Health New Zealand
Te Whatu Ora

National Collections Annual Maintenance Project 2026

Sector Consultation Business Requirements NCAMP 2026

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Te Whatu Ora

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1 Introduction

This document provides a vehicle for the discussion of the requests for changes to the National Collections and documents the requirements for the 2026 National Collections Annual Maintenance Project (NCAMP).

All feedback is welcomed and should be directed to ncamp@tewhatuora.govt.nz

1.1 Project Background: National Collections Annual Maintenance

NCAMP is run annually to perform maintenance on the Health New Zealand - Te Whatu Ora National Collections and to ensure it meets its ongoing statutory obligations. The project will deliver changes to the following National Collections/Systems:

- National Minimum Data Set (NMDS)
- National Non-Admitted Patient Collection (NNPAC)
- Programme for the Integration of Mental Health Data (PRIMHD)

Some NCAMP changes require Districts, Non-Governmental Organisations (NGOs) and private hospitals reporting directly to National Collections to implement changes to their Patient Administration Systems (PAS) or Patient Management Systems (PMS).

1.2 NCAMP Goals and Objectives

- To improve data quality to enable National Collections and Districts to accurately report on the provision and funding of services or treatment.
- To ensure data quality and integrity is maintained to avoid substantial rework by National Collections, Districts and NGOs.
- To improve National Collections and Districts ability to provide timely, accurate and comparative information. This will assist them to complete functions and meet objectives set out in the Pae Ora (Healthy Futures) Act 2022.
- To enable National Collections to meet its obligations of providing high quality data to the Districts, NGOs and other providers, particularly in relation to data processing and reporting, manual data entry, and application of data collection business rules.

2 Background

2.1 Assumptions

BA1. Maintenance items relating to the National Collections that do not impact Districts or NGO processes or systems may potentially be delivered in maintenance releases during the year.

BA2. Major increases in capability to the National Collections will be delivered through projects endorsed in the annual expenditure and are subject to business case approval.

2.2 Business Rules

Where relevant, for clarity or additional detail, the business rules will be listed individually with each change. Further detail may be provided in the sector notifications. All rules and requirements etc. are based on the National Collections and systems and care should be taken when analysing these taking into account local systems configuration.

2.3 Relevant Dates

- The cut-off date for requests for NCAMP 2026 was 31 August 2025
- The proposed scope for NCAMP 2026 was finalised on 30 September 2025
- Formal change notices will be issued in December after sector feedback is considered.

3 National Minimum Dataset (NMDS)

3.1 Annual WIESNZ and Cost Weight Changes for 2026/27

The New Zealand Casemix Framework for Publicly Funded Hospitals (WIESNZ) is a mandatory update for NCAMP each year. The requirements for the Weighted Inlier Equivalent Separation (WIESNZ) and cost weight changes are sourced from the national Cost Weights Working Group as part of the annual National Costing Collection Pricing Programme (NCCPP). WIESNZ is the methodology used to calculate the cost weight value for each event based on the assigned AR-DRG and New Zealand costs, and the assignment of purchase units. If WIESNZ26 is not implemented, National Collections and Districts will have to maintain the 2025/26 casemix framework (WIESNZ25), which will cause a significant impact on comparative cost analysis and subsequent resource allocation accuracy.

The 2026/27 New Zealand Casemix Framework for Publicly Funded Hospitals (WIESNZ26) document is expected to be available on the NCAMP website in December 2025.

3.2 Removal of 3-hour Emergency Department (ED) Admission Rule

The ED project team has investigated and consulted with Districts on the impact of change to the ED 3-hour admission rule. The ED project team's summary of issues and proposal to remove the ED 3-hour admission rule for NMDS reporting is provided below.

