Health and Social Care Information Centre

NHS Data Model and Dictionary Service

Type:	Change Request
Reference:	1514
Version No:	1.0
Subject:	Mental Health Services Data Set
Effective Date:	1 January 2016
Reason for Change:	Change to Data Standards
Publication Date:	13 July 2015

Background:

The Mental Health Services Data Set (MHSDS) is being introduced following an expansion to the scope of the Mental Health and Learning Disabilities Data Set (MHLDDS) to include:

- Child and Adolescent Mental Health Services (CAMHS) Data Set
- The former Adult Mental Health Care Clusters and the Clustering Tool Standards
- The KP90: Informal Patients and Patients Detained under the Mental Health Act: The Number of Uses of the Act Standard
- Elements of the Assuring Transformation Collection Standard
- Elements of the Learning Disability Census

A separate Change Request will retire the information in the NHS Data Model and Dictionary which relates to these Information Standards.

Note: the retirement of the KP90 Information Standard will be addressed in a future Information Standards Notice (ISN), which will be issued by the Standardisation Committee for Care Information (SCCI).

Further changes and amendments to the original content of the Mental Health and Learning Disabilities Data Set are also required which include:

- The incorporation of requirements in support of Children and Young People's Improving Access to Psychological Therapies
- Restructuring of the data set to support referral based reporting, through inclusion of a number of new unique identifiers. This is to allow for the effective collection of waiting times data, including waiting times for Early Intervention in Psychosis Services

This Change Request adds the Mental Health Services Data Set and supporting definitions to the NHS Data Model and Dictionary to support the Information Standard.

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

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

Summary of changes:

Diagrams	
ACTIVITY DIAGRAM	Changed Diagram
CHILDREN AND YOUNG PEOPLE'S HEALTH SERVICE SECONDARY USES DIAGRAM	Changed Diagram
HIV AND AIDS DIAGRAM	Changed Diagram
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES DIAGRAM	Changed Diagram

MATERNITY SERVICES DIAGRAM	Changed Diagram
NATIONAL RENAL DIAGRAM	Changed Diagram

Data Set

MENTAL HEALTH SERVICES DATA SET	New Data Set

Supporting Information

ADULT MENTAL HEALTH CARE CLUSTER renamed from MENTAL HEALTH CARE CLUSTER	Changed Name, Description
ADULT MENTAL HEALTH CLUSTERING TOOL renamed from MENTAL HEALTH CLUSTERING TOOL	Changed Name, Description
AUTISTIC SPECTRUM DISORDER	Changed Description
CARE CLUSTER ASSIGNMENT PERIOD	New Supporting Information
CARE CONTACT CANCELLATION DATE renamed from CARE CONTACT CANCELLATION DATE	Changed Name, Description
CARE CONTACT DATE renamed from CARE CONTACT DATE	Changed Name, Description
CARE CONTACT TIME renamed from CARE CONTACT TIME	Changed Name, Description
CARE PROFESSIONAL ADMITTED CARE EPISODE	New Supporting Information
CARE PROGRAMME APPROACH	New Supporting Information
CARE PROGRAMME APPROACH CARE EPISODE renamed from CARE PROGRAMME APPROACH EPISODE	Changed Name, Description
CARE PROGRAMME APPROACH REVIEW	Changed Description
CARE PROGRAMME APPROACH REVIEW DATE	Changed Description
CHILD AND ADOLESCENT MENTAL HEALTH SERVICES SECONDARY USES DIAGRAM OVERVIEW	Changed Description
CLINICAL DATA SETS MENU	Changed Description
CLINIC ATTENDANCE NON-CONSULTANT	Changed Description
CLUSTERING TOOL	New Supporting Information
COMMISSIONER ASSIGNMENT PERIOD	Changed Description
COMMUNITY TREATMENT ORDER	Changed Description
COMMUNITY TREATMENT ORDER RECALL	New Supporting Information
DATE OF RESTRICTIVE INTERVENTION	New Supporting Information
DAY CARE FACILITY	Changed Description
DIAGRAMS MENU	Changed Description
DISCHARGE LETTER ISSUED DATE (MENTAL HEALTH AND COMMUNITY CARE)	New Supporting Information
EARLY INTERVENTION IN PSYCHOSIS SERVICE	New Supporting Information
EARLY INTERVENTION IN PSYCHOSIS WAITING TIME MEASUREMENT	New Supporting Information
GROUP THERAPY	Changed Description
HEALTH OF THE NATION OUTCOME SCALE (WORKING AGE ADULTS)	Changed Description
HOME LEAVE	Changed Description
INDEPENDENT MENTAL CAPACITY ADVOCATE	New Supporting Information
INDEPENDENT MENTAL HEALTH ADVOCATE	New Supporting Information
INDIRECT ACTIVITY	New Supporting Information
INDIRECT ACTIVITY DATE	New Supporting Information
INDIRECT ACTIVITY TIME	New Supporting Information
MENTAL HEALTH ABSENCE WITHOUT LEAVE	Changed Description
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD renamed from MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD	Changed Name, Description
MENTAL HEALTH CARE CLUSTER SUPER CLASS	Changed Description
MENTAL HEALTH CARE COORDINATOR	New Supporting Information
MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD renamed from MENTAL HEALTH CARE COORDINATOR ASSIGNMENT	Changed Name, Description
MENTAL HEALTH CONDITIONAL DISCHARGE PERIOD	Changed Description
MENTAL HEALTH CRISIS PLAN CREATION DATE	New Supporting Information
MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE	New Supporting Information

MENTAL HEALTH DELAYED DISCHARGE PERIOD	Changed Description
MENTAL HEALTH LEAVE OF ABSENCE	Changed Description
MENTAL HEALTH RESPONSIBLE CLINICIAN	Changed Description
MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD renamed from MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT	Changed Name
MENTAL HEALTH SERVICE	New Supporting Information
MENTAL HEALTH SERVICES DATA SET OVERVIEW	New Supporting Information
NON-INSTRUCTED ADVOCATE	New Supporting Information
ONWARD REFERRAL DATE	New Supporting Information
OUT-PATIENT APPOINTMENT NON-CONSULTANT	Changed Description
OUT-PATIENT ATTENDANCE CONSULTANT	Changed Description
PATIENT PROXY	Changed Description
PLANNED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)	New Supporting Information
REFERRAL CLOSURE DATE	New Supporting Information
REFERRAL REJECTION DATE	New Supporting Information
REPLACEMENT APPOINTMENT BOOKED DATE	New Supporting Information
REPLACEMENT APPOINTMENT DATE OFFERED	New Supporting Information
RESTRICTIVE INTERVENTION	New Supporting Information
SERVICE DISCHARGE DATE	New Supporting Information
WARD ATTENDANCE	Changed Description
WARD STAY	Changed Description

Class Definitions

ACCOMMODATION	Changed Attributes
ACTIVITY GROUP	Changed Relationships, Attributes
ADMINISTRATIVE CATEGORY	Changed Description
ADMINISTRATIVE CATEGORY PERIOD	Changed Description
APPOINTMENT	Changed Description
ASSESSMENT TOOL	Changed Attributes
CARE CLUSTER renamed from MENTAL HEALTH CARE CLUSTER	Changed Name, Attributes, Description
CARE CONTACT	Changed Attributes
CARE PLAN	Changed Attributes
CARE PROFESSIONAL	Changed Attributes, Description
CARE PROFESSIONAL TEAM	Changed Description
CARE PROFESSIONAL TEAM MEMBER	Changed Description
CLINICAL INTERVENTION	Changed Attributes
CLINICAL INVESTIGATION RESULT ITEM	Changed Attributes
DISABILITY	Changed Attributes
LANGUAGE renamed from LANGUAGE CLASSIFICATION	Changed Name, Description
LEAVE	Changed Attributes
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION	Changed Attributes
PATIENT DIAGNOSIS	Changed Attributes
PERSON PROPERTY	Changed Relationships
PERSON PROPERTY ASSIGNMENT PERIOD	New Class
PLANNED ACTIVITY	Changed Relationships
PLANNED ACTIVITY DATE TIME	New Class
REFERRAL REQUEST	Changed Attributes
SERVICE	Changed Attributes
SESSION	Changed Attributes
UNIT OF MEASUREMENT	Changed Attributes
WARD	Changed Attributes

Attribute Definitions

ACTIVITY DATE TYPE	Changed Description
ACTIVITY GROUP TYPE	Changed Description
ACTIVITY LOCATION TYPE CODE	Changed Description
ACTIVITY TIME TYPE	Changed Description
ADMINISTRATIVE CATEGORY CODE	Changed Description
ADMISSION METHOD	Changed Description
ADULT MENTAL HEALTH CARE CLUSTER CODE renamed from MENTAL HEALTH CARE CLUSTER CODE	Changed Name, Description
ASSESSMENT TOOL TYPE	Changed Description
ATTENDED OR DID NOT ATTEND	Changed Description
CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH	New Attribute
CARE PROGRAMME APPROACH REVIEW ABUSE QUESTION ASKED INDICATOR	Changed Description
CATEGORY VALUED PERSON OBSERVATION TYPE	Changed Description
CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE	New Attribute
CHILD AND ADOLESCENT MENTAL HEALTH TIER OF SERVICE	Changed Description
CHILD PROTECTION PLAN INDICATION CODE renamed from CHILD PROTECTION PLAN INDICATOR	Changed Name, Description
CLINICAL INTERVENTION TYPE	Changed Description
CLINICAL RESPONSE PRIORITY TYPE	Changed Description
CLUSTERING TOOL ASSESSMENT CATEGORY	New Attribute
CLUSTERING TOOL ASSESSMENT REASON renamed from MENTAL HEALTH CLUSTERING TOOL ASSESSMENT REASON	Changed Name, Description
COMMUNITY TREATMENT ORDER END REASON renamed from SUPERVISED COMMUNITY TREATMENT END REASON	Changed Name, Description
CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR	New Attribute
CONSULTATION MEDIUM USED	Changed Description
CONSULTATION TYPE	New Attribute
DIAGNOSIS SCHEME IN USE	New Attribute
DISABILITY IMPACT PERCEPTION	New Attribute
FINDING SCHEME IN USE	New Attribute
FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE	New Attribute
FORENSIC MENTAL HEALTH CARE CLUSTER CODE	New Attribute
GROUP SESSION TYPE FOR MENTAL HEALTH	New Attribute
GROUP THERAPY INDICATOR	Changed Description
LANGUAGE CODE	New Attribute
LEARNING DISABILITIES CARE CLUSTER CODE	New Attribute
LOOKED AFTER CHILD INDICATOR	Changed Description
MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON renamed from ABSENCE WITHOUT LEAVE END REASON	Changed Name, Description
MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY renamed from MENTAL HEALTH ABSOLUTE DISCHARGE END METHOD	Changed Name, Description
MENTAL HEALTH ACT 2007 MENTAL CATEGORY	Changed Description
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON renamed from MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD END REASON CODE	Changed Name, Description
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON renamed from MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD START REASON CODE	Changed Name, Description
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE	Changed Description
MENTAL HEALTH CARE CLUSTER END REASON	Changed Description
MENTAL HEALTH CONDITIONAL DISCHARGE END REASON	Changed Description
MENTAL HEALTH DELAYED DISCHARGE REASON	Changed Description
MENTAL HEALTH LEAVE OF ABSENCE END REASON renamed from LEAVE OF ABSENCE END REASON	Changed Name, Description
OBSERVATION SCHEME IN USE	New Attribute
OBSERVATION VALUE	New Attribute

OFFERED FOR ADMISSION DATE	Changed Description
ONWARD REFERRAL REASON	New Attribute
OTHER PERSON IN ATTENDANCE AT CARE CONTACT	New Attribute
PERSON PROPERTY ASSIGNMENT PERIOD TYPE	New Attribute
PERSON PROPERTY RECORDED DATE	Changed Description
PLANNED ACTIVITY DATE	New Attribute
PLANNED ACTIVITY DATE TYPE	New Attribute
PROCEDURE SCHEME IN USE	New Attribute
PROFESSIONAL REGISTRATION BODY CODE	Changed Description
REASON FOR REFERRAL TO MENTAL HEALTH	New Attribute
REFERRAL CLOSURE REASON	New Attribute
REFERRAL REJECTION REASON	New Attribute
REFERRING CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH AND COMMUNITY CARE	New Attribute
RESTRICTIVE INTERVENTION TYPE	New Attribute
SERVICE OR TEAM TYPE FOR MENTAL HEALTH	New Attribute
SERVICE TYPE	Changed Description
SETTLED ACCOMMODATION INDICATOR	Changed Description
SOURCE OF REFERRAL FOR MENTAL HEALTH	Changed Description
UCUM UNIT OF MEASUREMENT	New Attribute
WAITING TIME MEASUREMENT TYPE	Changed Description
WARD SETTING TYPE FOR MENTAL HEALTH	New Attribute
WEEKLY HOURS WORKED	Changed Description
YOUNG CARER INDICATOR	Changed Description

Data Elements

ACCOMMODATION STATUS RECORDED DATE renamed from ACCOMMODATION STATUS DATE	Changed Name, Description, linked Attribute
ADULT MENTAL HEALTH CARE CLUSTER CODE (FINAL) renamed from MENTAL HEALTH CARE CLUSTER CODE (FINAL)	Changed Name, Description
ADULT MENTAL HEALTH CARE CLUSTER CODE (INITIAL) renamed from MENTAL HEALTH CARE CLUSTER CODE (INITIAL)	Changed Name, Description
CARE ACTIVITY IDENTIFIER	New Data Element
CARE CONTACT CANCELLATION DATE	Changed Description, linked Attribute
CARE CONTACT DATE	Changed Description, linked Attribute
CARE CONTACT IDENTIFIER	New Data Element
CARE CONTACT TIME	Changed Description, linked Attribute
CARE PROFESSIONAL LOCAL IDENTIFIER	New Data Element
CARE PROFESSIONAL SERVICE OR TEAM TYPE ASSOCIATION (MENTAL HEALTH)	New Data Element
CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH)	New Data Element
CARE PROFESSIONAL TEAM LOCAL IDENTIFIER	New Data Element
CARE PROGRAMME APPROACH CARE EPISODE IDENTIFIER	New Data Element
CARE PROGRAMME APPROACH REVIEW DATE renamed from REVIEW DATE	Changed Name, Description, linked Attribute
CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL)	New Data Element
CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL)	New Data Element
CHILD PROTECTION PLAN INDICATION CODE renamed from CHILD PROTECTION PLAN INDICATOR	Changed Name, Description
CLINICAL CONTACT DURATION OF CARE ACTIVITY	Changed Description
CLINICAL CONTACT DURATION OF CARE CONTACT	Changed Description
CLINICAL CONTACT DURATION OF GROUP SESSION	Changed Description
CLUSTERING TOOL ASSESSMENT CATEGORY	New Data Element

CLUSTERING TOOL ASSESSMENT IDENTIFIER	New Data Element
CLUSTERING TOOL ASSESSMENT REASON renamed from MENTAL HEALTH CLUSTERING TOOL ASSESSMENT REASON	Changed Name, Description
CODED ASSESSMENT TOOL TYPE (SNOMED CT)	New Data Element
CODED FINDING (CODED CLINICAL ENTRY)	New Data Element
CODED OBSERVATION (CLINICAL TERMINOLOGY)	New Data Element
CODED PROCEDURE (CLINICAL TERMINOLOGY)	New Data Element
COMMUNITY TREATMENT ORDER END REASON renamed from SUPERVISED COMMUNITY TREATMENT END REASON	Changed Name
CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR	New Data Element
CONSULTATION TYPE	New Data Element
DATE DETENTION COMMENCED	Changed Description
DATE OF ASSAULT ON PATIENT	Changed Description
DATE OF RESTRICTIVE INTERVENTION	New Data Element
DATE OF SELF-HARM renamed from DATE OF SELF HARM	Changed Name, Description
DIAGNOSIS SCHEME IN USE	Changed Description, linked Attribute
DISABILITY IMPACT PERCEPTION	New Data Element
DISCHARGE LETTER ISSUED DATE (MENTAL HEALTH AND COMMUNITY CARE)	New Data Element
DISCHARGE TIME (HOSPITAL PROVIDER SPELL)	Changed Description
DURATION OF INDIRECT ACTIVITY	New Data Element
DURATION OF RESTRICTIVE INTERVENTION	New Data Element
EARLIEST CLINICALLY APPROPRIATE DATE	Changed Description
EARLIEST REASONABLE OFFER DATE	Changed Description
EMERGENT PSYCHOSIS DATE	Changed Description, linked Attribute
EMPLOYMENT STATUS RECORDED DATE	Changed Description, linked Attribute
END DATE (CARE CLUSTER ASSIGNMENT PERIOD)	New Data Element
END DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)	New Data Element
END DATE (CARE PROGRAMME APPROACH CARE)	Changed Description
END DATE (COMMUNITY TREATMENT ORDER) renamed from END DATE (SUPERVISED COMMUNITY TREATMENT)	Changed Name, Description
END DATE (COMMUNITY TREATMENT ORDER RECALL) renamed from END DATE (SUPERVISED COMMUNITY TREATMENT RECALL)	Changed Name, Description
END DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD) renamed from END DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)	Changed Name, Description
END DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD) renamed from END DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT)	Changed Name, Description
END DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD)	Changed Description
END DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD) renamed from END DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT)	Changed Name
END TIME (CARE CLUSTER ASSIGNMENT PERIOD)	New Data Element
END TIME (COMMUNITY TREATMENT ORDER RECALL) renamed from END TIME (SUPERVISED COMMUNITY TREATMENT RECALL)	Changed Name, Description
END TIME (HOME LEAVE)	New Data Element
END TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE)	New Data Element
END TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD) renamed from END TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)	Changed Name, Description
END TIME (MENTAL HEALTH LEAVE OF ABSENCE)	New Data Element
EXPIRY DATE (COMMUNITY TREATMENT ORDER) renamed from EXPIRY DATE (SUPERVISED COMMUNITY TREATMENT)	Changed Name, Description, linked Attribute
EXPIRY DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)	

	Changed Description, linked Attribute
EXPIRY TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)	Changed Description, linked Attribute
FINDING SCHEME IN USE	New Data Element
FIRST PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION) renamed from PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION)	Changed Name, Description, linked Attribute
FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)	New Data Element
FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)	New Data Element
FORENSIC MENTAL HEALTH CARE CLUSTER CODE (FINAL)	New Data Element
FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL)	New Data Element
GROUP SESSION IDENTIFIER	New Data Element
GROUP SESSION TYPE (MENTAL HEALTH)	New Data Element
GROUP THERAPY INDICATOR	New Data Element
INDIRECT ACTIVITY DATE	New Data Element
INDIRECT ACTIVITY TIME	New Data Element
INTENDED AGE GROUP	Changed Description
INTENDED CLINICAL CARE INTENSITY CODE (MENTAL HEALTH)	Changed Description
LANGUAGE CODE (PREFERRED)	New Data Element
LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)	New Data Element
LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)	New Data Element
LOCAL PATIENT IDENTIFIER (EXTENDED)	Changed Description
LOOKED AFTER CHILD INDICATOR	Changed Description
MAIN SPECIALTY CODE (MENTAL HEALTH)	Changed Description
MANIFEST PSYCHOSIS DATE	Changed Description, linked Attribute
MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON renamed from ABSENCE WITHOUT LEAVE END REASON	Changed Name, Description
MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY renamed from MENTAL HEALTH ABSOLUTE DISCHARGE END METHOD	Changed Name, Description
MENTAL HEALTH ACT 2007 MENTAL CATEGORY	Changed Description, linked Attribute
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON renamed from MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD END REASON	Changed Name, Description
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER	New Data Element
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON renamed from MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD START REASON	Changed Name, Description
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE	Changed Description
MENTAL HEALTH CARE CLUSTER END REASON	Changed Description
MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE	Changed Description
MENTAL HEALTH CARE CONTACT IDENTIFIER	Changed Description
MENTAL HEALTH CRISIS PLAN CREATION DATE	Changed Description, linked Attribute
MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE	Changed Description, linked Attribute
MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE	Changed Description
MENTAL HEALTH DELAYED DISCHARGE REASON	Changed Description
MENTAL HEALTH LEAVE OF ABSENCE END REASON renamed from LEAVE OF ABSENCE END REASON	Changed Name, Description
NHS SERVICE AGREEMENT LINE NUMBER	Changed Description
NUMBER OF GROUP SESSION PARTICIPANTS	New Data Element
OBSERVATION SCHEME IN USE	New Data Element
OBSERVATION VALUE	New Data Element
ONWARD REFERRAL DATE	New Data Element

ONWARD REFERRAL REASON	New Data Element
ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT)	New Data Element
OTHER PERSON IN ATTENDANCE AT CARE CONTACT	New Data Element
OTHER REASON FOR REFERRAL (MENTAL HEALTH)	New Data Element
PERSON MARITAL STATUS	Changed Description
PERSON SCORE	New Data Element
PLANNED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)	New Data Element
POSTCODE OF MAIN VISITOR	New Data Element
PREVIOUS DIAGNOSIS (CODED CLINICAL ENTRY)	New Data Element
PRIMARY DATA COLLECTION SYSTEM IN USE	New Data Element
PRIMARY DIAGNOSIS (CODED CLINICAL ENTRY)	New Data Element
PRIMARY REASON FOR REFERRAL (MENTAL HEALTH)	New Data Element
PROCEDURE SCHEME IN USE	Changed Description, linked Attribute
PRODROME PSYCHOSIS DATE	Changed Description, linked Attribute
PROFESSIONAL REGISTRATION BODY CODE	New Data Element
PROVISIONAL DIAGNOSIS (CODED CLINICAL ENTRY)	New Data Element
PSYCHOSIS FIRST TREATMENT START DATE renamed from PSYCHOSIS TREATMENT START DATE	Changed Name, Description, linked Attribute
REFERRAL CLOSURE DATE	New Data Element
REFERRAL CLOSURE REASON	New Data Element
REFERRAL REJECTION DATE	New Data Element
REFERRAL REJECTION REASON	New Data Element
REFERRING CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH AND COMMUNITY CARE) renamed from REFERRING CARE PROFESSIONAL STAFF GROUP (COMMUNITY CARE)	Changed Name, Description
REPLACEMENT APPOINTMENT BOOKED DATE	New Data Element
REPLACEMENT APPOINTMENT DATE OFFERED	New Data Element
RESTRICTIVE INTERVENTION TYPE	New Data Element
SECONDARY DIAGNOSIS (CODED CLINICAL ENTRY)	New Data Element
SERVICE DISCHARGE DATE	New Data Element
SERVICE OR TEAM TYPE REFERRED TO (MENTAL HEALTH)	New Data Element
SETTLED ACCOMMODATION INDICATOR renamed from SETTLED ACCOMMODATION INDICATOR (MENTAL HEALTH)	Changed Name, Description
SEX OF PATIENTS CODE	Changed Description
START DATE (CARE CLUSTER ASSIGNMENT PERIOD)	New Data Element
START DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)	New Data Element
START DATE (CARE PROGRAMME APPROACH CARE)	Changed Description
START DATE (COMMUNITY TREATMENT ORDER) renamed from START DATE (SUPERVISED COMMUNITY TREATMENT)	Changed Name, Description
START DATE (COMMUNITY TREATMENT ORDER RECALL) renamed from START DATE (SUPERVISED COMMUNITY TREATMENT RECALL)	Changed Name, Description
START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD) renamed from START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)	Changed Name, Description
START DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD) renamed from START DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT)	Changed Name
START DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD)	Changed Description
START DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD) renamed from START DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT)	Changed Name, Description
START TIME (CARE CLUSTER ASSIGNMENT PERIOD)	New Data Element
START TIME (COMMUNITY TREATMENT ORDER RECALL) renamed from START TIME (SUPERVISED COMMUNITY TREATMENT RECALL)	Changed Name, Description
START TIME (HOME LEAVE)	New Data Element
START TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE)	New Data Element

START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD) renamed from START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)	Changed Name, Description
START TIME (MENTAL HEALTH CARE CLUSTER)	Changed Description
START TIME (MENTAL HEALTH LEAVE OF ABSENCE)	New Data Element
TREATMENT FUNCTION CODE (MENTAL HEALTH)	Changed Description
UCUM UNIT OF MEASUREMENT	New Data Element
WAITING TIME MEASUREMENT TYPE	Changed Description
WARD SETTING TYPE (MENTAL HEALTH)	New Data Element
WARD STAY IDENTIFIER	New Data Element
WEEKLY HOURS WORKED	Changed Description
YOUNG CARER INDICATOR	Changed Description

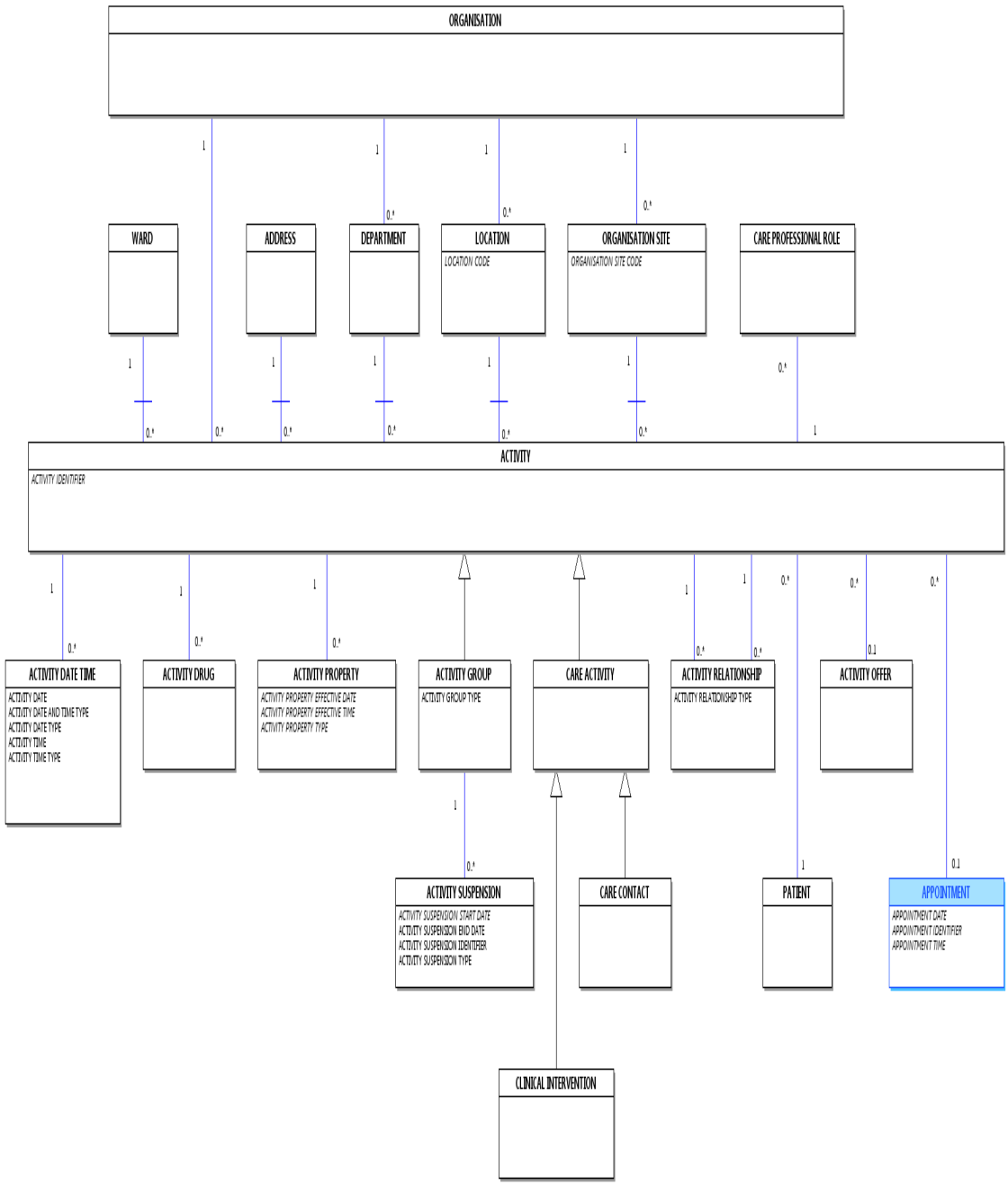
Date: 13 July 2015

Sponsor: Sarah McClinton, Director of Mental Health, Disability and Dementia, Department of Health

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

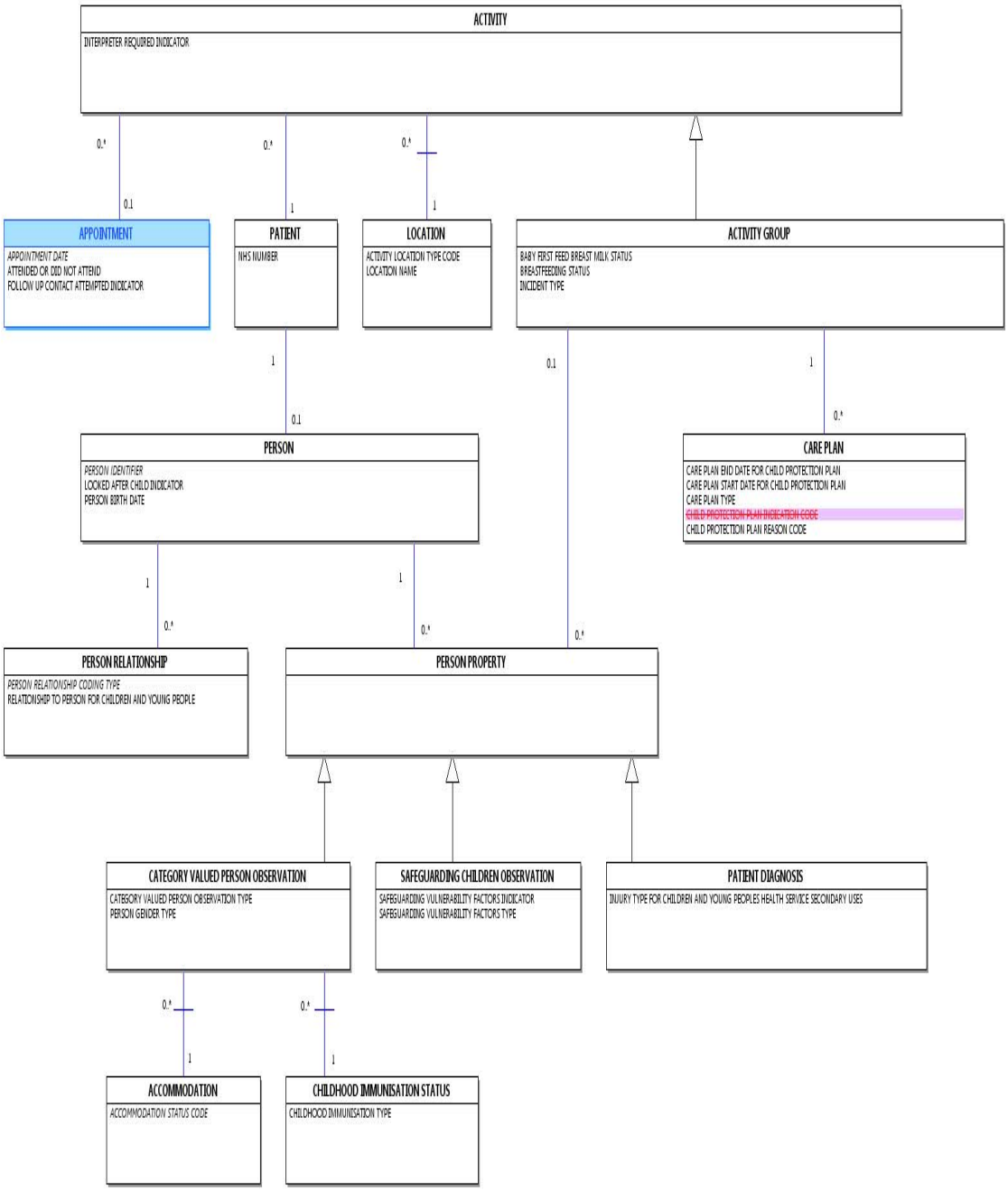
ACTIVITY DIAGRAM

Change to Diagram: Changed Diagram



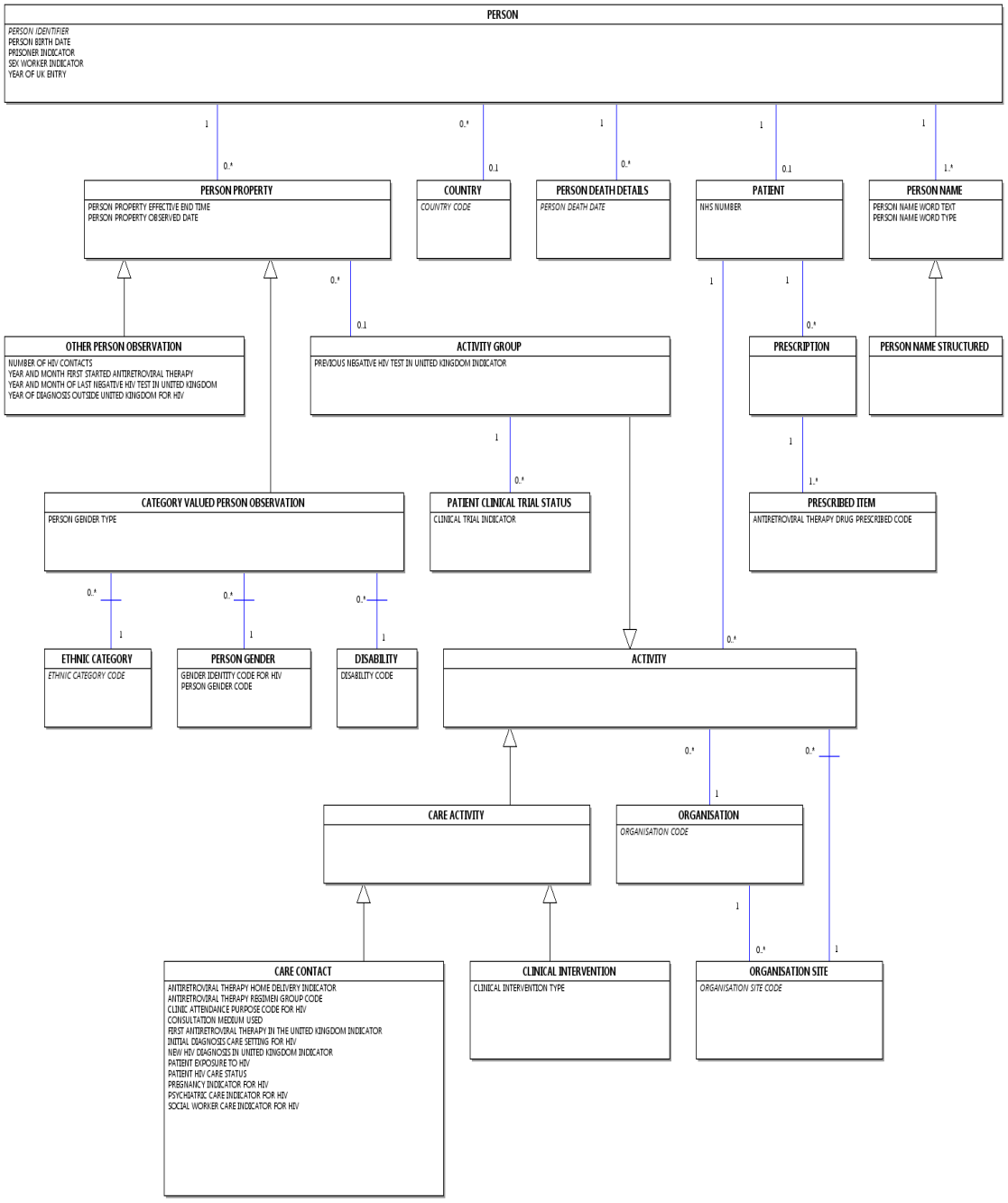
CHILDREN AND YOUNG PEOPLE'S HEALTH SERVICE SECONDARY USES DIAGRAM

Change to Diagram: Changed Diagram



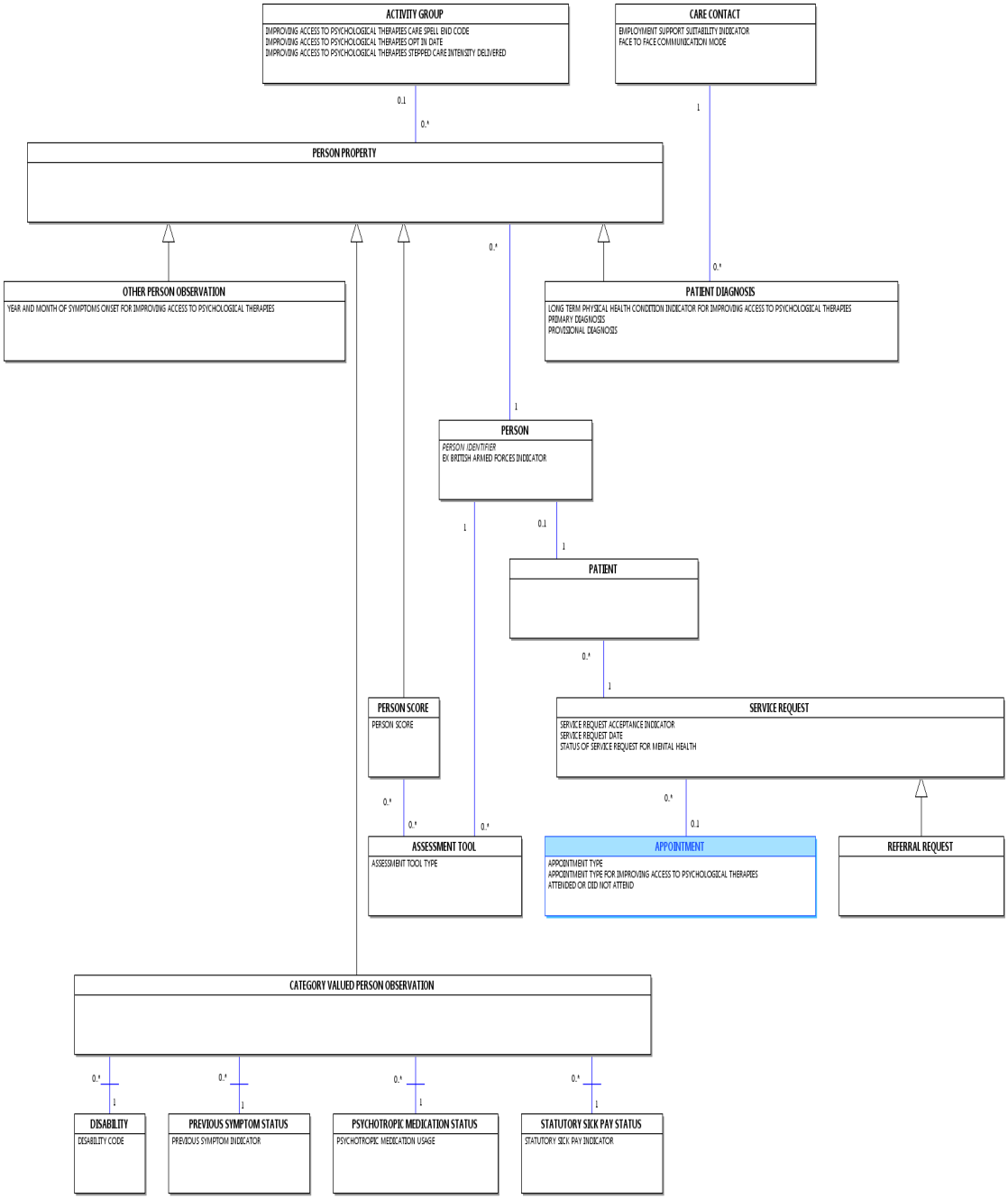
HIV AND AIDS DIAGRAM

Change to Diagram: Changed Diagram



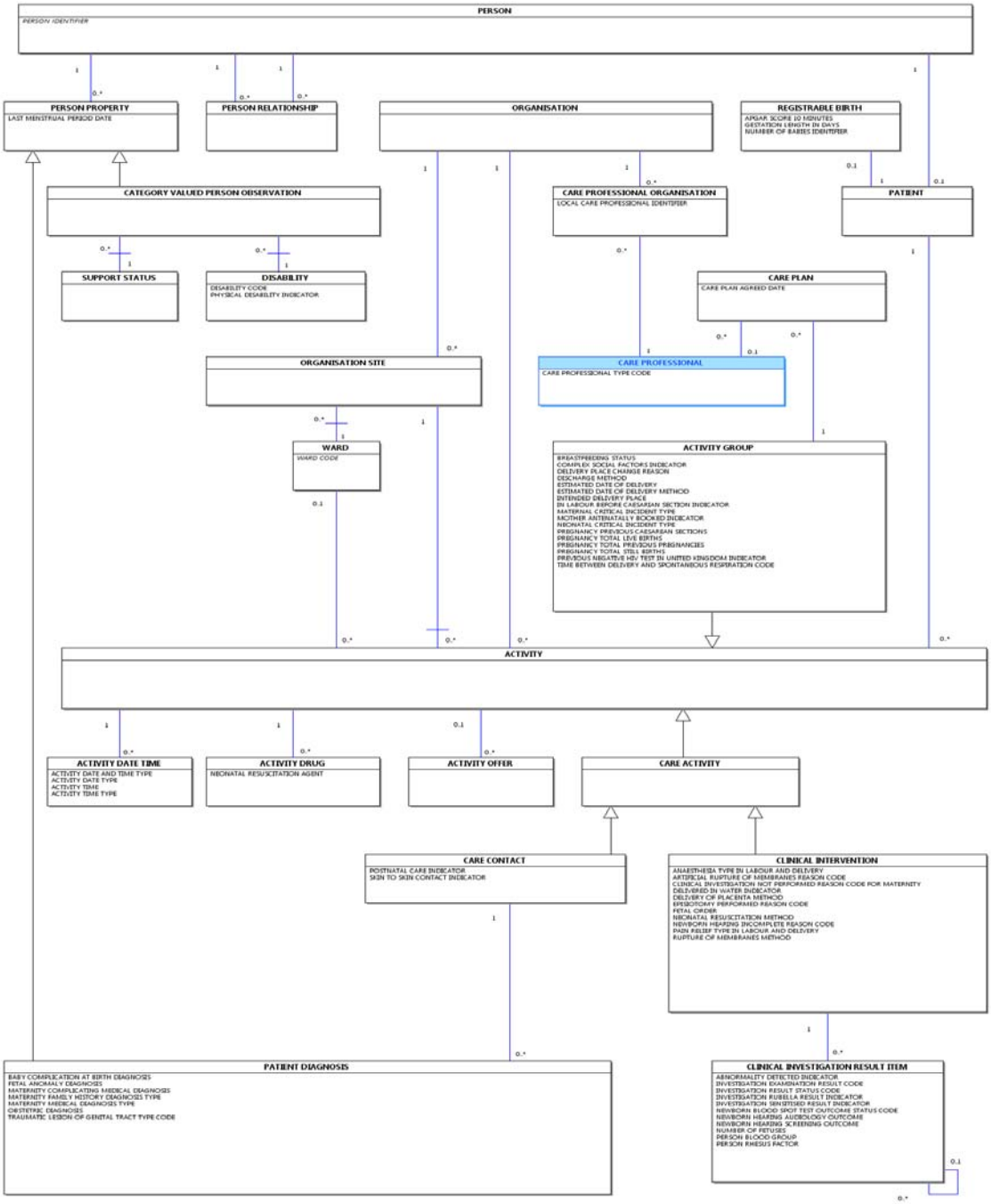
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES DIAGRAM

Change to Diagram: Changed Diagram



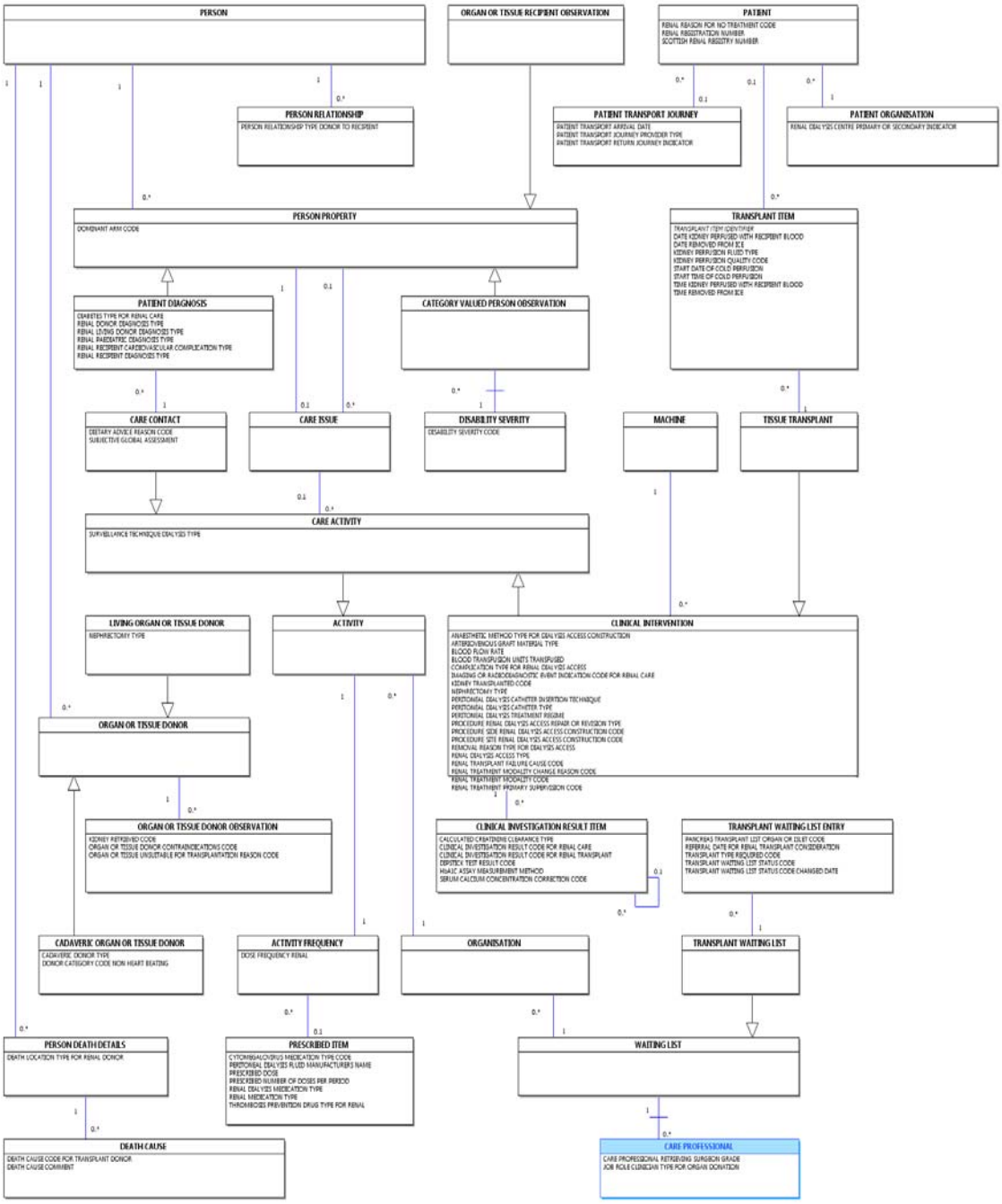
MATERNITY SERVICES DIAGRAM

Change to Diagram: Changed Diagram



NATIONAL RENAL DIAGRAM

Change to Diagram: Changed Diagram



MENTAL HEALTH SERVICES DATA SET

Change to Data Set: New Data Set

Mental Health Services Data Set Overview

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

- M = Mandatory: this data element is mandatory and the technical process (e.g. submission of the data set, production of output etc) cannot be completed without this data element being present
- R = Required: NHS business processes cannot be delivered without this data element
- P = Pilot: this data element is for piloting use only.

