NHS Data Model and Dictionary

Type:	Change Request
Reference:	1856
Version No:	1.0
Subject:	Mental Health Services Data Set Version 5.0 Corrigendum
Effective Date:	1 February 2022
Reason for Change:	Change to Information Standards
Publication Date:	23 December 2021

Background:

The Mental Health Services Data Set version 5.0 was approved by the Data Coordination Board (DCB) as: DCB0011: Mental Health Services Data Set.

Amendments to the Mental Health Services Data Set Version 5.0 have been identified since the current release was published.

The following items were defined as Mandatory (M) and they are being changed to Required (R):

- Family Involved in Care Plan Indicator
- Family Not Involved in Care Plan Reason

These changes are described in the Mental Health Services Data Set version 5 corrigendum.

This Change Request updates the NHS Data Model and Dictionary to support the corrigendum.

A short demonstration is available which describes "How to Read an NHS Data Model and Dictionary Change Request", in an easy to understand screen capture including a voice over and readable captions. This demonstration can be viewed at: https://datadictionary.nhs.uk/elearning/Change_Request/index.html.

Note: if the web page does not open, please copy the link and paste into the web browser. A guide to how to use the demonstration can be found at: Demonstrations.

Summary of changes:

Data Set

MENTAL HEALTH SERVICES DATA SET Changed Description

Date: 23 December 2021

Sponsor: Fiona Walshe, Director of Mental Health Policy, Dementia and Disabilities, Department of Health and Social Care

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

HEADER

Header: To carry header details for the submission. One occurrence of this group is required.	
M/R/O/P	**Data Set Data Elements**
M	DATA SET VERSION NUMBER
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 personal details of the patient. One occurrence of this group is required.	
M/R/O/P	**Data Set Data Elements**
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)
R	ORGANISATION IDENTIFIER (EDUCATIONAL ESTABLISHMENT)
R	NHS NUMBER
R	NHS NUMBER STATUS INDICATOR CODE (MENTAL HEALTH AND MATERNITY)
R	PERSON BIRTH DATE

R	POSTCODE OF USUAL ADDRESS
R	GENDER IDENTITY CODE
R	GENDER IDENTITY SAME AT BIRTH INDICATOR
R	PERSON STATED GENDER CODE
R	PERSON MARITAL STATUS
R	ETHNIC CATEGORY
P	ETHNIC CATEGORY 2021
R	LANGUAGE CODE (PREFERRED)
R	PERSON DEATH DATE

GP Practice Registration:
To carry 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/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)

Accommodation Status:
To carry accommodation details of the patient.
One occurrence of this group is permitted for each accommodation type.

M/R/O/P	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	ACCOMMODATION TYPE
R	SETTLED ACCOMMODATION INDICATOR
R	ACCOMMODATION TYPE RECORDED DATE
R	SECURE CHILDRENS HOME PLACEMENT TYPE
R	ACCOMMODATION TYPE START DATE
R	ACCOMMODATION TYPE END DATE

Employment Status:
To carry details of the employment status of the patient.
One occurrence of this group is permitted for each employment status.

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

Patient Indicators: To carry details of specific indicators relating to a patient. One occurrence of this group is permitted containing the current or most recently recorded status or indicators and psychosis information.	
M/R/O/P	**Data Set Data Elements**
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
R	CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR
R	PARENTAL RESPONSIBILITIES INDICATOR
R	YOUNG CARER INDICATOR
R	LOOKED AFTER CHILD INDICATOR
R	LOOKED AFTER CHILD LEGAL STATUS
R	EDUCATIONAL ASSESSMENT OUTCOME
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
R	REASONABLE ADJUSTMENT REQUIRED INDICATOR

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/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 details of the type of disability affecting a patient, based on their 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

Care Plan Type:
To carry details of Care Plans created for a patient by the organisation.
One occurrence of this group is permitted for each Care Plan created for the patient.

