DSC Notice: DSCN (2008) 05 (W)
English DSCN Equivalent: N/A
Initiating Welsh Reference: WHC (2008) 043
Date of Issue: 14th October 2008

WIGSB **Welsh Information Governance and Standards Board**	**Subject: Outpatient Referral Data Set**
	Implementation date: October 2008

DATA SET CHANGE CONTROL PROCEDURE

Summary of change: To introduce the Data Set and associated Data Definitions for the NHS Wales 'Outpatient Referral Data Set'

These changes will be applied in v2.19 of the NHS Wales Data Dictionary.

WIGSB Reference No:
IGRN 2008 / 005

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 Information 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/ or by contacting the above address.

Draft DSCN numbering format = (*year of draft*) 2-*alphacharacter sequence* (W).

Upon receiving approval for the change by WISGB, the draft DSCN number will be reformatted to:
DSCN number format = *year of issue* /*sequence number*, (W)

In addition,
WIGSB Reference No. format = year/month/day/sequence number (relates to when WIGSB approved change)

DSCN Distribution List

Name	Job Title	Organisation
Carol Davies	Data Services Co-ordinator	Abertawe Bro Morgannwg University NHS Trust
Helen Thomas	Acting Assistant Director of Information	Abertawe Bro Morgannwg University NHS Trust
Gareth Lee	Head of Information Services	Abertawe Bro Morgannwg University NHS Trust
Jan Macnamara	Data Quality Manager	Abertawe Bro Morgannwg University NHS Trust
Deborah Usher	Information Manager	Abertawe Bro Morgannwg University NHS Trust
John Dicker	Regional IM&T Manager	Business Services Centre
Eluned Cousins	Regional Information Manager	Business Services Centre
Mark Piper	Information Services Business Manager	Business Services Centre
Trevor Hughes	Regional Information Manager	Business Services Centre
Tim O'Sullivan	Regional Information Manager	Business Services Centre
Vince Lacey	Acting Head of IM&T Manager	Business Services Centre
Alan Roderick	Acting Head of Performance & Information	Cardiff and Vale NHS Trust
Kerry Ashmore	Information Modernisation & Development Manager	Cardiff and Vale NHS Trust
Steven Thomson	Information Manager	Cardiff and Vale NHS Trust
Dylan Williams	Head of IM&T	Conwy & Denbighshire
Peter Burcham	Data Quality Manager	Conwy & Denbighshire
Richard Walker	Information Manager	Conwy & Denbighshire
Gordon Craig	Head of Performance	Cwm Taf NHS Trust
Graham Crooks	Information Manager	Cwm Taf NHS Trust
Jack Attwood	Director of IM&T	Cwm Taf NHS Trust
Lloyd Bishop	Head of Information Services	Cwm Taf NHS Trust
Sonia Stevens	Head of Information	Gwent Healthcare NHS Trust
Carl Davies	Deputy Software Development Manager	Hywel Dda NHS Trust
Debbie Croft	Information Manager	Hywel Dda NHS Trust
Eric Lewis	Head of Information	Hywel Dda NHS Trust
Richard Noyce	Senior Information Analyst	Hywel Dda NHS Trust
Mark Bouchier	Head of IM&T	Hywel Dda NHS Trust
Nia Jones	Waiting List Co-ordinator	Hywel Dda NHS Trust
Sharon Baker	Information Services Manager	Hywel Dda NHS Trust
Michelle Campbell	Corporate Information Manager	Hywel Dda NHS Trust
Christine Fisher	Head of Information	North East Wales NHS Trust
Janet Holmes	Information Analyst Community & Mental Health	North East Wales NHS Trust
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Vaughan Hughes	Information Manager	North West Wales NHS Trust
Lynda James	Head of Information	Powys LHB
Mike Jones	Operational	Powys LHB
Tracey Jones	Information Services Manager	Powys LHB
Dave Morrey	Information Manager	Velindre NHS Trust
David Howells	Senior Analyst Programmer	Velindre NHS Trust
Sally Greenway	Head of Information Standards	Welsh Assembly Government
David Hawes	Corporate Health Information Programme	Welsh Assembly Government
Anthony Tracey	Corporate Health Information Programme	Welsh Assembly Government
Catherine Bridges	Information Services Division, Information Analysis	Welsh Assembly Government
Martyn Rees	Department of Health and Social Services	Welsh Assembly Government
Pam Hall	Corporate Health Information Programme	Welsh Assembly Government
Sue Leake	Health Statistics & Analysis Unit	Welsh Assembly Government
Denise Roberts	Financial Information Service	Welsh Assembly Government
Shelagh Reynolds	General Manager	Welsh Cancer Intelligence & Surveillance Unit

