Specialised Mental Health – Patient Level Dataset

User Guidance for Providers and Commissioners

NHS England and NHS Improvement

Specialised Mental Health – Patient Level Dataset: User Guidance for Providers and Commissioners

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This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact 0300 311 22 33 or email england.contactus@nhs.net.

1. How to make a submission

1. Submissions should be made as per the submission timetable held within Schedule 6. Any data received outside of the deadline window will not be processed/loaded.

2. All submissions for the Specialised Metal Health dataset specification should be made to the **Data Landing Portal (DLP)**. For further information please visit the following website. https://digital.nhs.uk/services/data-landing-portal

3. The following file naming conventions should be used: i.e.

   RRE_SMH_20200401_PATIENTS_V01
   RRE_SMH_20200401_REFERRALS_V01
   RRE_SMH_20200401_ADMISSIONS_V01
   RRE_SMH_20200401_WARDSTAYS_V01
   RRE_SMH_20200401_DELAYEDDISCHARGE_V01
   RRE_SMH_20200401_EPC_V01
   RRE_SMH_20200401_TRIALLEAVE_V01
   RRE_SMH_20200401_OPDCOR_V01

RRE_ SMH_ 20200401_PATIENTS_V01

Provider Code Len= Max 6	File Name Element Len =3	Reporting Date Element Len = 8	File Name Max = 10	Version Len = 3

PLEASE NOTE: The Date recorded should reflect the first day of the month to which a submission relates. i.e. The file above would be for April 2020. May 2020 would be 20200501, June 2020 20200601 etc.

4. Data will be rejected if we cannot ascertain the month to which the data relates. This will be taken from the file name. If this is not clear then the data will be rejected and you will be notified of this.

5. Any important information relating to the file being submitted should be communicated to the DSCRO using the 'notes' section available via the DLP e.g. why a file is being resubmitted, known information missing etc., no current months data.

6. All data must be submitted within a singular csv file/s per specification to the DLP which should include all activity by a provider (not a singular MH unit). Providers must not submit data for part months. If providers wish to submit at a unit level they must notify NECS colleagues (NECSU.nhsebi@nhs.net) of this in advance to enable specifications to be set up. If this is not done this could result in data not being processed.

7. If there are any difficulties within submitting data to the DLP, this should be communicated to the relevant commissioning hub and regional CSU colleague as soon as possible. Please also include NECS in the correspondence NECSU.nhsebi@nhs.net. This email address cannot receive data, any PCD sent to this mailbox would be an IG breach.

8. **Resubmissions Guidance – If providers need to or are required to submit files again they must resubmit ALL files originally submitted regardless of where changes have been made.** Please submit as above using the DLP and notify the relevant commissioning hub and regional CSU colleague as soon as possible. Please also include NECS in the correspondence NECSU.nhsebi@nhs.net. This email address cannot receive data, any PCD sent to this mailbox would be an IG breach.

9. Validations will be applied to the data on submission to the DLP. These validations are detailed in the data specification tab in the validation column. F stands for Format, in this instance the format in the field will be checked against the data format and max length listed. N stand for Null and means these fields cannot be blank. If these validations are triggered then you will receive a warning report via the DLP. Any validations should be addressed within your next submission. If you have any questions please contact your relevant commissioning hub or regional CSU colleague.

2. What to include in the submission

10. Submissions should be in the 2020/21 format only.

11. The provider data set will be submitted via the Data Landing Portal. All providers already use this for ACM submission. As the portal only accepts CSV files, 7 files will need to be uploaded each month, 1 for each of the specifications included where commissioned. (Patients, Referrals, Admissions, Ward Stays, Exceptional Packages of Care, Trial and Home Leave, Outpatient, Day care and Outreach)

12. Information on the DLP can be found here https://digital.nhs.uk/services/secondary-uses-service-sus/data-landing-portal-dlp. Data will be submitted using Smartcard validation or NHS Identity depending on the access each provider has.

13. Data should be provided for all specialised services listed under 'Specialised Mental Health Service Category Code' on the 'Codes' tab of the dataset specification where applicable.