Note: items in the M/R/P column which are shown with notation P have **not** been approved by the Standardisation Committee for Care Information and are included to facilitate piloting and testing of future data requirements, prior to formal inclusion in later versions of the Mental Health Services Data Set. These items have been included in the data set layout in order to provide advance notice to data providers and system suppliers of the intention to require these items at a later date. Unless ORGANISATIONS are engaged in piloting activities relating to these items, they should **NOT** submit any data item marked P.

HEADER

Header:
To carry the header details for the submission.
One occurrence of this group is required.

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

PATIENT DEMOGRAPHICS

Master Patient Index:
To carry the patient details of the patient.
One occurrence of this group is required.

M/R/P	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)
R	ORGANISATION CODE (RESIDENCE RESPONSIBILITY)
R	ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT)
R	NHS NUMBER
R	NHS NUMBER STATUS INDICATOR CODE
R	PERSON BIRTH DATE
R	POSTCODE OF USUAL ADDRESS
R	POSTCODE OF MAIN VISITOR
R	PERSON STATED GENDER CODE
R	ETHNIC CATEGORY
R	RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE
R	LANGUAGE CODE (PREFERRED)
R	PERSON DEATH DATE

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

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

Accommodation Status:
To carry the accommodation details of the patient.
Multiple occurrences of this group are permitted.

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

Employment Status:
To carry details of the employment status of the patient.
Multiple occurrences of this group are permitted.

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

Patient Indicators:
To carry the details of specific indicators relating to a patient.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
R	CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR
R	YOUNG CARER INDICATOR
R	LOOKED AFTER CHILD INDICATOR
R	CHILD PROTECTION PLAN INDICATION CODE
R	PRODROME PSYCHOSIS DATE
R	EMERGENT PSYCHOSIS DATE
R	MANIFEST PSYCHOSIS DATE
R	FIRST PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION)
R	PSYCHOSIS FIRST TREATMENT START DATE

Mental Health Care Coordinator:
To carry details of the Mental Health Care Coordinator assigned to a patient.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	START DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD)
R	CARE PROFESSIONAL LOCAL IDENTIFIER
R	END DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD)
R	CARE PROFESSIONAL SERVICE OR TEAM TYPE ASSOCIATION (MENTAL HEALTH)

Disability Type:
To carry the details of the type of disability affecting a patient, based on their perception or the perception of a patient proxy.
Multiple occurrences of this group are permitted.

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

Mental Health Crisis Plan:
To carry details of a Mental Health Crisis Plan created for the patient.
One occurrence of this Group is permitted.

M/R/P	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	MENTAL HEALTH CRISIS PLAN CREATION DATE
R	MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE

REFERRALS

Service or Team Referral:
To carry details of the Service or Team referral that the patient is subject to.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	SERVICE REQUEST IDENTIFIER
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	ORGANISATION CODE (CODE OF COMMISSIONER)
M	REFERRAL REQUEST RECEIVED DATE
R	REFERRAL REQUEST RECEIVED TIME
R	NHS SERVICE AGREEMENT LINE NUMBER
R	SOURCE OF REFERRAL FOR MENTAL HEALTH
R	REFERRING ORGANISATION CODE
R	REFERRING CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH AND COMMUNITY CARE)
R	CLINICAL RESPONSE PRIORITY TYPE
R	PRIMARY REASON FOR REFERRAL (MENTAL HEALTH)
R	SERVICE DISCHARGE DATE
R	DISCHARGE LETTER ISSUED DATE (MENTAL HEALTH AND COMMUNITY CARE)

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

M/R/P	Data Set Data Elements
R	CARE PROFESSIONAL TEAM LOCAL IDENTIFIER
M	SERVICE REQUEST IDENTIFIER
M	SERVICE OR TEAM TYPE REFERRED TO (MENTAL HEALTH)
R	CHILD AND ADOLESCENT MENTAL HEALTH TIER OF SERVICE
R	REFERRAL CLOSURE DATE
R	REFERRAL REJECTION DATE
R	REFERRAL CLOSURE REASON
R	REFERRAL REJECTION REASON

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

M/R/P	Data Set Data Elements
M	SERVICE REQUEST IDENTIFIER
M	OTHER REASON FOR REFERRAL (MENTAL HEALTH)

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

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

Onward Referral:
To carry details of any onward referral of the patient which has taken place.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	SERVICE REQUEST IDENTIFIER
M	ONWARD REFERRAL DATE
R	ONWARD REFERRAL REASON
R	ORGANISATION CODE (RECEIVING)

CARE CONTACT, CARE ACTIVITIES AND INDIRECT ACTIVITIES

Care Contact:
To carry details of any contacts with a patient which have taken place as part of a referral.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	CARE CONTACT IDENTIFIER
M	SERVICE REQUEST IDENTIFIER
R	CARE PROFESSIONAL TEAM LOCAL IDENTIFIER
M	CARE CONTACT DATE
R	CARE CONTACT TIME
R	ORGANISATION CODE (CODE OF COMMISSIONER)
R	ADMINISTRATIVE CATEGORY CODE
R	CLINICAL CONTACT DURATION OF CARE CONTACT
R	CONSULTATION TYPE
R	CARE CONTACT SUBJECT
R	CONSULTATION MEDIUM USED
R	ACTIVITY LOCATION TYPE CODE
R	SITE CODE (OF TREATMENT)
R	GROUP THERAPY INDICATOR
R	ATTENDED OR DID NOT ATTEND CODE
R	EARLIEST REASONABLE OFFER DATE
R	EARLIEST CLINICALLY APPROPRIATE DATE
R	CARE CONTACT CANCELLATION DATE
R	CARE CONTACT CANCELLATION REASON
R	REPLACEMENT APPOINTMENT DATE OFFERED
R	REPLACEMENT APPOINTMENT BOOKED DATE

Care Activity:
To carry details of any activities which have taken place as part of a contact.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements

M	CARE ACTIVITY IDENTIFIER
M	CARE CONTACT IDENTIFIER
R	CARE PROFESSIONAL LOCAL IDENTIFIER
R	CLINICAL CONTACT DURATION OF CARE ACTIVITY
R	PROCEDURE SCHEME IN USE
R	CODED PROCEDURE (CLINICAL TERMINOLOGY)
R	FINDING SCHEME IN USE
R	CODED FINDING (CODED CLINICAL ENTRY)
R	OBSERVATION SCHEME IN USE
R	CODED OBSERVATION (CLINICAL TERMINOLOGY)
R	OBSERVATION VALUE
R	UCUM UNIT OF MEASUREMENT

Other in Attendance:
To carry details of any other people in attendance during the care contact.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	CARE CONTACT IDENTIFIER
M	OTHER PERSON IN ATTENDANCE AT CARE CONTACT

Indirect Activity:
To carry details of indirect activity which takes place.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	SERVICE REQUEST IDENTIFIER
R	CARE PROFESSIONAL TEAM LOCAL IDENTIFIER
M	INDIRECT ACTIVITY DATE
R	INDIRECT ACTIVITY TIME
R	DURATION OF INDIRECT ACTIVITY
R	ORGANISATION CODE (CODE OF COMMISSIONER)
R	CARE PROFESSIONAL LOCAL IDENTIFIER
R	PROCEDURE SCHEME IN USE
R	CODED PROCEDURE (CLINICAL TERMINOLOGY)

GROUP SESSIONS

Group Session:
To carry details of any group sessions which have been provided.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	GROUP SESSION IDENTIFIER
M	GROUP SESSION DATE
M	ORGANISATION CODE (CODE OF COMMISSIONER)
R	CLINICAL CONTACT DURATION OF GROUP SESSION
R	GROUP SESSION TYPE (MENTAL HEALTH)
R	NUMBER OF GROUP SESSION PARTICIPANTS
R	ACTIVITY LOCATION TYPE CODE
R	SITE CODE (OF TREATMENT)
R	CARE PROFESSIONAL LOCAL IDENTIFIER
R	SERVICE OR TEAM TYPE REFERRED TO (MENTAL HEALTH)
R	NHS SERVICE AGREEMENT LINE NUMBER

MENTAL HEALTH ACT (MHA) EPISODES

Mental Health Act Legal Status Classification Period:
To carry details of Mental Health Act Legal Status Classification Period for patients formally detailed under the Mental Health Act 1983 or other Acts.
Multiple occurrences of this group are permitted, one for each separate section of the Mental Health Act that the patient is detained under.

M/R/P	Data Set Data Elements
M	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)
M	START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)
R	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON
R	EXPIRY DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)
R	EXPIRY TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)
R	END DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)
R	END TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)
R	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON
R	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE
R	MENTAL HEALTH ACT 2007 MENTAL CATEGORY

Mental Health Responsible Clinician Assignment:
To carry details of the assignment of a Mental Health Responsible Clinician to the patient.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER
M	START DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD)
M	CARE PROFESSIONAL LOCAL IDENTIFIER
R	END DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD)

Conditional Discharge:
To carry details of each separate period of conditional discharge for the patient.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER
M	START DATE (MENTAL HEALTH CONDITIONAL DISCHARGE)
R	END DATE (MENTAL HEALTH CONDITIONAL DISCHARGE)
R	MENTAL HEALTH CONDITIONAL DISCHARGE END REASON
R	MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY

Community Treatment Order:
To carry details of each separate period of a Community Treatment Order under section 17a of the Mental Health Act 1983 for the patient.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER
M	START DATE (COMMUNITY TREATMENT ORDER)
R	EXPIRY DATE (COMMUNITY TREATMENT ORDER)
R	END DATE (COMMUNITY TREATMENT ORDER)
R	COMMUNITY TREATMENT ORDER END REASON

Community Treatment Order Recall:
To carry details of each separate period of recall into hospital for a patient on a Community Treatment Order under section 17a of the Mental Health Act 1983.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER
M	START DATE (COMMUNITY TREATMENT ORDER RECALL)
M	START TIME (COMMUNITY TREATMENT ORDER RECALL)
R	END DATE (COMMUNITY TREATMENT ORDER RECALL)
R	END TIME (COMMUNITY TREATMENT ORDER RECALL)

HOSPITAL PROVIDER SPELLS

Hospital Provider Spell:
To carry details of each Hospital Provider Spell for a patient.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	HOSPITAL PROVIDER SPELL NUMBER
M	SERVICE REQUEST IDENTIFIER
M	START DATE (HOSPITAL PROVIDER SPELL)
R	START TIME (HOSPITAL PROVIDER SPELL)
R	SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL)
R	ADMISSION METHOD CODE (HOSPITAL PROVIDER SPELL)
R	PLANNED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)
R	DISCHARGE DATE (HOSPITAL PROVIDER SPELL)
R	DISCHARGE TIME (HOSPITAL PROVIDER SPELL)
R	DISCHARGE METHOD CODE (HOSPITAL PROVIDER SPELL)
R	DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL)

Ward Stay:
To carry details of Ward Stays which occurred during a Hospital Provider Spell for the patient.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	WARD STAY IDENTIFIER
M	HOSPITAL PROVIDER SPELL NUMBER
M	START DATE (WARD STAY)
R	START TIME (WARD STAY)
R	END DATE (WARD STAY)
R	END TIME (WARD STAY)
R	SITE CODE (OF TREATMENT)
R	WARD SETTING TYPE (MENTAL HEALTH)
R	SEX OF PATIENTS CODE
R	INTENDED CLINICAL CARE INTENSITY CODE (MENTAL HEALTH)
R	WARD SECURITY LEVEL

Assigned Care Professional:
To carry details of the Care Professional Admitted Care Episodes during a Hospital Provider Spell.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	HOSPITAL PROVIDER SPELL NUMBER
M	CARE PROFESSIONAL LOCAL IDENTIFIER
M	START DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)

R	END DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)
R	TREATMENT FUNCTION CODE (MENTAL HEALTH)

Mental Health Delayed Discharge:
To carry details of Mental Health Delayed Discharge Periods which occurred during a Hospital Provider Spell.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	HOSPITAL PROVIDER SPELL NUMBER
M	START DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD)
R	END DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD)
R	MENTAL HEALTH DELAYED DISCHARGE REASON
R	MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE

Restrictive Intervention:
To carry details of Restrictive Interventions during a Hospital Provider Spell.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	WARD STAY IDENTIFIER
M	DATE OF RESTRICTIVE INTERVENTION
R	RESTRICTIVE INTERVENTION TYPE
R	DURATION OF RESTRICTIVE INTERVENTION

Assault:
To carry details of Assaults on a patient during a Hospital Provider Spell.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	WARD STAY IDENTIFIER
M	DATE OF ASSAULT ON PATIENT

Self Harm:
To carry details of self harm by the patient during a Hospital Provider Spell.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	WARD STAY IDENTIFIER
M	DATE OF SELF-HARM

Home Leave:
To carry details of each separate period of Home Leave from a Hospital Provider Spell for a patient who is NOT liable for detention under the Mental Health Act 1983 and who is NOT on a Community Treatment Order.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	WARD STAY IDENTIFIER
M	START DATE (HOME LEAVE)
R	START TIME (HOME LEAVE)
R	END DATE (HOME LEAVE)
R	END TIME (HOME LEAVE)

Mental Health Leave of Absence:
To carry details of each separate period of Mental Health Leave of Absence under section 17 of the Mental Health Act 1983 involving an overnight stay for the patient.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements

M	WARD STAY IDENTIFIER
M	START DATE (MENTAL HEALTH LEAVE OF ABSENCE)
R	START TIME (MENTAL HEALTH LEAVE OF ABSENCE)
R	END DATE (MENTAL HEALTH LEAVE OF ABSENCE)
R	END TIME (MENTAL HEALTH LEAVE OF ABSENCE)
R	MENTAL HEALTH LEAVE OF ABSENCE END REASON

Mental Health Absence Without Leave:
To carry details of each separate period of Mental Health Absence Without Leave for the patient.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	WARD STAY IDENTIFIER
M	START DATE (MENTAL HEALTH ABSENCE WITHOUT LEAVE)
R	START TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE)
R	END DATE (MENTAL HEALTH ABSENCE WITHOUT LEAVE)
R	END TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE)
R	MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON

Hospital Provider Spell Commissioner:
To carry details of each Commissioner Assignment Period during a Hospital Provider Spell.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	HOSPITAL PROVIDER SPELL NUMBER
M	ORGANISATION CODE (CODE OF COMMISSIONER)
M	START DATE (COMMISSIONER ASSIGNMENT PERIOD)
R	END DATE (COMMISSIONER ASSIGNMENT PERIOD)

CLINICALLY CODED TERMINOLOGY

Medical History (Previous Diagnosis):
To carry the details of any previous diagnoses for a patient.
Multiple occurrences of this group are permitted.

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

Provisional Diagnosis:
To carry the details of a provisional diagnosis made.
Multiple occurrences of this group are permitted.

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

Primary Diagnosis:
To carry the details of the primary diagnosis made.
One occurrence of this Group is permitted.

M/R/P	Data Set Data Elements
M	SERVICE REQUEST IDENTIFIER

M	DIAGNOSIS SCHEME IN USE
M	PRIMARY DIAGNOSIS (CODED CLINICAL ENTRY)
R	DIAGNOSIS DATE

Secondary Diagnosis:
To carry the details of a secondary diagnosis made.
Multiple occurrences of this group are permitted.

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

Coded Scored Assessment (Referral):
To carry details of scored assessments that are issued and completed as part of a referral to a Mental Health Service, but do not take place at a specific contact.
Multiple occurrences of this group are permitted.

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

Coded Scored Assessment (Contact):
To carry details of scored assessments that are issued and completed as part of a specific care activity.
Multiple occurrences of this group are permitted.

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

ANONYMOUS SELF-ASSESSMENT

Anonymous Self-Assessment:
To carry details of anonymous self-assessments.
Multiple occurrences of this group are permitted.

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

CARE PROGRAMME APPROACH (CPA) CARE EPISODES

Care Programme Approach (CPA) Care Episode:
To carry details of the periods of time the patient spent on Care Programme Approach.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	CARE PROGRAMME APPROACH CARE EPISODE IDENTIFIER
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	START DATE (CARE PROGRAMME APPROACH CARE)

R	END DATE (CARE PROGRAMME APPROACH CARE)

Care Programme Approach (CPA) Review:
To carry details of Care Programme Approach reviews undertaken for the patient.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	CARE PROGRAMME APPROACH CARE EPISODE IDENTIFIER
M	CARE PROGRAMME APPROACH REVIEW DATE
R	CARE PROGRAMME APPROACH REVIEW ABUSE QUESTION ASKED INDICATOR
R	CARE PROFESSIONAL LOCAL IDENTIFIER

CARE CLUSTERS

Clustering Tool Assessment:
To carry details of clustering tool assessments.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	CLUSTERING TOOL ASSESSMENT IDENTIFIER
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	CLUSTERING TOOL ASSESSMENT CATEGORY
M	ASSESSMENT TOOL COMPLETION DATE
R	ASSESSMENT TOOL COMPLETION TIME
R	CLUSTERING TOOL ASSESSMENT REASON
R	MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE
R	ADULT MENTAL HEALTH CARE CLUSTER CODE (INITIAL)
P	CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL)
P	LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)
P	FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL)
P	FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)

Clustering Tool Assessment SNOMED CT:
To carry details of the SNOMED CT clustering tool assessment.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	CLUSTERING TOOL ASSESSMENT IDENTIFIER
M	CODED ASSESSMENT TOOL TYPE (SNOMED CT)
M	PERSON SCORE

Care Cluster:
To carry details of the Care Cluster resulting from a clustering tool assessment.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	CLUSTERING TOOL ASSESSMENT IDENTIFIER
R	ADULT MENTAL HEALTH CARE CLUSTER CODE (FINAL)
P	CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL)
P	LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)
P	FORENSIC MENTAL HEALTH CARE CLUSTER CODE (FINAL)
P	FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)
M	START DATE (CARE CLUSTER ASSIGNMENT PERIOD)
R	START TIME (CARE CLUSTER ASSIGNMENT PERIOD)
R	END DATE (CARE CLUSTER ASSIGNMENT PERIOD)

R	END TIME (CARE CLUSTER ASSIGNMENT PERIOD)

CARE PROFESSIONALS

Care Professionals: **To carry details of the Care Professionals involved in providing the patient's care.** **Multiple occurrences of this group are permitted.**	
M/R/P	**Data Set Data Elements**
M	CARE PROFESSIONAL LOCAL IDENTIFIER
R	PROFESSIONAL REGISTRATION BODY CODE
R	PROFESSIONAL REGISTRATION ENTRY IDENTIFIER
R	CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH)
R	MAIN SPECIALTY CODE (MENTAL HEALTH)
R	OCCUPATION CODE
R	CARE PROFESSIONAL (JOB ROLE CODE)

ADULT MENTAL HEALTH CARE CLUSTER renamed from MENTAL HEALTH CARE CLUSTER

Change to Supporting Information: Changed Name, Description

~~A Mental Health Care Cluster is a MENTAL HEALTH CARE CLUSTER which is a type of CATEGORY VALUED PERSON OBSERVATION.~~An Adult Mental Health Care Cluster is a type of CARE CLUSTER for adult PATIENTS.

~~A Mental Health Care Cluster is part of a currency developed to support the National Tariff Payment System for Mental Health Services. Mental Health Care Clusters are 21 groupings of Mental Health PATIENTS based on their characteristics, and are a way of classifying individuals utilising Mental Health Services that forms the basis for payment.~~An Adult Mental Health Care Cluster is part of a currency developed to support the National Tariff Payment System for Mental Health Services.

~~A Mental Health Care Cluster is assigned using a decision tree or algorithm based on the PERSON SCORE from the Mental Health Clustering Tool undertaken by a CARE PROFESSIONAL for the PATIENT.~~Adult Mental Health Care Clusters are 21 groupings of Mental Health PATIENTS based on their characteristics, and are a way of classifying individuals utilising Mental Health Services that forms the basis for payment.

~~This is done by first assigning the PATIENT to one of three Mental Health Care Cluster Super Classes, to narrow down the number of possible Mental Health Care Clusters which are applicable to the PATIENTS condition. The PATIENT is then assigned to the most appropriate of this sub-set of Mental Health Care Clusters.~~An Adult Mental Health Care Cluster is assigned using a decision tree or algorithm based on the PERSON SCORE from the Adult Mental Health Clustering Tool undertaken by a CARE PROFESSIONAL for the PATIENT.

~~The Mental Health Care Clusters into which the presenting needs of the PATIENT may fall are:~~This is done by first assigning the PATIENT to one of three Mental Health Care Cluster Super Classes, to narrow down the number of possible Adult Mental Health Care Clusters which are applicable to the PATIENTS condition. The PATIENT is then assigned to the most appropriate of this sub-set of Adult Mental Health Care Clusters.

~~**Care Cluster 0: Variance** – Despite careful consideration of all the other Mental Health Care Clusters, this group of PATIENTS are not adequately described by any of their descriptions. PATIENTS who cannot be initially assigned to a Mental Health Care Cluster Super Class during the clustering process will be automatically assigned to this Mental Health Care Cluster.~~

~~**Care Cluster 1: Common Mental Health Problems (Low Severity)** – This group of PATIENTS has definite but minor problems of depressed mood, anxiety or other disorder, but they do not present with any psychotic symptoms~~

Care Cluster 2: Common Mental Health Problems (Low Severity with Greater Need) – This group of PATIENTS has definite but minor problems of depressed mood, anxiety or other disorder, but not with any psychotic symptoms. They may have already received care associated with Care Cluster 1 and require more specific intervention, or previously been successfully treated at a higher level but are re-presenting with low level symptoms

Care Cluster 3: Non-Psychotic (Moderate Severity) – This group of PATIENTS have moderate problems involving depressed mood, anxiety or other disorder (not including psychosis)

Care Cluster 4: Non-Psychotic (Severe) – This group of PATIENTS is characterised by severe depression and/or anxiety and/or other disorders, and increasing complexity of needs. They may experience disruption to function in everyday life and there is an increasing likelihood of significant risks.

Care Cluster 5: Non-Psychotic Disorders (Very Severe) – This group of PATIENTS will be severely depressed and/or anxious and/or other. They will not present with hallucinations or delusions but may have some unreasonable beliefs. They may often be at high risk for suicide and they may present safeguarding issues and have severe disruption to everyday living.

Care Cluster 6: Non-Psychotic Disorder of Over-Valued Ideas – This group of PATIENTS suffer from moderate to very severe disorders that are difficult to treat. This may include treatment resistant eating disorders, Obsessive Compulsive Disorder etc, where extreme beliefs are strongly held, some personality disorders, and enduring depression.

Care Cluster 7: Enduring Non-Psychotic Disorders (High Disability) – This group of PATIENTS suffer from moderate to severe disorders that are very disabling. They will have received treatment for a number of years and although they may have an improvement in positive symptoms, considerable disability remains that is likely to affect role functioning in many ways.

Care Cluster 8: Non-Psychotic Chaotic and Challenging Disorders – This group of PATIENTS will have a wide range of symptoms and chaotic and challenging lifestyles. They are characterised by moderate to very severe repeat deliberate self-harm and/or other impulsive behaviour and chaotic, over-dependant engagement, and are often hostile with services.

Care Cluster 9: Cluster Under Review – Note: This Mental Health Care Cluster is under review and should not be used.

Care Cluster 10: First Episode Psychosis – This group of PATIENTS will be presenting to the Mental Health service for the first time with mild to severe psychotic phenomena. They may also have depressed mood and/or anxiety and/or other behaviours. Drinking or drug taking may be present but *will not* be the only problem.

Care Cluster 11: Ongoing Recurrent Psychosis (Low Symptoms) – This group of PATIENTS have a history of psychotic symptoms that are currently controlled and causing minor problems if any at all. They are currently experiencing a period of recovery where they are capable of full or near functioning. However, there may be impairment in self-esteem and efficacy and vulnerability to life.

Care Cluster 12: Ongoing or Recurrent Psychosis (High Disability) – This group of PATIENTS have a history of psychotic symptoms with a significant disability with major impact on role functioning. They are likely to be vulnerable to abuse or exploitation.

Care Cluster 13: Ongoing or Recurrent Psychosis (High Symptoms and Disability) – This group of PATIENTS will have a history of psychotic symptoms which are not controlled. They will present with moderate to severe psychotic symptoms and some anxiety or depression. They have a significant disability with major impact on role functioning.

Care Cluster 14: Psychotic Crisis – This group of PATIENTS will be experiencing an acute psychotic episode with severe symptoms that cause severe disruption to role functioning. They may present as vulnerable and a risk to others or themselves.

~~**Care Cluster 15: Severe Psychotic Depression** – This group of PATIENTS will be suffering from an acute episode of moderate to severe depressive symptoms. Hallucinations and delusions will be present. It is likely that this group will present a risk of suicide and have disruption in many areas of their lives.~~

~~**Care Cluster 16: Dual Diagnosis** – This group of PATIENTS have enduring, moderate to severe psychotic of affective symptoms with unstable, chaotic lifestyles and *co existing* substance misuse. They may present a risk to self and others and engage poorly with services. Role functioning is often globally impaired.~~

~~**Care Cluster 17: Psychosis and Affective Disorder (Difficult to Engage)** – This group of PATIENTS have moderate to severe psychotic symptoms with unstable, chaotic lifestyles. There may be some problems with drugs or alcohol not severe enough to warrant dual diagnosis care. This group have a history of non concordance, are vulnerable, and engage poorly with services.~~

~~**Care Cluster 18: Cognitive Impairment (Low Need)** – People who may be in the early stages of dementia (or who may have an organic brain disorder affecting their cognitive function) who have some memory problems, or other low level cognitive impairment, but who are still managing to cope reasonably well. Underlying reversible physical causes have been ruled out.~~

~~**Care Cluster 19: Cognitive Impairment or Dementia Complicated (Moderate Need)** – People who have problems with their memory, and/or other aspects of cognitive functioning resulting in moderate problems looking after themselves and maintaining social relationships. Probable risk of self neglect or harm to others and may be experiencing some anxiety or depression.~~

~~**Care Cluster 20: Cognitive Impairment or Dementia (High Need)** – People with dementia who are having significant problems in looking after themselves and whose behaviour may challenge their carers or services. They may have high levels of anxiety or depression, psychotic symptoms, or significant problems such as aggression or agitation. They may not be aware of their problems. They are likely to be at high risk of self neglect or harm to others, and there may be a significant risk of their care arrangements breaking down.~~

~~**Care Cluster 21: Cognitive Impairment or Dementia (High Physical or Engagement)** – People with cognitive impairment or dementia who are having significant problems in looking after themselves, and whose physical condition is becoming increasingly frail. They may not be aware of their problems and there may be a significant risk of their care arrangements breaking down.~~

~~Further information relating to the Mental Health Clustering Tool and Mental Health Care Clusters is available from the Monitor part of the gov.~~Further information relating to the Adult Mental Health Clustering Tool and Adult Mental Health Care Clusters is available from the Monitor part of the gov.uk website at: Guidance on mental health currencies and payment.

ADULT MENTAL HEALTH CARE CLUSTER renamed from MENTAL HEALTH CARE CLUSTER

Change to Supporting Information: Changed Name, Description

- Changed Name from Data_Dictionary.NHS_Business_Definitions.M.Mental_Health_Care_Cluster to Data_Dictionary.NHS_Business_Definitions.A.Adult_Mental_Health_Care_Cluster
- Changed Description

ADULT MENTAL HEALTH CLUSTERING TOOL renamed from MENTAL HEALTH CLUSTERING TOOL

Change to Supporting Information: Changed Name, Description

~~The Mental Health Clustering Tool is a type of ASSESSMENT TOOL.~~The Adult Mental Health Clustering Tool is a type of Clustering Tool for adult PATIENTS receiving Mental Health care.

~~The Mental Health Clustering Tool is a needs assessment tool designed to rate the care needs of a PATIENT, based upon a series of 18 rating scales.~~The Adult Mental Health Clustering Tool is a needs assessment tool designed to rate the care needs of a PATIENT, based upon a series of 18 rating scales.

The first 12 of these rating scales are the same as the Health of the Nation Outcome Scale (Working Age Adults) rating scales, originally developed by the Royal College of Psychiatrists. ~~These 12 rating scales are numbered 1 – 12 under 'Current Ratings' in the Mental Health Clustering Tool.~~ These 12 rating scales are numbered 1 - 12 under 'Current Ratings' in the Adult Mental Health Clustering Tool.

~~One additional 'current' rating and a new section relating to historical ratings have also been added, to form the Mental Health Clustering Tool.~~One additional 'current' rating and a new section relating to historical ratings have also been added, to form the Adult Mental Health Clustering Tool. These items are referred to as the Summary Assessment of Characteristics (SAC) items.

Part 1: Current Ratings

~~These ratings relate to the most severe occurrence in the two weeks prior to the Mental Health Clustering Tool ASSESSMENT TOOL COMPLETION DATE.~~These ratings relate to the most severe occurrence in the two weeks prior to the Adult Mental Health Clustering Tool ASSESSMENT TOOL COMPLETION DATE.

1. Overactive, aggressive, disruptive or agitated behaviour (current)
2. Non-accidental self injury (current)
3. Problem drinking or drug taking (current)
4. Cognitive problems (current)
5. Physical illness or disability problems (current)
6. Problems associated with hallucinations and delusions (current)
7. Problems with depressed mood (current)
8. Other mental and behavioural problems (current), qualified by specific disorders: and the alphabetical list of headings from the glossary:

    A Phobic
    B Anxiety
    C Obsessive-compulsive
    D Stress
    E Dissociative
    F Somatoform
    G Eating
    H Sleep
    I Sexual
    J Other

9. Problems with relationships (current)
10. Problems with activities of daily living (current)
11. Problems with living conditions (current)
12. Problems with occupation and activities (current)
13. Strong unreasonable beliefs occurring in non-psychotic disorders only (current)

Part 2: Historical Ratings

These ratings relate to problems that occur in an episodic or unpredictable way, from a more 'historical' perspective. ~~Whilst there may not be any direct observation or report of a manifestation during the two weeks prior to the Mental Health Clustering Tool ASSESSMENT TOOL COMPLETION DATE, the evidence and clinical judgement would suggest that there is still a cause for concern that cannot be disregarded.~~ Whilst there may not be any direct observation or report of a manifestation during the two weeks prior to the Adult Mental Health Clustering Tool ASSESSMENT TOOL COMPLETION DATE, the evidence and clinical judgement would suggest that there is still a cause for concern that cannot be disregarded. In these circumstances, any event that remains relevant to the current CARE PLAN should be included.

A. Agitated behaviour / expansive mood (historical)
B. Repeat self-harm (historical)
C. Safeguarding children and vulnerable dependant adults (historical)
D. Engagement (historical)
E. Vulnerability (historical)

~~The allowed responses to each of the 18 items in the Mental Health Clustering Tool are:~~The allowed responses to each of the 18 items in the Adult Mental Health Clustering Tool are:

- 0 - No problem
- 1 - Minor problem requiring no action
- 2 - Mild problem but definitely present
- 3 - Moderately severe problem
- 4 - Severe to very severe problem
- 9 - Not known

~~The PERSON SCORE from the Mental Health Clustering Tool is used to allocate the PATIENT to the most appropriate Mental Health Care Cluster.~~The PERSON SCORE from the Adult Mental Health Clustering Tool is used to allocate the PATIENT to the most appropriate Adult Mental Health Care Cluster.

~~Further information relating to the Mental Health Clustering Tool and Mental Health Care Clusters is available from the Monitor part of the gov.~~Further information relating to the Adult Mental Health Clustering Tool and Adult Mental Health Care Clusters is available from the Monitor part of the gov.uk website at: Guidance on mental health currencies and payment.

ADULT MENTAL HEALTH CLUSTERING TOOL renamed from MENTAL HEALTH CLUSTERING TOOL

Change to Supporting Information: Changed Name, Description

- Changed Name from Data_Dictionary.NHS_Business_Definitions.M.Mental_Health_Clustering_Tool to Data_Dictionary.NHS_Business_Definitions.A.Adult_Mental_Health_Clustering_Tool
- Changed Description

AUTISTIC SPECTRUM DISORDER

Change to Supporting Information: Changed Description

Autistic Spectrum Disorder is a DISABILITY.

Autistic Spectrum Disorder is defined as a lifelong condition that affects how a PERSON communicates with, and relates to, other people. Autistic Spectrum Disorder also affects how a PERSON makes sense of the world around them.

The three main areas of difficulty, which all people with Autism share, are known as the 'triad of impairments'. They are

- difficulty with social communication (e.g. problems using and understanding verbal and non-verbal language, such as gestures, facial expressions and tone of voice)
- difficulty with social interaction (e.g. problems in recognising and understanding other people's feelings and managing their own feelings)
- difficulty with social imagination (e.g. problems in understanding and predicting other people's intentions and behaviour and imagining situations outside their own routine)

~~For further information on Autistic Spectrum Disorder, see:~~For further information on Autistic Spectrum Disorder, see the:

- ~~the National Autistic Society website~~

- ~~the NHS Choices website~~
- National Autistic Society website
- NHS Choices website

CARE CLUSTER ASSIGNMENT PERIOD

Change to Supporting Information: New Supporting Information

A Care Cluster Assignment Period is a PERSON PROPERTY ASSIGNMENT PERIOD.

A Care Cluster Assignment Period is the period of time that a PATIENT is assigned to a CARE CLUSTER.

This supporting information is also known by these names:

Context	Alias
plural	Care Cluster Assignment Periods

CARE CONTACT CANCELLATION DATE renamed from CARE CONTACT CANCELLATION DATE

Change to Supporting Information: Changed Name, Description

~~The date on which a CARE CONTACT was cancelled.~~ A Care Contact Cancellation Date is an ACTIVITY DATE TIME.

A Care Contact Cancellation Date is the DATE on which a CARE CONTACT was cancelled.

CARE CONTACT CANCELLATION DATE renamed from CARE CONTACT CANCELLATION DATE

Change to Supporting Information: Changed Name, Description

- Changed Name from Data_Dictionary.Attributes.C.Card.CARE_CONTACT_CANCELLATION_DATE to Data_Dictionary.NHS_Business_Definitions.C.Care_Contact_Cancellation_Date
- Changed Description

CARE CONTACT DATE renamed from CARE CONTACT DATE

Change to Supporting Information: Changed Name, Description

~~The date on which a CARE CONTACT took place.~~A Care Contact Date is an ACTIVITY DATE TIME.

A Care Contact Date is the DATE on which a CARE CONTACT took place.

CARE CONTACT DATE renamed from CARE CONTACT DATE

Change to Supporting Information: Changed Name, Description

- Changed Name from Data_Dictionary.Attributes.C.Card.CARE_CONTACT_DATE to Data_Dictionary.NHS_Business_Definitions.C.Care_Contact_Date
- Changed Description

CARE CONTACT TIME renamed from CARE CONTACT TIME

Change to Supporting Information: Changed Name, Description

~~The time at which a CARE CONTACT took place.~~A Care Contact Time is an ACTIVITY DATE TIME.

A Care Contact Time is the TIME at which a CARE CONTACT took place.

CARE CONTACT TIME renamed from CARE CONTACT TIME

Change to Supporting Information: Changed Name, Description

- Changed Name from Data_Dictionary.Attributes.C.Card.CARE_CONTACT_TIME to Data_Dictionary.NHS_Business_Definitions.C.Care_Contact_Time
- Changed Description

CARE PROFESSIONAL ADMITTED CARE EPISODE

Change to Supporting Information: New Supporting Information

A Care Professional Admitted Care Episode is an ACTIVITY GROUP.

A Care Professional Admitted Care Episode is the period of time within a Hospital Provider Spell during which the PATIENT is under the medical responsibility of a:

- CONSULTANT
- MIDWIFE
- NURSE

A Care Professional Admitted Care Episode can be a:

- Consultant Episode (Hospital Provider)
- Midwife Episode
- Nursing Episode.

This supporting information is also known by these names:

Context	Alias
plural	Care Professional Admitted Care Episodes

CARE PROGRAMME APPROACH

Change to Supporting Information: New Supporting Information

The Care Programme Approach (CPA) provides a framework for effective mental health care planning, assessment, management, co-ordination and delivery.

The Care Programme Approach only applies to individuals with complex needs who are in contact with a number of SERVICES, or those at most risk.

For further information on the Care Programme Approach, see NHS Choices at: Care Programme Approach.

This supporting information is also known by these names:

Context	Alias
shortname	CPA

CARE PROGRAMME APPROACH CARE EPISODE renamed from CARE PROGRAMME APPROACH EPISODE

Change to Supporting Information: Changed Name, Description

~~A Care Programme Approach Episode is an ACTIVITY GROUP.~~A Care Programme Approach Care Episode is an ACTIVITY GROUP.

~~A Care Programme Approach Episode is a period of care provided as part of the care programme approach for an adult (including elderly) PATIENT. The Care Programme Approach Episode forms part of a Adult Mental Health, Learning Disability or Autism Spectrum Disorder Care Spell.~~A Care Programme Approach Care Episode is a period of care during which the PATIENT is receiving care under the Care Programme Approach.

~~The first Care Programme Approach Episode starts when the Adult Mental Health, Learning Disability or Autism Spectrum Disorder Care Spell initial assessment of the PATIENT determines that a plan of care or treatment is required which will be delivered under the care programme approach.~~A Care Programme Approach Care Episode starts when the initial assessment of the PATIENT determines that a plan of care or treatment is required which will be delivered under the Care Programme Approach.

~~The Care Programme Approach Episode ends when one of the following occurs:~~The Care Programme Approach Care Episode ends when one of the following occurs:

- ~~a review determines that no further care need be provided~~
- ~~a different level of care programme approach is required~~
- ~~a PATIENT transfers to another Health Care Provider with main responsibility for provision of mental health care also being transferred~~
- ~~death of the PATIENT~~
- A review determines that no further care need be provided
- A PATIENT transfers to another Health Care Provider with main responsibility for provision of mental health care also being transferred
- The death of the PATIENT

~~A Care Programme Approach Episode must involve all of the following key elements:~~A Care Programme Approach Care Episode must involve all of the following key elements:

~~a. An assessment of the PATIENT's health and social care needs~~
~~b. A written care plan to meet the assessed needs, the PATIENT being involved in drawing up the care plan~~
~~c. Regular reviews of the PATIENT's care plan~~
~~d. A named mental health worker, called a care coordinator, who is responsible for the PATIENT care under the care programme approach~~

- An assessment of the PATIENT's health and social care needs
- A written CARE PLAN to meet the assessed needs, the PATIENT being involved in drawing up the CARE PLAN
- Regular reviews of the CARE PLAN
- A named mental health worker, called a Mental Health Care Coordinator, who is responsible for the PATIENTs care under the Care Programme Approach.

~~Each Care Programme Approach Episode must be subject to at least one Care Programme Approach Review and at least one Care Programme Approach Care Co-ordinator Allocation.~~Each Care Programme Approach Care Episode must be subject to at least one Care Programme Approach Review and at least one Mental Health Care Coordinator Assignment Period.

CARE PROGRAMME APPROACH CARE EPISODE renamed from CARE PROGRAMME APPROACH EPISODE

Change to Supporting Information: Changed Name, Description

- Changed Name from Data_Dictionary.NHS_Business_Definitions.C.Care_Programme_Approach_Episode to Data_Dictionary.NHS_Business_Definitions.C.Care_Programme_Approach_Care_Episode
- Changed Description

CARE PROGRAMME APPROACH REVIEW

Change to Supporting Information: Changed Description

A Care Programme Approach Review is a CARE CONTACT.

~~A Care Programme Approach Review is a clinical review of the health and social needs of a PATIENT who is the subject of a Care Programme Approach Episode.~~A Care Programme Approach Review is a clinical review of the health and social needs of a PATIENT who is the subject of a Care Programme Approach Care Episode.

~~The review may take the form of a single meeting of interested parties, usually including the allocated care coordinator and the PATIENT or it may comprise a series of meetings and discussions over a number of days.~~The Care Programme Approach Review may take the form of a single meeting of interested parties, usually including the allocated Mental Health Care Coordinator and the PATIENT, or it may comprise a series of meetings and discussions over a number of days.

The Care Programme Approach Review ends when a definite outcome is established and recorded. The date when this is recorded will be taken as the Care Programme Approach Review Date. ~~The outcome will determine whether the Care Programme Approach Episode continues or is ended.~~ The outcome will determine whether the Care Programme Approach Care Episode continues or is ended.

CARE PROGRAMME APPROACH REVIEW DATE

Change to Supporting Information: Changed Description

A Care Programme Approach Review Date is an ACTIVITY DATE TIME.

~~A Care Programme Approach Review Date is the date an established outcome of a Care Programme Approach Review is recorded.~~A Care Programme Approach Review Date is the date of the Care Programme Approach Review.

CHILD AND ADOLESCENT MENTAL HEALTH SERVICES SECONDARY USES DIAGRAM OVERVIEW

Change to Supporting Information: Changed Description

~~The Child and Adolescent Mental Health Services Secondary Uses Diagram demonstrates the delivery of a Child and Adolescent Mental Health Care Spell, for the purposes of the Child and Adolescent Mental Health Services Secondary Uses Data Set.~~The Child and Adolescent Mental Health Services Secondary Uses Diagram demonstrates the delivery of a Child and Adolescent Mental Health Care Spell, for the purposes of the Child and Adolescent Mental Health Services Secondary Uses Data Set.

USING THE DIAGRAM

By clicking on a Class on the diagram opposite, the selected Class definition will be displayed. By clicking on an Attribute name displayed within the Class, the selected Attribute definition will be displayed.

Note that not all attributes for a class will be visible. The full list of attributes for a class can be viewed in the class definition, by selecting the 'Attribute' tab.

To view the diagram in full, select the 'Print Window' option, this will open a new window that will display only the diagram. You can also use this view to print the diagram, by right clicking on the diagram and selecting 'Print Picture'.

CLINICAL DATA SETS MENU

Change to Supporting Information: Changed Description

- **Message Documentation**

- Cancer Outcomes and Services Data Set
- ~~Child and Adolescent Mental Health~~
- Children and Young Peoples Health
- Chlamydia Testing Activity
- Community Information
- Diabetes (Summary Core)
- Diagnostic Imaging
- Female Genital Mutilation
- Genitourinary Medicine Clinic Activity
- HIV and AIDS Reporting
- Improving Access to Psychological Therapies
- Maternity Services
- ~~Mental Health and Learning Disabilities~~
- Mental Health Services
- National Cancer Waiting Times Monitoring
- National Neonatal
- National Renal
- NHS Health Checks
- Radiotherapy
- Sexual and Reproductive Health Activity
- Systemic Anti-Cancer Therapy

CLINIC ATTENDANCE NON-CONSULTANT

Change to Supporting Information: Changed Description

A Clinic Attendance Non-Consultant is a CARE CONTACT.

A Clinic Attendance Non-Consultant is an attendance at or contact with a Nurse Clinic, Midwife Clinic or Sexual and Reproductive Health Clinic. ~~This may have been as a result of an Out-Patient Appointment Non-Consultant.~~

~~If the PATIENT is currently subject to a Mental Health Care Spell and the NURSE they are in contact with during the attendance or contact is their allocated Care Programme Approach care coordinator then a Face To Face Contact CPA Care Coordinator should also be recorded.~~A Clinic Attendance Non-Consultant may be the result of an Out-Patient Appointment Non-Consultant.

~~Note: Attendances or contacts at clinics run by Paramedics are Professional Staff Group Contacts.~~

~~If an APPOINTMENT TIME was given, the time seen should be recorded.~~

~~Information recorded for a Clinic Attendance Non-Consultant includes:~~

~~ATTENDANCE DATE~~
~~ATTENDANCE IDENTIFIER~~
~~Time Seen O (if appointment time given)~~

CLUSTERING TOOL

Change to Supporting Information: New Supporting Information

A Clustering Tool is a type of ASSESSMENT TOOL.

A Clustering Tool is a needs assessment tool designed to rate the care needs of a PATIENT.

Examples of Clustering Tools include:

- Adult Mental Health Clustering Tool.

This supporting information is also known by these names:

Context	Alias
plural	Clustering Tools

COMMISSIONER ASSIGNMENT PERIOD

Change to Supporting Information: Changed Description

~~Commissioner Assignment Period is an ACTIVITY GROUP.~~A Commissioner Assignment Period is an ACTIVITY GROUP.

~~Commissioner Assignment Period is the period of time that an ORGANISATION CODE (CODE OF COMMISSIONER) is responsible for commissioning ACTIVITY for a PATIENT.~~A Commissioner Assignment Period is the period of time that a commissioner is responsible for commissioning ACTIVITY for a PATIENT.

COMMUNITY TREATMENT ORDER

Change to Supporting Information: Changed Description

~~See Supervised Community Treatment.~~

A Community Treatment Order applies to PATIENTS detained under the Mental Health Act 1983 as amended by the Mental Health Act 2007, typically under section 3 or 37. ~~The underlying MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE of the Adult Mental Health, Learning Disability or Autism Spectrum Disorder Care Spell will be carried through the period in the community although it will be suspended during that period.~~

~~A Community Treatment Order will be made by the Mental Health Responsible Clinician, in agreement with an Approved Mental Health Professional, under section 17A of the Mental Health Act 1983 (inserted by the Mental Health Act 2007).~~The MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE section in force at the time of the Community Treatment Order is suspended.

