

HES Data Dictionary: Admitted Patient Care

**Admitted Patient Care (APC) Hospital Episodes
Statistics (HES) Data Dictionary**

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Introduction - Admitted Patient Care Data Dictionary

Welcome to the HES Admitted Patient Care (APC) Data Dictionary. If you have any feedback or suggestions about this document please don't hesitate to contact us at enquiries@hscic.gov.uk

The Hospital Episode Statistics (HES) database is made up of many data items relating to admitted patient care delivered by NHS hospitals in England. Many of these items form part of the national Commissioning Data Set (CDS), and are generated by the patient administration systems within each hospital.

In addition to the CDS items, HES provides information that is derived from these. For example, the age of the patient is derived from their date of birth. These derivations assist in the production of aggregate summaries (tabulations), and also help ensure patient confidentiality.

HES contains APC data from 1 April 1989-90. Over the years, there have been several changes in the specification and meaning of various data items. From April 2003, this data was available in a normalised form that makes interpretation easier. This has been achieved by modifying the values of certain items for previous years so that, where possible, they conform to contemporary standards. This issue of the Data Dictionary reflects the situation after normalisation.

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Dataset: Admitted Patient Care

Augmented care period disposal (ACPDISP_N)

Field	ACPDISP_N
Field Name	Augmented care period disposal
Category	Augmented/critical care period
Length and format	2n
Availability	1997-98 to 2005-06
Description	

This field gives the destination of a discharged patient after a period of augmented care. Compare this field with disdest (destination on discharge from a hospital episode).

Value

- 01 = Ward in same hospital
- 02 = High dependency unit (HDU) in same hospital, including special care baby units
- 03 = Intensive care unit (ICU) in same hospital
- 04 = ICU in other hospital
- 05 = Other hospital (not ICU) including HDUs and Special Care Baby Units
- 06 = Normal residence or other

07 = Died

08 = No change in location: the augmented care period ended because the consultant episode ended

98 = Not applicable: augmented care period not finished

99 = Not known

Rule

Rules 920 and 930



Dataset: Admitted Patient Care

Augmented care period data quality indicator
(ACPDQIND_N)

Field	ACPDQIND_N
Field Name	Augmented care period data quality indicator
Category	Augmented/critical care period
Length and format	TBC
Availability	TBC
Description	
TBC	
Value	
TBC	
Rule	TBC



Dataset: Admitted Patient Care

Augmented care period end date (ACPEND_N)

Field ACPEND_N

Field Name Augmented care period end date

Category Augmented/critical care period

Length and format dd/mm/yyyy (Date)

Availability 1997-98 to 2005-06

Description

This field gives the end date of a period of augmented care (a null entry indicates that this data is not applicable).

Value

dd/mm/yyyy = Date augmented care period ended

Rule Rule 940



Dataset: Admitted Patient Care

Augmented care period local ID (ACPLCID_N)

Field	ACPLCID_N
Field Name	Augmented care period local ID
Category	Augmented/critical care period
Length and format	8an
Availability	2002-03 to 2005-06
Description	

There are no nationally agreed values for this item. This field contains sensitive data. Access to it requires the approval of the Data Access Advisory Group (DAAG).

Value

Not available

Rule	None
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Dataset: Admitted Patient Care

Augmented care location (ACPLOC_N)

Field	ACPLOC_N
Field Name	Augmented care location
Category	Augmented/critical care period
Length and format	2n
Availability	1997-98 to 2005-06
Description	

This field gives the location of a patient during a period of augmented care.

Value

01 = General intensive care unit (ICU). Adult intensive care, including wards labelled as surgical or medical ICU, but excluding the specialised units identified by other values. General ICUs may provide a mixture of high dependency unit (HDU) and ICU level care

02 = Cardiothoracic ICU, including units labelled as separate cardiac or thoracic units.

03 = Liver ICU

04 = Neurological ICU

05 = HDU

06 = Paediatric ICU: a unit generally admitting patients between 0 and 14 years old, but



excluding special care baby units

07 = Paediatric HDU

08 = Neonatal ICU: a unit generally admitting only new born babies up to two-week's post delivery

09 = Cardiac care unit or coronary care unit (CCU)

10 = Combined HDU and CCU; the beds and staff for the two units are in the same area

11 = Combined CCU and ICU; the beds and staff for the two units are in the same area

12 = Combined HDU and ICU; the beds and staff for the two units are in the same area

13 = Post operative recovery unit, including a theatre recovery area

14 = Spinal injury ICU: a unit designated for critical care rather than a spinal injury ward

15 = Burns critical care unit, including all special care burns facilities other than short-term post-operative care areas

16 = Renal unit, including an in-patient kidney dialysis unit, but excluding general nephrology or urology wards

17 = Not otherwise specified

99 = Not known

Rule

Rules 950 and 960



Dataset: Admitted Patient Care

Augmented care period number (ACPN_N)

Field	ACPN_N
Field Name	Augmented care period number
Category	Augmented/critical care period
Length and format	2n
Availability	1997-98 to 2005-06
Description	

This field contains a number representing the order of an episode within a sequence of episodes that make up a period of augmented care.

Value

2n = Order number in the range 01 to 97

99 = Not known: a validation error

Rule 970



Dataset: Admitted Patient Care

Augmented care period outcome indicator (ACPOUT_N)

Field ACPOUT_N

Field Name Augmented care period outcome indicator

Category Augmented/critical care period

Length and format 2n

Availability 1997-98 to 2005-06

Description

This field identifies whether a patient survived. For deaths it indicates whether organs were donated. Organs are defined as whole organs such as heart, lung, liver, kidney and pancreas. The value 03 does not include parts of organs such as corneas, heart valves, etc.

Value

01 = Survived

02 = Died: no organ donation

03 = Died: organs donated

98 = Not applicable: Augmented care period not finished

99 = Not known	
Rule	Rule 980 and Rule 990



Dataset: Admitted Patient Care

Augmented care period planned indicator (ACPPLAN_N)

Field	ACPPLAN_N
Field Name	Augmented care period planned indicator
Category	Augmented/critical care period
Length and format	1n
Availability	1997-98 to 2005-06
Description	
<p>This field indicates whether any part of the ACP was planned in advance of admission to the ACP location.</p>	
Value	
<p>1 = Yes</p> <p>2 = No</p> <p>9 = Not known</p>	
Rule	Rule 1000





Dataset: Admitted Patient Care

ACP sequence number (ACPSEQ)

Field	ACPSEQ
Field Name	ACP sequence number
Category	Augmented/critical care period
Length and format	1n
Availability	1997-98 to 2005-06
Description	
Augmented care period sequence number	
Value	
n = ACP sequence number	
Rule	None



Dataset: Admitted Patient Care

Augmented care period source (ACPSOUR_N)

Field	ACPSOUR_N
Field Name	Augmented care period source
Category	Augmented/critical care period
Length and format	2n
Availability	1997-98 to 2005-06
Description	

This field defines where the patient was immediately before the period of augmented care. Compare this field with admisorc (source of patient for a hospital episode).

Value

01 = Ward in same hospital

02 = High dependency unit (HDU) or other immediate care area in same hospital, including special care babies

03 = Intensive care unit (ICU) in same hospital

04 = Theatre or recovery unit in same hospital

05 = A&E department in same hospital

06 = X-ray or endoscopy department in same hospital

07 = ICU in other hospital

08 = Other hospital (not ICU) including HDUs and special care baby units

09 = Clinic, home or other

10 = No change in location: augmented care period started because consultant episode changed

99 = Not known

Rule

Rule 900 and Rule 910



Dataset: Admitted Patient Care

Augmented care period speciality function code (ACPSPEF_N)

Field ACPSPEF_N

Field Name Augmented care period speciality function code

Category Augmented/critical care period

Length and format 3n

Availability 1997-98 to 2005-06

Description

This field contains the code for the main specialty of the consultant clinically managing the period of augmented care. This consultant is not necessarily the same as the one responsible for the hospital episode. Where a patient is cared for by a team of specialists within an Intensive Care rota, this field contains the specialty of the team's clinical director. Where there are several specialties involved but none is considered responsible, this field contains the specialty of the consultant admitting the patient to the period of augmented care. If no specific consultant or team can be identified as organising the care associated with the ACP, then this should be the same as for the related consultant episode.

Value

100 = General surgery



101 = Urology

110 = Trauma and orthopaedics

120 = Ear, nose and throat (ENT)

130 = Ophthalmology

140 = Oral surgery

141 = Restorative dentistry

142 = Paediatric dentistry (available from 1999-2000)

143 = Orthodontics

145 = Oral and maxillo facial surgery (available from 2004-05)

146 = Endodontics (available from 2004-05) ; 147 = Periodontics (available from 2004-05)

148 = Prosthodontics (available from 2004-05)

149 = Surgical dentistry (available from 2004-05)

150 = Neurosurgery

160 = Plastic surgery

170 = Cardiothoracic surgery

171 = Paediatric surgery

180 = Accident and emergency (A&E)

190 = Anaesthetics

191 = Pain management (available from 1998-99 to 2003-04)

192 = Critical care medicine (available from 2004-05)

199 = Non-UK Provider - specialty function not known, treatment mainly surgical

300 = General medicine



301 = Gastroenterology;
302 = Endocrinology
303 = Clinical haematology
304 = Clinical physiology
305 = Clinical pharmacology
310 = Audiological medicine
311 = Clinical genetics
312 = Clinical cytogenetics and molecular genetics (available from 1990-91)
313 = Clinical immunology and allergy (available from 1991-92)
314 = Rehabilitation (available from 1991-92)
315 = Palliative medicine
320 = Cardiology
321 = Paediatric cardiology (available from 2004-05)
330 = Dermatology
340 = Respiratory medicine (also known as thoracic medicine)
350 = Infectious diseases
352 = Tropical medicine (available from 2004-05)
360 = Genito-urinary medicine
361 = Nephrology
370 = Medical oncology
371 = Nuclear medicine
400 = Neurology



401 = Clinical neuro-physiology

410 = Rheumatology

420 = Paediatrics

421 = Paediatric neurology

430 = Geriatric medicine

450 = Dental medicine (available from 1990-91)

460 = Medical ophthalmology (available from 1993-94)

499 = Non-UK Provider - specialty function not known, treatment mainly medical

501 = Obstetrics (prior to 2004-05: Obstetrics for patients using a hospital bed or delivery facilities)

502 = Gynaecology

560 = Midwifery (available from October 1995)

600 = General Medical Practice

601 = General Dental Practice

610 = General practice with maternity function (available to 2003-04)

620 = General practice other than maternity (available to 2003-04)

700 = Learning disability (previously known as mental handicap)

710 = Mental illness

711 = Child and adolescent psychiatry

712 = Forensic psychiatry

713 = Psychotherapy

715 = Old age psychiatry (available from 1990-91)

800 = Clinical oncology (previously Radiotherapy)

810 = Radiology

820 = General pathology

821 = Blood transfusion

822 = Chemical pathology

823 = Haematology

824 = Histopathology

830 = Immunopathology

831 = Medical microbiology

832 = Neuropathology (available to 2003-04)

900 = Community medicine

901 = Occupational medicine

902 = Community health services - dental (available from 2004-05)

903 = Public health medicine (available from 2004-05)

904 = Public health dental (available from 2004-05)

950 = Nursing episode (available from 2002-03)

960 = Allied health professional episode (available from 2006-07)

null = Other maternity event

& = Not known

Rule

Rule 1010



Dataset: Admitted Patient Care

Augmented care period start date (ACPSTAR_N)

Field	ACPSTAR_N
Field Name	Augmented care period start date
Category	Augmented/critical care period
Length and format	dd/mm/yyyy (Date)
Availability	1997-98 to 2005-06
Description	
This field states the start date of a period of augmented care.	
Value	
dd/mm/yyyy = Date period started null = Not applicable / not known	
Rule	Rule 1020



Dataset: Admitted Patient Care

Ambulatory Care Sensitive Condition Flag (ACSCFLAG)

Field	ACSCFLAG
Field Name	Ambulatory Care Sensitive Condition Flag
Category	Diagnosis
Length and format	1n
Availability	2007-08 onwards
Description	

Ambulatory Care Sensitive Condition flag is derived for finished APC episodes where the admission method is 'emergency'. The flag indicates whether the episode contains a diagnosis which is ambulatory care sensitive

Value

1 = episode contains a diagnosis that is ambulatory care sensitive

0 = episode doesn't contain a diagnosis that is ambulatory care sensitive

Rule Derived by rule 509



Dataset: Admitted Patient Care

Age at activity date (ACTIVAGE)

Field	ACTIVAGE
Field Name	Age at activity date
Category	Patient Data
Length and format	3n
Availability	2007-08 onwards
Description	

The patient's age, in years, at the time of activity, such as admission, discharge or birth.

Value

3n = age at activity date ;

999 = Not known, ie date of birth not known and age cannot be estimated

Rule	Data not cleaned
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Dataset: Admitted Patient Care

Admission date check flag (ADM_CFL)

Field	ADM_CFL
Field Name	Admission date check flag
Category	Admissions ; Period of Care
Length and format	1n
Availability	All years
Description	
Codes in this field indicate whether the patient's admission date is valid.	
Value	
0 = Valid (or missing because not required) ; 1 = Missing ; 2 = Invalid	
Rule	Not applicable (derived by rule 35)



Dataset: Admitted Patient Care

Age on admission (ADMIAGE)

Field	ADMIAGE
Field Name	Age on admission
Category	Patient Data
Length and format	3n
Availability	2007-08 onwards
Description	

A patient's age, in years, at the date of admission.

Value

3n = age at activity date ;

999 = Not known, ie date of birth not known and age cannot be estimated

Rule Data not cleaned



Dataset: Admitted Patient Care

Date of admission (ADMIDATE)

Field	ADMIDATE
Field Name	Date of admission
Category	Admissions ; Period of care
Length and format	dd/mm/yyyy (Date)
Availability	All years
Description	

This field contains the date the patient was admitted to hospital at the start of a hospital spell. Admidate is recorded on all episodes within a spell.

Value

2012/13 onwards:

01/01/1800 - null date submitted

01/01/1801 - invalid date submitted

1989/90 to 2011/12:

01/01/1600 – null date submitted

15/10/1582 – invalid date submitted



Rule	Rule 35
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Dataset: Admitted Patient Care

Admission episode flag (ADMIFLAG)

Field	ADMIFLAG
Field Name	Admission episode flag
Category	Patient Data
Length and format	1a
Availability	All years
Description	
Codes in this field indicate whether the episode is an admission episode.	
Value	
<p>Y = Episode is an admission episode, ie episode order equals 1 ;</p> <p>N = Episode is not an admission episode</p>	
Rule	None



Dataset: Admitted Patient Care

Method of admission (ADMIMETH)

Field	ADMIMETH
Field Name	Method of admission
Category	Admissions ; Period of care
Length and format	2n
Availability	All years
Description	

This field contains a code which identifies how the patient was admitted to hospital. Admimeth is recorded on the first and also all subsequent episodes within the spell (ie where the spell is made up of more than one episode).

Value

Elective Admission, when the decision to admit could be separated in time from the actual admission:

11 = Waiting list

12 = Booked

13 = Planned

Emergency Admission, when admission is unpredictable and at short notice because of



clinical need:

21 = Accident and emergency or dental casualty department of the Health Care Provider

22 = General Practitioner: after a request for immediate admission has been made direct to a Hospital Provider, i.e. not through a Bed bureau, by a General Practitioner: or deputy

23 = Bed bureau

24 = Consultant Clinic, of this or another Health Care Provider

25 = Admission via Mental Health Crisis Resolution Team (available from 2013/14. Prior to this date a value of 25 represented "Emergency - domiciliary visit by consultant")

2A = Accident and Emergency Department of another provider where the PATIENT had not been admitted

2B = Transfer of an admitted patient from another Hospital Provider in an emergency

2C = Baby born at home as intended

2D = Other emergency admission

(2A - 2D available from 2013/14)

28 = Other means, examples are:

- admitted from the Accident and Emergency Department of another provider where they had not been admitted
- transfer of an admitted patient from another Hospital Provider in an emergency
- baby born at home as intended

Maternity Admission, of a pregnant or recently pregnant woman to a maternity ward (including delivery facilities) except when the intention is to terminate the pregnancy:

31 = Admitted ante-partum

32 = Admitted post-partum

Other Admission not specified above:



82 = The birth of a baby in this Health Care Provider

83 = Baby born outside the Health Care Provider except when born at home as intended.

81 = Transfer of any admitted patient from other Hospital Provider other than in an emergency

98 = Not applicable

99 = Not known: a validation error

Rule	Rules 65, 70 and 320
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Dataset: Admitted Patient Care

Administrative category (ADMINCAT)

Field	ADMINCAT
Field Name	Administrative category
Category	Patient Data
Length and format	2n
Availability	2000-01 onwards
Description	

Administrative category on admission.

Value

01 = NHS patient, including overseas visitors charged under Section 121 of the NHS Act 1977 as amended by Section 7(12) and (14) of the Health and Medicine Act 1988 ;

02 = Private patient: one who uses accommodation or services authorised under section 65 and/or 66 of the NHS Act 1977 (Section 7(10) of Health and Medicine Act 1988 refers) as amended by Section 26 of the National Health Service and Community Care Act 1990 ;

03 = Amenity patient: one who pays for the use of a single room or small ward in accord with section 12 of the NHS Act 1977, as amended by section 7(12) and (14) of the Health and Medicine Act 1988 ;

04 = A category II patient: one for whom work is undertaken by hospital medical or dental staff within categories II as defined in paragraph 37 of the Terms and Conditions of Service of

Hospital Medical and Dental Staff ;

98 = Not applicable ;

99 = Not known: a validation error

Rule

Rule 125 (from 2002-03 onwards)



Dataset: Admitted Patient Care

Admin category at start of episode (ADMINCATST)

Field	ADMINCATST
Field Name	Admin category at start of episode
Category	Patient Data
Length and format	2n
Availability	2007-08 onwards
Description	

The patient's administrative category at the start of each episode of care. This may change during a spell as the patient may, for example, opt to change from NHS to private health care.

Value

01 = NHS patient ;
 02 = Private patient ;
 03 = Amenity patient ;
 04 = Category II patient ;
 98 = Not applicable ;
 99 = Not known: a validation error



Rule

Data not cleaned



Dataset: Admitted Patient Care

Source of admission (ADMISORC)

Field	ADMISORC
Field Name	Source of admission
Category	Admissions ; Period of care
Length and format	2n
Availability	All years
Description	

This field contains a code which identifies where the patient was immediately prior to admission. Most patients are admitted from home, but there are some significant exceptions. In particular, this field differentiates between patients admitted from home and patients transferred from another hospital provider or institution.

Value

19 = The usual place of residence, including no fixed abode

29 = Temporary place of residence when usually resident elsewhere, for example, hotels and residential educational establishments

30 = Repatriation from high security psychiatric hospital (1999-00 to 2006-07) ;

37 = Penal establishment: court (1999-00 to 2006-07)

- 38 = Penal establishment: police station (1999-00 to 2006-07)
- 39 = Penal establishment (court and police station excluded from 1999-2000)
- 48 = High security psychiatric hospital, Scotland (1999-00 to 2006-07)
- 49 = NHS other hospital provider: high security psychiatric accommodation in an NHS hospital provider (NHS trust)
- 50 = NHS other hospital provider: medium secure unit (1999-00 to 2006-07)
- 51 = NHS other hospital provider: ward for general patients or the younger physically disabled or A&E department
- 52 = NHS other hospital provider: ward for maternity patients or neonates
- 53 = NHS other hospital provider: ward for patients who are mentally ill or have learning disabilities
- 54 = NHS run nursing home, residential care home or group home
- 65 = Local authority Part 3 residential accommodation: where care is provided (from 1996-97)
- 66 = Local authority foster care, but not in Part 3 residential accommodation: where care is provided (from 1996-97)
- 69 = Local authority home or care (1989-90 to 1995-96)
- 79 = Babies born in or on the way to hospital
- 85 = Non-NHS (other than Local Authority) run residential care home (from 1996-97) 86 = Non-NHS (other than Local Authority) run nursing home (from 1996-97)
- 87 = Non-NHS run hospital
- 88 = non-NHS (other than Local Authority) run hospice
- 89 = Non-NHS institution (1989-90 to 1995-96)
- 98 = Not applicable
- 99 = Not known



Rule

Rule 80



Dataset: Admitted Patient Care

Psychiatric history on admission (ADMISTAT)

Field	ADMISTAT
Field Name	Psychiatric history on admission
Category	Psychiatric
Length and format	1n
Availability	1996-97 onwards
Description	

This field contains a code which identifies previous psychiatric care for psychiatric patients. It applies only to patients admitted or transferred to a consultant in one of the psychiatric specialties during a spell in hospital. It is recorded for the first such consultant episode but not for subsequent psychiatric consultant episodes or any non-psychiatric episodes. This field is used to indicate the turnover for psychiatric patients, and identify first time psychiatric admissions and re-admissions. Where a patient has a history of admission to several hospital providers, priority is given to the current hospital provider (code 1), regardless of whether the preceding admission was to the same hospital provider. This field replaces special (UK NHS specific) diagnosis codes commencing U69 (1 April 1989 to 31 March 1995) and U51 (1 April 1995 to 31 March 1996), and also the HES derived V code indicator data item.

Value

0 = No known previous hospital provider spell with a consultant episode having a psychiatric

specialty within any health care provider ;

1 = One or more previous hospital provider spells with a consultant episode having a psychiatric specialty within this health care provider ;

2 = One or more previous hospital provider spells with a consultant episode having a psychiatric specialty within another health care provider, but none with this healthcare provider ;

8 = Not applicable: the patient is not receiving admitted patient care under a consultant in a psychiatric specialty ;

9 = Not known: the patient is receiving admitted patient care under a consultant in a psychiatric specialty but the information is not available. This constitutes a validation error

Rule

Rule 380



Dataset: Admitted Patient Care

Record identifier (AEKEY)

Field AEKEY

Field Name Record identifier

Category System Data

Length and format 14n

Availability TBC

Description

This is a record identifier that is created by the HES system. The digits store a decimal number. This is commonly eight or nine digits but can be up to 14.

Value

14n = Record identifier

Rule Data not cleaned



Dataset: Admitted Patient Care

Principal alcohol related diagnosis (ALCDIAG)

Field	ALCDIAG
Field Name	Principal alcohol related diagnosis
Category	Diagnosis
Length and format	6an
Availability	2002-03 onwards
Description	

Indicates the diagnosis code with the highest alcohol attributable fraction. Where this applies to more than one code, the code that appears earliest in the sequence of diagnosis fields is used. Where no alcohol attributable diagnosis is present this field will be null. See "HES APC Data Dictionary - Supplementary Table" at <http://www.hscic.gov.uk/hesdatadictionary>

Value

annnna = A valid ICD-9 or ICD-10 diagnosis code

annnnn = A valid ICD-9 or ICD-10 diagnosis code

null = not applicable



Rule	derived by rule 1230
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Dataset: Admitted Patient Care

4 character concatenated alcohol related diagnosis (ALCDIAG_4)

Field	ALCDIAG_4
Field Name	4 character concatenated alcohol related diagnosis
Category	Diagnosis
Length and format	TBC
Availability	TBC
Description	
Provides a concatenated string of the principal alcohol related diagnosis (ALCDIAG) at 4 character level.	
Value	
TBC	
Rule	TBC

Dataset: Admitted Patient Care

Principal alcohol related fraction (ALCFRAC)

Field ALCFRAC

Field Name Principal alcohol related fraction

Category Diagnosis

Length and format n.nn

Availability 2002-03 onwards

Description

Indicates the highest alcohol attributable fraction within the episode based on the principal alcohol related diagnosis. See "HES APC Data Dictionary - Supplementary Table" at <http://www.hscic.gov.uk/hesdatadictionary>

Value

See Supplementary table

Rule derived by rule 1230



Dataset: Admitted Patient Care

**Gestation period in weeks at first antenatal
assessment (ANAGEST)**

Field	ANAGEST
Field Name	Gestation period in weeks at first antenatal assessment
Category	Maternity
Length and format	2n
Availability	All years
Description	<p>Gestation period in weeks at the date of the first antenatal assessment. This field is calculated from anadate, gestat and the dobbaby.</p>
Value	<p>2n = The gestation period in weeks ;</p> <p>null = Not valid / not known</p>
Rule	derived by rule 790



Dataset: Admitted Patient Care

First antenatal assessment date (ANASDATE)

Field	ANASDATE
Field Name	First antenatal assessment date
Category	Maternity
Length and format	dd/mm/yyyy (Date)
Availability	All years
Description	

This field contains the date when a pregnant woman was first assessed and arrangements were made for antenatal care. This is not necessarily the date when delivery arrangements were made.

Value

dd/mm/yyyy = Date of first antenatal assessment

01/01/1800 = null date submitted

01/01/1801 = invalid date submitted

Rule Rule 788



Dataset: Admitted Patient Care

Antenatal days of stay (ANTEDUR)

Field	ANTEDUR
Field Name	Antenatal days of stay
Category	Maternity
Length and format	3n
Availability	All years
Description	
<p>This derived field contains the number of days between the start of the episode (epistart) and the date of delivery of the first baby (dobbaby1).</p>	
Value	
<p>3n = The number of days of stay from 0 to 270 ;</p> <p>null = Not applicable / not known</p>	
Rule	derived by rule 800



Dataset: Admitted Patient Care

Area Team of GP Practice (AT_GP_PRACTICE)

Field	AT_GP_PRACTICE
Field Name	Area Team of GP Practice
Category	Geographical
Length and format	3an
Availability	2013-14 onwards
Description	<p>This derived field contains the code for the Area Team (AT) where the patient's GP practice is registered. It is derived from Code of GP practice (GPPRAC)</p>
Value	<p>ann = AT of patient's GP practice</p> <p>Y = Unknown</p>
Rule	derived by rule 1126



Dataset: Admitted Patient Care

Area Team of Residence (AT_RESIDENCE)

Field	AT_RESIDENCE
Field Name	Area Team of Residence
Category	Geographical
Length and format	3an
Availability	2013-14 onwards
Description	

This derived field contains the code for the Area Team (AT) where the patient lived immediately before admission. It is derived from the CCG of residence.

