

Type: Change Request
Reference: 1610
Version No: 1.0
Subject: Mental Health Services Data Set Version 3.0
Effective Date: 1 April 2018
Reason for Change: Change to Information Standards
Publication Date: 22 September 2017

Background:

The Mental Health Services Data Set Version 2.0 was approved by the Standardisation Committee for Care Information (SCCI) as [SCCI0011: Mental Health Services Data Set](#).

A number of changes have been identified since the last version, and the Mental Health Services Data Set Version 3.0 includes:

- New Data Items and amendments to National Code values and descriptions to cover:
 - Changes to enable reporting on access and waiting times for various identified mental health and autistic spectrum disorder pathways
 - Enhance collection of data for Children and Young People's Mental Health
 - Enhance collection of data for learning disability care services
 - Incorporation of the Specialised Commissioning Mental Health data collection
- Changes to Organisation and Organisation Site Code Data Items to reflect changes to organisation reference data maintained and published by the Organisation Data Service, as defined by [SCCI0090: Health and Social Care Organisation Reference Data](#).

To support the Information Standard, this Change Request updates the NHS Data Model and Dictionary to introduce Mental Health Services Data Set Version 3.0.

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.

Summary of changes:

Data Set

[MENTAL HEALTH SERVICES DATA SET](#)

Changed Dataset,
Description

Supporting Information

[CARE PLAN AGREED TIME](#)

New Supporting Information

[CARE PLAN CREATION TIME](#)

New Supporting Information

[CARE PLAN LAST UPDATED TIME](#)

New Supporting Information

[CHILD OR YOUNG PERSON'S MENTAL HEALTH TRANSITION PLAN](#)

New Supporting Information

[CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH SERVICE](#)

New Supporting Information

[DATA COORDINATION BOARD](#)

Changed Dataset

[ESTIMATED DISCHARGE DATE \(HOSPITAL PROVIDER SPELL\)](#)

New Supporting Information

[MENTAL HEALTH SERVICES DATA SET OVERVIEW](#)

Changed Dataset,
Description

[MENTAL HEALTH TRIAL LEAVE](#)

New Supporting Information

[ORGANISATION](#)

Changed Dataset

[PLANNED DISCHARGE DATE \(HOSPITAL PROVIDER SPELL\)](#)

Changed Description

[REFERRAL REJECTION DATE](#)

Changed Description

[REFERRAL REJECTION TIME](#)

New Supporting Information

[STANDARDISATION COMMITTEE FOR CARE INFORMATION](#)

Changed Dataset

Class Definitions

[LEAVE](#)

Changed Attributes

[SERVICE PROVIDED UNDER AGREEMENT](#)

Changed Attributes

Attribute Definitions

[ACCOMMODATION STATUS CODE](#)

Changed Dataset

[ACTIVITY DATE](#)

Changed Dataset

[ACTIVITY IDENTIFIER](#)

Changed Dataset

[ACTIVITY LOCATION TYPE CODE](#)

Changed Dataset

ACTIVITY TIME	Changed Dataset
ACTIVITY TIME TYPE	Changed Description
ADMINISTRATIVE CATEGORY CODE	Changed Dataset
ADMISSION METHOD	Changed Dataset
ADULT MENTAL HEALTH CARE CLUSTER CODE	Changed Dataset
AGE GROUP INTENDED FOR MENTAL HEALTH	Changed Dataset
APPOINTMENT DATE OFFERED	Changed Dataset
ATTENDED OR DID NOT ATTEND	Changed Dataset
CARE CONTACT CANCELLATION REASON	Changed Dataset
CARE CONTACT SUBJECT	Changed Dataset
CARE PLAN AGREED BY	Changed Dataset
CARE PLAN IDENTIFIER	Changed Dataset
CARE PLAN TYPE	Changed Description
CARE PLAN TYPE FOR MENTAL HEALTH	Changed Dataset, Description
CARE PROFESSIONAL IDENTIFIER	Changed Dataset
CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH	Changed Dataset
CARE PROFESSIONAL TEAM IDENTIFIER	Changed Dataset
CARE PROGRAMME APPROACH REVIEW ABUSE QUESTION ASKED INDICATOR	Changed Dataset
CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE	Changed Dataset, Description
CHILD AND ADOLESCENT MENTAL HEALTH TIER OF SERVICE	Changed Dataset
CHILD PROTECTION PLAN INDICATION CODE	Changed Dataset
CLINICAL CARE INTENSITY	Changed Dataset
CLINICAL CLASSIFICATION CODE	Changed Dataset
CLINICAL RESPONSE PRIORITY TYPE	Changed Dataset
CLINICAL TERMINOLOGY CODE	Changed Dataset
CLUSTERING TOOL ASSESSMENT CATEGORY	Changed Dataset
CLUSTERING TOOL ASSESSMENT REASON	Changed Dataset, Description
COMMUNITY TREATMENT ORDER END REASON	Changed Dataset
CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR	Changed Dataset
CONSULTATION MEDIUM USED	Changed Dataset
CONSULTATION TYPE	Changed Dataset
DECISION TO REFER DATE	Changed Dataset
DECISION TO REFER TIME	Changed Dataset
DIAGNOSIS SCHEME IN USE	Changed Dataset
DISABILITY CODE	Changed Dataset
DISABILITY IMPACT PERCEPTION	Changed Dataset
DISCHARGE DESTINATION	Changed Dataset
DISCHARGE METHOD	Changed Dataset
DISCHARGE PLAN AGREED BY	Changed Dataset
EMPLOYMENT STATUS	Changed Dataset
ESCORTED MENTAL HEALTH LEAVE OF ABSENCE INDICATOR	New Attribute
ETHNIC CATEGORY CODE	Changed Dataset
EX-BRITISH ARMED FORCES INDICATOR	Changed Dataset
FINDING SCHEME IN USE	Changed Dataset
FIVE FORENSIC PATHWAYS ASSESSMENT REASON	Changed Dataset, Description
FIVE FORENSIC PATHWAYS CODE	Changed Dataset
FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE	Changed Dataset
FORENSIC MENTAL HEALTH CARE CLUSTER CODE	Changed Dataset
GROUP SESSION TYPE FOR MENTAL HEALTH	Changed Dataset
JOB ROLE CODE	Changed Dataset
LANGUAGE CODE	Changed Dataset
LEARNING DISABILITIES CARE CLUSTER CODE	Changed Dataset
LEAVE TYPE	Changed Description
LOCAL PATIENT IDENTIFIER	Changed Dataset
LOCKED WARD INDICATOR	Changed Dataset
LOOKED AFTER CHILD INDICATOR	Changed Dataset
MAIN SPECIALTY CODE	Changed Dataset
MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON	Changed Dataset
MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY	Changed Dataset
MENTAL HEALTH ACT 2007 MENTAL CATEGORY	Changed Dataset

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON	Changed Dataset
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON	Changed Dataset
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE	Changed Dataset
MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE	Changed Dataset
MENTAL HEALTH CONDITIONAL DISCHARGE END REASON	Changed Dataset
MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE	Changed Dataset
MENTAL HEALTH DELAYED DISCHARGE REASON	Changed Dataset
MENTAL HEALTH LEAVE OF ABSENCE END REASON	Changed Dataset, Description
NHS NUMBER	Changed Dataset
NHS OCCUPATION CODE	Changed Dataset
NHS SERVICE AGREEMENT LINE NUMBER	Changed Dataset
OBSERVATION SCHEME IN USE	Changed Dataset
OBSERVATION VALUE	Changed Dataset
OFFENCE HISTORY INDICATION CODE	Changed Dataset
OFFERED FOR ADMISSION DATE	Changed Dataset
ONWARD REFERRAL REASON	Changed Dataset
ORGANISATION CODE	Changed Dataset
ORGANISATION IDENTIFIER	Changed Dataset
ORGANISATION SITE CODE	Changed Dataset
OTHER PERSON IN ATTENDANCE AT CARE CONTACT	Changed Dataset
PATIENT PATHWAY IDENTIFIER	Changed Dataset
PERSON BIRTH DATE	Changed Dataset
PERSON DEATH DATE	Changed Dataset
PERSON MARITAL STATUS CODE	Changed Dataset
PERSON PROPERTY EFFECTIVE DATE	Changed Dataset
PERSON PROPERTY EFFECTIVE END DATE	Changed Dataset
PERSON PROPERTY EFFECTIVE END TIME	Changed Dataset
PERSON PROPERTY OBSERVED DATE	Changed Dataset
PERSON PROPERTY RECORDED DATE	Changed Dataset
PERSON SCORE	Changed Dataset
PERSON STATED GENDER CODE	Changed Dataset
PLACE OF SAFETY INDICATOR	Changed Dataset
PLANNED ACTIVITY DATE	Changed Dataset
PLANNED ACTIVITY DATE TYPE	Changed Description
POSTCODE	Changed Dataset
PRESCRIPTION DATE	Changed Dataset
PROCEDURE SCHEME IN USE	Changed Dataset
PROFESSIONAL REGISTRATION BODY CODE	Changed Dataset
PROFESSIONAL REGISTRATION ENTRY IDENTIFIER	Changed Dataset
REASON FOR OUT OF AREA REFERRAL FOR ADULT ACUTE MENTAL HEALTH	Changed Dataset
REASON FOR REFERRAL TO MENTAL HEALTH	Changed Dataset, Description
REFERRAL CLOSURE REASON	Changed Dataset
REFERRAL REJECTION REASON	Changed Dataset
REFERRAL REQUEST RECEIVED DATE	Changed Dataset
REFERRAL REQUEST RECEIVED TIME	Changed Dataset
REFERRAL TO TREATMENT PERIOD END DATE	Changed Dataset
REFERRAL TO TREATMENT PERIOD START DATE	Changed Dataset
REFERRAL TO TREATMENT PERIOD STATUS	Changed Dataset
REFERRED OUT OF AREA REASON FOR ADULT ACUTE MENTAL HEALTH	Changed Dataset
REFERRING CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH AND COMMUNITY CARE	Changed Dataset
RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE	Changed Dataset
REPORTING PERIOD END DATE	Changed Dataset
REPORTING PERIOD START DATE	Changed Dataset
RESTRICTIVE INTERVENTION TYPE	Changed Dataset
SERVICE OR TEAM TYPE FOR MENTAL HEALTH	Changed Dataset, Description
SERVICE REQUEST IDENTIFIER	Changed Dataset
SERVICE TYPE	Changed Description
SESSION DATE	Changed Dataset
SETTLED ACCOMMODATION INDICATOR	Changed Dataset
SEX OF PATIENTS	Changed Dataset
SOURCE OF ADMISSION	Changed Dataset

SOURCE OF REFERRAL FOR MENTAL HEALTH	Changed Dataset, Description
SPECIALISED MENTAL HEALTH SERVICE CODE	Changed Dataset, Description
TREATMENT FUNCTION CODE	New Attribute
UCUM UNIT OF MEASUREMENT	Changed Dataset
WAITING TIME MEASUREMENT TYPE	Changed Dataset
WARD CODE	Changed Dataset
WARD SECURITY LEVEL	Changed Dataset
WARD SETTING TYPE FOR MENTAL HEALTH	Changed Dataset
WEEKLY HOURS WORKED	Changed Dataset, Description
YOUNG CARER INDICATOR	Changed Dataset
Data Elements	
ACCOMMODATION STATUS CODE	Changed Dataset
ACCOMMODATION STATUS RECORDED DATE	Changed Dataset
ACTIVITY LOCATION TYPE CODE	Changed Dataset
ADMINISTRATIVE CATEGORY CODE	Changed Dataset
ADMISSION METHOD CODE (HOSPITAL PROVIDER SPELL)	Changed Dataset
ADULT MENTAL HEALTH CARE CLUSTER CODE (FINAL)	Changed Dataset, Description
ADULT MENTAL HEALTH CARE CLUSTER CODE (INITIAL)	Changed Dataset, Description
ASSESSMENT TOOL COMPLETION DATE	Changed Dataset
ASSESSMENT TOOL COMPLETION TIME	Changed Dataset
ASSISTIVE TECHNOLOGY FINDING (SNOMED CT)	Changed Dataset
ATTENDED OR DID NOT ATTEND CODE	Changed Dataset
CARE ACTIVITY IDENTIFIER	Changed Dataset
CARE CONTACT CANCELLATION DATE	Changed Dataset
CARE CONTACT CANCELLATION REASON	Changed Dataset
CARE CONTACT DATE	Changed Dataset
CARE CONTACT IDENTIFIER	Changed Dataset
CARE CONTACT SUBJECT	Changed Dataset
CARE CONTACT TIME	Changed Dataset
CARE PLAN AGREED BY	Changed Dataset
CARE PLAN AGREED DATE	Changed Dataset
CARE PLAN AGREED TIME	New Data Element
CARE PLAN CREATION DATE	Changed Dataset
CARE PLAN CREATION TIME	New Data Element
CARE PLAN IDENTIFIER	Changed Dataset
CARE PLAN IMPLEMENTATION DATE	Changed Dataset
CARE PLAN LAST UPDATED DATE	Changed Dataset
CARE PLAN LAST UPDATED TIME	New Data Element
CARE PLAN TYPE (MENTAL HEALTH)	Changed Dataset, Description
CARE PROFESSIONAL (JOB ROLE CODE)	Changed Dataset
CARE PROFESSIONAL LOCAL IDENTIFIER	Changed Dataset
CARE PROFESSIONAL SERVICE OR TEAM TYPE ASSOCIATION (MENTAL HEALTH)	Changed Dataset
CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH)	Changed Dataset
CARE PROFESSIONAL TEAM LOCAL IDENTIFIER	Changed Dataset
CARE PROGRAMME APPROACH CARE EPISODE IDENTIFIER	Changed Dataset
CARE PROGRAMME APPROACH REVIEW ABUSE QUESTION ASKED INDICATOR	Changed Dataset
CARE PROGRAMME APPROACH REVIEW DATE	Changed Dataset
CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE	Changed Dataset, Description
CHILD AND ADOLESCENT MENTAL HEALTH TIER OF SERVICE	Changed Dataset
CHILD PROTECTION PLAN INDICATION CODE	Changed Dataset
CLINICAL CONTACT DURATION OF CARE ACTIVITY	Changed Dataset
CLINICAL CONTACT DURATION OF CARE CONTACT	Changed Dataset
CLINICAL CONTACT DURATION OF GROUP SESSION	Changed Dataset
CLINICAL RESPONSE PRIORITY TYPE	Changed Dataset
CLUSTERING TOOL ASSESSMENT CATEGORY	Changed Dataset
CLUSTERING TOOL ASSESSMENT IDENTIFIER	Changed Dataset

CLUSTERING TOOL ASSESSMENT REASON	Changed Dataset
CODED ASSESSMENT TOOL TYPE (SNOMED CT)	Changed Dataset
CODED FINDING (CODED CLINICAL ENTRY)	Changed Dataset
CODED OBSERVATION (CLINICAL TERMINOLOGY)	Changed Dataset
CODED PROCEDURE (CLINICAL TERMINOLOGY)	Changed Dataset
CODED PROCEDURE AND PROCEDURE STATUS (SNOMED CT)	New Data Element
COMMUNITY TREATMENT ORDER END REASON	Changed Dataset
CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR	Changed Dataset
CONSULTATION MEDIUM USED	Changed Dataset
CONSULTATION TYPE	Changed Dataset
DATA SET VERSION NUMBER	Changed Dataset
DATE AND TIME DATA SET CREATED	Changed Dataset
DATE OF ASSAULT ON PATIENT	Changed Dataset
DATE OF RESTRICTIVE INTERVENTION	Changed Dataset
DATE OF SELF-HARM	Changed Dataset
DECISION TO REFER DATE (ONWARD REFERRAL)	Changed Dataset
DECISION TO REFER TIME (ONWARD REFERRAL)	Changed Dataset
DIAGNOSIS DATE	Changed Dataset
DIAGNOSIS SCHEME IN USE	Changed Dataset
DISABILITY CODE	Changed Dataset
DISABILITY IMPACT PERCEPTION	Changed Dataset
DISCHARGE DATE (HOSPITAL PROVIDER SPELL)	Changed Dataset
DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL)	Changed Dataset
DISCHARGE LETTER ISSUED DATE (MENTAL HEALTH AND COMMUNITY CARE)	Changed Dataset
DISCHARGE METHOD CODE (HOSPITAL PROVIDER SPELL)	Changed Dataset
DISCHARGE PLAN AGREED BY	Changed Dataset
DISCHARGE PLAN AGREED DATE	Changed Dataset
DISCHARGE PLAN AGREED TIME	New Data Element
DISCHARGE PLAN CREATION DATE	Changed Dataset
DISCHARGE PLAN CREATION TIME	New Data Element
DISCHARGE PLAN LAST UPDATED DATE	Changed Dataset
DISCHARGE PLAN LAST UPDATED TIME	New Data Element
DISCHARGE TIME (HOSPITAL PROVIDER SPELL)	Changed Dataset
DURATION OF INDIRECT ACTIVITY	Changed Dataset
DURATION OF RESTRICTIVE INTERVENTION	Changed Dataset
EARLIEST CLINICALLY APPROPRIATE DATE	Changed Dataset
EARLIEST REASONABLE OFFER DATE	Changed Dataset
EMERGENT PSYCHOSIS DATE	Changed Dataset
EMPLOYMENT STATUS	Changed Dataset
EMPLOYMENT STATUS RECORDED DATE	Changed Dataset
END DATE (CARE CLUSTER ASSIGNMENT PERIOD)	Changed Dataset
END DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)	Changed Dataset
END DATE (CARE PROGRAMME APPROACH CARE)	Changed Dataset
END DATE (COMMISSIONER ASSIGNMENT PERIOD)	Changed Dataset
END DATE (COMMUNITY TREATMENT ORDER)	Changed Dataset
END DATE (COMMUNITY TREATMENT ORDER RECALL)	Changed Dataset
END DATE (GMP PATIENT REGISTRATION)	Changed Dataset
END DATE (HOME LEAVE)	Changed Dataset
END DATE (MENTAL HEALTH ABSENCE WITHOUT LEAVE)	Changed Dataset
END DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)	Changed Dataset
END DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD)	Changed Dataset
END DATE (MENTAL HEALTH CONDITIONAL DISCHARGE)	Changed Dataset
END DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD)	Changed Dataset
END DATE (MENTAL HEALTH LEAVE OF ABSENCE)	Changed Dataset
END DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD)	Changed Dataset
END DATE (MENTAL HEALTH TRIAL LEAVE)	New Data Element
END DATE (WARD STAY)	Changed Dataset
END TIME (CARE CLUSTER ASSIGNMENT PERIOD)	Changed Dataset
END TIME (COMMUNITY TREATMENT ORDER RECALL)	Changed Dataset
END TIME (HOME LEAVE)	Changed Dataset
END TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE)	Changed Dataset
END TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)	Changed Dataset
END TIME (MENTAL HEALTH LEAVE OF ABSENCE)	Changed Dataset

END TIME (MENTAL HEALTH TRIAL LEAVE)	New Data Element
END TIME (WARD STAY)	Changed Dataset
ESCORTED MENTAL HEALTH LEAVE OF ABSENCE INDICATOR	New Data Element
ESTIMATED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)	New Data Element
ETHNIC CATEGORY	Changed Dataset
EX-BRITISH ARMED FORCES INDICATOR	Changed Dataset
EXPIRY DATE (COMMUNITY TREATMENT ORDER)	Changed Dataset
EXPIRY DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)	Changed Dataset
EXPIRY TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)	Changed Dataset
FINDING SCHEME IN USE	Changed Dataset
FIRST PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION)	Changed Dataset
FIVE FORENSIC PATHWAYS ASSESSMENT DATE	Changed Dataset
FIVE FORENSIC PATHWAYS ASSESSMENT REASON	Changed Dataset
FIVE FORENSIC PATHWAYS CODE	Changed Dataset
FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)	Changed Dataset
FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)	Changed Dataset
FORENSIC MENTAL HEALTH CARE CLUSTER CODE (FINAL) renamed from FORENSIC MENTAL HEALTH CARE CLUSTER CODE (FINAL)	Changed Name, Dataset, Description
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	Changed Dataset
GROUP SESSION DATE	Changed Dataset
GROUP SESSION IDENTIFIER	Changed Dataset
GROUP SESSION TYPE (MENTAL HEALTH)	Changed Dataset
GROUP THERAPY INDICATOR	Changed Dataset
HOSPITAL PROVIDER SPELL NUMBER	Changed Dataset
INDIRECT ACTIVITY DATE	Changed Dataset
INDIRECT ACTIVITY TIME	Changed Dataset
INTENDED AGE GROUP (MENTAL HEALTH)	Changed Dataset
INTENDED CLINICAL CARE INTENSITY CODE (MENTAL HEALTH)	Changed Dataset
LANGUAGE CODE (PREFERRED)	Changed Dataset
LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)	Changed Dataset
LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)	Changed Dataset
LOCAL PATIENT IDENTIFIER (EXTENDED)	Changed Dataset
LOCKED WARD INDICATOR	Changed Dataset
LOOKED AFTER CHILD INDICATOR	Changed Dataset
MAIN SPECIALTY CODE (MENTAL HEALTH)	Changed Dataset
MANIFEST PSYCHOSIS DATE	Changed Dataset
MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON	Changed Dataset
MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY	Changed Dataset
MENTAL HEALTH ACT 2007 MENTAL CATEGORY	Changed Dataset
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON	Changed Dataset
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER	Changed Dataset
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON	Changed Dataset
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE	Changed Dataset
MENTAL HEALTH ADMITTED PATIENT CLASSIFICATION	Changed Dataset
MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE	Changed Dataset
MENTAL HEALTH CONDITIONAL DISCHARGE END REASON	Changed Dataset
MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE	Changed Dataset
MENTAL HEALTH DELAYED DISCHARGE REASON	Changed Dataset
MENTAL HEALTH LEAVE OF ABSENCE END REASON	Changed Dataset
NHS NUMBER	Changed Dataset
NHS NUMBER STATUS INDICATOR CODE	Changed Dataset
NHS SERVICE AGREEMENT LINE NUMBER	Changed Dataset
NUMBER OF GROUP SESSION PARTICIPANTS	Changed Dataset
OBSERVATION DATE (SUBSTANCE MISUSE EVIDENCE)	Changed Dataset
OBSERVATION SCHEME IN USE	Changed Dataset
OBSERVATION VALUE	Changed Dataset
OCCUPATION CODE	Changed Dataset
OFFENCE HISTORY INDICATION CODE	Changed Dataset
ONWARD REFERRAL DATE	Changed Dataset
ONWARD REFERRAL REASON	Changed Dataset
ONWARD REFERRAL TIME	Changed Dataset
ORGANISATION CODE (CODE OF COMMISSIONER)	Changed Dataset
ORGANISATION CODE (CODE OF PROVIDER)	Changed Dataset
ORGANISATION CODE (CODE OF SUBMITTING ORGANISATION)	Changed Dataset

ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT)	Changed Dataset
ORGANISATION CODE (GP PRACTICE RESPONSIBILITY)	Changed Dataset
ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)	Changed Dataset
ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)	Changed Dataset
ORGANISATION CODE (RECEIVING)	Changed Dataset
ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	Changed Dataset
ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	Changed Dataset
ORGANISATION IDENTIFIER (CODE OF PROVIDER)	Changed Dataset
ORGANISATION IDENTIFIER (CODE OF SUBMITTING ORGANISATION)	Changed Dataset
ORGANISATION IDENTIFIER (EDUCATIONAL ESTABLISHMENT)	Changed Dataset
ORGANISATION IDENTIFIER (GP PRACTICE RESPONSIBILITY)	Changed Dataset
ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)	Changed Dataset
ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)	Changed Dataset
ORGANISATION IDENTIFIER (RECEIVING)	Changed Dataset
ORGANISATION IDENTIFIER (REFERRING)	Changed Dataset, Description
ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	Changed Dataset
ORGANISATION IDENTIFIER (RESPONSIBLE LOCAL AUTHORITY MENTAL HEALTH DELAYED DISCHARGE)	New Data Element
ORGANISATION SITE IDENTIFIER (OF TREATMENT)	Changed Dataset
OTHER PERSON IN ATTENDANCE AT CARE CONTACT	Changed Dataset
OTHER REASON FOR REFERRAL (MENTAL HEALTH)	Changed Dataset
PATIENT PATHWAY IDENTIFIER	Changed Dataset
PERSON BIRTH DATE	Changed Dataset
PERSON DEATH DATE	Changed Dataset
PERSON MARITAL STATUS	Changed Dataset
PERSON SCORE	Changed Dataset
PERSON STATED GENDER CODE	Changed Dataset
PLACE OF SAFETY INDICATOR	Changed Dataset
PLANNED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)	Changed Dataset
PLANNED DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL)	Changed Dataset
POSTCODE OF DISCHARGE DESTINATION (HOSPITAL PROVIDER SPELL)	New Data Element
POSTCODE OF MAIN VISITOR	Changed Dataset
POSTCODE OF USUAL ADDRESS	Changed Dataset
PRESCRIPTION DATE (ASSISTIVE TECHNOLOGY)	Changed Dataset
PREVIOUS DIAGNOSIS (CODED CLINICAL ENTRY)	Changed Dataset
PRIMARY DATA COLLECTION SYSTEM IN USE	Changed Dataset
PRIMARY DIAGNOSIS (CODED CLINICAL ENTRY)	Changed Dataset
PRIMARY REASON FOR REFERRAL (MENTAL HEALTH)	Changed Dataset
PROCEDURE SCHEME IN USE	Changed Dataset
PRODROME PSYCHOSIS DATE	Changed Dataset
PROFESSIONAL REGISTRATION BODY CODE	Changed Dataset
PROFESSIONAL REGISTRATION ENTRY IDENTIFIER	Changed Dataset
PROVISIONAL DIAGNOSIS (CODED CLINICAL ENTRY)	Changed Dataset
PROVISIONAL DIAGNOSIS DATE	Changed Dataset
PSYCHOSIS FIRST TREATMENT START DATE	Changed Dataset
REASON FOR OUT OF AREA REFERRAL (ADULT ACUTE MENTAL HEALTH)	Changed Dataset, Description
REFERRAL CLOSURE DATE	Changed Dataset
REFERRAL CLOSURE REASON	Changed Dataset
REFERRAL CLOSURE TIME	Changed Dataset
REFERRAL REJECTION DATE	Changed Dataset
REFERRAL REJECTION REASON	Changed Dataset
REFERRAL REJECTION TIME	New Data Element
REFERRAL REQUEST RECEIVED DATE	Changed Dataset
REFERRAL REQUEST RECEIVED TIME	Changed Dataset
REFERRAL TO TREATMENT PERIOD END DATE	Changed Dataset
REFERRAL TO TREATMENT PERIOD START DATE	Changed Dataset
REFERRAL TO TREATMENT PERIOD STATUS	Changed Dataset
REFERRED OUT OF AREA REASON (ADULT ACUTE MENTAL HEALTH)	Changed Dataset
REFERRING CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH AND COMMUNITY CARE)	Changed Dataset
REFERRING ORGANISATION CODE	Changed Dataset
RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE	Changed Dataset
REPLACEMENT APPOINTMENT BOOKED DATE	Changed Dataset

REPLACEMENT APPOINTMENT DATE OFFERED	Changed Dataset
REPORTING PERIOD END DATE	Changed Dataset
REPORTING PERIOD START DATE	Changed Dataset
RESTRICTIVE INTERVENTION TYPE	Changed Dataset
SECONDARY DIAGNOSIS (CODED CLINICAL ENTRY)	Changed Dataset
SERVICE DISCHARGE DATE	Changed Dataset
SERVICE DISCHARGE TIME	Changed Dataset
SERVICE OR TEAM TYPE REFERRED TO (MENTAL HEALTH)	Changed Dataset
SERVICE REQUEST IDENTIFIER	Changed Dataset
SETTLED ACCOMMODATION INDICATOR	Changed Dataset
SEX OF PATIENTS CODE	Changed Dataset
SITE CODE (OF TREATMENT)	Changed Dataset
SNOMED CT EXPRESSION	New Data Element
SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT)	New Data Element
SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED DATE	New Data Element
SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL)	Changed Dataset
SOURCE OF REFERRAL FOR MENTAL HEALTH	Changed Dataset
SPECIALISED MENTAL HEALTH SERVICE CODE	New Data Element
START DATE (CARE CLUSTER ASSIGNMENT PERIOD)	Changed Dataset
START DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)	Changed Dataset
START DATE (CARE PROGRAMME APPROACH CARE)	Changed Dataset
START DATE (COMMISSIONER ASSIGNMENT PERIOD)	Changed Dataset
START DATE (COMMUNITY TREATMENT ORDER)	Changed Dataset
START DATE (COMMUNITY TREATMENT ORDER RECALL)	Changed Dataset
START DATE (GMP PATIENT REGISTRATION)	Changed Dataset
START DATE (HOME LEAVE)	Changed Dataset
START DATE (HOSPITAL PROVIDER SPELL)	Changed Dataset
START DATE (MENTAL HEALTH ABSENCE WITHOUT LEAVE)	Changed Dataset
START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)	Changed Dataset
START DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD)	Changed Dataset
START DATE (MENTAL HEALTH CONDITIONAL DISCHARGE)	Changed Dataset
START DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD)	Changed Dataset
START DATE (MENTAL HEALTH LEAVE OF ABSENCE)	Changed Dataset
START DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD)	Changed Dataset
START DATE (MENTAL HEALTH TRIAL LEAVE)	New Data Element
START DATE (WARD STAY)	Changed Dataset
START TIME (CARE CLUSTER ASSIGNMENT PERIOD)	Changed Dataset
START TIME (COMMUNITY TREATMENT ORDER RECALL)	Changed Dataset
START TIME (HOME LEAVE)	Changed Dataset
START TIME (HOSPITAL PROVIDER SPELL)	Changed Dataset
START TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE)	Changed Dataset
START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)	Changed Dataset
START TIME (MENTAL HEALTH LEAVE OF ABSENCE)	Changed Dataset
START TIME (MENTAL HEALTH TRIAL LEAVE)	New Data Element
START TIME (WARD STAY)	Changed Dataset
TREATMENT FUNCTION CODE (MENTAL HEALTH)	Changed Dataset
UCUM UNIT OF MEASUREMENT	Changed Dataset
WAITING TIME MEASUREMENT TYPE	Changed Dataset
WARD CODE	Changed Dataset
WARD SECURITY LEVEL	Changed Dataset
WARD SETTING TYPE (MENTAL HEALTH)	Changed Dataset
WARD STAY IDENTIFIER	Changed Dataset
WEEKLY HOURS WORKED	Changed Dataset
YOUNG CARER INDICATOR	Changed Dataset
<u>XML Schema Constraint</u>	
COMMISSIONING DATA SET VERSION 6-2 XML SCHEMA CONSTRAINTS	Changed Description

Date: 22 September 2017

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.

MENTAL HEALTH SERVICES DATA SET

Change to Data Set: Changed Dataset, Description

[Mental Health Services Data Set Overview](#)

The Mandatory or Required (M/R/P) column indicates the recommendation for the inclusion of data. For a "Full Screen" view, click [Mental Health Services Data Set](#).

In the "Full Screen" view, to return to the "Data Set" view, click the browser "back" button.

The Mandatory or Required (M/R/O/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
- O = Optional: the inclusion of this data element is optional as required for local purposes.
- 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](#). Note: items in the M/R/O/P column which are shown with notation P have **not** been approved by the [Data Coordination Board](#) 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/R/O/P	Data Set Data Elements
M	DATA SET VERSION NUMBER
M	ORGANISATION CODE (CODE OF PROVIDER)
M	ORGANISATION CODE (CODE OF SUBMITTING ORGANISATION)
M	ORGANISATION IDENTIFIER (CODE OF PROVIDER)
M	ORGANISATION IDENTIFIER (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/R/O/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)
M	ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)
R	ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)
R	ORGANISATION IDENTIFIER (EDUCATIONAL ESTABLISHMENT)
R	NHS NUMBER
R	NHS NUMBER STATUS INDICATOR CODE
R	PERSON BIRTH DATE
R	POSTCODE OF USUAL ADDRESS
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
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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/R/O/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)
R	ORGANISATION IDENTIFIER (GP PRACTICE RESPONSIBILITY)

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/R/O/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. One occurrence of this group is permitted, containing the most recently recorded employment details.	
M/R/P	Data Set-Data Elements
M/R/O/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. 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/R/O/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. One occurrence of this group is permitted for each Mental Health Care Coordinator assignment.	
M/R/P	Data Set-Data Elements
M/R/O/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 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
Disability Type: To carry the details of the type of disability affecting a person, based on formal diagnoses, the patient's perception or the perception of a patient proxy. One occurrence of this group is permitted for each disability identified.	
M/R/O/P	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	DISABILITY CODE
R	DISABILITY IMPACT PERCEPTION

M/R/P	Data Set-Data Elements
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/O/P	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	ASSISTIVE TECHNOLOGY FINDING (SNOMED CT)
R	PRESCRIPTION DATE (ASSISTIVE TECHNOLOGY)

M/R/P	Data Set-Data Elements
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/O/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 CREATION TIME
R	CARE PLAN LAST UPDATED DATE
R	CARE PLAN LAST UPDATED TIME
R	CARE PLAN IMPLEMENTATION DATE

M/R/P	Data Set-Data Elements
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/O/P	Data Set Data Elements
M	CARE PLAN IDENTIFIER
M	CARE PLAN AGREED BY
R	CARE PLAN AGREED DATE
R	CARE PLAN AGREED TIME

M/R/O/P	Data Set Data Elements
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/O/P	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	ASSISTIVE TECHNOLOGY FINDING (SNOMED CT)
R	PRESCRIPTION DATE (ASSISTIVE TECHNOLOGY)

M/R/O/P	Data Set Data Elements
Social and Personal Circumstances To carry details of social and personal circumstances of a person. One occurrence of this Group is permitted for each social and personal circumstance recorded.	
M/R/O/P	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT)
M	SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED DATE

REFERRALS

M/R/P	Data Set-Data Elements
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/O/P	Data Set Data Elements
M	SERVICE REQUEST IDENTIFIER
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	ORGANISATION CODE (CODE OF COMMISSIONER)

M	ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)
M	REFERRAL REQUEST RECEIVED DATE
R	REFERRAL REQUEST RECEIVED TIME
R	NHS SERVICE AGREEMENT LINE NUMBER
R	SPECIALISED MENTAL HEALTH SERVICE CODE
R	SOURCE OF REFERRAL FOR MENTAL HEALTH
R	REFERRING ORGANISATION CODE
R	ORGANISATION IDENTIFIER (REFERRING)
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 CREATION TIME
R	DISCHARGE PLAN LAST UPDATED DATE
R	DISCHARGE PLAN LAST UPDATED TIME
R	SERVICE DISCHARGE DATE
R	SERVICE DISCHARGE TIME
R	DISCHARGE LETTER ISSUED DATE (MENTAL HEALTH AND COMMUNITY CARE)

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/R/O/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
M/R/O/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 REJECTION TIME
R	REFERRAL CLOSURE REASON
R	REFERRAL REJECTION 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/R/O/P	Data Set Data Elements
M	SERVICE REQUEST IDENTIFIER
R	PATIENT PATHWAY IDENTIFIER
R	ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)
R	WAITING TIME MEASUREMENT TYPE
R	ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)
M	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. One occurrence of this group is permitted for each onward referral.	
M/R/P	Data Set Data Elements

M/R/O/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)
R	ORGANISATION IDENTIFIER (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/R/O/P	Data Set Data Elements
M	SERVICE REQUEST IDENTIFIER
R	DISCHARGE PLAN AGREED BY
M	DISCHARGE PLAN AGREED BY
R	DISCHARGE PLAN AGREED DATE
R	DISCHARGE PLAN AGREED TIME

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.
One occurrence of this group is permitted for each Care Contact.

M/R/P	Data Set Data Elements
M/R/O/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	ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)
R	ADMINISTRATIVE CATEGORY CODE
R	SPECIALISED MENTAL HEALTH SERVICE 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	ORGANISATION SITE IDENTIFIER (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.
One occurrence of this group is permitted for each Care Activity.

M/R/P	Data Set Data Elements
M/R/O/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	CODED PROCEDURE AND PROCEDURE STATUS (SNOMED CT)
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.
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/R/O/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.
One occurrence of this group is permitted for each instance of indirect activity taking place.

M/R/P	Data Set-Data Elements
M/R/O/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	ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)
R	CARE PROFESSIONAL LOCAL IDENTIFIER
R	PROCEDURE SCHEME IN USE
R	CODED PROCEDURE (CLINICAL TERMINOLOGY)
R	CODED PROCEDURE AND PROCEDURE STATUS (SNOMED CT)
R	FINDING SCHEME IN USE
R	CODED FINDING (CODED CLINICAL ENTRY)

GROUP SESSIONS

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/R/O/P	Data Set Data Elements
M	GROUP SESSION IDENTIFIER
M	GROUP SESSION DATE
M	ORGANISATION CODE (CODE OF COMMISSIONER)
M	ORGANISATION IDENTIFIER (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	ORGANISATION SITE IDENTIFIER (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 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/R/O/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. 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/R/O/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. One occurrence of this group is permitted for each conditional discharge.

M/R/P	Data Set-Data Elements
M/R/O/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, 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/R/O/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, 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/R/O/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. One occurrence of this group is permitted for each Hospital Provider Spell.	
M/R/P	Data Set-Data Elements
M/R/O/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	ESTIMATED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)
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)
R	POSTCODE OF DISCHARGE DESTINATION (HOSPITAL PROVIDER SPELL)

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/R/O/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 (MENTAL HEALTH TRIAL LEAVE)
R	END DATE (WARD STAY)
R	END TIME (WARD STAY)
R	SITE CODE (OF TREATMENT)
R	ORGANISATION SITE IDENTIFIER (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
R	SPECIALISED MENTAL HEALTH SERVICE CODE
O	WARD CODE

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/R/O/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. 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/R/O/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
R	ORGANISATION IDENTIFIER (RESPONSIBLE LOCAL AUTHORITY MENTAL HEALTH DELAYED DISCHARGE)

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/R/O/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 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/R/O/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.
One occurrence of this group is permitted whenever an incident of self-harm is reported.

M/R/P	Data Set-Data Elements
M/R/O/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.
One occurrence of this group is permitted whenever a period of home leave takes place.

M/R/P	Data Set-Data Elements
M/R/O/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.
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/R/O/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
R	ESCORTED MENTAL HEALTH LEAVE OF ABSENCE INDICATOR

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/R/O/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](#)

Mental Health Trial Leave:

To carry details of each separate period of Mental Health Trial Leave for the patient.
One occurrence of this Group is permitted whenever a period of Mental Health Trial Leave takes place.

M/R/O/P	Data Set Data Elements
M	WARD STAY IDENTIFIER
M	START DATE (MENTAL HEALTH TRIAL LEAVE)
R	START TIME (MENTAL HEALTH TRIAL LEAVE)
R	END DATE (MENTAL HEALTH TRIAL LEAVE)
R	END TIME (MENTAL HEALTH TRIAL LEAVE)

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/O/P	Data Set Data Elements
M	HOSPITAL PROVIDER SPELL NUMBER
M	ORGANISATION CODE (CODE OF COMMISSIONER)
M	ORGANISATION IDENTIFIER (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/O/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.
One occurrence of this group is permitted for each Previous Diagnosis.

M/R/O/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.
One occurrence of this group is permitted for each Provisional Diagnosis.

M/R/O/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 for the Primary Diagnosis.

M/R/O/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.
One occurrence of this group is permitted for each Secondary Diagnosis.

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

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.
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/R/O/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 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/R/O/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.
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/R/O/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)
R	ORGANISATION IDENTIFIER (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.
One occurrence of this group is required for each Care Programme Approach (CPA) care episode.

M/R/P	Data Set Data Elements
M/R/O/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.
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/R/O/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. One occurrence of this group is permitted for each Clustering Tool assessment that takes place.	
M/R/P	Data Set-Data Elements
M/R/O/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	LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)
P	FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)

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/R/O/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. 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/R/O/P	Data Set Data Elements
M	CLUSTERING TOOL ASSESSMENT IDENTIFIER
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)
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/R/O/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 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/R/O/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 \(JOB ROLE CODE\)](#)

CARE PLAN AGREED TIME

Change to Supporting Information: New Supporting Information

A [Care Plan Agreed Time](#) is an [ACTIVITY DATE TIME](#).

A [Care Plan Agreed Time](#) is the [TIME](#) 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 Times

CARE PLAN CREATION TIME

Change to Supporting Information: New Supporting Information

A [Care Plan Creation Time](#) is an [ACTIVITY DATE TIME](#).

A [Care Plan Creation Time](#) is the [TIME](#) that a [CARE PLAN](#) was created.

This supporting information is also known by these names:

Context	Alias
plural	Care Plan Creation Times

CARE PLAN LAST UPDATED TIME

Change to Supporting Information: New Supporting Information

A [Care Plan Last Updated Time](#) is an [ACTIVITY DATE TIME](#).

A [Care Plan Last Updated Time](#) is the [TIME](#) that a [CARE PLAN](#) was last updated.

This supporting information is also known by these names:

Context	Alias
plural	Care Plan Last Updated Times

CHILD OR YOUNG PERSON'S MENTAL HEALTH TRANSITION PLAN

Change to Supporting Information: New Supporting Information

A [Child or Young Person's Mental Health Transition Plan](#) is a [CARE PLAN](#).

A [Child or Young Person's Mental Health Transition Plan](#) is a joint-agency plan to prepare for transition out of a [Children and Young People's Mental Health Service \(CYPMHS\)](#) as a consequence of the [PATIENT's](#) age or change to care needs.

The purpose of a [Child or Young Person's Mental Health Transition Plan](#) is to prepare the [PATIENT](#), appropriate members of their support network (such as family/[Carers](#), with the [PATIENT's](#) agreement), and receiving [SERVICES](#) (including primary care) for transition out of a [Children and Young People's Mental Health Service](#).

The [Child or Young Person's Mental Health Transition Plan](#) must be agreed by both the sending and receiving [SERVICES](#), the [PATIENT](#) and appropriate members of their support network (with the [PATIENT's](#) agreement), at least 6 months prior to transition to:

- Agree [PATIENT](#) needs to inform the network of care around the [PATIENT](#) (such as parents/[Carers](#), and including the receiving [SERVICE](#))
- Support the [PATIENT](#) and their network of care to manage the process of transition
- Agree transition goals with the [PATIENT](#).

Note: where the [PATIENT](#) enters a [Children and Young People's Mental Health Service](#) less than 6 months prior to transitioning, the [Child or Young Person's Mental Health Transition Plan](#) must be agreed at least one month prior to transition.

