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Mental Health Services Data Set (MHSDS) v4.1 User Guidance

Document Management

Revision History

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4.1.0	14/11/2019	First release of the v4.1.0 User Guidance, based upon v4.0.3 of the v4.0 User Guidance, incorporating amendments in line with v4.1 changes.
4.1.1	27/04/2020	MHS504: Clarification for the submission of the Responsible LA field MHS102: Clarification that team type applies to community services only MHS011: Improvement to guidance for finding codes and correction to Religion mapping MHS201: Update to Place of Safety definition in line with v4.1 change Appendix 3: Inclusion of ReQol and CORE-OM within list of tools for submission] General review of hyperlinks and formatting
4.1.2	26/06/2020	• Removal of 'Section 5.1 MHSDS and the Commissioning Data Sets (CDS)'. Information on duplicate collections, can now be found on the Mental Health: Guidance for Service Providers and Suppliers page, under the header 'Further Information' • MHS201: Additional guidance included to Consultation Medium Used • MHS504: Additional guidance on Delayed Transfers of Care (DTOC) included within Section 5.4.35 and Appendix 6 • Inclusion of Appendix 2: Definitions for Restrictive Interventions for use in the MHSDS • Inclusion of Appendix 10 - Definitions for Hospital Bed Types and Team Types • MHS502: Further emphasis on completion of Ward Code

Reviewers

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Name	Title	Date	Version
Aaron Leathley	Business and Operational Delivery Manager	24/06/2020	4.1.2

Glossary of Terms

Term / Abbreviation	What it stands for
AHP RTT	Allied Health Professionals Referral To Treatment
AWOL	Absence Without Leave
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CDS	Commissioning Data Sets
CPA	Care Programme Approach - The Care Programme Approach has four main elements as defined in '*Building Bridges: A guide to arrangements for inter–agency working for the care and protection of severely mentally ill people*'. Components of CPA There are four distinct aspects to the CPA; assessment; care plan, Care Co–ordination and review. These are the cornerstones of the Care Programme Approach.
CQC	Care Quality Commission
CTO	Community Treatment Order
CYP IAPT	Children and Young People's Improving Access to Psychological Therapies
Data Item	A single component of a data set that holds one type of information and relates to a specific record.
Data Group	A collection of data items that describe a distinct event or episode. This can also be referred to as a table of data.
Data Set	The full collection of data groups. See 'Technical Output Specification'
DCB	The Data Coordination Board (DCB) replaces SCCI and is a sub-group of the Digital Delivery Board (DDB). Empowered by the Health and Social Care Act 2012, the DCB has delegated responsibility for approving information standards for the health and social care system in England. The DCB membership is drawn from a range of organisations operating within health and social care.
DHSC	Department of Health and Social Care
DNA	Did Not Attend
DPS	Data Processing Services
HoNOS	Health of the Nation Outcome Scales
HSCIC	The HSCIC was formed in April 2013 and established as an Executive Non-Departmental Public Body (ENDPB) under the Health and Social Care Act 2012. Through the Act, the HSCIC has a significant statutory duty to support the health and care system with regard to: • collecting, storing, analysing and disseminating England's health and care data • providing a trusted safe haven for some of an individual's most sensitive information • building and delivering the technical systems that enable data both to be used to support an individual's care and to deliver better, more effective care for the community as a whole. The HSCIC is also known as NHS Digital.
ICD 10	International Classification of Diseases (Revision 10)
IDB	Intermediate Database (a MS Access database used to submit data to the DPS)

ISN	A notice of an Information Standard approved by the Data Coordination Board (DCB). When a health and social care organisation in England receives an ISN, they will ensure that they and their contractors comply with the standard in a reasonable time (such time defined within the ISN). ISNs were previously published by the Standardisation Committee for Care Information (SCCI).
LOA	Mental Health Leave of Absence
Mental Health	The term 'mental health' includes patients of all ages (i.e. adults, adolescents and children) and is used generically to include patients with a learning disability or autism spectrum disorder as well as other mental health needs.
MHA	Mental Health Act
MHCC	Mental Health Care Cluster
MHCT	Mental Health Clustering Tool
MHLDDS	Mental Health and Learning Disabilities Data Set (superseded by MHSDS)
MHMDS	Mental Health Minimum Dataset (Superseded by MHLDDS)
MHSDS	Mental Health Services Data Set
NHS Digital	The preferred name for the HSCIC, with effect from 1 August 2016.
NICE	National Institute for Health and Clinical Excellence
Null	A data item with no value (i.e. blank) and therefore, has no meaning. This is different from a value of 0, since 0 is an actual value.
PAM	Patient Activation Measures
PAS	Patient Administration System
PbR	Payment by Results (now referred to as National Tariff Payment System)
PLD	Patient Level Data Set
RCPsych	Royal College of Psychiatrists
Reporting Period	The period (usually a calendar month) for which a particular data upload refers.
SCCI	The Standardisation committee for Care Information (SCCI) was a committee with membership drawn from a range of health and social care organisations with responsibility for overseeing the development, assurance and approval of information standards, data collections and data extractions used within the health and social care system. New national governance arrangements for information standards, data collections and data extractions came into effect on 1 April 2017. On 1 April 2017, the Data Coordination Board (DCB) took over responsibility for the approval of standards from SCCI.
SCT	Supervised Community Treatment
SDCS Cloud	Strategic Data Collection Service (SDCS) Cloud
SMH	Specialised Mental Health
SNOMED CT	Systematized Nomenclature of Medicine – Clinical Terms
TOS	Technical Output Specification

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1 About this Document

1.1 Purpose of the Document

The purpose of this document is to outline the manner by which the national data set should be used and interpreted by users, system suppliers and other stakeholders, for example by providing additional information on data groups and data items, along with supplementing the data set Technical Output Specification with additional guidance regarding the extraction and analysis of the data set.

1.2 Scope of the Document

This document is aimed at:

- Managers and clinical leads of organisations providing Mental Health, Learning Disabilities and Autism Spectrum Disorder Care services
- Information management departments within data provider organisations
- IT system suppliers operating on behalf of Mental Health, Learning Disabilities and Autism Spectrum Disorder Care services
- Other stakeholders responsible for the submission and analysis of MHSDS data including acute providers where they provide secondary mental health care services such as Liaison and Crisis Resolution.

The following areas are out of scope of this document:

- Detailed justification for the development of the Information Standard.
- Data submission framework (i.e. how data is submitted by data providers to the Strategic Data Collection Cloud (SDCS) Cloud). Further information about this is available from the MHSDS technical guidance.
- Restating information already accessible from the MHSDS Technical Output Specification (TOS).

This document should be read in conjunction with the following documents:

- MHSDS v4.1 Requirements Specification
- MHSDS v4.1 Change Request
- MHSDS v4.1 Technical Output Specification
- MHSDS v4.1 Implementation Guidance
- NHS Data Model and Dictionary

1.3 Schedule for Updating this Document

Please note this guidance document is considered to be a live document and NHS Digital reserves the right to review and update when necessary, for example in response to stakeholder feedback.

Changes to this document will not necessitate further acceptance from the Data Coordination Board (DCB); however this is on the understanding that the changes do not affect the scope of the Information Standard

2 Background Information

The MHSDS is a patient level, output based, secondary uses data set which seeks to deliver robust, comprehensive, nationally consistent and comparable person-based information for children, young people and adults who are in contact with Mental Health, Learning Disabilities or Autism Spectrum Disorder Services.

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

2.1 MHSDS v4.1

An ongoing requirement exists to update the Mental Health Services Data Set (MHSDS) to ensure the data set remains 'fit for purpose'. The changes included in this release relate to new government policy initiatives, resolution of issues within the current data collection, and inclusion of other key stakeholder requirements as follows:

- Extend and amend the service or team type list to better reflect current practice
- Removal of the CAMHS Tier of service data item in support of an algorithm approach using remaining MHSDS data items to identify CYP services
- Expansion of scope to include problem gambling services
- Removal of the option to submit Read codes
- Minor maintenance changes to respond to issues raised by, for example, the NHS Data Model and Dictionary Service
- Amendment to the definition of 'Place of Safety'
- Implementation of the multiple submission window model

2.2 MHSDS Scope Changes

A minor change of scope has been made as part of MHSDS v4.0 to allow for non-English service providers, as shown in the table below. The change in scope across the various historic versions of the Mental Health Services Data Set are summarised in the table below:

Scope	MHMDS v 3.0 /	MHMDS v 4.0 / 4.1	MHLDDS v1.0 / v1.1	MHSDS v 1.0/1.1/2.0/3.	MHSDS v4.0	MHSDS v4.1
Adult	Yes	Yes	Yes	Yes	Yes	Yes
Older Persons	Yes	Yes	Yes	Yes	Yes	Yes
Dual Diagnosis	Yes	Yes	Yes	Yes	Yes	Yes
IAPT (Adult)	No	No	No	No	No	No

High Secure	No	**Yes**	Yes	Yes	Yes	Yes
Medium Secure	Yes	Yes	Yes	Yes	Yes	Yes
Low Secure	Yes	Yes	Yes	Yes	Yes	Yes
Learning Disability	No	No	**Yes**	Yes	Yes	Yes
Autism Spectrum Disorder	No	No	**Yes**	Yes	Yes	Yes
Children and Young People Services	No	No	No	**Yes**	Yes	Yes
Early Intervention	Yes	Yes	Yes	Yes	Yes	Yes
Liaison Psychiatry	Yes	Yes	Yes	Yes	Yes	Yes
Independent Sector	Yes	Yes	Yes	Yes	Yes	Yes
Non-NHS Funded	No	No	**Yes (Optional)**	Yes (Optional)	Yes (Optional)	Yes (Optional)
Non-English Service Providers	No	No	No	No	**Yes (Optional)**	Yes (Optional)
Problem Gambling	No	No	No	No	No	**Yes**

2.3 Incorporation of Learning Disabilities and Autism Spectrum Disorder Services

The inclusion of learning disabilities and autism spectrum disorder services within the data set scope when MHLDDS went live brought a need for a series of changes within the data set. Following an assessment of burden of these on stakeholders (including NHS Digital, NHS Data Model and Dictionary, Service Providers and System Suppliers), a decision was made to implement changes with an incremental approach.

To allow learning disabilities and autism spectrum disorder services to start submitting data, a number of ‘basic’ changes were introduced in MHLDDS v1.0. These comprised inclusion of the Disability table, to help with identifying learning disabilities and autism spectrum disorder patients; and the inclusion of the HONOS-LD outcome tool to support providers using this tool.

A key element of development of the data set to support learning disabilities and autism spectrum disorder patients has been the incorporation of the Learning Disability Census and Assuring Transformation collection within the data model. The former has now come to an end. Work is ongoing to enable the Assuring Transformation collection to be retired.

Please note: Where a client is seen by a learning disabilities service, or other service covered by the MHSDS Information Standard, with regard solely to their physical health, pertinent data should be included for that patient in the MHSDS submission.

2.4 Child and Adolescent Mental Health Services (CAMHS)

The CAMHS Tier of Service is no longer a routinely recognised concept. An algorithm has been developed to identify services in the way previously envisaged by this data item. Removal of the data item from the data set will contribute to ensuring the data set remains pertinent and up to date. Removal will also mitigate concern that providers will concentrate on DQ in relation to an obsolete data item, rather than those data items that will inform the algorithm.

2.4.1 Scope Guidance (CAMHS)

The MHSDS is a patient focused data set and includes children and adolescents receiving specialist CAMH services operating in tiers 2, 3 and 4 of the four-tier strategic framework. Further details of the CAMHS four-tier strategic framework can be found on the website 'Every Child Matters'[1]. It also includes children and adolescents who are thought to have a mental illness, learning disability or autism spectrum disorder in receipt of any other secondary mental health care service such as the new community-based eating disorder services for children and young people.

Scope does not include Non-specialist CAMH services, and the provision of CAMH tier 1 services which are likely to include services provided by:

- GPs
- Health visitors
- Schools
- Social services departments
- Youth justice
- Voluntary agencies

2.5 Children and Young Persons Improving Access to Psychological Therapies (CYP IAPT) Programme

The Children and Young People's Improving Access to Psychological Therapies programme (CYP IAPT) is a service transformation programme that aims to improve existing Child and Adolescent Mental Health Services (CAMHS).A primary requirement for the MHSDS v1.0 was to include all CYP IAPT data (where possible) to allow submission through the MHSDS, retiring the separate CYP IAPT collection and submitting through the MHSDS.

The CYP IAPT and CAMHS Data Sets were previously aligned to ensure data collection in CAMHS is as consistent as possible. This alignment work has allowed the CYP IAPT to be brought into the MHSDS without the need for widespread changes.

At the heart of the CYP IAPT programme is a vision of using patient recorded, session by session, routine outcome measurement to improve the quality and experience of services. Collection of these Routine Outcome Measures (ROMs) will continue within the MHSDS, providing a strong driver for the move to SNOMED-CT to capture all outcome measures.

In MHSDS v4.1 CAMHS has been retired but as stated above an algorithm has been developed to identify services in the way previously envisaged by this data item.

More information about the programme can be found on NHS England CYP IAPT Programme webpage[2].

2.6 Integration of clinical terminologies within the MHSDS

2.6.1 Why are we further integrating clinical terminologies within the data set?

The data set can benefit significantly from implementing clinical terminologies within the data model:

- Providers can choose between multiple schemes to submit Care Activity information. Of which, providers can submit what they record over and above specific national information requirements. This enables commissioner information requirements to be better met through the data set.

- Using SNOMED CT to capture outcome measures reduces the need for individual tables for each measure. A single table can capture multiple measures using a common structure.

- The data set can respond more quickly to changes in clinical practice and information requirements. Terminology is updated at regular intervals and the data set automatically can capture the latest terms without the need for changing the data set through the DCB process.

2.6.2 How have we integrated clinical terminologies within the Data Set?

NHS Digital's Data Set Development Service have been working closely with the NHS Digital Terminologies and Classifications teams to restructure the data set to further cater for clinical terminology recording.

Within the MHSDS:

- Diagnoses can now be submitted using a select choice of Schemas.
- Assessment Tools must now be submitted using SNOMED CT. There are multiple ways to link this data within the data set such as against a specific Referral, Care Contact or anonymously.
- More detailed Care Activity information can now be submitted, using a select choice of Schemas. Procedures, observable entities and findings are all recordable.
- Social and Personal Circumstances can now be submitted using SNOMED CT, which will allow the flow of MHS001 data items and personal information in line with published SNOMED CT subsets.
- The MHS010 Assistive Technology table also follows this same convention, which will allow the flow of SNOMED CT concepts to identify the findings related to the assistive technology a person uses.

Section 4 of this document will address guidance issues related to the above developments at a table and data item level.

2.6.3 SNOMED CT

2.6.3.1 What is SNOMED CT?

SNOMED CT is the standard clinical terminology for the NHS to support recording of clinical information, in a way that supports data management and analysis to support patient care, while enabling data extraction and data exchange.

SNOMED CT provides a comprehensive set of clinical phrases or terms, this is called a terminology. SNOMED CT is much more than just a set of clinical phrases, for example it also includes groups with relationships between terms. It is the most comprehensive international terminology currently available and can be used across all care settings and all clinical domains.

SNOMED CT is managed and maintained internationally by SNOMED International[3] and in the UK by the UK National Release Centre (part of NHS Digital)[4].
SNOMED CT is specified as the single terminology to be used across the health system in 'Personalised Health and Care 2020: A Framework for Action[5].

2.6.3.2 What are the benefits of using SNOMED CT?

As the NHS moves to paperless, and the aspiration to exchange data electronically across the NHS, it is critical that all systems share the same clinical vocabulary. If every system uses its own vocabulary then interoperability is reduced to simply moving readable documents around the system and clinicians having to repeatedly transcribe data they need to be within their system, thus introducing errors.

The use of an international terminology enables system suppliers to design their system to a common terminology that can be implemented with less country specialisation across a number of countries. The last few years has seen a shift by suppliers from developing country specific solutions to global solutions with local configuration.

2.6.3.3 Further Resources for SNOMED CT

More information about SNOMED CT can be found on the NHS Digital SNOMED CT pages[6] including information about:

- **SNOMED CT in Mental Health**
  - A range of resources are available via the NHS Digital SNOMED CT in mental health webpage. They include live webinars (providing an overview of SNOMED CT) as well as training materials, guidance and a forum where members can contribute to discussions.

- **Licensing**

  - The UK is a SNOMED International member country. Use of SNOMED CT in the UK is free; however the use of SNOMED CT does require a license. All SNOMED CT licensing enquiries can be sent to information.standards@nhs.net

- **Training**

  - NHS Digital offer a range of ways for individuals to learn more about SNOMED CT and its uses. For those who feel they need more understanding of SNOMED CT, NHS Digital provide a number of training and education resources[7]. For an overview of SNOMED CT, the two live webinars provide a good introduction; you will also find case studies, brochures and technical guidance detailed on this web page. For system suppliers, you may also be interested in the more technical guidance provided through our recorded webinar on the release files[8].

2.7 Access and Waiting Times Standards

Alongside other national partners, including the Department of Health and Social Care (DHSC), NHS England are introducing access and waiting time standards for mental health services.

Existing guidance can be found on the Access and Waiting Times page of the NHS England website: https://www.england.nhs.uk/mental-health/resources/access-waiting-time/.

For example, specific guidance has been developed to support the EIP and CYP ED access and waiting times standard and explains how the indicators are constructed and confirms the data that will need to be submitted as part of the MHSDS, to measure progress and inform future development.

For any further queries on access and waiting time standards please contact NHS England at: england.improvingmhaccess@nhs.net.

2.8 Further Information

For additional guidance including technical guidance and specifications for specific care pathways please see the Mental health: guidance for service providers and suppliers webpage[9].

3 Configuration of local systems

The *Technical Output Specification* fully defines the data items within the MHSDS. The Technical Output Specification splits the data set into a number of tables, each containing related data items.

The MHSDS is an output data set. An output data set is a description of the data that needs to be extracted or derived from an existing patient administration system (PAS) or clinical system and does not directly support patient care. In many cases, the output data item will be identical to the input definition. However, the two may differ both in terms of the format of the data item and the range of values presented. The data collection system may represent the data in a different manner or in more granularity; however, providing the input data items can be mapped to the output data set, the input source will not require any modification.

This can be illustrated in the following table:

Provider System (Input system)		National Data Set	
Data item name	Format/Values	Data item name	Format/values
Date of Birth	dd/mm/yy	Person Birth Date[10]	ccyy-mm-dd
Leave of Absence End Reason	Patient returned on day specified Patient returned before day specified	Mental Health Leave of Absence End Reason[11]	Patient returned on or before day specified

The MHSDS is not a specification for the standardisation of a patient care record. Service Providers have the flexibility to adopt any local data collection process or system as long as the local data collection frameworks can output and submit data, as per the data set specification, to the Strategic Data Collection Service (SCDS) Cloud.

The data set is not a patient care record but is based on clinical and operational information. Providers should therefore look to re-use their clinical and operational systems to extract MHSDS data.

4 Constructing submission files

4.1 Key points relating to mandatory fields and validation

The *Technical Output Specification* fully defines the data items within the MHSDS. The Technical Output Specification splits the data set into a number of tables, each containing related data items.

Mandatory data items and/or tables

The requirements for each data item are outlined in the original levels of mandation as described to DCB (as outlined in the mandatory/required/optional/pilot column in the Technical Output Specification):

Mandatory: These data items MUST be reported. Failure to submit these items will result in the rejection of the record.

Required: These data items SHOULD be reported where they apply. Failure to submit these items will not result in the rejection of the record but may affect the derivation of national indicators or national analysis. (Please note that the purpose of the data set is not to change clinical practice.)

Optional: These data items MAY be submitted on an optional basis at the submitter's discretion.

Pilot: These data items have been included within the specification for piloting purposes only to support future implementation. These data items have not been approved and/or mandated and SHOULD NOT be submitted unless specifically requested by NHS Digital.

The three phases of validation correspond to these mandation levels. So for instance, if a data item is mandatory, it is likely to have data item level rejections for a null or invalid entry.

Whilst a particular table itself may not be mandatory, if a record is entered in this table then all of the table's mandatory fields must be completed.

The following tables are mandatory and MUST be submitted, as a minimum, for each service user:

- MHS001MPI
- MHS002GP
- MHS101Referral

In addition, the following table MUST contain a single record for each submission:

- MHS000Header

Other tables, such as MHS604PrimDiag only require a record to be present where applicable to the service user. For this example, not all service users will have a recorded Primary Diagnosis and this whole table can be left blank in these cases. If a record is entered into this table then it must be recorded against all mandatory fields.

Validation of records

Upon submission of the data to the central data warehouse, three phases of validation are undertaken:

1. **File level**
   Leading to rejection or issuing of warning messages. A rejection would be of the entire submission against the selected reporting period, requiring identified issue(s) to be rectified and a resubmission made. Warning messages should be addressed and required actions undertaken.

   Where these can be found: File-Level Rejects tab

   Example: MHSREJ003 - Failed Content Check. MPI Table is empty

2. **Table level**
   These compare records within or across multiple tables, leading to rejection of multiple records or a warning message displayed. For example, they could be to check referential integrity between tables or for duplicated records within a table. Rejected records would not progress to post deadline processing. Records with warnings would progress, but data quality would not be as required.

   Where these can be found: Individual table tab.

   Example: MHS00147 - Records rejected - More than one MHS001 provided for this NHS Number.

3. **Record level**
   These can be against a single data item or across multiple data items within a single record, leading to either the rejection of the record or a warning displayed. Rejected records would not progress to post deadline processing. Records with warnings would progress, but data quality would not be as required.

   Where these can be found: Individual table tabs

   Example: MHS00101 - Record rejected - Local Patient Identifier (Extended) is blank

Each data item within the data set specification may have any of the above types of validation.

Please see the validations and warnings in the Technical Output Specification to understand the submission requirements for each table.

4.2 Inclusion rules

MHSDS is referral driven. Each monthly submission should include all open/active referrals within that reporting period, which includes:

- referrals that were opened in the reporting period
- referrals that closed in the reporting period
- referrals that were open throughout the reporting period, even if no activity took place.

All episode tables (those with start and end dates) within the data set follow the same inclusion concept.

The rest of the tables have their own inclusion rules which specify when they should be included for a reporting period. For example, Care Contacts would be included only in the Reporting Period they took place, but other tables such as Diagnosis allow the “most recent” details to flow.

You can find out the rules by looking at the validations in the latest Technical Output Specification. The column “Additional Validation Rules” outlines the date restrictions. Please also see section 5 of this User Guidance which contains a description of each table.

If a large amount of data is submitted, outside of the required range, then numerous rejection messages will be generated back to the provider. This may hinder the provider’s ability to identify 'real' rejection messages that require corrections to be made to “included” data. Users are advised to place greater emphasis on checking the date validation rules, prior to submission, to identify and submit data that is relevant to the reporting period only.

4.2.1 Reporting of Event associated data

A recent change to the way Event-type tables (i.e. those where a status or activity is recorded against a single date, such as Employment Status Recorded Date) can be submitted was made as part of the move to the new MHSDS structure to aid improved data quality of related measures.

We have relaxed the validations across a number of these tables so that the “most recent” activity can always be submitted each month. This allows missed events to be submitted with the correct date in situations where there may be a delay in clinical coding/assurance or other data quality reasons.

This will help in the monitoring of established measures such as ‘Employment status for people on CPA’ and ‘People in contact with services at the end of the reporting period with a diagnosis recorded’.

Please see the examples highlighted below:

Data Item / Table	MHSDS Validation Rule	Change from MHLDDS
ACCOMMODATION STATUS RECORDED DATE (MHS003AccommStatus)	If Accommodation Status Recorded Date is after the end of the reporting period, the record will be rejected.	Validation relaxed, any status not submitted within the associated RP can still be submitted in any subsequent RP.
EMPLOYMENT STATUS RECORDED DATE (MHS004EmpStatus)	If EMPLOYMENT STATUS RECORDED DATE is after the end of the reporting period, the record will be rejected.	Validation relaxed, any status not submitted within the associated RP can still be submitted in any subsequent RP.
DIAGNOSIS DATE (MHS604PrimDiag)	If DIAGNOSIS DATE is after the end of the reporting period, the record will be rejected.	Validation relaxed, any diagnosis not submitted within the associated RP can still be submitted in any subsequent RP.
CARE PROGRAMME APPROACH REVIEW DATE (MHS702CPAReview)	If CPA REVIEW DATE is after the end of the reporting period, the record will be rejected.	Validation relaxed, any review not submitted within that RP can still be submitted in any subsequent RP.

5 Data Item Guidance

This section provides additional guidance with regard to data items included within the Technical Output Specification. Frequently asked questions and areas that need further clarification are addressed in this section.

5.1 Learning Disabilities and Autism Spectrum Disorder Services

Users of the data set and this document should be aware that a number of data items are labelled (or make reference to) 'mental health'. This is a reflection of the way the original MHMDS data items were designed, which will be reviewed. In the meantime, learning disabilities and autism spectrum disorder services are intended to populate these fields where appropriate to their service. As such, learning disabilities and autism spectrum disorder services should review each table and data item within the Technical Output Specification to decide if their services fall in scope.

5.2 Intended Age Group

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

5.3 Clinical Terminologies and Classifications General Guidance

5.3.1 ICD Codes

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

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

5.3.2 SNOMED CT Codes

During MHSDS assurance activities, two potential issues have been identified with the handling of

CT data across various third-party systems, which could affect the processing and accuracy of data outputs.

1. Loss of 16-Digit+ accuracy

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

Impact

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

For Assessment Tool data: This will lead to most (but not all - some coincidentally end in a "0") of the 16-18 digit SNOMED CT codes being rejected at the SDCS Cloud during validation. Some of the potentially affected Assessment Tools are as follows. We will include additional tools as they arise:

- The Experience of Service Questionnaire (ESQ)
- DIALOG
- Goal Based Outcomes (GBO)
- HoNOS-ABI
- Me and My Feelings Questionnaire
- Questionnaire about the process of recovery
- Session Feedback Questionnaire

For other SNOMED CT data: No reference data exists for validation therefore the incorrect SNOMED CT code would flow without warning and be available for future analysis.

2. SNOMED CT codes formatted in 'Scientific Notation'

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

Impact

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

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

Mitigating Guidance

The way round both these issues is to ensure that all SNOMED CT fields are formatted as text in all intermediary systems and import/export routines, and that identifiers are not copy/pasted or typed directly into a spreadsheet. However, this may not currently be the case with providers as SNOMED CT codes are defined in the NHS Data Model and Dictionary as numeric values.

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

5.3.3 Read Version 2 and Clinical Terms Version 3

Withdrawal of Read v2 and CTV3

Read v2 and CTV3 are planned for final withdrawal on 01/04/2020 and have therefore been removed completely from the MHSDS v4.1. For more information please refer to the NHS Digital Read Codes webpage[14].

5.4 Breakdown of Data Items by Table

Data items are listed in the following tables using the NHS Data Model and Dictionary data element names. The electronic copy of this document includes hyperlinks to the corresponding entries in the NHS Data Model and Dictionary where formal definition of the data item can be found and relationships with other data elements and attributes are defined.

Users should be aware that links to new data items will not be available immediately following ISN publication.

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

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

5.4.1 Repeating data items

5.4.1.1 Linkage Data Items

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

The below linkage data items are fully described within the *Technical Output Specification*. In order to understand the linkage between tables in MHSDS, the following information should be referenced in conjunction with the *Data Model*, available on the MHSDS web pages[15].

