NHS England

User guidance

Mental Health Services Data Set (MHSDS) v6.0

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Document filename:	**MHSDSv6.0_UserGuidance_v6.0.5_October 2026.docx**		
Data set	**Mental Health Services Data Set**		
Data set version	**6.0**	Status	**Published**
Development lead	**Gavin Harrison**	Document version	**6.0.5**
Author	**Julia Webb**	Version issue date	**15/10/2026**

Document management

Revision History

Version	Date	Summary of Changes
2.0	28/03/2024	Published
6.0.3	24/05/2024	Update to guidance in section 4.1, update to the table description for MHS101 and MHS102, update to guidance for MHS204 update to the table description for MHS205, minor corrections to the codes listed in Appendix 12, addition of placeholder for Appendix 13
6.0.4	03/03/2026	Updated links to the Specialised Mental Health Service Codes
6.0.5	15/10/2026	Amendment to the new “Mental health assessment scale procedures simple reference set” within the Coded Scored Assessments header. Addition of new digitally enabled psychological therapy codes within Section 13.1.8. Addition of 4 clinically led SNOMED CT reference sets within the CODED PROCEDURE AND PROCEDURE STATUS (SNOMED CT) data item. Additional guidance regarding SNOMED CT reference sets within the CODED FINDING (CODED CLINICAL ENTRY) data item. Additional guidance regarding SNOMED CT reference sets within the PRESENTING COMPLAINT data item. Amendment to two DIALOG assessment scales in Section 4.9.2 which had incorrect digits. Amendment to the initial memory assessment (procedure) SNOMED ID code in Section 13.1.8 SNOMED ID Mapping which had an incorrect digit.

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Reviewers

This document must be reviewed by the following people:

Reviewer name	Title / Responsibility	Status
Gavin Harrison	Senior Data Architect, Data Design Service	Reviewed

Approved by

This document must be approved by the following people:

Name	Title / Responsibility	Status
Tom Latham	Principal Data Architect and Head of Data Design	Approved

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Glossary of common terms and abbreviations

Term and Abbreviation	What it means
Coded Scored Assessment	Also commonly referred to as Routine Outcome Measure or Assessment Tool
Commissioning Data Sets (CDS)	CDS are national data sets that form the basis of data on activity carried out by NHS trusts reported centrally for monitoring and payment purposes.
Data Alliance Partnership Board (DAPB)	Provides oversight of the assurance and approval of information standards, data collections and data extractions (ISCE) across health and adult social care.
Data Item	A single component of a data set that holds one type of information and relates to a specific record.
Data Set	The full collection of data tables.
Data Table	A collection of data items that describe a distinct event or episode. This can also be referred to as a group of data.
Enhanced Technical Output Specification (ETOS)	This document defines the data items and groups that make up the MHSDS data set along with derivations, validations and SNOMED codes for MH Assessment Scales.
International Classification of Diseases (ICD 10 and ICD 11)	Provides a common language for recording, reporting and monitoring diseases. ICD 11 has not yet been implemented in the MHSDS.
Intermediate Database (IDB)	An MS Access database used to submit data to SCDS Cloud.
Information Standards Notice (ISN)	An information standard is defined in the Health and Social Care Act 2012 as: 'a document containing standards that relate to the processing of information'. It specifies rules for the processing, management and sharing of information, what process is needed and conformance criteria.
Mental Health Act (MHA)	The main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder.
Mental Health Services Data Set (MHSDS)	A patient level, output based, secondary uses data set which aims to deliver robust, comprehensive, nationally consistent and comparable person-based information for all patients of all ages who are in contact with Mental Health Services.
NHS Data Model and Dictionary (NHS DM&D)	A reference point for assured information standards, to support health care activities in the NHS in England. It provides the development, maintenance and support of NHS Information Standards.
NICE	National Institute for Health and Clinical Excellence
Null	A data item that is blank or has no value attached. This is distinct from a value of 0.
Organisation Data Service (ODS)	Codes that facilitate a patient’s treatment by providing unique identification codes for organisational entities of interest to the NHS, for example NHS Trusts or CCGs, organisation sites such as hospitals, or GP Practices.
Strategic Data Collection Service in the cloud (SDCS Cloud)	A secure data collection system which accepts uploads of submissions in a variety of formats.

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Term and Abbreviation	What it means
SNOMED CT	A clinical terminology that provides a standardised way to represent clinical phrases captured by the clinician and enables automatic interpretation of these.
Technical Output Specification (TOS)	Also called the Data Set Specification. This document defines the data items and groups that make up the MHSDS. It is governed by and published alongside the ISN.

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Contents

1 About this document 10

1.1 Purpose 10
1.2 Audience and scope 10
1.3 Update schedule 10
1.4 Availability of data items in the NHS DM&D 11

2 Background information 11

3 MHSDS v6.0 11

4 General guidance 11

4.1 Use of referral data items in MHS101, MHS102 and MHS902 11
4.2 Common Error Messages 12
4.3 Timestamps 13
4.4 MHSDS and the Commissioning Data Sets (CDS) 13
4.5 Assuring Transformation 14
4.6 Learning Disabilities and Autism Services 14
4.7 NHS England Who Pays 14
4.8 Intended Age Group 15
4.9 Clinical Terminologies and Classifications General Guidance 15

5 Repeating data items 18

5.1 Linkage Data Items 18

6 Breakdown of Data Items by Table 24

Header 24

MHS000 Header 24

Patient Demographics 25

MHS001 Master Patient Index 25
MHS002 GP Practice Registration 28
MHS003 Accommodation Status 29
MHS004 Employment Status 30
MHS005 Patient Indicators 31
MHS006 Mental Health Care Coordinator 34
MHS007 Disability Type 35
MHS008 Care Plan Type 36
MHS009 Care Plan Agreement 37
MHS010 Assistive Technology To Support Disability Type 37
MHS011 Social and Personal Circumstances 38

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MHS012 Overseas Visitor Charging Category 39
MHS014 eMED3 Fit Note 40

Referrals 40

MHS101 Service or Team Referral 40
MHS102 Other Service or Team Type 46
MHS103 Other Reason for Referral 47
MHS104 Referral to Treatment (RTT) 47
MHS105 Onward Referral 48
MHS106 Discharge Plan Agreement 49

Care Contact, Care Activities and Indirect Activities 50

MHS201 Care Contact 50
MHS202 Care Activity 55
MHS203 Other in Attendance 58
MHS204 Indirect Activity 58
MHS205 Patient Self-Directed Digital Intervention 59
MHS206 Staff Activity 59

Group Sessions 60

MHS301 Group Session 60
MHS302 Mental Health Drop In Contact 61

Mental Health Act (MHA) Episodes 63

MHS401 Mental Health Act Legal Status Classification Assignment Period 63
MHS402 Mental Health Responsible Clinician Assignment Period 66
MHS403 Conditional Discharge 66
MHS404 Community Treatment Order 66
MHS405 Community Treatment Order Recall 67

Hospital Provider Spells 67

MHS501 Hospital Provider Spell 67
MHS502 Ward Stay 68
MHS503 Assigned Care Professional 69
MHS505 Restrictive Intervention Incident 69
MHS515 Restrictive Intervention Type 70
MHS506 Assault 70
MHS507 Self Harm 71
MHS509 Home Leave 71
MHS510 Mental Health Leave of Absence 71
MHS511 Mental Health Absence Without Leave 72

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MHS512 Hospital Provider Spell Commissioner Assignment Period 73
MHS513 Substance Misuse 73
MHS514 Mental Health Trial Leave 73
MHS516 Police Assistance Request 74
MHS517 Specialised Mental Health Exceptional Package of Care (EPC) 74
MHS518 Clinically Ready for Discharge 74

Clinically Coded Classifications and Terminology 75

MHS601 Medical History (Previous Diagnosis) 75
MHS604 Primary Diagnosis 76
MHS605 Secondary Diagnosis 76
MHS606 Coded Scored Assessment (Referral) 76
MHS607 Coded Scored Assessment (Care Activity) 77
MHS608 Anonymous Self-Assessment 78
MHS609 Presenting Complaint 78

Care Programme Approach (CPA) Episodes 78

MHS701 Care Programme Approach (CPA) Care Episode 78
MHS702 Care Programme Approach (CPA) Review 78

Staff, Service and Ward 79

MHS901 Staff Details 79
MHS902 Service or Team Details 80
MHS903 Ward Details 81

Appendix 1 – Reason for Referral Guidance 83
Appendix 2 - Definitions for Restrictive Interventions for use in the MHSDS 84

Required reporting and working definitions 85

Appendix 3 – Guide for recording Assessment Tools 89

Appendix 3.1 List of accepted Assessment Tools for submission within MHSDS 89
Appendix 3.2 Licensing of Assessment Tools for use within systems 91
Appendix 3.3 Current View Selected Complexity Factors 91
Appendix 3.4 SNOMED CT Mapping 93

Appendix 4 – Removal of clustering tools for mental health in MHSDS v6.0 93
Appendix 5 - Out of Area Placements 93
Appendix 6 – Approach to collection of Ward Stay information to inform inpatient activity analysis 94
Appendix 7 – Care Activity Guidance 96
Appendix 8 – Commissioner Extract Inclusion Rules 98

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Appendix 8.1 Principles for data exclusion – Removal of identifiable data 99
Appendix 8.2 Inclusion Logic 99
Appendix 8.3 Hospital Provider Spells 100
Appendix 9 – Amendments to National Code Definitions 103
Appendix 9.1 Accommodation Status 103
Appendix 9.2 Service or Team Type (Mental Health) 104
Appendix 9.3 Mental Health Admitted Patient Classification Types 106
Appendix 10 - Definitions for Service or Team Types and Mental Health Admitted Patient Classification Types 108
Appendix 10.1 Service or Team Type definitions 108
Appendix 10.2 Mental Health Admitted Patient Classification Type definitions 116
Appendix 11 - Assuring Transformation 122
Appendix 12 – Future Reporting Clinically Ready for Discharge 122
Appendix 13 – Digital Mental Health Platforms 137

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1 About this document

1.1 Purpose

This document is designed to accompany the ETOS and provide users with more detailed information about the data requirements for the data tables and the data items contained within.

1.2 Audience and scope

This document is aimed at:

- Those involved in the collection of data within Mental Health Services, including service managers and clinical leads or organisations providing mental health services which are in scope of the data set
- Information management departments within data provider organisations
- IT system suppliers operating within mental health services which are within the scope of the data set
- Other stakeholders responsible for the submission and analysis of MHSDS data

This document should be read in conjunction with these documents, which can be found within the MHSDS information standard[1] web pages

- MHSDS v6.0 TOS
- MHSDS v6.0 Information Standards Notice
- MHSDS v6.0 Requirements Specification
- MHSDS v6.0 Change Specification
- MHSDS v6.0 Implementation Guidance
- NHS Data Model and Dictionary Change Request

And these documents, which can be found within the MHSDS v6.0 tools and guidance[2] web pages

- MHSDS v6.0 ETOS
- MHSDS v5.0 to v6.0 Mapping Guidance
- MHSDS v6.0 Data Model

Please refer to the MHSDS v5.0 to v6.0 Mapping Guidance document which shows the complete list of new tables and data items which have been introduced for v6.0.

1.3 Update schedule

This document will be reviewed and updated as necessary. Changes to this document will not require acceptance from the DAPB where the changes do not affect or alter the scope of the Information Standard.

[1] https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dapb0011-mental-health-services-data-set
[2] https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/tools-and-guidance

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1.4 Availability of data items in the NHS DM&D

The NHS DM&D[3] publishes data items and code lists relevant to current data flow. New codes and amendments in v6.0 will be published to the dictionary shortly before flow of the new data set, and therefore will not currently be consistent with the published ETOS and guidance.

2 Background information

The MHSDS covers services located in England or located outside England but treating patients commissioned by an English Integrated Care Board (ICB), or NHS England specialised commissioner or an NHS-led Provider Collaborative.

As a secondary uses data set, the MHSDS re-uses clinical and operational data for purposes other than direct patient care. It defines the data items, definitions and associated value sets extracted or derived from local information systems.

3 MHSDS v6.0

The changes introduced into MHSDS v6.0 relate to new government policy initiatives, resolution of issues within the current data collection, and inclusion of other key stakeholder requirements.

Changes included in this release are detailed in the Change Specification and ETOS documents.

4 General guidance

This section provides additional guidance for data items in the ETOS.

Frequently asked questions and clarification points are addressed in this section.

Detail information and guidance can be found on the overarching MHSDS webpages[4], from here there are linked pages to DAPB documentation, implementation tools and guidance, information on submitting data[5] and guidance on changes in care provider or system supplier[6].

4.1 Use of referral data items in MHS101, MHS102 and MHS902

As part of the re-design for MHSDS V6.0, there have been some changes to the tables and individual data items found in the data set.

Overview of key structure changes

- MHS101 Service or Team Referral table still captures details of each separate referral, and identifies the primary MH service or team involved in the referral

[3] https://www.datadictionary.nhs.uk/index.html
[4] https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set
[5] https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/submit-data
[6] https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/submit-data/guidance-on-changes-in-care-provider-provider-identifier-or-system-supplier

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- MHS102 Other Service or Team Type table captures details of any additional services or teams involved in the same referral submitted in MHS101
- The new MHS902 Service or Team Details table captures service and team details and acts as a look up table linked to MHS101 and/or MHS102
- Multiple referrals would require multiple MHS101 submissions, for example referrals to different mental health services
- The MHS101 referral needs to stay open for the duration of the referral and would be closed once all the related MHS102 activity is complete, for example involvement from other mental health teams

The change is not intended to capture the full referral pathway which would include other services, including non mental health services. The change is designed to ensure that all the mental health services and/or teams involved in the same referral can be identified.

As a result of the changes, if only one team or service is involved in the care of the patient, the MHS102 Other Service or Team Type table no longer needs to be submitted.

The primary team in MHS101 Service or Team Referral table is identified via linkage to the new MHS902 table and the MHS102 table now only captures details of any other team or service that is involved in the same referral.

Recording the rejection of a primary service referral

In order to enable the recording of the rejection of a primary service referral, for example, a referral from primary care which is deemed inappropriate, we have introduced the following four required data items into the MHS101 table:

- Referral Rejection Date
- Referral Rejection Time
- Referral Rejection Reason
- Referral Closure Reason

The introduction of these four data items in the MHS101 table now allows for the rejection of a referral to be captured in the MHS101 table for the primary team referred to, using the example in the scenario outlined above, and where the initial referral to the mental health service is deemed inappropriate and rejected.

A rejection can then be separately captured in the MHS102 table for any other team providing care as part of the same referral, where applicable.

4.2 Common Error Messages

The File-level Rejects tab outlines the most commonly occurring error codes and associated validation failure messages. Rejection messages can be looked up within this tab to try to ascertain the reason for the error message.

A common error code is MHSREJ001, which indicates a failed database structure check. This usually means that the database has been altered in some way or a date format has been entered incorrectly, causing the file to not be recognised.

If you get an error message, you can do the following:

- Check whether a "Paste Errors" or "Import Errors" table has been created within the Access database. Access has built in functionality that will automatically create these

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tables if there is any issue with copying data in or importing it using the Import Wizard. These tables are useful to you to know what data didn't get passed into a table, but they cannot be present when you come to upload the file as the process is not expecting them. If one of these is in the list of tables on the left, delete it and try submitting again.

- Check if the database has been changed in some way, such as a field or table being changed, added, removed or renamed. Providers need to be particularly mindful of this because fields have been added/deleted/changed in v6.0 and you cannot import the data in the same way as v5.0. You need to ensure that these changes are reflected in your internal systems. We recommend that you download a fresh version 6.0 IDB and compare this with the one you have populated to see if the fields are in the correct order.
- Check the Header table. Make sure the DateTimeDatSetCreate field is only populated with the date.

4.3 Timestamps

Valid timestamp formats are provided in the Technical Glossary tab in the ETOS.

The timestamp fields should always show the time 'as shown on the clock'. For example, a submitted value of '2021-05-31T23:30:00+01:00' is showing that the time when an activity took place was 23:30, during part of the year when British Summer Time applies.

The only valid offset times (at least for activity taking place in this country, which it all should be for MHSDS) are '+01:00', '+00:00' or '-00:00' (or a 'Z').

The following principles should be applied:

- The time zone offset should be factored into any date comparison validations, such as to check whether a timestamp is after the end of the reporting period. Dates should not need to be converted back to GMT, however, some logic may need to be developed to handle comparisons between timestamps and reporting periods that fall on the day that the clocks change.
- Offset times other than '+01:00', '+00:00' or '-00:00' (or 'Z') should be rejected, and inappropriate offset times (e.g. '+00:00' when British Summer Time applies) should also be rejected – a new validation message may be needed to handle this.

4.4 MHSDS and the Commissioning Data Sets (CDS)

MHSDS v6.0 includes data items that relate to hospital attendances in the outpatient, inpatient and ward stay tables. Some of the data items in these tables overlap with the Commissioning Data Sets[7] (CDS) both with regard to mental health and learning disabilities or autism services.

Mental Health data remains in scope of CDS. NHS England is aware that there is duplication in the provision of some data items and work is underway to investigate reducing the data collection burden on providers.

[7] https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/commissioning-data-sets

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4.5 Assuring Transformation

The Assuring Transformation[8] (AT) data collection is a separate collection to the MHSDS, developed in response to the Transforming Care[9] programme of work which was developed by NHS England in response to the Winterbourne View Review.

Assuring Transformation is a commissioner data collection for people with a learning disability and/or autistic people who are in a mental health hospital. The collection contains data about a person's stay in hospital, and the care they receive, and it supports NHS England to monitor progress in reducing reliance on hospital care for this group of patients.

Data on patients with a learning disability and autistic people in a mental health hospital, are also collected as part of the MHSDS.

An update to Assuring Transformation (AT v4.0), has been developed in parallel with MHSDS v6.0. The Data Set Development Service have assisted with the development of AT v4.0 to support the NHS England policy team in gaining DAPB approval, and as part of this work have ensured that MHSDS v6.0 and AT v4.0 are aligned. In particular:

- MHSDS v6.0 introduces two new data items designed to specifically identify patients with a learning disability or autism - Learning Disability Status and Autism Status.

  These items were introduced to make it easier to identify patients with a learning disability and autistic patients in the MHSDS and may help to enable some data fields in AT to be retired in future once MHSDS v6.0 is established.

- AT v4.0 introduces the Gender Identity Code data item, which is also used in MHSDS, as well as a question which replicates the Gender Identity Same at Birth Indicator item also used in MHSDS.

- MHSDS v6.0 and AT v4.0 utilise the same data items and national codes where relevant. For example, the national code list for Mental Health Clinically Ready for Discharge Delay Reason and Mental Health Admitted Patient Classification have been updated so that both data set use the same values. In a handful of cases more granular values exist in AT due to the specialist nature of that collection, but these values are mappable to higher level codes in MHSDS v6.0 to reduce any burden on care providers collecting data for both.

4.6 Learning Disabilities and Autism Services

There are data items where the name of the item references 'mental health'. Learning disabilities and autism services remain in scope and these services should populate these fields where appropriate.

4.7 NHS England Who Pays

The NHS England document Who (March 2024) sets out a framework for establishing responsibility for commissioning an individual's care within the NHS and determines[10] (March 2024) sets out a framework for establishing responsibility for commissioning an individual's care within the NHS and determines who pays for a patient's care.

[8] https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dapb2007-assuring-transformation
[9] https://www.england.nhs.uk/learning-disabilities/care/
[10] https://www.england.nhs.uk/who-pays/

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Updated guidance came into effect from 1 April 2024, replacing the 2022 version. Please refer to the NHS England document for further details.

Who Pays? (March 2024) is supported by the Commissioner Assignment Method (CAM) guidance[11] and flowcharts which provide practical tools to help identify the correct commissioner.

4.8 Intended Age Group

The MHSDS is intended to capture data relating to patients of any age. An applicable age group is implied either by the data item name, or the nature of the data it is intended to hold. Where it is appropriate to explicitly assign an age group, we will attempt to make this clear in the data item guidance. All other data items should be assumed to be applicable to patients of any age and should be submitted where applicable to the individual patient, irrespective of age.

4.9 Clinical Terminologies and Classifications General Guidance

4.9.1 ICD Codes

An ICD-10 code is the International Classification of Diseases (ICD) 10th Revision code.

ICD-10 diagnostic codes are at least four characters in length. The first character is always alphabetic. Where an undivided three-character code is used, the fourth character must be filled with 'X'. Further guidance regarding ICD-10 codes is available in the NHS DM&D[12].

ICD-11 codes cannot yet be submitted in MHSDS, but they will be included in a future version of the data set.

4.9.2 SNOMED CT Codes

During MHSDS assurance activities, two potential issues have been identified with the handling of SNOMED CT data across various third-party systems, which could affect the DSP and accuracy of data outputs.

1.SNOMED CT Codes authored for the DIALOG assessment scales

In the v5 ETOS, there are two DIALOG assessment tools listed in the ‘MH Assessment Scales’ tab which had been authored incorrectly. The code for item 6 had the outcome measure for item 7 and vice versa.

Preferred Term (SNOMED-CT)	Active Concept ID (SNOMED-CT)
DIALOG patient rated outcome measure item 6 score - how satisfied are you with your friendships	1037701000000108
DIALOG patient rated outcome measure item 7 score - how satisfied are you with your partner/family	1037711000000105

This discrepancy in the sequencing of the items had been present since the SNOMED-CT codes were authored in 2016. A resolution was identified and the current SNOMED-CT codes, detailed above have been inactivated and two newly authored concepts have been added to the SNOMED CT Browser, and to the v6.0 ETOS, which will be accepted for submission from 1 April 2024, as follows:

[11] https://www.england.nhs.uk/data-services/commissioning-flows/
[12] https://www.datadictionary.nhs.uk/data_elements/icd-10_code.html

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Preferred Term (SNOMED-CT)	Active Concept ID (SNOMED-CT)
DIALOG item 6 score - how satisfied are you with your relationship with your partner/family	1833391000000107
DIALOG item 7 score - how satisfied are you with your friendships	1833401000000105

2. Loss of 16-Digit+ accuracy

SNOMED CT IDs can be up to 18 digits long and contain only numbers. Entering a 16-digit (or greater) code into any number-formatted field in a system using the IEEE 754 standard will result in all digits after the 15th displaying as a "0", irrespective of what is entered.

Impact

This issue has a different impact depending on the specific data items:

For Assessment Tool data, this will lead to most of the 16-18 digit SNOMED CT codes being rejected at the DSP during validation. Some codes end in a “0” so these codes would not be affected.

List of affected Assessment Scales

- Behaviour Problems Inventory – Short (BPI-S)
- Brief Assessment Checklist for Children (BAC-C)
- Brief Assessment Checklist for Adolescents (BAC-A)
- Commission for Health Improvement Experience of Service Questionnaire (CHI-ESQ)
- DIALOG
- Goal Based Outcomes (GBO)
- HoNOS-ABI
- Me and My Feelings Questionnaire
- Nisonger Child Behaviour Rating Form (NCBRF)
- Questionnaire about the Process of Recovery (QPR)
- Session Feedback Questionnaire (SFQ)
- ReQoL (Recovering Quality of Life 20-item)
- ReQoL (Recovering Quality of Life 10-item)
- ASSIST-Lite (Adapted Alcohol, Smoking and Substance Involvement Screening Test)
- Eating Disorders Quality of Life Scale (EDQLS) outcome measure
- Binge Eating Scale score
- Perinatal POEM (Patient-rated Outcome and Experience Measure)
- Therapy Outcome Measures

Other SNOMED CT fields in the data set are not affected. No reference data exists for validation therefore the incorrect SNOMED CT code would flow without warning and be available for future analysis.

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3. SNOMED CT codes formatted in 'Scientific Notation'

When a large number (>11 digits) is entered in Excel and then formatted as text, Excel tries to be helpful and shows the number in scientific notation. E.g. 958051000000104 shows as 9.58051E+14. The IDB will interpret this as the literal text rather than the number that it represents.

Impact

For all SNOMED CT data: This issue will lead to the rejection of these incorrectly formatted codes at the DSP during validation.

The specific records affected will not be clearly identifiable from the DSP Summary Report. When importing the validations report into Excel, unless you specify that this field should be text, Excel will interpret it as a number and display it accordingly, therefore leading to a mismatch between what has been submitted and what shows in the validation report.

Mitigating Guidance

The way round both these issues is to ensure that all SNOMED CT fields are formatted as text in all intermediary systems and import/export routines, and that identifiers are not copy/pasted or typed directly into a spreadsheet.

SNOMED CT identifiers are not random numbers and do contain patterns. Part of this pattern is a check-digit. You can use the check-digit to ensure a particular SNOMED CT ID is valid. For more information on SNOMED CT identifiers and how to use the check-digit please see the SNOMED CT Technical Implementation Guide, Section 4.3.2 Representing SNOMED CT Identifiers[13].

4.9.3 Acceptance of codes

The MHSDS does not restrict the submission of codes based on whether they have been checked by a clinical coder. This should be decided by each trust and local process should be followed.

4.10 Digital Services

As part of the re-design for MHSDS V6.0, there have been numerous changes and updates related to digital platforms and services.

These changes aim to enable more digital mental health platforms, commissioned across the NHS, to submit to the MHSDS, improve the quality of data submitted and support improved analysis.

These changes are not intended to change how or what digital contacts count towards mental health access measures. In-line with existing NHS England guidance in 2024/25 all contacts (digital and non-digital) can be counted towards CYPMH access if the meet the below definition, as set out in the *2024/25 priorities and operational planning guidance: April 2024 – March 2025 Activity and performance technical definitions:*

- *A direct contact with a patient, parent or carer (as a patient proxy) or between professionals (as indirect activity), as long as they are clinically meaningful.*

Digital platforms and services should work with their local commissioning organisation to agree what activity/services on their platform meet this definition.

[13] https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/health-information-standards/bc-snomed-ct-implementation-guidance-for-hcvs-v1-2.pdf

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In preparation for 2025/26, NHS England is working with stakeholders across the mental health system to explore the breadth of service offerings through digital mental health platforms to determine what activity data should count to future iterations of the Children and Young People Mental Health (CYPMH) and Community Mental Health (CMH) access metrics.

4.10.1 Digitally Supported Services

Digitally supported services are where digital technologies e.g. video conferencing and telephony, are used to support “traditional” care delivery by a mental health professional employed by a mental health provider.

Recording of digitally supported services should be treated consistently with non-digital services, in-line with this guidance, but with the relevant digital consultation mechanism code recorded in MHS201 Care Contact.

4.10.2 Digital Mental Health Platforms

Digital Mental Health Platforms are phone or web-based applications or platforms, where a patient/service-user can access specific digitally enabled mental health care and support. These are distinct from digital supported services where digital technologies are used to support “traditional” care delivery e.g. video conferencing and telephony services.

Detailed guidance on the recording of digital mental health platforms is provided in Appendix 13 – Digital Mental Health Platforms.

The appendix includes guidance on how and when different digital mental health platforms should be recorded in MHSDS v6.0 and when to use the MHS201 Care Contact or MHS205 Patient Self-Directed Digital Intervention tables.

5 Repeating data items

5.1 Linkage Data Items

Linkage data items appear in more than one table and allow the relationship between records within different tables to be identified.

The below linkage data items are fully described within the ETOS. The following information should be referenced in conjunction with the Data Model, available on the MHSDS web pages[14] and the ‘Data Linkage’ tab in the ETOS.

[14] https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/tools-and-guidance

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Data Item Name	Additional Notes
LOCAL PATIENT IDENTIFIER (EXTENDED)	The Local Patient Identifier (Extended) is used to uniquely identify a patient within the Health Care Provider. It may be different from the patient's casenote number and may be assigned automatically by the computer system. This item is a primary key in the MHS001MPI table and must be unique to this table, within submission. No patient can have more than one Local Patient Identifier (Extended). This can be checked by looking at data items such as NHS number, postcode and date of birth. The Local Patient Identifier (Extended) provides a link between records in the MHS001 Master Patient Index table, associated referrals, and all non-referral-based data associated with the patient. To avoid the incorrect linkage of records the Local Patient Identifier (Extended) must not be reused i.e. it should only ever relate to one patient. This ensures that data relating to more than one patient does not get incorrectly identified as belonging to a single patient in MHSDS.
SERVICE REQUEST IDENTIFIER	The Service Request Identifier is used to uniquely identify the referral. It would normally be automatically generated by the local system upon recording a new Referral, although could be manually assigned. This item is a primary key in the MHS101Referral table and must be unique to this table, within submission. The Service Request Identifier provides a means for linking each Referral with additional data associated directly with that referral. Where multiple systems are used the submitted extract may include a prefix to the Service Request Identifier, which relates to the system. The prefix ensures each Service Request Identifier remains unique within submission.
CARE CONTACT IDENTIFIER	The Care Contact Identifier is used to uniquely identify the care contact within the Health Care Provider. It would normally be automatically generated by the local system upon recording a new Care Contact, although could be manually assigned. This item is a primary key in the MHS201 Care Contact table and must be unique to this table. The Care Contact Identifier provides a links between records in the MHS201 Care Contact table and associated Care Activity carried out during a care contact. We would like to remind providers of the importance of ensuring that the Care Contact Identifier is truly a unique data item, both within the same submission file and across multiple submission files. The Care Contact Identifier is a primary key for its respective table and is based upon the Activity Identifier[15] data attribute which is defined as “A unique number or set of characters that is applicable to only one Activity for a Patient within an Organisation”. This reiterates that these identifiers should be unique across submissions. These identifiers will typically be auto generated by the system in use, so will prevent duplicates when using the same system. Where multiple systems are used it is acceptable to include a prefix to the Care Contact Identifier, which relates to the system. The prefix enables each identifier to remain truly unique for all submissions from an organisation.

[15] https://www.datadictionary.nhs.uk/attributes/activity_identifier.html?hl=activity%2Cidentifier

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Data Item Name	Additional Notes
CARE ACTIVITY IDENTIFIER	The Care Activity Identifier is used to uniquely identify the care activity. It would normally be automatically generated by the local system upon recording a new activity, although could be manually assigned. This item is a primary key in the MHS202 Care Activity table and must be unique to this table. The Care Activity Identifier provides a link between records in the MHS202 Care Activity table and associated Coded Scored Assessments carried out during a care contact. We would like to remind providers of the importance of ensuring that the Care Activity Identifier is truly a unique data item, both within the same submission file and across multiple submission files. The Care Activity Identifier is a primary key for its respective table and is based upon the Activity Identifier[16] data attribute which is defined as "A unique number or set of characters that is applicable to only one Activity for a Patient within an Organisation". This reiterates that these identifiers should be unique across submissions. These identifiers will typically be auto generated by the system in use, so will prevent duplicates when using the same system. Where multiple systems are used it is acceptable to include a prefix to the Care Activity Identifier, which relates to the system. The prefix enables each identifier to remain truly unique for all submissions from an organisation.
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER	The Mental Health Act Legal Status Classification Assignment Period Identifier is used to uniquely identify the Mental Health Act Legal Status Classification Assignment Period. This item is a primary key in the MHS401 Mental Health Act Legal Status Classification Period table and must be unique to this table, within submission. The Mental Health Act Legal Status Classification Assignment Period Identifier provides a link between records in the MHS401 Mental Health Act Legal Status Classification Period table and associated MHA specific data.
HOSPITAL PROVIDER SPELL IDENTIFIER	The Hospital Provider Spell Number is used to uniquely identify the Hospital Provider Spell within Health Care Provider. This item is a primary key in the MHS501 Hospital Provider Spell table and must be unique to this table, within submission. The Hospital Provider Spell Number provides a link between records in the MHS501 Hospital Provider Spell table and associated Hospital Provider Spell and Ward Stay specific data.
WARD CODE	A unique identification of a Ward within a Health Care Provider. This item is a primary key in the MHS903 Ward Details table and must be unique to this table, within submission. The Ward Code also provides a link between the MHS903 Ward Details table and the MHS502 Ward Stay table.
WARD STAY IDENTIFIER	The Ward Stay Identifier is used to uniquely identify the patient Ward Stay within a Hospital Provider Spell. This item is a primary key in the MHS502 Ward Stay table and must be unique to this table, within submission.

[16] https://www.datadictionary.nhs.uk/attributes/activity_identifier.html?hl=activity%2Cidentifier

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Data Item Name	Additional Notes
	The Ward Stay Identifier provides a means for linking records in the MHS502 Ward Stay table with additional data associated directly with that Ward Stay.
CARE PROGRAMME APPROACH CARE EPISODE IDENTIFIER	The Care Programme Approach Care Episode Identifier is used to uniquely identify the Care Programme Approach Care Episode. This item is a primary key in the MHS701 Care Programme Approach (CPA) Care Episode table and must be unique to this table. The Care Programme Approach Care Episode Identifier provides a link between records in the MHS701 Care Programme Approach (CPA) Care Episode table and Associated Care Programme Approach Reviews.
CARE PROFESSIONAL LOCAL IDENTIFIER	The Care Professional Local Identifier is used to uniquely identify the care professional within provider. This item is a primary key in the MHS901 Staff Details table and must be unique to this table, within submission. The Care Professional Local Identifier provides a link between various tables and related Staff Details. Where a member of staff has multiple roles or works in more than one team concurrently, a separate record with a different Care Professional Local Identifier should be created to ensure correct staff characteristics such as Care Professional Staff Group and Main Speciality Code are attributed to each Care Contact and Activity.
CARE PROFESSIONAL TEAM LOCAL IDENTIFIER	The Care Professional Team Local Identifier is used to uniquely identify the Care Professional Team within a provider.
CARE PROFESSIONAL TEAM LOCAL IDENTIFIER (OTHER SERVICE OR TEAM)	A unique local identifier within a Health Care Provider used to identify any other team or service type that an additional Care Professional belongs to. This may be assigned automatically by the computer system.
ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)	The Organisation Identifier of the organisation that assigned the local patient identifier. This item is a foreign key in the MHS001 Master Patient Index table.
ORGANISATION IDENTIFIER (CARE PROFESSIONAL LOCAL IDENTIFIER)	The Organisation Identifier of the organisation that assigned the Care Professional local identifier. This item is a foreign key in the MHS901 Staff Details table.
ORGANISATION SITE IDENTIFIER (OF TREATMENT)	The Organisation Identifier of the Organisation Site where the Patient was treated. This item appears within the MHS201 and MHS301 tables.
CARE PLAN IDENTIFIER	This is a unique ID, which identifies each individual Care Plan within an organisation. This item is a primary key in the MHS008 Care Plan Type table and must be unique to this table, within submission.

5.1.1 SERVICE OR TEAM TYPE (MENTAL HEALTH)

The ‘Service or Team Type (Mental Health)’ data item is located in the new MHS902 Service or Team Details table.

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The previous iteration of this data item, 'Service or Team Type Referred To (Mental Health) has been removed from the MHS102 table. This data item captured the main service or team type that the patient had been referred to.

The MHS102 table has been renamed to "Other Service or Team Type" following a minor redesign of the data set structure. In v5.0 and previous, it was named "Service or Team Type Referred To". The table has also been re-purposed to capture the details of any other service or team that may be involved in the referral, for example where a multidisciplinary team is involved in treating the patient.

The main service or team type can now be identified via the new MHS902 Service or Team Details table. The MHS902 table is linked to the referral using the 'Care Professional Team Local Identifier' data item in the MHS101 Service or Team Referral table.

The new 'Care Professional Team Local Identifier (Other Service or Team)' appears in the MHS102 table, as well as the MHS201 Care Contact and MHS204 Indirect Activity tables, to enable the MHS102 table to be linked to care contacts and indirect activity to indicate where the other service has delivered the patient's care or indirect activity.

5.1.2 ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)

This data item repeats across a number of tables to ensure commissioners are able to access data that is necessary for them to undertake normal business and to also ensure that data cannot be accessed inappropriately:

Data Item Name	Additional Notes
ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	This is the Organisation Identifier of the organisation commissioning the provision of mental health care from the provider that initiated or commissioned the provision of care bound by the MHS101 Service or Team Referral record. This table will be for the entirety of the referral, and it is this table which identifies the commissioner who has paid for those services. For the MHSDS, the Organisation Identifier (Code of Commissioner) may typically relate to an ICB or an NHS England specialised commissioner for NHS-funded activity. However, the submission of ODS codes in this field is not restricted, particularly to allow the optional flow of non-NHS funded activity. Please refer to the additional information regarding the Integrated Care Boards (ICBs) and Integrated Care Services (ICSs) on our webpages. NHS Specialised Commissioner ODS codes are available alongside ICB codes in the ODS eccg data download[17] file. E.g. 14C - WEST MIDLANDS COMMISSIONING HUB. The NHS England 'Who Pays' guidance determines which NHS commissioner is responsible for commissioning healthcare services and making payments to providers. Further information can be found within section 4.7. NHS England are aware some services are commissioned and funded by charitable organisations outside of the NHS (e.g. national lottery), where the commissioner does not have an ODS code Interim guidance is to use the default commissioner code '"VPP00 - Private PATIENTS / Overseas Visitor liable for charge" for these arrangements. More granular default ODS codes are being considered for future use. Please refer to Appendix 8 - Commissioner Extract Inclusion Rules for a description of the purpose of this data item and how it should be used across

[17] https://digital.nhs.uk/services/organisation-data-service/data-downloads

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Data Item Name	Additional Notes
	multiple tables to ensure the correct responsible commissioner allocation of records. Please note, we recommend referring to the NHS England webpages for the most up to date guidance information on commissioners via the link referenced above. If you require further assistance determining commissioner responsibility, please contact england.responsiblecommissioner@nhs.net or your local commissioner.

Examples of ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)

MHS101 Service or Team Referral

This is the organisation identifier of the organisation that has initiated the provision of care under a referral or referral type. This can be used to identify a specialist commissioner.

The Organisation Identifier (Code of Commissioner) will remain the same in the MHS101 Service or Team Referral table for the entirety of the referral and it is this table which identifies the commissioner who has paid for those services.

The Organisation Identifier (Code of Commissioner) may typically relate to an ICB or an NHS England specialised commissioner for NHS-funded activity. However, the submission of ODS codes in this field is not restricted, particularly to allow the optional flow of non-NHS funded activity.

MHS201 Care Contact

This is the organisation identifier of the organisation that is commissioning health care provided by means of a care contact that has taken place as part of a referral.

MHS204 Indirect Activity

This is the organisation identifier of the organisation that is commissioning health care provided by means of an indirect care activity that has taken place as part of a referral.

MHS301 Group Session

This is the organisation identifier of the organisation that is commissioning health care provided by means of a group session as part of a referral.

MHS302 Mental Health Drop in Contact

This is the ORGANISATION IDENTIFIER of the ORGANISATION commissioning health care.

MHS512 Hospital Provider Spell Commissioner Assignment Period

This is the Organisation Identifier of the Organisation commissioning health care of a Commissioner Assignment Period during a Hospital Provider Spell as part of a referral.

Only one commissioner can be considered active at one time but can change during a patient's hospital provider spell.

When a record has been provided in the MHS501 Hospital Provider Spell table and there is no corresponding record in the MHS512 Hospital Provider Spell Commissioner table for the whole reporting period, or any part of a period created by a 'gap' in commissioner dates during a Hospital Provider Spell, the Organisation Identifier (Code of Commissioner) provided in the MHS101 Service or Team Referral Table must be used as the 'active' commissioner of the Hospital Provider Spell for this period.