A [Child or Young Person's Mental Health Transition Plan](#) may incorporate or be incorporated into a [Mental Health Care Plan](#) and/or a [Discharge Plan](#), and these multiple plans may also be brought into a single plan. However, the single plan must incorporate the requirements from the [Child or Young Person's Mental Health Transition Plan](#).

A [Child or Young Person's Mental Health Transition Plan](#) and a [Discharge Plan](#) may overlap, where the [PATIENT](#) is transitioning out of a [Children and Young People's Mental Health Service](#) into primary care or other [SERVICES](#) delivering mental health support (e.g. counselling at school or voluntary sector).

This supporting information is also known by these names:

Context	Alias
plural	Child or Young Person's Mental Health Transition Plans

CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH SERVICE

Change to Supporting Information: New Supporting Information

A [Children and Young People's Mental Health Service \(CYPMHS\)](#) is a [Mental Health Service](#).

A [Children and Young People's Mental Health Service](#) is a specialist [SERVICE](#) for children and young people who have a mental health problem.

The age range for a [Children and Young People's Mental Health Service](#) can vary depending on local commissioning arrangements.

This supporting information is also known by these names:

Context	Alias
shortname	CYPMHS
plural	Children and Young People's Mental Health Services

DATA COORDINATION BOARD

Change to Supporting Information: Changed Dataset

The [Data Coordination Board \(DCB\)](#) is an [Organisation](#).

The [Data Coordination Board](#) replaced the [Standardisation Committee for Care Information \(SCCI\)](#) on 1 April 2017.

The [Data Coordination Board](#) is one of three sub-groups of the Digital Delivery Board, the other two being the Enterprise Architecture Board and the Technology and Data Investment Board.

The [Data Coordination Board](#):

- has delegated authority from the Secretary of State to approve [Information Standards and Collections \(including Extractions\) \(ISCEs\)](#) for health and social care
- provides the authority to publish [Information Standards Notices \(ISN\)](#) under section 250 of the Health and Social Care Act 2012
- has responsibility for the approval of requests to change, deprecate and retire existing [Information Standards and Collections \(including Extractions\)](#)
- prioritises the progression of [Information Standards and Collections \(including Extractions\)](#)
- works to minimise the burden from [Data Collections](#), and maximise the benefit received from available data
- takes its membership from a wide range of national bodies and [Organisations](#) involved in the provision and management of health and social care services in England. This ensures a system-wide, joined-up approach to decision-making.

For further information on the [Data Coordination Board](#), see the [NHS Digital](#) website at: [Assurance and appraisal](#).

ESTIMATED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)

Change to Supporting Information: New Supporting Information

[Estimated Discharge Date \(Hospital Provider Spell\)](#) is a [PLANNED ACTIVITY DATE TIME](#).

[Estimated Discharge Date \(Hospital Provider Spell\)](#) is the [DATE](#) a [PATIENT](#) was estimated to be discharged from a [Hospital Provider Spell](#).

The [Estimated Discharge Date \(Hospital Provider Spell\)](#) is estimated at the point of admission to a [Hospital Provider Spell](#) and is different to the [Planned Discharge Date \(Hospital Provider Spell\)](#), which is set once the [PATIENT](#) has been confirmed for discharge.

This supporting information is also known by these names:

Context	Alias
plural	Estimated Discharge Dates (Hospital Provider Spell)

MENTAL HEALTH SERVICES DATA SET OVERVIEW

Change to Supporting Information: Changed Dataset, Description

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

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

All [ACTIVITY](#) relating to [PATIENTS](#) who receive specialist secondary [Mental Health Services](#) and have, or are thought to have:

- A mental illness
- A [Learning Disability](#)
- An [Autistic Spectrum Disorder](#)
- Any combination of mental health, [Learning Disability](#) or [Autistic Spectrum Disorder](#) needs

are within scope of the [Mental Health Services Data Set](#) is within scope of the [Mental Health Services Data Set](#).

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

For each [PATIENT](#):

- If the care is wholly funded by the NHS: the data submission for that [PATIENT](#) is mandatory
- If the care is partially funded by the NHS: the data submission for that [PATIENT](#) is mandatory
- If the care is wholly funded by any means that is not NHS: the data submission for that [PATIENT](#) is optional.

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

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

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

- NHS Mental Health Trusts
- NHS Learning Disabilities Trusts
- NHS Acute Trusts
- NHS [Care Trusts](#)
- [Independent Sector Healthcare Providers](#) offering a service model that includes NHS funded and non-NHS funded [PATIENTS](#)
- Any qualified provider offering specialist secondary mental health, [Learning Disability](#) or [Autistic Spectrum Disorder SERVICES](#).
- Any qualified provider offering specialist secondary mental health, [Learning Disability](#) or [Autistic Spectrum Disorder SERVICES](#)
- Community services offering secondary care to children.

Further information regarding the structure and submission of the [Mental Health Services Data Set](#) can be found on the [NHS Digital](#) website at: [Mental Health Services Data Set \(MHSDS\)](#).

MENTAL HEALTH TRIAL LEAVE

Change to Supporting Information: New Supporting Information

A [Mental Health Trial Leave](#) is a type of [LEAVE](#).

[Mental Health Trial Leave](#) occurs when a [PATIENT](#) using a secure [Hospital Bed](#) in a [WARD](#) spends a period of time in a less secure [Hospital Bed](#) in a different [WARD](#) on a trial basis.

For 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, [Mental Health Trial Leave](#) is granted through the use of [Mental Health Leave of Absence](#).

This supporting information is also known by these names:

Context	Alias
plural	Mental Health Trial Leaves

ORGANISATION

Change to Supporting Information: Changed Dataset

An [Organisation](#) is an [ORGANISATION](#).

An [Organisation](#) is a unique framework of authority within which a [PERSON](#) or [PERSONS](#) act, or are designated to act towards some purpose.

Note: this definition is adopted from the ISO (the International Organisation for Standardisation) and IEC (the International Electrotechnical Commission) standard ISO/IEC 6523-1:1998 which defines a structure for a globally unique and unambiguous identification of [Organisations](#) and [Organisation](#) parts. This is itself referenced by ISO 13940:2015 which defines the concepts needed to achieve continuity of care.

PLANNED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)

Change to Supporting Information: Changed Description

[Planned Discharge Date \(Hospital Provider Spell\)](#) is a [PLANNED ACTIVITY DATE TIME](#).

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

REFERRAL REJECTION DATE

Change to Supporting Information: Changed Description

A [Referral Rejection Date](#) is an [ACTIVITY DATE TIME](#).

A [Referral Rejection Date](#) is the date the [REFERRAL REQUEST](#) was rejected by a [SERVICE](#). A [Referral Rejection Date](#) is the [DATE](#) the [REFERRAL REQUEST](#) was rejected by a [SERVICE](#).

REFERRAL REJECTION TIME

Change to Supporting Information: New Supporting Information

A [Referral Rejection Time](#) is an [ACTIVITY DATE TIME](#).

A [Referral Rejection Time](#) is the [TIME](#) the [REFERRAL REQUEST](#) was rejected by a [SERVICE](#).

This supporting information is also known by these names:

Context	Alias
plural	Referral Rejection Times

STANDARDISATION COMMITTEE FOR CARE INFORMATION

Change to Supporting Information: Changed Dataset

The [Standardisation Committee for Care Information \(SCCI\)](#) closed on 31 March 2017.

Responsibility for the approval of Information Standards has transferred to the [Data Coordination Board \(DCB\)](#).

The following definition will remain in the NHS Data Model and Dictionary as it is relevant for Information Standards that were assured and approved by the [Standardisation Committee for Care Information](#) between 1 April 2014 and 31 March 2017.

The Standardisation Committee for Care Information replaced the Information Standards Board for Health and Social Care (ISB) on 1 April 2014.

The Standardisation Committee for Care Information:

- has delegated authority from the National Information Board (NIB) to accept Information Standards and Collections (including Extractions) (ISCEs) for health and social care
- is responsible for the need to change, deprecate and retire existing approved Information Standards and Collections (including Extractions) Notices
- takes its membership from a wide range of national bodies and Organisations involved in the provision and management of health and social care services in England. This ensures a system-wide, joined-up approach to decision-making

For further information on the Standardisation Committee for Care Information, see the NHS Digital website at: [Information Standards and Collections \(Including Extractions\) - National Governance](#).

LEAVE

Change to Class: Changed Attributes

Attributes of this Class are:

ESCORTED MENTAL HEALTH LEAVE OF ABSENCE INDICATOR
LEAVE TYPE
MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON
MENTAL HEALTH LEAVE OF ABSENCE END REASON

SERVICE PROVIDED UNDER AGREEMENT

Change to Class: Changed Attributes

Attributes of this Class are:

COMMISSIONED SERVICE CATEGORY CODE
LOCAL POINT OF DELIVERY DESCRIPTION
LOCAL POINT OF DELIVERY DESCRIPTION ADDITIONAL DETAIL
POINT OF DELIVERY CODE
SPECIALISED MENTAL HEALTH SERVICE CODE
SPECIALISED SERVICE CODE

ACCOMMODATION STATUS CODE

Change to Attribute: Changed Dataset

An indication of the type of accommodation that a [PATIENT](#) currently has. This should be based on the [PATIENT](#)'s main or permanent residence.

National Codes:

MA00 **Mainstream Housing**
MA01 Owner occupier
MA02 Settled mainstream housing with family/friends
MA03 Shared ownership scheme e.g. Social Homebuy Scheme (tenant purchase percentage of home value from landlord)
MA04 Tenant - [Local Authority](#)/Arms Length Management Organisation/Registered Landlord
MA05 Tenant - Housing Association
MA06 Tenant - private landlord
MA09 Other mainstream housing
HM00 **Homeless**
HM01 Rough sleeper
HM02 Squatting
HM03 Night shelter/emergency hostel/Direct access hostel (temporary accommodation accepting self referrals, no waiting list and relatively frequent vacancies)
HM04 Sofa surfing (sleeps on different friends floor each night)
HM05 Placed in temporary accommodation by [Local Authority](#) (including Homelessness resettlement service) e.g. Bed and Breakfast accommodation
HM06 Staying with friends/family as a short term guest
HM07 Other homeless
MH00 **Accommodation with mental health care support**
MH01 Supported accommodation (accommodation supported by staff or resident caretaker)
MH02 Supported lodgings (lodgings supported by staff or resident caretaker)
MH03 Supported group home (supported by staff or resident caretaker)
MH04 Mental Health Registered [Care Home](#)

MH09	Other accommodation with mental health care and support
HS00	Acute/long stay healthcare residential facility/hospital
HS01	NHS acute psychiatric ward
HS02	Independent hospital/clinic
HS03	Specialist rehabilitation/recovery
HS04	Secure psychiatric unit
HS05	Other NHS facilities/hospital
HS09	Other acute/long stay healthcare residential facility/hospital
CH00	Accommodation with other (not specialist mental health) care support
CH01	Foyer - accommodation for young people aged 16-25 who are homeless or in housing need
CH02	Refuge
CH03	Non-Mental Health Registered Care Home
CH09	Other accommodation with care and support (not specialist mental health)
CJ00	Accommodation with criminal justice support
CJ01	Bail/Probation hostel
CJ02	Prison
CJ03	Young Offenders Institute
CJ04	Detention Centre
CJ09	Other accommodation with criminal justice support such as ex-offender support
SH00	Sheltered Housing (accommodation with a scheme manager or warden living on the premises or nearby, contactable by an alarm system if necessary)
SH01	Sheltered housing for older persons
SH02	Extra care sheltered housing (also known as 'very sheltered housing'. For people who are less able to manage on their own, but who do need an extra level of care. Services offered vary between schemes, but meals and some personal care are often provided.)
SH03	Nursing Home for older persons
SH09	Other sheltered housing
ML00	Mobile accommodation
	Other
OC96	Not elsewhere classified

ACTIVITY DATE

Change to Attribute: Changed Dataset

Any [DATE](#) that is of relevance to an [ACTIVITY](#).

The specific nature of the [DATE](#) will be identified by the [ACTIVITY DATE TYPE](#).

ACTIVITY IDENTIFIER

Change to Attribute: Changed Dataset

A unique number or set of characters that is applicable to only one [ACTIVITY](#) for a [PATIENT](#) within an [Organisation](#).

ACTIVITY LOCATION TYPE CODE

Change to Attribute: Changed Dataset

The type of [LOCATION](#) for an [ACTIVITY](#):

- where [PATIENTS](#) are seen
- where [SERVICES](#) are provided or
- from which requests for [SERVICES](#) are sent.

National Codes:

CODE	VALUE	NOTES
	PATIENT Main Residence or Related Location	
A01	PATIENT 's Home	
A02	Carer 's Home	
A03	PATIENT 's Workplace	
A04	Other PATIENT Related Location	E.g. temporary address
	Health Centre Premises	
B01	Primary Care Health Centre	

		Primary Care Health Centre with or without GP Practice(s) based in it, providing community-based healthcare services such as podiatry, community dentistry, ophthalmology, minor injuries nursing etc, Sexual and Reproductive Health Service , health promotion etc, and sometimes hosting outreach services from NHS Trusts and NHS Foundation Trusts
B02	Polyclinic	Provide similar services to Primary Care Health Centre but also additional services such as diagnostics, minor procedures, Out-Patient Appointments , urgent care etc. and also co-located services with Local Authority Social Care. May also provide extended/out of hours services.
GENERAL PRACTITIONER and OPHTHALMIC MEDICAL PRACTITIONER		
C01	General Medical Practitioner Practice	Stand-alone GP Practice premises, not part of a Primary Care Health Centre
C02	Dental Practice	Stand-alone GP Practice premises, not part of a Primary Care Health Centre
C03	OPHTHALMIC MEDICAL PRACTITIONER Premises	
Walk In Centres, Out of Hours Premises and Emergency Community Dental Services		
D01	Walk In Centre	May be NHS GENERAL PRACTITIONER Led, NURSE -led, or provided by private company. May be sited in different areas - health care premises, in retail premises etc
D02	Out of Hours Centre	May be NHS GENERAL PRACTITIONER -Led, NURSE -led, or provided by private company. May be sited in different areas - health care premises, in retail premises etc
D03	Emergency Community Dental Service	Run by Community Dental Services not GENERAL DENTAL PRACTITIONERS
Locations on Hospital Premises		
E01	Out-Patient Clinic	
E02	WARD	
E03	Day Hospital	
E04	Accident and Emergency or Minor Injuries Department	
E99	Other Departments	E.g. Pathology Laboratories , physiotherapy, diagnostic imaging, Occupational Therapy, Pharmacy Premises etc
Hospice Premises		
F01	Hospice	
Nursing and Residential Homes		
G01	Care Home Without Nursing	
G02	Care Home With Nursing	
G03	Children's Home	
G04	Integrated Care Home Without Nursing and Care Home With Nursing *	
Day Centre Premises		
H01	Day Centre	Facilities operated by the NHS, Social Services or private or voluntary bodies, providing day care and respite care for elderly or disabled people
Resource Centre Premises		
J01	Resource Centre	Premises where information and support for PATIENTS and their families/ Carers is provided.
Dedicated Facilities for Children and Families		
K01	Sure Start Children's Centre	Children's centres are service hubs where children under five years old and their families can receive seamless integrated services and information. Services vary according to centre but may include: <ul style="list-style-type: none"> • Integrated early education and childcare • Support for parents including advice on parenting, local childcare options and access to specialist services for families • Child and family health services • Helping parents into work
K02	Child Development Centre	
Educational, Childcare and Training Establishments		
L01	School	Including Extended Services, where provided on School premises (where provided off School premises, use other appropriate location)
L02	Further Education College	
L03	University	
L04	Nursery Premises	Pre-school Nurseries attached to Schools would be classed as Schools in their own right

L05	Other Childcare Premises	E.g. Childminder
L06	Training Establishments	
L99	Other Educational Premises	Such as Teenage Pregnancy Units, School Preparation Units (for toddlers), Pupil Referral Units (excluded older children and young people), units providing specialist education e.g. deaf children, autistic children etc
Justice and Home Office Premises		
M01	Prison	
M02	Probation Service Premises	
M03	Police Station / Police Custody Suite	
M04	Young Offenders Institute	
M05	Immigration Removal Centre	
Public Locations		
N01	Street or other public open space	Public areas such as streets, parks, outdoor sports facilities etc
N02	Other publicly accessible area or building	Publicly accessible premises such as Youth Centres, supermarkets, shops and other retail locations such as shopping centres, community facilities such as libraries, church halls, community centres etc
N03	Voluntary or charitable agency premises	
N04	Dispensing Optician Premises	
N05	Dispensing Pharmacy Premises	Where it is not on a Hospital Site
Other Locations		
X01	Other locations not elsewhere classified	

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

ACTIVITY TIME

Change to Attribute: Changed Dataset

Any [TIME](#) that is of relevance to an [ACTIVITY](#).

The specific nature of the [TIME](#) will be identified by the [ACTIVITY TIME TYPE](#).

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](#)
- 73 [Service Discharge Time](#)
- 74 [Referral Closure Time](#)
- 75 [Onward Referral Time](#)
- 76 [Emergency Care Arrival Time](#)
- 77 [Emergency Care Initial Assessment Time](#)
- 78 [Emergency Care Time Seen For Treatment](#)
- 79 [Emergency Care Attendance Conclusion Time](#)
- 80 [Emergency Care Departure Time](#)
- 81 [Injury Time](#)
- 82 [Referred To Service Assessment Time](#)
- 83 [Procedure Time](#)
- [Care Plan Agreed Time](#)
- [Care Plan Creation Time](#)
- [Care Plan Last Updated Time](#)
- [Referral Rejection Time](#)

Note: This list is not in alphabetical order.

ADMINISTRATIVE CATEGORY CODE

Change to Attribute: Changed Dataset

This is recorded for [PATIENT ACTIVITY](#).

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

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

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

The category 'amenity [PATIENT](#)' is only applicable to [PATIENTS](#) using a [Hospital Bed](#).

National Codes:

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

ADMISSION METHOD

Change to Attribute: Changed Dataset

The method of admission to a [Hospital Provider Spell](#).

Note: see [ELECTIVE ADMISSION TYPE](#) for a full definition of [Elective Admission](#).

National Codes:

[Elective Admission](#), when the [DECISION TO ADMIT](#) could be separated in time from the actual admission:

- 11 Waiting list
- 12 Booked
- 13 Planned

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

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

- 21 Accident and emergency or dental casualty department of the [Health Care Provider](#)

- 22 [GENERAL PRACTITIONER](#): after a request for immediate admission has been made direct to a [Hospital Provider](#), i.e. not through a Bed bureau, by a [GENERAL PRACTITIONER](#) or deputy
- 23 Bed bureau
- 24 [Consultant Clinic](#), of this or another [Health Care Provider](#)
- 25 Admission via Mental Health Crisis Resolution Team
- 2A [Accident and Emergency Department](#) of another provider where the [PATIENT](#) had not been admitted *
- 2B Transfer of an admitted [PATIENT](#) from another [Hospital Provider](#) in an emergency *
- 2C Baby born at home as intended *
- 2D Other emergency admission *
- 28 Other means, examples are: **
 - admitted from the [Accident and Emergency Department](#) of another provider where they had not been admitted
 - transfer of an admitted [PATIENT](#) from another [Hospital Provider](#) in an emergency
 - baby born at home as intended

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

- 31 Admitted ante-partum
- 32 Admitted post-partum

Other Admission not specified above

- 82 The birth of a baby in this [Health Care Provider](#)
- 83 Baby born outside the [Health Care Provider](#) except when born at home as intended.
- 81 Transfer of any admitted [PATIENT](#) from other [Hospital Provider](#) other than in an emergency

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

* Note - National Codes 2A, 2B, 2C and 2D have been introduced to replace National Code 28 'Other means'. National Code 28 will be retired in the next version of the Commissioning Data Set.

** Note - National Code 28 is **NOT** valid for use in the [Mental Health Services Data Set](#).

ADULT MENTAL HEALTH CARE CLUSTER CODE

Change to Attribute: Changed Dataset

The [Adult Mental Health Care Cluster](#) assigned to a [PATIENT](#).

National Codes:

- 00 Care Cluster 0 - Variance (unable to assign [ADULT MENTAL HEALTH CARE CLUSTER CODE](#))
- 01 Care Cluster 1 - Common Mental Health Problems (Low Severity)
- 02 Care Cluster 2 - Common Mental Health Problems (Low Severity with Greater Need)
- 03 Care Cluster 3 - Non-Psychotic (Moderate Severity)
- 04 Care Cluster 4 - Non-Psychotic (Severe)
- 05 Care Cluster 5 - Non-Psychotic Disorders (Very Severe)
- 06 Care Cluster 6 - Non-Psychotic Disorder of Over-Valued Ideas
- 07 Care Cluster 7 - Enduring Non-Psychotic Disorders (High Disability)
- 08 Care Cluster 8 - Non-Psychotic Chaotic and Challenging Disorders
- 09 Care Cluster 9 - Cluster Under Review - Note: This [CARE CLUSTER](#) is under review and should not be used.
- 10 Care Cluster 10 - First Episode Psychosis
- 11 Care Cluster 11 - Ongoing Recurrent Psychosis (Low Symptoms)
- 12 Care Cluster 12 - Ongoing or Recurrent Psychosis (High Disability)
- 13 Care Cluster 13 - Ongoing or Recurrent Psychosis (High Symptoms and Disability)
- 14 Care Cluster 14 - Psychotic Crisis
- 15 Care Cluster 15 - Severe Psychotic Depression
- 16 Care Cluster 16 - Dual Diagnosis
- 17 Care Cluster 17 - Psychosis and Affective Disorder (Difficult to Engage)
- 18 Care Cluster 18 - Cognitive Impairment (Low Need)
- 19 Care Cluster 19 - Cognitive Impairment or Dementia Complicated (Moderate Need)
- 20 Care Cluster 20 - Cognitive Impairment or Dementia Complicated (High Need)
- 21 Care Cluster 21 - Cognitive Impairment or Dementia Complicated (High Physical or Engagement)

AGE GROUP INTENDED FOR MENTAL HEALTH

Change to Attribute: Changed Dataset

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

APPOINTMENT DATE OFFERED

Change to Attribute: Changed Dataset

The actual date offered for an [APPOINTMENT](#) in response to a [SERVICE REQUEST](#) or an invitation as part of a [HEALTH PROGRAMME](#).

ATTENDED OR DID NOT ATTEND

Change to Attribute: Changed Dataset

An indication of whether an [APPOINTMENT](#) for a [CARE CONTACT](#) took place.

If the [APPOINTMENT](#) did not take place it also indicates if advance warning was given.

When an [APPOINTMENT](#) is cancelled the [APPOINTMENT CANCELLED DATE](#) should also be recorded.

National Codes:

- 5 Attended on time or, if late, before the relevant [CARE PROFESSIONAL](#) was ready to see the [PATIENT](#)
- 6 Arrived late, after the relevant [CARE PROFESSIONAL](#) was ready to see the [PATIENT](#), but was seen
- 7 [PATIENT](#) arrived late and could not be seen
- 2 [APPOINTMENT](#) cancelled by, or on behalf of, the [PATIENT](#)
- 3 Did not attend - no advance warning given
- 4 [APPOINTMENT](#) cancelled or postponed by the [Health Care Provider](#)
- 0 Not applicable - [APPOINTMENT](#) occurs in the future *

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

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

- [Community Services Data Set](#)
- [Improving Access to Psychological Therapies Data Set](#)
- [Mental Health Services Data Set](#)

Use in the Future Outpatient Commissioning Data Set:

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

CARE CONTACT CANCELLATION REASON

Change to Attribute: Changed Dataset

The reason a [CARE CONTACT](#) was cancelled.

National Codes:

- 01 Cancelled for Clinical Reasons
- 02 Cancelled for Non-clinical Reasons

CARE CONTACT SUBJECT

Change to Attribute: Changed Dataset

The [PERSON](#) who was the subject of the [CARE CONTACT](#).

National Codes:

- 01 [PATIENT](#)
- 02 [Patient Proxy](#)

CARE PLAN AGREED BY

Change to Attribute: Changed Dataset

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

CARE PLAN IDENTIFIER

Change to Attribute: Changed Dataset

A unique identifier for a [CARE PLAN](#).

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 (Retired 01 September 2015)
- 05 [Antenatal Care Plan](#)
- 06 [Birth Care Plan](#)
- 07 [Postpartum Care Plan](#)
- 08 [Education, Health and Care Plan \(EHC\)](#)
- 09 [Discharge Plan](#)
- 10 [Mental Health Care Plan](#)
- 11 [Positive Behaviour Support Plan](#)
- 12 [Urgent and Emergency Mental Health Care Plan](#)
[Child or Young Person's Mental Health Transition Plan](#)

CARE PLAN TYPE FOR MENTAL HEALTH

Change to Attribute: Changed Dataset, Description

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](#)
- 14 [Child or Young Person's Mental Health Transition Plan](#)

CARE PROFESSIONAL IDENTIFIER

Change to Attribute: Changed Dataset

A number or set of characters which uniquely identifies a [CARE PROFESSIONAL](#).

CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH

Change to Attribute: Changed Dataset

The staff group of a [CARE PROFESSIONAL](#) working in a [Mental Health Service](#).

National Codes:

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

CARE PROFESSIONAL TEAM IDENTIFIER

Change to Attribute: Changed Dataset

A unique identifier for a [CARE PROFESSIONAL TEAM](#).

CARE PROGRAMME APPROACH REVIEW ABUSE QUESTION ASKED INDICATOR

Change to Attribute: Changed Dataset

An indication of whether the [PATIENT](#) was asked the Abuse Question during a [Care Programme Approach Review](#).

National Codes:

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

CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE

Change to Attribute: Changed Dataset, Description

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
NEU	Getting Advice: Neurodevelopmental Assessment (Retired 1 April 2018)
ADV	Getting Advice: Signposting and Self-management Advice (Retired 1 April 2018)
ADH	Getting Help: Attention Deficit Hyperactivity Disorder (ADHD) (Retired 1 April 2018)
AUT	Getting Help: Autism Spectrum (Retired 1 April 2018)
BEH	Getting Help: Behavioural and/or Conduct Disorders (Retired 1 April 2018)
BIP	Getting Help: Bipolar Disorder (Retired 1 April 2018)
DEP	Getting Help: Depression (Retired 1 April 2018)
GAP	Getting Help: Generalised Anxiety Disorder (GAD) and/or Panic Disorder (Retired 1 April 2018)
OCD	Getting Help: Obsessive compulsive disorder (OCD) (Retired 1 April 2018)
PTS	Getting Help: Post-traumatic stress disorder (PTSD) (Retired 1 April 2018)
SHA	Getting Help: Self-harm (Retired 1 April 2018)
SOC	Getting Help: Social Anxiety Disorder (Retired 1 April 2018)
BEM	Getting Help: Co-occurring Behavioural and Emotional Difficulties (Retired 1 April 2018)
EMO	Getting Help: Co-occurring Emotional Difficulties (Retired 1 April 2018)
DNC	Getting Help: Difficulties Not Covered by Other Groupings (Retired 1 April 2018)
EAT	Getting More Help: Eating Disorders (Retired 1 April 2018)
PBP	Getting More Help: Presentation Suggestive of Potential Borderline Personality Disorder (BPD) (Retired 1 April 2018)
PSY	Getting More Help: Psychosis (Retired 1 April 2018)
DSI	Getting More Help: Difficulties of Severe Impact (Retired 1 April 2018)
10	Getting Advice: Neurodevelopmental Assessment (NEU)
11	Getting Advice: Signposting and Self-management Advice (ADV)
12	Getting Help: Attention Deficit Hyperactivity Disorder (ADHD)
13	Getting Help: Autism Spectrum (AUT)
14	Getting Help: Behavioural and/or Conduct Disorders (BEH)
15	Getting Help: Bipolar Disorder (BIP)
16	Getting Help: Depression (DEP)
17	Getting Help: Generalised Anxiety Disorder and/or Panic Disorder (GAP)
18	Getting Help: Obsessive compulsive disorder (OCD)
19	Getting Help: Post-traumatic stress disorder (PTS)
20	Getting Help: Self-harm (SHA)
21	Getting Help: Social Anxiety Disorder (SOC)
22	Getting Help: Co-occurring Behavioural and Emotional Difficulties (BEM)
23	Getting Help: Co-occurring Emotional Difficulties (EMO)
24	Getting Help: Difficulties Not Covered by Other Groupings (DNC)
25	Getting More Help: Eating Disorders (EAT)
26	Getting More Help: Presentation Suggestive of Potential Borderline Personality Disorder (PBP)
27	Getting More Help: Psychosis (PSY)
28	Getting More Help: Difficulties of Severe Impact (DSI)

CHILD AND ADOLESCENT MENTAL HEALTH TIER OF SERVICE

Change to Attribute: Changed Dataset

The tier of [SERVICE](#) the Child and Adolescent Mental Health Care Team operates at for a [PATIENT](#).

National Codes:

- 1 **Tier 1** - Primary Care [SERVICES](#) who have first and regular contact with [PATIENTS](#) and families, such as [GENERAL MEDICAL PRACTITIONERS](#), [Health Visitors](#), [School Nurses](#), community health facilities and other primary care resources.
- 2 **Tier 2** - Child and Adolescent Mental Health Services delivered by an individual [CARE PROFESSIONAL](#), attached to a single agency, working directly with a child, adolescent or family.
- 3 **Tier 3** - Multi-disciplinary and/or multi-agency teams provide delivery of the most appropriate intervention for a child, adolescent or family.
- 4 **Tier 4** - Inpatient services for children and adolescents, usually delivered within a Hospital or specialist inpatient clinic.

CHILD PROTECTION PLAN INDICATION CODE

Change to Attribute: Changed Dataset

An indication of whether a [PERSON](#) is, or has previously been, subject to a [Child Protection Plan](#).

National Codes:

- 1 Has never been subject to a [Child Protection Plan](#)
- 2 Has previously been subject to a [Child Protection Plan](#)
- 3 Is currently subject to a [Child Protection Plan](#)

CLINICAL CARE INTENSITY

Change to Attribute: Changed Dataset

The level of resources and intensity of care which it is intended to provide or is provided in a particular [WARD](#).

National Codes:

For [PATIENTS](#) with mental illness

- 51 for intensive care: specially designated ward for [PATIENTS](#) needing containment and more intensive management. This is not to be confused with intensive nursing where [PATIENTS](#) may require one to one nursing while on a standard [WARD](#)
- 52 for short stay: [PATIENTS](#) intended to stay less than a year
- 53 for long stay: [PATIENTS](#) intended to stay a year or more

For [PATIENTS](#) with [Learning Disabilities](#)

- 61 designated or interim secure unit
- 62 [PATIENTS](#) intending to stay less than a year
- 63 [PATIENTS](#) intending to stay a year or more

For maternity [PATIENTS](#)

- 41 only for [PATIENTS](#) looked after by [CONSULTANTS](#)
- 43 only for [PATIENTS](#) looked after by [GENERAL MEDICAL PRACTITIONERS](#)
- 42 for joint use by [CONSULTANTS](#) & [GENERAL MEDICAL PRACTITIONERS](#)

For neonates

- 33 maternity: associated with the maternity [WARD](#) in that cots are in the maternity [WARD](#) nursery or in the [WARD](#) itself
- 32 non-maternity: not associated with the maternity [WARD](#) and without designated cots for intensive care
- 31 not associated with the maternity [WARD](#) and in which there are some designated cots for intensive care

For the younger physically disabled

- 21 spinal units, only those units which are nationally recognised
- 22 other units

For terminally ill/[Palliative Care](#)

- 81 terminally ill/[Palliative Care](#)

For general [PATIENTS](#)

- 11 for intensive therapy, including high dependency care
- 12 for normal therapy: where resources permit the admission of [PATIENTS](#) who might need all but intensive or high dependency therapy
- 13 for limited therapy: where nursing care rather than continuous medical care is provided. Such [WARDS](#) can be used only for [PATIENTS](#) carefully selected and restricted to a narrow range in terms of the extent and nature of disease

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

CLINICAL CLASSIFICATION CODE

Change to Attribute: Changed Dataset

A unique clinical classification identifier for a [CODED CLINICAL ENTRY](#).

This could be [OPCS Classification of Interventions and Procedures \(OPCS-4\)](#) codes or [International Classification of Diseases \(ICD\)](#) codes.

See [Clinical Coding](#) for further information about the types of [CODED CLINICAL ENTRIES](#).

CLINICAL RESPONSE PRIORITY TYPE

Change to Attribute: Changed Dataset

The clinical response priority of a [SERVICE REQUEST](#).

National Codes:

- 1 Emergency
- 2 Urgent/serious
- 3 Routine

CLINICAL TERMINOLOGY CODE

Change to Attribute: Changed Dataset

A unique clinical terminology identifier for a [CODED CLINICAL ENTRY](#).

This could be [Read Coded Clinical Terms](#), [SNOMED CT](#) concepts or defined in the [National Interim Clinical Imaging Procedure Code Set](#).

See [Clinical Coding](#) for further information about the types of [CODED CLINICAL ENTRIES](#).

Note: [SNOMED CT](#) is the Information Standard for clinical terminology for use within the NHS; it is planned that in time this will be the only terminology used by the NHS.

CLUSTERING TOOL ASSESSMENT CATEGORY

Change to Attribute: Changed Dataset

The category of the [Clustering Tool](#) assessment completed.

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 (Retired 01 April 2017)
 - 03 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](#)
-

CLUSTERING TOOL ASSESSMENT REASON

Change to Attribute: Changed Dataset, Description

The reason that a [Clustering Tool](#) assessment for a [PATIENT](#) was undertaken.

National Codes:

- 10 Initial assessment
 - 11 Scheduled re-assessment
 - 12 Re-assessment following significant unanticipated change in need
 - ~~97 Other Reason~~
 - 97 [Other Reason \(not listed\)](#)
-

COMMUNITY TREATMENT ORDER END REASON

Change to Attribute: Changed Dataset

The reason for the termination of a [Community Treatment Order](#).

National Codes:

- 01 [PATIENT](#) discharged
 - 02 [Community Treatment Order](#) revoked
 - 03 [PATIENT](#) died
 - 04 [PATIENT](#) transferred outside England
 - 05 [PATIENT](#) transferred to another [Health Care Provider](#)
-

CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR

Change to Attribute: Changed Dataset

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

National Codes:

- Y Yes - [PERSON](#) requires constant care and/or supervision
- N No - [PERSON](#) does not require constant care and/or supervision

CONSULTATION MEDIUM USED

Change to Attribute: Changed Dataset

[CONSULTATION MEDIUM USED](#) identifies the communication mechanism used to relay information between the [CARE PROFESSIONAL](#) and the [PERSON](#) who is the subject of the consultation, during a [CARE ACTIVITY](#).

The telephone or telemedicine consultation should directly support diagnosis and care planning and must replace a face to face [Out-Patient Attendance Consultant](#), [Clinic Attendance Nurse](#) or [Clinic Attendance Midwife](#), types of [CARE ACTIVITY](#). A record of the telephone or telemedicine consultation must be retained in the [PATIENT](#)'s records.

Telephone contacts solely for informing [PATIENTS](#) of results are excluded.

National Codes:

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

Notes:

- * National Code 98 'Other' is **only** used for the [Community Services Data Set](#), [Mental Health Services Data Set](#) and [Sexual and Reproductive Health Activity Data Set](#). It is **NOT** valid in any other data set including Commissioning Data Set version 6-2.
- ** National Codes 05 'Email' and 06 'Short Message Service (SMS) - Text Messaging' are **NOT** valid for Commissioning Data Set version 6-2.
- ** National Code 06 'Short Message Service (SMS) - Text Messaging' is **NOT** valid for the [HIV and AIDS Reporting Data Set](#).

CONSULTATION TYPE

Change to Attribute: Changed Dataset

The type of consultation between the [CARE PROFESSIONAL](#) and the [PATIENT](#).

National Codes:

- 01 Initial Consultation
- 02 Follow-up Consultation

DECISION TO REFER DATE

Change to Attribute: Changed Dataset

The date 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](#).

DECISION TO REFER TIME

Change to Attribute: Changed Dataset

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](#).

DIAGNOSIS SCHEME IN USE

Change to Attribute: Changed Dataset

The type of [CODED CLINICAL ENTRY](#) used for the [PATIENT DIAGNOSIS](#).

National Codes:

- 01 Accident & Emergency Diagnosis ***
- 02 [ICD-10](#)

- 03 Read Code 4Byte Version (retired 1 October 2009)
- 04 [Read Coded Clinical Terms](#) Version 2
- 05 [Read Coded Clinical Terms](#) Version 3 (CTV3) *
- 06 [SNOMED CT](#) **

Notes:

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

DISABILITY CODE

Change to Attribute: Changed Dataset

The [DISABILITY](#) of a [PERSON](#).

This could be where:

- the [PERSON](#) has been diagnosed as disabled or
- the [PERSON](#) considers themselves to be disabled.

A [PERSON](#) can have more than one [DISABILITY CODE](#).

National Codes:

- 01 Behaviour and Emotional
- 02 Hearing
- 03 Manual Dexterity
- 04 Memory or ability to concentrate, learn or understand ([Learning Disability](#))
- 05 Mobility and Gross Motor
- 06 Perception of Physical Danger
- 07 Personal, Self Care and Continence
- 08 Progressive Conditions and Physical Health (such as HIV, cancer, multiple sclerosis, fits etc)
- 09 Sight
- 10 Speech
- XX Other
- NN No [DISABILITY](#)
- ZZ Not Stated ([PERSON](#) asked but declined to provide a response)

DISABILITY IMPACT PERCEPTION

Change to Attribute: Changed Dataset

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

National Codes:

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

DISCHARGE DESTINATION

Change to Attribute: Changed Dataset

The destination of a [PATIENT](#) on completion of a [Hospital Provider Spell](#), or a note that the [PATIENT](#) died or was a still birth.

National Codes:

- 19 Usual place of residence unless listed below, for example, a private dwelling whether owner occupied or owned by [Local Authority](#), housing association or other landlord. This includes warden accommodation but not residential accommodation where health care is provided. It also includes [PATIENTS](#) with no fixed abode.
- 29 Temporary place of residence when usually resident elsewhere (includes hotel, residential [Educational Establishment](#))
- 30 Repatriation from high security psychiatric accommodation in an NHS [Hospital Provider](#) ([NHS Trust](#) or [NHS Foundation Trust](#))
- 37 [Court](#)
- 38 Penal establishment or police station

- 48 High Security Psychiatric Hospital, Scotland
- 49 NHS other [Hospital Provider](#) - high security psychiatric accommodation
- 50 NHS other [Hospital Provider](#) - medium secure unit
- 51 NHS other [Hospital Provider](#) - [WARD](#) for general [PATIENTS](#) or the younger physically disabled
- 52 NHS other [Hospital Provider](#) - [WARD](#) for maternity [PATIENTS](#) or [Neonates](#)
- 53 NHS other [Hospital Provider](#) - [WARD](#) for [PATIENTS](#) who are mentally ill or have [Learning Disabilities](#)
- 54 NHS run [Care Home](#)
- 65 [Local Authority](#) residential accommodation i.e. where care is provided
- 66 [Local Authority](#) foster care
- 79 Not applicable - [PATIENT](#) died or still birth
- 84 Non-NHS run hospital - medium secure unit
- 85 Non-NHS (other than [Local Authority](#)) run [Care Home](#)
- 87 Non-NHS run hospital
- 88 Non-NHS (other than [Local Authority](#)) run [Hospice](#)

DISCHARGE METHOD

Change to Attribute: Changed Dataset

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: Changed Dataset

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](#)

EMPLOYMENT STATUS

Change to Attribute: Changed Dataset

The current [EMPLOYMENT](#) status of a [PERSON](#).

National Codes:

- 01 Employed
- 02 Unemployed and Seeking Work
- 03 Students who are undertaking full (at least 16 hours per week) or part-time (less than 16 hours per week) education or training and who are not working or actively seeking work
- 04 Long-term sick or disabled, those who are receiving Incapacity Benefit, Income Support or both; or Employment and Support Allowance
- 05 Homemaker looking after the family or home and who are not working or actively seeking work
- 06 Not receiving benefits and who are not working or actively seeking work

- 07 Unpaid voluntary work who are not working or actively seeking work
- 08 Retired
- ZZ Not Stated ([PERSON](#) asked but declined to provide a response)

ESCORTED MENTAL HEALTH LEAVE OF ABSENCE INDICATOR

Change to Attribute: New Attribute

An indication of whether a period of [Mental Health Leave of Absence](#) is escorted.

Note: this is where the [Mental Health Responsible Clinician](#) directs that the [PATIENT](#) remains during their absence in the custody of one of:

- any officer on the staff of the hospital
- any other [PERSON](#) authorised in writing by the managers of the hospital
- if the [PATIENT](#) is required in accordance with conditions imposed on the grant of leave of absence to reside in another hospital, any officer on the staff of that other hospital.

For further information, see the legislation.gov.uk website at: [Leave of absence from hospital](#).

National Codes:

- Y Yes - a period of [Mental Health Leave of Absence](#) is escorted
- N No - a period of [Mental Health Leave of Absence](#) is not escorted

This attribute is also known by these names:

Context	Alias
plural	ESCORTED MENTAL HEALTH LEAVE OF ABSENCE INDICATORS

ESCORTED MENTAL HEALTH LEAVE OF ABSENCE INDICATOR

Change to Attribute: New Attribute

ESCORTED MENTAL HEALTH LEAVE OF ABSENCE INDICATOR

Data Elements:

ESCORTED MENTAL HEALTH LEAVE OF ABSENCE INDICATOR

ETHNIC CATEGORY CODE

Change to Attribute: Changed Dataset

The ethnicity of a [PERSON](#), as specified by the [PERSON](#).

Note: [ETHNIC CATEGORY](#) is the classification used for the 2001 census.

The [Office for National Statistics](#) has developed a further breakdown of the group from that given, which may be used locally.

National Codes:

White

- A British
- B Irish
- C Any other White background

Mixed

- D White and Black Caribbean
- E White and Black African
- F White and Asian
- G Any other mixed background

Asian or Asian British

- H Indian
- J Pakistani
- K Bangladeshi
- L Any other Asian background

Black or Black British

- M Caribbean
- N African
- P Any other Black background

Other Ethnic Groups

- R Chinese
- S Any other ethnic group

- Z Not stated

National code Z - Not Stated should be used where the [PERSON](#) has been given the opportunity to state their [ETHNIC CATEGORY](#) but chose not to.

EX-BRITISH ARMED FORCES INDICATOR

Change to Attribute: Changed Dataset

An indication of whether the [PERSON](#) is an ex-member of the British Armed Forces, i.e. army, navy or air force, or is a dependant of a [PERSON](#) who is an ex-services member.

