DSC Notice: 06/2008
Date of Issue: April 2008

Information Standards Board for Health and Social Care
IMPLEMENTABILITY INTEROPERABILITY SAFETY

Sponsoring Organisation:	Implementation Date:	1st April 2008
Department of Health	Subject:	
	Data Standards: Mental Health Minimum Data Set (version 3.0)	

DATA SET CHANGE NOTICE

This DSCN informs users of the approval of changes to an information requirement or information standard by the Information Standards Board for Health and Social Care (ISB HaSC) at its meeting on 27th February 2008.

The burden of collection has been agreed by the Review of Central Returns Steering Committee (ROCR) – ROCR No: **ROCR/OR/0017/FT6/002**

Summary:

This DSCN informs the NHS of required changes to the Mental Health Minimum Dataset (MHMDS) and should be read by all providers of adult mental health services in a secondary care setting, and specifically MHMDS leads and information departments. It will also be relevant to all suppliers of systems used in Mental Health services.

The changes support the information requirements in relation to the following areas:

- PSA Delivery Agreement 16 (Social Exclusion) effective April 2008
- Mental Health Act 2007 effective October 2008

In addition there are changes to naming conventions for some existing data items which need to be incorporated immediately.

Flows of information as a result of these changes will be incorporated within the existing quarterly, and annual, central submissions of the Mental Health Minimum Dataset (MHMDS) by Trusts to the Secondary Uses Service (SUS). For PSA Information this will be from Q2 2008-09 onwards with Mental Health Act information from Q3 2008-09 onwards.

All PSA and Mental Health Act information, including PSA information captured locally prior to Q2 2008-09, will be included within the 2008-09 MHMDS Annual Submissions.

Note

This DSCN is in two parts:
Part 1 provides the detailed policy information underpinning these changes
Part 2 provides the definitional, technical and modelling details that will be included in the NHS Data Model and Data Dictionary – Change Proposal CP934

Datasets / return affected:
MHMDS XML Schema
Commissioning Data Sets Type 170 – APC – Detained and/or Long Term Psychiatric Census CDS KP90 - Admissions, Changes in Status and Detentions under the Mental Health Act

Related DSCNs: DSCN 37/2007, DSCN 49/2002, DSCN48/2002, DSCN 29/2002, DSCN 27/2002, DSCN 20/99/P13

Impact of Change:

Service: Minor **System Suppliers:** Minor

The Information Standards Board for Health and Social Care (ISB HaSC) is responsible for approving information standards. Documents relating to the approval of this standard can be found at: http://www.isb.nhs.uk/docs/mental-health

DATA SET CHANGE NOTICE

Reference No:	DSCN 06/2008 ROCR/OR/0017/FT6/002
Version No:	v1.0
Subject:	Mental Health Minimum Data Set (version 3.0)
Type of Change:	Change to an Approved Information Standard
Implementation Date:	▪ **PSA**: April 2008 ▪ **MHA 2007**: October 2008 ▪ **Other changes**: Immediate
Business Justification:	To meet the information requirements of the: ▪ Mental Health Act 2007 ▪ PSA Delivery Agreement 16 (Social Exclusion) ▪ to reduce ambiguity in relation to several existing data items.
Effect on other Information Standards:	▪ MHMDS XML Schema ▪ Commissioning Data Sets (CDS) v6.0 Type 170 – APC – Detained and/or Long Term Psychiatric Census CDS

Introduction

The purpose of this DSCN is to inform the service of the Department of Health (DH) mandate for the changes to the Mental Health Minimum Dataset (MHMDS) Information Standard to facilitate the provision of information in relation to the following areas:

- PSA Delivery Agreement 16 (Social Exclusion)
- Mental Health Act 2007
- to reduce ambiguity in relation to several existing data items.

These changes will affect all providers of adult mental health services in a secondary care setting, and specifically MHMDS leads and information departments. It will also be relevant to all suppliers of systems used in Mental Health services.

Local capture of information to support the PSA Delivery Agreement 16 (Social Exclusion) will start from April 2008, with local capture of information to support the Mental Health Act 2007 starting October 2008.

Flows of information as a result of these changes will be incorporated within the existing quarterly, and annual, central submissions of the Mental Health Minimum Dataset (MHMDS) by Trusts to the Secondary Uses Service (SUS). For PSA Information this will be from Q2 2008-09 onwards with Mental Health Act information from Q3 2008-09 onwards.

All PSA and Mental Health Act information, including PSA information captured locally prior to Q2 2008-09, will be included within the 2008-09 MHMDS Annual Submissions.

Corresponding changes to the MHMDS Intermediate database and the MHMDS Assembler will also be required to support the flow of additional information into the Secondary Uses Service (SUS).

Background

The changes to the Mental Health Minimum Dataset (MHMDS) will meet the specific business and information requirements of three separate legislative/policy/technical areas as outlined below:

1. Mental Health Act 2007

The Mental Health Act 2007 comes into force in October 2008. This introduces a number of new policy instruments and also amends elements of the Mental Health Act 1983.

The NHS, including Mental Health Trusts, will have a legal requirement to administer and apply the new Act. To facilitate the data capture and central reporting required to allow analysis of the implementation and application of the Act, there will be a requirement to capture information from Trusts. This information will relate to the following areas of the Act:

- Supervised Community Treatment (SCT)
- Leave of Absence
- Absence Without Leave (AWOL)
- Changes to Professional Roles (Responsible Clinician)
- Changes to Mental Category

Further details relating to the Mental Health Act 2007 can be found on the Department of Health website:

http://www.dh.gov.uk/en/healthcare/nationalserviceframeworks/mentalhealth/index.htm

2. PSA Delivery Agreement 16 (Social Exclusion)

The PSA Delivery Agreement 16 (Social Exclusion) was published by HM Government in October 2007. It aims to tackle the social exclusion of adults from four at-risk client groups; including adults in contact with secondary mental health services.

The National Level indicators defined within the PSA relating to Mental Health are:

- NI 149: The proportion of adults in contact with secondary mental health services in settled accommodation
- NI 150: The proportion of adults in contact with secondary mental health services in employment

Further details relating to the PSA National Indicators can be found on the Social Exclusion Task Force website:

www.cabinetoffice.gov.uk/social_exclusion_task_force.aspx

3. Changes to naming conventions for two existing data items

The final changes are to existing data item names to reduce ambiguity and the potential for misinterpretation, promoting consistency across the NHS.

Details of Change

1. Mental Health Act 2007

a. Supervised Community Treatment (SCT) (S17A MHA 1983)

Supervised Community Treatment (SCT) was introduced by the Mental Health Act 2007. It creates powers to allow the supervised discharge of a patient sectioned under the MHA 1983, with powers to require compliance with a treatment regime, and powers of recall in the face of default or for other reasons of concern.

A Community Treatment Order (CTO) will be made by the Responsible Clinician, supported by a recommendation from the Approved Mental Health Professional, under the new section 17A of the MHA 1983.

Where necessary, patients subject to SCT under S17A of the MHA 1983 may be recalled into hospital for treatment for a period of up to 72 hours without this automatically ending the SCT. A period of recall into hospital for treatment must not exceed 72 hours and will end with the responsible clinician releasing the patient back into the community on the original CTO, or, where appropriate, and in agreement with the Approved Mental Health Professional, the Responsible Clinician can decide to revoke the SCT during this period.

A period of SCT can end by the following methods:

1. the patients discharge from treatment, or
2. the revocation of the CTO following recall of the patient to hospital for treatment for a period of more than 72 hours, or
3. the death of the patient, or
4. the patient was granted permission to move out of the country.

b. Leave of Absence

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.

There is a requirement to report information relating to Leave of Absence centrally to ensure that S17 Leave of Absence is not used as an alternative to S17A Supervised Community Treatment (SCT) introduced by the MHA 2007 which has more safeguards.

c. Absence without Leave (AWOL)

Absence without Leave (AWOL) occurs when a patient detained under the MHA 1983 leaves their place of normal detention without permission or fails to return from Leave of Absence within the specified time.

d. Changes to Mental Categories

The 2007 Act amends the wording of the definition of mental disorder in the 1983 Act from “mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind” to “any disorder or disability of the mind”. For this reason existing Mental Categories have been abolished and will be replaced by a single category, although there will still be a requirement to identify patients with a mental disorder that also have a learning disability.

The new categories should be used for all patients sectioned under the Mental Health Act 1983 after 1st October 2008 when the Act comes into force.

Trusts should continue to use existing values within MHMDS Submissions until 30th September 2008. Only new categories should be recorded for Mental Health patients detained under the Mental Health Act 1983 after this date, although old values may continue to flow within MHMDS for historical purposes.

e. Changes to Professional Roles

The Mental Health Act 2007 abolishes the role of the Responsible Medical Officer (RMO), instead replacing it with the role of Responsible Clinician (RC). Unlike the RMO, the RC will not necessarily be a consultant psychiatrist. He or she may be a doctor, nurse, psychologist, occupational therapist or social worker.

The Main Specialty (Mental Health) value list has been updated to reflect the expanded list of professionals that can act as the RC.

2. PSA Delivery Agreement 16 (Social Exclusion)

The National Indicators defined within the PSA Delivery Agreement 16 (Social Exclusion) relating to Mental Health are:

- NI 149: The proportion of adults in contact with secondary mental health services in settled accommodation
- NI 150: The proportion of adults in contact with secondary mental health services in employment

To facilitate the data capture and central reporting and derivation of these National Indicators by providers of adult mental health services in a secondary care setting, there will be a requirement to capture information from Trusts in relation to the following areas within MHMDS:

- Employment Status: based upon the patient's current employment status at the time of the review,
- Accommodation Status: based upon the patient's main or permanent place of residence at the time of review.

Both will typically be captured periodically by mental healthcare professionals as part of the Care Programme Approach (CPA) or similar review process, assessment or care-planning meeting.

Information will only need to be captured for patients on the CPA and between the ages of 18 – 69 years old.

National Indicators will be derived from information submitted by Trusts within annual MHMDS submissions from 2008-09 onwards.

3. Changes to reduce ambiguity

The final changes are to existing data item names to reduce ambiguity and hence promote consistency across the NHS.

a. Contacts (Psychotherapy)

The existing MHMDS data item Contacts (Consultant Psychotherapist) is being renamed as Contacts (Psychotherapist). This is to more accurately reflect the true nature of the data item as currently employed and to reduce ambiguity and avoid the possibility of misinterpretation by users.

This data item records the number of contacts between the patient and a psychotherapist, which may either be a consultant or a non-consultant psychotherapist. The intended use of this data item, as technically implemented, is to capture activity by any trained psychotherapists including those without a professional background in clinical psychology, nursing or medicine.

Trusts should be aware that all contacts with any psychotherapist should be included within the Professional Staff Group Contact MHMDS Intermediate DB table as Code [PSRX] Psychotherapist.

b. Social Worker Involvement

The existing MHMDS data item Social Worker Involvement is being renamed as Social Worker Involvement Indicator. This is to more accurately reflect the true nature of the data item as currently employed and to reduce ambiguity and avoid the possibility of misinterpretation by users.

The intended use of this data item is to indicate whether any involvement with a social worker is planned for the patient. Similar data items within MHMDS already include the term 'indicator'.

Changes to the Mental Health Minimum Dataset (MHMDS)

The table below outlines the changes to the Mental Health Minimum Dataset (MHMDS), as output by the MHMDS Assembler, for submission to Secondary Uses Service (SUS).

Data Item	Type of change	Business Justification	Effective from
Employment Status (Mental Health)	New data item	PSA 16	April 2008
Weekly Hours Worked	New data item	PSA 16	April 2008
Accommodation Status (Mental Health)	New data item	PSA 16	April 2008
Settled Accommodation Indicator (Mental Health)	New data item	PSA 16	April 2008
Supervised Community Treatment Total	New data item	MHA 2007	October 2008
Supervised Community Treatment Recalls Total	New data item	MHA 2007	October 2008
Supervised Community Treatment Discharges Total	New data item	MHA 2007	October 2008
Supervised Community Treatment Revocations Total	New data item	MHA 2007	October 2008
Leave of Absence Total	New data item	MHA 2007	October 2008
Leave of Absence Total Days	New data item	MHA 2007	October 2008
Leave of Absence End Reason (Last)	New data item	MHA 2007	October 2008
Absence Without Leave Total	New data item	MHA 2007	October 2008
Absence Without Leave Total Days	New data item	MHA 2007	October 2008
Absence Without Leave End Reason (Last)	New data item	MHA 2007	October 2008
Social Worker Involvement Indicator	Change to data item name	Reduce ambiguity	April 2008
Contacts (Psychotherapy)	Change to data item name	Reduce ambiguity	April 2008
Mental Health Care and Legal Status History	Changes data item definition	MHA 2007	October 2008

Please note that only additional data items and changes to existing data items are shown.

These changes will need to be accompanied by corresponding changes to the MHMDS Intermediate Database tables. Details of these can be found in Appendix 1.

The full definitional, technical and modelling details to support this change are included in Part 2.

Further details of changes and guidance

Full details of all changes to the Mental Health Minimum Dataset can be found in the MHMDS v3.0 Specification available on The Information Centre website:

www.ic.nhs.uk/mentalhealth/mhmds

These include data items, formats, definitions and data values for both the MHMDS Intermediate Database and MHMDS Output Specification as created by the MHMDS Assembler.

An updated version of the MHMDS Intermediate Database reflecting changes outlined within this DSCN will be released by The Information Centre by end August 2008.

Timescales for Local Capture and Implementation

The table below outlines the timescales for the implementation of these changes including the local capture of data by Trusts and central flow of information within quarterly and annual central MHMDS submissions.

	Local capture of information by Trusts	Flow of information centrally in MHMDS submissions from:
PSA Delivery Agreement 16 (Social Exclusion)	1st April 2008	Q2 (2008-09)
Mental Health Act 2007	1st October 2008	Q3 (2008-09)
Other changes	No additional data capture required by Trusts	No changes to information flows

Please note that although information should be captured locally by Trusts, it will not be immediately possible to flow the information centrally until technical changes to the MHMDS Intermediate DB tables, MHMDS Assembler, MHMDS XML Schema v3.4 and SUS Release 4 have been implemented.

Effects on Other Information Standards

1. MHMDS XML Schema: an updated version of the MHMDS XML Schema will be subsequently released.

2. Commissioning Data Sets (CDS) Type 170 – APC – Detained and/or Long Term Psychiatric Census CDS: changes to Mental Category, in line with legislation, will be incorporated into a future version of the CDS.

3. KP90 - Admissions, Changes in Status and Detentions under the Mental Health Act: changes to Mental Category, in line with legislation, will be incorporated into a subsequent KP90 ISB HaSC change submission.

Sponsor Details

Professor Louis Appleby
National Director for Mental Health
Department of Health

Naomi Eisenstadt
Director, Social Exclusion Task Force
Cabinet Office

Further Information and Support

MHMDS Dataset

Full details of these changes to the MHMDS, including the dataset specification and Human Behavioural, Organisational and Technical Guidance, can be found on The Information Centre for health and social care website: www.ic.nhs.uk/mentalhealth/mhmds

Or alternatively specific enquiries relating to these changes, or any other aspect of the MHMDS, can be submitted by email to enquiries@ic.nhs.uk by telephone (0845) 300 6016.

(Please include 'Mental Health Minimum Dataset' or 'MHMDS' in the subject line for email enquiries)

Mental Health Act 2007

Further information and guidance relating to the Mental Health Act 2007 legislation can be found on The Department of Health website:
http://www.dh.gov.uk/en/healthcare/nationalserviceframeworks/mentalhealth/index.htm

Or specific enquiries can be submitted by email to the Mental Health Legislation Team: MentalHealthAct2007@dh.gsi.gov.uk

PSA Delivery Agreement 16 (Social Exclusion)

Further information and guidance relating to the PSA National Indicators can be found on the Social Exclusion Task Force website: www.cabinetoffice.gov.uk/social_exclusion_task_force.aspx

Or specific enquiries can be submitted by email to: setaskforce@cabinet-office.x.gsi.gov.uk

Appendix 1: Changes to the MHMDS Intermediate Database Tables

The table below outlines the changes to the Mental Health Minimum Dataset (MHMDS) Intermediate Database data items, as populated from Trust systems.

Data Item	Type of change	Mandatory /Required/ Optional	Business Justification	
Employment Status (Mental Health)	New data item	R	PSA16	April 2008
Weekly Hours Worked	New data item	CR	PSA16	April 2008
Accommodation Status (Mental Health)	New data item	O	PSA16	April 2008
Settled Accommodation Indicator (Mental Health)	New data item	R	PSA16	April 2008
Supervised Community Treatment Start Date	New data item	R	MHA2007	October 2008
Supervised Community Treatment End Date	New data item	CR	MHA2007	October 2008
Supervised Community Treatment End Reason	New data item	CR	MHA2007	October 2008
Supervised Community Treatment Recall Start Date	New data item	R	MHA2007	October 2008
Supervised Community Treatment Recall Start Time	New data item	R	MHA2007	October 2008
Supervised Community Treatment Recall End Date	New data item	CR	MHA2007	October 2008
Supervised Community Treatment Recall End Time	New data item	CR	MHA2007	October 2008
Leave of Absence Start Date	New data item	R	MHA2007	October 2008
Leave of Absence End Date	New data item	CR	MHA2007	October 2008
Leave of Absence End Reason	New data item	O	MHA2007	October 2008
Absence Without Leave Start Date	New data item	R	MHA2007	October 2008
Absence Without Leave End Date	New data item	CR	MHA2007	October 2008
Absence Without Leave End Reason	New data item	O	MHA2007	October 2008
Mental Category	Retire data item	-	MHA2007	October 2008
Mental Health Act 2007 Mental Category	New data item	R	MHA2007	October 2008
Main Specialty (Mental Health)	Changes to data values	-	MHA2007	October 2008
Responsible Clinician Profession	New data item	R	MHA2007	October 2008
Psychotherapist Contacts (Professional Staff Group Contacts)	Clarification of definition	-	Reduce ambiguity	Immediate

[M] Mandatory: data item must be recorded and omission may result in failure of submission

[R] Required: data item should be included and will be required for example to derive National Indicators or statistics

[CR] Conditionally Required: data item is required but only where specific criteria are met i.e. Supervised Community Treatment End Reason is only required for patients on a Supervised Community Treatment that has ended.

[O] Optional: Trusts can decide whether to capture and submit data (Trust systems must still be capable of capturing the desired information)

Full details of the forthcoming changes to the MHMDS Intermediate DB including data item names, formats, definitions and associated data values can be found in the MHMDS v3.0 Specification available on The Information Centre website: www.ic.nhs.uk/mentalhealth/mhmds

Important

Trusts may have a requirement for differing local configuration of systems to meet specific business functions, such as expanded lists of data values, whilst still being capable of extracting information in the specified format for inclusion within MHMDS.

