Background Quality Report - Monthly Mental Health Minimum Dataset Reports:

2013-14, England

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enquiries@hscic.gov.uk

Author:	**Community and Mental Health team, Health and Social Care Information Centre**
Responsible statistician:	**Claire Thompson, Principal Information Analyst**
Version:	**V1.0**
Date of publication	**3 September 2013**

Contents

Introduction

This document constitutes a background quality report for the publication of monthly data from v 4.1 of the Mental Health Minimum Dataset (MHMDS). The elements included in this release are as follows:

- An Executive Summary reporting on measures of activity and people accessing specialist mental health services as headline figures, with new national measures and time series graphics;
- This background data quality report;
- Provider level data quality measures (also includes provisional data for next reporting period);
- A monthly data file containing underlying machine readable data at provider and Clinical Commissioning Group CCG level;
- A metadata document for the monthly data file.

It replaces the 'Routine Quarterly Mental Health Minimum Dataset Reports' publications, the last of which was produced for Q4 final data, 2012/13.

Context

Background to this publication

MHMDS statistics

The MHMDS is a mandatory monthly return for all NHS funded providers of adult secondary mental health services. It is received as record level anonymised data from patient administration systems, Care Programme Approach (CPA) systems and Mental Health Act (MHA) administration systems.

It contains records relating to all adults aged 18 or over (including elderly adults) who receive NHS funded specialist secondary mental health services and are, or are thought to be, suffering from a mental illness. Children and adolescents under the age of 18 should also be included where they are in receipt of care from adult services.

MHMDS was first mandated for submission from April 2003. Version 4.1 of MHMDS was implemented in April 2013 and is now a monthly rather than a quarterly collection. Version 4.1 has more detailed data on commissioners responsible for services to provide more accurate information to support the implementation of Mental Health PbR.

Further information on the MHMDS can be found on the Health and Social Care Information Centre (HSCIC) website at:

www.hscic.gov.uk/services/mhmds/spec

Providers make their MHMDS submissions via the Bureau Service Portal on Open Exeter[1]. Full details of the way in which submissions are processed can be found in the MHMDS v4.1 User Guidance and Appendices.
The most recent Information Standards Notice (ISN) for MHMDS can be found on the Information Standards Board (ISB) website at:

http://www.isb.nhs.uk/documents/isb-0011

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[1] Further details on how to access the Open Exeter portal can be found here :
http://www.hscic.gov.uk/mhmds/submissiontimetable

Purpose of this document

This paper aims to provide users with an evidence based assessment of the quality of the statistical output of the accompanying Monthly MHMDS Reports publication by reporting against those of the nine European Statistical System (ESS) quality dimensions and principles[2] appropriate to this output.

In doing so, this meets our obligation to comply with the UK Statistics Authority (UKSA) Code of Practice for Official Statistics[3], particularly Principle 4, Practice 2 which states:

> *"Ensure that official statistics are produced to a level of quality that meets users' needs, and that users are informed about the quality of statistical outputs, including estimates of the main sources of bias and other errors and other aspects of the European Statistical System definition of quality".*

For each dimension this paper describes how this applies to the publication and references any measures in the accompanying monthly data quality measures report that are relevant for assessing the quality of the output.

The Appendix contains a full list of the measures in the monthly data file with an item level summary of possible data quality issues and references to any data quality measures that can assist users in assessing specific provider level information.

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[2] The original quality dimensions are: relevance, accuracy and reliability, timeliness and punctuality, accessibility and clarity, and coherence and comparability; these are set out in Eurostat Statistical Law. However more recent quality guidance from Eurostat includes some additional quality principles on: output quality trade-offs, user needs and perceptions, performance cost and respondent burden, and confidentiality, transparency and security.
[3] UKSA Code of Practice for Statistics: http://www.statisticsauthority.gov.uk/assessment/code-of-practice/index.html

Assessment of statistics against quality dimensions and principles

Relevance

This dimension covers the degree to which the statistical product meets user need in both coverage and content.

This publication covers comprises a set of reports which have been produced from mental health providers' MHMDS monthly submissions processed by the Systems and Service Delivery team at NHS Connecting for Health (CFH) on behalf of the HSCIC. It provides the most timely information from MHMDS.

