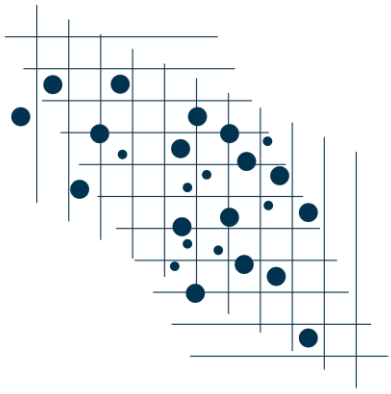
Professional Record Standards Body

Better records for better care



Mental Health Services Data Set Interventions:

Final Report

Document Management

Revision History

Version	Date	Summary of Changes
0.1	14-08-23	First Draft
0.2	21-08-23	Second Draft – reviewer / board member comments to 21-08-23
0.3	31-08-23	Board and Assurance Committee comments
1.0	31-08-23	Final

Reviewers

Reviewer name	Title / Responsibility	Date	Version
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Name	Title / Responsibility	Date	Version
Project Board		21-08-23	0.2
PRSB Assurance Group		31-08-23	0.2

Glossary of Terms

Term / Abbreviation	What it stands for
CBT	Cognitive Behavioural Therapy
CRS	Clinically led review of standards
EOG	Expert Oversight Group
ICB	Integrated Care Board
LTP	Long Term Plan
MHSDS	Mental Health Services Data Set
NICE	The National Institute for Health and Care Excellence
PRSB	Professional Record Standards Body
reference sets	SNOMED CT reference set
SNOMED CT	Systematized Nomenclature of Medicine -- Clinical Terms
TEWV	Tees, Eske and Wear Valley NHS Foundation Trust
UCD	User Centred Design

Planned Review Date and Route for User Feedback

The next maintenance review of this document is planned for [3 year period], subject to agreement with NHS Digital as the commissioning body.

Please direct any comments or enquiries related to the project report and implementation of the standard to support@theprsb.org

Contents

1 Executive Summary

Background

The Mental Health Services Data Set (MHSDS) is a patient level, output based secondary uses data set which aims to deliver robust, comprehensive, nationally consistent and comparable person-based information for patients who are in contact with Mental Health Services.

The MHSDS SNOMED CT dashboard (produced by NHS Digital) shows a wide variation of codes are being used to record interventions across the relevant pathways. Feedback from local systems is they need a national steer to bring clarity on what should be flowed to the MHSDS, to support the implementation of non-urgent community waiting time standards, and other areas of ambition and transformation. Some submitting organisations have developed their own local list and definitions of SNOMED CT codes to record local activity however variation exists across the local lists, and many organisations are yet to undertake significant local work to ensure consistency and clarity in code submitted.

NHS England commissioned PRSB to work jointly with them to develop relevant reference sets to provide clarity to submitters of MHSDS which codes are to be used for activity related to community mental health teams and to endorse the candidate reference sets with appropriate clinical bodies to support the formal production of the reference sets.

The overall aim was to achieve consensus on reference sets which includes the SNOMED codes to be used for mental health interventions to support consistent reporting. The non-urgent community mental health waiting time standards has been used as an example activity to benefit from a consistent reference sets to facilitate the analysis of waiting times, to demonstrate variation and inform local improvement.

The scope of this project is the non-urgent community mental health care pathway for both children and young people, and adults and older adults. These pathways will cover the start of therapeutic or social interventions, creation of a patient care plan and/or single-session interventions with children and young people, where appropriate.

Methodology and Consultation

The approach adopted to develop the Early Intervention in Psychosis guidance was utilised. This guidance was developed by NHS England, with direction provided by an expert oversight group (EOG), as well as an additional period of external engagement.

As a 'proof of concept,' this approach was adopted with the CBT intervention type. An EOG was established and two workshops held in December 22 to define the core list of CBT interventions. In the process, four intervention types were identified:

1. Mental Health Assessments
2. Medications and Physical Therapy interventions
3. Psychological therapies
4. Psychosocial interventions

Further EOG workshops were held in February and March 2023 to establish a draft interventions' list for MHSDS reporting for wider consultation. EOG participants are listed in Appendix B.

Having developed a draft interventions list from the work undertaken to end March 2023, the full standard development was undertaken to consult with stakeholders, iterate the draft where required, and develop a final standard which PRSB can then ask members to endorse.

The concept of the EOG has been maintained through the standard development process and all suggested interventions, queries and questions were referred to the group through an ongoing series of meetings culminating in the final meeting to agree the Version 1 of the SNOMED Interventions reference sets.

A workshop inviting all EOG members was held on 20th April 2023 to obtain broad engagement on the draft to undertake a first review and iteration of the categories (see Appendix B for participants). A series of events were then held:

Consultation Event	Date
EOG webinar – final draft for consultation	20-04-23
Survey – MHSDS submissions	05-06-23 to 22-06-23
Supplier interviews	30-05-23 to 21-07-23
MHSDS Interventions multidisciplinary webinar1	08-06-23
MHSDS Interventions multidisciplinary webinar2	29-06-23
EOG review	31-07-23
Final EOG review	09-08-23

Conclusions

MH Interventions SNOMED reference sets

There is huge support for national direction on which SNOMED concepts to use for interventions, both from providers and from system suppliers.

As anticipated in consultation, there are almost as many views as there are participants in this speciality area and so this first version of the reference sets will almost certainly not be considered to be complete by all parties. To that end, the opportunity to request changes through a formal process is key. In addition, the world of mental health support continually evolves and so they will never be static and unchanging.

Advance knowledge of impending changes would allow system suppliers and providers to prepare.

Expert Oversight Group

During the standard development, it was identified that there was a requirement to identify clinical ownership of the Interventions reference sets and that there would be a need for ongoing maintenance in terms of future additions and removal of SNOMED concepts.

A terms of reference has been developed for an EOG board and is included in Appendix I.

Policy area specific guidance

There is a drive to ensure that the required level of granularity is recorded and that higher level generic terms such as ‘therapy’ are not utilised as a catch all.

Local Mapping

The SNOMED concepts listed in the Interventions Reference Sets will be those which will be reported upon within the MHSDS for the purposes of waiting times clock stop. Any codes submitted which are not contained within the reference sets will not be reported on and will not, therefore, be counted in returns. There will need to be an exercise at a local level to map codes currently used to the reference sets.

End User Interface

Whilst the scope of this project is to define the reference sets for Interventions, it is essential that due consideration be given to the end user interface and that only relevant data is presented to the professional using the system.

MHSDS Submission Process

Several issues were raised with regard to the actual process of submitting MHSDS data including that it can be labour intensive, training in use can be a significant overhead, the process of uploading data seems complex, identification of submission errors is laborious and that indicators are not updated following resubmission

Publishing the benefits of the MHSDS

Many of those who submit data identify that it is a time consuming process which, in many cases, has an opportunity cost associated with it. There is, perhaps, an opportunity to publish the benefits derived from the MHSDS in order that people do not consider it a 'thankless task'.

Recommendations

MHSDS Interventions reference sets recommendations

The first version of the interventions reference set has been crystalised in the knowledge that it meets the goldilocks principle and is good enough, with a well-publicised mechanism of change control for future releases. Release 1 is shown in Appendix J.

It is recommended that, in order for necessary system changes to be made, a period of time be given before the SNOMED reference sets are mandated and MHSDS reporting only utilises these concepts.

It is also recommended that, as with this first version, proposed updates are published on NHS Futures to allow suppliers and providers to prepare for upcoming SNOMED releases. Consideration should also be given to utilising the NHS Standards Directory.

Expert Oversight Group recommendations

It is recommended that the EOG be established at the earliest opportunity and that the board formally approve the MHSDS Interventions reference sets Version 1 before publication. The EOG process and the change request submission criteria should be published alongside the link to the reference sets for information.

It is recommended that for the purposes of release of the first version of the reference sets, approval will be given by the Leadership Group of the National Mental Health Programme, NHS England, with the proposal that future authority will be delegated to the EOG.

The EOG will require a SNOMED expert to submit change requests. The PRSB could provide this service on a call off contract basis or an internal resource could be assigned.

In order to ensure continuity and time for this to be established, the PRSB will provide this service until 30th September 2023.

Policy area specific guidance recommendations

It is recommended that each policy team establish and maintain guidance for SNOMED concepts which have a specific clinical meaning where appropriate. For example, CYP utilise the term 'consultation' to refer to a mental health professional consultation input which may result in advice being given. From the perspective of waiting times, this is deemed to be a 'clock stop' and, as such, an intervention.

Local Mapping recommendations

It is recommended that guidance on the need for local mapping be published alongside the link to the reference sets for information.

End User Interface recommendations

It is recommended that, in conjunction with guidance on local mapping, a review is undertaken locally of end user interface requirements.

MHSDS Submission Process recommendations

It is recommended that there is a review of the submissions process to see if there are any opportunities to improve the process in particular:

- Might there be a way to support smaller organisations who are reliant on manual input
- Consider development of an online training module
- Review the submission error process and the use of resubmissions data

In addition, consideration should be given to whether digital therapeutic intervention CYP MH should be acknowledged as an intervention and included within MHSDS.

Publishing the benefits of the MHSDS recommendations

A targeted communications campaign to acknowledge the overhead of submitting data, to advise of the benefits derived from MHSDS and to outline the strategy to ultimately derive information from point of care systems once interoperability is achieved may help incentivise the provision of accurate data.

2 Introduction

2.1 Background and Context

The Mental Health Services Data Set (MHSDS) is a patient level, output based secondary uses data set which aims to deliver robust, comprehensive, nationally consistent and comparable person-based information for patients who are in contact with Mental Health Services.

The MHSDS covers Mental Health Services located in England, or located outside England but treating patients commissioned by an English Integrated Care Board (ICB), NHS England specialised commissioner or an NHS-led Provider Collaborative.

As a secondary uses data set, the MHSDS re-uses clinical and operational data for purposes other than direct patient care, and defines the data items, definitions and associated value sets to be extracted or derived from local information systems.

All activity relating to patients who receive assessments and treatment from Mental Health Services is within the scope of the MHSDS, where the patient has, or are thought to have:

- A mental health condition and/or
- A need for support with their mental wellbeing and/or
- A Learning Disability and/or
- Autism

or any other neurodevelopmental condition.

The scope of the MHSDS requires patient record level data submission from services as follows:

- For each patient attending a service located in England:
    - If the care is wholly funded by the NHS: the data submission for that patient is mandatory
    - If the care is partially funded by the NHS: the data submission for that patient is mandatory
    - If the care is wholly funded by any means that is not NHS: the data submission for that patient is optional.
- For each patient attending a service located outside England, but commissioned by an English ICB or NHS England specialised commissioner, the data submission is optional.

The MHSDS is used across the range of Health Care Providers and organisations that provide Mental Health Services (irrespective of funding arrangements) including:

- NHS Mental Health Trusts
- NHS Learning Disabilities Trusts
- NHS Acute Trusts
- NHS Care Trusts
- Independent Sector Healthcare Providers offering a service model that includes NHS funded and non-NHS funded patients
- Voluntary sector Health Care Providers
- Any qualified provider offering Mental Health Services
- Community services offering secondary care to children.

DCB0011 is the information standard for the MHSDS.

NHS England has outlined a clear commitment to driving a more equal response across mental and physical health in the NHS Long Term Plan. The NHS Mental Health Implementation Plan set an ambition to improve the quality of mental health data, particularly in relation to data flow to the Mental Health Services Data Set (MHSDS), to rapidly demonstrate delivery against those LTP commitments.

The SCCI0034: SNOMED CT Information Standard Notice sets the expectation that all providers "must use SNOMED CT as the clinical terminology standard within all electronic patient level recording and communications before 1 April 2020". The MHSDS relies on SNOMED CT codes to capture information on clinical interventions and clinical outcome measures, used in response to those commitments.