National Codes:

- 01 Yes - Currently Serving (including reservists) (Retired 1 April 2012)
- 02 Ex-services member
- 03 Not an ex-services member or their dependant
- 04 Dependent of a Current Serving Member (Retired 1 April 2012)
- 05 Dependant of an ex-services member
- UU Unknown ([PERSON](#) asked and does not know or is not sure)
- ZZ Not Stated ([PERSON](#) asked but declined to provide a response)

FINDING SCHEME IN USE

Change to Attribute: Changed Dataset

The type of [CODED CLINICAL ENTRY](#) used for the finding.

National Codes:

- 01 [ICD-10](#)
- 02 [Read Coded Clinical Terms](#) Version 2
- 03 [Read Coded Clinical Terms](#) Version 3 (CTV3)
- 04 [SNOMED CT](#)

FIVE FORENSIC PATHWAYS ASSESSMENT REASON

Change to Attribute: Changed Dataset, Description

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~~
- 97 [Other Reason \(not listed\)](#)

FIVE FORENSIC PATHWAYS CODE

Change to Attribute: Changed Dataset

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

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE

Change to Attribute: Changed Dataset

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 Dataset

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

National Codes:

- 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)

GROUP SESSION TYPE FOR MENTAL HEALTH

Change to Attribute: Changed Dataset

The type of [Group Session](#) provided by a [Mental Health Service](#).

National Codes:

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

JOB ROLE CODE

Change to Attribute: Changed Dataset

A National Code for a [POSITION](#) applicable to an [EMPLOYEE](#).

National Codes:

Code	Staff Group	Job Role Title

01000	Medical and Dental	
01001		Medical Director
01002		Clinical Director
01003		Professor
01004		Senior Lecturer
01005		CONSULTANT
01006		Dental surgeon acting as Hospital CONSULTANT
01007		Special salary scale in Public Health Medicine
01008		Associate Specialist (Closed to new entrants from 01 April 2008 or regrading from 01 April 2009)
01009		Staff Grade (Closed to new entrants 01 April 2008)
01010		Hospital Practitioner
01011		Clinical Assistant
01012		Specialist Registrar - Closed (Retired 01 April 2010)
01013		Senior House Officer - Closed (Retired 01 April 2010)
01014		House Officer - Pre-registration - Closed (Retired 01 April 2010)
01015		House Officer - Post-registration - Closed (Retired 01 April 2010)
01016		Trust Grade Doctor - House Officer level - Closed (Retired 01 April 2010)
01017		Trust Grade Doctor - SHO level - Closed (Retired 01 April 2010)
01018		Trust Grade Doctor - Specialist Registrar level - Closed (Retired 01 April 2010)
01019		Trust Grade Doctor - Career Grade level
01020		Director of Public Health
01021		Clinical Medical Officer
01022		Senior Clinical Medical Officer
01023		'Other' Community Health Service
01024		GENERAL DENTAL PRACTITIONER
01025		GENERAL MEDICAL PRACTITIONER
01026		Salaried GENERAL PRACTITIONER
01027		Regional Dental Officer
01028		Dental Clinical Director
01029		Dental Officer
01030		Senior Dental Officer
01031		Salaried Dental Practitioner
01032		Specialty Doctor
01033		Foundation Year 1
01034		Foundation Year 2
01035		Specialty Registrar
01036		Medical Student
01037		Trust Grade Doctor - Specialty Registrar
01038		Vocational Dental Practitioner
01039		Associate Postgraduate Dean
01040		Trust Grade Doctor - Foundation Level
01041		GP Senior Partner
01042		GP Partner/Provider
01043		GP Retainer
01044		GP Locum
02000	Students	
02001		Student NURSE - Adult Branch
02002		Student NURSE - Child Branch
02003		Student NURSE - Mental Health Branch
02004		Student NURSE - Learning Disabilities Branch
02005		Student MIDWIFE
02006		Student Health Visitor
02007		Student District Nurse
02008		Student School Nurse
02009		Student Practice Nurse
02010		Student Occupational Health Nurse
02011		Student Community Children's Nurse

02012		Student Mental Health Nurse
02013		Student Learning Disabilities Nurse
02014		Student Chiropodist
02015		Student Dietitian
02016		Student Occupational Therapist
02017		Student Orthoptist
02018		Student Physiotherapist
02019		Student Radiographer - Diagnostic
02020		Student Radiographer - Therapeutic
02021		Student Speech and Language Therapist
02022		Art, Music and Drama Student
02023		Student Psychotherapist
03000	Nursing and Midwifery Registered	
03001		Director of Nursing
03002		Nurse Consultant
03003		Nurse Manager
03004		Modern Matron
03005		Specialist Nurse Practitioner
03006		Sister/Charge Nurse
03007		Staff Nurse
03008		Enrolled Nurse
03009		Midwife - Consultant
03010		Midwife - Specialist Practitioner
03011		Midwife - Manager
03012		MIDWIFE - Sister/Charge Nurse (Retired 01 December 2012)
03013		MIDWIFE
03014		Community Practitioner
03015		Community Nurse
03016		Advanced Practitioner
03017		Practice Nurse
03018		Extended Role Practice Nurse
03019		Practice Nurse Partner
03020		Practice Research Nurse
03021		Practice Nurse Dispenser
04000	Allied Health Professionals	
04001		Art Therapist
04002		Art Therapist Consultant
04003		Art Therapist Manager
04004		Art Therapist Specialist Practitioner
04005		Chiropodist/Podiatrist
04006		Chiropodist/Podiatrist Consultant
04007		Chiropodist/Podiatrist Manager
04008		Chiropodist/Podiatrist Specialist Practitioner
04009		Dietitian
04010		Dietitian Consultant
04011		Dietitian Manager
04012		Dietitian Specialist Practitioner
04013		Drama Therapist
04014		Drama Therapist Consultant
04015		Drama Therapist Manager
04016		Drama Therapist Specialist Practitioner
04017		Multi Therapist
04018		Multi Therapist Consultant
04019		Multi Therapist Manager
04020		Multi Therapist Specialist Practitioner
04021		Music Therapist
04022		Music Therapist Consultant
04023		Music Therapist Manager

04024		Music Therapist Specialist Practitioner
04025		Occupational Therapist
04026		Occupational Therapist Consultant
04027		Occupational Therapist Manager
04028		Occupational Therapist Specialist Practitioner
04029		Orthoptist
04030		Orthoptist Consultant
04031		Orthoptist Manager
04032		Orthoptist Specialist Practitioner
04033		Orthotist
04034		Orthotist Consultant
04035		Orthotist Manager
04036		Orthotist Specialist Practitioner
04037		Paramedic
04038		Paramedic Consultant
04039		Paramedic Manager
04040		Paramedic Specialist Practitioner
04041		Physiotherapist
04042		Physiotherapist Consultant
04043		Physiotherapist Manager
04044		Physiotherapist Specialist Practitioner
04045		Prosthetist
04046		Prosthetist Consultant
04047		Prosthetist Manager
04048		Prosthetist Specialist Practitioner
04049		Radiographer - Diagnostic
04050		Radiographer - Diagnostic, Consultant
04051		Radiographer - Diagnostic, Manager
04052		Radiographer - Diagnostic, Specialist Practitioner
04053		Radiographer - Therapeutic
04054		Radiographer - Therapeutic, Consultant
04055		Radiographer - Therapeutic, Manager
04056		Radiographer - Therapeutic, Specialist Practitioner
04057		Speech and Language Therapist
04058		Speech and Language Therapist Consultant
04059		Speech and Language Therapist Manager
04060		Speech and Language Therapist Specialist Practitioner
04061		Advanced Practitioner
05000	Additional Professional, Scientific and Technical	
05001		Clinical Director
05002		OPTOMETRIST
05003		Pharmacist
05004		Psychotherapist
05005		Clinical Psychologist
05006		Chaplain
05007		Social Worker
05008		Approved Social Worker
05009		Youth Worker
05010		Specialist Practitioner
05011		Practitioner
05012		Technician
05013		Osteopath
05014		Psychological Therapist - Qualified
05015		Psychological Therapist - Trainee
05016		Physician Assistant (Retired 01 January 2016)
05017		Advanced Practitioner
05018		Physician Associate

06000	Healthcare Scientists	
06001		Clinical Scientist (Retired 01 April 2013)
06002		Consultant Healthcare Scientist
06003		Biomedical Scientist (Retired 01 April 2013)
06004		Technician (Retired 01 April 2013)
06005		Therapist (Retired 01 April 2013)
06006		Manager
06007		Specialist Healthcare Scientist
06008		Healthcare Scientist
06009		Specialist Healthcare Science Practitioner
06010		Healthcare Science Practitioner
07000	Additional Clinical Services	
07001		Health Care Support Worker
07002		Social Care Support Worker
07003		Home Help
07004		Healthcare Assistant
07005		Nursery Nurse
07006		Play Therapist
07007		Play Specialist
07008		Technician
07009		Technical Instructor
07010		Assistant/Associate Practitioner
07011		Counsellor
07012		Helper/Assistant
07013		Dental Surgery Assistant
07014		Medical Laboratory Assistant (Retired 01 January 2016)
07015		Phlebotomist
07016		Cytoscreener
07017		Student Technician
07018		Trainee Scientist
07019		Trainee Practitioner
07020		Nursing Cadet
07021		Healthcare Cadet
07022		Pre-reg Pharmacist
07023		Assistant Psychologist
07024		Assistant Psychotherapist
07025		Call Operator
07026		Gateway Worker
07027		Support, Time, Recovery Worker
07028		Psychological Wellbeing Practitioner - Qualified
07029		Psychological Wellbeing Practitioner - Trainee
07030		Apprentice
07031		Assistant/Associate Practitioner - Nursing
07032		Ambulance Care Assistant/Patient Transport Services (PTS) Driver
07033		Emergency Care Assistant
07034		Emergency Care Practitioners
07035		Emergency Medical Dispatcher/Call Handler
07036		Healthcare Science Associate
07037		Healthcare Science Assistant
07038		Trainee Healthcare Scientist
07039		Trainee Healthcare Science Practitioner
07040		Trainee Healthcare Science Associate
07041		Analyst
08000	Administrative and Clerical	
08001		Clerical Worker
08002		Receptionist
08003		Secretary
08004		Personal Assistant

08005		Medical Secretary
08006		Officer
08007		Manager
08009		Senior Manager
08010		Technician
08011		Accountant
08012		Librarian
08013		Interpreter
08014		Analyst
08015		Adviser
08016		Researcher
08017		Control Assistant
08018		Architect
08019		Lawyer
08020		Surveyor
08021		Chair
08022		Chief Executive
08023		Finance Director
08024		Other Executive Director
08025		Board Level director
08026		Non-executive Director
08027		Childcare Coordinator
08028		Apprentice
09000	Estates and Ancillary	
09001		Support Worker
09002		Housekeeper
09003		Cook
09004		Porter
09005		Driver
09006		Telephonist
09007		Gardener/Groundsperson
09008		Technician
09009		Electrician
09010		Fitter
09011		Assistant
09012		Labourer
09013		Plumber
09014		Carpenter
09015		Bricklayer
09016		Painter/Decorator
09017		Work Analyst
09018		Chargehand
09019		Supervisor
09020		Engineer
09021		Building Officer
09022		Maintenance Craftsperson
09023		Building Craftsperson
09024		Mechanic
09025		Apprentice
10000	Supplementary Roles	
10001		Assessor
10002		Clinical Supervisor
10003		Educational Supervisor
10004		Tutor

LANGUAGE CODE

Change to Attribute: Changed Dataset

The language used by a [PERSON](#).

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

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

LEARNING DISABILITIES CARE CLUSTER CODE

Change to Attribute: Changed Dataset

The Learning Disabilities Care Cluster assigned to a [PATIENT](#).

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

LEAVE TYPE

Change to Attribute: Changed Description

The type of [LEAVE](#).

National Codes:

- 01 [Mental Health Absence Without Leave](#)
- 02 [Home Leave](#)
- 03 [Mental Health Leave of Absence](#)
[Mental Health Trial Leave](#)

LOCAL PATIENT IDENTIFIER

Change to Attribute: Changed Dataset

A number used to identify a [PATIENT](#) uniquely within a [Health Care Provider](#). It may be different from the [PATIENT](#)'s casenote number and may be assigned automatically by the computer system.

Where care for NHS patients is sub-commissioned in the independent sector or overseas, the NHS commissioner PAS Number should be used. If no NHS PAS Number has been assigned the independent sector or overseas PAS Number should be used.

LOCKED WARD INDICATOR

Change to Attribute: Changed Dataset

An indication of whether a [WARD](#) is locked.

National Codes:

- Y Yes - is a locked [WARD](#)
- N No - is not a locked [WARD](#)

LOOKED AFTER CHILD INDICATOR

Change to Attribute: Changed Dataset

An indication of whether a [PERSON](#) is a [Looked After Child](#).

National Codes:

- Y Yes - is a [Looked After Child](#)
- N No - is not a [Looked After Child](#)

MAIN SPECIALTY CODE

Change to Attribute: Changed Dataset

A unique code identifying each [MAIN SPECIALTY](#) designated by Royal Colleges. This is the same as the [NHS OCCUPATION CODES](#) describing specialties.

Specialties are divisions of clinical work which may be defined by body systems (dermatology), age (paediatrics), clinical technology (nuclear medicine), clinical function (rheumatology), group of diseases (oncology) or combinations of these factors. Only Specialty titles recognised by the Royal Colleges and Faculties should be used. This list is maintained by the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003 and European Primary and Specialist Dental Qualifications Regulations 1998.

Each [CONSULTANT](#) should be assigned a [MAIN SPECIALTY](#) by the [Organisation](#) to which the [CONSULTANT](#) is contracted. For physicians and surgeons with a generalist component to their work, the [MAIN SPECIALTY](#) should be general medicine or general surgery. The hallmark of a general physician or general surgeon is the continued care of unselected emergency referrals. The [MAIN SPECIALTY](#) is specific to a [Health Care Provider](#). If, for example, a [CONSULTANT](#) physician working in two [Health Care Providers](#) has a generalist component to the work in one and not the other, general medicine is only assigned as the [MAIN SPECIALTY](#) in the former case. [CONSULTANTS](#) in general medicine or general surgery may also have specialist interests and these should be recorded as well as the [MAIN SPECIALTY](#).

The initial source of the information should be the designation on the [CONSULTANT](#)'s contract. This should be checked periodically against the work a [CONSULTANT](#) is actually doing so that the statistics can relate to a [CONSULTANT](#)'s current type of work.

The [MAIN SPECIALTY](#) only should be used for the purpose of producing Specialty costing statistics and for Workforce statistics where links with [ACTIVITY](#) and finance are required. Other specialist interests of [CONSULTANTS](#) may be recorded for workforce planning purposes.

This will be used to indicate the skill level of medical and dental employees.

Pseudo [MAIN SPECIALTY CODES](#) should be used in Commissioning Data Set messages for lead [CARE PROFESSIONALS](#) other than [CONSULTANT](#) medical and dental staff e.g. 560, 950 and 960.

The [MAIN SPECIALTY CODE](#) for [GENERAL PRACTITIONERS](#) is General Medical Practice or General Dental Practice.

Joint [Consultant Clinic ACTIVITY](#) should be recorded against the [MAIN SPECIALTY CODE](#) of the [CONSULTANT](#) managing the clinic.

For further information, contact [NHS Digital](#) by email at: enquiries@nhsdigital.nhs.uk with the subject "Main Specialty and Treatment Function Codes".

National Codes:

Code	Main Specialty Title
Surgical Specialties	
100	GENERAL SURGERY
101	UROLOGY
110	TRAUMA & ORTHOPAEDICS
120	ENT
130	OPHTHALMOLOGY
140	ORAL SURGERY
141	RESTORATIVE DENTISTRY
142	PAEDIATRIC DENTISTRY
143	ORTHODONTICS
145	ORAL & MAXILLO FACIAL SURGERY
146	ENDODONTICS
147	PERIODONTICS
148	PROSTHODONTICS
149	SURGICAL DENTISTRY
150	NEUROSURGERY
160	PLASTIC SURGERY
170	CARDIOTHORACIC SURGERY
171	PAEDIATRIC SURGERY
180	ACCIDENT & EMERGENCY
191	PAIN MANAGEMENT (Retired 1 April 2004)
Medical Specialties	
190	ANAESTHETICS
192	CRITICAL CARE MEDICINE
300	GENERAL MEDICINE
301	GASTROENTEROLOGY

	302	ENDOCRINOLOGY
	303	CLINICAL HAEMATOLOGY
	304	CLINICAL PHYSIOLOGY
	305	CLINICAL PHARMACOLOGY
	310	AUDIOLOGICAL MEDICINE
	311	CLINICAL GENETICS
*	312	CLINICAL CYTOGENETICS and MOLECULAR GENETICS (Retired 1 April 2010)
	313	CLINICAL IMMUNOLOGY and ALLERGY
	314	REHABILITATION
	315	PALLIATIVE MEDICINE
	320	CARDIOLOGY
	321	PAEDIATRIC CARDIOLOGY
	325	SPORT AND EXERCISE MEDICINE
	326	ACUTE INTERNAL MEDICINE
	330	DERMATOLOGY
	340	RESPIRATORY MEDICINE (also known as thoracic medicine)
	350	INFECTIOUS DISEASES
	352	TROPICAL MEDICINE
	360	GENITOURINARY MEDICINE
	361	NEPHROLOGY
	370	MEDICAL ONCOLOGY
	371	NUCLEAR MEDICINE
	400	NEUROLOGY
	401	CLINICAL NEURO-PHYSIOLOGY
	410	RHEUMATOLOGY
	420	PAEDIATRICS
	421	PAEDIATRIC NEUROLOGY
	430	GERIATRIC MEDICINE
	450	DENTAL MEDICINE SPECIALTIES
	451	SPECIAL CARE DENTISTRY
	460	MEDICAL OPHTHALMOLOGY
†	500	OBSTETRICS and GYNAECOLOGY
	501	OBSTETRICS
	502	GYNAECOLOGY
	504	COMMUNITY SEXUAL AND REPRODUCTIVE HEALTH
	510	ANTENATAL CLINIC (Retired 1 April 2004)
	520	POSTNATAL CLINIC (Retired 1 April 2004)
	560	MIDWIFE EPISODE
	600	GENERAL MEDICAL PRACTICE
	601	GENERAL DENTAL PRACTICE
	610	MATERNITY FUNCTION (Retired 1 April 2004)
	620	OTHER THAN MATERNITY (Retired 1 April 2004)
Psychiatry		
	700	LEARNING DISABILITY
	710	ADULT MENTAL ILLNESS
	711	CHILD and ADOLESCENT PSYCHIATRY
	712	FORENSIC PSYCHIATRY
	713	PSYCHOTHERAPY
	715	OLD AGE PSYCHIATRY
Radiology		
	800	CLINICAL ONCOLOGY (previously RADIOTHERAPY)
	810	RADIOLOGY
Pathology		
	820	GENERAL PATHOLOGY
	821	BLOOD TRANSFUSION
	822	CHEMICAL PATHOLOGY
	823	HAEMATOLOGY
	824	HISTOPATHOLOGY

	830	IMMUNOPATHOLOGY
	831	MEDICAL MICROBIOLOGY AND VIROLOGY
	832	NEUROPATHOLOGY (Retired 1 April 2004)
	833	MEDICAL MICROBIOLOGY (also known as MICROBIOLOGY AND BACTERIOLOGY)
	834	MEDICAL VIROLOGY
Other		
	900	COMMUNITY MEDICINE
	901	OCCUPATIONAL MEDICINE
	902	COMMUNITY HEALTH SERVICES DENTAL
	903	PUBLIC HEALTH MEDICINE
	904	PUBLIC HEALTH DENTAL
	950	NURSING EPISODE
	960	ALLIED HEALTH PROFESSIONAL EPISODE
	990	JOINT CONSULTANT CLINICS (Retired 1 April 2004)

Notes:

†	Code 500 is not acceptable for Central Returns including Hospital Episode Statistics
*	Code 312 is retained for CONSULTANTS qualified in this Main Specialty prior to 1 April 2010.

MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON

Change to Attribute: Changed Dataset
The reason the [Mental Health Absence Without Leave](#) ended.

National Codes:

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

MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY

Change to Attribute: Changed Dataset
The body or [PERSON](#) responsible for granting a Mental Health Absolute Discharge.

National Codes:

- 01 Mental Health Tribunal
- 02 Secretary of State

MENTAL HEALTH ACT 2007 MENTAL CATEGORY

Change to Attribute: Changed Dataset
The primary reason for the detention of [PATIENTS](#) under the Mental Health Act 1983, as amended by the Mental Health Act 2007.
[MENTAL HEALTH ACT 2007 MENTAL CATEGORY](#) should be used for [PATIENTS](#) detained from 3rd November 2008 when the relevant section of the Mental Health Act 2007 comes into force, and replaces [MENTAL CATEGORY](#) which is applicable until then.
A [PATIENT](#) should be included under only one [MENTAL HEALTH ACT 2007 MENTAL CATEGORY](#).

National Codes:

- A Mental disorder ([Learning Disability](#) not present or not primary reason for using Act)
- B Mental disorder ([Learning Disability](#) primary reason for using Act)

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON

Change to Attribute: Changed Dataset
The reason for the end of the [Mental Health Act Legal Status Classification Assignment Period](#).

National Codes:

- 01 Change in [MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE](#) (including to informal)
- 02 Unrestricted treatment order (Community Treatment Order) (Retired 01 January 2016)
- 03 Restricted treatment order (Conditional Discharge) (Retired 01 January 2016)
- 04 Transfer to other [Health Care Provider](#)
- 05 Death of [PATIENT](#)

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON

Change to Attribute: Changed Dataset

The reason for the start of the [Mental Health Act Legal Status Classification Assignment Period](#).

National Codes:

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

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE

Change to Attribute: Changed Dataset

A code which identifies the [MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION](#).

Note that the National Code 'Informal' is used for those [PATIENTS](#) who are neither formally detained nor receiving supervised aftercare.

Where applicable, [MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE](#) is aligned with descriptors for "Mental Health Act legal status findings" in [SNOMED CT](#)® as follows:

[SNOMED CT Subset](#) Metadata:

- [Subset](#) Name: Mental Health Act legal status findings
- [Subset](#) Original Id: 75081000000134
- [Refset](#) FSN: Mental Health Act legal status findings simple reference set
- [Refset](#) Id: 999003071000000100

For further details relating to the [SNOMED CT Subset](#) Metadata, see the [Data Dictionary for Care \(DD4C\)](#) website at: [Mental Health Act legal status findings](#).

National Codes:

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

- 35 Subject to guardianship under Mental Health Act Section 7
- 36 Subject to guardianship under Mental Health Act Section 37
- 37 Formally detained under Mental Health Act Section 45A (Limited direction in force)
- 38 Formally detained under Mental Health Act Section 45A (Limitation direction ended)

MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE

Change to Attribute: Changed Dataset

The [Mental Health Care Cluster Super Class](#) assigned to a [PATIENT](#).

National Codes:

- A Non-Psychotic
- B Psychotic
- C Organic

MENTAL HEALTH CONDITIONAL DISCHARGE END REASON

Change to Attribute: Changed Dataset

The reason a [Mental Health Conditional Discharge Period](#) ended.

National Codes:

- 01 Mental Health Absolute Discharge
- 02 Recall of [PATIENT](#)
- 03 Death of [PATIENT](#)

MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE

Change to Attribute: Changed Dataset

An indication to which [Organisation](#) the [Mental Health Delayed Discharge Period](#) is attributable.

National Codes:

- 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 Dataset

The reason that a [Mental Health Delayed Discharge Period](#) was initiated for a [PATIENT](#).

National Codes:

- 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 (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 (Retired 01 April 2017)
- I2 Housing - Awaiting availability of general needs housing/private landlord accommodation acceptance as [PATIENT](#) NOT covered by Housing Act and/or Care Act
- I3 Housing - Single homeless [PATIENTS](#) or asylum seekers NOT covered by 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)

MENTAL HEALTH LEAVE OF ABSENCE END REASON

Change to Attribute: Changed Dataset, Description

The reason a [Mental Health Leave of Absence](#) ended.

National Codes:

- 01 [PATIENT](#) returned on or before day specified
- 02 Leave revoked and [PATIENT](#) recalled by [Mental Health Responsible Clinician](#)
- 03 Period of leave to be extended
- 04 [PATIENT](#) failed to return on or before day specified and is absent without leave
- 05 [PATIENT](#)'s liability for detention terminated by [Mental Health Responsible Clinician](#)
- 06 [PATIENT](#)'s liability for detention terminated by Mental Health Act Review Tribunal
- 07 [PATIENT](#)'s liability for detention terminated by Hospital Managers
- 08 [PATIENT](#) died
- 96 ~~Other~~
- 96 [Other \(not listed\)](#)

NHS NUMBER

Change to Attribute: Changed Dataset

The [NHS NUMBER](#), the primary identifier of a [PERSON](#), is a unique identifier for a [PATIENT](#) within the NHS in England and Wales.

This will not vary by any [Organisation](#) of which a [PERSON](#) is a [PATIENT](#).

It is mandatory to record the [NHS NUMBER](#). There are exceptions, such as Accident and Emergency care, sexual health and major incidents, as defined in existing national policies.

The [NHS NUMBER](#) is 10 numeric digits in length. The tenth digit is a check digit used to confirm its validity. The check digit is validated using the Modulus 11 algorithm and the use of this algorithm is mandatory. There are 5 steps in the validation of the check digit:

Step 1 Multiply each of the first nine digits by a weighting factor as follows:

Digit Position

(starting from the left) Factor:

1	10
2	9
3	8
4	7

5	6
6	5
7	4
8	3
9	2

Step 2 Add the results of each multiplication together.

Step 3 Divide the total by 11 and establish the remainder.

Step 4 Subtract the remainder from 11 to give the check digit.

If the result is 11 then a check digit of 0 is used. If the result is 10 then the [NHS NUMBER](#) is invalid and not used.

Step 5 Check the remainder matches the check digit. If it does not, the [NHS NUMBER](#) is invalid.

Further guidance is available from the [NHS Digital](#) website at: [NHS Number](#).

Note:

This was [e-GIF](#) approved for use in NHS England.

[e-GIF](#) and the [Government Data Standards Catalogue](#) **have been archived** and are available for reference only.

NHS OCCUPATION CODE

Change to Attribute: Changed Dataset

An [NHS OCCUPATION CODE](#) for an [EMPLOYEE](#) filling a [POSITION](#).

The [NHS OCCUPATION CODES](#) are maintained by [NHS Digital](#), on behalf of the [Department of Health](#) and can be viewed in the [NHS Occupation Code Manual](#).

NHS SERVICE AGREEMENT LINE NUMBER

Change to Attribute: Changed Dataset

A number (alphanumeric) to provide a unique identifier for a line within a [NHS SERVICE AGREEMENT](#).

OBSERVATION SCHEME IN USE

Change to Attribute: Changed Dataset

The type of [CLINICAL TERMINOLOGY CODE](#) used for the observation.

National Codes:

- 01 [Read Coded Clinical Terms](#) Version 2
- 02 [Read Coded Clinical Terms](#) Version 3 (CTV3)
- 03 [SNOMED CT](#)

OBSERVATION VALUE

Change to Attribute: Changed Dataset

The value of a [CLINICAL INVESTIGATION RESULT ITEM](#).

OFFENCE HISTORY INDICATION CODE

Change to Attribute: Changed Dataset

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

OFFERED FOR ADMISSION DATE

Change to Attribute: Changed Dataset

The date offered for admission to hospital to start a [Hospital Provider Spell](#).

ONWARD REFERRAL REASON

Change to Attribute: Changed Dataset

The reason why the [PATIENT](#) was referred from one [SERVICE](#) to another [SERVICE](#), which may be in the same or a different [Organisation](#).

National Codes:

- 01 Transfer of Clinical Responsibility
- 02 For Opinion Only
- 03 For Diagnostic Test Only
- 04 New Referral (Non Transfer)
- 96 Other (not listed)

ORGANISATION CODE

Change to Attribute: Changed Dataset

[ORGANISATION CODE](#) will be replaced with [ORGANISATION IDENTIFIER](#), which is the most recent approved national information standard to describe the required definition.

An [ORGANISATION CODE](#) is a code which identifies an [Organisation](#) uniquely.

[ORGANISATION CODES](#) are managed by:

- [Organisation Data Service \(ODS\)](#)
- [NHS Prescription Services](#)
- [NHS Dental Services](#).

Notes:

- [Organisation Data Service](#) codes can be downloaded from [Technology Reference Data Update Distribution \(TRUD\)](#)
- [Organisation Data Service](#) contact details can be found at [Contact Details](#).

ORGANISATION CODING FRAMES

- All NHS [Organisations](#) are coded using coding frames, as shown in the tables below:

Character Position	1	2	3	4	5	6	7	8
Format	a/n	a/n	a/n	a/n	a/n	a/n	a/n	a/n
A Frame	Organisation Type Identifier	Organisation Identifier						
B Frame	Organisation Type Identifier			Organisation Identifier				

C Frame	Organisation Type Identifier	Organisation Identifier					
D Frame	Organisation Type Identifier	Organisation Identifier					
E Frame	Organisation Identifier						
F Frame	Organisation Type Identifier	Organisation Identifier					
G Frame	Organisation Type Identifier	Practice Identifier					
H Frame	Organisation Type Identifier	Organisation Identifier					
I Frame	Organisation Type Identifier	Organisation Identifier					
K Frame	Organisation Identifier						
L Frame	Organisation Type Identifier		Organisation Identifier	Organisation Type Identifier			
M Frame	Organisation and Organisation Type Identifier						
N Frame	Organisation Type Identifier		Organisation Identifier				

A Frame:

Example

Non NHS Organisation ([Independent Provider](#)) e.g. 8HA03

- 8 = Organisation Type Identifier
- Remainder = Organisation Identifier

B Frame:

Example

Local Service Provider e.g. LSP01

- LSP = Organisation Type Identifier
- 01 = Organisation Identifier

Also:

Application Service Provider
[Education Establishment](#)
 NHS Support Agency

e.g. YGM01
 e.g. YDF01
 e.g. YDD01

C Frame:

Example

[School](#) e.g. EE134290

- EE = Organisation Type Identifier
 - Remainder = Organisation Identifier
-

D Frame:

Example

[Care Trust](#) e.g. TAK

- T = Organisation Type Identifier
- AK = Organisation Identifier

Also:

Commissioning Support Unit (CSU) / Data Services for Commissioners Regional Office (DSCRO)	e.g. 0AA
High Level Health Geography, e.g. NHS England (Region Local Office)	e.g. Q72
Local Health Board (Wales)	e.g. 7A1
NHS Trust	e.g. RH8
Justice Organisation	e.g. VAA

E Frame:

Example

[Government Office Region \(GOR\)](#) e.g. K

- K = Organisation Identifier

Note: [Government Office Region \(GOR\)](#) is identified by a one character code; no other one character code exists.

F Frame:

Example

[Pharmacy](#) Headquarters e.g. P001

- P = Organisation Type Identifier
- 001 = Organisation Identifier

Also:

Care Home Headquarters	e.g. CA0A
Optical Headquarters	e.g. T1A1

G Frame:

Example

[GP Practices](#) in England and Wales e.g. Y00001

- Y = Organisation Type Identifier
- 00001 = Practice Identifier

Also:

Dental Practice	e.g. V20052
---------------------------------	-------------

H Frame:

Example

Cancer Network e.g. N01

- N0 (where the 2nd character is numeric and not alpha) = Organisation Type Identifier
- 1 = Organisation Identifier

Also:

Booking Management System (BMS) Call Centre Establishment	e.g. YF1
Government Department	e.g. XDA
Independent Sector Healthcare Provider (ISHP) (where the 2nd character is alpha)	e.g. NV7
National Application Service Provider	e.g. YEA
Other Statutory Authority (OSA)	e.g. X16

I Frame:

Example

[Special Health Authority \(SpHA\)](#) e.g. T1150

- T1 = Organisation Type Identifier
 - 150 = Organisation Identifier
-

K Frame:

Example

[NHS Wales Informatics Service](#) e.g. W00

- W00 = Organisation Identifier
-

L Frame:

Example

[Northern Ireland Local Commissioning Group](#) e.g. ZC010

- Characters 1-3 (ZC0) AND character 5 (0) = Organisation Type Identifier
- Character 4 = Organisation Identifier

Note: this is a 5 character method of displaying [Northern Ireland Local Commissioning Group](#) identifiers.

Characters 3 and 5 are 'fillers'. If a 3 character code is required (as used by the [Office for National Statistics](#) in the [NHS Postcode Directory](#)) zeros can be omitted, e.g. ZC1.

The 3 character method of displaying the [Northern Ireland Local Commissioning Group](#) identifiers fit under the H Frame.

Guidance on the use of Northern Ireland codes can be found in [Data Set Change Notice 19/2009](#).

M Frame:

Example

[Clinical Commissioning Group \(CCG\)](#) e.g. 12A

- 12A = Organisation and Organisation Type Identifier

Also:

[Local Authority](#) e.g.000

N Frame:

Example

GP Abeyance and Dispersal [GP Practice](#) e.g. G7817414

- G78 = Organisation Type Identifier
 - 17414 = Organisation Identifier
-

The structure and format of [ORGANISATION CODES](#) maintained by the [Organisation Data Service](#), [NHS Prescription Services](#), [NHS Dental Services](#) and other agencies are detailed in the tables below.

ORGANISATION CODES TABLES

Table 1: CODING FORMATS FOR ORGANISATIONS IN ENGLAND AND WALES

Organisation Type	Frame Type	Character Position								Code allocated by:	Notes/Comments
		1	2	3	4	5	6	7	8		

	See Coding Frames Table										
Application Service Provider	B	Y	G	M	A-9	A-9				ODS	E.g. YGM01
Booking Management System (BMS) Call Centre Establishment	H	Y	F	A-9						ODS	E.g. YF1
Cancer Network	H	N	0-9	A-9						ODS	E.g. N01
Cancer Registry	A	Y	0-9	0-9	0-9	0-9				ODS	E.g. Y0401 All Cancer Registries in England are now part of the National Cancer Registration and Analysis Service
Care Home Headquarters	F	A, C or D	A-9	A-9	A-9					ODS	E.g. CA0A
Care Trust (CT)	D	T	A-Y	A-Y						ODS	E.g. TAK
Clinical Commissioning Group (CCG)	M	0-9	0-9	A-Y						ODS	E.g. 12A
Clinical Network	B	Y	D	G	A-9	A-9				ODS	E.g. YDG01
Commissioning Support Unit (CSU) / Data Services for Commissioners Regional Office (DSCRO)	D	0	A-Y	A-Y						ODS	E.g. 0AA
Dental Practice - England and Wales	G	V	0-9	0-9	0-9	0-9	0-9			NHS Dental Services	E.g. V20052
Education Establishment	B	Y	D	F	A-9	A-9				ODS	E.g. YDF01
Executive Agency	N/A See Note 1	X	0-9	0-9						ODS	E.g. X09
Executive Agency Programme	N/A	X	0-9	0-9	0-9	0-9	0-9			ODS	

	See Note 1											First three characters denote Executive Agency E.g. X09001
Government Department	H	X	A-Y	A-Y							ODS	E.g. XDA
Government Office Region (GOR)	E	A-Y									ONS	E.g. K Government Office Regions (GORs) closed 31 March 2011 - from 1 April 2011 referred to as Regions
GP Abeyance and Dispersal GP Practice	N	G	7	8	0-9	0-9	0-9	0-9	0-9		ODS	E.g. G7817414
GP Practices in England and Wales	G	A-H, J-N, P, W & Y	0-9	0-9	0-9	0-9	0-9				NHS Prescription Services	Char 1 = W for Welsh GP Practice . All other values represent GP Practices in England. Note: from 2003, ALL newly allocated Practice Codes in England begin with a Y E.g. Y00001
Justice Organisation	D	V or W	A-Y	A-9							ODS	E.g. VAA
High Level Health Geography, e.g. NHS England (Region Local Office)	D	Q	A-9	A-9							ODS	E.g. Q72
Independent Sector Healthcare Provider (ISHP)	H	A, B, D, G, I, K, L, M, N, O, S, U, V, W	A-Y	A-Y, 0-9							ODS	E.g. NV7
Local Authority (LA)	M	0-9	0-9	0-9							ODS	E.g. 000

Local Health Board (Wales)	B	7	A-9	A-9						ODS	E.g. 7A1
Local Service Provider (LSP)	B	L	S	P	0-9	0-9				ODS	E.g. LSP01
Military Hospital	B	X	M	D	A-9	A-9				ODS	E.g.XMDA1
National Application Service Provider	H	Y	E	A-9						ODS	E.g. YEA
National Groupings (England)	H	Y	5	0-9						ODS	E.g. Y51
NHS Support Agency	B	Y	D	D	A-9	A-9				ODS	E.g. YDD01
NHS Trust	D	R	A-9	A-9						ODS	E.g. RH8
NHS Wales Informatics Service (NWIS)	K	W	0	0						ODS	Only one organisation of this type exists for Wales E.g. W00
Non NHS Organisation (Independent Provider)	A	8	A-Y	A-9	0-9	0-9				ODS	E.g. 8HA03
Northern Ireland Health & Social Care Board	N/A	Z	B	0	0	1				ODS	E.g. ZB001
Northern Ireland Health & Social Care Trust	I	Z	T	0-9	0-9	0-9				ODS	E.g. ZT001
Northern Ireland Local Commissioning Group	L	Z	C	0	0-9	0				Department for Health, Social Services and Public Safety (DHSSPS), Northern Ireland	E.g. ZC010 Note that characters 3 and 5 are 'fillers' to create a 5 character code. If a 3 character code is required (as used by the Office for National Statistics in the NHS Postcode Directory), zeros can be omitted and fits under the H frame: E.g. ZC1. <i>Guidance on the use of Northern Ireland codes can be found</i>

											in Data Set Change Notice 19/2009.
Optical Headquarters	F	T	0-9	A-9	A-9						ODS E.g. T1A1
Other Statutory Authority (OSA)	H	X	0-9	0-9							ODS E.g. X16
Pharmacy	A	F	A-Y	A-9	A-9	A-9					ODS E.g. FA002
Pharmacy Headquarters	F	P	A-9	A-9	A-9						ODS E.g. P001
Primary Care Trust (PCT)	D	5	A-9	A-9							ODS E.g. 5CT All Primary Care Trusts closed 31 March 2013
Prison Health Service	B	Y	D	E	A-9	A-9					ODS E.g. YDE01
School	C	E	E	A-9	A-9	A-9	A-9	A-9	A-9	Department for Education and ODS	E.g. EE134290
Special Health Authority (SpHA)	I	T	1	0-9	0-9	0					ODS E.g. T1150
Strategic Health Authority (SHA)	D	Q	A-9	A-9							ODS E.g. Q30 All Strategic Health Authorities in England closed 31 March 2013
Welsh Assembly	D	W	0-9	0-9							ODS E.g. W01
Welsh Health Commission	A	W	0-9	0-9	A-Y	A-Y					ODS E.g. W01HC

Notes:

- Codes for Executive Agency, Executive Agency Programme, Executive Agency Site and Executive Agency Programme Department do not easily fit into the coding frames as shown above and are therefore not included. This is due to their unusual structure in that there are more hierarchical 'tiers' than with other organisations.

Executive Agency and Executive Agency Programme are both considered Organisation level entities, although each Programme does have a relationship to an Executive Agency. Executive Agency codes are three characters long. Executive Agency Programme codes are six, and their first three characters are the same as the Executive Agency they are associated to.

Department codes of eight characters long can then be allocated underneath a Programme code (sharing the first six characters). Executive Agency Site codes of five characters long can be allocated under an Executive Agency code (and share the first three characters).

- A-9 indicates that characters A-Z and 0-9 are valid: except B, I, O, S, U and Z (to avoid ambiguity). This applies to all [ORGANISATION CODES](#) in the Coding Format Table above except [Independent Sector Healthcare Providers \(ISHP\)](#).

Table 2: CODING FORMATS FOR ORGANISATIONS IN SCOTLAND

Scottish [ORGANISATION CODES](#) are supplied by the Information Standards Directorate (ISD) from NHS Scotland and published by the [Organisation Data Service](#).

Organisation Type	Character Position						Code allocated by:	Notes/Comments
	1	2	3	4	5	6		
GP Practice - Scotland	S	0-9	0-9	0-9	0-9	0-9	NHS	
Scottish GP Fundholder	S	A-Z	B	0-9	0-9		ISD, Scotland	2nd character identifies the Health Board the GPFH reports to. 3rd character (always B) shows GPFH status.
Scottish Health Agency	S	D	0-9	0-9	0-9		ISD, Scotland	2nd character (D) identifies Scottish Office agencies
Scottish Health Board	S	A-Z	9	9	9		ISD, Scotland	
Scottish Provider	S	A-Z	A,C,D	0-9	0-9		ISD, Scotland	2nd character identifies the Health Board the organisation reports to. 3rd character identifies the organisation type: A= Health Unit C = Hospital Trust D = Nursing Home

Table 3: CODING FORMATS for ORGANISATIONS in OTHER HOME COUNTRIES

Organisation Type	Character Position						Code allocated by:	Notes/Comments
	1	2	3	4	5	6		
GP Practice - Alderney	A	L	D	0-9	0-9	0-9	NHS Prescription Services	
GP Practice - Guernsey	G	U	E	0-9	0-9	0-9	NHS Prescription Services	

GP Practice - Isle of Man (IOM)	Y	0-9	0-9	0-9	0-9	0-9	NHS Prescription Services	
GP Practice - Jersey	J	E	R	0-9	0-9	0-9	NHS Prescription Services	
Primary Healthcare Directorate (Isle of Man)	Y	K	A-9				ODS	E.g. YK1

Note: A-9 indicates that characters A-Z and 0-9 are valid: except B, I, O, S, U and Z (to avoid ambiguity).

ORGANISATION IDENTIFIER

Change to Attribute: Changed Dataset

A unique identifier for an [ORGANISATION](#).

Note:

- [ORGANISATION IDENTIFIERS](#) are governed by the fundamental standard for "Health and Social Care Organisation Reference Data" (HSC Org Ref Data).
- The standard only relates to [ORGANISATION IDENTIFIERS](#) which are maintained and published by the [Organisation Data Service \(ODS\)](#). See [Health and Social Care Organisation Reference Data](#).

The Format/Length of a published code for an:

- [Organisation](#) is min an3 max an8
- [Organisation Site](#) is min an5 max an9.

[ORGANISATION CODE](#) will be replaced with [ORGANISATION IDENTIFIER](#), which is the most recent approved national information standard to describe the required definition.

