

WELSH INFORMATION STANDARDS BOARD

DSC Notice:	DSCN 2022 / 03
Date of Issue:	24 th January 2022

Welsh Health Circular/Official Letter: Letter ref: RB/cam/qA918787, Appendix D	Subject: Welsh Emergency Care Data Set (WECDS) Phase 1 AMD
Sponsor: Roger Perks, Delivery & Performance Division, Delivery Directorate Health and Social Services Group, Welsh Government	
Implementation Date: With immediate effect	

DATA STANDARDS CHANGE NOTICE

A Data Standards 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) at its meeting on 20th January 2022.

WISB Reference: ISRN 2018 / 017

Summary:

- Retirement of Clinical Exception Date and Clinical Exception Time from the EDDS.
- To mandate submission of Treatment End Date and Time only where a clinical exception has been applied.

Data sets / returns affected:

Emergency Department Data Set

Please address enquiries about this Data Standards Change Notice to the Data Standards Team in Digital Health and Care Wales

E-mail: data.standards@wales.nhs.uk / Tel: 02920502539

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:

https://nhs.wales365.sharepoint.com/sites/DHC_DST/Lists/Information%20Standards%20Assurance%20Submission%20Log/AllItems.aspx

DATA STANDARDS CHANGE NOTICE

Introduction

DSCN 2019 / 08 was intended to support the reporting of clinical exceptions and the true treatment end times by separating them into individual fields. Feedback on the implementation of the DSCN resulted in halting the use of the Clinical Exception Date/Time fields and requesting that LHBs continued to report Clinical Exceptions as per previous practices (using Treatment End Date/Time). Operational pressures due to the Covid-19 pandemic led to a delay in the release of an official mandate.

The data items Clinical Exception Date and Clinical Exception Time will now be retired, and Treatment End Time will be used to record clinical exceptions. The specification for calculating performance against the four and eight hour waits in Emergency Departments will remain as outlined in Appendix C. In brief, EDDS daily and monthly submissions for patients who are identified as a clinical exception are required to contain data entries for Admin Start Time, Treatment End Time, and Departure Time. The Admin Start Time to Treatment End Time will be used to measure against the four and eight hour waits. All other patients who are not clinical exceptions should now only contain data entries for Admin Start Time and Departure Time, with Treatment End Time being left blank in EDDS submissions. For this group of patients, the four and eight hour measures will be calculated based on Admin Start Time to Departure Time.

Description of Change

To retire the data items Clinical Exception Date and Time from the EDDS and to amend Treatment End Date and Time. The requirements for submission of Treatment End Date and Time in the daily and monthly submissions have reverted to the original specification from 2011, refer to Appendix D. Treatment End Date and Time should only be submitted when a clinical exception applies.

Data Dictionary Version

Where applicable, this DSCN reflects changes introduced by DSCN and/or DDCN since the release of version 4.15 of the NHS Wales Data Dictionary.

The changes introduced by such DSCNs will be published in version 4.16 of the NHS Wales Data Dictionary.

Actions Required

Actions for Local Health Boards / Trusts:

- Ensure daily and monthly EDDS submissions only contain a Treatment End Time when a clinical exception applies.

Actions for the Welsh Government Delivery & Performance Division:

- Continue to use the specification for calculating performance against 4 and 8 hour wait outlined in Appendix C.

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 listed in alphabetical order and is shown in the sequence in which it appears in this DSCN.

Data Definition Type	Name	New/Retired/Changed	Page Number
Patient Level Data Set	Emergency Department Data Set	Changed	4
Data Item	Clinical Exception Date	Retired	7
Data Item	Clinical Exception Time	Retired	7
Data Item	Treatment End Date	Changed	7
Data Item	Treatment End Time	Changed	8

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 **strikethrough**. The text shaded in **grey** shows existing text copied from the NHS Wales Data Dictionary.