Description	**Removal of the 3-hour ED Admission rule** **Note that OB units are part of ED and acute assessment units are part of the hospital.** **Background** General Counting Standard for Admission in the Common Counting Standard references to a rule by which patients in ED longer than 3 hours from assessment to discharge must be reported as an inpatient event to NMDS. **Issue** **Counting variance:** It is difficult to derive comparable data on ED flows due to the presence of counting-only events and is time consuming for data analysts to build useable datasets to respond to queries. **Funding disparity:** ~31% of non-admitted patients are counted as inpatients due to the rule, despite only being treated in ED. Treatments delivered in ED are ~63% less expensive than the equivalent on a ward. Funding Districts based on admissions made under the 3-hour rule does not reflect the true cost of the services delivered, and under-represents ED service delivery. **Operational Redundancy:** Legacy Patient Administration Systems (PAS) in many Districts require manual, duplicate data entry and later manual clean-up by analysts. **Growing Impact:** Approximately 300,000 3-hour ED events are recorded annually and this volume is expected to rise; the financial and operational distortion is expanding, exacerbating inequities across Districts and misrepresenting actual service delivery.

#	
BR1.	Common Counting Standards documentation: • Update General Counting Standards general vs. specific example • Update Admission definition to exclude EDs from the 3-hour rule • Update Emergency Department Attendances definition to remove 3-hour statements
BR2.	NMDS File Spec document: Update 13.1 Event Start Time definition to remove 3-hour rule reference and state that event start is now on arrival at ward time for patients arriving from ED (including the AAU) • Update 13.2 to remove E* (except ED) event end type codes • Update 13.3 to remove E* (except ED) event end type codes • Add validations in NMDS for use of E* (except ED (patient died in ED)) event end type codes for events with an event end datetime on or after 01/07/26 Note: M05 speciality is still valid for use in NMDS for inpatients under the care of an Emergency Medical Specialist in an Acute Assessment Unit.
BR3.	NMDS file validation checks: • • The NMDS file validation will reject all records with an event end type of E – except ED (ie where the patient died in ED).
BR4.	NMDS Data Dictionary: • Remove all references to E* (except ED) event end type codes • Remove references to procedures in ED being coded against the NMDS event • Update Event start datetime definition to state that acute event start is from arrival at the ward • Update Total hours on mechanical ventilation definition • Appendix J (Guide for use of ED Event End Type codes) removed entirely and all references to Appendix J. This will be replaced with a new appendix for AAU patients showing the reporting flows.
BR5.	Update Event end type definitions document
BR6.	Update the NMDS datamart (Snowflake) dictionary and associated documentation
BR7.	Update HNZ webpages
BR8.	Historic reporting e.g. in Qlik apps is re-built showing past years NMDS data excluding all 3-hour ED events to allow reporting on past periods for forecasting. This includes the HDP and Northern Region snowflake environment.
BR9.	Casemix and non-Casemix breakdowns are adjusted to allow for correct share to be applied to Emergency events
BR10.	Districts update all material/policies that reference the 3-hour ED admission rule
BR11.	Update Appendix B: National Collections Glossary

4 National Non-Admitted Patient Collection (NNPAC)

4.1 Removal of 3-hour Emergency Department (ED) Admission Rule

The ED project team have investigated and consulted with Districts on the impact of a change to the ED 3-hour admission rule. The ED project team summary of issues and proposal to remove the ED 3-hour admission rule for NNPAC reporting are provided below.

Description	**Removal of the 3-hour ED admission rule** **Background** General Counting Standard for Admission in the Common Counting Standard references a rule by which events in ED longer than 3 hours from assessment to discharge must be reported as an inpatient event to NMDS. **Issue** **Counting variance:** It is difficult to derive comparable data on ED flows due to the presence of counting-only events and is time consuming for data analysts to build useable datasets to respond to queries. **Funding disparity:** ~31% of non-admitted patients are counted as inpatients due to the rule, despite only being treated in ED. Treatments delivered in ED are ~63% less expensive than the equivalent on a ward. Funding Districts based on admissions made under the 3-hour rule does not reflect the true cost of the services delivered, and under-represents ED service delivery. **Operational Redundancy:** Legacy Patient Administration Systems (PAS) in many Districts require manual, duplicate data entry during patient flow, and later manual clean-up by analysts. **Growing Impact:** Approximately 300,000 3-hour ED events are recorded annually and this is expected to rise; the financial and operational distortion is expanding, exacerbating inequities across Districts and misrepresenting actual service delivery.
#	
BR1.	NNPAC File Spec document: • Update NNPAC ID field to state NMDS PMS unique identifier is mandatory if the event end type code is EW or the clinical disposition is OAD. Currently, the “NMDS PMS unique identifier” field in the NNPAC file specification states it is mandatory where the PUC is “ED%A”. The proposal changes this rule to be “mandatory when the event end type is EW or the clinical disposition is OAD”. If the event end type indicates an admission occurred, then the file specification enforces that the admission that occurred is referenced. Update 11.6 end type code validation table
BR2.	NNPAC file validation checks: Fail validation with error when DW event end type code is used for events after 01/07/26

