCTPOUT Exception Outcome” and “12.14. - EXCPREA Exception Outcome Reason” provide guidance on the circumstances in which to submit a Suspended, Closed or Reactivate Exception.

Exceptions can close a Referral, with no further Activities recorded against that Referral, or can create an Exception period, with start (Suspended) and end (Reactivate) dates. The start date must be established by submission of an Exception Activity and the end date can only be established by a Reactivate Exception.

PLEASE NOTE: Although previous guidance indicated that submitting any other Activity would also reactivate a suspended Referral, concerns regarding inappropriate Reactivation of Suspended Referrals mean this is no longer an option.

The date of an Exception is the date on which the patient advice is received to either Close, Suspend or Reactivate the Referral.

4.9.1 Closed Exceptions

1. Closed Referrals should not be Reactivated.
2. Some Closed Referrals will be included in FCT reports, depending on the Exception Outcome Reason. For example, Faster Cancer Treatment 14 day Indicator report will include Referrals that have been closed with the reasons “Cancelled - patient referred to another DHB for care” and “Cancelled - patient medically unfit”.

4.9.2 Exception periods

1. A Suspended Exception Handling Activity will generally pause a referral, initiating an Exception period, for performance reporting purposes, however the specific effect of Exception periods will be specified in each report.
2. Suspended Referrals can be reactivated by submitting a Reactivate Exception. The reactivation date is the Date Exception Outcome Assigned, when the Service Sequence is Reactivated by a Reactivate Exception. **Note: This is a change from the project phases of NPF.**
3. A Suspended Referral that does not have a Reactivate Exception or subsequent Activities will be included in data quality reports after a reasonable period of time (to be determined) has elapsed.
4. A Reactivate Exception without a Suspended Exception will generally be ignored for performance reporting and clinical analysis purposes. It will be a candidate for inclusion in data quality reports.
5. Multiple Suspended Exceptions for a Referral will be treated individually, and will have the following impacts:

a. Where the Exception periods overlap, they will be generally be treated as one continuous period. The nature of an Exception period may require that this is not done.

b. Where the Exception periods do not overlap they will be treated separately.

6. The effect of Exceptions on a Patient Journey will be determined by the context of the analysis

5. How is data submitted?

This section contains an overview of:

- how batches of data files are transmitted to and from the Ministry
- how the Ministry processes the batches
- batch submission requirements.

Refer to section “4.6.3 NPF Submission Model” for an explanation of the submission structure.

5.1. File transmission

The following context diagram demonstrates the applicable environments when an organisation submits a batch to the NPF system.

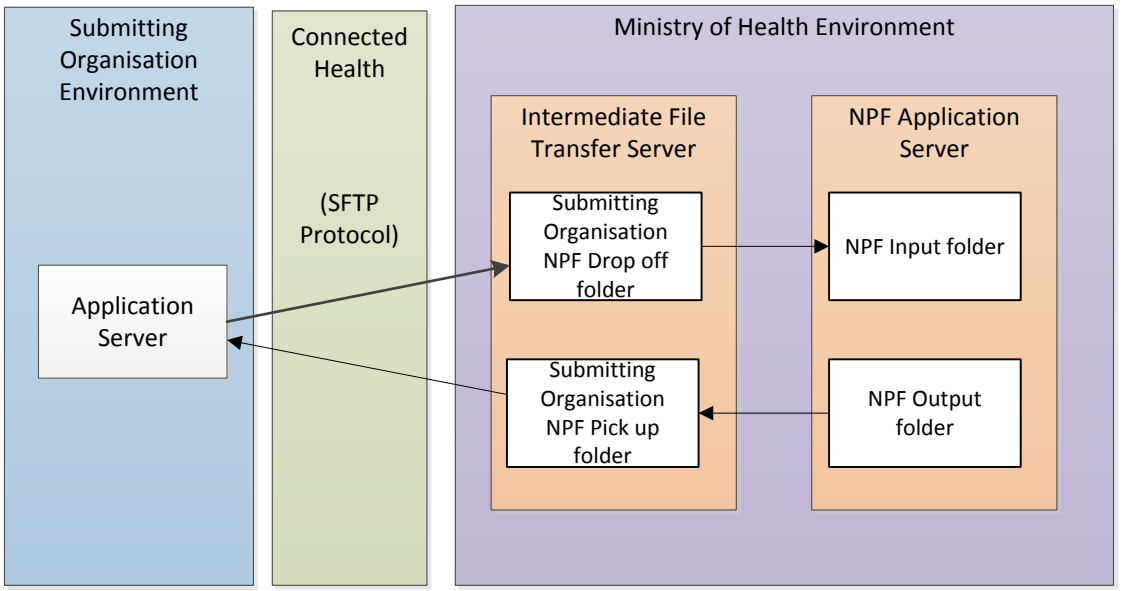


Figure 15: File Transmission Diagram

5.2. Batch Processing Overview

Batches for a submitter are processed in the order in which they are submitted. Where the NPF Scheduler finds two or more batches from the same Submitting Organisation waiting for processing, then those batches are processed in ascending order of batch creation time. Where the NPF Scheduler finds two or more batches that have the same batch creation time, then they are processed in the order in which they were submitted

The following diagram gives an overview of the batch processing steps and the outputs that are generated at each step. The steps are explained in more detail in the following sections.

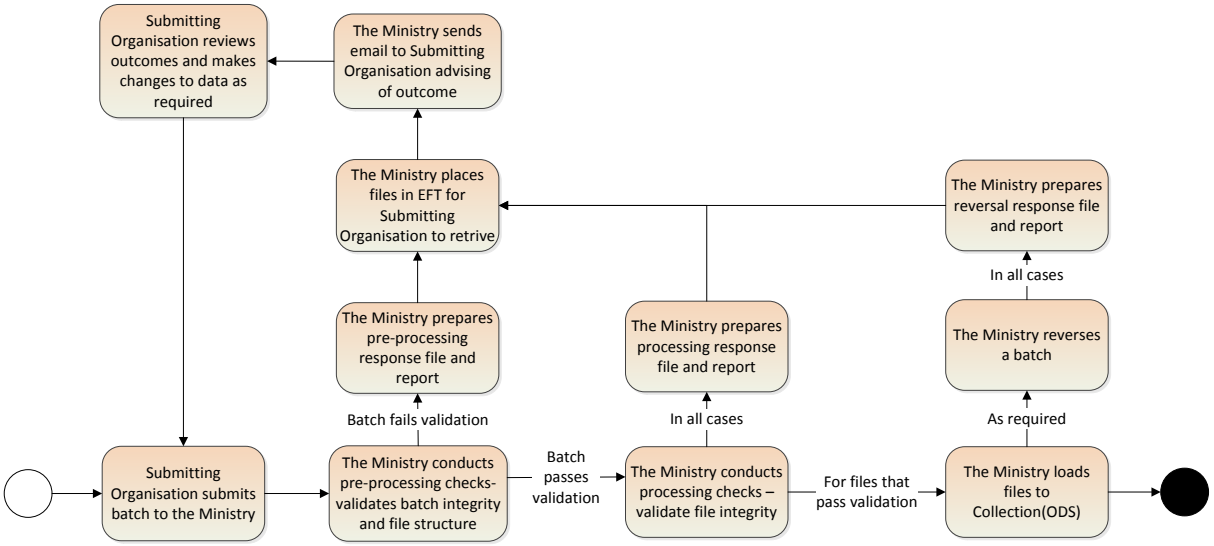


Figure 16: Batch Processing Overview

5.2.1 Batch integrity and file structure validation (pre-processing)

The first stage of processing validates the integrity of the batch file name, summary file name, summary file header and summary file validation. The following checks are made:

- The batch file name is checked for valid contents and consistency.
- The Summary File name is checked for valid contents and checked against the batch file name for consistency.
- The Summary File header is checked against the summary file name for consistency.
- The system validates the number of data file message types submitted in the batch matches the totals in the Summary File.
- Business Transaction ID and Correlation ID are checked for uniqueness within the batch and Submitting Organisation.
- If any of the above checks fail, the batch is rejected and the Submitting Organisation will be informed through email (See Appendix A) that response files (zip and EXCEL) are available in the pickup directory. More detail on the response file is provided in section “6.3 Output files”.
- If the above checks are successful, then the batch goes on for further processing.

5.2.2 Data file integrity validation (Processing)

During this stage each data file is validated and is accepted or rejected.

In this stage further validations are performed to check integrity of the data and adherence to business rules (data integrity):

- The structure of each data file is validated. Each data file must conform to the Collection XML Schema Definition e.g. the format and data types are correct and mandatory data is present. A file that fails this phase of validation will be rejected.
- The data files accepted in the previous step are then validated for conformance with data integrity business rules, code values are validated, the NHI number is checked against the NHI database, etc. A file that fails this phase of validation can be rejected, or accepted with warning.
- Files accepted or accepted with warning are processed into the Collection.
- Response files containing the outcome of both checks listed above are placed in the Submitter's pick-up directory. More detail on the response files is provided in "6.3 Output files".

5.2.3 Data Load

Valid data files are loaded into the NPF Operational Data Store (ODS) database.

5.2.4 Data Warehouse Load

The data in the NPF ODS is periodically loaded into the Data Warehouse for reporting and querying purposes.

5.3. Batch submission requirements

- Submitting Organisations are expected to provide referrals data to the Ministry at a minimum of once per week.
- A batch must contain no more than 10,000 data files.
- The Ministry of Health will ensure that processing of a submitted batch file is completed within two working days of receipt of data from a provider.

5.4. Batch Reversal

5.4.1 Reversal Process

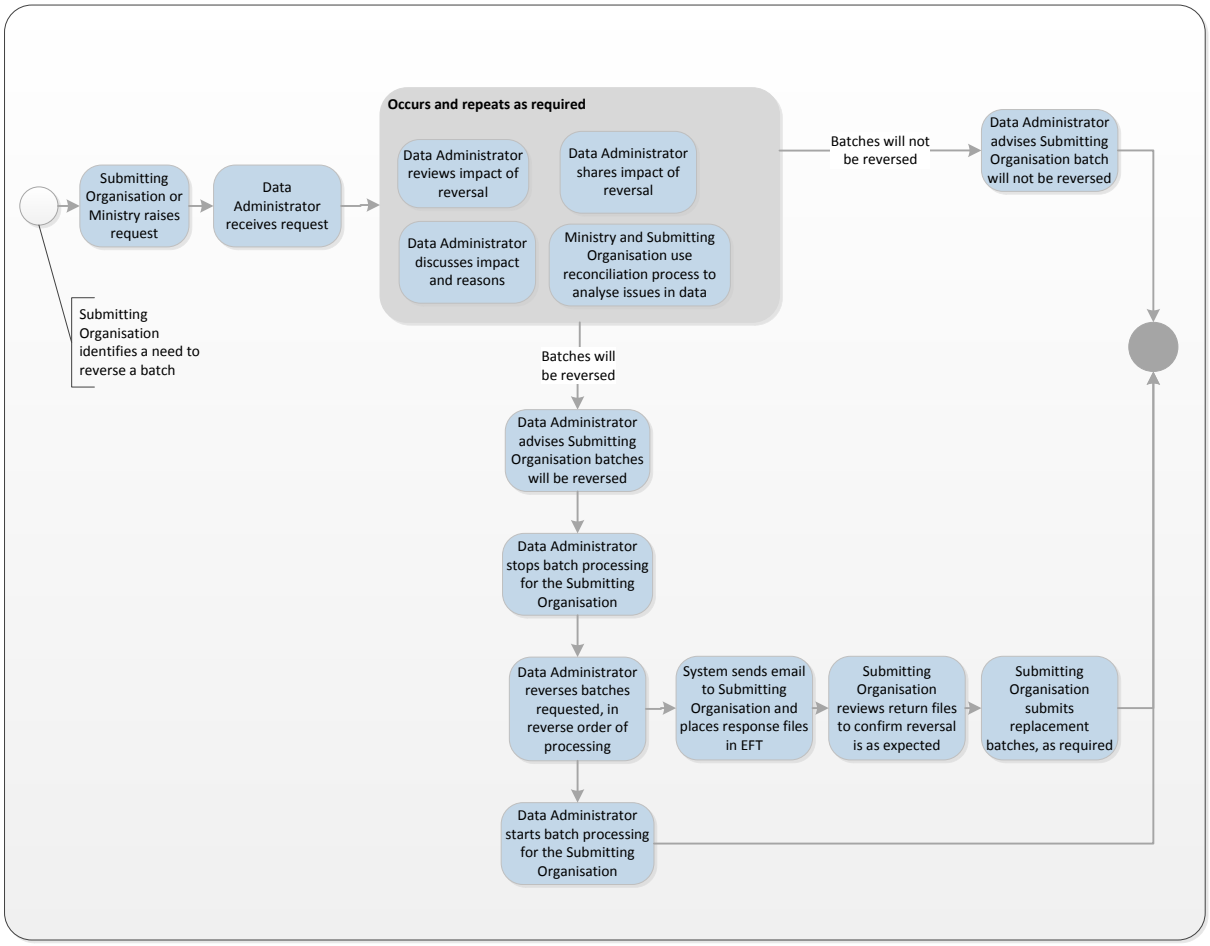


Figure 17: Reversals Process

1. Only the most recent batch in the Collection for a Submitting Organisation can be reversed. Once the most recent batch has been reversed, the new most recent batch can be reversed. The Submitting Organisation can request multiple batches be reversed, but they will be processed one at a time.
2. Reversals will be a manual operation, and each request will be reviewed to determine whether Reversal is the most effective or efficient method of correcting errors. The Data Management team will work with the Submitting Organisation throughout the process.
3. A Reversal will reverse all data files in a batch.
4. A reversal report is returned to the DHB for reconciliation purposes. Reversal processing rules

A Reversal undoes the last Batch in the Collection for a Submitting Organisation, returning the Collection Record affected by each Data File in the Batch to the state it was in prior to the Batch being processed.

The Collection records the Reversal by marking the data submitted in the Reversed Batch as Reversed. All records will be retained for reference within the NPF Collection.

Batch level rules:

1. A Batch can only be reversed once.
2. The Batch cannot be reversed unless it is the most recent non-reversed Batch for the Submitting Organisation.
3. The Batch cannot be reversed until the processing of Batches for the Submitting Organisation has been stopped.
4. A Batch that has been reversed can be re-submitted with the same Batch and Correlation IDs.

5.4.2 Reversal reports and response files

The Submitting Organisation is sent an email advising of completion using the batch reversal format set out in “14. - Appendix A: Emails”. Response files are placed in the Submitter’s pick-up directory. More detail on the response files is provided in “6.3 - Output files”.

6. What are the data files?

This section specifies:

- The input files for submitting data to the NPF Collection
- The output files detailing the results of input data processing.

6.1. Overview

A selection of NPF data files and a summary file will be packaged into a compressed format – referred to as a 'batch file' - before being uploaded to the Ministry. Each batch file can contain a number of different NPF data files.

Refer to section "4.6.3 - NPF Submission Model" for an explanation of the submission structure.

6.2. Inputs

The following files are inputs to the NPF system:

6.2.1 Batch File

- The batch file is a compressed (zip) file containing a number of data files and one summary file
- Each batch file has an identifier called a Business Transaction ID that is assigned by the Submitting Organisation and is unique within that organisation.

6.2.2 Data File

- Data files are submitted in batches
- A data file contains a dataset pertaining to a single Referral or Activity and the operation to be performed on the Collection.
- Each data file has a unique identifier that is the Correlation ID. This must be unique within the Submitting Organisation.
- The file is in XML format.

The data file contains the following:

Content	Description
Header	Contains control information for the batch that specifies the sender, and other identifying information
Dataset	Contains • applicable identifiers i.e. referral, activity, outcome • patient NHI data • referral or activity dataset

Refer to section "7 – What is in the Data File?" for details of the datasets and elements contained in the above records.

6.2.3 Summary File

- A Summary File is submitted within each Batch.
- The Summary File contains summary counts by Message Type of the data files within the Batch.
- The summary file is in XML format.

The summary file contains the following:

Content	Description
Header	Contains control information for the file that specifies the sender, and other identifying information.
Detail	Contains summary record counts for the files submitted in the batch.

Refer to section “7 – What is in the Data File?” for details of the elements contained in the above records.

6.3. Output Files

The following files are outputs of the NPF system:

6.3.1 Batch Response File

- The Batch Response File is a compressed (zip) file containing one or more XML response files.
- The Batch Response File has the same Business Transaction ID as the submitted Batch File.

6.3.2 Pre-processing Batch Response File

- The pre-processing Batch Response File (zip) contains only a Summary Response File
- The Summary Response File is in XML format.

The Summary Response File contains the following:

Content	Description
Response Header	Contains • control information for the batch that specifies the sender, and other identifying information • Acknowledgement code. A code indicating the result of the NPF system pre-processing the batch file.
Error	Contains errors that caused the batch to be rejected.

Refer to section “8 – What is in the Output Files?” for details of the fields contained in the above records.

6.3.3 Processing Batch Response File

- The processing Batch Response File (zip) contains one Summary Response File and a Data Response File for each Data File.
- The Summary/Data Response Files are in XML format.

The Summary Response File contains the following:

Content	Description
Response Header	Contains • control information for the input file that specifies the sender, and other identifying information • Acknowledgement code.

The Data Response File contains the following:

Content	Description
Response Header	Contains • control information for the input file that specifies the sender, and other identifying information • Acknowledgement code.
Error	Only present if the data file has been rejected because it contains errors.
Warning	Only present if the data file has been accepted with warnings.
Impacted Records	Only present if the operation in the data file was Remove, and the removal of the record specified by the data file resulted in the removal of dependent records. Lists the identifiers of dependent records that were removed.

Refer to section “8 – What is in the Output Files?” for details of the fields contained in the above records.

6.3.4 Batch Pre-processing Report

- A batch pre-processing report is returned at the end of batch pre-processing when a batch is rejected. It reports the errors that caused the batch to be rejected.
- The batch report is in Excel (xls) format.

6.3.5 Batch Processing Report

- A batch processing report is returned by the NPF system at the end of batch processing to report statistics and errors encountered while processing the batch
- The batch report is in Excel (xls) format.

6.3.6 Reverse Batch Report

- When a batch is successfully reversed a reverse batch report is produced. It reports the files that were reversed.
- The reverse batch report is in Excel (xls) format.

6.3.7 Response Files for Reverse Batch

- For a reverse request there is a compressed (zip) Reverse Batch Response file.
- The compressed file (zip) will contain one Summary Response File and a Data Response File for each data file in a reversed batch. These files are in XML format

The XML file contains the following:

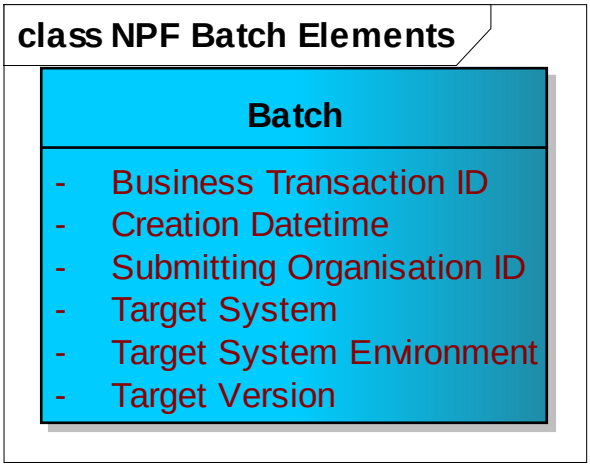
Content	Description
Response Header	Contains • control information for the reversed file that specifies the sender and other identifying information • Acknowledgement code.
Impacted records	This section will be included if: • The data file being reversed is a Remove operation • The Remove operation caused child records to be removed Reversing such a Remove must cause the child records to be restored. This section will list the child records that are restored by the reversal. Refer to section “9.2.3 Remove” for details on the remove operation

Refer to section “8 – What is in the Output Files?” for details of the fields contained in the above records.

6.4. Batch definition

A batch is a number of data files plus one summary file that are compressed into a zip file for transmission to the NPF Collection.

The batch file name contains identification information that is used for the management of the batch by the NPF System and Ministry of Health Data Administrators.



Refer to section “11.1.1 – Batch” for the definition of the batch data elements.

Validation

For batch integrity checking rules refer to the group of rules *What is a valid batch?* in the attached Business Rules Catalogue (17 - Appendix D: Business Rules and Error Messages).

6.4.1 File Names

6.4.1.1 Batch

The input Batch File name is in the following format:

<<Submitting Organisation ID>>_<<Creation Datetime>>_<<Business Transaction ID>>_<<Target System>>_<<Target System Environment>>_<<Target Version>>.zip

Example:

G00036-D_2014-07-01T094505_0000000001_NPF_PROD_3.0.zip

For batch file name validation rules refer to the group of rules *What is a valid batch filename?* in the attached Business Rules Catalogue (17 - Appendix D: Business Rules and Error Messages).

6.4.1.2 Response

The Batch Response File name is the same as the input batch file name with a prefix of ‘RESP’. It is in the following format:

RESP_<< Submitting Organisation ID>>_<<Creation Datetime>>_<<Business Transaction ID>>_<<Target System>>_<<Target System Environment>>_<<Target Version>>.zip

Example:

RESP_G00036-D_2014-07-01T102305_0000000001_NPF_PROD_3.0.zip

The Summary Response File name is the same as the Batch Response File name with an extension of ‘.xml’. It is in the following format:

RESP_<< Submitting Organisation ID>>_<<Creation Datetime>>_<<Business Transaction ID>>_<<Target System>>_<<Target System Environment>>_<<Target Version>>.xml

Example:

RESP_G00036-D_2014-07-01T102305_0000000001_NPF_PROD_3.0.xml

6.4.1.3 Reversal

The reversal batch file name is the same as the input batch file name with a prefix of ‘RESP_REV’. It is in the following format:

RESP_REV_<< Submitting Organisation ID>>_<<Creation Datetime>>_<<Business Transaction ID>>_<<Target System>>_<<Target System Environment>>_<<Target Version>>.zip

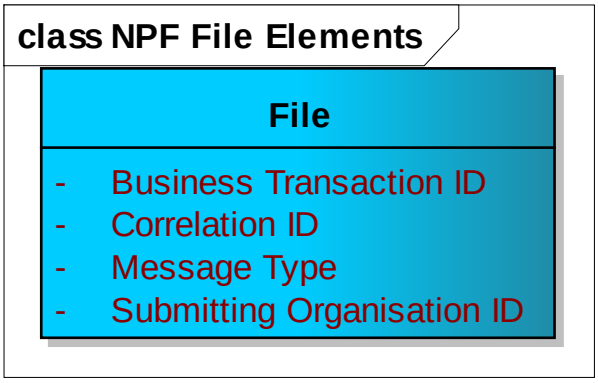
Example:

RESP_REV_G00036-D_2014-07-01T102305_0000000001_NPF_PROD_3.0.zip

6.5. Data/Summary file definition

The data/summary file name contains file identification information that is used for the management of the file by the NPF System and Ministry of Health Data Administrators.

The following diagram shows the file identification information:



Refer to section “11.1.4 – File” for the definition of the batch data elements.

Validation

For integrity checking rules refer to the group of rules *What is a valid data file?* and *What is a valid summary file?* in the attached Business Rules Catalogue (17 - Appendix D: Business Rules and Error Messages).

6.5.1 Data/Summary File Name

The data/summary file name is in the following format:

<<Submitting Organisation ID>>_<<Message Type>>_<<Correlation ID>>_<<Business Transaction ID>>.xml

Examples:

G00036-D_ADDREF_0000000001_0000000001.xml

G00036-D_ADDPTA_0000000002_0000000001.xml

G00036-D_SUM_0000000000_0000000001.xml

For data/summary file name validation rules refer to the group of rules *What is a valid data/summary filename?* in the attached Business Rules Catalogue (17 - Appendix D: Business Rules and Error Messages).

6.5.2 Processing Data Response File Name

Once a batch has been received and processed, response files will be generated. The content of the response files will depend on the processing outcome. Refer to section “8 – What is in the Output files?” for details of the content of the response files. The data response file name is the same as the data file name with a prefix of ‘RESP’. It is in the following format:

RESP_<<Submitting Organisation ID>>_<<Message Type>>_<<Correlation ID>>_<<Business Transaction ID>>.xml

Examples:

RESP_G00036-D_ADDREF_0000000001_0000000001.xml

RESP_G00036-D_ADDPTA_0000000002_0000000001.xml

6.5.3 Reversal Response Data File Name

The reversal response data file name is the same as the data file name with a prefix of 'RESP_REV'. It is in the following format:

RESP_REV<<Submitting Organisation ID>>_<<Message Type>>_<<Correlation ID>>_<<Business Transaction ID>>.xml

Examples:

RESP_REV_G00036-D_ADDREF_0000000001_0000000001.xml

RESP_REV_G00036-D_SUM_0000000002_0000000001.xml

6.6. Report file definition

6.6.1 Batch Pre-processing and Processing Report File Name

The file name for both the pre-processing and processing reports is the same as only one of the reports will be generated for a batch. The report file name is the same as the input batch file name with a prefix of 'RPT'. It is in the following format:

RPT_ << Submitting Organisation ID>>_<<Creation Datetime>>_<<Business Transaction ID>>_<<Target System>>_<<Target System Environment>>_<<Target Version>>.xls

Example:

RPT_ G00036-D_2014-07-01T102305_0000000001_NPF_PROD_3.0.xls

6.6.2 Reverse Batch Report File Name

The report file name is the same as for the input batch that was reversed with a prefix of 'RPT_REV'. It is in the following format:

RPT_REV_<< Submitting Organisation ID>>_<<Creation Datetime>>_<<Business Transaction ID>>_<<Target System>>_<<Target System Environment>>_<<Target Version>>.xls

7. What is in the Data File?

This section specifies the data files:

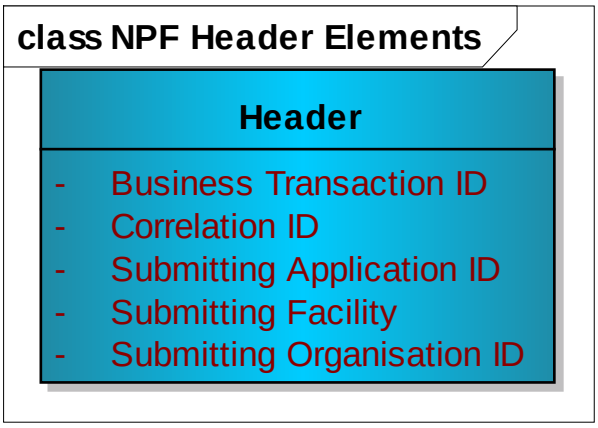
- The datasets – a logical grouping of data elements
- The data elements themselves
- Each data file contains a discrete dataset that relates to a single Referral or Activity.

Refer to section "4.6.3 - NPF Submission Model" for more information.

7.1. Header

The figure below shows the data elements that make up the Header Dataset.

For definitions of the data elements refer to Section 10 Data Element Definitions.



7.2. Referral Datasets for Add and Update

7.2.1 Overview

Diagnosis information may accompany a referral.

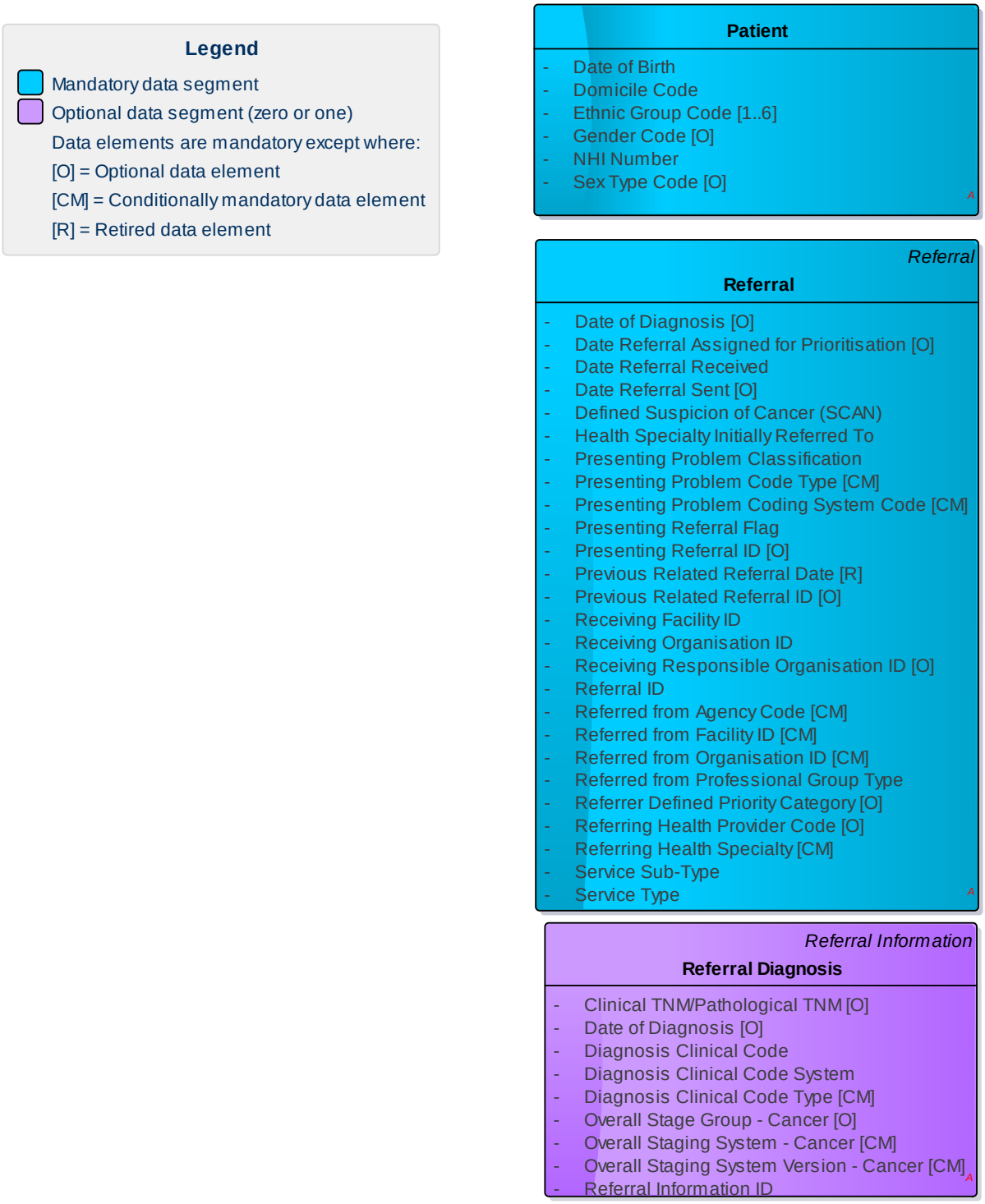
There can be multiple diagnoses at point of referral. Ideally there should be at least one Diagnosis provided with the Referral.

7.2.2 Referral Dataset

The figure on the next page shows the data elements that make up the Referral Dataset.

- A Referral must have a referral identifier that is unique within the Submitting Organisation (see 4.7 NPF Data Identifiers).
- A Referral Diagnosis can either be provided together with the Referral in the Referral Dataset or separately in the Referral Diagnosis Dataset. A Referral Diagnosis cannot be added to the Collection by an Update Referral data set and operation.

For definitions of the data elements refer to section “10 - Data Element Definitions”.


Legend
Mandatory data segment
Optional data segment (zero or one)
Data elements are mandatory except where:
[O] = Optional data element
[CM] = Conditionally mandatory data element
[R] = Retired data element
Patient
- Date of Birth
- Domicile Code
- Ethnic Group Code [1..6]
- Gender Code [O]
- NHI Number
- Sex Type Code [O]
Referral
Referral
- Date of Diagnosis [O]
- Date Referral Assigned for Prioritisation [O]
- Date Referral Received
- Date Referral Sent [O]
- Defined Suspicion of Cancer (SCAN)
- Health Specialty Initially Referred To
- Presenting Problem Classification
- Presenting Problem Code Type [CM]
- Presenting Problem Coding System Code [CM]
- Presenting Referral Flag
- Presenting Referral ID [O]
- Previous Related Referral Date [R]
- Previous Related Referral ID [O]
- Receiving Facility ID
- Receiving Organisation ID
- Receiving Responsible Organisation ID [O]
- Referral ID
- Referred from Agency Code [CM]
- Referred from Facility ID [CM]
- Referred from Organisation ID [CM]
- Referred from Professional Group Type
- Referrer Defined Priority Category [O]
- Referring Health Provider Code [O]
- Referring Health Specialty [CM]
- Service Sub-Type
- Service Type
Referral Information
Referral Diagnosis
- Clinical TNM/Pathological TNM [O]
- Date of Diagnosis [O]
- Diagnosis Clinical Code
- Diagnosis Clinical Code System
- Diagnosis Clinical Code Type [CM]
- Overall Stage Group - Cancer [O]
- Overall Staging System - Cancer [CM]
- Overall Staging System Version - Cancer [CM]
- Referral Information ID

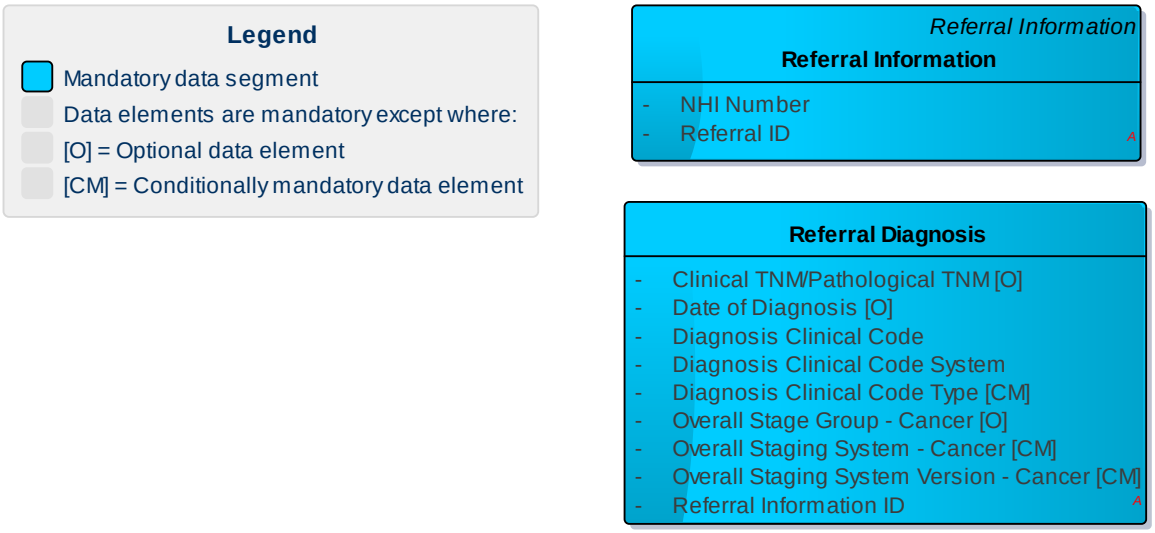
7.2.3 Referral Diagnosis Dataset

The figure below shows the data elements that make up the Referral Diagnosis Dataset.

- A Referral Diagnosis must be related to an existing Referral via the Referral identifier
- A Referral Diagnosis must have a Referral Information Identifier that is unique within the associated Referral.
- A Referral Diagnosis must be provided when there is a confirmed diagnosis of cancer at the point of referral (Defined Suspicion of Cancer is "10 - The patient has a confirmed diagnosis of cancer") and the Referred From Professional Group Type is "2 - Specialist Medical Officer (Own DHB)" or "3 - Specialist Medical Officer (Other DHB)". It can either be provided together with the Referral in the Referral Dataset or separately in the Referral Diagnosis Dataset.

  The obligation to provide this Dataset is not enforced when the file is processed. Compliance will be retrospectively measured through reporting.

For definitions of the data elements refer to section “10 - Data Element Definitions”.