This publication provides, in the form of an Executive Summary, a summary of key national information in the release (including end of month people counts, in month activity counts and calculated measures) with a time series and visual representations. A monthly data file contains underlying MHMDS data for provider and CCG combinations (end of month people counts and in month activity counts). These have been produced following consultation with users[4]. Changes to the previous content and format of the routine MHMDS reports have been announced in a methodological change paper[5]. These include most of the information previously included in the Routine Quarterly MHMDS Reports plus a wide range of additional information to meet users' evolving needs.

These are supported by national and provider level data quality measures, which include validation of key data items from the MHMDS and new data consistency measures.

This publication includes a detailed metadata file describing all of the measures in the executive summary and the monthly data file. This includes, for each measure, how it has been constructed from providers' submissions and how and where it is used. A full list of measures is also included in the Appendix to this Background Quality Report.

Some of the statistics in this publication series are presently marked as 'experimental' and may be subject to further change as we develop our statistics. Feedback is very welcome via our enquiries@hscic.gov.uk address (please quote 'MHMDS' in the subject line).

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[4] Consultation on statistics produced from the mental health minimum dataset (MHMDS):
http://www.hscic.gov.uk/mhmdsconsultation
[5] Announcement of methodological change: Routine Quarterly Mental Health Minimum Dataset (MHMDS) Reports:
http://www.hscic.gov.uk/media/12484/Monthly-Mental-Health-Minimum-Dataset-Reports/pdf/MethChange201307_MonthlyMHMDS.pdf

Accuracy and reliability

This dimension covers, with respect to the statistics, their proximity between an estimate and the unknown true value.

Accuracy

The MHMDS is a rich, person level dataset that records packages of care received by individuals in contact with NHS funded specialist health services and these packages of care vary widely. This means that each record contains different elements of the dataset. It is also an area where there have been frequent changes in service models and organisational changes such as mergers. Therefore, no single approach can measure the completeness and accuracy of the data collected and reported nationally. However the HSCIC provides a number of different reports at different stages in the data flow to ensure that the submitted data reflect the services that have been provided:

For data suppliers only:

At the point of submission:
- Providers receive immediate feedback on the quality of their submission, including detailed Data Summary Reports about coverage, code validity and data consistency. These are described in the MHMDS version 4.1 User Guidance Appendix 5. Providers have the opportunity to re-submit data up to the deadline and to send a refresh submission one month later.

On receipt of processed data by HSCIC:
- A variety of data quality checks are run as part of the validation and load process for monthly data, prior to production of this monthly release. Where there are concerns about data quality we contact providers directly so that any issues with local data extraction processes can be addressed for a future submission.

For all users:

On publication as part of this publication:

- Organisation level data quality measures (reports) that validate a selection of key data items by provider – on provisional and final data, part of this publication.

  These show the proportion of records as counts and percentages which have 'valid', 'other', 'default', 'invalid' and 'missing' values for the following fields:

  - DQM 1 NHS number
  - DQM 2 Postcode
  - DQM 3 Birthdate
  - DQM 4 Person Gender Current
  - DQM 5 Person Marital Status
  - DQM 6 Patient Ethnic Category
  - DQM 7 Organisation Code (Code of Commissioner)
  - DQM 8 General Medical Practice Code (Patient Registration)
  - DQM 9 NHS Occupation Code (Care Co-ordinator)
  - DQM 10 Legal Status Classification Code
  - DQM 11 Primary Diagnosis
  - DQM 12 HONOS
  - DQM 13 HONOS 65
  - DQM 14 Mental Health Team Type

- o   DQM 15 Main Specialty Code (Mental Health)
- o   DQM 16 Admission Method
- o   DQM 17 Ward Security Level
- o   DQM 18 Mental Health Clustering Tool Assessment Reason
- o   DQM 19 PbR Care Cluster
- o   DQM 32 MHCT Assessment Tool;

- New organisation level data consistency measures which indicate the extent to which duplication or unclosed episodes are affecting the accuracy of the information about the patient's spell of care:

    - o   DCM 1 Mental Health Act episodes
    - o   DCM2 Care Programme Approach episodes
    - o   DCM 3 Payment by Results Care Cluster episodes
    - o   DCM 4 Community Treatment Order episodes
    - o   DCM 5 Hospital Provider Spell episodes
    - o   DCM 6 Ward Stay episodes;

- DCM 7 Provider level time series analysis of spell volumes (using final data for the 4 most recent reporting periods);

- DCM 8: Provider level measures showing the proportion of records with potentially inactive spells (number of open spells at the end of the reporting period, number of open spells with no referral at the end of the reporting period and the difference (percentage);

- This background quality report which describes data quality issues relevant to the analysis in the release and is produced each time as part of the quarterly publication.

