WELSH INFORMATION STANDARDS BOARD

DSC Notice:	DSCN 2020 / 20
Date of Issue:	12th October 2020

Welsh Health Circular / Official Letter: N/A	**Subject:** NHS Wales Document Metadata Standard
Sponsor: Michael Prasad (Technology, Digital and Transformation, Welsh Government)	
Effective from: 1st October 2020	

DATA STANDARD CHANGE NOTICE

A Data Standard Change Notice (DSCN) is an information mandate for a new or revised information standard.

This DSCN was approved by the Welsh Information Standards Board (WISB) on 20th August 2020

WISB Reference: ISRN 2020 / 013

Summary:
To standardise the metadata used for storage of documents in any document repository.

Applies to:
This Standard applies to all bodies that commission or provide health and care services in Wales in partnership with the NHS including their relevant system suppliers.

Please address enquiries about this Data Standard Change Notice to the Data Standards Team in NHS Wales Informatics Service
E-mail: data.standards@wales.nhs.uk / Tel: 029 2050 3593

The Welsh Information Standards Board is responsible for appraising information standards. Submission documents and WISB Outcomes relating to the approval of this standard can be found at:
http://howis.wales.nhs.uk/sites3/page.cfm?orgid=742&pid=24632

DATA STANDARD CHANGE NOTICE

Introduction

The Welsh Care Record Service (WCRS) is a document repository for all documents generated in NHS Wales. At present there are over 30 million record stored within WCRS. A review of the documents that are stored within WCRS has been undertaken and it was found that there was huge variation in the naming of the documents are stored within WCRS. This can be attributed to the range of source systems from which these documents are generated, and the absence of robust validation processes or standards to be applied. This is perhaps understandable given that there are few operational standards to mandate appropriate value sets and reference data. In the absence of a common standard, different approaches have been adopted across each system, organisation, site and service. The current variation is therefore a somewhat inevitable consequence. Work has however already begun to clean up the existing content for items where national standards do exist, such as the use of Treatment Function Codes to denote the treatment specialty. There is also a mapping tool that has been created to try and apply some sort of standards across the documents that are held within the repository.

Scope

The Document Metadata Data Standard is fundamental to the creation and maintenance of accurate document information. This will also help to enable effective search and retrieval of documents stored within repositories across NHS Wales.

The proposed standard will apply to all documents generated by NHS Wales systems that are sent to the Welsh Care Record Service (WCRS).

A document is defined as 'a single set of coherent, identifiable, self-contained information that is a statement of Health and Care and can only be updated by total replacement'. Certain fields will be mandatory, and others will be optional. This is due to not all data items being available at time on entry.

All NHS Wales systems in procurement, or for future procurement must adhere to this Standard with immediate effect.

Description of Change

To introduce a standard set of metadata of all documents that are stored within WCRS.

Data Dictionary Version

Where applicable, this DSCN reflects changes introduced by DSCN and/or DDCN since the release of version 4.10 of the NHS Wales Data Dictionary.

The changes introduced by such DSCNs will be published in version 4.11 of the NHS Wales Data Dictionary.

Actions Required

Local Health Boards / Trust:

- To supply documents to NWIS in accordance with the information specification described in this DSCN.

NHS Wales Informatics Service:

- To work with health boards and trusts to develop technical solutions to allow documents to be collected locally; and

- To work with health boards and trusts to develop mechanisms which enable the data to be collected centrally and stored in a standardised way.

Implementation Plan

Implementation of the new standard is to be adopted by all systems in Wales by 1st April 2022. All HB's should start to work toward this new standard from 1st October 2020 with an aim to complete this work by 1st April 2022.
Any new system procurement that is undertaken from 1st October 2020 should adhered to this new standard, whether it be a local or national procurement.

Appendix A: Table reflecting areas that are impacted as a result of this DSCN

The following table shows where there are changes to the scope and/or definitions of applicable data sets, data items, terms and other associated areas that are linked with the changes documented within this DSCN.