7.3. Prioritisation Dataset for Add and Update

The Prioritisation Dataset contains the data elements that are to be submitted for a Prioritisation activity.

Note: If the patient is re-prioritised a new Prioritisation Dataset must be submitted (as distinct from an update to an existing Prioritisation activity).

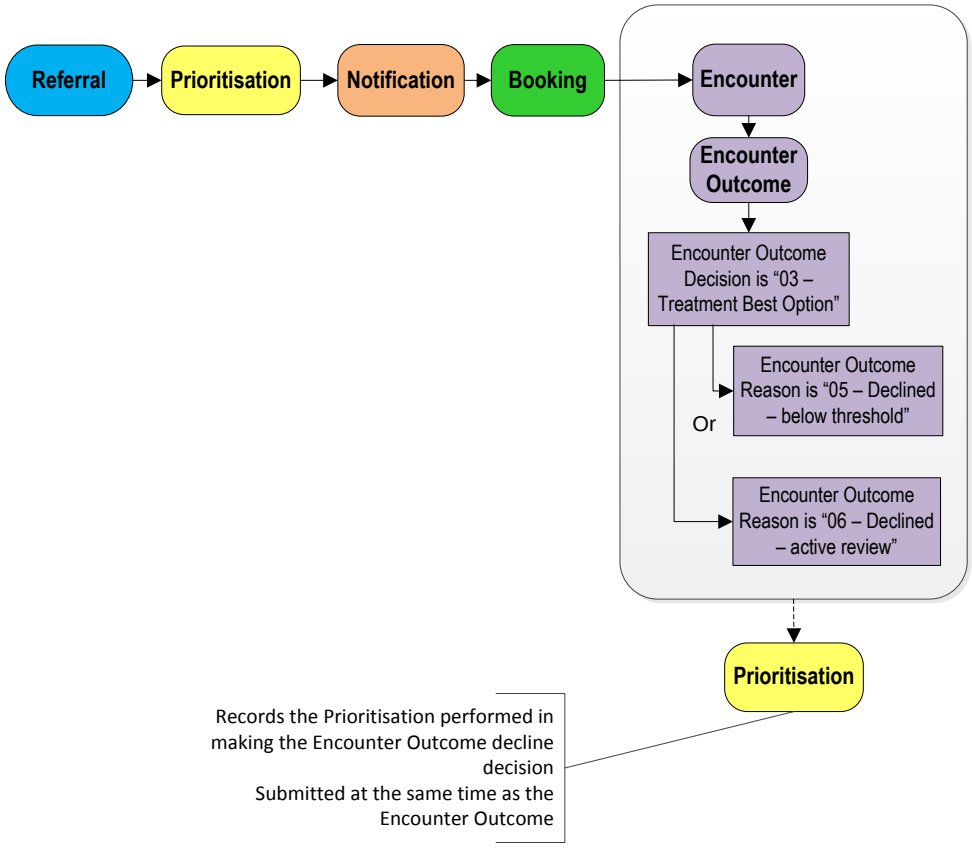
Performance reports will be dependent on receipt of this activity

The figure on the following page shows the data elements that make up the full Prioritisation Dataset.

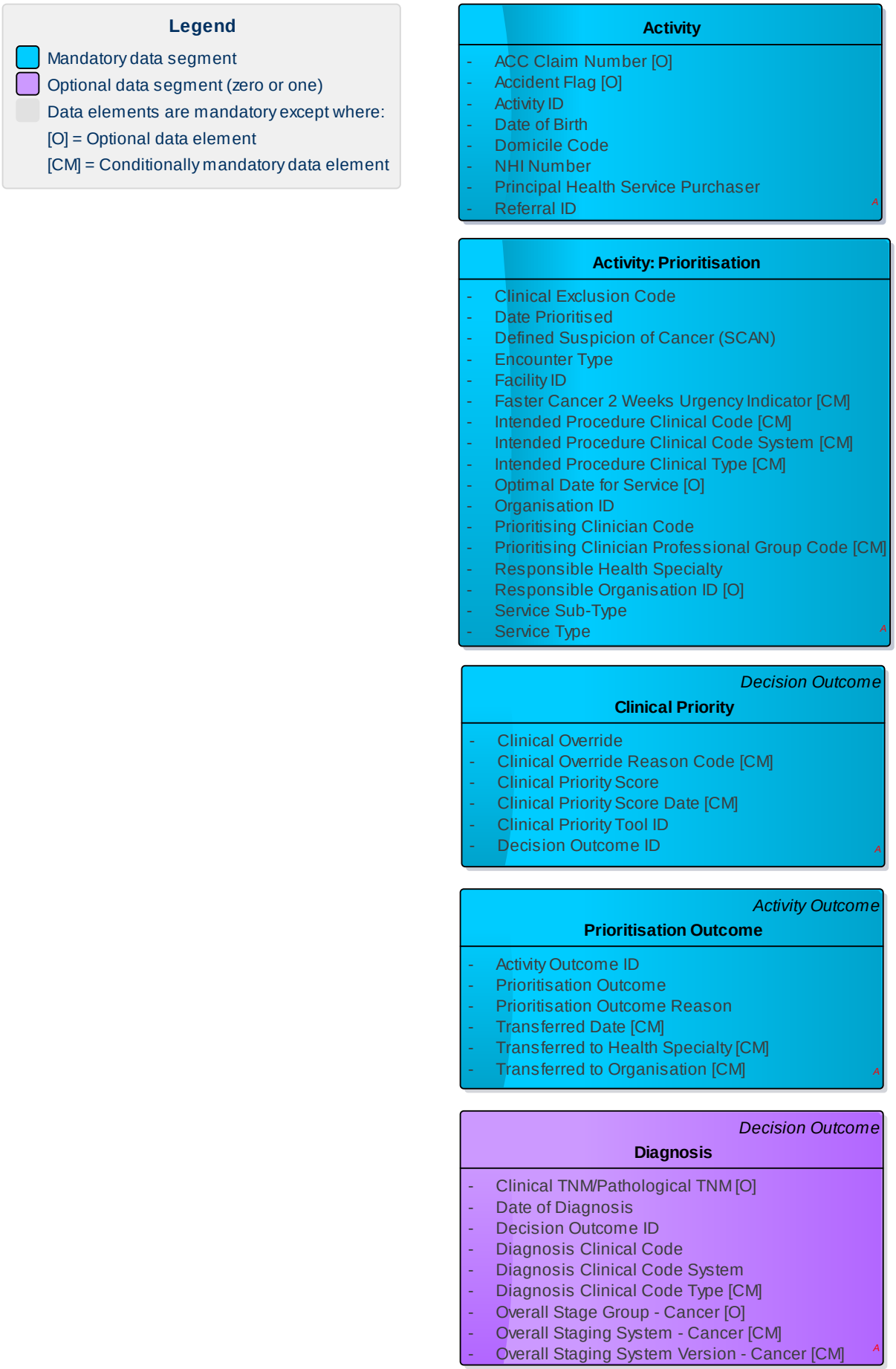
- A Prioritisation Activity must have an activity identifier that is unique within the associated Referral.
- A Prioritisation Activity must be related to an existing referral via the Referral identifier
- A Prioritisation Outcome must have an Activity Outcome Identifier that is unique within the associated Activity.
- A Clinical Priority must have a Decision Outcome Identifier that is unique within the associated Activity.
- A Diagnosis must have a Decision Outcome Identifier that is unique within the associated Activity.
- A Diagnosis can either be provided together with the Prioritisation in the Prioritisation Dataset or separately in the Diagnosis Dataset. A Diagnosis cannot be added to the Collection by an Update Prioritisation data set and operation.

Specific requirement: submission of a Prioritisation with an Encounter Outcome:

A Prioritisation must be submitted as part of the current Service Sequence when the Encounter Outcome Decision is “03 - Treatment Best Option” and the Encounter Outcome Reason is “05 – Declined – Below Threshold” or “06 – Declined – Active Review”. As a picture:



For definitions of the data elements refer to section “10 - Data Element Definitions”.

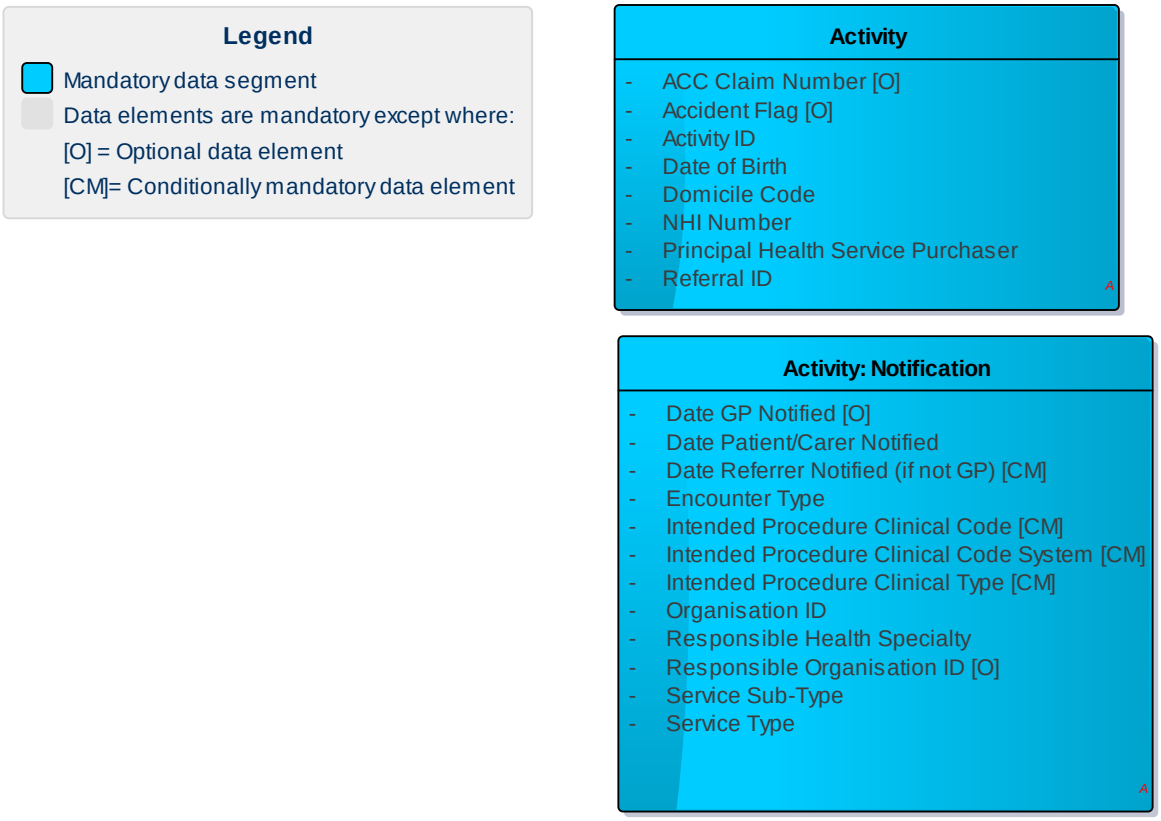

Legend
Mandatory data segment
Optional data segment (zero or one)
Data elements are mandatory except where:
[O] = Optional data element
[CM] = Conditionally mandatory data element
Activity
- ACC Claim Number [O]
- Accident Flag [O]
- Activity ID
- Date of Birth
- Domicile Code
- NHI Number
- Principal Health Service Purchaser
- Referral ID
Activity: Prioritisation
- Clinical Exclusion Code
- Date Prioritised
- Defined Suspicion of Cancer (SCAN)
- Encounter Type
- Facility ID
- Faster Cancer 2 Weeks Urgency Indicator [CM]
- Intended Procedure Clinical Code [CM]
- Intended Procedure Clinical Code System [CM]
- Intended Procedure Clinical Type [CM]
- Optimal Date for Service [O]
- Organisation ID
- Prioritising Clinician Code
- Prioritising Clinician Professional Group Code [CM]
- Responsible Health Specialty
- Responsible Organisation ID [O]
- Service Sub-Type
- Service Type
Decision Outcome
Clinical Priority
- Clinical Override
- Clinical Override Reason Code [CM]
- Clinical Priority Score
- Clinical Priority Score Date [CM]
- Clinical Priority Tool ID
- Decision Outcome ID
Activity Outcome
Prioritisation Outcome
- Activity Outcome ID
- Prioritisation Outcome
- Prioritisation Outcome Reason
- Transferred Date [CM]
- Transferred to Health Specialty [CM]
- Transferred to Organisation [CM]
Decision Outcome
Diagnosis
- Clinical TNM/Pathological TNM [O]
- Date of Diagnosis
- Decision Outcome ID
- Diagnosis Clinical Code
- Diagnosis Clinical Code System
- Diagnosis Clinical Code Type [CM]
- Overall Stage Group - Cancer [O]
- Overall Staging System - Cancer [CM]
- Overall Staging System Version - Cancer [CM]

7.4. Notification Dataset for Add and Update

The figure below shows the data elements that make up the Notification Dataset.

- A Notification Activity must have an Activity Identifier that is unique within the associated Referral.
- A Notification Activity must be related to an existing referral via the Referral Identifier.

For definitions of the data elements refer to section “10 - Data Element Definitions”.

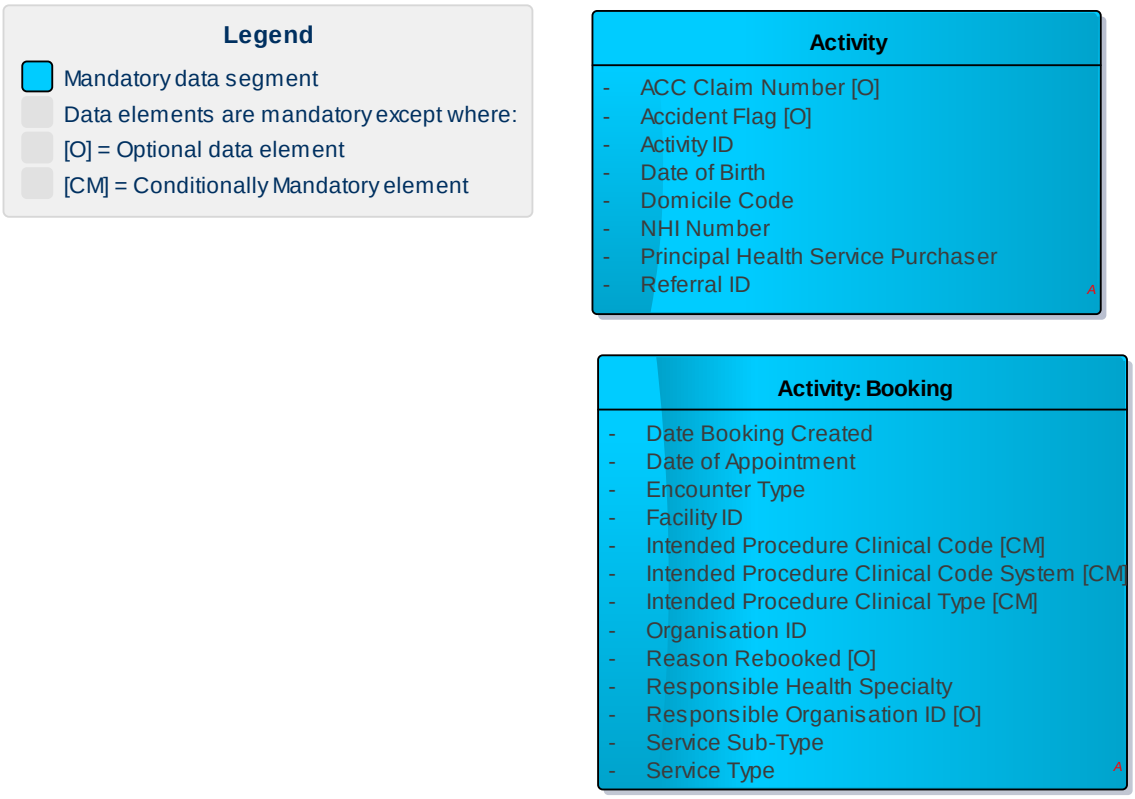


7.5. Booking Dataset for Add and Update

The figure below shows the data elements that make up the Booking Dataset.

- A Booking Activity must have an Activity Identifier that is unique within the associated Referral.
- A Booking Activity must be related to an existing referral via the Referral Identifier.

For definitions of the data elements refer to section “10 - Data Element Definitions”.



7.6. Encounter Datasets for Add and Update

7.6.1 Overview

The Encounter Datasets separate the Encounter Activity from the Encounter Outcomes to allow for situations where multiple Services are delivered within the boundaries of a single Referral and single Encounter. For example:

- Where a patient has an FSA and a procedure such as a skin lesion removal or colonoscopy at the same Encounter.

The rules for Encounters are as follows:

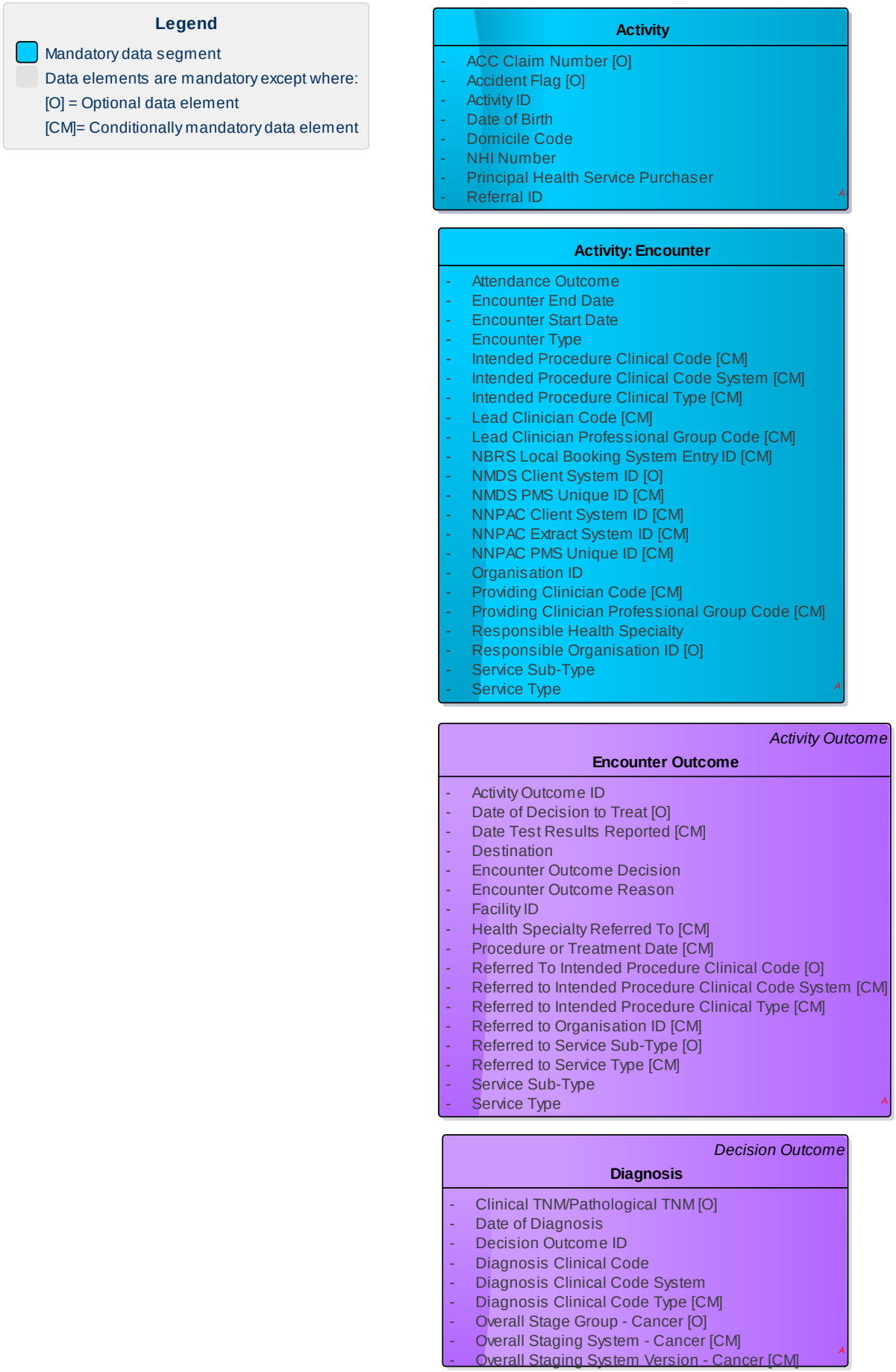
1. The type of Encounter will be one of :
    - **a.** Inpatient
    - **b.** Day Patient
    - **c.** Outpatient – Remote
    - **d.** Outpatient – Patient Present.
2. Multiple Encounter Outcomes can only be provided when the same Organisation and Responsible Organisation and Providing Clinician/Lead Clinician deliver the services described for a single Referral. Note that the facility where the service is being carried out may differ – primarily to cater for the investigation/test situation.
3. The Providing Clinician and Lead Clinician apply to both the Encounter and the Encounter Outcome

7.6.2 Encounter Dataset

The figure on the following page shows the data elements that make up the Encounter Dataset.

- An Encounter Activity must be related to an existing Referral via the Referral Identifier.
- An Encounter Activity must have an Activity Identifier that is unique within the associated Referral
- A Diagnosis or an Encounter Outcome can either be provided together with the Encounter in the Encounter Dataset or separately in the Diagnosis or Encounter Outcome Dataset. A Diagnosis or Encounter Outcome cannot be added to the Collection by an Update Encounter data set and operation.
- An Encounter Outcome, while it is optional to be provided at the same time as the Encounter, must be provided in order to ensure accurate performance reports.
- An Encounter Outcome (when it is provided) must have an Activity Outcome Identifier that is unique within the associated Activity.
- A Diagnosis (when it is provided) must have a Decision Outcome Identifier that is unique within the associated Activity. A Diagnosis must be provided when there is a confirmed diagnosis of cancer.

For definitions of the data elements refer to section “10 - Data Element Definitions”.

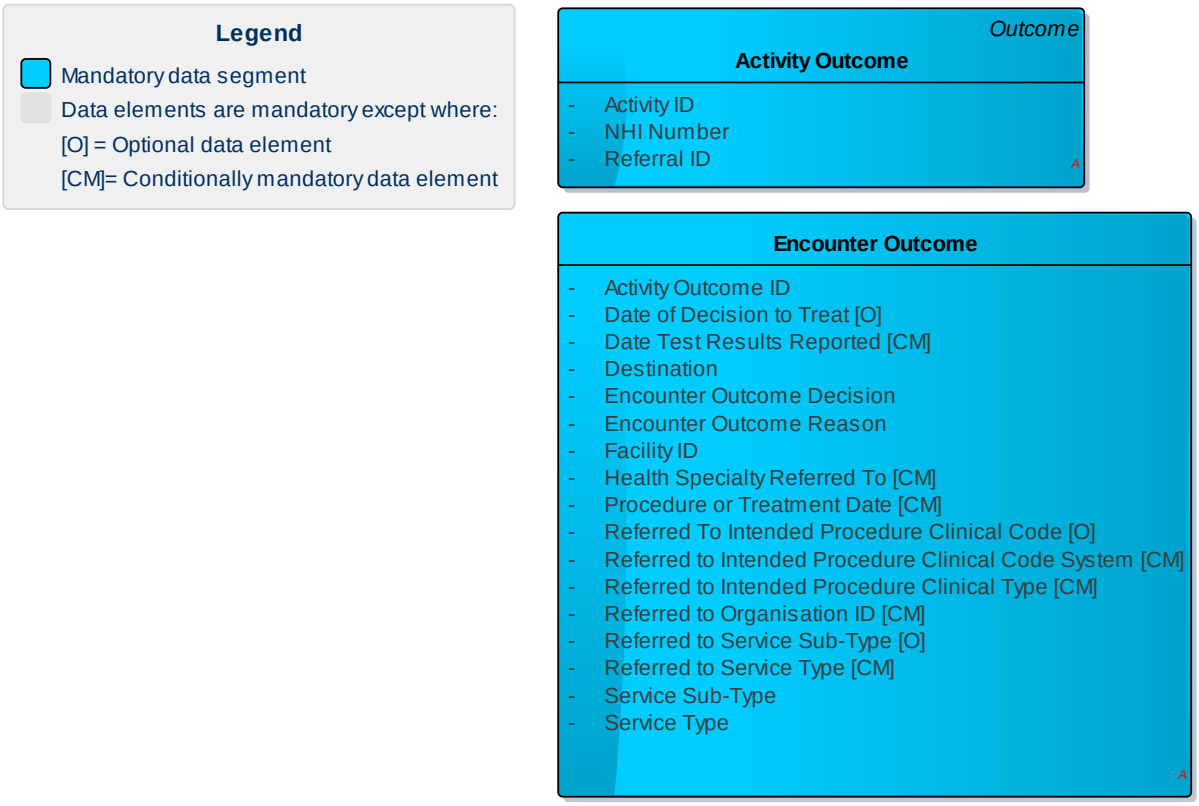

Legend
Mandatory data segment
Data elements are mandatory except where:
[O] = Optional data element
[CM]= Conditionally mandatory data element
Activity
- ACC Claim Number [O]
- Accident Flag [O]
- Activity ID
- Date of Birth
- Domicile Code
- NHI Number
- Principal Health Service Purchaser
- Referral ID
Activity: Encounter
- Attendance Outcome
- Encounter End Date
- Encounter Start Date
- Encounter Type
- Intended Procedure Clinical Code [CM]
- Intended Procedure Clinical Code System [CM]
- Intended Procedure Clinical Type [CM]
- Lead Clinician Code [CM]
- Lead Clinician Professional Group Code [CM]
- NBRS Local Booking System Entry ID [CM]
- NMDS Client System ID [O]
- NMDS PMS Unique ID [CM]
- NNPAC Client System ID [CM]
- NNPAC Extract System ID [CM]
- NNPAC PMS Unique ID [CM]
- Organisation ID
- Providing Clinician Code [CM]
- Providing Clinician Professional Group Code [CM]
- Responsible Health Specialty
- Responsible Organisation ID [O]
- Service Sub-Type
- Service Type
Activity Outcome
Encounter Outcome
- Activity Outcome ID
- Date of Decision to Treat [O]
- Date Test Results Reported [CM]
- Destination
- Encounter Outcome Decision
- Encounter Outcome Reason
- Facility ID
- Health Specialty Referred To [CM]
- Procedure or Treatment Date [CM]
- Referred To Intended Procedure Clinical Code [O]
- Referred to Intended Procedure Clinical Code System [CM]
- Referred to Intended Procedure Clinical Type [CM]
- Referred to Organisation ID [CM]
- Referred to Service Sub-Type [O]
- Referred to Service Type [CM]
- Service Sub-Type
- Service Type
Decision Outcome
Diagnosis
- Clinical TNM/Pathological TNM [O]
- Date of Diagnosis
- Decision Outcome ID
- Diagnosis Clinical Code
- Diagnosis Clinical Code System
- Diagnosis Clinical Code Type [CM]
- Overall Stage Group - Cancer [O]
- Overall Staging System - Cancer [CM]
- Overall Staging System Version - Cancer [CM]

7.6.3 Encounter Outcome Dataset

The figure below shows the data elements that make up the Encounter Activity Outcome Dataset.

- An Encounter Outcome must have an Activity Outcome Identifier that is unique within the associated Activity.
- An Encounter Outcome must be related to an existing Encounter via the Activity Identifier and an existing Referral via the Referral Identifier
- Submitting Organisations may send more than one Encounter Outcome Dataset. At least one of the Encounter Outcomes submitted must be for the prioritised service and should include one Reason and one Destination. If more than one Outcome is being provided, then the Service Type needs to be included with all additional encounter outcome sets of data.

For definitions of the data elements refer to section “10 - Data Element Definitions”.



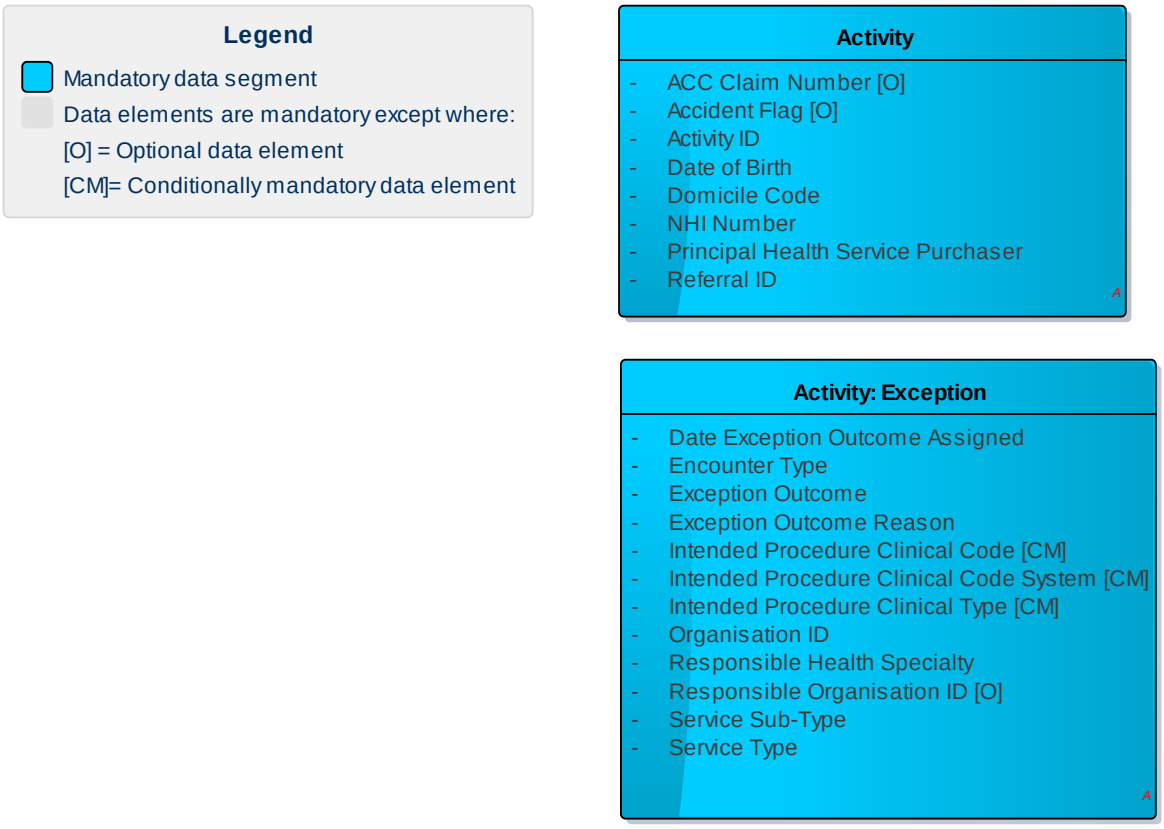
7.7. Exception Dataset for Add and Update

The figure below shows the data elements that make up the Exception Dataset.

Note that there is no separate Activity Outcome dataset for the Exception Activity.

- An Exception Activity must have an Activity Identifier that is unique within the associated Referral.
- An Exception Activity must be related to an existing Referral via the Referral Identifier

For definitions of the data elements refer to section “10 - Data Element Definitions”.

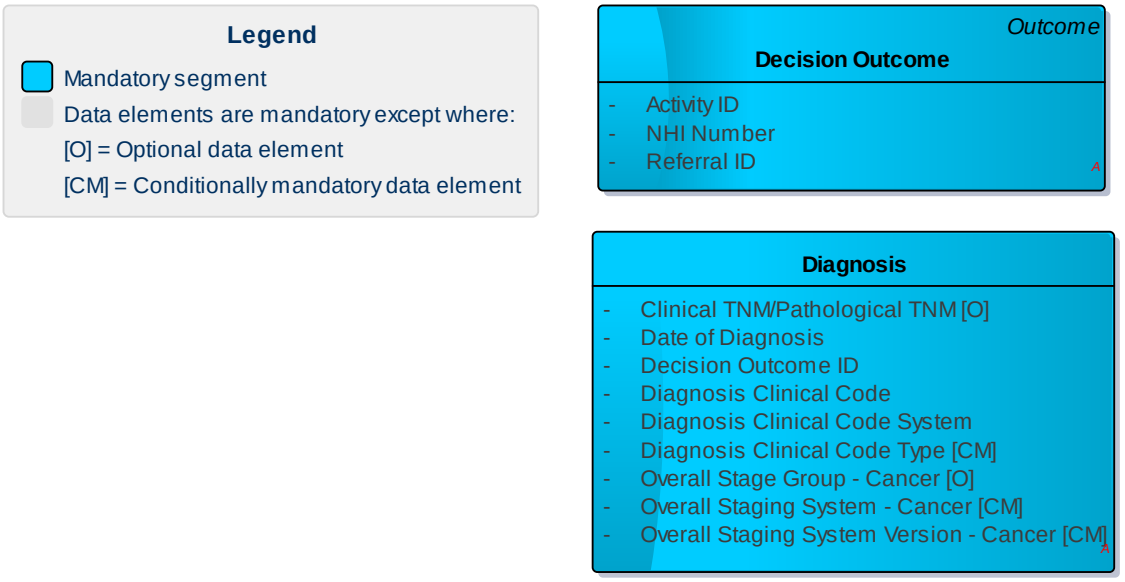


7.8. Diagnosis Dataset for Add and Update

The figure below shows the data elements that make up the Diagnosis Dataset.

- A Diagnosis must have a Decision Outcome Identifier that is unique within the Activity it is associated with.
- A Diagnosis must be related to an existing activity via the Activity Identifier and an existing Referral via the Referral Identifier.
- A Diagnosis must be provided when there is a confirmed diagnosis of cancer at the point of Referral. The obligation to provide this Dataset is not enforced at submission. Compliance will be retrospectively measured through reporting.

For definitions of the data elements refer to section “10 - Data Element Definitions”.



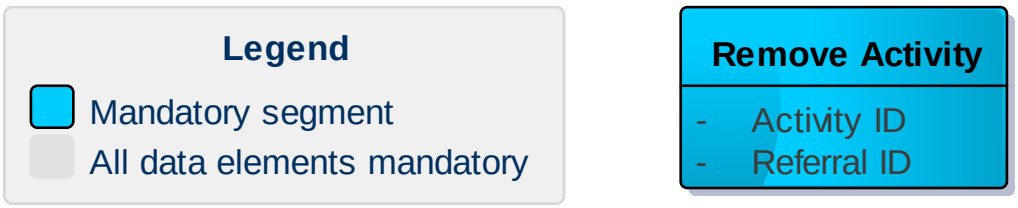
7.9. Remove Datasets

Remove datasets are used to remove records from the Collection.

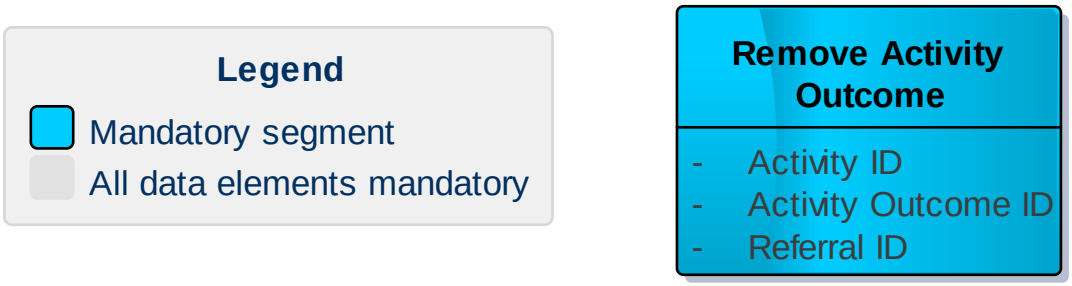
The figures below show the data elements that make up the Remove datasets

For definitions of the data elements refer to section “10 - Data Element Definitions”.

