CHI INVESTIGATION AT GOSPORT WAR MEMORIAL HOSPITAL

DATA FROM THE TRUST'S PATIENT ADMINISTRATION SYSTEM

Introduction

CHI requires access to an extract of data contained in the trust's inpatient/day case Patient Administration System (PAS), conforming to the protocol outlined here.

The data requested here is nothing more than the CMDS (contract minimum data set) the trust routinely submits to the NHS-Wide Clearing Service (NWCS). We have endeavoured to be prescriptive and unambiguous in the protocol below to ensure that the data we receive from trusts have standard content, structure and format. We would therefore ask that you follow the protocol and inform us promptly if there are areas that are problematic for your trust.

Experience has shown that trusts should consider at an early stage how they are to provide the extract as it may be necessary to involve the trust's systems suppliers if the extract cannot be prepared in-house.

We require the trust to provide a dataset, which follows the specification, to highlight deficiencies in the dataset and provide mapping files where data deviate from national standard codes.

The data can be submitted via e-mail to **CGR.trust@chi.nhs.uk** or copied to CD-ROM and sent by guaranteed overnight mail.

Period and Scope

The extract should comprise data for the last four complete financial years. We require both finished and unfinished hospital episodes, ie episodes that end within the period and those episodes that did not have an episode end date at the end of the period.

All specialties provided in the trust should be included. If the trust is unable to provide PAS information for a specific service this must be made clear.

Data Quality and Data Completeness

The set of information requested will be used by CHI both to produce the Summary of Evidence and undertake further, more detailed, analysis to clarify issues arising during the investigation process. It is therefore important that the PAS extract is as robust and complete as possible. We should therefore like details of particular issues concerning information contained within the PAS. Please produce a data quality report that addresses relevant issues under the following headings:

- Corporate information systems – brief summary of corporate systems set-up, eg PAS / casemix / query tools and use of systems in NWCS submission

- Data quality and data completeness – highlight known data quality problems, areas where not all activity is captured in the PAS and areas where patient details may be incomplete. Where data are lacking descriptions and explanations should be provided

- Clinical coding – coding is vital to most clinical data analyses. Please give a brief description of the trust's coding service (coding sources and details of last audit) and highlight services where clinical coding is known to be poor (accuracy and completeness).

Explanations and look-up tables

For most fields, provided the trust is using national standard codes there should be no need for look-up tables for codes. However, if non-standard codes are being used (ie codes different from those outlined in the Hospital Episode System (HES) definitions) then look-up tables should be provided. In addition, we will require a specific lookup table for **local specialty code (with description) to national specialty code and local directorate or care group (with description).** This requirement reflects the variations in management arrangements for individual specialties between trusts and will allow us to present our analysis in a way that best reflects the trust's management structure.

File Format

The extract should be a delimited 'flat file' in a format that will be easily importable into our database. The preferred format is a comma separated value file (.csv). All dates should be in the format dd/mm/yyyy (see note below with list of fields required).

Structure and Description

The following table outlines the data required. As all data items are included in Hospital Episode System (HES) and Patient Episode Database of Wales (PEDW), they should be available. HES and PEDW field names are included alongside data items to ensure clarity of what is meant in each field. The Admitted Patient Care (APC) field name is also included. In most cases this does not differ substantially from that used by HES and/or PEDW. If you need details of HES definitions, they can be found at **www.doh.gov.uk/hes.htm**

We would like you to submit the data with fields in the order presented here. Where data are not available for a specific field, **null fields should be reported** (and described in the data quality and completeness report). This will enable us to read the file directly into our database.

Confidentiality

The work that CHI is tasked to do necessarily requires access to data at the level of the individual. It does not require identification of individuals. CHI has a strict confidentiality policy for all staff, and provides a secure environment for the retention of data and information.

CHI had its case accepted by the Security and Confidentiality Advisory Group (SCAG) – the committee chaired by Professor Alastair Bellingham, which deals with the release of NHS data – for the provision of confidential data held centrally. This includes

fields such as NHS number and date of birth, which could potentially be used to identify the patient.

IM&T Visit

CHI analysts (or their representatives) will undertake an IM&T visit to the trust at some stage prior to or during the investigation week. This will normally take the form of a meeting lasting up to two hours. It is usual for the trust's Information Manager to attend, and the focus is around the use of information to support clinical governance, and related issues.

List of PAS fields required

Please send us the following fields from your PAS system. In addition, could you include any field, with a separate look-up table, identifying which ward the patients were on at the start of the episode. If your system allows for time as well as date of admission and discharge, please send these fields in a 'dd/mm/yyyy hh:mm' format.

	ENGLAND	WALES	WALES
DATA ITEM	HES FIELD NAME	PEDW FIELD NAME	APC FIELD NAME
Patient ID number	LOPATID	Case record number	Case record number
NHS Number	NEWNHSNO	NHS number	NHS number
Consultant	CONSULT	Consultant code	Consultant code
DHA of residence	RESDHA	DHA of residence	HA code of residence
Age at start of episode	STARTAGE	Age at episode start	Derived at HSW
Sex	SEX	Sex	Sex
Ethnicity	ETHNOS	Ethnic group	Ethnic group
GP practice code	GPPRAC	GP partnership code	Referring organisation code
Patient category	CATEGORY	Patient category	Admin category & legal status
Admission date	ADMIDATE	Date of admission	Start date spell
Admission method	ADMIMETH	Method of admission	Admission method
Admission source	ADMISORC	Source of admission	Source of admission
Discharge date	DISDATE	Date of discharge	Discharge date
Discharge method	DISMETH	Discharge method	Discharge method
Discharge destination	DISDEST	Discharge destination	Discharge destination
Elective wait	ELECDUR	Duration of elective wait	Duration of elective wait
Management intention	INTMANIG	Intended management	Intended management
Patient classification	CLASSPAT	Patient classification	Patient classification
Episode number	EPIORDER	Episode number	Episode number
Episode start	EPISTART	Episode start date	Episode start date
Episode end	EPIEND	Episode end date	Episode end date
Diagnosis 1-7	DIAGNSIS	Principal/subs/secondary diagnosis	ICD10 diagnosis Princ./subs./sec.
Operation 1-4	OPERATN	Code of 1-4 operation	OPCS procedure (prim. & 2-12)
Operation date 1-4	OPERDATE	Date of 1-4 operation	Procedure date
Consultant specialty code	MAINSPEF	Consultant's main specialty	Spec function code
Treatment specialty code	TRETSPEF	Not applicable	Conspec function code
Episode LOS	EPIDUR	Duration of episode	Duration of episode
Spell LOS	SPELDUR	Duration of provider spell	Duration of provider spell
Date of Birth	DOB	Date of Birth	Birth date
Spell Number	PROVSPNO	Provider spell number	Provider spell number
Date on Waiting list	ELECDATE	Date decided to admit	Decided to admit date
Episode status (finished/unfinished)	EPISTAT	Finished episodes only collected	Finished episodes only collected
Neonatal level of care	NEOCARE	U code in diagnosis	Neonatal level of care
Site of Treatment	SITETRET	Provider site code (of treatment)	Site code (of treatment)
External cause of injury or poisoning	CAUSE	Y code in diagnosis	Y code in diagnosis
Carer Support	CARERSI	Self support or living alone	Not applicable
Marital status	MARSTAT	Marital status	Marital status