Data Item Name	Additional Notes
LOCAL PATIENT IDENTIFIER (EXTENDED)	The Local Patient Identifier (Extended) is used to uniquely identify a patient within the Health Care Provider. This item is a primary key in the MHS001MPI table and must be unique to this table, within submission. No patient can have more than one Local Patient Identifier (Extended). This can be checked by looking at data items such as NHS number, postcode and date of birth. The Local Patient Identifier (Extended) provides a link between records in the MHS001 Master Patient Index table, associated referrals, and all non-referral-based data associated with the patient. To avoid the incorrect linkage of records the Local Patient Identifier (Extended) must not be reused i.e. it should only ever relate to one patient. This ensures that data relating to more than one patient does not get incorrectly identified as belonging to a single patient in MHSDS.
SERVICE REQUEST IDENTIFIER	The Service Request Identifier is used to uniquely identify the referral. This item is a primary key in the MHS101Referral table and must be unique to this table, within submission. The Service Request Identifier provides a means for linking each Referral with additional data associated directly with that referral. Where multiple systems are used the submitted extract may include a prefix to the Service Request Identifier, which relates to the system. The prefix ensures each Service Request Identifier remains unique within submission.
CARE CONTACT IDENTIFIER	The Care Contact Identifier is used to uniquely identify the care contact. This item is a primary key in the MHS201 Care Contact table and must be unique to this table. The Care Contact Identifier provides a links between records in the MHS 201 Care Contact table and associated Care Activity carried out during a care contact. We would like to remind providers of the importance of ensuring that the Care Contact Identifier is truly a unique data item, both within the same submission file and across multiple submission files. The Care Contact Identifier is a primary key for its respective table and is based upon the Activity Identifier[16] data attribute which is defined as “A unique number or set of characters that is applicable to only one ACTIVITY for a PATIENT within an Organisation”. This reiterates that these identifiers should be unique across submissions. These identifiers will typically be auto generated by the system in use, so will prevent duplicates when using the same system. Where multiple systems are used it is acceptable to include a prefix to the Care Contact Identifier, which relates to the system. The prefix enables each identifier to remain truly unique for all submissions from an organisation.

CARE ACTIVITY IDENTIFIER	The Care Activity Identifier is used to uniquely identify the care activity. This item is a primary key in the MHS202 Care Activity table and must be unique to this table. The Care Activity Identifier provides a link between records in the MHS202 Care Activity table and associated Coded Scored Assessments carried out during a care contact. We would like to remind providers of the importance of ensuring that the Care Activity Identifier is truly a unique data item, both within the same submission file and across multiple submission files. The Care Activity Identifier is a primary key for its respective table and is based upon the Activity Identifier[17] data attribute which is defined as “A unique number or set of characters that is applicable to only one ACTIVITY for a PATIENT within an Organisation”. This reiterates that these identifiers should be unique across submissions. These identifiers will typically be auto generated by the system in use, so will prevent duplicates when using the same system. Where multiple systems are used it is acceptable to include a prefix to the Care Activity Identifier, which relates to the system. The prefix enables each identifier to remain truly unique for all submissions from an organisation.
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD IDENTIFIER	The Mental Health Act Legal Status Classification Assignment Period Identifier is used to uniquely identify the Mental Health Act Legal Status Classification Assignment Period. This item is a primary key in the MHS401 Mental Health Act Legal Status Classification Period table and must be unique to this table, within submission. The Mental Health Act Legal Status Classification Assignment Period Identifier provides a link between records in the MHS401 Mental Health Act Legal Status Classification Period table and associated Mental Health Act specific data.
HOSPITAL PROVIDER SPELL NUMBER	The Hospital Provider Spell Number is used to uniquely identify the Hospital Provider Spell within Health Care Provider. This item is a primary key in the MHS501 Hospital Provider Spell table and must be unique to this table, within submission. The Hospital Provider Spell Number provides a link between records in the MHS501 Hospital Provider Spell table and associated Hospital Provider Spell and Ward Stay specific data.
WARD STAY IDENTIFIER	The Ward Stay Identifier is used to uniquely identify the patient Ward Stay within a Hospital Provider Spell. This item is a primary key in the MHS502 Ward Stay table and must be unique to this table, within submission. The Ward Stay Identifier provides a means for linking records in the MHS502 Ward Stay table with additional data associated directly with that Ward Stay.

CARE PROGRAMME APPROACH CARE EPISODE IDENTIFIER	The Care Programme Approach Care Episode Identifier is used to uniquely identify the Care Programme Approach Care Episode. This item is a primary key in the MHS701Care Programme Approach (CPA) Care Episode table and must be unique to this table, within submission. The Care Programme Approach Care Episode Identifier provides a link between records in the MHS701 Care Programme Approach (CPA) Care Episode table and Associated Care Programme Approach Reviews.
CLUSTERING TOOL ASSESSMENT IDENTIFIER	The Clustering Tool Assessment Identifier is used to uniquely identify the Clustering Tool Assessment that takes place for each patient. This item is a primary key in the MHS801Clustering Tool table and must be unique to this table, within submission. The Clustering Tool Assessment Identifier provides a link between records in the MHS801 Clustering Tool table and additional Care Cluster and Clustering Assessment data.
CARE PROFESSIONAL LOCAL IDENTIFIER	The Care Professional Local Identifier is used to uniquely identify the care professional within provider. This item is a primary key in the MHS901Staff Details table and must be unique to this table, within submission. The Care Professional Local Identifier provides a link between various tables and related Staff Details. Where a member of staff has multiple roles or works in more than one team concurrently, a separate record with a different Care Professional Local Identifier should be created to ensure correct staff characteristics such as Care Professional Staff Group and Main Speciality Code are attributed to each Care Contact and Activity.
CARE PROFESSIONAL TEAM LOCAL IDENTIFIER	The Care Professional Team Local Identifier is used to uniquely identify the Care Professional Team within provider. This item is not a primary key in the MHS102 Service or Team Type Referred To (or any other) table. There is no requirement for it to be unique to any table within submission. The Care Professional Team Local Identifier provides a link between records in the MHS102 Service or Team Type Referred To table and related care activity, for use where there is more than one MHS102 Service or Team Type Referred To associated with an MHS101 Service or Team Referral.
CARE PLAN IDENTIFIER	This is a unique ID, which identifies each individual Care Plan within an organisation. This item is a primary key in the MHS008 Care Plan Type table and must be unique to this table, within submission.

5.4.1.2 ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)

In order to ensure commissioners are able to access data that is necessary for them to undertake normal business, but cannot access data inappropriately, the ORGANISATION IDENTIFIER (CODE OF COMMISSIONER) repeats across a number of tables.

Data Item Name	Additional Notes
ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	This is the organisation identifier of the organisation that initiated the provision of care bound by the MHS101 Service or Team Referral record. For the MHSDS, the ORGANISATION IDENTIFIER (CODE OF COMMISSIONER) may typically relate to a CCG or an NHS England specialised commissioner for NHS-funded activity. However, the submission of ODS codes in this field is not restricted, particularly to allow the optional flow of non-NHS funded activity. NHS Specialised Commissioner ODS codes are available alongside CCG codes in the ODS 'eccg' data download[18] file. E.g. 14C - WEST MIDLANDS COMMISSIONING HUB The DHSC document Who pays? Establishing the Responsible Commissioner[19] 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). NHS Digital are aware some services are commissioned and funded by charitable organisations outside of the NHS (e.g. national lottery), where the commissioner does not have an ODS code.F Interim guidance is to use the default commissioner code '"VPP00 - Private PATIENTS / Overseas Visitor liable for charge" for these arrangements. More granular default ODS codes are being considered for future use. Please refer to Appendix 9 for a complete description of the purpose of this data item, in particular, how it should be used across multiple tables to ensure the correct responsible commissioner allocation of records.

5.4.2 MHS000 Header

MHS000 Header	
Description	
The Header should include metadata relating to the submission, including which organisation and reporting periods the data relates to, the primary system in use and the date/time the submission was created.	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
ORGANISATION IDENTIFIER (CODE OF SUBMITTING ORGANISATION)	This field will normally contain the same Identifier as ORGANISATION Identifier (CODE OF PROVIDER). It may be appropriate for the codes to differ, however provider and submitter should ensure that appropriate governance is in place for the flow of patient identifiable data between the two organisations. Further information can be found on the Information Governance pages of the NHS Digital website[20].
PRIMARY DATA COLLECTION SYSTEM IN USE	This is a free text field. Where multiple systems are in use, please indicate the primary system in use, from which the highest number of records is extracted.

5.4.3 MHS001 Master Patient Index

MHS001 Master Patient Index
Description
To carry the personal details of the patient. One occurrence of this Group is required for each patient. **General table guidance** This table contains information on patient identifiers, demographic information and organisational data. The collection of these data items can be used to analyse outcomes across different ethnic groups, age groups and geographic location. This table should include a record for each patient receiving care within Mental Health, Learning Disabilities or Autism Spectrum Disorder Care services. Please ensure that this table contains a record for all patients for whom activity is recorded within any of the other tables. Providers should supply MHS001 data as it was at the end of the reporting period. Providers must populate all known data items within this group even if they are unchanged since the last submission. Do not just provide data for all "changed" data items. Much of the data within this table will be obtained from the patient (or his/her informal carers) on first registration and then checked with the patient at appropriate intervals.
Additional Notes on Data Items

Data Item Name	Additional Notes
ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER)	This identifies the Local Patient Identifier issuing organisation, for example: where organisations have gone through a merger or split. - If Local Patient Identifiers are not modified during the merger or split, then the issuing Organisation Identifier of the Local Patient Identifier (even if now discontinued) should be sent in this field; - If the Local Patient Identifier has been modified since the organisation change i.e. by prefix etc., then the new organisation identifier should be used.
ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)	This field can routinely be left blank, however if populated it should contain the organisation identifier of the commissioner with which the patient is resident. The organisation identifier should be current at the end of the reporting period. This item is derived by NHS Digital based on postcode of usual address, using a lookup file which assigns the patient to an organisation. This derivation only applies when the ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY) is blank upon submission. Providers are able to override this derivation (for instance, if they are aware that a particular CCG has residence responsibility for a patient) by manually entering an organisation identifier in this field.
ORGANISATION IDENTIFIER (EDUCATIONAL ESTABLISHMENT)	This will identify the organisation identifier of the educational establishment that the patient attends. If the patient does not attend an educational establishment, this data item can be left blank. The allocated identification numbers for submission can be obtained through the Organisational Data Service[21] who are supplied extracts from the Department for Educations (DfE) EduBase. The ID is derived from the DfE Unique Reference Number (URN) which is six digits, but this is prefixed with 'EE' on the ODS reference file. The organisation identifier should be current at the end of the reporting period.
NHS NUMBER	Where the NHS Number is not known, this should be left blank. Duplicate NHS Numbers within this group will cause the entire file to be rejected. When an NHS number is provided it must pass the modulus 11 check. When an NHS number is provided it should have a corresponding status indicator code. NHS number is the primary source of identification for patients in England and Wales and should be submitted; however it is accepted that occasionally a patient will not have an NHS number therefore this data item is 'Required' and not 'Mandatory' in MHSDS, which ensures that data for the patient can still flow. Although it is not a mandated field, data quality reports will be produced with regard to completeness of this field. Further guidance about NHS Numbers can be found here: https://digital.nhs.uk/services/nhs-number

NHS NUMBER STATUS INDICATOR CODE	This data item is 'Required' however it should always be completed, irrespective of whether an NHS number is present. In cases where a patient's NHS number is unavailable (which may be because the patient does not possess one) data providers should submit a null NHS number and [07] Number not present and trace not required in NHS Number Status Indicator Code. In most cases, this data item will be flowed with value [01] - *Number present and verified*. The [01] will indicate that the data provider has validated the number against the central Patient Demographics Service (PDS), and therefore facilitates reliable data linkage. Data providers may flow data for patients with an NHS number status indicator code other than [01] and they will be accepted, however, reports that need reliable linkage may exclude these records (unless reliable linkage is available via LOCAL PATIENT IDENTIFIER)
PERSON BIRTH DATE	Every effort should be made to identify the patient's correct date of birth, or date that the patient has estimated to be their date of birth. However, where the patient's DOB cannot be determined precisely, estimation should be provided. If it is not possible/appropriate to estimate, then the data item should be left blank (Null). Estimates should not change once they have been made. Once the actual DOB is identified, it should be recorded and submitted correctly. When estimating a patient's DOB a consistent approach should be used, for example: use 1st July if only the year is known, 15th of the month if only the month is known, 1st January for beginning of the year, 31st December for end of the year, 25th December for Christmas etc.
POSTCODE OF USUAL ADDRESS	Please see the 'Technical Glossary' tab within the *Technical Output Specification* for further details regarding acceptable postcode formats and validations applied upon submission. Where the person has no fixed abode, this should be recorded as ZZ99 3VZ. If the postcode is unknown ZZ99 3WZ should be used. For overseas residents, please use the pseudo country postcode found in the 'Country names and pseudo country postcodes in pseudo country postcode order' file on the NHS Digital web page: Data supplied by the Office of National Statistics[22]. The postcode will be recorded in the format ZZ99 xxZ, where xx denotes the country pseudo postcode.
PERSON STATED GENDER CODE	National Code X 'Not Known' means that the sex of a PERSON has not been recorded National Code 9 'Not Specified' means indeterminate, i.e. unable to be classified as either male or female.
ETHNIC CATEGORY	The information recorded about the patient's ETHNIC CATEGORY must be obtained by asking the PATIENT. Capture and submission of Ethnic Category within the MHSDS is required for ALL patients, and not only those subject to an inpatient stay, in order to support ethnic monitoring as required of public bodies under the Race Relations Amendment Act 2000.

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

5.4.4 MHS002 GP Practice Registration

MHS002 GP Practice Registration	
Description	
To carry details of the GP Practice Registration of the patient. One occurrence of this Group is required for each change of GP Practice Registration. **General Table Guidance** Data providers should note that MHS002 is a mandatory group that must be included whenever any other groups are transmitted that refer to this patient. The group includes start and end dates for when the patient was registered with the practice.	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**

GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	The following default ODS codes apply: GP Practice Code not applicable - V81998 GP Practice Code not known - V81999 No Registered GP Practice - V81997 Please see GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION) for information on the use of the above codes. For more general information on default codes, please visit Organisation Data Service Default Codes[25].
START DATE (GMP PATIENT REGISTRATION)	This field is primarily to track changes to the GP and their commissioner during the referral. This field should only be populated if the actual start date is known. If this is not known, then it is acceptable to leave this field blank. If the patient changes General Medical Practice whilst under the care of the service provider, then a new GP Practice Registration record should be submitted, and the start date of the patient's new General Medical Practice registration populated.
END DATE (GMP PATIENT REGISTRATION)	This field is primarily to track changes to the GP and their commissioner during the referral. If this field is left blank the General Medical Practice Code recorded in this table will be assumed to be current. If the patient changes General Medical Practice whilst under the care of the service provider, then it is expected that the end date of the previous General Medical Practice should be populated in the GP Practice Registration record, and new record submitted containing details of the new GMP Registration.
ORGANISATION IDENTIFIER (GP PRACTICE RESPONSIBILITY)	This field can routinely be left blank, however if populated it should contain the organisation identifier of the commissioner that is associated with the patient's current registered GP Practice. This field is used to overwrite the commissioner associated with a GP's registered population, which is derived from the General Medical Practice Code Patient Registration by NHS Digital.

5.4.5 MHS003 Accommodation Status

MHS003 Accommodation Status	
Description	
To carry the accommodation details of the patient. One occurrence of this Group is permitted, containing the most recently recorded accommodation details. **General Table Guidance** 'This information should be submitted when reviewed and recorded as part of usual clinical practice, even if the status is the same, the review date would be updated.'	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
ACCOMMODATION STATUS CODE	Recent changes have been made to this code list to identify the 'type' of Secure Children's Home in which the Child or Young Person is accommodated in. This should be populated in conjunction with SECURE CHILDRENS HOME PLACEMENT TYPE which identifies the type of placement used.
SETTLED ACCOMMODATION INDICATOR	This should be captured periodically as part of a formal Care Programme Approach (CPA) review or other informal review or assessment. The current Settled Accommodation Indicator should be agreed by the care worker/coordinator and the client. Carers should also have an input where appropriate.
ACCOMMODATION STATUS RECORDED DATE	This is the date on which the assessment was done. This date should change with each review even if the Accommodation Status remains the same.
SECURE CHILDRENS HOME PLACEMENT TYPE	This data item is designed to be read in conjunction with the Accommodation Status Code to identify where the Child or Young Person may have been placed in inappropriate accommodation. For example, where a Child or Young Person is on a secure welfare placement, but may have been placed in accommodation solely designed for youth justice placements.

5.4.6 MHS004 Employment Status

MHS004 Employment Status	
Description	
The current employment status of a patient. One occurrence of this Group is permitted, containing the most recently recorded employment details. **General Table Guidance** This is not limited to details recorded at formal CPA Reviews. Therefore, this information should be captured on a regular basis (if possible at each contact) but at least annually. Flow of data in this table was previously constrained to patients aged 18-69, this constraint has now been lifted. It is not intended for an employment status to flow for every patient, however if the information is recorded locally it SHOULD flow.	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
EMPLOYMENT STATUS	**[01] Employed:** Employed refers to those who are employed by a company and have their National Insurance paid for directly from their wages. It also includes those who are self-employed (i.e. those who work for themselves and generally pay their National Insurance themselves); those who are in supported employment; and those who are in permitted work (i.e. those who are in paid work and who are also receiving Incapacity Benefit). It should also include those who are unpaid family workers (i.e. those who do unpaid work for a business they own or work for a business a relative owns). **[02] Unemployed and actively Seeking Work:** Unemployed refers to those who are not in paid work but are actively seeking work and are available to start or are waiting to start a paid job they have already obtained. Other Employment Status codes (03, 04, 05, 06, 07, 08) represent those who are economically inactive, that is, those who are not in paid work and who are not actively seeking work, or they are not available to start.
EMPLOYMENT STATUS RECORDED DATE	This is the date on which the assessment was done. This date should change with each review even if the Employment Status remains the same.

5.4.7 MHS005 Patient Indicators

MHS005 Patient Indicators	
Description	
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. **General Table Guidance** Indicators are required data items and should therefore be submitted where they are applicable to the patient. For example a forty year old patient could not be a young carer, and therefore the indicator should be left blank; however a sixteen year old patient may be a young carer, but have not been asked the question as part of their care, therefore the indicator should be submitted as Not Known. All date data items included in this table can be estimated if the precise date cannot be identified. When estimating dates please use a consistent approach, for example: use 1st July if only the year is known, 15th of the month if only the month is known, 1st January for beginning of the year, 31st December for end of the year, 25th December for Christmas etc.	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
PARENTAL RESPONSIBILITIES INDICATOR	The Parental Responsibilities Indicator is primarily to identify 'young parents' in contact with mental health services. However, this item is age agnostic and should be flowed in all instances where the information is recorded, there is no requirement to flow data that is not routinely collected as part of clinical practice
YOUNG CARER INDICATOR	This is an indicator for a child or young person who has a caring role for an ill or disabled parent, Carer or sibling. A Carer is a person who is either providing or intending to provide a substantial amount of unpaid care on a regular basis for someone who is disabled, ill or frail. This data item is applicable to children and young people only. CAMH services using Current View may capture this information using "Complexity 2. Young carer status". This factor would be submitted as a CODED FINDING in MHS202CareActivity. This Young Carer Indicator would then be completed/updated and continued to be submitted with the "most recent" status at end of each reporting period.

LOOKED AFTER CHILD INDICATOR	This is an indicator for a looked after child. A Looked After Child (also referred to as a Child Looked After) is a PERSON. A Looked After Child is a child in the care of a Local Authority either: • through a Care Order made by a Court or • voluntary agreement with their parent(s) to accommodate them. They may be looked after: in a Children's Home, by foster carers, or other family members. All Unaccompanied Asylum-Seeking Children are also Looked After Children. This data item is applicable to children and young people only. CAMH services using Current View may capture this information using "Complexity 1. Looked after child". This factor would be submitted as a CODED FINDING in MHS202CareActivity. This Looked After Child Indicator would then be completed/updated and continued to be submitted with the "most recent" status at end of each reporting period.
CHILD PROTECTION PLAN INDICATION CODE	An indication of whether a person is, or has previously been, subject to a Child Protection Plan[26]. A Child Protection Plan is a Care Plan and should: • assess the likelihood of the child suffering harm and look at ways that the child can be protected; • decide upon short and long term aims to reduce the likelihood of harm to the child and to protect the child's welfare; • clarify people's responsibilities and actions to be taken; and • outline ways of monitoring and evaluating progress. This data item is applicable to children and young people only. CAMH services using Current View may capture this information using "Complexity 7. Current protection plan". This factor would be submitted as a CODED FINDING in MHS202CareActivity. This Child Protection Plan Indication Code would then be completed/updated and continued to be submitted with the "most recent" status at end of each reporting period.
EX-BRITISH ARMED FORCES INDICATOR	As a reminder please refer to the published corrigendum[27] which explains a minor change to the code list since the v2 ISN publication. Please ensure codes 02,03 and 05 are used instead of 2,3 and 5.

OFFENCE HISTORY INDICATION CODE	**Scope** This data item is applicable to secure Forensic Services only and MUST only be submitted for a person in reporting periods where they are under an open/active Hospital Provider Spell to such a service. This data item should not be populated where a person is not within a secure service (as commissioned by NHS England) or in relation to any other service type referrals. As an example: Where a person is transferred from a secure Forensic Mental Health service to a non-forensic service, this data item should continue to be populated for the reporting period where the transfer occurs in, but then should no longer be submitted in subsequent reporting periods. **Local Collection** As a secondary uses data set, the MHSDS intends to re-use clinical and operational data for purposes other than direct patient care. It defines the data items, definitions and associated value sets to be extracted or derived from local information systems. Therefore, this data item should only be submitted if the included category mapping has been implemented locally (e.g. as part of pilot development work for the PbR Secure Services Data Set) and is collected and maintained locally with appropriate governance in place. For any primary use concerns, consult local arrangements as agreed with Caldicott Guardians and Clinical Leads in first instance. Guidance for data and information handling and sharing at both operational and secondary uses levels exists nationally. Please see section '3.2 Information Governance' of the latest Implementation Guidance[28] for further information. For further guidance on the effective commissioning of these specialised secure mental health services and the relationship between offence history and service delivery (including assessment, treatment and length of stay), please see section 6 of the NHS England Manual for Prescribed Specialised Services[29]. **Data Item Guidance** As per the PbR Secure Services Development Data Set, this data item should continue to be rated using the following guidance: *3 Yes - Serious offence:* including murder, attempted murder, rape, GBH with intent, arson with intent. Does not include indecent assault or ABH, simple arson or robbery and/or national notoriety. *2 Yes - Less serious offence:* those offences not covered under Serious Offence. Only convicted or index offences should be recorded as 2 or 3. Alleged offences would not be included and would be coded as "1 No – No offence".
PSYCHOSIS FIRST TREATMENT START DATE	This is the date the patient commenced prescribed medication and was compliant. Please note that for the majority of people, the 'Psychosis Treatment Start Date' will be the same date as the date of 'Psychosis Prescription Date'.

5.4.8 MHS006 Mental Health Care Coordinator

MHS006 Mental Health Care Coordinator	
Description	
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. **General Table Guidance** A Mental Health Care Coordinator is a professional member of staff working in specialist Mental Health services, who has been named and allocated as Care Coordinator to the PATIENT. Patients on the Care Programme Approach will have a named Care Coordinator assigned who will be responsible for coordinating all care for the patient. Care for patients not on CPA will be coordinated by one or more 'Lead Professionals', whose responsibility can be specific to a single pathway (e.g. EIP) or for coordinating multiple pathways (e.g. co-morbid conditions). The role of a Lead Professional may encompass, where specific to a single pathway, elements of patient engagement and biopsychosocial formulation. This table should include a record for each assignment of a Mental Health Care Coordinator or Lead Professional to a patient (and not only those formally assigned on CPA). The personal identifier of the Care Coordinator or Lead Professional should correspond to a record containing the details of the Care Coordinator/Lead Professional in the MHS901StaffDetails table.	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
CARE PROFESSIONAL SERVICE OR TEAM TYPE ASSOCIATION (MENTAL HEALTH)	Where a care professional is associated with the work of more than one service or team within provider, the CARE PROFESSIONAL SERVICE OR TEAM TYPE ASSOCIATION (MENTAL HEALTH) should relate to the team on whose behalf the Care Professional is working as Care Coordinator or Lead Professional for the patient. This data item will be used for the calculation of some waiting times. For example: Early Intervention in Psychosis waiting times, where allocation of an EIP Lead Professional forms part of the requirements signifying the end of the waiting time or 'clock stop'. **Team specific guidance** For team specific guidance, please see Service or Team Type Referred To in section '5.5.15'.

5.4.9 MHS007 Disability Type

MHS007 Disability Type	
Description	
To carry the details of the type of disability affecting a patient, based on their perception or the perception of a patient proxy. One occurrence of this Group is permitted for each disability identified. **General Table Guidance** The main focus of this table is to provide information about disabilities where they are present, however providers can choose to submit records for NN or ZZ should they record this locally. Records submitted against either of these codes will be classed as 'Other' for the Data Quality Measures.	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
DISABILITY CODE	**[01] Behaviour and Emotional** should be used where the patient has times when they lack control over their feelings or actions. **[02] Hearing** should be used where the patient has difficulty hearing, or need hearing aids, or need to lip-read what people say. **[03] Manual Dexterity** should be used where the patient experiences difficulty performing tasks with their hands. **[04] Memory or ability to concentrate, learn or understand (Learning Disability)** should be used where the patient has difficulty with memory or ability to concentrate, learn or understand which began before the age of 18. **[05] Mobility and Gross Motor** should be used where the patient has difficulty getting around physically without assistance or needs aids like wheelchairs or walking frames; or where the patient has difficulty controlling how their arms, legs or head move. **[06] Perception of Physical Danger** should be used where the patient has difficulty understanding that some things, places or situations can be dangerous and could lead to a risk of injury or harm. **[07] Personal, Self-Care and Continence** should be used where the patient has difficulty keeping clean and dressing the way they would like to. **[08] Progressive Conditions and Physical Health (such as HIV, cancer, multiple sclerosis, fits etc.)** should be used where the patient has any illness which affects what they can do, or which is making them more ill, which is getting worse, and which is going to continue getting worse. **[09] Sight** should be used where the patient has difficulty seeing signs or things printed on paper, or seeing things at a distance. **[10] Speech** should be used where the patient has difficulty speaking or using language to communicate or make their needs known. **[XX] Other** should be used where the patient has any other important health issue including dementia or autism.

DISABILITY IMPACT PERCEPTION	This data item should record patient perception of the impact of their disability. The level of disability can also be determined by the patient's proxy. If the impact of the disability cannot be determined by reference to either the patient or patient proxy it should be left blank. If either of the NN or ZZ options are chosen, Disability Impact Perception should be left blank as this won't be applicable.

5.4.10 MHS008 Care Plan Type

MHS008 Care Plan Type	
Description	
To carry details of Care Plans created for a patient by the organisation, excluding Discharge Plans which are contained in the Service of Team Referral table. One occurrence of this group is permitted for each Care Plan created for the patient. **General Table Guidance** As part of MHSDS v2.0 changes, MHS008CrisisPlan has been updated as a generic Care Plan Type table where different types of Care Plans for the patient can be recorded. Mental Health Crisis Plan data should continue to be submitted in this table according to the same definition. This table needs to be submitted for every patient who has a Care Plan. Only plans that are in place ('active') within the reporting period should be submitted each month. Plans that have historically been replaced or are no longer relevant for the reporting period are not required for submission.	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**

CARE PLAN TYPE (MENTAL HEALTH)	**10 – Mental Health Care Plan** A Mental Health Care Plan is a plan of the treatment or health care to be provided to a mental health PATIENT for a CARE ACTIVITY or within an ACTIVITY GROUP. **11 - Urgent and Emergency Mental Health Care Plan** An Urgent and Emergency Mental Health Care Plan aims to develop strategies to help people stay safe and establish a network of support. Additional Guidance An Urgent and Emergency Mental Health Care Plan is a plan jointly agreed and *created while the person is experiencing crisis* during that immediate episode of care. This plan is about immediate management of risk to the patient and others and describes what the immediate next steps are such as inpatient admission, signposting to safe haven, discharge if crisis has resolved or referral to home treatment etc. This differs from the Mental Health Crisis Plan, which instead is usually created when the person is well and contains information about what should be done or needs to happen in the event of a crisis. **12 – Mental Health Crisis Plan** A Mental Health Crisis Plan is a CARE PLAN outlining key information to be considered during a mental health crisis. It includes: • contact details • history of mental and physical illnesses • previous anti-depressants and psychotherapies • signs predicting relapse, and • instructions for care if a future relapse occurs Mental Health Crisis Plans play an important role in reducing the use of mental health inpatient services, and compulsory admission and treatment in PATIENTS with severe mental illness. **13 - Positive Behaviour Support Plan** A Positive Behaviour Support Plan is created to help understand and support children, young people and adults who have a Learning Disability and display behaviour that others find challenging. 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[30]. **14 - Child or Young Person's Mental Health Transition Plan** A Child or Young Person's Mental Health Transition Plan is a joint-agency plan to prepare for transition out of Children and Young People's Mental Health Services (CYPMHS) as a consequence of the

	patient's age or change to care needs. Its purpose is to prepare the patient, appropriate members of their support network (such as family/carers, with the patient's agreement), and receiving services (including primary care) for transition out of CYPMHS. It must be signed off by both sending and receiving services, by the young person and by appropriate members of their support network (with the patient's agreement), at least 6 months prior to transition*, to: • Agree patient needs to inform the network of care around the patient (such as parents/carers, and including the receiving service); • Support the patient and their network of care to manage the process of transition; • Agree transition goals with the patient. • *or, where the patient enters CYPMHS less than 6 months prior to transitioning, at least one month prior to transition. A Child or Young Person's Mental Health Transition Plan may incorporate or be incorporated into a Mental Health Care Plan and/or a Discharge Plan, and these multiple plans may also be brought into a single plan – but in order to fulfil this field, that plan must incorporate the requirements from this definition. Transition and Discharge Plans may overlap in particular where the patient is transitioning out of CYPMHS into primary care or other services delivering mental health support (e.g. counselling at school or voluntary sector). In this instance, the same applies: in order to fulfil a field, the plan must incorporate the requirements from the relevant definition.