Users of the data must make their own assessment of the quality of the data for a particular purpose, drawing on these resources.

In addition, local knowledge, or other comparative data sources, may be required to distinguish changes in volume between reporting periods that reflect changes in service delivery from those that are an artefact of changes in data quality. Such issues should be kept in mind when viewing time series analysis since year-on-year changes may sometimes be a product of shortfalls in earlier years and should not automatically be interpreted as trends in treatment practice or activity.

The analysis in this report is based on the latest data available after the refresh submission, providers' last opportunity to submit activity for the month. Final data is assembled from provisional data from providers plus any refresh data submitted (which supercedes primary submissions).

However, the analysis in the monthly report is potentially liable to future change because information about these episodes will be re-submitted until the episode ends and could potentially be amended.

It should also be noted that England level counts (and rounded counts where suppression at organisation level has been applied) are calculated as a sum total of organisational totals so there is a possibility of double counting.

We continue to invite and welcome feedback from users on our MHMDS constructions.

Reliability/known data quality issues

Coverage – are all eligible providers submitting data?

All providers of NHS funded specialist mental health services for adults (including people aged 65 and over) should submit MHMDS. However, at present only a small number of independent sector providers are making submissions. DCM7 in the accompanying Data quality measures file provides a full list of providers submitting data each period. When an organisation starts or ceases to submit data this can affect overall record numbers.

Coverage – how complete is data for Clinical Commissioning Groups?

The measures in the monthly data file are presented for each provider/CCG pairing, except where the total 'as at end of month' caseload was considered potentially disclosive. For each provider/CCG pairing where this number was less than 5, numbers have been aggregated to a 'provider/other CCGs' group. This means that the totals for CCGs that can be calculated from this file exclude data for that CCG from providers with less than 5 of their patients on the caseload at the end of the month.

It should be noted that the measures in the monthly data file are presented by CCG of GP practice, which might not be recorded as the commissioning organisation in the individual patient record. Commissioners' extracts from Open Exeter are filtered by Organisation Code of Commissioner and there may be discrepancies with these published reports if the commissioner has not been recorded as a CCG.

Coverage – is data for all eligible mental health service users included in the submission?

Local knowledge may be required to assess the completeness of a submission, based on information about local caseload and bed numbers. This publication provides detailed information about caseload and activity and providers and commissioners are encouraged to review this to ensure that submissions accurately reflect the local situation. Providers should also use all the aggregate record counts produced at the point of submission as part of the Data Summary Reports to check coverage in key areas (eg, CPA, Ward Stays, and Hospital Provider Spells etc.).

Each MHMDS record represents that part of a patient's Adult Mental Health Care Spell that occurs in the month and a record is generated for every patient with an open referral and at least one other episode or event recorded (e.g. an open Care Co-ordinator Assignment episode). It is therefore possible for records to be generated for people who have not had a face to face contact for months. A spell will only be closed when the patient is discharged from the provider's services and all associated episodes have also been ended.

It is clinically accepted that some spells of care can last for months or years without frequent contact, however providers will need to ensure that their submissions only include information for patients who are still considered to be on the caseload, even if contact is infrequent and that a discharge date is provided for referrals to the service that have now ended.

Providers receive a variety of metrics as part of the submission process which enables them to review their submissions to ensure that patients whose data is submitted are still part of their active case list. These reports make it possible for providers to check the content of their submissions whilst there is still a chance to re-submit and make improvements.

DCM8 provides information to assess the extent to which this may be a problem for individual providers.

Duplication of episodes

Submissions often include duplicate or overlapping entries for types of episodes which describe the status of a patient for a period of time (e.g. 'on CPA' – CPA episode, 'subject to the Mental Health Act' – Mental Health Act Event episode, 'assigned to a PbR cluster' – PbR Cluster episode, 'occupying a bed on a ward' – Ward Stay episode). There should only be one open episode at a time for a patient in a provider for these episode types and duplication or overlapping entries can affect the accuracy of information derived from this data.

