

Cover

Victorian healthcare experience survey

Potential Participant Data Upload Manual

Version 1.2: 09/2021

Key Contacts

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Purpose for Contact:	All operational related matters regarding uploading potential participant records listed within this document.



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Requirements

Summary

The requirements section of this manual sets out the expectation and action required by data managers responsible for uploading potential participant information.



Requirements

How to Access this Manual

This manual is available for download via the VHES Project Control Portal (PCP) (www.vhes.com.au/depthealth). Login to the PCP and view the download tab to download a copy of the manual.

When this manual is updated, an email communication will be sent to those responsible for uploading potential participant information advising that a new edition exists – highlighting specific areas where a change has been made and what impact, if any, the change has on the role of the data manager.



Requirements

How to Login to the Project Control Portal

Go to www.vhes.com.au/depthealth and enter your Username and Password.

Your Username is the four-digit campus code of the campus or campuses for which you are responsible for uploading potential participant records. Your password for the month is sent to both primary and secondary contacts. If you cannot recall your password, simply contact Joe Curran from Ipsos.

 Victorian healthcare experience survey

Log In

User name

Password

☐ Remember me?

Log In

If you have any queries or concerns about this project please contact Alex Simmonds - Project Manager at 0305 111 View on (02)9140 7750 or alex.simmonds@vhes.com.au
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Requirements

How to Update a Campus' Primary and Secondary Contact

Once you have logged in, you will be presented with this summary screen.

The 'Contacts' tab allows you to manage the primary (Contact 1) and secondary (Contact 2) contacts who are responsible for uploading potential participant records.

Simply overwrite the existing primary or secondary contact details when required (e.g. the primary contact is replaced within your organization).

All communications regarding uploading potential patient records will be directed to the primary contact. The secondary contact will be approached if the primary contact cannot be reached.

The table below the 'Contacts' section provides a summary overview of the number of potential participant records uploaded ('received') relative to expectation ('expectation'). Each quarter, Ipsos will monitor whether the expectation accurately reflects the quantity received – making adjustments as required.

Victorian healthcare experience survey

Username: rhh
Logout

Department of Health File Loader

Royal Melbourne

Contacts Load File

Contact 1

Given Name: John

Surname: Smith

Email: pblume@acceleon.com.au

Phone: 03 9670 9797

Contact 2

Given Name: Mary

Surname: Jones

Email: patrick.c.blume@gmail.com

Phone: 03 9670 9753

Cancel Save

	1/2014	2/2014	3/2014	4/2014	5/2014	6/2014	7/2014	8/2014	9/2014	10/2014	11/2014	12/2014	Total
Expectations:	605												605
Received:	915												915
Sampled:	153												153
Emailed:	72												72
Mailed:	76												76
Refused:	1												1
Responded:	4												4



Requirements

How to Create a File for Upload

A CSV template has been created for the purposes of creating a file for upload. This template is available for download on the PCP. Login to VHES website to download the CSV template <https://www.vhes.com.au/Account/Login>

This template is essential for a successful upload and will ensure your file does not encounter the “the file does not contain a recognized header row” error.

Please upload all available records, the PCP will:

1. Separate Adult and Pediatric records
2. Apply checks to ensure we are approaching people at an appropriate frequency
3. Randomly select a pre-arranged volume of records for participation

While the PCP will conduct checks on the data listed above, however it is each data-uploader’s responsibility to ensure all exclusions (listed below under Exclusions) are adhered to before the files are uploaded into the PCP.

Where possible, data fields required for a successful upload have been derived from fields defined within the Department of Health Victorian Admitted Episodes Dataset (VAED) User Manual, and the Victorian Emergency Minimum Dataset (VEMD).

Using your Campus Code as a reference, please select all potential participants for the given time period, ensuring that required fields are complete. Please also ensure that the ‘Datatype’, ‘Form’, ‘Field size’ and ‘Layout’ conventions outlined below are also adhered to.

You can combine all ‘admission types’ into one file (e.g. Inpatient, Non-Admitted Emergency and Maternity together) or provide multiple files within a given month comprising of separate ‘admission types’ (e.g. a file for Inpatient, a file for Non-Admitted Emergency and a file for Maternity).

Once your file is complete and you are confident all fields have been populated as specified, please save the file as a “.csv”, employing the naming convention below.



