NHS
Information Authority

# Mental Health Minimum Data Set

## Data Manual

**July 2001**

Version 2.0
For use with Version 2.0 of MH-MDS ASSEMBLER

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# MENTAL HEALTH MINIMUM DATA SET (MHMDS)

## Section 1 - Overview

1. This section covers the data items that need to be recorded about patients of the NHS specialist mental health services. It covers all types of services - inpatient, outpatient, community care and residential services.

2. Information is required by:

* **NHS specialist mental health care providers (NHS Trusts)** - to support clinical governance work and for reporting to commissioners in relation to NHS Service Agreements.

* **Commissioners - Health Authorities (HAs) and Primary Care Groups (PCGs)** - for monitoring trends in service usage, the amount and quality of work undertaken within the scope of NHS Service Agreements, and to plan and negotiate future agreements.

* **NHS Executive Regional Offices** - for monitoring local performance

* **Department of Health (DH)** - to provide a complete record of relevant service activity for a range of purposes related to overall service management and public accountability.

3 **Section 2** is intended to help those responsible for data collection to record all aspects about the care and treatment of patients of the specialist mental health care services. The data items listed are the minimum needed to meet Commissioner, Regional Office and DH requirements. It may be decided locally to collect additional data. This guidance should be read alongside guidance on Hospital Episode statistics (Chapter 7 of the Hospital Services module of the NHS Data Manual), and on the Common Information Core and Service and Financial Frameworks guidance which is issued periodically by the Department of Health.

4. **Section 3** gives guidance on how to gather the required data items and to run the Mental Health Minimum Data Set Assembler program.

5. **Section 4** lists the data items which make up the Mental Health Minimum Data Set, identifying who is expected to provide the data at each stage of the Mental Health Care Spell.

## Section 2 – Mental Health Services

6. Modern mental health services see a wide range of patients. Some require brief interventions for specific isolated problems. Others are disabled in many areas of their lives by chronic illnesses and need extensive social support in addition to specific treatments. Health Service staff caring for them provide a wide range of medical, nursing and psychological treatments working in a range of settings including clinics, day hospitals, community mental health centres, patients homes, and in-patient wards. Health Service staff work hand in hand with staff from local authority social services and housing departments as well as with voluntary sector agencies. These offer a similarly wide range of types of social care including sheltered residences, home support, day activities aimed at rehabilitation, support or respite and supported work schemes. Packages of care are tailored to the needs of individual patients and their informal carers using the 'Care Programme Approach' (CPA). This requires that services should have a single point of entry through which all new referral are channelled. Following referral, all patients should have their health and social care needs assessed and written care plans (including in some cases contingency plans for crises) developed. A Care Co-ordinator is identified to ensure that the plans work. As patients needs change, further reviews are undertaken and the mix of interventions modified as appropriate. The Mental Health Minimum Data Set (MHMDS) is designed to reflect the rich complexity of this style of service.

7. The MHMDS construes adult, (including elderly), patients who receive care in NHS specialist mental health services as having a 'Mental Health Care Spell'. This is defined as the total period during which the patient receives care from specialist mental health staff. For some patients this will comprise a small number of out-patient attendances over a few weeks. For others it may extend for many years and include hospital, community, out-patient and day care episodes, commonly overlapping. The Mental Health Care Spell starts when a member of the adult or elderly specialist mental health service staff first meets the patient. It should normally finish with a definite decision by the responsible staff that further specialist service involvement is not appropriate.

8. The MHMDS is produced for a defined period of time (a Reporting Period – usually a year or a quarter year) and comprises a record for each Mental Health Care Spell falling wholly or partly in that period. These records include data on the following areas:

- Characteristics of the patient including where they live
- The health and local authority organisations involved
- The nature of the problems suffered by the patient including their range and severity,
- The amounts of different interventions delivered to the patient,
- The way these are combined as packages and scheduled over time,
- How the patient's condition changes over time.

9. Provider units require information systems to collect information on the full range of activities undertaken by mental health services. Ideally these should integrate components from all service areas in ways which provide a fund of useful information to support clinical care. Systems of this type are usually based on extensive computer networks accessible to professional and administrative staff across the whole range of sites where they work. Many NHS Trusts undertaking mental health care do not yet have such sophisticated information facilities. In these, a number of smaller systems are usually in place to collect the information required for specific statistical returns. In either case, the data required about mental health care arises from many staff in many locations and contexts. These include:

- Initial patient registration and periodic updating of administrative details
- Care Programme Approach Reviews,
- Starting and ending of hospital episodes,
- Day hospital attendance,
- Face to face contacts with relevant professional staff groups,
- Changes in the patient's legal status.

Recent NHSE and Social Services Inspectorate guidance (*Effective Care Co-ordination in Mental Health Services*) has stressed the key role of computer based information systems in ensuring at least that CPA care and crisis plans are accessible to clinical staff at all Trust bases, at any time. Trusts are required to ensure that these are in place by March 2001. These will thus constitute the nucleus of Electronic Patient Records for mental health care and will be a key data source for the MHMDS.

10. The next section describes the data to be collected in each of these situations. It should be stressed that the combined picture of an individual patient's condition, care plan and progress given by the information specified here is likely, with minor additions, to be of enormous value to clinical staff in assessing the effectiveness and quality of the care they are providing. The data set is intended to be a key tool for local clinical governance. Professional staff are likely to contribute the required data willingly only if they in turn get some benefit from doing so. Care should thus be taken to ensure that they have easy access to the information in forms they are able to use for this purpose. A major part of the development has centred around the development of tools to make the data easily accessible to clinical staff. Ensuring that these tools are available for clinical governance purposes will be central to the success of the MHMDS.

**Recording details about patients**

11. The following set of standard data items should be recorded for each patient having a Mental Health Care Spell. Where the Trust has a number of separate information systems, it will be necessary to ensure that these items are available for all patients. Ideally they should be on the CPA information system.

Organisation code (code of provider)
Local Patient Identifier
NHS Number
Marital Status
Ethnic Group
Sex
Birth Date
Patient's Name including aliases
Patient's Usual Address
Postcode of Usual Address
General Medical Practice with which the patient is registered.

Two additional items with specific relevance to mental health care should be recorded. These are:

Year of first mental health treatment
Social services identification number for the patient

12. Record all the above items on the first occasion when a patient is registered as having a Mental Health Care Spell with the provider unit (at the Single Point of Referral). Several of the data items may change. Enter amendments on the system as soon as they are known. In the case of patients whose Mental Health Care Spell lasts in excess of a year, check the details at least annually. Where a Trust has more than one information system with different local patient identifiers, it will be helpful if one system, probably the CPA system, is designated as the local master patient index. For each patient this will need to have all the patient identification numbers each patient is allocated on other systems, as well as the patient's social services identification number.

13. General guidance about the data items which make up the patient's details can be found in the NHS Data Manual. Items specific to the Mental Health Minimum Data Set are:

**Year of first mental health treatment**

14. Record the first year in which the patient is known to have received care from any specialist mental health service. This may have been from the same or a different provider unit. It need not have been provided in the NHS or even in the UK. It will be necessary to ask the patient this question. Clinical case notes may provide additional information.

**Social Services Identification number**

15. If the patient is also receiving care from the local social services department, record the identification number used for the patient on their information system.

**Details about Mental Health Care Spell Suspensions**

16. Occasionally patients are transferred temporarily to another mental health care provider unit. Usually this is either for specialist treatment, which the catchment area mental health unit cannot provide, or because local admission facilities are full. In either case, the care is a continuation of what the patient has been receiving. These transfers are considered as suspensions rather than breaks in the patient's Mental Health Care Spell.

17. When a temporary transfer occurs, record the fact and the date of the transfer along with the appropriate end code. If the patient is returned to the provider unit within a year, record the fact and date of the return. These dates are required to calculate the number of days' care provided to the patient. If the receiving provider unit advises that the patient is not going to be returned, or if the one year limit for Mental Health Care Spell suspension is passed, reassign the end code accordingly and enter the start date of the suspension as the Mental Health Care Spell end date.

**Responsible Medical Officer**

18. Except in cases where the Mental Health Care Spell comprises only contact with a Community Psychiatric Nurse or a Clinical Psychologist, a consultant will be involved. Record the name of the consultant. This is not included in the formulation of the Mental Health Minimum Data Set for central DH returns, but is required to identify the specialty function code for the Mental Health Care Spell

**Recording Data from Care Programme Approach Reviews**

19. The following standard set of data items should be recorded or confirmed at each Care Programme Approach (CPA) review for each patient having a Mental Health Care Spell:

- Date of CPA review
- Level of CPA following the review
- Name of Care Co-ordinator following the review
- Patient's diagnosis
- Patient's full HoNOS rating
- The elements of the care plan agreed including:
  - Non-NHS residential care indicator
  - Day centre care indicator
  - Supported or sheltered work indicator
  - Social worker contact indicator
  - Other domiciliary care indicator
  - Mental Health Treatment procedures

20. It is anticipated that a form should be provided to the clinical staff prior to the review summarising the current position on all these items of information as known prior to the review. This should be designed to permit easy updating so that the patient's computerised record may be brought up to date with minimal burden to staff. Details of the elements of the patient's care plan will be required on new CPA information systems (detailed in *Effective Care Co-ordination in Mental Health Services*). Trust information departments should identify which of these categories covers each social care facility in their area so that these items can be derived automatically from the process of recording patients' care plans.