14. It is the provider's responsibility to submit the data to NECS DSCRO by the specified timetable held within Schedule 6. Once submitted, NECS DSCRO will process the data and perform some basic data quality checks. These checks, once complete should be shared by the NHSE local commissioning hub and used to improve data quality and correct errors within future submissions.

    Providers have responsibility to make sure their data is accurate upon submission. By exceptional circumstances a provider may resubmit if errors have been identified post submission. The last submission will be processed and will overwrite any other submissions made. It is important to note that if a file fails the identification of the reporting month, it will not pass to staging and so the previous submission will not be over written.

15. Items highlighted in a darker shade of yellow are 'mandatory' as per the MHSDS definition. Items highlighted in a lighter shade of yellow are 'required' as per the MHSDS definition. Items not highlighted are 'optional' as per the MHSDS definition.

For reference, the MHSDS definitions are as follows:

- **Mandatory** - These data items MUST be reported. Failure to submit these items will result in the rejection of the record.
- **Required** - These data items SHOULD be reported where they apply. Failure to submit these items will not result in the rejection of the record but may affect national and local analysis. (Please note that the purpose of the data set is not to change clinical practice.)
- **Optional** - These data items MAY be submitted on an optional basis at the submitter's discretion.

16. 'Originating CCG' refers to the CCG area from which the patient originates. This can be determined by reference to the Responsible Commissioner Guidance 2013 (see website link below).

https://www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf

17. All files are cumulative for the financial year – for inpatients, provider should enter details for all patients who were in a bed on 1 April in the relevant financial year and any who have been admitted since. We have had some returns where only details of admissions in the reporting month have been included.

    As a patient's status changes, e.g. at transfer or discharge, or where other information on a data row changes, the relevant details should be updated for the patient.

    If a patient is discharged (i.e. from a unit) but subsequently admitted to a different unit at that provider, as well as updating the 'old' records, new patient, admission and ward stay rows should be added.

    If a patient is discharged but subsequently admitted to the same unit, new admission and ward stay rows should be added (it is not necessary to add a new patient record).

    If a patient moves wards within the same unit, a new ward stay row only should be added.

    By way of example, for a transfer within a unit, a new row should be added to the 'Ward Stays' file and the ward end date should be updated on the 'old' ward stay row. At discharge, the relevant details on the 'Admissions' file should be updated for the patient (and ward end date updated on the 'Ward Stays' file).

    Please refer to the table in section 9 below for details of actions that should be taken in different scenarios. Please note that rows should not be removed from any file unless added in error.

18. For inpatients, the 'Patients', 'Admissions' and 'Ward Stays' files work together in that each patient can have more than one admission, and for each admission there may be more than one ward stay. Each inpatient should have at least one row on each of these files.

    NB. A new row should not be added to the Patients file for a new admission if one already exists for that unit/patient combination. Similarly, a new row should not be added to the Admissions file for a new ward stay if one already exists.

    'Admission ID/Ref' must be included. If the provider's PAS system does not provide this, the admission date in the format DDMMYY can be used. This

data item is required to tie the information on the Admissions and Ward Stays files together.

We have received some comments about duplication of data on the 'Admissions' and 'Ward Stays' files, but the specification has been designed in this way to minimise duplication.

19. By way of illustration, the table below confirms the actions that should be taken for common changes in a patient's status:

Status Change	Action 1	Action 2	Action 3
Admission	Add row on Patients file if not already there. Each unit/patient combination should be included only once on this file.	Add row on Admissions file.	Add row on Ward Stays file.
Discharge	Update relevant row on Admissions file with discharge details.	Update Ward End Date on relevant row on Ward Stays file.	
Discharge / Admission to a Different Unit (including Ward Transfer to a different unit)	Follow actions for 'Discharge' above.	Follow actions for 'Admission' above.	
Ward Transfer (same unit)	Update Ward End Date on relevant row on Ward Stays file.	Add new row on Ward Stays file.	
Change in Service Category Code (same ward)	Update Service Category Code on relevant row on Admissions file.	Update Service Category Code on relevant row on Ward Stays file.	
New Outpatient	Add row on Patients file if not already there.	Add row(s) to Outpatient & Day Care file.	
New Outreach Patient	Add row on Patients file if not already there.	Add row(s) to Outreach file.	
Misc Changes to Patient Information	Update details on relevant row.		
Patient Declared Fit for Discharge or Transfer but there is a Delay	Add row on Delayed Discharge file indicating date when delay began and the primary reason for the delay		
Referral	Add row on Referral file for each new referral and update (e.g. when closed).	Add row on Patients file if not already there.	Add Referral ID to other tabs where applicable.

