Change Request

NHS Connecting for Health

NHS Data Model and Dictionary Service

Reference:	Change Request 1290
Version No:	1.0
Subject:	Data Set Notation
Effective Date:	Immediate
Reason for Change:	Change to Data Set Notation
Publication Date:	1 March 2012

Background:

Queries have been received by the NHS Data Model and Dictionary Service relating to data set notation used on a number of Data Sets.

A NHS Data Model and Dictionary Consultation was set up to ask users of the NHS Data Model and Dictionary to comment on a proposed change to the data set notation. The majority of responders agreed with the new wording.

This Data Dictionary Change Notice (DDCN) amends the data set notation on existing data sets in the NHS Data Model and Dictionary as follows:

- M = Mandatory: this data element is mandatory and the technical process (e.g. submission of the data set, production of output etc) cannot be completed without this data element being present
- R = Required: NHS business processes cannot be delivered without this data element
- O = Optional: the inclusion of this data element is optional as required for local purposes.

Note: the Data Set Notation for the Commissioning Data Sets will be updated when the Information Standards Notice for 6-2 is published. All data sets in development will be amended to reflect the new notation.

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

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

Summary of changes:

Data Set	
AIDC FOR PATIENT IDENTIFICATION DATA SET	Changed Description
CHLAMYDIA TESTING ACTIVITY DATA SET	Changed Description
COMMUNITY INFORMATION DATA SET	Changed Description
DIAGNOSTICS WAITING TIMES AND ACTIVITY DATA SET	Changed Description
DIAGNOSTICS WAITING TIMES CENSUS DATA SET	Changed Description
GENITOURINARY MEDICINE CLINIC ACTIVITY DATA SET	Changed Description
IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES DATA SET	Changed Description
INTER-PROVIDER TRANSFER ADMINISTRATIVE MINIMUM DATA SET	Changed Description
MENTAL HEALTH MINIMUM DATA SET (VERSION 4-0)	Changed Description
NHS HEALTH CHECKS DATA SET	Changed Description
SYSTEMIC ANTI-CANCER THERAPY DATA SET	Changed Description

Date: 1 March 2012

Sponsor: Nicholas Oughtibridge, Acting Director of Data Standards and Products, Technology Office, Department of Health Informatics Directorate

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.

AIDC FOR PATIENT IDENTIFICATION DATA SET

Change to Data Set: Changed Description

AIDC for Patient Identification Data Set Overview

~~The Mandatory or Optional (M/R/O) column indicates the recommendation for the inclusion of data.~~The Mandatory, Required or Optional (M/R/O) column indicates the recommendation for the inclusion of data.

- ~~M = Mandatory: this data element is mandatory and the technical process cannot complete without this data element being present~~
- ~~R = Required: data is required as part of NHS business rules and must be included where available or applicable~~
- ~~O = Optional: the inclusion of this data is optional as required for local purposes.~~
- M = Mandatory: this data element is mandatory and the technical process (e.g. submission of the data set, production of output etc) cannot be completed without this data element being present
- R = Required: NHS business processes cannot be delivered without this data element
- O = Optional: the inclusion of this data element is optional as required for local purposes.

IDENTIFIERS

To carry Hospital (Provider) and Patient identifiers.
One occurrence of this group is permitted.

M/R/O	Data Set Data Elements
R	NHS NUMBER
R	ORGANISATION CODE (CODE OF PROVIDER)
R	LOCAL PATIENT IDENTIFIER Multiple occurrences of this data item are permitted

PATIENT DESCRIPTIVE DETAILS

To carry the Patient's Descriptive details.
One occurrence of this group is permitted.

M/R/O	Data Set Data Elements
R	PERSON FAMILY NAME
R	PERSON GIVEN NAME
R	DATE OF BIRTH (PATIENT IDENTIFICATION)
R	TIME OF BIRTH (PATIENT IDENTIFICATION)

BABY DETAILS

To carry details if the patient is a neonate or newborn baby.
One occurrence of this group is permitted.

M/R/O	Data Set Data Elements
R	NUMBER OF BABIES IDENTIFIER (PATIENT IDENTIFICATION)

R	PERSON FAMILY NAME (MOTHER OF BABY)
O	PERSON GIVEN NAME (MOTHER OF BABY)

CHLAMYDIA TESTING ACTIVITY DATA SET

Change to Data Set: Changed Description

Chlamydia Testing Activity Data Set Overview

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

~~M = Mandatory: this data element is mandatory, the message will be rejected if this data element is absent~~
~~R = Required: this data element is required as part of NHS business rules and must be included where available or applicable~~

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

Organisation Details: **To carry the details of the reporting period and testing service.**	
M / R	**Data Set Data Elements**
R	REPORTING PERIOD START DATE
R	REPORTING PERIOD END DATE
M	LABORATORY CODE
Person Demographics: **To carry the demographic details of the person tested.**	
M / R	**Data Set Data Elements**
R	LOCAL PATIENT IDENTIFIER (EXTENDED)
R	NHS NUMBER
R	NHS NUMBER STATUS INDICATOR CODE
M	PERSON GENDER CODE CURRENT
R	PERSON BIRTH DATE
M	ETHNIC CATEGORY
M	POSTCODE OF USUAL ADDRESS
M	POSTCODE OF GENERAL MEDICAL PRACTICE (PATIENT REGISTRATION)
M	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)
Testing Service Provider Details: **To carry the details of the testing service provider.**	
M / R	**Data Set Data Elements**
M	POSTCODE OF TESTING SERVICE (CHLAMYDIA TESTING)
M	ORGANISATION CODE (PCT OF TESTING SERVICE)
M	SERVICE TYPE (CHLAMYDIA TESTING)
R	CLINIC CODE (NATIONAL CHLAMYDIA SCREENING PROGRAMME)
Test Details: **To carry the details of the tests and results provided.**	
M / R	**Data Set Data Elements**
M	TEST IDENTIFIER (CHLAMYDIA TESTING)
M	SPECIMEN TYPE (CHLAMYDIA TESTING)

R	SAMPLE COLLECTION DATE
M	SAMPLE RECEIPT DATE
R	INVESTIGATION RESULT DATE
M	CHLAMYDIA TEST RESULT

COMMUNITY INFORMATION DATA SET

Change to Data Set: Changed Description

Community Information Data Set Overview

The Community Information Data Set is initially being introduced for local use only, from 1 April 2012. A future Information Standards Notice will be published to notify providers and system suppliers of the requirement to flow the data set nationally, and give further details relating to unique record identifiers and how the data will be handled by the receiving system. The layout of the data set shown below, and the definition of the Mandatory, Required or Optional column, show the data inclusion requirements which will apply when the data is required to flow nationally, to enable providers and system suppliers to prepare the data for national flow.

The Mandatory, Required or Optional (M/R/O) column indicates the recommendation for the inclusion of data:

~~**M** = Mandatory: This data element is mandatory, the message will be rejected if this data element is absent~~
~~**R** = Required: This data is required as part of NHS business rules and must be included where available or applicable~~
~~**O** = Optional: the flow of this data is optional. It should be included at the discretion of the submitting organisation and their commissioners as required for local purposes. Community systems must however enable the capture and reporting or derivation such items.~~

- M = Mandatory: this data element is mandatory and the technical process (e.g. submission of the data set, production of output etc) cannot be completed without this data element being present
- R = Required: NHS business processes cannot be delivered without this data element
- O = Optional: the inclusion of this data element is optional as required for local purposes. Community systems must however enable the capture and reporting or derivation such items.

Note - Items in the M/R/O column which are shown with notation **P**, have not yet been defined by the NHS Data Model and Dictionary Service, or approved by the Information Standards Board for Health and Social Care, and are included to facilitate piloting and testing of future Department of Health data requirements, prior to formal inclusion in later versions of the data set. These items have been included in the data set layout because the Community Information Data Set XML Schema Version 1.0.0 includes the facility to submit these items to support the piloting activities. Unless ORGANISATIONS are engaged in these piloting activities, they should NOT submit any data item marked **P**.

PERSON

Record Identity and Recipients: **To carry the unique record identifier and the recipient organisations.** **One occurrence of this group is permitted.**	
M/R/O	**Data Set Data Elements**
M	CIDS UNIQUE IDENTIFIER
M	ORGANISATION CODE (PROVIDER AT RECORD CREATION)
O	CIDS PRIME RECIPIENT IDENTITY
O	CIDS COPY RECIPIENT IDENTITY Multiple occurrences of this data item are permitted

One of the following Patient Identity Data Group Structures must be used:

Patient Identity (Standard): **To carry the details of the patient where there is no requirement to withhold the patient's identity.** **One occurrence of this group is required.**	
M/R/O	**Data Set Data Elements**
M	NHS NUMBER *and/or* LOCAL PATIENT IDENTIFIER *and* ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)
M	NHS NUMBER STATUS INDICATOR CODE

OR

Patient Identity (Withheld): **To carry the details of the patient where the patient details are withheld.** **One occurrence of this group is required.**	
M/R/O	**Data Set Data Elements**
M	NHS NUMBER STATUS INDICATOR CODE

Patient Characteristics: **To carry the details of the patient's characteristics.** **One occurrence of this group is permitted.**	
M/R/O	**Data Set Data Elements**
R	PERSON BIRTH DATE
R	PERSON DEATH DATE
R	POSTCODE OF USUAL ADDRESS
R	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)
R	ORGANISATION CODE (PCT OF GP PRACTICE)
R	PERSON GENDER CODE CURRENT
P	EMPLOYMENT STATUS
R	ETHNIC CATEGORY
O	PREFERRED COMMUNICATION LANGUAGE
P	CARER SUPPORT INDICATOR
P	PATIENT CARE RESPONSIBILITY INDICATOR
R	ORGANISATION CODE (PCT OF RESIDENCE)

Patient Disability: **To carry the disability details of the patient.** **Eleven occurrences of this group are permitted.**	
M/R/O	**Data Set Data Elements**
P	DISABILITY CODE

Patient Death Details: **To carry the death details of the patient. This group is only required where the patient is on an End of Life Care Pathway.** **One occurrence of this group is permitted.**	
M/R/O	**Data Set Data Elements**
R	DEATH LOCATION TYPE (PREFERRED)
R	DEATH LOCATION TYPE (ACTUAL)
P	DEATH NOT AT PREFERRED LOCATION REASON CODE

SERVICE REFERRAL

Record Identity and Recipients:
To carry the unique record identifier and the recipient organisations.
One occurrence of this group is permitted.

