

# Commissioning Data Sets (CDS)

## Consultation Exercise - CDS 6.2 Proposed Changes

### Purpose of this document

This document contains the feedback submitted by key stakeholders as part of the consultation exercise in relation to the proposed changes to the Commissioning Data Sets (CDS) v6.2. It also includes the Health and Social Care Information Centre's (HSCIC) response to these.

As part of our quality assurance, to ensure we identify and address any issues prior to seeking formal approval from the NHS Information Standards Board (ISB) - Stakeholders were asked whether the proposed changes were clearly defined, unambiguous, sensible and also whether they were any potential issues or barriers to implementing the changes.

Approximately 350 individual comments were received from 23 different organisations including the Department of Health, Care Quality Commission (CQC), NHS Data Dictionary and various Trusts. These comments have been addressed and wherever possible, suggested changes have been incorporated within the proposed changes to MHMDS v4.0.

The overall feedback has been positive, although some concerns have been raised in relation to timescales and burden.

### Document Version History

Version	Date Issued	Brief Summary of Change	Owner's Name
0.1	03/04/2012	Initial draft for review	Nitesh Patel
0.2	29/08/2012	Draft including updated HSCIC responses	Paul Croft
1.0	03/09/2012	Final version for publication	Paul Croft

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### Additional Notes

Please note the consultation feedback relates to the draft CDS 6.2 Specification issued for consultation purposes and not the final specification.



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## Commissioning Data Sets (CDS)

Consultation Exercise - CDS 6.2 Proposed Changes



The Information Centre

for health and social care

### Responses from email

Organisation	Requirement Domain	Data Element e.g. WARD CODE	Type of Comment	Comment	Response from IC
Berkshire Healthcare Foundation Trust	PbR	LENGTH OF STAY ADJUSTMENT	Specific Comment	Would this not be best calculated in SUS	<p>It will not be possible to calculate this within SUS as the required information is not available within submissions. In many providers equivalent fields are used in the local grouper for Length of Stay Adjustment purposes.</p> <p>This data element has been amended, the values have been split out into their own fields for SPC (02) and Rehabilitation (01) in draft Data Set Specification v0.6.0.</p>
Berkshire Healthcare Foundation Trust	PbR	LENGTH OF STAY ADJUSTMENT REASON	Specific Comment	Would this be defined by the speciality code?	<p>This can not necessarily be defined by either the Main Speciality or Treatment Function Code as the discrete period of rehabilitation or Specialist Palliative Care could occur as part of an episode for a different speciality.</p> <p>This data element has been amended, the values have been split out into their own fields for SPC (02) and Rehabilitation (01) in draft Data Set Specification v0.6.0.</p>
Berkshire Healthcare Foundation Trust	PbR	DIRECT ACCESS REFERRAL INDICATOR	Potential Barrier	I do not feel the description makes the need or purpose very clear, for community and mental health services we will not have any patients come for a diagnostic test, if you are not capturing the contact of someone have a scan, x-ray, blood test etc. then there is very little point in capturing this item	<p>Further guidance and definitions is available in the Human Behavioural, Organisational and Technical Guidance.</p> <p>Direct Access Referral Indicator indicates that the patient was referred into a Direct Access Service directly e.g. from primary care.</p> <p>A Direct Access Service is a service where patients are directly referred from primary and community care to the Direct Access Service for both diagnostic assessment and treatment.</p> <p>This change is required for non Mental Health CDS types to adhere to the PbR policy. This is an optional field therefore there is no mandate to flow it.</p>
Berkshire Healthcare Foundation Trust	SUG	WARD CODE	Specific Comment	Why and what benefit is ward code needed for?	<p>Ward Code information was previously collected using VGP fields. If as proposed VGP fields are removed in CDS 6.2, the remaining requirement for the collection of ward activity will be fulfilled by this new field.</p> <p>This is optional to support existing flows of information between providers and their commissioners.</p>

Berkshire Healthcare Foundation Trust	SUG	CLINIC CODE	Specific Comment	Why and what benefit is ward code needed for?	<p>Clinic information was previously collected using VGP fields. If as proposed VGP fields are removed in CDS 6.2, the remaining requirement for the collection of clinic activity will be fulfilled by this new field.</p> <p>This is optional to support existing flows of information between providers and their commissioners.</p>
Northamptonshire Healthcare NHS Foundation Trust	General	n/a	General Comment	Mental Health trusts submitted relevant data (for Inpatients and Outpatients) via the MHMDS. To 'reduce the burden' submission of SUS should not be required for MH Trusts.	We are committed to working to reduce the burden wherever possible and will raise this with the relevant parties for consideration in future strategy.
CareUK	XML Schema/NHS DD	SEX OF PATIENTS SEX OF PATIENTS CODE	Specific Comment	Just a copy paste error in the values ( 'Home Leave' listed as a gender)	<p>The value for Home Leave is an existing NHS Data Dictionary value and is not changed as part of CDS 6.2.</p> <p>The value of 'home leave' is used for mental health patients who are on home leave but remain under the care of the hospital.</p>
CareUK	XML Schema/NHS DD	WARD NIGHT PERIOD AVAILABILITY WARD NIGHT PERIOD AVAILABILITY CODE	Specific Comment	Copy paste error in values ( Home Leave again)	<p>The value for Home Leave is an existing NHS Data Dictionary value and is not changed as part of CDS 6.2.</p> <p>The value of 'home leave' is used for mental health patients who are on home leave but remain under the care of the hospital.</p>
CareUK	XML Schema/NHS DD	WARD DAY PERIOD AVAILABILITY WARD DAY PERIOD AVAILABILITY CODE	Specific Comment	Copy paste error in values ( Home Leave again)	<p>The value for Home Leave is an existing NHS Data Dictionary value and is not changed as part of CDS 6.2.</p> <p>The value of 'home leave' is used for mental health patients who are on home leave but remain under the care of the hospital.</p>
Frimley Park Hospital NHS Foundation Trust (RDU)	AHP RTT	WAITING TIME MEASUREMENT TYPE	General Comment	Should there not be a specific value for Direct Access Audiology RTT, given that this type exists already, rather than including under 'Other'	<p>Audiology is not mandated for the collection of Referral to Treatment information therefore at a National level should be mapped to national code [09] 'Other', - <a href="http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/a/allied_health_professional_referral_to_treatment_measurement_de.asp">http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/a/allied_health_professional_referral_to_treatment_measurement_de.asp</a> -</p> <p>A specific value may be assigned for local collection where required to support local uses which can then be mapped to the appropriate national code within CDS.</p>
Standards and Classifications, HSCIC	PbR	MULTI-PROFESSIONAL OR MULTIDISCIPLINARY ATTENDANCE INDICATION CODE		There will be an impact on Casemix grouping and on SUS PbR processing.	This requirement and transition from existing OPCS codes to the new data element will be agreed with Department of Health PbR team, Casemix and Standards & Classifications prior to progression.
Standards and Classifications, HSCIC	PbR	LENGTH OF STAY ADJUSTMENT		Already covered for Rehab and SPC in grouping. There will be an impact on SUS PbR processing.	This data element has been amended, the values have been split out into their own fields for SPC (02) and Rehabilitation (01) in draft Data Set Specification v0.6.0 to align with the local grouper.
Standards and Classifications, HSCIC	PbR	LENGTH OF STAY ADJUSTMENT REASON		<p>Already covered for Rehab and SPC in grouping. There will be an impact on SUS PbR processing.</p> <p>There will be an impact on grouping if more reasons are created. SUS PbR could cater for more reasons in the initial build.</p>	This data element has been amended, the values have been split out into their own fields for SPC (02) and Rehabilitation (01) in draft Data Set Specification v0.6.0.

Standards and Classifications, HSCIC	PbR	CONSULTATION MEDIUM USED		Possible impact on grouping and SUS PbR	This will potentially be a future requirement for the grouper, to allow it to align with PbR policy development.
Standards and Classifications, HSCIC	PbR	DIRECT ACCESS REFERRAL INDICATOR		Latent SUS PbR requirement awaiting this as a triggering indicator.	This is acknowledged and the developer will work with key stakeholders to ensure these are understood.
Standards and Classifications, HSCIC	PbR	ADMINISTRATIVE CATEGORY (AT START OF EPISODE)		Will require minor change to SUS PbR	ADMINISTRATIVE CATEGORY (AT START OF EPISODE) is being removed as there is no longer a PbR based need for this data to flow.
Standards and Classifications, HSCIC	PbR	ADMISSION METHOD (HOSPITAL PROVIDER SPELL)		Some values were added to SUS PbR reference data for R11 in anticipation of this change - but the values to be used have changed!! Will need to be dealt with in the grouper and in SUS PbR.	This is noted.  CDS 6.1 can still be used until changes made to the system to support the new values are in place. Guidance has been updated to ensure that new codes that may result in u-grouping of activity are not used prior to April 2013.
Standards and Classifications, HSCIC	Accident and Emergency (A&E)	SITE CODE (OF TREATMENT)		Query: Why can't the site be derived from characters 4/5 of the provider code?	Current guidance states that providers should only submit their provider code within the relevant field. As a result it will not be possible to derive the site code in most instances. Where the submitted code exceeds the permitted provider code format, this will be truncated within SUS.
Standards and Classifications, HSCIC	Clinical Practice	PRESENT ON ADMISSION INDICATOR		Is this really a local requirement? Does the data really need to flow? Unless data is sent immediately after admission then amended later could easily be "manipulated".	Full details relating to this requirement are outlined in the Human Behavioural Guidance. This includes the national requirement.  It also states that further work needs to be undertaken prior to collection of this information locally and submission within SUS. This states that Providers MUST NOT capture and submit the Present On Admission Indicator until the subset of conditions, coding mappings and detailed guidance have been clinically validated and published.  Initially this item will be captured on an optional basis however the intention is that this will be mandated for a small subset of conditions by the sponsor in the future.
Standards and Classifications, HSCIC	Clinical Practice	MAIN OPERATING HEALTHCARE PROFESSIONAL REGISTRATION CODE		Is this really a local requirement? Does the data really need to flow?	Full details relating to this requirement are outlined in the Human Behavioural Guidance. This includes the national requirement.  Initially this item will be captured on an optional basis however the intention is that this will be mandated for a small subset of conditions by the sponsor in the future.
Standards and Classifications, HSCIC	Clinical Practice	MAIN OPERATING HEALTHCARE PROFESSIONAL REGISTRATION BODY		Is this really a local requirement? Does the data really need to flow?	Full details relating to this requirement are outlined in the Human Behavioural Guidance. This includes the national requirement.  Initially this item will be captured on an optional basis however the intention is that this will be mandated for a small subset of conditions by the sponsor in the future.

Standards and Classifications, HSCIC	Clinical Practice	RESPONSIBLE ANAESTHETIST PROFESSIONAL REGISTRATION CODE		Is this really a local requirement? Does the data really need to flow?	Full details relating to this requirement are outlined in the Human Behavioural Guidance. This includes the national requirement.  Initially this item will be captured on an optional basis however the intention is that this will be mandated for a small subset of conditions by the sponsor in the future.
Standards and Classifications, HSCIC	Clinical Practice	RESPONSIBLE ANAESTHETIST PROFESSIONAL REGISTRATION BODY		Is this really a local requirement? Does the data really need to flow?	Full details relating to this requirement are outlined in the Human Behavioural Guidance. This includes the national requirement.  Initially this item will be captured on an optional basis however the intention is that this will be mandated for a small subset of conditions by the sponsor in the future.
Standards and Classifications, HSCIC	Mental Health	ADMISSION METHOD (HOSPITAL PROVIDER SPELL)		Some values were added to SUS PbR reference data for R11 in anticipation of this change. Will need to be dealt with in the grouper and in SUS PbR. (see earlier comment)	This is noted.  CDS 6.1 can still be used until changes made to the system to support the new values are in place. Guidance has been updated to ensure that new codes that may result in u-grouping of activity are not used prior to April 2013.
Standards and Classifications, HSCIC	TFC/MSC	TREATMENT FUNCTION CODE		Impact on grouping and SUS PbR	This is noted.  CDS 6.1 can still be used until changes made to the system to support the new values are in place. Guidance has been updated to ensure that new codes that may result in u-grouping of activity are not used prior to April 2013.
Standards and Classifications, HSCIC	TFC/MSC	MAIN SPECIALTY CODE		Impact on grouping and SUS PbR	This requirement has been withdrawn due to the potential impact upon national statistics in relation to Department of Health Central Returns.

Standards and Classifications, HSCIC	R/D/L/K	DISCHARGE TO HOSPITAL AT HOME SERVICE INDICATOR		Not enough information/knowledge to judge	<p>Further guidance and definitions is available in the Human Behavioural, Organisational and Technical Guidance.</p> <p>Discharged To Hospital At Home Service Indicator indicates whether a patient was discharged from a Hospital Provider Spell to a Hospital At Home Service.</p> <p>A Hospital At Home Service is a subtype of Intermediate Care, encompassing both the active treatment at home by health care professionals of patients (always for a limited period) who may otherwise be admitted to Hospital, and early supported discharge schemes following a Hospital Provider Spell.</p> <p>Further information on Hospital At Home Services can be found at the British Thoracic Society website.</p> <p><a href="http://www.brit-thoracic.org.uk/Portals/0/Guidelines/Intermediate%20Care%20-%20Hospital%20at%20Home/intermediatecarehospitalathomecopd%20feb07.pdf">http://www.brit-thoracic.org.uk/Portals/0/Guidelines/Intermediate%20Care%20-%20Hospital%20at%20Home/intermediatecarehospitalathomecopd%20feb07.pdf</a></p> <p>This change is required for non Mental Health CDS types to adhere to the PbR policy. This is an optional field therefore there is no mandate to flow it.</p>
Standards and Classifications, HSCIC	SUG	START TIME (HOSPITAL PROVIDER SPELL)		Support - but could affect spell construction in SUS. Should allows Day cases to go over midnight (and still be single day i.e. < 24 hours)	<p>This is for a completely new element and will not change existing construction of spells within SUS. The definition of a day case states - 'A patient admitted electively during the course of a day with the intention of receiving care who does not require the use of a hospital bed overnight and who returns home as scheduled. If this original intention is not fulfilled and the patient stays overnight, such a patient should be counted as an ordinary admission.'</p>
Standards and Classifications, HSCIC	SUG	DISCHARGE TIME (HOSPITAL PROVIDER SPELL)		Support - but could affect spell construction in SUS. Should allows Day cases to go over midnight (and still be single day i.e. < 24 hours)	<p>This has been included as a separate item to existing date to minimise impact upon existing systems and processes including existing construction of spells within SUS.</p> <p>The definition of a day case states - 'A patient admitted electively during the course of a day with the intention of receiving care who does not require the use of a hospital bed overnight and who returns home as scheduled. If this original intention is not fulfilled and the patient stays overnight, such a patient should be counted as an ordinary admission.'</p>

