

HES Data Dictionary: Admitted Patient Care

Admitted Patient Care (APC) Hospital Episode Statistics (HES) Data Dictionary





Contents

Introduction – Admitted Patient Care Data Dictionary	1
Augmented care period disposal (ACPDISP_N)	2
Augmented care period data quality indicator (ACPDQIND_N)	3
Augmented care period end date (ACPEND_N)	4
Augmented care period local ID (ACPLCID_N)	5
Augmented care location (ACPLOC_N)	
Augmented care period number (ACPN_N)	7
Augmented care period outcome indicator (ACPOUT_N)	8
Augmented care period planned indicator (ACPPLAN_N)	
ACP sequence number (ACPSEQ)	
Augmented care period source (ACPSOUR_N)	
Augmented care period specialty function code (ACPSPEF_N)	
Augmented care period start date (ACPSTAR_N)	
Ambulatory Care Sensitive Condition Flag (ACSCFLAG)	
Age at activity date (ACTIVAGE)	
Admission date check flag (ADM_CFL)	
Age on admission (ADMIAGE)	
Date of admission (ADMIDATE)	
Admission episode flag (ADMIFLAG)	20
Method of admission (ADMIMETH)	
Administrative category (ADMINCAT)	23
Admin category at start of episode (ADMINCATST)	24
Source of admission (ADMISORC)	25
Psychiatric history on admission (ADMISTAT)	26
Record identifier (AEKEY)	27
Principal alcohol related diagnosis (ALCDIAG)	28
Principal alcohol related diagnosis - 4 characters (ALCDIAG_4)	29
Principal alcohol related fraction (ALCFRAC)	30
Gestation period in weeks at first antenatal assessment (ANAGEST)	
First antenatal assessment date (ANASDATE)	
Antenatal days of stay (ANTEDUR)	33
Net applicable date (APPDATE)	34
Area Team of GP Practice (AT_GP_PRACTICE)	35
Area Team of Residence (AT_RESIDENCE)	
Area Team of Treatment (AT_TREATMENT)	
Baby sequence number (BABYSEQ)	38
Bed days within the year (BEDYEAR)	
Resuscitation method (BIRESUS_N)	
Birth order (BIRORDER_N)	
Birth status (BIRSTAT_N)	
Birth weight (BIRWEIT_N)	
Unique booking reference number (BOOKREFNO)	
Cancer network (CANNET)	
Cancer registry (CANREG)	
Carer support indicator (CARERSI)	
Administrative & legal status of patient (CATEGORY)	
Cause code (CAUSE)	
Cause code - 3 characters (CAUSE_3)	
Cause code - 4 characters (CAUSE_4)	51



CCG of GP Practice (CCG_GP_PRACTICE)	
CCG of Residence (CCG_RESIDENCE)	53
CCG of Responsibility (CCG_RESPONSIBILITY)	54
Origin of CCG of Responsibility (CCG_RESPONSIBILITY_ORIGIN)	55
CCG of Treatment (CCG_TREATMENT)	56
Origin of CCG of Treatment (CCG_TREATMENT_ORIGIN)	57
CDS version number (CDS_MESSAGE_VERSION_NUMBER)	58
CDS extract date (CDSEXTDATE)	59
CDS unique identifier (CDSUNIQUEID)	60
CDS protocol identifier (CDSVERPROTID)	61
Duration of care to psychiatric census date (CENDUR)	62
Age at psychiatric census date (CENSAGE)	63
Status of patient included in psychiatric census (CENSTAT)	64
Ward type at psychiatric census date (CENWARD)	65
Primary diagnosis chapter (CHAPTER)	67
Patient classification (CLASSPAT)	68
Consultant code (CONSULT)	69
Commissioning Region of GP Practice (CR_GP_PRACTICE)	70
Commissioning Region of Residence (CR_RESIDENCE)	71
Commissioning Region of Treatment (CR_TREATMENT)	72
Commissioning serial number (CSNUM)	73
Current electoral ward (CURRWARD)	74
Current electoral ward (ONS) (CURRWARD_ONS)	75
Delivery place change reason (DELCHANG)	76
Delivery place (intended) (DELINTEN)	77
Alternative Delivery method (Derived) (DELMETH_D)	78
Delivery method (DELMETH_N)	79
Labour/delivery onset method (DELONSET)	
Delivery place (actual) (DELPLAC_N)	
Anaesthetic given post-labour or delivery (DELPOSAN)	
Anaesthetic given during labour or delivery (DELPREAN)	
Status of person conducting delivery (DELSTAT_N)	
High-dependency care level (DEPDAYS)	
Date detention commenced check flag (DET_CFL)	
Duration of detention (DETDUR)	
Detention category (DETNCAT)	
Date detention commenced (DETNDATE)	
3 character concatenated diagnosis (DIAG_3_CONCAT)	
Diagnosis - 3 characters (DIAG_3_NN)	
4 character concatenated diagnosis (DIAG_4_CONCAT)	
Diagnosis - 4 characters (DIAG_4_NN)	
Count of diagnoses (DIAG_COUNT)	
All Diagnosis codes (DIAG_NN)	
Discharge date check flag (DIS_CFL)	
Date of discharge (DISDATE)	
Date of discharge - Uncleaned (DISDATE_UNCLN)	
Destination on discharge (DISDEST)	
Destination on discharge - uncleaned (DISDEST_UNCLN)	
Discharge episode flag (DISFLAG)	
Method of discharge (DISMETH)	
Method of discharge - uncleaned (DISMETH_UNCLN)	
Discharge ready date (DISREADYDATE)	104



Date of birth - patient (DOB)	
Date of birth check flag - patient (DOB_CFL)	106
Birth date (baby) (DOBBABY_N)	107
Trust derived dominant procedure (DOMPROC)	108
Earliest reasonable date offered (EARLDATOFF)	
Date of decision to admit check flag (ELEC_CFL)	110
Date of decision to admit (ELECDATE)	
Duration of elective wait (submitted) (ELECDUR)	112
Calculation of Elecdur (ELECDUR_CALC)	
Duration of elective wait (derived) (ELECDURD)	
Age at end of episode (ENDAGE)	
Episode duration (EPIDUR)	
Episode end date check flag (EPIE_CFL)	
Date episode ended (EPIEND)	
Record identifier (EPIKEY)	
Episode order (EPIORDER)	
Episode start date check flag (EPIS_CFL)	121
Date episode started (EPISTART)	
Episode status (EPISTAT)	
Episode type (EPITYPE)	
Ethnic category (ETHNOS)	
Ethnic character (audit version) (ETHRAW)	
Ethnic category (audit version) (ETHRAWL)	
Finished Admission Episode (FAE)	
Finished Admission Episode, emergency classification (FAE_EMERGENCY)	
Finished Consultant Episode (FCE)	
Finished consultant episode flag (FCEFLAG)	
Finished In-Year Discharge Episode (FDE)	
First regular day or night admission (FIRSTREG)	
Financial Year (FYEAR)	
Length of gestation (GESTAT)	
Government office region of treatment (GORTREAT)	
Code of GP practice (GPPRAC)	
Health Authority area where patient's GP is registered (GPPRACHA)	
Regional Office area where patient's GP was registered (GPPRACRO)	140
Primary Care Trust area where patient's GP was registered (GPPRPCT)	
Strategic Health Authority area where patient's GP was registered (GPPRSTHA)	
Ordnance Survey grid reference (GRIDLINK)	
Patient's health authority of residence, provided by NHS (HAR)	
Health Authority of treatment (HATREAT)	
Patient identifier - HES generated (HESID)	
Patient ID - HES generated (original) (HESID_ORIG)	
Healthly Neonate Indicator (HNEOIND)	
Postcode of patient (HOMEADD)	
Healthcare resource group: version 3.1 (HRG_N.N)	
Trust derived HRG value (HRGNHS)	
Version No. of Trust derived HRG (HRGNHSVN)	
IMD Index of Multiple Deprivation (IMD04)	
IMD Decile Group (IMD04_DECILE)	
IMD Crime Domain (IMD04C)	
IMD Education Training and Skills Domain (IMD04ED)	
IMD Employment Deprivation Domain (IMD04FM)	157



IMD Health and Disability Domain (IMD04HD)	. 158
IMD Barriers to Housing and Service Domain (IMD04HS)	. 159
IMD Income Domain (IMD04I)	.160
IMD Income affecting Adults Domain (IMD04IA)	.161
IMD Income affecting Children Domain (IMD04IC)	.162
IMD Living Environment Domain (IMD04LE)	.163
IMD Overall Rank (IMD04RK)	
Intensive care level days (INTDAYS_N)	. 165
Intended management (INTMANIG)	
In Year flag (INYRFLAG)	
Local authority district in 1998 (LAD98)	
Legal group of patient (LEGALGPA)	
Legal group of patient (psychiatric) (LEGALGPC)	
Legal category of patient (LEGLCAT)	
Legal status classification (LEGLSTAT)	
Legal status classification code on admission (LEGLSTATST)	
Local patient identifier (LOPATID)	
Lower Super Output Area (LSOA01)	
Lower Super Output Area (LSOA11)	
Main specialty (MAINSPEF)	
Marital status (psychiatric) (MARSTAT)	
Mother's age at delivery (MATAGE)	
Patient identifier (HES generated) - basis of match (MATCHID)	
Episode Type - Maternity (MATERNITY_EPISODE_TYPE)	
Mental category (MENTCAT)	
Mother's date of birth (MOTDOB)	
Mother's data of birth check flag (MOTDOB_CFL)	
Middle Super Output Area, 2001 (MSOA01)	
Middle Super Output Area, 2011 (MSOA11)	
Date of Birth - month and year (MYDOB)	
Neonatal level of care (NEOCARE)	
Age of baby in days (NEODUR)	
NHS number (NEWNHSNO)	
NHS Number valid flag (NEWNHSNO_CHECK)	
NHS number status indicator (NHSNOIND)	
Number of augmented care periods within episode (NUMACP)	
Number of babies (NUMBABY)	
Number of previous pregnancies (NUMPREG)	
Number of baby tails (NUMTAILB)	
Census Output Area, 2001 (OACODE01)	
Census Output Area, 2011 (OACODE11)	
Census output area, 2001 (6 character ward identifier) (OACODE6)	
Date of procedure (OPDATE_NN)	
Operation status code (OPERSTAT)	
3 character concatenated procedure (OPERTN_3_CONCAT)	
Main operative procedure - 3 characters (OPERTN_3_N)	
4 character concatenated procedure (OPERTN_4_CONCAT)	
Count of procedures (OPERTN_COUNT)	
Operative procedure (OPERTN_NN)	
Organisation code (patient pathway ID issuer) (ORGPPPID)	
Number of organ systems supported (ORGSUP)	



Year and month of HES dataset (PARTYEAR)	212
Patient pathway identifier (PATPATHID)	213
Programme Budgeting Category (PBC)	214
Postcode Found (PCFOUND)	
Primary care group (PCGCODE)	
Origin of primary care group (PCGORIG)	
Westminster parliamentary constituency (PCON)	
Westminster parliamentary constituency (ONS) (PCON_ONS)	
Pseudonymised consultant code (PCONSULT)	
Primary care trust of responsibility (PCTCODE)	
Historic PCT of responsibility (PCTCODE02)	
Current PCT of responsibility (PCTCODE06)	
Origin of primary care trust of responsibility (PCTORIG)	
Origin of primary care trust of responsibility - historic (PCTORIG02)	
Origin of primary care trust of responsibility - current (PCTORIG06)	
Primary Care Trust area of main provider (PCTTREAT)	
Reporting period end date (PEREND)	
Pseudonymised code of GP practice (PGPPRAC)	
Post-operative duration (POSOPDUR)	
Postcode district (POSTDIST)	
Postnatal stay (POSTDUR)	
Pseudonymised referrer code (PREFERRER)	
Pseudonymised code of patient's registered or referring GP (PREGGMP)	
Pre-operative duration (PREOPDUR)	
Provider Code (PROCODE)	
Provider code (3 character) (PROCODE3)	
Provider code (5 character) (PROCODE5)	
Provider code of treatment (PROCODET)	
Provider type (PROTYPE)	
Hospital provider spell number (PROVSPNO)	
Pseudonymised HES ID (PSEUDO_HESID)	
Commissioner code (PURCODE)	
Commissioner's Regional Office (PURRO)	
Commissioner's Strategic Health Authority (PURSTHA)	
Linkage - quality rank (RANK_ORDER)	
Referring organisation code (REFERORG)	
Code of patient's registered or referring general medical practitioner (REGGMP)	
County of residence (RESCTY)	252
Government Office region of residence (RESGOR)	
Government office region of residence (NESGOR_ONS)	
Health Authority of residence (RESHA)	
Local authority district of residence (RESLADST)	
Local authority district of residence (NLSLADST)	
Primary care trust of residence (RESPCT)	
PCT of residence - mapped according to data year (RESPCT_HIS)	
PCT of residence (2002) (RESPCT02)	
PCT of residence (2002) (RESPCT06)	
Regional Office of residence (RESRO)	
SHA of residence (RESSTHA)	



SHA of residence - mapped according to data year (RESSTHA_HIS)	266
SHA of residence (2002) (RESSTHA02)	267
SHA of residence (2006) (RESSTHA06)	268
Regional Office of treatment (ROTREAT)	269
RTT period end date (RTTPEREND)	270
RTT period start date (RTTPERSTART)	271
RTT period status (RTTPERSTAT)	273
Rural/Urban Indicator (RURURB_IND)	275
Sex of patient (SEX)	276
Sex of baby (SEXBABY)	277
Site code of treatment (SITETRET)	278
Beginning of spell indicator (SPELBGIN)	279
Duration of spell (SPELDUR)	280
End of spell indicator (SPELEND)	281
Age at start of episode (STARTAGE)	282
Age at start of episode - babies decimalised (STARTAGE_CALC)	283
SHA area of treatment (STHATRET)	284
Submission date (SUBDATE)	285
SUS generated Core Spell HRG (SUSCOREHRG)	286
SUS generated HRG (SUSHRG)	
SUS generated HRG version number (SUSHRGVERS)	288
SUS loaded staging date (SUSLDDATE)	289
SUS record ID (SUSRECID)	290
SUS generated spell identifier (SUSSPELLID)	291
Treatment specialty (TRETSPEF)	292
V code indicator (VIND)	297
Duration of wait (referral to treatment period) (WAITDAYS)	298
Method of Admission - Waiting List (WAITLIST)	299
Electoral ward in 1981 (WARD81)	300
Electoral ward in 1991 (WARD91)	301
Electoral ward in 1998 (WARD98)	302
Ward type at start of episode (WARDSTRT)	303
Well baby flag (WELL_BABY_IND)	304



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@nhsdigital.nhs.net

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. These fields are sourced from the NHS Data Model and Dictionary.

For these fields the NHS Data Model and Dictionary data element name is displayed in the 'NHS Field Name' item.

Read more about the NHS Data Model and Dictionary (external)

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.

Copyright

The re-use of this information for any commercial purpose is subject to the Re-use of Public Sector Information Regulations 2005.

For further information please contact iga@nhs.net



Augmented care period disposal (ACPDISP_N)

Field	ACPDISP_N
Field Name	Augmented care period disposal
NHS Field Name	N/A
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
Cleaning Rule	Rule # 920 and 930



Augmented care period data quality indicator (ACPDQIND_N)

Field	ACPDQIND_N
Field Name	Augmented care period data quality indicator
NHS Field Name	N/A
Category	Augmented/critical care period
Length and format	TBC
Availability	2003-04 to 2007-08
Description	TBC
Value	TBC
Cleaning Rule	Rule # 1055



Field

Field Name

Category

NHS Field Name

Admitted Patient Care (APC) Data Set

Augmented care period end date (ACPEND_N) ACPEND_N Augmented care period end date N/A

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

Augmented/critical care period

Cleaning Rule Rule # 940



Augmented care period local ID (ACPLCID_N)

Field	ACPLCID_N
Field Name	Augmented care period local ID
NHS Field Name	N/A
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 Independent Group Advising on the Release of Data (IGARD).
Value	Not available
Cleaning Rule	None



Augmented care location (AC	CPLOC_N)
-----------------------------	----------

Field	ACPLOC_N
Field Name	Augmented care location
NHS Field Name	N/A
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
Cleaning Rule	Rule # 950 and 960
-	



Augmented care period number (ACPN_N)

Field	ACPN_N
Field Name	Augmented care period number
NHS Field Name	N/A
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
Cleaning Rule	Rule # 970



Augmented care period outcome indicator (ACPOUT_N)

Field	ACPOUT_N
Field Name	Augmented care period outcome indicator
NHS Field Name	N/A
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
Cleaning Rule	Rule # 980 and 990



Augmented care period planned indicator (ACPPLAN_N)

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



ACP sequence number (ACPSEQ) Fi<u>e</u>ld **ACPSEQ** Field Name ACP sequence number NHS Field Name 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 Cleaning Rule None



Augmented care period source (ACPSOUR_N)

Field	ACPSOUR_N
Field Name	Augmented care period source
NHS Field Name	N/A
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
Cleaning Rule	Rule # 900 and 910



Augmented care period specialty function code (ACPSPEF_N)

