NHS Digital

NHS Data Model and Dictionary Service

Type:	Change Request
Reference:	1563
Version No:	1.0
Subject:	Mental Health Services Data Set Version 2.0
Effective Date:	1 April 2017
Reason for Change:	Change to Data Standards
Publication Date:	16 September 2016

Background:

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

Minor changes to the Information Standard were made in Mental Health Services Data Set Version 1.1 and further changes are now required.

To support the Information Standard, this Change Request updates the NHS Data Model and Dictionary to reflect Mental Health Services Data Set Version 2.0.

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

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

Summary of changes:

Diagrams	
CANCER OUTCOMES AND SERVICES DIAGRAM	Changed Diagram
MATERNITY SERVICES DIAGRAM	Changed Diagram
Data Set	
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES DATA SET	Changed Description, Dataset
MENTAL HEALTH SERVICES DATA SET	Changed Description, Dataset
Supporting Information	
ADULT MENTAL HEALTH CARE CLUSTER	Changed Description
ADULT MENTAL HEALTH CLUSTERING TOOL	Changed Description
CARE PLAN AGREED DATE	New Supporting Information
CARE PLAN CREATION DATE	New Supporting Information
CARE PLAN IMPLEMENTATION DATE	New Supporting Information
CARE PLAN LAST UPDATED DATE	New Supporting Information
CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING	New Supporting Information
CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING TOOL	New Supporting Information
DISCHARGE PLAN	New Supporting Information
FIVE FORENSIC PATHWAYS	New Supporting Information
FIVE FORENSIC PATHWAYS ASSESSMENT DATE	New Supporting Information
FORENSIC LEARNING DISABILITY SERVICE	New Supporting Information
FORENSIC MENTAL HEALTH CARE CLUSTER	New Supporting Information

FORENSIC MENTAL HEALTH CLUSTERING TOOL	New Supporting Information
FORENSIC MENTAL HEALTH PATIENT	New Supporting Information
FORENSIC MENTAL HEALTH SERVICE	New Supporting Information
HEALTH OF THE NATION OUTCOME SCALE (WORKING AGE ADULTS)	Changed Description
HOME LEAVE	Changed Description
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES DATA SET OVERVIEW	Changed Description, Dataset
MENTAL HEALTH CARE CLUSTER SUPER CLASS	Changed Description
MENTAL HEALTH CARE PLAN	New Supporting Information
MENTAL HEALTH CRISIS PLAN CREATION DATE (RETIRED) renamed from MENTAL HEALTH CRISIS PLAN CREATION DATE	Changed Description, Name, status to Retired
MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE (RETIRED) renamed from MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE	Changed Description, Name, status to Retired
MENTAL HEALTH SERVICES DATA SET OVERVIEW	Changed Dataset
ONWARD REFERRAL TIME	New Supporting Information
ORGANISATION	Changed Dataset
PLACE OF SAFETY	New Supporting Information
POSITIVE BEHAVIOUR SUPPORT PLAN	New Supporting Information
REFERENCED ORGANISATIONS MENU	Changed Description
REFERRAL CLOSURE TIME	New Supporting Information
ROYAL COLLEGE OF PSYCHIATRISTS	New Supporting Information
SERVICE DISCHARGE TIME	New Supporting Information
STANDARDISATION COMMITTEE FOR CARE INFORMATION	Changed Dataset
URGENT AND EMERGENCY MENTAL HEALTH CARE PLAN	New Supporting Information
WARD STAY	Changed Description

Class Definitions

APPOINTMENT	Changed Dataset
CARE CLUSTER	Changed Attributes
CARE CONTACT	Changed Attributes
CARE PLAN	Changed Attributes
DECISION TO REFER	Changed Attributes
LOCATION	Changed Attributes
PERSON PROPERTY	Changed Attributes
SERVICE REQUEST	Changed Attributes
WARD OPERATIONAL PLAN	Changed Attributes

Attribute Definitions

ACCOMMODATION STATUS CODE	Changed Dataset
ACTIVITY DATE	Changed Dataset
ACTIVITY DATE TYPE	Changed Description
ACTIVITY IDENTIFIER	Changed Dataset
ACTIVITY LOCATION TYPE CODE	Changed Dataset
ACTIVITY SUSPENSION END DATE	Changed Dataset
ACTIVITY SUSPENSION IDENTIFIER	Changed Dataset
ACTIVITY SUSPENSION START DATE	Changed Dataset
ACTIVITY TIME	Changed Dataset
ACTIVITY TIME TYPE	Changed Description
ADMINISTRATIVE CATEGORY CODE	Changed Dataset
ADMISSION METHOD	Changed Dataset
ADULT MENTAL HEALTH CARE CLUSTER CODE	Changed Dataset
AGE GROUP INTENDED FOR MENTAL HEALTH	New Attribute
APPOINTMENT DATE	Changed Dataset
APPOINTMENT DATE OFFERED	Changed Dataset
APPOINTMENT SLOT SHORT NOTICE CANCELLATION INDICATOR	Changed Dataset

APPOINTMENT TIME	Changed Dataset
APPOINTMENT TYPE FOR IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES	Changed Dataset
ASSESSMENT TOOL TYPE	Changed Description
ATTENDED OR DID NOT ATTEND	Changed Dataset
CARE CONTACT CANCELLATION REASON	Changed Dataset
CARE CONTACT SUBJECT	Changed Dataset
CARE PLAN AGREED BY	New Attribute
CARE PLAN AGREED DATE (RETIRED) renamed from CARE PLAN AGREED DATE	Changed Description, Name, status to Retired
CARE PLAN IDENTIFIER renamed from CARE PLAN NUMBER	Changed Description, Name, Dataset
CARE PLAN TYPE	Changed Description
CARE PLAN TYPE FOR MENTAL HEALTH	New Attribute
CARE PROFESSIONAL IDENTIFIER	Changed Dataset
CARE PROFESSIONAL ROLE CODE FOR IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES	Changed Dataset
CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH	Changed Dataset
CARE PROFESSIONAL TEAM IDENTIFIER	Changed Dataset
CARE PROGRAMME APPROACH REVIEW ABUSE QUESTION ASKED INDICATOR	Changed Dataset
CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (RETIRED) renamed from CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE	Changed Description, Name, Dataset, status to Retired
CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE	New Attribute
CHILD AND ADOLESCENT MENTAL HEALTH TIER OF SERVICE	Changed Dataset
CHILD PROTECTION PLAN INDICATION CODE	Changed Dataset
CLINICAL CARE INTENSITY	Changed Dataset
CLINICAL CLASSIFICATION CODE	Changed Dataset
CLINICAL RESPONSE PRIORITY TYPE	Changed Dataset
CLINICAL TERMINOLOGY CODE	Changed Dataset
CLUSTERING TOOL ASSESSMENT CATEGORY	Changed Description, Dataset
CLUSTERING TOOL ASSESSMENT REASON	Changed Dataset
COMMUNITY TREATMENT ORDER END REASON	Changed Dataset
CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR	Changed Dataset
CONSULTATION MEDIUM USED	Changed Dataset
CONSULTATION TYPE	Changed Dataset
DECISION TO REFER DATE	Changed Dataset
DECISION TO REFER TIME	New Attribute
DIAGNOSIS SCHEME IN USE	Changed Dataset
DISABILITY CODE	Changed Dataset
DISABILITY IMPACT PERCEPTION	Changed Dataset
DISCHARGE DESTINATION	Changed Dataset
DISCHARGE METHOD	Changed Description, Dataset
DISCHARGE PLAN AGREED BY	New Attribute
EMPLOYMENT STATUS	Changed Dataset
EMPLOYMENT SUPPORT SUITABILITY INDICATOR	Changed Dataset
ETHNIC CATEGORY CODE	Changed Dataset
EX-BRITISH ARMED FORCES INDICATOR	Changed Dataset
FACE TO FACE COMMUNICATION MODE	Changed Dataset
FINDING SCHEME IN USE	Changed Dataset
FIVE FORENSIC PATHWAYS ASSESSMENT REASON	New Attribute
FIVE FORENSIC PATHWAYS CODE	New Attribute
FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE	Changed Description, Dataset
FORENSIC MENTAL HEALTH CARE CLUSTER CODE	Changed Description, Dataset

GROUP SESSION TYPE FOR MENTAL HEALTH	Changed Dataset
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ACTIVITY SUSPENSION REASON	Changed Dataset
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES CARE SPELL END CODE	Changed Dataset
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES OPT IN DATE	Changed Dataset
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES STEPPED CARE INTENSITY DELIVERED	Changed Dataset
JOB ROLE CODE	Changed Dataset
LANGUAGE CODE	Changed Dataset
LEARNING DISABILITIES CARE CLUSTER CODE	Changed Dataset
LOCAL PATIENT IDENTIFIER	Changed Dataset
LOCKED WARD INDICATOR	Changed Dataset
LONG TERM PHYSICAL HEALTH CONDITION INDICATOR FOR IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES	Changed Dataset
LOOKED AFTER CHILD INDICATOR	Changed Dataset
MAIN SPECIALTY CODE	Changed Dataset
MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON	Changed Dataset
MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY	Changed Dataset
MENTAL HEALTH ACT 2007 MENTAL CATEGORY	Changed Dataset
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON	Changed Dataset
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON	Changed Dataset
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE	Changed Dataset
MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE	Changed Dataset
MENTAL HEALTH CONDITIONAL DISCHARGE END REASON	Changed Dataset
MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE	Changed Description, Dataset
MENTAL HEALTH DELAYED DISCHARGE REASON	Changed Description, Dataset
MENTAL HEALTH LEAVE OF ABSENCE END REASON	Changed Dataset
NHS NUMBER	Changed Dataset
NHS OCCUPATION CODE	Changed Dataset
NHS SERVICE AGREEMENT LINE NUMBER	Changed Dataset
OBSERVATION SCHEME IN USE	Changed Dataset
OBSERVATION VALUE	Changed Dataset
OFFENCE HISTORY INDICATION CODE	New Attribute
OFFERED FOR ADMISSION DATE	Changed Dataset
ONWARD REFERRAL REASON	Changed Dataset
ORGANISATION CODE	Changed Dataset
ORGANISATION SITE CODE	Changed Dataset
OTHER PERSON IN ATTENDANCE AT CARE CONTACT	Changed Description, Dataset
PATIENT PATHWAY IDENTIFIER	Changed Dataset
PERSON BIRTH DATE	Changed Dataset
PERSON DEATH DATE	Changed Dataset
PERSON GENDER CODE	Changed Dataset
PERSON MARITAL STATUS CODE	Changed Dataset
PERSON PROPERTY EFFECTIVE DATE	Changed Dataset
PERSON PROPERTY EFFECTIVE END DATE	Changed Dataset
PERSON PROPERTY EFFECTIVE END TIME	Changed Dataset
PERSON PROPERTY OBSERVED DATE	Changed Dataset
PERSON PROPERTY RECORDED DATE	Changed Dataset
PERSON SCORE	Changed Dataset
PERSON STATED GENDER CODE	Changed Dataset
PLACE OF SAFETY INDICATOR	New Attribute
PLANNED ACTIVITY DATE	Changed Dataset

POSTCODE	Changed Dataset
PRESCRIPTION DATE	Changed Dataset
PREVIOUS SYMPTOM INDICATOR	Changed Dataset
PROCEDURE SCHEME IN USE	Changed Dataset
PROFESSIONAL REGISTRATION BODY CODE	Changed Dataset
PROFESSIONAL REGISTRATION ENTRY IDENTIFIER	Changed Dataset
PROVISIONAL DIAGNOSIS	Changed Dataset
PSYCHOTROPIC MEDICATION USAGE	Changed Dataset
REASON FOR OUT OF AREA REFERRAL FOR ADULT ACUTE MENTAL HEALTH	New Attribute
REASON FOR REFERRAL TO MENTAL HEALTH	Changed Dataset
REFERRAL CLOSURE REASON	Changed Dataset
REFERRAL REJECTION REASON	Changed Dataset
REFERRAL REQUEST RECEIVED DATE	Changed Dataset
REFERRAL REQUEST RECEIVED TIME	Changed Description, Dataset
REFERRAL TO TREATMENT PERIOD END DATE	Changed Dataset
REFERRAL TO TREATMENT PERIOD START DATE	Changed Dataset
REFERRAL TO TREATMENT PERIOD STATUS	Changed Dataset
REFERRED OUT OF AREA REASON FOR ADULT ACUTE MENTAL HEALTH	New Attribute
REFERRING CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH AND COMMUNITY CARE	Changed Dataset
RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE	Changed Dataset
REPORTING PERIOD END DATE	Changed Dataset
REPORTING PERIOD START DATE	Changed Dataset
RESTRICTIVE INTERVENTION TYPE	Changed Dataset
SERVICE OR TEAM TYPE FOR MENTAL HEALTH	Changed Description, Dataset
SERVICE REQUEST ACCEPTANCE INDICATOR	Changed Dataset
SERVICE REQUEST DATE	Changed Dataset
SERVICE REQUEST IDENTIFIER	Changed Dataset
SESSION DATE	Changed Dataset
SETTLED ACCOMMODATION INDICATOR	Changed Dataset
SEX OF PATIENTS	Changed Dataset
SEXUAL ORIENTATION CODE	Changed Dataset
SOURCE OF ADMISSION	Changed Dataset
SOURCE OF REFERRAL FOR MENTAL HEALTH	Changed Dataset
STATUTORY SICK PAY INDICATOR	Changed Dataset
THERAPY TYPE FOR IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES	Changed Dataset
TREATMENT FUNCTION CODE	Changed Dataset
UCUM UNIT OF MEASUREMENT	Changed Dataset
UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)	Changed Dataset
WAITING TIME MEASUREMENT TYPE	Changed Dataset
WARD SECURITY LEVEL	Changed Dataset
WARD SETTING TYPE FOR MENTAL HEALTH	Changed Dataset
WEEKLY HOURS WORKED	Changed Dataset
YEAR AND MONTH OF SYMPTOMS ONSET FOR IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES	Changed Dataset
YOUNG CARER INDICATOR	Changed Dataset

Data Elements

ACCOMMODATION STATUS CODE	Changed Dataset
ACCOMMODATION STATUS RECORDED DATE	Changed Dataset
ACTIVITY LOCATION TYPE CODE	Changed Dataset
ACTIVITY SUSPENSION END DATE	Changed Dataset
ACTIVITY SUSPENSION START DATE	Changed Dataset
ADMINISTRATIVE CATEGORY CODE	Changed Dataset

ADMISSION METHOD CODE (HOSPITAL PROVIDER SPELL)	Changed Dataset
ADULT MENTAL HEALTH CARE CLUSTER CODE (FINAL)	Changed Dataset
ADULT MENTAL HEALTH CARE CLUSTER CODE (INITIAL)	Changed Dataset
AGORAPHOBIA MOBILITY INVENTORY SCORE (WHEN ACCOMPANIED)	Changed Dataset
AGORAPHOBIA MOBILITY INVENTORY SCORE (WHEN ALONE)	Changed Dataset
AGORAPHOBIA SCORE	Changed Dataset
APPOINTMENT DATE	Changed Dataset
APPOINTMENT SLOT SHORT NOTICE CANCELLATION INDICATOR	Changed Dataset
APPOINTMENT TIME	Changed Dataset
APPOINTMENT TYPE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)	Changed Dataset
ASSESSMENT TOOL COMPLETION DATE	Changed Dataset
ASSESSMENT TOOL COMPLETION TIME	Changed Dataset
ASSISTIVE TECHNOLOGY FINDING (SNOMED CT)	Changed Description, Dataset
ATTENDED OR DID NOT ATTEND CODE	Changed Dataset
CARE ACTIVITY IDENTIFIER	Changed Dataset
CARE CONTACT CANCELLATION DATE	Changed Dataset
CARE CONTACT CANCELLATION REASON	Changed Dataset
CARE CONTACT DATE	Changed Dataset
CARE CONTACT IDENTIFIER	Changed Dataset
CARE CONTACT SUBJECT	Changed Dataset
CARE CONTACT TIME	Changed Dataset
CARE PLAN AGREED BY	New Data Element
CARE PLAN AGREED DATE renamed from CARE PLAN AGREED DATE (RETIRED)	Changed Description, Name, Dataset, linked Attribute, status to Retired
CARE PLAN CREATION DATE	New Data Element
CARE PLAN IDENTIFIER	New Data Element
CARE PLAN IMPLEMENTATION DATE	New Data Element
CARE PLAN LAST UPDATED DATE	New Data Element
CARE PLAN TYPE (MENTAL HEALTH)	New Data Element
CARE PROFESSIONAL (JOB ROLE CODE)	Changed Dataset
CARE PROFESSIONAL LOCAL IDENTIFIER	Changed Dataset
CARE PROFESSIONAL ROLE CODE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)	Changed Dataset
CARE PROFESSIONAL SERVICE OR TEAM TYPE ASSOCIATION (MENTAL HEALTH)	Changed Dataset
CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH)	Changed Dataset
CARE PROFESSIONAL TEAM LOCAL IDENTIFIER	Changed Dataset
CARE PROGRAMME APPROACH CARE EPISODE IDENTIFIER	Changed Dataset
CARE PROGRAMME APPROACH REVIEW ABUSE QUESTION ASKED INDICATOR	Changed Dataset
CARE PROGRAMME APPROACH REVIEW DATE	Changed Dataset
CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL) (RETIRED) renamed from CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL)	Changed Description, Name, Dataset, linked Attribute, status to Retired
CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL) (RETIRED) renamed from CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL)	Changed Description, Name, Dataset, linked Attribute, status to Retired
CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE	New Data Element
CHILD AND ADOLESCENT MENTAL HEALTH TIER OF SERVICE	Changed Description, Dataset
CHILD PROTECTION PLAN INDICATION CODE	Changed Dataset
CLINICAL CONTACT DURATION OF APPOINTMENT	Changed Dataset
CLINICAL CONTACT DURATION OF CARE ACTIVITY	Changed Dataset
CLINICAL CONTACT DURATION OF CARE CONTACT	Changed Dataset
CLINICAL CONTACT DURATION OF GROUP SESSION	Changed Dataset

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

END DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD)	Changed Dataset
END DATE (MENTAL HEALTH CONDITIONAL DISCHARGE)	Changed Dataset
END DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD)	Changed Dataset
END DATE (MENTAL HEALTH LEAVE OF ABSENCE)	Changed Dataset
END DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD)	Changed Dataset
END DATE (WARD STAY)	Changed Dataset
END TIME (CARE CLUSTER ASSIGNMENT PERIOD)	Changed Dataset
END TIME (COMMUNITY TREATMENT ORDER RECALL)	Changed Dataset
END TIME (HOME LEAVE)	Changed Dataset
END TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE)	Changed Dataset
END TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)	Changed Dataset
END TIME (MENTAL HEALTH LEAVE OF ABSENCE)	Changed Dataset
END TIME (WARD STAY)	Changed Dataset
ETHNIC CATEGORY	Changed Dataset
EX-BRITISH ARMED FORCES INDICATOR	Changed Dataset
EXPIRY DATE (COMMUNITY TREATMENT ORDER)	Changed Dataset
EXPIRY DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)	Changed Dataset
EXPIRY TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)	Changed Dataset
FACE TO FACE COMMUNICATION MODE	Changed Dataset
FINDING SCHEME IN USE	Changed Dataset
FIRST PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION)	Changed Dataset
FIVE FORENSIC PATHWAYS ASSESSMENT DATE	New Data Element
FIVE FORENSIC PATHWAYS ASSESSMENT REASON	New Data Element
FIVE FORENSIC PATHWAYS CODE	New Data Element
FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)	Changed Dataset
FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)	Changed Dataset
FORENSIC MENTAL HEALTH CARE CLUSTER CODE (FINAL)	Changed Description, Dataset
FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL) (RETIRED) renamed from FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL)	Changed Description, Name, Dataset, linked Attribute, status to Retired
GENERALISED ANXIETY DISORDER PENN STATE WORRY SCORE	Changed Dataset
GENERALISED ANXIETY DISORDER SCORE	Changed Dataset
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	Changed Dataset
GROUP SESSION DATE	Changed Dataset
GROUP SESSION IDENTIFIER	Changed Dataset
GROUP SESSION TYPE (MENTAL HEALTH)	Changed Dataset
GROUP THERAPY INDICATOR	Changed Dataset
HEALTH ANXIETY INVENTORY SHORT WEEK SCALE SCORE	Changed Dataset
HOSPITAL PROVIDER SPELL NUMBER	Changed Dataset
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ACTIVITY SUSPENSION IDENTIFIER	Changed Dataset
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ACTIVITY SUSPENSION REASON	Changed Dataset
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ASSESSMENT CHOICE PATIENT EXPERIENCE QUESTION 1	Changed Dataset
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ASSESSMENT CHOICE PATIENT EXPERIENCE QUESTION 2	Changed Dataset
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ASSESSMENT CHOICE PATIENT EXPERIENCE QUESTION 3	Changed Dataset
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ASSESSMENT SATISFACTION PATIENT EXPERIENCE QUESTION 1	Changed Dataset
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES CARE SPELL END CODE	Changed Dataset
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES OPT IN DATE	Changed Dataset
	Changed Dataset

IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES STEPPED CARE INTENSITY DELIVERED	
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES TREATMENT PATIENT EXPERIENCE QUESTION 1	Changed Dataset
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES TREATMENT PATIENT EXPERIENCE QUESTION 2	Changed Dataset
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES TREATMENT PATIENT EXPERIENCE QUESTION 3	Changed Dataset
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES TREATMENT PATIENT EXPERIENCE QUESTION 4	Changed Dataset
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES TREATMENT PATIENT EXPERIENCE QUESTION 5	Changed Dataset
INDIRECT ACTIVITY DATE	Changed Dataset
INDIRECT ACTIVITY TIME	Changed Dataset
INTENDED AGE GROUP (MENTAL HEALTH)	New Data Element
INTENDED CLINICAL CARE INTENSITY CODE (MENTAL HEALTH)	Changed Dataset
LANGUAGE CODE (PREFERRED)	Changed Dataset
LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)	Changed Dataset
LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)	Changed Dataset
LOCAL PATIENT IDENTIFIER (EXTENDED)	Changed Dataset
LOCKED WARD INDICATOR	Changed Dataset
LONG TERM PHYSICAL HEALTH CONDITION INDICATOR (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)	Changed Dataset
LOOKED AFTER CHILD INDICATOR	Changed Dataset
MAIN SPECIALTY CODE (MENTAL HEALTH)	Changed Dataset
MANIFEST PSYCHOSIS DATE	Changed Dataset
MATERNITY CARE PLAN DATE	Changed Description, linked Attribute
MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON	Changed Dataset
MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY	Changed Dataset
MENTAL HEALTH ACT 2007 MENTAL CATEGORY	Changed Dataset
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON	Changed Dataset
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER	Changed Dataset
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON	Changed Dataset
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE	Changed Dataset
MENTAL HEALTH ADMITTED PATIENT CLASSIFICATION	New Data Element
MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE	Changed Dataset
MENTAL HEALTH CONDITIONAL DISCHARGE END REASON	Changed Dataset
MENTAL HEALTH CRISIS PLAN CREATION DATE (RETIRED) renamed from MENTAL HEALTH CRISIS PLAN CREATION DATE	Changed Description, Name, Dataset, linked Attribute, status to Retired
MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE (RETIRED) renamed from MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE	Changed Description, Name, Dataset, linked Attribute, status to Retired
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	Changed Dataset
NHS NUMBER	Changed Dataset
NHS NUMBER STATUS INDICATOR CODE	Changed Dataset
NHS SERVICE AGREEMENT LINE NUMBER	Changed Dataset
NUMBER OF GROUP SESSION PARTICIPANTS	Changed Dataset
OBSERVATION DATE (SUBSTANCE MISUSE EVIDENCE)	New Data Element
OBSERVATION SCHEME IN USE	Changed Dataset
OBSERVATION VALUE	Changed Dataset

OBSESSIVE COMPULSIVE DISORDER INVENTORY SCORE	Changed Dataset
OCCUPATION CODE	Changed Dataset
OFFENCE HISTORY INDICATION CODE	New Data Element
ONWARD REFERRAL DATE	Changed Dataset
ONWARD REFERRAL REASON	Changed Description, Dataset
ONWARD REFERRAL TIME	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)	Changed Dataset
ORGANISATION CODE (GP PRACTICE RESPONSIBILITY)	Changed Dataset
ORGANISATION CODE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES STEPPED TO PROVIDER)	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	Changed Dataset
OTHER REASON FOR REFERRAL (MENTAL HEALTH)	Changed Dataset
PANIC DISORDER SEVERITY SCALE SCORE	Changed Dataset
PATIENT PATHWAY IDENTIFIER	Changed Dataset
PERSON BIRTH DATE	Changed Dataset
PERSON DEATH DATE	Changed Dataset
PERSON GENDER CODE CURRENT	Changed Dataset
PERSON MARITAL STATUS	Changed Dataset
PERSON SCORE	Changed Dataset
PERSON STATED GENDER CODE	Changed Dataset
PHQ-9 TOTAL SCORE	Changed Dataset
PLACE OF SAFETY INDICATOR	New Data Element
PLANNED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)	Changed Dataset
PLANNED DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL)	New Data Element
POSTCODE OF MAIN VISITOR	Changed Description, Dataset
POSTCODE OF USUAL ADDRESS	Changed Dataset
POST TRAUMATIC STRESS DISORDER IMPACT OF EVENTS SCALE REVISED SCORE	Changed Dataset
PRESCRIPTION DATE (ASSISTIVE TECHNOLOGY)	Changed Dataset
PREVIOUS DIAGNOSIS (CODED CLINICAL ENTRY)	Changed Dataset
PREVIOUS SYMPTOM INDICATOR	Changed Dataset
PRIMARY DATA COLLECTION SYSTEM IN USE	Changed Dataset
PRIMARY DIAGNOSIS (CODED CLINICAL ENTRY)	Changed Dataset
PRIMARY REASON FOR REFERRAL (MENTAL HEALTH)	Changed Dataset
PROCEDURE SCHEME IN USE	Changed Dataset
PRODROME PSYCHOSIS DATE	Changed Dataset
PROFESSIONAL REGISTRATION BODY CODE	Changed Dataset
PROFESSIONAL REGISTRATION ENTRY IDENTIFIER	Changed Dataset
PROVISIONAL DIAGNOSIS (CODED CLINICAL ENTRY)	Changed Dataset
PROVISIONAL DIAGNOSIS (ICD)	Changed Dataset
PROVISIONAL DIAGNOSIS DATE	Changed Dataset
PSYCHOSIS FIRST TREATMENT START DATE	Changed Dataset
PSYCHOTROPIC MEDICATION USAGE	Changed Dataset
REASON FOR OUT OF AREA REFERRAL (ADULT ACUTE MENTAL HEALTH)	New Data Element
REFERRAL CLOSURE DATE	Changed Dataset
REFERRAL CLOSURE REASON	Changed Dataset
REFERRAL CLOSURE TIME	New Data Element

REFERRAL REJECTION DATE	Changed Dataset
REFERRAL REJECTION REASON	Changed Dataset
REFERRAL REQUEST RECEIVED DATE	Changed Dataset
REFERRAL REQUEST RECEIVED TIME	Changed Dataset
REFERRAL TO TREATMENT PERIOD END DATE	Changed Dataset
REFERRAL TO TREATMENT PERIOD START DATE	Changed Dataset
REFERRAL TO TREATMENT PERIOD STATUS	Changed Dataset
REFERRED OUT OF AREA REASON (ADULT ACUTE MENTAL HEALTH)	New Data Element
REFERRING CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH AND COMMUNITY CARE)	Changed Dataset
REFERRING ORGANISATION CODE	Changed Dataset
RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE	Changed Dataset
REPLACEMENT APPOINTMENT BOOKED DATE	Changed Dataset
REPLACEMENT APPOINTMENT DATE OFFERED	Changed Dataset
REPORTING PERIOD END DATE	Changed Dataset
REPORTING PERIOD START DATE	Changed Dataset
RESTRICTIVE INTERVENTION TYPE	Changed Dataset
SECONDARY DIAGNOSIS (CODED CLINICAL ENTRY)	Changed Dataset
SERVICE DISCHARGE DATE	Changed Dataset
SERVICE DISCHARGE TIME	New Data Element
SERVICE OR TEAM TYPE REFERRED TO (MENTAL HEALTH)	Changed Dataset
SERVICE REQUEST ACCEPTANCE INDICATOR	Changed Dataset
SERVICE REQUEST IDENTIFIER	Changed Dataset
SETTLED ACCOMMODATION INDICATOR	Changed Description, Dataset
SEX OF PATIENTS CODE	Changed Dataset
SEXUAL ORIENTATION (CURRENT)	Changed Dataset
SITE CODE (OF TREATMENT)	Changed Dataset
SOCIAL PHOBIA INVENTORY SCORE	Changed Dataset
SOCIAL PHOBIA SCORE	Changed Dataset
SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL)	Changed Dataset
SOURCE OF REFERRAL FOR MENTAL HEALTH	Changed Dataset
SPECIFIC PHOBIA SCORE	Changed Dataset
START DATE (CARE CLUSTER ASSIGNMENT PERIOD)	Changed Dataset
START DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)	Changed Dataset
START DATE (CARE PROGRAMME APPROACH CARE)	Changed Dataset
START DATE (COMMISSIONER ASSIGNMENT PERIOD)	Changed Dataset
START DATE (COMMUNITY TREATMENT ORDER)	Changed Dataset
START DATE (COMMUNITY TREATMENT ORDER RECALL)	Changed Dataset
START DATE (GMP PATIENT REGISTRATION)	Changed Dataset
START DATE (HOME LEAVE)	Changed Dataset
START DATE (HOSPITAL PROVIDER SPELL)	Changed Dataset
START DATE (MENTAL HEALTH ABSENCE WITHOUT LEAVE)	Changed Dataset
START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)	Changed Dataset
START DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD)	Changed Dataset
START DATE (MENTAL HEALTH CONDITIONAL DISCHARGE)	Changed Dataset
START DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD)	Changed Dataset
START DATE (MENTAL HEALTH LEAVE OF ABSENCE)	Changed Dataset
START DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD)	Changed Dataset
START DATE (WARD STAY)	Changed Dataset
START TIME (CARE CLUSTER ASSIGNMENT PERIOD)	Changed Dataset
START TIME (COMMUNITY TREATMENT ORDER RECALL)	Changed Dataset
START TIME (HOME LEAVE)	Changed Dataset
START TIME (HOSPITAL PROVIDER SPELL)	Changed Dataset

START TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE)	Changed Dataset
START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)	Changed Dataset
START TIME (MENTAL HEALTH LEAVE OF ABSENCE)	Changed Dataset
START TIME (WARD STAY)	Changed Dataset
STATUTORY SICK PAY INDICATOR	Changed Dataset
THERAPY TYPE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)	Changed Dataset
TREATMENT FUNCTION CODE (MENTAL HEALTH)	Changed Description, Dataset
UCUM UNIT OF MEASUREMENT	Changed Dataset
UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)	Changed Dataset
WAITING TIME MEASUREMENT TYPE	Changed Dataset
WARD SECURITY LEVEL	Changed Dataset
WARD SETTING TYPE (MENTAL HEALTH)	Changed Dataset
WARD STAY IDENTIFIER	Changed Dataset
WEEKLY HOURS WORKED	Changed Dataset
WORK AND SOCIAL ADJUSTMENT SCALE SCORE (HOME MANAGEMENT)	Changed Dataset
WORK AND SOCIAL ADJUSTMENT SCALE SCORE (PRIVATE LEISURE ACTIVITIES)	Changed Dataset
WORK AND SOCIAL ADJUSTMENT SCALE SCORE (RELATIONSHIPS)	Changed Dataset
WORK AND SOCIAL ADJUSTMENT SCALE SCORE (SOCIAL LEISURE ACTIVITIES)	Changed Dataset
WORK AND SOCIAL ADJUSTMENT SCALE SCORE (WORK)	Changed Dataset
YEAR AND MONTH OF SYMPTOMS ONSET (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)	Changed Dataset
YOUNG CARER INDICATOR	Changed Dataset

XML Schema Constraint

COMMISSIONING DATA SET VERSION 6-2 XML SCHEMA CONSTRAINTS	Changed Description

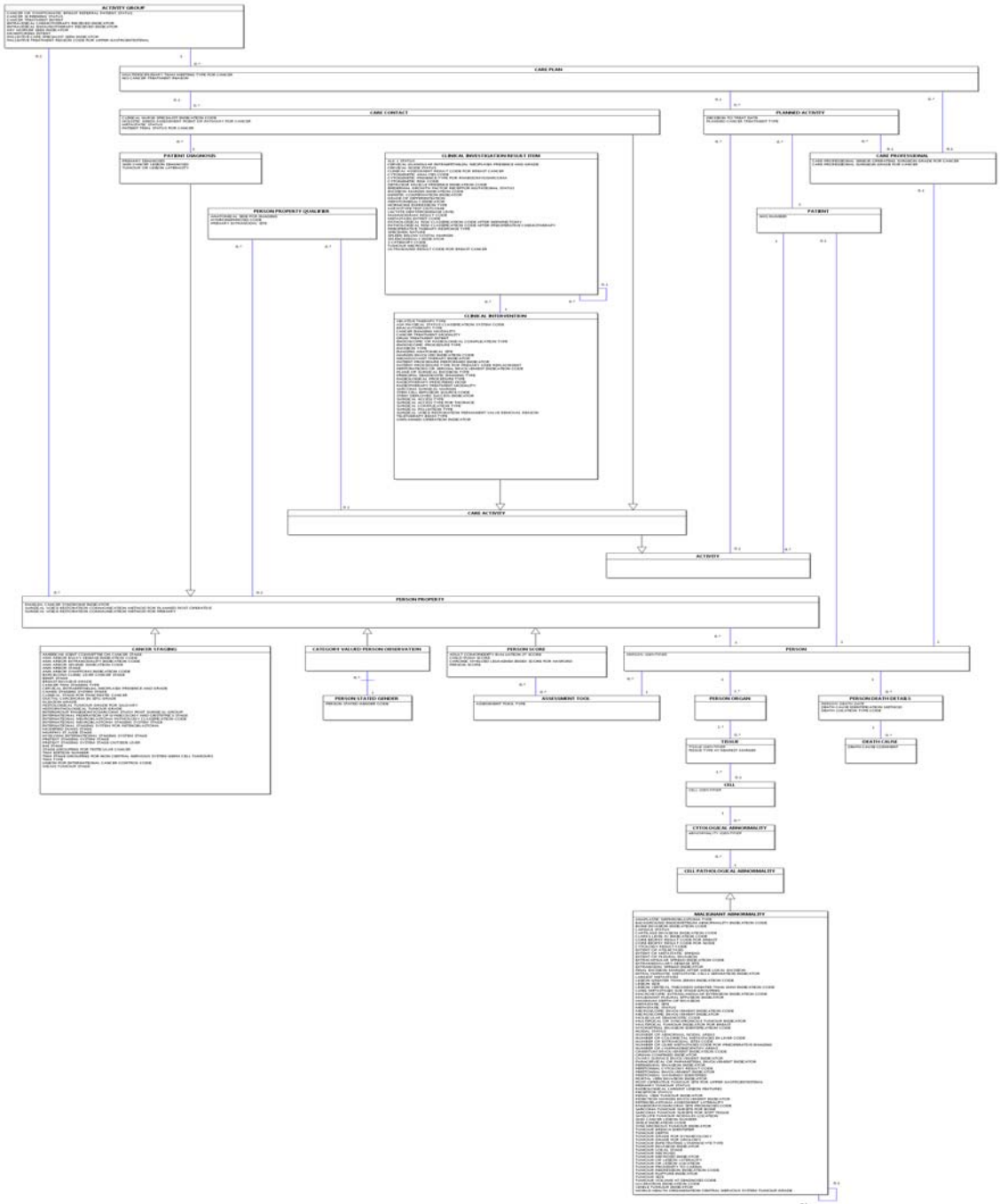
Date: 16 September 2016

Sponsor: Jonathan Marron, Director for Community, Mental Health and 7 Day Services, Department of Health

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

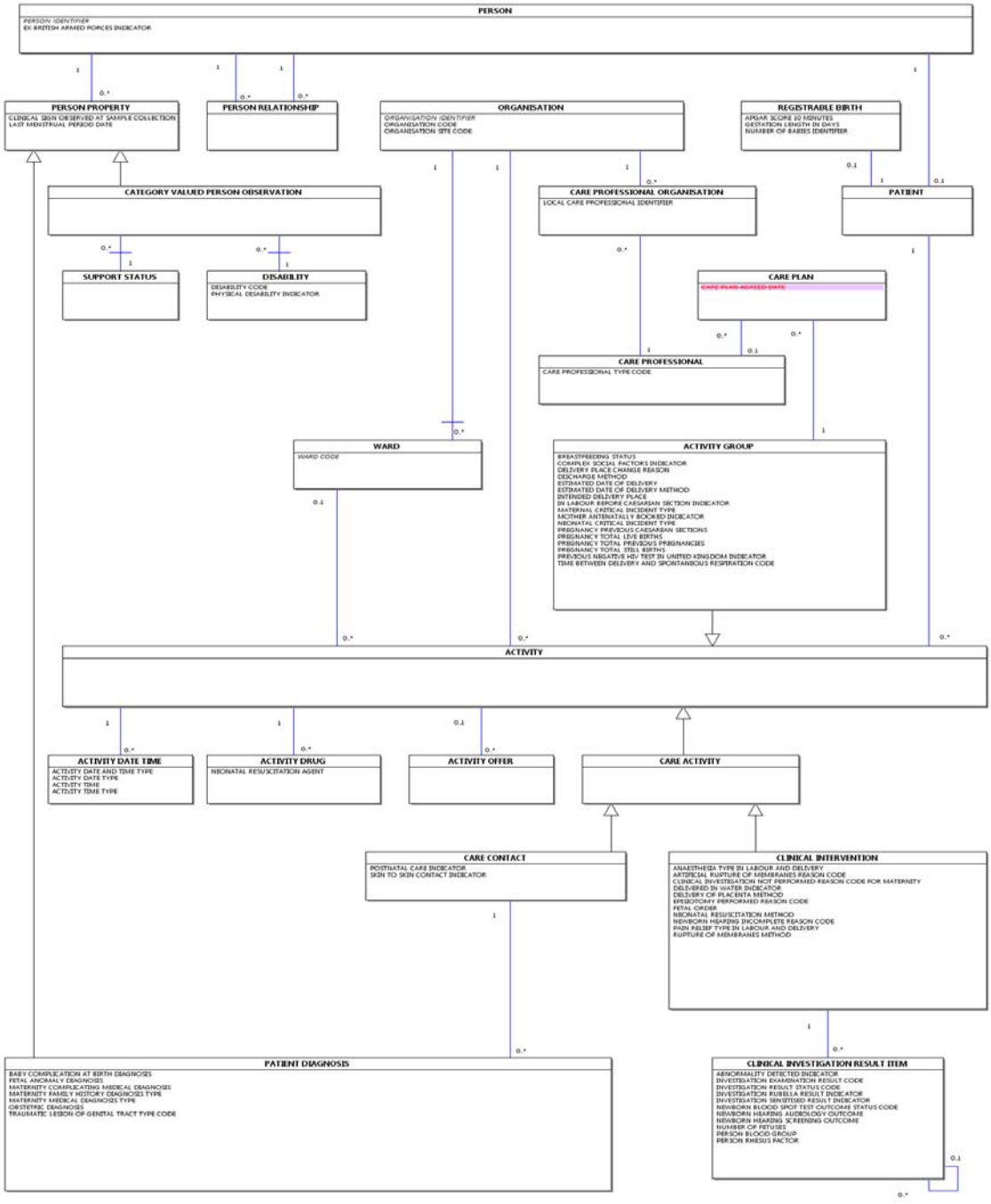
CANCER OUTCOMES AND SERVICES DIAGRAM

Change to Diagram: Changed Diagram



MATERNITY SERVICES DIAGRAM

Change to Diagram: Changed Diagram



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IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES DATA SET

Change to Data Set: Changed Description, Dataset

The Improving Access to Psychological Therapies Data Set will be in included in a future version of the Mental Health Services Data Set.