Standards and Classifications, HSCIC	SUG	START TIME (EPISODE)		May entail some changes in SUS PbR - Episode coverage validation, Critical care days calculations.	<p>This is acknowledged and the developer will work with key stakeholders to ensure these are understood.</p> <p>This has been included as a separate item to existing date to minimise impact upon existing systems and processes including existing construction of spells within SUS.</p> <p>This is an optional field therefore there is no mandate to flow it.</p>
Standards and Classifications, HSCIC	SUG	END TIME (EPISODE)		May entail some changes in SUS PbR - Episode coverage validation, Critical care days calculations.	<p>This is acknowledged and the developer will work with key stakeholders to ensure these are understood.</p> <p>This has been included as a separate item to existing date to minimise impact upon existing systems and processes including existing construction of spells within SUS.</p> <p>This is an optional field therefore there is no mandate to flow it.</p>
Standards and Classifications, HSCIC	SUG	APPOINTMENT TIME		Query - why no corresponding time that the patient is actually seen? But why should either of these values flow?	There is no national requirement identified to record the time the patient was actually seen. We understand that this is not routinely captured so would potentially have a significant burden on the NHS. This may be considered for inclusion in the future.
Standards and Classifications, HSCIC	SUG	OVERSEAS VISITORS STATUS CLASSIFICATION		May need to be considered in relation to SUS PbR exclusions	<p>This is acknowledged and the developer will work with key stakeholders to ensure these are understood.</p> <p>This is an optional field to support existing flows of information between providers and their commissioners following the removal of Very General Purpose (VGP) fields. There is no mandate to flow it.</p>
Standards and Classifications, HSCIC	Violent Incident Prevention	All fields		Why do these fields need to flow? Violence can already be picked up in APC.	<p>Violent Incident Reporting requirements have now been withdrawn by the Sponsor.</p> <p>These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.</p>
Standards and Classifications, HSCIC	XML Schema/NHS DD	Assorted fields - format change e.g. n2 to an2.		Supported - but would rather not have an associated field name change. There is likely to be some effect on SUS PbR because at least one field is defined as "NUMBER" even though there are leading zeros.	Acknowledged. The associated field name changes are required for CDS 6.2 as the original field names and formats will continue to be supported in CDS 6.1.1.
Standards and Classifications, HSCIC	Clinical Practice	Fields about staff		Probably useful information locally, but why do these fields need to flow? Further bloats the records.	<p>Full details relating to this requirement are outlined in the Human Behavioural Guidance. This includes the national requirement to support clinical safety monitoring and revalidation of clinicians and is supported by the Association of Royal Colleges.</p> <p>Initially this item will be captured on an optional basis however the intention is that this will be mandated for a small subset of conditions by the sponsor in the future.</p>

Sheffield Teaching Hospitals NHS Trust	PbR	Length of stay adjustment	General Comment	This is currently derived by SUS so I see no reason to have to send the value. PRB rules are constantly changing so potentially this data item may be irrelevant next year.	It will not be possible to calculate this within SUS as the required information is not available within submissions. In many providers equivalent fields are used in the local grouper for Length of Stay Adjustment purposes.  This data element has been amended, the values have been split out into their own fields for SPC (02) and Rehabilitation (01) in draft Data Set Specification v0.6.0.
Sheffield Teaching Hospitals NHS Trust	PbR	Length of stay adjustment reason	General Comment	See above, but if we are require to send then shouldn't the list of reasons be extended to included 'critical care' and possibly 'Other adjustment reason'.	It will not be possible to calculate this within SUS as the required information is not available within submissions. In many providers equivalent fields are used in the local grouper for Length of Stay Adjustment purposes.  This data element has been amended, the values have been split out into their own fields for SPC (02) and Rehabilitation (01) in draft Data Set Specification v0.6.0.  Critical Care has been excluded as this is currently calculated by SUS using information submitted within the Critical Care Data Set. Department of Health have confirmed that there are no immediate plans to expand the areas for which Length of Stay Adjustment is required.
NHS Gloucestershire	Health & Social Care Bill	Organisation code (Residence Responsibility) and PCT of Residence	General Comment	Removing the previous PCT of Residence field and replacing with a new CCG of residence will make it hard for comparative data. It will not always be possible to map from a PCT to a CCG when a PCT is split. Could the CCG be an additional field, and the Resident PCT populated with the old PCT equivalent?	Following detailed discussions with key stakeholders it was agreed that the requirement for a separate CCG field be withdrawn as no firm national requirement or sponsor identified to support changes. Also potentially significant impact upon systems and risk to SUS as a result of using two fields rather than a single field.  Locally providers and commissioners can derive the future CCG or historic PCT using GP Practice Code or Postcode of Usual Address as appropriate combined with Organisation Data Services (ODS) reference data.  Instead the existing Organisation Code (PCT of Residence) is being replaced by the new Organisation Code (Residence Responsibility) which will support the flow of PCT codes until April 2013 and then CCG code from 1st April 2013.
NHS Gloucestershire	PbR	Consultation Medium Used	General Comment	Will this be cross matched and DQ'd against the 'first attendance code'? E.g. not allowing a telephone consultation medium and a face to face appointment?	There is no intention to validate codes to ensure that they align with First Attendance however locally this item could be used in conjunction with other fields to derive First Attendance. This is required to support future PbR development to reflect different methods of non-face to face contacts within tariff. It is intended that First Attendance be amended in the future to remove reference to the type of attendance.
NHS Gloucestershire	PbR	Direct Access Referral Flag	General Comment	please make mandatory	This will start as an optional field however the sponsor will seek to mandate this in the future.  Due to the increased burden of collection, mandation is not an option from initial implementation of CDS
NHS Gloucestershire	PbR	Admission Method code split	General Comment	Could 2B be clarified to add a phrase that makes it clear that it is not for admission method 81 transfer?	Code 2B is for admissions 'in an emergency'. Code 81 is for admissions 'other than an emergency'.

NHS Gloucestershire	Accident and Emergency (A&E)	AE Site Code	General Comment	please make mandatory	This will start as an optional field however the sponsor will seek to mandate this in the future.  Due to the increased burden of collection, mandation is not an option from initial implementation of CDS
NHS Gloucestershire	TFC/MSC	New Treatment Function Codes	General Comment	If we are being as specific as 'Spinal Surgery' could we also not split T&O into Trauma and Orthopaedics. Orthopaedics is an area of great interest and it would be good to be able to analyse it without the trauma element. Also, why just spinal, why not other areas such and Hip or Knee?	Requests for new Treatment Function Codes should be submitted to the HSCIC via enquiries@ic.nhs.uk. All requests will be considered by the Treatment Function Maintenance Group. Splitting of Trauma and Orthopaedics into separate TFCs has been considered but deferred until Department of Health and National Commissioning Board policy are aligned.
NHS Gloucestershire	AHP RTT	Activity Location	General Comment	please make mandatory	This will start as an optional field however the sponsor will seek to mandate this in the future.  Due to the increased burden of collection, mandation is not an option from initial implementation of CDS 6.2.
NHS Gloucestershire	SUG	Start Time and Discharge Time Provider Spell	General Comment	please make mandatory	This will start as an optional field however the sponsor will seek to mandate this in the future.  Due to the increased burden of collection, mandation is not an option from initial implementation of CDS 6.2.
NHS Gloucestershire	SUG	AE attendance conclusion date	General Comment	The details in both of these lines is the same - should one be date and one be time?	Noted. This was a data entry error which has been fixed in version 0.6.0 of the CDS 6.2 Dataset Specification.  Change_ID CDS6.2_042 ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE should have been ACCIDENT AND EMERGENCY DATE SEEN FOR TREATMENT.
NHS Gloucestershire	SUG	Ward code	General Comment	Ward on admission/discharge/episode start / episode end? What happens with ward movements within a single episode?	Details of every Ward Stay within an Episode can currently be recorded in the Activity Location Group - Ward Stays data group. This allows details of up to 97 ward stays to be recorded for an episode.
NHS Gloucestershire	SUG	Clinic Code	General Comment	Excellent - but will there also be an additional field for the clinic/name or purpose. Would be useful to try to analyse OP data. Please make it mandatory.	Clinic information was previously collected using VGP fields. If as proposed VGP fields are removed in CDS 6.2, the remaining requirement for the collection of clinic activity will be fulfilled by this new field.  This is optional to support existing flows of information between providers and their commissioners. This field cannot be made mandatory as not all organisations supply the fields. This item is to support local uses and as such it is the responsibility of the provider to provide the descriptions relating to the clinic codes to the commissioner.
NHS Gloucestershire	Violent Incident Prevention	Assault method	General Comment	01 and 02 overlap, and aren't complete eg. elbow or hand (n.b. a hand is different to a fist). Why is knife not included in sharp bladed object? Hiding it in 05 won't help statistics on knife crime. What about tripping? Why no mention of acid/chemical? Are there not police or legal categories that could be reflected here? Seems a shame to only group broadly.	Violent Incident Reporting requirements have now been withdrawn by the Sponsor.  These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.

NHS Gloucestershire	Violent Incident Prevention	Assault Location	General Comment	Not free text please! Can we not have specified locations - e.g. bedroom, kitchen, street, pub, sports area etc.?	Violent Incident Reporting requirements have now been withdrawn by the Sponsor.  These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.
NHS Gloucestershire	XML Schema/NHS DD	Mandatory provider and commissioner code	General Comment	About time!	n/a
NHS Gloucestershire	XML Schema/NHS DD	Ref source 08	General Comment	Will records be accepted if populated with 08? Hope not.	No they will not, as code 08 is being highlighted for removal as part of the CDS 6.2 Dataset Specification. If the change is implemented as proposed code 08 would cause validation failure.
NHS Gloucestershire	XML Schema/NHS DD	AE rename to Accident and Emergency	General Comment	Why make field names so long and unwieldy? Surely AE or A and E is universally understood (I appreciate the need to remove the &). Fields need short, concise names.	Data Dictionary aim to make field names as unambiguous as possible, therefore general practice is against using acronyms and abbreviations where possible.
NHS Wiltshire and NHS BANES	SUG	ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE	Specific Comment	CDS6.2_042 and CDS6.2_043 currently have the same data element name. CDS6.2_042 could be 'ACCIDENT AND EMERGENCY ATTENDANCE SEEN DATE'?	Noted. This was a data entry error which has been fixed in version 0.6.0 of the CDS 6.2 Dataset Specification.  Change_ID CDS6.2_042 ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE should have been ACCIDENT AND EMERGENCY DATE SEEN FOR TREATMENT.
Indigo 4 Systems Ltd	PbR	CONSULTATION MEDIUM USED		There appears to be potential to overlap with the first attendance data item. Are we not creating an addition data item which is already in existence? Should we not just expand the possible values communicated through the First attendance data item?	There is no intention to validate codes to ensure that they align with First Attendance however locally this item could be used in conjunction with other fields to derive First Attendance. This is required to support future PbR development to reflect different methods of non-face to face contacts within tariff. It is intended that First Attendance be amended in the future to remove reference to the type of attendance. Because First Attendance combines multiple concepts it would be very difficult to change this to include different combinations of consultation mediums. This will also help align CDS to other data sets.
Indigo 4 Systems Ltd	PbR	DIRECT ACCESS REFERRAL INDICATOR		Why are Y and N being used in conjunction with 9, would it not be better to have 1 and 0 and 9?	Within the NHS Data Dictionary Y and N are used for Yes and No, rather than 1 or 0. 8 and 9 are standard within the Data Dictionary for meaning Not Applicable and Not Known. The CDS specification is following NHS Data Dictionary naming convention.
Indigo 4 Systems Ltd	PbR	ADMISSION METHOD (HOSPITAL PROVIDER SPELL)		If '28' is continued to be supported it will continue to be sent! In order to enforce the new values and be sure that they are sent, '28' needs to be removed as an option.	This is acknowledged and Code 28 will be removed from future versions of CDS however it has been retained to support the transition from the existing code to the new codes. The Human Behavioural Guidance states that the lower level values 2A, 2B, 2C and 2D are recommended for submission and providers should not use a mixed economy e.g. use of code 28 and new codes.
Indigo 4 Systems Ltd	Accident and Emergency (A&E)	SITE CODE (OF TREATMENT)		Why is this data item an an9?	This is mapped to NHS Data Dictionary ORGANISATION SITE CODE which has a format/length of an9.

Indigo 4 Systems Ltd	Clinical Practice	PRESENT ON ADMISSION INDICATOR		Why use Y and N with 8 and 9? Why not 1 and 0 with 8 and 9?	Within the NHS Data Dictionary Y and N are used for Yes and No, rather than 1 or 0. 8 and 9 are standard within the Data Dictionary for meaning Not Applicable and Not Known. The CDS specification is following NHS Data Dictionary naming convention.
Indigo 4 Systems Ltd	Clinical Practice	MAIN OPERATING HEALTHCARE PROFESSIONAL REGISTRATION CODE		This raises concerns over the interchange size, as there is the potential to send limitless procedural information, now coupled with the main operating professional and their professional body in addition to the Anaesthetist and their professional body!!!! This is going to cause issue with the size of the interchange - particularly if the data is continued to be sent in XML? A better approach might be to bundle the procedures performed by a professional, then you would send the professional and they body of registration once and the procedures they performed. Sending it on each procedure would be redundant.	We acknowledge that these changes may impact submission size, however various options were considered and these proposals have the lowest impact upon existing diagnosis and procedure reporting. It should be noted that these are optional so xml tags need not be flowed for null records.
Indigo 4 Systems Ltd	Clinical Practice	MAIN OPERATING HEALTHCARE PROFESSIONAL REGISTRATION BODY		This raises concerns over the interchange size, as there is the potential to send limitless procedural information, now coupled with the main operating professional and their professional body in addition to the Anaesthetist and their professional body!!!! This is going to cause issue with the size of the interchange - particularly if the data is continued to be sent in XML? A better approach might be to bundle the procedures performed by a professional, then you would send the professional and they body of registration once and the procedures they performed. Sending it on each procedure would be redundant.	We acknowledge that these changes may impact submission size, however various options were considered and these proposals have the lowest impact upon existing diagnosis and procedure reporting. It should be noted that these are optional so xml tags need not be flowed for null records.
Indigo 4 Systems Ltd	Clinical Practice	RESPONSIBLE ANAESTHETIST PROFESSIONAL REGISTRATION CODE		This raises concerns over the interchange size, as there is the potential to send limitless procedural information, now coupled with the main operating professional and their professional body in addition to the Anaesthetist and their professional body!!!! This is going to cause issue with the size of the interchange - particularly if the data is continued to be sent in XML? A better approach might be to bundle the procedures performed by a professional, then you would send the professional and they body of registration once and the procedures they performed. Sending it on each procedure would be redundant.	We acknowledge that these changes may impact submission size, however various options were considered and these proposals have the lowest impact upon existing diagnosis and procedure reporting. It should be noted that these are optional so xml tags need not be flowed for null records.
Indigo 4 Systems Ltd	Clinical Practice	RESPONSIBLE ANAESTHETIST PROFESSIONAL REGISTRATION BODY		This raises concerns over the interchange size, as there is the potential to send limitless procedural information, now coupled with the main operating professional and their professional body in addition to the Anaesthetist and their professional body!!!! This is going to cause issue with the size of the interchange - particularly if the data is continued to be sent in XML? A better approach might be to bundle the procedures performed by a professional, then you would send the professional and they body of registration once and the procedures they performed. Sending it on each procedure would be redundant.	We acknowledge that these changes may impact submission size, however various options were considered and these proposals have the lowest impact upon existing diagnosis and procedure reporting. It should be noted that these are optional so xml tags need not be flowed for null records.
Indigo 4 Systems Ltd	Mental Health	WARD SECURITY LEVEL		Is there a need to explicitly state that the patient is on a '0' ward could this not be assumed if the data item is not passed?	This is to align with the existing NHS Data Dictionary Standard as used within MHMDS. To ensure data quality we would require an explicit response to confirm that there is no security on the ward rather than data quality issues, i.e. the item not completed. This item should be captured within ward configuration on systems, rather than for each patient. Locally systems could use 0 non secure as a default.
Indigo 4 Systems Ltd	R/D/L/K	DISCHARGE TO HOSPITAL AT HOME SERVICE INDICATOR		Would this not be better placed being appended to the permissible values of the Discharge destination data item?	Inclusion of a new code in existing Discharge Method and Discharge Destination were considered, however it was felt that these changes would contradict NHS business definitions of discharge or result in non-mutually exclusive value lists. As a result a new optional indicator has been included
Indigo 4 Systems Ltd	Violent Incident Prevention	ASSAULT INDICATOR		Why are Y and N being used in conjunction with 9, would it not be better to have 1 and 0 and 9?	Violent Incident Reporting requirements have now been withdrawn by the Sponsor.  These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.