Requirements

Naming Conventions for File

Please employ the following naming convention for each file:

Campus Code (NNNN), Year (NNNN), Admission Type (“I” = Inpatient, “E” = Non-Admitted Emergency, “M” = Maternity, or “SC” = Specialist Clinic) Month (NN).

In practice, a combined file of potential participants from Bendigo Health [Bendigo Hospital Campus] who received Inpatient, Non-Admitted Emergency and Maternity care in March 2021 would look as follows:

“1021-2021-IEM-03”

In practice, a file of potential participants from Bendigo Health [Bendigo Hospital Campus] who received Inpatient care in March 2021 would look as follows:

“1021-2021-I-03”



Inclusions:

Inclusions	Rule
Inpatient and Maternity Episodes	Include all inpatient and maternity episodes with a discharge date/time within the date range of the extract with a coding status of 'Completed' (Separation prcae.cstat_refno = 'COMPL').
Inpatient and maternity episodes, Emergency Attendances and Specialist Clinic Outpatient appointments for clients that have provided consent to have their information included in the Victorian Healthcare Experience Survey.	Consent is identified using the VHES Consent field on the Patient Admit Form, A&E Attendance Details Form and Appointments Form, Patient Survey Tab Only include where USSCR, code = 'SWFUS_PS', and/or USSCR, code = 'SWFUS_PSOP' and/or USSCR, code = 'SWFUS_PSAE' LCLDS, code = 'SWFDS_PS', LCLDI, code = SWFD1_PS, LCLDA, ussob_value_nnn = N (i.e. box is un-ticked)
Inpatient and Maternity Episodes that have been separated to private residence/accommodation or left against medical advice.	Include inpatient and maternity episodes that have a VAED Separation Mode of H Separation to private residence/accommodation or Z Left against medical advice (PRVSP, dismt_refno VAED, else SR, else Main Code = H or Z)
Maternity Episodes where all associated baby inpatient episode have been separated to private residence/accommodation or left against medical advice.	Include maternity episodes where all associated baby inpatient episode have a VAED Separation Mode of H Separation to private residence/accommodation or Z Left against medical advice (PRVSP, dismt_refno VAED, else SR, else Main Code = H or Z)
Emergency Attendances	Include all emergency attendances with a departure date/time within the date range of the extract with a coding status of 'Completed' (aeatt.cstat+refno = 'COMPL').
Emergency Attendances that have been discharged to home and those who depart before treatment completed	Include emergency attendances that have a Departure Status main code listed in the System Profile SR_VHES_AE For example 1,11,10,30,5
Actual Appointments (excluding those entered via the Brokerage Form) attached to the Referral with Funding Arrangement of Specialist Clinic Outpatients (SCO)	Include all actual Appointments(excluding those entered via the Brokerage Form) with a Departure date within the date range of the extract that are attached to the Referral with Funding Arrangement (FUNDA) has an alternate identifier (RITYP) of VINAH with a value of SCO.



Exclusions from File:

Exclusion	Rule
Deceased patients	Exclude all patients where PATNT, decsd_flag = D or Y Technical Note: Update to also exclude Specialist Outpatient Clinic appointments for patients where PATNT, decsd_flag = D or Y.
Inpatient and Maternity Episodes and Emergency Attendances involving Termination of Pregnancy and Perinatal Death, Intentional self-harm, and Palliative Care	For Inpatient and Maternity Episodes, exclude: DGPRO, code Where ccsxt_code RITYP is 'VAED' = 'ICD', dptyp_code = 'DIAGN', 'PROCE' cancel_dttm = null For Maternity Episode exclude the patient under 16 for maternity Surveys Where DTTM_OF_BIRTH – Extract Run Date < 16 For Emergency Attendances, exclude: DGPRO, code Where sorce_code = AEATT and either: ccsxt_code RITYP is 'VAED' = 'ICD' (dptyp_code = DIAGN) or code (dptyp_code = DIAGN) has a link to another code where ccsxt_code RITYP is 'VAED' = 'ICD' (where extract end date falls within the code link period start and end range) For Inpatient Episodes, Maternity Episodes and Emergency Attendances diagnosis codes within the range X60 – X84 – Intentional self-harm O00-O08.9 – Pregnancy with abortive outcome, Z32.2 – Staged abortion Z37.1 – Single Stillbirth Z37.3 – Twins, one live born and one stillborn Z37.4 - Twins, both stillborn Z37.6 – Other multiple births, some live born Z37.7 – Other multiple births, all still born Z51.5 - Palliative care For Inpatient and Maternity Episode procedure codes 35640-00[1265] – 'Dilation & curettage of uterus [D&C]. 35640-01[1265] – Curettage or uterus without dilation 35640-03[1265] – Suction Curettage of uterus. 35643-03[1265] – Dilation and evacuation of uterus [D&E]
Maternity Episodes without a live birth (vaginal or caesarean)	For Maternity Episodes, exclude where the episode is not coded with one of the following ICD codes: Z37.0 Single live birth Z37.2 Twins, both liveborn Z37.5 Other multiple births, all liveborn Determined by: DGPRO, code Where ccsxt_code RITYP is 'VAED' = 'ICD', dptyp_code = 'DIAGN', cancel_dttm = null