Value

ann = AT of residence

S = Scotland

U = England (NOS)

W = Wales

X = Foreign (from 1990/1991 onwards)

Y = Not known



Z = Northern Ireland

Rule

derived by rule 1201



Dataset: Admitted Patient Care

Area Team of Treatment (AT_TREATMENT)

Field AT_TREATMENT

Field Name Area Team of Treatment

Category Geographical

Length and format 3an

Availability 2013-14 onwards

Description

This derived field contains the code for the Area Team (AT) where the patient was treated. It is derived from the CCG of Treatment.

Value

ann = AT of treatment

Y = Unknown

Rule derived by rule 1147



Dataset: Admitted Patient Care

Baby sequence number (BABYSEQ)

Field	BABYSEQ
Field Name	Baby sequence number
Category	Maternity
Length and format	1n
Availability	All years
Description	
Birth sequence	
Value	
1n = birth sequence	
Rule	None



Dataset: Admitted Patient Care

Bed days within the year (BEDYEAR)

Field	BEDYEAR
Field Name	Bed days within the year
Category	Episodes and spells ; Period of care
Length and format	3n
Availability	All years
Description	

This derived field provides the duration of an episode in days within the HES data year. It is derived from epistart (episode start date) and epiend (episode end date). For episodes that both start and finish in the data year, bedyear has the same value as epidur (episode duration). If the episode is unfinished, bedyear is calculated from epistart and the end of the data year. If epistart is before the beginning of the data year, bedyear is calculated from the start of the data year and epiend. If the record type is other maternity events (episode type 5 or 6), bedyear is null.

Value

nnn = The number of days of stay from 0 to 366 ;

null = Not applicable (other maternity event / not known)



Rule	Not applicable (derived by rule 240)
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Dataset: Admitted Patient Care

Resuscitation method (BIRESUS_N)

Field	BIRESUS_N
Field Name	Resuscitation method
Category	Maternity
Length and format	1n
Availability	All years
Description	

This field contains a code that identifies the method used to get the baby breathing normally. This item appears for each baby on multiple birth delivery records.

Value

- 1 = Positive pressure nil, drugs nil ;
- 2 = Positive pressure nil, drugs administered ;
- 3 = Positive pressure by mask, drugs nil ;
- 4 = Positive pressure by mask, drugs administered ;
- 5 = Positive pressure by endotracheal tube, drugs nil ;
- 6 = Positive pressure by endotracheal tube, drugs administered ;

8 = Not applicable: still born and no method of resuscitation attempted ;

9 = Not known

Rule

Rules 710 and 753



Dataset: Admitted Patient Care

Birth order (BIRORDER_N)

Field	BIRORDER_N
Field Name	Birth order
Category	Maternity
Length and format	1n or X
Availability	All years
Description	

The position in the sequence of births. This item appears for each baby on multiple birth delivery records. From 1996-97 the same value (1) is used for a single birth or the first born of several. Up until March 2002, only the first six births were recorded.

Value

- 1 = First, including single, birth ;
- 2 = Second ;
- 3 = Third ;
- 4 = Fourth ;
- 5 = Fifth ;
- 6 = Sixth ;

7 = Seventh ;

8 = Not applicable ;

9 = Not known: a validation error;

X = Not known

Rule

Rule 720



Dataset: Admitted Patient Care

Birth status (BIRSTAT_N)

Field	BIRSTAT_N
Field Name	Birth status
Category	Maternity
Length and format	1n
Availability	All years
Description	

This field contains a code which indicates whether the baby was born alive or dead (still birth). A still birth is a birth after a gestation period of 24 weeks (168) days where the baby shows no sign of life when delivered. This item appears for each baby on multiple birth delivery records.

Value

- 1 = Live ;
- 2 = Still birth: ante-partum ;
- 3 = Still birth: intra-partum ;
- 4 = Still birth: indeterminate ;
- 9 = Not known

Rule	Rules 710 and 753
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Dataset: Admitted Patient Care

Birth weight (BIRWEIT_N)

Field	BIRWEIT_N
Field Name	Birth weight
Category	Maternity
Length and format	4n
Availability	All years
Description	<p>This field contains the weight of the baby in grams immediately after birth. This item appears for each baby on multiple birth delivery records.</p>
Value	<p>4n = Weight in grams from 0001 to 6999</p> <p>7000 = 7000g or more</p> <p>9999 = Not known</p>
Rule	Rules 740 and 760

Dataset: Admitted Patient Care

Unique booking reference number (BOOKREFNO)

Field	BOOKREFNO
Field Name	Unique booking reference number
Category	Patient Pathway
Length and format	12n
Availability	2007-08 onwards
Description	<p>The booking reference number assigned by the Connecting for Health Choose and Book System when a patient accepts an appointment date, regardless of whether they subsequently attend or cancel the appointment. Each booking reference number is unique.</p>
Value	
	12n = unique booking reference number
Rule	Data not cleaned



Dataset: Admitted Patient Care

Cancer network (CANNET)

Field	CANNET
Field Name	Cancer network
Category	Geographical
Length and format	3an
Availability	2008-09 onwards
Description	

The cancer network that each postcode falls within. Further information on Cancer Network can be found on the Department of Health website [http://www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Cancer/DH_4068463].

Value

N01-N98 = Cancer Registry in England/Wales/Isle of Man

Z99 = Scotland/Northern Ireland/Channel Islands (pseudo)

Null = no information available

Rule	Not applicable (derived from postcode)
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Dataset: Admitted Patient Care

Cancer registry (CANREG)

Field	CANREG
Field Name	Cancer registry
Category	Geographical
Length and format	5an
Availability	2008-09 onwards
Description	

The cancer registry that each postcode falls within. Further information on Cancer Registries can be found on the Department of Health website [http://www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Cancer/DH_4068586].

Value

Y0201-Y1701 = Cancer Registry in England/Wales

Z9999 = Scotland/NI/Channel Island/Isle of Man (pseudo)

Null = No information available

Rule	Not applicable (derived from postcode)
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Dataset: Admitted Patient Care

Carer support indicator (CARERSI)

Field	CARERSI
Field Name	Carer support indicator
Category	Psychiatric
Length and format	2n
Availability	1997-98 onwards
Description	

This field contains a code which states whether carer support is available to the patient at home or other normal residence. This does not include any paid support or support from a voluntary organisation unless the patient is normally resident in a nursing home, group home or residential care home.

Value

01 = Yes ;
02 = No ;
99 = Not known

Rule Rule 400





Dataset: Admitted Patient Care

Administrative & legal status of patient (CATEGORY)

Field	CATEGORY
Field Name	Administrative & legal status of patient
Category	Patient Data
Length and format	2n
Availability	1989-90 to 2001-02
Description	

Many NHS hospitals have private wards where private patients may use the accommodation and services of the hospital provider. Some hospitals also provide amenity beds, usually located in small side wards for which a charge is made for the accommodation. Both of these categories of patient are defined by the NHS Act of 1977. Any categories of patient, whether NHS, private or amenity patients, can be formally detained under the provisions of the Mental Health Act 1983 and other legislation. Most patients in NHS hospitals or hospital units will come under category 10 (see below).

Value

10 = NHS patient: not formally detained ;

11 = NHS patient: formally detained under Part II of the Mental Health Act 1983 ;

12 = NHS patient: formally detained under Part III of the Mental Health Act 1983 or under

other Acts ;

13 = NHS patient: formally detained under part X, Mental Health Act 1983* ;

20 = Private patient: not formally detained ;

21 = Private patient: formally detained under Part II of the Mental Health Act 1983 ;

22 = Private patient: formally detained under Part III of the Mental Health Act 1983 or under other Acts ;

23 = Private patient: formally detained under part X, Mental health Act 1983* ;

30 = Amenity patient: not formally detained ;

31 = Amenity patient: formally detained under Part II of the Mental Health Act 1983 ;

32 = Amenity patient: formally detained under Part III of the Mental Health Act 1983 or under other Acts ;

33 = Amenity patient: formally detained under part X, Mental health Act 1983* ;

null = Other maternity event. ;

* Codes 13, 23 and 33 were introduced at the start of the 1994-95 HES year (1 April 1995)

Rule

Not applicable (derived by the Secondary Uses Service from Administrative category and Legal Status Classification)



Dataset: Admitted Patient Care

Cause code (CAUSE)

Field CAUSE

Field Name Cause code

Category Clinical

Length and format 6an

Availability All years

Description

External cause of injury or poisoning. This item is a copy of the first diagnosis code that represents an external cause.

Value

6an = Code copied from a diagnosis field: this is a standard ICD-10 code in the range V01-Y98

null = Unfinished episode, other maternity event or no cause code found

Rule Rules 460, 470, 510 and 530 (then derived by rule 580)



Dataset: Admitted Patient Care

Cause code - 3 characters (CAUSE_3)

Field CAUSE_3

Field Name Cause code - 3 characters

Category Clinical

Length and format 3an

Availability All years

Description

This item is a copy of the initial 3 characters of the first diagnosis code that represents an external cause, eg accidents or poisoning.

Value

ann = Code copied from a diagnosis field: this is a standard ICD-10 code in the range V01-Y98

null = Unfinished episode, other maternity event or no cause code found

Rule Rules 460, 470, 510 and 530 (then derived by rule 580)



Dataset: Admitted Patient Care

Cause code - 4 characters (CAUSE_4)

Field CAUSE_4

Field Name Cause code - 4 characters

Category Clinical

Length and format 4an

Availability All years

Description

This item is a copy of the initial 4 characters of the first diagnosis code that represents an external cause, eg accidents or poisoning.

Value

annn = Code copied from a diagnosis field: this is a standard ICD-10 code in the range V01-Y98

null = Unfinished episode, other maternity event or no cause code found

Rule Rules 460, 470, 510 and 530 (then derived by rule 580)



Dataset: Admitted Patient Care

CCG of GP Practice (CCG_GP_PRACTICE)

Field	CCG_GP_PRACTICE
Field Name	CCG of GP Practice
Category	Geographical
Length and format	5an
Availability	2013-14 onwards
Description	

This derived field contains the code for the Clinical Commissioning Group (CCG) where the patient's GP practice is registered. It is derived from GP Practice (GGPRAC).

Value

nna = CCG of patient's GP practice

59999 = Unknown

Rule	Rule 1126
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Dataset: Admitted Patient Care

CCG of Residence (CCG_RESIDENCE)

Field	CCG_RESIDENCE
Field Name	CCG of Residence
Category	Geographical
Length and format	5an
Availability	2013-14 onwards
Description	

This derived field contains the code for the Clinical Commissioning Group (CCG) where the patient lived immediately before admission. It is derived from post code (HOMEADD).

Value

nna = CCG of patient's residence

59999 = Unknown

Rule	Not applicable (derived by rule 1200)
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Dataset: Admitted Patient Care

CCG of Responsibility (CCG_RESPONSIBILITY)

Field	CCG_RESPONSIBILITY
Field Name	CCG of Responsibility
Category	Geographical
Length and format	5an
Availability	2013-14 onwards
Description	

This derived field contains the code for the most suitable Clinical Commissioning Group (CCG) of responsibility. It is derived firstly from the patient's GP practice but if not available the patient's CCG of residence then the CCG of treatment is used.

Value

nna = CCG of Responsibility

59999 = Unknown

Rule Rule 1205



Dataset: Admitted Patient Care

Origin of CCG of Responsibility (CCG_RESPONSIBILITY_ORIGIN)

Field	CCG_RESPONSIBILITY_ORIGIN
Field Name	Origin of CCG of Responsibility
Category	Geographical
Length and format	1n
Availability	2013-14 onwards
Description	

This derived field indicates the basis on which the CCG of Responsibility was assigned.

Value

- 1 = derived from gpprac
- 2 = derived from homeadd
- 3 = derived from postcode of sitetret
- 4 = derived from postcode of provider
- 9 = Unknown



Rule

Rule 1205



Dataset: Admitted Patient Care

CCG of Treatment (CCG_TREATMENT)

Field	CCG_TREATMENT
Field Name	CCG of Treatment
Category	Geographical
Length and format	5an
Availability	2013-14 onwards
Description	

This derived field contains the code for the Clinical Commissioning Group (CCG) where the patient was treated. It is derived from the postcode of the Site of Treatment firstly, but where not available the postcode of the Provider is used.

Value

nna = CCG of treatment

59999 = Unknown

Rule Rule 1146



Dataset: Admitted Patient Care

Origin of CCG of Treatment (CCG_TREATMENT_ORIGIN)

Field	CCG_TREATMENT_ORIGIN
Field Name	Origin of CCG of Treatment
Category	Geographical
Length and format	1n
Availability	2013-14 onwards
Description	

This derived field indicates the basis on which the CCG of Treatment was assigned.

Value

- 1 = derived from postcode of sitetret
- 2 = derived from postcode of procodet
- 9 = Unknown

Rule	Rule 1146
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Dataset: Admitted Patient Care

CDS extract date (CDSEXTDATE)

Field	CDSEXTDATE
Field Name	CDS extract date
Category	System Data
Length and format	dd/mm/yyyy (Date)
Availability	2007-08 onwards
Description	
CDS extract date.	
Value	
dd/mm/yyyy	
Rule	Data not cleaned



Dataset: Admitted Patient Care

CDS unique identifier (CDSUNIQUEID)

Field	CDSUNIQUEID
Field Name	CDS unique identifier
Category	System Data
Length and format	35an
Availability	2007-08 onwards
Description	
CDS unique identifier.	
Value	
35an = CDS Unique identifier	
Rule	Data not cleaned



Dataset: Admitted Patient Care

CDS protocol identifier (CDSVERPROTID)

Field CDSVERPROTID

Field Name CDS protocol identifier

Category System Data

Length and format 3an

Availability 2007-08 onwards

Description

CDS Protocol ID.

Value

3an = CDS Protocol Identifier

Rule Data not cleaned



Dataset: Admitted Patient Care

CDS version number (CDSVERSION)

Field	CDSVERSION
Field Name	CDS version number
Category	System Data
Length and format	6an
Availability	2007-08 onwards
Description	

The version of the commissioning data set (CDS) being used.

Value

6an = CDS version number

Rule Data not cleaned



Dataset: Admitted Patient Care

Duration of care to psychiatric census date (CENDUR)

Field	CENDUR
Field Name	Duration of care to psychiatric census date
Category	Psychiatric
Length and format	5n
Availability	All years
Description	<p>Duration of care in days to the psychiatric census date. This field is calculated from admidate (admission date) and the date of the psychiatric census (31 March every year). The maximum permitted value is 29,200 days (approximately 80 years).</p>
Value	<p>5n = Duration of stay in days at census date from 0 to 29,200 ;</p> <p>null = Not applicable (epitype is not 4) / not known</p>
Rule	Not applicable (derived by rule 870)



Dataset: Admitted Patient Care

Age at psychiatric census date (CENSAGE)

Field	CENSAGE
Field Name	Age at psychiatric census date
Category	Psychiatric
Length and format	3n
Availability	All years
Description	

This field is calculated from date of birth (dob) and the date of the psychiatric census (31 March every year). It is only calculated for psychiatric census records; if the episode type is not for a formally detained patient (epitype is not 4) or one that was admitted more than one year previously, censage is null. The maximum permitted value is 120 years.

Value

3n = Age in years from 1 to 119 on the date of the annual psychiatric census ;

120 = 120 years or more on the date of the annual psychiatric census ;

null = Not applicable (epitype is not 4) / not known



Rule	Not applicable (derived by rule 880)
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Dataset: Admitted Patient Care

Status of patient included in psychiatric census (CENSTAT)

Field	CENSTAT
Field Name	Status of patient included in psychiatric census
Category	Psychiatric
Length and format	1n
Availability	All years
Description	

This field contains a code which defines the legal status of the patient. It is derived from legal status (leglstat) and the length of stay recorded for the current spell.

Value

- 1 = Detained patient ;
- 2 = Long term patient ;
- 3 = Detained and long term patient ;
- null = Not applicable (1990-91 to 1995-96)



Rule	Not applicable
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Dataset: Admitted Patient Care

Ward type at psychiatric census date (CENWARD)

Field	CENWARD
Field Name	Ward type at psychiatric census date
Category	Psychiatric
Length and format	7n
Availability	All years
Description	

This field contains a code which defines the characteristics of a ward. The code has six parts: AABCDEF.

Value

A is as follows:

51 = for intensive care: specially designated ward for patients needing containment and more intensive management. This is not to be confused with intensive nursing where patients may require one to one nursing while on a standard ward

52 = for short stay: patients intended to stay less than a year

53 = for long stay: patients intended to stay a year or more

For patients with Learning Disabilities



61 = designated or interim secure unit

62 = Patients intending to stay less than a year

63 = Patients intending to stay a year or more

For maternity patients

41 = only for patients looked after by consultants

43 = only for patients looked after by general medical practitioners

42 = for joint use by consultants & general medical practitioners

For neonates

33 = maternity: associated with the maternity ward in that cots are in the maternity ward nursery or in the ward itself

32 = non-maternity: not associated with the maternity ward and without designated cots for intensive care

31 = not associated with the maternity ward and in which there are some designated cots for intensive care

For the younger physically disabled

21 = spinal units, only those units which are nationally recognised

22 = other units

For terminally ill/Palliative Care

81 = terminally ill/Palliative Care

For general patients

11 = for intensive therapy, including high dependency care

12 = for normal therapy: where resources permit the admission of patients who might need all but intensive or high dependency therapy

13 = for limited therapy: where nursing care rather than continuous medical care is provided. Such wards can be used only for patients carefully selected and restricted to a narrow range



in terms of the extent and nature of disease

additional codes

71 = Home leave, non-psychiatric ;

72 = Home leave, psychiatric ;

B is age as follows:

1 = Neonates ;

2 = Children and adolescents ;

3 = Elderly ;

8 = Any age ;

9 = Invalid ;

C is sex as follows:

1 = Male ;

2 = Female ;

8 = Not specified ;

9 = Invalid ;

D is the hospital provider as follows:

1 = NHS hospital provider ;

2 = Non-NHS hospital provider ;

9 = Invalid ; E is the number of days in a week that the ward is open only during the day. ;

F is the number of days in a week that the ward is open at night.

Rule

None





Dataset: Admitted Patient Care

Primary diagnosis chapter (CHAPTER)

Field	CHAPTER
Field Name	Primary diagnosis chapter
Category	Clinical
Length and format	4an
Availability	All years
Description	
This provides the chapter of the primary diagnosis (diag_01).	
Value	
Chapters I to XXII	
Rule	



Dataset: Admitted Patient Care

Patient classification (CLASSPAT)

Field	CLASSPAT
Field Name	Patient classification
Category	Clinical ; Period of care
Length and format	1n
Availability	All years
Description	

This field identifies day cases, ordinary admissions, regular day and regular night attenders, and the special case of mothers and babies using only delivery facilities. Data about regular day and regular night attenders are not available for analysis prior to 2002-03. Since the introduction of the NHS wide clearing service in April 1996, this field has been derived from related items in the Commissioning Data Set (eg intended management).

Value

- 1 = Ordinary admission ;
- 2 = Day case admission ;
- 3 = Regular day attender ;
- 4 = Regular night attender ;

5 = Mothers and babies using only delivery facilities ;

8 = Not applicable (other maternity event)

9 = Not known

Rule

Rule 261



Dataset: Admitted Patient Care

Consultant code (CONSULT)

Field	CONSULT
Field Name	Consultant code
Category	Practitioner
Length and format	8an
Availability	1997-98 onwards
Description	

The GMC code for the consultant, which identifies the consultant as an individual. Midwife and GP episodes are identified by a special code. The Consultant code (consult) field contains sensitive data. Access to it requires the approval of the Data Access Advisory Group (DAAG).

Value

8an = Consultant code ;

Cnnnnnnn - consultant

Dnnnnnnn - dentist

CDnnnnnnn - dental consultant

H9999998 (Other Healthcare professional)

M9999998 (Midwife)

N9999998 (Nurse)

C9999998 - consultant not known

D9999998 - dentist not known

CD999998 - dental consultant not known

& = Not Known

99 = Invalid (format only, does not verify number)

Rule

Rules 420



Dataset: Admitted Patient Care

Commissioning Region of GP Practice (CR_GP_PRACTICE)

Field	CR_GP_PRACTICE
Field Name	Commissioning Region of GP Practice
Category	Geographical
Length and format	3an
Availability	2013-14 onwards
Description	<p>This derived field contains the code for the Commissioning Region (CR) where the patient's GP practice is registered. Where not available, the code for the Area Team is used. It is derived from gpprac.</p>
Value	<p>ann = CR of patient's GP practice</p> <p>Y = Unknown</p>
Rule	derived by rule 1126





Dataset: Admitted Patient Care

Commissioning Region of Residence (CR_RESIDENCE)

Field CR_RESIDENCE

Field Name Commissioning Region of Residence

Category Geographical

Length and format 3an

Availability 2013-14 onwards

Description

This derived field contains the code for the Commissioning Region (CR) where the patient lived immediately before admission. Where not available, the code for the Area Team is used. It is derived from the CCG of Residence.

Value

ann = CR of Residence

Y = Unknown

Rule derived by rule 1201



Dataset: Admitted Patient Care

Commissioning Region of Treatment (CR_TREATMENT)

Field	CR_TREATMENT
Field Name	Commissioning Region of Treatment
Category	Geographical
Length and format	3an
Availability	2013-14 onwards
Description	
<p>This derived field contains the code for the Commissioning Region (CR) where the patient was treated. Where not available, the code for the Area Team is used. It is derived from the CCG of Treatment.</p>	
Value	
<p>ann = CR of treatment</p> <p>Y = Unknown</p>	
Rule	derived by rule 1147





Dataset: Admitted Patient Care

Commissioning serial number (CSNUM)

Field	CSNUM
Field Name	Commissioning serial number
Category	Organisation
Length and format	6an
Availability	2000-01 onwards
Description	

Contains the commissioning serial number (used in HES to identify OATs - Out of Area Treatments). This is a number used to uniquely identify a NHS SERVICE AGREEMENT by an ORGANISATION acting as commissioner of patient care services.

Value

6an = Commissioning serial number

Rule Data not cleaned



Dataset: Admitted Patient Care

Current electoral ward (CURRWARD)

Field	CURRWARD
Field Name	Current electoral ward
Category	Geographical
Length and format	2an
Availability	All years
Description	

This derived field contains a code which defines the pre-2011 electoral ward of the patient. It is derived from the patient's postcode in the field homeadd. When this field is concatenated with the other local authority district (RESLADST), the result is a unique value.

Value

2a = Electoral ward

Rule Not applicable (derived by rule 1200)



Dataset: Admitted Patient Care

Current electoral ward (ONS) (CURRWARD_ONS)

Field	CURRWARD_ONS
Field Name	Current electoral ward (ONS)
Category	Geographical
Length and format	9an
Availability	2011-12 onwards
Description	

This derived field contains a code which defines the current electoral ward of the patient. It is derived from the patient's postcode in the field homeadd.

Value

E followed by 8 digits = England

W followed by 8 digits = Wales

S followed by 8 digits = Scotland

Northern Ireland start with 95 followed by a letter, then space, then 2 digits (e.g. 95B 24)

Y = Not known

E99999999 (pseudo) = England



W99999999 (pseudo) = Wales

S99999999 (pseudo) = Scotland

L99999999 (pseudo) = Channel Islands

M99999999 (pseudo) = Isle of Man

Rule

Not applicable (derived by rule 1200)



Dataset: Admitted Patient Care

Delivery place change reason (DELCHANG)

Field DELCHANG

Field Name Delivery place change reason

Category Maternity

Length and format 1n

Availability All years

Description

This field contains a code that defines the reason for changing the delivery place type.

Value

- 1 = Decision made during pregnancy because the patient's address changed ;
- 2 = Decision made during pregnancy for clinical reasons ;
- 3 = Decision made during pregnancy for other reasons ;
- 4 = Decision made during labour for clinical reasons ;
- 5 = Decision made during labour for other reasons ;
- 6 = Occurred unintentionally during labour ;

8 = Not applicable: there was no change ;

9 = Not known ;

null = No change (before 1995-96)

Rule

Rules 710 and 750



Dataset: Admitted Patient Care

Delivery place (intended) (DELINTEN)

Field	DELINTEN
Field Name	Delivery place (intended)
Category	Maternity
Length and format	1n
Availability	All years
Description	

This field contains a code which defines the intended type of delivery place. The initial intention is designated by the General Medical Practitioner (GMP) and midwife, or by the GMP and hospital staff. The decision is normally made when the mother is assessed for delivery. The actual delivery place type is in delplac.

Value

- 0 = In NHS hospital: delivery facilities associated with midwife ward ;
- 1 = At a domestic address ;
- 2 = In NHS hospital: delivery facilities associated with consultant ward ;
- 3 = In NHS hospital: delivery facilities associated with GMP ward ;
- 4 = In NHS hospital: delivery facilities associated with consultant and GMP ward ;

5 = In private hospital ;

6 = In other hospital or institution ;

7 = In NHS hospital: ward or unit without delivery facilities ;

8 = Other than those above ;

9 = Not known ;

null = Not applicable (from 1990-91 to 1995-96)

Rule

Rules 710 and 750



Dataset: Admitted Patient Care

Alternative Delivery method (Derived) (DELMETH_D)

Field DELMETH_D

Field Name Alternative Delivery method (Derived)

Category Maternity

Length and format 2n or X

Availability All years

Description

This field contains a code which defines the method used to deliver a baby that is a registrable birth.

