Maternity Services Dataset Development

Data Items

Version 0.24a

Version	Comments	Date	Distribution
0.01	Initial from IR 0.05	08/03/2006	Jason Gardosi
0.02	Reassign **X Other** category, correct duplicate C2 entries, add EFM to F2	22/03/2006	Gill Foley
0.01a	Structure and comments from Jason Gardosi	22/03/2006	Liaison Group
0.03	Add comments from v0.01a and Liaison Group to v0.02	27/03/2006	None
0.04	Delete All tab, update sections, add summary	04/04/2006	Ref/Liaison Groups
0.05	Add in further questions for Ref Grp to answer re ambiguities, Comments MD, Ref Grp 04/05/06		
0.06	Perinatal Institute documentation comparison	13/06/2006	Andy Richardson
0.07	Add IR references and omissions	29/06/2006	Core items only - EE, JH, BD, PB Full version HD
0.08	Clarification of some Diabetes related items Added NHSP outcome values	03/07/2006	
0.09	Work with David Milligan - Neonatal Sections: G, J, K, L Erb's Palsy moved from G4 to J1	04/07/2006	
0.10	HES Data Dictionary items - Maternity	12/07/2006	
0.11	Neonatal Audit items Rename G6 - Baby, NNU	13/07/2006	
0.12a	Changes + Data Item numbering (v0.11)	25/07/2006	
0.13	Minor changes		
0.14	Consultation	07/05/2006	
0.15	V0.13 with columns unhidden and consultation responses (replaced after additional comments to 0.15.a)		
0.15a	Auto filter for consultation responses		
0.16	Barnsley comments and some more SNOMED		
0.17	Comments at maternity Reference Group 17/11/06	20/11/2006	BD/Sir David Hall
0.17		27/11/2006	Gill Foley
0.18	Responding to GF queries and data modelling	11/01/2007	
0.19	Bradford - eClipse work		
0.20	Definitional Testing - Newcastle (Antenatal and Birth/Delivery)	31/01/2007	Graham Ponting, CSC
0.21	Definitional Testing - Newcastle (Screening)		
0.22	Definitional Testing - Southampton		
0.23	Misc		
0.24	Final Draft		
0.24a	Final Draft formatted without DD/terminology		

		Instances	Always required or Required only if relevant	No of items	Input Items	Items that can be Derived from existing records or Input	Derived or Calculated Items
				941			
1	Mother's Demographics	One	A	6	6	0	0
2	Mother's Demographics @ Booking	One	A	26	17	4	5
3	Partner's Demographics @ Booking			6	2	3	1
	Partner's Demographics	One	A				
	Father's Demographics	One	A				
4	Mother's Medical History			10	0	10	0
	Mother's Medical Diagnoses	Repeating	O				
	Mother's Medication	Repeating	O				
	Diabetic Mother	One	O				
5	Previous Pregnancies			25	0	9	16
	Obstetric Diagnoses	One	O				
	Previous Pregnancies	Repeating	O				
	Diagnosis in previous child	Repeating	O				
	Death of previous child	Repeating	O				
	Obstetric History	One	A				
6	Pregnancy			21	12	3	6
	Pregnancy	One	A				
	Family History	Repeating	O				
7	Mother's Health Obs @ Booking	One	A	16	14	2	0
8	Disability	Repeating	O	4	0	4	0
9	Antenatal Observations	Repeating	O	11	10	0	1
10	Booking Screening - Mother			50	42	0	8
	Blood Group and Rhesus	One	A				
	Haemoglobin	One	A				
	Rhesus Antibodies	One	O				
	Rubella Antibodies	One	A				
	Hepatitis B	One	A				
	Syphilis	One	A				
	HIV	One	A		Yes No Not known		
11	Maternity Care Plans			5	3	2	0
12	Dating Scan			17	15	1	1
	Dating Scan	One	A				
	Dating Scan Observations	One	O				
13	Antenatal Sickle Cell Disease and Thalassaemia Screening			33	23	0	10
	Family Origin	Repeating	A				
	Screening General	One	O				
	Screening Tests	One	O				
	Follow up	One	O				
14	Downs Syndrome			21	17	0	4
	Downs Syndrome Screening	One	A				
	Serum Tests	Repeating	O				
	Follow Up	One	O				
15	Neural Tube Defects Screening	One	A	9	8	0	1
16	Anti-D			27	21	1	5
	Rhesus Antibodies	One	O				
	Routine Antenatal Anti D Prophylaxis	Repeating	O				
	RAADP Monitoring	One	O				
	Sensitising event	Repeating	O				
	Postnatal Anti-D Prophylaxis	One	O				
17	Diagnostic Testing			21	18	0	3
	Diagnostic Test	Repeating	O				
	Diagnostic Test Result	Repeating	O				
18	Fetal Anomaly			27	26	0	1
	Fetal Anomaly Screening	Repeating	O				
	Fetal Anomaly Screening Results	Repeating	O				
	Fetal Anomaly Diagnosis	Repeating	O				
19	TOP	One	O	3	2	0	1

20	Other Ultrasound Scans	Repeating	O	6	5	0	1
21	Antenatal Contacts			36	16	3	17
	Routine Antenatal Contact	Repeating	A				
	Antenatal Contacts	One	A				
	Other Antenatal Contact	Repeating	O				
	Specialist Referrals and Contacts	Repeating	O				
	Post-term Review	Repeating	O				
22	Antenatal Complications			13	8	0	5
	Infectious Diseases	Repeating	O				
	Obstetric Complications	Repeating	O				
	Diabetes - Antenatal	One	O				
23	FGM	One	O	10	6	0	4
24	Antenatal Admissions	Repeating	O	5	3	0	2
25	Tocolysis	One	O	7	4	0	3
26	Corticosteroid Therapy			13	8	0	5
	Corticosteroid Therapy	One	O				
	Corticosteroid Course	Repeating	O				
	Corticosteroid Dose	Repeating	O				
27	ECV	Repeating	O	9	7	0	2
28	Non-registrable Outcomes			8	7	0	1
	Ectopic Pregnancy	One	O				
	Miscarriage	One	O				
29	Induction and Augmentation			27	18	1	8
	Induction of Labour Offered	One	O				
	Induction of Labour	One	O				
	Membrane Sweep	One	O				
	Artificial Rupture of Membranes	One	O				
	Medical Induction	Repeating	O				
	Oxytocin	Repeating	O				
30	Rupture of Membranes	One	A	6	3	0	3
31	Labour and Delivery			44	25	3	16
	Intended delivery care plan	One	A				
	Plans for delivery	Repeating	A				
	Labour	One	A				
	Pain Relief	Repeating	A				
	Decision to accelerate delivery	One	O				
	Delivery	One	A				
	Birth Supporters	Repeating	A				
	Antibiotics in labour	One	O				
	Diabetes - Labour and Delivery	One	O				
32	Transfers	Repeating	O	7	5	1	1
33	Caesarean Section	One	O	9	9	0	0
34	Fetal Monitoring			8	8	0	0
	Continuous Electronic Fetal Monitoring	One	O				
	Fetal Blood Sampling	Repeating	O				
35	Critical Incidents and Complications	Repeating	O	3	2	1	0
36	Spontaneous Tears and Episiotomy			10	9	0	1
	Perineum	Repeating	O				
	Spontaneous Perineal Tear	One	O				
	Episiotomy	One	O				
	Perineal Repair	One	O				
37	Breastfeeding			14	12	0	2
	Initiation of Breastfeeding	One	A				
	Breastfeeding Difficulty	One	O				
	Tongue Tie	One	O				
38	Congenital Anomalies	Repeating	O	3	2	0	1
39	Outcome and Birth	Repeating for each fetus/baby		51	33	7	11
	Outcome for fetus	One	A				
	Birth	One	A				
	Place of birth	One	A				
	Assisted Delivery Methods	Repeating	O				
	Baby Birth Trauma	Repeating	O				
	Cord Bloods	One	O				
	Apgar Score	One	A				
	Person Delivering	One	A				
	Person Present at Delivery	Repeating	O				

	Complications at Delivery	Repeating	O				
	Reason for Caesarean	One	O				
40 Neonatal	Repeating for each baby			34	29	0	5
	Resuscitation	One	O				
	Resuscitation method	Repeating	O				
	Resuscitation tests	Repeating	O				
	Resuscitation drugs	Repeating	O				
	Neonatal Admission	Repeating	O				
41 Postnatal - Mother				61	50	1	10
	Mother's Demographics at Delivery	One	A				
	Postnatal - Mother	One	A				
	Delivery Substance Observations	One	A				
	Postnatal Smoking Observations	One	A				
	Postnatal Antibiotics	One	O				
	Postnatal Thromboprophylaxis	One	O				
	Postnatal Theatre Admission	Repeating	O				
	Postnatal Rubella Immunisation	One	O				
	Postnatal Check Up	One	A				
	Postnatal Contacts	Repeating	A				
	Postnatal Complications and Comorbidities	Repeating	O				
	Postnatal Readmission	Repeating	O				
42 Maternal Death				6	6	0	0
43 Postnatal - Baby	Repeating for each baby			23	19	0	4
	Postnatal - Baby	One	A				
	Vitamin K Prophylaxis	One	A				
	Neonatal Diagnosis	Repeating	O				
	Baby Weight	Repeating	A				
	Babies of Diabetic Mothers	One	O				
44 Infectious Diseases Follow Up	Repeating for each baby			23	23	0	0
	Hepatitis B	One	O				
	BCG	One	O				
	Syphilis	One	O				
	Group B Streptococcus	One	O				
	HIV	One	O				
	Other	Repeating	O				
45 Newborn Screening	Repeating for each baby			139	113	0	26
	Newborn Physical Screening	One	A				
	Newborn Hearing Screening	One	A				
	Bloodspot Screening	Repeating	A				
	Card						
	Phenylketonuria						
	Sickle Cell Disease						
	Cystic Fibrosis						
	Congenital Hypothyroidism						
	MCADD						
	Bloodspot Screening Follow Up	One	O				
	Phenylketonuria						
	Sickle Cell Disease						
	Cystic Fibrosis						
	Congenital Hypothyroidism						
	MCADD						
	6-8 Week Physical Screening	One	A				
46 Neonatal Death	Repeating for each baby		O	9	6	0	3
47 Mental Health				15	9	0	6
	Maternity Mental Health	One	O				
	Maternity Mental Health Referral	Repeating	O				
	Maternity Mental Health Admission	Repeating	O				
	Maternity Mental Health Care Plan	Repeating	O				
48 Other Referrals		Repeating	O	4	4	0	0