Field	ACPSPEF_N
Field Name	Augmented care period specialty function code
NHS Field Name	N/A
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 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 genetics 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
Cleaning Rule
                     Rule # 1010
```



Augmented care period start date (ACPSTAR_N) Field ACPSTAR_N Field Name Augmented care period start date NHS Field Name 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. dd/mm/yyyy = Date period started Null = Not applicable/ not known Value Rule # 1020 Cleaning Rule



Ambulatory Care Sensitive Condition Flag (ACSCFLAG) Field **ACSCFLAG** Field Name Ambulatory Care Sensitive Condition Flag NHS Field Name N/A Category Diagnosis Length and format 1n Availability 2007-08 onwards Ambulatory Care Sensitive Condition flag is derived for finished APC episodes where the admission method is 'emergency'. The flag indicates whether the Description episode contains a diagnosis which is ambulatory care sensitive. 1 = Episode contains a diagnosis that is ambulatory care sensitive Value 0 = Episode doesn't contain a diagnosis that is ambulatory care sensitive Cleaning Rule None



Age at activity date (ACTIVAGE)

Field	ACTIVAGE
Field Name	Age at activity date
NHS Field Name	AGE AT CDS 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, i.e. date of birth not known and age cannot be estimated
Cleaning Rule	None



Admission date check flag (ADM_CFL)

Field	ADM_CFL
Field Name	Admission date check flag
NHS Field Name	N/A
Category	Admissions; Period of Care
Length and format	1n
Availability	1989-90 onwards
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
Cleaning Rule	TBC



Age on admission (ADMIAGE) Field ADMIAGE Field Name Age on admission NHS 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. 3n = Age at activity date Value 999 = Not known, i.e. date of birth not known and age cannot be estimated Cleaning Rule None



Date of admission (ADMIDATE) Field **ADMIDATE** Field Name Date of admission NHS Field Name START DATE (HOSPITAL PROVIDER SPELL) Category Admissions; Period of Care Length and format dd/mm/yyyy (Date) Availability 1989-90 onwards This field contains the date the patient was admitted to hospital at the start of a Description hospital spell. Admidate is recorded on all episodes within a spell. 2012/13 onwards: 01/01/1800 - Null date submitted 01/01/1801 - Invalid date submitted Value 1989/90 to 2011/12: 01/01/1600 - Null date submitted 15/10/1582 - Invalid date submitted Cleaning Rule Rule # 35



Cleaning Rule

None

Admitted Patient Care (APC) Data Set

Admission episode flag (ADMIFLAG) Field **ADMIFLAG** Field Name Admission episode flag NHS Field Name N/A Category Patient Data Length and format 1a Availability 1989-90 onwards Description Codes in this field indicate whether the episode is an admission episode. Y = Episode is an admission episode, ie episode order equals 1 Value N = Episode is not an admission episode



Method of admission (ADMIMETH)	
e spell	
om the	
are	
made	
13/14) tient	
r	
ency	
ty ne	
as	
n in an	



	84 = Admission by Admissions Panel of a High Security Psychiatric Hospital, patient not entered on the HSPH Admissions Waiting List (available between 1999 and 2006) 89 = HSPH Admissions Waiting List of a High Security Psychiatric Hospital (available between 1999 and 2006) 98 = Not applicable (available from 1996/97) 99 = Not known: a validation error
Cleaning Rule	Rule # 70 and 320



Cleaning Rule

Rule # 125

Admitted Patient Care (APC) Data Set

Administrative category (ADMINCAT) Field **ADMINCAT** Field Name Administrative category **ADMINISTRATIVE CATEGORY (V6-1) NHS Field Name** ADMINISTRATIVE CATEGORY CODE (V6-2) Patient Data Category Length and format 2n Availability 2000-01 onwards Description Administrative category on admission. 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. Value 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.



Admin category at start of episode (ADMINCATST) Field **ADMINCATST** Field Name Admin category at start of episode ADMINISTRATIVE CATEGORY (ON ADMISSION) (V6-1) **NHS Field Name** ADMINISTRATIVE CATEGORY CODE (ON ADMISSION) (V6-2) Patient Data Category Length and format Availability 2007-08 - 2014-15 (phasing out from 2012-13) The patient's administrative category at the start of each episode of care. This may Description change during a spell as the patient may, for example, opt to change from NHS to private health care. 01 = NHS patient 02 = Private patient 03 = Amenity patient Value 04 = Category II patient 98 = Not applicable 99 = Not known: a validation error Cleaning Rule None



Field Name Source of admission NHS Field Name SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL) (V6-1) SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL) (V6-2) Admissions; Period of Care Length and format 2n Availability 2n Description 2n 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. 19 = The usual place of residence, unless listed below, for example, a private dwelling whether owner occupied or owned by Local Authority, housing association or other landlord. This includes wardened accommodation but not residential accommodation where health care is provided. It also includes PATIENTS with 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 nospital (1999-00 to 2006-07) 37 = Penal establishment: police station (1999-00 to 2006-07) 38 = Penal establishment: court (1999-00 to 2006-07) 39 = Penal establishment: police station (1999-00 to 2006-07) 49 = NHS other hospital provider: high security psychiatric accommodation in an NHS hospital provider (NHS trust or NHS Foundation 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 general patients or neonates 53 = NHS other hospital provider: ward for general patients or neonates 53 = NHS other hospital provider: ward for general patients or neonates 53 = NHS other hospital provider: ward for general patients or neonates 53 = NHS other hospital provider: ward for general patients or neonates 53 = NHS other hospital provider: ward for patients who are mentally ill or	Source of admission (ADMISORC)	
SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL) (V6-1) SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL) (V6-2)	Field	ADMISORC
Availability Description Pescription SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL) (V6-2) Admissions; Period of Care In 1989-90 onwards 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. 19 = The usual place of residence, unless listed below, for example, a private dwelling whether owner occupied or owned by Local Authority, housing association or other landlord. This includes wardened accommodation but not residential accommodation where health care is provided. It also includes PATIENTS with 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) 49 = NHS other hospital provider: police station (1999-00 to 2006-07) 49 = NHS other hospital provider: medium secure unit (1999-00 to 2006-07) 51 = 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 general 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 69 = Local authority foster care, but not in residential accommodation i.e. where care is provided 69 = Local authority foster care, but not in residential accommodation i.e. where care is provided 89 = Non-NHS (other than Local Authority) run nursing home 87 = Non-NHS institution (1989-90 to 1995-96) 98 = Not	Field Name	
Availability 1989-90 onwards 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. 19 = The usual place of residence, unless listed below, for example, a private dwelling whether owner occupied or owned by Local Authority, housing association or other landlord. This includes wardened accommodation but not residential accommodation where health care is provided. It also includes PATIENTS with 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: court (1999-00 to 2006-07) 39 = Penal establishment: police station / Police Custody Suite 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 or NHS Foundation Trust) 50 = 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 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 foster care, but not in residential accommodation i.e. where care is provided 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 care home 86 = Non-NHS (other than Local Authority) run hospice 89 = Non-NHS institution (1989-90 to 1995-96) 98 = Not applicable 99 = N	NHS Field Name	
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. 19 = The usual place of residence, unless listed below, for example, a private dwelling whether owner occupied or owned by Local Authority, housing association or other landlord. This includes wardened accommodation but not residential accommodation where health care is provided. It also includes PATIENTS with 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: police station (1999-00 to 2006-07) 49 = NHS other hospital provider: high security psychiatric accommodation in an NHS hospital provider (NHS trust or NHS Foundation 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 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 foster care, but not in residential accommodation i.e. where care is provided 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 care home 86 = Non-NHS (other than Local Authority) run norsing home 87 = Non-NHS (other than Local Authority) run hospice 89 = Non-NHS institut		· · · · · · · · · · · · · · · · · · ·
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. 19 = The usual place of residence, unless listed below, for example, a private dwelling whether owner occupied or owned by Local Authority, housing association or other landlord. This includes wardened accommodation but not residential accommodation where health care is provided. It also includes PATIENTS with 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; court or Police Station / Police Custody Suite 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 or NHS Foundation Trust) 50 = 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 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, but not in residential accommodation i.e. where care is provided 68 = Non-NHS (other than Local Authority) run nursing home 87 = Non-NHS (other than Local Authority) run nursing home 87 = Non-NHS (other than Local Authority) run hospice 89 = Not known		
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. 19 = The usual place of residence, unless listed below, for example, a private dwelling whether owner occupied or owned by Local Authority, housing association or other landlord. This includes wardened accommodation but not residential accommodation where health care is provided. It also includes PATIENTS with 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 or Police Station / Police Custody Suite 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 or NHS Foundation 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 Care Home 65 = Local authority residential accommodation i.e. where care is provided 66 = Local authority foster care, but not in residential accommodation i.e. where care is provided 66 = 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 care home 86 = Non-NHS (other than Local Authority) run hospice 89 = Not applicable 99 = Not known	Availability	
dwelling whether owner occupied or owned by Local Authority, housing association or other landlord. This includes wardened accommodation but not residential accommodation where health care is provided. It also includes PATIENTS with 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 or Police Station / Police Custody Suite 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 or NHS Foundation 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 maternity patients or neonates 53 = 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, but not in residential accommodation i.e. where care is provided 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 care home 86 = Non-NHS (other than Local Authority) run care home 87 = Non-NHS institution (1989-90 to 1995-96) 98 = Not applicable 99 = Not known	Description	to admission. Most patients are admitted from home, but there are some significant exceptions. In particular, this field differentiates between patients admitted from
Trail 11 00		19 = The usual place of residence, unless listed below, for example, a private dwelling whether owner occupied or owned by Local Authority, housing association or other landlord. This includes wardened accommodation but not residential accommodation where health care is provided. It also includes PATIENTS with 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 or Police Station / Police Custody Suite 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 or NHS Foundation 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 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, but not in residential accommodation i.e. where care is provided 69 = Local authority foster care, but not in residential accommodation i.e. where care is provided 69 = Local authority foster than Local Authority) run care home 86 = Non-NHS (other than Local Authority) run nursing home 87 = Non-NHS (other than Local Authority) run hospice 89 = Non-NHS institution (1989-90 to 1995-96) 98 = Not Applicable 99 = Not known
	Cleaning Rule	Rule # 80



Psychiatric history on admission (ADMISTAT)	
Field	ADMISTAT
Field Name	Psychiatric history on admission
NHS Field Name	PSYCHIATRIC PATIENT STATUS (V6-1) PSYCHIATRIC PATIENT STATUS CODE (V6-2)
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.
Cleaning Rule	Rule # 380



Record identifier (AEKEY) Field **AEKEY** Field Name Record identifier NHS Field Name N/A Category System Data Length and format 14n Availability TBC This is a record identifier that is created by the HES system. The digits store a Description decimal number. This is commonly eight or nine digits but can be up to 14. Value 14n = Record identifier Cleaning Rule None



Principal alcohol related diagnosis (ALCDIAG) Field **ALCDIAG** Field Name Principal alcohol related diagnosis NHS Field Name N/A Diagnosis Category Length and format 6an Availability 2002-03 onwards 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 Description field will be null. See "HES APC Data Dicitonary - Supplementary Table" at http://content.digital.nhs.uk/hesdatadictionary annnna = A valid ICD-9 or ICD-10 diagnosis code Value annnnn = A valid ICD-9 or ICD-10 diagnosis code Null = Not applicable Cleaning Rule None



Principal alcohol related diagnosis - 4 characters (ALCDIAG_4)

Field	ALCDIAG_4
Field Name	Principal alcohol related diagnosis - 4 characters
NHS Field Name	N/A
Category	Diagnosis
Length and format	4an
Availability	2002-03 onwards
Description	This provides the first four characters of the principle alcohol related diagnosis (ALCDIAG).
Value	4an = A valid ICD-9 or ICD-10 diagnosis code Null = Not applicable
Cleaning Rule	None



Principal alcohol related fraction (ALCFRAC) Field **ALCFRAC** Field Name Principal alcohol related fraction NHS Field Name N/A Category Diagnosis Length and format n.nn Availability 2002-03 onwards Indicates the highest alcohol attributable fraction within the episode based on the principal alcohol related diagnosis. See "HES APC Data Dicitonary - Supplementary Table" at http://www.hscic.gov.uk/hesdatadictionary Description Value See Supplementary table. Cleaning Rule None



Gestation period in weeks at first antenatal assessment (ANAGEST)

Field	ANAGEST
Field Name	Gestation period in weeks at first antenatal assessment
NHS Field Name	N/A
Category	Maternity
Length and format	2n
Availability	1989-90 onwards
Description	Gestation period in weeks at the date of the first antenatal assessment. This field is calculated from anadate, gestat and the dobbaby.
Value	2n = The gestation period in weeks Null = Not valid / not known
Cleaning Rule	None



Field

Field Name

Category

Availability

Description

Value

NHS Field Name

Length and format

Admitted Patient Care (APC) Data Set

First antenatal assessment date (ANASDATE) ANASDATE First antenatal assessment date FIRST ANTENATAL ASSESSMENT DATE Maternity dd/mm/yyyy (Date) 1989-90 onwards 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

01/01/1801 = Invalid date submitted

delivery arrangements were made.

Cleaning Rule Rule # 788



Cleaning Rule

None

Admitted Patient Care (APC) Data Set

Antenatal days of stay (ANTEDUR) Field **ANTEDUR** Field Name Antenatal days of stay NHS Field Name N/A Category Maternity Length and format 3n Availability 1989-90 onwards This derived field contains the number of days between the start of the episode Description (epistart) and the date of delivery of the first baby (dobbaby1). 3n = The number of days of stay from 0 to 270 Value Null = Not applicable / not known



Net applicable date (APPDATE) Field **APPDATE** Field Name Net applicable date NHS Field Name N/A Category System Data Length and format ddmmyyyy Availability 2003-04 onwards Description This field contains the CDS applicable date for the net change protocol. Value ddmmyyyy = Net applicable date Cleaning Rule None



Area Team of GP Practice (AT_GP_PRACTICE)

Field	AT_GP_PRACTICE
Field Name	Area Team of GP Practice
NHS Field Name	N/A
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's GP practice is registered. It is derived from Code of GP practice (GPPRAC).
Value	ann = AT of patient's GP practice Y = Unknown
Cleaning Rule	None



Area Team of Residence (AT_RESIDENCE)

Field	AT_RESIDENCE
Field Name	Area Team of Residence
NHS Field Name	N/A
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
Cleaning Rule	None



Area Team of Treatment (AT_TREATMENT)

Field	AT_TREATMENT
Field Name	Area Team of Treatment
NHS Field Name	N/A
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
Cleaning Rule	None



Baby sequence number (BABYSEQ) Field BABYSEQ Field Name Baby sequence number NHS Field Name N/A Category Maternity Length and format 1n Availability 1989-90 onwards Description Birth sequence. Value 1n = Birth sequence Cleaning Rule None



Bed days within the year (BEDYEAR) Field **BEDYEAR** Field Name Bed days within the year **NHS Field Name** Category Episodes and spells; Period of care Length and format Availability 1989-90 onwards 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 Description 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. nnn = The number of days of stay from 0 to 366 Value Null = Not applicable (other maternity event / not known) Cleaning Rule None



Cleaning Rule

Admitted Patient Care (APC) Data Set

Resuscitation method (BIRESUS_N) Field BIRESUS_N Field Name Resuscitation method **RESUSCITATION METHOD (V6-1) NHS Field Name** RESUSCITATION METHOD CODE (V6-2) Category Maternity Length and format 1n Availability 1989-90 onwards This field contains a code that identifies the method used to get the baby breathing Description normally. This item appears for each baby on multiple birth delivery records. 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 Value 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 # 710, 753 and 770



Birth order (BIRORDER_N) Field BIRORDER_N Field Name Birth order NHS Field Name **BIRTH ORDER** Category Maternity Length and format 1n or X Availability 1989-90 onwards 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 Description the first born of several. Up until March 2002, only the first six births were recorded. 8 - Not Applicable Value 9 - Not Known Cleaning Rule Rule # 720 and 770



Birth status (BIRSTAT_N) Field BIRSTAT_N Field Name Birth status LIVE OR STILL BIRTH (V6-1) **NHS Field Name** LIVE OR STILL BIRTH CODÉ (V6-2) Category Maternity Length and format 1n Availability 1989-90 onwards 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 Description where the baby shows no sign of life when delivered. This item appears for each baby on multiple birth delivery records. 1 = Live2 = Still birth: ante-partum Value 3 = Still birth: intra-partum 4 = Still birth: indeterminate 9 = Not known Rule # 710, 753 and 770 Cleaning Rule



Birth weight (BIRWEIT_N) Field BIRWEIT_N Field Name Birth weight NHS Field Name **BIRTH WEIGHT** Category Maternity Length and format 4n Availability 1989-90 onwards This field contains the weight of the baby in grams immediately after birth. This Description item appears for each baby on multiple birth delivery records. 4n = Weight in grams from 0001 to 6999 7000 = 7000g or more Value 9999 = Not known Cleaning Rule Rule # 740, 760 and 770



Unique booking reference number (BOOKREFNO) Field **BOOKREFNO** Field Name Unique booking reference number UNIQUE BOOKING REFERENCE NUMBER (CONVERTED) **NHS Field Name** Category Patient Pathway Length and format 12n Availability 2007-08 onwards 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 Description number is unique. Access to it requires the approval of The Independent Group Advising on the Release of Data (IGARD). Value 12n = Unique booking reference number Cleaning Rule None



Cancer network (CANNET)	
Field	CANNET
Field Name	Cancer network
NHS Field Name	N/A
Category	Geographical
Length and format	3an
Availability	2008-09 onwards
Description	The former cancer network that each postcode fell within. Further information on Cancer Network can be found on the NHS Postcode Directory using the following link; http://systems.digital.nhs.uk/data/ods/datadownloads/pcodedata
Value	N01-N98 = Cancer Registry in England/Wales/Isle of Man Z99 = Scotland/Northern Ireland/Channel Islands (pseudo) Null = No information available
Cleaning Rule	None



Cancer registry (CANREG) Field **CANREG** Field Name Cancer registry NHS Field Name N/A Category Geographical Length and format 5an Availability 2008-09 onwards The former cancer registry that each postcode fell within. Further information on Cancer Network can be found on the NHS Postcode Directory using the following Description http://systems.digital.nhs.uk/data/ods/datadownloads/pcodedata Y0201-Y1701 = Cancer Registry in England/Wales Z9999 = Scotland/NI/Channel Island/Isle of Man (pseudo) Value Null = No information available Cleaning Rule None



Carer support indicator (CARERSI) Field **CARERSI** Field Name Carer support indicator NHS Field Name CARER SUPPORT INDICATOR Category **Psychiatric** Length and format 2n Availability 1997-98 onwards Description http://systems.digital.nhs.uk/data/ods/datadownloads/pcodedata 01 = YesValue $02 = N_0$ 99 = Not known Cleaning Rule Rule # 400



Cleaning Rule

None

Admitted Patient Care (APC) Data Set

Administrative & legal status of patient (CATEGORY) Field **CATEGORY** Field Name Administrative & legal status of patient **NHS Field Name** N/A Category Patient Data Length and format 2n Availability 1989-90 to 2001-02 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 Description 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). Access to this field requires the approval of Data Access Advisory Group (DAAG). 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 Value 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)



Cause code (CAUSE)	
Field	CAUSE
Field Name	Cause code
NHS Field Name	N/A
Category	Clinical
Length and format	6an
Availability	1989-90 onwards
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
Cleaning Rule	None



Cause code - 3 characters (CAUSE_3)

Field	CAUSE_3
Field Name	Cause code - 3 characters
NHS Field Name	N/A
Category	Clinical
Length and format	3an
Availability	1989-90 onwards
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
Cleaning Rule	None



Cause code - 4 characters (CAUSE_4)

Field	CAUSE_4
Field Name	Cause code - 4 characters
NHS Field Name	N/A
Category	Clinical
Length and format	4an
Availability	1989-90 onwards
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
Cleaning Rule	None



CCG of GP Practice (CCG_GP_PRACTICE)

Field	CCG_GP_PRACTICE
Field Name	CCG of GP Practice
NHS Field Name	N/A
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 Pracrice (GGPRAC).
Value	nna = CCG of patient's GP practice 59999 = Unknown
Cleaning Rule	None



Field

Field Name

Category

Availability

NHS Field Name

Length and format

Admitted Patient Care (APC) Data Set

CCG of Residence (CCG_RESIDENCE) CCG_RESIDENCE CCG of Residence Geographical

This derived field contains the code for the Clinical Commissioning Group (CCG)

Description where the patient lived immediately before admission. It is derived from post code (HOMEADD).

nna = CCG of patient's residence

2013-14 onwards

Value 59898 = Not applicable 59999 = Unknown

5an

Cleaning Rule None



Field

Field Name

Category

Availability

Description

Value

NHS Field Name

Length and format

Admitted Patient Care (APC) Data Set

CCG of Responsibility (CCG_RESPONSIBILITY) CCG_RESPONSIBILITY CCG of Responsibility N/A Geographical 5an 2013-14 onwards

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. nna = CCG of Responsibility

59999 = Unknown

Cleaning Rule None



Origin of CCG of Responsibility (CCG_RESPONSIBILITY_ORIGIN)

Field	CCG_RESPONSIBILITY_ORIGIN
Field Name	Origin of CCG of Responsibility
NHS Field Name	N/A
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
Cleaning Rule	None



CCG of Treatment (CCG_TREATMENT)

Field	CCG_TREATMENT
Field Name	CCG of Treatment
NHS Field Name	N/A
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
Cleaning Rule	None



Origin of CCG of Treatment (CCG_TREATMENT_ORIGIN)

Field	CCG_TREATMENT_ORIGIN
Field Name	Origin of CCG of Treatment
NHS Field Name	N/A
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
Cleaning Rule	None



CDS version number (CDS_MESSAGE_VERSION_NUMBER)

Field	CDS_MESSAGE_VERSION_NUMBER
Field Name	CDS version number
NHS Field Name	N/A
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
Cleaning Rule	None



CDS extract date (CDSEXTDATE) Field CDSEXTDATE Field Name CDS extract date CDS EXTRACT DATE NHS Field Name Category System Data Length and format dd/mm/yyyy (Date) Availability 2007-08 onwards Description CDS extract date. Value dd/mm/yyyy Cleaning Rule None



Field

Field Name

Category

NHS Field Name

Length and format

Admitted Patient Care (APC) Data Set

CDS unique identifier (CDSUNIQUEID) CDSUNIQUEID CDS unique identifier CDS UNIQUE IDENTIFIER System Data

Availability 2007-08 onwards

Description CDS unique identifier.

35an

Value 35an = CDS Unique identifier

Cleaning Rule None



CDS protocol identifier (CDSVERPROTID) Field **CDSVERPROTID** Field Name CDS protocol identifier CDS PROTOCOL IDENTIFIER (V6-1) **NHS Field Name** CDS PROTOCOL IDENTIFIER CODÉ (V6-2) Category System Data Length and format 3an Availability 2007-08 onwards CDS Protocol ID is a code used to identify the Commissioning Data Set Description Submission Protocol i.e Bulk or Net. 010 = Net Change Update Mechanism (This is the recommended Protocol for Value Commissioning Data Set submissions) 020 = Bulk Replacement Update Mechanism Cleaning Rule None



Duration of care to psychiatric census date (CENDUR) Field **CENDUR** Field Name Duration of care to psychiatric census date DURATION OF CARE TO PSYCHIATRIC CENSUS DATE **NHS Field Name** Category **Psychiatric** Length and format 5n Availability 1989-90 onwards Duration of care in days to the psychiatric census date. This field is calculated from Description 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). 5n = Duration of stay in days at census date from 0 to 29,200 Value Null = Not applicable (epitype is not 4) / not known Cleaning Rule None



Age at psychiatric census date (CENSAGE) Field **CENSAGE** Field Name Age at psychiatric census date **NHS Field Name** Category **Psychiatric** Length and format 3n Availability 1989-90 onwards 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 Description that was admitted more than one year previously, censage is null. The maximum permitted value is 120 years. 3n = Age in years from 1 to 119 on the date of the annual psychiatric census Value 120 = 120 years or more on the date of the annual psychiatric census Null = Not applicable (epitype is not 4) / not known Cleaning Rule None