The mental health programme has provided specific guidance to support pathways where NICE guidance is forthcoming. However, a priority for mental health over the next year is to specifically support the NHS wide commitment to address waiting times.

The MHSDS SNOMED CT dashboard (produced by NHS Digital) shows a wide variation of codes are being used to record interventions across the relevant pathways. Feedback from local systems is they need a national steer to bring clarity on what should be flowed to the MHSDS, to support the implementation of non-urgent community waiting time standards, and other areas of ambition and transformation. Some submitting organisations have developed their own local list and definitions of SNOMED CT codes to record local activity however variation exists across the local lists, and many organisations are yet to undertake significant local work to ensure consistency and clarity in code submitted.

Current emphasis is on using the standards as routinely reported metrics, solving localised technical and data quality issues, ahead of setting performance thresholds. The national team are focused on reporting and use of data to inform local interrogation to evidence variation to identify learning between systems.

PRSB core business is to develop Information Record Standards. Different types of information standards are needed for information to flow between computer systems and these are defined in Appendix A.

NHS England commissioned PRSB to work jointly with them to develop relevant reference sets to provide clarity to submitters of MHSDS which codes are to be used for activity related to community mental health teams and to endorse the candidate reference sets with appropriate clinical bodies to support the formal production of the reference sets.

Within this project, PRSB provided support to define the data and terminology standards to be utilised for reporting a range of mental health interventions and will support the development of MHSDS waiting times reporting.

2.2 Aim and objectives

The overall aim was to achieve consensus on reference sets which includes the SNOMED codes to be used for mental health interventions to support consistent reporting. The non-urgent community mental health waiting time standards has been used as an example activity to benefit from a consistent reference sets to facilitate the analysis of waiting times, to demonstrate variation and inform local improvement.

The objectives were to:

- Identify a baseline reference sets for assessments and interventions used in non-urgent community mental health pathways
- Consult with appropriate clinical bodies to validate the SNOMED CT reference sets and gain consensus that it is comprehensive
- Present reference sets to NHSD terminology service for publication in the UK release of SNOMED CT
- Produce guidance for the implementation and use of the reference sets in mental health systems

2.3 Benefits

Long waits for mental health services are not only a poor experience for patients but also are associated with higher rates of presentation in an emergency and poor outcomes. Waiting time standards across urgent and community mental health pathways will significantly help to address this. Standardising what information is recorded about a service user is essential to understanding patient waits and improving the quality of direct care for patients.

The SNOMED CT reference sets will provide significant improvements at all levels across the system and will address those data quality issues which currently undermine the validity and utility of the MHSDS data. Effective implementation will enable NHSE&I to monitor waits and set trajectories for waiting times standards in mental health.

NHSE have a responsibility to report to Government on progress therefore it is essential that the MHSDS delivers in order to prevent the commissioning of duplicate bespoke data collections to measure variation.

A definitive list of SNOMED CT codes would also bring other added benefits with an impact on the patient/service user/client end:

- Reduced data burden on clinical teams and improved care by making data entry more consistent and preventing duplicate data entry in multiple systems;
- Improved analysis of data, making clinical and management audits quicker, easier and more comprehensive;
- Facilitated integrated care models by enabling data sharing and decision-making on care and patient safety. All relevant professionals involved in a person's care access, use and amend a shared view of a patient's healthcare
- The new Mental Health Currencies, replacing Clustering, will be built on routine data flows within national Mental Health datasets. At the granular level, we expect this to include SNOMED intervention codes. As such, this reference set of intervention codes is likely to be drawn on to identify key activities for use within the currency model. In turn, this implies that these interventions – among others – will be costed and cost benchmarked, with the potential to develop better understanding of effective and efficient provision. Eventually, we expect costed currencies to become the building blocks for Mental Health service funding flows.

2.4 Scope

2.4.1 In scope

The scope of this project is the non-urgent community mental health care pathway for both children and young people, and adults and older adults. These pathways will cover start of therapeutic or social interventions, creation of a patient care plan and/or single-session interventions with children and young people, where appropriate.

The project scope is limited to data submitted to the MHSDS as part of routine, required submissions from providers of NHS-commissioned metal health care, including Voluntary Care Sector and independent service providers. The first release of the SNOMED reference sets is for the purposes of waiting times clock stops only.

2.4.2 Exclusions from scope

Scope does not include community-based mental health crisis pathway services or emergency department pathway services.

The project scope does not include other mental health services and their corresponding datasets such as IAPT or physical health checks for patients with a severe mental illness.

Some clinical areas are covered by existing comprehensive SNOMED CT guidance documents such as the existing guidance for SNOMED CT reporting in Early Intervention in Psychosis services. These may be used for reference for re-usable guidance but are excluded from scope in the context of further development.

The scope of this project is community mental health and therefore inpatient care, acute, rehabilitation and forensic are outside the scope.

The offer of an intervention which is turned down, or where the subsequent appointment is not taken up, is excluded from this phase of the project.

It should be noted that, as a secondary use dataset, the MHSDS does not require a safety case or hazard log.

3 Methodology

3.1 Standards

PRSB core business is to develop Information Record Standards. Different types of information standards are needed for information to flow between computer systems and these are defined in Appendix A.

Within this project, PRSB are providing support to define the data and terminology standards to be utilised for reporting a range of mental health interventions and will support the development of MHSDS waiting times reporting.

3.1.1 Discovery Phase

In the Discovery Phase, the approach adopted to develop the Early Intervention in Psychosis guidance was utilised. This guidance was developed by NHS England, with direction provided by an expert oversight group (EOG), as well as an additional period of external engagement. This document and approach was utilised as a blueprint.

As a 'proof of concept,' this approach was adopted with the CBT intervention type. An EOG was established and two workshops held in December 22 to define the core list of CBT interventions.

The conclusions from the proof of concept pilot were:

1. The process of establishing an expert oversight group to consider intervention types and define a subset which meets the requirements of clinicians to define an intervention sub-classification is effective.
2. Four intervention types were identified:
    a. Assessments
    b. Medications (assess, prescribe, monitor, stop)
    c. Psychological therapies
    d. Psychosocial interventions

The original proof of concept workshop to consider CBT SNOMED codes illustrated the potential minefield to navigate in terms of selecting the correct code to utilise. A potential list of twenty five existing codes was reduced to eight.

Further EOG workshops were held in February and March 2023 to establish a draft interventions' list for MHSDS reporting for wider consultation. EOG participants are listed in Appendix B.

3.1.2 Standard Development

Having developed a draft interventions list from the work undertaken to end March 2023, the full standard development was undertaken to consult with stakeholders, iterate the draft where required, and develop a final standard which PRSB can then ask members to endorse.

The concept of the EOG has been maintained through the standard development process and all suggested interventions, queries and questions were referred to the group through an ongoing series of meetings culminating in the final meeting to agree the Version 1 of the SNOMED Interventions reference sets.

The candidate reference sets have been presented to the NHS D Terminology service for publication in the UK release of SNOMED CT.

Relevant members have been asked to endorse the standard and this process will complete on 31st November 2023.

4 Consultation Approach

4.1 Stakeholder engagement

Stakeholders are identified in Appendix C

4.2 Consultation Methods and Rationale

A workshop inviting all EOG members was held on 20th April 2023 to obtain broad engagement on the draft to undertake a first review and iteration of the categories (see Appendix B for participants). A series of events were then held:

Consultation Event	Date
EOG webinar – final draft for consultation	20-04-23
Survey – MHSDS submissions	05-06-23 to 22-06-23
Supplier interviews	30-05-23 to 21-07-23
MHSDS Interventions multidisciplinary webinar1	08-06-23
MHSDS Interventions multidisciplinary webinar2	29-06-23
EOG review	31-07-23
Final EOG review	09-08-23

4.3 Consultation Participants

The survey and system supplier interviews were undertaken on the basis of anonymity. The attendees of the MDT webinars are shown in Appendix D.

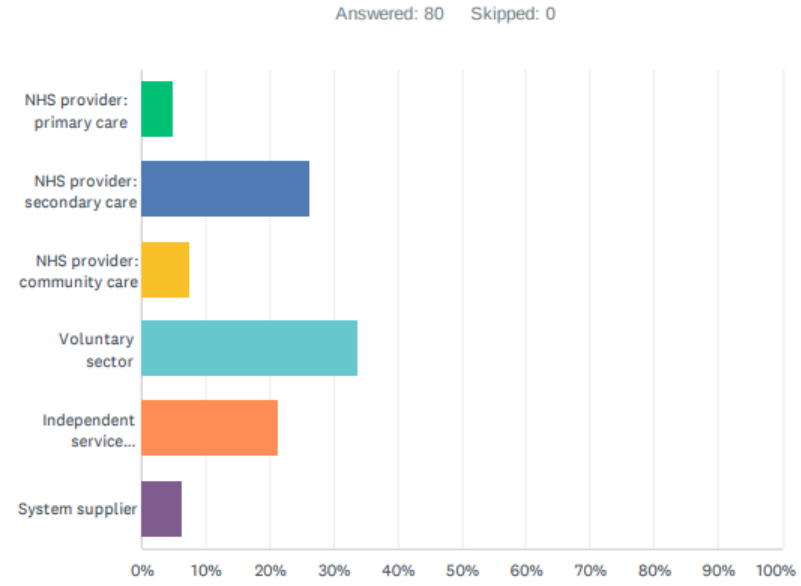
The EOG members are shown in Appendix I the Expert Oversight Group Board Terms of Reference.

4.4 Consultation Findings

4.4.1 Survey

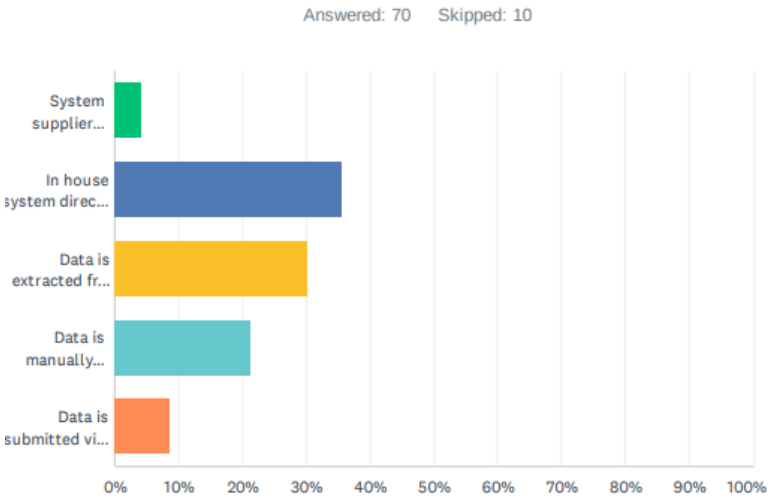
The survey ran from the 5th June 2023 to 22nd June 2023. Survey questions are shown in Appendix E. Questions are listed below and responses discussed.

Q1 Which of the following would best describe your organisation?



A total of 80 respondents from various organisations responded to the survey with 33.33% from the voluntary sector, 26.19% from NHS secondary care providers and 21.43% from independent service providers.

Q2 How is your Mental Health Services Dataset data submitted?



ANSWER CHOICES	RESPONSES	
System supplier directly provides submission data from point of care primary use system.	4.29%	3
In house system directly provides submission data from point of care primary use system	35.71%	25
Data is extracted from system(s) to Excel spreadsheet	30.00%	21
Data is manually entered into Excel spreadsheet	21.43%	15
Data is submitted via third party NHS Trust	8.57%	6
TOTAL		70

The question was asked “If the submission of data is not fully automated, please describe how this is currently being done. If possible, please give an estimate of the weekly person hours involved in this activity”. Answers were analysed by method of submission.

In-house system directly provides submission data from point of care primary care

Over a third of responses (35.62%) stated their main method of submitting MHSDS data was via in-house systems which directly provides submission of data from point of care.

The more mature in-house systems extracted to a central data warehouse from where the submission was made.