Change Request

NHS Connecting for Health

NHS Data Model and Dictionary Service

Reference:	Change Request 934
Version No:	1.0
Subject:	Introduction of Mental Health Minimum Data Set Version 3.0
Type of Change:	Changes to NHS Data Standards
Effective Date:	1 April 2008
Reason for Change:	Amendments to Mental Health Minimum Data Set

Background:

The Mental Health Act 2007 and Public Service Agreement Delivery Agreement 16 (Social Exclusion) requires changes to the Mental Health Minimum Data Set.

The Public Service Agreement Delivery Agreement 16 (Social Exclusion) is to be implemented from 1st April 2008 and Trusts will consequently be required to capture 'Employment Status', 'Weekly Hours Worked' and 'Settled Accommodation Indicator' locally from this date. These changes will flow centrally from October 2008 in the Mental Health Minimum Data Set.

The Mental Health Act 2007 comes into force in October 2008. Information relating to certain elements of the Act such as Supervised Community Treatment, changes to Mental Categories and changes to professional roles (responsible clinician) will only be captured by Trusts from this date. These changes will flow in the Mental Health Minimum Data Set from October 2008.

This document defines the specification for version 3.0 of the Mental Health Minimum Data Set. This includes the Mental Health Minimum Data Set Specification as output by the Mental Health Minimum Data Set Assembler. It aims to provide guidance and clarification for users involved in the creation and use of Mental Health Minimum Data Set submission data.

This paper provides data standards for the changes to the Mental Health Minimum Data Set v3.0, incorporating changes required for Mental Health Act 2007 and PSA Delivery Agreement 16 (Social Exclusion)

Related changes

The Commissioning Data Set ADMITTED PATIENT CARE - DETAINED AND/OR LONG TERM PSYCHIATRIC CENSUS CDS will be amended in Commissioning Data Set Version 6.1. This will be published in a subsequent Data Set Change Notice.

The central return KP90 Admissions, Changes in Status and Detentions under the Mental Health Act will be updated. This will be published in a subsequent Data Set Change Notice.

Summary of changes:

Class Definitions	
ACCOMMODATION STATUS	New Class
ACTIVITY GROUP	Change to Description
ACTIVITY GROUP	Change to Attributes
CARE CONTACT	Change to Attributes
CARE PLAN	Change to Attributes
CARE PROFESSIONAL	Change to Description
CARE PROFESSIONAL	Change to Attributes
CATEGORY VALUED PERSON OBSERVATION	Change to Description

CATEGORY VALUED PERSON OBSERVATION	Change to Attributes
CATEGORY VALUED PERSON OBSERVATION	Change to Relationships
DAILY WARD LISTING	Change to Description
EMPLOYMENT	New Class
LEAVE	Change to Description

Attribute Definitions

ABSENCE WITHOUT LEAVE END REASON	Change to Description
ACCOMMODATION STATUS CODE	New Attribute
ACTIVITY GROUP TYPE	Change to Description
CARE PROFESSIONAL ROLE CODE	Change to Description
EMPLOYMENT STATUS	Change to Description
LEAVE OF ABSENCE END REASON	Change to Description
MENTAL CATEGORY	Change to Description
MENTAL HEALTH ACT 2007 MENTAL CATEGORY	New Attribute
MENTAL HEALTH RESPONSIBLE CLINICIAN PROFESSION	New Attribute
PLANNED LEAVE RETURN DATE	Change to Description
SETTLED ACCOMMODATION INDICATOR	New Attribute
SOCIAL WORKER INVOLVEMENT	Change to Name
SOCIAL WORKER INVOLVEMENT renamed SOCIAL WORKER INVOLVEMENT INDICATOR	Change to Aliases
SUPERVISED COMMUNITY TREATMENT END REASON	New Attribute
WEEKLY HOURS WORKED	New Attribute

Data Elements

ABSENCE WITHOUT LEAVE END DATE	New Data Element
ABSENCE WITHOUT LEAVE END REASON (LAST)	New Data Element
ABSENCE WITHOUT LEAVE START DATE	New Data Element
ABSENCE WITHOUT LEAVE TOTAL	New Data Element
ABSENCE WITHOUT LEAVE TOTAL DAYS	New Data Element
ACCOMMODATION STATUS (MENTAL HEALTH)	New Data Element
BED DAYS (MENTAL HEALTH)	Change to Description
BED DAYS (MENTAL HEALTH INTENSIVE)	Change to Description
BED DAYS (MENTAL HEALTH MEDIUM SECURE)	Change to Description
BED DAYS (MENTAL HEALTH NHS COMMUNITY CARE)	Change to Description
CATEGORY OF PATIENT	Change to Description
CONTACTS (CONSULTANT PSYCHOTHERAPY)	Marked as Retired
CONTACTS (PSYCHOTHERAPY)	New Data Element
EMPLOYMENT STATUS (MENTAL HEALTH)	New Data Element
END DATE	Change to Description
END DATE (MENTAL HEALTH CARE SPELL)	Change to Description
END TIME	New Data Element
LEAVE OF ABSENCE END DATE	New Data Element
LEAVE OF ABSENCE END REASON (LAST)	New Data Element
LEAVE OF ABSENCE START DATE	New Data Element
LEAVE OF ABSENCE TOTAL	New Data Element
LEAVE OF ABSENCE TOTAL DAYS	New Data Element
MAIN SPECIALTY CODE (MENTAL HEALTH)	Change to Description
MENTAL CATEGORY	Change to Description
MENTAL HEALTH ACT 2007 MENTAL CATEGORY	New Data Element
MENTAL HEALTH CARE AND LEGAL STATUS HISTORY	Change to Description
MENTAL HEALTH RESPONSIBLE CLINICIAN PROFESSION	New Data Element
OCCUPATION (CPA CARE COORDINATOR)	Change to Description
SETTLED ACCOMMODATION INDICATOR (MENTAL HEALTH)	New Data Element
SOCIAL WORKER INVOLVEMENT	Change to Name

SOCIAL WORKER INVOLVEMENT renamed SOCIAL WORKER INVOLVEMENT INDICATOR	Change to Description
START DATE	Change to Description
START TIME	New Data Element
STATUS OF PATIENT INCLUDED IN THE PSYCHIATRIC CENSUS	Change to Description
SUPERVISED COMMUNITY TREATMENT DISCHARGES TOTAL	New Data Element
SUPERVISED COMMUNITY TREATMENT RECALLS TOTAL	New Data Element
SUPERVISED COMMUNITY TREATMENT REVOCATIONS TOTAL	New Data Element
SUPERVISED COMMUNITY TREATMENT TOTAL	New Data Element
WEEKLY HOURS WORKED	New Data Element

Dataset

MENTAL HEALTH MINIMUM DATA SET	Change to Table

Supporting Information

ABSENCE WITHOUT LEAVE	Change to Name
ABSENCE WITHOUT LEAVE renamed MENTAL HEALTH ABSENCE WITHOUT LEAVE	Change to Supporting Information
APPROVED MENTAL HEALTH PROFESSIONAL	New Supporting Information
CARE PROGRAMME APPROACH REVIEW	Change to Supporting Information
COMMUNITY TREATMENT ORDER	New Supporting Information
CONSULTANT EPISODE (HOSPITAL PROVIDER)	Change to Supporting Information
DAY CARE ATTENDANCE	Change to Supporting Information
HOME LEAVE	Change to Supporting Information
HOSPITAL PROVIDER SPELL	Change to Supporting Information
HOSPITAL STAY	Change to Supporting Information
LEAVE OF ABSENCE	Change to Name
LEAVE OF ABSENCE renamed MENTAL HEALTH LEAVE OF ABSENCE	Change to Aliases
MENTAL HEALTH ACT 1983 TABLE	Change to Name
MENTAL HEALTH ACT 1983 TABLE renamed MENTAL HEALTH ACT TABLE	Change to Aliases
MENTAL HEALTH CARE SPELL	Change to Supporting Information
MENTAL HEALTH MINIMUM DATA SET OVERVIEW	Change to Supporting Information
MENTAL HEALTH RESPONSIBLE CLINICIAN	New Supporting Information
NURSING EPISODE	Change to Supporting Information
REGULAR ATTENDER EPISODE	Change to Supporting Information
RESPONSIBLE MEDICAL OFFICER ASSIGNMENT	Deleted
SUPERVISED COMMUNITY TREATMENT	New Supporting Information
SUPERVISED COMMUNITY TREATMENT RECALL	New Supporting Information
SUPPORTING INFORMATION	Change to Supporting Information
WARD STAY	Change to Supporting Information

Date: 10 April 2008
Sponsor: David Lye, Mental Health Act Policy Lead

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

MENTAL HEALTH MINIMUM DATA SET

Change to Dataset: Change to Table

Mental Health Minimum Data Set Overview

The Mental Health Minimum Data Set concerns adult PATIENTS (including elderly) who receive care in NHS

specialist mental health services. This care is delivered within a Mental Health Care Spell. ~~For some PATIENTS care will comprise a small number of out-patient attendances over a few weeks.~~ For some PATIENTS, care will comprise a small number of Out-Patient Appointments over a few weeks. For others, it may extend over many years and include hospital, community, out-patient and day care attendances which may commonly overlap.

~~The Mental Health Minimum Data Set is assembled and produced for a defined period of time known as the Reporting Period (which may be monthly, quarterly or annually) and comprises a data set record for each Mental Health Care Spell which occurs wholly or partially within the REPORTING PERIOD.~~ The Mental Health Minimum Data Set is assembled and produced for a defined period of time known as the REPORTING PERIOD (which may be monthly, quarterly or annually) and comprises a data set record for each Mental Health Care Spell which occurs wholly or partially within the REPORTING PERIOD.

Data Set Data Elements
Patient Demographics
ORGANISATION CODE (CODE OF PROVIDER)
ORGANISATION CODE (CODE OF COMMISSIONER)
REPORTING PERIOD (MENTAL HEALTH)
NHS NUMBER
ELECTORAL WARD OF USUAL ADDRESS
ORGANISATION CODE (PCT OF RESIDENCE)
PERSON GENDER CURRENT
PERSON MARITAL STATUS
PERSON BIRTH DATE
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)
ORGANISATION CODE (PCT OF GP PRACTICE)
MHMDS LOCAL PATIENT IDENTIFIER
SOCIAL SERVICES CLIENT IDENTIFIER
ETHNIC CATEGORY
EMPLOYMENT STATUS (MENTAL HEALTH)
WEEKLY HOURS WORKED
ACCOMMODATION STATUS (MENTAL HEALTH)
SETTLED ACCOMMODATION INDICATOR
YEAR OF FIRST KNOWN PSYCHIATRIC CARE
Mental Health Care Spell Activity
CARE SPELL IDENTIFIER (MENTAL HEALTH)
CARE SPELL NUMBER IN REPORTING PERIOD
MAIN SPECIALTY CODE (MENTAL HEALTH)
START DATE (MENTAL HEALTH CARE SPELL)
SOURCE OF REFERRAL FOR MENTAL HEALTH
END DATE (MENTAL HEALTH CARE SPELL)
MENTAL HEALTH CARE SPELL END CODE
SPELL DAYS IN REPORTING PERIOD
SUSPENDED DAYS IN REPORTING PERIOD
MHCS SUSPENSION REASON (AT END OF REPORTING PERIOD)
CPA STANDARD DAYS
CPA ENHANCED DAYS
CPA LEVEL (AT END OF REPORTING PERIOD)
OCCUPATION (CPA CARE COORDINATOR)
DATE LAST SEEN (CPA CARE COORDINATOR)
DAYS LIABLE FOR DETENTION
DAYS OF SUPERVISED DISCHARGE
LEGAL STATUS CLASSIFICATION CODE (AT END OF REPORTING PERIOD)
LEGAL STATUS RESTRICTIVENESS (HIGHEST IN REPORTING PERIOD)

MHC WITHOUT PATIENT CONSENT IN REPORTING PERIOD
SSSA (NUMBER FOR DETENTION)
SSSA (NUMBER FOR COMMUNITY CARE)
DIAGNOSIS (ICD FIRST MOST RECENT)
DIAGNOSIS (ICD SECOND MOST RECENT)
DIAGNOSIS (ICD THIRD MOST RECENT)
DIAGNOSIS (ICD FOURTH MOST RECENT)
DIAGNOSIS (ICD FIFTH MOST RECENT)
DIAGNOSIS (ICD SIXTH MOST RECENT)
DIAGNOSIS (ICD SEVENTH MOST RECENT)
DIAGNOSIS (ICD EIGHTH MOST RECENT)
DIAGNOSIS (ICD NINTH MOST RECENT)
DIAGNOSIS (ICD TENTH MOST RECENT)
DIAGNOSIS (ICD ELEVENTH MOST RECENT)
DIAGNOSIS (ICD TWELFTH MOST RECENT)
HONOS RATING (FIRST IN MHCS)
HONOS SCORE DATE (FIRST IN MHCS)
HONOS RATING (MOST RECENT IN MHCS)
HONOS SCORE DATE (MOST RECENT IN MHCS)
HONOS RATING (WORST EVER RECORDED)
HONOS SCORE DATE (WORST EVER RECORDED)
HONOS RATING (BEST IN LAST TWELVE MONTHS)
HONOS SCORE DATE (BEST IN LAST TWELVE MONTHS)
SUPERVISED COMMUNITY TREATMENT TOTAL
SUPERVISED COMMUNITY TREATMENT RECALLS TOTAL
SUPERVISED COMMUNITY TREATMENT DISCHARGES TOTAL
SUPERVISED COMMUNITY TREATMENT REVOCATIONS TOTAL
LEAVE OF ABSENCE TOTAL
LEAVE OF ABSENCE TOTAL DAYS
LEAVE OF ABSENCE END REASON (LAST)
ABSENCE WITHOUT LEAVE TOTAL
ABSENCE WITHOUT LEAVE TOTAL DAYS
ABSENCE WITHOUT LEAVE END REASON (LAST)
Mental Health Package
BED DAYS (MENTAL HEALTH)
BED DAYS (MENTAL HEALTH MEDIUM SECURE)
BED DAYS (MENTAL HEALTH INTENSIVE)
CARE DAYS (ACUTE HOME-BASED)
BED DAYS (MENTAL HEALTH NHS COMMUNITY CARE)
RESIDENTIAL MH NON-NHS COMMUNITY CARE INDICATOR
DAY CARE ATTENDANCE (MENTAL HEALTH NHS SITE)
DAY CARE ATTENDANCE MH NON-NHS SITE INDICATOR
SHELTERED WORK ATTENDANCE INDICATOR
OUT-PATIENT ATTENDANCE CONSULTANT (MENTAL HEALTH)
CONTACTS (COMMUNITY PSYCHIATRIC NURSE)
CONTACTS (CLINICAL PSYCHOLOGIST)
CONTACTS (OCCUPATIONAL THERAPIST)
~~SOCIAL WORKER INVOLVEMENT~~
SOCIAL WORKER INVOLVEMENT INDICATOR
HOME HELP VISIT INDICATOR
PROCEDURE (READ FIRST MOST RECENT)

PROCEDURE (READ SECOND MOST RECENT)
PROCEDURE (READ THIRD MOST RECENT)
PROCEDURE (READ FOURTH MOST RECENT)
PROCEDURE (READ FIFTH MOST RECENT)
PROCEDURE (READ SIXTH MOST RECENT)
PROCEDURE (READ SEVENTH MOST RECENT)
PROCEDURE (READ EIGHTH MOST RECENT)
PROCEDURE (READ NINTH MOST RECENT)
PROCEDURE (READ TENTH MOST RECENT)
PROCEDURE (READ ELEVENTH MOST RECENT)
PROCEDURE (READ TWELFTH MOST RECENT)
PROCEDURE (ECT TREATMENTS ADMINISTERED)
ADMISSIONS (MENTAL HEALTH)
DISCHARGES (MENTAL HEALTH)
HOSPITAL STAYS LIST (MENTAL HEALTH)
COMMUNITY SURVIVAL TIMES LIST (MENTAL HEALTH)
FIRST CONTACT TIMES LIST (MENTAL HEALTH)
POSTCODE OF USUAL ADDRESS
MENTAL HEALTH CARE TEAM TYPE (AT END OF REPORTING PERIOD)
CONTACTS (PHYSIOTHERAPIST)
~~CONTACTS (CONSULTANT PSYCHOTHERAPY)~~
CONTACTS (PSYCHOTHERAPY)
CONTACTS (SOCIAL WORKER)
OUT-PATIENT DID NOT ATTENDS (MENTAL HEALTH)
DAY CARE DID NOT ATTENDS (MENTAL HEALTH NHS SITE)
CONTACTS (NHS DIRECT MENTAL HEALTH)
CARE PROGRAMME APPROACH REVIEWS (IN REPORTING PERIOD)
SPELL DEFINITION TYPE (ASSEMBLER MHCS)
MENTAL HEALTH CARE AND LEGAL STATUS HISTORY

ABSENCE WITHOUT LEAVE

Change to Supporting Information: Change to Name

~~Absence Without Leave~~ Mental Health Absence Without Leave

ABSENCE WITHOUT LEAVE renamed MENTAL HEALTH ABSENCE WITHOUT LEAVE

Change to Supporting Information: Change to Supporting Information
Mental Health Absence Without Leave is a type of LEAVE.

~~A period of Absence Without Leave occurs when PATIENTS who are for the time being liable to be detained in hospital under Part II of the Mental Health Act 1983, absent themselves from hospital without leave being granted, or absent themselves without permission from any place where they are required to reside in accordance with conditions imposed on granted Leave Of Absence, or fail to return to hospital by midnight on the day specified for return from granted Leave Of Absence.~~ A period of Mental Health Absence Without Leave occurs when PATIENTS who are liable to be detained in hospital under the Mental Health Act 1983 as amended by the Mental Health (Patients in the Community) Act 1995, subject to guardianship or who are on Supervised Community Treatment and have been recalled to hospital, absent themselves from hospital without leave being granted, or absent themselves without permission from any place where they are required to reside in accordance with conditions imposed on granted Mental Health Leave Of Absence, or fail to return to hospital by midnight on the day specified for return from granted Mental Health Leave Of Absence.

~~The PATIENT will still be liable to be taken into custody until the end of a period of six months beginning from the first day of absence or the end of the period for which the PATIENT is liable to be detained or subject to guardianship, whichever is the later.~~ The PATIENT will be liable to be taken into custody until the end of the relevant period set out in the Mental Health Act 1983.