DCM1 – DCM6 are new data consistency measures in the Monthly MHMDS Reports which aim to highlight this issue so that it can be addressed. The item level data quality information in the Appendix links specific measures in the monthly data file to relevant consistency measures.

Unclosed episodes

The submission requirements are for each episode to be submitted in every month where it is open (starting, continuing or closing) and for the episode End Date to be submitted in the month in which it occurs. Failure to do so results in episodes remaining unclosed. Failure to submit the same episode in a future month suggests that it has ended, but an end date cannot be derived. This will affect the accuracy of information calculated from episode end dates (e.g. Discharge from Hospital Provider Spell episodes) or durations (eg Bed Days, calculated from Start and End Dates of Ward Stay episodes). This issue can result in duplicate and overlapping episodes for a patient, as described above, and the same data consistency measures (DCM1-DCM6) are relevant to assessing the extent to which this might be an issue for individual provider organisations.

Providers are urged to ensure that episode end dates are provided in line with the submission requirements.

Local system issues

MHMDS provides data from provider organisations' patient administration systems. The primary purpose of such systems is to support the provision of patient care and not to provide data for secondary uses, such as national reporting. The configuration of local systems may affect the accuracy of extracts used for MHMDS submissions and may contribute to the issues described above. Providers are urged to use all the reports produced during the submission process, during loading and validation and at publication, to ensure that the data submitted is accurate as possible. The metadata file includes full details of how the measures have been constructed so that they can be replicated from locally held MHMDS extracts.

The submission requirements for MHMDS are that all episodes (eg CPA episodes, Ward Stay episodes, Mental Health Act Event episodes, Hospital Provider Spell episodes, etc.) be included in the submission for each month in which they start, continue or end. It is important that data providers ensure that NHS numbers are submitted consistently because this is a key piece of information for creating the person and care spell identifiers in our records. These identifiers are used to ensure that events which are part of the same care spell for a person can be linked and any inconsistencies will affect indicators which look back over the previous 12 months:

- People on CPA at the end of the RP with HoNOS recorded (mm04);
- People on CPA for 12 months with review at the end of the RP (mm06);
- People in contact with NHS funded adults secondary mental health services at the end of the RP with accommodation status recorded (mm13);
- People aged 18-69 on CPA at the end of the RP in settled accommodation (mm14);
- Proportion of people aged 18-69 on CPA in settled accommodation (mm15);
- People with employment status recorded at the end of the RP (mm16);
- People aged 18-69 on CPA at the end of the RP in employment. (mm17);
- Proportion of people aged 18-69 on CPA in employment (mm18).

Quality of Experimental Analysis

It should be noted that some of these statistics are presently experimental in nature and are likely to be subject to further refinement before the final constructions are confirmed; reference should be made to all accompanying footnotes and commentary when using these statistics.

Some of these measures may be used in the construction of official indicators (for example in the CCG Outcomes Indicator Set) but the monthly file presents potential numerator and denominator lines separately.

We are working with providers to define methodologies for new measures and welcome input from users of the data. These can be sent to us at enquiries@hscic.gov.uk, quoting 'New MHMDS Indicators' in the subject line.

Timeliness and punctuality

Timeliness refers to the time gap between publication and the reference period. Punctuality refers to the gap between planned and actual publication dates.

The executive summary and monthly data file are based on the most recent available final data. We aim to publish within 10 weeks of the month end. Data quality measures are produced from provisional data within 6 weeks of the month end. The submission deadlines for MHMDS are published here:

http://www.hscic.gov.uk/mhmds/submissiontimetable

Accessibility and clarity

Accessibility is the ease with which users are able to access the data, also reflecting the format in which the data are available and the availability of supporting information. Clarity refers to the quality and sufficiency of the metadata, illustrations and accompanying advice.

Accessibility

Alongside this data quality statement, an Executive Summary of the results included in this publication is accessible via the HSCIC website as a PDF document together with a supporting monthly data file containing machine readable underlying data (with an accompanying metadata document).

Re-use of our data is subject to conditions outlined here:

http://www.hscic.gov.uk/data-protection/terms-and-conditions

Providers and commissioners are able to obtain a record level data extract for their patients from the Open Exeter Bureau Service Portal. Commissioner's extracts are filtered by Org Code of Commissioner, as entered for each patient by the provider. It should be noted that the measures in the monthly data file are presented by CCG of GP practice, which might not be recorded as the commissioning organisation in the individual patient record.