Data Item Number	Input/ Derived	Data Item Name	Description	Purpose	Values/Format
Mother's Demographics: To carry the personal details of the Mother in a Maternity Episode					
One occurrence of this Group is required					
This may be known prior to this pregnancy or may be collected and/or checked as part of the routine assessment/enquiry process					
	I	NHS NUMBER (MOTHER)	The NHS Number of the mother in a maternity episode	Unique identifier of the pregnant woman	n10
	I	DATE OF BIRTH (MOTHER)	Date of birth of the mother in a maternity episode	Used to derive ages for comparison	n8 - ccyymmdd
	I	ETHNICITY (MOTHER)	The ethnicity of the mother in a maternity episode as specified by herself	Used to compare outcomes according to ethnicity	2001 Census values, or as updated in future
	I	COUNTRY OF BIRTH (MOTHER)	The country of birth of the mother in a maternity episode	Used to compare outcomes and choices according to country of birth	
	I	YEAR OF ARRIVAL IN UK (MOTHER)	The year in which a mother born abroad came to live in UK	Used to compare outcomes and choices according to country of birth and how long they have been living in UK	ccyy
	I	RELIGION OR FAITH (MOTHER)	The religion or faith of the mother	Used to compare outcomes for different groups and also identify factors influencing care	

Data Item Number	Input/ Derived	Data Item Name	Description	Purpose	Values/Format
Mother's Demographics at Booking: To carry the personal, social and other details of the Mother as they are first observed in the pregnancy One occurrence of this Group is required This group will normally be collected at the First Formal Antenatal Booking Appointment. Many of these items may also be collected at Delivery/Discharge					
	D	AGE (MOTHER AT BOOKING)	The age in years of the mother at the FIRST ANTENATAL ASSESSMENT DATE. This is derived from the mother's PERSON BIRTH DATE and the FIRST ANTENATAL ASSESSMENT DATE	Used to derive complicating factor for pregnancy (18 or under, 40 or over) and analysis by age of mother, including by typical bandings	n2
	I	POST CODE (MOTHER AT BOOKING)	The POSTCODE OF USUAL ADDRESS nominated by the mother at the FIRST ANTENATAL ASSESSMENT DATE	Used to derive PCT and other geographical areas, including Sure Start areas, for aggregation to compare outcomes and plan services	an8 (max)
	D	SURESTART AREA (MOTHER AT BOOKING)	The SureStart area in which the mother lives. This is derived from the mother's POST CODE (MOTHER AT BOOKING) and look up table from ???	Used to analyse outcomes and plan services at aggregated level	Look up table required
	D	PCT OF RESIDENCE (MOTHER AT BOOKING)	The PCT in which the mother lives derived from POST CODE (MOTHER AT BOOKING)	Used to aggregate by geographical area	an3
	I	GP CODE (MOTHER AT BOOKING)	Unique identifier of GP	Required for NN4B and aggregation by GP/Area	
	I	PRACTICE CODE (MOTHER AT BOOKING)	Unique identifier of GP Practice	Required for NN4B and aggregation by GP/Area	an6
	D	RESPONSIBLE PCT (MOTHER AT BOOKING)	This is the ORGANISATION CODE of the responsible Primary Care Trust. The Primary Care Trust is responsible for a population which comprises: - those persons registered with GENERAL PRACTITIONERS whose practices are within the Primary Care Trust, irrespective of whether they reside within the boundary of the Primary Care Trust, plus - those persons who are not registered with any GENERAL PRACTITIONER but who reside in the Primary Care Trust's geographic area	Used to aggregate by geographical area	an3
	I	ACCOMMODATION TYPE (MOTHER AT BOOKING)	The type of accommodation in which the mother lives at booking	Used as a factor in socio-economic analysis	Census 2001: *Whole House:* - Detached - Semi-detached - Terraced (including end terrace) *Flat:* - Purpose built - Converted or shared (including bed-sits) - In a commercial building (eg over shop) *Mobile or temporary building:* - Caravan or other mobile or temporary structure *Medical and Care establishments:* - General hospital - Psychiatric hospital or home - Other hospital - Nursing home - Residential care home - Children's home (including secure unit) - Other medical and care home *Other establishments:* - Defence establishment - Prison service establishment - Probation/bail hostel - Educational establishment (inc halls of residence) - Hotel, boarding house, guest house - Hostel - Civilian ship, boat, barge - Other

Data Item Number	Input/ Derived	Data Item Name	Description	Purpose	Values/Format
	I	HOMELESS INDICATOR (MOTHER AT BOOKING)	An indicator to identify pregnant mothers who are homeless	Used to compare outcomes for specific vulnerable groups	Yes No
	I	TRAVELLER INDICATOR (MOTHER AT BOOKING)	An indicator to identify pregnant mothers who are travellers	Used to compare outcomes for specific vulnerable groups	Yes No
	I	HOUSING TENURE (MOTHER AT BOOKING)	The tenure of accommodation in which the mother lives at booking	Used as a factor in socio-economic analysis	Census 2001: Owns outright Owns with mortgage or loan Pays part rent and part mortgage (shared ownership) Rents Lives rent free Not applicable (for other values where inappropriate - not a census value)
	I/D	REFUGEE/ASYLUM STATUS (MOTHER AT BOOKING)	Whether or not the mother is a refugee or seeking asylum at booking	Used to compare use of maternity services and outcomes for mothers in these groups and their babies	Refugee Asylum seeker test whether value is known - leave arrangements are not normally known, or have "yes/no" value as not crucial to have split
	I/D	PHYSICAL DISABILITY STATUS	Whether or not the mother is physically disabled under the Disability Discrimination Act (2005). Derived from ADULT DISABILITY TYPE, DISABILITY START and END DATEs as appropriate to this pregnancy. Excludes value 02 Learning Disability	Used to compare services and outcomes for mothers with a disability and their babies	Yes No
	I/D	LEARNING DISABILITY STATUS	Whether or not the mother is learning disabled under the Disability Discrimination Act (2005). Derived from ADULT DISABILITY TYPE value 02 Learning Disability, DISABILITY START and END DATEs as appropriate to this pregnancy	Used to compare services and outcomes for mothers with a disability and their babies	Yes No
	I	FIRST LANGUAGE	Whether or not the mother's first language is English	Used to compare uptake of services and outcomes for mothers for whom English is not their first language	LANGUAGE CLASSIFICATION CODE National Codes
	I	INTERPRETER REQUIRED INDICATOR	Whether or not an interpreter is required including BSL	Used to monitor requirement for interpretation resources	Yes No
	I	PREFERRED LANGUAGE	The language in which the mother prefers to communicate - including written information	Used to monitor requirement for interpretation resources	LANGUAGE CLASSIFICATION CODE National Codes

Data Item Number	Input/ Derived	Data Item Name	Description	Purpose	Values/Format
	I	EDUCATION LEVEL (MOTHER)	Highest education level the mother has achieved by this pregnancy	Used to compare outcomes for babies according to mother's education level - a factor in socio-economic analysis	01 Pre-school 02 Elementary or primary school 03 Lower secondary level (equivalent to year 11) 02 Upper secondary level (equivalent to 6th form) 03 Further education 04 Higher education short (4 years or less) 05 Higher education long (more than 4 years)
	I	AGE COMPLETED EDUCATION (MOTHER)	The age at which full-time education was completed	Used to compare outcomes for babies according to mother's education level - a factor in socio-economic analysis	16 16 or under years of age 17 17 years of age 18 18 years of age 19 19 or over years of age xx still in education
	I	OCCUPATION (MOTHER)	Mother's current or last occupation	Used to derive mother's occupational category	Free text
	I/D	OCCUPATIONAL CATEGORY (MOTHER)	Group most closely associated with mother's current or last occupation Needs to be derived from actual occupation	Used to compare outcomes for babies according to mother's occupation - a factor in socio-economic analysis	01 Modern Professional such as: teacher - nurse - physiotherapist - social worker - welfare officer - artist - musician - police officer (sergeant or above) - software designer 02 Clerical and intermediate occupation such as: secretary - personal assistant - clerical worker - office clerk - call centre agent - nursing auxiliary - nursery nurse 03 Senior managers or administrator (usually responsible for planning, organising and co-ordinating work and for finance) such as: finance manager - chief executive 04 Technical and craft occupation such as: motor mechanic - fitter - inspector - plumber - printer - tool maker - electrician - gardener - train driver 05 Semi-routine manual and service occupation such as: postal worker - machine operative - security guard - caretaker - farm worker - catering assistant - receptionist - sales assistant 06 Routine manual and service occupations such as: HGV driver - van driver - cleaner - porter - packer - sewing machinist - messenger - labourer - waiter / waitress - bar staff 07 Middle or junior managers such as: office manager - ret manager - warehouse manager - publican 08 Traditional professional occupations such as: accountai civil / mechanical engineer 09 ~~Unemployed~~ None 10 Family worker - At home looking after dependents: child
	I	EMPLOYMENT STATUS (MOTHER AT BOOKING)	Whether or not the mother is employed	Used to compare outcomes for babies according to mother's employment status - a factor in socio-economic analysis	Full time paid Part time paid Retired Student Looking after home/family Permanently sick/disabled Unemployed (seeking work) Unemployed (not seeking work)
	I	MARITAL STATUS (MOTHER AT BOOKING)	An indicator to identify the legal marital status of a PERSON	Used as a factor in socio-economic analysis	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

Data Item Number	Input/ Derived	Data Item Name	Description	Purpose	Values/Format
	I	PARTNERSHIP (MOTHER AT BOOKING)	An indicator to identify whether or not the mother is in a partnership, expanding on legal marital status, to include where a single, divorced or widowed woman is in a new partnership, or a married woman is no longer in a partnership	Used to assess support and social factors relevant to pregnancy and outcomes	Single Same sex partnership Heterosexual partnership
	I	SUPPORT STATUS (MOTHER AT BOOKING)	Whether or not the mother reports feeling supported in pregnancy and looking after a baby. The highest applicable value should be selected	Used to assess support and social factors relevant to pregnancy and outcomes	Full support of partner Full support of family Poor support of partner Poor support of family Support of friends Support of social services or other agency/organisation No support
	D	NO OF YEARS IN UK (MOTHER AT BOOKING)	The number of years since a mother born abroad came to live in UK, calculated from YEAR OF ARRIVAL IN UK (MOTHER) and APPOINTMENT DATE (FORMAL ANTENATAL BOOKING)	Used to compare outcomes and choices according to country of birth and how long they have been living in UK	n2