M/R/O/P	Data Set Data Elements
M	CARE PLAN IDENTIFIER
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	CARE PLAN TYPE (MENTAL HEALTH)
M	CARE PLAN CREATION DATE
R	CARE PLAN CREATION TIME
R	CARE PLAN LAST UPDATED DATE
R	CARE PLAN LAST UPDATED TIME
R	CARE PLAN IMPLEMENTATION DATE

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

M/R/O/P	Data Set Data Elements
M	CARE PLAN IDENTIFIER
~~M~~	~~FAMILY INVOLVED IN CARE PLAN INDICATOR~~
~~M~~	~~FAMILY NOT INVOLVED IN CARE PLAN REASON~~
R	FAMILY INVOLVED IN CARE PLAN INDICATOR
R	FAMILY NOT INVOLVED IN CARE PLAN REASON
M	CARE PLAN CONTENT AGREED BY
R	CARE PLAN CONTENT AGREED DATE
R	CARE PLAN CONTENT AGREED TIME

Assistive Technology to Support Disability Type:
To carry 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 TIMESTAMP (ASSISTIVE TECHNOLOGY)

Social and Personal Circumstances:
To carry details of social and personal circumstances of a patient.
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)
R	SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED TIMESTAMP

Overseas Visitor Charging Category:
To carry details of the Overseas Visitor Charging Category of the patient.
Multiple occurrences of this group are permitted, one for each Overseas Visitor Charging Category recorded for the patient.

M/R/O/P	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	OVERSEAS VISITOR CHARGING CATEGORY
R	OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE FROM DATE
R	OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE END DATE

Mental Health Currency Model:
To carry details of the Mental Health Currency Model.
One occurrence of this group is permitted for each Mental Health Resource Group recorded.

M/R/O/P	Data Set Data Elements
P	LOCAL PATIENT IDENTIFIER (EXTENDED)
P	MENTAL HEALTH RESOURCE GROUP TYPE (SNOMED CT)
P	START DATE (MENTAL HEALTH RESOURCE GROUP)
P	END DATE (MENTAL HEALTH RESOURCE GROUP)

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/O/P	Data Set Data Elements
M	SERVICE REQUEST IDENTIFIER
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
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 CATEGORY CODE
R	SOURCE OF REFERRAL FOR MENTAL HEALTH SERVICES DATA SET
R	ORGANISATION IDENTIFIER (REFERRING)
R	REFERRING CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH)
R	CLINICAL RESPONSE PRIORITY TYPE
R	PRIMARY REASON FOR REFERRAL (MENTAL HEALTH)
R	REASON FOR OUT OF AREA REFERRAL (ADULT ACUTE MENTAL HEALTH)
R	DECISION TO TREAT DATE (MENTAL HEALTH HOME TREATMENT)

R	DECISION TO TREAT TIME (MENTAL HEALTH HOME TREATMENT)
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

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/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/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	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 change in Referral To Treatment Period Status.

M/R/O/P	Data Set Data Elements
M	SERVICE REQUEST IDENTIFIER
R	PATIENT PATHWAY IDENTIFIER
R	ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)
M	WAITING TIME MEASUREMENT TYPE (MENTAL HEALTH)
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/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 (MENTAL HEALTH SERVICES DATA SET)
R	REFERRED OUT OF AREA REASON (ADULT ACUTE MENTAL HEALTH)
R	ORGANISATION IDENTIFIER (RECEIVING)
R	CODED REFERRAL PROCEDURE AND PROCEDURE STATUS (SNOMED CT)

Discharge Plan Agreement: To carry details of any agreements to a Discharge Plan by a person, team or organisation. One occurrence of this group is permitted for each agreement of a Discharge Plan.	
M/R/O/P	**Data Set Data Elements**
M	SERVICE REQUEST IDENTIFIER
M	DISCHARGE PLAN CONTENT AGREED BY
R	DISCHARGE PLAN CONTENT AGREED DATE
R	DISCHARGE PLAN CONTENT AGREED TIME

Medication Prescription: To carry details of each Prescription of Medication for the patient. One occurrence of this group is permitted for each Prescription.	
M/R/O/P	**Data Set Data Elements**
P	SERVICE REQUEST IDENTIFIER
P	PRESCRIPTION IDENTIFIER
P	PRESCRIPTION DATE (MEDICATION)
P	PRESCRIPTION TIME (MEDICATION)