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MHS517 Specialised Mental Health Exceptional Package of Care (EPC)

This is the Organisation Identifier of the Organisation commissioning the Specialised Mental Health Exceptional Package of Care (EPC) as part of the referral.

MHS608 Anonymous Self-Assessment

This is the organisation identifier of the organisation commissioning health care by way of a self-assessment as part of a referral.

6 Breakdown of Data Items by Table

Data items are listed in the following tables using the NHS DM&D data element names. New data items for v6.0 are listed in dark blue text

Links to new data items will not be available immediately following ISN publication.

Please note: data items are only included in this section where there is additional information provided that is not in the ETOS. If no additional information is available, the data item will not be included below.

This document is continually under review. Where data items do not have additional guidance, we will amend if suitable guidance becomes available.

Additional information on individual data items, can be found via the NHS DM&D webpage using the search bar.

Header

MHS000 Header

The Header should include metadata relating to the submission, including which organisation and reporting periods the data relates to, the primary system in use and the date/time the submission was created.

Data Item Name	Additional Notes
ORGANISATION IDENTIFIER (CODE OF PROVIDER)	This is the organisation Identifier that will be concatenated with any Local Patient Identifiers to form a unique "Local Patient Identifier" within the national database
ORGANISATION IDENTIFIER (CODE OF SUBMITTING ORGANISATION)	This field will normally contain the same Identifier as Organisation Identifier (Code of Provider), which is used to determine the Organisation Identifier of the Organisation acting as a Health Care Provider. It may be appropriate for the codes to differ, however provider and submitter should ensure that appropriate governance is in place for the flow of patient identifiable data between the two organisations. Further information can be found on the Information Governance pages of the NHS England website[18].
PRIMARY DATA COLLECTION SYSTEM IN USE	This is a free text field. Where multiple systems are in use, please indicate the primary system in use, from which the highest number of records is extracted.

[18] https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/codes-of-practice-for-handling-information-in-health-and-care

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Patient Demographics

MHS001 Master Patient Index

This table contains information on patient identifiers, demographic information and organisational data. The collection of these data items can be used to analyse outcomes across different ethnic groups, age groups and geographic location.

- This table should include a record for each patient receiving care within Mental Health, Learning Disabilities or Autism services.
- Please ensure that this table contains a record for all patients for whom activity is recorded within any of the other tables.
- Providers should supply MHS001 data as it was at the end of the reporting period.
- Providers must populate all known data items within this group even if they are unchanged since the last submission. Do not just provide data for all "changed" data items.
- Much of the data within this table will be obtained from the patient or their informal carer(s) on first registration and then checked with the patient at appropriate intervals.
- We have included some guidance on gender which has been produced by NHS England. This guidance can be found on the NHS England webpages, there is also additional guidance available. This document also contains a list of FAQs on why we need to collect data on gender and trans-status.

Data Item Name	Additional Notes
ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)	This identifies the Local Patient Identifier issuing organisation, for example: where organisations have gone through a merger or split. - If Local Patient Identifiers are not modified during the merger or split, then the issuing Organisation Identifier of the Local Patient Identifier (even if now discontinued) should be sent in this field. - If the Local Patient Identifier has been modified since the organisation change i.e. by prefix etc., then the new organisation identifier should be used.
ORGANISATION IDENTIFIER (EDUCATIONAL ESTABLISHMENT)	This will identify the organisation identifier of the educational establishment that the patient attends. If the patient does not attend an educational establishment, this data item can be left blank. The allocated identification numbers for submission can be obtained through the Organisational Data Service[19] who are supplied extracts from the Department for Educations (DfE) EduBase. The ID is derived from the DfE Unique Reference Number (URN) which is six digits, but this is prefixed with 'EE' on the ODS reference file. The organisation identifier should be current at the end of the reporting period. **Home Schooling** It is not possible to create an ODS code to capture Home Schooling at present. It is also not recommended using a default code on one concept, for example 'what school they go to', as the signifier of another, in this case 'are they home schooled'.

[19] https://digital.nhs.uk/organisation-data-service/data-downloads/non-nhs

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Data Item Name	Additional Notes
	We recommend submitting instances of home schooling via the MHS011 Social and Personal Circumstances table using the Receiving home tuition SNOMED CT concept.
NHS NUMBER	Where the NHS Number is not known, this should be left blank. NHS number[20] is the primary source of identification for patients in England and Wales and should be submitted; however, it is accepted that occasionally a patient will not have an NHS number therefore this data item is 'Required' and not 'Mandatory' in MHSDS. This ensures that data for the patient can still flow and data quality reports will be produced regarding completeness of this field.
NHS NUMBER STATUS INDICATOR CODE (MENTAL HEALTH AND MATERNITY)	This data item is 'Required' however it should always be completed, irrespective of whether an NHS number is present. In cases where a patient's NHS number is unavailable (which may be because the patient does not possess one) data providers should submit a null NHS number and [07] Number not present and trace not required in NHS Number Status Indicator Code. In most cases, this data item will be flowed with value [01] - Number present and verified. The [01] will indicate that the data provider has validated the number against the central Patient Demographics Service (PDS), and therefore facilitates reliable data linkage. Data providers may flow data for patients with an NHS number status indicator code other than [01] and they will be accepted, however, reports that need reliable linkage may exclude these records unless reliable linkage is available via Local Patient Identifier.
PERSON BIRTH DATE	Every effort should be made to identify the patient's correct date of birth, or date that the patient has estimated to be their date of birth. However, where the patient's DOB cannot be determined precisely, estimation should be provided. If it is not possible/appropriate to estimate, then the data item should be null. Estimates should not change once they have been made. Once the actual DOB is identified, it should be recorded and submitted correctly. When estimating a patient's DOB a consistent approach should be used, for example: use 1st July if only the year is known, 15th of the month if only the month is known, 1st January for beginning of the year, 31st December for end of the year, 25th December for Christmas etc.
POSTCODE OF USUAL ADDRESS	Please see the 'Technical Glossary' tab within the ETOS for further details regarding acceptable postcode formats and validations applied at the DSP. Where the person has no fixed abode, this should be recorded as ZZ99 3VZ. If the postcode is unknown ZZ99 3WZ should be used. For overseas residents, please use the pseudo country postcode found in the 'Country names and pseudo country postcodes in pseudo country postcode order' file on the NHS England web page: Data supplied by the Office of National Statistics[21]. The postcode will be recorded in the format ZZ99 xxZ, where xx denotes the country pseudo postcode.
GENDER IDENTITY CODE	This data item should capture how patients tell providers they would like their gender to be recorded and referred to by the service. It should be asked of the individual and is distinguishable from the Person Stated Gender Code, as it has

[20] https://digital.nhs.uk/services/nhs-number
[21] https://www.ons.gov.uk/

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Data Item Name	Additional Notes
	more inclusive gender options. This is to ensure that trans and non-binary people are being acknowledged and included by services. When filling in these questions face to face with the individual, it is recommended the person asking initially provides the options directly to the person completing the questions. An example is where a person describes themself as gender fluid. If there is not a gender fluid option to choose some people may be happy to be recorded as 'non-binary' whereas others would prefer to be recorded under 'other (not listed)'. If it is not possible to directly ask the individual, then select 'other (not listed)', to indicate that the list of options does not include the appropriate term for that individual. This data item should be completed using information provided by the patient as part of registrations and/or care contacts. It should not be completed by linkage to the NHS spine or assumed/inferred by the service. This means it may not match the gender recorded by other NHS services. The gender identity selected by a patient within a service should never be overwritten by information provided directly from other services or via the NHS Spine. This new gender identity data item is now the priority for providers to collect, largely replacing the previous item used. Please refer to the ETOS and the guidance on our webpages for additional details. Further details on Gender Identity can also be found here[22].
GENDER IDENTITY SAME AT BIRTH INDICATOR	This data item should be completed using information provided by the patient as part of registrations and/or care contacts. It should not be completed by linkage to the NHS spine or assumed/inferred by the service. This question should be asked of the individual by both their GP and by mental health services.
PERSON STATED GENDER CODE	This is the existing code used in PDS (Personal Demographics Service) which records somebody's stated gender. (This does not have to be their birth gender or their legal gender). This will record the person's gender at their GP (e.g. male or female) and will also match the PDS data which is provided by the GP. Note: Person Stated Gender Code and Gender Identity Code are different and have been included to prevent a breakdown with PDS. Please refer to the ETOS and the guidance on our webpages for additional details. Further details on Gender Identity can also be found here. National Code X 'Not Known (Person Stated Gender Code not recorded) ' means that the sex of a Person has not been recorded. National Code 9 'Indeterminate' means indeterminate, i.e. unable to be classified as either male or female.
ETHNIC CATEGORY	The information recorded about the patient's ethnic category must be obtained by asking the patient. Capture and submission of Ethnic Category within the MHSDS is required for ALL patients, and not only those subject to an inpatient stay. This is to support ethnic monitoring as required of public bodies under the Race Relations Amendment Act 2000.

[22] https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/submit-data/data-quality-of-protected-characteristics-and-other-vulnerable-groups/gender-identity

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Data Item Name	Additional Notes
	Codes [Z] – Not Stated, and [99] - Not Known should be applied as follows: The [Z] 'Not Stated' national code should only be used where the patient had been asked and had declined either because of refusal or genuine inability to choose. The [99] 'Not known' national default code should be used where the patient had not been asked or the patient was not in a condition to be asked. E.g. unconscious.
ETHNIC CATEGORY 2021	Placeholder data item to accommodate the 2021 census when it goes live. This pilot field should not be populated or submitted and this data item will become live once the census 2021 data and the Unified Information Standard for Protected Characteristics have been published.
LANGUAGE CODE (PREFERRED)	In order to populate this data item please select either: The two character code found in the ISO 639-1 Code column from the ISO 639.2 Codes for the Representation of Names of Languages (CRNL)[23]; code list; or one of the five communication method extensions detailed in NHS Data Model & Dictionary[24]. Please note: the format for this data item is an2. Only the ISO 639-1 Code column should be referenced. Please do not attempt to submit codes that appear in the ISO 639-2 Code column by truncating to two characters. In some cases, a valid code would be derived, however the valid code may link to a language that is unconnected to the intended language for submission. On submission validations would not be able to detect this therefore any reporting would include incorrect calculations related to preferred language.
PERSON DEATH DATE	This should be submitted for any known death, not only where a death certificate is issued.

MHS002 GP Practice Registration

MHS002 is a mandatory group that must be included whenever any other groups are transmitted that refer to this patient.

The group includes start and end dates for when the patient was registered with the practice.

Data Item Name	Additional Notes
GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION)	The following default ODS codes apply: • GP Practice Code not applicable - V81998 • GP Practice Code not known - V81999 • No Registered GP Practice - V81997 Please see General Medical Practice Code (Patient Registration) for information on the use of the above codes. We do not currently recommend recording branch surgery codes within this field. Please continue to submit the parent GP codes as these will continue to be assigned to the correct ICB. Further information can be found on the NHS Data Model and Dictionary webpage.

[23] http://www.loc.gov/standards/iso639-2/php/code_list.php
[24] https://www.datadictionary.nhs.uk/data_elements/language_code__preferred_.html?hl=language%2Ccode

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Data Item Name	Additional Notes
	For more general information on default codes, please visit Organisation Data Service Default Codes[25].
START DATE (GMP PATIENT REGISTRATION)	This field is primarily to track changes to the GP and their commissioner during the referral. This field should only be populated if the actual start date is known. If this is not known, then it is acceptable to leave this field blank. If the patient changes General Medical Practice whilst under the care of the service provider, then a new GP Practice Registration record should be submitted, and the start date of the patient's new General Medical Practice registration populated. The start date for the new GP can be the same date as the end date for the previous GP.
END DATE (GMP PATIENT REGISTRATION)	This field is primarily to track changes to the GP and their commissioner during the referral. If this field is left blank the General Medical Practice Code recorded in this table will be assumed to be current. If the patient changes General Medical Practice whilst under the care of the service provider, then it is expected that the end date of the previous General Medical Practice should be populated in the GP Practice Registration record, and new record submitted containing details of the new GMP Registration.

MHS003 Accommodation Status

One occurrence of this Group is permitted, containing the most recently recorded accommodation details.

This information should be submitted when reviewed and recorded as part of usual clinical practice, even if the status is the same, the review date would be updated.

Data Item Name	Additional Notes
SETTLED ACCOMMODATION INDICATOR	An indication of whether the main/permanent residence of the patient is settled accommodation. Settled accommodation' is 'reasonably secure or permanent accommodation. The expectation is that if someone can stay there for the foreseeable future or a significant length of time, then it is secure accommodation. Unsettled/insecure accommodation is 'precarious, temporary or transient accommodation'. This information should be captured and reviewed with patients periodically to ensure it's up to date. The information should be agreed by the patient and where appropriate their care worker/coordinator and any Carers should also have an input. Previously this was a key element of the formal CPA reviews but the CPA in many settings has been replaced by the community mental health framework for adults and older adults, and capturing this information should be an integral

[25] http://www.datadictionary.nhs.uk/web_site_content/supporting_information/organisation_data_service_default_codes.asp?shownav=1
https://www.datadictionary.nhs.uk/supporting_information/organisation_data_service_default_codes.html

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Data Item Name	Additional Notes
	element of the implementation of that framework. Additional mapping guidance is outlined within Appendix 9.1 - Accommodation Status.
ACCOMMODATION TYPE RECORDED DATE	This date should change with each review even if the Accommodation Type remains the same.
SECURE CHILDRENS HOME PLACEMENT TYPE	This data item is designed to be read in conjunction with the Accommodation Status Code to identify where the patient may have been placed in inappropriate accommodation. For example, where a patient is on a secure welfare placement, but may have been placed in accommodation solely designed for youth justice placements.

MHS004 Employment Status

One occurrence of this Group is permitted containing the most recently recorded employment details.

This is not limited to details recorded at formal CPA Reviews. If possible, this information should be captured at each contact. If not at each contact, it should be captured at least annually.

It is not intended for an employment status to flow for every patient, however if the information is recorded locally then it should flow.

Data Item Name	Additional Notes
EMPLOYMENT STATUS	**[01] Employed:** Employed refers to those who are employed by a company and have their National Insurance paid for directly from their wages. It also includes those who are self-employed, in supported employment, in permitted work and unpaid family workers. **[02] Unemployed and actively Seeking Work:** Unemployed refers to those who are not in paid work but are actively seeking work and are available to start or are waiting to start a paid job they have already obtained. Other Employment Status codes (03, 04, 05, 06, 07, 08) represent those who are not in paid work and who are not actively seeking work, or they are not available to start.
EMPLOYMENT STATUS RECORDED DATE	This is the date on which the assessment was done. This date should change with each review even if the Employment Status remains the same.
PATIENT PRIMARY EMPLOYMENT CONTRACT TYPE (MENTAL HEALTH)	This data item was introduced to allow the flow of data relating to patients working on zero-hour and variable hour contracts and other employment contract types. Please refer to the ETOS for the full list of national codes. Code- 08 refers to those people with no formal contract
WEEKLY HOURS WORKED	The number of hours worked in a typical week. This should be the typical weekly average for a month, where the hours could be variable.

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MHS005 Patient Indicators

One occurrence of this Group is permitted containing the current or most recently recorded status of indicator and psychosis information.

Indicators are required data items and should be submitted where they are applicable to the patient. For example, a forty-year-old patient could not be a young carer, and the indicator should be left blank. However, a sixteen-year-old patient may be a young carer but have not been asked the question as part of their care, therefore the indicator should be submitted as Not Known.

All date data items included in this table can be estimated if the precise date cannot be identified. When estimating dates please use a consistent approach, for example: use 1st July if only the year is known, 15th of the month if only the month is known, 1st January for beginning of the year, 31st December for end of the year, 25th December for Christmas etc.

Data Item Name	Additional Notes
PARENTAL RESPONSIBILITIES INDICATOR	The Parental Responsibilities Indicator is primarily to identify 'young parents' in contact with mental health services. However, this item is age agnostic and should be flowed in all instances where the information is recorded, there is no requirement to flow data that is not routinely collected as part of clinical practice
YOUNG CARER INDICATOR	**This data item is applicable to children and young people only.** This is an indicator for a child or young person who has a caring role for an ill or disabled parent, carer or sibling. A Carer is a person who is either providing or intending to provide a substantial amount of unpaid care on a regular basis for someone who is disabled, ill or frail. CAMH services using Current View may capture this information using "Complexity 2. Young carer status". This factor would be submitted as a Coded Finding in MHS202CAREACTIVITY. This Young Carer Indicator would then be completed/updated and continued to be submitted with the "most recent" status at end of each reporting period.
LOOKED AFTER CHILD INDICATOR	**This data item is applicable to children and young people only.** This is an indicator for a looked after child. A Looked After Child (also referred to as a Child Looked After) is a Person. A Looked After Child is a child in the care of a Local Authority either: • through a Care Order made by a Court; or • through a voluntary agreement with their parent(s) to accommodate them. They may be looked after: in a Children's Home by foster carers or other family members. All Unaccompanied Asylum-Seeking Children are also Looked After Children. CAMH services using Current View may capture this information using "Complexity 1. Looked after child". This factor would be submitted as a CODED FINDING in MHS202CareActivity. This Looked After Child Indicator would then be completed/updated and continued to be submitted with the "most recent" status at end of each reporting period.
LOOKED AFTER CHILD LEGAL STATUS	**This data item is applicable to children and young people only.**

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Data Item Name	Additional Notes
	This refers to the Children's Act 1989[26]: see details https://www.legislation.gov.uk/ukpga/1989/41/contents
CHILD PROTECTION PLAN INDICATION CODE	**This data item is applicable to children and young people only.** An indication of whether a person is, or has previously been, subject to a Child Protection Plan[27]. A Child Protection Plan is a Care Plan and should: • assess the likelihood of the child suffering harm and look at ways that the child can be protected. • decide upon short and long term aims to reduce the likelihood of harm to the child and to protect the child's welfare. • clarify people's responsibilities and actions to be taken; and • outline ways of monitoring and evaluating progress. CAMH services using Current View may capture this information using "Complexity 7. Current protection plan". This factor would be submitted as a Coded Finding in MHS202CareActivity. This Child Protection Plan Indication Code would then be completed/updated and continued to be submitted with the "most recent" status at end of each reporting period.
OFFENCE HISTORY INDICATION CODE	**Scope** This data item is applicable to secure Forensic Services only and MUST only be submitted for a person in reporting periods where they are under an open/active Hospital Provider Spell to such a service. This data item should not be populated where a person is not within a secure service (as commissioned by NHS England) or in relation to any other service type referrals. **Example** Where a person is transferred from a secure Forensic Mental Health service to a non-forensic service, this data item should continue to be populated for the reporting period where the transfer occurs in, but then should no longer be submitted in subsequent reporting periods. **Local Collection** As a secondary uses data set, the MHSDS intends to re-use clinical and operational data for purposes other than direct patient care. It defines the data items, definitions, and associated value sets to be extracted or derived from local information systems. Therefore, this data item should only be submitted if the included category mapping has been implemented locally and is collected and maintained locally with appropriate governance in place. For any primary use concerns, consult local arrangements as agreed with Caldicott Guardians and Clinical Leads in first instance. Guidance for data and information handling and sharing at both operational and secondary uses levels exists nationally. Please see section '3.2 Information Governance' of the latest Implementation Guidance[28] for further information.

[26] https://www.legislation.gov.uk/ukpga/1989/41/contents
[27] https://www.datadictionary.nhs.uk/data_elements/child_protection_plan_indication_code.html
[28] https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dcb0011-mental-health-services-data-set

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Data Item Name	Additional Notes
	For further guidance on the effective commissioning of these specialised secure mental health services and the relationship between offence history and service delivery including assessment, treatment and length of stay, please see section 6 of the NHS England Manual for Prescribed Specialised Services[29]. **Data Item Guidance** As per the guidance on the NHS Data Model and Dictionary, this data item should continue to be rated using the following guidance: *3 Yes - Serious offence:* including murder, attempted murder, rape, GBH with intent, arson with intent. Does not include indecent assault or ABH, simple arson or robbery and/or national notoriety. *2 Yes - Less serious offence:* those offences not covered under Serious Offence. Only convicted or index offences should be recorded as 2 or 3. Alleged offences would not be included and would be coded as “1 No – No offence”.
PSYCHOSIS FIRST TREATMENT START DATE	This is the date the patient commenced prescribed medication and was compliant. For the majority of people, the 'Psychosis Treatment Start Date' will be the same date as the date of 'Psychosis Prescription Date'.
PATIENT DIAGNOSIS STATUS (LEARNING DISABILITY)	. To identify whether a patient has a learning disability, a possible learning disability or no learning disability. Where a patient has a suspected learning disability, to identify if that patient is on a diagnostic pathway. Information should be collected and recorded for all patients who are referred and who are accessing all services. The information should be submitted for all patients and for every month where they have open and active referrals. This field should be regularly reviewed and updated as and when the diagnosis status changes. The Transforming Care data items have been removed in v6.0 as they only enabled identification of patients accessing inpatient services. This data item replaces the previous Transforming Care data items with the purpose of identifying patients accessing all mental health services. **Clinical involvement in diagnosis** In relation to the national codes below, the opinion of the patient or their parent(s) is not sufficient to be classed as a diagnosis, there has to have been clinical involvement or assessment. 2 - Suspected patient diagnosis of a learning disability and the patient is on a diagnostic patient pathway for a patient diagnosis of a learning disability - a clinician will have already been involved as the person is on the diagnostic pathway 3 – Suspected patient diagnosis of a learning disability but the patient is not on a diagnostic patient pathway for a patient diagnosis of a learning disability- clinical assessment has taken place and diagnosis is considered possible
PATIENT DIAGNOSIS STATUS (AUTISM)	To identify whether a patient is autistic, has suspected autism or is not autistic. Where a patient has suspected autism, to identify if that patient is on a diagnostic pathway. Information should be collected and recorded for all patients who are referred and who are accessing all services. The information should be submitted for all

[29] https://www.england.nhs.uk/publication/manual-for-prescribed-specialised-services/

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Data Item Name	Additional Notes
	patients and for every month where they have open and active referrals. This field should be regularly reviewed and updated as and when the diagnosis status changes. The Transforming Care data items have been removed in v6.0 as they only enabled identification of patients accessing inpatient services. This data item replaces the previous Transforming Care data items with the purpose of identifying patients accessing all mental health services. **Clinical involvement in diagnosis** In relation to the national codes below, the opinion of the patient or their parent(s) is not sufficient to be classed as a diagnosis, there has to have been clinical involvement or assessment. 2 - Suspected patient diagnosis of autism and the patient is on a diagnostic patient pathway for a patient diagnosis of autism - a clinician will have already been involved as the person is on the diagnostic pathway 3 – Suspected patient diagnosis of autism but the patient is not on a diagnostic patient pathway for a patient diagnosis of autism - clinical assessment has taken place and diagnosis is considered possible

MHS006 Mental Health Care Coordinator

A Mental Health Care Coordinator is a professional member of staff working in specialist Mental Health services, who has been named and allocated as Care Coordinator to the patient.

Patients on the CPA will have a named Care Coordinator assigned who will be responsible for coordinating all care for the patient. Care for patients not on CPA will be coordinated by one or more ‘Lead Professionals', whose responsibility can be specific to a single pathway, for example Early Interventions in Psychosis (EIP), or coordinating multiple pathways, for example co-morbid conditions. Where specific to a single pathway, the role of a Lead Professional may encompass elements of patient engagement and biopsychosocial formulation.

This table should include a record for each assignment of a Mental Health Care Coordinator or Lead Professional to a patient - not only those formally assigned on CPA.

The personal identifier of the Care Coordinator or Lead Professional should correspond to a record containing the details of the Care Coordinator or Lead Professional in the MHS901 Staff Details table.

Data Item Name	Additional Notes
CARE PROFESSIONAL SERVICE OR TEAM TYPE ASSOCIATION (MENTAL HEALTH)	Where a care professional is associated with the work of more than one service or team within provider, the Care Professional Service or Team Type Association (Mental Health) should relate to the team on whose behalf the Care Professional is working as Care Coordinator or Lead Professional for the patient. This data item will be used for the calculation of some waiting times. For example: Early Intervention in Psychosis waiting times, where allocation of an EIP Lead Professional forms part of the requirements signifying the end of the waiting time or ‘clock stop’. **Team specific guidance**

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	For team specific guidance, please see Section 5.1.1.

MHS007 Disability Type

The main focus of this table is to provide information about disabilities where they are present, however providers can choose to submit records for NN or ZZ should they record this locally. Records submitted against either of these codes will be classed as 'Other' for the Data Quality Measures.

Data Item Name	Additional Notes
DISABILITY CODE	**[01] Behaviour and Emotional** should be used where the patient has times when they lack control over their feelings or actions. **[02] Hearing** should be used where the patient has difficulty hearing, or need hearing aids, or need to lip-read what people say. **[03] Manual Dexterity** should be used where the patient experiences difficulty performing tasks with their hands. **[04] Memory or ability to concentrate, learn or understand (Learning Disability)** should be used where the patient has difficulty with memory or ability to concentrate, learn or understand which began before the age of 18. **[05] Mobility and Gross Motor** should be used where the patient has difficulty getting around physically without assistance or needs aids like wheelchairs or walking frames; or where the patient has difficulty controlling how their arms, legs or head move. **[06] Perception of Physical Danger** should be used where the patient has difficulty understanding that some things, places or situations can be dangerous and could lead to a risk of injury or harm. **[07] Personal, Self-Care and Continence** should be used where the patient has difficulty keeping clean and dressing the way they would like to. **[08] Progressive Conditions and Physical Health (such as HIV, cancer, multiple sclerosis, fits etc.)** should be used where the patient has any illness which affects what they can do, or which is making them more ill, which is getting worse, and which is going to continue getting worse. **[09] Sight** should be used where the patient has difficulty seeing signs or things printed on paper or seeing things at a distance. **[10] Speech** should be used where the patient has difficulty speaking or using language to communicate or make their needs known. **[XX] Other (not listed)** should be used where the patient has any other important health issue including dementia or autism. **[NN] No Disability** **[ZZ] Not Stated** (Person asked but declined to provide a response)
DISABILITY IMPACT PERCEPTION	This data item should record patient perception of the impact of their disability. The level of disability can also be determined by the patient's proxy. If the impact of the disability cannot be determined by reference to either the patient or patient proxy it should be left blank. If either of the NN or ZZ options are chosen, Disability Impact Perception should be left blank as this will not be applicable.

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MHS008 Care Plan Type

This table needs to be submitted for every patient who has a Care Plan. However, only plans that are in place and active within the reporting period should be submitted each month.

Plans that have historically been replaced or are no longer relevant for the reporting period are not required for submission. However, in instances where providers have more than one plan and are using the earliest iteration of a plan that that falls within a referral spell, they can use the plan created first (earliest) as the earliest clock-stop.

Additional Guidance:

An Urgent and Emergency Mental Health Care Plan is a plan jointly agreed and created while the person is experiencing crisis during that immediate episode of care. This plan is about immediate management of risk to the patient and others and describes what the immediate next steps are such as inpatient admission, signposting to safe haven, discharge if crisis has resolved or referral to home treatment etc.

This differs from the Mental Health Crisis Plan, which instead is usually created when the person is well and contains information about what should be done or needs to happen in the event of a crisis.

A Positive Behaviour Support Plan is an individualised care plan which is available to those who provide care and support, and should be informed by functional assessments. People and their families should be as fully involved as possible in developing and reviewing the plan.

For further information on Positive Behaviour Support Plans and the wider positive behaviour framework, see the PBS Academy website[30].

Data Item Name	Additional Notes
CARE PLAN TYPE (MENTAL HEALTH)	Please refer to the NHS Data Model and Dictionary pages (Business Definitions) for additional information **10 – Mental Health Care Plan** A Mental Health Care Plan is a plan of the treatment or health care to be provided to a mental health patient for a care activity or within an activity group. **11 - Urgent and Emergency Mental Health Care Plan** An Urgent and Emergency Mental Health Care Plan aims to develop strategies to help people stay safe and establish a network of support. **12 – Mental Health Crisis Plan** **13 - Positive Behaviour Support Plan** A Positive Behaviour Support Plan is created to help understand and support children, young people and adults who have a Learning Disability and display behaviour that others find challenging. **14 - Child or Young Person's Mental Health Transition Plan** A Child or Young Person's Mental Health Transition Plan is a joint-agency plan to prepare for transition out of Children and Young People's Mental Health

[30] http://pbsacademy.org.uk/

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Data Item Name	Additional Notes
	Services (CYPMHS) as a consequence of the patient's age or change to care needs.

MHS009 Care Plan Agreement

One occurrence of this table is permitted for each **agreement** of a Care Plan.

The table can flow multiple times in relation to one care plan where there is more than one person, team or organisation agreeing to the care plan.

Where the patient is incapacitous, a record with national code 10 – PATIENT or patient proxy would only be expected if the care plan has been agreed with the patient proxy.

Data Item Name	Additional Notes
FAMILY INVOLVED IN CARE PLAN INDICATOR	This only needs to be captured for inpatients that are in scope of Transforming Care, which is people with a learning disability and autistic people in a mental health inpatient setting. Code 'X Not applicable' should be used for patients who are not in scope.
FAMILY NOT INVOLVED IN CARE PLAN REASON	This only needs to be captured for inpatients that are in scope of Transforming Care, which is people with a learning disability and autistic people in a mental health inpatient setting. Code '98 Not applicable' should be used for patients who are not in scope.
CARE PLAN CONTENT AGREED BY	If a patient is incapacitous, they may have had little or no input into the agreement, however an agreement is still in place and information can flow. If a clinician has had a conversation with a member of the patient's family to agree on appropriate care for the incapacitous patient, then two records should flow. One to indicate that the clinician has agreed the care plan (13 – Clinical Service or Team) and one to indicate that the family member has agreed the care plan (15 - Family member or carer with parental responsibility or 17 - Family member or carer without parental responsibility). There is no agreement directly with the patient, and therefore no record to indicate patient agreement. If the only discussion that has taken place regards a patient's care plan is between a clinician and an incapacitous patient, this would not be sufficient to merit an agreement, as the patient is unable to understand or consent to the plan. In this scenario, the information should not flow in the care plan agreement table.

MHS010 Assistive Technology To Support Disability Type

There is no further additional information for this data table. All relevant detail about the data items can be found in the ETOS.

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MHS011 Social and Personal Circumstances

Services are required to submit the following circumstances as a minimum, where data is collected locally. NHS England do not place any restrictions on the activities or interventions that service providers can demonstrate through clinical terminology.

Religious or Other Belief System Affiliation Group Code or Religious or Other Belief System Affiliation Code

NHS DM&D link: Religious or Other Belief System Affiliation Group Code[31]

NHS DM&D link: Religious or Other Belief System Affiliation Code[32]

Person stated sexual orientated code

NHS DM&D link: Person Stated Sexual Orientation Code[33]

Please see the DCB2094 Sexual Orientation Monitoring[34] webpage for further details regarding this separate information Standard. In particular, Appendix A of the Implementation Guidance[35] contains a mapping table for the national codes.

Asylum Seeker Status

Information about asylum seeker status should be submitted to the data set where this is naturally recorded as part of clinical practice.

There are two levels of granularity enabling services to capture information to identify whether the person is an Asylum Seeker or Refugee and to further expand with 5 codes relating to the status of the Asylum Seeker.

SNOMED-CT Concept ID	SNOMED-CT Concept Preferred Term
390790000	Asylum Seeker
728611000000100	Asylum seeker awaiting decision on refugee status
728621000000106	Asylum seeker with application for asylum refused
729851000000109	Asylum seeker with discretionary leave to remain
728631000000108	Asylum seeker with humanitarian protection status
748241000000103	Unaccompanied child asylum seeker
446654005	Refugee

Home schooling

We recommend using the SNOMED CT concept Receiving home tuition to record instances of home schooling as there is no ODS code to submit in Organisation Identifier (Educational Establishment).ational Establishment).

General Table Guidance

[31] https://www.datadictionary.nhs.uk/attributes/religious_or_other_belief_system_affiliation_group_code.html
[32] https://www.datadictionary.nhs.uk/data_elements/religious_or_other_belief_system_affiliation_code.html
[33] https://www.datadictionary.nhs.uk/attributes/person_stated_sexual_orientation_code.html
[34] https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dcb2094-sexual-orientation-monitoring
[35] https://digital.nhs.uk/binaries/content/assets/website-assets/isce/dcb2094/2094512105guidance.pdf

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Please see the NHS Data Model and Dictionary for further information regarding the definitions and code lists for these data elements.

Please note that submission must be made using the specified SNOMED CT subsets for each data element, which can be found via the SNOMED CT Term Browser.

- Open up the NHS England SNOMED CT Browser
- Click the 'Go Browsing' and 'Search' tabs
- Enter the word the appropriate term for your search, for example 'religious', 'sexual orientation'
- Filter for 'foundation metadata concept'
- Click on the correct result
- Click on the member's tab

This will provide the full list of available SNOMED codes for the relevant Social and Personal Circumstances.

The SNOMED CT subsets for both data elements are aligned 1:1 with the NHS Data Model and Dictionary National Codes.

For further information and guidance, please refer to the SNOMED CT page on the NHS England website.

MHS012 Overseas Visitor Charging Category

Please see the Overseas Visitor Charging Category (OVCC)[36] fundamental standard for more information on the recording of the Overseas Visitor Charging Category.

Data Item Name	Additional Notes
OVERSEAS VISITOR CHARGING CATEGORY	This is the charging category relating to a patient's overseas visitor status and should be recorded using the appropriate national codes. There are 8 distinct categories. Category A (Standard NHS-funded Patient) applies when a patient has been resident in the UK and has permission to be in the UK for over 12 months. Therefore, all patients other than those living in the UK without immigration permission become eligible for NHS treatment on reaching the anniversary of their arrival to the UK. If a patient has always been resident in the UK, then code A Standard NHS-funded patient should be recorded.
OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE FROM DATE	The date when the patient's Overseas Visitor Charging Category was applicable from. If the applicable date is not available, this should be the date the Overseas Visitor Charging Category was recorded. The Overseas Visitor Charging Category Applicable Date can be used in conjunction with the Referral Request Received Date and the Service Discharge Date to identify which referral the OVCC relates to.

[36] https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dcb3017-overseas-visitor-charging-category-ovcc

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MHS014 eMED3 Fit Note

This table is designed to allow information about electronic fit notes issued in secondary care to be submitted to MHSDS, in support of the DAPB4011 eMED3 Fit Notes in Secondary Care information Standard[37].

Additional information is available on the FutureNHS webpages[38]. If you are not an existing user, you will need to register for an account to access the information.

Further additional information on who can issue fit notes, can be found on the Department for Work and Pensions[39] pages with additional guidance here[40].

Please refer to the ETOS for additional information.

Referrals

MHS101 Service or Team Referral

Please refer to section 4.1 of this document for more information about the changes to referral submissions in v6.

A referral is a request for care to be provided for a patient. It includes admission to hospital and self-referrals.

List of key points

- The Service Discharge Date should always be populated alongside the Referral Rejection Date, even if the referral has been rejected. This is in order to make it clear that in those circumstances where it may take a few days from a patient being referred, to the referral being rejected, that this then makes it clear that the patient is no longer under the care of that service.
- Both external and internal referrals should be reported.
- All data submissions for a service user must be accompanied by a linked referral. If the MHS101 Referral table is not included, with all mandatory data items submitted as a minimum, no other data can flow for that service user.
- If this table is blank within a submission file, the whole file will be rejected.
- The table includes referrals that were received but subsequently rejected by the provider.
- A patient may have multiple referrals or admissions within a reporting period.
- All referrals starting, ending or open/active within reporting period should be flowed with every submission for each period.

[37] https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dapb4011-emed3-fit-notes-in-secondary-care
[38] https://future.nhs.uk/system/login?nextURL=%2Fconnect%2Eti%2FDWPDigitalFitNoteSecondaryCare
[39] https://www.gov.uk/government/publications/who-can-issue-fit-notes-guidance-for-healthcare-professionals-and-their-employers/who-can-issue-fit-notes-guidance-for-healthcare-professionals-and-their-employers
[40] https://www.gov.uk/government/collections/fit-note#full-publication-update-history

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- It is acceptable to submit all of the team referrals into the MHS101 table if only one service or team is involved in that referral. The service type will now be captured in the new MHS902 Service or Team Details table.
- Where multiple services or teams are working and are funded together under a single referral, to support a specific care need of a patient, this would require additional submission(s) into the MHS102 Other Service or Team Type table, in order to identify those additional services or teams.
- Where each service starts at a different time, this would be more appropriately modelled as individual referrals in MHS101. If you have a service that has several pathways which run separately or concurrently (e.g Core CYPMH, ADHD, ASD0), each with their own separate referral. Each referral will need to be treated separately within the MHS101 table (with a unique Service Request ID).
- If you are a service that has different CYP pathways, depending on the specific pathway, there are quick guides available on what data items you might be expected to record in the MHSDS, to have your data counted against specific metrics.
- With the introduction of v6, there is a new table to record team details (MHS902). This captures the details of individual teams, linked using the Care Professional Team Local ID. Within the MHS902 table, you are then able to describe the service or team type the patient was referred to (ServTeamTypeMH) and the intended age group of patients treated by a specific team (ServTeamIntAgeGroup).

- The MHS902 table would then be linked using the ID to the MHS101 table, as the main team which is part of the individual referral. If there are more than one team involved under the single referral, further details would then be captured in the MHS102 table, which captures details off additional services or teams involved in the same referral. There has been a published Quick guide to submitting Service or Team Type.

Example 1 - If you had an initial referral to A01 Day Care Service, which also involved the C06 Looked After Children Service as part of a multidisciplinary referral to support the same care need, this would require a submission into the MHS101 table (with the A01 Day Care Service recorded in a linked MHS902 table) and also a submission into the MHS102 table (also with a linked MHS902 table to capture the C06 Looked After Children Service that is also involved in that referral).

Example 2 - If you had two, three, or four separate referrals, you would be expected to submit two, three or four referrals as separate instances of the MHS101 table with unique Service Request Identifiers for each. The ‘Care Professional Team Local Identifier’ data item within the new MHS902 Service or Team Details table then enables a linkage to the referral within the MHS101 table where this data item also sits to identify the service involved in each referral.

Identifying Start/End Dates

This table must contain a record for each distinct period of care by an individual service/team for the patient. This record should identify the start date of the period of care (Referral Request Received Date) and the end date (Service Discharge Date) once this becomes available.

This period of care may be identified in PAS’ or other systems as a ‘referral’. Where the concept of a referral does not exist, the dates may be determined by the presence of specific

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dates held by the system that mark the start and end date of a distinct period of care and can be mapped to the data items required for submission.

For example, the start and end dates of a Hospital Provider Spell (if appropriate). In which case, Start Date (Hospital Provider Spell) = Referral Request Received Date and Discharge Date (Hospital Provider Spell) = Service Discharge Date.

It may be that the start date for a hospital provider spell represents the beginning of a period of care (Referral Request Received Date), but following discharge from hospital, care continues under the same service on an outpatient basis. In this instance Service Discharge Date would be recorded when the patient concludes their outpatient appointments.

