Community Services Data Set (CSDS) v1.5 User Guidance

Information and technology
for better health and care

Document Management

Revision History

Version	Date	Summary of Changes
1.2	20/01/2020	Uplifted to reflect changes introduced in CSDS v1.5
1.3	03/08/2020	Further changes based on user feedback
1.4	26/01/2021	Update link for guidance issued by the British Academy of Childhood Disabilities (BACD) in CYP404 table Added link to Urgent community response – two-hour and two-day response standards: 2020/21 technical data guidance in CYP104 table

Reviewers

This document must be reviewed by the following people:

Reviewer name	Title / Responsibility	Date	Version
Gavin Harrison	Business and Operational Delivery Manager; NHS Digital	26/01/2021	1.4

Approved by

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Name	Signature	Title	Date	Version
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Document Control:

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Acronyms

Acronym	What it stands for
BAAS	Burden Advice and Assessment Services (replaced Review of Central Returns - ROCR)
BACD	British Academy of Childhood Disability
CAG	Confidentiality Advisory Group (replaced Ethics and Confidentiality Committee - ECC/National Information Governance Board - NIGB)
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CDS	Commissioning Data Sets
ChiMat	Child and Maternal Health Observatory
CIDS	Community Information Data Set
CQC	Care Quality Commission
CYPHS	Children's and Young People's Health Services
DFES	Department for Education and Skills
DH	Department of Health
e-GIF	e- Government Interoperability Framework
ERG	Expert Reference Group
EPR	Electronic Patient Record
CAG	Confidentiality Advisory Group
GP/GMP	General Medical Practitioner
HES	Hospital Episode Statistics
HRA	Health Research Authority
HSCIC	Health and Social Care Information Centre (also known as NHS Digital)
ISN	Information Standards Notice (replaced Data Set Change Notice - DSCN)
MCDS	Maternity and Children's Data Set
MSDS	Maternity Services Data Set
NICE	National Institute for Health and Clinical Excellence
NIRS	NHS Information Reporting Services
NPSA	National Patient Safety Agency
NSF	National Service Framework
OPCS	Office of Population Censuses and Survey
PAS	Patient Administration System
PDS	Personal Demographic Service
SSD	Systems and Service Delivery
SUS	Secondary Uses Service
TOS	Technical Output Specification

Glossary of Non-Clinical Terms

The glossary of non-clinical terms is for use within the Community Services Data Set.

Term / Abbreviation	What it stands for
Aggregate data set	A set of data items (i.e. a data set) that captures data in aggregate form. Each record within the data set pertains to a specific form of grouping.
AHP	Allied Health Professionals work across a wide range of locations and sectors within acute, primary and community care. They are made up of the following staff groups: • Art, Drama, Music Therapists • Chiropodists/Podiatrists • Occupational Therapists • Orthoptists • Physiotherapists • Prosthetists and Orthotists • Radiographers Diagnostic and Therapeutic • Speech and Language Therapists • Dietitians
Anonymisation	A method applied to patient identifiable data items to protect the identity of individuals. Under anonymisation, the relevant data items are either randomly encrypted and no keys retained, or completely removed. Anonymised data cannot be linked with other data sets for the same individual, nor can it be reversed to expose the identity of an individual. Anonymisation is different from Pseudonymisation.
AQP	Any Qualified Provider - a means of commissioning certain NHS services in England. Clinical Commissioning Groups (CCGs) will determine the services to be commissioned as AQP; the intention is to increase patient choice. All providers must meet the qualification criteria set for a particular service and once qualified their service will appear on choose and book for patients to select. The AQP scheme means that, for some conditions, patients will be able to choose from a range of approved providers, such as hospitals or high street service providers.
BAAS	The Burden Assessment and Advice Service (BAAS) process makes sure that information demands on the NHS are minimised, fit with current national health policies and are carried out in the most efficient way without duplication. It covers the Department of Health and its Arm's Length Bodies (ALBs).
Care Pathway	Care pathways describe the route that a patient will take from their first contact with a healthcare provider to the completion of their treatment.
Central Data Repository	A repository of data relating specifically to the CSDS. Could also be known as a Central Data Warehouse.
CIDS	The Community Information Data Set is an information standard, approved by the governing standards body, which defines a patient-level data set. CIDS is an 'output data set'; therefore it sets out to describe "what should be extracted" from local IT systems. CIDS is not an input standard or 'clinical data set'; therefore, CIDS does not define "what should be captured or collected" from local IT systems. CIDS is approved for local collection only and is being retired on introduction of the CSDS, eliminating the need for a separate local data flow.
Clinical Governance	Clinical governance is defined by the Department of Health as describing "the structures, processes and culture needed to ensure that healthcare organisations - and all individuals within them - can assure the quality of the care they provide and are continuously seeking to improve it".

Collection Date	The date when services within the scope of this standard should start data collection in their electronic systems.
Commissioned Currencies	The payment system in England under which commissioners pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient's healthcare needs. The two fundamental features being nationally determined currencies and tariffs. Currencies are the unit of healthcare for which a payment is made, and can take a number of forms covering different time periods from an outpatient attendance or a stay in hospital, to a year of care for a long term condition. Tariffs are the set prices paid for each currency.
Conformance Date	The date when services and IT systems must conform to standards and meet the specification as set out in the mandate and guidance. This can be read as when the first submission window closes for the CSDS and care providers must therefore be fully conformant.
CSDS	The Community Services Data Set is an information standard, approved by the governing standards body, which defines a patient-level data set for all patients in receipt of publicly-funded Community Services. CSDS is an 'output data set'; therefore it sets out to describe "what should be extracted" from local IT systems and periodically be submitted to the central data repository. CSDS is not an input standard or 'clinical data set'; therefore, this data set does not define "what should be captured or collected" from local IT systems.
CYPHS Data Set	The Children and Young People's Health Services Data Set was an information standard, approved by the governing standards body, which defined a patient-level data set for all patients, aged 0-18 inclusive, in receipt of NHS-funded Community Services. The CYPHS data set was an 'output data set'; therefore it sets out to describe "what should be extracted" from local IT systems and periodically be submitted to the central data repository. The CYPHS data set was not an input standard or 'clinical data set'; therefore, the data set did not define "what should be captured or collected" from local IT systems. The CSDS replaces the CYPHS data set.
Data Controller	A person who (either alone or jointly or in common with other persons) determines the purposes for which and the manner in which any personal data are, or are to be, processed. A data controller must be a "person" recognised in law, that is to say: • individuals; • organisations; and • other corporate and unincorporated bodies of persons. Data controllers will usually be organisations, but can be individuals, for example self-employed consultants. Even if an individual is given responsibility for data protection in an organisation, they will be acting on behalf of the organisation, which will be the data controller.
Data Group	A collection of data items that describe a distinct event or episode. This can also be referred to as a table of data.
Data Item	A single component of a data group that holds one piece of information relating to an event or episode.
Data Set	The full collection of data groups. See 'Technical Output Specification'.
Data Submission File	One file related to a data set that data providers submit to the central data repository. A data submission consists of an Extensible Markup Language (XML) file containing the data for one or two consecutive reporting periods in the format defined by NHS Digital. When submitting two reporting periods in a single file, this would be the primary submission for month one and the refresh submission for month two.
DCB	Data Coordination Board - a committee with membership drawn from a range of health and social care organisations with responsibility for overseeing the development, assurance and approval of information

	standards, data collections, and data extractions used within the health and social care system.
Derived	A data item populated at the central data repository as part of post-deadline processing. The derived data item is based on the manipulation of the 'source' data items using mathematical, logical or other types of transformation process, or by using source data to derive further data from national look-up tables.
HSCIC	Health and Social Care Information Centre - A non-departmental body created by statute, also known as NHS Digital.
Information Standard	An Information Standard as specified within the Health and Social Care Act 2012 is 'a document containing standards in relation to the processing and use of information'. An Information Standard specifies rules for the processing, management and sharing of information and specifies what process is needed, the 'quality' required in the form of conformance criteria and how it can be implemented.
ISN	Information Standards Notices (ISNs) are issued by the Data Coordination Board (DCB) to give notice of changes to information requirements and information standards used by the NHS and Social Care Services.
Last Good File	The most recent collection of valid records submitted by a data provider for a reporting period. I.E Last successful submission without any critical errors.
N3	The NHS national broadband network linking hospitals, medical centres and General Medical Practices in England and Scotland. To be replaced by the Health and Social Care Network (HSCN). http://www.n3.nhs.uk/
NHS Digital	A data, information and technology resource for the health and care system which plays a fundamental role in driving better care, better services and better outcomes for patients in England. Previously (and still legally) known as the HSCIC.
Null	A data item with no value (i.e. blank) which therefore has no meaning. This is different from a value of 0, since 0 is an actual value.
ODS	Organisation Data Service (ODS) codes facilitate a patient's treatment by providing unique identification codes for organisational entities of interest to the NHS, for example NHS Trusts or CCGs, organisation sites such as hospitals, or GP Practices. The codes are distributed to the wider NHS and uploaded on to IT systems, thus providing a set of organisational data and organisation types, names, addresses etc that are consistent across the board.
Output Data Set	A set of standardised data items defining "what should be extracted" from local clinical IT systems. NHS trusts have the flexibility of adopting any local data collection process and system they see fit, so long as the system can extract data as per the Technical Output Specification (TOS). An output data set is not usually used for direct patient care and is only for secondary uses purposes e.g. national reporting.
Patient Level	Relating to a single data subject (e.g. person or patient), as opposed to an aggregate data set.
Post-deadline Processing	The processing undertaken at the close of a submission window by the central data repository.
Pre-deadline Processing	The processing carried out immediately on a submitted file to validate the file as a whole, extract the records that are (or may be) for the particular reporting period, and validate those records.
Pseudonymisation	A method applied to identifiable data items to protect the identity of individuals. Under pseudonymisation, a standard encryption key is used to encode patient identifiable data items so that data linkages within and outside the data set, for the same individual, are feasible. Because the encryption key is retained by a single "Data Controller", there is also the potential to reverse the process (de-code) and expose the identity of the

	individual. The encryption key is only decoded for specific purposes (e.g.: migration of data into another platform or enable linkages to other data sets). Pseudonymisation is different from Anonymisation.
Reference Data Set	A data set containing data groups and data items which are outside the scope of the original Community Information Data Set (CIDS), providing a comprehensive secondary uses data set for community care. The Reference Data Set has not been approved as a national data standard by the Data Coordination Board (DCB) or predecessor board, nor does the central data repository provide any storage capability for its data items.
Reporting Period	The period (usually a calendar month) for which a particular data upload refers.
RTT	Referral To Treatment refers to the length of waiting time for a patient's treatment, focusing on the entire patient journey from the initial receipt of a referral to the first definitive treatment.
Screening	A public health service in which members of a defined population, who do not necessarily perceive they are at risk of, or are already affected by a disease or its complications, are asked a question or offered a test, to identify those individuals who are more likely to be helped than harmed by further tests or treatment to reduce the risk of a disease or its complications.
Secondary Uses	Re-using clinical and operational information for purposes other than direct patient care. For example, national reporting.
Submission Cycle	The data submission frequency and timescales to which Information Management Services must be able to compile electronic files and make periodical electronic submissions in accordance to the standard.
Submission Period or Submission Window	The time period (usually approximately one calendar month) during which a data provider may submit data uploads for a given reporting period.
Systemic Capability	The ability to record information (clinical, administrative or for any other purposes) in an electronic form. This applies to commercial IT solutions, bespoke IT systems or modular electronic services which have the functional capability of extracting the required data to meet the standards of a specific output specification.
TCS	Transforming Community Services was a Department of Health programme that aimed to provide essential care to people, families and communities, from health promotion to end of life care. This care is provided in many settings, at critical points in people's lives, and often to those in vulnerable situations.
TOS	Technical Output Specification – a specification that fully defines the data items within the output data set. The Technical Output Specification splits the data set into a number of data groups (tables), each containing related data items and values.

Contents

1. About this Document

1.1 Purpose of the Document

The purpose of this document is to outline:

- The key implications for providers of the Community Services Data Set (CSDS) as a result of the approval of this standard which comprises the national data set and implementation guidance.
- The manner by which the national data set should be used and interpreted by users, system suppliers and other stakeholders, for example by providing additional information on data groups and data items, beyond that stated in the data set Technical Output Specification (TOS), to further explain their use and validation.

The CSDS is intended for secondary uses purposes using data collected by CSDS providers as a result of direct care of the patient. Information in the data set will be extracted from local care provider information systems from the data recorded as part of the care process.

1.2 Scope of the Document

This document is aimed at:

- Managers and clinical leads or organisations providing community services which are within the scope of the data set
- Information management departments within data provider organisations
- IT system suppliers operating within community services which are within the scope of the data set.

1.3 Schedule for Updating this Document

This document will be reviewed and updated when necessary. Changes to this document will not necessitate further approval from the Data Coordination Board (DCB); however, this is on the understanding that the changes do not affect the scope of the Information Standard.

2. Background Information

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 publicly-funded Community 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.

CSDS v1.5 is a minor uplift to the established CSDS v1.0 and is required to keep the data set relevant with current clinical practices, maintain compliance with national data standards, meet policy requirements and allow further submission of data by all age patients. To deliver this, there are a number of small structural changes in this release, but their introduction will have a minimal burden on the care provider or system supplier organisations.

This Information Standard has been approved by the Data Coordination Board (DCB) and has been assigned information standard number DCB1069. This mandates the patient-level CSDS as a national data standard.

The ISN does not directly place any requirement on system suppliers to accommodate the CSDS within their systems. The contractual agreement between data providers and system suppliers will dictate whether system suppliers have to abide by the ISN.

The current, formal Information Standard can be found at:

https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dcb1069-community-services-data-set

Further information and supporting documents can be found at:

https://www.digital.nhs.uk/Community-Services-Data-Set

3. Integration of clinical terminologies within the CSDS

CSDS has the ability to capture and flow information in the form of clinical terminology, including SNOMED Clinical Terms (CT) codes (see Section 3.4). In addition to SNOMED CT, CSDS v1.5 allows the submission of other types of clinical terminology and classifications where captured locally and where applicable, specifically ICD-10, Read Version 2 and Clinical Terms Version 3 (CTV3), though the latter two have been deprecated.

3.1 Why we integrated clinical terminologies within the data set?

The data set can benefit significantly from implementing clinical terminologies within the data model:

• Providers can choose between multiple schemes to submit clinical information. Specifically, providers can submit what they record over and above specific national information requirements. This enables commissioner information requirements to be better met through the data set.