Data Item Number	Input/ Derived	Data Item Name	Description	Purpose	Values/Format
Partner's Demographics at Booking: To carry the personal, social and other details of the Father/Partner as they are first observed in the pregnancy One occurrence of this Group is required This group will normally be collected at the First Formal Antenatal Booking Appointment. Many of these items may also be collected at Delivery/Discharge					
	I	PARTNER IS BABYS FATHER INDICATOR	An indicator to identify whether or not the mother's partner is the baby's father	Used to derive biological or socio-economic factors	Yes No N/A
	I/D	OCCUPATION (PARTNER AT BOOKING)	The father's (or mother's partner's) current or last occupation at FIRST ANTENATAL ASSESSMENT DATE	Used to derive occupational category	Free text
	D	OCCUPATIONAL CATEGORY (PARTNER AT BOOKING)	Group most closely associated with the father's (or mother's partner's) current or last occupation Needs to be derived from actual occupation at FIRST ANTENATAL ASSESSMENT DATE	Used to compare outcomes for babies according to father's occupation - a factor in socio-economic analysis	01 Modern Professional such as: teacher - nurse - physiotherapist - social worker - welfare officer - artist - musician - police officer (sergeant or above) - software designer 02 Clerical and intermediate occupation such as: secretary - personal assistant - clerical worker - office clerk - call centre agent - nursing auxiliary - nursery nurse 03 Senior managers or administrator (usually responsible for planning, organising and co-ordinating work and for finance) such as: finance manager - chief executive 04 Technical and craft occupation such as: motor mechanic - fitter - inspector - plumber - printer - tool maker - electrician - gardener - train driver 05 Semi-routine manual and service occupation such as: postal worker - machine operative - security guard - caretaker - farm worker - catering assistant - receptionist - sales assistant 06 Routine manual and service occupations such as: HGV driver - van driver - cleaner - porter - packer - sewing machinist - messenger - labourer - waiter / waitress - bar staff 07 Middle or junior managers such as: office manager - ret manager - warehouse manager - publican 08 Traditional professional occupations such as: accountai civil / mechanical engineer 09 ~~Unemployed~~ None 10 Family worker - At home looking after dependents: chilc
	I	EMPLOYMENT STATUS (PARTNER AT BOOKING)	Whether or not the father (or mother's partner) is employed at FIRST ANTENATAL ASSESSMENT DATE	Used to compare outcomes for babies according to father's employment status - a factor in socio-economic analysis	Full time paid Part time paid Retired Student Looking after home/family Permanently sick/disabled Unemployed (seeking work) Unemployed (not seeking work)
	I/D	ETHNICITY (PARTNER)	The ethnicity of the partner in a maternity episode as specified by the mother	Used to compare outcomes according to ethnicity	2001 Census values, or as updated in future
Father's Demographics: To carry the personal, social and other details of the Father as they are first observed in the pregnancy One occurrence of this Group is required This group will normally be collected at the First Formal Antenatal Booking Appointment. Many of these items may also be collected at Delivery/Discharge					
	I/D	ETHNICITY (FATHER)	The ethnicity of the father in a maternity episode as specified by the mother	Used to compare outcomes according to ethnicity	2001 Census values, or as updated in future

Data Item Number	Input/ Derived	Data Item Name	Description	Purpose	Values/Format
Mother's medical diagnoses: To carry the pre-pregnancy and current medical diagnoses of the Mother					
One occurrence of this Group is required for each of the diagnoses					
This group will normally be available from existing diagnoses on the mother's record. Alternatively they may be collected/checked at the First Formal Antenatal Booking Appointment. New diagnoses should be added as derived from the diagnosis date.					
		MATERNITY COMPLICATING MEDICAL DIAGNOSIS		Used to monitor different targets for complicated/uncomplicated pregnancies and to inform commissioning and planning of types of services required	
	I/D	MATERNITY COMPLICATING MEDICAL DIAGNOSIS TYPE	The diagnosis or type of diagnosis presenting a risk or complicating factor for this pregnancy	Used to monitor different targets for complicated/uncomplicated pregnancies and to inform commissioning and planning of types of services required	Hypertension Cardiac disease Renal disease Mental health disorder Thromboembolic disorder Haematological disorder CNS disorder Diabetes Autoimmune disease Cancer HIV Infectious hepatitis A Serum hepatitis B Hepatitis C Genital herpes Endocrine disorder Respiratory disease Gastrointestinal disorder Musculoskeletal disorder Gynaecological problems
		Autoimmune disease			
		Cancer			
		Cardiac disease			
		CNS disorder			
		Diabetes			
		Endocrine disorder			
		Gastrointestinal disorder			
		Genital herpes			
		Gynaecological problems			
		Haematological disorder			
		Hepatitis C			
		HIV			
		Hypertension			
		Infectious hepatitis A			
		Mental health disorder			-past or present severe mental illness including schizophrenia, bipolar disorder, psychosis in the postnatal period and severe depression -previous treatment by a psychiatrist/specialist mental health team including inpatient care -treatment with antidepressants, eg for eating disorder
		Musculoskeletal disorder			
		Renal disease			
		Respiratory disease			
		Serum hepatitis B			
		Thromboembolic disorder			
	I/D	MATERNITY COMPLICATING MEDICAL DIAGNOSIS CURRENT TREATMENT TYPE	Whether or not treatment of the condition currently requires medication	Used to monitor different targets for complicated/uncomplicated pregnancies and to inform commissioning and planning of types of services required	Yes No

Data Item Number	Input/ Derived	Data Item Name	Description	Purpose	Values/Format
	I/D	MATERNITY COMPLICATING MEDICAL DIAGNOSIS DATE	The date (year) of diagnosis	Used to monitor different targets for complicated/uncomplicated pregnancies and to inform commissioning and planning of types of services required	ccyymmdd
	I/D	MATERNITY COMPLICATING MEDICAL DIAGNOSIS SURGERY	Whether or not the diagnosis resulted in surgery	Used to monitor different targets for complicated/uncomplicated pregnancies and to inform commissioning and planning of types of services required	Yes No
	I/D	MATERNITY COMPLICATING MEDICAL DIAGNOSIS ADMISSION	Whether or not the diagnosis resulted in an inpatient admission	Used to monitor different targets for complicated/uncomplicated pregnancies and to inform commissioning and planning of types of services required	Yes No
Mother's Medication: To carry details of medication taken during pregnancy and whilst breastfeeding One occurrence of this Group is required for each medication This group will normally be available from existing medication records. Alternatively they may be collected/checked at the First Formal Antenatal Booking Appointment. New medication should be added as derived from the prescription date.					
	I/D	MATERNITY MEDICATION	Record of drug taken in pregnancy or whilst breastfeeding	Used to monitor outcomes for mothers and babies where the mother requires ongoing medication, especially for management of mental health problems	
	I/D	MATERNITY MEDICATION START DATE	Date medication started	Used to monitor outcomes for mothers and babies where the mother requires ongoing medication, especially for management of mental health problems	ccyymmdd
	I/D	MATERNITY MEDICATION END DATE	Date medication ended	Used to monitor outcomes for mothers and babies where the mother requires ongoing medication, especially for management of mental health problems	ccyymmdd
Diabetic Mother: To carry details of antenatal care for a woman with pre-existing diabetes One occurrence of this Group is required for a mother with pre-existing diabetes This group will normally be available from existing diagnoses on the mother's record. Alternatively they may be collected/checked at the First Formal Antenatal Booking Appointment.					
	I/D	DIABETES METHOD OF CONTROL	Method by which individual is controlling their diabetes	Used to compare outcomes for women with diabetes and their babies	Oral hypoglycaemics Insulin Insulin and oral hypoglycaemics Diet and exercise None Unknown
	I/D	DIABETES REVIEW RESPONSIBILITY	Whether or not diabetes is being managed in primary or secondary care	Used to compare outcomes for women with diabetes and their babies	01 Diabetes practice programme 02 Diabetes care by hospital

Data Item Number	Input/ Derived	Data Item Name	Description	Purpose	Values/Format
Mother's previous obstetric diagnoses: To carry the previous obstetric diagnoses of the Mother One occurrence of this Group is required for each of the diagnoses This group will normally be available from previous maternity records. Alternatively they may be collected/checked at the First Formal Antenatal Booking Appointment.					
	I/D	MATERNITY COMPLICATING OBSTETRIC DIAGNOSIS TYPE	The diagnosis or type of obstetric diagnosis presenting a risk or complicating factor for this pregnancy	Used to monitor different targets for complicated/uncomplicated pregnancies and to inform commissioning and planning of types of services required	Severe pre-eclampsia HELLP Eclampsia Puerperal psychosis Liver cholestasis of pregnancy Gestational diabetes mellitus Gestational hypertension Gestational oedema Gestational proteinuria Antepartum haemorrhage Postpartum haemorrhage Feto-maternal haemorrhage
Mother's previous pregnancies: To carry the details of the Mother's previous pregnancies One occurrence of this Group is required for each previous pregnancy This group will normally be available from previous maternity records. Alternatively they may be collected/checked at the First Formal Antenatal Booking Appointment.					
	I/D	DATE OF DELIVERY (PREVIOUS PREGNANCY)	The date of delivery for the previous pregnancy	Used to derive chronology of previous pregnancies	ccyymmdd
	I/D	OUTCOME OF PREGNANCY (PREVIOUS PREGNANCY)	The outcome of the previous pregnancy	Used to determine which models of care may or may not be appropriate, and to monitor outcomes comparing previously nulliparous or parous women	Live Antepartum stillbirth Intrapartum stillbirth Indeterminate stillbirth Spontaneous miscarriage Miscarriage after invasive procedure TOP - medical TOP - surgical Alive but died Other
	I/D	GESTATION AT OUTCOME (PREVIOUS PREGNANCY)	The gestational age at the outcome of the previous pregnancy	Used to determine which models of care may or may not be appropriate, and to monitor outcomes comparing previously nulliparous or parous women	ww +d
	I/D	METHOD OF DELIVERY (PREVIOUS PREGNANCY)	The method of delivery for the previous pregnancy	Used to determine which models of care may or may not be appropriate, and to monitor outcomes comparing previously nulliparous or parous women	Emergency Caesarean Elective Caesarean Assisted vaginal Spontaneous vaginal
	I/D	NUMBER OF FETUSES (PREVIOUS PREGNANCY)	The number of fetuses in the previous pregnancy	Used to determine which models of care may or may not be appropriate, and to monitor outcomes comparing previously nulliparous or parous women	n2
Diagnosis in previous child: To carry the details of a diagnosis in a previous child One occurrence of this Group is required for each diagnosis in each child This group will normally be derivable from previous maternity and medical records. Alternatively details of each previous pregnancy may be collected/checked at the First Formal Antenatal Booking Appointment.					
	I/D	DIAGNOSIS (PREVIOUS PREGNANCY)	Diagnosis of Small or Large for gestational age, or a congenital abnormality in a child of a previous pregnancy	Used to identify risk factors for pregnancies and to inform commissioning and planning of types of maternity services required	