Clarity

The monthly data file is presented as a .csv file, with an accompanying metadata file in MS Excel format. A broad definition of each indicator, including the data items used in the analysis and constructions and current or intended uses are provided. Terminology is defined where appropriate.

Full details of the way that MHMDS returns are processed, which will be of use to analysts and other users of these data, are provided in the MHMDS v4.1 User Guidance, available on the HSCIC website:

http://www.hscic.gov.uk/services/mhmds/spec

In order to prevent disclosure of identities or information about service users, for each provider/CCG pairing where the caseload at the end of the month was less than 5, the numbers have been aggregated to a 'provider/other CCGs' group.

Coherence and comparability

Coherence is the degree to which data which have been derived from different sources or methods but refer to the same topic are similar. Comparability is the degree to which data can be compared over time and domain.

Coherence

There is no other monthly publication that includes the same measures as are included in this publication. However, measures that provide a snapshot count as at the end of the month are comparable with measures as at the end of a year (or a quarter).

Annual data for 2012/13 has not yet been published from the KP90 return, but the National Statistics publication produced from the 2011/12 KP90 collection[6] contains some comparable figures for the new measure 'Number of people subject to the Mental Health Act at the end of the month'. Providers who complete both the KP90 annual return and MHMDS can compare the total number of people detained in hospital and subject to a Community Treatment Order (CTO) at the end of 2012/13 with this measure. When making comparisons users should bear in mind that the MHMDS does not include children or people in learning disability services.

The monthly data file also includes a number of measures that were previously produced from the Community Mental Health Activity return.

From the April 2013/14 reporting period onwards, the Community Activity Return was discontinued following the publication of the results of the Secretary of State's Fundamental Review of Returns[7] (a public consultation on the Government's proposals to reduce up to a quarter of data returns in order to significantly reduce the burden on the NHS). We have demonstrated via our experimental analyses within the Routine Quarterly MHMDS Reports publication that comparable community mental health activity data can be produced for most of these from the MHMDS and many of these are part of the monthly release. Others may be produced in future subject to users' requirements being confirmed.

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[6] Inpatients formally detained in hospitals under the Mental Health Act 1983 and patients subject to supervised community treatment – England, 2011-2012, Annual Figures:
www.ic.nhs.uk/pubs/inpatientdetmha1112
[7] Fundamental Review of Data Returns: Consultation Response:
https://www.gov.uk/government/consultations/review-of-the-number-of-request-made-to-nhs-organisation-for-national-data-returns

Comparability

The Executive Summary presents monthly time series for the measures reported at national level and these may be affected by organisational change or re-configuration of local services, as well as by data quality issues. All these factors should be considered when interpreting change over time. DCM7 shows where a failure to submit or the discontinuation or introduction of services will have an impact on national counts.

Some changes have been made to the method for calculating measures formerly part of the Department of Health's (DH) Performance Framework for mental health trusts, in response to feedback. These changes are described in the Methodological Change Paper. This may result in slight changes in calculated indicator values from those published in 2012/13.

Trade-offs between output quality components

This dimension describes the extent to which different aspects of quality are balanced against each other.

The new format of this publication meets user needs of an increased frequency and greater wealth of available information from the MHMDS and supports reporting for PbR at new NHS geographies. Benefits to users include publication of underlying data and improved data quality measures, as well as a visual representation of the national picture on a monthly basis, with some time series.

The aggregate underlying data provides a much greater scope of analysis including initial metrics on patient pathways and will support a variety of local uses as well as meeting our obligations under the Code of Practice for National Statistics and the Transparency Agenda. It will provide a greater amount of basic information from MHMDS than has ever been produced before, including numerators and denominators for established indicator measures (as previously published in the quarterly reports).

The new format of this publication balances the need for increased frequency of reporting and scope of analysis with HSCIC resources and production time. As well as continuing to produce the majority of measures included in the previous version of this publication in the monthly data file, we are producing a large number of new measures in response to user feedback.

By publishing a range of clearly defined measures in a timely fashion we hope to support discussions between providers and commissioners about caseload and activity and promote a virtuous cycle of improving data quality, through use.

We no longer produce a suite of data tables as part of this publication. However the new machine readable data file is very detailed and allows data users to easily produce custom tabulations as required for their own analytical purposes.