M/R/O	Data Set Data Elements
M	CIDS UNIQUE IDENTIFIER
M	ORGANISATION CODE (PROVIDER AT RECORD CREATION)
O	CIDS PRIME RECIPIENT IDENTITY
O	CIDS COPY RECIPIENT IDENTITY Multiple occurrences of this data item are permitted

One of the following Patient Identity Data Group Structures must be used:

Patient Identity (Standard):
To carry the details of the patient where there is no requirement to withhold the patient's identity.
One occurrence of this group is required.

M/R/O	Data Set Data Elements
M	NHS NUMBER *and/or* LOCAL PATIENT IDENTIFIER *and* ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)
M	NHS NUMBER STATUS INDICATOR CODE

OR

Patient Identity (Withheld):
To carry the details of the patient where the patient details are withheld.
One occurrence of this group is required.

M/R/O	Data Set Data Elements
M	NHS NUMBER STATUS INDICATOR CODE

Referral Details:
To carry the referral details.
One occurrence of this group is required.

M/R/O	Data Set Data Elements
R	SERVICE REQUEST IDENTIFIER
M	REFERRAL REQUEST RECEIVED DATE
R	REFERRAL REQUEST RECEIVED TIME
R	ORGANISATION CODE (CODE OF COMMISSIONER)
R	SERVICE TYPE REFERRED TO (COMMUNITY CARE)
R	SOURCE OF REFERRAL FOR COMMUNITY
O	REFERRING ORGANISATION CODE
O	REFERRING CARE PROFESSIONAL STAFF GROUP (COMMUNITY CARE)
R	PRIORITY TYPE CODE

Referral Reason:
To carry the referral reason details.
One occurrence of this group is permitted.

M/R/O	Data Set Data Elements
R	PRIMARY REASON FOR REFERRAL (COMMUNITY CARE)
O	OTHER REASON FOR REFERRAL (COMMUNITY CARE) Six occurrences of this data item are permitted

Diagnosis at Referral: To carry the details of the diagnosis at referral. Multiple occurrences of this group are permitted.	
M/R/O	**Data Set Data Elements**
P	DIAGNOSIS SCHEME IN USE
P	DIAGNOSIS AT REFERRAL (COMMUNITY CARE) Twelve occurrences of this data item are permitted

Referral Closure: To carry the referral closure details. One occurrence of this group is permitted.	
M/R/O	**Data Set Data Elements**
R	REFERRAL CLOSURE DATE (COMMUNITY CARE)
R	REFERRAL CLOSURE REASON (COMMUNITY CARE)
R	DISCHARGE DATE (COMMUNITY HEALTH SERVICE)
R	DISCHARGE LETTER ISSUED DATE (COMMUNITY CARE)

REFERRAL TO TREATMENT

Record Identity and Recipients: To carry the unique record identifier and the recipient organisations. One occurrence of this group is permitted.	
M/R/O	**Data Set Data Elements**
M	CIDS UNIQUE IDENTIFIER
M	ORGANISATION CODE (PROVIDER AT RECORD CREATION)
O	CIDS PRIME RECIPIENT IDENTITY
O	CIDS COPY RECIPIENT IDENTITY Multiple occurrences of this data item are permitted

One of the following Patient Identity Data Group Structures must be used:

Patient Identity (Standard): To carry the details of the patient where there is no requirement to withhold the patient's identity. One occurrence of this group is required.	
M/R/O	**Data Set Data Elements**
M	NHS NUMBER *and/or* LOCAL PATIENT IDENTIFIER *and* ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)
M	NHS NUMBER STATUS INDICATOR CODE

OR

Patient Identity (Withheld): To carry the details of the patient where the patient details are withheld. One occurrence of this group is required.	
M/R/O	**Data Set Data Elements**
M	NHS NUMBER STATUS INDICATOR CODE

Referral To Treatment Period: To carry the details of Referral To Treatment Periods during the Patient Pathway. Multiple occurrences of this group are permitted.	
M/R/O	**Data Set Data Elements**

R	SERVICE REQUEST IDENTIFIER
R	COMMUNITY CARE CONTACT IDENTIFIER
R	UNIQUE BOOKING REFERENCE NUMBER (CONVERTED)
R	PATIENT PATHWAY IDENTIFIER
R	ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)
R	WAITING TIME MEASUREMENT TYPE
R	REFERRAL TO TREATMENT PERIOD START DATE
R	REFERRAL TO TREATMENT PERIOD END DATE
R	REFERRAL TO TREATMENT PERIOD STATUS

CARE CONTACT ACTIVITY

Record Identity and Recipients: **To carry the unique record identifier and the recipient organisations.** **One occurrence of this group is permitted.**	
M/R/O	**Data Set Data Elements**
M	CIDS UNIQUE IDENTIFIER
M	ORGANISATION CODE (PROVIDER AT RECORD CREATION)
O	CIDS PRIME RECIPIENT IDENTITY
O	CIDS COPY RECIPIENT IDENTITY Multiple occurrences of this data item are permitted

One of the following Patient Data Group Structures must be used:

Patient Identity (Standard): **To carry the details of the patient where there is no requirement to withhold the patient's identity.** **One occurrence of this group is required.**	
M/R/O	**Data Set Data Elements**
M	NHS NUMBER *and/or* LOCAL PATIENT IDENTIFIER *and* ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)
M	NHS NUMBER STATUS INDICATOR CODE

OR

Patient Identity (Withheld): **To carry the details of the patient where the patient details are withheld.** **One occurrence of this group is required.**	
M/R/O	**Data Set Data Elements**
M	NHS NUMBER STATUS INDICATOR CODE

Care Contact Details: **To carry the details of the care contact.** **One occurrence of this group is required.**	
M/R/O	**Data Set Data Elements**
R	COMMUNITY CARE CONTACT IDENTIFIER
R	SERVICE REQUEST IDENTIFIER
R	ORGANISATION CODE (CODE OF COMMISSIONER)
M	CARE CONTACT DATE
R	CARE CONTACT TIME
R	CLINICAL CONTACT DURATION OF CARE CONTACT

R	CARE CONTACT TYPE (COMMUNITY CARE)
R	CARE CONTACT SUBJECT
R	CONSULTATION MEDIUM USED
R	ACTIVITY LOCATION TYPE CODE
O	SITE CODE (OF TREATMENT)
R	ATTENDED OR DID NOT ATTEND CODE

Care Professional Staff Group Details: **To carry the details of the Care Professional Staff Group.** **Ten occurrences of this group are permitted.**	
M/R/O	**Data Set Data Elements**
R	CARE PROFESSIONAL STAFF GROUP (COMMUNITY CARE)

Appointment Offer Details: **To carry the details of the appointment offer.** **One occurrence of this group is permitted.**	
M/R/O	**Data Set Data Elements**
O	EARLIEST REASONABLE OFFER DATE
O	EARLIEST CLINICALLY APPROPRIATE DATE

Activity Cancellation Details: **To carry the Activity Cancellation details.** **One occurrence of this group is permitted.**	
M/R/O	**Data Set Data Elements**
R	CARE CONTACT CANCELLATION DATE
R	CARE CONTACT CANCELLATION REASON
R	REPLACEMENT APPOINTMENT BOOKED DATE (COMMUNITY CARE)
R	REPLACEMENT APPOINTMENT DATE OFFERED (COMMUNITY CARE)

Assessment Tool Used Details: **To carry the details of the Assessment Tool used.** **Six occurrences of this group are permitted.**	
M/R/O	**Data Set Data Elements**
P	ASSESSMENT TOOL TYPE (COMMUNITY CARE)
P	ASSESSMENT RATING SCALE (COMMUNITY ASSESSMENT TOOL)
P	PERSON SCORE (COMMUNITY ASSESSMENT TOOL)

Care Contact Activity Details: **To carry the details of the activities performed at the care contact.** **Multiple occurrences of this group are permitted.**	
M/R/O	**Data Set Data Elements**
M	COMMUNITY CARE ACTIVITY TYPE CODE
O	GROUP THERAPY INDICATOR (COMMUNITY CARE)
O	CLINICAL CONTACT DURATION OF CARE ACTIVITY

Nutritional Assessment Outcomes: **To carry details of Nutritional Assessments.** **One occurrence of this group is permitted.**	
M/R/O	**Data Set Data Elements**
P	NUTRITIONAL ASSESSMENT DATE

Anxiety or Depression Assessment Outcomes: To carry details of Anxiety or Depression Assessments. One occurrence of this group is permitted.	
M/R/O	**Data Set Data Elements**
P	ANXIETY OR DEPRESSION ASSESSMENT DATE

Falls Outcomes: To carry details of Falls. One occurrence of this group is permitted.	
M/R/O	**Data Set Data Elements**
P	FALL REPORTED DATE
P	FALL SEVERITY OF HARM CODE

Venous Leg Ulcer Wounds Initial Assessment Outcome: To carry details of Venous Leg Ulcer Wounds Initial Assessment outcome. One occurrence of this group is permitted.	
M/R/O	**Data Set Data Elements**
P	VENOUS LEG ULCER WOUNDS INITIAL ASSESSMENT DATE
P	VENOUS LEG ULCER WOUNDS AT INITIAL ASSESSMENT TOTAL

Venous Leg Ulcer Wounds Subsequent Assessment Outcomes: To carry details of Venous Leg Ulcer Wounds Subsequent Assessment outcomes. One occurrence of this group is permitted.	
M/R/O	**Data Set Data Elements**
P	VENOUS LEG ULCER WOUNDS SUBSEQUENT ASSESSMENT DATE
P	VENOUS LEG ULCER WOUNDS AT SUBSEQUENT ASSESSMENT TOTAL

Pressure Ulcer Assessment Outcomes: To carry details of Pressure Ulcer Assessments. One occurrence of this group is permitted.	
M/R/O	**Data Set Data Elements**
P	PRESSURE ULCER ASSESSMENT DATE
P	PRESSURE ULCER CLASSIFICATION CODE
P	INCIPIENT PRESSURE ULCER INDICATOR

Other Outcomes: To carry details of other outcome measures. Multiple occurrences of this group are permitted.	
M/R/O	**Data Set Data Elements**
P	PROBLEM TYPE
P	OUTCOME TYPE
P	OUTCOME MEASURE
P	OUTCOME VALUE

GROUP SESSION

Record Identity and Recipients: To carry the unique record identifier and the recipient organisations. One occurrence of this group is permitted.	

