

Health and Social Care Information Centre

NHS Data Model and Dictionary Service

Type: Change Request
Reference: 1514
Version No: 1.0
Subject: Mental Health Services Data Set
Effective Date: 1 January 2016
Reason for Change: Change to Data Standards
Publication Date: 13 July 2015

Background:

The Mental Health Services Data Set (MHSDS) is being introduced following an expansion to the scope of the Mental Health and Learning Disabilities Data Set (MHLDDS) to include:

- Child and Adolescent Mental Health Services (CAMHS) Data Set
- The former Adult Mental Health Care Clusters and the Clustering Tool Standards
- The KP90: Informal Patients and Patients Detained under the Mental Health Act: The Number of Uses of the Act Standard
- Elements of the Assuring Transformation Collection Standard
- Elements of the Learning Disability Census

A separate Change Request will retire the information in the NHS Data Model and Dictionary which relates to these Information Standards.

Note: the retirement of the KP90 Information Standard will be addressed in a future Information Standards Notice (ISN), which will be issued by the Standardisation Committee for Care Information (SCCI).

Further changes and amendments to the original content of the Mental Health and Learning Disabilities Data Set are also required which include:

- The incorporation of requirements in support of Children and Young People's Improving Access to Psychological Therapies
- Restructuring of the data set to support referral based reporting, through inclusion of a number of new unique identifiers. This is to allow for the effective collection of waiting times data, including waiting times for Early Intervention in Psychosis Services

This Change Request adds the Mental Health Services Data Set and supporting definitions to the NHS Data Model and Dictionary to support the Information Standard.

To view a demonstration on "How to Read an NHS Data Model and Dictionary Change Request", visit the NHS Data Model and Dictionary help pages at: http://www.datadictionary.nhs.uk/Flash_Files/changerequest.htm.

Note: if the web page does not open, please copy the link and paste into the web browser.

Summary of changes:

Diagrams

[ACTIVITY DIAGRAM](#)

Changed Diagram

[CHILDREN AND YOUNG PEOPLE'S HEALTH SERVICE SECONDARY USES DIAGRAM](#)

Changed Diagram

[HIV AND AIDS DIAGRAM](#)

Changed Diagram

[IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES DIAGRAM](#)

Changed Diagram

[MATERNITY SERVICES DIAGRAM](#)

Changed Diagram

[NATIONAL RENAL DIAGRAM](#)

Changed Diagram

Data Set

[MENTAL HEALTH SERVICES DATA SET](#)

New Data Set

Supporting Information

[ADULT MENTAL HEALTH CARE CLUSTER](#) renamed from [MENTAL HEALTH CARE CLUSTER](#)

Changed Description, Name

[ADULT MENTAL HEALTH CLUSTERING TOOL](#) renamed from [MENTAL HEALTH CLUSTERING TOOL](#)

Changed Description, Name

[AUTISTIC SPECTRUM DISORDER](#)

Changed Description

[CARE CLUSTER ASSIGNMENT PERIOD](#)

New Supporting Information

[CARE CONTACT CANCELLATION DATE](#) renamed from [CARE CONTACT CANCELLATION DATE](#)

Changed Description, Dataset, Name

[CARE CONTACT DATE](#) renamed from [CARE CONTACT DATE](#)

Changed Description, Dataset, Name

[CARE CONTACT TIME](#) renamed from [CARE CONTACT TIME](#)

Changed Description, Dataset, Name

[CARE PROFESSIONAL ADMITTED CARE EPISODE](#)

New Supporting Information

[CARE PROGRAMME APPROACH](#)

New Supporting Information

[CARE PROGRAMME APPROACH CARE EPISODE](#) renamed from [CARE PROGRAMME APPROACH EPISODE](#)

Changed Description, Name

[CARE PROGRAMME APPROACH REVIEW](#)

Changed Description

[CARE PROGRAMME APPROACH REVIEW DATE](#)

Changed Description

[CHILD AND ADOLESCENT MENTAL HEALTH SERVICES SECONDARY USES DIAGRAM OVERVIEW](#)

Changed Description

[CLINICAL DATA SETS MENU](#)

Changed Description

[CLINIC ATTENDANCE NON-CONSULTANT](#)

Changed Description

[CLUSTERING TOOL](#)

New Supporting Information

[COMMISSIONER ASSIGNMENT PERIOD](#)

Changed Description

[COMMUNITY TREATMENT ORDER](#)

Changed Description

[COMMUNITY TREATMENT ORDER RECALL](#)

New Supporting Information

[DATE OF RESTRICTIVE INTERVENTION](#)

New Supporting Information

[DAY CARE FACILITY](#)

Changed Description

[DIAGRAMS MENU](#)

Changed Description

[DISCHARGE LETTER ISSUED DATE \(MENTAL HEALTH AND COMMUNITY CARE\)](#)

New Supporting Information

[EARLY INTERVENTION IN PSYCHOSIS SERVICE](#)

New Supporting Information

[EARLY INTERVENTION IN PSYCHOSIS WAITING TIME MEASUREMENT](#)

New Supporting Information

[GROUP THERAPY](#)

Changed Description

[HEALTH OF THE NATION OUTCOME SCALE \(WORKING AGE ADULTS\)](#)

Changed Description

[HOME LEAVE](#)

Changed Description

[INDEPENDENT MENTAL CAPACITY ADVOCATE](#)

New Supporting Information

[INDEPENDENT MENTAL HEALTH ADVOCATE](#)

New Supporting Information

[INDIRECT ACTIVITY](#)

New Supporting Information

[INDIRECT ACTIVITY DATE](#)

New Supporting Information

[INDIRECT ACTIVITY TIME](#)

New Supporting Information

[MENTAL HEALTH ABSENCE WITHOUT LEAVE](#)

Changed Description

[MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD](#) renamed from [MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD](#)

Changed Description, Name

[MENTAL HEALTH CARE CLUSTER SUPER CLASS](#)

Changed Description

[MENTAL HEALTH CARE COORDINATOR](#)

New Supporting Information

[MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD](#) renamed from [MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD](#)

Changed Description, Name

[MENTAL HEALTH CONDITIONAL DISCHARGE PERIOD](#)

Changed Description

MENTAL HEALTH CRISIS PLAN CREATION DATE	New Supporting Information
MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE	New Supporting Information
MENTAL HEALTH DELAYED DISCHARGE PERIOD	Changed Description
MENTAL HEALTH LEAVE OF ABSENCE	Changed Description
MENTAL HEALTH RESPONSIBLE CLINICIAN	Changed Description
MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD renamed from MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT	Changed Name
MENTAL HEALTH SERVICE	New Supporting Information
MENTAL HEALTH SERVICES DATA SET OVERVIEW	New Supporting Information
NON-INSTRUCTED ADVOCATE	New Supporting Information
ONWARD REFERRAL DATE	New Supporting Information
OUT-PATIENT APPOINTMENT NON-CONSULTANT	Changed Description
OUT-PATIENT ATTENDANCE CONSULTANT	Changed Description
PATIENT PROXY	Changed Description
PLANNED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)	New Supporting Information
REFERRAL CLOSURE DATE	New Supporting Information
REFERRAL REJECTION DATE	New Supporting Information
REPLACEMENT APPOINTMENT BOOKED DATE	New Supporting Information
REPLACEMENT APPOINTMENT DATE OFFERED	New Supporting Information
RESTRICTIVE INTERVENTION	New Supporting Information
SERVICE DISCHARGE DATE	New Supporting Information
STANDARDISATION COMMITTEE FOR CARE INFORMATION	Changed Dataset
WARD ATTENDANCE	Changed Description
WARD STAY	Changed Description
Class Definitions	
ACCOMMODATION	Changed Attributes
ACTIVITY GROUP	Changed Attributes, Relationships
ADMINISTRATIVE CATEGORY	Changed Description
ADMINISTRATIVE CATEGORY PERIOD	Changed Description
APPOINTMENT	Changed Description
ASSESSMENT TOOL	Changed Attributes
CARE CLUSTER renamed from MENTAL HEALTH CARE CLUSTER	Changed Attributes, Description, Name
CARE CONTACT	Changed Attributes
CARE PLAN	Changed Attributes
CARE PROFESSIONAL	Changed Attributes, Description
CARE PROFESSIONAL TEAM	Changed Description
CARE PROFESSIONAL TEAM MEMBER	Changed Description
CLINICAL INTERVENTION	Changed Attributes
CLINICAL INVESTIGATION RESULT ITEM	Changed Attributes
DISABILITY	Changed Attributes
LANGUAGE renamed from LANGUAGE CLASSIFICATION	Changed Description, Name
LEAVE	Changed Attributes
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION	Changed Attributes
ORGANISATION	Changed Dataset
PATIENT DIAGNOSIS	Changed Attributes
PERSON PROPERTY	Changed Relationships
PERSON PROPERTY ASSIGNMENT PERIOD	New Class
PLANNED ACTIVITY	Changed Relationships
PLANNED ACTIVITY DATE TIME	New Class
REFERRAL REQUEST	Changed Attributes
SERVICE	Changed Attributes
SESSION	Changed Attributes

UNIT OF MEASUREMENT	Changed Attributes
WARD	Changed Attributes
Attribute Definitions	
ACCOMMODATION STATUS CODE	Changed Dataset
ACTIVITY DATE	Changed Dataset
ACTIVITY DATE TYPE	Changed Description
ACTIVITY GROUP TYPE	Changed Description
ACTIVITY IDENTIFIER	Changed Dataset
ACTIVITY LOCATION TYPE CODE	Changed Description, Dataset
ACTIVITY TIME	Changed Dataset
ACTIVITY TIME TYPE	Changed Description
ADMINISTRATIVE CATEGORY CODE	Changed Description, Dataset
ADMISSION METHOD	Changed Description, Dataset
ADULT MENTAL HEALTH CARE CLUSTER CODE renamed from MENTAL HEALTH CARE CLUSTER CODE	Changed Description, Dataset, Name
APPOINTMENT DATE OFFERED	Changed Dataset
ASSESSMENT TOOL TYPE	Changed Description
ATTENDED OR DID NOT ATTEND	Changed Description, Dataset
CARE CONTACT CANCELLATION REASON	Changed Dataset
CARE CONTACT SUBJECT	Changed Dataset
CARE PROFESSIONAL IDENTIFIER	Changed Dataset
CARE PROFESSIONAL STAFF GROUP FOR COMMUNITY CARE	Changed Dataset
CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH	New Attribute
CARE PROFESSIONAL TEAM IDENTIFIER	Changed Dataset
CARE PROGRAMME APPROACH REVIEW ABUSE QUESTION ASKED INDICATOR	Changed Description, Dataset
CATEGORY VALUED PERSON OBSERVATION TYPE	Changed Description
CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE	New Attribute
CHILD AND ADOLESCENT MENTAL HEALTH TIER OF SERVICE	Changed Description, Dataset
CHILD PROTECTION PLAN INDICATION CODE renamed from CHILD PROTECTION PLAN INDICATOR	Changed Description, Dataset, Name
CLINICAL CARE INTENSITY	Changed Dataset
CLINICAL CLASSIFICATION CODE	Changed Dataset
CLINICAL INTERVENTION TYPE	Changed Description
CLINICAL RESPONSE PRIORITY TYPE	Changed Description, Dataset
CLINICAL TERMINOLOGY CODE	Changed Dataset
CLUSTERING TOOL ASSESSMENT CATEGORY	New Attribute
CLUSTERING TOOL ASSESSMENT REASON renamed from MENTAL HEALTH CLUSTERING TOOL ASSESSMENT REASON	Changed Description, Dataset, Name
COMMUNITY TREATMENT ORDER END REASON renamed from SUPERVISED COMMUNITY TREATMENT END REASON	Changed Description, Dataset, Name
CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR	New Attribute
CONSULTATION MEDIUM USED	Changed Description, Dataset
CONSULTATION TYPE	New Attribute
DIAGNOSIS SCHEME IN USE	New Attribute
DISABILITY CODE	Changed Dataset
DISABILITY IMPACT PERCEPTION	New Attribute
DISCHARGE DESTINATION	Changed Dataset
DISCHARGE METHOD	Changed Dataset
EMPLOYMENT STATUS	Changed Dataset
ETHNIC CATEGORY CODE	Changed Dataset
FINDING SCHEME IN USE	New Attribute
FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE	New Attribute
FORENSIC MENTAL HEALTH CARE CLUSTER CODE	New Attribute

GROUP SESSION TYPE FOR MENTAL HEALTH	New Attribute
GROUP THERAPY INDICATOR	Changed Description, Dataset
JOB ROLE CODE	Changed Dataset
LANGUAGE CODE	New Attribute
LEARNING DISABILITIES CARE CLUSTER CODE	New Attribute
LOCAL PATIENT IDENTIFIER	Changed Dataset
LOOKED AFTER CHILD INDICATOR	Changed Description, Dataset
MAIN SPECIALTY CODE	Changed Dataset
MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON renamed from ABSENCE WITHOUT LEAVE END REASON	Changed Description, Dataset, Name
MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY renamed from MENTAL HEALTH ABSOLUTE DISCHARGE END METHOD	Changed Description, Dataset, Name
MENTAL HEALTH ACT 2007 MENTAL CATEGORY	Changed Description, Dataset
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON renamed from MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD END REASON CODE	Changed Description, Dataset, Name
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON renamed from MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD START REASON CODE	Changed Description, Dataset, Name
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE	Changed Description, Dataset
MENTAL HEALTH CARE CLUSTER END REASON	Changed Description
MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE	Changed Dataset
MENTAL HEALTH CONDITIONAL DISCHARGE END REASON	Changed Description, Dataset
MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE	Changed Dataset
MENTAL HEALTH DELAYED DISCHARGE REASON	Changed Description, Dataset
MENTAL HEALTH LEAVE OF ABSENCE END REASON renamed from LEAVE OF ABSENCE END REASON	Changed Description, Dataset, Name
NHS NUMBER	Changed Dataset
NHS OCCUPATION CODE	Changed Dataset
NHS SERVICE AGREEMENT LINE NUMBER	Changed Dataset
OBSERVATION SCHEME IN USE	New Attribute
OBSERVATION VALUE	New Attribute
OFFERED FOR ADMISSION DATE	Changed Description, Dataset
ONWARD REFERRAL REASON	New Attribute
ORGANISATION CODE	Changed Dataset
ORGANISATION SITE CODE	Changed Dataset
OTHER PERSON IN ATTENDANCE AT CARE CONTACT	New Attribute
PATIENT PATHWAY IDENTIFIER	Changed Dataset
PERSON BIRTH DATE	Changed Dataset
PERSON DEATH DATE	Changed Dataset
PERSON PROPERTY ASSIGNMENT PERIOD TYPE	New Attribute
PERSON PROPERTY EFFECTIVE DATE	Changed Dataset
PERSON PROPERTY EFFECTIVE END DATE	Changed Dataset
PERSON PROPERTY EFFECTIVE END TIME	Changed Dataset
PERSON PROPERTY OBSERVED DATE	Changed Dataset
PERSON PROPERTY RECORDED DATE	Changed Description, Dataset
PERSON SCORE	Changed Dataset
PERSON STATED GENDER CODE	Changed Dataset
PLANNED ACTIVITY DATE	New Attribute
PLANNED ACTIVITY DATE TYPE	New Attribute
POSTCODE	Changed Dataset
PRESCRIPTION DATE	Changed Dataset
PROCEDURE SCHEME IN USE	New Attribute
PROFESSIONAL REGISTRATION BODY CODE	Changed Description, Dataset
PROFESSIONAL REGISTRATION ENTRY IDENTIFIER	Changed Dataset
REASON FOR REFERRAL TO MENTAL HEALTH	New Attribute

REFERRAL CLOSURE REASON	New Attribute
REFERRAL REJECTION REASON	New Attribute
REFERRAL REQUEST RECEIVED DATE	Changed Dataset
REFERRAL REQUEST RECEIVED TIME	Changed Dataset
REFERRAL TO TREATMENT PERIOD END DATE	Changed Dataset
REFERRAL TO TREATMENT PERIOD START DATE	Changed Dataset
REFERRAL TO TREATMENT PERIOD STATUS	Changed Dataset
REFERRING CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH AND COMMUNITY CARE	New Attribute
RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE	Changed Dataset
REPORTING PERIOD END DATE	Changed Dataset
REPORTING PERIOD START DATE	Changed Dataset
RESTRICTIVE INTERVENTION TYPE	New Attribute
SERVICE OR TEAM TYPE FOR MENTAL HEALTH	New Attribute
SERVICE REQUEST IDENTIFIER	Changed Dataset
SERVICE TYPE	Changed Description
SESSION DATE	Changed Dataset
SETTLED ACCOMMODATION INDICATOR	Changed Description, Dataset
SEX OF PATIENTS	Changed Dataset
SOURCE OF ADMISSION	Changed Dataset
SOURCE OF REFERRAL FOR MENTAL HEALTH	Changed Description, Dataset
TREATMENT FUNCTION CODE	Changed Dataset
UCUM UNIT OF MEASUREMENT	New Attribute
UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)	Changed Dataset
WAITING TIME MEASUREMENT TYPE	Changed Description, Dataset
WARD SECURITY LEVEL	Changed Dataset
WARD SETTING TYPE FOR MENTAL HEALTH	New Attribute
WEEKLY HOURS WORKED	Changed Description, Dataset
YOUNG CARER INDICATOR	Changed Description, Dataset

Data Elements

ACCOMMODATION STATUS CODE	Changed Dataset
ACCOMMODATION STATUS RECORDED DATE renamed from ACCOMMODATION STATUS DATE	Changed Description, Dataset, Name, linked Attribute
ACTIVITY LOCATION TYPE CODE	Changed Dataset
ADMINISTRATIVE CATEGORY CODE	Changed Dataset
ADMISSION METHOD CODE (HOSPITAL PROVIDER SPELL)	Changed Dataset
ADULT MENTAL HEALTH CARE CLUSTER CODE (FINAL) renamed from MENTAL HEALTH CARE CLUSTER CODE (FINAL)	Changed Description, Dataset, Name
ADULT MENTAL HEALTH CARE CLUSTER CODE (INITIAL) renamed from MENTAL HEALTH CARE CLUSTER CODE (INITIAL)	Changed Description, Dataset, Name
ASSESSMENT TOOL COMPLETION DATE	Changed Dataset
ASSESSMENT TOOL COMPLETION TIME	Changed Dataset
ATTENDED OR DID NOT ATTEND CODE	Changed Dataset
CARE ACTIVITY IDENTIFIER	New Data Element
CARE CONTACT CANCELLATION DATE	Changed Description, Dataset, linked Attribute
CARE CONTACT CANCELLATION REASON	Changed Dataset
CARE CONTACT DATE	Changed Description, Dataset, linked Attribute
CARE CONTACT IDENTIFIER	New Data Element
CARE CONTACT SUBJECT	Changed Dataset
CARE CONTACT TIME	Changed Description, Dataset, linked Attribute
CARE PROFESSIONAL (JOB ROLE CODE)	Changed Dataset
CARE PROFESSIONAL LOCAL IDENTIFIER	New Data Element

CARE PROFESSIONAL SERVICE OR TEAM TYPE ASSOCIATION (MENTAL HEALTH)	New Data Element
CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH)	New Data Element
CARE PROFESSIONAL TEAM LOCAL IDENTIFIER	New Data Element
CARE PROGRAMME APPROACH CARE EPISODE IDENTIFIER	New Data Element
CARE PROGRAMME APPROACH REVIEW ABUSE QUESTION ASKED INDICATOR	Changed Dataset
CARE PROGRAMME APPROACH REVIEW DATE renamed from REVIEW DATE	Changed Description, Dataset, Name, linked Attribute
CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL)	New Data Element
CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL)	New Data Element
CHILD AND ADOLESCENT MENTAL HEALTH TIER OF SERVICE	Changed Dataset
CHILD PROTECTION PLAN INDICATION CODE renamed from CHILD PROTECTION PLAN INDICATOR	Changed Description, Dataset, Name
CLINICAL CONTACT DURATION OF CARE ACTIVITY	Changed Description, Dataset
CLINICAL CONTACT DURATION OF CARE CONTACT	Changed Description, Dataset
CLINICAL CONTACT DURATION OF GROUP SESSION	Changed Description, Dataset
CLINICAL RESPONSE PRIORITY TYPE	Changed Dataset
CLUSTERING TOOL ASSESSMENT CATEGORY	New Data Element
CLUSTERING TOOL ASSESSMENT IDENTIFIER	New Data Element
CLUSTERING TOOL ASSESSMENT REASON renamed from MENTAL HEALTH CLUSTERING TOOL ASSESSMENT REASON	Changed Description, Dataset, Name
CODED ASSESSMENT TOOL TYPE (SNOMED CT)	New Data Element
CODED FINDING (CODED CLINICAL ENTRY)	New Data Element
CODED OBSERVATION (CLINICAL TERMINOLOGY)	New Data Element
CODED PROCEDURE (CLINICAL TERMINOLOGY)	New Data Element
COMMUNITY TREATMENT ORDER END REASON renamed from SUPERVISED COMMUNITY TREATMENT END REASON	Changed Dataset, Name
CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR	New Data Element
CONSULTATION MEDIUM USED	Changed Dataset
CONSULTATION TYPE	New Data Element
DATA SET VERSION NUMBER	Changed Dataset
DATE AND TIME DATA SET CREATED	Changed Dataset
DATE DETENTION COMMENCED	Changed Description
DATE OF ASSAULT ON PATIENT	Changed Description, Dataset
DATE OF RESTRICTIVE INTERVENTION	New Data Element
DATE OF SELF-HARM renamed from DATE OF SELF HARM	Changed Description, Dataset, Name
DIAGNOSIS DATE	Changed Dataset
DIAGNOSIS SCHEME IN USE	Changed Description, Dataset, linked Attribute
DISABILITY CODE	Changed Dataset
DISABILITY IMPACT PERCEPTION	New Data Element
DISCHARGE DATE (HOSPITAL PROVIDER SPELL)	Changed Dataset
DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL)	Changed Dataset
DISCHARGE LETTER ISSUED DATE (MENTAL HEALTH AND COMMUNITY CARE)	New Data Element
DISCHARGE METHOD CODE (HOSPITAL PROVIDER SPELL)	Changed Dataset
DISCHARGE TIME (HOSPITAL PROVIDER SPELL)	Changed Description, Dataset
DURATION OF INDIRECT ACTIVITY	New Data Element
DURATION OF RESTRICTIVE INTERVENTION	New Data Element
EARLIEST CLINICALLY APPROPRIATE DATE	Changed Description, Dataset
EARLIEST REASONABLE OFFER DATE	Changed Description, Dataset
EMERGENT PSYCHOSIS DATE	Changed Description, Dataset, linked Attribute

EMPLOYMENT STATUS	Changed Dataset
EMPLOYMENT STATUS RECORDED DATE	Changed Description, Dataset, linked Attribute
END DATE (CARE CLUSTER ASSIGNMENT PERIOD)	New Data Element
END DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)	New Data Element
END DATE (CARE PROGRAMME APPROACH CARE)	Changed Description, Dataset
END DATE (COMMISSIONER ASSIGNMENT PERIOD)	Changed Dataset
END DATE (COMMUNITY TREATMENT ORDER) renamed from END DATE (SUPERVISED COMMUNITY TREATMENT)	Changed Description, Dataset, Name
END DATE (COMMUNITY TREATMENT ORDER RECALL) renamed from END DATE (SUPERVISED COMMUNITY TREATMENT RECALL)	Changed Description, Dataset, Name
END DATE (GMP PATIENT REGISTRATION)	Changed Dataset
END DATE (HOME LEAVE)	Changed Dataset
END DATE (MENTAL HEALTH ABSENCE WITHOUT LEAVE)	Changed Dataset
END DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD) renamed from END DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)	Changed Description, Dataset, Name
END DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD) renamed from END DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT)	Changed Description, Dataset, Name
END DATE (MENTAL HEALTH CONDITIONAL DISCHARGE)	Changed Dataset
END DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD)	Changed Description, Dataset
END DATE (MENTAL HEALTH LEAVE OF ABSENCE)	Changed Dataset
END DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD) renamed from END DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT)	Changed Dataset, Name
END DATE (WARD STAY)	Changed Dataset
END TIME (CARE CLUSTER ASSIGNMENT PERIOD)	New Data Element
END TIME (COMMUNITY TREATMENT ORDER RECALL) renamed from END TIME (SUPERVISED COMMUNITY TREATMENT RECALL)	Changed Description, Dataset, Name
END TIME (HOME LEAVE)	New Data Element
END TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE)	New Data Element
END TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD) renamed from END TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)	Changed Description, Dataset, Name
END TIME (MENTAL HEALTH LEAVE OF ABSENCE)	New Data Element
END TIME (WARD STAY)	Changed Dataset
ETHNIC CATEGORY	Changed Dataset
EXPIRY DATE (COMMUNITY TREATMENT ORDER) renamed from EXPIRY DATE (SUPERVISED COMMUNITY TREATMENT)	Changed Description, Dataset, Name, linked Attribute
EXPIRY DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)	Changed Description, Dataset, linked Attribute
EXPIRY TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)	Changed Description, Dataset, linked Attribute
FINDING SCHEME IN USE	New Data Element
FIRST PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION) renamed from PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION)	Changed Description, Dataset, Name, linked Attribute
FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)	New Data Element
FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)	New Data Element
FORENSIC MENTAL HEALTH CARE CLUSTER CODE (FINAL)	New Data Element
FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL)	New Data Element
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	Changed Dataset
GROUP SESSION DATE	Changed Dataset
GROUP SESSION IDENTIFIER	New Data Element
GROUP SESSION TYPE (MENTAL HEALTH)	New Data Element
GROUP THERAPY INDICATOR	New Data Element
HOSPITAL PROVIDER SPELL NUMBER	Changed Dataset
INDIRECT ACTIVITY DATE	New Data Element

INDIRECT ACTIVITY TIME	New Data Element
INTENDED AGE GROUP	Changed Description
INTENDED CLINICAL CARE INTENSITY CODE (MENTAL HEALTH)	Changed Description, Dataset
LANGUAGE CODE (PREFERRED)	New Data Element
LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)	New Data Element
LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)	New Data Element
LOCAL PATIENT IDENTIFIER (EXTENDED)	Changed Description, Dataset
LOOKED AFTER CHILD INDICATOR	Changed Description, Dataset
MAIN SPECIALTY CODE (MENTAL HEALTH)	Changed Description, Dataset
MANIFEST PSYCHOSIS DATE	Changed Description, Dataset, linked Attribute
MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON renamed from ABSENCE WITHOUT LEAVE END REASON	Changed Description, Dataset, Name
MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY renamed from MENTAL HEALTH ABSOLUTE DISCHARGE END METHOD	Changed Description, Dataset, Name
MENTAL HEALTH ACT 2007 MENTAL CATEGORY	Changed Description, Dataset, linked Attribute
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON renamed from MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD END REASON	Changed Description, Dataset, Name
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER	New Data Element
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON renamed from MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD START REASON	Changed Description, Dataset, Name
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE	Changed Description, Dataset
MENTAL HEALTH CARE CLUSTER END REASON	Changed Description
MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE	Changed Description, Dataset
MENTAL HEALTH CARE CONTACT IDENTIFIER	Changed Description
MENTAL HEALTH CONDITIONAL DISCHARGE END REASON	Changed Dataset
MENTAL HEALTH CRISIS PLAN CREATION DATE	Changed Description, Dataset, linked Attribute
MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE	Changed Description, Dataset, linked Attribute
MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE	Changed Description, Dataset
MENTAL HEALTH DELAYED DISCHARGE REASON	Changed Description, Dataset
MENTAL HEALTH LEAVE OF ABSENCE END REASON renamed from LEAVE OF ABSENCE END REASON	Changed Description, Dataset, Name
NHS NUMBER	Changed Dataset
NHS NUMBER STATUS INDICATOR CODE	Changed Dataset
NHS SERVICE AGREEMENT LINE NUMBER	Changed Description, Dataset
NUMBER OF GROUP SESSION PARTICIPANTS	New Data Element
OBSERVATION SCHEME IN USE	New Data Element
OBSERVATION VALUE	New Data Element
OCCUPATION CODE	Changed Dataset
ONWARD REFERRAL DATE	New Data Element
ONWARD REFERRAL REASON	New Data Element
ORGANISATION CODE (CODE OF COMMISSIONER)	Changed Dataset
ORGANISATION CODE (CODE OF PROVIDER)	Changed Dataset
ORGANISATION CODE (CODE OF SUBMITTING ORGANISATION)	Changed Dataset
ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT)	New Data Element
ORGANISATION CODE (GP PRACTICE RESPONSIBILITY)	Changed Dataset
ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)	Changed Dataset
ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)	Changed Dataset
ORGANISATION CODE (RECEIVING)	Changed Dataset
ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	Changed Dataset
OTHER PERSON IN ATTENDANCE AT CARE CONTACT	New Data Element

OTHER REASON FOR REFERRAL (MENTAL HEALTH)	New Data Element
PATIENT PATHWAY IDENTIFIER	Changed Dataset
PERSON BIRTH DATE	Changed Dataset
PERSON DEATH DATE	Changed Dataset
PERSON MARITAL STATUS	Changed Description
PERSON SCORE	New Data Element
PERSON STATED GENDER CODE	Changed Dataset
PLANNED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)	New Data Element
POSTCODE OF MAIN VISITOR	New Data Element
POSTCODE OF USUAL ADDRESS	Changed Dataset
PREVIOUS DIAGNOSIS (CODED CLINICAL ENTRY)	New Data Element
PRIMARY DATA COLLECTION SYSTEM IN USE	New Data Element
PRIMARY DIAGNOSIS (CODED CLINICAL ENTRY)	New Data Element
PRIMARY REASON FOR REFERRAL (MENTAL HEALTH)	New Data Element
PROCEDURE SCHEME IN USE	Changed Description, Dataset, linked Attribute
PRODROME PSYCHOSIS DATE	Changed Description, Dataset, linked Attribute
PROFESSIONAL REGISTRATION BODY CODE	New Data Element
PROFESSIONAL REGISTRATION ENTRY IDENTIFIER	Changed Dataset
PROVISIONAL DIAGNOSIS (CODED CLINICAL ENTRY)	New Data Element
PROVISIONAL DIAGNOSIS DATE	Changed Dataset
PSYCHOSIS FIRST TREATMENT START DATE renamed from PSYCHOSIS TREATMENT START DATE	Changed Description, Dataset, Name, linked Attribute
REFERRAL CLOSURE DATE	New Data Element
REFERRAL CLOSURE REASON	New Data Element
REFERRAL REJECTION DATE	New Data Element
REFERRAL REJECTION REASON	New Data Element
REFERRAL REQUEST RECEIVED DATE	Changed Dataset
REFERRAL REQUEST RECEIVED TIME	Changed Dataset
REFERRAL TO TREATMENT PERIOD END DATE	Changed Dataset
REFERRAL TO TREATMENT PERIOD START DATE	Changed Dataset
REFERRAL TO TREATMENT PERIOD STATUS	Changed Dataset
REFERRING CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH AND COMMUNITY CARE) renamed from REFERRING CARE PROFESSIONAL STAFF GROUP (COMMUNITY CARE)	Changed Description, Dataset, Name
REFERRING ORGANISATION CODE	Changed Dataset
RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE	Changed Dataset
REPLACEMENT APPOINTMENT BOOKED DATE	New Data Element
REPLACEMENT APPOINTMENT DATE OFFERED	New Data Element
REPORTING PERIOD END DATE	Changed Dataset
REPORTING PERIOD START DATE	Changed Dataset
RESTRICTIVE INTERVENTION TYPE	New Data Element
SECONDARY DIAGNOSIS (CODED CLINICAL ENTRY)	New Data Element
SERVICE DISCHARGE DATE	New Data Element
SERVICE OR TEAM TYPE REFERRED TO (MENTAL HEALTH)	New Data Element
SERVICE REQUEST IDENTIFIER	Changed Dataset
SETTLED ACCOMMODATION INDICATOR renamed from SETTLED ACCOMMODATION INDICATOR (MENTAL HEALTH)	Changed Description, Dataset, Name
SEX OF PATIENTS CODE	Changed Description, Dataset
SITE CODE (OF TREATMENT)	Changed Dataset
SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL)	Changed Dataset
SOURCE OF REFERRAL FOR MENTAL HEALTH	Changed Dataset
START DATE (CARE CLUSTER ASSIGNMENT PERIOD)	New Data Element
START DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)	New Data Element
START DATE (CARE PROGRAMME APPROACH CARE)	Changed Description, Dataset

START DATE (COMMISSIONER ASSIGNMENT PERIOD)	Changed Dataset
START DATE (COMMUNITY TREATMENT ORDER) renamed from START DATE (SUPERVISED COMMUNITY TREATMENT)	Changed Description, Dataset, Name
START DATE (COMMUNITY TREATMENT ORDER RECALL) renamed from START DATE (SUPERVISED COMMUNITY TREATMENT RECALL)	Changed Description, Dataset, Name
START DATE (GMP PATIENT REGISTRATION)	Changed Dataset
START DATE (HOME LEAVE)	Changed Dataset
START DATE (HOSPITAL PROVIDER SPELL)	Changed Dataset
START DATE (MENTAL HEALTH ABSENCE WITHOUT LEAVE)	Changed Dataset
START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD) renamed from START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)	Changed Description, Dataset, Name
START DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD) renamed from START DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT)	Changed Dataset, Name
START DATE (MENTAL HEALTH CONDITIONAL DISCHARGE)	Changed Dataset
START DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD)	Changed Description, Dataset
START DATE (MENTAL HEALTH LEAVE OF ABSENCE)	Changed Dataset
START DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD) renamed from START DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT)	Changed Description, Dataset, Name
START DATE (WARD STAY)	Changed Dataset
START TIME (CARE CLUSTER ASSIGNMENT PERIOD)	New Data Element
START TIME (COMMUNITY TREATMENT ORDER RECALL) renamed from START TIME (SUPERVISED COMMUNITY TREATMENT RECALL)	Changed Description, Dataset, Name
START TIME (HOME LEAVE)	New Data Element
START TIME (HOSPITAL PROVIDER SPELL)	Changed Dataset
START TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE)	New Data Element
START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD) renamed from START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)	Changed Description, Dataset, Name
START TIME (MENTAL HEALTH CARE CLUSTER)	Changed Description
START TIME (MENTAL HEALTH LEAVE OF ABSENCE)	New Data Element
START TIME (WARD STAY)	Changed Dataset
TREATMENT FUNCTION CODE (MENTAL HEALTH)	Changed Description, Dataset
UCUM UNIT OF MEASUREMENT	New Data Element
UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)	Changed Dataset
WAITING TIME MEASUREMENT TYPE	Changed Description, Dataset
WARD SECURITY LEVEL	Changed Dataset
WARD SETTING TYPE (MENTAL HEALTH)	New Data Element
WARD STAY IDENTIFIER	New Data Element
WEEKLY HOURS WORKED	Changed Description, Dataset
YOUNG CARER INDICATOR	Changed Description, Dataset

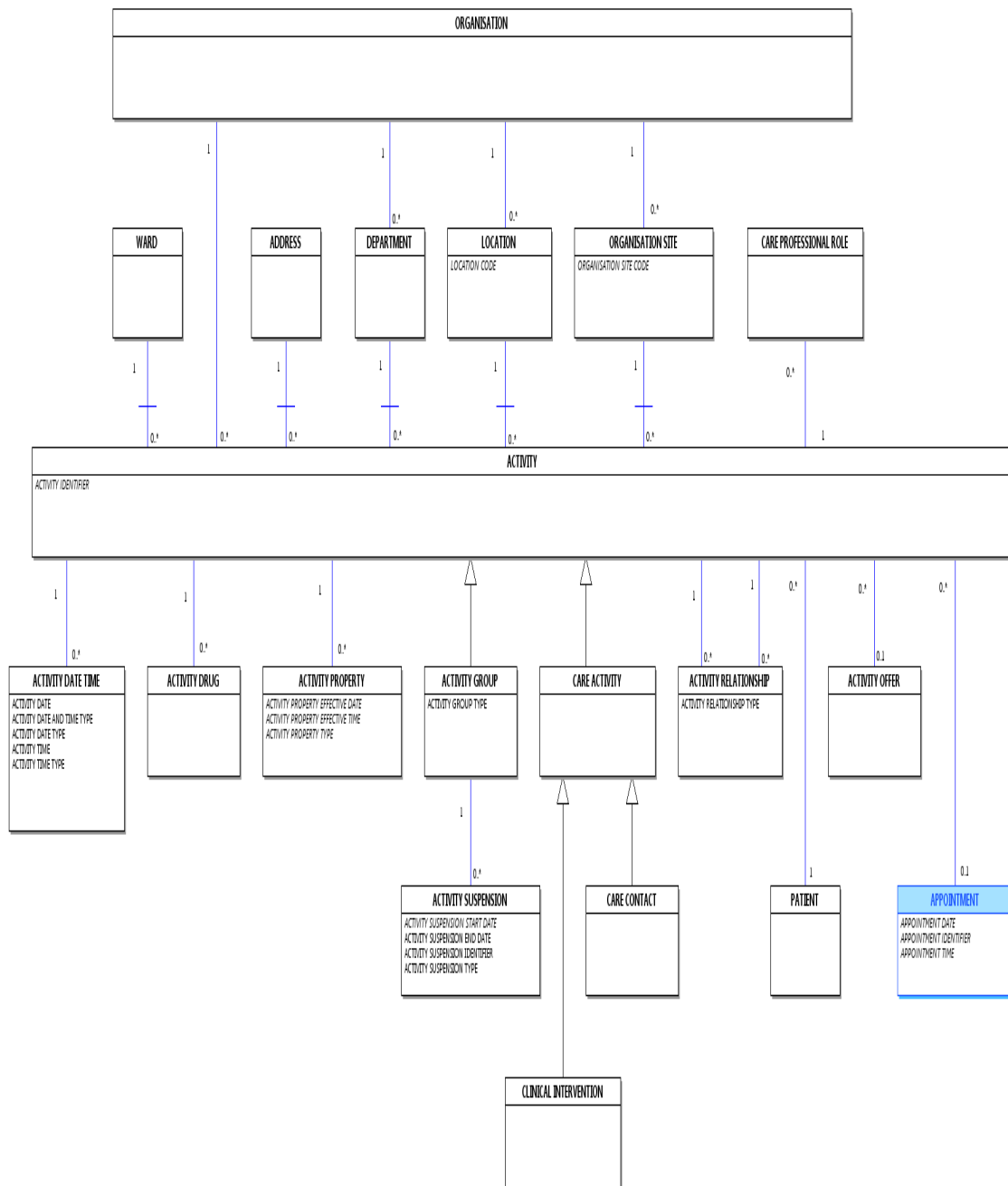
Date: 13 July 2015

Sponsor: Sarah McClinton, Director of Mental Health, Disability and Dementia, Department of Health

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

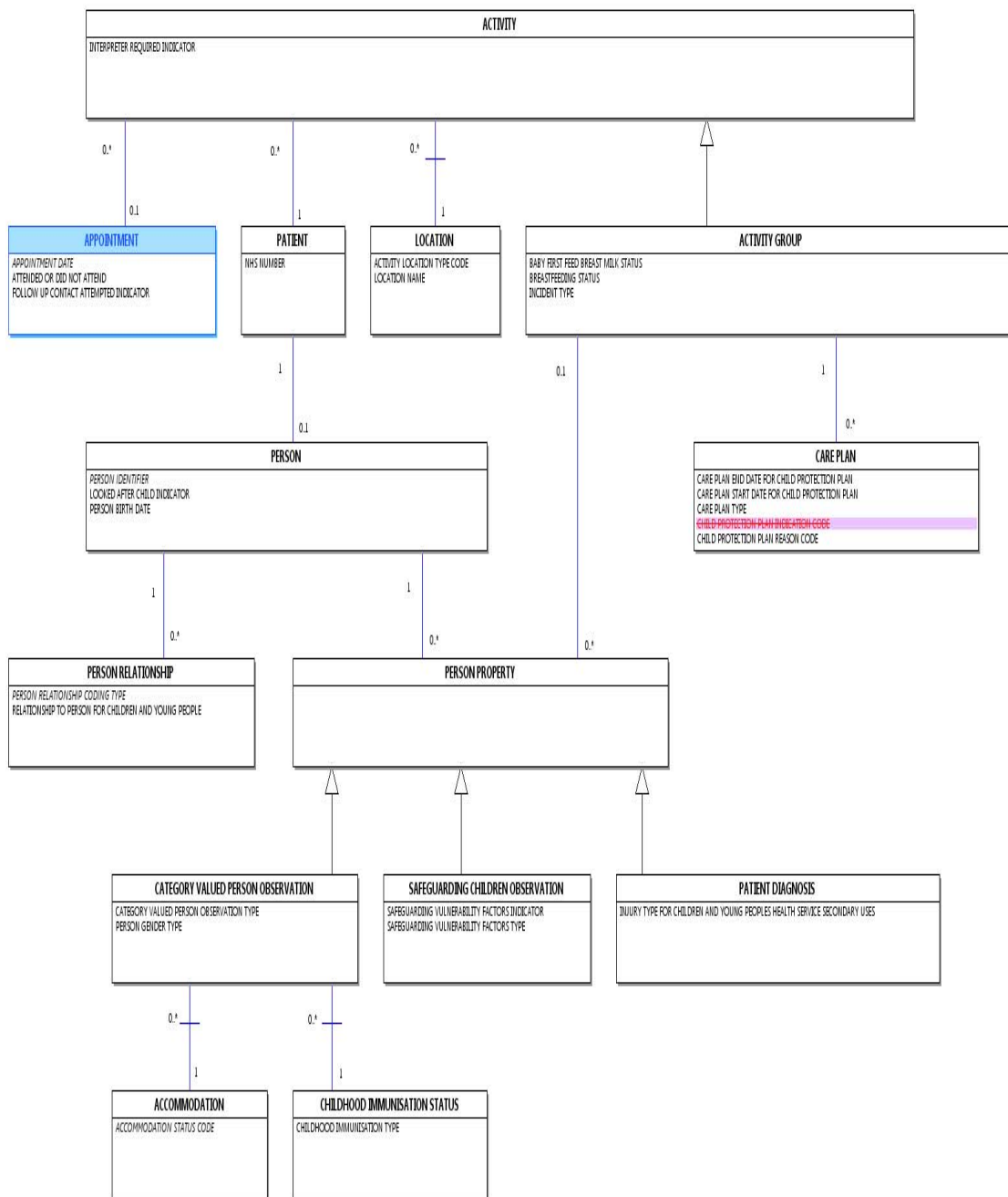
ACTIVITY DIAGRAM

Change to Diagram: Changed Diagram



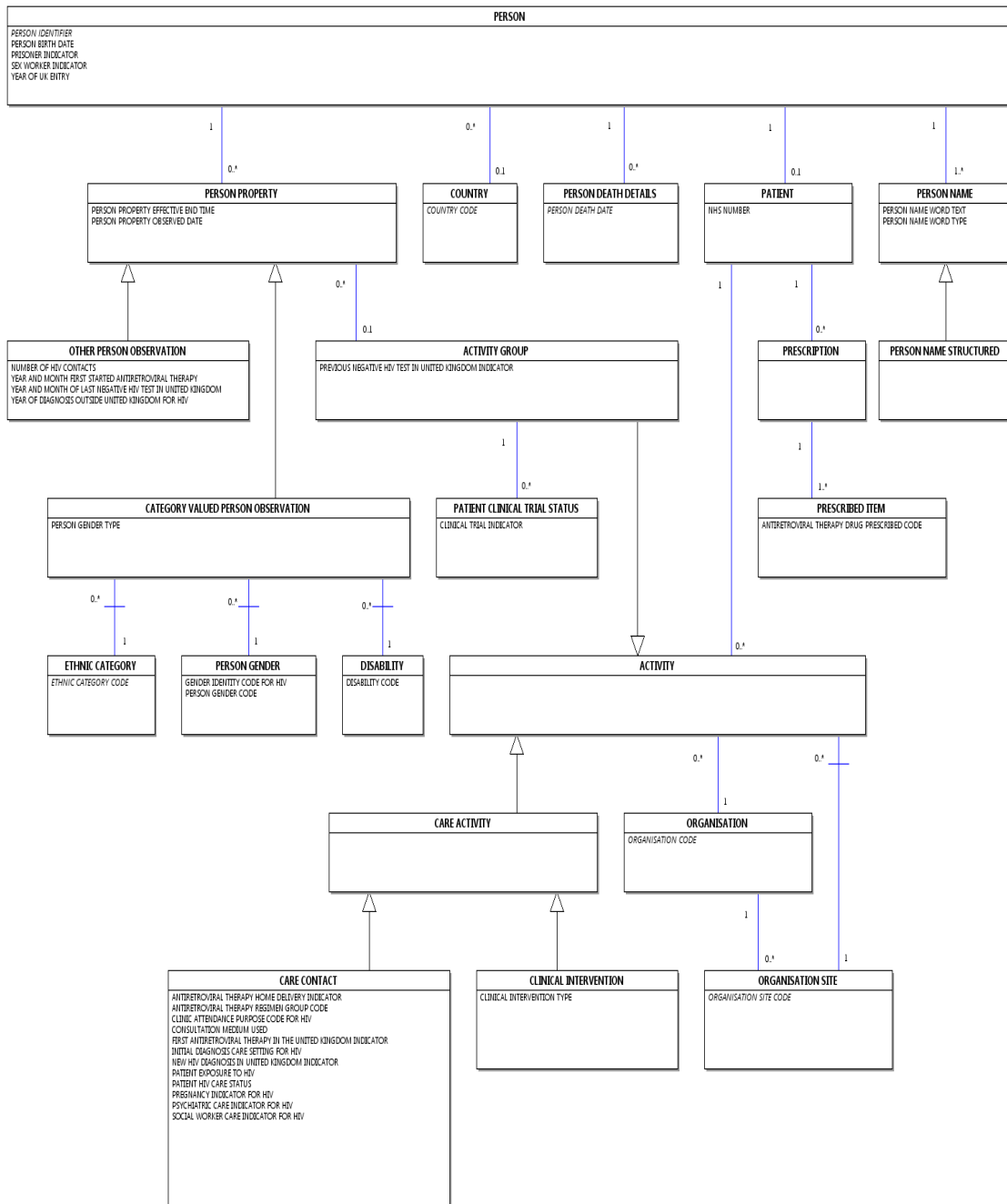
CHILDREN AND YOUNG PEOPLE'S HEALTH SERVICE SECONDARY USES DIAGRAM

Change to Diagram: Changed Diagram



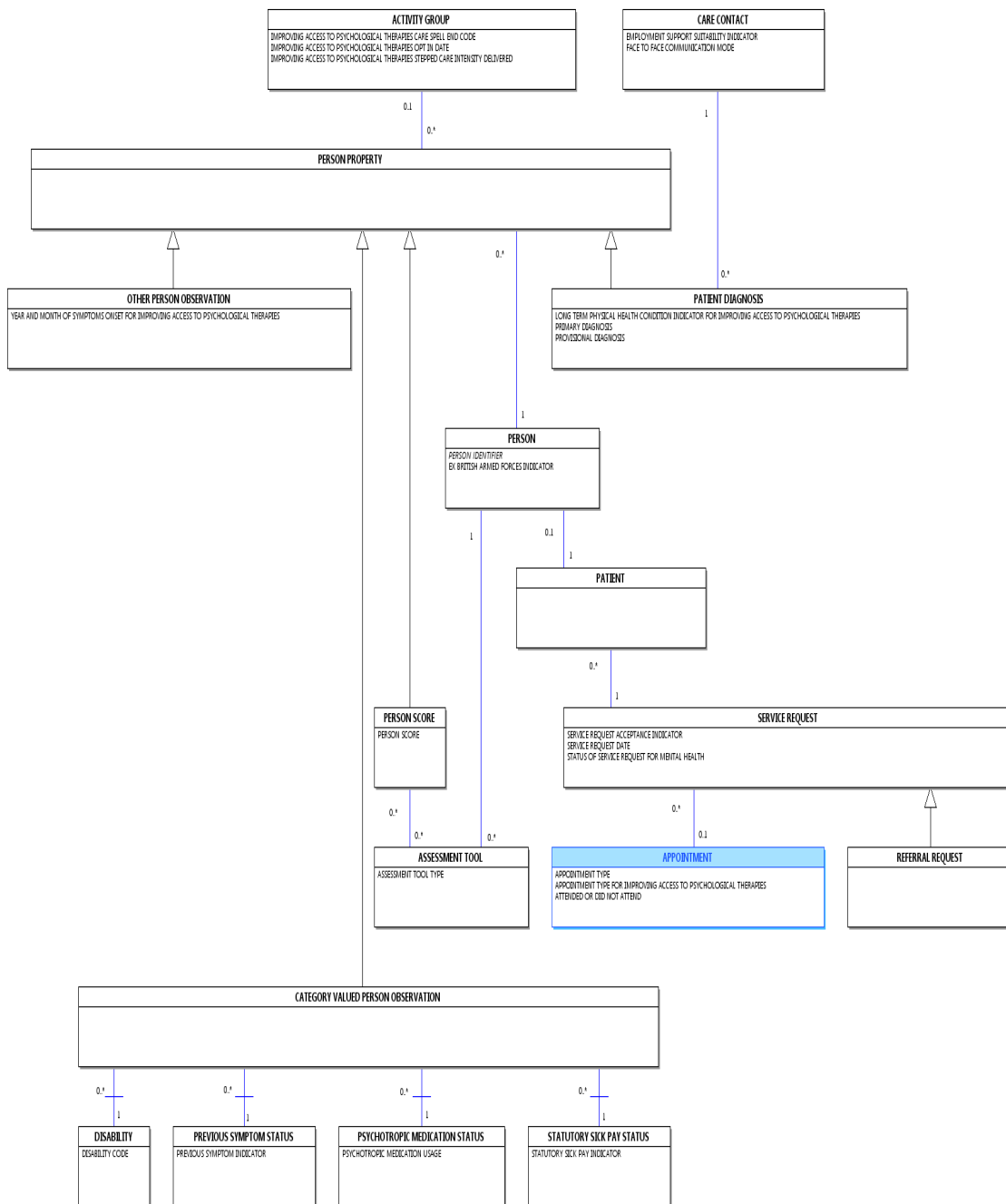
HIV AND AIDS DIAGRAM

Change to Diagram: Changed Diagram



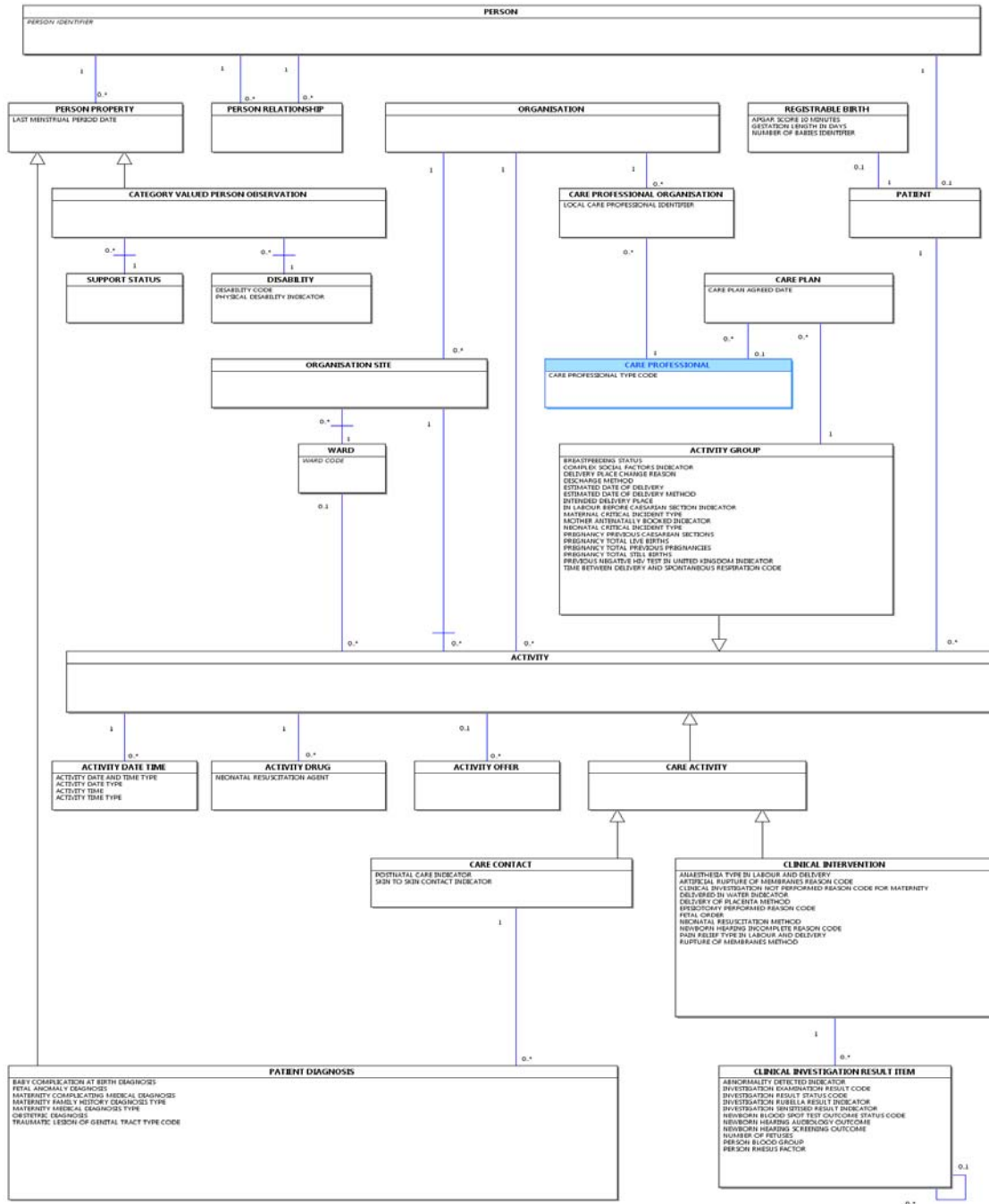
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES DIAGRAM

Change to Diagram: Changed Diagram



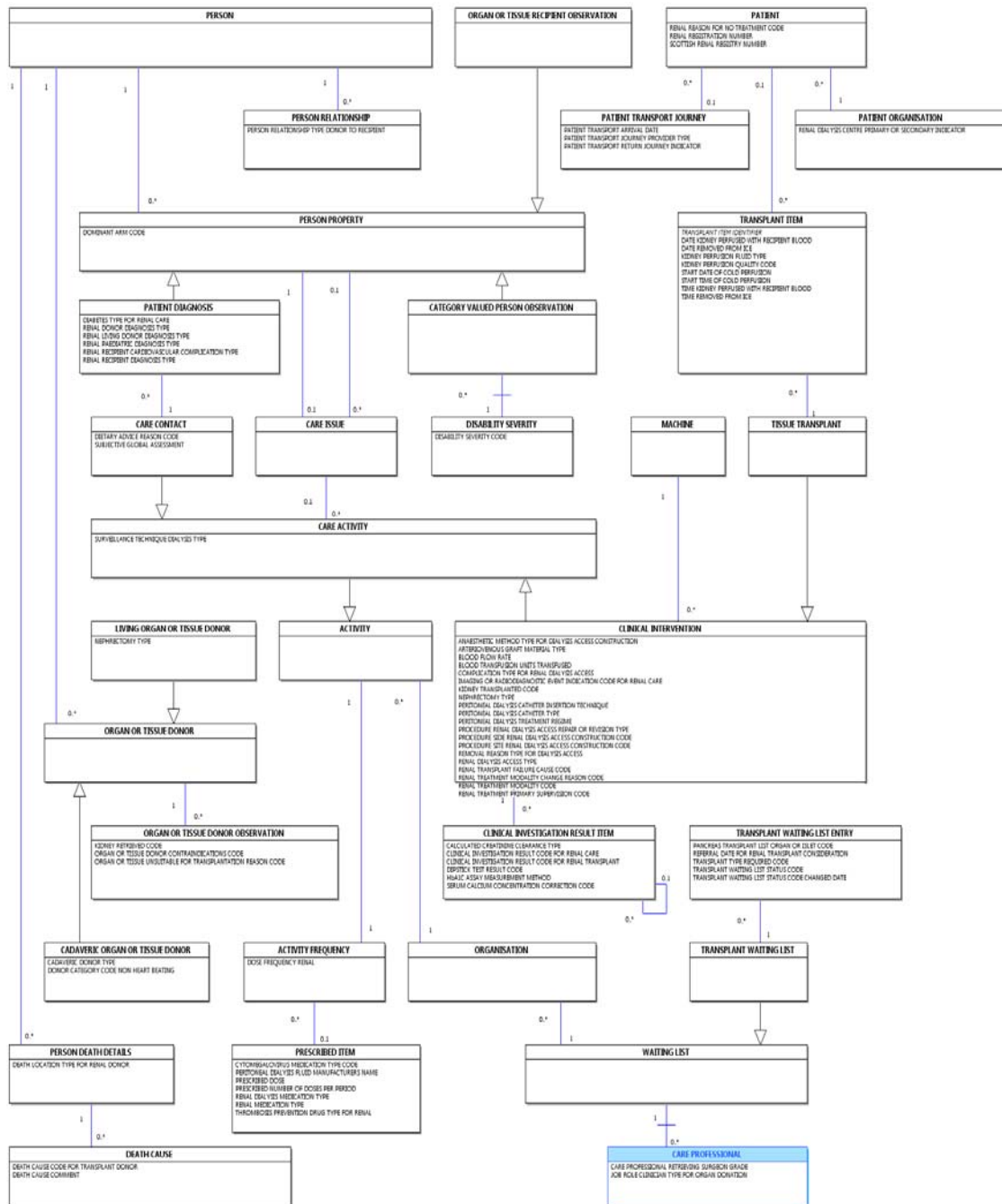
MATERNITY SERVICES DIAGRAM

Change to Diagram: Changed Diagram



NATIONAL RENAL DIAGRAM

Change to Diagram: Changed Diagram



MENTAL HEALTH SERVICES DATA SET

Change to Data Set: New Data Set

[Mental Health Services Data Set Overview](#)

The Mandatory or Required (M/R/P) column indicates the recommendation for the inclusion of data.