ORGANISATION SITE CODE

Change to Attribute: Changed Dataset

[ORGANISATION SITE CODE](#) will be replaced with [ORGANISATION IDENTIFIER](#), which is the most recent approved national information standard to describe the required definition.

An [ORGANISATION SITE CODE](#) is a code which identifies an [Organisation Site](#) uniquely.

Note: Only [ORGANISATION SITE CODES](#) which have been notified to and issued by the [Organisation Data Service](#) may be used.

Notes:

- [Organisation Data Service](#) codes can be downloaded from [Technology Reference Data Update Distribution \(TRUD\)](#)
- [Organisation Data Service](#) contact details can be found at [Contact Details](#).

ORGANISATION SITE CODING FRAMES

- All NHS [Organisation Sites](#) are coded using coding frames, as shown in the tables below:

Character Position	1	2	3	4	5	6	7	8	9
Format	a/n	a/n	a/n	a/n	a/n	a/n	a/n	a/n	a/n
A Frame	Organisation Type Identifier			Organisation Identifier					

				Site or Sub-Division Identifier			
B Frame	Organisation Type Identifier	Organisation Identifier	Site or Sub-Division Identifier				
C Frame	Organisation Type Identifier	Organisation Identifier	Site or Sub-Division Identifier				
D Frame	Organisation Type Identifier	Practice Identifier			Branch Surgery Identifier		
F Frame	Organisation Type Identifier	Organisation Identifier					
H Frame	Organisation Type Identifier		Organisation Identifier				
I Frame	Organisation Type Identifier	Organisation Identifier					
J Frame	Organisation Type Identifier	Organisation Identifier					
K Frame	Organisation and Organisation Type Identifier		Organisation Site Identifier				
L Frame	Organisation Type Identifier <i>and</i> Site or Sub-Division Identifier						

A Frame:

Example

Local Service Provider Site e.g. LSP0101

- LSP = Org Type Identifier
- 01 = Organisation Identifier
- 01 = Site or Sub-Division Identifier

B Frame:

Example

Care Trust Site e.g. TAK01

- T = Organisation Type Identifier
- AK = Organisation Identifier
- 01 = Site or Sub-Division Identifier

Also:

Government Department Site e.g. XDA01
 High Level Health Geography Site, e.g. [NHS England \(Region Local Office\)](#) site e.g. Q7201
[Local Authority](#) Site e.g. 000AA

Local Health Board (Wales) Site	e.g. 7A101
NHS Trust Site	e.g. RH802
Other Statutory Authority (OSA) Site	e.g. X1601
	e.g. Q3001

C Frame:

Example

[Independent Sector Healthcare Provider \(ISHP\) Site](#) e.g. NV701

- NV = Organisation Site Type Identifier
 - 7 = Organisation Identifier
 - 01 = Site or Sub-Division Identifier
-

D Frame

Example

[GP Practice Branch Surgery](#): e.g. H81010002

- H (and length of code) = Organisation Identifier
 - 81010 = Organisation Identifier (parent GP Practice)
 - 002 = Branch Surgery Identifier
-

F Frame

Example

[Commissioning Support Unit Site](#): e.g. 0AA01

- 0 = Organisation Type Identifier
 - AA01 = Organisation Identifier
-

H Frame

Example

Prison: e.g. YDE01

- YDE = Organisation Type Identifier
 - 01 = Site or Sub-Division Identifier
-

I Frame

Example

[Optical Site](#): e.g. TP01A

- TP = Organisation Type Identifier
 - 01A = Site or Sub-Division Identifier
-

J Frame

Example

[Care Home Site](#): e.g. VN01A

- VN = Organisation Type Identifier
- 01A = Site or Sub-Division Identifier

Also:

Health Observatory	e.g. XP001
Primary Healthcare Directorate (Isle of Man) Site	e.g. YK101

K Frame

Example

[Clinical Commissioning Group \(CCG\) Site](#) e.g. 11AAA - 99YZZ

- 11A = Organisation and Organisation Type Identifier

- AA = Organisation Site Identifier

L Frame

Example

[Special Health Authority \(SpHA\)](#) Site: e.g. T115A

- T115A – Organisation Type Identifier *and* Site or Sub-Division Identifier

The structure and format of [ORGANISATION SITE CODES](#) maintained by the [Organisation Data Service](#), [NHS Prescription Services](#) and other agencies are detailed in the tables below.

NHS ORGANISATION SITE CODES TABLES

Coding Formats

Table 1: CODING FORMATS FOR ORGANISATION SITES IN ENGLAND AND WALES

Organisation Site Type	Frame Type	Character Position									Code allocated by:	Notes/Comments
		1	2	3	4	5	6	7	8	9		
	See Coding Frames Table											
Care Home Site	J	V	L, M or N	A-9	A-9	A-9					ODS	E.g. VN01A, VM01A, VL01A
Care Trust Site	B	T	A-Y	A-Y	A-9	A-9					ODS	First three characters denote owning Care Trust E.g. TAK01
Clinical Commissioning Group (CCG) Site	K	0-9	0-9	A-Y	A-Y	A-Y					ODS	First three characters denote owning Clinical Commissioning Group E.g. 11AAA - 99YZZ
Commissioning Support Unit (CSU) Site	F	0	A-Y	A-Y	A-9	A-9					ODS	E.g. 0AA01
Executive Agency Site	N/A See Note	X	0-9	0-9	0-9	0-9					ODS	First three characters denote Executive Agency E.g. X0901
Government Department Site	B	X	A-Y	A-Y	0-9	0-9					ODS	First three characters denote Government Department E.g. XDA01

GP Practice Branch Surgery - England and Wales	D	A-H, J-N, P, W & Y	0-9	0-9	0-9	0-9	0-9	0-9	0-9	0-9	ODS	First 6 characters denote parent practice. Char 1 = W for Welsh GP Practice . All other values represent English GP Practices E.g. H81010002
Health Observatory	J	X	P	0-9	0-9	0-9					ODS	E.g. XP001
High Level Health Geography Site, e.g. NHS England (Region Local Office) site	B	Q	A-9	A-9	A-9	A-9					ODS	E.g. Q7201
Independent Sector Healthcare Provider (ISHP) Site	C	A, B, D, G, I, K, L, M, N, O, S, U, V, W	A-Y	A-Y, 0-9	A-Y, 0-9	A-Y, 0-9					ODS	First three characters denote owning Independent Sector Healthcare Provider (ISHP) E.g. NV701 Note: The A-Y range includes all letters except Z
Local Authority (LA) Site	B	0-9	0-9	0-9	A-Z	A-Z					ODS	First three characters denote parent Local Authority E.g. 000AA
Local Health Board (Wales) Site	B	7	A-9	A-9	A-9	A-9					ODS	First three characters denote owning NHS Trust E.g. 7A101
Local Service Provider Site	A	L	S	P	0-9	0-9	0-9	0-9			ODS	First five characters denote owning Local Service Provider E.g. LSP0101
NHS Trust Site	B	R	A-9	A-9	A-9	A-9					ODS	First three characters denote owning NHS Trust E.g. RH802
Optical Site	I	T	P or Q	0-9	A-9	A-9					ODS	E.g. TP01A, TQ01A

Other Statutory Authority (OSA) Site	B	X	0-9	0-9	0-9	0-9					ODS	First three characters denote owning Other Statutory Authority E.g. X1601
Primary Care Trust (PCT) Site	B	5	A-9	A-9	A-9	A-9					ODS	First three characters denote owning Primary Care Trust E.g. 5CT49 All Primary Care Trusts closed 31 March 2013
Special Health Authority (SpHA) Site	L	T	1	0-9	0-9	A-Y, 1-9					ODS	The characters do NOT denote any ownership. E.g. T115A
Strategic Health Authority (SHA) Site	B	Q	A-9	A-9	A-9	A-9					ODS	First three characters denote owning SHA Trust E.g. Q3001 All Strategic Health Authorities closed 31 March 2013 - from 1 April 2013 referred to as High Level Health Geography Site

Note: Codes for Executive Agency, Executive Agency Programme, Executive Agency Site and Executive Agency Programme Department do not easily fit into the coding frames as shown above and are therefore not included. This is due to their unusual structure in that there are more hierarchical 'tiers' than with other organisations.

Executive Agency and Executive Agency Programme are both considered Organisation level entities, although each Programme does have a relationship to an Executive Agency. Executive Agency codes are three characters long. Executive Agency Programme codes are six, and their first three characters are the same as the Executive Agency they are associated to.

Department codes of eight characters long can then be allocated underneath a Programme code (sharing the first six characters). Executive Agency Site codes of five characters long can be allocated under an Executive Agency code (and share the first three characters).

Note: A-9 indicates that characters A-Z and 0-9 are valid: except B, I, O, S, U and Z (to avoid ambiguity). This applies to all [ORGANISATION SITE CODES](#) in the Coding Format Table above except [Independent Sector Healthcare Provider \(ISHP\)](#) sites.

Table 2: CODING FORMATS FOR ORGANISATION SITES IN OTHER HOME COUNTRIES

Organisation Site Type	Frame Type	Character Position									Code allocated by:	Notes/Comments
	See Coding Frames Table	1	2	3	4	5	6	7	8	9		

Primary Healthcare Directorate (Isle of Man) Site	J	Y	K	A-9	A-9	A-9					ODS	E.g. YK101
---	---	---	---	-----	-----	-----	--	--	--	--	---------------------	------------

Note: A-9 indicates that characters A-Z and 0-9 are valid: except B, I, O, S, U and Z (to avoid ambiguity).

OTHER PERSON IN ATTENDANCE AT CARE CONTACT

Change to Attribute: Changed Dataset

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

PATIENT PATHWAY IDENTIFIER

Change to Attribute: Changed Dataset

An identifier, which together with the [ORGANISATION CODE](#) / [ORGANISATION IDENTIFIER](#) of the issuer, uniquely identifies a [PATIENT PATHWAY](#).

This is a specific type of the attribute [ACTIVITY IDENTIFIER](#).

Where a pathway is initiated by a [SERVICE REQUEST](#) using the [Choose and Book](#) system, the [PATIENT PATHWAY](#) will be uniquely identified by the Unique Booking Reference Number (UBRN) of the first referral and the [ORGANISATION CODE](#) of [Choose and Book](#) which is X09.

Where the pathway is initiated by some other method, the [PATIENT PATHWAY IDENTIFIER](#) will be allocated by the [Organisation](#) receiving the [SERVICE REQUEST](#) which together with that [Organisation's](#) [ORGANISATION CODE](#) / [ORGANISATION IDENTIFIER](#) will uniquely identify the [PATIENT PATHWAY](#).

PERSON BIRTH DATE

Change to Attribute: Changed Dataset

The date on which a [PERSON](#) was born or is officially deemed to have been born.

Note:

This was [e-GIF](#) approved for use in NHS England. [e-GIF](#) and the [Government Data Standards Catalogue](#) **have been archived** and are available for reference only.

PERSON DEATH DATE

Change to Attribute: Changed Dataset

The date on which a [PERSON](#) died or is officially deemed to have died.

This is as recorded on the Death Certificate.

Note:

This was [e-GIF](#) approved for use in NHS England. [e-GIF](#) and the [Government Data Standards Catalogue](#) **have been archived** and are available for reference only.

PERSON MARITAL STATUS CODE

Change to Attribute: Changed Dataset

An indicator to identify the legal marital status of a [PERSON](#).

National Codes:

S	Single
M	Married/Civil Partner
D	Divorced/Person whose Civil Partnership has been dissolved
W	Widowed/Surviving Civil Partner
P	Separated
N	Not disclosed

Previous specification, now obsolete and not for use:

1	Single (Retired 2006-10-01)
2	Married/separated (Retired 2006-10-01)
3	Divorced (Retired 2006-10-01)
4	Widowed (Retired 2006-10-01)

PERSON PROPERTY EFFECTIVE DATE

Change to Attribute: Changed Dataset

The date when a [PERSON PROPERTY](#) became effective for a [PATIENT](#).

Examples may be the date when the [PATIENT](#) experienced a symptom or gave up smoking.

PERSON PROPERTY EFFECTIVE END DATE

Change to Attribute: Changed Dataset

The date when a [PERSON PROPERTY](#) is no longer applicable to the [PATIENT](#).

PERSON PROPERTY EFFECTIVE END TIME

Change to Attribute: Changed Dataset

The time when a [PERSON PROPERTY](#) is no longer applicable to the [PATIENT](#).

PERSON PROPERTY OBSERVED DATE

Change to Attribute: Changed Dataset

The date when the [PERSON PROPERTY](#) was observed by a [PERSON](#).

PERSON PROPERTY RECORDED DATE

Change to Attribute: Changed Dataset

The date when the [PERSON PROPERTY](#) was recorded by a [PERSON](#).

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

PERSON SCORE

Change to Attribute: Changed Dataset

The score taken from an [ASSESSMENT TOOL](#).

This could be for an individual element of, or question within, an [ASSESSMENT TOOL](#), a subtotal or total score.

The purpose of the [PERSON SCORE](#) is to measure changes in health and wellbeing.

PERSON STATED GENDER CODE

Change to Attribute: Changed Dataset

The gender of a [PERSON](#).

[PERSON STATED GENDER CODE](#) is self declared or inferred by observation for those unable to declare their [PERSON STATED GENDER](#).

National Codes:

- 1 Male
- 2 Female
- 9 Indeterminate (unable to be classified as either male or female)

[PERSON GENDER CODE](#) will be replaced with [PERSON STATED GENDER CODE](#) or [PERSON PHENOTYPIC SEX CLASSIFICATION](#), which is the most recent approved national information standard to describe the required definition.

PLACE OF SAFETY INDICATOR

Change to Attribute: Changed Dataset

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](#)

PLANNED ACTIVITY DATE

Change to Attribute: Changed Dataset

Any [DATE](#) that is of relevance to a [PLANNED ACTIVITY](#).

The specific nature of the [DATE](#) will be identified by the [PLANNED ACTIVITY DATE TYPE](#).

PLANNED ACTIVITY DATE TYPE

Change to Attribute: Changed Description

The type of date that defines the usage with regard to the [PLANNED ACTIVITY](#).

A [PLANNED ACTIVITY](#) may have many dates associated with it but may only have one date of a particular type.

National Codes:

- 01 [Planned Discharge Date \(Hospital Provider Spell\)](#)
[Estimated Discharge Date \(Hospital Provider Spell\)](#)

Note: This list is not in alphabetical order.

POSTCODE

Change to Attribute: Changed Dataset

The code assigned by Royal Mail to identify postal delivery areas across the United Kingdom.

[POSTCODES](#) may also be used to identify a [GEOGRAPHIC AREA](#).

Note:

This was [e-GIF](#) approved for use in NHS England.

[e-GIF](#) and the [Government Data Standards Catalogue](#) have been archived and are available for reference only.

PRESCRIPTION DATE

Change to Attribute: Changed Dataset

The date on which the [PRESCRIPTION](#) was signed by the [CARE PROFESSIONAL](#).

PROCEDURE SCHEME IN USE

Change to Attribute: Changed Dataset

The type of [CODED CLINICAL ENTRY](#) used for the [CLINICAL INTERVENTION](#).

National Codes:

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

Notes:

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

PROFESSIONAL REGISTRATION BODY CODE

Change to Attribute: Changed Dataset

A code which identifies the [PROFESSIONAL REGISTRATION BODY](#).

National Codes:

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

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

PROFESSIONAL REGISTRATION ENTRY IDENTIFIER

Change to Attribute: Changed Dataset

The registration identifier allocated by an [Organisation](#).

Examples include:

- [GENERAL DENTAL COUNCIL REGISTRATION NUMBER](#)
 - [GENERAL MEDICAL COUNCIL REFERENCE NUMBER](#).
-

REASON FOR OUT OF AREA REFERRAL FOR ADULT ACUTE MENTAL HEALTH

Change to Attribute: Changed Dataset

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

REASON FOR REFERRAL TO MENTAL HEALTH

Change to Attribute: Changed Dataset, Description

The reason that a [PATIENT](#) was referred to a [Mental Health Service](#).

National Codes:

- 01 (Suspected) First Episode Psychosis
- 02 Ongoing or Recurrent Psychosis
- 03 Bi polar disorder
- 04 Depression
- 05 Anxiety
- 06 Obsessive compulsive disorder
- 07 Phobias
- 08 Organic brain disorder
- 09 Drug and alcohol difficulties
- 10 Unexplained physical symptoms
- 11 Post-traumatic stress disorder
- 12 Eating disorders
- 13 Perinatal mental health issues
- 14 Personality disorders
- 15 Self harm behaviours
- 16 Conduct disorders
- 17 ~~Neurodevelopmental conditions~~
- 17 [Neurodevelopmental conditions \(Retired 1 April 2018\)](#)
- 18 In crisis
- 19 Relationship difficulties
- 20 Gender Discomfort issues
- 21 Attachment difficulties
- 22 Self - care issues
- 23 Adjustment to health issues
- 24 [Neurodevelopmental Conditions, excluding Autism Spectrum Disorder](#)
- 25 [Suspected Autism Spectrum Disorder](#)
- 26 [Diagnosed Autism Spectrum Disorder](#)
- 27 [Preconception perinatal mental health concern](#)

REFERRAL CLOSURE REASON

Change to Attribute: Changed Dataset

The reason that a [REFERRAL REQUEST](#) was closed by a [Health Care Provider](#).

National Codes:

- 01 Admitted elsewhere (at the same or other [Health Care Provider](#))
- 02 Treatment completed
- 03 Moved out of the area
- 04 No further treatment appropriate

- 05 [PATIENT](#) did not attend
- 06 [PATIENT](#) died
- 07 [PATIENT](#) requested discharge
- 08 Referred to other speciality/[SERVICE](#) (at the same or other [Health Care Provider](#))
- 09 [PATIENT](#) refused to be seen

REFERRAL REJECTION REASON

Change to Attribute: Changed Dataset

The reason that a [REFERRAL REQUEST](#) was rejected by a [Health Care Provider](#).

National Codes:

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

REFERRAL REQUEST RECEIVED DATE

Change to Attribute: Changed Dataset

The date the [REFERRAL REQUEST](#) was received by the [Health Care Provider](#).

The waiting time for a first [Out-Patient Appointment](#) should be calculated from the date when the [REFERRAL REQUEST](#) is received.

- For electronic [REFERRAL REQUESTS](#) the [REFERRAL REQUEST RECEIVED DATE](#) is the date the [REFERRAL REQUEST](#) is received electronically by the [Health Care Provider](#)
- For [Choose and Book](#), the referral is received when the [PATIENT](#)'s Unique Booking Reference Number (UBRN) is used to book the first [Out-Patient Appointment](#) slot (i.e. converted).

Where an electronic [REFERRAL REQUEST](#) made through Choose and Book is rejected by the chosen provider, the [ORIGINAL REFERRAL REQUEST RECEIVED DATE](#) should be used when the [PATIENT](#) is subsequently re-referred to another service, so that [PATIENTS](#) are not unfairly disadvantaged when their waiting time calculations are made.

In the circumstance that a [PATIENT](#) calls the national [Choose and Book](#) Appointments Line and an [APPOINTMENT SLOT](#) is not available with the chosen [Health Care Provider](#), the national [Choose and Book](#) Appointments Line will electronically forward the [REFERRAL REQUEST](#) details to the chosen [Health Care Provider](#) so the [Health Care Provider](#) can liaise directly with the [PATIENT](#) to arrange their [Out-Patient Appointment](#). The [REFERRAL REQUEST RECEIVED DATE](#) will be the date that the [Health Care Provider](#) receives electronic notification from the national [Choose and Book](#) Appointments Line that the [PATIENT](#) has experienced slot unavailability. (Note that this is NOT the date that the [Health Care Provider](#) opens or actions the electronic notification).

For written [REFERRAL REQUESTS](#) letters must be opened and date stamped on the day of receipt. It is this date that must be entered on any Patient Administration System (PAS) or similar system, not the date on which the information is fed into the system if this is later than the date of receipt.

If the [REFERRAL REQUEST](#) takes the form of a phone call followed by a letter, record the date when the letter arrives. If there is no following letter, the date of the verbal request should be recorded.

REFERRAL REQUEST RECEIVED TIME

Change to Attribute: Changed Dataset

The time the [REFERRAL REQUEST](#) was received by the [Health Care Provider](#).

REFERRAL TO TREATMENT PERIOD END DATE

Change to Attribute: Changed Dataset

The end date of a [REFERRAL TO TREATMENT PERIOD](#).

This is a specific type of the attribute [ACTIVITY DATE](#).

[REFERRAL TO TREATMENT PERIOD END DATE](#) will be one of the following:

- the [ACTIVITY DATE](#):

- when the [PATIENT](#) is admitted for [First Definitive Treatment](#). If the start of a [PATIENT](#)'s treatment is cancelled (by the [Health Care Provider](#) or [PATIENT](#)) after admission, the [REFERRAL TO TREATMENT PERIOD](#) will continue.
- for [First Definitive Treatment](#) undertaken in an outpatient setting.
- for [First Definitive Treatment](#) undertaken by an [NHS Allied Health Professional Service \(Referral To Treatment Measurement\)](#).
- when the decision not to treat is made, with no further action at this time communicated to the [PATIENT](#). This will include [Discharge After Patient Did Not Attend](#) and discharge back to primary care for treatment.
- when the [PATIENT](#) declines offered treatment.
- when the [PATIENT](#) did not attend for the first [ACTIVITY](#) during a [REFERRAL TO TREATMENT PERIOD](#). See [REFERRAL TO TREATMENT PERIOD](#) for guidance on [PATIENTS](#) who do not attend.
- the clinical decision is made (and agreed with the [PATIENT](#)) that [Active Monitoring](#) will begin. If a [PATIENT](#) subsequently requires further treatment this decision would start a new [REFERRAL TO TREATMENT PERIOD](#) as part of the same [PATIENT PATHWAY](#). This includes any treatment that is planned for a specific date in the future as ongoing monitoring.
- a clinical decision is made and has been communicated to the [PATIENT](#), and subsequently their [GENERAL PRACTITIONER](#) and/or other referring [CARE PROFESSIONAL](#) without undue delay, to add the [PATIENT](#) to a transplant list.

or

- the [PERSON DEATH DATE](#).

In the event that a [PATIENT](#) is booked into the wrong clinic and needs to be re-referred to the right one, this will not end the [REFERRAL TO TREATMENT PERIOD](#) or restart it. The start of the [REFERRAL TO TREATMENT PERIOD](#) is still the original [REFERRAL REQUEST RECEIVED DATE](#).

REFERRAL TO TREATMENT PERIOD START DATE

Change to Attribute: Changed Dataset

The start date of a [REFERRAL TO TREATMENT PERIOD](#).

This is a specific type of the attribute [ACTIVITY DATE](#).

A [REFERRAL TO TREATMENT PERIOD START DATE](#) will be one of the following:

- **Initial Referral:**
 - the [REFERRAL REQUEST RECEIVED DATE](#) of a [SERVICE REQUEST](#) for a particular condition.
 - This will include a [PATIENT](#) being re-referred in to a [Consultant Led Service](#) or an [Interface Service](#) or an [NHS Allied Health Professional Service \(Referral To Treatment Measurement\)](#) as a new referral including after a [Discharge After Patient Did Not Attend](#). The [REFERRAL TO TREATMENT PERIOD STATUS](#) is '*National Code 10 - first activity*'
- **Following an [APPOINTMENT](#) that the [PATIENT](#) did not attend:**
 - the [APPOINTMENT ACCEPTED DATE](#) (or the [INVITATION OFFER DATE SENT](#) of the first [APPOINTMENT OFFER](#) where the [APPOINTMENT OFFER](#) is sent) for the first [APPOINTMENT](#) following the [PATIENT](#) not attending an [APPOINTMENT](#) or elective admission. See [REFERRAL TO TREATMENT PERIOD](#) and [Discharge After Patient Did Not Attend](#) for guidance on [PATIENTS](#) who do not attend
 - The [APPOINTMENT DATE](#) of the [APPOINTMENT](#) that the [PATIENT](#) did not attend should be used where it is not possible to identify the [APPOINTMENT ACCEPTED DATE](#) or the [INVITATION OFFER DATE SENT](#). The [REFERRAL TO TREATMENT PERIOD STATUS](#) is '*National Code 10 - first activity*'
- **Following active monitoring:**
 - the [ACTIVITY DATE](#) of a [CARE ACTIVITY](#) when a decision to treat was made following [Active Monitoring](#) and the [REFERRAL TO TREATMENT PERIOD STATUS](#) is '*National Code 11 - active monitoring end*'
 - This will include a decision to start a substantively new or different treatment that does not already form part of that [PATIENT](#)'s agreed [CARE PLAN](#).
- **On identifying a separate condition:**
 - the [REFERRAL REQUEST RECEIVED DATE](#) of a [SERVICE REQUEST](#) when a decision has been made to refer the [PATIENT](#) directly to a [Consultant Led Service](#) or an [NHS Allied Health Professional Service \(Referral To Treatment Measurement\)](#) for a separate condition (the [REFERRAL TO TREATMENT PERIOD STATUS](#) for the first [CARE ACTIVITY](#) with the new [CONSULTANT](#) or [NHS Allied Health Professional Service \(Referral To Treatment Measurement\)](#) is '*National Code 12 - consultant or NHS Allied Health Professional Service (Referral To Treatment) referral*').

Referral To Treatment Consultant Led Waiting Times:

For most [PATIENTS](#), the start of the [REFERRAL TO TREATMENT PERIOD](#) begins with a [SERVICE REQUEST](#) from a [GENERAL MEDICAL PRACTITIONER](#) to a [CONSULTANT](#).

[SERVICE REQUESTS](#) to [CONSULTANTS](#) who provide care [SERVICES](#) in community settings also start [REFERRAL TO TREATMENT PERIODS](#) and the [REFERRAL REQUEST RECEIVED DATE](#) will be the start of the [REFERRAL TO TREATMENT PERIOD](#).

A [REFERRAL TO TREATMENT PERIOD](#) may also start from [SERVICE REQUESTS](#) to [CONSULTANTS](#) from [GENERAL DENTAL PRACTITIONERS](#), [Practitioners with Special Interests](#), [OPTOMETRISTS](#) and [Orthoptists](#), National [Screening Programmes](#), Specialist [NURSES](#), other [CARE PROFESSIONALS](#) where commissioning [Organisations](#) have approved these mechanisms locally.

An 18-week clock also starts upon a self referral by a [PATIENT](#) to the above services, where these pathways have been agreed locally by commissioners and providers and once the referral is ratified by a [CARE PROFESSIONAL](#).

A [REFERRAL TO TREATMENT PERIOD](#) will also start where [PATIENTS](#) are transferred to an elective [Consultant Led Service](#) through [SERVICE REQUESTS](#) from [Accident and Emergency Departments](#) including Minor injuries units and Walk In Centres.

Allied Health Professional Referral To Treatment Measurement:

Further guidance relating to the Allied Health Professional Referral To Treatment can be found on the [Department of Health](#) part of the gov.uk website at: [Allied health professional referral to treatment revised guide](#).

REFERRAL TO TREATMENT PERIOD STATUS

Change to Attribute: Changed Dataset

The status of an [ACTIVITY](#) (or anticipated [ACTIVITY](#)) for the [REFERRAL TO TREATMENT PERIOD](#) decided by the lead [CARE PROFESSIONAL](#).

National Codes:

- The first [ACTIVITY](#) in a [REFERRAL TO TREATMENT PERIOD](#) where the [First Definitive Treatment](#) will be a subsequent [ACTIVITY](#)**
- 10 first [ACTIVITY](#) - first [ACTIVITY](#) in a [REFERRAL TO TREATMENT PERIOD](#)
- 11 [Active Monitoring](#) end - first [ACTIVITY](#) at the start of a new [REFERRAL TO TREATMENT PERIOD](#) following [Active Monitoring](#)
- 12 [CONSULTANT](#) or [NHS Allied Health Professional Service \(Referral To Treatment Measurement\)](#) referral - the first [ACTIVITY](#) at the start of a new [REFERRAL TO TREATMENT PERIOD](#) following a decision to refer directly to the [CONSULTANT](#) or [NHS Allied Health Professional Service \(Referral To Treatment Measurement\)](#) for a separate condition
- Subsequent [ACTIVITY](#) during a [REFERRAL TO TREATMENT PERIOD](#)**
- 20 subsequent [ACTIVITY](#) during a [REFERRAL TO TREATMENT PERIOD](#) - further [ACTIVITIES](#) anticipated
- 21 transfer to another [Health Care Provider](#) - subsequent [ACTIVITY](#) by another [Health Care Provider](#) during a [REFERRAL TO TREATMENT PERIOD](#) anticipated
- [ACTIVITY](#) that ends the [REFERRAL TO TREATMENT PERIOD](#)**
- 30 Start of [First Definitive Treatment](#)
- 31 start of [Active Monitoring](#) initiated by the [PATIENT](#)
- 32 start of [Active Monitoring](#) initiated by the [CARE PROFESSIONAL](#)
- 33 Did not attend - the [PATIENT](#) did not attend the first [CARE ACTIVITY](#) after the referral¹
- 34 decision not to treat - decision not to treat made or no further contact required²
- 35 [PATIENT](#) declined offered treatment
- 36 [PATIENT](#) died before treatment
- [ACTIVITY](#) that is not part of a [REFERRAL TO TREATMENT PERIOD](#)**
- 90 after treatment - [First Definitive Treatment](#) occurred previously (e.g. admitted as an emergency from A&E or the [ACTIVITY](#) is after the start of treatment)
- 91 [Active Monitoring](#) - [CARE ACTIVITY](#) during [Active Monitoring](#)
- 92 not yet referred - not yet referred for treatment, undergoing diagnostic tests by [GENERAL PRACTITIONER](#) before referral
- 98 not applicable - [ACTIVITY](#) not applicable to [REFERRAL TO TREATMENT PERIODS](#)
- [ACTIVITY](#) where the [REFERRAL TO TREATMENT PERIOD STATUS](#) is not yet known**
- 99 not yet known

Where the [REFERRAL TO TREATMENT PERIOD STATUS](#) is National Code 99 - "not yet known" the status is treated as if the [ACTIVITY](#) is a subsequent [ACTIVITY](#) during a [REFERRAL TO TREATMENT PERIOD](#). In this case the [REFERRAL TO TREATMENT PERIOD STATUS](#) should be corrected once it is possible to determine the correct value.

¹ [PATIENTS](#) who do not attend an appointment

National code 33 - "Did not attend - the [PATIENT](#) did not attend the first [CARE ACTIVITY](#) after the referral" may only be used where

- the [PATIENT](#) did not attend their first [APPOINTMENT](#) following the [REFERRAL REQUEST](#) that started the [REFERRAL TO TREATMENT PERIOD](#), provided that the [Health Care Provider](#) can demonstrate that the [APPOINTMENT](#) was clearly communicated to the [PATIENT](#).

[REFERRAL TO TREATMENT PERIODS](#) with [REFERRAL TO TREATMENT PERIOD STATUS](#) of National code 33 are excluded from the measurement of the 18 weeks [Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement](#) and the count of [Allied Health Professional Referral To Treatment Measurement REFERRAL TO TREATMENT PERIODS](#)

² Decision not to treat

National Code 34 - "decision not to treat - decision not to treat made or no further contact required" includes

- a [Discharge After Patient Did Not Attend](#) the second or a subsequent [CARE ACTIVITY](#) after the referral.
- a change resulting in care no longer being commissioned by the English NHS.

- a referral to a [Consultant Led Service](#) during a [Referral To Treatment Period Excluded From Target](#) for the same condition, disease or injury. A new [REFERRAL TO TREATMENT PERIOD](#) will start.

REFERRED OUT OF AREA REASON FOR ADULT ACUTE MENTAL HEALTH

Change to Attribute: Changed Dataset

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

REFERRING CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH AND COMMUNITY CARE

Change to Attribute: Changed Dataset

The staff group of a [CARE PROFESSIONAL](#) who referred a [PATIENT](#) to a [Community Health Service](#) or [Mental Health Service](#).

National Codes:

- Allied Health Professionals**
- A01 Art Therapist
- A02 [Clinical Psychologist](#)
- A03 [Dietitian](#)
- A04 Drama Therapist
- A05 Music Therapist
- A06 [Occupational Therapist](#)
- A07 [Orthotist](#)
- A08 [Physiotherapist](#)
- A09 [Podiatrist](#)
- A10 [Prosthetist](#)
- A11 Psychotherapist
- A12 [Radiographer](#)
- A13 [Speech and Language Therapist](#)
- A14 [Orthoptist](#)
- Medical/Dental**
- M01 Community Dentist
- M02 [CONSULTANT](#)
- M03 [GENERAL MEDICAL PRACTITIONER](#)
- M04 [General Practitioner With A Special Interest](#)
- Nursing, Health Visiting and Midwifery**
- N01 [MIDWIFE](#)
- N02 District [NURSE](#)
- N03 [Health Visitor](#)
- N04 Macmillan [NURSE](#)
- N05 [School Nurse](#)
- N06 Specialist Nursing - Active Case Management (Community Matrons)
- N07 Specialist Nursing - Arthritis Nursing/Liaison
- N08 Specialist Nursing - Asthma and Respiratory Nursing/Liaison
- N09 Specialist Nursing - Breast Care Nursing/Liaison
- N10 Specialist Nursing - Cancer Related
- N11 Specialist Nursing - Cardiac Nursing/Liaison

- N12 Specialist Nursing - Children's Services
- N13 Specialist Nursing - Community Cystic Fibrosis
- N14 Specialist Nursing - Continence Services
- N15 Specialist Nursing - Diabetic Nursing/Liaison
- N16 Specialist Nursing - Enteral Feeding Nursing Services
- N17 Specialist Nursing - Haemophilia Nursing Services
- N18 Specialist Nursing - HIV/AIDS Nursing Services (Retired 01 September 2015)
- N19 Specialist Nursing - Infectious Diseases
- N20 Specialist Nursing - Intensive Care Nursing
- N21 Specialist Nursing - Palliative/Respite Care
- N22 Specialist Nursing - Parkinson's and Alzheimers Nursing/Liaison
- N23 Specialist Nursing - Rehabilitation Nursing
- N24 Specialist Nursing - Stoma Care Services
- N25 Specialist Nursing - Tissue Viability Nursing/Liaison
- N26 Specialist Nursing - Transplantation Patients Nursing Services
- N27 Specialist Nursing - Treatment Room Nursing Services
- N28 Specialist Nursing - Tuberculosis Specialist Nursing
- N29 Specialist Nursing - Other Specialist Nursing
- N30 Specialist Nursing - Safeguarding
- N31 Practice Nursing
- N32 Staff [NURSE](#)
- N33 Other Registered [NURSE](#)
- N34 Public Health [NURSE](#)
- Other Care Professionals**
- C01 Appliances Technician
- C02 Audiologist
- C03 Counsellor
- C04 Nursery Nurse
- C06 Play Therapist
- C07 [Social Worker](#)
- C08 Voluntary Care Worker
- C09 Screener (in a National [Screening Programme](#))
- C10 Health Trainer (Non Clinical) *
- C11 Health Trainer (Clinical) *
- C12 Health Care Assistant *
- C13 Health Care Support Worker *
- C99 Other [CARE PROFESSIONAL](#) (not listed)

* Note: National Codes C10, C11, C12 and C13 are **only valid** for use in the [Community Services Data Set](#).

RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE

Change to Attribute: Changed Dataset

The [RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION](#) group of a [PERSON](#), as specified by a [PERSON](#).

Note: This is the [Religious Affiliation](#) of a [PERSON](#), not their [Religion](#).

[RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE](#) is aligned with descriptors for "Religious or other belief system affiliation groups" in [SNOMED CT](#)® as follows:

[SNOMED CT Subset](#) Metadata:

- [Subset](#) Name: Religious or other belief system affiliation groups
- [Subset](#) Original Id: 71981000000132
- [Refset](#) FSN: Religious or other belief system affiliation groups simple reference set (foundation metadata concept)
- [Refset](#) Id : 99900260100000106

For further details relating to the [SNOMED CT Subset](#) Metadata, see the [Data Dictionary for Care \(DD4C\)](#) website at: [Religious or other belief system affiliation groups](#).

National Codes:

- A Baha'i
- B Buddhist
- C Christian
- D Hindu

E	Jain
F	Jewish
G	Muslim
H	Pagan
I	Sikh
J	Zoroastrian
K	Other
L	None
M	Declines to Disclose
N	Patient Religion Unknown

REPORTING PERIOD END DATE

Change to Attribute: Changed Dataset

The date that a [REPORTING PERIOD](#) ends.

REPORTING PERIOD START DATE

Change to Attribute: Changed Dataset

The date that a [REPORTING PERIOD](#) begins.

RESTRICTIVE INTERVENTION TYPE

Change to Attribute: Changed Dataset

The type of [Restrictive Intervention](#) used on a [PATIENT](#) during a [Hospital Provider Spell](#).

National Codes:

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

SERVICE OR TEAM TYPE FOR MENTAL HEALTH

Change to Attribute: Changed Dataset, 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
A20	Health Based Place of Safety 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
D05	Individual Placement and Support Service
	Learning Disability Services
E01	Community Team for Learning Disabilities
E02	Epilepsy/Neurological Service
E03	Specialist Parenting Service
E04	Enhanced/Intensive Support 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

SERVICE REQUEST IDENTIFIER

Change to Attribute: Changed Dataset
The unique identifier for a [SERVICE REQUEST](#).

SERVICE TYPE

Change to Attribute: Changed Description

The type of [SERVICE](#).

National Codes:

- 01 [Ambulance Service](#)
- 02 [Cancer Service](#)
- 03 [Community Health Service](#)
- 04 [Consultant Led Service](#)
- 05 [Direct Access Service](#)
- 06 Enhanced Sexual Health Service (Retired November 2014)
- 07 [HIV Service](#)
- 08 [Hospital At Home Service](#)
- 09 [Improving Access to Psychological Therapies Service](#)
- 10 [Interface Service](#)
- 11 [Non-Consultant Led Service](#)
- 12 Professional Staff Group Service (Retired 01 January 2016)
- 13 [Sexual and Reproductive Health Service](#)
- 14 [Stop Smoking Service](#)
- 15 Contraceptive Service (Retired 01 April 2014)
- 16 [Radiotherapy Service](#)
- 17 [Sexual Health Service](#)
- 18 [Mental Health Service](#)
- 19 [Regional Clinical Genetics Service](#)
- [Children and Young People's Mental Health Service](#)

SESSION DATE

Change to Attribute: Changed Dataset

The date of a [SESSION](#) such as [Group Session](#), [Operating Theatre Session](#) or [Consultant Clinic Session](#).

SETTLED ACCOMMODATION INDICATOR

Change to Attribute: Changed Dataset

An indication of whether the main/permanent residence of a [PATIENT](#) is settled [ACCOMMODATION](#).

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

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

National Codes:

- Y Yes - Settled [ACCOMMODATION](#)
- N No - Non-settled [ACCOMMODATION](#)
- Z Not Stated ([PERSON](#) asked but declined to provide a response)

SEX OF PATIENTS

Change to Attribute: Changed Dataset

The sex of [PATIENTS](#) intended to use a [WARD](#) indicated in the operational plans.

Classification:

- a. Males
- b. Females
- c. Either sex

SOURCE OF ADMISSION

Change to Attribute: Changed Dataset, Description

The source of admission to a [Hospital Provider Spell](#) or a [Nursing Episode](#) when the [PATIENT](#) is in a [Hospital Site](#) or a [Care Home](#).

National Code 51 'NHS other hospital provider - [WARD](#) for general [PATIENTS](#) or the younger physically disabled or A & E department' should not be used if the [PATIENT](#) arrives at an [Accident and Emergency Department](#) and is admitted to the same [Hospital Provider](#).

National Codes:

- 19 Usual place of residence unless listed below, for example, a private dwelling whether owner occupied or owned by [Local Authority](#), housing association or other landlord. This includes warden accommodation but not residential accommodation where health care is provided. It also includes [PATIENTS](#) with no fixed abode.
- 29 Temporary place of residence when usually resident elsewhere (e.g. hotels, residential [Educational Establishments](#))
- 39 Penal establishment, [Court](#), or Police Station / [Police Custody Suite](#)
- 40 Penal establishment *
- 41 [Court](#) *
- 42 Police Station / [Police Custody Suite](#) *
- 49 NHS other [Hospital Provider](#) - high security psychiatric accommodation in an NHS [Hospital Provider](#) ([NHS Trust](#) or [NHS Foundation Trust](#))
- 51 NHS other [Hospital Provider](#) - [WARD](#) for general [PATIENTS](#) or the younger physically disabled or A & E department
- 52 NHS other [Hospital Provider](#) - [WARD](#) for maternity [PATIENTS](#) or [Neonates](#)
- 53 NHS other [Hospital Provider](#) - [WARD](#) for [PATIENTS](#) who are mentally ill or have [Learning Disabilities](#)
- 54 NHS run [Care Home](#)
- 65 [Local Authority](#) residential accommodation i.e. where care is provided
- 66 [Local Authority](#) foster care
- 79 Babies born in or on the way to hospital
- 85 Non-NHS (other than [Local Authority](#)) run [Care Home](#)
- 87 Non NHS run hospital
- 88 Non-NHS (other than [Local Authority](#)) run [Hospice](#)

* Note: National Codes 40, 41 and 42 have been introduced for the [Mental Health Services Data Set](#) **only** to add further granularity to National Code 39. However, National Code 39 is still valid for the [Mental Health Services Data Set](#) where extra detail cannot be collected. National Codes 40, 41 and 42 are **NOT** valid in any other data set including Commissioning Data Set version 6-2.

SOURCE OF REFERRAL FOR MENTAL HEALTH

Change to Attribute: Changed Dataset, Description

The source of referral to a [Mental Health Service](#).