Each data definition type is shown in the sequence in which it appears in this DSCN.

Data Definition Type	Name	New/Retired/ Changed	Page Number
Patient Details	NHS Number	New	
Patient Details	Local Patient Identifier	New	
Patient Details	Patient Name (Forename)	New	
Patient Details	Patient Name (Surname)	New	
Patient Details	Date of Birth	New	
Patient Details	Gender Identity	New	
Patient Details	Post Code	New	
Document Details	Source System	New	
Document Details	Originating Organisation	New	
Document Details	Document Type	New	
Document Details	Document Sub-Type	New	
Document Details	Document Date & Time	New	
Document Details	Document Transcriber	New	
Document Details	Document Author	New	
Document Details	Document Author Type	New	
Event Details	Event Site Code	New	
Event Details	Event Date & Time	New	
Event Details	Treatment Specialty	New	
Event Details	Care Setting	New	
Event Details	Responsible Clinician	New	

Appendix B: Information Specification – Document Metadata

Data Definition Type	Name	Format	Definition	Value Set / Example	Optional (O) or mandatory (M)
Patient Details	NHS Number	10-character alphanumeric	See existing NHS Wales Data Dictionary standard for NHS Number	e.g. 0123456789	O
Patient Details	Local Patient Identifier	10-character alphanumeric	See existing NHS Wales Data Dictionary standard for Local Patient Identifier	e.g. 9876543210	M
Patient Details	Patient Name (Forename)	35-character alphanumeric	See existing NHS Wales Data Dictionary standard for Patient's Name	e.g. John	M
Patient Details	Patient Name (Surname)	35-character alphanumeric	See existing NHS Wales Data Dictionary standard for Patient's Name	e.g. Smith	M
Patient Details	Date of Birth	CCYY-MM-DD	See existing NHS Wales Data Dictionary standard for Birth Date	e.g. 1950-01-31	M
Patient Details	Gender Identity	1-character alphanumeric	See existing NHS Wales Data Dictionary standard for Core Reference Data	e.g. F See existing standard for details	M
Patient Details	Post Code	8-Character alphanumeric	See existing NHS Wales Data Dictionary standard for Core Reference Data	e.g. CF11 9AD	M
Document Details	Unique Document ID	36-character alphanumeric	This is the unique identifier within the WCRS store	e.g. 8182AA66-4067-4DDD-9FB4-A4ED78036243	M
Document Details	Source System	3-digit numeric	This identifies the source system which generated and provided the document to the Welsh Care Record Service.	See Appendix D	M
Document Details	Originating Organisation	5-character alphanumeric	This is the organisation from which the document originated. See existing NHS Wales Data Dictionary standard for Organisation Code (Code of Provider)	e.g. 7A100 See existing standard for details	M
Document Details	Document Type	18-character alphanumeric	Document Type and Subtype are indexing metadata fields which enable the searching and retrieval of documents by clinicians.	See Appendix C	M

Data Definition Type	Name	Format	Definition	Value Set / Example	Optional (O) or mandatory (M)
Document Details	Document Sub-Type	18-character alphanumeric	Document Type and Subtype are indexing metadata fields which enable the searching and retrieval of documents by clinicians.	See Appendix C	M
Document Details	Document Date & Time	CCYY-MM-DD HH:MM:SS	This is the date and time the document was generated by the application. This should be the same as the date the patient completes the form.	e.g. 2020-01-31 00:00:00	M
Document Details	Document Transcriber	100-character alphanumeric	Where applicable, this is the person who transcribed the document. The user should be identified by their user credentials including name (SURNAME, First name, Middle initial, TITLE) and prof ID, if not available NADEX should be used).	e.g. OTHER, Alan, N, DR (GMC:1234567) OTHER, Alan, N, MR (NADEX:AL123456)	O
Document Details	Document Author	100-character alphanumeric	This is the person who authored the content of the document. The document author must always be present within the document metadata, for single authors they should be identified by their professional registration. The user should be identified by their user credentials including name (SURNAME, First name, Middle initial, TITLE) and prof ID, if not available NADEX should be used).	e.g. OTHER, Alan, N, DR (GMC:1234567) OTHER, Alan, N, MR (NADEX:AL123456)	M
Document Details	Document Author Type	3-character alphanumeric	This is the type of care professional who has been identified as the Document Author.	TBC	M
Event Details	Event Site Code	5-character alphanumeric	This is the hospital from which the document originated. See existing NHS Wales Data Dictionary standard for Site Code (of Treatment)	e.g. 7A1A1	M