Indigo 4 Systems Ltd	Violent Incident Prevention	ASSAULT LOCATION		Working on the assumption that data will be sent using the EDT Client. In our experience a free text field increases the likelihood will lead to characters which crash the EDT software. Also for auditing it might be better to have a specified list, with the option of bespoke information.	Violent Incident Reporting requirements have now been withdrawn by the Sponsor.  These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.
South West Yorkshire Partnership FT - Barnsley IM team	Health and Social Care Bill	ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	Specific Comment	Issues in Barnsley - currently no agreement in place with GPs - SHA involvement will presumably sort eventually. Question - who will map post codes to CCG? IC or providers?	Reference data will be published by ODS. In addition we will derive Clinical Commissioning Group (CCG) of Residence within SUS based upon patients GP practice and postcode respectively.
South West Yorkshire Partnership FT - Barnsley IM team	PbR	MULTI-PROFESSIONAL OR MULTIDISCIPLINARY ATTENDANCE INDICATION CODE	General Comment	Could lead to data quality issues - staff understanding difference between multi-disciplinary/multi-professional	Further guidance will be available upon publication of the Information Standards Notice (ISN)
South West Yorkshire Partnership FT - Barnsley IM team	PbR	DIRECT ACCESS REFERRAL INDICATOR	General Comment	Could lead to data quality issues - more for practitioners to understand which is more about administration than clinical practice	Further guidance will be available upon publication of the Information Standards Notice (ISN)
South West Yorkshire Partnership FT - Barnsley IM team	Clinical practice	Addition of Present on Admission Indicator	General Comment	Question - is it expected that this will be collected by clinicians and coded on systems or that clinical coders will derive from medical notes? Either way there will be implications for training clinicians and resource implications for coding staff.	Full details relating to this requirement are outlined in the Human Behavioural Guidance. This includes the national requirement.  It also states that further work needs to be undertaken prior to collection of this information locally and submission within SUS. This states that Providers MUST NOT capture and submit the Present On Admission Indicator until the subset of conditions, coding mappings and detailed guidance have been clinically validated and published.  Initially this item will be captured on an optional basis however the intention is that this will be mandated for a small subset of conditions by the sponsor in the future.
South West Yorkshire Partnership FT - Barnsley IM team	Clinical practice	MAIN OPERATING HEALTHCARE PROFESSIONAL REGISTRATION BODY	Specific Comment	Question - why are 13-15 on the list - surely management accountants etc. would not be performing procedures?	Values have been updated to a subset of the original to reflect only relevant professional bodies.
South West Yorkshire Partnership FT - Barnsley IM team	Clinical practice	RESPONSIBLE ANAESTHETIST PROFESSIONAL REGISTRATION BODY	Specific Comment	Question - why are 13-15 on the list - surely management accountants etc. would not be performing procedures?	Values have been updated to a subset of the original to reflect only relevant professional bodies.
South West Yorkshire Partnership FT - Barnsley IM team	Mental Health	WARD SECURITY LEVEL	General Comment	More opportunity for data input error. Would expect that this should be derived from ward profiles - this is not reducing the burden but increasing it.	This is optional and it is intended that it would be captured against ward details and not patient. It will be aligned to the MHMDS standard. Please see the Human Behavioural Guidance for further information.
South West Yorkshire Partnership FT - Barnsley IM team	IG	WITHHELD IDENTITY REASON	General Comment	Assuming this is recorded it would increase the work outside of systems probably for IM teams - once again increasing the burden.	This is acknowledged. Full details relating to this item are included in the Human Behavioural Guidance. It is expected that this can be automatically generated as part of the process to anonymise certain CDS records prior to submission e.g. where the patient has dissented or where the record contains a sensitive diagnosis or procedure.

South West Yorkshire Partnership FT - Barnsley IM team	SUG	OVERSEAS VISITORS STATUS START DATE	Specific Comment	Don't believe current systems support start and end dates - why are the changes being made if currently flowing to commissioners.	Overseas Visit Status information was previously collected and reported using Very General Purpose (VGP) fields. VGP fields are being removed from CDS 6.2 so the inclusion of these items is to continue to support existing flows of information between providers and their commissioners. These items are optional and are for local use only. Dates are to allow multiple Overseas Visitor Status to be recorded for a patient e.g., where their status changes during an episode.
South West Yorkshire Partnership FT - Barnsley IM team	SUG	OVERSEAS VISITORS STATUS END DATE	Specific Comment	Don't believe current systems support start and end dates - why are the changes being made if currently flowing to commissioners.	Overseas Visit Status information was previously collected and reported using Very General Purpose (VGP) fields. VGP fields are being removed from CDS 6.2 so the inclusion of these items is to continue to support existing flows of information between providers and their commissioners. These items are optional and are for local use only. Dates are to allow multiple Overseas Visitor Status to be recorded for a patient e.g., where their status changes during an episode.
South West Yorkshire Partnership FT - Barnsley IM team	Ambulance care	AMBULANCE INCIDENT NUMBER	Specific Comment	Current systems do not support - more data for ward staff to collect unless this only applies to A&E. Would question why Ambulance services shouldn't be supplying this data.	This is acknowledged. This is an optional field. As there is no mandate, it only needs to be collected if there is a local requirement or if it can be readily accessed.
South West Yorkshire Partnership FT - Barnsley IM team	Ambulance care	ORGANISATION CODE (CODE OF AMBULANCE TRUST)	Specific Comment	This trust does not have A&E services but this is additional data for busy A&E departments to collect, don't believe current systems would support and staff would have to know organisation codes etc.	This is acknowledged. This is an optional field. As there is no mandate, it only needs to be collected if there is a local requirement or if it can be readily accessed.
South West Yorkshire Partnership FT - Barnsley IM team	XML Schema/NHS DD	ORGANISATION CODE (CODE OF COMMISSIONER)	Specific Comment	Our system only supports use of PCT of registration or PCT of residence - there is no facility to override with different commissioner codes, e.g. AQP.	This is an optional field. As there is no mandate, it only needs to be collected if there is a local requirement or if it can be readily accessed.
South West Yorkshire Partnership FT - Barnsley IM team	XML Schema/NHS DD	PSYCHIATRIC PATIENT STATUS PSYCHIATRIC PATIENT STATUS CODE	Specific Comment	Data quality could be an issue - this is not always known on admission and not sure staff ever go back and amend details once it is known	Noted. However the only changes to this existing CDS item are the name and format to align with NHS Data Dictionary editorial policy. The longer term aim of the IC is to retire the CDS type 170 Psychiatric Census.
South West Yorkshire Partnership FT - Barnsley IM team	XML Schema/NHS DD	REFERRAL TO TREATMENT STATUS REFERRAL TO TREATMENT PERIOD STATUS	Specific Comment	The codes listed do not appear to be the full set	Unfortunately this is a limitation of Microsoft Excel, which limits the amount of data visible. Please find a full list of Values on the Data Dictionary website - <a href="http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/r/ref/referral_to_treatment_period_status_de.asp">http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/r/ref/referral_to_treatment_period_status_de.asp</a>  Note: This change is only for the name of the data element and its format. The value list remains the same.
South West Yorkshire Partnership FT - Barnsley IM team	XML Schema/NHS DD	SEX OF PATIENTS SEX OF PATIENTS CODE	Specific Comment	We have gender specific wards with a swing bed area which can be converted to either - would this need to be classed as 8 Not specified in the ward profile?	This field has only been renamed in CDS 6.2.  This query has been passed on to <a href="mailto:datastandards@nhs.net">datastandards@nhs.net</a> who will publish a response on their FAQs in the near future.
South West Yorkshire Partnership FT - Barnsley IM team		GENERAL COMMENT		Some of these changes may involve system development and we may be reliant on supplier engagement/collaboration.	The Consultation Exercise includes a wide range of participants including various system suppliers, hopefully this offers a suitable platform for relevant engagement/collaboration.

Mckesson Ltd	SUG	ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE	Specific Comment	CDS6.2_042 and CDS6.2_043 currently have the same data element name.	Noted. This was a data entry error which has been fixed in version 0.6.0 of the CDS 6.2 Dataset Specification.  Change_ID CDS6.2_042 ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE should have been ACCIDENT AND EMERGENCY DATE SEEN FOR TREATMENT.
BT LSP	CDS6.2_008 and CDS6.2_009	Addition of Length of Stay Adjustment & Reason	Specific Comment	It might be better to have these codes held against wards or beds so this data can be derived rather than entered directly, it will also allow for more than 1 rehab/palliative care ward stay within an episode	This data element has been amended, the values have been split out into their own fields for SPC (02) and Rehabilitation (01) in draft Data Set Specification v0.6.0 to align with the local grouper. These may be implemented locally in the most appropriate way to support the ease of collection.
BT LSP	CDS6.2_010	<b>Addition of Consultation Medium Used</b>	Potential Barrier	The first attendance indicator currently allows for telephone consultation values 3 and 4 this would need to be altered too to avoid conflict. Secondly the list of proposed values is not mutually exclusive or exhaustive. E.g. a person who uses Skype for video but cannot talk and there is no thought to future technology. These need to be rethought.	This has been based upon a subset of the approved consultation medium used where these are eligible as a method for the purposes of CDS. Changes to the existing approved list to reflect new methods of consultation medium will be considered separately.
BT LSP	CDS6.2_011	<b>Addition of Direct Access Referral Indicator</b>	Specific Comment	Could this lead to gaming whereby direct day case referrals e.g. for scopes are not used when they could to avoid being penalised under PbR. Additionally if a direct access referral happens and during the test something major is found or there is a problem e.g. a perforation this could change. This means it might be better to be an intention but have a way to determine that it stayed direct access.	This comment has been passed on to the Department of Health PbR team for consideration in developing future PbR Guidance.
BT LSP	CDS6.2_014	<b>Admission Method Code Split</b>	Potential Barrier	It might be better not to introduce alpha characters into numeric fields as some databases might need a lot of reformatting so it could be costly. Perhaps use 26,27 and 29 instead and then keep the 28 to include those that would be in 2D or alternatively consider have the baby born at home as 84 to keep them with codes 82 and 83.	Various options were considered for these changes however this option was felt to be the best solution whilst ensuring that all emergency admissions are in the range of numbers starting 2x.
BT LSP	CDS6.2_018	<b>Details of Staff Involved in Care</b>	Potential Barrier	Surely Accountants will not be operating on patients this list needs a sensibility check, it should also be made so it is mutually exclusive and exhaustive e.g. some people might belong to more than one body and there is no "other " or "not applicable" category for those who are not operated on	Values have been updated to a subset of the original to reflect only relevant professional bodies.
BT LSP	CDS6.2_020	<b>Details of Staff Involved in Care</b>	Potential Barrier	See above comment cell h99.	Values have been updated to a subset of the original to reflect only relevant professional bodies.
BT LSP	CDS6.2_025	<b>Admission Method Code Additional Value</b>	Specific Comment	see above comment cell h98. If a code other than 25 were used e.g. 40 then the 4 code admission method split could be accommodated within the 20s	Various options were considered for these changes however this option was felt to be the best solution whilst ensuring that all emergency admissions are in the 2* range.  Unfortunately 25 has already been approved as part of Mental Health Minimum Data Set (MHMDS) v4.0. It should be noted that Admission through a Crisis Resolution Team is deemed an emergency admission.
BT LSP	CDS6.2_029	<b>AHP RTT Identifier</b>	Specific Comment	Perhaps it better to make this a derived item from the treatment speciality.	This is not possible as AHP activity under main speciality 960 and corresponding AHP Treatment Function Codes could be part of a consultant led pathway or an AHP RTT pathway.
BT LSP	CDS6.2_030	<b>AHP RTT Activity Location</b>	Potential Barrier	It might be better not to have this in the EAL CDS. As this is an intention not an actuality and contrary to the description you have in cell R42 of the proposed changes sheet	This item has been included in EAL CDS to ensure that these remain broadly aligned to the structure of existing activity CDS.

BT LSP	CDS6.2_031	<b>Addition of Hospital At Home Indicator</b>	Potential Barrier	What is the purpose, is it a discharge and new spell or continuous. How does hospital at home work, how will these be sent to SUS who is the provider. If there is no change of provider then it might be a new episode but it is not a new spell. This needs to be looked at in a wider context for example can you change consultants when under hospital at home. Could you be admitted elsewhere and still be at hospital at home or on home leave?	This is intended to identify patients that have been discharged from hospital but will receive ongoing intermediate care, usually in their own homes.  This only identifies that the patient has been discharged to a hospital at home service. It does not identify activity that has occurred within a hospital at home service. This activity is not currently within scope of CDS.
BT LSP	CDS6.2_032	<b>Reasons for Withheld Identity by Provider</b>	Potential Barrier	This looks like an opt in only. Should there be not applicable where patients are happy to have their identity shared, is that the default. Will all patients be asked? If so is not yet asked a valid category. What happens with patients admitted who are unconscious. Is this held at care activity level or patient level. There might be occasions when someone doesn't mind details being shared for say a hernia but not for maternity.	This is only recorded within the patient identity withheld group, as a result it is only required where patients identity has been withheld. This will be recorded at activity record level.
BT LSP	CDS6.2_050	<b>Violent Incident Prevention</b>	Specific Comment	This should be picked up as part of the diagnosis and derived.	Violent Incident Reporting requirements have now been withdrawn by the Sponsor.  These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.
BT LSP	CDS6.2_052	<b>Violent Incident Prevention</b>	Specific Comment	As above, this kind of granularity is where SNOMED might be used	Violent Incident Reporting requirements have now been withdrawn by the Sponsor.  These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.
BT LSP	All related fields	<b>Violent Incident Prevention</b>	General Comment	Could the elements connected with Violent Incident Reporting be part of a separate CDS or data flow rather than added to CDS	Violent Incident Reporting requirements have now been withdrawn by the Sponsor.  These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.
BT LSP	CDS6.2_054	<b>Ambulance Incident Number</b>	Specific Comment	The ambulance CDS is for local use at present, if the idea is to join the two then the CDS should become national first, all that is needed is an ambulance indicator. Is this excluding air ambulance and were a patient brought in via a police vehicle in an emergency would this be counted	This is to support ambulance care quality indicators in the future. This should include air ambulance but would exclude a patient being brought by anything other than an ambulance i.e. police vehicle.
BT LSP	CDS6.2_055	<b>Ambulance Trust</b>	Specific Comment	The ambulance CDS is for local use at present, if the idea is to join the two then the CDS should become national first, all that is needed is an ambulance indicator. Is this excluding air ambulance and were a patient brought in via a police vehicle in an emergency would this be counted. Is this item necessary unless data sets are being joined	This is to support ambulance care quality indicators in the future. This should include air ambulance but would exclude a patient being brought by anything other than an ambulance i.e. police vehicle.
BT LSP	CDS6.2_057	<b>Provider Code Made Mandatory</b>	Specific Comment	This might be problematic with sub commissioning see wording in cell I69	This is acknowledged however this is causing significant issues for providers and commissioners in terms of activity that cannot be attributed to the correct provider or commissioner.
BT LSP	CDS6.2_058	<b>Commissioner Code Made Mandatory</b>	Specific Comment	This might be problematic with sub commissioning see wording in cell I70	This is acknowledged however this is causing significant issues for providers and commissioners in terms of activity that cannot be attributed to the correct provider or commissioner.