Status of patient included in psychiatric census (CENSTAT)

Field	CENSTAT
Field Name	Status of patient included in psychiatric census
NHS Field Name	STATUS OF PATIENT INCLUDED IN THE PSYCHIATRIC CENSUS (V6-1) STATUS OF PATIENT INCLUDED IN THE PSYCHIATRIC CENSUS CODE (V6-2)
Category	Psychiatric
Length and format	1n
Availability	1989-90 onwards
Description	This field contains a code which defines the legal status of the patient. It is derived from legal status (legIstat) 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)
Cleaning Rule	None



Ward type at psychiatric census date (CENWARD)		
Field	CENWARD	
Field Name	Ward type at psychiatric census date	
NHS Field Name	WARD TYPE AT PSYCHIATRIC CENSUS DATE	
Category	Psychiatric	
Length and format	7n	
Availability	1989-90 onwards	
Description	This field contains a code which defines the characteristics of a ward. The code has six parts: AABCDEF. Where: AA Clinical Care Intensity, see INTENDED CLINICAL CARE INTENSITY B Age, see AGE GROUP INTENDED C Sex, see SEX OF PATIENTS D Hospital provider, see HOSPITAL PROVIDER TYPE E Number of days open only during the day, see WARD DAY PERIOD AVAILABILITY F Number of days open at night, see WARD NIGHT PERIOD AVAILABILITY	
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 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 91 = 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 = Elderly8 = Any age 9 = Invalid C is sex as follows: 1 = Male2 = Female8 = 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. D is Hospital Provider Type as follows: 1 = NHS Hospital provider 2 = Non-NHS Hospital provider 9 = Home Leave 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. Cleaning Rule None



Primary diagnosis chapter (CHAPTER) Field CHAPTER Field Name Primary diagnosis chapter NHS Field Name N/A Category Clinical Length and format 4an Availability 1989-90 onwards Description This provides the chapter of the primary diagnosis (diag_01). Value Chapters I to XXII Cleaning Rule None



Patient classification (CLASSPAT)

Field	CLASSPAT
Field Name	Patient classification
NHS Field Name	PATIENT CLASSIFICATION (V6-1) PATIENT CLASSIFICATION CODE (V6-2)
Category	Clinical; Period of Care
Length and format	1n
Availability	1989-90 onwards
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
Cleaning Rule	None



Cleaning Rule

Admitted Patient Care (APC) Data Set

Consultant code (CONSULT) Field CONSULT Field Name Consultant code **NHS Field Name** CONSULTANT CODE Practitioner Category Length and format 8an Availability 1997-98 onwards 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 Description (consult) field contains sensitive data. Access to it requires the approval of The Independent Group Advising on the Release of Data (IGARD). 8an = Consultant code Cnnnnnn - consultant Dnnnnnn - dentist CDnnnnnn - dental consultant H9999998 (Other Healthcare professional) M9999998 (Midwife) Value 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 # 420



Commissioning Region of GP Practice (CR_GP_PRACTICE)

Field	CR_GP_PRACTICE
Field Name	Commissioning Region of GP Practice
NHS Field Name	N/A
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's GP practice is registered. Where not available, the code for the Area Team is used. It is derived from gpprac.
Value	ann = CR of patient's GP practice Y = Unknown
Cleaning Rule	None



Field

Field Name

Category

Availability

Description

Value

NHS Field Name

Admitted Patient Care (APC) Data Set

Commissioning Region of Residence (CR_RESIDENCE) CR_RESIDENCE Commissioning Region of Residence Geographical Length and format 3an 2013-14 onwards

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.

ann = CR of Residence Y = Unknown

Cleaning Rule None



Cleaning Rule

None

Admitted Patient Care (APC) Data Set

Commissioning Region of Treatment (CR_TREATMENT) Field CR_TREATMENT Field Name Commissioning Region of Treatment NHS Field Name Category Geographical Length and format 3an Availability 2013-14 onwards 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 Description derived from the CCG of Treatment. ann = CR of treatment Value Y = Unknown



Commissioning serial number (CSNUM) Field **CSNUM** Field Name Commissioning serial number NHS Field Name COMMISSIONING SERIAL NUMBER Category Organisation Length and format 6an Availability 2000-01 onwards 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 Description AGREEMENT by an ORGANISATION acting as commissioner of patient care services. Value 6an = Commissioning serial number Cleaning Rule



Current electoral ward (CURRWARD) Field **CURRWARD** Field Name Current electoral ward **NHS Field Name** N/A Category Geographical Length and format 2an Availability 1989-90 onwards This field, which is derived from the patient's postcode in the field HOMEADD, contains a code which defines the pre-2011 electoral ward of the patient. CURRWARD represents the old-style ONS geographical coding system, which was replaced in January 2011 - the new style code can be found in the field Description CURRWARD ONS. Because identical CURRWARD codes are allocated to many local authority districts, CURRWARD is meaningless in isolation. This field should be used in conjunction with RESLADST (local authority district) to produce a unique value indicating the ward within a given district where the patient resided. 2a = Electoral ward Value Y = Not Known Cleaning Rule None



Current electoral ward (ONS) (CURRWARD_ONS)

Field	CURRWARD_ONS
Field Name	Current electoral ward (ONS)
NHS Field Name	N/A
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 N99999999 (pseudo) = Northern Ireland L99999999 (pseudo) = Channel Islands M99999999 (pseudo) = Isle of Man
Cleaning Rule	None



Delivery place change reason (DELCHANG) Field **DELCHANG** Field Name Delivery place change reason DELIVERY PLACE CHANGE REASON (V6-1) **NHS Field Name** DELIVERY PLACE CHANGE REASON CODÉ (V6-2) Category Maternity Length and format 1n Availability 1989-90 onwards This field contains a code that defines the reason for changing the delivery place Description 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 Value 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) Cleaning Rule Rule # 710_MAT and #750



Delivery place (intended) (DELINTEN) Field **DELINTEN** Field Name Delivery place (intended) DELIVERY PLACE TYPE (INTENDED) (V6-1) **NHS Field Name** DELIVERY PLACE TYPE CODE (INTÉNDED) (V6-2) Category Maternity Length and format 1n Availability 1989-90 onwards 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 Description 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. 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 General Medical Practitioner 4 = In NHS hospital: delivery facilities associated with consultant / General Medical Practitioner / midwife ward, inclusive of any combination of two of the professionals Value mentioned 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) Cleaning Rule Rule # 710_MAT and 750



Alternative Delivery method (Derived) (DELMETH_D)

Field	DELMETH_D
Field Name	Alternative Delivery method (Derived)
NHS Field Name	N/A
Category	Maternity
Length and format	2n or X
Availability	2008-09 onwards
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
Cleaning Rule	None



Delivery method (DELMETH_N) Field DELMETH_N Field Name Delivery method **DELIVERY METHOD (V6-1) NHS Field Name** DELIVERY METHOD CODE (V6-2) Category Maternity Length and format 1n or X Availability 1989-90 onwards 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 Description method. This item appears for each baby on multiple birth delivery records. 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) Value 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 # 710_BAB, 753 and 770

Cleaning Rule



Labour/delivery onset method (DELONSET)

Field	DELONSET
Field Name	Labour/delivery onset method
NHS Field Name	LABOUR OR DELIVERY ONSET METHOD (V6-1) LABOUR OR DELIVERY ONSET METHOD CODE (V6-2)
Category	Maternity
Length and format	1n
Availability	1989-90 onwards
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)
Cleaning Rule	Rule # 710_MAT and 750



Delivery place (actual) (DELPLAC_N)

Field	DELPLAC_N
Field Name	Delivery place (actual)
NHS Field Name	DELIVERY PLACE TYPE (ACTUAL) (V6-1) DELIVERY PLACE TYPE CODE (ACTUAL) (V6-2)
Category	Maternity
Length and format	1n
Availability	1989-90 onwards
Description	This field contains a code which defines the actual type of delivery place (The intended delivery place is in delinten). 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 General Medical Practitioner ward 4 = In NHS hospital: delivery facilities associated with consultant / General Medical Practitioner / midwife ward, inclusive of any combination of two of the professionals mentioned 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
Cleaning Rule	Rule # 710_BAB, 753 and 770



Anaesthetic given post-labour or delivery (DELPOSAN)

Field	DELPOSAN
Field Name	Anaesthetic given post-labour or delivery
NHS Field Name	ANAESTHETIC GIVEN POST LABOUR OR DELIVERY (V6-1) ANAESTHETIC GIVEN POST LABOUR OR DELIVERY CODE (V6-2)
Category	Maternity
Length and format	1n
Availability	1989-90 onwards
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 i.e. no analgesic or anaesthetic administered 9 = Not known Null = Not applicable (from 1990-91 to 1994-95)
Cleaning Rule	Rule # 730



Anaesthetic given during labour or delivery (DELPREAN)

Field	DELPREAN
Field Name	Anaesthetic given during labour or delivery
NHS Field Name	ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY (V6-1) ANAESTHETIC GIVEN DURING LABOUR OR DELIVERY CODE (V6-2)
Category	Maternity
Length and format	1n
Availability	1989-90 onwards
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 i.e. no analgesic or anaesthetic administered 9 = Not known Null = Not applicable (from 1990-91 to 1994-95)
Cleaning Rule	Rule # 730



Status of person conducting delivery (DELSTAT_N) Field DELSTAT_N Field Name Status of person conducting delivery STATUS OF PERSON CONDUCTING DELIVERY (V6-1) **NHS Field Name** STATUS OF PERSON CONDUCTING DELIVERY CODE (V6-2) Maternity Category Length and format 1n Availability 1989-90 onwards 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 Description appears for each baby on multiple birth delivery records. 1 = Hospital doctor 2 = General practitioner Value 3 = Midwife8 = Other than above 9 = Not known: validation error Cleaning Rule Rule # 710_BAB, 753 and 770



High-dependency care level (DEPDAYS) Field **DEPDAYS** Field Name High-dependency care level NHS Field Name Category Augmented/critical care period Length and format Availability 1997-98 to 2005-06 This field contains the number of days of high dependency care in a period of Description augmented care. 4n = Number of days in the range 000 to 9998 Value 9999 = Not known: a validation error Cleaning Rule Rule # 1030



Date detention commenced check flag (DET_CFL) Field DET_CFL Field Name Date detention commenced check flag NHS Field Name N/A Category Psychiatric Length and format 1n Availability 1989-90 onwards Description Validation of date detention commenced. 0 = Valid (or missing because not required) Value 1 = Missing2 = Invalid Cleaning Rule None



Duration of detention (DETDUR) Field **DETDUR** Field Name **Duration of detention DURATION OF DETENTION NHS Field Name** Category **Psychiatric** Length and format 5n Availability 1989-90 onwards This derived field contains the number of days between the date the current Description detention commenced (detndate) and the date of the psychiatric census (31 March of cendate). The maximum period is 29,200 days (approximately 80 years). 5n = Duration of detention in days at census date from 0 to 29,200 Value Null = Not applicable (epitype is not 4) / not known None Cleaning Rule



Detention category (DETNCAT) Field **DETNCAT** Field Name **Detention category** NHS Field Name N/A **Psychiatric** Category Length and format 1n Availability 1999-00 to 2001-02 Indicates the legislation under which the patient was detained. The Detention Description category (detncat) field contains sensitive data. Access to it requires the approval of The Independent Group Advising on the Release of Data (IGARD). 0 = Informal, not formally detained 1 = Formally detained under Part II, Mental Health Act 1983 Value 2 = Formally detained under Part III, Mental Health Act 1983, and other legislation 3 = Formally detained under Part X, Mental Health Act 1983 Cleaning Rule None



Date detention commenced (DETNDATE)

Field	DETNDATE
Field Name	Date detention commenced
NHS Field Name	DATE DETENTION COMMENCED
Category	Psychiatric
Length and format	dd/mm/yyyy (Date)
Availability	1989-90 onwards
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
Cleaning Rule	Rule # 110



3 character concatenated diagnosis (DIAG_3_CONCAT)

Field	DIAG_3_CONCAT
Field Name	3 character concatenated diagnosis
NHS Field Name	N/A
Category	Clinical
Length and format	79an
Availability	1989-90 onwards
Description	Provides a concatenated string of all diagnoses from the record at a 3 character level, separated by a comma with no spaces. This enables the user to search across the full list of diagnoses to look at mentions and pairs of diagnosis codes.
Value	max 79n = concatenated string of all diagnosis codes (3-character level) separated by a comma.
Cleaning Rule	None



Diagnosis - 3 characters (DIAG_3_NN)

Field	DIAG_3_NN
Field Name	Diagnosis - 3 characters
NHS Field Name	N/A
Category	Clinical
Length and format	3an
Availability	1989-90 onwards
Description	This provides the first three characters of diagnosis codes.
Value	3an = A valid ICD-9 or ICD-10 diagnosis code Null = Not applicable R69 = Not known, invalid or null
Cleaning Rule	None



4 character concatenated diagnosis (DIAG_4_CONCAT)

Field	DIAG_4_CONCAT
Field Name	4 character concatenated diagnosis
NHS Field Name	N/A
Category	Clinical
Length and format	99an
Availability	1989-90 onwards
Description	Provides a concatenated string of all diagnoses from the record at a 4 character level, separated by a comma with no spaces. This enables the user to search across the full list of diagnoses to look at mentions and pairs of diagnosis codes.
Value	max 99n = concatenated string of all diagnosis codes (4-character level) separated by a comma.
Cleaning Rule	None



Diagnosis - 4 characters (DIAG_4_NN)

Field	DIAG_4_NN
Field Name	Diagnosis - 4 characters
NHS Field Name	N/A
Category	Clinical
Length and format	4an
Availability	1989-90 onwards
Description	This provides the first four characters of diagnosis codes.
Value	4an = A valid ICD-9 or ICD-10 diagnosis code Null = Not applicable R69X = Not known, invalid or null
Cleaning Rule	None



Count of diagnoses (DIAG_COUNT) Field DIAG_COUNT Field Name Count of diagnoses NHS Field Name N/A Category Diagnosis Length and format 2n Availability 1989-90 onwards Description The total number of diagnosis codes present on the record (maximum of 20) Value 2n = count of diagnoses Cleaning Rule None



All Diagnosis codes	(DIAG_NN)
---------------------	-----------

Field	DIAG_NN
Field Name	All Diagnosis codes
NHS Field Name	PRIMARY DIAGNOSIS (ICD) SECONDARY DIAGNOSIS (ICD)
Category	Clinical
Length and format	6an
Availability	1989-90 onwards
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 R96X - Not known R69X6 - Null (Primary diagnosis) R69X8 - Invalid R69X3 = Invalid (External Cause code entered as Primary Diagnosis)
Cleaning Rule	Rule # 455, 460, 470, 490, 500, 510, 530, 640, 840, 850 and 860



Discharge date check flag (DIS_CFL) Field DIS_CFL Field Name Discharge date check flag NHS Field Name Category Discharges; Period of Care Length and format Availability 1989-90 onwards Description Codes in this field indicate whether the discharge date (disdate) is valid. 0 = Valid (or missing because not required) Value 1 = Missing2 = Invalid Cleaning Rule None



Field

Value

Cleaning Rule

Admitted Patient Care (APC) Data Set

Date of discharge (DISDATE) DISDATE Field Name Date of discharge NHS Field Name DISCHARGE DATE (HOSPITAL PROVIDER SPELL) Category Discharges; Period of Care Length and format dd/mm/yyyy (Date) Availability 1989-90 onwards This field contains the date on which the patient was discharged from hospital.; It Description is only present in the record for the last episode of a spell.

01/01/1800 - Null date submitted 01/01/1801 - Invalid date submitted

2012/13 onwards:

1989/90 to 2011/12:



Date of discharge - Uncleaned (DISDATE_UNCLN) Field DISDATE_UNCLN Field Name Date of discharge - Uncleaned NHS Field Name Category Discharges; Period of Care Length and format dd/mm/yyyy (Date) 1989-90 onwards Availability This field contains the date on which the patient was discharged from hospital. This Description 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. dd/mm/yyyy = Date Value Null = Date not known / not applicable Cleaning Rule



Destination	on discharge	(DISDEST)
	9-	(/

Field	DISDEST
Field Name	Destination on discharge
NHS Field Name	DISCHARGE DESTINATION (HOSPITAL PROVIDER SPELL) (V6-1) DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL) (V6-2)
Category	Discharges; Period of Care
Length and format	2n
Availability	1989-90 onwards
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 Cleaning Pule	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) 49 = NHS other hospital provider - high security psychiatric bospital, Scotland (from 1999-2000) 49 = 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 (other than Local Authority) run Hospice 98 - Not applicable - Hospital Provider Spell not finished at episode end (i.e. not discharged) or current episode unfinished 99 - Not Known Pulle # 205 210 220 and 223
Cleaning Rule	99 - Not Known Rule # 205, 210, 220 and 223
	,



Destination on discharge - uncleaned	(DISDEST LINCLN)
Destination on discharge - uncleaned	(DISDEST GROEN)

Field	DISDEST_UNCLN
Field Name	Destination on discharge - uncleaned
NHS Field Name	N/A
Category	Discharges; Period of Care
Length and format	2n
Availability	1989-90 onwards
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) 40 = High security psychiatric hospital, Scotland (from 1999-2000) 41 = NHS other hospital provider - high security psychiatric 41 = NHS other hospital provider - ward for general PATIENTS or the younger physically disabled 42 = NHS other hospital provider - ward for maternity PATIENTS or Neonates 43 = NHS other hospital provider - ward for PATIENTS who are mentally ill or have learning disabilities 45 = NHS run Care Home 46 = Local Authority residential accommodation i.e. where care is provided 46 = Local Authority foster care 47 = Not applicable - PATIENT died or still birth 48 = Non-NHS run hospital - medium secure unit 48 = Non-NHS (other than Local Authority) run Care Home 48 = Non-NHS (other than Local Authority) run Care Home 49 = Not applicable - Hospital Provider Spell not finished at episode end (i.e. not discharged) or current episode unfinished 49 = Not Known
Cleaning Rule	Rule # 6
<u> </u>	



Discharge episode flag (DISFLAG) Field **DISFLAG** Field Name Discharge episode flag NHS Field Name N/A Category Patient Data Length and format 1a Availability 1989-90 onwards Description Codes in this field indicate whether the episode is a discharge episode. Y = Episode is a discharge episode, ie discharge method is 1-5 Value N = Episode is not a discharge episode Cleaning Rule None



Cleaning Rule

Admitted Patient Care (APC) Data Set

Method of discharge (DISMETH) Field **DISMETH** Method of discharge Field Name DISCHARGE METHOD (HOSPITAL PROVIDER SPELL) (V6-1) NHS Field Name DISCHARGE METHOD CODE (HOSPITAL PROVIDER SPELL) (V6-2) Discharges; Period of Care Category Length and format 1n Availability 1989-90 onwards 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 Description consultant. This field is only completed for the last episode in a spell. 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 = DiedValue 5 = Baby was still born 8 = Not applicable: patient still in hospital 9 = Not known: a validation error

Rule # 205, 210, 220, 223 and 320



Method of discharge - uncleaned (DISMETH_UNCLN) Field DISMETH_UNCLN Field Name Method of discharge - uncleaned NHS Field Name Discharges; Period of Care Category Length and format Availability 1989-90 onwards 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 Description with the record and hence may be different from DISMETH if this has been cleaned. 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 Value 4 = Died5 = Baby was still born 8 = Not applicable: patient still in hospital 9 = Not known: a validation error Rule # 6 Cleaning Rule



Discharge ready date (DISREADYDATE) Field DISREADYDATE Field Name Discharge ready date NHS Field Name DISCHARGE READY DATE (HOSPITAL PROVIDER SPELL) Category Discharges; Period of Care Length and format dd/mm/yyyy (Date) Availability 2007-08 onwards The date that a patient was medically ready for discharge from a hospital bed, but Description couldn't be discharged, therefore qualifying for delayed discharge payments. dd/mm/yyyy = Discharge ready date Value Cleaning Rule None



Date of birth - patient (DOB) Field DOB Field Name Date of birth - patient NHS Field Name PERSON BIRTH DATE Patient Data Category Length and format dd/mm/yyyy (Date) Availability 1989-90 onwards This field contains the patient's date of birth. For most enquiries the field startage (age at start of episode) is used. The Date or birth - patient (dob) field contains sensitive data. Access to it requires the approval of the Confidentiality Advisory Description Group (CAG). 2012/13 onwards: 01/01/1800 - Null date submitted 01/01/1801 - Invalid date submitted Value 1989/90 to 2011/12: 01/01/1600 - Null date submitted 15/10/1582 - Invalid date submitted Cleaning Rule Rule # 20



Date of birth check flag - patient (DOB_CFL) Field DOB_CFL Field Name Date of birth check flag - patient NHS Field Name N/A Category Patient Data Length and format 1n Availability 1989-90 onwards Description Validation of patient's date of birth. 0 = Valid (or missing because not required) Value 1 = Missing2 = Invalid Cleaning Rule None



Birth date (baby) (DOBBABY_N) Field DOBBABY_N Field Name Birth date (baby) NHS Field Name PERSON BIRTH DATE Category Maternity Length and format dd/mm/yyyy (Date) 1989-90 onwards Availability Baby's date of birth. This item appears for each baby on multiple birth delivery Description records. The Birth date - baby (dobbaby) field contains sensitive data. Access to it requires the approval of the Confidentiality Advisory Group (CAG). dd/mm/yyyy = Date of birth Null = Invalid/Not Known Value Cleaning Rule Rule # 670 and 770



Trust derived dominant procedure (DOMPROC) Field **DOMPROC** Field Name Trust derived dominant procedure NHS Field Name Category Healthcare resource groups (HRG) data Length and format 4an Availability 2001-02 to 2008-09 Contains the dominant procedure (operation) code assigned as part of the (NHS) Description HRG derivation process and submitted to SUS. 4an = Procedure code Value - = No operation performed & = Not known Cleaning Rule Rule # 570



Earliest reasonable date offered (EARLDATOFF) Field **EARLDATOFF** Field Name Earliest reasonable date offered **NHS Field Name** EARLIEST REASONABLE OFFER DATE Category Patient Pathway Length and format dd/mm/yyyy (Date) Availability 2008-09 onwards 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 Description 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 Cleaning Rule None



Cleaning Rule

None

Admitted Patient Care (APC) Data Set

Date of decision to admit check flag (ELEC_CFL) Field ELEC_CFL Field Name Date of decision to admit check flag NHS Field Name Category Admissions; Period of Care Length and format 1n Availability 1989-90 onwards Description Codes in this field indicate whether the decision to admit date is valid. 0 = Valid (or missing because not required) Value 1 = Missing 2 = Invalid



Date of decision to admit (ELECDATE)

Field	ELECDATE
Field Name	Date of decision to admit
NHS Field Name	DECIDED TO ADMIT DATE
Category	Admissions; Period of Care
Length and format	dd/mm/yyyy (Date)
Availability	1989-90 onwards
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
Cleaning Rule	Rule # 40 and 45



Duration of elective wait (submitted) (ELECDUR) Field **ELECDUR** Field Name Duration of elective wait (submitted) NHS Field Name **DURATION OF ELECTIVE WAIT** Admissions; Period of Care Category Length and format 4n Availability 1989-90 onwards This submitted field contains the difference in days between the date on which it was decided to admit the patient (elecdate) and the actual admission date Description (admidate). Elecdur is only applicable where an elective admission (ie the admission method is 11, 12 or 13) was scheduled and took place. 4n = duration of elective wait in days 9998 = not applicable Value 9999 = not known (i.e. no date known for decision to admit): a validation error null = not known / not applicable Cleaning Rule None



Cleaning Rule

Admitted Patient Care (APC) Data Set

Calculation of Elecdur (ELECDUR_CALC) Field ELECDUR_CALC Field Name Calculation of Elecdur NHS Field Name Category Admissions; Period of Care Length and format Availability 1989-90 onwards This field returns the elecdurd but excludes non-elective and planned admissions so only includes where the method of admission is 11 or 12. This is only calculated on the first episode in a hospital provider spell, and regular admissions are also Description excluded. If classpat in ('1','2','5') and epiorder = 1 and admimeth in ('11','12') then elecdur_calc = elecdurd 4n = Waiting time in days from 1 to 8887 Value

null = not known / not applicable

None



Duration of elective wait (derived) (ELECDURD) Field **ELECDURD** Field Name Duration of elective wait (derived) NHS Field Name Admissions; Period of Care Category Length and format Availability 1989-90 onwards 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 Description 11, 12 or 13) was scheduled and took place. It is not applicable to records that are 'other maternity events'. 4n = Waiting time in days from 1 to 8887 Value null = not known / not applicable Cleaning Rule None



Age at end	of episode	(ENDAGE)
------------	------------	----------

Field	ENDAGE
Field Name	Age at end of episode
NHS Field Name	N/A
Category	Patient Data
Length and format	4n
Availability	1989-90 onwards
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. The patient's age in years at the end of an episode is only relevant for General, Delivery or Birth records. It is recorded as a whole number of years (i.e. any days or months produced by the calculation are ignored, unless endage is less than 1 year).
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)
Cleaning Rule	None



Episode duration (EPIDUR) Field **EPIDUR** Field Name Episode duration NHS Field Name Category Episodes and spells; Period of care Length and format Availability 1989-90 onwards This field contains the difference in days between the episode start date (epistart) and the episode end date (epiend). Description This is the full duration of a finished episode only. Episode duration is not applicable for 'other maternity events' and shall therefore remain null. 5n = Duration of episode in days from 0 to 29,200 Value Null = Not applicable (other maternity event or not known) Cleaning Rule None



Episode end date check flag (EPIE_CFL) Field EPIE_CFL Episode end date check flag Field Name NHS Field Name Category Episodes and spells; Period of care Length and format Availability 1989-90 onwards Description This field validates the episode end date (epiend). 0 = Valid (or missing because not required) Value 1 = Missing2 = Invalid Cleaning Rule None