Data Definition Type	Name	Format	Definition	Value Set / Example	Optional (O) or mandatory (M)
Event Details	Event Date & Time	CCYY-MM-DD HH:MM:SS	Where applicable, date stamp recorded on the date the PROMs form was completed by the patient.	e.g. 2020-01-31 00:00:00	O
Event Details	Treatment Specialty	3-digit numeric	See existing NHS Wales Data Dictionary standard for Treatment Function Code	e.g. 100	M
Event Details	Care Setting	1-digit numeric	This is to identify the care setting relating to the event to which the document relates. It enables differentiation of the same document type across settings i.e. a Nursing Assessment.	Care Setting Code Hospital 1 Community 2 Primary Care 3 Social Care 4	M
Event Details	Senior Responsible Clinician	GNNNNNNN	This is the clinician who has the overall responsibility of the patient event to which the document relates to. The responsible clinician must have a professional registration with a professional registration body.	C2345678	M

Appendix C: Code and Description of Document type and Sub types

Document Type should use the DST Code (e.g. AL for Alerts and Risks) and for Subtype use the SNOMED code where available and if not use the DST Code.

REVISED DOCUMENT INDEXING STANDARDS (September 2019)			
DST Code	**Document Type/Subtype**	**Description (examples where applicable)**	**SNOMED Code**
AL	**Alerts & Risks**		
AL01	Allergies and Adverse Reactions	Any allergy or adverse reaction noted at a point in time	163221000000102
AL02	Alerts	Any alert noted at a point in time	37341000000109
AS	**Assessments**		
AS01	Nursing assessment tool	Any tool used by nursing staff for recording an assessment.	819981000000101
AS02	AHP Assessment	Any assessment completed by an AHP	819991000000104
AS03	CAF assessment	Common Assessment Framework - a standard approach to conducting assessments of children's additional needs.	820011000000105
AS04	SSA assessment	Single Shared Assessment - person-centred and more streamlined approach led by a single professional with other specialist involvement where appropriate.	820021000000104
AS05	CPA assessment	Care Programme Approach.	820031000000102
AS07	Multidisciplinary assessment	Any assessment completed by various clinical staff groups	820041000000106
AS08	Scored Assessment	Any completed scored assessment.	823571000000103
AS10	Pre-admission assessment	Any assessment completed prior to any admission.	820071000000100
AS11	Self-assessment form	Any assessment completed by a patient	820081000000103
AS12	Medical assessment	Any assessment completed by medical staff	820091000000101
AS13	Theatre Patient Checklist	Intervention/Procedure check prior to theatre	823591000000104
AS14	Social Services Assessment.	Any assessment completed for or by social services	820101000000109
AS15	Pre Op Assessment	Any assessment completed prior to an intervention/ procedure	823561000000105