~~The term Community Treatment Order refers to the actual instrument and Supervised Community Treatment to the treatment regime although both terms are used interchangeably.~~A Community Treatment Order will be made

by the Mental Health Responsible Clinician, in agreement with an Approved Mental Health Professional, under section 17A of the Mental Health Act 1983 (inserted by the Mental Health Act 2007).

A Community Treatment Order has the same duration and renewal periods as section 3 of the Mental Health Act 1983 - six months initially, then renewed for 6 months, then renewed annually.

A PATIENT on a Community Treatment Order may be recalled to hospital for treatment where deemed necessary by the Mental Health Responsible Clinician (Community Treatment Order Recall).

A Community Treatment Order period can be ended by the following methods:

- Discharge or death of the PATIENT
- Revocation of the Community Treatment Order following a period of recall to hospital. The PATIENT will return to being under the original underlying section of the Mental Health Act 1983 under which they were sectioned immediately prior to the issuing of the Community Treatment Order.

A Community Treatment Order must be considered as an option by the Mental Health Responsible Clinician prior to granting or extending a Mental Health Leave of Absence for more than seven days (or for an indefinite period).

COMMUNITY TREATMENT ORDER RECALL

Change to Supporting Information: New Supporting Information

A Community Treatment Order Recall is when a PATIENT is recalled into hospital for treatment whilst on a Community Treatment Order under section 17A of the Mental Health Act 1983 as amended by Mental Health Act 2007. The decision to recall a PATIENT to hospital will be made by the Mental Health Responsible Clinician.

If there is a risk to the PATIENT's health or safety or to that of someone else, the Mental Health Responsible Clinician may recall the PATIENT. If they go missing or do not report to hospital on recall or abscond once there, they are then subject to Mental Health Absence Without Leave provisions in the same way as a detained PATIENT and their Community Treatment Order is revoked.

A Community Treatment Order Recall will not automatically end the Community Treatment Order. Recall can only last for a maximum period of 72 hours. If the PATIENT needs more admitted PATIENT care treatment, the Community Treatment Order can be revoked and the PATIENT is detained in hospital again.

If the Community Treatment Order Recall period is less than 72 hours, the recall will not automatically end the Community Treatment Order.

If a PATIENT is recalled and the time in hospital goes over 72 hours, they must either have their Community Treatment Order revoked or continue the Community Treatment Order. This will either happen by the PATIENT being discharged from hospital or they could continue staying in hospital as an informal PATIENT but remain on a Community Treatment Order.

A Community Treatment Order Recall can end with the:

- PATIENT being discharged from hospital back to the original Community Treatment Order or
- Revocation of the Community Treatment Order should the Mental Health Responsible Clinician see fit and the PATIENT meets the criteria for detention.

This supporting information is also known by these names:

Context	Alias
plural	Community Treatment Order Recalls

DATE OF RESTRICTIVE INTERVENTION

Change to Supporting Information: New Supporting Information

Date of Restrictive Intervention is an ACTIVITY DATE TIME.

Date of Restrictive Intervention is the DATE of a reported incident of a Restrictive Intervention.

This supporting information is also known by these names:

Context	Alias
plural	Dates of Restrictive Intervention

DAY CARE FACILITY

Change to Supporting Information: Changed Description

A Day Care Facility is a CLINIC OR FACILITY.

~~A Day Care Facility provided for the clinical treatment, assessment and maintenance of function of PATIENTS, in particular, though not exclusively, those who are elderly, mentally ill or have learning difficulties. They may be called Day Hospitals, Centres, Facilities or Units.~~Day Care Facilities may be called Day Hospitals, Centres, Facilities or Units.

~~Day Care Facilities may be financed, planned and run solely by NHS ORGANISATIONS or solely by non-NHS ORGANISATIONS or jointly between NHS and non-NHS organisations.~~A Day Care Facility provided for the clinical treatment, assessment and maintenance of function of PATIENTS, in particular, though not exclusively, those who are elderly, mentally ill or have Learning Difficulties.

Day Care Facilities may be financed, planned and run solely by NHS ORGANISATIONS or solely by non-NHS ORGANISATIONS or jointly between NHS and non-NHS ORGANISATIONS. Jointly run facilities should still be managed by only one ORGANISATION.

The facilities specifically do not have Hospital Beds and function separately from any WARD.

~~Day Care Facilities are usually open during the five week days. In some places a service may be provided only once or twice a week and the service may take the form of evening or weekend Day Care Sessions.~~

DAY CARE FACILITY

Change to Supporting Information: Changed Description

- Changed Description

DIAGRAMS MENU

Change to Supporting Information: Changed Description

- Diagrams Introduction
- Diagramming Conventions

- Help Menu

- **Generic Diagrams**
- Activity
- Address
- Appointment
- Care Professional
- Organisation
- Patient Pathway
- Person
- Prescribing and Dispensing
- Service Request

- **Data Set Supporting Diagrams**
- Cancer Outcomes and Services
- ~~Child and Adolescent Mental Health~~
- Children and Young Peoples Health
- Community
- Diagnostic Imaging
- HIV and AIDS
- Improving Access to Psychological Therapies
- Maternity
- National Joint Registry
- National Renal
- National Workforce
- Radiotherapy
- Systemic Anti-Cancer Therapy

DISCHARGE LETTER ISSUED DATE (MENTAL HEALTH AND COMMUNITY CARE)

Change to Supporting Information: New Supporting Information

A Discharge Letter Issued Date (Mental Health and Community Care) is an ACTIVITY DATE TIME.

The Discharge Letter Issued Date (Mental Health and Community Care) is the date when the Discharge Letter was issued to the PATIENT by the Mental Health Service or Community Health Service.

This supporting information is also known by these names:

Context	Alias
plural	Discharge Letter Issued Dates (Mental Health and Community Care)

EARLY INTERVENTION IN PSYCHOSIS SERVICE

Change to Supporting Information: New Supporting Information

An Early Intervention in Psychosis (EIP) Service is a type of Mental Health Service.

An Early Intervention in Psychosis Service is a specialist community SERVICE providing care and treatment to people who are experiencing their first episode of psychosis, and for those who are at high risk of developing psychosis.

The overarching aim of an Early Intervention in Psychosis Service is to reduce the duration of untreated psychosis and produce effective outcomes in terms of recovery and reduction in relapse rates.

This supporting information is also known by these names:

Context	Alias
shortname	EIP Service
plural	Early Intervention in Psychosis Services
fullname	Early Intervention in Psychosis (EIP) Service

EARLY INTERVENTION IN PSYCHOSIS WAITING TIME MEASUREMENT

Change to Supporting Information: New Supporting Information

The Early Intervention in Psychosis Waiting Time Measurement ensures that:

- Anyone with an emerging psychosis and their families and key supporters can have timely access to specialist Early Intervention in Psychosis Services which provide interventions suited to age and phase of illness
- Individuals experiencing first episode psychosis have consistent access to a range of evidence-based biological, psychological and social interventions as recommended by the National Institute for Health and Care Excellence (NICE) guidelines for psychosis and schizophrenia in children and young people and in adults, and the National Institute for Health and Care Excellence guideline for psychosis with co-existing substance misuse
- Care is provided equitably - taking into account higher rates of psychosis in certain groups who may experience difficulties in accessing traditional services.

Further guidance relating to the Early Intervention in Psychosis Waiting Time Measurement can be found on the NHS England website at: Guidance on new mental health standards published.

This supporting information is also known by these names:

Context	Alias
plural	Early Intervention in Psychosis Waiting Time Measurements

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GROUP THERAPY

Change to Supporting Information: Changed Description

Group Therapy is a SESSION.

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.

~~For the Community Information Data Set, Group Therapy is recorded as a CARE CONTACT. Group Sessions are recorded when the attendees at the SESSION are not known in advance, and clinical notes are not made in individual PATIENT records.~~For the Community Information Data Set and Mental Health Services Data Set, Group Therapy is recorded as a CARE CONTACT.

Note: Group Sessions are recorded when the attendees at the SESSION are not known in advance, and clinical notes are not made in individual PATIENT records.

HEALTH OF THE NATION OUTCOME SCALE (WORKING AGE ADULTS)

Change to Supporting Information: Changed Description

The Health of the Nation Outcome Scale (Working Age Adults) (HoNOS (Working Age Adults)) is a type of ASSESSMENT TOOL.

The Health of the Nation Outcome Scale (Working Age Adults) is a means of measuring the health and social functioning of people of working age with severe mental illness. ~~It is assessed by a CARE PROFESSIONAL or Mental Health Care Team Member.~~ It is assessed by a CARE PROFESSIONAL.

The allowed responses for each of the 12 ratings in the Health of the Nation Outcome Scale (Working Age Adults) are as follows:

- 0 - No problem
- 1 - Minor problem requiring no action
- 2 - Mild problem but definitely present
- 3 - Moderately severe problem
- 4 - Severe to very severe problem
- 9 - Not known

For further information on Health of the Nation Outcome Scale (Working Age Adults), see the Royal College of Psychiatrists website.

HOME LEAVE

Change to Supporting Information: Changed Description

Home Leave is a type of LEAVE.

~~Home Leave occurs when a PATIENT who is not liable to be detained under Part II of the Mental Health Act 1983 and who is using a Hospital Bed in a WARD or a bed in a Care Home spends a period of time outside the hospital/Care Home, usually at home, with the intention of returning to the same type of WARD or Care Home to continue the same Consultant Episode (Hospital Provider), Midwife Episode or Nursing Episode.~~Home Leave occurs when a PATIENT who is not liable to be detained under Part II of the Mental Health Act 1983 and who is using a Hospital Bed in a WARD or a bed in a Care Home spends a period of time outside the hospital/Care Home, usually at home, with the intention of returning to the same type of WARD or Care Home to continue the same Care Professional Admitted Care Episode.

A PATIENT liable to be detained in hospital under Part II of the Mental Health Act 1983 and as amended by the Mental Health (Patients in the Community) Act 1985, should be granted Mental Health Leave of Absence instead of Home Leave.

~~For a PATIENT under a Nursing Episode or a Midwife Episode the period of time is at the discretion of the responsible NURSE or MIDWIFE. The period of time for all other PATIENTS should be a maximum of Saturday, Sunday, NHS, bank and public holidays plus another three days. If a PATIENT does not return on the day specified and has failed to make alternative arrangements with hospital/care home staff, such a PATIENT should be considered discharged from that day. The date on which a PATIENT leaves the WARD to go on Home Leave closes the preceding Ward Stay.~~For a PATIENT under a Nursing Episode or Midwife Episode the period of time is at the discretion of the responsible CARE PROFESSIONAL.

The period of time for all other PATIENTS should be a maximum of Saturday, Sunday, NHS, bank and public holidays plus another three days. If a PATIENT does not return on the day specified and has failed to make alternative arrangements with hospital/Care Home staff, such a PATIENT should be considered discharged from that day.

The date on which a PATIENT leaves the WARD to go on Home Leave closes the preceding Ward Stay.

INDEPENDENT MENTAL CAPACITY ADVOCATE

Change to Supporting Information: New Supporting Information

An Independent Mental Capacity Advocate (IMCA) is a PERSON.

An Independent Mental Capacity Advocate assists people who lack mental capacity to express their views.

For further information on Independent Mental Capacity Advocates, see the Office of Public Guardian and Department of Health part of the gov.uk website.

This supporting information is also known by these names:

Context	Alias
shortname	IMCA
plural	Independent Mental Capacity Advocates

INDEPENDENT MENTAL HEALTH ADVOCATE

Change to Supporting Information: New Supporting Information

An Independent Mental Health Advocate (IMHA) is a PERSON.

An Independent Mental Health Advocate is a specialist mental health advocate, who helps PATIENTS understand the legal provisions to which they are subject under the Mental Health Act.

For further information on Independent Mental Health Advocates, see the Department of Health part of the gov.uk website.

This supporting information is also known by these names:

Context	Alias
shortname	IMHA
plural	Independent Mental Health Advocates

INDIRECT ACTIVITY

Change to Supporting Information: New Supporting Information

An Indirect Activity is an ACTIVITY.

An Indirect Activity is ACTIVITY, with the specific purpose of supporting the care of a PATIENT, but where the PATIENT is not present.

An Indirect Activity may take place between:

- CARE PROFESSIONAL and another CARE PROFESSIONAL
- A CARE PROFESSIONAL and another professional such as a teacher

- Any other professional not acting in the capacity of a Patient Proxy.

Examples of Indirect Activity include:

- A CARE PROFESSIONAL seeking advice from another CARE PROFESSIONAL regarding the treatment or diagnosis of a specific PATIENT.
- A CARE PROFESSIONAL providing training to a teacher to support the medical needs of a specific PATIENT.
- A CARE PROFESSIONAL discussing the care of a PATIENT with another CARE PROFESSIONAL as part of a Multidisciplinary Team Meeting, where the PATIENT is not present.

Indirect Activity does not include discussions regarding groups of PATIENTS or other administrative activities such as writing up of notes or travel.

Note: For the Mental Health Services Data Set, contacts between a CARE PROFESSIONAL and a Patient Proxy should be captured as a CARE CONTACT with the CARE CONTACT SUBJECT set to 'Patient Proxy'.

This supporting information is also known by these names:

Context	Alias
plural	Indirect Activities

INDIRECT ACTIVITY DATE

Change to Supporting Information: New Supporting Information

An Indirect Activity Date is an ACTIVITY DATE TIME.

An Indirect Activity Date is the DATE on which an Indirect Activity took place.

This supporting information is also known by these names:

Context	Alias
plural	Indirect Activity Dates

INDIRECT ACTIVITY TIME

Change to Supporting Information: New Supporting Information

An Indirect Activity Time is an ACTIVITY DATE TIME.

An Indirect Activity Time is the TIME at which an Indirect Activity took place.

This supporting information is also known by these names:

Context	Alias
plural	Indirect Activity Times

MENTAL HEALTH ABSENCE WITHOUT LEAVE

Change to Supporting Information: Changed Description

Mental Health Absence Without Leave is a type of LEAVE.

~~A period of Mental Health Absence Without Leave occurs when PATIENTS who are liable to be detained in hospital under the Mental Health Act 1983, subject to guardianship or who are on Supervised Community Treatment and have been recalled to hospital, absent themselves from hospital without leave being granted, or absent themselves without permission from any place where they are required to reside in accordance with conditions imposed on granted Mental Health Leave of Absence, or fail to return to hospital by midnight on the day specified for return from granted Mental Health Leave of Absence.~~A period of Mental Health Absence Without Leave occurs when PATIENTS who are liable to be detained in hospital under the Mental Health Act 1983, subject to guardianship or who are on a Community Treatment Order and have been recalled to hospital, absent themselves from hospital without leave being granted, or absent themselves without permission from any place where they are required to reside in accordance with conditions imposed on granted Mental Health Leave of Absence, or fail to return to hospital by midnight on the day specified for return from granted Mental Health Leave of Absence.

~~The PATIENT will be liable to be taken into custody until the end of the relevant period set out in the Mental Health Act 1983.~~The PATIENT will be liable to be taken into custody until the end of the relevant period set out in the Mental Health Act 1983 as amended by the Mental Health (Patients in the Community) Act 1995.

~~The period of Mental Health Absence Without Leave starts on the day the PATIENTS absent themselves from hospital, or absent themselves from required place of residence or the day following the Mental Health Leave of Absence planned return date. Where PATIENTS absent themselves for a period less than a day and return on the same day, an occurrence of Mental Health Absence Without Leave should not be recorded.~~The period of Mental Health Absence Without Leave starts:

- On the day the PATIENT absents themselves from hospital, or absent themselves from required place of residence or
- The day following the Mental Health Leave of Absence planned return date.

Where PATIENTS absent themselves for a period less than a day and return on the same day, an occurrence of Mental Health Absence Without Leave should not be recorded.

PATIENTS who have absented themselves from hospital or Care Home and fail to return within 28 days from the first day of absence will be discharged from their current Hospital Provider Spell or Care Home Stay.

The period of Mental Health Absence Without Leave ends when the PATIENT:

- ~~returns voluntarily~~
- ~~is taken into custody~~
- ~~fails to return within the relevant period set out in the Mental Health Act 1983~~

~~Information recorded for a Mental Health Absence Without Leave includes:~~

~~Start Date~~
~~ABSENCE WITHOUT LEAVE END REASON~~ ~~O~~
~~End Date~~ ~~O~~

- returns voluntarily
- is taken into custody
- fails to return within the relevant period set out in the Mental Health Act 1983 as amended by the Mental Health (Patients in the Community) Act 1995.

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD renamed from MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD

Change to Supporting Information: Changed Name, Description

~~A Mental Health Act Legal Status Classification Period is an ACTIVITY GROUP.~~A Mental Health Act Legal Status Classification Assignment Period is a PERSON PROPERTY ASSIGNMENT PERIOD.

~~A Mental Health Act Legal Status Classification Period starts when a PATIENT commences a period of care with a mental health services Health Care Provider. This can include periods where the PATIENT is not detained but attracts a MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION of *'Informal (Not formally detained and receiving supervised aftercare)'*.~~A Mental Health Act Legal Status Classification Assignment Period starts when a PATIENT commences a period of care with a Mental Health or Learning Disability SERVICES Health Care Provider.

~~The MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD START REASON records the reason for the start of the Mental Health Act Legal Status Classification Period.~~The MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON records the reason for the start of the Mental Health Act Legal Status Classification Assignment Period.

~~The MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD END REASON records the reason for the end of the Mental Health Act Legal Status Classification Period. This may include PATIENTS who have a Mental Health Act Legal Status recorded but transfer to the responsibility of another Health Care Provider.~~The MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON records the reason for the end of the Mental Health Act Legal Status Classification Assignment Period. This may include PATIENTS who have a MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE recorded but transfer to the responsibility of another Health Care Provider.

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD renamed from MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD

Change to Supporting Information: Changed Name, Description

- Changed Name from Data_Dictionary.NHS_Business_Definitions.M.Mental_Health_Act_Legal_Status_Classification_Period to Data_Dictionary.NHS_Business_Definitions.M.Mental_Health_Act_Legal_Status_Classification_Assignment_
- Changed Description

MENTAL HEALTH CARE CLUSTER SUPER CLASS

Change to Supporting Information: Changed Description

~~A Mental Health Care Cluster Super Class is identified during the process of assigning a Mental Health Care Cluster to a PATIENT. It enables the number of applicable Mental Health Care Clusters to be narrowed down, by deciding if the origin of the presenting condition is primarily:~~A Mental Health Care Cluster Super Class is identified during the process of assigning a Adult Mental Health Care Cluster to a PATIENT.

A Mental Health Care Cluster Super Class enables the number of applicable Adult Mental Health Care Clusters to be narrowed down, by deciding if the origin of the presenting condition is primarily:

- ~~non-psychotic~~
- ~~psychotic or~~
- ~~organic~~
- Non-psychotic
- Psychotic or
- Organic

~~If the PATIENT cannot be assigned to a Mental Health Care Cluster, MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE is recorded as National Code Z '*Unable to assign* PATIENT *to Mental Health Care Cluster*', and the PATIENT will automatically be assigned to Mental Health Care Cluster 0 (Variance).~~If the PATIENT cannot be assigned to a Adult Mental Health Care Cluster, MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE is recorded as '*Unable to assign* PATIENT *to Mental Health Care Cluster Super Class*'. The PATIENT will automatically be assigned to the ADULT MENTAL HEALTH CARE CLUSTER CODE *'00 Care Cluster 0 - Variance (unable to assign ADULT MENTAL HEALTH CARE CLUSTER CODE).*'

~~Further information relating to the Mental Health Clustering Tool and Mental Health Care Clusters is available from the Monitor part of the gov.~~Further information relating to the Adult Mental Health Clustering Tool and Adult Mental Health Care Clusters is available from the Monitor part of the gov.uk website at: Guidance on mental health currencies and payment.

MENTAL HEALTH CARE COORDINATOR

Change to Supporting Information: New Supporting Information

A Mental Health Care Coordinator is a CARE PROFESSIONAL.

A Mental Health Care Coordinator is a CARE PROFESSIONAL working in specialist Mental Health Services, who has been named and allocated as a care coordinator to the PATIENT.

This supporting information is also known by these names:

Context	Alias
plural	Mental Health Care Coordinators

MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD_ renamed from MENTAL HEALTH CARE COORDINATOR ASSIGNMENT

Change to Supporting Information: Changed Name, Description

~~Mental Health Care Coordinator Assignment is a CARE PROFESSIONAL ROLE.~~A Mental Health Care Coordinator Assignment Period is an ACTIVITY GROUP.

~~A Mental Health Care Coordinator is a professional member of staff working in specialist mental health services, who has been named and allocated as care coordinator to the PATIENT.~~A Mental Health Care Coordinator Assignment Period is the period of time that a PATIENT is assigned to a Mental Health Care Coordinator.

~~If the PATIENT is subject to a Care Programme Approach Episode, the Mental Health Care Coordinator will also act as the CPA Care Coordinator.~~

MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD_ renamed from MENTAL HEALTH CARE COORDINATOR ASSIGNMENT

Change to Supporting Information: Changed Name, Description

- Changed Name from Data_Dictionary.NHS_Business_Definitions.M.Mental_Health_Care_Coordinator_Assignment to Data_Dictionary.NHS_Business_Definitions.M.Mental_Health_Care_Coordinator_Assignment_Period
- Changed Description

MENTAL HEALTH CONDITIONAL DISCHARGE PERIOD

Change to Supporting Information: Changed Description

A Mental Health Conditional Discharge Period is an ACTIVITY GROUP.

~~A Mental Health Conditional Discharge Period starts when a mental health tribunal or the Secretary of State decides that a PATIENT, who is detained under section 37/41 of the Mental Health Act, can be discharged from the care of a Health Care Provider subject to conditions which must be adhered to. If the PATIENT does not adhere to the conditions then they may be recalled to hospital, this would end the Mental Health Conditional Discharge Period.~~A Mental Health Conditional Discharge Period:

- Starts when a mental health tribunal or the Secretary of State decides that a PATIENT, who is detained under section 37/41 of the Mental Health Act, can be discharged from the care of a Health Care Provider subject to conditions which must be adhered to.

  ~~The Mental Health Conditional Discharge Period also ends where the patient receives absolute discharge from either the mental health tribunal or the Secretary of State, or the PATIENT dies.~~If the PATIENT does not adhere to the conditions then they may be recalled to hospital, this would end the Mental Health Conditional Discharge Period.

  - Ends where the PATIENT receives absolute discharge from either the mental health tribunal or the Secretary of State, or the PATIENT dies.

MENTAL HEALTH CRISIS PLAN CREATION DATE

Change to Supporting Information: New Supporting Information

Mental Health Crisis Plan Creation Date is an ACTIVITY DATE TIME.

Mental Health Crisis Plan Creation Date is the DATE that a Mental Health Crisis Plan was created.

This supporting information is also known by these names:

Context	Alias
plural	Mental Health Crisis Plan Creation Dates

MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE

Change to Supporting Information: New Supporting Information

Mental Health Crisis Plan Last Updated Date is an ACTIVITY DATE TIME.

Mental Health Crisis Plan Last Updated Date is the DATE that a Mental Health Crisis Plan was last updated.

This supporting information is also known by these names:

Context	Alias
plural	Mental Health Crisis Plan Last Updated Dates

MENTAL HEALTH DELAYED DISCHARGE PERIOD

Change to Supporting Information: Changed Description

A Mental Health Delayed Discharge Period is an ACTIVITY GROUP.

A Mental Health Delayed Discharge Period is the period of time during a Consultant Episode (Hospital Provider) under a MAIN SPECIALTY CODE (MENTAL HEALTH) that the PATIENT is fit and ready for discharge, but discharge is delayed due to external factors outside the control of the Hospital Provider. These reasons are detailed in MENTAL HEALTH DELAYED DISCHARGE REASON.

A PATIENT is ready for discharge when:

- ~~a clinical decision has been made that the PATIENT is ready for discharge~~
- ~~a multidisciplinary team decision has been made that the PATIENT is ready for discharge~~
- ~~the PATIENT is safe to discharge~~
- A clinical decision has been made that the PATIENT is ready for discharge
- A Multidisciplinary Team decision has been made that the PATIENT is ready for discharge
- The PATIENT is safe to discharge.

~~The Mental Health Delayed Discharge Period starts on the START DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD) and ends on the END DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD). The END DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD) may be the same as the DISCHARGE DATE (HOSPITAL PROVIDER SPELL), if the external factors are resolved while the PATIENT is still ready for discharge.~~The Mental Health Delayed Discharge Period:

- Starts on the START DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD) and
- Ends on the END DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD).

  The END DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD) may be the same as the DISCHARGE DATE (HOSPITAL PROVIDER SPELL), if the external factors are resolved while the PATIENT is still ready for discharge.

~~However if the PATIENT's condition deteriorates while awaiting discharge, the decision may be taken to end the Mental Health Delayed Discharge Period, and the Consultant Episode (Hospital Provider) and Hospital Provider Spell continue.~~However if the PATIENT's condition deteriorates while awaiting discharge, the decision may be taken to end the Mental Health Delayed Discharge Period, and the Care Professional Admitted Care Episode and Hospital Provider Spell continue.

~~Multiple Mental Health Delayed Discharge Periods may occur during a single Consultant Episode (Hospital Provider), and within a single Hospital Provider Spell (though they may occur in different Consultant Episodes (Hospital Provider) within that Hospital Provider Spell).~~Multiple Mental Health Delayed Discharge Periods may occur during a single Care Professional Admitted Care Episode, and within a single Hospital Provider Spell (though they may occur in different Care Professional Admitted Care Episodes within that Hospital Provider Spell).

MENTAL HEALTH LEAVE OF ABSENCE

Change to Supporting Information: Changed Description

A Mental Health Leave of Absence is a type of LEAVE.

A Mental Health Leave of Absence only applies to PATIENTS liable to be detained in hospital under the Mental Health Act 1983 as amended by the Mental Health (Patients in the Community) Act 1995.

~~The granting of a Mental Health Leave of Absence within a Mental Health Care Spell can only be authorised by the Mental Health Responsible Clinician for the PATIENT.~~The granting of a Mental Health Leave of Absence within a Hospital Provider Spell can only be authorised by the Mental Health Responsible Clinician for the PATIENT. The granted period of absence from hospital may be indefinite, a specified occasion or for any specified period and be escorted or unescorted. Where leave is granted for a specified period, that period may be extended by further

leave granted in absence of the PATIENT. If the period of leave is extended, the current Mental Health Leave of Absence will be ended, and a new one started.

A Mental Health Leave of Absence for a period up to a maximum of 28 days from the Start Date, will not interrupt the Consultant Episode (Hospital Provider), Care Home Stay (Consultant Care), Care Home Stay (Nursing Care) or Care Home Stay (Residential). A Mental Health Leave of Absence for a period greater than 28 days from the start date, will entail the PATIENT being discharged from the current Hospital Provider Spell or Care Home Stay (Nursing Care), or their Care Home Stay (Residential) being ended.

During the Mental Health Leave of Absence, the Mental Health Responsible Clinician continues to be responsible for the organisation and management of the PATIENT's continuing health and social care needs.

If a PATIENT does not return by midnight on the day specified, then the Mental Health Leave of Absence will be ended and a period of Mental Health Absence Without Leave started.

The Mental Health Responsible Clinician should consider Supervised Community Treatment for a PATIENT before granting Mental Health Leave of Absence for any period exceeding seven consecutive days.

~~Information recorded for each separate period of Mental Health Leave of Absence including an overnight stay includes:~~

- ~~Start Date~~
- ~~End Date O~~
- ~~LEAVE OF ABSENCE END REASON O~~
- ~~PLANNED LEAVE RETURN DATE O (if for a specified period or occasion)~~

MENTAL HEALTH RESPONSIBLE CLINICIAN

Change to Supporting Information: Changed Description

A Mental Health Responsible Clinician is a CARE PROFESSIONAL.

~~A Mental Health Responsible Clinician is a CARE PROFESSIONAL, with a MENTAL HEALTH RESPONSIBLE CLINICIAN PROFESSION within a particular TREATMENT FUNCTION, to act as the clinical supervisor for a Mental Health Care Spell.~~A Mental Health Responsible Clinician is a CARE PROFESSIONAL acting as the clinical supervisor for a Hospital Provider Spell.

There will be only one CARE PROFESSIONAL assigned to a PATIENT as the Mental Health Responsible Clinician at any one time. ~~These assignments may change during the course of a Mental Health Care Spell, though not necessarily at the time of a Care Programme Approach Review.~~ These assignments may change during the course of a Hospital Provider Spell, though not necessarily at the time of a Care Programme Approach Review.

The role of Mental Health Responsible Clinician was introduced in the Mental Health Act 2007 and replaces the role of the Responsible Medical Officer.

MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD renamed from MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT

Change to Supporting Information: Changed Name

- Changed Name from Data_Dictionary.NHS_Business_Definitions.M.Mental_Health_Responsible_Clinician_Assignment to Data_Dictionary.NHS_Business_Definitions.M.Mental_Health_Responsible_Clinician_Assignment_Period

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MENTAL HEALTH SERVICE

Change to Supporting Information: New Supporting Information

A Mental Health Service is a SERVICE.

A Mental Health Service is a SERVICE that provides specialist secondary mental health and/or Learning Disabilities and/or Autistic Spectrum Disorder SERVICES (irrespective of funding arrangements). This could be provided by ORGANISATIONS including:

- NHS Mental Health Trusts
- NHS Learning Disabilities Trusts
- NHS Acute Trusts
- NHS Care Trusts
- Independent Sector Healthcare Providers offering a service model that includes NHS funded and non-NHS funded PATIENTS
- Any qualified providers offering specialist secondary adult mental health, Learning Disabilities or Autistic Spectrum Disorder SERVICES.

SERVICES may be provided in various LOCATIONS and settings.

This supporting information is also known by these names:

Context	Alias
plural	Mental Health Services

MENTAL HEALTH SERVICES DATA SET OVERVIEW

Change to Supporting Information: New Supporting Information

The Mental Health Services Data Set (MHSDS) is a PATIENT level, output based, secondary uses data set which delivers robust, comprehensive, nationally consistent and comparable person-based information for children, young people and adults (including elderly people) who are in contact with specialist secondary Mental Health Services.

As a secondary uses data set, the Mental Health Services Data Set re-uses clinical and operational data for purposes other than direct PATIENT care and defines the data items, definitions and associated value sets to be extracted or derived from local information systems.

All ACTIVITY relating to PATIENTS who receive specialist secondary Mental Health Services and have, or are thought to have:

- A mental illness
- A Learning Disability
- An Autistic Spectrum Disorder
- Any combination of mental health, Learning Disability or Autistic Spectrum Disorder needs

are within scope of the Mental Health Services Data Set.

The scope of the Mental Health Services Data Set requires PATIENT record level data submission from SERVICES as follows:

For each PATIENT:

- If the care is wholly funded by the NHS: the data submission for that PATIENT is mandatory
- If the care is partially funded by the NHS: the data submission for that PATIENT is mandatory

- If the care is wholly funded by any means that is not NHS: the data submission for that PATIENT is optional.

Children and adolescents (including those with a Learning Disability and/or Autistic Spectrum Disorder) under the age of 18 should also be included where they are in receipt of care from a specialist secondary mental health, Learning Disabilities or Autistic Spectrum Disorder SERVICE or an Early Intervention in Psychosis (EIP) Service.

Children and young people in receipt of psychological therapies covered under the Children and Young People's Improving Access to Psychological Therapies Programme (CYP IAPT) are also included within the scope of this standard. However, ACTIVITY covered in the Adult Improving Access to Psychological Therapies Programme (IAPT) is out of scope; this is submitted under the Improving Access to Psychological Therapies Data Set.

The Mental Health Services Data Set is used across the range of Health Care Providers and ORGANISATIONS that provide specialist secondary mental health and/or Learning Disabilities and/or Autistic Spectrum Disorder SERVICES (irrespective of funding arrangements) including:

- NHS Mental Health Trusts
- NHS Learning Disabilities Trusts
- NHS Acute Trusts
- NHS Care Trusts
- Independent Sector Healthcare Providers offering a service model that includes NHS funded and non-NHS funded PATIENTS
- Any qualified provider offering specialist secondary mental health, Learning Disability or Autistic Spectrum Disorder SERVICES.

Further information regarding the structure and submission of the Mental Health Services Data Set can be found on the Health and Social Care Information Centre at: Mental Health Services Data Set (MHSDS).

NON-INSTRUCTED ADVOCATE

Change to Supporting Information: New Supporting Information

A Non-Instructed Advocate is a PERSON.

A Non-Instructed Advocate assists PATIENTS who are unable to communicate their views and wishes relating to the decision to be made.

For further information on Non-Instructed Advocate, see the Office of Public Guardian and Department of Health part of the gov.uk website.

This supporting information is also known by these names:

Context	Alias
plural	Non-Instructed Advocates

ONWARD REFERRAL DATE

Change to Supporting Information: New Supporting Information

An Onward Referral Date is an ACTIVITY DATE TIME.

An Onward Referral Date is the date the PATIENT was referred from one SERVICE to another SERVICE, which may be in the same or a different ORGANISATION.

This supporting information is also known by these names:

Context	Alias
plural	Onward Referral Dates

OUT-PATIENT APPOINTMENT NON-CONSULTANT

Change to Supporting Information: Changed Description

An Out-Patient Appointment Non-Consultant is an APPOINTMENT.

An Out-Patient Appointment Non-Consultant is an Out-Patient Appointment.

An Out-Patient Appointment Non-Consultant is an APPOINTMENT for a PATIENT to see or have contact with a CARE PROFESSIONAL, other than a CONSULTANT or member of the CONSULTANT's firm, at an Out-Patient Clinic.

~~The APPOINTMENT may result in a Clinic Attendance Non-Consultant or a Professional Staff Group Contact.~~The APPOINTMENT may result in a Clinic Attendance Non-Consultant.

OUT-PATIENT ATTENDANCE CONSULTANT

Change to Supporting Information: Changed Description

An Out-Patient Attendance Consultant is a CARE CONTACT.

An Out-Patient Attendance Consultant is an attendance at which a PATIENT is seen by or has contact with (face to face or via telephone/telemedicine) a CONSULTANT, in respect of one referral, that is not a visit to the home of a PATIENT for which a fee is payable under paragraph 140 of the Terms and Conditions of Service.

For an Out-Patient Attendance Consultant, a CONSULTANT includes a member of the CONSULTANT's firm or locum for such a member.

An Out-Patient Attendance Consultant will be part of a Consultant Out-Patient Episode.

If a PATIENT is seen by a CONSULTANT at a Consultant Clinic then this will be a Clinic Attendance Consultant. An attendance may involve more than one PERSON (e.g. a family). The number of attendances to be recorded should be the number of PATIENTS for whom the particular CONSULTANT has identifiable individual records and which will be maintained as a result of the attendance.

A visit to the home of a PATIENT made at the instance of a hospital or specialist to review the urgency of a proposed admission to hospital, or to continue to supervise treatment initiated or prescribed at a hospital or clinic is covered by this definition.

Out-Patient Attendance Consultant also includes a PATIENT being seen by a CONSULTANT from a different MAIN SPECIALTY CODE during a Consultant Episode (Hospital Provider) in circumstances where there is no transfer of responsibility for the care of the PATIENT.

~~If the PATIENT is currently subject to a Mental Health Care Spell and the CONSULTANT they are in contact with during attendance is their allocated Care Programme Approach care coordinator then a Face To Face Contact CPA Care Coordinator should also be recorded.~~

During the Out-Patient Attendance Consultant, a number of PATIENT DIAGNOSES and Patient Procedures may be recorded.

A series of Out-Patient Attendance Consultant will form a Consultant Out-Patient Episode, generated from a single referral. Note that it is possible to have two Consultant Out-Patient Episodes with the same CONSULTANT for different clinical conditions, if two referrals are made. An attendance may involve more than one PERSON - for example, a family. Out-Patient Attendance Consultant can take place outside a clinic session, and can take place at the PATIENT's normal place of residence.

A PATIENT attending a WARD for examination or care will be counted as an Out-Patient Attendance Consultant if he/she is seen by a doctor. If they are only seen by a NURSE, they are a Ward Attendance.

An Out-Patient Attendance Consultant should also be recorded where a PATIENT is seen by a CONSULTANT from a different MAIN SPECIALTY CODE during a Consultant Episode (Hospital Provider) where there is no transfer of responsibility for the care of the PATIENT. For example, a PATIENT who is admitted to hospital under a Gastroenterology specialty following an overdose may be seen while still in hospital by a psychiatrist who has been asked to assess their mental condition. The assessment by the psychiatrist should be recorded as an Out-Patient Attendance Consultant.

~~Information recorded for an Out-Patient Attendance Consultant includes:~~

- ~~ATTENDANCE DATE~~
- ~~ATTENDANCE IDENTIFIER~~
- ~~CONSULTATION MEDIUM USED~~
- ~~FIRST ATTENDANCE~~
- ~~ACTIVITY LOCATION TYPE CODE~~
- ~~MEDICAL STAFF TYPE SEEING PATIENT~~ ~~O~~
- ~~OUTCOME OF ATTENDANCE~~

PATIENT PROXY

Change to Supporting Information: Changed Description

A Patient Proxy is a PERSON.

A Patient Proxy is a representative of the PATIENT. ~~This is most likely to be the case where the PATIENT is unable to communicate effectively, for example, for an infant or a PERSON who is mentally ill or who has learning disabilities.~~ This is most likely to be the case where the PATIENT is unable to communicate effectively, for example, for an infant or a PERSON who is mentally ill or who has Learning Disabilities.

PLANNED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)

Change to Supporting Information: New Supporting Information

Planned Discharge Date (Hospital Provider Spell) is a PLANNED ACTIVITY DATE TIME.

Planned Discharge Date (Hospital Provider Spell) is the date a PATIENT was planned to be discharged from a Hospital Provider Spell.

This supporting information is also known by these names:

Context	Alias
plural	Planned Discharge Dates (Hospital Provider Spell)

REFERRAL CLOSURE DATE

Change to Supporting Information: New Supporting Information

A Referral Closure Date is an ACTIVITY DATE TIME.

A Referral Closure Date is the DATE the REFERRAL REQUEST was closed by a SERVICE.

This supporting information is also known by these names:

Context	Alias
plural	Referral Closure Dates

REFERRAL REJECTION DATE

Change to Supporting Information: New Supporting Information

A Referral Rejection Date is an ACTIVITY DATE TIME.

A Referral Rejection Date is the DATE the REFERRAL REQUEST was rejected by a SERVICE.

This supporting information is also known by these names:

Context	Alias
plural	Referral Rejection Dates

REPLACEMENT APPOINTMENT BOOKED DATE

Change to Supporting Information: New Supporting Information

A Replacement Appointment Booked Date is an ACTIVITY DATE TIME.

A Replacement Appointment Booked Date is the DATE on which a replacement APPOINTMENT was booked following the cancellation of an APPOINTMENT with the PATIENT by the Health Care Provider.

This supporting information is also known by these names:

Context	Alias
plural	Replacement Appointment Booked Dates

REPLACEMENT APPOINTMENT DATE OFFERED

Change to Supporting Information: New Supporting Information

A Replacement Appointment Date Offered is an ACTIVITY DATE TIME.

A Replacement Appointment Date Offered is the replacement APPOINTMENT DATE offered to the PATIENT by the Health Care Provider following the cancellation of an APPOINTMENT.

This supporting information is also known by these names:

Context	Alias
plural	Replacement Appointment Dates Offered

RESTRICTIVE INTERVENTION

Change to Supporting Information: New Supporting Information

A Restrictive Intervention is a CLINICAL INTERVENTION.

Restrictive Interventions are defined by the Department of Health as:

- Deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to:
  - take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and
  - end or reduce significantly the danger to the person or others; and
  - contain or limit the person's freedom for no longer than is necessary.

For further information on Restrictive Interventions, see the Department of Health part of the gov.uk website at: Positive and Proactive Care: reducing the need for restrictive interventions.

This supporting information is also known by these names:

Context	Alias
plural	Restrictive Interventions

SERVICE DISCHARGE DATE

Change to Supporting Information: New Supporting Information

A Service Discharge Date is an ACTIVITY DATE TIME.

A Service Discharge Date is the DATE a PATIENT was discharged from a SERVICE.

This supporting information is also known by these names:

Context	Alias
plural	Service Discharge Dates

WARD ATTENDANCE

Change to Supporting Information: Changed Description

A Ward Attendance is a CARE CONTACT.

A Ward Attendance is an attendance at a WARD by a PATIENT for nursing care, where the PATIENT is not currently admitted to that Health Care Provider. A Ward Attendance should be recorded for only one Nurse or Midwife Contact. If the attendance is primarily for the purpose of examination or treatment by a doctor it is an

Out-Patient Attendance Consultant and not a Ward Attendance. The care is for the prevention, cure, relief or investigation because of a disease, injury, health problem or other factor affecting their health status and may include one or more Patient Procedures. This includes:-

a. Disease (physical or mental) confirmed or suspected - inclusive of undiagnosed signs or symptoms.
b. Injury - inclusive of poisoning - confirmed or suspected.
c. Health problem e.g. prostheses or graft in situ
~~d. Other factors influencing the health status of non-sick PERSONS e.g~~
d. Other factors influencing the health status of non-sick PERSONS e.g.
    i. pregnancy
    ii. sexual and reproductive health (formerly known as family planning)
    iii. potential donor (organ or tissue)
    iv. potential problem requiring prophylactic (preventative) care
    v. bereavement or other problem requiring health professional counselling
    vi. cosmetic surgery
    vii. other

The ADMINISTRATIVE CATEGORY of the PATIENT can be recorded for the Ward Attendance.

The PATIENT's FIRST ATTENDANCE CODE whether the first in a series or the only attendance should be recorded.

~~If the PATIENT is currently subject to a Mental Health Care Spell and during attendance is in contact with the NURSE who is their allocated care programme approach care coordinator then a Face To Face Contact CPA Care Coordinator should also be recorded.~~

WARD STAY

Change to Supporting Information: Changed Description

A Ward Stay is an ACTIVITY GROUP.

A Ward Stay is the time a PATIENT, using a Hospital Bed and/or using a delivery facility, stays in one WARD.

Each Ward Stay is within only one Hospital Provider Spell.

~~When a PATIENT takes Home Leave, Mental Health Leave of Absence or has a current period of Mental Health Absence Without Leave, this should be recorded as a WARD transfer to 'Home Leave', 'leave of absence' or 'absence without leave' and a new Ward Stay should begin on return. In the case of Home Leave, the Nursing Episode, Midwife Episode or Consultant Episode (Hospital Provider), Hospital Stay or Hospital Provider Spell however remain uninterrupted. In the case of Mental Health Leave of Absence and Mental Health Absence Without Leave, the Nursing Episode, Midwife Episode, Consultant Episode (Hospital Provider) or Hospital Provider Spell however will only remain uninterrupted if the absence is for a period of 28 days or less.~~When a PATIENT takes Home Leave, Mental Health Leave of Absence or has a current period of Mental Health Absence Without Leave, this should be recorded as a WARD transfer and a new Ward Stay should begin on return.

In the case of Home Leave, the Nursing Episode, Midwife Episode, Consultant Episode (Hospital Provider), Hospital Stay or Hospital Provider Spell however remain uninterrupted.

In the case of Mental Health Leave of Absence and Mental Health Absence Without Leave, the Nursing Episode, Consultant Episode (Hospital Provider) or Hospital Provider Spell however will only remain uninterrupted if the absence is for a period of 28 days or less.

In the case of PATIENTS using maternity WARDS of the same type on the same site, these should be recorded as one WARD. There will therefore only be one Ward Stay rather than transfers between WARDS. For local purposes, however, such transfers may be identified.

~~For PATIENTS subject to a Mental Health Care Spell the End Time of the Ward Stay should be recorded, as well as the Start Time if systems permit.~~

For each Ward Stay there should be a named NURSE or MIDWIFE who is responsible for the nursing or midwifery care of the PATIENT. If the named NURSE or MIDWIFE changes, the change is recorded.

