Urgent community response – two-hour and two-day response standards

2020/21 Technical data guidance

November 2020

Statement on reducing health inequalities

Promoting equality and addressing health inequalities are at the heart of NHS England and NHS Improvement's values. Throughout the development of the policies and technical guidance defined in this document we have given:

- due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it
- regard to the need to reduce inequalities between patients in equity of access to, and outcomes from, healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Contents

Summary

From 1 July 2020 data has been collected on the delivery of the two urgent community response standards – crisis response care within two-hours from any referral source and reablement care within two-days from any referral source except a hospital ward/bed – through the Community Services Data Set (CSDS).[1]

All providers of publicly-funded community health services, including those funded through the Better Care Fund,[2] are legally mandated to collect and submit community health data, as provided for by section 250 of the Health and Social Care Act 2012.[3]

This technical guidance supports collection and recording of the relevant data to ensure a standardised approach across England.

For generic queries relating to reporting to CSDS, including any issues on uploading to SDCS cloud system, please contact NHS Digital at ssd.nationalservicedesk@nhs.net

For queries relating specifically to this guidance and the UCR national standards for 2-hour crisis and 2-day reablement response, please contact england.2h2d@nhs.net

[1] https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/community-services-data-set
[2] https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/
[3] https://www.legislation.gov.uk/ukpga/2012/7/section/250

1. Definitions and context

1.1 Standard service definitions

Urgent community response is the collective name for services that improve the quality and capacity of care for people through delivery of urgent, crisis response care within two-hours and/or reablement care responses within two-days. Some providers offer a single, integrated service that covers all these types of care from crisis response to reablement. This is the preferred service delivery model.

Urgent community response services will be available following changes in an individual's health or circumstances. They provide a person-centred approach to optimise independence and confidence, enable recovery and prevent a decline in functional ability. Services should have a 'no wrong door' approach and work flexibly based on need, not diagnosis/condition. This will:

- enable people to live healthy independent lives for as long as possible in their own homes, or the place they call home
- reduce the need for escalation of care to non-home settings
- facilitate timely return to their usual place of residence following temporary escalations of care to non-home settings
- support the collaborative working required to deliver the requirements of the hospital discharge operating model.[4]

Crisis response two-hour response standard

A crisis response service is a community-based service typically provided by a multi-skilled team to people in their usual place of residence with an urgent care need (required within two hours), and involves an assessment and short-term intervention(s) (typically lasting up to 48 hours). This is a national standard.

The two-hour response is designed to reduce preventable hospital admission. The referral source will typically be from general practice, NHS 111, A&E/same day

[4] https://www.gov.uk/government/publications/coronavirus-covid-19-hospital-discharge-service-requirements

emergency care, frailty assessment units, ambulance services, self-referral, carer referral or community-based health and social care (including care homes).

Reablement two-day response standard

These are community-based services, typically provided by a multi-skilled team to maximise independence, and involve an assessment and intervention(s) to achieve goals set with the person. This is the active process of an individual regaining the skills, confidence and independence to enable them to do things for themselves, rather than having things done for them. It is typically a time-limited service.

These interventions typically last less than six weeks and include:

- **reablement** – typically provided by **therapy/social care practitioners** to people in their usual place of residence (national standard)
- **home-based intermediate care** – typically provided by **healthcare professionals/a multi-skilled team** to people in their usual place of residence (not currently part of the national standard)
- **bed-based intermediate care** – provided to people in a bed-based service, not their usual place of residence (eg care home, private residence) typically but not exclusively by healthcare professionals (not currently part of the national standard).

1.2 Response standards

Crisis response two-hour standard

The crisis response two-hour standard is 120 minutes or less between clock start and clock stop.

Services should deliver crisis response care for those people who need it within a maximum of two hours. However, where the person being referred requires crisis response care, but delivery of this care within two hours is not clinically or socially appropriate, care should be delivered at the earliest opportunity.

Achievement of this standard is defined as: clock stop time is earlier than or equal to clock start time plus two hours.

Reablement two-day standard

The reablement two-day standard is two overnights or fewer between clock start and clock stop.

Services should deliver reablement care or intermediate care (home- or bed-based) for people who need it within a maximum of two days. However, where the person being referred requires reablement care or intermediate care (home- or bed-based), but delivery of this care within two days is not clinically or socially appropriate, care should be delivered at the earliest appropriate opportunity.