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

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

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

National Codes:

- Primary Health Care**
- A1 [GENERAL MEDICAL PRACTITIONER](#)
- A2 [Health Visitor](#)
- A3 Other Primary Health Care
- A4 [Maternity Service ****](#)
- Self Referral**
- B1 Self
- B2 [Carer](#)
- Local Authority Services**
- C1 Social Services
- C2 Education Service
- C3 [Housing Service ****](#)
- Employer**
- D1 Employer
- D2 [Occupational Health ****](#)
- Justice System**
- E1 Police
- E2 [Courts](#)
- E3 Probation Service
- E4 [Prison](#)
- E5 Court Liaison and Diversion Service
- Child Health**
- F1 [School Nurse](#)
- F2 Hospital-based Paediatrics
- F3 Community-based Paediatrics
- Independent/Voluntary Sector**
- G1 Independent sector - Medium Secure Inpatients
- G2 Independent Sector - Low Secure Inpatients
- G3 Other Independent Sector [Mental Health Services](#)
- G4 Voluntary Sector
- Acute Secondary Care**
- H1 [Accident and Emergency Department](#)
- H2 Other secondary care specialty
- Other Mental Health NHS Trust**
- I1 Temporary transfer from another Mental Health NHS Trust
- I2 Permanent transfer from another Mental Health NHS Trust
- Internal referrals from Community Mental Health Team (within own NHS Trust)**
- J1 Community Mental Health Team (Adult Mental Health) ***
- J2 Community Mental Health Team (Older People) ***
- J3 Community Mental Health Team ([Learning Disabilities](#)) ***
- J4 Community Mental Health Team (Child and Adolescent Mental Health) ***
- Internal referrals from Inpatient Service (within own NHS Trust)**
- K1 Inpatient Service (Adult Mental Health) ***
- K2 Inpatient Service (Older People) ***
- K3 Inpatient Service (Forensics) ***

- K4 Inpatient Service (Child and Adolescent Mental Health) ***
- K5 Inpatient Service ([Learning Disabilities](#)) ***
- Transfer by graduation (within own NHS Trust)**
- L1 Transfer by graduation from Child and Adolescent [Mental Health Service](#) to Adult [Mental Health Services](#)
- L2 Transfer by graduation from Adult [Mental Health Services](#) to Older Peoples [Mental Health Services](#)
- Other**
- M1 Asylum Services
- M2 Telephone or Electronic Access Service
- M3 Out of Area Agency
- M4 Drug Action Team / Drug Misuse Agency
- M5 Jobcentre Plus **
- M6 Other [SERVICE](#) or agency
- M7 Single Point of Access Service ****
- Improving Access to Psychological Therapies**
- N1 Stepped up from low intensity [Improving Access to Psychological Therapies Service](#) *
- N2 Stepped down from high intensity [Improving Access to Psychological Therapies Service](#) *
- N3 [Improving Access to Psychological Therapies Service](#) ****
- Internal**
- P1 Internal Referral ****

Notes:

- * National Codes N1 and N2 are for use in the [Improving Access to Psychological Therapies Data Set](#) only.
- ** National Code M5 can only be used for the [Mental Health Services Data Set](#), if referrals from Jobcentre Plus are accepted.
- *** National Codes J1, J2, J3, J4, K1, K2, K3, K4, K5, L1, and L2 are for use in the [Improving Access to Psychological Therapies Data Set](#) only.
- **** National Codes M7, N3 and P1 are for use in the [Mental Health Services Data Set](#) only.
- **** National Codes A4, C3, D2, M7, N3 and P1 are for use in the [Mental Health Services Data Set](#) only.

SPECIALISED MENTAL HEALTH SERVICE CODE

Change to Attribute: New Attribute

The type of specialised [Mental Health Service](#) provided in a [SERVICE PROVIDED UNDER AGREEMENT](#).

The [SPECIALISED MENTAL HEALTH SERVICE CODE](#) National Codes are published by [NHS England](#) and can be accessed at [Specialised Services Reporting Requirements](#).

This attribute is also known by these names:

Context	Alias
plural	SPECIALISED MENTAL HEALTH SERVICE CODES

SPECIALISED MENTAL HEALTH SERVICE CODE

Change to Attribute: New Attribute

SPECIALISED MENTAL HEALTH SERVICE CODE

Data Elements:

SPECIALISED MENTAL HEALTH SERVICE CODE
--

TREATMENT FUNCTION CODE

Change to Attribute: Changed Dataset

[TREATMENT FUNCTION CODE](#) is a unique identifier for a [TREATMENT FUNCTION](#).

[TREATMENT FUNCTION CODE](#) is recorded to report the specialised service within which the [PATIENT](#) is treated.

It is based on [MAIN SPECIALTY](#) but also includes approved sub-specialties and treatment specialties used by lead [CARE PROFESSIONALS](#) including [CONSULTANTS](#).

[TREATMENT FUNCTION](#), rather than the Royal College or Faculty specialty, is required on most activity returns and in the [Commissioning Data Sets](#).

[TREATMENT FUNCTION CODES](#) should be used for all aggregate Central Returns unless otherwise stated eg [National Workforce Data Set](#) uses [MAIN SPECIALTY CODES](#).

[GENERAL MEDICAL PRACTITIONER](#), [NURSE](#) and Allied Health Professional/ [Biomedical Scientist/ Clinical Scientist ACTIVITY](#) should be recorded against the [TREATMENT FUNCTION](#) under which the [PATIENT](#) is treated.

Joint [Consultant Clinic ACTIVITY](#) should be recorded against the [TREATMENT FUNCTION](#) which best describes the specialised service.

Assigning a Treatment Function Code:

- Assigning a [TREATMENT FUNCTION CODE](#) for a [SERVICE](#) is a decision which must be made locally. For national reporting purposes, only the [TREATMENT FUNCTION CODES](#) listed in the table below must be used.
- Recording of activity according to [TREATMENT FUNCTION CODES](#) is not on the basis of the procedure carried out, but should be allocated according to whether a specialised [SERVICE](#) exists within the [Health Care Provider](#) for that [TREATMENT FUNCTION CODE](#), such as a [CLINIC OR FACILITY](#).
- [TREATMENT FUNCTION CODES](#) have not been mapped to procedures or [MAIN SPECIALTY](#).
- [TREATMENT FUNCTION CODE](#) should be assigned irrespective of the type of [CARE PROFESSIONAL](#) responsible. This is also applicable where the name of the [TREATMENT FUNCTION CODE](#) suggests it is limited for use by a particular Healthcare Profession.
- A change in [TREATMENT FUNCTION CODE](#), but no change in responsible [CARE PROFESSIONAL](#), does not initiate a new episode of care. For the [Commissioning Data Sets](#), the [ACTIVITY TREATMENT FUNCTION CODE](#) reported should be that which is recorded at the [CDS ACTIVITY DATE](#).

For further information, contact [NHS Digital](#) by email at: enquiries@nhsdigital.nhs.uk with the subject "Main Specialty and Treatment Function Codes".

National Codes:

Code	Treatment Function Title	Comments
Surgical Specialties		
100	GENERAL SURGERY	Includes sub-categories not elsewhere listed e.g. endocrine surgery
101	UROLOGY	Surgical treatment of disorders of the urinary system and male reproductive system
102	TRANSPLANTATION SURGERY	Includes pre- and post-operative care for major organ transplants except heart and lung (see Cardiothoracic Transplantation). Excludes corneal grafts
103	BREAST SURGERY	Includes treatment for cancer, suspected neoplasms, cysts and post-cancer reconstructive surgery. Excludes cosmetic surgery
104	COLORECTAL SURGERY	Surgical treatment of disorders of the lower intestine (colon, anus and rectum)
105	HEPATOBIILIARY & PANCREATIC SURGERY	Includes liver surgery, but liver transplantation should be recorded in 102 Transplantation Surgery
106	UPPER GASTROINTESTINAL SURGERY	Surgical treatment of disorders of the upper parts of the gastrointestinal tract
107	VASCULAR SURGERY	Surgical treatment of diseases of the vascular system
108	SPINAL SURGERY SERVICE	Surgery concentrating on specialised and complex treatment of the back and spine. The SERVICE has a significantly different composition and profile from the SERVICE provided in TREATMENT FUNCTION CODE - 110 Trauma & Orthopaedic. Excludes Spinal Injuries - see TREATMENT FUNCTION CODE 323
110	TRAUMA & ORTHOPAEDICS	Surgery to treat injuries, congenital and acquired disorders of the bones, joints, and their associated soft tissues, including ligaments, nerves and muscles. Excludes Spinal Surgery Service - see TREATMENT FUNCTION CODE 108
120	ENT	Ear, nose and throat
130	OPHTHALMOLOGY	The surgical treatment of disorders and diseases of the eye. Excludes Medical Ophthalmology - see TREATMENT FUNCTION CODE 460
140	ORAL SURGERY	The diagnosis and surgical treatment of diseases, injuries and defects involving both the functional and aesthetic aspects of the hard and soft tissues of the head, mouth, teeth, gums, jaws and neck
141	RESTORATIVE DENTISTRY	Endodontics, Periodontics and Prosthodontics are all part of Restorative Dentistry
142	PAEDIATRIC DENTISTRY	Dentistry SERVICES dedicated to children with appropriate facilities and support staff
143	ORTHODONTICS	The treatment of malocclusions (improper bites). Orthodontic treatment can focus on dental displacement only, or can deal with the control and modification of facial growth
144	MAXILLO-FACIAL SURGERY	Mouth, jaw and face related surgery
150	NEUROSURGERY	The prevention, diagnosis, treatment, and rehabilitation of disorders which affect any portion of the nervous system including the brain, spinal cord, peripheral nerves, and extra-cranial cerebrovascular system
160	PLASTIC SURGERY	SERVICES to correct or restore form and function. In addition to cosmetic or aesthetic surgery, plastic surgery includes many types of reconstructive surgery, and the treatment of burns
161	BURNS CARE	

		To be used by recognised specialist units and associated outreach SERVICES only
170	CARDIOTHORACIC SURGERY	Should only be used where there are no separate SERVICES for Cardiac Surgery and Thoracic Surgery
171	PAEDIATRIC SURGERY	This is paediatric general surgery
172	CARDIAC SURGERY	Surgical treatment of the heart or great vessels
173	THORACIC SURGERY	Surgical treatment of diseases affecting organs inside the thorax (the chest). Generally treatment of conditions of the lungs, chest wall, and diaphragm
174	CARDIOTHORACIC TRANSPLANTATION	To be used by recognised specialist units and associated outreach services only. Includes pre- and post-operative services
180	ACCIDENT & EMERGENCY	SERVICES to care for PATIENTS with urgent problems delivered as part of an Accident and Emergency Attendance or admission at an Accident and Emergency Department
191	PAIN MANAGEMENT	Complex pain disorders requiring diagnosis and treatment by a specialist multi-professional team
<p>Other Children's Specialist Services - The Paediatric TREATMENT FUNCTION CODES represent CLINICS OR FACILITIES intended to provide dedicated SERVICES to children with appropriate facilities and support staff, i.e. they are designed for children only. If a CLINIC OR FACILITY provides this but also treats adult PATIENTS as part of the SERVICE then a Paediatric TREATMENT FUNCTION CODE may not be appropriate. The age of the PATIENT attending does not initiate a change to the TREATMENT FUNCTION CODE for the ACTIVITY.</p>		
211	PAEDIATRIC UROLOGY	Surgical treatment of disorders of the urinary system and male reproductive system
212	PAEDIATRIC TRANSPLANTATION SURGERY	Includes pre- and post-operative care for major organ transplants except heart and lung (see Cardiothoracic Transplantation). Excludes corneal grafts
213	PAEDIATRIC GASTROINTESTINAL SURGERY	Surgical treatment of disorders of the gastrointestinal tract
214	PAEDIATRIC TRAUMA AND ORTHOPAEDICS	Surgery to treat injuries, congenital and acquired disorders of the bones, joints, and their associated soft tissues, including ligaments, nerves and muscles. Excludes Spinal Surgery Service - see TREATMENT FUNCTION CODE 108
215	PAEDIATRIC EAR NOSE AND THROAT	Ear, nose and throat
216	PAEDIATRIC OPHTHALMOLOGY	The surgical treatment of disorders and diseases of the eye.
217	PAEDIATRIC MAXILLO-FACIAL SURGERY	Mouth, jaw and face related surgery
218	PAEDIATRIC NEUROSURGERY	The prevention, diagnosis, treatment, and rehabilitation of disorders which affect any portion of the nervous system including the brain, spinal cord, peripheral nerves, and extra-cranial cerebrovascular system
219	PAEDIATRIC PLASTIC SURGERY	SERVICES to correct or restore form and function. In addition to cosmetic or aesthetic surgery, plastic surgery includes many types of reconstructive surgery, and the treatment of burns
220	PAEDIATRIC BURNS CARE	To be used by recognised specialist units and associated outreach SERVICES only
221	PAEDIATRIC CARDIAC SURGERY	Surgical treatment of the heart or great vessels
222	PAEDIATRIC THORACIC SURGERY	Surgical treatment of diseases affecting organs inside the thorax (the chest). Generally treatment of conditions of the lungs, chest wall, and diaphragm
223	PAEDIATRIC EPILEPSY	Designated clinic which provides SERVICES to children led by CONSULTANT paediatrician with expertise in epilepsy supported by specialist staff
241	PAEDIATRIC PAIN MANAGEMENT	Complex pain disorders requiring diagnosis and treatment by a specialist multi-professional team
242	PAEDIATRIC INTENSIVE CARE	Only to be used by designated Paediatric Intensive Care Units
251	PAEDIATRIC GASTROENTEROLOGY	The treatment of disorders of the digestive system
252	PAEDIATRIC ENDOCRINOLOGY	The treatment of disorders of the endocrine system
253	PAEDIATRIC CLINICAL HAEMATOLOGY	Excludes Anticoagulant Service - see TREATMENT FUNCTION CODE 324
254	PAEDIATRIC AUDIOLOGICAL MEDICINE	The medical specialty concerned with the investigation, diagnosis and management of patients with disorders of balance, hearing, tinnitus and auditory communication. Excludes audiology and hearing tests
255	PAEDIATRIC CLINICAL IMMUNOLOGY AND ALLERGY SERVICE	Clinical Immunology is the treatment of disorders of the immune system. Allergy Service is the diagnosis and management of allergic disease
256	PAEDIATRIC INFECTIOUS DISEASES	SERVICES to diagnose and treat contagious or communicable diseases
257	PAEDIATRIC DERMATOLOGY	SERVICES for the treatment of diseases of the skin
258	PAEDIATRIC RESPIRATORY MEDICINE	Also known as Thoracic Medicine
259	PAEDIATRIC NEPHROLOGY	SERVICES to treat kidney conditions and abnormalities
260	PAEDIATRIC MEDICAL ONCOLOGY	The diagnosis and treatment, typically with Chemotherapy of PATIENTS with cancer
261	PAEDIATRIC METABOLIC DISEASE	The diagnosis and management of inherited metabolic conditions
262	PAEDIATRIC RHEUMATOLOGY	SERVICES to treat rheumatism, arthritis, and other disorders of the joints, muscles and ligaments

263	PAEDIATRIC DIABETIC MEDICINE	SERVICES to diagnose, treat and support PATIENTS with diabetes
264	PAEDIATRIC CYSTIC FIBROSIS	Specialised, multidisciplinary SERVICE concerned with the diagnosis, assessment and management of PATIENTS with cystic fibrosis. This TREATMENT FUNCTION CODE should be used by recognised specialist centres only
280	PAEDIATRIC INTERVENTIONAL RADIOLOGY	Diagnosis and treatment of diseases utilising minimally-invasive image-guided procedures. Not to be used for Diagnostic Imaging - see TREATMENT FUNCTION CODE 812
290	COMMUNITY PAEDIATRICS	Includes routine health surveillance, health promotion, behavioural paediatrics and Looked After Children . Excludes Paediatric Neuro-Disability
291	PAEDIATRIC NEURO-DISABILITY	Dedicated SERVICES for children with Cerebral Palsy and non-progressive handicapping neurological conditions, with or without Learning Disability
Medical Specialties		
190	ANAESTHETICS	This can be used in out-patients only. Pain Management should be recorded in 191
192	CRITICAL CARE MEDICINE	also known as Intensive Care Medicine
300	GENERAL MEDICINE	Includes sub-categories not elsewhere listed e.g. Metabolic Medicine.
301	GASTROENTEROLOGY	The treatment of disorders of the digestive system
302	ENDOCRINOLOGY	The treatment of disorders of the endocrine system
303	CLINICAL HAEMATOLOGY	Excludes Anticoagulant Service - see TREATMENT FUNCTION CODE 324
304	CLINICAL PHYSIOLOGY	Physiological measurement including ECG (e.g. exercise testing, stress testing), gastrointestinal physiology, cardiac physiology, vascular technology, urodynamics, and ophthalmic and vision science. Excludes Clinical Neurophysiology - see TREATMENT FUNCTION CODE 401, Audiology - see TREATMENT FUNCTION CODE 840 or Respiratory Physiology - see TREATMENT FUNCTION CODE 341
305	CLINICAL PHARMACOLOGY	SERVICES providing drug information, medication safety and other aspects of pharmacy practice
306	HEPATOLOGY	Also known as liver medicine
307	DIABETIC MEDICINE	SERVICES to diagnose, treat and support PATIENTS with diabetes
308	BLOOD AND MARROW TRANSPLANTATION	Previously coded within Clinical Haematology (TREATMENT FUNCTION CODE 303). Includes haemopoietic stem cell transplantation
309	HAEMOPHILIA SERVICE	Previously coded within Clinical Haematology (TREATMENT FUNCTION CODE 303).
310	AUDIOLOGICAL MEDICINE	The medical specialty concerned with the investigation, diagnosis and management of patients with disorders of balance, hearing, tinnitus and auditory communication. Excludes audiology and hearing tests
311	CLINICAL GENETICS	Diagnosis of disorders caused by genetic mechanisms and counselling SERVICE to PATIENTS and affected family members. To be used by recognised specialist units and associated outreach SERVICES only
312	not a Treatment Function	
313	CLINICAL IMMUNOLOGY and ALLERGY SERVICE	Should only be used where there are no separate SERVICES for Clinical Immunology and Allergy
314	REHABILITATION SERVICE	SERVICES to enhance and restore functional ability and quality of life to those with physical impairments or disabilities. Excludes Mental Health Recovery and Rehabilitation Service - see TREATMENT FUNCTION CODE 725
315	PALLIATIVE MEDICINE	The treatment for curable illnesses and those living with chronic diseases, as well as PATIENTS who are nearing the end of life
316	CLINICAL IMMUNOLOGY	The treatment of disorders of the immune system
317	ALLERGY SERVICE	The diagnosis and management of allergic disease (abnormal immune responses to external substances) and the exclusion of allergic causes in other conditions
318	INTERMEDIATE CARE	Intermediate care encompasses a range of multi-disciplinary SERVICES designed to safeguard independence by maximising rehabilitation and recovery after illness or injury
319	RESPIRE CARE	SERVICES providing temporary care of a dependant person, providing relief for their usual caregivers
320	CARDIOLOGY	SERVICES treating diseases and abnormalities of the heart
321	PAEDIATRIC CARDIOLOGY	Dedicated SERVICES to children with diseases and abnormalities of the heart, with appropriate facilities and support staff
322	CLINICAL MICROBIOLOGY	SERVICES to treat diseases caused by bacteria, viruses, fungi and parasites
323	SPINAL INJURIES	To be used by recognised specialist units and associated outreach SERVICES only, Excludes Spinal Surgery Service - see TREATMENT FUNCTION CODE 108
324	ANTICOAGULANT SERVICE	The monitoring and control of anticoagulant therapy including the initiation and/or supervision of oral anticoagulant therapy and the determination of anticoagulant dosage. This can be used in out-patients only

325	SPORT AND EXERCISE MEDICINE	The diagnosis and management of medical problems caused by physical activity, the prevention of related injury and disease and the role of exercise in disease treatment
327	CARDIAC REHABILITATION	Rehabilitation SERVICE for PATIENTS with or recovering from heart related conditions such as heart attacks or from procedures such as coronary artery bypass surgery to ensure that they achieve their full potential in terms of physical and psychological health
328	STROKE MEDICINE	For stroke services excluding Transient Ischaemic Attack - see TREATMENT FUNCTION CODE 329
329	TRANSIENT ISCHAEMIC ATTACK	A multidisciplinary SERVICE for rapid diagnosis and treatment of PATIENTS presenting with suspected Transient Ischaemic Attack and mini-strokes to minimise the chance of a full stroke occurring and maximise the chances of independent living after a stroke
330	DERMATOLOGY	SERVICES for the treatment of diseases of the skin
331	CONGENITAL HEART DISEASE SERVICE	The management and treatment of congenital heart disease, this includes the ongoing care of children in to adulthood
340	RESPIRATORY MEDICINE	Also known as Thoracic Medicine
341	RESPIRATORY PHYSIOLOGY	Physiological measurement of the function of the respiratory system. Includes Sleep Studies (the diagnosis and treatment of sleep disordered breathing, including upper airway resistance syndrome and sleep apnoea)
342	PROGRAMMED PULMONARY REHABILITATION	A multidisciplinary programme of care for PATIENTS with chronic respiratory impairment that is individually tailored and designed to optimise the individual's physical and social performance and autonomy
343	ADULT CYSTIC FIBROSIS SERVICE	Specialised, multidisciplinary SERVICE concerned with the diagnosis, assessment and management of PATIENTS with cystic fibrosis. This TREATMENT FUNCTION CODE should be used by recognised specialist centres only
344	COMPLEX SPECIALISED REHABILITATION SERVICE	Complex specialised rehabilitation SERVICE which meets the NHS Specialised Services Rehabilitation Services' criteria and is registered as a Level 1 service. For further information see the NHS Specialised Services website
345	SPECIALIST REHABILITATION SERVICE	Specialist rehabilitation SERVICE which meets the NHS Specialised Services Rehabilitation Services' criteria and is registered as a Level 2a service. For further information see the NHS Specialised Services website
346	LOCAL SPECIALIST REHABILITATION SERVICE	Local specialist rehabilitation SERVICE which meets the NHS Specialised Services Rehabilitation Services' criteria and is registered as a Level 2b service. For further information see the NHS Specialised Services website
350	INFECTIOUS DISEASES	SERVICES to diagnose and treat contagious or communicable diseases
352	TROPICAL MEDICINE	SERVICES to diagnose and treat diseases that are found most often in tropical or sub-tropical regions
360	GENITOURINARY MEDICINE	Primarily related to medicine dealing with sexually transmitted diseases
361	NEPHROLOGY	SERVICES to treat kidney conditions and abnormalities
370	MEDICAL ONCOLOGY	The diagnosis and treatment, typically with Chemotherapy , of PATIENTS with cancer
371	NUCLEAR MEDICINE	The treatment of PATIENTS through the use of radioactive substances
400	NEUROLOGY	SERVICES to diagnose and treat conditions and diseases of the central nervous system
401	CLINICAL NEUROPHYSIOLOGY	The study of the central and peripheral nervous systems through the recording of bioelectrical activity. Includes Electroencephalogram (EEG)
410	RHEUMATOLOGY	SERVICES to treat rheumatism, arthritis, and other disorders of the joints, muscles and ligaments
420	PAEDIATRICS	SERVICES to treat infants, children, and adolescents
421	PAEDIATRIC NEUROLOGY	Dedicated SERVICES to children to diagnose and treat conditions and diseases of the central nervous system, with appropriate facilities and support staff
422	NEONATOLOGY	Special Care, High Dependency and Intensive Care
424	WELL BABIES	Use when NEONATAL LEVEL OF CARE = 0 - Normal Care: Care given by the mother/substitute with medical and neonatal nursing advice if needed. See Well Baby
430	GERIATRIC MEDICINE	SERVICES to treat diseases and disabilities in older adults. There is no set age at which PATIENTS may be under the care of Geriatric Medicine, this decision should be determined by the individual PATIENT 's needs
450	DENTAL MEDICINE SPECIALTIES	Includes Oral Medicine.
460	MEDICAL OPHTHALMOLOGY	SERVICES to diagnose and treat medical conditions affecting the eye, orbits, and visual pathways
500	not a Treatment Function	
501	OBSTETRICS	The management of pregnancy and childbirth including miscarriages and still births but excluding planned terminations. Excludes Midwifery Service see TREATMENT FUNCTION CODE 560

502	GYNAECOLOGY	Disorders of the female reproductive system. Includes planned terminations
503	GYNAECOLOGICAL ONCOLOGY	SERVICES to treat cancers of the female reproductive system
510	Retired	Record as Obstetrics, antenatal clinic can be used as a local sub-specialty if required
520	Retired	Record as Obstetrics, postnatal clinic can be used as a local sub-specialty if required
560	MIDWIFERY SERVICE	SERVICES provided under the direct care of a MIDWIFE . Excludes Obstetrics see TREATMENT FUNCTION CODE 501
600	not a Treatment Function	
610	Retired	Record as Obstetrics
620	Retired	Use the appropriate function under which the patient is treated
Therapies		
650	PHYSIOTHERAPY	The treatment of human function and movement to help people to achieve their full physical potential. The use of physical approaches to promote, maintain and restore wellbeing
651	OCCUPATIONAL THERAPY	The use of specific activities to limit the effects of disability and promote independence in all aspects of daily life
652	SPEECH AND LANGUAGE THERAPY	The assessment, treatment and help to prevent speech, language and swallowing difficulties
653	PODIATRY	Also known as Chiroprody. The diagnosis and treatment of disorders, diseases and deformities of the feet. Excludes Podiatric Surgery see TREATMENT FUNCTION CODE 663
654	DIETETICS	The application of the science of nutrition to devise eating plans for PATIENTS to treat medical conditions. The promotion of good health by helping to facilitate a positive change in food choices amongst individuals, groups and communities
655	ORTHOPTICS	The diagnosis and treatment of visual problems involving eye movement and alignment
656	CLINICAL PSYCHOLOGY	The diagnosis and treatment of emotional and behavioural disorders
657	PROSTHETICS	The supply of prosthetics for PATIENTS
658	ORTHOTICS	The supply of orthoses for PATIENTS
659	DRAMA THERAPY	The use of drama and theatre techniques including role play, voice work and storytelling for therapeutic purposes
660	ART THERAPY	The use of art techniques including clay, paint and paper for therapeutic purposes and as a means of communication
661	MUSIC THERAPY	The use of music and all of its facets to help clients to improve or maintain their health
662	OPTOMETRY	The diagnosis and non-surgical treatment of disorders of the eye and vision care
663	PODIATRIC SURGERY	The treatment of foot problems, including soft tissue, bone and joint surgery of the foot, ankle and associated structures, excludes Podiatry see TREATMENT FUNCTION CODE - 653
Psychiatry		
700	LEARNING DISABILITY	SERVICES provided to PATIENTS with a Learning Disability
710	ADULT MENTAL ILLNESS	SERVICES provided to adult PATIENTS for the assessment, diagnosis and treatment of mental illness
711	CHILD and ADOLESCENT PSYCHIATRY	SERVICES providing diagnosis, treatment, and prevention of psychopathological disorders of children and adolescents
712	FORENSIC PSYCHIATRY	SERVICES to assess PATIENTS who have committed an offence and are receiving treatment in high, medium and low secure units or prisons
713	PSYCHOTHERAPY	SERVICES providing therapy used to treat emotional problems and mental health conditions
715	OLD AGE PSYCHIATRY	SERVICES providing the diagnosis, treatment, and prevention of mental and emotional disorders in older adult PATIENTS
720	EATING DISORDERS	A specialist SERVICE for the diagnosis and treatment of eating disorders including anorexia, bulimia and compulsive overeating
721	ADDICTION SERVICES	The prevention and treatment of substance misuse including drugs and alcohol. If PATIENTS have both severe mental illness and problematic substance misuse, see TREATMENT FUNCTION CODE 726 Dual Diagnosis Service
722	LIAISON PSYCHIATRY	The provision of psychiatric treatment to PATIENTS attending general hospitals including out-patient clinics, Accident and Emergency Departments and admission to wards. Deals with the interface between physical and psychological health.
723	PSYCHIATRIC INTENSIVE CARE	The provision of psychiatric SERVICES to vulnerable individuals who are admitted to Psychiatric Intensive Care Units from open acute wards and forensic settings
724	PERINATAL PSYCHIATRY	

		A specialist psychiatric SERVICE for the diagnosis and treatment of ante-natal and post-natal psychiatric problems
725	MENTAL HEALTH RECOVERY AND REHABILITATION SERVICE	SERVICES provided to support recovery from mental illness that maximises the PATIENT 's quality of life and social inclusion by encouraging their skills, promoting independence and autonomy
726	MENTAL HEALTH DUAL DIAGNOSIS SERVICE	SERVICES to provide support to PATIENTS with both severe mental illness and substance misuse problems. Personality disorder may coexist with psychiatric illness and/or substance misuse
727	DEMENTIA ASSESSMENT SERVICE	SERVICES for the assessment of PATIENTS with dementia, which may complicate care giving and can occur at any stage of the illness. In addition to memory impairment, dementia may include behavioural and psychological problems
Radiology		
800	CLINICAL ONCOLOGY (previously RADIOTHERAPY)	The diagnosis and treatment, typically with Radiotherapy , of PATIENTS with cancer.
810	not a Treatment Function	
811	INTERVENTIONAL RADIOLOGY	Diagnosis and treatment of diseases utilising minimally-invasive image-guided procedures. Not to be used for Diagnostic Imaging - see TREATMENT FUNCTION CODE 812
812	DIAGNOSTIC IMAGING	The production and interpretation of high quality images of the body to diagnose injuries and disease, e.g. x-rays, Ultrasound Scan , MRI Scan , PET Scan or CT Scan .
Pathology		
820	not a Treatment Function	
821	not a Treatment Function	
822	CHEMICAL PATHOLOGY	To be used for clinical management only
823	not a Treatment Function	See Clinical Haematology
824	not a Treatment Function	
830	not a Treatment Function	See Clinical Immunology
831	not a Treatment Function	See Clinical Microbiology
832	Retired	
834	MEDICAL VIROLOGY	The diagnosis and management and prevention of virus and related infections, in hospital and in the community including HIV/AIDS, other blood-borne infections like hepatitis B and C and viruses such as SARS and avian flu
Other		
840	AUDIOLOGY	Physiological measurement and diagnosis of hearing disorders, and the rehabilitation of PATIENTS with hearing loss
900	not a Treatment Function	
901	not a Treatment Function	
920	DIABETIC EDUCATION SERVICE	SERVICES providing dedicated small group education courses regarding self management for diabetic PATIENTS
950	not a Treatment Function	Use the appropriate function under which the patient is treated
960	not a Treatment Function	Use the appropriate function under which the patient is treated
990	Retired	

Notes:

†	Code 500 is not acceptable for Central Returns including Hospital Episode Statistics
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UCUM UNIT OF MEASUREMENT

Change to Attribute: Changed Dataset

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

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

WAITING TIME MEASUREMENT TYPE

Change to Attribute: Changed Dataset

The type of waiting time measurement methodology which may be applied during a [PATIENT PATHWAY](#).

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

National Codes:

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

Notes:

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

WARD CODE

Change to Attribute: Changed Dataset

A unique identification of a [WARD](#) within a [Health Care Provider](#).

WARD SECURITY LEVEL

Change to Attribute: Changed Dataset

The level of security for a [WARD](#).

National Codes:

- 0 **General (non-secure)**
Non secure accommodation or accommodation that only has normal levels of security such as general [WARDS](#)
- 1 **Low Secure**
Low secure [WARDS](#)/units deliver comprehensive, multidisciplinary, treatment and care by qualified staff for [PATIENTS](#) who demonstrate disturbed behaviour in the context of a serious mental disorder and who require the provision of security. This includes (but is not limited to) Psychiatric Intensive Care Unit (PICU), low secure forensic services, challenging behaviour services, and secure rehabilitation services.
- 2 **Medium Secure**
Medium secure [WARDS](#)/units deliver comprehensive, multidisciplinary treatment and care by qualified staff for [PATIENTS](#) who demonstrate disturbed behaviour in the context of a serious mental disorder and who may present a serious risk to others.
- 3 **High Secure**
High secure [WARDS](#)/hospitals provide comprehensive, multidisciplinary treatment and care by qualified staff for [PATIENTS](#) who demonstrate disturbed behaviour in the context of a serious mental disorder and have been assessed as presenting a grave and immediate danger to others. The Hospital must be part of an [NHS Trust](#) approved by the Secretary of State to provide high security psychiatric services.

WARD SETTING TYPE FOR MENTAL HEALTH

Change to Attribute: Changed Dataset

The type of [WARD](#) setting for a [Mental Health Service's](#) [PATIENT](#) during a [Hospital Provider Spell](#).

National Codes:

- 01 Child and Adolescent Mental Health [WARD](#)
- 02 Paediatric [WARD](#)
- 03 Adult Mental Health [WARD](#)
- 04 Non Mental Health [WARD](#)
- 05 [Learning Disabilities](#) [WARD](#)
- 06 Older People's Mental Health [WARD](#)

WEEKLY HOURS WORKED

Change to Attribute: Changed Dataset, Description

A code to identify the number of hours worked per week by a [PERSON](#).

National Codes:

- 01 30+ hours
- 02 16-29 hours
- 03 5-15 hours
- 04 1-4 hours
- 97 Not disclosed ([PATIENT](#) was asked but refused to respond)
- 97 Not Stated ([PERSON](#) asked but declined to provide a response)

YOUNG CARER INDICATOR

Change to Attribute: Changed Dataset

An indication of whether a child or young [PERSON](#) has a caring role for an ill or disabled parent, [Carer](#) or sibling.

National Codes:

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

ACCOMMODATION STATUS CODE

Change to Data Element: Changed Dataset

Format/Length:	an4
National Codes:	See ACCOMMODATION STATUS CODE
Default Codes:	OC97 - Not specified OC98 - Not applicable OC99 - Not known

Notes:

[ACCOMMODATION STATUS CODE](#) is the same as attribute [ACCOMMODATION STATUS CODE](#).

ACCOMMODATION STATUS RECORDED DATE

Change to Data Element: Changed Dataset

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

Notes:

[ACCOMMODATION STATUS RECORDED DATE](#) is the same as attribute [PERSON PROPERTY RECORDED DATE](#).

[ACCOMMODATION STATUS RECORDED DATE](#) is the [DATE](#) when the [ACCOMMODATION STATUS CODE](#) was recorded.

ACTIVITY LOCATION TYPE CODE

Change to Data Element: Changed Dataset

Format/Length:	an3
National Codes:	See ACTIVITY LOCATION TYPE CODE
Default Codes:	

Notes:

[ACTIVITY LOCATION TYPE CODE](#) is the same as attribute [ACTIVITY LOCATION TYPE CODE](#).

Use in Commissioning Data Set Version 6-2 onwards

Where [Out-Patient Clinics](#) are held on [WARDS](#) (such as Pre-assessment Clinics), these should be categorised as [ACTIVITY LOCATION TYPE CODE](#) National Code E01 'Out-Patient Clinic' and not National Code E02 'WARD'. This will allow [Ward Attendances](#) to be differentiated from [Out-Patient Clinics](#) in the [CDS V6-2 Type 020 - Outpatient Commissioning Data Set](#) flow.

For [ACTIVITY](#) falling under [Allied Health Professional Referral To Treatment Measurement](#), [ACTIVITY LOCATION TYPE CODE](#) may be submitted to allow identification of Allied Health Professional [ACTIVITY](#) taking place on [WARDS](#), which is not related to the [Hospital Provider Spell](#) for the [PATIENT](#) being seen by the Allied Health Professional. For example, if a [Podiatrist](#) were asked to see a patient who was currently admitted for a condition where the agreed care pathway did not include Podiatry services, then an [Out-Patient Appointment Non-Consultant](#) should be recorded, with the [ACTIVITY LOCATION TYPE CODE](#) of E02 'WARD'.

ADMINISTRATIVE CATEGORY CODE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See ADMINISTRATIVE CATEGORY CODE
Default Codes:	98 - Not applicable 99 - Not known: a validation error

Notes:

[ADMINISTRATIVE CATEGORY CODE](#) is the same as [ADMINISTRATIVE CATEGORY CODE](#).

ADMISSION METHOD CODE (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See ADMISSION METHOD
Default Codes:	98 - Not applicable 99 - Not known: a validation error

Notes:

[ADMISSION METHOD CODE \(HOSPITAL PROVIDER SPELL\)](#) is the same as attribute [ADMISSION METHOD](#).

[ADMISSION METHOD CODE \(HOSPITAL PROVIDER SPELL\)](#) is used by the [Secondary Uses Service](#) to derive the [Healthcare Resource Group 4](#). Failure to correctly populate this data element is likely to result in an incorrect [Healthcare Resource Group](#), usually associated with lower levels of healthcare resource.

For further information, please refer to the [NHS Digital](#) website at: [Payment by Results Guidance](#).

ADULT MENTAL HEALTH CARE CLUSTER CODE (FINAL)

Change to Data Element: Changed Dataset, Description

Format/Length:	max an4
Format/Length:	an2
National Codes:	See ADULT MENTAL HEALTH CARE CLUSTER CODE
Default Codes:	

Notes:

[ADULT MENTAL HEALTH CARE CLUSTER CODE \(FINAL\)](#) is the same as attribute [ADULT MENTAL HEALTH CARE CLUSTER CODE](#).

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

The determination of the [ADULT MENTAL HEALTH CARE CLUSTER CODE \(FINAL\)](#) may or may not have involved the use of the [National Tariff Payment System](#) clustering algorithm.

ADULT MENTAL HEALTH CARE CLUSTER CODE (INITIAL)

Change to Data Element: Changed Dataset, Description

Format/Length:	max an4
Format/Length:	an2
National Codes:	See ADULT MENTAL HEALTH CARE CLUSTER CODE
Default Codes:	

Notes:

[ADULT MENTAL HEALTH CARE CLUSTER CODE \(INITIAL\)](#) is the same as attribute [ADULT MENTAL HEALTH CARE CLUSTER CODE](#).

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

ASSESSMENT TOOL COMPLETION DATE

Change to Data Element: Changed Dataset

Format/Length:	See DATE
National Codes:	

Default Codes:

Notes:

[ASSESSMENT TOOL COMPLETION DATE](#) is the [DATE](#) the [ASSESSMENT TOOL](#) was completed.

ASSESSMENT TOOL COMPLETION TIME

Change to Data Element: Changed Dataset

Format/Length: See [TIME](#)
National Codes:
Default Codes:

Notes:

[ASSESSMENT TOOL COMPLETION TIME](#) is the [TIME](#) the [ASSESSMENT TOOL](#) was completed.

ASSISTIVE TECHNOLOGY FINDING (SNOMED CT)

Change to Data Element: Changed Dataset

Format/Length: See [SNOMED CT CODE](#)
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.

Note: The Format/Length of this Data Element for the [Mental Health Services Data Set](#) is incorrect in the Technical Output Specification published on the [NHS Digital web pages](#). The Technical Output Specification will be updated in the next version of the Information Standard.

ATTENDED OR DID NOT ATTEND CODE

Change to Data Element: Changed Dataset

Format/Length: an1
National Codes: See [ATTENDED OR DID NOT ATTEND](#)
Default Codes:

Notes:

[ATTENDED OR DID NOT ATTEND CODE](#) is the same as attribute [ATTENDED OR DID NOT ATTEND](#).

Use in the Future Outpatient CDS:

- Where the attendance is in the future (and has not been cancelled) use value 0 (zero) - *not applicable* - [APPOINTMENT](#) occurs in the future.
- Where the future attendance has been **cancelled**, use the appropriate value from the national codes (see [ATTENDED OR DID NOT ATTEND](#)).

CARE ACTIVITY IDENTIFIER

Change to Data Element: Changed Dataset

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

Notes:

[CARE ACTIVITY IDENTIFIER](#) is the [ACTIVITY IDENTIFIER](#) for a [CARE ACTIVITY](#).

CARE CONTACT CANCELLATION DATE

Change to Data Element: Changed Dataset

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[CARE CONTACT CANCELLATION DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Care Contact Cancellation Date](#)'.

CARE CONTACT CANCELLATION REASON

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See CARE CONTACT CANCELLATION REASON
Default Codes:	

Notes:

[CARE CONTACT CANCELLATION REASON](#) is the same as attribute [CARE CONTACT CANCELLATION REASON](#).

CARE CONTACT DATE

Change to Data Element: Changed Dataset

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

Notes:

[CARE CONTACT DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Care Contact Date](#)'.

CARE CONTACT IDENTIFIER

Change to Data Element: Changed Dataset

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

Notes:

[CARE CONTACT IDENTIFIER](#) is the [ACTIVITY IDENTIFIER](#) for a [CARE CONTACT](#).

CARE CONTACT SUBJECT

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See CARE CONTACT SUBJECT
Default Codes:	

Notes:

[CARE CONTACT SUBJECT](#) is the same as attribute [CARE CONTACT SUBJECT](#).

CARE CONTACT TIME

Change to Data Element: Changed Dataset

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

Notes:

[CARE CONTACT TIME](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Care Contact Time](#)'.

CARE PLAN AGREED BY

Change to Data Element: Changed Dataset

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](#).

CARE PLAN AGREED DATE

Change to Data Element: Changed Dataset

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 TIME

Change to Data Element: New Data Element

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

Notes:

[CARE PLAN AGREED TIME](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Care Plan Agreed Time](#)'.

This data element is also known by these names:

Context	Alias
plural	CARE PLAN AGREED TIMES

CARE PLAN AGREED TIME

Change to Data Element: New Data Element

CARE PLAN AGREED TIME

Attribute:

ACTIVITY TIME

CARE PLAN CREATION DATE

Change to Data Element: Changed Dataset

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](#)'.

CARE PLAN CREATION TIME

Change to Data Element: New Data Element

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

Notes:

[CARE PLAN CREATION TIME](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Care Plan Creation Time](#)'.

This data element is also known by these names:

Context	Alias
plural	CARE PLAN CREATION TIMES

CARE PLAN CREATION TIME

Change to Data Element: New Data Element

CARE PLAN CREATION TIME

Attribute:

ACTIVITY TIME

CARE PLAN IDENTIFIER

Change to Data Element: Changed Dataset

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

Notes:

[CARE PLAN IDENTIFIER](#) is the same as attribute [CARE PLAN IDENTIFIER](#).

CARE PLAN IMPLEMENTATION DATE

Change to Data Element: Changed Dataset

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](#)'.

CARE PLAN LAST UPDATED DATE

Change to Data Element: Changed Dataset

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](#).

CARE PLAN LAST UPDATED TIME

Change to Data Element: New Data Element

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

Notes:

[CARE PLAN LAST UPDATED TIME](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Care Plan Last Updated Time](#)'.

For the [Mental Health Services Data Set](#), where the [CARE PLAN](#) has not been updated since its creation, the [CARE PLAN LAST UPDATED TIME](#) will be the same as [CARE PLAN CREATION TIME](#).

This data element is also known by these names:

Context	Alias
plural	CARE PLAN CREATION TIMES

CARE PLAN LAST UPDATED TIME

Change to Data Element: New Data Element

CARE PLAN LAST UPDATED TIME

Attribute:

ACTIVITY TIME

CARE PLAN TYPE (MENTAL HEALTH)

Change to Data Element: Changed Dataset, Description

Format/Length:	an1
Format/Length:	an2
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](#).

CARE PROFESSIONAL (JOB ROLE CODE)

Change to Data Element: Changed Dataset

Format/Length:	an5
National Codes:	See JOB ROLE CODE
Default Codes:	

Notes:

[CARE PROFESSIONAL \(JOB ROLE CODE\)](#) is the same as attribute [JOB ROLE CODE](#).