M/R/O	Data Set Data Elements
M	CIDS UNIQUE IDENTIFIER
M	ORGANISATION CODE (PROVIDER AT RECORD CREATION)
O	CIDS PRIME RECIPIENT IDENTITY
O	CIDS COPY RECIPIENT IDENTITY Multiple occurrences of this data item are permitted

Group Session Details: To carry the details of the Group Session. One occurrence of this group is required.	
M/R/O	**Data Set Data Elements**
R	GROUP SESSION IDENTIFIER (COMMUNITY CARE)
R	ORGANISATION CODE (CODE OF COMMISSIONER)
M	GROUP SESSION DATE
R	CLINICAL CONTACT DURATION OF GROUP SESSION
R	GROUP SESSION TYPE CODE (COMMUNITY CARE)
R	NUMBER OF GROUP SESSION PARTICIPANTS (COMMUNITY CARE)
O	ACTIVITY LOCATION TYPE CODE
O	SITE CODE (OF TREATMENT)

Care Professional Staff Group Details: To carry the details of the Care Professional Staff Group. Ten occurrences of this group are permitted.	
M/R/O	**Data Set Data Elements**
R	CARE PROFESSIONAL STAFF GROUP (COMMUNITY CARE)

Group Session Cancellation Details: To carry the cancellation details of the Group Session. One occurrence of this group is permitted.	
M/R/O	**Data Set Data Elements**
P	GROUP SESSION CANCELLATION REASON (COMMUNITY CARE)

INDIRECT PATIENT ACTIVITY

Record Identity and Recipients: To carry the unique record identifier and the recipient organisations. One occurrence of this group is permitted.	
M/R/O	**Data Set Data Elements**
P	CIDS UNIQUE IDENTIFIER
P	ORGANISATION CODE (PROVIDER AT RECORD CREATION)
P	CIDS PRIME RECIPIENT IDENTITY
P	CIDS COPY RECIPIENT IDENTITY Multiple occurrences of this data item are permitted

One of the following Patient Identity Data Group Structures must be used:

Patient Identity (Standard): To carry the details of the patient where there is no requirement to withhold the patient's identity. One occurrence of this group is required.	
M/R/O	**Data Set Data Elements**

P	NHS NUMBER *and/or* LOCAL PATIENT IDENTIFIER *and* ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)
P	NHS NUMBER STATUS INDICATOR CODE

OR

Patient Identity (Withheld): **To carry the details of the patient where the patient details are withheld.** **One occurrence of this group is required.**	
M/R/O	**Data Set Data Elements**
P	NHS NUMBER STATUS INDICATOR CODE

Indirect Patient Activity Details: **To carry the details of the Indirect Patient Activity.** **One occurrence of this group is required.**	
M/R/O	**Data Set Data Elements**
P	INDIRECT PATIENT ACTIVITY IDENTIFIER
P	SERVICE REQUEST IDENTIFIER
P	ORGANISATION CODE (CODE OF COMMISSIONER)
P	INDIRECT PATIENT ACTIVITY DATE
P	INDIRECT PATIENT ACTIVITY DURATION
P	INDIRECT PATIENT ACTIVITY TYPE CODE (COMMUNITY CARE)

Care Professional Staff Group Details: **To carry the Care Professional Staff Group.** **Ten occurrences of this group are permitted.**	
M/R/O	**Data Set Data Elements**
P	CARE PROFESSIONAL STAFF GROUP (COMMUNITY CARE)

ONWARD REFERRAL

Record Identity and Recipients: **To carry the unique record identifier and the recipient organisations.** **One occurrence of this group is permitted.**	
M/R/O	**Data Set Data Elements**
P	CIDS UNIQUE IDENTIFIER
P	ORGANISATION CODE (PROVIDER AT RECORD CREATION)
P	CIDS PRIME RECIPIENT IDENTITY
P	CIDS COPY RECIPIENT IDENTITY Multiple occurrences of this data item are permitted

One of the following Patient Identity Data Group Structures must be used:

Patient Identity (Standard): **To carry the details of the patient where there is no requirement to withhold the patient's identity.** **One occurrence of this group is required.**	
M/R/O	**Data Set Data Elements**
P	NHS NUMBER *and/or* LOCAL PATIENT IDENTIFIER *and* ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)

P	NHS NUMBER STATUS INDICATOR CODE
P	ORGANISATION CODE (LOCAL PATIENT IDENTIFIER)

OR

Patient Identity (Withheld): **To carry the details of the patient where the patient details are withheld.** **One occurrence of this group is required.**	
M/R/O	**Data Set Data Elements**
P	NHS NUMBER STATUS INDICATOR CODE

Onward Referral: **To carry the details of the onward referral.** **One occurrence of this group is permitted.**	
M/R/O	**Data Set Data Elements**
P	ONWARD REFERRAL IDENTIFIER
P	SERVICE REQUEST IDENTIFIER
P	REASON FOR ONWARD REFERRAL (COMMUNITY CARE)
P	ONWARD REFERRAL DATE
P	ORGANISATION CODE (RECEIVING)

DIAGNOSTICS WAITING TIMES AND ACTIVITY DATA SET

Change to Data Set: Changed Description

Diagnostics Waiting Times and Activity Data Set Overview

The column headed Opt (Optionality) shows whether the data element is Mandatory M or Optional O.

- M = Mandatory: this data element is mandatory and the technical process (e.g. submission of the data set, production of output etc) cannot be completed without this data element being present
- O = Optional: the inclusion of this data element is optional as required for local purposes.

Opt	**Data Set Data Elements**
Organisation and Reporting Period	
M	ORGANISATION CODE (CODE OF COMMISSIONER)
M	ORGANISATION CODE (CODE OF PROVIDER)
M	REPORTING PERIOD START DATE
M	REPORTING PERIOD END DATE
Patients Still Waiting - at month end. **Imaging divided into Magnetic Resonance Imaging, Computer Tomography, Non-obstetric ultrasound, Barium Enema and dual energy X-ray absorptiometry (DEXA) scans** **Multiple occurrences of this group are permitted.**	
M	DIAGNOSTIC TEST (IMAGING)
M	DIAGNOSTICS REPORTING TIME BAND
M	PATIENTS WAITING FOR DIAGNOSTIC TEST
Patients still waiting - at month end. **Physiological Measurement divided into Audiology - audiological assessments, Cardiology - echocardiography and electrophysiology, Neurophysiology - peripheral neurophysiology, Respiratory physiology - sleep studies and Urodynamics - pressures & flows.** **Multiple occurrences of this group are permitted.**	
M	DIAGNOSTIC TEST (PHYSIOLOGICAL MEASUREMENT)
M	DIAGNOSTICS REPORTING TIME BAND

M	PATIENTS WAITING FOR DIAGNOSTIC TEST
Patients still waiting - at month end. Endoscopy divided into Colonoscopy, Flexible sigmoidoscopy, Cystoscopy and Gastroscopy. Multiple occurrences of this group are permitted.	
M	DIAGNOSTIC TEST (ENDOSCOPY)
M	DIAGNOSTICS REPORTING TIME BAND
M	PATIENTS WAITING FOR DIAGNOSTIC TEST
Activity - number of tests/procedures carried out during the month. Imaging divided into Magnetic Resonance Imaging, Computer Tomography, Non-obstetric ultrasound, Barium Enema and dual energy X-ray absorptiometry (DEXA) scans. Multiple occurrences of this group are permitted.	
M	DIAGNOSTIC TEST (IMAGING)
M	WAITING LIST DIAGNOSTIC TESTS DONE
M	PLANNED DIAGNOSTIC TESTS DONE
M	UNSCHEDULED DIAGNOSTIC TESTS DONE
M	DIAGNOSTIC TESTS DONE TOTAL
M	DIAGNOSTIC TESTS COMMISSIONED FROM INDEPENDENT SECTOR
Activity - number of tests/procedures carried out during the month. Physiological Measurement divided into Audiology - audiological assessments, Cardiology - echocardiography and electrophysiology, Neurophysiology - peripheral neurophysiology, Respiratory physiology - sleep studies and Urodynamics - pressures & flows. Multiple occurrences of this group are permitted.	
M	DIAGNOSTIC TEST (PHYSIOLOGICAL MEASUREMENT)
M	WAITING LIST DIAGNOSTIC TESTS DONE
M	PLANNED DIAGNOSTIC TESTS DONE
M	UNSCHEDULED DIAGNOSTIC TESTS DONE
M	DIAGNOSTIC TESTS DONE TOTAL
M	DIAGNOSTIC TESTS COMMISSIONED FROM INDEPENDENT SECTOR
Activity - number of tests/procedures carried out during the month. Endoscopy divided into Colonoscopy, Flexible sigmoidoscopy, Cystoscopy and Gastroscopy. Multiple occurrences of this group are permitted.	
M	DIAGNOSTIC TEST (ENDOSCOPY)
M	WAITING LIST DIAGNOSTIC TESTS DONE
M	PLANNED DIAGNOSTIC TESTS DONE
M	UNSCHEDULED DIAGNOSTIC TESTS DONE
M	DIAGNOSTIC TESTS DONE TOTAL
M	DIAGNOSTIC TESTS COMMISSIONED FROM INDEPENDENT SECTOR

DIAGNOSTICS WAITING TIMES CENSUS DATA SET

Change to Data Set: Changed Description

Diagnostics Waiting Times Census Data Set Overview

The column headed Opt (Optionality) shows whether the data element is Mandatory M or Optional O.