Date episode ended (EPIEND) Field **EPIEND** Field Name Date episode ended **NHS Field Name END DATE (EPISODE)** Episodes and spells; Period of care Category Length and format dd/mm/yyyy (Date) Availability 1989-90 onwards This field contains the date on which a patient left the care of a particular consultant, for one of the following reasons: Patient discharged from hospital (includes transfers) or moved to the care of another consultant. A null entry either Description indicates that the episode was unfinished at the end of the data year, or the date was unknown. 2012/13 onwards: 01/01/1800 - Null date submitted 01/01/1801 - Invalid date submitted Value 1989/90 to 2011/12: 01/01/1600 - Null date submitted 15/10/1582 - Invalid date submitted Rule # 190, 200, 203 and 1250 Cleaning Rule Data Removal # 0005 and 0006



Record identifier (EPIKEY) Field **EPIKEY** Field Name Record identifier NHS Field Name N/A Category System Data Length and format 14n Availability 1989-90 onwards This is a record identifier that is created by the HES system. The digits store a Description decimal number. This is commonly eight or nine digits but can be up to 14. Value 14n = Record identifier Cleaning Rule None



Episode order (EPIORDER) Field **EPIORDER** Field Name Episode order **NHS Field Name EPISODE NUMBER** Category Episodes and spells; Period of care Length and format Availability 1989-90 onwards 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 Description 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. 2n = The number of the episode in the sequence of episodes from 01-87 98 = Not applicable Value 99 = Not known: a validation error Null = Not applicable: other maternity event Cleaning Rule Rule # 130, 140 and 320



Episode start date check flag (EPIS_CFL) Field EPIS_CFL Episode start date check flag Field Name NHS Field Name Category Episodes and spells; Period of care Length and format Availability 1989-90 onwards Description This field validates the episode start date (epistart). 0 = Valid (or missing because not required) Value 1 = Missing2 = Invalid Cleaning Rule None



Date episode started	(EPISTART)
-----------------------------	------------

Field	EPISTART
Field Name	Date episode started
NHS Field Name	START DATE (EPISODE)
Category	Episodes and spells; Period of care
Length and format	dd/mm/yyyy (Date)
Availability	1989-90 onwards
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
Cleaning Rule	Rule # 30



Episode status (EPISTAT)		
Field	EPISTAT	
Field Name	Episode status	
NHS Field Name	N/A	
Category	Episodes and spells; Period of care	
Length and format	1n	
Availability	1989-90 onwards	
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)	
Cleaning Rule	Rule # 170 and 180 Data Removal # 0007 and 0008	



Episode type (EPITYPE) Field **EPITYPE** Field Name Episode type NHS Field Name Episodes and spells; Period of care Category Length and format Availability 1989-90 onwards This field contains a code that defines the type of episode, so that groups of similar Description episodes can be formed. 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 Value (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 # 150 and 160 Cleaning Rule



Ethnic category (ETHNOS)	
Field	ETHNOS
Field Name	Ethnic category
NHS Field Name	ETHNIC CATEGORY
Category	Patient Data
Length and format	1n or X
Availability	1989-90 onwards
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 Cleaning Rule Rule # 10



Cleaning Rule

None

Admitted Patient Care (APC) Data Set

Ethnic character (audit version) (ETHRAW) Field **ETHRAW** Field Name Ethnic character (audit version) **NHS Field Name** Category System Data Length and format 1a Availability 2003-04 onwards 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 Description copy of the raw data found in the right hand character is held in ethrawl. 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 Value 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 knownZ = Not stated



Field

Field Name

Category

NHS Field Name

Admitted Patient Care (APC) Data Set

Ethnic category (audit version) (ETHRAWL) ETHRAWL Ethnic category (audit version) N/A System Data

Length and format 1an

Availability 2003-04 onwards

Description 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.

Value 9 = Not Known (if ethraw also = 9)

Cleaning Rule None



Finished Admission Episode (FAE) Field FAE Field Name Finished Admission Episode NHS Field Name Category Episodes and spells; Period of care Length and format Availability 1989-90 onwards This indicates whether the episode is a finished admission episode (the first episode in a hospital provider spell). FAE is derived in HES, and is set to a value of Description 1 for finished admission episodes (where the Episode Status is 3 and Episode Order = 1 and Patient Classification is 1, 2 or 5). 1 = Finished Admission Episode Value 0 = All other episodes Cleaning Rule None



Finished Admission Episode, emergency classification (FAE_EMERGENCY)

Field	FAE_EMERGENCY
Field Name	Finished Admission Episode, emergency classification
NHS Field Name	N/A
Category	Episodes and spells; Period of care
Length and format	1n
Availability	1989-90 onwards
Description	Finished Admission Episode Flag where admission to hospital is from an emergency admission. This is set to a value of 1 for the admission episode where Patient Classification is 1,2 or 5 AND admission method begins with a 2*
Value	 1 = Finished Admission Episode Flag where admission to hospital is from an emergency admission 0 = All other episodes
Cleaning Rule	None



Finished Consultant Episode (FCE) Field **FCE** Field Name Finished Consultant Episode NHS Field Name Episodes and spells; Period of care Category Length and format Availability 1989-90 onwards Finished consultant episode (FCE) is a continuous period of admitted patient care under one consultant within one healthcare provider. FCEs do not represent the number of in-patients, as a person may have more than one period of care within Description the year. This field is derived in HES and it is set to a value of 1 for finished episodes i.e. where the Episode Status is 3 and the Patient Classification is 1, 2 or 5 (Ordinary admission, day case admission or mothers and babies using only delivery facilities). 1 = Finished Consultant Episode Value 0 = All other episodes Cleaning Rule None



Finished consultant episode flag (FCEFLAG) Field **FCEFLAG** Field Name Finished consultant episode flag NHS Field Name N/A Category Patient Data Length and format 1a Availability 1989-90 onwards Description Codes in this field indicate whether the episode is a finished consultant episode. Y = Episode is finished, ie episode status equals 3 Value N = Episode status is not equal to 3 Cleaning Rule None



Finished In-Year Discharge Episode (FDE) Field FDE Field Name Finished In-Year Discharge Episode NHS Field Name Category Episodes and spells; Period of care Length and format Availability 1989-90 onwards This indicates whether the episode is a finished discharge episode (whether the patient was discharged at the end of the episode). FDE is derived in HES, and is Description set to a value of 1 for finished discharge episodes (where the Episode Status is 3 and Discharge Method is 1-5 and Patient Classification is 1, 2 or 5,). 1 = Finished In-Year Discharge Episode Value 0 = All other episodes Cleaning Rule None



First regular day or night admission (FIRSTREG) Field **FIRSTREG** Field Name First regular day or night admission FIRST REGULAR DAY OR NIGHT ADMISSION (V6-1) **NHS Field Name** FIRST REGULAR DAY OR NIGHT ADMISSION CODÉ (V6-2) Category Admissions; Period of Care Length and format Availability 2002-03 onwards This field indicates whether the episode falls within a sequence of regular day and Description night admissions and, if so, whether it is the first or subsequent episode within the sequence. 0 = First in a series Value 1 = Subsequent to first in a series None Cleaning Rule



Financial Year (FYEAR) Field **FYEAR** Field Name Financial Year NHS Field Name Episodes and spells; Period of care Category Length and format Availability 1989-90 onwards Description Value 4n = Financial Year Cleaning Rule None



Cleaning Rule

Admitted Patient Care (APC) Data Set

Length of gestation (GESTAT) Field **GESTAT** Field Name Length of gestation NHS Field Name **GESTATION LENGTH IN WEEKS** Category Maternity Length and format 2n Availability 1989-90 onwards 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 Description 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 2n = Number of weeks in the range 10 to 49 Value 99 = Not known: a validation error

Rule # 710, 753 and 770



Government office region of treatment (GORTREAT) Field **GORTREAT** Field Name Government office region of treatment NHS Field Name Category Geographical Length and format 1a Availability 2002-03 onwards Government Office Region (GOR) of treatment. This field is derived from the Description hospital provider code (procode). It indicates the GOR area within which the treatment took place. A = North East B = North West D = Yorkshire and The Humber E = East Midlands F = West Midlands Value G = East of England H = London J = South East K = South West Y = Not known Cleaning Rule None



Code of GP practice (GPPRAC) Field **GPPRAC** Field Name Code of GP practice **NHS Field Name** GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION) Category Practitioner Length and format 6an Availability 1997-98 onwards 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 Description 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. 6an = GP's practice code (English GP's with codes commencing A-P only) V81997 = No Registered General Practitioner Practice Value V81998 = General Practitioner Practice Code not applicable V81999 = General Practitioner Practice Code not known (submitted value) & = Unknown (no code submitted) Cleaning Rule Rule # 440



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

Field	GPPRACHA
Field Name	Health Authority area where patient's GP is registered
NHS Field Name	N/A
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
Cleaning Rule	None



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

Field	GPPRACRO
Field Name	Regional Office area where patient's GP was registered
NHS Field Name	N/A
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
Cleaning Rule	None



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
NHS Field Name	N/A
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
Cleaning Rule	None



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
NHS Field Name	N/A
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
Cleaning Rule	None



Ordnance Survey grid reference (GRIDLINK) Field **GRIDLINK** Field Name Ordnance Survey grid reference NHS Field Name N/A Category Geographical 9n Length and format Availability 2002-03 onwards 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 Description 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 Independent Group Advising on the Release of Data (IGARD). Value 9n = Ordnance survey grid reference (4 digits eastings, 5 digits northings) Cleaning Rule None



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

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



Field

Description

Cleaning Rule

Value

Admitted Patient Care (APC) Data Set

Health Authority of treatment (HATREAT) HATREAT Field Name Health Authority of treatment NHS Field Name N/A Category Geographical Length and format За Availability 1989-90 onwards This field indicates the health authority (HA) where the treatment took place. It is

(contains the district health authority of treatment prior to 1 April 1996).

3a = Health authority of treatment

Y = Unknown

None

derived from the hospital provider code (procode). Health authority of treatment



Patient identifier - HES generated (HESID) Field **HESID** Field Name Patient identifier - HES generated NHS Field Name Category Patient Data Length and format 10n Availability 1997-98 onwards This field uniquely identifies a patient across all data years. It is generated by Description 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 Cleaning Rule None



Cleaning Rule

None

Admitted Patient Care (APC) Data Set

Patient ID - HES generated (original) (HESID_ORIG) <u>Fie</u>ld **HESID_ORIG** Field Name Patient ID - HES generated (original) NHS Field Name N/A Category Patient Data Length and format 10n Availability 1997-98 onwards 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 Description identifier, plus the patients' postcode, sex and date of birth. Value 10n = Patient ID - HES generated



Healthly Neonate Indicator (HNEOIND) Field **HNEOIND** Field Name Healthly Neonate Indicator NHS Field Name N/A Category Maternity Length and format 1a Availability 2011-12 onwards This derived field is a flag to indicate a healthly 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). Description Y = Healthy Neonate Value N = Not Healthy Neonate Cleaning Rule None



Cleaning Rule

Rule # 325 and 330

Admitted Patient Care (APC) Data Set

Postcode of patient (HOMEADD) Field **HOMEADD** Field Name Postcode of patient POSTCODE OF USUAL ADDRESS **NHS Field Name** Patient Data Category Length and format 8an Availability 1989-90 onwards 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 Description 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 Confidentiality Advisory Group (CAG). aann naa = Postcode ZZ99 3CZ = England, GB, UK (not otherwise stated) ZZ99 3VZ = No fixed abode ZZ99 3WZ = Not known + sundry categories Value 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)



Field

Field Name

Category

NHS Field Name

Admitted Patient Care (APC) Data Set

Healthcare resource group: version 3.1 (HRG_N.N) HRG_N.N Healthcare resource group: version 3.1 N/A Healthcare resource groups (HRG) data

Length and format ann
Availability 2001-02 to 2008-09

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

Cleaning Rule None



Trust derived HRG value (HRGNHS) Field **HRGNHS** Field Name Trust derived HRG value NHS Field Name Category Healthcare resource groups (HRG) data Length and format 3an Availability 2001-02 to 2008-09 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). Description 3an = Trust derived HRG Value Cleaning Rule None



Version No. of Trust derived HRG (HRGNHSVN) Field **HRGNHSVN** Field Name Version No. of Trust derived HRG NHS Field Name 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 Cleaning Rule None



IMD Index of Multiple Deprivation (IMD04) Field IMD04 Field Name IMD Index of Multiple Deprivation **NHS Field Name** N/A Category Socio-economic Length and format **TBC** Availability 1997-1998 onwards 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 Description 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 Cleaning Rule None



IMD Decile Group (IMD04_DECILE) Field IMD04_DECILE Field Name IMD Decile Group **NHS Field Name** Category Socio-economic Length and format 20an Availability 1995-96 onwards 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 Description http://www.communities.gov.uk/documents/communities/pdf/131206.pdf for further details. 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% Value 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% Cleaning Rule None



IMD Crime Domain (IMD04C) Field IMD04C Field Name **IMD Crime Domain** NHS Field Name N/A Socio-economic Category Length and format 3n Availability 1995-96 onwards 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 Description 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 Cleaning Rule None



IMD Education Training and Skills Domain (IMD04ED) Field IMD04ED Field Name IMD Education Training and Skills Domain NHS Field Name Socio-economic Category Length and format 4n Availability 1995-96 onwards 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 Description 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 Cleaning Rule None



IMD Employment Deprivation Domain (IMD04EM) Field IMD04EM Field Name **IMD Employment Deprivation Domain** NHS Field Name N/A Socio-economic Category Length and format 3n Availability 1995-96 onwards 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 Description 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 Cleaning Rule None



IMD Health and Disability Domain (IMD04HD) Field IMD04HD Field Name IMD Health and Disability Domain **NHS Field Name** Socio-economic Category Length and format 3n Availability 1995-96 onwards 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 Description 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 Cleaning Rule None



IMD Barriers to Housing and Service Domain (IMD04HS) Field IMD04HS Field Name IMD Barriers to Housing and Service Domain **NHS Field Name** Socio-economic Category Length and format 4n Availability 1995-96 onwards 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 Description 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 Cleaning Rule None



IMD Income Domain (IMD04I) Field IMD04I Field Name **IMD Income Domain** NHS Field Name N/A Socio-economic Category Length and format 3n Availability 1995-96 onwards 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 Description 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 Cleaning Rule None



IMD Income affecting Adults Domain (IMD04IA) Field IMD04IA Field Name IMD Income affecting Adults Domain **NHS Field Name** Socio-economic Category Length and format 3n Availability 1995-96 onwards 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 Description 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 Cleaning Rule None



IMD Income affecting Children Domain (IMD04IC) Field IMD04IC Field Name IMD Income affecting Children Domain **NHS Field Name** Category Socio-economic Length and format 3n Availability 1995-96 onwards 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 Description 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 Cleaning Rule None



Value

Cleaning Rule

Admitted Patient Care (APC) Data Set

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

4n = IMD Living Environment Domain value

details.

None



IMD Overall Rank (IMD04RK)

D04RK
DUTIN
D Overall Rank
A A
cio-economic
95-96 onwards
e IMD overall ranking is made by combining the seven IMD Domain scores ing the following weights: ficome (22.5%) mployment (22.5%) lealth Deprivation and Disability (13.5%) ducation, Skills and Training (13.5%) arriers to Housing and Services (9.3%) frime (9.3%) iving Environment (9.3%) le SOA (Super Output Area) with a rank of 1 is the most deprived, and 32482 the lest deprived, on this overall measure. lis IMD version was first published in 2004. See p://www.communities.gov.uk/documents/communities/pdf/131206.pdf for further tails.
= IMD Overall Ranking
ne



Intensive care level days (INTDAYS_N)

Field	INTDAYS_N
Field Name	Intensive care level days
NHS Field Name	N/A
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
Cleaning Rule	Rule # 1040



Intended management (INTMANIG) Field **INTMANIG** Field Name Intended management **INTENDED MANAGEMENT (V6-1) NHS Field Name** INTENDED MANAGEMENT CODÉ (V6-2) Clinical; Period of Care Category Length and format 1997-98 onwards Availability This field contains a code that defines what was planned to happen. The patient Description classification (classpat) defines what actually happened. 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 Value 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 Cleaning Rule Rule # 120



In Year flag (INYRFLAG) Field **INYRFLAG** Field Name In Year flag NHS Field Name N/A Category Patient Data Length and format 1a Availability 1989-90 onwards Codes in this field indicate whether the episode admission was within the current Description HES year. Y = Admitted within the HES year Value N = Not admitted within the year Cleaning Rule None



Local authority district in 1998 (LAD98)

Field	LAD98
Field Name	Local authority district in 1998
NHS Field Name	N/A
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
Cleaning Rule	None



Legal group of patient (LEGALGPA)

Field	LEGALGPA
Field Name	Legal group of patient
NHS Field Name	N/A
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 Independent Group Advising on the Release of Data (IGARD).
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
Cleaning Rule	None
Cleaning Rule	,



Legal group of patient (psychiatric) (LEGALGPC) Field **LEGALGPC** Field Name Legal group of patient (psychiatric) **NHS Field Name** N/A Category **Psychiatric** Length and format 1n Availability 2002-03 onwards Legal group of patient, an aggregation of legal status of a patient on psychiatric census date, legIstat. This field contains a code that allocates the legal status of a Description patient to one of eight groups. This field contains sensitive data. Access to it requires the approval of The Independent Group Advising on the Release of Data (IGARD). 0 = Legal status on psychiatric census date is not formally detained, legIstat =01 or spaces 1 = Legal status on psychiatric census date, legIstat = 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 Value 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 = $5/6 \cdot 10 = \text{Not known}$: any other value for legistat. Cleaning Rule None



Cleaning Rule

None

Admitted Patient Care (APC) Data Set

Legal category of patient (LEGLCAT)	
Field	LEGLCAT
Field Name	Legal category of patient
NHS Field Name	MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (AT CENSUS DATE)
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 Independent Group Advising on the Release of Data (IGARD).
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 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 17 = Formally detained under the Mental Health Act, Section 47 17 = Formally detained under the Mental Health Act, Section 48 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 Mental Health Act, Section 136 21 = Formally detained under the Mental Health Act, Section 136 21 = Formally detained under the Mental Health Act, Section 136 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



Legal status classification (LEGLSTAT)	
Field	LEGLSTAT
Field Name	Legal status classification
NHS Field Name	LEGAL STATUS CLASSIFICATION CODE (AT CENSUS DATE) (V6-1) MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (AT CENSUS DATE) (V6-2)
Category	Psychiatric
Length and format	2n
Availability	1989-90 onwards
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 (legIstat) field contains sensitive data. Access to it requires the approval of The Independent Group Advising on the Release of Data (IGARD).
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 17 = Formally detained under the Mental Health Act, Section 47 17 = Formally detained under the Mental Health Act, Section 48 19 = 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 135 30 = Formally detained under the Mental Health Act, Section 135 30 = Formally detained under the Mental Health Act, Section 135 30 = Formally detained under the Mental Health Act, Section 136 30 = Formally detained under the Mental Health Act, Section 136 30 = Formally detained under the Mental Health Act, Section 136 30 = Formally detained under the Mental Health Act, Section 136 30 = Formally detained under the Mental Health Act, Section 136 30 = Formally detained under the Mental Health Act, Section 136 30 = Formally detained under the Mental Health Act, Section 136 30 = Formally detained under the Mental Health Act, Section 136 30 = Formally detained under the Mental Health Act, Section 136 30 = Formally detained under the Mental Health Act, Section 136 30 = For



Cleaning Rule

None



Legal status classification code on admission (LEGLSTATST)

Field	LEGLSTATST
Field Name	Legal status classification code on admission
NHS Field Name	LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION) (V6-1) MENTAL HEALTH ACT LEGAL STATUS CLASSIFICATION CODE (ON ADMISSION) (V6-2)
Category	Patient Data
Length and format	2an
Availability	2007-08 onwards
Description	This field is identical to LEGLCAT, and so will eventually retire from HES. The legal category of all formally and informally detained patients on admission. See LEGLCAT field for full description. Access to this field requires the approval of 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 10 = Formally detained under the Mental Health Act, Section 37 12 = Formally detained under the Mental Health Act, Section 37 13 = 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 17 = Formally detained under the Mental Health Act, Section 47 17 = 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 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 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
Cleaning Rule	None
<u> </u>	



Local patient identifier (LOPATID) Field **LOPATID** Field Name Local patient identifier NHS Field Name LOCAL PATIENT IDENTIFIER Category Patient Data Length and format 10n Availability 1997-98 onwards 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 Description assigned automatically by the computer system. The Local patient identifier (lopatid) field contains sensitive data. Access to it requires the approval of The Independent Group Advising on the Release of Data (IGARD). Value 10n = Local patient identifier Cleaning Rule None



Lower Super Output Area (LSOA01)

Field	LSOA01
Field Name	Lower Super Output Area
NHS Field Name	
Category	Geographical
Length and format	9an
Availability	2003-04 onwards
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
Cleaning Rule	None



Value

Cleaning Rule

Admitted Patient Care (APC) Data Set

Lower Super Output Area (LSOA11) Field LSOA11 Lower Super Output Area Field Name **NHS Field Name** Category Geographical Length and format 9an Availability 2013-14 onwards 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 Description 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. 9an = Lower Super Output Area E01000001- E01033768 = England

TBA = Scotland95AA01S1 ? 95ZZ16S2 = Northern Ireland

W01000001- W01001958 = Wales

Z99999999 = Not known

None

L99999999 (pseudo) = Channel Islands M99999999 (pseudo) = Isle of Man



Admitted Fatient Gale (AFG) Data Set	
Main specialty (MAINSPEF)	
Field	MAINSPEF
Field Name	Main specialty
NHS Field Name	MAIN SPECIALTY CODE (V6-1) CARE PROFESSIONAL MAIN SPECIALTY CODE (V6-2)
Category	Clinical; Period of Care
Length and format	3n or &
Availability	1989-90 onwards
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 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 Gytogenics 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) 325 = Sport And Exercise Medicine 326 = Acute Internal Medicine 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)
                     451 = Special Care Dentistry
                     460 = Medical Ophthalmology (Available From 1993-94)
                     499 = Non-Uk Provider - Specialty Function Not Known, Treatment Mainly Medical
                     500 = Obstetrics And Gynaecology
                     501 = Obstetrics (Prior To 2004-05: Obstetrics For Patients Using A Hospital Bed
                     Or Delivery Facilities)
                     502 = Gynaecology
                     504 = Community Sexual And Reproductive Health
                     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 And Virology
                     832 = Neuropathology (Available To 2003-04)
                     833 = Medical Microbiolody
                     834 = Medical Virology
                     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
Cleaning Rule
                     Rule # 90, 320 and 350
```