UCLH	Overseas patients - PBR/ non-PBR	NCL		Need to provide reason why patient is charge exempt	Inclusion of Overseas Visitor Status within CDS 6.2 is only on an optional basis to replace existing flows between providers and commissioners previously achieved through use of Very General Purpose (VGP) fields. Items have been included based upon prioritisation of users.
NHS Barnsley	SEM/PbR	<b>LOCAL SPEC CODE</b>	A code to identify the local treatment (sub) specialty where the activity occurred for a patient. This MUST be extracted directly from system fields based upon a list of values. Fields captured as free text MUST not be used. This is for local use only. There is no national code for all wards within the NHS.  NB. Codes used must not identify a patient as having a sensitive condition e.g. HIV/Aids or procedure e.g. TERMINATION or similar.	an12 - Suggest inclusion of this as it is commonly required from VGP datasets to identify differently costed (PbR/locally costed) outpatients in the same national treatment spec code) and generally useful to look at sub-spec activity.	A number of Trusts have indicated that the best way to record local information "tagging" of specific patients is to utilise the CDS data items PROVIDER REFERENCE NUMBER or COMMISSIONER REFERENCE NUMBER. Either one of these data items will be able to and justified to carry local specialty codes in their an17 format, with an agreement with your commissioners to identify local specialty coding.
McKesson Ltd				I have reviewed these proposals from the perspective of McKesson's TotalCARE Patient Administration System (PAS) and the system would require enhancement to allow collection of new data items such as Length of Stay Adjustment and Reason; such changes could be undertaken in consultation with our customers BUT please note that under the terms of our current contracts with these customers, the product will cease being enhanced from 31 March 2013 and will cease being supported after 31 March 2014. This means that we need to understand the implementation date for CDS 6.2 (and/or the dates for the withdrawal of earlier CDS versions) before we can make a full commitment and unless full details of the CDS 6.2 data set has been formally published by 30 September 2012, we may not be able to incorporate it into TotalCARE PAS for use by our remaining customers.	Full details of these changes will be published following ISB in the form of an Information Standards Notice (ISN). We are currently working to publish this in August 2012.
SWBH NHS Trust	PbR	<b>LENGTH OF STAY ADJUSTMENT REASON</b>	Specific Comment	Why not have 2 fields, one for Rehab days and another for SPC days, or do you plan that both types will not be able to be present within a single episode? If this is going to be a repeating structure within XML of the two elements so that you could report several types of LOS Adjustment for an episode, this should have been made clearer, most of our staff still think in terms of flat-file data, and not Hierarchical XML Data structures. How are half days calculated? This could lead to having more days excluded than the total LOS. We don't have bed holding consultants for SPC, but provide service, but without discrete FCEs.	This data element has been amended, the values have been split out into their own fields for SPC (02) and Rehabilitation (01) in draft Data Set Specification v0.6.0.
SWBH NHS Trust	PbR	<b>DIRECT ACCESS REFERRAL INDICATOR</b>	Specific Comment	Concerns about the ability to link up the internal/external RTT identifiers.	This item is for Payment by Results purposes rather than RTT. This information should be captured as part of the referral process.

SWBH NHS Trust	Clinical Practice	<b>PRESENT ON ADMISSION INDICATOR</b>	Specific Comment	Cannot currently be captured. Would require process change at point of admission, which may confuse clinical coding as working diags suspected at admission may not be born out by investigations. If previous medical history is taken into account and recorded at admission as potential complications, PbR says this is upcoding/gaming the system, and is not allowable. If we document possible diags from previous medical history, this could be seen as a breach of the PbR rules.	This is acknowledged. Full details relating to this requirement are outlined in the Human Behavioural Guidance. This includes the national requirement.  It also states that further work needs to be undertaken prior to collection of this information locally and submission within SUS. This states that Providers MUST NOT capture and submit the Present On Admission Indicator until the subset of conditions, coding mappings and detailed guidance have been clinically validated and published.  Initially this item will be captured on an optional basis however the intention is that this will be mandated for a small subset of conditions by the sponsor in the future.
SWBH NHS Trust	Clinical Practice	<b>MAIN OPERATING HEALTHCARE PROFESSIONAL REGISTRATION CODE</b>	Potential Barrier	Cannot currently be captured. Major system change required to support this, plus a large amount of maintenance to update system for our 3 ontakes per year. Plus all of the technical staff who change. For FY1's GMC codes are not issued until the start date has been confirmed from the Deanery.	These fields are optional in CDS 6.2. If CDS 6.2 can not yet be implemented CDS v6.1.1 can be adhered to, where only the Responsible Consultant needs to be flowed.
SWBH NHS Trust	Clinical Practice	<b>MAIN OPERATING HEALTHCARE PROFESSIONAL REGISTRATION CODE; MAIN OPERATING HEALTHCARE PROFESSIONAL REGISTRATION BODY; RESPONSIBLE ANAESTHETIST PROFESSIONAL REGISTRATION CODE; RESPONSIBLE ANAESTHETIST PROFESSIONAL REGISTRATION BODY;</b>	Potential Barrier	"MAIN OPERATING HEALTHCARE PROFESSIONAL REGISTRATION CODE" "MAIN OPERATING HEALTHCARE PROFESSIONAL REGISTRATION BODY" "RESPONSIBLE ANAESTHETIST PROFESSIONAL REGISTRATION CODE" "RESPONSIBLE ANAESTHETIST PROFESSIONAL REGISTRATION BODY"  Cannot currently be captured. Would be better handled in a separate theatres submission, instead of making it part of the CDS. The size of the CDS file for conversion to XML would be prohibitive. The maintenance of the supporting systems to supply and collect the data would be huge.	These will initially be included as optional items with the view to mandating these in the future. Other options were considered but discounted as requiring significant duplication of data and burden on the NHS.
SWBH NHS Trust	TFC/MSC	<b>TREATMENT FUNCTION CODE</b>	General Comment	Would like code for Cardiac Heart Failure.	Requests for changes to included Treatment Function Codes require a DCSN form to be completed.
SWBH NHS Trust	AHP RTT	<b>WAITING TIME MEASUREMENT TYPE</b>	Specific Comment	Find this difficult to understand this item, it is ambiguous as to which other data items it works in relation to.	This relates to existing RTT items. Full details and improved guidance will be published along with the ISN.
SWBH NHS Trust	R/D/L/K	<b>DISCHARGE TO HOSPITAL AT HOME SERVICE INDICATOR</b>	Specific Comment	Change to DISCHARGE DESTINATION/METHOD Preferable.	Inclusion of a new code in existing Discharge Method and Discharge Destination were considered, however it was felt that these changes would contradict NHS business definitions of discharge or result in non-mutually exclusive value lists. As a result a new optional indicator has been included with plans to mandate this in the future.
SWBH NHS Trust	SUG	<b>START TIME (WARD STAY)</b>	Specific Comment	Meaningless unless you record all ward movements	This item is optional and has been included initially to support local analysis by providers and commissioners.
SWBH NHS Trust	SUG	<b>END TIME (WARD STAY)</b>	Specific Comment	Meaningless unless you record all ward movements	This item is optional and has been included initially to support local analysis by providers and commissioners.

SWBH NHS Trust	SUG	<b>WARD CODE</b>	General Comment	This is Meaningless unless you collect a ward based data set.	Ward Code information was previously collected using VGP fields. If as proposed VGP fields are removed in CDS 6.2, the remaining requirement for the collection of ward activity will be fulfilled by this new field.  This is optional to support existing flows of information between providers and their commissioners.
SWBH NHS Trust	SUG	<b>OVERSEAS VISITORS STATUS CLASSIFICATION</b>	Potential Barrier	No problem with optional field, as we would not populate this without full training for reception staff.	This is acknowledged.
SWBH NHS Trust	Violent Incident Prevention	<b>ASSAULT INDICATOR</b>	Specific Comment	Ambiguous, definition of Assault needed. Cannot currently be captured.	Violent Incident Reporting requirements have now been withdrawn by the Sponsor.  These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.
SWBH NHS Trust	Violent Incident Prevention	<b>ASSAULT TIME</b>	Specific Comment	Ambiguous, definition of Assault needed. Cannot currently be captured.	Violent Incident Reporting requirements have now been withdrawn by the Sponsor.  These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.
SWBH NHS Trust	Violent Incident Prevention	<b>ASSAULT METHOD</b>	Specific Comment	Categories not defined well enough. Cannot currently be captured.	Violent Incident Reporting requirements have now been withdrawn by the Sponsor.  These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.
SWBH NHS Trust	Violent Incident Prevention	<b>ASSAULT LOCATION</b>	Potential Barrier	We do not support free text fields, as they are ambiguous List of codes instead, such as A&E Incident location.	Violent Incident Reporting requirements have now been withdrawn by the Sponsor.  These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.
SWBH NHS Trust	Ambulance Care	<b>AMBULANCE INCIDENT NUMBER</b>	Potential Barrier	Can only be captured for RTAs at the moment.	Noted although feedback from other Organisations shows the incident number being used for all ambulance attendances. The field is optional therefore only requires populating where given however the intention is for this to be mandated in the future.
SWBH NHS Trust	Ambulance Care	<b>ORGANISATION CODE (CODE OF AMBULANCE TRUST)</b>	Potential Barrier	Cannot currently be captured.	This is acknowledged and it is noted that this will initially be optional.

The Phoenix Partnership	Health and Social Care Bill	Organisation Code (Residence Responsibility)	Potential Barrier	As we're sure you're aware, if this field replaces Organisation Code (PCT of Residence) no PCTs will be able to continue their flow of commissioning data, even if there are some PCTs that have a legitimate reason to do so for any period of time after this field is removed. It may be more prudent to go with the alternative suggestion and add Organisation Code (Residence Responsibility) without replacing Organisation Code (PCT of Residence) until such a time as it is certain that the latter field will not be required.	<p>Following detailed discussions with key stakeholders it was agreed that the requirement for a separate CCG field be withdrawn as no firm national requirement or sponsor identified to support changes. Also potentially significant impact upon systems and risk to SUS as a result of using two fields rather than a single field.</p> <p>Locally providers and commissioners can derive the future CCG or historic PCT using GP Practice Code or Postcode of Usual Address as appropriate combined with Organisation Data Services (ODS) reference data.</p> <p>Instead the existing Organisation Code (PCT of Residence) is being replaced by the new Organisation Code (Residence Responsibility) which will support the flow of PCT codes until April 2013 and then CCG code from 1st April 2013.</p>
The Phoenix Partnership	PbR	Multi-Professional/Multi-Disciplinary Attendance Indicator	Potential Barrier	SNOMED codes cannot be captured in SystmOne. From a development perspective we would prefer this to be a nationally defined value list as used for other fields, such as gender - this would allow us to populate the field without relying on the inclusion of SNOMED codes.	There are currently no proposals to use SNOMED within CDS 6.2.
The Phoenix Partnership	Clinical Practice	Present on Admission Indicator	Potential Barrier	This is not currently captured in SystmOne. If functionality did exist do allow this to be captured for every diagnosis code, it would mark an increase in work for users, and we're not sure where this would fit into existing NHS processes. If different organisations are also unclear and intend to implement business change to capture this in different ways this could become an issue.	<p>This is acknowledged. Full details relating to this requirement are outlined in the Human Behavioural Guidance. This includes the national requirement.</p> <p>It also states that further work needs to be undertaken prior to collection of this information locally and submission within SUS. This states that Providers MUST NOT capture and submit the Present On Admission Indicator until the subset of conditions, coding mappings and detailed guidance have been clinically validated and published.</p> <p>Initially this item will be captured on an optional basis however the intention is that this will be mandated for a small subset of conditions by the sponsor in the future.</p>
The Phoenix Partnership	R/D/L/K	Discharge to Hospital at Home Service Indicator	Potential Barrier	Not sure why you would ask users to record this in a separate field when it could be added to the value list for discharge method as suggested? Not a big issue, might just be that we don't understand the reasoning behind the decision.	Inclusion of a new code in existing Discharge Method and Discharge Destination were considered, however it was felt that these changes would contradict NHS business definitions of discharge or result in non-mutually exclusive value lists. As a result a new optional indicator has been included

The Phoenix Partnership	SUG	Addition of Time to Date based elements in APC/OP	Potential Barrier	Consider that recording the seconds for these times can result in problems when displaying results that show duration. The only way to prove that the derived duration is accurate is to show the seconds as well as the minutes, and seeing the number of seconds is of no practical use, other than to prove that the duration is correct, which is not a reason to include information on screens that should only display that which is operationally relevant. For example, the duration between 12:40:30 and 12:45:20 is 4:50. The seconds can't be truncated as this would display as 4m which would be confusing when the start and end time are displayed without seconds. You can't round up the seconds to 5m because of examples where the start time is 12:40:30 and the end time is 12:44:40. Because the visible duration (when seconds are not displayed) is 4m, whereas the actual duration when rounded up is 5m. So, because times, as conventionally displayed for these fields, do not and should not show seconds, requiring seconds to be used in calculations to derive duration will result in displays that look inaccurate. Because the number of seconds is not important when viewing or analysing the duration of e.g. hospital spells perhaps the formatting of the field could be HH:MM, or HH:MM:00. This prevents the discrepancies that arise between the displayed result and the mathematical result, due to the fact that the entirety of the latter is not displayed.	All time elements will need to be in e-GIF format e.g. HH:MM:SS however seconds can be defaulted to 00 as required.  Full guidance will be provided in the Human Behavioural, Organisational and Technical Guidance.
King's College Hospital FT	PbR	LENGTH OF STAY ADJUSTMENT REASON	Potential Barrier	Mandating this field without the option of local values is pointless. At King's we unbundle rehab, critical care, HASU and Medihome days for which we adjust net LOS for PbR Inpatient XSBD calculations. We also unbundle palliative care, but as a per-spell-charge, not on a bed day basis, hence do not adjust the net LOS for this. With the proposed option, populating this field is pointless for me as I can't effectively describe all unbundled bed days. Suggest at the very least you have an option for "Other Local Bed days"	At present there is no requirement to include other types of Length of Stay Adjustment to support PbR Policy. This will be passed to the Department of Health PbR team to consider as a future change to CDS.
King's College Hospital FT	PbR	PRESENT ON ADMISSION INDICATOR	Potential Barrier	This would be very difficult to capture on PAS	This is acknowledged. Full details relating to this requirement are outlined in the Human Behavioural Guidance. This includes the national requirement.  It also states that further work needs to be undertaken prior to collection of this information locally and submission within SUS. This states that Providers MUST NOT capture and submit the Present On Admission Indicator until the subset of conditions, coding mappings and detailed guidance have been clinically validated and published.  Initially this item will be captured on an optional basis however the intention is that this will be mandated for a small subset of conditions by the sponsor in the future.
		MULTI-PROFESSIONAL	General Comment	USEFUL FOR CONTRACTING BUT MAY BE CHALLENGING FOR PROVIDERS TO SUPPLY	This has been noted - The field is to be optional to be collected.
NHSC,K,W	CDS.2-008	LENGTH OF STAY ADJ	Potential Barrier	CONCERN OVER CONSISTENT APPLICATION BY PROVIDERS - WOULD NEED AUDIT/CHECKS BALANCES IN SYSTEM - PREFER TO KEEP UNDER COMMISSIONER CONTROL	This has been noted. These changes are to replicate the existing local grouper within the central SUS grouper.
NHSC,K,W	CDS.2-010	CONSULTATION MEDIUM	Support	WELCOMED - DATA COLLECTED LOCALLY BUT NOT SHARED WITH COMMISSIONERS IN STRUCTURED FORM	n/a
NHSC,K,W	CDS.2-011	DIRECT ACCESS REF	Support	WELCOMED - SHOULD BE MANDATED NOT OPTIONAL FIELD	The intention is that this will be mandated in the future to support Payment by Results based upon evidence that it can be implemented on an optional basis.