BR3.	NNPAC Data Mart Data Dictionary: • Update DW event end type to EW for consistency where patient leaves from the ED or OB. • Update Appendix E to include EC and EW Appendix I (Guide for use of ED Event End Type codes) updated
BR4.	Update Event end type definitions document
BR5.	Update HNZ webpages
BR6.	Districts update all material/policies that reference the 3-hour ED admission rule
BR7.	Update all Qlik apps and snowflake instances of NNPAC (including mirror sites at Northern Region and on the HDP) that have historical NNPAC time series data. Replace the associated documentation with the new NNPAC time series definitions and update that documentation with this change.

5 Programme for the Integration of Mental Health Data (PRIMHD)

5.1 New referral code for PAS migrations (referral to/from and referral end code)

Description	**New referral discharge (RD) Records codes for migrations from one PAS to a new PAS** **Background** Currently when an organisation migrates between patient management systems, the preferred method is to close all open referrals on a set date, then reopen those referrals on the same date in the new system. **Issue** The problem of the use of generic codes is twofold. Affecting the provider (due to confusion as to why the referral has "ended routinely" when it is ongoing) but predominantly for data management. The impact is that it is difficult to follow a patient's treatment pathway, if their provider (whether NGO or District) has been through a data migration project. This may also impact reporting with these referrals being classed as "ended routinely" when they have not. **Proposal** Add a new Migrated Referral code to three fields: Referral From, Referral To and Referral End Code to stipulate that data has been migrated and the treatment/referral is ongoing.
#	
BR1.	Add new MR – Migrated referral to the following three fields Referral From, Referral To and Referral End Code
BR2.	Update PRIMHD file specification section 5.3.2 Referral Discharge Code Set Elements
BR3.	Update PRIMHD file specification section 5.3.3 RD Record Business Rules

6 Advisories

6.1 National Health Index (NHI)

6.1.1 Advisory Change to National Health Index (NHI) Numbering System

Summary:
The National Health Index (NHI) has assigned the majority of the currently available NHI numbering range. Existing allocations of NHI numbers are forecast to be exhausted in 2026 based on current rates of allocation.

About the NHI
The NHI is crucial for linking patient health information in New Zealand. Created at birth or during the first interaction of an individual with health services, it includes a unique identifier and demographic information.

Current and new formats
• Current Format: AAANNNC (3 alpha, 3 numeric, 1 numeric check digit) - covers 9 million unique identifiers.
• New Format: AAANNAX (3 alpha, 2 numeric, 1 alpha, 1 alpha check digit) - expands to 33 million unique identifiers.

Both formats will co-exist.

Action required
Health IT suppliers must ensure systems support both formats by 30 June 2026.

Next steps
1. Self-compliance testing: Ensure your systems are ready for the change. [Click here for self-assessment]
2. Update compliance status: Update your compliance status, request support, and provide feedback. [Click here to update your status]

Additional support
For more information, please view the information on the HNZ website:
- NHI Overview
- NHI Format Change
- HISO Standard Compliance

Email: Integration@tewhatuora.govt.nz

6.1.2 Advisory Ethnicity Protocols

Summary:

The ethnicity protocols have been updated to address the move in the health and disability sector to electronic collection and storage of data. The protocols define appropriate processes for confirmation or correction of ethnicity where existing data is held for a respondent and an appropriate frequency for collecting ethnicity data.

