NHS Data Model and Dictionary

Type:	Change Request
Reference:	1690
Version No:	1.0
Subject:	Community Services Data Set Version 1.5
Effective Date:	1 April 2020
Reason for Change:	Change to Information Standards
Publication Date:	15 October 2019

Background:

The Community Services Data Set (CSDS) Version 1.0 was approved by the Standardisation Committee for Care (SCCI) as SCCI1069: Community Services Data Set.

A number of changes have been identified since the last version, and the Community Services Data Set Version 1.5 includes:

- Amendments to National Code values and descriptions
- New tables
- New Data Items
- Retirement of Data Items
- The Community Services Data Set will be submitted centrally via the Strategic Data Collection Service in the Cloud (SDCS Cloud) maintained by NHS Digital, using the XML Schema. This replaces the Bureau Service Portal (BSP) that was previously used.
- Changes to Organisation and Organisation Site Code Data Items to reflect changes to organisation reference data maintained and published by the Organisation Data Service, as defined by SCCI0090: Health and Social Care Organisation Reference Data.

To support the Information Standard, this Change Request updates the NHS Data Model and Dictionary to introduce the Community Services Data Set Version 1.5.

To view a demonstration on "How to Read an NHS Data Model and Dictionary Change Request", visit the NHS Data Model and Dictionary help pages at: http://www.datadictionary.nhs.uk/Flash_Files/changerequest.htm.

Note: if the web page does not open, please copy the link and paste into the web browser.

Summary of changes:

Diagrams

COMMUNITY SERVICES DIAGRAM	Changed Diagram

Data Set

COMMUNITY SERVICES DATA SET	Changed Description

Supporting Information

CLINICAL DATA SETS MESSAGE DOCUMENTATION	Changed Description
CLINICAL DATA SETS MESSAGE DOCUMENTATION MENU	Changed Description
COMMUNITY BED-BASED INTERMEDIATE CARE	New Supporting Information
COMMUNITY BED-BASED INTERMEDIATE CARE SERVICE	New Supporting Information
COMMUNITY SERVICES DATA SET OVERVIEW	Changed Description
CRISIS RESPONSE INTERMEDIATE CARE	New Supporting Information
CRISIS RESPONSE INTERMEDIATE CARE SERVICE	New Supporting Information
CRISIS RESPONSE INTERMEDIATE CARE WAITING TIME MEASUREMENT	New Supporting Information
CRISIS RESPONSE INTERMEDIATE CARE WITHIN 2 HOURS WAITING TIME MEASUREMENT	New Supporting Information
HOME-BASED INTERMEDIATE CARE	New Supporting Information
HOME-BASED INTERMEDIATE CARE SERVICE	New Supporting Information
INTERMEDIATE CARE	New Supporting Information
INTERMEDIATE CARE SERVICE	New Supporting Information
OTHER INTERMEDIATE CARE WAITING TIME MEASUREMENT	New Supporting Information
OTHER INTERMEDIATE CARE WITHIN 2 DAYS WAITING TIME MEASUREMENT	New Supporting Information
PERSONALISED CARE AND SUPPORT PLAN	New Supporting Information
REABLEMENT INTERMEDIATE CARE	New Supporting Information
REABLEMENT INTERMEDIATE CARE SERVICE	New Supporting Information
STRATEGIC DATA COLLECTION SERVICE IN THE CLOUD	New Supporting Information
YOUNG PERSONS TRANSITION PLAN	New Supporting Information

Class Definitions

CARE ACTIVITY	Changed Attributes
CARE PLAN	Changed Attributes
PERSON RELATIONSHIP	Changed Attributes
REFERRAL TO TREATMENT PERIOD	Changed Attributes
REPORTING PERIOD	Changed Attributes
SESSION	Changed Attributes

Attribute Definitions

ACCOMMODATION STATUS CODE	Changed Description
ACTIVITY GROUP TYPE	Changed Description
CARE PLAN TYPE FOR COMMUNITY CARE	New Attribute
CARE PROFESSIONAL STAFF GROUP FOR COMMUNITY CARE	Changed Description
CHILDHOOD IMMUNISATION TYPE	Changed Description
COMMUNITY CARE ACTIVITY TYPE renamed from COMMUNITY CARE ACTIVITY TYPE CODE	Changed Name
CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR	Changed Description
DISABILITY IMPACT PERCEPTION	Changed Description
GROUP SESSION TYPE FOR COMMUNITY CARE renamed from GROUP SESSION TYPE CODE FOR COMMUNITY CARE	Changed Name

PARENTAL RESPONSIBILITIES INDICATOR	Changed Description
PERSON AT RISK OF UNEXPECTED DEATH INDICATOR	Changed Description
PREFERRED DEATH LOCATION DISCUSSED INDICATOR	Changed Description
PROFESSIONAL REGISTRATION BODY CODE	Changed Description
REASON FOR REFERRAL TO COMMUNITY CARE	Changed Description
REFERRAL TO TREATMENT PERIOD END TIME	New Attribute
REFERRAL TO TREATMENT PERIOD START DATE	Changed Description
REFERRAL TO TREATMENT PERIOD START TIME	New Attribute
RELATIONSHIP TO PERSON FOR CHILDREN AND YOUNG PEOPLE	Changed Description
RELATIONSHIP TO PERSON FOR COMMUNITY	New Attribute
REPORTING PERIOD END TIME	New Attribute
REPORTING PERIOD START TIME	New Attribute
SERVICE OR TEAM TYPE REFERRED TO FOR COMMUNITY CARE	Changed Description
SERVICE TYPE	Changed Description
SETTLED ACCOMMODATION INDICATOR	Changed Description
WAITING TIME MEASUREMENT TYPE	Changed Description

Data Elements

ASSISTIVE TECHNOLOGY FINDING (SNOMED CT)	Changed Description
CARE PLAN LAST UPDATED DATE	Changed Description
CARE PLAN LAST UPDATED TIME	Changed Description
CARE PLAN TYPE (COMMUNITY CARE)	New Data Element
CHILDHOOD IMMUNISATION TYPE (CHILDREN AND YOUNG PEOPLE'S HEALTH SERVICES)	Changed Description
CHILD PROTECTION PLAN INDICATION CODE	Changed Description
COMMUNITY CARE ACTIVITY TYPE renamed from COMMUNITY CARE ACTIVITY TYPE CODE	Changed Name
GROUP SESSION TYPE (COMMUNITY CARE) renamed from GROUP SESSION TYPE CODE (COMMUNITY CARE)	Changed Name
HEALTH VISITOR FIRST ANTENATAL VISIT DATE	Changed Description
ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT) (RETIRED) renamed from ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT)	Changed status to Retired, linked Attribute, Name, Description
ORGANISATION CODE (GP PRACTICE RESPONSIBILITY) (RETIRED) renamed from ORGANISATION CODE (GP PRACTICE RESPONSIBILITY)	Changed status to Retired, linked Attribute, Name, Description
ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION) (RETIRED) renamed from ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION)	Changed status to Retired, linked Attribute, Name, Description
ORGANISATION IDENTIFIER (EDUCATIONAL ESTABLISHMENT)	Changed Description
ORGANISATION IDENTIFIER (GP PRACTICE RESPONSIBILITY)	Changed Description
ORGANISATION IDENTIFIER (IMMUNISATION RESPONSIBLE ORGANISATION)	Changed Description
PERSON RELATIONSHIP (MAIN CARER)	Changed linked Attribute, Description

REFERRAL TO TREATMENT PERIOD END TIME	New Data Element
REFERRAL TO TREATMENT PERIOD START TIME	New Data Element
SERVICE REQUEST DATE (NEWBORN HEARING AUDIOLOGY)	Changed linked Attribute, Description
WEEKLY HOURS WORKED	Changed Description

XML Schema Constraint

COMMUNITY SERVICES DATA SET CONSTRAINTS	New XML Schema Constraint

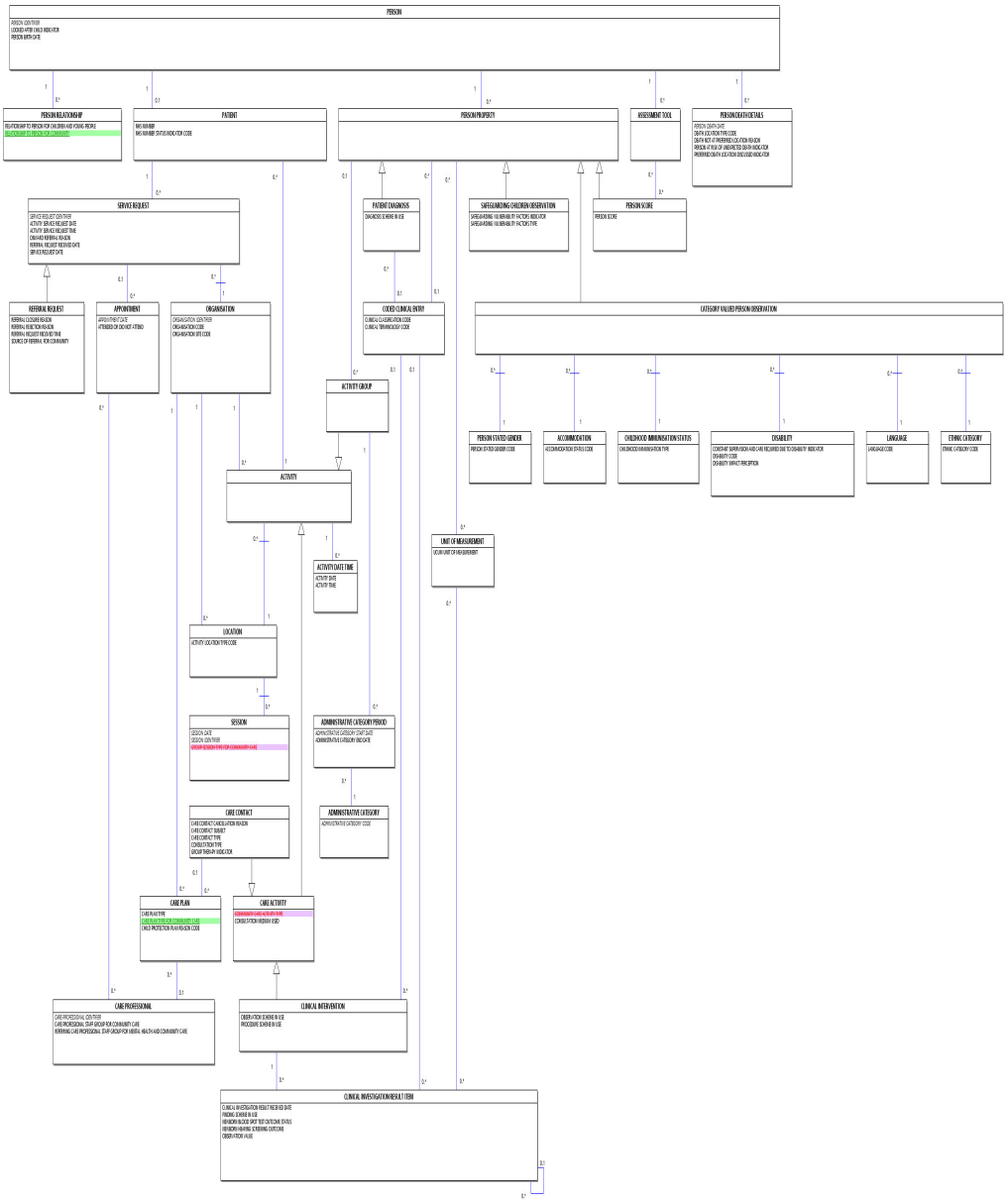
Date: 15 October 2019

Sponsor: Matthew Winn, Chief Executive - Cambridgeshire Community Services NHS Trust, Director Community Health and SRO for Ageing Well - NHS England/Improvement

Note: New text is shown with a blue background. Deleted text is crossed out. Retired text is shown in grey. Within the Diagrams deleted classes and relationships are red, changed items are blue and new items are green.

COMMUNITY SERVICES DIAGRAM

Change to Diagram: Changed Diagram



COMMUNITY SERVICES DATA SET

Change to Data Set: Changed Description

Community Services Data Set Overview

For a "Full Screen" view, click Community Services Data Set.

In the "Full Screen" view, to return to the "Data Set" view, click the browser "back" button.

The Mandatory, Required or Optional (M/R/O) column indicates the recommendation for the inclusion of data.

- M = Mandatory: this data element is mandatory and the technical process (e.g. submission of the data set, production of output etc) cannot be completed without this data element being present
- R = Required: NHS business processes cannot be delivered without this data element
- O = Optional: the inclusion of this data element is optional as required for local purposes.

For guidance on the Data Set constraints, see the Community Services Data Set Constraints.

For guidance on downloading the XML Schema, see XML Schema TRUD Download.

SUBMISSION IDENTIFIER

M/R/O	Data Set Data Elements
M	DATA SET VERSION NUMBER
~~M~~	~~ORGANISATION CODE (CODE OF PROVIDER)~~
~~M~~	~~ORGANISATION CODE (CODE OF SUBMITTING ORGANISATION)~~
M	ORGANISATION IDENTIFIER (CODE OF PROVIDER)
M	ORGANISATION IDENTIFIER (CODE OF SUBMITTING ORGANISATION)
M	PRIMARY DATA COLLECTION SYSTEM IN USE
M	REPORTING PERIOD START DATE
M	REPORTING PERIOD END DATE
M	DATE AND TIME DATA SET CREATED

PATIENT DEMOGRAPHICS

~~Master Patient Index and Risk Indicators:~~ ~~To carry the personal details of the person and the associated mother's NHS number (where applicable).~~ ~~One occurrence of this group is required.~~
Master Patient Index and Risk Indicators: **To carry the personal details of the patient and the associated mother's NHS number (where applicable).** **One occurrence of this group is required for each patient.**

M/R/O	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
~~M~~	~~ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)~~
~~R~~	~~ORGANISATION CODE (RESIDENCE RESPONSIBILITY)~~
~~R~~	~~ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT)~~
M	ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)
R	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)
R	ORGANISATION IDENTIFIER (EDUCATIONAL ESTABLISHMENT)
R	NHS NUMBER
R	NHS NUMBER STATUS INDICATOR CODE
R	PERSON BIRTH DATE
R	POSTCODE OF USUAL ADDRESS
R	PERSON STATED GENDER CODE
R	ETHNIC CATEGORY
R	LANGUAGE CODE (PREFERRED)
R	PERSON RELATIONSHIP (MAIN CARER)

R	HEALTH VISITOR FIRST ANTENATAL VISIT DATE
R	LOOKED AFTER CHILD INDICATOR
R	SAFEGUARDING VULNERABILITY FACTORS INDICATOR
R	CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR
R	EDUCATIONAL ASSESSMENT OUTCOME
R	PREFERRED DEATH LOCATION DISCUSSED INDICATOR
R	PERSON AT RISK OF UNEXPECTED DEATH INDICATOR
R	DEATH LOCATION TYPE CODE (PREFERRED)
R	PERSON DEATH DATE
R	DEATH LOCATION TYPE CODE (ACTUAL)
R	DEATH NOT AT PREFERRED LOCATION REASON
R	NHS NUMBER (MOTHER)
R	NHS NUMBER STATUS INDICATOR CODE (MOTHER)

~~**GP Practice Registration:**~~
~~**To carry details of the GP Practice Registration of the person.**~~
~~**One occurrence of this group is required.**~~

GP Practice Registration:
To carry details of the GP Practice Registration of the patient.
One occurrence of this group is required for each change of GP Practice Registration.