NHSC,K,W	CDS.2-012	ADM CATEGORY	Potential Barrier	FIELD USED LOCALLY TO DIFFERENTIATE BETWEEN MULTIPLE EPISODE SPELLS THAT ARE PRIVATE/NHS - HOW CAN WE DIFFERENTIATE IF THIS IS REMOVED?	This item has never been formally approved as part of CDS so should not be used. Existing approved Administrative Category items are being retained in CDS.
NHSC,K,W	CDS6.2-014	ADM METHOD	Support	WELCOMED FROM COMMISSIONING PERSPECTIVE - WOULD ADMISONS STAFF HAVE ACCESS TO THIS LEVEL OF DETAIL WHEN ADMITTING?	Yes this would be an option on the PAS systems for admitting staff to enter as far as we believe.
NHSC,K,W	CDS6.2-015	SITE OF TRT A&E	Specific Comment	WELCOMED - IDENTIFIED ALREADY AS LOCAL PRIORITY - MAKE REQUIRED NOT OPTIONAL FIELD	The intention is that this will be mandated in the future to support A&E Care Quality Indicators (CQIs) based upon evidence that it can be implemented on an optional basis.
NHSC,K,W	CDS6.2-016	PRESENT ON ADM INDICATOR	Potential Barrier	QUERY - HOW VALUABLE THIS FIELD WILL BE - HOW ACCURATE IT WILL BE?	Full details relating to this requirement are outlined in the Human Behavioural Guidance. This includes the national requirement.  It also states that further work needs to be undertaken prior to collection of this information locally and submission within SUS. This states that Providers MUST NOT capture and submit the Present On Admission Indicator until the subset of conditions, coding mappings and detailed guidance have been clinically validated and published.  Initially this item will be captured on an optional basis however the intention is that this will be mandated for a small subset of conditions by the sponsor in the future. Issues of accuracy will be identified during further piloting of this item prior to mandation.
NHSC,K,W	CDS6.2-017-20	STAFF INVOLVED IN CARE	Support	FROM COMMISSIONING PERSPECTIVE OFFERS GREATER SCRUTINY/ACCOUNTAILTY OF CLINICAL STAFF - SHOULD BE MANDATED	This is a national requirement to support clinical safety monitoring and revalidation of clinicians. This is supported by the Association of Royal Colleges. Initially this will be optional however the sponsor will seek to mandate this in the future.
NHSC,K,W	CDS6.2-021-26	MENTAL HEALTH	Support	REQUIRED FOR ACCURATE CONTRACTING INFORMATION	
NHSC,K,W	CDS6.2-030	ACTIVITY LOCATION	Specific Comment	WELCOME MANDATORY NOT OPTIONAL FIELD	The intention is that this will be mandated in the future to support AHP RTT based upon evidence that it can be implemented on an optional basis.
NHSC,K,W	CDS6.2-031	HOSPITAL AT HOME	Specific Comment	SUPPORT BUT AGREE WITH ALTERNATIVE PROPOSAL TO ADD TO DISCHARGE DESTINATION FIELDS	Inclusion of a new code in existing Discharge Method and Discharge Destination were considered, however it was felt that these changes would contradict NHS business definitions of discharge or result in non-mutually exclusive value lists. As a result a new optional indicator has been included with plans to mandate this in the future.
NHSC,K,W	CDS.2-032	WITHHELD REASON	Potential Barrier	THERE ARE OTHER FIELDS WE WOULD WISH PROVIDERS TO PRIORITISE OVER THIS ONE - SUGGEST CHANGING FROM REQUIRED TO OPTIONAL	This data element is required to ensure that records where the patient identifiers have been anonymised are legitimate rather than a data quality issue. In many cases it should be possible to derive this information automatically as part of the process of anonymising records prior to submission within CDS.
NHSC,K,W	CDS.2-045/46	WARD/CLINIC CODE	Specific Comment	WELCOMED - REQUIRED NOT OPTIONAL FIELD - SHOULDN'T BE DIFFIULCT FOR PROVIDERS TO SUPPLY - WOULD BE EXTREMELY HELPFUL TO MAP PATIENT TRANSFERS THROUGH SYSTEM	These items have been included within CDS 6.2 as optional items to support the continued flow of information between providers and commissioners following the removal of Very General Purpose (VGP) fields. There are currently no plans to mandate these items.

NHSC,K,W	CDS.2-047/049	OSV	Specific Comment	MANDATORY NOT OPTIONAL FIELD PLEASE	These items have been included within CDS 6.2 as optional items to support the continued flow of information between providers and commissioners following the removal of Very General Purpose (VGP) fields. There are currently no plans to mandate these items.
NHSC,K,W			General Comment	WHERE NOT REFERENCED/INDICATED WE SUPPORT PROPOSALS TO EITHER ADD OR REMOVE	n/a
IMS MAXIMS	Health and Social	<b>ORGANISATION CODE (RESIDENCE RESPONSIBILITY)</b>	Specific Comment	Replace PCT OF RESIDENCE with RESIDENCE RESPONSIBILITY and keep format AN	The existing Organisation Code (PCT of Residence) is being replaced by the new Organisation Code (Residence Responsibility) which will support the flow of PCT codes until April 2013 and then CCG code from 1st April 2013.
IMS MAXIMS	PbR	<b>MULTI-PROFESSIONAL OR MULTIDISCIPLINARY ATTENDANCE INDICATION CODE</b>	Potential Barrier	Legacy PAS systems unable to code in SNOMED	There are currently no proposals to use SNOMED within CDS 6.2 for the capture of this item.
IMS MAXIMS	PbR	<b>ADMISSION METHOD (HOSPITAL PROVIDER SPELL)</b>	Specific Comment	Format not shown as changed - n2 to an2, considerable change due to format change if to support all new values rather than use 28 as default, as current system record this as numeric value	This data item is undergoing 2 separate changes for CDS 6.2 a value list change and a name + format change. Please refer to Change_IDs CDS6.2_014 and CDS6.2_079 within the Dataset Specification for details.  The original data item named ADMISSION METHOD (HOSPITAL PROVIDER SPELL) will remain in place for CDS 6.1.1 with its value list and format as they currently are.
IMS MAXIMS	Accident and Emergency (A&E)	<b>Addition of Site Code of Treatment for A&amp;E</b>	General Comment	Keep format as an5	This will be the standard NHS Data Model and Dictionary format.
IMS MAXIMS	SUG	<b>START TIME (HOSPITAL PROVIDER SPELL)</b>	General Comment	Is this just for the time (including seconds) and not the length of the appointment / stay?	This is just the start time in e-GIF format. Further details are available within the Human Behavioural Guidance.
IMS MAXIMS	SUG	<b>DISCHARGE TIME (HOSPITAL PROVIDER SPELL)</b>	General Comment	Is this just for the time (including seconds) and not the length of the appointment / stay?	This is just the start time in e-GIF format. Further details are available within the Human Behavioural Guidance.
IMS MAXIMS	SUG	<b>START TIME (EPISODE)</b>	General Comment	Is this just for the time (including seconds) and not the length of the appointment / stay?	This is just the start time in e-GIF format. Further details are available within the Human Behavioural Guidance.
IMS MAXIMS	SUG	<b>END TIME (EPISODE)</b>	General Comment	Is this just for the time (including seconds) and not the length of the appointment / stay?	This is just the start time in e-GIF format. Further details are available within the Human Behavioural Guidance.
IMS MAXIMS	SUG	<b>START TIME (WARD STAY)</b>	General Comment	Is this just for the time (including seconds) and not the length of the appointment / stay?	This is just the start time in e-GIF format. Further details are available within the Human Behavioural Guidance.
IMS MAXIMS	SUG	<b>END TIME (WARD STAY)</b>	General Comment	Is this just for the time (including seconds) and not the length of the appointment / stay?	This is just the start time in e-GIF format. Further details are available within the Human Behavioural Guidance.
IMS MAXIMS	SUG	<b>APPOINTMENT TIME</b>	General Comment	Appointment slots are allocated in minutes.	This is standard e-GIF format for time HH:MM:SS. Where the seconds are not know this can be defaulted to '00'.
NICA - NHS CFH		START TIME (HOSPITAL PROVIDER SPELL)	General Comment	Would be helpful to see which date fields these new time data elements are linked to (same for other new time elements)	This is available within the Data Set Specification.
NICA - NHS CFH		ASSAULT TIME	General Comment	Need to ensure date/time formats are consistent across SUS. Is this the format used SUS-wide?	Violent Incident Reporting requirements have now been withdrawn by the Sponsor.  These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.
Wythenshawe Hospital	PbR	<b>Addition of Length of Stay Adjustment &amp; Reason</b>	Potential Barrier	This would prove a challenge operationally to manage - however I suggest that this is linked to a commissioning function where changes/ adjustments could be done in the back end and slow to the CDS	

Wythenshawe Hospital	PbR	<b>Addition of Length of Stay Adjustment &amp; Reason</b>	Potential Barrier	This would prove a challenge operationally to manage - however I suggest that this is linked to a commissioning function where changes/ adjustments could be done in the back end and slow to the CDS	
Wythenshawe Hospital	PbR	<b>Addition of Consultation Medium Used</b>	Support		Acknowledged.
Wythenshawe Hospital	PbR	<b>Addition of Direct Access Referral Indicator</b>	Support	Booking staff do not always get the information.	On account of the field being optional, there is not a necessity to flow the data, however it is required to support PbR so if the field is not populated, tariff may be reduced.
Wythenshawe Hospital	SUG	<b>OVERSEAS VISITORS STATUS CLASSIFICATION</b>	Specific Comment	Would also have a new code -Interim OSV status as there is often a query raised and the initial status can change.	Option 9 - Charging Rates Not Known should cover the query.
Wythenshawe Hospital	<b>Violent Incident Prevention</b>	<b>ASSAULT LOCATION</b>	Specific Comment	Concern about free text used as not good for analysis	Violent Incident Reporting requirements have now been withdrawn by the Sponsor.  These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.
Wythenshawe Hospital	<b>AHP RTT Activity Location</b>	<b>ACTIVITY LOCATION TYPE CODE</b>	Potential Barrier	As long as suppliers give the ability to record multi location types within a single clinic template.	It is expected that changes to systems will support the recording of this item in a way that minimises burden upon the NHS wherever possible.
NHS Information Centre	PbR	<b>MULTI-PROFESSIONAL OR MULTIDISCIPLINARY ATTENDANCE INDICATION CODE</b>	Specific Comment	If this is to indicate multi-professional involvement should a blank in an optional element indicate a single professional? This item would then only need to be used for a very small percentage of appointments. If indication of one professional is required could the description for value 1 be "Single ..." or "Lone Professional Attendance". "Uni-Professional ..." seems to add to the NHS lexicon of jargon!	An explicit value for Uni Professional is required to ensure that this is uni-professional rather than a data quality issue. Future changes to PbR processing will assume uni-professional in terms of tariff where this item is absent.  Descriptions are to align with the OPCS codes that they are intended to replace.
NHS Information Centre	PbR	<b>LENGTH OF STAY ADJUSTMENT and LENGTH OF STAY ADJUSTMENT REASON</b>	Specific Comment	If only two reasons for adjustment will apply this doesn't need a repeating group. Two new elements for "SPC LoS Adjustment" and "Rehab LoS Adjustment" would meet the purpose. This would be easier to add to source files and the XML interchange. It will also be easier to handle at SUS to provide extracted data to users in this form. I suggest that up to five reasons could be accommodated before a repeating group is necessary. Any further new reasons would need a schema change however this is implemented.	This has been amended, the values have been split out into their own fields for SPC (02) and Rehabilitation (01) for version 6.0
NHS Information Centre	PbR	<b>CONSULTATION MEDIUM USED</b>	Specific Comment	If codes 05, 06 and 98 should not be used in the CDS does this mean that the associated activity should not flow in the CDS?	It is not considered that activity using these methods would be within the scope of CDS. Only methods that replace a face-to-face appointment should be recorded.
NHS Information Centre	PbR	<b>ADMISSION METHOD (HOSPITAL PROVIDER SPELL)</b>	Specific Comment	If value 28 is retained in CDS 6.2 there is no incentive to use a more granular code for "Other". What is the difference between 28 and 2D? Why not change "2C Baby born at home as intended" to "84 Baby born at home as intended" as this places it with other baby admission methods? (Wouldn't a baby born at home subsequently admitted as an emergency (rather than non-electively) be covered by 21 or 22?) This would allow values 26 and 27 for "Admitted from other A&E" and "Emergency transfer" respectively. 28 would retain its current meaning for a smaller number of cases.	This is acknowledged and Code 28 will be removed from future versions of CDS however it has been retained to support the transition from the existing code to the new codes. The Human Behavioural Guidance states that the lower level values 2A, 2B, 2C and 2D are recommended for submission and providers should not use a mixed economy e.g. use of code 28 and new codes.  Existing Code 28 currently includes all of scenarios that relate to the new sub-divided codes whereas Code 2D excludes these.  Code 2C is for emergency admissions following a baby born at home as intended so need to be within the 2x number range.
NHS Information Centre	Accident and Emergency (A&E)	<b>SITE CODE (OF TREATMENT)</b>	Support	Will allow reporting at site level for Providers with more than one A&E department and/or walk-in centre	Noted.