Document Control

Version:	Issued on:	Owner	Details:
Following approval from WIGSB to proceed with Feasibility (20/9/06)			
0.01	11/12/06	Nicola Turner	Initial Draft Document
0.02	05/01/07	Nicola Turner	Update following comments from Anthony Tracey
0.03	14/03/07	Nicola Turner	Version for DSCN sub-group submission
0.04	26/03/07	Nicola Turner	Version updated following DSCN sub-group
0.05	30/03/07	Anthony Tracey	Updated following further discussions with Sally Greenway
0.06	04/04/07	Nicola Turner	Version for DSCN sub-group submission
0.07	08/04/07	Nicola Turner	Updated following DSCN sub-group for WIGSB submission
0.08	04/03/08	Rebecca Wells	DSCN updated following approval of final proposal submission to WIGSB (21/02/08). Version going to DSCN sub-group 7th March 08.
0.09	19/03/08	Rebecca Wells	Updated to include changes requested at DSCN sub-group 7th March 08. Version 0.09 to return to sub-group 1st April 08.
0.10	10/04/08	Rebecca Wells	Updated following DSCN sub-group 1 April 2008. Version 0.10 to be distributed to sub-group members.
0.11	06/05/08	Jennifer Evans	Updated following DSCN sub-group 29 April 2008. Inclusion of data item 'Source of Referral' and to add wording around all referrals to be included. Version 0.11 to be distributed to sub-group members.
1.0	02/06/2008	Rebecca Wells	Approved by WIGSB on 15th May 2008; previously known as DSCN (2006) BA (W)

DATA SET CHANGE NOTICE (2008) 05 (W)

Reference: WISGSB IGRN 2008 / 005

Subject: The Introduction of the Outpatient Referral Data Set

Reason for Change: To introduce the Data Set and associated Data Definitions for the NHS Wales 'Outpatient Referral Data Set'

Effective Date: 1st June 2008

Background:

In May 2001 a monthly aggregate collection of GP Referrals into secondary care was introduced and since June 2006 has been published by the Health Statistics and Analysis Unit, Welsh Assembly Government.

To enhance the information base for referrals into secondary care, an outpatient referral dataset was proposed.

In line with current guidance this data set should include all clinical referrals received into the Trust from General Practitioners, General Dental Practitioners, Community Dental Services, A&E Departments, self referrals, walk-ins or emergency patients accompanied by a GP letter, and Consultant to Consultant Referrals.

Referrals into Diagnostic and Therapy disciplines and those Welsh patients that are referred to English Trusts are to be considered outside the scope of the data set.

Once the data flow is established it is planned that a review of the submitted data will be undertaken over the following six months with a view of confirming business requirements with any associated refinements to the data set to be agreed.

Actions required:

Trusts are mandated to submit the Outpatient Referral data set via the secure file upload facility hosted by Health Solutions Wales on the 27th day of the month. This is to be in a fixed format file as per the NHS Wales Data Switching Service requirements.