M/R/O	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)
R	START DATE (GMP PATIENT REGISTRATION)
R	END DATE (GMP PATIENT REGISTRATION)
~~R~~	~~ORGANISATION CODE (GP PRACTICE RESPONSIBILITY)~~
R	ORGANISATION IDENTIFIER (GP PRACTICE RESPONSIBILITY)

~~**Accommodation Type:**~~
~~**To carry details of the type of accommodation for the person.**~~
~~**One occurrence of this group is permitted when accommodation details are recorded.**~~

Accommodation Type:
To carry details of the type of accommodation for the patient.
One occurrence of this group is permitted for each accommodation status.

M/R/O	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	ACCOMMODATION STATUS CODE
R	ACCOMMODATION STATUS RECORDED DATE

Care Plan Type:
To carry details of Care Plans created for a patient by the organisation.
One occurrence of this group is permitted for each Care Plan created for the patient.

M/R/O	Data Set Data Elements
M	CARE PLAN IDENTIFIER
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	CARE PLAN TYPE (COMMUNITY CARE)
M	CARE PLAN CREATION DATE

R	CARE PLAN CREATION TIME
R	CARE PLAN LAST UPDATED DATE
R	CARE PLAN LAST UPDATED TIME
R	CARE PLAN IMPLEMENTATION DATE

Care Plan Agreement:
To carry details of any agreements to a Care Plan by a patient, team or organisation.
One occurrence of this group is permitted for each agreement of a Care Plan.

M/R/O	Data Set Data Elements
M	CARE PLAN IDENTIFIER
M	CARE PLAN AGREED BY
R	CARE PLAN AGREED DATE
R	CARE PLAN AGREED TIME

Social and Personal Circumstances:
To carry details of social and personal circumstances of a patient.
One occurrence of this group is permitted for each social and personal circumstance recorded.

M/R/O	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT)
M	SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED DATE

Employment Status:
To carry details of the employment status of the patient.
One occurrence of this group is permitted for each employment status.

M/R/O	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	EMPLOYMENT STATUS
R	EMPLOYMENT STATUS RECORDED DATE
R	WEEKLY HOURS WORKED

REFERRALS

~~**Service or Team Referral:**~~
~~**To carry details of the Service or Team referral that the person is subject to.**~~
~~**One occurrence of this group is permitted for each referral.**~~

Service or Team Referral:
To carry details of the Service or Team referral that the patient is subject to.
One occurrence of this group is permitted for each referral.

M/R/O	Data Set Data Elements
M	SERVICE REQUEST IDENTIFIER
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
~~M~~	~~ORGANISATION CODE (CODE OF COMMISSIONER)~~
M	ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)
M	REFERRAL REQUEST RECEIVED DATE
R	REFERRAL REQUEST RECEIVED TIME
O	NHS SERVICE AGREEMENT LINE NUMBER
R	SOURCE OF REFERRAL FOR COMMUNITY

~~R~~	~~REFERRING ORGANISATION CODE~~
R	ORGANISATION IDENTIFIER (REFERRING)
R	REFERRING CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH AND COMMUNITY CARE)
R	PRIORITY TYPE CODE
R	PRIMARY REASON FOR REFERRAL (COMMUNITY CARE)
R	SERVICE DISCHARGE DATE
R	DISCHARGE LETTER ISSUED DATE (MENTAL HEALTH AND COMMUNITY CARE)

~~**Service or Team Type Referred To:**~~
~~**To carry details of the Service or Team that the person has been referred to.**~~
~~**One occurrence of this group is permitted for each service or team that a person has been referred to.**~~

Service or Team Type Referred To:
To carry details of the Service or Team that the patient has been referred to.
One occurrence of this group is permitted for each service or team that a patient has been referred to.

M/R/O	Data Set Data Elements
M	SERVICE REQUEST IDENTIFIER
R	CARE PROFESSIONAL TEAM LOCAL IDENTIFIER
M	SERVICE OR TEAM TYPE REFERRED TO (COMMUNITY CARE)
R	REFERRAL CLOSURE DATE
R	REFERRAL REJECTION DATE
R	REFERRAL CLOSURE REASON
R	REFERRAL REJECTION REASON

~~**Other Reason for Referral:**~~
~~**To carry details of additional reasons why a person has been referred to a specific service.**~~
~~**One occurrence of this group is permitted for each additional referral reason.**~~

Other Reason for Referral:
To carry details of additional reasons why a patient has been referred to a specific service.
One occurrence of this group is permitted for each additional referral reason.

M/R/O	Data Set Data Elements
M	SERVICE REQUEST IDENTIFIER
M	OTHER REASON FOR REFERRAL (COMMUNITY CARE)

~~**Referral To Treatment (RTT):**~~
~~**To carry Referral to Treatment details for the person's referral.**~~
~~**One occurrence of this group is permitted for Referral to Treatment activity.**~~

Referral To Treatment (RTT):
To carry Referral to Treatment details for the patient referral.
One occurrence of this group is permitted for each change in Referral To Treatment Period Status.

M/R/O	Data Set Data Elements
M	SERVICE REQUEST IDENTIFIER
R	UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)
R	PATIENT PATHWAY IDENTIFIER
~~R~~	~~ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)~~
R	ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)
R	WAITING TIME MEASUREMENT TYPE
R	REFERRAL TO TREATMENT PERIOD START DATE
R	REFERRAL TO TREATMENT PERIOD START TIME

R	REFERRAL TO TREATMENT PERIOD END DATE
R	REFERRAL TO TREATMENT PERIOD END TIME
R	REFERRAL TO TREATMENT PERIOD STATUS

~~Onward Referral:~~ ~~To carry details of any onward referral of the person which has taken place.~~ ~~One occurrence of this group is permitted where an onward referral has taken place.~~	
Onward Referral: **To carry details of any onward referral of the patient which has taken place.** **One occurrence of this group is permitted for each onward referral.**	
M/R/O	**Data Set Data Elements**
M	SERVICE REQUEST IDENTIFIER
M	ONWARD REFERRAL DATE
R	ONWARD REFERRAL REASON
~~R~~	~~ORGANISATION CODE (RECEIVING)~~
R	ORGANISATION IDENTIFIER (RECEIVING)

CARE CONTACT AND ACTIVITIES

~~Care Contact:~~ ~~To carry details of any contacts with a person which have taken place as part of a referral.~~ ~~One occurrence of this group is permitted for each contact.~~	
Care Contact: **To carry details of any contacts with a patient which have taken place as result of a referral.** **One occurrence of this group is permitted for each Care Contact.**	
M/R/O	**Data Set Data Elements**
M	CARE CONTACT IDENTIFIER
M	SERVICE REQUEST IDENTIFIER
R	CARE PROFESSIONAL TEAM LOCAL IDENTIFIER
M	CARE CONTACT DATE
R	CARE CONTACT TIME
~~R~~	~~ORGANISATION CODE (CODE OF COMMISSIONER)~~
R	ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)
R	ADMINISTRATIVE CATEGORY CODE
R	CLINICAL CONTACT DURATION OF CARE CONTACT
R	CONSULTATION TYPE
R	CARE CONTACT SUBJECT
R	CONSULTATION MEDIUM USED
R	ACTIVITY LOCATION TYPE CODE
~~R~~	~~SITE CODE (OF TREATMENT)~~
R	ORGANISATION SITE IDENTIFIER (OF TREATMENT)
R	GROUP THERAPY INDICATOR
R	ATTENDED OR DID NOT ATTEND CODE
R	EARLIEST REASONABLE OFFER DATE
R	EARLIEST CLINICALLY APPROPRIATE DATE
R	CARE CONTACT CANCELLATION DATE
R	CARE CONTACT CANCELLATION REASON

R	REPLACEMENT APPOINTMENT DATE OFFERED
R	REPLACEMENT APPOINTMENT BOOKED DATE

~~Care Activity:~~ ~~To carry details of any activities which have taken place as part of a contact with a person.~~ ~~One occurrence of this group is permitted for each activity.~~	
Care Activity: **To carry details of any activities which have taken place as part of a contact with a patient.** **One occurrence of this group is permitted for each Care Activity.**	
M/R/O	**Data Set Data Elements**
M	CARE ACTIVITY IDENTIFIER
M	CARE CONTACT IDENTIFIER
~~M~~	~~COMMUNITY CARE ACTIVITY TYPE CODE~~
M	COMMUNITY CARE ACTIVITY TYPE
R	CARE PROFESSIONAL LOCAL IDENTIFIER
R	CLINICAL CONTACT DURATION OF CARE ACTIVITY
R	PROCEDURE SCHEME IN USE
R	CODED PROCEDURE (CLINICAL TERMINOLOGY)
R	FINDING SCHEME IN USE
R	CODED FINDING (CODED CLINICAL ENTRY)
R	OBSERVATION SCHEME IN USE
R	CODED OBSERVATION (CLINICAL TERMINOLOGY)
R	OBSERVATION VALUE
R	UCUM UNIT OF MEASUREMENT

GROUP SESSIONS	
~~Group Session:~~ ~~To carry details of any group sessions which have been provided to a group of people during the reporting period.~~ ~~One occurrence of this group is permitted where group session activity has taken place.~~	
Group Session: **To carry details of any group sessions which have been provided to a group of people during the reporting period.** **One occurrence of this group is permitted for each Group Session activity.**	
M/R/O	**Data Set Data Elements**
M	GROUP SESSION IDENTIFIER
M	GROUP SESSION DATE
~~M~~	~~ORGANISATION CODE (CODE OF COMMISSIONER)~~
M	ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)
R	CLINICAL CONTACT DURATION OF GROUP SESSION
~~R~~	~~GROUP SESSION TYPE CODE (COMMUNITY CARE)~~
R	GROUP SESSION TYPE (COMMUNITY CARE)
R	NUMBER OF GROUP SESSION PARTICIPANTS
O	ACTIVITY LOCATION TYPE CODE
~~R~~	~~SITE CODE (OF TREATMENT)~~
R	ORGANISATION SITE IDENTIFIER (OF TREATMENT)

R	CARE PROFESSIONAL LOCAL IDENTIFIER
O	NHS SERVICE AGREEMENT LINE NUMBER

SOCIAL CIRCUMSTANCES

Special Educational Need Identified:
To carry details of the child's or young person's Special Educational Need.
One occurrence of this group is permitted for each Special Educational Need identified.

M/R/O	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	SPECIAL EDUCATIONAL NEED TYPE

Safeguarding Vulnerability Factor:
To carry details when the child's or young person is subject to any safeguarding concerns.
One occurrence of this group is permitted for each safeguarding concern.

M/R/O	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	SAFEGUARDING VULNERABILITY FACTORS TYPE

Child Protection Plan:
To carry details when the child or young person is subject to a child protection plan.
One occurrence of this group is permitted for each child protection plan.

M/R/O	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	CHILD PROTECTION PLAN REASON CODE
M	CHILD PROTECTION PLAN START DATE
R	CHILD PROTECTION PLAN END DATE

Assistive Technology to Support Disability Type:
To carry details when assistive technology is used to help support a disabled child or young person.
One occurrence of this group is permitted for each assistive technology type.

M/R/O	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	ASSISTIVE TECHNOLOGY FINDING (SNOMED CT)
R	PRESCRIPTION DATE (ASSISTIVE TECHNOLOGY)

IMMUNISATIONS

~~**Coded Immunisation:**~~
~~**To carry details of coded immunisation activity for a child or young person.**~~
~~**One occurrence of this group is permitted for each coded immunisation activity.**~~

Coded Immunisation:
To carry details of coded immunisation activity for a patient.
One occurrence of this group is permitted for each coded immunisation activity.

M/R/O	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	IMMUNISATION DATE
M	PROCEDURE SCHEME IN USE
M	IMMUNISATION PROCEDURE (CLINICAL TERMINOLOGY)
~~R~~	~~ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION)~~

R	ORGANISATION IDENTIFIER (IMMUNISATION RESPONSIBLE ORGANISATION)

Immunisation:
To carry details of immunisation activity for a child or young person.
One occurrence of this group is permitted for each immunisation activity.

M/R/O	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	IMMUNISATION DATE
M	CHILDHOOD IMMUNISATION TYPE (CHILDREN AND YOUNG PEOPLE'S HEALTH SERVICES)
~~R~~	~~ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION)~~
R	ORGANISATION IDENTIFIER (IMMUNISATION RESPONSIBLE ORGANISATION)

DIAGNOSES, TESTS AND OBSERVATIONS

~~**Medical History (Previous Diagnosis):**~~
~~**To carry details of any previous diagnoses for a person, which are stated by the patient or patient proxy or recorded in medical notes.**~~
~~**These do not have to have been diagnosed by the organisation submitting the data.**~~
~~**One occurrence of this group is permitted for each previous diagnosis.**~~

Medical History (Previous Diagnosis):
To carry details of any previous diagnoses for a patient, which are stated by the patient or patient proxy or recorded in medical notes.
These do not have to have been diagnosed by the organisation submitting the data.
One occurrence of this group is permitted for each previous diagnosis.

M/R/O	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	DIAGNOSIS SCHEME IN USE
M	PREVIOUS DIAGNOSIS (CODED CLINICAL ENTRY)
R	DIAGNOSIS DATE

~~**Disability Type:**~~
~~**To carry details of the type of disability affecting a person, based on their perception or the perception of a patient proxy.**~~
~~**One occurrence of this group is permitted for each disability identified.**~~

Disability Type:
To carry details of the type of disability affecting a patient, based on their perception or the perception of a patient proxy.
One occurrence of this group is permitted for each disability identified.

M/R/O	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	DISABILITY CODE
R	DISABILITY IMPACT PERCEPTION

~~**Newborn Hearing Screening Audiology Referral:**~~
~~**To carry details of how concerns following Newborn Hearing Screening are followed up.**~~
~~**One occurrence of this group is permitted if concerns are identified.**~~

Newborn Hearing Screening Audiology Referral:
To carry details of how concerns following Newborn Hearing Screening are followed up.
One occurrence of this group is permitted for each newborn hearing audiology test.

M/R/O	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
R	NEWBORN HEARING SCREENING OUTCOME
R	SERVICE REQUEST DATE (NEWBORN HEARING AUDIOLOGY)

R	PROCEDURE DATE (NEWBORN HEARING AUDIOLOGY)
R	NEWBORN HEARING AUDIOLOGY OUTCOME

~~**Blood Spot Result:**~~
~~**To carry details of the results of newborn blood spot tests.**~~
~~**One occurrence of this group is permitted where blood spot results are available.**~~

Blood Spot Result:
To carry details of the results of newborn blood spot tests.
One occurrence of this group is permitted for each newborn blood spot test.