Marital status (psychiatric) (MARSTAT)

Field	MARSTAT
Field Name	Marital status (psychiatric)
NHS Field Name	PERSON MARITAL STATUS
Category	Psychiatric
Length and format	1an
Availability	1989-90 onwards
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
Cleaning Rule	Rule # 355



Mother's age at delivery (MATAGE) Field **MATAGE** Field Name Mother's age at delivery NHS Field Name N/A Category Maternity Length and format 3n Availability 1989-90 onwards This field contains the mother's age in whole years on the date of delivery. It is Description calculated from the mother's date of birth and the first baby's date of birth. 3n = Age in yearsValue Null = Not valid Cleaning Rule None



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

Field	MATCHID
Field Name	Patient identifier (HES generated) - basis of match
NHS Field Name	N/A
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	
Cleaning Rule	None



Episode Type - Maternity (MATERNITY_EPISODE_TYPE) Field MATERNITY_EPISODE_TYPE Field Name Episode Type - Maternity NHS Field Name N/A Category Maternity Length and format 2n Availability 1989-90 onwards Description Determines if an episode is maternity related. 1 = Finished delivery episode 2 = Finished birth episode 3 = Finished other delivery episode Value 4 = Finished other birth episode 9 = Unfinished maternity episodes 99 = All other episodes Cleaning Rule None



Mental category (MENTCAT) Field **MENTCAT** Field Name Mental category MENTAL CATEGORY (V6-1) **NHS Field Name** MENTAL HEALTH ACT 2007 MENTAL CATEGORY (V6-2) **Psychiatric** Category Length and format 1n Availability 2007-08 - 2014-15 (phasing out from 2012-13) 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 Description than one mental category, mental illness takes precedence over the others, and mental impairment or severe mental impairment takes precedence over psychopathic disorder. 1 = Mental illness 2 = Mental impairment 3 = Severe mental impairment Value 4 = Psychopathic disorder 5 = Not specified (from 1995-96) 8 = Not applicable 9 = Not known Cleaning Rule None



Mother's date of birth (MOTDOB) Field **MOTDOB** Field Name Mother's date of birth NHS Field Name PERSON BIRTH DATE Category Maternity Length and format dd/mm/yyyy (Date) 1989-90 onwards Availability This field contains the mother's date of birth. It appears on birth records. The Description Mother's date of birth (motdob) field contains sensitive data. Access to it requires the approval of the Confidentiality Advisory Group (CAG). Value dd/mm/yyyy = Mother's date of birth Cleaning Rule Rule # 690



Mother's data of birth check flag (MOTDOB_CFL) Field MOTDOB_CFL Field Name Mother's data of birth check flag NHS Field Name N/A Category Maternity Length and format 1n Availability 1989-90 onwards Description Codes in this field validate the mother's date of birth (motdob). 0 = ValidValue 1 = Missing2 = Invalid Cleaning Rule None



Middle Super Output Area, 2001 (MSOA01) Field MSOA01 Middle Super Output Area, 2001 Field Name **NHS Field Name** Category Geographical Length and format 9an Availability 2003-04 onwards 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 Description 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. 9an = Middle Super Output Area E02000001- E02006781 = England W02000001- W02000413 = Wales S02000001 - S02001235 = Scotland Value N9999999 (pseudo) = Northern Ireland L9999999 (pseudo) = Channel Islands M9999999 (pseudo) = Isle of Man Z99999999 = Not known Cleaning Rule None



Cleaning Rule

None

Admitted Patient Care (APC) Data Set

Middle Super Output Area, 2011 (MSOA11) Field MSOA11 Field Name Middle Super Output Area, 2011 **NHS Field Name** Category Geographical Length and format 9an Availability 2013-14 onwards 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 Description 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. 9an = Middle Super Output Area E02000001- E02006934 = England W02000001- W02000423 = Wales TBA = Scotland Value N9999999 (pseudo) = Northern Ireland L9999999 (pseudo) = Channel Islands M9999999 (pseudo) = Isle of Man Z99999999 = Not known



Date of Birth - month and year (MYDOB) Field **MYDOB** Field Name Date of Birth - month and year NHS Field Name N/A Category Patient Data Length and format mm/yyyy Availability 1989-90 onwards Description Month and year of date of birth only. Day is not made available. Value mm/yyyy = Date of Birth - month and year Cleaning Rule None



Neonatal level of care (NEOCARE)	
Field	NEOCARE
Field Name	Neonatal level of care
NHS Field Name	NEONATAL LEVEL OF CARE (V6-1) NEONATAL LEVEL OF CARE CODE (V6-2)
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 newborn child (under 28 days of age). For patients over 28 days old, default code '8' would apply. (Along with psychiatric patient status (admistat), this field replaced the V code indicator (vind) field in 1996).
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
Cleaning Rule	Rule # 360 and 370



Value

Cleaning Rule

27 days

Rule # 300

Admitted Patient Care (APC) Data Set

Age of baby in days (NEODUR) Field **NEODUR** Field Name Age of baby in days NHS Field Name N/A Category Maternity Length and format 2n Availability 1989-90 onwards This field contains the age in days of a baby admitted as a patient. It is derived Description from admission date (admidate) and date of birth (dob). If the baby is older than 27 days, neodur is not calculated. 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



NHS number (NEWNHSNO)	
Field	NEWNHSNO
Field Name	NHS number
NHS 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 Confidentiality Advisory Group (CAG).
Value	10n = NHS Number
Cleaning Rule	None



NHS Number valid flag (NEWNHSNO_CHECK) Field NEWNHSNO_CHECK Field Name NHS Number valid flag NHS Field Name Category Patient Data Length and format 1a Availability 2007-08 onwards Description This field indicates whether the NHS Number supplied is valid or not. Y = YesValue N = NoCleaning Rule None



Cleaning Rule

None

Admitted Patient Care (APC) Data Set

NHS number status indicator (NHSNOIND) Field **NHSNOIND** Field Name NHS number status indicator NHS NUMBER STATUS INDICATOR (V6-1) NHS Field Name NHS NUMBER STATUS INDICATOR CODÉ (6-2) Category System Data Length and format an2 Availability 2002-03 onwards Codes in this field indicate whether the patients' NHS Number is present, and if it is Description verified. If the NHS Number is absent, the indicator gives the reason why. 01 = Number present and verified 02 = Number present but not traced 03 = Trace required 04 = Trace attempted - No match or multiple match found Value 05 = Trace needs to be resolved - (New NHS number or patient detail conflict) 06 = Trace in progress 07 = Number not present and trace not required 08 = Trace postponed (baby under six weeks old) 91 = Anonymised or pseudonymised by SUS



Number of augmented care periods within episode (NUMACP)

Field	NUMACP
Field Name	Number of augmented care periods within episode
NHS Field Name	N/A
Category	Augmented/critical care period
Length and format	2n
Availability	1997-98 to 2005-06
Description	This derived field gives the number of augmented care periods (ACPs) within episode.
Value	2n = Number of augmented care periods within the episode
Cleaning Rule	None



Number of babies (NUMBABY) Field **NUMBABY** Field Name Number of babies NUMBER OF BABIES (V6-1) NHS Field Name NUMBER OF BABIES INDICATION CODE (V6-2) Category Maternity Length and format 1n or X Availability 1989-90 onwards 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 Description of 6 babies could be recorded in HES. 1 = One2 = Two3 = Three4 = FourValue 5 = Five6 = Six or more 9 = Not Known: a validation error X = Not known Rule # 710 and 750 Cleaning Rule



Number of previous pregnancies (NUMPREG) Field **NUMPREG** Field Name Number of previous pregnancies NHS Field Name PREGNANCY TOTAL PREVIOUS PREGNANCIES Category Maternity Length and format 2n Availability 1989-90 onwards The number of previous pregnancies that resulted in a registrable birth (live or still Description born). This field only appears on delivery records (epitype 2 and 5). 2n = Number of previous pregnancies, from 00 to 19, resulting in a registrable birth Value 99 = Not knownCleaning Rule Rule # 750