• Using SNOMED CT to capture outcome measures reduces the need for individual tables for each measure. A single table can capture multiple measures using a common structure –

for example, multiple different scored assessments can be submitted in the CYP609 Coded Scored Assessment (Referral) and CYP612 Coded Scored Assessment (Contact) tables, rather than a separate table being needed for each type of scored assessment.
• The data set can respond more quickly to changes in clinical practice and information requirements. Terminology is updated at regular intervals (on a six-monthly basis for SNOMED CT) and the data set can automatically capture the latest terms without the need to change the structure or content of the data set through the DCB process.
• CSDS v1.5 conforms to the Personalised Health and Care 2020 policy, which requires local systems to move to using SNOMED CT as the single standard for holding data locally for primary use in all care settings by April 2020. This is also set out in the SCCI0034: SNOMED CT Information Standard.

3.2 What is SNOMED CT?

SNOMED CT is the standard clinical terminology for the NHS to support recording of clinical information, in a way that supports data management and analysis to support patient care, while enabling data extraction and data exchange.
SNOMED CT provides a comprehensive set of clinical phrases or terms; this is called a terminology. SNOMED CT is much more than just a set of clinical phrases, for example it also includes groups with relationships between terms. It is the most comprehensive international terminology currently available and can be used across all care settings and all clinical domains. SNOMED CT is managed and maintained internationally by SNOMED International and in the UK by the UK National Release Centre (part of NHS Digital).

3.3 What are the benefits of using SNOMED CT?

As the NHS moves to paperless records and the exchange of data electronically across the NHS, it is critical that all systems share the same clinical vocabulary. If every system uses its own vocabulary then interoperability is reduced to simply moving readable documents around the system and clinicians having to repeatedly transcribe data they need to be within their system, thus introducing errors.

The use of an international terminology enables system suppliers to design their system to a common terminology that can be implemented with less country specialisation across a number of countries. The last few years has seen a shift by suppliers from developing country specific solutions to global solutions with local configuration.

3.4 Further Resources for SNOMED CT

More information about SNOMED CT can be found on the NHS Digital SNOMED CT pages, including information about:
• Licensing the UK is a SNOMED International member country. Use of SNOMED CT in the UK is free; however, the use of SNOMED CT does require a licence. All SNOMED CT licensing enquiries can be sent to information.standards@nhs.net.
• Training NHS Digital offer a range of ways for individuals to learn more about SNOMED CT and its uses. For those who feel they need more understanding of SNOMED CT, NHS Digital provide a number of training and education resources. For an overview of SNOMED CT, the two live webinars provide a good introduction; you will also find case studies, brochures and technical guidance detailed on this web page. For system suppliers, you may also be interested in the more technical guidance provided through our recorded webinar on the release files.
• SNOMED CT browser The NHS Digital SNOMED CT browser enables users to search for SNOMED CT concepts and subsets. See also Section 5.2 for guidance covering the submission of SNOMED CT data items.

4. Configuration of local systems

The CSDS TOS fully defines the data items within the output data set. The TOS splits the data set into a number of groups, each containing related data items.

An output data set describes the set of data items data providers need to extract from local systems and submit to the central data warehouse. An output data set is distinctly different from a clinical data set, such as a Patient Administration System (PAS), in that it only defines the data that should be extracted, and so does not directly support patient care. In contrast, a clinical data set specifies data standards for clinical or operational purposes.

In many cases, the output data item will be identical to the operational definition. However, the two may differ both in terms of the format of the data item and the range of values presented.

The operational system may represent the data in a different manner or in more granularity; however, providing the operational data items can be mapped to the output data set, the operational system will not require any modification. This concept is illustrated in the following table:

Data Provider System (Clinical data set)		**CSDS Technical Output Specification**	
Data item name	**Format/Values**	**Data item name**	**Format/values**
Activity	- Blood pressure taken - Breast feeding advice given - Spinal injection	Community Care Activity Type Code	01 Administering Tests 04 Counselling, Advice, Support 03 Clinical Intervention
Location	- St Mary's Hospital - Appleby School	Activity Location Type Code	E03 Day Hospital L01 School

In each of the above scenarios, the input data items will map to the output data items.

It is possible that data providers may use the CSDS for local system implementation, and consequently only capture data as per the data set. However, this is imprudent and against the recommendations of NHS Digital. If CSDS is implemented as a clinical data standard, there is a possibility that key clinical care data items will be omitted from local systems, and this may adversely impact clinical care.

5. Constructing Submission Files

5.1 Key points relating to mandatory fields and validation

The CSDS Technical Output Specification fully defines the data items within the output data set and splits the data set into a number of tables, each containing related data items.

Mandatory data items and/or tables

The requirements for each data item are outlined in the original levels of mandation as described to DCB (as outlined in the mandatory/required/optional/pilot column in the Technical Output Specification):

Mandatory: These data items MUST be reported. Failure to submit these items will result in the rejection of the record.

Required: These data items SHOULD be reported where they apply. Failure to submit these items will not result in the rejection of the record but may affect the derivation of national indicators or national analysis. (Please note that the purpose of the data set is not to change clinical practice.)

Optional: These data items MAY be submitted on an optional basis at the submitters discretion.

Pilot: These data items have been included within the specification for piloting purposes only to support future implementation. These data items have not been approved and/or mandated and SHOULD NOT be submitted unless specifically requested by NHS Digital.

The three phases of validation correspond to these mandation levels. So for instance, if a data item is mandatory, it is likely to have data item level rejections for a null or invalid entry.

Whilst a particular table itself may not be mandatory, if a record is entered in this table then all of the table's mandatory fields must be completed.

The following tables are mandatory and MUST be submitted for all service users otherwise they will cause the whole file to reject if they do not:

CYP001 Master Patient Index and Risk Indicators and CYP002 GP Practice Registration.

In addition, the following table MUST contain a single record for each submission:

CYP000 CSDS Header

Other tables, such as the CYP607 Primary Diagnosis table, only require a record to be present where applicable to the service user. For this example, not all service users will have a recorded Primary Diagnosis and this whole table can be left blank in these cases. If a record is entered into this table then it must be recorded against all mandatory fields.

Validation of records

Upon submission of the data to the central data warehouse, three phases of validation are undertaken:

1. **File level**

Leading to rejection or issuing of a warning messages. A rejection would be of the entire submission against the selected reporting period, requiring identified issue(s) to be rectified and a resubmission made. Warning messages should be addressed and required actions undertaken.

Where these can be found: File-Level Rejects tab

Example: CYPREJ000 – Failed Submission File Format Check. The file is not a valid XML file.

2. Group level

These compare records within or across multiple tables, leading to rejection of multiple records or a warning message displayed. For example, they could be to check referential integrity between tables or for duplicated records within a table. Rejected records would not progress to post deadline processing. Records with warnings would progress, but data quality would not be as required.

Where these can be found: Individual table tab.

Example: CYP00171 – Group rejected - No valid CYP002 group transmitted for this Local Patient Identifier (Extended).

3. Record level

These can be against a single data item or across multiple data items within a single record, leading to either the rejection of the record or a warning displayed. Rejected records would not progress to post deadline processing. Records with warnings would progress, but data quality would not be as required.

Where these can be found: Individual table tabs

Example: CYP00104 - Record rejected - Local Patient Identifier (Extended) is blank

Each data item within the data set specification may have any of the above types of validation.

Please see the validations and warnings in the Technical Output Specification to understand the submission requirements for each table.

Inclusion rules

CSDS is referral driven. Each monthly submission should include all open referrals within that reporting period, which includes:

- referrals that were opened in the reporting period
- referrals that closed in the reporting period
- referrals that were open throughout the reporting period, even if no activity took place.

All episode tables (those with start and end dates) within the data set follow the same inclusion concept.

The rest of the tables have their own inclusion rules which specify when they should be included for a reporting period. For example, Care Contacts would be included only in the Reporting Period they took place, but other tables such as Diagnosis allow the “most recent” details to flow.

You can find out the rules by looking at the validations in the latest Technical Output Specification. The column “Additional Validation Rules” outlines the date restrictions. Please also see section 5 of this User Guidance which contains a description of each table.

If a large amount of data is submitted, outside of the required range, then numerous rejection messages will be generated back to the provider. This may hinder the provider’s ability to identify 'real' rejection messages that require corrections to be made to “included” data. Users are advised to place greater emphasis on checking the date validation rules, prior to submission, to identify and submit data that is relevant to the reporting period only.

6. Data Item Guidance

This section provides further clarity regarding the data items included within the Technical Output Specification where this is deemed to be necessary. This includes fully explaining how groups may or may not repeat and extending description and explanation of data items where space does not permit within the data set output specification.

6.1 Linkage and Identifier Data Items

The linkage data items are fully described within the Data Set Technical Output Specification.

Please note that linkage data items must be submitted in each table where they are included, however not all of the tables are required to be sent with each submission.

Local Patient Identifier (Extended) – this uniquely identifies a patient within the local information system. This is a mandatory requirement to enable linkage of the data.

This data item is included in the following tables:

- CYP001 – Master Patient Index and Risk Indicators
- CYP002 – GP Practice Registration
- CYP003 – Accommodation Type
- CYP004 – Care Plan Type
- CYP006 – Social and Personal Circumstances
- CYP007 – Employment Status
- CYP101 – Service or Team Referral
- CYP401 – Special Educational Need Identified
- CYP402 – Safeguarding Vulnerability Factor
- CYP403 – Child Protection Plan
- CYP404 – Assistive Technology To Support Disability Type
- CYP501 – Coded Immunisation
- CYP502 – Immunisation
- CYP601 – Medical History (Previous Diagnosis)
- CYP602 – Disability Type
- CYP603 – Newborn Hearing Screening Audiology Referral
- CYP604 – Blood Spot Result Type
- CYP605 – Infant Physical Examination (GP Delivered)

NHS Number – Whilst the patient's NHS number ***should*** be supplied wherever it is known, NHS Digital accepts that there may be occasions where the NHS number is not known.

When the NHS number is provided, this will be used instead of the Local Patient Identifier as the primary unique identifier for a person.

The capture of the NHS number is vital as this is the only identifier that allows a patient to be tracked across different organisations or across a single organisation when multiple Local Patient Identifiers have been used for a person.

In some cases, the NHS number can be used to replace the Local Patient Identifier. This is to support when a patient is referred to services using a number of different systems. In this

case, the NHS number would then populate both the NHS number and the Local Patient Identifier data items.

Although the NHS number is not a mandated field, as not every person will have one, data quality reports will be produced to identify the completeness of this field and it is recommended that local care providers use this as one of the primary data quality metrics for all patient level data sets.

In cases where a patient's NHS number is unavailable (which may be because the person does not possess one) data providers must submit a null NHS number and [07] *Number not present and trace not required* in NHS NUMBER STATUS INDICATOR CODE.

Service Request Identifier – this uniquely identifies a referral for a patient within the healthcare organisation.

This data item included in the following tables:

- CYP101 – Service or Team Referral
- CYP102 – Service or Team Type Referred To
- CYP103 – Other Reason For Referral
- CYP104 – Referral To Treatment
- CYP105 – Onward Referral
- CYP201 – Care Contact
- CYP606 – Provisional Diagnosis
- CYP607 – Primary Diagnosis
- CYP608 – Secondary Diagnosis
- CYP609 – Coded Scored Assessment (Referral)

Care Contact Identifier – this uniquely identifies a care contact between patient and clinician(s) within the healthcare organisation.

This data item is included in the following tables:

- CYP201 – Care Contact
- CYP202 – Care Activity

Care Activity Identifier – this uniquely identifies a care activity between patient and clinician(s) within the healthcare organisation.

This data item is included in the following tables:

- CYP202 – Care Activity
- CYP610 – Breastfeeding Status
- CYP611 – Observation
- CYP612 – Coded Scored Assessment (Contact)

Care Plan Identifier - this uniquely identifies a care plan between patient and clinician(s) within the healthcare organisation.

- CYP004 – Care Plan Type
- CYP005 – Care Plan Agreement

6.2 Data relating specifically to children

The CSDS was developed from the previous CYPHS data set. As such, while the data set covers all patients who are in contact with publicly-funded Community Services, a number of tables and items within the data set continue to relate specifically to children. These tables and items should only be submitted for patients aged 0-18, i.e. those who were previously within scope of the CYPHS data set. Validations are in place to prevent the flow of this data for patients above a certain age (usually 19 or over), or those where no date of birth is provided, and these are detailed in the TOS.

The specific tables and items affected are identified in Section 6.3, but a summary is also included below:

- CYP001 – Master Patient Index and Risk Indicators (specific data items as follows)
    - Looked After Child Indicator
    - Safeguarding Vulnerability Factors Indicator
    - NHS Number (Mother)
    - NHS Number Status Indicator Code (Mother)
- CYP401 – Special Educational Need Identified
- CYP402 – Safeguarding Vulnerability Factor
- CYP403 – Child Protection Plan
- CYP502 – Immunisation
- CYP603 – Newborn Hearing Screening Audiology Referral
- CYP604 – Blood Spot Result
- CYP605 – Infant Physical Examination (GP Delivered)
- CYP610 – Breastfeeding Status

In addition, the CYP501 Coded Immunisation table is only expected to be submitted for children. Providers are not expected to submit adult data in this table, though this is not prohibited through validation.

6.3 Breakdown of Data Items by Group

6.3.1 CYP000 CSDS Header

CYP000 CSDS Header	
Description	
The Header should include metadata relating to the submission, including which organisation and reporting periods the data relates, the primary system in use and the date/time the submission was created.	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
DATA SET VERSION NUMBER	The version of the CSDS that this submission file is for. The current version of the data set is 1.5.
ORGANISATION IDENTIFIER (CODE OF PROVIDER)	This is the Organisation Identifier of the organisation acting as a Health Care Provider.
ORGANISATION IDENTIFIER (CODE OF SUBMITTING ORGANISATION)	Organisation Identifier is the unique identifier of the organisation acting as the physical sender of a data set submission. This code provides an audit trail where a different organisation is undertaking the submission on behalf of the provider organisation. It will not be carried over into the national database.
PRIMARY DATA COLLECTION SYSTEM IN USE	This is a free text field. Where multiple systems are in use, please indicate the primary system in use, from which the highest number of records is extracted.
REPORTING PERIOD START DATE	The reporting period start date to which this file refers.
REPORTING PERIOD END DATE	The reporting period end date to which this file refers.
DATE AND TIME DATA SET CREATED	Date/time this upload file was created.