This data item is derived from the main procedure code.

Value

- 01 = Elective caesarean delivery;
- 02 = Other/emergency caesarean delivery;
- 03 = Breech extraction delivery;
- 04 = Other breech delivery;
- 05 = Low forceps cephalic delivery;

06 = Other Forceps Delivery;

07 = Ventouse (Vacuum) delivery;

08 = Spontaneous other delivery;

09 = Normal delivery (Spontaneous vertex);

10 = Other methods of delivery;

X = Not known

Rule

Rule 765



Dataset: Admitted Patient Care

Delivery method (DELMETH_N)

Field	DELMETH_N
Field Name	Delivery method
Category	Maternity
Length and format	1n or X
Availability	All years
Description	

This field contains a code which defines the method used to deliver a baby that is a registrable birth. The code is obtained from the ICD classification for delivery method. This item appears for each baby on multiple birth delivery records.

Value

- 0 = Spontaneous vertex (normal vaginal delivery, occipitoanterior) ;
- 1 = Spontaneous other cephalic (cephalic vaginal delivery with abnormal presentation of head at delivery, without instruments, with or without manipulation) ;
- 2 = Low forceps, not breech, including forceps delivery not otherwise specified (forceps, low application, without manipulation) ;
- 3 = Other forceps, not breech, including high forceps and mid forceps (forceps with manipulation) ;

4 = Ventouse, vacuum extraction ;

5 = Breech, including partial breech extraction (spontaneous delivery assisted or unspecified)
;

6 = Breech

7 = Elective caesarean section

8 = Emergency caesarean section

9 = Other

X = Not known

Rule

Rules 710, 753 and 770



Dataset: Admitted Patient Care

Labour/delivery onset method (DELONSET)

Field	DELONSET
Field Name	Labour/delivery onset method
Category	Maternity
Length and format	1n
Availability	All years
Description	

This field contains a code which defines the method used to induce (initiate) labour, rather than to accelerate it.

Value

- 1 = Spontaneous: the onset of regular contractions whether or not preceded by spontaneous rupture of the membranes ;
- 2 = Any caesarean section carried out immediately following the onset of labour, when the decision was made before labour ;
- 3 = Surgical induction by amniotomy ;
- 4 = Medical induction, including the administration of agents either orally, intravenously or intravaginally with the intention of initiating labour ;

5 = Combination of surgical induction and medical induction ;

8 = Not applicable (from 1996-97 onwards) ;

9 = Not known: validation error ;

null = Not applicable (from 1990-91 to 1994-95)

Rule	Rules 710 and 750
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Dataset: Admitted Patient Care

Delivery place (actual) (DELPLAC_N)

Field DELPLAC_N

Field Name Delivery place (actual)

Category Maternity

Length and format 1n

Availability All years

Description

This field contains a code which defines the actual type of delivery place (The intended delivery place is in delintn). This item appears for each baby on multiple birth delivery records.

Value

0 = In NHS hospital: delivery facilities associated with midwife ward ;

1 = At a domestic address ;

2 = In NHS hospital: delivery facilities associated with consultant ward ;

3 = In NHS hospital: delivery facilities associated with GMP ward ;

4 = In NHS hospital: delivery facilities associated with consultant, GMP or midwife ward, or any combination of two of these ;

5 = In private hospital ;

6 = In other hospital or institution ;

7 = In NHS hospital: ward or unit without delivery facilities ;

8 = Other than those above ;

9 = Not known

Rule

Rules 710, 753 and 770



Dataset: Admitted Patient Care

Anaesthetic given post-labour or delivery (DELPOSAN)

Field	DELPOSAN
Field Name	Anaesthetic given post-labour or delivery
Category	Maternity
Length and format	1n
Availability	All years
Description	

This field contains a code which defines the anaesthetic or analgesic administered after delivery.

Value

- 1 = General anaesthetic: the administration by a doctor of an agent to produce unconsciousness ;
- 2 = Epidural or caudal anaesthetic: the injection of a local anaesthetic into the epidural space ;
- 3 = Spinal anaesthetic: the injection of a local anaesthetic agent into the subarachnoid space ;
- 4 = General anaesthetic and epidural or caudal anaesthetic ;

5 = General anaesthetic and spinal anaesthetic ;

6 = Epidural or caudal, and spinal anaesthetic ;

7 = Other than 1 to 6 ;

8 = Not applicable ;

9 = Not known ;

null = Not applicable (from 1990-91 to 1994-95)

Rule

Rule 730



Dataset: Admitted Patient Care

Anaesthetic given during labour or delivery (DELPREAN)

Field	DELPREAN
Field Name	Anaesthetic given during labour or delivery
Category	Maternity
Length and format	1n
Availability	All years
Description	

This field contains a code which defines the anaesthetic or analgesic administered before and during labour and delivery.

Value

1 = General anaesthetic: the administration by a doctor of an agent to produce unconsciousness ;

2 = Epidural or caudal anaesthetic: the injection of a local anaesthetic into the epidural space ;

3 = Spinal anaesthetic: the injection of a local anaesthetic agent into the subarachnoid space ;



4 = General anaesthetic and epidural or caudal anaesthetic ;

5 = General anaesthetic and spinal anaesthetic ;

6 = Epidural or caudal, and spinal anaesthetic ;

7 = Other than 1 to 6 ;

8 = Not applicable ;

9 = Not known ;

null = Not applicable (from 1990-91 to 1994-95)

Rule

Rule 730



Dataset: Admitted Patient Care

Status of person conducting delivery (DELSTAT_N)

Field	DELSTAT_N
Field Name	Status of person conducting delivery
Category	Maternity
Length and format	1n
Availability	All years
Description	

This field normally provides the status of the person conducting the delivery. When a student delivers the baby, the code of the supervisor should be given. This item appears for each baby on multiple birth delivery records.

Value

- 1 = Hospital doctor ;
- 2 = General practitioner ;
- 3 = Midwife ;
- 8 = Other than above ;
- 9 = Not known: validation error

Rule

Rules 710, 753 and 770



Dataset: Admitted Patient Care

High-dependency care level (DEPDAYS)

Field	DEPDAYS
Field Name	High-dependency care level
Category	Augmented/critical care period
Length and format	4n
Availability	1997-98 to 2005-06
Description	

This field contains the number of days of high dependency care in a period of augmented care.

Value

4n = Number of days in the range 000 to 9998

9999 = Not known: a validation error

Rule	Rule 1030
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Dataset: Admitted Patient Care

Date detention commenced check flag (DET_CFL)

Field	DET_CFL
Field Name	Date detention commenced check flag
Category	Psychiatric
Length and format	1n
Availability	All years
Description	
Validation of date detention commenced.	
Value	
0 = Valid (or missing because not required) ; 1 = Missing ; 2 = Invalid	
Rule	Not applicable (derived by rule 110)



Dataset: Admitted Patient Care

Duration of detention (DETDUR)

Field DETDUR

Field Name Duration of detention

Category Psychiatric

Length and format 5n

Availability All years

Description

This derived field contains the number of days between the date the current detention commenced (detndate) and the date of the psychiatric census (31 March of cendate). The maximum period is 29,200 days (approximately 80 years).

Value

5n = Duration of detention in days at census date from 0 to 29,200 ;

null = Not applicable (epitype is not 4) / not known

Rule Not applicable (derived by rule 890)



Dataset: Admitted Patient Care

Detention category (DETNCAT)

Field	DETNCAT
Field Name	Detention category
Category	Psychiatric
Length and format	1n
Availability	1999-00 onwards
Description	

Indicates the legislation under which the patient was detained. The Detention category (detncat) field contains sensitive data. Access to it requires the approval of the Data Access Advisory Group (DAAG).

Value

- 0 = Informal, not formally detained ;
- 1 = Formally detained under Part II, Mental Health Act 1983 ;
- 2 = Formally detained under Part III, Mental Health Act 1983, and other legislation ;
- 3 = Formally detained under Part X, Mental Health Act 1983

Rule	Not applicable
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Dataset: Admitted Patient Care

Date detention commenced (DETNDATE)

Field	DETNDATE
Field Name	Date detention commenced
Category	Psychiatric
Length and format	dd/mm/yyyy (Date)
Availability	All years
Description	

For patients under a detention order at the date of the census, this field contains the date at which the first order commenced in the current continuous period of detention. Where the detention order is held by a hospital other than where the patient is at the date of the census, the latter is responsible for obtaining information relating to the detention order, and submitting the data.

Value

2012/13 onwards:

01/01/1800 - null date submitted

01/01/1801 - invalid date submitted

1989/90 to 2011/12:



01/01/1600 – null date submitted

15/10/1582 – invalid date submitted

Rule

Rule 110



Dataset: Admitted Patient Care

3 character concatenated diagnosis (DIAG_3_CONCAT)

Field	DIAG_3_CONCAT
Field Name	3 character concatenated diagnosis
Category	Clinical
Length and format	79n
Availability	All years
Description	

Provides a concatenated string of all diagnosis codes at a 3 character level - this enables the user to search across the full list of diagnoses to look at mentions and pairs of diagnosis codes.

Value

All 3-character codes present separated by a comma, no spaces. I.e. 79n for APC (20 diag ordinals)

Rule	Rule 8001a
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Dataset: Admitted Patient Care

Diagnosis - 3 characters (DIAG_3_NN)

Field	DIAG_3_NN
Field Name	Diagnosis - 3 characters
Category	Clinical
Length and format	3an
Availability	All years
Description	

This provides the first three characters of diagnosis codes.

Value

3an = A valid ICD-9 or ICD-10 diagnosis code

null = Not applicable

Rule	Not applicable (derived from a cleaned field)
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Dataset: Admitted Patient Care

4 character concatenated diagnosis (DIAG_4_CONCAT)

Field	DIAG_4_CONCAT
Field Name	4 character concatenated diagnosis
Category	Clinical
Length and format	99n
Availability	All years
Description	<p>Provides a concatenated string of all diagnosis codes at a 4 character level - this enables the user to search across the full list of diagnoses to look at mentions and pairs of diagnosis codes.</p>
Value	<p>All 4-character codes present separated by a comma, no spaces. I.e. 99n for APC (20 diag ordinals)</p>
Rule	Rule 8001a



Dataset: Admitted Patient Care

Diagnosis - 4 characters (DIAG_4_NN)

Field	DIAG_4_NN
Field Name	Diagnosis - 4 characters
Category	Clinical
Length and format	4an
Availability	All years
Description	

This provides the first four characters of diagnosis codes.

Value

4an = A valid ICD-9 or ICD-10 diagnosis code

null = Not applicable

Rule	Not applicable (derived from a cleaned field)
------	---

Dataset: Admitted Patient Care

Count of diagnoses (DIAG_COUNT)

Field	DIAG_COUNT
Field Name	Count of diagnoses
Category	Diagnosis
Length and format	2n
Availability	All years
Description	

This provides a total count of diagnoses for a particular episode (up to 20 APC)

Value

2n = Number of diagnosis codes present for episode

Rule Rule 8100b



Dataset: Admitted Patient Care

All Diagnosis codes (DIAG_NN)

Field DIAG_NN

Field Name All Diagnosis codes

Category Clinical

Length and format 6an

Availability All years

Description

There are twenty fields (fourteen before April 2007 and seven before April 2002), diag_01 to diag_20, which contain information about a patient's illness or condition. The field diag_01 contains the primary diagnosis. The other fields contain secondary/subsidiary diagnoses. The codes are defined in the International Statistical Classification of Diseases, Injuries and Causes of Death. HES records currently use the tenth revision (ICD-10). Prior to April 1995, the ninth revision was used (ICD-9). Diagnosis codes start with a letter and are followed by two or three digits. The third digit identifies variations on a main diagnosis code containing two digits. The third digit is preceded by a full stop in ICD-10, but this is not stored in the field.

Value

annnna = A valid ICD-9 or ICD-10 diagnosis code

annnnn = A valid ICD-9 or ICD-10 diagnosis code

null = not applicable

Rule	Rules 455, 460, 470, 490, 500, 510, 530, 630, 640, 840 and 850 and 860
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Dataset: Admitted Patient Care

Discharge date check flag (DIS_CFL)

Field	DIS_CFL
Field Name	Discharge date check flag
Category	Discharges ; Period of care
Length and format	1n
Availability	All years
Description	

Codes in this field indicate whether the discharge date (disdate) is valid.

Value

0 = Valid (or missing because not required) ;

1 = Missing ;

2 = Invalid

Rule	Not applicable (derived by rules Rules 205, 210, 220 and 223)
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Dataset: Admitted Patient Care

Date of discharge (DISDATE)

Field	DISDATE
Field Name	Date of discharge
Category	Discharges ; Period of care
Length and format	dd/mm/yyyy (Date)
Availability	All years
Description	

This field contains the date on which the patient was discharged from hospital. ; It is only present in the record for the last episode of a spell.

Value

2012/13 onwards:

01/01/1800 - null date submitted

01/01/1801 - invalid date submitted

1989/90 to 2011/12:

01/01/1600 – null date submitted

15/10/1582 – invalid date submitted

Rule	Rules 170, 205, 210, 220 and 223
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Dataset: Admitted Patient Care

Date of discharge - Uncleaned (DISDATE_UNCLN)

Field	DISDATE_UNCLN
Field Name	Date of discharge - Uncleaned
Category	Discharges ; Period of care
Length and format	dd/mm/yyyy (Date)
Availability	All years
Description	<p>This field contains the date on which the patient was discharged from hospital. This field contains the value of DISDATE that was originally submitted with the record and hence may be different from DISDATE if this has been cleaned.</p>
Value	<p>dd/mm/yyyy = Date ; null = Date not known / not applicable</p>
Rule	Rule 6



Dataset: Admitted Patient Care

Destination on discharge (DISDEST)

Field	DISDEST
Field Name	Destination on discharge
Category	Discharges ; Period of care
Length and format	2n
Availability	All years
Description	

This field contains a code which identifies where the patient was due to go on leaving hospital. In most cases they return home. For many patients discharge destination is the same as source of admission (admisorc).

Value

- 19 = The usual place of residence, including no fixed abode ;
- 29 = Temporary place of residence when usually resident elsewhere, for example, hotels and residential educational establishments ;
- 30 = Repatriation from high security psychiatric hospital (from 1999-2000) ;
- 37 = Penal establishment - court (from 1999-2000) ;
- 38 = Penal establishment - police station (from 1999-2000) ;

- 39 = Penal establishment - court and police station excluded (from 1999-2000) ;
- 48 = High security psychiatric hospital, Scotland (from 1999-2000) ;
- 49 = NHS other hospital provider - high security psychiatric
- 50 = NHS other hospital provider - medium secure unit
- 51 = NHS other hospital provider - ward for general PATIENTS or the younger physically disabled
- 52 = NHS other hospital provider - ward for maternity PATIENTS or Neonates
- 53 = NHS other hospital provider - ward for PATIENTS who are mentally ill or have learning disabilities
- 54 = NHS run Care Home
- 65 = Local Authority residential accommodation i.e. where care is provided
- 66 = Local Authority foster care
- 79 = Not applicable - PATIENT died or still birth
- 84 = Non-NHS run hospital - medium secure unit
- 85 = Non-NHS (other than Local Authority) run Care Home
- 87 = Non-NHS run hospital
- 88 = Non-NHS (other than Local Authority) run Hospice
- 98 - Not applicable
- 99 - Not Known

Rule	Rules 205, 210, 220 and 223
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Dataset: Admitted Patient Care

Destination on discharge - uncleaned (DISDEST_UNCLN)

Field	DISDEST_UNCLN
Field Name	Destination on discharge - uncleaned
Category	Discharges ; Period of care
Length and format	2n
Availability	All years
Description	

This field contains a code which identifies where the patient was due to go on leaving hospital. This field contains the value of DISDEST that was originally submitted with the record and hence may be different from DISDEST if this has been cleaned.

Value

- 19 = The usual place of residence, including no fixed abode ;
- 29 = Temporary place of residence when usually resident elsewhere, for example, hotels and residential educational establishments ;
- 30 = Repatriation from high security psychiatric hospital (from 1999-2000) ;
- 37 = Penal establishment - court (from 1999-2000) ;

- 38 = Penal establishment - police station (from 1999-2000) ;
- 39 = Penal establishment - court and police station excluded (from 1999-2000) ;
- 48 = High security psychiatric hospital, Scotland (from 1999-2000) ;
- 49 = NHS other hospital provider - high security psychiatric
- 50 = NHS other hospital provider - medium secure unit
- 51 = NHS other hospital provider - ward for general PATIENTS or the younger physically disabled
- 52 = NHS other hospital provider - ward for maternity PATIENTS or Neonates
- 53 = NHS other hospital provider - ward for PATIENTS who are mentally ill or have learning disabilities
- 54 = NHS run Care Home
- 65 = Local Authority residential accommodation i.e. where care is provided
- 66 = Local Authority foster care
- 79 = Not applicable - PATIENT died or still birth
- 84 = Non-NHS run hospital - medium secure unit
- 85 = Non-NHS (other than Local Authority) run Care Home
- 87 = Non-NHS run hospital
- 88 = Non-NHS (other than Local Authority) run Hospice
- 98 - Not applicable
- 99 - Not Known

Rule

Rule 6



Dataset: Admitted Patient Care

Discharge episode flag (DISFLAG)

Field	DISFLAG
Field Name	Discharge episode flag
Category	Patient Data
Length and format	1a
Availability	All years
Description	
Codes in this field indicate whether the episode is a discharge episode.	
Value	
Y = Episode is a discharge episode, ie discharge method is 1-5 ; N = Episode is not a discharge episode	
Rule	None



Dataset: Admitted Patient Care

Method of discharge (DISMETH)

Field	DISMETH
Field Name	Method of discharge
Category	Discharges ; Period of care
Length and format	1n
Availability	All years
Description	

This field contains a code which defines the circumstances under which a patient left hospital. For the majority of patients this is when they are discharged by the consultant. This field is only completed for the last episode in a spell.

Value

- 1 = Discharged on clinical advice or with clinical consent ;
- 2 = Self discharged, or discharged by a relative or advocate ;
- 3 = Discharged by a mental health review tribunal, the Home Secretary or a court ;
- 4 = Died ;
- 5 = Baby was still born ;
- 8 = Not applicable: patient still in hospital ;

9 = Not known: a validation error

Rule	Rules 205, 210, 220, 223 and 320
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Dataset: Admitted Patient Care

Method of discharge - uncleaned (DISMETH_UNCLN)

Field	DISMETH_UNCLN
Field Name	Method of discharge - uncleaned
Category	Discharges ; Period of care
Length and format	1n
Availability	All years
Description	

This field contains a code which defines the circumstances under which a patient left hospital. This field contains the value of DISMETH that was originally submitted with the record and hence may be different from DISMETH if this has been cleaned.

Value

- 1 = Discharged on clinical advice or with clinical consent ;
- 2 = Self discharged, or discharged by a relative or advocate ;
- 3 = Discharged by a mental health review tribunal, the Home Secretary or a court ;
- 4 = Died ;
- 5 = Baby was still born ;
- 8 = Not applicable: patient still in hospital ;

9 = Not known: a validation error

Rule

Rule 6



Dataset: Admitted Patient Care

Discharge ready date (DISREADYDATE)

Field	DISREADYDATE
Field Name	Discharge ready date
Category	Discharges ; Period of care
Length and format	dd/mm/yyyy (Date)
Availability	2007-08 onwards
Description	
<p>The date that a patient was medically ready for discharge from a hospital bed, but couldn't be discharged, therefore qualifying for delayed discharge payments.</p>	
Value	
<p>dd/mm/yyyy = discharge ready date</p>	
Rule	Data not cleaned



Dataset: Admitted Patient Care

Date of birth - patient (DOB)

Field DOB

Field Name Date of birth - patient

Category Patient Data

Length and format dd/mm/yyyy (Date)

Availability All years

Description

This field contains the patient's date of birth. For most enquiries the field startage (age at start of episode) is used. The Date of birth - patient (dob) field contains sensitive data.

Value

2012/13 onwards:

01/01/1800 - null date submitted

01/01/1801 - invalid date submitted

1989/90 to 2011/12:

01/01/1600 – null date submitted

15/10/1582 – invalid date submitted

Rule	Rule 20
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Dataset: Admitted Patient Care

Date of birth check flag - patient (DOB_CFL)

Field DOB_CFL

Field Name Date of birth check flag - patient

Category Patient Data

Length and format 1n

Availability All years

Description

Validation of patient's date of birth.

Value

0 = Valid (or missing because not required) ;

1 = Missing ;

2 = Invalid

Rule Not applicable (derived by rule 20)



Dataset: Admitted Patient Care

Birth date (baby) (DOBBABY_N)

Field	DOBBABY_N
Field Name	Birth date (baby)
Category	Maternity
Length and format	dd/mm/yyyy (Date)
Availability	All years
Description	
Baby's date of birth. This item appears for each baby on multiple birth delivery records. The Birth date - baby (dobbaby) field contains sensitive data.	
Value	
dd/mm/yyyy = Date of birth	
Null = Invalid/Not Known	
Rule	Rule 670 and 770



Dataset: Admitted Patient Care

Trust derived dominant procedure (DOMPROC)

Field	DOMPROC
Field Name	Trust derived dominant procedure
Category	Healthcare resource groups (HRG) data
Length and format	4an, - or &
Availability	2001-02 to 2008-09
Description	

Contains the dominant procedure (operation) code assigned as part of the (NHS) HRG derivation process and submitted to SUS.

Value

4an = Procedure code ;
- = No operation performed ;
& = Not known

Rule 570



Dataset: Admitted Patient Care

Earliest reasonable date offered (EARLDATOFF)

Field	EARLDATOFF
Field Name	Earliest reasonable date offered
Category	Patient Pathway
Length and format	dd/mm/yyyy (Date)
Availability	2008-09 onwards
Description	

The earliest reasonable (as defined by hospital staff; where a patient accepts an offer date the date is deemed reasonable) appointment or admission date offered. Where a patient cancels an appointment or offer for admission, the earliest reasonable offer date for the rearranged appointment/admission will remain as the earliest reasonable offer date of the cancelled appointment/admission. Where the healthcare provider cancels and rearrange an appointment/admission date, the earliest reasonable offer date for the re-arranged appointment/admission will be the date of the earliest reasonable offer made following cancellation.

Value

dd/mm/yyyy = earliest reasonable date offered

Rule Data not cleaned





Dataset: Admitted Patient Care

Date of decision to admit check flag (ELEC_CFL)

Field	ELEC_CFL
Field Name	Date of decision to admit check flag
Category	Admissions ; Period of care
Length and format	1n
Availability	All years
Description	
Codes in this field indicate whether the decision to admit date is valid.	
Value	
<p>0 = Valid (or missing because not required)</p> <p>1 = Missing</p> <p>2 = Invalid</p>	
Rule	Not applicable (derived by Rules 40 and 45)



Dataset: Admitted Patient Care

Date of decision to admit (ELECDATE)

Field	ELECDATE
Field Name	Date of decision to admit
Category	Admissions ; Period of care
Length and format	dd/mm/yyyy (Date)
Availability	All years
Description	

This field contains the date on which a consultant, or another member of the clinical staff, decided to admit the patient to a hospital. The patient may or may not be admitted immediately. The time between elecdate and admidate (admission date) is known as the waiting time.

Value

2012/13 onwards:

01/01/1800 - null date submitted

01/01/1801 - invalid date submitted

1989/90 to 2011/12:

01/01/1600 – null date submitted

15/10/1582 – invalid date submitted

Rule

Rules 40 and 45



Dataset: Admitted Patient Care

Waiting time (ELECDUR)

Field	ELECDUR
Field Name	Waiting time
Category	Admissions ; Period of care
Length and format	4n
Availability	All years
Description	<p>This field contains the difference in days between the date on which it was decided to admit the patient (elecdate) and the actual admission date (admidate). Elecdur is only applicable where an elective admission (ie the admission method is 11, 12 or 13) was scheduled and took place.</p>
Value	<p>4n = Waiting time in days from 1 to 8887</p> <p>null = Other maternity events / not known</p>
Rule	





Dataset: Admitted Patient Care

Calculation of Elecdur (ELECDUR_CALC)

Field	ELECDUR_CALC
Field Name	Calculation of Elecdur
Category	Admissions ; Period of care
Length and format	TBC
Availability	All years
Description	
This field returns the elecdur but excludes admissions from emergency, so only includes eledur where the method of admission (admimeth) is 11 or 12	
Value	
TBC	
Rule	Rule 8009



Dataset: Admitted Patient Care

Waiting time - derived (ELECDURD)

Field	ELECDURD
Field Name	Waiting time - derived
Category	Admissions ; Period of care
Length and format	4n
Availability	All years
Description	

This derived field contains the difference in days between the date on which it was decided to admit the patient (elecdate) and the actual admission date (admidate). Elecdur is only applicable where an elective admission (ie the admission method is 11, 12 or 13) was scheduled and took place.

Value

4n = Waiting time in days from 1 to 8887

null = Other maternity events / not known

Rule	Rule 271
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Dataset: Admitted Patient Care

Age at end of episode (ENDAGE)

Field	ENDAGE
Field Name	Age at end of episode
Category	Patient Data
Length and format	4n
Availability	All years
Description	

This derived field contains the patient's age in whole years at the end of a finished episode (from 1 to 115 (1990-91 to 1994-95) and from 1 to 120 (1995-96 onwards)). It is calculated from the episode end date (epiend) and the patient's date of birth (dob). For unfinished episodes it is calculated using the period end date, i.e. 31st March, instead of epiend. For patients under one year old, special codes apply.