ACCOMMODATION

Change to Class: Changed Attributes

Attributes of this Class are:

K ACCOMMODATION STATUS CODE
SETTLED ACCOMMODATION INDICATOR

ACTIVITY GROUP

Change to Class: Changed Relationships, Attributes

Attributes of this Class are:

A and E INCIDENT LOCATION TYPE
A and E PATIENT GROUP
ACTIVITY GROUP TYPE
ADMISSION METHOD
ASSAULT METHOD
BABY FIRST FEED BREAST MILK STATUS
BREASTFEEDING STATUS
CANCER OR SYMPTOMATIC BREAST REFERRAL PATIENT STATUS
CANCER REFERRAL TO TREATMENT PERIOD START DATE
CANCER SCREENING STATUS
CANCER SPECIALIST REFERRAL DATE
CANCER TREATMENT INTENT
CANCER TREATMENT PERIOD START DATE
CARE PROGRAMME APPROACH LEVEL
CARE PROGRAMME APPROACH REVIEW ABUSE QUESTION ASKED INDICATOR
CARER RESIDENT INDICATION CODE FOR NATIONAL NEONATAL DATA SET
CHILD AND ADOLESCENT MENTAL HEALTH INTERVENTION TYPE
CHILDREN TEENAGERS AND YOUNG ADULTS AGE CATEGORY
COMMUNITY TREATMENT ORDER END REASON
COMPLEX SOCIAL FACTORS INDICATOR
DAUGHTER BORN AT THIS ENCOUNTER INDICATOR
DELIVERY PLACE CHANGE REASON
DISCHARGE DESTINATION
DISCHARGED TO HOSPITAL AT HOME SERVICE INDICATOR
DISCHARGE FROM MENTAL HEALTH SERVICE REASON
DISCHARGE METHOD
ESTIMATED DATE OF DELIVERY
ESTIMATED DATE OF DELIVERY METHOD
FEMALE GENITAL MUTILATION AGE CATEGORY
FIRST REGULAR DAY OR NIGHT ADMISSION
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES CARE SPELL END CODE
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES OPT IN DATE
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES STEPPED CARE INTENSITY DELIVERED
INCIDENT TYPE

IN LABOUR BEFORE CAESARIAN SECTION INDICATOR
INTENDED DELIVERY PLACE
INTRAVESICAL CHEMOTHERAPY RECEIVED INDICATOR
INTRAVESICAL IMMUNOTHERAPY RECEIVED INDICATOR
KEY WORKER SEEN INDICATOR
LENGTH OF STAY ADJUSTMENT
LENGTH OF STAY ADJUSTMENT REASON
MATERNAL CRITICAL INCIDENT TYPE
MECONIUM PRESENT IN LIQUOR INDICATOR
~~MENTAL HEALTH ABSOLUTE DISCHARGE END METHOD~~
MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY
MENTAL HEALTH CONDITIONAL DISCHARGE END REASON
MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE
MENTAL HEALTH DELAYED DISCHARGE REASON
MONITORING INTENT
MOTHER ANTENATALLY BOOKED INDICATOR
NEONATAL CRITICAL INCIDENT TYPE
NEONATAL LEVEL OF CARE
NON SMOKING CONFIRMATION STATUS AT 4 WEEKS
ORGAN OR TISSUE UNSUITABLE ORGAN CODE RENAL TRANSPLANT
OUTCOME AT 4 WEEK FOLLOW-UP
PAEDIATRIC NEPHROLOGY REGISTRY STATUS CODE
PALLIATIVE CARE SPECIALIST SEEN INDICATOR
PALLIATIVE TREATMENT REASON CODE FOR UPPER GASTROINTESTINAL
PATIENT CLASSIFICATION
PATIENT RECEIVING ONE TO ONE NURSING CARE INDICATOR
PHARMACOTHERAPY STOP SMOKING AID RECEIVED
PREGNANCY OUTCOME CODE
PREGNANCY PREVIOUS CAESAREAN SECTIONS
PREGNANCY TOTAL LIVE BIRTHS
PREGNANCY TOTAL PREVIOUS LOSSES LESS THAN 24 WEEKS
PREGNANCY TOTAL PREVIOUS PREGNANCIES
PREGNANCY TOTAL STILL BIRTHS
PREVIOUS NEGATIVE HIV TEST IN UNITED KINGDOM INDICATOR
RADIOTHERAPY INTENT
RENAL DIALYSIS SCHEDULE TYPE
SMOKING QUIT DATE
SOURCE OF ADMISSION
~~SUPERVISED COMMUNITY TREATMENT END REASON~~
TIME BETWEEN DELIVERY AND SPONTANEOUS RESPIRATION CODE
TREATMENT START DATE FOR CANCER

ACTIVITY GROUP

Change to Class: Changed Relationships, Attributes

Each ACTIVITY GROUP

may be punctuated by one or more ACTIVITY SUSPENSION
may be classified by one or more ADMINISTRATIVE CATEGORY PERIOD
may be classified by one and only one BROAD PATIENT GROUP
may be the originator for one or more CARE PLAN
may be initiated by one and only one DECISION TO ADMIT
may be the result of one or more ELECTIVE ADMISSION LIST ENTRY
may be initiated by one and only one ELECTIVE ADMISSION LIST ENTRY
may be punctuated by one or more LEAVE

may be classified by one and only one LOCAL SUB-SPECIALTY
may be subject to one or more LODGED PATIENT
may be result in one or more PATIENT CLINICAL TRIAL STATUS
may be the context for one or more PERSON PROPERTY
may be classified by one or more PERSON PROPERTY ASSIGNMENT PERIOD
may be reference one or more SUBSTANCE MISUSED

ADMINISTRATIVE CATEGORY

Change to Class: Changed Description

Identifies if a PATIENT is required to pay for treatment provided within a particular ACTIVITY or for transport.

~~The same ADMINISTRATIVE CATEGORY will usually apply during the whole of a spell or episode but it may change, e.g. a PATIENT may start as an NHS PATIENT, but then opt to change to a private patient.~~

ADMINISTRATIVE CATEGORY PERIOD

Change to Class: Changed Description

A period of time during an ACTIVITY GROUP for which an ADMINISTRATIVE CATEGORY applies. ~~The same ADMINISTRATIVE CATEGORY will usually apply during the whole of the Hospital Provider Spell, Consultant Out-Patient Episode or Regular Attender Episode, but may change e.g. a PATIENT may start with an ADMINISTRATIVE CATEGORY of "NHS Patient", but then opt to change to "Private Patient".~~

The ADMINISTRATIVE CATEGORY will usually apply during the whole of an ACTIVITY, but may change e.g. a PATIENT may start with an ADMINISTRATIVE CATEGORY CODE of "NHS PATIENT", but then opt to change to "Private PATIENT".

APPOINTMENT

Change to Class: Changed Description

An arrangement for a PATIENT to be seen by or be in contact with one or more CARE PROFESSIONALS, following an Appointment Request.

An APPOINTMENT becomes an entry on the APPOINTMENT WAITING LIST when it is decided that an offer of an APPOINTMENT should be made following a SERVICE REQUEST for an out-patient APPOINTMENT being received. The offer of an APPOINTMENT is made by one or more APPOINTMENT OFFERS.

APPOINTMENTS include:

- Out-Patient Appointment Consultant
- Out-Patient Appointment Non-Consultant

~~APPOINTMENTS are also made for Screening Tests and Day Care Attendances.~~APPOINTMENTS are also made for Screening Tests.

When a PATIENT accepts an APPOINTMENT OFFER the APPOINTMENT DATE OFFERED and APPOINTMENT TIME OFFERED of the offer become the APPOINTMENT DATE and APPOINTMENT TIME of the accepted APPOINTMENT.

Where more than one APPOINTMENT OFFER has been made for an APPOINTMENT and one has been accepted all the others for the same APPOINTMENT should be refused.

The APPOINTMENT should be removed from the APPOINTMENT WAITING LIST when the APPOINTMENT has taken place.

A series of APPOINTMENTS should relate to the same SERVICE REQUEST which initiated the series within the ORGANISATION. The SERVICE REQUEST may be related to a previous SERVICE REQUEST either from within the same or another ORGANISATION and be related to subsequent SERVICE REQUEST to the same or another ORGANISATION.

ASSESSMENT TOOL

Change to Class: Changed Attributes

Attributes of this Class are:

ASSESSMENT TOOL COMPLETION POINT
ASSESSMENT TOOL TYPE
CLUSTERING TOOL ASSESSMENT CATEGORY
CLUSTERING TOOL ASSESSMENT REASON
EXPERIENCE OF SERVICE QUESTIONNAIRE VERSION
HEALTH OF THE NATION OUTCOME SCALE CHILDREN AND ADOLESCENTS VERSION
~~MENTAL HEALTH CLUSTERING TOOL ASSESSMENT REASON~~
STRENGTHS AND DIFFICULTIES QUESTIONNAIRE VERSION

CARE CLUSTER renamed from MENTAL HEALTH CARE CLUSTER

Change to Class: Changed Name, Attributes, Description

~~A MENTAL HEALTH CARE CLUSTER is part of a currency developed to support the National Tariff Payment System for Mental Health Services.~~A CARE CLUSTER is a way of measuring the outcome of an assessment using a pre agreed set of assessment measures.

~~Mental Health Care Clusters are 21 groupings of Mental Health~~ PATIENTS ~~based on their characteristics, and are a way of classifying individuals utilising Mental Health Services that forms the basis for payment.~~Each CARE CLUSTER has a set of corresponding scores that indicate a level of need which is then linked to a specific care package attached to that CARE CLUSTER.

CARE CLUSTER renamed from MENTAL HEALTH CARE CLUSTER

Change to Class: Changed Name, Attributes, Description

Attributes of this Class are:

~~MENTAL HEALTH CARE CLUSTER CODE~~
ADULT MENTAL HEALTH CARE CLUSTER CODE
CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE
FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE
FORENSIC MENTAL HEALTH CARE CLUSTER CODE
LEARNING DISABILITIES CARE CLUSTER CODE
MENTAL HEALTH CARE CLUSTER END REASON
MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE

CARE CLUSTER renamed from MENTAL HEALTH CARE CLUSTER

Change to Class: Changed Name, Attributes, Description

- Changed Name from Data_Dictionary.Classes.M.MENTAL_HEALTH_CARE_CLUSTER to Data_Dictionary.Classes.C.CARE_CLUSTER
- Changed Attributes
- Changed Description

CARE CONTACT

Change to Class: Changed Attributes

Attributes of this Class are:

A and E ATTENDANCE CATEGORY
A and E INITIAL ASSESSMENT TRIAGE CATEGORY
A and E STREAM
ACCIDENT AND EMERGENCY ARRIVAL MODE
ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL
ANTIRETROVIRAL THERAPY HOME DELIVERY INDICATOR
ANTIRETROVIRAL THERAPY REGIMEN GROUP CODE
BRIEF INTERVENTION PROVIDED INDICATOR
BRIEF INTERVENTION TYPE FOR NHS HEALTH CHECK
~~CARE CONTACT CANCELLATION DATE~~
CARE CONTACT CANCELLATION REASON
~~CARE CONTACT DATE~~
CARE CONTACT SERVICE TYPE FOR CHILDREN AND YOUNG PEOPLES HEALTH SERVICE SECONDARY USES
CARE CONTACT SUBJECT
~~CARE CONTACT TIME~~
CARE CONTACT TYPE
CARE CONTACT TYPE FOR CHILDREN AND YOUNG PEOPLES HEALTH SERVICE SECONDARY USES
CARE CONTACT TYPE FOR COMMUNITY CARE
CHILD DIFFICULT TO TEST REASON
CLINICAL NURSE SPECIALIST INDICATION CODE
CLINIC ATTENDANCE PURPOSE CODE FOR HIV
COLPOSCOPY PRIME PROCEDURE TYPE
CONSULTATION MEDIUM USED
CONSULTATION TYPE
CONTRACEPTIVE SERVICE TYPE
DECISION TO UNDERTAKE FURTHER ASSESSMENT INDICATOR
DIETARY ADVICE REASON CODE
EMPLOYMENT SUPPORT SUITABILITY INDICATOR
FACE TO FACE COMMUNICATION MODE
FEMALE GENITAL MUTILATION IDENTIFICATION METHOD CODE
FIRST ANTIRETROVIRAL THERAPY IN THE UNITED KINGDOM INDICATOR
FIRST ATTENDANCE
FURTHER ASSESSMENT TYPE FOR NHS HEALTH CHECK
HOLISTIC NEEDS ASSESSMENT POINT OF PATHWAY FOR CANCER
INFORMATION AND ADVICE PROVIDED INDICATOR
INFORMATION AND ADVICE TYPE PROVIDED FOR FEMALE GENITAL MUTILATION
INFORMATION AND ADVICE TYPE PROVIDED FOR NHS HEALTH CHECK
INITIAL CONTACT INDICATOR
INITIAL DIAGNOSIS CARE SETTING FOR HIV
MEDICAL STAFF TYPE SEEING PATIENT
METASTATIC STATUS
MULTIPROFESSIONAL OR MULTIDISCIPLINARY INDICATION CODE
NEW HIV DIAGNOSIS IN UNITED KINGDOM INDICATOR
OTHER PERSON IN ATTENDANCE AT CARE CONTACT

OUTCOME OF ATTENDANCE
OUTCOME OF ATTENDANCE FOR CHILDREN AND YOUNG PEOPLES HEALTH SERVICE SECONDARY USES
PATIENT EXPOSURE TO HIV
PATIENT HIV CARE STATUS
PATIENT TRIAL STATUS FOR CANCER
POST AND/OR PRE EXPOSURE PROPHYLAXIS CODE
POSTNATAL CARE INDICATOR
PREGNANCY INDICATOR FOR HIV
PSYCHIATRIC CARE INDICATOR FOR HIV
~~SETTLED ACCOMMODATION INDICATOR~~
SIGNPOSTING TO SERVICE INDICATOR
SIGNPOSTING TO SERVICE TYPE FOR NHS HEALTH CHECK
SKIN TO SKIN CONTACT INDICATOR
SOCIAL WORKER CARE INDICATOR FOR HIV
STATUTORY ASSESSMENT TYPE
SUBJECTIVE GLOBAL ASSESSMENT
THERAPY TYPE FOR IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES
TWO YEAR NEONATAL OUTCOMES ASSESSMENT NOT CARRIED OUT REASON
URGENT CARE SERVICE ACCESSED TYPE

CARE PLAN

Change to Class: Changed Attributes

Attributes of this Class are:

K CARE PLAN NUMBER
CANCER CARE PLAN INTENT
CANCER RECURRENCE CARE PLAN INDICATOR
CARE PLAN AGREED DATE
CARE PLAN END DATE FOR CHILD PROTECTION PLAN
CARE PLAN START DATE FOR CHILD PROTECTION PLAN
CARE PLAN TYPE
~~CHILD PROTECTION PLAN INDICATOR~~
CHILD PROTECTION PLAN INDICATION CODE
CHILD PROTECTION PLAN REASON CODE
MULTIDISCIPLINARY TEAM CANCER CARE PLAN DISCUSSED INDICATOR
MULTIDISCIPLINARY TEAM MEETING TYPE FOR CANCER
NO CANCER TREATMENT REASON

CARE PROFESSIONAL

Change to Class: Changed Attributes, Description

A PERSON who has a PROFESSIONAL REGISTRATION with a PROFESSIONAL REGISTRATION BODY.

~~Some CARE PROFESSIONALS, acting in a MENTAL HEALTH RESPONSIBLE CLINICIAN PROFESSION, may be the CARE PROFESSIONAL responsible for clinical decisions during a Mental Health Care Spell.~~

CARE PROFESSIONAL TYPE CODE provides a list of CARE PROFESSIONALS.

CARE PROFESSIONAL

Change to Class: Changed Attributes, Description

Attributes of this Class are:

K	CARE PROFESSIONAL IDENTIFIER
	CARE PROFESSIONAL FIRST ASSISTANT GRADE FOR JOINT REPLACEMENT
	CARE PROFESSIONAL LEAD OPERATING SURGEON GRADE FOR JOINT REPLACEMENT
	CARE PROFESSIONAL RETRIEVING SURGEON GRADE
	CARE PROFESSIONAL SENIOR OPERATING SURGEON GRADE FOR CANCER
	CARE PROFESSIONAL STAFF GROUP FOR COMMUNITY CARE
	CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH
	CARE PROFESSIONAL SURGEON GRADE FOR CANCER
	CARE PROFESSIONAL TYPE CODE
	JOB ROLE CLINICIAN TYPE FOR ORGAN DONATION
	MENTAL HEALTH RESPONSIBLE CLINICIAN PROFESSION
	PRIVATE CONTROLLED DRUG PRESCRIBER CODE
	REFERRING CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH AND COMMUNITY CARE

CARE PROFESSIONAL TEAM

Change to Class: Changed Description

A team of CARE PROFESSIONALS delivering specialist services to PATIENTS. ~~The team 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.~~

~~CARE PROFESSIONAL TEAMS include:~~The team 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.

- ~~Adult Mental Health Care Team~~
- ~~Child and Adolescent Mental Health Care Team~~

CARE PROFESSIONAL TEAM MEMBER

Change to Class: Changed Description

~~An association between a PERSON and a CARE PROFESSIONAL TEAM, which identifies a PERSON as being a member of a CARE PROFESSIONAL TEAM.~~An association between a CARE PROFESSIONAL and a CARE PROFESSIONAL TEAM, which identifies a CARE PROFESSIONAL as being a member of a CARE PROFESSIONAL TEAM.

CLINICAL INTERVENTION

Change to Class: Changed Attributes

Attributes of this Class are:

	ABDOMINAL XRAY PERFORMED REASON
	ABDOMINAL XRAY PERFORMED TO INVESTIGATE ABDOMINAL SIGNS INDICATOR
	ABLATIVE THERAPY TYPE
	ACCIDENT AND EMERGENCY INVESTIGATION
	ACCIDENT AND EMERGENCY TREATMENT
	ANAESTHESIA TYPE IN LABOUR AND DELIVERY
	ANAESTHETIC METHOD TYPE FOR DIALYSIS ACCESS CONSTRUCTION

ANAESTHETIC TYPE FOR JOINT REPLACEMENT
ANTI CANCER REGIMEN NUMBER
ARTERIOVENOUS GRAFT MATERIAL TYPE
ARTHROPLASTY REVISION TYPE
ARTIFICIAL RUPTURE OF MEMBRANES REASON CODE
ASA PHYSICAL STATUS CLASSIFICATION SYSTEM CODE
ASSOCIATED PROCEDURE TYPE FOR ANKLE REPLACEMENT
BILIARY STENT INSERTION REASON
BIOLOGICAL RESURFACING TYPE FOR SHOULDER REPLACEMENT
BLOOD FLOW RATE
BLOOD TRANSFUSION PRODUCT TYPE
BLOOD TRANSFUSION TYPE
BLOOD TRANSFUSION UNITS TRANSFUSED
BONE GRAFT INDICATION CODE FOR REVISION ANKLE REPLACEMENT
BONE GRAFT INDICATOR FOR JOINT REPLACEMENT
BONE GRAFT TYPE FOR REVISION ANKLE REPLACEMENT
BRACHYTHERAPY TYPE
BREAST ASSESSMENT OUTCOME
BREAST SCREENING TEST OUTCOME
CANCER IMAGING MODALITY
CANCER TREATMENT MODALITY
CHEMICAL THROMBOPROPHYLAXIS REGIME TYPE
CHEMO RADIATION INDICATOR
CHEMOTHERAPY ACTUAL DOSE
CHEST DRAIN IN SITU INDICATOR
CLINICAL INTERVENTION TYPE
CLINICAL INVESTIGATION NOT PERFORMED REASON CODE FOR MATERNITY
CO MORBIDITY ADJUSTMENT INDICATOR
COMPLICATION TYPE FOR RENAL DIALYSIS ACCESS
COMPONENT REMOVAL INDICATOR
CONTINUOUS INFUSION OF PULMONARY VASODILATOR RECEIVED INDICATOR
CONTINUOUS POSITIVE AIRWAY PRESSURE DELIVERY MODE
CONTRACEPTION METHOD STATUS
CYTOLOGY SCREENING ACTION TYPE
DEINFIBULATION UNDERTAKEN REASON
DELIVERED IN WATER INDICATOR
DELIVERY INSTRUMENT TYPE
DELIVERY OF PLACENTA METHOD
DRUG ADMINISTRATION DURATION
DRUG ADMINISTRATION STATUS
DRUG DAYS SUPPLY
DRUG DOSAGE AND ADMIN SPECIFICATION
DRUG IDENTIFICATION
DRUG INFORMATION COMMENT
DRUG INFORMATION TYPE
DRUG QUANTITY SUPPLIED
DRUG REGIMEN ACRONYM
DRUG TREATMENT INTENT
ENDOSCOPIC OR RADIOLOGICAL COMPLICATION TYPE
ENDOSCOPIC PROCEDURE TYPE
ENTERAL FEEDING METHOD
ENTERAL FEED TYPE GIVEN
EPISIOTOMY PERFORMED REASON CODE
EXCISION TYPE
FETAL ORDER

FIRST DEFINITIVE TREATMENT PROVIDED
FIRST DIAGNOSTIC TEST
FIXATION TYPE FOR ELBOW OR SHOULDER REPLACEMENT
FORMULA MILK OR MILK FORTIFIER TYPE
FRACTION NUMBER
HIP SURGERY PATIENT POSITION
IMAGE GUIDED SURGERY INDICATOR
IMAGING ANATOMICAL SITE
IMAGING INTERVENTION INDICATOR
IMAGING MODALITY
IMAGING OR RADIODIAGNOSTIC EVENT INDICATION CODE FOR RENAL CARE
INFECTION CULTURE TEST INDICATOR
INTERVENTION SESSION TYPE
INTRAPARTUM ANTIBIOTICS GIVEN INDICATOR
JOINT REPLACEMENT REVISION REASON CODE FOR ANKLE
JOINT REPLACEMENT REVISION REASON CODE FOR ELBOW
JOINT REPLACEMENT REVISION REASON CODE FOR HIP
JOINT REPLACEMENT REVISION REASON CODE FOR KNEE
JOINT REPLACEMENT REVISION REASON CODE FOR SHOULDER
KIDNEY TRANSPLANTED CODE
LABOUR FIRST STAGE LENGTH
LABOUR OR DELIVERY ONSET METHOD
LABOUR SECOND STAGE LENGTH
LAPAROTOMY FOR NECROTISING ENTEROCOLITIS INDICATION CODE
LONG HEAD BICEPS TENOTOMY INDICATOR
MARGIN INVOLVED INDICATION CODE
MECHANICAL THROMBOPROPHYLAXIS REGIME TYPE
MENTAL HEALTH INTERVENTION CODE
MINIMALLY INVASIVE SURGERY INDICATOR
MORE THAN THREE RECTAL WASHOUTS RECEIVED INDICATOR
NEOADJUVANT THERAPY INDICATOR
NEONATAL RESUSCITATION METHOD
NEONATAL RESUSCITATION METHOD FOR NATIONAL NEONATAL DATA SET
NEPHRECTOMY TYPE
NEURODEVELOPMENTAL ASSESSMENT ALREADY TAKEN INDICATOR
NEWBORN HEARING INCOMPLETE REASON CODE
NEWBORN HEARING SCREENING TEST TYPE
NITRIC OXIDE GIVEN INDICATOR
NUMBER OF TELETHERAPY FIELDS
OBSERVATION SCHEME IN USE
OPPORTUNISTIC SCREENING TYPE
PAIN RELIEF TYPE IN LABOUR AND DELIVERY
PARENTAL CONSENT TO ADMINISTER VITAMIN K INDICATOR
PARENTAL CONSENT TO POST MORTEM INDICATOR
PARENTERAL NUTRITION RECEIVED INDICATOR
PATHOLOGY INVESTIGATION PRIORITY
PATHOLOGY RESULT REPORTED DATE
PATIENT PROCEDURE PERFORMED INDICATOR
PATIENT PROCEDURE TYPE FOR PRIMARY ANKLE REPLACEMENT
PATIENT PROCEDURE TYPE FOR PRIMARY ELBOW REPLACEMENT
PATIENT PROCEDURE TYPE FOR PRIMARY HIP REPLACEMENT
PATIENT PROCEDURE TYPE FOR PRIMARY KNEE REPLACEMENT
PATIENT PROCEDURE TYPE FOR PRIMARY SHOULDER REPLACEMENT
PATIENT PROCEDURE TYPE FOR REVISION ANKLE REPLACEMENT
PATIENT PROCEDURE TYPE FOR REVISION ELBOW REPLACEMENT

PATIENT PROCEDURE TYPE FOR REVISION HIP REPLACEMENT
PATIENT PROCEDURE TYPE FOR REVISION KNEE REPLACEMENT
PATIENT PROCEDURE TYPE FOR REVISION SHOULDER REPLACEMENT
PATIENT SPECIFIC INSTRUMENTS INDICATOR FOR KNEE REPLACEMENT
PERFORATIONS OR SEROSAL INVOLVEMENT INDICATION CODE
PERITONEAL DIALYSIS CATHETER INSERTION TECHNIQUE
PERITONEAL DIALYSIS CATHETER TYPE
PERITONEAL DIALYSIS TREATMENT REGIME
PLANE OF SURGICAL EXCISION TYPE
PLANNED TREATMENT CHANGE REASON
POST MORTEM CARRIED OUT INDICATOR
POST MORTEM CONFIRMED NECROTISING ENTEROCOLITIS DIAGNOSIS INDICATOR
POST MORTEM TYPE
PREVIOUS BONY INFECTION INDICATOR OF TIBIA OR HINDFOOT
PREVIOUS FRACTURE INDICATOR FOR ANKLE REPLACEMENT
PREVIOUS SURGERY TYPE FOR ANKLE JOINT
PREVIOUS SURGERY TYPE FOR SHOULDER REPLACEMENT
PRINCIPAL DIAGNOSTIC IMAGING TYPE
PROCEDURE RENAL DIALYSIS ACCESS REPAIR OR REVISION TYPE
PROCEDURE SCHEME IN USE
PROCEDURE SIDE RENAL DIALYSIS ACCESS CONSTRUCTION CODE
PROCEDURE SITE RENAL DIALYSIS ACCESS CONSTRUCTION CODE
RADIOISOTOPE
RADIOLOGICAL PROCEDURE TYPE
RADIOTHERAPY ACTUAL DOSE
RADIOTHERAPY BEAM TYPE
RADIOTHERAPY PRESCRIBED DOSE
RADIOTHERAPY TREATMENT MODALITY
REMOVAL REASON TYPE FOR DIALYSIS ACCESS
RENAL DIALYSIS ACCESS TYPE
RENAL TRANSPLANT FAILURE CAUSE CODE
RENAL TREATMENT MODALITY CHANGE REASON CODE
RENAL TREATMENT MODALITY CODE
RENAL TREATMENT PRIMARY SUPERVISION CODE
REPLOGLE TUBE IN SITU INDICATOR
RESPIRATORY SUPPORT DEVICE TYPE FOR NATIONAL NEONATAL DATA SET
RESPIRATORY SUPPORT MODE FOR NATIONAL NEONATAL DATA SET
RESTRICTIVE INTERVENTION TYPE
RESULT SENT DIRECT
RETINOPATHY OF PREMATURITY SCREENING OUTCOME STATUS CODE
REVISION PROCEDURE TYPE FOR ANKLE OR KNEE REPLACEMENT
REVISION PROCEDURE TYPE FOR ELBOW OR SHOULDER REPLACEMENT
REVISION PROCEDURE TYPE FOR HIP REPLACEMENT
ROTATOR CUFF CONDITION
RUPTURE OF MEMBRANES METHOD
SARCOMA SURGICAL MARGIN
SENTINEL LYMPH NODE BIOPSY TYPE
SIGNIFICANT MATERNAL PYREXIA IN LABOUR INDICATOR
STEM CELL INFUSION DONOR TYPE
STEM CELL INFUSION SOURCE CODE
STENT DEPLOYED SUCCESS INDICATOR
STEROIDS GIVEN DURING PREGNANCY TO MATURE FETAL LUNGS INDICATOR
STOMA PRESENT INDICATOR
SURFACTANT GIVEN INDICATOR
SURGICAL ACCESS TYPE

SURGICAL ACCESS TYPE FOR THORACIC
SURGICAL APPROACH FOR PRIMARY HIP REPLACEMENT
SURGICAL APPROACH FOR PRIMARY KNEE REPLACEMENT
SURGICAL APPROACH FOR PRIMARY OR REVISION ANKLE REPLACEMENT
SURGICAL APPROACH FOR PRIMARY OR REVISION ELBOW REPLACEMENT
SURGICAL APPROACH FOR PRIMARY OR REVISION SHOULDER REPLACEMENT
SURGICAL APPROACH FOR REVISION HIP REPLACEMENT
SURGICAL APPROACH FOR REVISION KNEE REPLACEMENT
SURGICAL COMPLICATION TYPE
SURGICAL PALLIATION TYPE
SURGICAL VOICE RESTORATION PERMANENT VALVE REMOVAL REASON
SYSTEMIC ANTI CANCER THERAPY DRUG ROUTE OF ADMINISTRATION
SYSTEMIC ANTI CANCER THERAPY PROGRAMME NUMBER
SYSTEMIC ANTI CANCER THERAPY REGIMEN MODIFICATION INDICATOR
TELETHERAPY BEAM TYPE
TRACHEOSTOMY TUBE IN SITU INDICATOR
TREATMENT TYPE FOR NECROTISING ENTEROCOLITIS
TREATMENT TYPE FOR PATENT DUCTUS ARTERIOSUS
UNPLANNED OPERATION INDICATOR
UNTOWARD INTRAOPERATIVE EVENT CODE FOR ANKLE REPLACEMENT
UNTOWARD INTRAOPERATIVE EVENT CODE FOR ELBOW REPLACEMENT
UNTOWARD INTRAOPERATIVE EVENT CODE FOR HIP REPLACEMENT
UNTOWARD INTRAOPERATIVE EVENT CODE FOR KNEE REPLACEMENT
UNTOWARD INTRAOPERATIVE EVENT CODE FOR SHOULDER REPLACEMENT
VASCULAR LINE TYPE IN SITU
VISUAL INSPECTION CONFIRMED NECROTISING ENTEROCOLITIS DURING LAPAROTOMY INDICATOR
VITAMIN K ADMINISTERED INDICATOR
VITAMIN K ROUTE OF ADMINISTRATION

CLINICAL INVESTIGATION RESULT ITEM

Change to Class: Changed Attributes

Attributes of this Class are:

K	INVESTIGATION RESULT DATE
K	INVESTIGATION RESULT TIME
	ABNORMALITY DETECTED INDICATOR
	ALBUMINURIA STAGE
	ALK 1 STATUS
	ANKLE DORSIFLEXION CODE
	ANKLE PLANTARFLEXION CODE
	ARITHMETIC COMPARATOR
	BIOPSY REFERRAL OUTCOME
	BREAST BIOPSY REFERRAL OUTCOME
	BREAST CANCER HISTOLOGICAL TYPE
	BREAST SCREENING MAMMOGRAPHY OUTCOME CODE
	CALCULATED CREATININE CLEARANCE TYPE
	CANCER VASCULAR OR LYMPHATIC INVASION
	CENTRAL TONE STATUS
	CERVICAL GLANDULAR INTRAEPITHELIAL NEOPLASIA PRESENCE AND GRADE
	CERVICAL NODE STATUS
	CERVICAL SMEAR EXAMINED DATE
	CHLAMYDIA TEST RESULT
	CLINICAL ASSESSMENT RESULT CODE FOR BREAST CANCER

CLINICAL INVESTIGATION ITEM TYPE
CLINICAL INVESTIGATION ITEM UNIT OF MEASURE
CLINICAL INVESTIGATION RESULT CODE FOR RENAL CARE
CLINICAL INVESTIGATION RESULT CODE FOR RENAL TRANSPLANT
CLINICAL INVESTIGATION RESULT VALUE
CONDITION SEEN IN ABDOMEN DURING XRAY
CYSTIC PERIVENTRICULAR LEUKOMALACIA OBSERVED DURING CRANIAL ULTRASOUND SCAN INDICATOR
CYTOGENETIC ANALYSIS CODE
CYTOGENETIC PRESENCE TYPE FOR RHABDOMYOSARCOMA
CYTOGENETIC RISK CODE
CYTOLOGY RESULT TYPE
CYTOLOGY SMEAR REASON
DEGREES OF FIXED FLEXION DEFORMITY
DEGREES OF FLEXION RANGE
DETRUSOR MUSCLE PRESENCE INDICATION CODE
DEVIATING RESULT INDICATOR
DIPSTICK TEST RESULT CODE
EPIDERMAL GROWTH FACTOR RECEPTOR MUTATIONAL STATUS
EXCISION MARGIN INDICATION CODE
FINDING SCHEME IN USE
GENETIC CONFIRMATION INDICATOR
GRADE OF DIFFERENTIATION
HAEMOGLOBINOPATHY INVESTIGATION RESULT CODE FOR NATIONAL NEONATAL DATA SET
HbA1C ASSAY MEASUREMENT METHOD
HEPATOMEGALY INDICATOR
HORMONE EXPRESSION TYPE
INTRAVENTRICULAR HAEMORRHAGE GRADE
INVASIVE CANCER SPECIAL TYPE INDICATOR
INVESTIGATION EXAMINATION RESULT CODE
INVESTIGATION HAEMOGLOBINOPATHY RESULT CODE
INVESTIGATION RESULT STATUS CODE
INVESTIGATION RESULT TEXT
INVESTIGATION RISK RATIO RESULT CODE
INVESTIGATION RUBELLA RESULT INDICATOR
INVESTIGATION SENSITISED RESULT INDICATOR
KARYOTYPE TEST OUTCOME
LACTATE DEHYDROGENASE LEVEL
LYMPH NODE STATUS
MAMMOGRAM RESULT CODE
MEASURED GLOMERULAR FILTRATION RATE TYPE CODE
METASTASIS EXTENT CODE
NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE
NEWBORN HEARING AUDIOLOGY OUTCOME
NEWBORN HEARING SCREENING OUTCOME
NUMBER OF FETUSES
NUMERICAL VALUE
OBSERVATION VALUE
PATHOLOGICAL RISK CLASSIFICATION CODE AFTER NEPHRECTOMY
PATHOLOGICAL RISK CLASSIFICATION CODE AFTER PREOPERATIVE CHEMOTHERAPY
PERSON BLOOD GROUP
PERSON RHESUS FACTOR
PHYSIOLOGICAL MEASUREMENT INDICATION CODE FOR ELECTROCARDIOGRAM
PORENCEPHALIC CYST VISIBLE DURING CRANIAL ULTRASOUND SCAN INDICATOR
PREOPERATIVE THERAPY RESPONSE TYPE

RADIOLOGICAL RESULT VERIFIED DATE
RADIOLOGICAL RESULT VERIFIED TIME
RESULT ITEM STATUS
RETINOPATHY OF PREMATURITY CLOCK HOURS MAXIMUM STAGE
RETINOPATHY OF PREMATURITY MAXIMUM ZONE
RETINOPATHY OF PREMATURITY PLUS DISEASE STATUS
RETINOPATHY OF PREMATURITY STAGE
S CATEGORY CODE
SERUM CALCIUM CONCENTRATION CORRECTION CODE
SPECIMEN NATURE
SPLEEN BELOW COSTAL MARGIN
SPLENOMEGALY INDICATOR
SUBTALAR JOINT MOVEMENT CODE
TIBIA HINDFOOT ALIGNMENT CODE
TUMOUR NECROSIS
ULTRASOUND RESULT CODE FOR BREAST CANCER
VENTRICULAR DILATION DIAGNOSED DURING CRANIAL ULTRASOUND SCAN INDICATOR

DISABILITY

Change to Class: Changed Attributes

Attributes of this Class are:

CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR
DISABILITY CODE
DISABILITY IMPACT PERCEPTION
LEARNING DISABILITY INDICATOR
PHYSICAL DISABILITY INDICATOR

LANGUAGE renamed from LANGUAGE CLASSIFICATION

Change to Class: Changed Name, Description

~~A classification of a language used by a PERSON.~~A language used by a PERSON.

LANGUAGE renamed from LANGUAGE CLASSIFICATION

Change to Class: Changed Name, Description

- Changed Name from Data_Dictionary.Classes.L.LANGUAGE_CLASSIFICATION to Data_Dictionary.Classes.L.LANGUAGE
- Changed Description

LEAVE

Change to Class: Changed Attributes

Attributes of this Class are:

K LEAVE START DATE
~~ABSENCE WITHOUT LEAVE END REASON~~
LEAVE END DATE
~~LEAVE OF ABSENCE END REASON~~
LEAVE TYPE
MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON

MENTAL HEALTH LEAVE OF ABSENCE END REASON
PLANNED LEAVE RETURN DATE

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION

Change to Class: Changed Attributes

Attributes of this Class are:

K MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE
~~MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD END REASON CODE~~
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON
~~MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD START REASON CODE~~
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON

PATIENT DIAGNOSIS

Change to Class: Changed Attributes

Attributes of this Class are:

ACCIDENT AND EMERGENCY DIAGNOSIS
AIDS DEFINING ILLNESS TYPE
BABY COMPLICATION AT BIRTH DIAGNOSIS
BASIS OF DIAGNOSIS FOR CANCER
BREAST CANCER INVASIVE STATUS
CEREBRAL PALSY TYPE CODE FOR NATIONAL NEONATAL DATA SET
CYTOMEGALOVIRUS DISEASE CODE
DIABETES TYPE FOR RENAL CARE
DIAGNOSIS SCHEME IN USE
FEMALE GENITAL MUTILATION TYPE 4 CODE
FETAL ANOMALY DIAGNOSIS
HISTOLOGY CONFIRMED NECROTISING ENTEROCOLITIS FOLLOWING LAPAROTOMY INDICATOR
HISTORY OF FEMALE GENITAL MUTILATION INDICATOR
HYPOXIC ISCHEMIC ENCEPHALOTHAPY GRADE
INJURY TYPE FOR CHILDREN AND YOUNG PEOPLES HEALTH SERVICE SECONDARY USES
LONG TERM PHYSICAL HEALTH CONDITION INDICATOR FOR IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES
MATERNITY COMPLICATING MEDICAL DIAGNOSIS
MATERNITY FAMILY HISTORY DIAGNOSIS TYPE
MATERNITY MEDICAL DIAGNOSIS TYPE
NEONATAL ABSTINENCE SYNDROME OBSERVED INDICATOR
NEONATAL DIAGNOSIS
OBSTETRIC DIAGNOSIS
PATIENT DIAGNOSIS CODING SIGNIFICANCE
PATIENT DIAGNOSIS INDICATION FOR PRIMARY ANKLE REPLACEMENT
PATIENT DIAGNOSIS INDICATION FOR PRIMARY ELBOW REPLACEMENT
PATIENT DIAGNOSIS INDICATION FOR PRIMARY HIP REPLACEMENT
PATIENT DIAGNOSIS INDICATION FOR PRIMARY KNEE REPLACEMENT
PATIENT DIAGNOSIS INDICATION FOR PRIMARY SHOULDER REPLACEMENT
PATIENT DIAGNOSIS INDICATOR
PATIENT DIAGNOSIS TYPE FOR HIV
PATIENT DIAGNOSIS TYPE FOR NHS HEALTH CHECK
POST HAEMORRHAGIC HYDROCEPHALUS OBSERVED DURING CRANIAL ULTRASOUND SCAN INDICATOR
PRESENT ON ADMISSION INDICATOR
PRIMARY DIAGNOSIS

PROVISIONAL DIAGNOSIS
RENAL DONOR DIAGNOSIS TYPE
RENAL LIVING DONOR DIAGNOSIS TYPE
RENAL PAEDIATRIC DIAGNOSIS TYPE
RENAL RECIPIENT CARDIOVASCULAR COMPLICATION TYPE
RENAL RECIPIENT DIAGNOSIS TYPE
SEIZURE OCCURRED INDICATOR
SEPSIS SUSPECTED INDICATOR
SKIN CANCER LESION DIAGNOSIS
TRAUMATIC LESION OF GENITAL TRACT TYPE CODE
TUMOUR OR LESION LATERALITY

PERSON PROPERTY

Change to Class: Changed Relationships

Each PERSON PROPERTY

K must be owned by one and only one PERSON
must be reported by one and only one PERSON
must be recorded by one and only one PERSON
must be observed by one and only one PERSON
may be the context for one and only one ACTIVITY GROUP
may be required by one and only one CARE ISSUE
may be of relevance to one or more CARE ISSUE
may be acting as one and only one CARE ISSUE
may be classified as one and only one CODED CLINICAL ENTRY
may be applied for one or more PERSON PROPERTY ASSIGNMENT PERIOD
may be related to one or more PERSON PROPERTY QUALIFIER
may be qualified by one or more PERSON PROPERTY QUALIFIER
may be qualified by one or more UNIT OF MEASUREMENT

PERSON PROPERTY ASSIGNMENT PERIOD

Change to Class: New Class

A period of time during an ACTIVITY GROUP that a PERSON PROPERTY is assigned.

This class is also known by these names:

Context	Alias
plural	PERSON PROPERTY ASSIGNMENT PERIODS

PERSON PROPERTY ASSIGNMENT PERIOD

Change to Class: New Class

Attributes of this Class are:

PERSON PROPERTY ASSIGNMENT PERIOD TYPE

PERSON PROPERTY ASSIGNMENT PERIOD

Change to Class: New Class

Each PERSON PROPERTY ASSIGNMENT PERIOD

K must be a classifier of one and only one ACTIVITY GROUP

K must be for one and only one PERSON PROPERTY

PLANNED ACTIVITY

Change to Class: Changed Relationships

Each PLANNED ACTIVITY

K must be for one and only one PATIENT

may be planned by one and only one DEPARTMENT

must be the subject of one or more PLANNED ACTIVITY DATE TIME

may be the planning of one or more ACTIVITY

may be planned as a result of one and only one ACTIVITY

may be planned to be carried out at one and only one APPOINTMENT

may be a result of one and only one CARE PLAN

may be planned by one and only one CARE PROFESSIONAL

may be classified as one and only one CODED CLINICAL ENTRY

may be resultant in one or more DECISION TO ADMIT

may be the subject of one and only one ELECTIVE ADMISSION LIST ENTRY

may be planned to occur at one and only one LOCATION

may be intended to be provided by one and only one ORGANISATION

may be related to one or more SERVICE REPORT

may be resultant from one and only one SERVICE REQUEST

may be the cause of one or more TRANSPORT REQUIREMENT

PLANNED ACTIVITY DATE TIME

Change to Class: New Class

PLANNED ACTIVITY DATE TIME defines individual PLANNED ACTIVITY DATE TIME types.

PLANNED ACTIVITY DATE TYPE provide lists of PLANNED ACTIVITY DATE TIMES.

This class is also known by these names:

Context	Alias
plural	PLANNED ACTIVITY DATE TIMES

PLANNED ACTIVITY DATE TIME

Change to Class: New Class

Attributes of this Class are:

K PLANNED ACTIVITY DATE TYPE

PLANNED ACTIVITY DATE

PLANNED ACTIVITY DATE TIME

Change to Class: New Class

Each PLANNED ACTIVITY DATE TIME

must be for one and only one PLANNED ACTIVITY

REFERRAL REQUEST

Change to Class: Changed Attributes

Attributes of this Class are:

BENIGN THERAPEUTIC OPERATION INDICATOR
COLPOSCOPY REFERRAL INDICATION
COMMISSIONER REFERENCE NUMBER
ONWARD REFERRAL REASON
REASON FOR REFERRAL TO COMMUNITY CARE
REASON FOR REFERRAL TO MENTAL HEALTH
REFERRAL CLOSURE REASON
REFERRAL CLOSURE REASON FOR COMMUNITY CARE
REFERRAL REJECTION REASON
REFERRAL REQUEST ACCEPTANCE INDICATOR
REFERRAL REQUEST RECEIVED TIME
REFERRAL REQUEST SERVICE TYPE FOR NHS HEALTH CHECK
REFERRAL REQUEST TYPE
SCREENING REFERRAL SOURCE
SERVICE TYPE REQUESTED
SERVICE TYPE REQUESTED FOR CHILD AND ADOLESCENT MENTAL HEALTH
SOURCE OF REFERRAL FOR A and E
SOURCE OF REFERRAL FOR COMMUNITY
SOURCE OF REFERRAL FOR FEMALE GENITAL MUTILATION
SOURCE OF REFERRAL FOR MENTAL HEALTH
SOURCE OF REFERRAL FOR OUT-PATIENTS
SOURCE OF REFERRAL FOR PROF STAFF GROUP
TWO WEEK WAIT CANCER OR SYMPTOMATIC BREAST REFERRAL TYPE

SERVICE

Change to Class: Changed Attributes

Attributes of this Class are:

K	SERVICE TYPE
	SERVICE OR TEAM TYPE FOR MENTAL HEALTH
	SERVICE TYPE FOR CHLAMYDIA TESTING
	SERVICE TYPE REFERRED TO FOR COMMUNITY CARE

SESSION

Change to Class: Changed Attributes

Attributes of this Class are:

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

UNIT OF MEASUREMENT

Change to Class: Changed Attributes

Attributes of this Class are:

UCUM UNIT OF MEASUREMENT
UNIT OF MEASUREMENT

WARD

Change to Class: Changed Attributes

Attributes of this Class are:

K	WARD CODE
	CHILD AND ADOLESCENT MENTAL HEALTH ADMISSION SETTING
	CRITICAL CARE UNIT FUNCTION
	MIDWIFERY UNIT TYPE
	UNIT BED CONFIGURATION
	WARD NAME
	WARD SECURITY LEVEL
	WARD SETTING TYPE FOR MENTAL HEALTH
	WARD TYPE DISCHARGED TO FOR NATIONAL NEONATAL DATA SET

ACTIVITY DATE TYPE

Change to Attribute: Changed Description

The type of date that defines the usage with regard to the ACTIVITY.

An ACTIVITY may have many dates associated with it but may only have one date of a particular type.

National Codes:

001	Angiogram Date (Retired July 2012)
002	Arrival Date At Accident and Emergency Department
003	Breast Assessment Date (Retired 1 January 2013)
004	Cancer Dental Assessment Date
005	Colorectal or Stoma Nurse Seen Date (Retired 1 January 2013)
006	Coronary Angiography Date (Retired July 2012)
007	Care Programme Approach Review Date
008	Date Biopsy Taken (Retired 01 April 2014)
009	Discharge Date
010	Discharge Ready Date
011	End Date
012	Event Date (Retired July 2012)
013	Expected Delivery Date (Retired September 2012)
014	First Antenatal Assessment Date
015	Full Postnatal Examination Date (Retired September 2012)
016	Initial Patient Contact Date (Retired July 2012)
017	Investigation Transfer Date (Retired July 2012)
018	Intrauterine Device Application Date (Retired September 2012)
019	Intrauterine Device Fitted Date (Retired September 2012)
020	Last Dosage Date
021	Mental Health Care Assessment Date (Retired September 2012)
022	Miscarriage Date (Retired September 2012)
023	Pathology Result Due Date
024	Patient Informed Biopsy Result Date
025	Patient Informed Of Outcome Date (Retired September 2012)
026	Smoking Quit Date
027	Review Planned Date (Retired 01 April 2014)
028	Screening Result Date (Retired 01 April 2014)

029 Screening Result Sent Date
030 Specialist Palliative Care Date (Retired 01 April 2014)
031 Start Date
032 Cancer Symptoms First Noted Date
033 Attendance Date
034 Clinical Intervention Date
035 Immunisation Completion Date (Retired 01 October 2015)
036 Clinical Status Assessment Date
037 Dose Given Date (Retired September 2012)
038 Test Date (Retired September 2012)
039 Contact Date
040 Appointment Date
041 Primary Procedure Date
042 Second Operation Date (Retired 01 April 2014)
043 Speech and Language Assessment Date
044 Third Operation Date (Retired 01 April 2014)
045 Date First Seen
046 Statutory Assessment Date
047 Screening Test Date
048 Genitourinary Care Contact Date (Retired January 2014)
049 Consultant Upgrade Date
101 Referral Closure Date (Community Care)
102 Discharge Letter Issued Date (Community Care)
103 Systemic Anti-Cancer Therapy Administration Date
104 Procedure Date
105 Immunisation Dose Given Date
106 Antenatal Appointment Date
107 Antenatal Booking Appointment Date
108 Pregnancy First Contact Date
109 Screening Test Information Given Date
110 Assessment Date For Transplant Suitability
111 Accident and Emergency Initial Assessment Date
112 Accident and Emergency Date Seen For Treatment
113 Accident and Emergency Attendance Conclusion Date
114 Accident and Emergency Departure Date
115 Clinical Assessment Date
116 Imaging or Radiodiagnostic Event Date
117 Neonatal Critical Care Daily Care Date
118 Two Year Neonatal Outcomes Assessment Date
119 Date of Pregnancy Outcome (Current Fetus)
120 Neonatal Critical Incident Date
121 American Joint Committee on Cancer Stage Date
122 Ann Arbor Stage Date
123 Barcelona Clinic Liver Cancer Stage Date
124 Binet Stage Date
125 Chang Staging System Stage Date
126 Clinical Stage Date (Pancreatic Cancer)
127 Final Figo Stage Date
128 Holistic Needs Assessment Completed Date
129 Intergroup Rhabdomyosarcoma Study Post Surgical Group Date
130 International Neuroblastoma Staging System Date
131 Myeloma International Staging System Stage Date
132 Modified Dukes Stage Date
133 Multidisciplinary Team Discussion Date (Cancer)
134 Multidisciplinary Team Meeting Date (Cancer)
135 Murphy St Jude Stage Date
136 Rai Stage Date
137 Retinoblastoma Assessment Date

138 TNM Stage Grouping Date (Final Pretreatment)
139 TNM Stage Grouping Date (Integrated)
140 Wilms Tumour Stage Date
Care Contact Cancellation Date
Care Contact Date
Date of Restrictive Intervention
Discharge Letter Issued Date (Mental Health and Community Care)
Indirect Activity Date
Mental Health Crisis Plan Creation Date
Mental Health Crisis Plan Last Updated Date
Onward Referral Date
Referral Closure Date
Referral Rejection Date
Replacement Appointment Booked Date
Replacement Appointment Date Offered
Service Discharge Date

Note: This list is not in alphabetical order.

