Health and Social Care Information Centre

NHS Data Model and Dictionary Service

Type:	Change Request
Reference:	1549
Version No:	1.0
Subject:	Mental Health Services Data Set Version 1.1
Effective Date:	1 April 2016
Reason for Change:	Change to Data Standards
Publication Date:	7 February 2016

Background:

The Mental Health Services Data Set Version 1 was approved by the Standardisation Committee for Care Information (SCCI) as SCCI0011.

Minor changes to the Information Standard are now required. The changes are:

- New Data Element "LOCKED WARD INDICATOR" added to the Data Set
- New National Code "C09" added to the Attribute "SERVICE OR TEAM TYPE FOR MENTAL HEALTH".

To support the Information Standard, this Change Request updates the NHS Data Model and Dictionary to reflect Mental Health Services Data Set Version 1.1.

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:

Data Set	
MENTAL HEALTH SERVICES DATA SET	Changed Description
Supporting Information	
MULTIDISCIPLINARY TEAM MEETING	Changed Description
Class Definitions	
WARD	Changed Attributes
Attribute Definitions	
LOCKED WARD INDICATOR	New Attribute
SERVICE OR TEAM TYPE FOR MENTAL HEALTH	Changed Description
Data Elements	
LOCKED WARD INDICATOR	New Data Element

Date: 7 February 2016
Sponsor: Sarah McClinton, Director of Mental Health, Disability and Dementia, Department of Health

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

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	ETHNIC CATEGORY

R	RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE
R	LANGUAGE CODE (PREFERRED)
R	PERSON DEATH DATE

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

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

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

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

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

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

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

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

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

M/R/P	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)

M	START DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD)
R	CARE PROFESSIONAL LOCAL IDENTIFIER
R	END DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD)
R	CARE PROFESSIONAL SERVICE OR TEAM TYPE ASSOCIATION (MENTAL HEALTH)

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

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

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

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

REFERRALS

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

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

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

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

R	REFERRAL REJECTION DATE
R	REFERRAL CLOSURE REASON
R	REFERRAL REJECTION REASON

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

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

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

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

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

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

CARE CONTACT, CARE ACTIVITIES AND INDIRECT ACTIVITIES

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

M/R/P	Data Set Data Elements
M	CARE CONTACT IDENTIFIER
M	SERVICE REQUEST IDENTIFIER
R	CARE PROFESSIONAL TEAM LOCAL IDENTIFIER
M	CARE CONTACT DATE
R	CARE CONTACT TIME
R	ORGANISATION CODE (CODE OF COMMISSIONER)
R	ADMINISTRATIVE CATEGORY CODE
R	CLINICAL CONTACT DURATION OF CARE CONTACT
R	CONSULTATION TYPE
R	CARE CONTACT SUBJECT
R	CONSULTATION MEDIUM USED
R	ACTIVITY LOCATION TYPE CODE

R	SITE CODE (OF TREATMENT)
R	GROUP THERAPY INDICATOR
R	ATTENDED OR DID NOT ATTEND CODE
R	EARLIEST REASONABLE OFFER DATE
R	EARLIEST CLINICALLY APPROPRIATE DATE
R	CARE CONTACT CANCELLATION DATE
R	CARE CONTACT CANCELLATION REASON
R	REPLACEMENT APPOINTMENT DATE OFFERED
R	REPLACEMENT APPOINTMENT BOOKED DATE

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

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

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

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

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

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

GROUP SESSIONS

Group Session: To carry details of any group sessions which have been provided. Multiple occurrences of this group are permitted.	
M/R/P	**Data Set Data Elements**
M	GROUP SESSION IDENTIFIER
M	GROUP SESSION DATE
M	ORGANISATION CODE (CODE OF COMMISSIONER)
R	CLINICAL CONTACT DURATION OF GROUP SESSION
R	GROUP SESSION TYPE (MENTAL HEALTH)
R	NUMBER OF GROUP SESSION PARTICIPANTS
R	ACTIVITY LOCATION TYPE CODE
R	SITE CODE (OF TREATMENT)
R	CARE PROFESSIONAL LOCAL IDENTIFIER
R	SERVICE OR TEAM TYPE REFERRED TO (MENTAL HEALTH)
R	NHS SERVICE AGREEMENT LINE NUMBER