M/R/O	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
R	BLOOD SPOT CARD COMPLETION DATE
R	NEWBORN BLOOD SPOT TEST RESULT RECEIVED DATE
R	NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (PHENYLKETONURIA)
R	NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (SICKLE CELL DISEASE)
R	NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (CYSTIC FIBROSIS)
R	NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (CONGENITAL HYPOTHYROIDISM)
R	NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (MEDIUM CHAIN ACYL-COA DEHYDROGENASE DEFICIENCY)
R	NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (HOMOCYSTINURIA)
R	NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (MAPLE SYRUP URINE DISEASE)
R	NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (GLUTARIC ACIDURIA TYPE 1)
R	NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (ISOVALERIC ACIDURIA)

~~**Infant Physical Examination (General Medical Practitioner Delivered):**~~
~~**To carry details of the Infant Physical Examination carried out by the General Medical Practitioner.**~~
~~**One occurrence of this group is permitted when an Infant Physical Examination has taken place.**~~

Infant Physical Examination (General Medical Practitioner Delivered):
To carry details of the Infant Physical Examination carried out by the General Medical Practitioner.
One occurrence of this group is permitted for each Infant Physical Examination.

M/R/O	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	INFANT PHYSICAL EXAMINATION DATE
R	INFANT PHYSICAL EXAMINATION RESULT (HIPS)
R	INFANT PHYSICAL EXAMINATION RESULT (HEART)
R	INFANT PHYSICAL EXAMINATION RESULT (EYES)
R	INFANT PHYSICAL EXAMINATION RESULT (TESTES)

~~**Provisional Diagnosis:**~~
~~**To carry details of a provisional diagnosis for a person made by the service that the patient was referred to.**~~
~~**One occurrence of this group is permitted for each provisional diagnosis.**~~

Provisional Diagnosis:
To carry details of a provisional diagnosis for a patient made by the service that the patient was referred to.
One occurrence of this group is permitted for each provisional diagnosis.

M/R/O	Data Set Data Elements
M	SERVICE REQUEST IDENTIFIER
M	DIAGNOSIS SCHEME IN USE

M	PROVISIONAL DIAGNOSIS (CODED CLINICAL ENTRY)
R	PROVISIONAL DIAGNOSIS DATE

~~**Primary Diagnosis:**~~
~~**To carry details of the primary diagnosis for a person made by the service that the patient was referred to.**~~
~~**One occurrence of this group is permitted for the primary diagnosis. This can change during a reporting period.**~~

Primary Diagnosis:
To carry details of the primary diagnosis for a patient made by the service that the patient was referred to.
One occurrence of this group is permitted for the primary diagnosis. The primary diagnosis can change during a reporting period.

M/R/O	Data Set Data Elements
M	SERVICE REQUEST IDENTIFIER
M	DIAGNOSIS SCHEME IN USE
M	PRIMARY DIAGNOSIS (CODED CLINICAL ENTRY)
R	DIAGNOSIS DATE

~~**Secondary Diagnosis:**~~
~~**To carry details of a secondary diagnosis for a person made by the service that the patient was referred to.**~~
~~**One occurrence of this group is permitted for each secondary diagnosis.**~~

Secondary Diagnosis:
To carry details of a secondary diagnosis for a patient made by the service that the patient was referred to.
One occurrence of this group is permitted for each secondary diagnosis.

M/R/O	Data Set Data Elements
M	SERVICE REQUEST IDENTIFIER
M	DIAGNOSIS SCHEME IN USE
M	SECONDARY DIAGNOSIS (CODED CLINICAL ENTRY)
R	DIAGNOSIS DATE

Coded Scored Assessment (Referral):
To carry details of scored assessments that are issued and completed as part of a referral period where a specific service or team is responsible for the patient, but do not take place at a specific contact.
One occurrence of this group is permitted for each coded scored assessment question or dimension captured outside of a contact.

M/R/O	Data Set Data Elements
M	SERVICE REQUEST IDENTIFIER
M	CODED ASSESSMENT TOOL TYPE (SNOMED CT)
M	PERSON SCORE
R	ASSESSMENT TOOL COMPLETION DATE

~~**Breastfeeding Status:**~~
~~**To carry the child's breastfeeding details as recorded at a contact.**~~
~~**One occurrence of this group is permitted when observed.**~~

Breastfeeding Status:
To carry details of a child's breastfeeding status as recorded at a contact.
One occurrence of this group is permitted containing the most recently recorded breastfeeding status.

M/R/O	Data Set Data Elements
M	CARE ACTIVITY IDENTIFIER
M	BREASTFEEDING STATUS

~~**Observation:**~~
~~**To carry details of observations of a person which take place at a contact.**~~
~~**One occurrence of this group is permitted when an observation is recorded.**~~

Observation:
To carry details of observations of a patient which take place at a contact.
One occurrence of this group is permitted containing the most recently recorded observation(s).

M/R/O	Data Set Data Elements
M	CARE ACTIVITY IDENTIFIER
R	PERSON WEIGHT
R	PERSON HEIGHT IN METRES
R	PERSON LENGTH IN CENTIMETRES

Coded Scored Assessment (Contact):
To carry details of scored assessments that are issued and completed as part of a specific contact.
One occurrence of this group is permitted for each coded scored assessment question or dimension.

M/R/O	Data Set Data Elements
M	CARE ACTIVITY IDENTIFIER
M	CODED ASSESSMENT TOOL TYPE (SNOMED CT)
M	PERSON SCORE

ANONYMOUS SELF-ASSESSMENT

Anonymous Self-Assessment:
To carry details of anonymous assessments that are issued by the Community Health Service.
One occurrence of this group is permitted when an anonymous self-assessment is received from a patient.

M/R/O	Data Set Data Elements
M	ASSESSMENT TOOL COMPLETION DATE
M	CODED ASSESSMENT TOOL TYPE (SNOMED CT)
M	PERSON SCORE
R	ACTIVITY LOCATION TYPE CODE
~~R~~	~~ORGANISATION CODE (CODE OF COMMISSIONER)~~
R	ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)

STAFF DETAILS

~~**Staff Details:**~~
~~**To carry details of the staff involved in the treatment of a person.**~~
~~**One occurrence of this group is permitted for each staff member.**~~

Staff Details:
To carry details of the staff involved in the treatment of a patient.
One occurrence of this group is permitted for each staff member.

M/R/O	Data Set Data Elements
M	CARE PROFESSIONAL LOCAL IDENTIFIER
R	PROFESSIONAL REGISTRATION BODY CODE
R	PROFESSIONAL REGISTRATION ENTRY IDENTIFIER
R	CARE PROFESSIONAL STAFF GROUP (COMMUNITY CARE)
R	OCCUPATION CODE
R	CARE PROFESSIONAL (JOB ROLE CODE)

Change to Supporting Information: Changed Description

XML Schema Download:

- XML Schema TRUD Download

XML Schema Constraints:

- Cancer Outcomes and Services Data Set XML Schema Constraints
- Diagnostic Imaging Data Set XML Schema Constraints
- HIV and AIDS Reporting Data Set XML Schema Constraints

Data Set Constraints:

- Community Services Data Set Constraints
- Maternity Services Data Set Constraints
- Mental Health Services Data Set Constraints

CLINICAL DATA SETS MESSAGE DOCUMENTATION MENU

Change to Supporting Information: Changed Description

Clinical Data Sets Menu

XML Schema Download:

- XML Schema TRUD Download

XML Schema Constraints:

- Cancer Outcomes and Services
- Diagnostic Imaging
- HIV and AIDS

Data Set Constraints:

- Community Services
- Maternity Services
- Mental Health Services

COMMUNITY BED-BASED INTERMEDIATE CARE

Change to Supporting Information: New Supporting Information

Community Bed-based Intermediate Care is an ACTIVITY GROUP.

Community Bed-based Intermediate Care provides assessments and CLINICAL INTERVENTIONS to PATIENTS in a bed-based setting, such as a community-commissioned Hospital Bed in an acute hospital, community hospital, residential Care Home, Care Home With Nursing, stand-alone Community Bed-based Intermediate Care facility, Independent Sector Healthcare Provider facility, Local Authority facility or other bed-based setting.

Community Bed-based Intermediate Care aims to prevent unnecessary admissions to acute hospitals and premature admissions to long-term care, and to support timely discharge from hospital. For most PATIENTS, CLINICAL INTERVENTIONS last up to 6 weeks.

Community Bed-based Intermediate Care should be delivered within two days of being referred to the Community Bed-based Intermediate Care Service.

- Step up Community Bed-based Intermediate Care:
  - provides care (in a bed-based setting) to help avoid unnecessary hospital admission for PATIENTS who following assessment are at risk of admission to hospital
  - includes PATIENTS who may be in their last years or months of life but are not in their last days of life

- Step down Community Bed-based Intermediate Care:
  - provides care to PATIENTS (in a bed-based setting) following an admission to hospital and who are determined by a "medically optimised for discharge" decision making process to be no longer in need of hospital care
  - includes PATIENTS who may be in their last years or months of life but are not in their last days of life.

For further information on Community Bed-based Intermediate Care, see the:

- age.uk website at: What is intermediate care?
- National Institute for Health and Care Excellence (NICE) website at: Intermediate care including reablement: NICE guideline [NG74].

COMMUNITY BED-BASED INTERMEDIATE CARE SERVICE

Change to Supporting Information: New Supporting Information

A Community Bed-based Intermediate Care Service is a SERVICE.

A Community Bed-based Intermediate Care Service provides Community Bed-based Intermediate Care to PATIENTS.

A Community Bed-based Intermediate Care Service is usually delivered by a Multidisciplinary Team but most commonly by CARE PROFESSIONALS, such as NURSES, Allied Health Professionals or Care Workers (in Care Homes).

This supporting information is also known by these names:

Context	Alias
plural	Community Bed-based Intermediate Care Services

COMMUNITY SERVICES DATA SET OVERVIEW

Change to Supporting Information: Changed Description

Contextual Overview

The Community Services Data Set (CSDS) is a PATIENT level, output based, secondary uses data set which will deliver robust, comprehensive, nationally consistent and comparable person-centred

information for people who are in contact with NHS-funded Community Health Services. As a secondary uses data set it intends to re-use clinical and operational data for purposes other than direct PATIENT care. It defines the data items, definitions and associated value sets to be extracted or derived from local systems.

The data collected in the Community Services Data Set covers all NHS-funded Community Health Services provided by Health Care Providers in England. This includes all SERVICES listed in the SERVICE OR TEAM TYPE REFERRED TO FOR COMMUNITY CARE within the Community Services Data Set, including any SERVICES that have transitioned into new organisational forms as a result of the Transforming Community Services (TCS) programme. This includes acute and Independent Sector Healthcare Providers that provide NHS-funded Community Health Services.

The Community Services Data Set is used by the Department of Health and Social Care, commissioners and Health Care Providers of Community Health Services and PATIENTS, as the data set provides:

- National, comparable, standardised data about Community Health Services that are being delivered, which will support intelligent commissioning decisions and SERVICE provision
- Information on the use of resources to improve the operational management of SERVICES
- Information on outcomes, to help to address health inequalities
- Support for current national outcome indicators for Community Health Services
- Traceability and visibility of Community Health Service expenditure, allowing the implementation of new payment approaches for Community Health Services through the development of defined currencies which are underpinned by consistent data
- Information to improve reference costs for Community Health Services, to ensure that these are reported consistently
- Support for a nationally consistent clinical record for all PATIENTS across England, which can be used to support national research projects
- Information for the future development of Community Health Services.

Data Collection

~~The Community Services Data Set provides the definitions for data:~~The Community Services Data Set provides the definitions for data to provide timely, pseudonymised PATIENT-based data and information for purposes other than direct clinical care, e.g. planning, commissioning, public health, clinical audit, performance improvement, research, clinical governance.

- ~~To be lodged in the data warehouse regularly and routinely~~
- ~~To be assembled, compiled and to flow into a secondary uses data warehouse~~
- ~~To provide timely, pseudonymised PATIENT-based data and information for purposes other than direct clinical care, e.g. planning, commissioning, public health, clinical audit, performance improvement, research, clinical governance.~~

Data is expected to be collected from various clinical systems, collated and assembled. This standard is intended to facilitate electronic data recording and reporting but it is not intended to create clinical records for Community Health Services or to enable systems used by Community Health Services to interoperate with other clinical systems.

Submission Information

~~The Community Services Data Set is submitted to NHS Digital using the Community Services Data Set (CSDS) XML Schema.~~The Community Services Data Set is submitted via the Strategic Data

Collection Service in the Cloud (SDCS Cloud) maintained by NHS Digital using the Community Services Data Set (CSDS) XML Schema.

Format Information

Data for submission will be formatted into an XML file as per the Technology Reference Data Update Distribution (TRUD) page at: NHS Data Model and Dictionary: DD XML Schemas.

For enquiries regarding the XML Schema, please contact NHS Digital at enquiries@nhsdigital.nhs.uk.

Further Guidance

~~Further information and implementation guidance has been produced by NHS Digital and is available at: Community Services Data Set.~~Further information and implementation guidance has been produced by NHS Digital and is available at:

- Community Services Data Set
- Community Services Data Set user guidance.

CRISIS RESPONSE INTERMEDIATE CARE

Change to Supporting Information: New Supporting Information

Crisis Response Intermediate Care is an ACTIVITY GROUP.

Crisis Response Intermediate Care supports a PATIENT with identified care needs to remain at home when they are at risk of an unplanned hospital admission if unsupported.

Crisis Response Intermediate Care usually involves an assessment and may provide short-term CLINICAL INTERVENTIONS (typically up to 48 hours) if there is an urgent increase in the PATIENT's needs that can be safely managed at home. This includes care in the last days of life.

For further information on Crisis Response Intermediate Care, see the:

- age.uk website at: Crisis response
- National Institute for Health and Care Excellence (NICE) website at: Intermediate care including reablement: NICE guideline [NG74].

CRISIS RESPONSE INTERMEDIATE CARE SERVICE

Change to Supporting Information: New Supporting Information

A Crisis Response Intermediate Care Service is a SERVICE.

A Crisis Response Intermediate Care Service is a community-based SERVICE provided to PATIENTS in their own home or a Care Home within 2 hours of the need for Crisis Response Intermediate Care being identified.

The Crisis Response Intermediate Care Service is delivered by CARE PROFESSIONALS within a community-based Multidisciplinary Team. The Multidisciplinary Team could include: a community NURSE, Physiotherapist, Occupational Therapist, older PEOPLE's mental health NURSE, social care professional, for example, either a Social Worker or community care officer. Other therapy disciplines could work across their own specialist teams to support the Crisis Response Intermediate Care Service, for example, Dietitian, Speech and Language Therapist, Podiatrist.

This supporting information is also known by these names:

Context	Alias
plural	Crisis Response Intermediate Care Services

CRISIS RESPONSE INTERMEDIATE CARE WAITING TIME MEASUREMENT

Change to Supporting Information: New Supporting Information

A Crisis Response Intermediate Care Waiting Time Measurement is a REFERRAL TO TREATMENT PERIOD.

The Crisis Response Intermediate Care Waiting Time Measurement:

- is the duration between the REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD START TIME and REFERRAL TO TREATMENT PERIOD END DATE and REFERRAL TO TREATMENT PERIOD END TIME
- allows monitoring of waiting times for PATIENTS that are deemed not clinically appropriate for the Crisis Response Intermediate Care Within 2 Hours Waiting Time Measurement.