Less mature in-house systems submission process involved using a combination of SQL scripts, Microsoft access queries, core data base, paper diary, and excel. In some instances, this was then copied and pasted into the MHSDS database.

On average, this process consumed between 4-20 hours per month. Investigating errors and improving data quality was reported to be time consuming, sometimes involving several days a month.

Data is extracted from system(s) to Excel spreadsheet

Another common method for data submission was extracting data from system(s) to excel spreadsheets (31.51%) and then transferring from Excel to Access database into the SDCS (Strategic Data Collection Service) Cloud. The process of adding data into an Excel template involves Considerable manual checking and manipulation of data before copying into the Access files for submission.

There was wide variation in the time taken ranging from a few hours to up to 3 days per month.

Data is manually entered into Excel spreadsheet

Over one fifth (20.55%) manually entered data into excel spreadsheet. This involved manually entering the data from internal system and translating it into the correct format for the SDCS submission link. i.e., retrieve codes from the ODS portal, MPI codes for demographics etc. This process is very labour intensive.

Data is submitted via third party NHS Trust

Data submission via a third party was infrequently reported (8.22%).

Uncategorised data submission

The process of submitting data was also described as more complicated than the available survey answers. The process involved extraction of data into a warehouse and various automated processes to prepare it for analytical use and MHSDS submission. This is followed by manually running MHSDS procedures monthly to extract data from the warehouse into the MHSDS submission database.

Although this is a relatively quick process, there has been significant investment in developing and maintaining the systems.

When a new version of the dataset is released (normally annually), work must be carried out to update the systems. The number and complexity of the changes to the dataset determines how long the maintenance and renewal process takes.

However, in terms of regular monthly work, the main piece directly associated with the submission is the checking the quality of the data (via reports returned) and dealing with any errors or warnings.

Q3 If you provide health or social care services at point of care, do you need to be aware of the SNOMED CT codes which are utilised?

If yes, does your organisation have a list of SNOMED CT codes which can be used?

Over half of the respondents (56.06%) were aware of the SNOMED CT codes used to describe care. There was great variability in the availability of a SNOMED CT list to utilise.

Q4 Please identify any barriers or issues perceived in the submission process.

"The process of submitting is so time consuming and complicated, with so many meetings attached to using/learning the system. NHS work is less that 5% of our total service delivery so feels very disproportionate for our organisation."

"laborious. We have no way to check postcodes. So to get around the process rejecting everything we code ALL as ZZ99 3CZ. So the NHS lose out on all records rather than a few. When you introduce changes you dont consider the ramifications on data collection. ie we dont need so dont collect data you subsequently mandate. So, again we submit one value for all. eg "Organic Brain Disorder" for all."

"There is no easy way to check the accuracy of data until after the data has been published and we can request patient level data for indicators from data liaison, by which point it's too late to fix issues as indicators aren't updated using resubmission data."

"*Our digital therapeutic intervention CYP MH is NICE recommended as a first line treatment option for childhood anxiety and is a direct intervention, however within MHSDS digital care contact mechanisms (where a human isn't involved) are excluded from counting towards access"*

The main barriers reported in the MHSDS submission process were:

Lack of national guidance on which SNOMED codes to use

Whilst there is some specific guidance available, there is generally no clear and detailed national guidance on what are considered to be valid SNOMED codes for submission for interventions. Local protocols have been / are being developed resulting in variation across the board. In addition:

- Some EPRs do not currently use SNOMED codes
- Some submissions do not use SNOMED codes
- Some organisations resort to using a generic code which doesn't actually reflect service provision
- A road map of future SNOMED codes (both new and retired) would be useful to provide time to build into systems.

Submission process

In general, many participants identified that the whole process was laborious and time consuming, and diverted time from clinical activity. There is a particular challenge in terms of time and capacity to submit within timeframes when not automated eg small charity. In addition:

- Observations were made that there was a lack of clarity regarding all fields that are required to provide a 'full' data set. Further, where fields are mandated but not considered relevant, generic codes are submitted as a workaround.
- A common observation was that it was a complex process to upload data to Access and then to SCDS.
- Training for new staff who will make submissions was considered to be an overhead, again particularly for small organisations who are largely reliant on manual input.
- Submission error management process is laborious and difficult to identify the actual error
- The accuracy of the data can only be checked after been published. A patient level data for indicators can be requested from data liaison, by which point it's too late to fix the issues as the indicators aren't updated using resubmission data.

4.4.2 MDT Webinars

Webinars were held on 8th and 29th June 2023 with high attendance numbers (98 and 78) which perhaps reflects the interest in this subject matter. The proposed Interventions reference sets were circulated in advance of the meetings. The primary objective of the webinars was to share the reference sets and rationale, with the opportunity for people to post comments or provide feedback after the meetings.

The comments were analysed and categorised into queries for resolution by the EOG, policy questions (see Appendix G) and where individual responses were required.

4.4.3 Supplier interviews

"*As a system supplier we take on the responsibility to accurately code the data to flow into the MHSDS (e.g. The HoNOS review questions / answers s are 'translated' into the relevant SNOMED CT code). we do not believe that our customers (Independent Care Providers), nor the system suppliers should be tasked to select the appropriate SNOMED CT code. This can in our view only lead to inconsistency in the data flow. As such we very much welcome the creation of SNOMED CT code sub-sets to be used for all elements / tables associated with the MHSDS."*

The supplier-specific questionnaire is shown in Appendix F. Supplier engagement was relatively limited, but the consensus view was that the development of SNOMED reference sets identifying intervention codes would be very helpful.

Depending upon customer requirement, a data extract can be delivered to a providers data warehouse which can then make the submission, or a direct extract can be developed.

5 Conclusions

5.1 MHSDS Interventions SNOMED reference sets

There is huge support for national direction on which SNOMED concepts to use for interventions, both from providers and from system suppliers. Many organisations have gone down the route of defining their own subsets which has resulted in a lack of consistency. This, in itself, provides a challenge to professionals moving between organisations.

As anticipated in consultation, there are almost as many views as there are participants in this speciality area and so this first version of the reference sets will almost certainly not be considered to be complete by all parties. To that end, the opportunity to request changes through a formal process is key. In addition, the world of mental health support continually evolves and so they will never be static and unchanging.

Advance knowledge of impending changes would allow system suppliers and providers to prepare.

5.2 Expert Oversight Group

During the standard development, it was identified that there was a requirement to identify clinical ownership of the Interventions reference sets and that there would be a need for ongoing maintenance in terms of future additions and removal of SNOMED concepts.

A terms of reference has been developed for an EOG board comprising a small core membership of national clinical leads and a process has been developed for the submission of change requests to the reference sets. These are included in Appendix I.

5.3 Policy area specific guidance

There is a drive to ensure that the required level of granularity is recorded and that higher level generic terms such as 'therapy' are not utilised as a catch all.

In some instances e.g. cognitive behaviour therapy there would appear to be no need for additional guidance for end users but in others a concept may have been included for a specific purpose.

An example of this is the requirement of the Children and Young People's team for an intervention called 'consultation'. Clearly, this lends itself to being a generic code which anyone could use but is, in fact, specific to

consultation where options are considered and advice is given, but no other intervention is made. This 'consultation' would stop the clock for waiting times.

In relation to existing national guidance, in the context of clock stop, the reference sets will take precedent over existing guidance.

5.4 Local Mapping

The SNOMED concepts listed in the Interventions Reference Sets will be those which will be reported upon within the MHSDS for the non-urgent community mental health care pathway for both children and young people, and adults and older adults for the purposes of waiting times clock stop. Any codes submitted which are not contained within the reference sets will not be reported on and will not, therefore, be counted in returns.

Consideration was given to undertaking this centrally as a national exercise but in the spirit of locally managing the implementation of systems this was not considered viable. There will need to be an exercise at a local level to map codes currently used to the reference sets.

Appendix I provides an example of this.

5.5 End User Interface

Whilst the scope of this project is to define the reference sets for Interventions, it is essential that due consideration be given to the end user interface and that only relevant data is presented to the professional using the system.

5.6 MHSDS Submission Process

Several issues were raised with regard to the actual process of submitting MHSDS data. These seemed to primarily relate to:

- Where the process is not automated it is very labour intensive, particularly for smaller organisations
- There is a significant overhead in training someone to use the system
- The process itself seems to be quite complex to upload data to Access and then SCDS
- The identification of submission errors has been found to be a laborious process
- "*The accuracy of the data can only be checked after been published. A patient level data for indicators can be requested from data liaison, by which point it's too late to fix the issues as the indicators aren't updated using resubmission data."*

5.7 Publishing the benefits of the MHSDS

Many of those who submit data identify that it is a time consuming process which, in many cases, has an opportunity cost associated with it. There is, perhaps, an opportunity to publish the benefits derived from the MHSDS in order that people do not consider it a 'thankless task'.

6 Recommendations

6.1 MHSDS Interventions reference sets recommendations

The first version of the interventions reference set has been crystalised in the knowledge that it meets the goldilocks principle and is good enough, with a well-publicised mechanism of change control for future releases. Release 1 is shown in Appendix J.

It is recommended that, in order for necessary system changes to be made, a period of time be given before the SNOMED reference sets are mandated and MHSDS reporting only utilises these concepts.

It is also recommended that, as with this first version, proposed updates are published on NHS Futures to allow suppliers and providers to prepare for upcoming SNOMED releases. Consideration should also be given to utilising the NHS Standards Directory.

6.2 Expert Oversight Group recommendations

It is recommended that the EOG be established at the earliest opportunity and that the board formally approve the MHSDS Interventions reference sets Version 1 before publication. The EOG process and the change request submission criteria should be published alongside the link to the reference sets for information.

It is recommended that for the purposes of release of the first version of the reference sets, approval will be given by the Leadership Group of the National Mental Health Programme, NHS England, with the proposal that future authority will be delegated to the EOG.

The EOG will require a SNOMED expert to submit change requests. The PRSB could provide this service on a call off contract basis or an internal resource could be assigned.

In order to ensure continuity and time for this to be established, the PRSB will provide this service until 30th September 2023.

6.3 Policy area specific guidance recommendations

It is recommended that each policy team establish and maintain guidance for SNOMED concepts which have a specific clinical meaning where appropriate. For example, CYP utilise the term 'consultation' to refer to a mental health professional consultation input which may result in advice being given. From the perspective of waiting times, this is deemed to be a 'clock stop' and, as such, an intervention.

6.4 Local Mapping recommendations

It is recommended that guidance on the need for local mapping be published alongside the link to the reference sets for information.

6.5 End User Interface recommendations

It is recommended that, in conjunction with guidance on local mapping, a review is undertaken locally of end user interface requirements.

6.6 MHSDS Submission Process recommendations

It is recommended that there is a review of the submissions process to see if there are any opportunities to improve the process in particular:

- Might there be a way to support smaller organisations who are reliant on manual input
- Consider development of an online training module
- Review the submission error process and the use of resubmissions data

In addition, consideration should be given to whether digital therapeutic intervention CYP MH should be acknowledged as an intervention and included within MHSDS.

6.7 Publishing the benefits of the MHSDS recommendations

A targeted communications campaign to acknowledge the overhead of submitting data, to advise of the benefits derived from MHSDS and to outline the strategy to ultimately derive information from point of care systems once interoperability is achieved may help incentivise the provision of accurate data.

7 Appendix A Standards Definition

Information Record Standards

Information record standards define the information needed in a person's health and care record, such as their allergies, vaccinations and medications. They also include information that is important to the person, such as how best to communicate with them, how to help them feel at ease or details about how they like to take their medication.

PRSB standards are information record standards.

They standardise the recording of health and care information for a given situation or use case, so that everyone has the same understanding, and the information can be shared safely between digital systems with no loss of meaning to support safe, high quality care.

Data and Terminology Standards

Data definitions and terminology define formats, data types and values, so that information can be consistently recorded in systems. Record standards are mapped to data and terminology standards to set out how information should be recorded.