NHS Information Centre	Clinical Practice	<b>PRESENT ON ADMISSION INDICATOR</b>	Specific Comment	<p>Although a useful addition to clinical coding this will increase the time it takes to code a patient record. Why mix Y and N with 8 and 9? suggest use 1, 2, 8, 9 to represent Y, N, NA, NK instead.</p> <p>Could a separate new episode level CDS block for "Clinical Diagnosis on Admission Group" be considered? - this could be structured in the same way as the existing Clinical Diagnosis Group.</p>	<p>This is acknowledged. Full details relating to this requirement are outlined in the Human Behavioural Guidance. This includes the national requirement.</p> <p>It also states that further work needs to be undertaken prior to collection of this information locally and submission within SUS. This states that Providers MUST NOT capture and submit the Present On Admission Indicator until the subset of conditions, coding mappings and detailed guidance have been clinically validated and published.</p> <p>Initially this item will be captured on an optional basis however the intention is that this will be mandated for a small subset of conditions by the sponsor in the future.</p> <p>Usually within the NHS Data Dictionary Y and N are used for Yes and No, rather than 1 or 0. 8 and 9 are standard within the Data Dictionary for meaning Not Applicable and Not Known.</p> <p>Addition of a new Clinical Diagnosis on Admission group was considered but rejected due to the probable significant impact upon providers, system suppliers and national systems and analysis.</p>
NHS Information Centre	Clinical Practice	<b>MAIN OPERATING HEALTHCARE PROFESSIONAL REGISTRATION CODE and MAIN OPERATING HEALTHCARE PROFESSIONAL REGISTRATION BODY and RESPONSIBLE ANAESTHETIST PROFESSIONAL REGISTRATION CODE and RESPONSIBLE ANAESTHETIST PROFESSIONAL REGISTRATION BODY</b>	Specific Comment	<p>Although a useful addition to clinical coding this will increase the time it takes to code a patient record. Could these elements be treated as a new "Operating Professionals" block where all significant professionals are recorded at the episode level: Professional Registration Code Registration Body Operator/Anaesthetist (1 or 2)</p> <p>This would still enable analysis of clinical practice - and may make such analysis easier to perform. In the vast majority of cases there will be one surgeon and one anaesthetist recorded, repeating the same data against all procedures would unnecessarily inflate the CDS message. In the case of complaint or other problems the patient notes/theatre book will always be referred to for specific procedures. Would this be required for "Site of operation" (Y codes)?</p>	<p>This is acknowledged. Various options were considered however this was deemed the most appropriate in relation to meeting the requirement and having the minimal impact upon the existing collection of procedure information. These items are optional although the intention is that they will be mandated in the future.</p>
NHS Information Centre	SUG	<b>APPOINTMENT TIME</b>	Specific Comment	<p>Does this represent the "Scheduled Start Time" or the "Actual Time Seen"? It would be useful to also collect an "End Time" either scheduled or actual or the scheduled or actual duration of the appointment. In all of these cases the Scheduled Start Time and Duration should be readily available from the PAS system and would be the easiest to collect. Recording of actual times has the potential to add an extra burden on clinic staff if this is not already part of the normal management of an outpatient service.</p>	<p>This is the planned start time. This is to enable differentiation of appointments where the same patient has multiple appointments on the same date. Further details are available in the CDS 6.2 Human Behavioural Guidance.</p>
NHS Information Centre	Violent Incident Prevention	<b>ASSAULT INDICATOR</b>	Specific Comment	<p>Why mix Y and N with 9? - suggest use 1, 2, 9 (to represent Y, N, NK) instead.</p>	<p>Violent Incident Reporting requirements have now been withdrawn by the Sponsor.</p> <p>These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.</p>

NHS Information Centre	Violent Incident Prevention	ASSAULT METHOD	Specific Comment	Doesn't 05 Knife = 04 Sharp (bladed) object? Why hide Knife with other objects in 05 and why group Firearms and Explosives together? - wouldn't these better support policy as distinct separate values - two characters gives the scope to do this?	Violent Incident Reporting requirements have now been withdrawn by the Sponsor.  These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.
NHS Information Centre	Violent Incident Prevention		General Comment	What about an indication of the number of attackers - perhaps as a separate element? May help with gang related assaults and associated policy.	Violent Incident Reporting requirements have now been withdrawn by the Sponsor.  These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.
NHS Information Centre	Violent Incident Prevention	ASSAULT LOCATION	Specific Comment	Free text!!!  Up to 100 characters will render analysis very difficult if not impossible! Even text mining won't know all the possible spelling mistakes. A coded list, even including an "other" option, would be preferable.	Violent Incident Reporting requirements have now been withdrawn by the Sponsor.  These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.
NHS Information Centre	XML Schema/NHS DD	PREGNANCY TOTAL PREVIOUS PREGNANCIES	Specific Comment	Suggest add value 30 to mean "30 or more" in similar way to 6 means "6 or more" registrable births in "Number of Babies" element	This was considered however it was deemed that increasing the maximum value to 29 should be sufficient for the needs of the NHS.
NHS Information Centre	A&E Data Element Renaming		General Comment	Will changing "A and E" to "Accident and Emergency" add to the size of the XML tags used in the schema? Tags already inflate the size of the interchange!	We acknowledge that these changes may impact submission size, however various options were considered and these proposals have the lowest impact upon existing diagnosis and procedure reporting. It should be noted that these are optional so xml tags need not be flowed for null records. Also in some cases short versions are used in XML schema tags.
NHS Information Centre	Numeric Enumerations		General Comment	Is adding the word "Code" to many data elements strictly necessary? It is already implied and understood that elements carry codes and not descriptions. Will this also add to the size of the XML tags used in the schema? Tags already inflate the size of the interchange!	In many cases the word 'Code' has been included in replacement data elements to differentiate the new data element using the alphanumeric format from the existing data element.  It is not possible to simply change the format of existing data elements as these will continue to be supported in their existing format for CDS 6.1. As a result completely new data elements are required.
Information Standards Board	001,002	Organisation Code (Residence Responsibility) & Organisation Code (PCT of Residence)	General Comment	Will rules to establish commissioning body for patients not registered with a practice have to be changed when PCTs replaced by CCGs? This could be significant change for systems.	Full guidance will be published in an update to the Who Pays? Establishing the Responsible Commissioner guidance.
Information Standards Board	CDS6.2_001	Organisation Code (Residence Responsibility)	General Comment	The idea to make the data item more generic is a good one, so that all of the other health boards can be accompanied, however, the name just doesn't seem right, and could confuse users. Therefore, is the data item going to be used in Wales, Scotland & NI, and if the purpose of the data item to identify the Commissioning body in which the patient resides? Would 'ORGANISATION CODE (COMMISSIONING BODY OF RESIDENCE)' or perhaps 'ORGANISATION CODE (PRIMARY HEALTH PROVIDER OF RESIDENCE)' be more appropriate?	The naming of this item is intended to ensure that it is not ambiguous or confused with other similar items such as ORGANISATION CODE (CODE OF COMMISSIONER). The definition for the data element is similar to the existing ORGANISATION CODE (PCT OF RESIDENCE) which it replaces but refers to Clinical Commissioning Groups (CCGs).
Information Standards Board	003	MULTI-PROFESSIONAL OR MULTIDISCIPLINARY ATTENDANCE INDICATION CODE	General Comment	Are the values mutually exclusive?	Yes. Multi-professional and multi-disciplinary are different. Full details are included within the Human Behavioural Guidance.

Information Standards Board	CDS6.2_008	Length of Stay Adjustment	General Comment	Potentially we may need to record multiple adjustments against the a single spell	Adjustments should be recorded against each episode rather than the spell however this may result in multiple adjustments within a spell as the total of adjustments for each episode within the spell.  Multiple adjustments may occur for each episode for Rehabilitation and Specialist Palliative Care. Length of Stay adjustment may also be derived within SUS based upon critical care data.
Information Standards Board	CDS6.2_009	LENGTH OF STAY ADJUSTMENT REASON	General Comment	Do we need to add Critical Care & Delayed discharges (future proof)	Critical Care Length of Stay Adjustment is already calculated within SUS based upon critical car data. Department of Health have confirmed that there are no plans to add other types of Length of Stay Adjustment in the near future.
Information Standards Board	CDS6.2_014	ADMISSION METHOD (HOSPITAL PROVIDER SPELL)	General Comment	It is not clear how the splitting of code 28 of ADMISSION METHOD (HOSPITAL PROVIDER SPELL) will work, as it looks within the values column as if 2A, 2B, 2C will exist as items by themselves and also as components of national code 28.	This is acknowledged and Code 28 will be removed from future versions of CDS however it has been retained to support the transition from the existing code to the new codes. The Human Behavioural Guidance states that the lower level values 2A, 2B, 2C and 2D are recommended for submission and providers should not use a mixed economy e.g. use of code 28 and new codes.
Information Standards Board	CDS6.2_014	ADMISSION METHOD (HOSPITAL PROVIDER SPELL)	General Comment	Why are 'alpha' characters being added to a numeric field?	Various options were considered for these changes however this option was felt to be the best solution whilst ensuring that all emergency admissions are in the range of numbers starting 2x.
Information Standards Board	CDS6.2_015	SITE CODE (OF TREATMENT)	General Comment	Clarification how proposed changes are being made to the CDS messages for the A&E Care Quality Indicators when there has been no ISN for them yet...or indeed an appraisal of the CQI documentation by the ISB. Is this the introduction of standards by the back door?	This change is partially to support A&E Care Quality Indicators and partially to respond to the needs of users who require some way to identify activity for a particular site where the provider has multiple sites providing A&E facilities.
Information Standards Board	CDS6.2_015	SITE CODE (OF TREATMENT)	General Comment	No name has been proposed as SITE CODE (OF TREATMENT) is already being used, so if this is a new data item could it be called SITE CODE (A&E ACTIVITY)?	The same data item SITE CODE (OF TREATMENT) is used throughout CDS There is no need to introduce another variant for A&E only
Information Standards Board	CDS6.2_016	PRESENT ON ADMISSION INDICATOR	General Comment	Will require significant increase in clinical coding staff to facilitate extra validation whilst coding. Will require additional recording of this information by clinical staff. Will require additional clinical coding staff resource due to significant additional burden when entering coding onto system. Has this been piloted anywhere??	This is acknowledged. Full details relating to this requirement are outlined in the Human Behavioural Guidance. This includes the national requirement.  It also states that further work needs to be undertaken prior to collection of this information locally and submission within SUS. This states that Providers MUST NOT capture and submit the Present On Admission Indicator until the subset of conditions, coding mappings and detailed guidance have been clinically validated and published.  Initially this item will be captured on an optional basis however the intention is that this will be mandated for a small subset of conditions by the sponsor in the future.
Information Standards Board	CDS6.2_017 & 19	MAIN OPERATING HEALTHCARE PROFESSIONAL REGISTRATION CODE & RESPONSIBLE ANAESTHETIST PROFESSIONAL REGISTRATION CODE	General Comment	Could the existing data item CARE PROFESSIONAL ROLE CODE be used to identify the role being undertaken during the procedure. This could then be used for the care professional undertaking the procedure and for the anaesthetist.	CARE PROFESSIONAL ROLE CODE is a classification in the data dictionary, and relates to the National Joint Registry data set which is about to be deprecated.
Information Standards Board	CDS6.2_019	RESPONSIBLE ANAESTHETIST PROFESSIONAL REGISTRATION CODE	General Comment	For CDS6.2_019 the description is exactly the same as for CDS6.2_017.	Noted - this issue has been addressed.

Information Standards Board	CDS6.2_018	MAIN OPERATING HEALTHCARE PROFESSIONAL REGISTRATION BODY	General Comment	PROFESSIONAL REGISTRATION TYPE CODE already exists and appears to be very close to what is being asked for...could this list be revised? In terms of the data element names shouldn't they conform to the existing data items, for example PROFESSIONAL REGISTRATION TYPE CODE (MAIN OPERATING LEAD)	Professional Registration Type Code is used in the Workforce data set, but is at too detailed a level to identify merely the Professional Registration Body, as it differentiates between full and associate membership, for example. A subset of the existing PROFESSIONAL REGISTRATION BODY CODE has been as it is felt that this is most appropriate to meet the requirement.
Information Standards Board	CDS6.2_020	RESPONSIBLE ANAESTHETIST PROFESSIONAL REGISTRATION BODY	General Comment	PROFESSIONAL REGISTRATION TYPE CODE already exists and appears to be very close to what is being asked for...could this list be revised? In terms of the data element names shouldn't they conform to the existing data items, for example PROFESSIONAL REGISTRATION TYPE CODE (ANAESTHETIST LEAD)	Professional Registration Type Code is used in the Workforce data set, but is at too detailed a level to identify merely the Professional Registration Body, as it differentiates between full and associate membership, for example. A subset of the existing PROFESSIONAL REGISTRATION BODY CODE has been as it is felt that this is most appropriate to meet the requirement.
Information Standards Board	015-020		General Comment	These are marked as optional. As stated requirement is to support reporting of these data items ( CQIs, Clinical safety) should they be a requirement?	Initially this item will be captured on an optional basis however the intention is that this will be mandated for a small subset of conditions by the sponsor in the future.
Information Standards Board	017-020	STAFF INVOLVED IN CARE	General Comment	Requirement description. Should "one" be "only"?	Noted - this has been addressed.
Information Standards Board	027	TREATMENT FUNCTION CODE	General Comment	Should this be Activity Treatment Function Code – see 116. Is 500 allowable ( see 026)	Noted - There are two separate changes relating to Treatment Function Code - the addition of new Treatment Function Codes and the renaming of the item to Activity Treatment Function Code. Code 500 was proposed as a change to Main Specialty to allow the flow of national code [500] Obstetrics and Gynaecology however this was withdrawn due to the potential impact upon national statistics relating to central returns.
Information Standards Board	026	MENTAL CATEGORY	General Comment	Should format be an3 to be consistent with codes being alphanumeric? ( see later changes)	This is data element is being removed from CDS 6.2.
Information Standards Board	031	Discharge to Hospital at Home Service Indicator	General Comment	Is there a common definition/usage of Hospital at Home service to ensure consistent reporting?	This is available within the CDS 6.2 Human Behavioural Guidance.