The Crisis Response Intermediate Care Waiting Time Measurement:

- REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD START TIME:
    - The PATIENT is identified by a CARE PROFESSIONAL or Social Care Worker as needing support from a Crisis Response Intermediate Care Service (in a community or Urgent Emergency Care (UEC) setting).
- REFERRAL TO TREATMENT PERIOD END DATE and REFERRAL TO TREATMENT PERIOD END TIME:
    - The CARE CONTACT DATE and CARE CONTACT TIME of the first face-to-face contact between the PATIENT, CARE PROFESSIONAL and Social Care Worker from the Crisis Response Intermediate Care Service.

This supporting information is also known by these names:

Context	Alias
plural	Crisis Response Intermediate Care Waiting Time Measurements

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CRISIS RESPONSE INTERMEDIATE CARE WITHIN 2 HOURS WAITING TIME MEASUREMENT

Change to Supporting Information: New Supporting Information

A Crisis Response Intermediate Care Within 2 Hours Waiting Time Measurement is a REFERRAL TO TREATMENT PERIOD.

A Crisis Response Intermediate Care Within 2 Hours Waiting Time Measurement is measured to ensure there are 120 minutes or less between the REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD START TIME and REFERRAL TO TREATMENT PERIOD END DATE and REFERRAL TO TREATMENT PERIOD END TIME.

The Crisis Response Intermediate Care Within 2 Hours Waiting Time Measurement:

- REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD START TIME:
    - The PATIENT is identified by a CARE PROFESSIONAL or Social Care Worker as needing support from a Crisis Response Intermediate Care Service.
- REFERRAL TO TREATMENT PERIOD END DATE and REFERRAL TO TREATMENT PERIOD END TIME:
    - The CARE CONTACT DATE and CARE CONTACT TIME of the first face-to-face contact between the PATIENT, CARE PROFESSIONAL and Social Care Worker from the Crisis Response Intermediate Care Service.

This supporting information is also known by these names:

Context	Alias
plural	Crisis Response Intermediate Care Within 2 Hours Waiting Time Measurements

HOME-BASED INTERMEDIATE CARE

Change to Supporting Information: New Supporting Information

Home-based Intermediate Care is an ACTIVITY GROUP.

Home-based Intermediate Care provides clinical assessments and CLINICAL INTERVENTIONS to PATIENTS in their own home or in a Care Home. For most PATIENTS CLINICAL INTERVENTIONS last up to 6 weeks.

Home-based Intermediate Care aims to prevent hospital admissions, support faster recovery from illness, support timely discharge from hospital and maximise independent living.

Home-based Intermediate Care should be delivered within two days of being referred to the Home-based Intermediate Care Service.

- Step up Home-based Intermediate Care:

    - provides care (at home and/or in the community) to help avoid unnecessary hospital admission for PATIENTS who following assessment are at risk of being sent to and/or admitted to hospital
    - includes PATIENTS who may be in their last years or months of life but are not in their last days of life

- Step down Home-based Intermediate Care:
    - provides care to PATIENTS (at home or in their community) following an admission to hospital and who are determined by a "medically optimised for discharge" decision making process to be no longer in need of hospital care
    - includes PATIENTS who may be in their last years or months of life but are not in their last days of life.

For further information on Home-based Intermediate Care, see the:

- age.uk website at: What is intermediate care?
- National Institute for Health and Care Excellence (NICE) website at: Intermediate care including reablement: NICE guideline [NG74].

HOME-BASED INTERMEDIATE CARE SERVICE

Change to Supporting Information: New Supporting Information

A Home-based Intermediate Care Service is a SERVICE.

A Home-based Intermediate Care Service provides Home-based Intermediate Care to PATIENTS in their own home or in a Care Home.

A Home-based Intermediate Care Service is delivered by a Multidisciplinary Team but most commonly by CARE PROFESSIONALS, such as NURSES and Allied Health Professionals or Care Workers (in Care Homes).

This supporting information is also known by these names:

Context	Alias
plural	Home-based Intermediate Care Services

INTERMEDIATE CARE

Change to Supporting Information: New Supporting Information

Intermediate Care is an ACTIVITY GROUP.

Intermediate Care provides care to help PATIENTS achieve what they want to do, which may involve:

- remaining at home when the PATIENT starts to find things more difficult
- recovery after a fall, an acute illness or an operation
- avoiding going into hospital unnecessarily

- returning home more quickly after a hospital stay.

There are four types of Intermediate Care:

- Reablement Intermediate Care
- Crisis Response Intermediate Care
- Home-based Intermediate Care
- Community Bed-based Intermediate Care.

For further information on Intermediate Care, see the National Institute for Health and Care Excellence (NICE) website at: Understanding intermediate care.

INTERMEDIATE CARE SERVICE

Change to Supporting Information: New Supporting Information

An Intermediate Care Service is a SERVICE.

An Intermediate Care Service provides support for a short time to help PATIENTS recover and increase their independence.

There are four types of Intermediate Care Service:

- Reablement Intermediate Care Service
- Crisis Response Intermediate Care Service
- Home-based Intermediate Care Service
- Community Bed-based Intermediate Care Service.

This supporting information is also known by these names:

Context	Alias
plural	Intermediate Care Services

OTHER INTERMEDIATE CARE WAITING TIME MEASUREMENT

Change to Supporting Information: New Supporting Information

An Other Intermediate Care Waiting Time Measurement is a REFERRAL TO TREATMENT PERIOD.

The Other Intermediate Care Waiting Time Measurement:

- is for Intermediate Care other than Crisis Response Intermediate Care, i.e. Reablement Intermediate Care, Home-based Intermediate Care and Community Bed-based Intermediate Care
- allows monitoring of waiting times for PATIENTS that are deemed not clinically appropriate for the Other Intermediate Care Within 2 Days Waiting Time Measurement.

Reablement Intermediate Care:

The waiting time is the duration between the REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD START TIME and REFERRAL TO TREATMENT PERIOD END DATE and REFERRAL TO TREATMENT PERIOD END TIME.

The Reablement Intermediate Care Waiting Time Measurement:

- REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD START TIME:
  - The PATIENT is identified by a CARE PROFESSIONAL or Social Care Worker as needing reablement to enable care to be delivered in their own home as a safe alternative to hospital or Community Bed-based Intermediate Care.
    - For step up care, the need for the Reablement Intermediate Care Service is identified for a community-located PATIENT by a community-based CARE PROFESSIONAL or Social Care Worker
    - For step down care, the need for the Reablement Intermediate Care Service is identified for an acute hospital-located PATIENT based on a "medically optimised for discharge" decision making process that determines care in hospital is no longer needed.
- REFERRAL TO TREATMENT PERIOD END DATE and REFERRAL TO TREATMENT PERIOD END TIME:
  - The CARE CONTACT DATE and CARE CONTACT TIME of the first face-to-face contact from a reablement worker in their own home.

Home-based Intermediate Care:

The waiting time is the duration between the REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD START TIME and REFERRAL TO TREATMENT PERIOD END DATE and REFERRAL TO TREATMENT PERIOD END TIME.

The Home-based Intermediate Care Waiting Time Measurement:

- REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD START TIME:
  - The PATIENT is identified by a CARE PROFESSIONAL or Social Care Worker as needing Home-based Intermediate Care as a safe alternative to hospital or Community Bed-based Intermediate Care.
    - For step up care, the need for the Home-based Intermediate Care Service is identified for a community-located PATIENT by a community-based CARE PROFESSIONAL or Social Care Worker.
    - For step down care, the need for the Home-based Intermediate Care Service is identified for an acute hospital-located PATIENT based on a "medically optimised for discharge" decision making process that determines care in hospital is no longer needed.
- REFERRAL TO TREATMENT PERIOD END DATE and REFERRAL TO TREATMENT PERIOD END TIME:

- The CARE CONTACT DATE and CARE CONTACT TIME of the first face-to-face contact the PATIENT receives from an Intermediate Care Service CARE PROFESSIONAL in their own home.

Community Bed-based Intermediate Care:

The waiting time is measured to ensure there are 2 midnights or fewer between the REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD START TIME and REFERRAL TO TREATMENT PERIOD END DATE and REFERRAL TO TREATMENT PERIOD END TIME.

The Community Bed-based Intermediate Care Waiting Time Measurement:

- REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD START TIME:
  - The PATIENT is identified by a CARE PROFESSIONAL or Social Care Worker as needing Community Bed-based Intermediate Care as a safe alternative to acute hospital care.
    - For step up care, the need for the Community Bed-based Intermediate Care is identified for a community-located PATIENT by a community-based CARE PROFESSIONAL or Social Care Worker.
    - For step down care, the need for the Community Bed-based Intermediate Care is identified for an acute hospital-located PATIENT based on a "medically optimised for discharge" decision making process that determines care in hospital is no longer needed.
- REFERRAL TO TREATMENT PERIOD END DATE and REFERRAL TO TREATMENT PERIOD END TIME:
  - The PATIENT is admitted to community-commissioned Hospital Bed.

This supporting information is also known by these names:

Context	Alias
plural	Other Intermediate Care Waiting Time Measurements

OTHER INTERMEDIATE CARE WITHIN 2 DAYS WAITING TIME MEASUREMENT

Change to Supporting Information: New Supporting Information

An Other Intermediate Care Within 2 Days Waiting Time Measurement is a REFERRAL TO TREATMENT PERIOD.

An Other Intermediate Care Within 2 Days Waiting Time Measurement is for Intermediate Care other than Crisis Response Intermediate Care, i.e. Reablement Intermediate Care, Home-based Intermediate Care and Community Bed-based Intermediate Care.

Reablement Intermediate Care:

The waiting time is measured to ensure there are 2 midnights or fewer between the REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD START TIME and REFERRAL TO TREATMENT PERIOD END DATE and REFERRAL TO TREATMENT PERIOD END TIME.

The Reablement Intermediate Care Within 2 Days Waiting Time Measurement:

- REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD START TIME:
  - The PATIENT is identified by a CARE PROFESSIONAL or Social Care Worker as needing reablement to enable care to be delivered in their own home as a safe alternative to hospital or Community Bed-based Intermediate Care.
    - For step up care, the need for the Reablement Intermediate Care Service is identified for a community-located PATIENT by a community-based CARE PROFESSIONAL or Social Care Worker.
    - For step down care, the need for the Reablement Intermediate Care Service is identified for an acute hospital-located PATIENT based on a "medically optimised for discharge" decision making process that determines care in hospital is no longer needed.
- REFERRAL TO TREATMENT PERIOD END DATE and REFERRAL TO TREATMENT PERIOD END TIME:
  - The CARE CONTACT DATE and CARE CONTACT TIME of the first face-to-face contact from a reablement worker in their own home.

Home-based Intermediate Care:

The waiting time is measured to ensure there are 2 midnights or fewer between the REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD START TIME and REFERRAL TO TREATMENT PERIOD END DATE and REFERRAL TO TREATMENT PERIOD END TIME.

The Home-based Intermediate Care Within 2 Days Waiting Time Measurement:

- REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD START TIME:
  - The PATIENT is identified by a CARE PROFESSIONAL or Social Care Worker as needing Home-based Intermediate Care as a safe alternative to hospital or Community Bed-based Intermediate Care.
    - For step up care, the need for the Home-based Intermediate Care Service is identified for a community-located PATIENT by a community-based CARE PROFESSIONAL or Social Care Worker
    - For step down care, the need for the Home-based Intermediate Care Service is identified for an acute hospital-located PATIENT based on a "medically optimised for discharge" decision making process that determines care in hospital is no longer needed.
- REFERRAL TO TREATMENT PERIOD END DATE and REFERRAL TO TREATMENT PERIOD END TIME:

- The CARE CONTACT DATE and CARE CONTACT TIME of the first face-to-face contact the PATIENT receives from an Intermediate Care Service CARE PROFESSIONAL in their own home.

Community Bed-based Intermediate Care:

The waiting time is measured to ensure there are 2 midnights or fewer between the REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD START TIME and REFERRAL TO TREATMENT PERIOD END DATE and REFERRAL TO TREATMENT PERIOD END TIME.

The Community Bed-based Intermediate Care Within 2 Days Waiting Time Measurement:

- REFERRAL TO TREATMENT PERIOD START DATE and REFERRAL TO TREATMENT PERIOD START TIME:
  - The PATIENT is identified by a CARE PROFESSIONAL or Social Care Worker as needing Community Bed-based Intermediate Care as a safe alternative to acute hospital care.
    - For step up care, the need for the Community Bed-based Intermediate Care is identified for a community-located PATIENT by a community-based CARE PROFESSIONAL or Social Care Worker.
    - For step down care, the need for the Community Bed-based Intermediate Care is identified for an acute hospital-located PATIENT based on a "medically optimised for discharge" decision making process that determines care in hospital is no longer needed.
- REFERRAL TO TREATMENT PERIOD END DATE and REFERRAL TO TREATMENT PERIOD END TIME:
  - The PATIENT is admitted to community-commissioned Hospital Bed.

This supporting information is also known by these names:

Context	Alias
plural	Other Intermediate Care Within 2 Days Waiting Time Measurements

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PERSONALISED CARE AND SUPPORT PLAN

Change to Supporting Information: New Supporting Information

A Personalised Care and Support Plan is a CARE PLAN.

A Personalised Care and Support Plan is a plan that sets out all the health and wellbeing needs of a PATIENT following a comprehensive holistic assessment of those needs.

A Personalised Care and Support Plan:

- is a way of capturing and recording conversations, decisions and agreed outcomes in a way that makes sense to the PATIENT

- should be proportionate, flexible and coordinated and adaptable to a PATIENT's health condition, situation and care and support needs
- should include a description of the PATIENT, what matters to them and all the necessary elements that would make the plan achievable and effective.

For further information on Personalised Care and Support Plans, see the NHS England website at: Personalised care and support planning handbook: The journey to person-centred care.

This supporting information is also known by these names:

Context	Alias
plural	Personalised Care and Support Plans

REABLEMENT INTERMEDIATE CARE

Change to Supporting Information: New Supporting Information

Reablement Intermediate Care is an ACTIVITY GROUP.

Reablement Intermediate Care provides clinical assessments and CLINICAL INTERVENTIONS to PATIENTS in their own home to enable the PERSON to recover skills, and regain confidence, and to maximise their independence.

- Step up Reablement Intermediate Care:
  - provides care to PATIENTS (at home and/or in the community) to help avoid unnecessary hospital admission for PATIENTS who following assessment are at risk of being sent to and/or admitted to hospital
  - includes PATIENTS who may be in their last years or months of life but are not in their last days of life

- Step down Reablement Intermediate Care:
  - provides care to PATIENTS (at home or in their community) following an admission to hospital and who are determined by a "medically optimised for discharge" decision making process to be no longer in need of hospital care
  - includes PATIENTS who may be in their last years or months of life but are not in their last days of life.

For further information on Reablement Intermediate Care, see the:

- age.uk website at: Reablement
- National Institute for Health and Care Excellence (NICE) website at: Intermediate care including reablement: NICE guideline [NG74].

REABLEMENT INTERMEDIATE CARE SERVICE

Change to Supporting Information: New Supporting Information

A Reablement Intermediate Care Service is a SERVICE.

A Reablement Intermediate Care Service comprises assessments and CLINICAL INTERVENTIONS provided to PATIENTS in their home (or Care Home) within 2 days of need for Reablement Intermediate Care being identified, which aims to help them recover, and relearn skills, and regain confidence and to maximise their independence. For most PATIENTS CLINICAL INTERVENTIONS last up to 6 weeks.