Data Set Structure

	Format
<u>Record Id</u>	a1
CONTRACT DETAILS	
<u>Organisation Code (Code Of Provider)</u>	an5
PATIENT DETAILS	
<u>Local Patient Identifier (CRN)</u>	an10
<u>NHS Number</u>	n10
<u>NHS Number Status Indicator</u>	n2
<u>GP Practice Code</u>	an6
<u>Ethnic Group</u>	an2
<u>Patient's Name</u>	an70
<u>Name Format Code</u>	n1
<u>Birth Date</u>	ccyymmdd
<u>Birth Date Status</u>	n1
<u>Sex</u>	n1
<u>Patient's Usual Address1</u>	an35
<u>Patient's Usual Address2</u>	an35
<u>Patient's Usual Address 3</u>	an35
<u>Patient's Usual Address 4</u>	an35
<u>Patient's Usual Address 5</u>	an35
<u>Postcode of Usual Address</u>	an8
<u>Organisation Code (LHB Area of Residence)</u>	an3
REFERRAL DETAILS	
<u>Source of Service Request</u>	an2
<u>Referring Organisation Code</u>	an6
<u>Referrer Code</u>	an8
<u>Arrival Mode</u>	n2

<u>Ambulance Incident Number</u>	An8
ATTENDANCE DETAILS	
<u>Site Code (of Treatment)</u>	an5
<u>Administrative Arrival Date</u>	ccyymmdd
<u>Administrative Arrival Time</u>	hh:mm:ss
<u>Health Event Date</u>	ccyymmdd
<u>Health Event Time</u>	hh:mm:ss
<u>Attendance Group</u>	an2
<u>Attendance Category</u>	n2
<u>Triage Category</u>	n2
<u>Accident and Emergency Investigation 1</u>	n3
<u>Accident and Emergency Investigation 2</u>	n3
<u>Accident and Emergency Investigation 3</u>	n3
<u>Accident and Emergency Investigation 4</u>	n3
<u>Accident and Emergency Investigation 5</u>	n3
<u>Accident and Emergency Investigation 6</u>	n3
<u>Accident and Emergency Principal Diagnosis Type</u>	an3
<u>Accident and Emergency Diagnosis Type 2</u>	an3
<u>Accident and Emergency Diagnosis Type 3</u>	an3
<u>Accident and Emergency Diagnosis Type 4</u>	an3
<u>Accident and Emergency Diagnosis Type 5</u>	an3
<u>Accident and Emergency Diagnosis Type 6</u>	an3
<u>Anatomical Area 1</u>	n3
<u>Anatomical Area 2</u>	n3
<u>Anatomical Area 3</u>	n3
<u>Anatomical Area 4</u>	n3
<u>Anatomical Area 5</u>	n3
<u>Anatomical Area 6</u>	n3
<u>Anatomical Side 1</u>	n2
<u>Anatomical Side 2</u>	n2
<u>Anatomical Side 3</u>	n2
<u>Anatomical Side 4</u>	n2
<u>Anatomical Side 5</u>	n2

<u>Anatomical Side 6</u>	n2
<u>Accident and Emergency Treatment 1</u>	an3
<u>Accident and Emergency Treatment 2</u>	an3
<u>Accident and Emergency Treatment 3</u>	an3
<u>Accident and Emergency Treatment 4</u>	an3
<u>Accident and Emergency Treatment 5</u>	an3
<u>Accident and Emergency Treatment 6</u>	an3
<u>Additional Incident Details</u>	an255
<u>Appropriateness of Attendance</u>	n2
<u>Outcome of Attendance</u>	n2
<u>Treatment End Date</u>	ccyymmdd
<u>Treatment End Time</u>	hh:mm:ss
<u>Departure Date</u>	ccyymmdd
<u>Departure Time</u>	hh:mm:ss
<u>Alcohol Indicator</u>	n2
<u>Injury Location Type</u>	n2
<u>Road User</u>	n2
<u>Presenting Complaint</u>	an255
<u>Mechanism of Injury</u>	n2
<u>Activity at Time of Injury</u>	n2
<u>Sport Activity</u>	n2
<u>Triage Start Date</u>	ccyymmdd
<u>Triage Start time</u>	hh:mm:ss
<u>Triage End date</u>	ccyymmdd
<u>Triage End Time</u>	hh:mm:ss
<u>Triage Score</u>	n2
<u>Clinical Start Date</u>	ccyymmdd
<u>Clinical Start Time</u>	hh:mm:ss
<u>Clinical Exception Date</u>	ccyymmdd
<u>Clinical Exception Time</u>	hh:mm:ss

a) Changes to Existing Data Items

Clinical Exception Date

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
EDDS	8 th November 2019	

Clinical Exception Date is the date, where it is deemed clinically appropriate, any patient who meets the clinical exception criteria should be identified on the date a clinical decision is made.