20. **Reporting Delayed Discharges:**

The current Delayed Transfer of Care (DToC) codes and descriptions held within the MHSDS are not fully applicable to specialised MH and LD services and do not accurately describe delayed discharges within reporting. Therefore, new codes have been implemented within the SMH PLD dataset specification and are in line with national Delayed Transfer of Care (DToC) guidance. These codes will ensure that the accurate delay scenarios are captured for patients within Specialised MH and LD services to refine delay discharge reporting and support collaborative working across the system to improve the culture of reporting delays, complemented by the revised national guidance, which is expected to be updated during 2020/21. NHS England are working closely with NHS Digital to ensure the updated DToC codes list is reflected within future iterations of the MHSDS dataset specification.

A patient is ready for discharge or transfer when both of the following conditions are met:

- a clinical multidisciplinary team (MDT) decision has been made that the person is ready to be discharged or transferred to an alternative, more appropriate setting
- it is considered safe for the person to be discharged or transferred

A delayed discharge occurs when a patient has been declared fit for discharge (to be indicated within the 'Admissions' file, date declared fit for discharge) but has encountered one or more obstacles which are causing a delay to discharge (or transfer) beyond what could be reasonably expected as part of the discharge planning process, and as a result they remain in an inpatient hospital placement.

When a patient's discharge (or transfer of care) is delayed, the 'Delayed Discharge' file should be used to report all relevant information pertaining to the date on which the delay commenced and the primary reason for this delay.

Existing DToC codes in the MHSDS are not adequate for Specialised Mental Health services; therefore, please see a mapping table below to aid with submissions for the SMH PLD:

MHSDS Reporting Code	SMH PLD Code	Delay Domain or Description of Code	Current wording in Data Dictionary (i.e., codes which are being maintained with improved descriptions against current NHS Data Dictionary descriptions)
		Out of Hospital staff	
A2	A2	Awaiting care coordinator allocation	
	A3	Awaiting allocation of community psychiatrist	
	A4	Awaiting allocation of social worker	
		Legal requirements	
N1	N2	Awaiting Court of Protection proceedings	
	N3	Awaiting Deprivation of Liberty Safeguards (DOLS) Application	
	N4	Awaiting mental capacity assessment	
	N5	Delay due to consideration of specific court judgements (MM, PJ)	
	N1	Delay due to other legal requirements (MCA or MHA legislation)	Awaiting outcome of legal requirements (mental capacity/mental health legislation)
M1	M1	Awaiting Ministry of Justice permission for transfer or discharge	Awaiting Ministry of Justice agreement or permission on placement
		Availability of appropriate onward placement	
C1	C2	Awaiting clinically appropriate placement in a specialist inpatient service	
	C1	Awaiting clinically appropriate placement in non-acute, NHS-funded care	Awaiting further non-acute (including community and mental health) NHS care (including intermediate care, rehabilitation services etc)
	C3	Awaiting availability of placement in prison or Immigration Removal Centre	
		Adaptations and/or bespoke support	
D2	E2	Awaiting availability of additional nursing support or specialist staff in onward placement	
F2	F2	Awaiting equipment, telecare and/or environmental adaptations	Awaiting community equipment, telecare and/or adaptations
E1	E1	Awaiting care package in own home	
		Availability of out of hospital (community-based) placement, adults	
D1 or D2	D3	Awaiting availability of care home placement	
I2	I2	Awaiting availability of general needs housing or private tenancy	Housing - Awaiting availability of general needs housing/private landlord accommodation acceptance as PATIENT NOT covered by Housing Act and/or Care Act
J2	J2	Awaiting availability of supported accommodation	Housing - Awaiting supported accommodation
K2	K2	Awaiting emergency accommodation from the Local Authority under the Housing Act	Housing - Awaiting emergency accommodation from the Local Authority under the Housing Act
I3	I3	Delays due to homelessness or asylum seekers not covered by care act	Housing - Single homeless PATIENTS or asylum seekers NOT covered by Care Act
D1 or D2	J3	Awaiting availability of other adult social care funded placement	
		Availability of out of hospital (community-based) placement, children and young people	
L1	L2	Awaiting availability of specialist residential school placement	
	L3	Awaiting availability of foster placement	
	L4	Awaiting availability of residential children's home	
	L5	Awaiting availability of secure children's home (welfare or non-welfare)	
	L6	Awaiting availability of placement in Youth Offender Institution	
	L7	Awaiting availability of other specialist community placement for CYP	
	L8	Awaiting family placement	
		Funding issues and disputes	
B1	B2	Lack of agreed Health Care Funding	
	B3	Lack of agreed Social Care Funding	
	B4	Lack of agreed Education Funding	
	B5	Awaiting decision or agreement from funding panel	
H1 or B1	H2	Disputes about responsible commissioner (including where this relates to funding issues)	
H1	H3	Disputes about proposed pathway between clinical teams and/or care panels	
	H1	Delays due to all other types of disputes not covered above	Disputes
		Patient and/or Family Choice	
G2	G13	Patient disagreement about proposed pathway or onward placement	
	G14	Family and/or carer disagreement about proposed pathway or onward placement	

CODES NO LONGER TO BE IN USE FOR SPECIALISED MENTAL HEALTH PATIENT LEVEL DATASET (SMH PLD)

Effective from 1st April 2020

New (replacing) Code	Old Code	
D3	*D1*	*Awaiting Care Home Without Nursing placement or availability*
D3	*D2*	*Awaiting Care Home With Nursing placement or availability*
L2 - L8	*L1*	*Child or young person awaiting social care or family placement*
B2 - B5	*B1*	*Awaiting public funding*
G13 - G14	*G2*	*PATIENT or family choice (Reason not stated by PATIENT or family)*
	G3	*PATIENT or family choice - Non-acute (including community and mental health) NHS care (including intermediate care, rehabilitation services etc)*
	G4	*PATIENT or family choice - Care Home Without Nursing placement*
	G5	*PATIENT or family choice - Care Home With Nursing placement*
	G6	*PATIENT or family choice - Care package in own home*
	G7	*PATIENT or family choice - Community equipment, telecare and/or adaptations*
	G8	*PATIENT or Family Choice - general needs housing/private landlord acceptance as patient NOT covered by Housing Act/Care Act*
	G9	*PATIENT or family choice - Supported accommodation*
	G10	*PATIENT or family choice - Emergency accommodation from the Local Authority under the Housing Act*
	G11	*PATIENT or family choice - Child or young person awaiting social care or family placement*
	G12	*PATIENT or family choice - Ministry of Justice agreement/permission of proposed placement*

21. **CAMHS Inpatient Eating Disorder Services:** Recording of Service Category Code within all dataset specifications must correspond to the commissioned service, which may not be the same as the patient's diagnostic group or reason for treatment. For children and young people with disordered eating who are admitted to inpatient services, this applies as follows:

    - Patients placed in General Adolescent (GA) units should be recorded under the service category code corresponding to GA services, regardless of the diagnosis. A patient in a GA unit receiving treatment for disordered eating should still be reported under the GA service category code NCBPS23K/IP_ADOL but with the appropriate ICD-10 diagnostic information related to the disordered eating recorded in the dataset field(s) for diagnosis.
    - Patients placed in specialist Eating Disorder units should be recorded under the service category code NCBPS23K/IP_ADOL_ED. ICD-10 diagnostic information should be recorded as usual in the relevant diagnosis dataset fields.