Value

Add value 3n = age in years

7001 = Less than 1 day ;

7002 = 1 to 6 days ;

7003 = 7 to 28 days ;



7004 = 29 to 90 days (under 3 months) ;

7005 = 91 to 181 days (approximately 3 months to under 6 months) ;

7006 = 182 to 272 days (approximately 6 months to under 9 months) ;

7007 = 273 to 365 days (approximately 9 months to under 1 year) ;

null = Not applicable (other maternity event or not known)

Rule	Not applicable (derived by rule 280)
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Dataset: Admitted Patient Care

Episode duration (EPIDUR)

Field	EPIDUR
Field Name	Episode duration
Category	Episodes and spells ; Period of care
Length and format	5n
Availability	All years
Description	

This field contains the difference in days between the episode start date (epistart) and the episode end date (epiend).

Value

5n = Duration of episode in days from 0 to 29,200 ;
null = Not applicable (other maternity event or not known)

Rule 251



Dataset: Admitted Patient Care

Episode end date check flag (EPIE_CFL)

Field	EPIE_CFL
Field Name	Episode end date check flag
Category	Episodes and spells ; Period of care
Length and format	1n
Availability	All years
Description	

This field validates the episode end date (epiend).

Value

0 = Valid (or missing because not required) ;

1 = Missing ;

2 = Invalid

Rule	Not applicable
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Dataset: Admitted Patient Care

Date episode ended (EPIEND)

Field	EPIEND
Field Name	Date episode ended
Category	Episodes and spells ; Period of care
Length and format	dd/mm/yyyy (Date)
Availability	All years
Description	

This field contains the date on which a patient left the care of a particular consultant, for one of the following reasons: Discharged from hospital (includes transfers) or moved to the care of another consultant. A null entry either indicates that the episode was unfinished at the end of the data year, or the date was unknown.

Value

2012/13 onwards:

01/01/1800 - null date submitted

01/01/1801 - invalid date submitted

1989/90 to 2011/12:

01/01/1600 – null date submitted

15/10/1582 – invalid date submitted

Rule

Rules 190, 200 and 203 and 1250



Dataset: Admitted Patient Care

Record identifier (EPIKEY)

Field	EPIKEY
Field Name	Record identifier
Category	System Data
Length and format	14n
Availability	All years
Description	<p>This is a record identifier that is created by the HES system. The digits store a decimal number. This is commonly eight or nine digits but can be up to 14.</p>
Value	
	14n = Record identifier
Rule	Not applicable



Dataset: Admitted Patient Care

Episode order (EPIORDER)

Field	EPIORDER
Field Name	Episode order
Category	Episodes and spells ; Period of care
Length and format	2n
Availability	All years
Description	

This field contains the number of the episode within the current spell. All spells start with an episode where epiorder is 01. Many spells finish with this episode, but if the patient moves to the care of another consultant, a new episode begins. Episode numbers increase by 1 for each new episode until the patient is discharged (this includes transfers to another NHS trust or primary care trust - ie the first episode in the new trust will have epiorder 01). If the same patient returns for a different spell in hospital, epiorder is again set to 01. Admissions are calculated by counting the number of times epiorder is 01. When studying long term care, remember that it is not unusual to transfer psychiatric patients from one hospital to another.

Value

2n = The number of the episode in the sequence of episodes from 01-87 ;
98 = Not applicable ;

99 = Not known ;

null = Not applicable: other maternity event

Rule

Rules 130, 140 and 320



Dataset: Admitted Patient Care

Episode start date check flag (EPIS_CFL)

Field	EPIS_CFL
Field Name	Episode start date check flag
Category	Episodes and spells ; Period of care
Length and format	1n
Availability	All years
Description	

This field validates the episode start date (epistart).

Value

0 = Valid (or missing because not required) ;

1 = Missing ;

2 = Invalid

Rule	Not applicable (derived by rule 30)
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Dataset: Admitted Patient Care

Date episode started (EPISTART)

Field	EPISTART
Field Name	Date episode started
Category	Episodes and spells ; Period of care
Length and format	dd/mm/yyyy (Date)
Availability	All years
Description	

This field contains the date on which a patient was under the care of a particular consultant. If a patient has more than one episode in a spell, for each new episode there is a new value of epistart. However, the admission date which is copied to each new episode in a spell will remain unchanged and will be equal to the episode start date of the first episode in hospital.

Value

2012/13 onwards:

01/01/1800 - null date submitted

01/01/1801 - invalid date submitted

1989/90 to 2011/12:



01/01/1600 – null date submitted	
15/10/1582 – invalid date submitted	
Rule	Rule 30



Dataset: Admitted Patient Care

Episode status (EPISTAT)

Field	EPISTAT
Field Name	Episode status
Category	Episodes and spells ; Period of care
Length and format	1n
Availability	All years
Description	

This field tells you whether the episode had finished before the end of the HES data-year (ie whether the episode was still 'live' at midnight on 31 March). For example, if a patient was admitted on 25 March 2005 and was not discharged (or transferred to the care of another consultant) until 4 April 2005, there will be a record describing the unfinished episode (episode status = 1) in the 2004-05 data, and a separate record describing the finished episode (episode status = 3) in the 2005-06 data. Because hospital providers are advised not to include clinical data (diagnosis and operation codes) in unfinished records, these are normally excluded from analyses. Also, if unfinished episodes are included in time series analyses - where data for more than one year is involved - there is a danger of counting the same episode twice.

Value

1 = Unfinished ;



3 = Finished ;

9 = Derived unfinished (not present on processed data)

Rule

Rules 170 & 180



Dataset: Admitted Patient Care

Episode type (EPITYPE)

Field	EPITYPE
Field Name	Episode type
Category	Episodes and spells ; Period of care
Length and format	1n
Availability	All years
Description	

This field contains a code that defines the type of episode, so that groups of similar episodes can be formed.

Value

- 1 = General episode (anything that is not covered by the other codes) ;
- 2 = Delivery episode ;
- 3 = Birth episode ;
- 4 = Formally detained under the provisions of mental health legislation or long-term (over one year) psychiatric patients who should have additional information recorded on the psychiatric census. This value can only appear in unfinished records (Episode Status (EPISTAT) = 1)
- 5 = Other delivery event ;

6 = Other birth event	
Rule	Rules 150 & 160



Dataset: Admitted Patient Care

Ethnic category (ETHNOS)

Field	ETHNOS
Field Name	Ethnic category
Category	Patient Data
Length and format	1n or X
Availability	All years
Description	

This field contains a code that specifies some ethnic groups and some nationalities. It was introduced from the 1995-96 data year.

From April 2001 the codes were changed to conform to the 2001 census classification. However, HES continued to accept the old codes as well as the new codes for the 2001-02 and 2002-03 data years.

Ethnic Category has been mandatory for Admitted Patient Care Commissioning Dataset central returns since 1995. However birth episodes, and other CDS types have been optional.

From April 2009 Ethnic Category will be mandatory for all CDS types. I.e. to include: birth episodes; unfinished birth episodes; other birth event types; Out Patient CDSs and Accident and Emergency CDSs.

Note: 'Z – not stated' means that the person had been asked and had declined either refusing to provide this information, or a genuine inability to choose. 'X – Not known'

means that the person has not been asked or the patient was not in a condition to be asked. E.g. unconscious.

Value

From 2001-02 onwards:

A = British (White)

B = Irish (White)

C = Any other White background

D = White and Black Caribbean (Mixed)

E = White and Black African (Mixed)

F = White and Asian (Mixed)

G = Any other Mixed background

H = Indian (Asian or Asian British)

J = Pakistani (Asian or Asian British)

K = Bangladeshi (Asian or Asian British)

L = Any other Asian background

M = Caribbean (Black or Black British)

N = African (Black or Black British)

P = Any other Black background

R = Chinese (other ethnic group)

S = Any other ethnic group

Z = Not stated



99 = Not known

From 1995-96 to 2000-01:

0= White

1 = Black - Caribbean

2 = Black - African

3 = Black - Other

4 = Indian

5 = Pakistani

6 = Bangladeshi

7 = Chinese

8 = Any other ethnic group

9 = Not given

99 = Not known

Rule

Rule 10



Dataset: Admitted Patient Care

Ethnic character (audit version) (ETHRAW)

Field	ETHRAW
Field Name	Ethnic character (audit version)
Category	System Data
Length and format	1a
Availability	2003-04 onwards
Description	

Ethnic character is supplied by the trusts as a two-character field. Ethraw contains the left-hand character. The right hand character being available for local use. A copy of the raw data found in the right hand character is held in ethrawl.

Value

A = British (white) ;
 B = Irish (white) ;
 C = Any other white background ;
 D = White and Black Caribbean (mixed) ;
 E = White and Black African (mixed) ;
 F = White and Asian (mixed) ;

G = Any other mixed background ;
H = Indian (Asian or Asian British) ;
J = Pakistani ;
K = Bangladeshi (Asian or Asian British) ;
L = Any other Asian background ;
M = Caribbean (Black or Black British) ;
N = African (Black or Black British) ;
P = Any other Black background ;
R = Chinese (other ethnic group) ;
S = Any other ethnic group ;
X = Not known ;
Z = Not stated

RuleNone

Dataset: Admitted Patient Care

Ethnic category (audit version) (ETHRAWL)

Field	ETHRAWL
Field Name	Ethnic category (audit version)



Category	System Data
Length and format	1an
Availability	2003-04 onwards
Description	<p>Ethnic category is supplied by the trusts as a two-character field. Ethrawl contains the right-hand character. The left-hand character should contain the national code. A copy of the raw data found in the left hand character is held in ethraw.</p>
Value	<p>9 = Not Known (if ethraw also = 9)</p>
Rule	None



Dataset: Admitted Patient Care

Finished Admission Episode (FAE)

Field	FAE
Field Name	Finished Admission Episode
Category	Episodes and spells ; Period of care
Length and format	
Availability	All years
Description	
Value	
Rule	



Dataset: Admitted Patient Care

Finished Admission Episode, emergency classification (FAE_EMERGENCY)

Field	FAE_EMERGENCY
Field Name	Finished Admission Episode, emergency classification
Category	Episodes and spells ; Period of care
Length and format	1an
Availability	All years
Description	<p>Finished Admission Episode Flag where admission to hospital is from an emergency admission. This is set to the value of 1 for the admission episode where Patient Classification is 1,2 or 5 AND admission method begins with a 2*</p>
Value	<p>1an</p> <p>1 = Finished Admission Episode Flag where admission to hospital is from an emergency admission</p> <p>0 = All other episodes</p>
Rule	Rule 8010



Dataset: Admitted Patient Care

Finished Consultant Episode (FCE)

Field	FCE
Field Name	Finished Consultant Episode
Category	Episodes and spells ; Period of care
Length and format	
Availability	All years
Description	
Value	
Rule	



Dataset: Admitted Patient Care

Finished consultant episode flag (FCEFLAG)

Field FCEFLAG

Field Name Finished consultant episode flag

Category Patient Data

Length and format 1a

Availability All years

Description

Codes in this field indicate whether the episode is a finished consultant episode.

Value

Y = Episode is finished, ie episode status equals 3 ;

N = Episode status is not equal to 3

Rule None



Dataset: Admitted Patient Care

Finished In-Year Discharge Episode (FDE)

Field	FDE
Field Name	Finished In-Year Discharge Episode
Category	Episodes and spells ; Period of care
Length and format	1an
Availability	All years
Description	<p>Finished In-Year Discharge Episode flag. This is set to a value of 1 for the discharge episode where Patient Classification is 1,2 or 5 AND discharge method is 1-5</p>
Value	<p>1an</p> <p>1 = Finished In-Year Discharge Episode</p> <p>0 = All other episodes</p>
Rule	Rule 8010



Dataset: Admitted Patient Care

First regular day or night admission (FIRSTREG)

Field	FIRSTREG
Field Name	First regular day or night admission
Category	Admissions ; Period of care
Length and format	1n
Availability	2002-03 onwards
Description	

This field indicates whether the episode falls within a sequence of regular day and night admissions and, if so, whether it is the first or subsequent episode within the sequence.

Value

0 = First in a series

1 = Subsequent to first in a series

Rule	None
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Dataset: Admitted Patient Care

Financial Year (FYEAR)

Field	FYEAR
Field Name	Financial Year
Category	Episodes and spells ; Period of care
Length and format	4n
Availability	All years
Description	
Value	
4n = Financial Year	
Rule	



Dataset: Admitted Patient Care

Length of gestation (GESTAT)

Field GESTAT

Field Name Length of gestation

Category Maternity

Length and format 2n

Availability All years

Description

This is the number of weeks completed gestation, based upon an average 40 week gestation, which may be derived from:

- a) estimated date of delivery calculated by Ultrasound Scan measurements according to the trimester of the scan
- b) estimated date of delivery measured from the first day of last menstrual period (LMP)
- c) clinical assessment (in the absence of a or b) - antenatally for Maternity, postnatally for Neonatal

Value

2n = Number of weeks in the range 10 to 49 ;



99 = Not known: a validation error

Rule

Rules 710 and 753



Dataset: Admitted Patient Care

Government office region of treatment (GORTREAT)

Field	GORTREAT
Field Name	Government office region of treatment
Category	Geographical
Length and format	1a
Availability	2002-03 onwards
Description	

Government Office Region (GOR) of treatment. This field is derived from the hospital provider code (procode). It indicates the GOR area within which the treatment took place.

Value

A = North East ;
 B = North West ;
 D = Yorkshire and The Humber ;
 E = East Midlands ;
 F = West Midlands ;
 G = East of England ;

H = London ;

J = South East ;

K = South West ;

Y = Not known

Rule

Rule 1145



Dataset: Admitted Patient Care

Code of GP practice (GPPRAC)

Field	GPPRAC
Field Name	Code of GP practice
Category	Practitioner
Length and format	6an
Availability	1997-98 onwards
Description	

Code of GP Practice (registered GMP). This field was introduced for the 1997-98 data year. It contains a code which defines the practice of the patient's registered GP. It allows the GP to be notified about treatment given to the patient. The registered GP may not be the same as the referring GP.

Value

6an = GP's practice code (English GP's with codes commencing A-P only) ;

V81997 = No Registered General Practitioner Practice

V81998 = General Practitioner Practice Code not applicable

V81999 = General Practitioner Practice Code not known (submitted value)

& = Unknown (no code submitted)

Rule

Rule 440



Dataset: Admitted Patient Care

Health Authority area where patient's GP is registered (GPPRACHA)

Field	GPPRACHA
Field Name	Health Authority area where patient's GP is registered
Category	Organisation
Length and format	3an
Availability	1996-97 onwards
Description	
Provides the Health authority area in which the patient's GP is registered.	
Value	
aaa or aan = Health authority where patient's GP was registered ; Y = Unknown	
Rule	Not applicable (derived by rule 1110)



Dataset: Admitted Patient Care

Regional Office area where patient's GP was registered (GPPRACRO)

Field	GPPRACRO
Field Name	Regional Office area where patient's GP was registered
Category	Organisation
Length and format	3an
Availability	2002-03 onwards
Description	

Provides the Regional Office area in which the patient's GP is registered.

Value

Y01 = Northern and Yorkshire Regional Office ;

Y02 = Trent Regional Office ;

Y07 = West Midlands Regional Office ;

Y08 = North West Regional Office ;

Y09 = Eastern Regional Office ;

Y10 = London Regional Office ;



Y11 = South East Regional Office ;

Y12 = South West Regional Office ;

Y00 = Unknown

Rule

Not applicable (derived by rule 1120)



Dataset: Admitted Patient Care

Primary Care Trust area where patient's GP was registered (GPPRPCT)

Field	GPPRPCT
Field Name	Primary Care Trust area where patient's GP was registered
Category	Organisation
Length and format	3an
Availability	1997-98 onwards
Description	

This field gives details of the primary care trust area in which the patient's GP is registered.

Value

5nn = PCT

Taa = Care trust

59898 = Not applicable (non-England)

59999 = Unknown

Rule	Rule 1125
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Dataset: Admitted Patient Care

Strategic Health Authority area where patient's GP was registered (GPPRSTHA)

Field	GPPRSTHA
Field Name	Strategic Health Authority area where patient's GP was registered
Category	Organisation
Length and format	3an
Availability	1997-98 onwards
Description	

This field gives the strategic health authority (SHA) area in which the patient's GP is registered.

Value

3an = Strategic health authority ;

S = Scotland ;

U = England - Not Otherwise Specified ;

W = Wales ;

X = Foreign (including Isle of Man and Channel Islands) ;



Y = Unknown ;

Z = Northern Ireland

Rule

Rule 1125



Dataset: Admitted Patient Care

Ordnance Survey grid reference (GRIDLINK)

Field	GRIDLINK
Field Name	Ordnance Survey grid reference
Category	Geographical
Length and format	9n
Availability	2002-03 onwards
Description	

Ordnance survey postcode grid reference. Gridlink® is the name for a set of branded postcode products produced by the Gridlink Consortium (Royal Mail, Ordnance Survey (GB), General Register Office for Scotland (GROS), Ordnance Survey of Northern Ireland (OSNI) and ONS). The Gridlink field in HES is only available to the NHS. Access to it requires the approval of the Data Access Advisory Group (DAAG).

Value

9n = Ordnance survey grid reference (4 digits eastings, 5 digits northings)

Rule	Not applicable (derived by rule 1200)
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Dataset: Admitted Patient Care

Patient's health authority of residence, provided by NHS (HAR)

Field	HAR
Field Name	Patient's health authority of residence, provided by NHS
Category	Geographical
Length and format	3an
Availability	1999-00 onwards
Description	
The patient's health authority of residence provided by the NHS.	
Value	
<p>3an = Health authority of residence ;</p> <p>499 = Non-UK Provider ;</p> <p>X98 = Unknown</p>	
Rule	None



Dataset: Admitted Patient Care

Health Authority of treatment (HATREAT)

Field	HATREAT
Field Name	Health Authority of treatment
Category	Geographical
Length and format	3a
Availability	All years
Description	

This field indicates the health authority (HA) where the treatment took place. It is derived from the hospital provider code (procode). Health authority of treatment (contains the district health authority of treatment prior to 1 April 1996).

Value

3a = Health authority of treatment ;

Y = Unknown

Rule	Not applicable (derived by rule 1145)
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Dataset: Admitted Patient Care

Patient identifier - HES generated (HESID)

Field	HESID
Field Name	Patient identifier - HES generated
Category	Patient Data
Length and format	10n
Availability	1997-98 onwards
Description	

This field uniquely identifies a patient across all data years. It is generated by matching records for the same patient using a combination of NHS Number, local patient identifier, postcode, sex and date of birth.

Value

10n = Patient identifier – HES generated

Rule



Dataset: Admitted Patient Care

Patient ID - HES generated (original) (HESID_ORIG)

Field	HESID_ORIG
Field Name	Patient ID - HES generated (original)
Category	Patient Data
Length and format	10n
Availability	1997-98 onwards
Description	

Uniquely identifies a patient across all data years. It is generated by matching records for the same patient using a combination of NHS Number and local patient identifier, plus the patients' postcode, sex and date of birth.

Value

10n = Patient ID – HES generated

Rule



Dataset: Admitted Patient Care

Healthy Neonate Indicator (HNEOIND)

Field	HNEOIND
Field Name	Healthy Neonate Indicator
Category	Maternity
Length and format	1a
Availability	2011-12 onwards
Description	

This derived field is a flag to indicate a healthy baby based on episode type (EPITYPE) '3' (Birth Episode) and '6' (Other birth event) and SUS Generated HRG (SUSHRG) with a value of 'PB03Z' (Healthy Baby).

Value

Y = Healthy Neonate

N = Not Healthy Neonate

Rule derived by rule 830



Dataset: Admitted Patient Care

Postcode of patient (HOMEADD)

Field	HOMEADD
Field Name	Postcode of patient
Category	Patient Data
Length and format	8an
Availability	All years
Description	

This field normally contains the patient's home postcode. However, if a patient is away from home for long periods, such as in a university hall of residence, the postcode of their typical residence is used instead. If the postcode contains fewer than eight characters, spaces are placed between the two parts of the postcode so that the second part always starts at the sixth character position. The Postcode of patient (homeadd) field contains sensitive data. Access to it requires the approval of the Ethics and Confidentiality Committee (ECC).

Value

aann naa = Postcode ;

ZZ99 3CZ = England, GB, UK (not otherwise stated) ;

ZZ99 3VZ = No fixed abode ;



ZZ99 3WZ = Not known + sundry categories ;

ZZ99 2WZ = Northern Ireland ;

ZZ99 1WZ = Scotland ;

ZZ99 3GZ = Wales ;

ZZ99 NNN = Other pseudo codes used for patients normally resident abroad (where NNN is the country code listed in the NHS postcode directory)

Rule

Rule 330



Dataset: Admitted Patient Care

Healthcare resource group: version 3.1 (HRG_N.N)

Field	HRG_N.N
Field Name	Healthcare resource group: version 3.1
Category	Healthcare resource groups (HRG) data
Length and format	ann
Availability	2001-02 to 2008-09
Description	

This derived field contains healthcare resource group (HRG) values. HES adds the two most recent versions of HRG codes to records. For example, a record for 2004-05 will have codes for HRG version 3.1 and HRG version 3.5.

Value

3.1 = Applied HRG code from 1989-90 to 2005-06 inclusive ;

3.5 = Applied HRG code from 2003-04 onwards ;

4.0 = Applied HRG code from 2006-07 onwards ;

null = Not applicable



Rule	Not applicable
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Dataset: Admitted Patient Care

Trust derived HRG value (HRGNHS)

Field	HRGNHS
Field Name	Trust derived HRG value
Category	Healthcare resource groups (HRG) data
Length and format	3an
Availability	2001-02 to 2008-09
Description	
<p>The NHS-generated HRG code as submitted to SUS takes into account the dominant grouping procedure (domproc) and may differ from the HES derived HRG (HRG_n.n).</p>	
Value	
<p>3an = Trust derived HRG</p>	
Rule	Not applicable



Dataset: Admitted Patient Care

Version No. of Trust derived HRG (HRGNHSVN)

Field	HRGNHSVN
Field Name	Version No. of Trust derived HRG
Category	Healthcare resource groups (HRG) data
Length and format	3an
Availability	2001-02 to 2008-09
Description	
The version number for the Trust derived HRG value (hrgnhs).	
Value	
3an = Version No. of Trust derived	
Rule	Not applicable



Dataset: Admitted Patient Care

IMD Index of Multiple Deprivation (IMD04)

Field	IMD04
Field Name	IMD Index of Multiple Deprivation
Category	Socio-economic
Length and format	TBC
Availability	TBC
Description	

The Index of Multiple Deprivation (IMD) is a measure of multiple deprivation at Super Output Area level. The IMD has seven domains. The English Indices of Deprivation 2010 provide a relative measure of deprivation at small area level across England. Areas are ranked from least deprived to most deprived on seven different dimensions of deprivation and an overall composite measure of multiple deprivation. The domains used in the Indices of Deprivation 2010 are: income deprivation; employment deprivation; health deprivation and disability; education deprivation; crime deprivation; barriers to housing and services deprivation; and living environment deprivation. Each of these domains has its own scores and ranks, allowing users to focus on specific aspects of deprivation. In addition, two supplementary indices measure income deprivation amongst children - the Income Deprivation Affecting Children Index (IDACI) - and older people - the Income Deprivation Affecting Older People Index (IDAOPI).

Value



TBC	
Rule	TBC



Dataset: Admitted Patient Care

IMD Decile Group (IMD04_DECILE)

Field	IMD04_DECILE
Field Name	IMD Decile Group
Category	Socio-economic
Length and format	20an
Availability	1995-96 onwards
Description	

This field uses the IMD Overall Ranking to identify which one of ten groups a Super Output Area belongs to, from most deprived through to least deprived.

This IMD version was first published in 2004. See <http://www.communities.gov.uk/documents/communities/pdf/131206.pdf> for further details.

Value

Between 1 and 3248 = Most deprived 10% ;
 Between 3249 and 6496 = More deprived 10-20% ;
 Between 6497 and 9745 = More deprived 20-30% ;
 Between 9746 and 12993 = More deprived 30-40% ;



Between 12994 and 16241 = More deprived 40-50% ;

Between 16242 and 19489 = Less deprived 40-50% ;

Between 19490 and 22737 = Less deprived 30-40% ;

Between 22738 and 25986 = Less deprived 20-30% ;

Between 25987 and 29234 = Less deprived 10-20% ;

Between 29235 and 32482 = Least deprived 10%

Rule



Dataset: Admitted Patient Care

IMD Crime Domain (IMD04C)

Field	IMD04C
Field Name	IMD Crime Domain
Category	Socio-economic
Length and format	3n
Availability	1995-96 onwards
Description	

The Index of Multiple Deprivation (IMD) is a measure of multiple deprivation at Super Output Area level. The IMD has seven domains, one of which is the Crime Domain. The purpose of the Crime domain is to measure the incidence of recorded crime for four major crime themes:

1. burglary
2. theft
3. criminal damage
4. violence

This version of the Index was first published in 2004. See <http://www.communities.gov.uk/documents/communities/pdf/131206.pdf> for further details.

Value	
3n = IMD Crime Domain value	
Rule	



Dataset: Admitted Patient Care

IMD Education Training and Skills Domain (IMD04ED)

Field	IMD04ED
Field Name	IMD Education Training and Skills Domain
Category	Socio-economic
Length and format	4n
Availability	1995-96 onwards
Description	

The Index of Multiple Deprivation (IMD) is a measure of multiple deprivation at Super Output Area level. The IMD has seven domains, one of which is the Education, Skills and training Domain. The purpose of the Education, Skills and training domain is to capture the extent of deprivation in terms of education, skills and training in a local area.

This version of the Index was first published in 2004. See <http://www.communities.gov.uk/documents/communities/pdf/131206.pdf> for further details.