Format: ccddmmyy

When a patient has been deemed to be a clinical exception this date is to be captured in Clinical Exception Date and not in Treatment End Date. Please refer to Appendix C for further details.

Clinical Exception Time

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
EDDS	8 th November 2019	

Clinical Exception Time is the time, where it is deemed clinically appropriate, any patient who meets the clinical exception criteria should be identified at the time a clinical decision is made.

Format: hh:mm:ss

When a patient has been deemed to be a clinical exception this time is to be captured in Clinical Exception Time and not in Treatment End Time. Please refer to Appendix C for further details.

Treatment End Date

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
EDDS	8 th November 2019	

Emergency Department Attendance Treatment End Date is the date the Emergency Department clinical staff has finished treating the patient in their department.

This is the date that the patient is clinically defined as:

- ready to be discharged
- ready to be transferred via ambulance to continue treatment elsewhere
- ready for admission onto a ward

d. OR, the time that the patient self-discharges or dies.

Note: For patients being discharged from the Emergency Department because they are clinically fit to leave, the Treatment End Date and the Departure Date will be the same. Where a Treatment End Time is present in the daily and monthly EDDS submissions, it will be assumed that a clinical exception applies and the 4 and 8 hour measure will be based on this time. Where a Treatment End Time is not present, it will be assumed that a clinical exception does not apply and the 4 and 8 hour measure will be calculated using Departure Time.

Format: ccyyymmdd

The Treatment End Date no longer includes any clinical exceptions.

Please refer to the following document for further guidance:

<https://dhw.nhs.wales/information-services/information-standards/data-quality/data-quality-standards/edds-data-consistency/20111209-letter-unscheduled-care-4-and-8-hour-measurement-reporting-pdf/>

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This data item is / was included in the following data sets / collections between the dates shown:

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EDDS	8 th November 2019	

Emergency Department Attendance Treatment End Time is the time the Emergency Department clinical staff has finished treating the patient in their department.

This is the time that the patient is clinically defined as:

- a. ready to be discharged
- b. ready to be transferred via ambulance to continue treatment elsewhere
- c. ready for admission onto a ward
- d. OR, the time that the patient self-discharges or dies.

Note: For patients being discharged from the Emergency Department because they are clinically fit to leave, the Treatment End Time and the Departure Time will be the same. Where a Treatment End Time is present in the daily and monthly EDDS submissions, it will be assumed that a clinical exception applies and the 4 and 8 hour measure will be based on this time. Where a Treatment End Time is not present, it will be assumed that a clinical exception does not apply and the 4 and 8 hour measure will be calculated using Departure Time.

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Appendix C: Specification for calculating performance against 4 and 8 hour wait (time spent in A&E)

The following methodology is to be applied to monthly "official" reporting for attendances with a Departure Date (previously Admin End Date) of 1 December 2011 or later; and daily "management information" reporting for attendances with a Departure Date (previously Admin End Date) of 1 February 2012 or later.

For attendances with a Departure Date (previously Admin End Date) from 1 January 2013 onwards any attendances where the time in department \geq 24 hours are included.

Acronyms:

AADT – Admin Arrival Date/Time

DDT – Departure Date/Time

TEDT – Treatment End Date/Time

Starting Point - All Attendances

Daily and monthly calculation to be based on all attendances

Step 1 – Remove exclusions (from numerator and denominator)

Exclude:

- Known Planned Follow Ups (i.e. Attendance category = "02" (or "2"))
- Attendances where patient was dead on arrival* (i.e. Outcome of Attendance = "11" or Attendance Group = "30")
(* Patients who died in department (either Outcome of Attendance = "10") are not to be excluded)
- Attendances where time in department is greater than 24 hours (i.e. $DT - AADT \geq 24$ hours)
These attendances are included from the 1st January 2013

Step 2 – Perform measurement calculation

Actual calculation:

If TEDT is not blank, wait = TEDT - AADT, otherwise wait = DDT - AADT

Step 3 – Remove (from numerator and denominator) exclusions with calculation errors

Exclude:

- Attendances where the calculated wait results in a blank, negative or invalid value

Note: The numbers spending less than 4 hours is based on a calculation of time actually being less than 4 hours (e.g. up to and including 3 hrs 59 minutes 59 seconds). Exactly 4 hours is therefore a breach. The same applies for 8 hours (i.e. 7 hrs, 59 mins, 59 secs) and 12 hours (i.e. 11 hrs, 59 mins, 59 secs).