5.4.11 MHS009 Care Plan Agreement

MHS009 Care Plan Agreement	
Description	
To carry details of any agreements to a Care Plan by a person, team or organisation. One occurrence of this group is permitted for each agreement of a Care Plan, for example if agreement is with 13 – Clinical Service or Team but two representatives of the team were involved, only one record should flow. **General Table Guidance** This table can flow multiple times in relation to one care plan, allowing details of each person, team or organisation agreeing to the care plan to flow. Where the patient is incapacitous a record with national code 10 – PATIENT or patient proxy, would only be expected if the care plan has been agreed with the patient proxy.	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**

CARE PLAN AGREED BY	If a patient is incapacitous, they may have had little or no input into the agreement, however an agreement is still in place and information can flow. If a clinician has had a conversation with a member of the patient's family to agree on appropriate care for the incapacitous patient, then two records should flow. One to indicate that the clinician has agreed the care plan (13 – Clinical Service or Team) and one to indicate that the family member has agreed the care plan (11 – Family member or carer). There is no agreement directly with the patient, and therefore no record to indicate patient agreement. If the only discussion that has taken place regards a patient's care plan is between a clinician and an incapacitous patient, this would not be sufficient to merit an agreement, as the patient is unable to understand or consent to the plan. In this scenario, the information should not flow in the care plan agreement table.

5.4.12 MHS010 Assistive Technology To Support Disability Type

MHS010 Assistive Technology To Support Disability Type	
Description	
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. **General Table Guidance**	
Data Item Name	**Additional Notes**

5.4.13 MHS011 Social and Personal Circumstances

MHS011 Social and Personal Circumstances	
Description	
To carry details of Social and Personal Circumstances of a patient. One occurrence of this Group is permitted for each Social and Personal Circumstance recorded. **Scope** This table is currently limited to collect the following circumstances: Required - RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE or RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION CODE Required - PERSON STATED SEXUAL ORIENTATION CODE **General Table Guidance** Please see the NHS Data Model and Dictionary links above for further information regarding the definitions and code lists for these data elements. Please note that submission must be made using the specified SNOMED CT subsets for each data element, which can be found via the SNOMED CT Term Browser. The SNOMED CT subsets for both data elements are aligned 1:1 with the NHS Data Model and Dictionary National Codes.	
Data Item Name	**Additional Notes**

SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT)	**Locating and using SNOMED CT refsets for the relevant codes:** - Open the NHS Digital SNOMED CT Browser[31] - Click through the 'Go Browsing' welcome page - In the left windowpane, open the 'Refset' tab - Locate the relevant refset (listed in alphabetical order) and open - On the right hand windowpane, locate the 'Members' tab and open - This will display the relevant concepts **RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE** SNOMED CT Religious or other belief system affiliation group code subset: Religious or other belief system affiliation groups (Term Browser)[32] DD4C Subset Metadata: Religious or other belief system affiliation groups (DD4C)[33] NHS Data Model and Dictionary Service mapping: RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE Notes: Please note the following mapping between the National Codes and SNOMED CT Subset: "62458008 | Has religious belief (finding)" aligns with "K – Other" "763896000 | Refusal by patient to provide information about religion (situation)" aligns with "M – Declines to Disclose" "160552003 Not religious (finding)" aligns with "L – None" Please note the addition of "Agnostic (person)" within the SNOMED CT terms, which is currently not aligned with the NHS Data Model and Dictionary. **RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION CODE** SNOMED CT Religious or other belief system affiliation code subset: Religious or other belief system affiliation groups (Term Browser) DD4C Subset Metadata: Religious or other belief system affiliation (DD4C)[34] NHS Data Model and Dictionary Service mapping: RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION CODE **PERSON STATED SEXUAL ORIENTATION CODE** SNOMED CT Sexual orientation subset: Sexual orientation findings (Term Browser)[35] DD4C Subset Metadata**:** Sexual orientation findings (DD4C)[36]

	NHS Data Model and Dictionary Service mapping: PERSON STATED SEXUAL ORIENTATION Notes: Please see the DCB2094 Sexual Orientation Monitoring[37] webpage for further details regarding this separate information Standard. In particular, Appendix A of the Implementation Guidance contains a mapping table for the national codes.

5.4.14 MHS012 Overseas Visitor Charging Category

MHS012 Overseas Visitor Charging Category	
Description	
To carry details of the Overseas Visitor Charging Category of the patient. Multiple occurrences of this group are permitted, one for each Overseas Visitor Charging Category recorded for the patient. **General Table Guidance** Please see the Overseas Visitor Charging Category (OVCC)[38] fundamental standard for more information on the recording of the Overseas Visitor Charging Category.	
Data Item Name	**Additional Notes**
OVERSEAS VISITOR CHARGING CATEGORY	This is the charging category relating to a patient's OVERSEAS VISITOR STATUS and should be recorded using the appropriate national codes. There are 8 distinct categories. Category A (Standard NHS-funded PATIENT) applies when a patient has been resident in the UK, and has permission to be in the UK for over 12 months. Therefore, all patients (except illegal immigrants), on reaching the anniversary of their arrival to the UK, become eligible for NHS treatment. If a PATIENT has always been resident in the UK, then code A Standard NHS-funded PATIENT should be recorded.
OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE DATE	The OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE DATE can be used in conjunction with the REFERRAL REQUEST RECEIVED DATE and the SERVICE DISCHARGE DATE to identify which referral the OVCC relates to.

5.4.15 MHS101 Service or Team Referral

MHS101 Referral
Description
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. **General Table Guidance** A referral is a request for care to be provided for a patient. It includes admission to hospital and self-referrals. Both external and internal referrals should be reported. The table includes referrals that were received but subsequently rejected by the provider. A patient may have multiple referrals or admissions within a reporting period. All referrals starting, ending or open/active within reporting period should be flowed with every submission for each period. All data submissions for a service user must be accompanied by a linked referral. If the MHS101 Referral table is not included, with all mandatory data items submitted (as a minimum), no other data can flow for that service user. If this table is blank within a submission file, the whole file will be rejected. **Identifying Start/End Dates** This table must contain a record that identifies the start (REFERRAL REQUEST RECEIVED DATE) and (once available) end date (SERVICE DISCHARGE DATE) for each distinct period of care by an individual service/team for the patient. This period of care may be identified in PAS' or other systems as a 'referral'; however, where the concept of a referral does not exist, the dates may be determined by the presence of specific dates held by the system that mark the start and end date of a distinct period of care and can be mapped to the data items required for submission. For example: the start and end dates of a Hospital Provider Spell (if appropriate). (In which case START DATE (HOSPITAL PROVIDER SPELL) = REFERRAL REQUEST RECEIVED DATE and DISCHARGE DATE (HOSPITAL PROVIDER SPELL) = SERVICE DISCHARGE DATE.) It may be that the start date for a hospital provider spell represents the beginning of a period of care (REFERRAL REQUEST RECEIVED DATE), but following discharge from hospital, care continues under the same service on an outpatient basis. In this instance SERVICE DISCHARGE DATE would be recorded when the patient concludes their outpatient appointments. Where the provider data items used to represent the REFERRAL REQUEST RECEIVED DATE or SERVICE DISCHARGE DATE suggest more than one date could be used, consideration should be given to whether it is more appropriate to submit a single referral with more than one associated service/team type or multiple internal referrals – the data set does not prevent a service or team from making an internal referral to itself if necessary. If by mapping data items to the referral, key identifiers appear to be duplicated (for example: the SERVICE REQUEST ID required as a primary key for the Service or Team Type Referral table is the same ID as the HOSPITAL PROVIDER SPELL NUMBER required by the Hospital Provider Spell table, there are various ways this could be resolved. One example is to add a prefix to one of the IDs. E.g. HOSPITAL PROVIDER SPELL NUMBER 12345 becomes SERVICE REQUEST ID SR12345. In arriving at a solution providers should ensure that the basic rules applied to the IDs are followed such as maximum number of characters and no duplication within the tables for which they are a primary key. *The data model makes provision for various service models, however we recognise that difficulties may remain in populating the REFERRAL REQUEST RECEIVED DATE and the SERVICE DISCHARGE DATE for some providers. If this is the case, please get in touch and we can discuss how your data can be most effectively submitted within the structure available.*

Data Item Name	Additional Notes
REFERRAL REQUEST RECEIVED DATE	For both electronic and written referral requests the date that the request was received should be used and NOT the date that the referral was read, processed, or actioned i.e. the date stamped as the date of receipt and not the date entered onto a system. For referral requests received by telephone use the date of the follow up letter if received, otherwise the date of the phone call. For further guidance on what constitutes the REFERRAL REQUEST RECEIVED DATE please see the NHS Data Model and Dictionary[39]. The REFERRAL REQUEST RECEIVED DATE typically forms a key part of waiting times calculations in support of the National Tariff[40]. Please see section 2.8 of this document for further information regarding national waiting times.
REFERRAL REQUEST RECEIVED TIME	This data item should be submitted where available. Submission is important for priority referrals into services with target waiting times measured in hours. E.g. urgent and emergency mental health care. Please refer to section 2.8 of the document for further waiting times information
NHS SERVICE AGREEMENT LINE NUMBER	This data item is primarily for local use and enables Health Care Providers to associate specific referrals or referral types with unique service lines agreed with their Commissioners.
SPECIALISED MENTAL HEALTH SERVICE CATEGORY CODE	The 'SPECIALISED MENTAL HEALTH SERVICE CATEGORY CODE' is expected to be completed within the MHSDS where a record/s relate to a Specialised Mental Health service. All Specialised Mental Health services (and associated coding) is located on the following website https://www.england.nhs.uk/nhs-standard-contract/dc-reporting/. Please refer to the 'Aggregate Contract Monitoring (ACM) Specification' and tab labelled as 'Specialised MH Service Cat Code' and column A labelled as 'Specialised Mental Health Service Category Code' for details (e.g. NCBPS22E/ASSESS). Note: This field has been changed to Specialised Mental Health Service Category Code. This is to avoid confusion when read in conjunction with existing NHS England specialised commissioning guidance that references 'service category'.
SOURCE OF REFERRAL FOR MENTAL HEALTH	Where a data provider has a more extensive list of referral sources, then they should be mapped to an appropriate value stated in the output data item list. Where it is not possible to map a value against those stated in the output data item list then this should be mapped to the code '[M6] Other Service or Agency.' **Please note:** codes J1-J4, K1-K5, L1-L2 are no longer valid for use in the MHSDS. **[P1] Internal Referral** should be used to record internal referrals.

ORGANISATION IDENTIFIER (REFERRING)	The referring organisation may be the same organisation as the service referred to (i.e. internal referral.) If the referral is a self-referral the following default code should be used: X99998.
REFERRING CARE PROFESSIONAL STAFF GROUP (MENTAL HEALTH AND COMMUNITY CARE)	This will indicate the staff group of the Care Professional referring the patient into the service. This data item is not required where the referrer is not a care professional e.g. self-referral, carer or employer. In this circumstance this data item should be left blank (NULL).
CLINICAL RESPONSE PRIORITY TYPE	This indicates the Clinical Response Priority of a Service Request. The definition for each CLINICAL RESPONSE PRIORITY TYPE code varies dependant on care pathway and providers should reference National Guidance for the pathway in question. We will endeavour to enhance this section of guidance where additional information becomes available. For service requests to a Child and Adolescent Mental Health Care Team, a CLINICAL RESPONSE PRIORITY TYPE of 'Emergency' indicates that the patient needs to be seen within 48 hours of the REFERRAL REQUEST RECEIVED DATE. This priority is as assessed by, or on behalf of, the Child and Adolescent Mental Health Care Team. For service requests to a Liaison Psychiatry Team the definitions are as defined by the Royal College of Psychiatrists[41]. In addition, an 'Emergency' response will indicate that the PATIENT was referred as a result of A&E attendance.
PRIMARY REASON FOR REFERRAL (MENTAL HEALTH)	This is the presenting condition or symptom for which the patient was referred **to** the Mental Health Service. This will usually accompany the initial referral to the service. If multiple presenting conditions are recorded without clear indication of which is the primary reason, then one primary reason for referral should be selected based on local decision. Please see Appendix 1 for further guidance relating to specific codes.
REASON FOR OUT OF AREA REFERRAL (ADULT ACUTE MENTAL HEALTH)	Please see Appendix 5 Out of Area Placements for contextual and general information about Out of Area Placements and how the data collection will be undertaken through the MHSDS. *National Code 12 – Offending Restrictions*: This code can be used where an offending restriction has resulted in a referral for an Out of Area Placement. For example, a person may have offending restrictions, such as an anti-social behaviour order or a restraining order, that mean they are not able to go/live/stay in certain postcodes. These orders would still apply if the person needed to be admitted into an inpatient unit, so in this case the person's 'home/local' provider would have to place them Out of Area in order to comply with the person's offending restrictions. Please Note: if a patient has **not** been referred Out of Area, the REASON FOR OUT OF AREA REFERRAL (ADULT ACUTE MENTAL HEALTH) should not be populated and consequently left BLANK. A reason should only be recorded in circumstances where a patient has been referred Out of Area, as per the definition.

DISCHARGE PLAN CREATION DATE	The NHS Data Model and Dictionary definition for Discharge Plan is as follows: 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.
DISCHARGE LETTER ISSUED DATE (MENTAL HEALTH AND COMMUNITY CARE)	This data item supports the requirement to provide a Discharge Letter to the referrer within 24 hours of the SERVICE DISCHARGE DATE.

5.4.16 MHS102 Service or Team Type Referred To

MHS102 Service or Team Type Referred To	
Description	
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. **General Table Guidance** This table should only be completed where the referral is to a community service and is not required for inpatient services. For inpatient services, the relevant Hospital Provider Spell and Ward Stay data items must be completed, including the Hospital Bed Type. A full list of Hospital Bed Type and Team Type definitions can be found within Appendix 10. MHSDS v5.0 will include changes to the table name and items to clarify this point further. The relationship between MHS101 and MHS102 will typically be one-to-one within this data set; however providers may opt to submit a one-to-many relationship for particular referral scenarios, For example, where multiple services/teams are working (and funded) together under a single referral to support a specific care need of a patient. In this instance, each service element (MHS102) must start at the same time (REFERRAL REQUEST RECEIVED DATE) but may end at different points across the overarching referral. Where each service starts at a different time, this would be more appropriately modelled as individual referrals in MHS101.	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**

SERVICE OR TEAM TYPE REFERRED TO (MENTAL HEALTH)	This should be the service or team type that the patient was referred to. To reiterate the General Table Guidance above, this data item is applicable to community services only and must not be used for inpatient services. Hospital Bed Type must be completed for inpatient services instead. Please note that the data set is patient focused rather than service focused. Any of the team types listed could potentially be involved in the care of in-scope patients. However, this does not indicate that all patients referred to these teams are in scope. All patients for whom data is submitted must receive specialist secondary mental health care services and have, or are thought to have a mental illness; or receive specialist secondary learning disabilities or autism spectrum disorder services and are thought to have a learning disability or autism spectrum disorder. For example: Substance Misuse teams may treat a variety of people, only some of whom will have a mental illness, learning disability or autism spectrum disorder. A patient treated by the Substance Misuse Team but who does not suffer from mental illness or have a learning disability or autism spectrum disorder, would not be in scope. Similarly, a service may be in scope of the National Tariff Payment System (SERVICE OR TEAM TYPE REFERRED TO (MENTAL HEALTH) code Z01) but if the patient is not 'in-scope' of MHSDS, as per the MHSDS Requirements Specification[42] data should not be submitted. A full list of Team Type definitions can be found within Appendix 10.
REFERRAL CLOSURE REASON	A referral must either be rejected or closed. The REFERRAL REJECTION REASON and the REFERRAL CLOSURE REASON data items relate to different points in the patient journey. If a patient is rejected by the service, we would expect it to be for one of the three reasons outlined in the referral rejection reason. If the patient is not rejected, then at some point later in time, their referral will be closed, probably as a result of completed treatment, or onward referral to another service. When this occurs, we would expect one of the referral closure reasons to be recorded. Where a low-level intervention occurs, such as signposting, this will either be conducted by the referrer, in which case it is not information the referred-to service is expected to record or flow, or it takes place in the referred-to organisation. If it occurs in the referred-to organisation then, although a low-level intervention, the referral was not rejected, and a referral closure reason would apply.
REFERRAL REJECTION REASON	For guidance regarding the difference between the referral closure reason and the referral rejection reason please see REFERRAL CLOSURE REASON above.

5.4.17 MHS103 Other Reason for Referral

MHS103 Other Reason for Referral	
Description	
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. This group should only be included for submission when other additional reasons for referral are recorded in the patient's record.	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
OTHER REASON FOR REFERRAL (MENTAL HEALTH)	This is an additional presenting condition or symptom for which the patient was referred to a service for. This group is not for recording the primary presenting condition or symptom. The primary presenting condition or symptom should be recorded in MHS101Referral. Please see Appendix 1 for further guidance relating to specific codes and mapping.

5.4.18 MHS104 Referral To Treatment (RTT)

MHS104 Referral To Treatment (RTT)	
Description	
The purpose of this section is to collect Allied Health Professional Referral To Treatment (AHP RTT) data in order to support AHP RTT duration measurement and national benchmarking. For the purposes of MHSDS, the data collected within this section relates only to AHP RTT activity. The information submitted must be accurate as of the close of reporting period. The Allied Health Professional Referral to Treatment Guide (Department of Health 2010) will support NHS-funded AHP services to measure the time that patients wait to access patient NHS-funded AHP services, which includes mental health and learning disabilities. The scope of AHP RTT data collection and measurement is not exclusive to a mental health service. Further guidance for AHP RTT services outside the scope of this data set is being developed. The guide is aimed at improving patients' experience of NHS AHP services, reduce the time they wait for treatment and enable the delivery of productive, innovative, quality NHS AHP services. Please note: Mandatory reporting in relation to 18 weeks waiting times and Allied Health Professionals Referral To Treatment (AHP RTT) is still required through CDS regardless of data submitted in respect of MHSDS. For more information on AHP RTT please see link below: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215248/dh_131969.pdf	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
PATIENT PATHWAY IDENTIFIER	An identifier, which together with the organisation identifier of the issuer uniquely identifies a patient pathway. This is a specific type of the attribute activity identifier. Where 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 identifier of NHS Digital which is X26. Where the pathway is initiated by some other method, the patient pathway identifier will be allocated by the organisation receiving the service request which together with that organisation's organisation identifier will uniquely identify the patient pathway.
ORGANISATION IDENTIFIER (PATIENT PATHWAY IDENTIFIER ISSUER)	This is the Organisation identifier of the Organisation issuing the Patient Pathway Identifier. Where Choose and Book has been used, the Organisation identifier for NHS Digital (X26) should be recorded.
WAITING TIME MEASUREMENT TYPE	The type of waiting time measurement methodology which may be applied during a patient pathway. The methodology applied may be for one part of a patient pathway, such as the measurement of a referral to treatment period, or other parts of the patient pathway according to DHSC policy. This item is now mandatory and must be included within each record submitted in this table.

5.4.19 MHS105 Onward Referral

MHS105 Onward Referral	
Description	
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. **General Table Guidance** This table is to record and flow the details of the onward referral (where the patient is being referred/transferred within the services under the current organisation or to another external service/organisation). If the 'Onward Referral' was from one Mental Health service to another (in the same or a different provider), this should appear at a later point as a new referral in the Referral table. However, a patient could be referred to a service which is not Mental Health related, and is therefore outside the scope of the MHSDS. The referral would therefore appear in the Onward Referral table and would not appear as a new referral in the Referral table. Comparisons between the Referral and Onward Referral tables between providers are likely to be made for the purpose of data quality analysis. **Out of Area Treatment (Adult Acute Mental Health)** Please see Appendix 5 Out of Area Placements for details of the use of this table for identifying Out of Area Placements for adult acute mental health inpatient care.	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
REFERRED OUT OF AREA REASON (ADULT ACUTE MENTAL HEALTH)	Please see Appendix 5 Out of Area Placements for contextual and general information about Out of Area Placements and how the data collection will be undertaken through the MHSDS. *National Code 12 – Offending Restrictions*: This code can be used where an offending restriction has resulted in a referral for an Out of Area Placement. For example, a person may have offending restrictions, such as an anti-social behaviour order or a restraining order, that mean they are not able to go/live/stay in certain postcodes. These orders would still apply if the person needed to be admitted into an inpatient unit, so in this case the person's 'home/local' provider would have to place them Out of Area in order to comply with the person's offending restrictions. Please Note: if a patient has **not** been referred Out of Area, the REFERRED OUT OF AREA REASON (ADULT ACUTE MENTAL HEALTH) should not be populated and consequently left BLANK. A reason should only be recorded in circumstances where a patient has been referred Out of Area, as per the definition.
ORGANISATION IDENTIFIER (RECEIVING)	The ODS registered Organisational Identifier of the organisation where the patient was onward referred to. This should be populated if it is known/collected and can be left blank if not.

5.4.20 MHS106 Discharge Plan Agreements

MHS106 Discharge Plan Agreements	
Description	
To carry details of any agreements to a Discharge Plan by a person, team or organisation. One occurrence of this group is permitted for each agreement of a Discharge Plan. **General Table Guidance** The NHS Data Model and Dictionary supporting definition[43] is as follows: *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.*	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**

5.4.21 MHS107 Medication Prescription

MHS107 Medication Prescription	
Description	
IMPORTANT: PLEASE NOTE – This is a Pilot group and has been included within the specification for piloting purposes only to support future implementation. These data items have not been approved and/or mandated and SHOULD NOT be submitted unless specifically requested by NHS Digital. The purpose of this pilot table is to allow data linkage to be undertaken with other medication collections. The Prescription Identifier will provide the data linkage.	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
SERVICE REQUEST IDENTIFIER	This data item is a pilot item and currently not in use.
PRESCRIPTION IDENTIFIER	This data item is a pilot item and currently not in use.
PRESCRIPTION DATE (MEDICATION)	This data item is a pilot item and currently not in use.
PRESCRIPTION TIME (MEDICATION)	This data item is a pilot item and currently not in use.

5.4.22 MHS201 Care Contact

MHS201 Care Contact
Description

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.
 	
General Table Guidance
 	
This table should reflect Care Contacts from a patient perspective. For example, where multiple Care Professionals are involved in a single Care Contact, this will still represent a single Care Contact record, rather than creating multiple records linked to each involved Care Professional.
 	
This data group should include details of all care contacts (appointments and telephone consultations) for a patient within the reporting period. Care contacts that were cancelled by either the provider or the patient or where the patient Did Not Attend (DNA) should also be included.
 	
This should include all face-to-face contacts with the patient or a proxy such as a legal guardian E.g. the parent of a young child, where this is in lieu of a contact with the patient.
 	
Non face-to-face contacts should only be included where there is an opportunity for discussion between patient and healthcare professional. For instance, a telephone call to explain the ramifications of test results to a patient would be included, but texting (SMS) or emailing results would not. Non face-to-face telephone contacts solely to inform patients of results are excluded.
 	
Contact and Activity Scenarios
 	
The different scenarios can be broken down as follows:
 	
• Where the patient only is present, this should be recorded as a Care Contact.
• Where the patient and another attendee (this could be a relative/carer) are present this should be recorded as a Care Contact with supplementary MHS203 Other in Attendance records.
• Where the patient is not present but a patient proxy is in attendance, this should be recorded as a Care Contact.
• Contacts about the patient but not involving either the patient or their proxy (i.e. professional to professional) should NOT be recorded as a Care Contact, but recorded as an Indirect Activity in MHS204IndirectActivity.
• Contacts where the patient is not present but a family member/carer (not acting as a proxy) is present and receiving parent/carer interventions should NOT be recorded as a Care Contact, but recorded as an Indirect Activity in MHS204IndirectActivity
• Activities such as administrative tasks (e.g. note writing/travel), should not be included as these are not in scope for submission.
• Care Contacts should flow for both inpatients and outpatients. Therapeutic contacts taking place in inpatient and community settings must be submitted as a matter of course.
  ○ Please see Appendix 8 of this User Guidance document for further information with regard to flow of data with respect to Electric Convulsive Therapy (ECT) treatments.
  ○ Please see national guidance for further exceptions

Additional Notes on Data Items

Data Item Name	Additional Notes

CARE PROFESSIONAL TEAM LOCAL IDENTIFIER	A unique local CARE PROFESSIONAL TEAM IDENTIFIER within a Health Care Provider which may be assigned automatically by the computer system. This data item only applies for community teams where the MHS102 Service or Team Type Referred To table has been submitted.
ADMINISTRATIVE CATEGORY CODE	This is primarily for local use and identifies whether a contact is with an NHS funded or a non-NHS funded patient. The administrative Category code refers to a patient's status regarding payment for NHS services. It is relevant for all care contacts and applies to both in-patient and out-patient care.
CLINICAL CONTACT DURATION OF CARE CONTACT	The duration of the clinical contact should be recorded and accounted for, regardless of the type of contact (i.e. Telephone calls). The duration field should only be left blank if the Health Care professional (HCP) was unable to get through to the patient/the patient did not answer the phone. In which case it should also be recorded as a DNA.

CONSULTATION 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. If your service is delivering activity through a different medium than usual - to comply with physical distancing and enable remote working (e.g. online video consultation) - you can still flow this activity using existing data codes. Remote activity should only be flowed to the MHSDS if it is clinically meaningful. For example, contact that informs assessment and intervention that directly related to the identified/coded problem, and is intended to assess or change behaviour or construct and review plans for this. Moving forward, we are working to identify how we can better capture digital interventions in v5.0 of the MHSDS. 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. Telephone contacts solely for informing PATIENTS of results are excluded. **Code specific guidance**: **[01] Face to face communication:** Clinical contacts where the provider and patient are physically present with each other. **[02] Telephone:** Clinical contacts that are delivered over the phone, rather than face to face. **[03] Telemedicine:** Telemedicine is the use of telecommunication and information technology for the purpose of providing remote health assessments and therapeutic interventions. This could include video or voice messaging services on mobile phones, computers and tablets. This also includes clinical contacts that are delivered remotely using tele-conferencing tools (ie remote video), rather than face to face. **[04] Talk type for a PERSON unable to speak:** **[05] Email:** This consultation medium is not included in the CYP access metric* **[06] Short Message Service (SMS) - Text Messaging:** This consultation medium is not included in the CYP access metric* **[98] Other (not listed):** This could for example include chat / e-chat tools.