Changes:

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

Changes 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: Tables reflecting areas that are impacted as a result of this DSCN

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

Impacted Data Items

Data Definition Type	Name	New / Retired / Changed
Data Item	Administrative Category	Changed
Data Item	Birth Date	Changed
Data Item	Birth Date Status	Changed
Data Item	Case Record Number	Changed
Data Item	Clinical Referral Date	Changed
Data Item	Clinical Referral Date Status	Changed
Data Item	Date of Patient Referral	Changed
Data Item	Ethnic Group	Changed
Data Item	Local Health Board of Residence	Changed
Data Item	Local Patient Identifier	Changed
Data Item	Main Specialty (Consultant)	Changed
Data Item	Name Format Code	Changed
Data Item	NHS Number Status Indicator	Changed
Data Item	Patient Referral Date Status	Changed
Data Item	Patient's Name	Changed
Data Item	Patient's Usual Address	Changed
Data Item	Postcode of Usual Address	Changed
Data Item	Provider Code	Changed
Data Item	Reason for Referral	New
Data Item	Record ID	Changed
Data Item	Referral Identifier	New
Data Item	Referrer Priority Type	New
Data Item	Referrer Code	Changed
Data Item	Referring Organisation Code	Changed
Data Item	Service Type Requested	Changed
Data Item	Source of Referral: Outpatients	Changed
Data Item	Treatment Function Code	Changed
Term	Referral	New

Appendix C: 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 shown with a ~~strikethrough~~. The text shaded in grey shows existing text copied from the NHS Wales Data Dictionary.

a) Amendments to the 'Overview' section of the NHS Wales Data Dictionary:

The NHS Wales Data Dictionary includes data items and terms relating to the Outpatient Minimum Data Set (OP mds), the Elective Admission List Minimum Data Set (EAL mds), the Admitted Patient Care Data Set (APC ds99), ~~and~~ the Critical Care Minimum Data Set (CCmds), the Outpatient Referral Data Set (OPR ds), Diagnostic & Therapy Services data collection and Referral to Treatment Time data collection. It also includes the Health and Social Care guide, included within a separate chapter.

b) Amendments to the 'Scope' section of the NHS Wales Data Dictionary:

This version of the Dictionary contains definitions pertaining to:

- Admitted Patient Care Data Set 99 (APC ds99)
- Outpatient Minimum Data Set (OP mds)
- Outpatient Referral Data Set (OPR ds)
- Elective Admission List Minimum Data Set (EAL mds)
- Critical Care Minimum Data set (CC mds)
- Diagnostic and Therapy Services Waiting Times
- Referral to Treatment (RTT) Times
- Inpatient and Daycase Admissions and First Outpatient Appointments Waiting Times (PP01W)

c) New Section to be included under 'Data Items and Terms (Grouped by Data Set): Outpatient Referral Data Set

Data Items & Terms (Grouped by Data Set)

Admitted Patient Care Minimum Data Set (APC Mds)
Outpatient Minimum Data Set (OP Mds)
Outpatient Referral Data Set (OPR Ds)
Elective Admission List Minimum Data Set (EAL Mds)
Critical Care Minimum Data Set (CC Mds)
Diagnostic and Therapy Services Waiting Times
Referral to Treatment (RTT) Times
Inpatient and Daycase Admissions and First Outpatient Appointments Waiting Times (PP01W)
QS1
Psychiatric Census
SBH50-59a
SBL618
Korner Returns
Welsh Core Indicators
Non - Medical Staffing
Community Child Health 2000

New Section:

Outpatient Referral Data Set

Valid From: 1st June 2008

Rating 1=mandatory 2=optional		Format/Length
1	Record ID	an1
	CONTRACT DETAILS	
1	Provider Code	an5
	PATIENT DETAILS	
1	Local Patient Identifier	an10
1	NHS Number	n10
1	NHS Number Status Indicator	n2
1	Code of Registered GP Practice	an6
2	Ethnic Group	an2
1	Patient's Name	an70 or structured name with 2 an35 elements
1	Name Format Code	n1
1	Birth Date	ccyymmdd
1	Birth Date Status	n1
1	Sex	n1
1	Patient's Usual Address	an175 (5 lines each an35)
1	Postcode of Usual Address	an8
1	Local Health Board of Residence	an3
	REFERRAL DETAILS	
1	Source of Referral: Outpatients	an2
1	Referring Organisation Code	an6
1	Service Type Requested	n1
1	Referrer Code	an8
1	Administrative Category	n2
1	Date of Patient Referral	ccyymmdd
1	Patient Referral Date Status	n1
1	Clinical Referral Date	ccyymmdd
1	Clinical Referral Date Status	n1
1	Main Specialty (consultant)	n3
1	Referrer Priority Type	n1
2	Reason for Referral	an8
1	Referral Identifier	an12
1	Treatment Function Code	n3

Note: 'Ethnic Group' and 'Reason for Referral' are optional data items in this data set because the information may not be provided at the time of receipt of referral.

d) Changes to Existing Data Items

Date of Patient Referral

(OP mds/EAL mds/ OPR ds)

The date on which the patient was told about the referral. ~~for a first outpatient appointment.~~ The starting point should be the date of referral given on the ~~GP's~~ referral notification (not the date the letter was received in hospital). ~~The date of referral is the date on which the patient was told that he or she was to be referred to a hospital~~ In cases where the ~~GP~~ referrer fails to specify a date of referral, the date the referral notification was received should be used.
~~For Self Referrals the date of referral is equal to the date of attendance.~~

Dates to be used;

- Date the patient is told about the referral.
- Date on referral notification
- Date of receipt of referral notification (only to be used where no date on document present).
- Date of verbal referral - For verbal referrals, the date of referral is equal to the date on which the verbal request is received. This date must be documented; any follow up written referral documentation will not affect the verbal date of referral.
- Where a patient self refers the date of referral is equal to the date of attendance.

Format: 8 digit numeric, ccyymmdd
~~Format DD/MM/CCYY~~

Patient's Usual Address

(APC ds99/ EAL mds/ OP mds/CC mds/OPR ds)

This is the usual address nominated by the patient at the time of admission or attendance. If patients usually reside elsewhere are staying in hotels, hostels or other residential establishments for a short term, say a week, they should be recorded as staying at their usual place of residence. However if long term, such as at boarding school, the school address must be recorded. University students may nominate either their home address or the address of their university accommodation. Where patients are not capable of supplying this information, because of age or mental illness, for example, then the person responsible for the patient, such as a parent or guardian, should nominate the usual address. Patients not able to provide an address should be asked for their most recent address. If this cannot be established then you should record the address as `No fixed abode' or `Address unknown'. These patients are regarded as resident in the local geographical district for contracting purposes. For birth episodes this should refer to the mother's usual place of residence.

~~APC, CC EAL and OP mds~~ Format: 175 character alpha-numeric. This is based on 5 lines of 35 characters. This relates to the physical layout of the address, not the logical layout and does not require intelligent intervention when splitting the text string into lines.

Provider Code

(APC ds99/ EAL mds/ OP mds/CC mds/ OPR ds)

This is the organisation code of the healthcare provider. The provider code identifies the health care provider who is responsible for managing the treatment of the patient.

Notes

1. ~~***N.B.***~~ ***Although the healthcare provider identified in this data item s responsible for managing the patient's treatment, it may not necessarily be where the treatment is actually conducted. For example, where the treatment has been sub-contracted to another healthcare provider.***

2. ***For Outpatient Referrals, the Provider Code is that of the organisation receiving the referral, made up of XXX00 where XXX is the NHS Trust Code***

Format: 5 character alpha-numeric

Value	Meaning
XAABB	The organisation code for the provider

Default codes:

Value	Meaning
89997	Non-UK provider where no organisation code has been issued
89999	Non-NHS UK provider where no organisation code has been requested and issued

See **Organisation Code**
See **Appendix C**

Record Id

(APC ds99/OP mds/CC mds/OPR ds)

Field to identify the type of record being submitted.