Achievement of this standard is defined as: clock stop date is earlier than or equal to clock start date plus two days.

Where multiple urgent community response care activities are required, but these are not related, providers should consider recording these multiple referrals with the appropriate service type and waiting time measurement type, and using an appropriate clock start and clock stop. This may be dependent on the electronic patient record (EPR) system functionality. Each appropriate referral for the patient will be counted against the national standards.

1.3 Clock starts

Clock starts are required for each of the five referral routes into urgent community response services:

1. Accident and emergency (A&E) department:

- The time the person being referred is **estimated to leave the A&E department**. This should be rounded to the **nearest 15 minutes**, not the nearest hour or half hour.
- The date/time recorded will be as close as possible to the data collected by the A&E provider for the departure time (DEPTIME) field in A&E Episode Statistics (HES).
- The **referral from the A&E provider to the urgent community response service** must include the person's estimated departure date and time from the A&E department.

2 and 3. Acute hospital ward/bed and community hospital ward/bed

The hospital discharge operating model introduced new discharge to assess requirements – a framework to enable positive discharges to support people to leave hospital when safe and appropriate to do so. Reablement care should be delivered in a timely manner to enable discharge, assessment and provision of care within the most appropriate timeframe.

The hospital discharge operating model and its requirements apply to referrals from hospitals to ensure that people leave hospital when it is appropriate for them to do so.

- The reablement response two-day standard does not apply to this referral route. However, if a person's condition deteriorates when they are at home following discharge, the clock starts when they access urgent care services.
- Urgent community response services also need to collect and record data in the Community Services Data Set (CSDS) about provision of care in the community for people being referred via the discharge from acute/community ward/bed route. This will include when referrals are received from hospitals and details of subsequent assessments and provision of care that take place in the community. This ensures that CSDS accurately reflects all the care a person receives.

Acute providers will also collect data about the point at which a person no longer meets the clinical criteria to reside in hospital. If available, this information should be passed to the urgent community response service when referrals are made.

Receipt of referral should be when the referral is logged in the patient's electronic records and the provider has sufficient information to make an assessment.

4. Community-based health or social care worker (such as GP, paramedic, 999 clinical hubs and NHS 111 clinical assessment teams, community nurse or social care worker):

- The time at which the referral for the person being referred is **received by the provider** of urgent community response services.

5. Self-referral (from the person themselves or a carer, where appropriate):

- The time at which the referral for the person being referred is **received by the provider** of urgent community response services.

1.4 Clock stops

For all referral routes, the **clock stop** is the time at which crisis response or reablement care is **delivered** by the appropriate health or social care worker. While care is usually delivered face to face, or via telemedicine/virtual means in rare instances, regardless of how the care is delivered, the clock should only be stopped once the required intervention to safely address the crisis or provide the reablement support has been provided. The clock stop for the delivery of care, delivered face to face or via telemedicine/virtual means, will count towards the national standards.

1.5 Why data is important

The accurate collection, recording and reporting of data are critically important for ensuring that people are benefitting from effective urgent community response services, and will support:

- monitoring of the achievement of the two-hour and two-day response standards for crisis response and reablement by March 2023/24
- health and social care commissioners and providers to understand how responsive their local services are, which will lead to improvement of patient experience and outcomes
- reduced reliance on other, less appropriate NHS services
- alignment with the discharge to assess model in the hospital discharge operating model
- learning and continuous quality improvement
- identifying gaps in capacity and capability which may be affecting consistent delivery of the standards.

The reported data should include clock starts and clock stops to enable measurement against the response standards, but further data should also be recorded on:

- referral into urgent community response services/reablement
- the care delivered
- how care was delivered

- onward discharge from urgent community response services.

1.6 Mechanism for reporting data

The urgent community response standards require systematic collection of new data items. Commissioners and providers should ensure that this mandated data is reported to the CSDS and in EPR systems.

The CSDS is a national, patient-level, output-based, mandatory dataset for all providers of publicly-funded urgent community response services (including NHS and/or local authority funded). CSDS version 1.5 went live on 1 July 2020. It allows for reporting of urgent community response waiting times data, which will be used in conjunction with existing data items such as patient information, reason for referral, duration of care activities, procedures, observations and findings. Many providers already make a CSDS submission, submitting data to the Strategic Data Collection Service in the Cloud (SDCS Cloud) from August 2020.