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

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

~~The period of Absence Without Leave ends when the PATIENTS:~~ The period of Mental Health Absence Without Leave ends when the PATIENT:

- returns voluntarily
- is taken into custody
- ~~fails to return within six months beginning from the first day of absence or by the end of the period for which they are liable to be detained or subject to guardianship, whichever is the later~~
- fails to return within the relevant period set out in the Mental Health Act 1983

~~Information recorded for an Absence Without Leave includes:~~ Information recorded for an Mental Health Absence Without Leave includes:

Start Date
ABSENCE WITHOUT LEAVE END REASON O
End Date O

APPROVED MENTAL HEALTH PROFESSIONAL

Change to Supporting Information: New Supporting Information

Approved Mental Health Professional

An Approved Mental Health Professional is a CARE PROFESSIONAL approved by Local Social Services Authorities as trained to deal with PERSONS suffering from a mental disorder.

The Approved Mental Health Professional is responsible for co-ordinating the preliminary examination process and for providing a non-medical view when considering, with her/his colleagues, whether a PATIENT meets the conditions for treatment under the Mental Health Act 1983 as amended by the Mental Health Act 2007. Other duties include: registering PATIENTS, taking PATIENTS to hospital and taking PATIENTS who abscond or who are Absent Without Leave into custody.

CARE PROGRAMME APPROACH REVIEW

Change to Supporting Information: Change to Supporting Information

Care Programme Approach Review is a CARE CONTACT.

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

Episode. The review may take the form of a single meeting of interested parties, usually including the allocated care coordinator and the PATIENT or it may comprise a series of meetings and discussions over a number of days. The Care Programme Approach Review ends when a definite outcome is established and recorded. The date when this is recorded will be taken as the CPA review date. The outcome will determine whether the Care Programme Approach Episode continues or is ended.

The review will also include the assessment and recording of the HONOS SCORE and the assessment or re-assessment of the need for a Supervision Register Episode.

Information recorded for a Care Programme Approach Review includes:

CPA Review Date
CPA REVIEW OUTCOME
HOME HELP USE O (if Home Help Visits planned)
NON-NHS COMMUNITY BED USE O (if stay in non-NHS residential facilities planned)
NON-NHS DAY CARE FACILITY USE O (if attendance at non-NHS Day Care Facilities planned)
PATIENT INFORMED OF OUTCOME DATE
~~SHELTERED WORK FACILITY USE O (if attendance at Sheltered Work Facilities planned)~~
SHELTERED WORK FACILITY USE O (if attendance at Sheltered Work Facilities planned)
ACCOMMODATION STATUS CODE
EMPLOYMENT STATUS
WEEKLY HOURS WORKED
SETTLED ACCOMMODATION INDICATOR

COMMUNITY TREATMENT ORDER

Change to Supporting Information: New Supporting Information

Community Treatment Order

See Supervised Community Treatment.

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

A Community Treatment Order will be made by the Mental Health Responsible Clinician, in agreement with an Approved Mental Health Professional, under section 17A of the Mental Health Act 1983 (inserted by the Mental Health Act 2007).

The term Community Treatment Order refers to the actual instrument and Supervised Community Treatment to the treatment regime although both terms are used interchangeably.

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

CONSULTANT EPISODE (HOSPITAL PROVIDER)

Change to Supporting Information: Change to Supporting Information

Consultant Episode (Hospital Provider) is an ACTIVITY GROUP.

The time a PATIENT spends in the continuous care of one CONSULTANT using Hospital Site or Care Home bed(s) of one Health Care Provider or, in the case of shared care, in the care of two or more CONSULTANTS. Where care is provided by two or more CONSULTANTS within the same episode, one CONSULTANT will take overriding

responsibility for the PATIENT and only one Consultant Episode (Hospital Provider) is recorded. Additional CONSULTANTS participating in the care of PATIENTS are defined as Shared Care Consultants. A Consultant Episode (Hospital Provider) includes those episodes for which a GENERAL MEDICAL PRACTITIONER is acting as a CONSULTANT.

~~A PATIENT going on Home Leave, or Leave Of Absence for 28 days or less, or has a current period of Absence Without Leave of 28 days or less, does not interrupt the Consultant Episode (Hospital Provider).~~ A PATIENT going on Home Leave, or Mental Health Leave Of Absence for 28 days or less, or has a current period of Mental Health Absence Without Leave of 28 days or less, does not interrupt the Consultant Episode (Hospital Provider).

A PATIENT may not have concurrent Consultant Episodes (Hospital Provider) but can have Consultant Out-Patient Episodes overlapping with a Consultant Episode (Hospital Provider). A Consultant Episode (Hospital Provider) must not overlap with a Nursing Episode for the same PATIENT.

Any time spent as a LODGED PATIENT before being admitted to a WARD is included in the first Consultant Episode (Hospital Provider).

A CONSULTANT transfer occurs when the responsibility for a PATIENT transfers from one CONSULTANT (or GENERAL MEDICAL PRACTITIONER acting as a CONSULTANT) to another within a Hospital Provider Spell. In this case one Consultant Episode (Hospital Provider) will end and another one begin.

A transfer of responsibility may occur from a CONSULTANT to the PATIENT's own GENERAL MEDICAL PRACTITIONER (not acting as CONSULTANT) with the PATIENT still in a WARD or Care Home to receive nursing care. In this case the Consultant Episode (Hospital Provider) will end and a Nursing Episode will begin.

A transfer of responsibility from the PATIENT's own GENERAL MEDICAL PRACTITIONER to a CONSULTANT while the PATIENT is in a WARD or Care Home for nursing care will end the Nursing Episode and begin a Consultant Episode (Hospital Provider).

During the Consultant Episode (Hospital Provider) a number of Patient Procedures and PATIENT DIAGNOSES may be recorded.

If this is the first episode under a CONSULTANT in one of the psychiatric specialties within the Hospital Provider Spell, the appropriate PSYCHIATRIC PATIENT STATUS should be recorded.

Information recorded for a Consultant Episode (Hospital Provider) includes:

EPISODE NUMBER
PSYCHIATRIC PATIENT STATUS O

DAY CARE ATTENDANCE

Change to Supporting Information: Change to Supporting Information

Day Care Attendance is a CARE CONTACT.

One attendance, or expected attendance, by a PATIENT at a particular Day Care Session. ~~This will either be by a regular attender or by a PATIENT currently using a hospital bed (including Home Leave and Leave Of Absence for a period of 28 days or less).~~ This will either be by a regular attender or by a PATIENT currently using a hospital bed (including Home Leave and Mental Health Leave Of Absence for a period of 28 days or less).

If the PATIENT is currently subject to a Mental Health Care Spell and during attendance at the facility is in contact with the CARE PROFESSIONAL who is their allocated care programme approach care coordinator then a Face To Face Contact CPA Care Coordinator should also be recorded.

For Day Care Attendance, first attendance is the first of a series, or only attendance, at Day Care Facilities of an

ORGANISATION by either a PATIENT using a hospital bed or a regular day attender. A re-attendance is any subsequent attendance at a Day Care Session of the same Health Care Provider by a PATIENT whose attender status has not changed since the previous attendance.

Information recorded for a Day Care Attendance includes:

ATTENDED OR DID NOT ATTEND
FIRST ATTENDANCE

HOME LEAVE

Change to Supporting Information: Change to Supporting Information

Home Leave is a type of LEAVE.

Home Leave occurs when a PATIENT who is not liable to be detained under Part II of the Mental Health Act 1983 and who is using a bed in a WARD or care home spends a period of time outside hospital/care home, usually at home, with the intention of returning to the same type of WARD or care home to continue the same Consultant Episode (Hospital Provider), Midwife Episode or Nursing Episode.

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

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

Information recorded for a Home Leave includes:

Start Date
End Date

HOSPITAL PROVIDER SPELL

Change to Supporting Information: Change to Supporting Information

Hospital Provider Spell is an ACTIVITY GROUP.

The total continuous stay of a PATIENT using a bed on premises controlled by a Health Care Provider during which medical care is the responsibility of one or more CONSULTANTS, or the PATIENT is receiving care under one or more Nursing Episodes or Midwife Episodes in a WARD. During Nursing Episodes and Midwife Episodes general medical care is the responsibility of their own GENERAL MEDICAL PRACTITIONER, who is not acting as a CONSULTANT. The Hospital Provider Spell may be as a result of an ELECTIVE ADMISSION LIST ENTRY.

During the Hospital Provider Spell, the PATIENT may be subject to more than one ADMINISTRATIVE CATEGORY PERIODS. The PATIENT may be subject to one or more CRITICAL CARE PERIODS.

The Hospital Provider Spell starts when a CONSULTANT, NURSE or MIDWIFE assumes responsibility for care following the decision to admit the PATIENT. This may be before formal admission procedures have been completed and the PATIENT transferred to a WARD. For example, if a PATIENT is brought into hospital as an

emergency and dies in the operating theatre before being transferred to a ward, the PATIENT would have started a Hospital Provider Spell.

~~In some circumstances a PATIENT may take~~ ~~Home Leave, or~~ ~~Leave Of Absence~~ ~~for a period of 28 days or less, or have a current period of~~ ~~Absence Without Leave~~ ~~of 28 days or less, which does not interrupt the Hospital Provider Spell,~~ ~~Consultant Episode (Hospital Provider), Nursing Episode, Midwife Episode or~~ ~~Hospital Stay.~~ In some circumstances a PATIENT may take Home Leave, or Mental Health Leave Of Absence for a period of 28 days or less, or have a current period of Mental Health Absence Without Leave of 28 days or less, which does not interrupt the Hospital Provider Spell, Consultant Episode (Hospital Provider), Nursing Episode, Midwife Episode or Hospital Stay.

Each admission as part of a series of regular day/night admissions generates a separate Hospital Provider Spell and Consultant Episode (Hospital Provider). An admission is the start of the PATIENT's Hospital Provider Spell and the first Consultant Episodes (Hospital Provider), Midwife Episode or Nursing Episode within the spell. If the PATIENT is on a Hospital Site the admission will also start the first Hospital Stay and, unless the PATIENT has to spend time as a LODGED PATIENT, the admission will also start the first Ward Stay within that Hospital Provider Spell. If the PATIENT is in a care home the admission will start the first Care Home Stay (Consultant Care) within the Hospital Provider Spell. Any admission of a PERSON liable to be detained under the Mental Health Act 1983 cannot be in a care home and must be a Hospital Provider Spell.

A discharge will be the end of the last Consultant Episode (Hospital Provider), Midwife Episode or Nursing Episode, and the end of the last Care Home Stay (Consultant Care) or Hospital Stay and Ward Stay within that Hospital Provider Spell.

If there is any time spent as a LODGED PATIENT before transfer to a WARD this is included in the Hospital Provider Spell.

A Hospital Provider Spell starts with a HOSPITAL PROVIDER ADMISSION and ends with a HOSPITAL PROVIDER DISCHARGE.

HOSPITAL STAY

Change to Supporting Information: Change to Supporting Information

Hospital Stay is an ACTIVITY GROUP.

The time a PATIENT using a bed stays on one Hospital Site during a Hospital Provider Spell. ~~In some circumstances a PATIENT may take~~ ~~Home Leave, or~~ ~~Leave Of Absence~~ ~~for 28 days or less, or have a current period of~~ ~~Absence Without Leave~~ ~~of 28 days or less, which does not interrupt the Hospital Stay.~~ In some circumstances a PATIENT may take Home Leave, or Mental Health Leave Of Absence for 28 days or less, or have a current period of Mental Health Absence Without Leave of 28 days or less, which does not interrupt the Hospital Stay. If there is any time spent as a LODGED PATIENT before transfer to WARD this is included in the Hospital Stay.

LEAVE OF ABSENCE

Change to Supporting Information: Change to Name

~~Leave Of Absence~~ Mental Health Leave Of Absence

LEAVE OF ABSENCE renamed MENTAL HEALTH LEAVE OF ABSENCE

Change to Supporting Information: Change to Aliases, Change to Supporting Information

~~Leave Of Absence is a type of~~ ~~LEAVE.~~ Mental Health Leave Of Absence is a type of LEAVE.

~~Leave Of Absence only applies to PATIENTS 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 1995.~~ Mental Health Leave Of Absence only applies to PATIENTS liable to be detained in hospital under the Mental Health Act 1983 as amended by the Mental Health (Patients in the Community) Act 1995.

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

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

~~During the Leave Of Absence, the responsible medical officer continues to be responsible for the organisation and management of the PATIENT's continuing health and social care needs.~~ During the Mental Health Leave Of Absence, the Mental Health Responsible Clinician continues to be responsible for the organisation and management of the PATIENT's continuing health and social care needs.

~~If a PATIENT does not return by midnight on the day specified, then the Leave Of Absence will be ended and a period of Absence Without Leave started.~~ If a PATIENT does not return by midnight on the day specified, then the Mental Health Leave Of Absence will be ended and a period of Mental Health Absence Without Leave started.

~~Information recorded for a Leave Of Absence includes:~~ The Mental Health Responsible Clinician should consider Supervised Community Treatment for a PATIENT before granting Mental Health Leave Of Absence for any period exceeding seven consecutive days.

Information recorded for a Mental Health Leave Of Absence includes:

Start Date
End Date O
LEAVE OF ABSENCE END REASON O
PLANNED LEAVE RETURN DATE O (if for a specified period or occasion)

MENTAL HEALTH ACT 1983 TABLE

Change to Supporting Information: Change to Name

~~Mental Health Act 1983 Table~~ Mental Health Act Table

MENTAL HEALTH ACT 1983 TABLE renamed MENTAL HEALTH ACT TABLE

Change to Supporting Information: Change to Aliases
~~Mental Health Act 1983 Table~~

~~**MENTAL HEALTH ACT 1983**~~

Mental Health Act Table

MENTAL HEALTH ACT

~~The following table sets out the relationship between Parts and Sections of the Mental Health Act 1983 (amended by the Crime (Sentences) Act 1997), and specifies how the codes in Category of Patient, LEGAL STATUS CLASSIFICATION CODE, Status Of Patient Included in the Psychiatric Census and MENTAL CATEGORY interrelate.~~
The following table is effective from 1st October 2008 and sets out the relationship between Parts and Sections of the Mental Health Act 1983 (amended by the Crime (Sentences) Act 1997 and the Mental Health Act 2007), and specifies how the codes in Category of Patient, LEGAL STATUS CLASSIFICATION CODE, Status Of Patient Included in the Psychiatric Census and MENTAL HEALTH ACT 2007 MENTAL CATEGORY interrelate.

The underlying LEGAL STATUS CLASSIFICATION CODE of a Mental Health Care Spell will be carried through a period of Supervised Community Treatment although the LEGAL STATUS CLASSIFICATION will be suspended during that period.

PART	SECTIONS	LEGAL STATUS CLASSIFICATION CODE	Status of Patient In Psychiatric Census	MENTAL CATEGORY
Part II	2 - 34	02 - 06	1 or 3	A, B, 9
Part III	35 - 55	07 - 18, 34	1 or 3	A, B, 9
Part IV	56 - 64	Not listed, not relevant		
Part V	65 - 79	Not listed, not relevant		
Part VI	80 - 92	Not listed, not relevant		
Part VII	93 - 113	Not listed, not relevant		
Part VIII	114 - 125	Not listed, not relevant		
Part IX	126 - 130	Not listed, not relevant		
Part X	131 - 149	19 - 20	1 or 3	A, B, 9
Previous legislation (other acts)		30 - 32	1 or 3	A, B, 9
Not detained		01, 33, 35, 36	2	8

The following table is effective until 1st October 2008 and sets out the relationship between Parts and Sections of the Mental Health Act 1983 (amended by the Crime (Sentences) Act 1997), and specifies how the codes in Category of Patient, LEGAL STATUS CLASSIFICATION CODE, Status Of Patient Included in the Psychiatric Census and MENTAL CATEGORY interrelate.

PART	SECTIONS	LEGAL STATUS CLASSIFICATION CODE	Status of Patient In Psychiatric Census	MENTAL CATEGORY
Part II	2 - 34	02 - 06	1 or 3	1 - 5, 9
Part III	35 - 55	07 - 18, 34	1 or 3	1 - 5, 9
Part IV	56 - 64	Not listed, not relevant		
Part V	65 - 79	Not listed, not relevant		
Part VI	80 - 92	Not listed, not relevant		
Part VII	93 - 113	Not listed, not relevant		
Part VIII	114 - 125	Not listed, not relevant		
Part IX	126 - 130	Not listed, not relevant		
Part X	131 - 149	19 - 20	1 or 3	1 - 5, 9
Previous legislation (other acts)		30 - 32	1 or 3	1 - 5, 9
Not detained/ Supervised Discharge under Section 25		01, 33, 35, 36	2	8

MENTAL HEALTH CARE SPELL

Change to Supporting Information: Change to Supporting Information

Mental Health Care Spell is an ACTIVITY GROUP.

A Care Spell.

A continuous period of care or assessment for an adult (including elderly) PATIENT provided by a Health Care Provider's specialist mental health services. This includes the care or assessment of adult and elderly PATIENTS with drug or alcohol dependence but excludes child and adolescent psychiatry PATIENTS and PATIENTS whose only mental disorder is a learning disability. The specialist mental health services are delivered by mental health professionals, some of whom may receive referrals directly. Examples of mental health professionals would include consultants, clinical psychologists, community psychiatric nurses and mental health social workers any of whom could be nominated and allocated as the care coordinator to the PATIENT. ~~There may be more than one Responsible Medical Officer Assignment during the Mental Health Care Spell. Care for the PATIENT's mental health may be provided by more than Responsible Mental Health Care Team.~~ There may be more than one Mental Health Responsible Clinician assigned during the Mental Health Care Spell. Care for the PATIENT's mental health may be provided by more than one Responsible Mental Health Care Team.

A Mental Health Care Spell is initiated by a referral, or the temporary or permanent transfer of main responsibility for provision of mental health care for the PATIENT from another Health Care Provider.

For referrals, the Mental Health Care Spell commences with an initial assessment which will determine whether treatment or care by the Health Care Provider's specialist mental health services is appropriate. If not appropriate, then the Mental Health Care Spell will end. If treatment or care is required then this will usually be provided as part of the care programme approach. Treatment or care provided as part of the care programme approach will involve one or more Care Programme Approach Episodes each with one or more Care Programme Approach Reviews. The date a PATIENT was informed of the outcome of a Mental Health Care Spell assessment or Care Programme Approach Review. The requirement for the PATIENT to be informed of outcomes is laid down in The Patient's Charter - Mental Health Services.