- M = Mandatory: this data element is mandatory and the technical process (e.g. submission of the data set, production of output etc) cannot be completed without this data element being present
- O = Optional: the inclusion of this data element is optional as required for local purposes.

Opt	Data Set Data Elements
Organisation and Reporting Period	
M	ORGANISATION CODE (CODE OF COMMISSIONER)
M	ORGANISATION CODE (CODE OF PROVIDER)
M	REPORTING PERIOD START DATE
M	REPORTING PERIOD END DATE
Patients Still Waiting - at census Endoscopy Multiple occurrences of this group are permitted.	
M	DIAGNOSTIC TEST (ENDOSCOPY CENSUS)
M	DIAGNOSTICS REPORTING TIME BAND
M	PATIENTS WAITING FOR DIAGNOSTIC TEST
Patients still waiting - at census. Imaging Multiple occurrences of this group are permitted.	
M	DIAGNOSTIC TEST (IMAGING CENSUS)
M	DIAGNOSTICS REPORTING TIME BAND
M	PATIENTS WAITING FOR DIAGNOSTIC TEST
Patients still waiting - at census. Pathology Multiple occurrences of this group are permitted.	
M	DIAGNOSTIC TEST (PATHOLOGY CENSUS)
M	DIAGNOSTICS REPORTING TIME BAND
M	PATIENTS WAITING FOR DIAGNOSTIC TEST
Patients still waiting - at census. Physiological Measurement Multiple occurrences of this group are permitted.	
M	DIAGNOSTIC TEST (PHYSIOLOGICAL MEASUREMENT CENSUS)
M	DIAGNOSTICS REPORTING TIME BAND
M	PATIENTS WAITING FOR DIAGNOSTIC TEST

GENITOURINARY MEDICINE CLINIC ACTIVITY DATA SET

Change to Data Set: Changed Description

Genitourinary Medicine Clinic Activity Data Set Overview

The Opt (Optionality) column indicates the NHS recommendation for the inclusion of data:

~~**M = Mandatory** - This data element is mandatory, the message will be rejected by the Health Protection Agency if this data element is absent~~

~~**R = Required** - This data is required as part of NHS business rules and must be included where available or applicable.~~

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

Opt	Data Set Data Elements
M	SITE CODE (OF TREATMENT)

M	LOCAL PATIENT IDENTIFIER
R or R	SEXUAL HEALTH AND HIV ACTIVITY PROPERTY TYPE DIAGNOSTIC OR PROCEDURE CODING (SEXUAL HEALTH AND HUMAN IMMUNODEFICIENCY VIRUS RELEVANT READ CODES)
R	PERSON GENDER CURRENT
R	AGE AT ATTENDANCE DATE
R	SEXUAL ORIENTATION (CURRENT)
R	ETHNIC CATEGORY
R	COUNTRY CODE (BIRTH)
R	ORGANISATION CODE (PCT OF RESIDENCE)
R	LOWER LAYER SUPER OUTPUT AREA (RESIDENCE)
R	FIRST ATTENDANCE
M	ATTENDANCE DATE

IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES DATA SET

Change to Data Set: Changed Description

Improving Access to Psychological Therapies Data Set Overview

The Improving Access to Psychological Therapies Data Set has been incorporated early to allow users to see the changes, but please note that the implementation date is **1 April 2012**.

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

- ~~M = Mandatory: this data element is mandatory, the message will be rejected if this data element is absent~~
- ~~R = Required: this data element is required as part of NHS business rules and must be included where available or applicable~~
- M = Mandatory: this data element is mandatory and the technical process (e.g. submission of the data set, production of output etc) cannot be completed without this data element being present
- R = Required: NHS business processes cannot be delivered without this data element.

PERSONAL AND DEMOGRAPHIC DETAILS

Patient details: **To carry Patient Demographic details.** **One occurrence of this group is permitted.**	
M/R	**Data Set Data Elements**
R	NHS NUMBER
R	NHS NUMBER STATUS INDICATOR CODE
M	LOCAL PATIENT IDENTIFIER
M	ORGANISATION CODE (CODE OF PROVIDER)
M	PERSON BIRTH DATE
R	PERSON GENDER CODE CURRENT
M	POSTCODE OF USUAL ADDRESS
R	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)
R	ETHNIC CATEGORY
R	RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION CODE

R	SEXUAL ORIENTATION (CURRENT)
R	EX-BRITISH ARMED FORCES INDICATOR
R	LONG TERM PHYSICAL HEALTH CONDITION INDICATOR (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)

DISABILITY

Patient Disability details:
To carry details of the Patient's Perceived Disability.
Many occurrences of this group are permitted (one for each disability).

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

REFERRAL DETAILS

Improving Access to Psychological Therapies Referral details:
To carry details of the Referral.
Many occurrences of this group are permitted (one occurrence for each Referral).

M/R	Data Set Data Elements
R	NHS NUMBER
M	LOCAL PATIENT IDENTIFIER
M	ORGANISATION CODE (CODE OF PROVIDER)
M	SERVICE REQUEST IDENTIFIER
R	REFERRAL REQUEST RECEIVED DATE
R	SOURCE OF REFERRAL FOR MENTAL HEALTH
R	SERVICE REQUEST ACCEPTANCE INDICATOR
R	ORGANISATION CODE (CODE OF COMMISSIONER)
R	PROVISIONAL DIAGNOSIS (ICD)
R	YEAR AND MONTH OF SYMPTOMS ONSET (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)
R	PREVIOUS SYMPTOM INDICATOR
R	IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES CARE SPELL END CODE
R	END DATE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)

APPOINTMENT DETAILS

Improving Access to Psychological Therapies Appointment details:
To carry details of each Appointment.
Many occurrences of this group are permitted (one occurrence for each Appointment).

M/R	Data Set Data Elements
R	NHS NUMBER
M	LOCAL PATIENT IDENTIFIER
M	ORGANISATION CODE (CODE OF PROVIDER)
M	SERVICE REQUEST IDENTIFIER
M	APPOINTMENT DATE
R	CARE PROFESSIONAL ROLE CODE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)

M	ATTENDED OR DID NOT ATTEND CODE
R	CLINICAL CONTACT DURATION OF APPOINTMENT
R	APPOINTMENT TYPE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES)
R	CONSULTATION MEDIUM USED
R	THERAPY TYPE (IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES) (Up to four types may be recorded for each APPOINTMENT)
R	EMPLOYMENT STATUS
R	EMPLOYMENT SUPPORT SUITABILITY INDICATOR
R	EMPLOYMENT SUPPORT REFERRAL DATE
R	PSYCHOTROPIC MEDICATION USAGE
R	STATUTORY SICK PAY INDICATOR
R	PHQ-9 TOTAL SCORE
R	GENERALISED ANXIETY DISORDER SCORE
R	WORK AND SOCIAL ADJUSTMENT SCALE SCORE
R	AGORAPHOBIA MOBILITY INVENTORY SCORE (WHEN ACCOMPANIED)
R	AGORAPHOBIA MOBILITY INVENTORY SCORE (WHEN ALONE)
R	AGORAPHOBIA SCORE
R	GENERALISED ANXIETY DISORDER PENN STATE WORRY SCORE
R	HEALTH ANXIETY INVENTORY SHORT WEEK SCALE SCORE
R	OBSESSIVE COMPULSIVE DISORDER INVENTORY SCORE
R	PANIC DISORDER SEVERITY SCALE SCORE
R	POST TRAUMATIC STRESS DISORDER IMPACT OF EVENTS SCALE REVISED SCORE
R	SOCIAL PHOBIA INVENTORY SCORE
R	SOCIAL PHOBIA SCORE
R	SPECIFIC PHOBIA SCORE

INTER-PROVIDER TRANSFER ADMINISTRATIVE MINIMUM DATA SET

Change to Data Set: Changed Description

Inter-Provider Transfer Administrative Minimum Data Set Overview

The Opt (Optionality) column indicates the NHS recommendation for the inclusion of data:

- M = Mandatory: this data element is mandatory and the technical process (e.g. submission of the data set, production of output etc) cannot be completed without this data element being present
- O = Optional: the inclusion of this data element is optional as required for local purposes.

Opt	Data Set Data Elements
Patient details: To carry patient demographic details	
M	PERSON FAMILY NAME
M	PERSON GIVEN NAME
M	PERSON TITLE
M	CORRESPONDENCE ADDRESS
M	POSTCODE OF CORRESPONDENCE ADDRESS
M	PERSON BIRTH DATE
M	NHS NUMBER

M	LOCAL PATIENT IDENTIFIER
Patient contact details: The contact details of the patient or lead contact as applicable. If the name of a lead contact for the patient is present, the contact details apply to the lead contact and not the patient	
O	PERSON FULL NAME (PATIENT LEAD CONTACT)
O	CONTACT TELEPHONE NUMBER (HOME)
O	CONTACT TELEPHONE NUMBER (WORK)
O	CONTACT TELEPHONE NUMBER (MOBILE)
O	CONTACT EMAIL ADDRESS (PATIENT OR LEAD CONTACT)
General Practitioner Details: To carry details of the patient's specified General Medical Practitioner	
M	PERSON NAME (SPECIFIED GENERAL MEDICAL PRACTITIONER)
M	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)
Referring Organisation	
M	ORGANISATION NAME (REFERRING)
M	REFERRING ORGANISATION CODE
M	CARE PROFESSIONAL NAME (REFERRING)
M	REFERRER CODE
M	TREATMENT FUNCTION CODE (REFERRING SERVICE)
M	PERSON FULL NAME (REFERRER CONTACT)
O	CONTACT TELEPHONE NUMBER (REFERRING ORGANISATION)
O	CONTACT EMAIL ADDRESS (REFERRING ORGANISATION)
Referral To Treatment: To carry details of the patient's Referral To Treatment Status and Patient Pathway Information	
M	PATIENT PATHWAY IDENTIFIER
M	ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER ISSUER)
M	REFERRAL TO TREATMENT PERIOD STATUS (INTER-PROVIDER TRANSFER)
M	DECISION TO REFER DATE (INTER-PROVIDER TRANSFER)
M	REFERRAL TO TREATMENT PERIOD START DATE
M	REFERRAL RAISED REASON (INTER-PROVIDER TRANSFER)
Organisation along the Patient Pathway - Repeating group to carry all the Organisations involved in the Pathway up until this Service Request	
M	ORGANISATION CODE (ON PATHWAY)
Receiving Organisation: To carry details of the receiving Organisation and Care Professional	
M	ORGANISATION NAME (RECEIVING)
M	ORGANISATION CODE (RECEIVING)
O	CARE PROFESSIONAL NAME (RECEIVING)
M	TREATMENT FUNCTION CODE (RECEIVING SERVICE)
Details of the dates of the transfer information was sent and received	
M	SERVICE REQUESTED DATE (INTER-PROVIDER TRANSFER)
O	REFERRAL REQUEST RECEIVED DATE (INTER-PROVIDER TRANSFER)