Value

4n = IMD Education, Skills and Training Domain value

Rule



Dataset: Admitted Patient Care

IMD Employment Deprivation Domain (IMD04EM)

Field	IMD04EM
Field Name	IMD Employment Deprivation Domain
Category	Socio-economic
Length and format	3n
Availability	1995-96 onwards
Description	

The Index of Multiple Deprivation (IMD) is a measure of multiple deprivation at Super Output Area level. The IMD has seven domains, one of which is the Employment Deprivation Domain.

This domain measures employment deprivation conceptualised as involuntary exclusion of the working age population from the world of work.

This version of the Index was first published in 2004. See <http://www.communities.gov.uk/documents/communities/pdf/131206.pdf> for further details.

Value

3n = IMD Employment Deprivation Domain value

Rule



Dataset: Admitted Patient Care

IMD Health and Disability Domain (IMD04HD)

Field	IMD04HD
Field Name	IMD Health and Disability Domain
Category	Socio-economic
Length and format	3n
Availability	1995-96 onwards

Description

The Index of Multiple Deprivation (IMD) is a measure of multiple deprivation at Super Output Area level. The IMD has seven domains, one of which is the Health Deprivation and Disability Domain. The purpose of the Health deprivation and disability domain is to identify areas with relatively high rates of:

1. premature deaths
2. impaired quality of life, due to poor health
3. people with disabilities

This version of the Index was first published in 2004. See <http://www.communities.gov.uk/documents/communities/pdf/131206.pdf> for further details.

Value



3n = IMD Health and Disability Domain value

Rule



Dataset: Admitted Patient Care

IMD Barriers to Housing and Service Domain (IMD04HS)

Field	IMD04HS
Field Name	IMD Barriers to Housing and Service Domain
Category	Socio-economic
Length and format	4n
Availability	1995-96 onwards
Description	

The Index of Multiple Deprivation (IMD) is a measure of multiple deprivation at Super Output Area level. The IMD has seven domains, one of which is the Barriers to Housing and Services Domain. The purpose of the Barriers to Housing and Services domain is to measure barriers to housing and key local services. This version of the Index was first published in 2004. See <http://www.communities.gov.uk/documents/communities/pdf/131206.pdf> for further details.

Value

4n = IMD Barriers to Housing and Services Domain value

Rule



Dataset: Admitted Patient Care

IMD Income Domain (IMD04I)

Field	IMD04I
Field Name	IMD Income Domain
Category	Socio-economic
Length and format	3n
Availability	1995-96 onwards
Description	

The Index of Multiple Deprivation (IMD) is a measure of multiple deprivation at Super Output Area level. The IMD has seven domains, one of which is the Income Deprivation Domain. The purpose of this Domain is to capture the proportions of the population experiencing income deprivation in an area.

This version of the Index was first published in 2004. See <http://www.communities.gov.uk/documents/communities/pdf/131206.pdf> for further details.

Value

3n = IMD Income Domain value

Rule



Dataset: Admitted Patient Care

IMD Income affecting Adults Domain (IMD04IA)

Field	IMD04IA
Field Name	IMD Income affecting Adults Domain
Category	Socio-economic
Length and format	3n
Availability	1995-96 onwards
Description	

The Index of Multiple Deprivation (IMD) is a measure of multiple deprivation at Super Output Area level. The IMD has seven domains, one of which is the Income Deprivation Domain. The Income Deprivation Affecting Older People Index is a sub-set of the Income Deprivation Domain. The Index contains the percentage of a Super Output Area's population aged 60 and over who are claiming Income Support or Job Seeker's Allowance.

This version of the Index was first published in 2004. See <http://www.communities.gov.uk/documents/communities/pdf/131206.pdf> for further details.

Value

3n = IMD Income Affecting Adults Index value



Rule	
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Dataset: Admitted Patient Care

IMD Income affecting Children Domain (IMD04IC)

Field	IMD04IC
Field Name	IMD Income affecting Children Domain
Category	Socio-economic
Length and format	3n
Availability	1995-96 onwards
Description	

The Index of Multiple Deprivation (IMD) is a measure of multiple deprivation at Super Output Area level. The IMD has seven domains, one of which is the Income Deprivation Domain. The Income Deprivation Affecting Children Index is a sub-set of the Income Deprivation Domain. The Index contains the percentage of a Super Output Area's children under 16 who were living in families receiving specific financial support, such as Income Support or Job Seeker's Allowance.

This version of the Index was first published in 2004. See <http://www.communities.gov.uk/documents/communities/pdf/131206.pdf> for further details.

Value

3n = IMD Income Affecting Children Index value



Rule	
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Dataset: Admitted Patient Care

IMD Living Environment Domain (IMD04LE)

Field	IMD04LE
Field Name	IMD Living Environment Domain
Category	Socio-economic
Length and format	4n
Availability	1995-96 onwards
Description	

The Index of Multiple Deprivation (IMD) is a measure of multiple deprivation at Super Output Area level. The IMD has seven domains, one of which is the Living Environment domain. The Living Environment domain focuses on deprivation with respect to the characteristics of the living environment.

This version of the Index was first published in 2004. See <http://www.communities.gov.uk/documents/communities/pdf/131206.pdf> for further details.

Value

4n = IMD Living Environment Domain value

Rule



Dataset: Admitted Patient Care

IMD Overall Rank (IMD04RK)

Field	IMD04RK
Field Name	IMD Overall Rank
Category	Socio-economic
Length and format	5n
Availability	1995-96 onwards
Description	

The IMD overall ranking is made by combining the seven IMD Domain scores using the following weights:

- Income (22.5%)
- Employment (22.5%)
- Health Deprivation and Disability (13.5%)
- Education, Skills and Training (13.5%)
- Barriers to Housing and Services (9.3%)
- Crime (9.3%)
- Living Environment (9.3%)

The SOA (Super Output Area) with a rank of 1 is the most deprived, and 32482 the



least deprived, on this overall measure.

This IMD version was first published in 2004. See <http://www.communities.gov.uk/documents/communities/pdf/131206.pdf> for further details.

Value

5n = IMD Overall Ranking

Rule



Dataset: Admitted Patient Care

Intensive care level days (INTDAYS_N)

Field	INTDAYS_N
Field Name	Intensive care level days
Category	Augmented/critical care period
Length and format	4n
Availability	1997-98 to 2005-06
Description	

This field contains the number of days of intensive care in a period of augmented care.

Value

4n = Number of days in the range 0000 to 9998

null = Not known: a validation error

Rule	Rule 1040
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Dataset: Admitted Patient Care

Intended management (INTMANIG)

Field	INTMANIG
Field Name	Intended management
Category	Clinical ; Period of care
Length and format	1n
Availability	1997-98 onwards
Description	

This field contains a code that defines what was planned to happen. The patient classification (classpat) defines what actually happened.

Value

- 1 = Patient to stay in hospital for at least one night
- 2 = Patient not to stay in hospital overnight
- 3 = Patient to have a planned series of admissions; at least one overnight stay
- 4 = Patient to have a planned sequence of admissions; no overnight stay
- 5 = Patient to be admitted regularly for a sequence of nights; rest of the 24 hour period at home
- 8 = Not applicable

9 = Not known

Rule

Rule 120



Dataset: Admitted Patient Care

In Year flag (INYRFLAG)

Field	INYRFLAG
Field Name	In Year flag
Category	Patient Data
Length and format	1a
Availability	All years
Description	
Codes in this field indicate whether the episode admission was within the current HES year.	
Value	
Y = Admitted within the HES year ; N = Not admitted within the year	
Rule	None



Dataset: Admitted Patient Care

Local authority district in 1998 (LAD98)

Field	LAD98
Field Name	Local authority district in 1998
Category	Geographical
Length and format	4an
Availability	1999-00 to 2000-01
Description	

This derived field contains a code for the patient's county (first two characters) and local authority district (last two characters) of residence. It is derived from the patient's postcode (homeadd). This field is used in conjunction with currward (current electoral ward) to produce a unique value indicating the ward within a given district where the patient resided (ie because identical Currward codes are allocated to many local authority districts, currward is meaningless in isolation). If the patient is resident within a Unitary Authority, the first two characters will be 00 (zero, zero) and the local authority component may not be useable.

Value

nnaa = Local authority code ;

S = Scotland ;



U = England (NOS) ;

W = Wales ;

Y = Not known ;

Z = Northern Ireland ;

X = Foreign

Rule	Not applicable (derived item)
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Dataset: Admitted Patient Care

Legal group of patient (LEGALGPA)

Field	LEGALGPA
Field Name	Legal group of patient
Category	Psychiatric
Length and format	1n
Availability	2002-03 onwards
Description	

This field contains a code that allocates the legal status of a patient to one of eight groups. (An aggregation of legal status of a patient on admission, leglcat.) The Legal group of patient (legalgpa) field contains sensitive data. Access to it requires the approval of the Data Access Advisory Group (DAAG).

Value

0 = Not formally detained (Leglcat is 01 or spaces) ;

1 = Formally detained under Part II, Sections 2 to 34 of the Mental Health Act 1983 (Leglcat is 02 to 06, or 2 to 6) ;

2 = Formally detained under Part III, Sections 35 to 55 of the Mental Health Act 1983, or previous legislation (Leglcat is 07 to 18, 30 to 32, 34 or 7 to 9) ;

3 = Formally detained under Part X, Sections 131 to 149 of the Mental Health Act 1983

(Leglcat is 19 or 20) ;

4 = Supervised discharge under the Mental Health Act 1995 (Leglcat is 33) ;

5 = Guardianship (Sections 7 & 37) under the Mental Health Act 1983 (Leglcat is 35 or 36) ;

Not applicable = ie home births/deliveries where epitype is 5 or 6 ;

Not known = any other value for leglcat

Rule	
	Not applicable (derived by rule 1135)



Dataset: Admitted Patient Care

Legal group of patient (psychiatric) (LEGALGPC)

Field	LEGALGPC
Field Name	Legal group of patient (psychiatric)
Category	Psychiatric
Length and format	1n
Availability	2002-03 onwards
Description	

Legal group of patient, an aggregation of legal status of a patient on psychiatric census date, leglstat. This field contains a code that allocates the legal status of a patient to one of eight groups. This field contains sensitive data. Access to it requires the approval of the Data Access Advisory Group (DAAG).

Value

0 = Legal status on psychiatric census date is not formally detained, leglstat = 01 or spaces ;

1 = Legal status on psychiatric census date, leglstat = 02-06 or space2-space6: Formally detained under Part II (Section 2-34) of the Mental Health Act 1983 ;

2 = Legal status on admission, leglcat = 07-18, 30-32, 34 or space7-space9: Formally detained under Part III (Section 35-55) of the Mental Health Act 1983, or previous legislation ;

3 = Legal status on admission, leglcat = 19-20: Formally detained under Part X (Sections

131-149) of the Mental Health Act 1983 ;

4 = Legal status on admission, leglcat = 33: Supervised discharge under the Mental Health Act 1995 ;

5 = Legal status on admission, leglcat = 35, 36: Guardianship (Sections 7 & 37) under the Mental Health Act 1983 ;

8 = Not applicable ie home births/deliveries, where epitype = 5/6 ; 10 = Not known: any other value for leglstat.

Rule	Not applicable (derived by rule 895)
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Dataset: Admitted Patient Care

Legal category of patient (LEGLCAT)

Field	LEGLCAT
Field Name	Legal category of patient
Category	Patient Data
Length and format	2n
Availability	2000-01 onwards
Description	

The legal category of all formally and informally detained patients on admission. An informally detained patient is one who is not formally detained, but has been in hospital for a year or more in the care of a consultant in the psychiatric specialties. This item is required for all admissions to psychiatric specialties. The Legal category of patient (lelcat) field contains sensitive data. Access to it requires the approval of the Data Access Advisory Group (DAAG).

Value

- 01 = Informal ;
- 02 = Formally detained under the Mental Health Act, Section 2 ;
- 03 = Formally detained under the Mental Health Act, Section 3 ;
- 04 = Formally detained under the Mental Health Act, Section 4 ;

- 05 = Formally detained under the Mental Health Act, Section 5(2) ;
- 06 = Formally detained under the Mental Health Act, Section 5(4) ;
- 07 = Formally detained under the Mental Health Act, Section 35 ;
- 08 = Formally detained under the Mental Health Act, Section 36 ;
- 09 = Formally detained under the Mental Health Act, Section 37 with Section 41 restrictions ;
- 10 = Formally detained under the Mental Health Act, Section 37 excluding Section 37(4) ;
- 11 = Formally detained under the Mental Health Act, Section 37(4) ;
- 12 = Formally detained under the Mental Health Act, Section 38 ;
- 13 = Formally detained under the Mental Health Act, Section 44 ;
- 14 = Formally detained under the Mental Health Act, Section 46 ;
- 15 = Formally detained under the Mental Health Act, Section 47 with Section 49 restrictions ;
- 16 = Formally detained under the Mental Health Act, Section 47 ;
- 17 = Formally detained under the Mental Health Act, Section 48 with Section 49 restrictions ;
- 18 = Formally detained under the Mental Health Act, Section 48 ;
- 19 = Formally detained under the Mental Health Act, Section 135 ;
- 20 = Formally detained under the Mental Health Act, Section 136 ;
- 21 = Formally detained under the previous legislation (fifth schedule) ;
- 22 = Formally detained under Criminal Procedure (Insanity) Act 1964 as amended by the Criminal Procedures (Insanity and Unfitness to Plead) Act 1991 ;
- 23 = Formally detained under other Acts ;
- 24 = Supervised discharge under the Mental Health (Patients in the Community) Act 1995 ;
- 25 = Formally detained under the Mental Health Act, Section 45A ;
- 26 = Not applicable ;



27 = Not known

Rule

None



Dataset: Admitted Patient Care

Legal status classification (LEGLSTAT)

Field	LEGLSTAT
Field Name	Legal status classification
Category	Psychiatric
Length and format	2n
Availability	All years
Description	

This field contains a code which defines the legal status of all formally and informally detained patients at the date of the census. An informally detained patient is one who is not formally detained, but has been in hospital for a year or more in the care of a consultant in the psychiatric specialties. It is only for unfinished records of episode type 4. The Legal status classification (leglstat) field contains sensitive data. Access to it requires the approval of the Data Access Advisory Group (DAAG).

Value

- 01 = Informal ;
- 02 = Formally detained under the Mental Health Act, Section 2 ;
- 03 = Formally detained under the Mental Health Act, Section 3 ;
- 04 = Formally detained under the Mental Health Act, Section 4 ;

- 05 = Formally detained under the Mental Health Act, Section 5(2) ;
- 06 = Formally detained under the Mental Health Act, Section 5(4) ;
- 07 = Formally detained under the Mental Health Act, Section 35 ;
- 08 = Formally detained under the Mental Health Act, Section 36 ;
- 09 = Formally detained under the Mental Health Act, Section 37 with Section 41 restrictions ;
- 10 = Formally detained under the Mental Health Act, Section 37 excluding Section 37(4) ;
- 11 = Formally detained under the Mental Health Act, Section 37(4) ;
- 12 = Formally detained under the Mental Health Act, Section 38 ;
- 13 = Formally detained under the Mental Health Act, Section 44 ;
- 14 = Formally detained under the Mental Health Act, Section 46 ;
- 15 = Formally detained under the Mental Health Act, Section 47 with Section 49 restrictions ;
- 16 = Formally detained under the Mental Health Act, Section 47 ;
- 17 = Formally detained under the Mental Health Act, Section 48 with Section 49 restrictions ;
- 18 = Formally detained under the Mental Health Act, Section 48 ;
- 19 = Formally detained under the Mental Health Act, Section 135 ;
- 20 = Formally detained under the Mental Health Act, Section 136 ;
- 30 = Formally detained under the previous legislation (fifth schedule) ;
- 31 = Formally detained under Criminal Procedure (Insanity) Act 1964 as amended by the Criminal Procedures (Insanity and Unfitness to Plead) Act 1991 ;
- 32 = Formally detained under other Acts ;
- 33 = Supervised discharge under the Mental Health (Patients in the Community) Act 1995 ;
- 34 = Formally detained under the Mental Health Act, Section 45A ;
- 35 Subject to guardianship under Mental Health Act Section 7 ;



36 Subject to guardianship under Mental Health Act Section 37 ;

98 = Not applicable ;

99 = Not known

Rule

None



Dataset: Admitted Patient Care

Legal status classification code at start of episode (LEGLSTATST)

Field	LEGLSTATST
Field Name	Legal status classification code at start of episode
Category	Patient Data
Length and format	2an
Availability	2007-08 onwards
Description	

Required for all patients with a hospital provider spell that includes the care of a consultant in a psychiatric specialty or who have been discharged from such a spell and are receiving supervised aftercare under the provisions of the Mental Health Act 1995.

Value

- 01 = Informal ;
- 02 = Formally detained under the Mental Health Act, Section 2 ;
- 03 = Formally detained under the Mental Health Act, Section 3 ;
- 04 = Formally detained under the Mental Health Act, Section 4 ;

05 = Formally detained under the Mental Health Act, Section 5(2) ;

06 = Formally detained under the Mental Health Act, Section 5(4) ;

07 = Formally detained under the Mental Health Act, Section 35 ;

08 = Formally detained under the Mental Health Act, Section 36 ;

09 = Formally detained under the Mental Health Act, Section 37 with Section 41 restrictions ;

10 = Formally detained under the Mental Health Act, Section 37 ;

12 = Formally detained under the Mental Health Act, Section 38 ;

13 = Formally detained under the Mental Health Act, Section 44 ;

14 = Formally detained under the Mental Health Act, Section 46 ;

15 = Formally detained under the Mental Health Act, Section 47 with Section 49 restrictions ;

16 = Formally detained under the Mental Health Act, Section 47 ;

17 = Formally detained under the Mental Health Act, Section 48 with Section 49 restrictions ;

18 = Formally detained under the Mental Health Act, Section 48 ;

19 = Formally detained under the Mental Health Act, Section 135 ;

20 = Formally detained under the Mental Health Act, Section 136 ;

31 = Formally detained under Criminal Procedure (Insanity) Act 1964 as amended by the Criminal Procedures (Insanity and Unfitness to Plead) Act 1991 ;

32 = Formally detained under other acts ;

33 = Supervised Discharge (Mental Health (Patients in the Community) Act 1995) ;

34 = Formally detained under Mental Health Act Section 45A ;

35 = Subject to guardianship under Mental Health Act Section 7 ;

36 = Subject to guardianship under Mental Health Act Section 37 ;

98 = Not applicable ;



99 = Not known

Rule

Data not cleaned



Dataset: Admitted Patient Care

Local patient identifier (LOPATID)

Field	LOPATID
Field Name	Local patient identifier
Category	Patient Data
Length and format	10n
Availability	1997-98 onwards
Description	

This field contains the number used to identify a patient within a health care provider. It may be different from the patient's case note number and may be assigned automatically by the computer system. The Local patient identifier (lopatid) field contains sensitive data. Access to it requires the approval of the Data Access Advisory Group (DAAG).

Value

10n = Local patient identifier

Rule None



Dataset: Admitted Patient Care

Lower Super Output Area (LSOA01)

Field	LSOA01
Field Name	Lower Super Output Area
Category	Geographical
Length and format	9an
Availability	From 2003-04
Description	

The 2001 Census Lower Layer SOA code for England and Wales, SOA code for Northern Ireland and data zone code for Scotland. Pseudo codes are included for Channel Islands and Isle of Man. The field will otherwise be blank for postcodes with no grid reference. The first character is either E for England or W for Wales The next two characters are 01 for Lower Super Output Area and the remaining six characters make up the unique 6-digit tag for each zone.

Value

9an = Lower Super Output Area ;
E01000001- E01032482 = England;
W01000001- W01001896 = Wales;

S01000001- S01006505 = Scotland;

95AA01S1 - 95ZZ16S2 = Northern Ireland;

L99999999 (pseudo) = Channel Islands;

M99999999 (pseudo) = Isle of Man;

Z99999999 = Not known

Rule	
	Not applicable (derived by rule 1200)



Dataset: Admitted Patient Care

Lower Super Output Area (LSOA11)

Field	LSOA11
Field Name	Lower Super Output Area
Category	Geographical
Length and format	9an
Availability	From 2013-14
Description	

The 2011 Census lower layer SOA code for England and Wales, SOA code for Northern Ireland and data zone code for Scotland. Pseudo codes are included for Channel Islands and Isle of Man. The field will otherwise be blank for postcodes with no grid reference. N.B. this field remains blank for Scottish postcodes until this information is released. The first character is either E for England or W for Wales The next two characters are 01 for Lower Super Output Area and the remaining six characters make up the unique 6-digit tag for each zone.

Value

9an = Lower Super Output Area ;
E01000001- E01033768 = England;
W01000001- W01001958 = Wales;



TBA = Scotland;95AA01S1 ? 95ZZ16S2 = Northern Ireland;

L99999999 (pseudo) = Channel Islands;

M99999999 (pseudo) = Isle of Man;

Z99999999 = Not known

Rule	Not applicable (derived by rule 1200)
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Dataset: Admitted Patient Care

Main specialty (MAINSPEF)

Field	MAINSPEF
Field Name	Main specialty
Category	Clinical ; Period of care
Length and format	3n or &
Availability	All years
Description	

This field contains a code that defines the specialty under which the consultant is contracted. It can be compared with tretspef, the specialty under which the consultant worked.

Value

100 = General surgery ;
 101 = Urology ;
 110 = Trauma and orthopaedics ;
 120 = Ear, nose and throat (ENT) ;
 130 = Ophthalmology ;
 140 = Oral surgery ;

141 = Restorative dentistry ;

142 = Paediatric dentistry (available from 1999-2000) ;

143 = Orthodontics ;

145 = Oral and maxillo facial surgery (available from 2004-05) ;

146 = Endodontics (available from 2004-05) ; 147 = Periodontics (available from 2004-05) ;

148 = Prosthodontics (available from 2004-05) ;

149 = Surgical dentistry (available from 2004-05) ;

150 = Neurosurgery ;

160 = Plastic surgery ;

170 = Cardiothoracic surgery ;

171 = Paediatric surgery ;

180 = Accident and emergency (A&E) ;

190 = Anaesthetics ;

191 = Pain management (available from 1998-99 to 2003-04) ;

192 = Critical care medicine (available from 2004-05) ;

199 = Non-UK Provider - specialty function not known, treatment mainly surgical ;

300 = General medicine ;

301 = Gastroenterology ;

302 = Endocrinology ;

303 = Clinical haematology ;

304 = Clinical physiology ;

305 = Clinical pharmacology ;



310 = Audiological medicine ;

311 = Clinical genetics ;

312 = Clinical cytogenics and molecular genetics (available from 1990-91) ;

313 = Clinical immunology and allergy (available from 1991-92) ;

314 = Rehabilitation (available from 1991-92) ;

315 = Palliative medicine ;

320 = Cardiology ;

321 = Paediatric cardiology (available from 2004-05) ;

330 = Dermatology ;

340 = Respiratory medicine (also known as thoracic medicine) ;

350 = Infectious diseases ;

352 = Tropical medicine (available from 2004-05) ;

360 = Genito-urinary medicine ;

361 = Nephrology ;

370 = Medical oncology ;

371 = Nuclear medicine ;

400 = Neurology ;

401 = Clinical neuro-physiology ;

410 = Rheumatology ;

420 = Paediatrics ;

421 = Paediatric neurology ;

430 = Geriatric medicine ;



450 = Dental medicine (available from 1990-91) ;

460 = Medical ophthalmology (available from 1993-94) ;

499 = Non-UK Provider - specialty function not known, treatment mainly medical ;

501 = Obstetrics (prior to 2004-05: Obstetrics for patients using a hospital bed or delivery facilities) ;

502 = Gynaecology ;

560 = Midwifery (available from October 1995) ;

600 = General Medical Practice ;

601 = General Dental Practice;

610 = General practice with maternity function (available to 2003-04) ;

620 = General practice other than maternity (available to 2003-04) ;

700 = Learning disability (previously known as mental handicap) ;

710 = Adult mental illness ;

711 = Child and adolescent psychiatry ;

712 = Forensic psychiatry ;

713 = Psychotherapy ;

715 = Old age psychiatry (available from 1990-91) ;

800 = Clinical oncology (previously Radiotherapy) ;

810 = Radiology ;

820 = General pathology ;

821 = Blood transfusion ;

822 = Chemical pathology ;

823 = Haematology ;



824 = Histopathology ;

830 = Immunopathology ;

831 = Medical microbiology ;

832 = Neuropathology (available to 2003-04) ;

900 = Community medicine ;

901 = Occupational medicine ;

902 = Community health services - dental (available from 2004-05) ;

903 = Public health medicine (available from 2004-05) ;

904 = Public health dental (available from 2004-05) ;

950 = Nursing episode (available from 2002-03) ;

960 = Allied health professional episode (available from 2006-07) ;

null = Other maternity event ;

& = Not known

Rule

Rule 90, 350



Dataset: Admitted Patient Care

Marital status (psychiatric) (MARSTAT)

Field MARSTAT

Field Name Marital status (psychiatric)

Category Psychiatric

Length and format 1an

Availability All years

Description

This field contains a code that defines a patient's marital status where the consultant's specialty (mainspef) is one of the psychiatric specialties. Although the numerical codes were retired on 1/10/2006, these are still flowing so both sets of codes are seen.

Value

8 = Not applicable. From 1/10/2006 onwards:

S = Single ; M = Married/Civil Partner ;

D = Divorced/Person whose Civil Partnership has been dissolved ;

W = Widowed/Surviving Civil Partner ;

P = Separated ;

N = Not disclosed.