AS16	Nursing Profile	Any profile used by nursing staff to assess a patient.	819981000000101
AS34	Risk Assessment	Self-explanatory	886831000000103
AS35	Gait Analysis Assessment Record	This is a structured assessment of an individual's gait which may include graphs and charts, images of the objective findings.	927061000000101
AS99	Assessment	Not Specified or for bulk scanning	325931000000109
CA	**Care Plans**		
CA03	Clinical Care Plan	Any care plan involving clinicians and/or social services which may or may not be integrated. Also includes Care Pathway.	325661000000106
CA04	MDT Plan	Any care plan involving multi disciplinary staff groups for example Lung MDT Plan	823581000000101
CA05	Discharge Plan	Any care plan used for discharge planning including nursing	820121000000100
CA06	Anticipatory Care Plan (ELT)	End of Life Treatment decisions	935921000000102
CA07	Anticipatory Care Plan (ITG)	Individualised Treatment Guidelines for a patient with an unusual condition or difficulty treating a condition	962891000000106
CA99	Care Plan	Not Specified or for bulk scanning	325661000000106
CH	**Observations**		
CH03	Fluid Balance Chart	Any chart, form or document used to record fluid balance	526591000000108
CH04	Fundal height chart	Any chart, form or document used to record fundal height	820141000000107
CH05	Growth Chart	Any chart, form or document used to record growth	820161000000108
CH06	ITU & ICU chart	Any chart, form or document used to record intensive care or intensive therapy observations	823601000000105
CH07	Partogram	A graphical record of key data (maternal and fetal) during labour for example Cervical Dilatation	820191000000102
CH08	Temperature Chart	Any chart, form or document used to record temperature	824231000000100

CH09	Patient Safety Checklist	Any chart, form or document used for this purpose	820211000000103
CH10	Vital Signs Chart	Any chart, form or document used to vital signs	823611000000107
CH11	Weight Chart	Any chart, form or document used to record weight	820441000000103
CH99	Observation	Not specified or for bulk scanning	823621000000101
CL	**Clinical Notes**		
CL03	Inpatient medical note	Any inpatient information recorded by medical staff	820221000000109
CL04	Inpatient nursing note	Any inpatient information recorded by nursing staff	829201000000105
CL05	Medical note	Any information recorded by medical staff	820451000000100
CL06	Multidisciplinary note	Any information recorded by multiple staff groups	820461000000102
CL07	Nursing note	Any information recorded by nursing staff including community notes	820471000000109
CL08	OOH note	Any information recorded by Out of Hours service	823631000000104
CL09	Outpatient nursing note	Any outpatient information recorded by nursing staff	820481000000106
CL10	Outpatient medical note	Any outpatient information recorded by medical staff	820491000000108
CL11	AHP note	Any information recorded by an AHP e.g.. Dietetic Record Card	823641000000108
CL13	Telephone Consultation	Any clinical information pertaining to a telephone consultation	24681000000104
CL14	Video Consultation	Any clinical information pertaining to a video consultation	325921000000107
CL15	Summary record	Any clinical summary noted at a point in time	824321000000109
CL16	ED Card	Emergency department clinical note e.g. AE Card	445300006
CL99	Clinical note	Not Specified or for bulk scanning and remote notes including patient contacts by telephone and email.	823651000000106
CO	**Correspondence**		
CO02	Outpatient Letter	Created as a result of an out patient clinic attendance e.g. clinic letter	823681000000100
CO03	Clinical letter	Containing clinical information, not a clinic attendance or discharge	823691000000103

CO04	Discharge letter	Created as a result of discharge from care	823701000000103
CO06	Inpatient Final Discharge letter	Final inpatient discharge letter Includes day case	824331000000106
CO08	Immediate Inpatient Discharge letter	Immediate inpatient discharge letter includes day case	824341000000102
CO09	Letter from patient	Letter received from a patient	25731000000109
CO10	Letter to patient	Clinical letter sent to a patient	24711000000100
CO14	Referral letter	Referral from any source about the patient	25611000000107
CO15	Social service letter	Letter from social services	823721000000107
CO16	Transfer letter	Transfer of care letter	823731000000109
CO17	Administrative Letter	Administrative letters sent to patient e.g. Invitation letter, Admission letter and Recall letter	823761000000104
CO18	Did not Attend Letter	Letter sent to patient and/or GP advising of non-attendance and subsequent action.	909921000000109
CO19	Unscheduled Care	Unplanned/unscheduled contact e.g. AE letters, NHS24 letters, OOH	823771000000106
CO20	MDT Letter	Multi-Disciplinary Letter	823781000000108
CO99	Correspondence	Not Specified or for Bulk Scanning	163161000000103
IN	**Interventions/ Procedures**		
IN01	Anaesthetic record	Record of Anaesthesia	416779005
IN03	Nutritional record	Diet intake, enteral and parenteral feeding	820501000000102
IN04	Endoscopy record	Record of endoscopic intervention	820511000000100
IN05	Interventional radiology record	Record of radiological intervention e.g. Drainage of abscess under radiological guidance, coiling of aneurysm under radiological guidance, biopsy of tissue under radiological guidance	820251000000104
IN06	AHP therapy record	Record of AHP therapy	823831000000103
IN07	Operation note	Record of surgical intervention	823661000000109
IN08	Radiotherapy record	Record of radiotherapy treatment	823841000000107
IN09	UVA / PUVA Treatment Record	Intervention involving ultraviolet light therapy, often as an outpatient treatment	962901000000107