MENTAL HEALTH MINIMUM DATA SET (VERSION 4-0)

Change to Data Set: Changed Description

Mental Health Minimum Data Set Overview

~~The Mandatory or Required (M/R/O) column indicates the recommendation for the inclusion of data:~~The Mandatory, Required or Optional (M/R/O) column indicates the recommendation for the inclusion of data:

~~**M** = Mandatory: This data element is mandatory, the message will be rejected if this data element is absent~~
~~**R** = Required: This data is required as part of NHS business rules and must be included where available or applicable~~
~~**O** = Optional: the flow of this data is optional. It should be included at the discretion of the submitting organisation and their commissioners as required for local purposes.~~

- M = Mandatory: this data element is mandatory and the technical process (e.g. submission of the data set, production of output etc) cannot be completed without this data element being present
- R = Required: NHS business processes cannot be delivered without this data element
- O = Optional: the inclusion of this data element is optional as required for local purposes.

TABLE 1: MASTER PATIENT INDEX (MPI)	
Master Patient Index: **This table should include a record for every patient receiving care within the Mental Health Service.**	
M/R/O	**Data Set Data Elements**
M	MHMDS LOCAL PATIENT IDENTIFIER
R	PERSON BIRTH DATE
R	PERSON GENDER CODE CURRENT
R	PERSON MARITAL STATUS
R	ETHNIC CATEGORY
R	NHS NUMBER
R	POSTCODE OF USUAL ADDRESS
R	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)
R	ORGANISATION CODE (CODE OF COMMISSIONER)
O	YEAR OF FIRST KNOWN PSYCHIATRIC CARE

TABLE 2: PSYCHOSIS SERVICE (PSYCHOSIS)	
Psychosis Service: **This table should contain a record for each patient seen within specialist psychosis services including Early Intervention in Psychosis Services.**	
M/R/O	**Data Set Data Elements**
M	MHMDS LOCAL PATIENT IDENTIFIER
R	PRODROME PSYCHOSIS DATE
R	EMERGENT PSYCHOSIS DATE
R	MANIFEST PSYCHOSIS DATE
R	PRESCRIPTION DATE (ANTI-PSYCHOTIC MEDICATION)
R	PSYCHOSIS TREATMENT START DATE

TABLE 3: EMPLOYMENT STATUS (EMP)	
Employment Status: **This table should contain a record for each set of employment details recorded for the patient.**	
M/R/O	**Data Set Data Elements**
M	MHMDS LOCAL PATIENT IDENTIFIER
M	EMPLOYMENT STATUS RECORDED DATE
R	EMPLOYMENT STATUS
O	WEEKLY HOURS WORKED

TABLE 4: ACCOMMODATION STATUS (ACCOM)	
Accommodation Status: **This table should contain a record for each set of accommodation status details recorded for the patient.**	
M/R/O	**Data Set Data Elements**
M	MHMDS LOCAL PATIENT IDENTIFIER
M	ACCOMMODATION STATUS DATE
R	SETTLED ACCOMMODATION INDICATOR (MENTAL HEALTH)
O	ACCOMMODATION STATUS (MENTAL HEALTH)

TABLE 5: REFERRAL (REFER)	
Referral: **This table should contain a record for each external referral to the mental health care provider for the patient. This includes referrals which were not accepted.**	
M/R/O	**Data Set Data Elements**
M	MHMDS LOCAL PATIENT IDENTIFIER
M	REFERRAL REQUEST RECEIVED DATE
R	SOURCE OF REFERRAL FOR MENTAL HEALTH
O	SERVICE REQUEST STATUS DATE (MENTAL HEALTH)
R	STATUS OF SERVICE REQUEST (MENTAL HEALTH)
R	DISCHARGE DATE (MENTAL HEALTH SERVICE)
R	DISCHARGE REASON (MENTAL HEALTH SERVICE)

TABLE 6: MENTAL HEALTH TEAM EPISODE (TEAMEP)	
Mental Health Team Episode: **This table should contain a record for every non-inpatient Mental Health Care Team Episode for the patient.**	
M/R/O	**Data Set Data Elements**
M	MHMDS LOCAL PATIENT IDENTIFIER
M	START DATE (ADULT MENTAL HEALTH CARE TEAM EPISODE)
R	END DATE (ADULT MENTAL HEALTH CARE TEAM EPISODE)
R	ADULT MENTAL HEALTH CARE TEAM LOCAL UNIQUE IDENTIFIER

TABLE 7: NHS DAY CARE EPISODE (DAYEP)	
NHS Day Care Episode: **This table should contain a record for every Mental Health NHS Day Care Episode for the patient.**	
M/R/O	**Data Set Data Elements**
M	MHMDS LOCAL PATIENT IDENTIFIER
M	START DATE (MENTAL HEALTH NHS DAY CARE EPISODE)
R	END DATE (MENTAL HEALTH NHS DAY CARE EPISODE)

TABLE 8: CONSULTANT OUTPATIENT EPISODE (OPEP)	
Consultant Outpatient Episode: **This table should contain a record for every Consultant Outpatient Episode for the patient.**	
M/R/O	**Data Set Data Elements**
M	MHMDS LOCAL PATIENT IDENTIFIER
M	START DATE (CONSULTANT OUT-PATIENT EPISODE)

R	END DATE (CONSULTANT OUT-PATIENT EPISODE)

TABLE 9: ACUTE HOME BASED CARE EPISODE (HBCAREEP)	
Acute Home Based Care Episode: **This table should contain a record for every Mental Health Care Professional Episode (Acute Home Based) for the patient.**	
M/R/O	**Data Set Data Elements**
M	MHMDS LOCAL PATIENT IDENTIFIER
M	START DATE (MENTAL HEALTH CARE PROFESSIONAL EPISODE (ACUTE HOME BASED))
R	END DATE (MENTAL HEALTH CARE PROFESSIONAL EPISODE (ACUTE HOME BASED))

TABLE 10: MENTAL HEALTH NHS CARE HOME STAY EPISODE (NHSCAREHOMEEP)	
Mental Health NHS Care Home Stay Episode: **This table should contain a record for every Mental Health NHS Care Home Stay (Nursing Care) and/or Mental Health NHS Care Home Stay (Residential) for the patient.**	
M/R/O	**Data Set Data Elements**
M	MHMDS LOCAL PATIENT IDENTIFIER
M	START DATE (MENTAL HEALTH NHS CARE HOME STAY)
R	END DATE (MENTAL HEALTH NHS CARE HOME STAY)

TABLE 11: HOSPITAL PROVIDER SPELL (PROVSPELL)	
Hospital Provider Spell: **This table should contain a record for each Hospital Provider Spell for the patient.**	
M/R/O	**Data Set Data Elements**
M	MHMDS LOCAL PATIENT IDENTIFIER
M	START DATE (HOSPITAL PROVIDER SPELL)
R	DISCHARGE DATE (HOSPITAL PROVIDER SPELL)
R	ADMISSION METHOD CODE (HOSPITAL PROVIDER SPELL)
R	DISCHARGE METHOD CODE (HOSPITAL PROVIDER SPELL)

TABLE 12: INPATIENT EPISODE (INPATEP)	
Inpatient Episode: **This table should contain a record for every Consultant Episode (Hospital Provider) or Nursing Episode which occurred during a Hospital Provider Spell for the patient.**	
M/R/O	**Data Set Data Elements**
M	MHMDS LOCAL PATIENT IDENTIFIER
M	START DATE (EPISODE)
R	END DATE (EPISODE)
R	ADULT MENTAL HEALTH CARE PROFESSIONAL LOCAL UNIQUE IDENTIFIER

TABLE 13: WARD STAYS WITHIN HOSPITAL PROVIDER SPELL (WARDSTAYS)	
Ward Stays Within Hospital Provider Spell: **This table should contain a record for every Ward Stay which occurred during a Hospital Provider Spell for the patient.**	
M/R/O	**Data Set Data Elements**
M	MHMDS LOCAL PATIENT IDENTIFIER
M	START DATE (WARD STAY)
R	END DATE (WARD STAY)

R	INTENDED CLINICAL CARE INTENSITY CODE (MENTAL HEALTH)
R	WARD SECURITY LEVEL
R	SEX OF PATIENTS CODE
R	INTENDED AGE GROUP

TABLE 14: DELAYED DISCHARGE (DELAYEDDISCHARGE)	
Delayed Discharge: **This table should contain a record for every Mental Health Delayed Discharge Period which occurred during a Hospital Provider Spell.**	
M/R/O	**Data Set Data Elements**
M	MHMDS LOCAL PATIENT IDENTIFIER
M	START DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD)
R	END DATE (MENTAL HEALTH DELAYED DISCHARGE PERIOD)
R	MENTAL HEALTH DELAYED DISCHARGE REASON