Number of baby tails (NUMTAILB) Field **NUMTAILB** Field Name Number of baby tails NHS Field Name N/A Category Maternity Length and format 1n Availability 2002-03 onwards On delivery records only (epitype 2 and 5), the number of valid baby groups present on the record. A valid baby group is defined as one which has a valid Description birthweight and a valid delivery method. If no valid baby group is present on the delivery record, this field defaults to 1. Value 1n = Number of valid births associated with a delivery record Cleaning Rule



Census Output Area, 2001 (OACODE01) Field OACODE01 Field Name Census Output Area, 2001 **NHS Field Name** N/A Category Geographical Length and format 10an Availability 2003-04 onwards Census output areas are small geographical areas that cover similar population sizes and are as socially homogenous as possible. This derived field represents the 2001 census output area code associated with the postcode (homeadd). Note that this field uses old-style codes from the pre-January 2011 ONS geographical Description coding system. The structure is CCDDWWAAAA, where CC = county, DD = district or unitary authority, WW=ward, and AAAA = output area. This field contains sensitive data. Access to it requires the approval of The Independent Group Advising on the Release of Data (IGARD) 10an = 2001 Census Output Area Value Y = not known Cleaning Rule None



Census Output Area, 2011 (OACODE11)

Field	OACODE11
Field Name	Census Output Area, 2011
NHS Field Name	N/A
Category	Geographical
Length and format	9an
Availability	2013-14 onwards
Description	Census output areas are small geographical areas that cover similar population sizes and are as socially homogenous as possible. This derived field represents the 2011 census output area code associated with the postcode (homeadd). Pseudo codes are included for Channel Islands and Isle of Man. The field will otherwise be blank for postcodes with no grid reference. This field contains sensitive data. Access to it requires the approval of The Independent Group Advising on the Release of Data (IGARD)
Value	9an = 2011 Census Output Area E00000001 - E00176774 = England; W00000001 - W00010265 = Wales; S00088956 - S00135306 = Scotland; N00000001 - N00004537 = Northern Ireland; L99999999 (pseudo) = Channel Islands; M99999999 (pseudo) = Isle of Man; Y = not known
Cleaning Rule	None



Census output area, 2001 (6 character ward identifier) (OACODE6)

Field	OACODE6
Field Name	Census output area, 2001 (6 character ward identifier)
NHS Field Name	N/A
Category	Geographical
Length and format	6an
Availability	1995-96 onwards
Description	This derived field represents the first six-characters from the Census Output Area 2001 (OACODE01) field, which identifies the local government ward. The structure is CCDDWW, where CC = county, DD = district or unitary authority, and WW=ward.
Value	6an = 2001 census output area ward identifier code Y = not known
Cleaning Rule	None



Date of procedure (OPDATE_NN) Field OPDATE_NN Field Name Date of procedure NHS Field Name PROCEDURE DATE Category Clinical Length and format dd/mm/yyyy (Date) Availability 1989-90 onwards This field contains the date of the procedure recorded in the respectively numbered procedure code (opertn_nn) field. There is room for twenty four dates (twelve prior Description to April 2007 and four before April 2002). dd/mm/yyyy = Date of procedure 01/01/1801 = Null date submitted Value 01/01/1800 = Invalid date submitted Cleaning Rule Rule # 480, 485, 610 and 620



Operation status code (OPERSTAT) Field **OPERSTAT** Field Name Operation status code **OPERATION STATUS (V6-1) NHS Field Name** OPERATION STATUS CODÉ (V6-2) Category Clinical Length and format 1n Availability 2002-03 onwards Description Status of operation. 1 = One or more operative procedures carried out 8 = Not applicable, ie no operative procedures performed or intended Value 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.) Cleaning Rule None



3 character concatenated procedure (OPERTN_3_CONCAT)

Field	OPERTN_3_CONCAT
Field Name	3 character concatenated procedure
NHS Field Name	N/A
Category	Clinical
Length and format	95an
Availability	1989-90 onwards
Description	Provides a concatenated string of all procedures from the record at a 3 character level, separated by a comma with no spaces. This enables the user to search across the full list of procedures to look at mentions and pairs of procedure codes.
Value	max 95n = concatenated string of all procedure codes (3-character level) separated by a comma
Cleaning Rule	None



Main operative procedure - 3 characters (OPERTN_3_N) Field OPERTN_3_N Field Name Main operative procedure - 3 characters NHS Field Name N/A Category Clinical Length and format 3an, - or & Availability 1989-90 onwards Description This provides the first three characters of the main operation (oper_1). 3an = Procedure code Value - = No operation performed & = Not known Cleaning Rule None



4 character concatenated procedure (OPERTN_4_CONCAT)

Field	OPERTN_4_CONCAT
Field Name	4 character concatenated procedure
NHS Field Name	N/A
Category	Clinical
Length and format	119an
Availability	1989-90 onwards
Description	Provides a concatenated string of all procedures from the record at a 4 character level, separated by a comma with no spaces. This enables the user to search across the full list of procedures to look at mentions and pairs of procedure codes.
Value	max 119n = concatenated string of all procedure codes (4-character level) separated by a comma
Cleaning Rule	None



Main operative procedure - 4 characters (OPERTN_4_NN)

Field	OPERTN_4_NN
Field Name	Main operative procedure - 4 characters
NHS Field Name	N/A
Category	Clinical
Length and format	4an, - or &
Availability	1989-90 onwards
Description	This provides the first four characters of the main operation (oper_1).
Value	4an = Procedure code - = No operation performed & = Not known
Cleaning Rule	None



Count of procedures (OPERTN_COUNT) Field OPERTN_COUNT Field Name Count of procedures NHS Field Name N/A Category Clinical Length and format 2n Availability 1989-90 onwards Description The total number of procedure codes present on the record (maximum of 24) Value 2n = count of procedures Cleaning Rule None



Operative procedure (OPERTN_NN)		
Field	OPERTN_NN	
Field Name	Operative procedure	
NHS Field Name	PRIMARY PROCEDURE (OPCS) PROCEDURE (OPCS)	
Category	Clinical	
Length and format	4an	
Availability	1989-90 onwards	
Description	There are twenty-four fields (twelve before April 2007), 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 X998 = Outpatient procedure carried out but no appropriate OPCS-4 code available X999 = No outpatient procedure carried out X997 = Not known	
Cleaning Rule	Rule # 450, 540, 550, 560, 610 and 620	



Organisation code (patient pathway ID issuer) (ORGPPPID)

Field	ORGPPPID
Field Name	Organisation code (patient pathway ID issuer)
NHS Field Name	ORGANISATION CODE (PATIENT PATHWAY IDENTIFIER 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
Cleaning Rule	None



Number of organ systems supported (ORGSUP) Field **ORGSUP** Field Name Number of organ systems supported NHS Field Name Category Augmented/critical care period Length and format Availability 1997-98 to 2005-06 This field contains the number of organ support systems used (up to five) during a Description period of augmented care. 2n = Number of organ systems supported in the range 00 to 05 98 = Not applicable: Augmented care period not finished Value 99 = Not known: a validation error Cleaning Rule Rule # 1050



Year and month of HES dataset (PARTYEAR) Field **PARTYEAR** Field Name Year and month of HES dataset NHS Field Name Category Episodes and spells; Period of care Length and format yyyymm Availability 1989-90 onwards This field represents the year and month of the HES dataset in the format yyyymm. For example, 201601 represents the month 1 2016-17 HES dataset; 201602 Description represents the month 2 2016-17 HES dataset etc. yyyymm = HES partyear Value Cleaning Rule None



Cleaning Rule

None

Admitted Patient Care (APC) Data Set

Patient pathway identifier (PATPATHID) Field **PATPATHID** Field Name Patient pathway identifier **NHS Field Name** PATIENT PATHWAY IDENTIFIER Category Patient Pathway Length and format 20an Availability 2007-08 onwards A code that, when combined with the organisation code/organisation identifier of the issuer, identifies a patient pathway. Where a pathway is initiated by a service request using the Choose and Book system, the patient pathway will be uniquely identified by the Unique Booking Reference Number (BOOKREFNO) of the first referral and the organisation code of Choose and Book which is X09. Description Where the pathway is initiated by some other method, the patient pathway identifier will be allocated by the Organisation receiving the service request which together with that Organisation's organisation code / organisation identifier will uniquely identify the patient pathway. This field contains sensitive data. Access to it requires the approval of The Independent Group Advising on the Release of Data (IGARD). Value 20an = patient pathway identifier



Programme Budgeting Category (PBC) Field **PBC** Field Name **Programme Budgeting Category** NHS Field Name Category **Clinical Treatments** Length and format 5n Availability 2008-09 onwards The Programme Bugeting Categories are a list of programmes used to influence and track future expenditure. These categroies enable the analysis of expenditure Description on specific disease areas such as cancer, mental health, and circulatory diseases. Value 5n = Programme Budgeting Category Code Cleaning Rule Rule # 1220



Postcode Found (PCFOUND) Field **PCFOUND** Field Name Postcode Found NHS Field Name N/A Category Patient Data Length and format 1a Availability 1989-90 onwards Description This field indicates whether the postcode in the field homeadd is valid or not. Y = validValue N = invalid (or missing) Cleaning Rule None



Primary care group (PCGCODE) Field **PCGCODE** Field Name Primary care group NHS Field Name N/A 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 Cleaning Rule None



Origin of primary care group (PCGORIG) Field **PCGORIG** Field Name Origin of primary care group NHS Field Name N/A Category System Data Length and format 1n Availability 1999-00 to 2001-02 This derived field indicates the basis on which the primary care group (PCG) code Description was assigned. 1 = GPPRAC was used to derive the code 2 = REGGMP was used to derive the code 3 = PURCODE was used to derive the code Value 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 Cleaning Rule None



Westminster parliamentary constituency (PCON) Field **PCON** Field Name Westminster parliamentary constituency NHS Field Name Geographical Category 3n Length and format Availability 2008-09 onwards This field, which is derived from the patient's postcode in the field HOMEADD, defines the code for the English Westminster Parliamentary Constituency where the patient resides. Note that this field uses the old-style (pre-2011) ONS Description geographical coding system - the new-style code can be found in the field PCON_ONS. 3an = English Westminster Parliamentary Constituency S = Scotland U = no fixed abode Value W = Wales X = Foreign (includes Channel Islands and Isle of Man) Y = not knownZ = Northern Ireland Cleaning Rule None



Westminster parliamentary constituency (ONS) (PCON_ONS)

Field	PCON_ONS
Field Name	Westminster parliamentary constituency (ONS)
NHS Field Name	N/A
Category	Geographical
Length and format	9an
Availability	2011-12 onwards
Description	This field, which is derived from the patient's postcode in the field HOMEADD, defines the code for the English Westminster Parliamentary Constituency where the patient resides.
Value	9an = English Westminster Parliamentary Constituency E99999999 = England (not specified) L99999999 = Channel Islands M99999999 = Isle of Man N99999999 = Northern Ireland S99999999 = Scotland W99999999 = Wales U = no fixed abode X = foreign Y = not known
Cleaning Rule	None



Pseudonymised consultant code (PCONSULT) Field **PCONSULT** Field Name Pseudonymised consultant code NHS Field Name N/A Category Practitioner Length and format 16an Availability 1997-98 onwards A pseudonymised version of the General Medical Council (GMC) code for the Description consultant. The Consultant code (consult) field contains the actual GMC code. 16an = Pseudonymised consultant code Value & = consultant code is null 99 = consultant code is invalid Cleaning Rule None



Primary care trust of responsibility (PCTCODE) Field **PCTCODE** Field Name Primary care trust of responsibility NHS Field Name Category Organisation Length and format 3an Availability 1997-98 to 2005-06 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 Description 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. nan, naa or aaa = Primary care trust Value 59898 = Not applicable 59999 = Unknown Cleaning Rule None



Historic PCT of responsibility (PCTCODE02) Field PCTCODE02 Field Name Historic PCT of responsibility **NHS Field Name** N/A Category Organisation Length and format 3an Availability 2006-07 to 2012-13 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 Description 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. nan, naa or aaa = Primary care trust 59898 = Not applicable Value 59999 = Unknown Cleaning Rule None



Current PCT of responsibility (PCTCODE06) Field PCTCODE06 Field Name Current PCT of responsibility NHS Field Name N/A Category Organisation Length and format 3an Availability 2006-07 onwards 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 Description 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. 5nn = PCTtaa = Care trust Value 59898 = Not applicable 59999 = Unknown Cleaning Rule None



Origin of primary care trust of responsibility (PCTORIG) Field **PCTORIG** Field Name Origin of primary care trust of responsibility NHS Field Name N/A Category System Data Length and format 1n Availability 1997-98 to 2005-06 This derived field indicates the basis on which the primary care trust (PCT) of Description responsibility code was assigned. 1 = GPPRAC was used to derive the code 2 = REGGMP was used to derive the code 3 = PURCODE was used to derive the code Value 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 Cleaning Rule None



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

Field	PCTORIG02
Field Name	Origin of primary care trust of responsibility - historic
NHS Field Name	N/A
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
Cleaning Rule	None



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

Field	PCTORIG06
Field Name	Origin of primary care trust of responsibility - current
NHS Field Name	N/A
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
Cleaning Rule	None



	Primary Care Trust area of main provider (PCTTREAT)
Field	PCTTREAT
Field Name	Primary Care Trust area of main provider
NHS Field Name	N/A
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
Cleaning Rule	None



Reporting period end date (PEREND) Field **PEREND** Field Name Reporting period end date NHS Field Name CDS REPORT PERIOD END DATE Category System Data Length and format ddmmyyyy Availability 2003-04 onwards This is a system field used for the purposes of submitting data to SUS. It defines Description the end date for the date range of the data contained within a SUS submission. ddmmyyyy = The end date for the date range of data contained in the SUS Value submission Cleaning Rule None



Pseudonymised code of GP practice (PGPPRAC) Field **PGPPRAC** Field Name Pseudonymised code of GP practice NHS Field Name Category **Practitioner Data** Length and format 16an Availability 1997-98 onwards A pseudonymised version of the code of a patient's registered GP practice (registered GMP). Please note that the registered GP may not be the same as the Description referring GP (See Preferrer). The Code of GP Practice (Gpprac) field contains the actual practice code. 16an = pseudonymised code Value & = Unknown Cleaning Rule None



Post-operative duration (POSOPDUR) Field **POSOPDUR** Field Name Post-operative duration NHS Field Name N/A Clinical Category Length and format max 5n Availability 1989-90 onwards This derived field contains the difference in days between the date of the main Description procedure (opdate_01) and the date the episode ended (epiend). 1n-5n = Number of days between the main procedure and the end of the episode Value Null = Not applicable: no procedure or episode unfinished Cleaning Rule None



Postcode district (POSTDIST) Field **POSTDIST** Field Name Postcode district NHS Field Name N/A Category Patient Data Length and format 4an Availability 1989-90 onwards Contains the outward portion of the patient's postcode (ie all characters to the left Description 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). an, aan, ann, or aann = Postcode district Value ZZ99 = Unavailable / not applicable Cleaning Rule None



Postnatal stay (POSTDUR)	
Field	POSTDUR
Field Name	Postnatal stay
NHS Field Name	N/A
Category	Maternity
Length and format	3n
Availability	1989-90 onwards
Description	On delivery and birth records only (epitypes 2 and 3), this derived field calculates the number of days between the baby's birth and the end of the finished episode. It is calculated from the episode end date (epiend) and the baby's date of birth (dobbaby1 on delivery records, dob on birth records).
Value	3n = The number of days of stay, from 0 to 270 Null = Not applicable / not known
Cleaning Rule	None



Pseudonymised referrer code (PREFERRER) Field **PREFERRER** Field Name Pseudonymised referrer code NHS Field Name N/A Category Practitioner Length and format 16an Availability 1989-90 onwards A pseudonymised version of the code of the person referring the patient. The Description 'Person referring patient' (Referrer) field contains the actual code. 16an = pseudonymised referrer code & = referrer code is null Value 99 = referrer code is invalid Cleaning Rule None



Pseudonymised code of patient's registered or referring GP (PREGGMP)

Field	PREGGMP
Field Name	Pseudonymised code of patient's registered or referring GP
NHS Field Name	N/A
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.
Value	16an = pseudonymised registered or referring GP code & = registered or referring GP code is null 99 = registered or referring GP code is invalid
Cleaning Rule	None



Pre-operative duration (PREOPDUR) Field **PREOPDUR** Field Name Pre-operative duration NHS Field Name N/A Category Clinical Length and format 3n Availability 1989-90 onwards This derived field contains the difference in days between the date the episode Description started (epistart) and the date of the main operation (opdte_01). 3n = Number of days between the start of the episode and the main operation from Value 0-365 Null = Not applicable: no operation or episode unfinished Cleaning Rule None



Provider Code (PROCODE) Field **PROCODE** Field Name **Provider Code NHS Field Name** ORGANISATION CODE (CODE OF PROVIDER) Category Organisation data 5an Length and format Availability 2007-08 onwards The organisation code of the organisation acting as the health care provider. NHS organisations are allocated a main 3-character code, however this field may contain the 3-character organisation code or a full 5-character code (e.g. a site code, a HQ code ending 01 etc.). Independent providers will always be Description represented in this field by a 5-character code. Users wishing to group data at 3character level (which will identify an individual organisation - e.g. NHS Trust) may wish to use the field PROCODE3. Note that details of the site code can be found in the field 'site code of treatment' (SITETRET). 3an or 5an = provider code Value 89997 = UK provider where no organisation code has been issued 89999 = Non-NHS UK provider where no organisation code has been issued Cleaning Rule None



Provider code (3 character) (PROCODE3) Field PROCODE3 Field Name Provider code (3 character) NHS Field Name N/A Category Organisation Length and format 3an Availability 1989-90 onwards The organisation code of the organisation acting as the health care provider. This field contains the first 3-characters of the provider code (PROCODE) field, which Description can be used to identify an individual provider (e.g. NHS Trust or PCT* (*before April 2013)). Value 3an = 3-character provider code Cleaning Rule None



Provider code (5 character) (PROCODE5) Field PROCODE5 Field Name Provider code (5 character) NHS Field Name N/A Category Organisation Length and format 5an Availability 1989-90 onwards The organisation code of the organisation acting as the health care provider. This field contains the provider code (PROCODE) to 5-characters. Where the field PROCODE contains a 3-character code, it will be padded to the right with Description additional zeros in this field. Note that details of the site code can be found in the field 'site code of treatment' (SITETRET). 5an = 5-character provider code Value 89997 = Non-UK provider where no organisation code has been issued 89999 = Non-NHS UK provider where no organisation code has been issued Cleaning Rule None



Provider code of treatment (PROCODET) Field **PROCODET** Field Name Provider code of treatment **NHS Field Name** N/A Category Organisation Length and format 5an Availability 2003-04 onwards 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 or T. Trusts with associated treatment centres will have an '- X' following their code) Description 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 or A) For 3-character codes only see procode (provider code (3 character)) and for 5character codes only see procode5 (provider code (5 character)). Value 5an = Provider code Cleaning Rule None



Provider type (PROTYPE)	
Field	PROTYPE
Field Name	Provider type
NHS Field Name	N/A
Category	Organisation
Length and format	Various
Availability	2003-04 onwards
Description	Healthcare provider type
Value	CARETRUST = Care trust CCG = Clinical Commissioning Group 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
Cleaning Rule	None