Data Item Number	Input/ Derived	Data Item Name	Description	Purpose	Values/Format
Death of previous child: To carry the details of a previous child who died One occurrence of this Group is required for each child This group will normally be derivable from previous maternity and medical records. Alternatively details of each previous pregnancy may be collected/checked at the First Formal Antenatal Booking Appointment.					
	I/D	DATE OF DEATH (PREVIOUS CHILD)	The date of death of a previous child	Used to identify risk factors for pregnancies and to inform commissioning and planning of types of maternity services required	ccyymmdd
	I/D	AGE AT DEATH (PREVIOUS CHILD)	The age of a previous child when they died	Used to identify risk factors for pregnancies and to inform commissioning and planning of types of maternity services required	n2
Mother's obstetric history: To carry the details of the Mother's obstetric history One occurrence of this Group is required This group will normally be derivable from previous maternity and medical records. Alternatively details of each previous pregnancy may be collected/checked at the First Formal Antenatal Booking Appointment.					
	D	PREGNANCY TOTAL PREVIOUS PREGNANCIES	The number of previous pregnancies Note some pregnancies may be naturally aborted before the woman is aware she is pregnant or seeks antenatal/medical care	Used to determine which models of care may or may not be appropriate, and to monitor outcomes comparing previously nulliparous or parous women	000 ... 019
	D	PREGNANCY PREVIOUS CAESAREAN SECTIONS	The number of previous caesarean sections performed. This is part of the data recorded about the fetal outcome of previous pregnancies and forms part of the maternity clinical option.	Used to identify risk factors for pregnancies and to inform commissioning and planning of types of maternity services required	n2
	D	PREGNANCY TOTAL PREVIOUS VAGINAL BIRTHS	The number of previous pregnancies that resulted in a vaginal birth Note does this include multiple births where one VB and other CS?	Used to identify risk factors for pregnancies and to inform commissioning and planning of types of maternity services required	n2
	D	PREGNANCY TOTAL PREVIOUS VBAC	The number of previous pregnancies resulting in a vaginal birth after previously having a caesarean section	Used to identify risk factors for pregnancies and to inform commissioning and planning of types of maternity services required	n2
	D	PREGNANCY TOTAL ASSISTED BIRTHS	The number of previous pregnancies which resulted in an instrumental delivery	Used to identify risk factors for pregnancies and to inform commissioning and planning of types of maternity services required	n2
	D	PREGNANCY TOTAL PREVIOUS MISCARRIAGES	The number of previous pregnancies which resulted in a miscarriage (before 12 weeks gestation)	Used to identify risk factors for pregnancies and to inform commissioning and planning of types of maternity services required	n2
	D	PREGNANCY TOTAL PREVIOUS MIDTERM LOSSES	The number of previous pregnancies which resulted in a midterm loss (12-24 weeks gestation)	Used to identify risk factors for pregnancies and to inform commissioning and planning of types of maternity services required	n2
	D	PREGNANCY TOTAL PREVIOUS PRETERM DELIVERIES	The number of previous pregnancies which resulted in a registrable birth before 37 weeks gestation	Used to identify risk factors for pregnancies and to inform commissioning and planning of types of maternity services required	n2
	D	PREGNANCY TOTAL PREVIOUS LIVE BIRTHS	The number of previous pregnancies which resulted in a live birth	Used to inform commissioning and planning of types of maternity services required	n2

Data Item Number	Input/ Derived	Data Item Name	Description	Purpose	Values/Format
	D	PREGNANCY TOTAL PREVIOUS STILL BIRTHS	The number of registrable still births by the mother i.e. a birth after a gestation of 24 weeks (168 days), or more, where a baby shows no identifiable signs of life at delivery. This is part of the data recorded about the fetal outcome of previous pregnancies and forms part of the maternity clinical option.	Used to identify risk factors for pregnancies and to inform commissioning and planning of types of maternity services required	n2
	D	PREGNANCY TOTAL PREVIOUS NEONATAL DEATHS	The number of previous pregnancies which resulted in a neonatal death (before 28 days)	Used to identify risk factors for pregnancies and to inform commissioning and planning of types of maternity services required	n2
	D	PREGNANCY TOTAL PREVIOUS POST NEONATAL DEATHS	The number of previous pregnancies which resulted in the death of the baby after 28 days	Used to identify risk factors for pregnancies and to inform commissioning and planning of types of maternity services required	n2
	D	PREGNANCY TOTAL PREVIOUS BABY SGA	The number of previous pregnancies where the baby was diagnosed as small for gestational age (RCOG Guideline 31 or NICE 6 <5 centile)	Used to identify risk factors for pregnancies and to inform commissioning and planning of types of maternity services required	n2
	D	PREGNANCY TOTAL PREVIOUS BABY LGA	The number of previous pregnancies where the baby was large for gestational age (NICE 6 >95 centile)	Used to identify risk factors for pregnancies and to inform commissioning and planning of types of maternity services required	n2
	D	PREGNANCY TOTAL PREVIOUS BABY CONGENITAL ANOMALY	The number of previous pregnancies where the baby was diagnosed with a congenital anomaly	Used to identify risk factors for pregnancies and to inform commissioning and planning of types of maternity services required	n2
	D	PREGNANCY TOTAL PREVIOUS MULTIPLE BIRTHS	The number of previous pregnancies which resulted in a multiple birth	Used to identify risk factors for pregnancies and to inform commissioning and planning of types of maternity services required	n2

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Pregnancy: To carry key clinical and other details of the Mother as they are first observed in the pregnancy One occurrence of this Group is required This group will normally be collected at different times in the pregnancy					
	I	DATE (PREGNANCY FIRST CONTACT)	Date when mother first contacted NHS for antenatal/pregnancy care, either GP appointment or direct access to maternity services	Used to calculate timeliness of accessing maternity services in particular for vulnerable groups	ccyymmdd
	I	CARE PROFESSIONAL (PREGNANCY FIRST CONTACT)	The care professional with whom first contact was made for antenatal/pregnancy care		GP Midwife Other …
	I	CARE SETTING (PREGNANCY FIRST CONTACT)	The setting for the first pregnancy contact		GP Surgery Children's Centre Hospital Home Other …
	D	GESTATION (PREGNANCY FIRST CONTACT)	The gestational age at the PREGNANCY FIRST CONTACT		ww
	I	DATE OF LAST MENSTRUAL PERIOD	Date on which last menstrual period began	Primary item to calculate EDD	ccyymmdd
	D	ESTIMATED DATE OF DELIVERY (LMP)	Date on which delivery might be expected assuming exact 40 wk gestation, derived from date of last menstrual period and cycle length (where known)	Used as a guide for calculation of timing of tests and other interventions, and gestational age at birth for those requiring critical care,	ccyymmdd
	I	APPOINTMENT DATE (FORMAL ANTENATAL BOOKING)	The date on which the pregnant woman was assessed and arrangements made for antenatal care as part of the Pregnancy Episode. This is not necessarily the occasion on which arrangements were made for delivery. The CARE CONTACT TYPE for the CARE CONTACT will be 'First formal antenatal booking appointment'.	Used to monitor when in pregnancy mothers begin to receive care from maternity services	ccyymmdd
	D	GESTATION (FORMAL ANTENATAL BOOKING)	The gestational age at the FIRST ANTENATAL ASSESSMENT DATE	Used to monitor when in pregnancy mothers begin to receive care from maternity services	ww +d
	I	LEAD CARER (BOOKING)	Professional status of lead carer at formal 'booking' The type of professional who will personally give a substantial part of the care during the Pregnancy Episode and who is responsible for ensuring that the pregnant woman has access to care from other professionals as appropriate. The type of professional may change during pregnancy; if it does, record as changed	Used to monitor continuity of care or reasons for changes in care plan	a. MIDWIFE b. GENERAL MEDICAL PRACTITIONER c. Obstetrician
	I	MATERNAL WEIGHT (FIRST IN PREGNANCY)	The first of OBSERVATION TYPE Weight in this pregnancy	To derive BMI	kg to 1dp
	I	MATERNAL HEIGHT (FIRST IN PREGNANCY)	The first of OBSERVATION TYPE Height in this pregnancy	To derive BMI	m to 2dp
	D	BMI (FIRST IN PREGNANCY)	The first of OBSERVATION TYPE BMI in this pregnancy	Used to improve accuracy of screening tests and risk of complications in pregnancy	n2

Data Item Number		Data Item Name	Description	Purpose	Values/Format
	D	GESTATION (FIRST BMI IN PREGNANCY)	The gestational age at BMI (FIRST IN PREGNANCY)	Used to improve accuracy of screening tests and risk of complications in pregnancy	ww +d
	I	ESTIMATED DATE OF DELIVERY (AGREED)	The Estimated Date of Delivery that is agreed, being the Estimated Date of Delivery (LMP) if the scan agrees within 7 days (NMRP) or if the difference is more than 7 days, then the Estimated Date of Delivery by Scan. If neither of these are available, then a clinical assessment of due date is used.	Used as a guide for calculation of timing of tests and other interventions, and gestational age at birth for those requiring critical care	ccyymmdd
	I	AGREED EDD METHOD	The method by which the Agreed Estimated Date of Delivery was calculated		LMP LMP confirmed by USS Ultrasound dating Clinical Assessment
	I	CONSANGUINITY	The relationship of the mother and father		Not related First cousin First cousin once removed Second cousin Other degree Not known
	I	DATE INFECTIOUS DISEASES IN PREGNANCY LEAFLET GIVEN	The date on which the pregnant woman was given the leaflet, or other appropriate information, on routine screening for infectious diseases in pregnancy	To monitor routine screening guidance and implementation	ccyymmdd
	D	GESTATION (INFECTIOUS DISEASES IN PREGNANCY LEAFLET GIVEN)	The gestational age at DATE INFECTIOUS DISEASES IN PREGNANCY LEAFLET GIVEN	To monitor routine screening guidance and implementation	ww +d
Family history: To carry the details of family history of medical and obstetric diagnoses One occurrence of this Group is required for each of the diagnoses This group will normally be collected at the First Formal Antenatal Booking Appointment. Alternatively where appropriate record linkage exists this may be derived					
	I/D	MATERNITY FAMILY HISTORY DIAGNOSIS	The diagnosis presenting a risk or complicating factor for this pregnancy	Used to monitor different targets for complicated/uncomplicated pregnancies and to inform commissioning and planning of types of services required	
	I/D	MATERNITY FAMILY HISTORY DIAGNOSIS TYPE	The diagnosis or type of diagnosis presenting a risk or complicating factor for this pregnancy	Used to monitor different targets for complicated/uncomplicated pregnancies and to inform commissioning and planning of types of services required	
		Allergies			
		Congenital disorders	Hip problems, hearing loss, heart problems, other abnormalities		
		Diabetes			
		Fetal alcohol syndrome			
		Hereditary diseases			
		Hypertension			
		Learning difficulties			
		Mental health problems			a family history of perinatal mental illness
		Neonatal Group B streptococcal disease	In baby of mother's previous pregnancy only		

Data Item Number	Data Item Name	Description	Purpose	Values/Format
	Stillbirths or multiple miscarriages			
	Sudden infant death			
	Thrombosis			
	Tuberculosis			
	Twins			
	Other major problems			
I/D	MATERNITY FAMILY HISTORY DIAGNOSIS RELATIONSHIP	The relationship to the baby of the person with the diagnosis. Relationships to both maternal and paternal great-grandparents (ie parents' grandparents), grandparents, father, aunts, uncles, cousins and siblings, including previous children of the father with a different partner	Used to monitor different targets for complicated/uncomplicated pregnancies and to inform commissioning and planning of types of services required	