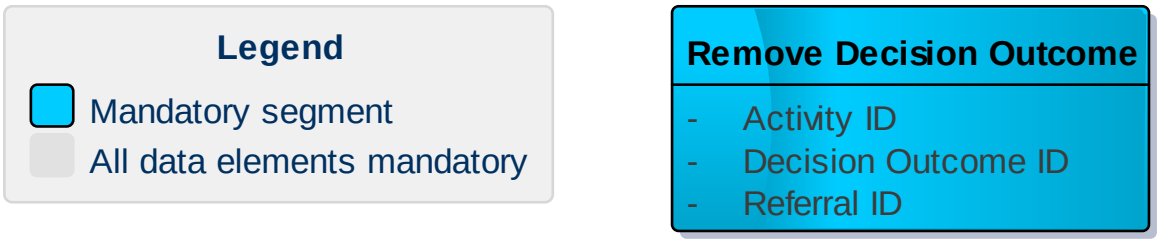
7.9.1 Remove Activity



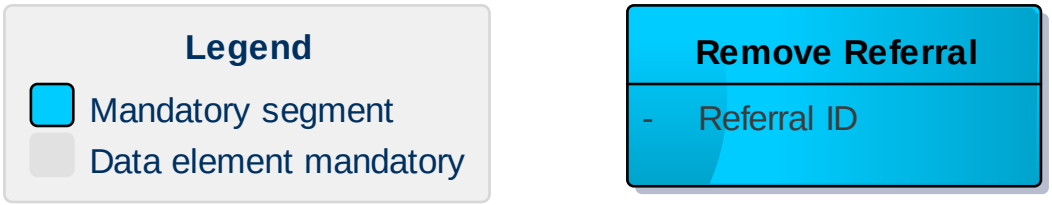
7.9.2 Remove Activity Outcome Dataset



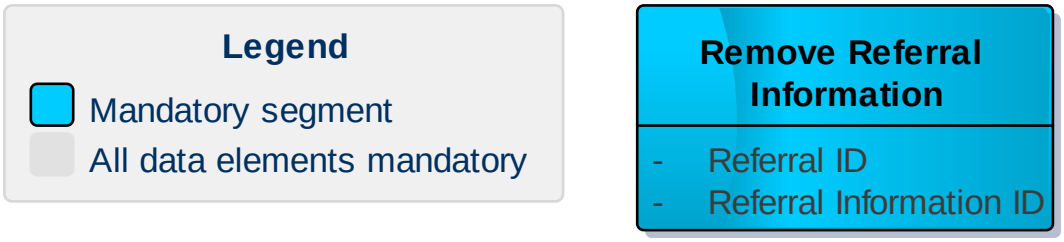
7.9.3 Remove Decision Outcome Dataset



7.9.4 NPF Remove Referral Dataset



7.9.5 NPF Remove Referral Information Dataset



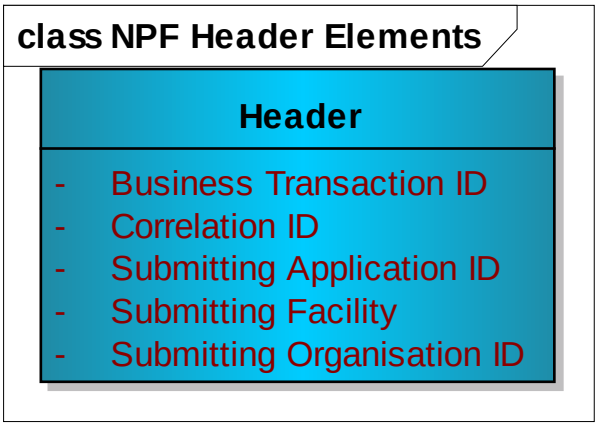
7.10. What is in a Summary File?

A Summary File contains a Header Dataset and a Batch Summary Dataset.

7.10.1 Header

The figure below shows the data elements that make up the Header Dataset.

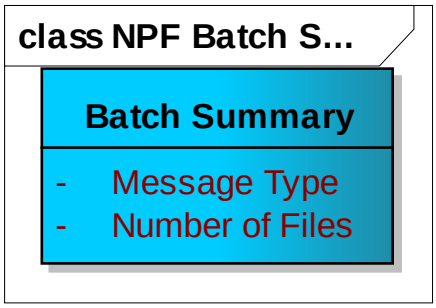
For definitions of the data elements refer to section “11 - Data Element Definitions”.



7.10.2 Batch Summary Dataset

The figure below shows the data elements that make up the Batch SummaryDataset.

For definitions of the data elements refer to section “11 - Data Element Definitions”.



8. What is in the Output files?

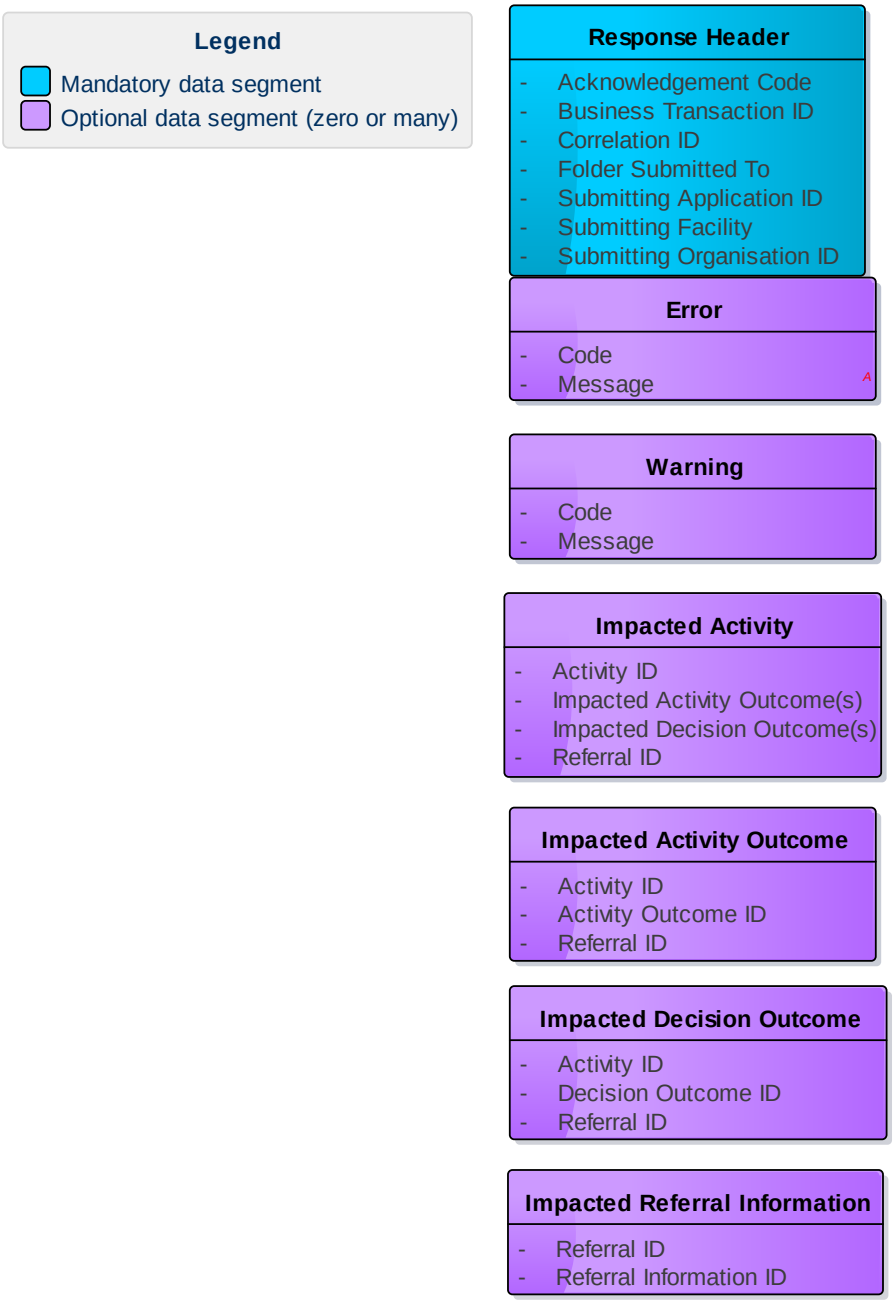
This section specifies the contents of the Output files.

8.1. Overview

1. A batch pre-processing report and Summary Response File are produced if the batch was rejected
2. A batch processing report, a Summary Response File and one or more Data Response Files are produced if the batch was processed
3. A batch reversal report , a Summary Response File and one or more Data Response Files are produced if a batch was successfully reversed

8.2. Summary/Data Response File

The same file format will be used for response files sent at Pre-processing, Processing and Reversal. The figure below shows the data elements that make up the file.



8.3. Pre-processing Report

The Batch Pre-processing Report contains:

- Details of the batch that was rejected.
- The errors that caused the batch to be rejected.

Refer to “15.1 - Batch Pre-processing Report” for a sample of the Batch Pre-processing Report.

8.4. Processing Report

The Batch Processing Report contains:

- The identifiers of the records that failed validation or were accepted with warnings. Also included is the associated error/warning message for each error/warning stating the reason for failure
- The dependent records that had to be removed because of remove operations in the Batch
- Summary totals by error/warning code.

Refer to “15.2 - Batch Processing Report” for a sample of the Batch Processing Report.

8.5. Reversal Report

The Batch Reversal Report contains:

- Batch identification information
- A summary of the number of files in the batch and the number of files reversed
- The files reversed and the IDs from the Collection Records affected by the reversal
- A list of the child records restored for any removes that are reversed, where applicable.

Refer to “15.3 - Batch Reversal Report” for a sample of the Batch Reversal Report.

9. Input Record Operations

This section will describe the type of operations that can be requested in input files and how errors will be managed.

9.1. Operation Types

The operation types for a dataset record are:

- Add
- Update
- Remove.

9.2. Operation Rules and Validation

9.2.1 Add

The Add operation allows a new Referral, Referral Diagnosis, Activity or Activity/Decision Outcome Dataset to be submitted for inclusion in the Collection.

During the Add process the system does the following checks:

	Check	Notes	Error ID
1	Is there a Collection record with the same ID in the database?	ID's checked are as follows: Referral: Referral ID (unique to Submitting Organisation) Activity: Activity ID (unique to Referral) Activity/Decision Outcome ID (unique to Activity) Referral Information ID (unique to Referral)	NPF00003
2	For an Activity is there a Referral to link the Activity to?	A Collection Referral record must be present	NPF00003
3	For an Activity/Decision Outcome is there an Activity to link the Activity/Decision Outcome to?	A Collection Activity record must be present	NPF00003
4	For a Referral Diagnosis is there a Referral to link to?	A Collection Referral record must be present	NPF00003
5	The NHI on all datasets for the same referral must be for the same patient	For Add Referral NPF will validate the NHI number against the NHI system. For subsequent Activities and Activity/Decision Outcomes the NHI number on the input record must be for the same patient as the NHI number recorded against the Referral	NPF00425
6	A single Submitting Organisation must submit all datasets that are associated with the same Service Sequence (i.e. All Activities and related Outcomes that are associated with a specific Referral)	There may be many Service Sequences across a Patient Journey, and each one may take place at different Submitting Organisations and therefore be submitted by different Submitting Organisations. However, datasets associated with each individual Service Sequence must be submitted by the same Submitting Organisation.	NPF00407, NPF00408, NPF00409

Validation business rules for Add

Refer to the *What is a valid Add Operation?* and *Has the patient's identity been verified?* groups of rules in the attached Business Rules Catalogue (17 - Appendix D: Business Rules and Error Messages).

9.2.2 Update

The Update operation allows an existing Referral, or Activity Collection record to be updated. In some cases, an Activity/Decision Outcome, which is part of an Activity record, can be updated.

When a record or a part of it is updated, the organisation must send the full relevant dataset with the new information. If optional data elements are left blank they will be treated as null.

All data contained within the record related to the submitted dataset is updated with the new data supplied.

The same integrity and validation rules as applied to an Add operation will be applied to datasets that accompany an Update operation.

During the update process the system does the following checks:

	Check	Notes	Error ID
1	Only the organisation that sent the dataset (Submitting Organisation) can update it.	Datasets associated with each individual Service Sequence must be submitted by the same Submitting Organisation.	NPF00414
2	The Record to be updated exists in the Collection.	The ID's are checked to ascertain the Record's presence as follows: Referral: Referral ID (unique to Submitting Organisation) Activity: Activity ID (unique to Referral) Activity/Decision Outcome ID (unique to Activity) Referral Information ID (Unique to Referral)	NPF00410, NPF00411, NPF00412, NPF00413
3	The ID's must not be updated	The ID's that must remain the same are as follows: Referral: Referral ID (unique to organisation) Activity: Activity ID (unique to Referral) Activity/Decision Outcome ID (unique to Activity) Referral Information ID (Unique to Referral)	NPF00416

Validation business rules for Update

Refer to the *What is a valid Update Operation?* group of rules in the attached Business Rules Catalogue (17 - Appendix D: Business Rules and Error Messages) .

9.2.3 Remove

The Remove operation makes a collection record a historical record. A collection record will no longer exist in the NPF collection if it is the subject of a remove operation.

The Remove operation may require other collection records and parts of collection records to be removed so that the NPF collection is in accordance with the business rules. The impact of the business rules is described in the following diagram.

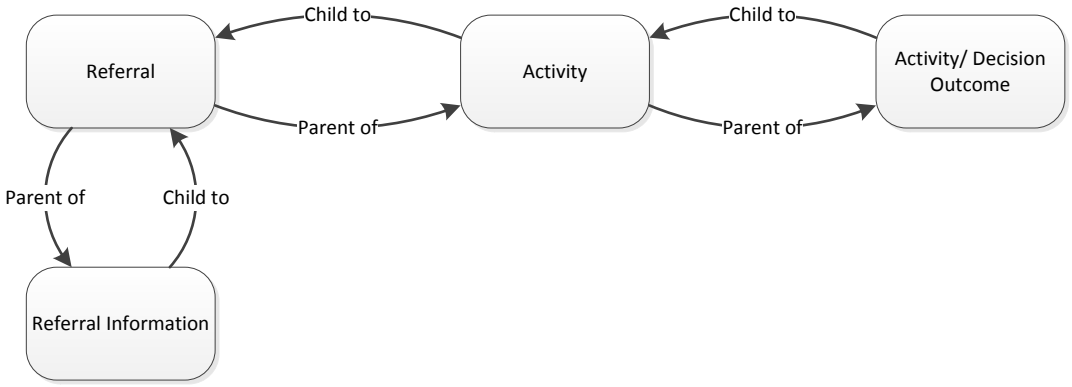


Figure 18: Remove impact on child records

When a Parent record is removed all Child records will also be removed, recursively.

For a dataset to be removed, the system confirms that it already exists in the NPF collection.

A removed or reversed Referral, Referral Information, Activity or Activity/Outcome Decision ID can be re-used.

During the Remove process the system does the following checks:

	Check	Notes	Error ID
1	Only the organisation that sent the dataset (Submitting Organisation) can remove it.	The Submitting Organisation is considered the source of truth for the data within a referral; therefore any changes to the data must come from the source of truth.	NPF00414
2	The dataset exists in the Collection.	The ID's checked to ascertain presence are as follows: Referral: Referral ID (unique to organisation) Activity: Activity ID (unique to Referral) Activity/Decision Outcome ID (unique to Activity) Referral Information ID (unique to Referral)	NPF00410, NPF00411, NPF00412, NPF00413
3	All Child records must be removed	To preserve the integrity of the Collection orphaned records may not exist.	No Error condition exists

Validation business rules for Remove

Refer to the *what is a valid Remove Operation?* group of rules in the attached Business Rules Catalogue (17 - Appendix D: Business Rules and Error Messages).

10. Data Element Definitions

This section contains the definitions of the data elements for each data segment (entity).

For code sets related to elements that contain coded values refer to “12 – Collection Code Sets”.

10.1. Element Format Notation

The format notation used in this document for elements is as follows:

Notation	Meaning
A	Alphabetic character
N	Numeric character
C	Check digit – calculated using modulus 11 algorithm Used in identifiers supplied by Ministry of Health e.g. NHI number
X	alphabetic, numeric or special characters For NPF ID elements the only permissible special character is‘-‘ (dash)
DD	Day of date
MM	Month of date
YYYY	Year of date
Hh	Hours
Mm	Minutes
Ss	Seconds
(..)	Repeats to a maximum field length e.g. A(3) means A, AA or AAA may be submitted

10.2. Element Types

10.2.1 Dates

- The Datetime data type is used to specify a date and a time
- Any date format that conforms with xs:dateTime will be accepted, except Batch Creation Date which must be in New Zealand Local Time
- All output for response files including error messages will be returned to Submitting Organisations in New Zealand Local Time
- As further reports are developed from NPF data the time formats provided in these reports will be specified. For Time, only hours, minutes and seconds should be submitted. Time information smaller than seconds should not be included.

10.2.2 Integers

- Specified as ‘Integer’
- These are integer numbers
- There must be no decimal points or commas included
- All integer values must be positive.

10.2.3 Decimals

- Specified as ‘Decimal’
- Decimal values must be expressed with a decimal point between the whole number and the fraction.

10.2.4 Alphabetic/Alphanumeric

- Specified as ‘Alphabetic’ or ‘Alphanumeric’
- Must contain ASCII characters only.

10.2.5 Y/N flags or binary indicators

- Specified as ‘Integer’
- Must contain ‘1’ (true) or ‘0’ (false).

10.3. Defining attributes

Name	A single or multi-word designation assigned to a data element. This appears in the heading for each data element definition.
Definition	A statement that expresses the essential nature of a data element and its differentiation from all other data elements.
Other names (optional)	Other names or previous names for the data element.
Data type	The type of field in which a data element is held. For example, alphabetic, integer, or numeric.
Layout	The representational layout of characters in data element values expressed by a character string representation. For example: - ‘N’ for a one-digit numeric field - ‘A’ for a one-character field - ‘X’ for a field that can hold either a character or a digit. Refer to Element Format Notation above.
Obligation	Stipulates whether an element is mandatory or optional.
Data domain	The permissible values for the data element. The set of values can be listed or specified by referring to a code table or code tables, for example, ICD-10-AM 2nd Edition.
Guide for use (optional)	Additional comments or advice on the interpretation or application of the data element. Includes historical information and advice regarding data quality.
MOH Internal ODS Column Name	Ministry of Health internal use only. Specifies the element’s column name in the NPF ODS database.

10.4. Activity

An Activity is an action or service that is provided as part of the patient's journey. Activities are component parts of a Service Sequence.

The data elements for Activity are common to all Activities - Prioritisation, Notification, Booking, Encounter and Exception.

Validation

For Activity integrity checking rules refer to the groups of rules *Generic Rules* and *What is a valid activity?* in the Business Rules Catalogue (17 - Appendix D: Business Rules and Error Messages).

MOH Internal ODS Table Name

ACTIVITY_HEADER

10.4.1 ACC Claim Number [O]

Definition	The Claim Number assigned by ACC for the accident relating to the referral
Data Type	Alphanumeric
Layout	X(12)
Data Domain	
Obligation	Optional
Guide for Use	Required to enable exclusion of ACC activity from certain reporting. Also required so that NPF data can be matched with ACC data.
Source	ACC
MOH Internal ODS Column Name	ACTIVITY_DETAIL_ACC_CLAIM

10.4.2 Accident Flag [O]

Definition	A code indicating whether the reason for referral is accident related.
Data Type	Integer
Layout	N
Data Domain	0 - No 1 – Yes

Obligation	Optional
Guide for Use	Should be provided when ACC claim number is supplied or when ACC is listed as the Principal Health Service Purchaser.
MOH Internal ODS Column Name	ACTIVITY_DETAIL_ACCIDENT_FLAG

10.4.3 Activity ID

Definition	An identifier that is unique within the Referral that the health care activity is associated with.
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -
Obligation	Mandatory
Guide for Use	
Other Names	Identifier (NPF Phase 1)
MOH Internal ODS Column Name	ACTIVITY_ID in ACTIVITY table

10.4.4 Date of Birth

Definition	The date of birth of the patient
Data Type	Alphanumeric
Layout	YYYY-MM-DD
Data Domain	
Obligation	Mandatory - collected at Referral and all Activities
Guide for Use	Used to derive the age of the patient. The age of the patient is used to help determine if health services are being provided in an equitable manner.
Standard	HISO 10046
MOH Internal ODS Column Name	ACTIVITY_DETAIL_DOB

10.4.5 Domicile Code

Definition	A unique code defining a geographic area that is used for statistical reporting and health funding payments. It is directly aligned with the census area unit.
Data Type	Alphanumeric
Layout	NNNN
Data Domain	Code Set Name: DOMCODE Refer to the Domicile Code table under Common Codes for National Collections on the Ministry's website: http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/domicile-code-table
Obligation	Mandatory
Guide for Use	The domicile code of the address where the patient is resident at the time of the activity. Used to help determine if health services are being provided in an equitable manner.
MOH Internal ODS Column Name	ACTIVITY_DETAIL_DOMCODE

10.4.6 NHI Number

Definition	A unique 7-character identification number, assigned to a patient by the Patient Index (National Health Index).
Data Type	Alphanumeric
Layout	AAANNNC
Obligation	Mandatory
Guide for Use	The NHI number of the patient associated with the activity
Standard	HISO 10046 NHI Number
MOH Internal ODS Column Name	ACTIVITY_DETAIL_NHI

10.4.7 Principal Health Service Purchaser

Definition	The organisation or body that purchased the healthcare service provided. In the case of more than one purchaser, the one who paid the most
Data Type	Alphanumeric
Layout	XX

Data Domain	Code Set Name: SVCPURCH For the full list of Principal Health Service Purchaser codes refer to the Common Codes for National Collections on the Ministry's website: http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/principal-health-service-purchaser-code-table
Obligation	Mandatory
Guide for Use	Codes expected to be used in the Collection: 20 - Overseas eligible - Used if the patient is resident in a country where there is an agreement for access to publicly funded non-emergency services, e.g. Tokelau. 33 - Ministry of Health Screening Pilot - Should only be used for colonoscopy referrals that have been initiated following a Bowel Screening Pilot positive test. 34 - Ministry of Health-funded purchase - Used for services directly purchased by the Ministry of Health, e.g. Mobile Surgical Services. 35 - DHB-funded purchase - Used for most DHB provider arm hospital activity. A0 – ACC – direct purchase. If a referral is prioritised but ACC is not confirmed, it should be entered as "35 – DHB-funded purchase" initially. The Principal Health Service Purchaser may be updated later to "A0". Referrals with other Principal Health Service Purchasers may also be submitted to NPF but are not mandated.
MOH Internal ODS Column Name	ACTIVITY_DETAIL_SVCPURCH

10.4.8 Referral ID

Definition	The identifier of the Referral that the Activity is directly associated with.
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -.
Obligation	Mandatory
Guide for Use	Used to link activities together within a Service Sequence
Other Names	Local Referral Identifier (Phase 1), Referral ID
MOH Internal ODS Column Name	The association to the Referral entity (REFERRAL) is via foreign key REFERRAL_KEY in ACTIVITY

10.5. Activity Outcome

An Activity Outcome is a class (generalisation) of Outcome for a Referral.

Validation

For Activity Outcome integrity checking rules refer to the groups of rules *Generic Rules* and *What is a valid Activity/Decision outcome?* in the Business Rules Catalogue (17 - Appendix D: Business Rules and Error Messages).

MOH Internal MOH Internal ODS Table Name

ACTIVITY_OUTCOME

10.5.1 Activity ID

Definition	The identifier of the Activity that the Activity Outcome is associated with.
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -.
Obligation	Mandatory
MOH Internal ODS Column Name	The association to the Activity entity (ACTIVITY) is via foreign key ACTIVITY-KEY

10.5.2 NHI Number

Definition	A unique 7-character identification number, assigned to a patient by the Patient Index (National Health Index).
Data Type	Alphanumeric
Layout	AAANNNC
Obligation	Mandatory
Guide for Use	The NHI number of the patient that is associated with the Activity Outcome
Standard	HISO 10046 NHI Number
MOH Internal ODS Column Name	PRIO_COLLECTION_NHI in PRIORITISATION_OUTCOME table or ENC_COLLECTION_NHI in ENCOUNTER_OUTCOME table

10.5.3 Referral ID

Definition	The identifier of the Referral that the Activity is directly associated with.
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -
Obligation	Mandatory
Guide for Use	Used to link activities together within a Service Sequence.
MOH Internal ODS Column Name	Association with referral is via Activity (ACTIVITY_KEY)

10.6. Activity: Booking

Booking is an Activity scheduling the patient for an Encounter.

Validation

For Booking integrity checking rules refer to the groups of rules *Generic Rules* and *What is a valid booking?* in the Business Rules Catalogue (17 - Appendix D: Business Rules and Error Messages).

MOH Internal MOH Internal ODS Table Name

ACT_BKG_DETAIL

10.6.1 Date Booking Created

Definition	The date that the health care provider organisation sent or provided the patient with firm advice about the date on which their Encounter would occur.
Data Type	Datetime
Layout	YYYY-MM-DDThh:mm:ss
Obligation	Mandatory
Guide for Use	Where this is a system generated date recording when the Booking is entered into the system it should be updated or corrected if the system date does not meet the definition above. The Date Booking Created must not be later than the date file processed.

MOH Internal ODS Column Name	BKG_DETAIL_DT_BKG_CREATED

10.6.2 Date of Appointment

Definition	The scheduled date for the patient's Encounter.
Data Type	Datetime
Layout	YYYY-MM-DDThh:mm:ss
Obligation	Mandatory
Guide For Use	The Date of Appointment should be the same as or after the Date Booking Created. It may be possible for a booking to be recorded retrospectively.
MOH Internal ODS Column Name	BKG_DETAIL_DT_APPOINTMENT

10.6.3 Encounter Type

Definition	A code representing the patient's type of encounter.
Data Type	Numeric
Layout	N
Data Domain	Code Set Name: ENCTYP
Obligation	Mandatory
Guide For Use	The Encounter Type in the Booking is the Encounter Type intended at the time of the Booking. It may differ from the Encounter Type in the Prioritisation or Encounter Activities. Used in conjunction with the Service Type data element to determine if specific data elements are conditionally mandatory or optional for a booking activity.
MOH Internal ODS Column Name	BKG_DETAIL_ENCOUNTER_TYPE_CODE

10.6.4 Facility ID

Definition	The HPI identifier of the Facility where the Encounter is booked to occur.
Data Type	Alphanumeric
Layout	FXXNNN-C
Data Domain	Code Set Name: FAC

Obligation	Mandatory
MOH Internal ODS Column Name	BKG_DETAIL_FACILITY_CODE

10.6.5 Intended Procedure Clinical Code [CM]

Definition	A clinical code identifying the intended procedure the patient is being booked for
Data Type	Alphanumeric
Layout	X(30)
Data Domain	A valid ICD10 code
Obligation	Conditionally mandatory if intended Encounter Type is Inpatient or Day patient and Service Type is Procedure/Treatment or Investigation/Test
Guide For Use	ICD-10-AM code for an intended procedure from the current ICD-10-AM version
MOH Internal ODS Column Name	BKG_DETAIL_IPROC_CLINICAL_CODE

10.6.6 Intended Procedure Clinical Code System [CM]

Definition	A code identifying the clinical coding system of the Intended Procedure Clinical Code.
Data Type	Numeric
Layout	NN
Data Domain	An ICD-10-AM system from CLINCODSYS
Obligation	Conditionally mandatory. Required if an Intended Procedure Clinical Code has been provided
Guide For Use	May be provided for all Encounter Types but must be an ICD-10-AM system
MOH Internal ODS Column Name	BKG_DETAIL_IPROC_CLINICAL_CODE_SYS

10.6.7 Organisation ID

Definition	The HPI Identifier of the organisation that provides the service to the patient.
Data Type	Alphanumeric
Layout	GNNNNN-C

Data Domain	Code Set Name: ORG
Obligation	Mandatory
MOH Internal ODS Column Name	BKG_DETAIL_ORG_CODE

10.6.8 Reason Rebooked [O]

Definition	The reason the Booking was rescheduled
Data Type	Numeric
Layout	NN
Data Domain	Code Set Name: REBOOK
Obligation	Optional
Guide For Use	If this is the first booking made, or an update to the first booking then this element should not be supplied. This data element is required for business purposes when the Encounter has been rescheduled, but the data set will not be rejected if it is empty. Failure to supply a data element will be included in Consolidation Reporting.
MOH Internal ODS Column Name	BKG_DETAIL_REASON_REBOOKED

10.6.9 Responsible Organisation ID [O]

Definition	The HPI Identifier of the Organisation that is responsible for the Service being provided to the patient.
Data Type	Alphanumeric
Layout	GNNNNN-C
Data Domain	Code Set Name: ORG
Obligation	Optional
Guide for Use	Responsible Organisation is the principal contract holder for the delivery of the Service. The Submitting Organisation will be treated as the Responsible Organisation if the Responsible Organisation ID is not provided. This data element is required for business purposes, but the data set will not be rejected if it is empty. Failure to supply a data element will be included in Consolidation Reporting.
MOH Internal ODS Column Name	BKG_DETAIL_RESP_ORG_CODE

10.6.10 Service Sub-Type

Definition	A code representing the sub type of the Service the patient is booked for. Provides additional information about the booked Service.
Data Type	Numeric
Layout	NNNN
Data Domain	Code Set Name: SRVSUB
Obligation	Mandatory
Guide For Use	
MOH Internal ODS Column Name	BKG_DETAIL_SRVC_SUB_TYPE

10.6.11 Service Type

Definition	A code for the category of Service the patient is booked for.
Data Type	Numeric
Layout	NN
Data Domain	Code Set Name: SRV
Obligation	Mandatory
Guide For Use	Because the Submitting Organisation can book more services than are reflected in the Prioritisation (for example, when follow up appointments are booked for the surgery that was the subject of the Prioritisation), it is not necessary for the Booking Service Type to 'match' the Prioritisation Service Type or the NNPAC Purchase Unit. It is expected that at least one Booking with a Service Type that matches the Prioritisation Service Type is submitted, unless there is an Exception.
MOH Internal ODS Column Name	BKG_DETAIL_SRVC_TYPE

10.6.12 Intended Procedure Clinical Code Type [CM]

Definition	A code representing the type of treatment identified by the Intended Procedure Clinical Code
Data Type	Alphabetic
Layout	A

Data Domain	CLINCODTYPE Must be a valid Clinical Code Type for the combination of the Clinical Code System and Clinical Code Set to “O” – Operation/procedure - when a placeholder value is required.
Obligation	Conditionally mandatory. Required when Intended Procedure Clinical Code System is one of: 13 - ICD-10-AM sixth edition 14 - ICD-10-AM eighth edition Must be null if not one of the above. Must be null if Intended Procedure Clinical Code is null
Guide for Use	This data element was introduced into the Collection in Phase 3 (July 2016). Prior to that it was assumed that the clinical code supplied was for a procedure and “O” was used for the Clinical Code Type when determining whether the supplied ICD-10-AM code was valid.
MOH Internal ODS Column Name	[To be supplied]

10.6.13 Responsible Health Specialty

Definition	The health specialty that is responsible for providing the service to the patient.
Data Type	Alphanumeric
Layout	ANN
Data Domain	Code Set Name: HLTHSP
Obligation	Mandatory
Guide for Use	Refer to Health Specialty Code in the Code Tables section for guidance on the use of codes.
MOH Internal ODS Column Name	[To be supplied]

10.7. Activity: Encounter

An Activity where the requested service is intended to be provided to the patient.

Validation

For Encounter integrity checking rules refer to the groups of rules *Generic Rules* and *What is a valid encounter?* in the Business Rules Catalogue (17 - Appendix D: Business Rules and Error Messages).

MOH Internal ODS Table Name

10.7.1 Attendance Outcome

Definition	A code indicating whether the encounter was attended by the patient or not
Data Type	Alphanumeric
Layout	XXX
Data Domain	Code Set Name: ATTOUT
Obligation	Mandatory
MOH Internal ODS Column Name	ENC_DETAIL_ATTENDANCE_OUTCOME

10.7.2 Encounter End Date

Definition	The date and time on which the requested service was provided to the patient.
Data Type	Datetime
Layout	YYYY-MM-DDThh:mm:ss
Obligation	Mandatory
Guide For Use	For inpatients use the actual procedure or treatment (intervention) date (note: this is not the discharge date in NMDS). For outpatients, the end and start dates will usually be the same. Note that for Service Sub Types where the test period extends beyond the start date (eg investigation involving the use of remote monitoring device over three week period) the Encounter End Date should be reported as the end of the monitoring period.
MOH Internal ODS Column Name	ENC_DETAIL_ENC_END_DT

10.7.3 Encounter Start Date

Definition	The date and time on which a Service began.
Data Type	Datetime
Layout	YYYY-MM-DDThh:mm:ss
Obligation	Mandatory
Guide For Use	Date admitted for inpatients. For outpatients, end and start dates will usually be the same.

MOH Internal ODS Column Name	ENC_DETAIL_ENC_START_DT

10.7.4 Encounter Type

Definition	A code representing the patient's type of encounter.
Data Type	Numeric
Layout	N
Data Domain	Code Set Name: ENCTYP
Obligation	Mandatory
Guide for Use	The Encounter Type is usually the same for all Activities (as decided at Prioritisation), but may change if the plan for the patient changes. Used in conjunction with the Service Type data element to determine if specific data elements are conditionally mandatory or optional.
MOH Internal ODS Column Name	ENC_DETAIL_ENC_TYPE

10.7.5 Lead Clinician Code [CM]

Definition	A code that identifies the clinician who has overall responsibility for the patient. This may not be the same as the clinician providing the service.
Data Type	Alphanumeric
Layout	X(10)
Data Domain	
Obligation	Conditionally mandatory. Required if Encounter Type is ‘Inpatient’ or ‘Day Patient’ and the Attendance Outcome is ‘Attended, service delivered’ or ‘Attended, service not delivered or incomplete’.
Guide for Use	For Inpatient, the Lead Clinician who has overall responsibility for the patient’s plan of care. For Outpatient, the Lead Clinician is assigned at time of booking. The code can either be a local code or registration authority code.
Source	Professional bodies such as NZ Medical Council and NZ Nursing Council or DHBs. Local doctor codes can be supplied instead.
MOH Internal ODS Column Name	ENC_DETAIL_LEAD_CLINICIAN_CODE

10.7.6 Lead Clinician Professional Group Code [CM]

Definition	The health professional group of the lead clinician
Data Type	Alphanumeric
Layout	AA
Data Domain	Code Set Name: PROFGRP
Obligation	Conditionally mandatory. Required if a Lead Clinician Code has been provided
MOH Internal ODS Column Name	ENC_DETAIL_LEAD_CLINICIAN_PROF_GRP_CODE

10.7.7 NBRS Local Booking System Entry ID [CM]

Definition	The identifier generated by the facility Booking system for the NBRS collection booking entry associated with the NPF Encounter.
Data Type	Alphanumeric
Layout	X(14)
Obligation	Conditionally mandatory. Required if Encounter Type is 'Inpatient' or 'Day Patient'.
Guide for Use	Applicable to Encounters that are associated with a waiting list entry in NBRS. This will enable NBRS to be linked with the NPF encounter using a common ID to enable additional analysis. If the Inpatient Encounter is not an elective procedure and is not recorded in NBRS then 'Non-NBRS' may be entered.
MOH Internal ODS Column Name	ENC_DETAIL_NBRS_LOCAL_BKG_SYS_ENTRY_ID

10.7.8 NMDS Client System ID [O]

Definition	The identifier generated by the facility health system for the NMDS collection admission record associated with the NPF Encounter.
Data Type	Alphanumeric
Layout	X(14)
Obligation	Optional
Guide for Use	This data element is required for business purposes when the Encounter Type is "Inpatient" or "Day Patient", but the data set will not be rejected if it is empty. Failure to supply a data element will be included in Consolidation Reporting.
MOH Internal ODS Column Name	ENC_DETAIL_NMDS_CLIENT_SYS_ID

10.7.9 NMDS PMS Unique ID [CM]

Definition	The PMS unique identifier submitted to the NMDS collection
Data Type	Alphanumeric
Layout	X(14)
Data Domain	Set to “Not req Ph2” when a placeholder value is required.
Obligation	Conditionally mandatory. Required when Encounter Type is ‘Inpatient’ or ‘Day Patient’.
Guide for Use	Where an Encounter is not reported to NMDS provide ‘Non NMDS’ code.