A Reablement Intermediate Care Service can be delivered by a Multidisciplinary Team, but is most commonly delivered by Social Care Workers.

This supporting information is also known by these names:

Context	Alias
plural	Reablement Intermediate Care Services

STRATEGIC DATA COLLECTION SERVICE IN THE CLOUD

Change to Supporting Information: New Supporting Information

The Strategic Data Collection Service in the Cloud (SDCS Cloud) is a secure solution using the cloud technology.

The Strategic Data Collection Service in the Cloud is different from other existing Strategic Data Collection Service collection tools.

The Strategic Data Collection Service in the Cloud provides:

- improved user experience and faster data quality feedback
- a secure solution using the cloud technology which will integrate with improved Data Processing Services.

For further information on the Strategic Data Collection Service in the Cloud, see the NHS Digital website at: Strategic Data Collection Service in the cloud (SDCS Cloud).

This supporting information is also known by these names:

Context	Alias
shortname	SDCS Cloud

YOUNG PERSONS TRANSITION PLAN

Change to Supporting Information: New Supporting Information

A Young Persons Transition Plan is a CARE PLAN.

A Young Persons Transition Plan is owned by NHS England and NHS Improvement.

A Young Persons Transition Plan is a PERSON-centred plan that sets out a process for transitioning from Children's Services to Adult Services that reflects their individual characteristics, aspirations, and families and the different SERVICES they use, rather than apply a pre-determined set of transition options.

A Young Persons Transition Plan is strengths-based, and focuses on what is positive and possible for the Child or Young Person responding fully to their preferences. It sees the PERSON using care and support as an individual and equal partner with health and CARE PROFESSIONALS to make choices about their own care and support.

For further information on Young Persons Transition Plans, see the NHS England website at: Commissioning for transition to adult services for young people with Special Educational Needs and Disability (SEND).

This supporting information is also known by these names:

Context	Alias
plural	Young Persons Transition Plans

CARE ACTIVITY

Change to Class: Changed Attributes

Attributes of this Class are:

CARE ACTIVITY TYPE FOR PATIENT LEVEL INFORMATION COSTING
~~COMMUNITY CARE ACTIVITY TYPE CODE~~
COMMUNITY CARE ACTIVITY TYPE
CONSULTATION MEDIUM USED
FEMALE GENITAL MUTILATION IDENTIFICATION METHOD CODE
METHOD OF COMMUNICATION FOR END OF CANCER FASTER DIAGNOSIS PATHWAY
MOTHER ANTENATALLY BOOKED INDICATOR
RESTRICTIVE INTERVENTION POST INCIDENT REVIEW HELD INDICATOR
RESTRICTIVE INTERVENTION POST INCIDENT REVIEW NOT HELD REASON FOR PATIENT
RESTRICTIVE INTERVENTION RESTRAINT INJURY INDICATOR
RESTRICTIVE INTERVENTION TYPE
SEXUAL AND REPRODUCTIVE HEALTH CARE ACTIVITY

CARE PLAN

Change to Class: Changed Attributes

Attributes of this Class are:

K CARE PLAN IDENTIFIER
CANCER CARE PLAN INTENT
CANCER RECURRENCE CARE PLAN INDICATOR

CARE PLAN AGREED BY
CARE PLAN TYPE
CARE PLAN TYPE FOR COMMUNITY CARE
CARE PLAN TYPE FOR MENTAL HEALTH
CHILD PROTECTION PLAN INDICATION CODE
CHILD PROTECTION PLAN REASON CODE
DISCHARGE PLAN AGREED BY
INTENDED DELIVERY PLACE
MATERNITY PERSONALISED CARE PLAN INDICATOR
MULTIDISCIPLINARY TEAM CANCER CARE PLAN DISCUSSED INDICATOR
MULTIDISCIPLINARY TEAM MEETING TYPE FOR CANCER
NO CANCER TREATMENT REASON

PERSON RELATIONSHIP

Change to Class: Changed Attributes

Attributes of this Class are:

LEAD CONTACT INDICATOR
PERSON RELATIONSHIP TYPE DONOR TO RECIPIENT
RELATIONSHIP TO PERSON FOR CHILDREN AND YOUNG PEOPLE
RELATIONSHIP TO PERSON FOR COMMUNITY

REFERRAL TO TREATMENT PERIOD

Change to Class: Changed Attributes

Attributes of this Class are:

K REFERRAL TO TREATMENT PERIOD START DATE
REFERRAL TO TREATMENT PERIOD END DATE
REFERRAL TO TREATMENT PERIOD END TIME
REFERRAL TO TREATMENT PERIOD START TIME
REFERRAL TO TREATMENT PERIOD STATUS

REPORTING PERIOD

Change to Class: Changed Attributes

Attributes of this Class are:

K REPORTING PERIOD END DATE
K REPORTING PERIOD START DATE
REPORTING PERIOD END TIME
REPORTING PERIOD QUARTER END DATE
REPORTING PERIOD QUARTER START DATE
REPORTING PERIOD START TIME

SESSION

Change to Class: Changed Attributes

Attributes of this Class are:

K	SESSION DATE
K	SESSION IDENTIFIER
K	SESSION TIME
	~~GROUP SESSION TYPE CODE FOR COMMUNITY CARE~~
	GROUP SESSION TYPE FOR COMMUNITY CARE
	GROUP SESSION TYPE FOR MENTAL HEALTH

ACCOMMODATION STATUS CODE

Change to Attribute: Changed Description

An indication of the type of accommodation that a PATIENT currently has. This should be based on the PATIENT's main or permanent residence.

National Codes:

MA00	**Mainstream Housing**
MA01	Owner occupier
MA02	Settled mainstream housing with family/friends
MA03	Shared ownership scheme e.g. Social Homebuy Scheme (tenant purchase percentage of home value from landlord)
MA04	Tenant - Local Authority/Arms Length Management Organisation/Registered Landlord
MA05	Tenant - Housing Association
MA06	Tenant - private landlord
~~MA09~~	~~Other mainstream housing~~
MA09	Other mainstream housing (not listed)
HM00	**Homeless**
HM01	Rough sleeper
HM02	Squatting
HM03	Night shelter/emergency hostel/Direct access hostel (temporary accommodation accepting self referrals, no waiting list and relatively frequent vacancies)
HM04	Sofa surfing (sleeps on different friends floor each night)
HM05	Placed in temporary accommodation by Local Authority (including Homelessness resettlement service) e.g. Bed and Breakfast accommodation
HM06	Staying with friends/family as a short term guest
~~HM07~~	~~Other homeless~~
HM07	Other homeless (not listed)
MH00	**Accommodation with mental health care support**
MH01	Supported accommodation (accommodation supported by staff or resident caretaker)
MH02	Supported lodgings (lodgings supported by staff or resident caretaker)
MH03	Supported group home (supported by staff or resident caretaker)
MH04	Mental Health Registered Care Home
~~MH09~~	~~Other accommodation with mental health care and support~~

MH09 Other accommodation with mental health care and support (not listed)
HS00 **Acute/long stay healthcare residential facility/hospital**
~~HS01 NHS acute psychiatric ward~~
HS01 NHS acute psychiatric WARD
HS02 Independent hospital/clinic
HS03 Specialist rehabilitation/recovery
HS04 Secure psychiatric unit
HS05 Other NHS facilities/hospital
~~HS09 Other acute/long stay healthcare residential facility/hospital~~
HS09 Other acute/long stay healthcare residential facility/hospital (not listed)
CH00 **Accommodation with other (not specialist mental health) care support**
CH01 Foyer - accommodation for young people aged 16-25 who are homeless or in housing need
CH02 Refuge
CH03 Non-Mental Health Registered Care Home
~~CH09 Other accommodation with care and support (not specialist mental health)~~
CH09 Other accommodation with care and support (not specialist mental health) (not listed)
CJ00 **Accommodation with criminal justice support**
CJ01 Bail/Probation hostel
CJ02 Prison
CJ03 Young Offender Institution
CJ04 Detention Centre
~~CJ05 Young Offender Institution (15-17) **~~
~~CJ06 Young Offender Institution (18-21) **~~
~~CJ07 Secure Children's Home (Secure Welfare Accommodation only) *~~
~~CJ08 Secure Children's Home (Youth Detention Accommodation only) *~~
~~CJ09 Other accommodation with criminal justice support such as ex-offender support ***~~
~~CJ10 Secure Children's Home (Secure Welfare Accommodation and Youth Detention Accommodation) *~~
~~CJ11 Secure Training Centre *~~
~~CJ12 Other accommodation with criminal justice support *~~
CJ05 Young Offender Institution (15-17)
CJ06 Young Offender Institution (18-21)
CJ07 Secure Children's Home (Secure Welfare Accommodation only)
CJ08 Secure Children's Home (Youth Detention Accommodation only)
CJ09 Other accommodation with criminal justice support such as ex-offender support (Retired 1 April 2020)
CJ10 Secure Children's Home (Secure Welfare Accommodation and Youth Detention Accommodation)
CJ11 Secure Training Centre
CJ12 Other accommodation with criminal justice support (not listed)
SH00 **Sheltered Housing (accommodation with a scheme manager or warden living on the premises or nearby, contactable by an alarm system if necessary)**
SH01 Sheltered housing for older persons
SH02 Extra care sheltered housing (also known as 'very sheltered housing'. For people who are less able to manage on their own, but who do need an extra level of care. Services offered vary between schemes, but meals and some personal care are often provided.)
SH03 Nursing Home for older persons

~~SH09~~ ~~Other sheltered housing~~

SH09 Other sheltered housing (not listed)

ML00 **Mobile accommodation**

Other

OC96 Not elsewhere classified

~~Notes:~~

- ~~* National Codes CJ07, CJ08, CJ10, CJ11 and CJ12 are **only** valid for the Mental Health Services Data Set. They are **NOT** valid in any other data set.~~
- ~~** National Codes CJ05 and CJ06 have been introduced for the Mental Health Services Data Set **only** to add further granularity to National Code CJ03. However, National Code CJ03 is still valid for the Mental Health Services Data Set where extra detail cannot be collected.~~
- ~~*** National Code CJ09 is **only** valid for the Community Services Data Set. It is **NOT** valid in any other data set.~~

ACTIVITY GROUP TYPE

Change to Attribute: Changed Description

The type of ACTIVITY GROUP.

National Codes:

01 Accident and Emergency Episode
02 Acute Myocardial Infarction Care Spell (Retired July 2012)
03 Augmented Care Period (Retired 1 April 2006)
04 Breast Cancer Care Spell
05 Cancer Care Spell
06 Care Home Stay (Consultant Care)
07 Care Home Stay (Midwife Care)
08 Care Home Stay (Nursing Care)
09 Care Home Stay (Residential)
10 Care Programme Approach Care Episode
11 Colorectal Cancer Care Spell
12 Community Episode (Retired 01 January 2016)
13 Mental Health Care Professional Episode (Acute Home-Based) (Retired 01 January 2016)
14 Consultant Episode (Hospital Provider)
15 Consultant Out-Patient Episode
16 Dental Episode (Retired 01 April 2014)
17 Drug Misuse Episode (Retired 1 April 2019)
18 Sexual Health and HIV Episode
19 Head and Neck Cancer Care Spell
20 Home Dialysis Episode
21 Hospital Provider Spell
22 Lung Cancer Care Spell
23

Adult Mental Health, Learning Disability or Autism Spectrum Disorder Care Spell (Retired 01 January 2016)

24 Midwife Episode
25 Neonatal Level Of Care Period
26 Nursing Episode
27 Palliative Care Episode
28 Person Stop Smoking Episode
29 Pregnancy Episode (Retired 1 April 2019)
30 Professional Staff Group Episode (Retired 01 January 2016)
31 Regular Attender Episode (Retired 01 January 2016)
32 Road Traffic Accident Treatment (Retired 01 April 2014)
33 Sarcoma Cancer Care Spell
34 Skin Cancer Care Spell
35 Supervised Discharge Episode (Retired 01 April 2014)
36 Supervision Register Episode (Retired 01 April 2014)
37 Upper Gastrointestinal Cancer Care Spell
38 Urological Cancer Care Spell
39 Ward Stay
40 Hospital Stay
41 Care Spell
42 CRITICAL CARE PERIOD
43 PATIENT PATHWAY
44 REFERRAL TO TREATMENT PERIOD
45 Active Monitoring
46 Supervised Community Treatment Recall (Retired 01 January 2016)
47 Supervised Community Treatment (Retired 01 January 2016)
48 Mental Health Care Without Patient Consent (Retired 01 January 2016)
49 Cancer Treatment Period
50 Gynaecological Cancer Care Spell
51 Mental Health Care Spell (Retired 01 January 2016)
52 Improving Access to Psychological Therapies Care Spell
53 Adult Mental Health Care Team Episode (Retired 01 January 2016)
54 Mental Health NHS Day Care Episode (Retired 01 January 2016)
55 Mental Health Delayed Discharge Period
56 Mental Health Care Cluster Assignment Period (Retired 01 January 2016)
57 Mental Health Care Coordinator Assignment Period
58 Child and Adolescent Mental Health Clinical Intervention Episode (Retired 01 January 2016)
59 Child and Adolescent Mental Health Care Spell (Retired 01 January 2016)
60 Maternity Episode
61 HIV Episode
62 Central Nervous System Cancer Care Spell
63 Children Teenagers and Young Adults Cancer Care Spell
64 Haematological Cancer Care Spell
65 Lung Cancer Care Spell (Retired 1 April 2018)
66 Commissioner Assignment Period
67 Breast Screening Episode

68 High Risk Breast Screening Episode
69 Open Breast Screening Episode
70 Neonatal Critical Care Spell
71 Radiotherapy Episode
72 Healthy Person Stay
73 Mental Health Responsible Clinician Assignment Period
74 Mental Health Conditional Discharge Period
75 Mental Health Act Legal Status Classification Period (Moved to PERSON PROPERTY ASSIGNMENT PERIOD TYPE 01 January 2016)
76 Care Professional Admitted Care Episode
77 Liver Cancer Care Spell
78 NHS Continuing Healthcare
79 NHS-funded Nursing Care
80 Package of Care
Community Bed-based Intermediate Care
Crisis Response Intermediate Care
Home-based Intermediate Care
Reablement Intermediate Care

Note:
The list is not in alphabetical order.

CARE PLAN TYPE FOR COMMUNITY CARE

Change to Attribute: New Attribute

The type of CARE PLAN for the PATIENT recorded by the SERVICE for the Community Services Data Set.

National Codes:

01 Young Persons Transition Plan
02 Discharge Plan
03 Personalised Care and Support Plan

This attribute is also known by these names:

Context	Alias
plural	CARE PLAN TYPES FOR COMMUNITY CARE

CARE PLAN TYPE FOR COMMUNITY CARE

Change to Attribute: New Attribute

CARE PLAN TYPE FOR COMMUNITY CARE

Data Elements:

CARE PLAN TYPE (COMMUNITY CARE)

CARE PROFESSIONAL STAFF GROUP FOR COMMUNITY CARE

Change to Attribute: Changed Description

The staff group of a CARE PROFESSIONAL working in a Community Health Service.