- **M = Mandatory:** this data element is mandatory and the technical process (e.g. submission of the data set, production of output etc) cannot be completed without this data element being present
- **R = Required:** NHS business processes cannot be delivered without this data element
- **P = Pilot:** this data element is for piloting use only.

Note: items in the M/R/P column which are shown with notation P have **not** been approved by the Standardisation Committee for Care Information and are included to facilitate piloting and testing of future data requirements, prior to formal inclusion in later versions of the Mental Health Services Data Set. These items have been included in the data set layout in order to provide advance notice to data providers and system suppliers of the intention to require these items at a later date. Unless ORGANISATIONS are engaged in piloting activities relating to these items, they should **NOT** submit any data item marked P.

HEADER

Header:

To carry the header details for the submission.
One occurrence of this group is required.

M/R/P	Data Set Data Elements
M	DATA SET VERSION NUMBER
M	<u>ORGANISATION CODE (CODE OF PROVIDER)</u>
M	<u>ORGANISATION CODE (CODE OF SUBMITTING ORGANISATION)</u>
M	<u>PRIMARY DATA COLLECTION SYSTEM IN USE</u>
M	<u>REPORTING PERIOD START DATE</u>
M	<u>REPORTING PERIOD END DATE</u>
M	<u>DATE AND TIME DATA SET CREATED</u>

PATIENT DEMOGRAPHICS

Master Patient Index:

To carry the patient details of the patient.
One occurrence of this group is required.

M/R/P	Data Set Data Elements
M	<u>LOCAL PATIENT IDENTIFIER (EXTENDED)</u>
M	<u>ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)</u>
R	<u>ORGANISATION CODE (RESIDENCE RESPONSIBILITY)</u>
R	<u>ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT)</u>
R	<u>NHS NUMBER</u>
R	<u>NHS NUMBER STATUS INDICATOR CODE</u>
R	<u>PERSON BIRTH DATE</u>
R	<u>POSTCODE OF USUAL ADDRESS</u>
R	<u>POSTCODE OF MAIN VISITOR</u>
R	<u>PERSON STATED GENDER CODE</u>
R	<u>ETHNIC CATEGORY</u>
R	<u>RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE</u>
R	<u>LANGUAGE CODE (PREFERRED)</u>
R	<u>PERSON DEATH DATE</u>

GP Practice Registration:

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

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

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

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

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

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

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

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

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

M/R/P	Data Set Data Elements
M	<u>LOCAL PATIENT IDENTIFIER (EXTENDED)</u>
M	<u>START DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD)</u>
R	<u>CARE PROFESSIONAL LOCAL IDENTIFIER</u>
R	<u>END DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD)</u>
R	<u>CARE PROFESSIONAL SERVICE OR TEAM TYPE ASSOCIATION (MENTAL HEALTH)</u>

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

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

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

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

REFERRALS

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

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

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

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

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

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

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

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

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

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

CARE CONTACT, CARE ACTIVITIES AND INDIRECT ACTIVITIES

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

M/R/P	Data Set Data Elements
M	<u>CARE CONTACT IDENTIFIER</u>
M	<u>SERVICE REQUEST IDENTIFIER</u>
R	<u>CARE PROFESSIONAL TEAM LOCAL IDENTIFIER</u>
M	<u>CARE CONTACT DATE</u>
R	<u>CARE CONTACT TIME</u>
R	<u>ORGANISATION CODE (CODE OF COMMISSIONER)</u>
R	<u>ADMINISTRATIVE CATEGORY CODE</u>
R	<u>CLINICAL CONTACT DURATION OF CARE CONTACT</u>
R	<u>CONSULTATION TYPE</u>
R	<u>CARE CONTACT SUBJECT</u>
R	<u>CONSULTATION MEDIUM USED</u>
R	<u>ACTIVITY LOCATION TYPE CODE</u>
R	<u>SITE CODE (OF TREATMENT)</u>
R	<u>GROUP THERAPY INDICATOR</u>
R	<u>ATTENDED OR DID NOT ATTEND CODE</u>
R	<u>EARLIEST REASONABLE OFFER DATE</u>
R	<u>EARLIEST CLINICALLY APPROPRIATE DATE</u>
R	<u>CARE CONTACT CANCELLATION DATE</u>
R	<u>CARE CONTACT CANCELLATION REASON</u>
R	<u>REPLACEMENT APPOINTMENT DATE OFFERED</u>
R	<u>REPLACEMENT APPOINTMENT BOOKED DATE</u>

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

M/R/P	Data Set Data Elements
-------	------------------------

M	<u>CARE ACTIVITY IDENTIFIER</u>
M	<u>CARE CONTACT IDENTIFIER</u>
R	<u>CARE PROFESSIONAL LOCAL IDENTIFIER</u>
R	<u>CLINICAL CONTACT DURATION OF CARE ACTIVITY</u>
R	<u>PROCEDURE SCHEME IN USE</u>
R	<u>CODED PROCEDURE (CLINICAL TERMINOLOGY)</u>
R	<u>FINDING SCHEME IN USE</u>
R	<u>CODED FINDING (CODED CLINICAL ENTRY)</u>
R	<u>OBSERVATION SCHEME IN USE</u>
R	<u>CODED OBSERVATION (CLINICAL TERMINOLOGY)</u>
R	<u>OBSERVATION VALUE</u>
R	<u>UCUM UNIT OF MEASUREMENT</u>

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

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

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

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

GROUP SESSIONS

Group Session:
To carry details of any group sessions which have been provided.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	<u>GROUP SESSION IDENTIFIER</u>
M	<u>GROUP SESSION DATE</u>
M	<u>ORGANISATION CODE (CODE OF COMMISSIONER)</u>
R	<u>CLINICAL CONTACT DURATION OF GROUP SESSION</u>
R	<u>GROUP SESSION TYPE (MENTAL HEALTH)</u>
R	<u>NUMBER OF GROUP SESSION PARTICIPANTS</u>
R	<u>ACTIVITY LOCATION TYPE CODE</u>
R	<u>SITE CODE (OF TREATMENT)</u>
R	<u>CARE PROFESSIONAL LOCAL IDENTIFIER</u>
R	<u>SERVICE OR TEAM TYPE REFERRED TO (MENTAL HEALTH)</u>
R	<u>NHS SERVICE AGREEMENT LINE NUMBER</u>

MENTAL HEALTH ACT (MHA) EPISODES

Mental Health Act Legal Status Classification Period:

To carry details of Mental Health Act Legal Status Classification Period for patients formally detailed under the Mental Health Act 1983 or other Acts.
Multiple occurrences of this group are permitted, one for each separate section of the Mental Health Act that the patient is detained under.

M/R/P	Data Set Data Elements
M	<u>MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER</u>
M	<u>LOCAL PATIENT IDENTIFIER (EXTENDED)</u>
M	<u>START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)</u>
M	<u>START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)</u>
R	<u>MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON</u>
R	<u>EXPIRY DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)</u>
R	<u>EXPIRY TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)</u>
R	<u>END DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)</u>
R	<u>END TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)</u>
R	<u>MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON</u>
R	<u>MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE</u>
R	<u>MENTAL HEALTH ACT 2007 MENTAL CATEGORY</u>

Mental Health Responsible Clinician Assignment:

To carry details of the assignment of a Mental Health Responsible Clinician to the patient.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	<u>MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER</u>
M	<u>START DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD)</u>
M	<u>CARE PROFESSIONAL LOCAL IDENTIFIER</u>
R	<u>END DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD)</u>

Conditional Discharge:

To carry details of each separate period of conditional discharge for the patient.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	<u>MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER</u>
M	<u>START DATE (MENTAL HEALTH CONDITIONAL DISCHARGE)</u>
R	<u>END DATE (MENTAL HEALTH CONDITIONAL DISCHARGE)</u>
R	<u>MENTAL HEALTH CONDITIONAL DISCHARGE END REASON</u>
R	<u>MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY</u>

Community Treatment Order:

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

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

Community Treatment Order Recall:

To carry details of each separate period of recall into hospital for a patient on a Community Treatment Order under section 17a of the Mental Health Act 1983.

Multiple occurrences of this group are permitted.

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

HOSPITAL PROVIDER SPELLS

Hospital Provider Spell:

To carry details of each Hospital Provider Spell for a patient.

Multiple occurrences of this group are permitted.

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

Ward Stay:

To carry details of Ward Stays which occurred during a Hospital Provider Spell for the patient.

Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	WARD STAY IDENTIFIER
M	HOSPITAL PROVIDER SPELL NUMBER
M	START DATE (WARD STAY)
R	START TIME (WARD STAY)
R	END DATE (WARD STAY)
R	END TIME (WARD STAY)
R	SITE CODE (OF TREATMENT)
R	WARD SETTING TYPE (MENTAL HEALTH)
R	SEX OF PATIENTS CODE
R	INTENDED CLINICAL CARE INTENSITY CODE (MENTAL HEALTH)
R	WARD SECURITY LEVEL

Assigned Care Professional:

To carry details of the Care Professional Admitted Care Episodes during a Hospital Provider Spell.

Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	HOSPITAL PROVIDER SPELL NUMBER
M	CARE PROFESSIONAL LOCAL IDENTIFIER
M	START DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)

R	<u>END DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)</u>
R	<u>TREATMENT FUNCTION CODE (MENTAL HEALTH)</u>

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CLINICALLY CODED TERMINOLOGY

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

M/R/P	Data Set Data Elements
M	<u>LOCAL PATIENT IDENTIFIER (EXTENDED)</u>
M	<u>DIAGNOSIS SCHEME IN USE</u>
M	<u>PREVIOUS DIAGNOSIS (CODED CLINICAL ENTRY)</u>
R	<u>DIAGNOSIS DATE</u>

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

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

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

M/R/P	Data Set Data Elements
M	<u>SERVICE REQUEST IDENTIFIER</u>

M	<u>DIAGNOSIS SCHEME IN USE</u>
M	<u>PRIMARY DIAGNOSIS (CODED CLINICAL ENTRY)</u>
R	<u>DIAGNOSIS DATE</u>

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

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

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

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

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

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

ANONYMOUS SELF-ASSESSMENT

Anonymous Self-Assessment:
To carry details of anonymous self-assessments.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	<u>ASSESSMENT TOOL COMPLETION DATE</u>
M	<u>CODED ASSESSMENT TOOL TYPE (SNOMED CT)</u>
M	<u>PERSON SCORE</u>
R	<u>ACTIVITY LOCATION TYPE CODE</u>
R	<u>ORGANISATION CODE (CODE OF COMMISSIONER)</u>

CARE PROGRAMME APPROACH (CPA) CARE EPISODES

Care Programme Approach (CPA) Care Episode:
To carry details of the periods of time the patient spent on Care Programme Approach.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	<u>CARE PROGRAMME APPROACH CARE EPISODE IDENTIFIER</u>
M	<u>LOCAL PATIENT IDENTIFIER (EXTENDED)</u>
M	<u>START DATE (CARE PROGRAMME APPROACH CARE)</u>

R	<u>END DATE (CARE PROGRAMME APPROACH CARE)</u>
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Care Programme Approach (CPA) Review:
To carry details of Care Programme Approach reviews undertaken for the patient.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	<u>CARE PROGRAMME APPROACH CARE EPISODE IDENTIFIER</u>
M	<u>CARE PROGRAMME APPROACH REVIEW DATE</u>
R	<u>CARE PROGRAMME APPROACH REVIEW ABUSE QUESTION ASKED INDICATOR</u>
R	<u>CARE PROFESSIONAL LOCAL IDENTIFIER</u>

CARE CLUSTERS

Clustering Tool Assessment:
To carry details of clustering tool assessments.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	<u>CLUSTERING TOOL ASSESSMENT IDENTIFIER</u>
M	<u>LOCAL PATIENT IDENTIFIER (EXTENDED)</u>
M	<u>CLUSTERING TOOL ASSESSMENT CATEGORY</u>
M	<u>ASSESSMENT TOOL COMPLETION DATE</u>
R	<u>ASSESSMENT TOOL COMPLETION TIME</u>
R	<u>CLUSTERING TOOL ASSESSMENT REASON</u>
R	<u>MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE</u>
R	<u>ADULT MENTAL HEALTH CARE CLUSTER CODE (INITIAL)</u>
P	<u>CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL)</u>
P	<u>LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)</u>
P	<u>FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL)</u>
P	<u>FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)</u>

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

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

Care Cluster:
To carry details of the Care Cluster resulting from a clustering tool assessment.
Multiple occurrences of this group are permitted.

M/R/P	Data Set Data Elements
M	<u>CLUSTERING TOOL ASSESSMENT IDENTIFIER</u>
R	<u>ADULT MENTAL HEALTH CARE CLUSTER CODE (FINAL)</u>
P	<u>CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL)</u>
P	<u>LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)</u>
P	<u>FORENSIC MENTAL HEALTH CARE CLUSTER CODE (FINAL)</u>
P	<u>FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)</u>
M	<u>START DATE (CARE CLUSTER ASSIGNMENT PERIOD)</u>
R	<u>START TIME (CARE CLUSTER ASSIGNMENT PERIOD)</u>
R	<u>END DATE (CARE CLUSTER ASSIGNMENT PERIOD)</u>

R	END TIME (CARE CLUSTER ASSIGNMENT PERIOD)
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CARE PROFESSIONALS

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

ADULT MENTAL HEALTH CARE CLUSTER_ renamed from MENTAL HEALTH CARE CLUSTER

Change to Supporting Information: Changed Description, Name

~~A Mental Health Care Cluster is a MENTAL HEALTH CARE CLUSTER which is a type of CATEGORY VALUED PERSON OBSERVATION. An Adult Mental Health Care Cluster is a type of CARE CLUSTER for adult PATIENTS.~~

~~A Mental Health Care Cluster is part of a currency developed to support the National Tariff Payment System for Mental Health Services. Mental Health Care Clusters are 21 groupings of Mental Health PATIENTS based on their characteristics, and are a way of classifying individuals utilising Mental Health Services that forms the basis for payment. An Adult Mental Health Care Cluster is part of a currency developed to support the National Tariff Payment System for Mental Health Services.~~

~~A Mental Health Care Cluster is assigned using a decision tree or algorithm based on the PERSON SCORE from the Mental Health Clustering Tool undertaken by a CARE PROFESSIONAL for the PATIENT. Adult Mental Health Care Clusters are 21 groupings of Mental Health PATIENTS based on their characteristics, and are a way of classifying individuals utilising Mental Health Services that forms the basis for payment.~~

~~This is done by first assigning the PATIENT to one of three Mental Health Care Cluster Super Classes, to narrow down the number of possible Mental Health Care Clusters which are applicable to the PATIENTS condition. The PATIENT is then assigned to the most appropriate of this sub-set of Mental Health Care Clusters. An Adult Mental Health Care Cluster is assigned using a decision tree or algorithm based on the PERSON SCORE from the Adult Mental Health Clustering Tool undertaken by a CARE PROFESSIONAL for the PATIENT.~~

~~The Mental Health Care Clusters into which the presenting needs of the PATIENT may fall are: This is done by first assigning the PATIENT to one of three Mental Health Care Cluster Super Classes, to narrow down the number of possible Adult Mental Health Care Clusters which are applicable to the PATIENTS condition. The PATIENT is then assigned to the most appropriate of this sub-set of Adult Mental Health Care Clusters.~~

~~**Care Cluster 0: Variance** — Despite careful consideration of all the other Mental Health Care Clusters, this group of PATIENTS are not adequately described by any of their descriptions. PATIENTS who cannot be initially assigned to a Mental Health Care Cluster Super Class during the clustering process will be automatically assigned to this Mental Health Care Cluster.~~

~~**Care Cluster 1: Common Mental Health Problems (Low Severity)** — This group of PATIENTS has definite but minor problems of depressed mood, anxiety or other disorder, but they do not present with any psychotic symptoms~~

~~**Care Cluster 2: Common Mental Health Problems (Low Severity with Greater Need)** —This group of [PATIENTS](#) has definite but minor problems of depressed mood, anxiety or other disorder, but not with any psychotic symptoms. They may have already received care associated with Care Cluster 1 and require more specific intervention, or previously been successfully treated at a higher level but are re-presenting with low level symptoms~~

~~**Care Cluster 3: Non-Psychotic (Moderate Severity)** —This group of [PATIENTS](#) have moderate problems involving depressed mood, anxiety or other disorder (not including psychosis)~~

~~**Care Cluster 4: Non-Psychotic (Severe)** —This group of [PATIENTS](#) is characterised by severe depression and/or anxiety and/or other disorders, and increasing complexity of needs. They may experience disruption to function in everyday life and there is an increasing likelihood of significant risks.~~

~~**Care Cluster 5: Non-Psychotic Disorders (Very Severe)** —This group of [PATIENTS](#) will be severely depressed and/or anxious and/or other. They will not present with hallucinations or delusions but may have some unreasonable beliefs. They may often be at high risk for suicide and they may present safeguarding issues and have severe disruption to everyday living.~~

~~**Care Cluster 6: Non-Psychotic Disorder of Over-Valued Ideas** —This group of [PATIENTS](#) suffer from moderate to very severe disorders that are difficult to treat. This may include treatment resistant eating disorders, Obsessive Compulsive Disorder etc, where extreme beliefs are strongly held, some personality disorders, and enduring depression.~~

~~**Care Cluster 7: Enduring Non-Psychotic Disorders (High Disability)** —This group of [PATIENTS](#) suffer from moderate to severe disorders that are very disabling. They will have received treatment for a number of years and although they may have an improvement in positive symptoms, considerable disability remains that is likely to affect role functioning in many ways.~~

~~**Care Cluster 8: Non-Psychotic Chaotic and Challenging Disorders** —This group of [PATIENTS](#) will have a wide range of symptoms and chaotic and challenging lifestyles. They are characterised by moderate to very severe repeat deliberate self-harm and/or other impulsive behaviour and chaotic, over-dependant engagement, and are often hostile with services.~~

~~**Care Cluster 9: Cluster Under Review** —Note: This [Mental Health Care Cluster](#) is under review and should not be used.~~

~~**Care Cluster 10: First Episode Psychosis** —This group of [PATIENTS](#) will be presenting to the Mental Health service for the first time with mild to severe psychotic phenomena. They may also have depressed mood and/or anxiety and/or other behaviours. Drinking or drug taking may be present but *will not* be the only problem.~~

~~**Care Cluster 11: Ongoing Recurrent Psychosis (Low Symptoms)** —This group of [PATIENTS](#) have a history of psychotic symptoms that are currently controlled and causing minor problems if any at all. They are currently experiencing a period of recovery where they are capable of full or near functioning. However, there may be impairment in self-esteem and efficacy and vulnerability to life.~~

~~**Care Cluster 12: Ongoing or Recurrent Psychosis (High Disability)** —This group of [PATIENTS](#) have a history of psychotic symptoms with a significant disability with major impact on role functioning. They are likely to be vulnerable to abuse or exploitation.~~

~~**Care Cluster 13: Ongoing or Recurrent Psychosis (High Symptoms and Disability)** —This group of [PATIENTS](#) will have a history of psychotic symptoms which are not controlled. They will present with moderate to severe psychotic symptoms and some anxiety or depression. They have a significant disability with major impact on role functioning.~~

~~**Care Cluster 14: Psychotic Crisis** —This group of [PATIENTS](#) will be experiencing an acute psychotic episode with severe symptoms that cause severe disruption to role functioning. They may present as vulnerable and a risk to others or themselves.~~

~~**Care Cluster 15: Severe Psychotic Depression** —This group of [PATIENTS](#) will be suffering from an acute episode of moderate to severe depressive symptoms. Hallucinations and delusions will be present. It is likely that this group will present a risk of suicide and have disruption in many areas of their lives.~~

~~**Care Cluster 16: Dual Diagnosis** —This group of [PATIENTS](#) have enduring, moderate to severe psychotic or affective symptoms with unstable, chaotic lifestyles and *co-existing* substance misuse. They may present a risk to self and others and engage poorly with services. Role functioning is often globally impaired.~~

~~**Care Cluster 17: Psychosis and Affective Disorder (Difficult to Engage)** —This group of [PATIENTS](#) have moderate to severe psychotic symptoms with unstable, chaotic lifestyles. There may be some problems with drugs or alcohol not severe enough to warrant dual diagnosis care. This group have a history of non-concordance, are vulnerable, and engage poorly with services.~~

~~**Care Cluster 18: Cognitive Impairment (Low Need)** —People who may be in the early stages of dementia (or who may have an organic brain disorder affecting their cognitive function) who have some memory problems, or other low level cognitive impairment, but who are still managing to cope reasonably well. Underlying reversible physical causes have been ruled out.~~

~~**Care Cluster 19: Cognitive Impairment or Dementia Complicated (Moderate Need)** —People who have problems with their memory, and/or other aspects of cognitive functioning resulting in moderate problems looking after themselves and maintaining social relationships. Probable risk of self neglect or harm to others and may be experiencing some anxiety or depression.~~

~~**Care Cluster 20: Cognitive Impairment or Dementia (High Need)** —People with dementia who are having significant problems in looking after themselves and whose behaviour may challenge their carers or services. They may have high levels of anxiety or depression, psychotic symptoms, or significant problems such as aggression or agitation. They may not be aware of their problems. They are likely to be at high risk of self neglect or harm to others, and there may be a significant risk of their care arrangements breaking down.~~

~~**Care Cluster 21: Cognitive Impairment or Dementia (High Physical or Engagement)** —People with cognitive impairment or dementia who are having significant problems in looking after themselves, and whose physical condition is becoming increasingly frail. They may not be aware of their problems and there may be a significant risk of their care arrangements breaking down.~~

~~Further information relating to the [Mental Health Clustering Tool](#) and [Mental Health Care Clusters](#) is available from the [Monitor](#) part of the gov.uk website at: [Guidance on mental health currencies and payment](#).~~

ADULT MENTAL HEALTH CARE CLUSTER renamed from **MENTAL HEALTH CARE CLUSTER**

Change to Supporting Information: Changed Description, Name

- Changed Description
- Changed Name from `Data_Dictionary.NHS_Business_Definitions.M.Mental_Health_Care_Cluster` to `Data_Dictionary.NHS_Business_Definitions.A.Adult_Mental_Health_Care_Cluster`

ADULT MENTAL HEALTH CLUSTERING TOOL renamed from **MENTAL HEALTH CLUSTERING TOOL**

Change to Supporting Information: Changed Description, Name

~~The [Mental Health Clustering Tool](#) is a type of [ASSESSMENT TOOL](#). The [Adult Mental Health Clustering Tool](#) is a type of [Clustering Tool](#) for adult [PATIENTS](#) receiving Mental Health care.~~

The ~~Mental Health Clustering Tool~~ is a needs assessment tool designed to rate the care needs of a ~~PATIENT~~, based upon a series of 18 rating scales. The ~~Adult Mental Health Clustering Tool~~ is a needs assessment tool designed to rate the care needs of a ~~PATIENT~~, based upon a series of 18 rating scales.

The first 12 of these rating scales are the same as the ~~Health of the Nation Outcome Scale (Working Age Adults)~~ rating scales, originally developed by the Royal College of Psychiatrists. These 12 rating scales are numbered 1 - 12 under 'Current Ratings' in the ~~Mental Health Clustering Tool~~. These 12 rating scales are numbered 1 - 12 under 'Current Ratings' in the ~~Adult Mental Health Clustering Tool~~.

One additional 'current' rating and a new section relating to historical ratings have also been added, to form the ~~Mental Health Clustering Tool~~. One additional 'current' rating and a new section relating to historical ratings have also been added, to form the ~~Adult Mental Health Clustering Tool~~. These items are referred to as the Summary Assessment of Characteristics (SAC) items.

Part 1: Current Ratings

These ratings relate to the most severe occurrence in the two weeks prior to the ~~Mental Health Clustering Tool~~ ~~ASSESSMENT TOOL COMPLETION DATE~~. These ratings relate to the most severe occurrence in the two weeks prior to the ~~Adult Mental Health Clustering Tool~~ ~~ASSESSMENT TOOL COMPLETION DATE~~.

1. Overactive, aggressive, disruptive or agitated behaviour (current)
2. Non-accidental self injury (current)
3. Problem drinking or drug taking (current)
4. Cognitive problems (current)
5. Physical illness or disability problems (current)
6. Problems associated with hallucinations and delusions (current)
7. Problems with depressed mood (current)
8. Other mental and behavioural problems (current), qualified by specific disorders: and the alphabetical list of headings from the glossary:
 - A Phobic
 - B Anxiety
 - C Obsessive-compulsive
 - D Stress
 - E Dissociative
 - F Somatoform
 - G Eating
 - H Sleep
 - I Sexual
 - J Other
9. Problems with relationships (current)
10. Problems with activities of daily living (current)
11. Problems with living conditions (current)
12. Problems with occupation and activities (current)
13. Strong unreasonable beliefs occurring in non-psychotic disorders only (current)

Part 2: Historical Ratings

These ratings relate to problems that occur in an episodic or unpredictable way, from a more 'historical' perspective. Whilst there may not be any direct observation or report of a manifestation during the two weeks prior to the ~~Mental Health Clustering Tool~~ ~~ASSESSMENT TOOL COMPLETION DATE~~, the evidence and clinical judgement would suggest that there is still a cause for concern that cannot be disregarded. Whilst there may not be any direct observation or report of a manifestation during the two weeks prior to the ~~Adult Mental Health Clustering Tool~~ ~~ASSESSMENT TOOL COMPLETION DATE~~, the evidence and clinical judgement would suggest that there is still a cause for concern that cannot be disregarded. In these circumstances, any event that remains relevant to the current ~~CARE PLAN~~ should be included.

- A. Agitated behaviour / expansive mood (historical)
- B. Repeat self-harm (historical)
- C. Safeguarding children and vulnerable dependant adults (historical)
- D. Engagement (historical)
- E. Vulnerability (historical)

The allowed responses to each of the 18 items in the [Mental Health Clustering Tool](#) are: The allowed responses to each of the 18 items in the [Adult Mental Health Clustering Tool](#) are:

- 0 - No problem
- 1 - Minor problem requiring no action
- 2 - Mild problem but definitely present
- 3 - Moderately severe problem
- 4 - Severe to very severe problem
- 9 - Not known

The [PERSON SCORE](#) from the [Mental Health Clustering Tool](#) is used to allocate the [PATIENT](#) to the most appropriate [Mental Health Care Cluster](#). The [PERSON SCORE](#) from the [Adult Mental Health Clustering Tool](#) is used to allocate the [PATIENT](#) to the most appropriate [Adult Mental Health Care Cluster](#).

Further information relating to the [Mental Health Clustering Tool](#) and [Mental Health Care Clusters](#) is available from the [Monitor](#) part of the gov. Further information relating to the [Adult Mental Health Clustering Tool](#) and [Adult Mental Health Care Clusters](#) is available from the [Monitor](#) part of the gov.uk website at: [Guidance on mental health currencies and payment](#).

ADULT MENTAL HEALTH CLUSTERING TOOL, renamed from MENTAL HEALTH CLUSTERING TOOL

Change to Supporting Information: Changed Description, Name

- Changed Description
- Changed Name from Data_Dictionary.NHS_Business_Definitions.M.Mental_Health_Clustering_Tool to Data_Dictionary.NHS_Business_Definitions.A.Adult_Mental_Health_Clustering_Tool

AUTISTIC SPECTRUM DISORDER

Change to Supporting Information: Changed Description

[Autistic Spectrum Disorder](#) is a [DISABILITY](#).

[Autistic Spectrum Disorder](#) is defined as a lifelong condition that affects how a [PERSON](#) communicates with, and relates to, other people. [Autistic Spectrum Disorder](#) also affects how a [PERSON](#) makes sense of the world around them.

The three main areas of difficulty, which all people with [Autism](#) share, are known as the 'triad of impairments'. They are

- difficulty with social communication (e.g. problems using and understanding verbal and non-verbal language, such as gestures, facial expressions and tone of voice)
- difficulty with social interaction (e.g. problems in recognising and understanding other people's feelings and managing their own feelings)
- difficulty with social imagination (e.g. problems in understanding and predicting other people's intentions and behaviour and imagining situations outside their own routine)

For further information on [Autistic Spectrum Disorder](#), see: For further information on [Autistic Spectrum Disorder](#), see the:

- the [National Autistic Society website](#)

- ~~the~~ [NHS Choices website](#)
- [National Autistic Society website](#)
- [NHS Choices website](#)

CARE CLUSTER ASSIGNMENT PERIOD

Change to Supporting Information: New Supporting Information

A [Care Cluster Assignment Period](#) is a [PERSON PROPERTY ASSIGNMENT PERIOD](#).

A [Care Cluster Assignment Period](#) is the period of time that a [PATIENT](#) is assigned to a [CARE CLUSTER](#).

This supporting information is also known by these names:

Context	Alias
plural	Care Cluster Assignment Periods

CARE CONTACT CANCELLATION DATE_ renamed from CARE CONTACT CANCELLATION DATE

Change to Supporting Information: Changed Description, Dataset, Name

~~The date on which a [CARE CONTACT](#) was cancelled.~~ A [Care Contact Cancellation Date](#) is an [ACTIVITY DATE TIME](#).

A [Care Contact Cancellation Date](#) is the [DATE](#) on which a [CARE CONTACT](#) was cancelled.

CARE CONTACT CANCELLATION DATE_ renamed from CARE CONTACT CANCELLATION DATE

Change to Supporting Information: Changed Description, Dataset, Name

- Changed Description
- null
- Changed Name from `Data_Dictionary.Attributes.C.Card.CARE_CONTACT_CANCELLATION_DATE` to `Data_Dictionary.NHS_Business_Definitions.C.Care_Contact_Cancellation_Date`

CARE CONTACT DATE_ renamed from CARE CONTACT DATE

Change to Supporting Information: Changed Description, Dataset, Name

~~The date on which a [CARE CONTACT](#) took place.~~ A [Care Contact Date](#) is an [ACTIVITY DATE TIME](#).

A [Care Contact Date](#) is the [DATE](#) on which a [CARE CONTACT](#) took place.

CARE CONTACT DATE_ renamed from CARE CONTACT DATE

Change to Supporting Information: Changed Description, Dataset, Name

- Changed Description
- null

- Changed Name from Data_Dictionary.Attributes.C.Card.CARE_CONTACT_DATE to Data_Dictionary.NHS_Business_Definitions.C.Care_Contact_Date

CARE CONTACT TIME_ renamed from CARE CONTACT TIME

Change to Supporting Information: Changed Description, Dataset, Name

The time at which a **CARE CONTACT** took place. A Care Contact Time is an **ACTIVITY DATE TIME**.

A Care Contact Time is the **TIME** at which a **CARE CONTACT** took place.

CARE CONTACT TIME_ renamed from CARE CONTACT TIME

Change to Supporting Information: Changed Description, Dataset, Name

- Changed Description
- null
- Changed Name from Data_Dictionary.Attributes.C.Card.CARE_CONTACT_TIME to Data_Dictionary.NHS_Business_Definitions.C.Care_Contact_Time

CARE PROFESSIONAL ADMITTED CARE EPISODE

Change to Supporting Information: New Supporting Information

A **Care Professional Admitted Care Episode** is an **ACTIVITY GROUP**.

A **Care Professional Admitted Care Episode** is the period of time within a **Hospital Provider Spell** during which the **PATIENT** is under the medical responsibility of a:

- **CONSULTANT**
- **MIDWIFE**
- **NURSE**

A **Care Professional Admitted Care Episode** can be a:

- **Consultant Episode (Hospital Provider)**
- **Midwife Episode**
- **Nursing Episode.**

This supporting information is also known by these names:

Context	Alias
plural	Care Professional Admitted Care Episodes

CARE PROGRAMME APPROACH

Change to Supporting Information: New Supporting Information

The **Care Programme Approach** (CPA) provides a framework for effective mental health care planning, assessment, management, co-ordination and delivery.

The **Care Programme Approach** only applies to individuals with complex needs who are in contact with a number of **SERVICES**, or those at most risk.

For further information on the [Care Programme Approach](#), see NHS Choices at: [Care Programme Approach](#).

This supporting information is also known by these names:

Context	Alias
shortname	CPA

CARE PROGRAMME APPROACH CARE EPISODE, renamed from CARE PROGRAMME APPROACH EPISODE

Change to Supporting Information: Changed Description, Name

~~A [Care Programme Approach Episode](#) is an [ACTIVITY GROUP](#).~~ A [Care Programme Approach Care Episode](#) is an [ACTIVITY GROUP](#).

A [Care Programme Approach Episode](#) is a period of care provided as part of the care programme approach for an adult (including elderly) [PATIENT](#). The [Care Programme Approach Episode](#) forms part of a [Adult Mental Health, Learning Disability or Autism Spectrum Disorder Care Spell](#). A [Care Programme Approach Care Episode](#) is a period of care during which the [PATIENT](#) is receiving care under the [Care Programme Approach](#).

~~The first [Care Programme Approach Episode](#) starts when the [Adult Mental Health, Learning Disability or Autism Spectrum Disorder Care Spell](#) initial assessment of the [PATIENT](#) determines that a plan of care or treatment is required which will be delivered under the care programme approach.~~ A [Care Programme Approach Care Episode](#) starts when the initial assessment of the [PATIENT](#) determines that a plan of care or treatment is required which will be delivered under the [Care Programme Approach](#).

~~The [Care Programme Approach Episode](#) ends when one of the following occurs:~~ The [Care Programme Approach Care Episode](#) ends when one of the following occurs:

- ~~a review determines that no further care need be provided~~
- ~~a different level of care programme approach is required~~
- ~~a [PATIENT](#) transfers to another [Health Care Provider](#) with main responsibility for provision of mental health care also being transferred~~
- ~~death of the [PATIENT](#)~~
- A review determines that no further care need be provided
- A [PATIENT](#) transfers to another [Health Care Provider](#) with main responsibility for provision of mental health care also being transferred
- The death of the [PATIENT](#)

~~A [Care Programme Approach Episode](#) must involve all of the following key elements:~~ A [Care Programme Approach Care Episode](#) must involve all of the following key elements:

- ~~a. An assessment of the [PATIENT](#)'s health and social care needs~~
- ~~b. A written care plan to meet the assessed needs, the [PATIENT](#) being involved in drawing up the care plan~~
- ~~c. Regular reviews of the [PATIENT](#)'s care plan~~
- ~~d. A named mental health worker, called a care coordinator, who is responsible for the [PATIENT](#) care under the care programme approach~~
- An assessment of the [PATIENT](#)'s health and social care needs
- A written [CARE PLAN](#) to meet the assessed needs, the [PATIENT](#) being involved in drawing up the [CARE PLAN](#)
- Regular reviews of the [CARE PLAN](#)
- A named mental health worker, called a [Mental Health Care Coordinator](#), who is responsible for the [PATIENT](#)'s care under the [Care Programme Approach](#).

~~Each [Care Programme Approach Episode](#) must be subject to at least one [Care Programme Approach Review](#) and at least one [Care Programme Approach Care Co-ordinator Allocation](#).~~ Each [Care Programme Approach Care](#)

Episode must be subject to at least one Care Programme Approach Review and at least one Mental Health Care Coordinator Assignment Period.

CARE PROGRAMME APPROACH CARE EPISODE_ renamed from CARE PROGRAMME APPROACH EPISODE

Change to Supporting Information: Changed Description, Name

- Changed Description
- Changed Name from Data_Dictionary.NHS_Business_Definitions.C.Care_Programme_Approach_Episode to Data_Dictionary.NHS_Business_Definitions.C.Care_Programme_Approach_Care_Episode

CARE PROGRAMME APPROACH REVIEW

Change to Supporting Information: Changed Description

A Care Programme Approach Review is a CARE CONTACT.

~~A Care Programme Approach Review is a clinical review of the health and social needs of a PATIENT who is the subject of a Care Programme Approach Episode.~~ A Care Programme Approach Review is a clinical review of the health and social needs of a PATIENT who is the subject of a Care Programme Approach Care Episode.

~~The review may take the form of a single meeting of interested parties, usually including the allocated care coordinator and the PATIENT or it may comprise a series of meetings and discussions over a number of days.~~ The Care Programme Approach Review may take the form of a single meeting of interested parties, usually including the allocated Mental Health Care Coordinator and the PATIENT, or it may comprise a series of meetings and discussions over a number of days.

The Care Programme Approach Review ends when a definite outcome is established and recorded. The date when this is recorded will be taken as the Care Programme Approach Review Date. ~~The outcome will determine whether the Care Programme Approach Episode continues or is ended.~~ The outcome will determine whether the Care Programme Approach Care Episode continues or is ended.

CARE PROGRAMME APPROACH REVIEW DATE

Change to Supporting Information: Changed Description

A Care Programme Approach Review Date is an ACTIVITY DATE TIME.

~~A Care Programme Approach Review Date is the date an established outcome of a Care Programme Approach Review is recorded.~~ A Care Programme Approach Review Date is the date of the Care Programme Approach Review.

CHILD AND ADOLESCENT MENTAL HEALTH SERVICES SECONDARY USES DIAGRAM OVERVIEW

Change to Supporting Information: Changed Description

~~The Child and Adolescent Mental Health Services Secondary Uses Diagram demonstrates the delivery of a Child and Adolescent Mental Health Care Spell, for the purposes of the Child and Adolescent Mental Health Services Secondary Uses Data Set.~~ The Child and Adolescent Mental Health Services Secondary Uses Diagram

demonstrates the delivery of a [Child and Adolescent Mental Health Care Spell](#), for the purposes of the [Child and Adolescent Mental Health Services Secondary Uses Data Set](#).

USING THE DIAGRAM

By clicking on a Class on the diagram opposite, the selected Class definition will be displayed. By clicking on an Attribute name displayed within the Class, the selected Attribute definition will be displayed.

Note that not all attributes for a class will be visible. The full list of attributes for a class can be viewed in the class definition, by selecting the 'Attribute' tab.

To view the diagram in full, select the 'Print Window' option, this will open a new window that will display only the diagram. You can also use this view to print the diagram, by right clicking on the diagram and selecting 'Print Picture'.

CLINICAL DATA SETS MENU

Change to Supporting Information: Changed Description

- [Message Documentation](#)
- [Cancer Outcomes and Services Data Set](#)
- [Child and Adolescent Mental Health](#)
- [Children and Young Peoples Health](#)
- [Chlamydia Testing Activity](#)
- [Community Information](#)
- [Diabetes \(Summary Core\)](#)
- [Diagnostic Imaging](#)
- [Female Genital Mutilation](#)
- [Genitourinary Medicine Clinic Activity](#)
- [HIV and AIDS Reporting](#)
- [Improving Access to Psychological Therapies](#)
- [Maternity Services](#)
- [Mental Health and Learning Disabilities](#)
- [Mental Health Services](#)
- [National Cancer Waiting Times Monitoring](#)
- [National Neonatal](#)
- [National Renal](#)
- [NHS Health Checks](#)
- [Radiotherapy](#)
- [Sexual and Reproductive Health Activity](#)
- [Systemic Anti-Cancer Therapy](#)

CLINIC ATTENDANCE NON-CONSULTANT

Change to Supporting Information: Changed Description

A [Clinic Attendance Non-Consultant](#) is a [CARE CONTACT](#).

A [Clinic Attendance Non-Consultant](#) is an attendance at or contact with a [Nurse Clinic](#), [Midwife Clinic](#) or [Sexual and Reproductive Health Clinic](#). This may have been as a result of an ~~[Out Patient Appointment Non-Consultant](#)~~.

If the [PATIENT](#) is currently subject to a [Mental Health Care Spell](#) and the [NURSE](#) they are in contact with during the attendance or contact is their allocated Care Programme Approach care coordinator then a [Face To Face](#)

~~Contact CPA Care Coordinator~~ should also be recorded. A Clinic Attendance Non-Consultant may be the result of an Out-Patient Appointment Non-Consultant.

Note: Attendances or contacts at clinics run by Paramedics are Professional Staff Group Contacts.

If an APPOINTMENT TIME was given, the time seen should be recorded.

Information recorded for a Clinic Attendance Non-Consultant includes:

ATTENDANCE DATE

ATTENDANCE IDENTIFIER

Time Seen 0 (if appointment time given)

CLUSTERING TOOL

Change to Supporting Information: New Supporting Information

A Clustering Tool is a type of ASSESSMENT TOOL.

A Clustering Tool is a needs assessment tool designed to rate the care needs of a PATIENT.

Examples of Clustering Tools include:

- Adult Mental Health Clustering Tool.

This supporting information is also known by these names:

Context	Alias
plural	Clustering Tools

COMMISSIONER ASSIGNMENT PERIOD

Change to Supporting Information: Changed Description

~~Commissioner Assignment Period~~ is an ACTIVITY GROUP. A Commissioner Assignment Period is an ACTIVITY GROUP.

~~Commissioner Assignment Period~~ is the period of time that an ORGANISATION CODE (CODE OF COMMISSIONER) is responsible for commissioning ACTIVITY for a PATIENT. A Commissioner Assignment Period is the period of time that a commissioner is responsible for commissioning ACTIVITY for a PATIENT.

COMMUNITY TREATMENT ORDER

Change to Supporting Information: Changed Description

See Supervised Community Treatment.

A Community Treatment Order applies to PATIENTS detained under the Mental Health Act 1983 as amended by the Mental Health Act 2007, typically under section 3 or 37. The underlying MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE of the Adult Mental Health, Learning Disability or Autism Spectrum Disorder Care Spell will be carried through the period in the community although it will be suspended during that period.

A Community Treatment Order will be made by the Mental Health Responsible Clinician, in agreement with an Approved Mental Health Professional, under section 17A of the Mental Health Act 1983 (inserted by the Mental Health Act 2007). The MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE section in force at the time of the Community Treatment Order is suspended.

The term Community Treatment Order refers to the actual instrument and Supervised Community Treatment to the treatment regime although both terms are used interchangeably. A Community Treatment Order will be made by the Mental Health Responsible Clinician, in agreement with an Approved Mental Health Professional, under section 17A of the Mental Health Act 1983 (inserted by the Mental Health Act 2007).

A Community Treatment Order has the same duration and renewal periods as section 3 of the Mental Health Act 1983 - six months initially, then renewed for 6 months, then renewed annually.

A PATIENT on a Community Treatment Order may be recalled to hospital for treatment where deemed necessary by the Mental Health Responsible Clinician (Community Treatment Order Recall).

A Community Treatment Order period can be ended by the following methods:

- Discharge or death of the PATIENT
- Revocation of the Community Treatment Order following a period of recall to hospital. The PATIENT will return to being under the original underlying section of the Mental Health Act 1983 under which they were sectioned immediately prior to the issuing of the Community Treatment Order.

A Community Treatment Order must be considered as an option by the Mental Health Responsible Clinician prior to granting or extending a Mental Health Leave of Absence for more than seven days (or for an indefinite period).

COMMUNITY TREATMENT ORDER RECALL

Change to Supporting Information: New Supporting Information

A Community Treatment Order Recall is when a PATIENT is recalled into hospital for treatment whilst on a Community Treatment Order under section 17A of the Mental Health Act 1983 as amended by Mental Health Act 2007. The decision to recall a PATIENT to hospital will be made by the Mental Health Responsible Clinician.

If there is a risk to the PATIENT's health or safety or to that of someone else, the Mental Health Responsible Clinician may recall the PATIENT. If they go missing or do not report to hospital on recall or abscond once there, they are then subject to Mental Health Absence Without Leave provisions in the same way as a detained PATIENT and their Community Treatment Order is revoked.

A Community Treatment Order Recall will not automatically end the Community Treatment Order. Recall can only last for a maximum period of 72 hours. If the PATIENT needs more admitted PATIENT care treatment, the Community Treatment Order can be revoked and the PATIENT is detained in hospital again.

If the Community Treatment Order Recall period is less than 72 hours, the recall will not automatically end the Community Treatment Order.

If a PATIENT is recalled and the time in hospital goes over 72 hours, they must either have their Community Treatment Order revoked or continue the Community Treatment Order. This will either happen by the PATIENT being discharged from hospital or they could continue staying in hospital as an informal PATIENT but remain on a Community Treatment Order.

A Community Treatment Order Recall can end with the:

- PATIENT being discharged from hospital back to the original Community Treatment Order or

- Revocation of the [Community Treatment Order](#) should the [Mental Health Responsible Clinician](#) see fit and the [PATIENT](#) meets the criteria for detention.

This supporting information is also known by these names:

Context	Alias
plural	Community Treatment Order Recalls

DATE OF RESTRICTIVE INTERVENTION

Change to Supporting Information: New Supporting Information

[Date of Restrictive Intervention](#) is an [ACTIVITY DATE TIME](#).

[Date of Restrictive Intervention](#) is the [DATE](#) of a reported incident of a [Restrictive Intervention](#).

This supporting information is also known by these names:

Context	Alias
plural	Dates of Restrictive Intervention

DAY CARE FACILITY

Change to Supporting Information: Changed Description

A [Day Care Facility](#) is a [CLINIC OR FACILITY](#).

~~A [Day Care Facility](#) provided for the clinical treatment, assessment and maintenance of function of [PATIENTS](#), in particular, though not exclusively, those who are elderly, mentally ill or have learning difficulties. They may be called Day Hospitals, Centres, Facilities or Units. [Day Care Facilities](#) may be called Day Hospitals, Centres, Facilities or Units.~~

~~[Day Care Facilities](#) may be financed, planned and run solely by NHS [ORGANISATIONS](#) or solely by non-NHS [ORGANISATIONS](#) or jointly between NHS and non-NHS organisations. A [Day Care Facility](#) provided for the clinical treatment, assessment and maintenance of function of [PATIENTS](#), in particular, though not exclusively, those who are elderly, mentally ill or have [Learning Difficulties](#).~~

~~[Day Care Facilities](#) may be financed, planned and run solely by NHS [ORGANISATIONS](#) or solely by non-NHS [ORGANISATIONS](#) or jointly between NHS and non-NHS [ORGANISATIONS](#). Jointly run facilities should still be managed by only one [ORGANISATION](#).~~

~~The facilities specifically do not have [Hospital Beds](#) and function separately from any [WARD](#).~~

~~[Day Care Facilities](#) are usually open during the five week days. In some places a service may be provided only once or twice a week and the service may take the form of evening or weekend [Day Care Sessions](#).~~

DAY CARE FACILITY

Change to Supporting Information: Changed Description

- Changed Description

DIAGRAMS MENU

Change to Supporting Information: Changed Description

- [Diagrams Introduction](#)
- [Diagramming Conventions](#)
- [Help Menu](#)

- **Generic Diagrams**
- [Activity](#)
- [Address](#)
- [Appointment](#)
- [Care Professional](#)
- [Organisation](#)
- [Patient Pathway](#)
- [Person](#)
- [Prescribing and Dispensing](#)
- [Service Request](#)

- **Data Set Supporting Diagrams**
- [Cancer Outcomes and Services](#)
- [Child and Adolescent Mental Health](#)
- [Children and Young Peoples Health](#)
- [Community](#)
- [Diagnostic Imaging](#)
- [HIV and AIDS](#)
- [Improving Access to Psychological Therapies](#)
- [Maternity](#)
- [National Joint Registry](#)
- [National Renal](#)
- [National Workforce](#)
- [Radiotherapy](#)
- [Systemic Anti-Cancer Therapy](#)

DISCHARGE LETTER ISSUED DATE (MENTAL HEALTH AND COMMUNITY CARE)

Change to Supporting Information: New Supporting Information

A [Discharge Letter Issued Date \(Mental Health and Community Care\)](#) is an [ACTIVITY DATE TIME](#).

The [Discharge Letter Issued Date \(Mental Health and Community Care\)](#) is the date when the Discharge Letter was issued to the [PATIENT](#) by the [Mental Health Service](#) or [Community Health Service](#).

This supporting information is also known by these names:

Context	Alias
plural	Discharge Letter Issued Dates (Mental Health and Community Care)

EARLY INTERVENTION IN PSYCHOSIS SERVICE

Change to Supporting Information: New Supporting Information

An [Early Intervention in Psychosis \(EIP\) Service](#) is a type of [Mental Health Service](#).

An [Early Intervention in Psychosis Service](#) is a specialist community [SERVICE](#) providing care and treatment to people who are experiencing their first episode of psychosis, and for those who are at high risk of developing psychosis.

The overarching aim of an [Early Intervention in Psychosis Service](#) is to reduce the duration of untreated psychosis and produce effective outcomes in terms of recovery and reduction in relapse rates.

This supporting information is also known by these names:

Context	Alias
shortname	EIP Service
plural	Early Intervention in Psychosis Services
fullname	Early Intervention in Psychosis (EIP) Service

EARLY INTERVENTION IN PSYCHOSIS WAITING TIME MEASUREMENT

Change to Supporting Information: New Supporting Information

The [Early Intervention in Psychosis Waiting Time Measurement](#) ensures that:

- Anyone with an emerging psychosis and their families and key supporters can have timely access to specialist [Early Intervention in Psychosis Services](#) which provide interventions suited to age and phase of illness
- Individuals experiencing first episode psychosis have consistent access to a range of evidence-based biological, psychological and social interventions as recommended by the [National Institute for Health and Care Excellence \(NICE\)](#) guidelines for psychosis and schizophrenia in children and young people and in adults, and the [National Institute for Health and Care Excellence](#) guideline for psychosis with co-existing substance misuse
- Care is provided equitably - taking into account higher rates of psychosis in certain groups who may experience difficulties in accessing traditional services.

Further guidance relating to the [Early Intervention in Psychosis Waiting Time Measurement](#) can be found on the [NHS England](#) website at: [Guidance on new mental health standards published.](#)

This supporting information is also known by these names:

Context	Alias
plural	Early Intervention in Psychosis Waiting Time Measurements

GROUP THERAPY

Change to Supporting Information: Changed Description

[Group Therapy](#) is a [SESSION](#).

[Group Therapy](#) is a [SESSION](#) where more than one [PATIENT](#) attends at the same time, to see one or more [CARE PROFESSIONALS](#). Clinical notes are recorded in each individual [PATIENT](#)'s casenotes.

For the [Community Information Data Set](#), [Group Therapy](#) is recorded as a [CARE CONTACT](#). [Group Sessions](#) are recorded when the attendees at the [SESSION](#) are not known in advance, and clinical notes are not made in individual [PATIENT](#) records. For the [Community Information Data Set](#) and [Mental Health Services Data Set](#), [Group Therapy](#) is recorded as a [CARE CONTACT](#).

Note: [Group Sessions](#) are recorded when the attendees at the [SESSION](#) are not known in advance, and clinical notes are not made in individual [PATIENT](#) records.

HEALTH OF THE NATION OUTCOME SCALE (WORKING AGE ADULTS)

Change to Supporting Information: Changed Description

The [Health of the Nation Outcome Scale \(Working Age Adults\)](#) ([HoNOS \(Working Age Adults\)](#)) is a type of [ASSESSMENT TOOL](#).

The [Health of the Nation Outcome Scale \(Working Age Adults\)](#) is a means of measuring the health and social functioning of people of working age with severe mental illness. ~~It is assessed by a [CARE PROFESSIONAL](#) or [Mental Health Care Team Member](#).~~ It is assessed by a [CARE PROFESSIONAL](#).

The allowed responses for each of the 12 ratings in the [Health of the Nation Outcome Scale \(Working Age Adults\)](#) are as follows:

- 0 - No problem
- 1 - Minor problem requiring no action
- 2 - Mild problem but definitely present
- 3 - Moderately severe problem
- 4 - Severe to very severe problem
- 9 - Not known

For further information on [Health of the Nation Outcome Scale \(Working Age Adults\)](#), see the [Royal College of Psychiatrists website](#).

HOME LEAVE

Change to Supporting Information: Changed Description

[Home Leave](#) is a type of [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 [Consultant Episode \(Hospital Provider\)](#), [Midwife Episode](#) or [Nursing Episode](#).~~ [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](#).

A [PATIENT](#) liable to be detained in hospital under Part II of the Mental Health Act 1983 and as amended by the Mental Health (Patients in the Community) Act 1985, should be granted [Mental Health Leave of Absence](#) instead of [Home Leave](#).

~~For a [PATIENT](#) under a [Nursing Episode](#) or a [Midwife Episode](#) the period of time is at the discretion of the responsible [NURSE](#) or [MIDWIFE](#). The period of time for all other [PATIENTS](#) should be a maximum of Saturday, Sunday, NHS, bank and public holidays plus another three days. If a [PATIENT](#) does not return on the day specified and has failed to make alternative arrangements with hospital/care home staff, such a [PATIENT](#) should be considered discharged from that day. The date on which a [PATIENT](#) leaves the [WARD](#) to go on Home Leave closes the preceding [Ward Stay](#).~~ For a [PATIENT](#) under a [Nursing Episode](#) or [Midwife Episode](#) the period of time is at the discretion of the responsible [CARE PROFESSIONAL](#).

The period of time for all other PATIENTS should be a maximum of Saturday, Sunday, NHS, bank and public holidays plus another three days. If a PATIENT does not return on the day specified and has failed to make alternative arrangements with hospital/Care Home staff, such a PATIENT should be considered discharged from that day.

The date on which a PATIENT leaves the WARD to go on Home Leave closes the preceding Ward Stay.

INDEPENDENT MENTAL CAPACITY ADVOCATE

Change to Supporting Information: New Supporting Information

An Independent Mental Capacity Advocate (IMCA) is a PERSON.

An Independent Mental Capacity Advocate assists people who lack mental capacity to express their views.

For further information on Independent Mental Capacity Advocates, see the Office of Public Guardian and Department of Health part of the gov.uk website.

This supporting information is also known by these names:

Context	Alias
shortname	IMCA
plural	Independent Mental Capacity Advocates

INDEPENDENT MENTAL HEALTH ADVOCATE

Change to Supporting Information: New Supporting Information

An Independent Mental Health Advocate (IMHA) is a PERSON.

An Independent Mental Health Advocate is a specialist mental health advocate, who helps PATIENTS understand the legal provisions to which they are subject under the Mental Health Act.

For further information on Independent Mental Health Advocates, see the Department of Health part of the gov.uk website.

This supporting information is also known by these names:

Context	Alias
shortname	IMHA
plural	Independent Mental Health Advocates

INDIRECT ACTIVITY

Change to Supporting Information: New Supporting Information

An Indirect Activity is an ACTIVITY.

An **Indirect Activity** is **ACTIVITY**, with the specific purpose of supporting the care of a **PATIENT**, but where the **PATIENT** is not present.

An **Indirect Activity** may take place between:

- **CARE PROFESSIONAL** and another **CARE PROFESSIONAL**
- A **CARE PROFESSIONAL** and another professional such as a teacher
- Any other professional not acting in the capacity of a **Patient Proxy**.

Examples of **Indirect Activity** include:

- 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**, where the **PATIENT** is not present.

Indirect Activity does not include discussions regarding groups of **PATIENTS** or other administrative activities such as writing up of notes or travel.

Note: For the **Mental Health Services Data Set**, contacts between a **CARE PROFESSIONAL** and a **Patient Proxy** should be captured as a **CARE CONTACT** with the **CARE CONTACT SUBJECT** set to '**Patient Proxy**'.

This supporting information is also known by these names:

Context	Alias
plural	Indirect Activities

INDIRECT ACTIVITY DATE

Change to Supporting Information: New Supporting Information

An **Indirect Activity Date** is an **ACTIVITY DATE TIME**.

An **Indirect Activity Date** is the **DATE** on which an **Indirect Activity** took place.

This supporting information is also known by these names:

Context	Alias
plural	Indirect Activity Dates

INDIRECT ACTIVITY TIME

Change to Supporting Information: New Supporting Information

An **Indirect Activity Time** is an **ACTIVITY DATE TIME**.

An **Indirect Activity Time** is the **TIME** at which an **Indirect Activity** took place.

This supporting information is also known by these names:

Context	Alias
---------	-------

Context	Alias
plural	Indirect Activity Times

MENTAL HEALTH ABSENCE WITHOUT LEAVE

Change to Supporting Information: Changed Description

[Mental Health Absence Without Leave](#) is a type of [LEAVE](#).

A period of [Mental Health Absence Without Leave](#) occurs when [PATIENTS](#) who are liable to be detained in hospital under the Mental Health Act 1983, subject to guardianship or who are on [Supervised Community Treatment](#) and have been recalled to hospital, absent themselves from hospital without leave being granted, or absent themselves without permission from any place where they are required to reside in accordance with conditions imposed on granted [Mental Health Leave of Absence](#), or fail to return to hospital by midnight on the day specified for return from granted [Mental Health Leave of Absence](#). A period of [Mental Health Absence Without Leave](#) occurs when [PATIENTS](#) who are liable to be detained in hospital under the Mental Health Act 1983, subject to guardianship or who are on a [Community Treatment Order](#) and have been recalled to hospital, absent themselves from hospital without leave being granted, or absent themselves without permission from any place where they are required to reside in accordance with conditions imposed on granted [Mental Health Leave of Absence](#), or fail to return to hospital by midnight on the day specified for return from granted [Mental Health Leave of Absence](#).

The [PATIENT](#) will be liable to be taken into custody until the end of the relevant period set out in the Mental Health Act 1983. The [PATIENT](#) will be liable to be taken into custody until the end of the relevant period set out in the Mental Health Act 1983 as amended by the Mental Health (Patients in the Community) Act 1995.