6.3.2 CYP001 Master Patient Index and Risk Indicators

CYP001 Master Patient Index and Risk Indicators	
Description	
This group contains information on patient identifiers, demographic information, organisational data, and risk indicators. The collection of these data items can be used to analyse outcomes across different ethnic groups, age groups and geographic location. This data group should include a record for each patient receiving care within the healthcare provider community services. It includes data items designed to capture information on patient identifiers, demographic information, details of the patient's GP, and organisational data. The demographic data can be used to analyse information across different demographic parameters. Personal and demographic data must be captured at time of registration and should be reviewed with the patient at appropriate intervals to ensure it is correct and up to date. Providers should supply CYP001 data as it was at the end of the reporting period. Providers must populate all known data items within this group even if they are unchanged since the last submission. Do not just provide data for all "changed" data items. **Please note that the CYP001 table is mandatory and must be included in every submission file, along with the CYP002 table.**	
Group Level Validation and Repeating Rules	
These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
LOCAL PATIENT IDENTIFIER (EXTENDED)	An identifier used to identify a patient uniquely within a health care provider. This is the primary key that enables groups of data to be joined together. As such this is a mandated item and the record will be rejected if it is not included within this group. Duplicate Local Patient Identifiers within the Patient group will cause the entire file to be rejected. Providers should ensure that Local Patient Identifiers are not duplicated across multiple submission files for different patients.

ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)	This will identify the organisation where the Local Patient Identifier was issued. It is necessary where organisations have gone through a merger or split into a new or existing organisation. If Local Patient Identifiers are not modified during the merger or split of an organisation, then the issuing Organisation Identifier of the Local Patient Identifier (even if now discontinued) should be sent in this field. However, if the Local Patient Identifier has been modified since the organisation change i.e. by prefix etc, then the new organisation identifier should be used.
ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	This field can routinely be left blank, however if populated it should contain the organisation identifier of the commissioner with which the patient is resident. The organisation identifier should be current at the end of the reporting period. If this item is left blank NHS Digital will derive this information based on postcode of usual address, using a lookup file which assigns the patient to an organisation. Providers are able to override this derivation (for instance, if they are aware that a particular CCG has residence responsibility for a patient) by manually entering an organisation Identifier in this field.
ORGANISATION IDENTIFIER (EDUCATIONAL ESTABLISHMENT)	This is an identification number allocated to each educational establishment by the Department for Education. The allocated identification number is six digits, but this is prefixed with 'EE' on the Organisation Data Service reference file.
NHS NUMBER	**The importance of the NHS Number** Although this is not a mandated field, as not all patients have NHS numbers, data quality reports will be produced to identify the completeness of this field and it is recommended that local care providers use this as one of the primary data quality metrics for all patient level data sets. Duplicate NHS Numbers within this group will cause the entire file to be rejected. Duplicate NHS Numbers across multiple submission files will cause both records to be rejected even if it is unique within each submission file.

NHS NUMBER STATUS INDICATOR CODE	In most cases, this data item will be flowed with value [01] - *Number present and verified*. The [01] will indicate that the data provider has validated the number against the central Personal Demographics Service (PDS), and therefore facilitates reliable data linkage. Data providers may flow data for patients with a NHS number status indicator code other than [01] and they will be accepted, however, reports that need reliable linkage of groups will exclude these data groups(unless reliable linkage is available via LOCAL PATIENT IDENTIFIER data items). **No NHS number** In cases where a patient's NHS number is unavailable (which may be because the patient does not possess one) data providers must submit a null NHS number and [07] *Number not present and trace not required* in NHS NUMBER STATUS INDICATOR CODE.
PERSON BIRTH DATE	The date on which a patient was born or is officially deemed to have been born. This is required to enable the positive identification of a patient.
POSTCODE OF USUAL ADDRESS	The postcode of usual address as stated by the person. If the person has no fixed abode this should be recorded with the appropriate code (ZZ99 3VZ). For overseas residents, the postcode will be recorded in the format ZZ99 xxZ, where xx denotes the country pseudo postcode. A full list of pseudo postcodes is available from: https://digital.nhs.uk/organisation-data-service/data-downloads
PERSON STATED GENDER CODE	Person Stated Gender Code is self-declared or inferred by observation for those unable to declare their Person Stated Gender. The current gender of the patient. The classification is phenotypical rather than genotypical i.e. it does not provide codes for medical or scientific purposes. The [0] *Not Known* national code should be used where the sex of the patient has not been recorded. The [9] *Not Specified* national code should be used where the gender of the patient is indeterminate i.e. unable to be classified as either male or female.

ETHNIC CATEGORY	Ethnicity, as specified by the person. The [Z] *Not Stated* national code should only be used where the patient has been asked and has declined to provide their ethnic category because of refusal or the inability to choose. The [99] *Not Known* national code should be used where the patient has not been asked or where the patient was not in a suitable condition to be asked.
LANGUAGE CODE (PREFERRED)	This is the language the patient prefers to use for communication with a Health Care Provider.
PERSON RELATIONSHIP (MAIN CARER)	The relationship between the patient and the person/s who undertake/s the main caring role for them.
HEALTH VISITOR FIRST ANTENATAL VISIT DATE	The date when a Health Visitor successfully attends the first antenatal visit with the pregnant woman who becomes the mother of the patient (unborn child). This data should be recorded against the child's record, rather than the mother's until further notice. NHS Digital will be consulting on how to record this data item in v2.0 of CSDS which may constitute a methodological change. Currently, this data item cannot take place after the patient was born and cannot take place more than 1 year before the patient was born.
LOOKED AFTER CHILD INDICATOR	This data item is only applicable to children and young people. The record is therefore rejected for patients aged 19 or over (or if no date of birth is supplied). Where it is relevant to collect information on whether the child or young person is in local authority care either [N] *No* or [Y] *Yes* should be recorded. If information is required about whether a child or young person is in local authority care but either it is not stated or disclosed at a contact then [X] *Not Known* should be recorded.
SAFEGUARDING VULNERABILITY FACTORS INDICATOR	A Yes/No indicator to show whether there are any Child Safeguarding vulnerability factors. This data item is required where applicable and only applies to children/young people. The record is therefore rejected for patients aged 19 or over (or if no date of birth is supplied).

CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR	This indicates that a disabled person needs round the clock care and/or supervision for maintenance of their safety and/or wellbeing.
EDUCATIONAL ASSESSMENT OUTCOME	The outcome of an Educational Assessment. The Education Assessment is a multidisciplinary assessment of the educational needs of a child involving both health and Local Authority staff.
PREFERRED DEATH LOCATION DISCUSSED INDICATOR	An indication of whether the preferred place of death was discussed with a patient or proxy by a clinician, in the event that there is an expected risk of death.
PERSON AT RISK OF UNEXPECTED DEATH INDICATOR	An indication of whether a patient is at risk of sudden, unexpected death.
DEATH LOCATION TYPE CODE (PREFERRED)	This is the preferred place of death as specified by the patient. The data value '4 - Patient's Own Home' should include the patient's usual place of residence, e.g. Prison. Should only be populated for patients on an End of Life pathway, in all other cases this field should be left blank.
PERSON DEATH DATE	This must be submitted for any known death not only where a death certificate is issued.
DEATH LOCATION TYPE CODE (ACTUAL)	The actual place where the patient died. The data value '4 - Patient's Own Home' should include the patient's usual place of residence, e.g. Prison. Should only be populated for patients on an End of Life pathway, in all other cases this field should be left blank.
DEATH NOT AT PREFERRED LOCATION REASON	This will indicate the reason why the person did not die at their preferred place of death.
NHS NUMBER (MOTHER)	NHS Number of the child's birth mother to link with the Maternity data set. This data item is only applicable to children and young people. The record is therefore rejected for patients aged 19 or over (or if no date of birth is supplied).

NHS NUMBER STATUS INDICATOR CODE (MOTHER)	The NHS NUMBER STATUS INDICATOR of the mother. This data item is only applicable to children and young people. A warning is output if the NHS number (Mother) provided is blank, and the person is under 19 at the start of the reporting period (as the mother's NHS Number should be supplied for patients aged 0-18, and an associated status should therefore also be provided even if the mother's NHS number is not available).

6.3.3 CYP002 GP Practice Registration

CYP002 GP Practice Registration	
Description	
Describes the GP practice where the patient is registered. The group includes start and end dates for when the patient was registered with the practice. **Please note that the CYP002 table is mandatory and must be included in every submission file, along with the CYP001 table.**	
Group Level Validation and Repeating Rules	
These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
LOCAL PATIENT IDENTIFIER (EXTENDED)	An identifier used to identify a patient uniquely within a health care provider. This is the primary key that enables groups of data to be joined together. As such this is a mandated item and the record will be rejected if it is not included within this group. Duplicate Local Patient Identifiers within the Patient group will cause the entire file to be rejected. Providers should ensure that Local Patient Identifiers are not duplicated across multiple submission files for different patients.

GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	General Medical Practice Code (Patient Registration) is the Organisation Code of the GP Practice that the patient is registered with. Where the patient is not registered to a GMP Practice, the data provider must submit V81997. Where the GMP Practice Code is not applicable, the data provider must submit V81998. Where the GMP Practice Code is not known, the data provider must submit V81999.
START DATE (GMP PATIENT REGISTRATION)	The start date on which the patient registered with the General Medical Practice. This field is primarily to track changes to the GP and their commissioner during the referral. This field should only be populated if the actual start date is known. If this is not known then it is acceptable to leave this field blank. If the patient changes General Medical Practice whilst under the care of Community Services then it is expected that the start date of the patient's new General Medical Practice will be populated.
END DATE (GMP PATIENT REGISTRATION)	The end date on which the patient registered with the General Medical Practice. This field is primarily to track changes to the GP and their commissioner during the referral. If this field is left blank the General Medical Practice Code recorded in this table will be assumed to be current. If the patient changes General Medical Practice whilst under the care of Community Services then it is expected that the end date of her previous General Medical Practice will be populated.
ORGANISATION IDENTIFIER (GP PRACTICE RESPONSIBILITY)	This field can routinely be left blank, however if populated it should contain the organisation identifier of the commissioner that is associated with the patient's current registered GP Practice. This field is used to overwrite the commissioner associated with a GP's registered population, which is derived from the General Medical Practice Code Patient Registration by NHS Digital.

6.3.4 CYP003 Accommodation Type

CYP003 Accommodation Type	
Description	
Describes the current accommodation status of the person. **General Table Guidance** It is good practice to keep an up-to-date record of a patient's accommodation status, taking into account the frequency of contacts with that individual patient. On average once a month should be sufficient, but this could be captured more frequently if this is required by clinical practice.	
Group Level Validation and Repeating Rules	
These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
LOCAL PATIENT IDENTIFIER (EXTENDED)	An identifier used to identify a patient uniquely within a health care provider. This is the primary key that enables groups of data to be joined together. As such this is a mandated item and the record will be rejected if it is not included within this group. Duplicate Local Patient Identifiers within the Patient group will cause the entire file to be rejected. Providers should ensure that Local Patient Identifiers are not duplicated across multiple submission files for different patients.

ACCOMMODATION STATUS CODE	The purpose of this data item is to identify any person who is either homeless or living in an institutional residence. Accommodation Status is a hierarchical list of values which may be captured either at the high/heading level e.g. [HM00] 'Homeless' or the lower more detailed level e.g. [HM04] 'Sofa surfing' depending on local arrangements. The '[OC96] Not elsewhere classified' national code should be used where an accommodation status is recorded but cannot be mapped to a value in the national list. The '[OC97] Not specified' is where the client was asked their accommodation status but did not provide a response. The '[OC98] Not applicable' national code should be used where it was not appropriate to capture an accommodation status for a client. The '[OC99] Not known' national code should be used where the client has not been asked or where the client was not in a suitable condition to be asked. Where data providers capture the information in a different format or at a lower level, then they should be mapped to an appropriate value stated in the national code list.
ACCOMMODATION STATUS RECORDED DATE	The date when the accommodation status was observed.

6.3.5 CYP004 Care Plan Type

CYP004 Care Plan Type
Description
To carry details of Care Plans created for a patient by the organisation, excluding Discharge Plans which are contained in the Service of Team Referral table. One occurrence of this group is permitted for each Care Plan created for the patient.
Group Level Validation and Repeating Rules
These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*
Additional Notes on Data Items

Data Item Name	Additional Notes
CARE PLAN TYPE (COMMUNITY CARE)	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.

6.3.6 CYP005 Care Plan Agreement

CYP005 Care Plan Agreement	
Description	
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.	
Group Level Validation and Repeating Rules	
These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
CARE PLAN AGREED BY	If a patient is incapacitated, they may have had little or no input into the agreement, however an agreement is still in place and information can flow. If a clinician has had a conversation with a member of the patient's family to agree on appropriate care for the incapacitated patient, then two records should flow. One to indicate that the clinician has agreed the care plan (13 – Clinical Service or Team) and one to indicate that the family member has agreed the care plan (11 – Family member or carer). There is no agreement directly with the patient, and therefore no record to indicate patient agreement. If the only discussion that has taken place regards a patient's care plan is between a clinician and an incapacitated patient, this would not be sufficient to merit an agreement, as the patient is unable to understand or consent to the plan. In this scenario, the information should not flow in the care plan agreement table.

6.3.7 CYP006 Social and Personal Circumstances

CYP006 Social and Personal Circumstances	
Description	
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. **General Table Guidance** Please note that submission must be made using the specified SNOMED CT subsets for each data element, which can be found via the SNOMED CT Term Browser. The SNOMED CT subsets for both data elements are aligned 1:1 with the NHS Data Model and Dictionary National Codes.	
Group Level Validation and Repeating Rules	
These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**

SOCIAL AND PERSONAL CIRCUMSTANCES (SNOMED CT)	**RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE** SNOMED CT Religious or other belief system affiliation group code subset: Religious or other belief system affiliation groups (Term Browser) This link provides the full list of Religious or other belief system affiliation group SNOMED codes. DD4C Subset Metadata: Religious or other belief system affiliation groups (DD4C) NHS Data Model and Dictionary Service mapping: RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE Notes: Please note the following mapping between the National Codes and SNOMED CT Subset: “62458008 | Has religious belief (finding)” aligns with “K – Other” “312865007 Religion not given – patient refused (finding)” aligns with “M – Declines to Disclose” “160552003 Not religious (finding)” aligns with “L – None” Please note the addition of “Agnostic (person)” within the SNOMED CT terms, which is currently not aligned with the NHS Data Model and Dictionary. **RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION CODE** NHS Data Model and Dictionary Service mapping: RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION CODE **PERSON STATED SEXUAL ORIENTATION CODE** SNOMED CT Sexual orientation subset: Sexual orientation findings (Term Browser) This link provides the full list of Sexual orientation SNOMED codes DD4C Subset Metadata: Sexual orientation findings (DD4C)

	NHS Data Model and Dictionary Service mapping: PERSON STATED SEXUAL ORIENTATION Notes: Please see the DCB2094 Sexual Orientation Monitoring webpage for further details regarding this separate information Standard. In particular, Appendix A of the Implementation Guidance contains a mapping table for the national codes.
SOCIAL AND PERSONAL CIRCUMSTANCES RECORDED DATE	This data item is a Mandatory data item within the Technical Output Specification.