**Date of Care Programme Approach review**

21. CPA reviews may occur in one of four ways. Simple reviews, for patients seeing only one member of staff, happen usually in a clinic setting in the context of a patient visit. For these, record the date of the contact. Multidisciplinary reviews usually comprise a meeting of all concerned staff. In these situations, record the date of the meeting. Occasionally it proves impossible to assemble all involved at a single time. In this case the review might comprise a series of conversations, perhaps some by phone, usually co-ordinated by the consultant. In these cases, the consultant, or other staff member taking responsibility for the process, should complete the process by recording the decisions finally taken about the care plan. In this case, record the date of completion of the form. Finally, some reviews may be carried out for the purpose of closing cases where the patient has defaulted contact. These may be undertaken by one or more staff. The review date will be the date on which the responsible clinician decides to close the case.

**Level of CPA following the review**

22. The CPA level is decided explicitly at a CPA review. It may be:

| CPA level | Code | Definition – Effective Care Co-ordination in Mental Health Services |
|---|---|---|
| Standard | 1 | The characteristics of people on standard CPA will include some of the following:<br><br>· they require the support or intervention of one agency or discipline or they require only low key support from more than one agency or discipline;<br><br>· they are more able to self-manage their mental health problems;<br><br>· they have an active informal support network;<br><br>· they pose little danger to themselves or others;<br>· they are more likely to maintain appropriate contact with services. |
| Enhanced | 2 | People on enhanced CPA are likely to have some of the following characteristics:<br><br>· they have multiple care needs, including housing, employment etc, requiring inter-agency co-ordination;<br><br>· they are only willing to co-operate with one professional or agency but they have multiple care needs;<br><br>· they may be in contact with a number of agencies (including the Criminal Justice System);<br><br>· they are likely to require more frequent and intensive interventions, perhaps with medication management;<br><br>· they are more likely to have mental health problems co-existing with other problems such as substance misuse;<br><br>· they are more likely to be at risk of harming themselves or others;<br><br>· they are more likely to disengage with services. |

Some services may have developed expanded classifications based on assessments of need or risk. The definitions above are drawn from NHS Executive guidance on the CPA, and are intended to provide a framework for national comparability. Trusts using more detailed classifications should ensure that they can be mapped to this standard.

**Name of Care Co-ordinator following the review**

23. Enter the name of the Care Co-ordinator. This is needed both for local purposes and to provide the CareCo-ordinator's Occupational Code which indicates staff group and grade which are of relevance for wider comparisons. It will always be needed for local operational purposes.

**Patient's diagnosis**

24. Most psychiatric patients have short-term involvement with the service. For these, the diagnosis will relate to the period of illness and, once established, will not change for the duration of the Mental Health Care Spell. For patients with longer term problems, change may occur. In either case there may be additional diagnoses, for example, of substance abuse in the context of a mental illness, which may be transient. For this reason clinicians should confirm (or amend) the diagnosis at each case review. Up to six ICD10 diagnoses may be entered. Local quality control mechanisms will be needed to ensure that clinicians' diagnoses are translated accurately into ICD10 codes.

Where patients are not seen by medical staff, the concise version of the ICD10 Primary Health Care classification should be used.

| Diagnosis | Code |
|---|---|
| Acute Psychosis | F23 |
| Adjustment Reaction And Adjustment Disorder | F43.2 |
| Alcohol Misuse | F10 |
| Bereavement | Z63 |
| Bipolar Disorder | F31 |
| Chronic Fatigue And Chronic Fatigue Syndrome | F48.0 |
| Chronic Mixed Anxiety And Depression | F41.2 |
| Chronic Psychotic Disorder | F20 |
| Delirium | F05 |
| Dementia | FOO |
| Depression | F32 |
| Dissociative (Conversion) Disorder | F44 |
| Drug Misuse | F11 |
| Eating Disorders | F50 |
| Generalized Anxiety | F41.1 |
| Panic Disorder | F41.0 |
| Phobic Disorder | F40 |
| Post Traumatic Stress Disorder | F43.1 |
| Sexual Disorders | F52 |
| Sleep Problems | F51 |
| Unexplained Somatic Complaints | F45 |

**Patient's HoNOS rating**

25. Enter the patient's HoNOS rating at the date of the review. The full thirteen character format is required. Note that it will be necessary to store all the HoNOS scorings assigned to each patient as the data set requires the first, the most recent, the worst ever and the best in year to be returned. You should ensure that your system does not overwrite this item.

**Non-NHS residential care indicator**

26. The data set requires an entry indicating whether the patient care plan includes time in non-NHS residential care. At each CPA review, record whether the care plan for the forthcoming period definitely includes this. Do

not include simply referrals or assessments for this type of care in the absence of definite availability or actual provision. Include use of short stay crisis hostels where these include specific care for people with mental health problems as part of their support programme. Include residential drug and alcohol treatment and rehabilitation programmes run outside the NHS. Do not include periods of planned respite care under this item. The number of days is not required.

**Day centre care and supported or sheltered work indicators**

27. Record whether or not the patient's care plan includes care at a day centre not provided by the NHS or in a supported of sheltered work programme. Do not include simply referrals or assessments for this type of care in the absence of definite availability or actual provision. Dates and numbers of attendances are not required here.

**Social worker contact indicator and Other domiciliary care indicator**

28. Record whether the patient's care plan includes contact with a social worker or social services domiciliary care worker. Do not include simply referrals or assessments for this type of care in the absence of definite availability or actual provision. Dates and numbers of contacts are not required here.

**Mental Health Treatment interventions**

29. These fields in the Mental Health Minimum Data Set are for recording treatments of specific national interest. A list of treatments falling into this category is maintained and reviewed periodically. Record any which the CPA review decides should be provided. Most operational Care Programme Approach systems will require you to enter all the care interventions planned for each patient. Data should be stored as Read codes although information systems should present pick lists in English. Clinical staff at CPA reviews will normally record the treatment planned in ordinary English. The coding should be assigned automatically by the computer.

30. Treatments currently requiring reporting are:

Psychological treatments:
- Type A: Psychological treatment as an integral component of mental health care.
- Type B: Eclectic psychological therapy and counselling.
- Type C: Formal psychotherapies.

Skills training
- Training in activities of daily living

Drug treatments – numbers in brackets refer to British National Formulary classification sections
- Anxiolytics (4.1.2)
- Antipsychotics (4.2.1 and 4.2.2) but excluding atypical antipsychotics
- Atypical Antipsychotics (these are in a distinct but un-numbered sub-section of 4.2.1)
- Antimanic drugs (4.2.3)
- ricyclics and related antidepressants (4.3.1)
- MAOIs (4.3.2)
- SSRIs and related antidepressants (4.3.3)
- Anti-dementia drugs (4.11)
- Anti-parkinsonian drugs (4.9)
- Other psychotropic

Respite care – This is usually provided for patients with dementia. It may be provided either by the social services department or the health service. It may be provided for periods of the day, for individual nights or for more extended periods. Read codes should indicate this. Do not include simply referrals or assessments for this type of care in the absence of definite availability. The number of days or nights is not required.

All of these types of treatment should be recorded as components of the patient's care plan. The coding should underlie these records.

**Review Type**

31. Identify the type of Review if either a Referral or Discharge review.

**Referral code**

32. This describes the method of the patient's initial referral at the start of the Mental Health Care Spell. It should be confirmed by the clinical staff at the first CPA review and recorded on the CPA information system. Enter one of the following for referral reviews only:

- GP
- A & E department
- Other specialist clinical department
- Social Services
- Education service
- Self
- Carer
- Police
- Criminal Justice system
- High security services – England
- High security services - Scotland
- Medium secure services
- Graduation from relating child and adolescent mental health services
- Temporary transfer from a Mental Health Care Spell with another health care provider
- Permanent transfer from a Mental Health Care Spell with another mental health care provider, other than graduating from relating child and adolescent mental health services
- Housing Service
- Voluntary or private Agency
- Other

**End code**

33. This describes the method of the patient's discharge at the end of the Mental Health Care Spell. It should be recorded by the clinical staff at the final Care Programme Approach review. Enter one of the following for discharge reviews only:

- Spell finished in accord with professional advice

- Spell finished against professional advice
- Spell finished by patient's non-attendance
- Patient died
- Patient's care transferred to a medium secure Health Care Provider
- Patient's care transferred to a high security Health Care Provider
- Patient's care transferred to any other Health Care Provider

**Administration of Electro-Convulsive Therapy (ECT)**

34. The Mental Health Minimum Data Set requires recording of the numbers of administrations of ECT for each patient within each reporting period. To satisfy this requirement, make a record, including the date, each time the patient receives an administration. Local operational requirements will usually require more detail than this.

**Starting and ending of hospital provider spells**

35. Record the following standard set of data items for each patient beginning or ending an period of hospital in-patient care in an adult or elderly mental illness specialty, as defined for the in-patient data set. All these patients will be in Mental Health Care Spells as a result of their admission, even if the two begin and end simultaneously. All are required for Hospital Episode Statistics. The definitions are not changed.

Date of start of psychiatric in-patient episode
Date of end of psychiatric in-patient episode
Admission method
Diagnoses

**Start and end dates of ward stays comprising part of a patient's spell of hospital care.**

36. Hospital in-patient episodes may include, or may be entirely composed of a period in a psychiatric intensive care or a designated 'interim secure' facility. These units are specially designated wards, or in some cases hospitals. Each period of time spend as an in-patient in a ward should be recorded along with the nature of the ward (its Clinical Care Intensity).

37. Take the opportunity of admission to hospital to check all the administrative details set out under 'Recording details about Patients' (see paragraph 11 above).