10.7.10 NNPAC Client System ID [CM]

Definition	The unique identifier for the client system that created the NNPAC record. The client system identifier is registered with the Ministry of Health by the provider. A client system is defined as the system that created the event record and its unique identifier.
Data Type	Alphanumeric
Layout	X(10)
Data Domain	Set to “Not req P2” when a placeholder value is required.
Obligation	Conditionally mandatory. Required if NNPAC PMS Unique ID is supplied.
Guide for Use	Applicable to non-admitted encounters reported to NNPAC. Together with NNPAC PMS Unique Identifier and NNPAC Extract System Identifier this will enable NNPAC to be linked with the NPF encounter using a common ID to enable additional analysis.
MOH Internal ODS Column Name	ENC_DETAIL_NNPAC_CLIENT_SYS_ID

10.7.11 NNPAC Extract System ID [CM]

Definition	The unique identifier for each extract system that reports to NNPAC. An extract system is defined as the system that produces the extract file.
Data Type	Alphanumeric
Layout	X(10)
Data Domain	Set to “Not req P2” when a placeholder value is required.

Obligation	Conditionally mandatory. Required if the NNPAC PMS Unique ID is supplied.
Guide for Use	Applicable to non-admitted encounters reported to NNPAC. Together with NNPAC PMS Unique Identifier and NNPAC Client System Identifier this will enable NNPAC to be linked with the NPF encounter using a common ID to enable additional analysis.
MOH Internal ODS Column Name	ENC_DETAIL_NNPAC_EXTRACT_SYS_ID

10.7.12 NNPAC PMS Unique ID [CM]

Definition	The PMS unique identifier submitted to the NNPAC collection
Data Type	Alphanumeric
Layout	X(14)
Data Domain	Set to “Not req P2” when a placeholder value is required.
Obligation	Conditionally mandatory. Required when the Encounter Type is ‘Outpatient – Patient Present’ or ‘Outpatient – Remote’.
Guide for Use	Applicable to non-admitted encounters reported to NNPAC. Together with NNPAC Extract System Identifier and NNPAC Client System Identifier this will enable NNPAC to be linked with the NPF Encounter using a common ID to enable additional analysis. If it is a non NNPAC event then record ‘Non NNPAC’.
MOH Internal ODS Column Name	ENC_DETAIL_NNPAC_PMS_UNIQUE_ID

10.7.13 Organisation ID

Definition	The HPI Identifier of the organisation that provides the service to the patient.
Data Type	Alphanumeric
Layout	GNNNNN-C
Data Domain	Code Set Name: ORG
Obligation	Mandatory
Guide for Use	

10.7.14 Providing Clinician Code [CM]

Definition	A unique code provided by an authorised body identifying the health care provider who provided the Service to the patient.

Data Type	Alphanumeric
Layout	X(10)
Data Domain	
Obligation	Conditionally mandatory. Required if the Attendance Outcome is 'Attended, service delivered' or 'Attended, service not delivered or incomplete'.
Guide for Use	An HPI is preferred. A registration authority code may be provided if an HPI is not available. The least preferred option is to use a local code.
MOH Internal ODS Column Name	ENC_DETAIL_PROVIDE_CLINICIAN_CODE

10.7.15 Providing Clinician Professional Group Code [CM]

Definition	A code representing the professional group of the providing clinician
Data Type	Alphabetic
Layout	AA
Data Domain	Code Set Name: PROFGRP
Obligation	Conditionally mandatory. Required if a Providing Clinician Code value has been provided
MOH Internal ODS Column Name	ENC_DETAIL_PROVIDE_CLINICIAN_PROF_GRP_CODE

10.7.16 Responsible Organisation ID [O]

Definition	The HPI Identifier of the organisation that funds the Service being provided to the patient.
Data Type	Alphanumeric
Layout	GNNNNN-C
Data Domain	Code Set Name: ORG
Obligation	Optional
Guide for Use	Responsible Organisation is the principal contract holder for the delivery of the Service. The Submitting Organisation will be treated as the Responsible Organisation if the Responsible Organisation ID is not provided. This data element is required for business purposes, but the data set will not be rejected if it is empty. Failure to supply a data element will be included in Consolidation Reporting.

MOH Internal ODS Column Name	ENC_DETAIL_RESP_ORG_CODE

10.7.17 Responsible Health Specialty

Definition	The health specialty that is responsible for providing the service to the patient.
Data Type	Alphanumeric
Layout	ANN
Data Domain	Code Set Name: HLTHSP
Obligation	Mandatory
Guide for Use	Refer to Health Specialty Code in the Code Tables section for guidance on the use of codes.
MOH Internal ODS Column Name	[To be supplied]

10.7.18 Intended Procedure Clinical Code [CM]

Definition	A clinical code identifying the intended procedure for this activity
Data Type	Alphanumeric
Layout	X(30)
Data Domain	A valid ICD10 code
Obligation	Conditionally mandatory. Required if intended Encounter Type is Inpatient or Day patient and Service Type is Procedure/Treatment or Investigation/Test
Guide For Use	ICD-10-AM code for an intended procedure from the current ICD-10-AM version
MOH Internal ODS Column Name	[To be supplied]

10.7.19 Intended Procedure Clinical Code Type [CM]

Definition	A code representing the type of treatment identified by the Intended Procedure Clinical Code
Data Type	Alphabetic
Layout	A
Data Domain	CLINCODTYPE

	Must be a valid Clinical Code Type for the Clinical Code and System combination
Obligation	Conditionally mandatory. Required when Intended Procedure Clinical Code System is one of: 13 - ICD-10-AM sixth edition 14 - ICD-10-AM eighth edition Must be null if not one of the above. Must be null if Intended Procedure Clinical Code is null
Guide for Use	This data element was introduced into the Collection in Phase 3 (July 2016). Prior to that it was assumed that the clinical code supplied was for a procedure and “O” was used for the Clinical Code Type when determining whether the supplied ICD-10-AM code was valid.
MOH Internal ODS Column Name	[To be supplied]

10.7.20 Intended Procedure Clinical Code System [CM]

Definition	A code identifying the clinical coding system of the Intended Procedure Clinical Code.
Data Type	Numeric
Layout	NN
Data Domain	An ICD-10-AM system from CLINCODSYS
Obligation	Conditionally mandatory. Required if an Intended Procedure Clinical Code has been provided
Guide For Use	May be provided for all Encounter Types but must be an ICD-10-AM system
MOH Internal ODS Column Name	[To be supplied]

10.7.21 Service Sub-Type

Definition	A code representing the sub type of the Service. Provides additional information about the Service.
Data Type	Numeric
Layout	NNNN
Data Domain	Code Set Name: SRVSUB
Obligation	Mandatory
Guide For Use	

MOH Internal ODS Column Name	[To be supplied]

10.7.22 Service Type

Definition	A code for the category of Service.
Data Type	Numeric
Layout	NN
Data Domain	Code Set Name: SRV
Obligation	Mandatory
Guide For Use	Because the Submitting Organisation can deliver more services than are reflected in the Prioritisation (for example, when follow up appointments are booked for the surgery that was the subject of the Prioritisation), it is not necessary for the Service Type to 'match' the Prioritisation Service Type or the NNPAC Purchase Unit in other Activities. It is expected that the full Service Sequence for a Service Type that matches the Prioritisation Service Type is submitted (or there is an Exception with a matching Service Type).
MOH Internal ODS Column Name	[To be supplied]

10.8. Activity: Exception

Exception is an administration activity that results in a referral being suspended, closed or reactivated. Known as Exception Handling in Phase 1.

Validation

For Exception integrity checking rules refer to the groups of rules *Generic Rules* and *What is a valid exception?* in the Business Rules Catalogue (17 - Appendix D: Business Rules and Error Messages).

MOH Internal ODS Table Name

ACT_EXCPT_DETAIL

10.8.1 Date Exception Outcome Assigned

Definition	Date of status change of the referral.
Data Type	Datetime
Layout	YYYY-MM-DDThh:mm:ss

Obligation	Mandatory
Guide	The Date Exception Outcome Assigned must not be later than the date file processed
MOH Internal ODS Column Name	EXCPT_DETAIL_DT_EXCPT_OUTCOME_ASSIGNED

10.8.2 Exception Outcome

Definition	The status of the referral
Data Type	Numeric
Layout	N
Data Domain	Code Set Name: EXCPTOUT
Obligation	Mandatory
MOH Internal ODS Column Name	EXCPT_DETAIL_EXCPT_OUTCOME

10.8.3 Exception Outcome Reason

Definition	The reason for the Exception
Data Type	Numeric
Layout	NN
Data Domain	Code Set Name: EXCPREA
Obligation	Mandatory
Guide for Use	Refer to code set notes.
MOH Internal ODS Column Name	EXCPT_DETAIL_EXCPT_OUTCOME_REASON

10.8.4 Organisation ID

Definition	The HPI Identifier of the Organisation that is responsible for the change of status in the Referral.
Data Type	Alphanumeric
Layout	GNNNNN-C
Data Domain	Code Set Name: ORG

Obligation	Mandatory
Guide for Use	
MOH Internal ODS Column Name	EXCPT_DETAIL_ORG_CODE

10.8.5 Responsible Organisation ID [O]

Definition	The HPI Identifier of the Organisation that is responsible for the change of status in the Referral.
Data Type	Alphanumeric
Layout	GNNNNN-C
Data Domain	Code Set Name: ORG
Obligation	Optional
Guide for Use	Responsible Organisation is the principal contract holder for the delivery of the Service. The Submitting Organisation will be treated as the Responsible Organisation if the Responsible Organisation ID is not provided. This data element is required for business purposes, but the data set will not be rejected if it is empty. Failure to supply a data element will be included in Consolidation Reporting.
MOH Internal ODS Column Name	EXCPT_DETAIL_RESP_ORG_CODE

10.8.6 Responsible Health Specialty

Definition	The health specialty that is responsible for providing the service to the patient.
Data Type	Alphanumeric
Layout	ANN
Data Domain	Code Set Name: HLTHSP
Obligation	Mandatory
Guide for Use	Refer to Health Specialty Code in the Code Tables section for guidance on the use of codes.
MOH Internal ODS Column Name	[To be supplied]

10.8.7 Encounter Type

Definition	A code representing the patient's type of encounter.
Data Type	Numeric
Layout	N
Data Domain	Code Set Name: ENCTYP
Obligation	Mandatory
Guide For Use	The Encounter Type is usually the same for all Activities (as decided at Prioritisation), but may change if the plan for the patient changes. Used in conjunction with the Service Type data element to determine if specific data elements are conditionally mandatory or optional.
MOH Internal ODS Column Name	[To be supplied]

10.8.8 Intended Procedure Clinical Code [CM]

Definition	A clinical code identifying the intended procedure for this activity
Data Type	Alphanumeric
Layout	X(30)
Data Domain	A valid ICD10 code
Obligation	Conditionally mandatory. Required if intended Encounter Type is Inpatient or Day patient and Service Type is Procedure/Treatment or Investigation/Test
Guide For Use	ICD-10-AM code for an intended procedure from the current ICD-10-AM version
MOH Internal ODS Column Name	[To be supplied]

10.8.9 Intended Procedure Clinical Code Type [CM]

Definition	A code representing the type of treatment identified by the Intended Procedure Clinical Code
Data Type	Alphabetic
Layout	A
Data Domain	CLINCODTYPE Must be a valid Clinical Code Type for the Clinical Code and System combination

Obligation	Conditionally mandatory. Required when Intended Procedure Clinical Code System is one of: 13 - ICD-10-AM sixth edition 14 - ICD-10-AM eighth edition Must be null if not one of the above. Must be null if Intended Procedure Clinical Code is null
Guide for Use	This data element was introduced into the Collection in Phase 3 (July 2016). Prior to that it was assumed that the clinical code supplied was for a procedure and “O” was used for the Clinical Code Type when determining whether the supplied ICD-10-AM code was valid.
MOH Internal ODS Column Name	[To be supplied]

10.8.10 Intended Procedure Clinical Code System [CM]

Definition	A code identifying the clinical coding system of the Intended Procedure Clinical Code.
Data Type	Numeric
Layout	NN
Data Domain	An ICD-10-AM system from CLINCODSYS
Obligation	Conditionally mandatory. Required if an Intended Procedure Clinical Code has been provided
Guide For Use	May be provided for all Encounter Types but must be an ICD-10-AM system
MOH Internal ODS Column Name	[To be supplied]

10.8.11 Service Sub-Type

Definition	A code representing the sub type of the Service. Provides additional information about the Service.
Data Type	Numeric
Layout	NNNN
Data Domain	Code Set Name: SRVSUB
Obligation	Mandatory
Guide For Use	

MOH Internal ODS Column Name	[To be supplied]

10.8.12 Service Type

Definition	A code for the category of Service.
Data Type	Numeric
Layout	NN
Data Domain	Code Set Name: SRV
Obligation	Mandatory
Guide For Use	Because the Submitting Organisation can deliver more services than are reflected in the Prioritisation (for example, when follow up appointments are booked for the surgery that was the subject of the Prioritisation), it is not necessary for the Service Type to 'match' the Prioritisation Service Type or the NNPAC Purchase Unit in other Activities. It is expected that the full Service Sequence for a Service Type that matches the Prioritisation is submitted (or there is an Exception with a matching Service Type).
MOH Internal ODS Column Name	[To be supplied]

10.9. Activity: Notification

Notification is an activity where the patient and the GP or Referrer are notified of the Prioritisation Outcome.

Validation

For Notification integrity checking rules refer to the groups of rules *Generic Rules* and *What is a valid notification?* in the Business Rules Catalogue (17 - Appendix D: Business Rules and Error Messages).

MOH Internal ODS Table Name

ACT_NFY_DETAIL

10.9.1 Date GP Notified [O]

Definition	The date the outcome of the Prioritisation Activity is notified to the GP
Type	Datetime
Layout	YYYY-MM-DDThh:mm:ss
Data Domain	

Obligation	Optional
Guide for Use	Notification should be to the patient/carer, the GP and the referrer if the GP is not the Referrer.
MOH Internal ODS Column Name	NFY_DETAIL_DT_GP_NFY

10.9.2 Date Patient/Carer Notified

Definition	The date the outcome is notified to the patient/carer
Data Type	Datetime
Layout	YYYY-MM-DDThh:mm:ss
Data Domain	
Obligation	Mandatory
Guide for Use	The Notification is expected to be sent after Prioritisation confirming the Outcome.
MOH Internal ODS Column Name	NFY_DETAIL_DT_PATIENT_NFY

10.9.3 Date Referrer Notified (if not GP) [CM]

Definition	The date the outcome is notified to the referrer
Type	Datetime
Layout	YYYY-MM-DDThh:mm:ss
Obligation	Conditionally mandatory. Required when Date GP Notified is null
Data Domain	Set to “1999-01-01” when a placeholder value is required. This value has a start date of 2014-07-01 and an end date of 2016-06-30.
Guide for Use	Notification should be to the patient/carer, the GP and the referrer if the GP is not the referrer.
MOH Internal ODS Column Name	NFY_DETAIL_DT_REF_NFY

10.9.4 Organisation ID

Definition	The HPI Identifier of the Organisation that provides the Service to the patient.
Type	Alphanumeric

Layout	GNNNNN-C
Data Domain	Code Set Name: ORG
Obligation	Mandatory
Guide for Use	
MOH Internal ODS Column Name	NFY_DETAIL_RESP_ORG_CODE

10.9.5 Responsible Organisation ID [O]

Definition	The HPI Identifier of the Organisation that is responsible for the Notification activity.
Type	Alphanumeric
Layout	GNNNNN-C
Data Domain	Code Set Name: ORG
Obligation	Optional
Guide for Use	Responsible Organisation is the principal contract holder for the delivery of the Service. The Submitting Organisation will be treated as the Responsible Organisation if the Responsible Organisation ID is not provided. This data element is required for business purposes, but the data set will not be rejected if it is empty. Failure to supply a data element will be included in Consolidation Reporting.
MOH Internal ODS Column Name	NFY_DETAIL_RESP_ORG_CODE

10.9.6 Responsible Health Specialty

Definition	The health specialty that is responsible for providing the service to the patient.
Data Type	Alphanumeric
Layout	ANN
Data Domain	Code Set Name: HLTHSP
Obligation	Mandatory
Guide for Use	Refer to Health Specialty Code in the Code Tables section for guidance on the use of codes.

MOH Internal ODS Column Name	[To be supplied]

10.9.7 Encounter Type

Definition	A code representing the patient's type of encounter.
Data Type	Numeric
Layout	N
Data Domain	Code Set Name: ENCTYP
Obligation	Mandatory
Guide For Use	The Encounter Type is usually the same for all Activities (as decided at Prioritisation), but may change if the plan for the patient changes. Used in conjunction with the Service Type data element to determine if specific data elements are conditionally mandatory or optional.
MOH Internal ODS Column Name	[To be supplied]

10.9.8 Intended Procedure Clinical Code [CM]

Definition	A clinical code identifying the intended procedure for this activity
Data Type	Alphanumeric
Layout	X(30)
Data Domain	A valid ICD10 code
Obligation	Conditionally mandatory. Required if intended Encounter Type is Inpatient or Day patient and Service Type is Procedure/Treatment or Investigation/Test
Guide For Use	ICD-10-AM code for an intended procedure from the current ICD-10-AM version
MOH Internal ODS Column Name	[To be supplied]

10.9.9 Intended Procedure Clinical Code Type [CM]

Definition	A code representing the type of treatment identified by the Intended Procedure Clinical Code
Data Type	Alphabetic
Layout	A

Data Domain	CLINCODTYPE Must be a valid Clinical Code Type for the Clinical Code and System combination
Obligation	Conditionally mandatory. Required when Intended Procedure Clinical Code System is one of: 13 - ICD-10-AM sixth edition 14 - ICD-10-AM eighth edition Must be null if not one of the above. Must be null if Intended Procedure Clinical Code is null
Guide for Use	This data element was introduced into the Collection in Phase 3 (July 2016). Prior to that it was assumed that the clinical code supplied was for a procedure and “O” was used for the Clinical Code Type when determining whether the supplied ICD-10-AM code was valid.
MOH Internal ODS Column Name	[To be supplied]

10.9.10 Intended Procedure Clinical Code System [CM]

Definition	A code identifying the clinical coding system of the Intended Procedure Clinical Code.
Data Type	Numeric
Layout	NN
Data Domain	An ICD-10-AM system from CLINCODSYS
Obligation	Conditionally mandatory. Required if an Intended Procedure Clinical Code has been provided
Guide For Use	May be provided for all Encounter Types but must be an ICD-10-AM system
MOH Internal ODS Column Name	[To be supplied]

10.9.11 Service Sub-Type

Definition	A code representing the sub type of the Service. Provides additional information about the Service.
Data Type	Numeric
Layout	NNNN
Data Domain	Code Set Name: SRVSUB
Obligation	Mandatory

Guide For Use	
MOH Internal ODS Column Name	[To be supplied]

10.9.12 Service Type

Definition	A code for the category of Service.
Data Type	Numeric
Layout	NN
Data Domain	Code Set Name: SRV
Obligation	Mandatory
Guide For Use	The Service Type is usually the same for all Activities (as decided at Prioritisation), but may change if the plan for the patient changes.
MOH Internal ODS Column Name	[To be supplied]

10.10. Activity: Prioritisation

Prioritisation refers to the decision and data related to the decision as to whether a patient will receive a service or not.

The Phase 1 equivalent was “Triage”.

Specific requirement: submission of a Prioritisation with an Encounter Outcome:

A Prioritisation must be submitted as part of the current Service Sequence when the Encounter Outcome Decision is “03 - Treatment Best Option” and the Encounter Outcome Reason is “05 – Declined – Below Threshold” or “06 – Declined – Active Review”. See “7.3. Prioritisation Dataset for Add and Update” for a diagram explaining this.

Validation

For Prioritisation integrity checking rules refer to the groups of rules *Generic Rules* and *What is a valid prioritisation?* in the Business Rules Catalogue.

MOH Internal ODS Table Name

ACT_PRIO_DETAIL

10.10.1 Clinical Exclusion Code

Definition	A code indicating whether the intended Encounter is to be managed within standard time frames or if there is clinical reason why time frames may be extended.
Data Type	Alphabetic
Layout	A
Data Domain	Code Set Name: CLINEX
Obligation	Mandatory
Guide for Use	The Clinical Exclusion Code 'Normal' should be used if no other values apply. Referral Service Sequences assigned a Clinical Exclusion Code of 'Normal' will be included in performance reporting. The Optimal Date for Service is required when a Clinical Exclusion Code of 'Planned', 'Surveillance' or 'Staged' is provided.
MOH Internal ODS Column Name	PRIO__DETAIL_CLINICAL_EXCL_CODE

10.10.2 Date Prioritised

Definition	The date on which the Prioritisation occurred
Data Type	Datetime
Layout	YYYY-MM-DDThh:mm:ss
Data Domain	
Obligation	Mandatory
Guide for Use	The Date Prioritised must not be later than the date file processed. This is also known as the "Date Patient assured".
MOH Internal ODS Column Name	PRIO_DETAIL_DT_PRIO

10.10.3 Defined Suspicion of Cancer (SCAN)

Definition	A code indicating the level of suspicion of cancer for the patient as determined by prioritisation process.
Data Type	Numeric
Layout	NN
Data Domain	Code Set Name: SCAN

	The code "99 - Not stated" is not permitted in the Prioritisation data segment.
Obligation	Mandatory
Guide for Use	SCAN is used to support Faster Cancer Treatment reporting.
MOH Internal ODS Column Name	PRIO_DETAIL_SCAN

10.10.4 Encounter Type

Definition	A code representing the intended type of Encounter
Data Type	Numeric
Layout	N
Data Domain	Code Set Name: ENCTYP
Obligation	Mandatory
Guide for Use	Used in conjunction with the Service Type data element to determine if specific data elements are conditionally mandatory or optional for a prioritisation activity. This field indicates the intended Encounter type at the time of Prioritisation
MOH Internal ODS Column Name	PRIO_DETAIL_ENCOUNTER_TYPE

10.10.5 Facility ID

Definition	The HPI identifier of the facility providing the services for the activity.
Data Type	Alphanumeric
Layout	AXXNNN-C
Data Domain	Code Set Name: FAC
Obligation	Mandatory
MOH Internal ODS Column Name	PRIO_DETAIL_FACILITY_CODE

10.10.6 Faster Cancer 2 Weeks Urgency Indicator [CM]

Definition	A flag indicating the clinician has deemed the patient needs to be seen within 2 weeks, and thus falls within the cohort of patients reported in the Faster Cancer Treatment Indicators.
Data Type	Integer

Layout	N
Data Domain	Code Set Name: FCT2WK
Obligation	Conditionally mandatory. Required if the Defined Suspicion of Cancer (SCAN) = ‘10 - The patient has a confirmed diagnosis of cancer ‘ or ’30 - There IS A HIGH suspicion of cancer‘.
Guide for Use	Set to '1' when the patient was triaged as needing to be seen within two weeks. This decision is at the discretion of the triaging clinician. Where there is not a high suspicion of cancer (SCAN code 20) the Faster Cancer 2 Weeks Urgency Indicator Flag should be set to ‘0 – No’ This indicator will be used in Faster Cancer Treatment reports. The Faster Cancer 2 Weeks Urgency Indicator may not have been collected in Phase 2 where the Defined Suspicion of Cancer was ‘10 - The patient has a confirmed diagnosis of cancer’. Provide ‘0 – No’ if this is the case when submitting changes to Phase 2 data.
Source Standard	Ministry of Health - Faster Cancer Treatment
MOH Internal ODS Column Name	PRIO_DETAIL_2WEEK_SCAN_URG_IND

10.10.7 Intended Procedure Clinical Code [CM]

Definition	A Clinical Code identifying the intended procedure the patient is being prioritised for
Data Type	Alphanumeric
Layout	X(30)
Data Domain	A valid ICD10 code
Obligation	Conditionally mandatory. Required if Encounter Type is Inpatient or Day patient and Service Type is Procedure/Treatment or Investigation/Test.
Guide for Use	ICD-10-AM code for an intended procedure from the current ICD-10-AM version
MOH Internal ODS Column Name	PRIO_DETAIL_IPROC_CLINICAL_CODE

10.10.8 Intended Procedure Clinical Code System [CM]

Definition	A code identifying the clinical coding system of the Intended Procedure Clinical Code.
Data Type	Numeric
Layout	NN

Data Domain	An ICD-10-AM system from CLINCODSYS
Obligation	Conditionally mandatory. Required if an Intended Procedure Clinical Code has been provided
Guide for Use	May be provided for all Encounter Types but must be an ICD-10-AM system
MOH Internal ODS Column Name	PRIO_DETAIL_IPROC_CLINICAL_CODE_SYS

10.10.9 Optimal Date for Service [O]

Definition	The clinically appropriate time frame for the intended service to occur. May have been determined during an earlier activity.
Data Type	Datetime
Layout	YYY-MM-DDThh:mm:ss
Data Domain	
Obligation	Optional
Guide for Use	The Optimal Date for Service will be clinically determined, and may be derived from the Responsible Health Specialty and Clinical Priority Score. The expectation is that this will be a maximum of 120 days from the receipt of the referral unless a Clinical Exclusion Code other than 'Normal' is provided. Provide an Optimal Date for Service when the Clinical Exclusion Code is “P – Planned”, "S - Surveillance" or "G - Staged".
MOH Internal ODS Column Name	PRIO_DETAIL_OPT_DT_SERV

10.10.10 Organisation ID

Definition	The HPI Identifier of the organisation that is prioritising the referral.
Data Type	Alphanumeric
Layout	GNNNNN-C
Data Domain	Code Set Name: ORG
Obligation	Mandatory
Guide for Use	This may not be the DHB organisation ID where another Organisation is delivering a service on behalf of the DHB. A Hospital Organisation ID may also be submitted where there is more than one hospital within the DHB.

10.10.11 Prioritising Clinician Code

Definition	A unique code provided by an authorised body identifying the healthcare provider prioritising the patient.
Data Type	Alphanumeric
Layout	X(10)
Data Domain	Set to “Not req P2” when a placeholder value is required.
Obligation	Mandatory
Guide for Use	For Inpatient Elective patients this is captured in NBRS as the ‘Assessor’ code. This may be an anonymised local DHB code that does not identify the clinician within the National Collection.
Source	Professional bodies such as NZ Medical Council and NZ Nursing Council or DHBs
MOH Internal ODS Column Name	PRIO_DETAIL_CLINICIAN_CODE

10.10.12 Prioritising Clinician Professional Group Code [CM]

Definition	A code representing the health professional group of the prioritising clinician
Data Type	Alphanumeric
Layout	AA
Data Domain	Code Set Name: PROFGRP
Obligation	Conditionally mandatory. Required if a Prioritising Clinician Code has been provided.
MOH Internal ODS Column Name	PRIO_DETAIL_PROF_GRP_CODE

10.10.13 Responsible Organisation ID [O]

Definition	The HPI Identifier of the organisation that is responsible for the service being provided to the patient.
Data Type	Alphanumeric
Layout	GNNNNN-C
Data Domain	Code Set Name: ORG
Obligation	Optional
Guide for Use	Responsible Organisation is the principal contract holder for the delivery of the Service.

	The Submitting Organisation will be treated as the Responsible Organisation if the Responsible Organisation ID is not provided. This data element is required for business purposes, but the data set will not be rejected if it is empty. Failure to supply a data element will be included in Consolidation Reporting.

10.10.14 Service Sub-Type

Definition	A code representing the sub type of the Service the patient was prioritised on. Provides additional information about the prioritised service.
Data Type	Numeric
Layout	NNNN
Data Domain	Code Set Name: SRVSUB
Obligation	Mandatory
Guide For Use	The Service Sub-Type data element is used for reporting on particular service sub-types that are of special interest to Electives and the Faster Cancer Treatment programme. The data element is used to provide contextual information when reporting national wait times.
MOH Internal ODS Column Name	PRIO_DETAIL_SRVSUB

10.10.15 Service Type

Definition	A code for the type of Service that the patient was prioritised on.
Data Type	Numeric
Layout	NN
Data Domain	Code Set Name: SRV
Obligation	Mandatory
MOH Internal ODS Column Name	PRIO_DETAIL_SRV

10.10.16 Intended Procedure Clinical Code Type [CM]

Definition	A code representing the type of treatment identified by the Intended Procedure Clinical Code
Data Type	Alphabetic
Layout	A

Data Domain	CLINCODTYPE Must be a valid Clinical Code Type for the combination of the Clinical Code System and Clinical Code Set to “O” – Operation/procedure - when a placeholder value is required.
Obligation	Conditionally mandatory. Required when Intended Procedure Clinical Code System is one of: 13 - ICD-10-AM sixth edition 14 - ICD-10-AM eighth edition Must be null if not one of the above. Must be null if Intended Procedure Clinical Code is null
Guide for Use	This data element was introduced into the Collection in Phase 3 (July 2016). Prior to that it was assumed that the clinical code supplied was for a procedure and “O” was used for the Clinical Code Type when determining whether the supplied ICD-10-AM code was valid.
MOH Internal ODS Column Name	[To be supplied]

10.10.17 Responsible Health Specialty

Definition	The health specialty that is responsible for providing the service to the patient.
Data Type	Alphanumeric
Layout	ANN
Data Domain	Code Set Name: HLTHSP
Obligation	Mandatory
Guide for Use	Refer to Health Specialty Code in the Code Tables section for guidance on the use of codes.
MOH Internal ODS Column Name	[To be supplied]

10.11. Clinical Priority

Priority assigned to a Prioritisation activity using a defined set of clinical criteria.

The dataset is mandatory for Prioritisation.

Validation

For Clinical Priority integrity checking rules refer to the groups of rules *Generic Rules* and *What is a valid clinical priority decision outcome?* in the Business Rules Catalogue.

MOH Internal ODS Table Name

CLINICAL_PRIORITY

10.11.1 Clinical Override

Definition	A flag indicating if the clinician has overridden the outcome determined by the assessment tool and decided to treat a patient who would have otherwise been declined.
Data Type	Integer
Layout	N
Data Domain	Code Set Name: CLINOVRIDE
Obligation	Mandatory
Guide For Use	This element will be used in reporting prioritisation outcome and wait times. A value of 'No' indicates the clinician has not over ridden the outcome determined by the assessment tool.
MOH Internal ODS Column Name	CLINICAL_PRIO_OVERRIDE

10.11.2 Clinical Override Reason Code [CM]

Definition	The reason why the clinician has overridden the outcome determined by the assessment tool.
Data Type	Numeric
Layout	N
Data Domain	1 - Clinical judgement 2 - Training requirement 3 - Other
Obligation	Conditionally mandatory. Required if Clinical Override is 'Yes'
MOH Internal ODS Column Name	CLINICAL_PRIO_OVERRIDE_REASON_CODE

10.11.3 Clinical Priority Score

Definition	The priority score for the patient using the notation appropriate for the prioritisation tool being used.
Data Type	Alphanumeric
Layout	X(5)
Data Domain	Typically a score is the number of points on a scale of 0 to 100, although the Prioritisation tool '1000 - Intended Outpatient Service Acuity Rating' scoring and some current local tools use numbers (e.g.0 to 5) for degrees of urgency, or an alphanumeric value (e.g. gastroscopy).
Obligation	Mandatory
Guide for Use	Clinical Priority Scores are assigned by clinicians to indicate the priority of a referral in accordance with the Clinical Priority Assessment Tool used. For Encounter Types of Inpatient or Day Patient, the Clinical Priority Score should be from a national or nationally recognised Clinical Prioritisation System or CPAC tool. For Encounter Types that are Outpatient (Patient Present or Remote) a Clinical Priority tool from the 1000 series should be used unless a specific tool has been developed. For the Prioritisation tool '1000 - Intended Outpatient Service Acuity Rating' the scores are 0 - Not prioritised 1 - Immediate 2 - Urgent 3 - Semi-urgent 4 - Routine 5 - Low priority 6 - Not determined - pending test
MOH Internal ODS Column Name	CLINICAL_PRIO_SCORE

10.11.4 Clinical Priority Score Date [CM]

Definition	The date that the patient's Clinical Priority Score was determined
Data Type	Datetime
Layout	YYYY-MM-DDThh:mm:ss
Data Domain	Set to "1999-01-01" when a placeholder value is required. This value has a start date of 2014-07-01 and an end date of 2016-06-30.
Obligation	Conditionally mandatory. Required on the Encounter Type being Inpatient or Day Patient
Guide for Use	This is the date on which the Clinical Priority Score was assigned by the clinician. It may be different to the date on which the Referral is Prioritised.

	When the Clinical Priority Score was assigned by the clinician at the Encounter, that is, when a Treatment Best Option decision was made in the Encounter, then that is the Clinical Priority Score Date.
MOH Internal ODS Column Name	CLINICAL_PRIO_SCORE_DATE

10.11.5 Clinical Priority Tool ID

Definition	A code identifying the assessment tool used to determine the Clinical Priority Score
Data Type	Alphanumeric
Layout	XXXX
Data Domain	CPAC Scoring System Code table in NBRS or '1000 Intended Outpatient Service Acuity Rating' http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/national-booking-reporting-system-code-tables/cpac-scoring-system-code-table
Obligation	Mandatory
Guide for Use	If the Encounter Type is Inpatient or Day patient, a valid CPAC tool code must be used. If Encounter Type is Outpatient (Patient Present or Remote) the Clinical Priority Tool ID is 1000 'Intended Outpatient Service Acuity Rating' unless a specific CPAC tool is available for use for the intended Service. An alternative valid CPAC tool may be used where the Encounter Type is Outpatient (Patient Present or Remote), e.g. a General Surgery CPAC tool may be used for the Service Sub Type - Colonoscopy. It is important that the correct tool is used to assess priority. The validation process is changing and this logic will be incorporated into National Patient Flow following the new implementation.
MOH Internal ODS Column Name	CLINICAL_PRIO_TOOL_ID

10.11.6 Decision Outcome ID

Definition	The identifier of a Decision Outcome that is unique to the Activity that it is associated with.
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -
Obligation	Mandatory
Guide for Use	In this case the Decision Outcome is a Clinical Priority

MOH Internal ODS Column Name	DECISION_OUTCOME_ID in DECISION_OUTCOME table

10.12. Decision Outcome

A decision outcome is a class (generalisation) of outcome for a referral.

Validation

For Decision Outcome integrity checking rules refer to the groups of rules *Generic Rules* and *What is a valid Activity/Decision outcome?* in the Business Rules Catalogue (17 - Appendix D: Business Rules and Error Messages).

MOH Internal ODS Table Name

DECISION_OUTCOME

10.12.1 Activity ID

Definition	The identifier of the Activity that the Decision Outcome is associated with.
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -.
Obligation	Mandatory
MOH Internal ODS Column Name	The association to the Activity entity (ACTIVITY) is via foreign key ACTIVITY-KEY

10.12.2 NHI Number

Definition	A unique 7-character identification number, assigned to a patient by the Patient Index (National Health Index).
Data Type	Alphanumeric
Layout	AAANNNC
Obligation	Mandatory
Guide for Use	The NHI number of the patient that is associated with the diagnosis
Standard	HISO 10046 NHI Number

MOH Internal ODS Column Name	DIAG_COLLECTION_NHI in DIAGNOSIS table

10.12.3 Referral ID

Definition	The identifier of the Referral that the Activity is directly associated with.
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -
Obligation	Mandatory
Guide for Use	Used to link activities together within a Service Sequence
MOH Internal ODS Column Name	Association with referral is via Activity (ACTIVITY_KEY)

10.13. Diagnosis

The decision reached from ascertaining the nature of diseases/illnesses by means of their symptoms or signs (clinical diagnosis) and/or its structural and functional manifestations (pathological diagnosis).