Providers need to make one CSDS submission at provider level to cover all relevant services; it is not possible to make separate submissions for different aspects of the provider's services. If a provider does not currently submit data to CSDS, they will need to register for SDCS Cloud; further information and contact details can be found on the SDCS Cloud webpage on NHS Digital's website.[5]

The information standard DCB1069 (CSDS), under section 250 of the Health and Social Care Act 2012, mandates providers to ensure all data outlined in the CSDS requirements specification, and relevant to the community health services provided, is collected, recorded and reported. NHS Digital has published comprehensive information about CSDS, the changes brought in through version 1.5 and wider background information.[6,7]

Multiple health and social care organisations, working in partnership, will contribute to achieving the urgent community response standards. Cultures, systems and referral processes within and across commissioners and providers will need to be

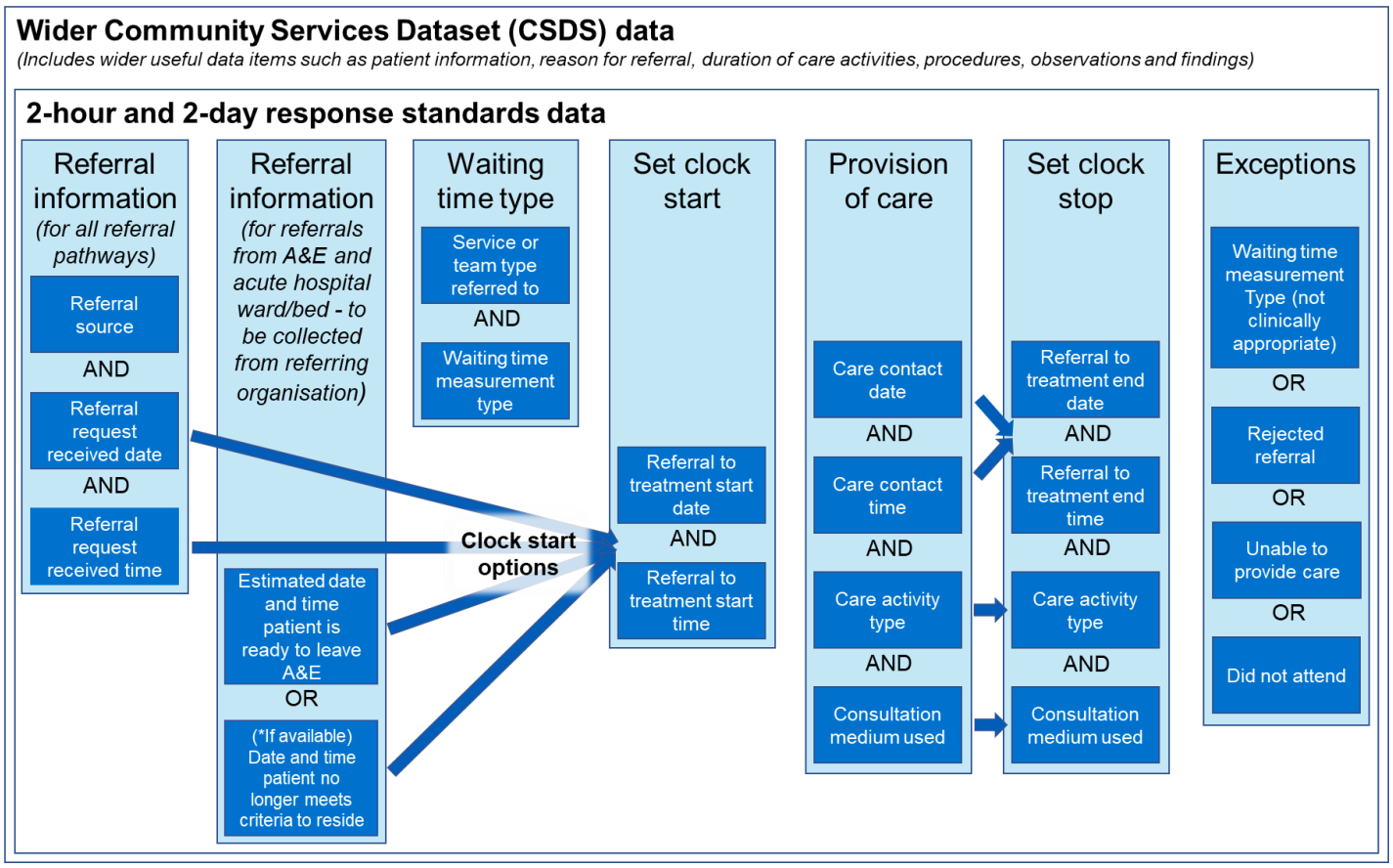
[5] https://digital.nhs.uk/services/strategic-data-collection-service-in-the-cloud-sdcs-cloud
[6] https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dcb1069-community-services-data-set
[7] https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/community-services-data-set

updated to support this achievement and to allow the collection and transfer of the corresponding data outlined in Sections 2.6 and 2.7 below.