Improving Access to Psychological Therapies Data Set Overview

The Mandatory or Required (M/R) 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.

PERSONAL AND DEMOGRAPHIC DETAILS

Patient:
To carry Patient and Demographic details.
One occurrence of this group is required.

M/R	Data Set Data Elements
R	NHS NUMBER
R	NHS NUMBER STATUS INDICATOR CODE
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	ORGANISATION CODE (CODE OF PROVIDER)
M	PERSON BIRTH DATE
R	PERSON GENDER CODE CURRENT
M	POSTCODE OF USUAL ADDRESS
R	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)
R	ETHNIC CATEGORY
R	RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE
R	SEXUAL ORIENTATION (CURRENT)
R	EX-BRITISH ARMED FORCES INDICATOR
R	LONG TERM PHYSICAL HEALTH CONDITION INDICATOR (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)

DISABILITY

Patient Disability:
To carry details of the Patient's Disability.
Many occurrences of this group are permitted.

M/R	Data Set Data Elements
R	NHS NUMBER
R	LOCAL PATIENT IDENTIFIER (EXTENDED)
R	ORGANISATION CODE (CODE OF PROVIDER)
R	DISABILITY CODE

REFERRAL DETAILS

Improving Access to Psychological Therapies Referral:
To carry details of the Referral.
Many occurrences of this group are permitted.

M/R	Data Set Data Elements
R	NHS NUMBER
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	ORGANISATION CODE (CODE OF PROVIDER)
M	SERVICE REQUEST IDENTIFIER
M	REFERRAL REQUEST RECEIVED DATE
R	IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES OPT IN DATE
R	SOURCE OF REFERRAL FOR MENTAL HEALTH
R	SERVICE REQUEST ACCEPTANCE INDICATOR
R	ORGANISATION CODE (CODE OF COMMISSIONER)
R	PROVISIONAL DIAGNOSIS (ICD)

R	YEAR AND MONTH OF SYMPTOMS ONSET (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)
R	PREVIOUS SYMPTOM INDICATOR
R	IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES CARE SPELL END CODE
R	END DATE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)
R	ORGANISATION CODE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES STEPPED TO PROVIDER)
R	ADULT MENTAL HEALTH CARE CLUSTER CODE (FINAL)

APPOINTMENT DETAILS

Improving Access to Psychological Therapies Appointment:
To carry details of each Appointment.
Many occurrences of this group are permitted.

M/R	Data Set Data Elements
R	NHS NUMBER
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	ORGANISATION CODE (CODE OF PROVIDER)
M	SERVICE REQUEST IDENTIFIER
M	APPOINTMENT DATE
M	APPOINTMENT TIME
R	IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES STEPPED CARE INTENSITY DELIVERED
R	CARE PROFESSIONAL ROLE CODE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)
M	ATTENDED OR DID NOT ATTEND CODE
R	APPOINTMENT SLOT SHORT NOTICE CANCELLATION INDICATOR
R	CLINICAL CONTACT DURATION OF APPOINTMENT
M	APPOINTMENT TYPE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)
R	CONSULTATION MEDIUM USED
R	FACE TO FACE COMMUNICATION MODE
R	THERAPY TYPE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES) (Up to four types may be recorded for each APPOINTMENT)
R	EMPLOYMENT STATUS
R	EMPLOYMENT SUPPORT SUITABILITY INDICATOR
R	EMPLOYMENT SUPPORT REFERRAL DATE
R	PSYCHOTROPIC MEDICATION USAGE
R	STATUTORY SICK PAY INDICATOR
R	PHQ-9 TOTAL SCORE
R	GENERALISED ANXIETY DISORDER SCORE
R	WORK AND SOCIAL ADJUSTMENT SCALE SCORE (WORK)
R	WORK AND SOCIAL ADJUSTMENT SCALE SCORE (HOME MANAGEMENT)
R	WORK AND SOCIAL ADJUSTMENT SCALE SCORE (SOCIAL LEISURE ACTIVITIES)
R	WORK AND SOCIAL ADJUSTMENT SCALE SCORE (PRIVATE LEISURE ACTIVITIES)
R	WORK AND SOCIAL ADJUSTMENT SCALE SCORE (RELATIONSHIPS)
R	AGORAPHOBIA MOBILITY INVENTORY SCORE (WHEN ACCOMPANIED)
R	AGORAPHOBIA MOBILITY INVENTORY SCORE (WHEN ALONE)
R	AGORAPHOBIA SCORE
R	GENERALISED ANXIETY DISORDER PENN STATE WORRY SCORE
R	HEALTH ANXIETY INVENTORY SHORT WEEK SCALE SCORE
R	OBSESSIVE COMPULSIVE DISORDER INVENTORY SCORE
R	PANIC DISORDER SEVERITY SCALE SCORE
R	POST TRAUMATIC STRESS DISORDER IMPACT OF EVENTS SCALE REVISED SCORE
R	SOCIAL PHOBIA INVENTORY SCORE

R	SOCIAL PHOBIA SCORE
R	SPECIFIC PHOBIA SCORE

WAITING TIME PAUSES

Waiting Time Pauses:
To carry details of the Waiting Time Pauses.
Many occurrences of this group are permitted.

M/R	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	ORGANISATION CODE (CODE OF PROVIDER)
M	SERVICE REQUEST IDENTIFIER
M	IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ACTIVITY SUSPENSION IDENTIFIER
M	ACTIVITY SUSPENSION START DATE
R	ACTIVITY SUSPENSION END DATE
R	IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ACTIVITY SUSPENSION REASON

TREATMENT QUESTIONNAIRE

Treatment Questionnaire:
To carry details of the Treatment Questionnaire completed by the Patient.
Many occurrences of this group are permitted.

M/R	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	ORGANISATION CODE (CODE OF PROVIDER)
M	SERVICE REQUEST IDENTIFIER
R	ASSESSMENT TOOL COMPLETION DATE
R	ASSESSMENT TOOL COMPLETION TIME
R	IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES TREATMENT PATIENT EXPERIENCE QUESTION 1
R	IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES TREATMENT PATIENT EXPERIENCE QUESTION 2
R	IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES TREATMENT PATIENT EXPERIENCE QUESTION 3
R	IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES TREATMENT PATIENT EXPERIENCE QUESTION 4
R	IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES TREATMENT PATIENT EXPERIENCE QUESTION 5

ASSESSMENT QUESTIONNAIRE

Assessment Questionnaire:
To carry details of the Assessment Questionnaire completed by the Patient.
Many occurrences of this group are permitted.

M/R	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	ORGANISATION CODE (CODE OF PROVIDER)
M	SERVICE REQUEST IDENTIFIER
R	ASSESSMENT TOOL COMPLETION DATE
R	ASSESSMENT TOOL COMPLETION TIME
R	IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ASSESSMENT CHOICE PATIENT EXPERIENCE QUESTION 1
R	IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ASSESSMENT CHOICE PATIENT EXPERIENCE QUESTION 2
R	IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ASSESSMENT CHOICE PATIENT EXPERIENCE QUESTION 3
R	

	IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ASSESSMENT SATISFACTION PATIENT EXPERIENCE QUESTION 1

MENTAL HEALTH SERVICES DATA SET

Change to Data Set: Changed Description, Dataset

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	ORGANISATION CODE (CODE OF PROVIDER)
M	ORGANISATION CODE (CODE OF SUBMITTING ORGANISATION)
M	PRIMARY DATA COLLECTION SYSTEM IN USE
M	REPORTING PERIOD START DATE
M	REPORTING PERIOD END DATE
M	DATE AND TIME DATA SET CREATED

PATIENT DEMOGRAPHICS

Master Patient Index: **To carry the patient details of the patient.** **One occurrence of this group is required.**	
M/R/P	**Data Set Data Elements**
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)
R	ORGANISATION CODE (RESIDENCE RESPONSIBILITY)
R	ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT)
R	NHS NUMBER
R	NHS NUMBER STATUS INDICATOR CODE
R	PERSON BIRTH DATE
R	POSTCODE OF USUAL ADDRESS
~~R~~	~~POSTCODE OF MAIN VISITOR~~
R	PERSON STATED GENDER CODE
R	PERSON MARITAL STATUS

R	ETHNIC CATEGORY
R	RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE
R	LANGUAGE CODE (PREFERRED)
R	PERSON DEATH DATE

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

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

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

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

Accommodation Status:
To carry the accommodation details of the patient.
One occurrence of this group is permitted, containing the most recently recorded accommodation details.

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

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

Employment Status:
To carry details of the employment status of the patient.
One occurrence of this group is permitted, containing the most recently recorded employment details.

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

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

Patient Indicators:
To carry the details of specific indicators relating to a patient.
One occurrence of this group is permitted containing the current or most recently recorded status of indicator and psychosis information.

M/R/P	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
R	CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR
R	YOUNG CARER INDICATOR

R	LOOKED AFTER CHILD INDICATOR
R	CHILD PROTECTION PLAN INDICATION CODE
R	EX-BRITISH ARMED FORCES INDICATOR
R	OFFENCE HISTORY INDICATION CODE
R	PRODROME PSYCHOSIS DATE
R	EMERGENT PSYCHOSIS DATE
R	MANIFEST PSYCHOSIS DATE
R	FIRST PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION)
R	PSYCHOSIS FIRST TREATMENT START DATE

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

Mental Health Care Coordinator:
To carry details of the Mental Health Care Coordinator assigned to a patient.
One occurrence of this group is permitted for each Mental Health Care Coordinator assignment.

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

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

Disability Type:
To carry the details of the type of disability affecting a person, based on formal diagnoses, the person's perception or the perception of a patient proxy.
One occurrence of this group is permitted for each disability identified.

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

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

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

M/R/P	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
~~M~~	~~MENTAL HEALTH CRISIS PLAN CREATION DATE~~
~~R~~	~~MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE~~
M	ASSISTIVE TECHNOLOGY FINDING (SNOMED CT)
R	PRESCRIPTION DATE (ASSISTIVE TECHNOLOGY)

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

M/R/P	Data Set Data Elements

M	CARE PLAN IDENTIFIER
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	CARE PLAN TYPE (MENTAL HEALTH)
M	CARE PLAN CREATION DATE
R	CARE PLAN LAST UPDATED DATE
R	CARE PLAN IMPLEMENTATION DATE

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

M/R/P	Data Set Data Elements
M	CARE PLAN IDENTIFIER
M	CARE PLAN AGREED BY
R	CARE PLAN AGREED 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.**~~

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

M/R/P	Data Set Data Elements
M	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	REASON FOR OUT OF AREA REFERRAL (ADULT ACUTE MENTAL HEALTH)
R	DISCHARGE PLAN CREATION DATE
R	DISCHARGE PLAN LAST UPDATED DATE
R	SERVICE DISCHARGE DATE
R	SERVICE DISCHARGE TIME
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.**~~

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

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

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

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

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

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

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

Onward Referral:
To carry details of any onward referral of the patient which has taken place.
One occurrence of this group is permitted for each onward referral.

M/R/P	Data Set Data Elements
M	SERVICE REQUEST IDENTIFIER
R	DECISION TO REFER DATE (ONWARD REFERRAL)
R	DECISION TO REFER TIME (ONWARD REFERRAL)
M	ONWARD REFERRAL DATE
R	ONWARD REFERRAL TIME

R	ONWARD REFERRAL REASON
R	REFERRED OUT OF AREA REASON (ADULT ACUTE MENTAL HEALTH)
R	ORGANISATION CODE (RECEIVING)

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

M/R/P	Data Set Data Elements
M	SERVICE REQUEST IDENTIFIER
R	DISCHARGE PLAN AGREED BY
R	DISCHARGE PLAN AGREED DATE

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.**~~

Care Contact:
To carry details of any contacts with a patient which have taken place as part of a referral.
One occurrence of this group is permitted for each Care Contact.

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

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

Care Activity:
To carry details of any activities which have taken place as part of a contact.
One occurrence of this group is permitted for each Care Activity.

M/R/P	Data Set Data Elements
M	CARE ACTIVITY IDENTIFIER

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

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

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

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

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

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

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

GROUP SESSIONS

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

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

M/R/P	Data Set Data Elements
M	GROUP SESSION IDENTIFIER
M	GROUP SESSION DATE
M	ORGANISATION CODE (CODE OF COMMISSIONER)
R	CLINICAL CONTACT DURATION OF GROUP SESSION
R	GROUP SESSION TYPE (MENTAL HEALTH)

R	NUMBER OF GROUP SESSION PARTICIPANTS
R	ACTIVITY LOCATION TYPE CODE
R	SITE CODE (OF TREATMENT)
R	CARE PROFESSIONAL LOCAL IDENTIFIER
R	SERVICE OR TEAM TYPE REFERRED TO (MENTAL HEALTH)
R	NHS SERVICE AGREEMENT LINE NUMBER

MENTAL HEALTH ACT (MHA) EPISODES

~~**Mental Health Act Legal Status Classification Period:**~~
~~**To carry details of Mental Health Act Legal Status Classification 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.**~~

Mental Health Act Legal Status Classification Period:
To carry details of Mental Health Act Legal Status Classification Periods for patients formally detailed under the Mental Health Act 1983 or other Acts.
One occurrence of this group is permitted for each Mental Health Act Legal Status Classification Period identified.

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

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

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

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

~~**Conditional Discharge:**~~
~~**To carry details of each separate period of conditional discharge for the patient.**~~
~~**Multiple occurrences of this group are permitted.**~~

Conditional Discharge:
To carry details of each separate period of conditional discharge for the patient.
One occurrence of this group is permitted for each conditional discharge.

M/R/P	Data Set Data Elements
M	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER

M	START DATE (MENTAL HEALTH CONDITIONAL DISCHARGE)
R	END DATE (MENTAL HEALTH CONDITIONAL DISCHARGE)
R	MENTAL HEALTH CONDITIONAL DISCHARGE END REASON
R	MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY

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

Community Treatment Order:
To carry details of each separate period of a Community Treatment Order under section 17a of the Mental Health Act 1983, as amended by the Mental Health Act 2007, for the patient.
One occurrence of this group is permitted whenever a Community Treatment Order occurs.

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

~~**Community Treatment Order Recall:**~~
~~**To carry details of each separate period of recall into hospital for a patient on a Community Treatment Order under section 17a of the Mental Health Act 1983.**~~
~~**Multiple occurrences of this group are permitted.**~~

Community Treatment Order Recall:
To carry details of each separate period of recall into hospital for a patient on a Community Treatment Order under section 17a of the Mental Health Act 1983, as amended by the Mental Health Act 2007.
One occurrence of this group is permitted whenever a patient on a Community Treatment Order is recalled into hospital.

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

Hospital Provider Spell:
To carry details of each Hospital Provider Spell for a patient.
One occurrence of this group is permitted for each Hospital Provider Spell.

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

R	PLANNED DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL)
R	DISCHARGE DATE (HOSPITAL PROVIDER SPELL)
R	DISCHARGE TIME (HOSPITAL PROVIDER SPELL)
R	DISCHARGE METHOD CODE (HOSPITAL PROVIDER SPELL)
R	DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL)

~~**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.**~~

Ward Stay:
To carry details of Ward Stays which occurred during a Hospital Provider Spell for the patient.
One occurrence of this group is permitted for each Ward Stay.

M/R/P	Data Set Data Elements
M	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	INTENDED AGE GROUP (MENTAL HEALTH)
R	SEX OF PATIENTS CODE
R	INTENDED CLINICAL CARE INTENSITY CODE (MENTAL HEALTH)
R	WARD SECURITY LEVEL
R	LOCKED WARD INDICATOR
R	MENTAL HEALTH ADMITTED PATIENT CLASSIFICATION

~~**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.**~~

Assigned Care Professional:
To carry details of the Care Professional Admitted Care Episodes during a Hospital Provider Spell.
One occurrence of this group is permitted for each Care Professional Admitted Care Episode.

M/R/P	Data Set Data Elements
M	HOSPITAL PROVIDER SPELL NUMBER
M	CARE PROFESSIONAL LOCAL IDENTIFIER
M	START DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)
R	END DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)
R	TREATMENT FUNCTION CODE (MENTAL HEALTH)

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

Mental Health Delayed Discharge:
To carry details of Mental Health Delayed Discharge Periods which occurred during a Hospital Provider Spell.
One occurrence of this group is permitted whenever a patient is subject to a Mental Health Delayed Discharge Period.

M/R/P	Data Set Data Elements
M	HOSPITAL PROVIDER SPELL NUMBER
M	START DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD)
R	END DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD)

R	MENTAL HEALTH DELAYED DISCHARGE REASON
R	MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE

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

Restrictive Intervention:
To carry details of Restrictive Interventions during a Hospital Provider Spell.
One occurrence of this group is permitted whenever a Restrictive Intervention is carried out.

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

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

Assault:
To carry details of each separate reported incident of assault on a patient by another patient during a Hospital Provider Spell.
One occurrence of this group is permitted whenever an assault on the patient occurs.

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

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

Self-Harm:
To carry details of self-harm by the patient during a Hospital Provider Spell.
One occurrence of this group is permitted whenever an incident of self-harm is reported.

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

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

Home Leave:
To carry details of each separate period of Home Leave from a Hospital Provider Spell for a patient who is NOT liable for detention under the Mental Health Act 1983 and who is NOT on a Community Treatment Order.
One occurrence of this group is permitted whenever a period of home leave takes place.

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

~~**Mental Health Leave of Absence:**~~
~~**To carry details of each separate period of Mental Health Leave of Absence under section 17 of the**~~

~~Mental Health Act 1983 involving an overnight stay for the patient.~~
~~Multiple occurrences of this group are permitted.~~

Mental Health Leave of Absence:
To carry details of each separate period of Mental Health Leave of Absence under section 17 of the Mental Health Act 1983 involving an overnight stay for the patient.
One occurrence of this group is permitted whenever a period of Mental Health Leave of Absence takes place.

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

~~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.~~

Mental Health Absence Without Leave:
To carry details of each separate period of Mental Health Absence Without Leave for the patient.
One occurrence of this group is permitted whenever a period of Mental Health Absence Without Leave takes place.

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

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

Hospital Provider Spell Commissioner:
To carry details of each Commissioner Assignment Period during a Hospital Provider Spell.
One occurrence of this group is permitted for each Commissioner Assignment.

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

Substance Misuse:
To carry observation details of evidence of substance misuse by a patient within a ward stay.
One occurrence of this group is permitted for each date that evidence was observed.

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

CLINICALLY CODED TERMINOLOGY

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

Medical History (Previous Diagnosis):
To carry the details of any previous diagnoses for a patient.
One occurrence of this group is permitted for each Previous Diagnosis.

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

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

Provisional Diagnosis:
To carry the details of a provisional diagnosis made.
One occurrence of this group is permitted for each Provisional Diagnosis.

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

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

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

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

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

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

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

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

Coded Scored Assessment (Referral):
To carry details of scored assessments that are issued and completed as part of a referral to a Mental Health Service, but do not take place at a specific contact.
One occurrence of this group is permitted for each coded scored assessment question or dimension captured outside of a Care Contact.

M/R/P	Data Set Data Elements

M	SERVICE REQUEST IDENTIFIER
M	CODED ASSESSMENT TOOL TYPE (SNOMED CT)
M	PERSON SCORE
M	ASSESSMENT TOOL COMPLETION DATE
R	CARE PROFESSIONAL LOCAL IDENTIFIER

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

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

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

ANONYMOUS SELF-ASSESSMENT

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

Anonymous Self-Assessment:
To carry details of anonymous self-assessments.
One occurrence of this group is permitted for each coded anonymous self-assessment question or dimension captured.

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

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.**~~

Care Programme Approach (CPA) Care Episode:
To carry details of the periods of time the patient spent on Care Programme Approach.
One occurrence of this group is required for each Care Programme Approach (CPA) care episode.

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

~~**Care Programme Approach (CPA) Review:**~~
~~**To carry details of Care Programme Approach reviews undertaken for the patient.**~~
~~**Multiple occurrences of this group are permitted.**~~

Care Programme Approach (CPA) Review:
To carry details of Care Programme Approach reviews undertaken for the patient.

One occurrence of this group is permitted for the most recent Care Programme Approach Review that has taken place.

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

CARE CLUSTERS

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

Clustering Tool Assessment:
To carry details of clustering tool assessments.
One occurrence of this group is permitted for each Clustering Tool assessment that takes place.

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

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

Coded Scored Assessment (Clustering Tool):
To carry details of scored assessments that are issued and completed as part of a clustering tool assessment.
One occurrence of this group is permitted for each coded scored assessment question or dimension captured as part of a Clustering Tool assessment.

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

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

Care Cluster:
To carry details of the Care Cluster resulting from a clustering tool assessment.
One occurrence of this group is permitted for each period of time that a patient was allocated to a Care Cluster.

M/R/P	Data Set Data Elements
M	CLUSTERING TOOL ASSESSMENT IDENTIFIER
~~R~~	~~ADULT MENTAL HEALTH CARE CLUSTER CODE (FINAL)~~
~~P~~	~~CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL)~~

~~P~~	~~LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)~~
~~P~~	~~FORENSIC MENTAL HEALTH CARE CLUSTER CODE (FINAL)~~
~~P~~	~~FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)~~
M	START DATE (CARE CLUSTER ASSIGNMENT PERIOD)
R	START TIME (CARE CLUSTER ASSIGNMENT PERIOD)
R	ADULT MENTAL HEALTH CARE CLUSTER CODE (FINAL)
R	CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE
P	LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)
R	FORENSIC MENTAL HEALTH CARE CLUSTER CODE (FINAL)
P	FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)
R	END DATE (CARE CLUSTER ASSIGNMENT PERIOD)
R	END TIME (CARE CLUSTER ASSIGNMENT PERIOD)

Five Forensic Pathways:
To carry details of the Five Forensic Pathways grouping allocated to the patient during a Five Forensic Pathways assessment.
One occurrence of this group is permitted for each initial assessment or review of the grouping allocation.

M/R/P	Data Set Data Elements
M	LOCAL PATIENT IDENTIFIER (EXTENDED)
M	FIVE FORENSIC PATHWAYS ASSESSMENT DATE
R	FIVE FORENSIC PATHWAYS ASSESSMENT REASON
M	FIVE FORENSIC PATHWAYS CODE

CARE PROFESSIONALS

~~**Care Professionals:**~~
~~**To carry details of the Care Professionals involved in providing the patient's care.**~~
~~**Multiple occurrences of this group are permitted.**~~

Care Professionals:
To carry details of the staff involved in providing the patient's care.
One occurrence of this group is permitted for each staff member.

M/R/P	Data Set Data Elements
M	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

Change to Supporting Information: Changed Description

An Adult Mental Health Care Cluster is a type of CARE CLUSTER for adult PATIENTS.

An Adult Mental Health Care Cluster is part of a currency developed to support the National Tariff Payment System for Mental Health Services.

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.

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.

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.

~~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.~~Further information relating to the Adult Mental Health Clustering Tool and Adult Mental Health Care Clusters is available from the gov.uk website at: The NHS payment system: documents and guidance.

ADULT MENTAL HEALTH CLUSTERING TOOL

Change to Supporting Information: Changed Description

The Adult Mental Health Clustering Tool is a type of Clustering Tool for adult PATIENTS receiving Mental Health care.

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.~~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 Adult 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 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 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 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 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 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.~~Further information relating to the Adult Mental Health Clustering Tool and Adult Mental Health Care Clusters is available from the gov.uk website at: The NHS payment system: documents and guidance.

CARE PLAN AGREED DATE

Change to Supporting Information: New Supporting Information

A Care Plan Agreed Date is an ACTIVITY DATE TIME.

A Care Plan Agreed Date is the DATE on which the CARE PLAN was agreed by a PATIENT or Patient Proxy.

This supporting information is also known by these names:

Context	Alias
plural	Care Plan Agreed Dates

CARE PLAN CREATION DATE

Change to Supporting Information: New Supporting Information

A Care Plan Creation Date is an ACTIVITY DATE TIME.

A Care Plan Creation Date is the DATE that a CARE PLAN was created.

This supporting information is also known by these names:

Context	Alias
plural	Care Plan Creation Dates

CARE PLAN IMPLEMENTATION DATE

Change to Supporting Information: New Supporting Information

A Care Plan Implementation Date is an ACTIVITY DATE TIME.

A Care Plan Implementation Date is the DATE that aspects of the CARE PLAN have commenced.

This supporting information is also known by these names:

Context	Alias
plural	Care Plan Implementation Dates

CARE PLAN LAST UPDATED DATE

Change to Supporting Information: New Supporting Information

A Care Plan Last Updated Date is an ACTIVITY DATE TIME.

A Care Plan Last Updated Date is the DATE that a CARE PLAN was last updated.

This supporting information is also known by these names:

Context	Alias
plural	Care Plan Last Updated Dates

CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING

Change to Supporting Information: New Supporting Information

A Child and Adolescent Mental Health Needs Based Grouping is a CARE CLUSTER.

Child and Adolescent Mental Health Needs Based Groupings are 21 groupings that categorise the need for advice or help of children, young people and/or families referred to a SERVICE.

A Child and Adolescent Mental Health Needs Based Grouping should be assigned via a process of shared decision making between the SERVICE provider and the PATIENT or Patient Proxy. The decision, undertaken by a CARE PROFESSIONAL, may be helped by using an algorithm that was created to develop the groupings.

For further information on the Child and Adolescent Mental Health Needs Based Groupings and the assignment process, see "A Guide to Choosing Needs-Based Groupings in Child and Adolescent Mental Health Services to Inform Payment Systems".

This supporting information is also known by these names:

Context	Alias
plural	Child and Adolescent Mental Health Needs Based Groupings

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CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING TOOL

Change to Supporting Information: New Supporting Information

The Child and Adolescent Mental Health Needs Based Grouping Tool is a type of Clustering Tool for child and adolescent PATIENTS receiving Mental Health care.

The Child and Adolescent Mental Health Needs Based Grouping Tool is a tool designed to categorise the need for advice or help of children, young people and/or families referred to a SERVICE.

For further information on the Child and Adolescent Mental Health Needs Based Grouping Tool, see "A Guide to Choosing Needs-Based Groupings in Child and Adolescent Mental Health Services to Inform Payment Systems".

DISCHARGE PLAN

Change to Supporting Information: New Supporting Information

A Discharge Plan is a CARE PLAN.

A Discharge Plan is developed for a PATIENT who is scheduled for discharge from care and a copy is provided to the PATIENT on discharge.

A Discharge Plan should contain information such as:

- The planned date and time of discharge
- The treatment and support the PATIENT will receive when discharged
- Arrangements for transfer to the planned discharge destination, such as planning for returning home or transfer to another care facility
- Agreements to the Discharge Plan by relevant individuals such as the PATIENT, family, CARE PROFESSIONAL or commissioners
- Any onward referrals to home care agencies and/or appropriate support organisations in the community, where required.

This supporting information is also known by these names:

Context	Alias
plural	Discharge Plans

FIVE FORENSIC PATHWAYS

Change to Supporting Information: New Supporting Information

Five Forensic Pathways (FFP) are part of a currency developed to support the National Tariff Payment System for Forensic Mental Health Services.

Five Forensic Pathways are 5 groupings of Forensic Mental Health Patients based on their presenting characteristics and projected care package needs.

Five Forensic Pathways are initially allocated on the basis of the pathway descriptors only. The allocation may be reviewed and adjusted if necessary on the basis of baseline measures.

This supporting information is also known by these names:

Context	Alias
shortname	FFP

FIVE FORENSIC PATHWAYS ASSESSMENT DATE

Change to Supporting Information: New Supporting Information

A Five Forensic Pathways Assessment Date is an ACTIVITY DATE TIME.

A Five Forensic Pathways Assessment Date is the date on which a Five Forensic Pathways assessment was completed for a PATIENT.

This supporting information is also known by these names:

Context	Alias
plural	Five Forensic Pathways Assessment Dates

FORENSIC LEARNING DISABILITY SERVICE

Change to Supporting Information: New Supporting Information

A Forensic Learning Disability Service is a type of Mental Health Service.

A Forensic Learning Disability Service provides specialist forensic assessment and treatment of Forensic Mental Health Patients who also have a Learning Disability.

This supporting information is also known by these names:

Context	Alias
plural	Forensic Learning Disability Services

FORENSIC MENTAL HEALTH CARE CLUSTER

Change to Supporting Information: New Supporting Information

A Forensic Mental Health Care Cluster is a type of CARE CLUSTER for PATIENTS accessing Forensic Mental Health Services.

A Forensic Mental Health Care Cluster is part of a currency developed to support the National Tariff Payment System for Forensic Mental Health Services.

Forensic Mental Health Care Clusters are 22 groupings of Forensic Mental Health Patients based on their characteristics.

A Forensic Mental Health Care Cluster is assigned using a decision tree or algorithm based on the PERSON SCORE from the Forensic Mental Health Clustering Tool undertaken by a CARE PROFESSIONAL for the PATIENT.

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 Forensic Mental Health Care Clusters which are applicable to the PATIENT's condition. The PATIENT is then assigned to the most appropriate of this sub-set of Forensic Mental Health Care Clusters.

Further information relating to the Forensic Mental Health Clustering Tool and Forensic Mental Health Care Cluster is available from the gov.uk website at: The NHS payment system: documents and guidance.

This supporting information is also known by these names:

Context	Alias
plural	Forensic Mental Health Care Clusters

FORENSIC MENTAL HEALTH CLUSTERING TOOL

Change to Supporting Information: New Supporting Information

The Forensic Mental Health Clustering Tool is a type of Clustering Tool for adult PATIENTS receiving care from Forensic Mental Health Services.

The Forensic Mental Health Clustering Tool is a needs assessment tool designed to rate the care needs of a PATIENT, based upon a series of 22 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 Forensic Mental Health Clustering Tool.

Two additional 'current' ratings and a section relating to 'Historical Ratings' are also included, to form the Forensic Mental Health Clustering Tool. These items are referred to as the Summary of Assessments of Risk and Need (SARN) items.

Part 1: Current Ratings

These ratings relate to the most severe occurrence in the two weeks prior to the Forensic 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 that are not psychotic in origin (current)
40. Need for physical security to provide safe treatment for the PATIENT (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 Forensic 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 other children and vulnerable adults (historical)
D. Engagement (historical)
E. Vulnerability (historical)
P. Interpersonal Dynamics (historical)
Q. Problem-drinking or drug-taking (historical)
R. Antisocial attitudes likely to result in behaviour that causes a risk to others (historical).

The allowed responses to each of the 22 items in the Forensic 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 Forensic Mental Health Clustering Tool is used to allocate the PATIENT to the most appropriate Forensic Mental Health Care Cluster.

This supporting information is also known by these names:

Context	Alias
plural	Forensic Mental Health Clustering Tools

FORENSIC MENTAL HEALTH PATIENT

Change to Supporting Information: New Supporting Information

A Forensic Mental Health Patient is a PATIENT being treated by a Forensic Mental Health Service.

A Forensic Mental Health Patient is someone in the following categories:

- Not guilty by reason of mental illness: a PERSON subject to a special verdict who has been found not guilty by reason of mental illness and detained in a hospital, Prison or other place, or who has been granted release into the community conditionally
- Unfit for trial: a PERSON who has been found unfit to be tried for the offences with which they have been charged
- Limiting term: a PERSON who has been given a limiting term following a special hearing and has been detained in a mental health facility, Prison or other place, or who has been granted conditional release
- Transferees: a PERSON who has been transferred from a Prison to a mental health facility whilst on remand or following conviction of a criminal offence and whilst serving a sentence of imprisonment

This supporting information is also known by these names:

Context	Alias
plural	Forensic Mental Health Patients

FORENSIC MENTAL HEALTH SERVICE

Change to Supporting Information: New Supporting Information

A Forensic Mental Health Service is a type of Mental Health Service.

A Forensic Mental Health Service is a specialist SERVICE for people who have a mental health problem who have been arrested, who are on remand or who have been to court and found guilty of a crime.

A Forensic Mental Health Service is an alternative to Prison for people who have a mental health problem and offers specialist mental health treatment and care.

For further information on Forensic Mental Health Services, see the Mental Health Care website.

This supporting information is also known by these names:

Context	Alias
plural	Forensic Mental Health Services

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.

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.~~For further information on Health of the Nation Outcome Scale (Working Age Adults), see the Royal College of Psychiatrists website at: Health of the Nation Outcome Scales.

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 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 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.

For Mental Health Services Data Set (MHSDS), the Ward Stay remains uninterrupted when a PATIENT leaves the WARD to take Home Leave.

IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES DATA SET OVERVIEW

Change to Supporting Information: Changed Description, Dataset

The Improving Access to Psychological Therapies Data Set will be in included in a future version of the Mental Health Services Data Set.

The collection of outcome data including clinical scores is a defining characteristic for stepped care and the National Institute for Health and Care Excellence (NICE) recommended model of delivery of psychological therapies.

The Improving Access to Psychological Therapies Data Set provides an agreed national standard for data collection for commissioned providers of psychological therapy for anxiety and depression. Standardised PATIENT centred information facilitates an integrated approach to the provision of psychological therapies and leads to improvements in the quality of services.

The Improving Access to Psychological Therapies Data Set supports:

- Clinicians to evaluate the effectiveness, refine and adapt the interventions provided using PATIENT outcome measures
- Development and refinement of policy relating to psychological therapies

- Monitoring the implementation and effectiveness of the Improving Access to Psychological Therapies (IAPT) Programme
- The equity of provision in relation to geographical, gender, age, ethnicity, religion, sexual orientation and DISABILITY coverage of the new services
- The profile of therapy types provided, diagnosis pattern and durations of interventions and the frequency of multi-step interventions; and the relationship of these to presenting problems, medication usage, outcomes (clinical, symptomatic, work and social)
- Performance management at Clinical Commissioning Group and national level
- Better planning and management of services at local level
- Waiting Time monitoring through the central calculation of waiting times
- Monitoring of PATIENT experience to inform service delivery
- Capture of activity and movement across the stepped care pathway
- The development of a payment system for Improving Access to Psychological Therapies Services.

The Improving Access to Psychological Therapies Data Set includes information on:

- PATIENT Demographics: Geographical, gender, age, ethnicity, religion, sexual orientation and DISABILITY
- Care Pathways: PROVISIONAL DIAGNOSIS information, psychological intervention types, referral and sessional details
- APPOINTMENTS: Clinical, economic and social outcomes relating to the interventions provided
- Waiting Time Pauses: ACTIVITY SUSPENSION periods across the PATIENT's care pathway
- Improving Access to Psychological Therapies Patient Experience Questionnaires: Improving Access to Psychological Therapies treatment and assessment questionnaires
- National Tariff Payment System: Additional data items to support the introduction and development of a payment system for Improving Access to Psychological Therapies Services.

Time period

The extract covers one month.

Frequency

Reports are run monthly.

Further Guidance

Further guidance relating to the Improving Access to Psychological Therapies Data Set is available on the:

- NHS Digital website at: Improving Access to Psychological Therapies Data Set
- Improving Access to Psychological Therapies (IAPT) Programme website at: Measuring Outcomes.

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

- Non-psychotic
- Psychotic or
- Organic

~~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).*~~If the PATIENT cannot be assigned to an Adult Mental Health Care Cluster or Forensic 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 or FORENSIC MENTAL HEALTH CARE CLUSTER CODE *'00 Care Cluster 0 - Variance.*'

~~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.~~Further information relating to the Adult Mental Health Clustering Tool and Adult Mental Health Care Clusters is available from the gov.uk website at: The NHS payment system: documents and guidance.

MENTAL HEALTH CARE PLAN

Change to Supporting Information: New Supporting Information

A Mental Health Care Plan is a CARE PLAN.

A Mental Health Care Plan is a plan of the treatment or health care to be provided to a mental health PATIENT for a CARE ACTIVITY or within an ACTIVITY GROUP.

This supporting information is also known by these names:

Context	Alias
plural	Mental Health Care Plans

MENTAL HEALTH CRISIS PLAN CREATION DATE (RETIRED) renamed from MENTAL HEALTH CRISIS PLAN CREATION DATE

Change to Supporting Information: Changed Description, Name, status to Retired

~~Mental Health Crisis Plan Creation Date is an ACTIVITY DATE TIME.~~**This item has been retired from the NHS Data Model and Dictionary.**

~~Mental Health Crisis Plan Creation Date is the DATE that a Mental Health Crisis Plan was created.~~ **The last live version of this item is available in the ?????? release of the NHS Data Model and Dictionary.**

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

MENTAL HEALTH CRISIS PLAN CREATION DATE (RETIRED) renamed from MENTAL HEALTH CRISIS PLAN CREATION DATE

Change to Supporting Information: Changed Description, Name, status to Retired

- Changed Description
- Changed Name from Data_Dictionary.NHS_Business_Definitions.M.Mental_Health_Crisis_Plan_Creation_Date to Retired.Data_Dictionary.NHS_Business_Definitions.M.Mental_Health_Crisis_Plan_Creation_Date
- Retired Mental Health Crisis Plan Creation Date

MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE (RETIRED)_ renamed from MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE

Change to Supporting Information: Changed Description, Name, status to Retired

~~Mental Health Crisis Plan Last Updated Date~~ ~~is an ACTIVITY DATE TIME~~.**This item has been retired from the NHS Data Model and Dictionary.**

~~Mental Health Crisis Plan Last Updated Date~~ ~~is the DATE~~ ~~that a Mental Health Crisis Plan~~ ~~was last updated.~~ **The last live version of this item is available in the ?????? release of the NHS Data Model and Dictionary.**

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE (RETIRED)_ renamed from MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE

Change to Supporting Information: Changed Description, Name, status to Retired

- Changed Description
- Changed Name from Data_Dictionary.NHS_Business_Definitions.M.Mental_Health_Crisis_Plan_Last_Updated_Date to Retired.Data_Dictionary.NHS_Business_Definitions.M.Mental_Health_Crisis_Plan_Last_Updated_Date
- Retired Mental Health Crisis Plan Last Updated Date

MENTAL HEALTH SERVICES DATA SET OVERVIEW

Change to Supporting Information: Changed Dataset

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 NHS Digital website at: Mental Health Services Data Set (MHSDS).

ONWARD REFERRAL TIME

Change to Supporting Information: New Supporting Information

An Onward Referral Time is an ACTIVITY DATE TIME.

An Onward Referral Time is the time 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 Times

ORGANISATION

Change to Supporting Information: Changed Dataset

An Organisation is an ORGANISATION.

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

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

PLACE OF SAFETY

Change to Supporting Information: New Supporting Information

A Place of Safety is a LOCATION.

A Place of Safety maybe:

- a residential ACCOMMODATION provided by a local social services authority under Part III of the National Assistance Act 1948
- a hospital as defined by the Mental Health Act 1983 as amended by the Mental Health Act 2007
- a police station
- an independent hospital or Care Home for mentally disordered PERSONS or
- any other suitable place

where the occupier of which is willing temporarily to accommodate a PATIENT detained under section 136 of the Mental Health Act 1983 as amended by the Mental Health Act 2007.

This supporting information is also known by these names:

Context	Alias
plural	Places of Safety

POSITIVE BEHAVIOUR SUPPORT PLAN

Change to Supporting Information: New Supporting Information

A Positive Behaviour Support Plan is a CARE PLAN.

A Positive Behaviour Support Plan is created to help understand and support children, young people and adults who have a Learning Disability and display behaviour that others find challenging.

A Positive Behaviour Support Plan is an individualised CARE PLAN which is available to those who provide care and support.

A Positive Behaviour Support Plan should be informed by functional assessments. People and their families should be as fully involved as possible in developing and reviewing the plan.

