

DSC Notice: DSCN (2008) 10 (W)
English DSCN Equivalent: N/A
Initiating Welsh Reference: EH/ML/020/08
Date of Issue: 17th February 2009

WIGSB Welsh Information Governance and Standards Board	Subject: Recording and Reporting of Outpatient Pre-Operative Assessment Activity
	Implementation date: 2008/09

Summary of change:

To introduce recording and reporting requirements of pre-operative assessment activity to the NHS Wales Data Dictionary.

These changes will be applied in version 2.21 of the NHS Wales Data Dictionary.

WIGSB Reference No: IGRN2008/006

Welsh Information Governance and Standards Board (WIGSB), is responsible for approving information standards.

Please address enquiries about Data Set change proposals to the Data Standards and Data Quality Team, HSW, Brunel House, 2 Fitzalan Road, Cardiff CF24 0HA Tel: 029 20502539 or E-mail Data.Standards@hsw.wales.nhs.uk

Data Set Change Notices are available via the Intranet Service HOWIS <http://howis.wales.nhs.uk/sites3/home.cfm?orgid=299> or by contacting the above address.

Draft DSCN numbering format = (year of draft) 2-character alpha (W).

Upon receiving approval for the change by WIGSB, the draft DSCN number will be reformatted to:

DSCN number format = (year of issue) 2-character numeric (W)

In addition,

WIGSB Reference No. format = WIGSB Submission Reference

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DSCN Distribution List

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Document Control

Version:	Changed on:	Owner	Details:
0.01	05/08/2008	Rebecca Wells	First Draft of DSCN following production of Definitions Document. To go to sub-group 27 th August 2008.
0.02	25/09/2008	Rebecca Wells	DSCN updated following August DSCN sub-group.
0.03	06/10/2008	Rebecca Wells	DSCN updated following September DSCN sub-group. Sent out for Comments 06/10/2008, Going to WIGSB for Approval 16 th October 2008.
0.04	10/12/2008	Rebecca Wells	DSCN updated following December DSCN sub-group. Going back to WIGSB for final sign off 18 th December 08.
1.0	17/02/2009	Rebecca Wells	DSCN approved by WIGSB 18 th December 2008.

DATA SET CHANGE NOTICE (2008) 10 (W)

WIGSB Reference: IGRN 2008 / 006

Subject: To introduce Recording and Reporting requirements of Outpatient Pre-Operative Assessment Activity to the NHS Wales Data Dictionary

Reason for Change: To ensure that there is a consistent approach to the recording and reporting of pre-operative assessment activity.

Implementation Date: 2008/09

Background:

The Welsh Assembly Government Resources Directorate commissioned a review of Acute Activity currencies used for contracting and costing purposes, as it was believed there were inconsistencies across NHS Wales leading to an inability to compare value for money in a transparent and accountable way.

A Task & Finish Group was established, reporting to the Financial Information Strategy (FIS) Reference Cost Group, to review the current position, to develop proposals for consistent currencies and to seek feedback from the service and stakeholders. This revealed a significant disparity across Wales. As a result a further Task & Finish Group was established and their recommendations were subsequently approved by the Financial Flows (FFR) Board on 20th November 2007. They recommended that outpatient activity should be contracted and costed based on New, Follow-up and Pre-op assessment attendances, by Specialty.

There are currently no definitions to enable the collection of pre-operative assessment activity; therefore there is a requirement to ensure uniformity across Trusts in terms of recording and reporting of pre-operative assessments.

Actions Required:

Trusts are mandated to submit via the Outpatient National Database, and via the Quarterly Statistics (QS1). Only those pre-operative assessments undertaken by a member of the consultant team or independent nurse will be collected.

Any pre-operative assessments not undertaken in an outpatient clinic (e.g. whilst currently an inpatient) are outside scope. The scope of this information requirement excludes pre-operative assessments carried out on the day of admission.

QS1 has been amended to enable Trusts to report Pre-Operative Assessments.

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Changes to be applied to the NHS Wales Data Dictionary:

Table reflecting areas that are impacted as a result of this DSCN can be found in Appendix A.

Changes to be made to the NHS Wales Data Dictionary are highlighted in Appendix B.

Changes as they will appear in the NHS Wales Data Dictionary can be found in Appendix C.

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

The following table show all Data Items, Terms and associated areas that are linked with the changes documented within this DSCN.