**Home Based Care Episodes**

38. In a few mental health provider units, special community-based teams provide intensive home-based nursing for individuals who otherwise would need admission to an acute hospital bed. Where this provision is made, record the dates on which patients are admitted to or discharged from the care of the acute home based care team. It may make sense for these teams to use Hospital in-patient data entry facilities, admitting patients to a ward designated as "Home Based Care".

**NHS Community residential care**

39. Some patients with long term, intensive nursing requirements are managed in NHS community beds. Record the start and finish dates for each episode of residence in a community bed.

**Consultant out-patient clinic attendance**

40. Patients may have episodes of out-patient care as part of their Mental Health Care Spell. Two types of record are required for this type of activity. Record the start and end dates for the out-patient episode (the period during which the patient has out-patient attendances). Record also each scheduled attendance by the patient, and

whether the patient attended or did not attend. Note that in some places out-patient clinics may be located in GP surgeries. These should be included. It may make sense to record domiciliary visits by doctors as out-patient attendances in a clinic designated "Home Visit".

**Day hospital attendance**

41. Patients may have episodes of NHS day-care as part of their Mental Health Care Spell. Two types of record are required for this type of activity. Record the start and end dates for the episode of the patient's daycare. Record also each scheduled attendance by the patient at the facility, and whether the patient attended or did not attend.

**Face to face contacts with relevant professional staff groups**

42. As part of their Mental Health Care Spell, patients may have episodes of contacts with community psychiatric nurses, occupational therapists or clinical psychologists, or of attendance at non-consultant out-patients. In each case two types of record are required. Record the start and end dates of the episode (the period during which the patient receives the specific type of contact). In addition to this, record the date, place and duration of each contact or attendance within the episode. Record also contacts with other staff members acting as patients' Care Co-ordinators. Special arrangements may be needed for contacts occurring in a day-care or domiciliary setting. For Korner aggregate statistics, recording of the locations of these contacts is required.

**Use of NHS direct.**

43. NHS direct is likely to develop a standard report-back mechanism which will ensure that clinical teams currently caring for patients are notified of their contacts made with the service. It is likely that data from this source will be included as a type of contact data for patients currently in a spell of mental health care. The details of this were not available at the time pilot work on the data set was undertaken and are currently being addressed.

**Changes in the patient's legal status**

44. All provider units undertaking mental health care which have the capability to provide care under the provisions of the Mental Health Act are required to identify a Mental Health Act Administrator. This individual maintains records of recommendations, applications and orders for detention, and associated assessments, including second opinions (under Section 58) and the decisions of Tribunals and Managers' Hearings.

45. The Mental Health Act Administrator should make a record of each change to the patient's legal status. This will be necessary for local operational purposes. For the MHMDS it will be necessary that the information system have a comprehensive record of all changes in each patient's legal status and the dates on which they occurred.

## Section 3 – Assembling the Mental Health Minimum Data Set

46. The Mental Health Minimum Data Set is a simple flat file, comprising one record for each spell of care for a patient occurring partly or wholly within a reporting period. Its production from the range of data elements described above requires a series of complex, rule-based logical operations. These define the range of summarisations needed to produce the flat file. The process is undertaken by the MHMDS Assembler software.

**Collating the data.**

47. In order to run the Assembler program, you will first need to extract a set of tables of the component parts from the system or systems on which you collect them. The extracts have been designed to mirror the format in which component information is usually stored in the range of information systems found in English mental health services. Usually a record-by-record extraction of a small selection of fields will be all that is required. Commonly information for a single Trust will be held on several different information systems. In this situation you will need to consolidate the various extracts onto a single computer. Where Trusts have recently merged, the information for individual tables may need to be derived from more than one system and subsequently merged.

48. To use Version 2 of the Assembler program, you will need to assemble the tables as a single Microsoft Access 97 database. The content of each of the required tables is set out in detail below. All tables, and all the specified fields, must be present whether or not they contain data. The field names and data types are all mandatory. A blank database is supplied with the tool called BLANK.MDB..

49. The program requires that each patient be identified by the same identifying number or alpha-numeric string in each table that contains data relating to them (the field called 'PTID'). Ideally this should be the patient's new format NHS number. Its length is limited to 20 characters. If you need to derive data from more than one source, and the systems involved do not use the same patient identifier, you will need to construct and maintain a master look-up table to convert system numbers to the uniform identifier. Each time a data extraction is run, you will need to convert the patient identifier in each table to the standard uniform identifier.

**Running the program**

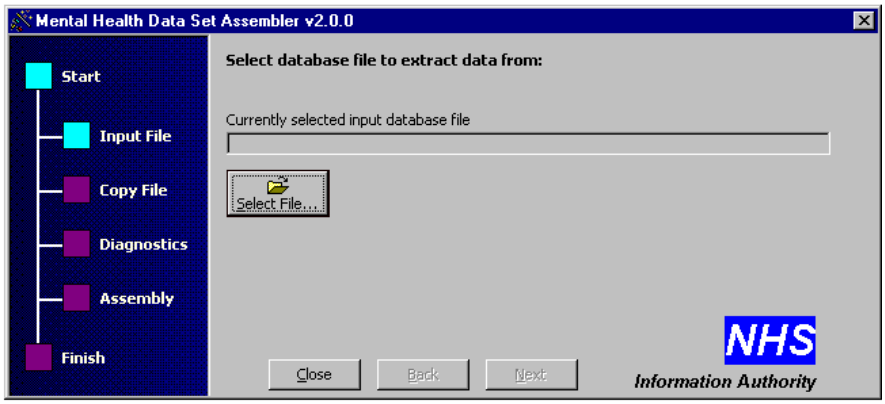
50. Once you have collected the data into a single Intermediate Access database, the process of assembling it, using the MHMDS Assembler should be simple. The program runs in a Windows 95 or Windows NT environment. Start it in the usual way by double clicking your mouse pointer on its icon.

51. The program has been designed as a wizard which has several benefits:

- The use of a wizard has become a Microsoft standard, which most users will be familiar with.
- The interface is intuitive, always displaying the current step that you've reached in completing the data assembly.
- There is far less scope for user error. As you complete each step, the wizard checks that the information you have entered is valid before allowing you to proceed. In this way it's far easier to track down where a problem lies if one does occur.

52. *Step 1*

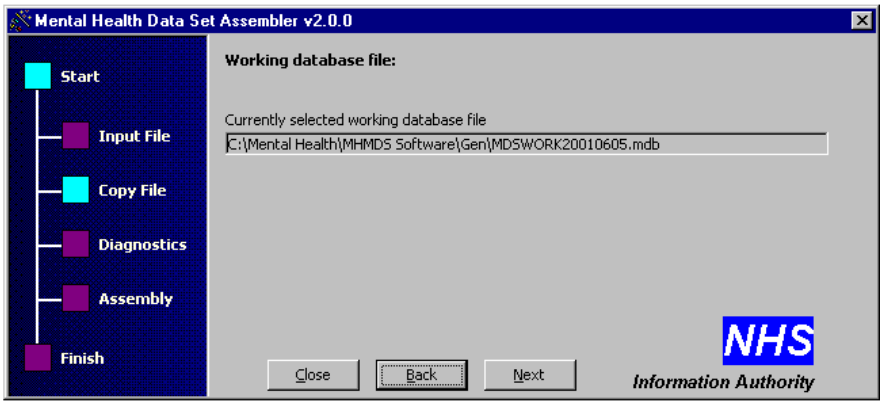
The first step in using the wizard allows you to select the input file. This is the Access database which contains your stored data. To select a database, you simply press the 'Select File' button, and use the Windows explorer to locate the source file.




53. *Step 2*

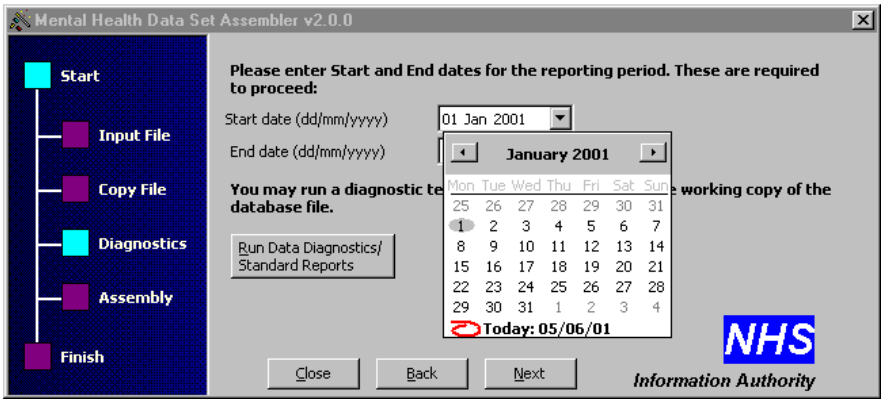
The Assembler will now copy the Intermediate database to a temporary working copy of the database, named MDSWORKyyyymmdd.
This is left in place at the end of the assembly run to allow inspection of the MHCSPELL table into which the program places details of any mental health care spells it defines.

The program undertakes an automatic format check on the data file. If it finds missing tables or missing or incorrectly specified fields, details are written into a file called CheckMSG.TXT. This is located on the same drive and in the same directory as the input data file. Simple errors, such as missing indexes or optional fields, are corrected automatically. Warning messages reporting this can be ignored. Required tables and fields which are missing or incorrectly specified cannot be corrected. If they are found the program will terminate, listing the errors in the file CheckMSG TXT.