IN10	Record of Implantation of cardiac electronic device	Record of initial or revision implant procedure including the procedure note and any initial programming or setup to the device itself.	1054141000000100
IN11	Record of Percutaneous Coronary Intervention	Record of intervention to a coronary artery e.g. stenting, balloon angioplasty, mechanical thrombectomy. Does not include reports for diagnostic only procedures where intervention does not occur.	1067211000000100
IN12	Record of direct current Cardioversion	Documentation (Report and or ECG traces) associated with an DC Cardioversion intervention	1129271000000109
IN99	Intervention	Not specified or for bulk scanning	826491000000106
LA	**Labs**		
LA01	Biochemistry Report	Any result from a test performed in a Biochemistry lab	4311000179106
LA02	Combined laboratory report	A summarised view of location/patient results	1076911000000100
LA03	Haematology Report	Any result from a test performed in a haematology lab	4321000179101
LA04	Cellular Pathology Report	Any result from a test performed in a cellular pathology lab, Includes Histopathology & Cytology	1054291000000100
LA05	Virology Report	Any result from a test performed in a virology lab	1054281000000100
LA06	Immunology Report	Any result from a test performed in an immunology lab	4331000179104
LA07	Microbiology Report	Any result from a test performed in a microbiology lab, including MSSU, MRSA Screening	4341000179107
LA08	Blood transfusion Report	Any result from a test performed in a blood transfusion lab	1054181000000100
LA09	Histocompatibility & Immunogenetics Report	Renal, Cardiac, Stem Cell transplant H&I investigations and HLA disease associations	909871000000100
LA20	Genetics Report	Any results from genetic investigations are to be filed here. Examples include: cytogenetics, clinical genetics, biochemical and molecular.	1054161000000100

LA99	Laboratory Report	Not specified or for bulk scanning	371528001
ME	**Medication**		
ME01	Controlled drugs dispensing	Any chart, form or document recording the dispensing of controlled drugs e.g., Morphine, Diamorphine	820261000000101
ME03	Drug administration chart	Any record of the administration of medicine for example Insulin or Warfarin	824781000000106
ME07	Medication record	Any medication record including Prescription records and repeat prescriptions.	163111000000100
ME08	Prescription and administration record	Any record for the prescribing and administration of medicine, for example Kardex as used in some Health Boards.	824791000000108
ME09	Chemotherapy record	Record of chemotherapy treatment for cancer	820271000000108
ME10	Medication review	Any communication or record of a medication review (includes level 0-3 reviews) and / or medication reconciliation procedures.	1099461000000101
ME99	Medication	Not specified or for bulk scanning	185361000000102
MI	**Miscellaneous**		
MI01	Miscellaneous	Non defined document within this section	826501000000100
MI02	Front sheet	Patient Master Index Sheet. For Bulk Scanning.	824801000000107
MI03	Legacy Bulk Scanned Record	Bulk scanned whole patient case record	24761000000103
NO	**Notification & Legal Documents**		
NO01	Fiscal Autopsy report	Formal Autopsy report from Fiscal office.	823871000000101
NO02	Child protection documentation	Record of child protection case conference, child safety action plan, summary of investigation.	229054004
NO03	Consent form	Document advising consent has been obtained	824831000000101
NO04	Death certificate	Certificate of death	307930005
NO05	Exemption form	Any record that relates to patient exemptions	826511000000103
NO06	Infectious disease notification	Notification of infectious disease for example to Public Health	820291000000107