Information Standards Board	CDS6.2_031	Discharge to Hospital at Home Service Indicator	General Comment	Probably best to keep it out of DISCHARGE DESTINATION and DISCHARGE METHOD, as this data element is identifying a service which is being provided as opposed to the destination itself. I'm not that up to speed on the 'Hospital at Home' services, but could these potentially be provided at the patient's usual place of residence and also any temporary places of residence?	Noted. Yes these services can be provided. Please refer to the draft definition for Hospital at Home which the NHS Data Dictionary team are looking to formalise.  "A Hospital At Home Service is a SERVICE.  A Hospital At Home Service is a type of Intermediate Care, encompassing both the active treatment at home of PATIENTS who may otherwise be admitted to Hospital (always for a limited period), and early supported discharge schemes following a Hospital Provider Spell."
Information Standards Board	CDS6.2_031	Discharge to Hospital at Home Service Indicator	General Comment	In terms of the name perhaps it could be DISCHARGED instead of DISCHARGE, to be consistent with other dictionary data items.	Noted. The item has been amended to DISCHARGED TO HOSPITAL AT HOME INDICATOR
Information Standards Board	CDS6.2_032	WITHHELD IDENTITY REASON	General Comment	To make the data item more generic it could be called ANONYMISED RECORD REASON	WITHHELD IDENTITY REASON is used in the WITHHELD IDENTITY STRUCTURE data group in the CDS. It has been named to align with this for consistency. The current definition (in draft DD CR) relates to its use in CDS but it could be extended for use in other data sets if we have a requirement to do so in future.
Information Standards Board	032	WITHHELD IDENTITY REASON	General Comment	Is this an entirely new data item? See point 1	Yes, this is a new data item.
Information Standards Board	CDS6.2_038 & 039	START TIME (WARD STAY) & END TIME (WARD STAY)	General Comment	How will the scenarios where a patient may transfer between wards during a sing FCE? Will there be the ability to flow multiple ward details?	Details of up to 97 separate Ward Stay may currently flow within a CDS Admitted Patient Care episode.
Information Standards Board	CDS6.2_038	START TIME (WARD STAY)	General Comment	START DATE (WARD STAY) doesn't currently exist in the CDS messages – so this needs to be added as an additional data item to be included...otherwise you will have START TIME (WARD STAY) but no start date!	The generic data element START DATE is used in the LOCATION GROUP (AT WARD STAY DATA GROUP) within CDS. The corresponding time element has been name Start Time (Ward Stay) to ensure that it is unambiguous.
Information Standards Board	CDS6.2_039	END TIME (WARD STAY)	General Comment	END DATE (WARD STAY) doesn't currently exist in the CDS messages – so this needs to be added as an additional data item to be included...otherwise you will have END TIME (WARD STAY) but no end date!	The generic data element END DATE is used in the LOCATION GROUP (AT WARD STAY DATA GROUP) within CDS. The corresponding time element has been name End Time (Ward Stay) to ensure that it is unambiguous.
Information Standards Board	CDS6.2_042	ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE	General Comment	Should this be called ACCIDENT AND EMERGENCY DATE SEEN FOR TREATMENT? otherwise it is a duplicate of CDS6.2_043	Noted. This was a data entry error which has been fixed in version 0.6.0 of the CDS 6.2 Dataset Specification.  Change_ID CDS6.2_042 ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE should have been ACCIDENT AND EMERGENCY DATE SEEN FOR TREATMENT.
Information Standards Board	034-044		General Comment	Same comment as point 6. Stated requirement not specific as to who/why this additional accuracy is needed.	These have been requested by users and are optional items for local use initially.
Information Standards Board	CDS6.2_045	WARD CODE	General Comment	How do we deal with patients who switch between multiple Wards during a Hospital Provider Spell and FCE?	Details of up to 97 separate Ward Stay may currently flow within a CDS Admitted Patient Care episode. The relevant Ward Code would be included within the details of each Ward Stay.
Information Standards Board	CDS6.2_048	OVERSEAS VISITORS STATUS START DATE	General Comment	How does this relate to the existing filed OVERSEAS VISITOR IK ARRIVAL DATE? Would the arrival date always be the same as the e OVERSEAS VISITORS STATUS START DATE?	The existing field OVERSEAS VISITOR UK ARRIVAL DATE is not currently used within CDS. The field is actually an attribute not an element,

Information Standards Board	CDS6.2_048	OVERSEAS VISITORS STATUS START DATE	General Comment	In what circumstances would there be more than one OVERSEAS VISITORS STATUS START DATE?	The Overseas Visitor Status Start Date relates to the specific Overseas Visitor Status. The status of a patient may change during an episode e.g. if they gain citizenship, and as a result the start and end dates indicate when the status related to the patient.
Information Standards Board	CDS6.2_048 & 049	OVERSEAS VISITORS STATUS START DATE & OVERSEAS VISITORS STATUS END DATE	General Comment	Are there better definitions for these two data items? Shouldn't there be an accompanying ISN?	These data items (attributes) have been in the DD for a long time. Overseas has recently been the subject of a DDCN ( <a href="http://www.connectingforhealth.nhs.uk/systemsandservices/data/nhsdms/ddcn/cp1128.pdf">http://www.connectingforhealth.nhs.uk/systemsandservices/data/nhsdms/ddcn/cp1128.pdf</a> ). Further details are available within the Human Behavioural Guidance.
Information Standards Board	CDS6.2_050	ASSAULT INDICATOR	General Comment	This appears to be mixed between A&E attendances and admissions...the values relate to an admission and the description to the A&E attendance...so perhaps this should be split?	Violent Incident Reporting requirements have now been withdrawn by the Sponsor.  These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.
Information Standards Board	CDS6.2_051	ASSAULT TIME	General Comment	Should possibly be called ASSAULT DATE TIME	Violent Incident Reporting requirements have now been withdrawn by the Sponsor.  These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.
Information Standards Board	CDS6.2_052	ASSAULT METHOD	General Comment	There should be an option for 'Not Stated' in the values section, as not everyone will be happy to share the information.	Violent Incident Reporting requirements have now been withdrawn by the Sponsor.  These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.
Information Standards Board	CDS6.2_052	ASSAULT METHOD	General Comment	Field values 01 and 02 appear to be the same...or is 02 meant to represent the use of 'Body Parts' instead of just one body part?	Violent Incident Reporting requirements have now been withdrawn by the Sponsor.  These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.
Information Standards Board	CDS6.2_052	ASSAULT METHOD	General Comment	Field values 04 and 05 appear to be similar, or does 05 represent the use of a combination of these things?	Violent Incident Reporting requirements have now been withdrawn by the Sponsor.  These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.
Information Standards Board	CDS6.2_053	ASSAULT LOCATION	General Comment	It's questionable whether free text fields should be allowed into the CDS...I'm not that keen on them and would recommend their removal.	Violent Incident Reporting requirements have now been withdrawn by the Sponsor.  These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.

Information Standards Board	CDS6.2_050 to 053	Violent Incident Prevention	General Comment	Where is the ISN for these new fields? Has it been established what the burden will be for the NHS and how useful the data will be. We have found that many people involved in violent incidents are usually VERY unwilling to pass over any details. It is critical that all of these go through Information Standards Board approval before being added to the CDS. These definitions appear to have been rushed and lack clear definitions.	Violent Incident Reporting requirements have now been withdrawn by the Sponsor.  These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.
Information Standards Board	CDS6.2_050 to 053	Violent Incident Prevention	General Comment	Have all of the Information Governance implications been taken into account? We would not always expect this sort of confidential data to flow through SUS.	Violent Incident Reporting requirements have now been withdrawn by the Sponsor.  These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.
Information Standards Board	051-053	Violent Incident Prevention	General Comment	Are these entirely new items to DD- see point 1	Violent Incident Reporting requirements have now been withdrawn by the Sponsor.  These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.
Information Standards Board	051-053	Violent Incident Prevention	General Comment	If these data items also apply to patients admitted directly to a ward then should they be reworded as currently imply only applicable to A&E	Violent Incident Reporting requirements have now been withdrawn by the Sponsor.  These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.
Information Standards Board	054-055	AMBULANCE INCIDENT NUMBER & ORGANISATION CODE (CODE OF AMBULANCE TRUST)	General Comment	See point 1. Who will be responsible for capturing this information? How will it be available?	These new data elements are being introduced on an optional basis initially although the sponsor plans to mandate these in the future.  This information will be captured by provider staff as part of the handover of care from ambulance staff to the hospital. Further details are available in the Human Behavioural Guidance.
Information Standards Board	102	NUMBER OF BABIES INDICATOR	General Comment	Should this be named a CODE to be consistent?	this item is now called NUMBER OF BABIES INDICATION CODE
Information Standards Board	109	REFERRAL TO TREATMENT STATUS REFERRAL TO TREATMENT PERIOD STATUS	General Comment	Should this be named a CODE to be consistent?	The change here is to align this item to the existing ATTRIBUTE name in the DD (the word 'period' was missing for the data element for some reason).
Information Standards Board	112	SEX OF PATIENTS SEX OF PATIENTS CODE	General Comment	Values are not correct	The value for Home Leave is an existing NHS Data Dictionary value and is not changed as part of CDS 6.2.  The value of 'home leave' is used for mental health patients who are on home leave but remain under the care of the hospital.
Information Standards Board	116	ACTIVITY TREATMENT FUNCTION CODE	General Comment	Should description be "A unique ... For Activity Function"?	This is acknowledged.
Cerner Ltd.	CDS6.2_010	<b>Addition of Consultation Medium Used</b>	General Comment	New field appears to overlap with existing FIRST ATTENDANCE field ( <a href="http://www.datadictionary.nhs.uk/data_dictionary/messages/cds_v6/data_sets/cds_v6_type_020_details_fr.asp?shownav=1">http://www.datadictionary.nhs.uk/data_dictionary/messages/cds_v6/data_sets/cds_v6_type_020_details_fr.asp?shownav=1</a> ) within 020 and 021 CDS.	First attendance data element only separates face to face from Telephone/Telemedicine. The requirement from PbR is to identify different types of Consultation Medium such as telemedicine so that activity can attract appropriate tariff. First Attendance currently supports several concepts and is widely used which makes the potential impact of changing this item significant.

Cerner Ltd.	CDS6.2_008	<b>Addition of Length of Stay Adjustment &amp; Reason</b>	General Comment	The description of this field appears to not provide enough data to be able to design and implement data-capture to be able to report it. At what point will information become available for users to be able to determine what treatment periods should be included in the adjustment?	Full details are available within the Human Behavioural Guidance.
Cerner Ltd.	CDS6.2_011	<b>Addition of Direct Access Referral Indicator</b>	Potential Barrier	The description of this field does not match the CDS types this field is to be associated to. The description implies that the diagnostic test will only take place during an outpatient appointment, and as such only the CDS types 020 and 021 would be required for this? Also, this raises a further question in that (assuming the above is true) the CDS types 020 and 021 are for consultant-led activity, yet a diagnostic appointment is often not consultant-led. Is there a proposal to change the definition of CDS type 020 and 021 to reflect this?	This item is within Outpatient and key Admitted Patient Care and EAL CDS Types. In some cases diagnostic tests may occur as part of an admission rather than in outpatients.  CDS Types 020 Outpatients and 021 Future Outpatients both support both consultant and non-consultant led activity and may include Allied Health Professional activity.  Further information is available on the NHS Data Dictionary website:  <a href="http://www.datadictionary.nhs.uk/data_dictionary/messages/cds_v6/overviews/cds_v6_type_020_overview.asp?shownav=1">http://www.datadictionary.nhs.uk/data_dictionary/messages/cds_v6/overviews/cds_v6_type_020_overview.asp?shownav=1</a>
Cerner Ltd.	CDS6.2_042	<b>Addition of Date to Time only based A&amp;E data elements</b>	Specific Comment	The name of this field appears incorrect; should it not be ACCIDENT AND EMERGENCY TREATMENT START DATE?	Noted. This was a data entry error which has been fixed in version 0.6.0 of the CDS 6.2 Dataset Specification.  Change_ID CDS6.2_042 ACCIDENT AND EMERGENCY ATTENDANCE CONCLUSION DATE should have been ACCIDENT AND EMERGENCY DATE SEEN FOR TREATMENT.
Cerner Ltd.	CDS6.2_051	<b>Violent Incident Prevention</b>	Specific Comment	The name of this field and the data type of it do not match. The name infers it will be a time only field, yet the data type infers it will be a date/time field. Also, the data type does not indicate how long this field will be.	Violent Incident Reporting requirements have now been withdrawn by the Sponsor.  These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.
Cerner Ltd.	CDS6.2_052	<b>Violent Incident Prevention</b>	General Comment	Should the ASSAULT METHOD be a repeating group? There could be more than one method per assault. In addition to this, should all the Violent Incident Prevention fields be in an over-arching repeating group? An unfortunate individual could suffer multiple assaults, for example.	Violent Incident Reporting requirements have now been withdrawn by the Sponsor.  These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.
Cerner Ltd.	CDS6.2_102	<b>Numeric Enumerations</b>	Specific Comment	The usage of the word 'Indicator' in the field's name is invalid. The technical definition of an indicator is something that represents a binary state. The previous name for this field seems acceptable. Also, the change to the data type of this field seems entirely unnecessary, given the description of it.	Acknowledged however this name has been formulated in accordance with NHS Data Model and Dictionary editorial policy.
Cerner Ltd.	CDS6.2_033	<b>Removal of VGP fields</b>	General Comment	Local Subspecialty is a VGP field that many of our clients make use of, and is being removed as per this change. We are concerned that Local Subspecialty now does not appear anywhere in the CDS output.	This has been included as a separate items within CDS 6.2 to support the continued flow of information between providers and commissioners following the removal of Very General Purpose (VGP) fields. This is optional and for local uses only.

Cerner Ltd.	ISB 0092	N/A	General Comment	ISB 0092 stated that a number of changes would be wrapped up into CDS 6.2, such as AMD 16/2011, AMD 73/2010 and 84/2010. However, there doesn't appear to be sign of the content of these AMDs in this consultation. A further change that was supposed to be included is 'Type 020: Outpatient (OPCDS): Radiotherapy', but also does not appear in the consultation document. If these items are not going to be included in CDS 6.2, at what point will they be deployed?	The specific changes to CDS to support Amd 16/2011 have been included within CDS 6.2. The other elements of A&E Care Quality Indicators will be definitional only. Amd 73/2010 has now been addressed via changes to SUS. The HSCIC is currently seeking a sponsor to mandate Future Outpatients in relation to 84/2010 and further communications will be published in due course.  Introduction of the Radiotherapy Data Set within CDS is a separate piece of work and was not possible to incorporate within CDS 6.2 timescales.
Cerner Ltd.	N/A	N/A	General Comment	A number of fields have had their data types changed from being purely numeric to being alphanumeric. This may cause issues in downstream systems.	These changes are required to address known issues resulting in leading zeros of codes being stripped by systems. Replacement data elements are required to differentiate the new data element using the alphanumeric format from the existing data element.  It is not possible to simply change the format of existing data elements as these will continue to be supported in their existing format for CDS 6.1. As a result completely new data elements are required.  Noted - 6.1 will be kept for legacy systems and once they have been updated they can then change to 6.2
The Royal Bournemouth & Christchurch NHS Foundation Trust		General	General Comment	It would be easier if additions had one colour and changes had a separate colour ( as deletions are separate) and they are identified in column G	Acknowledged.
The Royal Bournemouth & Christchurch NHS Foundation Trust	clinical practice		Potential Barrier	Where there is no ISB or Data dictionary link -We as a Trust will have much more of a job meeting the requirement on time - as our software supplier only responds to ISN's	Acknowledged. The Information Standards Notice (ISN) will be published shortly.
The Royal Bournemouth & Christchurch NHS Foundation Trust		General	General Comment	I found the document very easy to use & follow	Noted and thanks
The Royal Bournemouth & Christchurch NHS Foundation Trust	XML/Schema/NHS DD	General	General Comment	The Replaces data element -where the is a name & format change - as most PAS systems already collect this data, & most sites will need to do nothing here. So it may be easier to follow if these are shown in a section on their own - away from actual new and removed fields in the final document	Noted - We have attempted to do that by grouping all these changes at the end of the list of changes.
The Royal Bournemouth & Christchurch NHS Foundation Trust	SUG	overseas visitors status end date	Potential Barrier	This is not currently collected on our PAS - and I could not find any information in ISB/ISN website searching on log no. 25 - this overseas info is what I was most concerned about being able to obtain & could find least about. There was not enough information available for me to understand this data item fully	Overseas Visitor information was previously collected using VGP fields which are being withdrawn in CDS 6.2.  This is optional to support existing flows of information between providers and their commissioners.  Further details are available within the Human Behavioural Guidance.
The Royal Bournemouth & Christchurch NHS Foundation Trust	SUG	overseas visitors status start date	Potential Barrier	This is not currently collected on our PAS - and I could not find any information in ISB/ISN website searching on log no. 25 - this overseas info is what I was most concerned about being able to obtain & could find least about. There was not enough information available for me to understand this data item fully	Overseas Visitor information was previously collected using VGP fields which are being withdrawn in CDS 6.2.  This is optional to support existing flows of information between providers and their commissioners.  Further details are available within the Human Behavioural Guidance.