National Codes:

	Allied Health Professionals
A01	Art Therapist
A02	Clinical Psychologist
A03	Dietitian
A04	Drama Therapist
A05	Music Therapist
A06	Occupational Therapist
A07	Orthotist
A08	Physiotherapist
A09	Podiatrist
A10	Prosthetist
A11	Psychotherapist
A12	Radiographer
A13	Speech and Language Therapist
A14	Orthoptist
	Medical/Dental
M01	Community Dentist
M02	CONSULTANT
M03	GENERAL MEDICAL PRACTITIONER
M04	GENERAL MEDICAL PRACTITIONER with Special Interest
	Nursing, Health Visiting and Midwifery
N01	MIDWIFE
N02	District NURSE
N03	Health Visitor
N04	Macmillan NURSE
N05	School Nurse
N06	Specialist Nursing - Active Case Management (Community Matrons)
N07	Specialist Nursing - Arthritis Nursing/Liaison
N08	Specialist Nursing - Asthma and Respiratory Nursing/Liaison
N09	Specialist Nursing - Breast Care Nursing/Liaison
N10	Specialist Nursing - Cancer Related
N11	Specialist Nursing - Cardiac Nursing/Liaison
N12	Specialist Nursing - Children's Services
N13	Specialist Nursing - Community Cystic Fibrosis
N14	Specialist Nursing - Continence Services
N15	Specialist Nursing - Diabetic Nursing/Liaison
N16	Specialist Nursing - Enteral Feeding Nursing Services

N17 Specialist Nursing - Haemophilia Nursing Services
N18 Specialist Nursing - HIV/AIDS Nursing Services (Retired 01 September 2015)
N19 Specialist Nursing - Infectious Diseases
N20 Specialist Nursing - Intensive Care Nursing
N21 Specialist Nursing - Palliative/Respite Care
N22 Specialist Nursing - Parkinson's and Alzheimers Nursing/Liaison
N23 Specialist Nursing - Rehabilitation Nursing
N24 Specialist Nursing - Stoma Care Services
N25 Specialist Nursing - Tissue Viability Nursing/Liaison
N26 Specialist Nursing - Transplantation Patients Nursing Service
N27 Specialist Nursing - Treatment Room Nursing Services
N28 Specialist Nursing - Tuberculosis Specialist Nursing
N29 Specialist Nursing - Other Specialist Nursing
N30 Specialist Nursing - Safeguarding
N31 Practice Nursing (Retired 01 September 2015)
N32 Staff NURSE
N33 Other Registered NURSE
N34 Public Health NURSE

Other Care Professionals

C01 Appliances Technician
C02 Audiologist
C03 Counsellor
C04 Nursery Nurse
C06 Play Therapist
C07 Social Worker
C08 Voluntary Care Worker
C09 Screener (in a National Screening Programme)
C10 Health Trainer (Non Clinical)
C11 Health Trainer (Clinical)
C12 Health Care Assistant
C13 Health Care Support Worker
~~C99 Other CARE PROFESSIONAL~~
C99 Other CARE PROFESSIONAL (not listed)

CHILDHOOD IMMUNISATION TYPE

Change to Attribute: Changed Description

The type of childhood immunisation given to a child on the IMMUNISATION DATE.

Note: National Codes in bold are at a high level. Either the higher level national code or the lower level code national code should be reported as required by the Data Set.

National Codes:

010 Diphtheria
011 D3 - Diphtheria

012 D4 - Diphtheria booster
020 Pertussis
021 aP3 - Pertussis
022 aP4 - Pertussis booster
030 Tetanus
031 T3 - Tetanus
032 T4 - Tetanus booster
040 Polio
041 Po3 - Polio
042 Po4 - Polio booster
050 Haemophilus influenzae type b
051 Hib3 - Haemophilus influenzae type b
060 Measles, Mumps, Rubella (MMR)
061 MMR1 - Measles, Mumps, Rubella
062 MMR2 - Measles, Mumps, Rubella
070 Meningococcal serogroup C (MenC) **
080 Haemophilus influenzae type b and Meningococcal C (booster) (Hib/MenC (booster))
090 Pneumococcal (PCV)
091 PCV2 - Pneumococcal
092 PCV (booster) - Pneumococcal (booster)
100 Low dose Diphtheria
110 Human papillomavirus (HPV)
120 Rotavirus
130 Hepatitis B (Hep B)
131 Hepatitis B (Hep B3) - Routine *
132 Hepatitis B (Hep B) - Selective *
140 Tuberculosis (BCG)
150 Meningococcal serogroup B (MenB)
151 MenB2 - Meningococcal serogroup B
152 MenB (booster) - Meningococcal serogroup B (booster)
160 Meningococcal ACWY **
170 Nasal Flu Vaccination **

Notes:

- * National Codes 131 and 132 are not valid for use in the Community Services Data Set.
- ~~** National Code 70 is not valid for use in the Cover of Vaccination Evaluated Rapidly (COVER) Data Set.~~
- ** National Code 70, 160 and 170 are not valid for use in the Cover of Vaccination Evaluated Rapidly (COVER) Data Set.

COMMUNITY CARE ACTIVITY TYPE renamed from COMMUNITY CARE ACTIVITY TYPE CODE

Change to Attribute: Changed Name

- Changed Name from Data_Dictionary.Attributes.C.Com.COMMUNITY_CARE_ACTIVITY_TYPE_CODE to Data_Dictionary.Attributes.C.Com.COMMUNITY_CARE_ACTIVITY_TYPE

CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR

Change to Attribute: Changed Description

~~An indication of whether a disabled PERSON requires constant (round the clock) care and/or supervision for maintenance of their safety and/or wellbeing.~~An indication of whether a disabled PATIENT requires constant (round the clock) care and/or supervision for maintenance of their safety and/or wellbeing.

National Codes:

~~Y~~	~~Yes - PERSON requires constant care and/or supervision~~
~~N~~	~~No - PERSON does not require constant care and/or supervision~~
Y	Yes - PATIENT requires constant care and/or supervision
N	No - PATIENT does not require constant care and/or supervision

---

DISABILITY IMPACT PERCEPTION

Change to Attribute: Changed Description

The PATIENT or Patient Proxy's perception of whether the PATIENT's day-to-day activities are limited because of a health problem or DISABILITY which has lasted, or is expected to last, at least 12 months.

National Codes:

01	Yes - limited a lot
02	Yes - limited a little
03	No - not limited
~~04~~	~~Prefer not to say (PERSON asked but declined to provide a response)~~
04	Prefer not to say (PATIENT asked but declined to provide a response)

GROUP SESSION TYPE FOR COMMUNITY CARE renamed from GROUP SESSION TYPE CODE FOR COMMUNITY CARE

Change to Attribute: Changed Name

- Changed Name from Data_Dictionary.Attributes.G.Gr.GROUP_SESSION_TYPE_CODE_FOR_COMMUNITY_CARE to Data_Dictionary.Attributes.G.Gr.GROUP_SESSION_TYPE_FOR_COMMUNITY_CARE

PARENTAL RESPONSIBILITIES INDICATOR

Change to Attribute: Changed Description

~~An indication of whether a PERSON has parental responsibilities for a child or young PERSON, as stated by the PERSON.~~An indication of whether a PATIENT has parental responsibilities for a child or young person, as stated by the PATIENT.

For further information on parental responsibilities, see the gov.uk website at: Parental rights and responsibilities.

National Codes:

~~Y~~	~~Yes - PERSON has parental responsibilities for a child or young PERSON~~
~~N~~	~~No - PERSON does not have parental responsibilities for a child or young PERSON~~
~~Z~~	~~Not Stated (PERSON asked but declined to provide a response)~~
Y	Yes - PATIENT has parental responsibilities for a child or young person
N	No - PATIENT does not have parental responsibilities for a child or young person
Z	Not Stated (PATIENT asked but declined to provide a response)

PERSON AT RISK OF UNEXPECTED DEATH INDICATOR

Change to Attribute: Changed Description

An indication of whether a PATIENT is at risk of sudden, unexpected death, as assessed by a CARE PROFESSIONAL.

~~For the Community Services Data Set, this is whether a Child or Young Person is at risk of sudden, unexpected death before the age of 18.~~

National Codes:

Y	Yes - PATIENT at risk of unexpected death
N	No - PATIENT not at risk of unexpected death

PREFERRED DEATH LOCATION DISCUSSED INDICATOR

Change to Attribute: Changed Description

~~An indication of whether the preferred LOCATION of death was discussed with the PATIENT or Patient Proxy by a CARE PROFESSIONAL.~~An indication of whether the preferred LOCATION of death was discussed with the PATIENT or Patient Proxy by a CARE PROFESSIONAL, in the event that there is an expected risk of death of the PATIENT.

~~For the Community Services Data Set, this is whether the preferred LOCATION of death was discussed with the Child or Young Person or their family, in the event that there is an expected risk of death before the age of 18 for the Child or Young Person.~~

National Codes:

Y	Yes - the preferred LOCATION of death was discussed with the PATIENT or Patient Proxy
N	

No - the preferred LOCATION of death was not discussed with the PATIENT or Patient Proxy

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PROFESSIONAL REGISTRATION BODY CODE

Change to Attribute: Changed Description

A code which identifies the PROFESSIONAL REGISTRATION BODY.

National Codes:

01	General Chiropractic Council
02	General Dental Council
03	General Medical Council
04	General Optical Council
05	Social Care Wales **
06	Scottish Social Services Council (Retired 01 April 2013)
07	General Social Care Council (for England) (Retired 01 August 2012)
08	Health and Care Professions Council
09	Nursing and Midwifery Council
10	Royal Pharmaceutical Society (Retired 27 September 2010)
11	British Psychological Society (Retired 01 October 2017)
12	Association for Operating Department Practitioners (Retired January 2015)
13	Association of Chartered Certified Accountants (Retired 01 October 2017)
14	Chartered Institute of Personnel and Development (Retired 01 October 2017)
15	Chartered Institute of Management Accountants (Retired 01 October 2017)
16	General Pharmaceutical Council
~~17~~	~~General Osteopathic Council~~ ~~*~~
17	General Osteopathic Council

Notes:

- ~~* National Code 17 is not valid for use in the Community Services Data Set.~~
- ** The National Code description has been updated as a result of the work undertaken for the development of the National Workforce Data Set.
  ~~The Community Services Data Set and Maternity Services Data Set specifications will be updated in the next versions of the Information Standards where they are not already correct.~~
  The Maternity Services Data Set specification will be updated in the next version of the Information Standards where it is not already correct.

REASON FOR REFERRAL TO COMMUNITY CARE

Change to Attribute: Changed Description

The reason that a PATIENT was referred to a Community Health Service.

National Codes:

001 Accident/Trauma
002 Alopecia
003 Antenatal Care
004 Bereavement
005 Bladder Care
006 Blood Pressure
007 Bowel Problems
008 Cancer
009 Cardiac Conditions
010 Catheter Problems
011 Cerebral Palsy
012 Cleft Palate
013 Cognitive Problems
014 Colostomy Care
015 Continence Problems
016 Contraception and Sexual Health (Retired 01 September 2015)
017 Developmental Problems
018 Diabetes
019 Diarrhoea and Vomiting
020 Dizziness/Balance Problems
021 Downs Syndrome
022 Deep Vein Thrombosis
023 Ear Infections/Problems
024 Eating Disorder
025 Emotional/Behavioural Problems
026 End of Life Support
027 Epilepsy
028 Equipment Provision
029 Eustachian Tube Dysfunction
030 Falls Risk
031 Family Support
032 Feeding/Swallowing Problems
033 Foot Care/Problems
034 Head Injury
035 Hearing Problems/Loss
036 Immunisation
037 Laryngectomy
038 Leg Ulcer
039 Looked After Children
040 Low Muscle Tone
041 Lymphoedema Management
042 Mobility Problems
043 Musculoskeletal Problems
044 Neurological Problems
045 Healthy Child Pathway

046 Nutrition and Dietetics
047 Ophthalmic Problems
048 Over 75 Assessment
049 Pain/Symptom Control
~~050 Parkinsons Disease~~
050 Parkinson's Disease
051 Personal Hygiene
052 Post Operative Care
053 Pressure Ulcer
054 Problems with Activities of Daily Living
055 Psychological Conditions
056 Rehabilitation
057 Respiratory Conditions
058 Safeguarding
059 Skin Problems
060 Sleep Problems
061 Smoking Cessation
062 Speech and Language Problems
063 Stoma Care
064 Structural/Functional Impairment
065 Substance Misuse
066 Trismus/Restricted Mouth Opening
067 Tuberculosis
068 Vascular Problems
069 Vomiting/Nausea
070 Wound Care
071 Multiple Complex Communication Difficulties
072 Dental Care/Problems
073 Haematology/Phlebotomy
074 Chronic Fatigue Syndrome/Myalgic Encephalopathy
075 Chronic Allergy/Immunological Problem
076 Metabolic/Endocrine Disorders
077 Renal Problems
078 Minor Surgery
079 Gastrostomy Management/Care
080 Care of the Next Infant (CONI) Pathway
081 Failure to Thrive
082 Maternal Mood Problems
083 Complex Social Factors (as defined by the National Institute for Health and Care Excellence guidance)
084 Condition(s) Requiring Respite Care
085 Other Congenital Conditions
086 Blood Disorders
087 Genetic Disorders
088 Neonatal Abstinence Syndrome

Note: This list is not in alphabetical order.

REFERRAL TO TREATMENT PERIOD END TIME

Change to Attribute: New Attribute

The end time of a REFERRAL TO TREATMENT PERIOD.

This attribute is also known by these names:

Context	Alias
plural	REFERRAL TO TREATMENT PERIOD END TIMES

REFERRAL TO TREATMENT PERIOD END TIME

Change to Attribute: New Attribute

REFERRAL TO TREATMENT PERIOD END TIME

Data Elements:

REFERRAL TO TREATMENT PERIOD END TIME

REFERRAL TO TREATMENT PERIOD START DATE

Change to Attribute: Changed Description

The start date of a REFERRAL TO TREATMENT PERIOD.

This is a specific type of the attribute ACTIVITY DATE.

A REFERRAL TO TREATMENT PERIOD START DATE will be one of the following:

- **Initial Referral:**
  - the REFERRAL REQUEST RECEIVED DATE of a SERVICE REQUEST for a particular condition.
  - This will include a PATIENT being re-referred in to a Consultant Led Service or an Interface Service or an NHS Allied Health Professional Service (Referral To Treatment Measurement) as a new referral including after a Discharge After Patient Did Not Attend. The REFERRAL TO TREATMENT PERIOD STATUS is '*National Code 10 - first activity*'
- **Following an APPOINTMENT that the PATIENT did not attend:**
  - the APPOINTMENT ACCEPTED DATE (or the INVITATION OFFER DATE SENT of the first APPOINTMENT OFFER where the APPOINTMENT OFFER is sent) for the first APPOINTMENT following the PATIENT not attending an APPOINTMENT or elective admission. See REFERRAL TO TREATMENT PERIOD and Discharge After Patient Did Not Attend for guidance on PATIENTS who do not attend
  - The APPOINTMENT DATE of the APPOINTMENT that the PATIENT did not attend should be used where it is not possible to identify the APPOINTMENT ACCEPTED DATE or the INVITATION OFFER DATE SENT. The REFERRAL TO TREATMENT PERIOD STATUS is '*National Code 10 - first activity*'
- **Following active monitoring:**

    - the ACTIVITY DATE of a CARE ACTIVITY when a decision to treat was made following Active Monitoring and the REFERRAL TO TREATMENT PERIOD STATUS is '*National Code 11 - active monitoring end*'
    - This will include a decision to start a substantively new or different treatment that does not already form part of that PATIENT's agreed CARE PLAN.
- **On identifying a separate condition:**
    - the REFERRAL REQUEST RECEIVED DATE of a SERVICE REQUEST when a decision has been made to refer the PATIENT directly to a Consultant Led Service or an NHS Allied Health Professional Service (Referral To Treatment Measurement) for a separate condition (the REFERRAL TO TREATMENT PERIOD STATUS for the first CARE ACTIVITY with the new CONSULTANT or NHS Allied Health Professional Service (Referral To Treatment Measurement) is '*National Code 12 - consultant or NHS Allied Health Professional Service (Referral To Treatment) referral*').