A Positive Behaviour Support Plan should include the following elements:

- proactive strategies designed to improve quality of life and remove conditions that promote behaviour that challenges
- identification of environmental adaptations and strategies to support the development of new skills
- preventative (calming) strategies in response to early signs of distress
- reactive strategies to manage behaviours that are not preventable.

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

This supporting information is also known by these names:

Context	Alias
plural	Positive Behaviour Support Plans

REFERENCED ORGANISATIONS MENU

Change to Supporting Information: Changed Description

- NHS Business Definitions
- Organisations
- Regulatory Bodies

- ~~**Referenced Organisations:**~~
  - ~~American Joint Committee on Cancer~~
  - ~~British Association for Paediatric Nephrology~~
  - ~~British Psychological Society~~
  - ~~British Renal Society~~
  - ~~British Transplantation Society~~
  - ~~Burden Advice and Assessment Service~~
  - ~~Care Quality Commission~~
  - ~~Community Health Partnership (Scotland)~~
  - ~~Community Safety Partnership~~
  - ~~Department for Education~~
  - ~~Department for Work and Pensions~~
  - ~~Department for Work and Pensions Overseas Healthcare Team~~
  - ~~Department of Health~~
  - ~~European Renal Association~~
  - ~~Faculty of General Dental Practice (UK)~~
  - ~~GS1~~
  - ~~Health and Wellbeing Board~~
  - ~~Health Education England~~
  - ~~Health Research Authority~~
  - ~~Healthcare Quality Improvement Partnership~~
  - ~~Healthwatch England~~
  - ~~Improving Access to Psychological Therapies Programme~~
  - ~~Information Standards Board for Health and Social Care~~
  - ~~International Commission on Radiation Units and Measurements~~
  - ~~International Federation of Gynecology and Obstetrics~~
  - ~~International Health Terminology Standards Development Organisation~~
  - ~~International Society of Paediatric Oncology~~
  - ~~Local Health Board (Wales)~~
  - ~~Local Healthwatch~~
  - ~~Medicines and Healthcare Products Regulatory Agency~~
  - ~~Monitor~~
  - ~~National Cancer Registration and Analysis Service~~
  - ~~National Casemix Office~~
  - ~~National Contact Point~~
  - ~~National Commissioning Group~~
  - ~~National Information Board~~
  - ~~National Institute for Health and Care Excellence~~
  - ~~National Joint Registry~~
  - ~~National Kidney Federation~~
  - ~~National Specialised Commissioning Group~~
  - ~~Neonatal Data Analysis Unit~~
  - ~~NHS Business Services Authority~~
  - ~~NHS Dental Services~~
  - ~~NHS Digital~~
  - ~~NHS England~~
  - ~~NHS Prescription Services~~

    - ~~NHS Trust Development Authority~~
    - ~~NHS Wales Informatics Service~~
    - ~~Northern Ireland Local Commissioning Group~~
    - ~~Office for National Statistics~~
    - ~~Ofsted~~
    - ~~Public Health England~~
    - ~~Royal College of General Practitioners~~
    - ~~Royal Pharmaceutical Society~~
    - ~~Standardisation Committee for Care Information~~
    - ~~Sustainable Development Unit~~
    - ~~The Renal Association~~
    - ~~The Royal Marsden~~
    - ~~UK National Screening Committee~~
    - ~~UK Renal Registry~~
    - ~~UK Terminology Centre~~
    - ~~Union for International Cancer Control~~
    - ~~United Kingdom and Ireland Association of Cancer Registries~~
    - ~~World Health Organisation~~
- **Referenced Organisations:**
    - American Joint Committee on Cancer
    - British Association for Paediatric Nephrology
    - British Psychological Society
    - British Renal Society
    - British Transplantation Society
    - Burden Advice and Assessment Service
    - Care Quality Commission
    - Community Health Partnership (Scotland)
    - Community Safety Partnership
    - Department for Education
    - Department for Work and Pensions
    - Department for Work and Pensions Overseas Healthcare Team
    - Department of Health
    - European Renal Association
    - Faculty of General Dental Practice (UK)
    - GS1
    - Health and Wellbeing Board
    - Health Education England
    - Health Research Authority
    - Healthcare Quality Improvement Partnership
    - Healthwatch England
    - Improving Access to Psychological Therapies Programme
    - Information Standards Board for Health and Social Care
    - International Commission on Radiation Units and Measurements
    - International Federation of Gynecology and Obstetrics
    - International Health Terminology Standards Development Organisation
    - International Society of Paediatric Oncology
    - Local Health Board (Wales)
    - Local Healthwatch
    - Medicines and Healthcare Products Regulatory Agency
    - Monitor
    - National Cancer Registration and Analysis Service
    - National Casemix Office
    - National Contact Point
    - National Commissioning Group
    - National Information Board
    - National Institute for Health and Care Excellence
    - National Joint Registry

- National Kidney Federation
- National Specialised Commissioning Group
- Neonatal Data Analysis Unit
- NHS Business Services Authority
- NHS Dental Services
- NHS Digital
- NHS England
- NHS Prescription Services
- NHS Trust Development Authority
- NHS Wales Informatics Service
- Northern Ireland Local Commissioning Group
- Office for National Statistics
- Ofsted
- Public Health England
- Royal College of General Practitioners
- Royal College of Psychiatrists
- Royal Pharmaceutical Society
- Standardisation Committee for Care Information
- Sustainable Development Unit
- The Renal Association
- The Royal Marsden
- UK National Screening Committee
- UK Renal Registry
- UK Terminology Centre
- Union for International Cancer Control
- United Kingdom and Ireland Association of Cancer Registries
- World Health Organisation

REFERRAL CLOSURE TIME

Change to Supporting Information: New Supporting Information

A Referral Closure Time is an ACTIVITY DATE TIME.

A Referral Closure Time is the time the REFERRAL REQUEST was closed by a SERVICE.

This supporting information is also known by these names:

Context	Alias
plural	Referral Closure Times

ROYAL COLLEGE OF PSYCHIATRISTS

Change to Supporting Information: New Supporting Information

The Royal College of Psychiatrists is an Organisation.

The Royal College of Psychiatrists is the professional body responsible for education and training, and setting and raising standards in psychiatry.

For further information on the Royal College of Psychiatrists, see the Royal College of Psychiatrists website at: Improving the lives of people with mental illness.

SERVICE DISCHARGE TIME

Change to Supporting Information: New Supporting Information

A Service Discharge Time is an ACTIVITY DATE TIME.

A Service Discharge Time is the time a PATIENT was discharged from a SERVICE.

This supporting information is also known by these names:

Context	Alias
plural	Service Discharge Times

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 NHS Digital website at: Information Standards and Collections (Including Extractions) - National Governance.

URGENT AND EMERGENCY MENTAL HEALTH CARE PLAN

Change to Supporting Information: New Supporting Information

A Urgent and Emergency Mental Health Care Plan is a CARE PLAN.

An Urgent and Emergency Mental Health Care Plan aims to develop strategies to help people stay safe and establish a network of support.

This supporting information is also known by these names:

Context	Alias
plural	Urgent and Emergency Mental Health Care Plans

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 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.~~For Mental Health Services Data Set (MHSDS), the Ward Stay remains uninterrupted when a PATIENT leaves the WARD for Home Leave, Mental Health Leave of Absence or Mental Health Absence Without Leave.

~~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:

- Home Leave, the Nursing Episode, Midwife Episode, Consultant Episode (Hospital Provider), Hospital Stay or Hospital Provider Spell however remain uninterrupted
- 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
- 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.

~~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 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.

APPOINTMENT

Change to Class: Changed Dataset

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.

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.

CARE CLUSTER

Change to Class: Changed Attributes

Attributes of this Class are:

ADULT MENTAL HEALTH CARE CLUSTER CODE
~~CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE~~
CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE
FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE
FORENSIC MENTAL HEALTH CARE CLUSTER CODE
LEARNING DISABILITIES CARE CLUSTER CODE
MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE

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 REASON
CARE CONTACT SUBJECT
CARE CONTACT TYPE
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
FIVE FORENSIC PATHWAYS ASSESSMENT REASON
FIVE FORENSIC PATHWAYS CODE
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
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
SIGNPOSTING TO SERVICE INDICATOR
SIGNPOSTING TO SERVICE TYPE FOR NHS HEALTH CHECK
SKIN TO SKIN CONTACT INDICATOR
SOCIAL WORKER CARE INDICATOR FOR HIV
SUBJECTIVE GLOBAL ASSESSMENT
THERAPY TYPE FOR IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES
TWO YEAR NEONATAL OUTCOMES ASSESSMENT NOT CARRIED OUT REASON

CARE PLAN

Change to Class: Changed Attributes

Attributes of this Class are:

~~K~~ ~~CARE PLAN NUMBER~~
K CARE PLAN IDENTIFIER
CANCER CARE PLAN INTENT
CANCER RECURRENCE CARE PLAN INDICATOR
~~CARE PLAN AGREED DATE~~
CARE PLAN AGREED BY
CARE PLAN TYPE
CARE PLAN TYPE FOR MENTAL HEALTH
CHILD PROTECTION PLAN INDICATION CODE
CHILD PROTECTION PLAN REASON CODE
DISCHARGE PLAN AGREED BY
MULTIDISCIPLINARY TEAM CANCER CARE PLAN DISCUSSED INDICATOR
MULTIDISCIPLINARY TEAM MEETING TYPE FOR CANCER
NO CANCER TREATMENT REASON

DECISION TO REFER

Change to Class: Changed Attributes

Attributes of this Class are:

K	DECISION TO REFER DATE
K	DECISION TO REFER TIME

LOCATION

Change to Class: Changed Attributes

Attributes of this Class are:

ACTIVITY LOCATION TYPE CODE
ASSAULT LOCATION TYPE
INTERVENTION SETTING
LOCATION IN HOSPITAL TYPE
LOCATION OF HIGHEST LEVEL OF CARE
PLACE OF SAFETY INDICATOR

PERSON PROPERTY

Change to Class: Changed Attributes

Attributes of this Class are:

K	PERSON PROPERTY IDENTIFIER

CLINICAL SIGN OBSERVED AT SAMPLE COLLECTION
DOMINANT ARM CODE
FAMILIAL CANCER SYNDROME INDICATOR
FREE PRESCRIPTIONS INDICATOR
LAST MENSTRUAL PERIOD DATE
OFFENCE HISTORY INDICATION CODE
PERSON PROPERTY EFFECTIVE DATE
PERSON PROPERTY EFFECTIVE END DATE
PERSON PROPERTY EFFECTIVE END TIME
PERSON PROPERTY EFFECTIVE TIME
PERSON PROPERTY OBSERVED DATE
PERSON PROPERTY OBSERVED TIME
PERSON PROPERTY RECORDED DATE
PERSON PROPERTY RECORDED TIME
PREGNANCY STATUS
SURGICAL VOICE RESTORATION COMMUNICATION METHOD FOR PLANNED POST OPERATIVE
SURGICAL VOICE RESTORATION COMMUNICATION METHOD FOR PRIMARY
YOUNG CARER INDICATOR

SERVICE REQUEST

Change to Class: Changed Attributes

Attributes of this Class are:

K	SERVICE REQUEST IDENTIFIER

CLINICAL RESPONSE PRIORITY TYPE
DIAGNOSTIC SERVICE REQUEST TYPE
DIRECT ACCESS REFERRAL INDICATOR
ONWARD REFERRAL REASON
ORIGINAL REFERRAL REQUEST RECEIVED DATE
REASON FOR OUT OF AREA REFERRAL FOR ADULT ACUTE MENTAL HEALTH
REFERRAL REQUEST RECEIVED DATE

REFERRED OUT OF AREA REASON FOR ADULT ACUTE MENTAL HEALTH
SERVICE REQUEST ACCEPTANCE INDICATOR
SERVICE REQUEST DATE
SERVICE REQUEST RAISED REASON

WARD OPERATIONAL PLAN

Change to Class: Changed Attributes

Attributes of this Class are:

K WARD OPERATIONAL PLAN START DATE
AGE GROUP INTENDED
AGE GROUP INTENDED FOR MENTAL HEALTH
CLINICAL CARE INTENSITY
SEX OF PATIENTS
WARD DAY NIGHT INDICATOR
WARD DAY PERIOD AVAILABILITY
WARD NIGHT PERIOD AVAILABILITY
WARD OPERATIONAL PLAN END DATE

ACCOMMODATION STATUS CODE

Change to Attribute: Changed Dataset
An indication of the type of accommodation that a PATIENT currently has. This should be based on the PATIENT's main or permanent residence.

National Codes:

MA00	**Mainstream Housing**
MA01	Owner occupier
MA02	Settled mainstream housing with family/friends
MA03	Shared ownership scheme e.g. Social Homebuy Scheme (tenant purchase percentage of home value from landlord)
MA04	Tenant - Local Authority/Arms Length Management Organisation/Registered Landlord
MA05	Tenant - Housing Association
MA06	Tenant - private landlord
MA09	Other mainstream housing
HM00	**Homeless**
HM01	Rough sleeper
HM02	Squatting
HM03	Night shelter/emergency hostel/Direct access hostel (temporary accommodation accepting self referrals, no waiting list and relatively frequent vacancies)
HM04	Sofa surfing (sleeps on different friends floor each night)
HM05	Placed in temporary accommodation by Local Authority (including Homelessness resettlement service) e.g. Bed and Breakfast accommodation
HM06	Staying with friends/family as a short term guest
HM07	Other homeless
MH00	**Accommodation with mental health care support**
MH01	Supported accommodation (accommodation supported by staff or resident caretaker)
MH02	Supported lodgings (lodgings supported by staff or resident caretaker)
MH03	Supported group home (supported by staff or resident caretaker)
MH04	Mental Health Registered Care Home
MH09	Other accommodation with mental health care and support
HS00	**Acute/long stay healthcare residential facility/hospital**
HS01	NHS acute psychiatric ward
HS02	Independent hospital/clinic
HS03	Specialist rehabilitation/recovery

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

ACTIVITY DATE

Change to Attribute: Changed Dataset

Any DATE that is of relevance to an ACTIVITY.

The specific nature of the DATE will be identified by the ACTIVITY DATE TYPE.

ACTIVITY 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 September 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 (Retired 01 January 2016)
047 Screening Test Date
048 Genitourinary Care Contact Date (Retired January 2014)
049 Consultant Upgrade Date
101 Referral Closure Date (Community Care) (Retired 01 September 2015)
102 Discharge Letter Issued Date (Community Care) (Retired 01 September 2015)
103 Systemic Anti-Cancer Therapy Administration Date
104 Procedure Date
105 Immunisation 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
141 Care Contact Cancellation Date
142 Care Contact Date
143 Child Protection Plan End Date
144 Child Protection Plan Start Date
145 Discharge Letter Issued Date (Mental Health and Community Care)
146 Health Visitor First Antenatal Visit Date
147 Infant Physical Examination Date
148 Onward Referral Date
149 Referral Closure Date
150 Referral Rejection Date
151 Replacement Appointment Booked Date
152 Replacement Appointment Date Offered
153 Service Discharge Date
154 Date of Restrictive Intervention
155 Indirect Activity Date
~~156~~ ~~Mental Health Crisis Plan Creation Date~~
~~157~~ ~~Mental Health Crisis Plan Last Updated Date~~
156 Mental Health Crisis Plan Creation Date (Retired 01 April 2017)
157 Mental Health Crisis Plan Last Updated Date (Retired 01 April 2017)
Care Plan Agreed Date
Care Plan Creation Date
Care Plan Implementation Date
Care Plan Last Updated Date
Five Forensic Pathways Assessment Date

Note: This 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.

ACTIVITY LOCATION TYPE CODE

Change to Attribute: Changed Dataset

The type of LOCATION for an ACTIVITY:

- where PATIENTS are seen
- where SERVICES are provided or
- from which requests for SERVICES are sent.

National Codes:

CODE	VALUE	NOTES
	PATIENT Main Residence or Related Location	
A01	PATIENT's Home	
A02	Carer's Home	
A03	PATIENT's Workplace	
A04	Other PATIENT Related Location	E.g. temporary address
	Health Centre Premises	
B01	Primary Care Health Centre	Primary Care Health Centre with or without GP Practice (s) based in it, providing community-based healthcare services such as podiatry, community dentistry, ophthalmology, minor injuries nursing etc, Sexual and Reproductive Health Service, health promotion etc, and sometimes hosting outreach services from NHS Trusts and NHS Foundation Trusts
B02	Polyclinic	Provide similar services to Primary Care Health Centre but also additional services such as diagnostics, minor procedures, Out-Patient Appointments, urgent care etc. and also co-located services with Local Authority Social Care. May also provide extended/out of hours services.
	GENERAL PRACTITIONER and OPHTHALMIC MEDICAL PRACTITIONER	
C01	General Medical Practitioner Practice	Stand-alone GP Practice premises, not part of a Primary Care Health Centre
C02	Dental Practice	Stand-alone GP Practice premises, not part of a Primary Care Health Centre
C03	OPHTHALMIC MEDICAL PRACTITIONER Premises	
	Walk In Centres, Out of Hours Premises and Emergency Community Dental Services	
D01	Walk In Centre	May be NHS GENERAL PRACTITIONER Led, NURSE-led, or provided by private company. May be sited in different areas - health care premises, in retail premises etc
D02	Out of Hours Centre	May be NHS GENERAL PRACTITIONER-Led, NURSE-led, or provided by private company. May be sited in different areas - health care premises, in retail premises etc
D03	Emergency Community Dental Service	Run by Community Dental Services not GENERAL DENTAL PRACTITIONERS
	Locations on Hospital Premises	
E01	Out-Patient Clinic	
E02	WARD	
E03	Day Hospital	
E04	Accident and Emergency or Minor Injuries Department	
E99	Other Departments	E.g. Pathology Laboratories, physiotherapy, diagnostic imaging, Occupational Therapy, Pharmacy Premises etc
	Hospice Premises	
F01	Hospice	
	Nursing and Residential Homes	

G01	Care Home Without Nursing	
G02	Care Home With Nursing	
G03	Children's Home	
G04	Integrated Care Home Without Nursing and Care Home With Nursing *	
	Day Centre Premises	
H01	Day Centre	Facilities operated by the NHS, Social Services or private or voluntary bodies, providing day care and respite care for elderly or disabled people
	Resource Centre Premises	
J01	Resource Centre	Premises where information and support for PATIENTS and their families/Carers is provided.
	Dedicated Facilities for Children and Families	
K01	Sure Start Children's Centre	Children's centres are service hubs where children under five years old and their families can receive seamless integrated services and information. Services vary according to centre but may include: • 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 Children and Young People's Health Services Data Set, Community Information Data Set and Mental Health Services Data Set. The values are not currently permitted to flow in other data sets. Users of these other data sets must map National Code G04 locally to other appropriate ACTIVITY LOCATION TYPE CODES for the purposes of flowing data.

ACTIVITY SUSPENSION END DATE

Change to Attribute: Changed Dataset

The date on which the break from the ACTIVITY ends.

ACTIVITY SUSPENSION IDENTIFIER

Change to Attribute: Changed Dataset

A unique number to identify the ACTIVITY SUSPENSION.

ACTIVITY SUSPENSION START DATE

Change to Attribute: Changed Dataset

The date on which the break from the ACTIVITY starts.

ACTIVITY TIME

Change to Attribute: Changed Dataset

Any TIME that is of relevance to an ACTIVITY.

The specific nature of the TIME will be identified by the ACTIVITY TIME TYPE.

ACTIVITY TIME TYPE

Change to Attribute: Changed Description

The type of TIME that defines the usage with regard to the ACTIVITY.

An ACTIVITY may have many TIMES associated with it but may only have one TIME of a particular type.

National Codes:

50 Accident and Emergency Attendance Conclusion Time
51 Accident and Emergency Departure Time
52 Accident and Emergency Initial Assessment Time
53 Accident and Emergency Time Seen For Treatment
54 Arrival At Hospital Time (Retired April 2012)
55 ARRIVAL TIME (Retired April 2012)
56 End Time
57 Event Time (Retired July 2012)
58 Initial Patient Contact Time (Retired July 2012)
59 Last Dosage Time

60 Pathology Result Due Time
61 Start Time
62 Theatre Case Time In To Theatre Suite (Retired September 2012)
63 Theatre Case Time Out Of Theatre (Retired September 2012)
64 Theatre Case Time Out Of Theatre Suite (Retired September 2012)
65 Time Seen
66 Discharge Ready Time (Retired April 2012)
67 Arrival Time At Accident and Emergency Department
68 Arrival Time For Transport Requests (Retired September 2015)
69 Discharge Time
70 Clinical Intervention Time
71 Care Contact Time
72 Indirect Activity Time
Service Discharge Time
Referral Closure Time
Onward Referral Time

Note: This list is not in alphabetical order.

ADMINISTRATIVE CATEGORY CODE

Change to Attribute: Changed Dataset

This is recorded for PATIENT ACTIVITY.

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

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

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

The category 'amenity PATIENT' is only applicable to PATIENTS using a Hospital Bed.

National Codes:

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

ADMISSION METHOD

Change to Attribute: Changed Dataset

The method of admission to a Hospital Provider Spell.

Note: see ELECTIVE ADMISSION TYPE for a full definition of Elective Admission.

National Codes:

Elective Admission, when the DECISION TO ADMIT could be separated in time from the actual admission:

11 Waiting list
12 Booked
13 Planned

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

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

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

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

31 Admitted ante-partum
32 Admitted post-partum

Other Admission not specified above

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

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

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

** Note - National Code 28 is **NOT** valid for use in the Mental Health Services Data Set.

ADULT MENTAL HEALTH CARE CLUSTER CODE

Change to Attribute: Changed Dataset

The Adult Mental Health Care Cluster assigned to a PATIENT.

National Codes:

00 Care Cluster 0 - Variance (unable to assign ADULT MENTAL HEALTH CARE CLUSTER CODE)
01 Care Cluster 1 - Common Mental Health Problems (Low Severity)
02 Care Cluster 2 - Common Mental Health Problems (Low Severity with Greater Need)
03 Care Cluster 3 - Non-Psychotic (Moderate Severity)
04 Care Cluster 4 - Non-Psychotic (Severe)
05 Care Cluster 5 - Non-Psychotic Disorders (Very Severe)

06 Care Cluster 6 - Non-Psychotic Disorder of Over-Valued Ideas
07 Care Cluster 7 - Enduring Non-Psychotic Disorders (High Disability)
08 Care Cluster 8 - Non-Psychotic Chaotic and Challenging Disorders
09 Care Cluster 9 - Cluster Under Review - Note: This CARE CLUSTER is under review and should not be used.
10 Care Cluster 10 - First Episode Psychosis
11 Care Cluster 11 - Ongoing Recurrent Psychosis (Low Symptoms)
12 Care Cluster 12 - Ongoing or Recurrent Psychosis (High Disability)
13 Care Cluster 13 - Ongoing or Recurrent Psychosis (High Symptoms and Disability)
14 Care Cluster 14 - Psychotic Crisis
15 Care Cluster 15 - Severe Psychotic Depression
16 Care Cluster 16 - Dual Diagnosis
17 Care Cluster 17 - Psychosis and Affective Disorder (Difficult to Engage)
18 Care Cluster 18 - Cognitive Impairment (Low Need)
19 Care Cluster 19 - Cognitive Impairment or Dementia Complicated (Moderate Need)
20 Care Cluster 20 - Cognitive Impairment or Dementia Complicated (High Need)
21 Care Cluster 21 - Cognitive Impairment or Dementia Complicated (High Physical or Engagement)

AGE GROUP INTENDED FOR MENTAL HEALTH

Change to Attribute: New Attribute

The age group of PATIENTS intended to use a WARD indicated in the WARD OPERATIONAL PLAN for the Mental Health Services Data Set.

National Codes:

10 Child only
11 Adolescent only
12 Child and Adolescent
13 Adult only
14 Older Adult only
15 Adult and Older Adult
99 Any age

This attribute is also known by these names:

Context	Alias
plural	AGE GROUPS INTENDED FOR MENTAL HEALTH

AGE GROUP INTENDED FOR MENTAL HEALTH

Change to Attribute: New Attribute

AGE GROUP INTENDED FOR MENTAL HEALTH

Data Elements:

INTENDED AGE GROUP (MENTAL HEALTH)
MENTAL HEALTH ADMITTED PATIENT CLASSIFICATION

APPOINTMENT DATE

Change to Attribute: Changed Dataset

The date of an APPOINTMENT.

In the case of a PATIENT attending an Out-Patient Clinic without prior notice or APPOINTMENT, the PATIENT will be given an Out-Patient Appointment.

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.

APPOINTMENT SLOT SHORT NOTICE CANCELLATION INDICATOR

Change to Attribute: Changed Dataset

An indication of whether the APPOINTMENT SLOT could be reallocated, where the ATTENDED OR DID NOT ATTEND National Code is '*APPOINTMENT cancelled by, or on behalf of, the PATIENT*', where the APPOINTMENT was cancelled at short notice.

Note: For the Improving Access to Psychological Therapies Data Set, short notice is determined locally. See the NHS Digital website at: Improving Access to Psychological Therapies Data Set for further guidance.

National Codes:

Y	Yes - APPOINTMENT SLOT could be reallocated
N	No - APPOINTMENT SLOT could not be reallocated

APPOINTMENT TIME

Change to Attribute: Changed Dataset

The time, recorded using the 24 hour clock, advised to a PATIENT for when they can expect to see a relevant CARE PROFESSIONAL at an Out-Patient Clinic.

Note: The PATIENT may be advised to attend earlier for preliminary investigations.

APPOINTMENT TYPE FOR IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES

Change to Attribute: Changed Dataset

The type of Improving Access to Psychological Therapies APPOINTMENT.

National Codes:

01	Assessment
02	Treatment
03	Assessment and Treatment
04	Review Only
05	Review and Treatment
06	Follow-up APPOINTMENT after treatment end
07	Other

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) (Retired 01 January 2016)
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) (Retired 01 January 2016)
019 Health of the Nation Outcome Scale (Secure) (Retired 01 January 2016)
020 Adult Mental Health Clustering Tool
021 Cardiovascular Disease Risk Calculator
022 Strengths And Difficulties Questionnaire (Retired 01 January 2016)
023 Experience of Service Questionnaire (Retired 01 January 2016)
024 Children's Global Assessment Scale
025 Family Assessment Device (General Functioning Subscale)
026 Parenting Daily Hassles
027 Parent-Infant Relationship Global Assessment Scale (Retired 01 January 2016)
028 Paddington Complexity Scale
029 Goal Based Outcomes (Retired 01 January 2016)
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 (Retired 01 January 2016)
051 Protected Characteristic Protocol (Disability) (Retired 01 January 2016)
Forensic Mental Health Clustering Tool

Child and Adolescent Mental Health Needs Based Grouping Tool

ATTENDED OR DID NOT ATTEND

Change to Attribute: Changed Dataset

An indication of whether an APPOINTMENT for a CARE CONTACT took place.

If the APPOINTMENT did not take place it also indicates if advance warning was given.

When an APPOINTMENT is cancelled the APPOINTMENT CANCELLED DATE should also be recorded.

National Codes:

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

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

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

- Children and Young People's Health Services Data Set
- Community Information Data Set
- Improving Access to Psychological Therapies Data Set
- Mental Health Services Data Set

Use in the Future Outpatient Commissioning Data Set:

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

CARE CONTACT CANCELLATION REASON

Change to Attribute: Changed Dataset

The reason a CARE CONTACT was cancelled.

National Codes:

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

CARE CONTACT SUBJECT

Change to Attribute: Changed Dataset

The PERSON who was the subject of the CARE CONTACT.

National Codes:

01 PATIENT
02 Patient Proxy

CARE PLAN AGREED BY

Change to Attribute: New Attribute

The type of PERSON, SERVICE or Organisation that agreed the CARE PLAN for the PATIENT.

National Codes:

10 PATIENT or Patient Proxy
11 Family member or Carer
12 Advocate
13 Clinical Service or Team
14 Local Community Support Team
15 Commissioner

This attribute is also known by these names:

Context	Alias
plural	CARE PLANS AGREED BY

CARE PLAN AGREED BY

Change to Attribute: New Attribute

CARE PLAN AGREED BY

Data Elements:

CARE PLAN AGREED BY

CARE PLAN AGREED DATE (RETIRED) renamed from CARE PLAN AGREED DATE

Change to Attribute: Changed Description, Name, status to Retired

~~The DATE on which a CARE PLAN was agreed with the PATIENT.~~ **This item has been retired from the NHS Data Model and Dictionary.**

The last live version of this item is available in the ?????? release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

CARE PLAN AGREED DATE (RETIRED) renamed from CARE PLAN AGREED DATE

Change to Attribute: Changed Description, Name, status to Retired

- Changed Description
- Changed Name from Data_Dictionary.Attributes.C.Card.CARE_PLAN_AGREED_DATE to Retired.Data_Dictionary.Attributes.C.CARE_PLAN_AGREED_DATE

- Retired CARE PLAN AGREED DATE

CARE PLAN IDENTIFIER renamed from CARE PLAN NUMBER

Change to Attribute: Changed Description, Name, Dataset

~~A unique identifier of a CARE PLAN within a Care Spell.~~A unique identifier for a CARE PLAN.

CARE PLAN IDENTIFIER renamed from CARE PLAN NUMBER

Change to Attribute: Changed Description, Name, Dataset

- Changed Description
- Changed Name from Data_Dictionary.Attributes.C.Card.CARE_PLAN_NUMBER to Data_Dictionary.Attributes.C.Card.CARE_PLAN_IDENTIFIER
- null

CARE PLAN TYPE

Change to Attribute: Changed Description

The type of CARE PLAN.

National Codes:

01 Cancer Care Plan
02 Child Protection Plan
03 Mental Health Crisis Plan
04 Social Services Care Plan
05 Antenatal Care Plan
06 Birth Care Plan
07 Postpartum Care Plan
08 Education, Health and Care Plan (EHC)
Discharge Plan
Mental Health Care Plan
Positive Behaviour Support Plan
Urgent and Emergency Mental Health Care Plan

CARE PLAN TYPE FOR MENTAL HEALTH

Change to Attribute: New Attribute

The type of CARE PLAN for the PATIENT recorded by the SERVICE for the Mental Health Services Data Set.

National Codes:

10 Mental Health Care Plan
11 Urgent and Emergency Mental Health Care Plan
12 Mental Health Crisis Plan
13 Positive Behaviour Support Plan

This attribute is also known by these names:

Context	Alias

plural	CARE PLAN TYPES FOR MENTAL HEALTH

CARE PLAN TYPE FOR MENTAL HEALTH

Change to Attribute: New Attribute

CARE PLAN TYPE FOR MENTAL HEALTH

Data Elements:

CARE PLAN TYPE (MENTAL HEALTH)

CARE PROFESSIONAL IDENTIFIER

Change to Attribute: Changed Dataset

A number or set of characters which uniquely identifies a CARE PROFESSIONAL.

CARE PROFESSIONAL ROLE CODE FOR IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES

Change to Attribute: Changed Dataset

The primary role undertaken by a CARE PROFESSIONAL administering the therapy session in an Improving Access to Psychological Therapies Contact.

National Codes:

	Trainee
10	Psychological Well-being Practitioner (PWP) - Trainee
11	High Intensity Cognitive Behavioural Therapist - Trainee
12	High Intensity Counselling for Depression - Trainee
13	High Intensity Couple Therapist for Depression - Trainee
14	High Intensity Brief Dynamic Interpersonal Psychotherapist - Trainee
15	High Intensity Interpersonal Therapist - Trainee
16	Eye Movement Desensitisation Reprocessing - Trainee
17	Mindfulness based Cognitive Therapist - Trainee
	Qualified
40	Psychological Well-being Practitioner (PWP) - Qualified
41	Employment support worker - Qualified
42	Other low intensity Therapist - Qualified
43	High Intensity Cognitive Behavioural Therapist - Qualified
44	High Intensity Counselling for Depression - Qualified
45	High Intensity Couple Therapist for Depression - Qualified
46	High Intensity Brief Dynamic Interpersonal Psychotherapist - Qualified
47	High Intensity Interpersonal Therapist - Qualified
48	Eye Movement Desensitisation Reprocessing - Qualified
49	Mindfulness based Cognitive Therapist - Qualified
50	Other High Intensity Therapist - Qualified

CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH

Change to Attribute: Changed Dataset

The staff group of a CARE PROFESSIONAL working in a Mental Health Service.

National Codes:

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

CARE PROFESSIONAL TEAM IDENTIFIER

Change to Attribute: Changed Dataset

A unique identifier for a CARE PROFESSIONAL TEAM.

CARE PROGRAMME APPROACH REVIEW ABUSE QUESTION ASKED INDICATOR

Change to Attribute: Changed Dataset

An indication of whether the PATIENT was asked the Abuse Question during a Care Programme Approach Review.

National Codes:

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

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (RETIRED)_ renamed from CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE

Change to Attribute: Changed Description, Name, Dataset, status to Retired

~~The Child and Adolescent Mental Health Care Cluster assigned to a PATIENT.~~**This item has been retired from the NHS Data Model and Dictionary.**

~~**Note: This data item is included in the Mental Health Services Data Set, but should not be submitted until further development by NHS Digital has been undertaken.**~~**The last live version of this item is available in the ?**????? release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (RETIRED)_ renamed from CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE

Change to Attribute: Changed Description, Name, Dataset, status to Retired

- Changed Description
- Changed Name from Data_Dictionary.Attributes.C.Cen.CHILD_AND_ADOLESCENT_MENTAL_HEALTH_CARE_CLUSTER_CODE to Retired.Data_Dictionary.Attributes.C.CHILD_AND_ADOLESCENT_MENTAL_HEALTH_CARE_CLUSTER_CODE
- null
- Retired CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE

CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE

Change to Attribute: New Attribute

The Child and Adolescent Mental Health Needs Based Grouping code assigned to a PATIENT.

National Codes:

NEU	Getting Advice: Neurodevelopmental Assessment
ADV	Getting Advice: Signposting and Self-management Advice
ADH	Getting Help: Attention Deficit Hyperactivity Disorder (ADHD)
AUT	Getting Help: Autism Spectrum
BEH	Getting Help: Behavioural and/or Conduct Disorders
BIP	Getting Help: Bipolar Disorder
DEP	Getting Help: Depression
GAP	Getting Help: Generalised Anxiety Disorder (GAD) and/or Panic Disorder
OCD	Getting Help: Obsessive compulsive disorder (OCD)
PTS	Getting Help: Post-traumatic stress disorder (PTSD)
SHA	Getting Help: Self-harm
SOC	Getting Help: Social Anxiety Disorder
BEM	Getting Help: Co-occurring Behavioural and Emotional Difficulties
EMO	Getting Help: Co-occurring Emotional Difficulties
DNC	Getting Help: Difficulties Not Covered by Other Groupings
EAT	Getting More Help: Eating Disorders
PBP	Getting More Help: Presentation Suggestive of Potential Borderline Personality Disorder (BPD)
PSY	Getting More Help: Psychosis
DSI	Getting More Help: Difficulties of Severe Impact

This attribute is also known by these names:

Context	Alias
plural	CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODES

CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE

Change to Attribute: New Attribute

CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE

Data Elements:

CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE

CHILD AND ADOLESCENT MENTAL HEALTH TIER OF SERVICE

Change to Attribute: Changed Dataset
The tier of SERVICE the Child and Adolescent Mental Health Care Team operates at for a PATIENT.

National Codes:

1

Tier 1 - Primary Care SERVICES who have first and regular contact with PATIENTS and families, such as GENERAL MEDICAL PRACTITIONERS, Health Visitors, School Nurses, community health facilities and other primary care resources.

2 **Tier 2** - Child and Adolescent Mental Health Services delivered by an individual CARE PROFESSIONAL, attached to a single agency, working directly with a child, adolescent or family.

3 **Tier 3** - Multi-disciplinary and/or multi-agency teams provide delivery of the most appropriate intervention for a child, adolescent or family.

4 **Tier 4** - Inpatient services for children and adolescents, usually delivered within a Hospital or specialist inpatient clinic.

CHILD PROTECTION PLAN INDICATION CODE

Change to Attribute: Changed Dataset

An indication of whether a PERSON is, or has previously been, subject to a Child Protection Plan.

National Codes:

1 Has never been subject to a Child Protection Plan

2 Has previously been subject to a Child Protection Plan

3 Is currently subject to a Child Protection Plan

CLINICAL CARE INTENSITY

Change to Attribute: Changed Dataset

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

National Codes:

For PATIENTS with mental illness

51 for intensive care: specially designated ward for PATIENTS needing containment and more intensive management. This is not to be confused with intensive nursing where PATIENTS may require one to one nursing while on a standard WARD

52 for short stay: PATIENTS intended to stay less than a year

53 for long stay: PATIENTS intended to stay a year or more

For PATIENTS with Learning Disabilities

61 designated or interim secure unit

62 PATIENTS intending to stay less than a year

63 PATIENTS intending to stay a year or more

For maternity PATIENTS

41 only for PATIENTS looked after by CONSULTANTS

43 only for PATIENTS looked after by GENERAL MEDICAL PRACTITIONERS

42 for joint use by CONSULTANTS & GENERAL MEDICAL PRACTITIONERS

For neonates

33 maternity: associated with the maternity WARD in that cots are in the maternity WARD nursery or in the WARD itself

32 non-maternity: not associated with the maternity WARD and without designated cots for intensive care

31 not associated with the maternity WARD and in which there are some designated cots for intensive care

For the younger physically disabled

21 spinal units, only those units which are nationally recognised

22 other units

For terminally ill/Palliative Care

81 terminally ill/Palliative Care

For general PATIENTS

11 for intensive therapy, including high dependency care

12

for normal therapy: where resources permit the admission of PATIENTS who might need all but intensive or high dependency therapy

13 for limited therapy: where nursing care rather than continuous medical care is provided. Such WARDS can be used only for PATIENTS carefully selected and restricted to a narrow range in terms of the extent and nature of disease

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

CLINICAL CLASSIFICATION CODE

Change to Attribute: Changed Dataset

A unique clinical classification identifier for a CODED CLINICAL ENTRY.

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

See Clinical Coding for further information about the types of CODED CLINICAL ENTRIES.

CLINICAL RESPONSE PRIORITY TYPE

Change to Attribute: Changed Dataset

The clinical response priority of a SERVICE REQUEST.

National Codes:

1 Emergency
2 Urgent/serious
3 Routine

CLINICAL TERMINOLOGY CODE

Change to Attribute: Changed Dataset

A unique clinical terminology identifier for a CODED CLINICAL ENTRY.

This could be Read Coded Clinical Terms, 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: Changed Description, Dataset

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.~~Note: only CLUSTERING TOOL ASSESSMENT

CATEGORY National Codes *'Adult Mental Health Clustering Tool'*, *'Forensic Mental Health Clustering Tool'* and *'Child and Adolescent Mental Health Needs Based Grouping Tool'* are currently supported in the Mental Health Services Data Set. Other National Codes have been included to facilitate piloting and testing of future data requirements, prior to formal inclusion in later versions of the Mental Health Services Data Set.

National Codes:

01	Adult Mental Health Clustering Tool
~~02~~	~~Child and Adolescent Mental Health Clustering Tool~~
02	Child and Adolescent Mental Health Clustering Tool (Retired 01 April 2017)
03	Learning Disabilities Clustering Tool
~~04~~	~~Forensic (Mental Health) Clustering Tool~~
~~05~~	~~Forensic (Learning Disabilities) Clustering Tool~~
04	Forensic Mental Health Clustering Tool
05	Forensic Learning Disabilities Clustering Tool
06	Child and Adolescent Mental Health Needs Based Grouping Tool

---

CLUSTERING TOOL ASSESSMENT REASON

Change to Attribute: Changed Dataset
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

COMMUNITY TREATMENT ORDER END REASON

Change to Attribute: Changed Dataset

The reason for the termination of a Community Treatment Order.

National Codes:

01	PATIENT discharged
02	Community Treatment Order revoked
03	PATIENT died
04	PATIENT transferred outside England
05	PATIENT transferred to another Health Care Provider

CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR

Change to Attribute: Changed Dataset
An indication of whether a disabled PERSON requires constant (round the clock) care and/or supervision for maintenance of their safety and/or wellbeing.