6.3.8 CYP007 Employment Status

CYP007 Employment Status	
Description	
The current employment status of a patient. One occurrence of this Group is permitted for each employment status, containing the most recently recorded employment details. **General Table Guidance** It is good practice to keep an up-to-date record of a patient's employment status (where applicable), taking into account the frequency of contacts with that individual patient. On average once a month should be sufficient, but this could be captured more frequently if this is required by clinical practice. It is not intended for an employment status to flow for every patient, however if the information is recorded locally it SHOULD flow.	
Group Level Validation and Repeating Rules	
These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**

EMPLOYMENT STATUS	**[01] Employed:** Employed refers to those who are employed by a company and have their National Insurance paid for directly from their wages. It also includes those who are self-employed (i.e. those who work for themselves and generally pay their National Insurance themselves); those who are in supported employment; and those who are in permitted work (i.e. those who are in paid work and who are also receiving Incapacity Benefit). It should also include those who are unpaid family workers (i.e. those who do unpaid work for a business they own or work for a business a relative owns). **[02] Unemployed and actively Seeking Work:** Unemployed refers to those who are not in paid work but are actively seeking work and are available to start, or are waiting to start a paid job they have already obtained. Other Employment Status codes (03, 04, 05, 06, 07, 08) represent those who are economically inactive, that is, those who are not in paid work and who are not actively seeking work, or they are not available to start.
EMPLOYMENT STATUS RECORDED DATE	The date on which the assessment was done. This date should change with each review even if the Employment Status remains the same.
WEEKLY HOURS WORKED	The number of hours worked in a typical week.

6.3.9 CYP101 Service or Team Referral

CYP101 Service or Team Referral
Description
This group must contain a record for each open referral to the Community Healthcare Provider for the patient. This includes referrals that were not accepted by the provider. Both external and internal referrals should be included. A Service Referral is a request for a care service to be provided for a patient. It includes patient self-referrals for an appointment to see or be in contact with a Care Professional of an organisation. A patient may have multiple referrals within a reporting period. **Each submission must include all open referrals along with all associated records that have been updated or created within that reporting period. This includes referrals where no activity has taken place within that reporting period. Referrals that closed within the reporting period must also be submitted.**

Group Level Validation and Repeating Rules	
These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
SERVICE REQUEST IDENTIFIER	An identifier used to identify a referral uniquely within a health care provider. This is the primary key that enables groups of data to be joined together. As such this is a mandated item and the record will be rejected if it is not included within this group. Where multiple systems are used it is acceptable to include a prefix to the Service Request Identifier, which relates to the system. The prefix enables each identifier to remain truly unique for all submissions from an organisation. Duplicate Service Request Identifiers with the Service Referral group will cause the entire file to be rejected. Duplicate Service Request Identifiers across multiple submission files will cause both records to be rejected even if it is unique within each submission file.
LOCAL PATIENT IDENTIFIER (EXTENDED)	An identifier used to identify a patient uniquely within a health care provider. This is the primary key that enables groups of data to be joined together. As such this is a mandated item and the record will be rejected if it is not included within this group. Duplicate Local Patient Identifiers within the Patient group will cause the entire file to be rejected. Providers should ensure that Local Patient Identifiers are not duplicated across multiple submission files for different patients.
ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	This is the organisation identifier of the organisation that is commissioning health care provided under this referral or referral type. This can be used to identify a specialist commissioner.
REFERRAL REQUEST RECEIVED DATE	This is the date the referral request was received by the Health Care Provider. The waiting time for a first appointment should be calculated from the date when the referral request is received. For electronic referrals the referral request received date is the date the referral is received electronically by the Health Care Provider. For Choose and Book, the referral is received when the patient's Unique Booking Reference

	Number (UBRN) is used to book the first outpatient appointment slot (i.e. converted). Where an electronic referral made through Choose and Book is rejected by the chosen provider, the original referral request received date should be used when the patient is subsequently re-referred to another service, so that patients are not unfairly disadvantaged when their waiting time calculations are made. In the circumstance that a patient calls the national Choose and Book Appointments Line and an appointment slot is not available with the chosen Health Care Provider, the national Choose and Book Appointments Line will electronically forward the referral details to the chosen Health Care Provider so the Health Care Provider can liaise directly with the patient to arrange their appointment. The referral request received date will be the date that the Health Care Provider receives electronic notification from the national Choose and Book Appointments Line that the patient has experienced slot unavailability. (Note that this is NOT the date that the Health Care Provider opens or actions the electronic notification). Written referral letters must be opened and date stamped on the day of receipt. It is this date that must be entered on any PAS or similar system, not the date on which the information is fed into the system if this is later than the date of receipt. If the referral takes the form of a phone call followed by a letter, record the date when the letter arrives. If there is no following letter, the date of the verbal request should be recorded.
REFERRAL REQUEST RECEIVED TIME	This records the time the referral request was received. This item is only required for 'urgent' priority referrals into services with target waiting times measured in hours e.g. rapid response teams or urgent care. The time should be recorded using the 24 hour clock format in eGIF format i.e. hh:mm:ss.
NHS SERVICE AGREEMENT LINE NUMBER	This may be used to identify a specific NHS Service Agreement reference. This is primarily for local use and enables Health Care Providers to associate specific referrals or referral types with unique service lines agreed with their Commissioners.

SOURCE OF REFERRAL FOR COMMUNITY	A classification which identifies the source of referral to a Community Health Service. Internal referrals should normally be recorded as 'Community Service' and the Referring Organisation Identifier will be the same as the Organisation Identifier (Code of Provider). For example, for an internal referral the national code to use is 07 (as outlined within the Technical Output Specification), for Community Health Service (same or other Health Care Provider). Selected data value notes: ‘10 – Educational Establishment’ includes schools ’13 – Care Home’ includes Care Homes with and without nursing’ ’19 – Telephone or Electronic Access Service’ includes the NHS 111 service
ORGANISATION IDENTIFIER (REFERRING)	This field should contain the Organisation Identifier of the referring organisation. For internal referrals the Referring Organisation Identifier will be the same as the Organisation Identifier (Code of Provider). It will not be applicable for a self-referral and the following code should be used: X99998.
REFERRING CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH AND COMMUNITY CARE)	This will indicate the staff group of the Care Professional referring the patient into the community service. This data item is not required where the referrer is not a care professional e.g. self-referral, carer or employer. In this circumstance this data item should be left blank (NULL).
PRIORITY TYPE CODE	This is the priority of a request for services; in the case of services to be provided by a consultant, it is as assessed by or on behalf of the consultant. Priority Type 'Urgent' should be used where the request for services is defined as clinically urgent, but it does not fall under the criteria for 'Two Week Wait'. The value ‘Two Week Wait’ is not applicable for use by community care providers.
PRIMARY REASON FOR REFERRAL (COMMUNITY CARE)	The primary presenting condition or symptom for which the patient was referred to a Community Health Service.

SERVICE DISCHARGE DATE	The date a patient was discharged from the Community Health Service. In theory you may not always have a discharge date, but you should always have a Referral Closure Date. In practice however, some systems won't populate the Referral Closure Date so only discharge dates will be produced.
DISCHARGE LETTER ISSUED DATE (MENTAL HEALTH AND COMMUNITY CARE)	Discharge Letter Issued Date (Community Care) is the date when the Discharge Letter was issued by the provider of Community Health Services to the Referrer in accordance with National Guidelines. This data item supports the requirement to provide a Discharge Letter to the referrer within 24 hours of the Discharge Date (Community Health Service).

6.3.10 CYP102 Service or Team Type Referred To

CYP102 Service or Team Type Referred To	
Description	
This table should contain details for each service type, team or teams that a patient is referred to within the Health Service. The Service or Team Type Referred To can be multidisciplinary and may contain members who are employees of the Health Care Provider or be employees of another NHS or non-NHS organisation.	
Group Level Validation and Repeating Rules	
These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
SERVICE REQUEST IDENTIFIER	The unique identifier for a SERVICE REQUEST. It would normally be automatically generated by the local system upon recording a new Referral, although could be manually assigned.
CARE PROFESSIONAL TEAM LOCAL IDENTIFIER	A unique CARE PROFESSIONAL TEAM IDENTIFIER allocated to each care team within an ORGANISATION

SERVICE OR TEAM TYPE REFERRED TO (COMMUNITY CARE)	The type of community service that the patient has been referred into. Guidance regarding what is included in each Service or Team Type Referred To can be found in **Appendix 2** of this document. For organisations with a combined '0-19 service', these can be considered as a single, multidisciplinary team and should be coded as option '45 - Integrated Multi-Disciplinary Team (jointly commissioned)'. The 'Care Professional Team Local Identifier' in the *CYP201 Care Contact* table can be used to identify the '0-19 service' locally. In addition, the specific staff type involved in treating the patient for a specific contact can be recorded in the *CYP901 Staff Details* table, and linked to the *CYP202 Care Activity* table using the 'Care Professional Local Identifier'.
REFERRAL CLOSURE DATE	The date the Referral Request to a Community Health Service was closed or the patient was discharged from the Community Health Service.
REFERRAL REJECTION DATE	The date the referral request to a Health Care Provider's Service was rejected by the Health Care Provider's Service. The overarching referral may remain open if another service or team involved in the same referral is still actively treating the patient.
REFERRAL CLOSURE REASON	The Referral Closure Reason indicates the reason that a Referral Request has been closed. A Referral Request can be closed as a result of a Patient being discharged from the Community Health Service. Cancelled referrals such as those entered onto a system in error should not be submitted within the data set.
REFERRAL REJECTION REASON	The reason that a referral request has been rejected by the service.

6.3.11 CYP103 Other Reason for Referral

CYP103 Other Reason for Referral	
Description	
This group may contain additional reasons for referral for a patient. This group should only be included for submission when other additional reasons for referral are recorded in the patient's record.	
Group Level Validation and Repeating Rules	
These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
SERVICE REQUEST IDENTIFIER	An identifier used to identify a referral uniquely within a health care provider. This is a foreign key that enables this group to be joined to the Service Referral group. As such this is a mandated item and the record will be rejected if it is not included within this group. Where multiple systems are used it is acceptable to include a prefix to the Service Request Identifier, which relates to the system. The prefix enables each identifier to remain truly unique for all submissions from an organisation.
OTHER REASON FOR REFERRAL (COMMUNITY CARE)	This is an additional presenting condition or symptom for which the patient was referred to a Community Health Service. This group is not for recording the primary presenting condition or symptom. The primary presenting condition or symptom should be recorded in the Service Referral group.

6.3.12 CYP104 Referral To Treatment

CYP104 Referral To Treatment
Description
The purpose of this section is to collect Allied Health Professionals Referral To Treatment (AHP RTT) data in order to support RTT duration measurement and national benchmarking. For the purposes of the CSDS, the data collected within this section relates to AHP RTT activity where that activity is delivered as a Community Health Service (as defined in the CSDS ISN) and the Urgent Community Response – 2hour and 2-day response standards.
AHP Waiting Time Measurements The Allied Health Professional Referral to Treatment Guide (Department of Health 2010) will support NHS-funded AHP services to measure the time that patients wait to access patient NHS-funded AHP services, which includes mental health and learning disabilities. The scope of AHP RTT data collection and measurement is not exclusive to the CSDS. Further guidance for AHP RTT services outside the scope of the CSDS is being developed. The guide is aimed at improving patients' experience of NHS AHP services, reduce the time they wait for treatment and enable the delivery of productive, innovative, quality NHS AHP services. Each CSDS submission should include any details of the RTT activity that occurred during the submission period that the submission relates to. In practice, this could include more than one submission of the CYP104 table for the same Service Request Identifier. For example, if a referral to an AHP took place and the patient was seen within the same month/submission period, two instances of the table for the same referral could be submitted – one detailing the start of the RTT period and one showing the end, both containing a different RTT Period Status (the latter would show the reason for closure). Separate instances of the AHP RTT table could also be submitted for different referrals in the same month for the same patient (they would contain a different Service Request Identifier). The CSDS only covers AHP-led RTT. Unlike consultant-led RTT, AHP-led RTT does not allow for 'pauses'. As such, we would not expect separate submissions for different RTT periods which occur as part of the same pathway, as this scenario should not occur in AHP-led RTT. For more information on AHP RTT, including example scenarios, please see link below: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215248/dh_131969.pdf

Urgent Community Response – 2hour and 2-day response standards

For CSDS v1.5 some of the data items in the CYP104 table can be used to monitor compliance with the Urgent Community Response – 2hour and 2-day response standards. Providers should refer to the 'Urgent community response – two-hour and two-day response standards: 2020/21 technical data guidance', which has been published by NHS England/Improvement:

https://www.england.nhs.uk/coronavirus/publication/urgent-community-response-two-hour-and-two-day-response-standards-2020-21-technical-data-guidance/

Group Level Validation and Repeating Rules

These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*

Additional Notes on Data Items

Data Item Name	Additional Notes
SERVICE REQUEST IDENTIFIER	An identifier used to identify a referral uniquely within a health care provider. This is a foreign key that enables this group to be joined to the Service Referral group. As such this is a mandated item and the record will be rejected if it is not included within this group. Where multiple systems are used it is acceptable to include a prefix to the Service Request Identifier, which relates to the system. The prefix enables each identifier to remain truly unique for all submissions from an organisation.
UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)	The Unique Booking Reference Number Converted (UBRN) assigned by the NHS Choose and Book system when a patient accepts an appointment date offered where the offer was made via the NHS Choose and Book system. When a patient accepts an appointment date offered, the unique booking reference number issued and used during the booking process is considered to be 'converted' i.e. An appointment has been created and recorded; and the patient has been placed on an out-patient waiting list even if subsequently the patient does not attend or cancels the appointment. Unlike the Commissioning Data Set (CDS) the UBRN can be included with the Patient Pathway Identifier in the same submission. Please note that leading zeros should not be included in the UBRN if possible. Such a value will be accepted, but the leading zeros will be stripped during processing. The output value(s) in the post-deadline extract will therefore not match the input value(s).