The Mental Health Care Spell addresses the mental health care of the PATIENT and as such may comprise a series of episodes, attendances, contacts or stays each of which will be recorded, for example Consultant Out-Patient Episodes, Consultant Episodes (Hospital Provider), Community Episodes, Care Home Stays (Midwife Care) and Face To Face Contacts Community Care etc. These are recorded in addition to Care Programme Approach Episodes. A PATIENT may be subject to more than one MHC Without Patient Consent.

Treatment requiring the temporary transfer of the PATIENT to another Health Care Provider with the main responsibility for provision of mental health care also being transferred, will end the current Care Programme Approach Episode and initiate a Mental Health Care Spell Suspension. In cases of temporary transfer to another Health Care Provider for physical care without the main responsibility for mental health care being transferred, both the current Care Programme Approach Episode and the Mental Health Care Spell will continue and the Mental Health Care Spell will not be suspended.

Treatment requiring the permanent transfer of the PATIENT to another Health Care Provider will initiate the ending of the current Care Programme Approach Episode and the Mental Health Care Spell.

~~The Mental Health Care Spell ends when all associated episodes, attendances or days are explicitly closed or ended by default where a PATIENT has received in Patient care terminated other than by transfer or death or had a current period of Absence Without Leave (but still liable to detention), within the preceding 3 months.~~ The Mental Health Care Spell ends when all associated episodes, attendances or days are explicitly closed.

~~One or more Leave Of Absence may be granted during the Mental Health Care Spell.~~ One or more Mental Health Leave Of Absence may be granted during the Mental Health Care Spell. At the end of the Mental Health Care Spell the care assessment only indicator can be recorded.

Information recorded for a Mental Health Care Spell includes:

Care Assessment Only Indicator O (only if care spell has ended)
End Date O
Mental Health Care Assessment Date O (only if spell initiated by a referral for assessment)
MENTAL HEALTH CARE SPELL END CODE O
PATIENT INFORMED OF OUTCOME DATE O (only if spell initiated by a referral for assessment)
Start Date

MENTAL HEALTH MINIMUM DATA SET OVERVIEW

Change to Supporting Information: Change to Supporting Information

Mental Health Minimum Data Set Overview

The Mental Health Minimum Data Set was introduced by DSCN20/19/P13 in April 2000 in response to the lack of national clinical data collection in the mental health arena, in line with the information requirements of the emerging National Service Framework for Mental Health.

~~Since April 2003 (DSCN 49/2002) it has been a mandatory requirement that all Providers of specialist adult, including elderly, mental health services submit central Mental Health Minimum Data Set returns on a quarterly basis, with an additional annual submission.~~ Since April 2003 (DSCN 49/2002) it has been a mandatory requirement that all Providers of specialist adult, including elderly, mental health services submit central Mental Health Minimum Data Set returns on a quarterly basis, with an additional annual submission.

~~The Mental Health Minimum Data Set facilitates the collection of person-focussed clinical data and the sharing of such data to underpin the delivery of mental health care.~~ The Mental Health Minimum Data Set facilitates the collection of person-focussed clinical data and the sharing of such data to underpin the delivery of mental health care. It is structured around the clinical process and includes an outcome assessment (Health of the Nation Outcome Scales, or HoNOS). It records the key role played by partner agencies, particularly social services.

~~The Mental Health Minimum Data Set describes Mental Health Care Spells.~~ The Mental Health Minimum Data Set describes Mental Health Care Spells. These comprise all interventions made for a PATIENT by a specialist Mental Health Care Team from initial REFERRAL REQUEST to final discharge. ~~For some individuals the Mental Health Care Spell will comprise a short Out-Patient Episode; for others it may extend over many years and include hospital, community, out-patient and day care episodes.~~ For some individuals the Mental Health Care Spell will comprise a short Consultant Out-Patient Episode; for others it may extend over many years and include hospital, community, out-patient and day care episodes.

~~Information is collected relating to various stages in the PATIENTS journey, including activity such as inpatients, out-patients, community care, and NHS day care episodes; mental health reviews and assessments including Care Programme Approach (CPA) and Health of the National Outcome Scales (HoNOS); contacts with mental health professionals such as care co-ordinators, psychiatric NURSES and CONSULTANTS; and also any diagnosis and treatment.~~ Information is collected relating to various stages in the journey of the PATIENT, including activity such as Hospital Provider Spells, Consultant Out-Patient Episodes, community care, and NHS day care episodes; mental health reviews and assessments including Care Programme Approach (CPA) and Health of the National Outcome Scales (HoNOS); contacts with mental health professionals such as care co-ordinators, psychiatric NURSES and CONSULTANTS; and also any diagnosis and treatment.

~~The prime purpose of the Mental Health Minimum Data Set is to provide local clinicians and managers with better quality information for clinical audit, and service planning and management.~~ The prime purpose of the Mental Health Minimum Data Set is to provide local clinicians and managers with better quality information for clinical audit, and service planning and management.

Central collection provides improved national information, facilitating feedback to Trusts, and the setting of benchmarks. It will also allow the delivery of the National Service Framework for Mental Health priorities to be

monitored.

The Mental Health Minimum Data Set data is collected from NHS Trusts and submitted via the Mental Health Minimum Data Set Assembler to the Secondary Uses Service for storage, analysis and reporting by a variety of stakeholders including the Department of Health, Healthcare Commission, and the Health and Social Care Information Centre.

The Mental Health Minimum Data Set is transmitted to the Secondary Uses Service using Mental Health Minimum Data Set Message Schema Versions

Please note that the collection of the Mental Health Minimum Data Set does not replace any other collection of mental health data such as the Admitted Patient Care Commissioning Data Set Type Detained and/or Long Term Psychiatric Census, which should continue to be collected.

For further information on the Mental Health Minimum Data Set, please view the following Health and Social Care Information Centre website:

http://www.ic.nhs.uk/mentalhealth/mhmds

Mental Health Minimum Data Set Version History

Version	Date Issued	Summary of Changes	DSCN	Implementation Date
1.0	November 1999	Introduction of Mental Health Minimum Data Set	DSCN 20/99/P13	April 2000
1.1	June 2002	Data Standards - Changes to Mental Health Minimum Data Set (MHMDS)	DSCN 27/2002	April 2003
1.2	September 2002	Data Standards - Changes to Mental Health Minimum Data Set (MHMDS)	DSCN 29/2002	April 2003
1.3	October 2002	Data Standards - Changes to Mental Health Minimum Data Set (MHMDS)	DSCN 48/2002	April 2003
2.0	October 2002	Mental Health Minimum Data Set - Mandatory Central returns. This version of the data set incorporates changes defined in DSCN 27/2002, 29/2002 and 48/2002.	DSCN 49/2002	April 2003
2.1	November 2007	Introduction of Mental Health Minimum Data Set Version 2.1	DSCN 37/2007	November 2007
3.0	February 2008	Introduction of Mental Health Minimum Data Set Version 3.0 - incorporating changes required for Mental Health Act 2007 and Public Service Agreement Delivery Agreement 16 (Social Exclusion)	DSCN 06/2008	April 2008

MENTAL HEALTH RESPONSIBLE CLINICIAN

Change to Supporting Information: New Supporting Information

Mental Health Responsible Clinician

A CARE PROFESSIONAL, with a MENTAL HEALTH RESPONSIBLE CLINICIAN PROFESSION within a particular TREATMENT FUNCTION, to act as the clinical supervisor for a Mental Health Care Spell.

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

The role of Mental Health Responsible Clinician was introduced in the Mental Health Act 2007 and replaces the role of the Responsible Medical Officer.

Information recorded for a Mental Health Responsible Clinician includes:

START DATE
END DATE O
CARE PROFESSIONAL IDENTIFIER of the Mental Health Responsible Clinician
TREATMENT FUNCTION CODE under which the Mental Health Responsible Clinician is acting when treating the PATIENT
MENTAL HEALTH RESPONSIBLE CLINICIAN PROFESSION

NURSING EPISODE

Change to Supporting Information: Change to Supporting Information

Nursing Episode is an ACTIVITY GROUP.

A continuous period of residential nursing care for a client (PATIENT) given on site 24 hours a day as part of a Hospital Provider Spell or Care Home Stay (Nursing Care), under the direct care of a NURSE.

The NURSE with overall responsibility for a Nursing Episode must be identified. If the responsible NURSE changes then a new Nursing Episode or Consultant Episode (Hospital Provider) begins.

During a Nursing Episode the PATIENT is either in a care home or in one or more WARDS of a Hospital Site. ~~In some circumstances a PATIENT may take Home Leave, or Leave Of Absence for 28 days or less, or has a current period of Absence Without Leave of 28 days or less, which does not interrupt the Nursing Episode.~~ In some circumstances a PATIENT may take Home Leave, or Mental Health Leave Of Absence for 28 days or less, or has a current period of Mental Health Absence Without Leave of 28 days or less, which does not interrupt the Nursing Episode.

REGULAR ATTENDER EPISODE

Change to Supporting Information: Change to Supporting Information

Regular Attender Episode is an ACTIVITY GROUP.

This is a period of care for a regular day attender attending one or more Day Care Facilities of a Health Care Provider within a particular day care function. ~~Regular day attenders are PATIENTS attending a Day Care Facility who are not currently using a hospital bed or on Home Leave or on Leave Of Absence for a period of 28 days or less.~~ Regular day attenders are PATIENTS attending a Day Care Facility who are not currently using a hospital bed or on Home Leave or on Mental Health Leave Of Absence for a period of 28 days or less.

Regular Attender Episodes must be made up of one or more Day Care Attendances.

Information recorded for a Regular Attender Episode includes:

EPISODE NUMBER
DAY CARE FUNCTION
End Date O
Start Date

RESPONSIBLE MEDICAL OFFICER ASSIGNMENT

Change to Supporting Information: DeletedDeleted

SUPERVISED COMMUNITY TREATMENT

Change to Supporting Information: New Supporting Information

Supervised Community Treatment

Supervised Community Treatment is a type of ACTIVITY GROUP.

Supervised Community Treatment (section 17A) was introduced by the Mental Health Act 2007. It allows a PATIENT, sectioned under the Mental Health Act 1983 as amended in the Mental Health Act 2007, to be treated in the community, with powers to require compliance with a treatment regime, and powers of recall back to hospital for treatment if necessary.

Supervised Community Treatment applies to PATIENTS detained under the Mental Health Act 1983 and as amended in the Mental Health Act 2007, typically section 3 or 37. The underlying section of the PATIENT will be carried through the period in the community although it will be suspended during that period.

The term Supervised Community Treatment refers to the treatment regime and Community Treatment Order to the actual instrument although both terms are used interchangeably.

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

A PATIENT may be recalled to hospital for treatment during a period of Supervised Community Treatment. The recall will not automatically end the Community Treatment Order. Recall can only last for a maximum period of 72 hours. If the PATIENT needs more inpatient treatment, the Community Treatment Order can be revoked and the PATIENT is detained in hospital again.

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

Supervised Community Treatment period can be ended by the following methods:

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

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

Information recorded for a Supervised Community Treatment includes:

START DATE
END DATE O
SUPERVISED COMMUNITY TREATMENT END REASON O

SUPERVISED COMMUNITY TREATMENT RECALL

Change to Supporting Information: New Supporting Information

Supervised Community Treatment Recall

Supervised Community Treatment Recall is a type of ACTIVITY GROUP.

This is when a PATIENT is recalled into hospital for treatment whilst on Supervised Community Treatment under

section 17A of the Mental Health Act 1983 as amended by Mental Health Act 2007. The decision to recall a PATIENT to hospital will be made by the Mental Health Responsible Clinician.

If the Supervised Community Treatment Recall period is less than 72 hours, the recall will not automatically end the Supervised Community Treatment. If a PATIENT is recalled and the time in hospital goes over 72 hours, they must either have their Supervised Community Treatment revoked or continue the Supervised Community Treatment. This will either happen by the PATIENT being discharged from hospital or they could continue staying in hospital as an informal PATIENT but remain on Supervised Community Treatment.

A Supervised Community Treatment Recall can end with the PATIENT being discharged from hospital back to the original Community Treatment Order or with the revocation of the Community Treatment Order should the Mental Health Responsible Clinician see fit and the PATIENT meets the criteria for detention.

Information recorded for a Supervised Community Treatment Recall includes:

START DATE
START TIME
END DATE O
END TIME O

SUPPORTING INFORMATION

Change to Supporting Information: Change to Supporting Information

- NHS Trust Mergers
- ~~Mental Health Act 1983 Table~~
- Mental Health Act Table
- Default Codes Summary Table
- Clinical Coding
- Location Type Codes
- Administrative Codes
- NHS Postcode Directory
- Main Specialty and Treatment Function Codes
- Organisations
- Metadata Files
- Publication Version
- Navigating the NHS Data Model and Dictionary
- The NHS Data Model and Dictionary Elements
- Contact Details
- Disclaimer
- Publication Feedback
- Link to Data Set Change Notices (DSCNs)

WARD STAY

Change to Supporting Information: Change to Supporting Information

Ward Stay is an ACTIVITY GROUP.

The time a PATIENT, using a bed and/or using a delivery facility, stays in one WARD.

Each Ward Stay is within only one Hospital Provider Spell.

~~When a PATIENT takes Home Leave, Leave Of Absence or has a current period of Absence Without Leave, this~~

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

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

For PATIENTS subject to a Mental Health Care Spell the end time of the Ward Stay should be recorded, as well as the start time if systems permit.

For each Ward Stay there should be a named NURSE or MIDWIFE who is responsible for the nursing or midwifery care of the Patient. If the named NURSE or MIDWIFE changes, the change is recorded.

ACCOMMODATION STATUS

Change to Class: New Class

ACCOMMODATION STATUS

A categorisation of the ACCOMMODATION STATUS of the PERSON based on the PERSON's main or permanent residence.

This class is also known by these names:

Context	Alias
plural	ACCOMMODATION STATUSES

Attributes of this Class are:

K ACCOMMODATION STATUS CODE

Each ACCOMMODATION STATUS

may be category for one or more CATEGORY VALUED PERSON OBSERVATION

ACTIVITY GROUP

Change to Class: Change to Description

A subtype of ACTIVITY.

Subtypes of ACTIVITY GROUP are:

CRITICAL CARE PERIOD
PATIENT PATHWAY
REFERRAL TO TREATMENT PERIOD

A continuous period of care or assessment for a PATIENT by one or more CARE PROFESSIONAL. ACTIVITY GROUPS mainly consist of episodes, spells, stays or care periods.

An ACTIVITY GROUP may include one or more CARE ACTIVITIES.

ACTIVITY GROUPS include:

- Accident And Emergency Episode
- Acute Myocardial Infarction Care Spell
- Breast Cancer Care Spell
- Cancer Care Spell
- Care Home Stay (Consultant Care)
- Care Home Stay (Midwife Care)
- Care Home Stay (Nursing Care)
- Care Home Stay (Residential)
- Care Programme Approach Episode
- Care Spell
- Colorectal Cancer Care Spell
- Community Episode
- Consultant Episode (Acute Home-Based)
- Consultant Episode (Hospital Provider)
- Consultant Out-Patient Episode
- Dental Episode
- Drug Misuse Episode
- Genitourinary Episode
- Head And Neck Cancer Care Spell
- Home Dialysis Episode
- Hospital Provider Spell
- Hospital Stay
- Lung Cancer Care Spell
- Mental Health Care Spell
- MHC Without Patient Consent
- Midwife Episode
- Neonatal Level Of Care Period
- Nursing Episode
- Palliative Care Episode
- Person Smoking Cessation Episode
- Pregnancy Episode
- Professional Staff Group Episode
- Regular Attender Episode
- Sarcoma Care Spell
- Skin Cancer Care Spell
- Supervised Discharge Episode
- Supervised Community Treatment
- Supervised Community Treatment Recall
- Supervision Register Episode
- Upper GI Cancer Care Spell
- Urological Cancer Care Spell
- Ward Stay

This class is also known by these names:

Context	Alias
plural	ACTIVITY GROUPS

ACTIVITY GROUP

Change to Class: Change to Attributes

Attributes of this Class are:

A+E INCIDENT LOCATION TYPE
A+E PATIENT GROUP
ACTIVITY GROUP TYPE
ADMISSION METHOD
AMI ADMISSION DIAGNOSIS
AMI ADMISSION WARD TYPE
AMI ADMITTING CONSULTANT TYPE
AMI CAUSE OF DEATH IN HOSPITAL
AMI DISCHARGE DIAGNOSIS
AMI HEART RATE
BONE SARCOMA LOCATION
BROAD PATIENT GROUP CODE
CANCER STATUS
CANCER TREATMENT INTENT
COPD PRESENT
CORONARY ANGIOGRAPHY PERFORMED
CPA LEVEL
DELIVERY FACILITIES ONLY USED
DELIVERY PLACE CHANGE REASON
DIAGNOSTIC ROUTE
DISCHARGE DESTINATION
DISCHARGE METHOD
DISTRIBUTION OF LESIONS PRESENT
ECG DETERMINING TREATMENT
FIRST REGULAR DAY OR NIGHT ADMISSION
FULL POSTNATAL EXAMINATION DATE
GENERAL DENTAL SERVICE INDICATOR
GENETICALLY DETERMINED SKIN CANCER TYPE
GENITOURINARY EPISODE TYPE
INFECTION PROBABLE SOURCE
INITIAL CONTACT TYPE
INTENDED DELIVERY PLACE
INVESTIGATION OR INTERVENTION REFERRAL DATE
MATERNAL RUBELLA STATUS
MENSTRUAL STATUS
MENTAL HEALTH CARE SPELL END CODE
MIDWIFE EPISODE END REASON
NEONATAL LEVEL OF CARE
NON SMOKING CONFIRMED AT 4 WEEKS
NON SMOKING CONFIRMED AT 52 WEEKS
NURSING EPISODE END REASON
NUTRITIONAL SUPPORT PROVIDED TYPE
OUTCOME AT 4 WEEK FOLLOW-UP
OUTCOME AT 52 WEEK FOLLOW-UP
PATIENT CLASSIFICATION
PHARMACEUTICAL SMOKING CESSATION AID
POSSUM SCORE (AFTER SURGERY)
POSSUM SCORE (AT DIAGNOSIS)
PREGNANCY LEAD PROFESSIONAL TYPE