Appendix D: Letter - Director of Operations to Directors of Planning Performance

Yr Adran Iechyd, Gwasanaethau Cymdeithasol a Phlant
Department for Health, Social Services and Children



Llywodraeth Cymru
Welsh Government

To: All LHB Directors of Planning /Performance
All LHB Heads of Information

Cc: Medical Directors (for information)

Our Ref: RB/cam/qA918787
9th December 2011

Dear Colleagues

Unscheduled Care 4 & 8 Hour Measurement and Reporting

Further to previous discussions, I am writing to formalise the improvements in how NHS Wales will need to monitor patient flow through Emergency Departments (ED). The core principle for this change is to ensure that a clinician's decision about patient care **must** take priority above all else; regardless of whether this results in a four hour target being missed. Timely access to treatment will still remain an important quality measure for NHS Wales however we must recognise and increasingly focus on patient outcome measures.

These principles are recognised and supported by the College of Emergency Medicine and our staff.

Secondly, we anticipate that by formalising these changes, there is an expectation that there will be a standardisation in reporting practices across NHS Wales. Despite previous national guidance on how ED targets should be measured there remains considerable variation in reporting and if /when we attempt to benchmark against any of the home nations, the inconsistencies are compounded.

For example, other countries legitimately apply clinical exclusions for certain patient types in which ED offers the only appropriate facility and expertise that is suited to the patient's current condition. We need to recognise this approach within NHS Wales, as there are often circumstances where, in the judgement of the senior doctor and nurse, it is clinically appropriate for a patient to remain within the department for longer than four hours.

Clinical Criteria

In practice this means that:

- If a clinician decides that the safest place for a patient is the Emergency Department, the patient should remain there until it is safe to move them; and /or
- Patients should not be admitted **solely** to avoid a breach of the four hour target. Clinicians should admit patients only to appropriate facilities and only when it is appropriate to do so.

In order to deliver a consistent approach across Wales and with **immediate effect**, we will utilise the broad criteria recognised by the DH and the CEM for clinical exceptions who spend more than four hours in the emergency department.



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These patients are broken down into two broad categories:-

1. Those who need the facilities of the main emergency department, often the resuscitation room:
 - Patients in the resuscitation room undergoing active resuscitation whose clinical condition would be jeopardised by the transfer to another area;
 - Patients who unexpectedly deteriorate and need the continued care of emergency department specialists.
 - Patients who, despite the efforts of the emergency department team are expected to die imminently and should not be moved.

2. Those who are cared for by Emergency Medicine specialists but do not need the specific facilities of the main department (i.e. best cared for in a ward environment, for example an observation area or clinical decision unit that is adjacent to the main department):
 - Patients needing a short period of intensive investigation to rule out serious illness who are liable to go home e.g. patients with chest pain who need tests several hours after onset of the pain (examples included patients awaiting Troponin T Test);
 - Patients needing a period of a few hours recovery e.g. following sedation to enable a dislocation to be treated, after alcohol /drug ingestion, self-harm patients etc;
 - Patients requiring a period of brief treatment with the expectation of going home e.g. a person with mild dehydration who is given some fluids over a few hours;
 - Patients requiring observation, e.g. minor head injury, patients after a seizure to ensure full recovery and no further fits or after possible ingestion of excessive amounts of drugs.

The only exceptions to the target are those cases where it is believed that clinical care is best undertaken in the main emergency department.

Where it is deemed clinically appropriate, any patient who meets the above criteria should be identified at the time a clinical decision is made, this time will need to be recorded to ensure that 4 & 8 performance can be correctly recorded and reported (**Appendix 1** - Details the data capture requirements).

You will be aware that we recently established EDDS (Emergency Department Data Set) as the one source of data to be used in the production and publishing of four and eight hour waiting times for **major** emergency departments across NHS Wales on a daily and monthly basis.

Further enhancement of EDDS will still be required to fully capture and evidence the clinical criteria. This work will be undertaken to ensure that the necessary changes meet the needs of the Welsh Information Standards Board and will be issued as a DSCN at the earliest possible opportunity. The process has also been agreed and worked through with colleagues in Health Statistics (KAS).