Prior to 1/10/2006:

1 = Single ;

2 = Married, including separated ;

3 = Divorced ;

4 = Widowed ;

9 = Not known

Rule

Rule 355



Dataset: Admitted Patient Care

Mother's age at delivery (MATAGE)

Field	MATAGE
Field Name	Mother's age at delivery
Category	Maternity
Length and format	3n
Availability	All years
Description	<p>This field contains the mother's age in whole years on the date of delivery. It is calculated from the mother's date of birth and the first baby's date of birth.</p>
Value	<p>3n = Age in years ;</p> <p>null = Not valid</p>
Rule	Not applicable (derived by rule 810)

Dataset: Admitted Patient Care

Patient identifier (HES generated) - basis of match
(MATCHID)

Field	MATCHID
Field Name	Patient identifier (HES generated) - basis of match
Category	System Data
Length and format	1n
Availability	1997-98 onwards
Description	
This field indicates the basis on which the HES ID was allocated.	
Value	
Rule	Not applicable



Dataset: Admitted Patient Care

Episode Type - Maternity
(MATERNITY_EPISODE_TYPE)

Field	MATERNITY_EPISODE_TYPE
Field Name	Episode Type - Maternity
Category	Maternity
Length and format	1an
Availability	All years
Description	
Determines if an episode is maternity related	
Value	
1an	
1 = Finished delivery episode	
2 = Finished birth episode	
3 = Finished other delivery episode	
4 = Finished other birth episode	
9 = Unfinished maternity episodes	

99 = All other episodes

Rule

Rule 8011



Dataset: Admitted Patient Care

Mental category (MENTCAT)

Field	MENTCAT
Field Name	Mental category
Category	Psychiatric
Length and format	1n
Availability	All years
Description	

This field contains a code which defines the mental categories of a patient in accordance with the designations in the Mental Health Act 1983. A patient should be included in only one mental category. If a patient has been assigned to more than one mental category, mental illness takes precedence over the others, and mental impairment or severe mental impairment takes precedence over psychopathic disorder.

Value

- 1 = Mental illness ;
- 2 = Mental impairment ;
- 3 = Severe mental impairment ;
- 4 = Psychopathic disorder ;

5 = Not specified (from 1995-96) ;

8 = Not applicable ;

9 = Not known

Rule

None



Dataset: Admitted Patient Care

Mother's date of birth (MOTDOB)

Field	MOTDOB
Field Name	Mother's date of birth
Category	Maternity
Length and format	dd/mm/yyyy (Date)
Availability	All years
Description	<p>This field contains the mother's date of birth. It appears on birth records. The Mother's date of birth (motdob) field contains sensitive data. Access to it requires the approval of the Ethics and Confidentiality Committee (ECC).</p>
Value	<p>dd/mm/yyyy = Mother's date of birth</p>
Rule	Rule 690

Dataset: Admitted Patient Care

Mother's data of birth check flag (MOTDOB_CFL)

Field MOTDOB_CFL

Field Name Mother's data of birth check flag

Category Maternity

Length and format 1n

Availability All years

Description

Codes in this field validate the mother's date of birth (motdob).

Value

0 = Valid ;

1 = Missing ;

2 = Invalid

Rule Not applicable



Dataset: Admitted Patient Care

Middle Super Output Area, 2001 (MSOA01)

Field	MSOA01
Field Name	Middle Super Output Area, 2001
Category	Geographical
Length and format	9an
Availability	From 2003-04
Description	<p>The 2001 Census Middle Layer SOA (MSOA) code for England and Wales and intermediate zone for Scotland. Pseudo codes are included for Northern Ireland, Channel Islands and Isle of Man. The field will otherwise be blank for postcodes with no grid reference. The first character is either E for England or W for Wales. The next two characters are 02 for Middle Layer and the remaining six characters make up the unique 6-digit tag for each zone.</p>
Value	<p>9an = Middle Super Output Area ;</p> <p>E02000001- E02006781 = England;</p> <p>W02000001- W02000413 = Wales;</p>



S02000001 - S02001235 = Scotland;

N999999999 (pseudo) = Northern Ireland;

L999999999 (pseudo) = Channel Islands;

M999999999 (pseudo) = Isle of Man;

Z999999999 = Not known

Rule	
	Not applicable (derived by rule 1200)



Dataset: Admitted Patient Care

Middle Super Output Area, 2011 (MSOA11)

Field	MSOA11
Field Name	Middle Super Output Area, 2011
Category	Geographical
Length and format	9an
Availability	From 2013-14
Description	

The 2011 Census middle layer SOA (MSOA) code for England and Wales and intermediate zone for Scotland. Pseudo codes are included for Northern Ireland, Channel Islands and Isle of Man. The field will otherwise be blank for postcodes with no grid reference. N.B. this field remains blank for Scottish postcodes until this information is released. The first character is either E for England or W for Wales. The next two characters are 02 for Middle Layer and the remaining six characters make up the unique 6-digit tag for each zone.

Value

9an = Middle Super Output Area ;
E02000001- E02006934 = England;
W02000001- W02000423 = Wales;



TBA = Scotland;

N999999999 (pseudo) = Northern Ireland;

L999999999 (pseudo) = Channel Islands;

M999999999 (pseudo) = Isle of Man;

Z999999999 = Not known

Rule

Not applicable (derived by rule 1200)



Dataset: Admitted Patient Care

Date of Birth - month and year (MYDOB)

Field	MYDOB
Field Name	Date of Birth - month and year
Category	Patient Data
Length and format	mm/yyyy
Availability	
Description	
Month and year of date of birth only. Day is not made available	
Value	
mm/yyyy = Date of Birth - month and year	
Rule	



Dataset: Admitted Patient Care

Neonatal level of care (NEOCARE)

Field	NEOCARE
Field Name	Neonatal level of care
Category	Maternity
Length and format	1n
Availability	1996-97 onwards
Description	

This field contains a code that defines the level of care given to a new born child. (Along with psychiatric patient status (admistat), this field replaces the V code indicator (vind).)

Value

0 = Normal care: care given by the mother or mother substitute, with medical and neonatal nursing advice if needed ;

1 = Special care: care given in a special nursery, transitional care ward or postnatal ward, which provides care and treatment exceeding normal routine care. Some aspects of special care can be undertaken by a mother supervised by qualified nursing staff. Special nursing care includes support for and education of the infant's parents ;

2 = Level 2 intensive care (high dependency intensive care): care given in an intensive or special care nursery, which provides continuous skilled supervision by qualified and specially

trained nursing staff who may care for more babies than in level 1 intensive care. Care includes support for the infant's parents ;

3 = Level 1 intensive care (maximal intensive care): care given in an intensive or special care nursery, which provides continuous skilled supervision by qualified and specially trained nursing and medical staff. Care includes support for the infant's parents ;

8 = Not applicable: the episode of care does not involve a neonate at any time ;

9 = Not known: the episode of care involves a neonate and is finished but no data has been entered; this constitutes a validation error. Alternatively the episode involves a neonate but is unfinished, therefore no data need be present

Rule

Rules 360 and 370



Dataset: Admitted Patient Care

Age of baby in days (NEODUR)

Field NEODUR

Field Name Age of baby in days

Category Maternity

Length and format 2n

Availability All years

Description

This field contains the age in days of a baby admitted as a patient. It is derived from admission date (admidate) and date of birth (dob). If the baby is older than 27 days, neodur is not calculated.

Value

2n = Age of patient in days from 0 to 27 ;

null = Not applicable: other maternity event (epitype is 5 or 6) or baby is older than 27 days

Rule Rule 300



Dataset: Admitted Patient Care

NHS number (NEWNHSNO)

Field	NEWNHSNO
Field Name	NHS number
Category	Patient Data
Length and format	10n
Availability	1997-98 onwards
Description	

This field contains the NHS Number of the patient, which is the primary identifier of a person registered for health care; it is unique. Records for babies under six weeks of age and for patients admitted through accident and emergency tend to have null entries for this field. The NHS Number (newnhsno) field contains sensitive data. Access to it requires the approval of the Ethics and Confidentiality Committee (ECC).

Value

10n = NHS Number

Rule None



Dataset: Admitted Patient Care

NHS Number valid flag (NEWNHSNO_CHECK)

Field	NEWNHSNO_CHECK
Field Name	NHS Number valid flag
Category	Patient Data
Length and format	1a
Availability	2007-08 onwards
Description	
This field indicates whether the NHS Number supplied is valid or not.	
Value	
Y = Yes	
N = No	
Rule	Data not cleaned



Dataset: Admitted Patient Care

NHS number status indicator (NHSNOIND)

Field	NHSNOIND
Field Name	NHS number status indicator
Category	System Data
Length and format	2n
Availability	2002-03 onwards
Description	

Codes in this field indicate whether the patients' NHS Number is present, and if it is verified. If the NHS Number is absent, the indicator gives the reason why.

Value

- 01 = Number present and verified ;
- 02 = Number present but not traced ;
- 03 = Trace needed ;
- 04 = Trace attempted: no match, or multiple matches, found ;
- 05 = Trace needs to be resolved: New NHS Number or patient detail conflict ;
- 06 = Trace in progress ;

07 = Number not present and trace not needed ;

08 = Trace postponed (baby under six-weeks old)

Rule	None
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Dataset: Admitted Patient Care

Number of augmented care periods within episode
(NUMACP)

Field	NUMACP
Field Name	Number of augmented care periods within episode
Category	Augmented/critical care period
Length and format	2n
Availability	1997-98 to 2005-06
Description	<p>This derived field gives the number of augmented care periods (ACPs) within episode.</p>
Value	
	2n = Number of augmented care periods within the episode
Rule	Formerly Rule 1060



Dataset: Admitted Patient Care

Number of babies (NUMBABY)

Field	NUMBABY
Field Name	Number of babies
Category	Maternity
Length and format	1n or X
Availability	All years
Description	<p>This field contains the number of babies delivered at the end of a single pregnancy. Both live and stillborn babies are counted. Until 2002-03, a maximum of 6 babies could be recorded in HES.</p>
Value	<p>1 = One ;</p> <p>2 = Two ;</p> <p>3 = Three ;</p> <p>4 = Four ;</p> <p>5 = Five ;</p> <p>6 = Six or more ;</p>

9 = Not Known : a validation error ;

X = Not known

Rule

Rules 710 and 750



Dataset: Admitted Patient Care

Number of previous pregnancies (NUMPREG)

Field	NUMPREG
Field Name	Number of previous pregnancies
Category	Maternity
Length and format	2n
Availability	All years
Description	

This field contains the number of previous pregnancies that resulted in a registrable birth (live or still born). It appears on delivery records. In practice, numpreg1 has often been filled with the 'Not known' code, and the remainder have been left blank.

Value

2n = Number of previous pregnancies, from 00 to 19, resulting in a registrable birth ;

99 = Not known

Rule Rule 750



Dataset: Admitted Patient Care

Number of baby tails (NUMTAILB)

Field	NUMTAILB
Field Name	Number of baby tails
Category	Maternity
Length and format	1n
Availability	All years
Description	<p>This is the number of valid baby groups on the episode record. A valid baby group is defined as one which has a valid birthweight and a valid delivery method. This field defaults to 1.</p>
Value	<p>1n = Number of valid births associated with the episode record</p>
Rule	Rule 770



Dataset: Admitted Patient Care

Census Output Area, 2001 (OACODE01)

Field	OACODE01
Field Name	Census Output Area, 2001
Category	Geographical
Length and format	10an
Availability	From 2003-04
Description	

The 2001 Census Output Areas were built from unit postcodes and constrained to 2003 'statistical' wards, and they form the building bricks for defining higher level geographies. Pseudo codes are included for Channel Islands and Isle of Man. The field will otherwise be blank for postcodes with no grid reference.

Value

10an

E00000001 - E00165665 = England;

W00000001 - W00009769 = Wales;

S00000001 - S00042604 = Scotland;

95AA010001 - 95ZZ519999 = Northern Ireland;

L99999999 (pseudo) = Channel Islands;

M99999999 (pseudo) = Isle of Man;

Rule	
	Not applicable (derived by rule 1200)



Dataset: Admitted Patient Care

Census Output Area, 2011 (OACODE11)

Field	OACODE11
Field Name	Census Output Area, 2011
Category	Geographical
Length and format	9an
Availability	From 2013-14
Description	

The 2011 Census output areas were based on 2001 Census output areas, and they form the building bricks for defining higher level geographies. Pseudo codes are included for Channel Islands and Isle of Man. The field will otherwise be blank for postcodes with no grid reference.

Value

9an

E00000001 - E00176774 = England;

W00000001 - W00010265 = Wales;

S00088956 - S00135306 = Scotland;

N00000001 - N00004537 = Northern Ireland;

L99999999 (pseudo) = Channel Islands;

M99999999 (pseudo) = Isle of Man;

Rule	
	Not applicable (derived by rule 1200)



Dataset: Admitted Patient Care

Census Output Area, 2001 (6 character) (OACODE6)

Field	OACODE6
Field Name	Census Output Area, 2001 (6 character)
Category	Geographical
Length and format	6an
Availability	1995-06 onwards
Description	
A derived field showing the six-character ward identifier contained in the Census Output Area data. The structure is CCDDWW, where CC = county, DD = district or UA and WW=ward.	
Value	
6an	
Rule	Not applicable (derived by rule 1200)



Dataset: Admitted Patient Care

Date of operation (OPDATE_NN)

Field	OPDATE_NN
Field Name	Date of operation
Category	Clinical
Length and format	dd/mm/yyyy (Date)
Availability	All years
Description	

This field contains the dates for operations recorded in the operation codes (opernn_nn) field. There is room for twenty four dates (twelve prior to April 2007 and four before April 2002).

Value

dd/mm/yyyy = Date of operation

Rule Rules 480, 485, 610 and 620



Dataset: Admitted Patient Care

Operation status code (OPERSTAT)

Field	OPERSTAT
Field Name	Operation status code
Category	Clinical
Length and format	1n
Availability	2002-03 onwards
Description	

Status of operation.

Value

1 = One or more operative procedures carried out

8 = Not applicable, ie no operative procedures performed or intended

9 = Not known, ie finished episode but no data entered or the episode is unfinished and no data needs to be present. (This would only be a validation error for a finished episode.)

Rule None



Dataset: Admitted Patient Care

**3 character concatenated procedure
(OPERTN_3_CONCAT)**

Field	OPERTN_3_CONCAT
Field Name	3 character concatenated procedure
Category	Clinical
Length and format	TBC
Availability	All years
Description	
3 character concatenated procedure code	
Value	
TBC	
Rule	TBC



Dataset: Admitted Patient Care

Main operative procedure - 3 characters (OPERTN_3_N)

Field	OPERTN_3_N
Field Name	Main operative procedure - 3 characters
Category	Clinical
Length and format	3an, - or &
Availability	All years
Description	
This provides the first three characters of the main operation (oper_1).	
Value	
<p>3an = Procedure code</p> <p>- = No operation performed</p> <p>& = Not known</p>	
Rule	Not applicable (this item is derived from a cleaned field)



Dataset: Admitted Patient Care

**4 character concatenated procedure
(OPERTN_4_CONCAT)**

Field	OPERTN_4_CONCAT
Field Name	4 character concatenated procedure
Category	Clinical
Length and format	TBC
Availability	All years
Description	
4 character concatenated procedure code	
Value	
TBC	
Rule	TBC



Dataset: Admitted Patient Care

All Operative procedure codes (OPERTN_4_NN)

Field	OPERTN_4_NN
Field Name	All Operative procedure codes
Category	Clinical
Length and format	4an, - or &
Availability	All years
Description	

There are twenty-four fields (twelve before April 2007 and four prior to April 2002), oper_01 to oper_24, which contain information about a patient's operations. The field oper_01 contains the main (ie most resource intensive) procedure. The other fields contain secondary procedures. ; The codes are defined in the Tabular List of the Classification of Surgical Operations and Procedures. The current version is OPCS4. Procedure codes start with a letter and are followed by two or three digits. The third digit identifies variations on a main procedure code containing two digits. The third digit is preceded by a full stop in OPCS4, but this is not stored in the field. A single operation may contain more than one procedure.

Value

4an = Procedure code

- = No operation performed



& = Not known

Rule	
	Rules 450, 540, 550, 560, 610 and 620



Dataset: Admitted Patient Care

**Total number of procedures per episode
(OPERTN_COUNT)**

Field	OPERTN_COUNT
Field Name	Total number of procedures per episode
Category	Clinical
Length and format	TBC
Availability	TBC
Description	
Total number of procedures codes per episode	
Value	
TBC	
Rule	TBC



Dataset: Admitted Patient Care

Organisation code (patient pathway ID issuer) (ORGPPPID)

Field	ORGPPPID
Field Name	Organisation code (patient pathway ID issuer)
Category	Patient Pathway
Length and format	5an
Availability	2007-08 onwards
Description	
The organisation code of the patient pathway ID issuer. Where Choose and Book has been used, the Organisation Code for NHS Connecting For Health (X09) is used.	
Value	
5an = organisation code	
Rule	Data not cleaned



Dataset: Admitted Patient Care

Number of organ systems supported (ORGSUP)

Field ORGSUP

Field Name Number of organ systems supported

Category Augmented/critical care period

Length and format 2n

Availability 1997-98 to 2005-06

Description

This field contains the number of organ support systems used (up to five) during a period of augmented care.

Value

2n = Number of organ systems supported in the range 00 to 05

98 = Not applicable: Augmented care period not finished

99 = Not known: a validation error

Rule Rule 1050



Dataset: Admitted Patient Care

Year and month of data (PARTYEAR)

Field	PARTYEAR
Field Name	Year and month of data
Category	Episodes and spells ; Period of care
Length and format	mm/yyyy
Availability	All years
Description	
Year and month of data	
Value	
mm/yyyy	
Rule	



Dataset: Admitted Patient Care

Patient pathway ID (PATPATHID)

Field	PATPATHID
Field Name	Patient pathway ID
Category	Patient Pathway
Length and format	20an
Availability	2007-08 onwards
Description	

A code that, when combined with the organisation code of either the issuer or the organisation receiving the service request, identifies a patient's pathway. For example, the Unique Booking Reference Number of the first referral and X09 (the organisation code for NHS Connecting for Health).

Value

20an = patient pathway identifier

Rule Data not cleaned



Dataset: Admitted Patient Care

Postcode Found (PCFOUND)

Field	PCFOUND
Field Name	Postcode Found
Category	Patient Data
Length and format	1a
Availability	All years
Description	
Field confirms if postcode is valid	
Value	
Y = Postcode vaild, N = Postcode invalid	
Rule	Not applicable (derived by rule 1200)



Dataset: Admitted Patient Care

Primary care group (PCGCODE)

Field	PCGCODE
Field Name	Primary care group
Category	Organisation
Length and format	5an
Availability	1999-00 to 2001-02
Description	

A derived field providing the Primary Care Group responsible for the patient.

Value

Not available

Rule Not applicable (derived by rule 1160)

Dataset: Admitted Patient Care

Origin of primary care group (PCGORIG)

Field	PCGORIG
Field Name	Origin of primary care group
Category	System Data
Length and format	1n
Availability	1999-00 to 2005-06
Description	

This derived field indicates the basis on which the primary care group (PCG) code was assigned.

Value

- 1 = GPPRAC was used to derive the code ;
- 2 = REGGMP was used to derive the code ;
- 3 = PURCODE was used to derive the code ;
- 4 = POSTCODE was used to derive the code ;
- 5 = POSTCODE allocated code, PCG code was blank ;
- 6 = POSTCODE allocated code, PCG code was 49998 ;



9 = PCG code not known

Rule

Not applicable (derived by rule 1160)



Dataset: Admitted Patient Care

Westminster parliamentary constituency (PCON)

Field	PCON
Field Name	Westminster parliamentary constituency
Category	Geographical
Length and format	3n
Availability	2008-09 onwards
Description	

The pre-2011 Westminster Parliamentary Constituency code for each postcode. Pseudo codes are included for Channel Islands and Isle of Man. The field will be blank for postcodes with no grid reference.

Value

Rule Not applicable (derived by rule 1200)



Dataset: Admitted Patient Care

**Westminster parliamentary constituency (ONS)
(PCON_ONS)**

Field	PCON_ONS
Field Name	Westminster parliamentary constituency (ONS)
Category	Geographical
Length and format	3n
Availability	
Description	<p>The Westminster Parliamentary Constituency code for each postcode. Pseudo codes are included for Channel Islands and Isle of Man. The field will be blank for postcodes with no grid reference.</p>
Value	
Rule	Not applicable (derived by rule 1200)



Dataset: Admitted Patient Care

Pseudonymised consultant team code (PCONSULT)

Field	PCONSULT
Field Name	Pseudonymised consultant team code
Category	Practitioner
Length and format	16an
Availability	1997-98 onwards
Description	

A pseudonymised version of the General Medical Council (GMC) code for the consultant. The Consultant code (consult) field contains the actual GMC code. However, it is a sensitive field that requires the approval of the Data Access Advisory Group (DAAG) before you can be given access to it.

Value

16an = Pseudonymised consultant team code ;

& = Not known

Rule



Dataset: Admitted Patient Care

Primary care trust of responsibility (PCTCODE)

Field	PCTCODE
Field Name	Primary care trust of responsibility
Category	Organisation
Length and format	3an
Availability	1997-98 to 2005-06

Description

A derived field providing the primary care trust responsible for the patient. Commissioning responsibility for individual patients rests with the primary care trust (PCT) with whom the patient is registered. This means that patients with a GP in one PCT area may reside in a neighbouring or other area but remain the responsibility of the PCT with whom their GP of registration is associated. PCTs are also responsible for non-registered patients who are resident within their boundaries.

Value

nan, naa or aaa = Primary care trust ;

59898 = Not applicable ;

59999 = Unknown

Rule	Not applicable (derived by rule 1160)
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Dataset: Admitted Patient Care

Primary care trust of responsibility - historic (PCTCODE02)

Field	PCTCODE02
Field Name	Primary care trust of responsibility - historic
Category	Organisation
Length and format	3an
Availability	2006-07 to 2012-13
Description	

A derived field providing the primary care trust responsible for the patient. Commissioning responsibility for individual patients rests with the primary care trust (PCT) with whom the patient is registered. This means that patients with a GP in one PCT area may reside in a neighbouring or other area but remain the responsibility of the PCT with whom their GP of registration is associated. PCTs are also responsible for non-registered patients who are resident within their boundaries. In years post 2006/07 it is populated based on the structure that existed prior to the 1st of October 2006/07.

Value

nan, naa or aaa = Primary care trust ;



59898 = Not applicable ;

59999 = Unknown

Rule

rule 1165



Dataset: Admitted Patient Care

Primary care trust of responsibility - current (PCTCODE06)

Field	PCTCODE06
Field Name	Primary care trust of responsibility - current
Category	Organisation
Length and format	3an
Availability	2006-07 onwards
Description	

A derived field providing the primary care trust responsible for the patient. Commissioning responsibility for individual patients rests with the primary care trust (PCT) with whom the patient is registered. This means that patients with a GP in one PCT area may reside in a neighbouring or other area but remain the responsibility of the PCT with whom their GP of registration is associated. PCTs are also responsible for non-registered patients who are resident within their boundaries. In years before 2006/07 it is populated based on the structure that existed in 2006/07

Value

nan, naa or aaa = Primary care trust ;

59898 = Not applicable ;



59999 = Unknown

Rule

Not applicable (derived by rule 1160)



Dataset: Admitted Patient Care

Origin of primary care trust of responsibility (PCTORIG)

Field	PCTORIG
Field Name	Origin of primary care trust of responsibility
Category	System Data
Length and format	1n
Availability	1997-98 to 2005-06
Description	

This derived field indicates the basis on which the primary care trust (PCT) of responsibility code was assigned.

Value

- 1 = GPPRAC was used to derive the code ;
- 2 = REGGMP was used to derive the code ;
- 3 = PURCODE was used to derive the code ;
- 4 = POSTCODE was used to derive the code ;
- 5 = POSTCODE allocated code, PCT code was blank ;



6 = POSTCODE allocated code, PCT code ;

9 = PCT code not known

Rule

Not applicable (derived by rule 1160)



Dataset: Admitted Patient Care

Origin of primary care trust of responsibility - historic (PCTORIG02)

Field	PCTORIG02
Field Name	Origin of primary care trust of responsibility - historic
Category	System Data
Length and format	1n
Availability	2006-07 to 2012-13
Description	

This derived field indicates the basis on which the primary care trust (PCT) of responsibility code was assigned.

Value

- 1 = GPPRAC was used to derive the code ;
- 2 = REGGMP was used to derive the code ;
- 3 = PURCODE was used to derive the code ;
- 4 = POSTCODE was used to derive the code ;
- 5 = POSTCODE allocated code, PCT code was blank ;



6 = POSTCODE allocated code, PCT code was 59998 ;

9 = PCT code not known

Rule	
	Not applicable (derived by rule 1165)



Dataset: Admitted Patient Care

Origin of primary care trust of responsibility - current (PCTORIG06)

Field	PCTORIG06
Field Name	Origin of primary care trust of responsibility - current
Category	System Data
Length and format	1n
Availability	2006-07 onwards
Description	

This derived field indicates the basis on which the primary care trust (PCT) of responsibility code was assigned.

Value

- 1 = GPPRAC was used to derive the code ;
- 2 = REGGMP was used to derive the code ;
- 3 = PURCODE was used to derive the code ;
- 4 = POSTCODE was used to derive the code ;
- 5 = POSTCODE allocated code, PCT code was blank ;



6 = POSTCODE allocated code, PCT code was 59998 ;

9 = PCT code not known

Rule

Not applicable



Dataset: Admitted Patient Care

Primary Care Trust area of main provider (PCTTREAT)

Field	PCTTREAT
Field Name	Primary Care Trust area of main provider
Category	Geographical
Length and format	naa
Availability	1996-97 onwards
Description	

This field is derived from the hospital provider code (procode). It indicates the PCT area of the main provider of treatment. Note that the PCT itself may be the provider of treatment.