Format: 1 alphabetic

MDS	Value	Meaning
APC	L	New record
	A	Amendment record
	C	Deletion record
OP/CC/OPR	N	New record
	A	Amendment record
	D	Deletion record

Please note, there is no record id in the layout of the Elective Admission List (EAL) mandatory data set as this is a periodic census, providing a 'snapshot' on a specific date.
The values of the Record Id in the Admitted Patient Care (APC) layout were originally used for the Hospital Activity Analysis reporting. With the commencement of PEDW (early 1990's) these same values were carried forward into the APC development. At the time of the ~~O/P~~ Outpatient mandated data set it was agreed that these values should adopt a more logical standard.

Referrer Code

(APC ds99/ EAL mds/ OP mds/ OPR ds)

The nationally recognised code of the person making the referral. This may be a General Medical Practitioner (GMP), General Dental Practitioner (GDP), ~~or a~~ Consultant or Independent Nurse.
If the referral is not from a GMP, GDP, Consultant or Independent Nurse, use one of the default codes below:
Format: 8 character alpha-numeric

Default code:

Value	Meaning
M9999998	Midwife
N9999997	NHS Direct *
S9999998	Self Referral
A9999998	MOD doctor ~~refers~~
P9999981	Prison doctor ~~refers~~
R9999981	Referrer other than ~~GMP, GDP or Consultant~~ above

See Independent Nurse
See Consultant Code
See GP Code
See GP Code (Referring)

Treatment Function Code

(APC ds99/ EAL mds/ OP mds/ CC mds)

The specialty under which the patient is treated. This may either be the same as the specialty function recorded as the consultant's main specialty or a different specialty function which will be the consultant's interest specialty function. Note that both the main specialty function and the interest specialty function should be based on one of the Royal College specialties.

Note: For the Outpatient Referrals Data Set this is the specialty under which the patient is intended to be treated.

Format: 3 digit numeric

See Specialty/Specialty of Treatment Code
See Appendix A

Source of Referral: Outpatients

(OP mds/ OPR ds)

A classification which is used to identify the source of referral of each Outpatient episode or Outpatient Referral..

Format: 2 character alpha-numeric

Value	Meaning
Initiated by the Consultant or Independent Nurse responsible for the Outpatient episode	
01	Following an emergency admission
02	Following a domiciliary visit
10	Following an A&E attendance
11	Other
Not initiated by the Consultant or Independent Nurse responsible for the Outpatient episode	
03	Referral from General Medical Practitioner
04	Referral from an A&E department
05	Referral from a Consultant or Independent Nurse, other than in an

	A&E department
06	Self-referral
07**	Referral from Prosthetist
08**	Other source of referral
92	General Dental Practitioner
93	Community Dental Service

Note:

The classification has been listed in logical sequence rather than numeric order.

**** - those Source of Referrals which are to be excluded from the Outpatient Referrals data set**

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e) New Term

Referral

The term Referral is used to describe both an action which relates to the care of an individual patient and the general demand on the NHS to provide care services. In relation to individual patient care it is defined as a request or demand for the shifting of responsibility for a particular clinical problem. The actual transfer of responsibility is recorded by a change of responsible clinician for that problem. This may be described as a 'Clinical Referral'. The request may precede the assumption of responsibility by some time, the difference being the waiting time.

The general use relates to any request or demand for a service or services to be provided to a specific person. This may be described as a 'Service Demand'. The request to provide appropriate care to a patient may be to a care professional, team, service or organisation. A referral may be made by a person, team, service or organisation on behalf of a patient or by the patient him/herself. These demands will sometimes involve clinical referrals and sometimes not.