54. *Step 3*

Once the file has been accepted as useable, you need to enter a start and end date for the reporting period. This is accomplished by using the date selector drop down as shown in the figure below. The date can be entered by either entering the numerical values, or selecting a date from the dropdown calendar, or by using the up and down cursor keys, while the appropriate part of the date is selected. A maximum of one year can be chosen for the range between the two dates. The wizard automatically checks the validity of the dates entered, (end date is after start date, range is not greater than one year etc.)

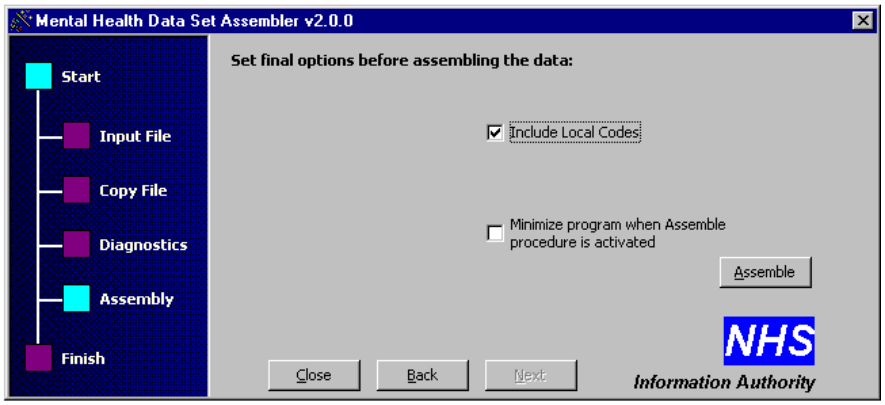



55. *Step 4*

It is recommended that you run the data diagnostics program before attempting a data assembly. This will examine the data set and report on its internal integrity. When this button is pressed you will be prompted for a name for the report file. Once you have entered this, the program will undertake its diagnostics run. This will take some time. A progress indicator will inform you how far through the process the program has reached and an on screen prompt will keep you up to date on the table it is working on. There are 15 in all.
The diagnostics section of the software produces two output files, a warnings file 'Diagnostic Messages txt' detailing any data issues and the reporting file, default name 'Diagnostic Report xls' containing the full diagnostic report.

56. *Step 5*

The Data Set Assembler can include in the record a series of items only of local interest to the Trust. These include the identity of the patient's Care Co-ordinator, the clinical team managing their care, and the map co-ordinates for the patient's home. By default these are included. If you wish to omit them, remove the tick (by clicking with your mouse pointer in the box) in the 'Include Local Codes' box.



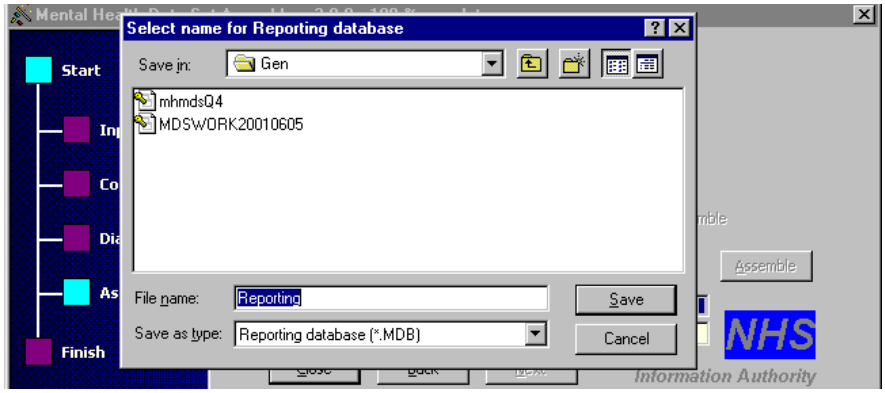

*57. Step 6*

Finally you should select the button to assemble the data set. This again will prompt you to enter a name for the output data file. This will usually take substantially longer than the diagnostics run. Again progress is reported on screen both graphically and textually.

The assembly section of the software can produce occasional warning messages if problems are encountered with individual patients' records. These are placed in the files called BuildMSG.TXT found in the directory where the data file is located.

*58. Step 7*

When the assembly process of the software has completed you will be prompted to enter the reporting database name that will be created for local usage.



## Detail of tables required:

**These tables detail the contents of the Intermediate database used by the Assembler software to produce the MHMDS.**

### 1. Table name ->MPI – Master patient index.

This is the table which the program uses as its principal guide. The program reads each entry in it and searches the other tables to see if any activity has occurred in the relevant time period. Patients not included in this table will therefore be ignored whether or not relevant activity data is present.

| | | |
|---|---|---|
| PTID | Uniform identifier | Text - Max 20 Chars - Patient ID |
| DOB | Date of birth | Date |
| SEX | Patient's sex | Text - Max 1 Chars |
| MARSTAT | Patient's marital status | Text - Max 2 Chars |
| ETHNIC | Patient's ethnic group | Text - Max 2 Chars |
| DISTNO | Local district identification number | Text - Max 10 Chars |
| NHSNO | Patient's NHS number | Text - Max 10 Chars |
| SOCSERVNUM | Patients local social services identification | Text – Max 20 Chars |
| GPCD | Standard Code for patient's registered General Medical Practice | Text – Max 6 Chars |

[*Note: Code to link to the Organisational Code field in Table 27 – General Medical Practice]*

| | | |
|---|---|---|
| POSTCODE | Postcode of patient's normal residence | Text - Max 8 Chars |
| FIRSTCARE | Date of patient's first mental health treatment Note – only the year is used. | Date |

Codes used.

| **Sex** | Code |
|---|---|
| N/K | 0 |
| Male | 1 |
| Female | 2 |
| Not specified | 9 |

| **Marital Status** | Code |
|---|---|
| Single | 1 |
| Married/separated | 2 |
| Divorced | 3 |
| Widowed | 4 |
| Not known | 9 |

*** Ethnic Classifications**

| | | |
|---|---|---|
| a. White | | |
| | British | A |
| | Irish | B |
| | Any other White background | C |
| b. Mixed | | |
| | White and Black Caribbean | D |
| | White and Black African | E |
| | White and Asian | F |
| | Any other mixed background | G |
| c. Asian or Asian British | | |
| | Indian | H |
| | Pakistani | J |
| | Bangladeshi | K |
| | Any other Asian background | L |
| d. Black or Black British | | |
| | Caribbean | M |
| | African | N |
| | Any other Black background | P |
| e. Other ethnic Groups | | |
| | Chinese | R |
| | Any other ethnic group | S |
| f. Not Stated | | |
| | Not stated | Z |

* Based on 2001 Census

## Activity episode tables.

Each summarises a period during which a patient received the relevant type of care. Definitions of all these types of Episode are found in the NHS data dictionary. In all cases except in-patient admission they are very brief, most including only start and end dates and the PTID patient identifier. OPEP and PGEP should encompass all episodes of psychologist, OT, or Consultant Out-Patient care whether occurring in hospital clinic, community mental health centre or primary care premises. Many Trusts use the convention of classifying home visits by doctors as a type of out-patient consultation.

This group of tables is used to define the Mental Health Care Spell dates for patients where care activity is present but no Mental Health Care Spell dates have been recorded in the MHCSPELL table. The program assembles all spells relating to the patient in chronological order. An initial check is made to ensure that end dates have been recorded where activity ceases for more than six months. The start date of the first Episode is selected as the STARTDATE for the first mental health care spell. Subsequent Episodes are examined to see if they follow within a 28 day period of the end of the preceding Episode or within 3 months if the Episode is an in-patient episode. Where they do, they are considered to be part of the same Mental Health Care Spell. Where there is a longer interval, the Spell is considered closed and a new one opened by the next Episode record. You should therefore include as long a history of episodes of other types of care as possible in each of these tables. This will provide a more accurate estimate of the spell start date for long standing patients. Where patients are known to have a spell of care pre-dating available records, the start of this may be entered on the MPI table.

### 2. Table name ->CEP – Community episode (of community psychiatric nursing)

| | | |
|---|---|---|
| PTID | Uniform Identifier | Text - Max 20 Chars - Patient ID |
| STARTDATE | Start date of community episode | Date |
| ENDDATE | End date of community episode | Date |

### 3. Table name ->DAYEP – NHS Day care episode

| | | |
|---|---|---|
| PTID | Uniform Identifier | Text - Max 20 Chars - Patient ID |
| STARTDATE | Start date of NHS Day care episode | Date |
| ENDDATE | End date of NHS Day care episode | Date |

### 4. Table name ->HBCAREEP – Acute home based treatment episode

| | | |
|---|---|---|
| PTID | Uniform Identifier | Text - Max 20 Chars - Patient ID |
| STARTDATE | Start date of acute home based treatment episode | Date |
| ENDDATE | End date of acute home based treatment episode | Date |

## 5. Table name ->IPEP – Hospital Provider Spell

This table should comprise one record for each hospital provider spell including one or more ward stays in a psychiatric ward of any type.

| | | |
|---|---|---|
| PTID | Uniform Identifier | Text - Max 20 Chars - Patient ID |
| STARTDATE | Start date of in-patient episode | Date |
| ENDDATE | End date of in-patient episode | Date |
| IPDIAG1 | First in-patient diagnosis | Text - Max 6 Chars |
| IPDIAG2 | Second in-patient diagnosis | Text - Max 6 Chars |
| IPDIAG3 | Third in-patient diagnosis | Text - Max 6 Chars |
| IPDIAG4 | Fourth in-patient diagnosis | Text - Max 6 Chars |
| IPDIAG5 | Fifth in-patient diagnosis | Text - Max 6 Chars |
| IPDIAG6 | Sixth in-patient diagnosis | Text - Max 6 Chars |
| ADMMODE | Admission method | Number |

Codes
In-patient diagnoses should be entered as ICD10 diagnostic codes. Where more than six codes are registered, those from the F section of the ICD should be given first preference, U or Z codes second preference, others third.