Exclusion	Rule
Patient care types for Palliative Care, Posthumous Organ Procurement, Unqualified Newborn], and Maintenance Care	Exclude where PRCAE, svcat_refno (care type) Main Code is listed in the System Profile SR_VHES_SVCAT_EXCL.
Inpatient and Maternity Episodes with a VAED Separation Referral to community palliative support	For inpatient and maternity episodes, exclude where PRVSP, rrfc_value RITYP = 'VAED5', else 'VAED', 'SR' or main code has a value listed of B Community palliative care support, arranged before discharge Note: PRVSP, rrfc_value is a comma separated list of rrfc_refno. Derive using each rrfc_refno listed
Emergency Attendances apart from those that have been discharged to home and those who departed before treatment completed	Exclude emergency attendances that have a Departure Status main code not listed in the System Profile SR_VHES_AE For example exclude emergency attendances with a departure status other than 1,11,10,30,5
Patients with a Preferred Language that is not one of the 23 nominated Community Languages (refer to page 29)	Exclude where PATNT, spokl_refno (preferred language) Main Code is not listed in the System Profile SR_VHES_LANG_INC. Technical Note: Update to exclude Emergency Attendances and Specialist Outpatient Clinic appointments for patients with a Preferred Language that is not one listed in the System Profile SR_VHES_LANG_INC.
Episodes apart from Inpatient and Maternity Inpatients discharged to a private residence/accommodation and those who leave against medical advice	For inpatient and maternity episodes, exclude where PRVSP, dismt_refno is neither H nor Z. Note: Use the VAED hierarchy of VAED, else SR, else Main Code.
Maternity Inpatients where any associated baby inpatient episode is not discharged to a private residence/accommodation and those who did leave against medical advice	For maternity episodes, exclude where any associated baby inpatient episode PRVSP, dismt_refno is neither H nor Z. Note: Use the VAED hierarchy of VAED, else SR, else Main Code.
Inpatient and Maternity Inpatients, Emergency Attendances and Specialist Clinic Outpatient appointments that opt for exclusion	Exclude all appointments, Inpatient, Maternity episodes and Emergency Attendances for patients who does not consent to Survery where USSCR, code = 'SWFUS_PS' and/or USSCR, code = 'SWFUS_PSOP' and/or USSCR, code = 'SWFUS_PSAE' LCLDS, code = 'SWFDS_PS' LCLDI, code = SWFD1_PS LCLDA, ussob_value_nnn = Y (i.e. box is ticked)
Emergency Attendances for a COVID-19 test only	Exclude emergency attendances that have A+E Attendance Category (Type of Visit), AEATT, atcat_refno is 19 (COVID-19 assessment clinic) Note: Use the VEMD hierarchy of VEMD, else SR, else main code.
Non Specialist Clinic Outpatient appointments	Exclude all appointments that are not attached to the referrals with Funding Arrangement of SCO (Specialist Clinic Outpatients).
Planned Appointments	Exclude all planned appointments
Did Not Attend Appointments	Exclude all appointments with an Outcome of 'Did Not Attend' where (SCHDL,scocm_refno VINAH = DNA).
Cancelled Appointments	Exclude all appointments that are Cancelled.
Appointments without a departure date.	Exclude all appointments without a departure date or with a departure date/time outside the date range of the extract.
Brokerage will not be reported for Specialist Clinics (Outpatients).	Appointments entered via Brokerage Form will be excluded.