ACTIVITY GROUP TYPE

Change to Attribute: Changed Description

The type of ACTIVITY GROUP.

National Codes:

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

28 Person Stop Smoking Episode
29 Pregnancy Episode
30 Professional Staff Group Episode
31 Regular Attender Episode
32 Road Traffic Accident Treatment (Retired 01 April 2014)
33 Sarcoma Care Spell
34 Skin Cancer Care Spell
35 Supervised Discharge Episode (Retired 01 April 2014)
36 Supervision Register Episode (Retired 01 April 2014)
37 Upper Gastrointestinal Cancer Care Spell
38 Urological Cancer Care Spell
39 Ward Stay
40 Hospital Stay
41 Care Spell
42 CRITICAL CARE PERIOD
43 PATIENT PATHWAY
44 REFERRAL TO TREATMENT PERIOD
45 Active Monitoring
46 Supervised Community Treatment Recall
47 Supervised Community Treatment
48 Mental Health Care Without Patient Consent
49 Cancer Treatment Period
50 Gynaecological Cancer Care Spell
51 Mental Health Care Spell
52 Improving Access to Psychological Therapies Care Spell
53 Adult Mental Health Care Team Episode
54 Mental Health NHS Day Care Episode
55 Mental Health Delayed Discharge Period
~~56~~ ~~Mental Health Care Cluster Assignment Period~~
~~57~~ ~~Mental Health Care Coordinator Assignment~~
56 Mental Health Care Cluster Assignment Period (Retired 01 January 2016)
57 Mental Health Care Coordinator Assignment Period
58 Child and Adolescent Mental Health Clinical Intervention Episode
59 Child and Adolescent Mental Health Care Spell
60 Maternity Episode
61 HIV Episode
62 Central Nervous System Cancer Care Spell
63 Children Teenagers and Young Adults Cancer Care Spell
64 Haematology Cancer Care Spell
65 Lung Cancer Care Spell
66 Commissioner Assignment Period
67 Breast Screening Episode
68 High Risk Breast Screening Episode
69 Open Breast Screening Episode
70 Neonatal Critical Care Spell
71 Radiotherapy Episode
72 Healthy Person Stay
~~73~~ ~~Mental Health Responsible Clinician Assignment~~
73 Mental Health Responsible Clinician Assignment Period
74 Mental Health Conditional Discharge Period
~~75~~ ~~Mental Health Act Legal Status Classification Period~~
75 Mental Health Act Legal Status Classification Period (Moved to PERSON PROPERTY ASSIGNMENT PERIOD TYPE 01 January 2016)
Care Professional Admitted Care Episode

Note:
The list is not in alphabetical order.

ACTIVITY LOCATION TYPE CODE

Change to Attribute: Changed Description

The type of LOCATION for an ACTIVITY:

- where PATIENTS are seen
- where SERVICES are provided or
- from which requests for SERVICES are sent.

ACTIVITY LOCATION TYPE CODE replaces LOCATION TYPE CODE and should be used for all new and developing data sets and for XML messages.

National Codes:

CODE	VALUE	NOTES
	PATIENT Main Residence or Related Location	
A01	PATIENT's Home	
A02	Carer's Home	
A03	PATIENT's Workplace	
A04	Other PATIENT Related Location	e.g. temporary address
	Health Centre Premises	
B01	Primary Care Health Centre	Primary Care Health Centre with or without GP Practice (s) based in it, providing community-based healthcare services such as podiatry, community dentistry, ophthalmology, minor injuries nursing etc, Sexual and Reproductive Health Service, health promotion etc, and sometimes hosting outreach services from NHS Trusts and NHS Foundation Trusts
B02	Polyclinic	Provide similar services to Primary Care Health Centre but also additional services such as diagnostics, minor procedures, Out-Patient Appointments, urgent care etc. and also co-located services with Local Authority Social Care. May also provide extended/out of hours services.
	GENERAL PRACTITIONER and OPHTHALMIC MEDICAL PRACTITIONER	
C01	General Medical Practitioner Practice	Stand-alone GP Practice premises, not part of a Primary Care Health Centre
C02	Dental Practice	Stand-alone GP Practice premises, not part of a Primary Care Health Centre
C03	OPHTHALMIC MEDICAL PRACTITIONER Premises	
	Walk In Centres, Out of Hours Premises and Emergency Community Dental Services	
D01	Walk In Centre	May be NHS GENERAL PRACTITIONER Led, NURSE-led, or provided by private company. May be sited in different areas - health care premises, in retail premises etc
D02	Out of Hours Centre	May be NHS GENERAL PRACTITIONER-Led, NURSE-led, or provided by private company. May be sited in different areas - health care premises, in retail premises etc
D03	Emergency Community Dental Service	Run by Community Dental Services not GENERAL DENTAL PRACTITIONERS
	Locations on Hospital Premises	
E01	Out-Patient Clinic	
E02	WARD	

~~E03~~	~~Day Hospital~~	
E03	Day Hospital	
E04	Accident and Emergency or Minor Injuries Department	
E99	Other Departments	e.g. Pathology Laboratories, physiotherapy, diagnostic imaging, Occupational Therapy, Pharmacy Premises etc
	Hospice Premises	
F01	Hospice	
	Nursing and Residential Homes	
G01	Care Home Without Nursing	
G02	Care Home With Nursing	
G03	Children's Home	
G04	Integrated Care Home Without Nursing and Care Home With Nursing *	
	Day Centre Premises	
H01	Day Centre	Facilities operated by the NHS, Social Services or private or voluntary bodies, providing day care and respite care for elderly or disabled people
	Resource Centre Premises	
J01	Resource Centre	Premises where information and support for PATIENTS and their families/carers is provided.
	Dedicated Facilities for Children and Families	
K01	Sure Start Children's Centre	Children's centres are service hubs where children under five years old and their families can receive seamless integrated services and information. Services vary according to centre but may include: • Integrated early education and childcare • Support for parents including advice on parenting, local childcare options and access to specialist services for families • Child and family health services • Helping parents into work
K02	Child Development Centre	
	Educational, Childcare and Training Establishments	
L01	School	Including Extended Services, where provided on School premises (where provided off School premises, use other appropriate location)
L02	Further Education College	
L03	University	
L04	Nursery Premises	Pre-school Nurseries attached to Schools would be classed as Schools in their own right
L05	Other Childcare Premises	e.g. Childminder
L06	Training Establishments	
L99	Other Educational Premises	Such as Teenage Pregnancy Units, School Preparation Units (for toddlers), Pupil Referral Units (excluded older children and young people), units providing specialist education e.g. deaf children, autistic children etc
	Justice and Home Office Premises	
M01	Prison	
M02	Probation Service Premises	
M03	Police Station / Police Custody Suite	
M04	Young Offenders Institute	
M05	Immigration Removal Centre	

	Public Locations	
N01	Street or other public open space	Public areas such as streets, parks, outdoor sports facilities etc
N02	Other publicly accessible area or building	Publicly accessible premises such as Youth Centres, supermarkets, shops and other retail locations such as shopping centres, community facilities such as libraries, church halls, community centres etc
N03	Voluntary or charitable agency premises	
N04	Dispensing Optician Premises	
N05	Dispensing Pharmacy Premises	Where it is not on a Hospital Site
	Other Locations	
X01	Other locations not elsewhere classified	

~~Note: * National Code G04 is for use in the Mental Health and Learning Disabilities Data Set. The values are not currently permitted to flow in other data sets. Users of these other data sets must map National Code G04 locally to other appropriate ACTIVITY LOCATION TYPE CODES for the purposes of flowing data.~~

ACTIVITY TIME TYPE

Change to Attribute: Changed Description

The type of TIME that defines the usage with regard to the ACTIVITY.

An ACTIVITY may have many TIMES associated with it but may only have one TIME of a particular type.

National Codes:

50 Accident and Emergency Attendance Conclusion Time
51 Accident and Emergency Departure Time
52 Accident and Emergency Initial Assessment Time
53 Accident and Emergency Time Seen For Treatment
54 Arrival At Hospital Time (Retired April 2012)
55 ARRIVAL TIME (Retired April 2012)
56 End Time
57 Event Time (Retired July 2012)
58 Initial Patient Contact Time (Retired July 2012)
59 Last Dosage Time
60 Pathology Result Due Time
61 Start Time
62 Theatre Case Time In To Theatre Suite (Retired September 2012)
63 Theatre Case Time Out Of Theatre (Retired September 2012)
64 Theatre Case Time Out Of Theatre Suite (Retired September 2012)
65 Time Seen
66 Discharge Ready Time (Retired April 2012)
67 Arrival Time At Accident and Emergency Department
68 Arrival Time For Transport Requests
69 Discharge Time
70 Clinical Intervention Time
Care Contact Time
Indirect Activity Time

Note: This list is not in alphabetical order.

ADMINISTRATIVE CATEGORY CODE

Change to Attribute: Changed Description

This is recorded for PATIENT ACTIVITY.

A PATIENT who is an Overseas Visitor does not qualify for free NHS healthcare and can choose to pay for NHS treatment or for private treatment. If they pay for NHS treatment then they should be recorded as NHS PATIENTS.

The PATIENT's ADMINISTRATIVE CATEGORY CODE may change during an episode or spell. For example, the PATIENT may opt to change from NHS to private health care. In this case, the start and end dates for each new ADMINISTRATIVE CATEGORY PERIOD (episode or spell) should be recorded.

If the ADMINISTRATIVE CATEGORY CODE changes during a Hospital Provider Spell the ADMINISTRATIVE CATEGORY CODE (ON ADMISSION) is used to derive the 'Category of PATIENT' for Hospital Episode Statistics (HES).

The category 'amenity PATIENT' is only applicable to PATIENTS using a Hospital Bed.

National Codes:

01	NHS PATIENT, including Overseas Visitors charged under the National Health Service (Overseas Visitors Hospital Charging Regulations)
~~02~~	~~Private PATIENT, one who uses accommodation or services authorised under the National Health Service Act 2006~~
02	Private PATIENT, one who uses accommodation or SERVICES authorised under the National Health Service Act 2006
03	Amenity PATIENT, one who pays for the use of a single room or small ward in accordance with the National Health Service Act 2006
04	Category II PATIENT, one for whom work is undertaken by hospital medical or dental staff within category II as defined in paragraph 37 of the Terms and Conditions of Service of Hospital Medical and Dental Staff.

ADMISSION METHOD

Change to Attribute: Changed Description

The method of admission to a Hospital Provider Spell.

Note: see ELECTIVE ADMISSION TYPE for a full definition of Elective Admission.

National Codes:

Elective Admission, when the DECISION TO ADMIT could be separated in time from the actual admission:

11	Waiting list
12	Booked
13	Planned

Note that this does not include a transfer from another Hospital Provider (see 81 below).

Emergency Admission, when admission is unpredictable and at short notice because of clinical need:

21	Accident and emergency or dental casualty department of the Health Care Provider
22	GENERAL PRACTITIONER: after a request for immediate admission has been made direct to a Hospital Provider, i.e. not through a Bed bureau, by a GENERAL PRACTITIONER or deputy
23	Bed bureau
24	Consultant Clinic, of this or another Health Care Provider
25	Admission via Mental Health Crisis Resolution Team
2A	Accident and Emergency Department of another provider where the PATIENT had not been admitted *
2B	Transfer of an admitted PATIENT from another Hospital Provider in an emergency *

2C Baby born at home as intended *

2D Other emergency admission *

~~28 Other means, examples are:~~
~~- admitted from the Accident and Emergency Department of another provider where they had not been admitted~~
~~- transfer of an admitted PATIENT from another Hospital Provider in an emergency~~
~~- baby born at home as intended~~

28 Other means, examples are: **
- admitted from the Accident and Emergency Department of another provider where they had not been admitted
- transfer of an admitted PATIENT from another Hospital Provider in an emergency
- baby born at home as intended

Maternity Admission, of a pregnant or recently pregnant woman to a maternity ward (including delivery facilities) except when the intention is to terminate the pregnancy

31 Admitted ante-partum

32 Admitted post-partum

Other Admission not specified above

82 The birth of a baby in this Health Care Provider

83 Baby born outside the Health Care Provider except when born at home as intended.

81 Transfer of any admitted PATIENT from other Hospital Provider other than in an emergency

Note: The classification has been listed in logical sequence rather than alphanumeric order.

~~*** Note - National Codes 2A, 2B, 2C and 2D have been introduced to replace National Code 28 *'Other means'*. Health Care Providers should use these codes as soon as possible. National Code 28 will be retired in the next version of the Commissioning Data Set.**~~* Note - National Codes 2A, 2B, 2C and 2D have been introduced to replace National Code 28 *'Other means'*. National Code 28 will be retired in the next version of the Commissioning Data Set.

** Note - National Code 28 is NOT valid for use in the Mental Health Services Data Set.

ADULT MENTAL HEALTH CARE CLUSTER CODE renamed from MENTAL HEALTH CARE CLUSTER CODE

Change to Attribute: Changed Name, Description

~~The Mental Health Care Cluster assigned to a PATIENT.~~The Adult Mental Health Care Cluster assigned to a PATIENT.

National Codes:

~~00 Care Cluster 0 - Variance (unable to assign MENTAL HEALTH CARE CLUSTER CODE)~~

00 Care Cluster 0 - Variance (unable to assign ADULT MENTAL HEALTH CARE CLUSTER CODE)

01 Care Cluster 1 - Common Mental Health Problems (Low Severity)

02 Care Cluster 2 - Common Mental Health Problems (Low Severity with Greater Need)

03 Care Cluster 3 - Non-Psychotic (Moderate Severity)

04 Care Cluster 4 - Non-Psychotic (Severe)

05 Care Cluster 5 - Non-Psychotic Disorders (Very Severe)

06 Care Cluster 6 - Non-Psychotic Disorder of Over-Valued Ideas

07 Care Cluster 7 - Enduring Non-Psychotic Disorders (High Disability)

08 Care Cluster 8 - Non-Psychotic Chaotic and Challenging Disorders

~~09 Care Cluster 9 - Cluster Under Review - Note: This Mental Health Care Cluster is under review and should not be used.~~

09 Care Cluster 9 - Cluster Under Review - Note: This CARE CLUSTER is under review and should not be used.

10 Care Cluster 10 - First Episode Psychosis

11 Care Cluster 11 - Ongoing Recurrent Psychosis (Low Symptoms)

12 Care Cluster 12 - Ongoing or Recurrent Psychosis (High Disability)
13 Care Cluster 13 - Ongoing or Recurrent Psychosis (High Symptoms and Disability)
14 Care Cluster 14 - Psychotic Crisis
15 Care Cluster 15 - Severe Psychotic Depression
16 Care Cluster 16 - Dual Diagnosis
17 Care Cluster 17 - Psychosis and Affective Disorder (Difficult to Engage)
18 Care Cluster 18 - Cognitive Impairment (Low Need)
19 Care Cluster 19 - Cognitive Impairment or Dementia Complicated (Moderate Need)
20 Care Cluster 20 - Cognitive Impairment or Dementia Complicated (High Need)
21 Care Cluster 21 - Cognitive Impairment or Dementia Complicated (High Physical or Engagement)

ADULT MENTAL HEALTH CARE CLUSTER CODE renamed from MENTAL HEALTH CARE CLUSTER CODE

Change to Attribute: Changed Name, Description

- Changed Name from Data_Dictionary.Attributes.M.Men.MENTAL_HEALTH_CARE_CLUSTER_CODE to Data_Dictionary.Attributes.A.Add.ADULT_MENTAL_HEALTH_CARE_CLUSTER_CODE
- Changed Description

ASSESSMENT TOOL TYPE

Change to Attribute: Changed Description

The type of ASSESSMENT TOOL.

National Codes:

001 Health of the Nation Outcome Scale (Working Age Adults)
002 Health of the Nation Outcome Scale (Children and Adolescents)
003 Patient Health Questionnaire-9
004 Agoraphobia Questionnaire
005 Agoraphobia Mobility Inventory Questionnaire 'When Accompanied'
006 Agoraphobia Mobility Inventory Questionnaire 'When Alone'
007 Employment Status Questionnaire
008 Generalised Anxiety Disorder Penn State Worry Questionnaire
009 Generalised Anxiety Disorder Questionnaire
010 Health Anxiety Inventory Short Week Scale
011 Obsessive Compulsive Disorder Inventory Questionnaire
012 Panic Disorder Severity Scale
013 Post Traumatic Stress Disorder Impacts of Events Revised Scale
014 Social Phobia Inventory Questionnaire
015 Social Phobia Questionnaire
016 Specific Phobia Questionnaire
017 Work and Social Adjustment Scale
018 Health of the Nation Outcome Scale 65+ (Older Adults)
019 Health of the Nation Outcome Scale (Secure)
~~020~~ ~~Mental Health Clustering Tool~~
020 Adult Mental Health Clustering Tool
021 Cardiovascular Disease Risk Calculator
022 Strengths And Difficulties Questionnaire
023 Experience of Service Questionnaire
024 Children's Global Assessment Scale
025 Family Assessment Device (General Functioning Subscale)
026 Parenting Daily Hassles
027 Parent-Infant Relationship Global Assessment Scale
028 Paddington Complexity Scale
029 Goal Based Outcomes

030 Mood And Feelings Questionnaire
031 Parenting Stress Index
032 Adult Comorbidity Evaluation - 27
033 Child-Pugh Score Calculator
034 Dysphagia Scoring System
035 Follicular Lymphoma International Prognostic Index
036 Hasenclever Index
037 Hasford Index
038 International Prognostic Scoring System
039 Nottingham Prognostic Index
040 Revised International Prognostic Index
041 Sokal Index
042 Oxford Orthopaedic Questionnaire
043 Oxford Orthopaedic Questionnaire (Shoulder)
044 Venous Thromboembolism Risk Assessment Tool
045 TPRG-SEND Two Year Corrected Age Outcome Assessment
046 Bayley Scales of Infant and Toddler Development (Third Edition)
047 Griffiths Mental Development Scales
048 Schedule of Growing Skills
049 Improving Access to Psychological Therapies Patient Experience Questionnaire
050 Health of the Nation Outcome Scale for People with Learning Disabilities
051 Protected Characteristic Protocol (Disability)

ATTENDED OR DID NOT ATTEND

Change to Attribute: Changed Description

An indication of 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.

National Codes:

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
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 Health Care Provider
0 Not applicable - APPOINTMENT occurs in the future *

Note: The classification has been listed in logical sequence rather than alphanumeric order.

* Note that code 0 - '*Not applicable - APPOINTMENT occurs in the future*' is NOT valid for use in the following data sets:

- ~~Child and Adolescent Mental Health Services Secondary Uses Data Set~~
- Children and Young People's Health Service Secondary Uses Data Set
- Community Information Data Set
- Improving Access to Psychological Therapies Data Set
- ~~Mental Health and Learning Disabilities Data Set~~.
- Mental Health Services Data Set

Use in the Future Outpatient Commissioning Data Set:

- For referral records with **no** APPOINTMENT yet made, or for **future** APPOINTMENTS, code 0 - *Not applicable - APPOINTMENT occurs in the future* should be used.
- Where the future attendance has been ***cancelled***, use the appropriate value from the National Codes.

CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH

Change to Attribute: New Attribute

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

National Codes:

01	Medical
02	Nursing
03	Psychology
04	Primary Mental Health
05	Child and Adolescent Psychotherapy
06	Counselling
07	Family and Systemic Psychotherapy
08	Occupational Therapy
09	Social Work
10	Creative Therapy
11	Other Therapy (Qualified)
12	Education
13	Speech and Language Therapy
97	Other (Qualified)
98	Other (Unqualified)

This attribute is also known by these names:

Context	Alias
plural	CARE PROFESSIONAL STAFF GROUPS FOR MENTAL HEALTH

CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH

Change to Attribute: New Attribute

CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH

Data Elements:

CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH)

CARE PROGRAMME APPROACH REVIEW ABUSE QUESTION ASKED INDICATOR

Change to Attribute: Changed Description

An indication of whether the PATIENT was asked the Abuse Question during a Care Programme Approach Review.

National Codes:

~~Y~~	~~Yes, the PATIENT was asked~~
~~N~~	~~No, the PATIENT was not asked~~
Y	Yes - the PATIENT was asked
N	No - the PATIENT was not asked

CATEGORY VALUED PERSON OBSERVATION TYPE

Change to Attribute: Changed Description

The type of CATEGORY VALUED PERSON OBSERVATION.

National Codes:

01	ALCOHOL STATUS (Retired 1 January 2013)
02	ASPIRIN THERAPY LOCATION (Retired July 2012)
03	BLEED COMPLICATION (Retired July 2012)
04	ETHNIC CATEGORY
05	JOINT REPLACEMENT REVISION CLASSIFICATION (Retired 1 April 2012)
~~06~~	~~LANGUAGE CLASSIFICATION~~
06	LANGUAGE
07	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION
08	PATIENT CLINICAL GROUP (Retired July 2012)
09	PERFORMANCE STATUS
10	PERSON GENDER
11	PERSON MARITAL STATUS
12	SARCOMA PREDISPOSING CONDITION (Retired 1 January 2013)
13	SKIN LYMPHOMA MORPHOLOGY (Retired 1 January 2013)
14	ACCOMMODATION
15	SEXUAL ORIENTATION
16	RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION
17	RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP (Retired August 2013)
18	CONTRACEPTION
19	DISABILITY
20	PREVIOUS SYMPTOM STATUS
21	PSYCHOTROPIC MEDICATION STATUS
22	STATUTORY SICK PAY STATUS
23	PERSON PHYSICAL ACTIVITY LEVEL
24	CHILDHOOD IMMUNISATION STATUS
25	FOLIC ACID SUPPLEMENT STATUS
26	SUPPORT STATUS
27	DISABILITY SEVERITY
28	CONSCIOUSNESS STATUS
29	PERSON PHENOTYPIC SEX
30	PERSON STATED GENDER
31	SOCIO-ECONOMIC CLASSIFICATION
	CARE CLUSTER

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE

Change to Attribute: New Attribute

The Child and Adolescent Mental Health Care Cluster assigned to a PATIENT.

Note: This data item is included in the Mental Health Services Data Set, but should not be submitted until further development by the Health and Social Care Information Centre has been undertaken.

This attribute is also known by these names:

Context	Alias
plural	CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODES

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE

Change to Attribute: New Attribute

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE

Data Elements:

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL)
CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL)

CHILD AND ADOLESCENT MENTAL HEALTH TIER OF SERVICE

Change to Attribute: Changed Description

~~The tier of service which a Child and Adolescent Mental Health Care Team is operating at whilst treating a PATIENT.~~The tier of SERVICE the Child and Adolescent Mental Health Care Team operates at for a PATIENT.

National Codes:

1 **Tier 1** - Primary Care SERVICES who have first and regular contact with PATIENTS and families, such as GENERAL MEDICAL PRACTITIONERS, Health Visitors, School Nurses, community health facilities and other primary care resources.

2 **Tier 2** - Child and Adolescent Mental Health Services delivered by an individual CARE PROFESSIONAL, attached to a single agency, working directly with a child, adolescent or family.

3 **Tier 3** - Multi-disciplinary and/or multi-agency teams provide delivery of the most appropriate intervention for a child, adolescent or family.

4 **Tier 4** - Inpatient services for children and adolescents, usually delivered within a Hospital or specialist inpatient clinic.

CHILD PROTECTION PLAN INDICATION CODE renamed from CHILD PROTECTION PLAN INDICATOR

Change to Attribute: Changed Name, Description

An indication of whether a PERSON is, or has previously been, subject to a Child Protection Plan.

National Codes:

~~0 Has never been subject to a Child Protection Plan~~

~~1 Has previously been subject to a Child Protection Plan~~

~~2 Is currently subject to a Child Protection Plan~~

1 Has never been subject to a Child Protection Plan

2 Has previously been subject to a Child Protection Plan

3 Is currently subject to a Child Protection Plan

CHILD PROTECTION PLAN INDICATION CODE renamed from CHILD PROTECTION PLAN INDICATOR

Change to Attribute: Changed Name, Description

- Changed Name from Data_Dictionary.Attributes.C.Cen.CHILD_PROTECTION_PLAN_INDICATOR to Data_Dictionary.Attributes.C.Cen.CHILD_PROTECTION_PLAN_INDICATION_CODE
- Changed Description

CLINICAL INTERVENTION TYPE

Change to Attribute: Changed Description

The type of CLINICAL INTERVENTION.

National Codes:

01	Anaesthetic Service (Retired November 2013)
02	Anti-Cancer Drug Cycle
03	Anti-Cancer Drug Fraction (Retired 1 January 2013)
04	Anti-Cancer Drug Programme
05	Anti-Cancer Drug Regimen
06	Brachytherapy Treatment Course
07	Contraceptive Service (Retired November 2013)
08	Dental Haemorrhage Service (Retired November 2013)
09	Dental Treatment (Retired 01 April 2014)
10	Drug Dosage and Administration (Retired 1 January 2013)
11	Drug Treatment
12	Emergency Treatment Service (Retired November 2013)
13	Endocrine Therapy (Retired 1 January 2013)
14	Fraction
15	Primary Hip Replacement Surgery
16	Imaging or Radiodiagnostic Event
17	Immunisation Dose Given
18	Joint Replacement Surgery
19	Primary Knee Replacement Surgery
20	Labour and Delivery
21	Lithotripsy Course Attendance (Retired 1 April 2014)
22	Maternity Medical Service (Retired November 2013)
23	Minor Surgery Procedure (Retired November 2013)
24	Pathology Laboratory Investigation (Retired January 2015)
25	Patient Procedure
26	Post Mortem
27	Radiotherapy Treatment Course
28	Screening Test (Retired November 2013)
29	Teletherapy Treatment Course (Retired 1 April 2014)
30	Test Of Immunity (Retired November 2013)
31	Therapy After Discharge (Retired July 2012)
32	Thromboprophylaxis Regime
33	Unsealed Source Treatment Course (Retired 1 April 2014)
34	Vaccination Service (Retired November 2013)
35	Vasectomy Performed (Retired November 2013)
36	Clinical Investigation
37	Systemic Anti-Cancer Drug Cycle
38	Systemic Anti-Cancer Drug Programme
39	Systemic Anti-Cancer Drug Regimen
40	Chemotherapy
41	Cytotoxic Chemotherapy
42	Hormone Therapy
43	Immunotherapy
44	Diagnostic Imaging (Retired January 2015)
45	6 - 8 Week Physical Examination (Retired January 2015)
46	Ultrasound Scan In Pregnancy (Retired January 2015)
47	Newborn Physical Examination (Retired January 2015)
48	Biological Therapy
49	Brachytherapy
50	Chemoradiotherapy

51 Cryotherapy
52 High Intensity Focused Ultrasound
53 Hyperbaric Oxygen Therapy
54 Laser Treatment
55 Light Therapy
56 Photodynamic Therapy
57 Proton Therapy
58 Psoralen and Ultraviolet A Therapy
59 Radiofrequency Ablation
60 Radioisotope Therapy
61 Radiosurgery
62 Radiotherapy
63 Teletherapy
64 Tissue Typing (Retired January 2015)
65 Blood Transfusion
66 Renal Dialysis
67 Antiretroviral Therapy
68 Drug Regimen
69 Ablative Therapy
70 Laparoscopy
71 Primary Ankle Replacement Surgery
72 Revision Ankle Replacement Surgery
73 Primary Elbow Replacement Surgery
74 Revision Elbow Replacement Surgery
75 Revision Hip Replacement Surgery
76 Revision Knee Replacement Surgery
77 Primary Shoulder Replacement Surgery
78 Revision Shoulder Replacement Surgery
79 Oxygen Therapy
80 Therapeutic Hypothermia
81 Parenteral Nutrition
82 Enteral Feeding
83 Radiotherapy Exposure
84 Mental Health Treatment
Restrictive Intervention

CLINICAL RESPONSE PRIORITY TYPE

Change to Attribute: Changed Description

The clinical response priority of a SERVICE REQUEST.

~~For SERVICE REQUESTS to a Child and Adolescent Mental Health Care Team, a CLINICAL RESPONSE PRIORITY TYPE of 'Emergency' indicates that the PATIENT needs to be seen within 48 hours of the REFERRAL REQUEST RECEIVED DATE. This priority is as assessed by, or on behalf of, the Child and Adolescent Mental Health Care Team.~~

National Codes:

1 Emergency
2 Urgent/serious
3 Routine

CLUSTERING TOOL ASSESSMENT CATEGORY

Change to Attribute: New Attribute

The category of the Clustering Tool assessment completed.

Note: only CLUSTERING TOOL ASSESSMENT CATEGORY National Code *'Adult Mental Health Clustering Tool'* is currently supported in the Mental Health Services Data Set. Other National Codes have been included to facilitate piloting and testing of future data requirements, prior to formal inclusion in later versions of the Mental Health Services Data Set.

National Codes:

01	Adult Mental Health Clustering Tool
02	Child and Adolescent Mental Health Clustering Tool
03	Learning Disabilities Clustering Tool
04	Forensic (Mental Health) Clustering Tool
05	Forensic (Learning Disabilities) Clustering Tool

This attribute is also known by these names:

Context	Alias
plural	CLUSTERING TOOL ASSESSMENT CATEGORIES

CLUSTERING TOOL ASSESSMENT CATEGORY

Change to Attribute: New Attribute

CLUSTERING TOOL ASSESSMENT CATEGORY

Data Elements:

CLUSTERING TOOL ASSESSMENT CATEGORY

CLUSTERING TOOL ASSESSMENT REASON renamed from MENTAL HEALTH CLUSTERING TOOL ASSESSMENT REASON

Change to Attribute: Changed Name, Description

~~The reason that a Mental Health Clustering Tool assessment for a PATIENT was undertaken.~~The reason that a Clustering Tool assessment for a PATIENT was undertaken.

National Codes:

10	Initial assessment
11	Scheduled re-assessment
12	Re-assessment following significant unanticipated change in need
~~97~~	~~Other reason~~
97	Other Reason

CLUSTERING TOOL ASSESSMENT REASON renamed from MENTAL HEALTH CLUSTERING TOOL ASSESSMENT REASON

Change to Attribute: Changed Name, Description

- Changed Name from Data_Dictionary.Attributes.M.Men.MENTAL_HEALTH_CLUSTERING_TOOL_ASSESSMENT_REASON to Data_Dictionary.Attributes.C.Cla.CLUSTERING_TOOL_ASSESSMENT_REASON
- Changed Description

COMMUNITY TREATMENT ORDER END REASON renamed from SUPERVISED COMMUNITY TREATMENT END REASON

Change to Attribute: Changed Name, Description

~~The reason for the termination of a period of Supervised Community Treatment.~~

The reason for the termination of a Community Treatment Order.

National Codes:

01	PATIENT discharged
~~02~~	~~Supervised Community Treatment revoked~~
02	Community Treatment Order revoked
03	PATIENT died
04	PATIENT transferred outside England
05	PATIENT transferred to another Health Care Provider

COMMUNITY TREATMENT ORDER END REASON renamed from SUPERVISED COMMUNITY TREATMENT END REASON

Change to Attribute: Changed Name, Description

- Changed Name from Data_Dictionary.Attributes.S.Sup.SUPERVISED_COMMUNITY_TREATMENT_END_REASON to Data_Dictionary.Attributes.C.Com.COMMUNITY_TREATMENT_ORDER_END_REASON
- Changed Description

CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR

Change to Attribute: New Attribute

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

National Codes:

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

This attribute is also known by these names:

Context	Alias
plural	CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATORS

CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR

Change to Attribute: New Attribute

CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR

Data Elements:

CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR

CONSULTATION MEDIUM USED

Change to Attribute: Changed Description

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.

National Codes:

01 Face to face communication
02 Telephone
03 Telemedicine web camera
04 Talk type for a PERSON unable to speak
05 Email **
06 Short Message Service (SMS) - Text Messaging **
98 Other *****

~~*** Note - National Code 98 *'Other'* is only used for the Community Information Data Set and the Sexual and Reproductive Health Activity Data Set.**~~ *** Note - National Code 98 *'Other'* is only used for the Community Information Data Set, Mental Health Services Data Set and the Sexual and Reproductive Health Activity Data Set**. It is NOT valid in any other data set including Commissioning Data Set version 6-2.

** **Note National Codes 05 '*Email*' and 06 '*Short Message Service (SMS) - Text Messaging*' are not valid for Commissioning Data Set version 6-2.**

CONSULTATION TYPE

Change to Attribute: New Attribute

The type of consultation between the CARE PROFESSIONAL and the PATIENT.

National Codes:

01 Initial Consultation
02 Follow-up Consultation

This attribute is also known by these names:

Context	Alias
plural	CONSULTATION TYPES

CONSULTATION TYPE

Change to Attribute: New Attribute

CONSULTATION TYPE

Data Elements:

CONSULTATION TYPE

DIAGNOSIS SCHEME IN USE

Change to Attribute: New Attribute

The type of CODED CLINICAL ENTRY used for the PATIENT DIAGNOSIS.

National Codes:

01	Accident & Emergency Diagnosis ***
02	ICD-10
03	Read Code 4Byte Version (retired 1 October 2009)
04	Read Coded Clinical Terms Version 2
05	Read Coded Clinical Terms Version 3 (CTV3) *
06	Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT) **

Notes:

- * Read Coded Clinical Terms Version 3 (CTV3) with qualifiers (previously known as 3.1) is not supported in the Commissioning Data Sets
- ** Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT) is not valid for Commissioning Data Set version 6-1 and 6-2
- *** Accident & Emergency Diagnosis is not valid for the Mental Health Services Data Set.

This attribute is also known by these names:

Context	Alias
plural	DIAGNOSIS SCHEMES IN USE

DIAGNOSIS SCHEME IN USE

Change to Attribute: New Attribute

DIAGNOSIS SCHEME IN USE

Data Elements:

DIAGNOSIS SCHEME IN USE

DISABILITY IMPACT PERCEPTION

Change to Attribute: New Attribute

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

National Codes:

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

This attribute is also known by these names:

Context	Alias
plural	DISABILITY IMPACT PERCEPTIONS

DISABILITY IMPACT PERCEPTION

Change to Attribute: New Attribute

DISABILITY IMPACT PERCEPTION

Data Elements:

DISABILITY IMPACT PERCEPTION

FINDING SCHEME IN USE

Change to Attribute: New Attribute

The type of CODED CLINICAL ENTRY used for the finding.

National Codes:

01 ICD-10
02 Read Coded Clinical Terms Version 2
03 Read Coded Clinical Terms Version 3 (CTV3)
04 Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT)

This attribute is also known by these names:

Context	Alias
plural	FINDING SCHEMES IN USE

FINDING SCHEME IN USE

Change to Attribute: New Attribute

FINDING SCHEME IN USE

Data Elements:

FINDING SCHEME IN USE

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE

Change to Attribute: New Attribute

The Forensic (Mental Health) Care Cluster assigned to a PATIENT.

Note: This data item is included in the Mental Health Services Data Set, but should not be submitted until further development by the Health and Social Care Information Centre has been undertaken.

This attribute is also known by these names:

Context	Alias
plural	FORENSIC LEARNING DISABILITIES CARE CLUSTER CODES

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE

Change to Attribute: New Attribute

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE

Data Elements:

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)
FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)

FORENSIC MENTAL HEALTH CARE CLUSTER CODE

Change to Attribute: New Attribute

The Forensic (Learning Disabilities) Care Cluster assigned to a PATIENT.

Note: This data item is included in the Mental Health Services Data Set, but should not be submitted until further development by the Health and Social Care Information Centre has been undertaken.

This attribute is also known by these names:

Context	Alias
plural	FORENSIC MENTAL HEALTH CARE CLUSTER CODES

FORENSIC MENTAL HEALTH CARE CLUSTER CODE

Change to Attribute: New Attribute

FORENSIC MENTAL HEALTH CARE CLUSTER CODE

Data Elements:

FORENSIC MENTAL HEALTH CARE CLUSTER CODE (FINAL)
FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL)

GROUP SESSION TYPE FOR MENTAL HEALTH

Change to Attribute: New Attribute

The type of Group Session provided by a Mental Health Service.

National Codes:

01	General Health Promotion Session
02	Telephone Support Session
03	Therapeutic Group Session

This attribute is also known by these names:

Context	Alias
plural	GROUP SESSION TYPES FOR MENTAL HEALTH

GROUP SESSION TYPE FOR MENTAL HEALTH

Change to Attribute: New Attribute

GROUP SESSION TYPE FOR MENTAL HEALTH

Data Elements:

GROUP SESSION TYPE (MENTAL HEALTH)

GROUP THERAPY INDICATOR

Change to Attribute: Changed Description

~~An indicator of whether a CARE ACTIVITY was delivered as Group Therapy.~~An indication of whether a CARE ACTIVITY was delivered as Group Therapy.

National Codes:

- ~~Y~~ ~~CARE ACTIVITY delivered as Group Therapy~~
- ~~N~~ ~~CARE ACTIVITY delivered individually~~
- Y Yes - CARE ACTIVITY was delivered as Group Therapy
- N No - CARE ACTIVITY was delivered individually

LANGUAGE CODE

Change to Attribute: New Attribute

The language used by a PERSON.

LANGUAGE CODE is based on the ISO 639-1 two character language codes (see the ISO Registration Authority website) plus five communication method extensions:

- q1 Braille - for people who are unable to see
- q2 American Sign Language
- q3 Australian Sign Language
- q4 British Sign Language
- q5 Makaton - devised for children and adults with a variety of communication and Learning Disabilities

This attribute is also known by these names:

Context	Alias
plural	LANGUAGE CODES

LANGUAGE CODE

Change to Attribute: New Attribute

LANGUAGE CODE

Data Elements:

LANGUAGE CODE (PREFERRED)

LEARNING DISABILITIES CARE CLUSTER CODE

Change to Attribute: New Attribute

The Learning Disabilities Care Cluster assigned to a PATIENT.

Note: This data item is included in the Mental Health Services Data Set, but should not be submitted until further development by the Health and Social Care Information Centre has been undertaken.

This attribute is also known by these names:

Context	Alias
plural	LEARNING DISABILITIES CARE CLUSTER CODES

LEARNING DISABILITIES CARE CLUSTER CODE

Change to Attribute: New Attribute

LEARNING DISABILITIES CARE CLUSTER CODE

Data Elements:

LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)
LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)

LOOKED AFTER CHILD INDICATOR

Change to Attribute: Changed Description

An indication of whether a PERSON is a Looked After Child.

National Codes:

~~Y~~	~~Is a Looked After Child~~
~~N~~	~~Is not a Looked After Child~~
Y	Yes - is a Looked After Child
N	No - is not a Looked After Child

MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON renamed from ABSENCE WITHOUT LEAVE END REASON

Change to Attribute: Changed Name, Description

~~A coding which identifies the reason an occurrence of Mental Health Absence Without Leave ended.~~The reason the Mental Health Absence Without Leave ended.

National Codes:

01	PATIENT returned voluntarily
02	PATIENT is taken back into custody
03	PATIENT fails to return by the end of the relevant period for which they are liable to be detained or subject to guardianship
04	PATIENT discharged, care or treatment finished
05	PATIENT died

MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON renamed from ABSENCE WITHOUT LEAVE END REASON

Change to Attribute: Changed Name, Description

- Changed Name from Data_Dictionary.Attributes.A.ABSENCE_WITHOUT_LEAVE_END_REASON to Data_Dictionary.Attributes.M.Men.MENTAL_HEALTH_ABSENCE_WITHOUT_LEAVE_END_REASON
- Changed Description

MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY renamed from MENTAL HEALTH ABSOLUTE DISCHARGE END METHOD

Change to Attribute: Changed Name, Description

~~The body or PERSON responsible for granting absolute discharge.~~The body or PERSON responsible for granting a Mental Health Absolute Discharge.

National Codes:

~~01~~	~~Tribunal~~
01	Mental Health Tribunal
02	Secretary of State

MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY renamed from MENTAL HEALTH ABSOLUTE DISCHARGE END METHOD

Change to Attribute: Changed Name, Description

- Changed Name from Data_Dictionary.Attributes.M.Men.MENTAL_HEALTH_ABSOLUTE_DISCHARGE_END_METHOD to Data_Dictionary.Attributes.M.Men.MENTAL_HEALTH_ABSOLUTE_DISCHARGE_RESPONSIBILITY
- Changed Description

MENTAL HEALTH ACT 2007 MENTAL CATEGORY

Change to Attribute: Changed Description

The primary reason for the detention of PATIENTS under the Mental Health Act 1983, as amended by the Mental Health Act 2007.

MENTAL HEALTH ACT 2007 MENTAL CATEGORY should be used for PATIENTS detained from 3rd November 2008 when the relevant section of the Mental Health Act 2007 comes into force, and replaces MENTAL CATEGORY which is applicable until then.

A PATIENT should be included under only one MENTAL HEALTH ACT 2007 MENTAL CATEGORY.

National Codes:

~~A~~	~~Mental disorder (Learning Disability not present or not primary reason for using Act)~~
~~B~~	~~Mental disorder (Learning Disability primary reason for using Act)~~
A	Mental disorder (Learning Disability not present or not primary reason for using Act)
B	Mental disorder (Learning Disability primary reason for using Act)

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON renamed from MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD END REASON CODE

Change to Attribute: Changed Name, Description

~~The reason for the end of the current Mental Health Act Legal Status Classification Period.~~The reason for the end of the Mental Health Act Legal Status Classification Assignment Period.

National Codes:

~~01~~	~~Change in Mental Health Act Legal Status (including to informal)~~
~~02~~	~~Unrestricted treatment order (Community Treatment Order)~~
~~03~~	~~Restricted treatment order (Conditional Discharge)~~
01	Change in MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (including to informal)
02	Unrestricted treatment order (Community Treatment Order) (Retired 01 January 2016)

03 Restricted treatment order (Conditional Discharge) (Retired 01 January 2016)
04 Transfer to other Health Care Provider
05 Death of PATIENT

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON renamed from MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD END REASON CODE

Change to Attribute: Changed Name, Description

- Changed Name from Data_Dictionary.Attributes.M.Men.MENTAL_HEALTH_ACT_LEGAL_STATUS_CLASSIFICATION_PERIOD_END to Data_Dictionary.Attributes.M.Men.MENTAL_HEALTH_ACT_LEGAL_STATUS_CLASSIFICATION_ASSIGNMENT
- Changed Description

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON renamed from MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD START REASON CODE

Change to Attribute: Changed Name, Description

~~The reason for the start of the current Mental Health Act Legal Status Classification Period.~~The reason for the start of the Mental Health Act Legal Status Classification Assignment Period.

National Codes:

~~01 Change in Mental Health Act Legal Status (including from informal)~~
~~02 Recall from unrestricted treatment order (Community Treatment Order)~~
~~03 Recall from restricted treatment order (Conditional Discharge)~~
01 Change in MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (including from informal)
02 Recall from unrestricted treatment order (Community Treatment Order) (Retired 01 January 2016)
03 Recall from restricted treatment order (Conditional Discharge) (Retired 01 January 2016)
04 Transfer from other Health Care Provider

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON renamed from MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD START REASON CODE

Change to Attribute: Changed Name, Description

- Changed Name from Data_Dictionary.Attributes.M.Men.MENTAL_HEALTH_ACT_LEGAL_STATUS_CLASSIFICATION_PERIOD_STA to Data_Dictionary.Attributes.M.Men.MENTAL_HEALTH_ACT_LEGAL_STATUS_CLASSIFICATION_ASSIGNMENT
- Changed Description

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE

Change to Attribute: Changed Description

~~A classification of Mental Health Act Legal Status. The classification 'informal' is used for those PATIENTS who are not formally detained or not receiving supervised aftercare.~~A code to identify the classification of Mental Health Act Legal Status.

Note that the National Code '*Informal*' is used for those PATIENTS who are neither formally detained nor receiving supervised aftercare.