PREGNANCY PREVIOUS CAESAREAN SECTIONS
PREGNANCY PREVIOUS INDUCED ABORTIONS
PREGNANCY TOTAL LIVE BIRTHS
PREGNANCY TOTAL NEONATAL DEATHS
PREGNANCY TOTAL NON-INDUCED ABORTIONS
PREGNANCY TOTAL PREVIOUS PREGNANCIES
PREGNANCY TOTAL STILL BIRTHS
PREVIOUS MATERNAL BLOOD TRANSFUSION
PREVIOUS TREATMENT ELSEWHERE
QUALITY OF LIFE
REHABILITATION REFERRAL
RTA FURTHER ADMISSION PLANNED
SARCOMA CONDITION FIRST SEEN
SARCOMA LARGEST DIAMETER
SARCOMA PART SITE
S CATEGORY FINAL PRETREATMENT
SERUM TUMOUR MARKER PSA AT DIAGNOSIS
SKIN TCELL CLINICAL VARIANT
SKIN TCELL SURFACE AREA
SOFT TISSUE SARCOMA LOCATION
SOURCE OF ADMISSION
SUPERVISED COMMUNITY TREATMENT END REASON
SUPERVISION REGISTER RISK
TELEPHONE CONTACT INDICATOR
WARD STAY TERMINATION REASON

CARE CONTACT

Change to Class: Change to Attributes
Attributes of this Class are:

A+E ARRIVAL MODE
A+E ATTENDANCE CATEGORY
A+E ATTENDANCE DISPOSAL
A+E INITIAL ASSESSMENT TRIAGE CATEGORY
A+E STREAM
ACUTE HOME-BASED TELEPHONE CONTACT
ANTENATAL OR POSTNATAL INDICATOR
BREAST CANCER NURSE SEEN
CARE ACTIVITY INFORMATION
CARE CONTACT TYPE
COLPOSCOPY PRIME PROCEDURE TYPE
CONSULTATION MEDIUM USED
CONSULTATION MEDIUM USED
CONTRACEPTION METHOD MAIN
CONTRACEPTION METHOD POST COITAL
CONTRACEPTIVE ADVICE GIVEN
CONTRACEPTIVE SERVICE TYPE
CPA REVIEW OUTCOME
DENTAL HAEMORRHAGE SERVICE TYPE
DENTAL REFERRAL INDICATOR
ELIGIBILITY OUTCOME
EMERGENCY TREATMENT FEE
EMERGENCY TREATMENT TYPE
FIRST ATTENDANCE

GENITOURINARY CONTACT TYPE CODE
HEALTH PROMOTION STAFF GROUP
HOME HELP USE
INITIAL CONTACT WITHIN FIVE DAYS
IUD APPLICATION DATE
MARKER RESPONSE STATUS
MATERNITY MEDICAL SERVICE TYPE
MATERNITY VISIT CALL REASON
MEDICAL STAFF TYPE SEEING PATIENT
METASTATIC STATUS
NODAL STATUS
NON-NHS COMMUNITY BED USE
NON-NHS DAY CARE FACILITY USE
OUTCOME OF ATTENDANCE
PATIENT INFORMED OF OUTCOME DATE
PATIENT REPORTED SYMPTOMS INDICATOR
PATIENT REPORTED WAIT
PATIENT TRIAL STATUS
PAYMENT FROM PATIENT RECEIVED
POSTNATAL CARE INDICATOR
PRIMARY TUMOUR STATUS
SETTLED ACCOMMODATION INDICATOR
SHELTERED WORK FACILITY USE
SIGHT TEST DOMICILIARY VISIT TYPE
SIGHT TEST FORM COMPLETED
SIGHT TEST PERSON SUBSIDY TYPE
SKIN TUMOUR STATUS
~~SOCIAL WORKER INVOLVEMENT~~
STATUTORY ASSESSMENT TYPE
SURVEILLANCE RESULT

CARE PLAN

Change to Class: Change to Attributes
Attributes of this Class are:

K CARE PLAN NUMBER
CANCER CARE PLAN INTENT
CARE PLAN AGREED DATE
CARE PLAN TYPE
MULTIDISCIPLINARY TEAM DISCUSSION DATE
NO CANCER TREATMENT REASON
PATIENT ON IMMUNOSUPPRESSIVE THERAPY
PRIMARY CARE COMMUNICATION SENT DATE
RECURRENCE INDICATOR
SOCIAL WORKER INVOLVEMENT INDICATOR

CARE PROFESSIONAL

Change to Class: Change to Description

Subtypes of CARE PROFESSIONAL include:

CONSULTANT

GENERAL PRACTITIONER
NURSE OR MIDWIFE
OPHTHALMIC MEDICAL PRACTITIONER
OPHTHALMIC OPTICIAN
OTHER CARE PROFESSIONAL

A PERSON who is professionally qualified to practise the delivery of care services.

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

This class is also known by these names:

Context	Alias
plural	CARE PROFESSIONALS

CARE PROFESSIONAL

Change to Class: Change to Attributes
Attributes of this Class are:

K	CARE PROFESSIONAL IDENTIFIER
	GYNAECOLOGICAL ONCOLOGY ACCREDITATION
	MENTAL HEALTH RESPONSIBLE CLINICIAN PROFESSION
	OVERSEAS SURGICAL TEAM MEMBER
	PRIVATE CONTROLLED DRUG PRESCRIBER

CATEGORY VALUED PERSON OBSERVATION

Change to Class: Change to Description

A type of PERSON PROPERTY.

Observations made regarding a PATIENT. These observations do not include information about a treatment or intervention. The observer may be a related PATIENT or a CARE PROFESSIONAL.

CATEGORY VALUED PERSON OBSERVATION allows coded classifications of observations about a PATIENT, whereas MEASURED PERSON OBSERVATION allows for recording of measurements about a PATIENT.

CATEGORY VALUED PERSON OBSERVATIONS include:

- ACCOMMODATION STATUS
- ALCOHOL STATUS
- ASPIRIN THERAPY LOCATION
- BLEED COMPLICATION
- ETHNIC CATEGORY
- JOINT REPLACEMENT REVISION CLASSIFICATION
- LANGUAGE CLASSIFICATION
- LEGAL STATUS CLASSIFICATION
- PATIENT CLINICAL GROUP
- PERFORMANCE STATUS
- PERSON GENDER
- PERSON MARITAL STATUS

- SARCOMA PREDISPOSING CONDITION
- SEXUAL ORIENTATION
- SKIN LYMPHOMA MORPHOLOGY

This class is also known by these names:

Context	Alias
plural	CATEGORY VALUED PERSON OBSERVATIONS

CATEGORY VALUED PERSON OBSERVATION

Change to Class: Change to Attributes
Attributes of this Class are:

CATEGORY VALUED PERSON OBSERVATION TYPE
JOINT IMPLANT REVISION INDICATOR
LANGUAGE USAGE
LEGAL STATUS RESTRICTIVENESS
MENTAL CATEGORY
(retired October 2008)
MENTAL HEALTH ACT 2007 MENTAL CATEGORY
PERSON GENDER TYPE

CATEGORY VALUED PERSON OBSERVATION

Change to Class: Change to Relationships
Each CATEGORY VALUED PERSON OBSERVATION

~~must be categorised by one and only one~~ ~~ALCOHOL STATUS~~
must be categorised by one and only one ACCOMMODATION STATUS
or must be categorised by one and only one ALCOHOL STATUS
or must be catergorised by one and only one ASPIRIN THERAPY LOCATION
or must be categorised by one and only one BLEED COMPLICATION
or must be categorised by one and only one ETHNIC CATEGORY
or must be categorised by one and only one JOINT REPLACEMENT REVISION CLASSIFICATION
or must be categorised by one and only one LANGUAGE CLASSIFICATION
or must be categorised by one and only one LEGAL STATUS CLASSIFICATION
or must be categorised by one and only one PATIENT CLINICAL GROUP
or must be categorised by one and only one PERFORMANCE STATUS
or must be categorised by one and only one PERSON GENDER
or must be categorised by one and only one PERSON MARITAL STATUS
or must be categorised by one and only one SARCOMA PREDISPOSING CONDITION
or must be categorised by one and only one SEXUAL ORIENTATION
or must be categorised by one and only one SKIN LYMPHOMA MORPHOLOGY

DAILY WARD LISTING

Change to Class: Change to Description

This records all the activity that has occurred in the WARD in the previous 24 hours and the bed availability status of the WARD. DAILY WARD LISTINGS should be completed at midnight, or during the working day in wards only open for limited periods.

Beds may be reserved and unavailable for a variety of reasons, including when they are vacated by PATIENTS who are on Home Leave.

~~A bed vacated by a PATIENT while on Home Leave or Leave Of Absence for 28 days or less, or with a current period of Absence Without Leave of 28 days or less, may be recorded on the DAILY WARD LISTING, if unoccupied, as reserved and not available because of Home Leave, Leave Of Absence or Absence Without Leave.~~ A bed vacated by a PATIENT while on Home Leave or Mental Health Leave Of Absence for 28 days or less, or with a current period of Absence Without Leave of 28 days or less, may be recorded on the DAILY WARD LISTING, if unoccupied, as reserved and not available because of Home Leave, Mental Health Leave Of Absence or Absence Without Leave.

However, if a bed that is reserved for whatever reason is occupied by another PATIENT it should be recorded as available and occupied.

Beds may be used sometimes by healthy persons accompanying a PATIENT. When this occurs the bed should be recorded as unavailable because it is being used by a healthy person.

Bed availability should be measured in terms of bed days for all WARDS which are open overnight. WARDS open only during the day time or at night should be separately identified and the bed availability measured on the basis of the number of days or nights for which a service is being provided. For WARDS open overnight, bed availability should be measured as at midnight.

For WARDS only open during the day, bed availability should be measured in the morning. If a WARD is open for five days and four nights, the bed availability on the fifth day should be measured in the morning.

This class is also known by these names:

Context	Alias
plural	DAILY WARD LISTINGS

EMPLOYMENT

Change to Class: New Class

EMPLOYMENT

A subtype of PERSON PROPERTY.

The EMPLOYMENT STATUS of a PERSON and the number of hours worked during a week.

This class is also known by these names:

Context	Alias
plural	EMPLOYMENTS

Attributes of this Class are:

EMPLOYMENT STATUS
WEEKLY HOURS WORKED

This class has no relationships.

LEAVE

Change to Class: Change to Description

LEAVE occurs when a PATIENT who is using a bed in a hospital WARD or care home, spends a period of time outside the hospital WARD or care home.

For some types of LEAVE, the PATIENT is intended to return after a specified period.

LEAVE includes:

- ~~Absence Without Leave~~
- Mental Health Absence Without Leave
- Home Leave
- ~~Leave Of Absence~~
- Mental Health Leave Of Absence

This class is also known by these names:

Context	Alias
plural	LEAVE

ABSENCE WITHOUT LEAVE END REASON

Change to Attribute: Change to Description

~~A classification which identifies the reason an occurrence of LEAVE was ended.~~A coding which identifies the reason an occurrence of Mental Health Absence Without Leave ended.

~~*Classification:*~~ *National Codes:*

~~a.~~	~~Patient returned voluntarily~~
01	PATIENT returned voluntarily
~~b.~~	~~Patient is taken back into custody~~
02	PATIENT is taken back into custody
03	PATIENT fails to return by the end of the relevant period for which they are liable to be detained or subject to guardianship
~~c.~~	~~Patient fails to return within six months beginning from the first day of absence~~
04	PATIENT discharged, care or treatment finished
~~d.~~	~~Patient fails to return by the end of the period for which they are liable to be detained or subject to guardianship~~
~~e.~~	~~Patient discharged, care or treatment finished~~
~~f.~~	~~Patient died~~
05	PATIENT died

This attribute is also known by these names:

Context	Alias
plural	ABSENCE WITHOUT LEAVE END REASONS

ACCOMMODATION STATUS CODE

Change to Attribute: New Attribute

ACCOMMODATION STATUS CODE

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

National Codes:

MA00	**Mainstream Housing**
MA01	Owner occupier
MA02	Settled mainstream housing with family/friends
MA03	Shared ownership scheme e.g. Social Homebuy Scheme (tenant purchase percentage of home value from landlord)
MA04	Tenant - Local Authority/Arms Length Management Organisation/Registered Landlord
MA05	Tenant - Housing Association
MA06	Tenant - private landlord
MA09	Other mainstream housing
HM00	**Homeless**
HM01	Rough sleeper
HM02	Squatting
HM03	Night shelter/emergency hostel/Direct access hostel (temporary accommodation accepting self referrals, no waiting list and relatively frequent vacancies)
HM04	Sofa surfing (sleeps on different friends floor each night)
HM05	Placed in temporary accommodation by Local Authority (including Homelessness resettlement service) e.g. Bed and Breakfast accommodation
HM06	Staying with friends/family as a short term guest
HM07	Other homeless
MH00	**Accommodation with mental health care support**
MH01	Supported accommodation (accommodation supported by staff or resident caretaker)
MH02	Supported lodgings (lodgings supported by staff or resident caretaker)
MH03	Supported group home (supported by staff or resident caretaker)
MH04	Mental Health Registered Care Home
MH09	Other accommodation with mental health care and support
HS00	**Acute/long stay healthcare residential facility/hospital**
HS01	NHS acute psychiatric ward
HS02	Independent hospital/clinic
HS03	Specialist rehabilitation/recovery
HS04	Secure psychiatric unit
HS05	Other NHS facilities/hospital
HS09	Other acute/long stay healthcare residential facility/hospital
CH00	**Accommodation with other (not specialist mental health) care support**
CH01	Foyer - accommodation for young people aged 16-25 who are homeless or in housing need
CH02	Refuge
CH03	Non-Mental Health Registered Care Home
CH09	Other accommodation with care and support (not specialist mental health)
CJ00	**Accommodation with criminal justice support**
CJ01	Bail/Probation hostel
CJ02	Prison
CJ03	Young Offenders Institution
CJ04	Detention Centre
CJ09	Other accommodation with criminal justice support such as ex-offender support
SH00	**Sheltered Housing (accommodation with a scheme manager or warden living on the premises or nearby, contactable by an alarm system if necessary)**
SH01	Sheltered housing for older persons
SH02	Extra care sheltered housing (also known as 'very sheltered housing'. For people who are less able to manage on their own, but who do need an extra level of care. Services offered vary between

schemes, but meals and some personal care are often provided.)

SH03 Nursing Home for older persons

SH09 Other sheltered housing

ML00 **Mobile accommodation**

Other

OC96 Not elsewhere classified

This attribute is also known by these names:

Context	Alias
plural	ACCOMMODATION STATUS CODES

ACTIVITY GROUP TYPE

Change to Attribute: Change to Description

One of the business definitions listed in the ACTIVITY GROUP class as a type of this class.

Consultant Episode (Hospital Provider) has four 'sub types' (General, Birth, Delivery and Detained and Long Term Psychiatric Patient Census) which form four individual ACTIVITY GROUP TYPE values.

National Codes:

01 Accident And Emergency Episode

02 Acute Myocardial Infarction Care Spell

03 Augmented Care Period (retired 1 Apr 2006) - **Retired CP724**

04 Breast Cancer Care Spell

05 Cancer Care Spell

06 Care Home Stay (Consultant Care)

07 Care Home Stay (Midwife Care)

08 Care Home Stay (Nursing Care)

09 Care Home Stay (Residential)

10 Care Programme Approach Episode

11 Colorectal Cancer Care Spell

12 Community Episode

13 Consultant Episode (Acute Home-Based)

14 Consultant Episode (Hospital Provider)

15 Consultant Out-Patient Episode

16 Dental Episode

17 Drug Misuse Episode

18 Genitourinary Episode

19 Head And Neck Cancer Care Spell

20 Home Dialysis Episode

21 Hospital Provider Spell

22 Lung Cancer Care Spell

23 Mental Health Care Spell

23 MHC Without Patient Consent

24 Midwife Episode

25 Neonatal Level Of Care Period

26 Nursing Episode

27 Palliative Care Episode

28 Person Smoking Cessation Episode

29 Pregnancy Episode

30 Professional Staff Group Episode
31 Regular Attender Episode
32 ROAD TRAFFIC ACCIDENT Treatment
33 Sarcoma Care Spell
34 Skin Cancer Care Spell
35 Supervised Discharge Episode
36 Supervision Register Episode
37 Upper GI Cancer Care Spell
38 Urological Cancer Care Spell
39 Ward Stay
40 Hospital Stay
41 Care Spell
42 CRITICAL CARE PERIOD
43 PATIENT PATHWAY
44 REFERRAL TO TREATMENT PERIOD
45 Supervised Community Treatment
46 Supervised Community Treatment Recall

Note: The list is not in alphabetical order.

This attribute is also known by these names:

Context	Alias
plural	ACTIVITY GROUP TYPES

CARE PROFESSIONAL ROLE CODE

Change to Attribute: Change to Description

Identifies the role undertaken by a CARE PROFESSIONAL during an ACTIVITY.

There may be several different value sets for a role which are identified by the CARE PROFESSIONAL ROLE TYPE. ~~Two examples of sets of values which might be used are given below.~~ Examples of sets of values which might be used are given below.

A role undertaken by a CARE PROFESSIONAL within a ACTIVITY such as a Mental Health Care Spell or a Hospital Provider Spell is classified as follows.

Classifications:

a. Responsible clinician
b. Shared care clinician

A Role undertaken by a CARE PROFESSIONAL within a CLINICAL INTERVENTION is classified as follows.

Classifications:

a. Performs the procedure
b. General Anaesthesia Administrator
c. Local Anaesthesia Administrator
d. Assists the procedure

~~References:~~
~~National Joint Registry Dataset: v.~~ References:

A Professional Advice and Support Staff Group are a grouping of staff carrying out activities in a Professional Advice And Support Programme. Their roles in activities may be classified as follows.

Classification:

a. Community medical officers
b. Health visitors
c. School nurses
d. Contact tracing nurses
e. Health education officers

This attribute is also known by these names:

Context	Alias
plural	CARE PROFESSIONAL ROLE CODES

EMPLOYMENT STATUS

Change to Attribute: Change to Description

~~An indication of whether a PATIENT is employed or unemployed.~~

The current EMPLOYMENT STATUS of the PATIENT.

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 for a business a relative owns).

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 such as education or training includes 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.
It includes the following:

- Students who are undertaking full (at least 16 hours per week) or part-time (less than 16 hours per week) education or training and who are not working or actively seeking work;
- The long-term sick or disabled, including those who are receiving Incapacity Benefit, income support or both, and who are not working or actively seeking work;
- Those looking after the family or home and who are not working or actively seeking work;
- Those who are not receiving benefits and who are not working or actively seeking work;
- Those who are in unpaid voluntary work who are not working or actively seeking work;
- Those of working age who have retired from paid work.