ADMMODE
Note that the codes in the NHS Data Manual relating to maternity are not relevant and have not been included here.

| | |
|---|---|
| Elective admission: | |
| Waiting list | 11 |
| Booked | 12 |
| Planned | 13 |
| Emergency admission: | |
| Accident and emergency, or dental casualty department of the Health Care Provider | 21 |
| General Practitioner after a request has been made direct to the Health Care Provider (i.e. not through a bed bureau) by a General Practitioner or deputy | 22 |
| Bed bureau | 23 |
| Consultant clinic of this or another Health Care Provider | 24 |
| Other means including admission through the accident and emergency department of another Health Care Provider | 28 |
| Other admission: | |
| Transfer of any admitted patient from other hospital provider other than in an emergency. This does not include admissions to high security psychiatric hospitals | 81 |
| Admission by Admissions Panel of a high security psychiatric hospital, patient not entered on the HSPH admission waiting list | 84 |
| HSPH admission waiting list of a high security psychiatric hospital | 89 |

## 6. Table name –> WARDSTAYS – Ward stays making up hospital provider spells.

| | | |
|---|---|---|
| PTID | Uniform Identifier | Text - Max 20 Chars - Patient ID |
| STARTDATE | Start date of ward stay | Date/Time |
| ENDDATE | End date of ward stay | Date/Time |
| CAREINTENS | Clinical Care intensity of ward | Number |

Relevant Codes:

| Clinical Care intensity of ward (codes listed relate only to wards for patients with a mental illness) | Code |
|---|---|
| For intensive care: a designated or interim secure ward | 51 |
| For short stay: patients intended to stay less than a year | 52 |
| For long stay: patients intended to stay more than a year | 53 |

## 7. Table name ->NHSCOMBEDEP – NHS community bed episode.

| | | |
|---|---|---|
| PTID | Uniform Identifier | Text - Max 20 Chars - Patient ID |
| STARTDATE | Start date of NHS community bed episode episode | Date |
| ENDDATE | End date of NHS community bed episode episode | Date |

## 8. Table name ->OPEP – Out patient episode.

| | | |
|---|---|---|
| PTID | Uniform Identifier | Text - Max 20 Chars - Patient ID |
| STARTDATE | Start date of out patient episode | Date |
| ENDDATE | End date of out patient episode | Date |

## 9. Table name ->PGEP Professional group episode

| | | |
|---|---|---|
| PTID | Uniform Identifier | Text - Max 20 Chars - Patient ID |
| STARTDATE | Start date of professional group episode | Date |
| ENDDATE | End date of professional group episode | Date |
| PROFGROUP | Professional Group for episode | Text - Max 6 Chars |

Codes

| Professional Group | Code |
|---|---|
| Clinical Psychology | PSY |
| Occupational Therapy | OT |
| Other therapist | OTHER |
| Social Worker | SW |

## Tables describing contacts with staff.

One record should be produced for each contact that occurs. These are only required for the period for which a report is being produced. However if it is easier to be more inclusive, this does not matter as the assembler program will pick only relevant records. Thus a single data file for a whole year can be used to generate a data set for each of the four quarters.

## 10. Table name ->CCONT – Community psychiatric nurse contacts

| | | |
|---|---|---|
| PTID | Uniform Identifier | Text - Max 20 Chars - Patient ID |
| EVENTDATE | Date of CPN contact | Date |
| LOCATION | Contact Location Type Code | Number |

Note LOCATION is currently optional to allow for further analysis of the Intermediate Database.

| Classification | Code |
|---|---|
| Client's or Patient's Home | 001 |
| Health Centre | 002 |
| Other GMP Premises | 003 |
| Ward on NHS Hospital Site | 004 |
| Hospice | 006 |
| Other Voluntary or Private Hospital or Nursing Home | 007 |
| Group Home managed by the NHS | 008 |
| Group Home managed by Local Authority | 009 |
| Group Home managed by Voluntary or Private Agents | 010 |
| Other Residential Care Homes managed by Local Authority | 011 |
| Other Residential Care Homes managed by Voluntary or Private Agents | 012 |
| NHS Day Care Facility on NHS Hospital Site | 013 |
| NHS Day Care Facility on Other Sites | 014 |
| Day Centre managed by Local Authority | 015 |
| Day Centre managed by Voluntary or Private Agents | 016 |
| NHS Consultant Clinic Premises on a NHS Hospital site | 017 |
| NHS Consultant Clinic Premises off a NHS Hospital site | 018 |
| Health Clinic managed by the NHS | 019 |
| Health Clinic managed by Voluntary or Private Agents | 020 |
| Resource Centre on NHS Hospital Site | 021 |
| Resource Centre managed by the NHS off NHS Hospital Site | 022 |
| Resource Centre managed by Local Authority | 023 |
| Resource Centre managed by Voluntary or Private Agents | 024 |
| Professional Staff Group Department on NHS Hospital Site | 025 |
| Professional Staff Group Department managed by the NHS off NHS Hospital Site | 026 |
| Professional Staff Group Department managed by Local Authority | 027 |
| Professional Staff Group Department managed by Voluntary or Private Agents | 028 |
| School Premises managed by Local Authority or Grant Maintained | 029 |
| School Premises managed by Voluntary or Private Agents | 030 |
| Other Health or Local Authority Facility on NHS Hospital Site | 031 |
| Other Health or Local Authority Site managed by the NHS off NHS Hospital Site | 032 |
| Other Health or Local Authority Site managed by Local Authority | 033 |
| Other Health or Local Authority Site managed by Voluntary or Private Agents | 034 |
| Prison Department Establishments | 035 |
| Public Place or Street or Police Station | 036 |
| Other locations not classified elsewhere | 037 |
| NHS Nursing Home | 038 |
| Other Residential Care Homes managed by the NHS | 039 |

## 11. Table name ->DAYATT – NHS day care facility attendance

| | | |
|---|---|---|
| PTID | Uniform Identifier | Text - Max 20 Chars - Patient ID |
| EVENTDATE | Date of NHS day care attendance | Date |
| ATTENDED | Indicator of whether the patient attended or Did not attend | Number |

Codes
ATTENDED

| | |
|---|---|
| Attended on time or, if late before the relevant professional was ready to see the patient | 5 |
| Arrived late, after the relevant professional was ready to see the patient but was seen | 6 |
| Patient arrived late and could not be seen | 7 |
| Appointment cancelled by the patient | 2 |
| Did not attend, no advance warning given | 3 |
| Appointment cancelled or postponed by the health care provider | 4 |

## 12. Table name ->OPATT – Consultant out patient attendance

| | | |
|---|---|---|
| PTID | Uniform Identifier | Text - Max 20 Chars - Patient ID |
| EVENTDATE | Date of OP attendance | Date |
| ATTENDED | Indicator of whether the patient attended or Did not attend | Number |
| LOCATION | Contact Location Type Code See Table 10 for codes. | Number |

Note LOCATION is currently optional to allow for further analysis of the Intermediate Database.

Codes
ATTENDED

| | |
|---|---|
| Attended on time or, if late, before the relevant professional was ready to see the patient | 5 |
| Arrived late, after the relevant professional was ready to see the patient but was seen | 6 |
| Patient arrived late and could not be seen | 7 |
| Appointment cancelled by the patient | 2 |
| Did not attend, no advance warning given | 3 |
| Appointment cancelled or postponed by the health care provider | 4 |

## 13. Table name ->PGCONT – Professional staff group contact

| | | |
|---|---|---|
| PTID | Uniform Identifier | Text - Max 20 Chars - Patient ID |
| EVENTDATE | Date of professional staff group contact | Date |
| PROFGROUP | Staff group of professional involved | Text - Max 6 Chars. |
| LOCATION | Contact Location Type Code | Number |

Note LOCATION is currently optional to allow for further analysis of the Intermediate

Codes

| Professional Group | Code |
|---|---|
| Clinical Psychology | PSY |
| Occupational Therapy | OT |
| Other therapist | OTHER |
| Psychotherapy | PSRX |
| Social Worker | SW |
| Physiotherapy | PHYSIO |

## 14. Table name ->KWCONT – Contact with Care Co-ordinator.

This table should be a record of a contact between the patient and the staff member who is at the time of the meeting their Care Co-ordinator.
Note that this will nearly always duplicate another contact - eg if the Care Co-ordinator is a CPN, a meeting with them should be recorded in the CCONT and the KWCONT tables.

| | | |
|---|---|---|
| PTID | Uniform Identifier | Text - Max 20 Chars - Patient ID |
| EVENTDATE | Date of Care Co-ordinator contact | Date |

## Care staff assignments

Patients are assigned to an RMO and a Care Co-ordinator. These assignments may change during the course of a MHC Spell, not necessarily at the time of reviews. Assignments are thus documented separately. In each case there is a further table which identifies characteristics of the individual Care Co-ordinator or RMO. If these assignments are made at each care review, it is important to include records from a sufficient time prior to the start of the reporting period, to cover all current patients.