The period of [Mental Health Absence Without Leave](#) starts on the day the [PATIENTS](#) absent themselves from hospital, or absent themselves from required place of residence or the day following the [Mental Health Leave of Absence](#) planned return date. Where [PATIENTS](#) absent themselves for a period less than a day and return on the same day, an occurrence of [Mental Health Absence Without Leave](#) should not be recorded. The period of [Mental Health Absence Without Leave](#) starts:

- On the day the [PATIENT](#) absents themselves from hospital, or absent themselves from required place of residence or
- The day following the [Mental Health Leave of Absence](#) planned return date.

Where [PATIENTS](#) absent themselves for a period less than a day and return on the same day, an occurrence of [Mental Health Absence Without Leave](#) should not be recorded.

[PATIENTS](#) who have absented themselves from hospital or [Care Home](#) and fail to return within 28 days from the first day of absence will be discharged from their current [Hospital Provider Spell](#) or [Care Home Stay](#).

The period of [Mental Health Absence Without Leave](#) ends when the [PATIENT](#):

- returns voluntarily
- is taken into custody
- fails to return within the relevant period set out in the Mental Health Act 1983

Information recorded for a [Mental Health Absence Without Leave](#) includes:

[Start Date](#)

[ABSENCE WITHOUT LEAVE END REASON](#) 

[End Date](#) 

- returns voluntarily
-

is taken into custody

- fails to return within the relevant period set out in the Mental Health Act 1983 as amended by the Mental Health (Patients in the Community) Act 1995.

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD_ renamed from MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD

Change to Supporting Information: Changed Description, Name

A Mental Health Act Legal Status Classification Period is an ACTIVITY GROUP. A Mental Health Act Legal Status Classification Assignment Period is a PERSON PROPERTY ASSIGNMENT PERIOD.

A Mental Health Act Legal Status Classification Period starts when a PATIENT commences a period of care with a mental health services Health Care Provider. This can include periods where the PATIENT is not detained but attracts a MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION of *Informal (Not formally detained and receiving supervised aftercare)*. A Mental Health Act Legal Status Classification Assignment Period starts when a PATIENT commences a period of care with a Mental Health or Learning Disability SERVICES Health Care Provider.

The MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD START REASON records the reason for the start of the Mental Health Act Legal Status Classification Period. The MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON records the reason for the start of the Mental Health Act Legal Status Classification Assignment Period.

The MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD END REASON records the reason for the end of the Mental Health Act Legal Status Classification Period. This may include PATIENTS who have a Mental Health Act Legal Status recorded but transfer to the responsibility of another Health Care Provider. The MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON records the reason for the end of the Mental Health Act Legal Status Classification Assignment Period. This may include PATIENTS who have a MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE recorded but transfer to the responsibility of another Health Care Provider.

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD_ renamed from MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD

Change to Supporting Information: Changed Description, Name

- Changed Description
- Changed Name from Data_Dictionary.NHS_Business_Definitions.M.Mental_Health_Act_Legal_Status_Classification_Period to Data_Dictionary.NHS_Business_Definitions.M.Mental_Health_Act_Legal_Status_Classification_Assignment_

MENTAL HEALTH CARE CLUSTER SUPER CLASS

Change to Supporting Information: Changed Description

A Mental Health Care Cluster Super Class is identified during the process of assigning a Mental Health Care Cluster to a PATIENT. It enables the number of applicable Mental Health Care Clusters to be narrowed down, by deciding if the origin of the presenting condition is primarily: A Mental Health Care Cluster Super Class is identified during the process of assigning a Adult Mental Health Care Cluster to a PATIENT.

A Mental Health Care Cluster Super Class enables the number of applicable Adult Mental Health Care Clusters to be narrowed down, by deciding if the origin of the presenting condition is primarily:

- non-psychotic

- psychotic or
- organic
- Non-psychotic
- Psychotic or
- Organic

If the PATIENT cannot be assigned to a Mental Health Care Cluster, MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE is recorded as National Code Z 'Unable to assign PATIENT to Mental Health Care Cluster', and the PATIENT will automatically be assigned to Mental Health Care Cluster 0 (Variance). If the PATIENT cannot be assigned to a Adult Mental Health Care Cluster, MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE is recorded as 'Unable to assign PATIENT to Mental Health Care Cluster Super Class'. The PATIENT will automatically be assigned to the ADULT MENTAL HEALTH CARE CLUSTER CODE '00 Care Cluster 0 - Variance (unable to assign ADULT MENTAL HEALTH CARE CLUSTER CODE)'.

Further information relating to the Mental Health Clustering Tool and Mental Health Care Clusters is available from the Monitor part of the gov. Further information relating to the Adult Mental Health Clustering Tool and Adult Mental Health Care Clusters is available from the Monitor part of the gov.uk website at: Guidance on mental health currencies and payment.

MENTAL HEALTH CARE COORDINATOR

Change to Supporting Information: New Supporting Information

A Mental Health Care Coordinator is a CARE PROFESSIONAL.

A Mental Health Care Coordinator is a CARE PROFESSIONAL working in specialist Mental Health Services, who has been named and allocated as a care coordinator to the PATIENT.

This supporting information is also known by these names:

Context	Alias
plural	Mental Health Care Coordinators

MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD_ renamed from MENTAL HEALTH CARE COORDINATOR ASSIGNMENT

Change to Supporting Information: Changed Description, Name

Mental Health Care Coordinator Assignment is a CARE PROFESSIONAL ROLE. A Mental Health Care Coordinator Assignment Period is an ACTIVITY GROUP.

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. A Mental Health Care Coordinator Assignment Period is the period of time that a PATIENT is assigned to a Mental Health Care Coordinator.

If the PATIENT is subject to a Care Programme Approach Episode, the Mental Health Care Coordinator will also act as the CPA Care Coordinator.

MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD_ renamed from MENTAL HEALTH CARE COORDINATOR ASSIGNMENT

Change to Supporting Information: Changed Description, Name

- Changed Description
- Changed Name
from
Data_Dictionary.NHS_Business_Definitions.M.Mental_Health_Care_Coordinator_Assignment to
Data_Dictionary.NHS_Business_Definitions.M.Mental_Health_Care_Coordinator_Assignment_Period

MENTAL HEALTH CONDITIONAL DISCHARGE PERIOD

Change to Supporting Information: Changed Description

A [Mental Health Conditional Discharge Period](#) is an [ACTIVITY GROUP](#).

~~A [Mental Health Conditional Discharge Period](#) starts when a mental health tribunal or the Secretary of State decides that a [PATIENT](#), who is detained under section 37/41 of the Mental Health Act, can be discharged from the care of a [Health Care Provider](#) subject to conditions which must be adhered to. If the [PATIENT](#) does not adhere to the conditions then they may be recalled to hospital, this would end the [Mental Health Conditional Discharge Period](#).~~ A [Mental Health Conditional Discharge Period](#):

- Starts when a mental health tribunal or the Secretary of State decides that a [PATIENT](#), who is detained under section 37/41 of the Mental Health Act, can be discharged from the care of a [Health Care Provider](#) subject to conditions which must be adhered to.

~~The [Mental Health Conditional Discharge Period](#) also ends where the patient receives absolute discharge from either the mental health tribunal or the Secretary of State, or the [PATIENT](#) dies. If the [PATIENT](#) does not adhere to the conditions then they may be recalled to hospital, this would end the [Mental Health Conditional Discharge Period](#).~~

- Ends where the [PATIENT](#) receives absolute discharge from either the mental health tribunal or the Secretary of State, or the [PATIENT](#) dies.

MENTAL HEALTH CRISIS PLAN CREATION DATE

Change to Supporting Information: New Supporting Information

[Mental Health Crisis Plan Creation Date](#) is an [ACTIVITY DATE TIME](#).

[Mental Health Crisis Plan Creation Date](#) is the [DATE](#) that a [Mental Health Crisis Plan](#) was created.

This supporting information is also known by these names:

Context	Alias
plural	Mental Health Crisis Plan Creation Dates

MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE

Change to Supporting Information: New Supporting Information

[Mental Health Crisis Plan Last Updated Date](#) is an [ACTIVITY DATE TIME](#).

[Mental Health Crisis Plan Last Updated Date](#) is the [DATE](#) that a [Mental Health Crisis Plan](#) was last updated.

This supporting information is also known by these names:

Context	Alias
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MENTAL HEALTH DELAYED DISCHARGE PERIOD

Change to Supporting Information: Changed Description

A [Mental Health Delayed Discharge Period](#) is an [ACTIVITY GROUP](#).

A [Mental Health Delayed Discharge Period](#) is the period of time during a [Consultant Episode \(Hospital Provider\)](#) under a [MAIN SPECIALTY CODE \(MENTAL HEALTH\)](#) that the [PATIENT](#) is fit and ready for discharge, but discharge is delayed due to external factors outside the control of the [Hospital Provider](#). These reasons are detailed in [MENTAL HEALTH DELAYED DISCHARGE REASON](#).

A [PATIENT](#) is ready for discharge when:

- a clinical decision has been made that the [PATIENT](#) is ready for discharge
- a multidisciplinary team decision has been made that the [PATIENT](#) is ready for discharge
- the [PATIENT](#) is safe to discharge
- A clinical decision has been made that the [PATIENT](#) is ready for discharge
- A [Multidisciplinary Team](#) decision has been made that the [PATIENT](#) is ready for discharge
- The [PATIENT](#) is safe to discharge.

~~The [Mental Health Delayed Discharge Period](#) starts on the [START DATE \(MENTAL HEALTH DELAYED DISCHARGE PERIOD\)](#) and ends on the [END DATE \(MENTAL HEALTH DELAYED DISCHARGE PERIOD\)](#). The [END DATE \(MENTAL HEALTH DELAYED DISCHARGE PERIOD\)](#) may be the same as the [DISCHARGE DATE \(HOSPITAL PROVIDER SPELL\)](#), if the external factors are resolved while the [PATIENT](#) is still ready for discharge.~~The [Mental Health Delayed Discharge Period](#):

- Starts on the [START DATE \(MENTAL HEALTH DELAYED DISCHARGE PERIOD\)](#) and
- Ends on the [END DATE \(MENTAL HEALTH DELAYED DISCHARGE PERIOD\)](#).

The [END DATE \(MENTAL HEALTH DELAYED DISCHARGE PERIOD\)](#) may be the same as the [DISCHARGE DATE \(HOSPITAL PROVIDER SPELL\)](#), if the external factors are resolved while the [PATIENT](#) is still ready for discharge.

~~However if the [PATIENT](#)'s condition deteriorates while awaiting discharge, the decision may be taken to end the [Mental Health Delayed Discharge Period](#), and the [Consultant Episode \(Hospital Provider\)](#) and [Hospital Provider Spell](#) continue.~~However if the [PATIENT](#)'s condition deteriorates while awaiting discharge, the decision may be taken to end the [Mental Health Delayed Discharge Period](#), and the [Care Professional Admitted Care Episode](#) and [Hospital Provider Spell](#) continue.

~~Multiple [Mental Health Delayed Discharge Periods](#) may occur during a single [Consultant Episode \(Hospital Provider\)](#), and within a single [Hospital Provider Spell](#) (though they may occur in different [Consultant Episodes \(Hospital Provider\)](#) within that [Hospital Provider Spell](#)).~~Multiple [Mental Health Delayed Discharge Periods](#) may occur during a single [Care Professional Admitted Care Episode](#), and within a single [Hospital Provider Spell](#) (though they may occur in different [Care Professional Admitted Care Episodes](#) within that [Hospital Provider Spell](#)).

MENTAL HEALTH LEAVE OF ABSENCE

Change to Supporting Information: Changed Description

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

A [Mental Health Leave of Absence](#) only applies to [PATIENTS](#) liable to be detained in hospital under the Mental Health Act 1983 as amended by the Mental Health (Patients in the Community) Act 1995.

The granting of a [Mental Health Leave of Absence](#) within a [Mental Health Care Spell](#) can only be authorised by the [Mental Health Responsible Clinician](#) for the [PATIENT](#). The granting of a [Mental Health Leave of Absence](#) within a [Hospital Provider Spell](#) can only be authorised by the [Mental Health Responsible Clinician](#) for the [PATIENT](#). The granted period of absence from hospital may be indefinite, a specified occasion or for any specified period and be escorted or unescorted. Where leave is granted for a specified period, that period may be extended by further leave granted in absence of the [PATIENT](#). If the period of leave is extended, the current [Mental Health Leave of Absence](#) will be ended, and a new one started.

A [Mental Health Leave of Absence](#) for a period up to a maximum of 28 days from the [Start Date](#), will not interrupt the [Consultant Episode \(Hospital Provider\)](#), [Care Home Stay \(Consultant Care\)](#), [Care Home Stay \(Nursing Care\)](#) or [Care Home Stay \(Residential\)](#). A [Mental Health Leave of Absence](#) for a period greater than 28 days from the start date, will entail the [PATIENT](#) being discharged from the current [Hospital Provider Spell](#) or [Care Home Stay \(Nursing Care\)](#), or their [Care Home Stay \(Residential\)](#) being ended.

During the [Mental Health Leave of Absence](#), the [Mental Health Responsible Clinician](#) continues to be responsible for the organisation and management of the [PATIENT](#)'s continuing health and social care needs.

If a [PATIENT](#) does not return by midnight on the day specified, then the [Mental Health Leave of Absence](#) will be ended and a period of [Mental Health Absence Without Leave](#) started.

The [Mental Health Responsible Clinician](#) should consider [Supervised Community Treatment](#) for a [PATIENT](#) before granting [Mental Health Leave of Absence](#) for any period exceeding seven consecutive days.

~~Information recorded for each separate period of [Mental Health Leave of Absence](#) including an overnight stay includes:~~

~~[Start Date](#)~~

~~[End Date](#)~~

~~[LEAVE OF ABSENCE END REASON](#)~~

~~[PLANNED LEAVE RETURN DATE](#) (if for a specified period or occasion)~~

MENTAL HEALTH RESPONSIBLE CLINICIAN

Change to Supporting Information: Changed Description

A [Mental Health Responsible Clinician](#) is a [CARE PROFESSIONAL](#).

~~A [Mental Health Responsible Clinician](#) is a [CARE PROFESSIONAL](#), with a [MENTAL HEALTH RESPONSIBLE CLINICIAN PROFESSION](#) within a particular [TREATMENT FUNCTION](#), to act as the clinical supervisor for a [Mental Health Care Spell](#). A [Mental Health Responsible Clinician](#) is a [CARE PROFESSIONAL](#) acting as the clinical supervisor for a [Hospital Provider Spell](#).~~

There will be only one [CARE PROFESSIONAL](#) assigned to a [PATIENT](#) as the [Mental Health Responsible Clinician](#) at any one time. These assignments may change during the course of a [Mental Health Care Spell](#), though not necessarily at the time of a [Care Programme Approach Review](#). These assignments may change during the course of a [Hospital Provider Spell](#), though not necessarily at the time of a [Care Programme Approach Review](#).

The role of [Mental Health Responsible Clinician](#) was introduced in the Mental Health Act 2007 and replaces the role of the Responsible Medical Officer.

MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD_ renamed from MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT

Change to Supporting Information: Changed Name

- Changed Name from Data_Dictionary.NHS_Business_Definitions.M.Mental_Health_Responsible_Clinician_Assignment to Data_Dictionary.NHS_Business_Definitions.M.Mental_Health_Responsible_Clinician_Assignment_Period
-

MENTAL HEALTH SERVICE

Change to Supporting Information: New Supporting Information

A Mental Health Service is a SERVICE.

A Mental Health Service is a SERVICE that provides specialist secondary mental health and/or Learning Disabilities and/or Autistic Spectrum Disorder SERVICES (irrespective of funding arrangements). This could be provided by ORGANISATIONS including:

- NHS Mental Health Trusts
- NHS Learning Disabilities Trusts
- NHS Acute Trusts
- NHS Care Trusts
- Independent Sector Healthcare Providers offering a service model that includes NHS funded and non-NHS funded PATIENTS
- Any qualified providers offering specialist secondary adult mental health, Learning Disabilities or Autistic Spectrum Disorder SERVICES.

SERVICES may be provided in various LOCATIONS and settings.

This supporting information is also known by these names:

Context	Alias
plural	Mental Health Services

MENTAL HEALTH SERVICES DATA SET OVERVIEW

Change to Supporting Information: New Supporting Information

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

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

All ACTIVITY relating to PATIENTS who receive specialist secondary Mental Health Services and have, or are thought to have:

- A mental illness
- A Learning Disability
- An Autistic Spectrum Disorder
- Any combination of mental health, Learning Disability or Autistic Spectrum Disorder needs

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

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

For each [PATIENT](#):

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

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

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

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

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

Further information regarding the structure and submission of the [Mental Health Services Data Set](#) can be found on the [Health and Social Care Information Centre](#) at: [Mental Health Services Data Set \(MHSDS\)](#).

NON-INSTRUCTED ADVOCATE

Change to Supporting Information: New Supporting Information

A [Non-Instructed Advocate](#) is a [PERSON](#).

A [Non-Instructed Advocate](#) assists [PATIENTS](#) who are unable to communicate their views and wishes relating to the decision to be made.

For further information on [Non-Instructed Advocate](#), see the [Office of Public Guardian](#) and [Department of Health](#) part of the [gov.uk](#) website.

This supporting information is also known by these names:

Context	Alias
plural	Non-Instructed Advocates

ONWARD REFERRAL DATE

Change to Supporting Information: New Supporting Information

An [Onward Referral Date](#) is an [ACTIVITY DATE TIME](#).

An [Onward Referral Date](#) is the date the [PATIENT](#) was referred from one [SERVICE](#) to another [SERVICE](#), which may be in the same or a different [ORGANISATION](#).

This supporting information is also known by these names:

Context	Alias
plural	Onward Referral Dates

OUT-PATIENT APPOINTMENT NON-CONSULTANT

Change to Supporting Information: Changed Description

An [Out-Patient Appointment Non-Consultant](#) is an [APPOINTMENT](#).

An [Out-Patient Appointment Non-Consultant](#) is an [Out-Patient Appointment](#).

An [Out-Patient Appointment Non-Consultant](#) is an [APPOINTMENT](#) for a [PATIENT](#) to see or have contact with a [CARE PROFESSIONAL](#), other than a [CONSULTANT](#) or member of the [CONSULTANT](#)'s firm, at an [Out-Patient Clinic](#).

The [APPOINTMENT](#) may result in a [Clinic Attendance Non-Consultant](#) or a [Professional Staff Group Contact](#). The [APPOINTMENT](#) may result in a [Clinic Attendance Non-Consultant](#).

OUT-PATIENT ATTENDANCE CONSULTANT

Change to Supporting Information: Changed Description

An [Out-Patient Attendance Consultant](#) is a [CARE CONTACT](#).

An [Out-Patient Attendance Consultant](#) is an attendance at which a [PATIENT](#) is seen by or has contact with (face to face or via telephone/telemedicine) a [CONSULTANT](#), in respect of one referral, that is not a visit to the home of a [PATIENT](#) for which a fee is payable under paragraph 140 of the Terms and Conditions of Service.

For an [Out-Patient Attendance Consultant](#), a [CONSULTANT](#) includes a member of the [CONSULTANT](#)'s firm or locum for such a member.

An [Out-Patient Attendance Consultant](#) will be part of a [Consultant Out-Patient Episode](#).

If a [PATIENT](#) is seen by a [CONSULTANT](#) at a [Consultant Clinic](#) then this will be a [Clinic Attendance Consultant](#). An attendance may involve more than one [PERSON](#) (e.g. a family). The number of attendances to be recorded should be the number of [PATIENTS](#) for whom the particular [CONSULTANT](#) has identifiable individual records and which will be maintained as a result of the attendance.

A visit to the home of a [PATIENT](#) made at the instance of a hospital or specialist to review the urgency of a proposed admission to hospital, or to continue to supervise treatment initiated or prescribed at a hospital or clinic is covered by this definition.

[Out-Patient Attendance Consultant](#) also includes a [PATIENT](#) being seen by a [CONSULTANT](#) from a different [MAIN SPECIALTY CODE](#) during a [Consultant Episode \(Hospital Provider\)](#) in circumstances where there is no transfer of responsibility for the care of the [PATIENT](#).

If the [PATIENT](#) is currently subject to a [Mental Health Care Spell](#) and the [CONSULTANT](#) they are in contact with during attendance is their allocated Care Programme Approach care coordinator then a [Face To Face Contact CPA Care Coordinator](#) should also be recorded.


During the [Out-Patient Attendance Consultant](#), a number of [PATIENT DIAGNOSES](#) and [Patient Procedures](#) may be recorded.

A series of [Out-Patient Attendance Consultant](#) will form a [Consultant Out-Patient Episode](#), generated from a single referral. Note that it is possible to have two [Consultant Out-Patient Episodes](#) with the same [CONSULTANT](#) for different clinical conditions, if two referrals are made. An attendance may involve more than one [PERSON](#) - for example, a family. [Out-Patient Attendance Consultant](#) can take place outside a clinic session, and can take place at the [PATIENT](#)'s normal place of residence.

A [PATIENT](#) attending a [WARD](#) for examination or care will be counted as an [Out-Patient Attendance Consultant](#) if he/she is seen by a doctor. If they are only seen by a [NURSE](#), they are a [Ward Attendance](#).

An [Out-Patient Attendance Consultant](#) should also be recorded where a [PATIENT](#) is seen by a [CONSULTANT](#) from a different [MAIN SPECIALTY CODE](#) during a [Consultant Episode \(Hospital Provider\)](#) where there is no transfer of responsibility for the care of the [PATIENT](#). For example, a [PATIENT](#) who is admitted to hospital under a Gastroenterology specialty following an overdose may be seen while still in hospital by a psychiatrist who has been asked to assess their mental condition. The assessment by the psychiatrist should be recorded as an [Out-Patient Attendance Consultant](#).

Information recorded for an [Out Patient Attendance Consultant](#) includes:

[ATTENDANCE DATE](#)
[ATTENDANCE IDENTIFIER](#)
[CONSULTATION MEDIUM USED](#)
[FIRST ATTENDANCE](#)
[ACTIVITY LOCATION TYPE CODE](#)
[MEDICAL STAFF TYPE SEEING PATIENT](#) 
[OUTCOME OF ATTENDANCE](#)

PATIENT PROXY

Change to Supporting Information: Changed Description

A [Patient Proxy](#) is a [PERSON](#).

A [Patient Proxy](#) is a representative of the [PATIENT](#). This is most likely to be the case where the [PATIENT](#) is unable to communicate effectively, for example, for an infant or a [PERSON](#) who is mentally ill or who has learning disabilities. This is most likely to be the case where the [PATIENT](#) is unable to communicate effectively, for example, for an infant or a [PERSON](#) who is mentally ill or who has [Learning Disabilities](#).

PLANNED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)

Change to Supporting Information: New Supporting Information

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

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

This supporting information is also known by these names:

Context	Alias
plural	Planned Discharge Dates (Hospital Provider Spell)

REFERRAL CLOSURE DATE

Change to Supporting Information: New Supporting Information

A Referral Closure Date is an ACTIVITY DATE TIME.

A Referral Closure Date is the DATE the REFERRAL REQUEST was closed by a SERVICE.

This supporting information is also known by these names:

Context	Alias
plural	Referral Closure Dates

REFERRAL REJECTION DATE

Change to Supporting Information: New Supporting Information

A Referral Rejection Date is an ACTIVITY DATE TIME.

A Referral Rejection Date is the DATE the REFERRAL REQUEST was rejected by a SERVICE.

This supporting information is also known by these names:

Context	Alias
plural	Referral Rejection Dates

REPLACEMENT APPOINTMENT BOOKED DATE

Change to Supporting Information: New Supporting Information

A Replacement Appointment Booked Date is an ACTIVITY DATE TIME.

A Replacement Appointment Booked Date is the DATE on which a replacement APPOINTMENT was booked following the cancellation of an APPOINTMENT with the PATIENT by the Health Care Provider.

This supporting information is also known by these names:

Context	Alias
plural	Replacement Appointment Booked Dates

REPLACEMENT APPOINTMENT DATE OFFERED

Change to Supporting Information: New Supporting Information

A Replacement Appointment Date Offered is an ACTIVITY DATE TIME.

A Replacement Appointment Date Offered is the replacement APPOINTMENT DATE offered to the PATIENT by the Health Care Provider following the cancellation of an APPOINTMENT.

This supporting information is also known by these names:

Context	Alias
plural	Replacement Appointment Dates Offered

RESTRICTIVE INTERVENTION

Change to Supporting Information: New Supporting Information

A Restrictive Intervention is a CLINICAL INTERVENTION.

Restrictive Interventions are defined by the Department of Health as:

- Deliberate 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 for no longer than is necessary.

For further information on Restrictive Interventions, see the Department of Health part of the gov.uk website at: Positive and Proactive Care: reducing the need for restrictive interventions.

This supporting information is also known by these names:

Context	Alias
plural	Restrictive Interventions

SERVICE DISCHARGE DATE

Change to Supporting Information: New Supporting Information

A Service Discharge Date is an ACTIVITY DATE TIME.

A Service Discharge Date is the DATE a PATIENT was discharged from a SERVICE.

This supporting information is also known by these names:

Context	Alias
plural	Service Discharge Dates

STANDARDISATION COMMITTEE FOR CARE INFORMATION

Change to Supporting Information: Changed Dataset

The [Standardisation Committee for Care Information \(SCCI\)](#) is an [ORGANISATION](#).

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

The [Standardisation Committee for Care Information](#):

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

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

WARD ATTENDANCE

Change to Supporting Information: Changed Description

A [Ward Attendance](#) is a [CARE CONTACT](#).

A [Ward Attendance](#) is an attendance at a [WARD](#) by a [PATIENT](#) for nursing care, where the [PATIENT](#) is not currently admitted to that [Health Care Provider](#). A [Ward Attendance](#) should be recorded for only one [Nurse or Midwife Contact](#). If the attendance is primarily for the purpose of examination or treatment by a doctor it is an [Out-Patient Attendance Consultant](#) and not a [Ward Attendance](#). The care is for the prevention, cure, relief or investigation because of a disease, injury, health problem or other factor affecting their health status and may include one or more [Patient Procedures](#). This includes:-

- a. Disease (physical or mental) confirmed or suspected - inclusive of undiagnosed signs or symptoms.
- b. Injury - inclusive of poisoning - confirmed or suspected.
- c. Health problem e.g. prostheses or graft in situ
- d. ~~Other factors influencing the health status of non-sick [PERSONS](#) e.g.~~
d. Other factors influencing the health status of non-sick [PERSONS](#) e.g.
 - i. pregnancy
 - ii. sexual and reproductive health (formerly known as family planning)
 - iii. potential donor (organ or tissue)
 - iv. potential problem requiring prophylactic (preventative) care
 - v. bereavement or other problem requiring health professional counselling
 - vi. cosmetic surgery
 - vii. other

The [ADMINISTRATIVE CATEGORY](#) of the [PATIENT](#) can be recorded for the [Ward Attendance](#).

The [PATIENT](#)'s [FIRST ATTENDANCE CODE](#) whether the first in a series or the only attendance should be recorded.

~~If the [PATIENT](#) is currently subject to a [Mental Health Care Spell](#) and during attendance is in contact with the [NURSE](#) who is their allocated care programme approach care coordinator then a [Face To Face Contact CPA Care Coordinator](#) should also be recorded.~~

WARD STAY

Change to Supporting Information: Changed Description

A [Ward Stay](#) is an [ACTIVITY GROUP](#).

A [Ward Stay](#) is the time a [PATIENT](#), using a [Hospital Bed](#) and/or using a delivery facility, stays in one [WARD](#).

Each [Ward Stay](#) is within only one [Hospital Provider Spell](#).

~~When a [PATIENT](#) takes [Home Leave](#), [Mental Health Leave of Absence](#) or has a current period of [Mental Health Absence Without Leave](#), this should be recorded as a [WARD](#) transfer to '[Home Leave](#)', 'leave of absence' or 'absence without leave' and a new [Ward Stay](#) should begin on return. In the case of [Home Leave](#), the [Nursing Episode](#), [Midwife Episode](#) or [Consultant Episode \(Hospital Provider\)](#), [Hospital Stay](#) or [Hospital Provider Spell](#) however remain uninterrupted. In the case of [Mental Health Leave of Absence](#) and [Mental Health Absence Without Leave](#), the [Nursing Episode](#), [Midwife Episode](#), [Consultant Episode \(Hospital Provider\)](#) or [Hospital Provider Spell](#) however will only remain uninterrupted if the absence is for a period of 28 days or less. When a [PATIENT](#) takes [Home Leave](#), [Mental Health Leave of Absence](#) or has a current period of [Mental Health Absence Without Leave](#), this should be recorded as a [WARD](#) transfer and a new [Ward Stay](#) should begin on return.~~

In the case of [Home Leave](#), the [Nursing Episode](#), [Midwife Episode](#), [Consultant Episode \(Hospital Provider\)](#), [Hospital Stay](#) or [Hospital Provider Spell](#) however remain uninterrupted.

In the case of [Mental Health Leave of Absence](#) and [Mental Health Absence Without Leave](#), the [Nursing Episode](#), [Consultant Episode \(Hospital Provider\)](#) or [Hospital Provider Spell](#) however will only remain uninterrupted if the absence is for a period of 28 days or less.

In the case of [PATIENTS](#) using maternity [WARDS](#) of the same type on the same site, these should be recorded as one [WARD](#). There will therefore only be one [Ward Stay](#) rather than transfers between [WARDS](#). For local purposes, however, such transfers may be identified.

For [PATIENTS](#) subject to a [Mental Health Care Spell](#) the [End Time](#) of the [Ward Stay](#) should be recorded, as well as the [Start Time](#) if systems permit.

For each [Ward Stay](#) there should be a named [NURSE](#) or [MIDWIFE](#) who is responsible for the nursing or midwifery care of the [PATIENT](#). If the named [NURSE](#) or [MIDWIFE](#) changes, the change is recorded.

ACCOMMODATION

Change to Class: Changed Attributes

Attributes of this Class are:

K ACCOMMODATION STATUS CODE
 [SETTLED ACCOMMODATION INDICATOR](#)

ACTIVITY GROUP

Change to Class: Changed Attributes, Relationships

Attributes of this Class are:

A and E INCIDENT LOCATION TYPE
A and E PATIENT GROUP

ACTIVITY GROUP TYPE
ADMISSION METHOD
ASSAULT METHOD
BABY FIRST FEED BREAST MILK STATUS
BREASTFEEDING STATUS
CANCER OR SYMPTOMATIC BREAST REFERRAL PATIENT STATUS
CANCER REFERRAL TO TREATMENT PERIOD START DATE
CANCER SCREENING STATUS
CANCER SPECIALIST REFERRAL DATE
CANCER TREATMENT INTENT
CANCER TREATMENT PERIOD START DATE
CARE PROGRAMME APPROACH LEVEL
CARE PROGRAMME APPROACH REVIEW ABUSE QUESTION ASKED INDICATOR
CARER RESIDENT INDICATION CODE FOR NATIONAL NEONATAL DATA SET
CHILD AND ADOLESCENT MENTAL HEALTH INTERVENTION TYPE
CHILDREN TEENAGERS AND YOUNG ADULTS AGE CATEGORY
COMMUNITY TREATMENT ORDER END REASON
COMPLEX SOCIAL FACTORS INDICATOR
DAUGHTER BORN AT THIS ENCOUNTER INDICATOR
DELIVERY PLACE CHANGE REASON
DISCHARGE DESTINATION
DISCHARGED TO HOSPITAL AT HOME SERVICE INDICATOR
DISCHARGE FROM MENTAL HEALTH SERVICE REASON
DISCHARGE METHOD
ESTIMATED DATE OF DELIVERY
ESTIMATED DATE OF DELIVERY METHOD
FEMALE GENITAL MUTILATION AGE CATEGORY
FIRST REGULAR DAY OR NIGHT ADMISSION
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES CARE SPELL END CODE
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES OPT IN DATE
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES STEPPED CARE INTENSITY DELIVERED
INCIDENT TYPE
IN LABOUR BEFORE CAESARIAN SECTION INDICATOR
INTENDED DELIVERY PLACE
INTRAVESICAL CHEMOTHERAPY RECEIVED INDICATOR
INTRAVESICAL IMMUNOTHERAPY RECEIVED INDICATOR
KEY WORKER SEEN INDICATOR
LENGTH OF STAY ADJUSTMENT
LENGTH OF STAY ADJUSTMENT REASON
MATERNAL CRITICAL INCIDENT TYPE
MECONIUM PRESENT IN LIQUOR INDICATOR
MENTAL HEALTH ABSOLUTE DISCHARGE END METHOD
MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY
MENTAL HEALTH CONDITIONAL DISCHARGE END REASON
MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE
MENTAL HEALTH DELAYED DISCHARGE REASON
MONITORING INTENT
MOTHER ANTENATALLY BOOKED INDICATOR
NEONATAL CRITICAL INCIDENT TYPE
NEONATAL LEVEL OF CARE
NON SMOKING CONFIRMATION STATUS AT 4 WEEKS
ORGAN OR TISSUE UNSUITABLE ORGAN CODE RENAL TRANSPLANT
OUTCOME AT 4 WEEK FOLLOW-UP
PAEDIATRIC NEPHROLOGY REGISTRY STATUS CODE
PALLIATIVE CARE SPECIALIST SEEN INDICATOR

PALLIATIVE TREATMENT REASON CODE FOR UPPER GASTROINTESTINAL
PATIENT CLASSIFICATION
PATIENT RECEIVING ONE TO ONE NURSING CARE INDICATOR
PHARMACOTHERAPY STOP SMOKING AID RECEIVED
PREGNANCY OUTCOME CODE
PREGNANCY PREVIOUS CAESAREAN SECTIONS
PREGNANCY TOTAL LIVE BIRTHS
PREGNANCY TOTAL PREVIOUS LOSSES LESS THAN 24 WEEKS
PREGNANCY TOTAL PREVIOUS PREGNANCIES
PREGNANCY TOTAL STILL BIRTHS
PREVIOUS NEGATIVE HIV TEST IN UNITED KINGDOM INDICATOR
RADIOTHERAPY INTENT
RENAL DIALYSIS SCHEDULE TYPE
SMOKING QUIT DATE
SOURCE OF ADMISSION
~~SUPERVISED COMMUNITY TREATMENT END REASON~~
TIME BETWEEN DELIVERY AND SPONTANEOUS RESPIRATION CODE
TREATMENT START DATE FOR CANCER

ACTIVITY GROUP

Change to Class: Changed Attributes, Relationships

Each ACTIVITY GROUP

may be punctuated by one or more ACTIVITY SUSPENSION
may be classified by one or more ADMINISTRATIVE CATEGORY PERIOD
may be classified by one and only one BROAD PATIENT GROUP
may be the originator for one or more CARE PLAN
may be initiated by one and only one DECISION TO ADMIT
may be the result of one or more ELECTIVE ADMISSION LIST ENTRY
may be initiated by one and only one ELECTIVE ADMISSION LIST ENTRY
may be punctuated by one or more LEAVE
may be classified by one and only one LOCAL SUB-SPECIALTY
may be subject to one or more LODGED PATIENT
may be result in one or more PATIENT CLINICAL TRIAL STATUS
may be the context for one or more PERSON PROPERTY
may be classified by one or more PERSON PROPERTY ASSIGNMENT PERIOD
may be reference one or more SUBSTANCE MISUSED

ADMINISTRATIVE CATEGORY

Change to Class: Changed Description

Identifies if a [PATIENT](#) is required to pay for treatment provided within a particular [ACTIVITY](#) or for transport.

~~The same [ADMINISTRATIVE CATEGORY](#) will usually apply during the whole of a spell or episode but it may change, e.g. a [PATIENT](#) may start as an NHS [PATIENT](#), but then opt to change to a private patient.~~

ADMINISTRATIVE CATEGORY PERIOD

Change to Class: Changed Description

A period of time during an [ACTIVITY GROUP](#) for which an [ADMINISTRATIVE CATEGORY](#) applies. ~~The same [ADMINISTRATIVE CATEGORY](#) will usually apply during the whole of the [Hospital Provider Spell](#), [Consultant Out-Patient Episode](#) or [Regular Attender Episode](#), but may change e.g. a [PATIENT](#) may start with an [ADMINISTRATIVE CATEGORY](#) of "NHS Patient", but then opt to change to "Private Patient".~~

The [ADMINISTRATIVE CATEGORY](#) will usually apply during the whole of an [ACTIVITY](#), but may change e.g. a [PATIENT](#) may start with an [ADMINISTRATIVE CATEGORY CODE](#) of "NHS PATIENT", but then opt to change to "Private PATIENT".

APPOINTMENT

Change to Class: Changed Description

An arrangement for a [PATIENT](#) to be seen by or be in contact with one or more [CARE PROFESSIONALS](#), following an [Appointment Request](#).

An [APPOINTMENT](#) becomes an entry on the [APPOINTMENT WAITING LIST](#) when it is decided that an offer of an [APPOINTMENT](#) should be made following a [SERVICE REQUEST](#) for an out-patient [APPOINTMENT](#) being received. The offer of an [APPOINTMENT](#) is made by one or more [APPOINTMENT OFFERS](#).

[APPOINTMENTS](#) include:

- [Out-Patient Appointment Consultant](#)
- [Out-Patient Appointment Non-Consultant](#)

~~[APPOINTMENTS](#) are also made for [Screening Tests](#) and [Day Care Attendances](#).~~ [APPOINTMENTS](#) are also made for [Screening Tests](#).

When a [PATIENT](#) accepts an [APPOINTMENT OFFER](#) the [APPOINTMENT DATE OFFERED](#) and [APPOINTMENT TIME OFFERED](#) of the offer become the [APPOINTMENT DATE](#) and [APPOINTMENT TIME](#) of the accepted [APPOINTMENT](#).

Where more than one [APPOINTMENT OFFER](#) has been made for an [APPOINTMENT](#) and one has been accepted all the others for the same [APPOINTMENT](#) should be refused.

The [APPOINTMENT](#) should be removed from the [APPOINTMENT WAITING LIST](#) when the [APPOINTMENT](#) has taken place.

A series of [APPOINTMENTS](#) should relate to the same [SERVICE REQUEST](#) which initiated the series within the [ORGANISATION](#). The [SERVICE REQUEST](#) may be related to a previous [SERVICE REQUEST](#) either from within the same or another [ORGANISATION](#) and be related to subsequent [SERVICE REQUEST](#) to the same or another [ORGANISATION](#).

ASSESSMENT TOOL

Change to Class: Changed Attributes

Attributes of this Class are:

ASSESSMENT TOOL COMPLETION POINT
ASSESSMENT TOOL TYPE
[CLUSTERING TOOL ASSESSMENT CATEGORY](#)
[CLUSTERING TOOL ASSESSMENT REASON](#)
EXPERIENCE OF SERVICE QUESTIONNAIRE VERSION
HEALTH OF THE NATION OUTCOME SCALE CHILDREN AND ADOLESCENTS VERSION

MENTAL HEALTH CLUSTERING TOOL ASSESSMENT REASON
STRENGTHS AND DIFFICULTIES QUESTIONNAIRE VERSION

CARE CLUSTER_ renamed from MENTAL HEALTH CARE CLUSTER

Change to Class: Changed Attributes, Description, Name

A ~~MENTAL HEALTH CARE CLUSTER~~ is part of a currency developed to support the [National Tariff Payment System](#) for Mental Health Services. A **CARE CLUSTER** is a way of measuring the outcome of an assessment using a pre agreed set of assessment measures.

~~Mental Health Care Clusters~~ are 21 groupings of Mental Health [PATIENTS](#) based on their characteristics, and are a way of classifying individuals utilising Mental Health Services that forms the basis for payment. Each **CARE CLUSTER** has a set of corresponding scores that indicate a level of need which is then linked to a specific care package attached to that **CARE CLUSTER**.

CARE CLUSTER_ renamed from MENTAL HEALTH CARE CLUSTER

Change to Class: Changed Attributes, Description, Name

Attributes of this Class are:

MENTAL HEALTH CARE CLUSTER CODE
ADULT MENTAL HEALTH CARE CLUSTER CODE
CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE
FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE
FORENSIC MENTAL HEALTH CARE CLUSTER CODE
LEARNING DISABILITIES CARE CLUSTER CODE
MENTAL HEALTH CARE CLUSTER END REASON
MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE

CARE CLUSTER_ renamed from MENTAL HEALTH CARE CLUSTER

Change to Class: Changed Attributes, Description, Name

- Changed Attributes
 - Changed Description
 - Changed Name from Data_Dictionary.Classes.M.MENTAL_HEALTH_CARE_CLUSTER to Data_Dictionary.Classes.C.CARE_CLUSTER
-

CARE CONTACT

Change to Class: Changed Attributes

Attributes of this Class are:

A and E ATTENDANCE CATEGORY
A and E INITIAL ASSESSMENT TRIAGE CATEGORY
A and E STREAM
ACCIDENT AND EMERGENCY ARRIVAL MODE
ACCIDENT AND EMERGENCY ATTENDANCE DISPOSAL
ANTIRETROVIRAL THERAPY HOME DELIVERY INDICATOR
ANTIRETROVIRAL THERAPY REGIMEN GROUP CODE
BRIEF INTERVENTION PROVIDED INDICATOR
BRIEF INTERVENTION TYPE FOR NHS HEALTH CHECK
CARE CONTACT CANCELLATION DATE

CARE CONTACT CANCELLATION REASON
~~CARE CONTACT DATE~~
CARE CONTACT SERVICE TYPE FOR CHILDREN AND YOUNG PEOPLES HEALTH SERVICE
SECONDARY USES
CARE CONTACT SUBJECT
~~CARE CONTACT TIME~~
CARE CONTACT TYPE
CARE CONTACT TYPE FOR CHILDREN AND YOUNG PEOPLES HEALTH SERVICE SECONDARY USES
CARE CONTACT TYPE FOR COMMUNITY CARE
CHILD DIFFICULT TO TEST REASON
CLINICAL NURSE SPECIALIST INDICATION CODE
CLINIC ATTENDANCE PURPOSE CODE FOR HIV
COLPOSCOPY PRIME PROCEDURE TYPE
CONSULTATION MEDIUM USED
CONSULTATION TYPE
CONTRACEPTIVE SERVICE TYPE
DECISION TO UNDERTAKE FURTHER ASSESSMENT INDICATOR
DIETARY ADVICE REASON CODE
EMPLOYMENT SUPPORT SUITABILITY INDICATOR
FACE TO FACE COMMUNICATION MODE
FEMALE GENITAL MUTILATION IDENTIFICATION METHOD CODE
FIRST ANTIRETROVIRAL THERAPY IN THE UNITED KINGDOM INDICATOR
FIRST ATTENDANCE
FURTHER ASSESSMENT TYPE FOR NHS HEALTH CHECK
HOLISTIC NEEDS ASSESSMENT POINT OF PATHWAY FOR CANCER
INFORMATION AND ADVICE PROVIDED INDICATOR
INFORMATION AND ADVICE TYPE PROVIDED FOR FEMALE GENITAL MUTILATION
INFORMATION AND ADVICE TYPE PROVIDED FOR NHS HEALTH CHECK
INITIAL CONTACT INDICATOR
INITIAL DIAGNOSIS CARE SETTING FOR HIV
MEDICAL STAFF TYPE SEEING PATIENT
METASTATIC STATUS
MULTIPROFESSIONAL OR MULTIDISCIPLINARY INDICATION CODE
NEW HIV DIAGNOSIS IN UNITED KINGDOM INDICATOR
OTHER PERSON IN ATTENDANCE AT CARE CONTACT
OUTCOME OF ATTENDANCE
OUTCOME OF ATTENDANCE FOR CHILDREN AND YOUNG PEOPLES HEALTH SERVICE SECONDARY
USES
PATIENT EXPOSURE TO HIV
PATIENT HIV CARE STATUS
PATIENT TRIAL STATUS FOR CANCER
POST AND/OR PRE EXPOSURE PROPHYLAXIS CODE
POSTNATAL CARE INDICATOR
PREGNANCY INDICATOR FOR HIV
PSYCHIATRIC CARE INDICATOR FOR HIV
~~SETTLED ACCOMMODATION INDICATOR~~
SIGNPOSTING TO SERVICE INDICATOR
SIGNPOSTING TO SERVICE TYPE FOR NHS HEALTH CHECK
SKIN TO SKIN CONTACT INDICATOR
SOCIAL WORKER CARE INDICATOR FOR HIV
STATUTORY ASSESSMENT TYPE
SUBJECTIVE GLOBAL ASSESSMENT
THERAPY TYPE FOR IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES
TWO YEAR NEONATAL OUTCOMES ASSESSMENT NOT CARRIED OUT REASON
URGENT CARE SERVICE ACCESSED TYPE

CARE PLAN

Change to Class: Changed Attributes

Attributes of this Class are:

K CARE PLAN NUMBER
CANCER CARE PLAN INTENT
CANCER RECURRENCE CARE PLAN INDICATOR
CARE PLAN AGREED DATE
CARE PLAN END DATE FOR CHILD PROTECTION PLAN
CARE PLAN START DATE FOR CHILD PROTECTION PLAN
CARE PLAN TYPE
~~CHILD PROTECTION PLAN INDICATOR~~
CHILD PROTECTION PLAN INDICATION CODE
CHILD PROTECTION PLAN REASON CODE
MULTIDISCIPLINARY TEAM CANCER CARE PLAN DISCUSSED INDICATOR
MULTIDISCIPLINARY TEAM MEETING TYPE FOR CANCER
NO CANCER TREATMENT REASON

CARE PROFESSIONAL

Change to Class: Changed Attributes, Description

A [PERSON](#) who has a [PROFESSIONAL REGISTRATION](#) with a [PROFESSIONAL REGISTRATION BODY](#).

~~Some [CARE PROFESSIONALS](#), acting in a [MENTAL HEALTH RESPONSIBLE CLINICIAN PROFESSION](#), may be the [CARE PROFESSIONAL](#) responsible for clinical decisions during a [Mental Health Care Spell](#).~~

[CARE PROFESSIONAL TYPE CODE](#) provides a list of [CARE PROFESSIONALS](#).

CARE PROFESSIONAL

Change to Class: Changed Attributes, Description

Attributes of this Class are:

K CARE PROFESSIONAL IDENTIFIER
CARE PROFESSIONAL FIRST ASSISTANT GRADE FOR JOINT REPLACEMENT
CARE PROFESSIONAL LEAD OPERATING SURGEON GRADE FOR JOINT REPLACEMENT
CARE PROFESSIONAL RETRIEVING SURGEON GRADE
CARE PROFESSIONAL SENIOR OPERATING SURGEON GRADE FOR CANCER
CARE PROFESSIONAL STAFF GROUP FOR COMMUNITY CARE
CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH
CARE PROFESSIONAL SURGEON GRADE FOR CANCER
CARE PROFESSIONAL TYPE CODE
JOB ROLE CLINICIAN TYPE FOR ORGAN DONATION
MENTAL HEALTH RESPONSIBLE CLINICIAN PROFESSION
PRIVATE CONTROLLED DRUG PRESCRIBER CODE
REFERRING CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH AND COMMUNITY CARE

CARE PROFESSIONAL TEAM

Change to Class: Changed Description

A team of [CARE PROFESSIONALS](#) delivering specialist services to [PATIENTS](#). ~~The team can be multidisciplinary and may contain members who are employees of the [Health Care Provider](#) or be employees of another NHS or non-NHS organisation.~~

~~[CARE PROFESSIONAL TEAMS](#) include:~~The team can be multidisciplinary and may contain members who are [EMPLOYEES](#) of the [Health Care Provider](#) or be [EMPLOYEES](#) of another NHS or non-NHS [ORGANISATION](#).

- [Adult Mental Health Care Team](#)
- [Child and Adolescent Mental Health Care Team](#)

CARE PROFESSIONAL TEAM MEMBER

Change to Class: Changed Description

~~An association between a [PERSON](#) and a [CARE PROFESSIONAL TEAM](#), which identifies a [PERSON](#) as being a member of a [CARE PROFESSIONAL TEAM](#).~~An association between a [CARE PROFESSIONAL](#) and a [CARE PROFESSIONAL TEAM](#), which identifies a [CARE PROFESSIONAL](#) as being a member of a [CARE PROFESSIONAL TEAM](#).

CLINICAL INTERVENTION

Change to Class: Changed Attributes

Attributes of this Class are:

ABDOMINAL XRAY PERFORMED REASON
ABDOMINAL XRAY PERFORMED TO INVESTIGATE ABDOMINAL SIGNS INDICATOR
ABLATIVE THERAPY TYPE
ACCIDENT AND EMERGENCY INVESTIGATION
ACCIDENT AND EMERGENCY TREATMENT
ANAESTHESIA TYPE IN LABOUR AND DELIVERY
ANAESTHETIC METHOD TYPE FOR DIALYSIS ACCESS CONSTRUCTION
ANAESTHETIC TYPE FOR JOINT REPLACEMENT
ANTI CANCER REGIMEN NUMBER
ARTERIOVENOUS GRAFT MATERIAL TYPE
ARTHROPLASTY REVISION TYPE
ARTIFICIAL RUPTURE OF MEMBRANES REASON CODE
ASA PHYSICAL STATUS CLASSIFICATION SYSTEM CODE
ASSOCIATED PROCEDURE TYPE FOR ANKLE REPLACEMENT
BILIARY STENT INSERTION REASON
BIOLOGICAL RESURFACING TYPE FOR SHOULDER REPLACEMENT
BLOOD FLOW RATE
BLOOD TRANSFUSION PRODUCT TYPE
BLOOD TRANSFUSION TYPE
BLOOD TRANSFUSION UNITS TRANSFUSED
BONE GRAFT INDICATION CODE FOR REVISION ANKLE REPLACEMENT
BONE GRAFT INDICATOR FOR JOINT REPLACEMENT
BONE GRAFT TYPE FOR REVISION ANKLE REPLACEMENT
BRACHYTHERAPY TYPE
BREAST ASSESSMENT OUTCOME
BREAST SCREENING TEST OUTCOME
CANCER IMAGING MODALITY
CANCER TREATMENT MODALITY

CHEMICAL THROMBOPROPHYLAXIS REGIME TYPE
CHEMO RADIATION INDICATOR
CHEMOTHERAPY ACTUAL DOSE
CHEST DRAIN IN SITU INDICATOR
CLINICAL INTERVENTION TYPE
CLINICAL INVESTIGATION NOT PERFORMED REASON CODE FOR MATERNITY
CO MORBIDITY ADJUSTMENT INDICATOR
COMPLICATION TYPE FOR RENAL DIALYSIS ACCESS
COMPONENT REMOVAL INDICATOR
CONTINUOUS INFUSION OF PULMONARY VASODILATOR RECEIVED INDICATOR
CONTINUOUS POSITIVE AIRWAY PRESSURE DELIVERY MODE
CONTRACEPTION METHOD STATUS
CYTOLOGY SCREENING ACTION TYPE
DEINFIBULATION UNDERTAKEN REASON
DELIVERED IN WATER INDICATOR
DELIVERY INSTRUMENT TYPE
DELIVERY OF PLACENTA METHOD
DRUG ADMINISTRATION DURATION
DRUG ADMINISTRATION STATUS
DRUG DAYS SUPPLY
DRUG DOSAGE AND ADMIN SPECIFICATION
DRUG IDENTIFICATION
DRUG INFORMATION COMMENT
DRUG INFORMATION TYPE
DRUG QUANTITY SUPPLIED
DRUG REGIMEN ACRONYM
DRUG TREATMENT INTENT
ENDOSCOPIC OR RADIOLOGICAL COMPLICATION TYPE
ENDOSCOPIC PROCEDURE TYPE
ENTERAL FEEDING METHOD
ENTERAL FEED TYPE GIVEN
EPISIOTOMY PERFORMED REASON CODE
EXCISION TYPE
FETAL ORDER
FIRST DEFINITIVE TREATMENT PROVIDED
FIRST DIAGNOSTIC TEST
FIXATION TYPE FOR ELBOW OR SHOULDER REPLACEMENT
FORMULA MILK OR MILK FORTIFIER TYPE
FRACTION NUMBER
HIP SURGERY PATIENT POSITION
IMAGE GUIDED SURGERY INDICATOR
IMAGING ANATOMICAL SITE
IMAGING INTERVENTION INDICATOR
IMAGING MODALITY
IMAGING OR RADIODIAGNOSTIC EVENT INDICATION CODE FOR RENAL CARE
INFECTION CULTURE TEST INDICATOR
INTERVENTION SESSION TYPE
INTRAPARTUM ANTIBIOTICS GIVEN INDICATOR
JOINT REPLACEMENT REVISION REASON CODE FOR ANKLE
JOINT REPLACEMENT REVISION REASON CODE FOR ELBOW
JOINT REPLACEMENT REVISION REASON CODE FOR HIP
JOINT REPLACEMENT REVISION REASON CODE FOR KNEE
JOINT REPLACEMENT REVISION REASON CODE FOR SHOULDER
KIDNEY TRANSPLANTED CODE
LABOUR FIRST STAGE LENGTH

LABOUR OR DELIVERY ONSET METHOD
LABOUR SECOND STAGE LENGTH
LAPAROTOMY FOR NECROTISING ENTEROCOLITIS INDICATION CODE
LONG HEAD BICEPS TENOTOMY INDICATOR
MARGIN INVOLVED INDICATION CODE
MECHANICAL THROMBOPROPHYLAXIS REGIME TYPE
MENTAL HEALTH INTERVENTION CODE
MINIMALLY INVASIVE SURGERY INDICATOR
MORE THAN THREE RECTAL WASHOUTS RECEIVED INDICATOR
NEOADJUVANT THERAPY INDICATOR
NEONATAL RESUSCITATION METHOD
NEONATAL RESUSCITATION METHOD FOR NATIONAL NEONATAL DATA SET
NEPHRECTOMY TYPE
NEURODEVELOPMENTAL ASSESSMENT ALREADY TAKEN INDICATOR
NEWBORN HEARING INCOMPLETE REASON CODE
NEWBORN HEARING SCREENING TEST TYPE
NITRIC OXIDE GIVEN INDICATOR
NUMBER OF TELETHERAPY FIELDS
OBSERVATION SCHEME IN USE
OPPORTUNISTIC SCREENING TYPE
PAIN RELIEF TYPE IN LABOUR AND DELIVERY
PARENTAL CONSENT TO ADMINISTER VITAMIN K INDICATOR
PARENTAL CONSENT TO POST MORTEM INDICATOR
PARENTERAL NUTRITION RECEIVED INDICATOR
PATHOLOGY INVESTIGATION PRIORITY
PATHOLOGY RESULT REPORTED DATE
PATIENT PROCEDURE PERFORMED INDICATOR
PATIENT PROCEDURE TYPE FOR PRIMARY ANKLE REPLACEMENT
PATIENT PROCEDURE TYPE FOR PRIMARY ELBOW REPLACEMENT
PATIENT PROCEDURE TYPE FOR PRIMARY HIP REPLACEMENT
PATIENT PROCEDURE TYPE FOR PRIMARY KNEE REPLACEMENT
PATIENT PROCEDURE TYPE FOR PRIMARY SHOULDER REPLACEMENT
PATIENT PROCEDURE TYPE FOR REVISION ANKLE REPLACEMENT
PATIENT PROCEDURE TYPE FOR REVISION ELBOW REPLACEMENT
PATIENT PROCEDURE TYPE FOR REVISION HIP REPLACEMENT
PATIENT PROCEDURE TYPE FOR REVISION KNEE REPLACEMENT
PATIENT PROCEDURE TYPE FOR REVISION SHOULDER REPLACEMENT
PATIENT SPECIFIC INSTRUMENTS INDICATOR FOR KNEE REPLACEMENT
PERFORATIONS OR SEROSAL INVOLVEMENT INDICATION CODE
PERITONEAL DIALYSIS CATHETER INSERTION TECHNIQUE
PERITONEAL DIALYSIS CATHETER TYPE
PERITONEAL DIALYSIS TREATMENT REGIME
PLANE OF SURGICAL EXCISION TYPE
PLANNED TREATMENT CHANGE REASON
POST MORTEM CARRIED OUT INDICATOR
POST MORTEM CONFIRMED NECROTISING ENTEROCOLITIS DIAGNOSIS INDICATOR
POST MORTEM TYPE
PREVIOUS BONY INFECTION INDICATOR OF TIBIA OR HINDFOOT
PREVIOUS FRACTURE INDICATOR FOR ANKLE REPLACEMENT
PREVIOUS SURGERY TYPE FOR ANKLE JOINT
PREVIOUS SURGERY TYPE FOR SHOULDER REPLACEMENT
PRINCIPAL DIAGNOSTIC IMAGING TYPE
PROCEDURE RENAL DIALYSIS ACCESS REPAIR OR REVISION TYPE
PROCEDURE SCHEME IN USE
PROCEDURE SIDE RENAL DIALYSIS ACCESS CONSTRUCTION CODE