National Codes:

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

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CONSULTATION MEDIUM USED

Change to Attribute: Changed Dataset

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

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

Telephone contacts solely for informing PATIENTS of results are excluded.

National Codes:

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

Notes:

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

CONSULTATION TYPE

Change to Attribute: Changed Dataset

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

National Codes:

01	Initial Consultation
02	Follow-up Consultation

DECISION TO REFER DATE

Change to Attribute: Changed Dataset
The date that a decision was made, by or on behalf of a CARE PROFESSIONAL, to refer a PATIENT to a particular Health Care Provider as a SERVICE REQUEST.

DECISION TO REFER TIME

Change to Attribute: New Attribute

The time that a decision was made, by or on behalf of a CARE PROFESSIONAL, to refer a PATIENT to a particular Health Care Provider as a SERVICE REQUEST.

This attribute is also known by these names:

Context	Alias
plural	DECISION TO REFER TIMES

DECISION TO REFER TIME

Change to Attribute: New Attribute

DECISION TO REFER TIME

Data Elements:

DECISION TO REFER TIME (ONWARD REFERRAL)

DIAGNOSIS SCHEME IN USE

Change to Attribute: Changed Dataset

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

National Codes:

01 Accident & Emergency Diagnosis ***
02 ICD-10
03 Read Code 4Byte Version (retired 1 October 2009)
04 Read Coded Clinical Terms Version 2
05 Read Coded Clinical Terms Version 3 (CTV3) *
06 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 6-2
- *** Accident & Emergency Diagnosis is not valid for the Children and Young People's Health Services Data Set, Community Information Data Set and Mental Health Services Data Set.

DISABILITY CODE

Change to Attribute: Changed Dataset

The DISABILITY of a PERSON.

This could be where:

- the PERSON has been diagnosed as disabled or
- the PERSON considers themself to be disabled.

A PERSON can have more than one DISABILITY CODE.

National Codes:

01 Behaviour and Emotional
02 Hearing
03 Manual Dexterity
04 Memory or ability to concentrate, learn or understand (Learning Disability)
05 Mobility and Gross Motor

06 Perception of Physical Danger
07 Personal, Self Care and Continence
08 Progressive Conditions and Physical Health (such as HIV, cancer, multiple sclerosis, fits etc)
09 Sight
10 Speech
XX Other
NN No DISABILITY
ZZ Not Stated (PERSON asked but declined to provide a response)

DISABILITY IMPACT PERCEPTION

Change to Attribute: Changed Dataset
The PATIENT or Patient Proxy's perception of whether the PATIENT's day-to-day activities are limited because of a health problem or DISABILITY which has lasted, or is expected to last, at least 12 months.

National Codes:

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

DISCHARGE DESTINATION

Change to Attribute: Changed Dataset

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

National Codes:

19 Usual place of residence unless listed below, for example, a private dwelling whether owner occupied or owned by Local Authority, housing association or other landlord. This includes 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 Description, Dataset

The method of discharge from a Hospital Provider Spell.

National Codes:

1 PATIENT discharged on clinical advice or with clinical consent
2 PATIENT discharged him/herself or was discharged by a relative or advocate
3 PATIENT discharged by mental health review tribunal, Home Secretary or Court
4 PATIENT died
5 Stillbirth
6 PATIENT discharged him/herself *
7 PATIENT discharged by a relative or advocate *

* Note: National Codes 6 and 7 have been introduced for the Mental Health Services Data Set **only** to add further granularity to National Code 2. However, National Code 2 is still valid for the Mental Health Services Data Set where extra detail cannot be collected. National Codes 6 and 7 are **NOT** valid in any other data set including Commissioning Data Set version 6-2.

DISCHARGE PLAN AGREED BY

Change to Attribute: New Attribute

The type of PERSON, SERVICE or Organisation that agreed the Discharge Plan for the PATIENT.

National Codes:

10 PATIENT or Patient Proxy
11 Family member or Carer
12 Advocate
13 Clinical Service or Team
14 Local Community Support Team
15 Current Commissioner
16 Commissioner of Planned DISCHARGE DESTINATION

This attribute is also known by these names:

Context	Alias
plural	DISCHARGE PLANS AGREED BY

DISCHARGE PLAN AGREED BY

Change to Attribute: New Attribute

DISCHARGE PLAN AGREED BY

Data Elements:

DISCHARGE PLAN AGREED BY

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)

EMPLOYMENT SUPPORT SUITABILITY INDICATOR

Change to Attribute: Changed Dataset

An indication of whether the PATIENT is a suitable candidate for referral to Employment Support.

This could be:

- at the request of the PATIENT
- identified by the CARE PROFESSIONAL:
    - as the PATIENT is unemployed and seeking work or long term sick or disabled and receiving Jobseekers Allowance, Incapacity Benefit, Employment and Support Allowance or Statutory Sick Pay
    - as indicated from the result of the Work and Social Adjustment Scale.

National Codes:

Y	Yes
N	No

ETHNIC CATEGORY CODE

Change to Attribute: Changed Dataset

The ethnicity of a PERSON, as specified by the PERSON.

Note: ETHNIC CATEGORY is the classification used for the 2001 census.

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

National Codes:

White

A	British
B	Irish
C	Any other White background

Mixed

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

Asian or Asian British

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

Black or Black British

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

Other Ethnic Groups

- R Chinese
- S Any other ethnic group

- Z Not stated

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

EX-BRITISH ARMED FORCES INDICATOR

Change to Attribute: Changed Dataset

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

National Codes:

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

FACE TO FACE COMMUNICATION MODE

Change to Attribute: Changed Dataset

The mode of face to face communication, where the CONSULTATION MEDIUM USED National Code is *'Face to face communication'*.

National Codes:

- 01 One to One
- 02 Group
- 03 Couple

FINDING SCHEME IN USE

Change to Attribute: Changed Dataset

The type of CODED CLINICAL ENTRY used for the finding.

National Codes:

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

FIVE FORENSIC PATHWAYS ASSESSMENT REASON

Change to Attribute: New Attribute

The reason the Five Forensic Pathways assessment was undertaken.

National Codes:

10	Initial Assessment
11	Scheduled Re-Assessment
12	Re-Assessment following significant unanticipated change in need
97	Other Reason

This attribute is also known by these names:

Context	Alias
plural	FIVE FORENSIC PATHWAYS ASSESSMENT REASONS

FIVE FORENSIC PATHWAYS ASSESSMENT REASON

Change to Attribute: New Attribute

FIVE FORENSIC PATHWAYS ASSESSMENT REASON

Data Elements:

FIVE FORENSIC PATHWAYS ASSESSMENT REASON

FIVE FORENSIC PATHWAYS CODE

Change to Attribute: New Attribute

The Five Forensic Pathways grouping code assigned to a PATIENT.

National Codes:

0	Unable to assign PATIENT to one of the Five Forensic Pathways
1	Treatment responsive group
2	Treatment resistant group - challenging behaviour
3	Treatment resistant group - continuing care
4	Personality disorder group - Prison transfer
5	Personality disorder group - co-morbidity

This attribute is also known by these names:

Context	Alias
plural	FIVE FORENSIC PATHWAYS CODES

FIVE FORENSIC PATHWAYS CODE

Change to Attribute: New Attribute

FIVE FORENSIC PATHWAYS CODE

Data Elements:

FIVE FORENSIC PATHWAYS CODE

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE

Change to Attribute: Changed Description, Dataset

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

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

FORENSIC MENTAL HEALTH CARE CLUSTER CODE

Change to Attribute: Changed Description, Dataset

The Forensic Mental Health Care Cluster assigned to a PATIENT.

~~The Forensic (Learning Disabilities) Care Cluster assigned to a PATIENT.~~*National Codes:*

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

00	Care Cluster 0: Variance
01	Care Cluster 1: Common Mental Health Problems (Low Severity)
02	Care Cluster 2: Common Mental Health Problems (Low Severity with Greater Need)
03	Care Cluster 3: Non-Psychotic (Moderate Severity)
04	Care Cluster 4: Non-Psychotic (Severe)
05	Care Cluster 5: Non-Psychotic Disorders (Very Severe)
06	Care Cluster 6: Non-Psychotic Disorder of Over-Valued Ideas
07	Care Cluster 7: Enduring Non-Psychotic Disorders (High Disability)
08	Care Cluster 8: Non-Psychotic Chaotic and Challenging Disorders
08b	Care Cluster 8b: Non Psychotic, Challenging and Anti-Social Disorders
10	Care Cluster 10: First Episode Psychosis
11	Care Cluster 11: Ongoing Recurrent Psychosis (Low Symptoms)
12	Care Cluster 12: Ongoing or Recurrent Psychosis (High Disability)
13	Care Cluster 13: Ongoing or Recurrent Psychosis (High Symptoms and Disability)
14	Care Cluster 14: Psychotic Crisis
15	Care Cluster 15: Severe Psychotic Depression
16	Care Cluster 16: Dual Diagnosis
17	Care Cluster 17: Psychosis and Affective Disorder (Difficult to Engage)
18	Care Cluster 18: Cognitive Impairment (Low Need)
19	Care Cluster 19: Cognitive Impairment or Dementia Complicated (Moderate Need)
20	Care Cluster 20: Cognitive Impairment or Dementia (High Need)
21	Care Cluster 21: Cognitive Impairment or Dementia (High Physical or Engagement)

GROUP SESSION TYPE FOR MENTAL HEALTH

Change to Attribute: Changed Dataset

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

National Codes:

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

IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ACTIVITY SUSPENSION REASON

Change to Attribute: Changed Dataset

The reason the PATIENT states they are unavailable for treatment for the purpose of the Improving Access to Psychological Therapies Data Set.

National Codes:

01	PATIENT unavailable due to holiday
02	PATIENT unavailable due to other health needs
03	PATIENT stated not available - other reason

IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES CARE SPELL END CODE

Change to Attribute: Changed Dataset

The reason for the termination of an Improving Access to Psychological Therapies Care Spell as determined by the CARE PROFESSIONAL.

National Codes:

	ASSESSED ONLY
10	Not suitable for Improving Access to Psychological Therapies Service - no action taken or directed back to referrer
11	Not suitable for the Improving Access to Psychological Therapies Service - signposted elsewhere with mutual agreement of PATIENT
12	Discharged by mutual agreement following advice and support
13	Referred to another therapy service by mutual agreement
14	Suitable for Improving Access to Psychological Therapies Service, but PATIENT declined treatment that was offered
15	Deceased (Assessed Only)
97	Not Known (Assessed Only)
	ASSESSED AND TREATED
40	Stepped up from low intensity Improving Access to Psychological Therapies Service
41	Stepped down from high intensity Improving Access to Psychological Therapies Service
42	Completed scheduled treatment
43	Dropped out of treatment (unscheduled discontinuation)
44	Referred to non Improving Access to Psychological Therapies Service
45	Deceased (Assessed and Treated)
98	Not Known (Assessed and Treated)

IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES OPT IN DATE

Change to Attribute: Changed Dataset

The date a PATIENT choses to be considered for treatment by an Improving Access to Psychological Therapies Service, where the Improving Access to Psychological Therapies Opt-In Model is used.

The IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES OPT IN DATE will start the Improving Access to Psychological Therapies Referral To Treatment Measurement if the Improving Access to Psychological Therapies Opt-In Model is used.

IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES STEPPED CARE INTENSITY DELIVERED

Change to Attribute: Changed Dataset

The intensity of care delivered to a PATIENT at an Improving Access to Psychological Therapies Contact during an Improving Access to Psychological Therapies Care Spell.

National Codes:

01 Low intensity - 1st step in current Improving Access to Psychological Therapies Care Spell
02 High intensity - 1st step in current Improving Access to Psychological Therapies Care Spell
03 Low intensity - Stepped down in current Improving Access to Psychological Therapies Care Spell
04 High intensity - stepped up in current Improving Access to Psychological Therapies Care Spell

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JOB ROLE CODE

Change to Attribute: Changed Dataset

A National Code for a POSITION applicable to an EMPLOYEE.

National Codes:

Code	Staff Group	Job Role Title
01000	**Medical and Dental**	
01001		Medical Director
01002		Clinical Director
01003		Professor
01004		Senior Lecturer
01005		CONSULTANT
01006		Dental surgeon acting as Hospital CONSULTANT
01007		Special salary scale in Public Health Medicine
01008		Associate Specialist (Closed to new entrants from 01 April 2008 or regrading from 01 April 2009)
01009		Staff Grade (Closed to new entrants 01 April 2008)
01010		Hospital Practitioner
01011		Clinical Assistant
01012		Specialist Registrar - Closed (Retired 01 April 2010)
01013		Senior House Officer - Closed (Retired 01 April 2010)
01014		House Officer - Pre-registration - Closed (Retired 01 April 2010)
01015		House Officer - Post-registration - Closed (Retired 01 April 2010)
01016		Trust Grade Doctor - House Officer level - Closed (Retired 01 April 2010)
01017		Trust Grade Doctor - SHO level - Closed (Retired 01 April 2010)
01018		Trust Grade Doctor - Specialist Registrar level - Closed (Retired 01 April 2010)

01019		Trust Grade Doctor - Career Grade level
01020		Director of Public Health
01021		Clinical Medical Officer
01022		Senior Clinical Medical Officer
01023		'Other' Community Health Service
01024		GENERAL DENTAL PRACTITIONER
01025		GENERAL MEDICAL PRACTITIONER
01026		Salaried GENERAL PRACTITIONER
01027		Regional Dental Officer
01028		Dental Clinical Director
01029		Dental Officer
01030		Senior Dental Officer
01031		Salaried Dental Practitioner
01032		Specialty Doctor
01033		Foundation Year 1
01034		Foundation Year 2
01035		Specialty Registrar
01036		Medical Student
01037		Trust Grade Doctor - Specialty Registrar
01038		Vocational Dental Practitioner
01039		Associate Postgraduate Dean
01040		Trust Grade Doctor - Foundation Level
01041		GP Senior Partner
01042		GP Partner/Provider
01043		GP Retainer
01044		GP Locum
02000	**Students**	
02001		Student NURSE - Adult Branch
02002		Student NURSE - Child Branch
02003		Student NURSE - Mental Health Branch
02004		Student NURSE - Learning Disabilities Branch
02005		Student MIDWIFE
02006		Student Health Visitor
02007		Student District Nurse
02008		Student School Nurse
02009		Student Practice Nurse
02010		Student Occupational Health Nurse
02011		Student Community Children's Nurse
02012		Student Mental Health Nurse
02013		Student Learning Disabilities Nurse
02014		Student Chiropodist
02015		Student Dietitian
02016		Student Occupational Therapist
02017		Student Orthoptist
02018		Student Physiotherapist
02019		Student Radiographer - Diagnostic
02020		Student Radiographer - Therapeutic
02021		Student Speech and Language Therapist
02022		Art, Music and Drama Student

02023		Student Psychotherapist
03000	**Nursing and Midwifery Registered**	
03001		Director of Nursing
03002		Nurse Consultant
03003		Nurse Manager
03004		Modern Matron
03005		Specialist Nurse Practitioner
03006		Sister/Charge Nurse
03007		Staff Nurse
03008		Enrolled Nurse
03009		Midwife - Consultant
03010		Midwife - Specialist Practitioner
03011		Midwife - Manager
03012		MIDWIFE - Sister/Charge Nurse (Retired 01 December 2012)
03013		MIDWIFE
03014		Community Practitioner
03015		Community Nurse
03016		Advanced Practitioner
03017		Practice Nurse
03018		Extended Role Practice Nurse
03019		Practice Nurse Partner
03020		Practice Research Nurse
03021		Practice Nurse Dispenser
04000	**Allied Health Professionals**	
04001		Art Therapist
04002		Art Therapist Consultant
04003		Art Therapist Manager
04004		Art Therapist Specialist Practitioner
04005		Chiropodist/Podiatrist
04006		Chiropodist/Podiatrist Consultant
04007		Chiropodist/Podiatrist Manager
04008		Chiropodist/Podiatrist Specialist Practitioner
04009		Dietitian
04010		Dietitian Consultant
04011		Dietitian Manager
04012		Dietitian Specialist Practitioner
04013		Drama Therapist
04014		Drama Therapist Consultant
04015		Drama Therapist Manager
04016		Drama Therapist Specialist Practitioner
04017		Multi Therapist
04018		Multi Therapist Consultant
04019		Multi Therapist Manager
04020		Multi Therapist Specialist Practitioner
04021		Music Therapist
04022		Music Therapist Consultant
04023		Music Therapist Manager
04024		Music Therapist Specialist Practitioner

04025		Occupational Therapist
04026		Occupational Therapist Consultant
04027		Occupational Therapist Manager
04028		Occupational Therapist Specialist Practitioner
04029		Orthoptist
04030		Orthoptist Consultant
04031		Orthoptist Manager
04032		Orthoptist Specialist Practitioner
04033		Orthotist
04034		Orthotist Consultant
04035		Orthotist Manager
04036		Orthotist Specialist Practitioner
04037		Paramedic
04038		Paramedic Consultant
04039		Paramedic Manager
04040		Paramedic Specialist Practitioner
04041		Physiotherapist
04042		Physiotherapist Consultant
04043		Physiotherapist Manager
04044		Physiotherapist Specialist Practitioner
04045		Prosthetist
04046		Prosthetist Consultant
04047		Prosthetist Manager
04048		Prosthetist Specialist Practitioner
04049		Radiographer - Diagnostic
04050		Radiographer - Diagnostic, Consultant
04051		Radiographer - Diagnostic, Manager
04052		Radiographer - Diagnostic, Specialist Practitioner
04053		Radiographer - Therapeutic
04054		Radiographer - Therapeutic, Consultant
04055		Radiographer - Therapeutic, Manager
04056		Radiographer - Therapeutic, Specialist Practitioner
04057		Speech and Language Therapist
04058		Speech and Language Therapist Consultant
04059		Speech and Language Therapist Manager
04060		Speech and Language Therapist Specialist Practitioner
04061		Advanced Practitioner
05000	**Additional Professional, Scientific and Technical**	
05001		Clinical Director
05002		OPTOMETRIST
05003		Pharmacist
05004		Psychotherapist
05005		Clinical Psychologist
05006		Chaplain
05007		Social Worker
05008		Approved Social Worker
05009		Youth Worker
05010		Specialist Practitioner

05011		Practitioner
05012		Technician
05013		Osteopath
05014		Psychological Therapist - Qualified
05015		Psychological Therapist - Trainee
05016		Physician Assistant (Retired 01 January 2016)
05017		Advanced Practitioner
05018		Physician Associate
06000	**Healthcare Scientists**	
06001		Clinical Scientist (Retired 01 April 2013)
06002		Consultant Healthcare Scientist
06003		Biomedical Scientist (Retired 01 April 2013)
06004		Technician (Retired 01 April 2013)
06005		Therapist (Retired 01 April 2013)
06006		Manager
06007		Specialist Healthcare Scientist
06008		Healthcare Scientist
06009		Specialist Healthcare Science Practitioner
06010		Healthcare Science Practitioner
07000	**Additional Clinical Services**	
07001		Health Care Support Worker
07002		Social Care Support Worker
07003		Home Help
07004		Healthcare Assistant
07005		Nursery Nurse
07006		Play Therapist
07007		Play Specialist
07008		Technician
07009		Technical Instructor
07010		Assistant/Associate Practitioner
07011		Counsellor
07012		Helper/Assistant
07013		Dental Surgery Assistant
07014		Medical Laboratory Assistant (Retired 01 January 2016)
07015		Phlebotomist
07016		Cytoscreener
07017		Student Technician
07018		Trainee Scientist
07019		Trainee Practitioner
07020		Nursing Cadet
07021		Healthcare Cadet
07022		Pre-reg Pharmacist
07023		Assistant Psychologist
07024		Assistant Psychotherapist
07025		Call Operator
07026		Gateway Worker
07027		Support, Time, Recovery Worker
07028		Psychological Wellbeing Practitioner - Qualified
07029		Psychological Wellbeing Practitioner - Trainee

07030		Apprentice
07031		Assistant/Associate Practitioner - Nursing
07032		Ambulance Care Assistant/Patient Transport Services (PTS) Driver
07033		Emergency Care Assistant
07034		Emergency Care Practitioners
07035		Emergency Medical Dispatcher/Call Handler
07036		Healthcare Science Associate
07037		Healthcare Science Assistant
07038		Trainee Healthcare Scientist
07039		Trainee Healthcare Science Practitioner
07040		Trainee Healthcare Science Associate
07041		Analyst
08000	**Administrative and Clerical**	
08001		Clerical Worker
08002		Receptionist
08003		Secretary
08004		Personal Assistant
08005		Medical Secretary
08006		Officer
08007		Manager
08009		Senior Manager
08010		Technician
08011		Accountant
08012		Librarian
08013		Interpreter
08014		Analyst
08015		Adviser
08016		Researcher
08017		Control Assistant
08018		Architect
08019		Lawyer
08020		Surveyor
08021		Chair
08022		Chief Executive
08023		Finance Director
08024		Other Executive Director
08025		Board Level director
08026		Non-executive Director
08027		Childcare Coordinator
08028		Apprentice
09000	**Estates and Ancillary**	
09001		Support Worker
09002		Housekeeper
09003		Cook
09004		Porter
09005		Driver
09006		Telephonist
09007		Gardener/Groundsperson

09008		Technician
09009		Electrician
09010		Fitter
09011		Assistant
09012		Labourer
09013		Plumber
09014		Carpenter
09015		Bricklayer
09016		Painter/Decorator
09017		Work Analyst
09018		Chargehand
09019		Supervisor
09020		Engineer
09021		Building Officer
09022		Maintenance Craftsperson
09023		Building Craftsperson
09024		Mechanic
09025		Apprentice
10000	**Supplementary Roles**	
10001		Assessor
10002		Clinical Supervisor
10003		Educational Supervisor
10004		Tutor

LANGUAGE CODE

Change to Attribute: Changed Dataset

The language used by a PERSON.

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

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

LEARNING DISABILITIES CARE CLUSTER CODE

Change to Attribute: Changed Dataset

The Learning Disabilities Care Cluster assigned to a PATIENT.

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

LOCAL PATIENT IDENTIFIER

Change to Attribute: Changed Dataset

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

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

LOCKED WARD INDICATOR

Change to Attribute: Changed Dataset

An indication of whether a WARD is locked.

National Codes:

Y	Yes - is a locked WARD
N	No - is not a locked WARD

LONG TERM PHYSICAL HEALTH CONDITION INDICATOR FOR IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES

Change to Attribute: Changed Dataset

An indication of whether the PATIENT has a Long Term Physical Health Condition, as stated by the PATIENT.

National Codes:

Y	Yes
N	No
U	Unknown (PERSON asked and does not know or is not sure)
Z	Not Stated (PERSON asked but declined to provide a response)

LOOKED AFTER CHILD INDICATOR

Change to Attribute: Changed Dataset

An indication of whether a PERSON is a Looked After Child.

National Codes:

Y	Yes - is a Looked After Child
N	No - is not a Looked After Child

MAIN SPECIALTY CODE

Change to Attribute: Changed Dataset

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

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

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

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

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

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

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

The MAIN SPECIALTY CODE for GENERAL PRACTITIONERS is General Medical Practice or General Dental Practice.

Joint Consultant Clinic ACTIVITY should be recorded against the MAIN SPECIALTY CODE of the CONSULTANT managing the clinic.

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

National Codes:

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

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

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

Notes:

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

MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON

Change to Attribute: Changed Dataset
The reason the Mental Health Absence Without Leave ended.

National Codes:

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

MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY

Change to Attribute: Changed Dataset

The body or PERSON responsible for granting a Mental Health Absolute Discharge.

National Codes:

01	Mental Health Tribunal
02	Secretary of State

MENTAL HEALTH ACT 2007 MENTAL CATEGORY

Change to Attribute: Changed Dataset

The primary reason for the detention of PATIENTS under the Mental Health Act 1983, as amended by the Mental Health Act 2007.

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

A PATIENT should be included under only one MENTAL HEALTH ACT 2007 MENTAL CATEGORY.

National Codes:

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

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON

Change to Attribute: Changed Dataset

The reason for the end of the Mental Health Act Legal Status Classification Assignment Period.

National Codes:

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

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON

Change to Attribute: Changed Dataset

The reason for the start of the Mental Health Act Legal Status Classification Assignment Period.

National Codes:

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

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE

Change to Attribute: Changed Dataset

A code which identifies the MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION.

Note that the National Code '*Informal*' is used for those PATIENTS who are neither formally detained nor receiving supervised aftercare.

National Codes:

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

MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE

Change to Attribute: Changed Dataset

The Mental Health Care Cluster Super Class assigned to a PATIENT.

National Codes:

A	Non-Psychotic
B	Psychotic
C	Organic

MENTAL HEALTH CONDITIONAL DISCHARGE END REASON

Change to Attribute: Changed Dataset

The reason a Mental Health Conditional Discharge Period ended.

National Codes:

01	Mental Health Absolute Discharge

02 Recall of PATIENT
03 Death of PATIENT

MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE

Change to Attribute: Changed Description, 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)~~
01 NHS (Retired 01 April 2017)
02 Social Care (Retired 01 April 2017)
03 Both (NHS and Social Care) (Retired 01 April 2017)
04 NHS, excluding housing
05 Social Care, excluding housing
06 Both (NHS and Social Care), excluding housing
07 Housing (including supported/specialist housing)

MENTAL HEALTH DELAYED DISCHARGE REASON

Change to Attribute: Changed Description, Dataset

The reason that a Mental Health Delayed Discharge Period was initiated for a PATIENT.

For further information, see the Department of Health part of the gov.uk website at: Mental Health Delayed Discharge Reason.

National Codes:

~~A1 Awaiting completion of assessment~~
A1 Awaiting completion of assessment (Retired 01 April 2017)
A2 Awaiting care coordinator allocation
B1 Awaiting public funding
C1 Awaiting further non-acute (including community and mental health) NHS care (including intermediate care, rehabilitation services etc)
D1 Awaiting Care Home Without Nursing placement or availability
D2 Awaiting Care Home With Nursing placement or availability
E1 Awaiting care package in own home
~~F1 Awaiting community equipment and adaptations~~
~~G1 PATIENT or family choice~~
F1 Awaiting community equipment and adaptations (Retired 01 April 2017)
F2 Awaiting community equipment, telecare and/or adaptations
G1 PATIENT or family choice (Retired 01 April 2017)
G2 PATIENT or family choice (Reason not stated by PATIENT or family)
G3 PATIENT or family choice - Non-acute (including community and mental health) NHS care (including intermediate care, rehabilitation services etc)
G4 PATIENT or family choice - Care Home Without Nursing placement
G5 PATIENT or family choice - Care Home With Nursing placement
G6 PATIENT or family choice - Care package in own home
G7 PATIENT or family choice - Community equipment, telecare and/or adaptations
G8 PATIENT or Family Choice - general needs housing/private landlord acceptance as patient NOT covered by Housing Act/Care Act
G9 PATIENT or family choice - Supported accommodation

G10	PATIENT or family choice - Emergency accommodation from the Local Authority under the Housing Act
G11	PATIENT or family choice - Child or young person awaiting social care or family placement
G12	PATIENT or family choice - Ministry of Justice agreement/permission of proposed placement
H1	Disputes
~~I1~~	~~Housing - PATIENT not covered by NHS and Community Care Act~~
~~J1~~	~~Awaiting availability of social care support~~
~~K1~~	~~Awaiting availability of local health service provision~~
~~Z1~~	~~Other Reason~~
I1	Housing - PATIENT not covered by NHS and Community Care Act (Retired 01 April 2017)
I2	Housing - Single homeless PATIENTS or asylum seekers NOT covered by Care Act
I3	Housing - Awaiting availability of general needs housing/private landlord accommodation acceptance as patient NOT covered by Housing Act and/or Care Act
J1	Awaiting availability of social care support (Retired 01 April 2017)
J2	Housing - Awaiting supported accommodation
K1	Awaiting availability of local health service provision (Retired 01 April 2017)
K2	Housing - Awaiting emergency accommodation from the Local Authority under the Housing Act
L1	Child or young person awaiting social care or family placement
M1	Awaiting Ministry of Justice agreement/permission of proposed placement
N1	Awaiting outcome of legal requirements (mental capacity/mental health legislation)
Z1	Other Reason (Retired 01 April 2017)

MENTAL HEALTH LEAVE OF ABSENCE END REASON

Change to Attribute: Changed Dataset

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

NHS NUMBER

Change to Attribute: Changed Dataset

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

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

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

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

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

Digit Position
(starting from the left) Factor:

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

Step 2 Add the results of each multiplication together.

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

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

If the result is 11 then a check digit of 0 is used. If the result is 10 then the NHS NUMBER is invalid and not used.

Step 5 Check the remainder matches the check digit. If it does not, the NHS NUMBER is invalid.

Further guidance is available from the NHS Digital website at: NHS Number.

Note:
This was e-GIF approved for use in NHS England.
e-GIF and the Government Data Standards Catalogue **have been archived** and are available for reference only.

NHS OCCUPATION CODE

Change to Attribute: Changed Dataset

An NHS OCCUPATION CODE for an EMPLOYEE filling a POSITION.

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

NHS SERVICE AGREEMENT LINE NUMBER

Change to Attribute: Changed Dataset

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

OBSERVATION SCHEME IN USE

Change to Attribute: Changed Dataset

The type of CLINICAL TERMINOLOGY CODE used for the observation.

National Codes:

01 Read Coded Clinical Terms Version 2
02 Read Coded Clinical Terms Version 3 (CTV3)
03 Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT)

OBSERVATION VALUE

Change to Attribute: Changed Dataset

The value of a CLINICAL INVESTIGATION RESULT ITEM.

OFFENCE HISTORY INDICATION CODE

Change to Attribute: New Attribute

An indication of whether the PERSON has a history of forensic offences, including index offences (i.e. the offence is recordable, committed in England or Wales and is prosecuted by the police. Breach of the peace offences are not included).

This may be completed by CARE PROFESSIONALS based on PATIENT history or may be informed by referral information.

National Codes:

1 No - No offence
2 Yes - Less serious offence
3 Yes - Serious offence

This attribute is also known by these names:

Context	Alias
plural	OFFENCE HISTORY INDICATION CODES

OFFENCE HISTORY INDICATION CODE

Change to Attribute: New Attribute

OFFENCE HISTORY INDICATION CODE

Data Elements:

OFFENCE HISTORY INDICATION CODE

OFFERED FOR ADMISSION DATE

Change to Attribute: Changed Dataset

The date offered for admission to hospital to start a Hospital Provider Spell.

ONWARD REFERRAL REASON

Change to Attribute: Changed Dataset

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

National Codes:

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

ORGANISATION CODE

Change to Attribute: Changed Dataset

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

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

ORGANISATION CODES are managed by:

- Organisation Data Service (ODS)
- NHS Prescription Services
- NHS Dental Services.

Notes:

- *Organisation Data Service codes can be downloaded:*
  - *from 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 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: 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 **All Cancer Registries in England are now part of the National Cancer Registration and Analysis Service**
Care Home Headquarters	F	A, C or D	A-9	A-9	A-9					ODS	E.g. CA0A
Care Trust (CT)	D	T	A-Y	A-Y						ODS	E.g. TAK
Clinical Commissioning Group (CCG)	M	0-9	0-9	A-Y						ODS	E.g. 12A
Clinical Network	B	Y	D	G	A-9	A-9				ODS	E.g. YDG01
Commissioning Support Unit (CSU) / Data Services for Commissioners Regional Office (DSCRO)	D	0	A-Y	A-Y						ODS	E.g. 0AA
Dental Practice - England and Wales	G	V	0-9	0-9	0-9	0-9	0-9			NHS Dental Services	E.g. V20052
Education Establishment	B	Y	D	F	A-9	A-9				ODS	E.g. YDF01
Executive Agency	N/A See Note 1	X	0-9	0-9						ODS	E.g. X09
Executive Agency Programme	N/A See Note 1	X	0-9	0-9	0-9	0-9	0-9			ODS	First three characters denote Executive Agency E.g. X09001
	H	X	A-Y	A-Y						ODS	E.g. XDA

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

Local Authority (LA)	M	0-9	0-9	0-9						ODS	E.g. 000
Local Health Board (Wales)	B	7	A-9	A-9						ODS	E.g. 7A1
Local Service Provider (LSP)	B	L	S	P	0-9	0-9				ODS	E.g. LSP01
Military Hospital	B	X	M	D	A-9	A-9				ODS	E.g.XMDA1
National Application Service Provider	H	Y	E	A-9						ODS	E.g. YEA
National Groupings (England)	H	Y	5	0-9						ODS	E.g. Y51
NHS Support Agency	B	Y	D	D	A-9	A-9				ODS	E.g. YDD01
NHS Trust	D	R	A-9	A-9						ODS	E.g. RH8
NHS Wales Informatics Service (NWIS)	K	W	0	0						ODS	**Only one organisation of this type exists for Wales** E.g. W00
Non NHS Organisation (Independent Provider)	A	8	A-Y	A-9	0-9	0-9				ODS	E.g. 8HA03
Northern Ireland Health & Social Care Board	N/A	Z	B	0	0	1				ODS	E.g. ZB001
Northern Ireland Health & Social Care Trust	I	Z	T	0-9	0-9	0-9				ODS	E.g. ZT001

Northern Ireland Local Commissioning Group	L	Z	C	0	0-9	0				Department for Health, Social Services and Public Safety (DHSSPS), Northern Ireland	E.g. ZC010 Note that characters 3 and 5 are 'fillers' to create a 5 character code. If a 3 character code is required (as used by the Office for National Statistics in the NHS Postcode Directory), zeros can be omitted and fits under the H frame: E.g. ZC1. *Guidance on the use of Northern Ireland codes can be found in Data Set Change Notice 19/2009*.
Optical Headquarters	F	T	0-9	A-9	A-9					ODS	E.g. T1A1
Other Statutory Authority (OSA)	H	X	0-9	0-9						ODS	E.g. X16
Pharmacy	A	F	A-Y	A-9	A-9	A-9				ODS	E.g. FA002
Pharmacy Headquarters	F	P	A-9	A-9	A-9					ODS	E.g. P001
Primary Care Trust (PCT)	D	5	A-9	A-9						ODS	E.g. 5CT **All Primary Care Trusts closed 31 March 2013**
Prison Health Service	B	Y	D	E	A-9	A-9				ODS	E.g. YDE01
School	C	E	E	A-9	A-9	A-9	A-9	A-9	A-9	Department for Education and ODS	E.g. EE134290
Special Health Authority (SpHA)	I	T	1	0-9	0-9	0				ODS	E.g. T1150

Strategic Health Authority (SHA)	D	Q	A-9	A-9						ODS	E.g. Q30 **All Strategic Health Authorities in England closed 31 March 2013**
Welsh Assembly	D	W	0-9	0-9						ODS	E.g. W01
Welsh Health Commission	A	W	0-9	0-9	A-Y	A-Y				ODS	E.g. W01HC

Notes:

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

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

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

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

Table 2: CODING FORMATS FOR ORGANISATIONS IN SCOTLAND

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

Organisation Type	Character Position						Code allocated by:	Notes/Comments
	1	2	3	4	5	6		
GP Practice - Scotland	S	0-9	0-9	0-9	0-9	0-9	NHS	
Scottish GP Fundholder	S	A-Z	B	0-9	0-9		ISD, Scotland	2nd character identifies the Health Board the GPFH reports to.

								3rd character (always B) shows GPFH status.
Scottish Health Agency	S	D	0-9	0-9	0-9		ISD, Scotland	2nd character (D) identifies Scottish Office agencies
Scottish Health Board	S	A-Z	9	9	9		ISD, Scotland	
Scottish Provider	S	A-Z	A,C,D	0-9	0-9		ISD, Scotland	2nd character identifies the Health Board the organisation reports to. 3rd character identifies the organisation type: A= Health Unit C = Hospital Trust D = Nursing Home

Table 3: CODING FORMATS for ORGANISATIONS in OTHER HOME COUNTRIES

Organisation Type	Character Position						Code allocated by:	Notes/Comments
	1	2	3	4	5	6		
GP Practice - Alderney	A	L	D	0-9	0-9	0-9	NHS Prescription Services	
GP Practice - Guernsey	G	U	E	0-9	0-9	0-9	NHS Prescription Services	
GP Practice - Isle of Man (IOM)	Y	0-9	0-9	0-9	0-9	0-9	NHS Prescription Services	
GP Practice - Jersey	J	E	R	0-9	0-9	0-9	NHS Prescription Services	

Primary Healthcare Directorate (Isle of Man)	Y	K	A-9				ODS	E.g. YK1

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

ORGANISATION SITE CODE

Change to Attribute: Changed Dataset

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

An ORGANISATION SITE CODE is a code which identifies an Organisation Site uniquely.

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

Notes:

- *Organisation Data Service codes can be downloaded:*
  - *from 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 Type Identifier	Organisation Identifier		Site or Sub-Division Identifier					
C Frame	Organisation Type Identifier		Organisation Identifier	Site or Sub-Division Identifier					
D Frame	Organisation Type Identifier	Practice Identifier					Branch Surgery Identifier		

F Frame	Organisation Type Identifier	Organisation Identifier				
H Frame	Organisation Type Identifier	Organisation Identifier				
I Frame	Organisation Type Identifier	Organisation Identifier				
J Frame	Organisation Type Identifier	Organisation Identifier				
K Frame	Organisation and Organisation Type Identifier	Organisation Site Identifier				
L Frame	Organisation Type Identifier *and* 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 - 99YZZ

- 11A = Organisation and Organisation Type Identifier
- AA = Organisation Site Identifier

L Frame

Example
Special Health Authority (SpHA) Site: e.g. T115A

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

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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
	See Coding Frames Table	1	2	3	4	5	6	7	8	9		
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
	F	0	A-Y	A-Y	A-9	A-9					ODS	E.g. 0AA01

Commissioning Support Unit (CSU) Site												
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
Independent Sector Healthcare Provider (ISHP) Site	C	A, B, D, G, I, K, L, M , N, O, S, U, V, W	A-Y	A-Y, 0-9	A-Y, 0-9	A-Y, 0-9					ODS	First three characters denote owning Independent Sector Healthcare Provider (ISHP) E.g. NV701 Note: The A-Y range includes all letters except Z
Local Authority (LA) Site	B	0-9	0-9	0-9	A-Z	A-Z					ODS	

												First three characters denote parent Local Authority E.g. 000AA
Local Health Board (Wales) Site	B	7	A-9	A-9	A-9	A-9					ODS	First three characters denote owning NHS Trust E.g. 7A101
Local Service Provider Site	A	L	S	P	0-9	0-9	0-9	0-9			ODS	First five characters denote owning Local Service Provider E.g. LSP0101
NHS Trust Site	B	R	A-9	A-9	A-9	A-9					ODS	First three characters denote owning NHS Trust E.g. RH802
Optical Site	I	T	P or Q	0-9	A-9	A-9					ODS	E.g. TP01A, TQ01A
Other Statutory Authority (OSA) Site	B	X	0-9	0-9	0-9	0-9					ODS	First three characters denote owning Other Statutory Authority E.g. X1601
Primary Care Trust (PCT) Site	B	5	A-9	A-9	A-9	A-9					ODS	First three characters denote owning Primary Care Trust E.g. 5CT49 **All Primary Care Trusts closed 31 March 2013**
Special Health Authority (SpHA) Site	L	T	1	0-9	0-9	A-Y, 1-9					ODS	The characters do **NOT** denote any ownership. E.g. T115A
Strategic Health Authority (SHA) Site	B	Q	A-9	A-9	A-9	A-9					ODS	First three characters denote owning SHA Trust

												E.g. Q3001 **All Strategic Health Authorities closed 31 March 2013 - from 1 April 2013 referred to as High Level Health Geography Site**

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

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

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

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

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

Organisation Site Type	Frame Type	Character Position									Code allocated by:	Notes/Comments
	See Coding Frames Table	1	2	3	4	5	6	7	8	9		
Primary Healthcare Directorate (Isle of Man) Site	J	Y	K	A-9	A-9	A-9					ODS	E.g. YK101

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

OTHER PERSON IN ATTENDANCE AT CARE CONTACT

Change to Attribute: Changed Description, Dataset

The other PERSON in attendance, with the PATIENT, at the CARE CONTACT.