NHI FHIR (Fast Healthcare Interoperability Resources) services are now available in production. Hospitals are expected to transition to NHI FHIR (or SOAP) services to update NHI ethnicity at level 4. Please contact ws_integration@health.govt.nz or refer to https://marketplace.hira.health.nz/apis/national-health-index/ for further information.

As an initial step, hospitals may choose to update and store level 4 ethnicities at a local system level. Once hospitals have transitioned to the new NHI services and are updating ethnicity at level 4 there will no longer be a requirement to report ethnicity in any load file to National Collections.

The HISO 10001:2017 Ethnicity Data Protocols define appropriate processes for confirmation or correction of ethnicity where existing data is held for a respondent and an appropriate frequency for collecting ethnicity data.

The protocols support a transition from the previous minimum requirements of recording up to three ethnicities at level 2 classification to recording up to six ethnicities at level 4 classification. This reflects the requirement for information systems to capture the greater population diversity and improved granularity of information to plan, fund and monitor health services. These changes represent a significant move forward in terms of ethnicity data collection and will make a valuable contribution for health. https://www.health.govt.nz/publication/hiso-100012017-ethnicity-data-protocols.

User Interfaces should align closely with this example based on the census on-line collection method. http://refraction.nz/eths

6.2 National Non-Admitted Patient Collection (NNPAC)

6.2.1 Advisory Change to Purchase Units for Community Radiology – CS01001

Summary

Currently Districts submit activity to NNPAC for CS01001 – Community Radiology (GP referred radiology into a hospital) with an RVU unit of measure. It is proposed that the unit of measure will change from an RVU to “test”.

As multiple radiology scans can be provided during the same event, the PMSUID will need to link to the radiology system event number rather than the local system event level ID as illustrated below:

A GP refers in a patient for radiology for an orthopaedic condition. The patient has an X-ray and a CT during the same visit generating a single event number in the District’s system for the visit, but two event numbers in the radiology system.

Current State - Unit of Measure = RVU:

One episode in NNPAC (episode no 600700) with an RVU of 4.6 consisting two scans, an X-ray and a CT.

- Radiology event 123456, episode 600700 (NNPAC) XR (RVU = 1)
- Radiology event 123457, episode 600700 (NNPAC) CT (RVU = 3.6)

Proposed Change – Unit of Measure = Test

Two episodes in NNPAC with a different episode number – each with a count of 1

- Radiology event 123456, episode 123456 (NNPAC) *modality = XR**
- Radiology event 123457, episode 123457 (NNPAC) *modality = CT**

Note, the modality requirement will be phased in from 1 July 2027. At this stage the purchase unit CS01001 will no longer be available for reporting in NNPAC.

Context of the change

- The unit of measure for community radiology (CS01001) is an RVU. This RVU is defined in the Community Radiology Service Specification (updated Sep 2024) as:

PU Measure	Reporting Requirements	
	Frequency	*Reporting Unit*
Relative Value Unit (RVU)	Monthly	• Total number of RVU. RVU is an individual operative/diagnostic/assessment procedure completed according to the Royal Australian and New Zealand College of Radiologists definition for RVUs and codes.
	Quarterly	Number of procedures by RVU • by type (plain film, non maternity ultrasounds, fluoroscopy, diagnostic mammography, CT, nuclear medicine, other) Number of clients • by ethnicity (NZ Māori, Pacific Island, Other) Average waiting time • by type (plain film, non maternity ultrasounds, fluoroscopy, diagnostic mammography, CT, nuclear medicine, other)

However, this RVU structure has not been updated from some years and Districts all use their own versions.