Validation

For Diagnosis integrity checking rules refer to the groups of rules *Generic Rules* and *What is a valid diagnosis decision outcome?* in the Business Rules Catalogue (17 - Appendix D: Business Rules and Error Messages).

MOH Internal ODS Table Name

DIAGNOSIS

10.13.1 Clinical TNM/Pathological TNM [O]

Definition	Indicates if the cancer is at a clinical or pathological stage
Data Type	Alphabetic
Layout	A
Data Domain	C - Clinical P - Pathological
Obligation	Optional

Guide for Use	Provide for a cancer diagnosis where relevant to the type of cancer diagnosed.
MOH Internal ODS Column Name	DIAG_CLINICAL_PATHO_TNM

10.13.2 Date of Diagnosis

Definition	The date on which the diagnosis was made
Data Type	Datetime
Layout	YYYY-MM-DDThh:mm:ss
Data Domain	
Obligation	Mandatory
Guide for Use	The Date of Diagnosis must not be later than the date file processed For cancer data the guide for use is as follows: The date of diagnosis is the date of the pathology report, if any, that first confirmed the diagnosis of cancer. This date may be found attached to a letter of referral or a patient's medical record from another institution or hospital. If this date is unavailable, or if no pathological test was done, then the date may be determined from one of the sources listed in the following sequence: 1. Date of the consultation at, or admission to, the hospital, clinic or institution when the cancer was first diagnosed. Note: do not use the admission date of the current admission if the patient had a prior diagnosis of this cancer. 2. Date of first diagnosis as stated by a recognised medical practitioner or dentist. Note: This date may be found attached to a letter of referral or a patient's medical record from an institution or hospital. 3. Date the patient states they were first diagnosed with cancer. Note: This may be the only date available in a few cases (for example, patient was first diagnosed in a foreign country). If a patient is admitted for another condition (for example a broken leg or pregnancy), and a cancer is diagnosed incidentally then the date of diagnosis is the date that the decision-to-treat as cancer was made. Derived from Faster Cancer Treatment Indicators: Business Rules and Data Definitions - March 2014
MOH Internal ODS Column Name	DIAG_DATE

10.13.3 Decision Outcome ID

Definition	The identifier of a Decision Outcome that is unique to the Activity that it is associated with.

Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -
Obligation	Mandatory
MOH Internal ODS Column Name	DECISION_OUTCOME_ID in DECISION_OUTCOME table

10.13.4 Diagnosis Clinical Code

Definition	A clinical code identifying the diagnosis of the patient's presenting problem
Data Type	Alphanumeric
Layout	X(30)
Data Domain	A single valid code in the code set identified in Diagnosis Clinical Code System Provide a Concept ID when the system code is SNOMED CT
Obligation	Mandatory
Guide for Use	
MOH Internal ODS Column Name	DIAG_CLINICAL_CODE

10.13.5 Diagnosis Clinical Code System

Definition	A code representing the system used to codify the Clinical Diagnosis
Data Type	Numeric
Layout	NN
Data Domain	Code System Name: CLINCODSYS
Obligation	Mandatory
Guide for Use	
MOH Internal ODS Column Name	DIAG_CLINICAL_CODE_SYSTEM

10.13.6 Overall Stage Group - Cancer [O]

Definition	Describes the anatomical extent of disease at diagnosis based on stage categories of a staging classification

Data Type	Alphanumeric
Layout	X(10)
Data Domain	A valid code in the classification system identified in Overall Staging System - Cancer and the version of the classification system identified in Overall Staging System Version - Cancer.
Obligation	Optional
Guide for Use	
MOH Internal ODS Column Name	DIAG_OVERALL_STAGE_GROUP

10.13.7 Overall Staging System - Cancer [CM]

Definition	Staging classification system used to determine the overall stage group.
Data Type	Numeric
Layout	NN
Data Domain	Code Set: STAGSYS
Obligation	Conditionally mandatory. Required if an Overall Stage Group - Cancer value has been provided.
Guide for Use	
MOH Internal ODS Column Name	DIAG_OVERALL_STAGE_SYS

10.13.8 Overall Staging System Version - Cancer [CM]

Definition	Version number of staging classification system.
Data Type	Alphanumeric
Layout	X(10)
Data Domain	
Obligation	Conditionally mandatory. Required if an Overall Staging System – Cancer value has been provided.
Guide for Use	For recording of an edition use: Ed *N* (eg, Ed 2 for 2nd Edition) For recording a version use: V *N* (eg, V 2 for Version 2) For recording the year published: *NNNN* (eg, 2015 if published in 2015)
MOH Internal ODS Column Name	DIAG_OVERALL_STAGE_SYS_VERSION

10.13.9 Diagnosis Clinical Code Type [CM]

Definition	A code denoting which section of the ICD-10-AM clinical code table the clinical code falls within. Not applicable to other coding systems.
Data Type	Alphabetic
Layout	A
Data Domain	Code System Name: CLINCODTYPE
Obligation	Conditionally Mandatory. Required when Diagnosis Clinical Coding System is an ICD-10-AM edition. Must be null if Diagnosis Clinical Coding System is not ICD-10-AM edition.
Guide for Use	This field is required to differentiate between different sections of the clinical code table. Must be a valid Clinical Code Type for the Clinical Code and System combination. This data element was introduced into the Collection in Phase 3 (July 2016). Prior to that the Clinical Code Type was not included in determining whether a supplied ICD-10-AM code was valid.
MOH Internal ODS Column Name	

10.14. Encounter Outcome

Encounter Outcome is a subclass of Activity Outcome (specialisation). It contains an outcome of an Encounter Activity.

. More than one Encounter Outcome dataset may be provided - if only one Encounter Outcome is going to be provided, it needs to be related to the service referred for and should include one reason and one destination. Where a treatment (Service Type 4 – Procedure / Treatment) requires a series of treatments or procedures, these must be recorded in a single Service Sequence, with a single Referral and Prioritisation, but with multiple Bookings, Encounters, Encounters Outcomes and Encounter Outcomes Reasons.

For example dialysis, radiotherapy and chemotherapy often require a series of Encounters booked at regular intervals and ongoing assessments. If the Referral (or request for service) is for cancer treatment and the best treatment option is a course of Radiotherapy, a single referral is recorded for Radiotherapy as a treatment for cancer. This Referral will be prioritised once and if accepted, in effect the DHB agrees to provide the full course of Radiotherapy treatment required. Each course of treatment should be recorded as a separate Booking, Encounter, Encounter Outcome and Encounter Outcome Reason, under the original single Referral and Service Sequence. In this scenario, the Service Sequence would include:

Referral	Referral Information Referral Diagnosis (Radiotherapy)
Prioritisation	Prioritisation Outcome (Accepted)
Notification	
Booking	Date
Encounter	Encounter Type (Outpatient) Encounter Outcome Decision (Ongoing Care) Encounter Outcome Reason (Additional Service Required)
Booking	Date

Encounter *This Booking and Encounter will repeat as many times as required*	Encounter Type (Outpatient) Encounter Outcome Decision (Ongoing Care) Encounter Outcome Reason (Additional Service Required)
Booking	Date
Encounter	Encounter Type (Outpatient) Encounter Outcome Decision (Nothing Further Required) Encounter Outcome Reason (Service Complete)

Validation

For Encounter Outcome integrity checking rules refer to the groups of rules *Generic Rules* and *What is a valid encounter outcome?* in the Business Rules Catalogue (17 - Appendix D: Business Rules and Error Messages).

Guidance on valid combinations of Attendance Outcome, Encounter Outcome Decision, Encounter Outcome Reason and Destination is provided in “Appendix E: Encounter Outcome Scenarios”.

MOH Internal ODS Table Name

ENCOUNTER_OUTCOME

10.14.1 Activity Outcome ID

Definition	The identifier of an Activity Outcome that is unique to the Activity it is associated with.
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -
Obligation	Mandatory
MOH Internal ODS Column Name	ACTIVITY_OUTCOME_ID in ACTIVITY_OUTCOME

10.14.2 Date of Decision to Treat [O]

Definition	The date when the decision was made for the patient’s treatment plan or other management plan, following discussion between the patient and the clinician responsible for treatment.
Data Type	Datetime
Layout	YYYY-MM-DDThh:mm:ss
Obligation	Optional
Guide For Use	This data element is required for business purposes when the SCAN code is ’10 The Patient has a Confirmed Diagnosis of Cancer’ or ’30 There is a high suspicion

	of Cancer', but the data set will not be rejected if it is empty. Failure to supply a data element will be included in Consolidation Reporting. Where there are two possible dates, the earliest date applies. When a patient has been discussed in a MDM, it is in the best interests of the patient that the decision-to-treat discussion with the patient takes place as soon as possible after the MDM. Where decision to treat is not routinely collected, the date that a booking request for treatment is made can be used as a surrogate for decision-to-treat. The National Patient Flow collection requires outpatient attendance outcome decision to be reported. The date that this is recorded is to be used in the first instance. Where there is no outpatient attendance outcome decision recorded then the following dates can be used as date of decision to treat (for the associated treatment type): • Surgery - Date booking for surgery was requested • Chemotherapy / Radiotherapy (or concurrent) - Date chemotherapy or radiotherapy booking was requested • Targeted therapy - Date prescription was written • Non – intervention management – date the decision of non-intervention management was recorded in the patient's record • Best supportive care – date referral was written
Source	National Health Service Scotland New Cancer Waiting Times Targets Data and Definitions Manual (2010).
MOH Internal ODS Column Name	ENC_OUTCOME_DT_DECISION_TREAT

10.14.3 Date Test Results Reported [CM]

Definition	Where the encounter Service Type is "Investigation/Test", the date on which the test results are reported to the referrer
Data Type	Datetime
Layout	YYYY-MM-DDThh:mm:ss
Obligation	Conditionally mandatory. Required if Service Sub-Type is 'CT Scan', CT angiography', 'CT colonography', 'MRI Scan', 'MRI angiography''
Guide For Use	This date is used to report on waiting time measures. There are specific diagnostic waiting time indicators for CT and MRI scan, which "close" on the date the Test is reported, not on the date of the Encounter. This is not the case for other tests.
MOH Internal ODS Column Name	ENC_OUTCOME_DT_TEST_RESULT_REPORT

10.14.4 Destination

Definition	A code representing the next step in the patient journey or the completion of the patient's journey for the purposes of the National Patient Flow collection.

Data Type	Numeric
Layout	NN
Data Domain	Code Set Name: DEST
Obligation	Mandatory
Guide for Use	
MOH Internal ODS Column Name	ENC_OUTCOME_DESTINATION

10.14.5 Encounter Outcome Decision

Definition	A code representing the Decision Outcome of the Encounter
Data Type	Numeric
Layout	NN
Data Domain	Code Set Name: ENCOUTD
Obligation	Mandatory
Guide for Use	The Decision on the most appropriate next step for a Patient following an Encounter. Where multiple Decisions apply, additional Encounter Outcomes may be supplied. With the Encounter Outcome Reason and the Destination, captures the “planned next step” for the Patient. See “Appendix E: Encounter Outcome Scenarios” for guidance.
MOH Internal ODS Column Name	ENC_OUTCOME_DECISION

10.14.6 Encounter Outcome Reason

Definition	A code representing the reason the encounter decision was made
Data Type	Numeric
Layout	NN
Data Domain	Code Set Name: ENCOUTR
Obligation	Mandatory
Guide for Use	Associated with the Encounter Outcome Reason to identify the planned next step for the patient. See “Appendix E: Encounter Outcome Scenarios” for common examples.

MOH Internal ODS Column Name	ENC_OUTCOME_REASON

10.14.7 Facility ID

Definition	The HPI identifier of the Facility where the Encounter occurred
Data Type	Alphanumeric
Layout	FXXNNN-C
Data Domain	Code Set Name: FAC
Obligation	Mandatory

10.14.8 Health Specialty Referred To [CM]

Definition	A code to identify the Health Specialty the patient has been referred to when the Encounter Outcome Destination is "Other health specialty"
Data Type	Alphanumeric
Layout	ANN
Data Domain	Code Set Name: HLTHSP
Obligation	Conditionally mandatory. Required if Destination is “Other health specialty”
Guide for Use	Where the Destination is Other Health Specialty, identifies the Health Specialty a patient is being referred to. May also be supplied if the Destination is Other DHB. This allows recording of both the Submitting Organisation and the specialty referred to. Submission of this data element is not limited to “Other health specialty” only.
MOH Internal ODS Column Name	ENC_OUTCOME_HEALTH_SPEC_REFERRED_TO

10.14.9 Procedure or Treatment Date [CM]

Definition	The date when the procedure or treatment occurred for an admitted patient
Data Type	Datetime
Layout	YYYY-MM-DDThh:mm:ss
Data Domain	
Obligation	Conditionally mandatory. Required if the Encounter Type is Inpatient and the Service Type is "Procedure/ Treatment" or "Investigation/Test"

Guide For Use	
MOH Internal ODS Column Name	ENC_OUTCOME_PROC_TREAT_DT

10.14.10 Referred to Organisation ID [CM]

Definition	A code identifying the Organisation the patient has been referred to when the Encounter Outcome Destination is 'Other DHB'
Data Type	Alphanumeric
Layout	GNNNNN-C
Data Domain	Code Set Name: ORG
Obligation	Conditionally mandatory. Required if Destination is "Other DHB”
Guide for Use	Identifies the Submitting Organisation the patient is being referred to. With Referred to Health Specialty, provides greater clarity on the referral destination.
MOH Internal ODS Column Name	ENC_OUTCOME_REFERRED_ORG_CODE

10.14.11 Service Sub-Type

Definition	A code representing the sub-type of Encounter that occurred. Provides additional information about the Service planned or provided during the Encounter.
Data Type	Numeric
Layout	NNNN
Data Domain	Code Set Name: SRVSUB
Obligation	Mandatory
Guide for Use	The Service Sub-Type data element is used for reporting on services that are of interest to Electives and the Faster Cancer Treatment programme. In addition to this the data element is used to provide information about national reporting times. Provide multiple Encounter Outcomes when more than one Service Sub-Type is provided at the Encounter
MOH Internal ODS Column Name	ENC_OUTCOME_SERV_SUB_TYPE

10.14.12 Service Type

Definition	A code for the specific Service Type of Encounter that occurred

Data Type	Numeric
Layout	N
Data Domain	Code Set Name: SRV
Obligation	Mandatory
Guide For Use	The Service Type that was intended or provided. If multiple Service Types are provided, additional Encounter Outcomes may be supplied, however at least one Encounter Outcome must be provided for the prioritised service.
MOH Internal ODS Column Name	ENC_OUTCOME_SERV_TYPE

10.14.13 Referred to Intended Procedure Clinical Code [O]

Definition	A clinical code identifying the intended procedure to be delivered under the next Referral
Data Type	Alphanumeric
Layout	X(30)
Data Domain	A valid ICD10 code
Obligation	Optional
Guide For Use	ICD-10-AM code for the procedure that is requested to be provided in the next Referral. Should be provided when a Related Referral is raised as a result of this Encounter. This data element should be supplied when the submitting organisation cannot provide either the Presenting Referral ID or the Previous Related Referral ID (in the Referral data set). It will assist in linking this Referral to the next Referral (a related referral, and for the same patient) when the Submitting Organisation is unable to provide the Presenting or Previous Related Referral IDs. It will be compared to the same data element in the Prioritisation for a subsequent Referral for the same Patient.
MOH Internal ODS Column Name	[To be supplied]

10.14.14 Referred to Intended Procedure Clinical Code Type [CM]

Definition	A code representing the type of treatment identified by the Referred to Intended Procedure Clinical Code
Data Type	Alphabetic
Layout	A

Data Domain	CLINCODTYPE
Obligation	Conditionally mandatory. Required when Referred to Intended Procedure Clinical Code System is one of: 13 - ICD-10-AM sixth edition 14 - ICD-10-AM eighth edition
Guide for Use	Must be a valid Clinical Code Type for the Clinical Code and System combination This data element should be supplied when the submitting organisation cannot provide either the Presenting Referral ID or the Previous Related Referral ID (in the Referral data set). It will assist in linking this Referral to the next Referral (a related referral, and for the same patient) when the Submitting Organisation is unable to provide the Presenting or Previous Related Referral IDs. It will be compared to the same data element in the Prioritisation for a subsequent Referral for the same Patient.
MOH Internal ODS Column Name	[To be supplied]

10.14.15 Referred to Intended Procedure Clinical Code System [CM]

Definition	A code identifying the clinical coding system of the Referred to Intended Procedure Clinical Code.
Data Type	Numeric
Layout	NN
Data Domain	An ICD-10-AM system from CLINCODSYS
Obligation	Conditionally mandatory. Required if a Referred to Intended Procedure Clinical Code has been provided
Guide For Use	Must be an ICD-10-AM system for an intended procedure This data element should be supplied when the submitting organisation cannot provide either the Presenting Referral ID or the Previous Related Referral ID (in the Referral data set). It will assist in linking this Referral to the next Referral (a related referral, and for the same patient) when the Submitting Organisation is unable to provide the Presenting or Previous Related Referral IDs. It will be compared to the same data element in the Prioritisation for a subsequent Referral for the same Patient.
MOH Internal ODS Column Name	[To be supplied]

10.14.16 Referred to Service Sub-Type [O]

Definition	A code representing the sub type of the Referred to Service. Provides additional information about the Service.

Data Type	Numeric
Layout	NNNN
Data Domain	Code Set Name: SRVSUB
Obligation	Optional
Guide For Use	The Service Sub-Type that is requested to be provided in the next Referral. Should be provided when a Related Referral is raised as a result of this Encounter. This data element should be supplied when the submitting organisation cannot provide either the Presenting Referral ID or the Previous Related Referral ID (in the Referral data set). It will assist in linking this Referral to the next Referral (a related referral, and for the same patient) when the Submitting Organisation is unable to provide the Presenting or Previous Related Referral IDs. It will be compared to the same data element in the Prioritisation for a subsequent Referral for the same Patient.
MOH Internal ODS Column Name	[To be supplied]

10.14.17 Referred to Service Type [CM]

Definition	A code for the category of Service to be provided in the next Referral.
Data Type	Numeric
Layout	NN
Data Domain	Code Set Name: SRV
Obligation	Conditionally mandatory. Required when the Referred to Service Sub-Type is provided
Guide For Use	The Service Type that is requested to be provided in the next Referral. Should be provided when a Related Referral is raised as a result of this Encounter. This data element should be supplied when the submitting organisation cannot provide either the Presenting Referral ID or the Previous Related Referral ID (in the Referral data set). It will assist in linking this Referral to the next Referral (a related referral, and for the same patient) when the Submitting Organisation is unable to provide the Presenting or Previous Related Referral IDs. It will be compared to the same data element in the Prioritisation for a subsequent Referral for the same Patient.
MOH Internal ODS Column Name	[To be supplied]

10.15. Patient

A person who receives medical attention, care or treatment.

NPF stores demographic data that are of significance to the Collection. Data about the patient is captured at the time of the referral or the activity.

Validation

For Patient integrity checking rules refer to the groups of rules *Generic Rules* and *Has the patient's identity been verified?* in the Business Rules Catalogue (17 - Appendix D: Business Rules and Error Messages).

MOH Internal ODS Table Name

PATIENT

10.15.1 Date of Birth

Definition	The date of birth of the patient
Data Type	Alphanumeric
Layout	YYYY-MM-DD
Data Domain	
Obligation	Mandatory
Guide for Use	Used to derive the age of the patient. The age of the patient is used to help determine if health services are being provided in an equitable manner.
Standard	HISO 10046
MOH Internal ODS Column Name	PATIENT_DOB

10.15.2 Domicile Code

Definition	New Zealand domicile code representing a patient's usual residential address.
Data Type	Numeric
Layout	NNNN
Data Domain	Code Set Name: DOMCODE Refer to the Domicile Code table under Common Codes for National Collections on the Ministry's website: http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/domicile-code-table
Obligation	Mandatory
Guide for Use	Used to help determine if health services are being provided in an equitable manner.

MOH Internal ODS Column Name	PATIENT_DOMICILE_CODE

10.15.3 Ethnic Group Code

Definition	A classification of the ethnicity of an individual patient as self-identified by the patient.
Data Type	Numeric
Layout	Defined as 9(10) in the NHI system - current maximum in use is 9(5)
Data Domain	Code Set Name: ETHNICITY
Obligation	Up to six Ethnic Group Codes may be supplied. The first Ethnic Group Code is mandatory and further codes are optional.
Guide for Use	
MOH Internal ODS Column Name	PATIENT_ETHNIC_GROUP_CODE

10.15.4 Gender Code [O]

Definition	A classification of the gender of the patient as self-identified by the patient
Data Type	Alphabetic
Layout	A
Data Domain	Code Set Name: GENDER
Obligation	Optional
Guide for Use	Gender is self-identified by the patient. Gender is different from sex, which refers to the biological and physiological characteristics. Used to help determine if health services are being provided in an equitable manner.
MOH Internal ODS Column Name	PATIENT_GENDER_CODE

10.15.5 NHI Number

Definition	A unique 7-character identification number, assigned to a patient by the Patient Index (National Health Index).
Data Type	Alphanumeric

Layout	AAANNNC
Obligation	Mandatory - collected at Referral and all Activities
Guide for Use	NHI numbers are not re-used once assigned to a patient identity. Where more than one number exists for a patient identity, one number is declared 'live' and all other numbers are made 'dormant' and attached to the live record. This NHI number is the NHI number provided on the input file with the Referral data.
Standard	HISO 10046 NHI Number
MOH Internal ODS Column Name	PATIENT_FILE_NHI

10.15.6 Sex Type Code [O]

Definition	A classification of the patient's biological sex
Data Type	Alphabetic
Layout	A
Data Domain	Code Set Name: SEXTYPE
Obligation	Optional
Guide for Use	Used to help determine if health services are being provided in an equitable manner.
MOH Internal ODS Column Name	PATIENT_SEX_TYPE_CODE

10.16. Prioritisation Outcome

Prioritisation Outcome is a subclass of Activity Outcome (specialisation).

It contains an outcome of a Prioritisation Activity.

Validation

For Prioritisation Outcome integrity checking rules refer to the groups of rules *Generic Rules* and *What is a valid prioritisation outcome?* in the Business Rules Catalogue (17 - Appendix D: Business Rules and Error Messages).

MOH Internal ODS Table Name

PRIORITISATION_OUTCOME

10.16.1 Activity Outcome ID

Definition	The identifier of an Activity Outcome that is unique to the Activity it is associated with.
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -
Obligation	Mandatory
MOH Internal ODS Column Name	ACTIVITY_OUTCOME_ID in ACTIVITY_OUTCOME

10.16.2 Prioritisation Outcome

Definition	The outcome of the Prioritisation.
Data Type	Alphabetic
Layout	A
Data Domain	Code Set Name: PRIOUT
Obligation	Mandatory
Guide for Use	Used with the Prioritisation Outcome Reason to describe what the next step in the Referral is. See “12.21. - PRIOUTR Prioritisation Outcome Reason” for guidance on using both the Prioritisation and Prioritisation Outcome Reason.
MOH Internal ODS Column Name	PRIO_OUTCOME_OUTCOME

10.16.3 Prioritisation Outcome Reason

Definition	The reason for the Prioritisation Outcome.
Data Type	Numeric
Layout	NN
Data Domain	Code Set Name: PRIOUTR
Obligation	Mandatory
Guide for Use	Used with the Prioritisation Outcome to describe what the next step in the Referral is. See “12.21. - PRIOUTR Prioritisation Outcome Reason” for guidance on using both the Prioritisation and Prioritisation Outcome Reason.

MOH Internal ODS Column Name	PRIO_OUTCOME_REASON

10.16.4 Transferred Date [CM]

Definition	The date the transfer was sent.
Data Type	Datetime
Layout	YYYY-MM-DDThh:mm:ss
Data Domain	Set to “1999-01-01” when a placeholder value is required. This value has a start date of 2014-07-01 and an end date of 2016-06-30.
Obligation	Conditionally mandatory. Required when the Prioritisation Outcome Reason is ‘Transferred to another specialty’ or ‘Transferred to another organisation’.
Guide for Use	When Prioritisation Outcome is ‘Transferred’ supply the date the referral was forwarded to the other Health Specialty or Organisation
MOH Internal ODS Column Name	PRIO_OUTCOME_TRANSF_DATE

10.16.5 Transferred to Health Specialty [CM]

Definition	A code that identifies the Health Specialty the patient has been transferred to
Data Type	Alphanumeric
Layout	ANN
Data Domain	Code Set Name: HLTHSP
Obligation	Conditionally mandatory. Required if Prioritisation Outcome is transferred and Prioritisation Outcome Reason is ‘Transferred to another specialty'
MOH Internal ODS Column Name	PRIO_OUTCOME_TRANSF_HEALTH_SPEC

10.16.6 Transferred to Organisation [CM]

Definition	The HPI identifier of the Organisation the patient has been transferred to
Data Type	Alphanumeric
Layout	ANNNNN-C
Data Domain	Code Set Name: ORG
Obligation	Conditionally mandatory. Required if Prioritisation Outcome is 'Transferred' and Prioritisation Outcome Reason is 'Transferred to another organisation.

MOH Internal ODS Column Name	PRIO_OUTCOME_TRANSF_TO_ORG

10.17. Referral

A communication requesting a service from a health practitioner that may involve the transfer of clinical responsibility.

Validation

For Referral integrity checking rules refer to the groups of rules *Generic Rules* and *What is a valid referral?* in the Business Rules Catalogue (17 - Appendix D: Business Rules and Error Messages).

MOH Internal ODS Table Name

REFERRAL_DETAIL

10.17.1 Date of Diagnosis [O]

Definition	The date on which the diagnosis was made if the Presenting Problem Code Type is diagnosis.
Data Type	Datetime
Layout	YYYY-MM-DDThh:mm:ss
Data Domain	
Obligation	Optional
Guide for Use	If the Presenting Problem Code Type is “D Diagnosis (if known)” enter the date the diagnosis was made. The Date of Diagnosis must not be later than the date file processed For cancer data the guide for use is as follows: The date of diagnosis is the date of the pathology report, if any, that first confirmed the diagnosis of cancer. This date may be found attached to a letter of referral or a patient's medical record from another institution or hospital. If this date is unavailable, or if no pathological test was done, then the date may be determined from one of the sources listed in the following sequence: 1. Date of the consultation at, or admission to, the hospital, clinic or institution when the cancer was first diagnosed. Note: do not use the admission date of the current admission if the patient had a prior diagnosis of this cancer. 2. Date of first diagnosis as stated by a recognised medical practitioner or dentist. Note: This date may be found attached to a letter of referral or a patient's medical record from an institution or hospital. 3. Date the patient states they were first diagnosed with cancer. Note: This may be the only date available in a few cases (for example, patient was first diagnosed in a foreign country).

	If a patient is admitted for another condition (for example a broken leg or pregnancy), and a cancer is diagnosed incidentally then the date of diagnosis is the date that the decision-to-treat as cancer was made. Derived from Faster Cancer Treatment Indicators: Business Rules and Data Definitions - March 2014
MOH Internal ODS Column Name	REFERRAL_DT_DIAGNOSIS

10.17.2 Date Referral Assigned for Prioritisation [O]

Definition	The date the receiving Submitting Organisation assigns the referral to be prioritised
Data Type	Datetime
Layout	YYYY-MM-DDThh:mm:ss
Data Domain	
Obligation	Optional
Guide for Use	To identify the gap between when administration hand over occurs and when prioritisation happens. The Date Referral Assigned for prioritisation must not be earlier than the Date Referral Received
MOH Internal ODS Column Name	REFERRAL_DT_REF_ASSG_PRIO

10.17.3 Date Referral Received

Definition	The date the referral is first received in the receiving Submitting Organisation
Data Type	Datetime
Layout	YYYY-MM-DDThh:mm:ss
Data Domain	
Obligation	Mandatory
Guide for Use	The Date Referral Received must not be later than the date file processed The date of receipt is the date first received within the Submitting Organisation, or the health specialty referred to or centralised referral office if an internal referral. The following applies: If received electronically, the eReferral date stamp is the date received If the Submitting Organisation manages referrals through a centralised referral office, the date received is the date first received by the Submitting Organisation (or speciality), which may be before it is received in the central office

	If received manually, either by fax or letter, upon opening the referral should be date stamped. This is the date that is entered as the “date received” If an internal referral, the date received is the date received in the health specialty referred to, or the central referral office, whichever is earlier Referrals that are received and transferred to another Submitting Organisation prior to Triage do not have to be submitted by the receiving Submitting Organisation but should be submitted by the Submitting Organisation where it has been transferred However, in line with Operational Policy Framework expectations, DHBs should have processes to ensure that there is effective information transfer between primary, secondary and tertiary providers, and that there will be systems in place to ensure that the referral sent has been received.
MOH Internal ODS Column Name	REFERRAL_DT_REF_RECEIVED

10.17.4 Date Referral Sent [O]

Definition	The date the referrer sends the referral to the receiving Submitting Organisation
Data Type	Datetime
Layout	YYYY-MM-DDThh:mm:ss
Data Domain	
Obligation	Optional
Guide for Use	The date of the referral letter, email or phone call that generated the referral. The Date Referral Sent must not be later than the date file processed This data element is required for business purposes, but the data set will not be rejected if it is empty. Failure to supply a data element will be included in Consolidation Reporting.
MOH Internal ODS Column Name	REFERRAL_DT_REF_SENT

10.17.5 Defined Suspicion of Cancer (SCAN)

Definition	A code indicating the suspicion of cancer for the patient as determined by the referrer
Data Type	Numeric
Layout	NN
Data Domain	Code Set Name: SCAN
Obligation	Mandatory

Guide for Use	This is the referrer provided suspicion of cancer. If this is not provided on the referral, submit “99 – Not stated”
Source	Ministry of Health - Faster Cancer Treatment code set
MOH Internal ODS Column Name	REFERRAL_SCAN

10.17.6 Health Specialty Initially Referred To

Definition	The health specialty that initially received the referral.
Data Type	Alphanumeric
Layout	ANN
Data Domain	Code Set Name: HLTHSP
Obligation	Mandatory
Guide for Use	Refer to Health Specialty Code in the Code Tables section for guidance on the use of codes.
MOH Internal ODS Column Name	REFERRAL_HEALTH_SPEC_INIT_REFD

10.17.7 Presenting Problem Classification

Definition	Presenting Problem Classification is used to codify the Reason for the Referral.
Data Type	Alphanumeric
Layout	X(30)
Data Domain	A single valid code in the code set identified in the Presenting Problem Coding System Code Provide a Concept ID when the system code is SNOMED CT. Set to “ZZ995” – Not required Phase 2 - when a placeholder value is required. This value has a start date of 2015-10-01 and an end date of 2016-06-30.
Obligation	Mandatory
Guide for Use	SNOMED-CT is the preferred code set. If a SNOMED code is not available, an ICD-10-AM or local code may be submitted, if available, with the ICD-10-AM code being preferred over the local code. Provide “261665006 – Unknown” from SNOMED CT or “R69 – Unknown and unspecified causes of morbidity” from ICD-10-AM when the Presenting Problem Classification is not stated on the referral or is not available. If using one of these codes please ensure the correct Presenting Problem Coding System Code and Presenting Problem Code Type is used.

MOH Internal ODS Column Name	REFERRAL_PRES_PROBLEM_CLASS

10.17.8 Presenting Problem Code Type [CM]

Definition	A code representing the type of diagnosis identified by the Presenting Problem Classification clinical code
Data Type	Alphabetic
Layout	A
Data Domain	Code System Name: PRESPROBCODTYPE
Obligation	Conditionally mandatory. Required if a Presenting Problem Classification has been provided
Guide for Use	If a Presenting Problem Classification code has been provided indicate the classification type. Provide “N – Not stated” when the Presenting Problem Code Type is not stated on the referral.
MOH Internal ODS Column Name	REFERRAL_PRES_PROBLEM_CODE_TYPE

10.17.9 Presenting Problem Coding System Code [CM]

Definition	A code identifying the clinical coding system that the Presenting Problem Classification belongs to
Data Type	Numeric
Layout	NN
Data Domain	Code System Name: CLINCODSYS
Obligation	Conditionally mandatory. Required if a Presenting Problem Code Type has been provided
Guide for Use	SNOMED-CT is the preferred Presenting Problem Coding System code.
MOH Internal ODS Column Name	REFERRAL_PRES_PROBLEM_SYS_CODE

10.17.10 Presenting Referral Flag

Definition	A flag indicating whether the referral is a presenting referral or not.
Data Type	Integer

Layout	N
Data Domain	0 No (default) 1 Yes
Obligation	Mandatory
Guide for Use	The “Yes” option in this field should only be used when a Submitting Organisation is certain that the Referral is a Presenting Referral.
MOH Internal ODS Column Name	REFERRAL_PRESENTING_REF_FLAG

10.17.11 Presenting Referral ID [O]

Definition	The identifier of the presenting referral.
Data Type	Alphanumeric
Layout	X(36)
Data Domain	
Obligation	Optional
Guide for Use	Where the Referral is the Presenting Referral, then the Presenting Referral ID is the Referral ID. The ID of the first known Referral for a particular Patient with a particular Presenting Problem. This data element is required for business purposes, but the data set will not be rejected if it is empty. Failure to supply a data element will be included in Consolidation Reporting.
Other Names	Initial Referral Identifier (Phase 1)
MOH Internal ODS Column Name	REFERRAL_PRESENTING_REF_ID

10.17.12 Previous Related Referral Date [R]

This data element is no longer required from Phase 3. It remains in the file spec to prevent rejection of changes to Phase 2 data.

Definition	Phase 2 guidance - Date of the previous related referral if unable to identify the Presenting Referral Identifier of the previously related referral.
Data Type	Datetime – will be enforced if data is submitted in this data element.
Layout	YYYY-MM-DDThh:mm:ss

Data Domain	
Obligation	Optional – Retired in Phase 3
Guide for Use	Retired in Phase 3
MOH Internal ODS Column Name	REFERRAL_PREV_RELATED_REF_DT

10.17.13 Previous Related Referral ID [O]

Definition	Records a previous related referral for the same "presenting problem"
Data Type	Alphanumeric
Layout	X(36)
Data Domain	
Obligation	Optional Must not be provided if the Presenting Referral Flag is set to “1 – Yes”
Guide for Use	Can be provided when a Presenting Referral ID is provided and where the current Referral is not the Presenting Referral.
MOH Internal ODS Column Name	REFERRAL_PREV_RELATED_REF_ID

10.17.14 Receiving Facility ID

Definition	The HPI identifier of the facility receiving the referral.
Data Type	Alphanumeric
Layout	FXXNNN-C
Data Domain	Code Set Name: FAC
Obligation	Mandatory
Guide for Use	
MOH Internal ODS Column Name	REFERRAL_RECEIVING_FACILITY_CODE

10.17.15 Receiving Organisation ID

Definition	The Health Provider Index (HPI) Identifier for the referred to organisation, i.e. the organisation receiving the Referral

Data Type	Alphanumeric
Layout	GNNNNN-C
Data Domain	Code Set Name: ORG
Obligation	Mandatory
Guide for Use	The Organisation that received the Referral. May differ to the Submitting Organisation and Receiving Responsible Organisation.

10.17.16 Receiving Responsible Organisation ID [O]

Definition	The HPI Identifier of the organisation that is responsible for funding the service the health user is being referred to.
Data Type	Alphanumeric
Layout	GNNNNN-C
Data Domain	Code Set Name: ORG
Obligation	Optional
Guide for Use	Responsible Organisation is the principal contract holder for the delivery of the Service. The Submitting Organisation will be treated as the Responsible Organisation if the Receiving Responsible Organisation ID is not provided. This data element is required for business purposes, but the data set will not be rejected if it is empty. Failure to supply a data element will be included in Consolidation Reporting.