## 15. Table name ->KWASS - Care Co-ordinator assignments

One record for each assignment.

| | | |
|---|---|---|
| PTID | Uniform Identifier | Text - Max 20 Chars - Patient ID |
| STARTDATE | Start date of Care Co-ordinator assignment | Date |
| ENDDATE | End date of Care Co-ordinator assignment | Date |
| KW | Care Co-ordinator's identifying code. This will usually be a staff number Text. It is needed to allow linkage to table 18 | Text - Max 10 Chars – |

## 16. Table name ->KWS – Care Co-ordinator

One record for each Care Co-ordinator The Care Co-ordinator's name is used only to generate the Access version of the data set for local analysis

Note : The occupation code must be recorded to allow for the Name to be generated in the local reporting database.

| | | |
|---|---|---|
| KW | Care Co-ordinator's identifying code. | Text - Max 10 Chars |
| KWOCC | Care Co-ordinator's occupation code | Text - Max 6 Chars |
| KWNAME | Care Co-ordinator's name | Text – Max 50 Chars |

Codes: The following grades are examples of codes likely to occur commonly. The full coding set is found in the NHS workforce census occupational coding manual.

| Care Co-ordinator's occupation codes | Code |
|---|---|
| Clin Psych: Manager | S0L |
| Clin Psych: Scientist | S2L |
| Clin Psych: Scientific Officer (inc asst) | S3L |
| Clin Psych: Technician | S4L |
| Clin Psych: Student/Trainee | S8L |
| CPN Manager | N0D |
| CPN Registered 1st level | N6D |
| CPN Registered 2nd level | N7D |
| Nursing assistant/auxilliary | N9D |
| OT Manager | S0C |
| OT Therapist | S1C |
| OT Instructor / teacher | S6C |
| OT Tutor | S7C |
| OT Student / trainee | S8C |
| OT Helper / Assistant | S9C |
| Social Worker | G2A |

For medical staff the grade and specialty is a four digit code, identified as follows:

First Digit:- The grade of medical staff:

| Medical Team Member Grade | Code |
|---|---|
| Consultant | 1 |
| Locum | 2 |
| Medical director | 3 |
| Senior registrar | 4 |
| Registrar or SHO | 5 |
| Clinical assistant / Staff grade doctor | 6 |

Second, Third and Fourth Digits: -The three digit NHS Occupation code, made up as follows:

| | |
|---|---|
| Mental illness | 052 |
| Forensic psychiatry | 054 |
| Psychotherapy | 055 |
| Old age psychiatry | 056 |

Therefore the code for a consultant psychotherapist would be 1055.

## 17. Table name ->RMOASS - Responsible medical officer assignments

One record for each assignment.

| | | |
|---|---|---|
| PTID | Uniform Identifier | Text - Max 20 Chars - Patient ID |

| | | |
|---|---|---|
| STARTDATE | Date of assignment to RMO | Date |
| RMO | Personal identifier for RMO. This should be a standard NHS consultant number. It is needed to allow linkage to the Specialty Function Code. | Text - Max 10 Chars |

## 18 . Table name ->RMOS - Responsible medical officers

One record for each consultant The consultant's name is used only to generate the Access version of the data set for local analysis.

| | | |
|---|---|---|
| RMO | Personal identifier for RMO. | Text - Max 10 Chars |
| SPECFC | Specialty function code<br>Note the standard code for this item is only three Characters long. This should be placed in characters 1-3 of the field. The two remaining characters (4 and 5) are intended to permit local differentiation. | Text - Max 5 Chars |
| RMONAME | Name of RMO | Text – Max 50 Chars |

Codes:

| Specialty | Code |
|---|---|
| Mental illness | 710 |
| Forensic psychiatry | 712 |
| Psychotherapy | 713 |
| Old age psychiatry | 715 |

## Reviews and assessments

The Review record gives much of the key detail about patients. This table should include all reviews of all patients, no matter how long prior to the reporting period. This is important for three reasons. First it allows the programme to select the first and most severe HoNOS rating in the mental health care spell. Second it is allows the programme to establish the CPA level for current patients at the start of the reporting period, prior to their

first review in the reporting period itself. Third, if social care facilities are discontinued at the first review during the reporting period, their use in it will only be apparent from the latest review preceding the period.

## 19. Table name ->REV – Reviews One record for each patient review.

| | | |
|---|---|---|
| PTID | Uniform Identifier | Text - Max 20 |
| EVENTDATE | Date of review | Date |
| HONSTRING | Full HoNOS rating made at review | Text - Max 13 Chars |
| CPALEVEL | CPA level assigned to patient at review. . | Text – Max 1 Char |
| RVDIAG1 | Diagnosis 1 made at review | Text - Max 6 Chars |
| RVDIAG2 | Diagnosis 2 made at review | Text - Max 6 Chars |
| RVDIAG3 | Diagnosis 3 made at review | Text - Max 6 Chars |
| RVDIAG4 | Diagnosis 4 made at review | Text - Max 6 Chars |
| RVDIAG5 | Diagnosis 5 made at review | Text - Max 6 Chars |
| RVDIAG6 | Diagnosis 6 made at review | Text - Max 6 Chars |
| RX1 | Treatment element 1 agreed at review | Text – Max 6 Chars |
| RX2 | Treatment element 2 agreed at review | Text – Max 6 Chars |
| RX3 | Treatment element 3 agreed at review | Text – Max 6 Chars |
| RX4 | Treatment element 4 agreed at review | Text – Max 6 Chars |
| RX5 | Treatment element 5 agreed at review | Text – Max 6 Chars |
| RX6 | Treatment element 6 agreed at review | Text – Max 6 Chars |

| | | |
|---|---|---|
| SWInvolved | Indicator that a social worker is involved in the patient's care | Text - Max 1 Char |
| DayCentreInvolved | Indicator that patient is using a local Authority day centre | Text - Max 1 Char |
| ShelteredWorkInvolved | Indicator that patient is using a sheltered work facility | Text - Max 1 Char |
| NonNHSResAccom | Indicator that the patient is living in some type of non-NHS supported housing | Text - Max 1 Char |
| DomicilCareInvolved | Indicator that the patient is using a local authority domiciliary care worker | Text - Max 1 Char |
| ClinTeam | Optional local code for clinical team delivering review. This is carried into the MHMDS if the appropriate data assembler switch is set. It should be omitted from data for central returns. The field may be omitted. | Text - Max 10 Chars |

| | | |
|---|---|---|
| REVTYPE | Indicator for referral and Discharge reviews | Text – Max 1 Char |
| REFERRAL | Source of initial referral | Text - Max 2 Chars |
| END | Method of termination | Text - Max 2 Chars |

Codes:

| CPA level | Code |
|---|---|
| No care | 0 |
| Standard | 1 |
| Enhanced | 2 |

Diagnoses are coded with ICD10. In some cases where medical staff are not involved in the patient's assessment or care it may be appropriate to use the brief version of the ICD10 Primary Health Care.

Treaments agreed may be medication or psychological interventions. Only those specified for national reporting (see paragraph 29 & 30 above) are required here. However for local uses it is recommended that all treatments agreed should be included. The Assembler program will simply collate an unduplicated list of all treatments found in each mental health care spell. Entries should be Read Codes.

Social worker involvement, Sheltered work provision, Day centre care, non-NHS residential care, Domiciliary care indicators

| Status | Code |
|---|---|
| Patient is receiving this type of care | 1 |
| Patient is not receiving this type of care | 0 |

| Review Type | |
|---|---|
| Referral review | R |
| Discharge | D |
| Other reviews | leave Blank |

| Referral Source | Code |
|---|---|
| GP | 00 |
| Self | 01 |
| LA Social Services | 02 |
| A & E department | 03 |
| Employer | 04 |
| Education Service | 05 |
| Police | 06 |
| Other clinical speciality | 07 |
| Carer | 08 |
| Courts | 09 |
| Probation service | 10 |
| High Security | 11 |
| Medium security | 12 |
| Other | 13 |
| Temporary transfer from mental health unit | 20 |
| Permanent transfer from mental health unit | 21 |
| Transfer by graduation from local child and adolescent mental health services | 22 |

| End codes | Code |
|---|---|
| Finished on professional advice | 00 |
| Finished against professional advice | 01 |
| Finished by patient's non attendance | 02 |
| Patient died | 03 |
| Transfer to medium secure | 21 |
| Transfer to high secure | 23 |
| Transfer to other health provider | 25 |

## 20. Table name ->SSASS Social service statutory assessment

One record for each statutory assessment. This will either be for community care or under the Mental Health Act.

| | | |
|---|---|---|
| PTID | Uniform Identifier | Text - Max 20 Chars - Patient ID |
| EVENTDATE | Date of Statutory assessment | Date |
| ASSESSMENT | Type of assessment | Text - Max 3 Chars |

Codes:

| Type of assessment | Code |
|---|---|
| Community Care Act 1990 | CC |
| Mental Health Act 1983 | MHA |

## 21. Table name ->MHAEVENT Mental Health Act Events

One record for each event which changes any aspect of the patient's legal status. Note when sections are terminated a record resulting in the legal status 01 (informal) should be recorded. Section 58 second opinions and imposition of Section 25a (supervised discharge) should be recorded in the same way.