- From an operational perspective, there has been a growing push to monitor CS01001 activity by test type, e.g. X-ray, CT etc.
- Over the past two years, cost data has been collected by modality to enable a new suite of purchase units to be developed with associated pricing work occurring alongside.
- The proposed suite of purchase units will be modality based, but some issues need to be resolved. For example:
  - Some Districts capture bone densitometry against CS01001 and others capture it against CS04005 – community referred endocrinology. There are other areas of inconsistency that need to be resolved, e.g. non maternity ultrasound.
  - The boundary between some areas is unclear. Some districts map image guided injections to fluoroscopy, while others map it to the modality used, e.g. Ultrasound

What is expected of the sector

- Due to timing, we are proposing a two year implementation process. Year 1 is a shift to report tests at an event level rather than RVU. Year 2 will be to report against new purchase units based on modality using a national agreed criteria.

- Districts will be required to change the unit of measure from 1 July 2026 where possible. Implementation of shifting to test from RVU and reporting against new purchase units based on modality will be mandatory from 1 July 2027.

6.2.2 Advisory NNPAC Minor Eye Procedures S40008

Hospitals are encouraged to do more same day surgery in an outpatient environment, which is beneficial for the patient and more efficient for the hospital, however it means that the clinical information about the procedure performed on a healthcare user is not captured when reporting to NNPAC.

NCAMP 2023 introduced five minor operation PUCs that can have procedures reported against them from 1 July 2023. After consultation with the sector, it was determined that further work was required for each of the minor procedures to finalise the procedures listed in the NNPAC minor procedures reference sets.

The list of procedures for minor eye procedures has been finalised and is available from the SNOMED International reference set library at SNOMED CT Reference Set Tool 2.0.

6.2.3 Advisory Standardised Recording in Emergency Departments

Summary

For every ED attendance a chief presenting complaint and one or more SNOMED CT diagnosis concepts are to be recorded and reported using the respective ED reference sets in the October 2025 release or later release of the SNOMED NZ Edition.

Context of the change

HNZ has set a standard for improved reporting of ED attendances that requires the chief presenting complaint and diagnoses to be recorded and reported using standard code sets for every ED attendance. With SNOMED CT as the standard for clinical terminology, these data elements must be recorded and reported using the respective reference sets in the SNOMED NZ Edition:

- New Zealand emergency care presenting complaint reference set (71000210108)
- New Zealand emergency care diagnosis reference set (61000210102).

See the statement on HISO 10048 Emergency Care Data Standard for more information about these reference sets.

Since the NCAMP21 introduction of mandatory submission of standard chief presenting complaint and diagnoses for every ED attendance, the reference sets have undergone many review cycles by the SNOMED ED clinical leadership group that meets every six months ahead of the April and October releases of the SNOMED NZ Edition.

Many sites have not updated their version of the emergency care reference sets since initial implementation in July 2021, whereas it is our expectation that these updates should occur at least yearly and ideally every six months in keeping with the SNOMED NZ Edition releases.

It is important that sites stay current with the reference sets for several reasons:

- The reported data is important to the Shorter Stays in Emergency Departments health targets. The SNOMED concepts enable mental health presentations to be identified and ensure all ED attendances can be categorised by presenting complaint and diagnosis type.

- Effective data analytics depends on sites using the same up-to-date emergency care reference sets. The use of many different versions of the reference sets across the country introduces complexities for analytics. SNOMED concepts that have been inactivated, removed or replaced, but are still being submitted by Districts, create an overhead because they require mapping to provide a consistent base from which analytics and target-related reporting can occur.
- Clinical utility and ease of use depends on staying current with emergency care reference sets that have undergone clinically-led refinement since mandatory implementation in 2021.The regular six-monthly improvement cycles by ED clinicians has meant that the reference sets have been refined to remove ambiguity, duplication, and to enhance clarity of meaning.
- Strengthened use of SNOMED in recording and reporting supports the ED three-hour rule change. Inpatient clinical coding for emergency patients remaining three hours or more from treatment is being removed from 1 July 2026. This means increased reliance on SNOMED recording and reporting for ED attendances.

What is expected of the sector

The minimum expectation is that ED information systems at all sites are updated to the October 2025 release or later release (expected April 2026) of the SNOMED ED reference sets by 1 July 2026.