CARE PROFESSIONAL LOCAL IDENTIFIER

Change to Data Element: Changed Dataset

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

Notes:

[CARE PROFESSIONAL LOCAL IDENTIFIER](#) is the same as attribute [CARE PROFESSIONAL IDENTIFIER](#).

[CARE PROFESSIONAL LOCAL IDENTIFIER](#) is a unique local [CARE PROFESSIONAL IDENTIFIER](#) within a [Health Care Provider](#) and may be assigned automatically by the computer system.

CARE PROFESSIONAL SERVICE OR TEAM TYPE ASSOCIATION (MENTAL HEALTH)

Change to Data Element: Changed Dataset

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

Notes:

[CARE PROFESSIONAL SERVICE OR TEAM TYPE ASSOCIATION \(MENTAL HEALTH\)](#) is the same as attribute [SERVICE OR TEAM TYPE FOR MENTAL HEALTH](#).

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

CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH)

Change to Data Element: Changed Dataset

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

Notes:

[CARE PROFESSIONAL STAFF GROUP \(MENTAL HEALTH\)](#) is the same as attribute [CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH](#).

CARE PROFESSIONAL TEAM LOCAL IDENTIFIER

Change to Data Element: Changed Dataset

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

Notes:

[CARE PROFESSIONAL TEAM LOCAL IDENTIFIER](#) is the same as attribute [CARE PROFESSIONAL TEAM IDENTIFIER](#).

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

CARE PROGRAMME APPROACH CARE EPISODE IDENTIFIER

Change to Data Element: Changed Dataset

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

Notes:

[CARE PROGRAMME APPROACH CARE EPISODE IDENTIFIER](#) is the same as attribute [ACTIVITY IDENTIFIER](#).

[CARE PROGRAMME APPROACH CARE EPISODE IDENTIFIER](#) is a unique identifier allocated to each [Care Programme Approach Care Episode](#).

CARE PROGRAMME APPROACH REVIEW ABUSE QUESTION ASKED INDICATOR

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See CARE PROGRAMME APPROACH REVIEW ABUSE QUESTION ASKED INDICATOR
Default Codes:	9 - Not known - It is not known if the Abuse Question was asked during the Care Programme Approach Review

Notes:

[CARE PROGRAMME APPROACH REVIEW ABUSE QUESTION ASKED INDICATOR](#) is the same as attribute [CARE PROGRAMME APPROACH REVIEW ABUSE QUESTION ASKED INDICATOR](#).

CARE PROGRAMME APPROACH REVIEW DATE

Change to Data Element: Changed Dataset

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

Notes:

[CARE PROGRAMME APPROACH REVIEW DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Care Programme Approach Review Date](#)'.

CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE

Change to Data Element: Changed Dataset, Description

Format/Length:	an3
Format/Length:	an2
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](#).

CHILD AND ADOLESCENT MENTAL HEALTH TIER OF SERVICE

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See CHILD AND ADOLESCENT MENTAL HEALTH TIER OF SERVICE
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](#).

CHILD PROTECTION PLAN INDICATION CODE

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See CHILD PROTECTION PLAN INDICATION CODE
Default Codes:	X - Not Known whether the PERSON is or has ever been the subject of a Child Protection Plan

Notes:

[CHILD PROTECTION PLAN INDICATION CODE](#) is the same as attribute [CHILD PROTECTION PLAN INDICATION CODE](#).

CLINICAL CONTACT DURATION OF CARE ACTIVITY

Change to Data Element: Changed Dataset

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

Notes:

[CLINICAL CONTACT DURATION OF CARE ACTIVITY](#) is the duration of a [CARE ACTIVITY](#) in minutes, excluding any administration time prior to or after the [CARE ACTIVITY](#) and the [CARE PROFESSIONAL](#)'s travelling time to the [LOCATION](#) where the [CARE ACTIVITY](#) was provided.

[CLINICAL CONTACT DURATION OF CARE ACTIVITY](#) is calculated from the [Start Time](#) and [End Time](#) of the [CARE ACTIVITY](#).

CLINICAL CONTACT DURATION OF CARE CONTACT

Change to Data Element: Changed Dataset

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

Notes:

[CLINICAL CONTACT DURATION OF CARE CONTACT](#) is the total duration of the [direct](#) clinical contact at [CARE CONTACT](#) in minutes, excluding any administration time prior to or after the [CARE CONTACT](#) and the [CARE PROFESSIONAL](#)'s travelling time to the [CARE CONTACT](#).

[CLINICAL CONTACT DURATION OF CARE CONTACT](#) includes the time spent on the different [CARE ACTIVITIES](#) that may be performed in a single [CARE CONTACT](#). The duration of each [CARE ACTIVITY](#) is recorded in [CLINICAL CONTACT DURATION OF CARE ACTIVITY](#).

[CLINICAL CONTACT DURATION OF CARE CONTACT](#) is calculated from the [Start Time](#) and [End Time](#) of the [CARE CONTACT](#).

CLINICAL CONTACT DURATION OF GROUP SESSION

Change to Data Element: Changed Dataset

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

Notes:

[CLINICAL CONTACT DURATION OF GROUP SESSION](#) is the duration of a [Group Session](#) in minutes, excluding any administration time prior to or after the [Group Session](#) and the [CARE PROFESSIONAL](#)'s travelling time to the [LOCATION](#) where the [Group Session](#) was provided.

[CLINICAL CONTACT DURATION OF GROUP SESSION](#) is calculated from the [Start Time](#) and [End Time](#) of the [Group Session](#).

CLINICAL RESPONSE PRIORITY TYPE

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See CLINICAL RESPONSE PRIORITY TYPE
Default Codes:	

Notes:

[CLINICAL RESPONSE PRIORITY TYPE](#) is the same as attribute [CLINICAL RESPONSE PRIORITY TYPE](#).

CLUSTERING TOOL ASSESSMENT CATEGORY

Change to Data Element: Changed Dataset

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

Notes:

[CLUSTERING TOOL ASSESSMENT CATEGORY](#) is the same as attribute [CLUSTERING TOOL ASSESSMENT CATEGORY](#).

CLUSTERING TOOL ASSESSMENT IDENTIFIER

Change to Data Element: Changed Dataset

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

Notes:

[CLUSTERING TOOL ASSESSMENT IDENTIFIER](#) is the same as attribute [ACTIVITY IDENTIFIER](#).

[CLUSTERING TOOL ASSESSMENT IDENTIFIER](#) is a unique identifier for each [Clustering Tool](#) assessment that takes place for each [PATIENT](#).

CLUSTERING TOOL ASSESSMENT REASON

Change to Data Element: Changed Dataset

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

Notes:

[CLUSTERING TOOL ASSESSMENT REASON](#) is the same as attribute [CLUSTERING TOOL ASSESSMENT REASON](#).

CODED ASSESSMENT TOOL TYPE (SNOMED CT)

Change to Data Element: Changed Dataset

Format/Length:	See SNOMED CT CODE
National Codes:	
Default Codes:	

Notes:

[CODED ASSESSMENT TOOL TYPE \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

[CODED ASSESSMENT TOOL TYPE \(SNOMED CT\)](#) is the [SNOMED CT](#)® concept ID which is used to identify an [ASSESSMENT TOOL](#).

Nationally published [SNOMED CT Subset](#) Metadata can be found on the [Data Dictionary for Care \(DD4C\)](#) website at: [Published Subset Metadata](#).

Note: The Format/Length of this Data Element for the [Mental Health Services Data Set](#) is incorrect in the Technical Output Specification published on the [NHS Digital web pages](#). The Technical Output Specification will be updated in the next version of the Information Standard.

CODED FINDING (CODED CLINICAL ENTRY)

Change to Data Element: Changed Dataset

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

Notes:

[CODED FINDING \(CODED CLINICAL ENTRY\)](#) is the same as attribute [CLINICAL CLASSIFICATION CODE](#) or [CLINICAL TERMINOLOGY CODE](#).

[CODED FINDING \(CODED CLINICAL ENTRY\)](#) is the [CODED CLINICAL ENTRY](#) which is used to identify a finding.

CODED OBSERVATION (CLINICAL TERMINOLOGY)

Change to Data Element: Changed Dataset

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

Notes:

[CODED OBSERVATION \(CLINICAL TERMINOLOGY\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

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

CODED PROCEDURE (CLINICAL TERMINOLOGY)

Change to Data Element: Changed Dataset

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

Notes:

[CODED PROCEDURE \(CLINICAL TERMINOLOGY\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

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

CODED PROCEDURE AND PROCEDURE STATUS (SNOMED CT)

Change to Data Element: New Data Element

Format/Length:	See SNOMED CT EXPRESSION
National Codes:	
Default Codes:	

Notes:

[CODED PROCEDURE AND PROCEDURE STATUS \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

[CODED PROCEDURE AND PROCEDURE STATUS \(SNOMED CT\)](#) is the [SNOMED CT EXPRESSION](#) which is used to identify a procedure plus the status of the procedure.

This data element is also known by these names:

Context	Alias
plural	CODED PROCEDURE AND PROCEDURE STATUSES (SNOMED CT)

CODED PROCEDURE AND PROCEDURE STATUS (SNOMED CT)

Change to Data Element: New Data Element

CODED PROCEDURE AND PROCEDURE STATUS (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

COMMUNITY TREATMENT ORDER END REASON

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See COMMUNITY TREATMENT ORDER END REASON
Default Codes:	

Notes:

[COMMUNITY TREATMENT ORDER END REASON](#) is the same as attribute [COMMUNITY TREATMENT ORDER END REASON](#).

CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR

Change to Data Element: Changed Dataset

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

Notes:

[CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR](#) is the same as attribute [CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR](#).

CONSULTATION MEDIUM USED

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See CONSULTATION MEDIUM USED
Default Codes:	

Notes:

[CONSULTATION MEDIUM USED](#) is the same as attribute [CONSULTATION MEDIUM USED](#).

CONSULTATION TYPE

Change to Data Element: Changed Dataset

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

Notes:

[CONSULTATION TYPE](#) is the same as attribute [CONSULTATION TYPE](#).

DATA SET VERSION NUMBER

Change to Data Element: Changed Dataset

Format/Length:	max n2.max n2
National Codes:	
Default Codes:	

Notes:

[DATA SET VERSION NUMBER](#) is the version number of a Data Set.

DATE AND TIME DATA SET CREATED

Change to Data Element: Changed Dataset

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

Notes:

[DATE AND TIME DATA SET CREATED](#) is the same as data element [DATE AND TIME](#).

[DATE AND TIME DATA SET CREATED](#) is the [DATE AND TIME](#) a data set was created.

DATE OF ASSAULT ON PATIENT

Change to Data Element: Changed Dataset

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

Notes:

[DATE OF ASSAULT ON PATIENT](#) is the [DATE](#) that an instance of assault occurred on the [PATIENT](#) by another [PATIENT](#).

For the [Mental Health Services Data Set](#), [DATE OF ASSAULT ON PATIENT](#) is during a [Hospital Provider Spell](#) and assault is defined as:

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

DATE OF RESTRICTIVE INTERVENTION

Change to Data Element: Changed Dataset

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

Notes:

[DATE OF RESTRICTIVE INTERVENTION](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Date of Restrictive Intervention](#)'.

DATE OF SELF-HARM

Change to Data Element: Changed Dataset

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

Notes:

[DATE OF SELF-HARM](#) is the [DATE](#) that an incident of self-harm by a [PATIENT](#) occurred.

For the [Mental Health Services Data Set](#), [DATE OF SELF-HARM](#) is during a [Hospital Provider Spell](#) and self-harm is defined as:

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

DECISION TO REFER DATE (ONWARD REFERRAL)

Change to Data Element: Changed Dataset

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](#).

DECISION TO REFER TIME (ONWARD REFERRAL)

Change to Data Element: Changed Dataset

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](#).

DIAGNOSIS DATE

Change to Data Element: Changed Dataset

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

Notes:

[DIAGNOSIS DATE](#) is the [PERSON PROPERTY OBSERVED DATE](#) for the [PATIENT DIAGNOSIS](#).

DIAGNOSIS SCHEME IN USE

Change to Data Element: Changed Dataset

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

Notes:

[DIAGNOSIS SCHEME IN USE](#) is the same as attribute [DIAGNOSIS SCHEME IN USE](#).

DISABILITY CODE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See DISABILITY CODE
Default Codes:	

Notes:

[DISABILITY CODE](#) is the same as attribute [DISABILITY CODE](#).

DISABILITY IMPACT PERCEPTION

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See DISABILITY IMPACT PERCEPTION
Default Codes:	

Notes:

[DISABILITY IMPACT PERCEPTION](#) is the same as attribute [DISABILITY IMPACT PERCEPTION](#).

DISCHARGE DATE (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Dataset

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[DISCHARGE DATE \(HOSPITAL PROVIDER SPELL\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Discharge Date](#)'.

[DISCHARGE DATE \(HOSPITAL PROVIDER SPELL\)](#) is the date a [PATIENT](#) was discharged from a [Hospital Provider Spell](#).

DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Dataset

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:

[DISCHARGE DESTINATION CODE \(HOSPITAL PROVIDER SPELL\)](#) is the same as attribute [DISCHARGE DESTINATION](#).

[DISCHARGE DESTINATION CODE \(HOSPITAL PROVIDER SPELL\)](#) is used by the [Secondary Uses Service](#) to derive the [Healthcare Resource Group](#) 4. Failure to correctly populate this data element is likely to result in an incorrect [Healthcare Resource Group](#), usually associated with lower levels of healthcare resource.

For further information, please refer to the [NHS Digital](#) website at: [Payment by Results Guidance](#).

DISCHARGE LETTER ISSUED DATE (MENTAL HEALTH AND COMMUNITY CARE)

Change to Data Element: Changed Dataset

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[DISCHARGE LETTER ISSUED DATE \(MENTAL HEALTH AND COMMUNITY CARE\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Discharge Letter Issued Date \(Mental Health and Community Care\)](#)'.

DISCHARGE METHOD CODE (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Dataset

Format/Length: an1
National Codes: See [DISCHARGE METHOD](#)
Default Codes: 8 - Not applicable - [Hospital Provider Spell](#) not finished at episode end (i.e. not discharged) or current episode unfinished
9 - Not known: a validation error

Notes:

[DISCHARGE METHOD CODE \(HOSPITAL PROVIDER SPELL\)](#) is the same as attribute [DISCHARGE METHOD](#).

[DISCHARGE METHOD CODE \(HOSPITAL PROVIDER SPELL\)](#) is used by the [Secondary Uses Service](#) to derive the [Healthcare Resource Group](#) 4. Failure to correctly populate this data element is likely to result in an incorrect [Healthcare Resource Group](#), usually associated with lower levels of healthcare resource.

For further information, please refer to the [NHS Digital](#) website at: [Payment by Results Guidance](#).

DISCHARGE PLAN AGREED BY

Change to Data Element: Changed Dataset

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](#).

DISCHARGE PLAN AGREED DATE

Change to Data Element: Changed Dataset

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](#).

DISCHARGE PLAN AGREED TIME

Change to Data Element: New Data Element

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

Notes:

[DISCHARGE PLAN AGREED TIME](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Care Plan Agreed Time](#)'.

[DISCHARGE PLAN AGREED TIME](#) is the [TIME](#) 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 TIMES

DISCHARGE PLAN AGREED TIME

Change to Data Element: New Data Element

DISCHARGE PLAN AGREED TIME

Attribute:

ACTIVITY TIME

DISCHARGE PLAN CREATION DATE

Change to Data Element: Changed Dataset

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.

DISCHARGE PLAN CREATION TIME

Change to Data Element: New Data Element

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

Notes:

[DISCHARGE PLAN CREATION TIME](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Care Plan Creation Time](#)'.

[DISCHARGE PLAN CREATION TIME](#) is the [TIME](#) that a [Discharge Plan](#) was created.

This data element is also known by these names:

Context	Alias
plural	DISCHARGE PLAN CREATION TIMES

DISCHARGE PLAN CREATION TIME

Change to Data Element: New Data Element

DISCHARGE PLAN CREATION TIME

Attribute:

ACTIVITY TIME

DISCHARGE PLAN LAST UPDATED DATE

Change to Data Element: Changed Dataset

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](#).

DISCHARGE PLAN LAST UPDATED TIME

Change to Data Element: New Data Element

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

Notes:

[DISCHARGE PLAN LAST UPDATED TIME](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Care Plan Last Updated Time](#)'.

[DISCHARGE PLAN LAST UPDATED TIME](#) is the [TIME](#) 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 TIME](#) will be the same as [DISCHARGE PLAN CREATION TIME](#).

This data element is also known by these names:

Context	Alias
plural	DISCHARGE PLAN CREATION TIMES

DISCHARGE PLAN LAST UPDATED TIME

Change to Data Element: New Data Element

DISCHARGE PLAN LAST UPDATED TIME

Attribute:

ACTIVITY TIME

DISCHARGE TIME (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Dataset

Format/Length: See [TIME](#)
National Codes:
Default Codes:

Notes:

[DISCHARGE TIME \(HOSPITAL PROVIDER SPELL\)](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Discharge Time](#)'.

[DISCHARGE TIME \(HOSPITAL PROVIDER SPELL\)](#) is the time a [PATIENT](#) was discharged from a [Hospital Provider Spell](#).

DURATION OF INDIRECT ACTIVITY

Change to Data Element: Changed Dataset

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

Notes:

[DURATION OF INDIRECT ACTIVITY](#) is the duration of an [Indirect Activity](#) in minutes, excluding any administration time prior to or after the [Indirect Activity](#) and the [CARE PROFESSIONAL](#)'s travelling time to the [LOCATION](#) where the [Indirect Activity](#) took place.

[DURATION OF INDIRECT ACTIVITY](#) is calculated from the [Start Time](#) and [End Time](#) of the [Indirect Activity](#).

DURATION OF RESTRICTIVE INTERVENTION

Change to Data Element: Changed Dataset

Format/Length: max n6
National Codes:
Default Codes:

Notes:

[DURATION OF RESTRICTIVE INTERVENTION](#) is the duration in minutes of a reported incident of a [Restrictive Intervention](#).

[DURATION OF RESTRICTIVE INTERVENTION](#) is calculated from the [Start Time](#) and [End Time](#) of the [Restrictive Intervention](#).

EARLIEST CLINICALLY APPROPRIATE DATE

Change to Data Element: Changed Dataset

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[EARLIEST CLINICALLY APPROPRIATE DATE](#) is the earliest [DATE](#) that it was clinically appropriate for an [ACTIVITY](#) to take place.

For the [Radiotherapy Data Set](#), [EARLIEST CLINICALLY APPROPRIATE DATE](#) is the:

- first date that the [PATIENT](#) would have been clinically fit to start [Radiotherapy](#) and
- same as the [DECISION TO TREAT DATE](#) unless there was an elective delay, i.e. a clinical reason, such as the [PATIENT](#) was not fit.

For the [Community Services Data Set](#), [Mental Health Services Data Set](#) and [Commissioning Data Sets](#) (version 6-2 onwards), the [EARLIEST CLINICALLY APPROPRIATE DATE](#) may be used locally to inform waiting time calculations. It can be used to account for periods of time where it is not appropriate to treat the [PATIENT](#) for clinical reasons, for example:

- where the [PATIENT](#) has been admitted to hospital for an unrelated condition and the [SERVICE](#) cannot commence planned treatment until the [PATIENT](#) has been discharged
- where the [PATIENT](#) is frail and cannot be treated until their condition improves, but it is not appropriate to discharge the [PATIENT](#) from the [SERVICE](#).

EARLIEST REASONABLE OFFER DATE

Change to Data Element: Changed Dataset

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[EARLIEST REASONABLE OFFER DATE](#) is the date of the earliest of the [Reasonable Offers](#) made to a [PATIENT](#) for an [APPOINTMENT](#) or [Elective Admission](#). It should only be included on the Commissioning Data Sets where the [PATIENT](#) has declined at least two [Reasonable Offers](#), and a Patient Pause is to be applied to the length of wait calculation performed by the [Secondary Uses Service](#).

For an [APPOINTMENT](#) this is the earliest of the [APPOINTMENT DATES OFFERED](#) where the [REASONABLE OFFER INDICATOR](#) of the [APPOINTMENT OFFER](#) is National Code '[Reasonable Offer](#)'.

For an [OFFER OF ADMISSION](#) this is the earliest of the [OFFERED FOR ADMISSION DATES](#) where the [REASONABLE OFFER INDICATOR](#) of the [OFFER OF ADMISSION](#) is National Code '[Reasonable Offer](#)'.

Patient Cancellations

Where, for any reason, a [PATIENT](#) cancels or does not attend an [APPOINTMENT](#) or an [OFFER OF ADMISSION](#) the [EARLIEST REASONABLE OFFER DATE](#) for the rearranged [APPOINTMENT](#) or [OFFER OF ADMISSION](#) will be the [EARLIEST REASONABLE OFFER DATE](#) of the cancelled [APPOINTMENT](#) or [OFFER OF ADMISSION](#).

Provider Cancellations

Where, for any reason, any [Health Care Provider](#) cancels and re-arranges an [APPOINTMENT](#) or an [OFFER OF ADMISSION](#), the [EARLIEST REASONABLE OFFER DATE](#) for the re-arranged [APPOINTMENT](#) or [OFFER OF ADMISSION](#) will be the date of the earliest [Reasonable Offer](#) made following the cancellation.

Patients who are unavailable

Where a [PATIENT](#) makes themselves unavailable for a longer period of time, for example a [PATIENT](#) who is a teacher who wishes to delay their admission until the summer holidays, making a [Reasonable Offer](#) may be inappropriate.

In these circumstances, so long as the [Health Care Provider](#) could have made at least two [Reasonable Offers](#), the [EARLIEST REASONABLE OFFER DATE](#) will be the date of the earliest [Reasonable Offer](#) that the provider could have offered the [PATIENT](#). This must be communicated to the [PATIENT](#).

Use in Commissioning Data Set version 6-0 onwards for Referral To Treatment Consultant-Led Waiting Times:

If the Commissioning Data Set record:

relates to a [Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement](#)

and

includes the [REFERRAL TO TREATMENT PERIOD END DATE](#) of the [REFERRAL TO TREATMENT PERIOD](#)

and

is of the following Commissioning Data Set Types:

- [CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode CDS](#)
- [CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode CDS](#)

then [EARLIEST REASONABLE OFFER DATE](#) must be populated in the Commissioning Data Set record if a Patient Pause (the [PATIENT](#) is paused on the [ELECTIVE ADMISSION LIST](#) because they have made themselves unavailable for treatment for a specified period (for non-clinical reasons)) is to be applied to a [REFERRAL TO TREATMENT PERIOD](#) by the [Secondary Uses Service](#).

Failure to include [EARLIEST REASONABLE OFFER DATE](#) in the Admitted Patient Care General Episode Commissioning Data Set record carrying the [REFERRAL TO TREATMENT PERIOD END DATE](#), will mean no Patient Pause is applied to the duration of wait calculation for the [REFERRAL TO TREATMENT PERIOD](#) performed by the [Secondary Uses Service](#).

Use in the [Community Services Data Set](#), [Mental Health Services Data Set](#) Commissioning Data Sets (version 6-2 onwards) for Allied Health Professional Referral To Treatment:

For the [Community Services Data Set](#), [Mental Health Services Data Set](#) and the [Commissioning Data Sets](#) (version 6-2 onwards) the [EARLIEST REASONABLE OFFER DATE](#) may be used locally to inform waiting time calculations for [Allied Health Professional Referral To Treatment Measurement](#). It can be used to account for periods of time where the [PATIENT](#) has not accepted the first available [APPOINTMENT OFFER](#) and this has extended the [Allied Health Professional Referral To Treatment Measurement](#) waiting time, for example:

- where a [PATIENT](#) who is a child has been offered an [APPOINTMENT](#) but their parent/carer states that they wish to wait until the school holidays commence. The [SERVICE](#) cannot commence planned treatment until the [PATIENT](#) is available.
- where the [PATIENT](#) works away and cannot attend for a period of time, but it is not appropriate to discharge the [PATIENT](#) from the [SERVICE](#).

EMERGENT PSYCHOSIS DATE

Change to Data Element: Changed Dataset

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[EMERGENT PSYCHOSIS DATE](#) is the same as attribute [PERSON PROPERTY OBSERVED DATE](#).

[EMERGENT PSYCHOSIS DATE](#) is the [DATE](#) at which there was first clear evidence of a positive psychotic symptom for the [PATIENT](#) (i.e. delusion, hallucination, or thought disorder), regardless of its duration.

EMPLOYMENT STATUS

Change to Data Element: Changed Dataset

Format/Length: an2
National Codes: See [EMPLOYMENT STATUS](#)
Default Codes:

Notes:

[EMPLOYMENT STATUS](#) is the same as attribute [EMPLOYMENT STATUS](#).

EMPLOYMENT STATUS RECORDED DATE

Change to Data Element: Changed Dataset

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[EMPLOYMENT STATUS RECORDED DATE](#) is the same as attribute [PERSON PROPERTY RECORDED DATE](#).

[EMPLOYMENT STATUS RECORDED DATE](#) is the [DATE](#) when the [EMPLOYMENT STATUS](#) was recorded.

END DATE (CARE CLUSTER ASSIGNMENT PERIOD)

Change to Data Element: Changed Dataset

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[END DATE \(CARE CLUSTER ASSIGNMENT PERIOD\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[End Date](#)' of a [Care Cluster Assignment Period](#).

END DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)

Change to Data Element: Changed Dataset

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[END DATE \(CARE PROFESSIONAL ADMITTED CARE EPISODE\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[End Date](#)' of the [Care Professional Admitted Care Episode](#).

END DATE (CARE PROGRAMME APPROACH CARE)

Change to Data Element: Changed Dataset

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[END DATE \(CARE PROGRAMME APPROACH CARE\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[End Date](#)' of the [Care Programme Approach](#) care for the [PATIENT](#).

END DATE (COMMISSIONER ASSIGNMENT PERIOD)

Change to Data Element: Changed Dataset

Format/Length: See [DATE](#)

National Codes:
Default Codes:

Notes:

[END DATE \(COMMISSIONER ASSIGNMENT PERIOD\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[End Date](#)' of the [Commissioner Assignment Period](#).

END DATE (COMMUNITY TREATMENT ORDER)

Change to Data Element: Changed Dataset

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[END DATE \(COMMUNITY TREATMENT ORDER\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[End Date](#)' of the [Community Treatment Order](#).

END DATE (COMMUNITY TREATMENT ORDER RECALL)

Change to Data Element: Changed Dataset

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[END DATE \(COMMUNITY TREATMENT ORDER RECALL\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[End Date](#)' of the [Community Treatment Order Recall](#).

END DATE (GMP PATIENT REGISTRATION)

Change to Data Element: Changed Dataset

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[END DATE \(GMP PATIENT REGISTRATION\)](#) is the same as [END DATE](#).

[END DATE \(GMP PATIENT REGISTRATION\)](#) is the [DATE](#) on which the [PERSON](#) ceased to be registered with a [General Medical Practitioner Practice](#).

END DATE (HOME LEAVE)

Change to Data Element: Changed Dataset

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[END DATE \(HOME LEAVE\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[End Date](#)' of the [Home Leave](#).

END DATE (MENTAL HEALTH ABSENCE WITHOUT LEAVE)

Change to Data Element: Changed Dataset

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[END DATE \(MENTAL HEALTH ABSENCE WITHOUT LEAVE\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[End Date](#)' of the [Mental Health Absence Without Leave](#).

END DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)

Change to Data Element: Changed Dataset

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[END DATE \(MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[End Date](#)' of the [Mental Health Act Legal Status Classification Assignment Period](#).

END DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD)

Change to Data Element: Changed Dataset

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

Notes:

[END DATE \(MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[End Date](#)' of the [Mental Health Care Coordinator Assignment Period](#).

END DATE (MENTAL HEALTH CONDITIONAL DISCHARGE)

Change to Data Element: Changed Dataset

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

Notes:

[END DATE \(MENTAL HEALTH CONDITIONAL DISCHARGE\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[End Date](#)' of the [Mental Health Conditional Discharge Period](#).

END DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD)

Change to Data Element: Changed Dataset

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

Notes:

[END DATE \(MENTAL HEALTH DELAYED DISCHARGE PERIOD\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[End Date](#)' of the [Mental Health Delayed Discharge Period](#).

END DATE (MENTAL HEALTH LEAVE OF ABSENCE)

Change to Data Element: Changed Dataset

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

Notes:

[END DATE \(MENTAL HEALTH LEAVE OF ABSENCE\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[End Date](#)' of the [Mental Health Leave of Absence](#).

END DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD)

Change to Data Element: Changed Dataset

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

Notes:

[END DATE \(MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[End Date](#)' of the [Mental Health Responsible Clinician Assignment Period](#).

END DATE (MENTAL HEALTH TRIAL LEAVE)

Change to Data Element: New Data Element

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

Notes:

[END DATE \(MENTAL HEALTH TRIAL LEAVE\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[End Date](#)' of the [Mental Health Trial Leave](#).

This data element is also known by these names:

Context	Alias
plural	END DATES (MENTAL HEALTH TRIAL LEAVE)

END DATE (MENTAL HEALTH TRIAL LEAVE)

Change to Data Element: New Data Element

END DATE (MENTAL HEALTH TRIAL LEAVE)

Attribute:

ACTIVITY DATE

END DATE (WARD STAY)

Change to Data Element: Changed Dataset

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

Notes:

[END DATE \(WARD STAY\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[End Date](#)' of the [Ward Stay](#).

END TIME (CARE CLUSTER ASSIGNMENT PERIOD)

Change to Data Element: Changed Dataset

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

Notes:

[END TIME \(CARE CLUSTER ASSIGNMENT PERIOD\)](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[End Time](#)' of a [Care Cluster Assignment Period](#).

END TIME (COMMUNITY TREATMENT ORDER RECALL)

Change to Data Element: Changed Dataset

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

Notes:

[END TIME \(COMMUNITY TREATMENT ORDER RECALL\)](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[End Time](#)' of the [Community Treatment Order Recall](#).

END TIME (HOME LEAVE)

Change to Data Element: Changed Dataset

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

Notes:

[END TIME \(HOME LEAVE\)](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[End Time](#)' of the [Home Leave](#).

END TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE)

Change to Data Element: Changed Dataset

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

Notes:

[END TIME \(MENTAL HEALTH ABSENCE WITHOUT LEAVE\)](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[End Time](#)' of the [Mental Health Absence Without Leave](#).

END TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)

Change to Data Element: Changed Dataset

Format/Length: See TIME
National Codes:

Default Codes:

Notes:

[END TIME \(MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD\)](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[End Time](#)' of the [Mental Health Act Legal Status Classification Assignment Period](#).

END TIME (MENTAL HEALTH LEAVE OF ABSENCE)

Change to Data Element: Changed Dataset

Format/Length: See [TIME](#)
National Codes:
Default Codes:

Notes:

[END TIME \(MENTAL HEALTH LEAVE OF ABSENCE\)](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[End Time](#)' of the [Mental Health Leave of Absence](#).

END TIME (MENTAL HEALTH TRIAL LEAVE)

Change to Data Element: New Data Element

Format/Length: See [TIME](#)
National Codes:
Default Codes:

Notes:

[END TIME \(MENTAL HEALTH TRIAL LEAVE\)](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[End Time](#)' of the [Mental Health Trial Leave](#).

This data element is also known by these names:

Context	Alias
plural	END TIMES (MENTAL HEALTH TRIAL LEAVE)

END TIME (MENTAL HEALTH TRIAL LEAVE)

Change to Data Element: New Data Element

END TIME (MENTAL HEALTH TRIAL LEAVE)

Attribute:

[ACTIVITY TIME](#)

END TIME (WARD STAY)

Change to Data Element: Changed Dataset

Format/Length: See [TIME](#)
National Codes:
Default Codes:

Notes:

[END TIME \(WARD STAY\)](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[End Time](#)' of the [Ward Stay](#).

ESCORTED MENTAL HEALTH LEAVE OF ABSENCE INDICATOR

Change to Data Element: New Data Element

Format/Length: an1
National Codes: See [ESCORTED MENTAL HEALTH LEAVE OF ABSENCE INDICATOR](#)
Default Codes:

Notes:

[ESCORTED MENTAL HEALTH LEAVE OF ABSENCE INDICATOR](#) is the same as attribute [ESCORTED MENTAL HEALTH LEAVE OF ABSENCE INDICATOR](#).

This data element is also known by these names:

Context	Alias
plural	ESCORTED MENTAL HEALTH LEAVE OF ABSENCE INDICATORS

ESCORTED MENTAL HEALTH LEAVE OF ABSENCE INDICATOR

Change to Data Element: New Data Element

ESCORTED MENTAL HEALTH LEAVE OF ABSENCE INDICATOR

Attribute:

ESCORTED MENTAL HEALTH LEAVE OF ABSENCE INDICATOR

ESTIMATED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)

Change to Data Element: New Data Element

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

Notes:

ESTIMATED DISCHARGE DATE (HOSPITAL PROVIDER SPELL) is the same as attribute PLANNED ACTIVITY DATE where the PLANNED ACTIVITY DATE TYPE is National Code 'Estimated Discharge Date (Hospital Provider Spell)'.

Note: for the Mental Health Services Data Set, this is different to the PLANNED DISCHARGE DATE (HOSPITAL PROVIDER SPELL), which is set once the PATIENT has been confirmed for discharge.

This data element is also known by these names:

Context	Alias
plural	ESTIMATED DISCHARGE DATES (HOSPITAL PROVIDER SPELL)

ESTIMATED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)

Change to Data Element: New Data Element

ESTIMATED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)

Attribute:

PLANNED ACTIVITY DATE

ETHNIC CATEGORY

Change to Data Element: Changed Dataset

Format/Length: an2
NWDS ID: PETH
NWDS Field Name: Ethnic Category
ESR Field Name: Ethnic Origin
National Codes: See ETHNIC CATEGORY CODE
Default Codes: 99 - Not known

Notes:

ETHNIC CATEGORY is the same as attribute ETHNIC CATEGORY CODE.

The 16+1 ethnic data categories defined in the 2001 census is the national mandatory standard for the collection and analysis of ethnicity.

The national code must be transmitted as the first character in the 2 character field. The second character is optional for use locally. It must, however, be able to be grouped consistently with the 16 main categories.

National code Z should be used where the PERSON has been given the opportunity to state their ETHNIC CATEGORY but chose not to. Default code 99 should be used where the PERSON's ETHNIC CATEGORY is not known.

EX-BRITISH ARMED FORCES INDICATOR

Change to Data Element: Changed Dataset

Format/Length: an2
National Codes: See EX-BRITISH ARMED FORCES INDICATOR
Default Codes:

Notes:

[EX-BRITISH ARMED FORCES INDICATOR](#) is the same as attribute [EX-BRITISH ARMED FORCES INDICATOR](#).

EXPIRY DATE (COMMUNITY TREATMENT ORDER)

Change to Data Element: Changed Dataset

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

Notes:

[EXPIRY DATE \(COMMUNITY TREATMENT ORDER\)](#) is the same as attribute [PERSON PROPERTY EFFECTIVE END DATE](#).

[EXPIRY DATE \(COMMUNITY TREATMENT ORDER\)](#) is the [DATE](#) when a [Community Treatment Order](#) for a [PATIENT](#) expires.

EXPIRY DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)

Change to Data Element: Changed Dataset

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

Notes:

[EXPIRY DATE \(MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION\)](#) is the same as attribute [PERSON PROPERTY EFFECTIVE END DATE](#).

[EXPIRY DATE \(MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION\)](#) is the [DATE](#) when a [MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION](#) for a [PATIENT](#) expires.

EXPIRY TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)

Change to Data Element: Changed Dataset

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

Notes:

[END TIME \(MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD\)](#) is the same as attribute [PERSON PROPERTY EFFECTIVE END TIME](#).

[END TIME \(MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD\)](#) is the [TIME](#) when a [MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION](#) for a [PATIENT](#) expires.

FINDING SCHEME IN USE

Change to Data Element: Changed Dataset

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

Notes:

[FINDING SCHEME IN USE](#) is the same as attribute [FINDING SCHEME IN USE](#).

FIRST PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION)

Change to Data Element: Changed Dataset

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

Notes:

[FIRST PRESCRIPTION DATE \(ANTI-PSYCHOTIC MEDICATION\)](#) is the same as attribute [PRESCRIPTION DATE](#).

[FIRST PRESCRIPTION DATE \(ANTI-PSYCHOTIC MEDICATION\)](#) is the date the [PATIENT](#) was first prescribed Anti-Psychotic Medication following referral into an [Early Intervention in Psychosis \(EIP\) Service](#).

FIVE FORENSIC PATHWAYS ASSESSMENT DATE

Change to Data Element: Changed Dataset

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](#)'.

FIVE FORENSIC PATHWAYS ASSESSMENT REASON

Change to Data Element: Changed Dataset

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](#).

FIVE FORENSIC PATHWAYS CODE

Change to Data Element: Changed Dataset

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](#).

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)

Change to Data Element: Changed Dataset

Format/Length:	max an4
National Codes:	See FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE
Default Codes:	

Notes:

[FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE \(FINAL\)](#) is the same as attribute [FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE](#).

[FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE \(FINAL\)](#) is the final [FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE](#) allocated by the [CARE PROFESSIONAL](#).

Note: This data item is included in the [Mental Health Services Data Set](#) but should not be submitted until further development by [NHS Digital](#) has been undertaken.

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)

Change to Data Element: Changed Dataset

Format/Length:	max an4
National Codes:	See FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE
Default Codes:	

Notes:

[FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE \(INITIAL\)](#) is the same as attribute [FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE](#).

[FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE \(INITIAL\)](#) is the initial [FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE](#) allocated by the [CARE PROFESSIONAL](#).

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

FORENSIC MENTAL HEALTH CARE CLUSTER CODE (FINAL) renamed from **FORENSIC MENTAL HEALTH CARE CLUSTER CODE (FINAL)**

Change to Data Element: Changed Name, Dataset, Description

Format/Length:	max an4
Format/Length:	max an3
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 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](#).~~ [FORENSIC MENTAL HEALTH CARE CLUSTER CODE \(FINAL\)](#) is the final [FORENSIC MENTAL HEALTH CARE CLUSTER CODE](#) allocated by the [CARE PROFESSIONAL](#).

GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)

Change to Data Element: Changed Dataset

Format/Length:	an6
National Codes:	
ODS Default Codes:	V81997 - No Registered GP Practice
	V81998 - GP Practice Code not applicable
	V81999 - GP Practice Code not known

Notes:

[GENERAL MEDICAL PRACTICE CODE \(PATIENT REGISTRATION\)](#) is the same as attribute [ORGANISATION CODE](#).

The data for [GENERAL MEDICAL PRACTICE CODE \(PATIENT REGISTRATION\)](#) is supplied by the [NHS Prescription Services](#).

[GENERAL MEDICAL PRACTICE CODE \(PATIENT REGISTRATION\)](#) is the [ORGANISATION CODE](#) of the [GP Practice](#) that the [PATIENT](#) is registered with.

Use of [Organisation Data Service Default Codes](#)

- **V81997** should be used when a [PATIENT](#) presents, who is not currently registered at a [GP Practice](#), *but is eligible to be registered should they wish to*.
- **V81998** should be used where a [PATIENT](#) should not have a registered [GP Practice](#), due for instance to them having only recently entered the country.
- **V81999** should be used where it is not possible to determine a [PATIENT](#)'s registered [GP Practice](#) code, but it is known that they should have one, or where it is impossible to determine whether they should or shouldn't have a registered practice (for instance the [PATIENT](#) cannot communicate and is unidentified).

GROUP SESSION DATE

Change to Data Element: Changed Dataset

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

Notes:

[GROUP SESSION DATE](#) is the [SESSION DATE](#) of the [Group Session](#).

GROUP SESSION IDENTIFIER

Change to Data Element: Changed Dataset

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

Notes:

[GROUP SESSION IDENTIFIER](#) is the [ACTIVITY IDENTIFIER](#) for a [Group Session](#).

GROUP SESSION TYPE (MENTAL HEALTH)

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See GROUP SESSION TYPE FOR MENTAL HEALTH
Default Codes:	

Notes:

[GROUP SESSION TYPE \(MENTAL HEALTH\)](#) is the same as attribute [GROUP SESSION TYPE FOR MENTAL HEALTH](#).

GROUP THERAPY INDICATOR

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See GROUP THERAPY INDICATOR
Default Codes:	Z - Not Known if the ACTIVITY was Group Therapy

Notes:

[GROUP THERAPY INDICATOR](#) is the same as attribute [GROUP THERAPY INDICATOR](#).

HOSPITAL PROVIDER SPELL NUMBER

Change to Data Element: Changed Dataset

Format/Length:	an12
National Codes:	
Default Codes:	

Notes:

[HOSPITAL PROVIDER SPELL NUMBER](#) is the same as attribute [ACTIVITY IDENTIFIER](#).

A [HOSPITAL PROVIDER SPELL NUMBER](#) is a unique identifier for each [Hospital Provider Spell](#) for a [Health Care Provider](#).

[HOSPITAL PROVIDER SPELL NUMBER](#) is used by the [Secondary Uses Service](#) to derive the [Healthcare Resource Group 4](#). Failure to correctly populate this data element is likely to result in an incorrect [Healthcare Resource Group](#), usually associated with lower levels of healthcare resource.

For further information, please refer to the [NHS Digital](#) website at: [Payment by Results Guidance](#).

INDIRECT ACTIVITY DATE

Change to Data Element: Changed Dataset

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

Notes:

[INDIRECT ACTIVITY DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Indirect Activity Date](#)'.

INDIRECT ACTIVITY TIME

Change to Data Element: Changed Dataset

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

Notes:

[INDIRECT ACTIVITY TIME](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Indirect Activity Time](#)'.

INTENDED AGE GROUP (MENTAL HEALTH)

Change to Data Element: Changed Dataset

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](#).

INTENDED CLINICAL CARE INTENSITY CODE (MENTAL HEALTH)

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	
Default Codes:	

Notes:

[INTENDED CLINICAL CARE INTENSITY CODE \(MENTAL HEALTH\)](#) is the same as attribute [CLINICAL CARE INTENSITY](#) for the [Mental Health Services Data Set](#).