Assessment of user needs and perceptions

This dimension covers the processes for finding out about users and uses and their views on the statistical products.

The purpose of these monthly MHMDS reports is to provide Mental Health service providers, commissioners and other stakeholders with timely information about caseload and activity at provider/ CCG level. This is intended to support changes in commissioning arrangements as mental health services move from block commissioning to commissioning based on activity and caseload and outcomes for patients.

For members of the public, researchers and other stakeholders, the release provides up to date information about the people in contact with services and introduces some monitoring of aspects of the Mental Health Act.

Our engagement with users during 2012/13 showed that providers and commissioners want greater involvement in the development of analysis and we are already working more closely with data users on refining experimental analysis and developing new measures.

We continue to invite and welcome feedback from users on our MHMDS constructions.

Performance, cost and respondent burden

This dimension describes the effectiveness, efficiency and economy of the statistical output.

The MHMDS has been identified as the data source to replace others in the Fundamental Review of Returns programme designed to reduce burden on the NHS. New analyses in the scope have been gradually being introduced into routine reporting from MHMDS, initially classified as experimental statistics, starting with the community activity data. Where possible we have provided some parallel running of statistics from the original source and from MHMDS, for comparison purposes.

Confidentiality, transparency and security

The procedures and policy used to ensure sound confidentiality, security and transparent practices.

- Organisations may provide a refresh of their data during the data collection window for the subsequent reporting period should they wish; this will be published as final data with the next release.
- All publications are subject to a standard HSCIC risk assessment prior to issue. Disclosure control is implemented where deemed necessary.

Please see links below to relevant HSCIC policies:

Statistical Governance Policy (see link in 'user documents' on right hand side of page)
http://www.hscic.gov.uk/pubs/calendar

Freedom of Information Process
http://www.hscic.gov.uk/foi

Data Access and Information Sharing Policy
http://portal/Documents/Policies/DAIS%20Policy%20Final%204.0%20updated.pdf

Privacy and data Protection
http://www.hscic.gov.uk/privacy

Appendix: Quality of individual measures

This table lists the measures in the Executive Summary and monthly data file, references related measures in the data quality measures file and provides some explanatory notes.

Monthly measure reference	Name of measure	Related DQM and DCM references	Notes on quality
	Month		Generated in processing of submissions
	CCG Code	DQM8	This is CCG code derived from General Medical Practice Code (Patient Registration). Where this data item was missing or was not for an English GP practice, no CCG was derived. These measures are reported at provider/ [blank CCG] level.
	Provider Code		This is derived at the point of submission and is present for every MHMDS record.
mm01	People in contact with services at the end of the Reporting Period	DCM1 - DCM7, DCM8	Any unclosed episodes will prevent a Spell from being closed and may inflate the caseload at the end of the RP. Large changes in overall MHMDS record volumes between RPs may be caused by local system issues or organisational change. These will affect the overall caseload at the end of the RP and all the related counts of people 'as at the end of the RP'. Local knowledge may be required to assess whether this applies.
mm02	People on CPA at the end of the RP	DCM2, DCM 7, DCM 8	Any CPA Episode episodes that have ceased but not been closed will affect the accuracy of this count. Large changes in overall MHMDS record volumes between RPs may be caused by local system issues or organisational change. These will affect the overall caseload at the end of the RP. Local knowledge may be required to assess whether this applies.
mm03	People on CPA aged 18-69 at the end of the RP	as for mm02, DQM3	Birthdate is a mandated item in the submission and a warning at the point of submission highlights records submitted for patients aged under 16.
mm04	People on CPA at the end of the RP with HoNOS recorded	as for mm02, DQM12-13, DQM32?	Any missing submissions for previous RPs will affect the accuracy since all variants of HoNOS and Mental Health Clustering Tool events from previous RPs are examined. The change in methodology from that used in Routine Quarterly MHMDS Reports is considered fairer.
mm05	People on CPA for 12 months at the end of the RP	as for mm02	The change in methodology from that used in Routine Quarterly MHMDS Reports is considered fairer.
mm06	People on CPA for 12 months with review at the end of the RP	as for mm02	Any missing submissions for previous RPs will affect the accuracy since CPA Review events from previous RPs are examined. The change in methodology from that used in Routine Quarterly MHMDS Reports is considered fairer.