National Codes:

	Advocacy Role
01	Independent Advocate (Family Member)
02	Independent Advocate (Independent PERSON)
03	Independent Mental Capacity Advocate (IMCA)
04	Independent Mental Health Advocate (IMHA)
05	Non-Instructed Advocate
	Non-Advocacy Role
10	Parent or relative
11	Friend or neighbour
12	Care Worker

PATIENT PATHWAY IDENTIFIER

Change to Attribute: Changed Dataset
An identifier, which together with the ORGANISATION CODE / ORGANISATION IDENTIFIER of the issuer, uniquely identifies a PATIENT PATHWAY.

This is a specific type of the attribute ACTIVITY IDENTIFIER.

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

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

PERSON BIRTH DATE

Change to Attribute: Changed Dataset

The date on which a PERSON was born or is officially deemed to have been born.

Note:
This was e-GIF approved for use in NHS England.
e-GIF and the Government Data Standards Catalogue **have been archived** and are available for reference only.

PERSON DEATH DATE

Change to Attribute: Changed Dataset

The date on which a PERSON died or is officially deemed to have died.

This is as recorded on the Death Certificate.

Note:
This was e-GIF approved for use in NHS England.
e-GIF and the Government Data Standards Catalogue **have been archived** and are available for reference only.

PERSON GENDER CODE

Change to Attribute: Changed Dataset

The classification is phenotypical rather than genotypical, i.e. it does not provide codes for medical or scientific purposes.

Notes:

- National Code *'Not Known'* means that the sex of a PERSON has not been recorded
- National Code '*Not Specified*' means indeterminate, i.e. unable to be classified as either male or female.

National Codes:

0	Not Known
1	Male
2	Female
9	Not Specified

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

PERSON MARITAL STATUS CODE

Change to Attribute: Changed Dataset

An indicator to identify the legal marital status of a PERSON.

National Codes:

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

Previous specification, now obsolete and not for use:

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

PERSON PROPERTY EFFECTIVE DATE

Change to Attribute: Changed Dataset

The date when a PERSON PROPERTY became effective for a PATIENT.

Examples may be the date when the PATIENT experienced a symptom or gave up smoking.

PERSON PROPERTY EFFECTIVE END DATE

Change to Attribute: Changed Dataset

The date when a PERSON PROPERTY is no longer applicable to the PATIENT.

PERSON PROPERTY EFFECTIVE END TIME

Change to Attribute: Changed Dataset

The time when a PERSON PROPERTY is no longer applicable to the PATIENT.

PERSON PROPERTY OBSERVED DATE

Change to Attribute: Changed Dataset

The date when the PERSON PROPERTY was observed by a PERSON.

PERSON PROPERTY RECORDED DATE

Change to Attribute: Changed Dataset

The date when the PERSON PROPERTY was recorded by a PERSON.

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

PERSON SCORE

Change to Attribute: Changed Dataset

The score taken from an ASSESSMENT TOOL.

This could be for an individual element of, or question within, an ASSESSMENT TOOL, a subtotal or total score.

The purpose of the PERSON SCORE is to measure changes in health and wellbeing.

PERSON STATED GENDER CODE

Change to Attribute: Changed Dataset

The gender of a PERSON.

PERSON STATED GENDER CODE is self declared or inferred by observation for those unable to declare their PERSON STATED GENDER.

National Codes:

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

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

PLACE OF SAFETY INDICATOR

Change to Attribute: New Attribute

An indication of whether a LOCATION is being used as a Place of Safety.

National Codes:

Y	Yes - is being used as a Place of Safety
N	No - is not being used as a Place of Safety

This attribute is also known by these names:

Context	Alias
plural	PLACE OF SAFETY INDICATORS

PLACE OF SAFETY INDICATOR

Change to Attribute: New Attribute

PLACE OF SAFETY INDICATOR

Data Elements:

PLACE OF SAFETY INDICATOR

PLANNED ACTIVITY DATE

Change to Attribute: Changed Dataset

Any DATE that is of relevance to a PLANNED ACTIVITY.

The specific nature of the DATE will be identified by the PLANNED ACTIVITY DATE TYPE.

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.

PREVIOUS SYMPTOM INDICATOR

Change to Attribute: Changed Dataset

An indication of whether this is a recurrence of a previously diagnosed condition, as stated by a PERSON.

National Codes:

Y	Yes
N	No
U	Unknown (PERSON asked and does not know or is not sure)
Z	Not Stated (PERSON asked but declined to provide a response)

PROCEDURE SCHEME IN USE

Change to Attribute: Changed Dataset

The type of CODED CLINICAL ENTRY used for the CLINICAL INTERVENTION.

National Codes:

01	Accident & Emergency Treatment ***
02	OPCS-4 ***
03	Read Code 4Byte Version (retired 1 October 2009)
04	Read Coded Clinical Terms Version 2
05	Read Coded Clinical Terms Version 3 (CTV3) *
06	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 6-2
- *** Accident & Emergency Treatment and OPCS-4 are not valid for the Children and Young People's Health Services Data Set, Community Information Data Set and Mental Health Services Data Set.

PROFESSIONAL REGISTRATION BODY CODE

Change to Attribute: Changed Dataset

A code which identifies the PROFESSIONAL REGISTRATION BODY.

National Codes:

01	General Chiropractic Council
02	General Dental Council
03	General Medical Council
04	General Optical Council
05	Care Council for Wales
06	Scottish Social Services Council (Retired 01 April 2013)
07	General Social Care Council (for England) (Retired 01 August 2012)
08	Health and Care Professions Council
09	Nursing and Midwifery Council

10	Royal Pharmaceutical Society (Retired 27 September 2010)
11	British Psychological Society *
12	Association for Operating Department Practitioners (Retired January 2015)
13	Association of Chartered Certified Accountants *
14	Chartered Institute of Personnel and Development *
15	Chartered Institute of Management Accountants *
16	General Pharmaceutical Council

* Note: National Codes 11, 13, 14 and 15 are not valid for use in the Children and Young People's Health Services Data Set, Community Information Data Set and Mental Health Services Data Set.

PROFESSIONAL REGISTRATION ENTRY IDENTIFIER

Change to Attribute: Changed Dataset

The registration identifier allocated by an Organisation.

Examples include:

- GENERAL DENTAL COUNCIL REGISTRATION NUMBER
- GENERAL MEDICAL COUNCIL REFERENCE NUMBER.

PROVISIONAL DIAGNOSIS

Change to Attribute: Changed Dataset

This is the provisional PATIENT DIAGNOSIS for the main condition treated or investigated during the relevant episode of healthcare.

PSYCHOTROPIC MEDICATION USAGE

Change to Attribute: Changed Dataset

An indication of whether the PATIENT is taking Psychotropic Medication, as stated by the PATIENT.

National Codes:

01	Prescribed but not taking
02	Prescribed and taking
03	Not Prescribed
UU	Unknown (PERSON asked and does not know or is not sure)
ZZ	Not Stated (PERSON asked but declined to provide a response)

REASON FOR OUT OF AREA REFERRAL FOR ADULT ACUTE MENTAL HEALTH

Change to Attribute: New Attribute

The reason why a SERVICE has received a REFERRAL REQUEST, for a PATIENT:

- with assessed acute mental health needs requiring adult mental health admitted PATIENT care and
- who is resident outside of the referring Organisation's usual local network of SERVICES.

For further information, see the Department of Health part of the gov.uk website at: Guidance on Out of Area Placements.

National Codes:

10	Unavailability of bed at referring Organisation
11	Safeguarding
12	Offending restrictions
13	Staff member or family/friend within the referring Organisation
14	PATIENT choice
15	PATIENT away from home

This attribute is also known by these names:

Context	Alias
plural	REASONS FOR OUT OF AREA REFERRAL FOR ADULT ACUTE MENTAL HEALTH

REASON FOR OUT OF AREA REFERRAL FOR ADULT ACUTE MENTAL HEALTH

Change to Attribute: New Attribute

REASON FOR OUT OF AREA REFERRAL FOR ADULT ACUTE MENTAL HEALTH

Data Elements:

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

REASON FOR REFERRAL TO MENTAL HEALTH

Change to Attribute: Changed Dataset

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

REFERRAL CLOSURE REASON

Change to Attribute: Changed Dataset

The reason that a REFERRAL REQUEST was closed by a Health Care Provider.

National Codes:

01	Admitted elsewhere (at the same or other Health Care Provider)
02	Treatment completed
03	Moved out of the area
04	No further treatment appropriate
05	PATIENT did not attend
06	PATIENT died
07	PATIENT requested discharge
08	Referred to other speciality/SERVICE (at the same or other Health Care Provider)
09	PATIENT refused to be seen

REFERRAL REJECTION REASON

Change to Attribute: Changed Dataset

The reason that a REFERRAL REQUEST was rejected by a Health Care Provider.

National Codes:

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

REFERRAL REQUEST RECEIVED DATE

Change to Attribute: Changed Dataset

The date the REFERRAL REQUEST was received by the Health Care Provider.

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

- For electronic REFERRAL REQUESTS the REFERRAL REQUEST RECEIVED DATE is the date the REFERRAL REQUEST is received electronically by the Health Care Provider
- For Choose and Book, the referral is received when the PATIENT's Unique Booking Reference Number (UBRN) is used to book the first 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 Description, Dataset

~~The time the REFERRAL REQUEST was received.~~The time the REFERRAL REQUEST was received by the Health Care Provider.

REFERRAL TO TREATMENT PERIOD END DATE

Change to Attribute: Changed Dataset
The end date of a REFERRAL TO TREATMENT PERIOD.

This is a specific type of the attribute ACTIVITY DATE.

REFERRAL TO TREATMENT PERIOD END DATE will be one of the following:

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

or

- the PERSON DEATH DATE.

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

REFERRAL TO TREATMENT PERIOD START DATE

Change to Attribute: Changed Dataset

The start date of a REFERRAL TO TREATMENT PERIOD.

This is a specific type of the attribute ACTIVITY DATE.

A REFERRAL TO TREATMENT PERIOD START DATE will be one of the following:

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

Referral To Treatment Consultant Led Waiting Times:

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

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

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

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

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

Allied Health Professional Referral To Treatment Measurement:

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

REFERRAL TO TREATMENT PERIOD STATUS

Change to Attribute: Changed Dataset
The status of an ACTIVITY (or anticipated ACTIVITY) for the REFERRAL TO TREATMENT PERIOD decided by the lead CARE PROFESSIONAL.

National Codes:

The first ACTIVITY in a REFERRAL TO TREATMENT PERIOD where the First Definitive Treatment will be a subsequent ACTIVITY

10 first ACTIVITY - first ACTIVITY in a REFERRAL TO TREATMENT PERIOD

11 Active Monitoring end - first ACTIVITY at the start of a new REFERRAL TO TREATMENT PERIOD following Active Monitoring

12 CONSULTANT or NHS Allied Health Professional Service (Referral To Treatment Measurement) referral - the first ACTIVITY at the start of a new REFERRAL TO TREATMENT PERIOD following a decision to refer directly to the CONSULTANT or NHS Allied Health Professional Service (Referral To Treatment Measurement) for a separate condition

Subsequent ACTIVITY during a REFERRAL TO TREATMENT PERIOD

20 subsequent ACTIVITY during a REFERRAL TO TREATMENT PERIOD - further ACTIVITIES anticipated

21 transfer to another Health Care Provider - subsequent ACTIVITY by another Health Care Provider during a REFERRAL TO TREATMENT PERIOD anticipated

ACTIVITY that ends the REFERRAL TO TREATMENT PERIOD

30 Start of First Definitive Treatment

31 start of Active Monitoring initiated by the PATIENT

32 start of Active Monitoring initiated by the CARE PROFESSIONAL

33 Did not attend - the PATIENT did not attend the first CARE ACTIVITY after the referral[1]

34 decision not to treat - decision not to treat made or no further contact required[2]

35 PATIENT declined offered treatment

36 PATIENT died before treatment

ACTIVITY that is not part of a REFERRAL TO TREATMENT PERIOD

90 after treatment - First Definitive Treatment occurred previously (e.g. admitted as an emergency from A&E or the ACTIVITY is after the start of treatment)

91 Active Monitoring - CARE ACTIVITY during Active Monitoring

92 not yet referred - not yet referred for treatment, undergoing diagnostic tests by GENERAL PRACTITIONER before referral

98 not applicable - ACTIVITY not applicable to REFERRAL TO TREATMENT PERIODS

ACTIVITY where the REFERRAL TO TREATMENT PERIOD STATUS is not yet known

99 not yet known

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

[1] PATIENTS who do not attend an appointment
National code 33 - "Did not attend - the PATIENT did not attend the first CARE ACTIVITY after the referral" may only be used where

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

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

[2] Decision not to treat

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

- a Discharge After Patient Did Not Attend the second or a subsequent CARE ACTIVITY after the referral.
- a change resulting in care no longer being commissioned by the English NHS.
- a referral to a Consultant Led Service during a Referral To Treatment Period Excluded From Target for the same condition, disease or injury. A new REFERRAL TO TREATMENT PERIOD will start.

REFERRED OUT OF AREA REASON FOR ADULT ACUTE MENTAL HEALTH

Change to Attribute: New Attribute

The reason a PATIENT:

- with assessed acute mental health needs and
- requiring adult mental health admitted PATIENT care

was referred to an ORGANISATION:

- that does not form part of the referring Organisation's usual local network of SERVICES and
- where the Mental Health Care Coordinator cannot visit the PATIENT as often as stated in the referring Organisation's policy.

For further information, see the Department of Health part of the gov.uk website at: Guidance on Out of Area Placements.

National Codes:

10	Unavailability of bed at referring Organisation
11	Safeguarding
12	Offending restrictions
13	Staff member or family/friend within the referring Organisation
14	PATIENT choice

This attribute is also known by these names:

Context	Alias
plural	REFERRED OUT OF AREA REASONS FOR ADULT ACUTE MENTAL HEALTH

REFERRED OUT OF AREA REASON FOR ADULT ACUTE MENTAL HEALTH

Change to Attribute: New Attribute

REFERRED OUT OF AREA REASON FOR ADULT ACUTE MENTAL HEALTH

Data Elements:

REFERRED OUT OF AREA REASON (ADULT ACUTE MENTAL HEALTH)

REFERRING CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH AND COMMUNITY CARE

Change to Attribute: Changed Dataset

The staff group of a CARE PROFESSIONAL who referred a PATIENT to a Community Health Service or Mental Health Service.

National Codes:

	Allied Health Professionals
A01	Art Therapist
A02	Clinical Psychologist
A03	Dietitian
A04	Drama Therapist
A05	Music Therapist
A06	Occupational Therapist
A07	Orthotist
A08	Physiotherapist
A09	Podiatrist
A10	Prosthetist
A11	Psychotherapist
A12	Radiographer
A13	Speech and Language Therapist
A14	Orthoptist
	Medical/Dental
M01	Community Dentist
M02	CONSULTANT
M03	GENERAL MEDICAL PRACTITIONER
M04	General Practitioner With A Special Interest
	Nursing, Health Visiting and Midwifery
N01	MIDWIFE
N02	District NURSE
N03	Health Visitor
N04	Macmillan NURSE
N05	School Nurse
N06	Specialist Nursing - Active Case Management (Community Matrons)
N07	Specialist Nursing - Arthritis Nursing/Liaison
N08	Specialist Nursing - Asthma and Respiratory Nursing/Liaison
N09	Specialist Nursing - Breast Care Nursing/Liaison
N10	Specialist Nursing - Cancer Related
N11	Specialist Nursing - Cardiac Nursing/Liaison
N12	Specialist Nursing - Children's Services
N13	Specialist Nursing - Community Cystic Fibrosis
N14	Specialist Nursing - Continence Services
N15	Specialist Nursing - Diabetic Nursing/Liaison
N16	Specialist Nursing - Enteral Feeding Nursing Services
N17	Specialist Nursing - Haemophilia Nursing Services
N18	Specialist Nursing - HIV/AIDS Nursing Services (Retired 01 September 2015)
N19	Specialist Nursing - Infectious Diseases
N20	Specialist Nursing - Intensive Care Nursing
N21	Specialist Nursing - Palliative/Respite Care
N22	Specialist Nursing - Parkinson's and Alzheimers Nursing/Liaison
N23	Specialist Nursing - Rehabilitation Nursing
N24	Specialist Nursing - Stoma Care Services
N25	Specialist Nursing - Tissue Viability Nursing/Liaison
N26	Specialist Nursing - Transplantation Patients Nursing 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	Screener (in a National Screening Programme)
C10	Health Trainer (Non Clinical) *
C11	Health Trainer (Clinical) *
C12	Health Care Assistant *
C13	Health Care Support Worker *
C99	Other CARE PROFESSIONAL

* Note: National Codes C10, C11, C12 and C13 are **only valid** for use in the Community Information Data Set and Children and Young People's Health Services Data Set.

RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE

Change to Attribute: Changed Dataset

The RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION group of a PERSON, as specified by a PERSON.

Note: This is the Religious Affiliation of a PERSON, not their Religion.

RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE is aligned with descriptors for religious 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: Changed Dataset

The type of Restrictive Intervention used on a PATIENT during a Hospital Provider Spell.

National Codes:

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

SERVICE OR TEAM TYPE FOR MENTAL HEALTH

Change to Attribute: Changed Description, Dataset

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

National Codes:

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

	Forensic Services
~~B01~~	~~Forensic Mental Health Service~~
~~B02~~	~~Forensic Learning Disability Service~~
B01	Forensic Mental Health Service
B02	Forensic Learning Disability Service
	Specialist Mental Health Services
C01	Autistic Spectrum Disorder Service
C02	Peri-Natal Mental Illness Service
C03	Eating Disorders/Dietetics Service
C04	Neurodevelopment Team
C05	Paediatric Liaison Service
C06	Looked After Children Service
C07	Community Young Offenders Service
C08	Acquired Brain Injury Service
C09	Community Eating Disorder Service (CEDS) for Children and Young People
	Other Mental Health Services
D01	Substance Misuse Team
D02	Criminal Justice Liaison and Diversion Service
D03	Prison Psychiatric Inreach Service
D04	Asylum Service
	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

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SERVICE REQUEST ACCEPTANCE INDICATOR

Change to Attribute: Changed Dataset

An indication of whether a SERVICE REQUEST was accepted by a Health Care Provider.

For an Improving Access to Psychological Therapies Service, this is following the initial APPOINTMENT with the Therapist.

National Codes:

Y	Yes
N	No

SERVICE REQUEST DATE

Change to Attribute: Changed Dataset

The date a SERVICE REQUEST for an APPOINTMENT was made and recorded.

SERVICE REQUEST IDENTIFIER

Change to Attribute: Changed Dataset
The unique identifier for a SERVICE REQUEST.

SESSION DATE

Change to Attribute: Changed Dataset

The date of a SESSION such as Group Session, Operating Theatre Session or Consultant Clinic Session.

SETTLED ACCOMMODATION INDICATOR

Change to Attribute: Changed Dataset

An indication of whether the main/permanent residence of a PATIENT is settled ACCOMMODATION.

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

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

National Codes:

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

SEX OF PATIENTS

Change to Attribute: Changed Dataset

The sex of PATIENTS intended to use a WARD indicated in the operational plans.

Classification:

a.	Males
b.	Females
c.	Either sex

SEXUAL ORIENTATION CODE

Change to Attribute: Changed Dataset

The SEXUAL ORIENTATION of a PATIENT.

National Codes:

1	Heterosexual
2	Gay/Lesbian
3	Bi-sexual
4	PERSON asked and does not know or is not sure *
Z	Not Stated (PERSON asked but declined to provide a response) *

*Note: ***** Code not to be used for the Genitourinary Medicine Clinic Activity Data Set.*

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 Dataset

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
G4	Voluntary Sector
	Acute Secondary Care
H1	Accident and Emergency Department
H2	Other secondary care specialty
	Other Mental Health NHS Trust
I1	Temporary transfer from another Mental Health NHS Trust
I2	Permanent transfer from another Mental Health NHS Trust
	Internal referrals from Community Mental Health Team (within own NHS Trust)
J1	Community Mental Health Team (Adult Mental Health) ***
J2	Community Mental Health Team (Older People) ***
J3	Community Mental Health Team (Learning Disabilities) ***
J4	Community Mental Health Team (Child and Adolescent Mental Health) ***
	Internal referrals from Inpatient Service (within own NHS Trust)
K1	Inpatient Service (Adult Mental Health) ***
K2	Inpatient Service (Older People) ***
K3	Inpatient Service (Forensics) ***
K4	Inpatient Service (Child and Adolescent Mental Health) ***
K5	Inpatient Service (Learning Disabilities) ***
	Transfer by graduation (within own NHS Trust)
L1	Transfer by graduation from Child and Adolescent Mental Health Service to Adult Mental Health Services
L2	Transfer by graduation from Adult Mental Health Services to Older Peoples Mental Health Services
	Other
M1	Asylum Services
M2	Telephone or Electronic Access Service
M3	Out of Area Agency
M4	Drug Action Team / Drug Misuse Agency
M5	Jobcentre Plus **
M6	Other SERVICE or agency
M7	Single Point of Access Service ****
	Improving Access to Psychological Therapies
N1	Stepped up from low intensity Improving Access to Psychological Therapies Service *
N2	Stepped down from high intensity Improving Access to Psychological Therapies Service *
N3	Improving Access to Psychological Therapies Service ****
	Internal
P1	Internal Referral ****

Notes:

- * National Codes N1 and N2 are for use in the Improving Access to Psychological Therapies Data Set **only**.
- ** National Code M5 can only be used for the Mental Health Services Data Set, if referrals from Jobcentre Plus are accepted.

- *** National Codes J1, J2, J3, J4, K1, K2, K3, K4, K5, L1, and L2 are for use in the Improving Access to Psychological Therapies Data Set **only**.
- **** National Codes M7, N3 and P1 are for use in the Mental Health Services Data Set **only.**

STATUTORY SICK PAY INDICATOR

Change to Attribute: Changed Dataset

An indication of whether a PERSON is currently receiving Statutory Sick Pay, as stated by the PERSON.

National Codes:

Y	Yes
N	No
U	Unknown (PERSON asked and does not know or is not sure)
Z	Not Stated (PERSON asked but declined to provide a response)

THERAPY TYPE FOR IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES

Change to Attribute: Changed Dataset

The type of therapy given to a PATIENT or planned to be given to a PATIENT during an Improving Access to Psychological Therapies Contact.

Note: the National Codes are National Institute for Health and Care Excellence (NICE) approved and/or evidence based (i.e. Employment Support is evidence based).

National Codes:

	Low Intensity
20	Guided Self Help (Book)
21	Non-guided Self Help (Book)
22	Guided Self Help (Computer)
23	Non-Guided Self Help (Computer)
24	Behavioural Activation (Low Intensity)
25	Structured Physical Activity
26	Ante/post natal counselling
27	Psychoeducational peer support
28	Other Low Intensity
29	Employment Support (Low Intensity)
	High Intensity
40	Applied relaxation
41	Behavioural Activation (High Intensity)
42	Couples Therapy for Depression
43	Collaborative care (for people with depression and a chronic physical health condition)
44	Counselling for Depression
45	Brief psychodynamic psychotherapy
46	Eye Movement Desensitisation Reprocessing
47	Mindfulness
48	Other High Intensity (not specified above)
49	Employment Support (High Intensity)
50	Cognitive Behaviour Therapy (CBT)
51	Interpersonal Psycho therapy (IPT)

TREATMENT FUNCTION CODE

Change to Attribute: Changed Dataset

TREATMENT FUNCTION CODE is a unique identifier for a TREATMENT FUNCTION.

TREATMENT FUNCTION CODE is recorded to report the specialised service within which the PATIENT is treated.

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

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

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

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

Joint Consultant Clinic ACTIVITY should be recorded against the TREATMENT FUNCTION which best describes the specialised service.

Assigning a Treatment Function Code:

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

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

National Codes:

Code	Treatment Function Title	Comments
Surgical Specialties		
100	GENERAL SURGERY	Includes sub-categories not elsewhere listed e.g. endocrine surgery
101	UROLOGY	Surgical treatment of disorders of the urinary system and male reproductive system
102	TRANSPLANTATION SURGERY	Includes pre- and post-operative care for major organ transplants except heart and lung (see Cardiothoracic Transplantation). Excludes corneal grafts
103	BREAST SURGERY	Includes treatment for cancer, suspected neoplasms, cysts and post-cancer reconstructive surgery. Excludes cosmetic surgery
104	COLORECTAL SURGERY	Surgical treatment of disorders of the lower intestine (colon, anus and rectum)
105	HEPATOBILIARY & 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	RESPITE 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
Other		
840	AUDIOLOGY	Physiological measurement and diagnosis of hearing disorders, and the rehabilitation of PATIENTS with hearing loss
900	not a Treatment Function	
901	not a Treatment Function	
920	DIABETIC EDUCATION SERVICE	SERVICES providing dedicated small group education courses regarding self management for diabetic PATIENTS
950	not a Treatment Function	Use the appropriate function under which the patient is treated
960	not a Treatment Function	Use the appropriate function under which the patient is treated
990	Retired	

Notes:

†	Code 500 is not acceptable for Central Returns including Hospital Episode Statistics

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UCUM UNIT OF MEASUREMENT

Change to Attribute: Changed Dataset

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

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

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 Dataset

The type of waiting time measurement methodology which may be applied during a PATIENT PATHWAY.

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

National Codes:

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

Notes:

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

WARD SECURITY LEVEL

Change to Attribute: Changed Dataset

The level of security for a WARD.

National Codes:

0	**General (non-secure)** Non secure accommodation or accommodation that only has normal levels of security such as general WARDS
1	**Low Secure** Low secure WARDS/units deliver comprehensive, multidisciplinary, treatment and care by qualified staff for PATIENTS who demonstrate disturbed behaviour in the context of a serious mental disorder and who require the provision of security. This includes (but is not limited to) Psychiatric Intensive Care Unit (PICU), low secure forensic services, challenging behaviour services, and secure rehabilitation services.

2 **Medium Secure**
Medium secure WARDS/units deliver comprehensive, multidisciplinary treatment and care by qualified staff for PATIENTS who demonstrate disturbed behaviour in the context of a serious mental disorder and who may present a serious risk to others.

3 **High Secure**
High secure WARDS/hospitals provide comprehensive, multidisciplinary treatment and care by qualified staff for PATIENTS who demonstrate disturbed behaviour in the context of a serious mental disorder and have been assessed as presenting a grave and immediate danger to others. The Hospital must be part of an NHS Trust approved by the Secretary of State to provide high security psychiatric services.

WARD SETTING TYPE FOR MENTAL HEALTH

Change to Attribute: Changed Dataset

The type of WARD setting for a Mental Health Service's PATIENT during a Hospital Provider Spell.

National Codes:

01 Child and Adolescent Mental Health WARD
02 Paediatric WARD
03 Adult Mental Health WARD
04 Non Mental Health WARD
05 Learning Disabilities WARD
06 Older People's Mental Health WARD

WEEKLY HOURS WORKED

Change to Attribute: Changed Dataset
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)

YEAR AND MONTH OF SYMPTOMS ONSET FOR IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES

Change to Attribute: Changed Dataset

The year and month the PATIENT first experienced the mental health symptoms, as stated by the PATIENT.

YOUNG CARER INDICATOR

Change to Attribute: Changed Dataset

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

National Codes:

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

ACCOMMODATION STATUS CODE

Change to Data Element: Changed Dataset

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

Notes:
ACCOMMODATION STATUS CODE is the same as attribute ACCOMMODATION STATUS CODE.

ACCOMMODATION STATUS RECORDED DATE

Change to Data Element: Changed Dataset

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

Notes:
ACCOMMODATION STATUS RECORDED DATE is the same as attribute PERSON PROPERTY RECORDED DATE.

ACCOMMODATION STATUS RECORDED DATE is the DATE when the ACCOMMODATION STATUS CODE was recorded.

ACTIVITY LOCATION TYPE CODE

Change to Data Element: Changed Dataset

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

Notes:
ACTIVITY LOCATION TYPE CODE is the same as attribute ACTIVITY LOCATION TYPE CODE.

Use in Commissioning Data Set Version 6-2 onwards

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

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

ACTIVITY SUSPENSION END DATE

Change to Data Element: Changed Dataset

Format/Length:	See DATE
National Codes:	

Default Codes:

Notes:
ACTIVITY SUSPENSION END DATE is the same as attribute ACTIVITY SUSPENSION END DATE.

ACTIVITY SUSPENSION START DATE

Change to Data Element: Changed Dataset

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

Notes:
ACTIVITY SUSPENSION START DATE is the same as attribute ACTIVITY SUSPENSION START DATE.

ADMINISTRATIVE CATEGORY CODE

Change to Data Element: Changed Dataset

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

Notes:
ADMINISTRATIVE CATEGORY CODE is the same as ADMINISTRATIVE CATEGORY CODE.

ADMISSION METHOD CODE (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Dataset

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

Notes:
ADMISSION METHOD CODE (HOSPITAL PROVIDER SPELL) is the same as attribute ADMISSION METHOD.

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

For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

ADULT MENTAL HEALTH CARE CLUSTER CODE (FINAL)

Change to Data Element: Changed Dataset

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

Notes:
ADULT MENTAL HEALTH CARE CLUSTER CODE (FINAL) is the same as attribute ADULT MENTAL HEALTH CARE CLUSTER CODE.

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

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

ADULT MENTAL HEALTH CARE CLUSTER CODE (INITIAL)

Change to Data Element: Changed Dataset

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

Notes:
ADULT MENTAL HEALTH CARE CLUSTER CODE (INITIAL) is the same as attribute ADULT MENTAL HEALTH CARE CLUSTER CODE.

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

AGORAPHOBIA MOBILITY INVENTORY SCORE (WHEN ACCOMPANIED)

Change to Data Element: Changed Dataset

Format/Length:	n1.max n2
National Codes:	
Default Codes:	

Notes:
AGORAPHOBIA MOBILITY INVENTORY SCORE (WHEN ACCOMPANIED) is the PERSON SCORE for an APPOINTMENT where the ASSESSMENT TOOL TYPE is '*Agoraphobia Mobility Inventory Questionnaire 'When Accompanied*'.

The score will be the average score in the range 0 to 5.00.

AGORAPHOBIA MOBILITY INVENTORY SCORE (WHEN ALONE)

Change to Data Element: Changed Dataset

Format/Length:	n1.max n2
National Codes:	
Default Codes:	

Notes:
AGORAPHOBIA MOBILITY INVENTORY SCORE (WHEN ALONE) is the PERSON SCORE for an APPOINTMENT where the ASSESSMENT TOOL TYPE is '*Agoraphobia Mobility Inventory Questionnaire 'When Alone*'.

The score will be the average score in the range 0 to 5.00.

AGORAPHOBIA SCORE

Change to Data Element: Changed Dataset

Format/Length:	n1
National Codes:	
Default Codes:	

Notes:
AGORAPHOBIA SCORE is the PERSON SCORE for an APPOINTMENT where the ASSESSMENT TOOL TYPE is '*Agoraphobia Questionnaire*'.

The score is in the range 0 to 8.

APPOINTMENT DATE

Change to Data Element: Changed Dataset

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

Notes:
APPOINTMENT DATE is the same as attribute APPOINTMENT DATE.

Usage in the CDS:
The Outpatient and Future Outpatient CDS Types use the APPOINTMENT DATE as the "CDS ORIGINATING DATE" as a mandatory requirement of the CDS Exchange Protocol, see CDS ACTIVITY DATE.

For the Future Outpatient CDS where no APPOINTMENT DATE is available from the healthcare system, a default date value of 2999-12-31 may be applied. Care must be taken to generate the correct CDS Exchange Protocol when using this default value.

When submitting a Referral To Treatment Clock Stop Administrative Event via the CDS V6-2 Type 020 - Outpatient Commissioning Data Set, APPOINTMENT DATE is equivalent to the REFERRAL TO TREATMENT PERIOD END DATE carried in the record.

APPOINTMENT SLOT SHORT NOTICE CANCELLATION INDICATOR

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See APPOINTMENT SLOT SHORT NOTICE CANCELLATION INDICATOR
Default Codes:	

Notes:
APPOINTMENT SLOT SHORT NOTICE CANCELLATION INDICATOR is the same as attribute APPOINTMENT SLOT SHORT NOTICE CANCELLATION INDICATOR.

APPOINTMENT TIME

Change to Data Element: Changed Dataset

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

Notes:
APPOINTMENT TIME is the same as attribute APPOINTMENT TIME.

APPOINTMENT TYPE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	

	See APPOINTMENT TYPE FOR IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES
Default Codes:	08 - Not Recorded

Notes:
APPOINTMENT TYPE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES) is the same as attribute APPOINTMENT TYPE FOR IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES.

ASSESSMENT TOOL COMPLETION DATE

Change to Data Element: Changed Dataset

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

Notes:
ASSESSMENT TOOL COMPLETION DATE is the DATE the ASSESSMENT TOOL was completed.

ASSESSMENT TOOL COMPLETION TIME

Change to Data Element: Changed Dataset

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

Notes:
ASSESSMENT TOOL COMPLETION TIME is the TIME the ASSESSMENT TOOL was completed.

ASSISTIVE TECHNOLOGY FINDING (SNOMED CT)

Change to Data Element: Changed Description, Dataset

Format/Length:	min an6 max an18
National Codes:	
Default Codes:	

Notes:
ASSISTIVE TECHNOLOGY FINDING (SNOMED CT) is the same as attribute CLINICAL TERMINOLOGY CODE.

ASSISTIVE TECHNOLOGY FINDING (SNOMED CT) is the SNOMED CT concept ID which is used to identify the finding relating to the Assistive Technology that a PERSON is dependent on.

ATTENDED OR DID NOT ATTEND CODE

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See ATTENDED OR DID NOT ATTEND
Default Codes:	

Notes:
ATTENDED OR DID NOT ATTEND CODE is the same as attribute ATTENDED OR DID NOT ATTEND.

Use in the Future Outpatient CDS:

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

CARE ACTIVITY IDENTIFIER

Change to Data Element: Changed Dataset

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

Notes:
CARE ACTIVITY IDENTIFIER is the ACTIVITY IDENTIFIER for a CARE ACTIVITY.

CARE CONTACT CANCELLATION DATE

Change to Data Element: Changed Dataset

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

Notes:
CARE CONTACT CANCELLATION DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Care Contact Cancellation Date*'.

CARE CONTACT CANCELLATION REASON

Change to Data Element: Changed Dataset

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

Notes:
CARE CONTACT CANCELLATION REASON is the same as attribute CARE CONTACT CANCELLATION REASON.

CARE CONTACT DATE

Change to Data Element: Changed Dataset

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

Notes:
CARE CONTACT DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Care Contact Date*'.

CARE CONTACT IDENTIFIER

Change to Data Element: Changed Dataset

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

Notes:
CARE CONTACT IDENTIFIER is the ACTIVITY IDENTIFIER for a CARE CONTACT.

CARE CONTACT SUBJECT

Change to Data Element: Changed Dataset

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

Notes:
CARE CONTACT SUBJECT is the same as attribute CARE CONTACT SUBJECT.

CARE CONTACT TIME

Change to Data Element: Changed Dataset

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

Notes:
CARE CONTACT TIME is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Care Contact Time*'.

CARE PLAN AGREED BY

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See CARE PLAN AGREED BY
Default Codes:	

Notes:
CARE PLAN AGREED BY is the same as attribute CARE PLAN AGREED BY.

This data element is also known by these names:

Context	Alias
plural	CARE PLANS AGREED BY

CARE PLAN AGREED BY

Change to Data Element: New Data Element

CARE PLAN AGREED BY

Attribute:

CARE PLAN AGREED BY

CARE PLAN AGREED DATE renamed from CARE PLAN AGREED DATE (RETIRED)

Change to Data Element: Changed Description, Name, Dataset, linked Attribute, status to Retired

~~**This item has been retired from the NHS Data Model and Dictionary.**~~

~~**The last live version of this item is available in the November 2012 release of the NHS Data Model and Dictionary.**~~

~~**Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.**~~

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

Notes:
CARE PLAN AGREED DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'Care Plan Agreed Date'*.

CARE PLAN AGREED DATE renamed from CARE PLAN AGREED DATE (RETIRED)

Change to Data Element: Changed Description, Name, Dataset, linked Attribute, status to Retired

CARE PLAN AGREED DATE

Attribute:

ACTIVITY DATE

CARE PLAN AGREED DATE renamed from CARE PLAN AGREED DATE (RETIRED)

Change to Data Element: Changed Description, Name, Dataset, linked Attribute, status to Retired

- Changed Description
- Changed Name from Retired.Data_Dictionary.Data_Field_Notes.C.CARE_PLAN_AGREED_DATE to Data_Dictionary.Data_Field_Notes.C.Care.CARE_PLAN_AGREED_DATE
- null
- null
- Retired CARE PLAN AGREED DATE (retired)

CARE PLAN CREATION DATE

Change to Data Element: New Data Element

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

Notes:
CARE PLAN CREATION DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'Care Plan Creation Date'*.

This data element is also known by these names:

Context	Alias
plural	CARE PLAN CREATION DATES

CARE PLAN CREATION DATE

Change to Data Element: New Data Element

CARE PLAN CREATION DATE

Attribute:

ACTIVITY DATE

CARE PLAN IDENTIFIER

Change to Data Element: New Data Element

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

Notes:
CARE PLAN IDENTIFIER is the same as attribute CARE PLAN IDENTIFIER.

This data element is also known by these names:

Context	Alias
plural	CARE PLAN IDENTIFIERS

CARE PLAN IDENTIFIER

Change to Data Element: New Data Element

CARE PLAN IDENTIFIER

Attribute:

CARE PLAN IDENTIFIER

CARE PLAN IMPLEMENTATION DATE

Change to Data Element: New Data Element

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

Notes:
CARE PLAN IMPLEMENTATION DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Care Plan Implementation Date*'.

This data element is also known by these names:

Context	Alias
plural	CARE PLAN IMPLEMENTATION DATES

CARE PLAN IMPLEMENTATION DATE

Change to Data Element: New Data Element

CARE PLAN IMPLEMENTATION DATE

Attribute:

ACTIVITY DATE

CARE PLAN LAST UPDATED DATE

Change to Data Element: New Data Element

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

Notes:

CARE PLAN LAST UPDATED DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Care Plan Last Updated Date*'.

For the Mental Health Services Data Set, where the CARE PLAN has not been updated since its creation, the CARE PLAN LAST UPDATED DATE will be the same as CARE PLAN CREATION DATE.

This data element is also known by these names:

Context	Alias
plural	CARE PLAN LAST UPDATED DATES

CARE PLAN LAST UPDATED DATE

Change to Data Element: New Data Element

CARE PLAN LAST UPDATED DATE

Attribute:

ACTIVITY DATE

CARE PLAN TYPE (MENTAL HEALTH)

Change to Data Element: New Data Element

Format/Length:	an1
National Codes:	See CARE PLAN TYPE FOR MENTAL HEALTH
Default Codes:	

Notes:
CARE PLAN TYPE (MENTAL HEALTH) is the same as attribute CARE PLAN TYPE FOR MENTAL HEALTH.

This data element is also known by these names:

Context	Alias
plural	CARE PLAN TYPES (MENTAL HEALTH)

CARE PLAN TYPE (MENTAL HEALTH)

Change to Data Element: New Data Element

CARE PLAN TYPE (MENTAL HEALTH)

Attribute:

CARE PLAN TYPE FOR MENTAL HEALTH

CARE PROFESSIONAL (JOB ROLE CODE)

Change to Data Element: Changed Dataset

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

Notes:
CARE PROFESSIONAL (JOB ROLE CODE) is the same as attribute JOB ROLE CODE.