As for the review table, it is important to include relevant records from before the start of the reporting period. The assembler programme needs these to indicate the patient's legal status at the start of the period.

| | | |
|---|---|---|
| PTID | Uniform Identifier | Text - Max 20 Chars - Patient ID |
| EVENTDATE | Date of mental health act event | Date |
| LSTATUS | Legal status resulting from the event | Text - Max 2 Chars |

| Legal Status | Code |
|---|---|
| Informal | 01 |
| Section 2 | 02 |
| Section 3 | 03 |
| Section 4 | 04 |
| Section 5.2 | 05 |
| Section 5.4 | 06 |
| Section 35 | 07 |
| Section 36 | 08 |
| Section 37/41 | 09 |
| Section 37 | 10 |
| Section 37(4) | 11 |
| Section 38 | 12 |
| Section 44 | 13 |
| Section 46 | 14 |
| Section 47/49 | 15 |
| Section 47 | 16 |
| Section 48/49 | 17 |
| Section 48 | 18 |
| Section 135 | 19 |
| Section 136 | 20 |
| Section 25A | 33 |
| Previous legislation | 30 |
| Criminal Proceedings (Insanity) Act | 31 |
| Criminal Courts Act S3 | 32 |
| Subject to guardianship – Section 7 | 35 |
| Subject to guardianship – Section 37 | 36 |

## 22. Table name ->ECT – Administrations of ECT

One record for each administration of ECT

| | | |
|---|---|---|
| PTID | Uniform Identifier | Text - Max 20 Chars - Patient ID |
| EVENTDATE | Date of administration | Date |

## 23. Table name -> CLINTEAM – Clinical Team

Reference table for linking local clinical teams to national groupings

| | | |
|---|---|---|
| CLINTEAM | Local Team Identifier | Text 10 Chars |
| CLINTEAMgrp | Team Classification Group | Text 2 Chars |

Team Classification Groups

- 01 General Adult Psychiatry
- 02 Psychiatry of Old Age
- 03 Substance Misuse Team
- 04 Crisis Resolution Team

05 Early Psychosis Intervention Team
06 Assertive Outreach Team
99 Other Teams

Note: Nationally agreed codes have yet to be issued for these classifications of Clinical Teams. The above codes are therefore interim for use in the Mental Health MDS software. When national codes have been agreed they will replace these interim codes.

## 24. Table name - > MHCSPELL - Mental Health Care Spells

The first task the Assembler program undertakes for each patient is to identify the start and end dates of any spell or spells of mental health care they received during the reporting period. This is automatically done by reference to the episode tables. However, for patients who have been in treatment continuously for a period longer than that covered by available detailed records, this will not give the correct starting date. For these patients and ONLY for these patients, include a record in the MHCSPELL table showing the start date (and the end date if the spell has ended).

For other patients, you will see spell entries in the MHCSPELL table with the temporary copy of the Intermediate Data Set database after an assembly run has been completed . You may wish to inspect the assignment of spell start and end dates.

| | | |
|---|---|---|
| PTID | Uniform identifier | Text - Max 20 Chars- Patient ID |
| START DATE | Date of start of MHCS | Date |
| ENDDATE | Date of end of MHCS | Date |

Calculation of end date:

This should usually reflect a formal decision to terminate care recorded in one of the episode tables. In cases where care episodes simply lapse, the program follows the NHS data standard that episodes are closed by default after six months' inactivity in the absence of further planned contact. Where an episode contributing to a Mental Health Care Spell is closed by default, the last contact date is taken as the episode end date. In defining Mental Health Care Spells, an interval of up to 56 days between episodes is allowed for handover of care. In the case of Consultant Episodes (Hospital Provider), NHS Community Episodes and Home Based Care Episodes, an interval of 84 days (12 weeks) is allowed. In any event the Mental Health Care Spell end date is the end date of the last contributing episode.

Where the first event in a patient's record is a care review, a handover period of up to 56 days is allowed for between the review date and the start of the first care episode.

## 25. Table name ->SPELLSUSPENSIONS – Mental Health Care Spell Suspensions

Spell suspensions should reflect a temporary transfer of a patient to another mental health care provider. See paragraph 16 in Section 2 above for details of dealing with spell suspensions.

| | | |
|---|---|---|
| PTID | Uniform identifier | Text - Max 20 Chars - Patient ID |
| STARTDATE | Date of start of MHCS suspension | Date |
| ENDDATE | Date of end of MHCS suspension | Date |

## Background coding tables

### 26. Table name ->POSTCODES – Postcodes for patients

This table is used to assign the geographic and administrative area details for the patient's address. These codes are routinely supplied to NHS organisations by the NHSE Organisational Coding Service on CD-ROM. They are supplied as fixed format text files (no field titles) in the \ONSdata\Data directory of the CD-ROM. The file format is set out in detail in section 5 of the OCS Handbook, also supplied on the CD-ROM (in PDF format). The 1991 census mappings are included to allow patients to be assigned to population groups on the basis of their address. Postcode to PCG mappings are used to assign a PCG to patients with no registered GP. The table is supplied in two formats, one comprising the whole of country, the other individual Regions. (On cursory inspection, the whole country version of the table appears to lack a number of the fields specified. This is because some do not appear to be produced for Scottish postcodes and the first section of the file covers Aberdeen postcodes.) Note that in releases of this table up to summer 1999 the tables supplied by OCS for some areas have a problem with double entries for a very small number of postcodes. ONS advice is that this occurs only in areas adjacent the Scottish or Welsh border. These duplicate entries need to be removed or record the assembler programme may produce duplicate entries for patients living in affected areas. Whether the problem affects an area can easily be identified by attempting to set the POSTCODE field in the table as a primary key. This is in any case appropriate for subsequent processing. If duplicates exist this will fail.

| | | |
|---|---|---|
| POSTCODE | Full postcode. | Text - Max 8 Chars |
| EASTING | Easting value for postcode centroid using OS format | Number |
| NORTHING | Northing value for postcode centroid using OS format | Number |
| LAWARD | Code for Local Authority and electoral ward relating to postcode. | Text - Max 6 Chars |
| HA | Code for Health Authority relating to postcode | Text - Max 3 Chars |
| PCG | Code for PCG relating to postcode | Text - Max 5 Chars |
| PCED91_Census | Code for Local Authority, electoral ward and ED relating to postcode at 1991 census. | Text - Max 6 Chars |

### 27. Table name -> General Medical Practice

This table indicates the assignment of GP practices to PCGs. It is routinely supplied to NHS organisations by the NHSE Organisational Coding Service. It is found in the Access database called ORGCURR in the \Ocsdb directory of the Regular CD-ROM issue.

| | | |
|---|---|---|
| Organisation code | Code for General Medical practice | Text – Max 6 Chars |
| Parent Organisation Code | Code for PCG | Text – Max 5 Chars |
| Organisation Name | Name of GP Practice | Text – Max 50 Chars |

### 28. Table name ->Primary Care Group

This table lists the current PCGs in England. It is only used to generate the Access version of the data set for local analysis. It is routinely supplied to NHS organisations by the NHSE Organisational Coding Service. It is found in the Access database called ORGCURR in the \Ocsdb directory of the Regular CD-ROM issue. The table contains a number of other fields which the assembler program will ignore.

| | | |
|---|---|---|
| Organisation Code | Code for Primary Care Group | Text – Max 8 Chars |
| Organisation Name | Name of Primary Care Group | Text – Max 50 Chars |

### 29. Table name -> LegalStatusScore

Used to assign the most restrictive legal status experienced by the patient within the Reporting Period. This table is standard. You should not include this table in your data file. The software will generate it automatically. It is shown here for information only.

| | | |
|---|---|---|
| LSTATNAME | Text title for Legal Status | Text - Max 50 Chars |
| LSTATUS | Legal status code | Text - Max 2 Chars |
| RESTRICTSCORE | Score for restrictiveness of legal status | Number |
| DURATION | Maximum duration of legal power in days. The value 999 indicates unlimited. | Number |

| LSTATNAME | LSTATUS | RESTRICTSCORE | DURATION |
|---|---|---|---|
| Informal | 01 | 0 | 999 |
| 5.4 | 06 | 1 | 1 |
| 5.2 | 05 | 2 | 3 |
| 135 | 19 | 3 | 3 |
| 136 | 20 | 4 | 3 |
| 4 | 04 | 5 | 3 |
| 2 | 02 | 6 | 28 |
| Section 25A Supervised discharge | 33 | 7 | 182 |
| 3 | 03 | 8 | 182 |
| 35 | 07 | 20 | 28 |
| 36 | 08 | 21 | 28 |
| 38 | 12 | 22 | 84 |
| 37 without 41 restrictions | 10 | 23 | 999 |
| 48 without 49 restrictions | 18 | 24 | 999 |
| 47 without 49 restrictions | 16 | 25 | 999 |
| 44 | 13 | 26 | 999 |
| 46 | 14 | 27 | 999 |
| 37 with 41 restrictions | 09 | 28 | 999 |
| 48 with 49 restrictions | 17 | 29 | 999 |
| 47 with 49 restrictions | 15 | 30 | 999 |

Ref :- Data Manual nww.standards.nhsia.nhs.uk/library/cards/c0000755.htm

## Section 4 - The Mental Health Minimum Data Set

Table 1 lists all the items which make up the minimum data set which, together with the changes to NHS data standards to support the minimum data set, has been issued as DSCN 20/99/P13. The table identifies who is expected to provide the data at each stage of the Mental Health Care Spell. Note that each record relates to the activity occurring in the recording period to which it relates.