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f) New Data Items

Referrer Priority Type

(OPR ds)

This is the Referrer's assessment of the priority of a request for services. The value may be obtained from the text in the referral notification and is unaffected by the priority as assessed by the Consultant or Independent Nurse responsible for the outpatient appointment on review of the referral notification.

Format: 1 digit numeric

Value	Meaning
1	Routine
2	Urgent

Note:
If a patient self-refers, this field should be populated with the default value of 1..

The 'routine' value is to be utilised as a default if no urgency or clinical priority is included within the referral notification. Where an urgency or clinical priority is included 'urgency' can be defined as per the extant guidance.

Reason for Referral

(OPR ds)

The reason(s) for the patient requiring involvement with care professionals. These may include any problem, issue or event affecting the patient's health and/ or well being

The information held within this data item must be a valid clinical code or term.

Format: 8 character alpha-numeric

Left justified and padded with spaces

Referral Identifier

(OPR ds)

A locally produced unique identifier for a referral.

Format: an12

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f) Existing Data Items solely amended to identify their inclusion in the Outpatient Referral ds:

Administrative Category
(APC ds99/ EAL mds/ OP mds/ CC mds/ OPR ds)

Birth Date
(APC ds99/ EAL mds/ OP mds/ CC mds/ OPR ds)

Birth Date Status
(APC ds99/ EAL mds/ OP mds/ CC mds/ OPR ds)

Clinical Referral Date
(APC ds99/ EAL mds/ OPR ds)

Clinical Referral Date Status
(APC ds99/ EAL mds/ OPR ds)

Ethnic Group
(APC ds99/ NCCHD/ CC mds/ OPR ds)

Local Health Board of Residence
(APC ds99/ EAL mds/ OP mds/ OPR ds)

Local Patient Identifier
(APC ds99/ EAL mds/ OP mds/ OPR ds)

Main Specialty (Consultant)
(APC ds99/ EAL mds/ OP mds/ OPR ds)

Name Format Code
(APC ds99/ EAL mds/ OP mds/ OPR ds)

NHS Number Status Indicator
(APC ds99/ EAL mds/ OP mds/ OPR ds)

Patient Referral Date Status
(OP mds/ OPR ds)

Patient's Name
(APC ds99/ EAL mds/ OP mds/ CC mds/ OPR ds)

Patient's Usual Address
(APC ds99/ EAL mds/ OP mds/ CC mds/ OPR ds)

Postcode of Usual Address
(APC ds99/ EAL mds/ OP mds/ OPR ds)

Referring Organisation Code
(APC ds99/ EAL mds/ OP mds/ OPR ds)

Service Type Requested
(OP mds/ OPR ds)

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

Outpatient Referral Data Set

Valid From: 1st June 2008

Rating 1=mandatory 2=optional		Format/Length
1	Record ID	an1
	CONTRACT DETAILS	
1	Provider Code	an5
	PATIENT DETAILS	
1	Local Patient Identifier	an10
1	NHS Number	n10
1	NHS Number Status Indicator	n2
1	Code of Registered GP Practice	an6
2	Ethnic Group	an2
1	Patient's Name	an70 or structured name with 2 an35 elements
1	Name Format Code	n1
1	Birth Date	ccyymmdd
1	Birth Date Status	n1
1	Sex	n1
1	Patient's Usual Address	an175 (5 lines each an35)
1	Postcode of Usual Address	an8
1	Local Health Board of Residence	an3
	REFERRAL DETAILS	
1	Source of Referral: Outpatients	an2
1	Referring Organisation Code	an6
1	Service Type Requested	n1
1	Referrer Code	an8
1	Administrative Category	n2
1	Date of Patient Referral	ccyymmdd
1	Patient Referral Date Status	n1
1	Clinical Referral Date	ccyymmdd
1	Clinical Referral Date Status	n1
1	Main Specialty (consultant)	n3
1	Referrer Priority Type	n1
2	Reason for Referral	an8
1	Referral Identifier	an12
1	Treatment Function Code	n3

Note: 'Ethnic Group' and 'Reason for Referral' are optional data items in this data set because the information may not be provided at the time of receipt of referral.

g) Changes to Existing Data Items

Date of Patient Referral

(OP mds/EAL mds/ OPR ds)

The date on which the patient was told about the referral. The starting point should be the date of referral given on the referral notification (not the date the letter was received in hospital). In cases where the referrer fails to specify a date of referral, the date the referral notification was received should be used.