22. **Children's Mental Health Inpatient Services**: Recording of Service Category Code within all dataset specifications must correspond to the commissioned service, which may not be the same as the patient's age category. For children and young people under the age of 13, this applies as follows:

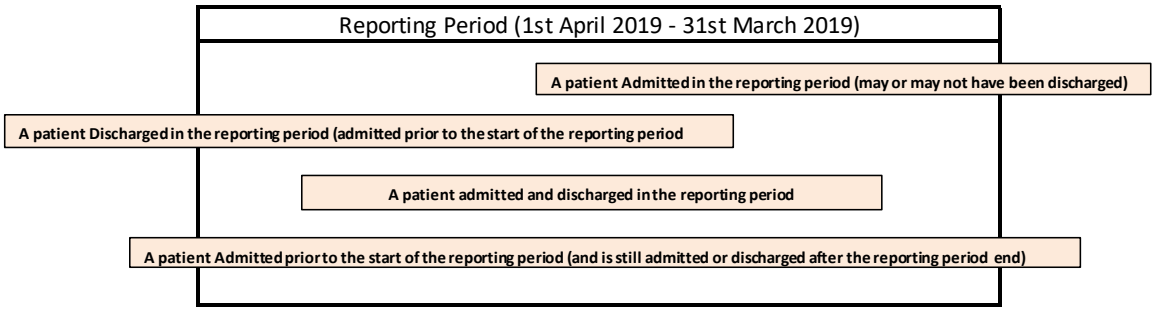
    - Patients placed in services specifically commissioned as Children's MH services should be recorded under the appropriate service category code corresponding to Children's services (NCBPS24E/IP_CHILD)

    - Patients placed in General Adolescent (GA) units should be recorded under the appropriate service category code corresponding to GA services (NCBPS23K/IP_ADOL), regardless of their age.

23. All in-year activity should be included in the template. For inpatient activity, the following should be included:

- Where a patient has been admitted in the financial year, whether or not they have been discharged.
- Where a patient has been admitted and discharged in the financial year.
- Where a patient has been discharged in the financial year but were admitted prior to 1 April.
- Where a patient was admitted before 1 April but was in a bed at some point in the financial year, whether now discharged or not.

i.e.



All these admission scenarios should be recorded on the Admissions file. The Ward Stays file should be populated using the same logic, with the same key fields linking to a row on the Admissions file. These key fields are:

- Unit Code
- NHS Number
- Local Patient Identifier (Extended)
- Admission ID/Ref

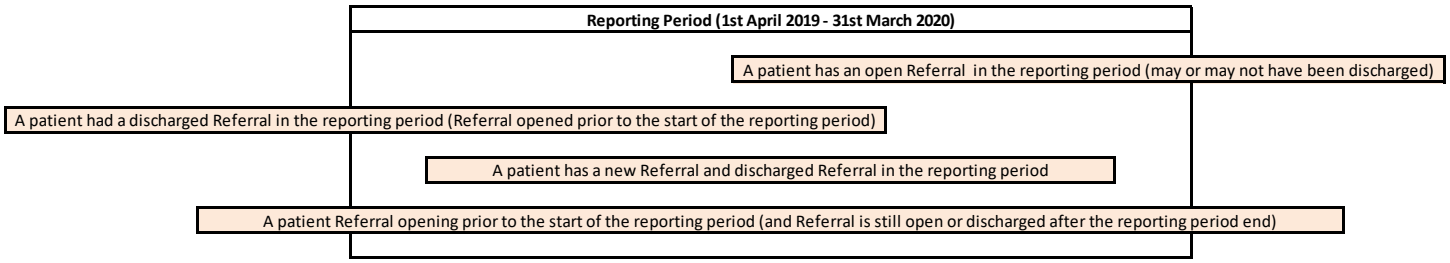
24. Ward Code Guidance - Insert name of the ward code that corresponds with the same ward code submitted within the MHSDS and the ACM dataset submissions. This should correspond to with the national NHS data dictionary definition. *https://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/w/war/ward_code_de.asp?shownav=1*

25. Contacts for non-inpatient only should be recorded on the 'Outpatients, Day Care & Outreach' tab cumulative for the financial year. Only one line is required for each patient and Activity Month, recording the total number of in-year contacts up to the reporting month. Please note the reporting month refers to the month the data is being submitted up to and not the activity month.