Referral To Treatment Consultant Led Waiting Times:

For most PATIENTS, the start of the REFERRAL TO TREATMENT PERIOD begins with a SERVICE REQUEST from a GENERAL MEDICAL PRACTITIONER to a CONSULTANT.

SERVICE REQUESTS to CONSULTANTS who provide care SERVICES in community settings also start REFERRAL TO TREATMENT PERIODS and the REFERRAL REQUEST RECEIVED DATE will be the start of the REFERRAL TO TREATMENT PERIOD.

A REFERRAL TO TREATMENT PERIOD may also start from SERVICE REQUESTS to CONSULTANTS from GENERAL DENTAL PRACTITIONERS, Practitioners with Special Interests, OPTOMETRISTS and Orthoptists, National Screening Programmes, Specialist NURSES, other CARE PROFESSIONALS where commissioning Organisations have approved these mechanisms locally.

An 18-week clock also starts upon a self referral by a PATIENT to the above services, where these pathways have been agreed locally by commissioners and providers and once the referral is ratified by a CARE PROFESSIONAL.

A REFERRAL TO TREATMENT PERIOD will also start where PATIENTS are transferred to an elective Consultant Led Service through SERVICE REQUESTS from Accident and Emergency Departments including Minor injuries units and Walk In Centres.

Allied Health Professional Referral To Treatment Measurement:

Further guidance relating to the Allied Health Professional Referral To Treatment can be found on the Department of Health and Social Care part of the gov.uk website at: Allied health professional referral to treatment revised guide.

Intermediate Care Measurement:

Further guidance relating to the Intermediate Care Waiting Time Measurements can be found on the NHS Digital website at: Community Services Data Set user guidance.

REFERRAL TO TREATMENT PERIOD START TIME

Change to Attribute: New Attribute

The start time of a REFERRAL TO TREATMENT PERIOD.

This attribute is also known by these names:

Context	Alias
plural	REFERRAL TO TREATMENT PERIOD START TIMES

REFERRAL TO TREATMENT PERIOD START TIME

Change to Attribute: New Attribute

REFERRAL TO TREATMENT PERIOD START TIME

Data Elements:

REFERRAL TO TREATMENT PERIOD START TIME

RELATIONSHIP TO PERSON FOR CHILDREN AND YOUNG PEOPLE

Change to Attribute: Changed Description

The relationship of the second PERSON to the first PERSON (the PATIENT) as used in the Community Services Data Set.

This is used to identify, for example, with whom the Child or Young Person is living in a permanent context or the relationship with the main Carer etc.

Note that Organisations may choose to collect the RELATIONSHIP TO PERSON FOR CHILDREN AND YOUNG PEOPLE codes at the high level (shown in **bold**) or at the more detailed level below each high-level code.

This item is not referenced in a data set in the NHS Data Model and Dictionary. It has been retained as the item is used by the Healthy Child Programme.

National Codes:

BPX	**Biological Parent**
BPM	Biological mother
BPF	Biological father
SPX	**Step-Parent**
SPM	Stepmother
SPF	Stepfather
GPX	**Grandparent**
GPM	Grandmother
GPF	Grandfather
ORX	**Other Relative**
ORA	Aunt

ORU	Uncle
ORS	Sister
ORB	Brother
ORO	Other (not listed)
APX	**Adoptive Parent**
APM	Adoptive mother
APF	Adoptive father
FPX	**Foster Parent**
FPM	Foster mother
FPF	Foster father
RCX	**Residential Carer**
OTX	**Other**
NOX	**None - Lives Alone**

RELATIONSHIP TO PERSON FOR COMMUNITY

Change to Attribute: New Attribute

The relationship of the second PERSON to the first PERSON (the PATIENT) as used in the Community Services Data Set.

Note that Organisations may choose to collect the RELATIONSHIP TO PERSON FOR COMMUNITY codes at the high level (shown in **bold**) or at the more detailed level below each high-level code.

National Codes:

BPX	**Biological Parent**
BPM	Biological Mother
BPF	Biological Father
SPX	**Step-Parent**
SPM	Stepmother
SPF	Stepfather
PIX	**Parents-in-Law**
PIF	Father-in-Law
PIM	Mother-in-Law
CHX	**Children**
CHS	Son
CHD	Daughter
CIX	**Children-in-Law**
CIS	Son-in-Law
CID	Daughter-in-Law
GPX	**Grandparent**
GPM	Grandmother
GPF	Grandfather
GCX	**Grandchild**
GCS	Grandson

GCD	Granddaugther
ORX	**Other Relative**
ORA	Aunt
ORU	Uncle
ORS	Sister
ORB	Brother
ORO	Other (not listed)
APX	**Adoptive Parent**
APM	Adoptive Mother
APF	Adoptive Father
FPX	**Foster Parent**
FPM	Foster Mother
FPF	Foster Father
RCX	**Residential Carer**
OTX	**Other**
NOX	**None - Lives Alone**

This attribute is also known by these names:

Context	Alias
plural	RELATIONSHIPS TO PERSON FOR COMMUNITY

RELATIONSHIP TO PERSON FOR COMMUNITY

Change to Attribute: New Attribute

RELATIONSHIP TO PERSON FOR COMMUNITY

Data Elements:

PERSON RELATIONSHIP (MAIN CARER)

REPORTING PERIOD END TIME

Change to Attribute: New Attribute

The time that a REPORTING PERIOD ends.

This attribute is also known by these names:

Context	Alias
plural	REPORTING PERIOD END TIMES

REPORTING PERIOD START TIME

Change to Attribute: New Attribute

The time that a REPORTING PERIOD begins.

This attribute is also known by these names:

Context	Alias
plural	REPORTING PERIOD START TIMES

SERVICE OR TEAM TYPE REFERRED TO FOR COMMUNITY CARE

Change to Attribute: Changed Description

The type of SERVICE or Multidisciplinary Team within a Community Health Service that a PATIENT was referred to.

For further information relating to the SERVICE OR TEAM TYPES REFERRED TO FOR COMMUNITY CARE, see the NHS Digital website at: Community Services Data Set user guidance.

National Codes:

01 Appliances Service
02 Arts Therapy Service
03 Cancer Service
04 Cardiac Service
05 Community Dental Service
06 Community Paediatrics Service
07 Continence Service
08 Contraception and Sexual Health Service (Retired 01 September 2015)
09 Counselling Service
10 Dermatology Service
11 Diabetes Service
12 District Nursing Service
13 Ear, Nose and Throat Service
14 End of Life Care Service
15 Gastrointestinal Service
16 Health Visiting Service
17 Hearing Service
~~18 Intermediate Care Service~~
18 Intermediate Care Service (Retired 01 April 2020)
19 Long Term Conditions Case Management Service
20 Musculoskeletal Service
21 Neurology Service
22 Nutrition and Dietetics Service
23 Occupational Therapy Service
24 Orthoptist Service
25 Pain Management Service
26 Physiotherapy Service
27 Podiatry Service

28 Public Health and Lifestyle Service
29 Rehabilitation Service
30 Respiratory Service
31 Rheumatology Service
32 School Nursing Service
33 Speech and Language Therapy Service
34 Vulnerable Children's Service
35 Vulnerable Adult's Service
36 Respite Care Service
37 Clinical Psychology Service
38 Children's Community Nursing Service
39 Diagnostic Service
40 Treatment Room Nursing Service
41 Haematology Service
42 Phlebotomy Service
43 Tissue Viability Service
44 Family Support Service
45 Integrated Multidisciplinary Team (jointly commissioned)
46 Prosthetic Service
47 Specialist Palliative Care Service
48 Enablement Service
49 Urgent Care Service
50 Wheelchair Service
51 Crisis Response Intermediate Care Service
52 Reablement Intermediate Care Service
53 Home-based Intermediate Care Service
54 Community Bed-based Intermediate Care Service

SERVICE TYPE

Change to Attribute: Changed Description

The type of SERVICE.

National Codes:

01 Ambulance Service
02 Cancer Service
03 Community Health Service
04 Consultant Led Service
05 Direct Access Service
06 Enhanced Sexual Health Service (Retired November 2014)
07 HIV Service
08 Hospital At Home Service
09 Improving Access to Psychological Therapies Service
10 Interface Service

11	Non-Consultant Led Service
12	Professional Staff Group Service (Retired 01 January 2016)
13	Sexual and Reproductive Health Service
14	Stop Smoking Service
15	Contraceptive Service (Retired 01 April 2014)
16	Radiotherapy Service
17	Sexual Health Service
18	Mental Health Service
19	Regional Clinical Genetics Service
20	Children and Young People's Mental Health Service
21	Screening Service
22	Sexually Transmitted Infection Service
23	Maternity Service
24	Health Visiting Service
25	Systemic Anti-Cancer Therapy Service
	Intermediate Care Service
	Community Bed-based Intermediate Care Service
	Crisis Response Intermediate Care Service
	Home-based Intermediate Care Service
	Reablement Intermediate Care Service

SETTLED ACCOMMODATION INDICATOR

Change to Attribute: Changed Description

An indication of whether the main/permanent residence of a PATIENT is settled ACCOMMODATION.

Settled ACCOMMODATION refers to secure, medium to long term ACCOMMODATION. The principle characteristic is that the occupier has security of tenure/residence in their usual accommodation in the medium to long term, or is part of a household whose head holds such security or tenure/residence.

~~Non-settled ACCOMMODATION refers to ACCOMMODATION arrangements that are precarious, or where the PERSON has no or low security of tenure/residence in their usual ACCOMMODATION and so may be required to leave at very short notice.~~Non-settled ACCOMMODATION refers to ACCOMMODATION arrangements that are precarious, or where the PATIENT has no or low security of tenure/residence in their usual ACCOMMODATION and so may be required to leave at very short notice.

National Codes:

Y	Yes - Settled ACCOMMODATION
N	No - Non-settled ACCOMMODATION
~~Z~~	~~Not Stated (PERSON asked but declined to provide a response)~~
Z	Not Stated (PATIENT asked but declined to provide a response)

WAITING TIME MEASUREMENT TYPE

Change to Attribute: Changed Description

The type of waiting time measurement methodology which may be applied during a PATIENT PATHWAY.

The methodology applied may be for one part of a PATIENT PATHWAY, such as the measurement of a REFERRAL TO TREATMENT PERIOD, or other parts of the PATIENT PATHWAY according to Department of Health and Social Care policy.

National Codes:

~~01~~ ~~Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement~~
01 Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement **
02 Allied Health Professional Referral To Treatment Measurement
03 Improving Access to Psychological Therapies Referral To Treatment Measurement *
04 Early Intervention in Psychosis Waiting Time Measurement *
~~09~~ ~~Other Referral To Treatment Measurement Type~~
05 Crisis Response Intermediate Care Within 2 Hours Waiting Time Measurement ***
06 Other Intermediate Care Within 2 Days Waiting Time Measurement ***
07 Crisis Response Intermediate Care Waiting Time Measurement ***
08 Other Intermediate Care Waiting Time Measurement ***
09 Other Referral To Treatment Measurement Type (not listed)

Notes:

- * National Codes 03 and 04 relate to the Waiting Time Measurements in the Improving Access to Psychological Therapies Data Set and Mental Health Services Data Set **only**. Other Data Sets which include WAITING TIME MEASUREMENT TYPE will not report National Codes 03 and 04.
- ~~** National Code 01 is also not valid for the Mental Health Services Data Set.~~
- ** National Code 01 is also not valid for the Mental Health Services Data Set
- *** National Codes 05, 06, 07 and 08 relate to the Waiting Time Measurements in the Community Services Data Set **only**. Other Data Sets which include WAITING TIME MEASUREMENT TYPE will not report National Codes 05, 06, 07 and 08.

ASSISTIVE TECHNOLOGY FINDING (SNOMED CT)

Change to Data Element: Changed Description

Format/Length:	See SNOMED CT CODE
National Codes:	
Default Codes:	

Notes:
ASSISTIVE TECHNOLOGY FINDING (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

~~ASSISTIVE TECHNOLOGY FINDING (SNOMED CT) is the SNOMED CT® concept ID which is used to identify the finding relating to the Assistive Technology that a PERSON is dependent on.~~ASSISTIVE TECHNOLOGY FINDING (SNOMED CT) is the SNOMED CT® concept ID which is used to identify the finding relating to the Assistive Technology that a PATIENT is dependent on.

CARE PLAN LAST UPDATED DATE

Change to Data Element: Changed Description

Format/Length:	an10 CCYY-MM-DD
National Codes:	
Default Codes:	

Notes:
CARE PLAN LAST UPDATED DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'Care Plan Last Updated Date'*.

~~For the Mental Health Services Data Set, where the CARE PLAN has not been updated since its creation, the CARE PLAN LAST UPDATED DATE will be the same as CARE PLAN CREATION DATE.~~For the Community Services Data Set and Mental Health Services Data Set, where the CARE PLAN has not been updated since its creation, the CARE PLAN LAST UPDATED DATE will be the same as CARE PLAN CREATION DATE.

CARE PLAN LAST UPDATED TIME

Change to Data Element: Changed Description

Format/Length:	an8 HH:MM:SS
National Codes:	
Default Codes:	

Notes:
CARE PLAN LAST UPDATED TIME is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code *'Care Plan Last Updated Time'*.

~~For the Mental Health Services Data Set, where the CARE PLAN has not been updated since its creation, the CARE PLAN LAST UPDATED TIME will be the same as CARE PLAN CREATION TIME.~~For the Community Services Data Set and Mental Health Services Data Set, where the CARE PLAN has not been updated since its creation, the CARE PLAN LAST UPDATED TIME will be the same as CARE PLAN CREATION TIME.

CARE PLAN TYPE (COMMUNITY CARE)

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See CARE PLAN TYPE FOR COMMUNITY CARE
Default Codes:	

Notes:
CARE PLAN TYPE (COMMUNITY CARE) is the same as attribute CARE PLAN TYPE FOR COMMUNITY CARE.