~~*Classification:*~~ *National Codes:*

~~a. Employed~~

01 Employed
~~b. Unemployed~~
02 Unemployed
~~c. Other~~
03 Other employment status such as in education or training

This attribute is also known by these names:

Context	Alias
plural	EMPLOYMENT STATUSES

LEAVE OF ABSENCE END REASON

Change to Attribute: Change to Description

~~A classification which identifies the reason a Leave Of Absence was terminated.~~ A coding which identifies the reason a Mental Health Leave Of Absence was terminated.

~~*Classification:*~~ *National Codes:*

~~a. Patient returned on or before day specified~~
~~b. Leave revoked and patient recalled by The Responsible Medical Officer~~
~~c. Period of leave to be extended~~
~~d. Patient failed to return on or before day specified and is absent without leave~~
~~e. Patient's liability for detention terminated by Responsible Medical Officer~~
~~f. Patient's liability for detention terminated by Mental Health Act Review Tribunal~~
~~g. Patient's liability for detention terminated by Hospital Managers~~
~~h. Patient death~~
~~i. Other~~
01 PATIENT returned on or before day specified
02 Leave revoked and PATIENT recalled by Mental Health Responsible Clinician
03 Period of leave to be extended
04 PATIENT failed to return on or before day specified and is absent without leave
05 PATIENT's liability for detention terminated by Mental Health Responsible Clinician
06 PATIENT's liability for detention terminated by Mental Health Act Review Tribunal
07 PATIENT's liability for detention terminated by Hospital Managers
08 PATIENT died
96 Other

This attribute is also known by these names:

Context	Alias
plural	LEAVE OF ABSENCE END REASONS

MENTAL CATEGORY

Change to Attribute: Change to Description
This attribute is effective until 30th September 2008. From 1st October 2008 MENTAL HEALTH ACT 2007 MENTAL CATEGORY should be used.

The mental category of detained PATIENTS only, and it should be classified as designated in the Mental Health Act 1983. A PATIENT should be included under only one MENTAL CATEGORY.

Note: PATIENTS detained under Section 2, 4, 5, 135 and 136 of the Mental Health Act 1983 do not have a specified form of mental disorder and, therefore, the 'not specified' classification should be used.

National Codes:

1 Mental illness
2 Mental impairment
3 Severe mental impairment
4 Psychopathic disorder
5 Not specified

This attribute is also known by these names:

Context	Alias
plural	MENTAL CATEGORIES

MENTAL HEALTH ACT 2007 MENTAL CATEGORY

Change to Attribute: New Attribute

MENTAL HEALTH ACT 2007 MENTAL CATEGORY

The mental category of detained PATIENTS as designated in the Mental Health Act 2007 to be used from 1 October 2008. A PATIENT should be included under only one MENTAL HEALTH ACT 2007 MENTAL CATEGORY.

National Codes:

A Mental disorder (without Learning Disability)
B Mental disorder (with Learning Disability)

This attribute is also known by these names:

Context	Alias
plural	MENTAL HEALTH ACT 2007 MENTAL CATEGORIES

MENTAL HEALTH RESPONSIBLE CLINICIAN PROFESSION

Change to Attribute: New Attribute

MENTAL HEALTH RESPONSIBLE CLINICIAN PROFESSION

The profession in which the CARE PROFESSIONAL has been trained and been approved to be able to act as a clinical supervisor for a Mental Health Care Spell provided they meet appropriate standards and competencies following training. The Mental Health Responsible Clinician for a PATIENT with a Mental Health Care Spell will be one of these CARE PROFESSIONALS approved from a particular profession.

National Codes:

01 Registered Medical Practitioners such as CONSULTANTS or GENERAL MEDICAL PRACTITIONERS)
02 Mental Health Nurse (first level registered with the Nursing and Midwifery Council)
03 Learning Disability Nurse (first level registered with the Nursing and Midwifery Council)
04 Psychologist (listed in the British Psychological Society register of chartered psychologists)
05 Occupational Therapist (registered with the Health Professions Council)
06 Social Worker (registered with the General Social Care Council)

This attribute is also known by these names:

Context	Alias
plural	MENTAL HEALTH RESPONSIBLE CLINICIAN PROFESSIONS

PLANNED LEAVE RETURN DATE

Change to Attribute: Change to Description

~~The planned return date of a Leave Of Absence.~~ The planned return date of a Mental Health Leave Of Absence.

This attribute is also known by these names:

Context	Alias
plural	PLANNED LEAVE RETURN DATES

SETTLED ACCOMMODATION INDICATOR

Change to Attribute: New Attribute

SETTLED ACCOMMODATION INDICATOR

An indication of whether the main/permanent residence of a PATIENT is settled or non-settled accommodation.

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

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

National Codes:

0 Non-settled Accommodation
1 Settled Accommodation

This attribute is also known by these names:

Context	Alias
plural	SETTLED ACCOMMODATION INDICATORS

SOCIAL WORKER INVOLVEMENT

Change to Attribute: Change to Name

~~SOCIAL WORKER INVOLVEMENT~~ SOCIAL WORKER INVOLVEMENT INDICATOR

SOCIAL WORKER INVOLVEMENT renamed SOCIAL WORKER INVOLVEMENT INDICATOR

Change to Attribute: Change to Aliases

An indication of whether or not a PATIENT's CARE PLAN, established during a Care Programme Approach Review, includes face to face contacts or involvement with local authority social services social workers.

National Codes:

0 no involvement of social worker
1 involvement of social worker

This attribute is also known by these names:

Context	Alias
~~plural~~	~~SOCIAL WORKER INVOLVEMENTS~~
plural	SOCIAL WORKER INVOLVEMENT INDICATORS
formerly	SOCIAL WORKER INVOLVEMENT

SUPERVISED COMMUNITY TREATMENT END REASON

Change to Attribute: New Attribute

SUPERVISED COMMUNITY TREATMENT END REASON

The reason for the termination of a period of Supervised Community Treatment.

National Codes:

01 PATIENT discharged
02 Supervised Community Treatment revoked
03 PATIENT died
04 PATIENT transferred outside England

This attribute is also known by these names:

Context	Alias
plural	SUPERVISED COMMUNITY TREATMENT END REASONS

WEEKLY HOURS WORKED

Change to Attribute: New Attribute

WEEKLY HOURS WORKED

The number of hours worked per week by a PERSON.

National Codes:

01	30+ hours
02	16-29 hours
03	5-15 hours
04	1-4 hours

This attribute is also known by these names:

Context	Alias
plural	WEEKLY HOURS WORKED

ABSENCE WITHOUT LEAVE END DATE

Change to Data Element: New Data Element

ABSENCE WITHOUT LEAVE END DATE

Format/length:	see DATE
HES item:	
National Codes:	
Default Codes:	

Notes:
This is the same as attribute LEAVE END DATE where the LEAVE TYPE is National Code 01 *Absence Without Leave*. This is the end date of a period of Mental Health Absence Without Leave for a PATIENT detained under the Mental Health Acts 1983.

This data element is also known by these names:

Context	Alias
plural	ABSENCE WITHOUT LEAVE END DATES

ABSENCE WITHOUT LEAVE END REASON (LAST)

Change to Data Element: New Data Element

ABSENCE WITHOUT LEAVE END REASON (LAST)

Format/length:	n2
HES item:	
National Codes:	See ABSENCE WITHOUT LEAVE END REASON
Default Codes:	99 Not known

Notes:
This is the ABSENCE WITHOUT LEAVE END REASON for the **last** Mental Health Absence Without Leave of the PATIENT, involving an overnight stay, that ended within the REPORTING PERIOD.

This data element is also known by these names:

Context	Alias
plural	ABSENCE WITHOUT LEAVE END REASONS (LAST)

ABSENCE WITHOUT LEAVE START DATE

Change to Data Element: New Data Element

ABSENCE WITHOUT LEAVE START DATE

Format/length:	see DATE
HES item:	
National Codes:	
Default Codes:	

Notes:
This is the same as attribute LEAVE START DATE where the LEAVE TYPE is National Code 01 *Absence Without Leave*. This is the start date of a period of Mental Health Absence Without Leave for a PATIENT detained under the Mental Health Acts 1983 as amended by the Mental Health Act 2007.

This data element is also known by these names:

Context	Alias
plural	ABSENCE WITHOUT LEAVE START DATES

ABSENCE WITHOUT LEAVE TOTAL

Change to Data Element: New Data Element

ABSENCE WITHOUT LEAVE TOTAL

Format/length:	n3
HES item:	
National Codes:	
Default Codes:	

Notes:
This is the total number of separate periods of Mental Health Absence Without Leave for the PATIENT within the Mental Health Care Spell and the REPORTING PERIOD where there has been an overnight stay.

This data item will be zero if the PATIENT has not been subject to any periods of Mental Health Absence Without Leave within the REPORTING PERIOD.

This is derived from any ABSENCE WITHOUT LEAVE START DATES and ABSENCE WITHOUT LEAVE END DATES within the REPORTING PERIOD. Only periods of Mental Health Absence Without Leave that have ended within the REPORTING PERIOD and those that have involved an overnight stay should be included.

This data element is also known by these names:

Context	Alias
plural	ABSENCE WITHOUT LEAVE TOTALS

ABSENCE WITHOUT LEAVE TOTAL DAYS

Change to Data Element: New Data Element

ABSENCE WITHOUT LEAVE TOTAL DAYS

Format/length:	n3
HES item:	
National Codes:	
Default Codes:	

Notes:
This is the total number of days within a Mental Health Care Spell and the REPORTING PERIOD that the PATIENT was Absent Without Leave that involved an overnight stay.

This data item will be zero if the REPORTING PERIOD has not been subject to any periods of Mental Health Absence Without Leave within the REPORTING PERIOD that involved an overnight stay.

This is derived from any ABSENCE WITHOUT LEAVE START DATES and ABSENCE WITHOUT LEAVE END DATES within the REPORTING PERIOD.

This data element is also known by these names:

Context	Alias
plural	ABSENCE WITHOUT LEAVE TOTALS DAYS

ACCOMMODATION STATUS (MENTAL HEALTH)

Change to Data Element: New Data Element

ACCOMMODATION STATUS (MENTAL HEALTH)

Format/length:	an4
HES item:	
National Codes:	See ACCOMMODATION STATUS CODE
Default Codes:	OC97 Not specified
	OC98 Not applicable
	OC99 Not known

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

The ACCOMMODATION STATUS CODE of PATIENTS with any mental disorder should be captured periodically, typically as part of the PATIENT's regular Care Programme Approach Review. The data item should be based on the PATIENT's main or permanent residence.

This data element is also known by these names:

Context	Alias
plural	ACCOMMODATION STATUSES (MENTAL HEALTH)

BED DAYS (MENTAL HEALTH)

Change to Data Element: Change to Description

Format/length:	n3
HES item:	
National Codes:	
Default Codes:	

Notes:
BED DAYS (MENTAL HEALTH) is optional in the Mental Health Minimum Dataset (MHMDS) collection record. It should only be present if:

a. one or more Consultant Episode (Hospital Provider) within the Mental Health Care Spell has occurred during the REPORTING PERIOD

and

~~b. where the main TREATMENT FUNCTION of the CONSULTANT is for an adult or mental illness MAIN SPECIALTY. The adult or mental illness MAIN SPECIALTIES being 700, 710, 712, 713 and 715.~~

b. where the MAIN SPECIALTY of the CONSULTANT is for an adult or mental illness MAIN SPECIALTY. The adult or mental illness MAIN SPECIALTIES being 700, 710, 712, 713 and 715.

It is the total number of bed days within the REPORTING PERIOD. Each period of bed days is recorded by a Consultant Episode (Hospital Provider) within a Hospital Provider Spell and there may be more than one such episode or stay during the course of a Mental Health Care Spell. This excludes any admissions to Hospital Provider Spell where the PATIENT CLASSIFICATION is National Code 2 'Day case admission'. This includes both Hospital Stays and Care Home Stays (Consultant Care) within the Hospital Provider Spell.

There is a Start Date and End Date for each Consultant Episode (Hospital Provider) and the calculation is based upon those bed days which have occurred during the REPORTING PERIOD adjusted for where periods of bed days overlap the REPORTING PERIOD START DATE and/or REPORTING PERIOD END DATE (this includes where the period of bed days has not yet ended). Where such overlaps occur the REPORTING PERIOD START DATE and/or REPORTING PERIOD END DATE should be used instead of that of the Consultant Episode (Hospital Provider).

BED DAYS (MENTAL HEALTH) is the sum of the calculated periods of bed days and should be recorded left justified with leading zeros. ~~The calculation should be adjusted for any periods of Leave Of Absence or Absence Without Leave of 28 days or less.~~ The calculation should be adjusted for any periods of Mental Health Leave Of Absence or Mental Health Absence Without Leave of 28 days or less.

~~A PATIENT going on Home Leave, or Leave Of Absence for 28 days or less, or who has a current period of Absence Without Leave of 28 days or less, does not interrupt the Consultant Episode (Hospital Provider) but are not using a bed during their period of absence.~~ A PATIENT going on Home Leave, or Mental Health Leave Of Absence for 28 days or less, or who has a current period of Mental Health Absence Without Leave of 28 days or less, does not interrupt the Consultant Episode (Hospital Provider) but are not using a bed during their period of absence.

Consultant Episode (Hospital Provider), Mental Health Care Spell, Hospital Provider Spell, Hospital Stay and Care Home Stay (Consultant Care) are the same as ACTIVITY GROUP where the ACTIVITY GROUP TYPE identifies the specific spell, episode or stay type.

~~Leave Of Absence, Absence Without Leave and Home Leave are instances of LEAVE where the LEAVE TYPE identifies the leave type.~~ Mental Health Leave Of Absence, Mental Health Absence Without Leave and Home

Leave are instances of LEAVE where the LEAVE TYPE identifies the leave type.

Start Date and End Date are the same as ACTIVITY DATE TIME where the ACTIVITY DATE TIME TYPE identifies the date type.

This data element is also known by these names:

Context	Alias
plural	BED DAYS (MENTAL HEALTH)

BED DAYS (MENTAL HEALTH INTENSIVE)

Change to Data Element: Change to Description

Format/length:	n3
HES item:	
National Codes:	
Default Codes:	

Notes:
BED DAYS (MENTAL HEALTH INTENSIVE) is optional in the Mental Health Minimum Dataset (MHMDS) collection record. It should only be present if:

a. one or more Consultant Episodes (Hospital Provider) within the Mental Health Care Spell has occurred during the REPORTING PERIOD

and

~~b. where the main TREATMENT FUNCTION of the CONSULTANT is for an adult or mental illness MAIN SPECIALTY. The adult or mental illness MAIN SPECIALTIES being 700, 710, 712, 713 and 715.~~

b. where the MAIN SPECIALTY of the CONSULTANT is for an adult or mental illness MAIN SPECIALTY. The adult or mental illness MAIN SPECIALTIES being 700, 710, 712, 713 and 715.

and

c. where the PATIENT was admitted to a bed in a WARD with a CLINICAL CARE INTENSITY National Code 51 'Specially designated ward for patients needing containment and more intensive management. This is not to be confused with intensive nursing where a patient may require one to one nursing while on a standard ward'.

It is the total number of bed days within the REPORTING PERIOD. Each period of bed days is recorded by a Consultant Episode (Hospital Provider) within a Hospital Provider Spell and there may be more than one such episode or stay during the course of a Mental Health Care Spell. This excludes any admissions to Hospital Provider Spells where the PATIENT CLASSIFICATION is National Code 2 'Day case admission'. This includes both Hospital Stays and Care Home Stays (Consultant Care) within the Hospital Provider Spell.

There is a Start Date and End Date for each Consultant Episode (Hospital Provider) and the calculation is based upon those bed days which have occurred during the REPORTING PERIOD adjusted for where periods of bed days overlap the REPORTING PERIOD START DATE and/or REPORTING PERIOD END DATE (this includes where the period of bed days has not yet ended). Where such overlaps occur the REPORTING PERIOD START DATE and/or REPORTING PERIOD END DATE should be used instead of that of the Consultant Episode (Hospital Provider).

BED DAYS (MENTAL HEALTH INTENSIVE) is the sum of the calculated periods of bed days and should be recorded left justified with leading zeros. ~~The calculation should be adjusted for any periods of Leave Of Absence or Absence Without Leave of 28 days or less.~~ The calculation should be adjusted for any periods of Mental Health Leave Of Absence or Mental Health Absence Without Leave of 28 days or less.

~~A PATIENT going on Home Leave, or Leave Of Absence for 28 days or less, or who has a current period of Absence Without Leave of 28 days or less, does not interrupt the Consultant Episode (Hospital Provider) but are~~

~~not using a bed during their period of absence.~~ A PATIENT going on Home Leave, or Mental Health Leave Of Absence for 28 days or less, or who has a current period of Mental Health Absence Without Leave of 28 days or less, does not interrupt the Consultant Episode (Hospital Provider) but are not using a bed during their period of absence.

Consultant Episode (Hospital Provider), Mental Health Care Spell, Hospital Provider Spell, Hospital Stay and Care Home Stay (Consultant Care) are the same as ACTIVITY GROUP where the ACTIVITY GROUP TYPE identifies the specific spell, episode or stay type.

~~Leave Of Absence, Absence Without Leave and Home Leave are instances of LEAVE where the LEAVE TYPE identifies the leave type.~~ Mental Health Leave Of Absence, Mental Health Absence Without Leave and Home Leave are instances of LEAVE where the LEAVE TYPE identifies the leave type.

Start Date and End Date are the same as ACTIVITY DATE TIME where the ACTIVITY DATE TIME TYPE identifies the date type.

This data element is also known by these names:

Context	Alias
plural	BED DAYS (MENTAL HEALTH INTENSIVE)

BED DAYS (MENTAL HEALTH MEDIUM SECURE)

Change to Data Element: Change to Description

Format/length:	n3
HES item:	
National Codes:	
Default Codes:	

Notes:
BED DAYS (MENTAL HEALTH MEDIUM SECURE) is optional in the Mental Health Minimum Dataset (MHMDS) collection record. It should only be present if:

a. one or more Consultant Episode (Hospital Provider) within the Mental Health Care Spell has occurred during the REPORTING PERIOD

and

~~b. where the main TREATMENT FUNCTION of the CONSULTANT is for an adult or mental illness MAIN SPECIALTY. The adult or mental illness MAIN SPECIALTIES being 700, 710, 712, 713 and 715.~~

b. where the MAIN SPECIALTY of the CONSULTANT is for an adult or mental illness MAIN SPECIALTY. The adult or mental illness MAIN SPECIALTIES being 700, 710, 712, 713 and 715.

and

c. where the PATIENT was admitted to an ORGANISATION SITE, SERVICE POINT or WARD with a SECURE ACCOMMODATION TYPE classification b. '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'.