Data Item Number	Input/ Derived	Data Item Name	Description	Purpose	Values/Format
Mother's health observations at booking: To carry observations of the Mother's health as they are first observed in the pregnancy					
One occurrence of this Group is required					
This group will normally be collected at the First Formal Antenatal Booking Appointment. Many of these items may also be collected at Delivery/Discharge					
	I/D	SUBSTANCE MISUSE STATUS (AT BOOKING)	The mother's self-reported status of whether or not she has used or is using non medicinal drugs or substances at FIRST ANTENATAL ASSESSMENT DATE	Used to monitor outcomes for mothers who have or are using non medicinal drugs or substances and their babies	Currently using Previously used Never used Unknown
	I/D	SUBSTANCE MISUSE INJECTING	Whether or not a mother who has reporting using non medicinal drugs or substances also reports injecting	Used to monitor outcomes for mothers who have or are using non medicinal drugs or substances and their babies	Yes No Not applicable
	I	SUBSTANCE MISUSE FREQUENCY (AT BOOKING)	A broad classification of the frequency of use of the SUBSTANCE MISUSED	Used to monitor outcomes for mothers who have or are using non medicinal drugs or substances and their babies	a. Daily b. Weekly c. Monthly d. Occasionally
	I	SUBSTANCE MISUSE CEASED DATE	The date on which the mother stopped using non medicinal drugs or substances where they are not currently using. If the exact date is not known, then the year should be recorded	Used to monitor outcomes for mothers who have or are using non medicinal drugs or substances and their babies	ccyymmdd
	I	SMOKING STATUS (MOTHER AT BOOKING)	The mother's self-reported status of whether or not she smokes or has ever smoked	Used to compare outcomes for babies of mothers who smoke	Current smoker ... Ex-smoker Non-smoker - history unknown Never smoked Unknown
	I	TOBACCO USAGE TYPE (MOTHER AT BOOKING)	The type of a PERSON's TOBACCO USAGE	Used to compare outcomes for babies of mothers who smoke	G Cigarettes P Pipe W Chewing
	I	TOBACCO CHEWING HISTORY (MOTHER AT BOOKING)	The PERSON's history of tobacco chewing as part of their TOBACCO USAGE	Used to compare outcomes for babies of mothers who smoke	1 Current 2 Ex 4 Never 9 Unknown
	I	CIGARETTES PER DAY (MOTHER AT BOOKING)	The number of cigarettes smoked by the PATIENT where they are a current or ex-smoker	Used to compare outcomes for babies of mothers who smoke	
	I	DATE STOPPED SMOKING	The date on which the PERSON stopped smoking where they are an ex-smoker. If the exact date is not known, then the year should be recorded	Used to derive the length of time prior to pregnancy mother stopped smoking	ccyymmdd
	I	SMOKING CESSATION SUPPORT OFFERED STATUS		Used to compare outcomes for babies of mothers who smoke	Offered and accepted Offered and declined Offered and undecided/considering Not offered Not applicable
	I	WEEKLY ALCOHOL UNITS (PRE-PREGNANCY)	The typical number of units the mother reports she drank per week prior to pregnancy	Use to identify possible alcohol misuse and compare outcomes for babies and mothers	
	I	WEEKLY ALCOHOL UNITS (AT BOOKING)	The typical number of units the mother reports she drinks per week at booking	Use to identify possible alcohol misuse and compare outcomes for babies and mothers	
	I	BINGE DRINKING (PRE-PREGNANCY)	The frequency of consuming more than 6 units on one day prior to pregnancy as reported by the mother	Use to identify possible alcohol misuse and compare outcomes for babies and mothers	Never Occasionally Monthly Weekly Daily

Data Item Number	Input/ Derived	Data Item Name	Description	Purpose	Values/Format
	I	BINGE DRINKING (AT BOOKING)	The frequency of consuming more than 6 units on one day currently as reported by the mother	Use to identify possible alcohol misuse and compare outcomes for babies and mothers	Never Occasionally Monthly Weekly Daily
	I	STATUS OF FOLIC ACID SUPPLEMENT	Whether or not the woman has been taking or intends to take folic acid supplements	Used to assess awareness of importance of folic acid in development of the fetus	Taking prior to pregnancy Taking once pregnancy confirmed Taking due to antenatal advice Not intending to take Not appropriate for stage in pregnancy Unknown
	I	MENTAL HEALTH PREDICTION AND DETECTION (AT BOOKING)	Whether or not the recommended questions for prediction and detection of mental health issues were asked	Used to monitor implementation of antenatal and postnatal mental health guidelines	Not asked Asked, no issues Asked, issues identified

Data Item Number	Data Item Name	Description	Purpose	Values/Format
Disability: To carry the details of a disability				
One occurrence of this Group is required for each Disability Type				
This may be known prior to this pregnancy or may be collected and/or checked as part of the routine assessment/enquiry process				
I/D	ADULT DISABILITY TYPE	The type of DISABILITY a PERSON is considered to have	Used to monitor standards for women with a disability	02 learning disability 03 an eye sight disability (unable to see clearly with or without spectacles/contact lenses) 04 hearing disability (unable to hear with or without a hearing aid) 05 manual dexterity disability (unable to touch and/or hold an object) 06 mobility disability (unable to move about the house and beyond unaided) 07 physical co-ordination disability (unable to lift, carry or otherwise move every day objects e.g. fill a kettle with water) 08 speech disability (unable to communicate with others and/or understand what others are saying) 09 continence disability (unable to control the passage of urine or faeces) 10 personal care disability (unable to wash, dress and go to the toilet) 11 life activities and participation
I/D	DISABILITY SEVERITY	The severity of a DISABILITY TYPE for a particular PERSON	Used to monitor standards for women with a disability	01 severe 02 moderate 03 slight 04 not considered disabled
I/D	DISABILITY START DATE	The date on which the association of a DISABILITY TYPE and its DISABILITY SEVERITY is deemed to have started	Used to monitor standards for women with a disability	ccyymmdd
I/D	DISABILITY END DATE	The date on which the association of a DISABILITY TYPE and its DISABILITY SEVERITY is deemed to have ended	Used to monitor standards for women with a disability	ccyymmdd

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Antenatal Observations: To carry the details of antenatal observations					
One occurrence of this Group is required for each Antenatal Observation Type					
This may be known prior to this pregnancy or may be collected and/or checked as part of the routine assessment/enquiry process					
	I	ANTENATAL OBSERVATION TYPE			
	I	ANTENATAL OBSERVATION DATE	Date of the Antenatal Observation		ccyymmdd
	D	GESTATION AT ANTENATAL OBSERVATION DATE	Gestation at the Antenatal Observation		ww +d
		Maternal Weight	Identifies the weight of a person on a given date. The type of measurement is Kilograms. Maternal weight and height should be measured at the first antenatal appointment, and the woman's body mass index (BMI) calculated (weight [kg]/height[m]2). Repeated weighing during pregnancy should be confined to circumstances where clinical management is likely to be influenced. (NICE 6)	To derive BMI. The first BMI in pregnancy is used to identify risk factors	kg to 1dp
		Maternal Height	The height of a PERSON on a given date. The unit of measurement is metres. Maternal weight and height should be measured at the first antenatal appointment, and the woman's body mass index (BMI) calculated (weight [kg]/height[m]2). Repeated weighing during pregnancy should be confined to circumstances where clinical management is likely to be influenced. (NICE 6)	To derive BMI. The first BMI in pregnancy is used to identify risk factors	m to 2dp
	I	Maternal Blood Pressure	A record of a PERSON's Blood Pressure which is comprised of a Systolic Pressure and a Diastolic Pressure. The values of the blood pressure are not as relevant as the fact that the blood pressure was measured and recorded at each antenatal appointment in conjunction with presence of proteinuria	To check whether routine screening for common risk factors are undertaken and the effects this has on outcomes for women and their babies	
	I	Maternal Urinalysis for proteinuria	A record of presence or otherwise of proteinuria in a PERSON's urine sample. The value of the record is not as relevant as the fact that the it was tested for and recorded at each antenatal appointment in conjunction with blood pressure	To check whether routine screening for common risk factors are undertaken and the effects this has on outcomes for women and their babies	
	I	Symphysis fundal height	A record of the measurement of the symphsis fundal height in women from the 25th week of pregnancy. The value of the record is not as relevant as the fact that it was measured and recorded at each antenatal appointment	To check whether routine screening for common risk factors are undertaken and the effects this has on outcomes for women and their babies	cm
	I	Domestic abuse	A record of the fact that the woman was asked about whether they have experienced or are experiencing domestic abuse. This may not be asked at every antenatal appointment, but it is recommended (although not in NICE 6) that women should be asked at an opportune moment about their experiences of domestic abuse.	To check whether routine screening for common risk factors are undertaken and the effects this has on outcomes for women and their babies and to support commissioning of services for women who request support for coping with domestic violence	no yes - explanation entered not asked - and reason

Data Item Number		Data Item Name	Description	Purpose	Values/Format
	I	Diabetes control review	A record of reviewing the diabetes control measurements for women with diabetes	To check whether routine screening for common risk factors are undertaken and the effects this has on outcomes for women and their babies	
	I	Diabetes control measurement	HbA1C measurement	To check whether routine screening for common risk factors are undertaken and the effects this has on outcomes for women and their babies	
	I	Presentation of fetus	Presentation of each fetus at appointments after 36 wks	Used to influence plans for birth, and assess the need for Ultrasound, ECV, elective Caesarean Sections	Breech Vertex Transverse/oblique
	I	Mental health prediction and detection	Whether or not the recommended questions for prediction and detection of mental health issues were asked	Used to monitor implementation of antenatal and postnatal mental health guidelines	Not asked Asked, no issues Asked, issues identified

Data Item Number	Data Item Name	Description	Purpose	Values/Format
Screening at Booking: To carry details of 'booking' screening tests One occurrence of this Group is required for each screening test This group will normally be collected at the appropriate times on the various screening pathways. Frequently the tests are discussed at the same time, consent given at the same time and samples for the various tests taken at the same time - usually at the FIRST ANTENATAL ASSESSMENT. Input of data should facilitate this, but also allow for them to be done at separate times. Laboratory items may be sent to the electronic record electronically, or may be manually input.				
Blood Group and Rhesus				
I	OFFER STATUS (MOTHER BLOOD GROUP AND RHESUS STATUS TEST)	Whether or not a mother was offered a screening test and whether or not she declined or accepted. The final value should be reported, including where a woman changes her decision. The default value would be 'Not offered', once explained and discussed but without a decision 'Offered and considering' should be chosen, when a decision is arrived at 'Offered and declined' or 'Offered and accepted' should be chosen.	Used to monitor explanation, offer and uptake of routine screening	Not offered Offered and considering Offered and declined Offered and accepted
I	OFFER STATUS DATE (MOTHER BLOOD GROUP AND RHESUS STATUS TEST)	The date on which the test was explained and offered	Used to monitor explanation, offer and uptake of routine screening	ccyymmdd
I	BLOOD TEST SAMPLE DATE (MOTHER BLOOD GROUP AND RHESUS STATUS)	Date blood test sample taken	Used to identify whether or not women are tested in early pregnancy	ccyymmdd
D	GESTATIONAL AGE AT (MOTHER BLOOD GROUP AND RHESUS STATUS TEST)	Gestational age derived from AGREED EDD if available or EDD(LMP) when blood test taken	Used to identify whether or not women are tested in early pregnancy	ww +d
	INVESTIGATION RESULT DATE TIME (BLOOD GROUP AND RHESUS STATUS TEST)	The date on which an investigation was concluded e.g. the date the result was authorised.	Used to monitor implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve and their babies	ccyymmdd hh:mm
I	BLOOD GROUP (MOTHER)	Blood group of mother	Used to monitor implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve and their babies	
I	RHESUS GROUP (MOTHER)	Rhesus group of mother	Used to monitor implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve and their babies	