This data element is also known by these names:

Context	Alias
plural	CARE PLAN TYPES (COMMUNITY CARE)

CARE PLAN TYPE (COMMUNITY CARE)

Change to Data Element: New Data Element

CARE PLAN TYPE (COMMUNITY CARE)

Attribute:

CARE PLAN TYPE FOR COMMUNITY CARE

CHILDHOOD IMMUNISATION TYPE (CHILDREN AND YOUNG PEOPLE'S HEALTH SERVICES)

Change to Data Element: Changed Description

Format/Length:	an3
National Codes:	
Default Codes:	

Notes:
CHILDHOOD IMMUNISATION TYPE (CHILDREN AND YOUNG PEOPLE'S HEALTH SERVICES) is the same as attribute CHILDHOOD IMMUNISATION TYPE for a Child or Young Person in the Community Services Data Set.

Permitted National Codes:

010	Diphtheria
020	Pertussis
030	Tetanus
040	Polio
050	Haemophilus influenzae type b
060	Measles, Mumps, Rubella (MMR)
070	Meningococcal serogroup C (MenC)
090	Pneumococcal (PCV)
100	Low dose Diphtheria
110	Human papillomavirus (HPV)
120	Rotavirus
130	Hepatitis B (Hep B)

140 Tuberculosis (BCG)
150 Meningococcal serogroup B (MenB)
160 Meningococcal ACWY
170 Nasal Flu Vaccination

CHILD PROTECTION PLAN INDICATION CODE

Change to Data Element: Changed Description

Format/Length:	an1
National Codes:	See CHILD PROTECTION PLAN INDICATION CODE
~~Default Codes:~~	~~X - Not Known whether the PERSON is or has ever been the subject of a Child Protection Plan~~
Default Codes:	X - Not Known whether the PATIENT is or has ever been the subject of a Child Protection Plan

Notes:
CHILD PROTECTION PLAN INDICATION CODE is the same as attribute CHILD PROTECTION PLAN INDICATION CODE.

COMMUNITY CARE ACTIVITY TYPE renamed from COMMUNITY CARE ACTIVITY TYPE CODE

Change to Data Element: Changed Name

- Changed Name from Data_Dictionary.Data_Field_Notes.C.Co.COMMUNITY_CARE_ACTIVITY_TYPE_CODE to Data_Dictionary.Data_Field_Notes.C.Co.COMMUNITY_CARE_ACTIVITY_TYPE

GROUP SESSION TYPE (COMMUNITY CARE) renamed from GROUP SESSION TYPE CODE (COMMUNITY CARE)

Change to Data Element: Changed Name

- Changed Name from Data_Dictionary.Data_Field_Notes.G.Gr.GROUP_SESSION_TYPE_CODE_(COMMUNITY_CARE) to Data_Dictionary.Data_Field_Notes.G.Gr.GROUP_SESSION_TYPE_(COMMUNITY_CARE)

HEALTH VISITOR FIRST ANTENATAL VISIT DATE

Change to Data Element: Changed Description

Format/Length:	an10 CCYY-MM-DD
National Codes:	
Default Codes:	

Notes:
HEALTH VISITOR FIRST ANTENATAL VISIT DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Care Contact Date*'.

~~HEALTH VISITOR FIRST ANTENATAL VISIT DATE~~ ~~is the date of the first antenatal CARE CONTACT between the Health Visitor and the pregnant woman.~~HEALTH VISITOR FIRST ANTENATAL VISIT DATE is the date of the first antenatal CARE CONTACT between the Health Visitor and the pregnant PERSON.

ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT) (RETIRED)_ renamed from ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT)

Change to Data Element: Changed status to Retired, linked Attribute, Name, Description

~~Format/Length:~~	~~min an5 max an8~~
~~National Codes:~~	
~~Default Codes:~~	

~~**Notes:**~~
~~ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT) is the same as attribute ORGANISATION CODE.~~

~~ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT) is the ORGANISATION CODE of the Educational Establishment, including Schools.~~**This item has been retired from the NHS Data Model and Dictionary.**

~~**ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT) will be replaced with ORGANISATION IDENTIFIER (EDUCATIONAL ESTABLISHMENT), when it has been approved for use in national information standards.**~~**The last live version of this item is available in the ?**????? release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT) (RETIRED)_ renamed from ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT)

Change to Data Element: Changed status to Retired, linked Attribute, Name, Description

~~ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT)~~

~~**Attribute:**~~

~~ORGANISATION CODE~~

ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT) (RETIRED)_ renamed from ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT)

Change to Data Element: Changed status to Retired, linked Attribute, Name, Description

- Retired ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT)
- null

- Changed Name from Data_Dictionary.Data_Field_Notes.O.Org.ORGANISATION_CODE_(EDUCATIONAL_ESTABLISHMENT) to Retired.Data_Dictionary.Data_Field_Notes.O.ORGANISATION_CODE_(EDUCATIONAL_ESTABLISHMENT)
- Changed Description

ORGANISATION CODE (GP PRACTICE RESPONSIBILITY) (RETIRED)_ renamed from ORGANISATION CODE (GP PRACTICE RESPONSIBILITY)

Change to Data Element: Changed status to Retired, linked Attribute, Name, Description

~~Format/Length:~~	~~an3~~
~~National Codes:~~	
~~ODS Default Codes~~:	~~Q99 - High Level Health Geography/Primary Care Organisation of Residence Not Known~~ ~~X98 - Primary Care Organisation Not Applicable (Overseas Visitors)~~

~~Notes:~~
~~ORGANISATION CODE (GP PRACTICE RESPONSIBILITY) is the same as attribute ORGANISATION CODE.~~

~~ORGANISATION CODE (GP PRACTICE RESPONSIBILITY) is the ORGANISATION CODE of the Organisation responsible for the GP Practice where the PATIENT is registered, irrespective of whether they reside within the boundary of the Clinical Commissioning Group.~~**This item has been retired from the NHS Data Model and Dictionary.**

~~ORGANISATION CODE (GP PRACTICE RESPONSIBILITY) will be replaced with ORGANISATION IDENTIFIER (GP PRACTICE RESPONSIBILITY), when it has been approved for use in national information standards.~~The last live version of this item is available in the ?????? release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

ORGANISATION CODE (GP PRACTICE RESPONSIBILITY) (RETIRED)_ renamed from ORGANISATION CODE (GP PRACTICE RESPONSIBILITY)

Change to Data Element: Changed status to Retired, linked Attribute, Name, Description

~~ORGANISATION CODE (GP PRACTICE RESPONSIBILITY)~~

~~Attribute:~~

~~ORGANISATION CODE~~

ORGANISATION CODE (GP PRACTICE RESPONSIBILITY) (RETIRED)_ renamed from ORGANISATION CODE (GP PRACTICE RESPONSIBILITY)

Change to Data Element: Changed status to Retired, linked Attribute, Name, Description

- Retired ORGANISATION CODE (GP PRACTICE RESPONSIBILITY)
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.O.Org.ORGANISATION_CODE_(GP_PRACTICE_RESPONSIBILITY) to Retired.Data_Dictionary.Data_Field_Notes.O.ORGANISATION_CODE_(GP_PRACTICE_RESPONSIBILITY)
- Changed Description

ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION) (RETIRED)___ renamed from ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION)

Change to Data Element: Changed status to Retired, linked Attribute, Name, Description

~~Format/Length:~~ ~~max an6~~ ~~National Codes:~~ ~~Default Codes:~~

~~**Notes:**~~
~~ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION)~~ ~~is the same as attribute ORGANISATION CODE.~~

~~ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION)~~ ~~is the~~ ~~ORGANISATION CODE~~ ~~of the~~ ~~Organisation~~ ~~carrying out the immunisation.~~**This item has been retired from the NHS Data Model and Dictionary.**

~~**ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION) will be replaced with ORGANISATION IDENTIFIER (IMMUNISATION RESPONSIBLE ORGANISATION), when it has been approved for use in national information standards.**~~**The last live version of this item is available in the ?**????? release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION) (RETIRED)___ renamed from ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION)

Change to Data Element: Changed status to Retired, linked Attribute, Name, Description

~~ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION)~~

~~**Attribute:**~~

~~ORGANISATION CODE~~

ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION) (RETIRED)___ renamed from ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION)

Change to Data Element: Changed status to Retired, linked Attribute, Name, Description

- Retired ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION)
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.O.Org.ORGANISATION_CODE_(IMMUNISATION_RESPONSIBLE_ORGANISATION) to Retired.Data_Dictionary.Data_Field_Notes.O.ORGANISATION_CODE_(IMMUNISATION_RESPONSIBLE_ORGANISATION)
- Changed Description

ORGANISATION IDENTIFIER (EDUCATIONAL ESTABLISHMENT)

Change to Data Element: Changed Description

Format/Length:	min an5 max an8
National Codes:	
Default Codes:	

Notes:
ORGANISATION IDENTIFIER (EDUCATIONAL ESTABLISHMENT) is the same as attribute ORGANISATION IDENTIFIER.

ORGANISATION IDENTIFIER (EDUCATIONAL ESTABLISHMENT) is the ORGANISATION IDENTIFIER of the Educational Establishment, including Schools.

~~**ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT) will be replaced with ORGANISATION IDENTIFIER (EDUCATIONAL ESTABLISHMENT), when it has been approved for use in national information standards.**~~

ORGANISATION IDENTIFIER (GP PRACTICE RESPONSIBILITY)

Change to Data Element: Changed Description

Format/Length:	min an3 max an5
National Codes:	
ODS Default Codes:	Q99 - High Level Health Geography/Primary Care Organisation of Residence Not Known X98 - Primary Care Organisation Not Applicable (Overseas Visitors)

Notes:
ORGANISATION IDENTIFIER (GP PRACTICE RESPONSIBILITY) is the same as attribute ORGANISATION IDENTIFIER.

ORGANISATION IDENTIFIER (GP PRACTICE RESPONSIBILITY) is the ORGANISATION IDENTIFIER of the Organisation responsible for the GP Practice where the PATIENT is registered, irrespective of whether they reside within the boundary of the Clinical Commissioning Group.

~~**ORGANISATION CODE (GP PRACTICE RESPONSIBILITY) will be replaced with ORGANISATION IDENTIFIER (GP PRACTICE RESPONSIBILITY), when it has been approved for use in national information standards.**~~

ORGANISATION IDENTIFIER (IMMUNISATION RESPONSIBLE ORGANISATION)

Change to Data Element: Changed Description

Format/Length:	min an3 max an6
National Codes:	
Default Codes:	

Notes:
ORGANISATION IDENTIFIER (IMMUNISATION RESPONSIBLE ORGANISATION) is the same as attribute ORGANISATION IDENTIFIER.

ORGANISATION IDENTIFIER (IMMUNISATION RESPONSIBLE ORGANISATION) is the ORGANISATION IDENTIFIER of the Organisation carrying out the immunisation.

~~**ORGANISATION CODE (IMMUNISATION RESPONSIBLE ORGANISATION) will be replaced with ORGANISATION IDENTIFIER (IMMUNISATION RESPONSIBLE ORGANISATION), when it has been approved for use in national information standards.**~~

PERSON RELATIONSHIP (MAIN CARER)

Change to Data Element: Changed linked Attribute, Description

Format/Length:	an3
~~National Codes:~~	~~See RELATIONSHIP TO PERSON FOR CHILDREN AND YOUNG PEOPLE~~
National Codes:	See RELATIONSHIP TO PERSON FOR COMMUNITY
Default Codes:	

Notes:
~~PERSON RELATIONSHIP (MAIN CARER) is the same as attribute RELATIONSHIP TO PERSON FOR CHILDREN AND YOUNG PEOPLE.~~PERSON RELATIONSHIP (MAIN CARER) is the same as attribute RELATIONSHIP TO PERSON FOR COMMUNITY.

PERSON RELATIONSHIP (MAIN CARER) is the relationship between the PATIENT and the PERSON who undertakes the main caring role for them.

PERSON RELATIONSHIP (MAIN CARER)

Change to Data Element: Changed linked Attribute, Description

PERSON RELATIONSHIP (MAIN CARER)

Attribute:

~~RELATIONSHIP TO PERSON FOR CHILDREN AND YOUNG PEOPLE~~
RELATIONSHIP TO PERSON FOR COMMUNITY

REFERRAL TO TREATMENT PERIOD END TIME

Change to Data Element: New Data Element

Format/Length:	an8 HH:MM:SS
National Codes:	
Default Codes:	

Notes:
REFERRAL TO TREATMENT PERIOD END TIME is the same as attribute REFERRAL TO TREATMENT PERIOD END TIME.

This data element is also known by these names:

Context	Alias
plural	REFERRAL TO TREATMENT PERIOD END TIMES

REFERRAL TO TREATMENT PERIOD END TIME

Change to Data Element: New Data Element

REFERRAL TO TREATMENT PERIOD END TIME

Attribute:

REFERRAL TO TREATMENT PERIOD END TIME

REFERRAL TO TREATMENT PERIOD START TIME

Change to Data Element: New Data Element

Format/Length:	an8 HH:MM:SS
National Codes:	
Default Codes:	

Notes:
REFERRAL TO TREATMENT PERIOD START TIME is the same as attribute REFERRAL TO TREATMENT PERIOD START TIME.

This data element is also known by these names:

Context	Alias
plural	REFERRAL TO TREATMENT PERIOD START TIMES

REFERRAL TO TREATMENT PERIOD START TIME

Change to Data Element: New Data Element

REFERRAL TO TREATMENT PERIOD START TIME

Attribute:

REFERRAL TO TREATMENT PERIOD START TIME

SERVICE REQUEST DATE (NEWBORN HEARING AUDIOLOGY)

Change to Data Element: Changed linked Attribute, Description

Format/Length:	an10 CCYY-MM-DD
National Codes:	
Default Codes:	

Notes:
~~SERVICE REQUEST DATE (NEWBORN HEARING AUDIOLOGY) is the same as data element SERVICE REQUEST DATE.~~SERVICE REQUEST DATE (NEWBORN HEARING AUDIOLOGY) is the same as attribute ACTIVITY SERVICE REQUEST DATE.

SERVICE REQUEST DATE (NEWBORN HEARING AUDIOLOGY) is the date on which a referral for a Newborn Hearing Audiology Test was made.

SERVICE REQUEST DATE (NEWBORN HEARING AUDIOLOGY)

Change to Data Element: Changed linked Attribute, Description

SERVICE REQUEST DATE (NEWBORN HEARING AUDIOLOGY)

Attribute:

~~SERVICE REQUEST DATE~~
ACTIVITY SERVICE REQUEST DATE

WEEKLY HOURS WORKED

Change to Data Element: Changed Description

Format/Length:	an2
National Codes:	See WEEKLY HOURS WORKED
~~Default Codes:~~	~~98 - Not applicable (PATIENT not employed)~~
Default Codes:	98 - Not applicable (PERSON not employed)
	99 - Number of hours worked not known

Notes:
WEEKLY HOURS WORKED is the same as attribute WEEKLY HOURS WORKED.

COMMUNITY SERVICES DATA SET CONSTRAINTS

Change to XML Schema Constraint: New XML Schema Constraint

Data Set constraints applied to the Community Services Data Set.

Data Element	Format/Length	Range	Pattern Match	Reason / Comment
ETHNIC CATEGORY	max an2	None	None	Existing Format/Length means fixed length which is incorrect. Unable to change this as it is used in other data sets. Data Set allows max an2
NHS SERVICE AGREEMENT LINE NUMBER	max an10	None	None	Existing Format/Length means fixed length which is incorrect. Unable to change this as it is used in other data sets. Data Set allows max an10

For enquiries about this Change Request, please email information.standards@nhs.net