Commissioners will need to consider referral processes for direct referrals between organisations, and referrals made via an interface service/intermediary organisation (that is, a single point of access (SPA) and NHS 111). Consideration should also be given to using data gathered through discharge hubs to inform multi-skilled team decision-making, and the support structure needed to enable timely discharge of people from hospital.

2. Recording response times

2.1 Overview of data collection



2.2 NHS Data Dictionary

The information in this section should be considered in conjunction with the NHS Data Dictionary[8] which gives definitions for all the data tables, fields and options referred to.

2.3 Service types

The appropriate service type should be reported in the following field in CSDS:

- CYP102 Service or Team Type Referred To Table (CYP102):

[8] https://www.datadictionary.nhs.uk/

SERVICE OR TEAM TYPE REFERRED TO (COMMUNITY CARE) / TeamType.

Four service types are applicable to urgent community response services:

- 51: Crisis response intermediate care service
- 52: Reablement intermediate care service
- 53: Home-based intermediate care service
- 54: Community bed-based intermediate care service.

Providers should ensure they are recording the appropriate service type for the type of care provided, and the appropriate waiting time measurement type. If the provider provides a single, integrated service that covers all these types of care, they should record the service type as:

- 45: Integrated multidisciplinary team (jointly commissioned)

and select the appropriate waiting time measurement type for the type and urgency of the care required.

Other service types

Other community health services may provide an urgent response, but not as part of a multi-skilled team, such as district nursing or community nursing services. While not in scope of the urgent community response standards, we encourage providers to monitor waiting times for these services. To do this, they should select the appropriate service type and the appropriate waiting time measurement type for the type and urgency of the care required.

2.4 Waiting time measurement type

As outlined in Section 1.2, crisis response care has a two-hour response time standard and reablement has a two-day response time standard

The appropriate waiting time measurement type should be reported in the following field in CSDS:

- Referral to Treatment Table (CYP104):
  WAITING TIME MEASUREMENT TYPE / WaitingTime_MeasurementType.

Four waiting time measurement types are applicable to urgent community response services:

- 05: Crisis response intermediate care within 2 hours waiting time measurement
- 06: Other intermediate care within 2 days waiting time measurement
- 07: Crisis response intermediate care waiting time measurement
- 08: Other intermediate care waiting time measurement.

Providers must consider the definitions of crisis response and reablement response to ensure that the correct waiting time measurement type is recorded and acted on when planning the delivery of care.

Crisis response

Where the person being referred requires crisis response care, the waiting time measurement type should be recorded as:

- 05: Crisis response intermediate care within 2-hours waiting time measurement.

However, where the person being referred requires crisis response care, **but delivery of this care within two hours is not clinically or socially appropriate**, care should be delivered at the earliest appropriate opportunity and the waiting time measurement type should be recorded as:

- 07: Crisis response intermediate care waiting time measurement.

Other intermediate care (including reablement)

Where the person being referred requires reablement care or intermediate care (home- or bed-based), the waiting time measurement type should be recorded as:

- 06: Other intermediate care within 2 days waiting time measurement.

However, where the person being referred requires reablement care or intermediate care (home- or bed-based) **but delivery of this care within two days is not clinically or socially appropriate**, care should be delivered at the earliest appropriate opportunity and the waiting time measurement type should be recorded as:

- 08: Other intermediate care waiting time measurement.

Other service types

Where other community health services provide an urgent response, but not as part of a multi-skilled team, such as district nursing or community nursing services, and wish to monitor response times, dependent on the type and urgency of the care required, the most appropriate waiting time measurement type should be recorded as:

- 07: Crisis response intermediate care waiting time measurement
- 08: Other intermediate care waiting time measurement.