Methods for updating to the current releases

1. Download the SNOMED NZ Edition file package from mlds.ihtsdotools.org to load into the ED information system or local terminology server.
2. Integrate the ED information system with the New Zealand Health Terminology Service (NZHTS) to access the reference sets via FHIR API or syndication feed and cache them in the local system. Request an NZHTS API key from the Digital Services Hub.
3. Use the Excel sheets available on our website.
4. Use a validated mapping. Some systems of record for ED data have not implemented SNOMED directly and they are mapping from existing local code systems. This is acceptable for NCAMP26 provided the site is using a validated mapping to a current release of the standard reference sets (October 2025 or later). To ensure these are clinically valid we ask that these mappings are submitted to the Standards team for clinical and technical review. Sites using mapping today should plan for direct use of the emergency care reference sets by NCAMP28.

Mandatory requirements

- The user interface must be appropriate for the data being entered and be quick and easy for the clinician.
- The concept identifiers should not be visible to the clinical user on the frontend, but the preferred term should be displayed.

Optional feature

- There should be the ability for synonyms to be used in code searches.

Implementation support

For implementation support contact standards@tewhatuora.govt.nz.

Refer to the SNOMED CT Search and Data Entry Guide for general guidance on user interface and application design.

6.3 Programme for the Integration of Mental Health Data (PRIMHD)

6.3.1 Advisory PRIMHD Principal Diagnosis Reporting

Summary:

All mental health and addiction tangata whaiora/consumers of Health New Zealand - Te Whatu Ora provider arm teams are to be assessed and a diagnosis documented within 91 days of the activity start date, or by the activity end date (whichever of these time periods occurs first) – refer to: HISO-10023-1-2023-PRIMHD-Data-Process-Standard.pdf

Context of the Change:

Currently many Mental Health & Addiction community services across New Zealand are not submitting community/referral based diagnosis information, and some systems do not seem to be set up to collect this information.

Business Rule Reference	Business Rule Description	Affected Data	Response Message Reference
BR-P61-15	▪ A *Type A Diagnosis* should be supplied within 91 days of the first face-to-face *Activity Start Date Time* for each referral, except in the following circumstances, when no *Type A Diagnosis* is required: ▪ If the Service Provider Organisation Type is not 001 (DHB). ▪ If the Referral End Code is one of the following: DG, DM, RI, RO, ID.	▪ Diagnosis Type ▪	▪ RM-P62-37 ▪
BR-P61-16	▪ A *Type A Diagnosis* should be supplied before the *Referral End Date Time* for each referral, except in the following circumstances, when no *Type A Diagnosis* is required: ▪ If the *Service Provider Organisation Type* is not 001 (DHB). ▪ If the *Referral End Code* is DG, DM, RI, RO, ID.	▪ Diagnosis Type ▪ Referral End Date	▪ RM-P62-38 ▪ RM-P62-38

What is Expected of the Sector:

A reminder that an inpatient and community referral diagnosis is required for all MH&AS referrals.

7 Appendix A – Definitions

Abbreviation	Definition
API	Application Programme Interface
AR-DRG	Australian Refined Diagnosis Related Groups
ED	Emergency Department
FHIR	Fast Healthcare Interoperability Resources
HISO	Health Information Standards Organisation
HL7	Health Level 7
ID	Identifier
NCAMP	National Collections Annual Maintenance Project
NCCPP	National Costing Collection Pricing Programme
NGO	Non-Government Organisation
NHI	National Health Index
NMDS	National Minimum Data Set
NNPAC	National Non-Admitted Patient Collection
NZ	New Zealand
PAS	Patient Administration System
PMS	Patient Management System
PRIMHD	Programme for the Integration of Mental Health Data
PUC	Purchase Unit Code
SNOMED-CT	Systematized Nomenclature of Medicine – Clinical Terms
SOAP	Simple Object Access Protocol
WIES	Weighted Inlier Equivalent Separation
WIESNZ	Weighted Inlier Equivalent Separation New Zealand

8 Appendix B – Document Control

Document Details

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