If you have any questions relating to this letter , please contact either Roger Perks roger.perks@wales.gsi.gov.uk or Andrew Sallows Andrew.sallows@wales.nhs.uk.

Yours sincerely

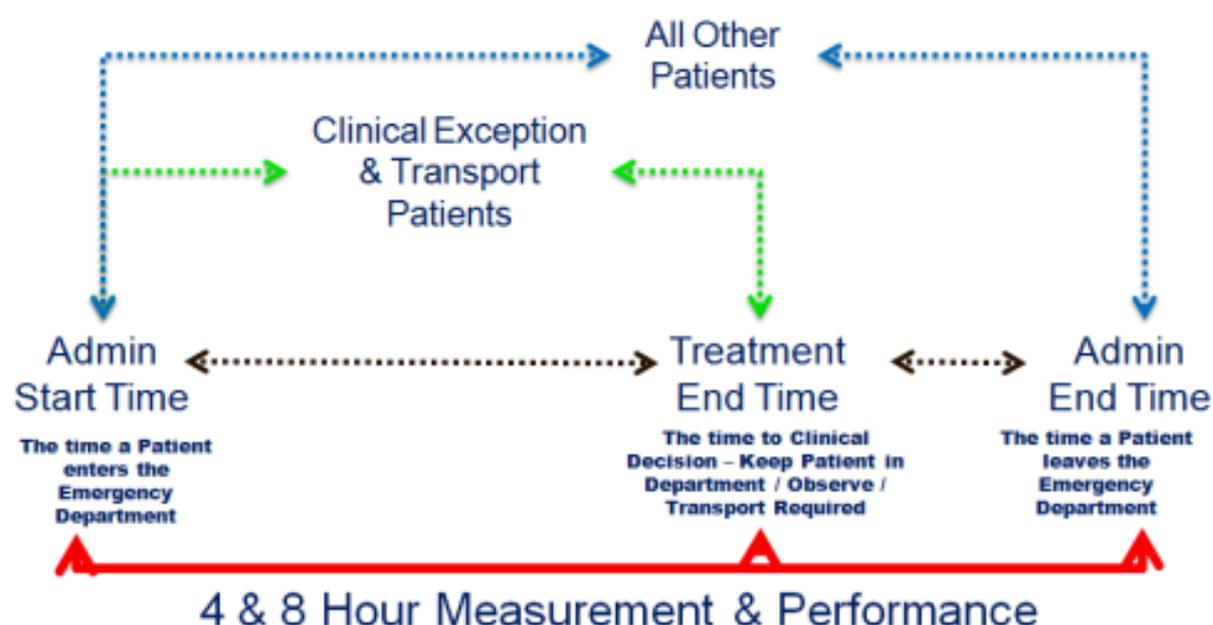


Richard Bowen
Director of Operations

4 & 8 Hour Data Capture Requirements

The changes to the 4 & 8 measurement guidelines outlined above will need to be fully captured within our current reporting mechanisms. In the longer term this will require enhancement of the EDDS dataset to facilitate and evidence the times and reasons for stopping the 4 & 8 measurements before the patient physically leaves the department.

However in the short term, we need to be able to capture and report performance using the new guidelines, a suggested process has been discussed and agreed with Heads of Information recently, the methodology for which is detailed in the diagram below :-



For daily and monthly data submissions where a patient is a clinical exception or is waiting for transport the EDDS submission will be expected to contain data entries for the Admin Start Time, Treatment End Time and Admin End Time.

The Admin Start Time to Treatment End Time will be recorded against the 4 & 8 hour measure for this patient cohort.

For all other patients the EDDS submission will contain data entries for the Admin Start Time and Admin End Time. The Treatment End Time, even if complete on your local system, should be blank in your daily and monthly EDDS submissions.

The Admin Start Time to Admin End Time will be recorded against the 4 & 8 hour measure for this patient cohort.

In summary, where a Treatment End Time is present in the daily and monthly EDDS submissions, it will be assumed that a clinical exception applies and the 4 & 8 hour measure will be based on this time. Where a Treatment End Time is **not** present, it will be assumed that a clinical exception does **not** apply and the 4 & 8 hour measure will be calculated using Admin End Time.

Utilising this approach will enable us to understand the frequency each LHB captures clinical exception and transport patients, these volumes will be shared and discussed with LHBs to help understand and explain any significant variations in practice and help inform the longer term enhancement requirements.