National Codes:

01	Informal
02	Formally detained under Mental Health Act Section 2
03	Formally detained under Mental Health Act Section 3
04	Formally detained under Mental Health Act Section 4
05	Formally detained under Mental Health Act Section 5(2)
06	Formally detained under Mental Health Act Section 5(4)
07	Formally detained under Mental Health Act Section 35
08	Formally detained under Mental Health Act Section 36
09	Formally detained under Mental Health Act Section 37 with section 41 restrictions
10	Formally detained under Mental Health Act Section 37
12	Formally detained under Mental Health Act Section 38
13	Formally detained under Mental Health Act Section 44
14	Formally detained under Mental Health Act Section 46
15	Formally detained under Mental Health Act Section 47 with section 49 restrictions
16	Formally detained under Mental Health Act Section 47
17	Formally detained under Mental Health Act Section 48 with section 49 restrictions
18	Formally detained under Mental Health Act Section 48
19	Formally detained under Mental Health Act Section 135
20	Formally detained under Mental Health Act Section 136
31	Formally detained under Criminal Procedure(Insanity) Act 1964 as amended by the Criminal Procedures (Insanity and Unfitness to Plead) Act 1991
32	Formally detained under other acts
33	Supervised Discharge (Mental Health (Patients in the Community) Act 1995) (Retired 03 November 2008 - but may apply to some patients until 3 May 2009)
34	Formally detained under Mental Health Act Section 45A (Retired 01 September 2014)
35	Subject to guardianship under Mental Health Act Section 7
36	Subject to guardianship under Mental Health Act Section 37
37	Formally detained under Mental Health Act Section 45A (Limited direction in force)
38	Formally detained under Mental Health Act Section 45A (Limitation direction ended)

MENTAL HEALTH CARE CLUSTER END REASON

Change to Attribute: Changed Description

~~The reason that the assignment of a PATIENT to a Mental Health Care Cluster ended.~~The reason that the assignment of a PATIENT to an Adult Mental Health Care Cluster ended.

National Codes:

~~01~~	~~PATIENT assigned to another Mental Health Care Cluster following a Mental Health Clustering Tool re-assessment~~
~~02~~	~~PATIENT discharged from Mental Health services~~
01	PATIENT assigned to another Adult Mental Health Care Cluster following an Adult Mental Health Clustering Tool re-assessment
02	PATIENT discharged from Mental Health Services
03	PATIENT transferred to another Health Care Provider
04	PATIENT died
05	PATIENT transferred to SERVICE not in scope of National Tariff Payment System within same Health Care Provider

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MENTAL HEALTH CONDITIONAL DISCHARGE END REASON

Change to Attribute: Changed Description

~~The reason for the termination of a Mental Health Conditional Discharge Period.~~The reason a Mental Health Conditional Discharge Period ended.

National Codes:

~~01~~	~~Absolute discharge~~
01	Mental Health Absolute Discharge
02	Recall of PATIENT
03	Death of PATIENT

MENTAL HEALTH DELAYED DISCHARGE REASON

Change to Attribute: Changed Description

~~The reason that a Mental Health Delayed Discharge Period was initiated for a PATIENT during a Consultant Episode (Hospital Provider).~~The reason that a Mental Health Delayed Discharge Period was initiated for a PATIENT.

National Codes:

A1	Awaiting completion of assessment
B1	Awaiting public funding
C1	Awaiting further non-acute (including community and mental health) NHS care (including intermediate care, rehabilitation services etc)
~~D1~~	~~Awaiting residential home placement or availability~~
~~D2~~	~~Awaiting nursing home placement or availability~~
D1	Awaiting Care Home Without Nursing placement or availability
D2	Awaiting Care Home With Nursing placement or availability
E1	Awaiting care package in own home
F1	Awaiting community equipment and adaptations
G1	PATIENT or family choice
H1	Disputes
I1	Housing - PATIENT not covered by NHS and Community Care Act
J1	Awaiting availability of social care support
K1	Awaiting availability of local health service provision
Z1	Other Reason

MENTAL HEALTH LEAVE OF ABSENCE END REASON renamed from LEAVE OF ABSENCE END REASON

Change to Attribute: Changed Name, Description

~~A coding which identifies the reason a Mental Health Leave of Absence was terminated.~~The reason a Mental Health Leave of Absence ended.

National Codes:

01	PATIENT returned on or before day specified
02	Leave revoked and PATIENT recalled by Mental Health Responsible Clinician
03	Period of leave to be extended
04	PATIENT failed to return on or before day specified and is absent without leave
05	PATIENT's liability for detention terminated by Mental Health Responsible Clinician
06	PATIENT's liability for detention terminated by Mental Health Act Review Tribunal
07	PATIENT's liability for detention terminated by Hospital Managers
08	PATIENT died
96	Other

MENTAL HEALTH LEAVE OF ABSENCE END REASON renamed from LEAVE OF ABSENCE END REASON

Change to Attribute: Changed Name, Description

- Changed Name from Data_Dictionary.Attributes.L.LEAVE_OF_ABSENCE_END_REASON to Data_Dictionary.Attributes.M.Men.MENTAL_HEALTH_LEAVE_OF_ABSENCE_END_REASON
- Changed Description

OBSERVATION SCHEME IN USE

Change to Attribute: New Attribute

The type of CLINICAL TERMINOLOGY CODE used for the observation.

National Codes:

01 Read Coded Clinical Terms Version 2
02 Read Coded Clinical Terms Version 3 (CTV3)
03 Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT)

This attribute is also known by these names:

Context	Alias
plural	OBSERVATION SCHEMES IN USE

OBSERVATION SCHEME IN USE

Change to Attribute: New Attribute

OBSERVATION SCHEME IN USE

Data Elements:

OBSERVATION SCHEME IN USE

OBSERVATION VALUE

Change to Attribute: New Attribute

The value of a CLINICAL INVESTIGATION RESULT ITEM.

This attribute is also known by these names:

Context	Alias
plural	OBSERVATION VALUES

OBSERVATION VALUE

Change to Attribute: New Attribute

OBSERVATION VALUE

Data Elements:

OBSERVATION VALUE

OFFERED FOR ADMISSION DATE

Change to Attribute: Changed Description

~~Date offered for admission to hospital to start a Hospital Provider Spell.~~The date offered for admission to hospital to start a Hospital Provider Spell.

ONWARD REFERRAL REASON

Change to Attribute: New Attribute

The reason why the PATIENT was referred from one SERVICE to another SERVICE, which may be in the same or a different ORGANISATION.

National Codes:

01	Transfer of Clinical Responsibility
02	For Opinion Only
03	For Diagnostic Test Only
04	New Referral (Non Transfer)
96	Other

This attribute is also known by these names:

Context	Alias
plural	ONWARD REFERRAL REASONS

ONWARD REFERRAL REASON

Change to Attribute: New Attribute

ONWARD REFERRAL REASON

Data Elements:

ONWARD REFERRAL REASON

OTHER PERSON IN ATTENDANCE AT CARE CONTACT

Change to Attribute: New Attribute

The other PERSON in attendance, with the PATIENT, at the CARE CONTACT.

National Codes:

01	Independent Advocate (Family Member)
02	Independent Advocate (Independent PERSON)
03	Independent Mental Capacity Advocate (IMCA)
04	Independent Mental Health Advocate (IMHA)
05	Non-Instructed Advocate

This attribute is also known by these names:

Context	Alias
plural	OTHER PERSONS IN ATTENDANCE AT CARE CONTACT

OTHER PERSON IN ATTENDANCE AT CARE CONTACT

Change to Attribute: New Attribute

OTHER PERSON IN ATTENDANCE AT CARE CONTACT

Data Elements:

OTHER PERSON IN ATTENDANCE AT CARE CONTACT

PERSON PROPERTY ASSIGNMENT PERIOD TYPE

Change to Attribute: New Attribute

The type of PERSON PROPERTY ASSIGNMENT PERIOD.

National Codes:

Care Cluster Assignment Period
Mental Health Act Legal Status Classification Assignment Period

Note: This list is not in alphabetical order.

This attribute is also known by these names:

Context	Alias
plural	PERSON PROPERTY ASSIGNMENT PERIOD TYPES

PERSON PROPERTY RECORDED DATE

Change to Attribute: Changed Description

The date when the PERSON PROPERTY was recorded by a PERSON. ~~In a computerised system this data would be derived from the time the information was entered.~~

For the National Renal Data Set, in a computerised system this data would be derived from the time the information was entered.

PLANNED ACTIVITY DATE

Change to Attribute: New Attribute

Any DATE that is of relevance to a PLANNED ACTIVITY.

The specific nature of the DATE will be identified by the PLANNED ACTIVITY DATE TYPE.

This attribute is also known by these names:

Context	Alias
plural	PLANNED ACTIVITY DATES

PLANNED ACTIVITY DATE

Change to Attribute: New Attribute

PLANNED ACTIVITY DATE

Data Elements:

PLANNED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)

PLANNED ACTIVITY DATE TYPE

Change to Attribute: New Attribute

The type of date that defines the usage with regard to the PLANNED ACTIVITY.

A PLANNED ACTIVITY may have many dates associated with it but may only have one date of a particular type.

National Codes:

Planned Discharge Date (Hospital Provider Spell)

Note: This list is not in alphabetical order.

This attribute is also known by these names:

Context	Alias
plural	PLANNED ACTIVITY DATE TYPES

PROCEDURE SCHEME IN USE

Change to Attribute: New Attribute

The type of CODED CLINICAL ENTRY used for the CLINICAL INTERVENTION.

National Codes:

01 Accident & Emergency Treatment ***
02 OPCS-4 ***
03 Read Code 4Byte Version (retired 1 October 2009)
04 Read Coded Clinical Terms Version 2
05 Read Coded Clinical Terms Version 3 (CTV3) *
06 Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT) **

Notes:

- * Read Coded Clinical Terms Version 3 (CTV3) with qualifiers (previously known as 3.1) is not supported in the Commissioning Data Sets
- ** Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT) is not valid for Commissioning Data Set version 6-1 and 6-2
- *** Accident & Emergency Treatment and OPCS-4 are not valid for the Mental Health Services Data Set.

This attribute is also known by these names:

Context	Alias
plural	PROCEDURE SCHEMES IN USE

PROCEDURE SCHEME IN USE

Change to Attribute: New Attribute

PROCEDURE SCHEME IN USE

Data Elements:

PROCEDURE SCHEME IN USE

PROFESSIONAL REGISTRATION BODY CODE

Change to Attribute: Changed Description

~~A code which identifies the PROFESSIONAL REGISTRATION BODY or Representative Body.~~A code which identifies the PROFESSIONAL REGISTRATION BODY.

National Codes:

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

* Note: National Codes 11, 13, 14 and 15 are not valid for use in the Mental Health Services Data Set.

REASON FOR REFERRAL TO MENTAL HEALTH

Change to Attribute: New Attribute

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

National Codes:

01	(Suspected) First Episode Psychosis
02	Ongoing or Recurrent Psychosis
03	Bi polar disorder
04	Depression
05	Anxiety
06	Obsessive compulsive disorder
07	Phobias
08	Organic brain disorder

09 Drug and alcohol difficulties
10 Unexplained physical symptoms
11 Post-traumatic stress disorder
12 Eating disorders
13 Perinatal mental health issues
14 Personality disorders
15 Self harm behaviours
16 Conduct disorders
17 Neurodevelopmental conditions
18 In crisis
19 Relationship difficulties
20 Gender Discomfort issues
21 Attachment difficulties
22 Self - care issues
23 Adjustment to health issues

This attribute is also known by these names:

Context	Alias
plural	REASONS FOR REFERRAL TO MENTAL HEALTH

REASON FOR REFERRAL TO MENTAL HEALTH

Change to Attribute: New Attribute

REASON FOR REFERRAL TO MENTAL HEALTH

Data Elements:

OTHER REASON FOR REFERRAL (MENTAL HEALTH)
PRIMARY REASON FOR REFERRAL (MENTAL HEALTH)

REFERRAL CLOSURE REASON

Change to Attribute: New Attribute

The reason that a REFERRAL REQUEST was closed by a Health Care Provider.

National Codes:

01 Admitted elsewhere (at the same or other Health Care 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 Health Care Provider)
09 PATIENT refused to be seen

This attribute is also known by these names:

Context	Alias
plural	REFERRAL CLOSURE REASONS

REFERRAL CLOSURE REASON

Change to Attribute: New Attribute

REFERRAL CLOSURE REASON

Data Elements:

REFERRAL CLOSURE REASON

REFERRAL REJECTION REASON

Change to Attribute: New Attribute

The reason that a REFERRAL REQUEST was rejected by a Health Care Provider.

National Codes:

01	Duplicate REFERRAL REQUEST (PATIENT already undergoing treatment for the same condition at the same or other Health Care Provider)
02	Inappropriate REFERRAL REQUEST (REFERRAL REQUEST is inappropriate for the SERVICES offered by the Health Care Provider)
03	Incomplete REFERRAL REQUEST (incomplete information on REFERRAL REQUEST)

This attribute is also known by these names:

Context	Alias
plural	REFERRAL REJECTION REASONS

REFERRAL REJECTION REASON

Change to Attribute: New Attribute

REFERRAL REJECTION REASON

Data Elements:

REFERRAL REJECTION REASON

REFERRING CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH AND COMMUNITY CARE

Change to Attribute: New Attribute

The staff group of a CARE PROFESSIONAL who referred a PATIENT to a Community Health Service or Mental Health Service.

National Codes:

	Allied Health Professionals
A01	Art Therapist
A02	Clinical Psychologist
A03	Dietitian
A04	Drama Therapist
A05	Music Therapist
A06	Occupational Therapist
A07	Orthotist
A08	Physiotherapist
A09	Podiatrist
A10	Prosthetist

A11	Psychotherapist
A12	Radiographer
A13	Speech and Language Therapist
A14	Orthoptist
	Medical/Dental
M01	Community Dentist
M02	CONSULTANT
M03	GENERAL MEDICAL PRACTITIONER
M04	General Practitioner With A Special Interest
	Nursing, Health Visiting and Midwifery
N01	MIDWIFE
N02	District NURSE
N03	Health Visitor
N04	Macmillan NURSE
N05	School Nurse
N06	Specialist Nursing - Active Case Management (Community Matrons)
N07	Specialist Nursing - Arthritis Nursing/Liaison
N08	Specialist Nursing - Asthma and Respiratory Nursing/Liaison
N09	Specialist Nursing - Breast Care Nursing/Liaison
N10	Specialist Nursing - Cancer Related
N11	Specialist Nursing - Cardiac Nursing/Liaison
N12	Specialist Nursing - Children's Services
N13	Specialist Nursing - Community Cystic Fibrosis
N14	Specialist Nursing - Continence Services
N15	Specialist Nursing - Diabetic Nursing/Liaison
N16	Specialist Nursing - Enteral Feeding Nursing Services
N17	Specialist Nursing - Haemophilia Nursing Services
N18	Specialist Nursing - HIV/AIDS Nursing Services (Retired 01 September 2015)
N19	Specialist Nursing - Infectious Diseases
N20	Specialist Nursing - Intensive Care Nursing
N21	Specialist Nursing - Palliative/Respite Care
N22	Specialist Nursing - Parkinson's and Alzheimers Nursing/Liaison
N23	Specialist Nursing - Rehabilitation Nursing
N24	Specialist Nursing - Stoma Care Services
N25	Specialist Nursing - Tissue Viability Nursing/Liaison
N26	Specialist Nursing - Transplantation Patients Nursing Service
N27	Specialist Nursing - Treatment Room Nursing Services
N28	Specialist Nursing - Tuberculosis Specialist Nursing
N29	Specialist Nursing - Other Specialist Nursing
N30	Specialist Nursing - Safeguarding
N31	Practice Nursing
N32	Staff NURSE
N33	Other Registered NURSE
N34	Public Health NURSE
	Other Care Professionals
C01	Appliances Technician
C02	Audiologist
C03	Counsellor
C04	Nursery Nurse
C06	Play Therapist
C07	Social Worker
C08	Voluntary Care Worker
C09	Screener (in a National Screening Programme)
C99	Other CARE PROFESSIONAL

This attribute is also known by these names:

Context	Alias

plural	REFERRING CARE PROFESSIONAL STAFF GROUPS FOR MENTAL HEALTH AND COMMUNITY CARE

RESTRICTIVE INTERVENTION TYPE

Change to Attribute: New Attribute

The type of Restrictive Intervention used on a PATIENT during a Hospital Provider Spell.

National Codes:

01	Physical restraint - Prone
02	Physical restraint - Excluding prone
03	Chemical restraint
04	Mechanical restraint
05	Seclusion
06	Segregation

This attribute is also known by these names:

Context	Alias
plural	RESTRICTIVE INTERVENTION TYPES

RESTRICTIVE INTERVENTION TYPE

Change to Attribute: New Attribute

RESTRICTIVE INTERVENTION TYPE

Data Elements:

RESTRICTIVE INTERVENTION TYPE

SERVICE OR TEAM TYPE FOR MENTAL HEALTH

Change to Attribute: New Attribute

The type of SERVICE or team within a Mental Health Service.

National Codes:

	General Mental Health Services
A01	Day Care Service
A02	Crisis Resolution Team/Home Treatment Service
A03	Crisis Resolution Team
A04	Home Treatment Service
A05	Primary Care Mental Health Service
A06	Community Mental Health Team - Functional
A07	Community Mental Health Team - Organic
A08	Assertive Outreach Team
A09	Rehabilitation and Recovery Service
A10	General Psychiatry Service
A11	Psychiatric Liaison Service
A12	Psychotherapy Service
A13	Psychological Therapy Service (non IAPT)
A14	Early Intervention Team for Psychosis
A15	Young Onset Dementia Team
A16	Personality Disorder Service

A17	Memory Services/Clinic
A18	Single Point of Access Service
	Forensic Services
B01	Forensic Mental Health Service
B02	Forensic Learning Disability Service
	Specialist Mental Health Services
C01	Autistic Spectrum Disorder Service
C02	Peri-Natal Mental Illness Service
C03	Eating Disorders/Dietetics Service
C04	Neurodevelopment Team
C05	Paediatric Liaison Service
C06	Looked After Children Service
C07	Community Young Offenders Service
C08	Acquired Brain Injury Service
	Other Mental Health Services
D01	Substance Misuse Team
D02	Criminal Justice Liaison and Diversion Service
D03	Prison Psychiatric Inreach Service
D04	Asylum Service
	Learning Disability Services
E01	Community Team for Learning Disabilities
E02	Epilepsy/Neurological Service
E03	Specialist Parenting Service
	Other
Z01	Other Mental Health Service - in scope of National Tariff Payment System
Z02	Other Mental Health Service - out of scope of National Tariff Payment System

This attribute is also known by these names:

Context	Alias
plural	SERVICE OR TEAM TYPES FOR MENTAL HEALTH

SERVICE OR TEAM TYPE FOR MENTAL HEALTH

Change to Attribute: New Attribute

SERVICE OR TEAM TYPE FOR MENTAL HEALTH

Data Elements:

CARE PROFESSIONAL SERVICE OR TEAM TYPE ASSOCIATION (MENTAL HEALTH)
SERVICE OR TEAM TYPE REFERRED TO (MENTAL HEALTH)

SERVICE TYPE

Change to Attribute: Changed Description

The type of SERVICE.

National Codes:

01	Ambulance Service
02	Cancer Service
03	Community Health Service
04	Consultant Led Service
05	Direct Access Service
06	Enhanced Sexual Health Service (Retired November 2014)

07 HIV Service
08 Hospital At Home Service
09 Improving Access to Psychological Therapies Service
10 Interface Service
11 Non-Consultant Led Service
12 Professional Staff Group Service
13 Sexual and Reproductive Health Service
14 Stop Smoking Service
15 Contraceptive Service (Retired 01 April 2014)
16 Radiotherapy Service
17 Sexual Health Service
Mental Health Service

SETTLED ACCOMMODATION INDICATOR

Change to Attribute: Changed Description

~~An indication of whether the main/permanent residence of a PATIENT is settled or non-settled accommodation.~~

~~Settled accommodation refers to secure, medium to long term accommodation.~~An indication of whether the main/permanent residence of a PATIENT is settled ACCOMMODATION.

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

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

National Codes:

~~0~~ ~~Non-settled Accommodation~~
~~1~~ ~~Settled Accommodation~~
Y Yes - Settled ACCOMMODATION
N No - Non-settled ACCOMMODATION
Z Not Stated (PERSON asked but declined to provide a response)

SOURCE OF REFERRAL FOR MENTAL HEALTH

Change to Attribute: Changed Description

~~The source of referral of a Mental Health Care Spell.~~The source of referral to a Mental Health Service.

Note: For the Mental Health Services Data Set, National Code P1 has been introduced to replace the National Codes under the headings:

- Internal referrals from Community Mental Health Team (within own NHS Trust)
- Internal referrals from Inpatient Service (within own NHS Trust) and
- Transfer by graduation (within own NHS Trust).

Users collecting the National Codes at the lower level must map to National Code P1 prior to submission of the Mental Health Services Data Set.

National Codes:

	Primary Health Care
A1	GENERAL MEDICAL PRACTITIONER
A2	Health Visitor
A3	Other Primary Health Care
	Self Referral
B1	Self
B2	Carer
	Local Authority Services
C1	Social Services
C2	Education Service
	Employer
D1	Employer
	Justice System
E1	Police
E2	Courts
E3	Probation Service
E4	Prison
E5	Court Liaison and Diversion Service
	Child Health
F1	School Nurse
F2	Hospital-based Paediatrics
F3	Community-based Paediatrics
	Independent/Voluntary Sector
G1	Independent sector - Medium Secure Inpatients
G2	Independent Sector - Low Secure Inpatients
~~G3~~	~~Other Independent Sector Mental Health Services~~
G3	Other Independent Sector Mental Health Services
G4	Voluntary Sector
	Acute Secondary Care
H1	Accident and Emergency Department
H2	Other secondary care specialty
	Other Mental Health NHS Trust
I1	Temporary transfer from another Mental Health NHS Trust
I2	Permanent transfer from another Mental Health NHS Trust
	Internal referrals from Community Mental Health Team (within own NHS Trust)
~~J1~~	~~Community Mental Health Team (Adult Mental Health)~~
~~J2~~	~~Community Mental Health Team (Older People)~~
~~J3~~	~~Community Mental Health Team (Learning Disabilities)~~
~~J4~~	~~Community Mental Health Team (Child and Adolescent Mental Health)~~
J1	Community Mental Health Team (Adult Mental Health) ***
J2	Community Mental Health Team (Older People) ***
J3	Community Mental Health Team (Learning Disabilities) ***
J4	Community Mental Health Team (Child and Adolescent Mental Health) ***
	Internal referrals from Inpatient Service (within own NHS Trust)
~~K1~~	~~Inpatient Service (Adult Mental Health)~~
~~K2~~	~~Inpatient Service (Older People)~~
~~K3~~	~~Inpatient Service (Forensics)~~
~~K4~~	~~Inpatient Service (Child and Adolescent Mental Health)~~
~~K5~~	~~Inpatient Service (Learning Disabilities)~~
K1	Inpatient Service (Adult Mental Health) ***
K2	Inpatient Service (Older People) ***
K3	Inpatient Service (Forensics) ***
K4	Inpatient Service (Child and Adolescent Mental Health) ***
K5	Inpatient Service (Learning Disabilities) ***
	Transfer by graduation (within own NHS Trust)
~~L1~~	

	~~Transfer by graduation from Child and Adolescent Mental Health Services to Adult Mental Health Services~~
~~L2~~	~~Transfer by graduation from Adult Mental Health Services to Older Peoples Mental Health Services~~
L1	Transfer by graduation from Child and Adolescent Mental Health Service to Adult Mental Health Services
L2	Transfer by graduation from Adult Mental Health Services to Older Peoples Mental Health Services
	Other
M1	Asylum Services
M2	Telephone or Electronic Access Service
M3	Out of Area Agency
M4	Drug Action Team / Drug Misuse Agency
M5	Jobcentre Plus **
~~M6~~	~~Other service or agency~~
M6	Other SERVICE or agency
M7	Single Point of Access Service ****
	Improving Access to Psychological Therapies
N1	Stepped up from low intensity Improving Access to Psychological Therapies Service *
N2	Stepped down from high intensity Improving Access to Psychological Therapies Service *
N3	Improving Access to Psychological Therapies Service ****
	Internal
P1	Internal Referral ****

Notes:

- * National Codes N1 and N2 are for use in the Improving Access to Psychological Therapies Data Set **only**.
- ~~** National Code M5 can only be used for the Mental Health and Learning Disabilities Data Set and Child and Adolescent Mental Health Services Secondary Uses Data Set, if referrals from Jobcentre Plus are accepted.~~
- ** National Code M5 can only be used for the Mental Health Services Data Set, if referrals from Jobcentre Plus are accepted.
- *** National Codes J1, J2, J3, J4, K1, K2, K3, K4, K5, L1, and L2 are for use in the Improving Access to Psychological Therapies Data Set **only**.
- **** National Codes M7, N3 and P1 are for use in the Mental Health Services Data Set **only.**

UCUM UNIT OF MEASUREMENT

Change to Attribute: New Attribute

The UNIT OF MEASUREMENT using the Unified Code for Units of Measure (UCUM) code system.

For further information on the Unified Code for Units of Measure (UCUM) code system, see the Unified Code for Units of Measure website.

This attribute is also known by these names:

Context	Alias
plural	UCUM UNITS OF MEASUREMENT

UCUM UNIT OF MEASUREMENT

Change to Attribute: New Attribute

UCUM UNIT OF MEASUREMENT

Data Elements:

UCUM UNIT OF MEASUREMENT

WAITING TIME MEASUREMENT TYPE

Change to Attribute: Changed Description

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

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

National Codes:

01	Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement
02	Allied Health Professional Referral To Treatment Measurement
03	Improving Access to Psychological Therapies Referral To Treatment Measurement *
04	Early Intervention in Psychosis Waiting Time Measurement *
09	Other Referral To Treatment Measurement Type

~~Note: * National Code 03 is used for the Improving Access to Psychological Therapies Data Set only.~~Notes:

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

WARD SETTING TYPE FOR MENTAL HEALTH

Change to Attribute: New Attribute

The type of WARD setting for a Mental Health Services PATIENT during a Hospital Provider Spell.

National Codes:

01	Child and Adolescent Mental Health WARD
02	Paediatric WARD
03	Adult Mental Health WARD
04	Non Mental Health WARD
05	Learning Disabilities WARD
06	Older People's Mental Health WARD

This attribute is also known by these names:

Context	Alias
plural	WARD SETTING TYPES FOR MENTAL HEALTH

WARD SETTING TYPE FOR MENTAL HEALTH

Change to Attribute: New Attribute

WARD SETTING TYPE FOR MENTAL HEALTH

Data Elements:

WARD SETTING TYPE (MENTAL HEALTH)

WEEKLY HOURS WORKED

Change to Attribute: Changed Description

~~The number of hours worked per week by a~~ PERSON~~.~~A code to identify the number of hours worked per week by a PERSON.

National Codes:

01	30+ hours
02	16-29 hours
03	5-15 hours
04	1-4 hours
97	Not disclosed (PATIENT was asked but refused to respond)

YOUNG CARER INDICATOR

Change to Attribute: Changed Description

An indication of whether a child or young PERSON has a caring role for an ill or disabled parent, carer or sibling.

National Codes:

~~Y~~	~~Yes~~
~~N~~	~~No~~
Y	Yes - child or young PERSON has a caring role for an ill or disabled parent, carer or sibling
N	No - child or young PERSON does not have a caring role for an ill or disabled parent, carer or sibling
Z	Not Stated (PERSON asked but declined to provide a response)

ACCOMMODATION STATUS RECORDED DATE renamed from ACCOMMODATION STATUS DATE

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

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
~~ACCOMMODATION STATUS DATE is the PERSON PROPERTY OBSERVED DATE when the ACCOMMODATION STATUS CODE was recorded.~~ACCOMMODATION STATUS RECORDED DATE is the same as attribute PERSON PROPERTY RECORDED DATE. ACCOMMODATION STATUS RECORDED DATE is the DATE when the ACCOMMODATION STATUS CODE was recorded.

ACCOMMODATION STATUS RECORDED DATE renamed from ACCOMMODATION STATUS DATE

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

~~ACCOMMODATION STATUS DATE~~

ACCOMMODATION STATUS RECORDED DATE

Attribute:

~~PERSON PROPERTY OBSERVED DATE~~

PERSON PROPERTY RECORDED DATE

ACCOMMODATION STATUS RECORDED DATE renamed from ACCOMMODATION STATUS DATE

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

- Changed Name from Data_Dictionary.Data_Field_Notes.A.ACCOMMODATION_STATUS_DATE to Data_Dictionary.Data_Field_Notes.A.ACCOMMODATION_STATUS_RECORDED_DATE
- Changed Description
- null

ADULT MENTAL HEALTH CARE CLUSTER CODE (FINAL) renamed from MENTAL HEALTH CARE CLUSTER CODE (FINAL)

Change to Data Element: Changed Name, Description

Format/Length:	max an4
~~National Codes:~~	~~See MENTAL HEALTH CARE CLUSTER CODE~~
National Codes:	See ADULT MENTAL HEALTH CARE CLUSTER CODE
Default Codes:	

Notes:

~~MENTAL HEALTH CARE CLUSTER CODE (FINAL) is the same as attribute MENTAL HEALTH CARE CLUSTER CODE.~~ADULT MENTAL HEALTH CARE CLUSTER CODE (FINAL) is the same as attribute ADULT MENTAL HEALTH CARE CLUSTER CODE.

ADULT MENTAL HEALTH CARE CLUSTER CODE (FINAL) is the final ADULT MENTAL HEALTH CARE CLUSTER CODE allocated by the CARE PROFESSIONAL.

~~MENTAL HEALTH CARE CLUSTER CODE (FINAL) is the final allocation of the MENTAL HEALTH CARE CLUSTER CODE by the CARE PROFESSIONAL, the determination of the Mental Health Care Cluster code may or may not have involved the use of the National Tariff Payment System clustering algorithm.~~The determination of the ADULT MENTAL HEALTH CARE CLUSTER CODE (FINAL) may or may not have involved the use of the National Tariff Payment System clustering algorithm.

ADULT MENTAL HEALTH CARE CLUSTER CODE (FINAL) renamed from MENTAL HEALTH CARE CLUSTER CODE (FINAL)

Change to Data Element: Changed Name, Description

- Changed Name from Data_Dictionary.Data_Field_Notes.M.Men.MENTAL_HEALTH_CARE_CLUSTER_CODE_(FINAL) to Data_Dictionary.Data_Field_Notes.A.Ad.ADULT_MENTAL_HEALTH_CARE_CLUSTER_CODE_(FINAL)
- Changed Description

ADULT MENTAL HEALTH CARE CLUSTER CODE (INITIAL) renamed from MENTAL HEALTH CARE CLUSTER CODE (INITIAL)

Change to Data Element: Changed Name, Description

Format/Length:	max an4
~~National Codes:~~	~~See MENTAL HEALTH CARE CLUSTER CODE~~
National Codes:	See ADULT MENTAL HEALTH CARE CLUSTER CODE
Default Codes:	

Notes:
~~MENTAL HEALTH CARE CLUSTER CODE (INITIAL) is the same as attribute MENTAL HEALTH CARE CLUSTER CODE.~~

ADULT MENTAL HEALTH CARE CLUSTER CODE (INITIAL) is the same as attribute ADULT MENTAL HEALTH CARE CLUSTER CODE.

~~MENTAL HEALTH CARE CLUSTER CODE (INITIAL) is the initial MENTAL HEALTH CARE CLUSTER CODE which is allocated by the CARE PROFESSIONAL without reference to the National Tariff Payment System clustering algorithm.~~ADULT MENTAL HEALTH CARE CLUSTER CODE (INITIAL) is the initial ADULT MENTAL HEALTH CARE CLUSTER CODE allocated by the CARE PROFESSIONAL without reference to the National Tariff Payment System clustering algorithm.

ADULT MENTAL HEALTH CARE CLUSTER CODE (INITIAL) renamed from MENTAL HEALTH CARE CLUSTER CODE (INITIAL)

Change to Data Element: Changed Name, Description

- Changed Name from Data_Dictionary.Data_Field_Notes.M.Men.MENTAL_HEALTH_CARE_CLUSTER_CODE_(INITIAL) to Data_Dictionary.Data_Field_Notes.A.Ad.ADULT_MENTAL_HEALTH_CARE_CLUSTER_CODE_(INITIAL)
- Changed Description

CARE ACTIVITY IDENTIFIER

Change to Data Element: New Data Element

Format/Length:	max an20
National Codes:	
Default Codes:	

Notes:
CARE ACTIVITY IDENTIFIER is the ACTIVITY IDENTIFIER for a CARE ACTIVITY.

This data element is also known by these names:

Context	Alias
plural	CARE ACTIVITY IDENTIFIERS

CARE ACTIVITY IDENTIFIER

Change to Data Element: New Data Element

CARE ACTIVITY IDENTIFIER

Attribute:

ACTIVITY IDENTIFIER

CARE CONTACT CANCELLATION DATE

Change to Data Element: Changed Description, linked Attribute

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
~~CARE CONTACT CANCELLATION DATE~~ ~~is the same as attribute~~ ~~CARE CONTACT CANCELLATION DATE~~.CARE CONTACT CANCELLATION DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Care Contact Cancellation Date*'.

CARE CONTACT CANCELLATION DATE

Change to Data Element: Changed Description, linked Attribute

CARE CONTACT CANCELLATION DATE

Attribute:

~~CARE CONTACT CANCELLATION DATE~~
ACTIVITY DATE

CARE CONTACT DATE

Change to Data Element: Changed Description, linked Attribute

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
~~CARE CONTACT DATE~~ ~~is the same as attribute~~ ~~CARE CONTACT DATE~~.CARE CONTACT DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'Care Contact Date*'.

CARE CONTACT DATE

Change to Data Element: Changed Description, linked Attribute

CARE CONTACT DATE

Attribute:

~~CARE CONTACT DATE~~
ACTIVITY DATE

CARE CONTACT IDENTIFIER

Change to Data Element: New Data Element

Format/Length:	max an20
National Codes:	
Default Codes:	

Notes:
CARE CONTACT IDENTIFIER is the ACTIVITY IDENTIFIER for a CARE CONTACT.

This data element is also known by these names:

Context	Alias
plural	CARE CONTACT IDENTIFIERS

CARE CONTACT IDENTIFIER

Change to Data Element: New Data Element

CARE CONTACT IDENTIFIER

Attribute:

ACTIVITY IDENTIFIER

CARE CONTACT TIME

Change to Data Element: Changed Description, linked Attribute

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:
~~CARE CONTACT TIME is the same as attribute CARE CONTACT TIME~~.CARE CONTACT TIME is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Care Contact Time*'.

CARE CONTACT TIME

Change to Data Element: Changed Description, linked Attribute

CARE CONTACT TIME

Attribute:

~~CARE CONTACT TIME~~
ACTIVITY TIME

CARE PROFESSIONAL LOCAL IDENTIFIER

Change to Data Element: New Data Element

Format/Length:	max an20
National Codes:	
Default Codes:	

Notes:
CARE PROFESSIONAL LOCAL IDENTIFIER is the same as attribute CARE PROFESSIONAL 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.

This data element is also known by these names:

Context	Alias
plural	CARE PROFESSIONAL LOCAL IDENTIFIERS

CARE PROFESSIONAL LOCAL IDENTIFIER

Change to Data Element: New Data Element

CARE PROFESSIONAL LOCAL IDENTIFIER

Attribute:

CARE PROFESSIONAL IDENTIFIER

CARE PROFESSIONAL SERVICE OR TEAM TYPE ASSOCIATION (MENTAL HEALTH)

Change to Data Element: New Data Element

Format/Length:	an3
National Codes:	See SERVICE OR TEAM TYPE FOR MENTAL HEALTH
Default Codes:	

Notes:
CARE PROFESSIONAL SERVICE OR TEAM TYPE ASSOCIATION (MENTAL HEALTH) is the same as attribute SERVICE OR TEAM TYPE FOR MENTAL HEALTH.

CARE PROFESSIONAL SERVICE OR TEAM TYPE ASSOCIATION (MENTAL HEALTH) is the type of SERVICE or team that the CARE PROFESSIONAL is associated with, within a Mental Health Service.

This data element is also known by these names:

Context	Alias
plural	CARE PROFESSIONAL SERVICE OR TEAM TYPE ASSOCIATIONS (MENTAL HEALTH)

CARE PROFESSIONAL SERVICE OR TEAM TYPE ASSOCIATION (MENTAL HEALTH)

Change to Data Element: New Data Element

CARE PROFESSIONAL SERVICE OR TEAM TYPE ASSOCIATION (MENTAL HEALTH)

Attribute:

SERVICE OR TEAM TYPE FOR MENTAL HEALTH

CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH)

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH
Default Codes:	

Notes:
CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH) is the same as attribute CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH.

This data element is also known by these names:

Context	Alias
plural	CARE PROFESSIONAL STAFF GROUPS (MENTAL HEALTH)

CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH)

Change to Data Element: New Data Element

CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH)

Attribute:

CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH

CARE PROFESSIONAL TEAM LOCAL IDENTIFIER

Change to Data Element: New Data Element

Format/Length:	max an20
National Codes:	
Default Codes:	

Notes:
CARE PROFESSIONAL TEAM LOCAL IDENTIFIER is the same as attribute CARE PROFESSIONAL TEAM IDENTIFIER.

CARE PROFESSIONAL TEAM LOCAL IDENTIFIER is a unique local CARE PROFESSIONAL TEAM IDENTIFIER within a Health Care Provider and may be assigned automatically by the computer system.

This data element is also known by these names:

Context	Alias
plural	CARE PROFESSIONAL TEAM LOCAL IDENTIFIERS

CARE PROFESSIONAL TEAM LOCAL IDENTIFIER

Change to Data Element: New Data Element

CARE PROFESSIONAL TEAM LOCAL IDENTIFIER

Attribute:

CARE PROFESSIONAL TEAM IDENTIFIER

CARE PROGRAMME APPROACH CARE EPISODE IDENTIFIER

Change to Data Element: New Data Element

Format/Length:	max an20
National Codes:	
Default Codes:	

Notes:
CARE PROGRAMME APPROACH CARE EPISODE IDENTIFIER is the same as attribute ACTIVITY IDENTIFIER.

CARE PROGRAMME APPROACH CARE EPISODE IDENTIFIER is a unique identifier allocated to each Care Programme Approach Care Episode.

This data element is also known by these names:

Context	Alias
shortname	CPA CARE EPISODE IDENTIFIER
plural	CARE PROGRAMME APPROACH CARE EPISODE IDENTIFIERS

CARE PROGRAMME APPROACH CARE EPISODE IDENTIFIER

Change to Data Element: New Data Element

CARE PROGRAMME APPROACH CARE EPISODE IDENTIFIER

Attribute:

ACTIVITY IDENTIFIER

CARE PROGRAMME APPROACH REVIEW DATE renamed from REVIEW DATE

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

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
~~REVIEW DATE is the DATE of a formal review of care carried out during a CARE CONTACT.~~CARE PROGRAMME APPROACH REVIEW DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Care Programme Approach Review Date*'.

CARE PROGRAMME APPROACH REVIEW DATE renamed from REVIEW DATE

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

CARE PROGRAMME APPROACH REVIEW DATE

Attribute:

ACTIVITY DATE

CARE PROGRAMME APPROACH REVIEW DATE renamed from REVIEW DATE

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

- Changed Name from Data_Dictionary.Data_Field_Notes.R.Rep.REVIEW_DATE to Data_Dictionary.Data_Field_Notes.C.Care.CARE_PROGRAMME_APPROACH_REVIEW_DATE
- Changed Description
- null

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL)

Change to Data Element: New Data Element

Format/Length:	max an4
National Codes:	See CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE
Default Codes:	

Notes:
CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL) is the same as attribute CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE.

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL) is the final CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE allocated by the CARE PROFESSIONAL.

Note: This data item is included in the Mental Health Services Data Set, but should not be submitted until further development by the Health and Social Care Information Centre has been undertaken.

This data element is also known by these names:

Context	Alias
plural	CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODES (FINAL)

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL)

Change to Data Element: New Data Element

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL)

Attribute:

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL)

Change to Data Element: New Data Element

Format/Length:	max an4
National Codes:	See CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE
Default Codes:	

Notes:
CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL) is the same as attribute CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE.

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL) is the initial CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE allocated by the CARE PROFESSIONAL.

Note: This data item is included in the Mental Health Services Data Set, but should not be submitted until further development by the Health and Social Care Information Centre has been undertaken.

This data element is also known by these names:

Context	Alias
plural	CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODES (INITIAL)

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL)

Change to Data Element: New Data Element

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL)

Attribute:

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE

CHILD PROTECTION PLAN INDICATION CODE renamed from CHILD PROTECTION PLAN INDICATOR

Change to Data Element: Changed Name, Description

Format/Length:	an1
~~National Codes:~~	~~See CHILD PROTECTION PLAN INDICATOR~~

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

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

CHILD PROTECTION PLAN INDICATION CODE renamed from CHILD PROTECTION PLAN INDICATOR

Change to Data Element: Changed Name, Description

- Changed Name from Data_Dictionary.Data_Field_Notes.C.Ce.CHILD_PROTECTION_PLAN_INDICATOR to Data_Dictionary.Data_Field_Notes.C.Ce.CHILD_PROTECTION_PLAN_INDICATION_CODE
- Changed Description

CLINICAL CONTACT DURATION OF CARE ACTIVITY

Change to Data Element: Changed Description

~~Format/Length:~~	~~n4~~
Format/Length:	max n4
National Codes:	
Default Codes:	

Notes:
CLINICAL CONTACT DURATION OF CARE ACTIVITY is 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.

CLINICAL CONTACT DURATION OF CARE ACTIVITY is calculated from the Start Time and End Time of the CARE ACTIVITY.

CLINICAL CONTACT DURATION OF CARE CONTACT

Change to Data Element: Changed Description

~~Format/Length:~~	~~n4~~
Format/Length:	max n4
National Codes:	
Default Codes:	

Notes:
CLINICAL CONTACT DURATION OF CARE CONTACT is 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.

CLINICAL CONTACT DURATION OF CARE CONTACT is calculated from the Start Time and End Time of the CARE CONTACT.

CLINICAL CONTACT DURATION OF GROUP SESSION

Change to Data Element: Changed Description

~~Format/Length:~~	~~n4~~
Format/Length:	max n4
National Codes:	
Default Codes:	

Notes:
CLINICAL CONTACT DURATION OF GROUP SESSION is 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.

CLINICAL CONTACT DURATION OF GROUP SESSION is calculated from the Start Time and End Time of the Group Session.

CLUSTERING TOOL ASSESSMENT CATEGORY

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See CLUSTERING TOOL ASSESSMENT CATEGORY
Default Codes:	

Notes:
CLUSTERING TOOL ASSESSMENT CATEGORY is the same as attribute CLUSTERING TOOL ASSESSMENT CATEGORY.

This data element is also known by these names:

Context	Alias
plural	CLUSTERING TOOL ASSESSMENT CATEGORIES

CLUSTERING TOOL ASSESSMENT CATEGORY

Change to Data Element: New Data Element

CLUSTERING TOOL ASSESSMENT CATEGORY

Attribute:

CLUSTERING TOOL ASSESSMENT CATEGORY

CLUSTERING TOOL ASSESSMENT IDENTIFIER

Change to Data Element: New Data Element

Format/Length:	max an20
National Codes:	
Default Codes:	

Notes:
CLUSTERING TOOL ASSESSMENT IDENTIFIER is the same as attribute ACTIVITY IDENTIFIER.

CLUSTERING TOOL ASSESSMENT IDENTIFIER is a unique identifier for each Clustering Tool assessment that takes place for each PATIENT.

This data element is also known by these names:

Context	Alias
plural	CLUSTERING TOOL ASSESSMENT IDENTIFIERS

CLUSTERING TOOL ASSESSMENT IDENTIFIER

Change to Data Element: New Data Element

CLUSTERING TOOL ASSESSMENT IDENTIFIER

Attribute:

ACTIVITY IDENTIFIER

CLUSTERING TOOL ASSESSMENT REASON renamed from MENTAL HEALTH CLUSTERING TOOL ASSESSMENT REASON

Change to Data Element: Changed Name, Description

Format/Length:	an2
~~National Codes:~~	~~See MENTAL HEALTH CLUSTERING TOOL ASSESSMENT REASON~~
~~Default Codes:~~	~~99 - Not known~~
National Codes:	See CLUSTERING TOOL ASSESSMENT REASON
Default Codes:	99 - CLUSTERING TOOL ASSESSMENT REASON Not known

Notes:
~~MENTAL HEALTH CLUSTERING TOOL ASSESSMENT REASON is the same as attribute MENTAL HEALTH CLUSTERING TOOL ASSESSMENT REASON.~~

CLUSTERING TOOL ASSESSMENT REASON is the same as attribute CLUSTERING TOOL ASSESSMENT REASON.

CLUSTERING TOOL ASSESSMENT REASON renamed from MENTAL HEALTH CLUSTERING TOOL ASSESSMENT REASON

Change to Data Element: Changed Name, Description

- Changed Name from Data_Dictionary.Data_Field_Notes.M.Men.MENTAL_HEALTH_CLUSTERING_TOOL_ASSESSMENT_REASON to Data_Dictionary.Data_Field_Notes.C.Cl.CLUSTERING_TOOL_ASSESSMENT_REASON
- Changed Description

CODED ASSESSMENT TOOL TYPE (SNOMED CT)

Change to Data Element: New Data Element

Format/Length:	min an6 max an18
National Codes:	
Default Codes:	

Notes:
CODED ASSESSMENT TOOL TYPE (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

CODED ASSESSMENT TOOL TYPE (SNOMED CT) is the SNOMED CT concept ID which is used to identify an ASSESSMENT TOOL.

This data element is also known by these names:

Context	Alias
plural	CODED ASSESSMENT TOOL TYPES (SNOMED CT)

CODED ASSESSMENT TOOL TYPE (SNOMED CT)

Change to Data Element: New Data Element

CODED ASSESSMENT TOOL TYPE (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

CODED FINDING (CODED CLINICAL ENTRY)

Change to Data Element: New Data Element

Format/Length:	min an4 max an18
National Codes:	
Default Codes:	

Notes:
CODED FINDING (CODED CLINICAL ENTRY) is the same as attribute CLINICAL CLASSIFICATION CODE or CLINICAL TERMINOLOGY CODE.

CODED FINDING (CODED CLINICAL ENTRY) is the CODED CLINICAL ENTRY which is used to identify a finding.

This data element is also known by these names:

Context	Alias
plural	CODED FINDINGS (CODED CLINICAL ENTRY)

CODED FINDING (CODED CLINICAL ENTRY)

Change to Data Element: New Data Element

CODED FINDING (CODED CLINICAL ENTRY)

Attribute:

CLINICAL CLASSIFICATION CODE
CLINICAL TERMINOLOGY CODE

CODED OBSERVATION (CLINICAL TERMINOLOGY)

Change to Data Element: New Data Element

Format/Length:	min an5 max an18
National Codes:	
Default Codes:	

Notes:
CODED OBSERVATION (CLINICAL TERMINOLOGY) is the same as attribute CLINICAL TERMINOLOGY CODE.