Dates to be used;

- Date the patient is told about the referral.
- Date on referral notification
- Date of receipt of referral notification (only to be used where no date on document present).
- Date of verbal referral - For verbal referrals, the date of referral is equal to the date on which the verbal request is received. This date must be documented; any follow up written referral documentation will not affect the verbal date of referral.
- Where a patient self refers the date of referral is equal to the date of attendance.

Format: 8 digit numeric, ccyymmdd

Patient's Usual Address

(APC ds99/ EAL mds/ OP mds/CC mds/OPR ds)

This is the usual address nominated by the patient at the time of admission or attendance. If patients usually reside elsewhere are staying in hotels, hostels or other residential establishments for a short term, say a week, they should be recorded as staying at their usual place of residence. However if long term, such as at boarding school, the school address must be recorded. University students may nominate either their home address or the address of their university accommodation. Where patients are not capable of supplying this information, because of age or mental illness, for example, then the person responsible for the patient, such as a parent or guardian, should nominate the usual address. Patients not able to provide an address should be asked for their most recent address. If this cannot be established then you should record the address as `No fixed abode' or `Address unknown'. These patients are regarded as resident in the local geographical district for contracting purposes. For birth episodes this should refer to the mother's usual place of residence.

Format: 175 character alpha-numeric. This is based on 5 lines of 35 characters. This relates to the physical layout of the address, not the logical layout and does not require intelligent intervention when splitting the text string into lines.

Provider Code

(APC ds99/ EAL mds/ OP mds/CC mds/ OPR ds)

This is the organisation code of the healthcare provider. The provider code identifies the health care provider who is responsible for managing the treatment of the patient.

Notes

1. ***Although the healthcare provider identified in this data item s responsible for managing the patient's treatment, it may not necessarily be where the treatment is actually conducted. For example, where the treatment has been sub-contracted to another healthcare provider.***
2. ***For Outpatient Referrals, the Provider Code is that of the organisation receiving the referral, made up of XXX00 where XXX is the NHS Trust Code***

Format: 5 character alpha-numeric

Value	Meaning
XAABB	The organisation code for the provider

Default codes:

Value	Meaning
89997	Non-UK provider where no organisation code has been issued
89999	Non-NHS UK provider where no organisation code has been requested and issued

See **Organisation Code**
See **Appendix C**

Record Id

(APC ds99/OP mds/CC mds/OPR ds)

Field to identify the type of record being submitted.

Format: 1 alphabetic

MDS	Value	Meaning
APC	L	New record
	A	Amendment record
	C	Deletion record
OP/CC/OPR	N	New record
	A	Amendment record
	D	Deletion record

Please note, there is no record id in the layout of the Elective Admission List (EAL) mandatory data set as this is a periodic census, providing a 'snapshot' on a specific date.
The values of the Record Id in the Admitted Patient Care (APC) layout were originally used for the Hospital Activity Analysis reporting. With the commencement of PEDW (early 1990's) these same values were carried forward into the APC development. At the time of the Outpatient mandated data set it was agreed that these values should adopt a more logical standard.