10.17.17 Referral ID

Definition	The identifier of the Referral that is unique within the Submitting Organisation.
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -
Obligation	Mandatory
Guide for Use	Used to link activities together within a Service Sequence
Other Names	Local Referral Identifier (NPF Phase 1)
MOH Internal ODS Column Name	REFERRAL_ID in REFERRAL table

10.17.18 Referred from Agency Code [CM]

Definition	A code that uniquely identifies an agency. An agency is an organisation, institution or group of institutions that contracts directly with the principal health service purchaser to deliver healthcare services to the community.
Data Type	Alphanumeric
Layout	XXXX
Data Domain	Code Set Name: AGENCY
Obligation	Conditionally mandatory A value must be provided for either Referred from Organisation ID, Referred from Facility ID or Referred from Agency Code when Referred from Professional Group Type is either Specialist Medical Officer (Own DHB), Specialist Medical Officer (Other DHB) or Specialist Medical Officer (Private).
Guide for Use	Organisation ID is preferred, if it is available. Where a referral is received from a Specialist Medical Officer, this is used to identify the organisational source of the referral.
Other Names	Health agency code, DHB
MOH Internal ODS Column Name	REFERRAL_REFD_FROM_AGENCY_CODE

10.17.19 Referred from Facility ID [CM]

Definition	The HPI identifier of the referred from Facility.
Data Type	Alphanumeric
Layout	AXXNNN-C
Data Domain	Code Set Name: FAC
Obligation	Conditionally mandatory A value must be provided for either Referred from Organisation ID, Referred from Facility ID or Referred from Agency Code when Referred from Professional Group Type is either Specialist Medical Officer (Own DHB), Specialist Medical Officer (Other DHB) or Specialist Medical Officer (Private).
Guide for Use	Organisation ID is preferred, if it is available. Where a referral is received from a Specialist Medical Officer, this is used to identify the organisational source of the referral.
MOH Internal ODS Column Name	

10.17.20 Referred from Organisation ID [CM]

Definition	The HPI Identifier of the Referred from Organisation.
Data Type	Alphanumeric
Layout	GNNNNN-C
Data Domain	Code Set Name: ORG
Obligation	Conditionally mandatory A value must be provided for either Referred from Organisation ID, Referred from Facility ID or Referred from Agency Code when Referred from Professional Group Type is either Specialist Medical Officer (Own DHB), Specialist Medical Officer (Other DHB) or Specialist Medical Officer (Private). Where a referral is received from a Specialist Medical Officer, this is used to identify the organisational source of the referral.
Guide for Use	

10.17.21 Referred from Professional Group Type

Definition	The health professional group of the referrer.
Data Type	Numeric
Layout	NN
Data Domain	Code Set Name: REFPGT
Obligation	Mandatory
Guide for Use	Referrals from agencies such as the National Screening Programme can be identified with a code that is appropriate for the clinician making the referral, or as “Other". Used to identify the Profession Group Type of the Referrer.
MOH Internal ODS Column Name	REFERRAL_REFD_PROF_GROUP_TYPE

10.17.22 Referrer Defined Priority Category [O]

Definition	A code indicating the urgency of the referral as determined by the referrer
Data Type	Numeric
Layout	N
Data Domain	Code Set Name: PRICAT
Obligation	Optional
Guide for Use	The PRICAT code table identifies priority score codes that can be accepted by NPF. If alternative codes are used by the Submitting Organisation they should be

	mapped appropriately to one of these codes. If the Referral does not contain a Priority, use '9 – Not stated". This data element is required for business purposes when the referral is cancer related or the Service Sub-Type is likely to result in an Outpatient encounter. The data set will not be rejected if it is empty. Failure to supply a data element will be included in Consolidation Reporting.
MOH Internal ODS Column Name	REFERRAL_DEFINED_PRIO_CATEG

10.17.23 Referring Health Provider Code [O]

Definition	A unique code provided by an authorised body identifying the healthcare provider referring the patient.
Data Type	Alphanumeric
Layout	X(10)
Data Domain	
Obligation	Optional
Guide for Use	A value needs to be provided for either the Referring Health Provider Code or the Referred from Professional Group Code.
Other Names	Registration number
Source	Professional bodies such as NZ Medical Council and NZ Nursing Council or DHBs
MOH Internal ODS Column Name	REFERRAL_REFG_HEALTH_PROVIDER_CODE

10.17.24 Service Sub-Type

Definition	A code representing the sub type of the requested service. Provides additional information about the service requested.
Data Type	Numeric
Layout	NNNN
Data Domain	Code Table: SRVSUB
Obligation	Mandatory
Guide for Use	The code as defined by the referrer. The Service Sub Type data element is used for reporting on services that are of interest to Electives and the Faster Cancer Treatment programme. In addition to this the data element is used to provide information about national reporting times.

MOH Internal ODS Column Name	REFERRAL_SERV_SUB_TYPE

10.17.25 Service Type

Definition	A code for the specific type of service the patient is referred for.
Data Type	Numeric
Layout	N
Data Domain	Code Set Name: SRV
Obligation	Mandatory
Guide For Use	The code as defined by the referrer or assumed by the Submitting Organisation prior to Prioritisation.
MOH Internal ODS Column Name	REFERRAL_SERVICE_TYPE

10.17.26 Referring Health Specialty [CM]

Definition	The health specialty that has requested the service for the patient.
Data Type	Alphanumeric
Layout	ANN
Data Domain	Code Set Name: HLTHSP
Obligation	Conditionally Mandatory. Required when Referred from Professional Group Type is Specialist Medical Officer (Own DHB) or Specialist Medical Officer (Other DHB).
Guide for Use	Refer to Health Specialty Code in the Code Tables section for guidance on the use of codes.
MOH Internal ODS Column Name	

10.18. Referral Diagnosis

Other diagnosis information accompanying the Referral

Validation

For Referral Diagnosis integrity checking rules refer to the groups of rules *Generic Rules* and *What is a valid referral diagnosis?* in the Business Rules Catalogue (17 - Appendix D: Business Rules and Error Messages).

MOH Internal ODS Table Name

REFERRAL_DIAGNOSIS

10.18.1 Clinical TNM/Pathological TNM [O]

Definition	Indicates if the cancer is at a clinical or pathological stage
Data Type	Alphabetic
Layout	A
Data Domain	C - Clinical P - Pathological
Obligation	Optional
Guide for Use	Provide for a cancer diagnosis where relevant to the type of cancer diagnosed.
MOH Internal ODS Column Name	REF_DIAG_CLINICAL_PATHO_TNM

10.18.2 Date of Diagnosis [O]

Definition	The date on which the diagnosis was made
Data Type	Datetime
Layout	YYYY-MM-DDThh:mm:ss
Data Domain	
Obligation	Optional
Guide for Use	The Date of Diagnosis must not be later than the date file processed If available, this date should be provided where there is a Cancer Diagnosis. For cancer data the guide for use is as follows: The date of diagnosis is the date of the pathology report, if any, that first confirmed the diagnosis of cancer. This date may be found attached to a letter of referral or a patient's medical record from another institution or hospital. If this date is unavailable, or if no pathological test was done, then the date may be determined from one of the sources listed in the following sequence: 1. Date of the consultation at, or admission to, the hospital, clinic or institution when the cancer was first diagnosed. Note: do not use the admission date of the current admission if the patient had a prior diagnosis of this cancer.

	2. Date of first diagnosis as stated by a recognised medical practitioner or dentist. Note: This date may be found attached to a letter of referral or a patient's medical record from an institution or hospital. 3. Date the patient states they were first diagnosed with cancer. Note: This may be the only date available in a few cases (for example, patient was first diagnosed in a foreign country). If a patient is admitted for another condition (for example a broken leg or pregnancy), and a cancer is diagnosed incidentally then the date of diagnosis is the date that the decision-to-treat as cancer was made. Derived from Faster Cancer Treatment Indicators: Business Rules and Data Definitions - March 2014
MOH Internal ODS Column Name	REF_DIAG_DATE

10.18.3 Diagnosis Clinical Code

Definition	A clinical code identifying the diagnosis of the patient's presenting problem
Data Type	Alphanumeric
Layout	X(30)
Data Domain	A single valid code in the code set identified in Clinical Code System Provide a Concept ID when the system code is SNOMED CT
Obligation	Mandatory
Guide for Use	Provide “261665006 – Unknown” from SNOMED CT or “R69 – Unknown and unspecified causes of morbidity” from ICD10 when the Diagnosis Clinical Code is not stated on the referral
MOH Internal ODS Column Name	REF_DIAG_CLINICAL_CODE

10.18.4 Diagnosis Clinical Code System

Definition	A code representing the clinical coding system of the diagnosis clinical code
Data Type	Numeric
Layout	NN
Data Domain	Code System Name: CLINCODSYS
Obligation	Mandatory
Guide for Use	Either SNOMED CT or ICD 10 AM should be used.

MOH Internal ODS Column Name	REF_DIAG_CLINICAL_CODE_SYSTEM

10.18.5 Overall Stage Group - Cancer [O]

Definition	Describes the anatomical extent of disease at diagnosis based on stage categories of a staging classification
Data Type	Alphanumeric
Layout	X(10)
Data Domain	A valid code in the classification system identified in Overall Staging System - Cancer and the version of the classification system identified in Overall Staging System Version - Cancer.
Obligation	Optional
Guide for Use	
MOH Internal ODS Column Name	REF_DIAG_OVERALL_STAGE_GROUP_CAN

10.18.6 Overall Staging System - Cancer [CM]

Definition	Staging classification system used to determine the overall stage group.
Data Type	Numeric
Layout	NN
Data Domain	Code Set: STAGSYS
Obligation	Conditionally mandatory. Required if an Overall Stage Group - Cancer value has been provided.
Guide for Use	
MOH Internal ODS Column Name	REF_DIAG_OVERALL_STAGE_SYS_CAN

10.18.7 Overall Staging System Version - Cancer [CM]

Definition	Version number of staging classification system.
Data Type	Alphanumeric
Layout	X(10)
Data Domain	

Obligation	Conditionally mandatory. Required if an Overall Staging System – Cancer value has been provided.
Guide for Use	For recording of an edition use: Ed *N* (eg, Ed 2 for 2nd Edition) For recording a version use: V *N* (eg, V 2 for Version 2) For recording the year published: *NNNN* (eg, 2015 if published in 2015)
MOH Internal ODS Column Name	REF_DIAG_OVERALL_STAGE_SYS_VERSION_CAN

10.18.8 Referral Information ID

Definition	The identifier of the Referral Information that is unique within the Referral that it is associated with.
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -
Obligation	Mandatory
MOH Internal ODS Column Name	REF_INFORMATION_ID in REFERRAL_INFORMATION

10.18.9 Diagnosis Clinical Code Type [CM]

Definition	A code denoting which section of the ICD-10-AM clinical code table the clinical code falls within. Not applicable to other coding systems.
Data Type	Alphabetic
Layout	A
Data Domain	Code System Name: CLINCODTYPE
Obligation	Conditionally Mandatory. Required when Diagnosis Clinical Coding System is an ICD-10-AM edition. Must be null if Diagnosis Clinical Coding System is not an ICD-10-AM edition.
Guide for Use	This field is required to differentiate between different sections of the clinical code table. Must be a valid Clinical Code Type for the Clinical Code and System combination. This data element was introduced into the Collection in Phase 3 (July 2016). Prior to that the Clinical Code Type was not included in determining whether a supplied ICD-10-AM code was valid.
MOH Internal ODS Column Name	

10.19. Referral Information

Information that accompanies the referral such as a diagnosis.

MOH Internal ODS Table Name

REFERRAL_INFORMATION

10.19.1 NHI Number

Definition	A unique 7-character identification number, assigned to a patient by the Patient Index (National Health Index).
Data Type	Alphanumeric
Layout	AAANNNC
Obligation	Mandatory
Guide for Use	The NHI number of the patient that is associated with the referral
Standard	HISO 10046 NHI Number

10.19.2 Referral ID

Definition	The identifier of the Referral that the Referral Information is directly associated with.
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -
Obligation	Mandatory
Guide for Use	Used to link activities and referral information together within a Service Sequence
MOH Internal ODS Column Name	The association to the Referral entity (REFERRAL) is via foreign key REFERRAL-KEY

10.20. Remove Activity

Remove Activity contains the identifiers needed to remove an Activity.

Validation

For remove validation rules refer to the group of rules *What is a valid Remove Operation?* in the attached Business Rules Catalogue (17 - Appendix D: Business Rules and Error Messages).

10.20.1 Activity ID

Definition	An identifier that is unique within the Referral that the health care activity is associated with.
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -
Obligation	Mandatory
Guide for Use	
Other Names	Identifier (NPF Phase 1)

10.20.2 Referral ID

Definition	The identifier of the Referral that the Activity is directly associated with.
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -
Obligation	Mandatory
Guide for Use	Used to link activities together within a Service Sequence

10.21. Remove Activity Outcome

Remove Activity Outcome contains the identifiers needed to remove an Activity Outcome.

Validation

For remove validation rules refer to the group of rules *What is a valid Remove Operation?* in the attached Business Rules Catalogue (17 - Appendix D: Business Rules and Error Messages).

10.21.1 Activity ID

Definition	An identifier that is unique within the Referral that the health care activity is associated with.
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -
Obligation	Mandatory
Guide for Use	
Other Names	Identifier (NPF Phase 1)

10.21.2 Activity Outcome ID

Definition	The identifier of an Activity Outcome that is unique to the Activity it is associated with.
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -
Obligation	Mandatory

10.21.3 Referral ID

Definition	The identifier of the Referral that the Activity Outcome is associated with.
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -
Obligation	Mandatory
Guide for Use	Used to link activities together within a Service Sequence

10.22. Remove Decision Outcome

Remove Decision Outcome contains the identifiers needed to remove a Decision Outcome.

Validation

For remove validation rules refer to the group of rules *What is a valid Remove Operation?* in the attached Business Rules Catalogue (17 - Appendix D: Business Rules and Error Messages).

10.22.1 Activity ID

Definition	An identifier that is unique within the Referral that the health care activity is associated with.
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -
Obligation	Mandatory
Guide for Use	
Other Names	Identifier (NPF Phase 1)

10.22.2 Decision Outcome ID

Definition	The identifier of a Decision Outcome that is unique to the Activity that it is associated with.
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -
Obligation	Mandatory

10.22.3 Referral ID

Definition	The identifier of the Referral that the Decision Outcome is associated with.
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -
Obligation	Mandatory
Guide for Use	Used to link activities together within a Service Sequence

10.23. Remove Referral

Remove Referral contains the identifiers needed to remove a Referral.

Validation

For remove validation rules refer to the group of rules *What is a valid Remove Operation?* in the attached Business Rules Catalogue (17 - Appendix D: Business Rules and Error Messages).

10.23.1 Referral ID

Definition	The identifier of the Referral.
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -
Obligation	Mandatory
Guide for Use	Used to link activities together within a Service Sequence

10.24. Remove Referral Information

Remove Referral Information contains the identifiers needed to remove a Referral Information entity.

Validation

For remove validation rules refer to the group of rules *What is a valid Remove Operation?* in the attached Business Rules Catalogue (17 - Appendix D: Business Rules and Error Messages).

10.24.1 Referral ID

Definition	The identifier of the Referral that the Referral Information is directly associated with.
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -
Obligation	Mandatory
Guide for Use	Used to link activities and referral information together within a Service Sequence

10.24.2 Referral Information ID

Definition	The identifier of the Referral Information that is unique within the Referral that it is associated with.
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -
Obligation	Mandatory

11. Data Elements – Operational Definitions

This section contains the definitions of the code sets specified in the Data Domain attribute of the data element definition for Collection data elements.

11.1.1 Batch

A batch is a unit of submission of data for the NPF Collection.

A batch comprises a collection of data files plus one summary file that is compressed into a zip file for transmission.

The batch file name contains identification information that is used for the management of the batch by the NPF System and MOH Data Administrators.

MOH Internal ODS Table Name

BATCH

11.1.1.1 Business Transaction ID

Definition	A unique identifier for a batch of files assigned by the organisation submitting the batch
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -
Obligation	Mandatory
Guide for Use	The Business Transaction ID can be reused if it has been rejected at the pre-processing stage or has been reversed.
Other names	Batch Identifier, Batch ID, Batch number
MOH Internal ODS Column Name	BATCH_BIZ_TRANS_ID

11.1.1.2 Creation Datetime

Definition	The date and time that the batch was created
Data Type	Datetime
Layout	YYYY-MM-DDThh:mm:ss
Obligation	Mandatory
Guide for Use	The Creation Datetime must not be later than the date file processed.

11.1.1.3 Submitting Organisation ID

Definition	The HPI identifier that uniquely identifies the organisation submitting the batch.

Data Type	Alphanumeric
Layout	ANNNNN-C
Data Domain	Code Set Name: ORG
Obligation	Mandatory
MOH Internal ODS Column Name	SUBMT_ORGANISATION_CODE

11.1.1.4 Target System

Definition	The target system in which the batch is to be processed eg. NPF
Data Type	Alphabetic
Layout	AAA
Data Domain	'NPF'
Obligation	Mandatory

11.1.1.5 Target System Environment

Definition	The target system environment in which the batch is to be processed
Data Type	Alphabetic
Layout	AAAA
Data Domain	Code Set Name: SYSENV
Obligation	Mandatory

11.1.1.6 Target Version

Definition	Target version for the business rules to apply to this batch. E.g 1.0
Data Type	Decimal
Layout	NNN.N
Obligation	Mandatory
Guide for Use	In Phase 3 the Target Version will always be 3.0.
MOH Internal ODS Column Name	BATCH_VERSION

11.1.2 Batch Summary

A summary total for a message type in a batch.

Each batch includes a summary file containing a Batch Message Type Summary for each Message Type in the batch.

11.1.2.1 Message Type

Definition	A code indicating the type of message in the file
Data Type	Alphabetic
Layout	A(6)
Data Domain	Code Set Name: MSGTYPE
Obligation	Mandatory
Other Names	Known as Event Type in Phase 1.

11.1.2.2 Number of Files

Definition	The total number of files in the batch for the Message Type
Data Type	Integer
Layout	N(5)
Obligation	Mandatory

11.1.3 Error

An error result from processing a file.

An error segment is attached to the response in the response file if a batch level error is detected in Batch Pre-Processing or a file level error is detected in Batch Processing.

11.1.3.1 Code

Definition	A code for the error
Data Type	Alphanumeric
Layout	AAANNNNN
Data Domain	Code Set Name: ERROR
Obligation	Mandatory

Guide for Use	The Code System attribute in the XML for an error code contains 'ERROR'

11.1.3.2 Message

Definition	A description of the error. May contain place-holders that are populated with contextual information by the application.
Data Type	Alphanumeric
Layout	X(1023)
Data Domain	The message associated with the Code. Refer to “13.1.4 - ERROR Error Message”.
Obligation	Mandatory

11.1.4 File

A file contains data and control information.

A file can be an input activity file containing data for the NPF collection or it could be an output response file containing results of processing an input activity file.

11.1.4.1 Business Transaction ID

Definition	The unique identifier assigned by the organisation for the batch containing the file
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -
Obligation	Mandatory
Other names	Batch Identifier, Batch ID, Batch number

11.1.4.2 Correlation ID

Definition	The unique identifier for the file assigned by the organisation submitting the file
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -
Obligation	Mandatory

Guide for Use	A Correlation ID may be reused if it is not active in the collection. The Correlation ID is active when it exists in the collection and a file to which it belongs has not been rejected or reversed. The Correlation ID for a summary file is treated in the same way as a Correlation ID for a data file in determining uniqueness.
Other Names	File Identifier, File ID

11.1.4.3 Message Type

Definition	A code indicating the type of message in the file
Data Type	Alphabetic
Layout	A(6)
Data Domain	Code Set Name: MSGTYPE
Obligation	Mandatory
Other Names	Known as Event Type in Phase 1.

11.1.4.4 Submitting Organisation ID

Definition	The HPI identifier that uniquely identifies the organisation submitting the file.
Data Type	Alphanumeric
Layout	GNNNNN-C
Data Domain	Code Set Name: ORG
Obligation	Mandatory

11.1.5 Header

The Header contains control information about the accompanying dataset.

Validation

For header validation rules refer to the group of rules *What is a valid input file header?* in the attached Business Rules Catalogue (17 - Appendix D: Business Rules and Error Messages).

11.1.5.1 Business Transaction ID

Definition	The unique identifier assigned by the organisation for the batch containing the file
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -

Obligation	Mandatory
Other names	Batch Identifier, Batch ID, Batch number

11.1.5.2 Correlation ID

Definition	The unique identifier for the file assigned by the organisation submitting the file
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -
Obligation	Mandatory
Other Names	File Identifier, File ID

11.1.5.3 Submitting Application ID

Definition	The ID of the application generating the file
Data Type	Alphanumeric
Layout	X(20)
Data Domain	NNPAC extract system identifier of the Submitting Organisation
Obligation	Mandatory
Guide for Use	

11.1.5.4 Submitting Facility

Definition	The HPI identifier that uniquely identifies the facility submitting the file.
Data Type	Alphanumeric
Layout	FNNNNN-C
Data Domain	Code Set Name: FAC
Obligation	Mandatory
Guide for Use	

11.1.5.5 Submitting Organisation ID

Definition	The HPI identifier that uniquely identifies the organisation submitting the file.
Data Type	Alphanumeric

Layout	GNNNNN-C
Data Domain	Code Set Name: ORG
Obligation	Mandatory
Guide for Use	

11.1.6 Warning

A warning result from processing a file.

A warning segment is attached to the response in the response file if a warning is generated in Batch Processing.

11.1.6.1 Code

Definition	A code for the warning
Data Type	Alphanumeric
Layout	AAANNNNN
Data Domain	Code Set Name: WARN
Obligation	Mandatory
Guide for Use	The Code System attribute in the XML for an error code contains 'WARN'

11.1.6.2 Message

Definition	A description of the warning. May contain place-holders that are populated with contextual information by the application.
Data Type	Alphanumeric
Layout	X(1023)
Data Domain	The message associated with the Code. Refer to “13.1.5 - WARN Warning Message”.
Obligation	Mandatory

11.1.7 Response Header

The Response Header contains the result of processing an input file.

If processing resulted in any errors or warnings there will be a dataset containing error/warning messages.

11.1.7.1 Acknowledgement Code

Definition	A code indicating the result of the NPF system processing the input file.
Data Type	Alphabetic
Layout	AA
Data Domain	Code Set Name: ACK
Obligation	Mandatory
Guide for Use	System generated. Applicable to the Response File Header only.

11.1.7.2 Business Transaction ID

Definition	The unique identifier assigned by the organisation for the batch containing the file
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, - or blank if this element was not received from the Submitting Organisation in an invalid file
Obligation	Mandatory
Other names	Batch Identifier, Batch ID, Batch number

11.1.7.3 Correlation ID

Definition	The unique identifier for the file assigned by the organisation submitting the file
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, - or blank if this element was not received from the Submitting Organisation in an invalid file
Obligation	Mandatory
Guide for Use	A Correlation ID may NOT be reused if an Activity File is rejected. The Correlation ID for the Summary File is neither validated nor recorded in the NPF system therefore it may be reused.

11.1.7.4 Submitting Application ID

Definition	The ID of the application generating the file
Data Type	Alphanumeric

Layout	X(20)
Data Domain	NNPAC extract system identifier of the Submitting Organisation or blank if this element was not received from the Submitting Organisation in an invalid file
Obligation	Mandatory

11.1.7.5 Submitting Facility

Definition	The HPI identifier that uniquely identifies the facility submitting the file.
Data Type	Alphanumeric
Layout	FNNNNN-C
Data Domain	Code Set Name: FAC or blank if this element was not received from the Submitting Organisation in an invalid file
Obligation	Mandatory

11.1.7.6 Submitting Organisation ID

Definition	The HPI identifier that uniquely identifies the organisation submitting the file.
Data Type	Alphanumeric
Layout	GNNNNN-C
Data Domain	Code Set Name: ORG or blank if this element was not received from the Submitting Organisation in an invalid file
Obligation	Mandatory

11.1.7.7 Folder Submitted To

Definition	The path of the folder the input file was submitted to
Data Type	Alphanumeric
Layout	X(30)
Data Domain	${Organisation ID}/${System Environment}/Dropoff
Obligation	Mandatory

11.1.8 Impacted Activity

Impacted Activity contains the identifiers of a child Activity record that was

- removed when a referral was removed during Batch Processing **or**
- re-instated when a remove operation is reversed during Batch Reversal.

11.1.8.1 Activity ID

Definition	The identifier of an activity that was removed or re-instated
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters A-Z, a-z, 0-9, -
Obligation	Mandatory

11.1.8.2 Impacted Activity Outcome(s)

Definition	Child Activity Outcome(s) of the Impacted Activity
Layout	Refer to Impacted Activity Outcome
Obligation	Optional
Guide for Use	When an Impacted Activity has dependent Activity Outcomes, the Impacted Activity Outcomes are included in the data structure as nested elements under the Impacted Activity.

11.1.8.3 Impacted Decision Outcome(s)

Definition	Child Decision Outcome(s) of the Impacted Activity
Layout	Refer to Impacted Decision Outcome
Obligation	Optional
Guide for Use	When an Impacted Activity has dependent Decision Outcomes, the Impacted Decision Outcomes are included in the data structure as nested elements under the Impacted Activity.

11.1.8.4 Referral ID

Definition	The identifier of the Referral that was removed or re-instated.
Data Type	Alphanumeric
Layout	X(36)

Data Domain	Characters A-Z, a-z, 0-9, -.
Obligation	Mandatory
Guide for Use	Used to link activities together within a Service Sequence

11.1.9 Impacted Activity Outcome

Impacted Activity Outcome contains the identifiers of a child Activity Outcome record that was

- removed when an activity was removed during Batch Processing **or**
- re-instated when a remove operation is reversed during Batch Reversal.

11.1.9.1 Activity ID

Definition	The identifier of the activity that was removed or re-instated
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters A-Z, a-z, 0-9, -
Obligation	Mandatory

11.1.9.2 Activity Outcome ID

Definition	The identifier of an Activity Outcome that was removed or re-instated.
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters A-Z, a-z, 0-9, -
Obligation	Mandatory

11.1.9.3 Referral ID

Definition	The identifier of the Referral that the Activity Outcome is associated with.
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters A-Z, a-z, 0-9, -.
Obligation	Mandatory
Guide for Use	Used to link activities together within a Service Sequence
Other Names	Local Referral Identifier (Phase 1), Referral ID

11.1.10 Impacted Decision Outcome

Impacted Decision Outcome contains the identifiers of a child Decision Outcome record that was

- removed when an activity was removed during Batch Processing **or**
- re-instated when a remove operation is reversed during Batch Reversal.

11.1.10.1 Activity ID

Definition	The identifier of the activity that the Decision Outcome is associated with
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -
Obligation	Mandatory

11.1.10.2 Decision Outcome ID

Definition	The identifier of a Decision Outcome that was removed or re-instated
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -
Obligation	Mandatory

11.1.10.3 Referral ID

Definition	The identifier of the Referral that the Decision Outcome is associated with.
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -.
Obligation	Mandatory
Guide for Use	Used to link activities together within a Service Sequence
Other Names	Local Referral Identifier (Phase 1), Referral ID

11.1.11 Impacted Referral Information

Impacted Referral Information contains the identifiers of a child Referral Information record that was

- removed when a referral was removed during Batch Processing **or**
- re-instated when a remove operation on a referral is reversed during Batch Reversal.

11.1.11.1 Referral ID

Definition	The identifier of the Referral that Referral Information is associated with.
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -
Obligation	Mandatory
Guide for Use	Used to link activities and referral information together within a Service Sequence

11.1.11.2 Referral Information ID

Definition	The identifier of the Referral Information that was removed or re-instated.
Data Type	Alphanumeric
Layout	X(36)
Data Domain	Characters allowed: A-Z, a-z, 0-9, -
Obligation	Mandatory

12. Collection Code Sets

This section contains the definitions of the code sets specified in the Data Domain attribute of the data element definition for Collection data elements.

12.1. Versioning of code sets

Changes to codes in the NPF code sets is managed by start and end dates for individual codes.

In this method each code has a date when the code was introduced and/or a date when the code was withdrawn from use. Code validation includes the following checks that the code is active when the activity in the dataset occurred:

- If the code Start Date is not null the event date on the input record must be greater than or equal to the code Start Date.
- If the code End Date is not null the event date on the input record must be less than or equal to the code End Date.

The event dates in the datasets that are used for validation are as follows:

Dataset	Event date
Referral	Date Referral Received
Referral Diagnosis	Date of Diagnosis
Prioritisation	Date Prioritised
Notification	Date Patient/Carer Notified
Booking	Date Booking Created
Encounter	Encounter End Date
Encounter Outcome	Encounter End Date of the associated Encounter
Exception	Date Exception Outcome Assigned
Diagnosis Decision Outcome	Date of Diagnosis

12.2. AGENCY Agency Code

Definition: A code that uniquely identifies an agency. An agency is an organisation, institution or group of institutions that contracts directly with the principal health service purchaser to deliver healthcare services to the community.

Source: Ministry of Health - National Collections - Common Code Tables

Common codes: Refer to the Agency Code Table under Common Codes for National Collections on the Ministry's web site at http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables.

NPF specific code: 9993 'Not required Phase 1' - Used to populate migrated Phase 1 data where the Agency Code was not captured and the data from Phase 2 onwards requires an Agency Code.

Agency Code 9993 is mapped to Organisation ID Z99993-Z 'Not required Phase 1' for reporting purposes.

Used in the Following Entities

Referral

12.3. ATTOUT Attendance Outcome

Definition: A code indicating whether the encounter was attended by the patient or not.

Other names: Attendance Code (NNPAC)

Source: Ministry of Health - National Collections - National Patient Flow code set as there are additional values in NPF to those in the NNPAC code set.

Note: The numeric code set of NPF Phase 1 has been replaced with an alphabetic code set containing commonly used codes.

Guidance on valid combinations of Attendance Outcome, Encounter Outcome Decision, Encounter Outcome Reason and Destination is provided in “Appendix E: Encounter Outcome Scenarios”.

Code	Description	Start date	End date	Explanation
ATT	Attended, service delivered	2014-07-01	9999-12-31	The patient attends their booked encounter
AND	Attended, service not delivered or incomplete	2014-07-01	9999-12-31	The patient attends the booked encounter however the appointment was cancelled by the Submitting Organisation or the service was incomplete.
DNA	Did not attend	2014-07-01	9999-12-31	The patient did not attend the booked encounter and there was no communication before the appointment. If there was a

Code	Description	Start date	End date	Explanation
				communication, this is classified as a cancellation. There is no agreed timeframe for communication prior to the appointment – Submitting Organisations need to determine this locally.
DNW	Did not wait	2014-07-01	9999-12-31	The patient arrives for a non-admitted encounter but does not wait to receive the service. If the patient leaves without arranging for a new Booking, the Encounter Outcome Decision is determined in the same way as a DNA. If the patient makes a new Booking before leaving this should be treated as a Patient Reschedule.

Used in the Following Entities

Activity: Encounter

12.4. CANDC Cancer Diagnosis Code

This code set is not used in the Collection, from Phase 3.

12.5. CLINCODSYS Clinical Coding System

Definition: A code identifying a clinical coding system

Source: Ministry of Health - National Collections - Common Codes

Code	System
13	ICD-10-AM sixth edition
14	ICD-10-AM eighth edition
50	SNOMED-CT

Code	System
90	MOH internal code
99	Local Code

Note: As experience with SNOMED CT grows, additional validation rules may be implemented to restrict submitted values to those relevant to the Collection.

Used in the Following Entities

Activity: Booking

Activity: Encounter

Activity: Exception

Activity: Notification

Activity: Prioritisation

Diagnosis

Encounter Outcome

Referral Diagnosis

12.6. CLINEX Clinical Exclusion Code

Definition: A code indicating whether the procedure is normal, planned, or surveillance (exclude from KPI).

Other names: Staged/Planned Procedure Flag (NBRS)

Source: Ministry of Health - National Collections NPF and NBRS code sets

Code	Description	Start date	End date	Explanation
N	Normal	2014-07-01	9999-12-31	Used where none of the other flags apply
P	Planned	2014-07-01	9999-12-31	Where the timing of the service is intentionally delayed for clinical reasons, but the timeframe is known. The Optimal Date for Service is to be provided. Examples: The assessment is an FSA that is a referral for follow up care from private or another

Code	Description	Start date	End date	Explanation
				Submitting Organisation and is required in 12 months. The referral is for a Diagnostic Test that is required three months post-surgery.
S	Surveillance	2014-07-01	9999-12-31	Not valid for use with a Service Type of "1 – First Specialist Assessment". A Surveillance code is used when the patient requires an ongoing series of routine surveillance procedures. The surveillance procedures are provided at regular (i.e. annual or longer) intervals to assess health status. The Optimal Date for Service is to be provided.
G	Staged	2014-07-01	9999-12-31	Used when the procedure requires two or more encounters to complete The Optimal Date for Service is to be provided.
T	Clinical Trial	2014-07-01	9999-12-31	Used when a patient has agreed to be involved in a clinical trial.
D	Waiting for Donor	2014-07-01	9999-12-31	Used when a patient is waiting for a deceased donor transplant

Used in the Following Entities

Activity: Prioritisation

12.7. DEST Destination

Definition: A code representing the next step in the patient journey or the completion of the patient's journey for the purposes of the Collection.

Source: Ministry of Health - National Collections - National Patient Flow code set

Guidance on valid combinations of Attendance Outcome, Encounter Outcome Decision, Encounter Outcome Reason and Destination is provided in "Appendix E: Encounter Outcome Scenarios".

Code	Description	Start Date	End Date	Explanation
01	Elective Waiting List	2014-07-01	9999-12-31	The patient is accepted on to the **Elective** wait list,
02	Other NON DHB organisation	2014-07-01	9999-12-31	For example, private hospital, Maori non GP provider. This

				could also includes coroner or funeral home.
03	DHB - Community support care	2014-07-01	9999-12-31	For example, specialist community nursing services, allied health
04	Other DHB	2014-07-01	9999-12-31	The patient requires a service provided by another DHB.
05	Other health specialty	2014-07-01	9999-12-31	Same Submitting Organisation, also includes radiology
06	Outpatient clinic	2014-07-01	9999-12-31	The patient requires assessment and/or treatment in the DHB's Outpatient Clinic
07	Aged residential care	2014-07-01	9999-12-31	The patient requires care in an Aged residential care setting
08	Hospice /palliative care services	2014-07-01	9999-12-31	The patient requires hospice or palliative care services
09	Primary care	2014-07-01	9999-12-31	The patient requires ongoing care or support by their Primary Care provider
10	Overseas	2014-07-01	9999-12-31	The patient will no longer be treated in New Zealand
11	Referrer	2014-07-01	9999-12-31	The patient is re-directed to the Referrer for further consideration and/or care. Note: this may be another DHB health professional.
12	Self-care	2014-07-01	9999-12-31	The DHB has provided the information, support and skills required to enable the patient to manage their own care.
13	Inpatient care	2014-07-01	9999-12-31	The patient requires inpatient care.
14	New booking	2014-07-01	9999-12-31	Another appointment is required to progress the assessment and/or treatment of the patient
15	MDM	2014-07-01	9999-12-31	A multidisciplinary meeting (MDM) is required to progress the patient's assessment and/or treatment.
92	Phase 1 referred for test	2014-07-01	9999-12-31	To be used for Phase 1 data that is migrated to Phase 2

Used in the Following Entities

Encounter Outcome

12.8. DOMCODE Domicile

Definition: Statistics NZ Health Domicile Code representing a person's usual residential address that is used for statistical reporting and health funding payments. It is directly aligned with the census area unit.