MENTAL HEALTH ACT (MHA) EPISODES

Mental Health Act Legal Status Classification Period: To carry details of Mental Health Act Legal Status Classification Period for patients formally detailed under the Mental Health Act 1983 or other Acts. Multiple occurrences of this group are permitted, one for each separate section of the Mental Health Act that the patient is detained under.	
M/R/P	**Data Set Data Elements**
M	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)
M	START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)
R	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON
R	EXPIRY DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)
R	EXPIRY TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)
R	END DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)
R	END TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)
R	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON
R	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE
R	MENTAL HEALTH ACT 2007 MENTAL CATEGORY

Mental Health Responsible Clinician Assignment: To carry details of the assignment of a Mental Health Responsible Clinician to the patient. Multiple occurrences of this group are permitted.	
M/R/P	**Data Set Data Elements**
M	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER
M	START DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD)
M	CARE PROFESSIONAL LOCAL IDENTIFIER
R	END DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD)

Conditional Discharge: To carry details of each separate period of conditional discharge for the patient. Multiple occurrences of this group are permitted.	
M/R/P	**Data Set Data Elements**
M	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER
M	START DATE (MENTAL HEALTH CONDITIONAL DISCHARGE)

R	END DATE (MENTAL HEALTH CONDITIONAL DISCHARGE)
R	MENTAL HEALTH CONDITIONAL DISCHARGE END REASON
R	MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY

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

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

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

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

HOSPITAL PROVIDER SPELLS

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

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

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

M/R/P	Data Set Data Elements
M	WARD STAY IDENTIFIER
M	HOSPITAL PROVIDER SPELL NUMBER
M	START DATE (WARD STAY)
R	START TIME (WARD STAY)

R	END DATE (WARD STAY)
R	END TIME (WARD STAY)
R	SITE CODE (OF TREATMENT)
R	WARD SETTING TYPE (MENTAL HEALTH)
R	SEX OF PATIENTS CODE
R	INTENDED CLINICAL CARE INTENSITY CODE (MENTAL HEALTH)
R	WARD SECURITY LEVEL
R	LOCKED WARD INDICATOR

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

M/R/P	Data Set Data Elements
M	HOSPITAL PROVIDER SPELL NUMBER
M	CARE PROFESSIONAL LOCAL IDENTIFIER
M	START DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)
R	END DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)
R	TREATMENT FUNCTION CODE (MENTAL HEALTH)

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

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

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

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

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

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

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

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

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

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

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

M/R/P	Data Set Data Elements
M	WARD STAY IDENTIFIER
M	START DATE (MENTAL HEALTH LEAVE OF ABSENCE)
R	START TIME (MENTAL HEALTH LEAVE OF ABSENCE)
R	END DATE (MENTAL HEALTH LEAVE OF ABSENCE)
R	END TIME (MENTAL HEALTH LEAVE OF ABSENCE)
R	MENTAL HEALTH LEAVE OF ABSENCE END REASON

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

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

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

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

CLINICALLY CODED TERMINOLOGY

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

M/R/P	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	DIAGNOSIS SCHEME IN USE

M	PREVIOUS DIAGNOSIS (CODED CLINICAL ENTRY)
R	DIAGNOSIS DATE

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

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

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

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

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

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

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

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

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

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

ANONYMOUS SELF-ASSESSMENT

Anonymous Self-Assessment: To carry details of anonymous self-assessments. Multiple occurrences of this group are permitted.	
M/R/P	**Data Set Data Elements**
M	ASSESSMENT TOOL COMPLETION DATE
M	CODED ASSESSMENT TOOL TYPE (SNOMED CT)
M	PERSON SCORE
R	ACTIVITY LOCATION TYPE CODE
R	ORGANISATION CODE (CODE OF COMMISSIONER)

CARE PROGRAMME APPROACH (CPA) CARE EPISODES

Care Programme Approach (CPA) Care Episode: To carry details of the periods of time the patient spent on Care Programme Approach. Multiple occurrences of this group are permitted.	
M/R/P	**Data Set Data Elements**
M	CARE PROGRAMME APPROACH CARE EPISODE IDENTIFIER
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	START DATE (CARE PROGRAMME APPROACH CARE)
R	END DATE (CARE PROGRAMME APPROACH CARE)