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/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 IDENTIFIER (CODE OF COMMISSIONER)
R	ADMINISTRATIVE CATEGORY CODE
R	SPECIALISED MENTAL HEALTH SERVICE CATEGORY CODE
R	CLINICAL CONTACT DURATION OF CARE CONTACT
R	CONSULTATION TYPE
R	CARE CONTACT SUBJECT
R	CONSULTATION MECHANISM (MENTAL HEALTH)
R	ACTIVITY LOCATION TYPE CODE
R	PLACE OF SAFETY INDICATOR
R	ORGANISATION SITE IDENTIFIER (OF TREATMENT)
R	COMMUNITY PERINATAL MENTAL HEALTH PARTNER ASSESSMENT OFFER INDICATOR
R	PLANNED CARE CONTACT INDICATOR
R	CARE CONTACT PATIENT THERAPY MODE
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	REASONABLE ADJUSTMENT MADE INDICATOR

Care Activity:
To carry details of any Care Activity undertaken at 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	CODED PROCEDURE AND PROCEDURE STATUS (SNOMED CT)
R	FINDING SCHEME IN USE (MENTAL HEALTH)
R	CODED FINDING (CODED CLINICAL ENTRY)
R	CODED OBSERVATION (SNOMED CT)
R	OBSERVATION VALUE
R	UCUM UNIT OF MEASUREMENT

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

M/R/O/P	Data Set Data Elements
M	CARE CONTACT IDENTIFIER
M	OTHER PERSON IN ATTENDANCE AT CARE CONTACT
R	REASON PATIENT DOES NOT HAVE INDEPENDENT MENTAL CAPACITY ADVOCATE
R	REASON PATIENT DOES NOT HAVE INDEPENDENT MENTAL HEALTH ADVOCATE

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

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 IDENTIFIER (CODE OF COMMISSIONER)
R	CARE PROFESSIONAL LOCAL IDENTIFIER
R	CODED INDIRECT ACTIVITY PROCEDURE AND PROCEDURE STATUS (SNOMED CT)
R	FINDING SCHEME IN USE (MENTAL HEALTH)
R	CODED FINDING (CODED CLINICAL ENTRY)

GROUP SESSIONS

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

M/R/O/P	Data Set Data Elements
M	GROUP SESSION IDENTIFIER
M	GROUP SESSION DATE
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	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 Drop In Contact: To carry details of any Mental Health drop in contacts which have been provided to a patient. One occurrence of this group is permitted for each Mental Health Drop In Contact activity.	
M/R/O/P	**Data Set Data Elements**
M	MENTAL HEALTH DROP IN CONTACT IDENTIFIER
M	CARE CONTACT DATE (MENTAL HEALTH DROP IN CONTACT)
R	MENTAL HEALTH DROP IN CONTACT SERVICE TYPE
R	START TIME (MENTAL HEALTH DROP IN CONTACT)
R	END TIME (MENTAL HEALTH DROP IN CONTACT)
R	LOCAL PATIENT IDENTIFIER (EXTENDED)
R	NHS NUMBER
R	PERSON BIRTH DATE
R	GENDER IDENTITY CODE
R	GENDER IDENTITY SAME AT BIRTH INDICATOR
R	ETHNIC CATEGORY
P	ETHNIC CATEGORY 2021
R	CONSULTATION MECHANISM (MENTAL HEALTH)
R	CARE PROFESSIONAL LOCAL IDENTIFIER
R	MENTAL HEALTH DROP IN CONTACT OUTCOME
R	ORGANISATION IDENTIFIER (RECEIVING)

MENTAL HEALTH ACT (MHA) EPISODES

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

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/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 for the patient.
One occurrence of this group is permitted whenever a patient on Community Treatment Order occurs.

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 a recall into hospital for a patient on a Community Treatment Order under section 17a of the Mental Health Act 1983. One occurrence of this group is permitted whenever a patient on a Community Treatment Order occurs.	
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/O/P	**Data Set Data Elements**
M	HOSPITAL PROVIDER SPELL IDENTIFIER
M	SERVICE REQUEST IDENTIFIER
R	DECIDED TO ADMIT DATE
R	DECIDED TO ADMIT TIME
M	START DATE (HOSPITAL PROVIDER SPELL)
R	START TIME (HOSPITAL PROVIDER SPELL)
R	ADMISSION SOURCE (MENTAL HEALTH HOSPITAL PROVIDER SPELL)
R	METHOD OF ADMISSION (MENTAL HEALTH HOSPITAL PROVIDER SPELL)
R	POSTCODE OF MAIN VISITOR
R	ESTIMATED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)
R	PLANNED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)
R	PLANNED DESTINATION OF DISCHARGE (HOSPITAL PROVIDER SPELL)
R	DISCHARGE DATE (HOSPITAL PROVIDER SPELL)
R	DISCHARGE TIME (HOSPITAL PROVIDER SPELL)
R	METHOD OF DISCHARGE (MENTAL HEALTH HOSPITAL PROVIDER SPELL)
R	DESTINATION OF DISCHARGE (HOSPITAL PROVIDER SPELL)
R	POSTCODE OF DISCHARGE DESTINATION (HOSPITAL PROVIDER SPELL)
R	TRANSFORMING CARE INDICATOR
R	TRANSFORMING CARE CATEGORY

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/O/P	Data Set Data Elements
M	WARD STAY IDENTIFIER
M	HOSPITAL PROVIDER SPELL IDENTIFIER
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	ORGANISATION SITE IDENTIFIER (OF TREATMENT)
R	WARD SETTING TYPE (MENTAL HEALTH)
R	INTENDED AGE GROUP (MENTAL HEALTH)
R	SEX OF PATIENTS CODE (MENTAL HEALTH)
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 CATEGORY CODE
R	WARD CODE

Assigned Care Professional:
To carry details of the Care Professional assigned responsibility for the care of the patient.
One occurrence of this group is permitted for each Care Professional Admitted Care Episode.

M/R/O/P	Data Set Data Elements
M	HOSPITAL PROVIDER SPELL IDENTIFIER
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 the patient's 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/O/P	Data Set Data Elements
M	HOSPITAL PROVIDER SPELL IDENTIFIER
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 Incident:
To carry details of each separate reported incident of a Restrictive Intervention of the patient by one or more members of staff in response to aggressive behaviour or resistance to treatment during a Hospital Provider Spell.
One occurrence of this group is permitted whenever a Restrictive Intervention is carried out.

M/R/O/P	Data Set Data Elements
M	RESTRICTIVE INTERVENTION INCIDENT IDENTIFIER
M	HOSPITAL PROVIDER SPELL IDENTIFIER
M	START DATE (RESTRICTIVE INTERVENTION INCIDENT)
R	START TIME (RESTRICTIVE INTERVENTION INCIDENT)
R	END DATE (RESTRICTIVE INTERVENTION INCIDENT)
R	END TIME (RESTRICTIVE INTERVENTION INCIDENT)
R	RESTRICTIVE INTERVENTION POST-INCIDENT REVIEW HELD INDICATOR (PATIENT)
R	RESTRICTIVE INTERVENTION POST-INCIDENT REVIEW NOT HELD REASON (PATIENT)
R	RESTRICTIVE INTERVENTION POST-INCIDENT REVIEW HELD INDICATOR (CARE PERSONNEL)
R	RESTRICTIVE INTERVENTION REASON

Restrictive Intervention Type:
To carry details of each separate reported type of a Restrictive Intervention used, as part of a Restrictive Intervention Incident, of the patient by one or more members of staff in response to aggressive behaviour or resistance to treatment during a Hospital Provider Spell.
One occurrence of this group is permitted for each Restrictive Intervention carried out as part of a Restrictive Intervention Incident.

M/R/O/P	Data Set Data Elements
M	RESTRICTIVE INTERVENTION INCIDENT IDENTIFIER
M	RESTRICTIVE INTERVENTION TYPE IDENTIFIER
M	START DATE (RESTRICTIVE INTERVENTION TYPE)
R	START TIME (RESTRICTIVE INTERVENTION TYPE)
R	RESTRICTIVE INTERVENTION TYPE
R	END DATE (RESTRICTIVE INTERVENTION TYPE)
R	END TIME (RESTRICTIVE INTERVENTION TYPE)
R	RESTRICTIVE INTERVENTION RESTRAINT INJURY INDICATOR (PATIENT)
R	RESTRICTIVE INTERVENTION RESTRAINT INJURY INDICATOR (CARE PERSONNEL)
R	RESTRICTIVE INTERVENTION RESTRAINT INJURY INDICATOR (OTHER PERSON)

Police Assistance Request:
To carry details of each separate reported police assistance request during a Ward Stay.
One occurrence of this group is permitted for each police assistance request.