Usual residential address is defined as the address of the dwelling where a person considers himself or herself to usually reside, except in circumstances listed in the guidelines. (Statistics NZ definition of 'usually resident'—see http://www.stats.govt.nz/surveys_and_methods/methods/classifications-and-standards/classification-related-stats-standards/usual-residence/definition.aspx)

If a person usually lives in a rest home or a hospital, that is considered their usual residential address.

Only used for patient data in NPF.

Source: Ministry of Health - National Collections - Common Code Tables

Refer to the Domicile Code table under Common Codes for National Collections on the Ministry's website:

http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/domicile-code-table

Note: The Domicile Codes are reviewed and updated periodically by Statistics NZ. The Ministry implements these changes at its discretion, and advises Submitting Organisations of the effective date of the change. The Collection requires submission of the Domicile Code approved for use by the Ministry at the time that the event took place to ensure accuracy and consistency in reporting. This was not enforced for Phase 1 data on implementation of Phase 2, but will be applied for data supplied as part of Phase 2 onwards.

Used in the Following Entities

Patient

Activity

12.9. ENCOUTD Encounter Outcome Decision

Definition: A code representing the outcome of the encounter

Source: Ministry of Health - National Patient Flow code set

Guidance on valid combinations of Attendance Outcome, Encounter Outcome Decision, Encounter Outcome Reason and Destination is provided in "Appendix E: Encounter Outcome Scenarios".

Code	Description	Start Date	End Date	Notes
01	Presenting Referral	2014-07-01	9999-12-31	Referred elsewhere for something unrelated to the current referral reason. When this Encounter Outcome Decision is being used, the Encounter Outcome Reason would be Service Complete.
02	Referral (Related)	2014-07-01	9999-12-31	Where the patient is going to be referred to another health specialty or organisation for the current referral reason (e.g., tests, surgery being

Code	Description	Start Date	End Date	Notes
				provided by another specialty, cardiology consult, anaesthetic assessment prior to decision to treat).
03	Treatment Best Option	2014-07-01	9999-12-31	Patient has been assessed and it is determined that the patient would benefit from treatment. Includes all patients where it is later determined that they are below the DHB's threshold for acceptance for treatment or are medically unfit for treatment.
04	Ongoing Care	2014-07-01	9999-12-31	Where the patient requires further care or support from the referring Service, or another Service. If the treatment required is a surgical procedure, 03 – Treatment Best Option should be used.
05	Nothing Further Required	2014-07-01	9999-12-31	Service is complete. Nothing further is required from this health speciality e.g. requested test has been completed and results sent to Referrer; requested procedure/ treatment has been provided and patient will receive follow-up care in the community. Use for all Attendance Outcomes, including Attended Not Delivered/Incomplete (AND), Did Not Attend (DNA) or Did Not Wait (DNW), if the decision is not to arrange a new Booking. Provide an Encounter Outcome Reason of Patient Choice/Declined for DNA or DNW. For AND, use one of the following: 09 - Patient Medical Reason 10 - Patient Choice/Declined 20 - Patient Deceased 50 - Equipment Unavailable 51 - Information Absent 52 - Personnel Unavailable
06	New Appointment Required	2014-07-01	9999-12-31	For Attended Not Delivered/Incomplete (AND), Did Not Attend (DNA) or Did Not Wait (DNW), where the patient is not referred back to primary care.
07	Palliative Care	2014-07-01	9999-12-31	Use when the Patient is to be admitted to a palliative care service. Do not use for an intervention that may be palliative in nature.

Code	Description	Start Date	End Date	Notes
08	Non-Intervention Management	2014-07-01	9999-12-31	An expectant or observational approach pending change in the patient's circumstances. It is a period of active management not unmanaged non-treatment.

Used in the Following Entities

Encounter Outcome

12.10. ENCOUTR Encounter Outcome Reason

Definition: The reason the encounter decision was made

Source: Ministry of Health - National Patient Flow code set

Guidance on valid combinations of Attendance Outcome, Encounter Outcome Decision, Encounter Outcome Reason and Destination is provided in "Appendix E: Encounter Outcome Scenarios".

Code	Description	Start date	End date	Explanation
01	Service Complete	2014-07-01	9999-12-31	The service referred for is now complete. Valid for Encounter Outcome Decisions of Presenting Referral and Nothing Further Required
02	Acute Admission	2014-07-01	9999-12-31	Valid for Encounter Outcome Decision of Treatment Best Option, and used with Destination – Inpatient Care
03	Arranged Admission	2014-07-01	9999-12-31	Patient to be admitted within 7 days of encounter
04	Accepted on Waitlist	2014-07-01	9999-12-31	Use when a patient is provided certainty; that is, when treatment is the best option, the patient is above the local access threshold and the patient has confirmed they are available for treatment.
05	Declined - Below Threshold	2014-07-01	9999-12-31	Use where the clinician determines that the patient would benefit from treatment, but the Referral is below the DHB's capacity or access threshold and

Code	Description	Start date	End date	Explanation
				the patient is to be returned to Primary Care. A Prioritisation Activity should be submitted with the Encounter Outcome.
06	Declined - Active Review	2014-07-01	9999-12-31	Use where the clinician determines that the patient would benefit from treatment but the Referral is just below the DHB's capacity or access threshold AND the DHB is using Active Review in NBRS AND the DHB intends to follow the patient in Outpatients. The Destination will be Outpatient Clinic. A Prioritisation Activity should be submitted with the Encounter Outcome.
07	Observation And Management	2014-07-01	9999-12-31	Where the patient will not receive treatment, but requires further care or support. Observation and Management requires active management of the patient by the agency/organisation identified as the Destination.
08	Declined - Patient Not Medically Fit	2014-07-01	9999-12-31	Use where the Encounter Outcome Decision is Treatment Best Option, however, it is determined that the patient is not medically suitable for treatment. May be submitted as a second or subsequent Encounter Outcome following an anaesthetic assessment.
09	Patient Medical Reason	2014-07-01	9999-12-31	Valid for Attendance Outcome of Attended – Not Delivered / Incomplete. Use when the Encounter was terminated prior to completion for a patient medical reason
10	Patient Choice/Declined	2014-07-01	9999-12-31	Use where Encounter Outcome Decision is Treatment Best Option and the Patient has declined, or chosen an alternative (such as Private, where the Destination will be Non DHB Organisation). May also be used where the Attendance Outcome is Attended Not Delivered/Incomplete and the Encounter Outcome Decision is Nothing Further Required
11	Additional Service Required	2014-07-01	9999-12-31	Use where the Encounter Outcome Decision is Related Referral, where there are Additional services that are required that are related to the Service

Code	Description	Start date	End date	Explanation
				provided (e.g., tests, cardiology consult, anaesthetic assessment).
12	MDM Required	2014-07-01	9999-12-31	Use when a multidisciplinary meeting (MDM) is required to progress the patient's assessment and/or treatment.
20	Patient Deceased	2014-07-01	9999-12-31	Patient attended the encounter but died during or as a result of that encounter. Use where the Attendance Outcome is Attended – Service Not Delivered/Incomplete, or where the Service (a procedure/treatment) was completed, but the patient died prior to discharge.
50	Equipment Unavailable	2014-07-01	9999-12-31	Use where Attendance Outcome is Attended – Service Not Delivered/Incomplete, because equipment needed for the procedure/test was unavailable.
51	Information Absent	2014-07-01	9999-12-31	Use where Attendance Outcome is Attended – Service Not Delivered/Incomplete, because information that was necessary for the encounter was not provided or was not available.
52	Personnel Unavailable	2014-07-01	9999-12-31	Use where Attendance Outcome is Attended – Service Not Delivered/Incomplete, and personnel scheduled for the encounter were unavailable.
53	Service Not Delivered	2014-07-01	9999-12-31	Use where the Attendance Outcome is DNA or DNW and the Encounter Outcome Decision is New Appointment Required
93	Not required Phase 1	2014-07-01	9999-12-31	To be used for Phase 1 to Phase 2 migration where Encounter Outcome Reason cannot be derived for Phase 1

Used in the Following Entities

Encounter Outcome

12.11. ENCTYP Encounter Type

Definition: A code representing the patient's type of encounter

Source: Ministry of Health - National Patient Flow code set

Code	Description	Start Date	End date	Explanation
1	Inpatient	2014-07-01	9999-12-31	Use where the intended procedure/treatment or investigation/test is intended to be provided as an inpatient admission
2	Day Patient	2014-07-01	9999-12-31	A patient admitted for healthcare with a length of stay three hours or more but less than one day, regardless of intent. Day case events will have the same event start and end date. This term is synonymous with ‘same day patient’ and ‘short stay event’
3	Outpatient – Patient Present	2014-07-01	9999-12-31	Use where the intent is for the Encounter to be provided on an Outpatient basis.
4	Outpatient – Remote	2014-07-01	9999-12-31	Use where the intent is for the Encounter to be provided remotely, either through non-contact assessment, or telemedicine. Would include MDMs
8	Not required Phase 1	2014-07-01	9999-12-31	Used to populate Phase 1 migrated data where an Encounter Outcome Reason cannot be derived from the Phase 1 Service Sub-Type
9	Not required Phase 2	2015-10-01	2016-06-30	

Used in the Following Entities

Activity: Booking

Activity: Encounter

Activity: Exception

Activity: Notification

Activity: Prioritisation

12.12. ETHNICITY Ethnicity

Definition: Ethnicity is the ethnic group or groups that people identify with or feel they belong to. Ethnicity is a measure of cultural affiliation, as opposed to race, ancestry, nationality or citizenship. Ethnicity is self-perceived and people can belong to more than one ethnic group.

An ethnic group is made up of people who have some or all of the following characteristics:

- a common proper name
- one or more elements of common culture which need not be specified, but may include religion, customs, or language
- unique community of interests, feelings and actions
- a shared sense of common origins or ancestry, and
- a common geographic origin.

Standard: HISO 10046 Ethnicity

Source: Statistics New Zealand

Ethnicity New Zealand Standard Classification 2005

Ethnicity Level 4 codes: Refer to Statistics New Zealand website: http://www.stats.govt.nz/methods/classifications-and-standards/classification-related-stats-standards/ethnicity.aspx

Ethnicity Level 2 codes: Refer to the Ethnicity Code table under Common Codes for National Collections on the Ministry's website: http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/ethnicity-code-tables

Note: The HISO standard is that ethnicity should be provided to level 4, however this standard is still being implemented. If ethnicity is recorded at code level 2 it should be submitted as such for the time being.

Used in the Following Entities

Patient

12.13. EXCPTOUT Exception Outcome

Definition: The status of the referral at a particular point in time.

Source: Ministry of Health - National Collections - National Patient Flow code set

Code	Description	Start date	End date	Explanation
1	Suspended	2014-07-01	9999-12-31	The referral is to be suspended for a patient reason – i.e. the patient is not available for a personal or medical reason. Suspends can only be used where a patient's pathway needs to be suspended by more than 10 days, or less than 120 days.
2	Closed	2014-07-01	9999-12-31	The referral is to be closed. This is applied when a patient (or referrer) notifies that the

				Service referred for is no longer required. A 'Closed' Exception code will close the Service Sequence. Once a referral is closed using Exception Handling no further Activities should be submitted for that referral. Closed referrals cannot be Reactivated.
3	Reactivate	2014-07-01	9999-12-31	This is used when a referral that had previously been Suspended is Reactivated.

Used in the Following Entities

Activity: Exception

12.14. EXCPREA Exception Outcome Reason

Definition: The reason for the exception

Source: Ministry of Health - National Collections - National Patient Flow code set

Code	Description	Start date	End date	Valid for Exception Outcome Code	Notes
1	Suspended – patient not available	2014-07-01	9999-12-31	1	Used where a patient has indicated they are not available to attend a planned Encounter for personal reasons, for longer than 10 days but less than 120 days. If not for patient's personal reasons this code should only be used following a DNA or DNW at Encounter.
2	Reactivated – patient available	2014-07-01	9999-12-31	3	Used to reactivate all suspension activities. An Exception Handling Activity of "3 – Reactivate" must be submitted for any suspended referrals before any other activity is submitted. The only exclusion to this requirement is that an Exception Handling Activity of "2 – Closed" may be submitted while a patient is suspended. **Please note that initial guidance in the file specification indicated that the submission of any activity (Notification, Booking, Prioritisation, Encounter) would reactivate a suspended referral; however as the data in the collection has matured it has become apparent that this approach is likely to result in confusion and accidental reactivation of referrals that should remain suspended. Therefore submitting an Exception Handling Reactivation Activity is the only way to reactivate a referral**
3	Cancelled – patient reason	2014-07-01	9999-12-31	2	To be used when the patient makes the decision not to proceed with the service. This might also include if the patient moves out of the region, and opts not to remain on the current DHB's list. This Exception Reason should not be used at the point of Referral or Prioritisation, as it should only be used after a Prioritisation is Accepted. It should only be used for emergent, unforeseen scenarios whereby the patient declines treatment.

Code	Description	Start date	End date	Valid for Exception Outcome Code	Notes
4	Cancelled – advised patient deceased	2014-07-01	9999-12-31	2	To be used where the DHB is made aware that the patient has died prior to receiving the service for which they were referred. If a patient dies during or after receiving the service all appropriate data elements and activities should still be submitted to NPF.
5	Cancelled – patient advised went private	2014-07-01	9999-12-31	2	To be used where the DHB is made aware that the patient has chosen to receive the service in a non-publicly funded environment (i.e. insurance or self-funded). This reason should only be used after Prioritisation.
6	Cancelled – opened in error	2014-07-01	9999-12-31	2	To be used where the DHB identifies that the original referral was created incorrectly and the patient does not actually require the referral or service recorded.
7	Cancelled – patient assessed acutely	2014-07-01	9999-12-31	2	To be used where the DHB identifies that the patient has received either an assessment or treatment for this referral acutely and no longer requires the referral. This may be either through an inpatient admission or ED presentation.
8	Cancelled – not eligible for publicly funded care	2014-07-01	9999-12-31	2	To be used where the DHB identifies that the patient is not eligible for publicly funded care (in this context this means DHB or Ministry of Health funded care). If a referral is determined to be ACC funded then the Principal Health Service Purchaser Code for the relevant Activities should be changed to A0 and resubmitted.
9	Cancelled - patient referred to another DHB for care	2014-07-01	9999-12-31	2	For patients who have been provided Certainty but their clinical condition or requirements change and the DHB decides a referral to a larger or more specialist centre is required.
10	Cancelled - patient medically unfit	2014-07-01	9999-12-31	2	Use when a patient is unavailable, for a medical reason and the DHB is not expecting the patient to be fit to receive the service in the future. This would typically only apply where there is an emergent change in a patient's

Code	Description	Start date	End date	Valid for Exception Outcome Code	Notes
					clinical case and/or a new, unexpected condition is diagnosed. If a patient recovers, a new Related Referral will need to be created as a Closed referral cannot be reactivated.
11	Suspended - patient medically unfit	2014-07-01	9999-12-31	1	Use when a patient is unavailable for a medical reason for longer than 10 days and less than 120 days. If the patient is not expected to be fit for treatment within 120 days, the DHB should refer the patient back to their GP or primary care provider, or to another speciality or organisation, for care until they are ready to be re-assessed for secondary care. This reason should only be used after a Prioritisation is Accepted. Patients who are not fit for treatment should not be Accepted at Prioritisation. The Service Sequence should be Reactivated once the patient is fit for treatment **or** closed using Exception Outcome Reason "10 – Cancelled - patient medically unfit" if the patient will not be fit for treatment for longer than 120 days.
12	Suspended - pending test result	2014-07-01	9999-12-31	1	Use when a test is required to determine if an FSA or treatment referral should be Accepted or not. Pathways should only be suspended where the test will take longer than 10 days and less than 120 days to complete. The Referral should be reactivated when the test result is available. **If the test is required as part of the normal or predicted treatment pathway, this Exception Outcome Reason should not be used.**
13	Suspended - pending confirmation of eligibility	2014-07-01	9999-12-31	1	Use if waiting to confirm whether a patient is eligible for publicly funded care in New Zealand. This should only occur at the point of Referral as a patient should not be Accepted for treatment prior to confirming their eligibility for care. The Referral should be reactivated **or** closed using Exception Outcome Reason "8 –

Code	Description	Start date	End date	Valid for Exception Outcome Code	Notes
					Cancelled not eligible for publicly funded care" once the patient's eligibility is determined.
14	Suspended - patient Did Not Attend booking	2014-07-01	9999-12-31	1	Did Not Attends (DNAs) and Did Not Waits (DNWs) should typically be recorded in NPF as Attendance Outcomes, not as an Exception. This Exception Reason should only be used in extraordinary circumstances, after the DHB has exhausted all avenues to contact the patient (in accordance with its local DNA policy) and where the patient is known to still require treatment. The Referral should be reactivated when a new booking is made. If it is later decided that the referral needs to be closed, the Exception Outcome Reason 3 – Cancelled – patient reason should be used.
15	Suspended - pending patient decision	2014-07-01	9999-12-31	1	Use if the patient has not yet decided to proceed with treatment. This Exception Reason is primarily for use in Cancer pathways, where the patient delays confirming they wish to proceed with treatment following an FSA; that is, before the Prioritisation is Accepted. This can also be used in other clinical pathways in exceptional circumstances. In these scenarios, the requirement that the suspended period is longer than 10 days does not apply. If a DHB wishes to use this Exception Reason, the DHB must ensure their local systems and processes are robust enough to ensure the patient does not get 'lost'. The Suspended Referral should be reactivated **or** closed using Exception Outcome Reason "3 – Cancelled patient reason" once the patient has made a decision.
16	Cancelled – managed in separate Referral	2014-07-01	9999-12-31	2	Use where two separate referrals for the same referral condition have been received. If a duplicate copy of one referral is received and an incorrect Referral created, this should be Removed rather than Closed with an Exception.

Used in the Following Entities

Activity: Exception

12.15. FAC Facility ID

Definition: A code identifying a facility providing health services.

Details about a facility such as name, address, facility type are maintained in the Health Provider Facility Index

Source: Ministry of Health - Health Provider Index - Facility

Refer to the Facility Code table under Common Codes for National Collections on the Ministry's website:

http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/facility-code-table

Used in the Following Entities

Activity: Booking

Activity: Encounter

Activity: Prioritisation

Encounter Outcome

Referral

Header

Response Header

12.16. GENDER Gender

Definition: A classification of the gender of the patient as self-identified by the patient.

Standard: HISO 10046 Gender

Gender code	Gender description	Start Date	End date
F	Female	2014-07-01	9999-12-31
M	Male	2014-07-01	9999-12-31
O	Other gender	2014-07-01	9999-12-31
U	Unspecified or unknown	2014-07-01	9999-12-31

Used in the Following Entities

Patient

12.17. HLTHSP Health Specialty Code

Definition: A classification describing the specialty or service to which a healthcare user has been assigned that reflects the nature of the services being provided or describing the specialty that raised a referral for the healthcare user.

Source: Ministry of Health - National Collections - Common Code Tables

Common codes: For the full list of Health Specialty codes refer to the Common Codes for National Collections on the Ministry's website:

http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/health-specialty-code-table

NPF Specific codes:

Code	Description	Start Date	End date	Explanation
A01	Allied Health And Other	2014-07-01	9999-12-31	
R01	Radiology	2014-07-01	9999-12-31	
Z93	Not required Phase 1	2014-07-01	9999-12-31	Used to populate migrated Phase 1 data where the Health Specialty Code was not captured and the data from Phase 2 onwards requires a Health Specialty Code.
Z95	Not stated on Referral	2014-07-01	9999-12-31	Only permitted for use in Referral: Referring Health Specialty. Used when the referring organisation did not supply a Referring Health Specialty.
Z97	Not required Phase 2	2015-10-01	2016-06-30	

Used in the Following Entities

Activity: Booking

Activity: Encounter

Activity: Exception

Activity: Notification

Activity: Prioritisation

Encounter Outcome

Referral

12.18. ORG Organisation ID

Definition: A code identifying an organisation providing health services.

Source: Ministry of Health - Health Provider Index - Organisation

Details about an organisation such as name, address, organisation type are maintained in the Health Provider Organisation Index

NPF specific code: Z99993-Z 'Not required Phase 1' - Used to populate migrated Phase 1 data where the Organisation Code was not captured and the data from Phase 2 onwards requires an Organisation Code.

Used in the Following Entities

Activity: Booking

Activity: Encounter

Activity: Exception

Activity: Notification

Activity: Prioritisation

Encounter Outcome

Prioritisation Outcome

Referral

Batch

File

Header

Response Header

12.19. PRICAT Priority Score

Definition: A code indicating the urgency of the referral determined by the prioritisation process.

Used in the Referral only. For Clinical Priority use CPAC.

Source: Ministry of Health - National Collections - National Patient Flow code set

Code	Description	Start date	End date	Explanation

0	Not prioritised	2014-07-01	9999-12-31	Used if Referral is being transferred without Prioritisation or the Prioritisation Outcome/ Reason is Declined Insufficient Information
1	Immediate	2014-07-01	9999-12-31	Requires the requested service within a short timeframe (usually 1-3 days)
2	Urgent	2014-07-01	9999-12-31	Requires the requested service urgently. Timeframe will vary according to specialty, but generally should be less than 4 weeks.
3	Semi-urgent	2014-07-01	9999-12-31	Referral considered less urgent than above.
4	Routine	2014-07-01	9999-12-31	Referral considered appropriate for the requested service but of a lower priority than above.
5	Low priority	2014-07-01	9999-12-31	Referrals that may be appropriate, but where the requested service considered less beneficial or the presenting problem is best treated or managed in Primary care or where an assessment is not required.
6	Not determined - pending test	2014-07-01	9999-12-31	At prioritisation the determination is that a test is required before a decision on appropriate priority score can be made
9	Not Stated	2014-07-01	9999-12-31	

Used in the Following Entities

Referral

12.20. PRIOUT Prioritisation Outcome

Definition: The outcome of the prioritisation as determined by the clinician.

Source: Ministry of Health - National Patient Flow code set

Code	Description	Start Date	End Date
A	Accepted	2014-07-01	9999-12-31
T	Transferred	2014-07-01	9999-12-31
N	Not Decided	2014-07-01	9999-12-31
D	Declined	2014-07-01	9999-12-31

Used in the Following Entities

Prioritisation Outcome

12.21. PRIOUTR Prioritisation Outcome Reason

Definition: The reason for the prioritisation outcome as determined by the clinician.

Source: Ministry of Health - National Collections - National Patient Flow code set

Code	Description	Start Date	End Date	Explanation	Valid for Prioritisation Outcome
00	Accepted	2014-07-01	9999-12-31	Use where the referral has been prioritised and the Service is to be offered to the patient	A – Accepted
01	Pending test results	2014-07-01	9999-12-31	The clinician has requested tests, and the Prioritisation Outcome decision is pending the results.	N – Not Decided
02	Pending confirmation of eligibility for	2014-07-01	9999-12-31	The Referral has been prioritised and the decision to Accept the referral is pending confirmation of patient	N – Not Decided

Code	Description	Start Date	End Date	Explanation	Valid for Prioritisation Outcome
	public funded care			eligibility. An Exception Handling Activity is required to close the Referral if the patient is later declined the Service.	
03	Insufficient information	2014-07-01	9999-12-31	The clinician determines that there is not sufficient information available to prioritise the Referral, for example, a diagnostic test is required prior to a decision and it is expected that the referrer will arrange this. A new Referral will be generated if additional information is provided.	D - Declined
04	Service not required	2014-07-01	9999-12-31	The prioritising clinician determines that the patient does not require the referred for Service, can be offered an equivalent or more suitable Service in Primary Care and/or is unlikely to benefit from the referred for Service *FSA advice: A plan of care may be provided for the patient (a plan of care is part of prioritisation, and is not a non-contact FSA).* *If an individually tailored letter is being provided (e.g. as a non-contact FSA) then the Prioritisation Outcome is Accepted as an FSA has been provided.*	D – Declined
05	Below threshold	2014-07-01	9999-12-31	The Referral is appropriate and the patient would benefit from the Service but the referral is below the submitting organisation's Capacity threshold.	D – Declined
06	Not eligible for publicly funded care.	2014-07-01	9999-12-31	It is determined at the point of prioritisation that the patient is not eligible for publicly funded care and the submitting organisation elects not to provide the requested Service.	D – Declined
07	Transferred to another specialty	2014-07-01	9999-12-31	Use when the patient is transferred to another service or specialty within the DHB.	T – Transferred
08	Transferred to another organisation	2014-07-01	9999-12-31	Use when the patient is transferred to another organisation.	T – Transferred
09	Patient not medically fit for service	2014-07-01	9999-12-31	The referral is appropriate and the patient would benefit from the Service	D – Declined

Code	Description	Start Date	End Date	Explanation	Valid for Prioritisation Outcome
				but the patient is not medically fit for the referred for Service.	

Used in the Following Entities

Prioritisation Outcome

12.22. REFPGT Referred From Professional Group Type

Definition: The health professional group of the referrer.

Known as PROFGRP in Phase 1.

Source: Ministry of Health - National Collections - National Patient Flow code set

Professional Group Code	Professional Group Description	Start Date	End Date
1	General practitioner	2014-07-01	9999-12-31
2	Specialist Medical Officer (Own DHB)	2014-07-01	9999-12-31
3	Specialist Medical Officer (Other DHB)	2014-07-01	9999-12-31
4	Specialist Medical Officer (Private)	2014-07-01	9999-12-31
5	Registered medical practitioner (Other)	2014-07-01	9999-12-31
6	Nurse	2014-07-01	9999-12-31
7	Midwife	2014-07-01	9999-12-31
8	Allied health practitioner	2014-07-01	9999-12-31
9	Dentist	2014-07-01	9999-12-31
10	Self	2014-07-01	9999-12-31
11	Other	2014-07-01	9999-12-31

Used in the Following Entities

Referral

12.23. PROFGRP Professional Group Code

Definition: A code to identify the type of professional group that assigned the clinician code of the healthcare provider. Generally this is the registration body for the professional group.

Other Names: Registration Authority Code

Source: Health Provider Index

Code	Description	Start Date	End Date
AC	ACC Provider Number	2014-07-01	9999-12-31
CH	Chiropractic Board Register	2014-07-01	9999-12-31
DD	Dental Council Register Number - Dentists	2014-07-01	9999-12-31
DH	Dental Council Register Number - Dental Hygienists	2014-07-01	9999-12-31
DI	Dietitians Board Register	2014-07-01	9999-12-31
DN	Dental Council Register Number - Dental Technicians	2014-07-01	9999-12-31
DT	Dental Council Register Number - Dental Therapists	2014-07-01	9999-12-31
HB	District Health Board	2014-07-01	9999-12-31
LT	Medical Laboratory Science Board Register	2014-07-01	9999-12-31
MC	Medical Council of New Zealand Register	2014-07-01	9999-12-31
MW	Midwifery Council Register	2014-07-01	9999-12-31
NC	Nursing Council of New Zealand Register	2014-07-01	9999-12-31
OD	Optometrists & Dispensing Opticians Board Register	2014-07-01	9999-12-31
OS	Osteopathic Council Register	2014-07-01	9999-12-31
OT	Occupational Therapists Register	2014-07-01	9999-12-31
PB	Psychotherapists Board Register	2014-07-01	9999-12-31
PC	Psychologists Board Register	2014-07-01	9999-12-31
PM	Pharmacy Council of New Zealand Register	2014-07-01	9999-12-31

Code	Description	Start Date	End Date
PO	Podiatrists Board Register	2014-07-01	9999-12-31
PT	Physiotherapy Board Register	2014-07-01	9999-12-31
RT	Medical Radiation Technologists Board Register	2014-07-01	9999-12-31

NPF Specific codes:

Code	Description	Start Date	End date	Explanation
HB	District Health Board	2014-07-01	9999-12-31	DHB staff codes that are not classified in the Registration Authority code set
ZM	NPF Internal	2014-07-01	9999-12-31	Used to populate data where the Professional Group Code was not captured and the current submission structure requires a Professional Group Code

Used in the Following Entities

Activity: Encounter

Activity: Prioritisation

12.24. REBOOK Reason Rebooked

Definition: The reason for a booking being rescheduled.

Source: Ministry of Health - National Collections - National Patient Flow code set

Code	Description	Start Date	End Date
01	Patient reason - appointment date/time not suitable	2015-07-01	9999-12-31
02	Patient reason - not specified	2015-07-01	9999-12-31
03	Patient reason - not fit to proceed	2015-07-01	9999-12-31
04	Patient reason - did not fast	2015-07-01	9999-12-31
05	Patient reason - discharge plans not in place	2015-07-01	9999-12-31
06	Patient reason - did not attend previous booking	2015-07-01	9999-12-31
07	Patient reason - did not wait for previous booking	2015-07-01	9999-12-31
08	Patient reason - requested earlier appointment	2015-07-01	9999-12-31

20	Hospital reason - clinical decision not to proceed	2015-07-01	9999-12-31
21	Hospital reason - staff unavailable	2015-07-01	9999-12-31
22	Hospital reason - equipment unavailable	2015-07-01	9999-12-31
23	Hospital reason - original booking made for wrong time	2015-07-01	9999-12-31
24	Hospital reason - session overbooked	2015-07-01	9999-12-31
25	Hospital reason - replaced by acute	2015-07-01	9999-12-31
26	Hospital reason - list over run	2015-07-01	9999-12-31
27	Hospital reason - earlier appointment available	2015-07-01	9999-12-31
28	Hospital reason - patient priority changed	2015-07-01	9999-12-31

Used in the Following Entities

Activity: Booking

12.25. SCAN Suspicion of Cancer

Definition: A code indicating the level of suspicion of cancer for the patient.

Source: Ministry of Health - Faster Cancer Treatment Programme

Guidance for what might constitute a High Suspicion for the Suspicion of Cancer data element in the context of different tumour groups can be found in the Faster Cancer Treatment: High Suspicion of Cancer Treatment document at the following link

http://nsfl.health.govt.nz/accountability/performance-and-monitoring/business-rules-and-templates-reporting/faster-cancer

Code	Description	Start date	End date	Explanation
10	The patient has a confirmed diagnosis of cancer	2014-07-01	9999-12-31	There is a confirmed pathological diagnosis of cancer* at the point of triage.
20	There is NOT A HIGH suspicion of cancer	2014-07-01	9999-12-31	Patient does not present with clinical features typical of cancer, and/or the triaging clinician does not suspect that there is a high probability of cancer.

Code	Description	Start date	End date	Explanation
30	There IS A HIGH suspicion of cancer	2014-07-01	9999-12-31	Patient presents with clinical features typical of cancer, or has less typical signs and symptoms but the triaging clinician suspects that there is a high probability of cancer.
93	Not required Phase 1	2014-07-01	9999-12-31	
95	Not required Phase 2	2015-10-01	2016-06-30	
99	Not stated	2015-07-01	9999-12-31	Only to be used for Referral. Not available for Prioritisation.

* For the purpose of the Faster Cancer Treatment project, the term cancer is defined as by the ICD10 primary diagnosis codes set out in Appendix B of the Faster Cancer Treatment Indicators: Business Rules and Data Definitions v1.3 March 2014 document.

Used in the Following Entities

Activity: Prioritisation

Referral

12.26. SEXTYPE Sex Type

Definition: A classification of the patient's biological sex.

Source: Ministry of Health - National Collections - Common Code Tables

Sex Type code	Sex Type description	Start Date	End Date
F	Female	2014-07-01	9999-12-31
I	Indeterminate	2014-07-01	9999-12-31
M	Male	2014-07-01	9999-12-31
U	Unknown	2014-07-01	9999-12-31

Also at Common Codes for National Collections on the Ministry's website:

http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/sex-type-code-table

Used in the Following Entities

Patient

12.27. SRVSUB Service Sub-Type

Definition: A further definition of the Service Type.

ICD10 codes must be used to classify inpatient activity when the Encounter Type is Inpatient or Day Patient.