ACTIVITY LOCATION TYPE CODE	Where contact is not face to face the ACTIVITY LOCATION TYPE of the patient should be used; not the location of the clinician. **[J01] Resource Centre premises:** A Mental Health, Learning Disabilities or Autism Spectrum Disorder Resource Centre is the focus for the provision of mental health, learning disabilities or autism spectrum disorder care services to a specific area of the community. It acts as the base of a multi-professional team whose core purpose is to provide community-based care for mental health, learning disabilities or autism spectrum disorder clients of all ages. The care usually comprises assessment, treatment and rehabilitation via domiciliary, consultant and other HCP outpatient, day hospital and outreach services, delivered at the centre, in the client's home and other suitable venues. **[B01] / [B02] Health Centre premises:** A health centre is a facility which is used for the provision of primary care services and a range of community health services. It provides a standard of amenity which it is not easy to provide in a traditional consulting room. Services provided include General Medical services and nursing services and may in addition include AHP services, other primary care services and specialist services. **[H01] Day Centre premises:** Daytime care for the needs of people who cannot be fully independent: such as children or the elderly. Day care centres can offer the person you care for an opportunity to take on new hobbies and arrange days out, and they can also provide you with a break from caring. Day care centres are run by social services departments, or voluntary organisations, such as charities **[D01] / D02] / [D03] Walk In Centres, Out of Hours Premises and Emergency Community Dental Services:** NHS Walk-in Centres are predominantly nurse–led primary care facilities dealing with illnesses and injuries – including infections and rashes, fractures and lacerations, emergency contraception and advice, stomach upsets, cuts and bruises, or minor burns and strains – without the need to register or make an appointment. They are not designed for treating long-term conditions or immediately life-threatening problems.

PLACE OF SAFETY INDICATOR	NHSE plan to release specific guidance regarding collection of data relating to the Mental Health Act 1983 and the 2007 revision, and the Mental Health Act (Place of Safety) Regulations 2017. Development of this guidance will include consultation with respect to the specific requirement to flow the Place of Safety Indicator as part of the MHSDS. Until new guidance is published, care provider organisations should continue to record care contacts that relate to S.136 events as per current local policy. A Place of Safety[44] may be: • a residential ACCOMMODATION provided by a local social services authority under Part III of the National Assistance Act 1948 • a hospital as defined by the Mental Health Act 1983 as amended by the Mental Health Act 2007 • a police station • an independent hospital or Care Home for mentally disordered PERSONS or • any other suitable place. The legislation.gov.uk website at: Restrictions on places that may be used as places of safety provides the following restrictions on places that may be used as places of safety: A house, flat or room where a PERSON is living may not be regarded as a suitable Place of Safety unless: • if the PERSON believed to be suffering from a mental disorder is the sole occupier of the place, that PERSON agrees to the use of the place as a Place of Safety • if the PERSON believed to be suffering from a mental disorder is an occupier of the place but not the sole occupier, both that PERSON and one of the other occupiers agree to the use of the place as a Place of Safety • if the PERSON believed to be suffering from a mental disorder is not an occupier of the place, both that PERSON and the occupier (or, if more than one, one of the occupiers) agree to the use of the place as a Place of Safety. A place other than the one mentioned above may not be regarded as a suitable place, unless a PERSON who appears to the constable exercising powers under this section to be responsible for the management of the place agrees to its use as a Place of Safety.

ATTENDED OR DID NOT ATTEND CODE	The ATTENDED OR DID NOT ATTEND CODE data item should be submitted irrespective of CONSULTATION MEDIUM USED. I.e. the data item is still applicable even if the contact is not face to face. **[2] Appointment cancelled by, or on behalf of the patient:** An appointment is classified as being 'cancelled by, on or behalf of the patient' where it is cancelled at any point in time prior to the start of the appointment. **[3] Did not attend, no advance warning given:** An appointment is classified as being a DNA if the patient does not attend for the entire duration of the appointment slot, or they do attend but there is insufficient time remaining to conduct the planned activity and therefore the appointment is not usable. In the case of telephone contacts, duration should be recorded as 0 and marked as DNA only if the contact was a planned telephone contact and the patient did not answer the phone. **4] Appointment cancelled or postponed by the health care provider:** An appointment is classified as being 'cancelled or postponed by the healthcare provider' where it is cancelled at any point in time prior to the start of the appointment. When an appointment is cancelled (by, or on behalf of the patient, or by the health care provider) the appointment cancelled date should also be recorded. This will identify instances where the appointment was cancelled on the day it was intended to take place. When an appointment is re-arranged this is effectively classed as a cancelled appointment. When it is re-arranged the original appointment is cancelled and a new one is created. Dependant on who cancelled (re-arranged) the appointment, the national code [2] or [4] should be used.

EARLIEST REASONABLE OFFER DATE	This value is the date of the earliest of the reasonable offers made to a patient for an appointment or elective admission. **In the case of AHP RTT monitoring only:** the EARLIEST REASONABLE OFFER DATE may be used locally to inform waiting time calculations. It can be used to account for periods of time where the patient has not accepted the first available appointment offer and this has extended the Allied Health Professional Referral To Treatment Measurement waiting time, for example: • Where a patient who is a child or adolescent has been offered an appointment but their parent/carer states that they wish to wait until the school holidays commence. The service cannot commence planned treatment until the patient is available. • Where the patient works away and cannot attend for a period of time, but it is not appropriate to discharge the patient from the service. **Patient cancellations** Where, for any reason, a patient cancels or does not attend an appointment or an offer of admission the earliest reasonable offer date for the rearranged appointment or offer of admission will be the earliest reasonable offer date of the cancelled appointment or offer of admission. **Provider cancellations** Where, for any reason, any health care provider cancels and re-arranges an appointment or an offer of admission, the earliest reasonable offer date for the re-arranged appointment or offer of admission will be the date of the earliest reasonable offer made following the cancellation. **Patients who are unavailable** If the patient has specifically requested to be unavailable for a longer period of time, for example a patient who is a student who wishes to delay their admission until the summer holidays, making a reasonable offer may be inappropriate. In these circumstances, so long as the health care provider could have made at least two reasonable offers, the earliest reasonable offer date will be the date of the earliest reasonable offer that the provider could have offered the patient. This must be communicated to the patient.
SPECIALISED MENTAL HEALTH SERVICE CATEGORY CODE	The 'SPECIALISED MENTAL HEALTH SERVICE CATEGORY CODE' is expected to be completed within the MHSDS where a record/s relate to a Specialised Mental Health service. All Specialised Mental Health services (and associated coding) is located on the following website https://www.england.nhs.uk/nhs-standard-contract/dc-reporting/. Please refer to the 'Aggregate Contract Monitoring (ACM) Specification' and tab labelled as 'Specialised MH Service Cat Code' and column A labelled as 'Specialised Mental Health Service Category Code' for details (e.g. NCBPS22E/ASSESS). Note: This field has been changed to Specialised Mental Health Service Category Code. This is to avoid confusion when read in conjunction with existing NHS England specialised commissioning guidance that references 'service category'.

5.4.23 MHS202 Care Activity

MHS202 Care Activity
Description
To carry details of any care activity undertaken at a Care Contact. One occurrence of this Group is permitted for each Care Activity. **General Table Guidance** This table should contain a record for each separate element of assessment, treatment or review that was undertaken within a Care Contact. However, there is no necessity to duplicate closely linked care activity. For example: if several Coded Scored Assessment (Contact) records are submitted, they can be linked to one appropriate care activity (as a result of local decision). This table should reflect Care Activity from a patient perspective. For example, where multiple Care Professionals are involved in a single Care Activity, a single record should flow for the 'lead' Care Professional, rather than creating multiple records linked to each involved Care Professional. Where the ATTENDED OR DID NOT ATTEND CODE submitted in the Care Contact table is **[7] Patient arrived late and could not be seen; [2] Appointment cancelled by, or on behalf of the patient; [3] Did not attend, no advance warning given; or [4] Appointment cancelled or postponed by the health care provider** a Care Activity record should not be submitted. NHS Digital will not be restricting the input of Coded Procedures/Findings/Observations through validation. Providers can opt to flow any activities and related information that are naturally recorded against the Care Contact. Additional guidance on procedures, findings, observations, observation values and units of measurement can be found within Appendix 8, including details of specific national reporting requirements related to the use of these data items.

Additional Notes on Data Items

Data Item Name	Additional Notes
CARE PROFESSIONAL LOCAL IDENTIFIER	Where multiple Care Professionals are involved in a single Care Activity, a 'lead' Care Professional should be allocated to the Care Activity. There is no requirement to duplicate records for a single Care Activity for each involved Care Professional.
CLINICAL CONTACT DURATION OF CARE ACTIVITY	The total summed duration of Care Activities linked to a Care Contact should not exceed the Clinical Contact Duration of the Care Contact. I.e. Duration should be reported from a patient perspective and not duplicated for reporting purposes, such as against multiple Care Professionals involved in a single Care Activity.

CODED PROCEDURE AND PROCEDURE STATUS (SNOMED CT)	This item can be used to record the specific activity that was undertaken within the Care Contact, through the submission of a SNOMED CT Expression[45] Procedure: "represents activities performed in the provision of health care. This includes not only invasive procedures but also administration of medicines, imaging, education, therapies and administrative procedures" – SNOMED CT Starter Guide[46] - Section 6 (page 21 onwards) Please see Appendix 8 for details of specific national reporting requirements related to the use of this data item. For further information on SNOMED CT Expressions, see the SNOMED CT Glossary at: Expression[47]. **Examples** **Precoordinated expression (procedure only)** Procedure only flows as a single code: 718026005 (Cognitive behaviour therapy for psychosis) I.e. no change from the previous method in MHSDS v1.0/v2.0 of flowing the Coded Procedure (Clinical Terminology) data item. For this example, in the absence of an additional qualifier, we will assume that this CBT intervention has been 'delivered'. **Post-coordinated expression (procedure + qualifier)** To flow a procedure and qualifier, three pieces of information are required: • The procedure code (for example: 718026005 Cognitive behaviour therapy for psychosis) • The qualifier code (for example: 410527000 Offered) • A code that links the procedure and the qualifier (in this case: 408730004 Procedure context) The three codes are concatenated for submission as follows: 718026005:408730004=410527000 (Cognitive behaviour therapy for psychosis:Procedure context=Offered)
FINDING SCHEME IN USE	Please note, this data item should not be submitted if data is not being submitted in the CODED FINDING (CODED CLINICAL ENTRY) field. This will cause the record to be rejected.
CODED FINDING (CODED CLINICAL ENTRY)	This data item should be used to report any Findings captured during the Care Activity. Finding: "represents the result of a clinical observation, assessment or judgment and includes normal and abnormal clinical states" – SNOMED CT Starter Guide[48] - Section 6 (page 21 onwards) Please see Appendix 8 for details of specific national reporting requirements related to the use of this data item

CODED OBSERVATION (SNOMED CT)	This data item should be used to report any Observations captured during the Care Activity. Observation: "represents a question or assessment which can produce an answer or result" – SNOMED CT Starter Guide[49] - Section 6 (page 21 onwards) Please see Appendix 8 for details of specific national reporting requirements related to the use of this data item.
OBSERVATION VALUE	Observation Value: represents the value of the observation
UCUM UNIT OF MEASUREMENT	Unit of Measure: represents the unit of measure of the observation value See http://unitsofmeasure.org/trac/.

5.4.24 MHS203 Other in Attendance

MHS203 Other in Attendance	
Description	
To carry details of any other people in attendance at a Care Contact. One occurrence of this Group is permitted for each other person in attendance at a Care Contact.	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
OTHER PERSON IN ATTENDANCE AT CARE CONTACT	For further information please see: Independent Mental Capacity Advocate (IMCA) https://www.gov.uk/government/publications/independent-mental-capacity-advocates Independent Mental Health Advocate (IMHA) https://www.gov.uk/government/publications/response-on-funding-allocations-for-independent-mental-health-services-and-the-treatment-of-armed-forces-compensation-in-charging-for-social-care

5.4.25 MHS204 Indirect Activity

MHS204 Indirect Activity	
Description	
To carry details of indirect activity which takes place as a result of the referral. One occurrence of this Group is permitted for each instance of indirect activity taking place. **General Table Guidance** An Indirect Activity is ACTIVITY, with the specific purpose of supporting the care of a PATIENT, but where the PATIENT is not present. An Indirect Activity may take place between a: • CARE PROFESSIONAL and another CARE PROFESSIONAL • CARE PROFESSIONAL and another professional such as a teacher • CARE PROFESSIONAL and another PERSON, such as a family member or Carer, not acting in the capacity of a Patient Proxy. Examples of Indirect Activity include a: • CARE PROFESSIONAL seeking advice from another CARE PROFESSIONAL regarding the treatment or diagnosis of a specific PATIENT • CARE PROFESSIONAL providing training to a teacher to support the medical needs of a specific PATIENT • CARE PROFESSIONAL discussing the care of a PATIENT with another CARE PROFESSIONAL as part of a Multidisciplinary Team Meeting, where the PATIENT is not present • CARE PROFESSIONAL providing training or advice to a family member or a Carer to support the medical needs of a specific PATIENT. Indirect Activity does not include discussions regarding groups of PATIENTS or other administrative activities such as writing up of notes or travel. Contacts between a CARE PROFESSIONAL and a Patient Proxy should be captured as a CARE CONTACT with the CARE CONTACT SUBJECT set to 'Patient Proxy'. There may be examples where it is appropriate to record the activity more than once, to cater for each care professional involved, for example: where two teams are providing treatment concurrently, however this will not be the norm. It is not intended that, for example: several members of a multidisciplinary team all submit a record in relation to one planning meeting. In this instance there may be one 'lead' clinician who would record such activity. In order to support the EIP care pathway, the scope of MHSDS has been amended to allow flow of data that relates to family members and carers in the Indirect Activity Table.	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
CODED PROCEDURE AND PROCEDURE STATUS (SNOMED CT)	This item can be used to record the specific indirect activity undertaken. Please see Appendix 8 for details of specific national reporting requirements related to the use of this data item.
CODED FINDING (CODED CLINICAL ENTRY)	This data item should be used to report any Findings captured during the Care Activity. Please see Appendix 8 for details of specific national reporting requirements related to the use of this data item.

5.4.26 MHS301 Group Session

MHS301 Group Session	
Description	
To carry details of any group sessions which have been provided to a group of patients during the reporting period. One occurrence of this group is permitted for each Group Session activity. **General Table Guidance** The Group Session table is designed to allow flow of data relating to activity that cannot be directly attributable to an individual and does not link to any other data group either through the local patient identifier or referral. Only Group Sessions that cannot be directly linked to each of the patients attending the Group Session should be included i.e. this table excludes Group Therapy sessions for a number of registered patients, which should be reported as a Care Contact for each individual patient. The MHS301 Group Session table holds data relating to Group Sessions, not Patients. Where multiple sessions, defined as a group session, take place during a reporting period, each session should be recorded once in the MHS301 Group Session table. The record should not be repeated for each participant of the session. If a group session is arranged, and subsequently cancelled, then providers should not submit data in relation to the cancelled session.	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
GROUP SESSION DATE	Where a Group Session spans multiple days the Start Date should be reported here.
SERVICE OR TEAM TYPE REFERRED TO (MENTAL HEALTH)	A full list of Team Type definitions can be found within Appendix 10.

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

ACTIVITY LOCATION TYPE CODE	Where contact is not face to face the ACTIVITY LOCATION TYPE of the patient should be used; not the location of the clinician. **[J01] Resource Centre premises:** A Mental Health, Learning Disabilities or Autism Spectrum Disorder Resource Centre is the focus for the provision of mental health, learning disabilities or autism spectrum disorder care services to a specific area of the community. It acts as the base of a multi-professional team whose core purpose is to provide community-based care for mental health, learning disabilities or autism spectrum disorder clients of all ages. The care usually comprises assessment, treatment and rehabilitation via domiciliary, consultant and other HCP outpatient, day hospital and outreach services, delivered at the centre, in the client's home and other suitable venues. **[B01] / [B02] Health Centre premises:** A health centre is a facility which is used for the provision of primary care services and a range of community health services. It provides a standard of amenity which it is not easy to provide in a traditional consulting room. Services provided include General Medical services and nursing services and may in addition include AHP services, other primary care services and specialist services. **[H01] Day Centre premises:** Daytime care for the needs of people who cannot be fully independent: such as children or the elderly. Day care centres can offer the person you care for an opportunity to take on new hobbies and arrange days out, and they can also provide you with a break from caring. Day care centres are run by social services departments, or voluntary organisations, such as charities **[D01] / D02] / [D03] Walk In Centres, Out of Hours Premises and Emergency Community Dental Services:** NHS Walk-in Centres are predominantly nurse–led primary care facilities dealing with illnesses and injuries - including infections and rashes, fractures and lacerations, emergency contraception and advice, stomach upsets, cuts and bruises, or minor burns and strains - without the need to register or make an appointment. They are not designed for treating long-term conditions or immediately life-threatening problems.
NHS SERVICE AGREEMENT LINE NUMBER	This is primarily for local use and enables Health Care Providers to associate specific referrals or referral types with unique service lines agreed with their Commissioners.

5.4.27 MHS401 Mental Health Act Legal Status Classification Period

MHS401 Mental Health Act Legal Status Classification Period	
Description	
To carry details of Mental Health Act Legal Status Classification Periods for patients formally detained 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. **General table guidance** This group will be collected and submitted by a health organisation involved in a person's Mental Health Act Legal Status Classification Period. A person will usually only have one Mental Health Act Legal Status Classification Period open at one time. Each record should reflect the entire time that the patient was detained under that specific section of the MHA, including any renewals. The Expiry Date and Time should be recorded for any time limited section. If the section is renewed the Expiry Date and Time data items should be updated to reflect the new Expiry Date and Time. It is important to record both the Date and Time of the Start, End and Expiry (where the section is time limited) of all legal status assignment periods to support accurate national reporting. Where the patient becomes subject to a Community Treatment Order (CTO) or a Conditional Discharge (CD) associated with a section recorded in the MHA Legal Status Classification Period table the MHA Legal Status Classification Period should remain open but the Expiry Date (where an expiry date is applicable), should reflect the date the patient became subject to the CTO/CD. The MHA Legal Status Classification Period End Date, End Time and End Reason should only be submitted when the MHA Legal Status Classification Period ends either without a subsequent CTO or CD; or the associated CTO/CD has an End Date and the End Reason is not '02 – Community Treatment Order revoked' (CTO) or '02 – Recall' (CD). If the CTO ends for reason '02 – Community Treatment Order revoked' or the CD ends for reason '02 – Recall' the MHA Legal Status Classification Period End Date and End Reason should remain unpopulated and a new Expiry Date (where an Expiry Date is applicable) and Expiry Time should be populated. Suspension of the MHA Legal Status Classification Period will be inferred, where a CTO/CD record is submitted that starts prior to an End Date being submitted for the MHA Legal Status Classification Period. Where there is a Community Treatment Order Recall record, the MHA Legal Status Classification Period End Date can be the same as or later than the Community Treatment Order Recall End Date. The end of the Community Treatment Order Recall does not necessarily denote the end of the MHA Legal Status Classification Period. However, where the patient is detained under an MHA section that is time bound the Expiry date should be extended.	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)	If a client is admitted informally and then sectioned later the same day the admission will be informal. The time of the detention is always recorded, and this is the start of the Section (the admission time is distinct from this).

START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)	The inclusion of MHA Legal Status Start Time will enable the order of transitions between different sections of the Mental Health Act to be calculated.
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD START REASON	This item has been added to support accurate reporting of uses of the Mental Health Act and transfers between providers under a section of the MHA. Any associated CTO or CD should run concurrently with the underlying MHA Legal Status Classification Period with an MHA Legal Status Classification Period Start Date that is prior to the CTO or CD Start Date.
EXPIRY DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)	The MHA Legal Status Expiry Date has been included to address data quality issues occurring where providers either failed to close a section or include a record for an MHA Legal Status of [01] Informal following discharge from section. This can be a future date.
EXPIRY TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)	The MHA Legal Status Expiry Time has been included to address data quality issues occurring where providers either failed to close a section or include a record for an MHA Legal Status of [01] Informal following discharge from section.
END DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)	The End Date (MHA Legal Status Classification Assignment Period) has been included to address data quality issues occurring where providers either failed to close a section or include a record for an MHA Legal Status of [01] Informal following discharge from section.
END TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION ASSIGNMENT PERIOD)	The MHA Legal Status End Time has been included to address data quality issues occurring where providers either failed to close a section or include a record for an MHA Legal Status of [01] Informal following discharge from section. The inclusion of MHA Legal Status End Time will enable the order of transitions between different sections of the Mental Health Act to be calculated.
MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION PERIOD END REASON	This item has been added to support accurate reporting of uses of the Mental Health Act and transfers between providers under a section of the MHA. Any associated CTO or CD should run concurrently with the underlying MHA Legal Status Classification Period with an MHA Legal Status Classification Period End Date that is the same as or after the CTO or CD End Date.

MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE	The Mental Health Act Legal Status Classification Code value list includes all available codes to align with other national standards such as the Commissioning Data Set (CDS). However, the following codes are not applicable to MHSDS: **[01] Informal:** The end of an MHA episode should be defined through use of End Date (Legal Status classification Period). There is no need for episodes to be recorded with a legal status of informal (01). 01 is not categorised as a valid code for MHA Legal Status Classification Period records in Monthly MHSDS Data Quality Reports. **[98] Not Applicable** is not appropriate for MHSDS and should not be used.
MENTAL HEALTH ACT 2007 MENTAL CATEGORY	

5.4.28 MHS402 Mental Health Responsible Clinician Assignment

MHS402 Mental Health Responsible Clinician Assignment
Description
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 (as defined in the Mental Health Act 2007) to the Mental Health Act Legal Status Classification Period. **General table guidance** The Care Professional Local Identifier of the Responsible Clinician should correspond to a record containing the details of the Responsible Clinician in the MHS901StaffDetails table. There will be only one care professional assigned to a patient as the Mental Health Responsible Clinician at any one time.
Additional Notes on Data Items – There are currently no additional notes

5.4.29 MHS403 Conditional Discharge

MHS403 Conditional Discharge	
Description	
To carry details of each separate period of conditional discharge (CD) for the patient. One occurrence of this Group is permitted for each Mental Health Conditional Discharge Period[50]. **General Table Guidance** Each record should reflect the entire time that the patient was subject to a CD. Any period of CD must occur in conjunction with an underlying MHA Legal Status Classification Period, therefore we would expect that a CD record would only be submitted where there is an associated MHA Legal Status Classification Period record open at the same time.	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
MENTAL HEALTH ABSOLUTE DISCHARGE RESPONSIBILITY	Mental Health Absolute Discharge Responsibility is only applicable where Mental Health Conditional Discharge End Reason is “01 Absolute Discharge”; however, this data item is 'Required' and should always be included where it is relevant.

5.4.30 MHS404 Community Treatment Order

MHS404 Community Treatment Order	
Description	
To carry details of each separate period of a Community Treatment Order (CTO) 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 CTO occurs. **General table guidance** Each record should reflect the entire time that the patient was subject to a CTO, including any renewals or recalls into hospital for treatment. Any period of CTO must occur in conjunction with an underlying MHA Legal Status Classification Period, therefore a CTO record should not be submitted unless there is an associated MHA Legal Status classification Period record open at the same time.	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
EXPIRY DATE (COMMUNITY TREATMENT ORDER)	Where the CTO is renewed the Expiry Date should be updated to reflect the new Expiry Date. Expiry Date is not required when the CTO has ended. This can be a future date.

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

5.4.31 MHS405 Community Treatment Order Recall

MHS405 Community Treatment Order Recall
Description
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. **General table guidance** Any period of CTO recall must occur in conjunction with an underlying MHA Legal Status Classification Period, therefore we would expect that a CTO Recall record would only be submitted where there is an associated MHA Legal Status Classification Period record open at the same time.
Additional Notes on Data Items - There are currently no additional notes

5.4.32 MHS501 Hospital Provider Spell

MHS501 Hospital Provider Spell	
Description	
To carry details of each Hospital Provider Spell for a patient. One occurrence of this Group is permitted for each Hospital Provider Spell. **General Table Guidance** This is a continuous period of inpatient care under a single Hospital Provider starting with a hospital admission and ending with a discharge from hospital. **For the purposes of MHSDS, a referral record must be in place for the Hospital Provider Spell record to link to. We appreciate that not all services associate spells with referrals, especially where admissions are non-elective, and providers may populate a dummy referral if required. We would expect the relationship to be 1:1 between the two tables.**	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**

SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL)	The SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL) should reflect the status of the referral into the organisation and not movement between different teams or services within one organisation. 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. Please note, the following code is not a valid code for MHSDS: [79] Babies born in or on the way to hospital **MHSDS v3.0 Change** National Codes 40, 41 and 42 are NOT valid in any other data set including Commissioning Data Set version 6-2. These codes were introduced for MHSDS only to add further granularity to National Code 39. National Code 39 is still valid for the MHSDS where extra detail is not collected locally.
ADMISSION METHOD CODE (HOSPITAL PROVIDER SPELL)	Please note, the following codes are not valid for MHSDS: [2C] Baby born at home as intended [31] Admitted ante-partum [32] Admitted post-partum [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
POSTCODE OF MAIN VISITOR	Please see the ‘Technical Glossary’ tab within the *Technical Output Specification* for further details regarding acceptable postcode formats and validations applied upon submission. Postcode of main visitor is collected to allow NHS Digital to measure the distance travelled by the patient’s main visitor (which may be, their next of kin) in order to visit the patient whilst they are in hospital. Where personal details are collected by a provider organisation from an individual who is not the patient, the individual should be given a ‘Fair processing’ or ‘Privacy notice’. Postcode of main visitor will only flow from provider to NHS Digital and in the return extracts to the provider. It will not be included in the Commissioner or National extracts, where distance calculations will appear as a derivation. The postcode of main visitor should be a valid UK postcode. If a UK postcode is not available, it should be left blank. Default postcodes (such as overseas pseudo country postcodes) cannot be used to drive distance calculations.

DISCHARGE METHOD CODE (HOSPITAL PROVIDER SPELL)	National Codes 6 and 7 have been introduced in MHSDS v2.0 only to add further granularity to National Code 2. However, National Code 2 is still valid for the MHSDS where extra detail is not collected. National Codes 6 and 7 are NOT valid in any other data set including Commissioning Data Set version 6-2. Please note, the following code is not a valid code for MHSDS: [5] Stillbirth
ESTIMATED DISCHARGE DATE (HOSPITAL PROVIDER SPELL)	This is the date a PATIENT was estimated to be discharged from a Hospital Provider Spell. This is estimated at the point of admission to a Hospital Provider Spell and is different to the Planned Discharge Date, which is set once the PATIENT has been confirmed for discharge.
POSTCODE OF DISCHARGE DESTINATION (HOSPITAL PROVIDER SPELL)	Please see the 'Technical Glossary' tab within the *Technical Output Specification* for further details regarding acceptable postcode formats and validations applied upon submission.

5.4.33 MHS502 Ward Stay

MHS502 Ward Stay	
Description	
This table should contain a record for each stay of a patient on a ward during an inpatient stay. A separate record should be created if the patient moves to a different ward. **V2.0 clarification**: The NHS Business Definition for Ward Stay has been amended as part of MHSDS v2.0 changes. The amendment clarifies the relationship between periods of leave (such as Mental Health Leave of Absence) and Ward Stays in that the start of a period of leave would not end the preceding Ward Stay. The amended definition for Ward Stay can be found on the NHS Data Model and Dictionary website[51] **General table guidance** Please note that information recorded within this table is used in NHS Digital's analysis to calculate the number of bed days. To ensure that these are calculated correctly please ensure that the Start Date and End Date are accurate and that the Ward Care Intensity and Ward Security Level are recorded.	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
START DATE (WARD STAY)	The start date of the first or earliest Ward Stay should be the same as the start date of the Hospital Provider Spell (or admission date).

END DATE (MENTAL HEALTH TRIAL LEAVE)	Please see MHS514 for the definition of Mental Health Trial Leave. This item in MHS502 is to be reported by the 'receiving' organisation only, to indicate that the Ward Stay was initially on a trial basis and that the trial has now ended. The 'sending' organisation will also report the End Date (Mental Health Trial Leave) item separately through the MHS514 Mental Health Trial Leave table, to show the original Ward for which the patient has left on trial basis.
END DATE (WARD STAY)	The end date of the last or latest Ward Stay should be the same as the end date of the Hospital Provider Spell (or discharge date).
INTENDED AGE GROUP (MENTAL HEALTH)	Please note that INTENDED AGE GROUP (MENTAL HEALTH) contains a different code list to INTENDED AGE GROUP used in CDS, to provide the required level of granularity needed for national analysis of the MHSDS. Providers currently submitting CDS using the existing list may require local data collection changes to record additional granularity for the MHSDS which can then be mapped back to CDS. Some providers may collect this additional granularity locally already. For example, codes 10, 11 and 12 map to the CDS equivalent code of "2 Children and /or adolescents".
SEX OF PATIENTS CODE	The sex of PATIENTS intended to use a WARD is required to monitor whether patients are accommodated within an appropriate ward in line with best practice guidelines.
WARD SECURITY LEVEL	Security Level is required to identify inpatient activity within a low, medium or high secure ward or hospital. There are four levels of secure accommodation: **[0] General (non-secure)** **[1] Low secure:** Other secure accommodation, which is classified as neither high nor medium, such as high dependency network or locked ward required **[2] Medium secure:** accommodation, a secure facility providing care at a regional level under the care of a forensic psychiatrist. This excludes high security accommodation in Hospital Site approved to provide high security psychiatric services. **[3] High Secure:** Hospital Site approved to provide high security psychiatric services. The Hospital Site must be part of an NHS Trust approved by the Secretary of State to provide such high security psychiatric services.
LOCKED WARD INDICATOR	This indicator is to allow us to identify whether a ward is locked/unlocked. 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.