M/R/O/P	Data Set Data Elements
M	WARD STAY IDENTIFIER
M	POLICE ASSISTANCE REQUEST DATE
R	POLICE ASSISTANCE REQUEST TIME
R	POLICE ASSISTANCE ARRIVAL DATE
R	POLICE ASSISTANCE ARRIVAL TIME
R	POLICE RESTRAINT OR FORCE USED INDICATOR

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

Self-Harm:
To carry details of each separate reported incident 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/O/P	Data Set Data Elements
M	WARD STAY IDENTIFIER
M	DATE OF SELF-HARM

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 evidence that Substance Misuse was observed.

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

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/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/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 under section 18 of the Mental Health Act 1983, as amended by the Mental Health (Patients in the Community) Act 1995. One occurrence of this group is permitted whenever a period of Mental Health Absence Without Leave takes place.	
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 Assignment Period: To carry details of each Commissioner Assignment Period during a Hospital Provider Spell. One occurrence of this group is permitted for each Commissioner Assignment Period.	
M/R/O/P	**Data Set Data Elements**
M	HOSPITAL PROVIDER SPELL IDENTIFIER

M	ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)
M	START DATE (COMMISSIONER ASSIGNMENT PERIOD)
R	END DATE (COMMISSIONER ASSIGNMENT PERIOD)

Specialised Mental Health Exceptional Package of Care:
To carry details of Specialised Mental Health Exceptional Packages of Care which occurred during a Hospital Provider Spell for the patient.
One occurrence of this group is permitted per Specialised Mental Health Exceptional Package of Care.

M/R/O/P	Data Set Data Elements
M	HOSPITAL PROVIDER SPELL IDENTIFIER
M	SPECIALISED MENTAL HEALTH EXCEPTIONAL PACKAGE OF CARE CHARGE
R	ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)
M	START DATE (SPECIALISED MENTAL HEALTH EXCEPTIONAL PACKAGE OF CARE)
R	END DATE (SPECIALISED MENTAL HEALTH EXCEPTIONAL PACKAGE OF CARE)

CLINICALLY CODED TERMINOLOGY

Medical History (Previous Diagnosis):
To carry details of any previous diagnoses for a patient which are stated by the patient or recorded in medical notes. These do not necessarily have been diagnosed by the organisation submitting the data.
One occurrence of this group is permitted for each Previous Diagnosis.

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

Provisional Diagnosis:
To carry details of unconfirmed provisional diagnoses recorded for a patient.
One occurrence of this group is permitted for each unconfirmed Provisional Diagnosis.

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

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

M/R/O/P	Data Set Data Elements

M	SERVICE REQUEST IDENTIFIER
M	DIAGNOSIS SCHEME IN USE (MENTAL HEALTH)
M	PRIMARY DIAGNOSIS (CODED CLINICAL ENTRY)
R	CODED DIAGNOSIS TIMESTAMP

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

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

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/O/P	Data Set Data Elements
M	SERVICE REQUEST IDENTIFIER
M	CODED ASSESSMENT TOOL TYPE (SNOMED CT)
M	PERSON SCORE
M	ASSESSMENT TOOL COMPLETION TIMESTAMP
R	CARE PROFESSIONAL LOCAL IDENTIFIER

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 that are issued and completed as part of a referral to a Mental Health Service.
One occurrence of this group is permitted for each coded anonymous self-assessment question or dimension captured.

M/R/O/P	Data Set Data Elements
M	ASSESSMENT TOOL COMPLETION TIMESTAMP
M	CODED ASSESSMENT TOOL TYPE (SNOMED CT)

M	PERSON SCORE
R	ACTIVITY LOCATION TYPE CODE
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/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/O/P	Data Set Data Elements
M	CARE PROGRAMME APPROACH CARE EPISODE IDENTIFIER
M	CARE PROGRAMME APPROACH REVIEW DATE
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/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/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/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)
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/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

Staff Details: 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/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)

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