Terminology standards include SNOMED CT, a clinical vocabulary used for capturing clinical terms for example for clinical findings, diagnoses and treatments in electronic patient records. Find out more about SNOMED CT and how it is used.

The NHS data model and data dictionary is a data standard that sets out how information should be formatted such as birth date YY-MM-DDDD and what values (or codes) can be used; for example, Ethnic Categories, A (White – British) or M (Black or Black British – Caribbean).

Technical standards and Specifications

Technical standards specify how information defined in a record standard is to be held or moved between systems.

These can be based on Fast Healthcare Interoperability Resources (FHIR) but do not need to be.

NHS Digital now uses HL7's FHIR standard in the development of technical standards as it is the global industry standard for passing healthcare data between systems.

Application Programming Interfaces (APIs) are examples of technical standards that enable communication between two systems. These can be developed using FHIR. Examples include FHIR UK Core APIs, Transfer of Care Inpatient Discharge – FHIR API (API catalogue – NHS Digital)

8 Appendix B Discovery Phase Expert Oversight Group Participants

Cognitive Behaviour Therapy

Name and surname	Organisation	Role	Area of expertise
James Woollard	Oxleas NHS Foundation Trust	Child Psychiatrist, CCIO	Children
Ayesha Rahim	Lancashire and South Cumbria NHS Foundation Trust	Adult Perinatal Psychiatrist, CCIO	Perinatal
Sheena Gohal	Oxleas NHS Foundation Trust	Mental Health Nurse	Children and Young People
Alison Brabban	Esk & Wear Valleys NHS Foundation Trust	Consultant Clinical Psychologist	Adults
Heather O'Mahen	University of Exeter	Clinical-Academic Psychologist	Perinatal
Adrian Whittington	Sussex Partnership NHS Foundation Trust	Clinical Psychologist	Psychological Professions and Psychological Therapies
Rebecca Poz and Kathryn Sams	Norfolk & Suffolk NHS Foundation Trust	Consultant Clinical Psychologist & Clinical Neuropsychologist	Older Adults
Amanda Thompsell	NHS England	Consultant Psychiatrist	Older Adults

Topic	Date	Attendees
Assessments	20-02-23	• Sheena Gohal Oxleas NHS FT Mental Health Nurse CAMHS and National Service Advisor • Kapila Sachdev East London NHS FT Consultant Psychiatrist Older Adults • Jo Dent Tees, Esk and Wear Valleys NHS FT (TEWV) Business Intelligence Development Manager • Alison Brabban TEWV Clinical psychologist National Clinical Adviser Adult Mental Health Policy • James Woolard Oxleas NHS FT CAMHS National Speciality Adviser DIGITAL MENTAL HEALTH CCIO • Steve Bentley PRSB • Pauline Swan PRSB • Nico Ventosa Mental Health Infrastructure (Data, Levers & Incentives) NHSE
Medications	27-02-23	• Peter Pratt Pharmacist National Speciality Adviser Mental Health Pharmacy - Medicines • Ayesha Rahim Surrey & borders Partnership NHS FT Consultant Psychiatrist CCIO Clinical Lead Digital Mental Health NHSE • Paul Bradley Hertfordshire Partnership University NHS FT Consultant Learning Difficulties Psychiatrist RPsych Special Adviser Informatics and member of PRSB Advisory Board • Steve Bentley PRSB • Pauline Swan PRSB

		• Nico Ventosa Mental Health Infrastructure (Data, Levers & Incentives) NHSE • Stuart Abbot Head of Pharmacy Terminology development NHSE
Psychological therapies	06-03-23	• Steve Bentley PRSB • Pauline Swan PRSB • Alison Brabban TEWV FT Clinical psychologist National Clinical Adviser Adult Mental Health Policy • James Woolard Oxleas NHS FT CAMHS National Speciality Adviser DIGITAL MENTAL HEALTH CCIO • Rebecca Poz NSFT Consultant clinical psychologist and neuropsychologist • Ann Cox MPFT Nurse consultant CAMHS • Catherine Green SLAM FT Clinical psychologist specialist perinatal services
Psychosocial interventions	13-03-23	• Steve Bentley PRSB • Pauline Swan PRSB • Alison Brabban TEWV FT Clinical psychologist National Clinical Adviser Adult Mental Health Policy • James Woolard Oxleas NHS FT CAMHS National Speciality Adviser DIGITAL MENTAL HEALTH CCIO • Jo Dent Tees, Esk and Wear Valleys NHS FT (TEWV) Business Intelligence Development Manager
Psychological therapies 2	27-03-23	• Steve Bentley PRSB • Pauline Swan PRSB • Alison Brabban TEWV FT Clinical psychologist National Clinical Adviser Adult Mental Health Policy • Stuart Abbot Head of Pharmacy Terminology development NHSE • James Woolard Oxleas NHS FT CAMHS National Speciality Adviser DIGITAL MENTAL HEALTH CCIO • Rebecca Poz NSFT Consultant clinical psychologist and neuropsychologist
Final Review	20-04-23	•

9 Appendix C Stakeholders

Organisation	Endorse	Stakeholders for consultation engagement		
		Essential	Desirable	Rationale
Academy of Medical Royal Colleges and Faculties in Scotland	?			
Academy of Medical Royal Colleges Wales	?			
Academy of Medical Royal Colleges	Y			
Faculty of Public Health	Y			
Royal College of Anaesthetists	Y			
Royal College of Emergency Medicine	Y		Y	Emergency care play a key role in mental health services
Royal College of General Practitioners	Y	Y		GP surgeries are involved in provision of mental health services and should be involved in developing this standard
Royal College of Obstetricians & Gynaecologists	Y			
Royal College of Ophthalmologists	Y			
Royal College of Paediatrics and Child Health	Y			
Royal College of Pathologists	Y			
Royal College of Physicians	Y			
Royal College of Radiologists	Y			
Royal College of Surgeons of England	Y			
Allied Health Professions Federation	Do not endorse			
British Association for Music Therapy	Y		Y	Involved in mental health service provision
Chartered Society of Physiotherapy	Y			
Royal College of Occupational Therapists	Y		Y	Involved in some aspects of mental health service provision particularly for people with dementia
Royal College of Speech and Language Therapists	Y			
British Dietetic Association	Y			
Clinical				
British Orthodontics Society	Y			
British Psychological Society	Y	Y		Central to mental health service provision
CCIO Network	Do not endorse		Y	Important to gain regional clinical leaders support
Community Practitioners and Health Visitors Association	Y			
Intensive Care Society	Y			
Queen's Nursing Institute	Y		Y	Community Nurses work with people with mental health needs
Resuscitation Council (UK)	Y			
Royal College of Midwives	Y		Y	May be involved in care for families experience peri-natal depression etc

Royal College of Nursing	Y	Y		Nursing staff are key in provision of mental health services
Digital Nurse Network	?		Y	Key to digital records for mental health care
Royal College of Psychiatrists	Y	Y		Lead on mental health care and are key users of mental health data
Royal Pharmaceutical Society	Y		Y	Drug therapies involved in mental health care and work closely with GPs as primary care providers.
British Geriatrics Society	Y		Y	Higher prevalence of certain mental health conditions in elderly people
British Dental Association	Y			
Defence Medical Services	?			
College of Optometrists	Y			
Association of British Dispensing Opticians	Y			
Social care				
Association of Directors of Adult Social Services	Do not endorse			
Association of Directors of Children's Services	Do not endorse			
Care Provider Alliance	Y		Y	Management of mental health in care home environments
National Care Forum	?		Y	Management of mental health in care home environments
Health and Social Care Alliance Scotland	Y			
National Association of Link Workers	Y		Y	Support mental health service users
Local Government Association	Y			
Association for Real Change	?			Support mental health service users
Association of Mental Health Providers	?			Support mental health service users
Associated Retirement Community Operators	?			
Homecare Association	?		Y	Management of mental health in home care
Public representative groups				
Compassion in Dying	Y			
National Voices	Do not endorse	Y		Support mental health service users
Patient Information Forum	Y	Y		support mental health service users
Tech and informatics groups				
Faculty of Clinical Informatics	Y		Y	Being able to record mental health data on waiting times using coding is key to improving services
HL7 UK	?		Y	Interoperability with digital solutions will improve overall record keeping
Institute of Health Records and Information Management	Y		y	Consider how information about waiting times can be best incorporated into people's records
techUK	Do not endorse	Y		Relevant system suppliers shall be invited to be involved
CASPA	?		Y	Relevant system suppliers shall be invited to be involved

British Computer Society	Do not endorse			
Research and Science				
Health Data Research UK	?			
Institute of Biomedical Science	?			
Four Nations				
Allied Health Professionals Northern Ireland	Do not endorse		Y	The collective voice for AHPs which include physiotherapy, OT, podiatry and orthotists - not essential though
Allied Health Professionals Scotland	Do not endorse		Y	The collective voice for AHPs which include physiotherapy, OT, podiatry and orthotists - not essential though
eHealth Ireland	Unlikely			
Digital health and care Northern Ireland	Do not endorse			
Digital health and care Scotland	Do not endorse			
Digital health and care Wales	Do not endorse			
Arm's length bodies				
National Institute of Health and Care Excellence (NICE)	Do not endorse		Y	Provide guidance on mental health service provision
Office for Health Improvement and Disparities	Y		Y	Focus on improving health and health inequalities
Parliamentary and Health Services Ombudsman	?			
Other				
UK Caldicott Guardian Council	?			
Institute of Biomedical Medicine	?			
HQIP	?			
Shared Care Record Local Government Network	?			
Independent Healthcare Providers Network	?		Y	Inviting all relevant providers to be involved
Non members				
Accelerate	?			
Age UK	?		Y	
AHSN Network	?		Y	
Association of British HealthTech Industries (ABHI)	?		Y	
Association of British Clinical Diabetologists	Y			
British Association of Dermatologists	Y			
British Association of Prosthetists and Orthotists (BAPO)	Y			
British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS)	Y			
British Healthcare Trades Association (BHTA)	?			
College of Paramedics	Y		Y	Paramedics often called out to mental health crises as first responders
Healthwatch	?		Y	
NHS Shared Business Services				
Patient Experience Network				

National Casemix Office (NCO)				
Getting it right first time (GIRFT)	?		Y	

10 Appendix D - MHSDS Consultation webinars

08/06/2023 98 attendees including PRSB members

Role/ Job title	Organisation
Clinical Lead	PRSB
Head of Stakeholder Relations	PRSB
Director of Strategy, Communications and Engagement	PRSB
Project Manager	PRSB
Communication Officer	PRSB
Analyst	PRSB
Senior Project Manager	NHS England
Head Occupational Therapist	Central and North West London NHS Foundation Trust
Transformation Lead CYP MH	Coventry and Warwickshire Partnership NHS Trust
Director of AHPs & Psychological Services	Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
Associate Director of Performance	East London NHS Foundation Trust
Programme Director	East London NHS Foundation Trust
N/A	EAST LONDON NHS FOUNDATION TRUST
EPR Project Manager	Essex Partnership University NHS Foundation Trust
Head of Information and Performance	Essex Partnership University NHS Foundation Trust
Consultant Clinical Informaticist	First Databank UK Limited
Head of IM&T Systems	Greater Manchester Mental Health NHS Foundation Trust
Associate Director Psychological Services	Greater Manchester Mental Health NHS Foundation Trust
N/A	Kingston & Richmond MHSTs (Guest)
Programme Lead Paperlite	Lancashire Teaching Hospitals NHS Foundation Trust
Head of Performance and Informatics	Leeds and York Partnership NHS Foundation Trust
CCIO	Leeds and York Partnership NHS Foundation Trust
Clinical Coding Assurance Manager	Leicestershire Partnership NHS Trust
Community Transformation Digital lead	Lincolnshire Partnership NHS Foundation Trust
Head of Psychological Services	London North West Healthcare NHS Trust
Analyst	Mayden
Product Owner	Mayden
Mental Health Division Psychology Lead	Mersey Care NHS Foundation Trust