Data Item Number	Data Item Name	Description	Purpose	Values/Format
Haemoglobin at Booking				
			Used to monitor explanation, offer and uptake of routine screening	
I	OFFER STATUS (MOTHER HAEMOGLOBIN AT BOOKING TEST)	Whether or not a mother was offered a screening test and whether or not she declined or accepted. The final value should be reported, including where a woman changes her decision. The default value would be 'Not offered', once explained and discussed but without a decision 'Offered and considering' should be chosen, when a decision is arrived at 'Offered and declined' or 'Offered and accepted' should be chosen.	Used to monitor explanation, offer and uptake of routine screening	Not offered Offered and considering Offered and declined Offered and accepted
I	OFFER STATUS DATE (MOTHER HAEMOGLOBIN AT BOOKING TEST)	The date on which the test was explained and offered	Used to monitor explanation, offer and uptake of routine screening	ccyymmdd
I	BLOOD TEST SAMPLE DATE (MOTHER HAEMOGLOBIN AT BOOKING TEST)	Date blood test sample taken	Used to monitor explanation, offer and uptake of routine screening	ccyymmdd
D	GESTATIONAL AGE AT (MOTHER HAEMOGLOBIN AT BOOKING TEST)	Gestational age derived from AGREED EDD if available or EDD(LMP) when blood test taken	Used to monitor explanation, offer and uptake of routine screening	ww +d
	INVESTIGATION RESULT (MOTHER HAEMOGLOBIN AT BOOKING TEST)	The result of the clinical investigation		
	INVESTIGATION RESULT DATE TIME (MOTHER HAEMOGLOBIN AT BOOKING TEST)	The date on which an investigation was concluded e.g. the date the result was authorised.		ccyymmdd hh:mm

Data Item Number	Data Item Name	Description	Purpose	Values/Format
Rhesus Antibodies (Rh -ve mothers only)				
I	OFFER STATUS (MOTHER RHESUS ANTIBODIES BOOKING)	Whether or not a mother was offered a screening test and whether or not she declined or accepted. The final value should be reported, including where a woman changes her decision. The default value would be 'Not offered', once explained and discussed but without a decision 'Offered and considering' should be chosen, when a decision is arrived at 'Offered and declined' or 'Offered and accepted' should be chosen.	Used to monitor explanation, offer and uptake of routine screening	Not offered Not applicable Offered and considering Offered and declined Offered and accepted
I	OFFER STATUS DATE (MOTHER RHESUS ANTIBODIES BOOKING)	The date on which the test was explained and offered	Used to monitor explanation, offer and uptake of routine screening	ccyymmdd
I	BLOOD TEST SAMPLE DATE (MOTHER RHESUS ANTIBODIES BOOKING)	Date blood test sample taken	Used to monitor explanation, offer and uptake of routine screening	ccyymmdd
D	GESTATIONAL AGE AT (MOTHER RHESUS ANTIBODIES BOOKING)	Gestational age derived from AGREED EDD if available or EDD(LMP) when blood test taken	Used to monitor explanation, offer and uptake of routine screening	ww +d
I	INVESTIGATION RESULT (MOTHER RHESUS ANTIBODIES BOOKING)	The result of the clinical investigation	Used to monitor implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve and their babies	
	INVESTIGATION RESULT DATE TIME (MOTHER RHESUS ANTIBODIES BOOKING)	The date on which an investigation was concluded e.g. the date the result was authorised.		ccyymmdd

Data Item Number	Data Item Name	Description	Purpose	Values/Format
Rubella Antibodies				
	I	OFFER STATUS (MOTHER RUBELLA ANTIBODIES)	Whether or not a mother was offered a screening test and whether or not she declined or accepted. The final value should be reported, including where a woman changes her decision. The default value would be 'Not offered', once explained and discussed but without a decision 'Offered and considering' should be chosen, when a decision is arrived at 'Offered and declined' or 'Offered and accepted' should be chosen.	Used to monitor explanation, offer and uptake of routine screening	Not offered Not applicable Offered and considering Offered and declined Offered and accepted
	I	OFFER STATUS DATE (MOTHER RUBELLA ANTIBODIES)	The date on which the test was explained and offered	Used to monitor explanation, offer and uptake of routine screening	ccyymmdd
	I	BLOOD TEST SAMPLE DATE (MOTHER RUBELLA ANTIBODIES)	Date blood test sample taken	Used to monitor explanation, offer and uptake of routine screening	ccyymmdd
	D	GESTATIONAL AGE AT (MOTHER RUBELLA ANTIBODIES)	Gestational age derived from AGREED EDD if available or EDD(LMP) when blood test taken	Used to monitor explanation, offer and uptake of routine screening	ww +d
	I	INVESTIGATION RESULT (MOTHER RUBELLA ANTIBODIES)	Evidence of Rubella immunity	Used to monitor seroprevalence of rubella and requirements of immunisation	Yes No
		INVESTIGATION RESULT DATE TIME (MOTHER RUBELLA ANTIBODIES)	The date on which an investigation was concluded e.g. the date the result was authorised.		ccyymmdd hh:mm
	I	SCREENING RESULT INFORMING DATE (MOTHER RUBELLA ANTIBODIES)	Date on which result of screening for infectious disease was informed to mother	Used to monitor implementation of screening guidelines	ccyymmdd
	I	SCREENING RESULT INFORMING METHOD (MOTHER RUBELLA ANTIBODIES)	How result of screening for infectious disease was communicated to mother	Used to monitor implementation of screening guidelines	Telephone Letter Personal visit Antenatal clinic

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Hepatitis B					
	I	SCREENING OFFER STATUS (MOTHER HEPATITIS B)	Whether or not a mother was offered a screening test and whether or not she declined or accepted. The final value should be reported, including where a woman changes her decision. The default value would be 'Not offered', once explained and discussed but without a decision 'Offered and considering' should be chosen, when a decision is arrived at 'Offered and declined' or 'Offered and accepted' should be chosen.	Used to monitor explanation, offer and uptake of routine screening	Not offered Not applicable - current diagnosis Offered and considering Offered and declined Offered and accepted
	I	SCREENING OFFER STATUS DATE (MOTHER HEPATITIS B)	The date on which the test was explained and offered	Used to monitor explanation, offer and uptake of routine screening	ccyymmdd
	I	SCREENING BLOOD TEST SAMPLE DATE (MOTHER HEPATITIS B)	Date blood test sample taken	Used to monitor explanation, offer and uptake of routine screening	ccyymmdd
	D	GESTATIONAL AGE AT (SCREENING MOTHER HEPATITIS B)	Gestational age derived from AGREED EDD if available or EDD(LMP) when blood test taken	Used to monitor explanation, offer and uptake of routine screening	ww +d
	I	SCREENING INVESTIGATION RESULT (MOTHER HEPATITIS B)	The result of the clinical investigation	Used to monitor extent of pregnant women with Hepatitis B and the planning of appropriate services	a. Previous test positive b. Test taken - positive result c. Test taken - negative result d. Test not taken
		SCREENING INVESTIGATION RESULT DATE TIME (MOTHER HEPATITIS B)	The date on which an investigation was concluded e.g. the date the result was authorised.		ccyymmdd hh:mm
	I	SCREENING RESULT INFORMING DATE (MOTHER HEPATITIS B)	Date on which result of screening for infectious disease was informed to mother	Used to monitor implementation of screening guidelines	ccyymmdd
	I	SCREENING RESULT INFORMING METHOD (MOTHER HEPATITIS B)	How result of screening for infectious disease was communicated to mother	Used to monitor implementation of screening guidelines	Telephone Letter Personal visit Antenatal clinic

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Syphilis					
	I	SCREENING OFFER STATUS (MOTHER SYPHILIS)	Whether or not a mother was offered a screening test and whether or not she declined or accepted. The final value should be reported, including where a woman changes her decision. The default value would be 'Not offered', once explained and discussed but without a decision 'Offered and considering' should be chosen, when a decision is arrived at 'Offered and declined' or 'Offered and accepted' should be chosen.	Used to monitor explanation, offer and uptake of routine screening	Not offered Not applicable - current diagnosis Offered and considering Offered and declined Offered and accepted
	I	SCREENING OFFER STATUS DATE (MOTHER SYPHILIS)	The date on which the test was explained and offered	Used to monitor explanation, offer and uptake of routine screening	ccyymmdd
	I	SCREENING BLOOD TEST SAMPLE DATE (MOTHER SYPHILIS)	Date blood test sample taken	Used to monitor explanation, offer and uptake of routine screening	ccyymmdd
	D	GESTATIONAL AGE AT (MOTHER SYPHILIS)	Gestational age derived from AGREED EDD if available or EDD(LMP) when blood test taken	Used to monitor explanation, offer and uptake of routine screening	ww +d
	I	SCREENING INVESTIGATION RESULT (MOTHER SYPHILIS)	The result of the clinical investigation	Used to monitor extent of pregnant women with HIV and the planning of appropriate services	a. Previous test positive b. Test taken - positive result c. Test taken - negative result d. Test not taken
		SCREENING INVESTIGATION RESULT DATE TIME (MOTHER SYPHILIS)	The date on which an investigation was concluded e.g. the date the result was authorised.		ccyymmdd hh:mm
	I	SCREENING RESULT INFORMING DATE (MOTHER SYPHILIS)	Date on which result of screening for infectious disease was informed to mother	Used to monitor implementation of screening guidelines	ccyymmdd
	I	SCREENING RESULT INFORMING METHOD (MOTHER SYPHILIS)	How result of screening for infectious disease was communicated to mother	Used to monitor implementation of screening guidelines	Telephone Letter Personal visit Antenatal clinic

Data Item Number		Data Item Name	Description	Purpose	Values/Format
HIV					
	I	SCREENING OFFER STATUS (MOTHER HIV)	Whether or not a mother was offered a screening test and whether or not she declined or accepted. The final value should be reported, including where a woman changes her decision. The default value would be 'Not offered', once explained and discussed but without a decision 'Offered and considering' should be chosen, when a decision is arrived at 'Offered and declined' or 'Offered and accepted' should be chosen.	Used to monitor explanation, offer and uptake of routine screening	Not offered Not applicable - current diagnosis Offered and considering Offered and declined Offered and accepted
	I	SCREENING OFFER STATUS DATE (MOTHER HIV)	The date on which the test was explained and offered	Used to monitor explanation, offer and uptake of routine screening	ccyymmdd
	I	SCREENING BLOOD TEST SAMPLE DATE (MOTHER HIV)	Date blood test sample taken	Used to monitor explanation, offer and uptake of routine screening	ccyymmdd
	D	GESTATIONAL AGE AT (MOTHER HIV)	Gestational age derived from AGREED EDD if available or EDD(LMP) when blood test taken	Used to monitor explanation, offer and uptake of routine screening	ww +d
	I	SCREENING INVESTIGATION RESULT (MOTHER HIV)	The result of the clinical investigation	Used to monitor extent of pregnant women with HIV and the planning of appropriate services	a. Previous test positive b. Test taken - positive result c. Test taken - negative result d. Test not taken
		SCREENING INVESTIGATION RESULT DATE TIME (MOTHER HIV)	The date on which an investigation was concluded e.g. the date the result was authorised.		ccyymmdd hh:mm
	I	SCREENING RESULT INFORMING DATE (MOTHER HIV)	Date on which result of screening for infectious disease was informed to mother	Used to monitor implementation of screening guidelines	ccyymmdd
	I	SCREENING RESULT INFORMING METHOD (MOTHER HIV)	How result of screening for infectious disease was communicated to mother	Used to monitor implementation of screening guidelines	Telephone Letter Personal visit Antenatal clinic