The Royal Bournemouth & Christchurch NHS Foundation Trust	PbR	Length of Stay adjustment	General Comment	I do not think ward clerks would know this - It looks like something that would need to be added away from the ward - may be coders? Or is it calculated?	This has been amended, the values have been split out into their own fields for SPC (02) and Rehabilitation (01) in draft Data Set Specification v0.6.0 LOS will be calculated.
The Royal Bournemouth & Christchurch NHS Foundation Trust	SUG	clinic code	General Comment	this will be great & very useful	Noted
The Royal Bournemouth & Christchurch NHS Foundation Trust	all	all	General Comment	ISB Log No - I can not find anything on is on the ISB website - if it is internal this is not clear - but if it is published I have been unable to find it easily	This was included for internal traceability and has now been removed.
The Royal Bournemouth & Christchurch NHS Foundation Trust	Violent Incident Prevention	Assault fields	Potential Barrier	This really needs an ISN to make trusts collect this information more easily	Violent Incident Reporting requirements have now been withdrawn by the Sponsor.  These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.
CHFT/THIS		008	Specific Comment	Assuming this is done on TFC for rehab or palliative care. Technically can do as use for contracting/costing calculations though some clear guidance would be useful. Also see no mention of removal of critical care days from gross LOS.	Further details are available within the Human Behavioural Guidance. Critical Care LOS will continue to be derived within SUS.
CHFT/THIS		011	Specific Comment	Sounds Tricky and not overly clear what being used for, as appears to refer to outpatients but inpatients also mentioned in CDS type list	Further information is available within the Human Behavioural Guidance which will be available upon publication of the Information Standards Notice (ISN)
CHFT/THIS		014	Specific Comment	Could do but requires update to PAS and Training for Staff, in addition this is not just an addition of new values but a change of data type from N2 to AN2, may have effect on commissioner systems and suppliers.	Noted regards to the Values changing and the extra burden in training staff.
CHFT/THIS		Present on Admission	Specific Comment	Is support within organisation but would be FAR too unwieldy for all diagnoses. Why not try specific code changes as per David Wise backing of Pressure Ulcer coding initiative (Pail H has details). Surely better to focus on areas that concerned about acquiring in hospital (MRSA, Pressure Ulcers, Septicaemia etc.). Also assume this refers to the CONDITION being present on admission as opposed to the diagnosis. Will require changes to the encoder which is an external product.	This one does refer to the condition being present on admission, for such things as pressure sores, MRSA, Septicaemia. There has been a lot of political agenda relating to this, and more guidance will be issued in the future.  Full details relating to this requirement are outlined in the Human Behavioural Guidance. This includes the national requirement.  It also states that further work needs to be undertaken prior to collection of this information locally and submission within SUS. This states that Providers MUST NOT capture and submit the Present On Admission Indicator until the subset of conditions, coding mappings and detailed guidance have been clinically validated and published.  Initially this item will be captured on an optional basis however the intention is that this will be mandated for a small subset of conditions by the sponsor in the future.
CHFT/THIS		017 -020	General Comment	Could be done but difficult in some areas, whilst ever optional will be little appetite to deliver this - lots of work to make real - do not underestimate size of challenge here, we've linked theatres to PAS records but far from perfect. Would require full reference files of all medics involved. Not sure of accuracy or completeness of TRUD data in these areas.	Noted regards to the burden, at present this will be optional and so no requirement to flow the data.
CHFT/THIS		031	Specific Comment	What is R/D/L/K, and what is Hospital at Home? Would require extra field in PAS.	This has been amended to Respiratory, Renal, Diabetes, Liver and Kidneys to reflect the Department of Health programme.

CHFT/THIS		034 -039	General Comment	Could be done but little validation on our PAS for times recording whilst ever optional will be little appetite to deliver this, although appreciate that really powerful information	Noted and as mentioned the field will be optional in the first instance. So long as the fields are submitted in HH:MM:SS format this will be fine.
CHFT/THIS		045 -	Specific Comment	Assume this is talking about the ward stay details in line 4 of multi line submission in which case should be ok as can have multiple ward stays in an episode.	This should be all ward stays throughout the episode/spell. Would it not go through the schema the same as multiple diagnosis/procedures do within A&E.
CHFT/THIS		048	Specific Comment	Not currently date stamped and might be difficult to collect from patient	This is an optional field. As there is no mandation, it only needs to be collected if there is a local requirement or if it can be readily accessed.
CHFT/THIS		049	Specific Comment	Not currently date stamped and might be difficult to collect from patient	This is an optional field. As there is no mandation, it only needs to be collected if there is a local requirement or if it can be readily accessed.
CHFT/THIS		057	Specific Comment	According to the XML Schema business rules the current business rule for this field is S8 which means that CDSs should already be rejected if this item is missing yet this is not the case as we received data from providers with this item missing. How can we be sure that the change from R to M will actually have any impact on submissions as SUS do not seem to apply the validation criteria correctly to submissions anyway?	Changing the mandation within the XML schema itself will ensure rejection as the XML file is validated against the XSD schema upon submission. This will improve the speed of response to providers.
CHFT/THIS		059	Specific Comment	? 8 doesn't appear to be a valid value in the first place so what is it being removed from?	This code was retired in DSCN 16/2007 (see <a href="http://www.isb.nhs.uk/documents/dscn/dscn2007/162007.pdf">http://www.isb.nhs.uk/documents/dscn/dscn2007/162007.pdf</a> ) – it was left in the schema because historical data containing this code would possibly flow to SUS thereafter (yearly updates etc.).
CHFT/THIS		061	Specific Comment	This should be changed to AN2 not N2 since 00 and 01 etc. are text values - bit of inconsistency in data types across these changes - anything with leading 0s should be a text field	This data element is numeric as it is effectively a number plus the default code [99] Not known.
BT LSP		General		Shouldn't there be an EAL equivalent statement even if only for consistency	EAL equivalent statement: These data set overviews have not changed at CDS 6-2 from CDS 6-0/6-1, and are as approved by ISB. I assume that as there are no exceptions stated, that all ADMINISTRATIVE CATEGORIES are acceptable, but I agree a statement of this would be helpful. The HSCIC were looking at updating the EAL CDS types and this can be picked up as part of that work, when it restarts.
BT LSP		Hospital at home service		What is the purpose, is it a discharge and new spell or continuous. How does hospital at home work, how will these be sent to SUS who is the provider. If there is no change of provider then it might be a new episode but it is not a new spell. This needs to be looked at in a wider context for example can you change consultants when under hospital at home. Could you be admitted elsewhere and still be at hospital at home or on home leave?	This is intended to identify patients that have been discharged from hospital but will receive ongoing intermediate care, usually in their own homes.  This only identifies that the patient has been discharged to a hospital at home service. It does not identify activity that has occurred within a hospital at home service. This activity is not currently within scope of CDS.  Further details will be included in the Human Behavioural, Organisational and Technical Guidance.
BT LSP		ACTIVITY AS RESULT OF ASSAULT INDICATOR		Y/N but why not unknown e.g. if patient is unconscious or does not know.  Why does this not apply to other CDS types as it might be an outpatient as a result of an assault treatment originally or is it only recorded for the first treatment after an assault.	Violent Incident Reporting requirements have now been withdrawn by the Sponsor.  These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.

BT LSP		ADMISSION METHOD		<p>Stick to numbers</p> <p>It might be better not to introduce alpha characters into numeric fields as some databases might need a lot of reformatting so it could be costly. Perhaps use 26,27 and 29 instead and then keep the 28 to include those that would be in 2D or alternatively consider have the baby born at home as 84 to keep them with codes 82 and 83. Or use a completely different number in the Mental Health Data Sets.</p>	<p>Admission Method: note that Admission Method (format n2) is being replaced with Admission Method Code (format an2) at this release - so we are not adding alpha codes into a numeric field. Agree that there may be work at the supplier end to change numeric to alpha, but HES have experienced problems with numeric fields stripping off leading zeroes so we are applying the replacements across the board to fix this and for consistency. These fields should not have been defined as numeric in any case. For the new codes themselves, we wanted to maintain the '2' prefix for emergency admission values. We cannot 'reuse' 28 (as what was in the 'other' category previously is now different to 'other' because the types of 'other' have been split out into 2A, 2B etc.). Normally we would retire 28 but can't do this because it is still in use in CDS 6-2 and MHMDS 4-0. So, we didn't have enough codes left to keep the 2 prefix, without going into alpha second characters.</p>
BT LSP		ASSAULT METHOD		<p>Why description to code 1 given description to code 2.</p> <p>What about using a vehicle e.g. a car? What about other? What about assaulted by more than one method e.g. knife and fist.</p> <p>This list is not exhaustive and not mutually exclusive so is bad set design and it is even acknowledged. Nor is it Guttman scale given the position of patient was pushed.</p> <p>Is this intended to include sexual assault or not.</p>	<p>Violent Incident Reporting requirements have now been withdrawn by the Sponsor.</p> <p>These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.</p>
BT LSP		CONSULTATION MEDIUM USED		<p>The first attendance indicator currently allows for telephone consultation values 3 and 4 this would need to be altered too to avoid conflict. Secondly the list of proposed values is not mutually exclusive or exhaustive. E.g. a person who uses Skype for video but cannot talk and there is no thought to future technology.</p> <p>What is the reason that is important that this data is collected? Is it to determine if the patient is present or the method of communication e.g. Visible for examination or not? However some devices e.g. with diabetes can send feedback to a consultant possibly real time. Communicates orally? Communicates via written language? Uses sign language? An Augmented Aid to Communication (AAC) device? Interpreter? The rational needs to be clear then the classifications can be arrived at so they are useful.</p>	<p>Consultation Medium Used: The rationale for this item is to allow differentiation between telephone and telemedicine contacts (as FIRST ATTENDANCE currently puts those in the same category). This is a PbR request and hence it will be to allow different tariffs for different types of activity. Guidance for what falls into the categories will be given at release of CDS 6-2 (and in PbR guidance, I imagine). Regarding FIRST ATTENDANCE, it would have been better to amend it in line with the values in Consultation Medium Used (or, just as values 'first' and 'follow up', with no split on activity type); however it is still in use in CDS 6-1, and the Payment Grouper will not be amended to use Consultation Medium Used until April 2013. Therefore we are unable to make changes to the item immediately, or users would not be able to use CDS 6-2 until April 13.</p>
BT LSP		CRITICAL CARE DISCHARGE STATUS		<p>Page 215 CRITICAL CARE DISCHARGE STATUS</p>	<p>Critical Care Discharge Status: Noted, but this change was approved by ISB in June 2010 - the new value 11 is added here to allow the CDS-XML schema to flow the approved value</p>
BT LSP		CRITICAL CARE DISCHARGE STATUS		<p>It might be better to have the donor categories as a different field. A patient might not die but still have donated an organ and hence are in critical care.</p>	<p>This is an approved change to the Critical Care Data Set. The only change to CDS is that the approved code will be included in the XML schema to allow it to flow nationally.</p>

BT LSP		DISCHARGED TO HOSPITAL AT HOME SERVICE INDICATOR		It should not be an 'indication' but a statement that a patient was discharged to hospital at home. Clearly prior to discharge this cannot be completed so under those cases for FCEs that are not discharges what if anything should be recorded. Perhaps this should be a different discharge destination or method rather than a new indicator.	Hospital At Home (page 216) - as above - these patients ARE discharged - the FCE doesn't continue.  Inclusion of a new code in existing Discharge Method and Discharge Destination were considered, however it was felt that these changes would contradict NHS business definitions of discharge or result in non-mutually exclusive value lists. As a result a new optional indicator has been included with plans to mandate this in the future.
BT LSP		LENGTH OF STAY ADJUSTMENT.		This should be attached to a ward and defined by ward stays. Asking staff to manually intervene could cause considerable data quality issues and there is no incentive to record it for providers.	Length of Stay Adjustment: This refers to the adjustment to be made to a Consultant Episode - the ward can change during an episode, so hanging this off ward stays would be incorrect. The incentive to record this item is that PbR require it....which is usually a good incentive!
BT LSP		LENGTH OF STAY ADJUSTMENT REASON		Is it possible that there could be two periods for each of the reasons within the same consultant episode? If so does this need to be changed, if the adjustment is attached to the ward then this could be recorded in the data group location group (at ward stay) elements.	Further details are available within the Human Behavioural Guidance.
BT LSP		"NEONATAL LEVEL OF CARE CODE replaces NEONATAL LEVEL OF CARE CODE"		What is the difference?  We were also hoping that there might be some more guidance on the data elements that are changing in A & E and how they will be used in the A & E indicators. Will this be following later?	Neonatal Level of Care Code: this is a mistake - it should read "NEONATAL LEVEL OF CARE CODE replaces NEONATAL LEVEL OF CARE..." (the original data element with numeric format). I will correct this in the final version
CSC	Violent Incident Prevention	Violent Incident Prevention		Violent Incident Prevention - this seems like clinical information and not best suited to data for commissioned services. I thought only a court could determine whether an assault had taken place and hence should be 'alleged assault' Also, determining whether the condition the patient was admitted and treated for was the consequence of another's violent action could be difficult for data capture - a participant in a bar brawl who collapses with chest pain may or may not be considered to be admitted because of an assault (especially if later it is determined they started it).	Violent Incident Reporting requirements have now been withdrawn by the Sponsor.  These remain a key national requirement and the Sponsor is currently seeking alternative implementation mechanisms to support the local capture and sharing with Community Safety Partnerships.
CSC	Clinical Practice	PRESENT ON ADMISSION INDICATOR		PRESENT ON ADMISSION INDICATOR - is there any indication from Clinical Coders how they would expect to support this as much of the burden will lie with them?	Full details relating to this requirement are outlined in the Human Behavioural Guidance. This includes the national requirement.  It also states that further work needs to be undertaken prior to collection of this information locally and submission within SUS. This states that Providers MUST NOT capture and submit the Present On Admission Indicator until the subset of conditions, coding mappings and detailed guidance have been clinically validated and published.  Initially this item will be captured on an optional basis however the intention is that this will be mandated for a small subset of conditions by the sponsor in the future. This will consider how and who should capture the information although this may vary from provider to provider.
CSC	Clinical Practice	PROFESSIONAL REGISTRATION ISSUER CODE		PROFESSIONAL REGISTRATION ISSUER CODE - is this provided in any published reference data? Will it (need to) be validated?	PROFESSIONAL REGISTRATION ISSUER CODE - this currently points to a list in the dictionary which is used within the Workforce data set (just a list of registration issuing bodies, basically) - so no, its not in any downloads that I am aware of. Trusts should be able to get this information from their ESR's when setting up care professionals on their systems.

CSC	AHP RTT	Earliest Clinically Appropriate Date		Earliest Clinically Appropriate Date - will only be required for AHP activity as determined by....? Main Specialty? If so, can we have a definitive list, please?	<p>EARLIEST CLINICALLY APPROPRIATE DATE - the list of AHP's this applies to is shown here <a href="http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/a/allied_health_professional_referral_to_treatment_measurement_de.asp?shownav=1">http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/a/allied_health_professional_referral_to_treatment_measurement_de.asp?shownav=1</a></p> <p>This page was introduced for the Community Information Data Set, but is being updated with the requirements for flowing data in CDS 6-2, in a separate ISN (again, CDS 6-2 is only enabling this standard). 'Dummy' Main Specialty 960 (Allied Health Professional Episode) does cover all these AHP's - but others as well, of course. You may be better using Treatment Function Code if you want to activate this field only in certain circumstances? (unless you have a list of Care Professional Types)</p>
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