2.5 Referral to treatment period status

The referral to treatment period status field is not applicable for the recording and reporting of urgent community response times. However, providers may choose to use this for referral management purposes.

- Referral to Treatment Table (CYP104):
  REFERRAL TO TREATMENT PERIOD STATUS / RTT_Status.

2.6 Clock start and corresponding data

Referral source

As outlined in Section 1.3, the clock start differs depending on the referral source. As such, data for the source of the referral will need to be collected and accurately recorded.

Referral source should be reported in the following field in CSDS:

- Service or Team Referral Table (CYP101):
  SOURCE OF REFERRAL FOR COMMUNITY / SourceOfReferral.

The most appropriate referral source should be used so that flow and demand across organisations and services can be understood locally and nationally, and quality improvements made.

Where the person needing care is being **referred from an A&E department**, the referral source should be recorded as:

- 05: Accident and emergency department.

Where the person needing care is being **referred from an acute hospital ward/bed**, the referral source should be recorded as:

- 06: Acute hospital inpatient/outpatient department.

Where the person needing care is being **referred from a community hospital ward/bed**, the referral source should be recorded as:

- 07: Community health service (same or other healthcare provider).

Where the person needing care is being **referred from a community-based health or social care worker** (that is, GP, paramedic, community nurse or social care worker), the referral source should be recorded as the most appropriate of the 24 available options. Likely examples are:

- 01: General medical practitioner practice
- 07: Community health service (same or other healthcare provider)
- 11: Local authority social services
- 13: Care home
- 19: Telephone or electronic access service (for use for NHS 111 referrals)
- 20: Voluntary sector
- 21: Independent sector
- 22: Ambulance service
- 23: Mental health service.

Where the person needing care is **self-referring**, the referral source should be recorded as either of the following options, as appropriate:

- 02: Self-referral
- 03: Carer/relative.

Clock start

The clock starts for each of the referral routes are summarised in the following table (further detail can be found in Section 1.3 above):

Referral source	Clock start
Accident and emergency department (A&E)	Estimated date/time of departure from A&E; information transferred when referral is made
Acute hospital ward/bed	Not applicable for reablement two-day standard (but, if available, record date/time the person being referred no longer meets criteria to reside in hospital)
Community hospital ward/bed	Not applicable for reablement two-day standard (but date/time that the urgent community response provider receives the referral should still be recorded)
Community-based health or social care worker	Date/time that the urgent community response provider receives the referral
Self-referral (from the person needing care or a carer)	Date/time that the urgent community response provider receives the referral

The clock start should be recorded in the following fields in CSDS:

- Referral to Treatment Table (CYP104):
  REFERRAL TO TREATMENT PERIOD START DATE / RTT_StartDate.
- Referral to Treatment Table (CYP104):
  REFERRAL TO TREATMENT PERIOD START TIME / RTT_StartTime.

Where the clock start is the time the person being referred is estimated to leave the A&E department, commissioners and providers will need to ensure this information is collected from/transferred by the referring organisation at the time the referral is made. **This should be rounded to the nearest 15 minutes, not the nearest hour or half hour.** It is expected that the date/time recorded will ideally be as close as possible to the data collected for the departure time (DEPTIME) field in A&E Hospital Episode Statistics (HES).

Where the clock start is the time the referral is received, providers should consider using the same data collected for and reported in the following fields in CSDS:

- Service or Team Referral Table (CYP101):
  REFERRAL REQUEST RECEIVED DATE / ReferralRequest_ReceivedDate.

- Service or Team Referral Table (CYP101):
  REFERRAL REQUEST RECEIVED TIME / ReferralRequest_ReceivedTime.

2.7 Clock stop and corresponding data

Clock stop

The clock stop for all referral sources is defined in Section 1.4. The necessary information for clock stop should be collected/recorded by the health or social care worker delivering the first care activity relevant to the referral when delivery of care starts.

Clock stop dates and times should be reported in the following fields in CSDS:

- Referral to Treatment Table (CYP104):
  REFERRAL TO TREATMENT PERIOD END DATE / RTT_EndDate.
- Referral to Treatment Table (CYP104):
  REFERRAL TO TREATMENT PERIOD END TIME / RTT_EndTime.

Providers should consider using the same data collected for the first care contact which meets the care activity type criteria and consultation medium used criteria outlined below. These should be reported in the following fields in CSDS:

- Care Contact Table (CYP201):
  CARE CONTACT DATE / Contact_Date.
- Care Contact Table (CYP201):
  CARE CONTACT TIME / Contact_Time.