**This table is for information only - it is the MHMDS flat file which is generated automatically by the Assembler program.**

**Table 1**

| DATA ITEM NAME | SOURCE |
|---|---|
| Reporting Period | |
| **PATIENT DETAILS** | |
| NHS Number | Entered at initial patient registration |
| Patient Electoral Ward | Derived from patient's postcode |
| Organisation Code (Health Authority) | Derived from Code of GP Practice and checked periodically |
| Sex | Entered at initial patient registration |
| Marital Status | Entered at initial patient registration; updated periodically by medical records staff |
| Birth Date | Entered at initial patient registration |
| Code Of GP Practice (Registered GMP) | Entered at initial patient registration |
| Organisation Code (Primary Care Group) | Derived from Code of GP Practice |
| Local Patient Identifier | Entered at initial patient registration |
| Social Services Identifier | Entered at initial patient registration |
| Ethnic Group | Entered at initial patient registration |
| Year Of First Mental Health Treatment | Entered at initial patient registration |
| **MENTAL HEALTH CARE SPELL DETAILS** | |
| Mental Health Care Spell Identifier | Entered automatically |
| Spell Number within Reporting Period | Entered automatically |
| Mental Health Specialty Function Code | Recorded for consultants. Entered automatically for patient based on consultant |
| Start Date | Entered by medical records staff |
| Source Of Referral: Mental Health | Entered by medical records staff |
| End Date | Entered usually by medical records staff |
| Mental Health Care Spell End Code | Entered usually by medical records staff or by health care practitioners as part of discharge process |

| | |
|---|---|
| Spell Days Within Reporting Period | Calculated from recording period and spell start and end date |
| Suspended Days Within Reporting Period | Calculated from recording period and start and end date of the suspension. |
| Suspension Reason Code | Recorded when the Mental Health Care Spell is suspended, and indicates the type of provider treating the patient during the suspension |
| Days Of Standard CPA | Assumes CPA level defined explicitly at each CPA review and recorded probably by health care practitioner or medical secretary |
| Days Of Enhanced CPA | Assumes CPA level defined explicitly at each CPA review and recorded probably by health care practitioner or medical secretary |
| CPA Level At End Of Reporting Period | Assumes CPA level defined explicitly at each CPA review and recorded probably by health care practitioner or medical secretary |
| CPA Care Co-ordinator Occupation Code | Assumes patient's Care Co-ordinator recorded explicitly at CPA review. |
| Date Last Saw Care Co-ordinator | Assumes identity of Care Co-ordinator recorded explicitly at CPA review and that contacts between Care Co-ordinator and patient recorded as part of on-going record of clinical contacts probably recorded by health care practitioner |
| Days Liable For Detention | Assumes that Mental Health Act administrator records change of status as they occur |
| Days Subject To Supervised Discharge | Assumes that Mental Health Act administrator records change of status as they occur |
| Legal Status At End Of Reporting Period | Assumes that Mental Health Act administrator records change of status as they occur |
| Most Restrictive Legal Status | Assumes that Mental Health Act administrator records change of status as they occur. Calculated from history of all legal statuses in reporting period |
| Care Without Patient Consent | Assumes that Mental Health Act administrator records change of status as they occur |
| Number Of Detention Assessments | Optional field. Included if contributed directly by Social Services department |
| Number OF Community Care Assessments | Optional field. Included if contributed directly by Social Services department |
| **CARE PROGRAMME APPROACH ASSESSMENT DETAILS** | |
| First Diagnosis (ICD10)<br><br>NOTE:<br>First to sixth diagnosis refers to electronic file order. Clinical encoding rules are not affected. | Assumes patient diagnosis recorded or confirmed explicitly at each CPA review, probably by health care practitioner or medical secretary.<br><br>It should be possible to record or confirm up to 6 ICD10 diagnoses at each review |
| Second Diagnosis (ICD10)<br><br>NOTE:<br>First to sixth diagnosis refers to electronic file order. Clinical encoding rules are not affected. | Assumes patient diagnosis recorded or confirmed explicitly at each CPA review, probably by health care practitioner or medical secretary.<br><br>It should be possible to record or confirm up to 6 ICD10 diagnoses at each review |
| Third Diagnosis (ICD10) | Assumes patient diagnosis recorded or confirmed explicitly at each CPA review, probably by health care practitioner or medical |

| | |
|---|---|
| NOTE:<br>First to sixth diagnosis refers to electronic file order. Clinical encoding rules are not affected. | secretary.<br><br>It should be possible to record or confirm up to6 ICD10 diagnoses at each review |
| Fourth Diagnosis (ICD10)<br><br>NOTE:<br>First to sixth diagnosis refers to electronic file order. Clinical encoding rules are not affected. | Assumes patient diagnosis recorded or confirmed explicitly at each CPA review, probably by health care practitioner or medical secretary.<br><br>It should be possible to record or confirm up to 6 ICD10 diagnoses at each review |
| Fifth Diagnosis (ICD10)<br><br>NOTE:<br>First to sixth diagnosis refers to electronic file order. Clinical encoding rules are not affected. | Assumes patient diagnosis recorded or confirmed explicitly at each CPA review, probably by health care practitioner or medical secretary.<br><br>It should be possible to record or confirm up to 6 ICD10 diagnoses at each review |
| Sixth Diagnosis (ICD10)<br><br>NOTE:<br>First to sixth diagnosis refers to electronic file order. Clinical encoding rules are not affected. | Assumes patient diagnosis recorded or confirmed explicitly at each CPA review, probably by health care practitioner or medical secretary.<br><br>It should be possible to record or confirm up to 6 ICD10 diagnoses at each review |
| First HoNOS In Mental Health Care Spell | Assumes HoNOS recorded explicitly at each CPA review, probably by health care practitioner or medical secretary |
| Date Of First HoNOS Rating | Assumes HoNOS recorded explicitly at each CPA review, probably by health care practitioner or medical secretary |
| Most Recent HoNOS | Assumes HoNOS recorded explicitly at each CPA review, probably by health care practitioner or medical secretary |
| Date Of Most Recent HoNOS Rating | Assumes HoNOS recorded explicitly at each CPA review, probably by health care practitioner or medical secretary |
| Best HoNOS In Reporting Period | Assumes HoNOS recorded explicitly at each CPA review, probably by health care practitioner or medical secretary. Choice of best in period undertaken automatically. Of relevance only to full year return |
| Date Of Best HoNOS Rating | Assumes HoNOS recorded explicitly at each CPA review, probably by health care practitioner or medical secretary |
| Worst HoNOS In Mental Health Care Spell | Assumes HoNOS recorded explicitly at each CPA review, probably by health care practitioner or medical secretary. Choice of worst in period undertaken automatically. Of relevance only to full year return |
| Date Of Worst HoNOS Rating | Assumes HoNOS recorded explicitly at each CPA review, probably by health care practitioner or medical secretary |
| **MENTAL HEALTH CARE PACKAGE DETAILS** | |
| Psychiatric In-patient Bed Days | Calculated automatically from admission, discharge and period dates. Admission and discharge dates recorded probably by ward nursing or administrative staff |
| Medium Secure In-patient Bed Days | Calculated automatically from admission, discharge and period dates. Admission and discharge dates recorded probably by ward nursing or administrative staff during the ward or nursing home stays |
| Intensive Care In-patient Bed Days | Calculated automatically from admission, discharge and period dates. Admission and discharge dates recorded probably by ward nursing or administrative staff |

| | |
|---|---|
| Acute Home-Based Days | Calculated automatically from admission, discharge and period dates. Admission and discharge dates recorded probably by ward nursing or administrative staff |
| NHS Community Bed Days | Dates of admission and discharge from NHS residential care units entered either by nursing staff of community residential unit |
| Non-NHS Community Bed Use | Recorded at CPA review directly by clinical staff. Entered on system either by clinical staff or medical secretary |
| NHS Day Care Facility Attendances | Recorded at time of attendance by day care facility staff |
| Non-NHS Day Care Facility Use | Recorded at CPA review directly by clinical staff. Entered on system either by clinical staff or medical secretary |
| Sheltered Work Facility Use | Recorded at CPA review directly by clinical staff. Entered on system either by clinical staff or medical secretary. |
| Psychiatric Out-patient Attendances | Recorded at time of attendance by clinical or out-patient administrative staff |
| Community Psychiatric Nursing Contacts | Recorded at time of contact by CPN |
| Clinical Psychology Contacts | Recorded at time of contact by Clinical Psychologist |
| Occupational Therapy Contacts | Recorded at time of contact by Occupational Therapist. |
| Social Worker Contact | Recorded at CPA review directly by clinical staff. Entered on system either by clinical staff or medical secretary |
| Social Services Domiciliary Care Use | Recorded at CPA review directly by clinical staff. Entered on system either by clinical staff or medical secretary |
| First Intervention (Read) | Assumes patient procedure recorded or confirmed explicitly at each CPA review, probably by health care practitioner or medical secretary. |
| Second Intervention(Read) | Assumes patient procedure recorded or confirmed explicitly at each CPA review, probably by health care practitioner or medical secretary. |
| Third Intervention (Read) | Assumes patient procedure recorded or confirmed explicitly at each CPA review, probably by health care practitioner or medical secretary. |
| Fourth Intervention (Read) | Assumes patient procedure recorded or confirmed explicitly at each CPA review, probably by health care practitioner or medical secretary. |
| Fifth Intervention (Read) | Assumes patient procedure recorded or confirmed explicitly at each CPA review, probably by health care practitioner or medical secretary. |
| Sixth Intervention (Read) | Assumes patient procedure recorded or confirmed explicitly at each CPA review, probably by health care practitioner or medical secretary. |
| Administrations Of ECT | Recorded at time of ECT by clinical staff |
| Admissions To In-patient Care | Derived automatically from admissions recorded by ward nursing staff or administrative staff. |
| Discharges From In-patient Care | Derived automatically from discharges recorded by ward nursing staff or administrative staff. |
| In-patient Stay Lengths | Derived automatically from admissions and discharge dates recorded by ward nursing staff or administrative staff. |
| Community Survival Times | Derived automatically from admissions and discharge dates recorded by ward nursing staff or administrative staff. |
| Discharge To First Contact Intervals | Derived automatically from discharge dates recorded by ward nursing or administrative staff and contact/attendances recorded at |

| | |
|---|---|
| | time of contact dates. |