26. Referrals information for patients should be included in the template, and entered on the Referral file. For Referral information, the following should be included:

- Where a patient has a new referral in the financial year, whether or not they have had a closed referral.
- Where a patient has been referred and discharged in the financial year.
- Where a patient has a referral closed in the financial year but was referred prior to 1 April.

- Where a patient was referred before 1 April but was open to service (referral still open) some point in the financial year, whether now discharged or not from service.



All these referral scenarios should be recorded on the Referrals file. The key fields to include are:

- ODS Provider Code
- Unit Code
- NHS Number
- Referral ID

The Referral ID should be added to the other files (e.g. Admissions, Ward Stays, Outpatients) to the link the activity to the matching referral.

27. Please utilise the latest referral ID within the admissions file which corresponds to an accepted referral for an Inpatient admission i.e. Assessment Outcome equals 04- Assessment for Admission Supported – for immediate admission to service' or '05- Assessment for Admission Supported – patient on waiting list for service. Do not include any referral ID's linked to rejected referrals or access assessments.

28. Referral ID Guidance – The referral ID submitted by healthcare providers within the referral's dataset specification should be unique upon submission. The access assessment and assessment for admission are terms/language described within the service specification accordingly and should correlate to the data being submitted.

    In some cases, an access assessment may be undertaken on the same day as and/or by the same organisation as the assessment for admission. Nevertheless, it is important to record the access to assessment and assessment for admission separately so that records for patients in these circumstances do not appear to be missing one part of what is a separate and distinct process for mange services (e.g., adult secure services). We therefore would expect unique referral ID's in this scenario i.e. ReferralID: "123456_01" and "123456_02" and use 123456_02 in the Admission/Ward stay dataset.

29. **IMPORTANT** Where a code requires a ‘0’ in front of another number, try the steps below which should enable the leading 0 to be retained:
    - Set the format of the column text
    - Enter the codes with the zeros in front, e.g. 01
    - Save and close
    - Then, if you open the CSV file using notepad rather than Excel it should show you the two digit codes. You can then submit the file. Note that opening the file in Excel and then saving again will revert the code to one digit.

This applies to:

- Withheld Identity Reason
- Primary/Secondary Reason for Referral (Mental Health)
- Assessment Type
- Assessment Outcome
- MHA Legal Status Classification Code
- Outcome of pre-admission (community) CTR/CETR
- Referral rejection reason
- Referral Closure Reason
- Forensic Mental Health Care Cluster Code (Final)

30. Exceptional Packages of Care: EPC End Date – include an EPC End Date when an EPC is agreed, this will ensure it is captured and not open-ended, the EPC end date can be updated in future submissions if required.

31. Sub-headings and totals should <u>not</u> be included within the data.

3. Checks carried out

32. Once submitted a number of further validations are carried out on the data to ensure that it meets Schedule 6 requirements. These form the basis of a provider compliance report which is shared on a monthly basis with individual providers.

    The validations check within each file and also carry out checks between the individual submissions. This ensures that the dataset is robust and useable for commissioning purposes. As mentioned above, if we cannot determine the month to which your submissions relate all files will be rejected and you will be asked to resubmit.

    A document is available upon request from NHS England which portrays a summary of the validations carried out and can be used to build internal checking processes prior to submission.

4. Additional Information

NHS Number Tracing Guidance

33. A document is available upon request from NHS England which portrays specific information on NHS number tracing. This is a key field in the dataset so the SMH data can be utilised for reporting. There is an expectation that NHS number will be populated wherever possible and only left blank in exceptional circumstances.

5. Equality and Health Inequalities Statement

34. Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

· Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

· Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.