CARE PROFESSIONAL LOCAL IDENTIFIER

Change to Data Element: Changed Dataset

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

Notes:
CARE PROFESSIONAL LOCAL IDENTIFIER is the same as attribute CARE PROFESSIONAL IDENTIFIER.

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

CARE PROFESSIONAL ROLE CODE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See CARE PROFESSIONAL ROLE CODE FOR IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES
Default Codes:	

Notes:
CARE PROFESSIONAL ROLE CODE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES) is the same as attribute CARE PROFESSIONAL ROLE CODE FOR IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES.

CARE PROFESSIONAL SERVICE OR TEAM TYPE ASSOCIATION (MENTAL HEALTH)

Change to Data Element: Changed Dataset

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

Notes:
CARE PROFESSIONAL SERVICE OR TEAM TYPE ASSOCIATION (MENTAL HEALTH) is the same as attribute SERVICE OR TEAM TYPE FOR MENTAL HEALTH.

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

CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH)

Change to Data Element: Changed Dataset

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

Notes:
CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH) is the same as attribute CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH.

CARE PROFESSIONAL TEAM LOCAL IDENTIFIER

Change to Data Element: Changed Dataset

Format/Length:	max an20
National Codes:	

Default Codes:	

Notes:
CARE PROFESSIONAL TEAM LOCAL IDENTIFIER is the same as attribute CARE PROFESSIONAL TEAM IDENTIFIER.

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

CARE PROGRAMME APPROACH CARE EPISODE IDENTIFIER

Change to Data Element: Changed Dataset

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

Notes:
CARE PROGRAMME APPROACH CARE EPISODE IDENTIFIER is the same as attribute ACTIVITY IDENTIFIER.

CARE PROGRAMME APPROACH CARE EPISODE IDENTIFIER is a unique identifier allocated to each Care Programme Approach Care Episode.

CARE PROGRAMME APPROACH REVIEW ABUSE QUESTION ASKED INDICATOR

Change to Data Element: Changed Dataset

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

Notes:
CARE PROGRAMME APPROACH REVIEW ABUSE QUESTION ASKED INDICATOR is the same as attribute CARE PROGRAMME APPROACH REVIEW ABUSE QUESTION ASKED INDICATOR.

CARE PROGRAMME APPROACH REVIEW DATE

Change to Data Element: Changed Dataset

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

Notes:
CARE PROGRAMME APPROACH REVIEW DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Care Programme Approach Review Date*'.

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL) (RETIRED)_ renamed from CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL)

Change to Data Element: Changed Description, Name, Dataset, linked Attribute, status to Retired

~~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 (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.**This item has been retired from the NHS Data Model and Dictionary.**

Note: This data item is included in the Mental Health Services Data Set, but should not be submitted until further development by NHS Digital has been undertaken.The last live version of this item is available in the ?????? release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL) (RETIRED) renamed from CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL)

Change to Data Element: Changed Description, Name, Dataset, linked Attribute, status to Retired

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 (FINAL) (RETIRED) renamed from CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL)

Change to Data Element: Changed Description, Name, Dataset, linked Attribute, status to Retired

- Changed Description
- Changed Name from Data_Dictionary.Data_Field_Notes.C.Ce.CHILD_AND_ADOLESCENT_MENTAL_HEALTH_CARE_CLUSTER_CO (FINAL) to Retired.Data_Dictionary.Data_Field_Notes.C.CHILD_AND_ADOLESCENT_MENTAL_HEALTH_CARE_CLUSTEF (FINAL)
- null
- null
- Retired CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (FINAL)

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL) (RETIRED) renamed from CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL)

Change to Data Element: Changed Description, Name, Dataset, linked Attribute, status to Retired

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~~**.This item has been retired from the NHS Data Model and Dictionary.**

~~Note: This data item is included in the~~ ~~Mental Health Services Data Set~~~~, but should not be submitted until further development by~~ ~~NHS Digital~~ ~~has been undertaken.~~The last live version of this item is available in the ?????? release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL) (RETIRED)_ renamed from CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL)

Change to Data Element: Changed Description, Name, Dataset, linked Attribute, status to Retired

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

~~**Attribute:**~~

~~CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE~~

CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL) (RETIRED)_ renamed from CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL)

Change to Data Element: Changed Description, Name, Dataset, linked Attribute, status to Retired

- Changed Description
- Changed Name from Data_Dictionary.Data_Field_Notes.C.Ce.CHILD_AND_ADOLESCENT_MENTAL_HEALTH_CARE_CLUSTER_CO (INITIAL) to Retired.Data_Dictionary.Data_Field_Notes.C.CHILD_AND_ADOLESCENT_MENTAL_HEALTH_CARE_CLUSTEF (INITIAL)
- null
- null
- Retired CHILD AND ADOLESCENT MENTAL HEALTH CARE CLUSTER CODE (INITIAL)

CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE

Change to Data Element: New Data Element

Format/Length:	an3
National Codes:	See CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE
Default Codes:	

Notes:
CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE is the same as attribute CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE.

This data element is also known by these names:

Context	Alias
plural	CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODES

CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE

Change to Data Element: New Data Element

CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE

Attribute:

CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE

CHILD AND ADOLESCENT MENTAL HEALTH TIER OF SERVICE

Change to Data Element: Changed Description, Dataset

Format/Length:	an1
National Codes:	See CHILD AND ADOLESCENT MENTAL HEALTH TIER OF SERVICE
~~Default Codes:~~	
Default Codes:	9 - Child and Adolescent Mental Health Service (CAMHS) Unspecified Tier

Notes:
CHILD AND ADOLESCENT MENTAL HEALTH TIER OF SERVICE is the same as attribute CHILD AND ADOLESCENT MENTAL HEALTH TIER OF SERVICE.

CHILD PROTECTION PLAN INDICATION CODE

Change to Data Element: Changed Dataset

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

Notes:
CHILD PROTECTION PLAN INDICATION CODE is the same as attribute CHILD PROTECTION PLAN INDICATION CODE.

CLINICAL CONTACT DURATION OF APPOINTMENT

Change to Data Element: Changed Dataset

Format/Length:	max n3
National Codes:	
Default Codes:	

Notes:
CLINICAL CONTACT DURATION OF APPOINTMENT is the duration of the direct clinical contact at an APPOINTMENT in minutes, excluding any administration time prior to or after the contact and excluding the CARE PROFESSIONAL's travelling time to an APPOINTMENT.

CLINICAL CONTACT DURATION OF APPOINTMENT is calculated from the Start Time and End Time of the clinical contact at an APPOINTMENT.

CLINICAL CONTACT DURATION OF CARE ACTIVITY

Change to Data Element: Changed Dataset

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

Notes:
CLINICAL CONTACT DURATION OF CARE ACTIVITY is the duration of a CARE ACTIVITY in minutes, excluding any

administration time prior to or after the CARE ACTIVITY and the CARE PROFESSIONAL's travelling time to the LOCATION where the CARE ACTIVITY was provided.

CLINICAL CONTACT DURATION OF CARE ACTIVITY is calculated from the Start Time and End Time of the CARE ACTIVITY.

CLINICAL CONTACT DURATION OF CARE CONTACT

Change to Data Element: Changed Dataset

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

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

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

CLINICAL CONTACT DURATION OF CARE CONTACT is calculated from the Start Time and End Time of the CARE CONTACT.

CLINICAL CONTACT DURATION OF GROUP SESSION

Change to Data Element: Changed Dataset

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

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

CLINICAL CONTACT DURATION OF GROUP SESSION is calculated from the Start Time and End Time of the Group Session.

CLINICAL RESPONSE PRIORITY TYPE

Change to Data Element: Changed Dataset

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

Notes:
CLINICAL RESPONSE PRIORITY TYPE is the same as attribute CLINICAL RESPONSE PRIORITY TYPE.

CLUSTERING TOOL ASSESSMENT CATEGORY

Change to Data Element: Changed Dataset

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

Notes:
CLUSTERING TOOL ASSESSMENT CATEGORY is the same as attribute CLUSTERING TOOL ASSESSMENT CATEGORY.

CLUSTERING TOOL ASSESSMENT IDENTIFIER

Change to Data Element: Changed Dataset

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

Notes:
CLUSTERING TOOL ASSESSMENT IDENTIFIER is the same as attribute ACTIVITY IDENTIFIER.

CLUSTERING TOOL ASSESSMENT IDENTIFIER is a unique identifier for each Clustering Tool assessment that takes place for each PATIENT.

CLUSTERING TOOL ASSESSMENT REASON

Change to Data Element: Changed Dataset

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

Notes:
CLUSTERING TOOL ASSESSMENT REASON is the same as attribute CLUSTERING TOOL ASSESSMENT REASON.

CODED ASSESSMENT TOOL TYPE (SNOMED CT)

Change to Data Element: Changed Dataset

Format/Length:	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.

CODED FINDING (CODED CLINICAL ENTRY)

Change to Data Element: Changed Dataset

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

Notes:
CODED FINDING (CODED CLINICAL ENTRY) is the same as attribute CLINICAL CLASSIFICATION CODE or CLINICAL TERMINOLOGY CODE.

CODED FINDING (CODED CLINICAL ENTRY) is the CODED CLINICAL ENTRY which is used to identify a finding.

CODED OBSERVATION (CLINICAL TERMINOLOGY)

Change to Data Element: Changed Dataset

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

Notes:
CODED OBSERVATION (CLINICAL TERMINOLOGY) is the same as attribute CLINICAL TERMINOLOGY CODE.

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

CODED PROCEDURE (CLINICAL TERMINOLOGY)

Change to Data Element: Changed Dataset

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

Notes:
CODED PROCEDURE (CLINICAL TERMINOLOGY) is the same as attribute CLINICAL TERMINOLOGY CODE.

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

COMMUNITY TREATMENT ORDER END REASON

Change to Data Element: Changed Dataset

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

Notes:
COMMUNITY TREATMENT ORDER END REASON is the same as attribute COMMUNITY TREATMENT ORDER END REASON.

CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR

Change to Data Element: Changed Dataset

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

Notes:
CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR is the same as attribute CONSTANT SUPERVISION AND CARE REQUIRED DUE TO DISABILITY INDICATOR.

CONSULTATION MEDIUM USED

Change to Data Element: Changed Dataset

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

Notes:
CONSULTATION MEDIUM USED is the same as attribute CONSULTATION MEDIUM USED.

CONSULTATION TYPE

Change to Data Element: Changed Dataset

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

Notes:
CONSULTATION TYPE is the same as attribute CONSULTATION TYPE.

DATA SET VERSION NUMBER

Change to Data Element: Changed Dataset

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

Notes:
DATA SET VERSION NUMBER is the version number of a Data Set.

DATE AND TIME DATA SET CREATED

Change to Data Element: Changed Dataset

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

Notes:
DATE AND TIME DATA SET CREATED is the same as data element DATE AND TIME.

DATE AND TIME DATA SET CREATED is the DATE AND TIME a data set was created.

DATE OF ASSAULT ON PATIENT

Change to Data Element: Changed Dataset

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

Notes:
DATE OF ASSAULT ON PATIENT is the DATE that an instance of assault occurred on the PATIENT by another PATIENT.

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

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

DATE OF RESTRICTIVE INTERVENTION

Change to Data Element: Changed Dataset

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

Notes:
DATE OF RESTRICTIVE INTERVENTION is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Date of Restrictive Intervention*'.

DATE OF SELF-HARM

Change to Data Element: Changed Dataset

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

Notes:
DATE OF SELF-HARM is the DATE that an incident of self-harm by a PATIENT occurred.

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

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

DECISION TO REFER DATE (ONWARD REFERRAL)

Change to Data Element: New Data Element

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

Notes:
DECISION TO REFER DATE (ONWARD REFERRAL) is the same as attribute DECISION TO REFER DATE.

DECISION TO REFER DATE (ONWARD REFERRAL) is the DATE on which a decision was made to refer the PATIENT from one SERVICE to another SERVICE, which may be in the same or a different Organisation.

This data element is also known by these names:

Context	Alias
plural	DECISION TO REFER DATES (ONWARD REFERRAL)

DECISION TO REFER DATE (ONWARD REFERRAL)

Change to Data Element: New Data Element

DECISION TO REFER DATE (ONWARD REFERRAL)

Attribute:

DECISION TO REFER DATE

DECISION TO REFER TIME (ONWARD REFERRAL)

Change to Data Element: New Data Element

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

Notes:
DECISION TO REFER TIME (ONWARD REFERRAL) is the same as attribute DECISION TO REFER TIME.

DECISION TO REFER TIME (ONWARD REFERRAL) is the TIME on which a decision was made to refer the PATIENT from one SERVICE to another SERVICE, which may be in the same or a different Organisation.

This data element is also known by these names:

Context	Alias
plural	DECISION TO REFER TIMES (ONWARD REFERRAL)

DECISION TO REFER TIME (ONWARD REFERRAL)

Change to Data Element: New Data Element

DECISION TO REFER TIME (ONWARD REFERRAL)

Attribute:

DECISION TO REFER TIME

DIAGNOSIS DATE

Change to Data Element: Changed Dataset

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

Notes:
DIAGNOSIS DATE is the PERSON PROPERTY OBSERVED DATE for the PATIENT DIAGNOSIS.

DIAGNOSIS SCHEME IN USE

Change to Data Element: Changed Dataset

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

Notes:
DIAGNOSIS SCHEME IN USE is the same as attribute DIAGNOSIS SCHEME IN USE.

DISABILITY CODE

Change to Data Element: Changed Dataset

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

Notes:
DISABILITY CODE is the same as attribute DISABILITY CODE.

DISABILITY IMPACT PERCEPTION

Change to Data Element: Changed Dataset

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

Notes:
DISABILITY IMPACT PERCEPTION is the same as attribute DISABILITY IMPACT PERCEPTION.

DISCHARGE DATE (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Dataset

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

Notes:
DISCHARGE DATE (HOSPITAL PROVIDER SPELL) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'Discharge Date'*.

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

DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See DISCHARGE DESTINATION
Default Codes:	98 - Not applicable - Hospital Provider Spell not finished at episode end (i.e. not discharged) or current episode unfinished 99 - Not known: a validation error

Notes:
DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL) is the same as attribute DISCHARGE DESTINATION.

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

For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

DISCHARGE LETTER ISSUED DATE (MENTAL HEALTH AND COMMUNITY CARE)

Change to Data Element: Changed Dataset

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

Notes:

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

DISCHARGE METHOD CODE (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Dataset

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

Notes:
DISCHARGE METHOD CODE (HOSPITAL PROVIDER SPELL) is the same as attribute DISCHARGE METHOD.

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

For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

DISCHARGE PLAN AGREED BY

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See DISCHARGE PLAN AGREED BY
Default Codes:	

Notes:
DISCHARGE PLAN AGREED BY is the same as attribute DISCHARGE PLAN AGREED BY.

This data element is also known by these names:

Context	Alias
plural	DISCHARGE PLANS AGREED BY

DISCHARGE PLAN AGREED BY

Change to Data Element: New Data Element

DISCHARGE PLAN AGREED BY

Attribute:

DISCHARGE PLAN AGREED BY

DISCHARGE PLAN AGREED DATE

Change to Data Element: New Data Element

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

Notes:

DISCHARGE PLAN AGREED DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Care Plan Agreed Date*'.

DISCHARGE PLAN AGREED DATE is the DATE on which the Discharge Plan was agreed by a PATIENT or Patient Proxy.

This data element is also known by these names:

Context	Alias
plural	DISCHARGE PLAN AGREED DATES

DISCHARGE PLAN AGREED DATE

Change to Data Element: New Data Element

DISCHARGE PLAN AGREED DATE

Attribute:

ACTIVITY DATE

DISCHARGE PLAN CREATION DATE

Change to Data Element: New Data Element

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

Notes:
DISCHARGE PLAN CREATION DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Care Plan Creation Date*'.

DISCHARGE PLAN CREATION DATE is the DATE that a Discharge Plan was created.

This data element is also known by these names:

Context	Alias
plural	DISCHARGE PLAN CREATION DATES

DISCHARGE PLAN CREATION DATE

Change to Data Element: New Data Element

DISCHARGE PLAN CREATION DATE

Attribute:

ACTIVITY DATE

DISCHARGE PLAN LAST UPDATED DATE

Change to Data Element: New Data Element

Format/Length:	See DATE

National Codes:
Default Codes:

Notes:
DISCHARGE PLAN LAST UPDATED DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Care Plan Last Updated Date*'.

DISCHARGE PLAN LAST UPDATED DATE is the DATE that a Discharge Plan was last updated.

For the Mental Health Services Data Set, where the Discharge Plan has not been updated since its creation, the DISCHARGE PLAN LAST UPDATED DATE will be the same as DISCHARGE PLAN CREATION DATE.

This data element is also known by these names:

Context	Alias
plural	DISCHARGE PLAN LAST UPDATED DATES

DISCHARGE PLAN LAST UPDATED DATE

Change to Data Element: New Data Element

DISCHARGE PLAN LAST UPDATED DATE

Attribute:

ACTIVITY DATE

DISCHARGE TIME (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Dataset

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

Notes:
DISCHARGE TIME (HOSPITAL PROVIDER SPELL) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Discharge Time*'.

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

DURATION OF INDIRECT ACTIVITY

Change to Data Element: Changed Dataset

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

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

DURATION OF INDIRECT ACTIVITY is calculated from the Start Time and End Time of the Indirect Activity.

DURATION OF RESTRICTIVE INTERVENTION

Change to Data Element: Changed Description, Dataset

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 RESTRICTIVE INTERVENTION 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.~~DURATION OF RESTRICTIVE INTERVENTION is calculated from the Start Time and End Time of the Restrictive Intervention.

EARLIEST CLINICALLY APPROPRIATE DATE

Change to Data Element: Changed Dataset

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

Notes:
EARLIEST CLINICALLY APPROPRIATE DATE is the earliest DATE that it was clinically appropriate for an ACTIVITY to take place.

For the Radiotherapy Data Set, EARLIEST CLINICALLY APPROPRIATE DATE is the:

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

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

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

EARLIEST REASONABLE OFFER DATE

Change to Data Element: Changed Dataset

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

Notes:
EARLIEST REASONABLE OFFER DATE is the date of the earliest of the Reasonable Offers made to a PATIENT for

an APPOINTMENT or Elective Admission. It should only be included on the Commissioning Data Sets where the PATIENT has declined at least two Reasonable Offers, and a Patient Pause is to be applied to the length of wait calculation performed by the Secondary Uses Service.

For an APPOINTMENT this is the earliest of the APPOINTMENT DATES OFFERED where the REASONABLE OFFER INDICATOR of the APPOINTMENT OFFER is National Code '*Reasonable Offer*'.

For an OFFER OF ADMISSION this is the earliest of the OFFERED FOR ADMISSION DATES where the REASONABLE OFFER INDICATOR of the OFFER OF ADMISSION is National Code '*Reasonable Offer*'.

Patient Cancellations
Where, for any reason, a PATIENT cancels or does not attend an APPOINTMENT or an OFFER OF ADMISSION the EARLIEST REASONABLE OFFER DATE for the rearranged APPOINTMENT or OFFER OF ADMISSION will be the EARLIEST REASONABLE OFFER DATE of the cancelled APPOINTMENT or OFFER OF ADMISSION.

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

Patients who are unavailable
Where a PATIENT makes themself 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, Children and Young People's Health Services Data Set, Mental Health Services Data Set and Commissioning Data Sets (version 6-2 onwards) for Allied Health Professional Referral To Treatment:

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

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

EMERGENT PSYCHOSIS DATE

Change to Data Element: Changed Dataset

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

Notes:
EMERGENT PSYCHOSIS DATE is the same as attribute PERSON PROPERTY OBSERVED DATE.

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

EMPLOYMENT STATUS

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See EMPLOYMENT STATUS
Default Codes:	

Notes:
EMPLOYMENT STATUS is the same as attribute EMPLOYMENT STATUS.

EMPLOYMENT STATUS RECORDED DATE

Change to Data Element: Changed Dataset

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

Notes:
EMPLOYMENT STATUS RECORDED DATE is the same as attribute PERSON PROPERTY RECORDED DATE.

EMPLOYMENT STATUS RECORDED DATE is the DATE when the EMPLOYMENT STATUS was recorded.

EMPLOYMENT SUPPORT REFERRAL DATE

Change to Data Element: Changed Dataset

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

Notes:
EMPLOYMENT SUPPORT REFERRAL DATE is the date the PATIENT was referred for Employment Support.

EMPLOYMENT SUPPORT SUITABILITY INDICATOR

Change to Data Element: Changed Dataset

Format/Length:	max an2
National Codes:	See EMPLOYMENT SUPPORT SUITABILITY INDICATOR
Default Codes:	NA - Not Applicable

Notes:
EMPLOYMENT SUPPORT SUITABILITY INDICATOR is the same as attribute EMPLOYMENT SUPPORT SUITABILITY INDICATOR.

END DATE (CARE CLUSTER ASSIGNMENT PERIOD)

Change to Data Element: Changed Dataset

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

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

END DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)

Change to Data Element: Changed Dataset

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

Notes:
END DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*End Date*' of the Care Professional Admitted Care Episode.

END DATE (CARE PROGRAMME APPROACH CARE)

Change to Data Element: Changed Dataset

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

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

END DATE (COMMISSIONER ASSIGNMENT PERIOD)

Change to Data Element: Changed Dataset

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

Notes:
END DATE (COMMISSIONER ASSIGNMENT PERIOD) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*End Date*' of the Commissioner Assignment Period.

END DATE (COMMUNITY TREATMENT ORDER)

Change to Data Element: Changed Dataset

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

Notes:
END DATE (COMMUNITY TREATMENT ORDER) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*End Date*' of the Community Treatment Order.

END DATE (COMMUNITY TREATMENT ORDER RECALL)

Change to Data Element: Changed Dataset

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

Notes:
END DATE (COMMUNITY TREATMENT ORDER RECALL) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*End Date*' of the Community Treatment Order Recall.

END DATE (GMP PATIENT REGISTRATION)

Change to Data Element: Changed Dataset

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

Notes:
END DATE (GMP PATIENT REGISTRATION) is the same as END DATE.

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

END DATE (HOME LEAVE)

Change to Data Element: Changed Dataset

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

Notes:
END DATE (HOME LEAVE) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*End Date*' of the Home Leave.

END DATE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)

Change to Data Element: Changed Dataset

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

Notes:
END DATE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code *'End Date'*.

END DATE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES) is the date the PATIENT is deemed by the CARE PROFESSIONAL to have completed treatment and discharged from the Improving Access to Psychological Therapies Service.

END DATE (MENTAL HEALTH ABSENCE WITHOUT LEAVE)

Change to Data Element: Changed Dataset

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

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

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

Change to Data Element: Changed Dataset

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

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

END DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD)

Change to Data Element: Changed Dataset

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

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

END DATE (MENTAL HEALTH CONDITIONAL DISCHARGE)

Change to Data Element: Changed Dataset

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

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

END DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD)

Change to Data Element: Changed Dataset

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

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

END DATE (MENTAL HEALTH LEAVE OF ABSENCE)

Change to Data Element: Changed Dataset

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

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

END DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD)

Change to Data Element: Changed Dataset

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

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

END DATE (WARD STAY)

Change to Data Element: Changed Dataset

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

Notes:
END DATE (WARD STAY) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*End Date*' of the Ward Stay.

END TIME (CARE CLUSTER ASSIGNMENT PERIOD)

Change to Data Element: Changed Dataset

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

Notes:
END TIME (CARE CLUSTER ASSIGNMENT PERIOD) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*End Time*' of a Care Cluster Assignment Period.

END TIME (COMMUNITY TREATMENT ORDER RECALL)

Change to Data Element: Changed Dataset

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

Notes:
END TIME (COMMUNITY TREATMENT ORDER RECALL) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*End Time*' of the Community Treatment Order Recall.

END TIME (HOME LEAVE)

Change to Data Element: Changed Dataset

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

Notes:
END TIME (HOME LEAVE) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*End Time*' of the Home Leave.

END TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE)

Change to Data Element: Changed Dataset

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

Notes:
END TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*End Time*' of the Mental Health Absence Without Leave.

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

Change to Data Element: Changed Dataset

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

Notes:
END TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*End Time*' of the Mental Health Act Legal Status Classification Assignment Period.

END TIME (MENTAL HEALTH LEAVE OF ABSENCE)

Change to Data Element: Changed Dataset

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

Notes:
END TIME (MENTAL HEALTH LEAVE OF ABSENCE) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*End Time*' of the Mental Health Leave of Absence.

END TIME (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
NWDS ID:	PETH
NWDS Field Name:	Ethnic Category
ESR Field Name:	Ethnic Origin
National Codes:	See ETHNIC CATEGORY CODE
Default Codes:	99 - Not known

Notes:
ETHNIC CATEGORY is the same as attribute ETHNIC CATEGORY CODE.

The 16+1 ethnic data categories defined in the 2001 census is the national mandatory standard for the collection and analysis of ethnicity.

The national code must be transmitted as the first character in the 2 character field. The second character is optional for use locally. It must, however, be able to be grouped consistently with the 16 main categories.

National code Z should be used where the PERSON has been given the opportunity to state their ETHNIC CATEGORY but chose not to. Default code 99 should be used where the PERSON's ETHNIC CATEGORY is not known.

EX-BRITISH ARMED FORCES INDICATOR

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See EX-BRITISH ARMED FORCES INDICATOR
Default Codes:	

Notes:
EX-BRITISH ARMED FORCES INDICATOR is the same as attribute EX-BRITISH ARMED FORCES INDICATOR.

EXPIRY DATE (COMMUNITY TREATMENT ORDER)

Change to Data Element: Changed Dataset

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

Notes:
EXPIRY DATE (COMMUNITY TREATMENT ORDER) is the same as attribute PERSON PROPERTY EFFECTIVE END DATE.

EXPIRY DATE (COMMUNITY TREATMENT ORDER) is the DATE when a Community Treatment Order for a PATIENT expires.

EXPIRY DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)

Change to Data Element: Changed Dataset

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

Notes:
EXPIRY DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION) is the same as attribute PERSON PROPERTY EFFECTIVE END DATE.

EXPIRY DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION) is the DATE when a MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION for a PATIENT expires.

EXPIRY TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)

Change to Data Element: Changed Dataset

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

Notes:
END TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD) is the same as attribute PERSON PROPERTY EFFECTIVE END TIME.

END TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD) is the TIME when a MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION for a PATIENT expires.

FACE TO FACE COMMUNICATION MODE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See FACE TO FACE COMMUNICATION MODE
Default Codes:	

Notes:
FACE TO FACE COMMUNICATION MODE is the same as attribute FACE TO FACE COMMUNICATION MODE.

FINDING SCHEME IN USE

Change to Data Element: Changed Dataset

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

Notes:
FINDING SCHEME IN USE is the same as attribute FINDING SCHEME IN USE.

FIRST PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION)

Change to Data Element: Changed Dataset

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

Notes:
FIRST PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION) is the same as attribute PRESCRIPTION DATE.

FIRST PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION) is the date the PATIENT was first prescribed Anti-Psychotic Medication following referral into an Early Intervention in Psychosis (EIP) Service.

FIVE FORENSIC PATHWAYS ASSESSMENT DATE

Change to Data Element: New Data Element

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

Notes:
FIVE FORENSIC PATHWAYS ASSESSMENT DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Five Forensic Pathways Assessment Date*'.

This data element is also known by these names:

Context	Alias
plural	FIVE FORENSIC PATHWAYS ASSESSMENT DATES

FIVE FORENSIC PATHWAYS ASSESSMENT DATE

Change to Data Element: New Data Element

FIVE FORENSIC PATHWAYS ASSESSMENT DATE

Attribute:

ACTIVITY DATE

FIVE FORENSIC PATHWAYS ASSESSMENT REASON

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See FIVE FORENSIC PATHWAYS ASSESSMENT REASON
Default Codes:	99 - Not known (Not Recorded)

Notes:
FIVE FORENSIC PATHWAYS ASSESSMENT REASON is the same as attribute FIVE FORENSIC PATHWAYS ASSESSMENT REASON.

This data element is also known by these names:

Context	Alias
plural	FIVE FORENSIC PATHWAYS ASSESSMENT REASONS

FIVE FORENSIC PATHWAYS ASSESSMENT REASON

Change to Data Element: New Data Element

FIVE FORENSIC PATHWAYS ASSESSMENT REASON

Attribute:

FIVE FORENSIC PATHWAYS ASSESSMENT REASON

FIVE FORENSIC PATHWAYS CODE

Change to Data Element: New Data Element

Format/Length:	an1
National Codes:	See FIVE FORENSIC PATHWAYS CODE
Default Codes:	

Notes:
FIVE FORENSIC PATHWAYS CODE is the same as attribute FIVE FORENSIC PATHWAYS CODE.

This data element is also known by these names:

Context	Alias
plural	FIVE FORENSIC PATHWAYS CODES

FIVE FORENSIC PATHWAYS CODE

Change to Data Element: New Data Element

FIVE FORENSIC PATHWAYS CODE

Attribute:

FIVE FORENSIC PATHWAYS CODE

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)

Change to Data Element: Changed Dataset

Format/Length:	max an4
National Codes:	See FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE
Default Codes:	

Notes:
FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (FINAL) is the same as attribute FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE.

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (FINAL) is the final FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE allocated by the CARE PROFESSIONAL.

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

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)

Change to Data Element: Changed Dataset

Format/Length:	max an4
National Codes:	See FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE
Default Codes:	

Notes:
FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL) is the same as attribute FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE.

FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL) is the initial FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE allocated by the CARE PROFESSIONAL.

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

FORENSIC MENTAL HEALTH CARE CLUSTER CODE (FINAL)

Change to Data Element: Changed Description, Dataset

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 NHS Digital has been undertaken.**~~

FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL) (RETIRED) renamed from FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL)

Change to Data Element: Changed Description, Name, Dataset, linked Attribute, status to Retired

~~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.~~ **This item has been retired from the NHS Data Model and Dictionary.**

~~FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL) is the initial FORENSIC MENTAL HEALTH CARE CLUSTER CODE allocated by the CARE PROFESSIONAL.~~**The last live version of this item is available in the ?????? release of the NHS Data Model and Dictionary.**

~~**Note: This data item is included in the Mental Health Services Data Set, but should not be submitted until further development by NHS Digital has been undertaken.**~~**Access to this version can be obtained by emailing information.**standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL) (RETIRED) renamed from FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL)

Change to Data Element: Changed Description, Name, Dataset, linked Attribute, status to Retired

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

~~**Attribute:**~~

~~FORENSIC MENTAL HEALTH CARE CLUSTER CODE~~

FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL) (RETIRED)_ renamed from FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL)

Change to Data Element: Changed Description, Name, Dataset, linked Attribute, status to Retired

- Changed Description
- Changed Name from Data_Dictionary.Data_Field_Notes.F.Fo.FORENSIC_MENTAL_HEALTH_CARE_CLUSTER_CODE_(INITIAL) to Retired.Data_Dictionary.Data_Field_Notes.F.FORENSIC_MENTAL_HEALTH_CARE_CLUSTER_CODE_(INITIAL)
- null
- null
- Retired FORENSIC MENTAL HEALTH CARE CLUSTER CODE (INITIAL)

GENERALISED ANXIETY DISORDER PENN STATE WORRY SCORE

Change to Data Element: Changed Dataset

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

Notes:
GENERALISED ANXIETY DISORDER PENN STATE WORRY SCORE is the PERSON SCORE for an APPOINTMENT where the ASSESSMENT TOOL TYPE is '*Generalised Anxiety Disorder Penn State Worry Questionnaire*'.

The score is in the range 16 to 80.

If one or two values are missing from the score, then they can be substituted with the average score of the non-missing items. Questionnaires with more than two missing values should be disregarded.

GENERALISED ANXIETY DISORDER SCORE

Change to Data Element: Changed Dataset

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

Notes:
GENERALISED ANXIETY DISORDER SCORE is the PERSON SCORE for an APPOINTMENT where the ASSESSMENT TOOL TYPE is '*Generalised Anxiety Disorder Questionnaire*'.

The score is in the range 0 to 21.

If one or two values are missing from the score, then they can be substituted with the average score of the non-missing items. Questionnaires with more than two missing values should be disregarded.

GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)

Change to Data Element: Changed Dataset

Format/Length:	an6
National Codes:	
ODS Default Codes:	V81997 - No Registered GP Practice V81998 - GP Practice Code not applicable

V81999 - GP Practice Code not known

Notes:
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION) is the same as attribute ORGANISATION CODE.

The data for GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION) is supplied by the NHS Prescription Services.

GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION) is the ORGANISATION CODE of the GP Practice that the PATIENT is registered with.

Use of Organisation Data Service Default Codes

- **V81997** should be used when a PATIENT presents, who is not currently registered at a GP Practice, *but is eligible to be registered should they wish to.*
- **V81998** should be used where a PATIENT should not have a registered GP Practice, due for instance to them having only recently entered the country.
- **V81999** should be used where it is not possible to determine a PATIENT's registered GP Practice code, but it is known that they should have one, or where it is impossible to determine whether they should or shouldn't have a registered practice (for instance the PATIENT cannot communicate and is unidentified).

GROUP SESSION DATE

Change to Data Element: Changed Dataset

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

Notes:
GROUP SESSION DATE is the SESSION DATE of the Group Session.

GROUP SESSION IDENTIFIER

Change to Data Element: Changed Dataset

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

Notes:
GROUP SESSION IDENTIFIER is the ACTIVITY IDENTIFIER for a Group Session.

GROUP SESSION TYPE (MENTAL HEALTH)

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See GROUP SESSION TYPE FOR MENTAL HEALTH
Default Codes:	

Notes:
GROUP SESSION TYPE (MENTAL HEALTH) is the same as attribute GROUP SESSION TYPE FOR MENTAL HEALTH.

GROUP THERAPY INDICATOR

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See GROUP THERAPY INDICATOR
Default Codes:	Z - Not Known if the ACTIVITY was Group Therapy

Notes:
GROUP THERAPY INDICATOR is the same as attribute GROUP THERAPY INDICATOR.

HEALTH ANXIETY INVENTORY SHORT WEEK SCALE SCORE

Change to Data Element: Changed Dataset

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

Notes:
HEALTH ANXIETY INVENTORY SHORT WEEK SCALE SCORE is the PERSON SCORE for an APPOINTMENT where the ASSESSMENT TOOL TYPE is '*Health Anxiety Inventory Short Week Scale*'.

The score is in the range 0 to 54.

HOSPITAL PROVIDER SPELL NUMBER

Change to Data Element: Changed Dataset

Format/Length:	an12
National Codes:	
Default Codes:	

Notes:
HOSPITAL PROVIDER SPELL NUMBER is the same as attribute ACTIVITY IDENTIFIER.

A HOSPITAL PROVIDER SPELL NUMBER is a unique identifier for each Hospital Provider Spell for a Health Care Provider.

HOSPITAL PROVIDER SPELL NUMBER is used by the Secondary Uses Service to derive the **Healthcare Resource Group 4**. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ACTIVITY SUSPENSION IDENTIFIER

Change to Data Element: Changed Dataset

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

Notes:
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ACTIVITY SUSPENSION IDENTIFIER is the same as attribute ACTIVITY SUSPENSION IDENTIFIER.

For the Improving Access to Psychological Therapies Data Set, IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ACTIVITY SUSPENSION IDENTIFIER is:

- used to uniquely identify the period of PATIENT initiated ACTIVITY SUSPENSION

- is locally generated and does not need to be sequential.

See the NHS Digital website at: Improving Access to Psychological Therapies Data Set for details of how this identifier is generated.

IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ACTIVITY SUSPENSION REASON

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ACTIVITY SUSPENSION REASON
Default Codes:	

Notes:
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ACTIVITY SUSPENSION REASON is same as attribute IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ACTIVITY SUSPENSION REASON.

IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ASSESSMENT CHOICE PATIENT EXPERIENCE QUESTION 1

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	
Default Codes:	

Notes:
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ASSESSMENT CHOICE PATIENT EXPERIENCE QUESTION 1 is the PERSON SCORE for question 1 of the *Improving Access to Psychological Therapies Patient Experience Questionnaire* relating to assessment choice.

The question relates to whether the PATIENT was given information about options for choosing a treatment that is appropriate to their problems.

Permitted National Codes:

Y	Yes
N	No

IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ASSESSMENT CHOICE PATIENT EXPERIENCE QUESTION 2

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	
Default Codes:	

Notes:
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ASSESSMENT CHOICE PATIENT EXPERIENCE QUESTION 2 is the PERSON SCORE for question 2 of the *Improving Access to Psychological Therapies Patient Experience Questionnaire* relating to assessment choice.

The question relates to whether the PATIENT preferred any of the treatments among the options available.

Permitted National Codes:

Y	Yes
N	No

IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ASSESSMENT CHOICE PATIENT EXPERIENCE QUESTION 3

Change to Data Element: Changed Dataset

Format/Length:	max an2
National Codes:	
Default Codes:	

Notes:
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ASSESSMENT CHOICE PATIENT EXPERIENCE QUESTION 3 is the PERSON SCORE for question 3 of the *Improving Access to Psychological Therapies Patient Experience Questionnaire* relating to assessment choice.

The question relates to whether the PATIENT was offered their preferred treatment.

Permitted National Codes:

Y	Yes
N	No
NA	Not Applicable

IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ASSESSMENT SATISFACTION PATIENT EXPERIENCE QUESTION 1

Change to Data Element: Changed Dataset

Format/Length:	n1
National Codes:	
Default Codes:	

Notes:
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES ASSESSMENT SATISFACTION PATIENT EXPERIENCE QUESTION 1 is the PERSON SCORE for question 1 of the *Improving Access to Psychological Therapies Patient Experience Questionnaire* relating to assessment satisfaction.

The question relates to whether the PATIENT was satisfied with their assessment.

The score is in the range 0 to 4.

IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES CARE SPELL END CODE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES CARE SPELL END CODE
Default Codes:	

Notes:
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES CARE SPELL END CODE is the same as attribute IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES CARE SPELL END CODE.

IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES OPT IN DATE

Change to Data Element: Changed Dataset

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

Notes:
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES OPT IN DATE is the same as attribute IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES OPT IN DATE.

IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES STEPPED CARE INTENSITY DELIVERED

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES STEPPED CARE INTENSITY DELIVERED
Default Codes:	

Notes:
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES STEPPED CARE INTENSITY DELIVERED is the same as attribute IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES STEPPED CARE INTENSITY DELIVERED.

IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES TREATMENT PATIENT EXPERIENCE QUESTION 1

Change to Data Element: Changed Dataset

Format/Length:	n1
National Codes:	
Default Codes:	

Notes:
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES TREATMENT PATIENT EXPERIENCE QUESTION 1 is the PERSON SCORE for question 1 of the *Improving Access to Psychological Therapies Patient Experience Questionnaire* relating to treatment.

The question relates to whether staff listened to the PATIENT and treated their concerns seriously.

The score is in the range 0 to 4.

IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES TREATMENT PATIENT EXPERIENCE QUESTION 2

Change to Data Element: Changed Dataset

Format/Length:	n1
National Codes:	
Default Codes:	

Notes:
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES TREATMENT PATIENT EXPERIENCE QUESTION 2 is the PERSON SCORE for question 2 of the *Improving Access to Psychological Therapies Patient Experience Questionnaire* relating to treatment.

The question relates to whether the PATIENT feels that the Improving Access to Psychological Therapies Service has helped them to better understand and address their difficulties.

The score is in the range 0 to 4.

IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES TREATMENT PATIENT EXPERIENCE QUESTION 3

Change to Data Element: Changed Dataset

Format/Length:	n1
National Codes:	
Default Codes:	

Notes:
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES TREATMENT PATIENT EXPERIENCE QUESTION 3 is the PERSON SCORE for question 3 of the *Improving Access to Psychological Therapies Patient Experience Questionnaire* relating to treatment.