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Asymptomatic Bacteriuria					
	I	OFFER STATUS (MOTHER ASYMPTOMATIC BACTERIURIA)	Whether or not a mother was offered a screening test and whether or not she declined or accepted. The final value should be reported, including where a woman changes her decision. The default value would be 'Not offered', once explained and discussed but without a decision 'Offered and considering' should be chosen, when a decision is arrived at 'Offered and declined' or 'Offered and accepted' should be chosen.	Used to monitor explanation, offer and uptake of routine screening	Not offered Not applicable Offered and considering Offered and declined Offered and accepted
	I	OFFER STATUS DATE (MOTHER ASYMPTOMATIC BACTERIURIA)	The date on which the test was explained and offered	Used to monitor explanation, offer and uptake of routine screening	ccyymmdd
	I	URINE TEST SAMPLE DATE (MOTHER ASYMPTOMATIC BACTERIURIA)	Date midstream urine sample collected	Used to monitor explanation, offer and uptake of routine screening	ccyymmdd
	D	GESTATIONAL AGE AT (MOTHER ASYMPTOMATIC BACTERIURIA)	Gestational age derived from AGREED EDD if available or EDD(LMP) when midstream urine sample collected	Used to monitor explanation, offer and uptake of routine screening	ww +d
	I	INVESTIGATION RESULT (MOTHER ASYMPTOMATIC BACTERIURIA)	Significant growth of bacteria on midstream urine culture	Used to monitor extent of women with asymptomatic bacteriuria and outcomes	Yes No
		INVESTIGATION RESULT DATE TIME (MOTHER ASYMPTOMATIC BACTERIURIA)	The date on which an investigation was concluded e.g. the date the result was authorised.		ccyymmdd hh:mm
	I	SCREENING RESULT INFORMING DATE (MOTHER ASYMPTOMATIC BACTERIURIA)	Date on which result of screening for infectious disease was informed to mother	Used to monitor implementation of screening guidelines	ccyymmdd
	I	SCREENING RESULT INFORMING METHOD (MOTHER ASYMPTOMATIC BACTERIURIA)	How result of screening for infectious disease was communicated to mother	Used to monitor implementation of screening guidelines	Telephone Letter Personal visit Antenatal clinic

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Maternity Care Plan: To carry details of the pregnancy Care Plan and Lead Carer and changes One occurrence of this Group is required for each change in care plan and/or lead carer This group will normally be collected together, but may be repeated at different times in the pregnancy					
	I	MATERNITY CARE PLAN DATE	The date on which the care plan changed	Used to monitor continuity of care or reasons for changes in care plan	ccyymmdd
	I/D	LEAD CARER PROFESSION	Profession/job title of individual identified as lead carer for the maternity	Used to monitor continuity of care or reasons for changes in care plan	
	I	LEAD CARER INDIVIDUAL	The unique ID of the individual identified as lead carer for the maternity	Used to monitor continuity of care or reasons for changes in care plan	
	I	LEAD CARER CHANGED REASON	Reason for change in lead carer	Used to monitor continuity of care or reasons for changes in care plan	Need values
	I/D	LEAD CARER CHANGED STAGE	The time during care when the lead carer profession changed	Used to monitor continuity of care or reasons for changes in care plan	Antenatal During labour During delivery Postnatal

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Dating Scan: To carry details of dating scan One occurrence of this Group is required This group will be collected at the first ultrasound (dating) scan					
	I	SCREENING OFFER STATUS (DATING SCAN)	Whether or not the scan was offered, accepted or declined	Used to monitor uptake of dating scan	Offered and accepted Offered and declined Not offered Not applicable
	I	SCREENING OFFER DATE (DATING SCAN)	The date on which a dating scan was offered	Used to monitor uptake of dating scan	ccyymmdd
	D	GESTATION (OFFER DATING SCAN)	Gestation at offer of dating scan	Used to monitor uptake of dating scan	ww +d
	I	PROCEDURE DATE (ULTRASOUND DATING SCAN)	Date on which the ULTRASOUND DATING SCAN took place	Used to monitor uptake of dating scan	ccyymmdd
	I/D	ESTIMATED DATE OF DELIVERY (USS)	Date on which delivery might be expected assuming exact 40 wk gestation, derived from measurement of fetus(es) by ultrasound	Used as a guide for calculation of timing of tests and other interventions, and gestational age at birth for those requiring critical care	ccyymmdd
	I	GESTATION (DATING SCAN)	The gestational age of the fetus(es) as measured by ultrasound scan	Used to monitor uptake of dating scan	ww +d
	I	NO OF FETUSES	Number of fetuses counted on scan	Used to monitor processes for pregnancies according to whether singleton or multiple	
	I	NO OF PLACENTAS	Number of placentas counted on scan	Used to monitor processes for pregnancies according to whether singleton or multiple	
	I	NO OF AMNIONS	Number of amnions counted on scan	Used to monitor processes for pregnancies according to whether singleton or multiple	
Dating Scan Observations: To carry details of each fetus at the dating scan One occurrence of this Group is required for each fetus This group will be collected at the first ultrasound (dating) scan					
	I	OBSERVATION (CROWN RUMP LENGTH)	Record of CRL measurement at dating scan	Used to confirm method of dating EDD	
	I	OBSERVATION (BIPARIETAL DIAMETER)	Record of Biparietal diameter measurement at dating scan	Used to confirm method of dating EDD	
	I	OBSERVATION (HEAD CIRCUMFERENCE MEASUREMENT)	Record of Head Circumference measurement at dating scan	Used to confirm method of dating EDD	
	I	OBSERVATION (FEMUR LENGTH)	Record of Femur Length measurement at dating scan	Used to confirm method of dating EDD	
	I	OBSERVATION (FETAL HEART)	Observation of fetal heart to assess pregnancy viability	Used to monitor screening process and incidence of anomalies	Normal Suspected abnormality Not examined
	I	OBSERVATION (NUCHAL TRANSLUCENCY)	Observation of Nuchal Translucency to assess risk of Downs Syndrome and other anomalies	Used to monitor screening process and incidence of anomalies	Normal Suspected abnormality Not examined
	I	OBSERVATION (ABDOMINAL WALL)	Observation of abdominal wall	Used to monitor screening process and incidence of anomalies	Normal Suspected abnormality Not examined
	I	OBSERVATION (OTHER STRUCTURAL ANOMALY)	Observation of any other congenital abnormality	Used to monitor screening process and incidence of anomalies	Normal Suspected abnormality Not examined

Data Item Number	Data Item Name	Description	Purpose	Values/Format
Antenatal Sickle Cell/Thalassaemia Screening Family Origin: To carry details of family origin which may indicate antenatal screening for Sickle Cell Disease and Thalassaemia traits One occurrence of this Group is required for each of the origins identified by the mother or father This group will normally be collected at the same time on the Family Origin Questionnaire - usually at the FIRST ANTENATAL ASSESSMENT. Input of data should facilitate this, but also allow for them to be recorded at separate times.				
Mother				
	I	FAMILY ORIGIN (MOTHER)	One or more regional origins of mother which may indicate a higher risk for Sickle Cell Disease or Thalassaemia	Used to monitor requirements for screening for Sickle Cell Disease and Thalassaemia	A. AFRICAN OR AFRICAN-CARIBBEAN(BLACK) Caribbean Islands Africa (excluding North Africa) Any other African or African-Caribbean family origins B. SOUTH ASIAN (ASIAN) India or African-Indian Pakistan Bangladesh C. SOUTH EAST ASIAN (ASIAN) China Thailand Malaysia, Vietnam, Philippines etc Any other Asian family origins D. OTHER NON-EUROPEAN (OTHER) North Africa, South America etc Middle East (Saudi Arabia, Iran etc) Any other Non-European family origins E. SOUTHERN & OTHER EUROPEAN (WHITE) Cyprus Greece, Turkey Italy, Portugal, Spain Any other Mediterranean country Albania, Czech Republic, Poland, Romania, Russia etc F. UNITED KINGDOM (WHITE) England, Scotland, N Ireland, Wales G. NORTHERN EUROPEAN (WHITE) Austria, Belgium, Ireland, France, Germany, Netherlands Scandinavia, Switzerland etc Any other European family origins, refer to chart H. DON'T KNOW (incl. pregnancies with donor egg/sperm) I. DECLINED TO ANSWER
	Father			
	I	FAMILY ORIGIN (FATHER)	One or more regional origins of father which may indicate a higher risk for Sickle Cell or Thalassaemia	Used to monitor requirements for screening for Sickle Cell Disease and Thalassaemia	A. AFRICAN OR AFRICAN-CARIBBEAN(BLACK) Caribbean Islands Africa (excluding North Africa) Any other African or African-Caribbean family origins B. SOUTH ASIAN (ASIAN) India or African-Indian Pakistan Bangladesh C. SOUTH EAST ASIAN (ASIAN) China Thailand Malaysia, Vietnam, Philippines etc Any other Asian family origins D. OTHER NON-EUROPEAN (OTHER) North Africa, South America etc Middle East (Saudi Arabia, Iran etc) Any other Non-European family origins E. SOUTHERN & OTHER EUROPEAN (WHITE) Cyprus Greece, Turkey Italy, Portugal, Spain Any other Mediterranean country Albania, Czech Republic, Poland, Romania, Russia etc F. UNITED KINGDOM (WHITE) England, Scotland, N Ireland, Wales G. NORTHERN EUROPEAN (WHITE) Austria, Belgium, Ireland, France, Germany, Netherlands Scandinavia, Switzerland etc Any other European family origins, refer to chart H. DON'T KNOW (incl. pregnancies with donor egg/sperm) I. DECLINED TO ANSWER