Where the provider data items used to represent the Referral Request Received Date or Service Discharge Date suggest more than one date could be used, consideration should be given to whether it is more appropriate to submit a single referral with more than one associated service/team type or multiple internal referrals – the data set does not prevent a service or team from making an internal referral to itself if necessary.

If by mapping data items to the referral, key identifiers appear to be duplicated, for example if the Service Request ID required as a primary key for the Service or Team Type Referral table is the same ID as the Hospital Provider Spell Number required by the Hospital Provider Spell table, there are various ways this could be resolved. One example is to add a prefix to one of the IDs. E.g. Hospital Provider Spell Number 12345 becomes Service Request ID SR12345. Please ensure that the basic rules applied to the IDs are followed such as maximum number of characters and that there is no duplication within the tables for which they are a primary key.

Recording Health Based Place of Safety Service for members of the public detained by the Police under Section 136 of the Mental Health Act who need a mental health assessment

The initial assessment for a Health Based Place of Safety Service should be submitted as a referral using the MHS101 Service or Team Referral table. This activity does not qualify as an admission and should not be submitted in the MHS501 table.

The MHS101 Service or Team Referral table should be submitted with an associated record in the MHS902 Service or Team Details table. This MHS902 submission should include the national code A20 – Health Based Place of Safety Service for the Service or Team Type (Mental Health) data item.

Data Item Name	Additional Notes
CARE PROFESSIONAL TEAM LOCAL IDENTIFIER	A unique local Care Professional Team Identifier within a Health Care Provider which may be assigned automatically by the computer system. This data item was added to the MHS101 Service or Team Referral table as part of the minor re-design of the data set structure for v6.0 which included the addition of the MHS902 Service or Team Details table. This data item also appears in the MHS902 Service Details table to link the referral to the service/team.
REFERRAL REQUEST RECEIVED DATE	For both electronic and written referral requests the date that the request was received should be used and NOT the date that the referral was read, processed, or actioned i.e. the date stamped as the date of receipt and not the date entered onto a system. For referral requests received by telephone use the date of the follow up letter if received, otherwise the date of the phone call.

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Data Item Name	Additional Notes
	For further guidance on what constitutes the Referral Request Received Date please see the NHS Data Model and Dictionary[41]. The Referral Request Received Date typically forms a key part of waiting times calculations in support of the NHS Payment Scheme[42] (previously referred to as the National Tariff Payment System).[43]
REFERRAL REQUEST RECEIVED TIME	This data item records the time the Referral Request was received. This item should be completed in all cases, however it is especially important to record this accurately in those pathways where response times are measured in hours. This data item should be submitted where available. Submission is important for priority referrals into services with target waiting times measured in hours. E.g. urgent and emergency mental health care.
NHS SERVICE AGREEMENT LINE IDENTIFIER	A number (alphanumeric) to provide a unique identifier for a line within an NHS Service Agreement. An NHS Service Agreement is a formal agreement between a Commissioner organisation and one or more Health Care Provider organisations for the provision of patient care services. This data item is primarily for local use and enables Health Care Providers to associate specific referrals or referral types with unique service lines agreed with their Commissioners. Both providers and commissioners can agree to use this data item to identify patients on specific funding pathways.
SPECIALISED MENTAL HEALTH SERVICE CATEGORY CODE	The 'Specialised Mental Health Service Category Code' is expected to be completed within the MHSDS where a record/s relate to a Specialised Mental Health service. Further information on specialised services and the Specialised Mental Health Service Codes can be found in the Price activity matrix (PAM) on the NHS England webpages - NHS England » NHS England service codes by year 2025/26 There is also a link to the specialised mental health service category codes with the Technical Glossary tab in the Enhanced Technical Output Specification (ETOS).
SOURCE OF REFERRAL FOR MENTAL HEALTH SERVICES DATA SET	For further guidance with regard to Source of Referral For Mental Health Services Data Set Please see the [44] Where a data provider has a more extensive list of referral sources, then they should be mapped to an appropriate value stated in the output data item list. Where it is not possible to map a value against those stated in the output data item list then this should be mapped to the code '[M6] Other Service or Agency.' The following codes are new for v6.0 of the MHSDS.

[41] https://www.datadictionary.nhs.uk/attributes/referral_request_received_date.html
[42] https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/
[43] https://www.england.nhs.uk/pay-syst/national-tariff/
[44] https://www.datadictionary.nhs.uk/attributes/source_of_referral_for_mental_health_services_data_set.html?hl=source,referral,mental,health,services,data,sethttps://www.datadictionary.nhs.uk/attributes/source_of_referral_for_mental_health_services_data_set.html

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Data Item Name	Additional Notes
	[I1] Temporary transfer from another Mental Health Service (NHS-funded) **[I2] Permanent transfer from another Mental Health Service (NHS-funded)** **[Q2] Education-based Mental Health Support Team**
ORGANISATION IDENTIFIER (REFERRING ORGANISATION)	The Organisation Identifier of the organisation from which the referral is made, such as a GP Practice, NHS Trust or NHS Foundation Trust. The format for this data item is 'min an3 max an8'. This was changed in the MHSDS v6.0 uplift to allow the flow of school organisation identifiers, which are 8 characters - 2 alpha, 6 numeric i.e., an8.
REFERRING CARE PROFESSIONAL TYPE (MENTAL HEALTH)	This will indicate the staff group of the Care Professional referring the patient into the mental health service. This data item is not required where the referrer is not a care professional e.g. self-referral, carer or employer. In this circumstance this data item should be left blank (NULL).
CLINICAL RESPONSE PRIORITY TYPE	This indicates the Clinical Response Priority of a Service Request. The definition for each Clinical Response Priority Type code varies dependant on care pathway. Clinical Response Priority definitions align with the UK Mental Health Triage Scale. Within the MHSDS, the Clinical Response Priority Type within the MHS101 Service or Team Referral Table, contains the following code list: 1 Emergency 2 Urgent/Serious 3 Routine 4 Very Urgent Using the UK Mental Health Triage Tool as a guide, code 1 would map to triage code A. Code 2 would map to a triage code of C. Code 3 would map to triage codes D to G. Code 4 would map to triage code B For service requests to a Liaison Psychiatry Team the definitions are as defined by the Royal College of Psychiatrists[45]. In addition, an 'Emergency' response will indicate that the Patient was referred as a result of Emergency Care.
PRIMARY REASON FOR REFERRAL (MENTAL HEALTH)	This is the presenting condition or symptom for which the patient was referred **to** the Mental Health Service. This will usually accompany the initial referral to the service.

[45] https://www.rcpsych.ac.uk/

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Data Item Name	Additional Notes
	If multiple presenting conditions are recorded without clear indication of which is the primary reason, then one primary reason for referral should be selected based on local decision. Please see Appendix 1 - Reason for Referral Guidance for further guidance relating to specific codes.
REASON FOR OUT OF AREA REFERRAL (ADULT ACUTE MENTAL HEALTH)	Please see Appendix 5 - Out of Area Placements for contextual and general information about Out of Area Placements and how the data collection will be undertaken through the MHSDS. Please also refer to the additional information on OAPs which can be found on our webpages. **National Code 10 - Unavailability of hospital bed at referring organisation***:* "Unavailability of hospital bed at referring organisation", refers to when someone is placed out of area due to the unavailability of a local bed, this is deemed an Inappropriate OAP. **National Codes 11-15 inclusive** - These are deemed Appropriate OAPs. **National code 11** – Safeguarding concern. **National Code 12 – Offending Restrictions** - This code can be used where an offending restriction has resulted in a referral for an Out of Area Placement. For example, a person may have offending restrictions, such as an anti-social behaviour order or a restraining order, that mean they are not able to go/live/stay in certain postcodes. These orders would still apply if the person needed to be admitted into an inpatient unit, so in this case the person's 'home/local' provider would have to place them Out of Area in order to comply with the person's offending restrictions. **National Code 99 - Not Known (Not Recorded) -** This should only be completed where a person with assessed acute mental health needs, who requires adult mental health inpatient care is admitted to a unit that does not form part of the usual local network of services and the reason for this placement is unknown. It should not be completed where the patient is not an Appropriate or Inappropriate OAP. There is a national commitment to end the use of inappropriate OAPs for adult acute mental health care as soon as possible. Please Note: if a patient has **not** been referred Out of Area, the Reason for Out Of Area Referral (Adult Acute Mental Health) should not be populated and consequently left blank. A reason should only be recorded in circumstances where a patient has been referred Out of Area, as per the definition.
DECISION TO TREAT DATE (MENTAL HEALTH HOME TREATMENT)	The date that it was first identified that the patient needs mental health treatment, but the formal service request has not yet been created. However, the patient may be formally under the care of the Home Treatment Service. This applies to home treatments. The home treatment functions apply to all ages, both adult and children and young people.
DECISION TO TREAT TIME (MENTAL HEALTH HOME TREATMENT)	The time that it was first identified that the patient needs mental health treatment, but the formal service request has not yet been created. However, the patient may be formally under the care of the Home Treatment Service. This applies to home treatments.

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Data Item Name	Additional Notes
	The home treatment functions apply to all ages, both adult and children and young people.
DISCHARGE PLAN CREATION DATE	A Discharge Plan should contain information such as: • The planned date and time of discharge • The treatment and support the patient will receive when discharged. • Arrangements for transfer to the planned discharge destination, such as planning for returning home or transfer to another care facility. • Agreements to the Discharge Plan by relevant individuals such as the patient, family, care professional or commissioners • Any onward referrals to home care agencies and/or appropriate support organisations in the community where required.

MHS102 Other Service or Team Type

Please refer to section 4.1 of this document for more information about the changes to referral submissions in v6.

Referrals

If only one team or service is involved in the care of the patient, the MHS102 Other Service or Team Type table does not need to be submitted. This is due to the introduction of the new MHS902 Service or Team Details table to capture service and team details and the minor redesign of the structure as a result. table to capture service and team details and the minor redesign of the structure as a result.

The primary team in MHS101 Service or Team Referral is identified via linkage to the new MHS902 table. The MHS102 table now only captures details of any other team or service that is involved in the same referral.

Please refer to Section 4.1 for additional details.

General guidance

This table should only be completed where the referral is to a community service and is not required for inpatient services. For inpatient services, the relevant Hospital Provider Spell and Ward Stay data items must be completed, including the Hospital Bed Type.

A full list of Hospital Bed Types is included in Appendix 10 - Definitions for Service or Team Types and Hospital Bed Types.

This table is designed to capture additional services or teams which are involved in the same referral. An example is where multiple services/teams are working and are funded together under a single referral to support a specific care need of a patient. In this instance, each additional service element (MHS102) must start at the same time as the referral (Referral Request Received Date) but may end at different points across the overarching referral. Where each service starts at a different time, this would be more appropriately modelled as individual referrals in MHS101 - Service or Team Referral.

Please refer to the detail outlined within the MHS101 - Service or Team Referral table above for clear definitions.

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Data Item Name	Additional Notes
CARE PROFESSIONAL TEAM LOCAL IDENTIFIER (OTHER SERVICE OR TEAM)	This is in addition to the Care Professional Team Local Identifier for the Service that the Patient was referred to.
REFERRAL CLOSURE REASON	A referral must either be rejected or closed. The Referral Rejection Reason and the Referral Closure Reason data items relate to different points in the patient journey. If a patient is rejected by the service, we would expect it to be for one of the three reasons outlined in the referral rejection reason. If the patient is not rejected, then at some point later in time, their referral will be closed, probably because of completed treatment, or onward referral to another service. When this occurs, we would expect one of the referral closure reasons to be recorded. Where a low-level intervention occurs, such as signposting, this will either be conducted by the referrer, in which case it is not information the referred-to service is expected to record or flow, or it takes place in the referred-to organisation. If it occurs in the referred-to organisation then, although a low-level intervention, the referral was not rejected, and a referral closure reason would apply.
REFERRAL REJECTION REASON	For guidance regarding the difference between the referral closure reason and the referral rejection reason please see Referral Closure Reason above.

MHS103 Other Reason for Referral

This group should only be included for submission when other additional reasons for referral are recorded in the patient's record.

Data Item Name	Additional Notes
OTHER REASON FOR REFERRAL (MENTAL HEALTH)	This is an additional presenting condition or symptom for which the patient was referred to a service for. This group is not for recording the primary presenting condition or symptom. The primary presenting condition or symptom should be recorded in MHS101Referral. Please see Appendix 1 - Reason for Referral Guidance for further guidance relating to specific codes and mapping.

MHS104 Referral to Treatment (RTT)

To help reduce burden, the completion of this table is now optional and should only be submitted by providers that are required locally to do so.

Please note: Mandatory reporting in relation to 18 weeks waiting times and Allied Health Professionals Referral to Treatment (AHP RTT) is still required through CDS regardless of data submitted in respect of MHSDS.

Further details are available on the RTT web pages[46] on the NHS England website.

[46] https://www.england.nhs.uk/rtt/

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The purpose of this table is to collect Allied Health Professional Referral to Treatment (AHP RTT) data in order to support AHP RTT duration measurement and national benchmarking.

For the purposes of MHSDS, the data collected within this section relates only to AHP RTT activity. The information submitted must be accurate as of the close of reporting period.

The Allied Health Professional Referral to Treatment Guide[47] was revised in 2011 and provides clarity for measuring waiting times for NHS Allied Health Professional (AHP) services. By introducing AHP RTT, the aim is to improve patients' experience of NHS services and reducing the time they wait for treatment.

Note: Choose and Book was replaced by the NHS e-Referral Service (e-RS) which provides an easy way for patients to choose their first hospital or clinic appointment with a specialist. Bookings can be made online, using the telephone, or directly in the GP surgery at the time of referral.

More information can be found on the NHS e-Referral Service webpages[48].

Data Item Name	Additional Notes
PATIENT PATHWAY IDENTIFIER	An identifier, which together with the organisation identifier of the issuer uniquely identifies a patient pathway. This is a specific type of the attribute activity identifier. Where the pathway is initiated by some other method, the patient pathway identifier will be allocated by the organisation receiving the service request which together with that organisation's organisation identifier will uniquely identify the patient pathway.
ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)	This is the Organisation identifier of the Organisation issuing the Patient Pathway Identifier.
WAITING TIME MEASUREMENT TYPE (MENTAL HEALTH)	The type of waiting time measurement methodology which may be applied during a patient pathway. The methodology applied may be for one part of a patient pathway, such as the measurement of a referral to treatment period, or other parts of the patient pathway according to DHSC policy.

MHS105 Onward Referral

This table is to record and flow the details of the onward referral where the patient is being referred or transferred within the services under the current organisation or to another external service or organisation.

If the 'Onward Referral' was from one Mental Health service to another in the same or different provider, this should appear at a later point as a new referral in the Referral table.

If a patient is referred to a service which is not Mental Health related, it is outside the scope of the MHSDS. This referral would instead appear in the Onward Referral table, not as a new referral in the Referral table. Comparisons between the Referral and Onward Referral tables between providers are likely to be made for the purpose of data quality analysis.

[47] https://www.gov.uk/government/publications/revised-guide-for-referral-to-treatment-for-allied-health-professionals
[48] https://digital.nhs.uk/services/e-referral-service

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Data Item Name	Additional Notes
REFERRED OUT OF AREA REASON (ADULT ACUTE MENTAL HEALTH)	Please see Appendix 5 - Out of Area Placements for contextual and general information about Out of Area Placements and how the data collection will be undertaken through the MHSDS. for contextual and general information about Out of Area Placements and how the data collection will be undertaken through the MHSDS. **National Code 12 – Offending Restrictions:** This code can be used where an offending restriction has resulted in a referral for an Out of Area Placement. For example, a person may have offending restrictions, such as an anti-social behaviour order or a restraining order, that mean they are not able to go/live/stay in certain postcodes. These orders would still apply if the person needed to be admitted into an inpatient unit, so in this case the person's 'home/local' provider would have to place them Out of Area in order to comply with the person's offending restrictions. **National code 15** – Patient away from home: Included as part of the v6.0 uplift. A reason should only be recorded in circumstances where a patient has been referred Out of Area. If a patient has **not** been referred Out of Area, this data item should be left blank.
ORGANISATION IDENTIFIER (RECEIVING ORGANISATION)	The ODS registered Organisational Identifier of the organisation where the patient was onward referred to. This should be populated if it is known/collected and can be left blank if not.
CODED REFERRAL PROCEDURE AND PROCEDURE STATUS (SNOMED CT))	The SNOMED CT expression which is used to identify a procedure plus the status of the procedure. Allows a specific purpose for the onward referral to be attributed. For example, you would not need to populate this if a patient had been referred elsewhere because there were not enough beds. The procedure would be more relevant for situations where a patient is referred to an organisation that provides services that another organisation does not, or where additional assessments are required etc. The procedure might be something like "Chronic pain control assessment (procedure)" or "Specialist mental health assessment (procedure)".

MHS106 Discharge Plan Agreement

One occurrence of this group is permitted for each agreement of a Discharge Plan.

The table can flow multiple times in relation to one discharge plan where there is more than one person, team or organisation agreeing to the discharge plan.

For example, where a discharge plan is agreed by both an advocate and a local community support team, two instances of this table should flow with the relevant Discharge Plan Content Agreed By national code included in the submission.

There is no further additional information for this data table. All relevant detail about the data items can be found in the ETOS.

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Care Contact, Care Activities and Indirect Activities

MHS201 Care Contact

This table should reflect Care Contact instances from a patient perspective. If multiple Care Professionals are involved in a single Care Contact, this represents a single Care Contact record. There should not be multiple records created and/or linked to each involved Care Professional.

This data table should include details of all care contacts for a patient within the reporting period. Care contacts that were cancelled by either the provider or the patient or where the patient Did Not Attend (DNA) should also be included.

For instances where a care contact is cancelled due to duplications or scheduling errors, this can be recorded within the Care Contact Cancellation Reason data item as being cancelled for a 'non-clinical reason'.

This should include all face-to-face contacts with the patient or a proxy such as a legal guardian.

Non-face-to-face contacts should only be included where there is an opportunity for discussion between patient and healthcare professional.

Activities typically completed by administrative staff where the primary purpose of that activity is administrative in nature, for example arranging appointments, appointment reminders, notification of test results via any consultation mechanism should not flow.

There may be instances where administrative staff perform activity relevant to the person's care for example, recording of outcome measures. In these cases that activity should flow.

Contact and Activity Scenarios

The different scenarios can be broken down as follows:

Scenarios that should flow as a care contact

Care Contacts should flow for both inpatients and outpatients. Therapeutic contacts taking place in inpatient and community settings must be submitted as a matter of course.

- Where the **patient only** is present.
- Where the **patient and another attendee,** for example a parent or carer, are present. Supplementary MHS203 Other in Attendance records should also be submitted.
- Where the patient is not present, but a **patient proxy** is in attendance.

Scenarios that should not flow as a care contact

Scenario	Where the data should be recorded
Instances of indirect contact between professionals about the patient that do not involve the patient or their proxy.	Indirect Activity in MHS204IndirectActivity.
Where the patient is not present, but a family member/carer is present. They are receiving parent/carer interventions, but not acting as a proxy.	Indirect Activity in MHS204IndirectActivity.
Activities such as administrative tasks, for example note writing or travel.	Not in scope for submission.

Please refer to the following guidance documents:

https://www.england.nhs.uk/mental-health/adults/crisis-and-acute-care/

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https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/

Data Item Name	Additional Notes
CARE PROFESSIONAL TEAM LOCAL IDENTIFIER (OTHER SERVICE OR TEAM)	This is in addition to the Care Professional Team Local Identifier for the service that the patient was referred to.
ADMINISTRATIVE CATEGORY CODE	This is primarily for local use and identifies whether a contact is with an NHS funded or a non-NHS funded patient. The administrative Category code refers to a patient's status regarding payment for NHS services. It is relevant for all care contacts and applies to both in-patient and out-patient care.
CLINICAL CONTACT DURATION OF CARE CONTACT	The duration of the clinical contact should be recorded and accounted for, regardless of the type of contact (i.e., Telephone calls). The duration field should only be left blank if the Health Care professional (HCP) was unable to get through to the patient/the patient did not answer the phone. In which case it should also be recorded as a DNA.
CONSULTATION TYPE	Please refer to the ETOS for a full list of Activity Location Type Codes. **Example scenario** **[01] Initial Consultation** **[02] Follow-up Consultation** It is expected that these codes should be populated as per the following scenario: An initial consultation has been made and should be populated even if the patient does not attend it. If they do not attend (DNA) this initial appointment and a follow-up appointment is then made which they do attend. Both the initial and follow-up appointments should be considered as an 'Initial Consultation'. Any further appointments which are made and attended, should be considered as a 'Follow-up Consultation'. The MHS201 Care Contact record for the Initial Consultation would also show that this initial appointment was a DNA.
CONSULTATION MECHANISM (MENTAL HEALTH)	Identifies the communication mechanism used to relay information between the Care Professional and the Person who is the subject of the consultation, during a Care Contact. A non-face to face consultation should directly support diagnosis and care planning and must replace a face to face Out-Patient Attendance Consultant, Clinic Attendance Nurse or Clinic Attendance Midwife, or other types of Care Contact. A record of the consultation must be retained in the Patient's records. Contact with Patients solely for the purpose of informing them of the outcome of Diagnostic Test results, with no other clinical interaction, are not classified as Care Contacts.

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Data Item Name	Additional Notes
ACTIVITY LOCATION TYPE CODE	Where contact is not face to face the Activity Location Type of the patient should be used, not the location of the clinician. Please note: this guidance is amended from MHLDDS and changes the requirement. Please refer to the ETOS for a full list of Activity Location Type Codes. **[J01] Resource Centre:** A Mental Health, Learning Disabilities or Autism Resource Centre is the focus for the provision of mental health, learning disabilities or autism services to a specific area of the community. It acts as the base of a multi-professional team whose core purpose is to provide community-based care for mental health, learning disabilities or autism clients of all ages. The care usually comprises assessment, treatment and rehabilitation via domiciliary, consultant and other HCP outpatient, day hospital and outreach services, delivered at the centre, in the client's home and other suitable venues. **[B01] / [B02] Primary Care Health Centre:** A health centre is a facility which is used for the provision of primary care services and a range of community health services. It provides a standard of amenity which it is not easy to provide in a traditional consulting room. Services provided include General Medical services and nursing services and may in addition include AHP services, other primary care services and specialist services. **[H01] Day Centre:** Daytime care for the needs of people who cannot be fully independent: such as children or the elderly. Day care centres can offer the person you care for an opportunity to take on new hobbies and arrange days out, and they can also provide you with a break from caring. Day care centres are run by social services departments, or voluntary organisations, such as charities. **[D01] / D02] / [D03] Walk In Centre, Out of Hours Centre and Emergency Community Dental Services:** NHS Walk-in Centres are predominantly nurse–led primary care facilities dealing with illnesses and injuries – including infections and rashes, fractures and lacerations, emergency contraception and advice, stomach upsets, cuts and bruises, or minor burns and strains – without the need to register or make an appointment. They are not designed for treating long-term conditions or immediately life-threatening problems.
PLACE OF SAFETY INDICATOR	A Place of Safety[49] may be: • a residential Accommodation provided by a local social services authority under Part III of the National Assistance Act 1948 • a hospital as defined by the Mental Health Act 1983 as amended by the Mental Health Act 2007 • a police station • an independent hospital or Care Home for mentally disordered Persons or • any other suitable place where the occupier of which is willing temporarily to accommodate a Patient detained under section 136 of the Mental Health Act 1983 as amended by the Mental Health Act 2007. (Definition under review)
ORGANISATION SITE IDENTIFIER (OF TREATMENT)	Providers should continue to use this data item to populate the ODS codes for schools where possible.

[49] https://www.datadictionary.nhs.uk/attributes/place_of_safety_indicator.html?hl=place%2Csafety%2Cindicator

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Data Item Name	Additional Notes
LANGUAGE CODE (TREATMENT)	The language used for the delivery of treatment to the Patient. This field should be populated where the patient's preferred language is a language other than English.
INTERPRETER PRESENT AT CARE CONTACT INDICATION CODE	An indication of whether an interpreter was present at a Care Contact for the purposes of communication, including Sign Language, between a Care Professional and a Patient or Patient Proxy and if so the type of interpreter.
ATTENDANCE STATUS	Attendance Status replaced Attended or Did Not Attend Code in MHSDS v6.0 to align with the NHS Data Model and Dictionary and other data sets. This indicates whether or not an Appointment for a Care Contact took place. If the Appointment did not take place, it also indicates whether or not advanced warning was given. The Attendance Status data item should be submitted irrespective of Consultation Mechanism Used, i.e. the data item is still applicable even if the contact is not face to face. **[2] Appointment cancelled by, or on behalf of the patient:** An appointment is classified as being 'cancelled by, on or behalf of the patient' where it is cancelled at any point in time prior to the start of the appointment. **[3] Did not attend, no advance warning given:** An appointment is classified as being a DNA if the patient does not attend for the entire duration of the appointment slot, or they do attend but there is insufficient time remaining to conduct the planned activity and therefore the appointment is not usable. In the case of telephone contacts, duration should be recorded as 0 and marked as DNA only if the contact was a planned telephone contact and the patient did not answer the phone. **4] Appointment cancelled or postponed by the health care provider:** An appointment is classified as being 'cancelled or postponed by the healthcare provider' where it is cancelled at any point in time prior to the start of the appointment. When an appointment is cancelled (by, or on behalf of the patient, or by the health care provider) the appointment cancelled date should also be recorded. This will identify instances where the appointment was cancelled on the day it was intended to take place. When an appointment is re-arranged or rescheduled, this is effectively classed as a cancelled appointment. When it is re-arranged or rescheduled, the original appointment is cancelled and a new one is created. Dependant on who cancelled (re-arranged or rescheduled) the appointment, the national code [2] or [4] should be used.
EARLIEST REASONABLE OFFER DATE	This value is the date of the earliest of the reasonable offers made to a patient for an appointment or elective admission. **In the case of AHP RTT monitoring only:** the Earliest Reasonable Offer Date may be used locally to inform waiting time calculations. It can be used to account for periods of time where the patient has not accepted the first available appointment offer and this has extended the Allied Health Professional Referral To Treatment Measurement waiting time, for example:

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Data Item Name	Additional Notes
	• Where a patient who is a child or adolescent has been offered an appointment but their parent/carer states that they wish to wait until the school holidays commence. The service cannot commence planned treatment until the patient is available. • Where the patient works away and cannot attend for a period of time, but it is not appropriate to discharge the patient from the service. **Patient cancellations** Where, for any reason, a patient cancels or does not attend an appointment or an offer of admission the earliest reasonable offer date for the rearranged appointment or offer of admission will be the earliest reasonable offer date of the cancelled appointment or offer of admission. **Provider cancellations** Where, for any reason, any health care provider cancels and re-arranges an appointment or an offer of admission, the earliest reasonable offer date for the re-arranged appointment or offer of admission will be the date of the earliest reasonable offer made following the cancellation. **Patients who are unavailable** If the patient has specifically requested to be unavailable for a longer period of time, for example a patient who is a student who wishes to delay their admission until the summer holidays, making a reasonable offer may be inappropriate. In these circumstances, so long as the health care provider could have made at least two reasonable offers, the earliest reasonable offer date will be the date of the earliest reasonable offer that the provider could have offered the patient. This must be communicated to the patient.
SPECIALISED MENTAL HEALTH SERVICE CATEGORY CODE	The 'Specialised Mental Health Service Category Code' is expected to be completed within the MHSDS where a record/s relate to a Specialised Mental Health service. Further information on specialised services and the Specialised Mental Health Service Codes can be found in the Price activity matrix (PAM) on the NHS England webpages - NHS England » NHS England service codes by year 2025/26 There is also a link to the specialised mental health service category codes with the Technical Glossary tab in the Enhanced Technical Output Specification (ETOS). The latest codes have been agreed nationally with Commissioners, and information can also be found on the Contract Monitoring webpages[50]:
REASONABLE ADJUSTMENT MADE INDICATOR	Was a reasonable adjustment made for this patient. This has been included as a flag to understand if these are being made and reported upon. Some reasonable adjustments may not be linked to a care contact, for example a letter in braille. As such, there are three national codes for this data item:

[50] https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/contract-monitoring

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Data Item Name	Additional Notes
	Y - Yes - a Reasonable Adjustment was made for the patient N - No - a Reasonable Adjustment was not made for the patient X – Not applicable (i.e. some reasonable adjustments may not be linked to a care contact, for example, letters in braille for a phone contact). Further information can be found on the NHS England Services webpages. With additional information on the gov.uk pages.
REASON PATIENT DOES NOT HAVE INDEPENDENT MENTAL CAPACITY ADVOCATE	Please refer to Appendix 11 - Assuring Transformation for additional information. Additional information can also be found in the Making Decisions guidance[51] published by the Mental Capacity Implementation Programme (MCIP)[52].
REASON PATIENT DOES NOT HAVE INDEPENDENT MENTAL HEALTH ADVOCATE	Please refer to Appendix 11 - Assuring Transformation for additional information. Additional information can also be found in the Making Decisions guidance (see previous footnote) published by the MCIP.

MHS202 Care Activity

This table should contain a record for each separate element of assessment, treatment or review that was undertaken within a Care Contact. However, there is no necessity to duplicate closely linked care activity. For example, if several Coded Scored Assessment (Contact) records are submitted, they can be linked to one appropriate care activity as a result of local decision.

This table should reflect Care Activity from a patient perspective. For example, where multiple Care Professionals are involved in a single Care Activity, a single record should flow for the 'lead' Care Professional, rather than creating multiple records linked to each involved Care Professional.

A Care Activity record should **not** be submitted if The Attended or Did Not Attend Code submitted in the Care Contact table is one of the following:

- [7] Patient arrived late and could not be seen
- [2] Appointment cancelled by, or on behalf of the patient
- [3] Did not attend, no advance warning given; or
- [4] Appointment cancelled or postponed by the health care provider

NHS England will not be restricting the input of coded procedures, findings or observations through validation. Providers can opt to flow any activities and related information that are naturally recorded against the Care Contact.

[51] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/365629/making-decisions-opg606-1207.pdf

[52] A joint government programme between the Department of Health and Social Care, the Ministry of Justice, the Office of the Public Guardian and the Welsh Assembly Government that was established to implement the organisation, processes and procedures to launch the Mental Capacity Act.

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Additional guidance on procedures, findings, observations, observation values and units of measurement can be found within Appendix 7 – Care and Indirect Activity Guidance, including details of specific national reporting requirements related to the use of these data items.

CODED PROCEDURE AND PROCEDURE STATUS (SNOMED CT):

There are four clinically led SNOMED CT reference sets that have been released to support providers to record and submit meaningful information on clinical assessments, psychological therapies, psychosocial interventions, and medications:

- SNOMED CT - Mental Health Services Data Set assessment procedures simple reference set (foundation metadata concept)
- SNOMED CT - Mental Health Services Data Set psychological therapies simple reference set (foundation metadata concept)
- SNOMED CT - Mental Health Services Data Set psychosocial interventions simple reference set (foundation metadata concept)
- SNOMED CT - Mental Health Services Data Set medication and physical therapy interventions simple reference set (foundation metadata concept)

Supporting guidance for these reference sets is available through the Improving Mental Health Services Dataset Data Quality - Futures. The Community Mental Health Service Activity guidance document provides clinical descriptors for each SNOMED CT concept and practical information to support local implementation by providers.

CODED FINDING (CODED CLINICAL ENTRY):

There is a proposed SNOMED CT reference set for clinical finding codes to support providers in submitting relevant findings for the MHS609 Presenting Complaint's field which can be also used for this field. Guidance is available in the Improving Mental Health Services Dataset Data Quality - Futures. The list of codes included in the appendix of this document has not yet been released as a formal reference set in the SNOMED CT Browser. However, it represents a clinically led and approved list of codes that providers can use to record findings during care appointments.

Data Item Name	Additional Notes
CLINICAL CONTACT DURATION OF CARE ACTIVITY	The total summed duration of Care Activities linked to a Care Contact should not exceed the Clinical Contact Duration of the Care Contact. Duration should be reported from a patient perspective and not duplicated for reporting purposes, such as against multiple Care Professionals involved in a single Care Activity.
CODED PROCEDURE AND PROCEDURE STATUS (SNOMED CT)	Procedure: "represents activities performed in the provision of health care. This includes not only invasive procedures but also administration of medicines, imaging, education, therapies and administrative procedures".

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Data Item Name	Additional Notes
	For further information on SNOMED CT Expressions, see the SNOMED CT Glossary[53]. **Examples** **Post-coordinated expression (procedure + qualifier)** To flow a procedure and qualifier, three pieces of information are required: • The procedure code (for example: 718026005 Cognitive behaviour therapy for psychosis) • The qualifier code (for example: 410527000 Offered) • A code that links the procedure and the qualifier (in this case: 408730004 Procedure context) The three codes are concatenated for submission as follows: 718026005:408730004=410527000 (Cognitive behaviour therapy for psychosis:Procedure context=Offered) **Precoordinated expression (procedure only)** Procedure only flows as a single code: 718026005 (Cognitive behaviour therapy for psychosis) In the absence of an additional qualifier, we will assume that this CBT intervention has been 'delivered'.
FINDING SCHEME IN USE (MENTAL HEALTH)	This data item should not be submitted if data is not being submitted in The Coded Finding (Coded Clinical Entry) field. This will cause the record to be rejected.
CODED FINDING (CODED CLINICAL ENTRY)	This data item should be used to report any Findings captured during the Care Activity. Finding: "represents the result of a clinical observation, assessment or judgment and includes normal and abnormal clinical states" – SNOMED CT Starter Guide[54] - Section 6 (page 21 onwards) Please see Appendix 7 – Care and Indirect Activity Guidance for details of specific national reporting requirements related to the use of this data item
CODED OBSERVATION (SNOMED CT)	This data item should be used to report any Observations captured during the Care Activity. Observation: "represents a question or assessment which can produce an answer or result" – SNOMED CT Starter Guide[55] - Section 6 (page 21 onwards) Please see Appendix 7 – Care and Indirect Activity Guidance for details of specific national reporting requirements related to the use of this data item.

[53] https://confluence.ihtsdotools.org/display/DOCGLOSS/Expression
[54] https://confluence.ihtsdotools.org/display/DOCSTART/SNOMED+CT+Starter+Guide
[55] https://confluence.ihtsdotools.org/display/DOCSTART/SNOMED+CT+Starter+Guide

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Data Item Name	Additional Notes
UNIT OF MEASUREMENT (UCUM)	Unit of Measure represents the unit of measure of the observation value, more information can be found on the UCUM website[56].

MHS203 Other in Attendance

One occurrence of this table is permitted for each other person in attendance at a care contact in addition to the patient. The table can flow multiple times in relation to one care contact where there is more than one other person in attendance.

This table is not intended to capture any additional staff in attendance at a care contact. Additional staff should be captured in the MHS206 Staff Activity table.

Data Item Name	Additional Notes
OTHER PERSON IN ATTENDANCE AT CARE CONTACT	This data item should be used to capture any other person in attendance with the patient who is not a member of staff. Examples include a family member, care worker or advocate. Further information is available with regard to Independent Mental Capacity Advocates[57] (IMCA) and Independent Mental Health Advocates[58] (IMHA).

MHS204 Indirect Activity

An Indirect Activity[59] is activity that takes place with the specific purpose of supporting the care of a patient, but where the patient is not present.

The information submitted in this table should reflect a patient perspective. If multiple care professionals are involved in a single indirect activity, this represents a single indirect activity. There should not be multiple records created and linked to each involved care professional. You should only submit two records if two separate indirect activities took place in relation to the referral where two separate teams were involved.

For example, if several members of a multidisciplinary team participate in a planning meeting, this indirect activity should be recorded by one ‘lead’ clinician. There is not a requirement for all team members to submit an individual record in relation to one planning meeting.

There may be situations where it is appropriate to record the activity more than once to capture each care professional team involved. For example, where two teams are providing treatment concurrently, though this will not be the norm.

An Indirect Activity may take place between care professionals, or between a care professional and another person who is not acting as a patient proxy. This could include a family member or a carer in the situation where they are receiving parent or carer interventions.

[56] https://ucum.org/
[57] https://www.gov.uk/government/publications/independent-mental-capacity-advocates
[58] https://www.gov.uk/government/publications/response-on-funding-allocations-for-independent-mental-health-services-and-the-treatment-of-armed-forces-compensation-in-charging-for-social-care
[59] https://www.datadictionary.nhs.uk/nhs_business_definitions/indirect_activity.html

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Examples of Indirect Activity

- A care professional seeking advice from another care professional regarding the treatment or diagnosis of a specific patient
- A care professional providing training to a teacher to support the medical needs of a specific patient
- A care professional discussing the care of a patient with another care professional as part of a multidisciplinary team meeting
- A care professional providing training or advice to a family member or a carer to support the medical needs of a specific patient

Indirect Activity does not include:

- Contacts between a care professional and a patient proxy – this should be captured under care contact
- Discussions regarding groups of patients
- Administrative activities such as writing up notes or travel, arranging appointments, appointment reminders, notification of test results etc

Data Item Name	Additional Notes
INDIRECT ACTIVITY PERSON CONSULTED TYPE	Where the Indirect Activity has taken place with a family member or a carer in the situation where they are receiving parent or carer interventions, you are not required to submit this item in v6. A code will be introduced in v7 to capture this activity.

MHS205 Patient Self-Directed Digital Intervention

MHS205 Patient Self-Directed Digital Intervention has been added to MHSDS v6.0 to support improved visibility of a broader range of digital mental health platforms and products being commissioned and used by patients across the NHS.

Patient self-directed digital interventions are where a patient/service-user accesses support through a digital mental health platform without the active support of a trained mental health professional.

Detailed guidance on the recording of digital mental health platforms is provided in Appendix 13 – Digital Mental Health Platforms.

The appendix includes guidance on how and when different digital mental health platforms should be recorded in MHSDS v6.0 and when to use the MHS201 Care Contact or MHS205 Patient Self-Directed Digital Intervention tables.

The Appendix also includes SNOMED ID Mapping to map relevant SNOMED ID codes to improve data quality and utility. MHS206 Staff Activity

This table creates a many to many relationship between the Care Activity and Staff Details tables. It will enable multiple staff to be recorded for each staff activity at a care activity.

More than one occurrence of this group is permitted for each care activity and more than one occurrence of the care activity group is permitted for each staff activity.

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This table creates a many-to-many relationship between the MHS202 Care Activity table and the MHS901 Staff Details table. This will allow one member of staff to deliver multiple activities during a contact and one activity to be associated with multiple members of staff.

Data Item Name	Additional Notes
CARE ACTIVITY IDENTIFIER	The unique identifier for a Care Activity. It would normally be automatically generated by the local system upon recording a new activity, although could be manually assigned.
CARE PROFESSIONAL LOCAL IDENTIFIER	A unique local Care Professional Identifier within a Health Care Provider which may be assigned automatically by the computer system. Care Professional Local Identifier is a unique local Care Professional Identifier within a Health Care Provider and may be assigned automatically by the computer system.

Group Sessions

MHS301 Group Session

This table is not linked to the rest of the data set at patient level. The group session is a stand-alone table with care being attributed within a face-to-face group setting, and as such details of any participants attending the group, are anonymous.

If details for individual participants are known, they would be recorded within the Care Contact and Care Activity tables.

The Group Session table is designed to allow flow of data relating to activity that cannot be directly attributable to an individual and does not link to any other data table either through the local patient identifier or referral. The table includes telephone contact with an individual that incorporates an element of mental health care, but the individual remains anonymous.