Source: Ministry of Health - National Collections - National Patient Flow code set

Code	Description	Start Date	End Date	Explanation	Valid for Service Type
1000	FSA	2014-07-01	9999-12-31	Where the intended Service is: First attendance to a Medical Officer at registrar level or above or nurse practitioner for specialist assessment (refer Purchase Unit Data Dictionary, and Common Counting Standards)	1 First Specialist Assessment
2000	Follow-up	2014-07-01	9999-12-31	Use if unable to differentiate	2 Assessment - Other
2001	Follow up – re-referral	2015-07-01	9999-12-31	Use if a new Referral is received for a patient currently or recently under care	2 Assessment - Other
2002	Follow up – subsequent to FSA	2015-07-01	9999-12-31	Use if an FSA has occurred, and one or more follow ups are planned	2 Assessment - Other
2003	Follow up – subsequent to procedure/treatment	2015-07-01	9999-12-31	Use for follow ups after a procedure or treatment has occurred	2 Assessment - Other

2010	Nurse / midwife assessment	2014-07-01	9999-12-31	Includes Cancer Coordinators	2 Assessment - Other
2011	Transplant/donor liaison coordinator assessment	2015-07-01	9999-12-31	Use if the assessment is for either a recipient or potential live donor for transplant eg renal, bone marrow	2 Assessment - Other
2012	Dialysis education	2015-07-01	9999-12-31	Pre dialysis education	2 Assessment - Other
2020	Anaesthetic assessment	2014-07-01	9999-12-31	Assessment to determine if the patient is fit for procedure	2 Assessment - Other
2050	Multi-disciplinary meeting	2015-07-01	9999-12-31	Where there is a formal agenda item related to this patient (ie, a booking is required). If patient is not discussed then record Attendance outcome Attended Not Delivered	2 Assessment - Other
3000	Acute assessment	2014-07-01	9999-12-31	Where patients are referred to an acute assessment unit	2 Assessment - Other
4000	Colonoscopy	2014-07-01	9999-12-31	Where the intended service is a colonoscopy procedure. Excludes rigid and flexible sigmoidoscopy, and CT colonography	4 Procedure/ Treatment
4005	Colonoscopy /Gastroscopy	2014-07-01	9999-12-31	Used when a colonoscopy and a gastroscopy are provided at the same encounter	4 Procedure/ Treatment
4010	Gastroscopy	2014-07-01	9999-12-31		4 Procedure/ Treatment
4020	ERCP	2014-07-01	9999-12-31	ERCP stands for endoscopic retrograde cholangiopancreatography	4 Procedure/ Treatment

4030	Flexi sigmoidoscopy	2014-07-01	9999-12-31		4 Procedure/ Treatment
4031	Rigid sigmoidoscopy	2014-07-01	9999-12-31		4 Procedure/ Treatment
4060	Colposcopy	2014-07-01	9999-12-31		4 Procedure/ Treatment
4070	Hysteroscopy	2014-07-01	9999-12-31		4 Procedure/ Treatment
4200	Radiotherapy	2014-07-01	9999-12-31		4 Procedure/ Treatment
4210	Chemotherapy	2014-07-01	9999-12-31		4 Procedure/ Treatment
4220	Targeted therapy	2014-07-01	9999-12-31	Refers to a medication/drug that targets a specific pathway in the growth and development of a tumour	4 Procedure/ Treatment
4240	Palliative/best supportive care	2014-07-01	9999-12-31	Covers the essential services provided to patients that are not surgical, chemotherapy or radiotherapy based. These are likely to be delivered by staff trained in delivering palliative and/or supportive care. The care may be delivered in the patient's home or in a palliative care setting.	4 Procedure/ Treatment

4250	Interventional radiology	2014-07-01	9999-12-31		4 Procedure/ Treatment
4300	Minor eye procedure	2014-07-01	9999-12-31		4 Procedure/ Treatment
4310	Eye injection	2014-07-01	9999-12-31	Where the intended Service is an intra-ocular injection of a pharmacological agent (refer Purchase Unit Data Dictionary – S40007)	4 Procedure/ Treatment
4320	Eye laser	2014-07-01	9999-12-31		4 Procedure/ Treatment
4400	Bronchoscopy	2014-07-01	9999-12-31		4 Procedure/ Treatment
4500	Botulinum toxin therapy	2014-07-01	9999-12-31		4 Procedure/ Treatment
4600	Cystoscopy	2014-07-01	9999-12-31		4 Procedure/ Treatment
4610	Urodynamics	2014-07-01	9999-12-31		4 Procedure/ Treatment
4620	Lithotripsy	2014-07-01	9999-12-31		4 Procedure/ Treatment

4700	Allied health treatment	2014-07-01	9999-12-31		4 Procedure/ Treatment
4850	Dental treatment	2014-07-01	9999-12-31		4 Procedure/ Treatment
4900	Minor operation	2014-07-01	9999-12-31	Minor procedures are performed in an outpatient setting under local or no anaesthetic. Use for minor procedures not elsewhere defined eg general surgery, plastics and gynaecology. (Use 4910 for Skin Lesion Removals and 4300 for Minor eye procedures.)	4 Procedure/ Treatment
4910	Skin lesion removal	2014-07-01	9999-12-31	Where the intended Service is: Surgical removal of lesion(s), excision of lesion(s), biopsy of skin lesion under local anaesthetic performed as an outpatient or day case (refer Purchase Unit Data Dictionary – MS02016)	4 Procedure/ Treatment
4950	Intended admitted procedure	2014-07-01	9999-12-31	For Inpatients or Day Patients	4 Procedure/ Treatment
4999	Cancer treatment - other	2014-07-01	9999-12-31	To be used for a cancer pathway service where there is no specific Service Sub-Type code	4 Procedure/ Treatment
5000	CT scan	2014-07-01	9999-12-31		5 Investigation/Test
5001	CT angiography	2014-07-01	9999-12-31		5 Investigation/Test
5002	CT colonography	2014-07-01	9999-12-31		5 Investigation/Test

5010	MRI scan	2014-07-01	9999-12-31		5 Investigation/Test
5011	MRI angiography	2014-07-01	9999-12-31		5 Investigation/Test
5020	PET scan	2014-07-01	9999-12-31		5 Investigation/Test
5030	Ultrasound	2014-07-01	9999-12-31		5 Investigation/Test
5040	Mammogram	2014-07-01	9999-12-31	Non screening Programme	5 Investigation/Test
5050	Nuclear medicine scan	2014-07-01	9999-12-31	Where the nuclear medicine is related to the delivery of radioactive treatment record as Radiotherapy	5 Investigation/Test
5060	Audiology	2014-07-01	9999-12-31		5 Investigation/Test
5100	ECG	2014-07-01	9999-12-31	ECG stands for electrocardiogram.	5 Investigation/Test
5110	Echo cardiogram - transoesophogeal	2014-07-01	9999-12-31		5 Investigation/Test
5111	Echo cardiogram - transthoracic	2014-07-01	9999-12-31		5 Investigation/Test
5120	ETT	2014-07-01	9999-12-31	ETT stands for exercise tolerance test	5 Investigation/Test
5130	Holter monitoring	2014-07-01	9999-12-31		5 Investigation/Test
5200	X-ray (plain)	2014-07-01	9999-12-31		5 Investigation/Test

5400	Lung function	2014-07-01	9999-12-31		5 Investigation/Test
5410	Sleep study	2014-07-01	9999-12-31		5 Investigation/Test
5500	EEG	2014-07-01	9999-12-31	EEG stands for electroencephalography.	5 Investigation/Test
5510	Nerve study	2014-07-01	9999-12-31		5 Investigation/Test
5999	Other	2014-07-01	9999-12-31	To be used with Service Type 5 'Investigation/Test' where there is no specific Service Sub-Type code	5 Investigation/Test
6000	Advice	2014-07-01	9999-12-31	Used for situations where the Referrer is not requesting a transfer of care but would like some advice. Most frequently this is clinician to clinician and does not include a written plan of care sent to the patient	7 Advice Only
9993	Not required Phase 1	2014-07-01	9999-12-31	Used to populate migrated Phase 1 data where the Service Sub-Type was not captured and the data from Phase 2 onwards requires a Service Sub-Type	All
9995	Not required Phase 2	2015-10-01	2016-06-30		All

Used in the Following Entities

Activity: Booking

Activity: Encounter

Activity: Exception

Activity: Notification

Activity: Prioritisation

Encounter Outcome

Referral

12.28. SRV Service Type

Definition: A code representing the type of service.

Source: Ministry of Health - National Collections - National Patient Flow code set

Code	Description	Start date	End date	Explanation
1	First Specialist Assessment	2014-07-01	9999-12-31	An FSA is a patient's first assessment by a registered medical practitioner of registrar level or above, or a registered nurse practitioner for a particular referral (or with a self-referral, for a discrete episode). The healthcare user receives treatment, therapy, advice, diagnostic or investigatory procedures within three hours of the start of the consultation. Service is provided in ward and/or designated outpatient clinic or by telehealth. Excludes ED and outpatient attendances for pre-admission assessment/screening.
2	Assessment - Other	2014-07-01	9999-12-31	A non FSA appointment for an assessment. May be a new referral for a patient already receiving treatment, or a patient recently discharged, but re-referred with the same condition. May include non-specialist assessments such as nurse assessment, anaesthetic pre-admission assessment, or allied health
4	Procedure/ Treatment	2014-07-01	9999-12-31	A procedure is a discrete therapeutic or diagnostic intervention. Identified within a subset of activity that is counted under specific procedural PUCs (see Service Sub Type Codes). Includes all intended elective admissions for a procedure or treatment. Some procedures include diagnostic component, such as a biopsy or angiography. As these include a therapeutic or interventional component they are classified as a Procedure in NPF.
5	Investigation/ Test	2014-07-01	9999-12-31	Tests may be community referred (i.e. referred by a GP or private specialist), or include diagnostic tests for people who are under treatment by a DHB, either as an inpatient or outpatient. (See Service Sub Type Codes). Investigation/Test is primarily a non-interventional investigation.
7	Advice Only	2014-07-01	9999-12-31	Referrals where the service provided is advice, but which does not include a written plan of care.
93	Not required Phase 1	2014-07-01	9999-12-31	Used to populate migrated Phase 1 data where the Service Type was not captured and the data from Phase 2 onwards requires a Service Type

Code	Description	Start date	End date	Explanation
95	Not required Phase 2	2015-10-01	2016-06-30	

Used in the Following Entities

Activity: Booking

Activity: Encounter

Activity: Exception

Activity: Notification

Activity: Prioritisation

Encounter Outcome

Referral

12.29. STAGSYS Overall Staging System - Cancer

Definition: Staging classification system used to determine the overall stage group.

Source: National Core Cancer Data Standard with value 1 included for TNM classification

Value	Meaning	Start Date	End Date
1	UICC TNM Classification	2014-07-01	9999-12-31
2	Durie & Salmon for multiple myeloma staging	2014-07-01	9999-12-31
3	FAB for leukaemia classification	2014-07-01	9999-12-31
4	Australian Clinico-pathological Staging (ACPS) system for colorectal cancer	2014-07-01	9999-12-31
6	Ann Arbor staging system for lymphomas	2014-07-01	9999-12-31
7	Binet Staging Classification for chronic lymphocytic leukemia	2014-07-01	9999-12-31
8	CML for chronic myeloid leukaemia	2014-07-01	9999-12-31
10	FIGO for gynaecological cancers	2014-07-01	9999-12-31

11	ISS for myeloma	2014-07-01	9999-12-31
12	Rai staging system for chronic lymphocytic leukaemia	2014-07-01	9999-12-31
13	Other	2014-07-01	9999-12-31
99	Unknown	2014-07-01	9999-12-31

Used in the Following Entities

Referral Diagnosis

Diagnosis

12.30. SVCPURCH Principal Health Service Purchaser

Definition: The organisation or body that purchased the healthcare service provided. In the case of more than one purchaser, the one who paid the most.

Source: Ministry of Health - National Collections Common Codes

For the full list of Principal Health Service Purchaser codes refer to the Common Codes for National Collections on the Ministry's website:

http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/common-code-tables/principal-health-service-purchaser-code-table

Used in the Following Entities

Activity

12.31. CPAC Clinical Priority Tool

Definition: Identifies the CPAC scoring system used to derive the Clinical Priority Score.

(CPAC - Clinical Priority Assessment Criteria)

Source: Ministry of Health - National Collections NBRS Code Table

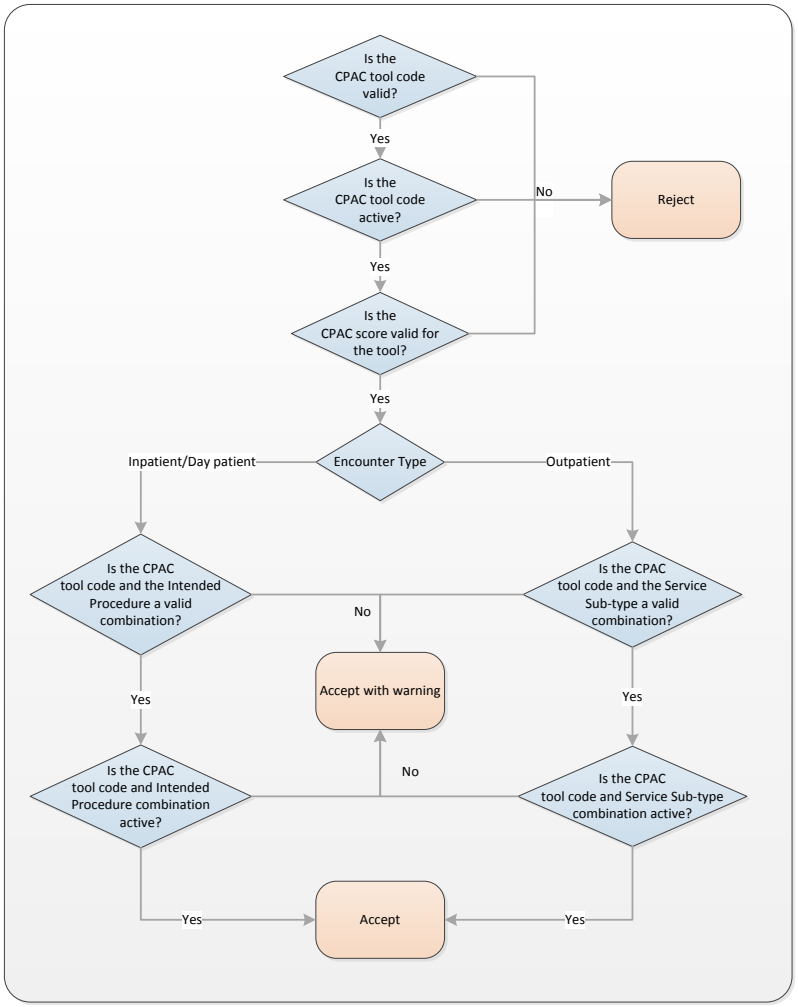
Refer to the CPAC Scoring System Code Table under National Booking Reporting System code tables on the Ministry's website for the commonly used CPAC scoring system codes: http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/national-booking-reporting-system-code-tables/cpac-scoring-system-code-table

For a more detailed list of codes please email npfadmin@moh.govt.nz.

Note: The CPAC tool "1000 - Intended Outpatient Service Acuity Rating" has been included for use in NPF. The scores for this tool are the same as PRICAT Priority Category, except that "9 – Not stated" is excluded.

Validation:

Phase 3 implements validation of CPAC scoring tools against the Intended Procedure Clinical Code or the Service Sub-type. The NPF validation is based on the NBRS validation, but is sufficiently different that it is explained in the following processing flow:



- The ‘valid’ check ensures that the code exists in the code set. Error message NPF00453 will be returned if the value is not valid.
- The ‘active’ check ensures that the event date falls between the start and end dates for the code. Error message NPF00454 will be returned if the value is not active.
- The reference to the Intended Procedure in the diagram is to the combination of the Intended Procedure Clinical Code, Type and System.
- Note that this validation ‘Accepts with warning’, which still requires follow up and correction by the Submitting Organisation.
- The mapping of valid CPAC tools to Intended Procedures and Service Sub-types is underway, using the NBRS data as its starting point.

Used in the Following Entities

Clinical Priority

12.32. CLINCODTYPE Clinical Code Type

Definition: A code denoting which section of the ICD-10-AM clinical code table the clinical code falls within.

Not applicable to other clinical coding systems.

Source: Ministry of Health - National Collections - Common Codes

Code	Description	Start Date	End Date	Notes
A	Diagnosis	2015-01-07	9999-12-31	
B	Injury	2015-01-07	9999-12-31	
D	DSM-IV	2015-01-07	9999-12-31	
E	External cause of injury	2015-01-07	9999-12-31	
M	Morphology (pathology)	2015-01-07	9999-12-31	
O	Operation/procedure	2015-01-07	9999-12-31	
V	V code (supplementary classification)	2015-01-07	9999-12-31	
Z	Not required Phase 2	2014-07-01	2016-06-30	

Used in the Following Entities

Activity: Booking

Activity: Encounter

Activity: Exception

Activity: Notification

Activity: Prioritisation

Diagnosis

Encounter Outcome

Referral Diagnosis

12.33. CLINOVRIDE Clinical Override

Definition: A code indicating if the clinician has overridden the outcome determined by the assessment tool and decided to treat a patient who would have otherwise been declined.

Source: Ministry of Health - National Collections - National Patient Flow code set

Code	Description	Start Date	End Date
0	No	2014-07-01	9999-12-31
1	Yes	2014-07-01	9999-12-31
7	Not required Phase 1	2014-07-01	9999-12-31
9	Not required Phase 2	2014-07-01	2016-06-30

Used in the Following Entities

Clinical Priority

12.34. FCT2WK Faster Cancer 2 Weeks Urgency Indicator

Definition: A flag indicating the clinician has deemed the patient needs to be seen within 2 weeks, and thus falls within the cohort of patients reported in the Faster Cancer Treatment Indicators.

Source: Ministry of Health - National Collections - National Patient Flow code set

Code	Description	Start Date	End Date
0	No	2014-07-01	9999-12-31
1	Yes	2014-07-01	9999-12-31
8	Not required Phase 1	2014-07-01	9999-12-31
9	Not required Phase 2	2014-07-01	2016-06-30

Used in the Following Entities

Activity: Prioritisation

12.35. PRESPROBCODTYPE Presenting Problem Code Type

Definition: A code representing the type of diagnosis identified by the Presenting Problem Classification clinical code

Source: Ministry of Health - National Collections - National Patient Flow code set

Code	Description	Start Date	End Date
C	Clinical impression	2014-07-01	9999-12-31
D	Diagnosis	2014-07-01	9999-12-31
S	Signs/symptoms	2014-07-01	9999-12-31
N	Not Stated	2014-07-01	9999-12-31
X	Not required Phase 1	2014-07-01	9999-12-31
Z	Not required Phase 2	2015-10-01	2016-06-30

Used in the Following Entities

Referral

12.36. MOH Internal Clinical Code

Definition: Placeholder codes for Presenting Problem Classification

Source: Ministry of Health - National Collections - National Patient Flow code set

Code	Description	Start Date	End Date
ZZ993	Not required Phase 1	2014-07-01	9999-12-31
ZZ995	Not required Phase 2	2015-10-01	2016-06-30

Used in the Following Entities

Referral

13. Operational Codes

This section contains the definitions of the codes specified in the Data Domain attribute of the data element definition for data elements relating to batches, files and headers.

13.1.1 ACK Acknowledgement Code

A code indicating the result of the NPF system processing the input file.

Code	Description
AA	Application accept – The file was processed successfully with no errors or warnings
AE	Application error
AR	Application reject – The file was rejected
AW	Application warning – The file was processed successfully with warnings

Used in the Following Entities

Response Header

13.1.2 MSGTYPE MessageType

A code representing the type of message in a file.

Message Type is a concatenation of the operation and dataset types.

Code	Root element in XSD	Description
ADDREF	AddReferral	Add Referral (Optionally adds Referral Diagnosis)
ADDPTA	AddPrioritisation	Add Prioritisation Activity (Optionally adds Diagnosis)
ADDNFY	AddNotification	Add Notification Activity
ADDBKG	AddBooking	Add Booking Activity

ADDENC	AddEncounter	Add Encounter Activity (Optionally adds Encounter Outcome and Diagnosis)
ADDENO	AddEncounterOutcome	Add Encounter Outcome (Activity Outcome)
ADDEXC	AddException	Add Exception Activity
ADDDGO	AddDiagnosis	Add Diagnosis (Decision Outcome)
ADDRDG	AddReferralDiagnosis	Add Referral Diagnosis
UPDREF	UpdateReferral	Update Referral (Optionally updates Referral Diagnosis)
UPDPTA	UpdatePrioritisation	Update Prioritisation Activity (Optionally updates Diagnosis)
UPDNFY	UpdateNotification	Update Notification Activity
UPDBKG	UpdateBooking	Update Booking Activity
UPDENC	UpdateEncounter	Update Encounter Activity (Optionally updates Encounter Outcome and Diagnosis)
UPDENO	UpdateEncounterOutcome	Update Encounter Outcome
UPDEXC	UpdateException	Update Exception Activity
UPDDGO	UpdateDiagnosis	Update Diagnosis
UPDRDG	UpdateReferralDiagnosis	Update Referral Diagnosis
REMREF	RemoveReferral	Remove Referral (Removes Activities, Outcomes and Referral Info if exist)
REMPTA	RemovePrioritisation	Remove Prioritisation Activity (Removes Diagnosis if exist)
REMNFY	RemoveNotification	Remove Notification Activity
REMBKG	RemoveBooking	Remove Booking Activity
REMENC	RemoveEncounter	Remove Encounter Activity (Removes Encounter Outcome and Diagnosis if exist)
REMENO	RemoveEncounterOutcome	Remove Encounter Outcome
REMEXC	RemoveException	Remove Exception Activity
REMDGO	RemoveDiagnosis	Remove Diagnosis

REMRDG	RemoveReferralDiagnosis	Remove Referral Diagnosis
SUM	BatchSummary	Batch Summary

Used in the Following Entities

Batch Summary

File

13.1.3 SYSENV System Environment

The system environment in which a file is to be processed

Code	Description
PROD	Live (Production)
CMPL	Compliance
TEST	Test
UAT	User Acceptance Test

Used in the Following Entities

File

Response Header

Header

Batch

13.1.4 ERROR Error Message

A code and message for an error that can be generated by the NPF system as part of input file validation.

Error Message Code	Message Text	Business Rule
NPF00001	${element}: ${value} should not be in the future	BR0058, BR0059, BR0060, BR0062, BR0072, BR0075, BR0081, BR0092

NPF00003	Duplicate or already processed ${element}: ${value}	BR0018, BR0033, BR0034, BR0035, BR0036, BR0037
NPF00004	Batch submitted to wrong Target System Environment: ${environment}	BR0022
NPF00005	${element} in Filename does not match corresponding element in Zip Filename	BR0030, BR0083
NPF00006	${element} in Header does not match corresponding element in Filename	BR0084, BR0085, BR0086
NPF00008	File failed XSD validation. ${details}	BR0028
NPF00010	Not registered to submit referrals to NPF	BR0019
NPF00011	Not authorised to submit batch to Target System Environment: ${environment}	BR0021
NPF00012	Batch does not contain a data file	BR0024
NPF00013	Number of files in the batch exceeds ${maxFiles}	BR0025
NPF00017	Batch for ${batchOrganisationId} in ${value} folder for ${folderOrganisationId}	BR0020
NPF00018	Filename: ${filename} invalid	BR0017, BR0029
NPF00020	${fileType} file corrupted or is not a ${fileType}	BR0024
NPF00021	Batch contains more than one summary file	BR0024
NPF00022	${Record type} record not present in file ${filename}	BR0027, BR0032, BR0055
NPF00025	A value should be supplied for ${element}	BR0003
NPF00026	Batch does not contain a summary file	BR0024
NPF00101	${element}: ${value} is not a valid code or identifier	BR0005, BR0113, BR0114, BR0115
NPF00102	${element}: ${value} not equal to or later than ${secondElement}: ${secondValue}	BR0082
NPF00106	National Health Index Number (NHI): ${nhi} does not exist in the NHI system	BR0063
NPF00109	${element}: ${value} is not an active code or identifier	BR0006, BR0007, BR0008, BR0009, BR0010, BR0011, BR0012, BR0013, BR0014, BR0015, BR0016
NPF00224	The Obligation Condition has not been met for ${data element name/s}	BR0004, BR0118
NPF00401	Format of ${element} is invalid	BR0001

NPF00402	${value} is not a valid value for ${element}	BR0002
NPF00403	Not an Active Target Version for this Organisation	BR0023
NPF00407	Referral ${Referral Id} does not exist in the Collection	BR0038
NPF00408	Activity ${Activity Id} does not exist in the Collection	BR0039
NPF00409	Referral ${Referral Id} does not exist in the Collection	BR0040
NPF00410	Referral for Organisation ID: ${organisationId}, Referral ID: ${ReferralId}, Identifier: does not exist in the Collection	BR0041, BR0048
NPF00411	Activity for Organisation ID: ${organisationId}, Referral ID: ${ReferralId}, Activity ${ActivityId} Identifier: does not exist in the Collection	BR0042, BR0049
NPF00412	Outcome for Organisation ID: ${organisationId}, Referral ID: ${ReferralId}, Activity ID: ${ActivityID}: Outcome ${OutcomeId} Identifier, does not exist in the Collection	BR0043, BR0050
NPF00413	Referral Diagnosis for Organisation ID: ${organisationId}, Referral ID: ${ReferralId}, Referral Diagnosis ${ReferralDiagnosisId} Identifier: does not exist in the Collection	BR0044, BR0051
NPF00414	Record can only be updated/removed by ${organisationId}	BR0045, BR0052
NPF00415	NHI: ${DatasetNHI} is not a related NHI for the Referral NHI ${ReferralNHI}	BR0046
NPF00416	${ID type} Identifier cannot be updated	BR0047
NPF00425	NHI: ${DatasetNHI} is not a related NHI for the Referral NHI ${ReferralNHI}	BR0067
NPF00426	Batch ${Business transaction id} has already been reversed once. Further reversals not permitted.	BR0087
NPF00427	Batch ${Business transaction id} is not the most recent submitted Batch.	BR0088
NPF00428	Unable to reverse Batch ${Business transaction Id} as processing is in progress	BR0089
NPF00429	Incorrect number of files for Message Type: ${MessageType}, expected ${numberOfFiles} found ${receivedCount}	BR0090
NPF00430	Type of dataset does not match the Message Type in the file name: ${filenameMessageType}	BR0091

NPF00431	${MessageType} appears more than once in summary file	BR0093
NPF00432	The Referral ID ${Referral ID} is present within another Referral with an Add operation within this batch	BR0094
NPF00433	The same combination of Referral ID ${Referral ID} and Referral information ID ${Referral Information ID} is present within another Referral Diagnosis with an Add operation within this batch	BR0095
NPF00434	The same combination of Referral ID ${Referral ID} and Activity ID ${Activity ID} is present within another Activity with an Add operation within this batch	BR0096
NPF00435	The same combination of Referral ID ${Referral ID}, Activity ID ${Activity ID}, and Activity Outcome ID ${Activity Outcome ID} is present within another Activity Outcome with an Add operation within this batch	BR0097
NPF00436	The same combination of Referral ID ${Referral ID}, Activity ID ${Activity ID}, and Decision Outcome ID ${Decision Outcome ID} is present within another Decision Outcome with an Add operation within this batch	BR0098
NPF00437	The Referral ID ${Referral ID} is present within another Referral with an Update operation within this batch	BR0099
NPF00438	The same combination of Referral ID ${Referral ID} and Referral information ID ${Referral Information ID} is present within another Referral Diagnosis with an Update operation within this batch	BR0100
NPF00439	The same combination of Referral ID ${Referral ID} and Activity ID ${Activity ID} is present within another Activity with an Update operation within this batch	BR0101
NPF00440	The same combination of Referral ID ${Referral ID}, Activity ID ${Activity ID}, and Activity Outcome ID ${Activity Outcome ID} is present within another Activity Outcome with an Update operation within this batch	BR0102
NPF00441	The same combination of Referral ID ${Referral ID}, Activity ID ${Activity ID}, and Decision Outcome ID ${Decision Outcome ID} is present within another Decision Outcome with an Update operation within this batch	BR0103
NPF00442	The Referral ID ${Referral ID} is present within another Referral with a Remove operation within this batch	BR0104
NPF00443	The same combination of Referral ID ${Referral ID} and Referral information ID ${Referral Information	BR0105

	ID} is present within another Referral Diagnosis with a Remove operation within this batch	
NPF00444	The same combination of Referral ID ${Referral ID} and Activity ID ${Activity ID} is present within another Activity with a Remove operation within this batch	BR0106
NPF00445	The same combination of Referral ID ${Referral ID}, Activity ID ${Activity ID}, and Activity Outcome ID ${Activity Outcome ID} is present within another Activity Outcome with a Remove operation within this batch	BR0107
NPF00446	The same combination of Referral ID ${Referral ID}, Activity ID ${Activity ID}, and Decision Outcome ID ${Decision Outcome ID} is present within another Decision Outcome with a Remove operation within this batch	BR0108
NPF00447	Correlation ID ${Correlation ID} is not unique within the ${Organisation/batch}	BR0031, BR0109
NPF00450	Presenting Referral: ${ReferralId} should not have Previous Related Referral: ${Previous Related Referral Id}	BR0117
NPF00451	An ICD-10-AM code must be provided for Intended Procedure Clinical Code	BR0116
NPF00500	XML validation failed: {XSD error code} {XSD error message}	BR0056 and other

Used in the Following Entities

Error

13.1.5 WARN Warning Message

A code and message for a warning that can be generated by the NPF system as part of input file validation.

Error Message Code	Message Text	Business Rule
NPF00422	Warning: NHI: ${DatasetNhi} is for a deceased patient for the Referral: ${referralId}	BR0064

NPF00423	Warning: Patient's Date of Birth: ${DatasetDateOfBirth} does not match NHI Date of Birth: ${NHIDateOfBirth}	BR0065
NPF00424	Warning: NHI ${DatasetNHI} is a dormant NHI. The live NHI of ${liveNhi} should be used	BR0066
NPF00453	Warning: Clinical Priority Tool ID {clinicalPriorityToolId} and {"Intended Procedure Clinical Code"/"Service Sub-type"} is not a valid combination	BR0119, BR0120
NPF00454	Warning: Clinical Priority Tool ID {clinicalPriorityToolId} and {"Intended Procedure Clinical Code"/"Service Sub-type"} is not an active combination	BR0119, BR0120

Used in the Following Entities

Warning

14. Appendix A: Emails

The NPF system automatically sends emails to the Submitter to:

1. acknowledge receipt of files
2. inform the Submitter that a batch file has been rejected
3. inform the Submitter that return files are available in the Submitter's pick-up directory

14.1. Pre-processing Email

This email is sent when a batch file has been pre-processed in the NPF System. The response batch file and report are loaded into the Submitter's pick-up directory before the email is sent.

Email Content:

Subject:

<<Submitting Organisation Name>>: NPF batch file <<filename>> has been pre-processed

Email Body:

<< Submitting Organisation Name>>: Your National Patient Flow (NPF) batch file, <<filename>>, has <<passed/failed>> batch pre-processing. <<If failed: An output file is available at your pick-up directory.>>.

Kind regards,

National Collections and Reporting
Information Group
National Health Board
Ministry of Health

14.2. Processing Email

This email is sent on completion of processing a batch, after the NPF system has loaded the response batch file and report into the Submitter's pick-up directory.

Email Content:

Subject:

<< Submitting Organisation Name>>: NPF batch file <<filename>> has completed processing and an output is available

Email Body:

<< Submitting Organisation Name>>: Your National Patient Flow (NPF) batch file, <filename>>, has completed processing and an output file is available at your pick-up directory. Of <<xx>> submitted files, << yy>> were rejected: a pass rate of <<zz>>%.

Kind regards,

National Collections and Reporting
Information Group
National Health Board
Ministry of Health

14.3. Reversal Email

This email is sent on completion of reversing a batch, after the NPF system has loaded the response batch file and report into the Submitter's pick-up directory.

Email Content:

Subject:

<< Submitting Organisation Name>>: NPF batch file <<filename>> has completed reversing and an output is available

Email Body:

<< Submitting Organisation Name>>: Your National Patient Flow (NPF) batch file, <filename>>, has been reversed and an output file is available at your pick-up directory.

Kind regards,

National Collections and Reporting
Information Group
National Health Board
Ministry of Health

15. Appendix B: Reports

Examples of the report layouts are provided as embedded Excel files.

15.1. Batch Pre-processing Report

NPF - Preprocessing report - V0.7.xls

15.2. Batch Processing Report

NPF - Processing report - V0.15.xls

15.3. Batch Reversal Report

NPF - Batch Reversal Report tem

16. Appendix C: System Glossary

Term	Type	Meaning
CPAC	Business	Clinical Priority Assessment Criteria
ODS	System	An operational data store (or "ODS") is a database designed to integrate data from multiple sources for additional operations on the data. Unlike a master data store the data is not passed back to operational systems. It may be passed for further operations and to the data warehouse for reporting.
PUC	Business	Purchase Unit Code
TNM	Business	Tumour, Node, Metastasis - Staging system that describes the extent of cancer (taken from the glossary of the National Cancer Core Data Definitions Interim Standard).

17. Appendix D: Business Rules and Error Messages

NPF Phase 3 Business Rules Catalogue v1.2.3

18. Appendix E: Encounter Outcome Scenarios

The files below contain common outcome scenarios.

The document below describes the scenarios

Encounter Outcome Scenarios.docx

The PDFs below contain the associated Activity Flow Diagrams

Activity flow - Extended model.pdf

Activity Flow - Most Common Scenarios

Activity Flow - Most Common Scenarios

This document shows the Encounter Outcome combinations in table form:

Encounter Outcome mappings

This document shows the outcomes decision tree for the clinician making a treatment best option decision:

NPF - Encounter Outcome decision tr

This document summarises how the Encounter Start Date, Encounter End Date, Procedure or Treatment Date and Date Test Results Reported apply to each Service Type.

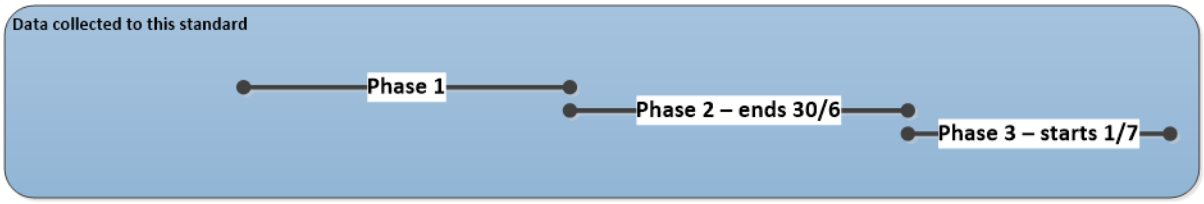
APPENDIX E - Encounter Date Information.xlsx

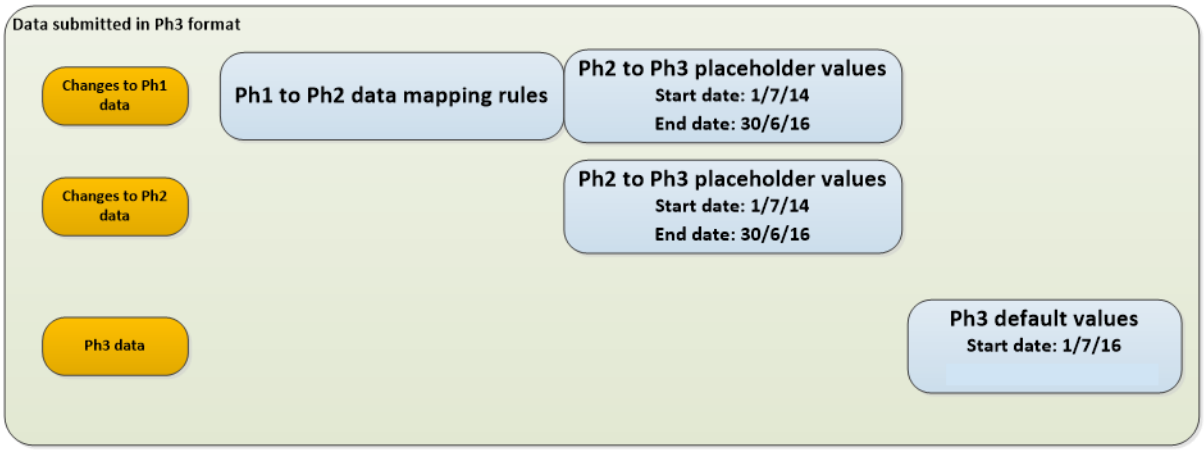
19. Appendix F: Moving from Phase 2 to Phase 3

19.1. Overview

- For the rationale and usage of placeholder and default values refer to “4.8 - Moving from Phase 2 to Phase 3 and handling of data element validation”
- Placeholder values allow changes to data gathered in Phase 2 to be submitted in the Phase 3 format. The placeholder values are included in this document.
- Default values allow those submitting organisations that cannot fully meet the Phase 3 requirements to submit to Phase 3. Default values are not included in this document as their use is subject to any remediation plans agreed with the Ministry.
- The following types of data elements are impacted:
    - Code sets
    - Data domains (those data elements that have a list of values in their data domain, rather than a code set name). Examples:
        - Presenting Problem Code Type
        - Faster Cancer 2 Weeks Urgency Indicator
    - Dates
    - Data elements that are required, but the values are not validated by the Collection. Examples:
        - NBRS Local Booking System Entry ID
        - Prioritising Clinician Code
        - Overall Stage Group – Cancer
- Changes to data gathered in Phase 1 are treated as Phase 2 data. That is, the Phase 1 to Phase 2 data mapping rules are applied, then the Phase 2 to Phase 3 placeholder values are included.

19.2. Managing the period of validity





- Most values will have a start and end date, including dates. Only values for data elements that are not validated will not have start and end dates.
- Default value start dates will be set to the start of the new phase, as placeholder values must be provided prior to that date.

- Default value end dates will be set to match the agreed exception period.
- Placeholder value start dates will be set to the start of the Collection (1 Jul 2014), as they will be required for changes to all data, back to the beginning of the Collection.
- Placeholder value end dates will be set to the day before the Phase 3 begins, as they are not permitted to be used in Phase 3.
- The dates in the diagram are examples. The actual dates are shown where relevant in this file spec. The dates 30/6/16 and 1/7/16 will change if the start date of Phase 3 of the Collection is changed.

19.3. Rules for impacted data types

19.3.1 Code sets

Are managed by providing a default and a placeholder code in the code set.

19.3.2 Data Domains

Are managed by converting these to code sets and then managing them as such. This file spec and the XSD reflect this change.

19.3.3 Dates

Are managed by providing a placeholder (1999-01-01) and default (1999-12-31) date.

These are validated by:

- First checking whether the submitted date is a placeholder or default date.
- If it is a placeholder or default date:
  - Check whether the event date (for that dataset) falls between the start and end dates for the placeholder or default date.
  - Reject the file if it does not fall between the start and end dates, accept it if it does.
  - Put the placeholder or default date into the Collection if it was accepted.
- If it is not a placeholder or default date:
  - Apply the normal rules to the date, if there are any.

19.3.4 Data elements that are not validated

Submitting Organisations are expected to provide the supplied placeholder and default values to improve reporting accuracy, but this is not checked in any way.

19.4. Phase 1 to Phase 3 mapping

The mapping of placeholder codes to Phase 3 data is set out in this sheet.

NPF Ph3 - Ph2 to Ph3 Mapping v1.2.xlsx

NPF Ph3 - Ph1 to Ph3 Mapping v1.0.xlsx

NPF Ph3 - Explaining the Ph2 to Ph3 Transit