mm07	People in contact with NHS funded adult secondary mental health services who have an open hospital spell at the end of the RP	DCM5, DCM7	Any Hospital Provider Spell episodes that have ended but for which an End Date of Hospital Provider Spell has not been recorded will affect the accuracy of this count. Large changes in overall MHMDS record volumes between RPs may be caused by local system issues or organisational change. These will affect the overall caseload at the end of the RP. Local knowledge may be required to assess whether this applies.
mm08	People subject to the Mental Health Act at the end of the RP	DQM10 DCM1, DCM4, DCM5, DCM6	The validity of Legal Status Classification Code Following Event data item will affect the accuracy and coverage of this report. Also any Mental Health Act Event, Community Treatment Order, Hospital Provider Spell or Ward Stay episodes which have ended but for which an End Date has not been submitted will affect the accuracy of this count. The coherence of this analysis can be assessed by comparison, at provider level, with reports included in the annual national statistics on uses of the Mental Health Act when figures for comparable reporting periods are available.
mm09	People subject to detention	as mm08 and see mm10	
mm10	People subject to CTO	DCM4	Any Community Treatment Order episode which has ended but for which an End Date has not been recorded will affect the accuracy of this count. This will have a knock on effect on the accuracy of mm09 if the CTO has ended with a revocation since such people should have been categorised as 'subject to detention'. The coherence of this analysis can be assessed by comparison, at provider level, with reports included in the annual national statistics on uses of the Mental Health Act when figures for comparable reporting periods are available.
mm11	People being treated by Early Intervention teams at the end of the RP	DQM14	The validity of Adult Mental Health Team Type data item will affect the accuracy and coverage of this report. Feedback from providers also suggests that many teams formerly defined as distinct Early Intervention teams have merged with other community mental health teams and can no longer be clearly identified in the MHMDS dataset. This will have an impact on coverage. Any Team episodes that have ended but for which an End Date has not been recorded will affect the accuracy of this count.

mm12	People being treated by Assertive Outreach teams at the end of the RP	DQM14	The validity of Adult Mental Health Team Type data item will affect the accuracy and coverage of this report. Feedback from providers also suggests that many teams formerly defined as distinct Assertive Outreach teams have merged with other community mental health teams and can no longer be clearly identified in the MHMDS dataset. This will have an impact on coverage. Any Team episodes that have ended but for which an End Date has not been recorded will affect the accuracy of this count.
mm13	People in contact with NHS funded adults secondary mental health services at the end of the RP with accommodation status recorded.	as mm01	Any missing submissions for previous RPs will affect the accuracy since Accommodation Status events from previous RPs are examined.
mm14	People aged 18-69 on CPA at the end of the RP in settled accommodation	as mm03 and mm01	The change in methodology from that used in Routine Quarterly MHMDS Reports is considered fairer.
mm15	Proportion of people aged 18-69 on CPA in settled accommodation	as mm13 and mm14	The change in methodology from that used in Routine Quarterly MHMDS Reports is considered fairer.
mm16	People with employment status recorded at the end of the RP	as mm01	Any missing submissions for previous RPs will affect the accuracy since Employment Status events from previous RPs are examined.
mm17	People aged 18-69 on CPA at the end of the RP in employment.	as mm03 and mm01	The change in methodology from that used in Routine Quarterly MHMDS Reports is considered fairer.
mm18	Proportion of people aged 18-69 on CPA in employment	as mm16 and mm14	The change in methodology from that used in Routine Quarterly MHMDS Reports is considered fairer.
mm19	People with a crisis plan in place at the end of the RP	as mm1	The accuracy of this measure depends on providers complying with the submission requirement to include information about Crisis Plans with every submission, so long as there is a crisis plan in place and not just when it is created.
mm20	People with a diagnosis recorded in the RP	as mm1 DQM11	The validity of Primary Diagnosis data item will affect the accuracy and coverage of this report. Any missing submissions for previous RPs will affect the accuracy since Primary Diagnosis events from previous RPs are examined.
mm21	People assigned to cluster at the end of the RP	DCM3	Any Payment by Results Care Cluster episode which has ended but for which a Care Cluster End Date has not been recorded will affect the accuracy of this count. This measure does not show whether the relevant Cluster episode has exceeded the review period and may therefore include people whose cluster has expired. This is currently considered experimental analysis and further related measures are in development.