Only Group Sessions that cannot be directly linked to each of the patients attending the Group Session should be included i.e., this table excludes Group Therapy sessions for a number of registered patients, which should be reported as a Care Contact for each individual patient.

The MHS301 Group Session table holds data relating to Group Sessions, not Patients. Where multiple sessions, defined as a group session, take place during a reporting period, each session should be recorded once in the MHS301 Group Session table. The record should not be repeated for each participant of the session.

If 10 participants attend one group session, but out of those, only 5 are anonymous, 5 should be recorded within the MHS201 Care Contact table and marked as a group session, and 5 should be recorded within the group session table itself.

If a group session is arranged, and subsequently cancelled, then providers should not submit data in relation to the cancelled session.

Data Item Name	Additional Notes
SERVICE OR TEAM TYPE REFERRED TO (MENTAL HEALTH)	For team specific guidance, please see the ETOS and Appendix 9 - Amendments to National Code Definitions.

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Data Item Name	Additional Notes
GROUP SESSION TYPE (MENTAL HEALTH)	The type of Group Session provided by a Mental Health Service. **[01] General Health Promotion Session:** A General Health Promotion Session is designed to help individuals improve their health, reduce health risks and promote healthy behaviours. General Health Promotion Sessions should only be included in the Group Session table where the participants and care given are otherwise in scope of MHSDS but are not registered patients to whom activity could be directly attributed. **[02] Telephone Support Session:** This option can be used to record a variety of activities including Group Sessions that have a 'teleconference' type format where the patient is not registered. This option can also be used to record telephone contact with an individual that incorporates an element of mental health, learning disability or autism care but the individual remains anonymous. For example, the individual makes a phone call 'in crisis' but the attending clinician is unable to determine their identity. **[03] Therapeutic Group Session:** This option will include any therapeutic activity which takes place in a group environment, where the participants are otherwise in scope of MHSDS but are not registered patients to whom activity could be directly attributed. Group sessions may include outreach sessions for the homeless or otherwise hard to engage groups which do not take place on service provider premises.

MHS302 Mental Health Drop In Contact

This table is not linked to the rest of the data set at patient level but includes data items that will allow some level of linkage in the analysis of the data.

Providers can only submit this table if it is included in a submission that also includes referral information alongside it. The referral information does not need to be linked to the data in the drop in contact table.

In some cases a trust or ICB will be contracting/subcontracting relevant services, such as a crisis line service, to an organisation that does not submit referrals to the MHSDS. Where this is the case, agreements will need to be in place for the drop in contact data to be submitted to the MHSDS by an organisation that is submitting full referral information, for example, the relevant NHS trust.

The primary route to recording contacts with services remains via the full recording of a referral. The drop in contact table has been established to enable recording of activity from functions such as all age 24/7 crisis lines, where service users are sometimes partially or entirely anonymous. For these service models the table also aims to support recording of activity where it is more challenging to capture referrals for every contact made with the service. The aim is to support better collection of key activity from services with minimised burden, while retaining the ability to understand the broader patient pathway wherever possible.

Where further NHS care is required for a service user, a service would always be expected to record a referral for that person regardless of whether information is recorded in the drop in contact table.

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This table should include details of all Mental Health Drop In Contacts occurring within the reporting period.

This table cannot be used to capture data for pre-referral contacts.

If the service is not considered a Single Point of Access (SPA) or a 24/7 crisis line, you are currently unable to submit contacts that take place prior to a referral having been received.

This may be developed in future iterations to include further service types, however it should currently only be used to flow data for the services listed. Please refer to the ETOS for further details.

The Urgent and emergency mental health care pathways guidance has been updated to support use of the drop in contact table in the context of recording activity from open access crisis line and single point of access services.

Data Item Name	Additional Notes
MENTAL HEALTH DROP IN CONTACT SERVICE TYPE	National code 'F01 Mental Health Support Team' (MHST) was added to this code list for MHSDS v6. The full list of service or team type definitions can be found in Appendix 10.1 – Service or Team Type definitions.
GENDER IDENTITY CODE	This should be asked of the individual and is distinguishable from the Person Stated Gender Code, as it has more inclusive gender options. This is to ensure that trans and non-binary people are being acknowledged and included by services. Please refer to the ETOS and the information on the NHS England webpages[60] for additional details.
GENDER IDENTITY SAME AT BIRTH INDICATOR	An indication of whether the patient's gender identity is the same as their gender/sex assigned at birth. This question should be asked of the individual by both their GP and by mental health services. Please refer to the ETOS and the information on the NHS England webpages for additional details.
CONSULTATION MECHANISM (MENTAL HEALTH)	Identifies the communication mechanism used to relay information between the Care Professional and the Person who is the subject of the consultation, during a Care Contact. A non-face to face consultation should directly support diagnosis and care planning and must replace a face to face Out-Patient Attendance Consultant, Clinic Attendance Nurse or Clinic Attendance Midwife, or other types of Care Contact. A record of the consultation must be retained in the Patient's records. Contact with Patients solely for the purpose of informing them of the outcome of Diagnostic Test results, with no other clinical interaction, are not classified as Care Contacts.
ORGANISATION IDENTIFIER (RECEIVING ORGANISATION)	This field should be used to identify the organisation in cases where the service is sub-contracted and the activity from that service is being submitted by the contracting organisation, who submit the MHS101Referral table

[60] https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/guidance-on-collecting-and-submitting-data-for-data-items-on-gender

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Mental Health Act (MHA) Episodes

MHS401 Mental Health Act Legal Status Classification Assignment Period

This table will be collected and submitted by a health organisation involved in a person's Mental Health Act Legal Status Classification Assignment Period.

A person will usually only have one Mental Health Act Legal Status Classification Assignment Period open at one time.

Each record should reflect the entire time that the patient was detained under that specific section of the MHA, including any renewals. The Expiry Date and Time should be recorded for any time limited section. If the section is renewed the Expiry Date and Time data items should be updated to reflect the new Expiry Date and Time. This is to support accurate national reporting.

Patient Transfers

The following is the minimum that should be submitted to tables relating to the MHA when a patient has moved from one provider to another provider but is still sectioned under the MHA.

When submitting data for the month of transfer, the **discharging** provider should submit an MHS401 record containing:

- End Date (Mental Health Act Legal Status Classification Assignment Period) populated with the date that the patient was transferred
- Mental Health Act Legal Status Classification Assignment Period End Reason populated with national code 04 – Transfer to other Health Care Provider

The **receiving** provider should submit an MHS401 record containing:

- Start Date (Mental Health Act Legal Status Classification Assignment Period) populated with the date the patient was transferred
- Mental Health Act Legal Status Classification Assignment Period Start Reason populated with national code 04 – Transfer from other Health Care Provider

Patients detained under Section 136 of the MHA

A MHS401 record should be submitted for both admitted and non-admitted patients who are detained under section 136 of the MHA.

This submission should include the national code ‘20 - Formally detained under Mental Health Act Section 136’ for the Mental Health Act Legal Status Classification Code data item.

If the patient is admitted once the assessment has been made, the MHS501 Hospital Provider Spell table and associated tables should be submitted accordingly.

If a patient is subsequently sectioned under a different part of the act, a further MHS401 record should be submitted.

Conditional Discharge (CD) and Community Treatment Order (CTO)

Details of the CD should be submitted in the MHS403 Conditional Discharge table

Details of the CTO should be submitted in MHS404 Community Treatment Order table.

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Key submission points

In the MHS401 submission:

- the Legal Status Code should be the underlying suspended section type. Default codes should not be used in place of the suspended section type
- Mental Health Act Legal Status Classification Assignment Period should remain open but where applicable, the Expiry Date should reflect the date the patient became subject to the CTO or CD.

The accompanying MHS403 Conditional Discharge or MHS404 Community Treatment Order submission must contain at a minimum the Mental Health Act Legal Status Classification Assignment Period Identifier and Start Date data items.

Example

If the patient was detained under Section 3 of the MHA and subsequently discharged on a CTO, the MHS401 record should continue to flow with the '03' Legal Status Code while the patient is on the CTO. This allows the identification of the patient pathway – e.g. the patient was detained under section 3 of the MHA and subsequently discharged on a CTO.

Further guidance

In MHS401, the Mental Health Act Legal Status Classification Assignment Period End Date, End Time and End Reason should only be submitted:

- when the Mental Health Act Legal Status Classification Assignment Period ends either without a subsequent CTO or CD; or
- the associated CTO/CD has an End Date and the End Reason is not '02 – Community Treatment Order revoked' (CTO) or '02 – Recall' (CD)

If the CTO ends for reason '02 – Community Treatment Order revoked' or the CD ends for reason '02 – Recall' the MHA Legal Status Classification Period:

- End Date and End Reason should remain unpopulated
- a new Expiry Date and Expiry Time should be populated where applicable

Suspension of the Mental Health Act Legal Status Classification Assignment Period will be inferred, where a CTO/CD record is submitted that starts prior to an End Date being submitted for the Mental Health Act Legal Status Classification Assignment Period.

Where there is a MHS405 Community Treatment Order Recall record, the Mental Health Act Legal Status Classification Assignment Period End Date can be the same as or later than the CTO Recall End Date.

The end of the CTO Recall does not necessarily denote the end of the Mental Health Act Legal Status Classification Assignment Period. However, where the patient is detained under a Mental Health Act section that is time bound, the Expiry Date should be extended.

Data Item Name	Additional Notes
START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)	If a client is admitted informally and then sectioned later the same day the admission will be informal. The time of the detention is always recorded, and this is the start of the Section (the admission time is distinct from this). Therefore the hospital provider spell tables would begin when the patient is admitted (informally) and the Mental Health Act tables would begin when the patient was sectioned.

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Data Item Name	Additional Notes
	If a client is admitted informally then this needs to be recorded in the hospital provider spell table but does not need to be recorded in the Mental Health Act table, as the client has not been admitted under the Mental Health Act. However, if a client is initially admitted informally, and then later detained in hospital under the Mental Health Act, then this will need to be recorded in the Mental Health Act table. The start time of detention must always be recorded (which in this case would be distinct from the time of admission).
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD START REASON	Any associated CTO or CD should run concurrently with the underlying MHA Legal Status Classification Period with an MHA Legal Status Classification Period Start Date that is prior to the CTO or CD Start Date.
EXPIRY DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)	The MHA Legal Status Expiry Date has been included to address data quality issues occurring where providers failed to close a section.
EXPIRY TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)	The MHA Legal Status Expiry Time has been included to address data quality issues occurring where providers failed to close a section.
END DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)	The End Date (MHA Legal Status Classification Assignment Period) has been included to address data quality issues occurring where providers failed to close a section.
END TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)	The MHA Legal Status End Time has been included to address data quality issues occurring where providers failed to close a section. The inclusion of MHA Legal Status End Time will enable the order of transitions between different sections of the Mental Health Act to be calculated.
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON	This item has been added to support accurate reporting of uses of the Mental Health Act and transfers between providers under a section of the MHA. Any associated CTO or CD should run concurrently with the underlying MHA Legal Status Classification Assignment Period with an MHA Legal Status Classification Assignment Period End Date that is the same as or after the CTO or CD End Date.
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE	**The following two codes are not applicable to the MHSDS:** **[01] Informal:** The end of an MHA episode should be defined through use of End Date (Legal Status classification Period). Code 01 Informal is not categorised as a valid code for MHA Legal Status Classification Period records in Monthly MHSDS Data Quality Reports. **[98] Not Applicable** is not appropriate for MHSDS and should not be used. **The following two codes need to be considered where appropriate:** **[32] Formally detained under other acts** should not be used for Community Treatment Orders (CTOs). **[20] Formally detained under Mental Health Act Section 136** should be submitted by providers.

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MHS402 Mental Health Responsible Clinician Assignment Period

The Care Professional Local Identifier of the Responsible Clinician should correspond to a record containing the details of the Responsible Clinician in the MHS901StaffDetails table.

There will be only one care professional assigned as the Mental Health Responsible Clinician to a patient at any one time.

There is no further additional information for this data table. All relevant detail about the data items can be found in the ETOS.

MHS403 Conditional Discharge

One occurrence of this Group is permitted for each separate Mental Health Conditional Discharge Period. Each record should reflect the entire time that the patient was subject to a CD.

Any period of CD must occur in conjunction with an underlying MHS401 Mental Health Act Legal Status Classification Assignment Period. A MHS403 record should only be submitted where there is an associated MHS401 record open at the same time.

Where there is an associated MHS401 record open for a CD, a MHS403 record should be submitted and must contain at a minimum the Mental Health Act Legal Status Classification Assignment Period Identifier and Start Date (Mental Health Conditional Discharge) data items.

Data Item Name	Additional Notes
MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY	Mental Health Absolute Discharge Responsibility is only applicable where Mental Health Conditional Discharge End Reason is “01 Absolute Discharge”. However, this data item is 'Required' and should always be included where it is relevant.

MHS404 Community Treatment Order

One occurrence of this Group is permitted whenever a CTO occurs. Each record should reflect the entire time that the patient was subject to a CTO, including any renewals or recalls into hospital for treatment.

Any period of CTO must occur in conjunction with an underlying MHS401 Mental Health Act Legal Status Classification Assignment Period.

Where there is an associated MHS401 record open for a CTO, a MHS404 record should be submitted and must contain at a minimum the Mental Health Act Legal Status Classification Assignment Period Identifier and Start Date (Community Treatment Order) data items.

A MHS404 record should only be submitted where there is an associated MHS401 record open at the same time.

Data Item Name	Additional Notes
EXPIRY DATE (COMMUNITY TREATMENT ORDER)	Where the CTO is renewed the Expiry Date should be updated to reflect the new Expiry Date. Expiry Date is not required when the CTO has ended. This can be a future date.

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COMMUNITY TREATMENT ORDER END REASON	Where the CTO ends with a revocation (code 02) there must be a record for the new detention in the MHS401 MHA Legal Status Classification Period table.

MHS405 Community Treatment Order Recall

Any period of CTO recall must occur in conjunction with an underlying MHS401 Mental Health Act Legal Status Classification Assignment Period. A CTO Recall record should only be submitted where there is an associated MHA Legal Status Classification Period record open at the same time.

There is no further additional information for this data table. All relevant detail about the data items can be found in the ETOS.

Hospital Provider Spells

MHS501 Hospital Provider Spell

This is a continuous period of inpatient care under a single Hospital Provider starting with a hospital admission and ending with a discharge from hospital.

For the purposes of MHSDS, a referral record must be in place for the Hospital Provider Spell record to link to. We appreciate that not all services associate spells with referrals, especially where admissions are non-elective, and providers may populate a dummy referral if required. We would expect the relationship to be 1:1 between the two tables.

Recording Health Based Place of Safety Service for members of the public detained by the Police under Section 136 of the Mental Health Act who need a mental health assessment

The initial assessment for a Health Based Place of Safety Service should be submitted as a referral using the MHS101 Service or Team Referral table. This activity does not qualify as an admission and should not be submitted in the MHS501 table.

Data Item Name	Additional Notes
ADMISSION SOURCE (MENTAL HEALTH HOSPITAL PROVIDER SPELL)	This should reflect the status of the referral into the organisation and not movement between different teams or services within one organisation. **National code 19** – We are aware that the length of the description may prove difficult to read across some systems. However, as long as the correct codes are recorded against the associated description, clinical systems will pick this up and submissions should continue to be made accordingly. **National Code 51** -NHS other Hospital Provider - ward for general patients or the younger physically disabled or Emergency Care Department. This code should not be used if the patient arrives at an Emergency Care Department and is admitted to the same Hospital Provider.
POSTCODE OF MAIN VISITOR	Postcode of main visitor is collected to allow NHS England to measure the distance travelled by the patient's main visitor, which may be their next of kin, in order to visit the patient whilst they are in hospital. Where personal details are collected by a provider organisation from an individual who is not the patient, the individual should be given a 'Fair processing' or 'Privacy notice'.

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Data Item Name	Additional Notes
	Postcode of main visitor will only flow from provider to NHS England and in the return extracts to the provider. It will not be included in the Commissioner or National extracts, where distance calculations will appear as a derivation. The postcode of main visitor should be a valid UK postcode. If a UK postcode is not available, it should be left blank. Default postcodes such as overseas pseudo country postcodes cannot be used to drive distance calculations.
ESTIMATED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)	This is estimated at the point of admission to a Hospital Provider Spell and is different to the Planned Discharge Date, which is set once the patient has been confirmed for discharge.
PLANNED DESTINATION OF DISCHARGE (HOSPITAL PROVIDER SPELL)	National code 19 – We are aware that the length of the description may prove difficult to read across some systems. However, as long as the correct codes are recorded against the associated description, clinical systems will pick this up and submissions should continue to be made accordingly.
DESTINATION OF DISCHARGE (HOSPITAL PROVIDER SPELL)	National code 19 – We are aware that the length of the description may prove difficult to read across some systems. However, as long as the correct codes are recorded against the associated description, clinical systems will pick this up and submissions should continue to be made accordingly.

MHS502 Ward Stay

This table should contain a record for each stay of a patient on a ward during an inpatient stay. A separate record should be created if the patient moves to a different ward.

Please note that information recorded within this table is used in NHS England's analysis to calculate the number of bed days. To ensure that these are calculated correctly please ensure that the Start Date and End Date are accurate.

Data Item Name	Additional Notes
END DATE (MENTAL HEALTH TRIAL LEAVE)	Please see MHS514 Mental Health Trial Leave for further information. This item in MHS502 is to be reported by the 'receiving' organisation only. It is reported to indicate that the Ward Stay was initially on a trial basis and that the trial has now ended. The 'sending' organisation will also report the End Date (Mental Health Trial Leave) item separately through the MHS514 Mental Health Trial Leave table, to show the original Ward for which the patient has left on trial basis.
MENTAL HEALTH ADMITTED PATIENT CLASSIFICATION TYPE	Please note that there is some additional guidance: 'Commissioner guidance for adult mental health rehabilitation inpatient services' Please refer to the * in Appendix 9.4 – Mental Health Admitted Patient Classification Types.
SPECIALISED MENTAL HEALTH SERVICE CATEGORY CODE	The 'Specialised Mental Health Service Category Code' is expected to be completed within the MHSDS where a record/s relate to a Specialised Mental Health service. Further information on specialised services and the Specialised Mental Health Service Codes can be found in the Price activity matrix (PAM)

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Data Item Name	Additional Notes
	on the NHS England webpages - NHS England » NHS England service codes by year[61]. The list of specialised mental health services can be found within the 'Technical Glossary tab in the ETOS. The latest codes have been agreed nationally with Commissioners, and information can also be found on the Contract Monitoring webpages[62].

MHS503 Assigned Care Professional

One occurrence of this Group is permitted for each Care Professional Admitted Care Episode. This is defined as a continuous period of care for a patient under the responsibility of a consultant, nurse or other healthcare professional.

A separate record should be included for each change in responsible consultant, nurse or other healthcare professional.

Data Item Name	Additional Notes
START DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)	The start date will not necessarily be the first ward stay this patient has ever had but should coincide with the start of the first Ward Stay during a continuous inpatient stay under the same provider. If there are successive ward stays, then this will be spanned by a single Hospital Provider Spell.
TREATMENT FUNCTION CODE (MENTAL HEALTH)	Treatment Function Code is required to add detail to the analysis of bed types. This is also captured in the 'MHS901 Staff Details' table. Please refer to the ETOS for the full list of national codes.

MHS505 Restrictive Intervention Incident

If this group is submitted, an accompanying MHS515 Restrictive Intervention Type group must also be submitted.

Restrictive Intervention incidents should only be submitted for inpatients.

Any incident of a Restrictive Intervention resulting in the providers Restrictive Intervention Policy being invoked should be reported.

Appendix 2 - Definitions for Restrictive Interventions for user in the MHSDS contains further information on how these tables should be recorded.

Data Item Name	Additional Notes
RESTRICTIVE INTERVENTION POST-INCIDENT REVIEW HELD INDICATOR (PATIENT)	This data item indicates whether a post-incident review is held with the patient within 48 hours of a restrictive intervention incident.

[61] https://www.england.nhs.uk/publication/nhs-england-service-codes/
[62] https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/contract-monitoring

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Data Item Name	Additional Notes
	If a review is held after the 48 hours following the incident, this should be submitted as 'no' as it has not occurred within the designated timescales.
RESTRICTIVE INTERVENTION POST-INCIDENT REVIEW NOT HELD REASON (PATIENT)	If a post-incident review is not held with the patient within 48 hours of a restrictive intervention incident, a reason must be given.
RESTRICTIVE INTERVENTION POST-INCIDENT REVIEW HELD INDICATOR (CARE PERSONNEL)	This data item indicates whether a post-incident review is held with a member of care personnel within 24 hours of a restrictive intervention incident. If a review is held after the 24 hours following the incident, this should be marked as 'no' as it has not occurred within the designated timescales.

MHS515 Restrictive Intervention Type

This table must be submitted to accompany the associated MHS505 Restrictive Intervention Incident.

Restrictive Intervention types should only be submitted for inpatients.

It is expected that the restrictive intervention types and data which is entered in this table, will correlate with the restrictive intervention incident information which is entered in the MHS505 Restrictive Intervention Incident table.

For example, a patient may have been restrained using two different intervention types which are entered in this MHS515 table, that relate to one single restrictive intervention incident, which has been entered into the MHS505 table.

Therefore, the start and end dates and times which are entered for the intervention types in this MHS515 table, need to fall within the same start and end date range of the incident information entered in MHS505.

Any type of a Restrictive Intervention resulting in the providers restrictive intervention Policy being invoked should be reported.

Appendix 2 - Definitions for Restrictive Interventions for user in the MHSDS contains further information on how these tables should be recorded.

There is no further additional information for this data table. All relevant detail about the data items can be found in the ETOS.

MHS506 Assault

Reporting of instances of an Assault are only required for inpatients.

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

Incidents of assault by the assaultive patient should NOT be included, only that of the assaulted patient.

There is no further additional information for this data table. All relevant detail about the data items can be found in the ETOS.

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MHS507 Self Harm

Reporting of self-harm instances is only required for inpatients.

The National Institute for Clinical Excellence describes self-harm as “intentional self-poisoning or injury, irrespective of the apparent purpose of the act”. NICE CG16[63]

Self-harm includes poisoning, asphyxiation, cutting, burning and other self-inflicted injuries.

Data Item Name	Additional Notes
DATE OF SELF-HARM	This is the date that an incident of self-harm for the patient occurred. This should NOT be the date that the self-harm incident was logged or updated on the system.

MHS509 Home Leave

This includes Home Leave for voluntary inpatients who are on Supervised Community Treatment (SCT) and whose CTO has not been revoked.

Mental Health Leave of Absence (LOA) or Mental Health Absence Without Leave (AWOL) should not be recorded within this table but should be recorded within the relevant tables - MHS510 Leave Of Absence and MHS511 Absence Without Leave.

Home Leave occurs when a patient who is not liable to be detained under Part II of the Mental Health Act 1983 and who is using a Hospital Bed in a ward or a bed in a Care Home spends a period of time outside the hospital/Care Home, usually at home, with the intention of returning to the same type of ward or Care Home to continue the same Care Professional Admitted Care Episode.

Home Leave can also occur when a mental health patient who is not subject to an MHA detention and placed on Section 17 leave, but does require a brief period or a few nights at an acute hospital for a physical health condition before returning to inpatient care. In this scenario, the bed would be kept open for the patient knowing that they will return.

Data Item Name	Additional Notes
END DATE (HOME LEAVE)	The End Date of Home Leave for a Patient refers to the planned date of return. However, the End Date ends on the actual date of return IF this is earlier then than the planned date of return.

MHS510 Mental Health Leave of Absence

Patients detained under the MHA 1983 may be granted a period of LOA under S17 of the MHA 1983 to allow them to be away from their place of detention.

The Mental Health Responsible Clinician must consider whether a CTO is the more appropriate way of managing the patient in the community as an alternative to granting longer term S17 Leave of Absence over 7 consecutive days or where leave is extended so the total leave granted exceeds 7 consecutive days due to the additional safeguards offered by CTO.

The requirement is to collect the actual time the patient was absent from hospital rather than the time for which permission was granted, provided the patient returns on or before the end of the permitted period of Leave of Absence. If the patient fails to return on or before the end

[63] https://www.nice.org.uk/guidance/cg16/chapter/1-Guidance

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of the permitted period of Leave of absence without a permitted extension, then the end of the permitted period of Leave of Absence should be recorded in the Mental Health Leave of Absence Table and consideration should be given to recording the subsequent time absent from hospital as AWOL.

Examples

- The patient is granted an initial period of 6 days Leave of Absence under s17 of MHA 1983 but choose to return after 3 days. LOA = 3 days
- The patient is granted an initial period of 6 days Leave of Absence under s17 of MHA 1983 which the authorities extended by a further 3 days. LOA = 9 days
- The patient is granted an initial period of 6 days Leave of Absence under s17 of MHA Act 1983 but fails to return. LOA = 6 days. AWOL should also be recorded where appropriate.
- The patient is granted an initial period of 6 days Leave of Absence under s17 of MHA 1983, but the authorities terminate the LOA after 3 days. LOA = 3 days

Home leave for patients on a CTO who are voluntary inpatients should be recorded in MHS509 Home Leave.

Data Item Name	Additional Notes
ESCORTED MENTAL HEALTH LEAVE OF ABSENCE INDICATOR	Escorted Mental Health Leave of Absence 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. Please see the legislation.gov.uk[64] website for further information.

MHS511 Mental Health Absence Without Leave

Mental Health AWOL is defined as 'any period of unauthorised absence which results in formal AWOL procedures being invoked'.

AWOL occurs when a patient detained under the MHA 1983 leaves their place of normal detention without permission or fails to return from Mental Health LOA within the permitted period of time.

As a minimum, any period of unauthorised absence (even if formal AWOL procedures are not triggered) that extends over midnight should be recorded.

There is no further additional information for this data table. All relevant detail about the data items can be found in the ETOS.

[64] http://www.legislation.gov.uk/ukpga/1983/20/section/17

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MHS512 Hospital Provider Spell Commissioner Assignment Period

Commissioner Assignment Periods will be used by NHS England for accurate commissioner extract generation to override the default commissioner allocation as identified in the MHS101 Referral table.

Inpatient records will be assigned to the responsible commissioner's extract based upon the Commissioner Assignment Periods identified in this MHS512 table.

If no Commissioner Assignment Periods are submitted for a Hospital Provider Spell, all related inpatient records will be allocated to the commissioner identified in the MHS101 Referral table.

Further details of the Commissioner Extract Inclusion Logic can be found in Appendix 8 - Commissioner Extract Inclusion Rules.

Data Item Name	Additional Notes
START DATE (COMMISSIONER ASSIGNMENT PERIOD)	Although the commissioner may be identified before inpatient admission, the requirement is for the commissioner assignment Start Date for the related Hospital Provider Spell for which a commissioner is responsible for, not the commissioner identification or contract start date.

MHS513 Substance Misuse

Evidence should be in relation to the actual use of illicit substances. Parallel behaviour such as drug seeking should not be included, as the criteria is evidence of substance misuse.

Evidence would be captured if there is an indication in the patient's presentation that there has been substance use. This will often be on a return from leave and the clinical team will request a drug screen to identify any substance use. However, this could be when a patient has brought substances into the ward for other patients. Therefore, this is not a routine screening for all patients all of the time.

There is no further additional information for this data table. All relevant detail about the data items can be found in the ETOS.

MHS514 Mental Health Trial Leave

This table is intended to record a period of Mental Health Trial Leave from the sender perspective.

The receiving organisation will also report the End Date (Mental Health Trial Leave) item separately through the MHS502 Ward Stay table to indicate the Ward for which the trial took place in and that the trial has ended.

The business definition for Mental Health Trial Leave can be found in the NHS DM&D[65].

There is no further additional information for this data table. All relevant detail about the data items can be found in the ETOS.

[65] https://www.datadictionary.nhs.uk/nhs_business_definitions/mental_health_trial_leave.html

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MHS516 Police Assistance Request

The recording of this activity relates to inpatients only.

The recording of police assistance is in relation to being asked to assist with a restrictive intervention and should not be used for any other requests for police assistance.

Any requests for police assistance, for example via phone call, should be included within this table. However, for instances where police assistance is requested, but for any reason the police do not need to come to a premises, it should still be recorded.

For this scenario, the 'Police Assistance Request Date' and 'Police Assistance Request Time' should be recorded, but the 'Police Assistance Arrival Date' and 'Police Assistance Arrival Time' should be left blank.

There is no further additional information for this data table. All relevant detail about the data items can be found in the ETOS.

MHS517 Specialised Mental Health Exceptional Package of Care (EPC)

Exceptional Packages of Care (EPC) are bespoke packages, exceptional in nature and do not replace enhanced observations. These are commissioned on top of the usual contracted activity on exceptional basis and healthcare providers, particularly finance teams, will know when an EPC has been agreed. There will be a separate cost attached to the EPC for an agreed time period.

<table>
<tr><th>Data Item Name</th><th>Additional Notes</th></tr>
<tr><td>SPECIALISED MENTAL HEALTH EXCEPTIONAL PACKAGE OF CARE CHARGE</td><td>This should be the amount charged in each reporting period. When the 'End Date (Specialised Mental Health Exceptional Package of Care)' is entered, the data will show
the amount charged by adding up each individual month to show the total over the reporting period and
the end date showing that this package has now ended (from the Start Date to End Date of the EPC).
For example, 3 months would have each individual month submitted. A total of £32,000 could be £12,000, £10,000 and £10,000 in their respective submissions<table>
<tr><th>EPC Start Date</th><th>EPC End Date</th><th>Cost</th></tr>
<tr><td>01/01/2021</td><td></td><td>£10,000</td></tr>
<tr><td>01/01/2021</td><td></td><td>£12,000</td></tr>
<tr><td>01/01/2021</td><td>31/03/2021</td><td>£10,000</td></tr>
</table></td></tr>
</table>

MHS518 Clinically Ready for Discharge

This table has been introduced in v6.0 to replace the removed MHS504 Mental Health Delayed Discharge table.

A Clinically Ready for Discharge (CRfD) period occurs when a patient is fit and ready for discharge from a hospital bed, but discharge is delayed due to external factors outside the control of the Hospital Provider.

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A patient is ready for discharge when all of the following criteria are met:

- a clinical decision has been made that the patient is ready for discharge
- a multi-disciplinary team (MDT) decision has been made that the patient is ready for discharge,and
- the patient is safe to discharge

Please refer to Appendix 12 – Future Reporting Clinically Ready for Discharge for additional information.

Data Item Name	Additional Notes
END DATE (MENTAL HEALTH CLINICALLY READY FOR DISCHARGE)	This may be the same as the Discharge Date (Hospital Provider Spell) if the external factors are resolved while the patient is still clinically ready for discharge. However, if the patient's condition deteriorates while awaiting discharge, the decision may be taken to end the Mental Health Clinically Ready for Discharge Period, and the Care Professional Admitted Care Episode and Hospital Provider Spell continue.
MENTAL HEALTH CLINICALLY READY FOR DISCHARGE PERIOD DELAY REASON	The reason that a patient was not able to be discharged despite being clinically ready for discharge. If you have one or more delayed reasons during the discharge period which is still open, you should record each of them sequentially. For example, if you have three delay reasons which are all part of one delayed discharge – you would submit the three records (if they are open in the reporting period or close in the reporting period). Once the first delay 'ends' – you should then populate the EndDateClinReadyforDisch field for the first record with the end date. The second delay starts when the first delay ends and so on.
MENTAL HEALTH CLINICALLY READY FOR DISCHARGE PERIOD ATTRIBUTABLE TO INDICATION CODE	Not all reasons for delay are applicable to each organisation type responsible for the delay. If code 04 is recorded, then the organisation identifier item does not need to be recorded. Similarly, if codes 05 and 06 are recorded, then the organisation identifier data item should also be recorded. Previous code '07 Housing (including supported/specialist housing)' has been removed for v6.0.

Clinically Coded Classifications and Terminology

MHS601 Medical History (Previous Diagnosis)

Previous diagnoses for disabilities, including autism, learning disabilities and neuro-disabilities should be recorded in this table.

Data Item Name	Additional Notes
CODED DIAGNOSIS TIMESTAMP	The diagnosis should be recorded with the date, time and time zone at the point at which it was discussed with the patient.

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MHS604 Primary Diagnosis

The primary diagnosis is the main condition treated or investigated in an episode of care. Where there is no definitive diagnosis the main symptom, abnormal finding or problem should be recorded.

Primary Diagnosis should be recorded as soon as it is available to ensure it can be submitted as part of an open referral. Diagnosis information cannot be submitted once the last submission window closes for which the associated referral remains open (i.e., the Refresh submission window for the reporting period in which the referral is discharged), which leads to risk that the referral will remain without any form of diagnosis in MHSDS if data recording is not timely.

Please refer to sections 5.4.1 and 5.4.2 for additional information relating to ICD-10 and SNOMED codes.

Data Item Name	Additional Notes
CODED DIAGNOSIS TIMESTAMP	The diagnosis should be recorded with the date, time and time zone at the point at which it was discussed with the patient.

MHS605 Secondary Diagnosis

This should include any secondary diagnosis of conditions treated or investigated in an episode of care which are NOT a primary diagnosis i.e., not the main condition treated or investigated. Where there is no definitive diagnosis, this may include any symptoms, abnormal findings or problems where these are not the main symptoms.

Secondary Diagnosis should be recorded as soon as it is available to ensure it can be submitted as part of an open referral. Diagnosis information cannot be submitted once the last submission window closes for which the associated referral remains open i.e., the Refresh submission window for the reporting period in which the referral is discharged, which leads to risk that the referral will remain without any form of diagnosis in MHSDS if data recording is not timely.

Please refer to sections 5.4.1 and 5.4.2 for additional information relating to ICD-10 and SNOMED codes.

Data Item Name	Additional Notes
SECONDARY DIAGNOSIS (CODED CLINICAL ENTRY)	Multiple Secondary Diagnoses may be recorded.
CODED DIAGNOSIS TIMESTAMP	The diagnosis should be recorded with the date, time and time zone at the point at which it was discussed with the patient.

MHS606 Coded Scored Assessment (Referral)

A list of the scored assessments that can be accepted in this table at the Data Services Platform can be found in Appendix 3 – Guide for recording Assessment Tools. A more detailed table including which ratings/scores are required, SNOMED CT mappings and expected values can be found in the MH Assessment Scales tab in the ETOS.

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Only the scored assessments listed in the MH Assessment Scales tab in the ETOS should be submitted. NHS England have acquired a licence to receive data relating to these assessments or confirmed that no licence is required. A complete list of assessments approved for use in NHS England data sets, and their respective licencing arrangements, is available on the NHS England website[66].

Recording and submitting HoNOS (Health of the Nation Outcome Scales)

In previous versions of the data set, HoNos could be recorded in both the MHS606 and MHS802 tables. The MHS802 table has been retired for V6, but you can continue to record HoNos using this table.

Data Item Name	Additional Notes
CARE PROFESSIONAL LOCAL IDENTIFIER	This data item should only be populated for clinician-rated assessment tool records. This data item has been included to aid paired outcome measuring by ensuring that clinician-rated outcome measures are rated by the same clinician when pairing outcomes.

MHS607 Coded Scored Assessment (Care Activity)

Where assessment tool details are recorded during a Care Contact, the Care Activity table should be populated with the mandatory fields to allow linkage between Care Contact and Care Activity. The Assessment tool and score details should be recorded in this table.

A list of the scored assessments that can be accepted in this table at the Data Services Platform can be found in Appendix 3 – Guide for recording Assessment Tools. A more detailed table including which ratings or scores are required, SNOMED CT mappings and accepted values can be found in the MH Assessment Scales tab in the ETOS.

Only the scored assessments listed in the MH Assessment Scales tab in the ETOS should be submitted. NHS England have acquired a licence to receive data relating to these assessments or confirmed that no licence is required. A complete list of assessments approved for use in NHS England data sets, and their respective licencing arrangements, is available on the NHS England website[67].

There is no validation relating to which specific MHS202 Care Activities should be linked to a MHS607 Coded Scored Assessment (Care Activity) record. Generic activities such as reviews or assessments would be acceptable.

Guidance relating to the use of outcome measures with regard to children and young people can be found in the Guide to Using Outcome Tools with Children, Young people and Families[68].

There is no further additional information for this data table. All relevant detail about the data items can be found in the ETOS.

[66] https://digital.nhs.uk/services/national-clinical-content-repository-copyright-licensing-service/nccr-tools-and-measures-library
[67] https://digital.nhs.uk/services/national-clinical-content-repository-copyright-licensing-service/nccr-tools-and-measures-library
[68] https://www.corc.uk.net/media/2112/201404guide_to_using_outcomes_measures_and_feedback_tools-updated.pdf

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MHS608 Anonymous Self-Assessment

There are currently no anonymous self-assessment outcome measures in scope for MHSDS. This table will allow the measures to flow in the future once they are identified as a requirement for submission.

MHS609 Presenting Complaint

This table has been introduced in v6.0 to replace the removed MHS603 Provisional Diagnosis table.

This table is designed to capture the condition or the pattern of symptoms recorded for a patient made by the service that the patient was referred or admitted to. This does not have to be a formal diagnosis, as a diagnosis may not be available at the point of initial referral.

It is also intended to align with the IAPT data set.

There is a proposed SNOMED CT reference set for clinical finding codes to support providers in submitting relevant findings for this field. Guidance is available in the Improving Mental Health Services Dataset Data Quality - Futures. The list of codes included in the appendix of this document can be found as the Mental Health Services Data Set clinical findings simple reference set (foundation metadata concept). This reference sets represents a clinically led and approved list of codes that providers can use to record clinical finding codes during care appointments and submit them via this table.

Care Programme Approach (CPA) Episodes

MHS701 Care Programme Approach (CPA) Care Episode

There is no national policy requirement to submit this table. The mandation has been changed from Required to Optional in v6. This allows the table to be submitted by any providers with a local requirement to do so.

Data Item Name	Additional Notes
START DATE (CARE PROGRAMME APPROACH CARE)	The start date refers to the start of the period that a patient is on CPA. The start date should not cover the part of the care pathway prior to the decision whether CPA is required. Therefore, this should not be the date of the referral (not unless this is same as the date the patient started CPA).
END DATE (CARE PROGRAMME APPROACH CARE)	The end date refers to the end date of the period that a patient was on CPA. This should be the date that they were no longer on CPA. This may be the same as the date of discharge.

MHS702 Care Programme Approach (CPA) Review

There is no national policy requirement to submit this table. The mandation has been changed from Required to Optional in v6. This allows the table to be submitted by any providers with a local requirement to do so.

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Staff, Service and Ward

MHS901 Staff Details

This table should include one record for every Mental Health and/or Learning Disability Care Professional responsible for providing the patients care, including Lead Care Professionals, Key Workers, Care Coordinators, Supervised Clinicians, and any other staff member who has a contact with a patient.

Where a member of staff has multiple roles or works in more than one team concurrently, a separate record with different Care Professional Local Identifier should be created to enable linkage to activity.

The Care Professional Local Identifier has been included in most activity tables to allow reporting of all activity by Job Role and Main Specialty.

Data Item Name	Additional Notes
ORGANISATION IDENTIFIER (CARE PROFESSIONAL LOCAL IDENTIFIER)	The Organisation Identifier of the organisation that assigned the Care Professional local identifier. This identifies the Care Professional Local Identifier issuing organisation, for example where organisations have gone through a merger or split. If Care Professional Local Identifiers are not modified during the merger or split, then the issuing Organisation Identifier of the Care Professional Local Identifier (even if now discontinued) should be sent in this field. If the Care Professional Local Identifier has been modified since the organisation change i.e. by prefix etc., then the new organisation identifier should be used.
MAIN SPECIALTY CODE (MENTAL HEALTH)	This will be recorded as 600 – General Medical Practice if the Responsible Clinician is the patients registered GP. Where the approved clinician is not a consultant the appropriate pseudo-specialty code should be used, or this item should be left blank.
OCCUPATION CODE	The NHS Occupation Codes are maintained by NHS England, on behalf of the DHSC and can be viewed in the NHS Occupation Code Manual[69]. Occupation codes are the traditional way of identifying numbers of staff in particular work sectors of the NHS in a consistent way. Occupation codes cover all staff in the Hospital and Community Health Service, both medical and non-medical. The manual covers NHS staff by their main functional groupings and is arranged in the following sections: A - Ambulance staff G - Administration and Estates staff H - Health care assistants and other support staff M - Medical and dental staff N - Nursing, midwifery and health visiting staff P - Nursing, midwifery and health visiting learners S - Scientific, therapeutic and technical staff U - Healthcare Science Z - General payments The occupation codes are based on staff roles and make no direct reference to pay scale information.

[69] https://digital.nhs.uk/data-and-information/areas-of-interest/workforce/nhs-occupation-codes

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Data Item Name	Additional Notes
CARE PROFESSIONAL (JOB ROLE CODE)	Capturing activity undertaken by a student or Agency: Student or agency work should be recorded under the relevant professional group.

MHS902 Service or Team Details

The MHS902 Service or Team Details table was introduced to capture service and team details and to enable a record to flow once per service rather than being connected to a patient.

The primary team in the MHS101 Service or Team Referral table, is identified via linkage to the MHS902 table.

Please refer to Section 4.1 for additional details.

This table is used to provide details about teams referenced within other tables. This is linked to the referral using the 'Care Professional Team Local Identifier' in the MHS101 Service or Team Referral table. The new 'Care Professional Team Local Identifier (Other Service or Team)' appears in the MHS102 Other Service or Team Type table, as well as the MHS201 Care Contact and MHS204 Indirect Activity tables to enable this table to be linked to care contacts and indirect activity where the other service has delivered the patient's care or indirect activity.

This table is a 'lookup' table and only one instance is required per Care Professional Team Local Identifier in an organisation's monthly submission.

For example, if an organisation has 100 patients using a service, only one record for that service needs to be submitted in that organisation's monthly submission. The Care Professional Team Local Identifier is used to identify the team that the Care Professional belongs to.

Data Item Name	Additional Notes
SERVICE OR TEAM TYPE (MENTAL HEALTH)	This data item was previously located in the MHS102 table and has been relocated to MHS902 in v6. For v6.0 code F04 Veterans Complex Treatment Service has been removed and replaced with code F07 Armed Forces Veterans Integrated Treatment Service. This is because the Armed Forces team are planning to use the original data element F04 to identify the submitted MHSDS for the OP Courage Integrated Veterans Mental Health Service[70] which starts on 1st April 2023. Currently, there are 3 separate veteran mental health services called TILS – Transition, Liaison and Intervention service, CTS – Complex Treatment Service and HIS – High Intensity Service. For this current service, there is a separate data collection, which they intend to cease at the end of March 2023 and use the MHSDS for reporting purposes for the new integrated veterans mental health service. As such, we have retired code F04 Veterans Complex Treatment Service and replaced it with new code F07 Armed Forces Veterans Integrated

[70] https://www.england.nhs.uk/2021/03/nhs-launches-op-courage-veterans-mental-health-service/

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Data Item Name	Additional Notes
	Treatment Service which is deemed more appropriate so as not to confuse with the historic CTS - Complex Treatment Service. If national code A20 - Health Based Place of Safety Service is submitted, an associated MHS101 Service or Team Referral record should also be submitted to capture the initial assessment.
MENTAL HEALTH SERVICE OR TEAM INTENDED PATIENT AGE GROUP	Intended age group of patients treated by the service. 01 – All Ages: A service or team whose delivery structure and style is primarily aimed at all patients regardless of age or stage of life. 02 – Children and Young Person: A service or team whose delivery structure and style is primarily aimed at children and young people (CYP). This may be defined by a specific upper age limit but may still include older people who aren't yet ready to receive a service designed for adults, or who started in a CYP service and are continuing in one for clinical or personal reasons. 03 – Adult and Older Adult: A service or team whose delivery structure and style is primarily aimed at adults and older adults. This may be defined by a specific lower age limit but may still include a proportion of people who are younger but elect to receive this service for clinical or personal reasons. 04 – Older Adult Only: A service or team whose delivery structure and style is primarily aimed at older adults. This may be defined by a specific lower age limit but will generally be aimed at a cohort of patients that exhibit some element of frailty or additional need linked with older age. It may still include a proportion of people who are younger but elect to receive this service for clinical or personal reasons.

MHS903 Ward Details

This is a new table introduced in v6.0 of the MHSDS to record the characteristics of and details about the ward, in a similar way to the Staff Details table, without being connected to a patient.

This table includes a number of data items that were previously located in the MHS502 Ward Stay table.

Data Item Name	Additional Notes
WARD INTENDED SEX OF PATIENTS	This data item was renamed in v6.0 from 'Sex Of Patients Code (Mental Health)' to align with the NHS Data Model and Dictionary and other national data sets. The data item was also relocated from the MHS502 Ward Stay table.
WARD INTENDED CLINICAL CARE INTENSITY (MENTAL HEALTH)	This data item was renamed in v6.0 from 'Intended Clinical Care Intensity Code (Mental Health)' to align with the NHS Data Model and Dictionary and other national data sets. The data item was also relocated from the MHS502 Ward Stay table.
LOCKED WARD INDICATOR	An indication of whether a Ward is locked. For the Mental Health Services Data Set, Locked Ward Indicator indicates whether a Ward which is used to provide care by a Mental Health Service and has a Ward Security Level National Code "General (non-secure)", is locked to prevent unauthorised entry and/or exit.

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Data Item Name	Additional Notes
	Note: Not all wards will be classified as 'locked' If there are wards that could also have patients not detained under the MHA (so non-secure), they should not be classified as 'locked' as they would be unlawfully be restricting patients. Understand the point about unauthorised access for people coming in but in theory anyone who is an inpatient who is not detained under the Act should be able to freely leave.
AVAILABLE BED DAYS DURING REPORTING PERIOD (MENTAL HEALTH)	The total number of beds available for the ward as identified through the Ward Code, multiplied by the number of days those beds could be used (both occupied and unoccupied). Bed days can be open both day and night over a 24-hour period.
CLOSED BED DAYS DURING REPORTING PERIOD (MENTAL HEALTH)	The total number of beds in the ward as identified through the Ward Code that are closed, multiplied by the number of days those beds had to be closed. Potential reasons could be due to COVID-19 or staff sickness.

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Appendix 1 – Reason for Referral Guidance

The below guidance is relevant for the Primary Reason For Referral (Mental Health) data item in the MHS101 – Service or Team Referral table and Other Reason For Referral (Mental Health) data item in the MHS103 – Other Reason for Referral table.

National Code	National Code Definition	Guidance
01	(Suspected) First Episode Psychosis	Includes schizophrenia
02	Ongoing or Recurrent Psychosis	Includes schizophrenia
03	Bipolar disorder	
04	Depression	
05	Anxiety	This could include Anxious away from caregivers, Anxious in social situations, Anxious generally, Panics, Avoids going out, Does not speak
06	Obsessive compulsive disorder	Includes: Repetitive problematic behaviours, compelled to do or think things
07	Phobias	Includes: Avoids specific things
08	Organic brain disorder	Includes Dementia
09	Drug and alcohol difficulties	
10	Unexplained physical symptoms	Includes Somatoform disorders
11	Post-traumatic stress disorder	
12	Eating disorders	
13	Perinatal mental health issues	
14	Personality disorders	Includes Persistent difficulties managing relationships with others
15	Self-harm behaviours	Includes Suicidal thoughts/ suicidal attempts
16	Conduct disorders	Includes: Behavioural difficulties, Poses risk to others, Carer management of CYP behaviour
18	In crisis	
19	Relationship difficulties	Includes family relationship and peer relationship difficulties
20	Gender Discomfort issues	
21	Attachment difficulties	
22	Self - care issues	Includes medical care management, obesity, doesn't get to toilet in time
23	Adjustment to health issues	
24	Neurodevelopmental Conditions, excluding Autism	Includes ADHD (e.g., Difficulties sitting still or concentrating) and other unexplained developmental difficulties but excludes Autism.
25	Suspected Autism	To identify referrals for an autism diagnostic assessment.
26	Diagnosed Autism	To identify referrals for ongoing care in relation to an existing diagnosis of autism.
27	Preconception perinatal mental health concern	To identify referrals to specialist community mental health services for women with severe mental illness seeking pre-conception advice.
28	Gambling Disorder	
29	Community Perinatal Mental Health Partner Assessment	
30	Behaviours that challenge due to a Learning Disability	
31	Employment Support	To identify referrals for mental health service users who require specialist employment support.

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Appendix 2 - Definitions for Restrictive Interventions for use in the MHSDS

The structure of the MHS505 – Restrictive Intervention Incident and MHS515 – Restrictive Intervention Type tables is intended to allow one overall incident to be recorded. A 'Restrictive Intervention Reason' can be captured in the MHS505 table and the MHS515 table can then record the details of each separate reported type of a Restrictive Intervention used as part of a Restrictive Intervention Incident of the patient.

Scenario:

Progression as follows:

Initially – Standing restraint – duration two minutes.

Followed by – Prone restraint – duration two minutes.

An injury to the service user was sustained during the prone restraint.

Followed by – Seated restraint – duration two minutes.

The following represents multiple restraints which could happen in one incident of restraint. In this scenario, an incident lasting 6 minutes would be recorded in the MHS505 table, and each individual restraint type would detailed within the MHS515 table, fitting the same date range as the relating incident in the MHS505 table.

MHS505 Restrictive Intervention Incident

RestrictiveIntIncId	HospProvSpellID	StartDateRe	StartTimeR	EndDateRe	EndTimeRe	RestrictiveIntPIReviewHeldPat	RestrictiveIntPIReviewNotHeldReasPat	RestrictiveIntPIReviewHeldCarePers	RestrictiveIntReason
abc	xyz	30/04/2019	23:50:00	30/04/2019	23:56:00	Y			

MHS515 Restrictive Intervention Type

RestrictiveIntIncId	RestrictiveIntTypeID	StartDateRe	StartTimeR	RestrictiveIr	EndDateRe	EndTimeRestrictiv	RestraintInjuryPatient	RestraintInjuryCarePers	RestraintInjuryOtherPers
abc	wf3	30/04/2019	23:50:00	7	30/04/2019	23:52:00			
abc	nh4	30/04/2019	23:52:00	1	30/04/2019	23:54:00	Y		
abc	bd9	30/04/2019	23:54:00	11	30/04/2019	23:56:00			

Restrictive Interventions

Restrictive interventions are defined as:

Planned or reactive acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to:

- take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and
- End or reduce significantly the danger to the person or others; and
- Contain or limit the person's freedom.

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Required reporting and working definitions

A. Physical restraint (sometimes referred to as manual restraint)

The MHSDS seeks to record incidents that meet:

1. the MHA code of practice (2015, DH) definition of physical restraint 'any direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another and
2. meets all parts of the above definition of restrictive interventions and
3. that take place in one of the following positions:

Position	Definition
Prone	A physical restraint in a chest down position, regardless of whether the person's face is down or to the side.
Supine	A physical restraint where the patient is held on their back.
Side	A physical restraint where the patient is held on their side.
Standing	Where the patient is restrained in a standing position.
Seated	Where the patient is held in a seated position.
Kneeling	Where the patient is held in a kneeling position.
Restricted Escort	Any restrictive hold where an individual is moved/ re-located from one area of a unit to another or between units regardless of level of hold

Notes on physical restraint

1. Incidents where there is no resistance from the patient, such as a guiding hand or directing a patient away from an area they are not supposed to enter, for example a male patient walking towards the female toilet, should not be recorded as restraint.
2. The intention of staff is irrelevant. If a patient is placed in, falls into, or puts themselves into any of the above positions, and the criteria for restraint to be recorded are present, the incident should be recorded as a restraint in that position.
3. The duration of the restraint is irrelevant. A restraint should be recorded if the patient is in one of the above positions, however briefly and regardless of intent.
4. Where a patient is held in order to facilitate care or a clinical procedure, sometimes referred to as clinical holding, the incident must be recorded as a restraint, provided that all criteria of the restraint definitions are present.

   For example, an older person with dementia may require restraint to be assisted with dressing and the use of the toilet, as there are periods during the day when communicating this need is difficult. This plan has been agreed through a 'best interests' meeting and relatives/carers are aware. The person lacks capacity, and the use of restraint varies dependant on how the person responds to staff at the time and the level of personal care needs. Whenever possible, staff will avoid restraint and wait for an appropriate opportunity to engage, however there are times when staff must intervene due to personal hygiene issues. Whenever restraint is used, even as part of planned care, this must be recorded as a restraint.

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5. It is irrelevant if a restraint is care planned. Any incident that meets all elements of the definition must be recorded.
6. The content of staff training and or provider policy is irrelevant. If a patient is placed, falls into or puts themselves in one of the above positions and the criteria for restraint are present, the incident should be recorded as a restraint.

See Section F for start and finish times

B. Mechanical restraint

Mechanical restraint refers to: 'the enforced use of mechanical aids such as belts, cuffs and restraints to forcibly control a patient's movement for the prime purpose of behavioural control.

Any incident recorded as mechanical restraint must meet all the criteria for a restrictive intervention.

C. Chemical restraint

Chemical restraint refers to: 'the use of medication which is prescribed and administered whether orally or by injection for the purpose of controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness'. Any incident recorded as chemical restraint must meet all the criteria of a restrictive intervention.

Restraint	Definition
Oral	Only record medication that is prescribed and offered as an alternative to the patient being subject to any other restrictive interventions.
Injection (rapid tranquilisation	The use of haloperidol, lorazepam, aripiprazole, olanzapine, promethazine, or diazepam by the parenteral route usually intramuscular but exceptionally intravenous, where the use of oral medication is not possible or appropriate, to achieve sedation.
Injection (other)	Any parenteral process that meets the criteria for a restrictive intervention and for chemical restraint but does not amount to rapid tranquillisation including the use of acuphase.
Other	Medication that meets the criteria for a restrictive intervention and for chemical restraint that is not given orally or by injection e.g., a nasal spray or breath actuated spray.

Notes on chemical restraint:

1. Do not record PRN medication where it does not meet the criteria for a restrictive intervention.

D. Seclusion

Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving MHA code of practice (2015, DH).

The code also provides the circumstances in which this intervention may be used -where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others.

Seclusion is a reactive intervention.

Guidance notes

The following practice **should** be recorded as seclusion.

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- A patient is locked in a seclusion room
- A patient is locked in a bedroom
- A patient is placed alone in a room and prevented from leaving either by the door being locked, held shut, blocked or staff standing in the doorway preventing the patient from leaving.
- Where a patient asks to be isolated from others and is then prevented from leaving the area in which they are isolated.

The following practice **should not** be recorded as seclusion

- If a patient is being restrained by staff, they are not being secluded.

E. Segregation

The MHA Code of Practice describes Long Term Segregation as a situation where a patient is prevented from mixing freely with other patients on the ward or unit on a long-term basis.

The rationale given in the “Code” is in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of the separated patient’s presentation. The use of long-term segregation is a planned rather than a reactive intervention.

However, patients are also prevented from mixing freely for other reasons such as autistic patients who are distressed but not necessarily violent. Any patient who is prevented from mixing freely with other patients on the ward or unit on a long-term basis, should be recorded as being segregated.

Guidance notes

The following examples **should** be recorded as segregation.

1. John is in medium secure care. Over the last 4 weeks John has assaulted other patients and several members of staff who attempted to intervene. He has previously been restrained and secluded for short periods of time. Each time John comes out of seclusion he makes threats and assaults other patients. The MDT call a meeting to discuss how best to support John and invite the specialised commissioning case manager and his advocate to attend. His families’ views are sought for the meeting. They decide that his behaviour presents a prolonged and continuing risk to the other patients and agree that John should be cared for away from other patients until the therapeutic interventions of staff have reduced his level of risk. They move John to the extra care area where he has an en-suite room, a small lounge area and, under the supervision of staff, access to a secure outside area.

2. John is moved to a different extra care area that does not have a separate lounge or access to outdoor space. He is still segregated.

3. Vicki is in an acute ward. Over the last 4 weeks Vicki has assaulted other patients and several members of staff who attempted to intervene. She has previously been restrained and secluded for short periods of time. Each time Vicki comes out of seclusion she assaults other patients. The multi-disciplinary team decides to care for Vicki away from other patients by partitioning off part of the ward. The commissioning authority is not consulted, nor is Vicki’s advocate or her family.

4. Marie has been in a variety of care settings for the last 15 years. A number of different diagnoses have been suggested in addition to her being autistic. Marie becomes very distressed when she is cared for on a ward with other patients. The commissioner

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responsible for her care agrees an individualised package of care, where she has no interaction with other patients. Marie and her family are happy with this arrangement.

F. Start and finish times

The start and finish time of each part of an incident should be recorded.

Example

1. A patient attempts to assault a member of staff. The member of staff prevents the patient from striking and restrains the patient in a standing position. The start and finish times for this part of the incident should be recorded as a restraint in a standing position.
2. The patient struggles and the member of staff requests assistance. The patient is moved by staff to a different area of the ward. The start and finish times of this part of the incident should be recorded as a restricted escort.
3. The staff moved to a seated position and held the patient in that position whilst attempting to de-escalate the situation. The start and finish times of this part of the incident should be recorded as a restraint in a seated position.

G. Post incident review

1. **Involving the patient**: discussion between at least one member of the clinical team and the patient as soon after the incident as is practicable and reasonable in all the circumstances.
2. **For the staff team**: a review involving as many members as possible of the staff team involved in the incident and the patient's care, and where possible the patient's carer or member of family. The purpose of this review is to learn lessons from what happened and to consider whether any changes are required in the patient's care plan.

H. Injuries

Injury to patient

Any injury recorded in the patient's care record as a result of a restrictive intervention, should be included as part of the incident record in MHSDS.

Injury to staff

Any injury sustained by staff immediately before or during the restraint incident, should be recorded.

Injury to others

Any injury sustained by a third party during or immediately preceding the restraint incident. This includes but is not limited to police, visitors and security staff not employed by the provider.

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Appendix 3 – Guide for recording Assessment Tools

Routine outcomes measurement is central to improving service quality and accountability.

It ensures the person having therapy and the clinician offering it have up-to-date information on an individual's progress, which is of value in itself.

At an overview level, where individual patients are anonymised, service providers and commissioners can see a performance pattern for the service.

The assessment tools within scope of the MHSDS should only be included in submissions if they are currently in use and appropriate for the service. If any of the below tools are not used by the service, they should not be included in the submission.

Only the scored assessments listed in the 'MHSDS Assessment Scales' tab in the ETOS should be submitted to MHSDS v6.0. NHS England have acquired a licence to receive data relating to these assessments or confirmed that no licence is required. A complete list of assessments approved for use in NHS England data sets, and their respective licencing arrangements, is available on the NHS England website[71].

Appendix 3.1 List of accepted Assessment Tools for submission within MHSDS

This list will remain under development and assessment tools may be added as and when identified as a requirement for submission through the MHSDS.

Please refer to the MH Assessment Scales tab within the ETOS for additional details on individual outcome measures including hyperlinks to each where available.

It is worth noting that any Procedure codes should be flowed to the MHS202 Care Activity table, rather than the MHS606 or MHS607 scored assessment tables which accept Observable Entity codes.

For further details on using the tools below, please use this link:
http://www.corc.uk.net/outcome-experience-measures/

- Brief Parental Self Efficacy Scale (BPSES)
- Behaviour Problems Inventory – Short (BPI-S)
- Brief Assessment Checklist for Children (BAC-C)
- Brief Assessment Checklist for Adolescents (BAC-A)
- Bristol Activities of Daily Living Scale (BADLS)
- Canadian Study of Health and Aging Clinical Frailty Scale
- Child Group Session Rating Scale (CGSR)
- Child Outcome Rating Scale (CORS)
- Child Session Rating Scale (CSRS)
- Children's Revised Impact of Event Scale (8) (CRIES 8)

[71] https://digital.nhs.uk/services/national-clinical-content-repository-copyright-licensing-service/nccr-tools-and-measures-library

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- Children's Global Assessment Scale (CGAS)
- Clinical Outcomes in Routine Evaluation 10 (CORE 10)
- Experience of Service Questionnaire (ESQ)
- Comprehensive Assessment of At-Risk Mental States (CAARMS)
- Current View
- DIALOG
- Eating Disorder Examination Questionnaire (EDE-Q)
- Generalized Anxiety Disorder 7 (GAD-7)
- Goal Attainment Scale (GAS)
- Goals Based Outcomes (GBO)
- Group Session Rating Scale (GSRS)
- HoNOS-ABI
- HoNOS Working Age Adults
- HoNOS 65+ (Older Persons)
- HoNOS-CA (Child and Adolescent)
- HoNOS-LD (Learning Disabilities)
- HoNOS-Secure
- How Are Things? Behavioural Difficulties (Oppositional Defiant Disorder) - Parent/Carer score
- Kessler Psychological Distress Scale 10
- Me and My Feelings Questionnaire
- Mothers' Object Relations Scale (MORS): includes 3 questionnaires for baby and child
- Nisonger Child Behaviour Rating Form (NCBRF)
- Outcome Rating Scale (ORS)
- Patient Health Questionnaire (PHQ-9)
- Questionnaire about the Process of Recovery (QPR)
- RCADS (Revised Children's Anxiety and Depression Scale)
- RCADS P (Revised Children's Anxiety and Depression Scale: Parent version)
- SCORE-15 Index of Family Functioning and Change
- Strengths and Difficulties Questionnaire (SDQ)
- Session Feedback Questionnaire (SFQ)
- Session Rating Scale (SRS)
- Sheffield Learning Disabilities Outcome Measure (SLDOM)
- Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS)

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- Treatment Outcomes Profile (TOP)
- Warwick-Edinburgh Mental Well-being Scale (WEMWBS)
- Young Child Outcome Rating Scale (YCORS)
- YP-CORE
- PGSI (Problem Gambling Severity Index)
- ReQoL (Recovering Quality of Life 20-item)
- ReQoL (Recovering Quality of Life 10-item)
- CORE-OM (Clinical Outcomes in Routine Evaluation - Outcome Measure)
- ASSIST-Lite (Adapted Alcohol, Smoking and Substance Involvement Screening Test)
- Eating Disorders Quality of Life Scale (EDQLS) outcome measure
- Binge Eating Scale score (BES)
- Perinatal POEM (Patient-rated Outcome and Experience Measure)
- IAPT Treatment Patient Experience Questionnaire
- IAPT Assessment Patient Experience Questionnaire
- Therapy Outcome Measure (TOMs)

Appendix 3.2 Licensing of Assessment Tools for use within systems

Providers and their IT suppliers are reminded of the need to ensure their compliance with Intellectual Property Law in relation to the use of copyright protected assessment tools.

SNOMED CT does not reproduce the text of the tools, so SNOMED CT values can flow to NHS England without any copyright infringement. However, reproduction of the tool, such as text, values and algorithms within IT systems requires suitable permissions to be in place. It is assumed that providers already have appropriate permissions in place for the assessment tools they use in paper form.

Permissions are required before using copyrighted assessment tools contained within the MHSDS. A list of all copyright-protected assessment tools and how to request permission to use them is available via the Copyright Licensing Service.

The service also provides the correct versions of the individual assessment tools to use. It is a legal requirement of every organisation, including IT suppliers, to gain permission to use the copyright-protected materials.

Appendix 3.3 Current View Selected Complexity Factors

The Current View component “Selected Complexity Factors” have been represented in SNOMED CT using Clinical Finding concepts in the SNOMED CT hierarchy.

These factors should be submitted using Coded Finding (Coded Clinical Entry) in the MHS202 Care Activity table or the MHS204 Indirect Activity table as they relate to “Findings” about a child or young person.

Please see the reference table below for mapping to SNOMED CT:

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Assessment Tool Question	Preferred Term (SNOMED-CT)	Concept ID (SNOMED CT)
Complexity 1. Looked after child**	Looked after child (finding)	764841000000100
Complexity 2. Young carer status**	Child is informal carer (finding)	204091000000106
Complexity 3. Learning disability	Developmental academic disorder (disorder)	1855002
Complexity 4. Serious physical health issues (including chronic fatigue)	Serious physical health problem (finding)	986381000000102
Complexity 5. Pervasive Developmental Disorders (Autism/Asperger's)	Pervasive developmental disorder (disorder)	35919005
Complexity 6. Neurological issues (e.g., Tics or Tourette's)	Disorder of nervous system (disorder)	118940003
Complexity 7. Current protection plan**	Subject to child protection plan (finding)	342191000000101
Complexity 8. Deemed "child in need" of social service input	Child in need (finding)	135891007
Complexity 9. Refugee or asylum seeker*	Refugee (person)	446654005
	Asylum seeker (person)	390790000
Complexity 10. Experience of war, torture or trafficking*	Victim of armed conflict (finding)	63721001
	Victim of torture (finding)	95318007
	Victim of human trafficking (finding)	863561000000103
Complexity 11. Experience of abuse or neglect*	Victim of child abuse (finding)	397940009
	Victim of infant/child neglect (finding)	419686005
Complexity 12. Parental health issues	Parental health issue (situation)	986391000000100
Complexity 13. Contact with Youth Justice System	Has contact with Youth Justice Service (finding)	986401000000102
Complexity 14. Living in financial difficulty	Financially poor (finding)	11403006

*Selected Complexity Factor one-to-many exceptions

Complexity factors 9, 10 and 11 have one-to-many mappings with SNOMED CT concepts. In these cases, automatic mapping is not possible. Services should manually map these factors to a single or many SNOMED CT concepts on a case-by-case basis. It is likely that the proportion of children and young people with those complexity factors will be low.

In the longer term, greater granularity within the form, in respect to these 3 factors, will be considered to align with the SNOMED CT concepts.

**Selected Complexity Factor relationships with MHS005 Patient Indicators

Factors 1, 2 and 7 capture information which can be used to populate associated indicators within the MHS005 Patient Indicators table. Please see MHS005 Patient Indicators for further guidance on updating these indicators.

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Appendix 3.4 SNOMED CT Mapping

A detailed table including which ratings/scores are required for each assessment tool, SNOMED CT mappings and expected value ranges can be found in the ETOS. Please see the “MH Assessment Scales” tab.

Maintaining SNOMED CT mapping

Organisations whose local systems are not fully SNOMED CT compliant may rely on Information departments to undertake manual mapping of data to SNOMED CT terms in order to submit the data. This mapping will require review at each SNOMED CT release (6 monthly cycle), as well as when new assessment tools are introduced to or retired from the scope of the MHSDS.

Appendix 4 – Removal of clustering tools for mental health in MHSDS v6.0

The following care cluster tables were removed from the MHSDS in the v6.0 uplift.

- MHS013 Mental Health Currency Model
- MHS801 Clustering Tool Assessment
- MHS802 Coded Scored Assessment (Clustering Tool)
- MHS803 Care Cluster
- MHS804 Five Forensic Pathways

Providers who were using the MHS801 Clustering Tool Assessment table to flow HONOS and DIALOG assessments, should now flow these using the MHS606 Coded Scored Assessment (Referral) and MHS607 Coded Scored Assessment (Care Activity) tables.

Appendix 5 - Out of Area Placements

Further information on Out of Area Placements can be found on the NHS England webpages, with the latest statistics on additional webpages.

Context

In April 2016, Alistair Burt, Minister of State for Community and Social Care, announced a national ambition to eliminate inappropriate Out of Area Placements for adult acute inpatients by 2020/21. Gathering intelligence to address Out of Area Placements is therefore a ministerial priority, however significant gaps in data make it difficult to monitor improvement.

The Five year forward view for Mental Health[72] recommendation 22 states: ‘introduce standards for acute MH care, with the expectation that care is provided in the least restrictive way and as close to home as possible’, and ‘Eliminate the practice of sending people out of area for acute inpatient care as a result of local acute bed pressure by no later than 2020/21’. The “Improving acute inpatient psychiatric care for adults in England[73]” report also recommends that *“The practice of sending acutely ill patients long distances for non-specialist treatment is phased out by October 2017”.*

[72] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
[73] http://media.wix.com/ugd/0e662e_a93c62b2ba4449f48695ed36b3cb24ab.pdf

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As well as this, the NHS Providers report Right Place, Right Time, Better Transfers of Care: a Call to Action[74]" highlighted the need for a clear definition of an Out of Area Placement and clarity around what is counted as an Out of Area Placement in order to make meaningful comparisons, and to identify and share best practice.

Development of national definition

In order to outline a plan to deliver on this ambition and to set out the milestones, nationally consistent and robust information is needed for Out of Area Placements.

The DHSC has led a Task and Finish group involving senior leads on mental health from NHS England. An output from this group is a national definition for inappropriate Out of Area Placements for adult acute mental health which will be implemented by DH with service providers on a national basis.

For further information relating to the development of the national definition and how it should be interpreted and implemented locally, please see the DHSC part of the gov.uk website[75].

Please note: The term "Out of Area Placement" replaces the term Out of Area Treatment (OAT) which was used throughout early development of the final definition. The change in terminology is to avoid any confusion with the historic use of 'Out of Area Treatment' which is a retired definition in NHS Data Model & Dictionary, associated with non-contract activity. Out of Area Placements are also referred to as Out of Area Admissions in NICE guidance[76]

Appendix 6 – Approach to collection of Ward Stay information to inform inpatient activity analysis

Context

There are distinct types of ward configuration and service provision within mental health, learning disabilities and autistic disorder inpatient services that cater for people with distinct needs. It is important to be able to understand this variation, particularly in context to different pathways of care, to ensure that inpatient capacity is effectively used to deliver mental health services. As an example, adult acute mental health care needs to be understood in context of adult community mental health team (CMHT) activity, adult crisis resolution home treatment team (CRHTT) activity and adult mental health rehabilitation inpatient activity.

In the recent Crisp Report[77], the Royal College of Psychiatrists stated that "*commissioners, providers and their partners in every area need to be able to easily find the number and type of specialist and non-specialist inpatient beds in their area…*". The report further stated the importance of data collection, as "*The absence of this essential information makes it almost impossible to make high quality decisions about many aspects of patient care and the deployment of staff and resources".*

NHS England has also reiterated a need to be able to identify and report on measures associated with specified 'hospital bed types' across mental health. This is relevant in a wide number of strategic and operational areas in mental health services including understanding Out of Area Placements, Delayed Transfers of Care, length of stay, and ensuring an optimal balance of care between inpatient and community-based services.

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[74] https://nhsproviders.org/resources/reports/right-place-right-time-better-transfers-of-care-a-call-to-action
[75] https://www.gov.uk/government/publications/oaps-in-mental-health-services-for-adults-in-acute-inpatient-care
[76] https://www.nice.org.uk/guidance/ng53
[77] https://nhsproviders.org/resources/briefings/on-the-day-briefing-crisp-commission-final-report

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This has introduced the case for specifying a comprehensive list of 'hospital bed types' to define this element of variation within the system.

Definitions for 'hospital bed types' for inpatient services, and 'team types' for community services, can be found within Appendix 10 - Definitions for Service or Team Types and Hospital Bed Types.

Development of 'hospital bed type' categories

The NHS Benchmarking Network (NHSBN) has been collecting inpatient activity by bed type for a number of years and the adult mental health categories used were agreed via a consensus exercise, led by the NHS Confederation Mental Health Network in 2012. These suggested categories are now familiar with providers and are used as a currency in national benchmarking assessments.

Whilst learning disability wards broadly map to the NHSBN categories, work is in progress by NHS England to consult and define further where required.

National Data Requirements

It is important to ensure data collection regarding the configurations of inpatient beds and wards effectively meets the needs for national and local reporting for:

- Children and young people's mental health services
- Adult mental health services
- Learning disability and autism services

Following the development of 'hospital bed type' categories, NHS England has been asked to ensure these categories are available for reporting from April 2017. However, work is also ongoing to derive the required information from existing data items such as Ward Security Level and Treatment Function Code.

Development of central derivations

Using the provided 'hospital bed type' categories and associated definitions, NHS England commenced development of derivations aiming to centrally derive this information using existing data within the MHSDS. The continued collection of Ward Setting Type, Ward Security Level, Clinical Care Intensity and Treatment Function Code allow a detailed understanding of the configuration of the inpatient ward and the service delivered.

NHS England is currently using these derivations to produce information from MHSDS about people in adult acute inpatient care (including adult acute and PICU beds) and specialised adult inpatient services (secure beds plus specialist mother and baby and eating disorder units).

Further reports, deriving information about the type of bed occupied from the data items described above, can be developed according to the priorities of key stakeholders.

A need exists to consolidate reporting requirements to ensure that burden is minimised for data submitters.

Maximising benefits

NHS England will proactively monitor the submission of data within the MHS502 Ward Stay to address common data quality issues associated with both included solutions. Detailed guidance on the submission of data within the MHS502 Ward Stay table can be found in section MHS502 Ward Stay of this document.

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NHS England will support implementation of these categories and associated definitions to ensure the included code list is well understood and developed in future where necessary.

NHS England will be working collaboratively to share stakeholder feedback in relation to both included solutions.

Long term approach

NHS England acknowledge additional burden is associated with the expanded MHS502 Ward Stay table and intend to minimise this burden as quickly as possible once a preferred solution has been agreed.

NHS England will utilise the data submitted and report comparative analysis within the MHSDS publications[78]. NHS England will also consolidate queries received to identify common issues or general feedback.

In light of analysis and feedback, NHS England will liaise with relevant programme boards with the aim of reaching an agreed solution for consolidation within a future annual release of the MHSDS.

Appendix 7 – Care Activity Guidance

NHS England are not placing any restrictions on the activities and/or interventions that service providers can demonstrate through clinical terminology.

It is likely the case that specific reporting needs for different policies will instigate work on developing comprehensive lists for service activities or intervention types. This approach is going to place emphasis on the development of terminology “subsets” to meet particular clinical needs and national and local reporting needs by the wider community such as DHSC, NHS England, NICE, RCPsych, clinicians and informatics staff.

NHS England will include references to appropriate nationally relevant subsets within this User Guidance appendix. However, this appendix should not be considered definitive, and it is essential service providers keep up to date with both national and local reporting requirements.

Illustration of MHS202 Care Activity fields

The following table provides a high-level illustration and basic example of the purpose and relationship between each data item within the MHS202 Care Activity table:

Hierarchy	Description	Example
Procedure	represents activities performed in the provision of health care. This includes not only invasive procedures but also administration of medicines, imaging, education, therapies and administrative procedures	‘Measuring weight’
Finding	represents the result of a clinical observation, assessment or judgment and includes normal and abnormal clinical states	Examples include: • ‘normal weight’ • ‘excessive weight loss’
Observation	represents a question or assessment which can produce an answer or result	‘Body weight’

[78] https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/mental-health-data-hub/statistical-publications

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Hierarchy	Description	Example
Obs Value	represents the value of the observation	90
Unit of Measure	represents the unit of measure of the observation value	kg

Further information with regard to the concept model of SNOMED CT can be found within the SNOMED CT Starter Guide[79], in particular please see section 6.

Mandatory reporting requirements for continuation of MHSDS data flow

Smoking Status

Patient smoking status should be collected on initial assessment and at subsequent CPA reviews, so will be collected at least annually.

Specific National Reporting Requirements

Coded Scored Assessments

A SNOMED CT subset exists containing SNOMED CT procedure codes for each Coded Scored Assessment in scope for MHSDS.

For example: “Assessment using Questionnaire about the Process of Recovery (procedure)”

This subset is “Mental health assessment scale procedures simple reference set” with SCTID 991461000000106.

These procedure codes can be used for linking MHS607 Coded Scored Assessment (Care Activity) records to a relevant MHS202 Care Activity record.

Only the scored assessments listed in the ‘MHSDS Assessment Scales’ tab in the ETOS should be submitted to MHSDS. NHS England have acquired a licence to receive data relating to these assessments or confirmed that no licence is required. A complete list of assessments approved for use in NHS England data sets, and their respective licencing arrangements, is available on the NHS England website.

CYP-ED and EIP Access and Waiting Times

Lists of commonly used NICE-recommended interventions and procedures for EIP and CYP Eating Disorder services which have now been developed and published as part of the Guidance for reporting against access and waiting time standards: CYP ED & EIP[80].

Providers should continue to submit the locally recorded interventions and/or procedures over and above this list where appropriate, but should review this list to ensure that the correct SNOMED CT codes are recorded on local IT systems and to understand the impact on national reporting.

Extended EIP interventions recording and reporting guidance

A detailed guidance document has been produced to support those services delivering care to people experiencing a first episode of psychosis. The guidance document details how to record and report on interventions and outcomes locally using SNOMED CT codes and how to them flow the data centrally via the MHSDS.

[79] https://confluence.ihtsdotools.org/display/DOCSTART/SNOMED+CT+Starter+Guide
[80] https://www.england.nhs.uk/mentalhealth/resources/access-waiting-time/

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Please refer to the document Early intervention in psychosis - recording and reporting[81] within the link 'Early intervention in psychosis services' on the following page for further information.

Care and Treatment Reviews

Each Care and Treatment Review (CTR) with the patient should be recorded using the appropriate SNOMED CT procedure concept from the list as follows:

- 1060741000000104 - Inpatient Care and Treatment Review (procedure)
- 1060751000000101 - Community Care and Treatment Review (procedure)
- 1060761000000103 - Post admission Care and Treatment Review (procedure)

Additional guidance on recording Care and Treatment Reviews[82] using the above codes has now been made available by NHS England, to ensure that health and social care providers capture this within the MHSDS.

For further general information about CTRs, please see the NHS England CTR webpage[83].

Current View Selected Complexity Factors

Please see Appendix 3.3 – Current View Selected Complexity Factors for mapping guidance to report these factors as Coded Findings within the MHS202 Care Activity or MHS204 Indirect Activity tables.

Legally unsharable clinical codes

NHS England are currently undertaking a review of clinical codes that are defined as sensitive (legally restricted) in order to ensure that its use of provider data is compliant with the Human Fertilisation and Embryology Act 1990 (as amended by the Human Fertilisation and Embryology Act 2008) and the Gender Recognition Act 2004 (as amended by The Gender Recognition (Disclosure of Information) (England, Wales and Northern Ireland) Order 2005).

As part of this work, NHS England sought feedback on a proposed list of legally unsharable clinical codes. The codes that have been identified will continue to be used for secondary purposes, but all related information that could potentially identify an individual would be removed where the codes are used for any other reason apart from direct care.

Until these lists of codes are finalised for use across national data sets, the Data Set Development Service advise services to take extra care when flowing clinical terminology which may fall in the scope of legally unsharable clinical codes. Services should consult with their local Caldicott Guardian in first instance where doubt exists.

Appendix 8 – Commissioner Extract Inclusion Rules

Data Services for Commissioners Regional Offices (DSCROs) are an intermediary service that process, analyse and package patient information for use by organisations commissioning healthcare. Commissioners require access to MHSDS information to plan current and future healthcare services but are not permitted to access person identifiable data because they do not directly provide patient care.

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[81] https://www.rcpsych.ac.uk/improving-care/nccmh/service-design-and-development/early-intervention-in-psychosis
[82] https://www.england.nhs.uk/learningdisabilities/ctr/
[83] https://www.england.nhs.uk/learningdisabilities/ctr/

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Each DSCRO receives the data that is required to be onwardly disseminated to their respective commissioning organisations. This is the data for each commissioner where that commissioner funds the service or activity provided to the patient, as identified through the MHS101 Service or Team Referral, MHS201 Care Contact, MHS204 Indirect Activity and MHS512 Hospital Provider Spell Commissioner tables. It also includes the data attributed to their respective commissioners in the MHS301 Group Session and MHS608 Anonymous Self-Assessment tables.

DSCROs are entitled to receive Patient Identifiable Data (PID) under the Health and Social Care Act 2012, with the provision of appropriate data controls, to support their allocated ICBs.

DSCRO extracts are required to be provided from the SDCS landing platform.

The DSCROs receive all the data at a national level. Minimisation is applied by the DSCROs before they disseminate rather than each DSCRO receiving data that relates to specific commissioners.

This minimisation is conducted by person - ICB registered footprint, ICB resident footprint and activity provided by an organisation hosted by the ICB.

De-identification procedures are also applied and as such, the old Bureau Service Portal (BSP) inclusion rules are no longer applied.

The updated Who document contains further information on determining[84] document contains further information on determining responsibility for payments to providers.

Appendix 8.1 Principles for data exclusion – Removal of identifiable data

DSCROs are part of NHS England, and as such they are authorised to have access to patient identifiable data. DSCRO extracts contain patient identifiers which enable linkage with other data sets.

Commissioners are not entitled to receive patient identifiable data. It is therefore a DSCRO responsibility to ensue appropriate information governance principles are applied when onwardly disseminating patient level data.

Additional information about DSCRO's can be found on the NHS England website[85].

Appendix 8.2 Inclusion Logic

Each DSCRO will receive the data that relate to its associated commissioning organisations according to the following principles:

The following tables include Organisation Identifiers for commissioners that are used as part of the inclusion processing:

Data Tables

- MHS101 Service or Team Referral
- MHS201 Care Contact
- MHS204 Indirect Activity

[84] https://www.england.nhs.uk/who-pays/
[85] https://digital.nhs.uk/services/data-services-for-commissioners

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- MHS301 Group Session
- MHS512 Hospital Provider Spell Commissioner
- MHS517 Specialised Mental Health Exceptional Package of Care (EPC)
- MHS608 Anonymous Self-Assessment

The 'Organisation Identifier (Code of Commissioner)' is recorded in multiple tables, as clinical services and activities can be commissioned in a number of ways. At the highest level a commissioner can fund all the treatment for a patient provided by a service or team, and the commissioner for this would be recorded in the MHS101 Service or Team Referral table. The commissioner which is allocated to the mandatory table MHS101 referral table, is the commissioner which is entitled to (by default) receive the referral and all of the linked records for that referral submitted within the reporting period.

This default attribution however, can be 'overwritten' as necessary for elements of the referral, by recording the commissioner in greater granularity in any of the following tables:

- MHS201 Care Contact
- MHS204 Indirect Activity
- MHS512 Hospital Provider Spell Commissioner Assignment Period

A commissioner may fund only part of the treatment for a patient; this would be recorded in the MHS201 Care Contact table.

In addition, the provider's submission may also contain specialist activity, where the commissioner has been recorded separately. This specialist activity is held in the MHS301 Group Session, MHS302 Mental Health Drop In Contact and MHS608 Anonymous Self-Assessment tables.

Appendix 8.3 Hospital Provider Spells

Hospital provider spells are identified separately as episodes, with the commissioner being allocated by entries in the MHS512 Hospital Provider Spell Commissioner Assignment Period table. The MHS5xx records will be grouped by the Hospital Provider Spell Identifier.

Data Tables/Items

- MHS512 Hospital Provider Spell Commissioner Assignment Period
- Organisation Identifier (Code of Commissioner)
- Start Date (Commissioner Assignment Period)
- End Date (Commissioner Assignment Period)

The start and end dates are used to identify the active commissioner assignment period during the hospital provider spell for the patient. Only one commissioner can be considered active at one time but can change during a patient's hospital provider spell. Only the active commissioner can receive the tables identified in the Record Level Inclusion Logic table (Figure 2).

Figure 1. Hospital episode commissioner example timeline.

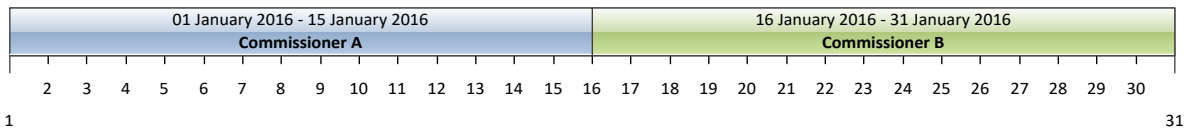

Figure 1 provides an example of when the commissioning arrangements of a single hospital episode changes during a submission period. In this example 'Commissioner A' funds the Hospital Provider Spell from 1st January to 15th January, and 'Commissioner B' funds the Hospital Provider Spell from 16th January to 31st January. In this situation both commissioners will receive all of the records captured for this patient in the January reporting period as defined in the Record Level Inclusion Logic table (Figure 2). MHS5xx records will be split by date by matching them to the date periods covered by the MHS512 record. A match constitutes a single common day of overlap.

When a record has been provided in the MHS501 Hospital Provider Spell table and there is no corresponding record in the MHS512 Hospital Provider Spell Commissioner Assignment Period table for the whole reporting period, or any part of a period created by a 'gap' in commissioner dates during a Hospital Provider Spell, the Organisation Identifier (Code of Commissioner) provided in the MHS101 Service or Team Referral Table must be used as the 'active' commissioner of the Hospital Provider Spell for this period.

8.3.1 Record Level Inclusion Logic

The Record Level Inclusion Logic table (Figure 2) shows which tables will be included in a DSCRO extract based on where the 'Organisation Identifier (Code of Commissioner)' has been recorded. The inclusion logic is applied at an individual record level.

Figure 2. Record level inclusion logic table.

Included in extract	Organisation Identifier (Code of Commissioner) Recorded					
	MHS101	MHS201	MHS204	MHS512	MHS301	MHS608
MHS000	✓	✓	✓	✓	✓	✓
MHS001	✓	✓	✓	✓		
MHS002	✓	✓	✓	✓		
MHS003	✓	✓	✓	✓		
MHS004	✓	✓	✓	✓		
MHS005	✓					
MHS006	✓	✓	✓	✓		
MHS007	✓	✓	✓	✓		
MHS008	✓	✓		✓		
MHS009	✓	✓		✓		
MHS010	✓	✓	✓	✓		
MHS011	✓	✓	✓	✓		
MHS012	✓	✓	✓	✓		
MHS101	✓	✓	✓	✓		
MHS102	✓	✓	✓	✓		
MHS103	✓	✓	✓	✓		
MHS104	✓	✓	✓	✓		
MHS105	✓			✓		
MHS106	✓	✓	✓	✓		
MHS107***						
MHS201	See note *	✓				
MHS202	See note *	✓				
MHS203	See note *	✓				
MHS204	See note		✓			
MHS301					✓	
MHS401	✓	✓	✓	✓		
MHS402	✓	✓	✓	✓		
MHS403	✓	✓	✓	✓		
MHS404	✓	✓	✓	✓		
MHS405	✓	✓	✓	✓		
MHS501	See note			✓		
MHS502	See note			✓		
MHS503	See note			✓		
MHS504	See note			✓		
MHS505	See note			✓		

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MHS506	**See note**			✓		
MHS507	**See note**			✓		
MHS509	**See note**			✓		
MHS510	**See note**			✓		
MHS511	**See note**			✓		
MHS512	**See note**			✓		
MHS513	**See note**			✓		
MHS514	**See note**			✓		
MHS601	✓	✓	✓	✓		
MHS603	✓	✓	✓	✓		
MHS604	✓	✓	✓	✓		
MHS605	✓	✓	✓	✓		
MHS606	✓	✓	✓	✓		
MHS607	**See note ***	✓				
MHS608						✓
MHS701	✓	✓	✓	✓		
MHS702	✓	✓	✓	✓		
MHS801	✓	✓	✓	✓		
MHS802	✓	✓	✓	✓		
MHS803	✓	✓	✓	✓		
MHS804	✓	✓	✓	✓		
MHS901	✓	✓	✓	✓	✓	

* If the Organisation Identifier (Code of Commissioner) is not provided in the MHS201 table, then the MHS201, MHS202, MHS203 and MHS607 data must only be included in the DSCRO extract for the commissioner identified in the MHS101 table. If the Organisation Identifier (Code of Commissioner) provided in the MHS201 table differs from the Organisation Identifier (Code of Commissioner) provided in the MHS101 table, then the MHS201, MHS202, MHS203 and MHS607 data must only be included in the DSCRO extract for the commissioner identified in the MHS201 table and not included in the DSCRO extract for the commissioner identified in the MHS101 table. In both of these scenarios all of the tables identified in the Record Level Inclusion Logic table (Figure 2) must also be included in the appropriate DSCRO extracts.

** If the Organisation Identifier (Code of Commissioner) is not provided in the MHS204 table, then the MHS204 data must only be included in the DSCRO extract for the commissioner identified in the MHS101 table. If the Organisation Identifier (Code of Commissioner) provided in the MHS204 table differs from the Organisation Identifier (Code of Commissioner) provided in the MHS101 table, then the MHS204 data must only be included in the DSCRO extract for the commissioner identified in the MHS204 table and not included in the DSCRO extract for the commissioner identified in the MHS101 table. In both of these scenarios all of the tables identified in the Record Level Inclusion Logic table (Figure 2) must also be included in the appropriate DSCRO extracts.

*** If a record has been provided in the MHS501 Hospital Provider Spell table and there is no corresponding record in the MHS512 Hospital Provider Spell Commissioner Assignment Period table, the Organisation Identifier (Code of Commissioner) provided in the MHS101 Service or Team Referral Table must be used as the ‘active’ commissioner of the Hospital Provider Spell for the whole reporting period or MHS512 ‘gap’ period.

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Appendix 9 – Amendments to National Code Definitions

Appendix 9.1 Accommodation Status

The expected likely mapping of the different accommodation types is set out within the following table.

This is based on the understanding that the non-settled accommodation types could be automatically mapped to the non-settled data item. Whereas the settled accommodation types should not be automatically mapped, but instead should only be completed if that status has been fully established.

For example, a 'settled accommodation' type, should only be deemed as settled for the foreseeable and immediate future, with the expectation that a situation may arise where 'settled' suddenly becomes 'unsettled'.

For these types of scenarios, we would recommend that additional questions should be asked by a service to ascertain that the accommodation is settled. For example, 'do you think that you will need to leave your accommodation within the next 2-6 months'.

Accommodation Type	Likely mapping to settled accommodation
01 - Owner occupier	**More likely to be settled but may not be**
02 - Tenant - Local Authority/Arm's Length Management Organisation/ registered social housing provider	
03 -Tenant – private landlord	
04 - Living with family	
05 - Living with friends	
06 - University or College accommodation	
07 - Accommodation tied to job (including Armed Forces)	
08 - Mobile accommodation	
09 - Care home without nursing	
10 - Care home with nursing	
11 - Specialist Housing (with suitable adaptations to meet impairment needs and support to live independently)	
12 - Rough sleeper	**Can always be mapped to non-settled**
13 - Squatting	
14 - Sofa surfing (sleeps on different friends floor each night)	
15 - Staying with friends/family as a short-term guest	
16 - Bed and breakfast accommodation to prevent or relieve homelessness	
17 - Sleeping in a night shelter	

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Accommodation Type	Likely mapping to settled accommodation
18 - Hostel to prevent or relieve homelessness	
19 - Temporary housing to prevent or relieve homelessness	
20 - Admitted patient settings	**Could be either depending on length of stay and accommodation arrangement afterwards**
21 - Criminal justice settings	
98 – Other (not listed)	

Appendix 9.2 Service or Team Type (Mental Health)

The Service or Team Type (Mental Health) data item has been amended in v6.0 of the MHSDS. This table was previously located within the MHS102 Service or Team Type Referred to table but is now located within the new MHS902 Service or Team Details table.

The code list within the Service or Team Type (Mental Health) data item has changed for v6.0 of the MHSDS. The following table shows the change of codes from MHSDS v5.0 to the new codes for v6.0.

Service or Team Type (Mental Health) v6.0	Service or Team Type Referred To (Mental Health) v5.0
A01 - Day Care Service	A01 - Day Care Service
A02 - Crisis Resolution Team/Home Treatment Service	A02 - Crisis Resolution Team/Home Treatment Service
A05 - Primary Care Mental Health Service	A05 - Primary Care Mental Health Service
A06 - Community Mental Health Team - Functional	A06 - Community Mental Health Team - Functional
A07 - Community Mental Health Team - Organic	A07 - Community Mental Health Team - Organic
A08 - Assertive Outreach Team	A08 - Assertive Outreach Team
A09 - Community Rehabilitation Service	A09 - Community Rehabilitation Service
A10 - General Psychiatry Service	A10 - General Psychiatry Service
A11 - Psychiatric Liaison Service	A11 - Psychiatric Liaison Service
A12 - Psychotherapy Service	A12 - Psychotherapy Service
A13 - Psychological Therapy Service (non IAPT)	A13 - Psychological Therapy Service (non IAPT)
A14 - Early Intervention Team for Psychosis	A14 - Early Intervention Team for Psychosis
A15 - Young Onset Dementia Team	A15 - Young Onset Dementia Team
A16 - Personality Disorder Service	A16 - Personality Disorder Service
A17 - Memory Services/Clinic/Drop-in service	A17 - Memory Services/Clinic/Drop-in service
A18 - Single Point of Access Service	A18 - Single Point of Access Service
A19 - 24/7 Crisis Response Line	A19 - 24/7 Crisis Response Line
A20 - Health Based Place of Safety Service	A20 - Health Based Place of Safety Service
A21 - Crisis Café/Safe Haven/Sanctuary Service	A21 - Crisis Café/Safe Haven/Sanctuary Service
A22 - Walk-in Crisis Assessment Unit Service	A22 - Walk-in Crisis Assessment Unit Service

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Service or Team Type (Mental Health) v6.0	Service or Team Type Referred To (Mental Health) v5.0
A23 - Psychiatric Decision Unit Service	A23 - Psychiatric Decision Unit Service
A24 - Acute Day Service	A24 - Acute Day Service
A25 - Crisis House Service	A25 - Crisis House Service
B01 - Forensic Mental Health Service	B01 - Forensic Mental Health Service
B02 - Forensic Learning Disability Service	B02 - Forensic Learning Disability Service
C01 - Autism Service	C01 - Autism Service
C02 - Specialist Perinatal Mental Health Community Service	C02 - Specialist Perinatal Mental Health Community Service
C04 - Neurodevelopment Team	C04 - Neurodevelopment Team
C05 - Paediatric Liaison Service	C05 - Paediatric Liaison Service
C06 - Looked After Children Service	C06 - Looked After Children Service
C07 - Youth Offending Service	C07 - Youth Offending Service
C08 - Acquired Brain Injury Service	C08 - Acquired Brain Injury Service
C10 - Community Eating Disorder Service	C10 - Community Eating Disorder Service
D01 - Substance Misuse Team	D01 - Substance Misuse Team
D02 - Criminal Justice Liaison and Diversion Service	D02 - Criminal Justice Liaison and Diversion Service
D03 - Prison Psychiatric In reach Service	D03 - Prison Psychiatric In reach Service
D04 - Asylum Service	D04 - Asylum Service
D05 - Individual Placement and Support Service	D05 - Individual Placement and Support Service
D06 - Mental Health In Education Service	D06 - Mental Health In Education Service
D07 - Problem Gambling Service	D07 - Problem Gambling Service
D08 - Rough Sleeping Service	D08 - Rough Sleeping Service
E01 - Community Team for Learning Disabilities	E01 - Community Team for Learning Disabilities
E02 - Epilepsy/Neurological Service	E02 - Epilepsy/Neurological Service
E03 - Specialist Parenting Service	E03 - Specialist Parenting Service
E04 - Enhanced/Intensive Support Service	E04 - Enhanced/Intensive Support Service
F01 – Education-based Mental Health Support Team	F01 - Mental Health Support Team
F02 - Maternal Mental Health Service	F02 - Maternal Mental Health Service
F03 - Mental Health Services for Deaf people	F03 - Mental Health Services for Deaf people
F07 Armed Forces Veterans Integrated Treatment Service	F04 - Veterans Complex Treatment Service
F05 - Enhanced care in care homes teams	F05 - Enhanced care in care homes teams
F06 - Mental Health and Wellbeing Hubs (See Appendix 10.1 – Service or Team Type definitions)	F06 - Mental Health and Wellbeing Hubs (See Appendix 10.1 – Service or Team Type definitions)

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Service or Team Type (Mental Health) v6.0	Service or Team Type Referred To (Mental Health) v5.0
Z01 - Other Mental Health Service - in scope of National Tariff Payment System (now referred to as the NHS Payment Scheme).	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 (now referred to as the NHS Payment Scheme).	Z02 - Other Mental Health Service - out of scope of National Tariff Payment System

Appendix 9.3 Mental Health Admitted Patient Classification Types

The Mental Health Admitted Patient Classification Type code list (previously referred to as the 'Hospital Bed Type (Mental Health) Mental Health Admitted Patient Classification code list' in v5.0 of the MHSDS), within the MHS502 Ward Stay table, has changed for v6.0 of the MHSDS. The following table shows the change of codes from MHSDS v5.0 to the new codes for v6.0 as they should be mapped across accordingly.

To note: The numbering was revised so that adult codes start with '200' and child codes start with '300'. This will allow the numbering across MHSDS v6.0 and Assuring Transformation v4.0 to match, without re-using any codes that were already included in AT v3.0.

Mental Health Admitted Patient Classification Type v6.0	Hospital Bed Type (Mental Health) Mental Health Admitted Patient Classification v5.0
200 - Acute adult mental health care	10 - Acute adult mental health care
201 - Acute older adult mental health care (organic and functional)	11 - Acute older adult mental health care (organic and functional)
202 - Adult Psychiatric Intensive Care Unit (acute mental health care)	12 - Adult Psychiatric Intensive Care Unit (acute mental health care)
203 - Adult Eating Disorders	13 - Adult Eating Disorders
204 - Mother and baby	14 - Mother and baby
205 - Acute Mental Health Unit for Adults with a Learning Disability and/or Autism See Appendix 10.2 – Mental Health Admitted Patient Classification Type definitions for further detail	15 - Adult Learning Disabilities
See codes 212 and 213 below	17 - Adult High dependency rehabilitation
206 – Adult Low Secure	19 - Adult Low secure
207 – Adult Medium Secure	20 - Adult Medium secure
208 – Adult High Secure	21 - Adult High secure
209 - Adult Neuropsychiatry / Acquired Brain Injury	22 - Adult Neuropsychiatry / Acquired Brain Injury
210 - Adult Personality Disorder	40 - Adult personality disorder
211 - Adult Mental Health Services for the Deaf	39 - Adult mental health admitted patient services for the Deaf
212 – Adult Mental Health Rehabilitation (Mainstream Service)Please refer to footnote *91	35 - Adult admitted patient continuing care 36 - Adult community rehabilitation unit

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Mental Health Admitted Patient Classification Type v6.0	Hospital Bed Type (Mental Health) Mental Health Admitted Patient Classification v5.0
	37 - Adult highly specialist high dependency rehabilitation unit 38 - Adult longer term high dependency rehabilitation unit
213 – Adult Mental Health Rehabilitation for Adults with a Learning Disability and/or Autism (Specialist Service)Please refer to footnote *91	35 - Adult admitted patient continuing care 36 - Adult community rehabilitation unit 37 - Adult highly specialist high dependency rehabilitation unit 38 - Adult longer term high dependency rehabilitation unit
300 - General Child and Young Person - Child (up to and including 12 years)	23 - General child and young person admitted patient - Child (including High Dependency)
301 - General Child and Young Person – Young Person (13 years up to and including 17 years)	24 - General child and young person admitted patient - Young Person (including High Dependency)
302 - Eating Disorders – Child and Young Person	25 - Eating Disorders admitted patient - Young person (13 years and over) 26 - Eating Disorders admitted patient - Child (12 years and under)
303 - Child and Young Person Low Secure Mental Illness	27 - Child and Young Person Low Secure Mental Illness
304 - Child and Young Person Medium Secure Mental Illness	28 - Child and Young Person Medium Secure Mental Illness
305 - Child Mental Health Services for the Deaf	29 - Child Mental Health admitted patient services for the Deaf
306 - Child and Young Person Low Secure Learning Disabilities	31 - Child and Young Person Low Secure Learning Disabilities
307 - Child and Young Person Medium Secure Learning Disabilities	32 - Child and Young Person Medium Secure Learning Disabilities
308 - Severe Obsessive-Compulsive Disorder and Body Dysmorphic Disorder - Young person	33 - Severe Obsessive-Compulsive Disorder and Body Dysmorphic Disorder - Young person
309 - Child and Young Person Psychiatric Intensive Care Unit	34 - Child and Young Person Psychiatric Intensive Care Unit
310 - Child and Young Person Learning Disabilities	30 - Child and Young Person Learning Disabilities / Autism admitted patient
311 - Child and Young Person Autism	30 - Child and Young Person Learning Disabilities / Autism admitted patient

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Appendix 10 - Definitions for Service or Team Types and Mental Health Admitted Patient Classification Types

Appendix 10.1 Service or Team Type definitions

The current list of Team Types applies to Community Services only.

The table below shows each Team Type and relevant national code as detailed in the ETOS, along with an additional definition.

National Code	Team Type	National Code Definition
A01	Day Care Service	TBC
A02	Crisis Resolution Team/Home Treatment Service	This code is to be used for teams that provide functions of urgent and acute mental health care in the community. This typically includes urgent mental health assessment, gatekeeping inpatient admissions, intensive home treatment as an alternative to admission, as well as facilitating early discharge from inpatient care. It may be more common for children and young people's crisis teams' services to combine all of the functions described above. These teams may also include an assertive outreach function. Solar Crisis and Street Triage teams would fall into this team type/code.
A05	Primary Care Mental Health Service	This service provides specialist mental health support to GP practices and practice staff: mental health professionals are likely to sit within primary care settings and are available to see patients with a range of illnesses and diagnoses, including severe mental illnesses, directly. Additionally, they will provide advice and consultation to GP practice staff. The service is most likely to involve staff employed by the local secondary mental health care provider operating within the primary care setting. However, arrangements may vary, e.g., practices directly employing mental health workers or ICB's contracting with the Voluntary, Community and Social Enterprise (VCSE), to provide VCSE staff who sit within primary care settings. These services may also be known as primary care liaison mental health services and may in reality differ very little from the functions conventionally fulfilled by generic Community Mental Health Teams (CMHTs). Services coded under this team type A05 should NOT include IAPT services co-located in primary care; all IAPT activity, whether co-located in primary care or not, should continue to flow through the IAPT Data Set.
A06	Community Mental Health Team - Functional	This is a service that provides a generic functional community mental health service, the model is similar across both adults, children and young people. This may include other functions e.g., neuro-developmental and organic presentations. The service activity takes place outside of primary care settings.

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National Code	Team Type	National Code Definition
		Some providers have named their generic community mental health teams “Recovery Teams”, but these teams’ activity should be recorded against this generic CMHT team type A06.
A07	Community Mental Health Team - Organic	This code is for teams that specifically respond predominantly to organic mental disorders. Teams that have a specific primary focus should use the appropriate code, (e.g., A15, C01, C04 etc)
A08	Assertive Outreach Team	For use only where assertive outreach is the primary function and activity of the team. This function may also be a feature of other team types, for example, A02, A03 and A04 teams.
A09	Community Rehabilitation Service *92	This code refers to community mental health rehabilitation, which are services that enable people who experience severe mental illness to acquire, or develop the lost skills and confidence required to enable them to live as independently as they would wish. For some people, the reduction of distressing symptoms may be all they need to function at their optimum, however, many others will also need specific and skilled rehabilitation support and intervention Tertiary mental health rehabilitation in the community is provided as an integral part of a local rehabilitation pathway where a person’s needs can be met outside hospital. This should include specific rehabilitation intervention, in-reach into inpatient care (mental health rehabilitation and acute care) and support, advice to and consultation with the wider system. This includes ensuring key interventions provided via VCFSE, eg, support with employment, housing, supported living, social prescribing and benefits advice, are accessible to people who have rehabilitation needs, and scaffolding wider and core community mental health services. This has the benefits of reducing transitions, facilitating early discharge and providing a link to the community. Note – Guidance pending publication
A10	General Psychiatry Service	This code is to be used only for a distinct service staffed by trained and accredited consultant psychiatrists (as well as staff in training or support staff).
A11	Psychiatric Liaison Service	This code describes a specialist mental health service that provides MH care in settings not traditionally equipped to provide it, such as emergency department or general hospital inpatient wards. Use C05 Paediatric Liaison Service if there is a dedicated CYP team to provide mental health support to paediatric wards with or without a response to the emergency department.
A12	Psychotherapy Service	This code is to be used only for a distinct service staffed by trained and accredited individual or group psychoanalytic/psychodynamic or systemic family therapists.
A13	Psychological Therapy Service (non IAPT)	This code is to be used only for a distinct service staffed by clinical and other practitioner psychologists.
A14	Early Intervention Team for Psychosis	This should be used for teams as set out in the service description in the Implementing the Early Intervention in Psychosis Access and Waiting Time Standard guidance document. Providing the full range of psychological, psychosocial, pharmacological and other

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National Code	Team Type	National Code Definition
		interventions shown to be effective in NICE guidelines and quality standards, including support for families and carers. EIP services also triage, assess and treat people with an 'at risk mental state' (people at high risk of developing psychosis), as well as help those not triaged to access appropriate treatment and support.
A15	Young Onset Dementia Team	This code is to be used for services who support people with a diagnosis of dementia under the age of 65, often called 'early' or 'young' onset dementia.
A16	Personality Disorder Service	This code is for services dedicated to providing treatment to those with personality disorder and complex emotional needs only.
A17	Memory Services/Clinic/Drop in service	This code is to be used for specialist services that provide assessment and diagnosis of dementia - and when appropriate, treatment - and provide ongoing support and information to people living with cognitive/memory issues and their carers.
A18	Single Point of Access Service	This code is for use where a single point of access service is the team's primary function. This code should not be used for activity coming via the NHS 111 select MH option. If this function is included with the functions of, for example, a general community mental health team the appropriate code (A06) should be used.
A19	24/7 Crisis Response Line	This code is for use where a 24/7 crisis response line is the team's primary function and should be used to record the total number of telephone referrals and contacts coming into these services. Only telephone contacts should be recorded for this team type. If this function is included with the functions of, for example, a Crisis Resolution Team/Home Treatment Service, the appropriate code (A02) should be used with telephone recorded as the means of contact. This code is for use for all activity coming through the NHS 111 select MH option and is therefore the organisations 24/7 crisis response line. It should be used to record the total number of telephone referrals and contacts coming into these services. This includes text messages for the crisis text service. This function may sit within what is referred to locally as a Single Point of Access Service. The broader activity, not coming in via the NHS 111 select MH option, should not be recorded against this team type and instead be recorded against the Single Point of Access team type. If this function is included with the functions of, for example, a Crisis Resolution Team/Home Treatment Service, the appropriate code (A02) should be used with telephone / text message recorded as the means of contact.
A20	Health Based Place of Safety Service	Section 136 of the MHA allows for someone believed by the police to have a mental disorder, and who may cause harm to themselves or another, to be detained in a public place and taken to a safe place where a mental health assessment can be carried out.

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National Code	Team Type	National Code Definition
		A place of safety could be a hospital, care home, or any other suitable place where the occupier is willing to receive the person while the assessment is completed. Police stations should only be used in exceptional circumstances. Health-based places of safety are most commonly part of a mental health unit on a mental health hospital or acute hospital site, or part of an accident and emergency department in an acute hospital. Unless the place of safety is an Emergency Care department, it will not usually be available to people who have not been detained by the police.
A21	Crisis Cafe/Safe Haven/Sanctuary Service	Crisis cafes offer mental health support to people, often in the evenings and weekends, when they may need help most. They aim to support people to reduce any immediate crisis and to safety plan; drawing on strengths, resilience, and coping mechanisms to manage their mental health and wellbeing. As well as offering support, professionals may also be able to refer and direct onwards to further services if required. A sanctuary or safe haven provides a safe, homely place for individuals experiencing crisis to go as an alternative to attending A&E. Primarily a physical location of safety, offering practical and emotional support during the evening (although they don't provide accommodation), they often include a 24-hour crisis support line/NHS 111 'select MH option'. While the functions and naming of these services may vary slightly in different geographies, they are included as a single 'team type' for the purposes of recording activity in the MHSDS. These services are typically, but not exclusively, provided by voluntary sector providers and tend to be staffed by a mixture of voluntary sector, support/peer support workers, and may sometimes have input from qualified NHS and Local Authority staff.
A22	Walk-in Crisis Assessment Unit Service (aka Crisis Assessment Service)	Specialist NHS services / facilities that operate alongside emergency departments to provide access to high quality, safe and compassionate care that interfaces across all internal and external agencies, for those in mental health crisis. Crisis Assessment Centres will be usually accessed via self-referral via, direct referral from other UEC mental health services, or 'a walk-in' where patients choose to do so. Services will be led by a consultant/nurse consultant, in easy-to-access locations, in close vicinity to emergency department(s), ideally co-located with other mental health services, including crisis teams, inpatient facilities and community mental health teams.
A23	Psychiatric Decision Unit Service	A psychiatric decision unit (PDU) is a dedicated mental health acute assessment unit, providing an additional facility for an enhanced assessment and offering short-term support to people in mental health crisis. People are typically referred to such units from an Emergency Care department or another urgent mental health service, as a place of respite for those experiencing acute and complex mental health crisis, for whom in-patient admission is being considered. They are predominantly assessment units, staffed by qualified NHS staff with overnight facilities (typically for up to 48/72 hours) for the assessment and development of treatment plans. The reduction in time pressure enables the service user to think

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National Code	Team Type	National Code Definition
		through more clearly the nature of their crisis and the sort of help they need to recover, both over the short and long term, and gives clinicians time for more thorough, ongoing assessment, and sometimes for the crisis to resolve or reduce. This enables treatment plans to be tailored to the needs of the service users, making full use of community services, and potentially less likely to result in an inpatient episode.
A24	Acute Day Service	Acute day services provide assessment and treatment to people experiencing a mental health crisis who would otherwise require admission to an inpatient service. People can also be referred to acute day services to shorten their time spent in an inpatient setting. The treatment that is provided in acute day services should be the same as that which could be accessed in an inpatient service. These services can be provided as a part of an acute hospital unit or as a separate unit. In some areas, they can also support relapse prevention or recovery work for people in community services who would not otherwise need the intensity of support or treatment from a Crisis Resolution Home Treatment Team (CRHTT).
A25	Crisis House Service	Crisis and recovery houses are community-based residential settings that give clinical and social support to people during a crisis. Some crisis houses may provide specialist care for a specific population, such as women, but most are accessible to the general population. Care is usually provided in supported housing in partnership with voluntary or social care organisations. The function of the Crisis House is to serve as an alternative to admission into hospital. The service is aimed at supporting people who are experiencing a mental health crisis which would result in them requiring admission, but who could be supported positively and safely in the crisis house instead. The crisis house provides a safe alternative to home where people can recover from their crisis, be reminded of useful skills, maintain their independence and access appropriate support. The staffing of crisis houses can vary. Some are staffed mainly by voluntary sector and/or support and peer support workers, some mainly by clinical staff, or a mixture.
B01	Forensic Mental Health Service	Use for NHS England commissioned community forensic mental health services. For adults this may include support and in-reach into medium and low secure mental health hospitals and excludes prisons. For children and young people this may include support and in-reach into Youth Offending/Youth Justice teams and secure settings excluding prisons.
B02	Forensic Learning Disability Service	A Forensic Learning Disability Service provides specialist forensic assessment and treatment of Forensic Mental Health Patients who also have a Learning Disability.
C01	Autism Service	Used only for services that only focus on Autism Spectrum Disorder. Use A07 for generic organic teams. For mixed neuro-development teams, including ADHD, use C04.
C02	Specialist Perinatal Mental Health Community Service	Used for specialist community perinatal mental health (PMH) services. These are multidisciplinary teams in secondary mental health services, commissioned to provide NICE-concordant

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National Code	Team Type	National Code Definition
		assessments and interventions for women who are experiencing, or are at risk of, moderate, severe/complex mental illness. Provision provided from pre-conception up to two years post birth. These are distinct from maternal mental health services (MMHS) which provide support to women whose needs arise from trauma and/or loss in the maternity/ perinatal/neonatal context. These services have a different team code.
C04	Neurodevelopment Team	Used for teams primarily focused on mixed neurodevelopmental disorders including, for example, Attention Deficit with Hyperactivity Disorder, Autistic Spectrum Conditions, etc.
C05	Paediatric Liaison Service	This code describes a service where the primary function is to provide mental health support to CYP in hospital paediatric services only. If combined with community crisis resolution and or home treatment service, use A02. For a service for all ages or adult-only liaison service please use A11.
C06	Looked After Children Service	This code describes a MH service mainly for Looked After Children. This may include care leavers and adoption services.
C07	Youth Offending Service	This code describes a service for community Young Offenders/Youth Justice Services only. See Forensic Services codes and D02 also.
C08	Acquired Brain Injury Service	(Not specific to secure) To support patients with Acquired Brain Injury (both traumatic and non-traumatic) and other co-morbidities including mental illness and substance misuse in a therapeutic, hospital environment. The purpose of admission may be acute care or longer-term rehabilitation to meet specific outcomes/goals for the individual.
C10	Community Eating Disorder Service	This code covers Community Eating Disorder services for Children and Young People and / or for Adults. N.B. Combination of previously used C03 'Eating Disorders/Dietetics Service' and C09 'Community Eating-Disorder Service for CYP' Eating Disorders Day Services would fall within this team type/code.
D01	Substance Misuse Team	TBC
D02	Criminal Justice Liaison and Diversion Service	Services that identify people who have mental health, learning disability, substance misuse or other vulnerabilities when they come into contact with the criminal justice system as suspects, defendants or offenders. These services support people through the early stages of criminal system pathway, refer them for appropriate health or social care or enable them to be diverted away from the criminal justice system into a more appropriate setting, if required.
D03	Prison Psychiatric In reach Service	TBC
D04	Asylum Service	TBC
D05	Individual Placement and Support Service	Individual Placement and Support (IPS)[86] supports people with severe mental health difficulties into employment. It involves intensive, individual support, a rapid job search followed by

[86] https://ipsgrow.org.uk/

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National Code	Team Type	National Code Definition
		placement in paid employment, and time-unlimited in-work support for both the employee and the employer. This code may be used where patients are supported in secondary mental health care or in primary care networks.
D06	Mental Health In Education Service	This code is to be used for services that are located in education settings and/or primarily focused on students in schools, colleges or universities. Services coded under this team type D06 should no longer include the activity of Mental Health Support Teams. Mental Health Support Teams' activity should now be coded using F01 'Education-based Mental Health Support Team'.
D07	Problem Gambling Service	This code is to be used for services that deliver specialised treatment for people with moderate to severe gambling disorder. This includes people presenting with severe gambling disorder (PGSI score of 8+), people presenting with gambling disorder and a comorbid mental and physical health condition and not requiring residential care, and services for children and young people (aged 13-25) with a gaming and gaming-related gambling problem.
D08	Rough sleeping service	These services would normally provide a multi-agency response to properly support rough sleepers with mental health needs. They integrate mental health support with existing homelessness services. Examples could include mental health teams alongside support such as outreach, substance misuse, occupational therapist and housing support teams.
E01	Community Team for Learning Disabilities	A multi-disciplinary team offering specialist assessment, treatment and care to adults with a learning disability in the community. These teams are likely to include a range of professionals such as community learning disability nurses, social workers, psychiatrists, psychologists and therapists. The team will carry out a range of functions including but not limited to social care assessment and care management; care co-ordination, support for daily living and maintaining good health.
E02	Epilepsy/Neurological Service	Where this service exists, it would usually be psychiatrists who have a special interest in epilepsy, supported by community nurses who have developed a specialism in epilepsy or epilepsy specialist nurses, who liaise with neurology directly and support appointments.
E03	Specialist Parenting Service	Teams and networks where Learning Disability Occupational Therapists have a specialist interest and will work with networks of health practitioners and health visitors. This could also be a function within the community learning disability team.
E04	Enhanced/Intensive Support Service	A community team offering short-term, urgent, assessment, treatment and care to adults with a learning disability and behaviour that challenges during a time of crisis. The service may be 24/7, offer a crisis response, may include respite care, may include a "longer term intensive support" function. Please see the model service specifications[87] which provides detail for commissioners about the purpose, functions and intended outcomes for enhanced (intensive) multi-disciplinary

[87] https://www.england.nhs.uk/wp-content/uploads/2017/02/model-service-spec-2017.pdf

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National Code	Team Type	National Code Definition
		health and social care support, specialist community forensic support and acute learning disability inpatient services.
F01	Education-based Mental Health Support Team	This code is to be used specifically for a Mental Health Support Team service. These schools- and college-based teams deliver evidence-based interventions for pupils and students with mild-to-moderate mental health issues, with a focus on early intervention and ongoing help. Any education-based service that is not a Mental Health Support Team should use D06 'Mental Health in Education Service'.
F02	Maternal Mental Health Service	Used for Maternal Mental Health Services (MMHS). These services provide NICE-concordant, evidence-based treatment with a focus on psychological interventions, to women with moderate-severe/complex mental health needs arising from trauma and/or loss in the maternity/ perinatal/neonatal context. These are distinct from the specialist community perinatal mental health (PMH) services, which serve a more general population of women with moderate to severe perinatal mental health needs, from pre-conception up to two years post birth. These services have a different team code.
F03	Mental Health Services for Deaf people	TBC
F05	Enhanced care in care homes teams	Care Home Liaison Team (part of older adult CMHTs) would fall into this category/code.
F06	Mental Health and Wellbeing hubs	Guidance on Reporting on staff mental health and wellbeing hubs for the Mental Health Services Data Set is available on the NHS Futures platform Further information is also available on the NHS England website To note: Code F06 does not cover any pre-existing staff support services, it is only to be used for the nationally-funded staff mental health and wellbeing hubs.
F07	Armed Forces Veterans Integrated Treatment Service	This code will be used by the NHSE Armed Forces Health Commissioning team to identify the submitted MHSDS for the OP Courage Integrated Veterans Mental Health Service[88] which started on 1st April 2023. This code replaces the previous F04 - Veterans Complex Treatment Service code, which has been retired for v6.
Z01	Other Mental Health Service - in scope of National Tariff Payment System	This code is for any mental health team whose function is not covered by any other codes but is still in scope of the National Tariff Payment System (now referred to as the NHS Payment Scheme).
Z02	Other Mental Health Service - out of scope of National Tariff Payment System	This code is for any mental health team whose function is not covered by any other codes and is out of scope of the National Tariff Payment System.

[88] https://www.nhs.uk/nhs-services/armed-forces-community/mental-health/veterans-reservists/

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Appendix 10.2 Mental Health Admitted Patient Classification Type definitions

The current list of Mental Health Admitted Patient Classification Types applies to inpatient services only. It is located in the MHS502 Ward Stay table.

The table below shows each Mental Health Admitted Patient Classification Type, its associated definition and relevant national code.

*Note: There is currently no code to identify respite care, instead the Presenting Complaint or Diagnosis tables can be used to identify this via the recording of ICD-10 codes.

National Code	Category	National Code Definition
200	Acute adult mental health care	An acute bed for adults of working age (18–65) for males or females. Patients may be informal or subject to the MHA. These wards are now expected to meet the single sex accommodation standards. Acute inpatient wards provide care with intensive medical and nursing support for patients in periods of acute psychiatric illness.
201	Acute older adult mental health care (organic and functional)	Older adult beds are provided for the psychiatric care of primarily older patients with complex co-morbidities, including enhanced levels of physical frailty. The patient needs supported by these services will include one or both of the following: 1. Organic mental illness which is a dysfunction of the brain associated with decreased mental function 2. Functional mental illness which covers a range of psychiatric illness including; psychosis, affective and behavioural disorders. Patients on Older Adult mental health wards, often exhibit complex co-morbidities including enhanced levels of physical frailty. Patients typically stay longer on Older Adult wards than on General Psychiatric wards given their poor state of physical and mental health and need for ongoing care and support.
202	Adult Psychiatric Intensive Care Unit (acute mental health care)	A PICU is a type of psychiatric inpatient ward. These wards are secure, meaning that they are locked and entry and exit of patients is controlled. Staffing levels are usually higher than on an acute inpatient ward, usually multi-disciplinary and sometimes with 1:1 nursing staffing ratios. They usually receive patients who cannot be managed on the acute inpatient wards due to the level of risk the patient poses to themselves or to others. In some cases, patients may also be referred from prisons or rehabilitation wards. Patients will usually be detained under the MHA. Length of stay is normally short (ranging from a few days to a few weeks, depending on the patient's needs), and patients are usually returned to the acute inpatient ward as soon their risk has reduced, and the more intensive treatment has started. Psychiatric intensive care is for compulsorily detained patients of adult working age, who are in an acutely disturbed phase of a serious mental disorder.
203	Adult Eating Disorders	A bed designated for the specific treatment of psychiatric illness associated with Eating Disorders. This is for the acute phase of treating Eating Disorders and will typically have high inputs of Medical, Nursing, and Therapy staff.

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National Code	Category	National Code Definition
204	Mother and baby	Specialist beds associated with the care of mothers and their babies for a range of mental illness associated with the puerperium. This can include psychosis and affective (mood) disorders. Perinatal mental health units care for both mother and baby, and typically have high intensity input from Medical, Nursing, and Therapy staff.
205	Acute Mental Health Unit for Adults with a Learning Disability and/or Autism	Adult acute mental health inpatient services specifically for people who have a learning disability and for autistic people - Some people refer to this as a 'specialist' service, or an 'enhanced' service but it simply means that the acute mental health inpatient service, and its team, has been designed especially with the needs of these groups of people in mind to ensure they receive high quality care for short periods of time where adult or older adult services cannot be reasonably adjusted sufficiently. People who are admitted to these hospitals are still being assessed and treated within the requirements of the MHA (whether admitted formally or informally). An admission to an acute mental health inpatient setting which is specifically for autistic adults and adults with a learning disability should only take place when: • The person has a learning disability or is autistic, and • They meet the criteria for admission to an acute mental health hospital, and • Sufficient reasonable adjustments cannot practicably be made to the physical environment, staffing, or general approach within adult and older adult acute mental health inpatient services to provide equitable outcomes (and this is evidenced). Further detail can be found in the 'National guidance to support ICBs to commission acute mental health inpatient services for adults with a learning disability and autistic adults (NHS England, 2023)' (This link will be available once live).
206	Adult Low secure	Low secure units deliver intensive, comprehensive, multidisciplinary treatment and care by qualified staff, for patients who demonstrate disturbed behaviour in the context of a serious mental disorder and who require the provision of security. This is according to an agreed philosophy of unit operation underpinned by the principles of rehabilitation and risk management. Such units aim to provide a homely secure environment, which has occupational and recreational opportunities, and links with community facilities. Patients will be detained under the MHA and may be restricted on legal grounds needing rehabilitation usually for up to two years. Access to this service is typically from local mental health services (including PICU), from medium secure services or from the criminal justice system.
207	Adult Medium secure	Medium secure services work within a framework of clinical governance, specialised assessment, treatment, rehabilitation and aftercare services for offenders with mental health problems, or those at risk of offending. Thereby seeking to reduce the distress associated with mental health problems, and their behavioural consequences, with reduction of risk of harm to others. Most patients enter medium secure care from court or prison, although some may be referred from general mental health services. All will be detained under the MHA. They may also move

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National Code	Category	National Code Definition
		to medium secure services by means of transfer from low or high secure services, as a consequence of changing needs. The average length of stay in medium secure care is 18–24 months, although some may require medium security for longer.
208	Adult High secure	High secure services work within a framework of clinical governance, specialised assessment, treatment, rehabilitation and aftercare services for offenders with mental health problems or those at risk of offending, and pose a grave or immediate risk to themselves or others. Thereby seeking to reduce the distress associated with mental health problems and their behavioural consequences, with reduction of risk of harm to others. Patients enter high secure care from court, prison or medium secure services, and occasionally from low secure services, and all will be detained under the MHA. The average length of stay in high secure care is around ten years with lifetime stays also evident due to the specific requirements of the justice system.
209	Adult Neuropsychiatry / Acquired Brain Injury	Neuropsychiatry and Acquired Brain Injury beds, are complex inpatient services for people who have suffered a brain injury or other impairment due to both traumatic and non-traumatic events. Patients suffer from brain cell damage that requires specialist brain injury help. Patients may suffer from progressive symptoms that require ongoing specialist management. Patients can suffer from complex physical, cognitive and behavioural co-morbidities that require specialist care. This specialist care can be associated with complex diagnostic and rehabilitation services, which include a large therapy component. Services provided typically span neuro-psychological and neuro-psychiatric services as well as a range of supporting physical and cognitive therapies.
210	Adult personality disorder	This code is for inpatient services (Tier 4 only) dedicated to providing treatment to those with personality disorder and complex emotional needs only.
211	Adult mental health services for the Deaf	TBC – Awaiting further policy guidance.
212	Adult Mental Health Rehabilitation (Mainstream Service)*91	This code refers to adult mental health rehabilitation inpatient services that should now be described as Level 1 and Level 2 services. Please refer to the following published guidance: NHS England » Commissioner guidance for adult mental health rehabilitation inpatient services). Level 1 services have many of the characteristics of inpatient services described elsewhere/previously as 'community rehabilitation units' Level 2 services (higher support needs) have many of the characteristics of services described elsewhere/previously as 'high dependency rehabilitation units' Note – the commissioner guidance clearly states that the commissioning of locked rehab should cease.
213	Adult Mental Health Rehabilitation for Adults with a Learning Disability	• • This code refers to adult mental health rehabilitation inpatient services that should now be described as Level 1

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National Code	Category	National Code Definition
	and/or Autism (Specialist Service)*91	and Level 2 services. Please refer to the following published guidance: NHS England » Commissioner guidance for adult mental health rehabilitation inpatient services • Level 1 services described elsewhere/previously as 'community rehabilitation units' • Level 2 services (higher support needs) have many of the characteristics of services described elsewhere/previously as 'high dependency rehabilitation units' • Note – the commissioner guidance clearly states that the commissioning of locked rehab should cease
300	General Child and Young Person - Child (up to and including 12 years)	Children and Young People's Services, deliver tertiary level care to children who are suffering from severe and/or complex mental health conditions. Units admit children aged pre-school to 12; one unit offers family admissions allowing admission for younger children and parents together. Services are provided for children with a wide range of disorders, including severe emotional and behavioural disorders, eating disorders, severe anxiety disorders and severe psychosomatic disorders.
301	General Child and Young Person – Young Person (13 years up to and including 17 years)	Children and Young People's Services, deliver tertiary level care and treatment to young people with severe and/or complex mental disorders. Services are provided for young people between 13 and up to including 17 years, with a range of mental disorders (including depression, psychoses, eating disorders, severe anxiety disorders, emerging personality disorder and severe psychosomatic disorders). All associated with significant impairment and/or significant risk to themselves or others, such that their needs cannot be safely and adequately met by community Tier 3 CAMHS. This includes young people with mild learning disability and Autism Spectrum Disorders, who do not require Tier 4 CAMHS Learning Disability Services.
302	Eating Disorders – Child and Young Person	Tier 4 CAMHS specialist eating disorder units, are for children and young people suffering from severe eating disorders, resulting in significant weight loss and/or severely impaired growth. Such that their health, growth and development are at risk, and who have not responded to Tier 3 CAMHS outpatient treatment. Children and young people may also be referred for treatment where at the point of referral, to Tier 3 CAMHS if they are within a high-risk low weight range and could not be safely treated within Tier 3 CAMHS. The primary reason for referral to such services, is the presence of a severe eating disorder, although units are able to treat the psychiatric co-morbidities which commonly accompany severe eating disorders. Tier 4 CAMHS specialist eating disorder services admit children and young people with anorexia nervosa, atypical anorexia, eating disorders not otherwise specified (EDNOS), food avoidant emotional disorder, refusal syndromes and phobias leading to severely restricted eating.

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National Code	Category	National Code Definition
303	Child and Young Person Low Secure Mental Illness	Low secure settings accommodate young people with mental and neurodevelopmental disorders at lower, but nevertheless significant levels of physical, relational and procedural security. Young people in such settings may belong to one of two groups: those with 'forensic' presentations involving significant risk of harm to others, and those with 'complex non-forensic' presentations principally associated with challenging behaviour, self-harm and vulnerability. Young people admitted to low and medium secure settings, generally require significant lengths of stay from months to years.
304	Child and Young Person Medium Secure Mental Illness	Medium secure settings accommodate young people with mental and neurodevelopmental disorders, who present with the highest levels of risk of harm to others, including those who have committed serious crimes. In such settings, there are prescribed stringent levels of physical security and high levels of relational and procedural security. Young people admitted to medium security generally have significant lengths of stay from months to years.
305	Child Mental Health services for the Deaf	Four arms (Northern, Central, South East and South West) supporting outreach provision and one specialist inpatient unit, Corner House (South East). Corner House is a six-bedded unit. For the purposes of this specification document the service will be referred to henceforth as NDCAMHS. NDCAMHS was established as a Highly Specialised Service (High Cost, Low Volume) in recognition of the specific complex needs associated with deaf children and young people with mental health problems, and the poorer mental health and life outcomes for this group of young people in both childhood and adulthood.
306	Child and Young Person Low Secure Learning Disabilities	Low secure settings accommodate young people with mental and neurodevelopmental disorders at lower, but nevertheless significant levels of physical, relational and procedural security. Young people in such settings may belong to one of two groups: those with 'forensic' presentations involving significant risk of harm to others and those with 'complex non-forensic' presentations principally associated with challenging behaviour, self-harm and vulnerability. Young people admitted to low and medium secure settings generally require significant lengths of stay from months to years.
307	Child and Young Person Medium Secure Learning Disabilities	Medium secure settings accommodate young people with mental and neurodevelopmental disorders, who present with the highest levels of risk of harm to others including those who have committed serious crimes. In such settings, there are prescribed stringent levels of physical security and high levels of relational and procedural security. Young people admitted to medium security generally have significant lengths of stay from months to years.
308	Severe Obsessive-Compulsive Disorder and Body Dysmorphic Disorder – Young Person	The national obsessive-compulsive disorder & Body Dysmorphic Disorder service (OCD/BDD), is commissioned to provide highly specialised assessment and treatment for patients experiencing severe OCD or BDD through out-patient, homebased, residential unit or in-patient services on behalf of NHS England for the Population of England.

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National Code	Category	National Code Definition
309	Child and Young Person Psychiatric Intensive Care Unit	Psychiatric intensive care units (PICU) for young people, allow for containment of short-term behavioural disturbance which cannot be contained within an open adolescent in-patient unit. This behaviour will be associated with a serious risk of either suicide, absconding with a significant threat to safety, aggression or vulnerability, for example, due to agitation or sexual disinhibition. They may present with a range of mental disorders (including depression, psychoses, eating disorders, severe anxiety disorders, emerging personality disorder and severe psychosomatic disorders) Levels of physical, relational and procedural security should be similar to those in low security. Whilst educational and recreational facilities should be available to young people in intensive care and secure settings, these provisions will tend to be set up differently in PICUs, which do not have the same emphasis on providing support over a long period of time.
310	Child and Young Person Learning Disabilities	Inpatient: The Tier 4 CAMHS Specialist Learning Disability Unit provides day/ in-patient care and treatment for children and young people with: • moderate to severe learning disabilities and co-morbid mental health problems, which cannot be adequately and safely treated within Tier 3 CAMHS/ Learning Disability Services, because of the associated risk to self or others • children and young people with mild learning disability and co-morbid mental health problems which cannot be adequately or safely treated within Tier 3 • CAMHS because of risk to self or others, and whose needs cannot be met within a Tier 4 CAMHS General Adolescent Unit, or Tier 4 CAMHS Children's Unit • children and young people with moderate to severe learning disabilities, and with complex behavioural difficulties who exhibit a lower level of risk, but where physical illnesses may be contributing to their problems, and this requires in-patient investigation and assessment, and who because of their behaviours, cannot be adequately or safely treated within a paediatric ward or medical ward. Autism Spectrum Disorders - The Tier 4 CAMHS Specialist Autism Spectrum Disorders (ASD) Services, work as integrated multidisciplinary CAMHS teams, providing outpatient assessment, including second opinions and consultation to Tier 3 CAMHS and child health teams (including full investigation, diagnostic advice and advice on management). Outreach and brief intensive specialist treatment, which may include intensive outreach and day-patient care for children and young people who are suffering from ASD and severe and/or complex neurodevelopmental and mental health conditions, that cannot be adequately treated by general Tier 3 CAMHS and child health units/services.
311	Child and Young Person Autism	

*91'NHS England Commissioner Guidance for Adult Mental Health Rehabilitation Inpatient Services'.

*92 pending publication of approved 'NHS England Commissioner Guidance for Community Mental Health Rehabilitation

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Appendix 11 - Assuring Transformation

Important note for providers of mental health inpatient services working with people who have a learning disability and/or are autistic

Assuring Transformation *is a data collection about people with a learning disability and/or autism in specialist hospitals with a mental disorder. The data is submitted by commissioners, using the NHS England's Clinical Audit Platform (CAP).*

Commissioners are required to submit data to AT on the use of restrictive interventions for individual inpatients for whom they commission inpatient services. If commissioners do not already have access to this data, they will ask providers to supply them with it.

If you provide specialist inpatient services for people with a learning disability and/or autism with a mental disorder, you need to share information about the use of restrictive interventions for these patients with the relevant commissioner.

Patients are in scope of AT if they:

- are receiving treatment / care in a facility that provides treatment and / or assessment for mental disorders and is registered by the Care Quality Commission as a hospital, operated by either an NHS or independent sector provider.
- have an inpatient bed normally designated for the treatment or care of people with a learning disability or a bed designated for mental illness treatment or care,
- have been diagnosed or is clinically understood to have a learning disability and/or autism.
- and if an NHS commissioner in England is responsible for commissioning their care.

Assuring Transformation asks for the number of times that patients have been restrained in the past month for different types of restrictive interventions, and the length of time they have been secluded or segregated (if at all). More information can be found at Assuring Transformation (AT) - NHS England. If you have any further questions, please contact ATdata@nhs.net.

Appendix 12 – Future Reporting Clinically Ready for Discharge

MHS518 – Clinically Ready for Discharge

Background

The Clinically Ready for Discharge (CRfD) categories are currently required for submission in both the MHSDS and the NHS England covid-19 MHLDA sitrep data collection.

The DHSC and NHS England previously agreed a review of the categories was required and have been focusing on understanding better what is causing delays in the mental health system. From the review, a single revised list of Mental Health Delayed Discharge Reason categories has been agreed for future use from April 2017. These new categories are fit for purpose for all mental health reporting requirements and are for use across mental health only.

Since April 2023, a new CRfD definition is being used to support the covid-19 MHLDA sitrep data collection and will be introduced to MHSDS v6.0 reporting. Ahead of this, providers are encouraged to start submitting CRfD data to the MHSDS where possible, however where the data doesn't currently quite meet the new CRfD definition they should continue to submit

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their data and we will work with providers to improve data quality in line with the definition ahead of the version 6.0 update. The new CRfD definition is as follows:

'The point at which someone is Clinically Ready for Discharge is reached when the multidisciplinary team (MDT) conclude that the person does not require any further assessments, interventions and/or treatments, which can only be provided in an inpatient mental health setting.

There are three key criteria which need to be met before the MDT can make this decision:

- There must be a clear plan for the ongoing care and support that the person requires after discharge, which covers their pharmacological, physical health, psychological, social, cultural, housing and finances, and any other individual needs or wishes.
- The MDT must have explicitly considered the person and their chosen carer/s' views and needs about discharge and involved them in co-developing the discharge plan.

The MDT must also have sought to involve any services external to the provider in their decision making where these services will play a key role in the person's ongoing care e.g. social care teams, housing.

Patients should only be counted in ONE category of delay for any one period recorded in the Mental Health Delayed Discharge table. Where the reason for the delayed discharge changes during the whole delayed discharge period, multiple reasons can be attributed, by flowing multiple records with consecutive Start and End dates.

Example: If the total length of the delay is 10 days, and the first two days were due to waiting for an NHS-led assessment to be arranged, and the following eight days, were due to awaiting availability of placement in care home without nursing, then the delayed days will be split across category 35 (two days), and category 7 (eight days).

In this scenario, any delays should be submitted sequentially, for example, if you have 3 delay reasons all part of one delayed discharge – you would submit the 3 records (if they are open in the Reporting Period or close in the Reporting Period).

Once the first delay 'ends' – you would populate the EndDateClinReadyforDisch field for the first record with the end date.

The second delay starts when the first delay ends and so on.

The mental health clinically ready for discharge period delay reason codes have been amended for MHSDS version 6.0. The following table shows the change of codes from MHSDS v5.0 to the new codes for v6.0 as they should be mapped across accordingly.

Mental Health Delayed Discharge Reason V5.0		Mental Health Clinically Ready For Discharge Period Delay Reason V6	
A2	Awaiting care coordinator allocation	01	Awaiting care coordinator allocation
B1	Awaiting public funding	04	Awaiting public funding or decision from funding panel
C1	Awaiting further non-acute (including community and mental health) NHS care (including intermediate care, rehabilitation services etc)	05	Awaiting further community or mental health NHS Services not delivered in an acute setting including intermediate care, rehabilitation services, step down service
D1	Awaiting Care Home Without Nursing placement or availability	07	Awaiting availability of placement in care home without nursing
D2	Awaiting Care Home With Nursing placement or availability	08	Awaiting availability of placement in care home with nursing

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Mental Health Delayed Discharge Reason V5.0		Mental Health Clinically Ready For Discharge Period Delay Reason V6	
E1	Awaiting care package in own home	09	Awaiting commencement of care package in usual or temporary place of residence
F2	Awaiting community equipment, telecare and/or adaptations	10	Awaiting provision of community equipment and/or adaptations to own home
G2	Patient or Family choice (reason not stated by patient or family)	11	Patient or Family choice
G3	Patient or Family choice - Non-acute (including community and mental health) NHS care (including intermediate care, rehabilitation services etc)	11	Patient or Family choice
G4	Patient or Family choice - Care Home Without Nursing placement	11	Patient or Family choice
G5	Patient or Family choice - Care Home With Nursing placement	11	Patient or Family choice
G6	Patient or Family choice - Care package in own home	11	Patient or Family choice
G7	Patient or Family choice - Community equipment, telecare and/or adaptations	11	Patient or Family choice
G8	Patient or Family Choice - general needs housing/private landlord acceptance as patient NOT covered by Housing Act/Care Act	11	Patient or Family choice
G9	Patient or Family choice - Supported accommodation	11	Patient or Family choice
G10	Patient or Family choice - Emergency accommodation from the Local Authority under the Housing Act	11	Patient or Family choice
G11	Patient or Family choice - Child or young person awaiting social care or family placement	11	Patient or Family choice
G12	Patient or Family choice - Ministry of Justice agreement/permission of proposed placement	11	Patient or Family choice
H1	Disputes	12	Disputes relating to responsible commissioner for post-discharge care
		13	Disputes relating to post-discharge care pathway between clinical teams and/or care panels
I2	Housing - Awaiting availability of general needs housing/private landlord accommodation acceptance as patient NOT covered by Housing Act and/or Care Act	14	Housing - awaiting availability of private rented accommodation
I3	Housing - Single homeless patients or asylum seekers NOT covered by Care Act	15	Housing - awaiting availability of social rented housing via council housing waiting list
		16	Housing - awaiting purchase/sourcing of own home
		17	Housing - Patient NOT eligible for funded care or support
J2	Housing - Awaiting supported accommodation	18	Housing - Awaiting supported accommodation

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Mental Health Delayed Discharge Reason V5.0		Mental Health Clinically Ready For Discharge Period Delay Reason V6	
K2	Housing - Awaiting emergency accommodation from the Local Authority under the Housing Act	19	Housing - Awaiting temporary accommodation from the Local Authority under housing legislation
L1	Child or young person awaiting social care or family placement	20	Awaiting availability of residential children's home (non-secure)
		21	Awaiting availability of residential children's home (welfare or non-welfare)
		22	Awaiting availability of placement in Youth Offender Institution
		23	Child or young person awaiting family or foster placement
M1	Awaiting Ministry of Justice agreement/permission of proposed placement	24	Awaiting Ministry of Justice agreement to proposed placement
N1	Awaiting outcome of legal requirements (mental capacity/mental health legislation)	25	Awaiting outcome of legal proceedings under relevant Mental Health legislation
		27	Awaiting Deprivation of Liberty Safeguards (DOLS) Application
P1	Awaiting residential special school or college placement or availability	29	Awaiting residential special school or college placement
Q1	Lack of local education support	30	Lack of local education support
R1	Public safety concern unrelated to clinical treatment need (care team)	31	Public safety concern unrelated to clinical treatment need (care team and/or ministry of justice)
R2	Public safety concern unrelated to clinical treatment need (Ministry of Justice)	31	Public safety concern unrelated to clinical treatment need (care team and/or ministry of justice)
S1	No lawful community care package available	33	No lawful support available in the community excluding social care
T1	Lack of health care service provision	34	No social care support including social care funded placement
T2	Lack of social care support	34	No social care support including social care funded placement
-	-	35	Delays to NHS-led assessments in the community
-	-	36	Hospital staff shortages
-	-	37	Delays to non-NHS led assessments in the community
98	No reason given	98	Reason not known

Guidance for Revised Reasons/Attributions

The following table outlines all the mental health clinically ready for discharge period delay reason codes for MHSDS version 6.0 in MHS518.

The table lists suggested attributions that can be used against each of the reason codes, however these are not mandatory and should only be submitted where there's a local need for it to be submitted.

The suggested attribution "Both" refers to both NHS and Social Care

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Code	National Code Definition	Suggested Attribution(s)	High level discharge category
01	Awaiting care coordinator allocation	NHS	Community
02	Awaiting allocation of community psychiatrist	NHS	Community
03	Awaiting allocation of social worker	Social care, Both	Social care/ local authority
04	Awaiting public funding or decision from funding panel	Both, NHS, Social care	Community
05	Awaiting further community or mental health NHS Services not delivered in an inpatient setting including intermediate care, rehabilitation services, step down service	Both, NHS, Social care	Community
06	Awaiting availability of placement in prison or Immigration Removal Centre	Both, NHS, Social care	Community
07	Awaiting availability of placement in care home without nursing	Both, NHS, Social care	Social care/ local authority
08	Awaiting availability of placement in care home with nursing	Both, NHS, Social care	Community
09	Awaiting commencement of care package in usual or temporary place of residence	Both, NHS, Social care	Community
10	Awaiting provision of community equipment and/or adaptations to own home	Both, NHS, Social care	Community
11	Patient or Family choice	Both, NHS, Social care	Hospital
12	Disputes relating to responsible commissioner for post-discharge care	Both, NHS, Social care	Community
13	Disputes relating to post-discharge care pathway between clinical teams and/or care panels	Both, NHS, Social care	Community
14	Housing - awaiting availability of private rented accommodation	Both, NHS, Social care	Housing
15	Housing - awaiting availability of social rented housing via council housing waiting list	Both, NHS, Social care	Housing
16	Housing - awaiting purchase/sourcing of own home	Both, NHS, Social care	Housing
17	Housing - Patient NOT eligible for funded care or support	Both, NHS, Social care	Housing
18	Housing - Awaiting supported accommodation	Both, NHS, Social care	Housing
19	Housing - Awaiting temporary accommodation from the Local Authority under housing legislation	Both, NHS, Social care	Housing
20	Awaiting availability of residential children's home (non-secure)	Both, NHS, Social care	Social care/local authority
21	Awaiting availability of residential children's home (welfare or non-welfare)	Both, NHS, Social care	Social care/local authority
22	Awaiting availability of placement in Youth Offender Institution	Both, NHS, Social care	Community
23	Child or young person awaiting family or foster placement	Both, NHS, Social care	Community
24	Awaiting Ministry of Justice agreement to proposed placement	Both, NHS, Social care	Community
25	Awaiting outcome of legal proceedings under relevant Mental Health legislation	Both, NHS, Social care	Community
26	Awaiting Court of Protection proceedings	Both, NHS, Social care	Community
27	Awaiting Deprivation of Liberty Safeguards (DOLS) Application	Both, NHS, Social care	Community
28	Delay due to consideration of specific court judgements	Both, NHS, Social care	Community

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Code	National Code Definition	Suggested Attribution(s)	High level discharge category
29	Awaiting residential special school or college placement	Both	Community
30	Lack of local education support	Both, NHS, Social care	Community
31	Public safety concern unrelated to clinical treatment need (care team and/or ministry of justice)	Both, NHS, Social care	Community
32	Highly bespoke housing and/or care arrangements not available in the community	Both, NHS, Social care	Housing
33	No lawful support available in the community excluding social care	Both, NHS	Community
34	No social care support including social care funded placement	Both, Social care	Social care/local authority
35	Delays to NHS-led assessments in the community	NHS	Hospital
36	Hospital staff shortages	NHS	Hospital
37	Delays to non-NHS led assessments in the community	Social care	Community
98	Reason not known	-	-

A person must only be counted in ONE category of delay each day. This category should be the one most appropriately describing their reason for delay on a given day however this category can change each day, as can the attribution (where this is recorded). The total numbers allocated across the reasons for delay must equal the total number of delayed days. Where the reason for the delayed discharge changes during the whole 'clinically ready for discharge' period, multiple reasons can be attributed, by flowing multiple records with consecutive Start and End dates.

For example, if the total length of delay is 10 days, the first two days were due to waiting for an NHS-led assessment to be arranged and the following eight days were due to awaiting availability of placement in care home without nursing, then the delayed days will be split across category 35 (two days) and category 07 (eight days).

Further definitions for the delayed discharge reason codes

This section provides further details of what is and is not covered under each of the delayed discharge reason codes, so that reporting against each of them is clear and consistent.

01 - Awaiting care coordinator allocation

This code should be used when a person's discharge is delayed due to awaiting allocation of a care coordinator in the community. According to best practice, the care-coordinator should be allocated before the decision that someone is clinically ready for discharge is made.

This reason code could be attributed to the NHS in the MHSDS.

02 - Awaiting allocation of community psychiatrist

This code should be used when a person's discharge is delayed due to awaiting allocation of a community psychiatrist. According to best practice, a community psychiatrist should be allocated before the decision that someone is clinically ready for discharge is made.

This reason code could be attributed to the NHS in the MHSDS.

03 - Awaiting allocation of social worker

This code should be used when a person's discharge is delayed due to awaiting allocation of a social worker. According to best practice, this process should be in place before the decision that someone is clinically ready for discharge is made.

This reason code could be attributed to social care, Both (NHS and social care)

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04 - Awaiting public funding or decision from funding panel

This category should be used when a person's discharge is delayed whilst waiting for funding (NHS or local authority), such as for residential placement or home care, or for NHS-funded nursing care or NHS continuing healthcare (CHC).

This category should also be used when the funding panel have not made a decision or communicated that decision about funding a person's post-discharge care. This could also include awaiting NHS and Social Care agreement to fund section 117 aftercare and delayed panel meetings.

This category includes (but is non-exhaustive):

- Where the Local Authority and NHS have failed to agree funding for a joint package of care.
- Where the person is awaiting approval of funding for package of care and placements, including decisions relating to high-cost packages of care.

This category's reason code could be attributed to either NHS, Social Care, or both (NHS and Social Care).

05 - Awaiting further community or mental health NHS Services not delivered in an acute setting including intermediate care, rehabilitation services, step down service

This category should be used when a person's discharge is delayed whilst waiting for care in the community. This includes awaiting access to rehabilitation and specialist health placements in the community. This category should only be used once funding for the placement has been agreed.

This category includes (but is non-exhaustive):

- Delays awaiting a specialised mental health placement in the community.
- Delays awaiting community bed rehabilitation or intermediate care, including rehabilitation services for people with complex mental health needs.
- Delays awaiting an end-of-life care (EOLC) hospice or other NHS CHC fast-track-funded bed.
- Delays awaiting long term NHS CHC placement.
- Delays awaiting an interim health placement for NHS CHC assessment, where the discharge to assess bed is solely NHS-funded.

This category excludes:

- Delays in providing NHS-funded care in the person's own home, such as that provided by community health services, in which case delays are counted under category "Awaiting commencement of care package in own home".
- All home-based health or social care packages of care, including intermediate care, in which case delays are counted under category "Awaiting commencement of care package in own home".
- Awaiting any further inpatient care.

This category's reason code could be attributed to either NHS, Social Care, or both (NHS and Social Care).

06 - Awaiting availability of placement in prison or Immigration Removal Centre

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This category should be used when a person's discharge is delayed whilst awaiting transfer or being remitted to prison or transfer to an immigration centre.

This category's reason code could be attributed to either NHS, Social Care, or both (NHS and Social Care).

07 - Awaiting availability of placement in care home without nursing

This category should be used when a person's discharge is delayed whilst waiting for a non-NHS funded residential or nursing home placement, including long-term or intermediate care. This is because a suitable placement is either not currently available or the person is awaiting confirmation from the home following assessment.

This category should be used if the residential care placement does not include NHS-funded nursing care. For placements that provide NHS funded nursing care, please select category "Awaiting availability of placement in care home with nursing".

This category should be used after funding has been agreed. In situations where it is difficult to find a suitable placement – funding in principle should be sought from the panel and then this category should be used.

According to the Care Quality Commission (CQC) a care home is a place where personal care and accommodation are provided together. People may live in the service for short or long periods. For many people, it is their sole place of residence and so it becomes their home, although they do not legally own or rent it. Both the care that people receive, and the premises are regulated.

Examples of services that fit under this category:

- Residential home
- Rest home
- Convalescent home
- Respite care
- Mental health crisis house
- Therapeutic communities

This category includes:

- Residential care pathways that are jointly funded.

This category excludes:

- Delays where the local authority funding has been agreed and two or more choices have been offered, but the person or their family are exercising their right to choose a home under the Care and Support and After-care (Choice of Accommodation) Regulations (2014), in which case delays are counted under the category "Patient or family choice".

This category's reason code could be attributed to either NHS, Social Care, or both (NHS and Social Care).

08 - Awaiting availability of placement in care home with nursing

This category should be used when a person's discharge is delayed whilst waiting for an NHS funded residential or nursing home placement, including long-term or intermediate care. This is because a suitable placement is either not currently available or the person is awaiting confirmation from the home following assessment.

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According to the CQC, a care home is a place where personal care and accommodation are provided together. People may live in the service for short or long periods. For many people, it is their sole place of residence and so it becomes their home, although they do not legally own or rent it. Both the care that people receive, and the premises are regulated. In addition, qualified nursing care is provided, to ensure that the full needs of the person using the service are met.

Examples of services that fit under this category:

- Nursing home
- Convalescent home with nursing
- Respite care with nursing
- Mental health crisis house with nursing

This category excludes:

- Residential care pathways that are jointly funded, these which would be categorised under “Awaiting availability of placement in care home without nursing”.
- Delays in providing NHS-funded care in the person’s own home, such as that provided by community health services, in which case delays are counted under category “Awaiting commencement of care package in usual or temporary place of residence”.
- All home-based health or social care packages of care, including intermediate care, in which case delays are counted under category “Awaiting commencement of care package in usual or temporary place of residence”.

This category’s reason code could be attributed to either NHS, Social Care, or both (NHS and Social Care).

09 - Awaiting commencement of care package in usual or temporary place of residence

This category should be used when a person’s discharge is delayed due to awaiting a package of care in their own home, or somewhere that they call home.

This category includes (but is non-exhaustive):

- Delays awaiting intermediate or other NHS-funded care in their own home or in a temporary place of residence
- Delays awaiting social care-funded reablement or home care
- Delays awaiting jointly funded home care
- Delays awaiting social or community health provided services in the home

The reason code for this category could be attributed to the NHS, Social Care, or both (NHS and Social Care).

10 - Awaiting provision of community equipment and/or adaptations to own home

This category should be used when a person’s discharge is delayed whilst waiting for items of community equipment or minor adaptations to be made to their home, for example, when awaiting adaptations to the sensory environment, the installation of technology to support independence and wellbeing, or adaptations to the building design to improve the robustness of the walls or remove ligature risks, the installation of handrails, ramp or bathing stool etc. This category includes (non-exhaustive):

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- Delays awaiting manual handling equipment, such as hoists
- Delays awaiting living equipment
- Delays awaiting a bed
- Delays awaiting house deep cleaning
- Delays awaiting house decorating
- Delays awaiting house decluttering

The reason code for this category could be attributed to the NHS, Social Care, or both (NHS and Social Care).

11 - Patient or Family choice

This category should be used when a person or chosen carer has been made a reasonable offer of care to meet their assessed needs as far as practicable, but who have refused or are not happy with this offer. In such circumstances, local choice policies should be implemented but any delays incurred while waiting for the person or their family to make another choice, are still reportable as the person is clinically ready for discharge. Patient or family choice may also include delays due to the family/carer no longer wishing to support the person or delays in accessing carer allowance etc.

Where a person's preferred care option is not immediately available, they should be offered a reasonable interim package of care. All interim arrangements should be based solely on the person's assessed needs and be designed to sustain or improve their level of independence. Local agreements for interim packages and placements should be in line with national guidance.

The reason code includes (but is non-exhaustive):

- Delays for people who are funding their own care, such as those opting for a residential or nursing home with no immediate vacancies, or delays incurred by people who want a residential or nursing home where the costs (fees) exceed the amount agreed by the local authority to meet eligible care and accommodation needs
- Delays where there is no alternative provided that can meet the person's needs
- Delays where a reasonable alternative service has been offered, either on an interim or more permanent, long-term basis
- Delays where the person or their families are holding up the discharge, for example, by not attending planning meetings

This category's reason code could be attributed to either NHS, Social Care, or both (NHS and Social Care).

12- Disputes relating to responsible commissioner for post-discharge care

This category should be used when a person's discharge is delayed due to a dispute between statutory agencies, for example, regarding the responsibility for the person's onward care.

This would also be used when there is a dispute about aspects of the post-discharge care e.g. around the catchment area or responsibility for the person. It also includes cases where statutory agencies have failed to agree funding for post-discharge care, however, in cases where the person is awaiting a funding decision from the local authority/NHS, this would be categorised as "Awaiting public funding or decision from funding panel".

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Disputes should occur infrequently, where there is an exceptional level of contention between the NHS and the local authority, they are expected to operate within a culture of problem solving and partnership, where formal dispute is a last resort, and high numbers of disputes should trigger a review of local partnership working.

This category excludes:

- Disagreements with the person or members of their family, in which case delays are counted under the category “Patient or family choice”.

The reason code for this category could be attributed to either the NHS, Social Care, or both (NHS and Social Care).

13 - Disputes relating to post-discharge care pathway between clinical teams and/or care panels

This category should be used when a person’s discharge is delayed due to a dispute between statutory agencies, for example, the appropriateness of the care package being offered.

This category includes disagreements about the type of post-discharge support that should be provided, or any aspects of it, between statutory agencies or clinical teams.

This category excludes:

- Disagreements with people or members of their family, in which case delays are counted under the category “Patient or family choice”.

The reason code for this category could be attributed to either the NHS, Social Care, or both (NHS and Social Care).

14 - Housing - awaiting availability of private rented accommodation

This category should be used when a person’s discharge is delayed whilst awaiting private rented accommodation to be discharged to.

The reason code for this category could be attributed to either the NHS, Social Care, or both (NHS and Social Care).

15 - Housing - awaiting availability of social rented housing via council housing waiting list

This category should be used when a person’s discharge is delayed whilst awaiting general needs social rented housing to be discharged to. People who fit into these circumstances should be given advice on how to find accommodation where needed. This category excludes awaiting the availability of supported housing, which is itself a type of social housing (for the definition of supported housing, please see reason 18).

The reason code for this category could be attributed to either the NHS, Social Care, or both (NHS and Social Care).

16 - Housing - awaiting purchase/sourcing of own home

This category should be used when a person’s discharge is delayed whilst waiting for the purchase of their home to go through or whilst identifying a home that they can be discharged to e.g. friends or family home, or while waiting for a new build home to be completed. The housing could be planned alongside the offer of personalised care and support, for those people who need this. This category excludes awaiting the availability of supported housing (for the definition of supported housing, please see reason 18). People who fit into these circumstances should be given advice on how to find accommodation where needed.

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This category excludes awaiting the availability of privately rented accommodation or social rented housing, see reason 14 and 15.

The reason code for this category could be attributed to either the NHS, Social Care, or both (NHS and Social Care).

17 - Housing - patient NOT eligible for funded care or support

This category should be used when a person's discharge is delayed due to having housing needs but who are not eligible for funded care and support, such as asylum seekers, patients from overseas, homeless people or those with no fixed abode, and are not within the remit of social services, because the local authority has no responsibility under the Care Act (2014).

People who fit into these circumstances should be given advice on how to find accommodation such as homeless shelters/private landlords etc. In some cases, people in these groups may be still the responsibility of a local authority housing service, although this is limited to meeting certain eligibility criteria, including immigration status.

There is a duty on specified public services to refer people they consider may be homeless or threatened with homelessness to a local housing authority, under the Homelessness Reduction Act (2017). For people who have no care needs, the Care Act assessment must clearly document the reasons why someone does not meet the Care Act, Human Rights Act and other case law thresholds.

Prior to discharge the individual should be provided with information and advice regarding local support agencies for street homelessness, and third sector organisations that provide advice to individuals who are not eligible for funded care or support. It is recommended that the individual is supported to make contact with the relevant local organisation prior to the discharge from the ward.

The reason code for this category could be attributed to either the NHS, Social Care, or both (NHS and Social Care).

18 - Housing - Awaiting supported accommodation

This category should be used when a person's discharge is delayed whilst waiting for extra care housing, adult placement schemes, crisis houses, refuges, short stay hostels and other specialist step up/step down accommodation. This should also be used for all requests for non-registered care – usually in-borough facilities providing low, medium or high levels of support. This should include supported housing as defined in the Government's Policy Statement on rents for social housing (2020).

The reason code for this category could be attributed to the NHS, Social Care, both (NHS and social care)

19 - Housing - Awaiting temporary accommodation from the Local Authority under housing legislation

This category should be used when a person's discharge is delayed whilst awaiting accommodation under housing legislation, for example, for people who are legally homeless or have a priority need. This is for people who require general needs housing who have already been accepted by the Housing Department.

This category includes:

- Delays for people who need rehousing

This category excludes:

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- Housing delays for people who are eligible for funded care and support, who are waiting for either an interim or more permanent long-term housing solution (see other housing related categories)

The reason code for this category could be attributed to either the NHS, Social Care, or both (NHS and Social Care).

20 - Awaiting availability of residential children's home (non-secure)

This category should be used when a child or young person's discharge is delayed because they are awaiting a placement in a residential children's home.

The reason code for this category could be attributed to either the NHS, Social Care, or both (NHS and Social Care).

21 - Awaiting availability of secure children's home (welfare or non-welfare)

This category should be used when a child or young person's discharge is delayed because they are awaiting a placement in a secure children's home.

The reason code for this category could be attributed to either the NHS, Social Care, or both (NHS and Social Care).

22 - Awaiting availability of placement in Youth Offender Institution

This category should be used when a child or young person's discharge is delayed because they are awaiting a placement in a youth offender institution or secure training centre.

The reason code for this category could be attributed to either the NHS or both (NHS and Social Care).

23 - Child or young person awaiting foster placement

This category should be used when a child or young person's discharge is delayed because they are awaiting a placement in a foster home.

The reason code for this category could be attributed to either the NHS, Social Care, or both (NHS and Social Care).

24 - Awaiting Ministry of Justice agreement to proposed placement

This category applies to restricted persons only. This category should be used when a person's discharge is delayed whilst waiting for Ministry of Justice (MoJ) approval. It should be used when a placement has been identified and funding has been agreed but the person cannot leave hospital as agreement has not been secured from the MoJ.

The reason code for this category could be attributed to either the NHS, Social Care, or both (NHS and Social Care).

25 - Awaiting outcome of legal proceedings under relevant Mental Health legislation

This category should be used when a person's discharge is delayed whilst awaiting decisions from Independent Mental Capacity Advocates (IMCA) or guardianship where condition of residence is delaying the application of the Mental Capacity Act e.g. best interests assessments/IMCA decisions.

The reason code for this category could be attributed to either the NHS, Social Care, or both (NHS and Social Care).

26 - Awaiting Court of Protection proceedings

This category should be used when a person's discharge is delayed whilst awaiting the outcome from a Court of Protection. This could include awaiting an outcome of an

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application for power of attorney. For example, if someone lacks capacity, then the court of protection will need to authorise a community placement where they may be deprived of their liberty, the person will not be able to be discharged until this is authorised.

The reason code for this category could be attributed to either the NHS, Social Care or both (NHS and Social Care).

27 - Awaiting Deprivation of Liberty Safeguards (DOLS) Application

This category should be used when a person's discharge is delayed whilst waiting for a deprivation of liberty safeguard (DoLS) to be agreed.

The reason code for this category could be attributed to either the NHS, Social Care, or both (NHS and Social Care).

28 - Delay due to consideration of specific court judgements

This category should be used when a person's discharge is delayed due to specific court judgements related to someone's detention, for example

The reason code for this category could be attributed to either the NHS, Social Care, or both (NHS and Social Care).

29 - Awaiting residential special school or college placement

This category should be used when a child or young person's discharge is delayed whilst waiting for a placement at a school or college for special educational needs, for example due to awaiting the completion of the Education Health and Care Plan.

The reason code for this category could be attributed to either the NHS, Social Care, or both (NHS and Social Care).

30 - Lack of local education support

This category should be used when a child or young person's discharge is delayed due to there not being any suitable education provision meaning the overall package of support would have a significant gap.

The reason code for this category could be attributed to either the NHS, Social Care, or both (NHS and Social Care).

31 - Public safety concern unrelated to clinical treatment need (care team and/or ministry of justice)

This category should be used when a person's discharge is delayed due to there being a public safety concern which needs to be managed. For example, the Ministry of Justice will need to give warrants or approval for any changes to detentions.

The reason code for this category could be attributed to either the NHS, Social Care, or both (NHS and Social Care).

32 - Highly bespoke housing and/or care arrangements not available in the community

This category should be used when a person's discharge is delayed due to the bespoke support needed is not available in the community. Due to the bespoke nature of the support needed, it may require time to arrange and set up the support or housing needed.

The reason code for this category could be attributed to either the NHS, Social Care, or both (NHS and Social Care).

33 - No lawful support available in the community excluding social care

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This category should be used for people whose discharge is delayed due to there not being any lawful support available in the community for example, due to a commissioning gap. To note this is different to the support or service being provided in the local community, but not being available for the next patient. This is about the identified support not being provided in the local community, for example specific registered care services.

The reason code for this category could be attributed to either the NHS, or both (NHS and Social Care).

34 - No social care support including social care funded placement

This category should be used for people whose discharge is delayed due to there being a lack of suitable social support to meet their assessed care needs, for example due to a commissioning gap. To note this is different to the support or service being provided in the local community but not being available for the next patient. This is about the identified support not being provided in the local community.

The reason code for this category could be attributed to either Both (NHS and social care), Social care.

35 - Delays to NHS-led assessments in the community

This category should be used for people whose discharge is delayed due to assessments not being arranged in a timely manner by NHS-commissioned services. This category should not include any assessments that are needed in an inpatient setting, as the person would not be clinically ready for discharge in this case. This covers any assessments that are needed in the community to support someone's discharge.

The reason code for this category could be attributed to the NHS.

36 - Hospital staff shortages

This category should be used for people who are clinically ready for discharge, but their discharge is delayed due to staff shortages in the multi-disciplinary inpatient team such as nursing or medical staff, which is preventing their discharge from taking place.

The reason code for this category could be attributed to the NHS.

37 - Delays to non-NHS led assessments in the community

This category should be used for people whose discharge is delayed due to assessments not being arranged in a timely manner by any services/bodies that are not NHS-commissioned, such as VCSE organisations or local authority. This category should not include any assessments that are needed in an inpatient setting, as the person would not be clinically ready for discharge in this case. This covers any assessments that are needed in the community to support someone's discharge.

The reason code for this category could be attributed to Both (NHS and social care) or social care.

98 - Reason not known

This category covers people who are assessed as clinically ready for discharge, but no reason has been provided for why their discharge has been delayed. This category should only be used in rare circumstances where the reason is not clear, providers are encouraged to use the best possible category that most resembles the reason for why someone's discharge has been delayed, so that any issues or barriers can be reported and escalated where needed.

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Appendix 13 – Digital Mental Health Platforms

As part of the re-design for MHSDS V6.0, there have been numerous changes and updates related to digital mental health platforms and products.

These changes aim to enable more digital mental health platforms, commissioned across the NHS to submit to the MHSDS, improve the quality of data submitted and enable improved analysis.

The appendix includes guidance on how and when different digital mental health platforms should be recorded in MHSDS v6.0 and when to use the MHS201 Care Contact or MHS205 Patient Self-Directed Digital Intervention tables. It also maps relevant SNOMED ID codes to improve data quality and utility.

These updates to the guidance have been co-developed with stakeholders across the mental health system.

13.1.1 Defining Digital Mental Health Platforms

Digital Mental Health Platforms are phone or web-based applications or platforms, where a patient/service-user can access specific digitally enabled mental health care and support. These are distinct from digital supported services where digital technologies are used to support “traditional” care delivery e.g. video conferencing and telephony services.

13.1.2 Digital Contacts Decision Tree

The following decision tree has been developed to support digital mental health platforms understand what service-user/patient activity should be submitted to the MHSDS and how to make the submissions.

Digital Mental Health Platform suppliers should work closely with their commissioning organisations to agree what data should be submitted, in-line with this guidance and the broader MHSDS V6.0 User Guidance.

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1.0 Identify if the service is a Digitally Supported Service or a Digital Mental Health Platform

- Digitally supported services are where digital technologies e.g. video conferencing and telephony, are used to support "traditional" care delivery by a mental health professional employed by a mental health provider.
  - Recording of Digitally Supported Service activity should be treated consistently with non-digital services, in-line with MHSDS V6.0 User Guidance and with the relevant digital consultation mechanism code recorded in MHS201 Care Contact.
- Digital Mental Health Platforms are phone or web-based applications or platforms, where a patient/service-user can access specific digitally enabled mental health care and support.
  - Recording of Digital Mental Health Platform activity should be recorded in-line with Appendix 7.1 of this Guidance.

2.0 For Digital Mental Health Platforms, identify the different types of service-user activity/contacts that occurs on the Digital Mental Health Platforms e.g. 1:1 counselling, responsive text-based chats, mental health assessments, peer to peer forums, signposting etc.

3.0 For each service-user activity/contact determine if it is either a Mental Health Professional Supported Digital Contact or a Self-Directed Digital Contact

- Mental health professional supported digital contacts are contacts where a patient/service-user accesses support through a digital mental health platform with the active support of a trained mental health professional, excluding where a mental health professional is just moderating the platform (additional detail provided at 7.1.4)
- Self-directed digital contacts are contacts where a patient/service-user accesses support through a digital mental health platform without the active support of a trained mental health professional (additional detail provided at 7.1.5)

4.a If a Mental Health Professional Supported Digital Contact, determine what sub-group the service-activity best describes the activity:

- MH Professional Supported Digitally Enabled Assessment Procedures
- MH Professional Supported Digitally Enabled Psychological Therapies
- MH Professional Supported Digitally Enabled Psychosocial Interventions
- MH Professional Supported Digitally Enabled Indirect Activity

An explanation of the sub-groups is provided at 7.1.4.

Alternatively, review the list of activities in the SNOMED Reference Sets (provided at 7.1.8) and identify the most relevant intervention and Reference Set.

If service-user activity not covered by sub-groups, it is unlikely to be activity which should be submitted to the MHSDS. If you disagree, discuss with your commissioning organisation or NHS England.

4.b If a Self-Directed Digital Contact, determine what sub-group the service-activity best describes the activity:

- Self-Directed Digitally Enabled Assessment Procedures
- Self-Directed Digitally Enabled Psychological Therapies
- Self-Directed Digitally Enabled Psychosocial Interventions
- Self-Directed Supported Digitally Enabled Indirect Activity

An explanation of the sub-groups is provided at 7.1.5.

Alternatively, review the list of activities in the SNOMED Reference Sets (provided at 7.1.8) and identify the most relevant intervention and Reference Set.

If service-user activity not covered by sub-groups, it is unlikely to be activity which should be submitted to the MHSDS. If you disagree discuss with your commissioning organisation or NHS England.

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13.1.3 Digital Contacts

Contacts with digital mental health platforms are divided into two groups:

- **Mental Health Professional Supported Digital Contacts** - These are contacts where a patient/service-user accesses support through a digital mental health platform with the active support of a trained mental health professional (see section 7.1.4 for more detail)
- **Self-directed Digital Contacts** – These are contacts where a patient/service-user accesses support through a digital mental health platform without the active support of a trained mental health professional (see 7.1.5 for more detail).

To support consistent treatment and coding of activity and contacts, each group has been divided into sub-groups aligned with the SNOMED Mental Health Services Data Set SNOMED CT Interventions Refset. Further explanation of each sub group is provided below.

To ensure contacts with digital mental health platform form a meaningful part of the care a service or system is providing to patients, definitions for each sub-group have been developed to define when activity is a contact and should be submitted to the MHSDS. The relevant definitions are outlined in detail in the following sections.

This guidance is not intended to change how or what digital contacts count towards mental health access measures. In-line with existing NHS England guidance in 2024/25 all contacts (digital and non-digital) can be counted towards CYPMH access if the meet the below definition, as set out in the *2024/25 priorities and operational planning guidance: April 2024 – March 2025 Activity and performance technical definitions*:

- *A direct contact with a patient, parent or carer (as a patient proxy) or between professionals (as indirect activity), as long as they are clinically meaningful.*

Digital platforms and services should work with their local commissioning organisation to agree what activity/services on their platform meet this definition.

In preparation for 2025/26, NHS England is working with stakeholders across the mental health system to explore the breadth of service offerings through digital mental health platforms to determine what activity data should count to future iterations of the Children and Young People Mental Health (CYPMH) and Community Mental Health (CMH) access metrics.

13.1.4 Mental Health Professional Supported Digital Contacts

Mental health professional supported digital contacts are contacts where a patient/service-user accesses support through a digital mental health platform with the active support of a trained mental health professional.

This group of contacts is most like more “traditional” mental health service delivery but the patient/service-user accesses support through a digital mental health platform with the active support of a trained mental health professional.

This group includes contacts where the patient/service-user is supported by either a mental health professional employed by the digital mental health platform supplier, or another mental health professional who is actively supporting or monitoring the patient/service-users progress through the digital mental health platform.

This group could include activity which involve the active facilitation of group or peer-support activities by a trained mental health professional but excludes activity which is just moderated or overseen by a mental health professional who does not regularly and actively engage with the patient/service users.

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This group includes support delivered through a broad range of digital contact mechanisms, including video, telephone, talk-type, and chat/messaging (asynchronous and synchronous).

Sub-Groups and Definitions

To support consistent treatment and coding of activity and contacts, Mental Health Professional Supported Digital Contacts have been divided into four sub-groups.

- MH Professional Supported Digitally Enabled Assessment Procedures
- MH Professional Supported Digitally Enabled Psychological Therapies
- MH Professional Supported Digitally Enabled Psychosocial Interventions
- MH Professional Supported Digitally Enabled Indirect Activity

These sub-groups are aligned with the SNOMED Mental Health Services Data Set SNOMED CT Interventions Refset. To support assessment of the right sub-group, the list of interventions in each SNOMED Reference Sets is provided at 7.1.8.

To ensure contacts with digital mental health platform form a meaningful part of the care a service or system is providing to patients, the following definitions have been co-developed with clinical, lived experience, commissioning and policy experts, to define when patient/service-user activity is a contact and should be submitted to the MHSDS.

These definitions are not coded into the MHSDS, but instead local commissioners and digital mental health platform suppliers are responsible for assessing what patient/service-user activity on their platforms meets or doesn't meet these definitions and therefore if that data should be submitted to MHSDS.

Sub-Group	Description	Definition
MH Professional Supported **Digitally Enabled Assessment Procedures**	These contacts involve the assessment of the needs of the service-users and identification of appropriate support. This can include informal discussions between MH professional and service-users, or more formal psychological and risk assessment procedures.	An interaction (or series of related interactions)* between an individual service-user, parent, or carer (as a service-user proxy), and an appropriately trained or qualified mental health professional, through a digital medium, for the specific purpose of assessing the needs of, or risk to the service user, and which includes appropriate safeguarding procedures.
MH Professional Supported **Digitally Enabled Psychological Therapies**	These contacts involve the delivery of recommended psychological therapies and counselling by an appropriately trained or qualified MH professional. This can include digitally enabled psychological therapies like Cognitive Behaviour Therapy (CBT), psychotherapy and counselling etc.	The provision of digitally enabled psychological support to a service-user, parent, or carer (as a service-user proxy), by an appropriately trained or qualified mental health professional, consistent with a recommended model of psychological therapy/counselling for the relevant condition, and appropriate safeguarding procedures.

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MH Professional Supported **Digitally Enabled Psychosocial Interventions**	These contacts involve the delivery of recommended psychosocial interventions by an appropriately trained or qualified MH professional. This includes a very broad range of digitally enabled interventions including, psychoeducation, psychosocial therapy behaviour promotion, parent/care giver support, care planning, formal peer support, and wayfinding/navigation etc.	The provision of a psychosocial intervention to a service-user, parent, or carer (as a service-user proxy), by an appropriately trained or qualified clinician, consistent with a recommended model of psychosocial intervention for the relevant condition, and appropriate safeguarding procedures. Professional Peer Support - The provision or active facilitation of peer support, to a service-user, parent, or carer (as a service-user proxy), through a digital medium, by an appropriately trained or qualified mental health professional and which include appropriate safeguarding procedures. This excludes peer-support which is just moderated by a trained mental health professional who does not regularly and actively engage with the patient/service users.
MH Professional Supported **Digitally Enabled Indirect Activity**	These contacts involve interactions between multiple MH professionals with the specific purpose of supporting the care of an individual service-user, but where the service-user is not present.	An interaction (or series of related interactions)* between appropriately trained or qualified mental health professionals, or between a mental health professional and another person who is not acting as a patient proxy, where the service-user is not present, through a digital medium, for the specific purpose of supporting the care of an individual service-user, excluding administrative activities.

Interaction (or series of related interactions)

Digital mental health platforms allow new and more flexible service model, which support patients to engage in their own time compared to a more traditional appointment-based service offering which can more easily be defined as a single contact. To support equivalent treatment between digital and non-digital services, it is important to ensure a series of related interactions are recorded as a single contact rather than multiple individual contacts.

For example, a series of messages between a patient/service-user and trained mental health professional which occur over a series of days but relate to the same request or offer of support, should be recorded a single contact.

There may also be numerous different activities e.g. signposting, goal setting etc. which happen during an interaction (or series of related activities) these sub-activities should not be recorded as individual contacts but as part of the single connected contact.

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13.1.5 Self-Directed Digital Contacts

Self-directed digital contacts are contacts where a patient/service-user accesses support through a digital mental health platform without the active support of a trained mental health professional.

This group includes contacts where a self-directed digital mental health platform is moderated by a trained mental health professional, but where that mental health professional does not actively support the individual patient/service-user to use the service.

Sub-Groups and Definitions

To support consistent treatment and coding of activity and contacts, Self-Directed Digital Contacts have been divided into four sub-groups.

- Self-Directed Supported Digitally Enabled Assessment Procedures
- Self-Directed Digitally Enabled Psychological Therapies
- Self-Directed Digitally Enabled Psychosocial Interventions
- Self-Directed Digitally Enabled Indirect Activity

These sub-groups are aligned with the SNOMED Mental Health Services Data Set SNOMED CT Interventions Refset. To support assessment of the right sub-group, the list of interventions in each SNOMED Reference Sets is provided at 7.1.8.

To ensure contacts with digital mental health platform form a meaningful part of the care a service or system is providing to patients, the following definitions have been developed to define when patient/service-user activity is a contact and should be submitted to the MHSDS.

These definitions are not coded into the MHSDS, but instead local commissioners and digital mental health platform suppliers are responsible for assessing what patient/service-user activity on their platforms meets or doesn't meet these definitions and therefore if that data should be submitted to MHSDS.

Sub-Group	Description	Definition
Self-Directed **Digitally Enabled Assessment Procedures**	These contacts involve the assessment of the needs of the service-users and identification of appropriate support. This can include mental health triaging and psychological and risk assessment procedures.	Completion of an appropriate digitally enabled assessment procedure by an individual service-user, parent or carer (as a service-user proxy), in-line with relevant guidance and appropriate safeguarding procedures, without the support of an appropriately trained or qualified mental health professional (inc. where supported by AI).
Self-Directed **Digitally Enabled Psychological Therapies**	These contacts involve the delivery of modules of structured psychological support without the support of appropriately trained or qualified MH professional. This can include digitally enabled psychological therapies like	The completion of a defined module/activity of a digitally enabled psychological therapy by a service-user, parent or carer (as a service-user proxy), consistent with a recommended model of psychological therapy for the relevant condition and appropriate safeguarding procedures, without

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	Cognitive Behaviour Therapy (CBT) etc.	the support of an appropriately trained or qualified mental health professional (inc. where supported by AI).
Self-Directed **Digitally Enabled Psychosocial** **Interventions**	These contacts involve the delivery of modules of structured psychosocial interventions without the support of appropriately trained or qualified MH professional. This includes a very broad range of digitally enabled interventions including, psychoeducation, psychosocial therapy behaviour promotion, parent/care giver support, care planning, peer support and wayfinding/navigation etc.	The completion of a defined module/activity of a digitally enabled psychosocial intervention by a service-user, parent or carer (as a service-user proxy), consistent with a recommended model of psychosocial intervention for the relevant condition and appropriate safeguarding procedures, without the support of an appropriately trained or qualified mental health professional (inc. where supported by AI). Self-directed peer-support – An occurrence of moderated community peer support, through a digital medium, which includes, a service user requesting support and a meaningful response to the request, and appropriate safeguarding procedures (inc. where supported by AI).

13.1.6 Submitting to the MHSDS v6.0

The recording of activity on digital mental health platforms should be completed in accordance with this guidance. Additional detail and specific examples for digital mental health platforms is provided below.

MHS201 Care Contact

In-line with “2024/25 priorities and operational planning guidance: April 2024 – March 2025 Activity and performance technical definitions”, all Mental Health Professional Supported Digital Contacts (except Mental Health Professional Supported Digitally Enabled Indirect Activity) which meet the relevant definitions, should be recorded in the MHS201 Care Contact table, using the most appropriate consultation

mechanism available.

All Self-Directed Digital Contacts, which meet the relevant definitions should be recorded in MHS205 Patient Self-Directed Digital Intervention (see below).

Recording in MHS201 Care Contact should be completed in accordance with the relevant section of MHSDS V6.0 User Guidance and the additional guidance below.

It is the responsibility of the digital mental health platform supplier and the commissioning organisation to determine the most appropriate consultation mechanism(s). However, email

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should not be used as a consultation medium for Mental Health Professional Supported Digital Contacts as email is designated for administrative activities.

To support digital mental health platforms, make appropriate submissions, key data fields are explained in more detail below.

CLINICAL CONTACT DURATION OF CARE CONTACT

The total duration of the direct clinical contact at a CARE CONTACT in minutes, excluding any administration time prior to or after the CARE CONTACT and the CARE PROFESSIONAL's travelling time to the CARE CONTACT.

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

This should be recorded in minutes.

Where there are a series of related digital interactions e.g. multiple asynchronous messages between a patient/service-user and mental health professional as part of the same conversation, these should be converted to and recorded as a single consultation. For asynchronous interactions, the mental health professional should estimate and record the cumulative time, in minutes, directly spent on the interaction or series of interactions, not the entire length of time from the first to last interaction in the series.

EARLIEST REASONABLE OFFER DATE

Where a digital mental health platform offers patient/service-users support with mental health professionals, the earliest reasonable offer date should be recorded as either the date when the patient/service-user requested support from a mental health professional or the date the patient/service-user was offered support from a mental health professional.

MHS202 Care Activity

This table should contain a record for each separate element of assessment, treatment or review that was undertaken within a Care Contact. Accordingly, this table should be completed for all Mental Health Professional Supported Digital Contacts (except Mental Health Professional Supported Digitally Enabled Indirect Activity) which meet the relevant definitions.

Recording in MHS202 Care Activity should be completed in accordance with the relevant section of MHSDS V6.0 User Guidance, and the additional guidance below.

It is the responsibility of the of the digital mental health platform supplier and the commissioning organisation to determine the most appropriate and up-to-date SNOMED CT ID codes for the relevant digital contacts. To support this, the relevant SNOMED CT ID codes have been provided at “7.1.8 SNOMED ID Mapping” of this guidance.

CLINICAL CONTACT DURATION OF CARE ACTIVITY

Where there are a series of related digital interactions e.g. multiple asynchronous messages between a patient/service-user and mental health professional as part of the same conversation, these should be converted to and recorded as a single consultation. For asynchronous interactions, the mental health professional should estimate and record the cumulative time, in minutes, directly spent on the interaction or series of interactions, not the entire length of time from the first to last interaction in the series.

MHS204 Indirect Activity

These contacts involve interactions between multiple mental health professionals, or a mental health professional and someone else involved in the direct care of the individual e.g.

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teacher, social worker etc. with the specific purpose of supporting the care of an individual service-user, but where the service-user is not present.

Mental Health Professional Supported Digitally Enabled Indirect Activity, which meet the relevant definition, should be recorded in MHS204 Indirect Activity.

Recording in MHS204 Indirect Activity should be completed in accordance with the relevant section of this guidance.

MHS205 Patient Self-Directed Digital Intervention

All Self-Directed Digital Contacts, which meet the relevant definitions should be recorded in MHS205 Patient Self-Directed Digital Intervention.

Data Item Name	Additional Notes
SERVICE REQUEST IDENTIFIER	The Service Request Identifier is used to uniquely identify the referral. It would normally be automatically generated by the local system upon recording a new Referral, although could be manually assigned. This item is a primary key in the MHS101 Referral table and must be unique to this table, within submission. The Service Request Identifier provides a means for linking each Referral with additional data associated directly with that referral. Where multiple systems are used the submitted extract may include a prefix to the Service Request Identifier, which relates to the system. The prefix ensures each Service Request Identifier remains unique within submission.
ORGANISATION IDENTIFIER (PATIENT SELF-DIRECTED DIGITAL INTERVENTION PROVIDER)	Is the Organisation Identifier for the provider of patient self-directed digital interventions.
START DATE (PATIENT SELF-DIRECTED DIGITAL INTERVENTION)	Is the date when the patient is directed to a digital intervention and given access to it.
END DATE (PATIENT SELF-DIRECTED DIGITAL INTERVENTION)	This should be recorded as the last login date for the in a reporting period an individual patient/service-user used the digital mental health platform.
PATIENT SELF-DIRECTED DIGITAL INTERVENTION MECHANISM (PRIMARY)	Primary mechanism of delivery of therapy or assessment through an internet or digital based programme, which is accessed by the patient in their own time. The available mechanisms are: • Website (i.e. the support was accessed through a standalone website) • Application software (i.e. the support was accessed through a standalone app) • Instant messaging (Synchronous) (i.e. the support was provided through an instant messaging service e.g. chat bot)

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	• Instant messaging (Asynchronous) (i.e. the support was provided through an asynchronous messaging service e.g. SMS) • Virtual reality (i.e. the support was provided using Virtual Reality (VR) or Augmented Reality (AR)) • Other (not listed) It is the responsibility of the digital mental health platform supplier and the commissioning organisation to determine the most appropriate consultation mechanism(s).
PATIENT SELF-DIRECTED DIGITAL INTERVENTION PROCEDURE (SNOMED CT)	A structured combination of one or more SNOMED CT concept identifiers which is used to describe a patient procedure. Allows the primary type of patient self-directed digital intervention to be recorded. It is the responsibility of the of the digital mental health platform and the commissioning organisation to determine the most appropriate and up-to-date SNOMED CT ID codes for the relevant digital contacts. To support this, the relevant SNOMED CT ID codes have been provided at “7.1.6 SNOMED ID Mapping” of this guidance.
RECORD NUMBER	This is a unique ID, which identifies each flowed MHSDS record. The rows in the MHS001MPI and associated episode and event tables that make up a single MHSDS record are linked via the Record Number
MHS205 UNIQUE ID	A unique row count for this table. This continues across reporting periods and across providers. This uniquely identifies a row of data within this table.
ORGANISATION IDENTIFIER (CODE OF PROVIDER)	This is the ORGANISATION IDENTIFIER of the ORGANISATION acting as a Health Care Provider. Derived from submitted Header record within submission.
PERSON ID	A nationally unique pseudonymised ID for the patient generated by the Master Person Service (MPS).
UNIQUE SUBMISSION ID	A unique ID applied when original data file was uploaded to the Submission Portal.
UNIQUE SERVICE REQUEST IDENTIFIER	To uniquely identify the referral
UNIQUE MONTH ID	An incremental month number, with month 0001 being April 1900
EFFECTIVE FROM	The date and time the file was received by the portal.

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13.1.7 Example digital mental health platform submission to MHSDS v6.0

The below example is provided for illustrative purposes only.

It is the responsibility of the digital mental health platform supplier and the commissioning organisation to ensure they are completing appropriate and accurate MHSDS submissions.

Example: A digital mental health platform supplier which provides both Mental Health Professional Supported and Self-Directed Digital Contacts.

Group	Sub-group	Contact	MHSDS	SNOMED Ref Set	SNOMED ID
MH Professional Supported Digital Contacts	MH Professional Supported Digitally Enabled Assessment Procedures	Structured single sessions and responsive chats with a mental health professional, which primary purpose of assessing need/risk	MHS201	MHSDS assessment procedures simple reference set	Mental health triage (procedure) 1751061000000103
	MH Professional Supported Digitally Enabled Psychological Therapies	Structured single sessions and responsive chats with a mental health professional, which primary purpose of delivering psychological therapy or counselling	MHS201	MHSDS psychological therapies simple reference set	Counselling (procedure) 409063005
	MH Professional Supported Digitally Enabled Indirect Activity	Consultations between mental health professionals regarding individual service user	MHS204	MHSDS psychosocial interventions simple reference set	Consultation (procedure) 11429006
Self-Directed Digital Contacts	Self-directed Digitally Enabled Psychosocial Interventions	Self-directed online mental health resources	MHS205	MHSDS psychosocial interventions simple reference set	Psychoeducation (procedure) 702545008
		Signposting to other services and	MHS205	MHSDS psychosocial interventions	Signposting (procedure) 975131000000104

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		other self-directed activities e.g. posting stories		simple reference set	
	Self-directed Other Digitally Enabled Interventions	Moderated self-directed peer support discussion boards	MHS205	MHSDS psychosocial interventions simple reference set	Formal peer support intervention (regime/therapy) 1833031000000109

13.1.8 SNOMED ID Mapping

It is the responsibility of the of the digital mental health platform supplier and the commissioning organisation to determine the most appropriate and up-to-date SNOMED CT ID codes for the relevant digital contacts.

Group and SNOMED Reference Set	Intervention Group	Intervention Name	SNOMED ID
Digitally Enabled Assessment Procedures MHSDS (Mental Health Service Data Set) assessment procedures simple reference set	Mental Health Triage	Mental health triage (procedure)	1751061000000103
		Risk assessment (procedure)	225338004
	Psychological Assessments	Psychological assessment (procedure)	405783006
		Neuropsychological testing (procedure)	307808008
		Mental health assessment (procedure)	391281002
		Specialist mental health assessment (procedure)	163801000000107
	Other Assessments	Assessment for dementia (procedure)	869561000000101
		Autism spectrum disorder diagnostic assessment (procedure)	1085671000000109
		Assessment of mental capacity in accordance with Mental Capacity ACT (2005) (procedure)	517301000000103
		Neuropsychological testing (procedure)	307808008
		Initial memory assessment (procedure)	888901000000102
		Biopsychosocial assessment (procedure)	1067261000000105
		Neurological mental status determination (procedure)	392257007
		Occupational therapy assessment (procedure)	410155007
Digitally Enabled Psychological Therapies MHSDS (Mental Health Service Data Set) psychological therapies simple reference set	Counselling	Counselling (procedure)	409063005
		Psychosexual counselling (procedure)	171023003
	Cognitive Behaviour Therapy	Cognitive behavioural therapy (regime/therapy)	228557008
		Group cognitive behavioural therapy (regime/therapy)	859501000000107
		Cognitive behavioural therapy for psychosis (regime/therapy)	718026005

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		Cognitive behavioural therapy for eating disorders (regime/therapy)	1111811000000109
		Cognitive behavioural therapy for personality disorder (regime/therapy)	149451000000104
		Group cognitive and behavioural therapy for bipolar disorder (regime/therapy)	149591000000108
		Guided self-help cognitive behavioural therapy (regime/therapy)	444175001
		Mindfulness-based cognitive therapy (regime/therapy)	1423361000000109
		Trauma focused cognitive behavioural therapy (regime/therapy)	149521000000105
		Group cognitive behavioural therapy for eating disorder (regime/therapy)	1362001000000104
		Cognitive behavioural therapy parenting programme (regime/therapy)	883841000000104
		Cognitive behavioural therapy (regime/therapy)	228557008
	Other Behaviour Therapy	Behavioural therapy (regime/therapy)	166001
		Dialectical behaviour therapy (regime/therapy)	405780009
		Behavioural couple therapy (regime/therapy)	1129481000000107
		Provision of access to digitally enabled psychological therapy	2652551000000107
		Provision of access to artificial intelligence augmented digitally enabled psychological therapy	2652561000000105
		Provision of access to virtual reality digitally enabled psychological therapy	2652571000000103
		Provision of access to gamified digitally enabled psychological therapy	2652581000000101
	Psychotherapy	Group psychotherapy (regime/therapy)	76168009
		Psychotherapy (regime/therapy)	75516001
		Adolescent focused psychotherapy for anorexia nervosa (regime/therapy)	1833251000000107
		Child psychotherapy (regime/therapy)	429159005
		Interpersonal psychotherapy (regime/therapy)	443730003
		Interpersonal psychotherapy for group (regime/therapy)	1106951000000105
		Integrative psychotherapy (regime/therapy)	304826003
		Transference focused psychotherapy (regime/therapy)	1111671000000100
		Couple psychotherapy (regime/therapy)	440274001
		Brief solution focused psychotherapy (regime/therapy)	401157001
	Psychodynamic Therapy	Psychodynamic psychotherapy (regime/therapy) 314034001	314034001

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	Focal psychodynamic therapy (regime/therapy)	718023002
	Eating-disorder-focused focal psychodynamic therapy (regime/therapy)	1323681000000103
Family Therapy	Family intervention for psychosis and bipolar disorder (regime/therapy)	1365951000000107
	Family intervention for psychosis (regime/therapy)	985451000000105
	Family intervention for bipolar disorder (regime/therapy)	1833221000000102
	Family therapy (regime/therapy)	51484002
	Family, systemic, couple and sex therapy (regime/therapy)	302245002
Parenting Therapy	Responsive parenting intervention (regime/therapy)	1054301000000103
	Video-feedback Intervention to promote Positive Parenting (regime/therapy)	1423891000000105
	Video-feedback Intervention to promote Positive Parenting and Sensitive Discipline (regime/therapy)	1423881000000108
	Behavioural parent training (regime/therapy)	882381000000106
	Responsive parenting intervention (regime/therapy)	1054301000000103
Other Therapy	Attachment-based therapy (regime/therapy)	700445002
	Interpersonal and social rhythm therapy (regime/therapy)	1108261000000102
	Acceptance and commitment therapy (regime/therapy)	1363681000000106
	Schema focused therapy (regime/therapy)	1111691000000101
	Mentalisation based treatment (regime/therapy)	1111681000000103
	Cognitive analytic therapy (regime/therapy)	390773006
	Eye movement desensitization and reprocessing therapy (regime/therapy)	449030000
	Prolonged Grief Disorder Therapy (regime/therapy)	1423401000000100
	Compassion-focused therapy (regime/therapy)	143891000000107
	Maudsley Model of Anorexia Nervosa Treatment for Adults (regime/therapy)	1323471000000102
	Cognitive rehabilitation therapy (regime/therapy)	702474001
	Cognitive remediation therapy (regime/therapy)	1751051000000101
	Play therapy (regime/therapy)	76075007
	Video interaction guidance (regime/therapy)	712652008
	Art therapy (regime/therapy)	65153003
	Creative therapy (regime/therapy)	278415002
	Dance therapy (regime/therapy)	69711002

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		Music therapy (regime/therapy)	21065008
		Psychodrama (regime/therapy)	53508008
		Narrative therapy (regime/therapy)	1730671000000106
		Guided self-help using book (regime/therapy)	748051000000105
		Anger management therapy (regime/therapy)	712558003
	Other (Clinical)	Structured Clinical Management (regime/therapy)	1108271000000109
		Specialist supportive clinical management (procedure)	1323451000000106
		Psychological formulation (procedure)	1751081000000107
Digitally Enabled Psychosocial Interventions MHSDS (Mental Health Service Data Set) psychosocial interventions simple reference set	Psychosocial Therapy	Daily living activity therapy (regime/therapy)	183345007
		Emotional support (regime/therapy)	133921002
		Bereavement support (regime/therapy)	395076009
		Behavioural activation therapy (regime/therapy)	443119008
		Active monitoring (regime/therapy)	413433006
		Hallucination management (regime/therapy)	386316003
		Exposure - behaviour therapy (regime/therapy)	225224008
		Cognitive stimulation (regime/therapy)	386241007
		Reminiscence therapy (regime/therapy)	228549005
		Applied relaxation (regime/therapy)	1127281000000100
		Social skills behaviour modification (regime/therapy)	386525005
		Emotional support (regime/therapy)	133921002
		Mindfulness-based therapy (regime/therapy)	933221000000107
		Guided self-help psychological therapy (regime/therapy)	1129491000000109
		Mental health promotion (regime/therapy)	385891009
		Radically Open Dialectical Behaviour Therapy (regime/therapy)	1751091000000109
		Watch, Wait and Wonder therapy (regime/therapy)	1403231000000102
		Safeguarding intervention (regime/therapy)	1053881000000102
		Speech therapy (regime/therapy)	5154007
		Occupational therapy (regime/therapy)	84478008
		Dialectical behavioural therapy skills group intervention (regime/therapy)	1659561000000104
		Vocational rehabilitation (regime/therapy)	70082004
		Positive behaviour support (regime/therapy)	1833041000000100
		Guided self-help psychological therapy for bulimia nervosa (regime/therapy)	1833011000000101

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	Behaviour promotion	Relapse prevention (procedure)	405782001
		Coping skills training (procedure)	302256002
		Management of negative emotional state (procedure)	710965006
		Management of anxiety (procedure)	710060004
		Promotion of sleep hygiene (procedure)	1172583004
		Self-esteem enhancement (procedure)	386422006
		Smoking cessation education (procedure)	225323000
		Recommendation to exercise (procedure)	281090004
	Parent / Care Giver Support	Mental health caregiver support (regime/therapy)	390826005
		Caregiver focused education and support program (situation)	726052009
		Promotion of caregiver child attachment (procedure)	710141009
		Parent-infant psychotherapy (regime/therapy)	700446001
		Triple P - Positive Parenting Program (regime/therapy)	709009001
	Other life skills	Life skills training (procedure)	228642009
		Lifestyle education (procedure)	313204009
		Skills training (procedure)	278445004
		Nutrition education (procedure)	61310001
	Other Support	Assistance with obtaining accommodation (procedure)	1091471000000109
		Individual Placement and Support (regime/therapy)	772822000
		Problem solving (procedure)	765601000000101
		Facilitating engagement in therapy (procedure)	975441000000104
		Motivational interviewing technique (procedure)	713144002
		Pain management (procedure)	278414003
		Employment education, guidance, and counselling (procedure)	410287004
	Signposting / Navigation	Signposting (procedure)	975131000000104
		Recommendation to (procedure)	420227002
		Care navigation (procedure)	1761281000000106
	Care Planning	Mental health care and treatment planning (procedure)	861361000000109
	Psychoeducation	Psychoeducation (procedure)	702545008
	Indirect Activity	Consultation (procedure)	11429006
	Other Procedure	Mental Health Act procedure (procedure)	5301000000106
	Peer Support	Formal peer support intervention (regime/therapy)	1833031000000109

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