CPPO	Mersey Care NHS Foundation Trust
data quality manager	Midlands Partnership NHS Foundation Trust
Data Analyst	Midlands Partnership NHS Foundation Trust
Transformation Lead	Midlands Partnership NHS Foundation Trust
Business Architect	Midlands Partnership NHS Foundation Trust
N/A	N/A
N/A	N/A
Director of Psychology & Psychological Therapies	NHS Berkshire West
GIRFT National Clinical Lead CYPMH	NHS Berkshire West
Clinical Advisor	NHS England
Senior Manager-CYP Mental Health	NHS England
N/A	NHS England
Consultant Psychiatrist, DCO	NHS England
Head of Performance and Information	NHS England
MH Delivery Manager	NHS England
Consultant Psychologist & Approved Clinician	NHS England
Programme Manager	NHS England
ST7 Liaison Psychiatry	NHS England
Info Development Manager	NHS England
National Clinical Lead Crisis/Acute MH GIRFT	NHS England
National Children's Services Advisor	NHS England
Information manager	NHS England
BI Operational and Clinical Coding Manager	NHS England
Business Intelligence Development Manager	NHS England
PM	NHS England
Strategy and Transformation Manager	NHS England
CPPO	NHS England
Senior Lead Reports Developer	NHS England
Senior Project Manager	NHS England
Consultant Psychiatrist, ACD	NHS England
Director of Psychology	NHS England

Head of Adult Community Psychological Services Mid	NHS England
AD of Strategy Transformation and Partnerships	NHS England
CPPO	NHS England
Clinical Lead	NHS England
National Service Advisor	NHS England
Head of Psychological Therapies	NHS England
Interim Demand & Capacity Lead	NHS England
Business Information Manager	NHS England
Head Occupational Therapist for Hillingdon	NHS England
Consultant Clinical Psychologist	NHS England
Head of Psychology and Psychotherapies CAMHS & ED	NHS South West London & St George's Mental Health NHS Trust
Clinical Psychologist	NHS St George's University Hospitals NHS Foundation Trust
Head of Psychological Therapies	NHS St George's University Hospitals NHS Foundation Trust
Lead - Information and Performance	NHS West London NHS Trust
Lead Data Set Analyst (National Data)	Norfolk and Suffolk NHS Foundation Trust
Business Change	Norfolk and Suffolk NHS Foundation Trust
SNOMED CT Assurance Lead	Norfolk and Suffolk NHS Foundation Trust
Business Intelligence Manager	Norfolk and Waveney Health and Care ICS
BI and Performance Manager	Norfolk and Waveney Health and Care ICS
Business Information Manager	North Central London Partners in health and care ICS
Head of Service MHST Kent and Medway	North East London NHS Foundation Trust
Senior Data & Information Analyst	North East London NHS Foundation Trust
Clinical Psychologist	Nottinghamshire Healthcare NHS Foundation Trust
Transformation programme manager	Nottinghamshire Healthcare NHS Foundation Trust
Consultant Psychiatrist	Oxleas NHS Foundation Trust
Trust Lead for Psychological Therapies	Oxleas NHS Foundation Trust
Digital Transformation and Training manager	Oxleas NHS Foundation Trust
Honorary President	Rethink Mental Illness
Specialist Advisor on MH Informatics	Royal College of Psychiatrists
Lead for PTNC	Royal Free London

Head of OPMH Services	Somerset NHS Foundation Trust
Interim Director of Therapies	Surrey and Borders Partnership NHS Foundation Trust
Operational and Strategic Lead for MHSTs	Surrey and Borders Partnership NHS Foundation Trust
Associate Director Psychological Professions	Sussex Partnership NHS Foundation Trust (SPFT)
Psychology Lead	Tavi-Port
Product Manager	Thalamos
Consultant Clinical Health Psych Director ACP-UK	The Mid Yorkshire Hospitals NHS Trust
WY ICS Psychological professions workforce lead	West Yorkshire and Harrogate Health and Care Partnership
Consultant Clinical Psychologist	York and Scarborough Teaching Hospitals NHS Foundation Trust

29/06/2023 78 attendees including PRSB members.

Role/ Job title	Organisation
Clinical Lead	PRSB
Head of Stakeholder Relations	PRSB
Director of Strategy, Communications and Engagement	PRSB
Project Manager	PRSB
Analyst	PRSB
Senior Project Manager	NHS England
Data Lead	Alliance Psychology
Senior Administrator	Alliance Psychology
Chair, Association of Clinical Psychologists UK	Association of Clinical Psychologists
project manager	Berkshire Healthcare NHS Foundation Trust
Bi Lead	Bradford District Care NHS Foundation Trust
BI Manager	Bristol, North Somerset and South Gloucestershire CCG
Head of Performance Improvement	Camden and Islington NHS Foundation Trust
Senior EPR Architect	Central and North West London NHS Foundation Trust
Deputy Clinical Lead	Central and North West London NHS Foundation Trust
Head of Performance	Central and North West London NHS Foundation Trust
MH Intelligence Manager	Cheshire and Merseyside Health and Care Partnership ICS
Business Systems Analyst	Compass
Transformation Lead CYP MH	Coventry and Warwickshire Partnership NHS Trust
Education Mental Health Practitioner	Coventry and Warwickshire Partnership NHS Trust
Data Warehouse manager	Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
BI Developer	Dorset Health Care University NHS Foundation Trust
Head of Information Management	East London NHS Foundation Trust
Clinical Systems Manager	East London NHS Foundation Trust
Trustwide Planning and Performance Manager	East London NHS Foundation Trust
Clinical Manager EIP/ARMS	Essex Partnership University NHS Foundation Trust
Admin	FirstStepsED
Head of Programme Management	FirstStepsED

specialist support officer	FirstStepsED
Data Development Manager	Gloucestershire Health and Care NHS Foundation Trust
Consultant Clinical Psychologist	Hertfordshire Partnership University NHS Foundation Trust
Norfolk and WAVENEY Integrated Front Door Lead	Joe Krasinski Consultancy
Deputy Director of Mental Health Services	Leicester, Leicestershire and Rutland ICS
Director	Mayden
CMH Transformation Performance Manager	Mersey Care NHS Foundation Trust
Speech & Language Therapist	N/A
Team manager	NHS England
Clinical Business Manager	NHS England
Data Quality Specialist	NHS England
Head of Psychological Therapies	NHS England
SLT	NHS England
Advanced practitioner SLT	NHS England
Programme Manager	NHS England
CAMHS Quality Facilitator	NHS England
Information Analyst	NHS England
MH Delivery Manager	NHS England
Principal Information Analyst	NHS England
Senior Project Manager	NHS England
Programme Manager	NHS England
Database Principal	NHS England
Senior Programme Manager	NHS England
Clinical Lead	NHS England
Chair, Rapid Review MH inpatient safety informatic	NHS England
Senior Project Manager	NHS England
Senior Project Manager	NHS England
Senior Practitioner	NHS England
SNOMED CT Assurance Lead	Norfolk and Suffolk NHS Foundation Trust
Associate Chief Psychological Professionals Office	Norfolk and Suffolk NHS Foundation Trust
Clinical Lead for Mental Health Outcomes	North East London NHS Foundation Trust

Medical Records Manager	North East London NHS Foundation Trust
Consultant Clinical Psychologist	North Staffordshire Combined Healthcare NHS Trust
Service Manager	North Staffordshire Combined Healthcare NHS Trust
Quality Improvement Nurse	North Staffordshire Combined Healthcare NHS Trust
Clinical Psychologist	Nottinghamshire Healthcare NHS Foundation Trust
Speech and Language Therapist	Oxleas NHS Foundation Trust
Head of Strategic Planning and Performance	Pennine Care NHS Foundation Trust
CNIO	Pennine Care NHS Foundation Trust
Honorary President	Rethink Mental Illness
UK Professional Lead for Mental Health	Royal College of Nursing
Early year prevention worker	Sheffield City Council
Consultant Occupational Therapist	Solent NHS Trust
Consultant Clinical Psychologist	South West Yorkshire Partnership NHS Foundation Trust
Data Analyst	South West Yorkshire Partnership NHS Foundation Trust
Business Intelligence Lead	South West Yorkshire Partnership NHS Foundation Trust
Head OT	Southern Health NHS Foundation Trust
Professional Lead for SALT	Surrey and Borders Partnership NHS Foundation Trust
Consultant Clinical Health Psych Director ACP-UK	The Mid Yorkshire Hospitals NHS Trust
IT & Data Team Leader	TICplus
Data manager	Young Somerset

11 Appendix E – Survey Questionnaire

Introduction

The MHSDS SNOMED CT dashboard (produced by NHS Digital) shows a wide variation of codes are being used to record interventions across the relevant pathways. Feedback from local systems is they need a national steer to bring clarity on what should be flowed to the MHSDS, to support the implementation of non-urgent community waiting time standards, and other areas of ambition and transformation. Some submitting organisations have developed their own local list and definitions of SNOMED CT codes to record local activity however variation exists across the local lists, and many organisations are yet to undertake significant local work to ensure consistency and clarity in code submitted.

Current emphasis is on using the standards as routinely reported metrics, solving localised technical and data quality issues, ahead of setting performance thresholds. The national team are focused on reporting and use of data to inform local interrogation to evidence variation to identify learning between systems.

NHS England have commissioned PRSB to work jointly with them to develop relevant reference sets to provide clarity to submitters of MHSDS which codes are to be used for activity related to community mental health teams and to endorse the candidate reference sets with appropriate clinical bodies to support the formal production of the reference sets.

The objective of this survey is to better understand the mechanisms for submitting data and the barriers which submitters currently face.

Q1 Which of the following would best describe your organisation:

1. NHS provider – primary care
2. NHS provider – community care
3. NHS provider – secondary care
4. Voluntary sector
5. Independent service provider
6. System supplier
7. Other (please specify)

Q2 How is your MHSDS data submitted?

1. System supplier directly provides submission data from point of care primary use system
2. In house system directly provides submission data from point of care primary use system
3. Data is extracted from system(s) to excel spreadsheet
4. Data is manually entered into excel spreadsheet
5. Data is submitted via a third party NHS Trust
6. Other (please specify)

If the submission of data is not fully automated, please describe how this is currently being done. If possible, please give an estimate of the weekly person hours involved in this activity.

Q3 If you provide health or social care services at point of care, do you need to be aware of the SNOMED CT codes which are utilised?

If yes, does your organisation have a list of SNOMED CT codes which can be used?

Q4 Please identify any barriers or issues perceived in the submission process.

12 Appendix F – MHSDS Supplier Questionnaire

Introduction

The Mental Health Services Data Set (MHSDS) is a patient level, output based secondary uses data set which aims to deliver robust, comprehensive, nationally consistent and comparable person-based information for patients who are in contact with Mental Health Services.
The MHSDS covers Mental Health Services located in England, or located outside England but treating patients commissioned by an English Integrated Care Board (ICB), NHS England specialised commissioner or an NHS-led Provider Collaborative.
As a secondary uses data set, the MHSDS re-uses clinical and operational data for purposes other than direct patient care, and defines the data items, definitions and associated value sets to be extracted or derived from local information systems.
All activity relating to patients who receive assessments and treatment from Mental Health Services is within the scope of the MHSDS, where the patient has, or are thought to have:

- A mental health condition and/or
- A need for support with their mental wellbeing and/or
- A Learning Disability and/or
- Autism

or any other neurodevelopmental condition.
The scope of the MHSDS requires patient record level data submission from services as follows:

- For each patient attending a service located in England:
  - If the care is wholly funded by the NHS: the data submission for that patient is mandatory
  - If the care is partially funded by the NHS: the data submission for that patient is mandatory
  - If the care is wholly funded by any means that is not NHS: the data submission for that patient is optional.
- For each patient attending a service located outside England, but commissioned by an English ICB or NHS England specialised commissioner, the data submission is optional.

