NHS Data Model and Dictionary

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 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
ESTIMATED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)	New Supporting Information
MENTAL HEALTH SERVICES DATA SET OVERVIEW	Changed Description
MENTAL HEALTH TRIAL LEAVE	New Supporting Information
PLANNED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)	Changed Description
REFERRAL REJECTION DATE	Changed Description
REFERRAL REJECTION TIME	New Supporting Information
Class Definitions	
LEAVE	Changed Attributes
SERVICE PROVIDED UNDER AGREEMENT	Changed Attributes
Attribute Definitions	
ACTIVITY TIME TYPE	Changed Description
CARE PLAN TYPE	Changed Description
CARE PLAN TYPE FOR MENTAL HEALTH	Changed Description
CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE	Changed Description
CLUSTERING TOOL ASSESSMENT REASON	Changed Description
ESCORTED MENTAL HEALTH LEAVE OF ABSENCE INDICATOR	New Attribute
FIVE FORENSIC PATHWAYS ASSESSMENT REASON	Changed Description
LEAVE TYPE	Changed Description

MENTAL HEALTH LEAVE OF ABSENCE END REASON	Changed Description
PLANNED ACTIVITY DATE TYPE	Changed Description
REASON FOR REFERRAL TO MENTAL HEALTH	Changed Description
SERVICE OR TEAM TYPE FOR MENTAL HEALTH	Changed Description
SERVICE TYPE	Changed Description
SOURCE OF ADMISSION	Changed Description
SOURCE OF REFERRAL FOR MENTAL HEALTH	Changed Description
SPECIALISED MENTAL HEALTH SERVICE CODE	New Attribute
WEEKLY HOURS WORKED	Changed Description

Data Elements

ADULT MENTAL HEALTH CARE CLUSTER CODE (FINAL)	Changed Description
ADULT MENTAL HEALTH CARE CLUSTER CODE (INITIAL)	Changed Description
CARE PLAN AGREED TIME	New Data Element
CARE PLAN CREATION TIME	New Data Element
CARE PLAN LAST UPDATED TIME	New Data Element
CARE PLAN TYPE (MENTAL HEALTH)	Changed Description
CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE	Changed Description
CODED PROCEDURE AND PROCEDURE STATUS (SNOMED CT)	New Data Element
DISCHARGE PLAN AGREED TIME	New Data Element
DISCHARGE PLAN CREATION TIME	New Data Element
DISCHARGE PLAN LAST UPDATED TIME	New Data Element
END DATE (MENTAL HEALTH TRIAL LEAVE)	New Data Element
END TIME (MENTAL HEALTH TRIAL LEAVE)	New Data Element
ESCORTED MENTAL HEALTH LEAVE OF ABSENCE INDICATOR	New Data Element
ESTIMATED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)	New Data Element
FORENSIC MENTAL HEALTH CARE CLUSTER CODE (FINAL) renamed from FORENSIC MENTAL HEALTH CARE CLUSTER CODE (FINAL)	Changed Description, Name
ORGANISATION IDENTIFIER (REFERRING)	Changed Description
ORGANISATION IDENTIFIER (RESPONSIBLE LOCAL AUTHORITY MENTAL HEALTH DELAYED DISCHARGE)	New Data Element
POSTCODE OF DISCHARGE DESTINATION (HOSPITAL PROVIDER SPELL)	New Data Element
REASON FOR OUT OF AREA REFERRAL (ADULT ACUTE MENTAL HEALTH)	Changed Description
REFERRAL REJECTION TIME	New Data Element
SNOMED CT EXPRESSION	New Data Element
SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT)	New Data Element
SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED DATE	New Data Element
SPECIALISED MENTAL HEALTH SERVICE CODE	New Data Element
START DATE (MENTAL HEALTH TRIAL LEAVE)	New Data Element
START TIME (MENTAL HEALTH TRIAL LEAVE)	New Data Element

XML Schema Constraint

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 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

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

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

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

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

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

~~M/R/P~~	~~Data Set Data Elements~~
M/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

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

~~M/R/P~~	~~Data Set Data Elements~~
M/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

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)

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

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

~~M/R/P~~	~~Data Set Data Elements~~
M/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~~
Care Activity: **To carry details of any activities which have taken place as part of a Care Contact.** **One occurrence of this group is permitted for each Care Activity.**	
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/P~~	~~Data Set Data Elements~~
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/P~~	~~Data Set Data Elements~~
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/P~~	~~Data Set Data Elements~~
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/P~~	~~Data Set Data Elements~~
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/P~~	~~Data Set Data Elements~~
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/P~~	~~Data Set Data Elements~~
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

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

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 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

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

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

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.

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 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

CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE

Change to Attribute: Changed 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)

CLUSTERING TOOL ASSESSMENT REASON

Change to Attribute: Changed 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)

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

FIVE FORENSIC PATHWAYS ASSESSMENT REASON

Change to Attribute: Changed 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)

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

MENTAL HEALTH LEAVE OF ABSENCE END REASON

Change to Attribute: Changed 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)

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.

REASON FOR REFERRAL TO MENTAL HEALTH

Change to Attribute: Changed 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

SERVICE OR TEAM TYPE FOR MENTAL HEALTH

Change to Attribute: Changed Description

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

National Codes:

	General Mental Health Services
A01	Day Care Service
A02	Crisis Resolution Team/Home Treatment Service
A03	Crisis Resolution Team
A04	Home Treatment Service
A05	Primary Care Mental Health Service
A06	Community Mental Health Team - Functional
A07	Community Mental Health Team - Organic
A08	Assertive Outreach Team
A09	Rehabilitation and Recovery Service
A10	General Psychiatry Service
A11	Psychiatric Liaison Service
A12	Psychotherapy Service
A13	Psychological Therapy Service (non IAPT)
A14	Early Intervention Team for Psychosis
A15	Young Onset Dementia Team
A16	Personality Disorder Service
A17	Memory Services/Clinic
A18	Single Point of Access Service
A19	24/7 Crisis Response Line
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

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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

SOURCE OF ADMISSION

Change to Attribute: Changed 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 wardened 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 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

WEEKLY HOURS WORKED

Change to Attribute: Changed 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)

ADULT MENTAL HEALTH CARE CLUSTER CODE (FINAL)

Change to Data Element: Changed 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 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.

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 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 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 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.

CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE

Change to Data Element: Changed 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.

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

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 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 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

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 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

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

FORENSIC MENTAL HEALTH CARE CLUSTER CODE (FINAL), renamed from FORENSIC MENTAL HEALTH CARE CLUSTER CODE (FINAL)

Change to Data Element: Changed Description, Name

~~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.

ORGANISATION IDENTIFIER (REFERRING)

Change to Data Element: Changed 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 (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)

Change to Data Element: New Data Element

ORGANISATION IDENTIFIER (RESPONSIBLE LOCAL AUTHORITY MENTAL HEALTH DELAYED DISCHARGE)

Attribute:

ORGANISATION IDENTIFIER

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

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

Change to Data Element: Changed Description

~~Format/Length:~~	~~an1~~
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 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

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

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 (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 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

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
GASTRO-INTESTINAL SUPPORT DAYS	max n3	None	None	None	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 PATIENT IDENTIFIER)	min an3 max an12	None	None	None	Field size extended to future proof for 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 (PATIENT PATHWAY IDENTIFIER ISSUER)	min an3 max an12	None	None	None	Field size extended to future proof for ODS ORGANISATION CODE changes
ORGANISATION CODE	min an3 max an12	Removed	None	None	Field size extended to future proof for ODS

(RESIDENCE RESPONSIBILITY)					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