Uploading a File

Logging in and Drag and Drop functionality

- 1) To log in and upload your file, please visit:
<https://vhес.com.au/Account/Login>
- 2) Once you have logged in please click “Load File” up the top right of the page:



- 3) Once a file has been saved it is ready for upload. There are two options for uploading a file. The first option: ‘Drag and Drop’ requires the user to simply drag the saved file into the “Drop files here to upload” window below. Once done, the file will either be accepted or rejected. If applicable a summary of the reasons why certain records failed will be shown on the screen. Please refer to the FAQ section below if you have any queries about the messages you’re seeing.

Department of Health File Loader

Important Documents
Please use the following documents as a reference to help loading patient files into the system.

The Data Upload Manual (VHES)

Upload Template (VHES)

Example Upload (VHES)

Load File

The health service has no records to upload this month ☐

Authorised by:

Save

OR

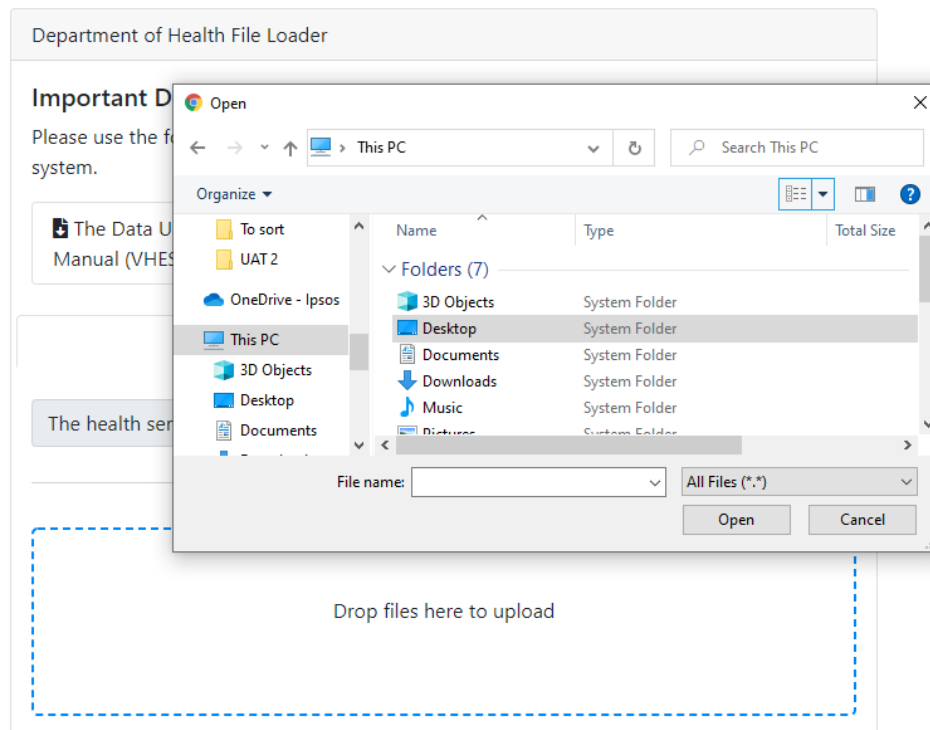
Drop files here to upload



Uploading a File

Manual Upload

- 1) The second option: a 'Manual Upload' requires the user to click the "Drop files here to upload" window. Doing so will open a window from which the user can select the file. If applicable a summary of the reasons why certain records failed will be shown on the screen. Please refer to the FAQ section below if you have any queries about the messages you're seeing.



Appendix 1

Data Definitions

Where possible, all the data fields have been derived from fields defined within the Department of Health Victorian Admitted Episodes Dataset (VAED) User Manual, and the Victorian Emergency Minimum Dataset (VEMD).