The MHSDS is used across the range of Health Care Providers and organisations that provide Mental Health Services (irrespective of funding arrangements) including:

- NHS Mental Health Trusts
- NHS Learning Disabilities Trusts
- NHS Acute Trusts
- NHS Care Trusts
- Independent Sector Healthcare Providers offering a service model that includes NHS funded and non-NHS funded patients
- Voluntary sector Health Care Providers
- Any qualified provider offering Mental Health Services
- Community services offering secondary care to children.

DCB0011 is the information standard for the MHSDS

The MHSDS SNOMED CT dashboard (produced by NHS Digital) shows a wide variation of codes are being used to record interventions across the relevant pathways. Feedback from local systems is they need a national steer to bring clarity on what should be flowed to the MHSDS, to support the implementation of non-urgent community waiting time standards, and other areas of ambition and transformation. Some submitting organisations have developed their own local list and definitions of SNOMED CT codes to record local activity however variation exists across the local lists, and many organisations are yet to undertake significant local work to ensure consistency and clarity in code submitted.

The SCCI0034: SNOMED CT Information Standard Notice sets the expectation that all providers "must use SNOMED CT as the clinical terminology standard within all electronic patient level recording and

communications before 1 April 2020". The MHSDS relies on SNOMED CT codes to capture information on clinical interventions and clinical outcome measures, used in response to those commitments.

NHS England have commissioned PRSB to work jointly with them to develop relevant reference sets to provide clarity to submitters of MHSDS which codes are to be used for activity related to community mental health teams and to endorse the candidate reference sets with appropriate clinical bodies to support the formal production of the reference sets.

A draft set of interventions has been developed through consultation with an expert oversight group in four categories:

- Assessments
- Medications
- Psychological therapies
- Psychosocial interventions

We would welcome the opportunity to discuss this work with your lead on MHSDS submissions and get your perspective on the issues and proposals.

Q1 Do you extract MHSDS submission data on behalf of customers? If so, please provide an overview.

Q2 Do you use SNOMED CT as the clinical terminology standard within your system? If not, please describe the current coding convention and the process of conversion.

Q3 How do you validate intervention codes?

Q4 Does the care provider require any awareness of the SNOMED CT codes?

Q5 Do you perceive any issues with the current method of submitting MHSDS data?

Q6 As a system supplier, are there any changes which would improve the process from your perspective?

Q7 Would the provision of a definitive interventions SNOMED reference set for MHSDS data submission be helpful?

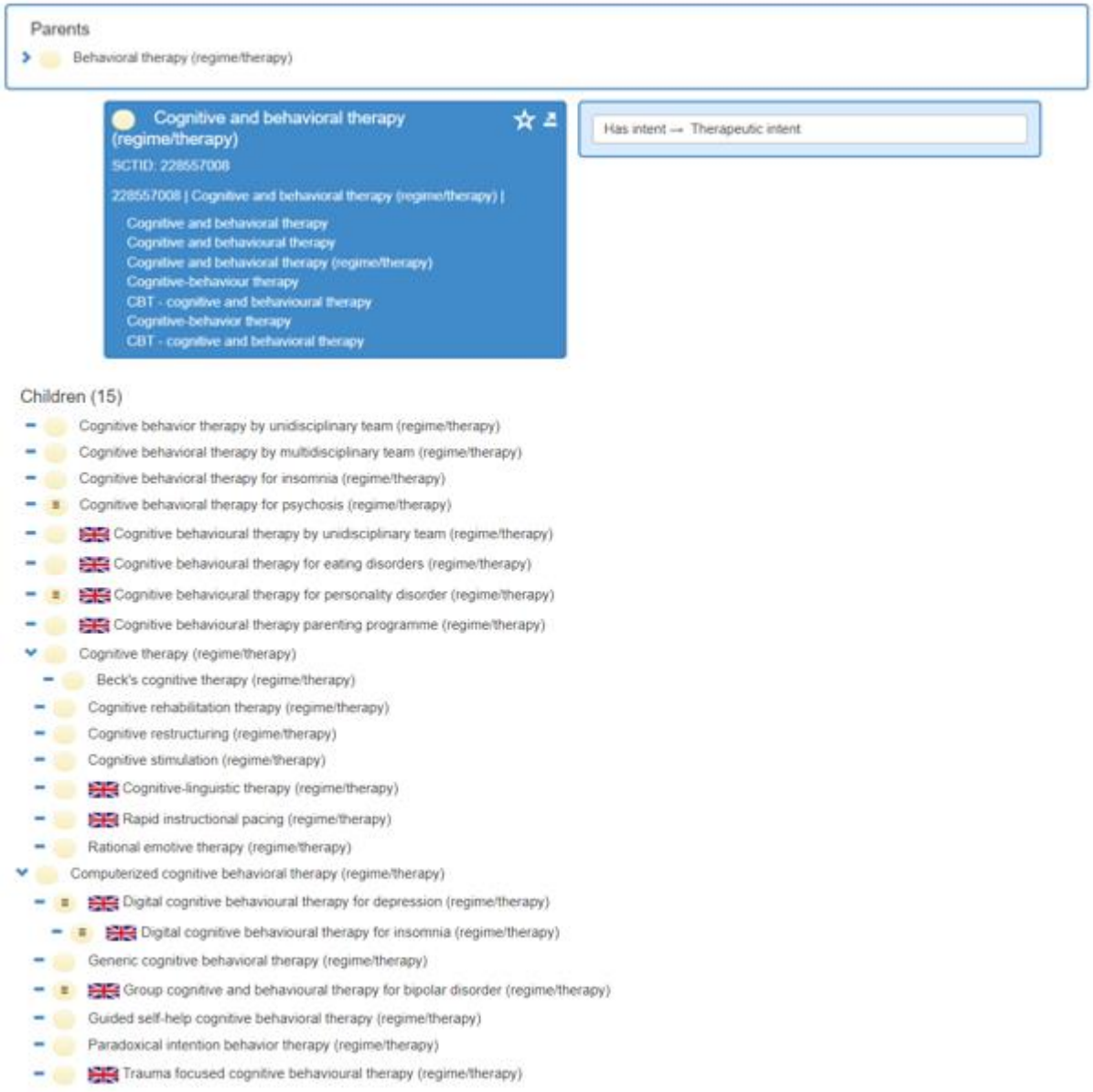
13 Appendix G Policy Questions

The policy questions raised in the webinars are listed below:

- If we include smoking cessation education, should alcohol, drug/substance, gambling addiction interventions also be added – these services are included in the scope of the MHDS?
- The PID says scope is non-urgent community mental health care pathway – could that include specialist mental health services carried out in acute trusts (which is what it says in the scope of the MHDS in the ISN)?
- Which AHPs interventions are in scope?
- Is sex therapy in scope?
    - This relates to a specific comment: If you collapse the code for Sex therapy into family, systemic only you lose this detail which for specialist Psychosexual services will matter. I am concerned that the detail is so extensive that most people will just use psychotherapy.
- Which guidance documents will be updated?
    - This relates to a specific question: Does the list compliment or supersede the SNOMED for Psychological Therapies and Interventions for Severe Mental Health Problems: Technical Guidance Document? - 211118 PTSMHP SNOMED Reporting Guidance v1.0 - NHS England National Adult and Older Adult Mental Health Programme - FutureNHS Collaboration Platform - https://future.nhs.uk/AdultMH/view?objectId=117745029
- How should multiple meds admin recordings e.g. on a meds chart be reported – what is the policy for reporting this?
    - This relates to a specific question: Admin of medication - will this be counted for each medication on a meds chart, multiple times daily?
- What questions do we want to answer from this data set (what analysis will it be used for?) - this will determine the level of granularity needed?
- Is the scope of this work to support the waiting time standards in non-urgent community MH services only or will the data be used for other purposes - if so what? (As per question above)
- When is the final reference sets and associated guidance due to be published?
- Should indirect patient consultation codes be included in scope? The MHDS includes indirect activity, however should these codes be in scope for the reference sets?
- Should only one intervention code or multiple intervention codes be recorded for an appointment/contact where appropriate?
    - Questions were raised about this so it might be worth including this in the guidance. Apparently it is possible for the MHDS to flow multiple SNOMED interventions per contact and confirmation that this is the policy position would be helpful.

14 Appendix H Example of local mapping requirement

The current SNOMED concepts for CBT are shown below:



The agreed subset of SNOMED codes included in the Psychological Therapies Reference Set are shown below:

PSYCHOLOGICAL THERAPIES		
	Intervention name (SNOMED FSN)	**SNOMED ID**
COGNITIVE BEHAVIOUR THERAPY	▪ Cognitive and behavioural therapy	228557008
	▪ Cognitive behavioural therapy for psychosis	718026005
	▪ Cognitive behavioural therapy for eating disorders	1111811000000109
	▪ Cognitive behavioural therapy for personality disorder	149451000000104
	▪ Group cognitive and behavioural therapy for bipolar disorder	149591000000108
	▪ Guided self-help cognitive behavioural therapy	444175001
	▪ Mindfulness-based cognitive therapy	1423361000000109
	▪ Trauma focused cognitive behavioural therapy	149521000000105

All CBT SNOMED concepts which do not directly map to one of these eight codes would need to be mapped to the first 'Cognitive and behaviour therapy' SNOMED ID 228557008.

For example, a clinician may want to record an intervention type of 'digital cognitive behaviour therapy for insomnia' (an existing SNOMED code) but reporting requirements might only require that a 'cognitive and behaviour therapy' had been prescribed in order to assess waiting times.

15 Appendix I MHSDS Interventions Expert Oversight Group Board Terms of Reference

Background

General

The Mental Health Services Data Set (MHSDS) is a patient level, output based secondary uses data set which aims to deliver robust, comprehensive, nationally consistent and comparable person-based information for patients who are in contact with Mental Health Services.

The MHSDS covers Mental Health Services located in England, or located outside England but treating patients commissioned by an English Integrated Care Board (ICB), NHS England specialised commissioner or an NHS-led Provider Collaborative.

As a secondary uses data set, the MHSDS re-uses clinical and operational data for purposes other than direct patient care, and defines the data items, definitions and associated value sets to be extracted or derived from local information systems.

All activity relating to patients who receive assessments and treatment from Mental Health Services is within the scope of the MHSDS, where the patient has, or are thought to have:

- A mental health condition and/or
- A need for support with their mental wellbeing and/or
- A Learning Disability and/or
- Autism

or any other neurodevelopmental condition.

The scope of the MHSDS requires patient record level data submission from services as follows:

- For each patient attending a service located in England:
    - If the care is wholly funded by the NHS: the data submission for that patient is mandatory
    - If the care is partially funded by the NHS: the data submission for that patient is mandatory
    - If the care is wholly funded by any means that is not NHS: the data submission for that patient is optional.
- For each patient attending a service located outside England, but commissioned by an English ICB or NHS England specialised commissioner, the data submission is optional.

The MHSDS is used across the range of Health Care Providers and organisations that provide Mental Health Services (irrespective of funding arrangements) including:

- NHS Mental Health Trusts
- NHS Learning Disabilities Trusts
- NHS Acute Trusts
- NHS Care Trusts
- Independent Sector Healthcare Providers offering a service model that includes NHS funded and non-NHS funded patients
- Voluntary sector Health Care Providers
- Any qualified provider offering Mental Health Services
- Community services offering secondary care to children.
- Local Authorities providing mental health services.

DCB0011 is the information standard for the MHSDS

NHS England has outlined a clear commitment to driving a more equal response across mental and physical health in the NHS Long Term Plan. The NHS Mental Health Implementation Plan set an ambition to improve the quality of mental health data, particularly in relation to data flow to the Mental Health Services Data Set (MHSDS), to rapidly demonstrate delivery against those LTP commitments.