Permitted National Codes:

For [PATIENTS](#) with Mental Illness:

- 51 For Intensive Care - specially designated ward for [PATIENTS](#) needing containment and more intensive management (eg Psychiatric Intensive Care Unit (PICU)). This is not to be confused with intensive nursing where a [PATIENT](#) may require one-to-one nursing while on a standard [WARD](#)
- 52 For Short Stay - [PATIENTS](#) intended to stay for less than a year
- 53 For Long Stay - [PATIENTS](#) intended to stay for a year or more

For [PATIENTS](#) with [Learning Disabilities](#):

- 61 Designated or interim secure unit
- 62 [PATIENTS](#) intending to stay less than a year
- 63 [PATIENTS](#) intending to stay a year or more

LANGUAGE CODE (PREFERRED)

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See LANGUAGE CODE
Default Codes:	

Notes:

[LANGUAGE CODE \(PREFERRED\)](#) is the same as the attribute [LANGUAGE CODE](#).

[LANGUAGE CODE \(PREFERRED\)](#) is the language the [PATIENT](#), [Patient Proxy](#) or [Carer](#) prefers to use for communication with a [Health Care Provider](#).

LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)

Change to Data Element: Changed Dataset

Format/Length:	max an4
National Codes:	See LEARNING DISABILITIES CARE CLUSTER CODE
Default Codes:	

Notes:

[LEARNING DISABILITIES CARE CLUSTER CODE \(FINAL\)](#) is the same as attribute [LEARNING DISABILITIES CARE CLUSTER CODE](#).

[LEARNING DISABILITIES CARE CLUSTER CODE \(FINAL\)](#) is the final [LEARNING DISABILITIES CARE CLUSTER CODE](#) allocated by the [CARE PROFESSIONAL](#).

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

LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)

Change to Data Element: Changed Dataset

Format/Length:	max an4
National Codes:	See LEARNING DISABILITIES CARE CLUSTER CODE
Default Codes:	

Notes:

[LEARNING DISABILITIES CARE CLUSTER CODE \(INITIAL\)](#) is the same as attribute [LEARNING DISABILITIES CARE CLUSTER CODE](#).

[LEARNING DISABILITIES CARE CLUSTER CODE \(INITIAL\)](#) is the initial [LEARNING DISABILITIES CARE CLUSTER CODE](#) allocated by the [CARE PROFESSIONAL](#).

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

LOCAL PATIENT IDENTIFIER (EXTENDED)

Change to Data Element: Changed Dataset

Format/Length:	max an20
National Codes:	

Default Codes:

Notes:

[LOCAL PATIENT IDENTIFIER \(EXTENDED\)](#) is the same as attribute [LOCAL PATIENT IDENTIFIER](#).

[LOCAL PATIENT IDENTIFIER \(EXTENDED\)](#) is used where IT systems have a [LOCAL PATIENT IDENTIFIER](#) which is longer than 10 characters and [LOCAL PATIENT IDENTIFIER](#) cannot be used for data submission.

LOCKED WARD INDICATOR

Change to Data Element: Changed Dataset

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.

LOOKED AFTER CHILD INDICATOR

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See LOOKED AFTER CHILD INDICATOR
Default Codes:	X - Not known if the PERSON is a Looked After Child

Notes:

[LOOKED AFTER CHILD INDICATOR](#) is the same as attribute [LOOKED AFTER CHILD INDICATOR](#).

MAIN SPECIALTY CODE (MENTAL HEALTH)

Change to Data Element: Changed Dataset

Format/Length:	an3
National Codes:	
Default Codes:	

Notes:

[MAIN SPECIALTY CODE \(MENTAL HEALTH\)](#) is the same as attribute [MAIN SPECIALTY CODE](#).

[MAIN SPECIALTY CODE \(MENTAL HEALTH\)](#) is the [MAIN SPECIALTY CODE](#) of the [CARE PROFESSIONAL](#) working in a [Mental Health Service](#), who is responsible for the [PATIENT](#) within the [REPORTING PERIOD](#).

Permitted National Codes:

600	General Medical Practice
700	Learning Disability
710	Adult Mental Illness
711	Child and Adolescent Psychiatry
712	Forensic Psychiatry
713	Psychotherapy
715	Old Age Psychiatry
950	Nursing Episode
960	Allied Health Professional Episode

MANIFEST PSYCHOSIS DATE

Change to Data Element: Changed Dataset

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

Notes:

[MANIFEST PSYCHOSIS DATE](#) is the same as attribute [PERSON PROPERTY OBSERVED DATE](#).

[MANIFEST PSYCHOSIS DATE](#) is the [DATE](#) at which a positive psychotic symptom for the [PATIENT](#) (i.e. delusion, hallucination, or thought disorder) has lasted for a week. This is usually a week after the [DATE](#) of the first psychotic symptom.

MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON
Default Codes:	99 - MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON Not known

Notes:

[MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON](#) is the same as attribute [MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON](#).

MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY
Default Codes:	

Notes:

[MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY](#) is the same as attribute [MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY](#).

MENTAL HEALTH ACT 2007 MENTAL CATEGORY

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See MENTAL HEALTH ACT 2007 MENTAL CATEGORY
Default Codes:	8 - Not applicable (i.e. not detained) 9 - Not known

Notes:

[MENTAL HEALTH ACT 2007 MENTAL CATEGORY](#) is the same as attribute [MENTAL HEALTH ACT 2007 MENTAL CATEGORY](#).

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON
Default Codes:	

Notes:

[MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON](#) is the same as attribute [MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON](#).

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER

Change to Data Element: Changed Dataset

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

Notes:

[MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER](#) is the same as attribute [ACTIVITY IDENTIFIER](#).

[MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER](#) is a unique identifier allocated to each [Mental Health Act Legal Status Classification Assignment Period](#).

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON
Default Codes:	

Notes:

[MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON](#) is the same as attribute [MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON](#).

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE
Default Codes:	98 - Not Applicable 99 - Not Known

Notes:

[MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE](#) is the same as attribute [MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE](#).

[MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE](#) is required for all [PATIENTS](#) who have a [Hospital Provider Spell](#) which includes the care of a [CONSULTANT](#) in the psychiatric specialties or have been discharged from such a [Hospital Provider Spell](#) and are required to receive supervised aftercare under the provisions of the Mental Health (Patients in the Community) Act 1995.

MENTAL HEALTH ADMITTED PATIENT CLASSIFICATION

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	
Default Codes:	

Notes:

[MENTAL HEALTH ADMITTED PATIENT CLASSIFICATION](#) is derived from the attributes [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](#).

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

MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE
Default Codes:	Z - Unable to assign PATIENT to Mental Health Care Cluster Super Class

Notes:

[MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE](#) is the same as attribute [MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE](#).

MENTAL HEALTH CONDITIONAL DISCHARGE END REASON

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See MENTAL HEALTH CONDITIONAL DISCHARGE END REASON
Default Codes:	

Notes:

[MENTAL HEALTH CONDITIONAL DISCHARGE END REASON](#) is the same as attribute [MENTAL HEALTH CONDITIONAL DISCHARGE END REASON](#).

MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE
Default Codes:	

Notes:

[MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE](#) is the same as attribute [MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE](#).

MENTAL HEALTH DELAYED DISCHARGE REASON

Change to Data Element: Changed Dataset

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](#).

MENTAL HEALTH LEAVE OF ABSENCE END REASON

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See MENTAL HEALTH LEAVE OF ABSENCE END REASON
Default Codes:	99 - MENTAL HEALTH LEAVE OF ABSENCE END REASON Not known

Notes:

[MENTAL HEALTH LEAVE OF ABSENCE END REASON](#) is the same as attribute [MENTAL HEALTH LEAVE OF ABSENCE END REASON](#).

NHS NUMBER

Change to Data Element: Changed Dataset

Format/Length:	n10
National Codes:	
Default Codes:	

Notes:

[NHS NUMBER](#) is the same as attribute [NHS NUMBER](#).

For the [AIDC for Patient Identification Data Set](#), [NHS NUMBER](#) must be displayed in accordance with the [NHS Common User Interface Information Standard - NHS Number Input and Display \(ISB 1504\)](#).

NHS NUMBER STATUS INDICATOR CODE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	
Default Codes:	

Notes:

[NHS NUMBER STATUS INDICATOR CODE](#) is the trace status of the [NHS NUMBER](#).

Permitted National Codes:

- 01 Number present and verified
- 02 Number present but not traced
- 03 Trace required
- 04 Trace attempted - No match or multiple match found
- 05 Trace needs to be resolved - (NHS Number or [PATIENT](#) detail conflict)
- 06 Trace in progress
- 07 Number not present and trace not required
- 08 Trace postponed (baby under six weeks old)

NHS SERVICE AGREEMENT LINE NUMBER

Change to Data Element: Changed Dataset

Format/Length: an10
National Codes:
Default Codes:

Notes:

[NHS SERVICE AGREEMENT LINE NUMBER](#) is the same as attribute [NHS SERVICE AGREEMENT LINE NUMBER](#).

The [NHS SERVICE AGREEMENT LINE NUMBERS](#) may be used to identify a specific [NHS SERVICE AGREEMENT](#) reference where the main identifier refers to a general omnibus agreement.

NUMBER OF GROUP SESSION PARTICIPANTS

Change to Data Element: Changed Dataset

Format/Length: max n3
National Codes:
Default Codes:

Notes:

[NUMBER OF GROUP SESSION PARTICIPANTS](#) is the number of [PERSON](#)'s who participate in a [Group Session](#) (excluding the [CARE PROFESSIONALS](#) responsible for the [Group Session](#)).

OBSERVATION DATE (SUBSTANCE MISUSE EVIDENCE)

Change to Data Element: Changed Dataset

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](#).

OBSERVATION SCHEME IN USE

Change to Data Element: Changed Dataset

Format/Length: an2
National Codes: See [OBSERVATION SCHEME IN USE](#)
Default Codes:

Notes:

[OBSERVATION SCHEME IN USE](#) is the same as attribute [OBSERVATION SCHEME IN USE](#).

OBSERVATION VALUE

Change to Data Element: Changed Dataset

Format/Length: max an10

National Codes:
Default Codes:

Notes:

[OBSERVATION VALUE](#) is the same as attribute [OBSERVATION VALUE](#).

OCCUPATION CODE

Change to Data Element: Changed Dataset

Format/Length: an3
[NWDS](#) ID: GROC
[NWDS](#) Field Name: Occupation Code
National Codes:
Default Codes:

Notes:

[OCCUPATION CODE](#) is the same as attribute [NHS OCCUPATION CODE](#).

OFFENCE HISTORY INDICATION CODE

Change to Data Element: Changed Dataset

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](#).

ONWARD REFERRAL DATE

Change to Data Element: Changed Dataset

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[ONWARD REFERRAL DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Onward Referral Date](#)'.

ONWARD REFERRAL REASON

Change to Data Element: Changed Dataset

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

Notes:

[ONWARD REFERRAL REASON](#) is the same as attribute [ONWARD REFERRAL REASON](#).

ONWARD REFERRAL TIME

Change to Data Element: Changed Dataset

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](#)'.

ORGANISATION CODE (CODE OF COMMISSIONER)

Change to Data Element: Changed Dataset

Format/Length: an3 or an5
National Codes:
[ODS Default Codes:](#) VPP00 - Private [PATIENTS](#) / [Overseas Visitor](#) liable for charge
XMD00 - Commissioner Code for Ministry of Defence (MoD) Healthcare
YDD82 - Episodes funded directly by the [National Commissioning Group](#) for England

Notes:

[ORGANISATION CODE \(CODE OF COMMISSIONER\)](#) is the same as attribute [ORGANISATION CODE](#).

[ORGANISATION CODE \(CODE OF COMMISSIONER\)](#) is the [ORGANISATION CODE](#) of the [Organisation](#) commissioning health care.

For [Commissioning Data Sets](#), the [ORGANISATION CODE \(CODE OF COMMISSIONER\)](#) should always be the [ORGANISATION CODE](#) of the original commissioner to support the [National Tariff Payment System](#).

The [NHS England](#) document "[Who pays? Determining responsibility for payments to providers](#)" sets out a framework for establishing responsibility for commissioning an individual's care within the NHS, (i.e. determining who pays for a [PATIENT](#)'s care.)

The document includes information on the following:

- General Rules
- Applying the rules to [Clinical Commissioning Group](#) commissioned services
- Exceptions to the general rules
- Examples to help clarify the boundaries of responsibility between commissioning [Organisations](#).

For further information on this document contact [NHS England](#) at "[Contact us](#)".

[ORGANISATION CODE \(CODE OF COMMISSIONER\)](#) will be replaced with [ORGANISATION IDENTIFIER \(CODE OF COMMISSIONER\)](#), when it has been approved for use in national information standards.

ORGANISATION CODE (CODE OF PROVIDER)

Change to Data Element: Changed Dataset

Format/Length:	an3, an5 or an6
National Codes:	
ODS Default Codes :	89997 - Non-UK provider where no ORGANISATION CODE has been issued 89999 - Non-NHS UK provider where no ORGANISATION CODE has been issued

Notes:

[ORGANISATION CODE \(CODE OF PROVIDER\)](#) is the same as the attribute [ORGANISATION CODE](#).

[ORGANISATION CODE \(CODE OF PROVIDER\)](#) is the [ORGANISATION CODE](#) of the [Organisation](#) acting as a [Health Care Provider](#).

For [Commissioning Data Sets](#), the [ORGANISATION CODE \(CODE OF PROVIDER\)](#) should always be the [ORGANISATION CODE](#) of the [Health Care Provider](#) receiving the [National Tariff Payment System](#) income.

[ORGANISATION CODE \(CODE OF PROVIDER\)](#) is used by the [Secondary Uses Service](#) to derive the [Healthcare Resource Group 4](#). Failure to correctly populate this data element is likely to result in an incorrect [Healthcare Resource Group](#), usually associated with lower levels of healthcare resource.

For further information, please refer to the [NHS Digital](#) website at: [Payment by Results Guidance](#).

[ORGANISATION CODE \(CODE OF PROVIDER\)](#) will be replaced with [ORGANISATION IDENTIFIER \(CODE OF PROVIDER\)](#), when it has been approved for use in national information standards.

ORGANISATION CODE (CODE OF SUBMITTING ORGANISATION)

Change to Data Element: Changed Dataset

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

Notes:

[ORGANISATION CODE \(CODE OF SUBMITTING ORGANISATION\)](#) is the same as attribute [ORGANISATION CODE](#).

[ORGANISATION CODE \(CODE OF SUBMITTING ORGANISATION\)](#) is the [ORGANISATION CODE](#) of the [Organisation](#) acting as the physical sender of a Data Set submission.

[ORGANISATION CODE \(CODE OF SUBMITTING ORGANISATION\)](#) will be replaced with [ORGANISATION IDENTIFIER \(CODE OF SUBMITTING ORGANISATION\)](#), when it has been approved for use in national information standards.

ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT)

Change to Data Element: Changed Dataset

Format/Length:	min an5 max an8
National Codes:	
Default Codes:	

Notes:

[ORGANISATION CODE \(EDUCATIONAL ESTABLISHMENT\)](#) is the same as attribute [ORGANISATION CODE](#).

[ORGANISATION CODE \(EDUCATIONAL ESTABLISHMENT\)](#) is the [ORGANISATION CODE](#) of the [Educational Establishment](#), including [Schools](#).

[ORGANISATION CODE \(EDUCATIONAL ESTABLISHMENT\)](#) will be replaced with [ORGANISATION IDENTIFIER \(EDUCATIONAL ESTABLISHMENT\)](#), when it has been approved for use in national information standards.

ORGANISATION CODE (GP PRACTICE RESPONSIBILITY)

Change to Data Element: Changed Dataset

Format/Length:	an3
National Codes:	
ODS Default Codes:	Q99 - High Level Health Geography/Primary Care Organisation of Residence Not Known X98 - Primary Care Organisation Not Applicable (Overseas Visitors)

Notes:

[ORGANISATION CODE \(GP PRACTICE RESPONSIBILITY\)](#) is the same as attribute [ORGANISATION CODE](#).

[ORGANISATION CODE \(GP PRACTICE RESPONSIBILITY\)](#) is the [ORGANISATION CODE](#) of the [Organisation](#) responsible for the [GP Practice](#) where the [PATIENT](#) is registered, irrespective of whether they reside within the boundary of the [Clinical Commissioning Group](#).

[ORGANISATION CODE \(GP PRACTICE RESPONSIBILITY\)](#) will be replaced with [ORGANISATION IDENTIFIER \(GP PRACTICE RESPONSIBILITY\)](#), when it has been approved for use in national information standards.

ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)

Change to Data Element: Changed Dataset

Format/Length:	an3 or an5
National Codes:	
Default Codes:	

Notes:

[ORGANISATION CODE \(LOCAL PATIENT IDENTIFIER\)](#) is the same as attribute [ORGANISATION CODE](#).

[ORGANISATION CODE \(LOCAL PATIENT IDENTIFIER\)](#) is the [ORGANISATION CODE](#) of the [Organisation](#) that assigned the [LOCAL PATIENT IDENTIFIER](#).

[ORGANISATION CODE \(LOCAL PATIENT IDENTIFIER\)](#) will be replaced with [ORGANISATION IDENTIFIER \(LOCAL PATIENT IDENTIFIER\)](#), when it has been approved for use in national information standards.

ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)

Change to Data Element: Changed Dataset

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

Notes:

[ORGANISATION CODE \(PATIENT PATHWAY IDENTIFIER ISSUER\)](#) is the same as attribute [ORGANISATION CODE](#).

[ORGANISATION CODE \(PATIENT PATHWAY IDENTIFIER ISSUER\)](#) is the [ORGANISATION CODE](#) of the [Organisation](#) issuing the [PATIENT PATHWAY IDENTIFIER](#).

Where [Choose and Book](#) has been used, the [ORGANISATION CODE](#) X09 should be used.

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a [Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement](#), and is of the following Commissioning Data Set Types:

- [CDS V6-2 Type 020 - Outpatient Commissioning Data Set](#)
- [CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 030 - Elective Admission List - End of Period Census \(Standard\) Commissioning Data Set](#)

- [CDS V6-2 Type 060 - Elective Admission List - Event During Period \(Add\) Commissioning Data Set](#)
- [CDS V6-2 Type 070 - Elective Admission List - Event During Period \(Remove\) Commissioning Data Set](#)
- [CDS V6-2 Type 080 - Elective Admission List - Event During Period \(Offer\) Commissioning Data Set](#)

then [ORGANISATION CODE \(PATIENT PATHWAY IDENTIFIER ISSUER\)](#) must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.

[ORGANISATION CODE \(PATIENT PATHWAY IDENTIFIER ISSUER\)](#) will be replaced with [ORGANISATION IDENTIFIER \(PATIENT PATHWAY IDENTIFIER ISSUER\)](#), when it has been approved for use in national information standards.

ORGANISATION CODE (RECEIVING)

Change to Data Element: Changed Dataset

Format/Length:	an3 or an5
National Codes:	
Default Codes:	ZZ201 - Not applicable (not discharged to another Organisation) *

Notes:

[ORGANISATION CODE \(RECEIVING\)](#) is the same as the attribute [ORGANISATION CODE](#).

[ORGANISATION CODE \(RECEIVING\)](#) is the [ORGANISATION CODE](#) of the [Organisation](#) that is receiving the [PATIENT](#) from another [Health Care Provider](#).

For the [National Neonatal Data Set - Episodic and Daily Care](#), this is the [ORGANISATION CODE](#) of the [Organisation](#) where a baby is transferred to on discharge from the neonatal critical care.

* Note: default code ZZ201 is ONLY valid for the [National Neonatal Data Set - Episodic and Daily Care](#).

[ORGANISATION CODE \(RECEIVING\)](#) will be replaced with [ORGANISATION IDENTIFIER \(RECEIVING\)](#), when it has been approved for use in national information standards.

ORGANISATION CODE (RESIDENCE RESPONSIBILITY)

Change to Data Element: Changed Dataset

Format/Length:	an3
National Codes:	
ODS Default Codes:	Q99 - High Level Health Geography/Primary Care Organisation of Residence Not Known Note: This code must not be used in the Commissioning Data Set header. It is not a default commissioner code.
	X98 - Primary Care Organisation Not Applicable (Overseas Visitors) Note: this code must not be used in the Commissioning Data Set (CDS) header. It is not a default Commissioner code.

Notes:

[ORGANISATION CODE \(RESIDENCE RESPONSIBILITY\)](#) is the same as attribute [ORGANISATION CODE](#).

[ORGANISATION CODE \(RESIDENCE RESPONSIBILITY\)](#) is the [ORGANISATION CODE](#) derived from the [PATIENT](#)'s [POSTCODE OF USUAL ADDRESS](#), where they reside within the boundary of a:

- [Clinical Commissioning Group](#)
- [Care Trust](#)
- [Local Health Board \(Wales\)](#)
- [Scottish Health Board](#)
- [Northern Ireland Local Commissioning Group](#): *Guidance on the use of Northern Ireland codes can be found in [Data Set Change Notice 19/2009](#)*
- [Primary Healthcare Directorate \(Isle of Man\)](#)
- [Local Authority](#).

[ORGANISATION CODES](#) can be downloaded from [Technology Reference Data Update Distribution \(TRUD\)](#). For further information, see [Organisation Data Service](#).

For [PATIENTS](#) who are [Overseas Visitors](#): [Organisation Data Service Default Code](#) X98 'Primary Care Organisation Not Applicable ([Overseas Visitors](#))' should be reported.

Note: A review of [Organisation Data Service Default Codes](#) is planned to be carried out and this default code will be updated as part of that.

For the purposes of sending Commissioning Data Set messages to the [Secondary Uses Service](#) (regardless of how local systems hold the data), it is essential at present to continue using a 3 character field, using the first 3 characters of the [ORGANISATION CODE \(RESIDENCE RESPONSIBILITY\)](#) and following the same update rules relating to Prime Recipient as are currently in place. This is necessary, primarily to preserve the integrity of the current Commissioning Data Set message and the [CDS PRIME RECIPIENT IDENTITY](#) which is derived from the [ORGANISATION CODE \(RESIDENCE RESPONSIBILITY\)](#).

The [Organisation Data Service](#) provides postcode files which link postcodes to the [Clinical Commissioning Group](#). See [NHS Postcode Directory](#).

[ORGANISATION CODE \(RESIDENCE RESPONSIBILITY\)](#) will be replaced with [ORGANISATION IDENTIFIER \(RESIDENCE RESPONSIBILITY\)](#), when it has been approved for use in national information standards.

ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)

Change to Data Element: Changed Dataset

Format/Length:	min an3 max an5
National Codes:	
ODS Default Codes:	VPP00 - Private PATIENTS / Overseas Visitor liable for charge XMD00 - Commissioner Code for Ministry of Defence (MoD) Healthcare YDD82 - Episodes funded directly by the National Commissioning Group for England

Notes:

[ORGANISATION IDENTIFIER \(CODE OF COMMISSIONER\)](#) is the same as attribute [ORGANISATION IDENTIFIER](#).

[ORGANISATION IDENTIFIER \(CODE OF COMMISSIONER\)](#) is the [ORGANISATION IDENTIFIER](#) of the [Organisation](#) commissioning health care.

For [Commissioning Data Sets](#), the [ORGANISATION IDENTIFIER \(CODE OF COMMISSIONER\)](#) should always be the [ORGANISATION IDENTIFIER](#) of the original commissioner to support the [National Tariff Payment System](#).

The [NHS England](#) document "[Who pays? Determining responsibility for payments to providers](#)" sets out a framework for establishing responsibility for commissioning an individual's care within the NHS, (i.e. determining who pays for a [PATIENT](#)'s care.)

The document includes information on the following:

- General Rules
- Applying the rules to [Clinical Commissioning Group](#) commissioned services
- Exceptions to the general rules
- Examples to help clarify the boundaries of responsibility between commissioning [Organisations](#).

For further information on this document contact [NHS England](#) at "[Contact us](#)".

[ORGANISATION CODE \(CODE OF COMMISSIONER\)](#) will be replaced with [ORGANISATION IDENTIFIER \(CODE OF COMMISSIONER\)](#), when it has been approved for use in national information standards.

ORGANISATION IDENTIFIER (CODE OF PROVIDER)

Change to Data Element: Changed Dataset

Format/Length:	min an3 max an6
National Codes:	
ODS Default Codes:	89997 - Non-UK provider where no ORGANISATION IDENTIFIER has been issued 89999 - Non-NHS UK provider where no ORGANISATION IDENTIFIER has been issued

Notes:

[ORGANISATION IDENTIFIER \(CODE OF PROVIDER\)](#) is the same as the attribute [ORGANISATION IDENTIFIER](#).

[ORGANISATION IDENTIFIER \(CODE OF PROVIDER\)](#) is the [ORGANISATION IDENTIFIER](#) of the [Organisation](#) acting as a [Health Care Provider](#).

For [Commissioning Data Sets](#), the [ORGANISATION IDENTIFIER \(CODE OF PROVIDER\)](#) should always be the [ORGANISATION IDENTIFIER](#) of the [Health Care Provider](#) receiving the [National Tariff Payment System](#) income.

[ORGANISATION CODE \(CODE OF PROVIDER\)](#) is used by the [Secondary Uses Service](#) to derive the [Healthcare Resource Group 4](#). Failure to correctly populate this data element is likely to result in an incorrect [Healthcare Resource Group](#), usually associated with lower levels of healthcare resource.

For further information, please refer to the [NHS Digital](#) website at: [Payment by Results Guidance](#).

[ORGANISATION CODE \(CODE OF PROVIDER\)](#) will be replaced with [ORGANISATION IDENTIFIER \(CODE OF PROVIDER\)](#), when it has been approved for use in national information standards.

ORGANISATION IDENTIFIER (CODE OF SUBMITTING ORGANISATION)

Change to Data Element: Changed Dataset

Format/Length:	min an3 max an6
National Codes:	
Default Codes:	

Notes:

[ORGANISATION IDENTIFIER \(CODE OF SUBMITTING ORGANISATION\)](#) is the same as attribute [ORGANISATION IDENTIFIER](#).

[ORGANISATION IDENTIFIER \(CODE OF SUBMITTING ORGANISATION\)](#) is the [ORGANISATION IDENTIFIER](#) of the [Organisation](#) acting as the physical sender of a Data Set submission.

[ORGANISATION CODE \(CODE OF SUBMITTING ORGANISATION\)](#) will be replaced with [ORGANISATION IDENTIFIER \(CODE OF SUBMITTING ORGANISATION\)](#), when it has been approved for use in national information standards.

ORGANISATION IDENTIFIER (EDUCATIONAL ESTABLISHMENT)

Change to Data Element: Changed Dataset

Format/Length:	min an5 max an8
National Codes:	
Default Codes:	

Notes:

[ORGANISATION IDENTIFIER \(EDUCATIONAL ESTABLISHMENT\)](#) is the same as attribute [ORGANISATION IDENTIFIER](#).

[ORGANISATION IDENTIFIER \(EDUCATIONAL ESTABLISHMENT\)](#) is the [ORGANISATION IDENTIFIER](#) of the [Educational Establishment](#), including [Schools](#).

[ORGANISATION CODE \(EDUCATIONAL ESTABLISHMENT\)](#) will be replaced with [ORGANISATION IDENTIFIER \(EDUCATIONAL ESTABLISHMENT\)](#), when it has been approved for use in national information standards.

ORGANISATION IDENTIFIER (GP PRACTICE RESPONSIBILITY)

Change to Data Element: Changed Dataset

Format/Length:	min an3 max an5
National Codes:	
ODS Default Codes:	Q99 - High Level Health Geography/Primary Care Organisation of Residence Not Known X98 - Primary Care Organisation Not Applicable (Overseas Visitors)

Notes:

[ORGANISATION IDENTIFIER \(GP PRACTICE RESPONSIBILITY\)](#) is the same as attribute [ORGANISATION IDENTIFIER](#).

[ORGANISATION IDENTIFIER \(GP PRACTICE RESPONSIBILITY\)](#) is the [ORGANISATION IDENTIFIER](#) of the [Organisation](#) responsible for the [GP Practice](#) where the [PATIENT](#) is registered, irrespective of whether they reside within the boundary of the [Clinical Commissioning Group](#).

[ORGANISATION CODE \(GP PRACTICE RESPONSIBILITY\)](#) will be replaced with [ORGANISATION IDENTIFIER \(GP PRACTICE RESPONSIBILITY\)](#), when it has been approved for use in national information standards.

ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)

Change to Data Element: Changed Dataset

Format/Length:	min an3 max an5
National Codes:	
Default Codes:	

Notes:

[ORGANISATION IDENTIFIER \(LOCAL PATIENT IDENTIFIER\)](#) is the same as attribute [ORGANISATION IDENTIFIER](#).

[ORGANISATION IDENTIFIER \(LOCAL PATIENT IDENTIFIER\)](#) is the [ORGANISATION IDENTIFIER](#) of the [Organisation](#) that assigned the [LOCAL PATIENT IDENTIFIER](#).

[ORGANISATION CODE \(LOCAL PATIENT IDENTIFIER\)](#) will be replaced with [ORGANISATION IDENTIFIER \(LOCAL PATIENT IDENTIFIER\)](#), when it has been approved for use in national information standards.

ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)

Change to Data Element: Changed Dataset

Format/Length:	min an3 max an5
National Codes:	
Default Codes:	

Notes:

[ORGANISATION IDENTIFIER \(PATIENT PATHWAY IDENTIFIER ISSUER\)](#) is the same as attribute [ORGANISATION IDENTIFIER](#).

[ORGANISATION IDENTIFIER \(PATIENT PATHWAY IDENTIFIER ISSUER\)](#) is the [ORGANISATION IDENTIFIER](#) of the [Organisation](#) issuing the [PATIENT PATHWAY IDENTIFIER](#).

Where [Choose and Book](#) has been used, the [ORGANISATION IDENTIFIER](#) X09 should be used.

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a [Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement](#), and is of the following Commissioning Data Set Types:

- [CDS V6-2 Type 020 - Outpatient Commissioning Data Set](#)
- [CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 030 - Elective Admission List - End of Period Census \(Standard\) Commissioning Data Set](#)
- [CDS V6-2 Type 060 - Elective Admission List - Event During Period \(Add\) Commissioning Data Set](#)
- [CDS V6-2 Type 070 - Elective Admission List - Event During Period \(Remove\) Commissioning Data Set](#)
- [CDS V6-2 Type 080 - Elective Admission List - Event During Period \(Offer\) Commissioning Data Set](#)

then [ORGANISATION CODE \(PATIENT PATHWAY IDENTIFIER ISSUER\)](#) must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.

[ORGANISATION CODE \(PATIENT PATHWAY IDENTIFIER ISSUER\)](#) will be replaced with [ORGANISATION IDENTIFIER \(PATIENT PATHWAY IDENTIFIER ISSUER\)](#), when it has been approved for use in national information standards.

ORGANISATION IDENTIFIER (RECEIVING)

Change to Data Element: Changed Dataset

Format/Length:	min an3 max an5
National Codes:	
Default Codes:	ZZ201 - Not applicable (not discharged to another Organisation) *

Notes:

[ORGANISATION IDENTIFIER \(RECEIVING\)](#) is the same as the attribute [ORGANISATION IDENTIFIER](#).

[ORGANISATION IDENTIFIER \(RECEIVING\)](#) is the [ORGANISATION IDENTIFIER](#) of the [Organisation](#) that is receiving the [PATIENT](#) from another [Health Care Provider](#).

For the [National Neonatal Data Set - Episodic and Daily Care](#), this is the [ORGANISATION CODE](#) of the [Organisation](#) where a baby is transferred to on discharge from the neonatal critical care.

* Note: default code ZZ201 is ONLY valid for the [National Neonatal Data Set - Episodic and Daily Care](#).

[ORGANISATION CODE \(RECEIVING\)](#) will be replaced with [ORGANISATION IDENTIFIER \(RECEIVING\)](#), when it has been approved for use in national information standards.

ORGANISATION IDENTIFIER (REFERRING)

Change to Data Element: Changed Dataset, Description

Format/Length:	min an3 max an6
National Codes:	
ODS Default Codes:	X99998 - Referring ORGANISATION IDENTIFIER not applicable
	X99999 - Referring ORGANISATION IDENTIFIER not known

Notes:

[ORGANISATION IDENTIFIER \(REFERRING\)](#) is the same as attribute [ORGANISATION IDENTIFIER](#).

[ORGANISATION IDENTIFIER \(REFERRING\)](#) is the [ORGANISATION IDENTIFIER](#) of the [Organisation](#) from which the referral is made, such as a [GP Practice](#), [NHS Trust](#) or [NHS Foundation Trust](#).

This information is essential for managing service agreements which are based on patterns of referral.

REFERRING ORGANISATION CODE will be replaced with **ORGANISATION IDENTIFIER (REFERRING)**, when it has been approved for use in national information standards.

ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)

Change to Data Element: Changed Dataset

Format/Length:	min an3 max an5
National Codes:	
<u>ODS Default Codes:</u>	Q99 - High Level Health Geography/Primary Care Organisation of Residence Not Known Note: This code must not be used in the Commissioning Data Set header. It is not a default commissioner code. X98 - Primary Care Organisation Not Applicable (Overseas Visitors) Note: this code must not be used in the Commissioning Data Set (CDS) header. It is not a default Commissioner code.

Notes:

[ORGANISATION IDENTIFIER \(RESIDENCE RESPONSIBILITY\)](#) is the same as attribute [ORGANISATION IDENTIFIER](#).

[ORGANISATION IDENTIFIER \(RESIDENCE RESPONSIBILITY\)](#) is the [ORGANISATION IDENTIFIER](#) derived from the [PATIENT's POSTCODE OF USUAL ADDRESS](#), where they reside within the boundary of a:

- [Clinical Commissioning Group](#)
- [Care Trust](#)
- [Local Health Board \(Wales\)](#)
- [Scottish Health Board](#)
- [Northern Ireland Local Commissioning Group](#): *Guidance on the use of Northern Ireland codes can be found in [Data Set Change Notice 19/2009](#)*
- [Primary Healthcare Directorate \(Isle of Man\)](#)
- [Local Authority](#).

For [PATIENTS](#) who are [Overseas Visitors](#): [Organisation Data Service Default Code](#) X98 'Primary Care Organisation Not Applicable ([Overseas Visitors](#))' should be reported.

Note: A review of [Organisation Data Service Default Codes](#) is planned to be carried out and this default code will be updated as part of that.

For the purposes of sending Commissioning Data Set messages to the [Secondary Uses Service](#) (regardless of how local systems hold the data), it is essential at present to continue using a 3 character field, using the first 3 characters of the [ORGANISATION IDENTIFIER \(RESIDENCE RESPONSIBILITY\)](#) and following the same update rules relating to Prime Recipient as are currently in place. This is necessary, primarily to preserve the integrity of the current Commissioning Data Set message and the [CDS PRIME RECIPIENT IDENTITY](#) which is derived from the [ORGANISATION IDENTIFIER \(RESIDENCE RESPONSIBILITY\)](#).

ORGANISATION CODE (RESIDENCE RESPONSIBILITY) will be replaced with **ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)**, when it has been approved for use in national information standards.

ORGANISATION IDENTIFIER (RESPONSIBLE LOCAL AUTHORITY MENTAL HEALTH DELAYED DISCHARGE)

Change to Data Element: New Data Element

Format/Length:	min an3 max an5
National Codes:	
Default Codes:	

Notes:

[ORGANISATION IDENTIFIER \(RESPONSIBLE LOCAL AUTHORITY MENTAL HEALTH DELAYED DISCHARGE\)](#) is the same as attribute [ORGANISATION IDENTIFIER](#).

[ORGANISATION IDENTIFIER \(RESPONSIBLE LOCAL AUTHORITY MENTAL HEALTH DELAYED DISCHARGE\)](#) is the [ORGANISATION IDENTIFIER](#) of the [Local Authority](#) responsible for the social care attributed [Mental Health Delayed Discharge Period](#).

This data element is also known by these names:

Context	Alias
plural	ORGANISATION IDENTIFIERS (RESPONSIBLE LOCAL AUTHORITY MENTAL HEALTH DELAYED DISCHARGE)

ORGANISATION IDENTIFIER (RESPONSIBLE LOCAL AUTHORITY MENTAL HEALTH DELAYED DISCHARGE)

ORGANISATION IDENTIFIER (RESPONSIBLE LOCAL AUTHORITY MENTAL HEALTH DELAYED DISCHARGE)

Attribute:

[ORGANISATION IDENTIFIER](#)

ORGANISATION SITE IDENTIFIER (OF TREATMENT)

Change to Data Element: Changed Dataset

Format/Length:	min an5 max an9
National Codes:	
ODS Default Codes:	R9998 - Not a hospital site (for use on Out-Patient CDS) 89999 - Non-NHS UK Provider where no ORGANISATION IDENTIFIER has been issued 89997 - Non-UK Provider where no ORGANISATION IDENTIFIER has been issued

Notes:

[ORGANISATION SITE IDENTIFIER \(OF TREATMENT\)](#) is the same as attribute [ORGANISATION IDENTIFIER](#).

[ORGANISATION SITE IDENTIFIER \(OF TREATMENT\)](#) is the [ORGANISATION IDENTIFIER](#) of the [Organisation Site](#) where the [PATIENT](#) was treated, i.e. it should enable the treating [Organisation](#) to be identified.

[ORGANISATION SITE IDENTIFIER \(OF TREATMENT\)](#) identifies the [Organisation Site](#) within the [Organisation](#) on which the [PATIENT](#) was treated, since facilities may vary on different hospital sites.

The code recorded should always be the national code; if the treatment is sub-commissioned to another NHS [Health Care Provider](#) or an independent UK provider, the [ORGANISATION SITE IDENTIFIER \(OF TREATMENT\)](#) used should be the [ORGANISATION IDENTIFIER](#) of the [Health Care Provider](#) actually carrying out the work.

Where treatment is sub-commissioned to an overseas provider the [Organisation Data Service Default Code](#) 89997 'Non-UK Provider where no [ORGANISATION IDENTIFIER](#) has been issued' is applicable.

Each [Organisation](#) has a unique [ORGANISATION IDENTIFIER](#). However, where an [Organisation](#) has more than one site from which it provides [SERVICES](#), then each site is uniquely identified. These sites are [Organisation Sites](#) and are uniquely identified by an [ORGANISATION IDENTIFIER](#).

For out-patients, [ACTIVITY](#) may take place outside the hospital, such as in the [PATIENT'S](#) home; in such cases, raising a site code is impractical. Therefore, code R9998 'Not a hospital site (for use on Out-Patient CDS)' would be used in these circumstances.

Note: [LOCATION CLASS](#) is used in the Commissioning Data Set (CDS) message to indicate the classification of the physical [LOCATION](#) within which the [ACTIVITY](#) occurred.

Use in the Future Outpatient CDS:

If the [INTENDED SITE CODE \(OF TREATMENT\)](#) is not known, this data element should be omitted.

[SITE CODE \(OF TREATMENT\)](#) will be replaced with [ORGANISATION SITE IDENTIFIER \(OF TREATMENT\)](#), when it has been approved for use in national information standards.

OTHER PERSON IN ATTENDANCE AT CARE CONTACT

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See OTHER PERSON IN ATTENDANCE AT CARE CONTACT
Default Codes:	

Notes:

[OTHER PERSON IN ATTENDANCE AT CARE CONTACT](#) is the same as attribute [OTHER PERSON IN ATTENDANCE AT CARE CONTACT](#).

OTHER REASON FOR REFERRAL (MENTAL HEALTH)

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See REASON FOR REFERRAL TO MENTAL HEALTH
Default Codes:	

Notes:

[OTHER REASON FOR REFERRAL \(MENTAL HEALTH\)](#) is the same as attribute [REASON FOR REFERRAL TO MENTAL HEALTH](#).

[OTHER REASON FOR REFERRAL \(MENTAL HEALTH\)](#) is the secondary presenting conditions or symptoms for which the [PATIENT](#) was referred to a [Mental Health Service](#).

PATIENT PATHWAY IDENTIFIER

Change to Data Element: Changed Dataset

Format/Length:	an20
National Codes:	
Default Codes:	

Notes:

[PATIENT PATHWAY IDENTIFIER](#) is the same as [PATIENT PATHWAY IDENTIFIER](#).

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a [Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement](#), and is of the following Commissioning Data Set Types:

- [CDS V6-2 Type 020 - Outpatient Commissioning Data Set](#)
- [CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 030 - Elective Admission List - End of Period Census \(Standard\) Commissioning Data Set](#)
- [CDS V6-2 Type 060 - Elective Admission List - Event During Period \(Add\) Commissioning Data Set](#)
- [CDS V6-2 Type 070 - Elective Admission List - Event During Period \(Remove\) Commissioning Data Set](#)
- [CDS V6-2 Type 080 - Elective Admission List - Event During Period \(Offer\) Commissioning Data Set](#)

then either [UNIQUE BOOKING REFERENCE NUMBER \(CONVERTED\)](#) or [PATIENT PATHWAY IDENTIFIER](#) must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.

PERSON BIRTH DATE

Change to Data Element: Changed Dataset

Format/Length:	See DATE
NWDS ID:	PEBD
NWDS Field Name:	Date of Birth
National Codes:	
Default Codes:	

Notes:

[PERSON BIRTH DATE](#) is the same as attribute [PERSON BIRTH DATE](#).

PERSON DEATH DATE

Change to Data Element: Changed Dataset

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

Notes:

[PERSON DEATH DATE](#) is the same as attribute [PERSON DEATH DATE](#).

PERSON MARITAL STATUS

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See PERSON MARITAL STATUS CODE
Default Codes:	8 - Not applicable, i.e. not a psychiatric episode 9 - Not known

Notes:

[PERSON MARITAL STATUS](#) is the same as attribute [PERSON MARITAL STATUS CODE](#).

Commissioning Data Set Messages

Following the recommendation of the Data Protection Registrar, [PERSON MARITAL STATUS](#) should not be recorded by providers in the [Commissioning Data Sets](#) except in respect of the psychiatric specialties in the Admitted Patient Care Commissioning Data Set. The data item remains in the data standards since it will be needed by the provider.

PERSON SCORE

Change to Data Element: Changed Dataset

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

Notes:

[PERSON SCORE](#) is the same as attribute [PERSON SCORE](#).

PERSON STATED GENDER CODE

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See PERSON STATED GENDER CODE
Default Codes:	X - Not Known (PERSON STATED GENDER CODE not recorded)

Notes:

[PERSON STATED GENDER CODE](#) is the same as attribute [PERSON STATED GENDER CODE](#).

[PERSON GENDER CURRENT](#) and [PERSON GENDER CODE CURRENT](#) will be replaced with [PERSON STATED GENDER CODE](#) or [PERSON PHENOTYPIC SEX](#), which is the most recent approved national information standard to describe the required definition.

PLACE OF SAFETY INDICATOR

Change to Data Element: Changed Dataset

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](#).

PLANNED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Dataset

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

Notes:

[PLANNED DISCHARGE DATE \(HOSPITAL PROVIDER SPELL\)](#) is the same as attribute [PLANNED ACTIVITY DATE](#) where the [PLANNED ACTIVITY DATE TYPE](#) is National Code '*Planned Discharge Date (Hospital Provider Spell)*'.