PATIENT PATHWAY IDENTIFIER	An identifier, which together with the organisation identifier of the issuer, uniquely identifies a patient pathway. This is a specific type of the attribute activity identifier. Where a pathway is initiated by a service request using the Choose and Book system, the patient pathway will be uniquely identified by the Unique Booking Reference Number (UBRN) of the first referral and the organisation identifier of NHS Digital which is X26. Where the pathway is initiated by some other method, the patient pathway identifier will be allocated by the organisation receiving the service request which together with that organisation's organisation identifier will uniquely identify the patient pathway. Unlike the Commissioning Data Set (CDS) the Patient Pathway Identifier can be included with the UBRN in the same submission.
ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)	This is the Organisation Identifier of the Organisation issuing the Patient Pathway Identifier. Where Choose and Book has been used, the Organisation identifier for NHS Digital (X26) should be recorded.
WAITING TIME MEASUREMENT TYPE	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 policy.
REFERRAL TO TREATMENT PERIOD START DATE	The start date of a referral to treatment period. See NHS Data Model and Dictionary for further details and guidance: http://www.datadictionary.nhs.uk/data_dictionary/attributes/r/red/referral_to_treatment_period_start_date_de.asp?shownav=1
REFERRAL TO TREATMENT PERIOD END DATE	The end date of a referral to treatment period. See NHS Data Model and Dictionary for further details and guidance: http://www.datadictionary.nhs.uk/data_dictionary/attributes/r/red/referral_to_treatment_period_end_date_de.asp?shownav=1
REFERRAL TO TREATMENT PERIOD STATUS	The status of an activity (or anticipated activity) for the Referral To Treatment period decided by the lead care professional.

6.3.13 CYP105 Onward Referral

CYP105 Onward Referral	
Description	
This data group should include details of any onward referral of the patient which has taken place. This table is to record and flow the details of the onward referral (where the patient is being referred/transferred within the services under the current organisation or to another external service/organisation). If the 'Onward Referral' was from one Health service to another (in the same or a different provider), this should appear at a later point as a new referral in the Referral table. However, a patient could be referred to a service which is outside the scope of the CSDS and the referral would therefore not appear as a new referral in the Referral table. Comparisons between the Referral and Onward Referral tables are likely be made for the purpose of data quality analysis.	
Group Level Validation and Repeating Rules	
These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
SERVICE REQUEST IDENTIFIER	The unique identifier for a SERVICE REQUEST. It would normally be automatically generated by the local system upon recording a new Referral, although could be manually assigned.
ONWARD REFERRAL DATE	This will be the date the patient was referred to another service, which may be in the same or a different organisation.
ONWARD REFERRAL REASON	The reason why the person was referred to another service, which may be in the same or a different organisation.
ORGANISATION IDENTIFIER (RECEIVING)	ORGANISATION IDENTIFIER (RECEIVING) is the ORGANISATION IDENTIFIER of the ORGANISATION that is receiving the PATIENT from another Health Care Provider.

6.3.14 CYP201 Care Contact

CYP201 Care Contact	
Description	
This data group should include details of all care contacts (appointments and telephone consultations) for a patient within the reporting period. Care contacts that were cancelled by either the provider or the patient or where the patient Did Not Attend (DNA) should also be included. This should include all face-to-face contacts with the patient, or a proxy such as a legal guardian e.g. the parent of a young child, where this is in lieu of a contact with the patient. Where the patient and relative/carer are present this should be recorded as a patient contact. Non face-to-face contacts should only be included where there is an opportunity for discussion between patient and healthcare professional. For instance, a telephone call to explain the ramifications of test results to a patient would be included, but texting (SMS) or emailing results would not. Non face-to-face telephone contacts solely to inform patients of results are excluded. Contacts about the patient but not involving the patient or their proxy should NOT be recorded as a Care Contact.	
Group Level Validation and Repeating Rules	
These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
CARE CONTACT IDENTIFIER	An identifier used to identify a care contact uniquely within a health care provider. This is the primary key that enables groups of data to be joined together. As such this is a mandated item and the record will be rejected if it is not included within this group. Where multiple systems are used it is acceptable to include a prefix to the Care Contact Identifier, which relates to the system. The prefix enables each identifier to remain truly unique for all submissions from an organisation. The Care Contact Identifier is truly a unique data item, both within the same submission file and across multiple submission files. The Care Contact Identifier is a primary key for its respective table and is based upon the Activity Identifier data attribute which is defined as “A unique number or set of characters that is applicable to only one ACTIVITY for a PATIENT within an Organisation”. This

	reiterates that these identifiers should be unique across submissions.
SERVICE REQUEST IDENTIFIER	An identifier used to identify a referral uniquely within a health care provider. This is a foreign key that enables this group to be joined to the Service Referral group. As such this is a mandated item and the record will be rejected if it is not included within this group. Where multiple systems are used it is acceptable to include a prefix to the Service Request Identifier, which relates to the system. The prefix enables each identifier to remain truly unique for all submissions from an organisation.
CARE PROFESSIONAL TEAM LOCAL IDENTIFIER	A unique CARE PROFESSIONAL TEAM IDENTIFIER allocated to each care team within an ORGANISATION
CARE CONTACT DATE	The date on which a Care Contact took place, or, if cancelled, was scheduled to take place. This should be recorded in the eGIF Date format CCYY-MM-DD.
CARE CONTACT TIME	The time at which a Care Contact took place. The time should be recorded using the 24 hour clock format in eGIF format i.e. hh:mm:ss.
ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	This is the organisation identifier of the organisation that is commissioning health care provided as part of this care contact.
ADMINISTRATIVE CATEGORY CODE	This is primarily for local use and identifies whether a contact is with an NHS patient or a non-NHS funded patient. Activity for non-NHS funded patients is not for inclusion in the CSDS and should be removed prior to submission.
CLINICAL CONTACT DURATION OF CARE CONTACT	The total duration of the direct clinical contact at care contact in minutes, excluding any administration time prior to or after the care contact and the care professional's travelling time to the care contact. Clinical contact duration of care contact includes the time spent on the different care activities that may be performed in a single care contact. The duration of each care activity is recorded in clinical contact duration of care activity.

CONSULTATION TYPE	This indicates the type of consultation for a SERVICE.
CARE CONTACT SUBJECT	The person who was the subject of the care contact.
CONSULTATION MEDIUM USED	Identifies the communication mechanism used to relay information between the care professional and the person who is the subject of the consultation, during a care activity. The telephone or telemedicine consultation should directly support diagnosis and care planning and must replace a face to face out-patient attendance consultant, clinic attendance nurse or clinic attendance midwife, types of care activity. A record of the telephone or telemedicine consultation must be retained in the patient's records. Telephone contacts solely for informing patients of results are excluded.
ACTIVITY LOCATION TYPE CODE	The type of physical location where patients are seen or where services are provided or from which requests for services are sent. For a non face-to-face contact (e.g. by telephone), this item should be left blank. If your system prevents this, the location of the clinician can be used instead.
ORGANISATION SITE IDENTIFIER (OF TREATMENT)	Organisation Site Identifier (of treatment) is the organisation identifier of the organisation site where the patient was treated. This identifies the site within the organisation at which the patient was treated, since facilities may vary on different hospital sites. The identifier recorded should always be the national code; if the treatment is sub-commissioned to another provider, the site identifier used should be that of the provider actually carrying out the work. If the site identifier is not available and only the organisation identifier is available, then this field should be left as null. If a patient is treated at home, the site identifier (of treatment) field should be left as null.
GROUP THERAPY INDICATOR	An indicator of whether a Care Activity was delivered as Group Therapy. Group Therapy is a SESSION where more than one PATIENT attends at the same time, to see one or more CARE PROFESSIONALS. Clinical notes are recorded in each individual PATIENT's casenotes.

ATTENDED OR DID NOT ATTEND CODE	This indicates whether an appointment for a care contact took place. If the appointment did not take place it also indicates if advance warning was given. When an appointment is cancelled the appointment cancelled date should also be recorded. Appointments are classed as cancelled when advance notice is given that the patient will not attend their appointment. When an appointment is re-arranged this is effectively classed as a cancelled appointment. When it is re-arranged the original appointment is cancelled and a new one is created. Dependant on who cancelled (re-arranged) the appointment, the national code 2 ('Appointment cancelled by, or on behalf of, the patient') or 4 ('Appointment cancelled or postponed by the Health Care Provider') should be used. An appointment is classified as being a DNA if the patient does not attend for the entire duration of the appointment slot, or they do attend but there is insufficient time remaining to conduct the planned activity and therefore the appointment is not usable. Please note that this data item can also be used to record the status of home visits.
EARLIEST REASONABLE OFFER DATE	It is the date of the earliest of the Reasonable Offers made to a PATIENT for an APPOINTMENT or Elective Admission. It should only be included on the Commissioning Data Sets where the PATIENT has declined at least two Reasonable Offers, and a Patient Pause is to be applied to the length of wait calculation performed by the Secondary Uses Service. Patient Cancellations Where, for any reason, a PATIENT cancels or does not attend an APPOINTMENT or an OFFER OF ADMISSION the EARLIEST REASONABLE OFFER DATE for the rearranged APPOINTMENT or OFFER OF ADMISSION will be the EARLIEST REASONABLE OFFER DATE of the cancelled APPOINTMENT or OFFER OF ADMISSION. Provider Cancellations Where, for any reason, any Health Care Provider cancels and re-arranges an APPOINTMENT or an OFFER OF ADMISSION, the EARLIEST REASONABLE OFFER DATE for the re-arranged APPOINTMENT or OFFER OF ADMISSION will be the date of the earliest Reasonable Offer made following the cancellation. Patients who are unavailable

	Where a PATIENT makes themself unavailable for a longer period of time, for example a PATIENT who is a teacher who wishes to delay their admission until the summer holidays, making a Reasonable Offer may be inappropriate. In these circumstances, so long as the Health Care Provider could have made at least two Reasonable Offers, the EARLIEST REASONABLE OFFER DATE will be the date of the earliest Reasonable Offer that the provider could have offered the PATIENT. This must be communicated to the PATIENT.
EARLIEST CLINICALLY APPROPRIATE DATE	The earliest DATE that it was clinically appropriate for an ACTIVITY to take place.
CARE CONTACT CANCELLATION DATE	The date that a Care Contact was cancelled by the Provider or Patient.
CARE CONTACT CANCELLATION REASON	The reason that a Care Contact was cancelled.
REPLACEMENT APPOINTMENT BOOKED DATE	The date that a replacement appointment was booked following the cancellation of an appointment with the patient by the provider.
REPLACEMENT APPOINTMENT DATE OFFERED	The replacement appointment date offered by the Provider to the patient following the cancellation of an appointment by the Provider.

6.3.15 CYP202 Care Activity

CYP202 Care Activity	
Description	
To carry details of any care activity undertaken at a Care Contact. One occurrence of this Group is permitted for each Care Activity. **General Table Guidance** This table should contain a record for each separate element of assessment, treatment or review that was undertaken within a Care Contact. However there is no necessity to duplicate closely linked care activity. For example: if several Coded Scored Assessment (Contact) records are submitted, they can be linked to one appropriate care activity (as a result of local decision). This table should reflect Care Activity from a patient perspective. For example, where multiple Care Professionals are involved in a single Care Activity, a single record should flow for the 'lead' Care Professional, rather than creating multiple records linked to each involved Care Professional. Where the ATTENDED OR DID NOT ATTEND CODE submitted in the Care Contact table is **[7] Patient arrived late and could not be seen; [2] Appointment cancelled by, or on behalf of the patient; [3] Did not attend, no advance warning given; or [4] Appointment cancelled or postponed by the health care provider** a Care Activity record should not be submitted. NHS Digital will not be restricting the input of Coded Procedures/Findings/Observations through validation. Providers can opt to flow any activities and related information that are naturally recorded against the Care Contact.	
Group Level Validation and Repeating Rules	
These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
CARE ACTIVITY IDENTIFIER	The unique identifier for a CARE ACTIVITY. It would normally be automatically generated by the local system upon recording a new activity, although could be manually assigned. Where multiple systems are used it is acceptable to include a prefix to the Care Activity Identifier, which relates to the system. The prefix enables each identifier to remain truly unique for all submissions from an organisation. The Care Activity Identifier is truly a unique data item, both within the same submission file and across multiple submission files. The Care Activity Identifier is a primary key for the CYP202 table and is based upon the Contact

	Identifier data attribute which is defined as “A unique number or set of characters that is applicable to only one Contact for a PATIENT within an Organisation”. This reiterates that these identifiers should be unique across submissions.
CARE CONTACT IDENTIFIER	An identifier used to identify a care contact uniquely within a health care provider. This is a foreign key that enables this group to be joined to the Care Contact group. As such this is a mandated item and the record will be rejected if it is not included within this group. These identifiers will typically be auto generated by the system in use, so will prevent duplicates when using the same system. Where multiple systems are used it is acceptable to include a prefix to the Care Contact Identifier, which relates to the system. The prefix enables each identifier to remain truly unique for all submissions from an organisation. The Care Contact Identifier is truly a unique data item, both within the same submission file and across multiple submission files. The Care Contact Identifier is a primary key for its respective table and is based upon the Activity Identifier data attribute which is defined as “A unique number or set of characters that is applicable to only one ACTIVITY for a PATIENT within an Organisation”. This reiterates that these identifiers should be unique across submissions.
COMMUNITY CARE ACTIVITY TYPE CODE	This indicates the type of Care Contact for Community Health Services. The values are as follows: 01 Administering Tests – for example, taking blood 02 Assessment – for example, a breast feeding assessment 03 Clinical Intervention – for example, dressing a wound 04 Counselling, Advice, Support – for example, advice on how to use a blood pressure monitor 05 Patient Specific Health Promotion – for example, a weight loss programme 06 Multidisciplinary Team Review 07 Supporting Another Clinician 08 Health Visitor New Birth Visit 09 Health Visitor Health Review (6-8 weeks) 10 Health Visitor Health Review (1 year) 11 Health Visitor Health Review (2-2.5 years)

	12 Health Visitor Formal handover to School Nursing Service (4-5 years) 97 Other
CARE PROFESSIONAL LOCAL IDENTIFIER	A number or set of characters which uniquely identifies a CARE PROFESSIONAL within a healthcare provider and may be assigned automatically by the computer. Where multiple Care Professionals are involved in a single Care Activity, a 'lead' Care Professional should be allocated to the Care Activity. There is no requirement to duplicate records for a single Care Activity for each involved Care Professional.
CLINICAL CONTACT DURATION OF CARE ACTIVITY	The duration of a CARE ACTIVITY in minutes, excluding any administration time prior to or after the CARE ACTIVITY and the CARE PROFESSIONAL's travelling time to the LOCATION where the CARE ACTIVITY was provided. This is calculated from the Start Time and End Time of the CARE ACTIVITY. The total summed duration of Care Activities linked to a Care Contact should not exceed the Clinical Contact Duration of the Care Contact. I.e. Duration should be reported from a patient perspective and not duplicated for reporting purposes, such as against multiple Care Professionals involved in a single Care Activity.
PROCEDURE SCHEME IN USE	The code scheme basis of a procedure.
CODED PROCEDURE (CLINICAL TERMINOLOGY)	A unique identifier for a procedure from a specific clinical terminology.
FINDING SCHEME IN USE	The code scheme basis of a procedure.
CODED FINDING (CODED CLINICAL ENTRY)	A unique identifier for a finding from a specific classification or clinical terminology. Please note that breastfeeding information can flow within this data item using the following recommended clinical terms.