The SCCI0034: SNOMED CT Information Standard Notice sets the expectation that all providers "must use SNOMED CT as the clinical terminology standard within all electronic patient level recording and

communications before 1 April 2020". The MHSDS relies on SNOMED CT codes to capture information on clinical interventions and clinical outcome measures, used in response to those commitments.

The mental health programme has provided specific guidance to support pathways where NICE guidance is forthcoming. However, a priority for mental health over the next year is to specifically support the NHS wide commitment to address waiting times.

The MHSDS SNOMED CT dashboard (produced by NHS Digital) shows a wide variation of codes are being used to record interventions across the relevant pathways. Feedback from local systems is they need a national steer to bring clarity on what should be flowed to the MHSDS, to support the implementation of non-urgent community waiting time standards, and other areas of ambition and transformation. Some submitting organisations have developed their own local list and definitions of SNOMED CT codes to record local activity however variation exists across the local lists, and many organisations are yet to undertake significant local work to ensure consistency and clarity in code submitted.

Current emphasis is on using the standards as routinely reported metrics, solving localised technical and data quality issues, ahead of setting performance thresholds. The national team are focused on reporting and use of data to inform local interrogation to evidence variation to identify learning between systems.

SNOMED Interventions Reference Sets

PRSB are providing support to define the data and terminology standards to be utilised for reporting a range of mental health interventions.

In the Discovery Phase, the approach adopted to develop the Early Intervention in Psychosis guidance was utilised. This guidance was developed by NHS England, with direction provided by an expert oversight group (EOG), as well as an additional period of external engagement. This document and approach was utilised as a blueprint.

As a 'proof of concept,' this approach was adopted with the CBT intervention type. An EOG was established and two workshops held in December 22 to define the core list of CBT interventions.

The conclusions from the proof of concept pilot were:

1. The process of establishing an expert oversight group to consider intervention types and define a subset which meets the requirements of clinicians to define an intervention sub-classification is effective.
2. Four intervention types were identified:
    e. Assessments
    f. Medications (assess, prescribe, monitor, stop)
    g. Psychological therapies
    h. Psychosocial interventions

The original proof of concept workshop to consider CBT SNOMED codes illustrates the potential minefield to navigate in terms of selecting the correct code to utilise. A potential list of twenty five existing codes was reduced to eight.

For each intervention, in this case Cognitive Behaviour Therapy, if there are potential codes which are not to be used directly but which may be required for clinical recording purposes at point of care, there must be one general subcategory, in this case Cognitive and behavioural therapy, which can be used to represent those. In this instance, there are the eight core subcategories from the original 25, and the remaining 17 would be rolled into the general category for reporting purposes.

Further EOG workshops were held in February and March 2023 to establish a draft interventions' list (see Appendix B) for wider consultation.

This consultation is currently underway and the EOG will review feedback in the context of interventions to be included within the SNOMED reference sets. These sets will define interventions which will be reported on within the MHSDS.

Authority

NHS England has established the EOG Board to be the clinical decision making authority with regard to the interventions included within the SNOMED reference sets.

The process for submission of requests to make amendments to the reference sets is outlined in Appendix A.

Roles and Responsibilities

The EOG Board is responsible for providing oversight, decision-making and support to define the interventions content of the SNOMED reference sets. The role of the EOG Board includes:

- Consider proposed interventions for inclusion in SNOMED reference sets.
- Articulate rationale where interventions are not considered suitable for inclusion.
- Identify new SNOMED concepts to be added, together with a justification for doing so.
- Identify SNOMED concepts to be retired, together with a justification for doing so.
- Follow the process for submission of changes or requesting of new SNOMED CT concepts stated to be added to a reference set outlined on Appendix B.

The role of the individual members of the EOG Board includes:

- Be an advocate for, and actively involved in, supporting the clinical case for inclusion of appropriate interventions ensuring the requirements of stakeholders are met for their speciality area.
- Liaise with their clinical networks, with support from their national policy leads, in case their feedback is needed to make a decision.
- Help balance conflicting priorities and resources.
- Provide guidance on the criteria for inclusion of interventions.
- Consider and advise on proposed interventions.

Once the SNOMED reference sets have been established, the EOG Board will take ownership of the reference sets and will be responsible for maintenance of the reference sets including the inclusion and retirement of relevant SNOMED intervention concepts.

Individual board members are responsible for ensuring that there is representation at each board and that a deputy is nominated to attend if they are unable to do so.

Membership

Core members:

Area of expertise	Name and surname	Role
Digital Mental Health	James Woollard (Chair)	Chief Clinical Information Officer, Caldicott Guardian, National Advisor
SNOMED CT	Stuart Abbott	Principal Terminology Specialist, Terminology and Classifications Service
Perinatal	Heather O'Mahen	Clinical Psychologist, National Advisor
Children and Young People	Sheena Gohal	Mental Health Nurse, National Advisor
Adults	Alison Brabban	Consultant Clinical Psychologist, National Advisor
Older Adults	Amanda Thompsell	Consultant Psychiatrist, National Advisor
Psychological Professions and Psychological Therapies	Adrian Whittington	National Clinical Lead for Psychological Professions

Additional members may be co-opted if required:

Area of expertise	Name and surname	Role
Nursing	Emma Wadey	Deputy Director for Mental Health Nursing, National Specialty Advisor
Primary Care	Emma Tiffin	National GP Advisor Community and Primary Care
Pharmacy	Peter Pratt	Specialist Mental Health Pharmacy Advisor
Learning Disabilities and Autism	Janine Robinson	Consultant Clinical Psychologist, NSA for Autism
Allied Health Professions	Rachel Wakefield	Occupational Therapist, Regional Chief AHP and NSA for mental health

Quorum and Voting

The EOG Board will reach decisions based on consensus wherever possible.

All members will have a vote, except where they declare a conflict of interest or they choose to abstain for some other reason.

Each member will nominate a deputy if they are unable to attend. The deputy should agree with the ToR of the EOG Board.

All clinical areas must provide representation to constitute a quorum for recommendations or decisions of the meeting to be valid. Where the EOG Board is split, the Chair will have final decision making authority.

Frequency

The EOG Board will meet approximately quarterly.

Inputs

Documentation required for the board will be distributed at least five working days prior to the Board and includes:

- Agenda
- Proposals for inclusion of new SNOMED intervention concepts, together with justification
- Proposals for retirement of SNOMED intervention concepts, together with justification.

Outputs

Outputs from the board will be circulated within four weeks after the meeting and will include:

- A brief rationale for decisions taken - in no specific format.

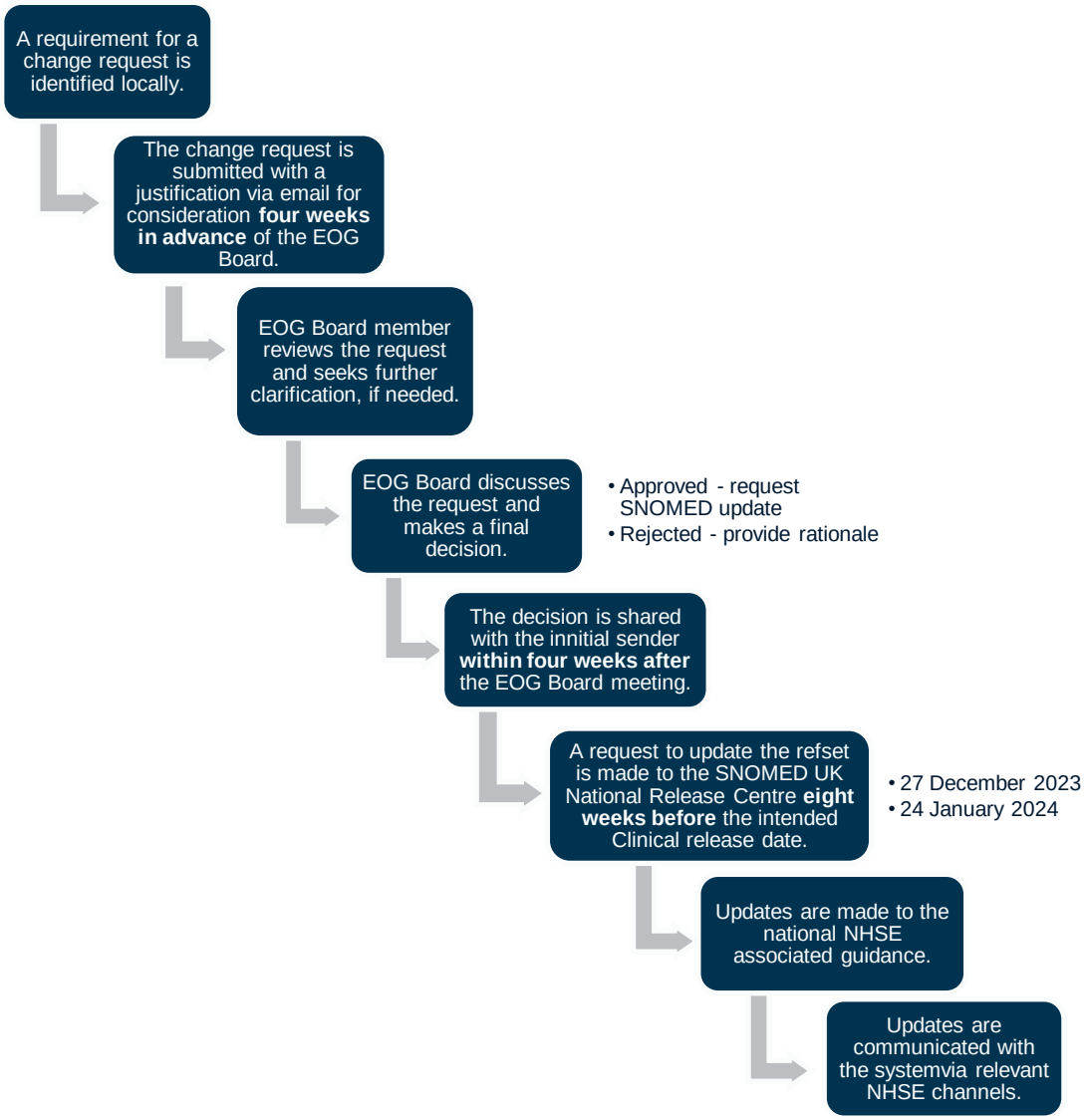
- Identification of new SNOMED intervention concepts to be requested.
- Identification of retirement of SNOMED intervention concepts to be requested.

Requirements to submit a change request

The following requirements should be followed to submit a change request:

- It should be in line with the scope, spirit and overall design of the national reference set. For example, observable entity concepts cannot be requested in a refset with a design that states procedures only.
- A requirement for a change request can be identified and submitted by local clinicians or professional bodies as a group with sufficient clinical rationale behind it.
- The request should include:
    - the SNOMED CT concept ID and Fully Specified Name (FSN) of the concept(s) to be added
    - the SNOMED CT concept ID and Fully Specified name (FSN) of the reference set(s) the concepts need to be added to
    - the clinical rationale behind this request.
- Please note to clarify in your request if the SNOMED CT concept ID and FSN requested are already available in the SNOMED CT Browser or if the request requires the creation of a new code to be reported.
- Requests can be sent directly to NHSE National Specialty Advisors, but should always have the relevant team email addresses copied for information:
    - Perinatal: england.perinatalMH@nhs.net
    - CYP: england.cyp-mentalhealth@nhs.net
    - Adult: england.adultmh@nhs.net
- Requests need to be submitted at least four weeks before the next EOG meeting to allow enough time to request further clarification, should it be needed, and review before the meeting.

Appendix A: Outline process and timescales for submission of change requests to the Expert Oversight Group during the 22/23 financial year.