PROCEDURE SITE RENAL DIALYSIS ACCESS CONSTRUCTION CODE
RADIOISOTOPE
RADIOLOGICAL PROCEDURE TYPE
RADIOTHERAPY ACTUAL DOSE
RADIOTHERAPY BEAM TYPE
RADIOTHERAPY PRESCRIBED DOSE
RADIOTHERAPY TREATMENT MODALITY
REMOVAL REASON TYPE FOR DIALYSIS ACCESS
RENAL DIALYSIS ACCESS TYPE
RENAL TRANSPLANT FAILURE CAUSE CODE
RENAL TREATMENT MODALITY CHANGE REASON CODE
RENAL TREATMENT MODALITY CODE
RENAL TREATMENT PRIMARY SUPERVISION CODE
REPLOGLE TUBE IN SITU INDICATOR
RESPIRATORY SUPPORT DEVICE TYPE FOR NATIONAL NEONATAL DATA SET
RESPIRATORY SUPPORT MODE FOR NATIONAL NEONATAL DATA SET
RESTRICTIVE INTERVENTION TYPE
RESULT SENT DIRECT
RETINOPATHY OF PREMATURITY SCREENING OUTCOME STATUS CODE
REVISION PROCEDURE TYPE FOR ANKLE OR KNEE REPLACEMENT
REVISION PROCEDURE TYPE FOR ELBOW OR SHOULDER REPLACEMENT
REVISION PROCEDURE TYPE FOR HIP REPLACEMENT
ROTATOR CUFF CONDITION
RUPTURE OF MEMBRANES METHOD
SARCOMA SURGICAL MARGIN
SENTINEL LYMPH NODE BIOPSY TYPE
SIGNIFICANT MATERNAL PYREXIA IN LABOUR INDICATOR
STEM CELL INFUSION DONOR TYPE
STEM CELL INFUSION SOURCE CODE
STENT DEPLOYED SUCCESS INDICATOR
STEROIDS GIVEN DURING PREGNANCY TO MATURE FETAL LUNGS INDICATOR
STOMA PRESENT INDICATOR
SURFACTANT GIVEN INDICATOR
SURGICAL ACCESS TYPE
SURGICAL ACCESS TYPE FOR THORACIC
SURGICAL APPROACH FOR PRIMARY HIP REPLACEMENT
SURGICAL APPROACH FOR PRIMARY KNEE REPLACEMENT
SURGICAL APPROACH FOR PRIMARY OR REVISION ANKLE REPLACEMENT
SURGICAL APPROACH FOR PRIMARY OR REVISION ELBOW REPLACEMENT
SURGICAL APPROACH FOR PRIMARY OR REVISION SHOULDER REPLACEMENT
SURGICAL APPROACH FOR REVISION HIP REPLACEMENT
SURGICAL APPROACH FOR REVISION KNEE REPLACEMENT
SURGICAL COMPLICATION TYPE
SURGICAL PALLIATION TYPE
SURGICAL VOICE RESTORATION PERMANENT VALVE REMOVAL REASON
SYSTEMIC ANTI CANCER THERAPY DRUG ROUTE OF ADMINISTRATION
SYSTEMIC ANTI CANCER THERAPY PROGRAMME NUMBER
SYSTEMIC ANTI CANCER THERAPY REGIMEN MODIFICATION INDICATOR
TELETHERAPY BEAM TYPE
TRACHEOSTOMY TUBE IN SITU INDICATOR
TREATMENT TYPE FOR NECROTISING ENTEROCOLITIS
TREATMENT TYPE FOR PATENT DUCTUS ARTERIOSUS
UNPLANNED OPERATION INDICATOR
UNTOWARD INTRAOPERATIVE EVENT CODE FOR ANKLE REPLACEMENT
UNTOWARD INTRAOPERATIVE EVENT CODE FOR ELBOW REPLACEMENT

UNTOWARD INTRAOPERATIVE EVENT CODE FOR HIP REPLACEMENT
UNTOWARD INTRAOPERATIVE EVENT CODE FOR KNEE REPLACEMENT
UNTOWARD INTRAOPERATIVE EVENT CODE FOR SHOULDER REPLACEMENT
VASCULAR LINE TYPE IN SITU
VISUAL INSPECTION CONFIRMED NECROTISING ENTEROCOLITIS DURING LAPAROTOMY INDICATOR
VITAMIN K ADMINISTERED INDICATOR
VITAMIN K ROUTE OF ADMINISTRATION

CLINICAL INVESTIGATION RESULT ITEM

Change to Class: Changed Attributes

Attributes of this Class are:

K INVESTIGATION RESULT DATE
K INVESTIGATION RESULT TIME
ABNORMALITY DETECTED INDICATOR
ALBUMINURIA STAGE
ALK 1 STATUS
ANKLE DORSIFLEXION CODE
ANKLE PLANTARFLEXION CODE
ARITHMETIC COMPARATOR
BIOPSY REFERRAL OUTCOME
BREAST BIOPSY REFERRAL OUTCOME
BREAST CANCER HISTOLOGICAL TYPE
BREAST SCREENING MAMMOGRAPHY OUTCOME CODE
CALCULATED CREATININE CLEARANCE TYPE
CANCER VASCULAR OR LYMPHATIC INVASION
CENTRAL TONE STATUS
CERVICAL GLANDULAR INTRAEPITHELIAL NEOPLASIA PRESENCE AND GRADE
CERVICAL NODE STATUS
CERVICAL SMEAR EXAMINED DATE
CHLAMYDIA TEST RESULT
CLINICAL ASSESSMENT RESULT CODE FOR BREAST CANCER
CLINICAL INVESTIGATION ITEM TYPE
CLINICAL INVESTIGATION ITEM UNIT OF MEASURE
CLINICAL INVESTIGATION RESULT CODE FOR RENAL CARE
CLINICAL INVESTIGATION RESULT CODE FOR RENAL TRANSPLANT
CLINICAL INVESTIGATION RESULT VALUE
CONDITION SEEN IN ABDOMEN DURING XRAY
CYSTIC PERIVENTRICULAR LEUKOMALACIA OBSERVED DURING CRANIAL ULTRASOUND SCAN INDICATOR
CYTOGENETIC ANALYSIS CODE
CYTOGENETIC PRESENCE TYPE FOR RHABDOMYOSARCOMA
CYTOGENETIC RISK CODE
CYTOLOGY RESULT TYPE
CYTOLOGY SMEAR REASON
DEGREES OF FIXED FLEXION DEFORMITY
DEGREES OF FLEXION RANGE
DETRUSOR MUSCLE PRESENCE INDICATION CODE
DEVIATING RESULT INDICATOR
DIPSTICK TEST RESULT CODE
EPIDERMAL GROWTH FACTOR RECEPTOR MUTATIONAL STATUS
EXCISION MARGIN INDICATION CODE
FINDING SCHEME IN USE

GENETIC CONFIRMATION INDICATOR
GRADE OF DIFFERENTIATION
HAEMOGLOBINOPATHY INVESTIGATION RESULT CODE FOR NATIONAL NEONATAL DATA SET
HbA1C ASSAY MEASUREMENT METHOD
HEPATOMEGALY INDICATOR
HORMONE EXPRESSION TYPE
INTRAVENTRICULAR HAEMORRHAGE GRADE
INVASIVE CANCER SPECIAL TYPE INDICATOR
INVESTIGATION EXAMINATION RESULT CODE
INVESTIGATION HAEMOGLOBINOPATHY RESULT CODE
INVESTIGATION RESULT STATUS CODE
INVESTIGATION RESULT TEXT
INVESTIGATION RISK RATIO RESULT CODE
INVESTIGATION RUBELLA RESULT INDICATOR
INVESTIGATION SENSITISED RESULT INDICATOR
KARYOTYPE TEST OUTCOME
LACTATE DEHYDROGENASE LEVEL
LYMPH NODE STATUS
MAMMOGRAM RESULT CODE
MEASURED GLOMERULAR FILTRATION RATE TYPE CODE
METASTASIS EXTENT CODE
NEWBORN BLOOD SPOT TEST OUTCOME STATUS CODE
NEWBORN HEARING AUDIOLOGY OUTCOME
NEWBORN HEARING SCREENING OUTCOME
NUMBER OF FETUSES
NUMERICAL VALUE
OBSERVATION VALUE
PATHOLOGICAL RISK CLASSIFICATION CODE AFTER NEPHRECTOMY
PATHOLOGICAL RISK CLASSIFICATION CODE AFTER PREOPERATIVE CHEMOTHERAPY
PERSON BLOOD GROUP
PERSON RHESUS FACTOR
PHYSIOLOGICAL MEASUREMENT INDICATION CODE FOR ELECTROCARDIOGRAM
PORENCEPHALIC CYST VISIBLE DURING CRANIAL ULTRASOUND SCAN INDICATOR
PREOPERATIVE THERAPY RESPONSE TYPE
RADIOLOGICAL RESULT VERIFIED DATE
RADIOLOGICAL RESULT VERIFIED TIME
RESULT ITEM STATUS
RETINOPATHY OF PREMATURITY CLOCK HOURS MAXIMUM STAGE
RETINOPATHY OF PREMATURITY MAXIMUM ZONE
RETINOPATHY OF PREMATURITY PLUS DISEASE STATUS
RETINOPATHY OF PREMATURITY STAGE
S CATEGORY CODE
SERUM CALCIUM CONCENTRATION CORRECTION CODE
SPECIMEN NATURE
SPLEEN BELOW COSTAL MARGIN
SPLENOMEGALY INDICATOR
SUBTALAR JOINT MOVEMENT CODE
TIBIA HINDFOOT ALIGNMENT CODE
TUMOUR NECROSIS
ULTRASOUND RESULT CODE FOR BREAST CANCER
VENTRICULAR DILATION DIAGNOSED DURING CRANIAL ULTRASOUND SCAN INDICATOR

DISABILITY

Change to Class: Changed Attributes

Attributes of this Class are:

CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR
DISABILITY CODE
DISABILITY IMPACT PERCEPTION
LEARNING DISABILITY INDICATOR
PHYSICAL DISABILITY INDICATOR

LANGUAGE_ renamed from LANGUAGE CLASSIFICATION

Change to Class: Changed Description, Name

A classification of a language used by a [PERSON](#). A language used by a [PERSON](#).

LANGUAGE_ renamed from LANGUAGE CLASSIFICATION

Change to Class: Changed Description, Name

- Changed Description
- Changed Name from Data_Dictionary.Classes.L.LANGUAGE_CLASSIFICATION to Data_Dictionary.Classes.L.LANGUAGE

LEAVE

Change to Class: Changed Attributes

Attributes of this Class are:

K LEAVE START DATE
~~ABSENCE WITHOUT LEAVE END REASON~~
LEAVE END DATE
~~LEAVE OF ABSENCE END REASON~~
LEAVE TYPE
MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON
MENTAL HEALTH LEAVE OF ABSENCE END REASON
PLANNED LEAVE RETURN DATE

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION

Change to Class: Changed Attributes

Attributes of this Class are:

K MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE
~~MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD END REASON CODE~~
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON
~~MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD START REASON CODE~~
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON

ORGANISATION

Change to Class: Changed Dataset

One or more people with a common purpose of function (e.g. a General Practice). This includes public, private or voluntary sector [ORGANISATIONS](#) whose activities encompass the funding or provision of health care and support services.

Note: A 'dummy [ORGANISATION](#)' for 'private [PATIENTS](#)' has been introduced.

A list of [ORGANISATIONS](#) contained in the NHS Data Model and Dictionary can be found at [Organisations](#).

PATIENT DIAGNOSIS

Change to Class: Changed Attributes

Attributes of this Class are:

ACCIDENT AND EMERGENCY DIAGNOSIS
AIDS DEFINING ILLNESS TYPE
BABY COMPLICATION AT BIRTH DIAGNOSIS
BASIS OF DIAGNOSIS FOR CANCER
BREAST CANCER INVASIVE STATUS
CEREBRAL PALSY TYPE CODE FOR NATIONAL NEONATAL DATA SET
CYTOMEGALOVIRUS DISEASE CODE
DIABETES TYPE FOR RENAL CARE
[DIAGNOSIS SCHEME IN USE](#)
FEMALE GENITAL MUTILATION TYPE 4 CODE
FETAL ANOMALY DIAGNOSIS
HISTOLOGY CONFIRMED NECROTISING ENTEROCOLITIS FOLLOWING LAPAROTOMY INDICATOR
HISTORY OF FEMALE GENITAL MUTILATION INDICATOR
HYPOXIC ISCHEMIC ENCEPHALOTHAPY GRADE
INJURY TYPE FOR CHILDREN AND YOUNG PEOPLES HEALTH SERVICE SECONDARY USES
LONG TERM PHYSICAL HEALTH CONDITION INDICATOR FOR IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES
MATERNITY COMPLICATING MEDICAL DIAGNOSIS
MATERNITY FAMILY HISTORY DIAGNOSIS TYPE
MATERNITY MEDICAL DIAGNOSIS TYPE
NEONATAL ABSTINENCE SYNDROME OBSERVED INDICATOR
NEONATAL DIAGNOSIS
OBSTETRIC DIAGNOSIS
PATIENT DIAGNOSIS CODING SIGNIFICANCE
PATIENT DIAGNOSIS INDICATION FOR PRIMARY ANKLE REPLACEMENT
PATIENT DIAGNOSIS INDICATION FOR PRIMARY ELBOW REPLACEMENT
PATIENT DIAGNOSIS INDICATION FOR PRIMARY HIP REPLACEMENT
PATIENT DIAGNOSIS INDICATION FOR PRIMARY KNEE REPLACEMENT
PATIENT DIAGNOSIS INDICATION FOR PRIMARY SHOULDER REPLACEMENT
PATIENT DIAGNOSIS INDICATOR
PATIENT DIAGNOSIS TYPE FOR HIV
PATIENT DIAGNOSIS TYPE FOR NHS HEALTH CHECK
POST HAEMORRHAGIC HYDROCEPHALUS OBSERVED DURING CRANIAL ULTRASOUND SCAN INDICATOR
PRESENT ON ADMISSION INDICATOR
PRIMARY DIAGNOSIS
PROVISIONAL DIAGNOSIS
RENAL DONOR DIAGNOSIS TYPE
RENAL LIVING DONOR DIAGNOSIS TYPE
RENAL PAEDIATRIC DIAGNOSIS TYPE
RENAL RECIPIENT CARDIOVASCULAR COMPLICATION TYPE
RENAL RECIPIENT DIAGNOSIS TYPE
SEIZURE OCCURRED INDICATOR
SEPSIS SUSPECTED INDICATOR
SKIN CANCER LESION DIAGNOSIS

TRAUMATIC LESION OF GENITAL TRACT TYPE CODE
TUMOUR OR LESION LATERALITY

PERSON PROPERTY

Change to Class: Changed Relationships

Each PERSON PROPERTY

- K must be owned by one and only one PERSON
- must be reported by one and only one PERSON
- must be recorded by one and only one PERSON
- must be observed by one and only one PERSON
- may be the context for one and only one ACTIVITY GROUP
- may be required by one and only one CARE ISSUE
- may be of relevance to one or more CARE ISSUE
- may be acting as one and only one CARE ISSUE
- may be classified as one and only one CODED CLINICAL ENTRY
- may be applied for one or more PERSON PROPERTY ASSIGNMENT PERIOD
- may be related to one or more PERSON PROPERTY QUALIFIER
- may be qualified by one or more PERSON PROPERTY QUALIFIER
- may be qualified by one or more UNIT OF MEASUREMENT

PERSON PROPERTY ASSIGNMENT PERIOD

Change to Class: New Class

A period of time during an ACTIVITY GROUP that a PERSON PROPERTY is assigned.

This class is also known by these names:

Context	Alias
plural	PERSON PROPERTY ASSIGNMENT PERIODS

PERSON PROPERTY ASSIGNMENT PERIOD

Change to Class: New Class

Attributes of this Class are:

PERSON PROPERTY ASSIGNMENT PERIOD TYPE

PERSON PROPERTY ASSIGNMENT PERIOD

Change to Class: New Class

Each PERSON PROPERTY ASSIGNMENT PERIOD

- K must be a classifier of one and only one ACTIVITY GROUP
- K must be for one and only one PERSON PROPERTY

PLANNED ACTIVITY

Change to Class: Changed Relationships

Each PLANNED ACTIVITY

- K must be for one and only one PATIENT
- may be planned by one and only one DEPARTMENT
- must be the subject of one or more PLANNED ACTIVITY DATE TIME
- may be the planning of one or more ACTIVITY
- may be planned as a result of one and only one ACTIVITY
- may be planned to be carried out at one and only one APPOINTMENT
- may be a result of one and only one CARE PLAN
- may be planned by one and only one CARE PROFESSIONAL
- may be classified as one and only one CODED CLINICAL ENTRY
- may be resultant in one or more DECISION TO ADMIT
- may be the subject of one and only one ELECTIVE ADMISSION LIST ENTRY
- may be planned to occur at one and only one LOCATION
- may be intended to be provided by one and only one ORGANISATION
- may be related to one or more SERVICE REPORT
- may be resultant from one and only one SERVICE REQUEST
- may be the cause of one or more TRANSPORT REQUIREMENT

PLANNED ACTIVITY DATE TIME

Change to Class: New Class

PLANNED ACTIVITY DATE TIME defines individual PLANNED ACTIVITY DATE TIME types.

PLANNED ACTIVITY DATE TYPE provide lists of PLANNED ACTIVITY DATE TIMES.

This class is also known by these names:

Context	Alias
plural	PLANNED ACTIVITY DATE TIMES

PLANNED ACTIVITY DATE TIME

Change to Class: New Class

Attributes of this Class are:

- K PLANNED ACTIVITY DATE TYPE
- PLANNED ACTIVITY DATE

PLANNED ACTIVITY DATE TIME

Change to Class: New Class

Each PLANNED ACTIVITY DATE TIME must be for one and only one PLANNED ACTIVITY

REFERRAL REQUEST

Change to Class: Changed Attributes

Attributes of this Class are:

- BENIGN THERAPEUTIC OPERATION INDICATOR
- COLPOSCOPY REFERRAL INDICATION
- COMMISSIONER REFERENCE NUMBER

ONWARD REFERRAL REASON
REASON FOR REFERRAL TO COMMUNITY CARE
REASON FOR REFERRAL TO MENTAL HEALTH
REFERRAL CLOSURE REASON
REFERRAL CLOSURE REASON FOR COMMUNITY CARE
REFERRAL REJECTION REASON
REFERRAL REQUEST ACCEPTANCE INDICATOR
REFERRAL REQUEST RECEIVED TIME
REFERRAL REQUEST SERVICE TYPE FOR NHS HEALTH CHECK
REFERRAL REQUEST TYPE
SCREENING REFERRAL SOURCE
SERVICE TYPE REQUESTED
SERVICE TYPE REQUESTED FOR CHILD AND ADOLESCENT MENTAL HEALTH
SOURCE OF REFERRAL FOR A and E
SOURCE OF REFERRAL FOR COMMUNITY
SOURCE OF REFERRAL FOR FEMALE GENITAL MUTILATION
SOURCE OF REFERRAL FOR MENTAL HEALTH
SOURCE OF REFERRAL FOR OUT-PATIENTS
SOURCE OF REFERRAL FOR PROF STAFF GROUP
TWO WEEK WAIT CANCER OR SYMPTOMATIC BREAST REFERRAL TYPE

SERVICE

Change to Class: Changed Attributes

Attributes of this Class are:

K SERVICE TYPE
SERVICE OR TEAM TYPE FOR MENTAL HEALTH
SERVICE TYPE FOR CHLAMYDIA TESTING
SERVICE TYPE REFERRED TO FOR COMMUNITY CARE

SESSION

Change to Class: Changed Attributes

Attributes of this Class are:

K SESSION DATE
K SESSION IDENTIFIER
K SESSION TIME
DAY CARE FUNCTION
GROUP SESSION TYPE CODE FOR COMMUNITY CARE
GROUP SESSION TYPE FOR MENTAL HEALTH

UNIT OF MEASUREMENT

Change to Class: Changed Attributes

Attributes of this Class are:

UCUM UNIT OF MEASUREMENT
UNIT OF MEASUREMENT

WARD

Change to Class: Changed Attributes

Attributes of this Class are:

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

ACCOMMODATION STATUS CODE

Change to Attribute: Changed Dataset

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

National Codes:

MA00 **Mainstream Housing**
MA01 Owner occupier
MA02 Settled mainstream housing with family/friends
MA03 Shared ownership scheme e.g. Social Homebuy Scheme (tenant purchase percentage of home value from landlord)
MA04 Tenant - [Local Authority](#)/Arms Length Management Organisation/Registered Landlord
MA05 Tenant - Housing Association
MA06 Tenant - private landlord
MA09 Other mainstream housing
HM00 **Homeless**
HM01 Rough sleeper
HM02 Squatting
HM03 Night shelter/emergency hostel/Direct access hostel (temporary accommodation accepting self referrals, no waiting list and relatively frequent vacancies)
HM04 Sofa surfing (sleeps on different friends floor each night)
HM05 Placed in temporary accommodation by [Local Authority](#) (including Homelessness resettlement service) e.g. Bed and Breakfast accommodation
HM06 Staying with friends/family as a short term guest
HM07 Other homeless
MH00 **Accommodation with mental health care support**
MH01 Supported accommodation (accommodation supported by staff or resident caretaker)
MH02 Supported lodgings (lodgings supported by staff or resident caretaker)
MH03 Supported group home (supported by staff or resident caretaker)
MH04 Mental Health Registered [Care Home](#)
MH09 Other accommodation with mental health care and support
HS00 **Acute/long stay healthcare residential facility/hospital**
HS01 NHS acute psychiatric ward
HS02 Independent hospital/clinic
HS03 Specialist rehabilitation/recovery
HS04 Secure psychiatric unit
HS05 Other NHS facilities/hospital
HS09 Other acute/long stay healthcare residential facility/hospital
CH00 **Accommodation with other (not specialist mental health) care support**
CH01 Foyer - accommodation for young people aged 16-25 who are homeless or in housing need
CH02 Refuge
CH03 Non-Mental Health Registered [Care Home](#)
CH09 Other accommodation with care and support (not specialist mental health)
CJ00 **Accommodation with criminal justice support**
CJ01 Bail/Probation hostel

CJ02	Prison
CJ03	Young Offenders Institution
CJ04	Detention Centre
CJ09	Other accommodation with criminal justice support such as ex-offender support
SH00	Sheltered Housing (accommodation with a scheme manager or warden living on the premises or nearby, contactable by an alarm system if necessary)
SH01	Sheltered housing for older persons
SH02	Extra care sheltered housing (also known as 'very sheltered housing'. For people who are less able to manage on their own, but who do need an extra level of care. Services offered vary between schemes, but meals and some personal care are often provided.)
SH03	Nursing Home for older persons
SH09	Other sheltered housing
ML00	Mobile accommodation Other
OC96	Not elsewhere classified

ACTIVITY DATE

Change to Attribute: Changed Dataset

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

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

ACTIVITY DATE TYPE

Change to Attribute: Changed Description

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

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

National Codes:

001	Angiogram Date (Retired July 2012)
002	Arrival Date At Accident and Emergency Department
003	Breast Assessment Date (Retired 1 January 2013)
004	Cancer Dental Assessment Date
005	Colorectal or Stoma Nurse Seen Date (Retired 1 January 2013)
006	Coronary Angiography Date (Retired July 2012)
007	Care Programme Approach Review Date
008	Date Biopsy Taken (Retired 01 April 2014)
009	Discharge Date
010	Discharge Ready Date
011	End Date
012	Event Date (Retired July 2012)
013	Expected Delivery Date (Retired September 2012)
014	First Antenatal Assessment Date
015	Full Postnatal Examination Date (Retired September 2012)
016	Initial Patient Contact Date (Retired July 2012)
017	Investigation Transfer Date (Retired July 2012)
018	Intrauterine Device Application Date (Retired September 2012)
019	Intrauterine Device Fitted Date (Retired September 2012)
020	Last Dosage Date
021	Mental Health Care Assessment Date (Retired September 2012)
022	Miscarriage Date (Retired September 2012)
023	Pathology Result Due Date

024 [Patient Informed Biopsy Result Date](#)
025 Patient Informed Of Outcome Date (Retired September 2012)
026 [Smoking Quit Date](#)
027 Review Planned Date (Retired 01 April 2014)
028 Screening Result Date (Retired 01 April 2014)
029 [Screening Result Sent Date](#)
030 Specialist Palliative Care Date (Retired 01 April 2014)
031 [Start Date](#)
032 [Cancer Symptoms First Noted Date](#)
033 [Attendance Date](#)
034 [Clinical Intervention Date](#)
035 Immunisation Completion Date (Retired 01 October 2015)
036 [Clinical Status Assessment Date](#)
037 Dose Given Date (Retired September 2012)
038 Test Date (Retired September 2012)
039 [Contact Date](#)
040 [Appointment Date](#)
041 [Primary Procedure Date](#)
042 Second Operation Date (Retired 01 April 2014)
043 [Speech and Language Assessment Date](#)
044 Third Operation Date (Retired 01 April 2014)
045 [Date First Seen](#)
046 [Statutory Assessment Date](#)
047 [Screening Test Date](#)
048 Genitourinary Care Contact Date (Retired January 2014)
049 [Consultant Upgrade Date](#)
101 [Referral Closure Date \(Community Care\)](#)
102 [Discharge Letter Issued Date \(Community Care\)](#)
103 [Systemic Anti-Cancer Therapy Administration Date](#)
104 [Procedure Date](#)
105 [Immunisation Dose Given Date](#)
106 [Antenatal Appointment Date](#)
107 [Antenatal Booking Appointment Date](#)
108 [Pregnancy First Contact Date](#)
109 [Screening Test Information Given Date](#)
110 [Assessment Date For Transplant Suitability](#)
111 [Accident and Emergency Initial Assessment Date](#)
112 [Accident and Emergency Date Seen For Treatment](#)
113 [Accident and Emergency Attendance Conclusion Date](#)
114 [Accident and Emergency Departure Date](#)
115 [Clinical Assessment Date](#)
116 [Imaging or Radiodiagnostic Event Date](#)
117 [Neonatal Critical Care Daily Care Date](#)
118 [Two Year Neonatal Outcomes Assessment Date](#)
119 [Date of Pregnancy Outcome \(Current Fetus\)](#)
120 [Neonatal Critical Incident Date](#)
121 [American Joint Committee on Cancer Stage Date](#)
122 [Ann Arbor Stage Date](#)
123 [Barcelona Clinic Liver Cancer Stage Date](#)
124 [Binet Stage Date](#)
125 [Chang Staging System Stage Date](#)
126 [Clinical Stage Date \(Pancreatic Cancer\)](#)
127 [Final Figo Stage Date](#)
128 [Holistic Needs Assessment Completed Date](#)
129 [Intergroup Rhabdomyosarcoma Study Post Surgical Group Date](#)
130 [International Neuroblastoma Staging System Date](#)
131 [Myeloma International Staging System Stage Date](#)
132 [Modified Dukes Stage Date](#)

- 133 [Multidisciplinary Team Discussion Date \(Cancer\)](#)
- 134 [Multidisciplinary Team Meeting Date \(Cancer\)](#)
- 135 [Murphy St Jude Stage Date](#)
- 136 [Rai Stage Date](#)
- 137 [Retinoblastoma Assessment Date](#)
- 138 [TNM Stage Grouping Date \(Final Pretreatment\)](#)
- 139 [TNM Stage Grouping Date \(Integrated\)](#)
- 140 [Wilms Tumour Stage Date](#)
- [Care Contact Cancellation Date](#)
- [Care Contact Date](#)
- [Date of Restrictive Intervention](#)
- [Discharge Letter Issued Date \(Mental Health and Community Care\)](#)
- [Indirect Activity Date](#)
- [Mental Health Crisis Plan Creation Date](#)
- [Mental Health Crisis Plan Last Updated Date](#)
- [Onward Referral Date](#)
- [Referral Closure Date](#)
- [Referral Rejection Date](#)
- [Replacement Appointment Booked Date](#)
- [Replacement Appointment Date Offered](#)
- [Service Discharge Date](#)

Note: This list is not in alphabetical order.

ACTIVITY GROUP TYPE

Change to Attribute: Changed Description

The type of [ACTIVITY GROUP](#).

National Codes:

- 01 [Accident and Emergency Episode](#)
- 02 Acute Myocardial Infarction Care Spell (Retired July 2012)
- 03 Augmented Care Period (Retired 1 April 2006)
- 04 [Breast Cancer Care Spell](#)
- 05 [Cancer Care Spell](#)
- 06 [Care Home Stay \(Consultant Care\)](#)
- 07 [Care Home Stay \(Midwife Care\)](#)
- 08 [Care Home Stay \(Nursing Care\)](#)
- 09 [Care Home Stay \(Residential\)](#)
- ~~10~~ [Care Programme Approach Episode](#)
- 10 [Care Programme Approach Care Episode](#)
- 11 [Colorectal Cancer Care Spell](#)
- 12 [Community Episode](#)
- ~~13~~ [Mental Health Care Professional Episode \(Acute Home-Based\)](#)
- 13 [Mental Health Care Professional Episode \(Acute Home-Based\) \(Retired 01 January 2016\)](#)
- 14 [Consultant Episode \(Hospital Provider\)](#)
- 15 [Consultant Out-Patient Episode](#)
- 16 Dental Episode (Retired 01 April 2014)
- 17 [Drug Misuse Episode](#)
- 18 [Sexual Health and HIV Episode](#)
- 19 [Head and Neck Cancer Care Spell](#)
- 20 [Home Dialysis Episode](#)
- 21 [Hospital Provider Spell](#)
- 22 [Lung Cancer Care Spell](#)

23 [Adult Mental Health, Learning Disability or Autism Spectrum Disorder Care Spell](#)

24 [Midwife Episode](#)

25 [Neonatal Level Of Care Period](#)

26 [Nursing Episode](#)

27 [Palliative Care Episode](#)

28 [Person Stop Smoking Episode](#)

29 [Pregnancy Episode](#)

30 [Professional Staff Group Episode](#)

31 [Regular Attender Episode](#)

32 Road Traffic Accident Treatment (Retired 01 April 2014)

33 [Sarcoma Care Spell](#)

34 [Skin Cancer Care Spell](#)

35 Supervised Discharge Episode (Retired 01 April 2014)

36 Supervision Register Episode (Retired 01 April 2014)

37 [Upper Gastrointestinal Cancer Care Spell](#)

38 [Urological Cancer Care Spell](#)

39 [Ward Stay](#)

40 [Hospital Stay](#)

41 [Care Spell](#)

42 [CRITICAL CARE PERIOD](#)

43 [PATIENT PATHWAY](#)

44 [REFERRAL TO TREATMENT PERIOD](#)

45 [Active Monitoring](#)

46 [Supervised Community Treatment Recall](#)

47 [Supervised Community Treatment](#)

48 [Mental Health Care Without Patient Consent](#)

49 [Cancer Treatment Period](#)

50 [Gynaecological Cancer Care Spell](#)

51 [Mental Health Care Spell](#)

52 [Improving Access to Psychological Therapies Care Spell](#)

53 [Adult Mental Health Care Team Episode](#)

54 [Mental Health NHS Day Care Episode](#)

55 [Mental Health Delayed Discharge Period](#)

56 [Mental Health Care Cluster Assignment Period](#)

57 [Mental Health Care Coordinator Assignment](#)

56 [Mental Health Care Cluster Assignment Period \(Retired 01 January 2016\)](#)

57 [Mental Health Care Coordinator Assignment Period](#)

58 [Child and Adolescent Mental Health Clinical Intervention Episode](#)

59 [Child and Adolescent Mental Health Care Spell](#)

60 [Maternity Episode](#)

61 [HIV Episode](#)

62 [Central Nervous System Cancer Care Spell](#)

63 [Children Teenagers and Young Adults Cancer Care Spell](#)

64 [Haematology Cancer Care Spell](#)

65 [Lung Cancer Care Spell](#)

66 [Commissioner Assignment Period](#)

67 [Breast Screening Episode](#)

68 [High Risk Breast Screening Episode](#)

69 [Open Breast Screening Episode](#)

70 [Neonatal Critical Care Spell](#)

71 [Radiotherapy Episode](#)

72 [Healthy Person Stay](#)

73 [Mental Health Responsible Clinician Assignment](#)

73 [Mental Health Responsible Clinician Assignment Period](#)

74 [Mental Health Conditional Discharge Period](#)

75 [Mental Health Act Legal Status Classification Period](#)

75 [Mental Health Act Legal Status Classification Period \(Moved to PERSON PROPERTY ASSIGNMENT PERIOD TYPE 01 January 2016\)](#)

Care Professional Admitted Care Episode

Note:

The list is not in alphabetical order.

ACTIVITY IDENTIFIER

Change to Attribute: Changed Dataset

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

As these are often locally generated at present, they will not be unique in their own right, but as the NHS moves towards central systems, new [ACTIVITY IDENTIFIERS](#) should become enough to identify an [ACTIVITY](#) without knowing the [PATIENT](#) or [ORGANISATION](#).

ACTIVITY LOCATION TYPE CODE

Change to Attribute: Changed Description, Dataset

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

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

[ACTIVITY LOCATION TYPE CODE](#) replaces [LOCATION TYPE CODE](#) and should be used for all new and developing data sets and for XML messages.

National Codes:

CODE	VALUE	NOTES
	PATIENT Main Residence or Related Location	
A01	PATIENT 's Home	
A02	Carer's Home	
A03	PATIENT 's Workplace	
A04	Other PATIENT Related Location	e.g. temporary address
	Health Centre Premises	
B01	Primary Care Health Centre	Primary Care Health Centre with or without GP Practice (s) based in it, providing community-based healthcare services such as podiatry, community dentistry, ophthalmology, minor injuries nursing etc, Sexual and Reproductive Health Service , health promotion etc, and sometimes hosting outreach services from NHS Trusts and NHS Foundation Trusts
B02	Polyclinic	Provide similar services to Primary Care Health Centre but also additional services such as diagnostics, minor procedures, Out-Patient Appointments , urgent care etc. and also co-located services with Local Authority Social Care . May also provide extended/out of hours services.
	GENERAL PRACTITIONER and OPHTHALMIC MEDICAL PRACTITIONER	
C01	General Medical Practitioner Practice	Stand-alone GP Practice premises, not part of a Primary Care Health Centre
C02	Dental Practice	

		Stand-alone GP Practice premises, not part of a Primary Care Health Centre
C03	OPHTHALMIC MEDICAL PRACTITIONER Premises	
Walk In Centres, Out of Hours Premises and Emergency Community Dental Services		
D01	Walk In Centre	May be NHS GENERAL PRACTITIONER Led, NURSE -led, or provided by private company. May be sited in different areas - health care premises, in retail premises etc
D02	Out of Hours Centre	May be NHS GENERAL PRACTITIONER -Led, NURSE -led, or provided by private company. May be sited in different areas - health care premises, in retail premises etc
D03	Emergency Community Dental Service	Run by Community Dental Services not GENERAL DENTAL PRACTITIONERS
Locations on Hospital Premises		
E01	Out-Patient Clinic	
E02	WARD	
E03	Day Hospital	
E03	Day Hospital	
E04	Accident and Emergency or Minor Injuries Department	
E99	Other Departments	e.g. Pathology Laboratories , physiotherapy, diagnostic imaging, Occupational Therapy, Pharmacy Premises etc
Hospice Premises		
F01	Hospice	
Nursing and Residential Homes		
G01	Care Home Without Nursing	
G02	Care Home With Nursing	
G03	Children's Home	
G04	Integrated Care Home Without Nursing and Care Home With Nursing *	
Day Centre Premises		
H01	Day Centre	Facilities operated by the NHS, Social Services or private or voluntary bodies, providing day care and respite care for elderly or disabled people
Resource Centre Premises		
J01	Resource Centre	Premises where information and support for PATIENTS and their families/carers is provided.
Dedicated Facilities for Children and Families		
K01	Sure Start Children's Centre	Children's centres are service hubs where children under five years old and their families can receive seamless integrated services and information. Services vary according to centre but may include: <ul style="list-style-type: none"> • Integrated early education and childcare • Support for parents including advice on parenting, local childcare options and access to specialist services for families • Child and family health services • Helping parents into work
K02	Child Development Centre	
Educational, Childcare and Training Establishments		
L01	School	Including Extended Services, where provided on School premises (where provided off School premises, use other appropriate location)
L02	Further Education College	

L03	University	
L04	Nursery Premises	Pre-school Nurseries attached to Schools would be classed as Schools in their own right
L05	Other Childcare Premises	e.g. Childminder
L06	Training Establishments	
L99	Other Educational Premises	Such as Teenage Pregnancy Units, School Preparation Units (for toddlers), Pupil Referral Units (excluded older children and young people), units providing specialist education e.g. deaf children, autistic children etc
Justice and Home Office Premises		
M01	Prison	
M02	Probation Service Premises	
M03	Police Station / Police Custody Suite	
M04	Young Offenders Institute	
M05	Immigration Removal Centre	
Public Locations		
N01	Street or other public open space	Public areas such as streets, parks, outdoor sports facilities etc
N02	Other publicly accessible area or building	Publicly accessible premises such as Youth Centres, supermarkets, shops and other retail locations such as shopping centres, community facilities such as libraries, church halls, community centres etc
N03	Voluntary or charitable agency premises	
N04	Dispensing Optician Premises	
N05	Dispensing Pharmacy Premises	Where it is not on a Hospital Site
Other Locations		
X01	Other locations not elsewhere classified	

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

ACTIVITY TIME

Change to Attribute: Changed Dataset

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

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

ACTIVITY TIME TYPE

Change to Attribute: Changed Description

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

An [ACTIVITY](#) may have many [TIMES](#) associated with it but may only have one [TIME](#) of a particular type.

National Codes:

- 50 [Accident and Emergency Attendance Conclusion Time](#)
- 51 [Accident and Emergency Departure Time](#)
- 52 [Accident and Emergency Initial Assessment Time](#)

- 53 [Accident and Emergency Time Seen For Treatment](#)
- 54 Arrival At Hospital Time (Retired April 2012)
- 55 ARRIVAL TIME (Retired April 2012)
- 56 [End Time](#)
- 57 Event Time (Retired July 2012)
- 58 Initial Patient Contact Time (Retired July 2012)
- 59 [Last Dosage Time](#)
- 60 [Pathology Result Due Time](#)
- 61 [Start Time](#)
- 62 Theatre Case Time In To Theatre Suite (Retired September 2012)
- 63 Theatre Case Time Out Of Theatre (Retired September 2012)
- 64 Theatre Case Time Out Of Theatre Suite (Retired September 2012)
- 65 [Time Seen](#)
- 66 Discharge Ready Time (Retired April 2012)
- 67 [Arrival Time At Accident and Emergency Department](#)
- 68 [Arrival Time For Transport Requests](#)
- 69 [Discharge Time](#)
- 70 [Clinical Intervention Time](#)
- [Care Contact Time](#)
- [Indirect Activity Time](#)

Note: This list is not in alphabetical order.

ADMINISTRATIVE CATEGORY CODE

Change to Attribute: Changed Description, Dataset

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

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

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

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

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

National Codes:

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

ADMISSION METHOD

Change to Attribute: Changed Description, Dataset

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

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

National Codes:

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

- 11 Waiting list
- 12 Booked
- 13 Planned

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

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

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

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

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

Other Admission not specified above

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

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

~~*** Note - National Codes 2A, 2B, 2C and 2D have been introduced to replace National Code 28 'Other means'. [Health Care Providers](#) should use these codes as soon as possible. National Code 28 will be retired in the next version of the Commissioning Data Set.**~~ * Note - National Codes 2A, 2B, 2C and 2D have been introduced to replace National Code 28 'Other means'. National Code 28 will be retired in the next version of the Commissioning Data Set.

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

ADULT MENTAL HEALTH CARE CLUSTER CODE_ renamed from MENTAL HEALTH CARE CLUSTER CODE

Change to Attribute: Changed Description, Dataset, Name

The ~~Mental Health Care Cluster~~ assigned to a ~~PATIENT~~. The Adult Mental Health Care Cluster assigned to a ~~PATIENT~~.

National Codes:

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

ADULT MENTAL HEALTH CARE CLUSTER CODE_ renamed from MENTAL HEALTH CARE CLUSTER CODE

Change to Attribute: Changed Description, Dataset, Name

- Changed Description
- null
- Changed Name from Data_Dictionary.Attributes.M.Men.MENTAL_HEALTH_CARE_CLUSTER_CODE to Data_Dictionary.Attributes.A.Add.ADULT_MENTAL_HEALTH_CARE_CLUSTER_CODE

APPOINTMENT DATE OFFERED

Change to Attribute: Changed Dataset

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

ASSESSMENT TOOL TYPE

Change to Attribute: Changed Description

The type of [ASSESSMENT TOOL](#).

National Codes:

- 001 [Health of the Nation Outcome Scale \(Working Age Adults\)](#)
- 002 [Health of the Nation Outcome Scale \(Children and Adolescents\)](#)
- 003 [Patient Health Questionnaire-9](#)
- 004 [Agoraphobia Questionnaire](#)
- 005 [Agoraphobia Mobility Inventory Questionnaire 'When Accompanied'](#)
- 006 [Agoraphobia Mobility Inventory Questionnaire 'When Alone'](#)
- 007 [Employment Status Questionnaire](#)
- 008 [Generalised Anxiety Disorder Penn State Worry Questionnaire](#)
- 009 [Generalised Anxiety Disorder Questionnaire](#)
- 010 [Health Anxiety Inventory Short Week Scale](#)
- 011 [Obsessive Compulsive Disorder Inventory Questionnaire](#)
- 012 [Panic Disorder Severity Scale](#)
- 013 [Post Traumatic Stress Disorder Impacts of Events Revised Scale](#)
- 014 [Social Phobia Inventory Questionnaire](#)
- 015 [Social Phobia Questionnaire](#)
- 016 [Specific Phobia Questionnaire](#)
- 017 [Work and Social Adjustment Scale](#)
- 018 [Health of the Nation Outcome Scale 65+ \(Older Adults\)](#)
- 019 [Health of the Nation Outcome Scale \(Secure\)](#)
- 020 [Mental Health Clustering Tool](#)
- 020 [Adult Mental Health Clustering Tool](#)
- 021 [Cardiovascular Disease Risk Calculator](#)
- 022 [Strengths And Difficulties Questionnaire](#)
- 023 [Experience of Service Questionnaire](#)
- 024 [Children's Global Assessment Scale](#)
- 025 [Family Assessment Device \(General Functioning Subscale\)](#)
- 026 [Parenting Daily Hassles](#)
- 027 [Parent-Infant Relationship Global Assessment Scale](#)
- 028 [Paddington Complexity Scale](#)
- 029 [Goal Based Outcomes](#)
- 030 [Mood And Feelings Questionnaire](#)
- 031 [Parenting Stress Index](#)
- 032 [Adult Comorbidity Evaluation - 27](#)
- 033 [Child-Pugh Score Calculator](#)
- 034 [Dysphagia Scoring System](#)
- 035 [Follicular Lymphoma International Prognostic Index](#)
- 036 [Hasenclever Index](#)
- 037 [Hasford Index](#)
- 038 [International Prognostic Scoring System](#)
- 039 [Nottingham Prognostic Index](#)
- 040 [Revised International Prognostic Index](#)
- 041 [Sokal Index](#)
- 042 [Oxford Orthopaedic Questionnaire](#)
- 043 [Oxford Orthopaedic Questionnaire \(Shoulder\)](#)
- 044 [Venous Thromboembolism Risk Assessment Tool](#)
- 045 [TPRG-SEND Two Year Corrected Age Outcome Assessment](#)
- 046 [Bayley Scales of Infant and Toddler Development \(Third Edition\)](#)
- 047 [Griffiths Mental Development Scales](#)
- 048 [Schedule of Growing Skills](#)
- 049 [Improving Access to Psychological Therapies Patient Experience Questionnaire](#)
- 050 [Health of the Nation Outcome Scale for People with Learning Disabilities](#)
- 051 [Protected Characteristic Protocol \(Disability\)](#)

ATTENDED OR DID NOT ATTEND

Change to Attribute: Changed Description, Dataset

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

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

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

National Codes:

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

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

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

- [Child and Adolescent Mental Health Services Secondary Uses Data Set](#)
- [Children and Young People's Health Service Secondary Uses Data Set](#)
- [Community Information Data Set](#)
- [Improving Access to Psychological Therapies Data Set](#)
- [Mental Health and Learning Disabilities Data Set](#)
- [Mental Health Services Data Set](#)

Use in the Future Outpatient Commissioning Data Set:

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

CARE CONTACT CANCELLATION REASON

Change to Attribute: Changed Dataset

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

National Codes:

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

CARE CONTACT SUBJECT

Change to Attribute: Changed Dataset

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

National Codes:

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

CARE PROFESSIONAL IDENTIFIER

Change to Attribute: Changed Dataset

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

CARE PROFESSIONAL STAFF GROUP FOR COMMUNITY CARE

Change to Attribute: Changed Dataset

The staff group of a [CARE PROFESSIONAL](#) working in, or referring to, a [Community Health Service](#).

National Codes:

Allied Health Professionals

- A01 Art Therapist
- A02 [Clinical Psychologist](#)
- A03 [Dietitian](#)
- A04 Drama Therapist
- A05 Music Therapist
- A06 [Occupational Therapist](#)
- A07 [Orthotist](#)
- A08 [Physiotherapist](#)
- A09 [Podiatrist](#)
- A10 [Prosthetist](#)
- A11 Psychotherapist
- A12 [Radiographer](#)
- A13 [Speech and Language Therapist](#)
- A14 [Orthoptist](#)

Medical/Dental

- M01 Community Dentist
- M02 [CONSULTANT](#)
- M03 [GENERAL MEDICAL PRACTITIONER](#)
- M04 [GENERAL MEDICAL PRACTITIONER](#) with Special Interest

Nursing, Health Visiting and Midwifery

- N01 Community [MIDWIFE](#)
- N02 District [NURSE](#)
- N03 [Health Visitor](#)
- N04 Macmillan [NURSE](#)
- N05 [School Nurse](#)
- N06 Specialist Nursing - Active Case Management (Community Matrons)
- N07 Specialist Nursing - Arthritis Nursing/Liaison
- N08 Specialist Nursing - Asthma and Respiratory Nursing/Liaison
- N09 Specialist Nursing - Breast Care Nursing/Liaison
- N10 Specialist Nursing - Cancer Related
- N11 Specialist Nursing - Cardiac Nursing/Liaison
- N12 Specialist Nursing - Children's Services
- N13 Specialist Nursing - Community Cystic Fibrosis
- N14 Specialist Nursing - Continence Services
- N15 Specialist Nursing - Diabetic Nursing/Liaison
- N16 Specialist Nursing - Enteral Feeding Nursing Services

- N17 Specialist Nursing - Haemophilia Nursing Services
- N18 Specialist Nursing - HIV/AIDS Nursing Services
- N19 Specialist Nursing - Infectious Diseases
- N20 Specialist Nursing - Intensive Care Nursing
- N21 Specialist Nursing - Palliative/Respite Care
- N22 Specialist Nursing - Parkinson's and Alzheimers Nursing/Liaison
- N23 Specialist Nursing - Rehabilitation Nursing
- N24 Specialist Nursing - Stoma Care Services
- N25 Specialist Nursing - Tissue Viability Nursing/Liaison
- N26 Specialist Nursing - Transplantation Patients Nursing Service
- N27 Specialist Nursing - Treatment Room Nursing Services
- N28 Specialist Nursing - Tuberculosis Specialist Nursing
- N29 Other Specialist Nursing

Other Care Professionals

- C01 Appliances Technician
- C02 Audiologist
- C03 Counsellor
- C04 Nursery Nurse
- C06 Play Therapist
- C07 [Social Worker](#)
- C08 Voluntary Care Worker
- C09 Screener (in a National [Screening Programme](#))
- C99 Other [CARE PROFESSIONAL](#)

CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH

Change to Attribute: New Attribute

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

National Codes:

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

This attribute is also known by these names:

Context	Alias
plural	CARE PROFESSIONAL STAFF GROUPS FOR MENTAL HEALTH

CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH

Change to Attribute: New Attribute

CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH

Data Elements:

CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH)

CARE PROFESSIONAL TEAM IDENTIFIER

Change to Attribute: Changed Dataset

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

CARE PROGRAMME APPROACH REVIEW ABUSE QUESTION ASKED INDICATOR

Change to Attribute: Changed Description, Dataset

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

National Codes:

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

CATEGORY VALUED PERSON OBSERVATION TYPE

Change to Attribute: Changed Description

The type of [CATEGORY VALUED PERSON OBSERVATION](#).

National Codes:

01	ALCOHOL STATUS (Retired 1 January 2013)
02	ASPIRIN THERAPY LOCATION (Retired July 2012)
03	BLEED COMPLICATION (Retired July 2012)
04	ETHNIC CATEGORY
05	JOINT REPLACEMENT REVISION CLASSIFICATION (Retired 1 April 2012)
06	LANGUAGE CLASSIFICATION
06	LANGUAGE
07	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION
08	PATIENT CLINICAL GROUP (Retired July 2012)
09	PERFORMANCE STATUS
10	PERSON GENDER
11	PERSON MARITAL STATUS
12	SARCOMA PREDISPOSING CONDITION (Retired 1 January 2013)
13	SKIN LYMPHOMA MORPHOLOGY (Retired 1 January 2013)
14	ACCOMMODATION
15	SEXUAL ORIENTATION
16	RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION
17	RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP (Retired August 2013)
18	CONTRACEPTION
19	DISABILITY
20	PREVIOUS SYMPTOM STATUS
21	PSYCHOTROPIC MEDICATION STATUS
22	STATUTORY SICK PAY STATUS

- 23 [PERSON PHYSICAL ACTIVITY LEVEL](#)
- 24 [CHILDHOOD IMMUNISATION STATUS](#)
- 25 [FOLIC ACID SUPPLEMENT STATUS](#)
- 26 [SUPPORT STATUS](#)
- 27 [DISABILITY SEVERITY](#)
- 28 [CONSCIOUSNESS STATUS](#)
- 29 [PERSON PHENOTYPIC SEX](#)
- 30 [PERSON STATED GENDER](#)
- 31 [SOCIO-ECONOMIC CLASSIFICATION](#)
- [CARE CLUSTER](#)

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE

Change to Attribute: New Attribute

The Child and Adolescent Mental Health Care Cluster assigned to a [PATIENT](#).

Note: This data item is included in the Mental Health Services Data Set, but should not be submitted until further development by the Health and Social Care Information Centre has been undertaken.

This attribute is also known by these names:

Context	Alias
plural	CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODES

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE

Change to Attribute: New Attribute

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE

Data Elements:

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL)
CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL)

CHILD AND ADOLESCENT MENTAL HEALTH TIER OF SERVICE

Change to Attribute: Changed Description, Dataset

The tier of service which a [Child and Adolescent Mental Health Care Team](#) is operating at whilst treating a [PATIENT](#). The tier of [SERVICE](#) the Child and Adolescent Mental Health Care Team operates at for a [PATIENT](#).

National Codes:

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

CHILD PROTECTION PLAN INDICATION CODE_ renamed from CHILD PROTECTION PLAN INDICATOR

Change to Attribute: Changed Description, Dataset, Name

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

National Codes:

- ~~0~~ Has never been subject to a [Child Protection Plan](#)
- ~~1~~ Has previously been subject to a [Child Protection Plan](#)
- ~~2~~ Is currently subject to a [Child Protection Plan](#)
- 1 Has never been subject to a [Child Protection Plan](#)
- 2 Has previously been subject to a [Child Protection Plan](#)
- 3 Is currently subject to a [Child Protection Plan](#)

CHILD PROTECTION PLAN INDICATION CODE_ renamed from CHILD PROTECTION PLAN INDICATOR

Change to Attribute: Changed Description, Dataset, Name

- Changed Description
- null
- Changed Name from Data_Dictionary.Attributes.C.Cen.CHILD_PROTECTION_PLAN_INDICATOR to Data_Dictionary.Attributes.C.Cen.CHILD_PROTECTION_PLAN_INDICATION_CODE

CLINICAL CARE INTENSITY

Change to Attribute: Changed Dataset

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

National Codes:

For [PATIENTS](#) with mental illness

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

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

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

For maternity [PATIENTS](#)

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

For neonates

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

For the younger physically disabled

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

For terminally ill/[Palliative Care](#)

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

For general [PATIENTS](#)

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

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

CLINICAL CLASSIFICATION CODE

Change to Attribute: Changed Dataset

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

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

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

CLINICAL INTERVENTION TYPE

Change to Attribute: Changed Description

The type of [CLINICAL INTERVENTION](#).

National Codes:

- 01 Anaesthetic Service (Retired November 2013)
- 02 [Anti-Cancer Drug Cycle](#)
- 03 Anti-Cancer Drug Fraction (Retired 1 January 2013)
- 04 [Anti-Cancer Drug Programme](#)
- 05 [Anti-Cancer Drug Regimen](#)
- 06 [Brachytherapy Treatment Course](#)
- 07 Contraceptive Service (Retired November 2013)
- 08 Dental Haemorrhage Service (Retired November 2013)
- 09 Dental Treatment (Retired 01 April 2014)
- 10 Drug Dosage and Administration (Retired 1 January 2013)
- 11 [Drug Treatment](#)
- 12 Emergency Treatment Service (Retired November 2013)
- 13 Endocrine Therapy (Retired 1 January 2013)
- 14 [Fraction](#)
- 15 [Primary Hip Replacement Surgery](#)
- 16 [Imaging or Radiodiagnostic Event](#)
- 17 [Immunisation Dose Given](#)
- 18 [Joint Replacement Surgery](#)
- 19 [Primary Knee Replacement Surgery](#)
- 20 [Labour and Delivery](#)
- 21 Lithotripsy Course Attendance (Retired 1 April 2014)
- 22 Maternity Medical Service (Retired November 2013)
- 23 Minor Surgery Procedure (Retired November 2013)
- 24 Pathology Laboratory Investigation (Retired January 2015)
- 25 [Patient Procedure](#)
- 26 [Post Mortem](#)
- 27 [Radiotherapy Treatment Course](#)

28 Screening Test (Retired November 2013)
29 Teletherapy Treatment Course (Retired 1 April 2014)
30 Test Of Immunity (Retired November 2013)
31 Therapy After Discharge (Retired July 2012)
32 [Thromboprophylaxis Regime](#)
33 Unsealed Source Treatment Course (Retired 1 April 2014)
34 Vaccination Service (Retired November 2013)
35 Vasectomy Performed (Retired November 2013)
36 [Clinical Investigation](#)
37 [Systemic Anti-Cancer Drug Cycle](#)
38 [Systemic Anti-Cancer Drug Programme](#)
39 [Systemic Anti-Cancer Drug Regimen](#)
40 [Chemotherapy](#)
41 [Cytotoxic Chemotherapy](#)
42 [Hormone Therapy](#)
43 [Immunotherapy](#)
44 Diagnostic Imaging (Retired January 2015)
45 6 - 8 Week Physical Examination (Retired January 2015)
46 Ultrasound Scan In Pregnancy (Retired January 2015)
47 Newborn Physical Examination (Retired January 2015)
48 [Biological Therapy](#)
49 [Brachytherapy](#)
50 [Chemoradiotherapy](#)
51 [Cryotherapy](#)
52 [High Intensity Focused Ultrasound](#)
53 [Hyperbaric Oxygen Therapy](#)
54 [Laser Treatment](#)
55 [Light Therapy](#)
56 [Photodynamic Therapy](#)
57 [Proton Therapy](#)
58 [Psoralen and Ultraviolet A Therapy](#)
59 [Radiofrequency Ablation](#)
60 [Radioisotope Therapy](#)
61 [Radiosurgery](#)
62 [Radiotherapy](#)
63 [Teletherapy](#)
64 Tissue Typing (Retired January 2015)
65 [Blood Transfusion](#)
66 [Renal Dialysis](#)
67 [Antiretroviral Therapy](#)
68 [Drug Regimen](#)
69 [Ablative Therapy](#)
70 [Laparoscopy](#)
71 [Primary Ankle Replacement Surgery](#)
72 [Revision Ankle Replacement Surgery](#)
73 [Primary Elbow Replacement Surgery](#)
74 [Revision Elbow Replacement Surgery](#)
75 [Revision Hip Replacement Surgery](#)
76 [Revision Knee Replacement Surgery](#)
77 [Primary Shoulder Replacement Surgery](#)
78 [Revision Shoulder Replacement Surgery](#)
79 [Oxygen Therapy](#)
80 [Therapeutic Hypothermia](#)
81 [Parenteral Nutrition](#)
82 [Enteral Feeding](#)
83 [Radiotherapy Exposure](#)
84 [Mental Health Treatment](#)
[Restrictive Intervention](#)

CLINICAL RESPONSE PRIORITY TYPE

Change to Attribute: Changed Description, Dataset

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

~~For [SERVICE REQUESTS](#) to a [Child and Adolescent Mental Health Care Team](#), a [CLINICAL RESPONSE PRIORITY TYPE](#) of 'Emergency' indicates that the [PATIENT](#) needs to be seen within 48 hours of the [REFERRAL REQUEST RECEIVED DATE](#). This priority is as assessed by, or on behalf of, the [Child and Adolescent Mental Health Care Team](#).~~

National Codes:

- 1 Emergency
- 2 Urgent/serious
- 3 Routine

CLINICAL TERMINOLOGY CODE

Change to Attribute: Changed Dataset

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

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

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

Note: [SNOMED CT](#) is the current fundamental standard for clinical terminology for use within the NHS; it is planned that in time this will be the only terminology used by the NHS. For further information, see the [Information Standards Board for Health and Social Care](#) website at: [ISB 0034 Amd 26/2006](#).

CLUSTERING TOOL ASSESSMENT CATEGORY

Change to Attribute: New Attribute

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

Note: only [CLUSTERING TOOL ASSESSMENT CATEGORY](#) National Code '[Adult Mental Health Clustering Tool](#)' is currently supported in the [Mental Health Services Data Set](#). Other National Codes have been included to facilitate piloting and testing of future data requirements, prior to formal inclusion in later versions of the [Mental Health Services Data Set](#).