Spreadsheet Fields

The following fields are required to be correctly populated for each data-upload of potential participants:

1. Campus Code
2. Hospital Code
3. Unique Key
4. Separation Date
5. Title*
6. Given Name
7. Surname
8. Address Ln 1
9. Address Ln 2*
10. Locality
11. State
12. Postcode
13. Email Address
14. Admission Type
15. Preferred language
16. Date of Birth
17. Separation Status
18. Indigenous Status
19. Ward of Discharge code*
20. Ward of Discharge code (description)*
21. Mobile Phone Number
22. Contact Delivery Mode*
23. Gender
24. Date Of Admission*

*Not mandatory. Therefore, fields can be left blank. However, the field must still be included in the header row.

Additionally, please note at least one contact method must be include these are:

- **Address:** Address Ln 1, Locality, State, Postcode
- **Email:** Email Address
- **Mobile Number:** Mobile Phone Number



Header:	Campus Code
Definition:	The code for the hospital campus from which the potential participant is separated.
Datatype:	Numeric
Form:	Code
Field size:	4
Layout:	NNNN
Code set:	Select the appropriate Campus Code from the Campus Code list in Appendix 2
Purpose:	Identification of the campus for which the data is submitted.



Header:	Hospital Code
Definition:	The code for the hospital from which the potential participant is separated.
Datatype:	Numeric
Form:	Code
Field size:	3
Layout:	NNN
Code set:	Select derive the Hospital Code from the Campus Code
Purpose:	Identification of the hospital for which the data is submitted. Potential use for reporting to facilitate small sites receiving unique representation.



Header: Unique Key

Definition: A unique identifier specific to the individual admitted patient episode of care that is consistent with data submitted to the Victorian Admitted Episodes Dataset (specifically the episode number) or the Victorian Emergency Minimum Dataset. This is NOT the UR number or patient number.

Datatype: Alphanumeric

Form: NA

Field size: 9

Layout: XXXXXXXXX; Right justified, leading zeros filled

Code set: Hospital generated

Purpose: A unique identifier specific to an individual presentation.



Header:	Separation Date
Definition:	The date of the separation for potential participants.
Datatype:	Numeric
Form:	DATE
Field size:	8
Layout:	DDMMCCYY
Code set:	NA
Purpose:	Used for on invitation (“Tell us about your experience on XXXX”) and analysis.



Header: Title

Definition: The abbreviated, preferred title of each potential participant.

Datatype: Alphanumeric

Form: Text

Field size: 12 (max)

Layout: Left justified, trailing spaces

Code set: Select the first appropriate abbreviated title from the list of commonly used titles.

BR	Brother
DAME	Dame
DR	Doctor
MSTR	Master
MISS	Miss
MR	Mister
MRS	Mrs
MS	Ms
PROF	Professor
REV	Reverend
SIR	Sir

Purpose: Covering and reminder / thank you letter



Header:	Given Name
Definition:	The first name of the potential participant.
Datatype:	Alphabetic
Form:	Text
Field size:	50
Layout:	Left justified, trailing spaces.
Code set:	NA
Purpose:	Invitation and reminder communications



Header:	Surname
Definition:	The surname or family name of the potential participant.
Datatype:	Alphabetic
Form:	Text
Field size:	50
Layout:	Left justified, trailing spaces.
Code set:	NA
Purpose:	Invitation and reminder communications



Header:	Address Ln 1
Definition:	The street or postal box address associated with the postal address for each potential participant.
Datatype:	Alphanumeric
Form:	Text
Field size:	180
Layout:	Left justified, trailing spaces.
Code set:	NA
Purpose:	Invitation and reminder communications



Header: **Address Ln 2**

Definition: The street or postal box address associated with the postal address for each potential participant. Only required if more than one address provided. For example, if the person has a 'Name' and then an 'Address'. In example: "Happy Farm", "123 Smith Street". In this example "Happy Farm" would appear in Address Ln 1, "123 Smith Street" would appear in Address Ln 2.

Datatype: Alphanumeric

Form: Text

Field size: 180

Layout: Left justified, trailing spaces.