Care activity type

The clock stop requires the provision of care to have started. To identify whether the provision of care has started, the following field in CSDS should be used:

- Care Activity Table (CYP202):
  COMMUNITY CARE ACTIVITY TYPE / Activity_Type.

The most appropriate care activity type should be recorded; five care activity types are applicable to the clock stop and available for selection:

- 01: Administering tests
- 02: Assessment
- 03: Clinical intervention
- 04: Counselling, advice, support
- 05: Patient specific health promotion.

Consultation medium

Telemedicine is increasingly being used to supplement, or be used in place of, face-to-face contact as a consultation medium. While consultation medium is not applicable to the clock stop, it will be useful to record the increasing use of telemedicine and, more generally, how care is being delivered. To record this, the following field in CSDS should be used:

- Care Contact Table (CYP201):
  CONSULTATION MEDIUM USED / Consultation_MediumUsed.

The most appropriate consultation medium should be recorded; seven care activity types are available for selection:

- 01: Face-to-face communication
- 02: Telephone
- 03: Telemedicine
- 04: Talk type for person unable to speak
- 05: Email
- 06: SMS – Text messaging
- 98: Other (not listed).

3. Additional useful data

The CSDS collects data on community health service provision in general, not just waiting times for the provision of these services. This includes, among other things, data about the people who are in contact with community health services and the nature of care provided.

Examples of particularly useful information for commissioners (for commissioning) and providers (for quality improvement) are:

- Service or Team Referral Table (CYP101):
  PRIMARY REASON FOR REFERRAL (COMMUNITY CARE) / PrimaryReferralReason
- Care Contact Table (CYP201)
  CLINICAL CONTACT DURATION OF CARE CONTACT / CareContact_Duration
- Care Activity Table (CYP202):
  PROCEDURE SCHEME IN USE/ Procedure_Scheme, AND;
  CODED PROCEDURE (CLINICAL TERMINOLOGY) / CodedProcedure
- Care Activity Table (CYP202):
  FINDING SCHEME IN USE/ Finding_Scheme, AND;
  CODED FINDING (CODED CLINICAL ENTRY) / FindingCode
- Care Activity Table (CYP202):
  OBSERVATION SCHEME IN USE/ Observation_Scheme, AND;
  CODED OBSERVATION (CLINICAL TERMINOLOGY) / CodedObservation.

These fields can provide an understanding of health and care need for community health services across the population served. Additionally, understanding resource use and resource use by need is extremely useful for service planning and design.

4. Exceptions and exclusions

All the below exceptions and exclusions should be monitored by commissioners and providers to understand any potential issues with service provision, and efforts should be made to reduce their prevalence where appropriate. Exceptions and exclusions will be monitored by NHS England and NHS Improvement to support the principle of ‘no wrong door’.

Rejected referrals

Urgent community response services should be inclusive, and all people being referred into these services should receive the most appropriate care. a referral is rejected, providers should endeavour to re-direct the referral to an appropriate service in keeping with the ‘no wrong door’ ethos of urgent community response care. Where a referral is inappropriate, providers should ensure that rejected referrals are properly recorded using the following fields in CSDS:

- Service or Team Type Referred To Table (CYP102): REFERRAL REJECTION DATE / Referral_RejectionDate.
- Service or Team Type Referred To Table (CYP102): REFERRAL REJECTION REASON / Referral_RejectionReason.

The most appropriate referral rejection reason code should be recorded; there are three available for selection:

- 01: Duplicate referral request (patient already undergoing treatment for the same condition at the same or other healthcare provider)
- 02: Inappropriate referral request (referral request is inappropriate for the services offered by the healthcare provider)
- 03: Incomplete referral request (incomplete information on referral request).

Where any of these options are selected, the applicable referral will be excluded from measurement of the response standard.

No access visit/did not attend (DNA)

No access visits and DNAs should be rare occurrences. However, where the person requiring care is not in their own home when the need for care is identified, there may be issues and delays with transporting that person home to receive care.

Urgent community response services should ensure that the risk of no access visits and DNAs is minimised as far as reasonably possible. Where this does happen, providers should ensure that no access visits and DNAs are recorded using the following field in CSDS:

- Care Contact Table (CYP201):
  ATTENDED OR DID NOT ATTEND CODE / AttendOrNot.