Preferred Term (Main)	Preferred Term (Sub)	SNOMED CT Code	Read Code
Breast fed (finding)		169741004	62P1.
	Bottle changed to breast (finding)	169751003	62PB.
	Breastfeeding at discharge from hospital	364991000000100	XaPO0
	Breastfeeding started	169745008	62P5.
	Demand fed (finding)	230127002	Ub1ve
	Breast fed at 1 year (finding)	169999006	6462.
Breastfeeding with supplement		169743001	62P3.
	Breastfeeding and supplementary bottle feeding at discharge from hospital	365091000000100	XaPO8
	Breast and supplement fed at 1 year (finding)	170001007	6463.
Infant bottle fed (finding)		268472006	XE1SF
	Bottle feeding at discharge from hospital	365171000000100	XaPOG
	Bottle feeding started (finding)	169747000	62P7.
	Breast changed to bottle feed (finding)	169744007	62P4.
	Bottle fed at 1 year (finding)	169998003	6461.

OBSERVATION SCHEME IN USE	The code scheme basis of an observation.
CODED OBSERVATION (CLINICAL TERMINOLOGY)	A unique identifier for an observation from a specific clinical terminology.
OBSERVATION VALUE	The numeric value resulting from a clinical OBSERVATION. The value entered must be accurate and not an approximation. If there isn't sufficient evidence to arrive at an accurate value please refrain from entering a value that can be misinterpreted or is imprecise.
UCUM UNIT OF MEASUREMENT	The unit of measurement used to measure the result of a clinical OBSERVATION. See http://unitsofmeasure.org/trac/.

6.3.16 CYP301 Group Session

CYP301 Group Session	
Description	
A Group Session is a session held by at least one member of a health promotion staff group as part of a programme to improve the general awareness of a group of people about particular functions, conditions or aspects of behaviour affecting the health of the community. Only Group Sessions that cannot be directly linked to each of the patients attending the Group Session should be included i.e. this table excludes Group Therapy which should be reported as a Care Contact. Please note that this data group does not link to any other data group either through the local patient identifier or referral. This data group is required to fully reflect the activity undertaken by community providers.	
Group Level Validation and Repeating Rules	
These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
GROUP SESSION IDENTIFIER	The Group Session Identifier is used to uniquely identify the group session within the Health Care Provider. It would normally be automatically generated by the local system upon recording a new Group Session, although could be manually assigned. This may be the same as the Community Care Contact Identifier depending upon the local system.
GROUP SESSION DATE	The date that a Group Session took place, or, if cancelled, was scheduled to take place. Where a Group Session spans multiple days the Start Date should be reported here. This should be reported in eGIF date format CCYY-MM-DD.
ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	This is the organisation identifier of the organisation that is commissioning health care provided as part of this group session.
CLINICAL CONTACT DURATION OF GROUP SESSION	The duration of a Group Session in minutes, excluding any administration time prior to or after the Group Session and the care professional's travelling time to the location where the Group Session was provided.

GROUP SESSION TYPE CODE (COMMUNITY CARE)	The type of Group Session provided by a Community Health Service. A Group Session would include any health promotion programme where there are a number of participants participating in an initiative designed to help individuals improve their health, reduce health risks and promote healthy behaviours. Health promotion programmes can target a range of different health concerns and areas, such as physical activity, stress, smoking, and nutrition. The NHS number of the participants in a group session would normally not be recorded.
NUMBER OF GROUP SESSION PARTICIPANTS	The number of persons who participated in the Group Session excluding the care professionals.
ACTIVITY LOCATION TYPE CODE	The type of physical location where patients are seen or where services are provided or from which requests for services are sent.
ORGANISATION SITE IDENTIFIER (OF TREATMENT)	Organisation Site Identifier (Of Treatment) is the Organisation Identifier of the Organisation Site where the patient was treated. This identifies the site within the organisation on which the patient was treated, since facilities may vary on different hospital sites. The code recorded should always be the national code; if the treatment is sub-commissioned to another provider, the site code used should be that of the provider actually carrying out the work. If the Site Identifier is not available and only the Organisation Identifier is available, then this field should be left as null.
CARE PROFESSIONAL LOCAL IDENTIFIER	A unique CARE PROFESSIONAL LOCAL IDENTIFIER allocated to each care team within an ORGANISATION.
NHS SERVICE AGREEMENT LINE NUMBER	This may be used to identify a specific NHS Service Agreement reference. This is primarily for local use and enables Health Care Providers to associate specific referrals or referral types with unique service lines agreed with their Commissioners.

6.3.17 CYP401 Special Educational Need Identified

CYP401 Special Educational Need Identified	
Description	
To carry details of the child or young person's Special Educational Need. This group will be collected and submitted by a health organisation involved in a person's education assessment. This table is only applicable to children and young people in CSDS v1.0. This table is therefore rejected for patients aged 19 or over (or if no date of birth is supplied).	
Group Level Validation and Repeating Rules	
These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
LOCAL PATIENT IDENTIFIER (EXTENDED)	An identifier used to identify a patient uniquely within a health care provider. This is the primary key that enables groups of data to be joined together. As such this is a mandated item and the record will be rejected if it is not included within this group. Duplicate Local Patient Identifiers within the Patient group will cause the entire file to be rejected. Providers should ensure that Local Patient Identifiers are not duplicated across multiple submission files for different patients.
SPECIAL EDUCATIONAL NEED TYPE	The type of special educational need(s) cited by the Local Education Authority. Where data providers capture the information in a different format or at a lower level, then they should be mapped to an appropriate value stated in the national code list.

6.3.18 CYP402 Safeguarding Vulnerability Factor

CYP402 Safeguarding Vulnerability Factor	
Description	
To record details when the child is subject to any safeguarding concerns. For children with a number of Safeguarding Vulnerability Factors, the group is repeated for each factor. Where data providers capture the information in a different format or at a lower level, then they should be mapped to an appropriate value stated in the national code list. This table is only applicable to children and young people in CSDS v1.0. This table is therefore rejected for patients aged 19 or over (or if no date of birth is supplied).	
Group Level Validation and Repeating Rules	
These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
LOCAL PATIENT IDENTIFIER (EXTENDED)	An identifier used to identify a patient uniquely within a health care provider. This is the primary key that enables groups of data to be joined together. As such this is a mandated item and the record will be rejected if it is not included within this group. Duplicate Local Patient Identifiers within the Patient group will cause the entire file to be rejected. Providers should ensure that Local Patient Identifiers are not duplicated across multiple submission files for different patients.
SAFEGUARDING VULNERABILITY FACTORS TYPE	The type of Child Safeguarding vulnerability factors identified.

6.3.19 CYP403 Child Protection Plan

CYP403 Child Protection Plan	
Description	
This group identifies whether or not the child/young person is subject to an active child protection plan. The Child Protection Plan is a multi-agency plan formulated by children's social care to ensure that children who are at continuing risk of harm are protected. Its aim is to facilitate and make explicit a co-ordinated approach to the protection from further harm of each child. If a provider is made aware that a child's Child Protection Status has been updated in a given month, this information should still be recorded and flowed even if the provider has not seen the child during that month. This table is only applicable to children and young people. This table is therefore rejected for patients aged 19 or over (or if no date of birth is supplied).	
Group Level Validation and Repeating Rules	
These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
LOCAL PATIENT IDENTIFIER (EXTENDED)	An identifier used to identify a patient uniquely within a health care provider. This is the primary key that enables groups of data to be joined together. As such this is a mandated item and the record will be rejected if it is not included within this group. Duplicate Local Patient Identifiers within the Patient group will cause the entire file to be rejected. Providers should ensure that Local Patient Identifiers are not duplicated across multiple submission files for different patients.
CHILD PROTECTION PLAN REASON CODE	The reason the child or young person is subject to an active Child Protection Plan. If a provider is made aware that the CHILD PROTECTION PLAN REASON CODE has been updated in a given month, this information should still be recorded and flowed even if the provider has not seen the child during that month.
CHILD PROTECTION PLAN START DATE	The date on which a child or young person is placed on a Child Protection Plan.

CHILD PROTECTION PLAN END DATE	The date on which a child or young person is removed from a Child Protection Plan.

6.3.20 CYP404 Assistive Technology To Support Disability Type

CYP404 Assistive Technology To Support Disability Type	
Description	
To carry the details of when assistive technology is used to support a disabled patient. A patient may have multiple disabilities, or they may have none. This has a direct impact on the assistive technology to support the disability type. A list of recommended SNOMED CT codes can be found in guidance produced by the British Academy of Childhood Disabilities (BACD) – see item description below. One occurrence of this group is permitted for each assistive technology type.	
Group Level Validation and Repeating Rules	
These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
LOCAL PATIENT IDENTIFIER (EXTENDED)	An identifier used to identify a patient uniquely within a health care provider. This is the primary key that enables groups of data to be joined together. As such this is a mandated item and the record will be rejected if it is not included within this group. Duplicate Local Patient Identifiers within the Patient group will cause the entire file to be rejected. Providers should ensure that Local Patient Identifiers are not duplicated across multiple submission files for different patients.

ASSISTIVE TECHNOLOGY FINDING (SNOMED CT)	The SNOMED CT concept ID which is used to identify the finding relating to the Assistive Technology that a PERSON is dependent on. A list of recommended SNOMED CT codes for this item can be found in guidance produced by the British Academy of Childhood Disabilities (BACD). This guidance is designed to support data collection by Paediatricians at the point of clinical care – see page 83 of their Explanatory Glossary of Terms for the list of assistive technology types: https://www.bacdis.org.uk/resources/6-community-services-data-set
PRESCRIPTION DATE (ASSISTIVE TECHNOLOGY)	The date when a person is prescribed a specific type of assistive technology.

6.3.21 CYP501 Coded Immunisation

CYP501 Coded Immunisation	
Description	
This group contains the details of any immunisation activity attended by or undertaken on behalf of a child or young person. Providers are expected to include childhood vaccinations in this table, where they hold this information as clinical terms. Providers are also able to flow adult immunisation data in this table where applicable, although this is not a mandated requirement.	
Group Level Validation and Repeating Rules	
These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
LOCAL PATIENT IDENTIFIER (EXTENDED)	An identifier used to identify a patient uniquely within a health care provider. This is the primary key that enables groups of data to be joined together. As such this is a mandated item and the record will be rejected if it is not included within this group. Duplicate Local Patient Identifiers within the Patient group will cause the entire file to be rejected. Providers should ensure that Local Patient Identifiers are not duplicated across multiple submission files for different patients.

IMMUNISATION DATE	The date on which the immunisation was carried out. This item is mandatory and therefore must be provided along with any other information from this group in order to identify separate immunisations/boosters (see *PCV – Pneumococcal* example above).
PROCEDURE SCHEME IN USE	The code scheme basis of a procedure.
IMMUNISATION PROCEDURE (CLINICAL TERMINOLOGY)	A unique identifier for an immunisation from a specific clinical terminology
ORGANISATION IDENTIFIER (IMMUNISATION RESPONSIBLE ORGANISATION)	The Organisation Identifier of the organisation carrying out the immunisation.

6.3.22 CYP502 Immunisation

CYP502 Immunisation

Description

This group contains the details of any immunisation activity attended by or undertaken on behalf of a child or young person. This includes activity carried out in other care settings, such as GP practices, that the Community provider is made aware of.

Immunisation activity will be recorded in line with the latest version of the Immunisation Against Infectious Disease schedule ("the green book").

Where combination vaccines are administered, each disease vaccinated against should be listed separately in the CHILDHOOD IMMUNISATION TYPE (CHILDREN AND YOUNG PEOPLE'S HEALTH SERVICES) field.

Age Due	Immunisation
8 weeks	**DTaP/IPV/Hib, PCV and Rotavirus** (Diptheria, Tetanus, acellular Pertussis (whooping cough), Inactivated Polio Vaccine, Haemophilus influenzae b (Hib),Pneumococcal Conjugate Vaccine and Rotavirus)
12 weeks	**DTaP/IPV/Hib,Men C and Rotavirus** (Diptheria, Tetanus, acellular Pertussis (whooping cough), Inactivated Polio Vaccine, Haemophilus influenzae b (Hib) , Meningococcal C and Rotavirus)
16 weeks	**DTaP/IPV/Hib, , PCV** (Diptheria, Tetanus, acellular Pertussis (whooping cough), Inactivated Polio Vaccine, Haemophilus influenzae b (Hib) and Pneumococcal Conjugate Vaccine)
12 months	**Hib/Men C (**Haemophilus influenzae b (Hib) and Meningococcal C)
13 months	**MMR (1st) and PCV** (Measels, Mumps, Rubella and Pneumococcal Conjugate Vaccine)
3 years 4 months	**DTaP/IPV or dTaP/IPV** (Diphtheria or low dose diphtheria, Tetanus, acellular Pertussis, Inactivated Polio Cavvine pre-school booster)
3 years 4 months	**MMR (2nd)** (Measles, Mumps and Rubella)
12–13 years (girls)	**HPV** (Human Papilloma Vaccine) (3 doses over 6 months)
13-18 years	**Td/IPV** (low dose diphtheria, Tetanus, Inactivated Polio Vaccine booster)

This table is only applicable to children and young people in CSDS v1.5. This table is therefore rejected for patients aged 19 or over (or if no date of birth is supplied).

Group Level Validation and Repeating Rules

These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*

Additional Notes on Data Items	
Data Item Name	**Additional Notes**
LOCAL PATIENT IDENTIFIER (EXTENDED)	An identifier used to identify a patient uniquely within a health care provider. This is the primary key that enables groups of data to be joined together. As such this is a mandated item and the record will be rejected if it is not included within this group. Duplicate Local Patient Identifiers within the Patient group will cause the entire file to be rejected. Providers should ensure that Local Patient Identifiers are not duplicated across multiple submission files for different patients.
IMMUNISATION DATE	The date on which the immunisation was carried out. This item is mandatory and therefore must be provided along with any other information from this group in order to identify separate immunisations/boosters (see *PCV – Pneumococcal* example above).
CHILDHOOD IMMUNISATION TYPE (CHILDREN AND YOUNG PEOPLE'S HEALTH SERVICES)	Whether or not a child's immunisations are up to date, derived from Red Book 2009. The childhood immunisation type value set lists each type of immunisation and booster immunisation separately. Therefore, for example, in the case of [09] *PCV – Pneumococcal*, this should be submitted on 3 occasions to take account of the 8 week, 16 week and 13 month immunisations.
ORGANISATION IDENTIFIER (IMMUNISATION RESPONSIBLE ORGANISATION)	The Organisation Identifier of the organisation carrying out the immunisation.