The question relates to whether the PATIENT felt involved in making choices about their treatment and care.

The score is in the range 0 to 4.

IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES TREATMENT PATIENT EXPERIENCE QUESTION 4

Change to Data Element: Changed Dataset

Format/Length:	n1
National Codes:	
Default Codes:	

Notes:
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES TREATMENT PATIENT EXPERIENCE QUESTION 4 is the PERSON SCORE for question 4 of the *Improving Access to Psychological Therapies Patient Experience Questionnaire* relating to treatment.

The question relates to whether the PATIENT felt that they got the help that mattered to them.

The score is in the range 0 to 4.

IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES TREATMENT PATIENT EXPERIENCE QUESTION 5

Change to Data Element: Changed Dataset

Format/Length:	n1
National Codes:	
Default Codes:	

Notes:
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES TREATMENT PATIENT EXPERIENCE QUESTION 5 is the PERSON SCORE for question 5 of the *Improving Access to Psychological Therapies Patient Experience Questionnaire* relating to treatment.

The question relates to whether the PATIENT has confidence in their therapist and their skills and techniques.

The score is in the range 0 to 4.

INDIRECT ACTIVITY DATE

Change to Data Element: Changed Dataset

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

Notes:

INDIRECT ACTIVITY DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Indirect Activity Date*'.

INDIRECT ACTIVITY TIME

Change to Data Element: Changed Dataset

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

Notes:
INDIRECT ACTIVITY TIME is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Indirect Activity Time*'.

INTENDED AGE GROUP (MENTAL HEALTH)

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See AGE GROUP INTENDED FOR MENTAL HEALTH
Default Codes:	

Notes:
INTENDED AGE GROUP (MENTAL HEALTH) is the same as attribute AGE GROUP INTENDED FOR MENTAL HEALTH.

This data element is also known by these names:

Context	Alias
plural	INTENDED AGE GROUPS (MENTAL HEALTH)

INTENDED AGE GROUP (MENTAL HEALTH)

Change to Data Element: New Data Element

INTENDED AGE GROUP (MENTAL HEALTH)

Attribute:

AGE GROUP INTENDED FOR MENTAL HEALTH

INTENDED CLINICAL CARE INTENSITY CODE (MENTAL HEALTH)

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	
Default Codes:	

Notes:
INTENDED CLINICAL CARE INTENSITY CODE (MENTAL HEALTH) is the same as attribute CLINICAL CARE INTENSITY for the Mental Health Services Data Set.

Permitted National Codes:

For PATIENTS with Mental Illness:

51 For Intensive Care - specially designated ward for PATIENTS needing containment and more intensive management (eg Psychiatric Intensive Care Unit (PICU)). This is not to be confused with intensive nursing where a PATIENT may require one-to-one nursing while on a standard WARD

52 For Short Stay - PATIENTS intended to stay for less than a year

53 For Long Stay - PATIENTS intended to stay for a year or more

For PATIENTS with Learning Disabilities:

61 Designated or interim secure unit

62 PATIENTS intending to stay less than a year

63 PATIENTS intending to stay a year or more

LANGUAGE CODE (PREFERRED)

Change to Data Element: Changed Dataset

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

Notes:

LANGUAGE CODE (PREFERRED) is the same as the attribute LANGUAGE CODE.

LANGUAGE CODE (PREFERRED) is the language the PATIENT, Patient Proxy or Carer prefers to use for communication with a Health Care Provider.

LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)

Change to Data Element: Changed Dataset

Format/Length:	max an4
National Codes:	See LEARNING DISABILITIES CARE CLUSTER CODE
Default Codes:	

Notes:

LEARNING DISABILITIES CARE CLUSTER CODE (FINAL) is the same as attribute LEARNING DISABILITIES CARE CLUSTER CODE.

LEARNING DISABILITIES CARE CLUSTER CODE (FINAL) is the final LEARNING DISABILITIES CARE CLUSTER CODE allocated by the CARE PROFESSIONAL.

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

LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)

Change to Data Element: Changed Dataset

Format/Length:	max an4
National Codes:	See LEARNING DISABILITIES CARE CLUSTER CODE
Default Codes:	

Notes:

LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL) is the same as attribute LEARNING DISABILITIES CARE CLUSTER CODE.

LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL) is the initial LEARNING DISABILITIES CARE CLUSTER CODE allocated by the CARE PROFESSIONAL.

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

LOCAL PATIENT IDENTIFIER (EXTENDED)

Change to Data Element: Changed Dataset

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

Notes:
LOCAL PATIENT IDENTIFIER (EXTENDED) is the same as attribute LOCAL PATIENT IDENTIFIER.

LOCAL PATIENT IDENTIFIER (EXTENDED) is used where IT systems have a LOCAL PATIENT IDENTIFIER which is longer than 10 characters and LOCAL PATIENT IDENTIFIER cannot be used for data submission.

LOCKED WARD INDICATOR

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See LOCKED WARD INDICATOR
Default Codes:	

Notes:
LOCKED WARD INDICATOR is the same as attribute LOCKED WARD INDICATOR.

For the Mental Health Services Data Set, LOCKED WARD INDICATOR indicates whether a WARD which is used to provide care by a Mental Health Service, and has a WARD SECURITY LEVEL National Code "General (non-secure)", is locked to prevent unauthorised entry and/or exit.

LONG TERM PHYSICAL HEALTH CONDITION INDICATOR (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See LONG TERM PHYSICAL HEALTH CONDITION INDICATOR FOR IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES
Default Codes:	

Notes:
LONG TERM PHYSICAL HEALTH CONDITION INDICATOR (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES) is the same as attribute LONG TERM PHYSICAL HEALTH CONDITION INDICATOR FOR IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES.

LOOKED AFTER CHILD INDICATOR

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See LOOKED AFTER CHILD INDICATOR
Default Codes:	X - Not known if the PERSON is a Looked After Child

Notes:
LOOKED AFTER CHILD INDICATOR is the same as attribute LOOKED AFTER CHILD INDICATOR.

MAIN SPECIALTY CODE (MENTAL HEALTH)

Change to Data Element: Changed Dataset

Format/Length:	an3
National Codes:	

Default Codes:

Notes:
MAIN SPECIALTY CODE (MENTAL HEALTH) is the same as attribute MAIN SPECIALTY CODE.

MAIN SPECIALTY CODE (MENTAL HEALTH) is the MAIN SPECIALTY CODE of the CARE PROFESSIONAL working in a Mental Health Service, who is responsible for the PATIENT within the REPORTING PERIOD.

Permitted National Codes:

600	General Medical Practice
700	Learning Disability
710	Adult Mental Illness
711	Child and Adolescent Psychiatry
712	Forensic Psychiatry
713	Psychotherapy
715	Old Age Psychiatry
950	Nursing Episode
960	Allied Health Professional Episode

MANIFEST PSYCHOSIS DATE

Change to Data Element: Changed Dataset

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

Notes:
MANIFEST PSYCHOSIS DATE is the same as attribute PERSON PROPERTY OBSERVED DATE.

MANIFEST PSYCHOSIS DATE is the DATE at which a positive psychotic symptom for the PATIENT (i.e. delusion, hallucination, or thought disorder) has lasted for a week. This is usually a week after the DATE of the first psychotic symptom.

MATERNITY CARE PLAN DATE

Change to Data Element: Changed Description, linked Attribute

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

Notes:
~~MATERNITY CARE PLAN DATE is the same as attribute CARE PLAN AGREED DATE for a Maternity Episode.~~MATERNITY CARE PLAN DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Care Plan Agreed Date*' for a Maternity Episode.

MATERNITY CARE PLAN DATE

Change to Data Element: Changed Description, linked Attribute

MATERNITY CARE PLAN DATE

Attribute:

~~CARE PLAN AGREED DATE~~
ACTIVITY DATE

MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON
Default Codes:	99 - MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON Not known

Notes:
MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON is the same as attribute MENTAL HEALTH ABSENCE WITHOUT LEAVE END REASON.

MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY
Default Codes:	

Notes:
MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY is the same as attribute MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY.

MENTAL HEALTH ACT 2007 MENTAL CATEGORY

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See MENTAL HEALTH ACT 2007 MENTAL CATEGORY
Default Codes:	8 - Not applicable (i.e. not detained) 9 - Not known

Notes:
MENTAL HEALTH ACT 2007 MENTAL CATEGORY is the same as attribute MENTAL HEALTH ACT 2007 MENTAL CATEGORY.

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON
Default Codes:	

Notes:
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON is the same as attribute MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD END REASON.

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER

Change to Data Element: Changed Dataset

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

Notes:
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER is the same as attribute ACTIVITY IDENTIFIER.

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER is a unique identifier allocated to each Mental Health Act Legal Status Classification Assignment Period.

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON
Default Codes:	

Notes:
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON is the same as attribute MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD START REASON.

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE
Default Codes:	98 - Not Applicable 99 - Not Known

Notes:
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE is the same as attribute MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE.

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE is required for all PATIENTS who have a Hospital Provider Spell which includes the care of a CONSULTANT in the psychiatric specialties or have been discharged from such a Hospital Provider Spell and are required to receive supervised aftercare under the provisions of the Mental Health (Patients in the Community) Act 1995.

MENTAL HEALTH ADMITTED PATIENT CLASSIFICATION

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	
Default Codes:	

Notes:
MENTAL HEALTH ADMITTED PATIENT CLASSIFICATION is a derived from the attribute WARD SETTING TYPE FOR MENTAL HEALTH, WARD SECURITY LEVEL, AGE GROUP INTENDED FOR MENTAL HEALTH, CLINICAL CARE INTENSITY and TREATMENT FUNCTION CODE.

MENTAL HEALTH ADMITTED PATIENT CLASSIFICATION is the classification of the admitted PATIENT during a Ward Stay for the Mental Health Services Data Set.

For further information, see the NHS England website.

Permitted National Codes:

	Adult
10	Acute adult mental health care
11	Acute older adult mental health care (organic and functional)

12	Psychiatric Intensive Care Unit (acute mental health care)
13	Eating Disorders
14	Mother and baby
15	Learning Disabilities
16	Low secure/locked rehabilitation
17	High dependency rehabilitation
18	Long term complex rehabilitation/ Continuing Care
19	Low secure
20	Medium secure
21	High secure
22	Neuro-psychiatry / Acquired Brain Injury
	Children and Young people
23	General Child and Adolescent Mental Health (CAMHS) inpatient - Child (including High Dependency)
24	General Child and Adolescent Mental Health (CAMHS) inpatient - Adolescent (including High Dependency)
25	Eating Disorders inpatient - Adolescent (above 12)
26	Eating Disorders inpatient - Child (12 years and under)
27	Low Secure Mental Illness
28	Medium Secure Mental Illness
29	Child Mental Health inpatient services for the Deaf
30	Learning Disabilities / Autistic Spectrum Disorder inpatient
31	Low Secure Learning Disabilities
32	Medium Secure Learning Disabilities
33	Severe Obsessive Compulsive Disorder and Body Dysmorphic Disorder - Adolescent
34	Psychiatric Intensive Care Unit

This data element is also known by these names:

Context	Alias
alsoknownas	HOSPITAL BED TYPE (MENTAL HEALTH)
plural	MENTAL HEALTH ADMITTED PATIENT CLASSIFICATIONS

MENTAL HEALTH ADMITTED PATIENT CLASSIFICATION

Change to Data Element: New Data Element

MENTAL HEALTH ADMITTED PATIENT CLASSIFICATION

Attribute:

AGE GROUP INTENDED FOR MENTAL HEALTH
CLINICAL CARE INTENSITY
TREATMENT FUNCTION CODE
WARD SECURITY LEVEL
WARD SETTING TYPE FOR MENTAL HEALTH

MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE
Default Codes:	Z - Unable to assign PATIENT to Mental Health Care Cluster Super Class

Notes:

MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE is the same as attribute MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE.

MENTAL HEALTH CONDITIONAL DISCHARGE END REASON

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See MENTAL HEALTH CONDITIONAL DISCHARGE END REASON
Default Codes:	

Notes:
MENTAL HEALTH CONDITIONAL DISCHARGE END REASON is the same as attribute MENTAL HEALTH CONDITIONAL DISCHARGE END REASON.

MENTAL HEALTH CRISIS PLAN CREATION DATE (RETIRED) renamed from MENTAL HEALTH CRISIS PLAN CREATION DATE

Change to Data Element: Changed Description, Name, Dataset, linked Attribute, status to Retired

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

~~**Notes:**~~
~~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*'.~~ **This item has been retired from the NHS Data Model and Dictionary.**

The last live version of this item is available in the ?????? release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

MENTAL HEALTH CRISIS PLAN CREATION DATE (RETIRED) renamed from MENTAL HEALTH CRISIS PLAN CREATION DATE

Change to Data Element: Changed Description, Name, Dataset, linked Attribute, status to Retired

~~MENTAL HEALTH CRISIS PLAN CREATION DATE~~

~~**Attribute:**~~

~~ACTIVITY DATE~~

MENTAL HEALTH CRISIS PLAN CREATION DATE (RETIRED) renamed from MENTAL HEALTH CRISIS PLAN CREATION DATE

Change to Data Element: Changed Description, Name, Dataset, linked Attribute, status to Retired

- Changed Description
- Changed Name from Data_Dictionary.Data_Field_Notes.M.Men.MENTAL_HEALTH_CRISIS_PLAN_CREATION_DATE to Retired.Data_Dictionary.Data_Field_Notes.M.MENTAL_HEALTH_CRISIS_PLAN_CREATION_DATE
- null
- null
- Retired MENTAL HEALTH CRISIS PLAN CREATION DATE

MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE (RETIRED) renamed from MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE

Change to Data Element: Changed Description, Name, Dataset, linked Attribute, status to Retired

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

~~Notes:~~

~~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.~~**This item has been retired from the NHS Data Model and Dictionary.**

The last live version of this item is available in the ?????? release of the NHS Data Model and Dictionary.

Access to this version can be obtained by emailing information.standards@nhs.net with "NHS Data Model and Dictionary - Archive Request" in the email subject line.

MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE (RETIRED)_ renamed from MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE

Change to Data Element: Changed Description, Name, Dataset, linked Attribute, status to Retired

~~MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE~~

~~Attribute:~~

~~ACTIVITY DATE~~

MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE (RETIRED)_ renamed from MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE

Change to Data Element: Changed Description, Name, Dataset, linked Attribute, status to Retired

- Changed Description
- Changed Name from Data_Dictionary.Data_Field_Notes.M.Men.MENTAL_HEALTH_CRISIS_PLAN_LAST_UPDATED_DATE to Retired.Data_Dictionary.Data_Field_Notes.M.MENTAL_HEALTH_CRISIS_PLAN_LAST_UPDATED_DATE
- null
- null
- Retired MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE

MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE
Default Codes:	

Notes:

MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE is the same as attribute MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE.

MENTAL HEALTH DELAYED DISCHARGE REASON

Change to Data Element: Changed Description, Dataset

~~Format/Length:~~	~~an2~~
Format/Length:	max an3
National Codes:	See MENTAL HEALTH DELAYED DISCHARGE REASON
Default Codes:	

Notes:
MENTAL HEALTH DELAYED DISCHARGE REASON is the same as attribute MENTAL HEALTH DELAYED DISCHARGE REASON.

MENTAL HEALTH LEAVE OF ABSENCE END REASON

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See MENTAL HEALTH LEAVE OF ABSENCE END REASON
Default Codes:	99 - MENTAL HEALTH LEAVE OF ABSENCE END REASON Not known

Notes:
MENTAL HEALTH LEAVE OF ABSENCE END REASON is the same as attribute MENTAL HEALTH LEAVE OF ABSENCE END REASON.

NHS NUMBER

Change to Data Element: Changed Dataset

Format/Length:	n10
National Codes:	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 Dataset

Format/Length:	an10
National Codes:	
Default Codes:	

Notes:
NHS SERVICE AGREEMENT LINE NUMBER is the same as attribute NHS SERVICE AGREEMENT LINE NUMBER.

The NHS SERVICE AGREEMENT LINE NUMBERS may be used to identify a specific NHS SERVICE AGREEMENT reference where the main identifier refers to a general omnibus agreement.

NUMBER OF GROUP SESSION PARTICIPANTS

Change to Data Element: Changed Dataset

Format/Length:	max n3
National Codes:	
Default Codes:	

Notes:
NUMBER OF GROUP SESSION PARTICIPANTS is the number of PERSON's who participate in a Group Session (excluding the CARE PROFESSIONALS responsible for the Group Session).

OBSERVATION DATE (SUBSTANCE MISUSE EVIDENCE)

Change to Data Element: New Data Element

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

Notes:
OBSERVATION DATE (SUBSTANCE MISUSE EVIDENCE) is the same as attribute PERSON PROPERTY OBSERVED DATE.

OBSERVATION DATE (SUBSTANCE MISUSE EVIDENCE)) is the date that evidence of current substance misuse by a PATIENT was observed by a CARE PROFESSIONAL.

For the Mental Health Services Data Set, OBSERVATION DATE (SUBSTANCE MISUSE EVIDENCE) is recorded within a Ward Stay.

This data element is also known by these names:

Context	Alias
plural	OBSERVATION DATES (SUBSTANCE MISUSE EVIDENCE)

OBSERVATION DATE (SUBSTANCE MISUSE EVIDENCE)

Change to Data Element: New Data Element

OBSERVATION DATE (SUBSTANCE MISUSE EVIDENCE)

Attribute:

PERSON PROPERTY OBSERVED DATE

OBSERVATION SCHEME IN USE

Change to Data Element: Changed Dataset

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

Notes:
OBSERVATION SCHEME IN USE is the same as attribute OBSERVATION SCHEME IN USE.

OBSERVATION VALUE

Change to Data Element: Changed Dataset

Format/Length:	max an10
National Codes:	
Default Codes:	

Notes:
OBSERVATION VALUE is the same as attribute OBSERVATION VALUE.

OBSESSIVE COMPULSIVE DISORDER INVENTORY SCORE

Change to Data Element: Changed Dataset

Format/Length:	max n3
National Codes:	
Default Codes:	

Notes:
OBSESSIVE COMPULSIVE DISORDER INVENTORY SCORE is the PERSON SCORE for an APPOINTMENT where the ASSESSMENT TOOL TYPE is '*Obsessive Compulsive Disorder Inventory Questionnaire*'.

The score is in the range 0 to 168.

If one or two values are missing from the score, then they can be substituted with the average score of the non-missing items. Questionnaires with more than two missing values should be disregarded.

OCCUPATION CODE

Change to Data Element: Changed Dataset

Format/Length:	an3
NWDS ID:	GROC
NWDS Field Name:	Occupation Code
National Codes:	
Default Codes:	

Notes:
OCCUPATION CODE is the same as attribute NHS OCCUPATION CODE.

OFFENCE HISTORY INDICATION CODE

Change to Data Element: New Data Element

Format/Length:	an1
National Codes:	See OFFENCE HISTORY INDICATION CODE
Default Codes:	X - Not Known (Not Recorded)

Notes:
OFFENCE HISTORY INDICATION CODE is the same as attribute OFFENCE HISTORY INDICATION CODE.

This data element is also known by these names:

Context	Alias
plural	OFFENCE HISTORY INDICATION CODES

OFFENCE HISTORY INDICATION CODE

Change to Data Element: New Data Element

OFFENCE HISTORY INDICATION CODE

Attribute:

OFFENCE HISTORY INDICATION CODE

ONWARD REFERRAL DATE

Change to Data Element: Changed Dataset

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

Notes:
ONWARD REFERRAL DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Onward Referral Date*'.

ONWARD REFERRAL REASON

Change to Data Element: Changed Description, Dataset

Format/Length:	an2
National Codes:	See ONWARD REFERRAL REASON
Default Codes:	98 - Onward Referral Reason Not Applicable ~~99 - Onward Referral Reason Not Known~~ 99 - Not Known (Not Recorded)

Notes:
ONWARD REFERRAL REASON is the same as attribute ONWARD REFERRAL REASON.

ONWARD REFERRAL TIME

Change to Data Element: New Data Element

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

Notes:
ONWARD REFERRAL TIME is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Onward Referral Time*'.

This data element is also known by these names:

Context	Alias

plural	ONWARD REFERRAL TIMES

ONWARD REFERRAL TIME

Change to Data Element: New Data Element

ONWARD REFERRAL TIME

Attribute:

ACTIVITY TIME

ORGANISATION CODE (CODE OF COMMISSIONER)

Change to Data Element: Changed Dataset

Format/Length:	an3 or an5
National Codes:	
ODS Default Codes:	VPP00 - Private PATIENTS / Overseas Visitor liable for charge XMD00 - Commissioner Code for Ministry of Defence (MoD) Healthcare YDD82 - Episodes funded directly by the National Commissioning Group for England

Notes:
ORGANISATION CODE (CODE OF COMMISSIONER) is the same as attribute ORGANISATION CODE.

ORGANISATION CODE (CODE OF COMMISSIONER) is the ORGANISATION CODE of the Organisation commissioning health care.

For Commissioning Data Sets, the ORGANISATION CODE (CODE OF COMMISSIONER) should always be the ORGANISATION CODE of the original commissioner to support the National Tariff Payment System.

The NHS England document "Who pays? Determining responsibility for payments to providers" sets out a framework for establishing responsibility for commissioning an individual's care within the NHS, (i.e. determining who pays for a PATIENT's care.)

The document includes information on the following:

- General Rules
- Applying the rules to Clinical Commissioning Group commissioned services
- Exceptions to the general rules
- Examples to help clarify the boundaries of responsibility between commissioning Organisations.

For further information on this document contact NHS England at "Contact us".

ORGANISATION CODE (CODE OF COMMISSIONER) will be replaced with ORGANISATION IDENTIFIER (CODE OF COMMISSIONER), when it has been approved for use in national information standards.

ORGANISATION CODE (CODE OF PROVIDER)

Change to Data Element: Changed Dataset
a

Format/Length:	an3, an5 or an6
National Codes:	
ODS Default Codes:	89997 - Non-UK provider where no ORGANISATION CODE has been issued 89999 - Non-NHS UK provider where no ORGANISATION CODE has been issued

Notes:
ORGANISATION CODE (CODE OF PROVIDER) is the same as the attribute ORGANISATION CODE.

ORGANISATION CODE (CODE OF PROVIDER) is the ORGANISATION CODE of the Organisation acting as a Health Care Provider.

For Commissioning Data Sets, the ORGANISATION CODE (CODE OF PROVIDER) should always be the ORGANISATION CODE of the Health Care Provider receiving the National Tariff Payment System income.

ORGANISATION CODE (CODE OF PROVIDER) is used by the Secondary Uses Service to derive the **Healthcare Resource Group 4**. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

ORGANISATION CODE (CODE OF PROVIDER) will be replaced with ORGANISATION IDENTIFIER (CODE OF PROVIDER), when it has been approved for use in national information standards.

ORGANISATION CODE (CODE OF SUBMITTING ORGANISATION)

Change to Data Element: Changed Dataset

Format/Length:	max an6
National Codes:	
Default Codes:	

Notes:
ORGANISATION CODE (CODE OF SUBMITTING ORGANISATION) is the same as attribute ORGANISATION CODE.

ORGANISATION CODE (CODE OF SUBMITTING ORGANISATION) is the ORGANISATION CODE of the Organisation acting as the physical sender of a Data Set submission.

ORGANISATION CODE (CODE OF SUBMITTING ORGANISATION) will be replaced with ORGANISATION IDENTIFIER (CODE OF SUBMITTING ORGANISATION), when it has been approved for use in national information standards.

ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT)

Change to Data Element: Changed Dataset

Format/Length:	min an5 max an8
National Codes:	
Default Codes:	

Notes:
ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT) is the same as attribute ORGANISATION CODE.

ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT) is the ORGANISATION CODE of the Educational Establishment, including Schools.

ORGANISATION CODE (EDUCATIONAL ESTABLISHMENT) will be replaced with ORGANISATION IDENTIFIER (EDUCATIONAL ESTABLISHMENT), when it has been approved for use in national information standards.

ORGANISATION CODE (GP PRACTICE RESPONSIBILITY)

Change to Data Element: Changed Dataset

Format/Length:	an3
National Codes:	
ODS Default Codes:	Q99 - High Level Health Geography/Primary Care Organisation of Residence Not Known X98 - Primary Care Organisation Not Applicable (Overseas Visitors)

Notes:
ORGANISATION CODE (GP PRACTICE RESPONSIBILITY) is the same as attribute ORGANISATION CODE.

ORGANISATION CODE (GP PRACTICE RESPONSIBILITY) is the ORGANISATION CODE of the Organisation responsible for the GP Practice where the PATIENT is registered, irrespective of whether they reside within the boundary of the Clinical Commissioning Group.

ORGANISATION CODE (GP PRACTICE RESPONSIBILITY) will be replaced with ORGANISATION IDENTIFIER (GP PRACTICE RESPONSIBILITY), when it has been approved for use in national information standards.

ORGANISATION CODE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES STEPPED TO PROVIDER)

Change to Data Element: Changed Dataset

Format/Length:	an3, an5 or an6
National Codes:	
ODS Default Codes:	89997 - Non-UK provider where no ORGANISATION CODE has been issued 89999 - Non-NHS UK provider where no ORGANISATION CODE has been issued

Notes:
ORGANISATION CODE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES STEPPED TO PROVIDER) is the same as the attribute ORGANISATION CODE.

ORGANISATION CODE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES STEPPED TO PROVIDER) is the ORGANISATION CODE (CODE OF PROVIDER) of the Organisation stepped to during an Improving Access to Psychological Therapies Care Spell.

ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)

Change to Data Element: Changed Dataset

Format/Length:	an3 or an5
National Codes:	
Default Codes:	

Notes:
ORGANISATION CODE (LOCAL PATIENT IDENTIFIER) is the same as attribute ORGANISATION CODE.

ORGANISATION CODE (LOCAL PATIENT IDENTIFIER) is the ORGANISATION CODE of the Organisation that assigned the LOCAL PATIENT IDENTIFIER.

ORGANISATION CODE (LOCAL PATIENT IDENTIFIER) will be replaced with ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER), when it has been approved for use in national information standards.

ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)

Change to Data Element: Changed Dataset

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

Notes:
ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER) is the same as attribute ORGANISATION CODE.

ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER) is the ORGANISATION CODE of the Organisation issuing the PATIENT PATHWAY IDENTIFIER.

Where Choose and Book has been used, the ORGANISATION CODE X09 should be used.

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement, and is of the following Commissioning Data Set Types:

- CDS V6-2 Type 020 - Outpatient Commissioning Data Set
- CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set
- CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set
- CDS V6-2 Type 030 - Elective Admission List - End of Period Census (Standard) Commissioning Data Set
- CDS V6-2 Type 060 - Elective Admission List - Event During Period (Add) Commissioning Data Set
- CDS V6-2 Type 070 - Elective Admission List - Event During Period (Remove) Commissioning Data Set
- CDS V6-2 Type 080 - Elective Admission List - Event During Period (Offer) Commissioning Data Set

then ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER) must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.

ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER) will be replaced with ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER), when it has been approved for use in national information standards.

ORGANISATION CODE (RECEIVING)

Change to Data Element: Changed Dataset

Format/Length:	an3 or an5
National Codes:	
Default Codes:	ZZ201 - Not applicable (not discharged to another Organisation) *

Notes:
ORGANISATION CODE (RECEIVING) is the same as the attribute ORGANISATION CODE.

ORGANISATION CODE (RECEIVING) is the ORGANISATION CODE of the Organisation that is receiving the PATIENT from another Health Care Provider.

For the National Neonatal Data Set - Episodic and Daily Care, this is the ORGANISATION CODE of the Organisation where a baby is transferred to on discharge from the neonatal critical care.

* Note: default code ZZ201 is ONLY valid for the National Neonatal Data Set - Episodic and Daily Care.

ORGANISATION CODE (RECEIVING) will be replaced with ORGANISATION IDENTIFIER (RECEIVING), when it has been approved for use in national information standards.

ORGANISATION CODE (RESIDENCE RESPONSIBILITY)

Change to Data Element: Changed Dataset

Format/Length:	an3
National Codes:	
ODS Default Codes:	Q99 - High Level Health Geography/Primary Care Organisation of Residence Not Known Note: This code must not be used in the Commissioning Data Set header. It is not a default commissioner code. X98 - Primary Care Organisation Not Applicable (Overseas Visitors) Note: this code must not be used in the Commissioning Data Set (CDS) header. It is not a default Commissioner code.

Notes:
ORGANISATION CODE (RESIDENCE RESPONSIBILITY) is the same as attribute ORGANISATION CODE.

ORGANISATION CODE (RESIDENCE RESPONSIBILITY) is the ORGANISATION CODE derived from the PATIENT's POSTCODE OF USUAL ADDRESS, where they reside within the boundary of a:

- Clinical Commissioning Group
- Care Trust
- Local Health Board (Wales)
- Scottish Health Board
- Northern Ireland Local Commissioning Group: *Guidance on the use of Northern Ireland codes can be found in Data Set Change Notice 19/2009*
- Primary Healthcare Directorate (Isle of Man)
- Local Authority.

ORGANISATION CODES can be downloaded from 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 (RESIDENCE RESPONSIBILITY) and following the same update rules relating to Prime Recipient as are currently in place. This is necessary, primarily to preserve the integrity of the current Commissioning Data Set message and the CDS PRIME RECIPIENT IDENTITY which is derived from the ORGANISATION CODE (RESIDENCE RESPONSIBILITY).

The Organisation Data Service provides postcode files which link postcodes to the Clinical Commissioning Group. See NHS Postcode Directory.

ORGANISATION CODE (RESIDENCE RESPONSIBILITY) will be replaced with ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY), when it has been approved for use in national information standards.

OTHER PERSON IN ATTENDANCE AT CARE CONTACT

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See OTHER PERSON IN ATTENDANCE AT CARE CONTACT
Default Codes:	

Notes:
OTHER PERSON IN ATTENDANCE AT CARE CONTACT is the same as attribute OTHER PERSON IN ATTENDANCE AT CARE CONTACT.

OTHER REASON FOR REFERRAL (MENTAL HEALTH)

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See REASON FOR REFERRAL TO MENTAL HEALTH
Default Codes:	

Notes:
OTHER REASON FOR REFERRAL (MENTAL HEALTH) is the same as attribute REASON FOR REFERRAL TO MENTAL HEALTH.

OTHER REASON FOR REFERRAL (MENTAL HEALTH) is the secondary presenting conditions or symptoms for which the PATIENT was referred to a Mental Health Service.

PANIC DISORDER SEVERITY SCALE SCORE

Change to Data Element: Changed Dataset

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

Notes:
PANIC DISORDER SEVERITY SCALE SCORE is the PERSON SCORE for an APPOINTMENT where the ASSESSMENT TOOL TYPE is '*Panic Disorder Severity Scale*'.

The score is in the range 0 to 28.

PATIENT PATHWAY IDENTIFIER

Change to Data Element: Changed Dataset

Format/Length:	an20
National Codes:	
Default Codes:	

Notes:
PATIENT PATHWAY IDENTIFIER is the same as PATIENT PATHWAY IDENTIFIER.

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement, and is of the following Commissioning Data Set Types:

- CDS V6-2 Type 020 - Outpatient Commissioning Data Set
- CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set
- CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set
- CDS V6-2 Type 030 - Elective Admission List - End of Period Census (Standard) Commissioning Data Set
- CDS V6-2 Type 060 - Elective Admission List - Event During Period (Add) Commissioning Data Set
- CDS V6-2 Type 070 - Elective Admission List - Event During Period (Remove) Commissioning Data Set
- CDS V6-2 Type 080 - Elective Admission List - Event During Period (Offer) Commissioning Data Set

then either UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) or PATIENT PATHWAY IDENTIFIER must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.

PERSON BIRTH DATE

Change to Data Element: Changed Dataset

Format/Length:	See DATE
NWDS ID:	PEBD
NWDS Field Name:	Date of Birth
National Codes:	
Default Codes:	

Notes:
PERSON BIRTH DATE is the same as attribute PERSON BIRTH DATE.

PERSON DEATH DATE

Change to Data Element: Changed Dataset

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

Notes:
PERSON DEATH DATE is the same as attribute PERSON DEATH DATE.

PERSON GENDER CODE CURRENT

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See PERSON GENDER CODE
Default Codes:	

Notes:
PERSON GENDER CODE CURRENT is the same as attribute PERSON GENDER CODE where the PERSON GENDER TYPE is National Code *'Person Gender Current'*.

PERSON GENDER CODE CURRENT is a PERSON's gender currently.

PERSON GENDER CODE CURRENT is used by the Secondary Uses Service to derive the **Healthcare Resource Group 4**. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

PERSON GENDER CODE CURRENT will be replaced with PERSON STATED GENDER CODE or PERSON PHENOTYPIC SEX, which is the most recent approved national information standard to describe the required definition.

PERSON MARITAL STATUS

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See PERSON MARITAL STATUS CODE
Default Codes:	8 - Not applicable, i.e. not a psychiatric episode
	9 - Not known

Notes:
PERSON MARITAL STATUS is the same as attribute PERSON MARITAL STATUS CODE.

Commissioning Data Set Messages

Following the recommendation of the Data Protection Registrar, PERSON MARITAL STATUS should not be recorded by providers in the Commissioning Data Sets except in respect of the psychiatric specialties in the Admitted Patient Care Commissioning Data Set. The data item remains in the data standards since it will be needed by the provider.

PERSON SCORE

Change to Data Element: Changed Dataset

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

Notes:
PERSON SCORE is the same as attribute PERSON SCORE.

PERSON STATED GENDER CODE

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See PERSON STATED GENDER CODE
Default Codes:	X - Not Known (PERSON STATED GENDER CODE not recorded)

Notes:
PERSON STATED GENDER CODE is the same as attribute PERSON STATED GENDER CODE.

PERSON GENDER CURRENT and PERSON GENDER CODE CURRENT will be replaced with PERSON STATED GENDER CODE or PERSON PHENOTYPIC SEX, which is the most recent approved national information standard to describe the required definition.

PHQ-9 TOTAL SCORE

Change to Data Element: Changed Dataset

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

Notes:
PHQ-9 TOTAL SCORE is the total PERSON SCORE for the Patient Health Questionnaire-9, calculated by adding together the scores from questions 1 - 9.

The score is in the range 0 to 27.

PLACE OF SAFETY INDICATOR

Change to Data Element: New Data Element

Format/Length:	an1

National Codes:	See PLACE OF SAFETY INDICATOR
Default Codes:	

Notes:
PLACE OF SAFETY INDICATOR is the same as attribute PLACE OF SAFETY INDICATOR.

This data element is also known by these names:

Context	Alias
plural	PLACE OF SAFETY INDICATORS

PLACE OF SAFETY INDICATOR

Change to Data Element: New Data Element

PLACE OF SAFETY INDICATOR

Attribute:

PLACE OF SAFETY INDICATOR

PLANNED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Dataset

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

Notes:
PLANNED DISCHARGE DATE (HOSPITAL PROVIDER SPELL) is the same as attribute PLANNED ACTIVITY DATE where the PLANNED ACTIVITY DATE TYPE is National Code *'Planned Discharge Date (Hospital Provider Spell)'*.

PLANNED DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL)

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See DISCHARGE DESTINATION
Default Codes:	98 - Not applicable - Hospital Provider Spell not finished at episode end (i.e. not discharged) or current episode unfinished 99 - Not known: a validation error

Notes:
PLANNED DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL) is the same as attribute DISCHARGE DESTINATION.

PLANNED DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL) is the planned destination of a PATIENT on completion of a Hospital Provider Spell.

This data element is also known by these names:

Context	Alias
plural	PLANNED DISCHARGE DESTINATION CODES (HOSPITAL PROVIDER SPELL)

PLANNED DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL)

Change to Data Element: New Data Element

PLANNED DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL)

Attribute:

DISCHARGE DESTINATION

POSTCODE OF MAIN VISITOR

Change to Data Element: Changed Description, Dataset

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

Notes:
POSTCODE OF MAIN VISITOR is the same as data element POSTCODE.

POSTCODE OF MAIN VISITOR is the POSTCODE of the ADDRESS of the PATIENT's main visitor where the ADDRESS ASSOCIATION TYPE is *'Main Permanent Residence'* or *'Other Permanent Residence'.*

~~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.~~For the Mental Health Services Data Set, POSTCODE OF MAIN VISITOR is the POSTCODE of the PATIENT's main visitor to the PATIENT whilst they are being treated as part of a Hospital Provider Spell.

POSTCODE OF USUAL ADDRESS

Change to Data Element: Changed Dataset

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

Notes:
POSTCODE OF USUAL ADDRESS is the same as data element POSTCODE.

POSTCODE OF USUAL ADDRESS is the POSTCODE of the ADDRESS nominated by the PATIENT where the ADDRESS ASSOCIATION TYPE is *'Main Permanent Residence'* or *'Other Permanent Residence'.*

POST TRAUMATIC STRESS DISORDER IMPACT OF EVENTS SCALE REVISED SCORE

Change to Data Element: Changed Dataset

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

Notes:
POST TRAUMATIC STRESS DISORDER IMPACT OF EVENTS SCALE REVISED SCORE is the PERSON SCORE for an APPOINTMENT where the ASSESSMENT TOOL TYPE is '*Post Traumatic Stress Disorder Impacts of Events Revised Scale*'.

The score is in the range 0 to 88.

If one or two values are missing from the score, then they can be substituted with the average score of the non-missing items. Questionnaires with more than two missing values should be disregarded.

PRESCRIPTION DATE (ASSISTIVE TECHNOLOGY)

Change to Data Element: Changed Dataset

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

Notes:
PRESCRIPTION DATE (ASSISTIVE TECHNOLOGY) is the same as attribute PRESCRIPTION DATE for the prescription of Assistive Technology.

PREVIOUS DIAGNOSIS (CODED CLINICAL ENTRY)

Change to Data Element: Changed Dataset

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

Notes:
PREVIOUS DIAGNOSIS (CODED CLINICAL ENTRY) is the same as attribute CLINICAL CLASSIFICATION CODE or CLINICAL TERMINOLOGY CODE.

PREVIOUS DIAGNOSIS (CODED CLINICAL ENTRY) is the CODED CLINICAL ENTRY used to identify the previous PATIENT DIAGNOSIS.

PREVIOUS SYMPTOM INDICATOR

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See PREVIOUS SYMPTOM INDICATOR
Default Codes:	

Notes:
PREVIOUS SYMPTOM INDICATOR is the same as attribute PREVIOUS SYMPTOM INDICATOR.

PRIMARY DATA COLLECTION SYSTEM IN USE

Change to Data Element: Changed Dataset

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

Notes:
PRIMARY DATA COLLECTION SYSTEM IN USE is the name of the Primary Data Collection System in use by the Health Care Provider.

PRIMARY DIAGNOSIS (CODED CLINICAL ENTRY)

Change to Data Element: Changed Dataset

Format/Length:	min an4 max an18
National Codes:	

Default Codes:

Notes:
PRIMARY DIAGNOSIS (CODED CLINICAL ENTRY) is the same as attribute CLINICAL CLASSIFICATION CODE or CLINICAL TERMINOLOGY CODE.

PRIMARY DIAGNOSIS (CODED CLINICAL ENTRY) is the CODED CLINICAL ENTRY used to identify the PRIMARY DIAGNOSIS.

PRIMARY REASON FOR REFERRAL (MENTAL HEALTH)

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See REASON FOR REFERRAL TO MENTAL HEALTH
Default Codes:	

Notes:
PRIMARY REASON FOR REFERRAL (MENTAL HEALTH) is the same as attribute REASON FOR REFERRAL TO MENTAL HEALTH.

PRIMARY REASON FOR REFERRAL (MENTAL HEALTH) is the primary presenting condition or symptom for which the PATIENT was referred to a Mental Health Service.