Note: This field was formerly known as “Primary care trust area of treatment”

Value	
	3an = Primary care trust of main provider
	59898 = Not applicable



59999 = Unknown

Rule

Not applicable (derived by rule 1145)



Dataset: Admitted Patient Care

Post-operative duration (POSOPDUR)

Field POSOPDUR

Field Name Post-operative duration

Category Clinical

Length and format 3n

Availability All years

Description

This derived field contains the difference in days between the date of the main operation (opdte_01) and the date the episode ended (epiend).

Value

3n = Number of days between the main operation and the end of the episode from 0-365

null = Not applicable: no operation or episode unfinished

Rule Not applicable (derived by rule 1070)



Dataset: Admitted Patient Care

Postcode district of patient's residence (POSTDIST)

Field	POSTDIST
Field Name	Postcode district of patient's residence
Category	Patient Data
Length and format	4an
Availability	All years
Description	Contains the outward portion of the patient's postcode (ie all characters to the left of the space). The code ZZ99 indicates the postcode was either unavailable, or that the patient did not have one (eg because they were normally resident abroad).
Value	
	aann = Postcode district ; ZZ99 = Unavailable / not applicable
Rule	Not applicable (derived from homeadd by rule 1200)



Dataset: Admitted Patient Care

Postnatal stay (POSTDUR)

Field POSTDUR

Field Name Postnatal stay

Category Maternity

Length and format 3n

Availability All years

Description

This derived field contains the number of days between the baby's birth and the end of the finished episode. It is calculated from episode end date (epiend) and the first baby's date of birth (dobbaby).

Value

3n = The number of days of stay, from 0 to 270 ;

null = Not applicable / not known

Rule Not applicable (derived by rule 820)



Dataset: Admitted Patient Care

Pseudonymised referrer code (PREFERRER)

Field	PREFERRER
Field Name	Pseudonymised referrer code
Category	Practitioner
Length and format	16an
Availability	All years
Description	

A pseudonymised version of the code of the person referring the patient. The Person referring patient (Referrer) field contains the actual codes. However, it is a sensitive field that requires the approval of the Data Access Advisory Group (DAAG) before you can be given access to it.

Value

16an = pseudonymised referrer code ;
& = Unknown

Rule



Dataset: Admitted Patient Care

Pseudonymised code of patient's registered or referring general medical practitioner (PREGGMP)

Field	PREGGMP
Field Name	Pseudonymised code of patient's registered or referring general medical practitioner
Category	Practitioner
Length and format	16an
Availability	1997-98 onwards
Description	

A pseudonymised version of the code of the patient's registered or referring general medical practitioner. The Code of patient's registered or referring general medical practitioner (reggmp) field contains the actual codes. However, it is a sensitive field that requires the approval of the Data Access Advisory Group (DAAG) before you can be given access to it.

Value

16an = Pseudonymised registered GP code ;

& = Unknown



Rule



Dataset: Admitted Patient Care

Pre-operative duration (PREOPDUR)

Field PREOPDUR

Field Name Pre-operative duration

Category Clinical

Length and format 3n

Availability All years

Description

This derived field contains the difference in days between the date the episode started (epistart) and the date of the main operation (opde_01).

Value

3n = Number of days between the start of the episode and the main operation from 0-365

null = Not applicable: no operation or episode unfinished

Rule Not applicable (derived by rule 1075)



Dataset: Admitted Patient Care

Provider code - 3 character (PROCEDURE3)

Field	PROCEDURE3
Field Name	Provider code - 3 character
Category	Organisation
Length and format	3an
Availability	All years
Description	

A provider code is a unique code that identifies an organisation acting as a health care provider. The code is managed by the National Administrative Codes Service (NACS) and supports the identification of organisations exchanging information within the NHS. Procedure3 contains only the first three characters (the organisation code) and can be used to identify an individual provider (eg NHS Trust or PCT).

Value

3an = 3-character provider code

Rule



Dataset: Admitted Patient Care

Provider code - 5 character (PROCEDURE5)

Field	PROCEDURE5
Field Name	Provider code - 5 character
Category	Organisation
Length and format	5an
Availability	All years
Description	

A provider code is a unique code that identifies an organisation acting as a health care provider. The code is managed by the National Administrative Codes Service (NACS) and supports the identification of organisations exchanging information within the NHS. Procode contains the complete NHS provider code (ie organisation code plus site code).

Value

5an = 5-character provider code ;

89997 = Non-UK provider where no organisation code has been issued ;

89999 = Non-NHS UK provider where no organisation code has been issued

Rule	
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Dataset: Admitted Patient Care

Provider code (PROCODET)

Field	PROCODET
Field Name	Provider code
Category	Organisation
Length and format	5an
Availability	2003-04 onwards
Description	

This field gives a combination of 3-character and 5-character provider codes. Procodet enables you to view a combined list of codes, and related data, from: 1. Primary care trusts (3 character, beginning with 5) 2. NHS trusts (3 character, beginning with R. Trusts with associated treatment centres will have an ' - X' following their code) 3. NHS trust treatment centres (5 character; listed separately to the NHS trusts) 4. Independent providers (5 character, beginning with 8) 5. Independent sector healthcare providers (5 character, beginning with N) For 3-character codes only see procode (provider code - 3 character) and for 5-character codes only see procode (provider code

Value

5an = Provider code

Rule



Dataset: Admitted Patient Care

Provider type (PROTYPE)

Field	PROTYPE
Field Name	Provider type
Category	Organisation
Length and format	Various
Availability	2003-04 onwards
Description	
Healthcare provider type	
Value	
Caretrust = Care trust ; Foundation = NHS foundation trust ; Ind = Independent sector provider ; Indsite = Independent sector provider site ; Indsitetc = Treatment centre at independent sector provider site ; Otherprov = Other provider organisation ; PCT = Primary care trust ; Trust = NHS trust ;	



Trustsitetc = Treatment centre at NHS trust site

Rule

Not applicable (derived from reference data)



Dataset: Admitted Patient Care

Hospital provider spell number (PROVSPNO)

Field	PROVSPNO
Field Name	Hospital provider spell number
Category	Episodes and spells ; Period of care
Length and format	12an
Availability	1997-98 onwards
Description	
Hospital provider spell number. A number to provide a unique identifier for each Hospital Provider Spell for a Health Care Provider.	
Value	
Not available	
Rule	None



Dataset: Admitted Patient Care

Commissioner code (PURCODE)

Field	PURCODE
Field Name	Commissioner code
Category	Organisation
Length and format	5an
Availability	All years
Description	

This field contains a code for the organisation commissioning the patient's treatment. There are six main types of purchaser, the prevalence of each being dependent on the data year:

1. Health Authorities
2. GP fund holders
3. Primary care Groups
4. Primary care Trusts
5. Private patients
6. Department of Health - the Department purchases treatment for patients from abroad (either under EU regulations or other reciprocal agreements) and for certain UK residents whose treatment is centrally financed, notably those treated by Special

Health Authorities.	
Value	
5an = Commissioner code	
Rule	Rule 340



Dataset: Admitted Patient Care

Commissioner's Regional Office (PURRO)

Field	PURRO
Field Name	Commissioner's Regional Office
Category	Organisation
Length and format	5an
Availability	1995-96 to 2001-02
Description	

This field contains a code which identifies the Regional Office (RO) in which the purchaser is located. It is derived from the purcode field.

The current codes include those used in 1995-96 and those used subsequently. There were alterations to the codes from April 1996 and April 1999 to reflect changes in the regional organisation.

Value

From 1999-2000 to 2001-2002:

S or S0000 = Scotland ;

W or W0000 = Wales ;

Y01 = Northern and Yorkshire ;



Y02 = Trent ;

Y07 = West Midlands ;

Y08 = North West ;

Y09 = Eastern ;

Y10 = London ;

Y11 = South East ;

Y12 = South West ;

Z or Z0000 = Northern Ireland ;

null = Not known ;

From 1996-97 to 1998-99:

S or S0000 = Scotland ;

W or W0000 = Wales ;

Y01 = Northern and Yorkshire ;

Y02 = Trent ;

Y03 = Anglia and Oxford ;

Y04 = North Thames ;

Y05 = South Thames ;

Y06 = South and West ;

Y07 = West Midlands ;

Y08 = North West ;

Z or Z0000 = Northern Ireland ;

null = Not known ;



9999 = Not known ;

1995-96:

A0000 = Northern ;

B0000 = Yorkshire ;

C0000 = Trent ;

D0000 = East Anglia ;

E0000 = North West Thames ;

F0000 = North East Thames ;

G0000 = South East Thames ;

H0000 = South West Thames ;

J0000 = Wessex ;

K0000 = South Western ;

M0000 = West Midlands ;

N0000 = Mersey ;

P0000 = North Western ;

Z or Z0000 = Northern Ireland ;

null = Not known ;

9999 = Not known

Rule

Not applicable (derived by rule 1150)



Dataset: Admitted Patient Care

Commissioner's Strategic Health Authority (PURSTHA)

Field	PURSTHA
Field Name	Commissioner's Strategic Health Authority
Category	Organisation
Length and format	3an
Availability	2002-03 to 2012-13
Description	

This field contains a code which identifies the strategic health authority (SHA) in which the commissioner is located. It is derived from the purcode field.

Value

3an = Commissioner's strategic health authority ;

S = Scotland ;

X = Foreign (including Isle of Man and Channel Islands) ;

Y = Unknown ;

Z = Northern Ireland

Rule	Not applicable (derived by rule 1155)
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Dataset: Admitted Patient Care

Commissioner code status (PURVAL)

Field	PURVAL
Field Name	Commissioner code status
Category	Organisation
Length and format	1n
Availability	1995-96 onwards
Description	

A derived field that indicates whether the purchaser code (purcode) is one that is recognised throughout the NHS. If not, the code may have been agreed locally between the hospital provider and the health care purchaser.

Value

0 = Purchaser code is not recognised throughout the NHS ;

1 = Purchaser code is recognised throughout the NHS

Rule	Not applicable (derived by rule 1150)
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Dataset: Admitted Patient Care

Referring organisation code (REFERORG)

Field	REFERORG
Field Name	Referring organisation code
Category	Practitioner
Length and format	6an
Availability	2002-03 onwards
Description	

The organisation code of the organisation from which the referral is made, such as GP practice or NHS trust.

Value

6an = Referring organisation code ;

X99998 = Not applicable ;

X99999 = Not known

Rule	None
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Dataset: Admitted Patient Care

Referrer code (REFERRER)

Field	REFERRER
Field Name	Referrer code
Category	Practitioner
Length and format	8an
Availability	1997-98 onwards
Description	

The code for the person referring the patient. This may be the GMC code for the consultant, or the code that defines the practice of the patient's registered GMP or GDP. This field contains sensitive data. Access to it requires the approval of the Data Access Advisory Group (DAAG).

Value

Cnnnnnnn = Consultant's GMC code ;

CD999998 = Dental consultant: General Medical Council (GMC) number / General Dental Council (GDC) number not known ;

Dnnnnnnn = Dentist's GMC code ;

R9999981 = Referrer other than General Medical Practitioner, General Dental Practitioner or Consultant ;



X9999998 = Not applicable: no code available (referrer not a GMP, GDP or consultant or emergency admission not via GP or GP not located in England) ;

& = Not known

Rule

Rule 410



Dataset: Admitted Patient Care

Code of patient's registered or referring general medical practitioner (REGGMP)

Field	REGGMP
Field Name	Code of patient's registered or referring general medical practitioner
Category	Practitioner
Length and format	8an
Availability	1997-98 onwards
Description	

This is normally the code of the General Medical Practitioner with whom the patient is registered. This field contains sensitive data. Access to it requires the approval of the Data Access Advisory Group (DAAG).

Value

G9999998 = GP code is unknown ;

G9999981 = No registered GP ;

R9999981 = No referring GP ;

A9999998 = MOD doctor refers ;



P9999981 = Prison doctor

Rule

Rule 430



Dataset: Admitted Patient Care

County of residence (RESCTY)

Field	RESCTY
Field Name	County of residence
Category	Geographical
Length and format	2an
Availability	All years
Description	

This field contains a code that defines the county of residence of the patient. It is derived from the patient's postcode in the field homeadd.

Value

00 = Not available (patient was resident within a Unitary Authority)

11 = Buckinghamshire ;

12 = Cambridgeshire ;

16 = Cumbria ;

17 = Derbyshire ;

18 = Devon ;

19 = Dorset ;
21 = East Sussex ;
22 = Essex ;
23 = Gloucestershire ;
24 = Hampshire ;
26 = Hertfordshire ;
29 = Kent ;
30 = Lancashire ;
31 = Leicestershire ;
32 = Lincolnshire ;
33 = Norfolk ;
34 = Northamptonshire ;
36 = North Yorkshire ;
37 = Nottinghamshire ;
38 = Oxfordshire ;
40 = Somerset ;
41 = Staffordshire ;
42 = Suffolk ;
43 = Surrey ;
44 = Warwickshire ;
45 = West Sussex ;
47 = Worcestershire ;



S = Scotland ;

U = England ;

W = Wales ;

X = Foreign (from 1990-91 onwards) ;

Y = Not known ;

Z = Northern Ireland ;

Rule	Not applicable (derived by rule 1200)
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Dataset: Admitted Patient Care

County of residence (ONS) (RESCTY_ONS)

Field	RESCTY_ONS
Field Name	County of residence (ONS)
Category	Geographical
Length and format	9an
Availability	
Description	<p>This field contains a code that defines the county of residence of the patient. It is derived from the patient's postcode in the field homeadd.</p>
Value	
	<p>9an = Country of Residence (ONS)</p>
Rule	Not applicable (derived by rule 1200)



Dataset: Admitted Patient Care

Government office region of residence (RESGOR)

Field	RESGOR
Field Name	Government office region of residence
Category	Geographical
Length and format	1a
Availability	1996-97 onwards
Description	

This derived field contains a code that defines the Government Office Region of residence of the patient. It is derived from the patient's postcode in the field homeadd.

Value

A = North East ;
B = North West ;
C = Merseyside (until 1998-99) ;
D = Yorkshire and Humber ;
E = East Midlands ;
F = West Midlands ;

G = East of England ;

H = London ;

J = South East ;

K = South West ;

S = Scotland ;

U = No fixed above ;

W = Wales ;

X = Foreign (including Isle of Man and Channel Islands) ;

Y = Unknown ;

Z = Northern Ireland

Rule

Not applicable (derived by rule 1200)



Dataset: Admitted Patient Care

**Government office region of residence (ONS)
(RESGOR_ONS)**

Field	RESGOR_ONS
Field Name	Government office region of residence (ONS)
Category	Geographical
Length and format	9an
Availability	
Description	<p>This derived field contains a code that defines the Government Office Region of residence of the patient. It is derived from the patient's postcode in the field homeadd.</p>
Value	<p>9an = Government office region of residence (ONS)</p>
Rule	Not applicable (derived by rule 1200)



Dataset: Admitted Patient Care

Health Authority of residence (RESHA)

Field	RESHA
Field Name	Health Authority of residence
Category	Geographical
Length and format	3a
Availability	All years
Description	

Health Authority (HA) of residence (contains the District Health Authority of residence prior to 1 April 1996). This derived field contains the code for the HA in which the patient lived immediately before admission. Resha is derived from the patient's postcode in the field homeadd. (This may not be the area where treatment took place (hatreat).) If homeadd is not recognised, resha may be derived from the health authority of residence notified by the hospital (har). From 2002-03 information relating to the strategic health authority of residence is available.

Value

3a = Health authority of residence ;
S = Scotland ;
U = England - not otherwise specified ;

W = Wales ;

X = Foreign (including Isle of Man and Channel Islands) ;

Y = Unknown ;

Z = Northern Ireland

Rule

Not applicable - derived by the following rules: Rule 1200



Dataset: Admitted Patient Care

Local authority district (RESLADST)

Field	RESLADST
Field Name	Local authority district
Category	Geographical
Length and format	4an
Availability	All years
Description	

This derived field contains a code for the patient's county (first two characters) and local authority district (last two characters) of residence. It is derived from the patient's postcode in the field homeadd. This field is used in conjunction with currward (current electoral ward) to produce a unique value indicating the ward within a given district where the patient resided (ie because identical Currward codes are allocated to many local authority districts, currward is meaningless in isolation). If the patient is resident within a Unitary Authority, the first two characters will be 00 (zero, zero) and the local authority component may not be useable.

Value

nnaa = Local authority code ;

S = Scotland ;



U = England (NOS) ;

W = Wales ;

Y = Not known ;

Z = Northern Ireland ;

X = Foreign (from 1991 onwards) ;

9999 = Not known

Rule	
	Not applicable (derived by rule 1200)



Dataset: Admitted Patient Care

Local authority district (ONS) (RESLADST_ONS)

Field	RESLADST_ONS
Field Name	Local authority district (ONS)
Category	Geographical
Length and format	4an
Availability	TBC
Description	

This derived field contains a code for the patient's county (first two characters) and local authority district (last two characters) of residence. It is derived from the patient's postcode in the field homeadd. This field is used in conjunction with currward (current electoral ward) to produce a unique value indicating the ward within a given district where the patient resided (ie because identical Currward codes are allocated to many local authority districts, currward is meaningless in isolation). If the patient is resident within a Unitary Authority, the first two characters will be 00 (zero, zero) and the local authority component may not be useable.

Value

TBC

Rule Not applicable (derived by rule 1200)



Dataset: Admitted Patient Care

Patient's Primary Care Trust of residence (RESPCT)

Field RESPCT

Field Name Patient's Primary Care Trust of residence

Category Geographical

Length and format 3an

Availability 1997-98 to 2005-06

Description

This derived field contains the code for the primary care trust (PCT) in which the patient lived immediately before admission. It is derived from the patient's postcode in the field homeadd.

Value

naa or nan = Primary care trust of residence ;

59999 = Unknown ;

59898 = Not applicable

Rule Not applicable (derived by rule 1200)



Dataset: Admitted Patient Care

**The primary care trust of residence - mapped
according to source year (RESPCT_HIS)**

Field	RESPCT_HIS
Field Name	The primary care trust of residence - mapped according to source year
Category	Geographical
Length and format	TBC
Availability	TBC
Description	
TBC	
Value	
TBC	
Rule	Not applicable (derived by rule 1200)



Dataset: Admitted Patient Care

Patient's Primary Care Trust of residence - historic (RESPCT02)

Field	RESPCT02
Field Name	Patient's Primary Care Trust of residence - historic
Category	Geographical
Length and format	3an
Availability	2006-07 to 2012-13
Description	

This derived field contains the code for the primary care trust (PCT) in which the patient lived immediately before admission. It is derived from the patient's postcode in the field homeadd.

Value

naa or nan = Primary care trust of residence ;

59999 = Unknown ;

59898 = Not applicable



Rule	Not applicable (derived by rule 1200)
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Dataset: Admitted Patient Care

Patient's Primary Care Trust of residence – current (RESPCT06)

Field	RESPCT06
Field Name	Patient's Primary Care Trust of residence – current
Category	Geographical
Length and format	3an
Availability	2006-07 onwards
Description	

This derived field contains the code for the primary care trust (PCT) in which the patient lived immediately before admission. It is derived from the patient's postcode in the field homeadd.

Value

naa or nan = Primary care trust of residence ;

59999 = Unknown ;

59898 = Not applicable



Rule	Not applicable (derived by rule 1200)
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Dataset: Admitted Patient Care

Regional Office of residence (RESRO)

Field	RESRO
Field Name	Regional Office of residence
Category	Geographical
Length and format	3an
Availability	1996-97 onwards
Description	

Regional Office (RO) of residence (contains the Regional Health Authority of residence prior to 1 April 1996). It contains the code for the RO in which the patient lived immediately before admission. It is derived from the patient's postcode in the field homeadd.

Value

From 1 April 1999:

Y01 = Northern and Yorkshire ;

Y02 = Trent ;

Y07 = West Midlands ;

Y08 = North West ;

Y09 = Eastern ;

Y10 = London ;

Y11 = South East ;

Y12 = South West ;

W00 = Wales ;

S00 = Scotland ;

Z00 = Northern Ireland ;

U00 = England - not otherwise specified ;

Y00 = Unknown ;

X00 = Foreign (including the Isle of Man and Channel Islands) ;

From 1 April 1996 to 31 March 1999:

Y01 = Northern and Yorkshire ;

Y02 = Trent ;

Y03 = Anglia and Oxford ;

Y04 = North Thames ;

Y05 = South Thames ;

Y06 = South and West ;

Y07 = West Midlands ;

Y08 = North West ;

W = Wales ;

S = Scotland ;

Z = Northern Ireland ;



U = England NOS ;

Y = Not known ;

X = Foreign ;

From 1 April 1989 to 31 March 1996:

Y0A = Northern RHA ;

Y0B = Yorkshire RHA ;

Y0C = Trent RHA ;

Y0D = East Anglian RHA ;

Y0E = North West Thames RHA ;

Y0F = North East Thames RHA ;

Y0G = South East Thames RHA ;

Y0H = South West Thames RHA ;

Y0J = Wessex RHA ;

Y0K = Oxford RHA ;

Y0L = South Western RHA ;

Y0M = West Midlands RHA ;

Y0N = Mersey RHA ;

Y0P = North Western RHA ;

Y0Y = Not known

Rule

Not applicable - derived by the following rules: Rule 1200



Dataset: Admitted Patient Care

Patient's Strategic Health Authority of residence (RESSTHA)

Field	RESSTHA
Field Name	Patient's Strategic Health Authority of residence
Category	Geographical
Length and format	3an
Availability	1997-98 to 2005-06
Description	<p>This derived field contains the code for the strategic health authority (SHA) in which the patient lived immediately before admission. It is derived from the patient's postcode in the field homeadd.</p>
Value	<p>3an = Strategic health authority of residence ;</p> <p>Y = Not known</p>
Rule	Not applicable (derived by rule 1200)



Dataset: Admitted Patient Care

Patient's Strategic Health Authority of residence - historic (RESSTHA02)

Field	RESSTHA02
Field Name	Patient's Strategic Health Authority of residence - historic
Category	Geographical
Length and format	3an
Availability	2006-07 to 2012-13
Description	

This derived field contains the code for the strategic health authority (SHA) in which the patient lived immediately before admission. It is derived from the patient's postcode in the field homeadd.

Value

3an = Strategic health authority of residence ;

Y = Not known

Rule	Not applicable (derived by rule 1200)
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Dataset: Admitted Patient Care

Patient's Strategic Health Authority of residence - current (RESSTHA06)

Field	RESSTHA06
Field Name	Patient's Strategic Health Authority of residence - current
Category	Geographical
Length and format	3an
Availability	2006-07 onwards
Description	

This derived field contains the code for the strategic health authority (SHA) in which the patient lived immediately before admission. It is derived from the patient's postcode in the field homeadd.

Value

3an = Strategic health authority of residence ; Y = Not known

Rule Not applicable (derived by rule 1200)



Dataset: Admitted Patient Care

Region of treatment (ROTREAT)

Field	ROTREAT
Field Name	Region of treatment
Category	Geographical
Length and format	3an
Availability	All years
Description	

Region of treatment (contains the Regional Health Authority of treatment prior to 1 April 1996). This derived field is extracted from the hospital provider code (procode). It defines the Regional Office (RO) where the treatment took place.

Value

From 1 April 1999:

Y01 = Northern and Yorkshire ;

Y02 = Trent ;

Y07 = West Midlands ;

Y08 = North West ;

Y09 = Eastern ;

Y10 = London ;

Y11 = South East ;

Y12 = South West ;

Y = Not Known ;

From 1 April 1996 to 31 March 1999:

Y01 = Northern and Yorkshire ;

Y02 = Trent ;

Y03 = Anglia and Oxford ;

Y04 = North Thames ;

Y05 = South Thames ;

Y06 = South and West ;

Y07 = West Midlands ;

Y08 = North West ;

Y = Not Known ;

From 1 April 1989 to 31 March 1996:

Y0A = Northern RHA ;

Y0B = Yorkshire RHA ;

Y0C = Trent RHA ;

Y0D = East Anglian RHA ;

Y0E = North West Thames RHA ;

Y0F = North East Thames RHA ;

Y0G = South East Thames RHA ;



Y0H = South West Thames RHA ;

Y0J = Wessex RHA ;

Y0K = Oxford RHA ;

Y0L = South Western RHA ;

Y0M = West Midlands RHA ;

Y0N = Mersey RHA ;

Y0P = North Western RHA ;

Y0Y = Not known

Rule	Not applicable (derived by rule 1145)
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Dataset: Admitted Patient Care

RTT period end date (RTTPEREND)

Field	RTTPEREND
Field Name	RTT period end date
Category	Patient Pathway
Length and format	dd/mm/yyyy (Date)
Availability	2007-08 onwards
Description	
The end date, for the referral to treatment period.	
Value	
dd/mm/yyyy = RTT period end date	
Rule	Data not cleaned



Dataset: Admitted Patient Care

RTT period start date (RTTPERSTART)

Field	RTTPERSTART
Field Name	RTT period start date
Category	Patient Pathway
Length and format	dd/mm/yyyy (Date)
Availability	2007-08 onwards
Description	
The start date, for the referral to treatment period.	
Value	
dd/mm/yyyy = RTT period start date	
Rule	Data not cleaned



Dataset: Admitted Patient Care

RTT period status (RTTPERSTAT)

Field	RTTPERSTAT
Field Name	RTT period status
Category	Patient Pathway
Length and format	2n
Availability	2007-08 onwards
Description	

The status of an activity, or anticipated activity, for the referral to treatment period.