Care Programme Approach (CPA) Review: To carry details of Care Programme Approach reviews undertaken for the patient. Multiple occurrences of this group are permitted.	
M/R/P	**Data Set Data Elements**
M	CARE PROGRAMME APPROACH CARE EPISODE IDENTIFIER
M	CARE PROGRAMME APPROACH REVIEW DATE
R	CARE PROGRAMME APPROACH REVIEW ABUSE QUESTION ASKED INDICATOR
R	CARE PROFESSIONAL LOCAL IDENTIFIER

CARE CLUSTERS

Clustering Tool Assessment: To carry details of clustering tool assessments. Multiple occurrences of this group are permitted.	
M/R/P	**Data Set Data Elements**
M	CLUSTERING TOOL ASSESSMENT IDENTIFIER
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	CLUSTERING TOOL ASSESSMENT CATEGORY
M	ASSESSMENT TOOL COMPLETION DATE
R	ASSESSMENT TOOL COMPLETION TIME
R	CLUSTERING TOOL ASSESSMENT REASON
R	MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE
R	ADULT MENTAL HEALTH CARE CLUSTER CODE (INITIAL)
P	CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL)
P	LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)
P	FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL)
P	FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)

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

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

Care Cluster: **To carry details of the Care Cluster resulting from a clustering tool assessment.** **Multiple occurrences of this group are permitted.**	
M/R/P	**Data Set Data Elements**
M	CLUSTERING TOOL ASSESSMENT IDENTIFIER
R	ADULT MENTAL HEALTH CARE CLUSTER CODE (FINAL)
P	CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL)
P	LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)
P	FORENSIC MENTAL HEALTH CARE CLUSTER CODE (FINAL)
P	FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)
M	START DATE (CARE CLUSTER ASSIGNMENT PERIOD)
R	START TIME (CARE CLUSTER ASSIGNMENT PERIOD)
R	END DATE (CARE CLUSTER ASSIGNMENT PERIOD)
R	END TIME (CARE CLUSTER ASSIGNMENT PERIOD)

CARE PROFESSIONALS

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

MULTIDISCIPLINARY TEAM MEETING

Change to Supporting Information: Changed Description

A Multidisciplinary Team Meeting is a CARE ACTIVITY.

~~The following definition is used for the National Cancer Waiting Times Monitoring Data Set and Cancer Outcomes and Services Data Set:~~The following definition is used for the National Cancer Waiting Times Monitoring Data Set and Cancer Outcomes and Services Data Set:

- A Multidisciplinary Team Meeting is a meeting of the group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatment of individual PATIENTS.
- Multidisciplinary Teams may specialise in certain conditions, such as Cancer. Clinical decisions are made based on reviews of clinical documentation such as case notes, test results, diagnostic imaging etc. The PATIENT may or may not be present.

WARD

Change to Class: Changed Attributes

Attributes of this Class are:

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

LOCKED WARD INDICATOR

Change to Attribute: New Attribute

An indication of whether a WARD is locked.

National Codes:

Y	Yes - is a locked WARD
N	No - is not a locked WARD

This attribute is also known by these names:

Context	Alias
plural	LOCKED WARD INDICATORS

LOCKED WARD INDICATOR

Change to Attribute: New Attribute

LOCKED WARD INDICATOR

Data Elements:

LOCKED WARD INDICATOR

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
	Forensic Services
B01	Forensic Mental Health Service
B02	Forensic Learning Disability Service
	Specialist Mental Health Services
C01	Autistic Spectrum Disorder Service
C02	Peri-Natal Mental Illness Service
C03	Eating Disorders/Dietetics Service
C04	Neurodevelopment Team
C05	Paediatric Liaison Service
C06	Looked After Children Service
C07	Community Young Offenders Service
C08	Acquired Brain Injury Service
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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LOCKED WARD INDICATOR

Change to Data Element: New Data Element

Format/Length:	an1
National Codes:	See LOCKED WARD INDICATOR
Default Codes:	

Notes:
LOCKED WARD INDICATOR is the same as attribute LOCKED WARD INDICATOR.

For the Mental Health Services Data Set, LOCKED WARD INDICATOR indicates whether a WARD which is used to provide care by a Mental Health Service, and has a WARD SECURITY LEVEL National Code "General (non-secure)", is locked to prevent unauthorised entry and/or exit.

This data element is also known by these names:

Context	Alias

plural	LOCKED WARD INDICATORS

LOCKED WARD INDICATOR

Change to Data Element: New Data Element

LOCKED WARD INDICATOR

Attribute:

LOCKED WARD INDICATOR

For enquiries about this Change Request, please email information.standards@hscic.gov.uk