PROCEDURE SCHEME IN USE

Change to Data Element: Changed Dataset

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

Notes:
PROCEDURE SCHEME IN USE is the same as attribute PROCEDURE SCHEME IN USE.

PRODROME PSYCHOSIS DATE

Change to Data Element: Changed Dataset

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

Notes:
PRODROME PSYCHOSIS DATE is the same as attribute PERSON PROPERTY OBSERVED DATE.

PRODROME PSYCHOSIS DATE is the DATE at which first noticeable change in behaviour or mental state of the PATIENT occurred, prior to emergence of full-blown psychosis. There should be clear deterioration in functioning from previous levels.

PROFESSIONAL REGISTRATION BODY CODE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See PROFESSIONAL REGISTRATION BODY CODE
Default Codes:	

Notes:
PROFESSIONAL REGISTRATION BODY CODE is the same as attribute PROFESSIONAL REGISTRATION BODY CODE.

PROFESSIONAL REGISTRATION ENTRY IDENTIFIER

Change to Data Element: Changed Dataset

Format/Length:	max an32
NWDS ID:	EPRN
NWDS Field Name:	Professional Registration Number
National Codes:	
Default Codes:	

Notes:
PROFESSIONAL REGISTRATION ENTRY IDENTIFIER is the same as attribute PROFESSIONAL REGISTRATION ENTRY IDENTIFIER.

PROVISIONAL DIAGNOSIS (CODED CLINICAL ENTRY)

Change to Data Element: Changed Dataset

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

Notes:
PROVISIONAL DIAGNOSIS (CODED CLINICAL ENTRY) is the same as attribute CLINICAL CLASSIFICATION CODE or CLINICAL TERMINOLOGY CODE.

PROVISIONAL DIAGNOSIS (CODED CLINICAL ENTRY) is the CODED CLINICAL ENTRY used to identify the PROVISIONAL DIAGNOSIS.

PROVISIONAL DIAGNOSIS (ICD)

Change to Data Element: Changed Dataset

Format/Length:	See ICD-10 CODE
National Codes:	
Default Codes:	

Notes:
PROVISIONAL DIAGNOSIS (ICD) is the same as attribute PROVISIONAL DIAGNOSIS.

PROVISIONAL DIAGNOSIS (ICD) is the International Classification of Diseases (ICD) code used to identify the PROVISIONAL DIAGNOSIS.

For the Cancer Outcomes and Services Data Set, PROVISIONAL DIAGNOSIS (ICD) is the working PATIENT DIAGNOSIS as defined at the Multidisciplinary Team Meeting where the First Definitive Treatment is agreed. This is the clinical opinion which may also be informed by Biopsy, radiological and/or other investigations.

Note:

- The format/length of this Data Element has been corrected as a result of the work undertaken for the development of the Coding Strategy.
- The data set specifications of the data sets that contain this Data Element will be updated in the next version of the information standard where it is not already correct.

PROVISIONAL DIAGNOSIS DATE

Change to Data Element: Changed Dataset

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

Notes:
PROVISIONAL DIAGNOSIS DATE is the date on which a PROVISIONAL DIAGNOSIS was made.

PSYCHOSIS FIRST TREATMENT START DATE

Change to Data Element: Changed Dataset

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

Notes:
PSYCHOSIS FIRST TREATMENT START DATE is the same as attribute PERSON PROPERTY EFFECTIVE DATE.

PSYCHOSIS FIRST TREATMENT START DATE is the DATE the PATIENT first commenced prescribed anti-psychotic medication, following referral into an Early Intervention in Psychosis (EIP) Service, and thereafter was compliant for at least 75% of the time during the subsequent month (using clinical judgement).

For the majority of PATIENTS this will be the same as the FIRST PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION).

PSYCHOTROPIC MEDICATION USAGE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See PSYCHOTROPIC MEDICATION USAGE
Default Codes:	

Notes:
PSYCHOTROPIC MEDICATION USAGE is the same as attribute PSYCHOTROPIC MEDICATION USAGE.

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

Change to Data Element: New Data Element

Format/Length:	an1
National Codes:	See REASON FOR OUT OF AREA REFERRAL FOR ADULT ACUTE MENTAL HEALTH
Default Codes:	99 - Reason Not Known

Notes:
REASON FOR OUT OF AREA REFERRAL (ADULT ACUTE MENTAL HEALTH) is the same as attribute REASON FOR OUT OF AREA REFERRAL FOR ADULT ACUTE MENTAL HEALTH.

This data element is also known by these names:

Context	Alias

plural	REASONS FOR OUT OF AREA REFERRAL (ADULT ACUTE MENTAL HEALTH)

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

Change to Data Element: New Data Element

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

Attribute:

REASON FOR OUT OF AREA REFERRAL FOR ADULT ACUTE MENTAL HEALTH

REFERRAL CLOSURE DATE

Change to Data Element: Changed Dataset

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

Notes:
REFERRAL CLOSURE DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Referral Closure Date*'.

REFERRAL CLOSURE REASON

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See REFERRAL CLOSURE REASON
Default Codes:	

Notes:
REFERRAL CLOSURE REASON is the same as attribute REFERRAL CLOSURE REASON.

REFERRAL CLOSURE TIME

Change to Data Element: New Data Element

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

Notes:
REFERRAL CLOSURE TIME is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Referral Closure Time*'.

This data element is also known by these names:

Context	Alias
plural	REFERRAL CLOSURE TIMES

REFERRAL CLOSURE TIME

Change to Data Element: New Data Element

REFERRAL CLOSURE TIME

Attribute:

ACTIVITY TIME

REFERRAL REJECTION DATE

Change to Data Element: Changed Dataset

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

Notes:
REFERRAL REJECTION DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Referral Rejection Date*'.

REFERRAL REJECTION REASON

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See REFERRAL REJECTION REASON
Default Codes:	

Notes:
REFERRAL REJECTION REASON is the same as attribute REFERRAL REJECTION REASON.

REFERRAL REQUEST RECEIVED DATE

Change to Data Element: Changed Dataset

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

Notes:
REFERRAL REQUEST RECEIVED DATE is the same as attribute REFERRAL REQUEST RECEIVED DATE.

For the purposes of the National Cancer Waiting Times Monitoring Data Set, REFERRAL REQUEST RECEIVED DATE is used to derive the CANCER REFERRAL TO TREATMENT PERIOD START DATE.

REFERRAL REQUEST RECEIVED TIME

Change to Data Element: Changed Dataset

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

Notes:
REFERRAL REQUEST RECEIVED TIME is the same as attribute REFERRAL REQUEST RECEIVED TIME.

REFERRAL TO TREATMENT PERIOD END DATE

Change to Data Element: Changed Dataset

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

Notes:
REFERRAL TO TREATMENT PERIOD END DATE is the same as attribute REFERRAL TO TREATMENT PERIOD END DATE.

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement, and is of the following Commissioning Data Set Types:

- CDS V6-2 Type 020 - Outpatient Commissioning Data Set
- CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set
- CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set
- CDS V6-2 Type 030 - Elective Admission List - End of Period Census (Standard) Commissioning Data Set
- CDS V6-2 Type 060 - Elective Admission List - Event During Period (Add) Commissioning Data Set
- CDS V6-2 Type 070 - Elective Admission List - Event During Period (Remove) Commissioning Data Set
- CDS V6-2 Type 080 - Elective Admission List - Event During Period (Offer) Commissioning Data Set

then REFERRAL TO TREATMENT PERIOD END DATE must be present in the Commissioning Data Set PATIENT PATHWAY Data Group, where the REFERRAL TO TREATMENT PERIOD has ended.

REFERRAL TO TREATMENT PERIOD START DATE

Change to Data Element: Changed Dataset

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

Notes:
REFERRAL TO TREATMENT PERIOD START DATE is the same as attribute REFERRAL TO TREATMENT PERIOD START DATE.

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement, and is of the following Commissioning Data Set Types:

- CDS V6-2 Type 020 - Outpatient Commissioning Data Set
- CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set
- CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set
- CDS V6-2 Type 030 - Elective Admission List - End of Period Census (Standard) Commissioning Data Set
- CDS V6-2 Type 060 - Elective Admission List - Event During Period (Add) Commissioning Data Set
- CDS V6-2 Type 070 - Elective Admission List - Event During Period (Remove) Commissioning Data Set
- CDS V6-2 Type 080 - Elective Admission List - Event During Period (Offer) Commissioning Data Set

then REFERRAL TO TREATMENT PERIOD START DATE must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.

REFERRAL TO TREATMENT PERIOD STATUS

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See REFERRAL TO TREATMENT PERIOD STATUS
Default Codes:	

Notes:
REFERRAL TO TREATMENT PERIOD STATUS is the same as attribute REFERRAL TO TREATMENT PERIOD STATUS.

Use in Commissioning Data Set version 6-0 onwards

If the Commissioning Data Set record relates to a Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement, and is of the following Commissioning Data Set Types:

- CDS V6-2 Type 020 - Outpatient Commissioning Data Set
- CDS V6-2 Type 130 - Admitted Patient Care - Finished General Episode Commissioning Data Set
- CDS V6-2 Type 190 - Admitted Patient Care - Unfinished General Episode Commissioning Data Set
- CDS V6-2 Type 030 - Elective Admission List - End of Period Census (Standard) Commissioning Data Set
- CDS V6-2 Type 060 - Elective Admission List - Event During Period (Add) Commissioning Data Set
- CDS V6-2 Type 070 - Elective Admission List - Event During Period (Remove) Commissioning Data Set
- CDS V6-2 Type 080 - Elective Admission List - Event During Period (Offer) Commissioning Data Set

then REFERRAL TO TREATMENT PERIOD STATUS must be present in the Commissioning Data Set PATIENT PATHWAY Data Group.

REFERRED OUT OF AREA REASON (ADULT ACUTE MENTAL HEALTH)

Change to Data Element: New Data Element

Format/Length:	an2
National Codes:	See REFERRED OUT OF AREA REASON FOR ADULT ACUTE MENTAL HEALTH
Default Codes:	99 - Not Known (Not Recorded)

Notes:
REFERRED OUT OF AREA REASON (ADULT ACUTE MENTAL HEALTH) is the same as attribute REFERRED OUT OF AREA REASON FOR ADULT ACUTE MENTAL HEALTH.

This data element is also known by these names:

Context	Alias
plural	REFERRED OUT OF AREA REASONS (ADULT ACUTE MENTAL HEALTH)

REFERRED OUT OF AREA REASON (ADULT ACUTE MENTAL HEALTH)

Change to Data Element: New Data Element

REFERRED OUT OF AREA REASON (ADULT ACUTE MENTAL HEALTH)

Attribute:

REFERRED OUT OF AREA REASON FOR ADULT ACUTE MENTAL HEALTH

REFERRING CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH AND COMMUNITY CARE)

Change to Data Element: Changed Dataset

Format/Length:	an3
National Codes:	See REFERRING CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH AND COMMUNITY CARE
Default Codes:	

Notes:
REFERRING CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH AND COMMUNITY CARE) is the same as attribute REFERRING CARE PROFESSIONAL STAFF GROUP FOR MENTAL HEALTH AND COMMUNITY CARE.

REFERRING ORGANISATION CODE

Change to Data Element: Changed Dataset

Format/Length:	max an6
National Codes:	
ODS Default Codes:	X99998 - Referring ORGANISATION CODE not applicable X99999 - Referring ORGANISATION CODE not known

Notes:
REFERRING ORGANISATION CODE is the same as attribute ORGANISATION CODE.

REFERRING ORGANISATION CODE is the ORGANISATION CODE of the Organisation from which the referral is made, such as a GP Practice, NHS Trust or NHS Foundation Trust.

This information is essential for managing service agreements which are based on patterns of referral.

REFERRING ORGANISATION CODE will be replaced with REFERRING ORGANISATION IDENTIFIER, when it has been approved for use in national information standards.

RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE
Default Codes:	

Notes:
RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE is the same as attribute RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE.

REPLACEMENT APPOINTMENT BOOKED DATE

Change to Data Element: Changed Dataset

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

Notes:
REPLACEMENT APPOINTMENT BOOKED DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Replacement Appointment Booked Date*'.

REPLACEMENT APPOINTMENT DATE OFFERED

Change to Data Element: Changed Dataset

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

Notes:
REPLACEMENT APPOINTMENT DATE OFFERED is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Replacement Appointment Date Offered*'.

REPORTING PERIOD END DATE

Change to Data Element: Changed Dataset

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

Notes:
REPORTING PERIOD END DATE is the same as attribute REPORTING PERIOD END DATE.

REPORTING PERIOD END DATE is the end date of the REPORTING PERIOD and is used in conjunction with REPORTING PERIOD START DATE to specify the actual period the reported information relates to.

The date should not be before the REPORTING PERIOD START DATE although it can be the same if the period being reported only covers 1 day.

REPORTING PERIOD START DATE

Change to Data Element: Changed Dataset

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

Notes:
REPORTING PERIOD START DATE is the same as attribute REPORTING PERIOD START DATE.

REPORTING PERIOD START DATE is the start date of the REPORTING PERIOD and is used in conjunction with REPORTING PERIOD END DATE to specify the actual period the reported information relates to.

The date should not be after the REPORTING PERIOD END DATE although it can be the same if the period being reported only covers 1 day.

RESTRICTIVE INTERVENTION TYPE

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See RESTRICTIVE INTERVENTION TYPE
Default Codes:	

Notes:
RESTRICTIVE INTERVENTION TYPE is the same as the attribute RESTRICTIVE INTERVENTION TYPE.

SECONDARY DIAGNOSIS (CODED CLINICAL ENTRY)

Change to Data Element: Changed Dataset

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

Notes:
SECONDARY DIAGNOSIS (CODED CLINICAL ENTRY) is the same as attribute CLINICAL CLASSIFICATION CODE or CLINICAL TERMINOLOGY CODE.

SECONDARY DIAGNOSIS (CODED CLINICAL ENTRY) is the CODED CLINICAL ENTRY used to identify the secondary PATIENT DIAGNOSIS.

SERVICE DISCHARGE DATE

Change to Data Element: Changed Dataset

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

Notes:
SERVICE DISCHARGE DATE is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Service Discharge Date*'.

SERVICE DISCHARGE TIME

Change to Data Element: New Data Element

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

Notes:
SERVICE DISCHARGE TIME is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Service Discharge Time*'.

This data element is also known by these names:

Context	Alias
plural	SERVICE DISCHARGE TIMES

SERVICE DISCHARGE TIME

Change to Data Element: New Data Element

SERVICE DISCHARGE TIME

Attribute:

ACTIVITY TIME

SERVICE OR TEAM TYPE REFERRED TO (MENTAL HEALTH)

Change to Data Element: Changed Dataset

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

Notes:
SERVICE OR TEAM TYPE REFERRED TO (MENTAL HEALTH) is the same as attribute SERVICE OR TEAM TYPE FOR MENTAL HEALTH.

SERVICE OR TEAM TYPE REFERRED TO (MENTAL HEALTH) is the type of SERVICE or team within a Mental Health Service that a PATIENT was referred to.

SERVICE REQUEST ACCEPTANCE INDICATOR

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See SERVICE REQUEST ACCEPTANCE INDICATOR
Default Codes:	

Notes:
SERVICE REQUEST ACCEPTANCE INDICATOR is the same as attribute SERVICE REQUEST ACCEPTANCE INDICATOR.

SERVICE REQUEST IDENTIFIER

Change to Data Element: Changed Dataset

Format/Length:	max an20
National Codes:	

Default Codes:

Notes:
SERVICE REQUEST IDENTIFIER is the same as attribute SERVICE REQUEST IDENTIFIER.

SETTLED ACCOMMODATION INDICATOR

Change to Data Element: Changed Description, Dataset

Format/Length:	an1
National Codes:	See SETTLED ACCOMMODATION INDICATOR
~~Default Codes:~~	~~9 - Not Known~~
Default Codes:	9 - Not Known (Not Recorded)

Notes:
SETTLED ACCOMMODATION INDICATOR is the same as attribute SETTLED ACCOMMODATION INDICATOR.

SEX OF PATIENTS CODE

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	
Default Codes:	

Notes:
SEX OF PATIENTS CODE is the same as attribute SEX OF PATIENTS.

SEX OF PATIENTS CODE is based on the SEX OF PATIENTS National Codes, with the addition of Home Leave:

Permitted National Codes:

1	Male
2	Female
8	Not specified
9	Home Leave *

* Note - National Code 9 is not valid for the Mental Health Services Data Set.

SEXUAL ORIENTATION (CURRENT)

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See SEXUAL ORIENTATION CODE
Default Codes:	9 - Unknown

Notes:
SEXUAL ORIENTATION (CURRENT) is the same as attribute SEXUAL ORIENTATION CODE.

SEXUAL ORIENTATION (CURRENT) is the current SEXUAL ORIENTATION of a PERSON.

For the purposes of the Genitourinary Medicine Clinic Activity Data Set, National Codes *'4 PERSON asked and does not know or is not sure'* and *'Z Not Stated (PERSON asked but declined to provide a response)'* cannot be used.

National Codes 4 and Z should be mapped to '*9 Unknown*' for central reporting purposes.

SITE CODE (OF TREATMENT)

Change to Data Element: Changed Dataset

Format/Length:	min an5 max an9
National Codes:	
ODS Default Codes:	R9998 - Not a hospital site (for use on Out-Patient CDS)
	89999 - Non-NHS UK Provider where no ORGANISATION SITE CODE has been issued
	89997 - Non-UK Provider where no ORGANISATION SITE CODE has been issued

Notes:
SITE CODE (OF TREATMENT) is the same as attribute ORGANISATION SITE CODE.

SITE CODE (OF TREATMENT) is the ORGANISATION SITE CODE of the Organisation where the PATIENT was treated, i.e. it should enable the treating Organisation to be identified.

This identifies the Organisation Site within the Organisation on which the PATIENT was treated, since facilities may vary on different hospital sites.

The code recorded should always be the national code; if the treatment is sub-commissioned to another NHS Health Care Provider or an independent UK provider, the SITE CODE (OF TREATMENT) used should be the ORGANISATION SITE CODE of the Health Care Provider actually carrying out the work.

Where treatment is sub-commissioned to an overseas provider the Organisation Data Service Default Code 89997 *'Non-UK Provider where no ORGANISATION SITE CODE has been issued'* is applicable.

Each Organisation has a unique ORGANISATION CODE. However, where an Organisation has more than one site from which it provides SERVICES, then each site is uniquely identified. These sites are Organisation Sites and are uniquely identified by ORGANISATION SITE CODE. The ORGANISATION SITE CODE contains the first 3 digits of the ORGANISATION CODE with the last two digits being the site identifier.

Example:

RA700	ORGANISATION CODE of the Organisation
RA701	ORGANISATION SITE CODE of the first identified Organisation Site within the Organisation
RA702	ORGANISATION SITE CODE of the second identified Organisation Site within the Organisation

For out-patients, ACTIVITY may take place outside the hospital, such as in the PATIENT'S home; in such cases, raising a site code is impractical. Therefore, code R9998 *'Not a hospital site (for use on Out-Patient CDS)'* would be used in these circumstances.
Note: LOCATION CLASS is used in the Commissioning Data Set (CDS) message to indicate the classification of the physical LOCATION within which the ACTIVITY occurred.

Use in the Future Outpatient CDS:
If the INTENDED SITE CODE (OF TREATMENT) is not known, this data element should be omitted.

SITE CODE (OF TREATMENT) will be replaced with ORGANISATION SITE IDENTIFIER (OF TREATMENT), when it has been approved for use in national information standards.

SOCIAL PHOBIA INVENTORY SCORE

Change to Data Element: Changed Dataset

Format/Length:	max n2
National Codes:	

Default Codes:

Notes:
SOCIAL PHOBIA INVENTORY SCORE is the PERSON SCORE for an APPOINTMENT where the ASSESSMENT TOOL TYPE is '*Social Phobia Inventory Questionnaire*'.

The score is in the range 0 to 68.

SOCIAL PHOBIA SCORE

Change to Data Element: Changed Dataset

Format/Length:	n1
National Codes:	
Default Codes:	

Notes:
SOCIAL PHOBIA SCORE is the PERSON SCORE for an APPOINTMENT where the ASSESSMENT TOOL TYPE is '*Social Phobia Questionnaire*'.

The score is in the range 0 to 8.

SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Dataset

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

Notes:
SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL) is the same as attribute SOURCE OF ADMISSION.

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

For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

SOURCE OF REFERRAL FOR MENTAL HEALTH

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See SOURCE OF REFERRAL FOR MENTAL HEALTH
Default Codes:	

Notes:
SOURCE OF REFERRAL FOR MENTAL HEALTH is the same as attribute SOURCE OF REFERRAL FOR MENTAL HEALTH.

SPECIFIC PHOBIA SCORE

Change to Data Element: Changed Dataset

Format/Length:	n1

National Codes:
Default Codes:

Notes:
SPECIFIC PHOBIA SCORE is the PERSON SCORE for an APPOINTMENT where the ASSESSMENT TOOL TYPE is "*Specific Phobia Questionnaire*".

The score is in the range 0 to 8.

START DATE (CARE CLUSTER ASSIGNMENT PERIOD)

Change to Data Element: Changed Dataset

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

Notes:
START DATE (CARE CLUSTER ASSIGNMENT PERIOD) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Start Date*' of a Care Cluster Assignment Period.

START DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)

Change to Data Element: Changed Dataset

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

Notes:
START DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Start Date*' of the Care Professional Admitted Care Episode.

START DATE (CARE PROGRAMME APPROACH CARE)

Change to Data Element: Changed Dataset

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

Notes:
START DATE (CARE PROGRAMME APPROACH CARE) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Start Date*' of the Care Programme Approach care for the PATIENT.

START DATE (COMMISSIONER ASSIGNMENT PERIOD)

Change to Data Element: Changed Dataset

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

Notes:
START DATE (COMMISSIONER ASSIGNMENT PERIOD) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Start Date*' of the Commissioner Assignment Period.

START DATE (COMMUNITY TREATMENT ORDER)

Change to Data Element: Changed Dataset

Format/Length:	See DATE

National Codes: Default Codes:

Notes:
START DATE (COMMUNITY TREATMENT ORDER) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Start Date*' of the Community Treatment Order.

START DATE (COMMUNITY TREATMENT ORDER RECALL)

Change to Data Element: Changed Dataset

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

Notes:
START DATE (COMMUNITY TREATMENT ORDER RECALL) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Start Date*' of the Community Treatment Order Recall.

START DATE (GMP PATIENT REGISTRATION)

Change to Data Element: Changed Dataset

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

Notes:
START DATE (GMP PATIENT REGISTRATION) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Start Date*' on which the PERSON registered with a General Medical Practitioner Practice.

START DATE (HOME LEAVE)

Change to Data Element: Changed Dataset

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

Notes:
START DATE (HOME LEAVE) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Start Date*' of the Home Leave.

START DATE (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Dataset

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

Notes:
START DATE (HOSPITAL PROVIDER SPELL) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Start Date*' of the Hospital Provider Spell.

The Start Date of the Hospital Provider Spell is the date of admission: the CONSULTANT or MIDWIFE has assumed responsibility for care following the DECISION TO ADMIT the PATIENT.

START DATE (HOSPITAL PROVIDER SPELL) is used by the Secondary Uses Service to derive the **Healthcare Resource Group 4**. Failure to correctly populate this data element is likely to result in an incorrect Healthcare Resource Group, usually associated with lower levels of healthcare resource.

For further information, please refer to the NHS Digital website at: Payment by Results Guidance.

START DATE (MENTAL HEALTH ABSENCE WITHOUT LEAVE)

Change to Data Element: Changed Dataset

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

Notes:
START DATE (MENTAL HEALTH ABSENCE WITHOUT LEAVE) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Start Date*' of the Mental Health Absence Without Leave.

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

Change to Data Element: Changed Dataset

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

Notes:
START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Start Date*' of the Mental Health Act Legal Status Classification Assignment Period.

START DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD)

Change to Data Element: Changed Dataset

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

Notes:
START DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT PERIOD) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Start Date*' of the Mental Health Care Coordinator Assignment Period.

START DATE (MENTAL HEALTH CONDITIONAL DISCHARGE)

Change to Data Element: Changed Dataset

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

Notes:
START DATE (MENTAL HEALTH CONDITIONAL DISCHARGE) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Start Date*' of the Mental Health Conditional Discharge Period.

START DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD)

Change to Data Element: Changed Dataset

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

Notes:

START DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Start Date*' of the Mental Health Delayed Discharge Period.

START DATE (MENTAL HEALTH LEAVE OF ABSENCE)

Change to Data Element: Changed Dataset

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

Notes:
START DATE (MENTAL HEALTH LEAVE OF ABSENCE) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Start Date*' of the Mental Health Leave of Absence.

START DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD)

Change to Data Element: Changed Dataset

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

Notes:
START DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT PERIOD) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Start Date*' of the Mental Health Responsible Clinician Assignment Period.

START DATE (WARD STAY)

Change to Data Element: Changed Dataset

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

Notes:
START DATE (WARD STAY) is the same as attribute ACTIVITY DATE where the ACTIVITY DATE TYPE is National Code '*Start Date*' of the Ward Stay.

START TIME (CARE CLUSTER ASSIGNMENT PERIOD)

Change to Data Element: Changed Dataset

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

Notes:
START TIME (CARE CLUSTER ASSIGNMENT PERIOD) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Start Time*' of a Care Cluster Assignment Period.

START TIME (COMMUNITY TREATMENT ORDER RECALL)

Change to Data Element: Changed Dataset

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

Notes:
START TIME (COMMUNITY TREATMENT ORDER RECALL) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Start Time*' of the Community Treatment Order Recall.

START TIME (HOME LEAVE)

Change to Data Element: Changed Dataset

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

Notes:
START TIME (HOME LEAVE) is the same as the attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Start Time*' of the Home Leave.

START TIME (HOSPITAL PROVIDER SPELL)

Change to Data Element: Changed Dataset

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

Notes:
START TIME (HOSPITAL PROVIDER SPELL) is the same as the attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Start Time*' of the Hospital Provider Spell.

START TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE)

Change to Data Element: Changed Dataset

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

Notes:
START TIME (MENTAL HEALTH ABSENCE WITHOUT LEAVE) is the same as the attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Start Time*' of the Mental Health Absence Without Leave.

START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)

Change to Data Element: Changed Dataset

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

Notes:
START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD) is the same as attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Start Time*' of the Mental Health Act Legal Status Classification Assignment Period.

START TIME (MENTAL HEALTH LEAVE OF ABSENCE)

Change to Data Element: Changed Dataset

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

Notes:
START TIME (MENTAL HEALTH LEAVE OF ABSENCE) is the same as the attribute ACTIVITY TIME where the ACTIVITY TIME TYPE is National Code '*Start Time*' of the Mental Health Leave of Absence.

START TIME (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.

STATUTORY SICK PAY INDICATOR

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See STATUTORY SICK PAY INDICATOR
Default Codes:	

Notes:
STATUTORY SICK PAY INDICATOR is the same as attribute STATUTORY SICK PAY INDICATOR.

For the Improving Access to Psychological Therapies Data Set, this is taken from the PATIENT's completed Employment Status Questionnaire during the current Improving Access to Psychological Therapies Care Spell.

THERAPY TYPE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See THERAPY TYPE FOR IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES
Default Codes:	

Notes:
THERAPY TYPE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES) is the same as attribute THERAPY TYPE FOR IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES.

TREATMENT FUNCTION CODE (MENTAL HEALTH)

Change to Data Element: Changed Description, Dataset

Format/Length:	an3
National Codes:	
Default Codes:	

Notes:
TREATMENT FUNCTION CODE (MENTAL HEALTH) is the same as attribute TREATMENT FUNCTION CODE.

TREATMENT FUNCTION CODE (MENTAL HEALTH) is the TREATMENT FUNCTION CODE for the PATIENT treated by a Mental Health Service.

Permitted National Codes:

319	Respite Care
700	Learning Disability
710	Adult Mental Illness
711	Child and Adolescent Psychiatry
712	Forensic Psychiatry
713	Psychotherapy
715	Old Age Psychiatry
720	Eating Disorders
721	Addiction Services

722 Liaison Psychiatry
723 Psychiatric Intensive Care
724 Perinatal Psychiatry
725 Mental Health Recovery and Rehabilitation Service
726 Mental Health Dual Diagnosis Service
727 Dementia Assessment Service

UCUM UNIT OF MEASUREMENT

Change to Data Element: Changed Dataset

Format/Length:	max an10
National Codes:	
Default Codes:	

Notes:
UCUM UNIT OF MEASUREMENT is the same as attribute UCUM UNIT OF MEASUREMENT.

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 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: Changed Dataset

Format/Length:	an2
National Codes:	See WARD SETTING TYPE FOR MENTAL HEALTH
Default Codes:	

Notes:
WARD SETTING TYPE (MENTAL HEALTH) is the same as attribute WARD SETTING TYPE FOR MENTAL HEALTH.

WARD STAY IDENTIFIER

Change to Data Element: Changed Dataset

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

Notes:
WARD STAY IDENTIFIER is the same as attribute ACTIVITY IDENTIFIER.

WARD STAY IDENTIFIER is a unique identifier allocated for each Ward Stay during a Hospital Provider Spell.

WEEKLY HOURS WORKED

Change to Data Element: Changed Dataset

Format/Length:	an2
National Codes:	See WEEKLY HOURS WORKED
Default Codes:	98 - Not applicable (PATIENT not employed) 99 - Number of hours worked not known

Notes:
WEEKLY HOURS WORKED is the same as attribute WEEKLY HOURS WORKED.

WORK AND SOCIAL ADJUSTMENT SCALE SCORE (HOME MANAGEMENT)

Change to Data Element: Changed Dataset

Format/Length:	n1
National Codes:	
Default Codes:	

Notes:

WORK AND SOCIAL ADJUSTMENT SCALE SCORE (HOME MANAGEMENT) is the PERSON SCORE for the *Work and Social Adjustment Scale* question relating to the PATIENT's *'home management'*.

The score is in the range 0 to 8.

WORK AND SOCIAL ADJUSTMENT SCALE SCORE (PRIVATE LEISURE ACTIVITIES)

Change to Data Element: Changed Dataset

Format/Length:	n1
National Codes:	
Default Codes:	

Notes:
WORK AND SOCIAL ADJUSTMENT SCALE SCORE (PRIVATE LEISURE ACTIVITIES) is the PERSON SCORE for the *Work and Social Adjustment Scale* question relating to the PATIENT's *'private leisure activities'*.

The score is in the range 0 to 8.

WORK AND SOCIAL ADJUSTMENT SCALE SCORE (RELATIONSHIPS)

Change to Data Element: Changed Dataset

Format/Length:	n1
National Codes:	
Default Codes:	

Notes:
WORK AND SOCIAL ADJUSTMENT SCALE SCORE (RELATIONSHIPS) is the PERSON SCORE for the *Work and Social Adjustment Scale* question relating to the PATIENT's *'close relationships'*.

The score is in the range 0 to 8.

WORK AND SOCIAL ADJUSTMENT SCALE SCORE (SOCIAL LEISURE ACTIVITIES)

Change to Data Element: Changed Dataset

Format/Length:	n1
National Codes:	
Default Codes:	

Notes:
WORK AND SOCIAL ADJUSTMENT SCALE SCORE (SOCIAL LEISURE ACTIVITIES) is the PERSON SCORE for the *Work and Social Adjustment Scale* question relating to the PATIENT's *'social leisure activities'*.

The score is in the range 0 to 8.

WORK AND SOCIAL ADJUSTMENT SCALE SCORE (WORK)

Change to Data Element: Changed Dataset

Format/Length:	n1
National Codes:	
Default Codes:	9 - Not Applicable

Notes:

WORK AND SOCIAL ADJUSTMENT SCALE SCORE (WORK) is the PERSON SCORE for the *Work and Social Adjustment Scale* question relating to the PATIENT's *'ability to work'*.

The score is in the range 0 to 8.

YEAR AND MONTH OF SYMPTOMS ONSET (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)

Change to Data Element: Changed Dataset

Format/Length:	See YEAR AND MONTH
National Codes:	
Default Codes:	

Notes:
YEAR AND MONTH OF SYMPTOMS ONSET (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES) is the same as attribute YEAR AND MONTH OF SYMPTOMS ONSET FOR IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES.

For the Improving Access to Psychological Therapies Data Set, it is expected that the PATIENT will always know the year and month that the current mental health problem was first experienced, therefore there is no default code.

YOUNG CARER INDICATOR

Change to Data Element: Changed Dataset

Format/Length:	an1
National Codes:	See YOUNG CARER INDICATOR
Default Codes:	X - Not known whether the PERSON is a young Carer

Notes:
YOUNG CARER INDICATOR is the same as attribute YOUNG CARER INDICATOR.

COMMISSIONING DATA SET VERSION 6-2 XML SCHEMA CONSTRAINTS

Change to XML Schema Constraint: Changed Description

XML Schema constraints applied to the Commissioning Data Sets.

The "Allowed Values" column indicates the NHS Data Model and Dictionary National Codes and Default Codes present in the XML Schema:

- None = The National Codes and Default Codes are included in the XML Schema
- Removed = The National Codes and Default Codes are not included in the XML Schema.

Data Element	XML Schema Format/Length	Allowed Values	Range
A and E ATTENDANCE NUMBER	max an12	None	None
ACCIDENT AND EMERGENCY DIAGNOSIS - FIRST	min an2 max an6	None	None
ACCIDENT AND EMERGENCY DIAGNOSIS - SECOND	min an2 max an6	None	None
		None	None

ACCIDENT AND EMERGENCY INVESTIGATION - FIRST	min an2 max an6		
ACCIDENT AND EMERGENCY INVESTIGATION - SECOND	min an2 max an6	None	None
ACCIDENT AND EMERGENCY TREATMENT - FIRST	min an2 max an6	None	None
ACCIDENT AND EMERGENCY TREATMENT - SECOND	min an2 max an6	None	None
ACTIVITY LOCATION TYPE CODE	None	A01,A02,A03,A04,B01,B02,C01,C02,C03,D01,D02,D03, E01,E02,E03,E04,E99,F01,G01,G02,G03,H01,J01,K01,K02, L01,L02,L03,L04,L05,L06,L99,M01,M02,M03,M04,M05, N01,N02,N03,N04,N05,X01	None
ADVANCED CARDIOVASCULAR SUPPORT DAYS	max n3	None	None
ADVANCED RESPIRATORY SUPPORT DAYS	max n3	None	None
AGE AT CDS ACTIVITY DATE	max n3	None	None
AGE AT CENSUS	max n3	None	None
AGE ON ADMISSION	max n3	None	None
ATTENDANCE IDENTIFIER	max an12	None	None
BASIC CARDIOVASCULAR SUPPORT DAYS	max n3	None	None
BASIC RESPIRATORY SUPPORT DAYS	max n3	None	None
BIRTH WEIGHT	max n4	None	None
CARE PROFESSIONAL MAIN SPECIALTY CODE	None	100,101,110,120,130,140,141,142,143,145,146,147,148,149, 150,160,170,171,180,190,192,300,301,302,303,304,305,310, 311,312,313,314,315,320,321,325,326,330,340,350,352,360, 361,370,371,400,401,410,420,421,430,450,451,460,501,502, 504,560,600,601,700,710,711,712,713,715,800,810,820,821, 822,823,824,830,831,833,834,900,901,902,903,904,950,960, 199,499	None
CDS COPY RECIPIENT IDENTITY	min an3 max an12	Removed	None
CDS MESSAGE REFERENCE	max n7	None	None
CDS MESSAGE VERSION NUMBER	None	CDS062	None

CDS PRIME RECIPIENT IDENTITY	min an3 max an12	Removed	None
CDS SENDER IDENTITY	min an3 max an12	None	None
CDS UNIQUE IDENTIFIER	max an35	None	None
COMMISSIONER REFERENCE NUMBER	max an17	None	None
COMMISSIONING SERIAL NUMBER	max an6	None	None
CONSULTATION MEDIUM USED	None	01,02,03,04	None
COUNT OF DAYS SUSPENDED	max n4	None	None
CRITICAL CARE ACTIVITY CODE	None	01,02,03,04,05,06,07,08,09,10,11,12,13,14, 15,16,21,22,23,24,25,26,27,28,29,50,51,52, 53,55,56,57,58,59,60,61,62,63,64,65,66,67, 68,69,70,71,72,73,74,99	None
CRITICAL CARE LEVEL 2 DAYS	max n3	None	None
CRITICAL CARE LEVEL 3 DAYS	max n3	None	None
CRITICAL CARE LOCAL IDENTIFIER	max an8	None	None
DERMATOLOGICAL SUPPORT DAYS	max n3	None	None
~~DURATION OF CARE TO PSYCHIATRIC CENSUS DATE~~	~~max n5~~	~~None~~	Existing Format/Len states n3 - XML Schem allows max
DISCHARGE METHOD CODE (HOSPITAL PROVIDER SPELL)	None	1,2,3,4,5,8,9	None
DURATION OF CARE TO PSYCHIATRIC CENSUS DATE	max n5	None	None
DURATION OF DETENTION	max n5	None	None
DURATION OF ELECTIVE WAIT	max n4	None	None
	max an12	None	None

ELECTIVE ADMISSION LIST ENTRY NUMBER			
EPISODE NUMBER	max an2	None	None
ETHNIC CATEGORY	max an2	None	None
GASTRO-INTESTINAL SUPPORT DAYS	max n3	None	None
GENERAL MEDICAL PRACTITIONER PRACTICE (ANTENATAL CARE)	min an3 max an12	Removed	None
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	min an3 max an12	Removed	None
GENERAL MEDICAL PRACTITIONER (ANTENATAL CARE)	None	Removed	None
GENERAL MEDICAL PRACTITIONER (SPECIFIED)	None	Removed	None
HOSPITAL PROVIDER SPELL NUMBER	max an12	None	None
INTENDED SITE CODE (OF TREATMENT)	min an3 max an12	Removed	None
LIVER SUPPORT DAYS	max n3	None	None
LOCAL PATIENT IDENTIFIER	max an10	None	None
LOCAL PATIENT IDENTIFIER (BABY)	max an10	None	None
LOCAL PATIENT IDENTIFIER (MOTHER)	max an10	None	None
MENTAL HEALTH ACT LEGAL STATUS	None	01,02,03,04,05,06,07,08,09,10,11,12,13,14, 15,16,17,18,19,20,31,32,34,35,36,37,38	None

CLASSIFICATION CODE (AT CENSUS DATE)			
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION)	None	01,02,03,04,05,06,07,08,09,10,11,12,13,14, 15,16,17,18,19,20,31,32,34,35,36,37,38	None
NEUROLOGICAL SUPPORT DAYS	max n3	None	None
NHS SERVICE AGREEMENT LINE NUMBER	max an10	None	None
ORGAN SUPPORT MAXIMUM	None	None	00-06
ORGANISATION CODE (CODE OF COMMISSIONER)	min an3 max an12	Removed	None
ORGANISATION CODE (CODE OF PROVIDER)	min an3 max an12	Removed	None
ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)	min an3 max an12	None	None
ORGANISATION CODE (LOCAL PATIENT IDENTIFIER (BABY))	min an3 max an12	None	None
ORGANISATION CODE (LOCAL PATIENT IDENTIFIER (MOTHER))	min an3 max an12	None	None
ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)	min an3 max an12	None	None
ORGANISATION CODE (RESIDENCE RESPONSIBILITY)	min an3 max an12	Removed	None
PERSON WEIGHT	n3.n3	None	None
PRIMARY DIAGNOSIS (READ)	max an5	None	None
PROVIDER REFERENCE NUMBER	max an17	None	None
REFERRER CODE	None	Removed	None

REFERRING ORGANISATION CODE	min an3 max an12	Removed	None
RENAL SUPPORT DAYS	max n3	None	None
SECONDARY DIAGNOSIS (READ)	max an5	None	None
SITE CODE (OF TREATMENT)	min an3 max an12	Removed	None

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