TABLE 15: CLINICAL TEAM (CLINTEAM)	
Clinical Team: **This table should contain a record for each Adult Mental Health Care Team.**	
M/R/O	**Data Set Data Elements**
M	ADULT MENTAL HEALTH CARE TEAM LOCAL UNIQUE IDENTIFIER
O	ADULT MENTAL HEALTH CARE TEAM NAME
R	ADULT MENTAL HEALTH CARE TEAM TYPE

TABLE 16: STAFF (STAFF)	
Staff: **This table should contain a record for every Mental Health professional responsible for providing the patient's care.**	
M/R/O	**Data Set Data Elements**
M	ADULT MENTAL HEALTH CARE PROFESSIONAL LOCAL UNIQUE IDENTIFIER
R	MAIN SPECIALTY CODE (MENTAL HEALTH)
R	OCCUPATION CODE
R	CARE PROFESSIONAL (JOB ROLE CODE)

TABLE 17: CARE CO-ORDINATOR ASSIGNMENT(CCASS)	
Care Co-ordinator Assignment: **This table should contain a record for each assignment of a Care Co-ordinator to the patient.**	
M/R/O	**Data Set Data Elements**
M	MHMDS LOCAL PATIENT IDENTIFIER
M	START DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT)
R	END DATE (MENTAL HEALTH CARE COORDINATOR ASSIGNMENT)
R	ADULT MENTAL HEALTH CARE PROFESSIONAL LOCAL UNIQUE IDENTIFIER

TABLE 18: RESPONSIBLE CLINICIAN ASSIGNMENT(RCASS)	
Responsible Clinician Assignment: **This table should contain a record for each assignment of a Mental Health Responsible Clinician to the patient.**	
M/R/O	**Data Set Data Elements**
M	MHMDS LOCAL PATIENT IDENTIFIER

M	START DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT)
R	END DATE (MENTAL HEALTH RESPONSIBLE CLINICIAN ASSIGNMENT)
R	ADULT MENTAL HEALTH CARE PROFESSIONAL LOCAL UNIQUE IDENTIFIER

TABLE 19: HEALTH CARE PROFESSIONAL CONTACTS (HCPCONT)

Health Care Professional Contacts:
This table should contain a record for each separate contact with a health care professional for the patient, including Consultant Out-patient Appointments, Professional Staff Group Contacts, Care Coordinator Contacts, and Community Psychiatric Nurse Contacts.

M/R/O	Data Set Data Elements
M	MHMDS LOCAL PATIENT IDENTIFIER
M	CARE CONTACT DATE (MENTAL HEALTH)
O	CARE CONTACT TIME (MENTAL HEALTH)
R	CLINICAL CONTACT DURATION OF APPOINTMENT
R	ADULT MENTAL HEALTH CARE PROFESSIONAL LOCAL UNIQUE IDENTIFIER
R	ADULT MENTAL HEALTH CARE TEAM LOCAL UNIQUE IDENTIFIER
R	CONSULTATION MEDIUM USED
R	CARE CONTACT SUBJECT
R	ACTIVITY LOCATION TYPE CODE
R	ATTENDED OR DID NOT ATTEND CODE

TABLE 20: NHS DAY CARE FACILITY ATTENDANCES (DAYATT)

NHS Day Care Facility Attendances:
This table should contain a record for each separate Mental Health NHS Day Care Attendance for the patient.

M/R/O	Data Set Data Elements
M	MHMDS LOCAL PATIENT IDENTIFIER
M	CARE CONTACT DATE (MENTAL HEALTH)
R	ATTENDED OR DID NOT ATTEND CODE

TABLE 21: REVIEWS (REV)

Reviews:
This table should contain a record for each review undertaken for the patient.

M/R/O	Data Set Data Elements
M	MHMDS LOCAL PATIENT IDENTIFIER
M	REVIEW DATE
R	CARE PROGRAMME APPROACH REVIEW ABUSE QUESTION ASKED INDICATOR
R	ADULT MENTAL HEALTH CARE PROFESSIONAL LOCAL UNIQUE IDENTIFIER
R	ADULT MENTAL HEALTH CARE TEAM LOCAL UNIQUE IDENTIFIER

TABLE 22: PRIMARY DIAGNOSIS (PRIMDIAG)

Primary Diagnosis:
This table should contain a record for the Primary Diagnosis recorded for the patient, using ICD10 codes.

M/R/O	Data Set Data Elements
M	MHMDS LOCAL PATIENT IDENTIFIER
M	DIAGNOSIS DATE
R	PRIMARY DIAGNOSIS (ICD)

TABLE 23: SECONDARY DIAGNOSIS (SECDIAG)	
Secondary Diagnosis: **This table should contain a record for each Secondary Diagnosis recorded for the patient, using ICD10 codes.**	
M/R/O	**Data Set Data Elements**
M	MHMDS LOCAL PATIENT IDENTIFIER
M	DIAGNOSIS DATE
R	SECONDARY DIAGNOSIS (ICD)

TABLE 24: CPA EPISODE (CPAEP)	
CPA Episode: **This table should contain a record for each separate period of time the patient spent on Care Programme Approach.**	
M/R/O	**Data Set Data Elements**
M	MHMDS LOCAL PATIENT IDENTIFIER
R	START DATE (CARE PROGRAMME APPROACH CARE)
R	END DATE (CARE PROGRAMME APPROACH CARE)

TABLE 25: CRISIS PLAN (CRISISPLAN)	
Crisis Plan: **This table should contain a record for each Mental Health Crisis Plan created for the patient.**	
M/R/O	**Data Set Data Elements**
M	MHMDS LOCAL PATIENT IDENTIFIER
R	MENTAL HEALTH CRISIS PLAN CREATION DATE
R	MENTAL HEALTH CRISIS PLAN LAST UPDATED DATE

TABLE 26: MENTAL HEALTH CLUSTERING TOOL (MHCT)	
Mental Health Clustering Tool: **This table should contain details of each Mental Health Clustering Tool assessment undertaken for a patient.**	
M/R/O	**Data Set Data Elements**
M	MHMDS LOCAL PATIENT IDENTIFIER
M	ASSESSMENT TOOL COMPLETION DATE
R	MENTAL HEALTH CLUSTERING TOOL ASSESSMENT REASON
R	HONOS RATING 1 SCORE
R	HONOS RATING 2 SCORE
R	HONOS RATING 3 SCORE
R	HONOS RATING 4 SCORE
R	HONOS RATING 5 SCORE
R	HONOS RATING 6 SCORE
R	HONOS RATING 7 SCORE
R	HONOS RATING 8 SCORE
R	HONOS RATING 8 TYPE
R	HONOS RATING 9 SCORE
R	HONOS RATING 10 SCORE
R	HONOS RATING 11 SCORE
R	HONOS RATING 12 SCORE

R	SUMMARY ASSESSMENT OF CHARACTERISTICS RATING 13 SCORE
R	SUMMARY ASSESSMENT OF CHARACTERISTICS RATING A SCORE
R	SUMMARY ASSESSMENT OF CHARACTERISTICS RATING B SCORE
R	SUMMARY ASSESSMENT OF CHARACTERISTICS RATING C SCORE
R	SUMMARY ASSESSMENT OF CHARACTERISTICS RATING D SCORE
R	SUMMARY ASSESSMENT OF CHARACTERISTICS RATING E SCORE
R	MENTAL HEALTH CARE CLUSTER SUPER CLASS CODE
R	MENTAL HEALTH CARE CLUSTER CODE

TABLE 27: PAYMENT BY RESULTS CARE CLUSTER (CLUSTER)

Payment By Results Care Cluster:
This table should contain details of the period that the patient is assigned to a Mental Health Care Cluster following a Mental Health Care Clustering Tool Assessment.

M/R/O	Data Set Data Elements
M	MHMDS LOCAL PATIENT IDENTIFIER
M	START DATE (MENTAL HEALTH CARE CLUSTER)
R	END DATE (MENTAL HEALTH CARE CLUSTER)
R	MENTAL HEALTH CARE CLUSTER CODE
R	MENTAL HEALTH CARE CLUSTER END REASON

TABLE 28: HEALTH OF THE NATION OUTCOME SCALE (HONOS)

Health of the Nation Outcome Scale:
This table should contain details of each Health of the Nation Outcome Scale (Working Age Adults) assessment undertaken for a patient.

M/R/O	Data Set Data Elements
M	MHMDS LOCAL PATIENT IDENTIFIER
M	ASSESSMENT TOOL COMPLETION DATE
R	HONOS RATING 1 SCORE
R	HONOS RATING 2 SCORE
R	HONOS RATING 3 SCORE
R	HONOS RATING 4 SCORE
R	HONOS RATING 5 SCORE
R	HONOS RATING 6 SCORE
R	HONOS RATING 7 SCORE
R	HONOS RATING 8 SCORE
R	HONOS RATING 8 TYPE
R	HONOS RATING 9 SCORE
R	HONOS RATING 10 SCORE
R	HONOS RATING 11 SCORE
R	HONOS RATING 12 SCORE

TABLE 29: HEALTH OF THE NATION OUTCOME SCALE 65+ (HONOS65+)

Health of the Nation Outcome Scale 65+:
This table should contain details of each Health of the Nation Outcome Scale (65+) assessment undertaken for a patient.

M/R/O	Data Set Data Elements
M	MHMDS LOCAL PATIENT IDENTIFIER

M	ASSESSMENT TOOL COMPLETION DATE
R	HONOS 65+ RATING 1 SCORE
R	HONOS 65+ RATING 2 SCORE
R	HONOS 65+ RATING 3 SCORE
R	HONOS 65+ RATING 4 SCORE
R	HONOS 65+ RATING 5 SCORE
R	HONOS 65+ RATING 6 SCORE
R	HONOS 65+ RATING 7 SCORE
R	HONOS 65+ RATING 8 SCORE
R	HONOS 65+ RATING 8 TYPE
R	HONOS 65+ RATING 9 SCORE
R	HONOS 65+ RATING 10 SCORE
R	HONOS 65+ RATING 11 SCORE
R	HONOS 65+ RATING 12 SCORE

TABLE 30: HEALTH OF THE NATION OUTCOME SCALE (CHILDREN AND ADOLESCENTS) (HONOSCA)

Health of the Nation Outcome Scale (Children and Adolescents):
This table should contain details of each Health of the Nation Outcome Scale (Children and Adolescents) assessment undertaken for a patient.