CODED OBSERVATION (CLINICAL TERMINOLOGY) is the CLINICAL TERMINOLOGY CODE which is used to identify an observation.

This data element is also known by these names:

Context	Alias
plural	CODED OBSERVATIONS (CLINICAL TERMINOLOGY)

CODED OBSERVATION (CLINICAL TERMINOLOGY)

Change to Data Element: New Data Element

CODED OBSERVATION (CLINICAL TERMINOLOGY)

Attribute:

CLINICAL TERMINOLOGY CODE

CODED PROCEDURE (CLINICAL TERMINOLOGY)

Change to Data Element: New Data Element

Format/Length:	min an5 max an18
National Codes:	
Default Codes:	

Notes:
CODED PROCEDURE (CLINICAL TERMINOLOGY) is the same as attribute CLINICAL TERMINOLOGY CODE.

CODED PROCEDURE (CLINICAL TERMINOLOGY) is the CLINICAL TERMINOLOGY CODE which is used to identify a Patient Procedure.

This data element is also known by these names:

Context	Alias
plural	CODED PROCEDURES (CLINICAL TERMINOLOGY)

CODED PROCEDURE (CLINICAL TERMINOLOGY)

Change to Data Element: New Data Element

CODED PROCEDURE (CLINICAL TERMINOLOGY)

Attribute:

CLINICAL TERMINOLOGY CODE

COMMUNITY TREATMENT ORDER END REASON renamed from SUPERVISED COMMUNITY TREATMENT END REASON

Change to Data Element: Changed Name

- Changed Name from Data_Dictionary.Data_Field_Notes.S.Su.SUPERVISED_COMMUNITY_TREATMENT_END_REASON to Data_Dictionary.Data_Field_Notes.C.Co.COMMUNITY_TREATMENT_ORDER_END_REASON

CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR

Change to Data Element: New Data Element

Format/Length:	an1
National Codes:	See CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR
Default Codes:	

Notes:
CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR is the same as attribute CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR.

This data element is also known by these names:

Context	Alias
plural	CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATORS

CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR

Change to Data Element: New Data Element

CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR

Attribute:

CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR

CONSULTATION TYPE

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See CONSULTATION TYPE
Default Codes:	

Notes:
CONSULTATION TYPE is the same as attribute CONSULTATION TYPE.

This data element is also known by these names:

Context	Alias
plural	CONSULTATION TYPES

CONSULTATION TYPE

Change to Data Element: New Data Element

CONSULTATION TYPE

Attribute:

CONSULTATION TYPE

DATE DETENTION COMMENCED

Change to Data Element: Changed Description

~~Format/length:~~	~~see DATE~~
~~HES item:~~	~~DETNDATE~~
Format/Length:	See DATE
HES Item:	DETNDATE
National Codes:	
Default Codes:	

Notes:

~~DATE DETENTION COMMENCED is the same as the attribute PERSON PROPERTY EFFECTIVE DATE.~~DATE DETENTION COMMENCED is the PERSON PROPERTY EFFECTIVE DATE of the first MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION where the PATIENT is detained.

~~This is the PERSON PROPERTY EFFECTIVE DATE of the Mental Health Act Legal Status. It is the date on which the first order was made in this period of detention, even though the section of the Act under which the PATIENT is detained may have changed, the PATIENT may have been transferred to another provider or the PATIENT was detained under the Act after admission to the current provider. All changes in MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE should be recorded, and the continuous period of detention obtained by comparing the PERSON PROPERTY EFFECTIVE DATES for the historical Mental Health Act Legal Status records.~~DATE DETENTION COMMENCED is the date on which the first order was made in this period of detention, even though the section of the Act under which the PATIENT is detained may have changed, the PATIENT may have been transferred to another provider or the PATIENT was detained under the Act after admission to the current provider. All changes in MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE should be recorded, and the continuous period of detention obtained by comparing the PERSON PROPERTY EFFECTIVE DATES for the historical Mental Health Act Legal Status records. (Act refers to the 1983 Mental Health Act).

Where the detention order is held by a hospital other than that where the PATIENT is present at the date of the census, the latter should ensure the information relating to this detention order is obtained from the former hospital. Only the hospital where the PATIENT is treated should submit the data.

~~Mental Health Act Legal Status is a CATEGORY VALUED PERSON OBSERVATION where CATEGORY VALUED PERSON OBSERVATION TYPE is National Code 07 '*Legal Status Classification*'.~~

DATE OF ASSAULT ON PATIENT

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:

~~DATE OF ASSAULT ON PATIENT is the DATE of a reported instance of assault on the PATIENT by another PATIENT.~~DATE OF ASSAULT ON PATIENT is the DATE that an instance of assault occurred on the PATIENT by another PATIENT.

~~For the Mental Health and Learning Disabilities Data Set, assault is defined as:~~For the Mental Health Services Data Set, DATE OF ASSAULT ON PATIENT is during a Hospital Provider Spell and assault is defined as:

The intentional application of force to the person of another, without lawful justification, resulting in physical injury or personal discomfort.

~~DATE OF ASSAULT ON PATIENT is only reported in the Mental Health and Learning Disabilities Data Set if the assault occurred during a Hospital Provider Spell.~~

DATE OF RESTRICTIVE INTERVENTION

Change to Data Element: New Data Element

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
DATE OF RESTRICTIVE INTERVENTION is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Date of Restrictive Intervention*'.

This data element is also known by these names:

Context	Alias
plural	DATES OF RESTRICTIVE INTERVENTION

DATE OF RESTRICTIVE INTERVENTION

Change to Data Element: New Data Element

DATE OF RESTRICTIVE INTERVENTION

Attribute:

ACTIVITY DATE

DATE OF SELF-HARM renamed from DATE OF SELF HARM

Change to Data Element: Changed Name, Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
~~DATE OF SELF HARM is the DATE of a reported incident of self-harm by a PATIENT.~~DATE OF SELF-HARM is the DATE that an incident of self-harm by a PATIENT occurred.

~~For the Mental Health and Learning Disabilities Data Set, self-harm is defined as:~~For the Mental Health Services Data Set, DATE OF SELF-HARM is during a Hospital Provider Spell and self-harm is defined as:

Intentional self-poisoning or injury, irrespective of the apparent purpose of the act. Self-harm includes poisoning, asphyxiation, cutting, burning and other self-inflicted injuries.

~~DATE OF SELF HARM is only reported in the Mental Health and Learning Disabilities Data Set if the self-harm occurred during a Hospital Provider Spell.~~

DATE OF SELF-HARM renamed from DATE OF SELF HARM

Change to Data Element: Changed Name, Description

- Changed Name from Data_Dictionary.Data_Field_Notes.D.DATE_OF_SELF_HARM to Data_Dictionary.Data_Field_Notes.D.DATE_OF_SELF-HARM
- Changed Description

DIAGNOSIS SCHEME IN USE

Change to Data Element: Changed Description, linked Attribute

Format/Length:	an2
~~National Codes:~~	
National Codes:	See DIAGNOSIS SCHEME IN USE
Default Codes:	

Notes:
DIAGNOSIS SCHEME IN USE ~~is used in the Clinical Information Group of the Commissioning Data Set to denote the code scheme basis of the Diagnosis.~~

~~*Permitted National Codes:*~~

~~01~~	~~Accident & Emergency Diagnosis~~
~~02~~	~~ICD-10~~
~~03~~	~~Read Code 4Byte Version (retired 1 October 2009)~~
~~04~~	~~Read Code Version 2~~
~~05~~	~~Read Code Clinical Terms Version 3 (CTV3)~~

~~Read Code Clinical Terms Version 3 (CTV3) with qualifiers (previously known as 3.1) is not supported in the Commissioning Data Sets.~~

~~**CDS XML Message:**~~

~~The codes specified above must be used in Commissioning Data Set – XML messages.~~

DIAGNOSIS SCHEME IN USE is the same as attribute DIAGNOSIS SCHEME IN USE.

DIAGNOSIS SCHEME IN USE

Change to Data Element: Changed Description, linked Attribute

DIAGNOSIS SCHEME IN USE

Attribute:

DIAGNOSIS SCHEME IN USE

DISABILITY IMPACT PERCEPTION

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See DISABILITY IMPACT PERCEPTION
Default Codes:	

Notes:
DISABILITY IMPACT PERCEPTION is the same as attribute DISABILITY IMPACT PERCEPTION.

This data element is also known by these names:

Context	Alias
plural	DISABILITY IMPACT PERCEPTIONS

DISABILITY IMPACT PERCEPTION

Change to Data Element: New Data Element

DISABILITY IMPACT PERCEPTION

Attribute:

DISABILITY IMPACT PERCEPTION

DISCHARGE LETTER ISSUED DATE (MENTAL HEALTH AND COMMUNITY CARE)

Change to Data Element: New Data Element

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
DISCHARGE LETTER ISSUED DATE (MENTAL HEALTH AND COMMUNITY CARE) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'Discharge Letter Issued Date (Mental Health and Community Care)'*.

This data element is also known by these names:

Context	Alias
plural	DISCHARGE LETTER ISSUED DATES (MENTAL HEALTH AND COMMUNITY CARE)

DISCHARGE LETTER ISSUED DATE (MENTAL HEALTH AND COMMUNITY CARE)

Change to Data Element: New Data Element

DISCHARGE LETTER ISSUED DATE (MENTAL HEALTH AND COMMUNITY CARE)

Attribute:

ACTIVITY DATE

DISCHARGE TIME (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Description

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:
DISCHARGE TIME (HOSPITAL PROVIDER SPELL) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Discharge Time*'. DISCHARGE TIME (HOSPITAL PROVIDER SPELL) is the time a PATIENT was discharged from a Hospital Provider Spell.

DURATION OF INDIRECT ACTIVITY

Change to Data Element: New Data Element

Format/Length:	max n4
National Codes:	
Default Codes:	

Notes:
DURATION OF INDIRECT ACTIVITY is the duration of an Indirect Activity in minutes, excluding any administration time prior to or after the Indirect Activity and the CARE PROFESSIONAL's travelling time to the LOCATION where the Indirect Activity took place.

DURATION OF INDIRECT ACTIVITY is calculated from the Start Time and End Time of the Indirect Activity.

This data element is also known by these names:

Context	Alias
plural	DURATION OF INDIRECT ACTIVITIES

DURATION OF RESTRICTIVE INTERVENTION

Change to Data Element: New Data Element

Format/Length:	max n6
National Codes:	
Default Codes:	

Notes:
DURATION OF PHYSICAL RESTRAINT is the duration in minutes of a reported incident of a Restrictive Intervention.

DURATION OF PHYSICAL RESTRAINT is calculated from the Start Time and End Time of the Restrictive Intervention.

This data element is also known by these names:

Context	Alias
plural	DURATIONS OF RESTRICTIVE INTERVENTION

EARLIEST CLINICALLY APPROPRIATE DATE

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
EARLIEST CLINICALLY APPROPRIATE DATE is the earliest DATE that it was clinically appropriate for an ACTIVITY to take place.

For the Radiotherapy Data Set, EARLIEST CLINICALLY APPROPRIATE DATE is the:

- first date that the PATIENT would have been clinically fit to start Radiotherapy and
- same as the DECISION TO TREAT DATE unless there was an elective delay, i.e. a clinical reason, such as the PATIENT was not fit.

~~For the Community Information Data Set and Commissioning Data Sets (version 6-2 onwards), the EARLIEST CLINICALLY APPROPRIATE DATE may be used locally to inform waiting time calculations.~~For the Community Information Data Set, Mental Health Services Data Set and Commissioning Data Sets (version 6-2 onwards), the EARLIEST CLINICALLY APPROPRIATE DATE may be used locally to inform waiting time calculations. It can be used to account for periods of time where it is not appropriate to treat the PATIENT for clinical reasons, for example:

- ~~where the PATIENT has been admitted to hospital for an unrelated condition and the Community Health Service cannot commence planned treatment until the PATIENT has been discharged~~
- ~~where the PATIENT is frail and cannot be treated until their condition improves, but it is not appropriate to discharge the PATIENT from the Community Health Service.~~
- where the PATIENT has been admitted to hospital for an unrelated condition and the Community Health Service or Mental Health Service cannot commence planned treatment until the PATIENT has been discharged
- where the PATIENT is frail and cannot be treated until their condition improves, but it is not appropriate to discharge the PATIENT from the Community Health Service or Mental Health Service.

EARLIEST REASONABLE OFFER DATE

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
EARLIEST REASONABLE OFFER DATE 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.

For an APPOINTMENT this is the earliest of the APPOINTMENT DATES OFFERED where the REASONABLE OFFER INDICATOR of the APPOINTMENT OFFER is National Code '*Reasonable Offer*'.

For an OFFER OF ADMISSION this is the earliest of the OFFERED FOR ADMISSION DATES where the REASONABLE OFFER INDICATOR of the OFFER OF ADMISSION is National Code '*Reasonable Offer*'.

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.

Use in Commissioning Data Set version 6-0 onwards for Referral To Treatment Consultant-Led Waiting Times:

If the Commissioning Data Set record:

> relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement

and

> includes the REFERRAL TO TREATMENT PERIOD END DATE of the REFERRAL TO TREATMENT PERIOD

and

> is of the following Commissioning Data Set Types:
>
> - CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode CDS
> - CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode CDS

then EARLIEST REASONABLE OFFER DATE must be populated in the Commissioning Data Set record if a Patient Pause (the PATIENT is paused on the ELECTIVE ADMISSION LIST because they have made themselves unavailable for treatment for a specified period (for non-clinical reasons)) is to be applied to a REFERRAL TO TREATMENT PERIOD by the Secondary Uses Service.

Failure to include EARLIEST REASONABLE OFFER DATE in the Admitted Patient Care General Episode Commissioning Data Set record carrying the REFERRAL TO TREATMENT PERIOD END DATE, will mean no Patient Pause is applied to the duration of wait calculation for the REFERRAL TO TREATMENT PERIOD performed by the Secondary Uses Service.

~~**Use in the Community Information Data Set and Commissioning Data Set (version 6-2 onwards) for Allied Health Professional Referral To Treatment:**~~**Use in the Community Information Data Set, Mental Health Services Data Set and Commissioning Data Set (version 6-2 onwards) for Allied Health Professional Referral To Treatment:**

~~For the Community Information Data Set and the Commissioning Data Sets (version 6-2 onwards) the EARLIEST REASONABLE OFFER DATE may be used locally to inform waiting time calculations for Allied Health Professional Referral To Treatment Measurement.~~For the Community Information Data Set, Mental Health Services Data Set and the Commissioning Data Sets (version 6-2 onwards) the EARLIEST REASONABLE OFFER DATE may be used locally to inform waiting time calculations for Allied Health Professional Referral To Treatment Measurement. It can be used to account for periods of time where the PATIENT has not accepted the first available APPOINTMENT OFFER and this has extended the Allied Health Professional Referral To Treatment Measurement waiting time, for example:

- ~~where a PATIENT who is a child has been offered an APPOINTMENT but their parent/carer states that they wish to wait until the school holidays commence. The Community Health Service cannot commence planned treatment until the PATIENT is available.~~
- ~~where the PATIENT works away and cannot attend for a period of time, but it is not appropriate to discharge the PATIENT from the Community Health Service.~~

- where a PATIENT who is a child has been offered an APPOINTMENT but their parent/carer states that they wish to wait until the school holidays commence. The Community Health Service or Mental Health Service cannot commence planned treatment until the PATIENT is available.
- where the PATIENT works away and cannot attend for a period of time, but it is not appropriate to discharge the PATIENT from the Community Health Service or Mental Health Service.

EMERGENT PSYCHOSIS DATE

Change to Data Element: Changed Description, linked Attribute

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
~~EMERGENT PSYCHOSIS DATE is the date at which there was first clear evidence of a positive psychotic symptom for the PATIENT (i.e. delusion, hallucination, or thought disorder), regardless of its duration.~~EMERGENT PSYCHOSIS DATE is the same as attribute PERSON PROPERTY OBSERVED DATE. EMERGENT PSYCHOSIS DATE is the DATE at which there was first clear evidence of a positive psychotic symptom for the PATIENT (i.e. delusion, hallucination, or thought disorder), regardless of its duration.

EMERGENT PSYCHOSIS DATE

Change to Data Element: Changed Description, linked Attribute

EMERGENT PSYCHOSIS DATE

Attribute:

PERSON PROPERTY OBSERVED DATE

EMPLOYMENT STATUS RECORDED DATE

Change to Data Element: Changed Description, linked Attribute

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
~~EMPLOYMENT STATUS RECORDED DATE is the DATE that the EMPLOYMENT STATUS of a PATIENT was recorded.~~EMPLOYMENT STATUS RECORDED DATE is the same as attribute PERSON PROPERTY RECORDED DATE. EMPLOYMENT STATUS RECORDED DATE is the DATE when the EMPLOYMENT STATUS was recorded.

EMPLOYMENT STATUS RECORDED DATE

Change to Data Element: Changed Description, linked Attribute

EMPLOYMENT STATUS RECORDED DATE

Attribute:

PERSON PROPERTY RECORDED DATE

END DATE (CARE CLUSTER ASSIGNMENT PERIOD)

Change to Data Element: New Data Element

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
END DATE (CARE CLUSTER ASSIGNMENT PERIOD) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'End Date'* of a Care Cluster Assignment Period.

This data element is also known by these names:

Context	Alias
plural	END DATES (CARE CLUSTER ASSIGNMENT PERIOD)

END DATE (CARE CLUSTER ASSIGNMENT PERIOD)

Change to Data Element: New Data Element

END DATE (CARE CLUSTER ASSIGNMENT PERIOD)

Attribute:

ACTIVITY DATE

END DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)

Change to Data Element: New Data Element

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
END DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'End Date'* of the Care Professional Admitted Care Episode.

This data element is also known by these names:

Context	Alias
plural	END DATES (CARE PROFESSIONAL ADMITTED CARE EPISODE)

END DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)

Change to Data Element: New Data Element

END DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)

Attribute:

ACTIVITY DATE

END DATE (CARE PROGRAMME APPROACH CARE)

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
~~END DATE (CARE PROGRAMME APPROACH CARE) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'End Date'* of a period of care for a PATIENT, when the CARE PROGRAMME APPROACH LEVEL was National Code *'New Care Programme Approach Care'*.~~ END DATE (CARE PROGRAMME APPROACH CARE) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'End Date'* of the Care Programme Approach care for the PATIENT.

END DATE (COMMUNITY TREATMENT ORDER) renamed from END DATE (SUPERVISED COMMUNITY TREATMENT)

Change to Data Element: Changed Name, Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
~~END DATE (SUPERVISED COMMUNITY TREATMENT) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'End Date'* of the Supervised Community Treatment.~~END DATE (COMMUNITY TREATMENT ORDER) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'End Date'* of the Community Treatment Order.

END DATE (COMMUNITY TREATMENT ORDER) renamed from END DATE (SUPERVISED COMMUNITY TREATMENT)

Change to Data Element: Changed Name, Description

- Changed Name from Data_Dictionary.Data_Field_Notes.E.En.END_DATE_(SUPERVISED_COMMUNITY_TREATMENT) to Data_Dictionary.Data_Field_Notes.E.En.END_DATE_(COMMUNITY_TREATMENT_ORDER)
- Changed Description

END DATE (COMMUNITY TREATMENT ORDER RECALL) renamed from END DATE (SUPERVISED COMMUNITY TREATMENT RECALL)

Change to Data Element: Changed Name, Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
~~END DATE (SUPERVISED COMMUNITY TREATMENT RECALL) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'End Date'* of the Supervised Community Treatment Recall.~~END DATE (COMMUNITY TREATMENT ORDER RECALL) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'End Date'* of the Community Treatment Order Recall.

END DATE (COMMUNITY TREATMENT ORDER RECALL) renamed from END DATE (SUPERVISED COMMUNITY TREATMENT RECALL)

Change to Data Element: Changed Name, Description

- Changed Name from Data_Dictionary.Data_Field_Notes.E.En.END_DATE_(SUPERVISED_COMMUNITY_TREATMENT_RECALL) to Data_Dictionary.Data_Field_Notes.E.En.END_DATE_(COMMUNITY_TREATMENT_ORDER_RECALL)

- Changed Description

END DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)_ renamed from END DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)

Change to Data Element: Changed Name, Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
~~END DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*End Date*' of the MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION for a PATIENT.~~END DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*End Date*' of the Mental Health Act Legal Status Classification Assignment Period.

END DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)_ renamed from END DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)

Change to Data Element: Changed Name, Description

- Changed Name from Data_Dictionary.Data_Field_Notes.E.En.END_DATE_(MENTAL_HEALTH_ACT_LEGAL_STATUS_CLASSIFICATION) to Data_Dictionary.Data_Field_Notes.E.En.END_DATE_(MENTAL_HEALTH_ACT_LEGAL_STATUS_CLASSIFICATION_ASSIGNMENT_PERIOD)
- Changed Description

END DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD)_ renamed from END DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT)

Change to Data Element: Changed Name, Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
~~END DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*End Date*' of the Mental Health Care Coordinator Assignment.~~END DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*End Date*' of the Mental Health Care Coordinator Assignment Period.

END DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD)_ renamed from END DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT)

Change to Data Element: Changed Name, Description

- Changed Name from Data_Dictionary.Data_Field_Notes.E.En.END_DATE_(MENTAL_HEALTH_CARE_COORDINATOR_ASSIGNMENT) to Data_Dictionary.Data_Field_Notes.E.En.END_DATE_(MENTAL_HEALTH_CARE_COORDINATOR_ASSIGNMENT_PERIOD)
- Changed Description

END DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD)

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
END DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*End Date*' of the Mental Health Delayed Discharge Period.

~~END DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD) is the date where the clinical decision is taken that the PATIENT is no longer fit for discharge, and further inpatient care is required.~~

END DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD) renamed from END DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT)

Change to Data Element: Changed Name

- Changed Name from Data_Dictionary.Data_Field_Notes.E.En.END_DATE_(MENTAL_HEALTH_RESPONSIBLE_CLINICIAN_ASSIGNMENT) to Data_Dictionary.Data_Field_Notes.E.En.END_DATE_(MENTAL_HEALTH_RESPONSIBLE_CLINICIAN_ASSIGNMENT_PERIOD)

END TIME (CARE CLUSTER ASSIGNMENT PERIOD)

Change to Data Element: New Data Element

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:
END TIME (CARE CLUSTER ASSIGNMENT PERIOD) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*End Time*' of a Care Cluster Assignment Period.

This data element is also known by these names:

Context	Alias
plural	END TIMES (CARE CLUSTER ASSIGNMENT PERIOD)

END TIME (CARE CLUSTER ASSIGNMENT PERIOD)

Change to Data Element: New Data Element

END TIME (CARE CLUSTER ASSIGNMENT PERIOD)

Attribute:

ACTIVITY TIME

END TIME (COMMUNITY TREATMENT ORDER RECALL) renamed from END TIME (SUPERVISED COMMUNITY TREATMENT RECALL)

Change to Data Element: Changed Name, Description

Format/Length:	See TIME

National Codes:
Default Codes:

Notes:
~~END TIME (SUPERVISED COMMUNITY TREATMENT RECALL) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*End Time*' of the Supervised Community Treatment Recall.~~END TIME (COMMUNITY TREATMENT ORDER RECALL) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*End Time*' of the Community Treatment Order Recall.

END TIME (COMMUNITY TREATMENT ORDER RECALL) renamed from END TIME (SUPERVISED COMMUNITY TREATMENT RECALL)

Change to Data Element: Changed Name, Description

- Changed Name from Data_Dictionary.Data_Field_Notes.E.En.END_TIME_(SUPERVISED_COMMUNITY_TREATMENT_RECALL) to Data_Dictionary.Data_Field_Notes.E.En.END_TIME_(COMMUNITY_TREATMENT_ORDER_RECALL)
- Changed Description

END TIME (HOME LEAVE)

Change to Data Element: New Data Element

Format/Length: See TIME
National Codes:
Default Codes:

Notes:
END TIME (HOME LEAVE) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*End Time*' of the Home Leave.

This data element is also known by these names:

Context	Alias
plural	END TIMES (HOME LEAVE)

END TIME (HOME LEAVE)

Change to Data Element: New Data Element

END TIME (HOME LEAVE)

Attribute:

ACTIVITY TIME

END TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE)

Change to Data Element: New Data Element

Format/Length: See TIME
National Codes:
Default Codes:

Notes:
END TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*End Time*' of the Mental Health Absence Without Leave.

This data element is also known by these names:

Context	Alias
plural	END TIMES (MENTAL HEALTH ABSENCE WITHOUT LEAVE)

END TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE)

Change to Data Element: New Data Element

END TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE)

Attribute:

ACTIVITY TIME

END TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)_ renamed from END TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)

Change to Data Element: Changed Name, Description

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:
~~END TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*End Time*' of the MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION for a PATIENT.~~END TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*End Time*' of the Mental Health Act Legal Status Classification Assignment Period.

END TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)_ renamed from END TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)

Change to Data Element: Changed Name, Description

- Changed Name from Data_Dictionary.Data_Field_Notes.E.En.END_TIME_ (MENTAL_HEALTH_ACT_LEGAL_STATUS_CLASSIFICATION) to Data_Dictionary.Data_Field_Notes.E.En.END_TIME_ (MENTAL_HEALTH_ACT_LEGAL_STATUS_CLASSIFICATION_ASSIGNMENT_PERIOD)
- Changed Description

END TIME (MENTAL HEALTH LEAVE OF ABSENCE)

Change to Data Element: New Data Element

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:
END TIME (MENTAL HEALTH LEAVE OF ABSENCE) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*End Time*' of the Mental Health Leave of Absence.

This data element is also known by these names:

Context	Alias
plural	END TIMES (MENTAL HEALTH LEAVE OF ABSENCE)

END TIME (MENTAL HEALTH LEAVE OF ABSENCE)

Change to Data Element: New Data Element

END TIME (MENTAL HEALTH LEAVE OF ABSENCE)

Attribute:

ACTIVITY TIME

EXPIRY DATE (COMMUNITY TREATMENT ORDER) renamed from EXPIRY DATE (SUPERVISED COMMUNITY TREATMENT)

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

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
~~EXPIRY DATE (SUPERVISED COMMUNITY TREATMENT)~~ ~~is the~~ DATE ~~when~~ ~~Supervised Community Treatment~~ ~~for a~~ ~~PATIENT~~ ~~expires.~~EXPIRY DATE (COMMUNITY TREATMENT ORDER) is the same as attribute PERSON PROPERTY EFFECTIVE END DATE. EXPIRY DATE (COMMUNITY TREATMENT ORDER) is the DATE when a Community Treatment Order for a PATIENT expires.

EXPIRY DATE (COMMUNITY TREATMENT ORDER) renamed from EXPIRY DATE (SUPERVISED COMMUNITY TREATMENT)

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

EXPIRY DATE (COMMUNITY TREATMENT ORDER)

Attribute:

PERSON PROPERTY EFFECTIVE END DATE

EXPIRY DATE (COMMUNITY TREATMENT ORDER) renamed from EXPIRY DATE (SUPERVISED COMMUNITY TREATMENT)

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

- Changed Name from Data_Dictionary.Data_Field_Notes.E.Ex.EXPIRY_DATE_(SUPERVISED_COMMUNITY_TREATMENT) to Data_Dictionary.Data_Field_Notes.E.Ex.EXPIRY_DATE_(COMMUNITY_TREATMENT_ORDER)
- Changed Description
- null

EXPIRY DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)

Change to Data Element: Changed Description, linked Attribute

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
EXPIRY DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION) is the same as attribute PERSON PROPERTY EFFECTIVE END DATE.

EXPIRY DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION) is the DATE when a MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION for a PATIENT expires.

EXPIRY DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)

Change to Data Element: Changed Description, linked Attribute

EXPIRY DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)

Attribute:

PERSON PROPERTY EFFECTIVE END DATE

EXPIRY TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)

Change to Data Element: Changed Description, linked Attribute

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:

~~END TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION) is the TIME when a MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION for a PATIENT expires.~~END TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD) is the same as attribute PERSON PROPERTY EFFECTIVE END TIME. END TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD) is the TIME when a MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION for a PATIENT expires.

EXPIRY TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)

Change to Data Element: Changed Description, linked Attribute

EXPIRY TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)

Attribute:

PERSON PROPERTY EFFECTIVE END TIME

FINDING SCHEME IN USE

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See FINDING SCHEME IN USE
Default Codes:	

Notes:

FINDING SCHEME IN USE is the same as attribute FINDING SCHEME IN USE.

This data element is also known by these names:

Context	Alias
plural	FINDING SCHEMES IN USE

FINDING SCHEME IN USE

Change to Data Element: New Data Element

FINDING SCHEME IN USE

Attribute:

FINDING SCHEME IN USE

FIRST PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION)_ renamed from PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION)

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

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
~~PRESCRIPTION_DATE_(ANTI-PSYCHOTIC_MEDICATION) is the PRESCRIPTION_DATE where the PRESCRIBED ITEM is *'Anti-Psychotic Medication'.*~~ FIRST PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION) is the same as attribute PRESCRIPTION DATE.

FIRST PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION) is the date the PATIENT was first prescribed Anti-Psychotic Medication following referral into an Early Intervention in Psychosis (EIP) Service.

FIRST PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION)_ renamed from PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION)

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

FIRST PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION)

Attribute:

PRESCRIPTION DATE

FIRST PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION)_ renamed from PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION)

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

- Changed Name from Data_Dictionary.Data_Field_Notes.P.Pres.PRESCRIPTION_DATE_(ANTI-PSYCHOTIC_MEDICATION) to Data_Dictionary.Data_Field_Notes.F.FIRST_PRESCRIPTION_DATE_(ANTI-PSYCHOTIC_MEDICATION)
- Changed Description
- null

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)

Change to Data Element: New Data Element

Format/Length:	max an4
National Codes:	See FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE
Default Codes:	

Notes:
FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (FINAL) is the same as attribute FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE.

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (FINAL) is the final FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE allocated by the CARE PROFESSIONAL.

Note: This data item is included in the Mental Health Services Data Set but should not be submitted until further development by the Health and Social Care Information Centre has been undertaken.

This data element is also known by these names:

Context	Alias
plural	FORENSIC LEARNING DISABILITIES CARE CLUSTER CODES (FINAL)

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)

Change to Data Element: New Data Element

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)

Attribute:

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)

Change to Data Element: New Data Element

Format/Length:	max an4
National Codes:	See FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE
Default Codes:	

Notes:
FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL) is the same as attribute FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE.

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL) is the initial FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE allocated by the CARE PROFESSIONAL.

Note: This data item is included in the Mental Health Services Data Set, but should not be submitted until further development by the Health and Social Care Information Centre has been undertaken.

This data element is also known by these names:

Context	Alias
plural	FORENSIC LEARNING DISABILITIES CARE CLUSTER CODES (INITIAL)

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)

Change to Data Element: New Data Element

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)

Attribute:

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE

FORENSIC MENTAL HEALTH CARE CLUSTER CODE (FINAL)

Change to Data Element: New Data Element

Format/Length:	max an4
National Codes:	See FORENSIC MENTAL HEALTH CARE CLUSTER CODE
Default Codes:	

Notes:
FORENSIC MENTAL HEALTH CARE CLUSTER CODE (FINAL) is the same as attribute FORENSIC MENTAL HEALTH CARE CLUSTER CODE.

FORENSIC MENTAL HEALTH CARE CLUSTER CODE (FINAL) is the final FORENSIC MENTAL HEALTH CARE CLUSTER CODE allocated by the CARE PROFESSIONAL.

Note: This data item is included in the Mental Health Services Data Set, but should not be submitted until further development by the Health and Social Care Information Centre has been undertaken.

This data element is also known by these names:

Context	Alias
plural	FORENSIC MENTAL HEALTH CARE CLUSTER CODES (FINAL)

FORENSIC MENTAL HEALTH CARE CLUSTER CODE (FINAL)

Change to Data Element: New Data Element

FORENSIC MENTAL HEALTH CARE CLUSTER CODE (FINAL)

Attribute:

FORENSIC MENTAL HEALTH CARE CLUSTER CODE

FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL)

Change to Data Element: New Data Element

Format/Length:	max an4
National Codes:	See FORENSIC MENTAL HEALTH CARE CLUSTER CODE
Default Codes:	

Notes:
FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL) is the same as attribute FORENSIC MENTAL HEALTH CARE CLUSTER CODE.

FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL) is the initial FORENSIC MENTAL HEALTH CARE CLUSTER CODE allocated by the CARE PROFESSIONAL.

Note: This data item is included in the Mental Health Services Data Set, but should not be submitted until further development by the Health and Social Care Information Centre has been undertaken.

This data element is also known by these names:

Context	Alias

plural	FORENSIC MENTAL HEALTH CARE CLUSTER CODES (INITIAL)

FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL)

Change to Data Element: New Data Element

FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL)

Attribute:

FORENSIC MENTAL HEALTH CARE CLUSTER CODE

GROUP SESSION IDENTIFIER

Change to Data Element: New Data Element

Format/Length:	max an20
National Codes:	
Default Codes:	

Notes:
GROUP SESSION IDENTIFIER is the ACTIVITY IDENTIFIER for a Group Session.

This data element is also known by these names:

Context	Alias
plural	GROUP SESSION IDENTIFIERS

GROUP SESSION IDENTIFIER

Change to Data Element: New Data Element

GROUP SESSION IDENTIFIER

Attribute:

ACTIVITY IDENTIFIER

GROUP SESSION TYPE (MENTAL HEALTH)

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See GROUP SESSION TYPE FOR MENTAL HEALTH
Default Codes:	

Notes:
GROUP SESSION TYPE (MENTAL HEALTH) is the same as attribute GROUP SESSION TYPE FOR MENTAL HEALTH.

This data element is also known by these names:

Context	Alias
plural	GROUP SESSION TYPES (MENTAL HEALTH)

GROUP SESSION TYPE (MENTAL HEALTH)

Change to Data Element: New Data Element

GROUP SESSION TYPE (MENTAL HEALTH)

Attribute:

GROUP SESSION TYPE FOR MENTAL HEALTH

GROUP THERAPY INDICATOR

Change to Data Element: New Data Element

Format/Length:	an1
National Codes:	See GROUP THERAPY INDICATOR
Default Codes:	Z - Not Known if the ACTIVITY was Group Therapy

Notes:
GROUP THERAPY INDICATOR is the same as attribute GROUP THERAPY INDICATOR.

This data element is also known by these names:

Context	Alias
plural	GROUP THERAPY INDICATORS

GROUP THERAPY INDICATOR

Change to Data Element: New Data Element

GROUP THERAPY INDICATOR

Attribute:

GROUP THERAPY INDICATOR

INDIRECT ACTIVITY DATE

Change to Data Element: New Data Element

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
INDIRECT ACTIVITY DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'Indirect Activity Date'*.

This data element is also known by these names:

Context	Alias
plural	INDIRECT ACTIVITY DATES

INDIRECT ACTIVITY DATE

Change to Data Element: New Data Element

INDIRECT ACTIVITY DATE

Attribute:

ACTIVITY DATE

INDIRECT ACTIVITY TIME

Change to Data Element: New Data Element

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:
INDIRECT ACTIVITY TIME is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Indirect Activity Time*'.

This data element is also known by these names:

Context	Alias
plural	INDIRECT ACTIVITY TIMES

INDIRECT ACTIVITY TIME

Change to Data Element: New Data Element

INDIRECT ACTIVITY TIME

Attribute:

ACTIVITY TIME

INTENDED AGE GROUP

Change to Data Element: Changed Description

Format/Length:	an1
National Codes:	
Default Codes:	

Notes:
INTENDED AGE GROUP is the same as attribute AGE GROUP INTENDED.

INTENDED AGE GROUP is based on the AGE GROUP INTENDED National Codes, with the addition of Home Leave:

Permitted National Codes:

1 Neonates
2 Children and /or adolescents
3 Elderly
8 Any age
9 Home Leave *

~~* Note - National Code 9 is not valid for the Mental Health and Learning Disabilities Data Set.~~* Note - National Code 9 is not valid for the Mental Health Services Data Set.

INTENDED CLINICAL CARE INTENSITY CODE (MENTAL HEALTH)

Change to Data Element: Changed Description

Format/Length:	an2
National Codes:	
Default Codes:	

Notes:
~~INTENDED CLINICAL CARE INTENSITY CODE (MENTAL HEALTH) is the same as attribute CLINICAL CARE INTENSITY.~~INTENDED CLINICAL CARE INTENSITY CODE (MENTAL HEALTH) is the same as attribute CLINICAL CARE INTENSITY for the Mental Health Services Data Set.

Permitted National Codes:

For PATIENTS with Mental Illness:

51 For Intensive Care - specially designated ward for PATIENTS needing containment and more intensive management (eg Psychiatric Intensive Care Unit (PICU)). This is not to be confused with intensive nursing where a PATIENT may require one-to-one nursing while on a standard WARD

52 For Short Stay - PATIENTS intended to stay for less than a year

53 For Long Stay - PATIENTS intended to stay for a year or more

For PATIENTS with Learning Disabilities:

61 Designated or interim secure unit

62 PATIENTS intending to stay less than a year

63 PATIENTS intending to stay a year or more

~~In addition to this, the following value which is not part of the National Codes is also permitted for the Child and Adolescent Mental Health Services Secondary Uses Data Set (see INTENDED CLINICAL CARE INTENSITY CODE):~~

~~72 Home Leave, psychiatric *~~

~~* Note - National Code 72 is not valid for the Mental Health and Learning Disabilities Data Set.~~

LANGUAGE CODE (PREFERRED)

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See LANGUAGE CODE
Default Codes:	

Notes:
LANGUAGE CODE (PREFERRED) is the same as the attribute LANGUAGE CODE.

LANGUAGE CODE (PREFERRED) is the language the PATIENT, Patient Proxy or carer prefers to use for communication with a Health Care Provider.

This data element is also known by these names:

Context	Alias
plural	LANGUAGE CODES (PREFERRED)

LANGUAGE CODE (PREFERRED)

Change to Data Element: New Data Element

LANGUAGE CODE (PREFERRED)

Attribute:

LANGUAGE CODE

LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)

Change to Data Element: New Data Element

Format/Length:	max an4
National Codes:	See LEARNING DISABILITIES CARE CLUSTER CODE
Default Codes:	

Notes:
LEARNING DISABILITIES CARE CLUSTER CODE (FINAL) is the same as attribute LEARNING DISABILITIES CARE CLUSTER CODE.

LEARNING DISABILITIES CARE CLUSTER CODE (FINAL) is the final LEARNING DISABILITIES CARE CLUSTER CODE allocated by the CARE PROFESSIONAL.

Note: This data item is included in the Mental Health Services Data Set, but should not be submitted until further development by the Health and Social Care Information Centre has been undertaken.

This data element is also known by these names:

Context	Alias
plural	LEARNING DISABILITIES CARE CLUSTER CODES (FINAL)

LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)

Change to Data Element: New Data Element

LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)

Attribute:

LEARNING DISABILITIES CARE CLUSTER CODE

LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)

Change to Data Element: New Data Element

Format/Length:	max an4
National Codes:	See LEARNING DISABILITIES CARE CLUSTER CODE
Default Codes:	

Notes:
LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL) is the same as attribute LEARNING DISABILITIES CARE CLUSTER CODE.

LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL) is the initial LEARNING DISABILITIES CARE CLUSTER CODE allocated by the CARE PROFESSIONAL.

Note: This data item is included in the Mental Health Services Data Set, but should not be submitted until further development by the Health and Social Care Information Centre has been undertaken.

This data element is also known by these names:

Context	Alias
plural	LEARNING DISABILITIES CARE CLUSTER CODES (INITIAL)

LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)

Change to Data Element: New Data Element

LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)

Attribute:

LEARNING DISABILITIES CARE CLUSTER CODE

LOCAL PATIENT IDENTIFIER (EXTENDED)

Change to Data Element: Changed Description

Format/Length:	max an20
National Codes:	
Default Codes:	

Notes:
LOCAL PATIENT IDENTIFIER (EXTENDED) is the same as attribute LOCAL PATIENT IDENTIFIER. LOCAL PATIENT IDENTIFIER (EXTENDED) is used where IT systems have a LOCAL PATIENT IDENTIFIER which is longer than 10 characters and LOCAL PATIENT IDENTIFIER cannot be used for data submission.

LOOKED AFTER CHILD INDICATOR

Change to Data Element: Changed Description

Format/Length:	an1
National Codes:	See LOOKED AFTER CHILD INDICATOR
~~Default Codes:~~	~~X - Not known~~
Default Codes:	X - Not known if the PERSON is a Looked After Child

Notes:
LOOKED AFTER CHILD INDICATOR is the same as attribute LOOKED AFTER CHILD INDICATOR.

MAIN SPECIALTY CODE (MENTAL HEALTH)

Change to Data Element: Changed Description

Format/Length:	an3
National Codes:	
Default Codes:	

Notes:
~~MAIN SPECIALTY CODE (MENTAL HEALTH) is the MAIN SPECIALTY CODE of the Mental Health Responsible Clinician for the PATIENT within the REPORTING PERIOD. If there is more than one during the REPORTING PERIOD, this will be the last or final one of REPORTING PERIOD.~~MAIN SPECIALTY CODE (MENTAL HEALTH) is the same as attribute MAIN SPECIALTY CODE.

~~If the Mental Health Responsible Clinician is the PATIENT's GENERAL MEDICAL PRACTITIONER, the code will be 600. If the Mental Health Responsible Clinician is a CONSULTANT, it will typically be one of the adult or elderly mental health MAIN SPECIALTIES, although it may be either a learning disability or child and adolescent psychiatry in certain circumstances. When the Mental Health Responsible Clinician is not a CONSULTANT, this should be the appropriate pseudo specialty code or left blank.~~MAIN SPECIALTY CODE (MENTAL HEALTH) is the MAIN SPECIALTY CODE of the CARE PROFESSIONAL working in a Mental Health Service, who is responsible for the PATIENT within the REPORTING PERIOD.

Permitted National Codes:

600	General Medical Practice
~~700~~	~~Learning Disability~~
700	Learning Disability
710	Adult Mental Illness
711	Child and Adolescent Psychiatry
712	Forensic Psychiatry
713	Psychotherapy
715	Old Age Psychiatry
950	Nursing Episode
960	Allied Health Professional Episode

MANIFEST PSYCHOSIS DATE

Change to Data Element: Changed Description, linked Attribute

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
MANIFEST PSYCHOSIS DATE is the same as attribute PERSON PROPERTY OBSERVED DATE.

MANIFEST PSYCHOSIS DATE is the DATE at which a positive psychotic symptom for the PATIENT (i.e. delusion, hallucination, or thought disorder) has lasted for a week. This is usually a week after the DATE of the first psychotic symptom.

MANIFEST PSYCHOSIS DATE

Change to Data Element: Changed Description, linked Attribute

MANIFEST PSYCHOSIS DATE

Attribute:

PERSON PROPERTY OBSERVED DATE

MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON renamed from ABSENCE WITHOUT LEAVE END REASON

Change to Data Element: Changed Name, Description

Format/Length:	an2
~~National Codes:~~	~~See ABSENCE WITHOUT LEAVE END REASON~~
~~Default Codes:~~	~~99 Not known~~
National Codes:	See MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON
Default Codes:	99 - MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON Not known

Notes:

~~ABSENCE WITHOUT LEAVE END REASON is the same as attribute ABSENCE WITHOUT LEAVE END REASON.~~MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON is the same as attribute MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON.

MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON renamed from ABSENCE WITHOUT LEAVE END REASON

Change to Data Element: Changed Name, Description

- Changed Name from Data_Dictionary.Data_Field_Notes.A.ABSENCE_WITHOUT_LEAVE_END_REASON to Data_Dictionary.Data_Field_Notes.M.Men.MENTAL_HEALTH_ABSENCE_WITHOUT_LEAVE_END_REASON
- Changed Description

MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY renamed from MENTAL HEALTH ABSOLUTE DISCHARGE END METHOD

Change to Data Element: Changed Name, Description

Format/Length:	an2
~~National Codes:~~	~~See MENTAL HEALTH ABSOLUTE DISCHARGE END METHOD~~
National Codes:	See MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY
Default Codes:	

Notes:
~~MENTAL HEALTH ABSOLUTE DISCHARGE END METHOD is the same as attribute MENTAL HEALTH ABSOLUTE DISCHARGE END METHOD.~~

~~MENTAL HEALTH ABSOLUTE DISCHARGE END METHOD is only required if the period of Mental Health Conditional Discharge is ended and the MENTAL HEALTH CONDITIONAL DISCHARGE END REASON is National Code '*Absolute discharge*'.~~

MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY is the same as attribute MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY.

MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY renamed from MENTAL HEALTH ABSOLUTE DISCHARGE END METHOD

Change to Data Element: Changed Name, Description

- Changed Name from Data_Dictionary.Data_Field_Notes.M.Men.MENTAL_HEALTH_ABSOLUTE_DISCHARGE_END_METHOD to Data_Dictionary.Data_Field_Notes.M.Men.MENTAL_HEALTH_ABSOLUTE_DISCHARGE_RESPONSIBILITY
- Changed Description

MENTAL HEALTH ACT 2007 MENTAL CATEGORY

Change to Data Element: Changed Description, linked Attribute

Format/Length:	an1
National Codes:	See MENTAL HEALTH ACT 2007 MENTAL CATEGORY
Default Codes:	8 - Not applicable (i.e. not detained) 9 - Not known

Notes:
MENTAL HEALTH ACT 2007 MENTAL CATEGORY is the same as attribute MENTAL HEALTH ACT 2007 MENTAL CATEGORY.

~~See Mental Health Act Table for details of how MENTAL HEALTH ACT 2007 MENTAL CATEGORY relates to Parts and Sections of the Act.~~

MENTAL HEALTH ACT 2007 MENTAL CATEGORY

Change to Data Element: Changed Description, linked Attribute

MENTAL HEALTH ACT 2007 MENTAL CATEGORY

Attribute:

MENTAL HEALTH ACT 2007 MENTAL CATEGORY

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON renamed from MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD END REASON

Change to Data Element: Changed Name, Description

Format/Length:	an2
~~National Codes:~~	~~See MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD END REASON CODE~~
National Codes:	See MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON
Default Codes:	

Notes:

~~MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD END REASON is the same as attribute MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD END REASON CODE.~~MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON is the same as attribute MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON.

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON renamed from MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD END REASON

Change to Data Element: Changed Name, Description

- Changed Name from Data_Dictionary.Data_Field_Notes.M.Men.MENTAL_HEALTH_ACT_LEGAL_STATUS_CLASSIFICATION_PERIO to Data_Dictionary.Data_Field_Notes.M.Men.MENTAL_HEALTH_ACT_LEGAL_STATUS_CLASSIFICATION_ASSI
- Changed Description

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER

Change to Data Element: New Data Element

Format/Length:	max an20
National Codes:	
Default Codes:	

Notes:

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER is the same as attribute ACTIVITY IDENTIFIER.

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER is a unique identifier allocated to each Mental Health Act Legal Status Classification Assignment Period.

This data element is also known by these names:

Context	Alias
plural	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD IDENTIFIERS

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER

Change to Data Element: New Data Element

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER

Attribute:

ACTIVITY IDENTIFIER

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON_ renamed from MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD START REASON

Change to Data Element: Changed Name, Description

Format/Length:	an2
~~National Codes:~~	~~See MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD START REASON CODE~~
National Codes:	See MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON
Default Codes:	

Notes:
~~MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD START REASON is the same as attribute MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD START REASON CODE.~~MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON is the same as attribute MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON.

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON_ renamed from MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD START REASON

Change to Data Element: Changed Name, Description

- Changed Name from Data_Dictionary.Data_Field_Notes.M.Men.MENTAL_HEALTH_ACT_LEGAL_STATUS_CLASSIFICATION_PERIO to Data_Dictionary.Data_Field_Notes.M.Men.MENTAL_HEALTH_ACT_LEGAL_STATUS_CLASSIFICATION_ASSI
- Changed Description

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE

Change to Data Element: Changed Description

Format/Length:	an2
National Codes:	See MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE
Default Codes:	98 - Not Applicable 99 - Not Known

Notes:
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE is the same as attribute MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE.

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE is required for all PATIENTS who have a Hospital Provider Spell which includes the care of a CONSULTANT in the psychiatric specialties or have been discharged from such a Hospital Provider Spell and are required to receive supervised aftercare under the provisions of the Mental Health (Patients in the Community) Act 1995.

~~Note that the term "informal" is used for those PATIENTS who are neither formally detained nor receiving supervised aftercare.~~

MENTAL HEALTH CARE CLUSTER END REASON

Change to Data Element: Changed Description

Format/Length:	an2
National Codes:	See MENTAL HEALTH CARE CLUSTER END REASON
~~Default Codes:~~	~~NA - PATIENT continues on same Mental Health Care Cluster following review~~ ~~99 - Not known~~
Default Codes:	NA - PATIENT continues on same Adult Mental Health Care Cluster following review 99 - Not known

Notes:
MENTAL HEALTH CARE CLUSTER END REASON is the same as attribute MENTAL HEALTH CARE CLUSTER END REASON.

MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE

Change to Data Element: Changed Description

Format/Length:	an1
National Codes:	See MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE
Default Codes:	Z - Unable to assign PATIENT to Mental Health Care Cluster Super Class

Notes:
MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE is the same as attribute MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE.

MENTAL HEALTH CARE CONTACT IDENTIFIER

Change to Data Element: Changed Description

Format/Length:	max an20
National Codes:	
Default Codes:	

Notes:
MENTAL HEALTH CARE CONTACT IDENTIFIER is the ACTIVITY IDENTIFIER for a CARE CONTACT within a Mental Health Care Spell.

The MENTAL HEALTH CARE CONTACT IDENTIFIER is used to uniquely identify the CARE CONTACT within the Health Care Provider.

MENTAL HEALTH CRISIS PLAN CREATION DATE

Change to Data Element: Changed Description, linked Attribute

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
~~MENTAL HEALTH CRISIS PLAN CREATION DATE is the DATE that a Mental Health Crisis Plan was created.~~ MENTAL HEALTH CRISIS PLAN CREATION DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Mental Health Crisis Plan Creation Date*'.

MENTAL HEALTH CRISIS PLAN CREATION DATE

Change to Data Element: Changed Description, linked Attribute

MENTAL HEALTH CRISIS PLAN CREATION DATE

Attribute:

ACTIVITY DATE

MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE

Change to Data Element: Changed Description, linked Attribute

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
~~MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE is the DATE that a Mental Health Crisis Plan was last updated.~~MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Mental Health Crisis Plan Last Updated Date*'.

Where the Mental Health Crisis Plan has not been updated since its creation, the MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE is the same as the MENTAL HEALTH CRISIS PLAN CREATION DATE.

MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE

Change to Data Element: Changed Description, linked Attribute

MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE

Attribute:

ACTIVITY DATE

MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE

Change to Data Element: Changed Description

Format/Length:	an2
National Codes:	

	See MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE
Default Codes:	

Notes:
MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE is the same as attribute MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE.

MENTAL HEALTH DELAYED DISCHARGE REASON

Change to Data Element: Changed Description

Format/Length:	an2
National Codes:	See MENTAL HEALTH DELAYED DISCHARGE REASON
Default Codes:	

Notes:
MENTAL HEALTH DELAYED DISCHARGE REASON is the same as attribute MENTAL HEALTH DELAYED DISCHARGE REASON.

MENTAL HEALTH LEAVE OF ABSENCE END REASON renamed from LEAVE OF ABSENCE END REASON

Change to Data Element: Changed Name, Description

Format/Length:	an2
~~National Codes:~~	~~See LEAVE OF ABSENCE END REASON~~
~~Default Codes:~~	~~99 Not known~~
National Codes:	See MENTAL HEALTH LEAVE OF ABSENCE END REASON
Default Codes:	99 - MENTAL HEALTH LEAVE OF ABSENCE END REASON Not known

Notes:
~~LEAVE OF ABSENCE END REASON is the same as attribute LEAVE OF ABSENCE END REASON.~~MENTAL HEALTH LEAVE OF ABSENCE END REASON is the same as attribute MENTAL HEALTH LEAVE OF ABSENCE END REASON.

MENTAL HEALTH LEAVE OF ABSENCE END REASON renamed from LEAVE OF ABSENCE END REASON

Change to Data Element: Changed Name, Description

- Changed Name from Data_Dictionary.Data_Field_Notes.L.Le.LEAVE_OF_ABSENCE_END_REASON to Data_Dictionary.Data_Field_Notes.M.Men.MENTAL_HEALTH_LEAVE_OF_ABSENCE_END_REASON
- Changed Description

NHS SERVICE AGREEMENT LINE NUMBER

Change to Data Element: Changed Description

~~Format/length:~~	~~an10~~
Format/Length:	an10
National Codes:	
Default Codes:	

Notes:
NHS SERVICE AGREEMENT LINE NUMBER is the same as attribute NHS SERVICE AGREEMENT LINE NUMBER.

The NHS SERVICE AGREEMENT LINE NUMBERS may be used to identify a specific NHS SERVICE AGREEMENT reference where the main identifier refers to a general omnibus agreement.

NUMBER OF GROUP SESSION PARTICIPANTS

Change to Data Element: New Data Element

Format/Length:	max n3
National Codes:	
Default Codes:	

Notes:
NUMBER OF GROUP SESSION PARTICIPANTS is the number of PERSON's who participate in a Group Session (excluding the CARE PROFESSIONALS responsible for the Group Session).

OBSERVATION SCHEME IN USE

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See OBSERVATION SCHEME IN USE
Default Codes:	

Notes:
OBSERVATION SCHEME IN USE is the same as attribute OBSERVATION SCHEME IN USE.

This data element is also known by these names:

Context	Alias
plural	OBSERVATION SCHEMES IN USE

OBSERVATION SCHEME IN USE

Change to Data Element: New Data Element

OBSERVATION SCHEME IN USE

Attribute:

OBSERVATION SCHEME IN USE

OBSERVATION VALUE

Change to Data Element: New Data Element

Format/Length:	max an10
National Codes:	
Default Codes:	

Notes:
OBSERVATION VALUE is the same as attribute OBSERVATION VALUE.

This data element is also known by these names:

Context	Alias
plural	OBSERVATION VALUES

OBSERVATION VALUE

Change to Data Element: New Data Element

OBSERVATION VALUE

Attribute:

OBSERVATION VALUE

ONWARD REFERRAL DATE

Change to Data Element: New Data Element

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
ONWARD REFERRAL DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'Onward Referral Date'*.

This data element is also known by these names:

Context	Alias
plural	ONWARD REFERRAL DATES

ONWARD REFERRAL DATE

Change to Data Element: New Data Element

ONWARD REFERRAL DATE

Attribute:

ACTIVITY DATE

ONWARD REFERRAL REASON

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See ONWARD REFERRAL REASON
Default Codes:	98 - ONWARD REFERRAL REASON Not Applicable 99 - ONWARD REFERRAL REASON Not Known

Notes:
ONWARD REFERRAL REASON is the same as attribute ONWARD REFERRAL REASON.

This data element is also known by these names:

Context	Alias
plural	ONWARD REFERRAL REASONS

ONWARD REFERRAL REASON

Change to Data Element: New Data Element

ONWARD REFERRAL REASON

Attribute:

ONWARD REFERRAL REASON

ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT)

Change to Data Element: New Data Element

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

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

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

This data element is also known by these names:

Context	Alias
plural	ORGANISATION CODES (EDUCATIONAL ESTABLISHMENT)

ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT)

Change to Data Element: New Data Element

ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT)

Attribute:

ORGANISATION CODE

OTHER PERSON IN ATTENDANCE AT CARE CONTACT

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See OTHER PERSON IN ATTENDANCE AT CARE CONTACT
Default Codes:	

Notes:
OTHER PERSON IN ATTENDANCE AT CARE CONTACT is the same as attribute OTHER PERSON IN ATTENDANCE AT CARE CONTACT.

This data element is also known by these names:

Context	Alias
plural	OTHER PERSONS IN ATTENDANCE AT CARE CONTACT

OTHER PERSON IN ATTENDANCE AT CARE CONTACT

Change to Data Element: New Data Element

OTHER PERSON IN ATTENDANCE AT CARE CONTACT

Attribute:

OTHER PERSON IN ATTENDANCE AT CARE CONTACT

OTHER REASON FOR REFERRAL (MENTAL HEALTH)

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See REASON FOR REFERRAL TO MENTAL HEALTH
Default Codes:	

Notes:
OTHER REASON FOR REFERRAL (MENTAL HEALTH) is the same as attribute REASON FOR REFERRAL TO MENTAL HEALTH.

OTHER REASON FOR REFERRAL (MENTAL HEALTH) is the secondary presenting conditions or symptoms for which the PATIENT was referred to a Mental Health Service.

This data element is also known by these names:

Context	Alias
plural	OTHER REASONS FOR REFERRAL (MENTAL HEALTH)

OTHER REASON FOR REFERRAL (MENTAL HEALTH)

Change to Data Element: New Data Element

OTHER REASON FOR REFERRAL (MENTAL HEALTH)

Attribute:

REASON FOR REFERRAL TO MENTAL HEALTH

PERSON MARITAL STATUS

Change to Data Element: Changed Description

Format/Length:	an1
National Codes:	See PERSON MARITAL STATUS CODE
Default Codes:	8 - Not applicable, i.e. not a psychiatric episode 9 - Not known

Notes:
PERSON MARITAL STATUS is the same as attribute PERSON MARITAL STATUS CODE.

Commissioning Data Set Messages

Following the recommendation of the Data Protection Registrar, PERSON MARITAL STATUS should not be recorded by providers in the Commissioning Data Sets except in respect of the psychiatric specialties in the Admitted Patient Care Commissioning Data Set. The data item remains in the data standards since it will be needed by the provider.

~~**Mental Health and Learning Disabilities Data Set Messages**~~

~~For the Mental Health and Learning Disabilities Data Set, PERSON MARITAL STATUS must be recorded and kept up to date for all psychiatric PATIENTS.~~

PERSON SCORE

Change to Data Element: New Data Element

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

Notes:
PERSON SCORE is the same as attribute PERSON SCORE.

This data element is also known by these names:

Context	Alias
plural	PERSON SCORES

PERSON SCORE

Change to Data Element: New Data Element

PERSON SCORE

Attribute:

PERSON SCORE

PLANNED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)

Change to Data Element: New Data Element

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
PLANNED DISCHARGE DATE (HOSPITAL PROVIDER SPELL) is the same as attribute PLANNED ACTIVITY DATE where the PLANNED ACTIVITY DATE TYPE is National Code *'Planned Discharge Date (Hospital Provider Spell)'*.

This data element is also known by these names:

Context	Alias
plural	PLANNED DISCHARGE DATES (HOSPITAL PROVIDER SPELL)

PLANNED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)

Change to Data Element: New Data Element

PLANNED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)

Attribute:

PLANNED ACTIVITY DATE

POSTCODE OF MAIN VISITOR

Change to Data Element: New Data Element

Format/Length:	See POSTCODE
National Codes:	
Default Codes:	

Notes:
POSTCODE OF MAIN VISITOR is the same as data element POSTCODE.

POSTCODE OF MAIN VISITOR is the POSTCODE of the ADDRESS of the PATIENT's main visitor where the ADDRESS ASSOCIATION TYPE is *'Main Permanent Residence'* or *'Other Permanent Residence'.*

POSTCODE OF MAIN VISITOR is the POSTCODE of the PATIENT's main visitor to the PATIENT whilst they are being treated as part of a Hospital Provider Spell.

POSTCODE OF MAIN VISITOR

Change to Data Element: New Data Element

POSTCODE OF MAIN VISITOR

Attribute:

POSTCODE

PREVIOUS DIAGNOSIS (CODED CLINICAL ENTRY)

Change to Data Element: New Data Element

Format/Length:	min an4 max an18
National Codes:	
Default Codes:	

Notes:
PREVIOUS DIAGNOSIS (CODED CLINICAL ENTRY) is the same as attribute CLINICAL CLASSIFICATION CODE or CLINICAL TERMINOLOGY CODE.

PREVIOUS DIAGNOSIS (CODED CLINICAL ENTRY) is the CODED CLINICAL ENTRY used to identify the previous PATIENT DIAGNOSIS.

This data element is also known by these names:

Context	Alias
plural	PREVIOUS DIAGNOSES (CODED CLINICAL ENTRY)

PREVIOUS DIAGNOSIS (CODED CLINICAL ENTRY)

Change to Data Element: New Data Element

PREVIOUS DIAGNOSIS (CODED CLINICAL ENTRY)

Attribute:

CLINICAL CLASSIFICATION CODE
CLINICAL TERMINOLOGY CODE

PRIMARY DATA COLLECTION SYSTEM IN USE

Change to Data Element: New Data Element

Format/Length:	max an20
National Codes:	
Default Codes:	

Notes:
PRIMARY DATA COLLECTION SYSTEM IN USE is the name of the Primary Data Collection System in use by the Health Care Provider.

PRIMARY DIAGNOSIS (CODED CLINICAL ENTRY)

Change to Data Element: New Data Element

Format/Length:	min an4 max an18
National Codes:	
Default Codes:	

Notes:
PRIMARY DIAGNOSIS (CODED CLINICAL ENTRY) is the same as attribute CLINICAL CLASSIFICATION CODE or CLINICAL TERMINOLOGY CODE.

PRIMARY DIAGNOSIS (CODED CLINICAL ENTRY) is the CODED CLINICAL ENTRY used to identify the PRIMARY DIAGNOSIS.

This data element is also known by these names:

Context	Alias
plural	PRIMARY DIAGNOSES (CODED CLINICAL ENTRY)

PRIMARY DIAGNOSIS (CODED CLINICAL ENTRY)

Change to Data Element: New Data Element

PRIMARY DIAGNOSIS (CODED CLINICAL ENTRY)

Attribute:

CLINICAL CLASSIFICATION CODE
CLINICAL TERMINOLOGY CODE

PRIMARY REASON FOR REFERRAL (MENTAL HEALTH)

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See REASON FOR REFERRAL TO MENTAL HEALTH
Default Codes:	

Notes:
PRIMARY REASON FOR REFERRAL (MENTAL HEALTH) is the same as attribute REASON FOR REFERRAL TO MENTAL HEALTH.

PRIMARY REASON FOR REFERRAL (MENTAL HEALTH) is the primary presenting condition or symptom for which the PATIENT was referred to a Mental Health Service.

This data element is also known by these names:

Context	Alias
plural	PRIMARY REASONS FOR REFERRAL (MENTAL HEALTH)

PRIMARY REASON FOR REFERRAL (MENTAL HEALTH)

Change to Data Element: New Data Element

PRIMARY REASON FOR REFERRAL (MENTAL HEALTH)

Attribute:

REASON FOR REFERRAL TO MENTAL HEALTH

PROCEDURE SCHEME IN USE

Change to Data Element: Changed Description, linked Attribute

Format/Length:	an2
~~National Codes:~~	
National Codes:	See PROCEDURE SCHEME IN USE
Default Codes:	

Notes:

~~PROCEDURE SCHEME IN USE is used in the Clinical Activity Group of the Commissioning Data Set to denote the scheme basis of an Intervention, Operation or A&E Treatment.~~

~~*Permitted National Codes:*~~

~~01~~	~~Accident & Emergency Treatment~~
~~02~~	~~OPCS-4~~
~~03~~	~~Read Code 4Byte Version (retired 1 October 2009)~~
~~04~~	~~Read Coded Clinical Terms Version 2~~
~~05~~	~~Read Coded Clinical Terms Version 3 (CTV3)~~

~~Read Coded Clinical Terms Version 3 (CTV3) with qualifiers (previously known as 3.1) is not supported in the Commissioning Data Sets.~~

~~**CDS XML Message:**~~

~~The codes as specified above must be used in Commissioning Data Set - XML messages.~~

PROCEDURE SCHEME IN USE is the same as attribute PROCEDURE SCHEME IN USE.

PROCEDURE SCHEME IN USE

Change to Data Element: Changed Description, linked Attribute

PROCEDURE SCHEME IN USE

Attribute:

PROCEDURE SCHEME IN USE

PRODROME PSYCHOSIS DATE

Change to Data Element: Changed Description, linked Attribute

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
~~PRODROME PSYCHOSIS DATE is the date at which first noticeable change in behaviour or mental state of the PATIENT occurred, prior to emergence of full blown psychosis.~~PRODROME PSYCHOSIS DATE is the same as attribute PERSON PROPERTY OBSERVED DATE.

PRODROME PSYCHOSIS DATE is the DATE at which first noticeable change in behaviour or mental state of the PATIENT occurred, prior to emergence of full-blown psychosis. There should be clear deterioration in functioning from previous levels.

PRODROME PSYCHOSIS DATE

Change to Data Element: Changed Description, linked Attribute

PRODROME PSYCHOSIS DATE

Attribute:

PERSON PROPERTY OBSERVED DATE

PROFESSIONAL REGISTRATION BODY CODE

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See PROFESSIONAL REGISTRATION BODY CODE
Default Codes:	

Notes:
PROFESSIONAL REGISTRATION BODY CODE is the same as attribute PROFESSIONAL REGISTRATION BODY CODE.

This data element is also known by these names:

Context	Alias
plural	PROFESSIONAL REGISTRATION BODY CODES

PROFESSIONAL REGISTRATION BODY CODE

Change to Data Element: New Data Element

PROFESSIONAL REGISTRATION BODY CODE

Attribute:

PROFESSIONAL REGISTRATION BODY CODE

PROVISIONAL DIAGNOSIS (CODED CLINICAL ENTRY)

Change to Data Element: New Data Element

Format/Length:	min an4 max an18

National Codes:
Default Codes:

Notes:
PROVISIONAL DIAGNOSIS (CODED CLINICAL ENTRY) is the same as attribute CLINICAL CLASSIFICATION CODE or CLINICAL TERMINOLOGY CODE.

PROVISIONAL DIAGNOSIS (CODED CLINICAL ENTRY) is the CODED CLINICAL ENTRY used to identify the PROVISIONAL DIAGNOSIS.

This data element is also known by these names:

Context	Alias
plural	PROVISIONAL DIAGNOSES (CODED CLINICAL ENTRY)

PROVISIONAL DIAGNOSIS (CODED CLINICAL ENTRY)

Change to Data Element: New Data Element

PROVISIONAL DIAGNOSIS (CODED CLINICAL ENTRY)

Attribute:

CLINICAL CLASSIFICATION CODE
CLINICAL TERMINOLOGY CODE

PSYCHOSIS FIRST TREATMENT START DATE renamed from PSYCHOSIS TREATMENT START DATE

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

Format/Length: See DATE
National Codes:
Default Codes:

Notes:
~~PSYCHOSIS TREATMENT START DATE is the DATE the PATIENT commenced prescribed anti-psychotic medication and thereafter was compliant for at least 75% of the time during the subsequent month (using clinical judgement).~~PSYCHOSIS FIRST TREATMENT START DATE is the same as attribute PERSON PROPERTY EFFECTIVE DATE. PSYCHOSIS FIRST TREATMENT START DATE is the DATE the PATIENT first commenced prescribed anti-psychotic medication, following referral into an Early Intervention in Psychosis (EIP) Service, and thereafter was compliant for at least 75% of the time during the subsequent month (using clinical judgement).

~~For the majority of PATIENTS this will be the same as the PRESCRIPTION DATE (ANTI PSYCHOTIC MEDICATION).~~For the majority of PATIENTS this will be the same as the FIRST PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION).

PSYCHOSIS FIRST TREATMENT START DATE renamed from PSYCHOSIS TREATMENT START DATE

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

PSYCHOSIS FIRST TREATMENT START DATE

Attribute:

PERSON PROPERTY EFFECTIVE DATE

PSYCHOSIS FIRST TREATMENT START DATE renamed from PSYCHOSIS TREATMENT START DATE

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

- Changed Name from Data_Dictionary.Data_Field_Notes.P.Prod.PSYCHOSIS_TREATMENT_START_DATE to Data_Dictionary.Data_Field_Notes.P.Prod.PSYCHOSIS_FIRST_TREATMENT_START_DATE
- Changed Description
- null

REFERRAL CLOSURE DATE

Change to Data Element: New Data Element

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
REFERRAL CLOSURE DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Referral Closure Date*'.

This data element is also known by these names:

Context	Alias
plural	REFERRAL CLOSURE DATES

REFERRAL CLOSURE DATE

Change to Data Element: New Data Element

REFERRAL CLOSURE DATE

Attribute:

ACTIVITY DATE

REFERRAL CLOSURE REASON

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See REFERRAL CLOSURE REASON
Default Codes:	

Notes:
REFERRAL CLOSURE REASON is the same as attribute REFERRAL CLOSURE REASON.

This data element is also known by these names:

Context	Alias
plural	REFERRAL CLOSURE REASONS

REFERRAL CLOSURE REASON

Change to Data Element: New Data Element

REFERRAL CLOSURE REASON

Attribute:

REFERRAL CLOSURE REASON

REFERRAL REJECTION DATE

Change to Data Element: New Data Element

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
REFERRAL REJECTION DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'Referral Rejection Date'*.

This data element is also known by these names:

Context	Alias
plural	REFERRAL REJECTION DATES

REFERRAL REJECTION DATE

Change to Data Element: New Data Element

REFERRAL REJECTION DATE

Attribute:

ACTIVITY DATE

REFERRAL REJECTION REASON

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See REFERRAL REJECTION REASON
Default Codes:	

Notes:
REFERRAL REJECTION REASON is the same as attribute REFERRAL REJECTION REASON.

This data element is also known by these names:

Context	Alias
plural	REFERRAL REJECTION REASONS

REFERRAL REJECTION REASON

Change to Data Element: New Data Element

REFERRAL REJECTION REASON

Attribute:

REFERRAL REJECTION REASON

REFERRING CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH AND COMMUNITY CARE)_ renamed from REFERRING CARE PROFESSIONAL STAFF GROUP (COMMUNITY CARE)

Change to Data Element: Changed Name, Description

Format/Length:	an3
~~National Codes:~~	~~See CARE PROFESSIONAL STAFF GROUP FOR COMMUNITY CARE~~
National Codes:	See REFERRING CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH AND COMMUNITY CARE
Default Codes:	

Notes:
~~REFERRING CARE PROFESSIONAL STAFF GROUP (COMMUNITY CARE) is the same as attribute CARE PROFESSIONAL STAFF GROUP FOR COMMUNITY CARE.~~

~~The staff group of the CARE PROFESSIONAL who referred the PATIENT to the Community Health Service, where applicable (if the referrer is not a CARE PROFESSIONAL, for example, if the referrer is an employer, this item should be omitted).~~

REFERRING CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH AND COMMUNITY CARE) is the same as attribute REFERRING CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH AND COMMUNITY CARE.

REFERRING CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH AND COMMUNITY CARE)_ renamed from REFERRING CARE PROFESSIONAL STAFF GROUP (COMMUNITY CARE)

Change to Data Element: Changed Name, Description

- Changed Name from Data_Dictionary.Data_Field_Notes.R.Ref.REFERRING_CARE_PROFESSIONAL_STAFF_GROUP_(COMMUNITY_CARE) to Data_Dictionary.Data_Field_Notes.R.Ref.REFERRING_CARE_PROFESSIONAL_STAFF_GROUP_(MENTAL_HEALTH_AND_COMMUNITY_CARE)
- Changed Description

REPLACEMENT APPOINTMENT BOOKED DATE

Change to Data Element: New Data Element

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
REPLACEMENT APPOINTMENT BOOKED DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'Replacement Appointment Booked Date'*.

This data element is also known by these names:

Context	Alias
plural	REPLACEMENT APPOINTMENT BOOKED DATES

REPLACEMENT APPOINTMENT BOOKED DATE

Change to Data Element: New Data Element

REPLACEMENT APPOINTMENT BOOKED DATE

Attribute:

ACTIVITY DATE

REPLACEMENT APPOINTMENT DATE OFFERED

Change to Data Element: New Data Element

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
REPLACEMENT APPOINTMENT DATE OFFERED is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'Replacement Appointment Date Offered'*.

This data element is also known by these names:

Context	Alias
plural	REPLACEMENT APPOINTMENT DATES OFFERED

REPLACEMENT APPOINTMENT DATE OFFERED

Change to Data Element: New Data Element

REPLACEMENT APPOINTMENT DATE OFFERED

Attribute:

ACTIVITY DATE

RESTRICTIVE INTERVENTION TYPE

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See RESTRICTIVE INTERVENTION TYPE
Default Codes:	

Notes:
RESTRICTIVE INTERVENTION TYPE is the same as the attribute RESTRICTIVE INTERVENTION TYPE.

This data element is also known by these names:

Context	Alias
plural	RESTRICTIVE INTERVENTION TYPES

RESTRICTIVE INTERVENTION TYPE

Change to Data Element: New Data Element

RESTRICTIVE INTERVENTION TYPE

Attribute:

RESTRICTIVE INTERVENTION TYPE

SECONDARY DIAGNOSIS (CODED CLINICAL ENTRY)

Change to Data Element: New Data Element

Format/Length:	min an4 max an18
National Codes:	
Default Codes:	

Notes:
SECONDARY DIAGNOSIS (CODED CLINICAL ENTRY) is the same as attribute CLINICAL CLASSIFICATION CODE or CLINICAL TERMINOLOGY CODE.

SECONDARY DIAGNOSIS (CODED CLINICAL ENTRY) is the CODED CLINICAL ENTRY used to identify the secondary PATIENT DIAGNOSIS.

This data element is also known by these names:

Context	Alias
plural	SECONDARY DIAGNOSES (CODED CLINICAL ENTRY)

SECONDARY DIAGNOSIS (CODED CLINICAL ENTRY)

Change to Data Element: New Data Element

SECONDARY DIAGNOSIS (CODED CLINICAL ENTRY)

Attribute:

CLINICAL CLASSIFICATION CODE
CLINICAL TERMINOLOGY CODE

SERVICE DISCHARGE DATE

Change to Data Element: New Data Element

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
SERVICE DISCHARGE DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Service Discharge Date*'.

This data element is also known by these names:

Context	Alias
plural	SERVICE DISCHARGE DATES

SERVICE DISCHARGE DATE

Change to Data Element: New Data Element

SERVICE DISCHARGE DATE

Attribute:

ACTIVITY DATE

SERVICE OR TEAM TYPE REFERRED TO (MENTAL HEALTH)

Change to Data Element: New Data Element

Format/Length:	an3
National Codes:	See SERVICE OR TEAM TYPE FOR MENTAL HEALTH
Default Codes:	

Notes:
SERVICE OR TEAM TYPE REFERRED TO (MENTAL HEALTH) is the same as attribute SERVICE OR TEAM TYPE FOR MENTAL HEALTH.

SERVICE OR TEAM TYPE REFERRED TO (MENTAL HEALTH) is the type of SERVICE or team within a Mental Health Service that a PATIENT was referred to.

This data element is also known by these names:

Context	Alias
plural	SERVICE OR TEAM TYPES REFERRED TO (MENTAL HEALTH)

SERVICE OR TEAM TYPE REFERRED TO (MENTAL HEALTH)

Change to Data Element: New Data Element

SERVICE OR TEAM TYPE REFERRED TO (MENTAL HEALTH)

Attribute:

SERVICE OR TEAM TYPE FOR MENTAL HEALTH

SETTLED ACCOMMODATION INDICATOR renamed from SETTLED ACCOMMODATION INDICATOR (MENTAL HEALTH)

Change to Data Element: Changed Name, Description

~~Format/length:~~	~~an1~~
Format/Length:	an1
National Codes:	See SETTLED ACCOMMODATION INDICATOR
~~Default Codes:~~	~~7 Not disclosed~~ ~~8 Not applicable~~ ~~9 Not known~~
Default Codes:	9 - Not Known

Notes:
~~SETTLED ACCOMMODATION INDICATOR (MENTAL HEALTH) is the same as attribute SETTLED ACCOMMODATION INDICATOR.~~

~~The SETTLED ACCOMMODATION INDICATOR of the PATIENT with any mental disorder should be captured periodically, typically as part of the PATIENT's regular Care Programme Approach Review.~~

SETTLED ACCOMMODATION INDICATOR is the same as attribute SETTLED ACCOMMODATION INDICATOR.

SETTLED ACCOMMODATION INDICATOR renamed from SETTLED ACCOMMODATION INDICATOR (MENTAL HEALTH)

Change to Data Element: Changed Name, Description

- Changed Name from Data_Dictionary.Data_Field_Notes.S.Set.SETTLED_ACCOMMODATION_INDICATOR_(MENTAL_HEALTH) to Data_Dictionary.Data_Field_Notes.S.Set.SETTLED_ACCOMMODATION_INDICATOR
- Changed Description

SEX OF PATIENTS CODE

Change to Data Element: Changed Description

Format/Length:	an1
National Codes:	
Default Codes:	

Notes:
SEX OF PATIENTS CODE is the same as attribute SEX OF PATIENTS.

SEX OF PATIENTS CODE is based on the SEX OF PATIENTS National Codes, with the addition of Home Leave:

Permitted National Codes:

1 Male
2 Female
8 Not specified
9 Home Leave *

~~* Note - National Code 9 is not valid for the Mental Health and Learning Disabilities Data Set.~~* Note - National Code 9 is not valid for the Mental Health Services Data Set.

START DATE (CARE CLUSTER ASSIGNMENT PERIOD)

Change to Data Element: New Data Element

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
START DATE (CARE CLUSTER ASSIGNMENT PERIOD) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'Start Date'* of a Care Cluster Assignment Period.

This data element is also known by these names:

Context	Alias
plural	START DATES (CARE CLUSTER ASSIGNMENT PERIOD)

START DATE (CARE CLUSTER ASSIGNMENT PERIOD)

Change to Data Element: New Data Element

START DATE (CARE CLUSTER ASSIGNMENT PERIOD)

Attribute:

ACTIVITY DATE

START DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)

Change to Data Element: New Data Element

Format/Length:	See DATE
National Codes:	

Default Codes:

Notes:
START_DATE_(CARE_PROFESSIONAL_ADMITTED_CARE_EPISODE) is the same as attribute ACTIVITY_DATE where the ACTIVITY_DATE_TYPE is National Code '*Start Date*' of the Care Professional Admitted Care Episode.

This data element is also known by these names:

Context	Alias
plural	START DATES (CARE PROFESSIONAL ADMITTED CARE EPISODE)

START DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)

Change to Data Element: New Data Element

START DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)

Attribute:

ACTIVITY DATE

START DATE (CARE PROGRAMME APPROACH CARE)

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
~~START DATE (CARE PROGRAMME APPROACH CARE) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Start Date*' of a period of care for a PATIENT, when the CARE PROGRAMME APPROACH LEVEL is National Code '*New Care Programme Approach Care*'.~~START_DATE_(CARE_PROGRAMME_APPROACH_CARE) is the same as attribute ACTIVITY_DATE where the ACTIVITY_DATE_TYPE is National Code '*Start Date*' of the Care Programme Approach care for the PATIENT.

START DATE (COMMUNITY TREATMENT ORDER) renamed from START DATE (SUPERVISED COMMUNITY TREATMENT)

Change to Data Element: Changed Name, Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
~~START_DATE_(SUPERVISED_COMMUNITY_TREATMENT) is the same as attribute ACTIVITY_DATE where the ACTIVITY_DATE_TYPE is National Code '*Start Date*' of the Supervised Community Treatment.~~START_DATE_(COMMUNITY_TREATMENT_ORDER) is the same as attribute ACTIVITY_DATE where the ACTIVITY_DATE_TYPE is National Code '*Start Date*' of the Community Treatment Order.

START DATE (COMMUNITY TREATMENT ORDER) renamed from START DATE (SUPERVISED COMMUNITY TREATMENT)

Change to Data Element: Changed Name, Description

- Changed Name from Data_Dictionary.Data_Field_Notes.S.Star.START_DATE_(SUPERVISED_COMMUNITY_TREATMENT) to Data_Dictionary.Data_Field_Notes.S.Star.START_DATE_(COMMUNITY_TREATMENT_ORDER)

- Changed Description

START DATE (COMMUNITY TREATMENT ORDER RECALL) renamed from START DATE (SUPERVISED COMMUNITY TREATMENT RECALL)

Change to Data Element: Changed Name, Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
~~START DATE (SUPERVISED COMMUNITY TREATMENT RECALL) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Start Date*' of the Supervised Community Treatment Recall.~~START DATE (COMMUNITY TREATMENT ORDER RECALL) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Start Date*' of the Supervised Community Treatment Recall.

START DATE (COMMUNITY TREATMENT ORDER RECALL) renamed from START DATE (SUPERVISED COMMUNITY TREATMENT RECALL)

Change to Data Element: Changed Name, Description

- Changed Name from Data_Dictionary.Data_Field_Notes.S.Star.START_DATE_(SUPERVISED_COMMUNITY_TREATMENT_RECALL) to Data_Dictionary.Data_Field_Notes.S.Star.START_DATE_(COMMUNITY_TREATMENT_ORDER_RECALL)
- Changed Description

START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD) renamed from START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)

Change to Data Element: Changed Name, Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
~~START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Start Date*' of the MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION.~~START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Start Date*' of the Mental Health Act Legal Status Classification Assignment Period.

START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD) renamed from START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)

Change to Data Element: Changed Name, Description

- Changed Name from Data_Dictionary.Data_Field_Notes.S.Star.START_DATE_(MENTAL_HEALTH_ACT_LEGAL_STATUS_CLASSIFICATION) to Data_Dictionary.Data_Field_Notes.S.Star.START_DATE_(MENTAL_HEALTH_ACT_LEGAL_STATUS_CLASSIFICATION_ASSIGNMENT_PERIOD)
- Changed Description

START DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD) renamed from START DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT)

Change to Data Element: Changed Name

- Changed Name from Data_Dictionary.Data_Field_Notes.S.Star.START_DATE_(MENTAL_HEALTH_CARE_COORDINATOR_ASSIGNMENT) to Data_Dictionary.Data_Field_Notes.S.Star.START_DATE_(MENTAL_HEALTH_CARE_COORDINATOR_ASSIGNMENT_PERIOD)

START DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD)

Change to Data Element: Changed Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
START_DATE_(MENTAL_HEALTH_DELAYED_DISCHARGE_PERIOD) is the same as attribute ACTIVITY_DATE where the ACTIVITY_DATE_TYPE is National Code '*Start Date*' of the Mental Health Delayed Discharge Period.

~~START_DATE_(MENTAL_HEALTH_DELAYED_DISCHARGE_PERIOD) is the date that the clinical decision was taken that the PATIENT is fit and ready for discharge, but external factors prevent the discharge taking place.~~

START DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD) renamed from START DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT)

Change to Data Element: Changed Name, Description

Format/Length:	See DATE
National Codes:	
Default Codes:	

Notes:
~~START_DATE_(MENTAL_HEALTH_RESPONSIBLE_CLINICIAN_ASSIGNMENT) is the same as attribute ACTIVITY_DATE where the ACTIVITY_DATE_TYPE is National Code '*Start Date*' of the Mental Health Responsible Clinician Assignment.~~START_DATE_(MENTAL_HEALTH_RESPONSIBLE_CLINICIAN_ASSIGNMENT_PERIOD) is the same as attribute ACTIVITY_DATE where the ACTIVITY_DATE_TYPE is National Code '*Start Date*' of the Mental Health Responsible Clinician Assignment Period.

START DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD) renamed from START DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT)

Change to Data Element: Changed Name, Description

- Changed Name from Data_Dictionary.Data_Field_Notes.S.Star.START_DATE_(MENTAL_HEALTH_RESPONSIBLE_CLINICIAN_ASSIGNMENT) to Data_Dictionary.Data_Field_Notes.S.Star.START_DATE_(MENTAL_HEALTH_RESPONSIBLE_CLINICIAN_ASSIGNMENT_PERIOD)
- Changed Description

START TIME (CARE CLUSTER ASSIGNMENT PERIOD)

Change to Data Element: New Data Element

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:
START TIME (CARE CLUSTER ASSIGNMENT PERIOD) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code *'Start Time'* of a Care Cluster Assignment Period.

This data element is also known by these names:

Context	Alias
plural	START TIMES (CARE CLUSTER ASSIGNMENT PERIOD)

START TIME (CARE CLUSTER ASSIGNMENT PERIOD)

Change to Data Element: New Data Element

START TIME (CARE CLUSTER ASSIGNMENT PERIOD)

Attribute:

ACTIVITY TIME

START TIME (COMMUNITY TREATMENT ORDER RECALL) renamed from START TIME (SUPERVISED COMMUNITY TREATMENT RECALL)

Change to Data Element: Changed Name, Description

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:
~~START TIME (SUPERVISED COMMUNITY TREATMENT RECALL) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code *'Start Time'* of the Supervised Community Treatment Recall.~~START TIME (COMMUNITY TREATMENT ORDER RECALL) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code *'Start Time'* of the Community Treatment Order Recall.

START TIME (COMMUNITY TREATMENT ORDER RECALL) renamed from START TIME (SUPERVISED COMMUNITY TREATMENT RECALL)

Change to Data Element: Changed Name, Description

- Changed Name from Data_Dictionary.Data_Field_Notes.S.Star.START_TIME_(SUPERVISED_COMMUNITY_TREATMENT_RECALL) to Data_Dictionary.Data_Field_Notes.S.Star.START_TIME_(COMMUNITY_TREATMENT_ORDER_RECALL)
- Changed Description

START TIME (HOME LEAVE)

Change to Data Element: New Data Element

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:
START TIME (HOME LEAVE) is the same as the attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code *'Start Time'* of the Home Leave.

This data element is also known by these names:

Context	Alias
plural	START TIMES (HOME LEAVE)

START TIME (HOME LEAVE)

Change to Data Element: New Data Element

START TIME (HOME LEAVE)

Attribute:

ACTIVITY TIME

START TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE)

Change to Data Element: New Data Element

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:
START TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE) is the same as the attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Start Time*' of the Mental Health Absence Without Leave.

This data element is also known by these names:

Context	Alias
plural	START TIMES (MENTAL HEALTH ABSENCE WITHOUT LEAVE)

START TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE)

Change to Data Element: New Data Element

START TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE)

Attribute:

ACTIVITY TIME

START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD) renamed from START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)

Change to Data Element: Changed Name, Description

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:
~~START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Start Time*' of the MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION.~~START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Start Time*' of the Mental Health Act Legal Status Classification Assignment Period.

START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD) renamed from START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)

Change to Data Element: Changed Name, Description

- Changed Name from Data_Dictionary.Data_Field_Notes.S.Star.START_TIME_(MENTAL_HEALTH_ACT_LEGAL_STATUS_CLASSIFICATION) to Data_Dictionary.Data_Field_Notes.S.Star.START_TIME_(MENTAL_HEALTH_ACT_LEGAL_STATUS_CLASSIFICATION_ASSIGNMENT_PERIOD)
- Changed Description

START TIME (MENTAL HEALTH CARE CLUSTER)

Change to Data Element: Changed Description

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:
~~START TIME (MENTAL HEALTH CARE CLUSTER) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code 'Start Time' of a Mental Health Care Cluster Assignment Period for a PATIENT.~~START TIME (MENTAL HEALTH CARE CLUSTER) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code *'Start Time'* of a Mental Health Care Cluster Assignment Period for a PATIENT.

START TIME (MENTAL HEALTH LEAVE OF ABSENCE)

Change to Data Element: New Data Element

Format/Length:	See TIME
National Codes:	
Default Codes:	

Notes:
START TIME (MENTAL HEALTH LEAVE OF ABSENCE) is the same as the attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code *'Start Time'* of the Mental Health Leave of Absence.

This data element is also known by these names:

Context	Alias
plural	START TIMES (MENTAL HEALTH LEAVE OF ABSENCE)

START TIME (MENTAL HEALTH LEAVE OF ABSENCE)

Change to Data Element: New Data Element

START TIME (MENTAL HEALTH LEAVE OF ABSENCE)

Attribute:

ACTIVITY TIME

TREATMENT FUNCTION CODE (MENTAL HEALTH)

Change to Data Element: Changed Description

Format/Length:	an3
~~National Codes:~~	~~See TREATMENT FUNCTION CODE~~

National Codes:
Default Codes:

Notes:
~~TREATMENT FUNCTION CODE (MENTAL HEALTH) is the same as attribute TREATMENT FUNCTION CODE.~~TREATMENT FUNCTION CODE (MENTAL HEALTH) is the same as attribute TREATMENT FUNCTION CODE.

~~TREATMENT FUNCTION CODE (MENTAL HEALTH) is the TREATMENT FUNCTION Mental Health SERVICE under which the PATIENT is treated. It may be the same as the MAIN SPECIALTY CODE or a different TREATMENT FUNCTION which will be the CARE PROFESSIONAL's treatment interest.~~TREATMENT FUNCTION CODE (MENTAL HEALTH) is the TREATMENT FUNCTION CODE for a PATIENT treated by a Mental Health Service.

Permitted National Codes:

~~700~~	~~Learning Disability~~
700	Learning Disability
710	Adult Mental Illness
711	Child and Adolescent Psychiatry
712	Forensic Psychiatry
713	Psychotherapy
715	Old Age Psychiatry
720	Eating Disorders
721	Addiction Services
722	Liaison Psychiatry
723	Psychiatric Intensive Care
724	Perinatal Psychiatry
725	Mental Health Recovery and Rehabilitation Service
726	Mental Health Dual Diagnosis Service
727	Dementia Assessment Service

UCUM UNIT OF MEASUREMENT

Change to Data Element: New Data Element

Format/Length: max an10
National Codes:
Default Codes:

Notes:
UCUM UNIT OF MEASUREMENT is the same as attribute UCUM UNIT OF MEASUREMENT.

This data element is also known by these names:

Context	Alias
plural	UCUM UNITS OF MEASUREMENT

UCUM UNIT OF MEASUREMENT

Change to Data Element: New Data Element

UCUM UNIT OF MEASUREMENT

Attribute:

UCUM UNIT OF MEASUREMENT

WAITING TIME MEASUREMENT TYPE

Change to Data Element: Changed Description

Format/Length:	an2
National Codes:	See WAITING TIME MEASUREMENT TYPE
Default Codes:	

Notes:
WAITING TIME MEASUREMENT TYPE is the same as attribute WAITING TIME MEASUREMENT TYPE. Note: National Codes 01, 03 and 04 are not valid for the Referral To Treatment (RTT) data group in the Mental Health Services Data Set.

WARD SETTING TYPE (MENTAL HEALTH)

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See WARD SETTING TYPE FOR MENTAL HEALTH
Default Codes:	

Notes:
WARD SETTING TYPE (MENTAL HEALTH) is the same as attribute WARD SETTING TYPE FOR MENTAL HEALTH.

This data element is also known by these names:

Context	Alias
plural	WARD SETTING TYPES (MENTAL HEALTH)

WARD SETTING TYPE (MENTAL HEALTH)

Change to Data Element: New Data Element

WARD SETTING TYPE (MENTAL HEALTH)

Attribute:

WARD SETTING TYPE FOR MENTAL HEALTH

WARD STAY IDENTIFIER

Change to Data Element: New Data Element

Format/Length:	max an20
National Codes:	
Default Codes:	

Notes:
WARD STAY IDENTIFIER is the same as attribute ACTIVITY IDENTIFIER.

WARD STAY IDENTIFIER is a unique identifier allocated for each Ward Stay during a Hospital Provider Spell.

This data element is also known by these names:

Context	Alias
plural	WARD STAY IDENTIFIERS

WARD STAY IDENTIFIER

Change to Data Element: New Data Element

WARD STAY IDENTIFIER

Attribute:

ACTIVITY IDENTIFIER

WEEKLY HOURS WORKED

Change to Data Element: Changed Description

Format/Length:	an2
National Codes:	See WEEKLY HOURS WORKED
~~Default Codes:~~	~~97 - Not disclosed (PATIENT was asked but refused to respond)~~ ~~98 - Not applicable (PATIENT not employed or has not received secondary mental health services)~~ ~~99 - Not known~~
Default Codes:	98 - Not applicable (PATIENT not employed) 99 - Number of hours worked not known

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

YOUNG CARER INDICATOR

Change to Data Element: Changed Description

Format/Length:	an1
National Codes:	See YOUNG CARER INDICATOR
~~Default Codes:~~	~~X - Not known - Not known whether the PERSON is a young carer~~
Default Codes:	X - Not known whether the PERSON is a young carer

Notes:
YOUNG CARER INDICATOR is the same as attribute YOUNG CARER INDICATOR.

For enquiries about this Change Request, please email information.standards@hscic.gov.uk.
For enquires regarding the Data Set, please contact enquiries@hscic.gov.uk,