The most appropriate DNA/attendance code should be recorded; there are six available for selection:

- 2: Appointment cancelled by, or on behalf of, the patient
- 3: Did not attend – no advance warning given
- 4: Appointment cancelled or postponed by the healthcare provider
- 5: Attended on time or, if late, before the relevant care professional was ready to see the patient
- 6: Arrived late, after the relevant care professional was ready to see the patient, but was seen
- 7: Patient arrived late and could not be seen.

No access visits and DNAs will only be regarded as an exclusion where the clock stop criteria outlined in Section 2.7 (‘Care activity type’ and ‘Consultation medium’) are met.

Where options 2, 3 or 7 are selected, the applicable care contact will be excluded from measurement of the response standard.

Option 7 should be reported where issues with transporting the person requiring care home meant that care could not be provided.

Providers should then attempt to contact the patient/referring organisation and, when the person’s need for care has been reviewed, consider:

- recording the new, appropriate clock start (the time the need was re-conveyed) against the same referral, and ensuring the date and time of the next care contact are used for the clock stop (following the clock stop guidance outlined in Section 2.7), or
- closing the existing referral (Following the 'Unable to provide care' guidance outlined earlier in this section) and recording a new referral with the appropriate service type and waiting time measurement type, and appropriate new clock start.

Late referral

As outlined in Section 1.4, the clock start differs for different referral routes. It can be:

- the time the person being referred is estimated to leave the A&E department
- if available, the time the person being referred no longer meets the criteria to reside in hospital
- where the clock start is the time the referral is received.

It is expected that a well-functioning system will ensure that a referral into the service is received before that person is assessed as not meeting the clinical criteria to reside in hospital. However, on occasion, a referral may arrive later than this. When this happens, the referral date and time will be taken as the clock start, and should be used to calculate whether the appropriate response standard was met. This should be recorded in the following fields in CSDS:

- Service or Team Referral Table (CYP101):
  REFERRAL REQUEST RECEIVED DATE / ReferralRequest_ReceivedDate.
- Service or Team Referral Table (CYP101):
  REFERRAL REQUEST RECEIVED TIME / ReferralRequest_ReceivedTime.

Not appropriate clinically or for social care, family or carers support – for a two-hour or two-day response

Urgent community response services should be inclusive, and all people being referred into these services should receive the most appropriate care within the

relevant urgent community response standard – two hours for crisis response and two days for reablement.

However, where it is judged that a person requiring care **should not** receive care within the relevant urgent community response standard (and thus be excluded from measurement of the response standard), this should be recorded. Where it is not clinically appropriate for a person to receive a two-hour or two-day response, this data should be reported in the following field in CSDS:

- Referral to Treatment Table (CYP104):
  WAITING TIME MEASUREMENT TYPE / WaitingTime_MeasurementType.

Where the person being referred requires **crisis response care**, but this should not be delivered within two hours, the waiting time measurement type should be recorded as:

- 07: Crisis response intermediate care waiting time measurement.

Where the person being referred requires **reablement care or intermediate care (home-based or bed-based)**, but this should not be delivered within two days, the waiting time measurement type should be recorded as:

- 08: Other intermediate care waiting time measurement.

Clock starts and stops should still be recorded, following the guidance outlined in Sections 2.6 and 2.7.

Closing referrals

By default, all referrals should be closed when and where it is appropriate to do so. There may be times, outside the influence of the provider, when it is not possible to deliver care. Where this does happen, providers should ensure that referrals are properly closed and recorded using the following fields in CSDS:

- Service or Team Type Referred To Table (CYP102):
  REFERRAL CLOSURE DATE / Referral_CloseDate.
- Service or Team Type Referred To Table (CYP102):
  REFERRAL CLOSURE REASON / Referral_ClosureReason.

The most appropriate referral closure reason code should be recorded; there are nine available for selection:

- 01: Admitted elsewhere (at the same or other Healthcare Provider)
- 02: Treatment completed
- 03: Moved out of the area
- 04: No further treatment appropriate
- 05: Patient did not attend
- 06: Patient died
- 07: Patient requested discharge
- 08: Referred to other speciality/service (at the same or other healthcare provider)
- 09: Patient refused to be seen.

Where a clock start has been reported without a clock stop, and any of the options besides options 1, 2 and 4, are selected, the applicable referral will be excluded from measurement of the response standard.

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