M/R/O	Data Set Data Elements
M	MHMDS LOCAL PATIENT IDENTIFIER
M	ASSESSMENT TOOL COMPLETION DATE
R	HONOS-CA RATING 1 SCORE
R	HONOS-CA RATING 2 SCORE
R	HONOS-CA RATING 3 SCORE
R	HONOS-CA RATING 4 SCORE
R	HONOS-CA RATING 5 SCORE
R	HONOS-CA RATING 6 SCORE
R	HONOS-CA RATING 7 SCORE
R	HONOS-CA RATING 8 SCORE
R	HONOS-CA RATING 9 SCORE
R	HONOS-CA RATING 10 SCORE
R	HONOS-CA RATING 11 SCORE
R	HONOS-CA RATING 12 SCORE
R	HONOS-CA RATING 13 SCORE
R	HONOS-CA RATING B14 SCORE
R	HONOS-CA RATING B15 SCORE

TABLE 31: HEALTH OF THE NATION OUTCOME SCALE (SECURE) (HONOSSECURE)

Health of the Nation Outcome Scale (Secure):
This table should contain details of each Health of the Nation Outcome Scale (Secure) assessment undertaken for a patient.

M/R/O	Data Set Data Elements
M	MHMDS LOCAL PATIENT IDENTIFIER
M	ASSESSMENT TOOL COMPLETION DATE
R	HONOS-SECURE RATING A SCORE
R	HONOS-SECURE RATING B SCORE

R	HONOS-SECURE RATING C SCORE
R	HONOS-SECURE RATING D SCORE
R	HONOS-SECURE RATING E SCORE
R	HONOS-SECURE RATING F SCORE
R	HONOS-SECURE RATING G SCORE

TABLE 32: PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Patient Health Questionnaire:
This table should contain details of each Patient Health Questionnaire-9 assessment undertaken for a patient.

M/R/O	Data Set Data Elements
M	MHMDS LOCAL PATIENT IDENTIFIER
M	ASSESSMENT TOOL COMPLETION DATE
O	PHQ-9 QUESTION 1 SCORE
O	PHQ-9 QUESTION 2 SCORE
O	PHQ-9 QUESTION 3 SCORE
O	PHQ-9 QUESTION 4 SCORE
O	PHQ-9 QUESTION 5 SCORE
O	PHQ-9 QUESTION 6 SCORE
O	PHQ-9 QUESTION 7 SCORE
O	PHQ-9 QUESTION 8 SCORE
O	PHQ-9 QUESTION 9 SCORE
O	PHQ-9 TOTAL SCORE

TABLE 33: SOCIAL SERVICE STATUTORY ASSESSMENT (SSASS)

Social Service Statutory Assessment:
This table should contain a record for each Social Services Statutory Assessment undertaken for a patient.

M/R/O	Data Set Data Elements
M	MHMDS LOCAL PATIENT IDENTIFIER
M	STATUTORY ASSESSMENT DATE
O	STATUTORY ASSESSMENT TYPE

TABLE 34: MENTAL HEALTH ACT EVENT EPISODES (MHAEVENT)

Mental Health Act Event:
This table should contain a record for patients formally detailed under the Mental Health Act 1983 or other Acts. A separate record should be included for every separate section of the Mental Health Act that the patient is detained under.

M/R/O	Data Set Data Elements
M	MHMDS LOCAL PATIENT IDENTIFIER
M	START DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)
M	START TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)
R	EXPIRY DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)
R	EXPIRY TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)
R	END DATE (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)
R	END TIME (MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION)
R	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE
R	MENTAL HEALTH ACT 2007 MENTAL CATEGORY

TABLE 35: SUPERVISED COMMUNITY TREATMENT (SCT)	
Supervised Community Treatment: **This table should contain a record for each separate period of Supervised Community Treatment under section 17a of the Mental Health Act 1983 for the patient.**	
M/R/O	**Data Set Data Elements**
M	MHMDS LOCAL PATIENT IDENTIFIER
M	START DATE (SUPERVISED COMMUNITY TREATMENT)
R	EXPIRY DATE (SUPERVISED COMMUNITY TREATMENT)
R	END DATE (SUPERVISED COMMUNITY TREATMENT)
R	SUPERVISED COMMUNITY TREATMENT END REASON

TABLE 36: SUPERVISED COMMUNITY TREATMENT RECALL (SCTRECALL)	
Supervised Community Treatment Recall: **This table should contain a record for each separate period of recall into hospital for a patient on Supervised Community Treatment under section 17a of the Mental Health Act 1983.**	
M/R/O	**Data Set Data Elements**
M	MHMDS LOCAL PATIENT IDENTIFIER
M	START DATE (SUPERVISED COMMUNITY TREATMENT RECALL)
M	START TIME (SUPERVISED COMMUNITY TREATMENT RECALL)
R	END DATE (SUPERVISED COMMUNITY TREATMENT RECALL)
R	END TIME (SUPERVISED COMMUNITY TREATMENT RECALL)

TABLE 37: INTERVENTION (READ) (INTERVENTION)	
Intervention (READ): **This table should contain a record for each element of treatment or intervention recorded for the patient, using READ codes.**	
M/R/O	**Data Set Data Elements**
M	MHMDS LOCAL PATIENT IDENTIFIER
M	DATE OF PATIENT TREATMENT OR INTERVENTION (READ)
O	PATIENT TREATMENT OR INTERVENTION (READ)

TABLE 38: ADMINISTRATIONS OF ECT (ECT)	
Administrations of ECT: **This table should contain a record for each separate instance of Electro-Convulsive Therapy administered to the patient.**	
M/R/O	**Data Set Data Elements**
M	MHMDS LOCAL PATIENT IDENTIFIER
M	PROCEDURE DATE (ELECTRO-CONVULSIVE THERAPY)

TABLE 39: MENTAL HEALTH LEAVE OF ABSENCE (LOA)	
Mental Health Leave of Absence: **This table should contain a record for each separate period of Mental Health Leave of Absence under section 17 of the Mental Health Act 1983 involving an overnight stay for the patient.**	
M/R/O	**Data Set Data Elements**
M	MHMDS LOCAL PATIENT IDENTIFIER
M	START DATE (MENTAL HEALTH LEAVE OF ABSENCE)
R	END DATE (MENTAL HEALTH LEAVE OF ABSENCE)
R	LEAVE OF ABSENCE END REASON

TABLE 40: MENTAL HEALTH ABSENCE WITHOUT LEAVE (AWOL)	
Mental Health Absence Without Leave: **This table should contain a record for each separate period of Mental Health Absence Without Leave for the patient.**	
M/R/O	**Data Set Data Elements**
M	MHMDS LOCAL PATIENT IDENTIFIER
M	START DATE (MENTAL HEALTH ABSENCE WITHOUT LEAVE)
R	END DATE (MENTAL HEALTH ABSENCE WITHOUT LEAVE)
R	ABSENCE WITHOUT LEAVE END REASON

TABLE 41: HOME LEAVE (HOMELEAVE)	
Home Leave: **This table should contain a record for each separate period of Home Leave from a Hospital Provider Spell for a patient who is NOT liable for detention under the Mental Health Act 1983 and who is NOT on Supervised Community Treatment.**	
M/R/O	**Data Set Data Elements**
M	MHMDS LOCAL PATIENT IDENTIFIER
M	START DATE (HOME LEAVE)
R	END DATE (HOME LEAVE)

TABLE 42: SELF HARM (SELFHARM)	
Self Harm: **This table should contain a record for each separate reported incident of self harm by the patient during a Hospital Provider Spell.**	
M/R/O	**Data Set Data Elements**
M	MHMDS LOCAL PATIENT IDENTIFIER
M	DATE OF SELF HARM

TABLE 43: USE OF RESTRAINT (RESTRAINT)	
Restraint: **This table should contain a record for each separate reported incident of physical restraint of the patient by one or more members of staff in response to aggressive behaviour or resistance to treatment, during a Hospital Provider Spell.**	
M/R/O	**Data Set Data Elements**
M	MHMDS LOCAL PATIENT IDENTIFIER
M	DATE OF PHYSICAL RESTRAINT
O	DURATION OF PHYSICAL RESTRAINT

TABLE 44: ASSAULTS ON PATIENT (ASSAULT)	
Assaults on Patient: **This table should contain a record for each separate reported incident of assault on the patient by another patient during a Hospital Provider Spell.**	
M/R/O	**Data Set Data Elements**
M	MHMDS LOCAL PATIENT IDENTIFIER
M	DATE OF ASSAULT ON PATIENT

TABLE 45: PERIODS OF SECLUSION (SECLUSION)
Periods of Seclusion: **This table should contain a record for each separate incident of seclusion of the patient during a**

Hospital Provider Spell.	
M / R / O	**Data Set Data Elements**
M	MHMDS LOCAL PATIENT IDENTIFIER
M	DATE OF SECLUSION
O	DURATION OF SECLUSION

NHS HEALTH CHECKS DATA SET

Change to Data Set: Changed Description

NHS Health Checks Data Set Overview

The NHS Health Checks Data Set has been incorporated early to allow users to see the changes, but please note that the implementation date is **1 July 2012**.