Hospital Bed Type (Mental Health) MENTAL HEALTH ADMITTED PATIENT CLASSIFICATION	Definitions to support each included Hospital Bed Type will be published by NHS England on the gov.uk website shortly. Please see Appendix 7 for additional context regarding intended reporting for this data item.
SPECIALISED MENTAL HEALTH SERVICE CATEGORY CODE	The 'SPECIALISED MENTAL HEALTH SERVICE CATEGORY CODE' is expected to be completed within the MHSDS where a record/s relate to a Specialised Mental Health service. All Specialised Mental Health services (and associated coding) is located on the following website https://www.england.nhs.uk/nhs-standard-contract/dc-reporting/. Please refer to the 'Aggregate Contract Monitoring (ACM) Specification' and tab labelled as 'Specialised MH Service Cat Code' and column A labelled as 'Specialised Mental Health Service Category Code' for details (e.g. NCBPS22E/ASSESS). Note: This field has been changed to Specialised Mental Health Service Category Code. This is to avoid confusion when read in conjunction with existing NHS England specialised commissioning guidance that references 'service category'. These changes have not yet been applied to the Data Dictionary guidance pages.
WARD CODE	WARD CODE is an optional item for local reporting purposes only, such as with local commissioners. It must NOT contain any text which may identify the PATIENT DIAGNOSIS of the PATIENTS using the WARD (for example, it must not include the acronym 'HIV') or the Patient Procedure being undertaken (for example using the acronym 'TOP' for terminations of pregnancy). Use of such identifiers contravenes the legal requirements for withholding identifiable information about PATIENTS with identified conditions. See Security Issues and Patient Confidentiality for further details. Ward Code is a key data item within the MHSDS to enable the Specialised Mental Health (SMH) activity to be priced. The activity is priced by using the information from SMH Patient Activation Measures (PAMs), (by linking on Unit/Site Code, SMH Service Category Code and Ward Code/Name). In 2020/21 the SMH Patient Level Data Set (PLD), (local dataflow) and the SMH Mental Health PAM now include Ward Code (previously only Ward Name) to allow for linkage to MHSDS. By including Ward Code, NHS England can triangulate the three data sets and price up the activity in both patient level data sets. We request that all Providers submit the Ward Code within the MHSDS and align this with the same code within SMH MH PAM and SMH PLD.

5.4.34 MHS503 Assigned Care Professional

MHS503 Assigned Care Professional	
Description	
To carry details of the Care Professional assigned responsibility for the care of the patient. One occurrence of this Group is permitted for each Care Professional Admitted Care Episode. **General Table Guidance** This is defined as a continuous period of care for a patient under the responsibility of a consultant, nurse or other healthcare professional. Please note that a separate record should be included for each change in responsible consultant, nurse or other healthcare professional.	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
START DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)	The start date won't necessarily be the first ward stay this patient has ever had but should coincide with the start of the first Ward Stay during a continuous inpatient stay under the same provider. If there are successive ward stays, then this will be spanned by a single Hospital Provider Spell.
TREATMENT FUNCTION CODE (MENTAL HEALTH)	Treatment Function Code is required to add detail to the analysis of bed types.

5.4.35 MHS504 Mental Health Delayed Discharge

MHS504 Mental Health Delayed Discharge
Description

To carry details of the patient's Mental Health Delayed Discharge Periods which occurred during a Hospital Provider Spell.

Multiple occurrences of this group are permitted, one for each Mental Health Delayed Discharge Period within the Hospital Provider Spell.

General table guidance

A Mental Health Delayed Discharge Period[52] occurs when a patient is fit and ready for discharge from a hospital bed but discharge is delayed due to external factors outside the control of the Hospital Provider.

A patient is ready for discharge when:

- a clinical decision has been made that the patient is ready for discharge

- a multi-disciplinary team decision has been made that the patient is ready for discharge

- the patient is safe to discharge

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

For example, if the reason for a delay changes from Awaiting Care Coordinator allocation (A2) to Awaiting Care Home With Nursing placement or availability (D2), you would supply an end date for the current reason and a new start date – the same day as the end date of the previous one – with a new reason. You also need to ensure that the organisation the delay is attributable to is updated if needed; in the example below, this remains the same – NHS (04).

HospProvSpellNum	StartDateDelayDisch	EndDateDelayDisch	DelayDischReason	AttribToIndic	OrgIDRespLADelayDisch
Supply spell number	01/10/2019	05/10/2019	A2	04	Identify ODS code of LA
Supply spell number	05/10/2019	10/10/2019	D2	04	Identify ODS code of LA

Whilst the NHS England Delayed Transfers of Care Monthly Situation Report[53] (MSitDT or SITREP) collects delays for adults (over 18s) only, the MHSDS collects all delays, irrespective of the age of the patient.

Delay reasons and attribution categories were amended from MHSDS v2.0 onwards. These changes had an impact on data collection/submission across the MHSDS and the NHS England MSitDT collected through SDCS Classic.

Please see Appendix 6 for key messages and guidance on the revised delay categories for mental health.

Additional Notes on Data Items	
Data Item Name	**Additional Notes**

START DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD)	The date that the clinical decision was taken that the PATIENT is fit and ready for discharge, but external factors prevent the discharge taking place. NHS England guidance outlines that a delay does not become reportable as a DToC until the second day of the delay. NHS Digital will remove the first midnight when calculating the length of the delay, so the date to be supplied is the proposed discharge date, as determined by the multi-disciplinary team.
END DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD)	This may be the same as the Discharge Date (Hospital Provider Spell), if the external factors are resolved while the patient is still ready for discharge. However, if the patient's condition deteriorates while awaiting discharge, the decision may be taken to end the Mental Health Delayed Discharge Period, and the Care Professional Admitted Care Episode and Hospital Provider Spell continue. If the reason/attribution for delay changes then an end date would be supplied. A new record with a start date matching this end date would be supplied along with new delay reason/attribution (see example above).
MENTAL HEALTH DELAYED DISCHARGE REASON	Descriptions and guidance for the new reason categories, as amended in MHSDS v2.0, can be found in Appendix 6. Only one reason is allowed per delay period.
MENTAL HEALTH DELAYED DISCHARGE ATTRIBUTABLE TO INDICATION CODE	Not all reasons for delay are applicable to each organisation type responsible for the delay. Guidance for the attribution categories, including for the new Housing option, can be found in Appendix 6.
ORGANISATION IDENTIFIER (RESPONSIBLE LOCAL AUTHORITY MENTAL HEALTH DELAYED DISCHARGE)	This data item MUST be populated in all cases where the local authority responsible for the delayed discharge is different to the person's local authority of usual residence.

5.4.36 MHS505 Restrictive Intervention

MHS505 Restrictive Intervention
Description
To carry details of each separate reported incident of a Restrictive Intervention of the patient by one or more members of staff in response to aggressive behaviour or resistance to treatment, during a Hospital Provider Spell. One occurrence of this Group is permitted whenever a restrictive intervention is carried out. **General Table Guidance** Restrictive Intervention incidents should only be submitted for inpatients. Any incident of a Restrictive Intervention resulting in the providers Restrictive Intervention Policy being invoked should be reported.

Please note: National guidance that will support submission of this table is currently under development and will be linked from this User Guidance document in due course. Please refer to Appendix 2 for a complete list of definitions for Restrictive Interventions for use in the MHSDS.

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

5.4.37 MHS506 Assault

MHS506 Assault
Description
To carry details of each separate reported instance of assault on the patient by another patient during a Hospital Provider Spell. One occurrence of this Group is permitted whenever an assault on the patient occurs. **General Table Guidance** Reporting of instances of an Assault are only required for inpatients. Assault is defined as the intentional application of force to the person of another, without lawful justification, resulting in physical injury or personal discomfort. Note: Incidents of assault by the assaultive patient should NOT be included, only that of the assaulted patient.

Additional Notes on Data Items	
Data Item Name	**Additional Notes**
DATE OF ASSAULT ON PATIENT	This is the date that a reported incident of assault on the patient occurred. This should NOT be the date that the reported incident was logged or updated on the system.

5.4.38 MHS507 Self Harm

MHS507 Self Harm	
Description	
To carry details of each separate reported incident of self-harm by the patient. One occurrence of this Group is permitted whenever an incident of self-harm is reported. **General Table Guidance** Reporting of self-harm instances are only required for inpatients. The National Institute for Clinical Excellence describes self-harm as “intentional self-poisoning or injury, irrespective of the apparent purpose of the act”. NICE CG16[54] Self-harm includes poisoning, asphyxiation, cutting, burning and other self-inflicted injuries.	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
DATE OF SELF-HARM	This is the date that an incident of self-harm for the patient occurred. This should NOT be the date that the self-harm incident was logged or updated on the system.

5.4.39 MHS509 Home Leave

MHS509 Home Leave	
Description	
To carry details of each separate period of Home Leave from a Hospital Provider Spell for a patient NOT liable for detention under the MHA 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. **General Table Guidance** This includes Home Leave for voluntary inpatients who are on Supervised Community Treatment (SCT) and whose Community Treatment Order (CTO) has not been revoked. **V2.0 clarification**: The NHS Business Definition for Ward Stay has been amended as part of MHSDS v2.0 changes. The amendment clarifies the relationship between AWOL and Ward Stays in that the start of a period of AWOL would not end the preceding Ward Stay. The amended definition for Ward Stay can be found on the NHS Data Model and Dictionary website[55]. **General table guidance** Mental Health Leave of Absence (LOA) or Mental Health Absence Without Leave (AWOL) should not be recorded within this table but should be recorded within the relevant MHSDS tables (MHS510LeaveOfAbsence and MHS511AbsenceWithoutLeave). 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.	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
END DATE (HOME LEAVE)	The End Date of Home Leave for a Patient refers to the planned date of return. However, the End Date ends on the actual date of return IF this is earlier then than the planned date of return.

5.4.40 MHS510 Mental Health Leave of Absence

MHS510 Mental Health Leave of Absence
Description
To carry details of each separate period of Mental Health Leave of Absence (LOA) under section 17 of the MHA 1983, as amended by the Mental Health (Patients in the Community) Act 1995, 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. **V2.0 clarification**: The NHS Business Definition for Ward Stay has been amended as part of MHSDS v2.0 changes. The amendment clarifies the relationship between AWOL and Ward Stays in that the start of a period of AWOL would not end the preceding Ward Stay. The amended definition for Ward Stay can be found on the NHS Data Model and Dictionary website[56]. **General Table Guidance** Patients detained under the MHA 1983 may be granted a period of Leave of Absence under S17 of the MHA 1983 to allow them to be away from their place of detention. The Mental Health Responsible Clinician must consider whether a CTO is the more appropriate way of managing the patient in the community as an alternative to granting longer term S17 Leave of Absence over 7 consecutive days (or where leave is extended so the total leave granted exceeds 7 consecutive days) due to the additional safeguards offered by CTO. The requirement is to collect the actual time the patient was absent from hospital rather than the time for which permission was granted, provided the patient returns on or before the end of the permitted period of Leave of Absence. If the patient fails to return on or before the end of the permitted period of Leave of absence (without a permitted extension) then the end of the permitted period of Leave of Absence should be recorded in the Mental Health Leave of Absence Table and consideration should be given to recording the subsequent time absent from hospital as Absent Without Leave (AWOL). Examples: - The patient is granted an initial period of 6 days Leave of Absence under s17 of MHA 1983 but choose to return after 3 days. LOA = 3 days - The patient is granted an initial period of 6 days Leave of Absence under s17 of MHA 1983 which the authorities extended by a further 3 days. LOA = 9 days - The patient is granted an initial period of 6 days Leave of Absence under s17 of MHA Act 1983 but fails to return. LOA = 6 days. AWOL should also be recorded where appropriate. - The patient is granted an initial period of 6 days Leave of Absence under s17 of MHA 1983 but the authorities terminate the LOA after 3 days. LOA = 3 days Home leave for patients on a CTO who are voluntary inpatients should be recorded in MHS509HomeLeave.
Additional Notes on Data Items - There are currently no additional notes

ESCORTED MENTAL HEALTH LEAVE OF ABSENCE INDICATOR	The NHS Data Model and Dictionary business definition for Escorted Mental Health Leave of Absence is as follows: *Escorted Mental Health Leave of Absence is where the Mental Health Responsible Clinician directs that the patient remains during their absence in the custody of one of:* • *any officer on the staff of the hospital* • *any other person authorised in writing by the managers of the hospital* • *if the patient is required in accordance with conditions imposed on the grant of leave of absence to reside in another hospital, any officer on the staff of that other hospital.* *Please see the legislation.gov.uk[57] website for further information.*

5.4.41 MHS511 Mental Health Absence Without Leave

MHS511 Mental Health Absence Without Leave
Description
To carry details of each separate period of Mental Health Absence without Leave (AWOL) for the person under section 18 of the Mental Health Act 1983, as amended by the Mental Health (Patients in the Community) Act 1995. One occurrence of this Group is permitted whenever a period of Mental Health Absence Without Leave takes place. **V2.0 clarification**: The NHS Business Definition for Ward Stay has been amended as part of MHSDS v2.0 changes. The amendment clarifies the relationship between AWOL and Ward Stays in that the start of a period of AWOL would not end the preceding Ward Stay. The amended definition for Ward Stay can be found on the NHS Data Model and Dictionary website[58]. **General Table Guidance** Mental Health Absence Without Leave (AWOL) is defined as 'any period of unauthorised absence which results in formal AWOL procedures being invoked'. AWOL occurs when a patient detained under the MHA 1983 leaves their place of normal detention without permission or fails to return from Mental Health Leave of Absence (LOA) within the permitted period of time. As a minimum, any period of unauthorised absence (even if formal AWOL procedures are not triggered) that extends over midnight should be recorded.
Additional Notes on Data Items - There are currently no additional notes

5.4.42 MHS512 Hospital Provider Spell Commissioner

MHS512 Hospital Provider Spell Commissioner	
Description	
To carry details of each Commissioner Assignment Period during a Hospital Provider Spell. One occurrence of this Group is permitted for each Commissioner Assignment Period. **General Table Guidance** Commissioner Assignment Periods will be used by NHS Digital for accurate commissioner extract generation to override the default commissioner allocation as identified in the MHS101Referral table. Inpatient records (MHS5xx tables) will be assigned to the responsible commissioner's extract based upon the Commissioner Assignment Periods identified in this MHS512 table. If no Commissioner Assignment Periods are submitted for a Hospital Provider Spell, all related inpatient records (MHS5xx tables) will be allocated to the commissioner identified in the MHS101Referral table. Further details of the Commissioner Extract Inclusion Logic can be found in Appendix 9.	
Additional Notes on Data Items - There are currently no additional notes	
START DATE (COMMISSIONER ASSIGNMENT PERIOD)	This should be equal to or greater than the START DATE (HOSPITAL PROVIDER SPELL). Although the commissioner may be identified before inpatient admission, the requirement is for the commissioner assignment Start Date for the related Hospital Provider Spell for which a Commissioner is responsible for (not the commissioner identification or contract start date).
END DATE (COMMISSIONER ASSIGNMENT PERIOD)	This should be equal to or less than the DISCHARGE DATE (HOSPITAL PROVIDER SPELL).

5.4.43 MHS513 Substance Misuse

MHS513 Substance Misuse	
Description	
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 evidence was observed.	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
OBSERVATION DATE (SUBSTANCE MISUSE EVIDENCE)	Evidence should be in relation to the actual use of illicit substances. Parallel behaviour (such as drug seeking) should not be included, as the criteria is evidence of substance misuse. Evidence would be captured if there is an indication in the patient's presentation that there has been substance use. This will often be on a return from leave and the clinical team will request a drug screen to identify any substance use. However, this could be when a patient has brought substances into the ward for other patients. Therefore, this is not a routine screening for all patients all of the time.

5.4.44 MHS514 Mental Health Trial Leave

MHS514 Mental Health Trial Leave
Description
To carry details of each separate period of Mental Health Trial Leave for the patient. One occurrence of this group is permitted whenever a period of Mental Health Trial Leave takes place. **General Table Guidance** The NHS Data Model and Dictionary business definition for Mental Health Trial Leave is as follows: *Trial Leave occurs when a PATIENT using a secure Hospital Bed in a Ward spends a period of time in a less secure Hospital Bed in a different Ward on a trial basis.* *For a PATIENT liable to be detained in hospital under Part II of the Mental Health Act 1983 and as amended by the Mental Health (Patients in the Community) Act 1985, Trial Leave is granted through the use of Mental Health Leave of Absence.* This table is intended to record a period of Mental Health Trial Leave from the 'sender' perspective. The 'receiving' organisation will also report the End Date (Mental Health Trial Leave) item separately through the MHS502 Ward Stay table to indicate the Ward for which the trial took place in and that the trial has ended.
Additional Notes on Data Items – There are currently no additional notes

5.4.45 MHS601 Medical History (Previous Diagnosis)

MHS601 Medical History (Previous Diagnosis)	
Description	
To carry details of any previous diagnoses for a patient which are stated by the patient or recorded in medical notes. These do not necessarily have to have been diagnosed by the organisation submitting the data. One occurrence of this Group is permitted for each previous diagnosis.	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
PREVIOUS DIAGNOSIS (CODED CLINICAL ENTRY)	This is the previous diagnosis of the patient for the main condition treated or investigated during the previous episode of healthcare.
DIAGNOSIS DATE	This is the date that the previous diagnosis was made.

5.4.46 MHS603 Provisional Diagnosis

MHS603 Provisional Diagnosis
Description
To carry details of each provisional diagnosis recorded for a patient made by the service that the patient was referred or admitted to. One occurrence of this Group is permitted for each provisional diagnosis. **General Table Guidance** Provisional Diagnosis should be recorded as soon as it is available to ensure it can be submitted as part of an open referral. Diagnosis information cannot be submitted once the last submission window closes for which the associated referral remains open (i.e. the Refresh submission window for the reporting period in which the referral is discharged), which leads to risk that the referral will remain without any form of diagnosis in MHSDS if data recording is not timely. Provisional diagnosis could also be termed a ‘working diagnosis’. Provisional diagnosis can be used by professionals who might otherwise feel that they are not qualified, or it would be inappropriate for them, to record a definitive Primary Diagnosis; or where it is too early in the care pathway to make a definitive diagnosis, but an indication of the likely diagnosis can be recorded. Provisional Diagnosis in MHSDS is independent of both Primary Diagnosis and Secondary Diagnosis. A Provisional Diagnosis will not be overwritten by a Primary Diagnosis when it becomes available. Data submitted will remain part of the data set irrespective of the nature of any future diagnoses. Please note: Analysts and Information Managers should recognise the ‘provisional’ nature of this data item when drawing additional conclusions from published statistics or local analyses and treat results with caution.

Additional Notes on Data Items - There are currently no additional notes
Please refer to sections 5.4.1 and 5.4.2 for additional information relating to ICD-10 and SNOMED codes.

5.4.47 MHS604 Primary Diagnosis

MHS604 Primary Diagnosis
Description
To carry the details of the primary diagnosis recorded for the patient made by the service that the patient was referred or admitted to. This can change during a reporting period. One occurrence of this Group is permitted for primary diagnosis. **General Table Guidance** The primary diagnosis is the main condition treated or investigated in an episode of care. Where there is no definitive diagnosis the main symptom, abnormal finding or problem should be recorded. Primary Diagnosis should be recorded as soon as it is available to ensure it can be submitted as part of an open referral. Diagnosis information cannot be submitted once the last submission window closes for which the associated referral remains open (i.e. the Refresh submission window for the reporting period in which the referral is discharged), which leads to risk that the referral will remain without any form of diagnosis in MHSDS if data recording is not timely.
Additional Notes on Data Items - There are currently no additional notes
Please refer to sections 5.4.1 and 5.4.2 for additional information relating to ICD-10 and SNOMED codes.

5.4.48 MHS605 Secondary Diagnosis

MHS605 Secondary Diagnosis
Description
To carry details of each secondary diagnosis recorded for a patient made by the service that the patient was referred or admitted to. One occurrence of this Group is permitted for each secondary diagnosis. **General Table Guidance** This should include any secondary diagnosis of conditions treated or investigated in an episode of care which are NOT a primary diagnosis i.e. not the main condition treated or investigated. Where there is no definitive diagnosis this may include any symptoms, abnormal findings or problems where these are not the main symptoms. Secondary Diagnosis should be recorded as soon as it is available to ensure it can be submitted as part of an open referral. Diagnosis information cannot be submitted once the last submission window closes for which the associated referral remains open (i.e. the Refresh submission window for the reporting period in which the referral is discharged), which leads to risk that the referral will remain without any form of diagnosis in MHSDS if data recording is not timely.
Additional Notes on Data Items - There are currently no additional notes Please refer to sections 5.4.1 and 5.4.2 for additional information relating to ICD-10 and SNOMED codes.

5.4.49 MHS606 Coded Scored Assessment (Referral)

MHS606 Coded Scored Assessment (Referral)	
Description	
To carry details of scored assessments that are issued and completed as part of a referral to a mental health service, but that do not take place at a specific contact. E.g. assessment completed at home and returned. One occurrence of this Group is permitted for each coded scored assessment question or dimension captured outside of a Care Contact. **General Table Guidance** A list of the scored assessments that can be accepted in this table can be found in Appendix 3. A more detailed table including which ratings/scores are required, SNOMED CT mappings and expected values can be found in the Technical Output Specification. Please see the "MH Assessment Scales" tab. Only the scored assessments listed in the 'MHSDS Assessment Scales' tab in the TOS should be submitted to MHSDS v4.0. NHS Digital have acquired a licence to receive data relating to these assessments or confirmed that no licence is required. A complete list of assessments approved for use in NHS Digital data sets, and their respective licencing arrangements, is available on the NHS Digital website.	
Additional Notes on Data Items - There are currently no additional notes	
CARE PROFESSIONAL LOCAL IDENTIFIER	This data item should only be populated for clinician-rated assessment tool records. This data item has been included to aid paired outcome measuring by ensuring that clinician-rated outcome measures are rated by the same clinician when pairing outcomes.

5.4.50 MHS607 Coded Scored Assessment (Care Activity)

MHS607 Coded Scored Assessment (Care Activity)
Description
To carry details of scored assessments that are issued and completed as part of a specific Care Activity. One occurrence of this Group is permitted for each coded scored assessment question or dimension captured as part of a specific Care Activity. **General Table Guidance** Where assessment tool details are recorded during a Care Contact, the Care Activity table should be populated with the mandatory fields to allow linkage between Care Contact and Care Activity. The Assessment tool and score details can be recorded in MHS607 Coded Scored Assessment (Care Activity). A list of the scored assessments that can be accepted in this table can be found in Appendix 3. A more detailed table including which ratings/scores are required, SNOMED CT mappings and expected values can be found in the Technical Output Specification. Please see the "MH Assessment Scales" tab. Only the scored assessments listed in the 'MHSDS Assessment Scales' tab in the TOS should be submitted to MHSDS v4.0. NHS Digital have acquired a licence to receive data relating to these assessments or confirmed that no licence is required. A complete list of assessments approved for use in NHS Digital data sets, and their respective licencing arrangements, is available on the NHS Digital website. There is no validation relating to which specific MHS202 Care Activities should be linked to a MHS607 Coded Scored Assessment (Care Activity) record however generic activities such as reviews or assessments would be acceptable. Guidance relating to the use of outcome measures with regard to children and young people can be found in the Guide to Using Outcome Tools with Children, Young people and Families[59].
Additional Notes on Data Items - There are currently no additional notes

5.4.51 MHS608 Anonymous Self-Assessment

MHS608 Anonymous Self-Assessment	
Description	
To carry details of anonymous assessments that are issued and completed as part of a referral to a Mental Health Service. One occurrence of this Group is permitted for each coded anonymous self-assessment question or dimension captured. **General Table Guidance** This table is not linked to the rest of MHSDS at patient level and included records cannot be linked to specific individuals in any way. **Please note: There are currently no anonymous self-assessment outcome measures in scope for MHSDS. This table will allow such measures to flow in future, once identified as a requirement for submission.**	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**

5.4.52 MHS701 Care Programme Approach (CPA) Care Episode

MHS701 Care Programme Approach (CPA) Care Episode	
Description	
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. **General Table Guidance** The Care Programme Approach (CPA) was introduced in 1991 and it provides a framework for effective mental health care planning, assessment, management, co-ordination and delivery. CPA was reviewed in 2008 and the key outcome of the review was that from October 2008, CPA only applied to individuals with complex needs who are in contact with a number of services, or those at most risk. This equates to patients previously on 'enhanced' CPA. Patients previously on 'standard' CPA are no longer cared for under CPA. Refocusing the Care Programme Approach: policy and positive practice guidance[60]	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**

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

5.4.53 MHS702 Care Programme Approach (CPA) Review

MHS702 Care Programme Approach (CPA) Review	
Description	
To carry details of the Care Programme Approach (CPA) reviews undertaken for the patient. One occurrence of this Group is permitted for the most recent Care Programme Approach Review that has taken place.	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
CARE PROGRAMME APPROACH REVIEW ABUSE QUESTION ASKED INDICATOR	Please note the Abuse Question Asked Indicator refers to the asking of this question (in the clinical setting) and should NOT be used to record the answer to the Abuse Question itself. The reporting requirement for this is to record whether this question has been put to the patient on CPA at some point. Policy guidelines do not require this question to be asked at every review. The response should be recorded in the clinical record to avoid the question being asked repeatedly.

5.4.54 MHS801 Clustering Tool Assessment

MHS801 Clustering Tool Assessment	
Description	
To carry details of all clustering tool assessments for all patients. One occurrence of this group is permitted for each Clustering Tool assessment that takes place. **PLEASE NOTE: The clustering tables have been genericised where possible to allow further care cluster categories (e.g. learning disability clusters) to flow in future.** **General table guidance** A list of the clustering tools that can be accepted, and accompanying guidance, can be found in Appendix 4. For a CAMHS Needs Based Grouping assessment, please flow a record for the date the grouping assessment was undertaken, leading to the chosen grouping. *Please note "*Appendix A - A Guide to Choosing Needs-Based Groupings in Child and Adolescent Mental Health Services to Inform Payment Systems*" was available from the pbrcamhs.org website[61] which had further information on assessing groupings. However, the website no longer exists. An equivalent document can be found via Corc[62].	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
CLUSTERING TOOL ASSESSMENT CATEGORY	Please note: Only the following codes are valid for v2.0 until further categories become in scope for MHSDS: 01 Adult Mental Health Clustering Tool 04 Forensic Mental Health Clustering Tool 06 Child and Adolescent Mental Health Needs Based Grouping Tool
ASSESSMENT TOOL COMPLETION TIME	The inclusion of Assessment Tool Completion Time allows for the tool to be completed more than once in one day and recorded and ordered correctly in the data set.
MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE	This data item is applicable to Adult Mental Health and Forensic Mental Health clustering. This data item is not applicable for CAMHS needs based groupings.