Hospital provider spell number (PROVSPNO) Field **PROVSPNO** Field Name Hospital provider spell number NHS Field Name HOSPITAL PROVIDER SPELL NUMBER Category Episodes and spells; Period of care Length and format 12an Availability 1989-90 onwards A unique identifier for each Hospital Provider Spell for a Health Care Provider. Description This field contains sensitive data. Access to it requires the approval of The Independent Group Advising on the Release of Data (IGARD). Value 12an = hospital provider spell number Cleaning Rule None



Pseudonymised HES ID (PSEUDO_HESID) Field PSEUDO_HESID Field Name Pseudonymised HES ID NHS Field Name Category Patient Data Length and format 32an Availability 2007-08 onwards This field contains a unique identifier for each individual patient. This allows an individual's care to be tracked across years and continuous periods to be Description identified. This is a pseudonymised version of the HES ID field based on an updated matching algorithm, which supersedes and is compatible with the original HES ID, which is no longer available. Value 32an = Pseudonymised HESID Cleaning Rule None



Commissioner code (PURCODE) Field **PURCODE** Field Name Commissioner code NHS Field Name ORGANISATION CODE (CODE OF COMMISSIONER) Category Organisation Length and format 5an Availability 1989-90 onwards This field contains a code for the organisation commissioning the patient's health Description care. Value an3 or an5 = organisation code of commissioner Rule # 340 Cleaning Rule



Field

Field Name

Category

Availability

Description

Value

NHS Field Name

Length and format

Admitted Patient Care (APC) Data Set

Commissioner's Regional Office (PURRO) PURRO Commissioner's Regional Office N/A Organisation 5an 1995-96 to 2001-02 This field contains a code which identifies the Regional Office (RO) in which the commissioner is located. It is derived from the purcode field. The 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. 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 = LondonY11 = South East Y12 = South West Z or Z0000 = Northern Ireland Null = Not known From 1996-97 to 1998-99:

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

S or S0000 = Scotland W or W0000 = Wales

Y03 = Anglia and Oxford

Y04 = North Thames

Y02 = Trent

Y01 = Northern and Yorkshire

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

Cleaning Rule

None



Commissioner's Strategic Health Authority (PURSTHA) PURSTHA Commissioner's Strategic Health Authority

Field	PURSTHA
Field Name	Commissioner's Strategic Health Authority
NHS Field Name	N/A
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
Cleaning Rule	None



Commissioner code status (PURVAL) Field **PURVAL** Field Name Commissioner code status NHS Field Name N/A Category Organisation Length and format 1n Availability 1995-96 onwards A derived field that indicates whether the commissioner code (purcode) is one that Description is recognised throughout the NHS. If not, the code may have been agreed locally between the hospital provider and the health care purchaser. 0 = Purchaser code is not recognised throughout the NHS Value 1 = Purchaser code is recognised throughout the NHS Cleaning Rule None



Linkage - quality rank (RANK_ORDER) Field RANK_ORDER Field Name Linkage - quality rank **NHS Field Name** Category Patient Pathway Length and format Availability 2008-09 onwards This field is present on A&E and APC linked records only. Linkage between these two datasets enables patient pathways to be followed and provides additional information beyond what is available from the standalone datasets. A score of one to four is applied to each linked record, with a score of one meaning a very good link and a score of four meaning a poor link. Records that score poor Description in quality, rating either three or four, are excluded from the final output of linked data available to users. Full details of the methodology used to link A&E and APC records, and the filters used to assess linkage quality, can be found on the following page of our website: http://content.digital.nhs.uk/article/1824/How-do-we-collect-and-process-HES-data Value 1 - 4, where 1 is a strong link and 4 is a poor link between the two records Cleaning Rule None



Cleaning Rule

None

Admitted Patient Care (APC) Data Set

Referring organisation code (REFERORG) Field REFERORG Field Name Referring organisation code NHS Field Name REFERRING ORGANISATION CODE Category Practitioner Length and format 6an Availability 2002-03 onwards The organisation code of the organisation from which the referral is made, such as Description GP practice or NHS trust. max 6an = Referring organisation code X99998 = Not applicable Value X99999 = Not known



Referrer code (REFERRER) Field REFERRER Field Name Referrer code **NHS Field Name** REFERRER CODE Practitioner Category Length and format 8an Availability 1997-98 onwards 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 Description This field contains sensitive data. Access to it requires the approval of The Independent Group Advising on the Release of Data (IGARD). an8 = referrer code A9999998 - Ministry of Defence Doctor C9999998 - Consultant, General Medical Council (GMC) number not known D9999998 - Dentist, General Dental Practitioner Code (GDC) not known Value CD999998 = Dental consultant: GMC / GDC number not known R9999981 = Referrer other than GP, general dental practitioner or consultant X999998 = Not applicable, e.g. patient has self-presented or not known & = referrer code not recorded 99 = referrer code invalid Cleaning Rule Rule # 410



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
NHS Field Name	GENERAL MEDICAL PRACTITIONER (SPECIFIED)
Category	Practitioner
Length and format	8an
Availability	1997-98 onwards
Description	The General Medical Practitioner PPD code of the GP specified by the patient, which identifies the GP as an individual. This GP works within the General Medical Practice with which the patient is registered. This field contains sensitive data. Access to it requires the approval of The Independent Group Advising on the Release of Data (IGARD).
Value	8an = GP code G9999998 = GP code is unknown G9999981 = No registered GP R9999981 = referrer other than General Medical Practitioner, General Dental Practitioner or Consultant A9999998 = Ministry of Defence doctor P9999981 = Prison doctor & = Registered GP not recorded 99 = Registered GP code invalid
Cleaning Rule	Rule # 430



County of residence (RESCTY)	
Field	RESCTY
Field Name	County of residence
NHS Field Name	N/A
Category	Geographical
Length and format	2an
Availability	1989-90 onwards
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 (postcode of patient). Note that this field uses old-style geographical codes that were superseded in 2011 and are now no longer supported by ONS. The field RESCTY_ONS represents the county of residence using codes from the current ONS geographical coding system.
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 = No fixed abode W = Wales X = Foreign (from 1990-91 onwards) Y = Not known Z = Northern Ireland
Cleaning Rule	Z = Northern Ireland None



County of residence (ONS) (RESCTY_ONS)

Field	RESCTY_ONS
Field Name	County of residence (ONS)
NHS Field Name	N/A
Category	Geographical
Length and format	9an
Availability	2011-12 onwards
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	E10000002 - E10000034 = county of residence (England) E99999999 = Unitary Authority (England) W99999999 = Wales S99999999 = Scotland N99999999 = Northern Ireland L99999999 = Channel Islands M99999999 = Isle of Man U = No fixed abode X = Foreign Y = Not known
Cleaning Rule	None



Cleaning Rule

None

Admitted Patient Care (APC) Data Set

Government Office region of residence (RESGOR) Field **RESGOR** Field Name Government Office region of residence **NHS Field Name** Category Geographical Length and format 1an Availability 1996-97 onwards The Government Office Region of residence 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. The Government Office Regions closed on 31 March 2011, but this regional geography is maintained for statistical purposes and after this date referred to simply as 'regions'. Description Note that this field uses old-style geographical codes that were superseded in 2011 and are now no longer supported by ONS. The field RESGOR_ONS represents the Government Office Region of residence using codes from the current ONS geographical coding system. A = North East B = North West C = Mersevside (until 1998-99) D = Yorkshire and Humber E = East Midlands F = West Midlands G = East of England H = LondonValue J = South East K = South West S = Scotland U = No fixed abode W = Wales X = Foreign (including Isle of Man and Channel Islands) Y = UnknownZ = Northern Ireland



Government office region of residence (ONS) (RESGOR_ONS)

RESGOR_ONS
Government office region of residence (ONS)
N/A
Geographical
9an
2011-12 onwards
The Government Office Region of residence 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. The Government Office Regions closed on 31 March 2011, but this regional geography is maintained for statistical purposes and after this date referred to simply as 'regions'.
E12000001 =North East E12000002 = North West E12000003 = Yorkshire and Humber E12000004 = East Midlands E12000005 = West Midlands E12000006 = East of England E12000007 = London E12000008 = South East E12000009 = South West E99999999 = England (not otherwise stated) L99999999 = Channel Islands M99999999 = Isle of Man N99999999 = Northern Ireland S99999999 = Scotland W99999999 = Wales U = No fixed abode X = Foreign Y = Unknown
None



Health Authority of residence (RESHA) Field **RESHA** Field Name Health Authority of residence **NHS Field Name** N/A Category Geographical Length and format 3an Availability 1989-90 onwards This field contains a code that defines the Health Authority of residence of the patient. It is derived from the patient's postcode in the field homeadd. In 2002 following a reorganisation of health areas, Health Authorities were Description replaced by Strategic Health Authorities. This field has continued to be derived after this date as a 'frozen' geography. 3an = Health authority of residence S = Scotland U = no fixed abode Value W = Wales X = Foreign (including Isle of Man and Channel Islands) Y = UnknownZ = Northern Ireland Cleaning Rule None



Local authority district of residence (RESLADST) Field **RESLADST** Field Name Local authority district of residence **NHS Field Name** Category Geographical Length and format 4an Availability 1989-90 onwards This field contains a code that defines the county (first two characters) and local authority district (last two characters) of residence of the patient. It is derived from the patient's postcode in the field homeadd. Note that this field uses old-style geographical codes that were superseded in 2011 and are now no longer supported by ONS. The field RESLADST_ONS represents the local authority district of residence using codes from the current ONS geographical coding Description RESLADST 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. 4an = Local authority district code S = ScotlandU = no fixed abode Value W = Wales Y = Not known Z = Northern Ireland X = Foreign (includes Isle of Man) Cleaning Rule None



Local authority district of residence (ONS) (RESLADST_ONS)

Field	RESLADST_ONS
Field Name	Local authority district of residence (ONS)
NHS Field Name	N/A
Category	Geographical
Length and format	9an
Availability	2011-12 onwards
Description	This derived field contains a code which defines the current local authority district of residence of the patient. It is derived from the patient's postcode in the field homeadd.
Value	9an = Local authority district code E99999999 = England (not otherwise stated) L99999999 = Channel Islands M99999999 = Isle of Man N99999999 = Northern Ireland S99999999 = Scotland W9999999 = Wales U = No fixed abode X = Foreign Y = Not known
Cleaning Rule	None



Primary care trust of residence (RESPCT) Field **RESPCT** Field Name Primary care trust of residence NHS Field Name Category Geographical Length and format 5an 1997-98 to 2005-06 Availability This derived field contains the code for the primary care trust (PCT) in which the Description patient lived immediately before admission. It is derived from the patient's postcode in the field homeadd. naa or nan = Primary care trust of residence Value 59999 = Unknown 59898 = Not applicable Cleaning Rule None



PCT of residence - mapped according to data year (RESPCT_HIS)

Field	RESPCT_HIS
Field Name	PCT of residence - mapped according to data year
NHS Field Name	N/A
Category	Geographical
Length and format	5an
Availability	1996-97 onwards
Description	The Primary Care Trust (PCT) of residence dependent on the data year. If the HES data year is 2006 or later, it will return the value from the field RESPCT06. If the data year is earlier than 2006, it will return the value from the field RESPCT02.
Value	5** = PCT Taa = Care trust 6** = Wales S** = Scotland Y** = Manx and Channel Islands Z** = Northern Ireland 59898 = Other not applicable (non-England) 59999 = Unknown PCT
Cleaning Rule	None



PCT of residence (2002) (RESPCT02)

Field	RESPCT02
Field Name	PCT of residence (2002)
NHS Field Name	N/A
Category	Geographical
Length and format	5an
Availability	2006-07 to 2012-13
Description	This field contains a code that defines the Primary Care Trust (PCT) of residence of the patient, based on 2002-03 PCT boundaries. It is derived from the patient's postcode in the field homeadd. This PCT structure was superseded in 2006 - the code representing the PCTs that were in place after this restructure can be found in the field RESPCT06.
Value	5** = PCT Taa = Care trust 6** = Wales S** = Scotland Y** = Manx and Channel Islands Z** = Northern Ireland 59898 = Other not applicable (non-England) 59999 = Unknown PCT
Cleaning Rule	None



PCT of residence (2006) (RESPCT06)

Field	RESPCT06
Field Name	PCT of residence (2006)
NHS Field Name	N/A
Category	Geographical
Length and format	5an
Availability	2006-07 onwards
Description	This field contains a code that defines the Primary Care Trust (PCT) of residence of the patient, based on 2006-07 PCT boundaries. It is derived from the patient's postcode in the field homeadd.
Value	5** = PCT Taa = Care trust 6** = Wales S** = Scotland Y** = Manx and Channel Islands Z** = Northern Ireland 59898 = Other not applicable (non-England) 59999 = Unknown PCT
Cleaning Rule	None



Regional Office of residence (RESRO) Field **RESRO** Field Name Regional Office of residence **NHS Field Name** N/A Category Geographical Length and format 3an Availability 1996-97 onwards This field contains a code that defines the Regional Office (RO) area of residence of the patient. It is derived from the patient's postcode in the field homeadd. Description ROs were abolished in 2002. This field has continued to be derived after this date as a 'frozen' geography. From 1 April 1999: Y01 = Northern and Yorkshire Y02 = Trent Y07 = West Midlands Y08 = North West Y09 = Eastern Y10 = LondonY11 = South East Y12 = South West W00 = WalesS00 = ScotlandZ00 = Northern Ireland U00 = no fixed abodeY00 = UnknownX00 = Foreign (includes Channel Islands and the Isle of Man) From 1 April 1996 to 31 March 1999: Y01 = Northern and Yorkshire Y02 = Trent Y03 = Anglia and Oxford Y04 = North Thames Value Y05 = South Thames Y06 = South and West Y07 = West Midlands Y08 = North West W = Wales S = Scotland Z = Northern Ireland U = no fixed abode Y = Not known X = ForeignFrom 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
Cleaning Rule	None
Cleaning Rule	



SHA of residence (RESSTHA) Field **RESSTHA** Field Name SHA of residence NHS Field Name N/A Category Geographical Length and format 3an 1997-98 to 2005-06 Availability This derived field contains the code for the strategic health authority (SHA) in Description which the patient lived immediately before admission. It is derived from the patient's postcode in the field homeadd. 3an = Strategic health authority of residence Value Y = Not known Cleaning Rule None



SHA of residence - mapped according to data year (RESSTHA_HIS)

Field	RESSTHA_HIS
Field Name	SHA of residence - mapped according to data year
NHS Field Name	N/A
Category	Geographical
Length and format	3an
Availability	1996-97 onwards
Description	The Strategic Health Authority (SHA) of residence dependent on the data year. If the HES data year is 2006 or later, it will return the value from the field RESSTHA06. If the data year is earlier than 2006, it will return the value from the field RESSTHA02.
Value	Q** = SHA S = Scotland U = no fixed abode W or Q99 = Wales X = Foreign (includes Channel Islands and the Isle of Man) Y = Unknown Z = Northern Ireland
Cleaning Rule	None



SHA of residence (2002) (RESSTHA02)

Field	RESSTHA02
Field Name	SHA of residence (2002)
NHS Field Name	N/A
Category	Geographical
Length and format	3an
Availability	2006-07 to 2012-13
Description	This field contains a code that defines the Strategic Health Authority (SHA) of residence of the patient, based on historic SHA boundaries that existed between 2002 and 2006. It is derived from the patient's postcode in the field homeadd. This structure was superseded in 2006 - the code representing the SHAs that were in place after this restructure can be found in the field RESSTHA06.
Value	Q** = SHA S = Scotland U = no fixed abode W or Q99 = Wales X = Foreign (includes Channel Islands and the Isle of Man) Y = Unknown Z = Northern Ireland
Cleaning Rule	None



SHA of residence (2006) (RESSTHA06)

Field	RESSTHA06
Field Name	SHA of residence (2006)
NHS Field Name	N/A
Category	Geographical
Length and format	3an
Availability	2006-07 onwards
Description	This field contains a code that defines the Strategic Health Authority (SHA) of residence of the patient, based on historic SHA boundaries that existed between 2006 and 2013. It is derived from the patient's postcode in the field homeadd.
Value	Q** = SHA S = Scotland U = no fixed abode W or Q99 = Wales X = Foreign (includes Channel Islands and the Isle of Man) Y = Unknown Z = Northern Ireland
Cleaning Rule	None



Regional Office of treatment (ROTREAT) Field **ROTREAT** Field Name Regional Office of treatment **NHS Field Name** N/A Category Geographical Length and format 3an Availability 1989-90 onwards This field contains a code that defines the Regional Office (RO) area where the treatment took place (in data prior to 1996 it contains the Regional Health Authority of treatment). It is derived from the hospital provider code in the field procode. Description Note: (1) for NHS trusts, care provided at subsidiary sites will be attributed to the main trust location. ROs were abolished in 2002. This field has continued to be derived after this date as a 'frozen' geography. From 1 April 1999: Y01 = Northern and Yorkshire Y02 = Trent Y07 = West Midlands Y08 = North West Y09 = Eastern Y10 = LondonY11 = South East Y12 = South West Y00 = 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 Value Y08 = North West Y00 = 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 RHAY0L = South Western RHA

Y0M = West Midlands RHA

Y0N = Mersey RHA Y0P = North Western RHA

Y0Y = Not known

None

Cleaning Rule



RTT period end date (RTTPEREND)		
Field	RTTPEREND	
Field Name	RTT period end date	
NHS Field Name	REFERRAL TO TREATMENT PERIOD END DATE	
Category	Patient Pathway	
Length and format	an10 CCYY-MM-DD	
Availability	2007-08 onwards	
Description	The end date of a referral to treatment period. Referral to Treatment Period End Date will be one of the following: The activity date: • when the Patient is admitted for First Definitive Treatment. If the start of a Patient's treatment is cancelled (by the Health Care Provider or Patient) after admission, the Referral to Treatment Period will continue. • for First Definitive Treatment undertaken in an outpatient setting. • for First Definitive Treatment undertaken by an NHS Allied Health Professional Service (Referral to Treatment Measurement). • when the decision not to treat is made, with no further action at this time communicated to the Patient. This will include Discharge after Patient did not Attend and discharge back to primary care for treatment. • when the Patient declines offered treatment. • when the Patient did not attend for the first activity during a Referral to Treatment Period. See Referral to Treatment Period for guidance on Patients who do not attend. • the clinical decision is made (and agreed with the Patient) that Active Monitoring will begin. If a Patient subsequently requires further treatment this decision would start a new Referral to Treatment Period as part of the same Patient pathway. This includes any treatment that is planned for a specific date in the future as ongoing monitoring. • a clinical decision is made and has been communicated to the Patient, and subsequently their General Practitioner and/or other referring care professional without undue delay, to add the Patient to a transplant list. or • the person death date. In the event that a Patient is booked into the wrong clinic and needs to be re-referred to the right one, this will not end the Referral to Treatment Period or restart it. The start of the Referral to Treatment Period is still the original referral request received date.	
Value	dd/mm/yyyy = RTT period end date	
Cleaning Rule	None	



Admitted Patient Care (APC) Data Set		
RTT period start date (RTTPERSTART)		
Field	RTTPERSTART	
Field Name	RTT period start date	
NHS Field Name	REFERRAL TO TREATMENT PERIOD START DATE	
Category	Patient Pathway	
Length and format	an10 CCYY-MM-DD	
Availability	2007-08 onwards	
	The Start Date of a Referral to Treatment Period. A referral to treatment period start date will be one of the following: Initial Referral: the referral request received date of a service request for a particular condition. This will include a patient being re-referred in to a Consultant Led Service or an	
	Interface Service or an NHS Allied Health Professional Service (Referral To Treatment Measurement) as a new referral including after a Discharge After Patient Did Not Attend. The referral to treatment period status is 'National Code 10 - first activity' •Following an appointment that the patient did not attend: • the appointment accepted date (or the invitation offer date sent of the first appointment offer where the appointment offer is sent) for the first appointment following the patient not attending an appointment or elective admission. See referral to treatment period and Discharge After Patient Did Not Attend for guidance on patients who do not attend • The appointment date of the appointment that the Patient did not attend should be used where it is not possible to identify the appointment accepted date or the invitation offer date sent. The Referral to Treatment Period Status is 'National Code 10 - first activity' •Following active monitoring: • the activity date of a care activity when a decision to treat was made following Active Monitoring and the Referral to Treatment Period Status is 'National Code 11	
Description	 active monitoring end' This will include a decision to start a substantively new or different treatment that does not already form part of that Patient's agreed care plan. On identifying a separate condition: the referral request received date of a service request when a decision has been made to refer the Patient directly to a Consultant Led Service or an NHS Allied Health Professional Service (Referral To Treatment Measurement) for a separate condition (the Referral to Treatment Period status for the first care activity with the new consultant or NHS Allied Health Professional Service (Referral To Treatment Measurement) is 'National Code 12 - consultant or NHS Allied Health Professional Service (Referral To Treatment) referral'). Referral to Treatment Consultant Led Waiting Times: For most Patients, the start of the Referral to Treatment Period begins with a service request from a General Medical Practitioner to a Consultant. Service requests to consultants who provide care services in community settings also start referral to treatment periods and the referral request received date will be the start of the referral to treatment periods 	

the start of the referral to treatment period.

mechanisms locally.