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

~~M = Mandatory - This data element is mandatory, the message will be rejected if this data element is absent~~
~~R = Required - This data is required as part of NHS business rules and must be included where available or applicable~~

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

Reporting Period Details: To carry the details of the reporting period and the eligible population.	
M / R	**Data Set Data Elements**
M	REPORTING PERIOD START DATE
M	REPORTING PERIOD END DATE
M	ELIGIBLE POPULATION TOTAL (NHS HEALTH CHECK)
Organisation Details: **To carry the details of the provider and commissioner organisations for the NHS Health Check.**	
M / R	**Data Set Data Elements**
M	ORGANISATION CODE (NHS HEALTH CHECK PROVIDER)
M	ORGANISATION CODE (CODE OF COMMISSIONER)
Person Demographics: **To carry the demographic details of the person.**	
M / R	**Data Set Data Elements**
M	LOWER LAYER SUPER OUTPUT AREA (RESIDENCE)
M	AGE AT ATTENDANCE DATE
M	PERSON GENDER CODE CURRENT
M	ETHNIC CATEGORY
Health Check Person Record: **To carry the details of the person's NHS Health Check invitation.**	
M / R	**Data Set Data Elements**
R	INVITATION OFFER SENT INDICATOR (NHS HEALTH CHECK)
Health Check Person Assessment: **To carry the details of the person's NHS Health Check Assessment.**	
M / R	**Data Set Data Elements**

M	ACTIVITY LOCATION TYPE CODE (NHS HEALTH CHECK)
M	BODY MASS INDEX
M	BLOOD PRESSURE SITTING
M	TOTAL CHOLESTEROL HIGH DENSITY LIPOPROTEIN RATIO
M	TOTAL CHOLESTEROL LEVEL
M	PHYSICAL ACTIVITY LEVEL
M	SMOKING STATUS CODE
M	CARDIOVASCULAR DISEASE RISK SCORE

Health Check Information and Advice:
To carry the details of information and advice provided at an NHS Health Check Assessment.

M/R	Data Set Data Elements
R	INFORMATION AND ADVICE PROVIDED INDICATOR (GENERAL LIFESTYLE ADVICE)
R	INFORMATION AND ADVICE PROVIDED INDICATOR (STOP SMOKING ADVICE)
R	INFORMATION AND ADVICE PROVIDED INDICATOR (WEIGHT MANAGEMENT ADVICE)

Health Check Brief Interventions Provided:
To carry the details of brief interventions provided at an NHS Health Check Assessment.

M/R	Data Set Data Elements
R	BRIEF INTERVENTION PROVIDED INDICATOR (PHYSICAL ACTIVITY BRIEF)

Health Check Signposting:
To carry the details of signposting to services provided at an NHS Health Check Assessment.

M/R	Data Set Data Elements
R	SIGNPOSTING TO SERVICE INDICATOR (PHYSICAL ACTIVITY SERVICE)
R	SIGNPOSTING TO SERVICE INDICATOR (STOP SMOKING SERVICE)
R	SIGNPOSTING TO SERVICE INDICATOR (WEIGHT MANAGEMENT SERVICE)

Health Check Referrals:
To carry the details of referrals for services made at an NHS Health Check Assessment.

M/R	Data Set Data Elements
R	REFERRAL TO SERVICE ACCEPTANCE INDICATOR (PHYSICAL ACTIVITY SERVICE)
R	REFERRAL TO SERVICE ACCEPTANCE INDICATOR (STOP SMOKING SERVICE)
R	REFERRAL TO SERVICE ACCEPTANCE INDICATOR (WEIGHT MANAGEMENT SERVICE)

Health Check Further Assessments Required:
To carry the details of further assessments required following an NHS Health Check Assessment.

M/R	Data Set Data Elements
R	FURTHER ASSESSMENT REQUIRED INDICATOR (DIABETES ASSESSMENT)
R	FURTHER ASSESSMENT REQUIRED INDICATOR (SERUM CREATININE ASSESSMENT)
R	FURTHER ASSESSMENT REQUIRED INDICATOR (HYPERTENSION ASSESSMENT)
R	FURTHER ASSESSMENT REQUIRED INDICATOR (FASTING CHOLESTEROL ASSESSMENT)
R	FURTHER ASSESSMENT REQUIRED INDICATOR (IMPAIRED FASTING GLYCAEMIA IMPAIRED GLUCOSE TOLERANCE LIFESTYLE MANAGEMENT)

Health Check Prescriptions:
To carry the details of the prescriptions provided as a result of an NHS Health Check Assessment.

M/R	Data Set Data Elements
R	PRESCRIPTION PROVIDED INDICATOR (STATINS)
R	PRESCRIPTION PROVIDED INDICATOR (ANTI-HYPERTENSIVES)

Health Check Diagnosis:
To carry the details of the diagnosis provided as a result of an NHS Health Check Assessment.

M/R	Data Set Data Elements

R	PATIENT DIAGNOSIS INDICATOR (CHRONIC KIDNEY DISEASE STAGE 3)
R	PATIENT DIAGNOSIS INDICATOR (CHRONIC KIDNEY DISEASE STAGE 4)
R	PATIENT DIAGNOSIS INDICATOR (CHRONIC KIDNEY DISEASE STAGE 5)
R	PATIENT DIAGNOSIS INDICATOR (TYPE 2 DIABETES)
R	PATIENT DIAGNOSIS INDICATOR (HYPERTENSION)
R	PATIENT DIAGNOSIS INDICATOR (NON DIABETIC HYPERGLYCAEMIA)

SYSTEMIC ANTI-CANCER THERAPY DATA SET

Change to Data Set: Changed Description

Systemic Anti-Cancer Therapy Data Set Overview

The Systemic Anti-Cancer Therapy Data Set has been incorporated early to allow users to see the changes, but please note that the implementation date is **1 April 2012**.

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

- ~~M = Mandatory: this data element is mandatory, the message will be rejected if this data element is absent~~
- ~~R = Required: data is required as part of NHS business rules and must be included where available or applicable~~
- ~~O = Optional: the flow of this data is optional. It should be included at the discretion of the submitting organisation and their commissioners as required for local purposes.~~
- M = Mandatory: this data element is mandatory and the technical process (e.g. submission of the data set, production of output etc) cannot be completed without this data element being present
- R = Required: NHS business processes cannot be delivered without this data element
- O = Optional: the inclusion of this data element is optional as required for local purposes.

DEMOGRAPHICS AND CONSULTANT

To carry personal, organisation and consultant details. One occurrence of this group is required.	
M/R/O	**Data Set Data Elements**
M	NHS NUMBER
M	PERSON BIRTH DATE
R	PERSON GENDER CODE CURRENT
R	ETHNIC CATEGORY
M	POSTCODE OF USUAL ADDRESS
R	GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)
R	CONSULTANT CODE (INITIATED SYSTEMIC ANTI-CANCER THERAPY)
R	CARE PROFESSIONAL MAIN SPECIALTY CODE (START SYSTEMIC ANTI-CANCER THERAPY)
M	ORGANISATION CODE (CODE OF PROVIDER)

CLINICAL STATUS

To carry the clinical status details. One occurrence of this group is required.	
M/R/O	**Data Set Data Elements**

M	PRIMARY DIAGNOSIS (ICD AT START SYSTEMIC ANTI-CANCER THERAPY) *and/or* MORPHOLOGY (ICD-O AT START SYSTEMIC ANTI-CANCER THERAPY)
R	TNM CATEGORY (FINAL PRETREATMENT)

PROGRAMME AND REGIMEN

To carry details of the Systemic Anti-Cancer Therapy Programme and Systemic Anti-Cancer Drug Regimen.
Multiple occurrences of this group are permitted (at least one must be present).

M/R/O	Data Set Data Elements
R	SYSTEMIC ANTI-CANCER THERAPY PROGRAMME NUMBER
R	ANTI-CANCER REGIMEN NUMBER
R	DRUG TREATMENT INTENT
M	DRUG REGIMEN ACRONYM
R	PERSON HEIGHT IN METRES
R	PERSON WEIGHT
R	PERFORMANCE STATUS (ADULT) *or* PERFORMANCE STATUS (YOUNG PERSON)
R	CO-MORBIDITY ADJUSTMENT INDICATOR
R	DECISION TO TREAT DATE (ANTI-CANCER DRUG REGIMEN)
M	START DATE (ANTI-CANCER DRUG REGIMEN)
R	CLINICAL TRIAL INDICATOR
R	CHEMO-RADIATION INDICATOR
R	NUMBER OF SYSTEMIC ANTI-CANCER THERAPY CYCLES PLANNED

CYCLE

To carry details of each Systemic Anti-Cancer Therapy Cycle.
Multiple occurrences of this group are permitted (at least one must be present).

M/R/O	Data Set Data Elements
M	ANTI-CANCER DRUG CYCLE IDENTIFIER
R	START DATE (SYSTEMIC ANTI-CANCER DRUG CYCLE)
O	PERSON WEIGHT
R	PERFORMANCE STATUS (ADULT) *or* PERFORMANCE STATUS (YOUNG PERSON)
R	PRIMARY PROCEDURE (OPCS)

DRUG DETAILS

To carry details of the Systemic Anti-Cancer Therapy Drugs.
Multiple occurrences of this group are permitted (one occurrence for each Systemic Anti-Cancer Therapy Drug - at least one must be present).

M/R/O	Data Set Data Elements
R	SYSTEMIC ANTI-CANCER DRUG NAME
R	CHEMOTHERAPY ACTUAL DOSE
R	SYSTEMIC ANTI-CANCER THERAPY DRUG ROUTE OF ADMINISTRATION
R	SYSTEMIC ANTI-CANCER THERAPY ADMINISTRATION DATE

R	ORGANISATION CODE (CODE OF PROVIDER)
R	PRIMARY PROCEDURE (OPCS)

OUTCOME

To carry details of the outcome / summary. One occurrence of this group is permitted.	
M/R/O	**Data Set Data Elements**
R	START DATE (FINAL SYSTEMIC ANTI-CANCER THERAPY)
R	SYSTEMIC ANTI-CANCER THERAPY REGIMEN MODIFICATION INDICATOR (DOSE REDUCTION)
R	SYSTEMIC ANTI-CANCER THERAPY REGIMEN MODIFICATION INDICATOR (TIME DELAY)
R	SYSTEMIC ANTI-CANCER THERAPY REGIMEN MODIFICATION INDICATOR (DAYS REDUCED)
R	PLANNED TREATMENT CHANGE REASON
R	PERSON DEATH DATE

For enquiries about this Change Request, please email datastandards@nhs.net