Glossary of Terms

**Admission:** The number of Deaths and Discharges are used as an approximation to count admissions. HIS records contain the admission date along with the method of admission (i.e. whether the patient was admitted from a waiting list, or as an emergency, or by another method). Also recorded is the source of admission (e.g. from normal place of residence, from a nursing home, or from another hospital).

**Day Case:** An elective admission where the patient was treated during the course of a single day. Most day cases are episodes involving minor surgical procedures - the patient having been on a waiting list. HIS records contain a data item for patient classification, which enables day cases to be separately identified.

**Elective Admission:** An admission from a waiting list (including booked admissions), or a planned admission. As planned admissions are those deferred for medical reasons, these are not included in waiting time analyses.

**Emergency Admission:** There are a number of categories of emergency admission (admission via an accident and emergency department, or via a General Practitioner etc). HIS records contain codes that separately identify these, although for most analyses they are amalgamated into a single 'emergency admission' group.

**ICD-10:** The International Classification of Diseases (ICD) is used to translate the diagnoses of diseases and other health problems into an alphanumeric code. ICD-10 (version 10) codes consist of a single letter followed by 3 or more digits, with a decimal point between the second and third (e.g. K35.1, "Acute Appendicitis with peritoneal abscess"). As there are many thousands of variations at the 4 character level - where all three digits are used - it is common practice to summarise at the 3 character level (e.g. K35, "Acute appendicitis", which includes peritoneal abscess and all other forms of the condition).

There are diagnosis tables available for download from this site at a summary level which groups associated 3 character codes into chapters and blocks. The diagnoses are presented in code order (i.e. rather than by the diagnosis name).

The International Classification of Diseases is published and maintained by the World Health Organization, Geneva.

**OPCS:** OPCS (Office of Population Censuses and Surveys) coding is the classification of surgical operations and procedures. OPCS-4 codes consist of a letter followed by 3 figures. The letters denote the 22 Chapters of the classification - each chapter dealing with a different part, or 'system' of the body.

**Bed day:** A day of bed occupation by an admitted inpatient (beds used for day cases admissions and regular day/night attenders are not included). HIS is frequently used to analyse bed occupancy as a measure of the resources expended by the Health Service. If there are 100 inpatients who each remain in hospital for 5 days, the bed days figure will be 500. The total number of bed days has been calculated using the stay duration field within the Hospital Inpatient System; this is in contrast to the Northern Ireland Hospital Statistics: Inpatient and Day Case Activity Statistics publication which uses specialty level bed occupancy data from the KH03a aggregate return.
**Finished Consultant Episode (FCE):** A period of continuous admitted patient treatment under the care of a consultant. If, during an admission, a patient is transferred from one consultant to another, a new Consultant Episode commences. An episode if considered to be finished if it ended before midnight on the last day of the HIS year (31st March). The HIS dataset for a particular year consists of all episodes which finished during the year, including those which began in previous years. Also stored are a much smaller number of records (approximately 2% of the total) for episodes, which began during the year, but were continuing at the end of the year. However, this latter group (the unfinished episodes) are normally excluded from analyses (for every unfinished episode there will, eventually, be a FCE recorded in a later data year).

**Specialty:** A specialty title recognised by the Royal Colleges and Faculties (e.g. General Surgery). HIS records contain a code for the specialty title given in the consultants contract, and also (from April 1996) the specialty title appropriate to the episode of treatment (the two are not always the same because it may be appropriate for a consultant with a mix of skills to work in an area outside of that for which they were primarily contracted by their employer).

**Emergency:** An admission which was unpredictable and at short notice because of clinical need.

**Waiting list:** A patient admitted electively from a waiting list having been given no date of admission at a time a decision was made to admit.

**Primary Diagnosis:** The condition established as the main reason for admission after all investigations, diagnostic examinations and procedures have been carried out.

**HRG:** Healthcare Resource Groups (HRGs) are standard groupings of clinically similar treatments which use common levels of healthcare resource. HIS adds HRG codes to each episode – version 3.5 codes are attached to all records and from 2006/07 version 4 codes are also included.

**Procedure/Intervention:** a procedure or series of procedures aimed at restoring or improving the health of a patient, as by correcting a malformation, removing diseased parts, implanting new parts, etc. Defined by an OPCS code recorded in any of the procedure fields in the Hospital Inpatient System excluding codes Y80, Y81, Y82, Y84, Y90 and all Z codes.

**Operation:** An OPCS code recorded in any of the procedure fields the Hospital Inpatient System excluding all Y and Z codes.

**Chapters/Blocks:** The diagnosis and operations tables group associated diagnosis/procedure codes into chapters and blocks (i.e. sub chapters) in line with those designated by the World Health Organisation/OPCS respectively.