A referral to treatment period may also start from service requests to consultants from general dental practitioners, Practitioners with Special Interests, optometrists and Orthoptists, National Screening Programmes, specialist nurses, other care professionals where commissioning Organisations have approved these



	An 18-week clock also starts upon a self-referral by a Patient to the above services, where these pathways have been agreed locally by commissioners and providers and once the referral is ratified by a care professional. A Referral to Treatment Period will also start where Patients are transferred to an elective Consultant Led Service through service requests from Accident and Emergency Departments including Minor injuries units and Walk In Centres.
Value	dd/mm/yyyy = RTT period start date
Cleaning Rule	None



RTT period status (RTTPERSTAT)		
Field	RTTPERSTAT	
Field Name	RTT period status	
NHS Field Name	REFERRAL TO TREATMENT STATUS (V6-1) REFERRAL TO TREATMENT PERIOD STATUS (V6-2)	
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. The first activity in a Referral to Treatment period where the First Definitive	
	Treatment will be a subsequent Activity	
	10 first activity - first activity in a Referral to treatment period	
	11 Active Monitoring end - first activity at the start of a new Referral to treatment period following Active Monitoring	
	12 Consultant or NHS Allied Health Professional Service (Referral To Treatment Measurement) referral - the first activity at the start of a new Referral to treatment period following a decision to refer directly to the Consultant or NHS Allied Health Professional Service (Referral To Treatment Measurement) for a separate condition	
	Subsequent activity during a Referral to treatment period 20 subsequent activity during a Referral to treatment period - further activities anticipated	
	21 transfer to another Health Care Provider - subsequent activity by another Health Care Provider during a Referral to treatment period anticipated Activity that ends the Referral to treatment period 30 Start of First Definitive Treatment	
	31 Start of Active Monitoring initiated by the patient	
	32 Start of Active Monitoring initiated by the care professional33 Did not attend - the patient did not attend the first care activity after the	
Value	referral1 34 Decision not to treat - decision not to treat made or no further contact required2 35 Patient declined offered treatment	
	36 Patient died before treatment	
	Activity that is not part of a Referral to treatment period	
	90 After treatment - First Definitive Treatment occurred previously (e.g. admitted as an emergency from A&E or the activity is after the start of treatment)	
	91 Active Monitoring - Care activity during Active Monitoring 92 Not yet referred - not yet referred for treatment, undergoing diagnostic tests by General Practitioner before referral	
	98 Not applicable - activity not applicable to Referral to treatment periods Activity where the Referral to treatment period status is not yet known	
	99 Not yet known	
	Where the Referral to treatment period status is National Code 99 - "not yet known" the status is treated as if the activity is a subsequent activity during a Referral to treatment period. In this case the Referral to treatment period status should be corrected once it is possible to determine the correct value.	
	1 Patients who do not attend an appointment National code 33 - "Did not attend - the Patient did not attend the first care activity after the referral" may only be used where	
	The Patient did not attend their first appointment following the Referral request that started the Referral to treatment period, provided that the Health Care	



Provider can demonstrate that the appointment was clearly communicated to the Patient. Referral to treatment periods with Referral to treatment period status of National code 33 are excluded from the measurement of the 18 weeks Referral To Treatment Period Included In Referral To Treatment Consultant-Led Waiting Times Measurement and the count of Allied Health Professional Referral To Treatment Measurement Referral to treatment periods 2 Decision not to treat National Code 34 - "decision not to treat - decision not to treat made or no further contact required" includes A Discharge After Patient Did Not Attend the second or a subsequent CARE activity after the referral. • A change resulting in care no longer being commissioned by the English NHS. • A referral to a Consultant Led Service during a Referral To Treatment Period Excluded From Target for the same condition, disease or injury. A new Referral to treatment period will start. Cleaning Rule None



Cleaning Rule

None

Admitted Patient Care (APC) Data Set

Rural/Urban Indicator (RURURB_IND) Field RURURB IND Field Name Rural/Urban Indicator **NHS Field Name** N/A Category Geographical Length and format 1n Availability 1995-96 onwards Describes the nature of an Output Area in terms of its morphology (hamlet, town, Description urban, etc) and context (sparse or less sparse). 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 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 falls 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 Value 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/pseudo postcodes Space = No information available



Sex of patient (SEX) Field SEX Field Name Sex of patient PERSON GENDER CURRENT (V6-1) **NHS Field Name** PERSON GENDER CODE CURRENT (V6-2) Patient Data Category Length and format 1n Availability 1989-90 onwards Defines the sex of the patient. The classification is phenotypical rather than genotypical, i.e. it does not provide codes for medical or scientific purposes. Notes: • National Code 'Not Known' means that the sex of a person has not been Description recorded • National Code 'Not Specified' means indeterminate, i.e. unable to be classified as either male or female. From 1996-97 onwards: 1 = Male 2 = Female9 = Not specified Value 0 = Not known Prior to April 1996: 1 = Male 2 = Female3 = Indeterminate, including those undergoing sex change operations Cleaning Rule Rule # 60 and 650



Sex of baby (SEXBABY) Field **SEXBABY** Field Name Sex of baby PERSON GENDER CURRENT (BABY) (V6-1) NHS Field Name PERSON GENDER CODE CURRENT (BABY) (V6-2) Category Maternity Length and format 1n Availability 1989-90 onwards This field contains a code that defines the sex of the baby. This item appears for Description each baby on multiple birth delivery records. From 1996-97: 1 = Male2 = Female9 = Not specified Value 0 = Not knownUp to 1996-97: 1 = Male 2 = Female3 = Indeterminate, including those undergoing sex change operations None Cleaning Rule



Site code of treatment (SITETRET)

Field	SITETRET
Field Name	Site code of treatment
NHS Field Name	SITE CODE (OF TREATMENT)
Category	Geographical
Length and format	5an - 9an
Availability	1997-98 onwards
Description	This field contains a code that defines the site on which the patient was treated within an organisation. The code recorded should be the one of the Health Care Provider actually carrying out the work. It contains the first 3 digit of the Provider Code with the last two digits being the site identifier.
Value	5an = Site code of treatment 89999 = Non-NHS UK provider where no organisation site code has been issued 89997 = Non-UK Provider where no organisation site code has been issued R9998 - Not a hospital site
Cleaning Rule	None



Beginning of spell indicator (SPELBGIN) Field **SPELBGIN** Field Name Beginning of spell indicator NHS Field Name Category Episodes and spells; Period of care Length and format Availability 1989-90 onwards This derived field contains a code that defines whether the episode is the first of a Description spell, and whether the spell started in the current year or a previous year. Other maternity events are excluded. 0 = Not the first episode of spell 1 = First episode of spell that started in a previous year Value 2 = First episode of spell that started in current year Null = Not applicable Cleaning Rule None



Duration of spell (SPELDUR) Field **SPELDUR** Field Name **Duration of spell** NHS Field Name Episodes and spells; Period of care Category Length and format Availability 1989-90 onwards This derived field gives the duration of the spell in days. It contains the difference in days between the admission date (admidate) and the discharge date (epiend) Description 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. 5n = Duration of spell in days from 0 to 29,200 Value Null = Not applicable: patient not discharged (dismeth not in range 1-5), other maternity event (epitype is 5 or 6) or not valid Cleaning Rule None



End of spell indicator (SPELEND) Field **SPELEND** Field Name End of spell indicator NHS Field Name Category Episodes and spells; Period of care Length and format Availability 1989-90 onwards This derived field contains a code that defines whether the episode is the last of a spell. It is set on finished general, delivery and birth episodes (where epistat = 3Description and epitype = 1, 2 or 3), provided the discharge method (dismeth) confirms that the spell has finished. Y = Last episode of spell Value N = Not last episode of spell Cleaning Rule None



Age at start of episode (STARTAGE)

Field	STARTAGE
Field Name	Age at start of episode
NHS Field Name	N/A
Category	Patient Data
Length and format	4n
Availability	1989-90 onwards
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)
Cleaning Rule	None



Age at start of episode - babies decimalised (STARTAGE_CALC)

Field	STARTAGE_CALC
Field Name	Age at start of episode - babies decimalised
NHS Field Name	N/A
Category	Patient Data
Length and format	nnn.nnn
Availability	1989-90 onwards
Description	Age at start of the episode (STARTAGE), with decimalised values for babies.
Value	STARTAGE = 7001 then 0.002 STARTAGE = 7002 then 0.010 STARTAGE = 7003 then 0.048 STARTAGE = 7004 then 0.167 STARTAGE = 7005 then 0.375 STARTAGE = 7006 then 0.625 STARTAGE = 7007 then 0.875 Else STARTAGE
Cleaning Rule	None



Cleaning Rule

None

Admitted Patient Care (APC) Data Set

SHA area of treatment (STHATRET) Field **STHATRET** Field Name SHA area of treatment NHS Field Name N/A Geographical Category Length and format 3an Availability 1996-97 onwards This field contains a code that defines the Strategic Health Authority (SHA) area where the treatment took place. It is derived from the hospital provider code in the field procode. Note: (1) for NHS trusts, care provided at subsidiary sites will be Description attributed to the main trust location. SHAs were abolished in 2013. This field has continued to be derived after this date as a 'frozen' geography. 3an = Strategic health authority of treatment Value Y = not known



Submission date (SUBDATE) Field **SUBDATE** Field Name Submission date NHS Field Name N/A Category System Data Length and format dd/mm/yyyy (Date) Availability 2000-01 onwards 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 Description December 2006). Value ddmmyyyy = The date on which data was received Cleaning Rule None



Value

Cleaning Rule

Admitted Patient Care (APC) Data Set

SUS generated Core Spell HRG (SUSCOREHRG) Field SUSCOREHRG Field Name SUS generated Core Spell HRG **NHS Field Name** Category Healthcare resource groups (HRG) data 5an Length and format Availability 2009-10 onwards The SUS PbR derived main 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 Description 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.

Null = Spells that have been excluded from PbR in SUS as the activity is outside

5an = SUS generated Core Spell HRG

the scope of PbR

None



Cleaning Rule

Admitted Patient Care (APC) Data Set

SUS generated HRG (SUSHRG) Field **SUSHRG** Field Name SUS generated HRG NHS Field Name Category Healthcare resource groups (HRG) data Length and format 5an Availability 2009-10 onwards The SUS PbR derived healthcare resource group (HRG) code (HRG4 from 2009-Description 10) at episode level. 5an = SUS generated HRG Value Null = Records that have been excluded from PbR in SUS as the activity is outside

the scope of PbR

None



SUS generated HRG version number (SUSHRGVERS) Field **SUSHRGVERS** Field Name SUS generated HRG version number NHS Field Name 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). 4.0 = HRG4Value Null = Not applicable Cleaning Rule None



SUS loaded staging date (SUSLDDATE)

Field	SUSLDDATE
Field Name	SUS loaded staging date
NHS Field Name	N/A
Category	System Data
Length and format	dd/mm/yyyy hh:mm (Date)
Availability	2007-08 onwards
Description	The date that the record was loaded into the SUS staging system.
Value	dd/mm/yyyy hh:mm = SUS loaded staging date
Cleaning Rule	None



SUS record ID (SUSRECID) Fi<u>e</u>ld SUSRECID Field Name SUS record ID NHS Field Name N/A Category System Data Length and format 14n Availability 2007-08 onwards Description SUS (Secondary Uses Service)-generated record identifier. Value 14n = SUS-generated record identifier Cleaning Rule None



SUS generated spell identifier (SUSSPELLID) Field **SUSSPELLID** Field Name SUS generated spell identifier NHS Field Name Category System Data Length and format 10n Availability 2009-10 onwards Description SUS generated spell identifier 10n = SUS spell ID Value Null = Records that have excluded from PbR in SUS as the activity is outside the scope of PbR Cleaning Rule None



Treatment specialty (TRETSPEF)		
Field	TRETSPEF	
Field Name	Treatment specialty	
Tielu Name	TREATMENT FUNCTION CODE (V6-1)	
NHS Field Name	ACTIVITY TREATMENT FUNCTION CODE (V6-2)	
Category	Clinical; Period of Care	
Length and format	3n	
Availability	1989-90 onwards	
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 108 = Spinal Surgery Service (From April 2013) 110 = Trauma & Orthopaedics 120 = Ear, Nose And Throat (ENT) 130 = Ophthalmology 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 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 = Anaesthetics 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)
223 = Paediatric Epilepsy (From April 2013)
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 Haetology (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 Pheumalogy (From 2006-07)
263 = Paediatric Diabetic Medicine
264 = Paediatric Cystic Fibrosis
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 Service
315 = Palliative Medicine
316 = Clinical Immunology
317 = Allergy Service
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) 324 = Anticoagulant Service 325 = Sport And Exercise Medicine 327 = Cardiac Rehabilitation 328 = Stroke Medicine 329 = Transient Ischaemic Attack 330 = Dermatology 331 = Congenital Heart Disease Service (From April 2013) 340 = Respiratory Medicine (Previously Known As Thoracic Medicine) 341 = Respiratory Physiology (Previously Known As Sleep Studies) 342 = Programmed Pulmonary Rehabilitation 343 = Adult Cystic Fibrosis Service 344 = Complex Specialised Rehabilitation Service (From April 2013) 345 = Specialist Rehabilitation Service (From April 2013) 346 = Local Specialist Rehabilitation Service (From April 2013) 350 = Infectious Diseases 352 = Tropical Medicine 360 = Genitourinary 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 Specialities 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 = Not A Treatment Function 520 = Not A Treatment Function 560 = Midwifery Service 600 = Not A Treatment Function 610 = Not A Treatment Function 620= Not A Treatment Function 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) 657 = Prosthetics 658 = Orthotics 659 = Drama Therapy 660 = Art Therapy 661 = Music Therapy 662 = Optometry 663 = Podiatric Surgery (From April 2013) 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)
725 = Mental Health Recovery And Rehabilitation Service (From April 2013)
726 = Mental Health Dual Diagnosis Service (From April 2013)
727 = Dementia Assessment Service (From April 2013)
800 = Clinical Oncology (Previously Known As Radiotherapy)
810 = Not A Treatment Function
811 = Interventional Radiology
812 = Diagnostic Imaging (From 2008-09)
820 = Not A Treatment Function
821 = Not A Treatment Function
822 = Chemical Pathology
823 = Not A Treatment Function
824 = Not A Treatment Function
830 = Not A Treatment Function
831 = Not A Treatment Function
832 = Not A Treatment Function
834 = Medical Virology
840 = Audiology (From 2008-09)
900 = Not A Treatment Function
901 = Not A Treatment Function
920 = Diabetic Education Service (From April 2013)
950 = Not A Treatment Function
960 = Not A Treatment Function
990 Not A Treatment Function
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 Cytogenics 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 Cleaning Rule Rule # 100 and 320



V code indicator (VIND)		
Field	VIND	
Field Name	V code indicator	
NHS Field Name	N/A	
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.	
Cleaning Rule	None	



Field	WAITDAYS
Field Name	Duration of wait (referral to treatment period)
NHS Field Name	N/A
Category	Patient Pathway
Length and format	4n
Availability	2008-09 onwards
Description	This field is derived in HES to calculate the number of days that a patient waited in a referral to treatment period - this is the difference between the Referral to Treatment Start Date (RTTPERSTART) and Referral to Treatment End Date (RTTPEREND).
Value	4n = Waiting time in days from 1 to 8887 null = not applicable / not known
Cleaning Rule	None



Cleaning Rule

None

Admitted Patient Care (APC) Data Set

Method of Admission - Waiting List (WAITLIST) Field WAITLIST Field Name Method of Admission - Waiting List NHS Field Name Category Patient Pathway Length and format 1n Availability 1989-90 onwards Calculation determining patients whose method of admission was from the waiting Description list 1 - Patient who was admitted via the waiting list Value 0 - Patient not admitted via the waiting list



Electoral ward in 1981 (WARD81) Field WARD81 Field Name Electoral ward in 1981 NHS Field Name N/A Category Geographical Length and format 5a 1989-90 to 1995-96 Availability This field contains a code that indicates the patient's local authority and electoral Description 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. Value 5a = Electoral ward Cleaning Rule None



Electoral ward in 1991 (WARD91) Field WARD91 Field Name Electoral ward in 1991 NHS Field Name N/A Category Geographical Length and format 6a Availability 1996-97 onwards This field contains the patient's full frozen 1991 Census electoral ward and local Description authority of residence. It is derived from the patient's postcode in the field homeadd. 6a = Electoral ward Value Y = Not knownCleaning Rule None



Electoral ward in 1998 (WARD98) Field WARD98 Field Name Electoral ward in 1998 NHS Field Name N/A Category Geographical Length and format 6a Availability 1999-00 to 2000-01 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 Description homeadd. Value 6a = Electoral ward Cleaning Rule None



Ward type at start of episode (WARDSTRT)

Field	WARDSTRT
Field Name	Ward type at start of episode
NHS Field Name	N/A
Category	Episodes and spells; Period of care
Length and format	7n
Availability	1997-98 to 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
Cleaning Rule	None
<u> </u>	



Well baby flag (WELL_BABY_IND) Field WELL_BABY_IND Field Name Well baby flag NHS Field Name N/A Category Maternity Length and format 1a Availability 1989-90 onwards Codes in this field indicate whether the episode relates to a well baby (a neonate Description receiving normal levels of care, usually given by a mother or mother substitute). Y = Well baby episode Value N = Any other episode Cleaning Rule None



Published by NHS Digital

Part of the Government Statistical Service

For further information

www.digital.nhs.uk

0300 303 5678

enquiries@nhsdigital.nhs.net

Copyright © 2016, Health and Social Care Information Centre. NHS Digital is the trading name of the Health and Social Care Information Centre.

This work remains the sole and exclusive property of the Health and Social Care Information Centre and may only be reproduced where there is explicit reference to the ownership of the Health and Social Care Information Centre.

This work may be re-used by NHS and government organisations without permission.