mm22	Adult Mental Health Spell days in RP	as mm01	Any unclosed episodes will prevent a Spell from being closed and may affect the accuracy of this calculation.
mm23	Adult Mental Health Spells starting in RP	as mm01	Any unclosed episodes will prevent a Spell from being closed. A new Spell can only occur where a previous Spell for the same person in the same provider has ended. Otherwise new activity will be part of the continuing Spell.
mm24	Bed days in RP	DCM6	Any unclosed or overlapping Ward Stay episodes will affect the calculation of this measure
mm25	Bed days less leave in RP	DCM6	Any unclosed or overlapping Ward Stay episodes will affect the calculation of this measure
mm26	Admissions to hospital in RP	DCM5	Any duplication of Hospital Provider Spell episodes will affect the accuracy of this measure.
mm27	Detentions on admission to hospital in RP	DQM10 DCM1, DCM5	The validity of Legal Status Classification Code Following Event data item will affect the accuracy and coverage of this report. Any duplication of Mental Health Act Event or Hospital Provider Spell episodes will affect the accuracy of this count. The coherence of this analysis can be assessed by comparison, at provider level, with reports included in the annual national statistics on uses of the Mental Health Act when figures for comparable reporting periods are available.
mm28	Discharges from hospital in RP	DCM5	Any duplication of Hospital Provider Spell episodes of failure to record the End Date of Hospital Provider Spell will affect the calculation of this measure.
mm29	Discharges from hospital, net, in RP	as mm28	This is an experimental measure and subject to further refinement of the method.
mm30	Discharges from hospital, net, followed up within 7 days in RP	as mm28	This is an experimental measure and subject to further refinement of the method.
mm31	Proportion of discharges from hospital followed up within 7 days	as mm28	This is an experimental measure and subject to further refinement of the method.
mm32	Contacts and daycare attendances in RP		Local knowledge will be required to assess the coverage. Providers receive feedback on activity volumes within the Data Summary Reports produced on submission, so they can check coverage for these measures.
mm33	Attended contacts and daycare attendances in RP		see mm33
mm34	Days of delayed discharge in RP		This is a new measure and local knowledge may be required to assess the accuracy.
mm35	MHCT assessments in RP		This is a new measure and local knowledge may be required to assess the accuracy. Providers receive feedback on activity volumes within the Data Summary Reports produced on submission, so they can check coverage for these measures.
mm36	MHCT assessments new referral in RP		see mm35

mm37	Clusters started in RP	DCM3	This is a new experimental measure. Any duplication of <u>Payment by Results Care Cluster</u> episodes will affect the accuracy of this measure. *Data providers should note that this is based on a list of valid PbR Cluster codes and that DQM19 should be referred to in order to understand any differences between this and figures generated as part of the Portal Cluster Summary Report.*
mm38	Clusters ended in RP		This is a new experimental measure. Any <u>Payment by Results Care Cluster</u> episode which has ended but for which a Care Cluster End Date has not been recorded will affect the accuracy of this calculation. *Data providers should note that this is based on a list of valid PbR Cluster codes and that DQM19 should be referred to in order to understand any differences between this and figures generated as part of the Portal Cluster Summary Report.*
mm39	AWOL episodes in RP		The change in methodology from that used in Routine Quarterly MHMDS Reports makes this figure more comparable with notifications provided to the Care Quality Commission about overnight AWOL episodes, which should make it easier for providers to validate.
mm40	Under 16 bed days in RP	DQM3, DCM6	Birthdate is a mandated item in the submission and a warning at the point of submission highlights records submitted for patients aged under 16 so there is an opportunity to remove any ineligible patient records from the submission. Any unclosed or overlapping <u>Ward Stay</u> episodes will affect the calculation of this measure
mm41-61	Days on cluster [00] in RP	DQM19 DCM3	Coverage will be affected the validity of <u>PbR Care Cluster</u> data item. Any unclosed or overlapping <u>PbR Care Cluster</u> episodes will affect the calculation of this measure, *Data providers should note that this is based on a list of valid PbR Cluster codes and that DQM19 should be referred to in order to understand any differences between this and figures generated as part of the Portal Cluster Summary Report.*

Published by the Health and Social Care Information Centre

Part of the Government Statistical Service

Claire Thompson

Principal Information Analyst, Community and Mental Health team

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For further information:

www.hscic.gov.uk

0845 300 6016

enquiries@hscic.gov.uk