Code set: NA

Purpose: Invitation and reminder communications



Header:	Locality
Definition:	The suburb / town associated with the postal address for each potential participant.
Datatype:	Text/Alphabetic
Form:	Text
Field size:	46
Layout:	Left justified, trailing spaces.
Code set:	NA
Purpose:	Invitation and reminder communications



Header:	State
Definition:	The state associated with the postal address for each potential participant.
Datatype:	Alphabetic
Form:	Text
Field size:	15
Layout:	Left justified, trailing spaces.
Code set:	NA
Purpose:	Invitation and reminder communications



Header:	Postcode
Definition:	The postcode associated with the postal address for each potential participant.
Datatype:	Numeric
Form:	Code
Field size:	4
Layout:	NNNN
Code set:	NA
Purpose:	Covering and reminder / thank you letter



Header:	Email Address
Definition:	The email address associated with the postal address for each potential participant.
Datatype:	Alphanumeric
Form:	Text
Field size:	250
Layout:	[username]@[domain].[domain-suffix].[country-code](if-applicable) e.g. "johnsmith@example.com.au"
Code set:	NA
Purpose:	Invitation and reminder communications



Header: Admission Type

Definition: The category of admission (patient characteristic) relating to this episode of care.

Datatype: Alphabetic

Form: Code

Field size: 2

Layout: A

Code set: One of either: I, E, M or SC

Format/Comment: Select the relevant **Code**.

Descriptor	Code
If the inpatient episode has an Admission Type not equal to M (PRVSP, admet_refno RITYP VAED, else SR, else main code does not = M). (VAED CODES: S, Y, C, O, P)	I
If the inpatient episode has an Admission type equal to M (PRVSP, admet_refno RITYP VAED, else SR, else main code = M)	M
For all Emergency Attendances. (Code Set: 1, 5, 10, 11, 30).	E
For all Specialist Clinic Outpatients Appointments	SC

Purpose: To determine the survey type the patient should receive



Header: Preferred Language

Definition: The preferred language most preferred by the patient for communication. This may be a language other than English even where the person can speak fluent English.

Datatype: Numeric

Form: Code

Field size: 4

Layout: NNNN

Code set:

Descriptor	Code
English	1201
Arabic	4202
Polish	3602
Italian	2401
Chinese (Mandarin)	7104
Russian	3402
Macedonian	3504
Croatian	3503
Serbian	3505
Maltese	2501
Greek	2201
Cantonese	7101
Turkish	4301
Hindi	5203
Spanish	2303
Vietnamese	6302
Amharic	9214
Burmese	6101
Dari	4105
Khmer	6301
Oromo	9206
Persian	4106
Tibetan	7901

Purpose: To determine which language the potential participant receives the questionnaire in.



Header:	Date of Birth
Definition:	The date of birth of the person
Datatype:	Numeric
Form:	Code
Field size:	8
Layout:	DDMMCCYY
Code set:	NA
Purpose:	To determine if patient receives an adult or child questionnaire.



Header: Separation Status

Definition: Status at separation of the person, and place to which the person is released (where applicable)

Datatype: Numeric OR Alphabetic

Form: Code

Field size: Min 1 – Max 2

Layout: NA

Code set:

Code Set for Inpatient and Maternity Episodes
Z - Left against medical advice
H - Separation to private residence/accommodation

Code Set for Emergency Attendances
1 - Home
5 - Left at own risk, after treatment started
10 - Left after clinical advice regarding treatment options
11 - Left at own risk, without treatment
30 - Left after clinical advice regarding treatment options – GP Co-Located Clinic

Code Set for Specialist Clinic Outpatients
N/A - Report N/A for Specialist Clinic Outpatients Appointments

Purpose: To determine if the patient is eligible for a survey



Header: Indigenous Status

Definition: An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives.

Datatype: Numeric

Form: Code

Field size: 1

Layout: N

Code set: Select the relevant **Code**.

Descriptor	Code
Aboriginal but not Torres Strait Islander origin	1
Torres Strait Islander but not Aboriginal origin	2
Both Aboriginal and Torres Strait Islander origin	3
Neither Aboriginal nor Torres Strait Islander origin	4
Question unable to be asked	8
Patient refused to answer	9



Header: **Ward of Discharge code**

Definition:

Datatype: Alphanumeric

Form: Code

Field size:

Layout:

Code set:

Purpose: For analysis

Format/Comment:

For admission system should extract the latest ward details(description) for e.g. while course of stay if a patient transferred from bed A to bed b and the got discharged from Bed B then system should extract Bed B as Ward of Discharge

For Emergency similarly system should extract the latest patient location(description) in emergency department for e.g. in case patient moved from location A to location B before getting discharge from emergency then the service point for location B should get reported