ADULT MENTAL HEALTH CARE CLUSTER CODE (INITIAL)	The initial cluster is assigned based on the clinician's assessment/decision to allocate appropriate cluster following completion of the Mental Health Clustering Tool. Please note: The initial cluster allocation is only for use in allocating a cluster following initial assessment. It should not be recorded for reviews. This must be recorded for the current episode of care following completion of the MH Clustering Tool. Only the standard HoNOS (Working Age Adult) may be used as part of a MHCT assessment. Other versions including HoNOS 65+ (Older Persons), HoNOS-CA (Child and Adolescent), HoNOS-Secure (Secure Services), HoNOS-LD (Learning Disabilities) may not currently be used for MHCT purposes. National code [09] Cluster Under Review is not a valid code and should not be submitted The use of initial and final Mental Health Care Cluster Codes allows for analysis of the effect that the availability of the decision support clustering algorithm has on clinician judgement with regard to patient cluster assignment. The initial cluster is assigned based on the clinician's assessment of appropriate cluster following completion of the Mental Health Clustering Tool. Please note: The initial cluster allocation is only for use in allocating a cluster following initial assessment. It should not be recorded for reviews. Please note: Due to a change in format and validation, you must include the leading zero within the code lists (i.e. 01, 02 etc), we will no longer accept as 1, 2, etc.
LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)	This data item is a pilot item and currently not in use.
FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (INITIAL)	This data item is a pilot item and currently not in use.

5.4.55 MHS802 Coded Scored Assessment (Clustering Tool)

MHS802 Coded Scored Assessment (Clustering Tool)	
Description	
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. **PLEASE NOTE: The clustering tables have been genericised where possible to allow further care cluster categories (e.g. learning disability clusters) to flow in future.** **General Table Guidance** Each record in this table will correspond to a specific rating/question and the resultant Person Score. For example, for the Mental Health Clustering Tool (MHCT), a record should be submitted for each HoNOS and SAC rating score. A list of the clustering tools that can be accepted, and accompanying guidance, can be found in Appendix 4. A more detailed table including the individual scores, SNOMED CT mapping and expected values can be found in the Technical Output Specification. Please see the “Cluster Tools for MH” tab. This table allows multiple records to flow which are linked to the single MHS801 assessment record. The MHS802 should contain a record for each question of the relevant tool (e.g. for the MHCT: 13 HoNOS + 6 SARN ratings). The Coded Assessment Tool Type (SNOMED CT) codes will link the question the Person Score relates to. HoNOS assessment may be captured separately and not as part of a MHCT assessment. If the HoNOS assessment scales are used as part of a Mental Health Clustering Tool (MHCT) assessment, then the data would be submitted in MHS802. If the HoNOS is used separately and not part of a MHCT assessment, then this can be submitted in MHS607 or MHS606 (if applicable).	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**

CODED ASSESSMENT TOOL TYPE (SNOMED CT)	HoNOS Rating 8 Type should be in upper case (permissible values are A-J). The HoNOS Rating 8 Type is an additional item to Type HoNOS Rating 8 Score and therefore should have a corresponding letter in relation to the selected score as outlined below: - Score 0 - The additional item [HoNOS Rating 8] should be left blank - Score 1 - The additional item [HoNOS Rating 8] must contain a letter (A-J) to identify the type of problem - Score 2 - The additional item [HoNOS Rating 8] must contain a letter (A-J) to identify the type of problem - Score 3 - The additional item [HoNOS Rating 8] must contain a letter (A-J) to identify the type of problem - Score 4 - The additional item [HoNOS Rating 8] must contain a letter (A-J) to identify the type of problem - Score 9 - The additional item [HoNOS Rating 8] should be left blank - The justification being that if the assessing clinician has identified what the type could be, then they are also able to quantify the severity of the problem.

5.4.56 MHS803 Care Cluster

MHS803 Care Cluster	
Description	
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 person was allocated to a Care Cluster. **PLEASE NOTE: The clustering tables have been genericised where possible to allow further care cluster categories (e.g. learning disability clusters) to flow in future.** **General table guidance** For information relating to the NHS National Tariff Payment System, including the latest Mental Health Clustering Tool booklet, please see: https://improvement.nhs.uk/resources/national-tariff-1920-consultation/ For further support regarding mental health currencies and payment, please see 'Guidance on mental health currencies and payment' published by Monitor. Available at: https://www.gov.uk/government/publications/mental-health-currencies-and-payment-guidance	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**

START DATE (MENTAL HEALTH CARE CLUSTER)	A start entry is triggered by a clustering tool assessment and this is mandatory field. A service user may have an MHCT Assessment that confirms the existing care cluster allocated to the patient, and hence does not lead to a cluster end and/or start. In such cases, the successor entry will either be another MHCT Assessment or an MH care cluster end entry triggered by external circumstances, such as the death of the patient, or the explicit or implicit refusal of further treatment
START TIME (MENTAL HEALTH CARE CLUSTER)	START TIME (MENTAL HEALTH CARE CLUSTER ASSIGNMENT PERIOD) is required to uniquely identify and order cluster assignments where there is more than one cluster assigned in one day.
ADULT MENTAL HEALTH CARE CLUSTER CODE (FINAL)	Please note, code **[09] Cluster Under Review** is not a valid code and should not be submitted. The final cluster may be assigned in a number of ways: 1. Clinician uses the MHCT and assigns an 'Initial' cluster. The clinician then chooses to make no further assessment and uses the same cluster assignment for the 'Final' cluster; 2. Clinician uses the MHCT and assigns an 'Initial' cluster. The clinician then uses the algorithm which suggests the same cluster allocation and so the clinician also records this cluster as 'Final' cluster; 3. Clinician uses the MHCT and assigns an 'Initial' cluster. The clinician then uses the decision support algorithm which results in a different possible cluster allocation. The clinician decides to record the algorithm suggested cluster allocation as 'Final' cluster; 4. Clinician uses the MHCT and assigns an 'Initial' cluster. The clinician then uses the decision support algorithm which results in a different possible cluster allocation. The clinician disagrees with algorithm suggestion and instead records his/her original decision as 'Final' cluster; 5. Clinician uses the MHCT and assigns an 'Initial' cluster. The clinician then uses the decision support algorithm which suggests a different cluster allocation. The clinician disagrees with algorithm cluster allocation but also reassesses his/her original decision and records a new clinician assigned 'Final' cluster Please note: Due to a change in format and validation, you must include the leading zero within the code lists (i.e. 01, 02 etc), we will no longer accept as 1, 2, etc.

CHILD AND ADOLESCENT MENTAL HEALTH NEEDS BASED GROUPING CODE	Further detail about needs based groupings was originally found within the guide "*Appendix A - A Guide to Choosing Needs-Based Groupings in Child and Adolescent Mental Health Services to Inform Payment Systems*" available from the pbrcamhs.org website[63]. which provided information on each of the groupings and corresponding definitions. *However, please note that this website no longer exists, additional information can be found via Corc[64]. For further information regarding the current CAMHS Currency Development Project, for existing pilot providers and non-pilot providers, please contact NHS England at england.camhsproject@nhs.net. "*10 Getting Advice: Neurodevelopmental Assessment (NEU)"* - This is the only grouping that can be chosen alongside other groupings.
LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)	This data item is a pilot item and currently not in use.
FORENSIC LEARNING DISABILITIES CARE CLUSTER CODE (FINAL)	This data item is a pilot item and currently not in use.

5.4.57 MHS804 Five Forensic Pathways

MHS804 Five Forensic Pathways	
Description	
To carry details of the Five Forensic Pathway grouping allocated to the patient during a Five Forensic Pathway assessment. One occurrence of this group is permitted for each initial assessment or review of the grouping allocation. **General Table Guidance** Further information about Five Forensic Pathways can be found in the National cost collection guidance 2019.	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**

5.4.58 MHS901 Staff Details

MHS901 Staff Details	
Description	
To carry details of the staff involved in providing the patient's care. One occurrence of this Group is permitted for each staff member. **General Table guidance** This table should include one record for every Mental Health and/or learning Disability Care Professional (responsible for providing the patients care), including Lead Care Professionals, Key Workers, Care Coordinators, Supervised Clinicians and any other staff member who has a contact with a patient. Where a member of staff has multiple roles or works in more than one team concurrently, a separate record with different Care Professional Local Identifier should be created to enable linkage to activity. The Care Professional Local Identifier has been included in most activity tables to allow reporting of all activity by Job Role and Main Specialty.	
Additional Notes on Data Items	
Data Item Name	**Additional Notes**
MAIN SPECIALTY CODE (MENTAL HEALTH)	This will be recorded as 600 – General Medical Practice if the Responsible Clinician is the patients registered GP. Where the approved clinician is not a consultant the appropriate pseudo-specialty code should be used, or this item should be left blank.
OCCUPATION CODE	The NHS OCCUPATION CODES are maintained by NHS Digital, on behalf of the DHSC and can be viewed in the NHS Occupation Code Manual[65]. Occupation codes are the traditional way of identifying numbers of staff in particular work sectors of the NHS in a consistent way. Occupation codes cover all staff in the Hospital and Community Health Service, both medical and non-medical. Note: The occupation codes are based on staff roles, and make no direct reference to pay scale information.
CARE PROFESSIONAL (JOB ROLE CODE)	Capturing activity undertaken by a Student or Agency: Student or agency work should be recorded under the relevant professional group.

Appendix 1 – Reason For Referral Guidance

The below guidance is relevant for the PRIMARY REASON FOR REFERRAL (MENTAL HEALTH) and OTHER REASON FOR REFERRAL (MENTAL HEALTH) data items:

National Code	National Code Definition	Guidance
01	(Suspected) First Episode Psychosis	Includes schizophrenia
02	Ongoing or Recurrent Psychosis	Includes schizophrenia
03	Bipolar disorder	
04	Depression	
05	Anxiety	This could include: Anxious away from caregivers, Anxious in social situations, Anxious generally, Panics, Avoids going out, Does not speak
06	Obsessive compulsive disorder	Includes: Repetitive problematic behaviours, Compelled to do or think things
07	Phobias	Includes: Avoids specific things
08	Organic brain disorder	Includes Dementia
09	Drug and alcohol difficulties	
10	Unexplained physical symptoms	Includes Somatoform disorders
11	Post-traumatic stress disorder	
12	Eating disorders	
13	Perinatal mental health issues	
14	Personality disorders	Includes Persistent difficulties managing relationships with others
15	Self-harm behaviours	Includes Suicidal thoughts/ suicidal attempts
16	Conduct disorders	Includes: Behavioural difficulties, Poses risk to others, Carer management of CYP behaviour
18	In crisis	
19	Relationship difficulties	Includes family relationship and peer relationship difficulties
20	Gender Discomfort issues	
21	Attachment difficulties	
22	Self - care issues	Includes medical care management, obesity, doesn't get to toilet in time
23	Adjustment to health issues	
24	Neurodevelopmental Conditions, excluding Autism Spectrum Disorder	Includes ADHD (e.g. Difficulties sitting still or concentrating) and other unexplained developmental difficulties but excludes Autism Spectrum Disorders. Please note: As part of MHSDS v3.0 changes, this code replaces '17 – Neurodevelopmental Conditions' which previously included autism spectrum disorders.
25	Suspected Autism Spectrum Disorder	To identify referrals for an autism diagnostic assessment.
26	Diagnosed Autism Spectrum Disorder	To identify referrals for ongoing care in relation to an existing diagnosis of autism.
27	Preconception perinatal mental health concern	To identify referrals to specialist community mental health services for women with severe mental illness seeking pre-conception advice.
28	Gambling Disorder	

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

The National Restrictive Practices Oversight Group have now made available updated definitions for the 'Restrictive Intervention Types', to support consistent data recording in the MHSDS. These definitions include revisions to the Seclusion and Segregation categories to incorporate stakeholder feedback.

The national restrictive practice oversight group comprises membership from NHS England and Improvement, NHS Digital, Care Quality Commission, Department of Health and Social Care as well as experts by experience and campaigning and professional bodies. It seeks to provide system leadership for NHS funded inpatient services through a national programme and is supported by an expert reference group made of a range of stakeholders including clinical practitioners and people with lived experience.

Restrictive Interventions

Restrictive interventions are defined as:

(1) 'Planned or reactive acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to: -take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken';

and

(2) end or reduce significantly the danger to the person or others;

and

(3) contain or limit the person's freedom.

Required reporting and working definitions

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

This revised data set seeks to record incidents that meet:

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

Position	Definition
Prone	A physical restraint in a chest down position, regardless of whether the person's face is down or to the side.
Supine	A physical restraint where the patient is held on their back.
Side	A physical restraint where the patient is held on their side.
Standing	Where the patient is restrained in a standing position.
Seated	Where the patient is held in a seated position.

Kneeling	Where the patient is held in a kneeling position.
Restricted Escort	Any restrictive hold where an individual is moved/ re-located from one area of a unit to another or between units regardless of level of hold

A - Notes on physical restraint

(1) Incidents where there is no resistance from the patient, such as a guiding hand or directing a patient away from an area they are not supposed to enter, (a male patient walking towards the female toilet) should not be recorded as restraint.
(2) The intention of staff is irrelevant. If a patient is placed in, falls into, or puts themselves into any of the above positions, and the criteria for restraint to be recorded are present, the incident should be recorded as a restraint in that position.
(3) The duration of the restraint is irrelevant. A restraint should be recorded if the patient is in one of the above positions, however briefly and regardless of intent.
(4) Where a patient is held in order to facilitate care or a clinical procedure (sometimes referred to as clinical holding), the incident must be recorded as a restraint, provided that all criteria of the restraint definitions are present. For example, an older person with dementia may require restraint to be assisted with dressing and the use of the toilet, as there are periods during the day when communicating this need is difficult. This plan has been agreed through a 'best interests' meeting and relatives/carers are aware. The person lacks capacity and the use of restraint varies dependant on how the person responds to staff at the time and the level of personal care needs. Whenever possible, staff will avoid restraint and wait for an appropriate opportunity to engage, however there are times when staff must intervene due to personal hygiene issues. Whenever restraint is used, even as part of planned care, this must be recorded as a restraint.
(5) It is irrelevant if a restraint is care planned. Any incident that meets all elements of the definition must be recorded.
(6) The content of staff training and or provider policy is irrelevant. If a patient is placed, falls into or puts themselves in one of the above positions and the criteria for restraint are present, the incident should be recorded as a restraint.

See section F for start and finish times

B - Mechanical restraint

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

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

C - Chemical restraint

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

	Definition
Oral	Only record medication that is prescribed and offered as an alternative to the patient being subject to any other restrictive interventions.
Injection (rapid tranquilisation	The use of haloperidol, lorazepam, aripiprazole, olanzapine, promethazine, or diazepam by the parenteral route usually intramuscular but exceptionally

	intravenous, where the use of oral medication is not possible or appropriate, to achieve sedation.
Injection (other)	Any parenteral process that meets the criteria for a restrictive intervention and for chemical restraint but does not amount to rapid tranquillisation including the use of acuphase.
Other	Medication that meets the criteria for a restrictive intervention and for chemical restraint that is not given orally or by injection e.g. a nasal spray or breath actuated spray.

Notes on chemical restraint:

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

D –Seclusion

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

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

Seclusion is a reactive intervention.

Guidance notes

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

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

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

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

E – Segregation

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

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

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

Guidance notes

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

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

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

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

(4) Marie has been in a variety of care settings for the last 15 years. A number of different diagnoses have been suggested in addition to her being autistic. Marie becomes very distressed when she is cared for on a ward with other patients. The commissioner responsible for her care agrees an individualised package of care, where she has no interaction with other patients. Marie and her family are happy with this arrangement.

F Start and finish times

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

Example

(1) A patient attempts to assault a member of staff. The member of staff prevents the patient from striking and restrains the patient in a standing position. The start and finish times for this part of the incident should be recorded as a restraint in a standing position.

(2) The patient struggles and the member of staff requests assistance. The patient is moved by staff to a different area of the ward. The start and finish times of this part of the incident should be recorded as a restricted escort.

(3) The staff moved to a seated position and held the patient in that position whilst attempting to de-escalate the situation. The start and finish times of this part of the incident should be recorded as a restraint in a seated position.

G Post incident review

(1) Involving the patient: discussion between at least one member of the clinical team and the patient as soon after the incident as is practicable and reasonable in all the circumstances.

(2) For the staff team: a review involving as many members as possible of the staff team involved in the incident and the patient's care, and where possible the patient's carer or member of family. The purpose of this review is to learn lessons from what happened and to consider whether any changes are required in the patient's care plan.

H Injuries

Injury to patient

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

Injury to staff

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

Injury to others

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

Appendix 3 – Guide for recording Assessment Tools

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

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

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

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

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

CYP IAPT Tools

Many of the tools in scope of the MHSDS were introduced in MHSDS v1.0 as part of the integration of CYP IAPT programme reporting requirements. For further information on using these tools locally, please see the Child Outcomes Research Consortium (CORC) website, in particular the 'Guide to Using Outcome Measures and Feedback Tools' available from the following page:

http://www.corc.uk.net/information-hub/

Information in regard to specific tools can be found on the following CORC webpage:

http://www.corc.uk.net/outcome-experience-measures/

Appendix 3.1 List of accepted Assessment Tools for submission within MHSDS

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

Table 3.1

No	Tool	Collection Start Date	Guidance
1	Brief Parental Self Efficacy Scale (BPSES)	01/01/2016	For further details on using this tool please click on the link below: http://www.corc.uk.net/outcome-experience-measures/
2	Child Outcome Rating Scale (CORS)	01/01/2016	For further details on using this tool please click on the link below: http://www.corc.uk.net/outcome-experience-measures/
3	Child Session Rating Scale	01/04/2016	For further details on using this tool please click on the link below: http://www.corc.uk.net/outcome-experience-measures/
4	Children's Global Assessment Scale (CGAS)	01/01/2016	For further details on using this tool please click on the link below: http://www.corc.uk.net/outcome-experience-measures/

5	Children's Revised Impact of Event Scale (8) (CRIES 8)	01/01/2016	For further details on using this tool please click on the link below: http://www.corc.uk.net/outcome-experience-measures/
6	Clinical Outcomes in Routine Evaluation 10 (CORE 10)	01/01/2016	For further details on using this tool please click on the link below: http://www.corc.uk.net/information-hub/
7	Clinical Outcomes in Routine Evaluation Measure (CORE-OM)	01/04/2020	
8	The Experience of Service Questionnaire	01/04/2016	For further details on using this tool please click on the link below: http://www.corc.uk.net/outcome-experience-measures/ There is no total score for this tool and individual scores are required for submission. The following versions are available to submit: • Parent or Carer • Self-report for 9 – 11 year olds • Self-report for 12 – 18 year olds
9	Comprehensive Assessment of At-Risk Mental States (CAARMS)	01/04/2016	
10	Current View	01/01/2016	For further details on using this tool please click on the link below: http://www.corc.uk.net/outcome-experience-measures/ There are two parts to current View: 1. A number of 'complexity factors' – These flow as part of the MHS202 Care Activity table as a clinical finding, please see Appendix 3.3 in the User Guidance for mapping details and further information. 2. A number of 'provisional problem descriptors' and 'contextual problems' – These flow in one of the two Coded Scored Assessment tables (MHS606/607), depending on whether the tool was completed during a direct contact with the patient or not. Please see Appendix 3.3 for specific mapping guidance related to the Selected Complexity factors.
11	DIALOG	01/04/2016	The scores for each of the 11 questions, have been given a rating of 1-8, the rating of 8 being as 'no response'.
12	Eating Disorder Examination Questionnaire (EDE-Q)	01/01/2016	For further details on using this tool please click on the link below: http://www.corc.uk.net/outcome-experience-measures/
13	Generalized anxiety disorder 7 (GAD-7)	01/01/2016	For further details on using this tool for CYP, please click on the link below: http://www.corc.uk.net/outcome-experience-measures/
14	Goals Based Outcomes (GBOs)	01/01/2016	For further details on using this tool please click on the link below: http://www.corc.uk.net/outcome-experience-measures/ Three separate and identifiable concepts are available to record multiple goals and track progress of each goal across reporting periods.
15	Group Session Rating Scale (GSRS)	01/01/2016	For further details on using this tool please click on the link below: http://www.corc.uk.net/outcome-experience-measures/

16	HoNOS-ABI	01/04/2017	For further information on HoNOS-ABI please see: https://www.rcpsych.ac.uk/events/in-house-training/health-of-nation-outcome-scales
17	HoNOS (Working Age Adult)	01/01/2016	For further information regarding HoNOS, please refer to http://www.rcpsych.ac.uk/traininpsychiatry/eventsandcourses/courses/honos/workingageadults.aspx Where HoNOS Rating 8 Type is left blank, there is no requirement to submit a record for this rating with a blank Person Score. A blank score will cause the record to be rejected. NHS Digital will derive where this item has correctly been omitted, based on the score of HoNOS Rating 8 Score as follows: The HoNOS Rating 8 Type is an additional item to HoNOS Rating 8 Score and therefore should have a corresponding letter in relation to the selected score as outlined below: - Score 0 - The additional item [Rating 8 Type] would be Null and a record should not be submitted. - Score 1 - The additional item [Rating 8 Type] must be submitted and contain a letter (A-J) to identify the type of problem - Score 2 - The additional item [Rating 8 Type] must be submitted and contain a letter (A-J) to identify the type of problem - Score 3 - The additional item [Rating 8 Type] must be submitted and contain a letter (A-J) to identify the type of problem - Score 4 - The additional item [Rating 8 Type] must be submitted and contain a letter (A-J) to identify the type of problem - Score 9 - The additional item [Rating 8 Type] would be Null and a record should not be submitted. The justification being that if the assessing clinician has identified what the type could be, then they are also able to quantify the severity of the problem.
18	HoNOS 65+ (Older Persons)	01/01/2016	HoNOS65+ may be used for a patient of working age as the chosen assessment should be based on their service needs. The scales for HoNOS and HoNOS65+ are identical, and scored in the same way, so are directly comparable. However, the HoNOS65+ glossary is more detailed than that for HoNOS, and is particularly aimed at common situations in old age psychiatry. Where Rating 8 Type is left blank, there is no requirement to submit a record for this rating with a blank Person Score. A blank score will cause the record to be rejected. NHS Digital will derive where this item has correctly been omitted, based on the score of Rating 8 Score as follows: The Rating 8 Type is an additional item to Rating 8 Score and therefore should have a corresponding letter in relation to the selected score as outlined below: - Score 0 - The additional item [Rating 8 Type] would be Null and a record should not be submitted. - Score 1 - The additional item [Rating 8 Type] must be submitted and contain a letter (A-J) to identify the type of problem - Score 2 - The additional item [Rating 8 Type] must be submitted and contain a letter (A-J) to identify the type of problem - Score 3 - The additional item [Rating 8 Type] must be submitted and contain a letter (A-J) to identify the type of problem - Score 4 - The additional item [Rating 8 Type] must be submitted and contain a letter (A-J) to identify the type of problem - Score 9 - The additional item [Rating 8 Type] would be Null and a record should not be submitted. The justification being that if the assessing clinician has identified what the type could be, then they are also able to quantify the severity of the problem.

			For further information regarding HoNOS65+, please refer to http://www.rcpsych.ac.uk/traininpsychiatry/eventsandcourses/courses/honos/olderadults.aspx
19	HoNOS-CA (Child and Adolescent)	01/01/2016	HoNOS-CA has been included as a practitioner rated health and social functioning scale for children and young people aged 3 – 18 years. Please note the HoNOS-CA assessment does not require collection of HoNOS-CA Rating Item 8 Type (Item8Type is only required for HoNOS – Working Age Adults). For further information regarding HoNOS-CA, please refer to: http://www.rcpsych.ac.uk/traininpsychiatry/eventsandcourses/courses/honos/childrenandadolescents.aspx http://www.corc.uk.net/outcome-experience-measures/
20	HoNOS-LD (Learning Disabilities)	01/01/2016	Health of the Nation Outcome Scales for People with Learning Disabilities are designed for use with people with a learning disability with mental health needs irrespective of the degree of their disability. Please note: Where a client is seen by a learning disabilities service with regard solely to their physical health, and the HoNOS-LD Tool is used, the resulting data should be included in the MHSDS submission. For further information on HoNOS-LD please see: http://www.rcpsych.ac.uk/traininpsychiatry/eventsandcourses/courses/honos/learningdisabilities.aspx http://bjp.rcpsych.org/content/180/1/67.full
21	HoNOS Secure	01/01/2016	HoNOS-Secure is specifically designed for use in health and social care settings such as secure psychiatric, prison health care and related forensic services, including those based in the community. Parts of the original HoNOS can be hard to interpret in secure settings, and this scale meets that need. Please note that each HoNOS-Secure assessment should also have a corresponding HoNOS (Working Age Adult) for the same date, although in some instances one of the other HoNOS variants may be used as more clinically appropriate. -For HoNOS-Secure assessments in adult secure / forensic settings, the standard HoNOS assessment (scales 1 to 12) should be completed in numerical order (with the same assessment date). -For HoNOS-Secure assessments in other settings, the appropriate specialist HoNOS variant e.g. HoNOS-65+, HoNOS-CA etc. must be completed (with the same assessment date). For further information regarding HoNOS-SECURE, please refer to http://www.rcpsych.ac.uk/traininpsychiatry/eventsandcourses/courses/honos/secure.aspx
22	Kessler Psychological Distress Scale 10	01/01/2016	For further details on using this tool please click on the link below: http://www.corc.uk.net/outcome-experience-measures/
23	MAMS (Me and My School) Questionnaire	01/01/2016	For further details on using this tool please click on the link below: http://www.corc.uk.net/outcome-experience-measures/
24	Me and My Feelings Questionnaire	01/04/2016	For further details on using this tool please click on the link below: http://www.corc.uk.net/outcome-experience-measures/
25	Outcome Rating Scale (ORS)	01/01/2016	For further details on using this tool please click on the link below: http://www.corc.uk.net/outcome-experience-measures/
26	ODD (Parent)	01/01/2016	For further details on using this tool please click on the link below: http://www.corc.uk.net/outcome-experience-measures/

27	Patient Health Questionnaire (PHQ-9)	01/01/2016	The Patient Health Questionnaire (PHQ-9) is the depression module which scores each of the 9 criteria. Please see following website for further information: http://www.phqscreeners.com/
28	PGSI (Problem Gambling Severity Index)	01/04/2020	The Problem Gambling Severity Index (PGSI) is the standardised measure of at risk behaviour in problem gambling. It is a tool based on research on the common signs and consequences of problematic gambling. Assessing where your client is now can help you make informed decisions on how to assist them. For further details on using this tool please click on the link below: https://responsiblegambling.vic.gov.au/for-professionals/health-and-community-professionals/problem-gambling-severity-index-pgsi/
29	Questionnaire about the Process of Recovery (QPR)	**01/04/2016**	The version included in the MHSDS is the 15-item version. More information about this use of this tool can be found in the "Implementing the Early Intervention in Psychosis Access and Waiting Time Standard: Guidance" document available from: https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/04/eip-guidance.pdf
30	RCADS (Revised Children's Anxiety and Depression Scale)	01/01/2016	For further details on using this tool please click on the link below: http://www.corc.uk.net/outcome-experience-measures/
31	ReQoL (Recovering Quality of Life)	01/04/2020	ReQoL is a Patient Reported Outcome Measure (PROM) that has been developed to assess the quality of life for people with different mental health conditions. A PROM is a questionnaire that patients complete about their health. For further details on using this tool please click on the link below: https://www.reqol.org.uk/p/overview.html There are two variants that can be submitted to the MHSDS, a 20-item variant and a 10-item variant.
32	SCORE-15 Index of Family Functioning and Change	01/01/2016	For further details on using this tool please click on the link below: http://www.corc.uk.net/outcome-experience-measures/
33	SDQ (Strengths and Difficulties Questionnaire)	01/01/2016	For further details on using this tool please click on the link below: http://www.corc.uk.net/outcome-experience-measures/
34	Session Feedback Questionnaire (SFQ)	**01/04/2016**	For further details on using this tool please click on the link below: http://www.corc.uk.net/outcome-experience-measures/ There is no total score for this tool and individual scores are required for submission.
35	Session Rating Scale (SRS)	01/01/2016	For further details on using this tool please click on the link below: http://www.corc.uk.net/outcome-experience-measures/
36	Sheffield Learning Disabilities Outcome Measure (SLDOM)	01/01/2016	For further details on using this tool please click on the link below: http://www.corc.uk.net/outcome-experience-measures/
37	Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS)	01/01/2016	For further details on using this tool please click on the link below: http://www.corc.uk.net/outcome-experience-measures/
38	Warwick-Edinburgh Mental	01/01/2016	For further details on using this tool please click on the link below: http://www.corc.uk.net/outcome-experience-measures/

	Well-being Scale (WEMWBS)		
39	Young Child Outcome Rating Scale (YCORS)	01/01/2016	For further details on using this tool please click on the link below: http://www.corc.uk.net/outcome-experience-measures/
40	Young Person's Clinical Outcomes in Routine Evaluation (YP-CORE)	01/01/2016	For further details on using this tool please click on the link below: http://www.corc.uk.net/outcome-experience-measures/

Appendix 3.2 Assessment Tools Under Review

The following tools are currently under review for future use, and therefore not included at this stage.