6.3.23 CYP601 Medical History (Previous Diagnosis)

CYP601 Medical History (Previous Diagnosis)	
Description	
This data group should include 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 necessarily have to have been diagnosed by the organisation submitting the data. Please note that information related to childhood disabilities should be included in this table where applicable. The BACD has produced an Explanatory Glossary of Paediatric Disability Terms to support data collection by paediatricians at the point of clinical care. This guidance document includes a list of SNOMED CT codes that can be submitted within this table, and is available from https://www.bacdis.org.uk/resources/6-community-services-data-set	
Group Level Validation and Repeating Rules	
These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
LOCAL PATIENT IDENTIFIER (EXTENDED)	An identifier used to identify a patient uniquely within a health care provider. This is the primary key that enables groups of data to be joined together. As such this is a mandated item and the record will be rejected if it is not included within this group. Duplicate Local Patient Identifiers within the Patient group will cause the entire file to be rejected. Providers should ensure that Local Patient Identifiers are not duplicated across multiple submission files for different patients.
DIAGNOSIS SCHEME IN USE	The code scheme basis of the diagnosis.
PREVIOUS DIAGNOSIS (CODED CLINICAL ENTRY)	A unique identifier for a CLINICAL DIAGNOSIS from a specific clinical terminology. This should also include childhood disabilities, including codes taken from the BACD's: https://www.bacdis.org.uk/resources/6-community-services-data-set
DIAGNOSIS DATE	DIAGNOSIS DATE is the PERSON PROPERTY OBSERVED DATE for the PATIENT DIAGNOSIS.

6.3.24 CYP602 Disability Type

CYP602 Disability Type	
Description	
To carry the details of the type of disability affecting a person, based on their perception or the perception of a patient proxy. This table holds details of patient disability. A patient may have multiple disabilities, or they may have none. Co-morbid physical or mental health disability should be collected early in the care pathway, some even prior to initial assessment where this data is available from the referrer. Any disabilities which are present should be recorded within this table.	
Group Level Validation and Repeating Rules	
These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
LOCAL PATIENT IDENTIFIER (EXTENDED)	An identifier used to identify a patient uniquely within a health care provider. This is the primary key that enables groups of data to be joined together. As such this is a mandated item and the record will be rejected if it is not included within this group. Duplicate Local Patient Identifiers within the Patient group will cause the entire file to be rejected. Providers should ensure that Local Patient Identifiers are not duplicated across multiple submission files for different patients.
DISABILITY CODE	An indication of whether a PERSON is disabled. Under the Disability Discrimination Act (DDA), a disabled PERSON is defined as "someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities". See the Government website: https://www.gov.uk/definition-of-disability-under-equality-act-2010
DISABILITY IMPACT PERCEPTION	The patient's perception of whether their 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.

6.3.25 CYP603 Newborn Hearing Screening Audiology Referral

CYP603 Newborn Hearing Screening Audiology Referral	
Description	
The purpose of this group is to monitor the outcomes for those babies referred from Newborn Hearing Screening, which is a clinical investigation recommended to be undertaken on all newborn babies. The data items in this group capture the original outcome of the newborn hearing screening, and additionally any follow-up outcome resulting from an audiology test. Details of the screening appointment are captured by the maternity system. For further information on Newborn Hearing Screening, see the NHS Newborn Hearing Screening Programme website: http://hearing.screening.nhs.uk/ This table is only applicable to babies under 1 year old. This table is therefore rejected for patients aged 1 or over (or if no date of birth is supplied).	
Group Level Validation and Repeating Rules	
These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
LOCAL PATIENT IDENTIFIER (EXTENDED)	An identifier used to identify a patient uniquely within a health care provider. This is the primary key that enables groups of data to be joined together. As such this is a mandated item and the record will be rejected if it is not included within this group. Duplicate Local Patient Identifiers within the Patient group will cause the entire file to be rejected. Providers should ensure that Local Patient Identifiers are not duplicated across multiple submission files for different patients.
NEWBORN HEARING SCREENING OUTCOME	The result of a Newborn Hearing Screening Test.
SERVICE REQUEST DATE (NEWBORN HEARING AUDIOLOGY)	The date on which a referral for audiology testing was made.

PROCEDURE DATE (NEWBORN HEARING AUDIOLOGY)	The date that a NEWBORN HEARING AUDIOLOGY TEST took place.
NEWBORN HEARING AUDIOLOGY OUTCOME	The result of a Newborn Hearing Audiology Test. A referral for Newborn Audiology testing is made if the child fails the Newborn Hearing Screening Test.

6.3.26 CYP604 Blood Spot Result

CYP604 Blood Spot Result	
Description	
This table captures data items on the results of blood spot screening for the nine conditions tested based on the newborn blood spot card. The tests themselves flow as part of the Maternity Services Data Set. Where samples are retaken on new blood spot cards, irrespective of reason, and data providers record both results, then two groups can be submitted, with completion date reflecting the two different days the sample was taken. Where data providers do not record all the "intermediate" results (or where the two samples were taken on the same day), then one group may be submitted with the final result recorded in the RESULT STATUS. The national standards on blood spot screening are developed by UK National Screening Committee (UK NSC) and are available from the following link: http://newbornbloodspot.screening.nhs.uk/standards This table is only applicable to babies under 1 year old. This table is therefore rejected for patients aged 1 or over (or if no date of birth is supplied).	
Group Level Validation and Repeating Rules	
These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
LOCAL PATIENT IDENTIFIER (EXTENDED)	An identifier used to identify a patient uniquely within a health care provider. This is the primary key that enables groups of data to be joined together. As such this is a mandated item and the record will be rejected if it is not included within this group. Duplicate Local Patient Identifiers within the Patient group will cause the entire file to be rejected.

	Providers should ensure that Local Patient Identifiers are not duplicated across multiple submission files for different patients.
BLOOD SPOT CARD COMPLETION DATE	The blood sample collection date for a Newborn Blood Spot Test for a neonate.
NEWBORN BLOOD SPOT TEST RESULT RECEIVED DATE	The date that a BLOOD SPOT TEST RESULT was received.

NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (PHENYLKETONURIA)

NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (SICKLE CELL DISEASE)

NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (CYSTIC FIBROSIS)

NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (CONGENITAL HYPOTHYROIDISM)

NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (MEDIUM CHAIN ACYL-COA DEHYDROGENASE DEFICIENCY)

NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (HOMOCYSTINURIA)

NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (MAPLE SYRUP URINE DISEASE)

Where data providers capture the information in a different format or at a lower level, then they should be mapped to an appropriate value stated in the national code list:

01	Specimen received in Laboratory
02	Screening declined
03	Further sample required
04	Condition not suspected
05	Carrier
06	Sickle Cell Disease not suspected, carrier of other haemoglobin
07	Condition not suspected, other disorders follow up
08	Condition suspected
09	Not screened/screening incomplete
10	Sickle Cell Disease not suspected (by DNA) No other haemoglobin/thalassemia excluded

Please note that value ‘02 Screening declined’ relates to the wishes of the parents/legal guardians of the child rather than a statement by the testing laboratory. The value ‘declined’ is recorded on the Blood Spot Screening Card so that the lab are made aware. This applies to each screening test individually.

Value ‘05 Carrier’ applies to Sickle Cell, Cystic Fibrosis and Medium Chain Acyl-Coa Dehydrogenase Deficiency screening tests only.

Value ‘06 Sickle Cell Disease not suspected, carrier of other haemoglobin’ applies to Sickle Cell Disease screening test only.

NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (GLUTARIC ACIDURIA TYPE 1) **NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE (ISOVALERIC ACIDURIA)**	Value '09 Not screened/screening incomplete' could be used for the following reasons (this list is not exhaustive): • Patient died • Unreliable result • Patient moved out of area • Patient not contactable, reasonable efforts made • Patient too old for screening Value '10 Sickle Cell Disease not suspected (by DNA) No other haemoglobin/thalassemia excluded' applies to Sickle Cell Disease screening test only.

6.3.27 CYP605 Infant Physical Examination (GP Delivered)

CYP605 Infant Physical Examination (GP Delivered)	
Description	
This group captures data on the infant physical screening activity, as performed by GPs at 6 to 8 weeks, to find those babies who may have a problem with their eyes, heart, hips and, in boys, testicles. Data on the outcome of the corresponding 72 hours physical examination will be captured by the Maternity Services Data Set. This table is only intended to be submitted for babies who have the 6 to 8 weeks check. The table is therefore rejected for patients where no date of birth is supplied, and at an item level for babies over 99 days old (see 'Infant Physical Examination Date' below).	
Group Level Validation and Repeating Rules	
These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
LOCAL PATIENT IDENTIFIER (EXTENDED)	An identifier used to identify a patient uniquely within a health care provider. This is the primary key that enables groups of data to be joined together. As such this is a mandated item and the record will be rejected if it is not included within this group. Duplicate Local Patient Identifiers within the Patient group will cause the entire file to be rejected. Providers should ensure that Local Patient Identifiers are not duplicated across multiple submission files for different patients.

INFANT PHYSICAL EXAMINATION DATE	The date the physical examination of the infant took place. The record is rejected where the examination happens more than 99 days after the infant is born.
INFANT PHYSICAL EXAMINATION RESULT (HIPS)	Whether or not a problem was detected or suspected with the hips.
INFANT PHYSICAL EXAMINATION RESULT (HEART)	Whether or not a problem was detected or suspected with the heart.
INFANT PHYSICAL EXAMINATION RESULT (EYES)	Whether or not a problem was detected or suspected with the eyes.

<table>
<tr>
<td>INFANT PHYSICAL EXAMINATION RESULT (TESTES)</td>
<td>
Whether or not a problem was detected or suspected with the testes.

Where data providers capture the information in a different format or at a lower level, then they should be mapped to an appropriate value stated in the national code list.

Testes examination for girls

For girls, data providers must submit [NN] Not Examined.

Alignment to ‘My personal child health record’

These four data items are also captured in the ‘My personal child health record’, albeit in additional granularity.

The community expert reference group ruled that the SPOTRN coding scheme was not appropriate as it combines findings (problems, observations) with actions (treatment, refer). In addition, the values are not mutually exclusive; an examination outcome could be classed as both Problem and Refer. As a consequence, the CSDS is adopting a simplified value list:

For data providers who currently record results using SPOTRN coding, the following mapping must be followed:
<table>
<tr><th>SPOTRN Value</th><th>CSDS/MSDS national code list</th></tr>
<tr><td>Satisfactory</td><td>[01] Satisfactory</td></tr>
<tr><td>Problem</td><td>[02] Problem Identified</td></tr>
<tr><td>Observation</td><td>[03] Problem Suspected</td></tr>
<tr><td>Treatment</td><td>[02] Problem Identified</td></tr>
<tr><td>Refer</td><td>[03] Problem Suspected</td></tr>
<tr><td>Not Examined</td><td>[NN] Not Examined</td></tr>
</table>
</td>
</tr>
</table>

6.3.28 CYP606 Provisional Diagnosis

CYP606 Provisional Diagnosis	
Description	
This data group should include details of a provisional diagnosis recorded for a child or young person made by the service that the patient was referred to.	
Group Level Validation and Repeating Rules	
These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
SERVICE REQUEST IDENTIFIER	The unique identifier for a SERVICE REQUEST. It would normally be automatically generated by the local system upon recording a new referral, although could be manually assigned.
DIAGNOSIS SCHEME IN USE	The code scheme basis of a diagnosis.
PROVISIONAL DIAGNOSIS (CODED CLINICAL ENTRY)	This is the provisional DIAGNOSIS of the person for the main condition treated or investigated during the relevant episode of healthcare.
PROVISIONAL DIAGNOSIS DATE	The date of diagnosis.

6.3.29 CYP607 Primary Diagnosis

CYP607 Primary Diagnosis	
Description	
This table should contain a record for each primary diagnosis recorded for a person made by the service that the patient was referred to. The primary diagnosis is the main condition treated or investigated in an episode of care. Where there is no definitive diagnosis the main symptom, abnormal finding or problem should be recorded.	
Group Level Validation and Repeating Rules	
These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
SERVICE REQUEST IDENTIFIER	The unique identifier for a SERVICE REQUEST. It would normally be automatically generated by the local system upon recording a new Referral, although could be manually assigned.
DIAGNOSIS SCHEME IN USE	The code scheme basis of a diagnosis.
PRIMARY DIAGNOSIS (CODED CLINICAL ENTRY)	This is the primary diagnosis of the patient for the main condition treated or investigated during the relevant episode of healthcare, and where there is no definitive diagnosis, the main symptom, abnormal findings or problem.
DIAGNOSIS DATE	The date of the primary diagnosis.

6.3.30 CYP608 Secondary Diagnosis

CYP608 Secondary Diagnosis	
Description	
This table should contain a record for each secondary diagnosis recorded for a person. This should include any secondary diagnosis of conditions treated or investigated in an episode of care which are NOT a primary diagnosis i.e. not the main condition treated or investigated. Where there is no definitive diagnosis this may include any symptoms, abnormal findings or problems where these are not the main symptoms.	
Group Level Validation and Repeating Rules	
These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
SERVICE REQUEST IDENTIFIER	The unique identifier for a SERVICE REQUEST. It would normally be automatically generated by the local system upon recording a new referral, although could be manually assigned.
DIAGNOSIS SCHEME IN USE	The code scheme basis of a diagnosis.
SECONDARY DIAGNOSIS (CODED CLINICAL ENTRY)	This is any other diagnosis other than the primary diagnosis. Multiple Secondary Diagnoses may be recorded.
DIAGNOSIS DATE	The date of the secondary diagnosis.

6.3.31 CYP609 Coded Scored Assessment (Referral)

CYP609 Coded Scored Assessment (Referral)	
Description	
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 e.g. assessment completed at home and returned. Coded assessments such as the Ages and Stages Questionnaire (ASQ) must be submitted as a Coded Assessment Tool Type (SNOMED CT) as part of this table. The reference table in the Assessment Tools tab in the Technical Output Specification (TOS) outlines the equivalent SNOMED CT codes for each measure. Only those measures that appear in the list can be submitted as part of the CSDS. Any code that is not in the list will be rejected at the Submission Portal. It should also be noted that Coded Scored Assessments must not be submitted within the CYP202 Care Activity table. Please see Appendix 1 for an explanation on licensing agreements. Please see the section covering the CYP612 Coded Scored Assessment (Contact) table for examples of how the data may look when submitted.	
Group Level Validation and Repeating Rules	
These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
SERVICE REQUEST IDENTIFIER	The unique identifier for a SERVICE REQUEST. It would normally be automatically generated by the local system upon recording a new Referral, although could be manually assigned.
CODED ASSESSMENT TOOL TYPE (SNOMED CT)	A unique identifier for an ASSESSMENT in SNOMED CT.
PERSON SCORE	The numeric value (score) resulting from an ASSESSMENT.
ASSESSMENT TOOL COMPLETION DATE	The date on which an assessment took place.