NO07	Legal notice	Any legal notice	826621000000105
NO08	Mental Health Act notice	Emergency Detention Certificate, Short Term Detention Certificate, Compulsory Treatment Order, Revocation.	826631000000107
NO09	Refusal Form	Notice that patient has refused treatment	826521000000109
NO10	Employment report	Self-explanatory	308575004
NO11	Housing report	Self-explanatory	310854009
NO12	War Pensions report	Self-explanatory	308619006
NO13	Disabled driver badge report	Self-explanatory	270372007
NO14	Driving licence fitness report	Self-explanatory	270370004
NO15	DSS RMO RM2 report	Self-explanatory	307881004
NO16	Insurance (life) report	Self-explanatory	270358003
NO17	RM10-DHSS DMO report	Self-explanatory	308621001
NO18	DLA 370 report	Self-explanatory	308584004
NO19	DS 1500 report	Self-explanatory	308585003
NO20	Adoption Report	Self-explanatory	820301000000106
NO21	Adult Incapacity Report	Self-explanatory	823951000000100
NO22	Power of attorney/Legal Guardianship	Self-explanatory	826541000000102
NO99	Notification & Legal Document	Not specified or for bulk scanning	826651000000100
PH	**Patient held records**		
PH01	Patient held record	Any record held by the patient	408403008
PA	**Patient Preferences/Instructions**		
PA01	DNAR order	Any patient instruction regarding resuscitation	823881000000104
PA02	Living Wills & Advance directives	Any patient instruction regarding treatment/care	827701000000106
PA03	Organ donor card	Any patient instruction regarding organ donation	822751000000105
PA99	Patient Preferences/Instruction	Not Specified or for bulk scanning	822761000000108
PR	**Patient reported outcome measures/ Patient reported experience measures**		
PR01	Patient reported outcome measure	Self-explanatory	718650006
PR02	Patient reported experience measure	Self-explanatory	To be added
RE	**Research/Study**		

RE01	Research Study Consent and Participant Information Sheet	Signed Consent Form and associated Participant Information Sheet. From a practical and governance perspective, it is important that the correct, matching-paired versions of PIS and Consent are always stored together. Additionally, it is often the case that these are supplied as single, combined documents. It is therefore best to categorise these as the same document sub-type.	824831000000101
RE02	Research Study Visit document	Documents used by Clinical Trials Staff, Research Nurses or Investigators to collect study data during patient visits – examples include Source Data Worksheets, Study Data Capture Forms, Clinical Sheets	1054111000000100
RE03	Research Study Randomisation documentation	Any documentation detailing randomisation	1054101000000100
RE04	Research Study Adverse Event document	Details of any participant adverse events. This category would only be used where details of the Adverse Event are not recorded elsewhere – e.g. within a Study Visit Document. Sponsors' SAE/ SUSAR Forms, etc., are stored in the CRF rather than the medical notes.	1054091000000100
RE05	Research Study withdrawal / un-blinding	Any study document completed as a result of withdrawal or un-blinding of a study participant	1054071000000100
RE99	Research Study Document – not otherwise specified	Any other study-specific document that does not fit into any of the above categories or for bulk scanning	1054061000000100
TH	**Third party documents**		
TH01	Non-Statutory provider document	Any document from a non-statutory organisation for example, local authority information	823901000000101
TH02	Private provider note	Any document from private health care provision	823931000000107
TH99	Third party document	Not specified or for bulk scanning	823941000000103

Appendix D: System Codes

This document shows the system codes

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ning%20Authority%2