Table 3.2

No	Tool
1	Modified Strengths and Difficulties Questionnaire 8
2	Eating Disorders Quality of Life Scale (EDQLS) outcome measure
3	ASSIST-Lite (Adapted Alcohol, Smoking and Substance Involvement Screening Test)
4	Perinatal POEM (Patient-rated Outcome and Experience Measure)
5	Binge eating scale

Once these tools have been accepted for submission, they will be included in Table 3.1.

Appendix 3.3 SNOMED CT Mapping

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

Maintaining SNOMED CT mapping

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

Appendix 3.4 Licensing of Assessment Tools for use within systems

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

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

NHS England has commissioned NHS Digital to work towards securing permissions for the use of MHSDS assessment tools within care provider IT systems. This work is underway and updates on progress will be posted regularly to the following website:
https://digital.nhs.uk/National-Clinical-Content-Repository

The website is regularly updated. It contains details on how providers and their suppliers can obtain permission to use assessment tools within their systems and the tools for which we are seeking permissions.

Appendix 3.5 Current View Selected Complexity Factors

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

These factors should be submitted using CODED FINDING (CODED CLINICAL ENTRY) in the MHS202CareActivity table or the MHS204 Indirect Activity table as they relate to “Findings” about a child or young person

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

Table 3.5

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

Complexity 13. Contact with Youth Justice System	Has contact with Youth Justice Service (finding)	986401000000102
Complexity 14. Living in financial difficulty	Financially poor (finding)	11403006

***Selected Complexity Factor one-to-many exceptions**

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

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

****Selected Complexity Factor relationships with MHS005 Patient Indicators**

Factors 1, 2 and 7 capture information which can be used to populate associated indicators within the MHS005 Patient Indicators table. Please see "5.5.7 MHS005 Patient Indicators" for further guidance on updating these indicators.

Appendix 4 – Clustering tools for mental health

The currencies currently in scope for MHSDS are:

- Adult Mental Health Care Clusters
- Forensic Mental Health Care Clusters
- Child and Adolescent Mental Health Needs Based Groupings

The following clustering tools form the acceptable list of tools, of which ratings/scores can be submitted within the MHS802ClusterAssess table. Any clustering tool not in this list should not be provided in MHSDS submissions and such records will be rejected upon submission.
A more detailed table including the individual ratings/scores, SNOMED CT mapping and expected value ranges can be found in the Technical Output Specification. Please see the “Cluster Tools for MH” tab.

Table 4

Clustering Tool	Guidance
Mental Health Clustering Tool (MHCT)	Mental health professionals will be required to capture information relating to the assessment of patients using the Mental Health Clustering Tool (MHCT). This will enable mental health professionals to accurately assign patients to a Care Cluster based upon their needs. Clinicians will be responsible for assessing patients using the MHCT and allocating them to a care cluster. They will also be required to reassess patients on a periodic basis to ensure that the allocated care cluster is correct. It is therefore suggested that an assessment takes place at every review as well as at key points of the care pathway. Please note HoNOS assessment may be captured separately and not as part of a MHCT assessment. Only the standard HoNOS (Working Age Adult) may be used as part of a MHCT assessment. Other versions including HoNOS 65+ (Older Persons), HoNOS-CA (Child and Adolescent), HoNOS-Secure (Secure Services), HoNOS-LD (Learning Disabilities) may not currently be used for MHCT purposes. A MHCT assessment includes HoNOS in its entirety so the relevant items can also be used to populate the relevant Scored Assessment table. Due to the clinical nature of HoNOS, in some cases clinicians may NOT want include the relevant items of a MHCT assessment as a HoNOS e.g. if HoNOS 65+ is deemed more appropriate for the patient. For information relating to the NHS National Tariff Payment System 2014/15, including the latest Mental Health Clustering Tool booklet, please see: https://www.gov.uk/government/collections/the-nhs-payment-system-regulating-prices-for-nhs-funded-healthcare For further support regarding mental health currencies and payment, please see 'Guidance on mental health currencies and payment' published by Monitor. Available at: https://www.gov.uk/government/publications/mental-health-currencies-and-payment-guidance For further information with regard to HONOS please see: http://www.rcpsych.ac.uk/traininpsychiatry/eventsandcourses/courses/honos/workingageadults.aspx
Forensic Mental Health Clustering Tool (F-MHCT)	For further information regarding the Forensic Mental Health Clustering Tool, including the Forensic Mental Health Clustering Booklet, please see the Care Pathways and Packages Project website: http://www.cppconsortium.nhs.uk/forensic.php

Appendix 5 - Out of Area Placements

Context

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

The "Five year forward view for Mental Health[66]" recommendation 22 states: 'introduce standards for acute MH care, with the expectation that care is provided in the least restrictive way and as close to home as possible', and 'Eliminate the practice of sending people out of area for acute inpatient care as a result of local acute bed pressure by no later than 2020/21'. The "Improving acute inpatient psychiatric care for adults in England[67]" report also recommends that *"The practice of sending acutely ill patients long distances for non-specialist treatment is phased out by October 2017".*

As well as this, the NHS Providers report "Right Place, Right Time, Better Transfers of Care: a Call to Action[68]" highlighted the need for a clear definition of an Out of Area Placement and clarity around what is counted as an Out of Area Placement in order to make meaningful comparisons, and to identify and share best practice.

Development of national definition

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

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

For further information relating to the development of the national definition and how it should be interpreted and implemented locally, please see the DHSC part of the gov.uk website at: https://www.gov.uk/government/publications/oaps-in-mental-health-services-for-adults-in-acute-inpatient-care

Please note: The term "Out of Area Placement" replaces the term Out of Area Treatment (OAT) which was used throughout early development of the final definition. The change in terminology is to avoid any confusion with the historic use of 'Out of Area Treatment' which is a retired definition in NHS Data Model & Dictionary, associated with non-contract activity. Out of Area Placements are also referred to as Out of Area Admissions in NICE guidance https://www.nice.org.uk/guidance/ng53

Data collection through MHSDS v2.0

Data set changes have been prioritised for inclusion in MHSDS v2.0 which, underpinned by the national definition, will facilitate national reporting for Out of Area Placements.

In order to effectively identify Out of Area Placements for adult acute mental health, data items have been included for both the "sending provider" and "receiving provider" to return as follows:

Sending provider

The identification of Out of Area Placements will be explicitly through the "sending provider" who refers a person for an "Out of Area Placement". The MHS105 Onward Referral table will be used by

the “sending provider” to identify these placements. A new data item, based upon the national definition, has been added for this identification purpose as follows:

REFERRED OUT OF AREA REASON (ADULT ACUTE MENTAL HEALTH)	The reason that a person with assessed acute mental health needs requiring adult mental health acute inpatient care is being referred to a unit that does not form part of the organisation's usual local network of services, where the person's Mental Health Care Coordinator cannot visit the person as often as stated in the Organisation's policy.	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
		99	Not Known (Not Recorded)

Receiving provider

It is acknowledged that not all Out of Area Placements will be as a result of a “sending provider” referring the person for the placement. E.g. where a patient is admitted whilst away from home

A new data item has been added to the MHS101Referral table for population by the “receiving provider” who facilitates the Out of Area Placement. The new item will:

1) identify Out of Area Placements that are not as a result of a “sending provider” onward referral.
2) aid data quality validation through comparison with the data submitted by the “sending provider”.

The new data item is defined as follows:

REASON FOR OUT OF AREA REFERRAL (ADULT ACUTE MENTAL HEALTH)	The reason why a SERVICE has received a REFERRAL REQUEST, for a PERSON: -with assessed acute mental health needs requiring adult mental health acute inpatient care and -who is resident outside of the ORGANISATION's usual local network of SERVICES.	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
		99	Not Known (Not Recorded)

Please see the Technical Output Specification for full details of the above data items and associated submission rules.

Out of Area Placements interim collection

- Submissions for both Clinical Audit Platform OAP’s and MHSDS OAP’s is required until further notice.
- Over the past year NHS Digital have assessed differences in reporting figures for all 57 providers who submit to the duplicate collection. All providers have been contacted about data quality issues.
- To help providers submit the correct data to MHSDS, NHS Digital have written bespoke guidance, held a webinar, written letters to the chief execs of non-compliant providers and had bespoke communication with providers where needed

Appendix 6 - Future Reporting of Mental Health Delayed Discharge Periods

Background

'Mental Health Delayed Discharge Periods' and the associated 'Mental Health Delayed Discharge Reason' categories are currently required for submission in both the NHS Digital Mental Health Services Data Set (MHSDS) and the NHS England Delayed Transfers of Care Monthly Situation Report (MSitDT or SITREP) collected through SDCS Classic. The MSitDT collection will no longer expect delays that are reported in MHSDS to also be reported in the MSitDT publication; NHS England will formally communicate to providers when this will happen.

The MSitDT return collects delays for adults (over 18s) across the NHS, not just for mental health, and Official statistics for all delays are currently published from this collection.

The MHSDS relational model collects Mental Health Delayed Discharge Periods for all ages, linked to the wider patient care pathway, allowing a greater range of national analysis to be produced. A single measure, 'MHS26 - Days of delayed discharge in RP', has been altered to bring it into line with NHS England guidance on delayed transfers of care and to include additional breakdowns such as delay reason and organisation attributable to. This is reported on a monthly basis. This measure is not an official statistic.

Small differences in the categories existed between MHSDS (v1.1) and the MSitDT.

The DHSC and NHS England agreed a review of the categories was required and have been focusing on understanding better what is causing delays in the mental health system.

From the review, a single revised list of Mental Health Delayed Discharge Reason categories has been agreed for future use from April 2017. These new categories are fit for purpose for all mental health reporting requirements and are for use across mental health only.

Key Messages for Data Collection

1. The revised categories have been included in MHSDS v2.0, for which data collection started from 1st April 2017. This represented a change to the categories only and no change to the scope was made.

2. The revised categories will not be implemented in the MSitDT.

3. Mental Health Delayed Discharge Periods will be removed from the scope of MSitDT at a future date, after which MSitDT will continue with a reduced scope.

4. Dual running across the two submissions continued past April 2017, after which there will be wider differences between the categories used.

5. NHS Digital and NHS England advise mental health delays to be recorded using the MHSDS categories in first instance and then mapped to the MSitDT categories.

6. A new 'Other' category was added to MSitDT for the April 2017 collection onwards, to support instances where the MHSDS categories do not easily map to the MSitDT categories. Further mapping guidance for submitting mental health delays to MSitDT from April 2017 can be found on the NHS England DToC webpage.

Key Messages for Reporting

7. Wide consultation will be undertaken with respect to the removal of mental health delays from the scope of MSitDT, including with the UK Statistics Authority.

8. Following the removal of Mental Health Delayed Discharge Periods from the scope of MSitDT, it is anticipated that:
    a. There will be at least a 20% reduction in the overall level of delays reported through MSitDT.
    b. The time series for a number of the reason codes will be broken.

Further messages in respect to future reporting as expected to be added throughout transition planning and consultations.

Guidance for Revised Reasons/Attributions

A number of the included categories remain the same of those included in the MSitDT collection. Definitions and guidance for these existing delay categories can be found at the following link:

https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/

The table on the next page sets out further considerations for the categories from MHSDS v2.0 onwards for mental health service providers.

Category Description	Category Guidance	Attributable to:			
		NHS, excluding housing	Social Care, excluding housing	Both (NHS & Social Care), excluding housing	Housing (inc. supported /specialist housing)
A2: Awaiting Care coordinator allocation	**Addition for MHSDS v2**	✓	×	×	×
B1: Awaiting public funding	For mental health providers, this could also typically include awaiting NHS and Social Care agreement to funding of S117 aftercare, and may include delayed panel meetings or disputes around catchment area / responsibility for the patient.	✓	✓	✓	×
C1: Awaiting further non-acute (including community and mental health) NHS care (including intermediate care, rehabilitation services etc.)	This could include delays relating to physical health care, or transition to adult services (community or inpatient)	✓	×	×	×
D1: Awaiting Care Home Without Nursing placement or availability	This category should be used if the residential care placement does not include NHS-funded nursing care. For placements including NHS-funded nursing care, please select category D2.	×	✓	×	×
D2: Awaiting Care Home With Nursing placement or availability	This category should be used if the residential care placement includes NHS-funded nursing care. For placements that do not include NHS-funded nursing care, please select category D1.	✓	✓	✓	×
E1: Awaiting care package in own home	See existing Unify guidance	✓	✓	✓	×
F2: Awaiting community equipment, telecare and/or adaptations	**Description amended for MHSDS v2** See existing Unify guidance	✓	✓	✓	×
G2: Patient or Family choice (Reason not stated by family)	**Addition for MHSDS v2** Patient or family choice may also include delays due to family/carer no longer wishing to support the person, or related to carer allowance/adaptations. The v2.0 changes allow recording of delays in G3-G12 that are the choice of the patient or family, but also related to one of the other categories.	✓	✓	×	×
G3: Patient or Family choice - Non-acute (including community and mental health) NHS care (including intermediate care, rehabilitation services etc)	See G2 above	✓	×	×	×
G4: Patient or Family choice - Care Home Without Nursing placement	See G2 above	×	✓	×	×
G5: Patient or Family choice - Care Home With Nursing placement	See G2 above	✓	✓	✓	×
G6: Patient or Family choice - Care package in own home	See G2 above	✓	✓	✓	×
G7: Patient or Family choice - Community equipment, telecare and/or adaptations	See G2 above	✓	✓	✓	×
G8: Patient or Family Choice - general needs housing/private landlord acceptance as patient NOT covered by Housing Act/Care Act	See G2 above	✓	✓	×	✓

G9: Patient or Family choice - Supported accommodation	See G2 above	✓	✓	×	✓
G10: Patient or Family choice - Emergency accommodation from the Local Authority under the Housing Act	See G2 above	✓	✓	×	✓
G11: Patient or Family choice - Child or young person awaiting social care or family placement	See G2 above	✓	✓	×	×
G12: Patient or Family choice - Ministry of Justice agreement/permission of proposed placement	See G2 above	✓	×	×	×
H1: Disputes	See existing Unify guidance	✓	✓	×	✓
I2: Housing-Awaiting availability of general needs housing/private landlord accommodation acceptance as patient NOT covered by Housing Act and/or Care Act	**Addition for MHSDS v2** This category should be used for housing delays that are for people without care and support needs under the Care Act. For instance, this may include medical nomination/referral, arrangement or transfer to accessible or adapted housing, occupational therapy assessment for aids and adaptions, access to floating support or housing related support.	✓	✓	×	✓
I3: Housing – single homeless patients or asylum seekers NOT patients not covered by Care Act	**Addition for MHSDS v2** This category includes people with no recourse to public funds.	✓	×	×	✓
J2: Housing- Awaiting supported accommodation	**Addition for MHSDS v2** This would typically include delays when people are waiting for sheltered housing, long and short term supported housing, extra care housing, adult placement schemes, crisis houses, refuges, therapeutic communities, short stay hostels and other specialist step up/step down accommodation.	✓	✓	×	✓
K2: Housing- Awaiting emergency accommodation from the Local Authority under the Housing Act	**Addition for MHSDS v2** This category should be used when a person cannot be discharged from care because they are awaiting accommodation under the Housing Act, for example, for people who are legally homeless, or have a priority need.	✓	✓	×	✓
L1: Child or young person awaiting social care or family placement	**Addition to MHSDS v2** This category should be used for children and young people whose discharge is delayed because they are awaiting placements in children❼s homes, foster care placements or kinship care	✓	✓	×	×
M1: Awaiting Ministry of Justice agreement/ permission of proposed placement	**Addition to MHSDS v2**	✓	×	×	×
N1: Awaiting outcome of legal requirements (mental capacity/mental health legislation)	**Addition to MHSDS v2** This could typically include delays relating to decisions from Independent Mental Capacity Advocates (IMCA) and/or for a deprivation of liberty safeguard (DOLs)	✓	✓	×	✓ in sheltered or supported housing

Appendix 7 – Approach to collection of Ward Stay information to inform inpatient activity analysis

Context

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

In the recent Crisp Report[69], the Royal College of Psychiatrists stated that "*commissioners, providers and their partners in every area need to be able to easily find the number and type of specialist and non-specialist inpatient beds in their area…*". The report further stated the importance of data collection, as "*The absence of this essential information makes it almost impossible to make high quality decisions about many aspects of patient care and the deployment of staff and resources".*

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

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

Definitions for 'hospital bed types' for inpatient services, and 'team types' for community services, can be found within Appendix 10.

Development of 'hospital bed type' categories

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

CAMHS categories have been identified in Tier 4 CAMHS and are described further in NHS England's CAMHS Tier 4 report[70] as well as being used in NHS England's specialised commissioning contract specifications.

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

National Data Requirements

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

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

Consultation has been undertaken by various departmental bodies to improve understanding of the best way to effectively collect this information.

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

Development of central derivations

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

NHS Digital is currently using these derivations to produce information from MHSDS about people in adult acute inpatient care (including adult acute and PICU beds) and specialised adult inpatient services (secure beds plus specialist mother and baby and eating disorder units). The derivation uses methods developed through consultation with provider organisations in 2014 and used in some experimental analysis from MHLDDS, the previous version of the data set. Further reports, deriving information about the type of bed occupied from the data items described above, can be developed according to the priorities of key stakeholders.

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

Identifying and agreeing a solution for national reporting

Two options of obtaining the required information through the MHSDS in the long term were put forward for consideration and agreement for national reporting, both of which stakeholders of the MHSDS will be familiar with:

1) Option 1 - Direct collection of Hospital Bed Type for adult and CYP mental health and learning disabilities
2) Option 2 - Central derivation of such categories using existing defined properties of the Ward and service provision

Consultation Outcome

NHS Digital has consulted on MHSDS v2.0 requirements with a wide range of stakeholders throughout 2016 through public consultations, events and workshops. NHS England has also provided feedback from separate NHS Benchmarking Network consultations.

From feedback presented, a preferred solution was not directly identifiable and both methods provided a mixture of opinion across stakeholder groups. For example, direct collection would provide a more transparent analysis method but could produce ambiguities in the data set where the bed type is not consistent with other recorded properties such as Ward Security Level.

In the absence of a single preferred solution, a recommendation was made by the Independent Standards Assurance Service (ISAS) to provisionally dual run both solutions as a pilot exercise. This approach was agreed with senior representatives of NHS England, DH and NHS Digital and subsequently accepted by SCCI.

MHSDS v2.0 Approach – 'dual running' pilot

In order to ascertain explicitly the best solution to collect the required information for all three service areas and to ensure the resulting categories are comprehensive and fit for purpose, both identified solutions will be 'dual run' for a limited period of time within the MHSDS.

1. Option 1 - Direct collection of Hospital Bed Type

   Data Set solution: The addition of Hospital Bed Type (Mental Health) within the MHS502 Ward Stay table allows the direct submission of the NHSBN categories by service providers based upon local knowledge of inpatient provision in light of the specified categories and guidance.

   Outcome if chosen: Revisit code list in respect of queries submitted. Full assessment of impact on existing published measures, potentially leading to removal of other items in MHS502 Ward Stay table which are no longer required.

2. Option 2 - Central derivation using defined properties of the Ward and service provision

   Data Set solution: The continued collection of existing Ward Stay data items will be supplemented with the addition of Intended Age Group within the MHS502 Ward Stay table to aid understanding and inform derivation methodology. NHS Digital proposes to continue development of central derivations to provide the required information.

   Outcome if chosen: Removal of Hospital Bed Type and adoption of agreed central derivations.

The above solutions have been incorporated within MHSDS v2.0, with data collection commencing April 2017. The associated data items for both solutions are all designated as Required and MUST be submitted where they apply.

The objectives of this dual running are identified as follows:

- Collect feedback regarding the local derivation and submission of the Hospital Bed Type code list for each 3 service areas.
- Compare the information produced using both the existing derivation method and the new Hospital Bed Type data item to inform decision making.
- Understand the least burdensome and most meaningful solution for all stakeholders.

Maximising benefits

NHS Digital will proactively monitor the submission of data within the MHS502 Ward Stay to address common data quality issues associated with both included solutions. Detailed guidance on the submission of data within the MHS502 Ward Stay table can be found in section '5.5.31 MHS502 Ward Stay' of this document.

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

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

Long term approach

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

NHS Digital will utilise the data submitted and report comparative analysis within the MHSDS publications[71]. NHS Digital will also consolidate queries received to identify common issues or general feedback.

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

Feedback and further information

For specific enquiries or to provide feedback regarding these changes, please contact:

Mental Health and Community Care Team

NHS Digital

Telephone: 0300 303 5678

Email: enquiries@nhsdigital.nhs.uk (please include ‘FAO MHSDS’ in subject line)

Appendix 8 – Care and Indirect Activity Guidance

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

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

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

Illustration of MHS202 Care Activity fields

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

Hierarchy	Description	Example
Procedure	represents activities performed in the provision of health care. This includes not only invasive procedures but also administration of medicines, imaging, education, therapies and administrative procedures	'Measuring weight'
Finding	represents the result of a clinical observation, assessment or judgment and includes normal and abnormal clinical states	Examples include: • 'normal weight' • 'excessive weight loss'
Observation	represents a question or assessment which can produce an answer or result	'Body weight'
Obs Value	represents the value of the observation	90
Unit of Measure	represents the unit of measure of the observation value	kg

Further information with regard to the concept model of SNOMED CT can be found within the SNOMED CT Starter Guide[72], in particular please see section 6.

Mandatory reporting requirements for continuation of MHLDDS data flow

Smoking Status

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

For data continuation purposes, NHS Digital have provided mapping from clinical terminologies to the pre-defined list contained in MHLDDS v1.1. However, where greater granularity is already recorded

providers can submit that data and it will be aggregated to the higher-level during analysis. E.g. if 'Ex-very heavy cigarette smoker (40+/day)' is submitted it would appear in analysis as 'ex-smoker'.

The appropriate SNOMED CT code should be submitted. Validations will not permit MHLDDS codes or Names.

MHLDDS v1.1 Code	SNOMED-CT Equivalent (Name)	SNOMED-CT Equivalent (ID)
1 - Current Smoker	smoker (finding)	77176002
2 - Ex-Smoker	ex-smoker (finding)	8517006
3 - Non-Smoker (History unknown)	current non-smoker but past smoking history unknown (finding)	405746006
4 - Never Smoked	never smoked tobacco (finding)	266919005

Electro-convulsive Therapy (ECT)

Each separate instance of Electro-Convulsive Therapy (ECT) administered to a patient should be recorded as a Care Activity.

The following SNOMED CT code can be used:

- Name: Electroconvulsive therapy (procedure)
- SNOMED CT Concept ID: 23835007

Note that as part of MHSDS v3.0 changes, SNOMED CT is the only schema accepted for procedure codes.

Clinical terminology may contain a greater granularity in options and providers can opt to submit what is naturally recorded. E.g. if collected in more detail.

Specific National Reporting Requirements

Coded Scored Assessments

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

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

This subset is "Mental health assessment procedures simple reference set" with SCTID 991461000000106.

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

Only the scored assessments listed in the 'MHSDS Assessment Scales' tab in the TOS should be submitted to MHSDS v4.1. NHS Digital have acquired a licence to receive data relating to these assessments or confirmed that no licence is required. A complete list of assessments approved for use in NHS Digital data sets, and their respective licencing arrangements, is available on the NHS Digital website.

CYP-ED and EIP Access and Waiting Times

Lists of commonly used NICE-recommended interventions and procedures for EIP and CYP Eating Disorder services which have now been developed and published as part of the "Guidance for reporting against access and waiting time standards: CYP ED & EIP[73]".

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

Extended EIP interventions recording and reporting guidance

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

Please refer to the document 'Early intervention in psychosis - recording and reporting[74]' within the link 'Early intervention in psychosis services' on the following page for further information.

Care and Treatment Reviews

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

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

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

A link to this guidance can be found in the following document 'Care and Treatment Reviews: Reporting in the Mental Health Services Data Set'[75].

For further general information about CTRs, please see the NHS England CTR webpage: https://www.england.nhs.uk/learningdisabilities/ctr/

Current View Selected Complexity Factors

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

Legally unsharable clinical codes

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

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

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

Appendix 9 – Commissioner Extract Inclusion Rules

Appendix 9.1 Introduction

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

Data Services for Commissioners Regional Offices (DSCRO) are entitled to receive Patient Identifiable Data (PID) under the Health and Social Care Act 2012, with the provision of appropriate data controls, to support their allocated CCGs.

There are ten DSCROs as detailed below:

- DSCRO Central Southern
- DSCRO Central Midlands
- DSCRO Greater East Midlands
- DSCRO North and East London
- DSCRO North of England
- DSCRO North West
- DSCRO South
- DSCRO South London
- DSCRO South West
- DSCRO Yorkshire

Additional information about DSCROs can be found on the NHS Digital website[76].

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

The DSCRO extract must include all of the data items as specified in the TOS, which the Provider sent in their submission. The extract must only include records that have passed the submission validations. The DSCRO extract must also include all of the derived data items as specified in the TOS.

Extracts must only be produced for DSCROs where the pertinent Organisation Identifier (Code of Commissioner) has been identified as valid as per the submission validations.

Appendix 9.2 Principles for data inclusion

DSCRO extracts include clinical activity and associated administrative data for patients being treated by services that their respective Clinical Commissioning Groups (CCGs) have paid for. Where applicable, they may also hold data for Local Authorities as commissioners, as they are also entitled to have data onwardly disseminated, for the services that they fund.

The DSCRO extracts contain patient level records submitted by the care providers, plus additional centrally derived items. The TOS is provided alongside this document which details the individual data items, values and derivations that will form the DSCRO extracts.

Appendix 9.3 Principles for data exclusion

9.3.1 Removal of identifiable data

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

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

Appendix 9.4 Inclusion Logic

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

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

Data Tables

- MHS101 Service or Team Referral
- MHS201 Care Contact
- MHS204 Indirect Activity
- MHS301 Group Session
- MHS512 Hospital Provider Spell Commissioner
- MHS608 Anonymous Self-Assessment

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

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

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

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

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

9.4.1 Hospital Provider Spells

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

Data Tables/Items

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

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

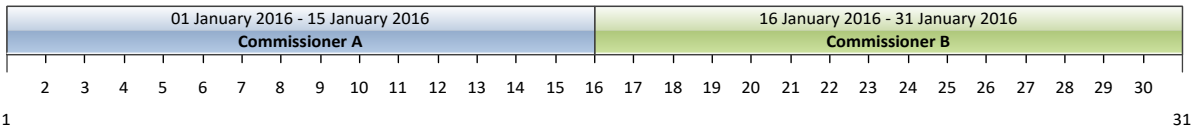

Figure 1. Hospital episode commissioner example timeline.

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

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

9.4.2 Record Level Inclusion Logic

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

Included in extract	Organisation Identifier (Code of Commissioner) Recorded					
	MHS101	MHS201	MHS204	MHS512	MHS301	MHS608
MHS000	✓	✓	✓	✓	✓	✓
MHS001	✓	✓	✓	✓		
MHS002	✓	✓	✓	✓		
MHS003	✓	✓	✓	✓		
MHS004	✓	✓	✓	✓		
MHS005	✓					
MHS006	✓	✓	✓	✓		
MHS007	✓	✓	✓	✓		
MHS008	✓	✓		✓		
MHS009	✓	✓		✓		
MHS010	✓	✓	✓	✓		
MHS011	✓	✓	✓	✓		
MHS012	✓	✓	✓	✓		
MHS101	✓	✓	✓	✓		
MHS102	✓	✓	✓	✓		
MHS103	✓	✓	✓	✓		
MHS104	✓	✓	✓	✓		
MHS105	✓			✓		
MHS106	✓	✓	✓	✓		
MHS107****						
MHS201	See note *	✓				
MHS202	See note *	✓				
MHS203	See note *	✓				
MHS204	See note **		✓			
MHS301					✓	
MHS401	✓	✓	✓	✓		
MHS402	✓	✓	✓	✓		
MHS403	✓	✓	✓	✓		
MHS404	✓	✓	✓	✓		
MHS405	✓	✓	✓	✓		
MHS501	See note ***			✓		
MHS502	See note ***			✓		
MHS503	See note ***			✓		
MHS504	See note ***			✓		
MHS505	See note ***			✓		
MHS506	See note ***			✓		
MHS507	See note ***			✓		
MHS509	See note ***			✓		
MHS510	See note ***			✓		
MHS511	See note ***			✓		
MHS512	See note ***			✓		
MHS513	See note ***			✓		
MHS514	See note ***			✓		
MHS601	✓	✓	✓	✓		
MHS603	✓	✓	✓	✓		
MHS604	✓	✓	✓	✓		
MHS605	✓	✓	✓	✓		
MHS606	✓	✓	✓	✓		
MHS607	See note *	✓				
MHS608						✓
MHS701	✓	✓	✓	✓		
MHS702	✓	✓	✓	✓		
MHS801	✓	✓	✓	✓		
MHS802	✓	✓	✓	✓		

MHS803	✓	✓	✓	✓		
MHS804	✓	✓	✓	✓		
MHS901	✓	✓	✓	✓	✓	

Figure 2. Record level inclusion logic table.