6.3.32 CYP610 Breastfeeding Status

CYP610 Breastfeeding Status	
Description	
Breastfeeding data is captured to monitor breast feeding rates. The introduction of any non-breast milk feed, even if this was only one feed for a baby who otherwise only has breast milk, excludes them from the 'Exclusive breastfeeding' category. It is expected that breast feeding status will be captured as part of the routine child review programme. Breastfeeding status should be captured at a number of points during the child's first year, these include: • at discharge • as part of the primary course of immunisation (8, 12, 16 weeks) • as part of the new baby review (normally between 10 and 14 days) plus the 6-8 week review Breastfeeding status will normally be captured by a member of health visiting team; normally a public health nurse or health visitor. **Please note:** breastfeeding data can alternatively be flowed in the CYP202 table using clinical terminology in the CODED FINDING (CODED CLINICAL ENTRY) data item. This data does not need to be submitted in both tables. This table is only applicable to children and young people in CSDS v1.0, in particular at the key points described above. This table is rejected for patients aged 19 or over (or if no date of birth is supplied).	
Group Level Validation and Repeating Rules	
These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
CARE ACTIVITY IDENTIFIER	The unique identifier for a CARE ACTIVITY. It would normally be automatically generated by the local system upon recording a new activity, although could be manually assigned.
BREASTFEEDING STATUS	This is the type of feed a baby is receiving **[01]** ***Exclusively Breast Milk Feeding*** The child is receiving only breast milk from his/her mother, or expressed breast milk, and no other liquids or solids.

	The introduction of any non-breast milk feed, even if this was only one feed for a baby who otherwise only has breast milk, excludes them from the Exclusively Breast Milk Feeding category. **[02] *Partially Breast Milk Feeding*** The child is receiving some breast milk by any method, but is also being given other food or food-based fluids, such as formula milk or weaning foods. **[03] *No Breast Milk Feeding at all*** The child receives no breast milk at all. Where data providers capture the information in a different format or at a lower level, then they should be mapped to an appropriate value stated in the national code list.

6.3.33 CYP611 Observation

CYP611 Observation	
Description	
This segment captures information to derive the person's Body Mass Index (BMI). BMI is generally calculated by dividing weight by height squared. BMI categories are a tool for measuring whether individuals are underweight, overweight or obese. The data is used to produce BMI trend analysis. For children, it is expected that these values will be repeated and trended in the child health record as part of the developmental checks undertaken throughout the childhood years.	
Group Level Validation and Repeating Rules	
These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification*.	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
CARE ACTIVITY IDENTIFIER	The unique identifier for a CARE ACTIVITY. It would normally be automatically generated by the local system upon recording a new activity, although could be manually assigned.
PERSON WEIGHT	The weight of the person in kilograms. The measurement must be submitted as a decimal to at least 1 decimal place and at most 3 decimal places.

PERSON HEIGHT IN METRES	The height of the person in metres where the person is able to stand. The measurement must be submitted as a decimal to at least 1 decimal place and at most 2 decimal places. Please note that this item and 'Person Length in Centimetres' should not be submitted together.
PERSON LENGTH IN CENTIMETRES	A value used to measure a person when they are unable to stand – their length (as opposed to height) is therefore measured. This item is designed to be used when measuring babies. The measurement must be submitted as a decimal to 1 decimal place. Please note that this item and 'Person Height in Metres' should not be submitted together.

6.3.34 CYP612 Coded Scored Assessment (Contact)

CYP612 Coded Scored Assessment (Contact)
Description
Coded Scored Assessment: To carry details of scored assessments that are issued and completed as part of a specific contact. Coded assessments such as the Ages and Stages Questionnaire (ASQ) must be submitted as a Coded Assessment Tool Type (SNOMED CT) as part of this table. The reference table in the Assessment Tools tab in the Technical Output Specification (TOS) outlines the equivalent SNOMED CT codes for each measure. Only those measures that appear in the list can be submitted as part of the CSDS. Any code that is not in the list will be rejected at the Submission Portal. It should also be noted that Coded Scored Assessments must not be submitted within the CYP202 Care Activity table. An example of how a SNOMED CT assessment may look when submitted is shown below. There is a separate SNOMED CT code for each dimension (section) of the ASQ-3 questionnaire. Providers will therefore need to separately submit the SNOMED code for each dimension, along with the corresponding score (between 0 and 60) for each. The table below shows some of the SNOMED codes for the different dimensions that make up the 27 month questionnaire:

SNOMED CT Description	SNOMED CT Code
ASQ-3 (Ages and Stages Questionnaires Third Edition) 27 month questionnaire - problem solving score	953291000000109
ASQ-3 (Ages and Stages Questionnaires Third Edition) 27 month questionnaire - personal-social score	953301000000108
ASQ-3 (Ages and Stages Questionnaires Third Edition) 27 month questionnaire - communication score	953261000000103
ASQ-3 (Ages and Stages Questionnaires Third Edition) 27 month questionnaire - fine motor score	953271000000105

The following table shows an example of how the data may look when submitted:

Care Activity Identifier/ Service Request Identifier	Coded Assessment Tool Type (SNOMED CT)	Person Score
12345	953291000000109	55
12345	953301000000108	40
12345	953261000000103	40
12345	953271000000105	45
12350	953291000000109	35
12350	953301000000108	45

Scores are linked back to patients using Care Activity Identifiers (for assessments which take place as part of a contact) or Service Request Identifiers (for assessments which take place elsewhere but as part of a referral).

We would only expect dimensions from one Ages and Stages Questionnaire to flow in one period. For example, we would not expect the 24 month and 27 month ASQ scores to flow for the same patient in the same month.

The score is a total score for the ASQ:SE assessment, which is not split by 'dimensions'. There are 31 questions, with a possible score of 0 - 15 for each question. The total score should be reported.

Please see Appendix 1 for an explanation of licensing agreements.

Group Level Validation and Repeating Rules

These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*

Additional Notes on Data Items

Data Item Name	Additional Notes
CARE ACTIVITY IDENTIFIER	The unique identifier for a CARE ACTIVITY. It would normally be automatically generated by the local system upon recording a new activity, although could be manually assigned.
CODED ASSESSMENT TOOL TYPE (SNOMED CT)	The SNOMED CT concept ID which is used to identify an ASSESSMENT in SNOMED CT.
PERSON SCORE	The numeric value (score) resulting from an ASSESSMENT.

6.3.35 CYP613 Anonymous Self-Assessment

CYP613 Anonymous Self-Assessment	
Description	
Anonymous Self-Assessment: To carry details of anonymous assessments that are issued by the community health service. This data group is not linked to the rest of the data set at patient level. At present, while coded assessments such as the Ages and Stages Questionnaire (ASQ) are within scope of the CSDS and are licensed for use (see Appendix 1), we would not expect these assessments to be completed anonymously. As such, no data is currently expected to flow in this table.	
Group Level Validation and Repeating Rules	
These rules are fully described in the appropriate section for this group within the *CSDS Technical Output Specification.*	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
ASSESSMENT TOOL COMPLETION DATE	SELF ASSESSMENT COMPLETION DATE is the DATE the completed ASSESSMENT was completed.
CODED ASSESSMENT TOOL TYPE (SNOMED CT)	A unique identifier for an ASSESSMENT in SNOMED CT.
PERSON SCORE	The numeric value (score) resulting from an ASSESSMENT.
ACTIVITY LOCATION TYPE CODE	The type of physical LOCATION where PATIENTS complete the self-assessment.
ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	This is the organisation identifier of the organisation commissioning health care as part of this self-assessment.

6.3.36 CYP901 Staff Details

CYP901 Staff Details	
Description	
This table should include one record for every Health Professional (responsible for providing the patients care), including Lead Care Professionals, Key Workers, Care Coordinators, Supervised Clinicians and any other staff member who has a contact with a patient. Where a member of staff has multiple roles or works in more than one team concurrently, a separate record with different Care Professional Local Identifier should be created to enable linkage to activity. **General table guidance** The Care Professional Local Identifier has been included in most activity tables to allow reporting of all activity by Job Role and Main Specialty.	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
CARE PROFESSIONAL LOCAL IDENTIFIER	CARE PROFESSIONAL LOCAL IDENTIFIER is a unique local CARE PROFESSIONAL IDENTIFIER within a Health Care Provider and may be assigned automatically by the computer system.
PROFESSIONAL REGISTRATION BODY CODE	A code which identifies the PROFESSIONAL REGISTRATION BODY or Representative Body.
PROFESSIONAL REGISTRATION ENTRY IDENTIFIER	The registration identifier allocated by an ORGANISATION.
CARE PROFESSIONAL STAFF GROUP (COMMUNITY CARE)	The staff group of a CARE PROFESSIONAL working in a Community Health Service.
OCCUPATION CODE	Occupation codes are the traditional way of identifying numbers of staff in particular work sectors of the NHS in a consistent way. Occupation codes cover all staff in the Hospital and Community Health Service, both medical and non-medical.

	The manual covers NHS staff by their main functional groupings and is arranged in the following sections: A - Ambulance staff G - Administration and Estates staff H - Health care assistants and other support staff M - Medical and dental staff N - Nursing, midwifery and health visiting staff P - Nursing, midwifery and health visiting learners S - Scientific, therapeutic and technical staff T - Healthcare Scientists Z - General payments Note: The occupation codes are based on staff roles, and make no direct reference to pay scale information.
CARE PROFESSIONAL (JOB ROLE CODE)	Capturing activity undertaken by a Student or Agency: Student or agency work should be recorded under the relevant professional group.

Appendix 1 – Background and Licensing of Assessment Tools for use within systems

The Department of Health has asked health visiting teams in England to use ASQ-3 and ASQ:SE as part of two year health and development reviews. The assessments will generate data for a population measure of child development at age 2-2.5, which will be included in the Public Health Outcomes Framework. The Department of Health have published an updated guidance note about the ASQ-3 and ASQ:SE questionnaires, which can be found here.

Health Visiting teams were asked to use ASQ-3 questionnaires to record data on children's ASQ-3 scores at the two year review, on their local child health information systems, from October 2015. From 1 October 2016, providers and Area Teams were expected to start collecting ASQ:SE in addition to ASQ-3 data.

Providers and their IT suppliers are reminded of the need to ensure their compliance with Intellectual Property Law in relation to the use of copyright protected assessment tools.

Whilst SNOMED CT values can flow to NHS Digital without any copyright infringement (because SNOMED CT does not reproduce the text of the tools), reproduction of the tool within IT systems (text, values and algorithms etc.) requires suitable permissions to be in place. It is assumed that providers already have appropriate permissions in place for the assessment tools they use in paper form.

Appendix 2 – Service or Team Type Referred To Guidance

The following guidance provides information regarding the type of community service that the patient has been referred into.

Data values and notes:

’01 - Appliances Service’ includes all services relating to distribution and maintenance of patient appliances such as orthotics, wheelchairs, prosthetics, mattresses.

‘02 - Arts Therapy Service’ includes Art, Drama and Music Therapy

‘03 - Cancer Service’ include direct cancer treatment (excluding Palliative Care), for example the treatment of head and neck cancer, leukaemia, and/or chemotherapy provided in the community.

’04 - Cardiac Service’ should include patients directly treated for conditions related to heart disease. Including myocardial infarction, angina and cardiac rehabilitation.

‘05 - Community Dental Service’ includes all community dental services (for all ages) excluding personal dental services.

‘06 - Community Paediatrics Service’

’07 - Continence Service’ includes treatment of patients with continence problems including physiotherapy, pelvic floor treatments and pants and pads service.

’09 - Counselling Service’

‘10 - Dermatology Service’ includes treatment of skin, hair and nails excluding leg ulcer and wound care treatment (see separate value) and excluding treatment of skin cancer.

‘11 - Diabetes Service’ incorporates direct treatment of patients with diabetes including type 1 and 2. Includes interventions such as glucose monitoring and training on administering insulin.

’12 - District Nursing Service’

‘13 - Ear Nose and Throat Service’

‘14 - End of Life Care Service’ encompasses the care of a patient during the last stage of their life (patients in a progressive state of decline). This includes Palliative Care and Terminal Care.

‘15 - Gastrointestinal Service’ includes patients directly treated for conditions relating to the gastrointestinal system

‘16 - Health Visiting Service’

‘17 - Hearing Service’ includes hearing tests and maintenance of hearing aids, excludes neonatal screening).

‘18 - Intermediate Care Service’

‘19 - Long Term Conditions Case Management Service’ includes Community Matron-led services

‘20 - Musculoskeletal Service’ including treatment of bones, joints and supporting muscles. All patients receiving treatment for MSK conditions such as hip replacement, knee replacement and other joint disorders. Includes MSK rehabilitation.

‘21 - Neurology Service’

‘22 - Nutrition and Dietetics Service’

’23 - Occupational Therapy Service’

’24 - Orthoptist Service’

’25 - Pain Management Service’ excludes mobility

’26 - Physiotherapy Service’

‘27 - Podiatry Service’ includes Podiatric Surgery

‘28 - Public Health and Lifestyle Service’ includes all discreet Health Protection services such as vaccination programmes. Also includes all discreet health prevention/promotion services such as smoking cessation, obesity, falls and health inequalities programmes. Includes drug and alcohol programmes.

‘29 - Rehabilitation Service’

‘30 - Respiratory Service’ incorporates respiratory disease including Chronic Obstructive Pulmonary Disease and asthma.

‘31 - Rheumatology Service’ encompasses inflammatory diseases of the muscles and joints, including arthritis.

‘32 - School Nursing Service’

‘33 -Speech and Language Therapy Service’ includes children's and adults services as well as voice rehabilitation e.g. after a stroke, language development and swallowing difficulties.

’34 - Vulnerable Children's Service’ includes Looked after Children services and Safeguarding services

‘35 - Vulnerable Adult's Service’ includes homeless services

‘36 - Respite Care Service’

’37 - Clinical Psychology Service’

‘38 - Children's Community Nursing Service’ could include children under 16 who have a health need requiring nursing support or children under 19 years if they have a complex disability and remain under the care of a consultant paediatrician.

’39 - Diagnostic Service’ includes Colposcopy

’40 - Treatment Room Nursing Service’

‘41 - Haematology Service’

‘42 - Phlebotomy Service’

‘43 - Tissue Viability Service’ includes leg ulcer and complex wound care treatment

‘44 - Family Support Service’ does not include 'Family Nurse Partnership'

‘45 - Integrated Multi-Disciplinary 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’