- Requests for change sent by relevant system colleagues **by Friday 3rd November 2023.**
- EOG Board meeting and discussion **by Friday 8th December 2023.**
- Requests that are approved by the EOG Board will be sent to the SNOMED UK National Release Centre **by Wednesday 27th December 2023.**
- Updates to MHSDS Interventions Refset guidance will be made **by the Thursday 29th February 2024.**
- The updated MHSDS Interventions Refset guidance will be and published in NHS Futures and cascaded with ICBs via regions **by Friday 29th March 2024.**

Appendix B: Outline process for submission of changes to a reference set and requesting new SNOMED CT concepts

We need to know:

- the SNOMED CT concept ID and Fully Specified Name (FSN) of the concept(s) to be added
- the SNOMED CT concept ID and Fully Specified name (FSN) of the reference set(s) the concepts need to be added to
- confirmation from the EOG that they have approved it for

Once the concept(s) to the refset(s) have been approved for addition or exclusion, the EOG (or a known/agreed representative of the EOG) will submit a request via the Request Submission Portal to ask the SNOMED UK National Release Centre for the change.

The evidence that it is correct and necessary is that the MHSDS has asked for the change. No further information is required as we are trusting that the EOG has done the initial checks and agree the changes.

However, if the concept request doesn't exist in the SNOMED CT Browser, then it needs to be requested as a brand new concept first. The process for requesting a new SNOMED CT concept is here.

The request would need to include some evidence (see the process above) to allow the SNOMED CT authors something to work from.

16 Appendix J MH Interventions reference sets Version 1.1

Mental Health Assessments	
Intervention name (SNOMED FSN)	SNOMED ID
▪ Mental health triage (procedure)	1751061000000103
▪ Mental health assessment (procedure)	391281002
▪ Specialist mental health assessment (procedure)	163801000000107
▪ Biopsychosocial assessment (procedure)	1067261000000105
▪ Psychological assessment (procedure)	405783006
▪ Initial memory assessment (procedure)	888901000000102
▪ Assessment for dementia (procedure)	869561000000101
▪ Neurological mental status determination (procedure)	392257007
▪ Autism spectrum disorder diagnostic assessment (procedure)	1085671000000109
▪ Neuropsychological testing (procedure)	307808008
▪ Risk assessment (procedure)	225338004
▪ Occupational therapy assessment (procedure)	410155007
▪ Assessment of mental capacity in accordance with Mental Capacity Act (2005) (procedure)	517301000000103

Medication and Physical Therapy Interventions	
Intervention name (SNOMED FSN)	SNOMED ID
▪ Recommendation to General Practitioner to start patient medication (procedure)	417589003
▪ Recommendation to general practitioner to stop patient medication (procedure)	41110801000000101
▪ Prescription of drug (procedure)	33633005
▪ Drug therapy discontinued (situation)	274512008
▪ Administration of drug or medicament (procedure)	18629005
▪ Injection of depot antipsychotic agent (procedure)	440701009
▪ Review of medication (procedure)	182836005
▪ Mental health medication review (procedure)	413143000
▪ Management of compliance with medical regimen (regime/therapy)	410121009
▪ Medication monitoring (regime/therapy)	395170001
▪ Medication education (procedure)	967006
▪ Clozapine therapy (procedure)	723948002
▪ Monitoring of clozapine therapy (regime/therapy)	838422006
▪ Clozapine therapy stopped (situation)	1751121000000105
▪ Lithium therapy (procedure)	68852009
▪ Lithium monitoring (finding)	275917000
▪ Lithium stopped (situation)	170688000
▪ Valproate therapy (procedure)	1751141000000103
▪ Valproate monitoring	New code requested
▪ Valproate therapy stopped (situation)	1751131000000107
▪ Electroconvulsive therapy (procedure)	23835007
▪ Transcranial magnetic stimulation of brain (procedure)	264603002

Psychological therapies	
Intervention name (SNOMED FSN)	SNOMED ID
▪ Counselling (procedure)	409063005
▪ Group psychotherapy (regime/therapy)	76168009
▪ Psychotherapy (regime/therapy)	75516001
▪ Cognitive behavioural therapy (regime/therapy)	228557008
▪ Behavioural therapy (regime/therapy)	166001
▪ Group cognitive behavioural therapy (regime/therapy)	859501000000107
▪ Cognitive behavioural therapy for psychosis (regime/therapy)	718026005
▪ Cognitive behavioural therapy for eating disorders (regime/therapy)	1111811000000109
▪ Cognitive behavioural therapy for personality disorder (regime/therapy)	149451000000104
▪ Group cognitive and behavioural therapy for bipolar disorder (regime/therapy)	149591000000108
▪ Guided self-help cognitive behavioural therapy (regime/therapy)	444175001
▪ Mindfulness-based cognitive therapy (regime/therapy)	1423361000000109
▪ Trauma focused cognitive behavioural therapy (regime/therapy)	149521000000105
▪ Group cognitive behavioural therapy for eating disorder (regime/therapy)	1362001000000104
▪ Cognitive behavioural therapy parenting programme (regime/therapy)	883841000000104
▪ Family intervention for psychosis and bipolar disorder (regime/therapy)	1365951000000107
▪ Family intervention for psychosis (regime/therapy)	985451000000105
▪ Adolescent focused psychotherapy for anorexia nervosa	New concept requested
▪ Family intervention for bipolar disorder	New concept requested
▪ Family therapy (regime/therapy)	51484002
▪ Attachment-based therapy (regime/therapy)	700445002
▪ Child psychotherapy (regime/therapy)	429159005
▪ Interpersonal and social rhythm therapy (regime/therapy)	1108261000000102
▪ Interpersonal psychotherapy (regime/therapy)	443730003

Psychological therapies	
Intervention name (SNOMED FSN)	SNOMED ID
▪ Interpersonal psychotherapy for group (regime/therapy)	1106951000000105
▪ Acceptance and commitment therapy (regime/therapy)	1363681000000106
▪ Schema focused therapy (regime/therapy)	1111691000000101
▪ Dialectical behaviour therapy (regime/therapy)	405780009
▪ Mentalisation based treatment (regime/therapy)	1111681000000103
▪ Cognitive analytic therapy (regime/therapy)	390773006
▪ Integrative psychotherapy (regime/therapy)	304826003
▪ Structured Clinical Management (regime/therapy)	1108271000000109
▪ Transference focused psychotherapy (regime/therapy)	1111671000000100
▪ Eye movement desensitization and reprocessing therapy (regime/therapy)	449030000
▪ Psychodynamic psychotherapy (regime/therapy)	314034001
▪ Focal psychodynamic therapy (regime/therapy)	718023002
▪ Prolonged Grief Disorder Therapy (regime/therapy)	1423401000000100
▪ Compassion-focused therapy (regime/therapy)	143891000000107
▪ Maudsley Model of Anorexia Nervosa Treatment for Adults (regime/therapy)	1323471000000102
▪ Eating-disorder-focused focal psychodynamic therapy (regime/therapy)	1323681000000103
▪ Specialist supportive clinical management (procedure)	1323451000000106
▪ Couple psychotherapy (regime/therapy)	440274001
▪ Behavioural couple therapy (regime/therapy)	1129481000000107
▪ Family, systemic, couple and sex therapy (regime/therapy)	302245002
▪ Psychosexual counselling (procedure)	171023003
▪ Cognitive rehabilitation therapy (regime/therapy)	702474001
▪ Cognitive remediation therapy (regime/therapy)	1751051000000101
▪ Play therapy (regime/therapy)	76075007

Psychological therapies	
Intervention name (SNOMED FSN)	SNOMED ID
▪ Responsive parenting intervention (regime/therapy)	1054301000000103
▪ Video-feedback Intervention to promote Positive Parenting (regime/therapy)	1423891000000105
▪ Video-feedback Intervention to promote Positive Parenting and Sensitive Discipline (regime/therapy)	1423881000000108
▪ Video interaction guidance (regime/therapy)	712652008
▪ Art therapy (regime/therapy)	65153003
▪ Creative therapy	278415002
▪ Dance therapy (regime/therapy)	69711002
▪ Music therapy (regime/therapy)	21065008
▪ Psychodrama (regime/therapy)	53508008
▪ Narrative therapy (regime/therapy)	1730671000000106
▪ Psychological formulation (procedure)	1751081000000107
▪ Guided self-help using book (regime/therapy)	748051000000105
▪ Guided self-help using computer (regime/therapy)	748041000000107
▪ Behavioural parent training (regime/therapy)	882381000000106
▪ Anger management therapy (regime/therapy)	712558003
▪ Brief solution focused psychotherapy (regime/therapy)	401157001

Psychosocial interventions	
Intervention name (SNOMED FSN)	SNOMED ID
▪ Care Planning	New code requested
▪ Consultation (procedure)	11429006
▪ Assistance with obtaining accommodation (procedure)	1091471000000109
▪ Individual Placement and Support (regime/therapy)	772822000
▪ Vocational rehabilitation (regime/therapy)	70082004
▪ Employment education, guidance, and counselling (procedure)	410287004
▪ Life skills training (procedure)	228642009
▪ Lifestyle education (procedure)	313204009
▪ Skills training (procedure)	278445004
▪ Nutrition education (procedure)	61310001
▪ Psychoeducation (procedure)	702545008
▪ Relapse prevention (procedure)	405782001
▪ Coping skills training (procedure)	302256002
▪ Emotional support (regime/therapy)	133921002
▪ Bereavement support (regime/therapy)	395076009
▪ Signposting (procedure)	975131000000104
▪ Recommendation to (procedure)	420227002
▪ Problem solving (procedure)	765601000000101
▪ Behaviour management (regime/therapy)	225333008
▪ Behavioural activation therapy (regime/therapy)	443119008
▪ Management of negative emotional state (procedure)	710965006
▪ Active monitoring (regime/therapy)	413433006

Psychosocial interventions	
Intervention name (SNOMED FSN)	SNOMED ID
▪ Hallucination management (regime/therapy)	386316003
▪ Management of anxiety (procedure)	710060004
▪ Exposure - behaviour therapy (regime/therapy)	225224008
▪ Cognitive stimulation (regime/therapy)	386241007
▪ Reminiscence therapy (regime/therapy)	228549005
▪ Applied relaxation (regime/therapy)	1127281000000100
▪ Promotion of sleep hygiene (procedure)	1172583004
▪ Social skills behaviour modification (regime/therapy)	386525005
▪ Emotional support (regime/therapy)	133921002
▪ Mindfulness-based therapy (regime/therapy)	933221000000107
▪ Self-esteem enhancement (procedure)	386422006
▪ Facilitating engagement in therapy (procedure)	975441000000104
▪ Smoking cessation education (procedure)	225323000
▪ Recommendation to exercise (procedure)	281090004
▪ Motivational interviewing technique (procedure)	713144002
▪ Guided self-help psychological therapy (regime/therapy)	1129491000000109
▪ Mental health promotion (regime/therapy)	385891009
▪ Mental health caregiver support (regime/therapy)	390826005
▪ Pain management (procedure)	278414003
▪ Caregiver focused education and support program (situation)	726052009
▪ Radically Open Dialectical Behaviour Therapy (regime/therapy)	1751091000000109
▪ Promotion of caregiver child attachment (procedure)	710141009
▪ Parent-infant psychotherapy (regime/therapy)	700446001
▪ Watch, Wait and Wonder therapy (regime/therapy)	1403231000000102

Psychosocial interventions	
Intervention name (SNOMED FSN)	SNOMED ID
▪ Triple P - Positive Parenting Program (regime/therapy)	709009001
▪ Mental Health Act procedure (procedure)	5301000000106
▪ Safeguarding intervention (regime/therapy)	1053881000000102
▪ Speech therapy (regime/therapy)	5154007
▪ Occupational therapy (regime/therapy)	84478008
▪ Care navigation (procedure)	1761281000000106
▪ Dialectical behavioural therapy skills group intervention (regime/therapy)	1659561000000104
▪ Daily living activity therapy (regime/therapy)	183345007
▪ Positive behaviour support	New concept requested
▪ Formal peer support	New concept requested
▪ Guided self-help for bulimia	New concept requested