Referrer Code

(APC ds99/ EAL mds/ OP mds/ OPR ds)

The nationally recognised code of the person making the referral. This may be a General Medical Practitioner (GMP), General Dental Practitioner (GDP), Consultant or Independent Nurse**.**
If the referral is not from a GMP, GDP, Consultant or Independent Nurse, use one of the default codes below:
Format: 8 character alpha-numeric

Default code:

Value	Meaning
M9999998	Midwife

N9999997	NHS Direct *
S9999998	Self Referral
A9999998	MOD doctor
P9999981	Prison doctor
R9999981	Referrer other than above

See Independent Nurse
See Consultant Code
See GP Code
See GP Code (Referring)

Treatment Function Code

(APC ds99/ EAL mds/ OP mds/ CC mds)

The specialty under which the patient is treated. This may either be the same as the specialty function recorded as the consultant's main specialty or a different specialty function which will be the consultant's interest specialty function. Note that both the main specialty function and the interest specialty function should be based on one of the Royal College specialties.

Note: For the Outpatient Referrals Data Set this is the specialty under which the patient is intended to be treated.

Format: 3 digit numeric

See Specialty/Specialty of Treatment Code
See Appendix A

Source of Referral: Outpatients

(OP mds/ OPR ds)

A classification which is used to identify the source of referral of each Outpatient episode or Outpatient Referral.

Format: 2 character alpha-numeric

Value	Meaning
Initiated by the Consultant or Independent Nurse responsible for the Outpatient episode	
01	Following an emergency admission
02	Following a domiciliary visit
10	Following an A&E attendance
11	Other
Not initiated by the Consultant or Independent Nurse responsible for the Outpatient episode	
03	Referral from General Medical Practitioner
04	Referral from an A&E department
05	Referral from a Consultant or Independent Nurse, other than in an A&E department
06	Self-referral

07**	Referral from Prosthetist
08**	Other source of referral
92	General Dental Practitioner
93	Community Dental Service

Note:

The classification has been listed in logical sequence rather than numeric order.

**** - those Source of Referrals which are to be excluded from the Outpatient Referrals data set**

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h) New Term

Referral

The term Referral is used to describe both an action which relates to the care of an individual patient and the general demand on the NHS to provide care services. In relation to individual patient care it is defined as a request or demand for the shifting of responsibility for a particular clinical problem. The actual transfer of responsibility is recorded by a change of responsible clinician for that problem. This may be described as a 'Clinical Referral'. The request may precede the assumption of responsibility by some time, the difference being the waiting time.

The general use relates to any request or demand for a service or services to be provided to a specific person. This may be described as a 'Service Demand'. The request to provide appropriate care to a patient may be to a care professional, team, service or organisation. A referral may be made by a person, team, service or organisation on behalf of a patient or by the patient him/herself. These demands will sometimes involve clinical referrals and sometimes not.

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i) New Data Items

Referrer Priority Type

(OPR ds)

This is the Referrer's assessment of the priority of a request for services. The value may be obtained from the text in the referral notification and is unaffected by the priority as assessed by the Consultant or Independent Nurse responsible for the outpatient appointment on review of the referral notification.

Format: 1 digit numeric

Value	Meaning
1	Routine
2	Urgent

Note:
If a patient self-refers, this field should be populated with the default value of 1..
The 'routine' value is to be utilised as a default if no urgency or clinical priority is included within the referral notification. Where an urgency or clinical priority is included 'urgency' can be defined as per the extant guidance.

Reason for Referral

(OPR ds)

The reason(s) for the patient requiring involvement with care professionals. These may include any problem, issue or event affecting the patient's health and/ or well being

The information held within this data item must be a valid clinical code or term.

Format: 8 character alpha-numeric

Left justified and padded with spaces

Referral Identifier

(OPR ds)

A locally produced unique identifier for a referral.

Format: an12

Additional Information:

Please address enquiries about this DSCN to: -

Data Standards and Information Quality Team
Health Solutions Wales
14th Floor - Brunel House
2 Fitzalan Road
Cardiff
CF24 0HA

Tel: 029 20502539
Fax: 029 20502504

E-mail: Datastandards@hsw.wales.nhs.uk