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

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

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

**** Table MHS107 is for pilot purposes only. There is no requirement for data submitted in this table to be disseminated to the commissioning organisation.

Appendix 10 – Definitions for Hospital Bed Types and Team Types

Appendix 10.1 - Hospital Bed Types

The current list of Hospital Bed Types, applies to inpatient services only.

The table below shows each Hospital Bed Type, its associated definition and relevant national code. They are also found within the Technical Output Specification.

Adult Hospital Beds

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

13	Eating Disorders	A bed designated for the specific treatment of psychiatric illness associated with Eating Disorders. This is for the acute phase of treating Eating Disorders and will typically have high inputs of Medical, Nursing, and Therapy staff.
14	Mother and baby	Specialist beds associated with the care of mothers and their babies for a range of mental illness associated with the puerperium. This can include psychosis and affective (mood) disorders. Perinatal mental health units care for both mother and baby, and typically have high intensity input from Medical, Nursing, and Therapy staff.
15	Learning Disabilities	The aim of acute learning disability inpatient services, is to provide the following three core functions of support: Assessment (including for potential mental illness) of the causes of challenging behaviour, where it cannot be safely carried out in the community. Treatment of mental illness where this is the cause of challenging behaviour (complemented by other interventions as appropriate), where it cannot be safely carried out in the community. Reintegration of the individual back into the community after hospital treatment, including provision of support/guidance to families and support providers. Admission to the service should only ever be considered when adjustments to equivalent generic adult mental health services' (i.e. environments, care pathways and policies, in order to render them as accessible and effective as they are for the general population), are either unlikely to ensure equity of outcome, or could not reasonably (i.e. in all the relevant circumstances) be made. The majority of patients should be assessed and, if appropriate, treated and then discharged/referred to other services within 3 months of admission. Around 90% of patients should be assessed and, if appropriate, treated and then discharged/referred to other services within 6 months of admission. It is expected that no local area will need non-secure inpatient provision (of which acute learning disability beds would be one type), for more than 10-15 in-patients with a learning disability and/or autism, per million population, at any one time.
16	Low secure/locked rehabilitation	Low secure rehabilitation services are hospital based, providing care for clients who have all been involved in offending or challenging behaviour. Clients will all be detained under the Mental Health Act and will have varying levels of functional skills. They are likely to require therapeutic programmes tailored to their offending behaviour in addition to their mental disorders. The usual aim of treatment is to move on to a high dependency or community rehabilitation unit. Length of stay varies depending on the nature of the offending or challenging

		behaviour and psychopathology, but is usually around two years.
17	High dependency rehabilitation	These units provide rehabilitation to clients with active symptoms, more complex needs and challenging behaviours. Such units are hospital based and accept referrals from acute admission wards, PICUs and secure services. The usual aim of treatment is to move on to other facilities in the rehabilitation service prior to independent/supported community living. Domestic services are provided by the unit. Such units are higher staffed than generic rehabilitation units, and often have locked/lockable doors to manage behavioural disturbance. These units should be available in all trusts serving a population of between around 600,000 and one million. They have a major role in repatriating patients from secure services and out-of-area placements. The average size is 14 beds and the usual length of stay is one to two years.
18	Long term complex rehabilitation/ Continuing Care	These units are provided for patients with high levels of disability, who have limited potential for future improvement, and those who continue to pose significant risk to their own health or safety, or to that of others. Co-morbidity with serious physical health problems is common, requiring on-going monitoring and treatment. Such units can be community or hospital based and domestic services are provided. These units should be available in all trusts serving a population of between around 600,000 and one million. We do not have data on the average size nationally, but one trust reported 20 beds with an average length of stay of over five years.
19	Low secure	Low secure units deliver intensive, comprehensive, multidisciplinary treatment and care by qualified staff, for patients who demonstrate disturbed behaviour in the context of a serious mental disorder and who require the provision of security. This is according to an agreed philosophy of unit operation underpinned by the principles of rehabilitation and risk management. Such units aim to provide a homely secure environment, which has occupational and recreational opportunities, and links with community facilities. Patients will be detained under the Mental Health Act and may be restricted on legal grounds needing rehabilitation usually for up to two years. Access to this service is typically from local mental health services (including PICU), from medium secure services or from the criminal justice system.
20	Medium secure	Medium secure services work within a framework of clinical governance, specialised assessment, treatment, rehabilitation and aftercare services for offenders with mental health problems, or those at risk of offending. Thereby seeking to reduce the distress associated with mental health problems, and their behavioural consequences, with reduction of risk of harm to others.

		Most patients enter medium secure care from court, although some may be referred from general mental health services. All will be detained under the Mental Health Act. They may also move to medium secure services by means of transfer from low to high secure services, as a consequence of changing needs. The average length of stay in medium secure care is 18–24 months, although some may require medium security for longer.
21	High secure	High secure services work within a framework of clinical governance, specialised assessment, treatment, rehabilitation and aftercare services for offenders with mental health problems or those at risk of offending. Thereby seeking to reduce the distress associated with mental health problems and their behavioural consequences, with reduction of risk of harm to others. Patients enter high secure care from court, and all will be detained under the Mental Health Act. The average length of stay in high secure care is around ten years with lifetime stays also evident due to the specific requirements of the justice system.
22	Neuro-psychiatry / Acquired Brain Injury	Neuro-Psychiatry and Acquired Brain Injury beds, are complex inpatient services for people who have suffered a brain injury or other impairment due to both traumatic and non-traumatic events. Patients suffer from brain cell damage that requires specialist brain injury help. Patients may suffer from progressive symptoms that require ongoing specialist management. Patients can suffer from complex physical, cognitive and behavioural co-morbidities that require specialist care. This specialist care can be associated with complex diagnostic and rehabilitation services, which include a large therapy component. Services provided typically span neuro-psychological and neuro-psychiatric services as well as a range of supporting physical and cognitive therapies.

Children and Young People Beds

National Code	Bed Type Category	National Code Definition
23	General Child and Adolescent Mental Health (CAMHS) inpatient - Child (including High Dependency)	Child and Adolescent Mental Health (CAMHS) Tier 4 Children's Services, deliver tertiary level care to children who are suffering from severe and/or complex mental health conditions. Units admit children aged pre-school to 13; one unit offers family admissions allowing admission for younger children and parents together. Services are provided for children with a wide range of disorders (including severe emotional and behavioural disorders, eating disorders, severe anxiety disorders and severe psychosomatic disorders).

24	General Child and Adolescent Mental Health (CAMHS) inpatient - Adolescent (including High Dependency)	Tier 4 Child and Adolescent Mental Health Services (CAMHS) General Adolescent Services, deliver tertiary level care and treatment to young people with severe and/or complex mental disorders. Services are provided for young people between 13 and 18 years, with a range of mental disorders (including depression, psychoses, eating disorders, severe anxiety disorders, emerging personality disorder and severe psychosomatic disorders). All associated with significant impairment and/or significant risk to themselves or others, such that their needs cannot be safely and adequately met by community Tier 3 CAMHS. This includes young people with mild learning disability and Autism Spectrum Disorders, who do not require Tier 4 CAMHS Learning Disability Services.
25	Eating Disorders inpatient - Adolescent (above 12)	Tier 4 CAMHS specialist eating disorder units, are for children and young people suffering from severe eating disorders, resulting in significant weight loss and/or severely impaired growth. Such that their health, growth and development are at risk, and who have not responded to Tier 3 CAMHS outpatient treatment. Children and young people may also be referred for treatment where at the point of referral, to Tier 3 CAMHS if they are within a high-risk low weight range and could not be safely treated within Tier 3 CAMHS. The primary reason for referral to such services, is the presence of a severe eating disorder, although units are able to treat the psychiatric co-morbidities which commonly accompany severe eating disorders. Tier 4 CAMHS specialist eating disorder services admit children and young people with anorexia nervosa, atypical anorexia, eating disorders not otherwise specified (EDNOS), food avoidant emotional disorder, refusal syndromes and phobias leading to severely restricted eating.
26	Eating Disorders inpatient - Child (12 years and under)	Tier 4 CAMHS specialist eating disorder units, are for children and young people suffering from severe eating disorders resulting in significant weight loss and/or severely impaired growth such that their health, growth and development are at risk and who have not responded to Tier 3 CAMHS outpatient treatment. Children and young people may also be referred for treatment where at the point of referral to Tier 3 CAMHS, if they are within a high-risk low weight range, and could not be safely treated within Tier 3 CAMHS. The primary reason for referral to such services is the presence of a severe eating disorder, although units are able to treat the psychiatric co-morbidities which commonly accompany severe eating disorders. Tier 4 CAMHS specialist eating disorder services, admit children and young people with anorexia nervosa, atypical

		anorexia, eating disorders not otherwise specified (EDNOS), food avoidant emotional disorder, refusal syndromes and phobias leading to severely restricted eating.
27	Low Secure Mental Illness	Low secure settings accommodate young people with mental and neurodevelopmental disorders at lower, but nevertheless significant levels of physical, relational and procedural security. Young people in such settings may belong to one of two groups: those with 'forensic' presentations involving significant risk of harm to others, and those with 'complex non-forensic' presentations principally associated with challenging behaviour, self-harm and vulnerability. Young people admitted to low and medium secure settings, generally require significant lengths of stay from months to years.
28	Medium Secure Mental Illness	Medium secure settings accommodate young people with mental and neurodevelopmental disorders, who present with the highest levels of risk of harm to others, including those who have committed serious crimes. In such settings, there are prescribed stringent levels of physical security and high levels of relational and procedural security. Young people admitted to medium security generally have significant lengths of stay from months to years.
29	Child Mental Health inpatient services for the Deaf	Four arms (Northern, Central, South East and South West) supporting outreach provision and one specialist inpatient unit, Corner House (South East). Corner House is a six-bedded unit. For the purposes of this specification document the service will be referred to henceforth as NDCAMHS. NDCAMHS was established as a Highly Specialised Service (High Cost, Low Volume) in recognition of the specific complex needs associated with deaf children and young people with mental health problems, and the poorer mental health and life outcomes for this group of young people in both childhood and adulthood.
30	Learning Disabilities / Autistic Spectrum Disorder inpatient	Inpatient: The Tier 4 CAMHS Specialist Learning Disability Unit provides day/ in-patient care and treatment for children and young people with: • moderate to severe learning disabilities and co-morbid mental health problems, which cannot be adequately and safely treated within Tier 3 CAMHS/ Learning Disability Services, because of the associated risk to self or others • children and young people with mild learning disability and co-morbid mental health problems which cannot be adequately or safely treated within Tier 3 • CAMHS because of risk to self or others, and whose needs cannot be met within a Tier 4 CAMHS General Adolescent Unit, or Tier 4 CAMHS Children's Unit • children and young people with moderate to severe learning disabilities, and with complex behavioural difficulties who exhibit a lower level of risk, but where physical illnesses may

		be contributing to their problems, and this requires in-patient investigation and assessment, and who because of their behaviours, cannot be adequately or safely treated within a paediatric ward or medical ward. Autism Spectrum Disorders - The Tier 4 CAMHS Specialist Autism Spectrum Disorders (ASD) Services, work as integrated multidisciplinary CAMHS teams, providing outpatient assessment, including second opinions and consultation to Tier 3 CAMHS and child health teams (including full investigation, diagnostic advice and advice on management). Outreach and brief intensive specialist treatment, which may include intensive outreach and day-patient care for children and young people who are suffering from ASD and severe and/or complex neurodevelopmental and mental health conditions, that cannot be adequately treated by general Tier 3 CAMHS and child health units/services.
31	Low Secure Learning Disabilities	Low secure settings accommodate young people with mental and neurodevelopmental disorders at lower, but nevertheless significant levels of physical, relational and procedural security. Young people in such settings may belong to one of two groups: those with ‘forensic’ presentations involving significant risk of harm to others and those with ‘complex non-forensic’ presentations principally associated with challenging behaviour, self-harm and vulnerability. Young people admitted to low and medium secure settings generally require significant lengths of stay from months to years.
32	Medium Secure Learning Disabilities	Medium secure settings accommodate young people with mental and neurodevelopmental disorders, who present with the highest levels of risk of harm to others including those who have committed serious crimes. In such settings, there are prescribed stringent levels of physical security and high levels of relational and procedural security. Young people admitted to medium security generally have significant lengths of stay from months to years.
33	Severe Obsessive Compulsive Disorder and Body Dysmorphic Disorder - Adolescent	The national Obsessive-Compulsive Disorder & Body Dysmorphic Disorder service (OCD/BDD), is commissioned to provide highly specialised assessment and treatment for patients experiencing severe OCD or BDD through out-patient, homebased, residential unit or in-patient services on behalf of NHS England for the Population of England. The national OCD/BDD service, delivers highly specialised interventions in conjunction with local mental health services, and is available to people of all ages on the basis of need. The aim of the service is to improve the mental health state of both adolescents and adults suffering with the most profound OCD/BDD at Level 6 of the NICE guidelines, who have failed all previous treatments (including home-based treatments). By delivering tailored enhanced treatment packages in a safe environment, specifically by:

		•improving mental health and well-being; •reducing the burden of the disorder; •minimising the risks posed by patients to themselves and to others; •improving quality of life; •promoting social inclusion and return to employment; •enabling patients to function in daily life to the best of their ability. The services aim to provide an effective and cost-effective comprehensive treatment package for the most severely disabled patients with OCD/BDD by working in collaboration with local services. Services are available for children, adolescents and adults and include: •out-patient treatment; •intensive out-patient and home-based treatment, including intensive liaison with local CMHTs and telephone monitoring; •residential unit treatment; and•in-patient treatment (for patients requiring 24 hour nursing care).
34	Psychiatric Intensive Care Unit	Psychiatric intensive care units (PICU) for young people, allow for containment of short-term behavioural disturbance which cannot be contained within an open adolescent in-patient unit. This behaviour will be associated with a serious risk of either suicide, absconding with a significant threat to safety, aggression or vulnerability; for example, due to agitation or sexual disinhibition. Levels of physical, relational and procedural security should be similar to those in low security. Whilst educational and recreational facilities should be available to young people in intensive care and secure settings, these provisions will tend to be set up differently in PICUs, which do not have the same emphasis on providing support over a long period of time.

Appendix 10.2 Service or Team Type Definitions

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

The table below shows each Team Type, its associated definition and relevant national code. They are also found within the Technical Output Specification.

Team Type	National Code	National Code Definition
General Mental Health Services		
Day Care Service	A01	TBC
Crisis Resolution Team/Home Treatment Service	A02	This code is to be used for teams that provide functions of urgent and acute mental health care in the community. This typically includes urgent mental health assessment, gatekeeping inpatient admissions, intensive home treatment

		as an alternative to admission, as well as facilitating early discharge from inpatient care. It may be more common for children and young people's crisis teams' services to combine all of the functions described above. These teams may also include an assertive outreach function.
Crisis Resolution Team	A03	This code is to be used for teams that provide functions of urgent and acute mental health care in the community. This typically includes urgent mental health assessment, gatekeeping inpatient admissions, intensive home treatment as an alternative to admission, as well as facilitating early discharge from inpatient care. It may be more common for children and young people's crisis teams' services to combine all of the functions described above. These teams may also include an assertive outreach function.
Home Treatment Service	A04	This code is to be used for teams that provide functions of urgent and acute mental health care in the community. This typically includes urgent mental health assessment, gatekeeping inpatient admissions, intensive home treatment as an alternative to admission, as well as facilitating early discharge from inpatient care. It may be more common for children and young people's crisis teams' services to combine all of the functions described above. These teams may also include an assertive outreach function.
Primary Care Mental Health Service	A05	This service provides specialist mental health support to GP practices and practice staff: mental health professionals are likely to sit within primary care settings, and are available to see patients with a range of illnesses and diagnoses, including severe mental illnesses, directly. Additionally, they will provide advice and consultation to GP practice staff. The service is most likely to involve staff employed by the local secondary mental health care provider operating within the primary care setting. However, arrangements may vary, e.g. practices directly employing mental health workers or Clinical Commissioning Groups (CCGs) contracting with the Voluntary, Community and Social Enterprise (VCSE), to provide VCSE staff who sit within primary care settings. These services may also be known as primary care liaison mental health services and may in reality differ very little from the functions conventionally fulfilled by generic Community Mental Health Teams (CMHTs). Services coded under this team type A05 should NOT include IAPT services co-located in primary care; all IAPT activity, whether co-located in primary care or not, should continue to flow through the IAPT Data Set.
Community Mental Health Team - Functional	A06	This is a service that provides a generic functional community mental health service, the model is similar across both adults, children and young people. This may include other functions

		e.g. neuro-developmental and organic presentations. The service activity takes place outside of primary care settings. Some providers have named their generic community mental health teams “Recovery Teams” but these teams’ activity should be recorded against this generic CMHT team type A06.
Community Mental Health Team - Organic	A07	This code is for teams that specifically respond predominantly to organic mental disorders. Teams that have a specific primary focus should use the appropriate code, (e.g. A15, C01, C04 etc)
Assertive Outreach Team	A08	For use only where assertive outreach is the primary function and activity of the team. This function may also be a feature of other team types, for example, A02, A03 and A04 teams.
Community Rehabilitation Service	A09	This code refers to specialist community mental health rehabilitation teams which support and care co-ordinate people with complex mental health needs in community-based CCG and/or Local Authority funded placements. They mainly support people with complex psychosis and related conditions, helping them to acquire or regain the skills and confidence to live as independently as possible by addressing and minimising symptoms and functional impairment; screening for physical health problems; promoting healthy living; supporting carers and promoting meaningful occupation. Overseeing transition from hospital, managing community placements, and ensuring people achieve and sustain their optimum level of independence is a central part of these teams’ expertise. They can also provide advisory and in-reach functions to support people under the care of generic community mental health teams and acute inpatient settings.
General Psychiatric Service	A10	This code is to be used only for a distinct service staffed by trained and accredited consultant psychiatrists (as well staff in training or support staff).
Psychiatric Liaison Service	A11	This code describes a specialist mental health service that provides MH care in settings not traditionally equipped to provide it, such as emergency department or general hospital inpatient wards. Use C05 Paediatric Liaison Service if there is a dedicated CYP team to provide mental health support to paediatric wards with or without a response to the emergency department.
Psychotherapy Service	A12	This code is to be used only for a distinct service staffed by trained and accredited individual or group psychoanalytic/psychodynamic or systemic family therapists.
Psychological Therapy Service (non IAPT)	A13	This code is to be used only for a distinct service staffed by clinical and other practitioner psychologists.
Early Intervention Team for Psychosis	A14	This should be used for teams as set out in the service description in the Implementing the Early Intervention in Psychosis Access and Waiting Time Standard guidance document. Providing the full range of psychological, psychosocial, pharmacological and other interventions shown

		to be effective in NICE guidelines and quality standards, including support for families and carers. EIP services also triage, assess and treat people with an 'at risk mental state' (people at high risk of developing psychosis), as well as help those not triaged to access appropriate treatment and support.
Young Onset Dementia Team	A15	This code is to be used for services who support people with a diagnosis of dementia under the age of 65, often called 'early' or 'young' onset dementia.
Personality Disorder Service	A16	This code is for services dedicated to providing treatment to those with personality disorder and complex emotional needs only.
Memory Services/Clinic	A17	This code is to be used for specialist services that provide assessment and diagnosis of dementia - and when appropriate, treatment - and provide ongoing support and information to people living with cognitive/memory issues and their carers.
Single Point of Access Service	A18	This code is for use where a single point of access service is the team's primary function. This code should be used if the team also includes a mental health enquiry and/or crisis response line. If this function is included with the functions of, for example, a general community mental health team the appropriate code (A06) should be used.
24/7 Crisis Response Line	A19	This code is for use where a 24/7 crisis response line is the team's primary function and should be used to record the total number of telephone referrals and contacts coming into these services. Only telephone contacts should be recorded for this team type. If this function is included with the functions of, for example, a Crisis Resolution Team/Home Treatment Service, the appropriate code (A02) should be used with telephone recorded as the means of contact.
Health Based Place Of Safety Service	A20	Section 136 of the Mental Health Act, allows for someone believed by the police to have a mental disorder, and who may cause harm to themselves or another, to be detained in a public place and taken to a safe place where a mental health assessment can be carried out. A place of safety could be a hospital, care home, or any other suitable place where the occupier is willing to receive the person while the assessment is completed. Police stations should be only be used in exceptional circumstances. Health-based places of safety are most commonly part of a mental health unit on a mental health hospital or acute hospital site, or part of an accident and emergency department in an acute hospital.

		Unless the place of safety is an A&E department, it will not usually be available to people who have not been detained by the police.
Crisis Cafe/Safe Haven/Sanctuary Service	A21	Crisis cafes offer mental health support to people, often in the evenings and weekends, when they may need help most. They aim to support people to reduce any immediate crisis and to safety plan; drawing on strengths, resilience, and coping mechanisms to manage their mental health and wellbeing. As well as offering support, professionals may also be able to refer and direct onwards to further services if required. A sanctuary or safe haven provides a safe, homely place for individuals experiencing crisis to go as an alternative to attending A&E. Primarily a physical location of safety, offering practical and emotional support during the evening (although they don't provide accommodation), they often include a 24-hour crisis support line too. While the functions and naming of these services may vary slightly in different geographies, they are included as a single 'team type' for the purposes of recording activity in the MHSDS. These services are typically (but not exclusively) provided by voluntary sector providers and tend to be staffed by a mixture of voluntary sector, support / peer support workers, and may sometimes have input from qualified NHS and Local Authority staff.
Walk-in Crisis Assessment Unit Service	A22	This is defined as an open access 'walk-in' NHS facility where people experiencing a mental health crisis can access support and assessment of their needs. They are sometimes viewed as an 'A&E equivalent' for mental health and are staffed primarily by NHS mental health nurses and other qualified professionals. For the purposes of team type definitions in the MHSDS, this team is defined as one where people can self-refer, or other system partners such as police and ambulance can signpost or take people without necessarily having had a prior assessment of referral from another NHS service.
Psychiatric Decision Unit Service	A23	A psychiatric decision unit (PDU) is a dedicated mental health acute assessment unit, providing an additional facility for an enhanced assessment and offering short-term support to people in mental health crisis. People are typically referred to such units from A&E or another urgent mental health service, as a place of respite for those experiencing acute and complex mental health crisis, for whom in-patient admission is being considered. They are predominantly assessment units, staffed by qualified NHS staff with overnight facilities (typically for up to 48/72 hours) for the assessment and development of treatment plans. The reduction in time pressure enables the service user to think through more clearly the nature of their crisis and the

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

Forensic Learning Disability Service	B02	A Forensic Learning Disability Service provides specialist forensic assessment and treatment of Forensic Mental Health Patients who also have a Learning Disability.
Specialist Mental Health Services		
Autistic Spectrum Disorder Service	C01	Used only for services that only focus on Autism Spectrum Disorder. Use A07 for generic organic teams. For mixed neuro-development teams (e.g. including ADHD) use C04.
Specialist Perinatal Mental Health Community Service	C02	Used for specialist community perinatal mental health multidisciplinary teams in secondary mental health services, commissioned to provide NICE concordant assessments and interventions for women who are experiencing, or are at risk of, moderate, severe/complex mental illness. Provision provided from pre-conception up to two years post birth.
Neurodevelopment Team	C04	Used for teams primarily focused on mixed neurodevelopmental disorders including, for example, Attention Deficit with Hyperactivity Disorder, Autistic Spectrum Conditions, etc.
Paediatric Liaison Service	C05	This code describes a service where the primary function is to provide mental health support to CYP in hospital paediatric services only. If combined with community crisis resolution and or home treatment service, use A02. For a service for all ages or adult-only liaison service please use A11.
Looked After Children Service	C06	This code describes a MH service mainly for Looked After Children. This may include care leavers and adoption services.
Youth Offending Service	C07	This code describes a service for community Young Offenders/Youth Justice Services only. See Forensic Services codes and D02 also.
Acquired Brain Injury Service	C08	(Not specific to secure) To support patients with Acquired Brain Injury (both traumatic and non-traumatic) and other co-morbidities including mental illness and substance misuse in a therapeutic, hospital environment. The purpose of admission may be acute care or longer-term rehabilitation to meet specific outcomes/goals for the individual.
Community Eating Disorder Service	C10	This code covers Community Eating Disorder services for Children and Young People and / or for Adults. N.B. Combination of previously used C03 ‘Eating Disorders/Dietetics Service’ and C09 ‘Community Eating-Disorder Service for CYP’
Other Mental Health Services		
Substance Misuse Team	D01	TBC
Criminal Justice Liaison and Diversion Service	D02	Services that identify people who have mental health, learning disability, substance misuse or other vulnerabilities when they come into contact with the criminal justice system as suspects, defendants or offenders. These services support people through the early stages of criminal system pathway, refer them for appropriate health or social care or enable them to be diverted away from the criminal justice system into a more appropriate setting, if required.

Prison Psychiatric Inreach Service	D03	TBC
Asylum Service	D04	TBC
Individual Placement and Support Service	D05	This code describes a specific model of evidence-based employment support for people with severe mental illness (SMI). This code may be used where patients are supported in secondary mental health care or in primary care networks.
Mental Health In Education Service	D06	This code is to be used for services that are located in education settings and/or primarily focused on students in schools, colleges or universities. New education based 'Mental Health Support Teams' should use this code when submitting data.
Problem Gambling Service	D07	This code is to be used for services that deliver specialised treatment for people with moderate to severe gambling disorder. This includes people presenting with severe gambling disorder (PGSI score of 8+), people presenting with gambling disorder and a comorbid mental and physical health condition and not requiring residential care, and services for children and young people (aged 13-25) with a gaming and gaming-related gambling problem.
Rough sleeping service	D08	These services would normally provide a multi-agency response to properly support rough sleepers with mental health needs. They integrate mental health support with existing homelessness services. Examples could include mental health teams alongside support such as outreach, substance misuse, occupational therapist and housing support teams.
Learning Disability Services		
Community Team for Learning Disabilities	E01	A multi-disciplinary team offering specialist assessment, treatment and care to adults with a learning disability in the community. These teams are likely to include a range of professionals such as community learning disability nurses, social workers, psychiatrists, psychologists and therapists. The team will carry out a range of functions including but not limited to: social care assessment and care management; care co-ordination, support for daily living and maintaining good health.
Epilepsy/Neurological Service	E02	Where this service exists, it would usually be psychiatrists who have a special interest in epilepsy, supported by community nurses who have developed a specialism in epilepsy or epilepsy specialist nurses, who liaise with neurology directly and support appointments.
Specialist Parenting Service	E03	Teams and networks where Learning Disability Occupational Therapists have a specialist interest, and will work with networks of health practitioners and health visitors. This could also be a function within the community learning disability team.
Enhanced/Intensive Support Service	E04	A community team offering short-term, urgent, assessment, treatment and care to adults with a learning disability and behaviour that challenges during a time of crisis. The service may be 24/7, offer a crisis response, may include respite care, may include a “longer term intensive support” function.
Other		

Other Mental Health Service - in scope of National Tariff Payment System	Z01	This code is for any mental health team whose function is not covered by any other codes but is still in scope of the National Tariff Payment System.
Other Mental Health Service - out of scope of National Tariff Payment System	Z02	This code is for any mental health team whose function is not covered by any other codes and is out of scope of the National Tariff Payment System.

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