PLANNED DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Dataset

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](#).

POSTCODE OF DISCHARGE DESTINATION (HOSPITAL PROVIDER SPELL)

Change to Data Element: New Data Element

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

Notes:

[POSTCODE OF DISCHARGE DESTINATION \(HOSPITAL PROVIDER SPELL\)](#) is the same as data element [POSTCODE](#).

[POSTCODE OF DISCHARGE DESTINATION \(HOSPITAL PROVIDER SPELL\)](#) is the [POSTCODE](#) of the [ADDRESS](#) of the [PATIENT](#)'s destination on completion of a [Hospital Provider Spell](#).

POSTCODE OF DISCHARGE DESTINATION (HOSPITAL PROVIDER SPELL)

Change to Data Element: New Data Element

POSTCODE OF DISCHARGE DESTINATION (HOSPITAL PROVIDER SPELL)

Attribute:

POSTCODE

POSTCODE OF MAIN VISITOR

Change to Data Element: Changed Dataset

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'.

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](#).

POSTCODE OF USUAL ADDRESS

Change to Data Element: Changed Dataset

Format/Length: See [POSTCODE](#)

National Codes:

Default Codes:

Notes:

[POSTCODE OF USUAL ADDRESS](#) is the same as data element [POSTCODE](#).

[POSTCODE OF USUAL ADDRESS](#) is the [POSTCODE](#) of the [ADDRESS](#) nominated by the [PATIENT](#) where the [ADDRESS ASSOCIATION TYPE](#) is 'Main Permanent Residence' or 'Other Permanent Residence'.

PRESCRIPTION DATE (ASSISTIVE TECHNOLOGY)

Change to Data Element: Changed Dataset

Format/Length: See [DATE](#)

National Codes:

Default Codes:

Notes:

[PRESCRIPTION DATE \(ASSISTIVE TECHNOLOGY\)](#) is the same as attribute [PRESCRIPTION DATE](#) for the prescription of [Assistive Technology](#).

PREVIOUS DIAGNOSIS (CODED CLINICAL ENTRY)

Change to Data Element: Changed Dataset

Format/Length: min an4 max an18

National Codes:

Default Codes:

Notes:

[PREVIOUS DIAGNOSIS \(CODED CLINICAL ENTRY\)](#) is the same as attribute [CLINICAL CLASSIFICATION CODE](#) or [CLINICAL TERMINOLOGY CODE](#).

[PREVIOUS DIAGNOSIS \(CODED CLINICAL ENTRY\)](#) is the [CODED CLINICAL ENTRY](#) used to identify the previous [PATIENT DIAGNOSIS](#).

PRIMARY DATA COLLECTION SYSTEM IN USE

Change to Data Element: Changed Dataset

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

Notes:

[PRIMARY DATA COLLECTION SYSTEM IN USE](#) is the name of the Primary Data Collection System in use by the [Health Care Provider](#).

PRIMARY DIAGNOSIS (CODED CLINICAL ENTRY)

Change to Data Element: Changed Dataset

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

Notes:

[PRIMARY DIAGNOSIS \(CODED CLINICAL ENTRY\)](#) is the same as attribute [CLINICAL CLASSIFICATION CODE](#) or [CLINICAL TERMINOLOGY CODE](#).

[PRIMARY DIAGNOSIS \(CODED CLINICAL ENTRY\)](#) is the [CODED CLINICAL ENTRY](#) used to identify the [PRIMARY DIAGNOSIS](#).

PRIMARY REASON FOR REFERRAL (MENTAL HEALTH)

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See REASON FOR REFERRAL TO MENTAL HEALTH
Default Codes:	

Notes:

[PRIMARY REASON FOR REFERRAL \(MENTAL HEALTH\)](#) is the same as attribute [REASON FOR REFERRAL TO MENTAL HEALTH](#).

[PRIMARY REASON FOR REFERRAL \(MENTAL HEALTH\)](#) is the primary presenting condition or symptom for which the [PATIENT](#) was referred to a [Mental Health Service](#).

PROCEDURE SCHEME IN USE

Change to Data Element: Changed Dataset

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

Notes:

[PROCEDURE SCHEME IN USE](#) is the same as attribute [PROCEDURE SCHEME IN USE](#).

PRODROME PSYCHOSIS DATE

Change to Data Element: Changed Dataset

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

Notes:

[PRODROME PSYCHOSIS DATE](#) is the same as attribute [PERSON PROPERTY OBSERVED DATE](#).

[PRODROME PSYCHOSIS DATE](#) is the [DATE](#) at which first noticeable change in behaviour or mental state of the [PATIENT](#) occurred, prior to emergence of full-blown psychosis. There should be clear deterioration in functioning from previous levels.

PROFESSIONAL REGISTRATION BODY CODE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See PROFESSIONAL REGISTRATION BODY CODE
Default Codes:	

Notes:

[PROFESSIONAL REGISTRATION BODY CODE](#) is the same as attribute [PROFESSIONAL REGISTRATION BODY CODE](#).

PROFESSIONAL REGISTRATION ENTRY IDENTIFIER

Change to Data Element: Changed Dataset

Format/Length:	max an32
NWDS ID:	EPRN
NWDS Field Name:	Professional Registration Number
National Codes:	
Default Codes:	

Notes:

[PROFESSIONAL REGISTRATION ENTRY IDENTIFIER](#) is the same as attribute [PROFESSIONAL REGISTRATION ENTRY IDENTIFIER](#).

PROVISIONAL DIAGNOSIS (CODED CLINICAL ENTRY)

Change to Data Element: Changed Dataset

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

Notes:

[PROVISIONAL DIAGNOSIS \(CODED CLINICAL ENTRY\)](#) is the same as attribute [CLINICAL CLASSIFICATION CODE](#) or [CLINICAL TERMINOLOGY CODE](#).

[PROVISIONAL DIAGNOSIS \(CODED CLINICAL ENTRY\)](#) is the [CODED CLINICAL ENTRY](#) used to identify the [PROVISIONAL DIAGNOSIS](#).

PROVISIONAL DIAGNOSIS DATE

Change to Data Element: Changed Dataset

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

Notes:

[PROVISIONAL DIAGNOSIS DATE](#) is the date on which a [PROVISIONAL DIAGNOSIS](#) was made.

PSYCHOSIS FIRST TREATMENT START DATE

Change to Data Element: Changed Dataset

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

Notes:

[PSYCHOSIS FIRST TREATMENT START DATE](#) is the same as attribute [PERSON PROPERTY EFFECTIVE DATE](#).

[PSYCHOSIS FIRST TREATMENT START DATE](#) is the [DATE](#) the [PATIENT](#) first commenced prescribed anti-psychotic medication, following referral into an [Early Intervention in Psychosis \(EIP\) Service](#), and thereafter was compliant for at least 75% of the time during the subsequent month (using clinical judgement).

For the majority of [PATIENTS](#) this will be the same as the [FIRST PRESCRIPTION DATE \(ANTI-PSYCHOTIC MEDICATION\)](#).

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

Change to Data Element: Changed Dataset, Description

Format/Length:	an4
Format/Length:	an2
National Codes:	See REASON FOR OUT OF AREA REFERRAL FOR ADULT ACUTE MENTAL HEALTH
Default Codes:	99 - Reason Not Known
Default Codes:	99 - Not Known (Not Recorded)

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](#).

REFERRAL CLOSURE DATE

Change to Data Element: Changed Dataset

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

Notes:

[REFERRAL CLOSURE DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Referral Closure Date](#)'.

REFERRAL CLOSURE REASON

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See REFERRAL CLOSURE REASON
Default Codes:	

Notes:

[REFERRAL CLOSURE REASON](#) is the same as attribute [REFERRAL CLOSURE REASON](#).

REFERRAL CLOSURE TIME

Change to Data Element: Changed Dataset

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](#)'.

REFERRAL REJECTION DATE

Change to Data Element: Changed Dataset

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

Notes:

[REFERRAL REJECTION DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Referral Rejection Date](#)'.

REFERRAL REJECTION REASON

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See REFERRAL REJECTION REASON
Default Codes:	

Notes:

[REFERRAL REJECTION REASON](#) is the same as attribute [REFERRAL REJECTION REASON](#).

REFERRAL REJECTION TIME

Change to Data Element: New Data Element

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

Notes:

[REFERRAL REJECTION TIME](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Referral Rejection Time](#)'.

This data element is also known by these names:

Context	Alias
plural	REFERRAL REJECTION TIMES

REFERRAL REJECTION TIME

Change to Data Element: New Data Element

REFERRAL REJECTION TIME

Attribute:

ACTIVITY TIME

REFERRAL REQUEST RECEIVED DATE

Change to Data Element: Changed Dataset

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[REFERRAL REQUEST RECEIVED DATE](#) is the same as attribute [REFERRAL REQUEST RECEIVED DATE](#).

For the purposes of the [National Cancer Waiting Times Monitoring Data Set](#), [REFERRAL REQUEST RECEIVED DATE](#) is used to derive the [CANCER REFERRAL TO TREATMENT PERIOD START DATE](#).

REFERRAL REQUEST RECEIVED TIME

Change to Data Element: Changed Dataset

Format/Length: See [TIME](#)
National Codes:
Default Codes:

Notes:

[REFERRAL REQUEST RECEIVED TIME](#) is the same as attribute [REFERRAL REQUEST RECEIVED TIME](#).

REFERRAL TO TREATMENT PERIOD END DATE

Change to Data Element: Changed Dataset

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[REFERRAL TO TREATMENT PERIOD END DATE](#) is the same as attribute [REFERRAL TO TREATMENT PERIOD END DATE](#).

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a [Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement](#), and is of the following Commissioning Data Set Types:

- [CDS V6-2 Type 020 - Outpatient Commissioning Data Set](#)
- [CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 030 - Elective Admission List - End of Period Census \(Standard\) Commissioning Data Set](#)
- [CDS V6-2 Type 060 - Elective Admission List - Event During Period \(Add\) Commissioning Data Set](#)
- [CDS V6-2 Type 070 - Elective Admission List - Event During Period \(Remove\) Commissioning Data Set](#)
- [CDS V6-2 Type 080 - Elective Admission List - Event During Period \(Offer\) Commissioning Data Set](#)

then [REFERRAL TO TREATMENT PERIOD END DATE](#) must be present in the Commissioning Data Set PATIENT PATHWAY Data Group, where the [REFERRAL TO TREATMENT PERIOD](#) has ended.

REFERRAL TO TREATMENT PERIOD START DATE

Change to Data Element: Changed Dataset

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[REFERRAL TO TREATMENT PERIOD START DATE](#) is the same as attribute [REFERRAL TO TREATMENT PERIOD START DATE](#).

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a [Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement](#), and is of the following Commissioning Data Set Types:

- [CDS V6-2 Type 020 - Outpatient Commissioning Data Set](#)
- [CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 030 - Elective Admission List - End of Period Census \(Standard\) Commissioning Data Set](#)
- [CDS V6-2 Type 060 - Elective Admission List - Event During Period \(Add\) Commissioning Data Set](#)
- [CDS V6-2 Type 070 - Elective Admission List - Event During Period \(Remove\) Commissioning Data Set](#)
- [CDS V6-2 Type 080 - Elective Admission List - Event During Period \(Offer\) Commissioning Data Set](#)

then [REFERRAL TO TREATMENT PERIOD START DATE](#) must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.

REFERRAL TO TREATMENT PERIOD STATUS

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See REFERRAL TO TREATMENT PERIOD STATUS
Default Codes:	

Notes:

[REFERRAL TO TREATMENT PERIOD STATUS](#) is the same as attribute [REFERRAL TO TREATMENT PERIOD STATUS](#).

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a [Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement](#), and is of the following Commissioning Data Set Types:

- [CDS V6-2 Type 020 - Outpatient Commissioning Data Set](#)
- [CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 030 - Elective Admission List - End of Period Census \(Standard\) Commissioning Data Set](#)
- [CDS V6-2 Type 060 - Elective Admission List - Event During Period \(Add\) Commissioning Data Set](#)
- [CDS V6-2 Type 070 - Elective Admission List - Event During Period \(Remove\) Commissioning Data Set](#)
- [CDS V6-2 Type 080 - Elective Admission List - Event During Period \(Offer\) Commissioning Data Set](#)

then [REFERRAL TO TREATMENT PERIOD STATUS](#) must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.

REFERRED OUT OF AREA REASON (ADULT ACUTE MENTAL HEALTH)

Change to Data Element: Changed Dataset

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](#).

REFERRING CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH AND COMMUNITY CARE)

Change to Data Element: Changed Dataset

Format/Length:	an3
National Codes:	See REFERRING CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH AND COMMUNITY CARE
Default Codes:	

Notes:

[REFERRING CARE PROFESSIONAL STAFF GROUP \(MENTAL HEALTH AND COMMUNITY CARE\)](#) is the same as attribute [REFERRING CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH AND COMMUNITY CARE](#).

REFERRING ORGANISATION CODE

Change to Data Element: Changed Dataset

Format/Length:	max an6
National Codes:	
ODS Default Codes:	X99998 - Referring ORGANISATION CODE not applicable
	X99999 - Referring ORGANISATION CODE not known

Notes:

[REFERRING ORGANISATION CODE](#) is the same as attribute [ORGANISATION CODE](#).

[REFERRING ORGANISATION CODE](#) is the [ORGANISATION CODE](#) of the [Organisation](#) from which the referral is made, such as a [GP Practice](#), [NHS Trust](#) or [NHS Foundation Trust](#).

This information is essential for managing service agreements which are based on patterns of referral.

[REFERRING ORGANISATION CODE](#) will be replaced with [ORGANISATION IDENTIFIER \(REFERRING\)](#), when it has been approved for use in national information standards.

RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE
Default Codes:	

Notes:

[RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE](#) is the same as attribute [RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE](#).

REPLACEMENT APPOINTMENT BOOKED DATE

Change to Data Element: Changed Dataset

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

Notes:

[REPLACEMENT APPOINTMENT BOOKED DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Replacement Appointment Booked Date](#)'.

REPLACEMENT APPOINTMENT DATE OFFERED

Change to Data Element: Changed Dataset

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

Notes:

[REPLACEMENT APPOINTMENT DATE OFFERED](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Replacement Appointment Date Offered](#)'.

REPORTING PERIOD END DATE

Change to Data Element: Changed Dataset

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

Notes:

[REPORTING PERIOD END DATE](#) is the same as attribute [REPORTING PERIOD END DATE](#).

[REPORTING PERIOD END DATE](#) is the end date of the [REPORTING PERIOD](#) and is used in conjunction with [REPORTING PERIOD START DATE](#) to specify the actual period the reported information relates to.

The date should not be before the [REPORTING PERIOD START DATE](#) although it can be the same if the period being reported only covers 1 day.

REPORTING PERIOD START DATE

Change to Data Element: Changed Dataset

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

Notes:

[REPORTING PERIOD START DATE](#) is the same as attribute [REPORTING PERIOD START DATE](#).

[REPORTING PERIOD START DATE](#) is the start date of the [REPORTING PERIOD](#) and is used in conjunction with [REPORTING PERIOD END DATE](#) to specify the actual period the reported information relates to.

The date should not be after the [REPORTING PERIOD END DATE](#) although it can be the same if the period being reported only covers 1 day.

RESTRICTIVE INTERVENTION TYPE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See RESTRICTIVE INTERVENTION TYPE
Default Codes:	

Notes:

[RESTRICTIVE INTERVENTION TYPE](#) is the same as the attribute [RESTRICTIVE INTERVENTION TYPE](#).

SECONDARY DIAGNOSIS (CODED CLINICAL ENTRY)

Change to Data Element: Changed Dataset

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

Notes:

[SECONDARY DIAGNOSIS \(CODED CLINICAL ENTRY\)](#) is the same as attribute [CLINICAL CLASSIFICATION CODE](#) or [CLINICAL TERMINOLOGY CODE](#).

[SECONDARY DIAGNOSIS \(CODED CLINICAL ENTRY\)](#) is the [CODED CLINICAL ENTRY](#) used to identify the secondary [PATIENT DIAGNOSIS](#).

SERVICE DISCHARGE DATE

Change to Data Element: Changed Dataset

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

Notes:

[SERVICE DISCHARGE DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Service Discharge Date](#)'.

SERVICE DISCHARGE TIME

Change to Data Element: Changed Dataset

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](#)'.

SERVICE OR TEAM TYPE REFERRED TO (MENTAL HEALTH)

Change to Data Element: Changed Dataset

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

Notes:

[SERVICE OR TEAM TYPE REFERRED TO \(MENTAL HEALTH\)](#) is the same as attribute [SERVICE OR TEAM TYPE FOR MENTAL HEALTH](#).

[SERVICE OR TEAM TYPE REFERRED TO \(MENTAL HEALTH\)](#) is the type of [SERVICE](#) or team within a [Mental Health Service](#) that a [PATIENT](#) was referred to.

SERVICE REQUEST IDENTIFIER

Change to Data Element: Changed Dataset

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

Notes:

[SERVICE REQUEST IDENTIFIER](#) is the same as attribute [SERVICE REQUEST IDENTIFIER](#).

SETTLED ACCOMMODATION INDICATOR

Change to Data Element: Changed Dataset

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

Notes:

[SETTLED ACCOMMODATION INDICATOR](#) is the same as attribute [SETTLED ACCOMMODATION INDICATOR](#).

SEX OF PATIENTS CODE

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	
Default Codes:	

Notes:

[SEX OF PATIENTS CODE](#) is the same as attribute [SEX OF PATIENTS](#).

[SEX OF PATIENTS CODE](#) is based on the [SEX OF PATIENTS](#) National Codes, with the addition of [Home Leave](#):

Permitted National Codes:

- | | |
|---|------------------------------|
| 1 | Male |
| 2 | Female |
| 8 | Not specified |
| 9 | Home Leave * |

* Note - National Code 9 is not valid for the [Mental Health Services Data Set](#).

SITE CODE (OF TREATMENT)

Change to Data Element: Changed Dataset

Format/Length:	min an5 max an9
National Codes:	
ODS Default Codes:	R9998 - Not a hospital site (for use on Out-Patient CDS) 89999 - Non-NHS UK Provider where no ORGANISATION SITE CODE has been issued 89997 - Non-UK Provider where no ORGANISATION SITE CODE has been issued

Notes:

[SITE CODE \(OF TREATMENT\)](#) is the same as attribute [ORGANISATION SITE CODE](#).

[SITE CODE \(OF TREATMENT\)](#) is the [ORGANISATION SITE CODE](#) of the [Organisation](#) where the [PATIENT](#) was treated, i.e. it should enable the treating [Organisation](#) to be identified.

This identifies the [Organisation Site](#) within the [Organisation](#) on which the [PATIENT](#) was treated, since facilities may vary on different hospital sites.

The code recorded should always be the national code; if the treatment is sub-commissioned to another NHS [Health Care Provider](#) or an independent UK provider, the [SITE CODE \(OF TREATMENT\)](#) used should be the [ORGANISATION SITE CODE](#) of the [Health Care Provider](#) actually carrying out the work.

Where treatment is sub-commissioned to an overseas provider the [Organisation Data Service Default Code](#) 89997 'Non-UK Provider where no [ORGANISATION SITE CODE](#) has been issued' is applicable.

Each [Organisation](#) has a unique [ORGANISATION CODE](#). However, where an [Organisation](#) has more than one site from which it provides [SERVICES](#), then each site is uniquely identified. These sites are [Organisation Sites](#) and are uniquely identified by [ORGANISATION SITE CODE](#). The [ORGANISATION SITE CODE](#) contains the first 3 digits of the [ORGANISATION CODE](#) with the last two digits being the site identifier.

Example:

- RA700 [ORGANISATION CODE](#) of the [Organisation](#)
- RA701 [ORGANISATION SITE CODE](#) of the first identified [Organisation Site](#) within the [Organisation](#)
- RA702 [ORGANISATION SITE CODE](#) of the second identified [Organisation Site](#) within the [Organisation](#)

For out-patients, [ACTIVITY](#) may take place outside the hospital, such as in the [PATIENT'S](#) home; in such cases, raising a site code is impractical. Therefore, code R9998 'Not a hospital site (for use on Out-Patient CDS)' would be used in these circumstances.
 Note: [LOCATION CLASS](#) is used in the Commissioning Data Set (CDS) message to indicate the classification of the physical [LOCATION](#) within which the [ACTIVITY](#) occurred.

Use in the Future Outpatient CDS:

If the [INTENDED SITE CODE \(OF TREATMENT\)](#) is not known, this data element should be omitted.

[SITE CODE \(OF TREATMENT\)](#) will be replaced with [ORGANISATION SITE IDENTIFIER \(OF TREATMENT\)](#), when it has been approved for use in national information standards.

SNOMED CT EXPRESSION

Change to Data Element: New Data Element

Format/Length:	min an6 max an56
National Codes:	
Default Codes:	

Notes:

[SNOMED CT EXPRESSION](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

[SNOMED CT EXPRESSION](#) is structure combination of one or more concept identifiers to express a clinical idea.

Note: a concept identifier is a [SNOMED CT](#) identifier that uniquely identifies a concept (meaning).

For further information on [SNOMED CT EXPRESSIONS](#), see the [SNOMED CT](#) Glossary at: [Expression](#).

This data element is also known by these names:

Context	Alias
plural	SNOMED CT EXPRESSIONS

SNOMED CT EXPRESSION

Change to Data Element: New Data Element

SNOMED CT EXPRESSION

Attribute:

CLINICAL TERMINOLOGY CODE

SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT)

Change to Data Element: New Data Element

Format/Length:	See SNOMED CT CODE
National Codes:	
Default Codes:	

Notes:

[SOCIAL AND PERSONAL CIRCUMSTANCE \(SNOMED CT\)](#) is the same as attribute [CLINICAL TERMINOLOGY CODE](#).

[SOCIAL AND PERSONAL CIRCUMSTANCE \(SNOMED CT\)](#) is the [SNOMED CT®](#) concept ID which is used to identify a social and personal circumstance for a [PERSON](#).

This data element is also known by these names:

Context	Alias
plural	SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT)

SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT)

Change to Data Element: New Data Element

SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED DATE

Change to Data Element: New Data Element

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED DATE](#) is the same as attribute [PERSON PROPERTY RECORDED DATE](#).

[SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED DATE](#) is the [DATE](#) when the [SOCIAL AND PERSONAL CIRCUMSTANCE \(SNOMED CT\)](#) was recorded.

This data element is also known by these names:

Context	Alias
plural	SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED DATES

SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED DATE

Change to Data Element: New Data Element

SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED DATE

Attribute:

PERSON PROPERTY RECORDED DATE

SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Dataset

Format/Length: an2
National Codes: See [SOURCE OF ADMISSION](#)
Default Codes: 98 - Not applicable
99 - Not known: a validation error

Notes:

[SOURCE OF ADMISSION CODE \(HOSPITAL PROVIDER SPELL\)](#) is the same as attribute [SOURCE OF ADMISSION](#).

[SOURCE OF ADMISSION CODE \(HOSPITAL PROVIDER SPELL\)](#) is used by the [Secondary Uses Service](#) to derive the [Healthcare Resource Group](#) 4. Failure to correctly populate this data element is likely to result in an incorrect [Healthcare Resource Group](#), usually associated with lower levels of Healthcare resource.

For further information, please refer to the [NHS Digital](#) website at: [Payment by Results Guidance](#).

SOURCE OF REFERRAL FOR MENTAL HEALTH

Change to Data Element: Changed Dataset

Format/Length: an2
National Codes: See [SOURCE OF REFERRAL FOR MENTAL HEALTH](#)
Default Codes:

Notes:

[SOURCE OF REFERRAL FOR MENTAL HEALTH](#) is the same as attribute [SOURCE OF REFERRAL FOR MENTAL HEALTH](#).

SPECIALISED MENTAL HEALTH SERVICE CODE

Change to Data Element: New Data Element

Format/Length:	max an50
National Codes:	
Default Codes:	

Notes:

[SPECIALISED MENTAL HEALTH SERVICE CODE](#) is the same as attribute [SPECIALISED MENTAL HEALTH SERVICE CODE](#).

This data element is also known by these names:

Context	Alias
plural	SPECIALISED MENTAL HEALTH SERVICE CODES

SPECIALISED MENTAL HEALTH SERVICE CODE

Change to Data Element: New Data Element

SPECIALISED MENTAL HEALTH SERVICE CODE

Attribute:

SPECIALISED MENTAL HEALTH SERVICE CODE
--

START DATE (CARE CLUSTER ASSIGNMENT PERIOD)

Change to Data Element: Changed Dataset

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

Notes:

[START DATE \(CARE CLUSTER ASSIGNMENT PERIOD\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of a [Care Cluster Assignment Period](#).

START DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)

Change to Data Element: Changed Dataset

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

Notes:

[START DATE \(CARE PROFESSIONAL ADMITTED CARE EPISODE\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Care Professional Admitted Care Episode](#).

START DATE (CARE PROGRAMME APPROACH CARE)

Change to Data Element: Changed Dataset

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

Notes:

[START DATE \(CARE PROGRAMME APPROACH CARE\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Care Programme Approach](#) care for the [PATIENT](#).

START DATE (COMMISSIONER ASSIGNMENT PERIOD)

Change to Data Element: Changed Dataset

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

Notes:

[START DATE \(COMMISSIONER ASSIGNMENT PERIOD\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Commissioner Assignment Period](#).

START DATE (COMMUNITY TREATMENT ORDER)

Change to Data Element: Changed Dataset

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

Notes:

[START DATE \(COMMUNITY TREATMENT ORDER\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Community Treatment Order](#).

START DATE (COMMUNITY TREATMENT ORDER RECALL)

Change to Data Element: Changed Dataset

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

Notes:

[START DATE \(COMMUNITY TREATMENT ORDER RECALL\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Community Treatment Order Recall](#).

START DATE (GMP PATIENT REGISTRATION)

Change to Data Element: Changed Dataset

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

Notes:

[START DATE \(GMP PATIENT REGISTRATION\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' on which the [PERSON](#) registered with a [General Medical Practitioner Practice](#).

START DATE (HOME LEAVE)

Change to Data Element: Changed Dataset

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

Notes:

[START DATE \(HOME LEAVE\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Home Leave](#).

START DATE (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Dataset

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

Notes:

[START DATE \(HOSPITAL PROVIDER SPELL\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Hospital Provider Spell](#).

The [Start Date](#) of the [Hospital Provider Spell](#) is the date of admission: the [CONSULTANT](#) or [MIDWIFE](#) has assumed responsibility for care following the [DECISION TO ADMIT](#) the [PATIENT](#).

[START DATE \(HOSPITAL PROVIDER SPELL\)](#) is used by the [Secondary Uses Service](#) to derive the [Healthcare Resource Group 4](#). Failure to correctly populate this data element is likely to result in an incorrect [Healthcare Resource Group](#), usually associated with lower levels of healthcare resource.

For further information, please refer to the [NHS Digital](#) website at: [Payment by Results Guidance](#).

START DATE (MENTAL HEALTH ABSENCE WITHOUT LEAVE)

Change to Data Element: Changed Dataset

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

Notes:

[START DATE \(MENTAL HEALTH ABSENCE WITHOUT LEAVE\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Mental Health Absence Without Leave](#).

START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)

Change to Data Element: Changed Dataset

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[START DATE \(MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Mental Health Act Legal Status Classification Assignment Period](#).

START DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD)

Change to Data Element: Changed Dataset

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[START DATE \(MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Mental Health Care Coordinator Assignment Period](#).

START DATE (MENTAL HEALTH CONDITIONAL DISCHARGE)

Change to Data Element: Changed Dataset

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[START DATE \(MENTAL HEALTH CONDITIONAL DISCHARGE\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Mental Health Conditional Discharge Period](#).

START DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD)

Change to Data Element: Changed Dataset

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[START DATE \(MENTAL HEALTH DELAYED DISCHARGE PERIOD\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Mental Health Delayed Discharge Period](#).

START DATE (MENTAL HEALTH LEAVE OF ABSENCE)

Change to Data Element: Changed Dataset

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[START DATE \(MENTAL HEALTH LEAVE OF ABSENCE\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Mental Health Leave of Absence](#).

START DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD)

Change to Data Element: Changed Dataset

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[START DATE \(MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Mental Health Responsible Clinician Assignment Period](#).

START DATE (MENTAL HEALTH TRIAL LEAVE)

Change to Data Element: New Data Element

Format/Length: See [DATE](#)
National Codes:
Default Codes:

Notes:

[START DATE \(MENTAL HEALTH TRIAL LEAVE\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Mental Health Trial Leave](#).

This data element is also known by these names:

Context	Alias
plural	START DATES (MENTAL HEALTH TRIAL LEAVE)

START DATE (MENTAL HEALTH TRIAL LEAVE)

Change to Data Element: New Data Element

START DATE (MENTAL HEALTH TRIAL LEAVE)

Attribute:

ACTIVITY DATE

START DATE (WARD STAY)

Change to Data Element: Changed Dataset

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

Notes:

[START DATE \(WARD STAY\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Ward Stay](#).

START TIME (CARE CLUSTER ASSIGNMENT PERIOD)

Change to Data Element: Changed Dataset

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

Notes:

[START TIME \(CARE CLUSTER ASSIGNMENT PERIOD\)](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Start Time](#)' of a [Care Cluster Assignment Period](#).

START TIME (COMMUNITY TREATMENT ORDER RECALL)

Change to Data Element: Changed Dataset

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

Notes:

[START TIME \(COMMUNITY TREATMENT ORDER RECALL\)](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Start Time](#)' of the [Community Treatment Order Recall](#).

START TIME (HOME LEAVE)

Change to Data Element: Changed Dataset

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

Notes:

[START TIME \(HOME LEAVE\)](#) is the same as the attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Start Time](#)' of the [Home Leave](#).

START TIME (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Dataset

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

Notes:

[START TIME \(HOSPITAL PROVIDER SPELL\)](#) is the same as the attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Start Time](#)' of the [Hospital Provider Spell](#).

START TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE)

Change to Data Element: Changed Dataset

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

Notes:

[START TIME \(MENTAL HEALTH ABSENCE WITHOUT LEAVE\)](#) is the same as the attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Start Time](#)' of the [Mental Health Absence Without Leave](#).

START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)

Change to Data Element: Changed Dataset

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

Notes:

[START TIME \(MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD\)](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Start Time](#)' of the [Mental Health Act Legal Status Classification Assignment Period](#).

START TIME (MENTAL HEALTH LEAVE OF ABSENCE)

Change to Data Element: Changed Dataset

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

Notes:

[START TIME \(MENTAL HEALTH LEAVE OF ABSENCE\)](#) is the same as the attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Start Time](#)' of the [Mental Health Leave of Absence](#).

START TIME (MENTAL HEALTH TRIAL LEAVE)

Change to Data Element: New Data Element

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

Notes:

[START TIME \(MENTAL HEALTH TRIAL LEAVE\)](#) is the same as the attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Start Time](#)' of the [Mental Health Trial Leave](#).

This data element is also known by these names:

Context	Alias
plural	START TIMES (MENTAL HEALTH TRIAL LEAVE)

START TIME (MENTAL HEALTH TRIAL LEAVE)

Change to Data Element: New Data Element

START TIME (MENTAL HEALTH TRIAL LEAVE)

Attribute:

ACTIVITY TIME

START TIME (WARD STAY)

Change to Data Element: Changed Dataset

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

Notes:

[START TIME \(WARD STAY\)](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Start Time](#)' of the [Ward Stay](#).

TREATMENT FUNCTION CODE (MENTAL HEALTH)

Change to Data Element: Changed Dataset

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

UCUM UNIT OF MEASUREMENT

Change to Data Element: Changed Dataset

Format/Length:	max an10
National Codes:	
Default Codes:	

Notes:

[UCUM UNIT OF MEASUREMENT](#) is the same as attribute [UCUM UNIT OF MEASUREMENT](#).

WAITING TIME MEASUREMENT TYPE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See WAITING TIME MEASUREMENT TYPE
Default Codes:	

Notes:

[WAITING TIME MEASUREMENT TYPE](#) is the same as attribute [WAITING TIME MEASUREMENT TYPE](#).

Note: National Codes 01, 03 and 04 are not valid for the Referral To Treatment (RTT) data group in the [Mental Health Services Data Set](#).

WARD CODE

Change to Data Element: Changed Dataset

Format/Length:	max an12
National Codes:	
Default Codes:	

Notes:

[WARD CODE](#) is the same as attribute [WARD CODE](#).

For Commissioning Data Set version 6-2, [WARD CODE](#) identifies the [WARD](#) where [ACTIVITY](#) during a [Hospital Provider Spell](#) took place.

[WARD CODE](#) is an optional item in the Commissioning Data Set version 6-2, and is for local use only. However it must NOT contain any text which may identify the [PATIENT DIAGNOSIS](#) of the [PATIENTS](#) using the [WARD](#) (for example, it must not include the acronym 'HIV') or the [Patient Procedure](#) being undertaken (for example using the acronym 'TOP' for terminations of pregnancy). Use of such identifiers contravenes the legal requirements for withholding identifiable information about [PATIENTS](#) with identified conditions. See [Security Issues and Patient Confidentiality](#) for further details.

WARD SECURITY LEVEL

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See WARD SECURITY LEVEL
Default Codes:	

Notes:[WARD SECURITY LEVEL](#) is the same as attribute [WARD SECURITY LEVEL](#).

WARD SETTING TYPE (MENTAL HEALTH)

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See WARD SETTING TYPE FOR MENTAL HEALTH
Default Codes:	

Notes:[WARD SETTING TYPE \(MENTAL HEALTH\)](#) is the same as attribute [WARD SETTING TYPE FOR MENTAL HEALTH](#).

WARD STAY IDENTIFIER

Change to Data Element: Changed Dataset

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

Notes:[WARD STAY IDENTIFIER](#) is the same as attribute [ACTIVITY IDENTIFIER](#).[WARD STAY IDENTIFIER](#) is a unique identifier allocated for each [Ward Stay](#) during a [Hospital Provider Spell](#).

WEEKLY HOURS WORKED

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See WEEKLY HOURS WORKED
Default Codes:	98 - Not applicable (PATIENT not employed) 99 - Number of hours worked not known

Notes:[WEEKLY HOURS WORKED](#) is the same as attribute [WEEKLY HOURS WORKED](#).

YOUNG CARER INDICATOR

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See YOUNG CARER INDICATOR
Default Codes:	X - Not known whether the PERSON is a young Carer

Notes:[YOUNG CARER INDICATOR](#) is the same as attribute [YOUNG CARER INDICATOR](#).

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](#) V6-2.

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	Pattern Match	Reason / Comment / XML Choice
A and E ATTENDANCE NUMBER	max an12	None	None	None	Existing Format/Length states an12 - XML Schema allows max an12

ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST	min an2 max an6	None	None	None	Existing Format/Length states an6 - XML Schema allows min an2 max an6
ACCIDENT AND EMERGENCY DIAGNOSIS - SECOND	min an2 max an6	None	None	None	Existing Format/Length states an6 - XML Schema allows min an2 max an6
ACCIDENT AND EMERGENCY INVESTIGATION - FIRST	min an2 max an6	None	None	None	Existing Format/Length states an6 - XML Schema allows min an2 max an6
ACCIDENT AND EMERGENCY INVESTIGATION - SECOND	min an2 max an6	None	None	None	Existing Format/Length states an6 - XML Schema allows min an2 max an6
ACCIDENT AND EMERGENCY TREATMENT - FIRST	min an2 max an6	None	None	None	Existing Format/Length states an6 - XML Schema allows min an2 max an6
ACCIDENT AND EMERGENCY TREATMENT - SECOND	min an2 max an6	None	None	None	Existing Format/Length states an6 - XML Schema allows min an2 max an6
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	None	National Code G04 removed (not allowed in XML Schema)
ADVANCED CARDIOVASCULAR SUPPORT DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
ADVANCED RESPIRATORY SUPPORT DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
AGE AT CDS ACTIVITY DATE	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
AGE AT CENSUS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
AGE ON ADMISSION	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
ATTENDANCE IDENTIFIER	max an12	None	None	None	Existing Format/Length states an12 - XML Schema allows max an12
BASIC CARDIOVASCULAR SUPPORT DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
BASIC RESPIRATORY SUPPORT DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
BIRTH WEIGHT	max n4	None	None	None	Existing Format/Length states n4 - XML Schema allows max n4
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	None	National Code 500 removed (not allowed in XML Schema)
CDS COPY RECIPIENT IDENTITY	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
CDS MESSAGE REFERENCE	max n7	None	None	None	Existing Format/Length states n7 - XML Schema allows max n14 but SUS accepts max n7
CDS MESSAGE VERSION NUMBER	None	CDS062	None	None	Message version is hard coded in the XML Schema

CDS PRIME RECIPIENT IDENTITY	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
CDS SENDER IDENTITY	min an3 max an12	None	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
CDS UNIQUE IDENTIFIER	max an35	None	None	None	Existing Format/Length states an35 - XML Schema allows max an35
COMMISSIONER REFERENCE NUMBER	max an17	None	None	None	Existing Format/Length states an17 - XML Schema allows max an17
COMMISSIONING SERIAL NUMBER	max an6	None	None	None	Existing Format/Length states an6 - XML Schema allows max an6
CONSULTATION MEDIUM USED	None	01,02,03,04	None	None	National Codes 05, 06 and 98 are not used in CDS version 6-2
COUNT OF DAYS SUSPENDED	max n4	None	None	None	Existing Format/Length states n4 - XML Schema allows max n4
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	None	National Codes 80, 81, 82, 83, 84, 85, 94, 95, 96 and 97 removed (not allowed in the XML Schema)
CRITICAL CARE LEVEL 2 DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
CRITICAL CARE LEVEL 3 DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
CRITICAL CARE LOCAL IDENTIFIER	max an8	None	None	None	Existing Format/Length states an8 - XML Schema allows max an8
DERMATOLOGICAL SUPPORT DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
DISCHARGE METHOD CODE (HOSPITAL PROVIDER SPELL)	None	1,2,3,4,5,8,9	None	None	National Codes 6 and 7 are not used in CDS version 6-2
DURATION OF CARE TO PSYCHIATRIC CENSUS DATE	max n5	None	None	None	Existing Format/Length states n5 - XML Schema allows max n5
DURATION OF DETENTION	max n5	None	None	None	Existing Format/Length states n5 - XML Schema allows max n5
DURATION OF ELECTIVE WAIT	max n4	None	None	None	Existing Format/Length states n4 - XML Schema allows max n4
ELECTIVE ADMISSION LIST ENTRY NUMBER	max an12	None	None	None	Existing Format/Length states an12 - XML Schema allows max an12
EPISODE NUMBER	max an2	None	None	None	Existing Format/Length states an2 - XML Schema allows max an2
ETHNIC CATEGORY	max an2	None	None	None	Existing Format/Length means fixed length which is incorrect. Unable to change this as it is used in other data sets. Second character can be for local use. Format/Length amended to max an2
	max n3	None	None	None	

GASTRO- INTESTINAL SUPPORT DAYS					Existing Format/Length states n3 - XML Schema allows max n3
GENERAL MEDICAL PRACTITIONER PRACTICE (ANTENATAL CARE)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
GENERAL MEDICAL PRACTITIONER (ANTENATAL CARE)	None	Removed	None	None	National Codes and default codes not enumerated in the XML Schema
GENERAL MEDICAL PRACTITIONER (SPECIFIED)	None	Removed	None	None	National Codes and default codes not enumerated in the XML Schema
HOSPITAL PROVIDER SPELL NUMBER	max an12	None	None	None	Existing Format/Length states an12 - XML Schema allows max an12
INTENDED SITE CODE (OF TREATMENT)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
LIVER SUPPORT DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
LOCAL PATIENT IDENTIFIER	max an10	None	None	None	Existing Format/Length states an10 - XML Schema allows max an10
LOCAL PATIENT IDENTIFIER (BABY)	max an10	None	None	None	Existing Format/Length states an10 - XML Schema allows max an10
LOCAL PATIENT IDENTIFIER (MOTHER)	max an10	None	None	None	Existing Format/Length states an10 - XML Schema allows max an10
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (AT CENSUS DATE)	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	None	Additional National Codes 37 and 38 added
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	None	Additional National Codes 37 and 38 added
NEUROLOGICAL SUPPORT DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
NHS SERVICE AGREEMENT LINE NUMBER	max an10	None	None	None	Existing Format/Length states an10 - XML Schema allows max an10
ORGAN SUPPORT MAXIMUM	None	None	00-06	None	Range 00-06 allowed
ORGANISATION CODE (CODE OF COMMISSIONER)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
ORGANISATION CODE (CODE OF PROVIDER)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION SITE CODE changes
ORGANISATION CODE (LOCAL	min an3 max an12	None	None	None	Field size extended to future proof for

PATIENT IDENTIFIER					ODS ORGANISATION CODE changes
ORGANISATION CODE (LOCAL PATIENT IDENTIFIER (BABY))	min an3 max an12	None	None	None	Field size extended to future proof for ODS ORGANISATION SITE CODE changes
ORGANISATION CODE (LOCAL PATIENT IDENTIFIER (MOTHER))	min an3 max an12	None	None	None	Field size extended to future proof for ODS ORGANISATION SITE CODE changes
ORGANISATION CODE (LOCAL PATIENT IDENTIFIER (MOTHER))	min an3 max an12	None	None	None	Field size extended to future proof for ODS ORGANISATION SITE CODE changes
ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)	min an3 max an12	None	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
PERSON WEIGHT	n3.n3	None	None	None	Existing Format/Length states max n3.max n3 - XML Schema enforces 3 digits before and after the decimal point - max removed
PRIMARY DIAGNOSIS (READ)	max an5	None	None	None	Existing Format/Length allows for all clinical classifications -XML Schema allows max an5
PROVIDER REFERENCE NUMBER	max an17	None	None	None	Existing Format/Length states an17 - XML Schema allows max an17
REFERRER CODE	None	Removed	None	None	National Codes and default codes not enumerated in the XML Schema
REFERRING ORGANISATION CODE	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
RENAL SUPPORT DAYS	max n3	None	None	None	Existing Format/Length states n3 - XML Schema allows max n3
SECONDARY DIAGNOSIS (READ)	max an5	None	None	None	Existing Format/Length allows for all clinical classifications -XML Schema allows max an5
SITE CODE (OF TREATMENT)	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS ORGANISATION SITE CODE changes

Field size extended to future proof for [ODS ORGANISATION SITE CODE](#) changesSOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL)None

19,29,39,49,51,52,53,54,65,66,79,85,87,88

None

None

National Codes 40, 41 and 42 are not used in CDS version 6-2

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