National Codes:

- 01 [Adult Mental Health Clustering Tool](#)
- 02 [Child and Adolescent Mental Health Clustering Tool](#)
- 03 [Learning Disabilities Clustering Tool](#)
- 04 [Forensic \(Mental Health\) Clustering Tool](#)
- 05 [Forensic \(Learning Disabilities\) Clustering Tool](#)

This attribute is also known by these names:

Context	Alias
plural	CLUSTERING TOOL ASSESSMENT CATEGORIES

CLUSTERING TOOL ASSESSMENT CATEGORY

Change to Attribute: New Attribute

CLUSTERING TOOL ASSESSMENT CATEGORY

Data Elements:

CLUSTERING TOOL ASSESSMENT CATEGORY

CLUSTERING TOOL ASSESSMENT REASON_ renamed from MENTAL HEALTH CLUSTERING TOOL ASSESSMENT REASON

Change to Attribute: Changed Description, Dataset, Name

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

National Codes:

- 10 Initial assessment
- 11 Scheduled re-assessment
- 12 Re-assessment following significant unanticipated change in need
- ~~97 Other reason~~
- 97 Other Reason

CLUSTERING TOOL ASSESSMENT REASON_ renamed from MENTAL HEALTH CLUSTERING TOOL ASSESSMENT REASON

Change to Attribute: Changed Description, Dataset, Name

- Changed Description
- null
- Changed Name from Data_Dictionary.Attributes.M.Men.MENTAL_HEALTH_CLUSTERING_TOOL_ASSESSMENT_REASON to Data_Dictionary.Attributes.C.Cla.CLUSTERING_TOOL_ASSESSMENT_REASON

COMMUNITY TREATMENT ORDER END REASON_ renamed from SUPERVISED COMMUNITY TREATMENT END REASON

Change to Attribute: Changed Description, Dataset, Name

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

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

National Codes:

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

COMMUNITY TREATMENT ORDER END REASON_ renamed from SUPERVISED COMMUNITY TREATMENT END REASON

Change to Attribute: Changed Description, Dataset, Name

- Changed Description
- null
- Changed Name from Data_Dictionary.Attributes.S.Sup.SUPERVISED_COMMUNITY_TREATMENT_END_REASON to Data_Dictionary.Attributes.C.Com.COMMUNITY_TREATMENT_ORDER_END_REASON

CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR

Change to Attribute: New Attribute

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

National Codes:

- Y Yes - **PERSON** requires constant care and/or supervision
- N No - **PERSON** does not require constant care and/or supervision

This attribute is also known by these names:

Context	Alias
plural	CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATORS

CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR

Change to Attribute: New Attribute

CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR

Data Elements:

CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR
--

CONSULTATION MEDIUM USED

Change to Attribute: Changed Description, Dataset

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

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

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

National Codes:

- 01 Face to face communication
- 02 Telephone
- 03 Telemedicine web camera
- 04 Talk type for a [PERSON](#) unable to speak
- 05 Email **

- 06 Short Message Service (SMS) - Text Messaging **
- 98 Other *

~~* Note - National Code 98 'Other' is only used for the Community Information Data Set and the Sexual and Reproductive Health Activity Data Set.~~ * Note - National Code 98 'Other' is only used for the Community Information Data Set, Mental Health Services Data Set and the Sexual and Reproductive Health Activity Data Set. It is NOT valid in any other data set including Commissioning Data Set version 6-2.

** Note National Codes 05 'Email' and 06 'Short Message Service (SMS) - Text Messaging' are not valid for Commissioning Data Set version 6-2.

CONSULTATION TYPE

Change to Attribute: New Attribute

The type of consultation between the CARE PROFESSIONAL and the PATIENT.

National Codes:

- 01 Initial Consultation
- 02 Follow-up Consultation

This attribute is also known by these names:

Context	Alias
plural	CONSULTATION TYPES

CONSULTATION TYPE

Change to Attribute: New Attribute

CONSULTATION TYPE

Data Elements:

CONSULTATION TYPE

DIAGNOSIS SCHEME IN USE

Change to Attribute: New Attribute

The type of CODED CLINICAL ENTRY used for the PATIENT DIAGNOSIS.

National Codes:

- 01 Accident & Emergency Diagnosis ***
- 02 ICD-10
- 03 Read Code 4Byte Version (retired 1 October 2009)
- 04 Read Coded Clinical Terms Version 2
- 05 Read Coded Clinical Terms Version 3 (CTV3) *
- 06 Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT) **

Notes:

- * [Read Coded Clinical Terms Version 3 \(CTV3\)](#) with qualifiers (previously known as 3.1) is not supported in the Commissioning Data Sets
- ** [Systematized Nomenclature of Medicine Clinical Terms \(SNOMED CT\)](#) is not valid for Commissioning Data Set version 6-1 and 6-2
- *** Accident & Emergency Diagnosis is not valid for the [Mental Health Services Data Set](#).

This attribute is also known by these names:

Context	Alias
plural	DIAGNOSIS SCHEMES IN USE

DIAGNOSIS SCHEME IN USE

Change to Attribute: New Attribute

DIAGNOSIS SCHEME IN USE

Data Elements:

DIAGNOSIS SCHEME IN USE

DISABILITY CODE

Change to Attribute: Changed Dataset

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

This could be where:

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

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

National Codes:

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

DISABILITY IMPACT PERCEPTION

Change to Attribute: New Attribute

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

National Codes:

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

This attribute is also known by these names:

Context	Alias
plural	DISABILITY IMPACT PERCEPTIONS

DISABILITY IMPACT PERCEPTION

Change to Attribute: New Attribute

DISABILITY IMPACT PERCEPTION

Data Elements:

DISABILITY IMPACT PERCEPTION
--

DISCHARGE DESTINATION

Change to Attribute: Changed Dataset

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

National Codes:

- 19 Usual place of residence unless listed below, for example, a private dwelling whether owner occupied or owned by [Local Authority](#), housing association or other landlord. This includes wardened accommodation but not residential accommodation where health care is provided. It also includes [PATIENTS](#) with no fixed abode.
- 29 Temporary place of residence when usually resident elsewhere (includes hotel, residential [Educational Establishment](#))
- 30 Repatriation from high security psychiatric accommodation in an NHS [Hospital Provider \(NHS Trust](#) or [NHS Foundation Trust](#))
- 37 [Court](#)
- 38 Penal establishment or police station
- 48 High Security Psychiatric Hospital, Scotland
- 49 NHS other [Hospital Provider](#) - high security psychiatric accommodation
- 50 NHS other [Hospital Provider](#) - medium secure unit
- 51 NHS other [Hospital Provider](#) - [WARD](#) for general [PATIENTS](#) or the younger physically disabled
- 52 NHS other [Hospital Provider](#) - [WARD](#) for maternity [PATIENTS](#) or [Neonates](#)
- 53 NHS other [Hospital Provider](#) - [WARD](#) for [PATIENTS](#) who are mentally ill or have [Learning Disabilities](#)
- 54 NHS run [Care Home](#)
- 65 [Local Authority](#) residential accommodation i.e. where care is provided
- 66 [Local Authority](#) foster care
- 79 Not applicable - [PATIENT](#) died or still birth
- 84 Non-NHS run hospital - medium secure unit
- 85 Non-NHS (other than [Local Authority](#)) run [Care Home](#)
- 87 Non-NHS run hospital
- 88 Non-NHS (other than [Local Authority](#)) run [Hospice](#)

DISCHARGE METHOD

Change to Attribute: Changed Dataset

The method of discharge from a [Hospital Provider Spell](#).

National Codes:

- 1 [PATIENT](#) discharged on clinical advice or with clinical consent
- 2 [PATIENT](#) discharged him/herself or was discharged by a relative or advocate
- 3 [PATIENT](#) discharged by mental health review tribunal, Home Secretary or [Court](#)
- 4 [PATIENT](#) died
- 5 Stillbirth

EMPLOYMENT STATUS

Change to Attribute: Changed Dataset

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

National Codes:

- 01 Employed
- 02 Unemployed and Seeking Work
- 03 Students who are undertaking full (at least 16 hours per week) or part-time (less than 16 hours per week) education or training and who are not working or actively seeking work
- 04 Long-term sick or disabled, those who are receiving Incapacity Benefit, Income Support or both; or Employment and Support Allowance
- 05 Homemaker looking after the family or home and who are not working or actively seeking work
- 06 Not receiving benefits and who are not working or actively seeking work
- 07 Unpaid voluntary work who are not working or actively seeking work
- 08 Retired
- ZZ Not Stated ([PERSON](#) asked but declined to provide a response)

ETHNIC CATEGORY CODE

Change to Attribute: Changed Dataset

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

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

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

National Codes:

White

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

Mixed

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

Asian or Asian British

- H Indian

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

Black or Black British

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

Other Ethnic Groups

- R Chinese
- S Any other ethnic group

- Z Not stated

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

FINDING SCHEME IN USE

Change to Attribute: New Attribute

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

National Codes:

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

This attribute is also known by these names:

Context	Alias
plural	FINDING SCHEMES IN USE

FINDING SCHEME IN USE

Change to Attribute: New Attribute

FINDING SCHEME IN USE

Data Elements:

FINDING SCHEME IN USE

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE

Change to Attribute: New Attribute

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

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

This attribute is also known by these names:

Context	Alias
plural	FORENSIC LEARNING DISABILITIES CARE CLUSTER CODES

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE

Change to Attribute: New Attribute

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE

Data Elements:

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)
FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)

FORENSIC MENTAL HEALTH CARE CLUSTER CODE

Change to Attribute: New Attribute

The Forensic (Learning Disabilities) Care Cluster assigned to a PATIENT.

Note: This data item is included in the Mental Health Services Data Set, but should not be submitted until further development by the Health and Social Care Information Centre has been undertaken.

This attribute is also known by these names:

Context	Alias
plural	FORENSIC MENTAL HEALTH CARE CLUSTER CODES

FORENSIC MENTAL HEALTH CARE CLUSTER CODE

Change to Attribute: New Attribute

FORENSIC MENTAL HEALTH CARE CLUSTER CODE

Data Elements:

FORENSIC MENTAL HEALTH CARE CLUSTER CODE (FINAL)
FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL)

GROUP SESSION TYPE FOR MENTAL HEALTH

Change to Attribute: New Attribute

The type of Group Session provided by a Mental Health Service.

National Codes:

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

This attribute is also known by these names:

Context	Alias
---------	-------

plural

GROUP SESSION TYPES FOR MENTAL HEALTH

GROUP SESSION TYPE FOR MENTAL HEALTH

Change to Attribute: New Attribute

GROUP SESSION TYPE FOR MENTAL HEALTH

Data Elements:

GROUP SESSION TYPE (MENTAL HEALTH)

GROUP THERAPY INDICATOR

Change to Attribute: Changed Description, Dataset

An indicator of whether a [CARE ACTIVITY](#) was delivered as [Group Therapy](#). An indication of whether a [CARE ACTIVITY](#) was delivered as [Group Therapy](#).

National Codes:

- Y [CARE ACTIVITY](#) delivered as [Group Therapy](#)
- N [CARE ACTIVITY](#) delivered individually
- Y Yes - [CARE ACTIVITY](#) was delivered as [Group Therapy](#)
- N No - [CARE ACTIVITY](#) was delivered individually

JOB ROLE CODE

Change to Attribute: Changed Dataset

A National Code for a [POSITION](#) applicable to an [EMPLOYEE](#), as required by the [National Workforce Data Set](#).

National Codes:

Code	Staff Group	Job Role Title
01000	Medical and Dental	
01001		Medical Director
01002		Clinical Director
01003		Professor
01004		Senior Lecturer
01005		CONSULTANT
01006		Dental surgeon acting as Hospital CONSULTANT
01007		Special salary scale in Public Health Medicine
01008		Associate Specialist (Closed to new entrants from 01 April 2008 or regrading from 01 April 2009)
01009		Staff Grade (Closed to new entrants 01 April 2008)
01010		Hospital Practitioner
01011		Clinical Assistant
01012		Specialist Registrar - Closed (Retired 01 April 2010)
01013		Senior House Officer - Closed (Retired 01 April 2010)
01014		House Officer - Pre-registration - Closed (Retired 01 April 2010)
01015		House Officer - Post-registration - Closed (Retired 01 April 2010)
01016		

		Trust Grade Doctor - House Officer level - Closed (Retired 01 April 2010)
01017		Trust Grade Doctor - SHO level - Closed (Retired 01 April 2010)
01018		Trust Grade Doctor - Specialist Registrar level - Closed (Retired 01 April 2010)
01019		Trust Grade Doctor - Career Grade level
01020		Director of Public Health
01021		Clinical Medical Officer
01022		Senior Clinical Medical Officer
01023		'Other' Community Health Service
01024		GENERAL DENTAL PRACTITIONER
01025		GENERAL MEDICAL PRACTITIONER
01026		Salaried GENERAL PRACTITIONER
01027		Regional Dental Officer
01028		Dental Clinical Director
01029		Dental Officer
01030		Senior Dental Officer
01031		Salaried Dental Practitioner
01032		Specialty Doctor
01033		Foundation Year 1
01034		Foundation Year 2
01035		Specialty Registrar
01036		Medical Student
01037		Trust Grade Doctor - Specialty Registrar
01038		Vocational Dental Practitioner
02000	Students	
02001		Student NURSE - Adult Branch
02002		Student NURSE - Child Branch
02003		Student NURSE - Mental Health Branch
02004		Student NURSE - Learning Disabilities Branch
02005		Student MIDWIFE
02006		Student Health Visitor
02007		Student District Nurse
02008		Student School Nurse
02009		Student Practice Nurse
02010		Student Occupational Health Nurse
02011		Student Community Children's Nurse
02012		Student Mental Health Nurse
02013		Student Learning Disabilities Nurse
02014		Student Chiropodist
02015		Student Dietitian
02016		Student Occupational Therapist
02017		Student Orthoptist
02018		Student Physiotherapist
02019		Student Radiographer - Diagnostic
02020		Student Radiographer - Therapeutic
02021		Student Speech and Language Therapist
02022		Art, Music and Drama Student
02023		Student Psychotherapist
03000		

	Nursing and Midwifery Registered	
03001		Director of Nursing
03002		Nurse Consultant
03003		Nurse Manager
03004		Modern Matron
03005		Specialist Nurse Practitioner
03006		Sister/Charge Nurse
03007		Staff Nurse
03008		Enrolled Nurse
03009		Midwife - Consultant
03010		Midwife - Specialist Practitioner
03011		Midwife - Manager
03012		MIDWIFE - Sister/Charge Nurse (Retired 01 December 2012)
03013		MIDWIFE
03014		Community Practitioner
03015		Community Nurse
03016		Advanced Practitioner
04000	Allied Health Professionals	
04001		Art Therapist
04002		Art Therapist Consultant
04003		Art Therapist Manager
04004		Art Therapist Specialist Practitioner
04005		Chiropodist/Podiatrist
04006		Chiropodist/Podiatrist Consultant
04007		Chiropodist/Podiatrist Manager
04008		Chiropodist/Podiatrist Specialist Practitioner
04009		Dietitian
04010		Dietitian Consultant
04011		Dietitian Manager
04012		Dietitian Specialist Practitioner
04013		Drama Therapist
04014		Drama Therapist Consultant
04015		Drama Therapist Manager
04016		Drama Therapist Specialist Practitioner
04017		Multi Therapist
04018		Multi Therapist Consultant
04019		Multi Therapist Manager
04020		Multi Therapist Specialist Practitioner
04021		Music Therapist
04022		Music Therapist Consultant
04023		Music Therapist Manager
04024		Music Therapist Specialist Practitioner
04025		Occupational Therapist
04026		Occupational Therapist Consultant
04027		Occupational Therapist Manager
04028		Occupational Therapist Specialist Practitioner
04029		Orthoptist
04030		Orthoptist Consultant

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

05017		Advanced Practitioner
06000	Healthcare Scientists	
06001		Clinical Scientist (Retired 01 April 2013)
06002		Consultant Healthcare Scientist
06003		Biomedical Scientist (Retired 01 April 2013)
06004		Technician (Retired 01 April 2013)
06005		Therapist (Retired 01 April 2013)
06006		Manager
06007		Specialist Healthcare Scientist
06008		Healthcare Scientist
06009		Specialist Healthcare Science Practitioner
06010		Healthcare Science Practitioner
07000	Additional Clinical Services	
07001		Health Care Support Worker
07002		Social Care Support Worker
07003		Home Help
07004		Healthcare Assistant
07005		Nursery Nurse
07006		Play Therapist
07007		Play Specialist
07008		Technician
07009		Technical Instructor
07010		Assistant/Associate Practitioner
07011		Counsellor
07012		Helper/Assistant
07013		Dental Surgery Assistant
07014		Medical Laboratory Assistant
07015		Phlebotomist
07016		Cytoscreener
07017		Student Technician
07018		Trainee Scientist
07019		Trainee Practitioner
07020		Nursing Cadet
07021		Healthcare Cadet
07022		Pre-reg Pharmacist
07023		Assistant Psychologist
07024		Assistant Psychotherapist
07025		Call Operator
07026		Gateway Worker
07027		Support, Time, Recovery Worker
07028		Psychological Wellbeing Practitioner - Qualified
07029		Psychological Wellbeing Practitioner - Trainee
07030		Apprentice
07031		Assistant/Associate Practitioner - Nursing
07032		Ambulance Care Assistant/Patient Transport Services (PTS) Driver
07033		Emergency Care Assistant
07034		Emergency Care Practitioners
07035		Emergency Medical Dispatcher/Call Handler

07036		Healthcare Science Associate
07037		Healthcare Science Assistant
07038		Trainee Healthcare Scientist
07039		Trainee Healthcare Science Practitioner
07040		Trainee Healthcare Science Associate
08000	Administrative and Clerical	
08001		Clerical Worker
08002		Receptionist
08003		Secretary
08004		Personal Assistant
08005		Medical Secretary
08006		Officer
08007		Manager
08009		Senior Manager
08010		Technician
08011		Accountant
08012		Librarian
08013		Interpreter
08014		Analyst
08015		Adviser
08016		Researcher
08017		Control Assistant
08018		Architect
08019		Lawyer
08020		Surveyor
08021		Chair
08022		Chief Executive
08023		Finance Director
08024		Other Executive Director
08025		Board Level director
08026		Non-executive Director
08027		Childcare Coordinator
08028		Apprentice
09000	Estates and Ancillary	
09001		Support Worker
09002		Housekeeper
09003		Cook
09004		Porter
09005		Driver
09006		Telephonist
09007		Gardener/Groundsperson
09008		Technician
09009		Electrician
09010		Fitter
09011		Assistant
09012		Labourer
09013		Plumber
09014		Carpenter
09015		Bricklayer

09016		Painter/Decorator
09017		Work Analyst
09018		Chargehand
09019		Supervisor
09020		Engineer
09021		Building Officer
09022		Maintenance Craftsperson
09023		Building Craftsperson
09024		Mechanic
09025		Apprentice
10000	Supplementary Roles	
10001		Assessor
10002		Clinical Supervisor
10003		Educational Supervisor
10004		Tutor

LANGUAGE CODE

Change to Attribute: New Attribute

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

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

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

This attribute is also known by these names:

Context	Alias
plural	LANGUAGE CODES

LANGUAGE CODE

Change to Attribute: New Attribute

LANGUAGE CODE

Data Elements:

LANGUAGE CODE (PREFERRED)

LEARNING DISABILITIES CARE CLUSTER CODE

Change to Attribute: New Attribute

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

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

This attribute is also known by these names:

Context	Alias
plural	LEARNING DISABILITIES CARE CLUSTER CODES

LEARNING DISABILITIES CARE CLUSTER CODE

Change to Attribute: New Attribute

LEARNING DISABILITIES CARE CLUSTER CODE

Data Elements:

LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)
LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)

LOCAL PATIENT IDENTIFIER

Change to Attribute: Changed Dataset

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

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

LOOKED AFTER CHILD INDICATOR

Change to Attribute: Changed Description, Dataset

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

National Codes:

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

MAIN SPECIALTY CODE

Change to Attribute: Changed Dataset

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

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

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

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

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

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

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

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

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

For further information, contact the [Health and Social Care Information Centre](#) by email at: enquiries@hscic.gov.uk with the subject "Main Specialty and Treatment Function Codes".

National Codes:

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

Medical Specialties		
	190	ANAESTHETICS
	192	CRITICAL CARE MEDICINE
	300	GENERAL MEDICINE
	301	GASTROENTEROLOGY
	302	ENDOCRINOLOGY
	303	CLINICAL HAEMATOLOGY
	304	CLINICAL PHYSIOLOGY
	305	CLINICAL PHARMACOLOGY
	310	AUDIOLOGICAL MEDICINE
	311	CLINICAL GENETICS
*	312	CLINICAL CYTOGENETICS and MOLECULAR GENETICS (Retired 1 April 2010)
	313	CLINICAL IMMUNOLOGY and ALLERGY
	314	REHABILITATION
	315	PALLIATIVE MEDICINE
	320	CARDIOLOGY
	321	PAEDIATRIC CARDIOLOGY
	325	SPORT AND EXERCISE MEDICINE
	326	ACUTE INTERNAL MEDICINE
	330	DERMATOLOGY
	340	RESPIRATORY MEDICINE (also known as thoracic medicine)
	350	INFECTIOUS DISEASES
	352	TROPICAL MEDICINE
	360	GENITOURINARY MEDICINE
	361	NEPHROLOGY
	370	MEDICAL ONCOLOGY
	371	NUCLEAR MEDICINE
	400	NEUROLOGY
	401	CLINICAL NEURO-PHYSIOLOGY
	410	RHEUMATOLOGY
	420	PAEDIATRICS
	421	PAEDIATRIC NEUROLOGY
	430	GERIATRIC MEDICINE
	450	DENTAL MEDICINE SPECIALTIES
	451	SPECIAL CARE DENTISTRY
	460	MEDICAL OPHTHALMOLOGY
†	500	OBSTETRICS and GYNAECOLOGY
	501	OBSTETRICS
	502	GYNAECOLOGY
	504	COMMUNITY SEXUAL AND REPRODUCTIVE HEALTH
	510	ANTENATAL CLINIC (Retired 1 April 2004)
	520	POSTNATAL CLINIC (Retired 1 April 2004)
	560	MIDWIFE EPISODE
	600	GENERAL MEDICAL PRACTICE
	601	GENERAL DENTAL PRACTICE
	610	MATERNITY FUNCTION (Retired 1 April 2004)
	620	OTHER THAN MATERNITY (Retired 1 April 2004)
Psychiatry		
	700	LEARNING DISABILITY

	710	ADULT MENTAL ILLNESS
	711	CHILD and ADOLESCENT PSYCHIATRY
	712	FORENSIC PSYCHIATRY
	713	PSYCHOTHERAPY
	715	OLD AGE PSYCHIATRY
Radiology		
	800	CLINICAL ONCOLOGY (previously RADIOTHERAPY)
	810	RADIOLOGY
Pathology		
	820	GENERAL PATHOLOGY
	821	BLOOD TRANSFUSION
	822	CHEMICAL PATHOLOGY
	823	HAEMATOLOGY
	824	HISTOPATHOLOGY
	830	IMMUNOPATHOLOGY
	831	MEDICAL MICROBIOLOGY AND VIROLOGY
	832	NEUROPATHOLOGY (Retired 1 April 2004)
	833	MEDICAL MICROBIOLOGY (also known as MICROBIOLOGY AND BACTERIOLOGY)
	834	MEDICAL VIROLOGY
Other		
	900	COMMUNITY MEDICINE
	901	OCCUPATIONAL MEDICINE
	902	COMMUNITY HEALTH SERVICES DENTAL
	903	PUBLIC HEALTH MEDICINE
	904	PUBLIC HEALTH DENTAL
	950	NURSING EPISODE
	960	ALLIED HEALTH PROFESSIONAL EPISODE
	990	JOINT CONSULTANT CLINICS (Retired 1 April 2004)

Notes:

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

MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON_ renamed from ABSENCE WITHOUT LEAVE END REASON

Change to Attribute: Changed Description, Dataset, Name

A coding which identifies the reason an occurrence of [Mental Health Absence Without Leave](#) ended. The reason the [Mental Health Absence Without Leave](#) ended.

National Codes:

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

MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON_ renamed from ABSENCE WITHOUT LEAVE END REASON

Change to Attribute: Changed Description, Dataset, Name

- Changed Description
- null
- Changed Name from Data_Dictionary.Attributes.A.ABSENCE_WITHOUT_LEAVE_END_REASON to Data_Dictionary.Attributes.M.Men.MENTAL_HEALTH_ABSENCE_WITHOUT_LEAVE_END_REASON

MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY_ renamed from MENTAL HEALTH ABSOLUTE DISCHARGE END METHOD

Change to Attribute: Changed Description, Dataset, Name

The body or [PERSON](#) responsible for granting absolute discharge. The body or [PERSON](#) responsible for granting a Mental Health Absolute Discharge.

National Codes:

- ~~01~~ Tribunal
- [01](#) Mental Health Tribunal
- 02 Secretary of State

MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY_ renamed from MENTAL HEALTH ABSOLUTE DISCHARGE END METHOD

Change to Attribute: Changed Description, Dataset, Name

- Changed Description
- null
- Changed Name from Data_Dictionary.Attributes.M.Men.MENTAL_HEALTH_ABSOLUTE_DISCHARGE_END_METHOD to Data_Dictionary.Attributes.M.Men.MENTAL_HEALTH_ABSOLUTE_DISCHARGE_RESPONSIBILITY

MENTAL HEALTH ACT 2007 MENTAL CATEGORY

Change to Attribute: Changed Description, Dataset

The primary reason for the detention of [PATIENTS](#) under the Mental Health Act 1983, as amended by the Mental Health Act 2007.

[MENTAL HEALTH ACT 2007 MENTAL CATEGORY](#) should be used for [PATIENTS](#) detained from 3rd November 2008 when the relevant section of the Mental Health Act 2007 comes into force, and replaces [MENTAL CATEGORY](#) which is applicable until then.

A [PATIENT](#) should be included under only one [MENTAL HEALTH ACT 2007 MENTAL CATEGORY](#).

National Codes:

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

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON_ renamed from MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD END REASON CODE

Change to Attribute: Changed Description, Dataset, Name

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

National Codes:

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

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON_ renamed from MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD END REASON CODE

Change to Attribute: Changed Description, Dataset, Name

- Changed Description
- null
- Changed Name from Data_Dictionary.Attributes.M.Men.MENTAL_HEALTH_ACT_LEGAL_STATUS_CLASSIFICATION_PERIOD_END to Data_Dictionary.Attributes.M.Men.MENTAL_HEALTH_ACT_LEGAL_STATUS_CLASSIFICATION_ASSIGNMENT

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON_ renamed from MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD START REASON CODE

Change to Attribute: Changed Description, Dataset, Name

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

National Codes:

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

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON_ renamed from MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD START REASON CODE

Change to Attribute: Changed Description, Dataset, Name

- Changed Description
- null
- Changed Name from Data_Dictionary.Attributes.M.Men.MENTAL_HEALTH_ACT_LEGAL_STATUS_CLASSIFICATION_PERIOD_STA to Data_Dictionary.Attributes.M.Men.MENTAL_HEALTH_ACT_LEGAL_STATUS_CLASSIFICATION_ASSIGNMENT

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE

Change to Attribute: Changed Description, Dataset

A classification of [Mental Health Act Legal Status](#). The classification 'informal' is used for those [PATIENTS](#) who are not formally detained or not receiving supervised aftercare. A code to identify the classification of Mental Health Act Legal Status.

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

National Codes:

- 01 Informal
- 02 Formally detained under Mental Health Act Section 2
- 03 Formally detained under Mental Health Act Section 3
- 04 Formally detained under Mental Health Act Section 4
- 05 Formally detained under Mental Health Act Section 5(2)
- 06 Formally detained under Mental Health Act Section 5(4)
- 07 Formally detained under Mental Health Act Section 35
- 08 Formally detained under Mental Health Act Section 36
- 09 Formally detained under Mental Health Act Section 37 with section 41 restrictions
- 10 Formally detained under Mental Health Act Section 37
- 12 Formally detained under Mental Health Act Section 38
- 13 Formally detained under Mental Health Act Section 44
- 14 Formally detained under Mental Health Act Section 46
- 15 Formally detained under Mental Health Act Section 47 with section 49 restrictions
- 16 Formally detained under Mental Health Act Section 47
- 17 Formally detained under Mental Health Act Section 48 with section 49 restrictions
- 18 Formally detained under Mental Health Act Section 48
- 19 Formally detained under Mental Health Act Section 135
- 20 Formally detained under Mental Health Act Section 136
- 31 Formally detained under Criminal Procedure (Insanity) Act 1964 as amended by the Criminal Procedures (Insanity and Unfitness to Plead) Act 1991
- 32 Formally detained under other acts
- 33 Supervised Discharge (Mental Health (Patients in the Community) Act 1995) (Retired 03 November 2008 - but may apply to some patients until 3 May 2009)
- 34 Formally detained under Mental Health Act Section 45A (Retired 01 September 2014)
- 35 Subject to guardianship under Mental Health Act Section 7
- 36 Subject to guardianship under Mental Health Act Section 37
- 37 Formally detained under Mental Health Act Section 45A (Limited direction in force)
- 38 Formally detained under Mental Health Act Section 45A (Limitation direction ended)

MENTAL HEALTH CARE CLUSTER END REASON

Change to Attribute: Changed Description

The reason that the assignment of a [PATIENT](#) to a [Mental Health Care Cluster](#) ended. The reason that the assignment of a [PATIENT](#) to an Adult Mental Health Care Cluster ended.

National Codes:

- 01 [PATIENT](#) assigned to another [Mental Health Care Cluster](#) following a [Mental Health Clustering Tool](#) re-assessment
- 02 [PATIENT](#) discharged from Mental Health services
- 01 [PATIENT](#) assigned to another [Adult Mental Health Care Cluster](#) following an [Adult Mental Health Clustering Tool](#) re-assessment
- 02 [PATIENT](#) discharged from [Mental Health Services](#)

- 03 [PATIENT](#) transferred to another [Health Care Provider](#)
- 04 [PATIENT](#) died
- 05 [PATIENT](#) transferred to [SERVICE](#) not in scope of [National Tariff Payment System](#) within same [Health Care Provider](#)

MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE

Change to Attribute: Changed Dataset

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

National Codes:

- A Non-Psychotic
- B Psychotic
- C Organic

MENTAL HEALTH CONDITIONAL DISCHARGE END REASON

Change to Attribute: Changed Description, Dataset

~~The reason for the termination of a [Mental Health Conditional Discharge Period](#).~~ The reason a [Mental Health Conditional Discharge Period](#) ended.

National Codes:

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

MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE

Change to Attribute: Changed Dataset

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

National Codes:

- 01 NHS
- 02 Social Care
- 03 Both (NHS and Social Care)

MENTAL HEALTH DELAYED DISCHARGE REASON

Change to Attribute: Changed Description, Dataset

~~The reason that a [Mental Health Delayed Discharge Period](#) was initiated for a [PATIENT](#) during a [Consultant Episode \(Hospital Provider\)](#).~~ The reason that a [Mental Health Delayed Discharge Period](#) was initiated for a [PATIENT](#).

National Codes:

- A1 Awaiting completion of assessment
- B1 Awaiting public funding

- C1 Awaiting further non-acute (including community and mental health) NHS care (including intermediate care, rehabilitation services etc)
- ~~D1 Awaiting residential home placement or availability~~
- ~~D2 Awaiting nursing home placement or availability~~
- D1 Awaiting Care Home Without Nursing placement or availability
- D2 Awaiting Care Home With Nursing placement or availability
- E1 Awaiting care package in own home
- F1 Awaiting community equipment and adaptations
- G1 PATIENT or family choice
- H1 Disputes
- I1 Housing - PATIENT not covered by NHS and Community Care Act
- J1 Awaiting availability of social care support
- K1 Awaiting availability of local health service provision
- Z1 Other Reason

MENTAL HEALTH LEAVE OF ABSENCE END REASON_ renamed from LEAVE OF ABSENCE END REASON

Change to Attribute: Changed Description, Dataset, Name

A coding which identifies the reason a Mental Health Leave of Absence was terminated. The reason a Mental Health Leave of Absence ended.

National Codes:

- 01 PATIENT returned on or before day specified
- 02 Leave revoked and PATIENT recalled by Mental Health Responsible Clinician
- 03 Period of leave to be extended
- 04 PATIENT failed to return on or before day specified and is absent without leave
- 05 PATIENT's liability for detention terminated by Mental Health Responsible Clinician
- 06 PATIENT's liability for detention terminated by Mental Health Act Review Tribunal
- 07 PATIENT's liability for detention terminated by Hospital Managers
- 08 PATIENT died
- 96 Other

MENTAL HEALTH LEAVE OF ABSENCE END REASON_ renamed from LEAVE OF ABSENCE END REASON

Change to Attribute: Changed Description, Dataset, Name

- Changed Description
- null
- Changed Name from Data_Dictionary.Attributes.L.LEAVE_OF_ABSENCE_END_REASON to Data_Dictionary.Attributes.M.Men.MENTAL_HEALTH_LEAVE_OF_ABSENCE_END_REASON

NHS NUMBER

Change to Attribute: Changed Dataset

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

This will not vary by any ORGANISATION of which a PERSON is a PATIENT.

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

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

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

Digit Position

(starting from the left) Factor:

1	10
2	9
3	8
4	7
5	6
6	5
7	4
8	3
9	2

Step 2 Add the results of each multiplication together.

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

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

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

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

Further guidance is available from the [Health and Social Care Information Centre website](#).

Note:

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

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

NHS OCCUPATION CODE

Change to Attribute: Changed Dataset

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

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

NHS SERVICE AGREEMENT LINE NUMBER

Change to Attribute: Changed Dataset

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

OBSERVATION SCHEME IN USE

Change to Attribute: New Attribute

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

National Codes:

- 01 [Read Coded Clinical Terms Version 2](#)
- 02 [Read Coded Clinical Terms Version 3 \(CTV3\)](#)
- 03 [Systematized Nomenclature of Medicine Clinical Terms \(SNOMED CT\)](#)

This attribute is also known by these names:

Context	Alias
plural	OBSERVATION SCHEMES IN USE

OBSERVATION SCHEME IN USE

Change to Attribute: New Attribute

OBSERVATION SCHEME IN USE

Data Elements:

[OBSERVATION SCHEME IN USE](#)

OBSERVATION VALUE

Change to Attribute: New Attribute

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

This attribute is also known by these names:

Context	Alias
plural	OBSERVATION VALUES

OBSERVATION VALUE

Change to Attribute: New Attribute

OBSERVATION VALUE

Data Elements:

[OBSERVATION VALUE](#)

OFFERED FOR ADMISSION DATE

Change to Attribute: Changed Description, Dataset

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

ONWARD REFERRAL REASON

Change to Attribute: New Attribute

The reason why the **PATIENT** was referred from one **SERVICE** to another **SERVICE**, which may be in the same or a different **ORGANISATION**.

National Codes:

- 01 Transfer of Clinical Responsibility
- 02 For Opinion Only
- 03 For Diagnostic Test Only
- 04 New Referral (Non Transfer)
- 96 Other

This attribute is also known by these names:

Context	Alias
plural	ONWARD REFERRAL REASONS

ONWARD REFERRAL REASON

Change to Attribute: New Attribute

ONWARD REFERRAL REASON

Data Elements:

ONWARD REFERRAL REASON

ORGANISATION CODE

Change to Attribute: Changed Dataset

An **ORGANISATION CODE** is a code which identifies an **ORGANISATION** uniquely.

ORGANISATION CODES are managed by:

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

Notes:

- [Organisation Data Service](#) codes can be downloaded:
 - from the [Organisation Data Service website](#) and
 - via files issued by the [Technology Reference Data Update Distribution Service \(TRUD\)](#)
- [Organisation Data Service](#) contact details can be found at [Contact Details](#).

ORGANISATION CODING FRAMES

- All NHS **ORGANISATIONS** are coded using coding frames, as shown in the tables below:

Character Position	1	2	3	4	5	6	7	8
---------------------------	----------	----------	----------	----------	----------	----------	----------	----------

Format	a/n	a/n	a/n	a/n	a/n	a/n	a/n	a/n
A Frame	Organisation Type Identifier	Organisation Identifier						
B Frame	Organisation Type Identifier		Organisation Identifier					
C Frame	Organisation Type Identifier	Organisation Identifier						
D Frame	Organisation Type Identifier	Organisation Identifier						
E Frame	Organisation Identifier							
F Frame	Organisation Type Identifier	Organisation Identifier						
G Frame	Organisation Type Identifier	Practice Identifier						
H Frame	Organisation Type Identifier	Organisation Identifier						
I Frame	Organisation Type Identifier	Organisation Identifier						
K Frame	Organisation Identifier							
L Frame	Organisation Type Identifier		Organisation Identifier	Organisation Type Identifier				
M Frame								

	Organisation and Organisation Type Identifier					
N Frame	Organisation Type Identifier	Organisation Identifier				

A Frame:

Example

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

- 8 = Organisation Type Identifier
- Remainder = Organisation Identifier

B Frame:

Example

Local Service Provider e.g. LSP01

- LSP = Organisation Type Identifier
- 01 = Organisation Identifier

Also:

Application Service Provider	e.g. YGM01
Education Establishment	e.g. YDF01
NHS Support Agency	e.g. YDD01

C Frame:

Example

[School](#) e.g. EE134290

- EE = Organisation Type Identifier
- Remainder = Organisation Identifier

D Frame:

Example

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

- T = Organisation Type Identifier
- AK = Organisation Identifier

Also:

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

E Frame:

Example

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

- K = Organisation Identifier

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

F Frame:

Example

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

- P = Organisation Type Identifier
- 001 = Organisation Identifier

Also:

[Care Home](#) Headquarters

e.g.CA0A

[Optical Headquarters](#)

e.g.T1A1

G Frame:

Example

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

- Y = Organisation Type Identifier
- 00001 = Practice Identifier

Also:

[Dental Practice](#)

e.g.V20052

H Frame:

Example

Cancer Network e.g. N01

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

Also:

Booking Management System (BMS) Call Centre Establishment

e.g. YF1

Government Department

e.g. XDA

[Independent Sector Healthcare Provider \(ISHP\)](#) (where the 2nd character is alpha)

e.g. NV7

National Application Service Provider

e.g. YEA

[Other Statutory Authority \(OSA\)](#)

e.g. X16

I Frame:

Example

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

- T1 = Organisation Type Identifier
- 150 = Organisation Identifier

K Frame:**Example**

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

- W00 = Organisation Identifier
-

L Frame:**Example**

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

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

Note: this is a 5 character method of displaying [Northern Ireland Local Commissioning Group](#) identifiers. Characters 3 and 5 are 'fillers'. If a 3 character code is required (as used by the [Office for National Statistics](#) in the [NHS Postcode Directory](#)) zeros can be omitted, e.g. ZC1.

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

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

M Frame:**Example**

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

- 12A = Organisation and Organisation Type Identifier

Also:

[Local Authority](#)

e.g.000

N Frame:**Example**

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

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

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

ORGANISATION CODES TABLES**Table 1: CODING FORMATS FOR ORGANISATIONS IN ENGLAND AND WALES**

Organisation Type	Frame Type	Character Position							Code allocated by:	Notes/Comments

	See Coding Frames Table	1	2	3	4	5	6	7	8		
Application Service Provider	B	Y	G	M	A-9	A-9				ODS	E.g. YGM01
Booking Management System (BMS) Call Centre Establishment	H	Y	F	A-9						ODS	E.g. YF1
Cancer Network	H	N	0-9	A-9						ODS	E.g. N01
Cancer Registry	A	Y	0-9	0-9	0-9	0-9				ODS	E.g. Y0401
Care Home Headquarters	F	A, C or D	A-9	A-9	A-9					ODS	E.g. CA0A
Care Trust (CT)	D	T	A-Y	A-Y						ODS	E.g. TAK
Clinical Commissioning Group (CCG)	M	0-9	0-9	A-Y						ODS	E.g. 12A
Clinical Network	B	Y	D	G	A-9	A-9				ODS	E.g. YDG01
Commissioning Support Unit (CSU) / Data Management and Integration Centre (DMIC) / Data Services for Commissioners Regional Office (DSCRO)	D	0	A-Y	A-Y						ODS	E.g. 0AA
Dental Practice - England and Wales	G	V	0-9	0-9	0-9	0-9	0-9			NHS Dental Services	E.g. V20052
Education Establishment	B	Y	D	F	A-9	A-9				ODS	E.g. YDF01

Executive Agency	N/A See Note 1	X	0-9	0-9						ODS	E.g. X09
Executive Agency Programme	N/A See Note 1	X	0-9	0-9	0-9	0-9	0-9			ODS	First three characters denote Executive Agency E.g. X09001
Government Department	H	X	A-Y	A-Y						ODS	E.g. XDA
Government Office Region (GOR)	E	A-Y								ONS	E.g. K Government Office Regions (GORs) closed 31 March 2011 - from 1 April 2011 referred to as Regions
GP Abeyance and Dispersal GP Practice	N	G	7	8	0-9	0-9	0-9	0-9	0-9	ODS	E.g. G7817414
GP Practices in England and Wales	G	A-H, J-N, P, W & Y	0-9	0-9	0-9	0-9	0-9			NHS Prescription Services	Char 1 = W for Welsh GP Practice . All other values represent GP Practices in England. Note: from 2003, ALL newly allocated Practice Codes in England begin with a Y E.g. Y00001
Justice Organisation	D	V or W	A-Y	A-9						ODS	E.g. VAA
High Level Health Geography, e.g.	D	Q	A-9	A-9						ODS	E.g. Q72

NHS England Region (Geography)											
Independent Sector Healthcare Provider (ISHP)	H	A, B, D, G, I, K, L, M, N, O, S, U, V, W	A-Y	A-Y, 0-9						ODS	E.g. NV7
Local Authority (LA)	M	0-9	0-9	0-9						ODS	E.g. 000
Local Health Board (Wales)	B	7	A-9	A-9						ODS	E.g. 7A1
Local Service Provider (LSP)	B	L	S	P	0-9	0-9				ODS	E.g. LSP01
Military Hospital	B	X	M	D	A-9	A-9				ODS	E.g. XMDA1
National Application Service Provider	H	Y	E	A-9						ODS	E.g. YEA
National Groupings (England)	H	Y	5	0-9						ODS	E.g. Y51
NHS Support Agency	B	Y	D	D	A-9	A-9				ODS	E.g. YDD01
NHS Trust	D	R	A-9	A-9						ODS	E.g. RH8
NHS Wales Informatics Service (NWIS)	K	W	0	0						ODS	Only one organisation of this type exists for Wales E.g. W00
	A	8	A-Y	A-9	0-9	0-9				ODS	E.g. 8HA03

Non NHS Organisation (Independent Provider)											
Northern Ireland Health & Social Care Board	N/A	Z	B	0	0	1				ODS	E.g. ZB001
Northern Ireland Health & Social Care Trust	I	Z	T	0-9	0-9	0-9				ODS	E.g. ZT001
Northern Ireland Local Commissioning Group	L	Z	C	0	0-9	0				Department for Health, Social Services and Public Safety (DHSSPS), Northern Ireland	E.g. ZC010 Note that characters 3 and 5 are 'fillers' to create a 5 character code. If a 3 character code is required (as used by the Office for National Statistics in the NHS Postcode Directory), zeros can be omitted and fits under the H frame: E.g. ZC1. <i>Guidance on the use of Northern Ireland codes can be found in Data Set Change Notice 19/2009.</i>
Optical Headquarters	F	T	0-9	A-9	A-9					ODS	E.g. T1A1
Other Statutory Authority (OSA)	H	X	0-9	0-9						ODS	E.g. X16
Pharmacy	A	F	A-Y	A-9	A-9	A-9				ODS	E.g. FA002
Pharmacy Headquarters	F	P	A-9	A-9	A-9					ODS	E.g. P001
Primary Care Trust (PCT)	D	5	A-9	A-9						ODS	E.g. 5CT

												All Primary Care Trusts closed 31 March 2013
Prison Health Service	B	Y	D	E	A-9	A-9					ODS	E.g. YDE01
School	C	E	E	A-9	A-9	A-9	A-9	A-9	A-9		Department for Education and ODS	E.g. EE134290
Special Health Authority (SpHA)	I	T	1	0-9	0-9	0					ODS	E.g. T1150
Strategic Health Authority (SHA)	D	Q	A-9	A-9							ODS	E.g. Q30 All Strategic Health Authorities in England closed 31 March 2013
Welsh Assembly	D	W	0-9	0-9							ODS	E.g. W01
Welsh Health Commission	A	W	0-9	0-9	A-Y	A-Y					ODS	E.g. W01HC

Notes:

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

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

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

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

Table 2: CODING FORMATS FOR ORGANISATIONS IN SCOTLAND

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

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

Table 3: CODING FORMATS for ORGANISATIONS in OTHER HOME COUNTRIES

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

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

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

ORGANISATION SITE CODE

Change to Attribute: Changed Dataset

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

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

Notes:

- [Organisation Data Service](#) codes can be downloaded:
 - from the [Organisation Data Service website](#) and
 - via files issued by the [Technology Reference Data Update Distribution Service \(TRUD\)](#)
- [Organisation Data Service](#) contact details can be found at [Contact Details](#).

ORGANISATION SITE CODING FRAMES

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

Character Position	1	2	3	4	5	6	7	8	9
Format	a/n	a/n	a/n	a/n	a/n	a/n	a/n	a/n	a/n
A Frame	Organisation Type Identifier			Organisation Identifier		Site or Sub-Division Identifier			
B Frame		Organisation Identifier		Site or Sub-Division Identifier					

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

A Frame:

Example

Local Service Provider Site e.g. LSP0101

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

B Frame:

Example

Care Trust Site e.g. TAK01

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

Also:

Government Department Site	e.g. XDA01
High Level Health Geography Site, e.g. NHS England Region (Geography) site	e.g. Q7201
Local Authority Site	e.g. 000AA
Local Health Board (Wales) Site	e.g. 7A101
NHS Trust Site	e.g. RH802
Other Statutory Authority (OSA) Site	e.g. X1601
	e.g. Q3001

C Frame:

Example

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

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

D Frame

Example

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

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

F Frame

Example

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

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

H Frame

Example

Prison: e.g. YDE01

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

I Frame

Example

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

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

J Frame

Example

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

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

Also:

Health Observatory e.g. XP001

[Primary Healthcare Directorate \(Isle of Man\)](#) Site e.g. YK101

K Frame

Example

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

- 11A = Organisation and Organisation Type Identifier
- AA = Organisation Site Identifier

L Frame

Example

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

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

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

NHS ORGANISATION SITE CODES TABLES

Coding Formats

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

Organisation Site Type	Frame Type	Character Position									Code allocated by:	Notes/Comments	
		1	2	3	4	5	6	7	8	9			
	See Coding Frames Table												
Care Home Site	J	V	L, M or N	A-9	A-9	A-9						ODS	E.g. VN01A, VM01A, VL01A
Care Trust Site	B	T	A-Y	A-Y	A-9	A-9						ODS	

												First three characters denote owning Care Trust E.g. TAK01
Clinical Commissioning Group (CCG) Site	K	0-9	0-9	A-Y	A-Y	A-Y					ODS	First three characters denote owning Clinical Commissioning Group E.g. 11AAA - 99YZZ
Commissioning Support Unit (CSU) Site	F	0	A-Y	A-Y	A-9	A-9					ODS	E.g. 0AA01
Executive Agency Site	N/A See Note	X	0-9	0-9	0-9	0-9					ODS	First three characters denote Executive Agency E.g. X0901
Government Department Site	B	X	A-Y	A-Y	0-9	0-9					ODS	First three characters denote Government Department E.g. XDA01
GP Practice Branch Surgery - England and Wales	D	A-H, J-N, P, W & Y	0-9	0-9	0-9	0-9	0-9	0-9	0-9	0-9	ODS	First 6 characters denote parent practice. Char 1 = W for Welsh GP Practice . All other values represent English GP Practices E.g. H81010002
Health Observatory	J	X	P	0-9	0-9	0-9					ODS	E.g. XP001
High Level Health Geography Site, e.g. NHS England Region (Geography) site	B	Q	A-9	A-9	A-9	A-9					ODS	E.g. Q7201
	C		A-Y								ODS	

Independent Sector Healthcare Provider (ISHP) Site		A, B, D, G, I, K, L, M, N, O, S, U, V, W		A-Y, 0-9	A-Y, 0-9	A-Y, 0-9						First three characters denote owning Independent Sector Healthcare Provider (ISHP) E.g. NV701 Note: The A-Y range includes all letters except Z
Local Authority (LA) Site	B	0-9	0-9	0-9	A-Z	A-Z					ODS	First three characters denote parent Local Authority E.g. 000AA
Local Health Board (Wales) Site	B	7	A-9	A-9	A-9	A-9					ODS	First three characters denote owning NHS Trust E.g. 7A101
Local Service Provider Site	A	L	S	P	0-9	0-9	0-9	0-9			ODS	First five characters denote owning Local Service Provider E.g. LSP0101
NHS Trust Site	B	R	A-9	A-9	A-9	A-9					ODS	First three characters denote owning NHS Trust E.g. RH802
Optical Site	I	T	P or Q	0-9	A-9	A-9					ODS	E.g. TP01A, TQ01A
Other Statutory Authority (OSA) Site	B	X	0-9	0-9	0-9	0-9					ODS	First three characters denote owning Other Statutory Authority E.g. X1601
Primary Care Trust (PCT) Site	B	5	A-9	A-9	A-9	A-9					ODS	First three characters denote owning Primary Care Trust E.g. 5CT49

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

Note:

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

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

PERSON DEATH DATE

Change to Attribute: Changed Dataset

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

This is as recorded on the Death Certificate.

Note:

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

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

PERSON PROPERTY ASSIGNMENT PERIOD TYPE

Change to Attribute: New Attribute

The type of [PERSON PROPERTY ASSIGNMENT PERIOD](#).

National Codes:

[Care Cluster Assignment Period](#)

[Mental Health Act Legal Status Classification Assignment Period](#)

Note: This list is not in alphabetical order.

This attribute is also known by these names:

Context	Alias
plural	PERSON PROPERTY ASSIGNMENT PERIOD TYPES

PERSON PROPERTY EFFECTIVE DATE

Change to Attribute: Changed Dataset

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

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

PERSON PROPERTY EFFECTIVE END DATE

Change to Attribute: Changed Dataset

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

PERSON PROPERTY EFFECTIVE END TIME

Change to Attribute: Changed Dataset

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

PERSON PROPERTY OBSERVED DATE

Change to Attribute: Changed Dataset

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

PERSON PROPERTY RECORDED DATE

Change to Attribute: Changed Description, Dataset

The date when the [PERSON PROPERTY](#) was recorded by a [PERSON](#). ~~In a computerised system this data would be derived from the time the information was entered.~~

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

PERSON SCORE

Change to Attribute: Changed Dataset

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

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

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

PERSON STATED GENDER CODE

Change to Attribute: Changed Dataset

The gender of a [PERSON](#).

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

National Codes:

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

[PERSON STATED GENDER CODE](#) replaces [PERSON GENDER CODE](#) and should be used for all new and developing data sets and for XML messages.

PLANNED ACTIVITY DATE

Change to Attribute: New Attribute

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

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

This attribute is also known by these names:

Context	Alias
plural	PLANNED ACTIVITY DATES

PLANNED ACTIVITY DATE

Change to Attribute: New Attribute

PLANNED ACTIVITY DATE

Data Elements:

PLANNED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)
--

PLANNED ACTIVITY DATE TYPE

Change to Attribute: New Attribute

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

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

National Codes:

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

Note: This list is not in alphabetical order.

This attribute is also known by these names:

Context	Alias
plural	PLANNED ACTIVITY DATE TYPES

POSTCODE

Change to Attribute: Changed Dataset

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

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

Note:

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

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

PRESCRIPTION DATE

Change to Attribute: Changed Dataset

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

PROCEDURE SCHEME IN USE

Change to Attribute: New Attribute

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

National Codes:

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

Notes:

- * [Read Coded Clinical Terms Version 3 \(CTV3\)](#) with qualifiers (previously known as 3.1) is not supported in the Commissioning Data Sets
- ** [Systematized Nomenclature of Medicine Clinical Terms \(SNOMED CT\)](#) is not valid for Commissioning Data Set version 6-1 and 6-2
- *** [Accident & Emergency Treatment](#) and [OPCS-4](#) are not valid for the [Mental Health Services Data Set](#).

This attribute is also known by these names:

Context	Alias
plural	PROCEDURE SCHEMES IN USE

PROCEDURE SCHEME IN USE

Change to Attribute: New Attribute

PROCEDURE SCHEME IN USE**Data Elements:**

PROCEDURE SCHEME IN USE

PROFESSIONAL REGISTRATION BODY CODE

Change to Attribute: Changed Description, Dataset

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

National Codes:

- 01 [General Chiropractic Council](#)

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

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

PROFESSIONAL REGISTRATION ENTRY IDENTIFIER

Change to Attribute: Changed Dataset

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

Examples include:

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

REASON FOR REFERRAL TO MENTAL HEALTH

Change to Attribute: New Attribute

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

National Codes:

- 01 (Suspected) First Episode Psychosis
- 02 Ongoing or Recurrent Psychosis
- 03 Bi polar disorder
- 04 Depression
- 05 Anxiety
- 06 Obsessive compulsive disorder
- 07 Phobias
- 08 Organic brain disorder
- 09 Drug and alcohol difficulties
- 10 Unexplained physical symptoms
- 11 Post-traumatic stress disorder
- 12 Eating disorders
- 13 Perinatal mental health issues
- 14 Personality disorders
- 15 Self harm behaviours

- 16 Conduct disorders
- 17 Neurodevelopmental conditions
- 18 In crisis
- 19 Relationship difficulties
- 20 Gender Discomfort issues
- 21 Attachment difficulties
- 22 Self - care issues
- 23 Adjustment to health issues

This attribute is also known by these names:

Context	Alias
plural	REASONS FOR REFERRAL TO MENTAL HEALTH

REASON FOR REFERRAL TO MENTAL HEALTH

Change to Attribute: New Attribute

REASON FOR REFERRAL TO MENTAL HEALTH

Data Elements:

OTHER REASON FOR REFERRAL (MENTAL HEALTH)
PRIMARY REASON FOR REFERRAL (MENTAL HEALTH)

REFERRAL CLOSURE REASON

Change to Attribute: New Attribute

The reason that a REFERRAL REQUEST was closed by a Health Care Provider.

National Codes:

- 01 Admitted elsewhere (at the same or other Health Care Provider)
- 02 Treatment completed
- 03 Moved out of the area
- 04 No further treatment appropriate
- 05 PATIENT did not attend
- 06 PATIENT died
- 07 PATIENT requested discharge
- 08 Referred to other speciality/SERVICE (at the same or other Health Care Provider)
- 09 PATIENT refused to be seen

This attribute is also known by these names:

Context	Alias
plural	REFERRAL CLOSURE REASONS

REFERRAL CLOSURE REASON

Change to Attribute: New Attribute

REFERRAL CLOSURE REASON

Data Elements:

REFERRAL CLOSURE REASON

REFERRAL REJECTION REASON

Change to Attribute: New Attribute

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

National Codes:

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

This attribute is also known by these names:

Context	Alias
plural	REFERRAL REJECTION REASONS

REFERRAL REJECTION REASON

Change to Attribute: New Attribute

REFERRAL REJECTION REASON

Data Elements:

REFERRAL REJECTION REASON

REFERRAL REQUEST RECEIVED DATE

Change to Attribute: Changed Dataset

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

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

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

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

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

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

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

REFERRAL REQUEST RECEIVED TIME

Change to Attribute: Changed Dataset

The time the [REFERRAL REQUEST](#) was received.

REFERRAL TO TREATMENT PERIOD END DATE

Change to Attribute: Changed Dataset

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

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

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

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

or

- the [PERSON DEATH DATE](#).

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

REFERRAL TO TREATMENT PERIOD START DATE

Change to Attribute: Changed Dataset

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

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

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

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

Referral To Treatment Consultant Led Waiting Times:

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

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

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

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

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

Allied Health Professional Referral To Treatment Measurement:

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

REFERRAL TO TREATMENT PERIOD STATUS

Change to Attribute: Changed Dataset

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

National Codes:

The first [ACTIVITY](#) in a [REFERRAL TO TREATMENT PERIOD](#) where the [First Definitive Treatment](#) will be a subsequent [ACTIVITY](#)

- 10 first [ACTIVITY](#) - first [ACTIVITY](#) in a [REFERRAL TO TREATMENT PERIOD](#)
- 11 [Active Monitoring](#) end - first [ACTIVITY](#) at the start of a new [REFERRAL TO TREATMENT PERIOD](#) following [Active Monitoring](#)
- 12 [CONSULTANT](#) or [NHS Allied Health Professional Service \(Referral To Treatment Measurement\)](#) referral - the first [ACTIVITY](#) at the start of a new [REFERRAL TO TREATMENT PERIOD](#) following a decision to refer directly to the [CONSULTANT](#) or [NHS Allied Health Professional Service \(Referral To Treatment Measurement\)](#) for a separate condition

Subsequent [ACTIVITY](#) during a [REFERRAL TO TREATMENT PERIOD](#)

- 20 subsequent [ACTIVITY](#) during a [REFERRAL TO TREATMENT PERIOD](#) - further [ACTIVITIES](#) anticipated
- 21 transfer to another [Health Care Provider](#) - subsequent [ACTIVITY](#) by another [Health Care Provider](#) during a [REFERRAL TO TREATMENT PERIOD](#) anticipated

[ACTIVITY](#) that ends the [REFERRAL TO TREATMENT PERIOD](#)

- 30 Start of [First Definitive Treatment](#)
- 31 start of [Active Monitoring](#) initiated by the [PATIENT](#)
- 32 start of [Active Monitoring](#) initiated by the [CARE PROFESSIONAL](#)
- 33 Did not attend - the [PATIENT](#) did not attend the first [CARE ACTIVITY](#) after the referral¹
- 34 decision not to treat - decision not to treat made or no further contact required²
- 35 [PATIENT](#) declined offered treatment
- 36 [PATIENT](#) died before treatment

[ACTIVITY](#) that is not part of a [REFERRAL TO TREATMENT PERIOD](#)

- 90 after treatment - [First Definitive Treatment](#) occurred previously (e.g. admitted as an emergency from A&E or the [ACTIVITY](#) is after the start of treatment)
- 91 [Active Monitoring](#) - [CARE ACTIVITY](#) during [Active Monitoring](#)
- 92 not yet referred - not yet referred for treatment, undergoing diagnostic tests by [GENERAL PRACTITIONER](#) before referral
- 98 not applicable - [ACTIVITY](#) not applicable to [REFERRAL TO TREATMENT PERIODS](#)

[ACTIVITY](#) where the [REFERRAL TO TREATMENT PERIOD STATUS](#) is not yet known

- 99 not yet known

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

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

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

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

[APPOINTMENT](#) was clearly communicated to the [PATIENT](#).