Data Definition Type	Name	New / Retired / Changed
Data Items and Terms Grouped By Data Set	Outpatient Minimum Data Set	Changed
Data Item	First Attendance	Retired
Data Item	Attendance Category	New
Term	Outpatient Clinic	New
Term	Outpatient Clinic Pre-Operative Assessment	New

Appendix B: Highlighted changes to be made to the NHS Wales Data Dictionary

Changes to the NHS Wales Data Dictionary are detailed below, with new text being highlighted in **blue** and deletions are shown with a ~~strike through~~. The text shaded in **grey** shows existing text copied from the NHS Wales Data Dictionary.

a) Data Items and Terms Grouped by Data Set

OP MDS

THE OUTPATIENT MINIMUM DATA SET (OP MDS)

IMPLEMENTED APRIL 1999

Layout of Outpatient Minimum Data Set:-

Rating 1=mandatory 2=optional		Format/length
1	Record Id	an1
	CONTRACT DETAILS	
1	Organisation Code (code of Provider)	an5
1	Code of Commissioner	an5
1	Commissioning Serial Number	an6
2	Health Care Contract Line Number	an10
1	Commissioners Reference Number	an17
	PATIENT DETAILS	
1	NHS Number	n10
1	NHS Number Status Indicator	n2 - from April 1999
1	Patient's name	an70 or structured name with 2 an35 elements
1	Name Format Code	n1
1	Patient's Usual Address	an175 (5 lines each an35)
1	Postcode of Usual Address	an8
1	Local Health Board of Residence	an3
1	Sex	n1
2	Carer Support Indicator	an2
1	Birth Date	ccyymmdd
1	Birth Date Status	n1
2	† (see below)	an8
1	Code of Registered GP Practice	an6

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1	Local Patient Identifier	an10
	REFERRAL DETAILS	
1	Referrer Code	an8
1	Referring Organisation Code	an6
1	Service Type Requested	n1
1	Date of Patient Referral	ccyymmdd
1	Patient Referral Date Status	n1
1	Clinical Referral Date	ccyymmdd
1	Clinical Referral Date Status	n1
1	Priority Type (new patients)	n1
	EPISODE DETAILS	
1	Source of Referral: Outpatients	an2
1	Main Specialty (consultant)	n3
1	Treatment Function Code	n3
2	Local Sub-Specialty	an3
1	Clinic Purpose	an15
1	Consultant Code	an8
	APPOINTMENT AND ATTENDANCE DETAILS	
1	Attendance Identifier	an12
1	Administrative Category	n2
1	Location Type Code	n2
1	Site Code (of Treatment)	an5
1	Medical Staff Type Seeing Patient	an2
1	Attendance Date	ccyymmdd
1	Attendance Date Status	n1
1	First Attendance Attendance Category	n1
1	Attended or Did Not Attend	n1
1	Outcome of Attendance	n1
1	Last DNA or Patient Cancelled Date	ccyymmdd
1	Last DNA or Patient Cancelled Date Status	n1
	Patient Diagnostic Codes (optional)	
2	Primary (ICD)	an6
2	Subsidiary (ICD)	an6
2	1st Secondary (ICD)	an6
	Patient Procedure Codes	
1	Operation Status (per attendance)	n1
	OPCS procedure coding	

1	Primary Procedure Code (OPCS)	an4
1	Procedure Code 2 (OPCS)	an4
1	Procedure Code 3 (OPCS)	an4
1	Procedure Code 4 (OPCS)	an4
1	Procedure Code 5 (OPCS)	an4
1	Procedure Code 6 (OPCS)	an4
1	Procedure Code 7 (OPCS)	an4
1	Procedure Code 8 (OPCS)	an4
1	Procedure Code 9 (OPCS)	an4
1	Procedure Code 10 (OPCS)	an4
1	Procedure Code 11 (OPCS)	an4
1	Procedure Code 12 (OPCS)	an4
	Waiting List Details	
1	Waiting List Date	ccymmdd
1	Waiting List Date Status	n1

† Where no data is present, the field must be populated with spaces due to the fixed field length format of the submitted file. However, if necessary 'General Medical Practitioner (Code of Registered GMP)' may still be included in the submitted file.

b) Changes to Existing Data Items

First Attendance

(OP mds)

The first attendance is the start of the Outpatient episode and is the first attendance in a series with the same Consultant or Independent Nurse following a referral.

Format: 1 digit numeric

Value	Meaning
1	New attendance
2	Follow up attendance

This data item has been retired as a result of DSCN (2008) 10 (W).

See: [Attendance Category](#)

c) **New Data Item**

Attendance Category

(OP mds)

This categorises the type of attendance

For Outpatient Clinics:

Value	Meaning
1	New Attendance
2	Follow-up Attendance
3	Pre-Operative Assessment Attendance

Format: 1 digit numeric

d) **New Terms**

Outpatient Clinic

At a summary level, an administrative arrangement enabling patients to see a Consultant, Independent Nurse, a member of his/ her firm or associated health professionals, providing the opportunity for consultation, investigation and treatment.

Outpatient Clinic Pre-Operative Assessment Attendance

Pre-Operative Assessment is where the purpose is to assess medically the patient's fitness for anaesthetic and /or surgery prior to elective surgery.

Pre-Operative Assessment Attendance is a pre-operative assessment carried out in an outpatient clinic and excludes assessments carried out on the day of admission.

Appendix C: Data Items and Term as they will appear in the Data Dictionary.

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Data Items

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See: [Attendance Category](#)

New Data Item

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Additional Information:

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