It is the total number of bed days within the REPORTING PERIOD. Each period of bed days is recorded by a Consultant Episode (Hospital Provider) within a Hospital Provider Spell and there may be more than one such episode or stay during the course of a Mental Health Care Spell. This excludes any admissions to Hospital Provider Spells where the PATIENT CLASSIFICATION is National Code 2 'Day case admission'. This includes both Hospital Stays and Care Home Stays (Consultant Care) within the Hospital Provider Spell.

There is a Start Date and End Date for each Consultant Episode (Hospital Provider) and the calculation is based upon those bed days which have occurred during the REPORTING PERIOD adjusted for where periods of bed days overlap the REPORTING PERIOD START DATE and/or REPORTING PERIOD END DATE (this includes where

the period of bed days has not yet ended). Where such overlaps occur the REPORTING PERIOD START DATE and/or REPORTING PERIOD END DATE should be used instead of that of the Consultant Episode (Hospital Provider).

BED DAYS (MENTAL HEALTH MEDIUM SECURE) is the sum of the calculated periods of bed days and should be recorded left justified with leading zeros. ~~The calculation should be adjusted for any periods of Leave Of Absence or Absence Without Leave of 28 days or less.~~ The calculation should be adjusted for any periods of Mental Health Leave Of Absence or Mental Health Absence Without Leave of 28 days or less.

~~A PATIENT going on Home Leave, or Leave Of Absence for 28 days or less, or who has a current period of Absence Without Leave of 28 days or less, does not interrupt the Consultant Episode (Hospital Provider) but are not using a bed during their period of absence.~~ A PATIENT going on Home Leave, or Mental Health Leave Of Absence for 28 days or less, or who has a current period of Mental Health Absence Without Leave of 28 days or less, does not interrupt the Consultant Episode (Hospital Provider) but are not using a bed during their period of absence.

Consultant Episode (Hospital Provider), Mental Health Care Spell, Hospital Provider Spell, Hospital Stay and Care Home Stay (Consultant Care) are the same as ACTIVITY GROUP where the ACTIVITY GROUP TYPE identifies the specific spell, episode or stay type.

~~Leave Of Absence, Absence Without Leave and Home Leave are instances of LEAVE where the LEAVE TYPE identifies the leave type.~~ Mental Health Leave Of Absence, Mental Health Absence Without Leave and Home Leave are instances of LEAVE where the LEAVE TYPE identifies the leave type.

Start Date and End Date are the same as ACTIVITY DATE TIME where the ACTIVITY DATE TIME TYPE identifies the date type.

This data element is also known by these names:

Context	Alias
plural	BED DAYS (MENTAL HEALTH MEDIUM SECURE)

BED DAYS (MENTAL HEALTH NHS COMMUNITY CARE)

Change to Data Element: Change to Description

Format/length:	n3
HES item:	
National Codes:	
Default Codes:	

Notes:
BED DAYS (MENTAL HEALTH NHS COMMUNITY CARE) is optional in the Mental Health Minimum Dataset (MHMDS) collection record. It should only be present if:

a. one or more Care Home Stay (Nursing Care) and/or Care Home Stay (Residential) within the Mental Health Care Spell has occurred during the REPORTING PERIOD

and

b. where the BROAD PATIENT GROUP CODE is National Code 5 'Patients with mental illness'

and

c. where the Care Home is operated and managed by an NHS ORGANISATION as classified by ORGANISATION TYPE

It is the total number of bed days within the REPORTING PERIOD. Each period of bed days is recorded by a Care Home Stay (Nursing Care) or Care Home Stay (Residential) and there may be more than one such stay during

the course of a Mental Health Care Spell.

There is a Start Date and End Date for each Care Home Stay (Nursing Care) or Care Home Stay (Residential) and the calculation is based upon those bed days which have occurred during the REPORTING PERIOD adjusted for where periods of bed days overlap the REPORTING PERIOD START DATE and/or REPORTING PERIOD END DATE (this includes where the period of bed days has not yet ended). Where such overlaps occur the REPORTING PERIOD START DATE and/or REPORTING PERIOD END DATE should be used instead of that of the Care Home Stay (Nursing Care) or Care Home Stay (Residential).

BED DAYS (MENTAL HEALTH NHS COMMUNITY CARE) is the sum of the calculated periods of bed days and should be recorded left justified with leading zeros. ~~The calculation should be adjusted for any periods of Leave Of Absence or Absence Without Leave of 28 days or less.~~ The calculation should be adjusted for any periods of Mental Health Leave Of Absence or Mental Health Absence Without Leave of 28 days or less.

~~A PATIENT going on Home Leave, or Leave Of Absence for 28 days or less, or who has a current period of Absence Without Leave of 28 days or less, does not interrupt the Care Home Stay (Nursing Care) or Care Home Stay (Residential) but are not using a bed during their period of absence.~~ A PATIENT going on Home Leave, or Mental Health Leave Of Absence for 28 days or less, or who has a current period of Mental Health Absence Without Leave of 28 days or less, does not interrupt the Care Home Stay (Nursing Care) or Care Home Stay (Residential) but are not using a bed during their period of absence.

Care Home Stay (Nursing Care), Care Home Stay (Residential) and Mental Health Care Spell are the same as ACTIVITY GROUP where the ACTIVITY GROUP TYPE identifies the specific spell, episode or stay type.

~~Leave Of Absence, Absence Without Leave and Home Leave are instances of LEAVE where the LEAVE TYPE identifies the leave type.~~ Mental Health Leave Of Absence, Mental Health Absence Without Leave and Home Leave are instances of LEAVE where the LEAVE TYPE identifies the leave type.

Start Date and End Date are the same as ACTIVITY DATE TIME where the ACTIVITY DATE TIME TYPE identifies the date type.

Care Home is an ORGANISATION SITE where the Care Home is an ORGANISATION SITE.

This data element is also known by these names:

Context	Alias
plural	BED DAYS (MENTAL HEALTH NHS COMMUNITY CARE)

CATEGORY OF PATIENT

Change to Data Element: Change to Description

Format/length:	n2
HES item:	CATEGORY
National Codes:	Click on the attribute tab to display the attribute that contains the National Codes.
Default Codes:	

Notes:

~~This data item is not in the CDS. At the NHS-wide Clearing Service, the code values of ADMINISTRATIVE CATEGORY CODE and LEGAL STATUS CLASSIFICATION CODE are extracted and included in the HES extract. HES uses them to derive the HES data item CATEGORY OF PATIENT.~~ This data item is not in the Commissioning Data Set. At the NHS-wide Clearing Service, the code values of ADMINISTRATIVE CATEGORY CODE and LEGAL STATUS CLASSIFICATION CODE are extracted and included in the Hospital Episode Statistics extract. Hospital Episode Statistics uses them to derive the Hospital Episode Statistics data item CATEGORY OF PATIENT.

~~See the Mental Health Act 1983 Table for details of how CATEGORY OF PATIENT relates to Parts and Sections of the Act.~~ See the Mental Health Act Table for details of how CATEGORY OF PATIENT relates to Parts and Sections of the Act.

This data element is also known by these names:

Context	Alias
plural	CATEGORIES OF PATIENT

CONTACTS (CONSULTANT PSYCHOTHERAPY)

Change to Data Element: Marked as Retired, DeletedRetired

CONTACTS (PSYCHOTHERAPY)

Change to Data Element: New Data Element

CONTACTS (PSYCHOTHERAPY)

Format/length:	n3
HES item:	
National Codes:	
Default Codes:	

Notes:
This is an optional data element in the Mental Health Minimum Data Set and should only be present if:

a. one or more CARE CONTACTS within the Mental Health Care Spell has occurred during the REPORTING PERIOD

and

b. where the TREATMENT FUNCTION for the CARE PROFESSIONAL is 713 'PSYCHOTHERAPY'

It is the total number of such contacts within the REPORTING PERIOD.

There is a Contact Date for each CARE CONTACT and the calculation is based upon those contacts which have occurred during the REPORTING PERIOD. Where the CARE PROFESSIONAL is also the allocated Care Programme Approach care coordinator for the PATIENT then a Face To Face Contact CPA Care Coordinator should also be recorded.

Mental Health Care Spell is an ACTIVITY GROUP where the ACTIVITY GROUP TYPE is National Code 23 '*Mental Health Care Spell*'.

Contact Date is the same as attribute ACTIVITY DATE of ACTIVITY DATE TIME where the ACTIVITY DATE TIME TYPE is National Code 39 '*Contact Date*'.

This data element is also known by these names:

Context	Alias
plural	CONTACTS (PSYCHOTHERAPY)

EMPLOYMENT STATUS (MENTAL HEALTH)

Change to Data Element: New Data Element

EMPLOYMENT STATUS (MENTAL HEALTH)

Format/length:	n2
HES item:	
National Codes:	See EMPLOYMENT STATUS
Default Codes:	97 - Not disclosed (PATIENT was asked but refused to respond) 98 - Not applicable (PATIENT has not received secondary mental health services or is not aged 18-69) 99 Not known

Notes:
This is the same as attribute EMPLOYMENT STATUS.

Required to be captured locally from 1st April 2008 and nationally from October 2008.

The EMPLOYMENT STATUS (MENTAL HEALTH) of PATIENTS with any mental disorder should be captured periodically for all PATIENTS aged 18-69, typically as part of the PATIENT's regular Care Programme Approach Review or as part of other informal reviews. The data item should reflect the EMPLOYMENT STATUS (MENTAL HEALTH) of the PATIENT in the seven days prior to the review.

PATIENTS who meet the criteria for being employed (1 or more hours per week) or unemployed may also be undertaking another form of activity, such as education or training, unpaid voluntary work, or looking after home or family. PATIENTS in such circumstances should only be reported as employed or unemployed and should not be reported in the 'other' category. For example:
- 'Patient A' is in paid work (4 hours per week) and in full-time education or training. 'Patient A' should only be reported as employed.
- 'Patient B' is unemployed (i.e.not in paid work but actively seeking work and available to start) and in unpaid voluntary work. 'Patient B' should be reported as unemployed.

This data element is also known by these names:

Context	Alias
plural	EMPLOYMENT STATUSES (MENTAL HEALTH)

END DATE

Change to Data Element: Change to Description

Format/length:	see DATE
HES item:	
National Codes:	
Default Codes:	

Notes:
~~END DATE is a generalised element used in more than one message which is an ACTIVITY DATE of ACTIVITY DATE TIME where ACTIVITY DATE TIME TYPE is National Code 11 *'End Date'*, containing the end date of an episode.~~ END DATE is a generalised element definition which can be applied to the end of a stay, episode, period covered by a plan or other time period. This is the ACTIVITY DATE of ACTIVITY DATE TIME where ACTIVITY DATE TIME TYPE is National Code 11 *'End Date'*.

This data element is also known by these names:

Context	Alias
plural	END DATES

END DATE (MENTAL HEALTH CARE SPELL)

Change to Data Element: Change to Description

Format/length:	see DATE
HES item:	
National Codes:	
Default Codes:	

Notes:
END DATE (MENTAL HEALTH CARE SPELL) is the same as attribute ACTIVITY DATE of ACTIVITY DATE TIME where ACTIVITY DATE TIME TYPE is National Code 11 *'End Date'*. It is an optional data element in the Mental Health Minimum Dataset (MHMDS) collection record and should only be present if the Mental Health Care Spell has ended.

~~The Mental Health Care Spell ends when all associated episodes, attendances or days are explicitly closed or ended by default where a PATIENT has received in-patient care terminated other than by transfer or death or had a current period of Absence Without Leave (but still liable to detention), within the preceding 3 months.~~ The Mental Health Care Spell ends when all associated episodes, attendances or days are explicitly closed or ended by default where a PATIENT has received in-patient care terminated other than by transfer or death or had a current period of Mental Health Absence Without Leave (but still liable to detention), within the preceding 3 months.

For Mental Health Minimum Dataset purposes where the Health Care Provider cannot initiate and maintain Mental Health Care Spell it is the function of the assembler process itself to determine whether the assembled Mental Health Care Spell has ended or not, and provide the appropriate date to be used for the END DATE (MENTAL HEALTH CARE SPELL).

Mental Health Care Spell is an ACTIVITY GROUP where ACTIVITY GROUP TYPE is National Code 23 *'Mental Health Care Spell'*.

~~Absence Without Leave is a LEAVE where LEAVE TYPE is National Code 01 *'Absence Without Leave'*.~~ Mental Health Absence Without Leave is a LEAVE where LEAVE TYPE is National Code 01 *'Absence Without Leave'*.

This data element is also known by these names:

Context	Alias
plural	END DATES (MENTAL HEALTH CARE SPELLS)

END TIME

Change to Data Element: New Data Element

END TIME

Format/length:	see TIME
HES item:	
National Codes:	

Default Codes:	

Notes:
END TIME has a generalised definition which can be applied to the start of a stay, episode, period covered by a plan or other time period.

This is the ACTIVITY TIME of the ACTIVITY DATE TIME with an ACTIVITY DATE TIME TYPE of National Code 56 *'End Time'*.

This data element is also known by these names:

Context	Alias
plural	END TIMES

LEAVE OF ABSENCE END DATE

Change to Data Element: New Data Element

LEAVE OF ABSENCE END DATE

Format/length:	see LEAVE END DATE
HES item:	
National Codes:	
Default Codes:	

Notes:
This is the same as attribute LEAVE END DATE where the LEAVE TYPE is National Code 03 *Leave of Absence*. This is the end date of a period of Mental Health Leave Of Absence for a PATIENT detained under the Mental Health Acts 1983 as amended by the Mental Health Act 2007.

This data element is also known by these names:

Context	Alias
plural	LEAVE OF ABSENCE END DATES

LEAVE OF ABSENCE END REASON (LAST)

Change to Data Element: New Data Element

LEAVE OF ABSENCE END REASON (LAST)

Format/length:	n2
HES item:	
National Codes:	See LEAVE OF ABSENCE END REASON
Default Codes:	99 Not known

Notes:
This is the LEAVE OF ABSENCE END REASON for the **last** Mental Health Leave Of Absence of the PATIENT, involving an overnight stay, that ended within the REPORTING PERIOD.

This data element is also known by these names:

Context	Alias
plural	LEAVE OF ABSENCE END REASONS (LAST)

LEAVE OF ABSENCE START DATE

Change to Data Element: New Data Element

LEAVE OF ABSENCE START DATE

Format/length:	see DATE
HES item:	
National Codes:	
Default Codes:	

Notes:
This is the same as attribute LEAVE START DATE where the LEAVE TYPE is National Code 03 *Leave of Absence*. This is the start date of a period of Mental Health Leave Of Absence for a PATIENT detained under the Mental Health Acts 1983 as amended by the Mental Health Act 2007.

This data element is also known by these names:

Context	Alias
plural	LEAVE OF ABSENCE START DATES

LEAVE OF ABSENCE TOTAL

Change to Data Element: New Data Element

LEAVE OF ABSENCE TOTAL

Format/length:	n3
HES item:	
National Codes:	
Default Codes:	

Notes:
This is the number of complete periods of Mental Health Leave Of Absence for the PATIENT within the Mental Health Care Spell and the REPORTING PERIOD where there has been an overnight stay.

This data item will be zero if the PATIENT has not been subject to any periods of Mental Health Leave Of Absence within the REPORTING PERIOD.

This is derived from any LEAVE OF ABSENCE START DATE and LEAVE OF ABSENCE END DATE within the REPORTING PERIOD. Only periods of Mental Health Leave Of Absence that have ended within the REPORTING PERIOD and those that have involved an overnight stay should be included.

This data element is also known by these names:

Context	Alias
plural	LEAVE OF ABSENCE TOTALS

LEAVE OF ABSENCE TOTAL DAYS

Change to Data Element: New Data Element

LEAVE OF ABSENCE TOTAL DAYS

Format/length:	n3
HES item:	
National Codes:	
Default Codes:	

Notes:
This is the total number of days within a Mental Health Care Spell and the REPORTING PERIOD that the PATIENT was on Mental Health Leave Of Absence that involved an overnight stay.

This data item will be zero if the PATIENT has not been subject to any Mental Health Leave Of Absence within the REPORTING PERIOD that involved an overnight stay.

This is derived from any LEAVE OF ABSENCE START DATES and LEAVE OF ABSENCE END DATES within the REPORTING PERIOD.

This data element is also known by these names:

Context	Alias
plural	LEAVE OF ABSENCE TOTALS DAYS

MAIN SPECIALTY CODE (MENTAL HEALTH)

Change to Data Element: Change to Description

Format/length:	n3
HES item:	
~~National Codes:~~	
National Codes:	See Main Specialty And Treatment Function Codes
Default Codes:	

Notes:
~~The latest main psychiatric specialty recorded for the PATIENT within a Mental Health Care Spell.~~ This is the MAIN SPECIALTY CODE of the Mental Health Responsible Clinician for the PATIENT within the REPORTING PERIOD. If there is more than one during the REPORTING PERIOD, this will be the last or final one of REPORTING PERIOD.

~~It is the MAIN SPECIALTY CODE of:~~

If the Mental Health Responsible Clinician is the PATIENT's GENERAL MEDICAL PRACTITIONER, the code will be 600. If the Mental Health Responsible Clinician is a CONSULTANT, it will typically be one of the adult or elderly mental health MAIN SPECIALTIES, although it may be either a learning disability or child and adolescent psychiatry in certain circumstances. When the Mental Health Responsible Clinician is not a CONSULTANT, this should be the appropriate pseudo-specialty code or left blank.

The allowable values are listed below:

~~Consultant Episode (Acute Home Based)~~

600	General Medical Practice
700	Learning Disability
710	Adult Mental Illness
~~or~~	~~Consultant Episode (Hospital Provider)~~
711	Child and Adolescent Psychiatry
712	Forensic Psychiatry
713	Psychotherapy
~~or~~	~~Consultant Out-Patient Episode~~
715	Old Age Psychiatry
950	Nursing Episode
960	Allied Health Professional Episode

~~with the latest ACTIVITY DATE of the ACTIVITY DATE TIME TYPE 'Start Date' within the assembled Mental Health Care Spell.~~

~~See Main Specialty And Treatment Function Codes for the full list of codes.~~

This data element is also known by these names:

Context	Alias
plural	MAIN SPECIALTY CODES (MENTAL HEALTH)

MENTAL CATEGORY

Change to Data Element: Change to Description

Format/length:	n1
HES item:	MENTCAT
~~National Codes:~~	~~Click on the attribute tab to display the attribute that contains the National Codes.~~
National Codes:	See MENTAL CATEGORY
Default Codes:	8 - Not applicable (i.e. not detained) 9 - Not known: a validation error

Notes:
~~See Mental Health Act 1983 Table for details of how MENTAL CATEGORIES relates to Parts and Sections of the Act.~~ See Mental Health Act Table for details of how MENTAL CATEGORIES relates to Parts and Sections of the Act. This data element is effective until 30th September 2008. From 1st October 2008 MENTAL HEALTH ACT 2007 MENTAL CATEGORY should be used.