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

² Decision not to treat

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

- a [Discharge After Patient Did Not Attend](#) the second or a subsequent [CARE ACTIVITY](#) after the referral.
- a change resulting in care no longer being commissioned by the English NHS.
- a referral to a [Consultant Led Service](#) during a [Referral To Treatment Period Excluded From Target](#) for the same condition, disease or injury. A new [REFERRAL TO TREATMENT PERIOD](#) will start.

REFERRING CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH AND COMMUNITY CARE

Change to Attribute: New Attribute

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

National Codes:

Allied Health Professionals	
A01	Art Therapist
A02	Clinical Psychologist
A03	Dietitian
A04	Drama Therapist
A05	Music Therapist
A06	Occupational Therapist
A07	Orthotist
A08	Physiotherapist
A09	Podiatrist
A10	Prosthetist
A11	Psychotherapist
A12	Radiographer
A13	Speech and Language Therapist
A14	Orthoptist
Medical/Dental	
M01	Community Dentist
M02	CONSULTANT
M03	GENERAL MEDICAL PRACTITIONER
M04	General Practitioner With A Special Interest
Nursing, Health Visiting and Midwifery	
N01	MIDWIFE
N02	District NURSE
N03	Health Visitor
N04	Macmillan NURSE
N05	School Nurse
N06	Specialist Nursing - Active Case Management (Community Matrons)
N07	Specialist Nursing - Arthritis Nursing/Liaison
N08	Specialist Nursing - Asthma and Respiratory Nursing/Liaison
N09	Specialist Nursing - Breast Care Nursing/Liaison
N10	Specialist Nursing - Cancer Related
N11	Specialist Nursing - Cardiac Nursing/Liaison
N12	Specialist Nursing - Children's Services

- N13 Specialist Nursing - Community Cystic Fibrosis
- N14 Specialist Nursing - Continence Services
- N15 Specialist Nursing - Diabetic Nursing/Liaison
- N16 Specialist Nursing - Enteral Feeding Nursing Services
- N17 Specialist Nursing - Haemophilia Nursing Services
- N18 Specialist Nursing - HIV/AIDS Nursing Services (Retired 01 September 2015)
- N19 Specialist Nursing - Infectious Diseases
- N20 Specialist Nursing - Intensive Care Nursing
- N21 Specialist Nursing - Palliative/Respite Care
- N22 Specialist Nursing - Parkinson's and Alzheimers Nursing/Liaison
- N23 Specialist Nursing - Rehabilitation Nursing
- N24 Specialist Nursing - Stoma Care Services
- N25 Specialist Nursing - Tissue Viability Nursing/Liaison
- N26 Specialist Nursing - Transplantation Patients Nursing Service
- N27 Specialist Nursing - Treatment Room Nursing Services
- N28 Specialist Nursing - Tuberculosis Specialist Nursing
- N29 Specialist Nursing - Other Specialist Nursing
- N30 Specialist Nursing - Safeguarding
- N31 Practice Nursing
- N32 Staff NURSE
- N33 Other Registered NURSE
- N34 Public Health NURSE
- Other Care Professionals**
- C01 Appliances Technician
- C02 Audiologist
- C03 Counsellor
- C04 Nursery Nurse
- C06 Play Therapist
- C07 Social Worker
- C08 Voluntary Care Worker
- C09 Screeener (in a National Screening Programme)
- C99 Other CARE PROFESSIONAL

This attribute is also known by these names:

Context	Alias
plural	REFERRING CARE PROFESSIONAL STAFF GROUPS FOR MENTAL HEALTH AND COMMUNITY CARE

RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE

Change to Attribute: Changed Dataset

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

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

[RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE](#) is aligned with descriptors for religious and other belief system affiliations in [SNOMED CT](#)® as follows:

- the [SNOMED CT Subset](#):
 - original ID is 10791000000130 and
 - name is Religious or Other Belief System Affiliation.

National Codes:

- A Baha'i
- B Buddhist

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

REPORTING PERIOD END DATE

Change to Attribute: Changed Dataset

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

REPORTING PERIOD START DATE

Change to Attribute: Changed Dataset

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

RESTRICTIVE INTERVENTION TYPE

Change to Attribute: New Attribute

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

National Codes:

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

This attribute is also known by these names:

Context	Alias
plural	RESTRICTIVE INTERVENTION TYPES

RESTRICTIVE INTERVENTION TYPE

Change to Attribute: New Attribute

RESTRICTIVE INTERVENTION TYPE

Data Elements:

RESTRICTIVE INTERVENTION TYPE

SERVICE OR TEAM TYPE FOR MENTAL HEALTH

Change to Attribute: New Attribute

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

National Codes:

General Mental Health Services

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

Forensic Services

- B01 Forensic Mental Health Service
- B02 Forensic Learning Disability Service

Specialist Mental Health Services

- C01 Autistic Spectrum Disorder Service
- C02 Peri-Natal Mental Illness Service
- C03 Eating Disorders/Dietetics Service
- C04 Neurodevelopment Team
- C05 Paediatric Liaison Service
- C06 Looked After Children Service
- C07 Community Young Offenders Service
- C08 Acquired Brain Injury Service

Other Mental Health Services

- D01 Substance Misuse Team
- D02 Criminal Justice Liaison and Diversion Service
- D03 Prison Psychiatric Inreach Service
- D04 Asylum Service

Learning Disability Services

- E01 Community Team for Learning Disabilities
- E02 Epilepsy/Neurological Service
- E03 Specialist Parenting Service

Other

- Z01 Other Mental Health Service - in scope of National Tariff Payment System
- Z02 Other Mental Health Service - out of scope of National Tariff Payment System

This attribute is also known by these names:

Context	Alias
plural	SERVICE OR TEAM TYPES FOR MENTAL HEALTH

SERVICE OR TEAM TYPE FOR MENTAL HEALTH

Change to Attribute: New Attribute

SERVICE OR TEAM TYPE FOR MENTAL HEALTH**Data Elements:**

CARE PROFESSIONAL SERVICE OR TEAM TYPE ASSOCIATION (MENTAL HEALTH)
--

SERVICE OR TEAM TYPE REFERRED TO (MENTAL HEALTH)
--

SERVICE REQUEST IDENTIFIER

Change to Attribute: Changed Dataset

The unique identifier for a [SERVICE REQUEST](#).

SERVICE TYPE

Change to Attribute: Changed Description

The type of [SERVICE](#).

National Codes:

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

SESSION DATE

Change to Attribute: Changed Dataset

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

SETTLED ACCOMMODATION INDICATOR

Change to Attribute: Changed Description, Dataset

An indication of whether the main/permanent residence of a [PATIENT](#) is settled or non-settled accommodation.

~~Settled accommodation refers to secure, medium to long term accommodation.~~ An indication of whether the main/permanent residence of a [PATIENT](#) is settled [ACCOMMODATION](#).

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

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

National Codes:

- ~~0~~ Non-settled Accommodation
- ~~1~~ Settled Accommodation
- Y Yes - Settled [ACCOMMODATION](#)
- N No - Non-settled [ACCOMMODATION](#)
- Z Not Stated ([PERSON](#) asked but declined to provide a response)

SEX OF PATIENTS

Change to Attribute: Changed Dataset

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

Classification:

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

SOURCE OF ADMISSION

Change to Attribute: Changed Dataset

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

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

National Codes:

- 19 Usual place of residence unless listed below, for example, a private dwelling whether owner occupied or owned by [Local Authority](#), housing association or other landlord. This includes wardened accommodation but not residential accommodation where health care is provided. It also includes [PATIENTS](#) with no fixed abode.
- 29 Temporary place of residence when usually resident elsewhere (e.g. hotels, residential [Educational Establishments](#))
- 39 Penal establishment, [Court](#), or Police Station / [Police Custody Suite](#)
- 49 NHS other [Hospital Provider](#) - high security psychiatric accommodation in an NHS [Hospital Provider](#) ([NHS Trust](#) or [NHS Foundation Trust](#))
- 51 NHS other [Hospital Provider](#) - [WARD](#) for general [PATIENTS](#) or the younger physically disabled or A & E department
- 52 NHS other [Hospital Provider](#) - [WARD](#) for maternity [PATIENTS](#) or [Neonates](#)

- 53 NHS other [Hospital Provider](#) - [WARD](#) for [PATIENTS](#) who are mentally ill or have [Learning Disabilities](#)
- 54 NHS run [Care Home](#)
- 65 [Local Authority](#) residential accommodation i.e. where care is provided
- 66 [Local Authority](#) foster care
- 79 Babies born in or on the way to hospital
- 85 Non-NHS (other than [Local Authority](#)) run [Care Home](#)
- 87 Non NHS run hospital
- 88 Non-NHS (other than [Local Authority](#)) run [Hospice](#)

SOURCE OF REFERRAL FOR MENTAL HEALTH

Change to Attribute: Changed Description, Dataset

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

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

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

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

National Codes:

- Primary Health Care**
- A1 [GENERAL MEDICAL PRACTITIONER](#)
- A2 [Health Visitor](#)
- A3 Other Primary Health Care
- Self Referral**
- B1 Self
- B2 Carer
- Local Authority Services**
- C1 Social Services
- C2 Education Service
- Employer**
- D1 Employer
- Justice System**
- E1 Police
- E2 [Courts](#)
- E3 Probation Service
- E4 [Prison](#)
- E5 Court Liaison and Diversion Service
- Child Health**
- F1 [School Nurse](#)
- F2 Hospital-based Paediatrics
- F3 Community-based Paediatrics
- Independent/Voluntary Sector**
- G1 Independent sector - Medium Secure Inpatients
- G2 Independent Sector - Low Secure Inpatients
- ~~G3 Other Independent Sector Mental Health Services~~
- [G3 Other Independent Sector Mental Health Services](#)
- G4 Voluntary Sector
- Acute Secondary Care**
- H1 [Accident and Emergency Department](#)
- H2 Other secondary care specialty

Other Mental Health NHS Trust

- I1 Temporary transfer from another Mental Health NHS Trust
 - I2 Permanent transfer from another Mental Health NHS Trust
- Internal referrals from Community Mental Health Team (within own NHS Trust)**

- ~~J1 Community Mental Health Team (Adult Mental Health)~~
- ~~J2 Community Mental Health Team (Older People)~~
- ~~J3 Community Mental Health Team (Learning Disabilities)~~
- ~~J4 Community Mental Health Team (Child and Adolescent Mental Health)~~
- J1 Community Mental Health Team (Adult Mental Health) ***
- J2 Community Mental Health Team (Older People) ***
- J3 Community Mental Health Team (Learning Disabilities) ***
- J4 Community Mental Health Team (Child and Adolescent Mental Health) ***

Internal referrals from Inpatient Service (within own NHS Trust)

- ~~K1 Inpatient Service (Adult Mental Health)~~
- ~~K2 Inpatient Service (Older People)~~
- ~~K3 Inpatient Service (Forensics)~~
- ~~K4 Inpatient Service (Child and Adolescent Mental Health)~~
- ~~K5 Inpatient Service (Learning Disabilities)~~
- K1 Inpatient Service (Adult Mental Health) ***
- K2 Inpatient Service (Older People) ***
- K3 Inpatient Service (Forensics) ***
- K4 Inpatient Service (Child and Adolescent Mental Health) ***
- K5 Inpatient Service (Learning Disabilities) ***

Transfer by graduation (within own NHS Trust)

- ~~L1 Transfer by graduation from Child and Adolescent Mental Health Services to Adult Mental Health Services~~
- ~~L2 Transfer by graduation from Adult Mental Health Services to Older Peoples Mental Health Services~~
- L1 Transfer by graduation from Child and Adolescent Mental Health Service to Adult Mental Health Services
- L2 Transfer by graduation from Adult Mental Health Services to Older Peoples Mental Health Services

Other

- M1 Asylum Services
- M2 Telephone or Electronic Access Service
- M3 Out of Area Agency
- M4 Drug Action Team / Drug Misuse Agency
- M5 Jobcentre Plus **
- ~~M6 Other service or agency~~
- M6 Other SERVICE or agency
- M7 Single Point of Access Service ****

Improving Access to Psychological Therapies

- N1 Stepped up from low intensity [Improving Access to Psychological Therapies Service](#) *
- N2 Stepped down from high intensity [Improving Access to Psychological Therapies Service](#) *
- N3 [Improving Access to Psychological Therapies Service](#) ****

Internal

- P1 Internal Referral ****

Notes:

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

TREATMENT FUNCTION CODE

Change to Attribute: Changed Dataset

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

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

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

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

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

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

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

Assigning a Treatment Function Code:

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

For further information, contact the [Health and Social Care Information Centre](#) by email at: enquiries@hscic.gov.uk with the subject "Main Specialty and Treatment Function Codes".

National Codes:

Code	Treatment Function Title	Comments
Surgical Specialties		
100	GENERAL SURGERY	Includes sub-categories not elsewhere listed e.g. endocrine surgery
101	UROLOGY	Surgical treatment of disorders of the urinary system and male reproductive system
102	TRANSPLANTATION SURGERY	Includes pre- and post-operative care for major organ transplants except heart and lung (see Cardiothoracic Transplantation). Excludes corneal grafts
103	BREAST SURGERY	Includes treatment for cancer, suspected neoplasms, cysts and post-cancer reconstructive surgery. Excludes cosmetic surgery

104	COLORECTAL SURGERY	Surgical treatment of disorders of the lower intestine (colon, anus and rectum)
105	HEPATOBIILIARY & PANCREATIC SURGERY	Includes liver surgery, but liver transplantation should be recorded in 102 Transplantation Surgery
106	UPPER GASTROINTESTINAL SURGERY	Surgical treatment of disorders of the upper parts of the gastrointestinal tract
107	VASCULAR SURGERY	Surgical treatment of diseases of the vascular system
108	SPINAL SURGERY SERVICE	Surgery concentrating on specialised and complex treatment of the back and spine. The SERVICE has a significantly different composition and profile from the SERVICE provided in TREATMENT FUNCTION CODE - 110 Trauma & Orthopaedic. Excludes Spinal Injuries - see TREATMENT FUNCTION CODE 323
110	TRAUMA & ORTHOPAEDICS	Surgery to treat injuries, congenital and acquired disorders of the bones, joints, and their associated soft tissues, including ligaments, nerves and muscles. Excludes Spinal Surgery Service - see TREATMENT FUNCTION CODE 108
120	ENT	Ear, nose and throat
130	OPHTHALMOLOGY	The surgical treatment of disorders and diseases of the eye. Excludes Medical Ophthalmology - see TREATMENT FUNCTION CODE 460
140	ORAL SURGERY	The diagnosis and surgical treatment of diseases, injuries and defects involving both the functional and aesthetic aspects of the hard and soft tissues of the head, mouth, teeth, gums, jaws and neck
141	RESTORATIVE DENTISTRY	Endodontics, Periodontics and Prosthodontics are all part of Restorative Dentistry
142	PAEDIATRIC DENTISTRY	Dentistry SERVICES dedicated to children with appropriate facilities and support staff
143	ORTHODONTICS	The treatment of malocclusions (improper bites). Orthodontic treatment can focus on dental displacement only, or can deal with the control and modification of facial growth
144	MAXILLO-FACIAL SURGERY	Mouth, jaw and face related surgery
150	NEUROSURGERY	The prevention, diagnosis, treatment, and rehabilitation of disorders which affect any portion of the nervous system including the brain, spinal cord, peripheral nerves, and extra-cranial cerebrovascular system
160	PLASTIC SURGERY	SERVICES to correct or restore form and function. In addition to cosmetic or aesthetic surgery, plastic surgery includes many types of reconstructive surgery, and the treatment of burns
161	BURNS CARE	To be used by recognised specialist units and associated outreach SERVICES only
170	CARDIOTHORACIC SURGERY	Should only be used where there are no separate SERVICES for Cardiac Surgery and Thoracic Surgery
171	PAEDIATRIC SURGERY	This is paediatric general surgery
172	CARDIAC SURGERY	Surgical treatment of the heart or great vessels
173	THORACIC SURGERY	Surgical treatment of diseases affecting organs inside the thorax (the chest). Generally treatment of conditions of the lungs, chest wall, and diaphragm
174	CARDIOTHORACIC TRANSPLANTATION	To be used by recognised specialist units and associated outreach services only. Includes pre- and post-operative services
180	ACCIDENT & EMERGENCY	SERVICES to care for PATIENTS with urgent problems delivered as part of an Accident and Emergency Attendance or admission at an Accident and Emergency Department
191	PAIN MANAGEMENT	Complex pain disorders requiring diagnosis and treatment by a specialist multi-professional team
Other Children's Specialist Services - The Paediatric TREATMENT FUNCTION CODES represent CLINICS OR FACILITIES intended to provide dedicated SERVICES to children with appropriate facilities and support staff,		

i.e. they are designed for children only. If a [CLINIC OR FACILITY](#) provides this but also treats adult [PATIENTS](#) as part of the [SERVICE](#) then a Paediatric [TREATMENT FUNCTION CODE](#) may not be appropriate. The age of the [PATIENT](#) attending does not initiate a change to the [TREATMENT FUNCTION CODE](#) for the [ACTIVITY](#).

211	PAEDIATRIC UROLOGY	Surgical treatment of disorders of the urinary system and male reproductive system
212	PAEDIATRIC TRANSPLANTATION SURGERY	Includes pre- and post-operative care for major organ transplants except heart and lung (see Cardiothoracic Transplantation). Excludes corneal grafts
213	PAEDIATRIC GASTROINTESTINAL SURGERY	Surgical treatment of disorders of the gastrointestinal tract
214	PAEDIATRIC TRAUMA AND ORTHOPAEDICS	Surgery to treat injuries, congenital and acquired disorders of the bones, joints, and their associated soft tissues, including ligaments, nerves and muscles. Excludes Spinal Surgery Service - see TREATMENT FUNCTION CODE 108
215	PAEDIATRIC EAR NOSE AND THROAT	Ear, nose and throat
216	PAEDIATRIC OPHTHALMOLOGY	The surgical treatment of disorders and diseases of the eye.
217	PAEDIATRIC MAXILLO-FACIAL SURGERY	Mouth, jaw and face related surgery
218	PAEDIATRIC NEUROSURGERY	The prevention, diagnosis, treatment, and rehabilitation of disorders which affect any portion of the nervous system including the brain, spinal cord, peripheral nerves, and extra-cranial cerebrovascular system
219	PAEDIATRIC PLASTIC SURGERY	SERVICES to correct or restore form and function. In addition to cosmetic or aesthetic surgery, plastic surgery includes many types of reconstructive surgery, and the treatment of burns
220	PAEDIATRIC BURNS CARE	To be used by recognised specialist units and associated outreach SERVICES only
221	PAEDIATRIC CARDIAC SURGERY	Surgical treatment of the heart or great vessels
222	PAEDIATRIC THORACIC SURGERY	Surgical treatment of diseases affecting organs inside the thorax (the chest). Generally treatment of conditions of the lungs, chest wall, and diaphragm
223	PAEDIATRIC EPILEPSY	Designated clinic which provides SERVICES to children led by CONSULTANT paediatrician with expertise in epilepsy supported by specialist staff
241	PAEDIATRIC PAIN MANAGEMENT	Complex pain disorders requiring diagnosis and treatment by a specialist multi-professional team
242	PAEDIATRIC INTENSIVE CARE	Only to be used by designated Paediatric Intensive Care Units
251	PAEDIATRIC GASTROENTEROLOGY	The treatment of disorders of the digestive system
252	PAEDIATRIC ENDOCRINOLOGY	The treatment of disorders of the endocrine system
253	PAEDIATRIC CLINICAL HAEMATOLOGY	Excludes Anticoagulant Service - see TREATMENT FUNCTION CODE 324
254	PAEDIATRIC AUDIOLOGICAL MEDICINE	The medical specialty concerned with the investigation, diagnosis and management of patients with disorders of balance, hearing, tinnitus and auditory communication. Excludes audiology and hearing tests
255	PAEDIATRIC CLINICAL IMMUNOLOGY AND ALLERGY SERVICE	Clinical Immunology is the treatment of disorders of the immune system. Allergy Service is the diagnosis and management of allergic disease
256	PAEDIATRIC INFECTIOUS DISEASES	SERVICES to diagnose and treat contagious or communicable diseases
257	PAEDIATRIC DERMATOLOGY	SERVICES for the treatment of diseases of the skin
258	PAEDIATRIC RESPIRATORY MEDICINE	Also known as Thoracic Medicine
259	PAEDIATRIC NEPHROLOGY	SERVICES to treat kidney conditions and abnormalities
260	PAEDIATRIC MEDICAL ONCOLOGY	The diagnosis and treatment, typically with Chemotherapy of PATIENTS with cancer
261	PAEDIATRIC METABOLIC DISEASE	The diagnosis and management of inherited metabolic conditions

262	PAEDIATRIC RHEUMATOLOGY	SERVICES to treat rheumatism, arthritis, and other disorders of the joints, muscles and ligaments
263	PAEDIATRIC DIABETIC MEDICINE	SERVICES to diagnose, treat and support PATIENTS with diabetes
264	PAEDIATRIC CYSTIC FIBROSIS	Specialised, multidisciplinary SERVICE concerned with the diagnosis, assessment and management of PATIENTS with cystic fibrosis. This TREATMENT FUNCTION CODE should be used by recognised specialist centres only
280	PAEDIATRIC INTERVENTIONAL RADIOLOGY	Diagnosis and treatment of diseases utilising minimally-invasive image-guided procedures. Not to be used for Diagnostic Imaging - see TREATMENT FUNCTION CODE 812
290	COMMUNITY PAEDIATRICS	Includes routine health surveillance, health promotion, behavioural paediatrics and Looked After Children . Excludes Paediatric Neuro-Disability
291	PAEDIATRIC NEURO-DISABILITY	Dedicated SERVICES for children with Cerebral Palsy and non-progressive handicapping neurological conditions, with or without Learning Disability
Medical Specialties		
190	ANAESTHETICS	This can be used in out-patients only. Pain Management should be recorded in 191
192	CRITICAL CARE MEDICINE	also known as Intensive Care Medicine
300	GENERAL MEDICINE	Includes sub-categories not elsewhere listed e.g. Metabolic Medicine.
301	GASTROENTEROLOGY	The treatment of disorders of the digestive system
302	ENDOCRINOLOGY	The treatment of disorders of the endocrine system
303	CLINICAL HAEMATOLOGY	Excludes Anticoagulant Service - see TREATMENT FUNCTION CODE 324
304	CLINICAL PHYSIOLOGY	Physiological measurement including ECG (e.g. exercise testing, stress testing), gastrointestinal physiology, cardiac physiology, vascular technology, urodynamics, and ophthalmic and vision science. Excludes Clinical Neurophysiology - see TREATMENT FUNCTION CODE 401, Audiology - see TREATMENT FUNCTION CODE 840 or Respiratory Physiology - see TREATMENT FUNCTION CODE 341
305	CLINICAL PHARMACOLOGY	SERVICES providing drug information, medication safety and other aspects of pharmacy practice
306	HEPATOLOGY	Also known as liver medicine
307	DIABETIC MEDICINE	SERVICES to diagnose, treat and support PATIENTS with diabetes
308	BLOOD AND MARROW TRANSPLANTATION	Previously coded within Clinical Haematology (TREATMENT FUNCTION CODE 303). Includes haemopoietic stem cell transplantation
309	HAEMOPHILIA SERVICE	Previously coded within Clinical Haematology (TREATMENT FUNCTION CODE 303).
310	AUDIOLOGICAL MEDICINE	The medical specialty concerned with the investigation, diagnosis and management of patients with disorders of balance, hearing, tinnitus and auditory communication. Excludes audiology and hearing tests
311	CLINICAL GENETICS	Diagnosis of disorders caused by genetic mechanisms and counselling SERVICE to PATIENTS and affected family members. To be used by recognised specialist units and associated outreach SERVICES only
312	not a Treatment Function	
313	CLINICAL IMMUNOLOGY and ALLERGY SERVICE	Should only be used where there are no separate SERVICES for Clinical Immunology and Allergy
314	REHABILITATION SERVICE	SERVICES to enhance and restore functional ability and quality of life to those with physical impairments or disabilities. Excludes Mental Health Recovery and Rehabilitation Service - see TREATMENT FUNCTION CODE 725
315	PALLIATIVE MEDICINE	

		The treatment for curable illnesses and those living with chronic diseases, as well as PATIENTS who are nearing the end of life
316	CLINICAL IMMUNOLOGY	The treatment of disorders of the immune system
317	ALLERGY SERVICE	The diagnosis and management of allergic disease (abnormal immune responses to external substances) and the exclusion of allergic causes in other conditions
318	INTERMEDIATE CARE	Intermediate care encompasses a range of multi-disciplinary SERVICES designed to safeguard independence by maximising rehabilitation and recovery after illness or injury
319	RESPIRE CARE	SERVICES providing temporary care of a dependant person, providing relief for their usual caregivers
320	CARDIOLOGY	SERVICES treating diseases and abnormalities of the heart
321	PAEDIATRIC CARDIOLOGY	Dedicated SERVICES to children with diseases and abnormalities of the heart, with appropriate facilities and support staff
322	CLINICAL MICROBIOLOGY	SERVICES to treat diseases caused by bacteria, viruses, fungi and parasites
323	SPINAL INJURIES	To be used by recognised specialist units and associated outreach SERVICES only, Excludes Spinal Surgery Service - see TREATMENT FUNCTION CODE 108
324	ANTICOAGULANT SERVICE	The monitoring and control of anticoagulant therapy including the initiation and/or supervision of oral anticoagulant therapy and the determination of anticoagulant dosage. This can be used in out-patients only
325	SPORT AND EXERCISE MEDICINE	The diagnosis and management of medical problems caused by physical activity, the prevention of related injury and disease and the role of exercise in disease treatment
327	CARDIAC REHABILITATION	Rehabilitation SERVICE for PATIENTS with or recovering from heart related conditions such as heart attacks or from procedures such as coronary artery bypass surgery to ensure that they achieve their full potential in terms of physical and psychological health
328	STROKE MEDICINE	For stroke services excluding Transient Ischaemic Attack - see TREATMENT FUNCTION CODE 329
329	TRANSIENT ISCHAEMIC ATTACK	A multidisciplinary SERVICE for rapid diagnosis and treatment of PATIENTS presenting with suspected Transient Ischaemic Attack and mini-strokes to minimise the chance of a full stroke occurring and maximise the chances of independent living after a stroke
330	DERMATOLOGY	SERVICES for the treatment of diseases of the skin
331	CONGENITAL HEART DISEASE SERVICE	The management and treatment of congenital heart disease, this includes the ongoing care of children in to adulthood
340	RESPIRATORY MEDICINE	Also known as Thoracic Medicine
341	RESPIRATORY PHYSIOLOGY	Physiological measurement of the function of the respiratory system. Includes Sleep Studies (the diagnosis and treatment of sleep disordered breathing, including upper airway resistance syndrome and sleep apnoea)
342	PROGRAMMED PULMONARY REHABILITATION	A multidisciplinary programme of care for PATIENTS with chronic respiratory impairment that is individually tailored and designed to optimise the individual's physical and social performance and autonomy
343	ADULT CYSTIC FIBROSIS SERVICE	Specialised, multidisciplinary SERVICE concerned with the diagnosis, assessment and management of PATIENTS with cystic fibrosis. This TREATMENT FUNCTION CODE should be used by recognised specialist centres only
344	COMPLEX SPECIALISED REHABILITATION SERVICE	Complex specialised rehabilitation SERVICE which meets the NHS Specialised Services Rehabilitation Services' criteria and is registered as a Level 1 service. For further information see the NHS Specialised Services website
345	SPECIALIST REHABILITATION SERVICE	Specialist rehabilitation SERVICE which meets the NHS Specialised Services Rehabilitation Services' criteria and is

		registered as a Level 2a service. For further information see the NHS Specialised Services website
346	LOCAL SPECIALIST REHABILITATION SERVICE	Local specialist rehabilitation SERVICE which meets the NHS Specialised Services Rehabilitation Services' criteria and is registered as a Level 2b service. For further information see the NHS Specialised Services website
350	INFECTIOUS DISEASES	SERVICES to diagnose and treat contagious or communicable diseases
352	TROPICAL MEDICINE	SERVICES to diagnose and treat diseases that are found most often in tropical or sub-tropical regions
360	GENITOURINARY MEDICINE	Primarily related to medicine dealing with sexually transmitted diseases
361	NEPHROLOGY	SERVICES to treat kidney conditions and abnormalities
370	MEDICAL ONCOLOGY	The diagnosis and treatment, typically with Chemotherapy , of PATIENTS with cancer
371	NUCLEAR MEDICINE	The treatment of PATIENTS through the use of radioactive substances
400	NEUROLOGY	SERVICES to diagnose and treat conditions and diseases of the central nervous system
401	CLINICAL NEUROPHYSIOLOGY	The study of the central and peripheral nervous systems through the recording of bioelectrical activity. Includes Electroencephalogram (EEG)
410	RHEUMATOLOGY	SERVICES to treat rheumatism, arthritis, and other disorders of the joints, muscles and ligaments
420	PAEDIATRICS	SERVICES to treat infants, children, and adolescents
421	PAEDIATRIC NEUROLOGY	Dedicated SERVICES to children to diagnose and treat conditions and diseases of the central nervous system, with appropriate facilities and support staff
422	NEONATOLOGY	Special Care, High Dependency and Intensive Care
424	WELL BABIES	Use when NEONATAL LEVEL OF CARE = 0 - Normal Care: Care given by the mother/substitute with medical and neonatal nursing advice if needed. See Well Baby
430	GERIATRIC MEDICINE	SERVICES to treat diseases and disabilities in older adults. There is no set age at which PATIENTS may be under the care of Geriatric Medicine, this decision should be determined by the individual PATIENT 's needs
450	DENTAL MEDICINE SPECIALTIES	Includes Oral Medicine.
460	MEDICAL OPHTHALMOLOGY	SERVICES to diagnose and treat medical conditions affecting the eye, orbits, and visual pathways
500	not a Treatment Function	
501	OBSTETRICS	The management of pregnancy and childbirth including miscarriages and still births but excluding planned terminations. Excludes Midwifery Service see TREATMENT FUNCTION CODE 560
502	GYNAECOLOGY	Disorders of the female reproductive system. Includes planned terminations
503	GYNAECOLOGICAL ONCOLOGY	SERVICES to treat cancers of the female reproductive system
510	Retired	Record as Obstetrics, antenatal clinic can be used as a local sub-specialty if required
520	Retired	Record as Obstetrics, postnatal clinic can be used as a local sub-specialty if required
560	MIDWIFERY SERVICE	SERVICES provided under the direct care of a MIDWIFE . Excludes Obstetrics see TREATMENT FUNCTION CODE 501
600	not a Treatment Function	
610	Retired	Record as Obstetrics
620	Retired	Use the appropriate function under which the patient is treated
Therapies		
650	PHYSIOTHERAPY	

		The treatment of human function and movement to help people to achieve their full physical potential. The use of physical approaches to promote, maintain and restore wellbeing
651	OCCUPATIONAL THERAPY	The use of specific activities to limit the effects of disability and promote independence in all aspects of daily life
652	SPEECH AND LANGUAGE THERAPY	The assessment, treatment and help to prevent speech, language and swallowing difficulties
653	PODIATRY	Also known as Chiropody. The diagnosis and treatment of disorders, diseases and deformities of the feet. Excludes Podiatric Surgery see TREATMENT FUNCTION CODE 663
654	DIETETICS	The application of the science of nutrition to devise eating plans for PATIENTS to treat medical conditions. The promotion of good health by helping to facilitate a positive change in food choices amongst individuals, groups and communities
655	ORTHOPTICS	The diagnosis and treatment of visual problems involving eye movement and alignment
656	CLINICAL PSYCHOLOGY	The diagnosis and treatment of emotional and behavioural disorders
657	PROSTHETICS	The supply of prosthetics for PATIENTS
658	ORTHOTICS	The supply of orthoses for PATIENTS
659	DRAMA THERAPY	The use of drama and theatre techniques including role play, voice work and storytelling for therapeutic purposes
660	ART THERAPY	The use of art techniques including clay, paint and paper for therapeutic purposes and as a means of communication
661	MUSIC THERAPY	The use of music and all of its facets to help clients to improve or maintain their health
662	OPTOMETRY	The diagnosis and non-surgical treatment of disorders of the eye and vision care
663	PODIATRIC SURGERY	The treatment of foot problems, including soft tissue, bone and joint surgery of the foot, ankle and associated structures, excludes Podiatry see TREATMENT FUNCTION CODE - 653
Psychiatry		
700	LEARNING DISABILITY	SERVICES provided to PATIENTS with a Learning Disability
710	ADULT MENTAL ILLNESS	SERVICES provided to adult PATIENTS for the assessment, diagnosis and treatment of mental illness
711	CHILD and ADOLESCENT PSYCHIATRY	SERVICES providing diagnosis, treatment, and prevention of psychopathological disorders of children and adolescents
712	FORENSIC PSYCHIATRY	SERVICES to assess PATIENTS who have committed an offence and are receiving treatment in high, medium and low secure units or prisons
713	PSYCHOTHERAPY	SERVICES providing therapy used to treat emotional problems and mental health conditions
715	OLD AGE PSYCHIATRY	SERVICES providing the diagnosis, treatment, and prevention of mental and emotional disorders in older adult PATIENTS
720	EATING DISORDERS	A specialist SERVICE for the diagnosis and treatment of eating disorders including anorexia, bulimia and compulsive overeating
721	ADDICTION SERVICES	The prevention and treatment of substance misuse including drugs and alcohol. If PATIENTS have both severe mental illness and problematic substance misuse, see TREATMENT FUNCTION CODE 726 Dual Diagnosis Service
722	LIAISON PSYCHIATRY	The provision of psychiatric treatment to PATIENTS attending general hospitals including out-patient clinics, Accident and Emergency Departments and admission to wards. Deals with the interface between physical and psychological health.
723	PSYCHIATRIC INTENSIVE CARE	The provision of psychiatric SERVICES to vulnerable individuals who are admitted to Psychiatric Intensive Care Units from open acute wards and forensic settings
724	PERINATAL PSYCHIATRY	

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

Notes:

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

Change to Attribute: New Attribute

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

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

This attribute is also known by these names:

Context	Alias
plural	UCUM UNITS OF MEASUREMENT

UCUM UNIT OF MEASUREMENT

Change to Attribute: New Attribute

UCUM UNIT OF MEASUREMENT

Data Elements:

UCUM UNIT OF MEASUREMENT
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UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)

Change to Attribute: Changed Dataset

The unique booking reference number assigned by the [Choose and Book](#) system when a [PATIENT](#) accepts an [APPOINTMENT DATE OFFERED](#) of an [APPOINTMENT OFFER](#) where the offer was made via the [Choose and Book](#) system.

When a [PATIENT](#) accepts an [APPOINTMENT DATE OFFERED](#), the unique booking reference number issued and used during the booking process is considered to be 'converted' i.e. an [APPOINTMENT](#) has been created and recorded; and the [PATIENT](#) has been placed on an [Out-Patient Waiting List](#) even if subsequently the [PATIENT](#) does not attend or cancels the [APPOINTMENT](#).

[UNIQUE BOOKING REFERENCE NUMBER \(CONVERTED\)](#) should only be recorded where the type of booking system is the [Choose and Book](#) system.

WAITING TIME MEASUREMENT TYPE

Change to Attribute: Changed Description, Dataset

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

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

National Codes:

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

Note: * National Code 03 is used for the [Improving Access to Psychological Therapies Data Set](#) only. Notes:

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

- ** National Code 01 is also not valid for the [Mental Health Services Data Set](#).

WARD SECURITY LEVEL

Change to Attribute: Changed Dataset

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

National Codes:

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

WARD SETTING TYPE FOR MENTAL HEALTH

Change to Attribute: New Attribute

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

National Codes:

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

This attribute is also known by these names:

Context	Alias
plural	WARD SETTING TYPES FOR MENTAL HEALTH

WARD SETTING TYPE FOR MENTAL HEALTH

Change to Attribute: New Attribute

WARD SETTING TYPE FOR MENTAL HEALTH

Data Elements:

WARD SETTING TYPE (MENTAL HEALTH)

WEEKLY HOURS WORKED

Change to Attribute: Changed Description, Dataset

The number of hours worked per week by a PERSON. A code to identify the number of hours worked per week by a PERSON.

National Codes:

- 01 30+ hours
- 02 16-29 hours
- 03 5-15 hours
- 04 1-4 hours
- 97 Not disclosed (PATIENT was asked but refused to respond)

YOUNG CARER INDICATOR

Change to Attribute: Changed Description, Dataset

An indication of whether a child or young PERSON has a caring role for an ill or disabled parent, carer or sibling.

National Codes:

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

ACCOMMODATION STATUS CODE

Change to Data Element: Changed Dataset

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

Notes:

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

ACCOMMODATION STATUS RECORDED DATE_ renamed from ACCOMMODATION STATUS DATE

Change to Data Element: Changed Description, Dataset, Name, linked Attribute

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

Notes:

~~ACCOMMODATION STATUS DATE~~ is the ~~PERSON PROPERTY OBSERVED DATE~~ when the ~~ACCOMMODATION STATUS CODE~~ was recorded. ACCOMMODATION STATUS RECORDED DATE is the same as attribute PERSON PROPERTY RECORDED DATE. ACCOMMODATION STATUS RECORDED DATE is the DATE when the ACCOMMODATION STATUS CODE was recorded.

ACCOMMODATION STATUS RECORDED DATE renamed from ACCOMMODATION STATUS DATE

Change to Data Element: Changed Description, Dataset, Name, linked Attribute

ACCOMMODATION STATUS DATE	ACCOMMODATION	STATUS
ACCOMMODATION STATUS RECORDED DATE	RECORDED	DATE
Attribute:	renamed	
PERSON PROPERTY OBSERVED DATE	from ACCOMMODATION	
PERSON PROPERTY RECORDED DATE	STATUS	
	DATE	

Change to Data Element: Changed

Description, Dataset, Name, linked Attribute

- Changed Description
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.A.ACCOMMODATION_STATUS_DATE to Data_Dictionary.Data_Field_Notes.A.ACCOMMODATION_STATUS_RECORDED_DATE
- null

ACTIVITY LOCATION TYPE CODE

Change to Data Element: Changed Dataset

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

Notes:

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

Use in Commissioning Data Set Version 6-2 onwards

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

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

ADMINISTRATIVE CATEGORY CODE

Change to Data Element: Changed Dataset

Format/Length:	an2
HES Item:	ADMINCAT

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

Notes:

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

ADMISSION METHOD CODE (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Dataset

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

Notes:

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

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

For further information, please refer to the [Secondary Uses Service Guidance](#) page.

ADULT MENTAL HEALTH CARE CLUSTER CODE (FINAL). renamed from MENTAL HEALTH CARE CLUSTER CODE (FINAL)

Change to Data Element: Changed Description, Dataset, Name

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

Notes:

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

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

~~[MENTAL HEALTH CARE CLUSTER CODE \(FINAL\)](#) is the final allocation of the [MENTAL HEALTH CARE CLUSTER CODE](#) by the [CARE PROFESSIONAL](#), the determination of the [Mental Health Care Cluster](#) code may or may not have involved the use of the [National Tariff Payment System](#) clustering algorithm.~~ The determination of the [ADULT MENTAL HEALTH CARE CLUSTER CODE \(FINAL\)](#) may or may not have involved the use of the [National Tariff Payment System](#) clustering algorithm.

ADULT MENTAL HEALTH CARE CLUSTER CODE (FINAL). renamed from MENTAL HEALTH CARE CLUSTER CODE (FINAL)

Change to Data Element: Changed Description, Dataset, Name

- Changed Description

- null
- Changed Name from Data_Dictionary.Data_Field_Notes.M.Men.MENTAL_HEALTH_CARE_CLUSTER_CODE_(FINAL) to Data_Dictionary.Data_Field_Notes.A.Ad.ADULT_MENTAL_HEALTH_CARE_CLUSTER_CODE_(FINAL)

ADULT MENTAL HEALTH CARE CLUSTER CODE (INITIAL) renamed from **MENTAL HEALTH CARE CLUSTER CODE (INITIAL)**

Change to Data Element: Changed Description, Dataset, Name

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

Notes:

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

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

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

ADULT MENTAL HEALTH CARE CLUSTER CODE (INITIAL) renamed from **MENTAL HEALTH CARE CLUSTER CODE (INITIAL)**

Change to Data Element: Changed Description, Dataset, Name

- Changed Description
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.M.Men.MENTAL_HEALTH_CARE_CLUSTER_CODE_(INITIAL) to Data_Dictionary.Data_Field_Notes.A.Ad.ADULT_MENTAL_HEALTH_CARE_CLUSTER_CODE_(INITIAL)

ASSESSMENT TOOL COMPLETION DATE

Change to Data Element: Changed Dataset

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

Notes:

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

ASSESSMENT TOOL COMPLETION TIME

Change to Data Element: Changed Dataset

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

Notes:

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

ATTENDED OR DID NOT ATTEND CODE

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See ATTENDED OR DID NOT ATTEND
Default Codes:	

Notes:

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

Use in the Future Outpatient CDS:

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

CARE ACTIVITY IDENTIFIER

Change to Data Element: New Data Element

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

Notes:

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

This data element is also known by these names:

Context	Alias
plural	CARE ACTIVITY IDENTIFIERS

CARE ACTIVITY IDENTIFIER

Change to Data Element: New Data Element

CARE ACTIVITY IDENTIFIER

Attribute:

ACTIVITY IDENTIFIER

CARE CONTACT CANCELLATION DATE

Change to Data Element: Changed Description, Dataset, linked Attribute

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

Notes:

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

CONTACT CANCELLATION DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Care Contact Cancellation Date'.

CARE CONTACT CANCELLATION DATE

Change to Data Element: Changed Description, Dataset, linked Attribute

CARE CONTACT CANCELLATION DATE

Attribute:

CARE CONTACT CANCELLATION DATE
ACTIVITY DATE

CARE CONTACT CANCELLATION REASON

Change to Data Element: Changed Dataset

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

Notes:

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

CARE CONTACT DATE

Change to Data Element: Changed Description, Dataset, linked Attribute

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

Notes:

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

CARE CONTACT DATE

Change to Data Element: Changed Description, Dataset, linked Attribute

CARE CONTACT DATE

Attribute:

CARE CONTACT DATE
ACTIVITY DATE

CARE CONTACT IDENTIFIER

Change to Data Element: New Data Element

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

Notes:

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

This data element is also known by these names:

Context	Alias
plural	CARE CONTACT IDENTIFIERS

CARE CONTACT IDENTIFIER

Change to Data Element: New Data Element

CARE CONTACT IDENTIFIER

Attribute:

[ACTIVITY IDENTIFIER](#)

CARE CONTACT SUBJECT

Change to Data Element: Changed Dataset

Format/Length: an2
National Codes: See [CARE CONTACT SUBJECT](#)
Default Codes:

Notes:

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

CARE CONTACT TIME

Change to Data Element: Changed Description, Dataset, linked Attribute

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

Notes:

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

CARE CONTACT TIME

Change to Data Element: Changed Description, Dataset, linked Attribute

CARE CONTACT TIME

Attribute:

[CARE CONTACT TIME](#)

[ACTIVITY TIME](#)

CARE PROFESSIONAL (JOB ROLE CODE)

Change to Data Element: Changed Dataset

Format/Length: an5
National Codes: See [JOB ROLE CODE](#)
Default Codes:

Notes:

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

CARE PROFESSIONAL LOCAL IDENTIFIER

Change to Data Element: New Data Element

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

Notes:

CARE PROFESSIONAL LOCAL IDENTIFIER is the same as attribute CARE PROFESSIONAL IDENTIFIER.

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

This data element is also known by these names:

Context	Alias
plural	CARE PROFESSIONAL LOCAL IDENTIFIERS

CARE PROFESSIONAL LOCAL IDENTIFIER

Change to Data Element: New Data Element

CARE PROFESSIONAL LOCAL IDENTIFIER

Attribute:

CARE PROFESSIONAL IDENTIFIER

CARE PROFESSIONAL SERVICE OR TEAM TYPE ASSOCIATION (MENTAL HEALTH)

Change to Data Element: New Data Element

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

Notes:

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

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

This data element is also known by these names:

Context	Alias
plural	CARE PROFESSIONAL SERVICE OR TEAM TYPE ASSOCIATIONS (MENTAL HEALTH)

CARE PROFESSIONAL SERVICE OR TEAM TYPE ASSOCIATION (MENTAL HEALTH)

Change to Data Element: New Data Element

CARE PROFESSIONAL SERVICE OR TEAM TYPE ASSOCIATION (MENTAL HEALTH)

Attribute:

SERVICE OR TEAM TYPE FOR MENTAL HEALTH

CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH)

Change to Data Element: New Data Element

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

Notes:

CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH) is the same as attribute CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH.

This data element is also known by these names:

Context	Alias
plural	CARE PROFESSIONAL STAFF GROUPS (MENTAL HEALTH)

CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH)

Change to Data Element: New Data Element

CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH)

Attribute:

CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH

CARE PROFESSIONAL TEAM LOCAL IDENTIFIER

Change to Data Element: New Data Element

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

Notes:

CARE PROFESSIONAL TEAM LOCAL IDENTIFIER is the same as attribute CARE PROFESSIONAL TEAM IDENTIFIER.

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

This data element is also known by these names:

Context	Alias
plural	CARE PROFESSIONAL TEAM LOCAL IDENTIFIERS

CARE PROFESSIONAL TEAM LOCAL IDENTIFIER

Change to Data Element: New Data Element

CARE PROFESSIONAL TEAM LOCAL IDENTIFIER

Attribute:

CARE PROFESSIONAL TEAM IDENTIFIER

CARE PROGRAMME APPROACH CARE EPISODE IDENTIFIER

Change to Data Element: New Data Element

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

Notes:

CARE PROGRAMME APPROACH CARE EPISODE IDENTIFIER is the same as attribute ACTIVITY IDENTIFIER.

CARE PROGRAMME APPROACH CARE EPISODE IDENTIFIER is a unique identifier allocated to each Care Programme Approach Care Episode.

This data element is also known by these names:

Context	Alias
shortname	CPA CARE EPISODE IDENTIFIER
plural	CARE PROGRAMME APPROACH CARE EPISODE IDENTIFIERS

CARE PROGRAMME APPROACH CARE EPISODE IDENTIFIER

Change to Data Element: New Data Element

CARE PROGRAMME APPROACH CARE EPISODE IDENTIFIER

Attribute:

ACTIVITY IDENTIFIER

CARE PROGRAMME APPROACH REVIEW ABUSE QUESTION ASKED INDICATOR

Change to Data Element: Changed Dataset

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

Notes:

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

CARE PROGRAMME APPROACH REVIEW DATE_ renamed from REVIEW DATE

Change to Data Element: Changed Description, Dataset, Name, linked Attribute

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

Notes:

REVIEW DATE is the DATE of a formal review of care carried out during a CARE CONTACT. CARE PROGRAMME APPROACH REVIEW DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Care Programme Approach Review Date'.

CARE PROGRAMME APPROACH REVIEW DATE_ renamed from REVIEW DATE

Change to Data Element: Changed Description, Dataset, Name, linked Attribute

CARE PROGRAMME APPROACH REVIEW DATE

Attribute:

ACTIVITY DATE

CARE PROGRAMME APPROACH REVIEW DATE_ renamed from REVIEW DATE

Change to Data Element: Changed Description, Dataset, Name, linked Attribute

- Changed Description
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.R.Rep.REVIEW_DATE to Data_Dictionary.Data_Field_Notes.C.Care.CARE_PROGRAMME_APPROACH_REVIEW_DATE
- null

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL)

Change to Data Element: New Data Element

Format/Length:	max an4
National Codes:	See <u>CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE</u>
Default Codes:	

Notes:

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL) is the same as attribute CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE.

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL) is the final CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE allocated by the CARE PROFESSIONAL.

Note: This data item is included in the Mental Health Services Data Set, but should not be submitted until further development by the Health and Social Care Information Centre has been undertaken.

This data element is also known by these names:

Context	Alias
plural	<u>CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODES (FINAL)</u>

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL)

Change to Data Element: New Data Element

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL)

Attribute:

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL)

Change to Data Element: New Data Element

Format/Length:	max an4
National Codes:	See CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE
Default Codes:	

Notes:

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

[CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE \(INITIAL\)](#) is the initial [CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE](#) allocated by the [CARE PROFESSIONAL](#).

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

This data element is also known by these names:

Context	Alias
plural	CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODES (INITIAL)

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL)

Change to Data Element: New Data Element

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL)**Attribute:**

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE
--

CHILD AND ADOLESCENT MENTAL HEALTH TIER OF SERVICE

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See CHILD AND ADOLESCENT MENTAL HEALTH TIER OF SERVICE
Default Codes:	

Notes:

[CHILD AND ADOLESCENT MENTAL HEALTH TIER OF SERVICE](#) is the same as attribute [CHILD AND ADOLESCENT MENTAL HEALTH TIER OF SERVICE](#).

CHILD PROTECTION PLAN INDICATION CODE_ renamed from CHILD PROTECTION PLAN INDICATOR

Change to Data Element: Changed Description, Dataset, Name

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

Notes:

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

CHILD PROTECTION PLAN INDICATION CODE_ renamed from CHILD PROTECTION PLAN INDICATOR

Change to Data Element: Changed Description, Dataset, Name

- Changed Description
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.C.Ce.CHILD_PROTECTION_PLAN_INDICATOR to Data_Dictionary.Data_Field_Notes.C.Ce.CHILD_PROTECTION_PLAN_INDICATION_CODE

CLINICAL CONTACT DURATION OF CARE ACTIVITY

Change to Data Element: Changed Description, Dataset

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

Notes:

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

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

CLINICAL CONTACT DURATION OF CARE CONTACT

Change to Data Element: Changed Description, Dataset

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

Notes:

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

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

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

CLINICAL CONTACT DURATION OF GROUP SESSION

Change to Data Element: Changed Description, Dataset

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

Notes:

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

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

CLINICAL RESPONSE PRIORITY TYPE

Change to Data Element: Changed Dataset

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

Notes:

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

CLUSTERING TOOL ASSESSMENT CATEGORY

Change to Data Element: New Data Element

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

Notes:

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

This data element is also known by these names:

Context	Alias
plural	CLUSTERING TOOL ASSESSMENT CATEGORIES

CLUSTERING TOOL ASSESSMENT CATEGORY

Change to Data Element: New Data Element

CLUSTERING TOOL ASSESSMENT CATEGORY

Attribute:

CLUSTERING TOOL ASSESSMENT CATEGORY

CLUSTERING TOOL ASSESSMENT IDENTIFIER

Change to Data Element: New Data Element

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

Notes:

CLUSTERING TOOL ASSESSMENT IDENTIFIER is the same as attribute ACTIVITY IDENTIFIER.

CLUSTERING TOOL ASSESSMENT IDENTIFIER is a unique identifier for each Clustering Tool assessment that takes place for each PATIENT.

This data element is also known by these names:

Context	Alias
plural	CLUSTERING TOOL ASSESSMENT IDENTIFIERS

CLUSTERING TOOL ASSESSMENT IDENTIFIER

Change to Data Element: New Data Element

CLUSTERING TOOL ASSESSMENT IDENTIFIER

Attribute:

<u>ACTIVITY IDENTIFIER</u>

CLUSTERING TOOL ASSESSMENT REASON renamed from **MENTAL HEALTH CLUSTERING TOOL ASSESSMENT REASON**

Change to Data Element: Changed Description, Dataset, Name

Format/Length:	an2
National Codes:	See <u>MENTAL HEALTH CLUSTERING TOOL ASSESSMENT REASON</u>
Default Codes:	99 - Not known
National Codes:	See <u>CLUSTERING TOOL ASSESSMENT REASON</u>
Default Codes:	99 - <u>CLUSTERING TOOL ASSESSMENT REASON</u> Not known

Notes:

~~MENTAL HEALTH CLUSTERING TOOL ASSESSMENT REASON is the same as attribute MENTAL HEALTH CLUSTERING TOOL ASSESSMENT REASON.~~

CLUSTERING TOOL ASSESSMENT REASON is the same as attribute CLUSTERING TOOL ASSESSMENT REASON.

CLUSTERING TOOL ASSESSMENT REASON renamed from **MENTAL HEALTH CLUSTERING TOOL ASSESSMENT REASON**

Change to Data Element: Changed Description, Dataset, Name

- Changed Description
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.M.Men.MENTAL_HEALTH_CLUSTERING_TOOL_ASSESSMENT_REASON to Data_Dictionary.Data_Field_Notes.C.Cl.CLUSTERING_TOOL_ASSESSMENT_REASON

CODED ASSESSMENT TOOL TYPE (SNOMED CT)

Change to Data Element: New Data Element

Format/Length: min an6 max an18
National Codes:
Default Codes:

Notes:

CODED ASSESSMENT TOOL TYPE (SNOMED CT) is the same as attribute **CLINICAL TERMINOLOGY CODE**.

CODED ASSESSMENT TOOL TYPE (SNOMED CT) is the **SNOMED CT** concept ID which is used to identify an **ASSESSMENT TOOL**.

This data element is also known by these names:

Context	Alias
plural	CODED ASSESSMENT TOOL TYPES (SNOMED CT)

CODED ASSESSMENT TOOL TYPE (SNOMED CT)

Change to Data Element: New Data Element

CODED ASSESSMENT TOOL TYPE (SNOMED CT)

Attribute:

CLINICAL TERMINOLOGY CODE

CODED FINDING (CODED CLINICAL ENTRY)

Change to Data Element: New Data Element

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

Notes:

CODED FINDING (CODED CLINICAL ENTRY) is the same as attribute **CLINICAL CLASSIFICATION CODE** or **CLINICAL TERMINOLOGY CODE**.

CODED FINDING (CODED CLINICAL ENTRY) is the **CODED CLINICAL ENTRY** which is used to identify a finding.

This data element is also known by these names:

Context	Alias
plural	CODED FINDINGS (CODED CLINICAL ENTRY)

CODED FINDING (CODED CLINICAL ENTRY)

Change to Data Element: New Data Element

CODED FINDING (CODED CLINICAL ENTRY)

Attribute:

CLINICAL CLASSIFICATION CODE
CLINICAL TERMINOLOGY CODE

CODED OBSERVATION (CLINICAL TERMINOLOGY)

Change to Data Element: New Data Element

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

Notes:

CODED OBSERVATION (CLINICAL TERMINOLOGY) is the same as attribute CLINICAL TERMINOLOGY CODE.

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

This data element is also known by these names:

Context	Alias
plural	CODED OBSERVATIONS (CLINICAL TERMINOLOGY)

CODED OBSERVATION (CLINICAL TERMINOLOGY)

Change to Data Element: New Data Element

CODED OBSERVATION (CLINICAL TERMINOLOGY)

Attribute:

CLINICAL TERMINOLOGY CODE

CODED PROCEDURE (CLINICAL TERMINOLOGY)

Change to Data Element: New Data Element

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

Notes:

CODED PROCEDURE (CLINICAL TERMINOLOGY) is the same as attribute CLINICAL TERMINOLOGY CODE.

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

This data element is also known by these names:

Context	Alias
plural	CODED PROCEDURES (CLINICAL TERMINOLOGY)

CODED PROCEDURE (CLINICAL TERMINOLOGY)

Change to Data Element: New Data Element

CODED PROCEDURE (CLINICAL TERMINOLOGY)

Attribute:

CLINICAL TERMINOLOGY CODE

COMMUNITY TREATMENT ORDER END REASON renamed from SUPERVISED COMMUNITY TREATMENT END REASON

Change to Data Element: Changed Dataset, Name

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

Notes:

~~SUPERVISED COMMUNITY TREATMENT END REASON~~ is the same as attribute ~~SUPERVISED COMMUNITY TREATMENT END REASON~~. COMMUNITY TREATMENT ORDER END REASON is the same as attribute COMMUNITY TREATMENT ORDER END REASON.

COMMUNITY TREATMENT ORDER END REASON renamed from SUPERVISED COMMUNITY TREATMENT END REASON

Change to Data Element: Changed Dataset, Name

- null
- Changed Name from Data_Dictionary.Data_Field_Notes.S.Su.SUPERVISED_COMMUNITY_TREATMENT_END_REASON to Data_Dictionary.Data_Field_Notes.C.Co.COMMUNITY_TREATMENT_ORDER_END_REASON

CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR

Change to Data Element: New Data Element

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

Notes:

CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR is the same as attribute CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR.