Header: **Ward of Discharge code (description)**

Definition:

Datatype: Alphanumeric

Form: Code

Field size:

Layout: N

Code set:

Purpose: For analysis

Format/Comment:

For admission system should extract the latest ward details(description) for e.g. while course of stay if a patient transferred from bed A to bed b and the got discharged from Bed B then system should extract Bed B as Ward of Discharge

For Emergency similarly system should extract the latest patient location(description) in emergency department for e.g. in case patient moved from location A to location B before getting discharge from emergency then the service point for location B should get reported



Header: **Mobile Phone Number**

Definition: Patients mobile number

Datatype: Numeric

Form: Code

Field size: Min=9 & Max=12

Layout: N

Code set: An example of valid mobile numbers is demonstrated below

412345678 (Max Len = 9)
0412345678 (Max Len = 10)
+61412345678 (Max Len = 12)

Purpose: To send the patient an SMS Invitation or reminder



Header: **Contact Delivery Mode**

Definition: The mode of provision of the service during the contact

Datatype: Alphanumeric

Form: Code

Field size: 3

Layout: 'N' or 'N/A'

Code set: Select the relevant **Code**.

Descriptor	Code
Face to face	1
Telephone	2
Telehealth	3
Written – Postal/Courier	4
Electronic mail	5
Not Applicable	9

***This field can be left blank if this data is not captured or not applicable to the patient.**

Format/Comment:

DPRES, resrc_refno where RITYP = VINAH, else 1 for all other appointments.

Report N/A for Inpatient, Maternity episodes and Emergency Attendances



Header: **Gender**

Definition:

Datatype: Numeric

Form: Code

Field size: 1

Layout: N

Code set: Select the relevant **Code**.

Descriptor	Code
Male	1
Female	2
Indeterminate	3
Other	4

Purpose: For weighting & analysis



Header: Date of Admission

Definition: The date of admission for potential participants (inpatients only)

Datatype: Numeric

Form: Date

Field size: 8

Layout: DDMMCCYY

Code set: NA

Purpose:



Frequently Asked Questions

What is the website address so I can upload my file?

The address is: www.vhes.com.au/DeptHealth

What is my campus code?

Your campus Code is the 4 digit code which was sent out to you in an email – listed next to your campus name.

Contact samuel.gardner@ipsos.com if you need to be sent your campus code again.

What is my hospital code?

Your hospital code is the first three numbers of your campus code. E.G Campus code = 4325 Hospital code = 432.

What is my password?

Your password will be emailed to you on the first of every month and it will be applicable until a new password is emailed to you again.

How do I generate the data I need? / What is the extraction process?

You should be able to pass on the data upload manual too the relevant personal responsible for patient data and they should be able to create the required patient data for a successful upload. Please contact Cathy Fraser if you require more information on this.

I cannot upload my file in the “Load File” tab?

This issue could be for a number of reasons. You are best to contact your I.T department and inform them that you are not able to drag and drop a file into your web browser as there may be security measures in place. It could also be because you are running an older version of internet explorer.

What file format do I need to save my spreadsheet file in?

You will need to make sure the file is saved in csv. File format (this is required as it allows the program to read the file).

I’m getting an error message stating that there is not a recognized header line, why?

This is most likely because the headings (the top row of the excel file which should list – Campus Code, Hospital Code, Unique Key etc...) are incorrect. All hospitals should have been provided with an excel template. This template will ensure your file does have this error message. To ensure a successful upload you are best to paste your patient data into the VHES template and ensure you save the file as ‘.csv’.



There are errors but it seems as though my file has been uploaded. Is this ok?

Yes. The VHES website will highlight the issues but still accept the patient data that has no errors. If the system notes the file has been received and only some patient records have an error, your file has uploaded successfully.

I want to check that the data I am about to upload is correctly entered, what can I do?

There was an example included in the email with the data upload manual that shows what the patient file should look like. Reference this if you have any concerns. If there are no discrepancies your data file should successfully upload.



Signing Off a Month with No Records

To use this feature, Log into the VHES Upload site and follow the steps below:

- 1) Go to the load file tab:



- 2) Click the “no data available for this month” check box:

No data available for this month: ☐

- 3) Type your first and last name into the text box:

Authorised by:

- 4) Click Save:

