NHS Digital

NHS Data Model and Dictionary Service

Type:	Change Request
Reference:	1563
Version No:	1.0
Subject:	Mental Health Services Data Set Version 2.0
Effective Date:	1 April 2017
Reason for Change:	Change to Data Standards
Publication Date:	16 September 2016

Background:

The Mental Health Services Data Set Version was approved by the Standardisation Committee for Care Information (SCCI) as SCCI0011 Mental Health Services Data Set.

Minor changes to the Information Standard were made in Mental Health Services Data Set Version 1.1 and further changes are now required.

To support the Information Standard, this Change Request updates the NHS Data Model and Dictionary to reflect Mental Health Services Data Set Version 2.0.

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	
CANCER OUTCOMES AND SERVICES DIAGRAM	Changed Diagram
MATERNITY SERVICES DIAGRAM	Changed Diagram
Data Set	
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES DATA SET	Changed Description
MENTAL HEALTH SERVICES DATA SET	Changed Description
Supporting Information	
ADULT MENTAL HEALTH CARE CLUSTER	Changed Description
ADULT MENTAL HEALTH CLUSTERING TOOL	Changed Description
CARE PLAN AGREED DATE	New Supporting Information
CARE PLAN CREATION DATE	New Supporting Information
CARE PLAN IMPLEMENTATION DATE	New Supporting Information
CARE PLAN LAST UPDATED DATE	New Supporting Information
CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING	New Supporting Information
CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING TOOL	New Supporting Information
DISCHARGE PLAN	New Supporting Information
FIVE FORENSIC PATHWAYS	New Supporting Information
FIVE FORENSIC PATHWAYS ASSESSMENT DATE	New Supporting Information
FORENSIC LEARNING DISABILITY SERVICE	New Supporting Information
FORENSIC MENTAL HEALTH CARE CLUSTER	New Supporting Information

FORENSIC MENTAL HEALTH CLUSTERING TOOL	New Supporting Information
FORENSIC MENTAL HEALTH PATIENT	New Supporting Information
FORENSIC MENTAL HEALTH SERVICE	New Supporting Information
HEALTH OF THE NATION OUTCOME SCALE (WORKING AGE ADULTS)	Changed Description
HOME LEAVE	Changed Description
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES DATA SET OVERVIEW	Changed Description
MENTAL HEALTH CARE CLUSTER SUPER CLASS	Changed Description
MENTAL HEALTH CARE PLAN	New Supporting Information
MENTAL HEALTH CRISIS PLAN CREATION DATE (RETIRED) renamed from MENTAL HEALTH CRISIS PLAN CREATION DATE	Changed Description, status to Retired, Name
MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE (RETIRED) renamed from MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE	Changed Description, status to Retired, Name
ONWARD REFERRAL TIME	New Supporting Information
PLACE OF SAFETY	New Supporting Information
POSITIVE BEHAVIOUR SUPPORT PLAN	New Supporting Information
REFERENCED ORGANISATIONS MENU	Changed Description
REFERRAL CLOSURE TIME	New Supporting Information
ROYAL COLLEGE OF PSYCHIATRISTS	New Supporting Information
SERVICE DISCHARGE TIME	New Supporting Information
URGENT AND EMERGENCY MENTAL HEALTH CARE PLAN	New Supporting Information
WARD STAY	Changed Description

Class Definitions

CARE CLUSTER	Changed Attributes
CARE CONTACT	Changed Attributes
CARE PLAN	Changed Attributes
DECISION TO REFER	Changed Attributes
LOCATION	Changed Attributes
PERSON PROPERTY	Changed Attributes
SERVICE REQUEST	Changed Attributes
WARD OPERATIONAL PLAN	Changed Attributes

Attribute Definitions

ACTIVITY DATE TYPE	Changed Description
ACTIVITY TIME TYPE	Changed Description
AGE GROUP INTENDED FOR MENTAL HEALTH	New Attribute
ASSESSMENT TOOL TYPE	Changed Description
CARE PLAN AGREED BY	New Attribute
CARE PLAN AGREED DATE (RETIRED) renamed from CARE PLAN AGREED DATE	Changed Description, status to Retired, Name
CARE PLAN IDENTIFIER renamed from CARE PLAN NUMBER	Changed Description, Name
CARE PLAN TYPE	Changed Description
CARE PLAN TYPE FOR MENTAL HEALTH	New Attribute
CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (RETIRED) renamed from CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE	Changed Description, status to Retired, Name
CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE	New Attribute
CLUSTERING TOOL ASSESSMENT CATEGORY	Changed Description
DECISION TO REFER TIME	New Attribute
DISCHARGE METHOD	Changed Description
DISCHARGE PLAN AGREED BY	New Attribute
FIVE FORENSIC PATHWAYS ASSESSMENT REASON	New Attribute
FIVE FORENSIC PATHWAYS CODE	New Attribute
FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE	Changed Description

FORENSIC MENTAL HEALTH CARE CLUSTER CODE	Changed Description
MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE	Changed Description
MENTAL HEALTH DELAYED DISCHARGE REASON	Changed Description
OFFENCE HISTORY INDICATION CODE	New Attribute
OTHER PERSON IN ATTENDANCE AT CARE CONTACT	Changed Description
PLACE OF SAFETY INDICATOR	New Attribute
REASON FOR OUT OF AREA REFERRAL FOR ADULT ACUTE MENTAL HEALTH	New Attribute
REFERRAL REQUEST RECEIVED TIME	Changed Description
REFERRED OUT OF AREA REASON FOR ADULT ACUTE MENTAL HEALTH	New Attribute
SERVICE OR TEAM TYPE FOR MENTAL HEALTH	Changed Description

Data Elements

ASSISTIVE TECHNOLOGY FINDING (SNOMED CT)	Changed Description
CARE PLAN AGREED BY	New Data Element
CARE PLAN AGREED DATE renamed from CARE PLAN AGREED DATE (RETIRED)	Changed Description, status to Retired, linked Attribute, Name
CARE PLAN CREATION DATE	New Data Element
CARE PLAN IDENTIFIER	New Data Element
CARE PLAN IMPLEMENTATION DATE	New Data Element
CARE PLAN LAST UPDATED DATE	New Data Element
CARE PLAN TYPE (MENTAL HEALTH)	New Data Element
CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL) (RETIRED) renamed from CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL)	Changed Description, status to Retired, linked Attribute, Name
CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL) (RETIRED) renamed from CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL)	Changed Description, status to Retired, linked Attribute, Name
CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE	New Data Element
CHILD AND ADOLESCENT MENTAL HEALTH TIER OF SERVICE	Changed Description
DECISION TO REFER DATE (ONWARD REFERRAL)	New Data Element
DECISION TO REFER TIME (ONWARD REFERRAL)	New Data Element
DISCHARGE PLAN AGREED BY	New Data Element
DISCHARGE PLAN AGREED DATE	New Data Element
DISCHARGE PLAN CREATION DATE	New Data Element
DISCHARGE PLAN LAST UPDATED DATE	New Data Element
DURATION OF RESTRICTIVE INTERVENTION	Changed Description
FIVE FORENSIC PATHWAYS ASSESSMENT DATE	New Data Element
FIVE FORENSIC PATHWAYS ASSESSMENT REASON	New Data Element
FIVE FORENSIC PATHWAYS CODE	New Data Element
FORENSIC MENTAL HEALTH CARE CLUSTER CODE (FINAL)	Changed Description
FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL) (RETIRED) renamed from FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL)	Changed Description, status to Retired, linked Attribute, Name
INTENDED AGE GROUP (MENTAL HEALTH)	New Data Element
MATERNITY CARE PLAN DATE	Changed Description, linked Attribute
MENTAL HEALTH ADMITTED PATIENT CLASSIFICATION	New Data Element
MENTAL HEALTH CRISIS PLAN CREATION DATE (RETIRED) renamed from MENTAL HEALTH CRISIS PLAN CREATION DATE	Changed Description, status to Retired, linked Attribute, Name
MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE (RETIRED) renamed from MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE	Changed Description, status to Retired, linked Attribute, Name
MENTAL HEALTH DELAYED DISCHARGE REASON	Changed Description
OBSERVATION DATE (SUBSTANCE MISUSE EVIDENCE)	New Data Element
OFFENCE HISTORY INDICATION CODE	New Data Element
ONWARD REFERRAL REASON	Changed Description

ONWARD REFERRAL TIME	New Data Element
PLACE OF SAFETY INDICATOR	New Data Element
PLANNED DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL)	New Data Element
POSTCODE OF MAIN VISITOR	Changed Description
REASON FOR OUT OF AREA REFERRAL (ADULT ACUTE MENTAL HEALTH)	New Data Element
REFERRAL CLOSURE TIME	New Data Element
REFERRED OUT OF AREA REASON (ADULT ACUTE MENTAL HEALTH)	New Data Element
SERVICE DISCHARGE TIME	New Data Element
SETTLED ACCOMMODATION INDICATOR	Changed Description
TREATMENT FUNCTION CODE (MENTAL HEALTH)	Changed Description

XML Schema Constraint

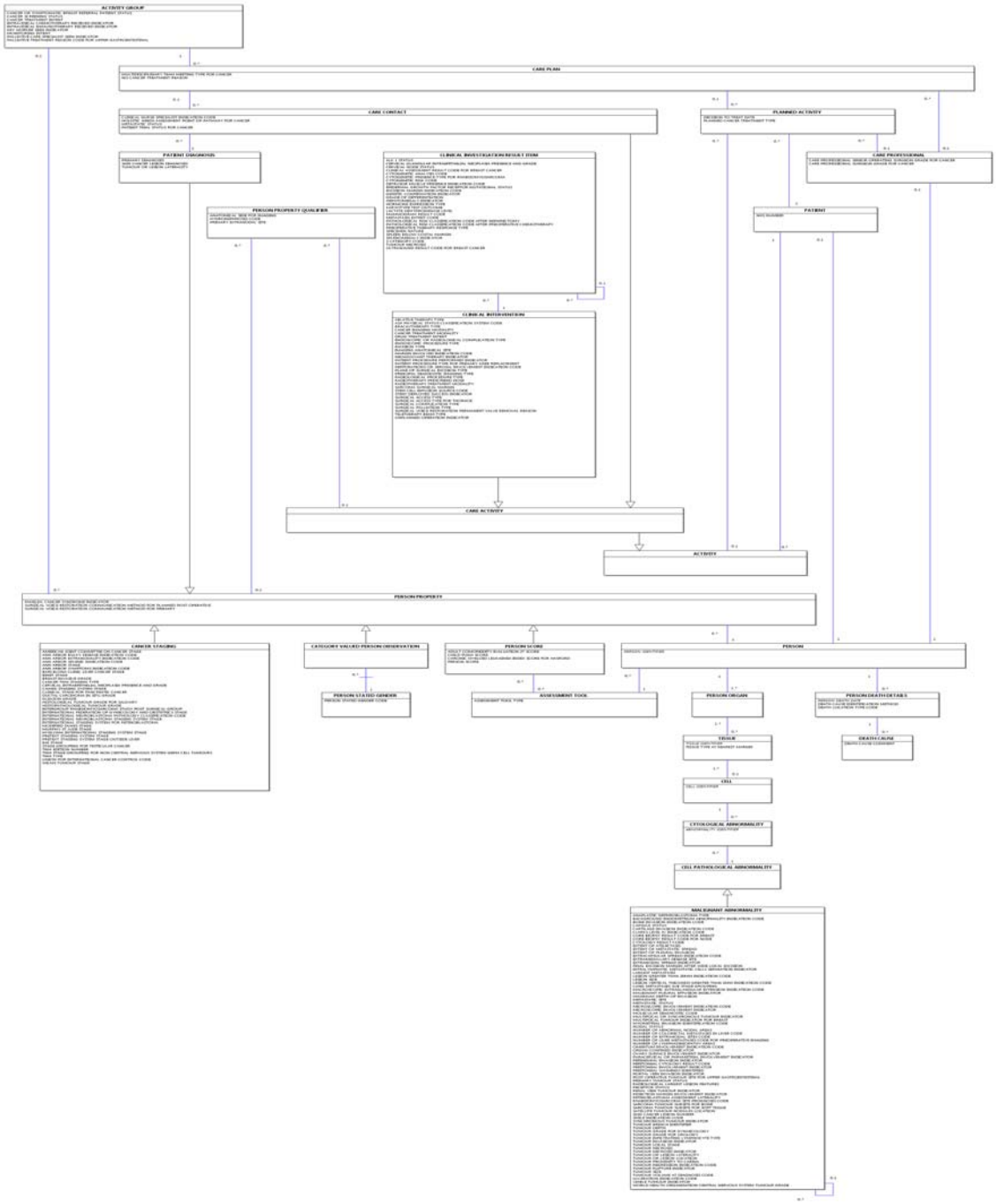
COMMISSIONING DATA SET VERSION 6-2 XML SCHEMA CONSTRAINTS	Changed Description

Date: 16 September 2016
Sponsor: Jonathan Marron, Director for Community, Mental Health and 7 Day Services, 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.

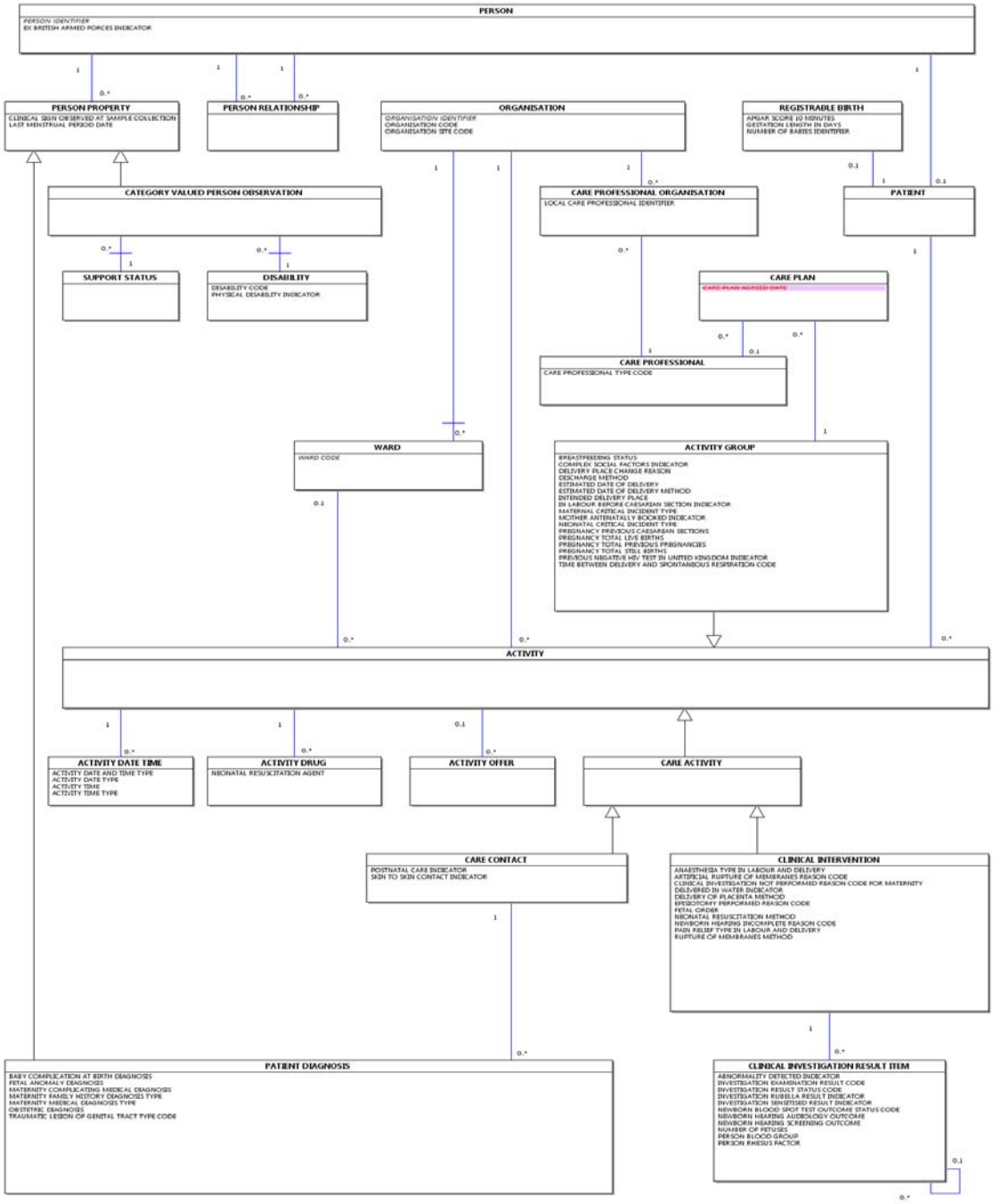
CANCER OUTCOMES AND SERVICES DIAGRAM

Change to Diagram: Changed Diagram



MATERNITY SERVICES DIAGRAM

Change to Diagram: Changed Diagram



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IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES DATA SET

Change to Data Set: Changed Description

The Improving Access to Psychological Therapies Data Set will be in included in a future version of the Mental Health Services Data Set.

Improving Access to Psychological Therapies Data Set Overview

The Mandatory or Required (M/R) 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.

PERSONAL AND DEMOGRAPHIC DETAILS

Patient:
To carry Patient and Demographic details.
One occurrence of this group is required.

M/R	Data Set Data Elements
R	NHS NUMBER
R	NHS NUMBER STATUS INDICATOR CODE
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	ORGANISATION CODE (CODE OF PROVIDER)
M	PERSON BIRTH DATE
R	PERSON GENDER CODE CURRENT
M	POSTCODE OF USUAL ADDRESS
R	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)
R	ETHNIC CATEGORY
R	RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE
R	SEXUAL ORIENTATION (CURRENT)
R	EX-BRITISH ARMED FORCES INDICATOR
R	LONG TERM PHYSICAL HEALTH CONDITION INDICATOR (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)

DISABILITY

Patient Disability:
To carry details of the Patient's Disability.
Many occurrences of this group are permitted.

M/R	Data Set Data Elements
R	NHS NUMBER
R	LOCAL PATIENT IDENTIFIER (EXTENDED)
R	ORGANISATION CODE (CODE OF PROVIDER)
R	DISABILITY CODE

REFERRAL DETAILS

Improving Access to Psychological Therapies Referral:
To carry details of the Referral.
Many occurrences of this group are permitted.

M/R	Data Set Data Elements
R	NHS NUMBER
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	ORGANISATION CODE (CODE OF PROVIDER)
M	SERVICE REQUEST IDENTIFIER
M	REFERRAL REQUEST RECEIVED DATE
R	IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES OPT IN DATE
R	SOURCE OF REFERRAL FOR MENTAL HEALTH
R	SERVICE REQUEST ACCEPTANCE INDICATOR
R	ORGANISATION CODE (CODE OF COMMISSIONER)
R	PROVISIONAL DIAGNOSIS (ICD)

R	YEAR AND MONTH OF SYMPTOMS ONSET (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)
R	PREVIOUS SYMPTOM INDICATOR
R	IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES CARE SPELL END CODE
R	END DATE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)
R	ORGANISATION CODE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES STEPPED TO PROVIDER)
R	ADULT MENTAL HEALTH CARE CLUSTER CODE (FINAL)

APPOINTMENT DETAILS

Improving Access to Psychological Therapies Appointment:
To carry details of each Appointment.
Many occurrences of this group are permitted.

M/R	Data Set Data Elements
R	NHS NUMBER
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	ORGANISATION CODE (CODE OF PROVIDER)
M	SERVICE REQUEST IDENTIFIER
M	APPOINTMENT DATE
M	APPOINTMENT TIME
R	IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES STEPPED CARE INTENSITY DELIVERED
R	CARE PROFESSIONAL ROLE CODE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)
M	ATTENDED OR DID NOT ATTEND CODE
R	APPOINTMENT SLOT SHORT NOTICE CANCELLATION INDICATOR
R	CLINICAL CONTACT DURATION OF APPOINTMENT
M	APPOINTMENT TYPE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)
R	CONSULTATION MEDIUM USED
R	FACE TO FACE COMMUNICATION MODE
R	THERAPY TYPE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES) (Up to four types may be recorded for each APPOINTMENT)
R	EMPLOYMENT STATUS
R	EMPLOYMENT SUPPORT SUITABILITY INDICATOR
R	EMPLOYMENT SUPPORT REFERRAL DATE
R	PSYCHOTROPIC MEDICATION USAGE
R	STATUTORY SICK PAY INDICATOR
R	PHQ-9 TOTAL SCORE
R	GENERALISED ANXIETY DISORDER SCORE
R	WORK AND SOCIAL ADJUSTMENT SCALE SCORE (WORK)
R	WORK AND SOCIAL ADJUSTMENT SCALE SCORE (HOME MANAGEMENT)
R	WORK AND SOCIAL ADJUSTMENT SCALE SCORE (SOCIAL LEISURE ACTIVITIES)
R	WORK AND SOCIAL ADJUSTMENT SCALE SCORE (PRIVATE LEISURE ACTIVITIES)
R	WORK AND SOCIAL ADJUSTMENT SCALE SCORE (RELATIONSHIPS)
R	AGORAPHOBIA MOBILITY INVENTORY SCORE (WHEN ACCOMPANIED)
R	AGORAPHOBIA MOBILITY INVENTORY SCORE (WHEN ALONE)
R	AGORAPHOBIA SCORE
R	GENERALISED ANXIETY DISORDER PENN STATE WORRY SCORE
R	HEALTH ANXIETY INVENTORY SHORT WEEK SCALE SCORE
R	OBSESSIVE COMPULSIVE DISORDER INVENTORY SCORE
R	PANIC DISORDER SEVERITY SCALE SCORE
R	POST TRAUMATIC STRESS DISORDER IMPACT OF EVENTS SCALE REVISED SCORE
R	SOCIAL PHOBIA INVENTORY SCORE

R	SOCIAL PHOBIA SCORE
R	SPECIFIC PHOBIA SCORE

WAITING TIME PAUSES

Waiting Time Pauses:
To carry details of the Waiting Time Pauses.
Many occurrences of this group are permitted.

M/R	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	ORGANISATION CODE (CODE OF PROVIDER)
M	SERVICE REQUEST IDENTIFIER
M	IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ACTIVITY SUSPENSION IDENTIFIER
M	ACTIVITY SUSPENSION START DATE
R	ACTIVITY SUSPENSION END DATE
R	IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ACTIVITY SUSPENSION REASON

TREATMENT QUESTIONNAIRE

Treatment Questionnaire:
To carry details of the Treatment Questionnaire completed by the Patient.
Many occurrences of this group are permitted.

M/R	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	ORGANISATION CODE (CODE OF PROVIDER)
M	SERVICE REQUEST IDENTIFIER
R	ASSESSMENT TOOL COMPLETION DATE
R	ASSESSMENT TOOL COMPLETION TIME
R	IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES TREATMENT PATIENT EXPERIENCE QUESTION 1
R	IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES TREATMENT PATIENT EXPERIENCE QUESTION 2
R	IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES TREATMENT PATIENT EXPERIENCE QUESTION 3
R	IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES TREATMENT PATIENT EXPERIENCE QUESTION 4
R	IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES TREATMENT PATIENT EXPERIENCE QUESTION 5

ASSESSMENT QUESTIONNAIRE

Assessment Questionnaire:
To carry details of the Assessment Questionnaire completed by the Patient.
Many occurrences of this group are permitted.

M/R	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	ORGANISATION CODE (CODE OF PROVIDER)
M	SERVICE REQUEST IDENTIFIER
R	ASSESSMENT TOOL COMPLETION DATE
R	ASSESSMENT TOOL COMPLETION TIME
R	IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ASSESSMENT CHOICE PATIENT EXPERIENCE QUESTION 1
R	IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ASSESSMENT CHOICE PATIENT EXPERIENCE QUESTION 2
R	IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ASSESSMENT CHOICE PATIENT EXPERIENCE QUESTION 3
R	

	IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ASSESSMENT SATISFACTION PATIENT EXPERIENCE QUESTION 1

MENTAL HEALTH SERVICES DATA SET

Change to Data Set: Changed Description

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	PERSON MARITAL STATUS

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.~~

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

M/R/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.~~

Accommodation Status:
To carry the accommodation details of the patient.
One occurrence of this group is permitted, containing the most recently recorded accommodation details.

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.~~

Employment Status:
To carry details of the employment status of the patient.
One occurrence of this group is permitted, containing the most recently recorded employment details.

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.~~

Patient Indicators:
To carry the details of specific indicators relating to a patient.
One occurrence of this group is permitted containing the current or most recently recorded status of indicator and psychosis information.

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	EX-BRITISH ARMED FORCES INDICATOR
R	OFFENCE HISTORY 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.**~~

Mental Health Care Coordinator:
To carry details of the Mental Health Care Coordinator assigned to a patient.
One occurrence of this group is permitted for each Mental Health Care Coordinator assignment.

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.**~~

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

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.**~~

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

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~~
M	ASSISTIVE TECHNOLOGY FINDING (SNOMED CT)
R	PRESCRIPTION DATE (ASSISTIVE TECHNOLOGY)

Care Plan Type:
To carry details of Care Plans created for a patient by the organisation, excluding Discharge Plans which are contained in the Service or Team Referral table.
One occurrence of this group is permitted for each Care Plan created for the patient.

M/R/P	Data Set Data Elements

M	CARE PLAN IDENTIFIER
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	CARE PLAN TYPE (MENTAL HEALTH)
M	CARE PLAN CREATION DATE
R	CARE PLAN LAST UPDATED DATE
R	CARE PLAN IMPLEMENTATION DATE

Care Plan Agreement:
To carry details of any agreements to a Care Plan by a patient, team or organisation, excluding Discharge Plans which are contained in the Discharge Plan Agreement table.
One occurrence of this group is permitted for each agreement of a Care Plan.

M/R/P	Data Set Data Elements
M	CARE PLAN IDENTIFIER
M	CARE PLAN AGREED BY
R	CARE PLAN AGREED 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.**~~

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

M/R/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	REASON FOR OUT OF AREA REFERRAL (ADULT ACUTE MENTAL HEALTH)
R	DISCHARGE PLAN CREATION DATE
R	DISCHARGE PLAN LAST UPDATED DATE
R	SERVICE DISCHARGE DATE
R	SERVICE DISCHARGE TIME
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.**~~

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

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

Service or Team Type Referred To:
To carry details of the service or team that a patient is referred to.
One occurrence of this group is permitted 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 CLOSURE TIME
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.**~~

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

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.**~~

Onward Referral:
To carry details of any onward referral of the patient which has taken place.
One occurrence of this group is permitted for each onward referral.

M/R/P	Data Set Data Elements
M	SERVICE REQUEST IDENTIFIER
R	DECISION TO REFER DATE (ONWARD REFERRAL)
R	DECISION TO REFER TIME (ONWARD REFERRAL)
M	ONWARD REFERRAL DATE
R	ONWARD REFERRAL TIME

R	ONWARD REFERRAL REASON
R	REFERRED OUT OF AREA REASON (ADULT ACUTE MENTAL HEALTH)
R	ORGANISATION CODE (RECEIVING)

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

M/R/P	Data Set Data Elements
M	SERVICE REQUEST IDENTIFIER
R	DISCHARGE PLAN AGREED BY
R	DISCHARGE PLAN AGREED DATE

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.**~~

Care Contact:
To carry details of any contacts with a patient which have taken place as part of a referral.
One occurrence of this group is permitted for each Care Contact.

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	PLACE OF SAFETY INDICATOR
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.**~~

Care Activity:
To carry details of any activities which have taken place as part of a contact.
One occurrence of this group is permitted for each Care Activity.

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.**~~

Other in Attendance:
To carry details of any other people in attendance during the care contact.
One occurrence of this group is permitted for each other patient in attendance at a Care Contact.

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.**~~

Indirect Activity:
To carry details of indirect activity which takes place.
One occurrence of this group is permitted for each instance of indirect activity taking place.

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.**~~

Group Session:
To carry details of any group sessions which have been provided.
One occurrence of this group is permitted for each Group Session activity.

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.**~~

Mental Health Act Legal Status Classification Period:
To carry details of Mental Health Act Legal Status Classification Periods for patients formally detailed under the Mental Health Act 1983 or other Acts.
One occurrence of this group is permitted for each Mental Health Act Legal Status Classification Period identified.

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.**~~

Mental Health Responsible Clinician Assignment:
To carry details of the assignment of a Mental Health Responsible Clinician to the patient.
One occurrence of this group is permitted for each assigned Mental Health Responsible Clinician to the Mental Health Act Legal Status Classification Period.

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.**~~

Conditional Discharge:
To carry details of each separate period of conditional discharge for the patient.
One occurrence of this group is permitted for each conditional discharge.

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.**~~

Community Treatment Order:
To carry details of each separate period of a Community Treatment Order under section 17a of the Mental Health Act 1983, as amended by the Mental Health Act 2007, for the patient.
One occurrence of this group is permitted whenever a Community Treatment Order occurs.

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.**~~

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, as amended by the Mental Health Act 2007.
One occurrence of this group is permitted whenever a patient on a Community Treatment Order is recalled into hospital.

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.**~~

Hospital Provider Spell:
To carry details of each Hospital Provider Spell for a patient.
One occurrence of this group is permitted for each Hospital Provider Spell.

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	POSTCODE OF MAIN VISITOR
R	PLANNED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)

R	PLANNED DISCHARGE DESTINATION CODE (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.**~~

Ward Stay:
To carry details of Ward Stays which occurred during a Hospital Provider Spell for the patient.
One occurrence of this group is permitted for each Ward Stay.

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	INTENDED AGE GROUP (MENTAL HEALTH)
R	SEX OF PATIENTS CODE
R	INTENDED CLINICAL CARE INTENSITY CODE (MENTAL HEALTH)
R	WARD SECURITY LEVEL
R	LOCKED WARD INDICATOR
R	MENTAL HEALTH ADMITTED PATIENT CLASSIFICATION

~~**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.**~~

Assigned Care Professional:
To carry details of the Care Professional Admitted Care Episodes during a Hospital Provider Spell.
One occurrence of this group is permitted for each Care Professional Admitted Care Episode.

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.**~~

Mental Health Delayed Discharge:
To carry details of Mental Health Delayed Discharge Periods which occurred during a Hospital Provider Spell.
One occurrence of this group is permitted whenever a patient is subject to a Mental Health Delayed Discharge Period.

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.**~~

Restrictive Intervention:
To carry details of Restrictive Interventions during a Hospital Provider Spell.
One occurrence of this group is permitted whenever a Restrictive Intervention is carried out.

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.**~~

Assault:
To carry details of each separate reported incident of assault on a patient by another patient during a Hospital Provider Spell.
One occurrence of this group is permitted whenever an assault on the patient occurs.

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.**~~

Self-Harm:
To carry details of self-harm by the patient during a Hospital Provider Spell.
One occurrence of this group is permitted whenever an incident of self-harm is reported.

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.**~~

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.
One occurrence of this group is permitted whenever a period of home leave takes place.

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.~~

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.
One occurrence of this group is permitted whenever a period of Mental Health Leave of Absence takes place.

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.~~

Mental Health Absence Without Leave:
To carry details of each separate period of Mental Health Absence Without Leave for the patient.
One occurrence of this group is permitted whenever a period of Mental Health Absence Without Leave takes place.

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.~~

Hospital Provider Spell Commissioner:
To carry details of each Commissioner Assignment Period during a Hospital Provider Spell.
One occurrence of this group is permitted for each Commissioner Assignment.

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)

Substance Misuse:
To carry observation details of evidence of substance misuse by a patient within a ward stay.
One occurrence of this group is permitted for each date that evidence was observed.

M/R/P	Data Set Data Elements
M	WARD STAY IDENTIFIER
M	OBSERVATION DATE (SUBSTANCE MISUSE EVIDENCE)

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.~~

Medical History (Previous Diagnosis):
To carry the details of any previous diagnoses for a patient.
One occurrence of this group is permitted for each Previous Diagnosis.

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.**~~

Provisional Diagnosis:
To carry the details of a provisional diagnosis made.
One occurrence of this group is permitted for each Provisional Diagnosis.

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.**~~

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

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.**~~

Secondary Diagnosis:
To carry the details of a secondary diagnosis made.
One occurrence of this group is permitted for each Secondary Diagnosis.

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.**~~

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.
One occurrence of this group is permitted for each coded scored assessment question or dimension captured outside of a Care Contact.

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
R	CARE PROFESSIONAL LOCAL IDENTIFIER

~~**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.**~~

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

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.**~~

Anonymous Self-Assessment:
To carry details of anonymous self-assessments.
One occurrence of this group is permitted for each coded anonymous self-assessment question or dimension captured.

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.**~~

Care Programme Approach (CPA) Care Episode:
To carry details of the periods of time the patient spent on Care Programme Approach.
One occurrence of this group is required for each Care Programme Approach (CPA) care episode.

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.**~~

Care Programme Approach (CPA) Review:
To carry details of Care Programme Approach reviews undertaken for the patient.

One occurrence of this group is permitted for the most recent Care Programme Approach Review that has taken place.

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.**~~

Clustering Tool Assessment:
To carry details of clustering tool assessments.
One occurrence of this group is permitted for each Clustering Tool assessment that takes place.

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.**~~

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

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.**~~

Care Cluster:
To carry details of the Care Cluster resulting from a clustering tool assessment.
One occurrence of this group is permitted for each period of time that a patient was allocated to a Care Cluster.

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	ADULT MENTAL HEALTH CARE CLUSTER CODE (FINAL)
R	CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE
P	LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)
R	FORENSIC MENTAL HEALTH CARE CLUSTER CODE (FINAL)
P	FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)
R	END DATE (CARE CLUSTER ASSIGNMENT PERIOD)
R	END TIME (CARE CLUSTER ASSIGNMENT PERIOD)

Five Forensic Pathways:
To carry details of the Five Forensic Pathways grouping allocated to the patient during a Five Forensic Pathways assessment.
One occurrence of this group is permitted for each initial assessment or review of the grouping allocation.

M/R/P	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	FIVE FORENSIC PATHWAYS ASSESSMENT DATE
R	FIVE FORENSIC PATHWAYS ASSESSMENT REASON
M	FIVE FORENSIC PATHWAYS CODE

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.**~~

Care Professionals:
To carry details of the staff involved in providing the patient's care.
One occurrence of this group is permitted for each staff member.

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

Change to Supporting Information: Changed Description

An Adult Mental Health Care Cluster is a type of CARE CLUSTER for adult PATIENTS.

An Adult Mental Health Care Cluster is part of a currency developed to support the National Tariff Payment System for Mental Health Services.

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.

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.

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.

~~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.~~Further information relating to the Adult Mental Health Clustering Tool and Adult Mental Health Care Clusters is available from the gov.uk website at: The NHS payment system: documents and guidance.

ADULT MENTAL HEALTH CLUSTERING TOOL

Change to Supporting Information: Changed Description

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

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.~~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 Adult 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 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 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 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 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 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.~~Further information relating to the Adult Mental Health Clustering Tool and Adult Mental Health Care Clusters is available from the gov.uk website at: The NHS payment system: documents and guidance.

CARE PLAN AGREED DATE

Change to Supporting Information: New Supporting Information

A Care Plan Agreed Date is an ACTIVITY DATE TIME.

A Care Plan Agreed Date is the DATE on which the CARE PLAN was agreed by a PATIENT or Patient Proxy.

This supporting information is also known by these names:

Context	Alias
plural	Care Plan Agreed Dates

CARE PLAN CREATION DATE

Change to Supporting Information: New Supporting Information

A Care Plan Creation Date is an ACTIVITY DATE TIME.

A Care Plan Creation Date is the DATE that a CARE PLAN was created.

This supporting information is also known by these names:

Context	Alias
plural	Care Plan Creation Dates

CARE PLAN IMPLEMENTATION DATE

Change to Supporting Information: New Supporting Information

A Care Plan Implementation Date is an ACTIVITY DATE TIME.

A Care Plan Implementation Date is the DATE that aspects of the CARE PLAN have commenced.

This supporting information is also known by these names:

Context	Alias
plural	Care Plan Implementation Dates

CARE PLAN LAST UPDATED DATE

Change to Supporting Information: New Supporting Information

A Care Plan Last Updated Date is an ACTIVITY DATE TIME.

A Care Plan Last Updated Date is the DATE that a CARE PLAN was last updated.

This supporting information is also known by these names:

Context	Alias
plural	Care Plan Last Updated Dates

CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING

Change to Supporting Information: New Supporting Information

A Child and Adolescent Mental Health Needs Based Grouping is a CARE CLUSTER.

Child and Adolescent Mental Health Needs Based Groupings are 21 groupings that categorise the need for advice or help of children, young people and/or families referred to a SERVICE.

A Child and Adolescent Mental Health Needs Based Grouping should be assigned via a process of shared decision making between the SERVICE provider and the PATIENT or Patient Proxy. The decision, undertaken by a CARE PROFESSIONAL, may be helped by using an algorithm that was created to develop the groupings.

For further information on the Child and Adolescent Mental Health Needs Based Groupings and the assignment process, see "A Guide to Choosing Needs-Based Groupings in Child and Adolescent Mental Health Services to Inform Payment Systems".

This supporting information is also known by these names:

Context	Alias
plural	Child and Adolescent Mental Health Needs Based Groupings

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CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING TOOL

Change to Supporting Information: New Supporting Information

The Child and Adolescent Mental Health Needs Based Grouping Tool is a type of Clustering Tool for child and adolescent PATIENTS receiving Mental Health care.

The Child and Adolescent Mental Health Needs Based Grouping Tool is a tool designed to categorise the need for advice or help of children, young people and/or families referred to a SERVICE.

For further information on the Child and Adolescent Mental Health Needs Based Grouping Tool, see "A Guide to Choosing Needs-Based Groupings in Child and Adolescent Mental Health Services to Inform Payment Systems".

DISCHARGE PLAN

Change to Supporting Information: New Supporting Information

A Discharge Plan is a CARE PLAN.

A Discharge Plan is developed for a PATIENT who is scheduled for discharge from care and a copy is provided to the PATIENT on discharge.

A Discharge Plan should contain information such as:

- The planned date and time of discharge
- The treatment and support the PATIENT will receive when discharged
- Arrangements for transfer to the planned discharge destination, such as planning for returning home or transfer to another care facility
- Agreements to the Discharge Plan by relevant individuals such as the PATIENT, family, CARE PROFESSIONAL or commissioners
- Any onward referrals to home care agencies and/or appropriate support organisations in the community, where required.

This supporting information is also known by these names:

Context	Alias
plural	Discharge Plans

FIVE FORENSIC PATHWAYS

Change to Supporting Information: New Supporting Information

Five Forensic Pathways (FFP) are part of a currency developed to support the National Tariff Payment System for Forensic Mental Health Services.

Five Forensic Pathways are 5 groupings of Forensic Mental Health Patients based on their presenting characteristics and projected care package needs.

Five Forensic Pathways are initially allocated on the basis of the pathway descriptors only. The allocation may be reviewed and adjusted if necessary on the basis of baseline measures.

This supporting information is also known by these names:

Context	Alias
shortname	FFP

FIVE FORENSIC PATHWAYS ASSESSMENT DATE

Change to Supporting Information: New Supporting Information

A Five Forensic Pathways Assessment Date is an ACTIVITY DATE TIME.

A Five Forensic Pathways Assessment Date is the date on which a Five Forensic Pathways assessment was completed for a PATIENT.

This supporting information is also known by these names:

Context	Alias
plural	Five Forensic Pathways Assessment Dates

FORENSIC LEARNING DISABILITY SERVICE

Change to Supporting Information: New Supporting Information

A Forensic Learning Disability Service is a type of Mental Health Service.

A Forensic Learning Disability Service provides specialist forensic assessment and treatment of Forensic Mental Health Patients who also have a Learning Disability.

This supporting information is also known by these names:

Context	Alias
plural	Forensic Learning Disability Services

FORENSIC MENTAL HEALTH CARE CLUSTER

Change to Supporting Information: New Supporting Information

A Forensic Mental Health Care Cluster is a type of CARE CLUSTER for PATIENTS accessing Forensic Mental Health Services.

A Forensic Mental Health Care Cluster is part of a currency developed to support the National Tariff Payment System for Forensic Mental Health Services.

Forensic Mental Health Care Clusters are 22 groupings of Forensic Mental Health Patients based on their characteristics.

A Forensic Mental Health Care Cluster is assigned using a decision tree or algorithm based on the PERSON SCORE from the Forensic Mental Health Clustering Tool undertaken by a CARE PROFESSIONAL for the PATIENT.

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 Forensic Mental Health Care Clusters which are applicable to the PATIENT's condition. The PATIENT is then assigned to the most appropriate of this sub-set of Forensic Mental Health Care Clusters.

Further information relating to the Forensic Mental Health Clustering Tool and Forensic Mental Health Care Cluster is available from the gov.uk website at: The NHS payment system: documents and guidance.

This supporting information is also known by these names:

Context	Alias
plural	Forensic Mental Health Care Clusters

FORENSIC MENTAL HEALTH CLUSTERING TOOL

Change to Supporting Information: New Supporting Information

The Forensic Mental Health Clustering Tool is a type of Clustering Tool for adult PATIENTS receiving care from Forensic Mental Health Services.

The Forensic Mental Health Clustering Tool is a needs assessment tool designed to rate the care needs of a PATIENT, based upon a series of 22 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 Forensic Mental Health Clustering Tool.

Two additional 'current' ratings and a section relating to 'Historical Ratings' are also included, to form the Forensic Mental Health Clustering Tool. These items are referred to as the Summary of Assessments of Risk and Need (SARN) items.

Part 1: Current Ratings

These ratings relate to the most severe occurrence in the two weeks prior to the Forensic 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 that are not psychotic in origin (current)
40. Need for physical security to provide safe treatment for the PATIENT (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 Forensic 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 other children and vulnerable adults (historical)
D. Engagement (historical)
E. Vulnerability (historical)
P. Interpersonal Dynamics (historical)
Q. Problem-drinking or drug-taking (historical)
R. Antisocial attitudes likely to result in behaviour that causes a risk to others (historical).

The allowed responses to each of the 22 items in the Forensic 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 Forensic Mental Health Clustering Tool is used to allocate the PATIENT to the most appropriate Forensic Mental Health Care Cluster.

This supporting information is also known by these names:

Context	Alias
plural	Forensic Mental Health Clustering Tools

FORENSIC MENTAL HEALTH PATIENT

Change to Supporting Information: New Supporting Information

A Forensic Mental Health Patient is a PATIENT being treated by a Forensic Mental Health Service.

A Forensic Mental Health Patient is someone in the following categories:

- Not guilty by reason of mental illness: a PERSON subject to a special verdict who has been found not guilty by reason of mental illness and detained in a hospital, Prison or other place, or who has been granted release into the community conditionally
- Unfit for trial: a PERSON who has been found unfit to be tried for the offences with which they have been charged
- Limiting term: a PERSON who has been given a limiting term following a special hearing and has been detained in a mental health facility, Prison or other place, or who has been granted conditional release
- Transferees: a PERSON who has been transferred from a Prison to a mental health facility whilst on remand or following conviction of a criminal offence and whilst serving a sentence of imprisonment

This supporting information is also known by these names:

Context	Alias
plural	Forensic Mental Health Patients

FORENSIC MENTAL HEALTH SERVICE

Change to Supporting Information: New Supporting Information

A Forensic Mental Health Service is a type of Mental Health Service.

A Forensic Mental Health Service is a specialist SERVICE for people who have a mental health problem who have been arrested, who are on remand or who have been to court and found guilty of a crime.

A Forensic Mental Health Service is an alternative to Prison for people who have a mental health problem and offers specialist mental health treatment and care.

For further information on Forensic Mental Health Services, see the Mental Health Care website.

This supporting information is also known by these names:

Context	Alias
plural	Forensic Mental Health Services

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.

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

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 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 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.

For Mental Health Services Data Set (MHSDS), the Ward Stay remains uninterrupted when a PATIENT leaves the WARD to take Home Leave.

IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES DATA SET OVERVIEW

Change to Supporting Information: Changed Description

The Improving Access to Psychological Therapies Data Set will be in included in a future version of the Mental Health Services Data Set.

The collection of outcome data including clinical scores is a defining characteristic for stepped care and the National Institute for Health and Care Excellence (NICE) recommended model of delivery of psychological therapies.

The Improving Access to Psychological Therapies Data Set provides an agreed national standard for data collection for commissioned providers of psychological therapy for anxiety and depression. Standardised PATIENT centred information facilitates an integrated approach to the provision of psychological therapies and leads to improvements in the quality of services.

The Improving Access to Psychological Therapies Data Set supports:

- Clinicians to evaluate the effectiveness, refine and adapt the interventions provided using PATIENT outcome measures
- Development and refinement of policy relating to psychological therapies

- Monitoring the implementation and effectiveness of the Improving Access to Psychological Therapies (IAPT) Programme
- The equity of provision in relation to geographical, gender, age, ethnicity, religion, sexual orientation and DISABILITY coverage of the new services
- The profile of therapy types provided, diagnosis pattern and durations of interventions and the frequency of multi-step interventions; and the relationship of these to presenting problems, medication usage, outcomes (clinical, symptomatic, work and social)
- Performance management at Clinical Commissioning Group and national level
- Better planning and management of services at local level
- Waiting Time monitoring through the central calculation of waiting times
- Monitoring of PATIENT experience to inform service delivery
- Capture of activity and movement across the stepped care pathway
- The development of a payment system for Improving Access to Psychological Therapies Services.

The Improving Access to Psychological Therapies Data Set includes information on:

- PATIENT Demographics: Geographical, gender, age, ethnicity, religion, sexual orientation and DISABILITY
- Care Pathways: PROVISIONAL DIAGNOSIS information, psychological intervention types, referral and sessional details
- APPOINTMENTS: Clinical, economic and social outcomes relating to the interventions provided
- Waiting Time Pauses: ACTIVITY SUSPENSION periods across the PATIENT's care pathway
- Improving Access to Psychological Therapies Patient Experience Questionnaires: Improving Access to Psychological Therapies treatment and assessment questionnaires
- National Tariff Payment System: Additional data items to support the introduction and development of a payment system for Improving Access to Psychological Therapies Services.

Time period

The extract covers one month.

Frequency

Reports are run monthly.

Further Guidance

Further guidance relating to the Improving Access to Psychological Therapies Data Set is available on the:

- NHS Digital website at: Improving Access to Psychological Therapies Data Set
- Improving Access to Psychological Therapies (IAPT) Programme website at: Measuring Outcomes.

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

- Non-psychotic
- Psychotic or
- Organic

~~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).*~~If the PATIENT cannot be assigned to an Adult Mental Health Care Cluster or Forensic 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 or FORENSIC MENTAL HEALTH CARE CLUSTER CODE *'00 Care Cluster 0 - Variance.*'

~~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.~~Further information relating to the Adult Mental Health Clustering Tool and Adult Mental Health Care Clusters is available from the gov.uk website at: The NHS payment system: documents and guidance.

MENTAL HEALTH CARE PLAN

Change to Supporting Information: New Supporting Information

A Mental Health Care Plan is a CARE PLAN.

A Mental Health Care Plan is a plan of the treatment or health care to be provided to a mental health PATIENT for a CARE ACTIVITY or within an ACTIVITY GROUP.

This supporting information is also known by these names:

Context	Alias
plural	Mental Health Care Plans

MENTAL HEALTH CRISIS PLAN CREATION DATE (RETIRED) renamed from MENTAL HEALTH CRISIS PLAN CREATION DATE

Change to Supporting Information: Changed Description, status to Retired, Name

~~Mental Health Crisis Plan Creation Date is an ACTIVITY DATE TIME.~~**This item has been retired from the NHS Data Model and Dictionary.**

~~Mental Health Crisis Plan Creation Date is the DATE that a Mental Health Crisis Plan was created.~~ **The last live version of this item is available in the ?????? release of the NHS Data Model and Dictionary.**

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

MENTAL HEALTH CRISIS PLAN CREATION DATE (RETIRED) renamed from MENTAL HEALTH CRISIS PLAN CREATION DATE

Change to Supporting Information: Changed Description, status to Retired, Name

- Changed Description
- Retired Mental Health Crisis Plan Creation Date
- Changed Name from Data_Dictionary.NHS_Business_Definitions.M.Mental_Health_Crisis_Plan_Creation_Date to Retired.Data_Dictionary.NHS_Business_Definitions.M.Mental_Health_Crisis_Plan_Creation_Date

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MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE (RETIRED)_ renamed from MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE

Change to Supporting Information: Changed Description, status to Retired, Name

~~Mental Health Crisis Plan Last Updated Date~~ ~~is an ACTIVITY DATE TIME~~.**This item has been retired from the NHS Data Model and Dictionary.**

~~Mental Health Crisis Plan Last Updated Date~~ ~~is the DATE~~ ~~that a Mental Health Crisis Plan~~ ~~was last updated.~~ **The last live version of this item is available in the ?????? release of the NHS Data Model and Dictionary.**

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

MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE (RETIRED)_ renamed from MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE

Change to Supporting Information: Changed Description, status to Retired, Name

- Changed Description
- Retired Mental Health Crisis Plan Last Updated Date
- Changed Name from Data_Dictionary.NHS_Business_Definitions.M.Mental_Health_Crisis_Plan_Last_Updated_Date to Retired.Data_Dictionary.NHS_Business_Definitions.M.Mental_Health_Crisis_Plan_Last_Updated_Date

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ONWARD REFERRAL TIME

Change to Supporting Information: New Supporting Information

An Onward Referral Time is an ACTIVITY DATE TIME.

An Onward Referral Time is the time 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 Times

PLACE OF SAFETY

Change to Supporting Information: New Supporting Information

A Place of Safety is a LOCATION.

A Place of Safety maybe:

- a residential ACCOMMODATION provided by a local social services authority under Part III of the National Assistance Act 1948
- a hospital as defined by the Mental Health Act 1983 as amended by the Mental Health Act 2007
- a police station
- an independent hospital or Care Home for mentally disordered PERSONS or
- any other suitable place

where the occupier of which is willing temporarily to accommodate a PATIENT detained under section 136 of the Mental Health Act 1983 as amended by the Mental Health Act 2007.

This supporting information is also known by these names:

Context	Alias
plural	Places of Safety

POSITIVE BEHAVIOUR SUPPORT PLAN

Change to Supporting Information: New Supporting Information

A Positive Behaviour Support Plan is a CARE PLAN.

A Positive Behaviour Support Plan is created to help understand and support children, young people and adults who have a Learning Disability and display behaviour that others find challenging.

A Positive Behaviour Support Plan is an individualised CARE PLAN which is available to those who provide care and support.

A Positive Behaviour Support Plan should be informed by functional assessments. People and their families should be as fully involved as possible in developing and reviewing the plan.

A Positive Behaviour Support Plan should include the following elements:

- proactive strategies designed to improve quality of life and remove conditions that promote behaviour that challenges
- identification of environmental adaptations and strategies to support the development of new skills
- preventative (calming) strategies in response to early signs of distress
- reactive strategies to manage behaviours that are not preventable.

For further information on Positive Behaviour Support Plans and the wider positive behaviour framework, see the PBS Academy website.

This supporting information is also known by these names:

Context	Alias
plural	Positive Behaviour Support Plans

REFERENCED ORGANISATIONS MENU

Change to Supporting Information: Changed Description

- NHS Business Definitions
- Organisations
- Regulatory Bodies

- ~~**Referenced Organisations:**~~
  - ~~American Joint Committee on Cancer~~
  - ~~British Association for Paediatric Nephrology~~
  - ~~British Psychological Society~~

- ~~British Renal Society~~
- ~~British Transplantation Society~~
- ~~Burden Advice and Assessment Service~~
- ~~Care Quality Commission~~
- ~~Community Health Partnership (Scotland)~~
- ~~Community Safety Partnership~~
- ~~Department for Education~~
- ~~Department for Work and Pensions~~
- ~~Department for Work and Pensions Overseas Healthcare Team~~
- ~~Department of Health~~
- ~~European Renal Association~~
- ~~Faculty of General Dental Practice (UK)~~
- ~~GS1~~
- ~~Health and Wellbeing Board~~
- ~~Health Education England~~
- ~~Health Research Authority~~
- ~~Healthcare Quality Improvement Partnership~~
- ~~Healthwatch England~~
- ~~Improving Access to Psychological Therapies Programme~~
- ~~Information Standards Board for Health and Social Care~~
- ~~International Commission on Radiation Units and Measurements~~
- ~~International Federation of Gynecology and Obstetrics~~
- ~~International Health Terminology Standards Development Organisation~~
- ~~International Society of Paediatric Oncology~~
- ~~Local Health Board (Wales)~~
- ~~Local Healthwatch~~
- ~~Medicines and Healthcare Products Regulatory Agency~~
- ~~Monitor~~
- ~~National Cancer Registration and Analysis Service~~
- ~~National Casemix Office~~
- ~~National Contact Point~~
- ~~National Commissioning Group~~
- ~~National Information Board~~
- ~~National Institute for Health and Care Excellence~~
- ~~National Joint Registry~~
- ~~National Kidney Federation~~
- ~~National Specialised Commissioning Group~~
- ~~Neonatal Data Analysis Unit~~
- ~~NHS Business Services Authority~~
- ~~NHS Dental Services~~
- ~~NHS Digital~~
- ~~NHS England~~
- ~~NHS Prescription Services~~
- ~~NHS Trust Development Authority~~
- ~~NHS Wales Informatics Service~~
- ~~Northern Ireland Local Commissioning Group~~
- ~~Office for National Statistics~~
- ~~Ofsted~~
- ~~Public Health England~~
- ~~Royal College of General Practitioners~~
- ~~Royal Pharmaceutical Society~~
- ~~Standardisation Committee for Care Information~~
- ~~Sustainable Development Unit~~
- ~~The Renal Association~~
- ~~The Royal Marsden~~
- ~~UK National Screening Committee~~
- ~~UK Renal Registry~~

    - ~~UK Terminology Centre~~
    - ~~Union for International Cancer Control~~
    - ~~United Kingdom and Ireland Association of Cancer Registries~~
    - ~~World Health Organisation~~
- **Referenced Organisations:**
    - American Joint Committee on Cancer
    - British Association for Paediatric Nephrology
    - British Psychological Society
    - British Renal Society
    - British Transplantation Society
    - Burden Advice and Assessment Service
    - Care Quality Commission
    - Community Health Partnership (Scotland)
    - Community Safety Partnership
    - Department for Education
    - Department for Work and Pensions
    - Department for Work and Pensions Overseas Healthcare Team
    - Department of Health
    - European Renal Association
    - Faculty of General Dental Practice (UK)
    - GS1
    - Health and Wellbeing Board
    - Health Education England
    - Health Research Authority
    - Healthcare Quality Improvement Partnership
    - Healthwatch England
    - Improving Access to Psychological Therapies Programme
    - Information Standards Board for Health and Social Care
    - International Commission on Radiation Units and Measurements
    - International Federation of Gynecology and Obstetrics
    - International Health Terminology Standards Development Organisation
    - International Society of Paediatric Oncology
    - Local Health Board (Wales)
    - Local Healthwatch
    - Medicines and Healthcare Products Regulatory Agency
    - Monitor
    - National Cancer Registration and Analysis Service
    - National Casemix Office
    - National Contact Point
    - National Commissioning Group
    - National Information Board
    - National Institute for Health and Care Excellence
    - National Joint Registry
    - National Kidney Federation
    - National Specialised Commissioning Group
    - Neonatal Data Analysis Unit
    - NHS Business Services Authority
    - NHS Dental Services
    - NHS Digital
    - NHS England
    - NHS Prescription Services
    - NHS Trust Development Authority
    - NHS Wales Informatics Service
    - Northern Ireland Local Commissioning Group
    - Office for National Statistics
    - Ofsted
    - Public Health England

- Royal College of General Practitioners
- Royal College of Psychiatrists
- Royal Pharmaceutical Society
- Standardisation Committee for Care Information
- Sustainable Development Unit
- The Renal Association
- The Royal Marsden
- UK National Screening Committee
- UK Renal Registry
- UK Terminology Centre
- Union for International Cancer Control
- United Kingdom and Ireland Association of Cancer Registries
- World Health Organisation

REFERRAL CLOSURE TIME

Change to Supporting Information: New Supporting Information

A Referral Closure Time is an ACTIVITY DATE TIME.

A Referral Closure Time is the time the REFERRAL REQUEST was closed by a SERVICE.

This supporting information is also known by these names:

Context	Alias
plural	Referral Closure Times

ROYAL COLLEGE OF PSYCHIATRISTS

Change to Supporting Information: New Supporting Information

The Royal College of Psychiatrists is an Organisation.

The Royal College of Psychiatrists is the professional body responsible for education and training, and setting and raising standards in psychiatry.

For further information on the Royal College of Psychiatrists, see the Royal College of Psychiatrists website at: Improving the lives of people with mental illness.

SERVICE DISCHARGE TIME

Change to Supporting Information: New Supporting Information

A Service Discharge Time is an ACTIVITY DATE TIME.

A Service Discharge Time is the time a PATIENT was discharged from a SERVICE.

This supporting information is also known by these names:

Context	Alias
plural	Service Discharge Times

URGENT AND EMERGENCY MENTAL HEALTH CARE PLAN

Change to Supporting Information: New Supporting Information

A Urgent and Emergency Mental Health Care Plan is a CARE PLAN.

An Urgent and Emergency Mental Health Care Plan aims to develop strategies to help people stay safe and establish a network of support.

This supporting information is also known by these names:

Context	Alias
plural	Urgent and Emergency Mental Health Care Plans

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 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.~~For Mental Health Services Data Set (MHSDS), the Ward Stay remains uninterrupted when a PATIENT leaves the WARD for Home Leave, Mental Health Leave of Absence or Mental Health Absence Without Leave.

~~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:

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

~~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 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.

CARE CLUSTER

Change to Class: Changed Attributes

Attributes of this Class are:

ADULT MENTAL HEALTH CARE CLUSTER CODE
~~CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE~~
CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE
FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE
FORENSIC MENTAL HEALTH CARE CLUSTER CODE
LEARNING DISABILITIES CARE CLUSTER CODE
MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE

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 REASON
CARE CONTACT SUBJECT
CARE CONTACT TYPE
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
FIVE FORENSIC PATHWAYS ASSESSMENT REASON
FIVE FORENSIC PATHWAYS CODE
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
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
SIGNPOSTING TO SERVICE INDICATOR
SIGNPOSTING TO SERVICE TYPE FOR NHS HEALTH CHECK
SKIN TO SKIN CONTACT INDICATOR
SOCIAL WORKER CARE INDICATOR FOR HIV
SUBJECTIVE GLOBAL ASSESSMENT
THERAPY TYPE FOR IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES
TWO YEAR NEONATAL OUTCOMES ASSESSMENT NOT CARRIED OUT REASON

CARE PLAN

Change to Class: Changed Attributes

Attributes of this Class are:

~~K~~	~~CARE PLAN NUMBER~~
K	CARE PLAN IDENTIFIER
	CANCER CARE PLAN INTENT
	CANCER RECURRENCE CARE PLAN INDICATOR
	~~CARE PLAN AGREED DATE~~
	CARE PLAN AGREED BY
	CARE PLAN TYPE
	CARE PLAN TYPE FOR MENTAL HEALTH
	CHILD PROTECTION PLAN INDICATION CODE
	CHILD PROTECTION PLAN REASON CODE
	DISCHARGE PLAN AGREED BY
	MULTIDISCIPLINARY TEAM CANCER CARE PLAN DISCUSSED INDICATOR
	MULTIDISCIPLINARY TEAM MEETING TYPE FOR CANCER
	NO CANCER TREATMENT REASON

DECISION TO REFER

Change to Class: Changed Attributes

Attributes of this Class are:

K	DECISION TO REFER DATE
K	DECISION TO REFER TIME

LOCATION

Change to Class: Changed Attributes

Attributes of this Class are:

ACTIVITY LOCATION TYPE CODE
ASSAULT LOCATION TYPE
INTERVENTION SETTING

LOCATION IN HOSPITAL TYPE
LOCATION OF HIGHEST LEVEL OF CARE
PLACE OF SAFETY INDICATOR

PERSON PROPERTY

Change to Class: Changed Attributes

Attributes of this Class are:

K	PERSON PROPERTY IDENTIFIER
	CLINICAL SIGN OBSERVED AT SAMPLE COLLECTION
	DOMINANT ARM CODE
	FAMILIAL CANCER SYNDROME INDICATOR
	FREE PRESCRIPTIONS INDICATOR
	LAST MENSTRUAL PERIOD DATE
	OFFENCE HISTORY INDICATION CODE
	PERSON PROPERTY EFFECTIVE DATE
	PERSON PROPERTY EFFECTIVE END DATE
	PERSON PROPERTY EFFECTIVE END TIME
	PERSON PROPERTY EFFECTIVE TIME
	PERSON PROPERTY OBSERVED DATE
	PERSON PROPERTY OBSERVED TIME
	PERSON PROPERTY RECORDED DATE
	PERSON PROPERTY RECORDED TIME
	PREGNANCY STATUS
	SURGICAL VOICE RESTORATION COMMUNICATION METHOD FOR PLANNED POST OPERATIVE
	SURGICAL VOICE RESTORATION COMMUNICATION METHOD FOR PRIMARY
	YOUNG CARER INDICATOR

SERVICE REQUEST

Change to Class: Changed Attributes

Attributes of this Class are:

K	SERVICE REQUEST IDENTIFIER
	CLINICAL RESPONSE PRIORITY TYPE
	DIAGNOSTIC SERVICE REQUEST TYPE
	DIRECT ACCESS REFERRAL INDICATOR
	ONWARD REFERRAL REASON
	ORIGINAL REFERRAL REQUEST RECEIVED DATE
	REASON FOR OUT OF AREA REFERRAL FOR ADULT ACUTE MENTAL HEALTH
	REFERRAL REQUEST RECEIVED DATE
	REFERRED OUT OF AREA REASON FOR ADULT ACUTE MENTAL HEALTH
	SERVICE REQUEST ACCEPTANCE INDICATOR
	SERVICE REQUEST DATE
	SERVICE REQUEST RAISED REASON

WARD OPERATIONAL PLAN

Change to Class: Changed Attributes

Attributes of this Class are:

K	WARD OPERATIONAL PLAN START DATE
	AGE GROUP INTENDED
	AGE GROUP INTENDED FOR MENTAL HEALTH

CLINICAL CARE INTENSITY
SEX OF PATIENTS
WARD DAY NIGHT INDICATOR
WARD DAY PERIOD AVAILABILITY
WARD NIGHT PERIOD AVAILABILITY
WARD OPERATIONAL PLAN END DATE

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 September 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 (Retired 01 January 2016)
047 Screening Test Date
048 Genitourinary Care Contact Date (Retired January 2014)
049 Consultant Upgrade Date
101 Referral Closure Date (Community Care) (Retired 01 September 2015)
102 Discharge Letter Issued Date (Community Care) (Retired 01 September 2015)
103 Systemic Anti-Cancer Therapy Administration Date
104 Procedure Date
105 Immunisation 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
141 Care Contact Cancellation Date
142 Care Contact Date
143 Child Protection Plan End Date
144 Child Protection Plan Start Date
145 Discharge Letter Issued Date (Mental Health and Community Care)
146 Health Visitor First Antenatal Visit Date
147 Infant Physical Examination Date
148 Onward Referral Date
149 Referral Closure Date

150 Referral Rejection Date
151 Replacement Appointment Booked Date
152 Replacement Appointment Date Offered
153 Service Discharge Date
154 Date of Restrictive Intervention
155 Indirect Activity Date
~~156~~ ~~Mental Health Crisis Plan Creation Date~~
~~157~~ ~~Mental Health Crisis Plan Last Updated Date~~
156 Mental Health Crisis Plan Creation Date (Retired 01 April 2017)
157 Mental Health Crisis Plan Last Updated Date (Retired 01 April 2017)
Care Plan Agreed Date
Care Plan Creation Date
Care Plan Implementation Date
Care Plan Last Updated Date
Five Forensic Pathways Assessment Date

Note: This list is not in alphabetical order.

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 (Retired September 2015)
69 Discharge Time
70 Clinical Intervention Time
71 Care Contact Time
72 Indirect Activity Time
Service Discharge Time
Referral Closure Time
Onward Referral Time

Note: This list is not in alphabetical order.

AGE GROUP INTENDED FOR MENTAL HEALTH

Change to Attribute: New Attribute

The age group of PATIENTS intended to use a WARD indicated in the WARD OPERATIONAL PLAN for the Mental Health Services Data Set.

National Codes:

10	Child only
11	Adolescent only
12	Child and Adolescent
13	Adult only
14	Older Adult only
15	Adult and Older Adult
99	Any age

This attribute is also known by these names:

Context	Alias
plural	AGE GROUPS INTENDED FOR MENTAL HEALTH

AGE GROUP INTENDED FOR MENTAL HEALTH

Change to Attribute: New Attribute

AGE GROUP INTENDED FOR MENTAL HEALTH

Data Elements:

INTENDED AGE GROUP (MENTAL HEALTH)
MENTAL HEALTH ADMITTED PATIENT CLASSIFICATION

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) (Retired 01 January 2016)
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) (Retired 01 January 2016)
019 Health of the Nation Outcome Scale (Secure) (Retired 01 January 2016)
020 Adult Mental Health Clustering Tool
021 Cardiovascular Disease Risk Calculator
022 Strengths And Difficulties Questionnaire (Retired 01 January 2016)
023 Experience of Service Questionnaire (Retired 01 January 2016)
024 Children's Global Assessment Scale
025 Family Assessment Device (General Functioning Subscale)
026 Parenting Daily Hassles
027 Parent-Infant Relationship Global Assessment Scale (Retired 01 January 2016)
028 Paddington Complexity Scale
029 Goal Based Outcomes (Retired 01 January 2016)
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 (Retired 01 January 2016)
051 Protected Characteristic Protocol (Disability) (Retired 01 January 2016)
Forensic Mental Health Clustering Tool
Child and Adolescent Mental Health Needs Based Grouping Tool

CARE PLAN AGREED BY

Change to Attribute: New Attribute

The type of PERSON, SERVICE or Organisation that agreed the CARE PLAN for the PATIENT.

National Codes:

10 PATIENT or Patient Proxy
11 Family member or Carer
12 Advocate
13 Clinical Service or Team
14 Local Community Support Team
15 Commissioner

This attribute is also known by these names:

Context	Alias
plural	CARE PLANS AGREED BY

CARE PLAN AGREED BY

Change to Attribute: New Attribute

CARE PLAN AGREED BY

Data Elements:

CARE PLAN AGREED BY

CARE PLAN AGREED DATE (RETIRED) renamed from CARE PLAN AGREED DATE

Change to Attribute: Changed Description, status to Retired, Name

~~The DATE on which a CARE PLAN was agreed with the PATIENT.~~ **This item has been retired from the NHS Data Model and Dictionary.**

The last live version of this item is available in the ?????? release of the NHS Data Model and Dictionary.

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

CARE PLAN AGREED DATE (RETIRED) renamed from CARE PLAN AGREED DATE

Change to Attribute: Changed Description, status to Retired, Name

- Changed Description
- Retired CARE PLAN AGREED DATE
- Changed Name from Data_Dictionary.Attributes.C.Card.CARE_PLAN_AGREED_DATE to Retired.Data_Dictionary.Attributes.C.CARE_PLAN_AGREED_DATE

CARE PLAN IDENTIFIER renamed from CARE PLAN NUMBER

Change to Attribute: Changed Description, Name

~~A unique identifier of a CARE PLAN within a Care Spell.~~A unique identifier for a CARE PLAN.

CARE PLAN IDENTIFIER renamed from CARE PLAN NUMBER

Change to Attribute: Changed Description, Name

- Changed Description
- Changed Name from Data_Dictionary.Attributes.C.Card.CARE_PLAN_NUMBER to Data_Dictionary.Attributes.C.Card.CARE_PLAN_IDENTIFIER

CARE PLAN TYPE

Change to Attribute: Changed Description

The type of CARE PLAN.

National Codes:

01 Cancer Care Plan
02 Child Protection Plan
03 Mental Health Crisis Plan
04 Social Services Care Plan
05 Antenatal Care Plan
06 Birth Care Plan
07 Postpartum Care Plan
08 Education, Health and Care Plan (EHC)
Discharge Plan
Mental Health Care Plan
Positive Behaviour Support Plan
Urgent and Emergency Mental Health Care Plan

CARE PLAN TYPE FOR MENTAL HEALTH

Change to Attribute: New Attribute

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

National Codes:

10 Mental Health Care Plan
11 Urgent and Emergency Mental Health Care Plan
12 Mental Health Crisis Plan
13 Positive Behaviour Support Plan

This attribute is also known by these names:

Context	Alias
plural	CARE PLAN TYPES FOR MENTAL HEALTH

CARE PLAN TYPE FOR MENTAL HEALTH

Change to Attribute: New Attribute

CARE PLAN TYPE FOR MENTAL HEALTH

Data Elements:

CARE PLAN TYPE (MENTAL HEALTH)

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (RETIRED) renamed from CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE

Change to Attribute: Changed Description, status to Retired, Name

~~The Child and Adolescent Mental Health Care Cluster assigned to a PATIENT.~~**This item has been retired from the NHS Data Model and Dictionary.**

~~**Note: This data item is included in the Mental Health Services Data Set, but should not be submitted until further development by NHS Digital has been undertaken.**~~**The last live version of this item is available in the ?**????? release of the NHS Data Model and Dictionary.

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

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (RETIRED)_ renamed from CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE

Change to Attribute: Changed Description, status to Retired, Name

- Changed Description
- Retired CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE
- Changed Name from Data_Dictionary.Attributes.C.Cen.CHILD_AND_ADOLESCENT_MENTAL_HEALTH_CARE_CLUSTER_CODE to Retired.Data_Dictionary.Attributes.C.CHILD_AND_ADOLESCENT_MENTAL_HEALTH_CARE_CLUSTER_CODE

CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE

Change to Attribute: New Attribute

The Child and Adolescent Mental Health Needs Based Grouping code assigned to a PATIENT.

National Codes:

NEU	Getting Advice: Neurodevelopmental Assessment
ADV	Getting Advice: Signposting and Self-management Advice
ADH	Getting Help: Attention Deficit Hyperactivity Disorder (ADHD)
AUT	Getting Help: Autism Spectrum
BEH	Getting Help: Behavioural and/or Conduct Disorders
BIP	Getting Help: Bipolar Disorder
DEP	Getting Help: Depression
GAP	Getting Help: Generalised Anxiety Disorder (GAD) and/or Panic Disorder
OCD	Getting Help: Obsessive compulsive disorder (OCD)
PTS	Getting Help: Post-traumatic stress disorder (PTSD)
SHA	Getting Help: Self-harm
SOC	Getting Help: Social Anxiety Disorder
BEM	Getting Help: Co-occurring Behavioural and Emotional Difficulties
EMO	Getting Help: Co-occurring Emotional Difficulties
DNC	Getting Help: Difficulties Not Covered by Other Groupings
EAT	Getting More Help: Eating Disorders
PBP	Getting More Help: Presentation Suggestive of Potential Borderline Personality Disorder (BPD)
PSY	Getting More Help: Psychosis
DSI	Getting More Help: Difficulties of Severe Impact

This attribute is also known by these names:

Context	Alias
plural	CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODES

CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE

Change to Attribute: New Attribute

CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE

Data Elements:

CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE

CLUSTERING TOOL ASSESSMENT CATEGORY

Change to Attribute: Changed Description

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.~~Note: only CLUSTERING TOOL ASSESSMENT CATEGORY National Codes '*Adult Mental Health Clustering Tool*', '*Forensic Mental Health Clustering Tool*' and '*Child and Adolescent Mental Health Needs Based Grouping Tool*' are 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~~
02 Child and Adolescent Mental Health Clustering Tool (Retired 01 April 2017)
03 Learning Disabilities Clustering Tool
~~04 Forensic (Mental Health) Clustering Tool~~
~~05 Forensic (Learning Disabilities) Clustering Tool~~
04 Forensic Mental Health Clustering Tool
05 Forensic Learning Disabilities Clustering Tool
06 Child and Adolescent Mental Health Needs Based Grouping Tool

DECISION TO REFER TIME

Change to Attribute: New Attribute

The time that a decision was made, by or on behalf of a CARE PROFESSIONAL, to refer a PATIENT to a particular Health Care Provider as a SERVICE REQUEST.

This attribute is also known by these names:

Context	Alias
plural	DECISION TO REFER TIMES

DECISION TO REFER TIME

Change to Attribute: New Attribute

DECISION TO REFER TIME

Data Elements:

DECISION TO REFER TIME (ONWARD REFERRAL)

DISCHARGE METHOD

Change to Attribute: Changed Description

The method of discharge from a Hospital Provider Spell.

National Codes:

1 PATIENT discharged on clinical advice or with clinical consent
2 PATIENT discharged him/herself or was discharged by a relative or advocate

3 PATIENT discharged by mental health review tribunal, Home Secretary or Court
4 PATIENT died
5 Stillbirth
6 PATIENT discharged him/herself *
7 PATIENT discharged by a relative or advocate *

* Note: National Codes 6 and 7 have been introduced for the Mental Health Services Data Set **only** to add further granularity to National Code 2. However, National Code 2 is still valid for the Mental Health Services Data Set where extra detail cannot be collected. National Codes 6 and 7 are **NOT** valid in any other data set including Commissioning Data Set version 6-2.

DISCHARGE PLAN AGREED BY

Change to Attribute: New Attribute

The type of PERSON, SERVICE or Organisation that agreed the Discharge Plan for the PATIENT.

National Codes:

10 PATIENT or Patient Proxy
11 Family member or Carer
12 Advocate
13 Clinical Service or Team
14 Local Community Support Team
15 Current Commissioner
16 Commissioner of Planned DISCHARGE DESTINATION

This attribute is also known by these names:

Context	Alias
plural	DISCHARGE PLANS AGREED BY

DISCHARGE PLAN AGREED BY

Change to Attribute: New Attribute

DISCHARGE PLAN AGREED BY

Data Elements:

DISCHARGE PLAN AGREED BY

FIVE FORENSIC PATHWAYS ASSESSMENT REASON

Change to Attribute: New Attribute

The reason the Five Forensic Pathways assessment was undertaken.

National Codes:

10 Initial Assessment
11 Scheduled Re-Assessment
12 Re-Assessment following significant unanticipated change in need
97 Other Reason

This attribute is also known by these names:

Context	Alias
plural	FIVE FORENSIC PATHWAYS ASSESSMENT REASONS

FIVE FORENSIC PATHWAYS ASSESSMENT REASON

Change to Attribute: New Attribute

FIVE FORENSIC PATHWAYS ASSESSMENT REASON

Data Elements:

FIVE FORENSIC PATHWAYS ASSESSMENT REASON

FIVE FORENSIC PATHWAYS CODE

Change to Attribute: New Attribute

The Five Forensic Pathways grouping code assigned to a PATIENT.

National Codes:

0 Unable to assign PATIENT to one of the Five Forensic Pathways
1 Treatment responsive group
2 Treatment resistant group - challenging behaviour
3 Treatment resistant group - continuing care
4 Personality disorder group - Prison transfer
5 Personality disorder group - co-morbidity

This attribute is also known by these names:

Context	Alias
plural	FIVE FORENSIC PATHWAYS CODES

FIVE FORENSIC PATHWAYS CODE

Change to Attribute: New Attribute

FIVE FORENSIC PATHWAYS CODE

Data Elements:

FIVE FORENSIC PATHWAYS CODE

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE

Change to Attribute: Changed Description

~~The Forensic (Mental Health) Care Cluster assigned to a PATIENT.~~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 NHS Digital has been undertaken.

FORENSIC MENTAL HEALTH CARE CLUSTER CODE

Change to Attribute: Changed Description

The Forensic Mental Health Care Cluster assigned to a PATIENT.

~~The Forensic (Learning Disabilities) Care Cluster assigned to a PATIENT.~~*National Codes:*

~~**Note: This data item is included in the Mental Health Services Data Set, but should not be submitted until further development by NHS Digital has been undertaken.**~~

00	Care Cluster 0: Variance
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
08b	Care Cluster 8b: Non Psychotic, Challenging and Anti-Social Disorders
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 (High Need)
21	Care Cluster 21: Cognitive Impairment or Dementia (High Physical or Engagement)

MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE

Change to Attribute: Changed Description

An indication to which Organisation the Mental Health Delayed Discharge Period is attributable.

National Codes:

~~01~~	~~NHS~~
~~02~~	~~Social Care~~
~~03~~	~~Both (NHS and Social Care)~~
01	NHS (Retired 01 April 2017)
02	Social Care (Retired 01 April 2017)
03	Both (NHS and Social Care) (Retired 01 April 2017)
04	NHS, excluding housing
05	Social Care, excluding housing
06	Both (NHS and Social Care), excluding housing
07	Housing (including supported/specialist housing)

MENTAL HEALTH DELAYED DISCHARGE REASON

Change to Attribute: Changed Description

The reason that a Mental Health Delayed Discharge Period was initiated for a PATIENT.

For further information, see the Department of Health part of the gov.uk website at: Mental Health Delayed Discharge Reason.

National Codes:

~~A1~~	~~Awaiting completion of assessment~~
A1	Awaiting completion of assessment (Retired 01 April 2017)
A2	Awaiting care coordinator allocation
B1	Awaiting public funding
C1	Awaiting further non-acute (including community and mental health) NHS care (including intermediate care, rehabilitation services etc)
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~~
F1	Awaiting community equipment and adaptations (Retired 01 April 2017)
F2	Awaiting community equipment, telecare and/or adaptations
G1	PATIENT or family choice (Retired 01 April 2017)
G2	PATIENT or family choice (Reason not stated by PATIENT or family)
G3	PATIENT or family choice - Non-acute (including community and mental health) NHS care (including intermediate care, rehabilitation services etc)
G4	PATIENT or family choice - Care Home Without Nursing placement
G5	PATIENT or family choice - Care Home With Nursing placement
G6	PATIENT or family choice - Care package in own home
G7	PATIENT or family choice - Community equipment, telecare and/or adaptations
G8	PATIENT or Family Choice - general needs housing/private landlord acceptance as patient NOT covered by Housing Act/Care Act
G9	PATIENT or family choice - Supported accommodation
G10	PATIENT or family choice - Emergency accommodation from the Local Authority under the Housing Act
G11	PATIENT or family choice - Child or young person awaiting social care or family placement
G12	PATIENT or family choice - Ministry of Justice agreement/permission of proposed placement
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~~
I1	Housing - PATIENT not covered by NHS and Community Care Act (Retired 01 April 2017)
I2	Housing - Single homeless PATIENTS or asylum seekers NOT covered by Care Act
I3	Housing - Awaiting availability of general needs housing/private landlord accommodation acceptance as patient NOT covered by Housing Act and/or Care Act
J1	Awaiting availability of social care support (Retired 01 April 2017)
J2	Housing - Awaiting supported accommodation
K1	Awaiting availability of local health service provision (Retired 01 April 2017)
K2	Housing - Awaiting emergency accommodation from the Local Authority under the Housing Act
L1	Child or young person awaiting social care or family placement
M1	Awaiting Ministry of Justice agreement/permission of proposed placement
N1	Awaiting outcome of legal requirements (mental capacity/mental health legislation)
Z1	Other Reason (Retired 01 April 2017)

OFFENCE HISTORY INDICATION CODE

Change to Attribute: New Attribute

An indication of whether the PERSON has a history of forensic offences, including index offences (i.e. the offence is recordable, committed in England or Wales and is prosecuted by the police. Breach of the peace offences are not included).

This may be completed by CARE PROFESSIONALS based on PATIENT history or may be informed by referral information.

National Codes:

1	No - No offence
2	Yes - Less serious offence
3	Yes - Serious offence

This attribute is also known by these names:

Context	Alias
plural	OFFENCE HISTORY INDICATION CODES

OFFENCE HISTORY INDICATION CODE

Change to Attribute: New Attribute

OFFENCE HISTORY INDICATION CODE

Data Elements:

OFFENCE HISTORY INDICATION CODE

OTHER PERSON IN ATTENDANCE AT CARE CONTACT

Change to Attribute: Changed Description

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

National Codes:

	Advocacy Role
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
	Non-Advocacy Role
10	Parent or relative
11	Friend or neighbour
12	Care Worker

PLACE OF SAFETY INDICATOR

Change to Attribute: New Attribute

An indication of whether a LOCATION is being used as a Place of Safety.

National Codes:

Y	Yes - is being used as a Place of Safety
N	No - is not being used as a Place of Safety

This attribute is also known by these names:

Context	Alias
plural	PLACE OF SAFETY INDICATORS

PLACE OF SAFETY INDICATOR

Change to Attribute: New Attribute

PLACE OF SAFETY INDICATOR

Data Elements:

PLACE OF SAFETY INDICATOR

REASON FOR OUT OF AREA REFERRAL FOR ADULT ACUTE MENTAL HEALTH

Change to Attribute: New Attribute

The reason why a SERVICE has received a REFERRAL REQUEST, for a PATIENT:

- with assessed acute mental health needs requiring adult mental health admitted PATIENT care and
- who is resident outside of the referring Organisation's usual local network of SERVICES.

For further information, see the Department of Health part of the gov.uk website at: Guidance on Out of Area Placements.

National Codes:

10	Unavailability of bed at referring Organisation
11	Safeguarding
12	Offending restrictions
13	Staff member or family/friend within the referring Organisation
14	PATIENT choice
15	PATIENT away from home

This attribute is also known by these names:

Context	Alias
plural	REASONS FOR OUT OF AREA REFERRAL FOR ADULT ACUTE MENTAL HEALTH

REASON FOR OUT OF AREA REFERRAL FOR ADULT ACUTE MENTAL HEALTH

Change to Attribute: New Attribute

REASON FOR OUT OF AREA REFERRAL FOR ADULT ACUTE MENTAL HEALTH

Data Elements:

REASON FOR OUT OF AREA REFERRAL (ADULT ACUTE MENTAL HEALTH)

REFERRAL REQUEST RECEIVED TIME

Change to Attribute: Changed Description

~~The time the~~ REFERRAL REQUEST ~~was received.~~The time the REFERRAL REQUEST was received by the Health Care Provider.

REFERRED OUT OF AREA REASON FOR ADULT ACUTE MENTAL HEALTH

Change to Attribute: New Attribute

The reason a PATIENT:

- with assessed acute mental health needs and
- requiring adult mental health admitted PATIENT care

was referred to an ORGANISATION:

- that does not form part of the referring Organisation's usual local network of SERVICES and
- where the Mental Health Care Coordinator cannot visit the PATIENT as often as stated in the referring Organisation's policy.

For further information, see the Department of Health part of the gov.uk website at: Guidance on Out of Area Placements.

National Codes:

10	Unavailability of bed at referring Organisation
11	Safeguarding
12	Offending restrictions
13	Staff member or family/friend within the referring Organisation
14	PATIENT choice

This attribute is also known by these names:

Context	Alias
plural	REFERRED OUT OF AREA REASONS FOR ADULT ACUTE MENTAL HEALTH

REFERRED OUT OF AREA REASON FOR ADULT ACUTE MENTAL HEALTH

Change to Attribute: New Attribute

REFERRED OUT OF AREA REASON FOR ADULT ACUTE MENTAL HEALTH

Data Elements:

REFERRED OUT OF AREA REASON (ADULT ACUTE MENTAL HEALTH)

SERVICE OR TEAM TYPE FOR MENTAL HEALTH

Change to Attribute: Changed Description

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
A19	24/7 Crisis Response Line
	Forensic Services
~~B01~~	~~Forensic Mental Health Service~~
~~B02~~	~~Forensic Learning Disability Service~~
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
C09	Community Eating Disorder Service (CEDS) for Children and Young People
	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

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ASSISTIVE TECHNOLOGY FINDING (SNOMED CT)

Change to Data Element: Changed Description

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

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

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

CARE PLAN AGREED BY

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See CARE PLAN AGREED BY
Default Codes:	

Notes:
CARE PLAN AGREED BY is the same as attribute CARE PLAN AGREED BY.

This data element is also known by these names:

Context	Alias
plural	CARE PLANS AGREED BY

CARE PLAN AGREED BY

Change to Data Element: New Data Element

CARE PLAN AGREED BY

Attribute:

CARE PLAN AGREED BY

CARE PLAN AGREED DATE renamed from CARE PLAN AGREED DATE (RETIRED)

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

~~**This item has been retired from the NHS Data Model and Dictionary.**~~

~~**The last live version of this item is available in the November 2012 release of the NHS Data Model and Dictionary.**~~

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

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

Notes:
CARE PLAN AGREED DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Care Plan Agreed Date*'.

CARE PLAN AGREED DATE renamed from CARE PLAN AGREED DATE (RETIRED)

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

CARE PLAN AGREED DATE

Attribute:

ACTIVITY DATE

CARE PLAN AGREED DATE_ renamed from CARE PLAN AGREED DATE (RETIRED)

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

- Changed Description
- Retired CARE PLAN AGREED DATE (retired)
- null
- Changed Name from Retired.Data_Dictionary.Data_Field_Notes.C.CARE_PLAN_AGREED_DATE to Data_Dictionary.Data_Field_Notes.C.Care.CARE_PLAN_AGREED_DATE

CARE PLAN CREATION DATE

Change to Data Element: New Data Element

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

Notes:
CARE PLAN CREATION DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Care Plan Creation Date*'.

This data element is also known by these names:

Context	Alias
plural	CARE PLAN CREATION DATES

CARE PLAN CREATION DATE

Change to Data Element: New Data Element

CARE PLAN CREATION DATE

Attribute:

ACTIVITY DATE

CARE PLAN IDENTIFIER

Change to Data Element: New Data Element

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

Notes:
CARE PLAN IDENTIFIER is the same as attribute CARE PLAN IDENTIFIER.

This data element is also known by these names:

Context	Alias
plural	CARE PLAN IDENTIFIERS

CARE PLAN IDENTIFIER

Change to Data Element: New Data Element

CARE PLAN IDENTIFIER

Attribute:

CARE PLAN IDENTIFIER

CARE PLAN IMPLEMENTATION DATE

Change to Data Element: New Data Element

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

Notes:
CARE PLAN IMPLEMENTATION DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Care Plan Implementation Date*'.

This data element is also known by these names:

Context	Alias
plural	CARE PLAN IMPLEMENTATION DATES

CARE PLAN IMPLEMENTATION DATE

Change to Data Element: New Data Element

CARE PLAN IMPLEMENTATION DATE

Attribute:

ACTIVITY DATE

CARE PLAN LAST UPDATED DATE

Change to Data Element: New Data Element

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

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

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

This data element is also known by these names:

Context	Alias
plural	CARE PLAN LAST UPDATED DATES

CARE PLAN LAST UPDATED DATE

Change to Data Element: New Data Element

CARE PLAN LAST UPDATED DATE

Attribute:

ACTIVITY DATE

CARE PLAN TYPE (MENTAL HEALTH)

Change to Data Element: New Data Element

Format/Length:	an1
National Codes:	See CARE PLAN TYPE FOR MENTAL HEALTH
Default Codes:	

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

This data element is also known by these names:

Context	Alias
plural	CARE PLAN TYPES (MENTAL HEALTH)

CARE PLAN TYPE (MENTAL HEALTH)

Change to Data Element: New Data Element

CARE PLAN TYPE (MENTAL HEALTH)

Attribute:

CARE PLAN TYPE FOR MENTAL HEALTH

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL) (RETIRED)_ renamed from CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL)

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

~~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.~~**This item has been retired from the NHS Data Model and Dictionary.**

~~**Note: This data item is included in the Mental Health Services Data Set, but should not be submitted until further development by NHS Digital has been undertaken.**~~**The last live version of this item is available in the ?**????? release of the NHS Data Model and Dictionary.

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

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL) (RETIRED)_ renamed from CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL)

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

~~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 (FINAL) (RETIRED)_ renamed from CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL)

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

- Changed Description
- Retired CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL)
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.C.Ce.CHILD_AND_ADOLESCENT_MENTAL_HEALTH_CARE_CLUSTER_CO (FINAL) to Retired.Data_Dictionary.Data_Field_Notes.C.CHILD_AND_ADOLESCENT_MENTAL_HEALTH_CARE_CLUSTEF (FINAL)

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL) (RETIRED)_ renamed from CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL)

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

~~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.~~**This item has been retired from the NHS Data Model and Dictionary.**

~~**Note: This data item is included in the Mental Health Services Data Set, but should not be submitted until further development by NHS Digital has been undertaken.**~~**The last live version of this item is available in the ?**????? release of the NHS Data Model and Dictionary.

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

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL) (RETIRED)_ renamed from CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL)

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

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

~~**Attribute:**~~

~~CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE~~

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL) (RETIRED) renamed from CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL)

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

- Changed Description
- Retired CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL)
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.C.Ce.CHILD_AND_ADOLESCENT_MENTAL_HEALTH_CARE_CLUSTER_CO (INITIAL) to Retired.Data_Dictionary.Data_Field_Notes.C.CHILD_AND_ADOLESCENT_MENTAL_HEALTH_CARE_CLUSTEF (INITIAL)

CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE

Change to Data Element: New Data Element

Format/Length:	an3
National Codes:	See CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE
Default Codes:	

Notes:
CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE is the same as attribute CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE.

This data element is also known by these names:

Context	Alias
plural	CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODES

CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE

Change to Data Element: New Data Element

CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE

Attribute:

CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE

CHILD AND ADOLESCENT MENTAL HEALTH TIER OF SERVICE

Change to Data Element: Changed Description

Format/Length:	an1
National Codes:	See CHILD AND ADOLESCENT MENTAL HEALTH TIER OF SERVICE
~~Default Codes:~~	
Default Codes:	9 - Child and Adolescent Mental Health Service (CAMHS) Unspecified Tier

Notes:
CHILD AND ADOLESCENT MENTAL HEALTH TIER OF SERVICE is the same as attribute CHILD AND ADOLESCENT MENTAL HEALTH TIER OF SERVICE.

DECISION TO REFER DATE (ONWARD REFERRAL)

Change to Data Element: New Data Element

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

Notes:
DECISION TO REFER DATE (ONWARD REFERRAL) is the same as attribute DECISION TO REFER DATE.

DECISION TO REFER DATE (ONWARD REFERRAL) is the DATE on which a decision was made to refer the PATIENT from one SERVICE to another SERVICE, which may be in the same or a different Organisation.

This data element is also known by these names:

Context	Alias
plural	DECISION TO REFER DATES (ONWARD REFERRAL)

DECISION TO REFER DATE (ONWARD REFERRAL)

Change to Data Element: New Data Element

DECISION TO REFER DATE (ONWARD REFERRAL)

Attribute:

DECISION TO REFER DATE

DECISION TO REFER TIME (ONWARD REFERRAL)

Change to Data Element: New Data Element

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

Notes:
DECISION TO REFER TIME (ONWARD REFERRAL) is the same as attribute DECISION TO REFER TIME.

DECISION TO REFER TIME (ONWARD REFERRAL) is the TIME on which a decision was made to refer the PATIENT from one SERVICE to another SERVICE, which may be in the same or a different Organisation.

This data element is also known by these names:

Context	Alias
plural	DECISION TO REFER TIMES (ONWARD REFERRAL)

DECISION TO REFER TIME (ONWARD REFERRAL)

Change to Data Element: New Data Element

DECISION TO REFER TIME (ONWARD REFERRAL)

Attribute:

DECISION TO REFER TIME

DISCHARGE PLAN AGREED BY

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See DISCHARGE PLAN AGREED BY
Default Codes:	

Notes:
DISCHARGE PLAN AGREED BY is the same as attribute DISCHARGE PLAN AGREED BY.

This data element is also known by these names:

Context	Alias
plural	DISCHARGE PLANS AGREED BY

DISCHARGE PLAN AGREED BY

Change to Data Element: New Data Element

DISCHARGE PLAN AGREED BY

Attribute:

DISCHARGE PLAN AGREED BY

DISCHARGE PLAN AGREED DATE

Change to Data Element: New Data Element

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

Notes:
DISCHARGE PLAN AGREED DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Care Plan Agreed Date*'.

DISCHARGE PLAN AGREED DATE is the DATE on which the Discharge Plan was agreed by a PATIENT or Patient Proxy.

This data element is also known by these names:

Context	Alias
plural	DISCHARGE PLAN AGREED DATES

DISCHARGE PLAN AGREED DATE

Change to Data Element: New Data Element

DISCHARGE PLAN AGREED DATE

Attribute:

ACTIVITY DATE

DISCHARGE PLAN CREATION DATE

Change to Data Element: New Data Element

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

Notes:
DISCHARGE PLAN CREATION DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'Care Plan Creation Date'*.

DISCHARGE PLAN CREATION DATE is the DATE that a Discharge Plan was created.

This data element is also known by these names:

Context	Alias
plural	DISCHARGE PLAN CREATION DATES

DISCHARGE PLAN CREATION DATE

Change to Data Element: New Data Element

DISCHARGE PLAN CREATION DATE

Attribute:

ACTIVITY DATE

DISCHARGE PLAN LAST UPDATED DATE

Change to Data Element: New Data Element

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

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

DISCHARGE PLAN LAST UPDATED DATE is the DATE that a Discharge Plan was last updated.

For the Mental Health Services Data Set, where the Discharge Plan has not been updated since its creation, the DISCHARGE PLAN LAST UPDATED DATE will be the same as DISCHARGE PLAN CREATION DATE.

This data element is also known by these names:

Context	Alias
plural	DISCHARGE PLAN LAST UPDATED DATES

DISCHARGE PLAN LAST UPDATED DATE

Change to Data Element: New Data Element

DISCHARGE PLAN LAST UPDATED DATE

Attribute:

ACTIVITY DATE

DURATION OF RESTRICTIVE INTERVENTION

Change to Data Element: Changed Description

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 RESTRICTIVE INTERVENTION 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.~~DURATION OF RESTRICTIVE INTERVENTION is calculated from the Start Time and End Time of the Restrictive Intervention.

FIVE FORENSIC PATHWAYS ASSESSMENT DATE

Change to Data Element: New Data Element

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

Notes:

FIVE FORENSIC PATHWAYS ASSESSMENT DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Five Forensic Pathways Assessment Date*'.

This data element is also known by these names:

Context	Alias
plural	FIVE FORENSIC PATHWAYS ASSESSMENT DATES

FIVE FORENSIC PATHWAYS ASSESSMENT DATE

Change to Data Element: New Data Element

FIVE FORENSIC PATHWAYS ASSESSMENT DATE

Attribute:

ACTIVITY DATE

FIVE FORENSIC PATHWAYS ASSESSMENT REASON

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See FIVE FORENSIC PATHWAYS ASSESSMENT REASON
Default Codes:	99 - Not known (Not Recorded)

Notes:
FIVE FORENSIC PATHWAYS ASSESSMENT REASON is the same as attribute FIVE FORENSIC PATHWAYS ASSESSMENT REASON.

This data element is also known by these names:

Context	Alias
plural	FIVE FORENSIC PATHWAYS ASSESSMENT REASONS

FIVE FORENSIC PATHWAYS ASSESSMENT REASON

Change to Data Element: New Data Element

FIVE FORENSIC PATHWAYS ASSESSMENT REASON

Attribute:

FIVE FORENSIC PATHWAYS ASSESSMENT REASON

FIVE FORENSIC PATHWAYS CODE

Change to Data Element: New Data Element

Format/Length:	an1
National Codes:	See FIVE FORENSIC PATHWAYS CODE
Default Codes:	

Notes:
FIVE FORENSIC PATHWAYS CODE is the same as attribute FIVE FORENSIC PATHWAYS CODE.

This data element is also known by these names:

Context	Alias
plural	FIVE FORENSIC PATHWAYS CODES

FIVE FORENSIC PATHWAYS CODE

Change to Data Element: New Data Element

FIVE FORENSIC PATHWAYS CODE

Attribute:

FIVE FORENSIC PATHWAYS CODE

FORENSIC MENTAL HEALTH CARE CLUSTER CODE (FINAL)

Change to Data Element: Changed Description

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 NHS Digital has been undertaken.**~~

FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL) (RETIRED) **renamed from FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL)**

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

~~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.~~ **This item has been retired from the NHS Data Model and Dictionary.**

~~FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL) is the initial FORENSIC MENTAL HEALTH CARE CLUSTER CODE allocated by the CARE PROFESSIONAL.~~**The last live version of this item is available in the ?????? release of the NHS Data Model and Dictionary.**

~~**Note: This data item is included in the Mental Health Services Data Set, but should not be submitted until further development by NHS Digital has been undertaken.**~~**Access to this version can be obtained by emailing information.**standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL) (RETIRED) **renamed from FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL)**

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

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

~~**Attribute:**~~

FORENSIC MENTAL HEALTH CARE CLUSTER CODE

FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL) (RETIRED) **renamed from FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL)**

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

- Changed Description
- Retired FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL)
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.F.Fo.FORENSIC_MENTAL_HEALTH_CARE_CLUSTER_CODE_(INITIAL) to Retired.Data_Dictionary.Data_Field_Notes.F.FORENSIC_MENTAL_HEALTH_CARE_CLUSTER_CODE_(INITIAL)

INTENDED AGE GROUP (MENTAL HEALTH)

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See AGE GROUP INTENDED FOR MENTAL HEALTH
Default Codes:	

Notes:
INTENDED AGE GROUP (MENTAL HEALTH) is the same as attribute AGE GROUP INTENDED FOR MENTAL HEALTH.

This data element is also known by these names:

Context	Alias
plural	INTENDED AGE GROUPS (MENTAL HEALTH)

INTENDED AGE GROUP (MENTAL HEALTH)

Change to Data Element: New Data Element

INTENDED AGE GROUP (MENTAL HEALTH)

Attribute:

AGE GROUP INTENDED FOR MENTAL HEALTH

MATERNITY CARE PLAN DATE

Change to Data Element: Changed Description, linked Attribute

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

Notes:
~~MATERNITY CARE PLAN DATE is the same as attribute CARE PLAN AGREED DATE for a Maternity Episode.~~MATERNITY CARE PLAN DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Care Plan Agreed Date*' for a Maternity Episode.

MATERNITY CARE PLAN DATE

Change to Data Element: Changed Description, linked Attribute

MATERNITY CARE PLAN DATE

Attribute:

~~CARE PLAN AGREED DATE~~
ACTIVITY DATE

MENTAL HEALTH ADMITTED PATIENT CLASSIFICATION

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	
Default Codes:	

Notes:
MENTAL HEALTH ADMITTED PATIENT CLASSIFICATION is a derived from the attribute WARD SETTING TYPE FOR

MENTAL HEALTH, WARD SECURITY LEVEL, AGE GROUP INTENDED FOR MENTAL HEALTH, CLINICAL CARE INTENSITY and TREATMENT FUNCTION CODE.

MENTAL HEALTH ADMITTED PATIENT CLASSIFICATION is the classification of the admitted PATIENT during a Ward Stay for the Mental Health Services Data Set.

For further information, see the NHS England website.

Permitted National Codes:

	Adult
10	Acute adult mental health care
11	Acute older adult mental health care (organic and functional)
12	Psychiatric Intensive Care Unit (acute mental health care)
13	Eating Disorders
14	Mother and baby
15	Learning Disabilities
16	Low secure/locked rehabilitation
17	High dependency rehabilitation
18	Long term complex rehabilitation/ Continuing Care
19	Low secure
20	Medium secure
21	High secure
22	Neuro-psychiatry / Acquired Brain Injury
	Children and Young people
23	General Child and Adolescent Mental Health (CAMHS) inpatient - Child (including High Dependency)
24	General Child and Adolescent Mental Health (CAMHS) inpatient - Adolescent (including High Dependency)
25	Eating Disorders inpatient - Adolescent (above 12)
26	Eating Disorders inpatient - Child (12 years and under)
27	Low Secure Mental Illness
28	Medium Secure Mental Illness
29	Child Mental Health inpatient services for the Deaf
30	Learning Disabilities / Autistic Spectrum Disorder inpatient
31	Low Secure Learning Disabilities
32	Medium Secure Learning Disabilities
33	Severe Obsessive Compulsive Disorder and Body Dysmorphic Disorder - Adolescent
34	Psychiatric Intensive Care Unit

This data element is also known by these names:

Context	Alias
alsoknownas	HOSPITAL BED TYPE (MENTAL HEALTH)
plural	MENTAL HEALTH ADMITTED PATIENT CLASSIFICATIONS

MENTAL HEALTH ADMITTED PATIENT CLASSIFICATION

Change to Data Element: New Data Element

MENTAL HEALTH ADMITTED PATIENT CLASSIFICATION

Attribute:

AGE GROUP INTENDED FOR MENTAL HEALTH
CLINICAL CARE INTENSITY
TREATMENT FUNCTION CODE
WARD SECURITY LEVEL

WARD SETTING TYPE FOR MENTAL HEALTH

MENTAL HEALTH CRISIS PLAN CREATION DATE (RETIRED) renamed from MENTAL HEALTH CRISIS PLAN CREATION DATE

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

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

~~Notes:~~

~~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*'.~~ **This item has been retired from the NHS Data Model and Dictionary.**

The last live version of this item is available in the ?????? release of the NHS Data Model and Dictionary.

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

MENTAL HEALTH CRISIS PLAN CREATION DATE (RETIRED) renamed from MENTAL HEALTH CRISIS PLAN CREATION DATE

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

~~MENTAL HEALTH CRISIS PLAN CREATION DATE~~

~~Attribute:~~

~~ACTIVITY DATE~~

MENTAL HEALTH CRISIS PLAN CREATION DATE (RETIRED) renamed from MENTAL HEALTH CRISIS PLAN CREATION DATE

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

- Changed Description
- Retired MENTAL HEALTH CRISIS PLAN CREATION DATE
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.M.Men.MENTAL_HEALTH_CRISIS_PLAN_CREATION_DATE to Retired.Data_Dictionary.Data_Field_Notes.M.MENTAL_HEALTH_CRISIS_PLAN_CREATION_DATE

MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE (RETIRED) renamed from MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE

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

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

~~Notes:~~

~~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.~~**This item has been retired from the NHS Data Model and Dictionary.**

The last live version of this item is available in the ?????? release of the NHS Data Model and Dictionary.

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

MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE (RETIRED)_ renamed from MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE

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

~~MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE~~

~~**Attribute:**~~

~~ACTIVITY DATE~~

MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE (RETIRED)_ renamed from MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE

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

- Changed Description
- Retired MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.M.Men.MENTAL_HEALTH_CRISIS_PLAN_LAST_UPDATED_DATE to Retired.Data_Dictionary.Data_Field_Notes.M.MENTAL_HEALTH_CRISIS_PLAN_LAST_UPDATED_DATE

MENTAL HEALTH DELAYED DISCHARGE REASON

Change to Data Element: Changed Description

~~Format/Length:~~	~~an2~~
Format/Length:	max an3
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.

OBSERVATION DATE (SUBSTANCE MISUSE EVIDENCE)

Change to Data Element: New Data Element

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

Notes:
OBSERVATION DATE (SUBSTANCE MISUSE EVIDENCE) is the same as attribute PERSON PROPERTY OBSERVED DATE.

OBSERVATION DATE (SUBSTANCE MISUSE EVIDENCE)) is the date that evidence of current substance misuse by a PATIENT was observed by a CARE PROFESSIONAL.

For the Mental Health Services Data Set, OBSERVATION DATE (SUBSTANCE MISUSE EVIDENCE) is recorded within a Ward Stay.

This data element is also known by these names:

Context	Alias
plural	OBSERVATION DATES (SUBSTANCE MISUSE EVIDENCE)

OBSERVATION DATE (SUBSTANCE MISUSE EVIDENCE)

Change to Data Element: New Data Element

OBSERVATION DATE (SUBSTANCE MISUSE EVIDENCE)

Attribute:

PERSON PROPERTY OBSERVED DATE

OFFENCE HISTORY INDICATION CODE

Change to Data Element: New Data Element

Format/Length:	an1
National Codes:	See OFFENCE HISTORY INDICATION CODE
Default Codes:	X - Not Known (Not Recorded)

Notes:
OFFENCE HISTORY INDICATION CODE is the same as attribute OFFENCE HISTORY INDICATION CODE.

This data element is also known by these names:

Context	Alias
plural	OFFENCE HISTORY INDICATION CODES

OFFENCE HISTORY INDICATION CODE

Change to Data Element: New Data Element

OFFENCE HISTORY INDICATION CODE

Attribute:

OFFENCE HISTORY INDICATION CODE

ONWARD REFERRAL REASON

Change to Data Element: Changed Description

Format/Length:	an2
National Codes:	See ONWARD REFERRAL REASON
Default Codes:	98 - Onward Referral Reason Not Applicable ~~99 - Onward Referral Reason Not Known~~ 99 - Not Known (Not Recorded)

Notes:
ONWARD REFERRAL REASON is the same as attribute ONWARD REFERRAL REASON.

ONWARD REFERRAL TIME

Change to Data Element: New Data Element

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

Notes:
ONWARD REFERRAL TIME is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Onward Referral Time*'.

This data element is also known by these names:

Context	Alias
plural	ONWARD REFERRAL TIMES

ONWARD REFERRAL TIME

Change to Data Element: New Data Element

ONWARD REFERRAL TIME

Attribute:

ACTIVITY TIME

PLACE OF SAFETY INDICATOR

Change to Data Element: New Data Element

Format/Length:	an1
National Codes:	See PLACE OF SAFETY INDICATOR
Default Codes:	

Notes:
PLACE OF SAFETY INDICATOR is the same as attribute PLACE OF SAFETY INDICATOR.

This data element is also known by these names:

Context	Alias
plural	PLACE OF SAFETY INDICATORS

PLACE OF SAFETY INDICATOR

Change to Data Element: New Data Element

PLACE OF SAFETY INDICATOR

Attribute:

PLACE OF SAFETY INDICATOR

PLANNED DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL)

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See DISCHARGE DESTINATION
Default Codes:	98 - Not applicable - Hospital Provider Spell not finished at episode end (i.e. not discharged) or current episode unfinished 99 - Not known: a validation error

Notes:
PLANNED DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL) is the same as attribute DISCHARGE DESTINATION.

PLANNED DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL) is the planned destination of a PATIENT on completion of a Hospital Provider Spell.

This data element is also known by these names:

Context	Alias
plural	PLANNED DISCHARGE DESTINATION CODES (HOSPITAL PROVIDER SPELL)

PLANNED DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL)

Change to Data Element: New Data Element

PLANNED DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL)

Attribute:

DISCHARGE DESTINATION

POSTCODE OF MAIN VISITOR

Change to Data Element: Changed Description

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.~~For the Mental Health Services Data Set, 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.

REASON FOR OUT OF AREA REFERRAL (ADULT ACUTE MENTAL HEALTH)

Change to Data Element: New Data Element

Format/Length:	an1
National Codes:	See REASON FOR OUT OF AREA REFERRAL FOR ADULT ACUTE MENTAL HEALTH
Default Codes:	99 - Reason Not Known

Notes:
REASON FOR OUT OF AREA REFERRAL (ADULT ACUTE MENTAL HEALTH) is the same as attribute REASON FOR OUT OF AREA REFERRAL FOR ADULT ACUTE MENTAL HEALTH.

This data element is also known by these names:

Context	Alias
plural	REASONS FOR OUT OF AREA REFERRAL (ADULT ACUTE MENTAL HEALTH)

REASON FOR OUT OF AREA REFERRAL (ADULT ACUTE MENTAL HEALTH)

Change to Data Element: New Data Element

REASON FOR OUT OF AREA REFERRAL (ADULT ACUTE MENTAL HEALTH)

Attribute:

REASON FOR OUT OF AREA REFERRAL FOR ADULT ACUTE MENTAL HEALTH

REFERRAL CLOSURE TIME

Change to Data Element: New Data Element

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

Notes:
REFERRAL CLOSURE TIME is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Referral Closure Time*'.

This data element is also known by these names:

Context	Alias
plural	REFERRAL CLOSURE TIMES

REFERRAL CLOSURE TIME

Change to Data Element: New Data Element

REFERRAL CLOSURE TIME

Attribute:

ACTIVITY TIME

REFERRED OUT OF AREA REASON (ADULT ACUTE MENTAL HEALTH)

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See REFERRED OUT OF AREA REASON FOR ADULT ACUTE MENTAL HEALTH
Default Codes:	99 - Not Known (Not Recorded)

Notes:
REFERRED OUT OF AREA REASON (ADULT ACUTE MENTAL HEALTH) is the same as attribute REFERRED OUT OF AREA REASON FOR ADULT ACUTE MENTAL HEALTH.

This data element is also known by these names:

Context	Alias
plural	REFERRED OUT OF AREA REASONS (ADULT ACUTE MENTAL HEALTH)

REFERRED OUT OF AREA REASON (ADULT ACUTE MENTAL HEALTH)

Change to Data Element: New Data Element

REFERRED OUT OF AREA REASON (ADULT ACUTE MENTAL HEALTH)

Attribute:

REFERRED OUT OF AREA REASON FOR ADULT ACUTE MENTAL HEALTH

SERVICE DISCHARGE TIME

Change to Data Element: New Data Element

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

Notes:
SERVICE DISCHARGE TIME is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Service Discharge Time*'.

This data element is also known by these names:

Context	Alias
plural	SERVICE DISCHARGE TIMES

SERVICE DISCHARGE TIME

Change to Data Element: New Data Element

SERVICE DISCHARGE TIME

Attribute:

ACTIVITY TIME

SETTLED ACCOMMODATION INDICATOR

Change to Data Element: Changed Description

Format/Length:	an1
National Codes:	See SETTLED ACCOMMODATION INDICATOR
~~Default Codes:~~	~~9 - Not Known~~
Default Codes:	9 - Not Known (Not Recorded)

Notes:
SETTLED ACCOMMODATION INDICATOR is the same as attribute SETTLED ACCOMMODATION INDICATOR.

TREATMENT FUNCTION CODE (MENTAL HEALTH)

Change to Data Element: Changed Description

Format/Length:	an3
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 TREATMENT FUNCTION CODE for the PATIENT treated by a Mental Health Service.

Permitted National Codes:

319	Respite Care
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

COMMISSIONING DATA SET VERSION 6-2 XML SCHEMA CONSTRAINTS

Change to XML Schema Constraint: Changed Description

XML Schema constraints applied to the Commissioning Data Sets.

The "Allowed Values" column indicates the NHS Data Model and Dictionary National Codes and Default Codes present in the XML Schema:

- None = The National Codes and Default Codes are included in the XML Schema
- Removed = The National Codes and Default Codes are not included in the XML Schema.

Data Element	XML Schema Format/Length	Allowed Values	Range
A and E ATTENDANCE NUMBER	max an12	None	None
ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST	min an2 max an6	None	None
ACCIDENT AND EMERGENCY DIAGNOSIS - SECOND	min an2 max an6	None	None

ACCIDENT AND EMERGENCY INVESTIGATION - FIRST	min an2 max an6	None	None
ACCIDENT AND EMERGENCY INVESTIGATION - SECOND	min an2 max an6	None	None
ACCIDENT AND EMERGENCY TREATMENT - FIRST	min an2 max an6	None	None
ACCIDENT AND EMERGENCY TREATMENT - SECOND	min an2 max an6	None	None
ACTIVITY LOCATION TYPE CODE	None	A01,A02,A03,A04,B01,B02,C01,C02,C03,D01,D02,D03, E01,E02,E03,E04,E99,F01,G01,G02,G03,H01,J01,K01,K02, L01,L02,L03,L04,L05,L06,L99,M01,M02,M03,M04,M05, N01,N02,N03,N04,N05,X01	None
ADVANCED CARDIOVASCULAR SUPPORT DAYS	max n3	None	None
ADVANCED RESPIRATORY SUPPORT DAYS	max n3	None	None
AGE AT CDS ACTIVITY DATE	max n3	None	None
AGE AT CENSUS	max n3	None	None
AGE ON ADMISSION	max n3	None	None
ATTENDANCE IDENTIFIER	max an12	None	None
BASIC CARDIOVASCULAR SUPPORT DAYS	max n3	None	None
BASIC RESPIRATORY SUPPORT DAYS	max n3	None	None
BIRTH WEIGHT	max n4	None	None
CARE PROFESSIONAL MAIN SPECIALTY CODE	None	100,101,110,120,130,140,141,142,143,145,146,147,148,149, 150,160,170,171,180,190,192,300,301,302,303,304,305,310, 311,312,313,314,315,320,321,325,326,330,340,350,352,360, 361,370,371,400,401,410,420,421,430,450,451,460,501,502, 504,560,600,601,700,710,711,712,713,715,800,810,820,821, 822,823,824,830,831,833,834,900,901,902,903,904,950,960, 199,499	None
CDS COPY RECIPIENT IDENTITY	min an3 max an12	Removed	None
CDS MESSAGE REFERENCE	max n7	None	None
CDS MESSAGE VERSION NUMBER	None	CDS062	None

CDS PRIME RECIPIENT IDENTITY	min an3 max an12	Removed	None
CDS SENDER IDENTITY	min an3 max an12	None	None
CDS UNIQUE IDENTIFIER	max an35	None	None
COMMISSIONER REFERENCE NUMBER	max an17	None	None
COMMISSIONING SERIAL NUMBER	max an6	None	None
CONSULTATION MEDIUM USED	None	01,02,03,04	None
COUNT OF DAYS SUSPENDED	max n4	None	None
CRITICAL CARE ACTIVITY CODE	None	01,02,03,04,05,06,07,08,09,10,11,12,13,14, 15,16,21,22,23,24,25,26,27,28,29,50,51,52, 53,55,56,57,58,59,60,61,62,63,64,65,66,67, 68,69,70,71,72,73,74,99	None
CRITICAL CARE LEVEL 2 DAYS	max n3	None	None
CRITICAL CARE LEVEL 3 DAYS	max n3	None	None
CRITICAL CARE LOCAL IDENTIFIER	max an8	None	None
DERMATOLOGICAL SUPPORT DAYS	max n3	None	None
~~DURATION OF CARE TO PSYCHIATRIC CENSUS DATE~~	~~max n5~~	~~None~~	Existing Format/Len states n3 - XML Schem allows max
DISCHARGE METHOD CODE (HOSPITAL PROVIDER SPELL)	None	1,2,3,4,5,8,9	None
DURATION OF CARE TO PSYCHIATRIC CENSUS DATE	max n5	None	None
DURATION OF DETENTION	max n5	None	None
DURATION OF ELECTIVE WAIT	max n4	None	None
	max an12	None	None

ELECTIVE ADMISSION LIST ENTRY NUMBER			
EPISODE NUMBER	max an2	None	None
ETHNIC CATEGORY	max an2	None	None
GASTRO-INTESTINAL SUPPORT DAYS	max n3	None	None
GENERAL MEDICAL PRACTITIONER PRACTICE (ANTENATAL CARE)	min an3 max an12	Removed	None
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	min an3 max an12	Removed	None
GENERAL MEDICAL PRACTITIONER (ANTENATAL CARE)	None	Removed	None
GENERAL MEDICAL PRACTITIONER (SPECIFIED)	None	Removed	None
HOSPITAL PROVIDER SPELL NUMBER	max an12	None	None
INTENDED SITE CODE (OF TREATMENT)	min an3 max an12	Removed	None
LIVER SUPPORT DAYS	max n3	None	None
LOCAL PATIENT IDENTIFIER	max an10	None	None
LOCAL PATIENT IDENTIFIER (BABY)	max an10	None	None
LOCAL PATIENT IDENTIFIER (MOTHER)	max an10	None	None
MENTAL HEALTH ACT LEGAL STATUS	None	01,02,03,04,05,06,07,08,09,10,11,12,13,14, 15,16,17,18,19,20,31,32,34,35,36,37,38	None

CLASSIFICATION CODE (AT CENSUS DATE)			
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION)	None	01,02,03,04,05,06,07,08,09,10,11,12,13,14, 15,16,17,18,19,20,31,32,34,35,36,37,38	None
NEUROLOGICAL SUPPORT DAYS	max n3	None	None
NHS SERVICE AGREEMENT LINE NUMBER	max an10	None	None
ORGAN SUPPORT MAXIMUM	None	None	00-06
ORGANISATION CODE (CODE OF COMMISSIONER)	min an3 max an12	Removed	None
ORGANISATION CODE (CODE OF PROVIDER)	min an3 max an12	Removed	None
ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)	min an3 max an12	None	None
ORGANISATION CODE (LOCAL PATIENT IDENTIFIER (BABY))	min an3 max an12	None	None
ORGANISATION CODE (LOCAL PATIENT IDENTIFIER (MOTHER))	min an3 max an12	None	None
ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)	min an3 max an12	None	None
ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	min an3 max an12	Removed	None
PERSON WEIGHT	n3.n3	None	None
PRIMARY DIAGNOSIS (READ)	max an5	None	None
PROVIDER REFERENCE NUMBER	max an17	None	None
REFERRER CODE	None	Removed	None

REFERRING ORGANISATION CODE	min an3 max an12	Removed	None
RENAL SUPPORT DAYS	max n3	None	None
SECONDARY DIAGNOSIS (READ)	max an5	None	None
SITE CODE (OF TREATMENT)	min an3 max an12	Removed	None

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