This data element is also known by these names:

Context	Alias
plural	CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATORS

CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR

Change to Data Element: New Data Element

CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR

Attribute:

CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR

CONSULTATION MEDIUM USED

Change to Data Element: Changed Dataset

Format/Length: an2
National Codes: See [CONSULTATION MEDIUM USED](#)
Default Codes:

Notes:

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

CONSULTATION TYPE

Change to Data Element: New Data Element

Format/Length: an2
National Codes: See [CONSULTATION TYPE](#)
Default Codes:

Notes:

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

This data element is also known by these names:

Context	Alias
plural	CONSULTATION TYPES

CONSULTATION TYPE

Change to Data Element: New Data Element

CONSULTATION TYPE

Attribute:

[CONSULTATION TYPE](#)

DATA SET VERSION NUMBER

Change to Data Element: Changed Dataset

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

Notes:

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

DATE AND TIME DATA SET CREATED

Change to Data Element: Changed Dataset

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

Notes:

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

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

DATE DETENTION COMMENCED

Change to Data Element: Changed Description

Format/length:	see DATE
HES item:	DETNDATE
Format/Length:	See DATE
HES Item:	DETNDATE
National Codes:	
Default Codes:	

Notes:

~~[DATE DETENTION COMMENCED](#) is the same as the attribute [PERSON PROPERTY EFFECTIVE DATE](#). [DATE DETENTION COMMENCED](#) is the [PERSON PROPERTY EFFECTIVE DATE](#) of the first [MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION](#) where the [PATIENT](#) is detained.~~

~~This is the [PERSON PROPERTY EFFECTIVE DATE](#) of the [Mental Health Act Legal Status](#). It is the date on which the first order was made in this period of detention, even though the section of the Act under which the [PATIENT](#) is detained may have changed, the [PATIENT](#) may have been transferred to another provider or the [PATIENT](#) was detained under the Act after admission to the current provider. All changes in [MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE](#) should be recorded, and the continuous period of detention obtained by comparing the [PERSON PROPERTY EFFECTIVE DATES](#) for the historical [Mental Health Act Legal Status records](#).~~ [DATE DETENTION COMMENCED](#) is the date on which the first order was made in this period of detention, even though the section of the Act under which the [PATIENT](#) is detained may have changed, the [PATIENT](#) may have been transferred to another provider or the [PATIENT](#) was detained under the Act after admission to the current provider. All changes in [MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE](#) should be recorded, and the continuous period of detention obtained by comparing the [PERSON PROPERTY EFFECTIVE DATES](#) for the historical Mental Health Act Legal Status records. (Act refers to the 1983 Mental Health Act).

Where the detention order is held by a hospital other than that where the [PATIENT](#) is present at the date of the census, the latter should ensure the information relating to this detention order is obtained from the former hospital. Only the hospital where the [PATIENT](#) is treated should submit the data.

~~[Mental Health Act Legal Status](#) is a [CATEGORY VALUED PERSON OBSERVATION](#) where [CATEGORY VALUED PERSON OBSERVATION TYPE](#) is National Code 07 'Legal Status Classification'.~~

DATE OF ASSAULT ON PATIENT

Change to Data Element: Changed Description, Dataset

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

Notes:

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

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

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

~~[DATE OF ASSAULT ON PATIENT](#) is only reported in the [Mental Health and Learning Disabilities Data Set](#) if the assault occurred during a [Hospital Provider Spell](#).~~

DATE OF RESTRICTIVE INTERVENTION

Change to Data Element: New Data Element

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

Notes:

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

This data element is also known by these names:

Context	Alias
plural	DATES OF RESTRICTIVE INTERVENTION

DATE OF RESTRICTIVE INTERVENTION

Change to Data Element: New Data Element

DATE OF RESTRICTIVE INTERVENTION**Attribute:**

ACTIVITY DATE

DATE OF SELF-HARM_ renamed from DATE OF SELF HARM

Change to Data Element: Changed Description, Dataset, Name

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

Notes:

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

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

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

~~[DATE OF SELF HARM](#) is only reported in the [Mental Health and Learning Disabilities Data Set](#) if the self harm occurred during a [Hospital Provider Spell](#).~~

DATE OF SELF-HARM_ renamed from DATE OF SELF HARM

Change to Data Element: Changed Description, Dataset, Name

- Changed Description
- null

- Changed Name from Data_Dictionary.Data_Field_Notes.D.DATE_OF_SELF_HARM to Data_Dictionary.Data_Field_Notes.D.DATE_OF_SELF-HARM

DIAGNOSIS DATE

Change to Data Element: Changed Dataset

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

Notes:

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

DIAGNOSIS SCHEME IN USE

Change to Data Element: Changed Description, Dataset, linked Attribute

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

Notes:

[DIAGNOSIS SCHEME IN USE](#) is used in the Clinical Information Group of the Commissioning Data Set to denote the code scheme basis of the Diagnosis.

Permitted National Codes:

01	Accident & Emergency Diagnosis
02	ICD-10
03	Read Code 4Byte Version (retired 1 October 2009)
04	Read Code Version 2
05	Read Code Clinical Terms Version 3 (CTV3)

~~Read Code Clinical Terms Version 3 (CTV3) with qualifiers (previously known as 3.1) is not supported in the Commissioning Data Sets.~~

~~CDS XML Message:~~

~~The codes specified above must be used in Commissioning Data Set XML messages.~~

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

DIAGNOSIS SCHEME IN USE

Change to Data Element: Changed Description, Dataset, linked Attribute

DIAGNOSIS SCHEME IN USE

Attribute:

DIAGNOSIS SCHEME IN USE

DISABILITY CODE

Change to Data Element: Changed Dataset

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

Notes:

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

DISABILITY IMPACT PERCEPTION

Change to Data Element: New Data Element

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

Notes:

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

This data element is also known by these names:

Context	Alias
plural	DISABILITY IMPACT PERCEPTIONS

DISABILITY IMPACT PERCEPTION

Change to Data Element: New Data Element

DISABILITY IMPACT PERCEPTION

Attribute:

DISABILITY IMPACT PERCEPTION
--

DISCHARGE DATE (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Dataset

Format/Length:	See DATE
HES Item:	DISDATE
National Codes:	
Default Codes:	

Notes:

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

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

DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Dataset

Format/Length:	an2
HES Item:	DISDEST
National Codes:	See DISCHARGE DESTINATION
Default Codes:	98 - Not applicable - Hospital Provider Spell not finished at episode end (i.e. not discharged) or current episode unfinished 99 - Not known: a validation error

Notes:

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

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

For further information, please refer to the [Secondary Uses Service Guidance](#) page.

DISCHARGE LETTER ISSUED DATE (MENTAL HEALTH AND COMMUNITY CARE)

Change to Data Element: New Data Element

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

Notes:

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

This data element is also known by these names:

Context	Alias
plural	DISCHARGE LETTER ISSUED DATES (MENTAL HEALTH AND COMMUNITY CARE)

DISCHARGE LETTER ISSUED DATE (MENTAL HEALTH AND COMMUNITY CARE)

Change to Data Element: New Data Element

DISCHARGE LETTER ISSUED DATE (MENTAL HEALTH AND COMMUNITY CARE)

Attribute:

ACTIVITY DATE

DISCHARGE METHOD CODE (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Dataset

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

Notes:

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

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

For further information, please refer to the [Secondary Uses Service Guidance](#) page.

DISCHARGE METHOD CODE (HOSPITAL PROVIDER SPELL) replaces **DISCHARGE METHOD (HOSPITAL PROVIDER SPELL)** and should be used for all new and developing data sets and for XML messages.

DISCHARGE TIME (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Description, Dataset

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

Notes:

[DISCHARGE TIME \(HOSPITAL PROVIDER SPELL\)](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Discharge Time](#)'. [DISCHARGE TIME \(HOSPITAL PROVIDER SPELL\)](#) is the time a [PATIENT](#) was discharged from a [Hospital Provider Spell](#).

DURATION OF INDIRECT ACTIVITY

Change to Data Element: New Data Element

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

Notes:

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

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

This data element is also known by these names:

Context	Alias
plural	DURATION OF INDIRECT ACTIVITIES

DURATION OF RESTRICTIVE INTERVENTION

Change to Data Element: New Data Element

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

Notes:

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

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

This data element is also known by these names:

Context	Alias
plural	DURATIONS OF RESTRICTIVE INTERVENTION

EARLIEST CLINICALLY APPROPRIATE DATE

Change to Data Element: Changed Description, Dataset

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

Notes:

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

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

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

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

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

EARLIEST REASONABLE OFFER DATE

Change to Data Element: Changed Description, Dataset

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

Notes:

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

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

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

Patient Cancellations

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

Provider Cancellations

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

Patients who are unavailable

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

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

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

If the Commissioning Data Set record:

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

and

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

and

is of the following Commissioning Data Set Types:

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

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

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

~~Use in the Community Information Data Set and Commissioning Data Set (version 6-2 onwards) for Allied Health Professional Referral To Treatment:~~ Use in the Community Information Data Set, Mental

Health Services Data Set and Commissioning Data Set (version 6-2 onwards) for Allied Health Professional Referral To Treatment:

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

- where a [PATIENT](#) who is a child has been offered an [APPOINTMENT](#) but their parent/carer states that they wish to wait until the school holidays commence. The [Community Health 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 [Community Health Service](#).
- where a [PATIENT](#) who is a child has been offered an [APPOINTMENT](#) but their parent/carer states that they wish to wait until the school holidays commence. The [Community Health Service](#) or [Mental Health 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 [Community Health Service](#) or [Mental Health Service](#).

EMERGENT PSYCHOSIS DATE

Change to Data Element: Changed Description, Dataset, linked Attribute

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

Notes:

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

EMERGENT PSYCHOSIS DATE

Change to Data Element: Changed Description, Dataset, linked Attribute

EMERGENT PSYCHOSIS DATE

Attribute:

PERSON PROPERTY OBSERVED DATE

EMPLOYMENT STATUS

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See EMPLOYMENT STATUS
Default Codes:	

Notes:

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

EMPLOYMENT STATUS RECORDED DATE

Change to Data Element: Changed Description, Dataset, linked Attribute

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

Notes:

~~[EMPLOYMENT STATUS RECORDED DATE](#) is the [DATE](#) that the [EMPLOYMENT STATUS](#) of a [PATIENT](#) was recorded.~~ [EMPLOYMENT STATUS RECORDED DATE](#) is the same as attribute [PERSON PROPERTY RECORDED DATE](#). [EMPLOYMENT STATUS RECORDED DATE](#) is the [DATE](#) when the [EMPLOYMENT STATUS](#) was recorded.

EMPLOYMENT STATUS RECORDED DATE

Change to Data Element: Changed Description, Dataset, linked Attribute

EMPLOYMENT STATUS RECORDED DATE

Attribute:

PERSON PROPERTY RECORDED DATE

END DATE (CARE CLUSTER ASSIGNMENT PERIOD)

Change to Data Element: New Data Element

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

Notes:

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

This data element is also known by these names:

Context	Alias
plural	END DATES (CARE CLUSTER ASSIGNMENT PERIOD)

END DATE (CARE CLUSTER ASSIGNMENT PERIOD)

Change to Data Element: New Data Element

END DATE (CARE CLUSTER ASSIGNMENT PERIOD)

Attribute:

ACTIVITY DATE

END DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)

Change to Data Element: New Data Element

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

Notes:

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

This data element is also known by these names:

Context	Alias
plural	END DATES (CARE PROFESSIONAL ADMITTED CARE EPISODE)

END DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)

Change to Data Element: New Data Element

END DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)

Attribute:

ACTIVITY DATE

END DATE (CARE PROGRAMME APPROACH CARE)

Change to Data Element: Changed Description, Dataset

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

Notes:

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

END DATE (COMMISSIONER ASSIGNMENT PERIOD)

Change to Data Element: Changed Dataset

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

Notes:

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

END DATE (COMMUNITY TREATMENT ORDER)_ renamed from END DATE (SUPERVISED COMMUNITY TREATMENT)

Change to Data Element: Changed Description, Dataset, Name

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

Notes:

~~END DATE (SUPERVISED COMMUNITY TREATMENT)~~ is the same as attribute ~~ACTIVITY DATE~~ where the ~~ACTIVITY DATE TYPE~~ is National Code '~~End Date~~' of the ~~Supervised Community Treatment~~. ~~END DATE (COMMUNITY TREATMENT ORDER)~~ is the same as attribute ~~ACTIVITY DATE~~ where the ~~ACTIVITY DATE TYPE~~ is National Code '~~End Date~~' of the ~~Community Treatment Order~~.

END DATE (COMMUNITY TREATMENT ORDER)_ renamed from END DATE (SUPERVISED COMMUNITY TREATMENT)

Change to Data Element: Changed Description, Dataset, Name

- Changed Description
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.E.En.END_DATE_(SUPERVISED_COMMUNITY_TREATMENT) to Data_Dictionary.Data_Field_Notes.E.En.END_DATE_(COMMUNITY_TREATMENT_ORDER)

END DATE (COMMUNITY TREATMENT ORDER RECALL)_ renamed from END DATE (SUPERVISED COMMUNITY TREATMENT RECALL)

Change to Data Element: Changed Description, Dataset, Name

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

Notes:

~~END DATE (SUPERVISED COMMUNITY TREATMENT RECALL)~~ is the same as attribute ~~ACTIVITY DATE~~ where the ~~ACTIVITY DATE TYPE~~ is National Code '~~End Date~~' of the ~~Supervised Community Treatment Recall~~. ~~END DATE (COMMUNITY TREATMENT ORDER RECALL)~~ is the same as attribute ~~ACTIVITY DATE~~ where the ~~ACTIVITY DATE TYPE~~ is National Code '~~End Date~~' of the ~~Community Treatment Order Recall~~.

END DATE (COMMUNITY TREATMENT ORDER RECALL)_ renamed from END DATE (SUPERVISED COMMUNITY TREATMENT RECALL)

Change to Data Element: Changed Description, Dataset, Name

- Changed Description
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.E.En.END_DATE_(SUPERVISED_COMMUNITY_TREATMENT_RECALL) to Data_Dictionary.Data_Field_Notes.E.En.END_DATE_(COMMUNITY_TREATMENT_ORDER_RECALL)

END DATE (GMP PATIENT REGISTRATION)

Change to Data Element: Changed Dataset

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

Notes:

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

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

END DATE (HOME LEAVE)

Change to Data Element: Changed Dataset

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

Notes:

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

END DATE (MENTAL HEALTH ABSENCE WITHOUT LEAVE)

Change to Data Element: Changed Dataset

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

Notes:

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

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

Change to Data Element: Changed Description, Dataset, Name

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

Notes:

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

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

Change to Data Element: Changed Description, Dataset, Name

- Changed Description
 - null
 - Changed Name from Data_Dictionary.Data_Field_Notes.E.En.END_DATE_(MENTAL_HEALTH_ACT_LEGAL_STATUS_CLASSIFICATION) to Data_Dictionary.Data_Field_Notes.E.En.END_DATE_(MENTAL_HEALTH_ACT_LEGAL_STATUS_CLASSIFICATION_ASSIGNMENT_PERIOD)
-

END DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD)_ renamed from END DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT)

Change to Data Element: Changed Description, Dataset, Name

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

Notes:

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

END DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD)_ renamed from END DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT)

Change to Data Element: Changed Description, Dataset, Name

- Changed Description
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.E.En.END_DATE_(MENTAL_HEALTH_CARE_COORDINATOR_ASSIGNMENT) to Data_Dictionary.Data_Field_Notes.E.En.END_DATE_(MENTAL_HEALTH_CARE_COORDINATOR_ASSIGNMENT_PERIOD)

END DATE (MENTAL HEALTH CONDITIONAL DISCHARGE)

Change to Data Element: Changed Dataset

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

Notes:

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

END DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD)

Change to Data Element: Changed Description, Dataset

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

Notes:

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

~~[END DATE \(MENTAL HEALTH DELAYED DISCHARGE PERIOD\)](#) is the date where the clinical decision is taken that the [PATIENT](#) is no longer fit for discharge, and further inpatient care is required.~~

END DATE (MENTAL HEALTH LEAVE OF ABSENCE)

Change to Data Element: Changed Dataset

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

Notes:

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

END DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD) renamed from **END DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT)**

Change to Data Element: Changed Dataset, Name

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

Notes:

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

END DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD) renamed from **END DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT)**

Change to Data Element: Changed Dataset, Name

- null
- Changed Name from Data_Dictionary.Data_Field_Notes.E.En.END_DATE_(MENTAL_HEALTH_RESPONSIBLE_CLINICIAN_ASSIGNMENT) to Data_Dictionary.Data_Field_Notes.E.En.END_DATE_(MENTAL_HEALTH_RESPONSIBLE_CLINICIAN_ASSIGNMENT_PERIOD)

END DATE (WARD STAY)

Change to Data Element: Changed Dataset

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

Notes:

[END DATE \(WARD STAY\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[End Date](#)' of the [Ward Stay](#).

END TIME (CARE CLUSTER ASSIGNMENT PERIOD)

Change to Data Element: New Data Element

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

Notes:

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

This data element is also known by these names:

Context	Alias
plural	END TIMES (CARE CLUSTER ASSIGNMENT PERIOD)

END TIME (CARE CLUSTER ASSIGNMENT PERIOD)

Change to Data Element: New Data Element

END TIME (CARE CLUSTER ASSIGNMENT PERIOD)

Attribute:

ACTIVITY TIME

END TIME (COMMUNITY TREATMENT ORDER RECALL)_ renamed from END TIME (SUPERVISED COMMUNITY TREATMENT RECALL)

Change to Data Element: Changed Description, Dataset, Name

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

Notes:

~~END TIME (SUPERVISED COMMUNITY TREATMENT RECALL)~~ is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[End Time](#)' of the ~~Supervised Community Treatment Recall~~. ~~END TIME (COMMUNITY TREATMENT ORDER RECALL)~~ is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[End Time](#)' of the [Community Treatment Order Recall](#).

END TIME (COMMUNITY TREATMENT ORDER RECALL)_ renamed from END TIME (SUPERVISED COMMUNITY TREATMENT RECALL)

Change to Data Element: Changed Description, Dataset, Name

- Changed Description
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.E.En.END_TIME_(SUPERVISED_COMMUNITY_TREATMENT_RECALL) to Data_Dictionary.Data_Field_Notes.E.En.END_TIME_(COMMUNITY_TREATMENT_ORDER_RECALL)

END TIME (HOME LEAVE)

Change to Data Element: New Data Element

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

Notes:

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

This data element is also known by these names:

Context	Alias
plural	END TIMES (HOME LEAVE)

END TIME (HOME LEAVE)

Change to Data Element: New Data Element

END TIME (HOME LEAVE)

Attribute:

ACTIVITY TIME

END TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE)

Change to Data Element: New Data Element

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

Notes:

END TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code 'End Time' of the Mental Health Absence Without Leave.

This data element is also known by these names:

Context	Alias
plural	END TIMES (MENTAL HEALTH ABSENCE WITHOUT LEAVE)

END TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE)

Change to Data Element: New Data Element

END TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE)

Attribute:

ACTIVITY TIME

END TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)_ renamed from END TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)

Change to Data Element: Changed Description, Dataset, Name

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

Notes:

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

END TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)_ renamed from END TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)

Change to Data Element: Changed Description, Dataset, Name

- Changed Description
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.E.En.END_TIME_(MENTAL_HEALTH_ACT_LEGAL_STATUS_CLASSIFICATION) to

END TIME (MENTAL HEALTH LEAVE OF ABSENCE)

Change to Data Element: New Data Element

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

Notes:

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

This data element is also known by these names:

Context	Alias
plural	END TIMES (MENTAL HEALTH LEAVE OF ABSENCE)

END TIME (MENTAL HEALTH LEAVE OF ABSENCE)

Change to Data Element: New Data Element

END TIME (MENTAL HEALTH LEAVE OF ABSENCE)

Attribute:

ACTIVITY TIME

END TIME (WARD STAY)

Change to Data Element: Changed Dataset

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

Notes:

[END TIME \(WARD STAY\)](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[End Time](#)' of the [Ward Stay](#).

ETHNIC CATEGORY

Change to Data Element: Changed Dataset

Format/Length:	an2
HES Item:	ETHNOS
NWDS ID:	PETH
NWDS Field Name:	Ethnic Category
ESR Field Name:	Ethnic Origin
National Codes:	See ETHNIC CATEGORY CODE
Default Codes:	99 - Not known

Notes:

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

The 16+1 ethnic data categories defined in the 2001 census is the national mandatory standard for the collection and analysis of ethnicity.

The national code must be transmitted as the first character in the 2 character field. The second character is optional for use locally. It must, however, be able to be grouped consistently with the 16 main categories.

The information recorded about [ETHNIC CATEGORIES](#) must be obtained by asking the [PATIENT](#).

National code Z should be used where the [PERSON](#) has been given the opportunity to state their [ETHNIC CATEGORY](#) but chose not to. Default code 99 should be used where the [PERSON](#)'s [ETHNIC CATEGORY](#) is not known.

EXPIRY DATE (COMMUNITY TREATMENT ORDER) renamed from EXPIRY DATE (SUPERVISED COMMUNITY TREATMENT)

Change to Data Element: Changed Description, Dataset, Name, linked Attribute

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

Notes:

[EXPIRY DATE \(SUPERVISED COMMUNITY TREATMENT\)](#) is the [DATE](#) when [Supervised Community Treatment](#) for a [PATIENT](#) expires. [EXPIRY DATE \(COMMUNITY TREATMENT ORDER\)](#) is the same as attribute [PERSON PROPERTY EFFECTIVE END DATE](#). [EXPIRY DATE \(COMMUNITY TREATMENT ORDER\)](#) is the [DATE](#) when a [Community Treatment Order](#) for a [PATIENT](#) expires.

EXPIRY DATE (COMMUNITY TREATMENT ORDER) renamed from EXPIRY DATE (SUPERVISED COMMUNITY TREATMENT)

Change to Data Element: Changed Description, Dataset, Name, linked Attribute

EXPIRY DATE (COMMUNITY TREATMENT ORDER)

Attribute:

PERSON PROPERTY EFFECTIVE END DATE
--

EXPIRY DATE (COMMUNITY TREATMENT ORDER) renamed from EXPIRY DATE (SUPERVISED COMMUNITY TREATMENT)

Change to Data Element: Changed Description, Dataset, Name, linked Attribute

- Changed Description
- null
- Changed Name from `Data_Dictionary.Data_Field_Notes.E.Ex.EXPIRY_DATE_(SUPERVISED_COMMUNITY_TREATMENT)` to `Data_Dictionary.Data_Field_Notes.E.Ex.EXPIRY_DATE_(COMMUNITY_TREATMENT_ORDER)`
- null

EXPIRY DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)

Change to Data Element: Changed Description, Dataset, linked Attribute

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

Notes:

[EXPIRY DATE \(MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION\)](#) is the same as attribute [PERSON PROPERTY EFFECTIVE END DATE](#).

[EXPIRY DATE \(MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION\)](#) is the [DATE](#) when a [MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION](#) for a [PATIENT](#) expires.

EXPIRY DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)

Change to Data Element: Changed Description, Dataset, linked Attribute

EXPIRY DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)

Attribute:

[PERSON PROPERTY EFFECTIVE END DATE](#)

EXPIRY TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)

Change to Data Element: Changed Description, Dataset, linked Attribute

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

Notes:

~~[END TIME \(MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION\)](#) is the [TIME](#) when a [MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION](#) for a [PATIENT](#) expires.~~ [END TIME \(MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD\)](#) is the same as attribute [PERSON PROPERTY EFFECTIVE END TIME](#). [END TIME \(MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD\)](#) is the [TIME](#) when a [MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION](#) for a [PATIENT](#) expires.

EXPIRY TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)

Change to Data Element: Changed Description, Dataset, linked Attribute

EXPIRY TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)

Attribute:

[PERSON PROPERTY EFFECTIVE END TIME](#)

FINDING SCHEME IN USE

Change to Data Element: New Data Element

Format/Length: an2
National Codes: See [FINDING SCHEME IN USE](#)
Default Codes:

Notes:

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

This data element is also known by these names:

Context	Alias
plural	FINDING SCHEMES IN USE

FINDING SCHEME IN USE

Change to Data Element: New Data Element

FINDING SCHEME IN USE

Attribute:

FINDING SCHEME IN USE

FIRST PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION)_ renamed from PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION)

Change to Data Element: Changed Description, Dataset, Name, linked Attribute

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

Notes:

~~PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION) is the PRESCRIPTION DATE where the PRESCRIBED ITEM is 'Anti Psychotic Medication'.~~ **FIRST PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION) is the same as attribute PRESCRIPTION DATE.**

FIRST PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION) is the date the PATIENT was first prescribed Anti-Psychotic Medication following referral into an Early Intervention in Psychosis (EIP) Service.

FIRST PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION)_ renamed from PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION)

Change to Data Element: Changed Description, Dataset, Name, linked Attribute

FIRST PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION)

Attribute:

PRESCRIPTION DATE

FIRST PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION)_ renamed from PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION)

Change to Data Element: Changed Description, Dataset, Name, linked Attribute

- Changed Description
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.P.Pres.PRESCRIPTION_DATE_(ANTI-PSYCHOTIC_MEDICATION) to Data_Dictionary.Data_Field_Notes.F.FIRST_PRESCRIPTION_DATE_(ANTI-PSYCHOTIC_MEDICATION)
- null

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)

Change to Data Element: New Data Element

Format/Length: max an4
National Codes: See FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE
Default Codes:

Notes:

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (FINAL) is the same as attribute FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE.

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (FINAL) is the final FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE allocated by the CARE PROFESSIONAL.

Note: This data item is included in the Mental Health Services Data Set but should not be submitted until further development by the Health and Social Care Information Centre has been undertaken.

This data element is also known by these names:

Context	Alias
plural	<u>FORENSIC LEARNING DISABILITIES CARE CLUSTER CODES (FINAL)</u>

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)

Change to Data Element: New Data Element

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)

Attribute:

<u>FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE</u>

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)

Change to Data Element: New Data Element

Format/Length:	max an4
National Codes:	See <u>FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE</u>
Default Codes:	

Notes:

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL) is the same as attribute FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE.

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL) is the initial FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE allocated by the CARE PROFESSIONAL.

Note: This data item is included in the Mental Health Services Data Set, but should not be submitted until further development by the Health and Social Care Information Centre has been undertaken.

This data element is also known by these names:

Context	Alias
plural	<u>FORENSIC LEARNING DISABILITIES CARE CLUSTER CODES (INITIAL)</u>

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)

Change to Data Element: New Data Element

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)

Attribute:

--

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE

FORENSIC MENTAL HEALTH CARE CLUSTER CODE (FINAL)

Change to Data Element: New Data Element

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

Notes:

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

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

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

This data element is also known by these names:

Context	Alias
plural	FORENSIC MENTAL HEALTH CARE CLUSTER CODES (FINAL)

FORENSIC MENTAL HEALTH CARE CLUSTER CODE (FINAL)

Change to Data Element: New Data Element

FORENSIC MENTAL HEALTH CARE CLUSTER CODE (FINAL)

Attribute:

[FORENSIC MENTAL HEALTH CARE CLUSTER CODE](#)

FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL)

Change to Data Element: New Data Element

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

Notes:

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

[FORENSIC MENTAL HEALTH CARE CLUSTER CODE \(INITIAL\)](#) is the initial [FORENSIC MENTAL HEALTH CARE CLUSTER CODE](#) allocated by the [CARE PROFESSIONAL](#).

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

This data element is also known by these names:

Context	Alias
plural	FORENSIC MENTAL HEALTH CARE CLUSTER CODES (INITIAL)

FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL)

Change to Data Element: New Data Element

FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL)

Attribute:

FORENSIC MENTAL HEALTH CARE CLUSTER CODE
--

GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)

Change to Data Element: Changed Dataset

Format/Length:	an6
HES Item:	GPPRAC
National Codes:	
ODS Default Codes:	V81997 - No Registered GP Practice
	V81998 - GP Practice Code not applicable
	V81999 - GP Practice Code not known

Notes:

[GENERAL MEDICAL PRACTICE CODE \(PATIENT REGISTRATION\)](#) is the same as attribute [ORGANISATION CODE](#).

[GENERAL MEDICAL PRACTICE CODE \(PATIENT REGISTRATION\)](#) is the [ORGANISATION CODE](#) of the [GP Practice](#) that the [PATIENT](#) is registered with.

Use of [Organisation Data Service Default Codes](#)

- **V81997** should be used when a [PATIENT](#) presents, who is not currently registered at a [GP Practice](#), *but is eligible to be registered should they wish to*.
- **V81998** should be used where a [PATIENT](#) should not have a registered [GP Practice](#), due for instance to them having only recently entered the country.
- **V81999** should be used where it is not possible to determine a [PATIENT](#)'s registered [GP Practice](#) code, but it is known that they should have one, or where it is impossible to determine whether they should or shouldn't have a registered practice (for instance the [PATIENT](#) cannot communicate and is unidentified).

GROUP SESSION DATE

Change to Data Element: Changed Dataset

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

Notes:

[GROUP SESSION DATE](#) is the [SESSION DATE](#) of the [Group Session](#).

GROUP SESSION IDENTIFIER

Change to Data Element: New Data Element

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

Notes:

GROUP SESSION IDENTIFIER is the ACTIVITY IDENTIFIER for a Group Session.

This data element is also known by these names:

Context	Alias
plural	GROUP SESSION IDENTIFIERS

GROUP SESSION IDENTIFIER

Change to Data Element: New Data Element

GROUP SESSION IDENTIFIER

Attribute:

ACTIVITY IDENTIFIER

GROUP SESSION TYPE (MENTAL HEALTH)

Change to Data Element: New Data Element

Format/Length: an2
National Codes: See GROUP SESSION TYPE FOR MENTAL HEALTH
Default Codes:

Notes:

GROUP SESSION TYPE (MENTAL HEALTH) is the same as attribute GROUP SESSION TYPE FOR MENTAL HEALTH.

This data element is also known by these names:

Context	Alias
plural	GROUP SESSION TYPES (MENTAL HEALTH)

GROUP SESSION TYPE (MENTAL HEALTH)

Change to Data Element: New Data Element

GROUP SESSION TYPE (MENTAL HEALTH)

Attribute:

GROUP SESSION TYPE FOR MENTAL HEALTH

GROUP THERAPY INDICATOR

Change to Data Element: New Data Element

Format/Length: an1
National Codes: See GROUP THERAPY INDICATOR
Default Codes: Z - Not Known if the ACTIVITY was Group Therapy

Notes:

GROUP THERAPY INDICATOR is the same as attribute GROUP THERAPY INDICATOR.

This data element is also known by these names:

Context	Alias
plural	GROUP THERAPY INDICATORS

GROUP THERAPY INDICATOR

Change to Data Element: New Data Element

GROUP THERAPY INDICATOR

Attribute:

GROUP THERAPY INDICATOR

HOSPITAL PROVIDER SPELL NUMBER

Change to Data Element: Changed Dataset

Format/Length:	an12
HES Item:	PROVSPNO
National Codes:	
Default Codes:	

Notes:

[HOSPITAL PROVIDER SPELL NUMBER](#) is the same as attribute [ACTIVITY IDENTIFIER](#).

A [HOSPITAL PROVIDER SPELL NUMBER](#) is a unique identifier for each [Hospital Provider Spell](#) for a [Health Care Provider](#).

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

For further information, please refer to the [Secondary Uses Service Guidance](#) page.

INDIRECT ACTIVITY DATE

Change to Data Element: New Data Element

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

Notes:

[INDIRECT ACTIVITY DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Indirect Activity Date](#)'.

This data element is also known by these names:

Context	Alias
plural	INDIRECT ACTIVITY DATES

INDIRECT ACTIVITY DATE

Change to Data Element: New Data Element

INDIRECT ACTIVITY DATE

Attribute:

ACTIVITY DATE

INDIRECT ACTIVITY TIME

Change to Data Element: New Data Element

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

Notes:

[INDIRECT ACTIVITY TIME](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '*Indirect Activity Time*'.

This data element is also known by these names:

Context	Alias
plural	INDIRECT ACTIVITY TIMES

INDIRECT ACTIVITY TIME

Change to Data Element: New Data Element

INDIRECT ACTIVITY TIME

Attribute:

ACTIVITY TIME

INTENDED AGE GROUP

Change to Data Element: Changed Description

Format/Length: an1
National Codes:
Default Codes:

Notes:

[INTENDED AGE GROUP](#) is the same as attribute [AGE GROUP INTENDED](#).

[INTENDED AGE GROUP](#) is based on the [AGE GROUP INTENDED](#) National Codes, with the addition of [Home Leave](#):

Permitted National Codes:

- 1 [Neonates](#)
- 2 Children and /or adolescents
- 3 Elderly
- 8 Any age
- 9 [Home Leave](#) *

* Note - National Code 9 is not valid for the [Mental Health and Learning Disabilities Data Set](#). * Note - National Code 9 is not valid for the [Mental Health Services Data Set](#).

INTENDED CLINICAL CARE INTENSITY CODE (MENTAL HEALTH)

Change to Data Element: Changed Description, Dataset

Format/Length:	an2
National Codes:	
Default Codes:	

Notes:

~~INTENDED CLINICAL CARE INTENSITY CODE (MENTAL HEALTH) is the same as attribute CLINICAL CARE INTENSITY.~~ INTENDED CLINICAL CARE INTENSITY CODE (MENTAL HEALTH) is the same as attribute CLINICAL CARE INTENSITY for the [Mental Health Services Data Set](#).

Permitted National Codes:

For PATIENTS with Mental Illness:

- 51 For Intensive Care - specially designated ward for [PATIENTS](#) needing containment and more intensive management (eg Psychiatric Intensive Care Unit (PICU)). This is not to be confused with intensive nursing where a [PATIENT](#) may require one-to-one nursing while on a standard [WARD](#)
- 52 For Short Stay - [PATIENTS](#) intended to stay for less than a year
- 53 For Long Stay - [PATIENTS](#) intended to stay for a year or more

For PATIENTS with Learning Disabilities:

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

~~In addition to this, the following value which is not part of the National Codes is also permitted for the [Child and Adolescent Mental Health Services Secondary Uses Data Set](#) (see [INTENDED CLINICAL CARE INTENSITY CODE](#)).~~

- 72 [Home Leave](#), psychiatric *

* Note ~~National Code 72 is not valid for the [Mental Health and Learning Disabilities Data Set](#).~~

LANGUAGE CODE (PREFERRED)

Change to Data Element: New Data Element

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

Notes:

[LANGUAGE CODE \(PREFERRED\)](#) is the same as the attribute [LANGUAGE CODE](#).

[LANGUAGE CODE \(PREFERRED\)](#) is the language the [PATIENT](#), [Patient Proxy](#) or carer prefers to use for communication with a [Health Care Provider](#).

This data element is also known by these names:

Context	Alias
plural	LANGUAGE CODES (PREFERRED)

LANGUAGE CODE (PREFERRED)

Change to Data Element: New Data Element

LANGUAGE CODE (PREFERRED)

Attribute:

LANGUAGE CODE

LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)

Change to Data Element: New Data Element

Format/Length: max an4
National Codes: See LEARNING DISABILITIES CARE CLUSTER CODE
Default Codes:

Notes:

LEARNING DISABILITIES CARE CLUSTER CODE (FINAL) is the same as attribute LEARNING DISABILITIES CARE CLUSTER CODE.

LEARNING DISABILITIES CARE CLUSTER CODE (FINAL) is the final LEARNING DISABILITIES CARE CLUSTER CODE allocated by the CARE PROFESSIONAL.

Note: This data item is included in the Mental Health Services Data Set, but should not be submitted until further development by the Health and Social Care Information Centre has been undertaken.

This data element is also known by these names:

Context	Alias
plural	LEARNING DISABILITIES CARE CLUSTER CODES (FINAL)

LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)

Change to Data Element: New Data Element

LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)

Attribute:

LEARNING DISABILITIES CARE CLUSTER CODE

LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)

Change to Data Element: New Data Element

Format/Length: max an4
National Codes: See LEARNING DISABILITIES CARE CLUSTER CODE
Default Codes:

Notes:

LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL) is the same as attribute LEARNING DISABILITIES CARE CLUSTER CODE.

LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL) is the initial LEARNING DISABILITIES CARE CLUSTER CODE allocated by the CARE PROFESSIONAL.

Note: This data item is included in the Mental Health Services Data Set, but should not be submitted until further development by the Health and Social Care Information Centre has been undertaken.

This data element is also known by these names:

Context	Alias
plural	LEARNING DISABILITIES CARE CLUSTER CODES (INITIAL)

LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)

Change to Data Element: New Data Element

LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)

Attribute:

<u>LEARNING DISABILITIES CARE CLUSTER CODE</u>
--

LOCAL PATIENT IDENTIFIER (EXTENDED)

Change to Data Element: Changed Description, Dataset

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

Notes:

LOCAL PATIENT IDENTIFIER (EXTENDED) is the same as attribute LOCAL PATIENT IDENTIFIER. LOCAL PATIENT IDENTIFIER (EXTENDED) is used where IT systems have a LOCAL PATIENT IDENTIFIER which is longer than 10 characters and LOCAL PATIENT IDENTIFIER cannot be used for data submission.

LOOKED AFTER CHILD INDICATOR

Change to Data Element: Changed Description, Dataset

Format/Length:	an1
National Codes:	See <u>LOOKED AFTER CHILD INDICATOR</u>
Default Codes:	X - Not known
Default Codes:	X - Not known if the <u>PERSON</u> is a <u>Looked After Child</u>

Notes:

LOOKED AFTER CHILD INDICATOR is the same as attribute LOOKED AFTER CHILD INDICATOR.

MAIN SPECIALTY CODE (MENTAL HEALTH)

Change to Data Element: Changed Description, Dataset

Format/Length:	an3
National Codes:	
Default Codes:	

Notes:

~~MAIN SPECIALTY CODE (MENTAL HEALTH) is the MAIN SPECIALTY CODE of the Mental Health Responsible Clinician for the PATIENT within the REPORTING PERIOD. If there is more than one during the REPORTING PERIOD, this will be the last or final one of REPORTING PERIOD.~~ MAIN SPECIALTY CODE (MENTAL HEALTH) is the same as attribute MAIN SPECIALTY CODE.

~~If the Mental Health Responsible Clinician is the PATIENT's GENERAL MEDICAL PRACTITIONER, the code will be 600. If the Mental Health Responsible Clinician is a CONSULTANT, it will typically be one of the adult or elderly mental health MAIN SPECIALTIES, although it may be either a learning disability or child and adolescent psychiatry in certain circumstances. When the Mental Health Responsible Clinician is not a CONSULTANT, this should be the appropriate pseudo specialty code or left blank.~~ MAIN SPECIALTY CODE (MENTAL HEALTH) is the MAIN SPECIALTY CODE of the CARE PROFESSIONAL working in a Mental Health Service, who is responsible for the PATIENT within the REPORTING PERIOD.

Permitted National Codes:

- 600 General Medical Practice
- ~~700 Learning Disability~~
- 700 Learning Disability
- 710 Adult Mental Illness
- 711 Child and Adolescent Psychiatry
- 712 Forensic Psychiatry
- 713 Psychotherapy
- 715 Old Age Psychiatry
- 950 Nursing Episode
- 960 Allied Health Professional Episode

MANIFEST PSYCHOSIS DATE

Change to Data Element: Changed Description, Dataset, linked Attribute

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

Notes:

MANIFEST PSYCHOSIS DATE is the same as attribute PERSON PROPERTY OBSERVED DATE.

MANIFEST PSYCHOSIS DATE is the DATE at which a positive psychotic symptom for the PATIENT (i.e. delusion, hallucination, or thought disorder) has lasted for a week. This is usually a week after the DATE of the first psychotic symptom.

MANIFEST PSYCHOSIS DATE

Change to Data Element: Changed Description, Dataset, linked Attribute

MANIFEST PSYCHOSIS DATE

Attribute:

PERSON PROPERTY OBSERVED DATE

MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON renamed from **ABSENCE WITHOUT LEAVE END REASON**

Change to Data Element: Changed Description, Dataset, Name

Format/Length:	an2
National Codes:	See ABSENCE WITHOUT LEAVE END REASON
Default Codes:	99 - Not known
National Codes:	See MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON
Default Codes:	99 - MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON Not known

Notes:

~~[ABSENCE WITHOUT LEAVE END REASON](#) is the same as attribute [ABSENCE WITHOUT LEAVE END REASON](#).~~ [MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON](#) is the same as attribute [MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON](#).

MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON_ renamed from ABSENCE WITHOUT LEAVE END REASON

Change to Data Element: Changed Description, Dataset, Name

- Changed Description
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.A.ABSENCE_WITHOUT_LEAVE_END_REASON to Data_Dictionary.Data_Field_Notes.M.Men.MENTAL_HEALTH_ABSENCE_WITHOUT_LEAVE_END_REASON

MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY_ renamed from MENTAL HEALTH ABSOLUTE DISCHARGE END METHOD

Change to Data Element: Changed Description, Dataset, Name

Format/Length:	an2
National Codes:	See MENTAL HEALTH ABSOLUTE DISCHARGE END METHOD
National Codes:	See MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY
Default Codes:	

Notes:

~~[MENTAL HEALTH ABSOLUTE DISCHARGE END METHOD](#) is the same as attribute [MENTAL HEALTH ABSOLUTE DISCHARGE END METHOD](#).~~

~~[MENTAL HEALTH ABSOLUTE DISCHARGE END METHOD](#) is only required if the period of Mental Health Conditional Discharge is ended and the [MENTAL HEALTH CONDITIONAL DISCHARGE END REASON](#) is National Code 'Absolute discharge'.~~

[MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY](#) is the same as attribute [MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY](#).

MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY_ renamed from MENTAL HEALTH ABSOLUTE DISCHARGE END METHOD

Change to Data Element: Changed Description, Dataset, Name

- Changed Description
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.M.Men.MENTAL_HEALTH_ABSOLUTE_DISCHARGE_END_METHOD to Data_Dictionary.Data_Field_Notes.M.Men.MENTAL_HEALTH_ABSOLUTE_DISCHARGE_RESPONSIBILITY

MENTAL HEALTH ACT 2007 MENTAL CATEGORY

Change to Data Element: Changed Description, Dataset, linked Attribute

Format/Length:	an1
National Codes:	See MENTAL HEALTH ACT 2007 MENTAL CATEGORY

Default Codes: 8 - Not applicable (i.e. not detained)
9 - Not known

Notes:

[MENTAL HEALTH ACT 2007 MENTAL CATEGORY](#) is the same as attribute [MENTAL HEALTH ACT 2007 MENTAL CATEGORY](#).

See [Mental Health Act Table](#) for details of how [MENTAL HEALTH ACT 2007 MENTAL CATEGORY](#) relates to Parts and Sections of the Act.

MENTAL HEALTH ACT 2007 MENTAL CATEGORY

Change to Data Element: Changed Description, Dataset, linked Attribute

MENTAL HEALTH ACT 2007 MENTAL CATEGORY

Attribute:

[MENTAL HEALTH ACT 2007 MENTAL CATEGORY](#)

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON_ renamed from MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD END REASON

Change to Data Element: Changed Description, Dataset, Name

Format/Length: an2
National Codes: See [MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD END REASON CODE](#)
National Codes: See [MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON](#)
Default Codes:

Notes:

[MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD END REASON](#) is the same as attribute [MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD END REASON CODE](#). [MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON](#) is the same as attribute [MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON](#).

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON_ renamed from MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD END REASON

Change to Data Element: Changed Description, Dataset, Name

- Changed Description
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.M.Men.MENTAL_HEALTH_ACT_LEGAL_STATUS_CLASSIFICATION_PERIC to Data_Dictionary.Data_Field_Notes.M.Men.MENTAL_HEALTH_ACT_LEGAL_STATUS_CLASSIFICATION_ASSI

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER

Change to Data Element: New Data Element

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

Notes:

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER is the same as attribute ACTIVITY IDENTIFIER.

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER is a unique identifier allocated to each Mental Health Act Legal Status Classification Assignment Period.

This data element is also known by these names:

Context	Alias
plural	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD IDENTIFIERS

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER

Change to Data Element: New Data Element

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER

Attribute:

ACTIVITY IDENTIFIER

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON_ renamed from MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD START REASON

Change to Data Element: Changed Description, Dataset, Name

Format/Length:	an2
National Codes:	See <u>MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD START REASON CODE</u>
National Codes:	See <u>MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON</u>
Default Codes:	

Notes:

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD START REASON is the same as attribute MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD START REASON CODE. MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON is the same as attribute MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON.

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON_ renamed from MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD START REASON

Change to Data Element: Changed Description, Dataset, Name

- Changed Description
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.M.Men.MENTAL_HEALTH_ACT_LEGAL_STATUS_CLASSIFICATION_PERIC to Data_Dictionary.Data_Field_Notes.M.Men.MENTAL_HEALTH_ACT_LEGAL_STATUS_CLASSIFICATION_ASSI

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE

Change to Data Element: Changed Description, Dataset

Format/Length:	an2
National Codes:	See MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE
Default Codes:	98 - Not Applicable 99 - Not Known

Notes:

[MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE](#) is the same as attribute [MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE](#).

[MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE](#) is required for all [PATIENTS](#) who have a [Hospital Provider Spell](#) which includes the care of a [CONSULTANT](#) in the psychiatric specialties or have been discharged from such a [Hospital Provider Spell](#) and are required to receive supervised aftercare under the provisions of the Mental Health (Patients in the Community) Act 1995.

~~Note that the term "informal" is used for those [PATIENTS](#) who are neither formally detained nor receiving supervised aftercare.~~

MENTAL HEALTH CARE CLUSTER END REASON

Change to Data Element: Changed Description

Format/Length:	an2
National Codes:	See MENTAL HEALTH CARE CLUSTER END REASON
Default Codes:	NA - PATIENT continues on same Mental Health Care Cluster following review 99 - Not known
Default Codes:	NA - PATIENT continues on same Adult Mental Health Care Cluster following review 99 - Not known

Notes:

[MENTAL HEALTH CARE CLUSTER END REASON](#) is the same as attribute [MENTAL HEALTH CARE CLUSTER END REASON](#).

MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE

Change to Data Element: Changed Description, Dataset

Format/Length:	an1
National Codes:	See MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE
Default Codes:	Z - Unable to assign PATIENT to Mental Health Care Cluster Super Class

Notes:

[MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE](#) is the same as attribute [MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE](#).

MENTAL HEALTH CARE CONTACT IDENTIFIER

Change to Data Element: Changed Description

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

Notes:

[MENTAL HEALTH CARE CONTACT IDENTIFIER](#) is the [ACTIVITY IDENTIFIER](#) for a [CARE CONTACT](#) within a [Mental Health Care Spell](#).

The [MENTAL HEALTH CARE CONTACT IDENTIFIER](#) is used to uniquely identify the [CARE CONTACT](#) within the [Health Care Provider](#).

MENTAL HEALTH CONDITIONAL DISCHARGE END REASON

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See MENTAL HEALTH CONDITIONAL DISCHARGE END REASON
Default Codes:	

Notes:

[MENTAL HEALTH CONDITIONAL DISCHARGE END REASON](#) is the same as attribute [MENTAL HEALTH CONDITIONAL DISCHARGE END REASON](#).

MENTAL HEALTH CRISIS PLAN CREATION DATE

Change to Data Element: Changed Description, Dataset, linked Attribute

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

Notes:

~~[MENTAL HEALTH CRISIS PLAN CREATION DATE](#) is the [DATE](#) that a [Mental Health Crisis Plan](#) was created.~~
[MENTAL HEALTH CRISIS PLAN CREATION DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Mental Health Crisis Plan Creation Date](#)'.

MENTAL HEALTH CRISIS PLAN CREATION DATE

Change to Data Element: Changed Description, Dataset, linked Attribute

MENTAL HEALTH CRISIS PLAN CREATION DATE

Attribute:

ACTIVITY DATE

MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE

Change to Data Element: Changed Description, Dataset, linked Attribute

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

Notes:

~~[MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE](#) is the [DATE](#) that a [Mental Health Crisis Plan](#) was last~~

~~updated.~~ **MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE** is the same as attribute **ACTIVITY DATE** where the **ACTIVITY DATE TYPE** is National Code '*Mental Health Crisis Plan Last Updated Date*'.

Where the [Mental Health Crisis Plan](#) has not been updated since its creation, the **MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE** is the same as the **MENTAL HEALTH CRISIS PLAN CREATION DATE**.

MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE

Change to Data Element: Changed Description, Dataset, linked Attribute

MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE**Attribute:**

ACTIVITY DATE

MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE

Change to Data Element: Changed Description, Dataset

Format/Length:	an2
National Codes:	See MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE
Default Codes:	

Notes:

[MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE](#) is the same as attribute [MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE](#).

MENTAL HEALTH DELAYED DISCHARGE REASON

Change to Data Element: Changed Description, Dataset

Format/Length:	an2
National Codes:	See MENTAL HEALTH DELAYED DISCHARGE REASON
Default Codes:	

Notes:

[MENTAL HEALTH DELAYED DISCHARGE REASON](#) is the same as attribute [MENTAL HEALTH DELAYED DISCHARGE REASON](#).

MENTAL HEALTH LEAVE OF ABSENCE END REASON renamed from **LEAVE OF ABSENCE END REASON**

Change to Data Element: Changed Description, Dataset, Name

Format/Length:	an2
National Codes:	See LEAVE OF ABSENCE END REASON
Default Codes:	99 - Not known
National Codes:	See MENTAL HEALTH LEAVE OF ABSENCE END REASON
Default Codes:	99 - MENTAL HEALTH LEAVE OF ABSENCE END REASON Not known

Notes:

~~[LEAVE OF ABSENCE END REASON](#) is the same as attribute [LEAVE OF ABSENCE END REASON](#).~~ [MENTAL HEALTH LEAVE OF ABSENCE END REASON](#) is the same as attribute [MENTAL HEALTH LEAVE OF ABSENCE END REASON](#).

MENTAL HEALTH LEAVE OF ABSENCE END REASON_ renamed from LEAVE OF ABSENCE END REASON

Change to Data Element: Changed Description, Dataset, Name

- Changed Description
 - null
 - Changed Name from Data_Dictionary.Data_Field_Notes.L.Le.LEAVE_OF_ABSENCE_END_REASON to Data_Dictionary.Data_Field_Notes.M.Men.MENTAL_HEALTH_LEAVE_OF_ABSENCE_END_REASON
-

NHS NUMBER

Change to Data Element: Changed Dataset

Format/Length:	n10
HES Item:	NEWNHSNO
National Codes:	See NHS NUMBER
Default Codes:	

Notes:

[NHS NUMBER](#) is the same as attribute [NHS NUMBER](#).

For the [AIDC for Patient Identification Data Set](#), [NHS NUMBER](#) must be displayed in accordance with the [NHS Common User Interface Information Standard - NHS Number Input and Display \(ISB 1504\)](#).

NHS NUMBER STATUS INDICATOR CODE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	
Default Codes:	

Notes:

Permitted National Codes:

- 01 Number present and verified
 - 02 Number present but not traced
 - 03 Trace required
 - 04 Trace attempted - No match or multiple match found
 - 05 Trace needs to be resolved - (NHS Number or [PATIENT](#) detail conflict)
 - 06 Trace in progress
 - 07 Number not present and trace not required
 - 08 Trace postponed (baby under six weeks old)
-

NHS SERVICE AGREEMENT LINE NUMBER

Change to Data Element: Changed Description, Dataset

Format/Length:	an10
Format/Length:	an10
National Codes:	
Default Codes:	

Notes:

[NHS SERVICE AGREEMENT LINE NUMBER](#) is the same as attribute [NHS SERVICE AGREEMENT LINE NUMBER](#).

The [NHS SERVICE AGREEMENT LINE NUMBERS](#) may be used to identify a specific [NHS SERVICE AGREEMENT](#) reference where the main identifier refers to a general omnibus agreement.

NUMBER OF GROUP SESSION PARTICIPANTS

Change to Data Element: New Data Element

Format/Length:	max n3
National Codes:	
Default Codes:	

Notes:

[NUMBER OF GROUP SESSION PARTICIPANTS](#) is the number of [PERSON's](#) who participate in a [Group Session](#) (excluding the [CARE PROFESSIONALS](#) responsible for the [Group Session](#)).

OBSERVATION SCHEME IN USE

Change to Data Element: New Data Element

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

Notes:

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

This data element is also known by these names:

Context	Alias
plural	OBSERVATION SCHEMES IN USE

OBSERVATION SCHEME IN USE

Change to Data Element: New Data Element

OBSERVATION SCHEME IN USE**Attribute:**

OBSERVATION SCHEME IN USE

OBSERVATION VALUE

Change to Data Element: New Data Element

Format/Length:	max an10
National Codes:	
Default Codes:	

Notes:

[OBSERVATION VALUE](#) is the same as attribute [OBSERVATION VALUE](#).

This data element is also known by these names:

Context	Alias
plural	OBSERVATION VALUES

OBSERVATION VALUE

Change to Data Element: New Data Element

OBSERVATION VALUE**Attribute:**

OBSERVATION VALUE

OCCUPATION CODE

Change to Data Element: Changed Dataset

Format/Length:	an3
NWDS ID :	GROC
NWDS Field Name :	Occupation Code
National Codes:	
Default Codes:	

Notes:

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

ONWARD REFERRAL DATE

Change to Data Element: New Data Element

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

Notes:

[ONWARD REFERRAL DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code 'Onward Referral Date'.

This data element is also known by these names:

Context	Alias
plural	ONWARD REFERRAL DATES

ONWARD REFERRAL DATE

Change to Data Element: New Data Element

ONWARD REFERRAL DATE**Attribute:**

ACTIVITY DATE

ONWARD REFERRAL REASON

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See ONWARD REFERRAL REASON
Default Codes:	98 - ONWARD REFERRAL REASON Not Applicable 99 - ONWARD REFERRAL REASON Not Known

Notes:

[ONWARD REFERRAL REASON](#) is the same as attribute [ONWARD REFERRAL REASON](#).

This data element is also known by these names:

Context	Alias
plural	ONWARD REFERRAL REASONS

ONWARD REFERRAL REASON

Change to Data Element: New Data Element

ONWARD REFERRAL REASON

Attribute:

ONWARD REFERRAL REASON
--

ORGANISATION CODE (CODE OF COMMISSIONER)

Change to Data Element: Changed Dataset

Format/Length:	an3 or an5
HES Item:	PURCODE
National Codes:	
ODS Default Codes:	VPP00 - Private PATIENTS / Overseas Visitor liable for charge XMD00 - Commissioner Code for Ministry of Defence (MoD) Healthcare YDD82 - Episodes funded directly by the National Commissioning Group for England

Notes:

[ORGANISATION CODE \(CODE OF COMMISSIONER\)](#) is the same as attribute [ORGANISATION CODE](#).

[ORGANISATION CODE \(CODE OF COMMISSIONER\)](#) is the [ORGANISATION CODE](#) of the [ORGANISATION](#) commissioning health care.

For [Commissioning Data Sets](#), the [ORGANISATION CODE \(CODE OF COMMISSIONER\)](#) should always be the [ORGANISATION CODE](#) of the original commissioner to support the [National Tariff Payment System](#).

The [NHS England](#) document "[Who pays? Determining responsibility for payments to providers](#)" sets out a framework for establishing responsibility for commissioning an individual's care within the NHS, (i.e. determining who pays for a [PATIENT](#)'s care.)

The document includes information on the following:

- General Rules
- Applying the rules to [Clinical Commissioning Group](#) commissioned services
- Exceptions to the general rules
- Examples to help clarify the boundaries of responsibility between commissioning [ORGANISATIONS](#).

For further information on this document contact [NHS England](#) at "[Contact us](#)".

ORGANISATION CODE (CODE OF PROVIDER)

Change to Data Element: Changed Dataset

Format/Length:	an3, an5 or an6
HES Item:	PROCEDURE

National Codes:

[ODS Default Codes](#): 89997 - Non-UK provider where no [ORGANISATION CODE](#) has been issued
89999 - Non-NHS UK provider where no [ORGANISATION CODE](#) has been issued

Notes:

[ORGANISATION CODE \(CODE OF PROVIDER\)](#) is the same as the attribute [ORGANISATION CODE](#).

[ORGANISATION CODE \(CODE OF PROVIDER\)](#) is the [ORGANISATION CODE](#) of the [ORGANISATION](#) acting as a [Health Care Provider](#).

For [Commissioning Data Sets](#), the [ORGANISATION CODE \(CODE OF PROVIDER\)](#) should always be the [ORGANISATION CODE](#) of the [Health Care Provider](#) receiving the [National Tariff Payment System](#) income.

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

For further information, please refer to the [Secondary Uses Service Guidance](#) page.

ORGANISATION CODE (CODE OF SUBMITTING ORGANISATION)

Change to Data Element: Changed Dataset

Format/Length: max an6
National Codes:
Default Codes:

Notes:

[ORGANISATION CODE \(CODE OF SUBMITTING ORGANISATION\)](#) is the same as attribute [ORGANISATION CODE](#).

[ORGANISATION CODE \(CODE OF SUBMITTING ORGANISATION\)](#) is the [ORGANISATION CODE](#) of the [ORGANISATION](#) acting as the physical sender of a Data Set submission.

ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT)

Change to Data Element: New Data Element

Format/Length: min an5 max an8
National Codes:
Default Codes:

Notes:

[ORGANISATION CODE \(EDUCATIONAL ESTABLISHMENT\)](#) is the same as attribute [ORGANISATION CODE](#).

[ORGANISATION CODE \(EDUCATIONAL ESTABLISHMENT\)](#) is the [ORGANISATION CODE](#) of the [Educational Establishment](#), including [Schools](#).

This data element is also known by these names:

Context	Alias
plural	ORGANISATION CODES (EDUCATIONAL ESTABLISHMENT)

ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT)

Change to Data Element: New Data Element

ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT)

Attribute:

ORGANISATION CODE

ORGANISATION CODE (GP PRACTICE RESPONSIBILITY)

Change to Data Element: Changed Dataset

Format/Length:	an3
National Codes:	
<u>ODS Default Codes:</u>	Q99 - High Level Health Geography/Primary Care <u>ORGANISATION</u> of Residence Not Known
	X98 - Primary Care <u>ORGANISATION</u> Not Applicable (<u>Overseas Visitors</u>)

Notes:

ORGANISATION CODE (GP PRACTICE RESPONSIBILITY) is the same as attribute ORGANISATION CODE.