Value

The first activity in a referral to treatment period:

10 - First activity ;

11 - End of active monitoring ;

12 - Consultant referral ; Subsequent activity during a referral to treatment period:

20 - subsequent activity. Further activities anticipated ;

21 - Transfer to another healthcare provider ; Activity that ends a referral to treatment period:

30 - First treatment - the start of the first treatment that's intended to manage a patient's

disease, condition or injury. ;

31 - Start of active monitoring, initiated by the patient ;

32 - Start of active monitoring, initiated by the care professional ;

33 - Failure to attend the first care activity after referral ; 34 - Decision not to treat or not further contact required ;

35 - Patient decline offered treatment ;

36 - Patient died before treatment ; Activity that is not part of a referral to treatment period:

90 - After treatment - first treatment occurred previously, eg admitted as an emergency from A&E

91 - Active monitoring (the patient is observed but not treated) ;

92 - Not yet referred ;

98 - Not applicable ; Activity where the referral to treatment period status is not yet known:

99 - Not yet known

Rule

Data not cleaned



Dataset: Admitted Patient Care

Rural/Urban Indicator (RURURB_IND)

Field	RURURB_IND
Field Name	Rural/Urban Indicator
Category	Geographical
Length and format	1n
Availability	1995-96 onwards
Description	

Describes the nature of an Output Area in terms of its morphology (hamlet, town, urban, etc) and context (sparse or less sparse).

Value

1 = Urban =>10K - sparse: Output Area falls within Urban settlements with a population of 10,000 or more and the wider surrounding area is sparsely populated. ;

2 = Town and Fringe - sparse. Output Area falls within the Small Town and Fringe areas category and the wider surrounding area is sparsely populated. ;

3 = Village - sparse. Output Area falls within the Village category and the wider surrounding area is sparsely populated. ;

4 = Hamlet and Isolated dwelling - sparse. Output Area fall within the Hamlet & Isolated Dwelling category and the wider surrounding area is sparsely populated. ;

5 = Urban =>10K - less sparse. Output Area falls within Urban settlements with a population of 10,000 or more and the wider surrounding area is less sparsely populated. ;

6 = Town and Fringe - less sparse. Output Area falls within the Small Town and Fringe areas category and the wider surrounding area is less sparsely populated. ;

7 = Village - less sparse. Output Area falls within the Village category and the wider surrounding area is less sparsely populated. ;

8 = Hamlet and Isolated Dwelling - less sparse. Output Area falls within the Hamlet & Isolated Dwelling category and the wider surrounding area is less sparsely populated. ;

9 = postcode in Scotland/NI/Channel Islands/Isle of Man/pseudopostcodes ;

Space = No information available

Rule

Data not cleaned



Dataset: Admitted Patient Care

Sex of patient (SEX)

Field	SEX
Field Name	Sex of patient
Category	Patient Data
Length and format	1n
Availability	All years
Description	

This field contains a code which defines the sex of the patient. The field based on the field 'Person Gender Code' as defined in the NHS Data Dictionary:
<http://www.datadictionary.nhs.uk>

Value

From 1996-97 onwards:

1 = Male ;

2 = Female ;

9 = Not specified ;

0 = Not known ;

Prior to April 1996:



1 = Male ;

2 = Female ;

3 = Indeterminate, including those undergoing sex change operations

Rule

Rules 50, 60 and 650



Dataset: Admitted Patient Care

Sex of baby (SEXBABY)

Field	SEXBABY
Field Name	Sex of baby
Category	Maternity
Length and format	1n
Availability	All years
Description	<p>This field contains a code that defines the sex of the baby. This item appears for each baby on multiple birth delivery records.</p>
Value	<p>From 1996-97:</p> <p>1 = Male ;</p> <p>2 = Female ;</p> <p>9 = Not specified ;</p> <p>0 = Not known ;</p> <p>Up to 1996-97:</p>



1 = Male ;

2 = Female ;

3 = Indeterminate, including those undergoing sex change operations

Rule

None



Dataset: Admitted Patient Care

Site code of treatment (SITETRET)

Field	SITETRET
Field Name	Site code of treatment
Category	Geographical
Length and format	5an
Availability	1997-98 onwards
Description	

This field contains a code that defines the site on which the patient was treated within an organisation.

Value

5an = Site code of treatment ;

89999 = Non-NHS UK provider where no organisation site code has been issued ;

89997 = Not applicable: non-UK provider

Rule	None
------	------



Dataset: Admitted Patient Care

Beginning of spell (SPELBGIN)

Field	SPELBGIN
Field Name	Beginning of spell
Category	Episodes and spells ; Period of care
Length and format	1n
Availability	All years
Description	

This derived field contains a code that defines whether the episode is the first of a spell and whether the spell started in the current or previous year. Other maternity events are excluded.

Value

- 0 = Not first episode of spell ;
- 1 = First episode of spell that started in previous year ;
- 2 = First episode of spell that started in current year ;
- null = Not applicable

Rule	Not applicable (derived by rule 1170)
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Dataset: Admitted Patient Care

Duration of spell (SPELDUR)

Field	SPELDUR
Field Name	Duration of spell
Category	Episodes and spells ; Period of care
Length and format	5n
Availability	All years
Description	

This derived field contains the difference in days between the admission date (admidate) and the discharge date (epiend) provided the discharge method (dismeth) confirms that the spell has finished. If the episode has not finished it is calculated from the end of the year and admidate.

Value

5n = Duration of spell in days from 0 to 29,200 ;

null = Not applicable: patient not discharged (dismeth not in range 1-5), other maternity event (epitype is 5 or 6) or not valid

Rule Not applicable (derived by rule 1180)



Dataset: Admitted Patient Care

End of spell (SPELEND)

Field	SPELEND
Field Name	End of spell
Category	Episodes and spells ; Period of care
Length and format	1a
Availability	All years
Description	

This field contains a code which defines whether the episode is the last of a spell. It is set for finished episodes (episode status - epistat - is 3) for general, delivery or birth episodes (episode type - epitype - is 1, 2 or 3) provided the discharge method (dismeth) confirms that the spell has finished.

Value

Y = Last episode of spell ;

N = Not last episode of spell

Rule Not applicable (derived by rule 1190)



Dataset: Admitted Patient Care

Age at start of episode (STARTAGE)

Field STARTAGE

Field Name Age at start of episode

Category Patient Data

Length and format 4n

Availability All years

Description

This derived field, calculated from episode start date (epistart) and date of birth (dob), contains the patient's age in whole years (From 1 to 115 (1990-91 to 1994-95) and from 1 to 120 (1995-96 onwards)). For patients under 1 year old, special codes in the range 7001 to 7007 apply.

Value

7001 = Less than 1 day ;

7002 = 1 to 6 days ;

7003 = 7 to 28 days ;

7004 = 29 to 90 days (under 3 months) ;

7005 = 91 to 181 days (approximately 3 months to under 6 months) ;



7006 = 182 to 272 days (approximately 6 months to under 9 months) ;

7007 = 273 to 364 days (approximately 9 months to under 1 year) ; null = Not applicable
(other maternity event or not known)

Rule	
	Not applicable (derived by rule 290)



Dataset: Admitted Patient Care

**Age of patients at start of episode, babies restated
(STARTAGE_CALC)**

Field	STARTAGE_CALC
Field Name	Age of patients at start of episode, babies restated
Category	Patient Data
Length and format	TBC
Availability	TBC
Description	
TBC	
Value	
TBC	
Rule	TBC



Dataset: Admitted Patient Care

Strategic Health Authority area of treatment (STHATRET)

Field	STHATRET
Field Name	Strategic Health Authority area of treatment
Category	Geographical
Length and format	3an
Availability	1996-97 onwards
Description	<p>This field is derived from the hospital provider code (procode). It indicates the strategic health authority (SHA) area within which the treatment took place.</p>
Value	<p>3an = Strategic health authority of treatment ;</p> <p>Y = Unknown</p>
Rule	Not applicable (derived by rule 1145)



Dataset: Admitted Patient Care

Submission date (SUBDATE)

Field	SUBDATE
Field Name	Submission date
Category	System Data
Length and format	dd/mm/yyyy (Date)
Availability	2000-01 onwards
Description	<p>Date on which the data used to generate the HES record was received by the Secondary Uses Service (or the NHS-Wide Clearing Service (NWCS) prior to December 2006).</p>
Value	<p>dd/mm/yyyy = Date data received</p>
Rule	Data not cleaned



Dataset: Admitted Patient Care

SUS generated Core Spell HRG (SUSCOREHRG)

Field	SUSCOREHRG
Field Name	SUS generated Core Spell HRG
Category	Healthcare resource groups (HRG) data
Length and format	5an
Availability	2009-10 onwards
Description	

The SUS PbR derived healthcare resource group (HRG) code (HRG4 from 2009-10) at Spell level.

Please note that due to possible disparities between the processing times of PbR and SUS Extract Mart, data submitted to SUS close to the deadline may have not yet been assigned a HRG. Also, analysing this field by episode in HES could lead to over-counting.

Value

5an = SUS generated Core Spell HRG

Null = Spells that have been excluded from PbR in SUS as the activity is outside the scope of PbR



Rule	Not applicable
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Dataset: Admitted Patient Care

SUS generated HRG (SUSHRG)

Field	SUSHRG
Field Name	SUS generated HRG
Category	Healthcare resource groups (HRG) data
Length and format	5an
Availability	2009-10 onwards
Description	

The SUS PbR derived healthcare resource group (HRG) code (HRG4 from 2009-10) at Episode level.

Value

5an = SUS generated HRG

Null = Records that have been excluded from PbR in SUS as the activity is outside the scope of PbR

Rule	Not applicable
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Dataset: Admitted Patient Care

SUS generated HRG version number (SUSHRGVERS)

Field	SUSHRGVERS
Field Name	SUS generated HRG version number
Category	Healthcare resource groups (HRG) data
Length and format	3an
Availability	2009-10 onwards
Description	
The version number for the SUS generated HRG code (sushrg).	
Value	
<p>4.0 = HRG4</p> <p>null = Not applicable</p>	
Rule	Not applicable



Dataset: Admitted Patient Care

SUS loaded staging date (SUSLDDATE)

Field	SUSLDDATE
Field Name	SUS loaded staging date
Category	System Data
Length and format	dd/mm/yyyy (Date)
Availability	2007-08 onwards
Description	
The date that the data was loaded into the SUS staging system.	
Value	
<div> <div>dd/mm/yyyy = SUS loaded staging date. hh:mm = SUS loaded staging date)</div> <div>*(From 2000-01 to 2007: dd/mm/yyyy</div> </div>	
Rule	Data not cleaned



Dataset: Admitted Patient Care

SUS record id (SUSRECID)

Field	SUSRECID
Field Name	SUS record id
Category	System Data
Length and format	14n
Availability	2007-08 onwards
Description	
SUS generated record identifier.	
Value	
14n = SUS record ID	
Rule	Data not cleaned



Dataset: Admitted Patient Care

SUS generated spell id (SUSSPELLID)

Field	SUSSPELLID
Field Name	SUS generated spell id
Category	System Data
Length and format	10n
Availability	2009-10 onwards
Description	
SUS generated spell id	
Value	
<p>10n = SUS spell ID</p> <p>Null = Records that have excluded from PbR in SUS as the activity is outside the scope of PbR</p>	
Rule	Data not cleaned



Dataset: Admitted Patient Care

Treatment specialty (TRETSPF)

Field	TRETSPF
Field Name	Treatment specialty
Category	Clinical ; Period of care
Length and format	3n or &
Availability	All years
Description	

This field contains a code that defines the specialty in which the consultant was working during the period of care. It can be compared with mainspef, the specialty under which the consultant is contracted. Prior to 1 April 1996, this data item contained the code for the sub-specialty (subspef). From April 2004 a new list of treatment specialities was introduced (see below). The new list describes the specialised service within which the patient was treated.

Value

From 1 April 2004:

100 = General surgery ;

101 = Urology ;

102 = Transplantation surgery (includes renal and liver transplants, excludes cardiothoracic

transplantation) ;

103 = Breast surgery (includes suspected neoplasms, cysts etc, does not include cosmetic surgery) ;

104 = Colorectal surgery (surgical treatment of disorders of the lower intestine - colon, anus and rectum) ;

105 = Hepatobiliary & pancreatic surgery (includes liver surgery but excludes liver transplantation see transplantation surgery) ;

106 = Upper gastrointestinal surgery ;

107 = Vascular surgery ;

110 = Trauma & orthopaedics ;

120 = Ear, nose and throat (ENT) ;

130 = Ophthalmology ;

140 = Oral surgery ;

141 = Restorative dentistry (endodontics, periodontics and prosthodontics) ;

142 = Paediatric dentistry ;

143 = Orthodontics ;

144 = Maxillo-facial surgery ;

150 = Neurosurgery ;

160 = Plastic surgery ;

161 = Burns care (recognised specialist services only - includes 'outreach' facilities) ;

170 = Cardiothoracic surgery (where there are no separate services for cardiac and thoracic surgery) ;

171 = Paediatric surgery ;

172 = Cardiac surgery ;



173 = Thoracic surgery ;

174 = Cardiothoracic transplantation (recognised specialist services only - includes 'outreach' facilities) ;

180 = Accident & emergency (A&E) ;

190 = Not a treatment function ;

191 = Pain management (complex pain disorders requiring diagnosis and treatment by a specialist multi-professional team) ;

192 = Critical care medicine (also known as intensive care medicine) ;

199 = Non-UK Provider - specialty function not known, treatment mainly surgical ;

211 = Paediatric Urology (from 2006-07) ;

212 = Paediatric Transplantation Surgery (from 2006-07);

213 = Paediatric Gastrointestinal Surgery (from 2006-07);

214 = Paediatric Trauma and Orthopaedics (from 2006-07);

215 = Paediatric Ear Nose and Throat (from 2006-07);

216 = Paediatric Ophthalmology (from 2006-07);

217 = Paediatric Maxillo-Facial Surgery (from 2006-07);

218 = Paediatric Neurosurgery (from 2006-07);

219 = Paediatric Plastic Surgery (from 2006-07);

220 = Paediatric Burns Care (from 2006-07);

221 = Paediatric Cardiac Surgery (from 2006-07);

222 = Paediatric Thoracic Surgery (from 2006-07);

241 = Paediatric Pain Management (from 2006-07);

242 = Paediatric Intensive Care (from 2006-07);



251 = Paediatric Gastroenterology (from 2006-07);
252 = Paediatric Endocrinology (from 2006-07);
253 = Paediatric Clinical Haematology (from 2006-07);
254 = Paediatric Audiological Medicine (from 2006-07);
255 = Paediatric Clinical Immunology and Allergy (from 2006-07);
256 = Paediatric Infectious diseases (from 2006-07);
257 = Paediatric Dermatology (from 2006-07);
258 = Paediatric Respiratory Medicine (from 2006-07);
259 = Paediatric Nephrology (from 2006-07);
260 = Paediatric Medical Oncology (from 2006-07);
261 = Paediatric Metabolic disease (from 2006-07);
262 = Paediatric Pneumology (from 2006-07);
280 = Paediatric Interventional Radiology (from 2006-07);
290 = Community Paediatrics (from 2006-07);
291 = Paediatric Neuro-disability (from 2006-07);
300 = General medicine ;
301 = Gastroenterology ;
302 = Endocrinology ;
303 = Clinical haematology ;
304 = Clinical Physiology (from 2008-09) ;
305 = Clinical pharmacology ;
306 = Hepatology ;



307 = Diabetic medicine ;

308 = Bone and marrow transplantation (previously part of clinical haematology) ;

309 = Haemophilia (previously part of clinical haematology) ;

310 = Audiological medicine ;

311 = Clinical genetics ;

312 = Not a treatment function ;

313 = Clinical immunology and allergy (where there are no separate services for clinical immunology and allergy) ;

314 = Rehabilitation ;

315 = Palliative medicine ;

316 = Clinical immunology ;

317 = Allergy ;

318 = Intermediate care (encompasses a range of multidisciplinary services designed to safeguard independence by maximising rehabilitation and recovery) ;

319 = Respite care ;

320 = Cardiology ;

321 = Paediatric cardiology ;

322 = Clinical microbiology ;

323 = Spinal Injuries (from 2006-07);

330 = Dermatology ;

340 = Thoracic medicine ;

341 = Respiratory Physiology (previously known as Sleep studies) ;

350 = Infectious diseases ;



352 = Tropical medicine ;

360 = Genito-urinary medicine ;

361 = Nephrology ;

370 = Medical oncology ;

371 = Nuclear Medicine (from 2008-09) ;

400 = Neurology ;

401 = Clinical Neurophysiology (from 2008-09);

410 = Rheumatology ;

420 = Paediatrics ;

421 = Paediatric neurology ;

422 = Neonatology ;

424 = Well babies (care given by the mother/substitute, with nursing advice if needed) ;

430 = Geriatric medicine ;

450 = Dental medicine ;

460 = Medical ophthalmology ;

499 = Non-UK Provider - specialty function not known, treatment mainly medical;

500 = Not a treatment function ;

501 = Obstetrics ;

502 = Gynaecology ;

503 = Gynaecological oncology ;

510 and 520 = Not treatment functions ;

560 = Midwife episode ;



600, 610 and 620 = Not treatment functions ;

650 = Physiotherapy (from 2006-07);

651 = Occupational Therapy (from 2006-07);

652 = Speech and Language Therapy (from 2006-07);

653 = Podiatry (from 2006-07);

654 = Dietetics (from 2006-07);

655= Orthoptics (from 2006-07);

656 = Clinical Psychology (from 2006-07);

700 = Learning disability (previously known as mental handicap) ;

710 = Adult mental illness ;

711 = Child and adolescent psychiatry ;

712 = Forensic psychiatry ;

713 = Psychotherapy ;

715 = Old age psychiatry ;

720 = Eating Disorders (from 2006-07);

721 = Addiction Services (from 2006-07);

722 = Liaison Psychiatry (from 2006-07);

723 = Psychiatric Intensive Care(from 2006-07);

724 = Perinatal Psychiatry (from 2006-07);

800 = Clinical oncology (previously known as Radiotherapy) ;

810 = Radiology (until 2005-06) ;

811 = Interventional radiology ;



812 = Diagnostic Imaging (from 2008-09);

820 and 821 = Not treatment functions ;

822 = Chemical pathology ;

823, 824, 830, 831 832, 900, 901, 950 and 990 = Not treatment functions ;

840 = Audiology (from 2008-09);

null = Other maternity event ;

& = Not known ;

Until 31 March 2004:

100 = General surgery ;

101 = Urology ;

110 = Trauma and orthopaedics ;

120 = Ear, nose and throat (ENT) ;

130 = Ophthalmology ;

140 = Oral surgery ;

141 = Restorative dentistry ;

142 = Paediatric dentistry (from 1999-2000) ;

143 = Orthodontics ;

150 = Neurosurgery ;

160 = Plastic surgery ;

170 = Cardiothoracic surgery ;

171 = Paediatric surgery ;

180 = Accident and emergency (A&E) ;



190 = Anaesthetics ;

191 = Pain management (from 1998-99) ;

300 = General medicine ;

301 = Gastroenterology ;

302 = Endocrinology ;

303 = Haematology (clinical) ;

304 = Clinical physiology ;

305 = Clinical pharmacology ;

310 = Audiological medicine ;

311 = Clinical genetics ;

312 = Clinical cytogenetics and molecular genetics (from 1990-91) ;

313 = Clinical immunology and allergy (from 1991-92) ;

314 = Rehabilitation (from 1991-92) ;

315 = Palliative medicine ;

320 = Cardiology ;

330 = Dermatology ;

340 = Thoracic medicine ;

350 = Infectious diseases ;

360 = Genito-urinary medicine ;

361 = Nephrology ;

370 = Medical oncology ;

371 = Nuclear medicine ;



400 = Neurology ;

401 = Clinical neuro-physiology ;

410 = Rheumatology ;

420 = Paediatrics ;

421 = Paediatric neurology ;

430 = Geriatric medicine ;

450 = Dental medicine (from 1990-91) ;

460 = Medical ophthalmology (from 1993-94) ;

501 = Obstetrics for patients using a hospital bed or delivery facilities ;

502 = Gynaecology ;

560 = Midwifery (from October 1995) ;

610 = General practice with maternity function ;

620 = General practice other than maternity ;

700 = Learning disability (previously known as mental handicap) ;

710 = Mental illness ;

711 = Child and adolescent psychiatry ;

712 = Forensic psychiatry ;

713 = Psychotherapy ;

715 = Old age psychiatry (from 1990-91) ;

800 = Clinical oncology (previously known as Radiotherapy) ;

810 = Radiology ;

820 = General pathology ;



821 = Blood transfusion ;
822 = Chemical pathology ;
823 = Haematology ;
824 = Histopathology ;
830 = Immunopathology ;
831 = Medical microbiology ;
832 = Neuropathology ;
900 = Community medicine ;
901 = Occupational medicine ;
950 = Nursing episode (from 2002-03) ;
null = Other maternity event ;
& = Not known

Rule

Rule 100



Dataset: Admitted Patient Care

V code indicator (VIND)

Field	VIND
Field Name	V code indicator
Category	Psychiatric
Length and format	1n
Availability	1989-90 to 1995-96
Description	

This derived field contains a code that indicates whether any of the diagnosis fields (diag_01 to diag_07) contains a valid V code (see diag_nn). For 1995-1996 only, U codes replaced the V codes. Although classed as Psychiatric data, values 1 to 3 indicate the level of neonatal care for a patient aged under 29 days.

Value

From 1989-90:

1 = V290 - Neonate: normal care usually given by a mother in a maternity neonatal ward, supervised by a midwife and doctor but requiring minimal medical or nursing advice ;

2 = V291 - Neonate: special care which provided observation and treatment falling short of intensive care but exceeding routine care ;

3 = V292 - Neonate: intensive care which involved continuous skills supervision by nursing and medical staff for at least one hour or until death. Resuscitation carried out immediately

after birth and completed within an hour or so does not constitute intensive care ;

4 = V690 - Psychiatric: not previously known to be admitted to a psychiatric hospital or hospital unit ;

5 = V691 - Psychiatric: previously admitted to a psychiatric hospital or hospital unit of the provider ;

6 = V692 - Psychiatric: previously admitted to a psychiatric hospital or a hospital unit of another provider ;

For the 1995-96 year only, the codes were changed to the following (see above for definitions):

V290 became U500 ;

V291 became U501 ;

V292 became U502 or U503 (U502 denoting a level of care higher than that previously denoted by V291 but falling short of the highest, for which U503 was used) ;

V690 became U510 ;

V691 became U511 ;

V692 became U512 ;

From 1996-97 this field was replaced by neocare and admistat.

Rule

Not applicable



Dataset: Admitted Patient Care

Duration of elective wait (WAITDAYS)

Field	WAITDAYS
Field Name	Duration of elective wait
Category	Patient Pathway
Length and format	4n
Availability	2007-08 onwards
Description	<p>The number of days that a patient waited from the date when a decision was taken for treatment to when they received the treatment.</p>
Value	<p>n4 = duration of elective wait ;</p> <p>9998 = Not applicable ;</p> <p>9999 = Not known</p>
Rule	Rule 277



Dataset: Admitted Patient Care

Method of Admission - Waiting List (WAITLIST)

Field	WAITLIST
Field Name	Method of Admission - Waiting List
Category	Patient Pathway
Length and format	1n
Availability	
Description	
Calculation determining patients whose method of admission was from the waiting list	
Value	
1 - Patient who was admitted via the waiting list	
0 - patient not admitted via the waiting list	
Rule	



Dataset: Admitted Patient Care

Electoral ward in 1981 (WARD81)

Field	WARD81
Field Name	Electoral ward in 1981
Category	Geographical
Length and format	5a
Availability	1989-90 to 1995-96
Description	<p>This field contains a code that indicates the patient's local authority and electoral ward of residence in 1981. It is derived from the patient's postcode in the field homeadd. From the 1996-1997 data year, this field becomes ward91.</p>
Value	<p>5a = Electoral ward</p>
Rule	Not applicable (derived by rule 1200)



Dataset: Admitted Patient Care

Electoral ward in 1991 (WARD91)

Field	WARD91
Field Name	Electoral ward in 1991
Category	Geographical
Length and format	6a
Availability	1996-97 to 1998-99
Description	
This field contains the patient's full frozen 1991 Census electoral ward and local authority of residence. It is derived from the patient's postcode in the field homeadd.	
Value	
6a = Electoral ward	
Rule	Not applicable (derived by rule 1200)



Dataset: Admitted Patient Care

Electoral ward in 1998 (WARD98)

Field	WARD98
Field Name	Electoral ward in 1998
Category	Geographical
Length and format	6a
Availability	1999-00 to 2000-01
Description	
This field contains the patient's full frozen 1998 Census electoral ward and local authority of residence. It is derived from the patient's postcode in the field homeadd.	
Value	
6a = Electoral ward	
Rule	Not applicable (derived by rule 1200)



Dataset: Admitted Patient Care

Ward type at start of episode (WARDSTRT)

Field	WARDSTRT
Field Name	Ward type at start of episode
Category	Episodes and spells ; Period of care
Length and format	7n
Availability	1997-98 until 2000-01
Description	

This field contains a code that defines the characteristics of a ward. The code has six parts: AABCDEF.

Value

A is as follows:

71 = Home leave, non-psychiatric ;

72 = Home leave, psychiatric ;

B is age as follows:

1 = Neonates ;

2 = Children and adolescents ;



3 = Elderly ;

8 = Any age ;

9 = Invalid ;

C is sex as follows:

8 = Not specified ;

9 = Invalid ;

D is the hospital provider as follows:

1 = NHS hospital provider ;

2 = Non-NHS hospital provider ;

9 = Invalid ;

E is the number of days in a week that the ward is open only during the day ;

F is the number of days in a week that the ward is open at night

Rule	None
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Dataset: Admitted Patient Care

Well baby flag (WELL_BABY_IND)

Field	WELL_BABY_IND
-------	---------------

Field Name	Well baby flag
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Category	Maternity
Length and format	a
Availability	All years
Description	<p>Codes in this field indicate whether the episode relates to a well baby (a neonate receiving normal levels of care, usually given by a mother or mother substitute).</p>
Value	<p>Y = Well baby episode ;</p> <p>N = Any other episode</p>
Rule	TBC



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