This data element is also known by these names:

Context	Alias
plural	MENTAL CATEGORIES

MENTAL HEALTH ACT 2007 MENTAL CATEGORY

Change to Data Element: New Data Element

MENTAL HEALTH ACT 2007 MENTAL CATEGORY

Format/length:	an1
HES item:	
National Codes:	See MENTAL HEALTH ACT 2007 MENTAL CATEGORY
Default Codes:	8 - Not applicable (i.e. not detained) 9 - Not known

Notes:
See Mental Health Act Table for details of how MENTAL HEALTH ACT 2007 MENTAL CATEGORY relates to Parts and Sections of the Act.

PATIENTS detained under Section 2, 4, 5, 135 and 136 of the Mental Health Act 1983 do not have a specified form of mental disorder and, therefore, the 'not specified' classification should be used.

This data element is also known by these names:

Context	Alias
plural	MENTAL HEALTH ACT 2007 MENTAL CATEGORIES

MENTAL HEALTH CARE AND LEGAL STATUS HISTORY

Change to Data Element: Change to Description

~~Format/length:~~	~~an3312~~
Format/length:	an4048
HES item:	
National Codes:	
Default Codes:	

Notes:
The mental health care provided to a PATIENT and their Legal Status on each day of the REPORTING PERIOD. ~~This data is recorded within the Mental Health Minimum Dataset (MHMDS) record as a bit pattern string assembled from relevant daily activity, Legal Status and MENTAL CATEGORY data.~~ This data element is generated by the Mental Health Minimum Data Set Assembler as a bit pattern string assembled from recorded relevant daily activity, Legal Status and MENTAL HEALTH ACT 2007 MENTAL CATEGORY data.

Each day is represented by 9 bytes with each bit set on if appropriate as follows:

Byte	Bit	Content if bit set on
1	1	Legal Status : Informal
1	2	Legal Status : Section 2
1	3	Legal Status : Section 3
1	4	Legal Status : Section 4
1	5	Legal Status : Section 5(2)
1	6	not used
1	7	Legal Status : Section 5(4)
1	8	Legal Status : Section 35
2	1	Legal Status : Section 36
2	2	Legal Status : Section 37 with section 41 restrictions
2	3	Legal Status : Section 37
2	4	Legal Status : Section 38
2	5	Legal Status : Section 44
2	6	not used
2	7	Legal Status : Section 46
2	8	Legal Status : Section 47 with section 49 restrictions

3	1	Legal Status : Section 47
3	2	Legal Status : Section 48 with section 49 restrictions
3	3	Legal Status : Section 48
3	4	Legal Status : Section 135
3	5	Legal Status : Section 136
3	6	not used
3	7	Legal Status : Supervised discharge
3	8	Legal Status : Criminal Procedures (Insanity) Act
4	1	Legal Status : Formally detained under other acts
4	2	Legal Status : Subject to Guardianship Section 7
4	3	Legal Status : Subject to Guardianship Section 37
4	4	Legal Status : Section 45A
4	5	not used
4	6	not used
4	7	not used
4	8	not used
~~5~~	~~1~~	~~MENTAL CATEGORY : Mental Illness~~
5	1	not used
~~5~~	~~2~~	~~MENTAL CATEGORY : Mental Impairment~~
5	2	not used
~~5~~	~~3~~	~~MENTAL CATEGORY : Severe mental impairment~~
5	3	not used
~~5~~	~~4~~	~~MENTAL CATEGORY : Psychopathic disorder~~
5	4	not used
~~5~~	~~5~~	~~MENTAL CATEGORY : Not specified~~
5	5	not used
5	6	not used
~~5~~	~~7~~	~~Mental Category not applicable~~
5	7	MENTAL HEALTH ACT 2007 MENTAL CATEGORY: not applicable
~~5~~	~~8~~	~~Mental Category not known~~
5	8	MENTAL HEALTH ACT 2007 MENTAL CATEGORY: not known
6	1	Care contact: OUT-PATIENT ATTENDANCE CONSULTANT (MENTAL HEALTH)
6	2	Care contact: CONTACTS (COMMUNITY PSYCHIATRIC NURSE)
6	3	Care contact: CONTACTS (CLINICAL PSYCHOLOGIST)
6	4	Care contact: CONTACTS (OCCUPATIONAL THERAPIST)
6	5	Care contact: CONTACTS (SOCIAL WORKER)
6	6	not used
6	7	Care contact: OUT-PATIENT DID NOT ATTENDS (MENTAL HEALTH)
~~6~~	~~8~~	~~Care contact: CONTACTS (CONSULTANT PSYCHOTHERAPY)~~
6	8	Care contact: CONTACTS (PSYCHOTHERAPY)
7	1	Care contact: DAY CARE ATTENDANCE (MENTAL HEALTH NHS SITE)
7	2	Care contact: CONTACTS (NHS DIRECT MENTAL HEALTH)
7	3	Care contact: not used
7	4	Care contact: CONTACTS (PHYSIOTHERAPIST)
7	5	Care contact: CARE DAYS (ACUTE HOME-BASED)
7	6	not used
7	7	Care contact: DAY CARE DID NOT ATTENDS (MENTAL HEALTH NHS SITE)
7	8	Care contact: PROCEDURE (ECT TREATMENTS ADMINISTERED)
8	1	Care stay: BED DAYS (MENTAL HEALTH)
8	2	Care stay: BED DAYS (MENTAL HEALTH INTENSIVE)
8	3	Care stay: BED DAYS (MENTAL HEALTH MEDIUM SECURE)
8	4	MENTAL HEALTH CARE TEAM TYPE: General Adult Psychiatry
8	5	MENTAL HEALTH CARE TEAM TYPE: Psychiatry of old age
8	6	not used

8	7	MENTAL HEALTH CARE TEAM TYPE: Substance of Misuse Team
8	8	MENTAL HEALTH CARE TEAM TYPE: Home Treatment/Crisis Resolution
9	1	Mental Health Care Spell: In being
9	2	CPA LEVEL: Standard
9	3	CPA LEVEL: Enhanced
9	4	Care Programme Approach Review: Held
9	5	MENTAL HEALTH CARE TEAM TYPE: Early Intervention in Psychosis
9	6	not used
9	7	MENTAL HEALTH CARE TEAM TYPE: Assertive Outreach Team
9	8	MENTAL HEALTH CARE TEAM TYPE: Other Teams
10	1	Supervised Community Treatment
10	2	Supervised Community Treatment Recall
10	3	Mental Health Leave Of Absence
10	4	Mental Health Absence Without Leave
10	5	not used
10	6	not used
10	7	MENTAL HEALTH ACT 2007 MENTAL CATEGORY: A (Mental Disorder without Learning Disability)
10	8	MENTAL HEALTH ACT 2007 MENTAL CATEGORY: B (Mental Disorder with Learning Disability)
11	1-8	Supervised Community Treatment Recall Hours

This data element is also known by these names:

Context	Alias
plural	MENTAL HEALTH CARE AND LEGAL STATUS HISTORIES

MENTAL HEALTH RESPONSIBLE CLINICIAN PROFESSION

Change to Data Element: New Data Element

MENTAL HEALTH RESPONSIBLE CLINICIAN PROFESSION

Format/length:	n2
HES item:	
National Codes:	See MENTAL HEALTH RESPONSIBLE CLINICIAN PROFESSION
Default Codes:	98 - Not applicable

Notes:
This is the same as attribute MENTAL HEALTH RESPONSIBLE CLINICIAN PROFESSION.

This data element is also known by these names:

Context	Alias
plural	MENTAL HEALTH RESPONSIBLE CLINICIAN PROFESSIONS

OCCUPATION (CPA CARE COORDINATOR)

Change to Data Element: Change to Description

Format/length:	an3
HES item:	
National Codes:	

Default Codes:

Notes:

~~For purposes of the Mental Health Minimum Data Set (MHMDS) collection, OCCUPATION (CPA CARE COORDINATOR) is the NHS occupation or non-NHS occupation of the Mental Health Care Team Member allocated as the named CPA care coordinator at the end of the REPORTING PERIOD.~~ For purposes of the Mental Health Minimum Data Set collection, OCCUPATION (CPA CARE COORDINATOR) is the NHS occupation or non-NHS occupation of the Mental Health Care Team Member allocated as the named Care Programme Approach care coordinator at the end of the REPORTING PERIOD.

~~This is derived from the ROLE END DATE and ROLE START DATE of CARE PROFESSIONAL ROLE with the MENTAL HEALTH CARE TEAM TYPE classifying whether the CPA care coordinator is an NHS or Non-NHS employee.~~ This is derived from the ROLE END DATE and ROLE START DATE of CARE PROFESSIONAL ROLE with the MENTAL HEALTH CARE TEAM TYPE classifying whether the Care Programme Approach care coordinator is an NHS or Non-NHS employee.

NHS occupations are defined in the NHS Occupation Code Manual.

~~The following is used to classify the occupation of a Mental Health Care Team Member who is directly employed by a non-NHS organisation and cannot be classified by an NHS occupation.~~ The following is used to classify the occupation of a Mental Health Care Team Member who is directly employed by a non-NHS ORGANISATION and cannot be classified by an NHS occupation.

Classification:

~~a~~	~~Social Worker~~ ~~i. Approved Social Worker – approved by Social Services to deal with persons suffering from mental disorder~~ ~~ii. Other~~
a	Approved Mental Health Professional
b	Probation Officer
c	Child Care Officer
d	Community Officer
e	Community Worker
f	Welfare Officer
g	Matron/Manager - Nursing Home
h	Warden/Manager - Residential Care Home or Group Home
i	Manager - Hostel or Sheltered Work Facility
j	Care Assistant
k	Care Attendant
l	Home Care Assistant
m	Night Care Assistant
~~n~~	~~Other~~
n	Other Social Worker
o	Other

This data element is also known by these names:

Context	Alias
plural	OCCUPATIONS (CPA CARE COORDINATOR)

SETTLED ACCOMMODATION INDICATOR (MENTAL HEALTH)

Change to Data Element: New Data Element

SETTLED ACCOMMODATION INDICATOR (MENTAL HEALTH)

Format/length:	n1
HES item:	
National Codes:	See SETTLED ACCOMMODATION INDICATOR
Default Codes:	7 Not disclosed 8 Not applicable 9 Not known

Notes:
This is the same as attribute SETTLED ACCOMMODATION INDICATOR.

Required to be collected locally from 1st April 2008 and nationally from October 2008.

The SETTLED ACCOMMODATION INDICATOR of the PATIENT with any mental disorder should be captured periodically, typically as part of the PATIENT's regular Care Programme Approach Review.

This data element is also known by these names:

Context	Alias
plural	SETTLED ACCOMMODATION INDICATORS (MENTAL HEALTH)

SOCIAL WORKER INVOLVEMENT

Change to Data Element: Change to Name

~~SOCIAL WORKER INVOLVEMENT~~ SOCIAL WORKER INVOLVEMENT INDICATOR

SOCIAL WORKER INVOLVEMENT renamed SOCIAL WORKER INVOLVEMENT INDICATOR

Change to Data Element: Change to Description

~~Format/length:~~	~~n~~
Format/length:	n1
HES item:	
~~National Codes:~~	~~Click on the attribute tab to display the attribute that contains the National Codes.~~
National Codes:	See SOCIAL WORKER INVOLVEMENT INDICATOR
Default Codes:	

Notes:
~~This is an optional data element in the Mental Health Minimum Dataset (MHMDS) collection record and should only be present if at least one Care Programme Approach Review within the Mental Health Care Spell during the REPORTING PERIOD recorded a SOCIAL WORKER INVOLVEMENT.~~ This is an optional data element in the Mental Health Minimum Data Set and should only be present if at least one Care Programme Approach Review within the Mental Health Care Spell during the REPORTING PERIOD recorded a SOCIAL WORKER INVOLVEMENT INDICATOR.

Care Programme Approach Review is a CARE CONTACT where the CARE CONTACT TYPE is National Code 05 '*Care Programme Approach Review*'.

Mental Health Care Spell is an ACTIVITY GROUP where ACTIVITY GROUP TYPE is National Code 23 '*Mental Health Care Spell*'.

This data element is also known by these names:

Context	Alias
~~plural~~	~~SOCIAL WORKER INVOLVEMENTS~~
plural	SOCIAL WORKER INVOLVEMENT INDICATORS

START DATE

Change to Data Element: Change to Description

Format/length:	see DATE
HES item:	
National Codes:	
Default Codes:	

Notes:
START DATE has a generalised definition which can be applied to the start of a stay, episode, period covered by a plan or other time period. This is the ACTIVITY DATE of the ACTIVITY DATE TIME with an ACTIVITY DATE TIME TYPE of National Code 31 *'Start Date'*.

This data element is also known by these names:

Context	Alias
plural	START DATES

START TIME

Change to Data Element: New Data Element

START TIME

Format/length:	see TIME
HES item:	
National Codes:	
Default Codes:	

Notes:
START TIME has a generalised definition which can be applied to the start of a stay, episode, period covered by a plan or other time period.

This is the ACTIVITY TIME of the ACTIVITY DATE TIME with an ACTIVITY DATE TIME TYPE of National Code 61 *'Start Time'*.

This data element is also known by these names:

Context	Alias
plural	START TIMES

STATUS OF PATIENT INCLUDED IN THE PSYCHIATRIC CENSUS

Change to Data Element: Change to Description

Format/length:	n1
HES item:	CENSAT
National Codes:	
Default Codes:	

Notes:
The information about the current detained status is derived from LEGAL STATUS CLASSIFICATION CODE (AT CENSUS DATE) and the length of stay in hospital derived from details held about the current Hospital Provider Spell

~~See Mental Health Act 1983 Table for details of how this data item relates to Parts and Sections of the Act.~~ See Mental Health Act Table for details of how this data item relates to Parts and Sections of the Act.

The following values can be used:

1 Detained patient
2 Long term patient
3 Detained and long term patient

Hospital Provider Spell is an ACTIVITY GROUP where ACTIVITY GROUP TYPE is National Code 21 '*Hospital Provider Spell*'.

This data element is also known by these names:

Context	Alias
plural	STATUSES OF PATIENT INCLUDED IN THE PSYCHIATRIC CENSUS

SUPERVISED COMMUNITY TREATMENT DISCHARGES TOTAL

Change to Data Element: New Data Element

SUPERVISED COMMUNITY TREATMENT DISCHARGES TOTAL

Format/length:	n3
HES item:	
National Codes:	
Default Codes:	

Notes:
This is the number of complete periods of Supervised Community Treatment for the PATIENT within the Mental Health Care Spell and the REPORTING PERIOD that have ended with the PATIENT being discharged.

This data item will be zero if the PATIENT has not been subject to any Supervised Community Treatment discharges within the REPORTING PERIOD.

This is derived from the START DATE and END DATE for any period of Supervised Community Treatment within the Mental Health Care Spell during the REPORTING PERIOD where the SUPERVISED COMMUNITY TREATMENT END REASON is National Code 1 *'Patient discharged'*.

This data element is also known by these names:

Context	Alias
plural	SUPERVISED COMMUNITY TREATMENT DISCHARGES TOTALS

SUPERVISED COMMUNITY TREATMENT RECALLS TOTAL

Change to Data Element: New Data Element

SUPERVISED COMMUNITY TREATMENT RECALLS TOTAL

Format/length:	n3
HES item:	
National Codes:	
Default Codes:	

Notes:
This is the total number of periods of Supervised Community Treatment Recall for the PATIENT within the Mental Health Care Spell and the REPORTING PERIOD.

This data item will be zero if the PATIENT has not been subject to any periods of Supervised Community Treatment Recall within the REPORTING PERIOD.

This is derived from the START DATE and END DATE for any period of Supervised Community Treatment Recall within the Mental Health Care Spell during the REPORTING PERIOD.

This data element is also known by these names:

Context	Alias
plural	SUPERVISED COMMUNITY TREATMENT RECALLS TOTALS

SUPERVISED COMMUNITY TREATMENT REVOCATIONS TOTAL

Change to Data Element: New Data Element

SUPERVISED COMMUNITY TREATMENT REVOCATIONS TOTAL

Format/length:	n3
HES item:	
National Codes:	
Default Codes:	

Notes:
This is the number of complete periods of Supervised Community Treatment for the PATIENT within the Mental Health Care Spell and the REPORTING PERIOD that have ended with the Community Treatment Order being revoked.

This data item will be zero if the PATIENT has not been subject to any periods of Supervised Community Treatment where it has ended with the Community Treatment Order being revoked within the REPORTING PERIOD.

This is derived from the START DATE and END DATE for any period of Supervised Community Treatment within the Mental Health Care Spell during the REPORTING PERIOD where the SUPERVISED COMMUNITY TREATMENT

END REASON is National Code 2 *'Supervised Community Treatment revoked'*.

This data element is also known by these names:

Context	Alias
plural	SUPERVISED COMMUNITY TREATMENT REVOCATIONS TOTALS

SUPERVISED COMMUNITY TREATMENT TOTAL

Change to Data Element: New Data Element

SUPERVISED COMMUNITY TREATMENT TOTAL

Format/length:	n3
HES item:	
National Codes:	
Default Codes:	

Notes:
This is the number of separate periods of Supervised Community Treatment for the PATIENT within the Mental Health Care Spell and the REPORTING PERIOD.

This data item will be zero if the PATIENT has not been subject to any periods of Supervised Community Treatment within the REPORTING PERIOD.

This is derived from the START DATE and END DATE for any period of Supervised Community Treatment within the Mental Health Care Spell during the REPORTING PERIOD.

This data element is also known by these names:

Context	Alias
plural	SUPERVISED COMMUNITY TREATMENT TOTALS

WEEKLY HOURS WORKED

Change to Data Element: New Data Element

WEEKLY HOURS WORKED

Format/length:	n2
HES item:	
National Codes:	See WEEKLY HOURS WORKED
Default Codes:	97 - Not disclosed (PATIENT was asked but refused to respond) 98 - Not applicable (PATIENT not employed or has not received secondary mental health services) 99 - Not known

Notes:
This is the same as attribute WEEKLY HOURS WORKED.

Required to be collected locally from 1st April 2008 and nationally from October 2008.

This data element is also known by these names:

Context	Alias
plural	WEEKLY HOURS WORKED

For enquiries about this Data Set Change Notice, please email datastandards@nhs.net