ORGANISATION CODE (GP PRACTICE RESPONSIBILITY) is the ORGANISATION CODE of the ORGANISATION responsible for the GP Practice where the PATIENT is registered, irrespective of whether they reside within the boundary of the Clinical Commissioning Group.

ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)

Change to Data Element: Changed Dataset

Format/Length:	an3 or an5
National Codes:	
Default Codes:	

Notes:

ORGANISATION CODE (LOCAL PATIENT IDENTIFIER) is the same as attribute ORGANISATION CODE.

ORGANISATION CODE (LOCAL PATIENT IDENTIFIER) is the ORGANISATION CODE of the ORGANISATION that assigned the LOCAL PATIENT IDENTIFIER.

ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)

Change to Data Element: Changed Dataset

Format/Length:	max an5
HES Item:	
National Codes:	
Default Codes:	

Notes:

ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER) is the same as attribute ORGANISATION CODE.

ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER) is the ORGANISATION CODE of the ORGANISATION issuing the PATIENT PATHWAY IDENTIFIER.

Where Choose and Book has been used, the ORGANISATION CODE X09 should be used.

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a [Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement](#), and is of the following Commissioning Data Set Types:

- [CDS V6-2 Type 020 - Outpatient Commissioning Data Set](#)
- [CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 030 - Elective Admission List - End of Period Census \(Standard\) Commissioning Data Set](#)
- [CDS V6-2 Type 060 - Elective Admission List - Event During Period \(Add\) Commissioning Data Set](#)
- [CDS V6-2 Type 070 - Elective Admission List - Event During Period \(Remove\) Commissioning Data Set](#)
- [CDS V6-2 Type 080 - Elective Admission List - Event During Period \(Offer\) Commissioning Data Set](#)

then [ORGANISATION CODE \(PATIENT PATHWAY IDENTIFIER ISSUER\)](#) must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.

ORGANISATION CODE (RECEIVING)

Change to Data Element: Changed Dataset

Format/Length:	an3 or an5
National Codes:	
Default Codes:	ZZ201 - Not applicable (not discharged to another ORGANISATION) *

Notes:

[ORGANISATION CODE \(RECEIVING\)](#) is the same as the attribute [ORGANISATION CODE](#).

[ORGANISATION CODE \(RECEIVING\)](#) is the [ORGANISATION CODE](#) of the [ORGANISATION](#) that is receiving the [PATIENT](#) from another [Health Care Provider](#).

For the [National Neonatal Data Set - Episodic and Daily Care](#), this is the [ORGANISATION CODE](#) of the [ORGANISATION](#) where a baby is transferred to on discharge from the neonatal critical care.

* Note: default code ZZ201 is ONLY valid for the [National Neonatal Data Set - Episodic and Daily Care](#).

ORGANISATION CODE (RESIDENCE RESPONSIBILITY)

Change to Data Element: Changed Dataset

Format/Length:	an3
National Codes:	
ODS Default Codes :	Q99 - High Level Health Geography/Primary Care ORGANISATION of Residence Not Known Note: This code must not be used in the Commissioning Data Set header. It is not a default commissioner code. X98 - Primary Care ORGANISATION Not Applicable (Overseas Visitors) Note: this code must not be used in the Commissioning Data Set (CDS) header. It is not a default Commissioner code.

Notes:

[ORGANISATION CODE \(RESIDENCE RESPONSIBILITY\)](#) is the same as attribute [ORGANISATION CODE](#).

[ORGANISATION CODE \(RESIDENCE RESPONSIBILITY\)](#) is the [ORGANISATION CODE](#) derived from the [PATIENT](#)'s [POSTCODE OF USUAL ADDRESS](#), where they reside within the boundary of a:

- [Primary Care Trust](#) (until 31 March 2013) *
- [Clinical Commissioning Group](#) (from 1st April 2013)
- [Care Trust](#)
- [Local Health Board \(Wales\)](#)
- [Scottish Health Board](#)

- [Northern Ireland Local Commissioning Group](#): Guidance on the use of Northern Ireland codes can be found in [Data Set Change Notice 19/2009](#)
- [Primary Healthcare Directorate \(Isle of Man\)](#)
- [Local Authority](#).

* Note: The [Cover of Vaccination Evaluated Rapidly \(COVER\) Data Set](#) requires reporting at [Primary Care Trust \(PCT\)](#) level until April 2016.

[ORGANISATION CODES](#) can be downloaded from the [Organisation Data Service website](#) or through the online [Technology Reference Data Update Distribution Service \(TRUD\)](#). For further information, see [Organisation Data Service](#).

For [PATIENTS](#) who are [Overseas Visitors](#): [Organisation Data Service Default Code](#) X98 'Primary Care Organisation Not Applicable ([Overseas Visitors](#))' should be reported.

Note: A review of [Organisation Data Service Default Codes](#) is planned to be carried out and this default code will be updated as part of that.

For the purposes of sending Commissioning Data Set messages to the [Secondary Uses Service](#) (regardless of how local systems hold the data), it is essential at present to continue using a 3 character field, using the first 3 characters of the [ORGANISATION CODE \(PCT OF RESIDENCE\)](#) or [ORGANISATION CODE \(RESIDENCE RESPONSIBILITY\)](#) and following the same update rules relating to Prime Recipient as are currently in place. This is necessary, primarily to preserve the integrity of the current Commissioning Data Set message and the [CDS PRIME RECIPIENT IDENTITY](#) which is derived from the [ORGANISATION CODE \(PCT OF RESIDENCE\)](#) or [ORGANISATION CODE \(RESIDENCE RESPONSIBILITY\)](#).

The [Organisation Data Service](#) provides postcode files which link postcodes to the [Primary Care Trust](#) or [Clinical Commissioning Group](#). See [NHS Postcode Directory](#).

OTHER PERSON IN ATTENDANCE AT CARE CONTACT

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See OTHER PERSON IN ATTENDANCE AT CARE CONTACT
Default Codes:	

Notes:

[OTHER PERSON IN ATTENDANCE AT CARE CONTACT](#) is the same as attribute [OTHER PERSON IN ATTENDANCE AT CARE CONTACT](#).

This data element is also known by these names:

Context	Alias
plural	OTHER PERSONS IN ATTENDANCE AT CARE CONTACT

OTHER PERSON IN ATTENDANCE AT CARE CONTACT

Change to Data Element: New Data Element

OTHER PERSON IN ATTENDANCE AT CARE CONTACT

Attribute:

OTHER PERSON IN ATTENDANCE AT CARE CONTACT
--

OTHER REASON FOR REFERRAL (MENTAL HEALTH)

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See REASON FOR REFERRAL TO MENTAL HEALTH
Default Codes:	

Notes:

[OTHER REASON FOR REFERRAL \(MENTAL HEALTH\)](#) is the same as attribute [REASON FOR REFERRAL TO MENTAL HEALTH](#).

[OTHER REASON FOR REFERRAL \(MENTAL HEALTH\)](#) is the secondary presenting conditions or symptoms for which the [PATIENT](#) was referred to a [Mental Health Service](#).

This data element is also known by these names:

Context	Alias
plural	OTHER REASONS FOR REFERRAL (MENTAL HEALTH)

OTHER REASON FOR REFERRAL (MENTAL HEALTH)

Change to Data Element: New Data Element

OTHER REASON FOR REFERRAL (MENTAL HEALTH)

Attribute:

REASON FOR REFERRAL TO MENTAL HEALTH
--

PATIENT PATHWAY IDENTIFIER

Change to Data Element: Changed Dataset

Format/Length:	an20
National Codes:	
Default Codes:	

Notes:

[PATIENT PATHWAY IDENTIFIER](#) is the same as [PATIENT PATHWAY IDENTIFIER](#).

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a [Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement](#), and is of the following Commissioning Data Set Types:

- [CDS V6-2 Type 020 - Outpatient Commissioning Data Set](#)
- [CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 030 - Elective Admission List - End of Period Census \(Standard\) Commissioning Data Set](#)
- [CDS V6-2 Type 060 - Elective Admission List - Event During Period \(Add\) Commissioning Data Set](#)
- [CDS V6-2 Type 070 - Elective Admission List - Event During Period \(Remove\) Commissioning Data Set](#)
- [CDS V6-2 Type 080 - Elective Admission List - Event During Period \(Offer\) Commissioning Data Set](#)

then either [UNIQUE BOOKING REFERENCE NUMBER \(CONVERTED\)](#) or [PATIENT PATHWAY IDENTIFIER](#) must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.

PERSON BIRTH DATE

Change to Data Element: Changed Dataset

Format/Length:	See DATE
HES Item:	DOB
NWDS ID :	PEBD
NWDS Field Name:	Date of Birth
National Codes:	
Default Codes:	

Notes:

[PERSON BIRTH DATE](#) is the same as attribute [PERSON BIRTH DATE](#).

[PERSON BIRTH DATE](#) should be used for all new and developing systems and for XML messages.

PERSON DEATH DATE

Change to Data Element: Changed Dataset

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

Notes:

[PERSON DEATH DATE](#) is the same as attribute [PERSON DEATH DATE](#).

PERSON MARITAL STATUS

Change to Data Element: Changed Description

Format/Length:	an1
National Codes:	See PERSON MARITAL STATUS CODE
Default Codes:	8 - Not applicable, i.e. not a psychiatric episode 9 - Not known

Notes:

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

Commissioning Data Set Messages

Following the recommendation of the Data Protection Registrar, [PERSON MARITAL STATUS](#) should not be recorded by providers in the [Commissioning Data Sets](#) except in respect of the psychiatric specialties in the Admitted Patient Care Commissioning Data Set. The data item remains in the data standards since it will be needed by the provider.

~~Mental Health and Learning Disabilities Data Set Messages~~

~~For the [Mental Health and Learning Disabilities Data Set](#), [PERSON MARITAL STATUS](#) must be recorded and kept up to date for all psychiatric [PATIENTS](#).~~

PERSON SCORE

Change to Data Element: New Data Element

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

Notes:

[PERSON SCORE](#) is the same as attribute [PERSON SCORE](#).

This data element is also known by these names:

Context	Alias
plural	PERSON SCORES

PERSON SCORE

Change to Data Element: New Data Element

PERSON SCORE

Attribute:

PERSON SCORE

PERSON STATED GENDER CODE

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See PERSON STATED GENDER CODE
Default Codes:	X - Not Known (PERSON STATED GENDER CODE not recorded)

Notes:

[PERSON STATED GENDER CODE](#) is the same as attribute [PERSON STATED GENDER CODE](#).

[PERSON STATED GENDER CODE](#) replaces [PERSON GENDER CURRENT](#) and [PERSON GENDER CODE CURRENT](#), which should be used for all new and developing systems and for XML messages.

PLANNED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)

Change to Data Element: New Data Element

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

Notes:

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

This data element is also known by these names:

Context	Alias
plural	PLANNED DISCHARGE DATES (HOSPITAL PROVIDER SPELL)

PLANNED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)

Change to Data Element: New Data Element

PLANNED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)

Attribute:

PLANNED ACTIVITY DATE

POSTCODE OF MAIN VISITOR

Change to Data Element: New Data Element

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

Notes:

[POSTCODE OF MAIN VISITOR](#) is the same as data element [POSTCODE](#).

[POSTCODE OF MAIN VISITOR](#) is the [POSTCODE](#) of the [ADDRESS](#) of the [PATIENT](#)'s main visitor where the [ADDRESS ASSOCIATION TYPE](#) is 'Main Permanent Residence' or 'Other Permanent Residence'.

[POSTCODE OF MAIN VISITOR](#) is the [POSTCODE](#) of the [PATIENT](#)'s main visitor to the [PATIENT](#) whilst they are being treated as part of a [Hospital Provider Spell](#).

POSTCODE OF MAIN VISITOR

Change to Data Element: New Data Element

POSTCODE OF MAIN VISITOR

Attribute:

POSTCODE

POSTCODE OF USUAL ADDRESS

Change to Data Element: Changed Dataset

Format/Length: See [POSTCODE](#)
HES Item: HOMEADD
National Codes:
Default Codes:

Notes:

[POSTCODE OF USUAL ADDRESS](#) is the same as data element [POSTCODE](#).

[POSTCODE OF USUAL ADDRESS](#) is the [POSTCODE](#) of the [ADDRESS](#) nominated by the [PATIENT](#) where the [ADDRESS ASSOCIATION TYPE](#) is 'Main Permanent Residence' or 'Other Permanent Residence'.

PREVIOUS DIAGNOSIS (CODED CLINICAL ENTRY)

Change to Data Element: New Data Element

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

Notes:

PREVIOUS DIAGNOSIS (CODED CLINICAL ENTRY) is the same as attribute CLINICAL CLASSIFICATION CODE or CLINICAL TERMINOLOGY CODE.

PREVIOUS DIAGNOSIS (CODED CLINICAL ENTRY) is the CODED CLINICAL ENTRY used to identify the previous PATIENT DIAGNOSIS.

This data element is also known by these names:

Context	Alias
plural	PREVIOUS DIAGNOSES (CODED CLINICAL ENTRY)

PREVIOUS DIAGNOSIS (CODED CLINICAL ENTRY)

Change to Data Element: New Data Element

PREVIOUS DIAGNOSIS (CODED CLINICAL ENTRY)

Attribute:

CLINICAL CLASSIFICATION CODE
CLINICAL TERMINOLOGY CODE

PRIMARY DATA COLLECTION SYSTEM IN USE

Change to Data Element: New Data Element

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

Notes:

PRIMARY DATA COLLECTION SYSTEM IN USE is the name of the Primary Data Collection System in use by the Health Care Provider.

PRIMARY DIAGNOSIS (CODED CLINICAL ENTRY)

Change to Data Element: New Data Element

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

Notes:

PRIMARY DIAGNOSIS (CODED CLINICAL ENTRY) is the same as attribute CLINICAL CLASSIFICATION CODE or CLINICAL TERMINOLOGY CODE.

PRIMARY DIAGNOSIS (CODED CLINICAL ENTRY) is the CODED CLINICAL ENTRY used to identify the PRIMARY DIAGNOSIS.

This data element is also known by these names:

Context	Alias
plural	PRIMARY DIAGNOSES (CODED CLINICAL ENTRY)

PRIMARY DIAGNOSIS (CODED CLINICAL ENTRY)

Change to Data Element: New Data Element

PRIMARY DIAGNOSIS (CODED CLINICAL ENTRY)**Attribute:**

CLINICAL CLASSIFICATION CODE
CLINICAL TERMINOLOGY CODE

PRIMARY REASON FOR REFERRAL (MENTAL HEALTH)

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See REASON FOR REFERRAL TO MENTAL HEALTH
Default Codes:	

Notes:

[PRIMARY REASON FOR REFERRAL \(MENTAL HEALTH\)](#) is the same as attribute [REASON FOR REFERRAL TO MENTAL HEALTH](#).

[PRIMARY REASON FOR REFERRAL \(MENTAL HEALTH\)](#) is the primary presenting condition or symptom for which the [PATIENT](#) was referred to a Mental Health Service.

This data element is also known by these names:

Context	Alias
plural	PRIMARY REASONS FOR REFERRAL (MENTAL HEALTH)

PRIMARY REASON FOR REFERRAL (MENTAL HEALTH)

Change to Data Element: New Data Element

PRIMARY REASON FOR REFERRAL (MENTAL HEALTH)**Attribute:**

REASON FOR REFERRAL TO MENTAL HEALTH
--

PROCEDURE SCHEME IN USE

Change to Data Element: Changed Description, Dataset, linked Attribute

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

Notes:

[PROCEDURE SCHEME IN USE](#) is used in the Clinical Activity Group of the Commissioning Data Set to denote the scheme basis of an Intervention, Operation or A&E Treatment.

Permitted National Codes:

01 Accident & Emergency Treatment

- 02 [OPCS-4](#)
- 03 ~~Read Code 4Byte Version (retired 1 October 2009)~~
- 04 ~~[Read Coded Clinical Terms](#) Version 2~~
- 05 ~~[Read Coded Clinical Terms](#) Version 3 (CTV3)~~

~~[Read Coded Clinical Terms](#) Version 3 (CTV3) with qualifiers (previously known as 3.1) is not supported in the Commissioning Data Sets.~~

CDS-XML Message:

~~The codes as specified above must be used in Commissioning Data Set XML messages.~~

PROCEDURE SCHEME IN USE is the same as attribute **PROCEDURE SCHEME IN USE**.

PROCEDURE SCHEME IN USE

Change to Data Element: Changed Description, Dataset, linked Attribute

PROCEDURE SCHEME IN USE

Attribute:

PROCEDURE SCHEME IN USE

PRODROME PSYCHOSIS DATE

Change to Data Element: Changed Description, Dataset, linked Attribute

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

Notes:

~~[PRODROME PSYCHOSIS DATE](#) is the date at which first noticeable change in behaviour or mental state of the [PATIENT](#) occurred, prior to emergence of full-blown psychosis. **PRODROME PSYCHOSIS DATE** is the same as attribute [PERSON PROPERTY OBSERVED DATE](#).~~

PRODROME PSYCHOSIS DATE is the **DATE** at which first noticeable change in behaviour or mental state of the **PATIENT** occurred, prior to emergence of full-blown psychosis. There should be clear deterioration in functioning from previous levels.

PRODROME PSYCHOSIS DATE

Change to Data Element: Changed Description, Dataset, linked Attribute

PRODROME PSYCHOSIS DATE

Attribute:

PERSON PROPERTY OBSERVED DATE

PROFESSIONAL REGISTRATION BODY CODE

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See PROFESSIONAL REGISTRATION BODY CODE
Default Codes:	

Notes:

[PROFESSIONAL REGISTRATION BODY CODE](#) is the same as attribute [PROFESSIONAL REGISTRATION BODY CODE](#).

This data element is also known by these names:

Context	Alias
plural	PROFESSIONAL REGISTRATION BODY CODES

PROFESSIONAL REGISTRATION BODY CODE

Change to Data Element: New Data Element

PROFESSIONAL REGISTRATION BODY CODE

Attribute:

PROFESSIONAL REGISTRATION BODY CODE

PROFESSIONAL REGISTRATION ENTRY IDENTIFIER

Change to Data Element: Changed Dataset

Format/Length:	max an32
NWDS ID :	EPRN
NWDS Field Name:	Professional Registration Number
National Codes:	
Default Codes:	

Notes:

[PROFESSIONAL REGISTRATION ENTRY IDENTIFIER](#) is the same as attribute [PROFESSIONAL REGISTRATION ENTRY IDENTIFIER](#).

PROVISIONAL DIAGNOSIS (CODED CLINICAL ENTRY)

Change to Data Element: New Data Element

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

Notes:

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

[PROVISIONAL DIAGNOSIS \(CODED CLINICAL ENTRY\)](#) is the [CODED CLINICAL ENTRY](#) used to identify the [PROVISIONAL DIAGNOSIS](#).

This data element is also known by these names:

Context	Alias
plural	PROVISIONAL DIAGNOSES (CODED CLINICAL ENTRY)

PROVISIONAL DIAGNOSIS (CODED CLINICAL ENTRY)

Change to Data Element: New Data Element

PROVISIONAL DIAGNOSIS (CODED CLINICAL ENTRY)

Attribute:

CLINICAL CLASSIFICATION CODE

CLINICAL TERMINOLOGY CODE

PROVISIONAL DIAGNOSIS DATE

Change to Data Element: Changed Dataset

Format/Length: See [DATE](#)

National Codes:

Default Codes:

Notes:

[PROVISIONAL DIAGNOSIS DATE](#) is the date on which a [PROVISIONAL DIAGNOSIS](#) was made.

PSYCHOSIS FIRST TREATMENT START DATE_ renamed from PSYCHOSIS TREATMENT START DATE

Change to Data Element: Changed Description, Dataset, Name, linked Attribute

Format/Length: See [DATE](#)

National Codes:

Default Codes:

Notes:

~~[PSYCHOSIS TREATMENT START DATE](#) is the [DATE](#) the [PATIENT](#) commenced prescribed anti-psychotic medication and thereafter was compliant for at least 75% of the time during the subsequent month (using clinical judgement).~~ [PSYCHOSIS FIRST TREATMENT START DATE](#) is the same as attribute [PERSON PROPERTY EFFECTIVE DATE](#). [PSYCHOSIS FIRST TREATMENT START DATE](#) is the [DATE](#) the [PATIENT](#) first commenced prescribed anti-psychotic medication, following referral into an [Early Intervention in Psychosis \(EIP\) Service](#), and thereafter was compliant for at least 75% of the time during the subsequent month (using clinical judgement).

~~For the majority of [PATIENTS](#) this will be the same as the [PRESCRIPTION DATE \(ANTI-PSYCHOTIC MEDICATION\)](#).~~ For the majority of [PATIENTS](#) this will be the same as the [FIRST PRESCRIPTION DATE \(ANTI-PSYCHOTIC MEDICATION\)](#).

PSYCHOSIS FIRST TREATMENT START DATE_ renamed from PSYCHOSIS TREATMENT START DATE

Change to Data Element: Changed Description, Dataset, Name, linked Attribute

PSYCHOSIS FIRST TREATMENT START DATE

Attribute:

PERSON PROPERTY EFFECTIVE DATE

PSYCHOSIS FIRST TREATMENT START DATE_ renamed from PSYCHOSIS TREATMENT START DATE

Change to Data Element: Changed Description, Dataset, Name, linked Attribute

- Changed Description
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.P.Prod.PSYCHOSIS_TREATMENT_START_DATE to Data_Dictionary.Data_Field_Notes.P.Prod.PSYCHOSIS_FIRST_TREATMENT_START_DATE

- null

REFERRAL CLOSURE DATE

Change to Data Element: New Data Element

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

Notes:

REFERRAL CLOSURE DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Referral Closure Date'.

This data element is also known by these names:

Context	Alias
plural	REFERRAL CLOSURE DATES

REFERRAL CLOSURE DATE

Change to Data Element: New Data Element

REFERRAL CLOSURE DATE

Attribute:

ACTIVITY DATE

REFERRAL CLOSURE REASON

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See REFERRAL CLOSURE REASON
Default Codes:	

Notes:

REFERRAL CLOSURE REASON is the same as attribute REFERRAL CLOSURE REASON.

This data element is also known by these names:

Context	Alias
plural	REFERRAL CLOSURE REASONS

REFERRAL CLOSURE REASON

Change to Data Element: New Data Element

REFERRAL CLOSURE REASON

Attribute:

REFERRAL CLOSURE REASON

REFERRAL REJECTION DATE

Change to Data Element: New Data Element

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

Notes:

[REFERRAL REJECTION DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Referral Rejection Date](#)'.

This data element is also known by these names:

Context	Alias
plural	REFERRAL REJECTION DATES

REFERRAL REJECTION DATE

Change to Data Element: [New Data Element](#)

REFERRAL REJECTION DATE

Attribute:

[ACTIVITY DATE](#)

REFERRAL REJECTION REASON

Change to Data Element: [New Data Element](#)

Format/Length: [an2](#)
National Codes: See [REFERRAL REJECTION REASON](#)
Default Codes:

Notes:

[REFERRAL REJECTION REASON](#) is the same as attribute [REFERRAL REJECTION REASON](#).

This data element is also known by these names:

Context	Alias
plural	REFERRAL REJECTION REASONS

REFERRAL REJECTION REASON

Change to Data Element: [New Data Element](#)

REFERRAL REJECTION REASON

Attribute:

[REFERRAL REJECTION REASON](#)

REFERRAL REQUEST RECEIVED DATE

Change to Data Element: [Changed Dataset](#)

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

Notes:

[REFERRAL REQUEST RECEIVED DATE](#) is the same as attribute [REFERRAL REQUEST RECEIVED DATE](#).

For the purposes of the [National Cancer Waiting Times Monitoring Data Set](#), [REFERRAL REQUEST RECEIVED DATE](#) is used to derive the [CANCER REFERRAL TO TREATMENT PERIOD START DATE](#).

REFERRAL REQUEST RECEIVED TIME

Change to Data Element: Changed Dataset

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

Notes:

[REFERRAL REQUEST RECEIVED TIME](#) is the same as attribute [REFERRAL REQUEST RECEIVED TIME](#).

REFERRAL TO TREATMENT PERIOD END DATE

Change to Data Element: Changed Dataset

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

Notes:

[REFERRAL TO TREATMENT PERIOD END DATE](#) is the same as attribute [REFERRAL TO TREATMENT PERIOD END DATE](#).

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a [Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement](#), and is of the following Commissioning Data Set Types:

- [CDS V6-2 Type 020 - Outpatient Commissioning Data Set](#)
- [CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 030 - Elective Admission List - End of Period Census \(Standard\) Commissioning Data Set](#)
- [CDS V6-2 Type 060 - Elective Admission List - Event During Period \(Add\) Commissioning Data Set](#)
- [CDS V6-2 Type 070 - Elective Admission List - Event During Period \(Remove\) Commissioning Data Set](#)
- [CDS V6-2 Type 080 - Elective Admission List - Event During Period \(Offer\) Commissioning Data Set](#)

then [REFERRAL TO TREATMENT PERIOD END DATE](#) must be present in the Commissioning Data Set PATIENT PATHWAY Data Group, where the [REFERRAL TO TREATMENT PERIOD](#) has ended.

REFERRAL TO TREATMENT PERIOD START DATE

Change to Data Element: Changed Dataset

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

Notes:

[REFERRAL TO TREATMENT PERIOD START DATE](#) is the same as attribute [REFERRAL TO TREATMENT PERIOD START DATE](#).

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a [Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement](#), and is of the following Commissioning Data Set Types:

- [CDS V6-2 Type 020 - Outpatient Commissioning Data Set](#)
- [CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 030 - Elective Admission List - End of Period Census \(Standard\) Commissioning Data Set](#)
- [CDS V6-2 Type 060 - Elective Admission List - Event During Period \(Add\) Commissioning Data Set](#)
- [CDS V6-2 Type 070 - Elective Admission List - Event During Period \(Remove\) Commissioning Data Set](#)
- [CDS V6-2 Type 080 - Elective Admission List - Event During Period \(Offer\) Commissioning Data Set](#)

then [REFERRAL TO TREATMENT PERIOD START DATE](#) must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.

REFERRAL TO TREATMENT PERIOD STATUS

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See REFERRAL TO TREATMENT PERIOD STATUS
Default Codes:	

Notes:

[REFERRAL TO TREATMENT PERIOD STATUS](#) is the same as attribute [REFERRAL TO TREATMENT PERIOD STATUS](#).

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a [Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement](#), and is of the following Commissioning Data Set Types:

- [CDS V6-2 Type 020 - Outpatient Commissioning Data Set](#)
- [CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 030 - Elective Admission List - End of Period Census \(Standard\) Commissioning Data Set](#)
- [CDS V6-2 Type 060 - Elective Admission List - Event During Period \(Add\) Commissioning Data Set](#)
- [CDS V6-2 Type 070 - Elective Admission List - Event During Period \(Remove\) Commissioning Data Set](#)
- [CDS V6-2 Type 080 - Elective Admission List - Event During Period \(Offer\) Commissioning Data Set](#)

then [REFERRAL TO TREATMENT PERIOD STATUS](#) must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.

REFERRING CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH AND COMMUNITY CARE) renamed from REFERRING CARE PROFESSIONAL STAFF GROUP (COMMUNITY CARE)

Change to Data Element: Changed Description, Dataset, Name

Format/Length:	an3
National Codes:	See CARE PROFESSIONAL STAFF GROUP FOR COMMUNITY CARE
National Codes:	See REFERRING CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH AND COMMUNITY CARE
Default Codes:	

Notes:

~~[REFERRING CARE PROFESSIONAL STAFF GROUP \(COMMUNITY CARE\)](#) is the same as attribute [CARE PROFESSIONAL STAFF GROUP FOR COMMUNITY CARE](#).~~

~~The staff group of the [CARE PROFESSIONAL](#) who referred the [PATIENT](#) to the [Community Health Service](#), where applicable (if the referrer is not a [CARE PROFESSIONAL](#), for example, if the referrer is an employer, this item should be omitted).~~

REFERRING CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH AND COMMUNITY CARE) is the same as attribute **REFERRING CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH AND COMMUNITY CARE**.

REFERRING CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH AND COMMUNITY CARE)_ renamed from REFERRING CARE PROFESSIONAL STAFF GROUP (COMMUNITY CARE)

Change to Data Element: Changed Description, Dataset, Name

- Changed Description
- null
- Changed Name from
Data_Dictionary.Data_Field_Notes.R.Ref.REFERRING_CARE_PROFESSIONAL_STAFF_GROUP_(COMMUNITY_CARE) to
Data_Dictionary.Data_Field_Notes.R.Ref.REFERRING_CARE_PROFESSIONAL_STAFF_GROUP_(MENTAL_HEALTH_AND_COMMUNITY_CARE)

REFERRING ORGANISATION CODE

Change to Data Element: Changed Dataset

Format/Length:	max an6
National Codes:	
ODS Default Codes:	X99998 - Referring ORGANISATION CODE not applicable X99999 - Referring ORGANISATION CODE not known

Notes:

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

[REFERRING ORGANISATION CODE](#) is the [ORGANISATION CODE](#) of the [ORGANISATION](#) from which the referral is made, such as a [GP Practice](#), [NHS Trust](#) or [NHS Foundation Trust](#).

This information is essential for managing service agreements which are based on patterns of referral.

RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE
Default Codes:	

Notes:

[RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE](#) is the same as attribute [RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE](#).

REPLACEMENT APPOINTMENT BOOKED DATE

Change to Data Element: New Data Element

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

Notes:

[REPLACEMENT APPOINTMENT BOOKED DATE](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '*Replacement Appointment Booked Date*'.

This data element is also known by these names:

Context	Alias
plural	REPLACEMENT APPOINTMENT BOOKED DATES

REPLACEMENT APPOINTMENT BOOKED DATE

Change to Data Element: New Data Element

REPLACEMENT APPOINTMENT BOOKED DATE

Attribute:

ACTIVITY DATE

REPLACEMENT APPOINTMENT DATE OFFERED

Change to Data Element: New Data Element

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

Notes:

[REPLACEMENT APPOINTMENT DATE OFFERED](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '*Replacement Appointment Date Offered*'.

This data element is also known by these names:

Context	Alias
plural	REPLACEMENT APPOINTMENT DATES OFFERED

REPLACEMENT APPOINTMENT DATE OFFERED

Change to Data Element: New Data Element

REPLACEMENT APPOINTMENT DATE OFFERED

Attribute:

ACTIVITY DATE

REPORTING PERIOD END DATE

Change to Data Element: Changed Dataset

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

Notes:

[REPORTING PERIOD END DATE](#) is the same as attribute [REPORTING PERIOD END DATE](#).

[REPORTING PERIOD END DATE](#) is the end date of the [REPORTING PERIOD](#) and is used in conjunction with [REPORTING PERIOD START DATE](#) to specify the actual period the reported information relates to.

The date should not be before the [REPORTING PERIOD START DATE](#) although it can be the same if the period being reported only covers 1 day.

REPORTING PERIOD START DATE

Change to Data Element: Changed Dataset

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

Notes:

[REPORTING PERIOD START DATE](#) is the same as attribute [REPORTING PERIOD START DATE](#).

[REPORTING PERIOD START DATE](#) is the start date of the [REPORTING PERIOD](#) and is used in conjunction with [REPORTING PERIOD END DATE](#) to specify the actual period the reported information relates to.

The date should not be after the [REPORTING PERIOD END DATE](#) although it can be the same if the period being reported only covers 1 day.

RESTRICTIVE INTERVENTION TYPE

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See RESTRICTIVE INTERVENTION TYPE
Default Codes:	

Notes:

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

This data element is also known by these names:

Context	Alias
plural	RESTRICTIVE INTERVENTION TYPES

RESTRICTIVE INTERVENTION TYPE

Change to Data Element: New Data Element

RESTRICTIVE INTERVENTION TYPE

Attribute:

RESTRICTIVE INTERVENTION TYPE

SECONDARY DIAGNOSIS (CODED CLINICAL ENTRY)

Change to Data Element: New Data Element

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

Notes:

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

[SECONDARY DIAGNOSIS \(CODED CLINICAL ENTRY\)](#) is the [CODED CLINICAL ENTRY](#) used to identify the secondary [PATIENT DIAGNOSIS](#).

This data element is also known by these names:

Context	Alias
plural	SECONDARY DIAGNOSES (CODED CLINICAL ENTRY)

SECONDARY DIAGNOSIS (CODED CLINICAL ENTRY)

Change to Data Element: New Data Element

SECONDARY DIAGNOSIS (CODED CLINICAL ENTRY)

Attribute:

CLINICAL CLASSIFICATION CODE
CLINICAL TERMINOLOGY CODE

SERVICE DISCHARGE DATE

Change to Data Element: New Data Element

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

Notes:

SERVICE DISCHARGE DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Service Discharge Date'.

This data element is also known by these names:

Context	Alias
plural	SERVICE DISCHARGE DATES

SERVICE DISCHARGE DATE

Change to Data Element: New Data Element

SERVICE DISCHARGE DATE

Attribute:

ACTIVITY DATE

SERVICE OR TEAM TYPE REFERRED TO (MENTAL HEALTH)

Change to Data Element: New Data Element

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

Notes:

SERVICE OR TEAM TYPE REFERRED TO (MENTAL HEALTH) is the same as attribute SERVICE OR TEAM TYPE FOR MENTAL HEALTH.

SERVICE OR TEAM TYPE REFERRED TO (MENTAL HEALTH) is the type of SERVICE or team within a Mental Health Service that a PATIENT was referred to.

This data element is also known by these names:

Context	Alias
plural	<u>SERVICE OR TEAM TYPES REFERRED TO (MENTAL HEALTH)</u>

SERVICE OR TEAM TYPE REFERRED TO (MENTAL HEALTH)

Change to Data Element: New Data Element

SERVICE OR TEAM TYPE REFERRED TO (MENTAL HEALTH)

Attribute:

<u>SERVICE OR TEAM TYPE FOR MENTAL HEALTH</u>

SERVICE REQUEST IDENTIFIER

Change to Data Element: Changed Dataset

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

Notes:

SERVICE REQUEST IDENTIFIER is the same as attribute SERVICE REQUEST IDENTIFIER.

SETTLED ACCOMMODATION INDICATOR, renamed from **SETTLED ACCOMMODATION INDICATOR (MENTAL HEALTH)**

Change to Data Element: Changed Description, Dataset, Name

Format/Length:	an1
Format/Length:	an1
National Codes:	See <u>SETTLED ACCOMMODATION INDICATOR</u>
Default Codes:	7 - Not disclosed 8 - Not applicable 9 - Not known
Default Codes:	9 - Not Known

Notes:

~~SETTLED ACCOMMODATION INDICATOR (MENTAL HEALTH) is the same as attribute SETTLED ACCOMMODATION INDICATOR.~~

The ~~SETTLED ACCOMMODATION INDICATOR~~ of the ~~PATIENT~~ with any mental disorder should be captured periodically, typically as part of the ~~PATIENT~~'s regular ~~Care Programme Approach Review~~.

SETTLED ACCOMMODATION INDICATOR is the same as attribute SETTLED ACCOMMODATION INDICATOR.

SETTLED ACCOMMODATION INDICATOR, renamed from **SETTLED ACCOMMODATION INDICATOR (MENTAL HEALTH)**

Change to Data Element: Changed Description, Dataset, Name

- Changed Description
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.S.Set.SETTLED_ACCOMMODATION_INDICATOR_(MENTAL_HEALTH) to Data_Dictionary.Data_Field_Notes.S.Set.SETTLED_ACCOMMODATION_INDICATOR

SEX OF PATIENTS CODE

Change to Data Element: Changed Description, Dataset

Format/Length:	an1
National Codes:	
Default Codes:	

Notes:

[SEX OF PATIENTS CODE](#) is the same as attribute [SEX OF PATIENTS](#).

[SEX OF PATIENTS CODE](#) is based on the [SEX OF PATIENTS](#) National Codes, with the addition of [Home Leave](#):

Permitted National Codes:

- 1 Male
- 2 Female
- 8 Not specified
- 9 [Home Leave](#) *

* Note - National Code 9 is not valid for the [Mental Health and Learning Disabilities Data Set](#). * Note - National Code 9 is not valid for the [Mental Health Services Data Set](#).

SITE CODE (OF TREATMENT)

Change to Data Element: Changed Dataset

Format/Length:	min an5 max an9
HES Item:	SITETRET
National Codes:	
ODS Default Codes:	R9998 - Not a hospital site (for use on Out-Patient CDS)
	89999 - Non-NHS UK Provider where no ORGANISATION SITE CODE has been issued
	89997 - Non-UK Provider where no ORGANISATION SITE CODE has been issued

Notes:

[SITE CODE \(OF TREATMENT\)](#) is the same as attribute [ORGANISATION SITE CODE](#).

[SITE CODE \(OF TREATMENT\)](#) is the [ORGANISATION SITE CODE](#) of the [ORGANISATION](#) where the [PATIENT](#) was treated, i.e. it should enable the treating [ORGANISATION](#) to be identified.

This identifies the [ORGANISATION SITE](#) within the [ORGANISATION](#) on which the [PATIENT](#) was treated, since facilities may vary on different hospital sites.

The code recorded should always be the national code; if the treatment is sub-commissioned to another NHS [Health Care Provider](#) or an independent UK provider, the [SITE CODE \(OF TREATMENT\)](#) used should be the [ORGANISATION SITE CODE](#) of the [Health Care Provider](#) actually carrying out the work.

Where treatment is sub-commissioned to an overseas provider the [Organisation Data Service Default Code](#) 89997 'Non-UK Provider where no [ORGANISATION SITE CODE](#) has been issued' is applicable.

Each [ORGANISATION](#) has a unique [ORGANISATION CODE](#). However, where an [ORGANISATION](#) has more than one site from which it provides [SERVICES](#), then each site is uniquely identified. These sites are [ORGANISATION SITES](#) and are uniquely identified by [ORGANISATION SITE CODE](#). The [ORGANISATION SITE CODE](#) contains the first 3 digits of the [ORGANISATION CODE](#) with the last two digits being the site identifier.

Example:

- RA700 [ORGANISATION CODE](#) of the [ORGANISATION](#)
- RA701 [ORGANISATION SITE CODE](#) of the first identified [ORGANISATION SITE](#) within the [ORGANISATION](#)
- RA702 [ORGANISATION SITE CODE](#) of the second identified [ORGANISATION SITE](#) within the [ORGANISATION](#)

For out-patients, [ACTIVITY](#) may take place outside the hospital, such as in the [PATIENT](#)'S home; in such cases, raising a site code is impractical. Therefore, code R9998 'Not a hospital site (for use on Out-Patient CDS)' would be used in these circumstances.

Note: [LOCATION CLASS](#) is used in the Commissioning Data Set (CDS) message to indicate the classification of the physical [LOCATION](#) within which the [ACTIVITY](#) occurred.

Use in the Future Outpatient CDS:

If the [INTENDED SITE CODE \(OF TREATMENT\)](#) is not known, this data element should be omitted.

SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Dataset

Format/Length:	an2
HES Item:	ADMISORC
National Codes:	See SOURCE OF ADMISSION
Default Codes:	98 - Not applicable 99 - Not known: a validation error

Notes:

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

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

For further information, please refer to the [Secondary Uses Service Guidance](#) page.

SOURCE OF REFERRAL FOR MENTAL HEALTH

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See SOURCE OF REFERRAL FOR MENTAL HEALTH
Default Codes:	

Notes:

[SOURCE OF REFERRAL FOR MENTAL HEALTH](#) is the same as attribute [SOURCE OF REFERRAL FOR MENTAL HEALTH](#).

START DATE (CARE CLUSTER ASSIGNMENT PERIOD)

Change to Data Element: New Data Element

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

Notes:

START DATE (CARE CLUSTER ASSIGNMENT PERIOD) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Start Date' of a Care Cluster Assignment Period.

This data element is also known by these names:

Context	Alias
plural	START DATES (CARE CLUSTER ASSIGNMENT PERIOD)

START DATE (CARE CLUSTER ASSIGNMENT PERIOD)

Change to Data Element: New Data Element

START DATE (CARE CLUSTER ASSIGNMENT PERIOD)

Attribute:

ACTIVITY DATE

START DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)

Change to Data Element: New Data Element

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

Notes:

START DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Start Date' of the Care Professional Admitted Care Episode.

This data element is also known by these names:

Context	Alias
plural	START DATES (CARE PROFESSIONAL ADMITTED CARE EPISODE)

START DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)

Change to Data Element: New Data Element

START DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)

Attribute:

ACTIVITY DATE

START DATE (CARE PROGRAMME APPROACH CARE)

Change to Data Element: Changed Description, Dataset

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

Notes:

~~START DATE (CARE PROGRAMME APPROACH CARE) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Start Date' of a period of care for a PATIENT, when the CARE PROGRAMME APPROACH LEVEL is National Code 'New Care Programme Approach'. START DATE (CARE PROGRAMME~~

APPROACH CARE) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Start Date' of the Care Programme Approach care for the PATIENT.

START DATE (COMMISSIONER ASSIGNMENT PERIOD)

Change to Data Element: Changed Dataset

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

Notes:

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

START DATE (COMMUNITY TREATMENT ORDER), renamed from START DATE (SUPERVISED COMMUNITY TREATMENT)

Change to Data Element: Changed Description, Dataset, Name

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

Notes:

~~[START DATE \(SUPERVISED COMMUNITY TREATMENT\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Supervised Community Treatment](#).~~ [START DATE \(COMMUNITY TREATMENT ORDER\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Community Treatment Order](#).

START DATE (COMMUNITY TREATMENT ORDER), renamed from START DATE (SUPERVISED COMMUNITY TREATMENT)

Change to Data Element: Changed Description, Dataset, Name

- Changed Description
 - null
 - Changed Name from Data_Dictionary.Data_Field_Notes.S.Star.START_DATE_(SUPERVISED_COMMUNITY_TREATMENT) to Data_Dictionary.Data_Field_Notes.S.Star.START_DATE_(COMMUNITY_TREATMENT_ORDER)
-

START DATE (COMMUNITY TREATMENT ORDER RECALL), renamed from START DATE (SUPERVISED COMMUNITY TREATMENT RECALL)

Change to Data Element: Changed Description, Dataset, Name

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

Notes:

~~[START DATE \(SUPERVISED COMMUNITY TREATMENT RECALL\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Supervised Community Treatment Recall](#).~~ [START DATE \(COMMUNITY TREATMENT ORDER RECALL\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Supervised Community Treatment Recall](#).

START DATE (COMMUNITY TREATMENT ORDER RECALL), renamed from START DATE (SUPERVISED COMMUNITY TREATMENT RECALL)

Change to Data Element: Changed Description, Dataset, Name

- Changed Description
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.S.Star.START_DATE_(SUPERVISED_COMMUNITY_TREATMENT_RECALL) to Data_Dictionary.Data_Field_Notes.S.Star.START_DATE_(COMMUNITY_TREATMENT_ORDER_RECALL)

START DATE (GMP PATIENT REGISTRATION)

Change to Data Element: Changed Dataset

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

Notes:

[START DATE \(GMP PATIENT REGISTRATION\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' on which the [PERSON](#) registered with a [General Medical Practitioner Practice](#).

START DATE (HOME LEAVE)

Change to Data Element: Changed Dataset

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

Notes:

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

START DATE (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Dataset

Format/Length:	See DATE
HES Item:	ADMIDATE
National Codes:	
Default Codes:	

Notes:

[START DATE \(HOSPITAL PROVIDER SPELL\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Hospital Provider Spell](#).

The [Start Date](#) of the [Hospital Provider Spell](#) is the date of admission: the [CONSULTANT](#) or [MIDWIFE](#) has assumed responsibility for care following the [DECISION TO ADMIT](#) the [PATIENT](#).

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

For further information, please refer to the [Secondary Uses Service Guidance](#) page.

START DATE (MENTAL HEALTH ABSENCE WITHOUT LEAVE)

Change to Data Element: Changed Dataset

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

Notes:

START DATE (MENTAL HEALTH ABSENCE WITHOUT LEAVE) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Start Date' of the Mental Health Absence Without Leave.

START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD) renamed from **START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)**

Change to Data Element: Changed Description, Dataset, Name

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

Notes:

~~START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)~~ is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Start Date' of the MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION. START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Start Date' of the Mental Health Act Legal Status Classification Assignment Period.

START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD) renamed from **START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)**

Change to Data Element: Changed Description, Dataset, Name

- Changed Description
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.S.Star.START_DATE_(MENTAL_HEALTH_ACT_LEGAL_STATUS_CLASSIFICATION) to Data_Dictionary.Data_Field_Notes.S.Star.START_DATE_(MENTAL_HEALTH_ACT_LEGAL_STATUS_CLASSIFICATION_ASSIGNMENT_PERIOD)

START DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD) renamed from **START DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT)**

Change to Data Element: Changed Dataset, Name

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

Notes:

~~START DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT)~~ is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Start Date' of the Mental Health Care Coordinator Assignment. START DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code 'Start Date' of the Mental Health Care Coordinator Assignment Period.

START DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD) renamed from **START DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT)**

Change to Data Element: Changed Dataset, Name

- null
- Changed Name from Data_Dictionary.Data_Field_Notes.S.Star.START_DATE_(MENTAL_HEALTH_CARE_COORDINATOR_ASSIGNMENT) to

START DATE (MENTAL HEALTH CONDITIONAL DISCHARGE)

Change to Data Element: Changed Dataset

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

Notes:

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

START DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD)

Change to Data Element: Changed Description, Dataset

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

Notes:

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

~~[START DATE \(MENTAL HEALTH DELAYED DISCHARGE PERIOD\)](#) is the date that the clinical decision was taken that the [PATIENT](#) is fit and ready for discharge, but external factors prevent the discharge taking place.~~

START DATE (MENTAL HEALTH LEAVE OF ABSENCE)

Change to Data Element: Changed Dataset

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

Notes:

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

START DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD)_ renamed from START DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT)

Change to Data Element: Changed Description, Dataset, Name

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

Notes:

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

START DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD)_ renamed from **START DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT)**

Change to Data Element: Changed Description, Dataset, Name

- Changed Description
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.S.Star.START_DATE_(MENTAL_HEALTH_RESPONSIBLE_CLINICIAN_ASSIGNMENT) to Data_Dictionary.Data_Field_Notes.S.Star.START_DATE_(MENTAL_HEALTH_RESPONSIBLE_CLINICIAN_ASSIGNMENT_PERIOD)

START DATE (WARD STAY)

Change to Data Element: Changed Dataset

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

Notes:

[START DATE \(WARD STAY\)](#) is the same as attribute [ACTIVITY DATE](#) where the [ACTIVITY DATE TYPE](#) is National Code '[Start Date](#)' of the [Ward Stay](#).

START TIME (CARE CLUSTER ASSIGNMENT PERIOD)

Change to Data Element: New Data Element

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

Notes:

[START TIME \(CARE CLUSTER ASSIGNMENT PERIOD\)](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Start Time](#)' of a [Care Cluster Assignment Period](#).

This data element is also known by these names:

Context	Alias
plural	START TIMES (CARE CLUSTER ASSIGNMENT PERIOD)

START TIME (CARE CLUSTER ASSIGNMENT PERIOD)

Change to Data Element: New Data Element

START TIME (CARE CLUSTER ASSIGNMENT PERIOD)

Attribute:

[ACTIVITY TIME](#)

START TIME (COMMUNITY TREATMENT ORDER RECALL)_ renamed from **START TIME (SUPERVISED COMMUNITY TREATMENT RECALL)**

Change to Data Element: Changed Description, Dataset, Name

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

Notes:

START TIME (SUPERVISED COMMUNITY TREATMENT RECALL) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code 'Start Time' of the Supervised Community Treatment Recall. START TIME (COMMUNITY TREATMENT ORDER RECALL) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code 'Start Time' of the Community Treatment Order Recall.

START TIME (COMMUNITY TREATMENT ORDER RECALL)_ renamed from START TIME (SUPERVISED COMMUNITY TREATMENT RECALL)

Change to Data Element: Changed Description, Dataset, Name

- Changed Description
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.S.Star.START_TIME_(SUPERVISED_COMMUNITY_TREATMENT_RECALL) to Data_Dictionary.Data_Field_Notes.S.Star.START_TIME_(COMMUNITY_TREATMENT_ORDER_RECALL)

START TIME (HOME LEAVE)

Change to Data Element: New Data Element

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

Notes:

START TIME (HOME LEAVE) is the same as the attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code 'Start Time' of the Home Leave.

This data element is also known by these names:

Context	Alias
plural	START TIMES (HOME LEAVE)

START TIME (HOME LEAVE)

Change to Data Element: New Data Element

START TIME (HOME LEAVE)

Attribute:

<u>ACTIVITY TIME</u>

START TIME (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Dataset

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

Notes:

START TIME (HOSPITAL PROVIDER SPELL) is the same as the attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code 'Start Time' of the Hospital Provider Spell.

START TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE)

Change to Data Element: New Data Element

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

Notes:

[START TIME \(MENTAL HEALTH ABSENCE WITHOUT LEAVE\)](#) is the same as the attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Start Time](#)' of the [Mental Health Absence Without Leave](#).

This data element is also known by these names:

Context	Alias
plural	START TIMES (MENTAL HEALTH ABSENCE WITHOUT LEAVE)

START TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE)

Change to Data Element: New Data Element

START TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE)

Attribute:

ACTIVITY TIME

START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)_ renamed from **START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)**

Change to Data Element: Changed Description, Dataset, Name

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

Notes:

~~[START TIME \(MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION\)](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Start Time](#)' of the [MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION](#).~~ [START TIME \(MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD\)](#) is the same as attribute [ACTIVITY TIME](#) where the [ACTIVITY TIME TYPE](#) is National Code '[Start Time](#)' of the [Mental Health Act Legal Status Classification Assignment Period](#).

START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)_ renamed from **START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)**

Change to Data Element: Changed Description, Dataset, Name

- Changed Description
- null
- Changed Name from Data_Dictionary.Data_Field_Notes.S.Star.START_TIME_(MENTAL_HEALTH_ACT_LEGAL_STATUS_CLASSIFICATION) to Data_Dictionary.Data_Field_Notes.S.Star.START_TIME_(MENTAL_HEALTH_ACT_LEGAL_STATUS_CLASSIFICATION_ASSIGNMENT_PERIOD)

START TIME (MENTAL HEALTH CARE CLUSTER)

Change to Data Element: Changed Description

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

Notes:

~~START TIME (MENTAL HEALTH CARE CLUSTER) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code 'Start Time' of a Mental Health Care Cluster Assignment Period for a PATIENT.~~ START TIME (MENTAL HEALTH CARE CLUSTER) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code 'Start Time' of a Mental Health Care Cluster Assignment Period for a PATIENT.

START TIME (MENTAL HEALTH LEAVE OF ABSENCE)

Change to Data Element: New Data Element

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

Notes:

START TIME (MENTAL HEALTH LEAVE OF ABSENCE) is the same as the attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code 'Start Time' of the Mental Health Leave of Absence.

This data element is also known by these names:

Context	Alias
plural	START TIMES (MENTAL HEALTH LEAVE OF ABSENCE)

START TIME (MENTAL HEALTH LEAVE OF ABSENCE)

Change to Data Element: New Data Element

START TIME (MENTAL HEALTH LEAVE OF ABSENCE)

Attribute:

[ACTIVITY TIME](#)

START TIME (WARD STAY)

Change to Data Element: Changed Dataset

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

Notes:

START TIME (WARD STAY) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code 'Start Time' of the Ward Stay.

TREATMENT FUNCTION CODE (MENTAL HEALTH)

Change to Data Element: Changed Description, Dataset

Format/Length: an3
National Codes: See [TREATMENT FUNCTION CODE](#)
National Codes:
Default Codes:

Notes:

~~TREATMENT FUNCTION CODE (MENTAL HEALTH) is the same as attribute TREATMENT FUNCTION CODE.~~
TREATMENT FUNCTION CODE (MENTAL HEALTH) is the same as attribute TREATMENT FUNCTION CODE.

TREATMENT FUNCTION CODE (MENTAL HEALTH) is the TREATMENT FUNCTION Mental Health SERVICE under which the PATIENT is treated. It may be the same as the MAIN SPECIALTY CODE or a different TREATMENT FUNCTION which will be the CARE PROFESSIONAL's treatment interest. TREATMENT FUNCTION CODE (MENTAL HEALTH) is the TREATMENT FUNCTION CODE for a PATIENT treated by a Mental Health Service.

Permitted National Codes:

- 700 Learning Disability
- 700 Learning Disability
- 710 Adult Mental Illness
- 711 Child and Adolescent Psychiatry
- 712 Forensic Psychiatry
- 713 Psychotherapy
- 715 Old Age Psychiatry
- 720 Eating Disorders
- 721 Addiction Services
- 722 Liaison Psychiatry
- 723 Psychiatric Intensive Care
- 724 Perinatal Psychiatry
- 725 Mental Health Recovery and Rehabilitation Service
- 726 Mental Health Dual Diagnosis Service
- 727 Dementia Assessment Service

UCUM UNIT OF MEASUREMENT

Change to Data Element: New Data Element

Format/Length:	max an10
National Codes:	
Default Codes:	

Notes:

UCUM UNIT OF MEASUREMENT is the same as attribute UCUM UNIT OF MEASUREMENT.

This data element is also known by these names:

Context	Alias
plural	UCUM UNITS OF MEASUREMENT

UCUM UNIT OF MEASUREMENT

Change to Data Element: New Data Element

UCUM UNIT OF MEASUREMENT
UCUM UNIT OF MEASUREMENT

UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)

Change to Data Element: Changed Dataset

Format/Length:	n12
National Codes:	

Default Codes:

Notes:

[UNIQUE BOOKING REFERENCE NUMBER \(CONVERTED\)](#) is the same as attribute [UNIQUE BOOKING REFERENCE NUMBER \(CONVERTED\)](#).

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a [Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement](#), and is of the following Commissioning Data Set Types:

- [CDS V6-2 Type 020 - Outpatient Commissioning Data Set](#)
- [CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set](#)
- [CDS V6-2 Type 030 - Elective Admission List - End of Period Census \(Standard\) Commissioning Data Set](#)
- [CDS V6-2 Type 060 - Elective Admission List - Event During Period \(Add\) Commissioning Data Set](#)
- [CDS V6-2 Type 070 - Elective Admission List - Event During Period \(Remove\) Commissioning Data Set](#)
- [CDS V6-2 Type 080 - Elective Admission List - Event During Period \(Offer\) Commissioning Data Set](#)

then either [UNIQUE BOOKING REFERENCE NUMBER \(CONVERTED\)](#) or [PATIENT PATHWAY IDENTIFIER](#) must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.

WAITING TIME MEASUREMENT TYPE

Change to Data Element: Changed Description, Dataset

Format/Length:	an2
National Codes:	See WAITING TIME MEASUREMENT TYPE
Default Codes:	

Notes:

[WAITING TIME MEASUREMENT TYPE](#) is the same as attribute [WAITING TIME MEASUREMENT TYPE](#). Note: National Codes 01, 03 and 04 are not valid for the Referral To Treatment (RTT) data group in the [Mental Health Services Data Set](#).

WARD SECURITY LEVEL

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See WARD SECURITY LEVEL
Default Codes:	

Notes:

[WARD SECURITY LEVEL](#) is the same as attribute [WARD SECURITY LEVEL](#).

WARD SETTING TYPE (MENTAL HEALTH)

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See WARD SETTING TYPE FOR MENTAL HEALTH
Default Codes:	

Notes:

[WARD SETTING TYPE \(MENTAL HEALTH\)](#) is the same as attribute [WARD SETTING TYPE FOR MENTAL HEALTH](#).

This data element is also known by these names:

Context	Alias
plural	WARD SETTING TYPES (MENTAL HEALTH)

WARD SETTING TYPE (MENTAL HEALTH)

Change to Data Element: New Data Element

WARD SETTING TYPE (MENTAL HEALTH)

Attribute:

WARD SETTING TYPE FOR MENTAL HEALTH

WARD STAY IDENTIFIER

Change to Data Element: New Data Element

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

Notes:

[WARD STAY IDENTIFIER](#) is the same as attribute [ACTIVITY IDENTIFIER](#).

[WARD STAY IDENTIFIER](#) is a unique identifier allocated for each [Ward Stay](#) during a [Hospital Provider Spell](#).

This data element is also known by these names:

Context	Alias
plural	WARD STAY IDENTIFIERS

WARD STAY IDENTIFIER

Change to Data Element: New Data Element

WARD STAY IDENTIFIER

Attribute:

ACTIVITY IDENTIFIER

WEEKLY HOURS WORKED

Change to Data Element: Changed Description, Dataset

Format/Length:	an2
National Codes:	See WEEKLY HOURS WORKED
Default Codes:	97— Not disclosed (PATIENT was asked but refused to respond) 98— Not applicable (PATIENT not employed or has not received secondary mental health services) 99— Not known

Default Codes:	98 - Not applicable (<u>PATIENT</u> not employed)
	99 - Number of hours worked not known

Notes:

WEEKLY HOURS WORKED is the same as attribute WEEKLY HOURS WORKED.

YOUNG CARER INDICATOR

Change to Data Element: Changed Description, Dataset

Format/Length:	an1
National Codes:	See <u>YOUNG CARER INDICATOR</u>
Default Codes:	X - Not known - Not known whether the <u>PERSON</u> is a young carer
Default Codes:	X - Not known whether the <u>PERSON</u> is a young carer

Notes:

YOUNG CARER INDICATOR is the same as attribute YOUNG CARER INDICATOR.

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

For enquires regarding the Data Set, please contact enquiries@hscic.gov.uk,