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Antenatal Sickle Cell/Thalassaemia Screening: To carry details of antenatal screening for Sickle Cell Disease and Thalassaemia traits					
One occurrence of this Group is required					
This group will normally be collected at the appropriate times on the screening pathway. Frequently the tests are discussed at the same time, consent given at the same time and samples for the various tests taken at the same time - usually at the FIRST ANTENATAL ASSESSMENT. Input of data should facilitate this, but also allow for them to be done at separate times. Testing of the father might be prompted on receipt of an abnormal result for the mother.					
General					
	I	DATE FAMILY ORIGIN QUESTIONNAIRE (MOTHER)	The date on which the family origin questionnaire was filled out for the mother	Used to calculate gestational age	
	D	GESTATION (MOTHER FAMILY ORIGIN QUESTIONNAIRE)	The gestational age when the family origin questionnaire was filled out for the mother	Used to monitor requirements for screening for Sickle Cell Disease and Thalassaemia	
	D	FAMILY ORIGIN QUESTIONNAIRE COMPLETED (MOTHER)	Indicates whether the family origin questionnaire was completed for the mother	Responses recorded on the Family Origin questionnaire form the basis of the decision to screen in low prevalence areas. It is important to the effectiveness of the screening programme to be able to monitor patient response to the request to answer the questions on this form.	Yes No Declined
	I	DATE FAMILY ORIGIN QUESTIONNAIRE (FATHER)	The date on which the family origin questionnaire was filled out for the father	Used to calculate gestational age	
	D	GESTATION (FATHER FAMILY ORIGIN QUESTIONNAIRE)	The gestational age when the family origin questionnaire was filled out for the father	Used to monitor requirements for screening for Sickle Cell Disease and Thalassaemia	
	D	FAMILY ORIGIN QUESTIONNAIRE COMPLETED (FATHER)	Indicates whether the family origin questionnaire was completed for the father	Responses recorded on the Family Origin questionnaire form the basis of the decision to screen in low prevalence areas. It is important to the effectiveness of the screening programme to be able to monitor patient response to the request to answer the questions on this form.	Yes No Declined
	I	HAEMOGLOBINOPATHY SCREENING OFFERED REASON	The reason why haemoglobinopathy screening is offered	Used to monitor requirements for screening for Sickle Cell Disease and Thalassaemia	Not offered High prevalence area Origin other than UK/Northern Europe
	I	HAEMOGLOBINOPATHY SCREENING REQUESTED	Indicates whether haemoglobinopathy screening was requested by the mother	Used to monitor requirements for screening for Sickle Cell Disease and Thalassaemia	Yes No
	D	HAEMOGLOBINOPATHY SCREENING OUTCOME	Whether or not the pregnancy is at risk, derived from screening risk in either/both mother and father	Used to monitor requirements for screening for Sickle Cell Disease and Thalassaemia	Yes No
	D	GESTATIONAL AGE AT (HAEMOGLOBINOPATHY RISK IDENTIFIED)	The gestational age when the risk of SCD or Thalassaemia was identified	Used to monitor requirements for screening for Sickle Cell Disease and Thalassaemia	ww +d

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Mother					
	I	OFFER STATUS (MOTHER HAEMOGLOBINOPATHY TEST)	Whether or not a mother was offered a screening test and whether or not she declined or accepted. The final value should be reported, including where a woman changes her decision. The default value would be 'Not offered', once explained and discussed but without a decision 'Offered and considering' should be chosen, when a decision is arrived at 'Offered and declined' or 'Offered and accepted' should be chosen.	Used to monitor requirements for screening for Sickle Cell Disease and Thalassaemia	Not offered Offered and considering Offered and declined Offered and accepted Previous screening result available
	I	OFFER STATUS DATE (MOTHER HAEMOGLOBINOPATHY TEST)	The date on which the test was explained and offered	Used to monitor requirements for screening for Sickle Cell Disease and Thalassaemia	ccyymmdd
	D	GESTATION (MOTHER OFFER HAEMOGLOBINOPATHY TEST)	Gestational age at date mother was offered haemoglobinopathy testing	Used to monitor requirements for screening for Sickle Cell Disease and Thalassaemia	ww +d
Father					
	I	OFFER STATUS (FATHER HAEMOGLOBINOPATHY TEST)	Whether or not a father was offered a screening test and whether or not she declined or accepted. The final value should be reported, including where a woman changes her decision. The default value would be 'Not offered', once explained and discussed but without a decision 'Offered and considering' should be chosen, when a decision is arrived at 'Offered and declined' or 'Offered and accepted' should be chosen.	Used to monitor requirements for screening for Sickle Cell Disease and Thalassaemia	Not offered Father not available Offered and considering Offered and declined Offered and accepted Previous screening result available
	I	OFFER STATUS DATE (FATHER HAEMOGLOBINOPATHY TEST)	The date on which the test was explained and offered	Used to monitor requirements for screening for Sickle Cell Disease and Thalassaemia	ccyymmdd
	D	GESTATION (FATHER OFFER HAEMOGLOBINOPATHY TEST)	Gestational age at date father was offered haemoglobinopathy testing	Used to monitor requirements for screening for Sickle Cell Disease and Thalassaemia	ww +d

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Antenatal Sickle Cell/Thalassaemia Screening Tests: To carry details of antenatal screening tests for Sickle Cell Disease and Thalassaemia traits One occurrence of this Group is required for each test This group will normally be collected at the appropriate times on the various screening pathways. Frequently the tests are discussed at the same time, consent given at the same time and samples for the various tests taken at the same time - usually at the FIRST ANTENATAL ASSESSMENT. Input of data should facilitate this, but also allow for them to be done at separate times. Testing of the father might be prompted on receipt of an abnormal result for the mother. Laboratory items may be sent to the electronic record electronically, or may be manually input. Where previous test results are available indicating normal or abnormal haemoglobinopathies, these should be included for this pregnancy. A test may need to be repeated.					
	I	HAEMOGLOBINOPATHY SCREENING SUBJECT	The parent to which this test is attributable	Used to monitor requirements for screening for Sickle Cell Disease and Thalassaemia	Mother Father
	I	BLOOD TEST SAMPLE DATE (HAEMOGLOBINOPATHY TEST)	Date blood test sample taken	Used to monitor requirements for screening for Sickle Cell Disease and Thalassaemia	ccyymmdd
	D	GESTATIONAL AGE AT (HAEMOGLOBINOPATHY TEST)	Gestational age derived from AGREED EDD if available or EDD(LMP) when blood test taken	Used to monitor requirements for screening for Sickle Cell Disease and Thalassaemia	ww +d
	I	SCREENING TEST LAB RECEIPT DATE (HAEMOGLOBINOPATHY TEST)	Date on which laboratory received the sample if this is available by message from laboratory system to care record	Used to monitor requirements for screening for Sickle Cell Disease and Thalassaemia	ccyymmdd
	I	INVESTIGATION RESULT DATE TIME (HAEMOGLOBINOPATHY TEST)	The date on which an investigation was concluded e.g. the date the result was authorised.	Used to monitor requirements for screening for Sickle Cell Disease and Thalassaemia	ccyymmdd hh:mm
	D	TIME FROM LABORATORY RECEIPT OF SAMPLE TO REPORT ISSUE (HAEMOGLOBINOPATHY TEST)	Working days between SCREENING TEST LAB RECEIPT DATE and INVESTIGATION RESULT DATE	Used to monitor requirements for screening for Sickle Cell Disease and Thalassaemia	
	I	INVESTIGATION RESULT (HAEMOGLOBINOPATHY TEST)	Hb phenotype result of screening for SCD/Thal. The result of a screening test prior to this pregnancy should also be included	Used to monitor requirements for screening for Sickle Cell Disease and Thalassaemia and as an indicator for risk to baby	
	I	SCREENING RESULT INFORMING DATE (HAEMOGLOBINOPATHY TEST)	Date on which result of haemoglobinopathy screening was informed to mother	Used to monitor requirements for screening for Sickle Cell Disease and Thalassaemia	ccyymmdd
	I	SCREENING RESULT INFORMING METHOD (HAEMOGLOBINOPATHY TEST)	How result of haemoglobinopathy screening was communicated to mother	Used to monitor requirements for screening for Sickle Cell Disease and Thalassaemia	Telephone Letter Personal visit Antenatal clinic
	I	SCREENING OUTCOME (HAEMOGLOBINOPATHY TEST)	The derived outcome of screening for SCD/Thalassaemia	Used to monitor requirements for screening for Sickle Cell Disease and Thalassaemia	0 Not tested 1 NAD (AA) 2 Non-significant carrier (AGPhiladelphia or αthal/iron deficiency from low risk group) 3 Non-significant homozygote (DIran/DIran) 4 Significant carrier (AS, AC, ADPunjab, AE, AOArab, ALepore, βthal trait, βδthal trait, or αthal/iron deficiency from high risk group) 5 Significant disorder (SS, SC, SD, SE, SOArab, Sβthal) 6 Repeat required (Any variant or condition not yet identified) 7 Result pending (Any variant or condition not yet identified) 8 Declined testing

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Antenatal Haemoglobinopathy Screening Follow Up: To carry details of options following high risk screening Sickle Cell and Thalassaemia					
One occurrence of this Group is required					
This group will normally be collected at the appropriate times on the screening pathway or derived from such items					
	I	POST SCREENING FOLLOW UP APPOINTMENT (HAEMOGLOBINOPATHY)	Evidence of a follow up appointment with a Specialist Midwife or Consultant to discuss positive screening for Sickle Cell and Thalassaemia	Used to monitor screening process	
	I	POST SCREENING FOLLOW UP DATE (HAEMOGLOBINOPATHY)	Date of a follow up appointment with a Specialist Midwife or Consultant to discuss positive screening for Sickle Cell and Thalassaemia	Used to monitor screening process	ccyymmdd
	I	OFFER DIAGNOSTIC TESTING (HAEMOGLOBINOPATHY)	Evidence of an appointment at which diagnostic testing was offered	Used to monitor screening process	
	I	OFFER DATE DIAGNOSTIC TESTING (HAEMOGLOBINOPATHY)	Date diagnostic testing was offered	Used to monitor screening process	ccyymmdd
	I	OFFER STATUS (HAEMOGLOBINOPATHY DIAGNOSTIC TESTING)	Whether or not a mother was offered a diagnostic test and whether or not she declined or accepted. The final value should be reported, including where a woman changes her decision. The default value would be 'Not offered', once explained and discussed but without a decision 'Offered and considering' should be chosen, when a decision is arrived at 'Offered and declined' or 'Offered and accepted' should be chosen.	Used to monitor screening process	Not offered Offered and considering Offered and declined Offered and accepted

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Downs Syndrome Screening: To carry details of screening for Downs Syndrome One occurrence of this Group is required This group will normally be collected at the appropriate times on the screening pathway or derived from such items					
	I	DATE DOWNS SYNDROME SCREENING LEAFLET GIVEN	The date on which the pregnant woman was given the leaflet, or other appropriate information, on screening for Downs Syndrome	Used to monitor screening process and uptake of routine screening	ccyymmdd
	I	SCREENING OFFER STATUS (DOWNS SYNDROME)	Whether or not screening for Downs Syndrome was offered, accepted or declined	Used to monitor screening process and uptake of routine screening	Not offered Not eligible Alternative choice Offered and considering Offered and declined Offered and accepted
	I	SCREENING OFFER DATE (DOWNS SYNDROME)	Date screening for Downs Syndrome was offered	Used to monitor screening process and uptake of routine screening	ccyymmdd
	D	GESTATION (SCREENING OFFER DOWNS SYNDROME)	Gestation at offer of Downs Syndrome screening	Used to monitor screening process and uptake of routine screening	ww +d
	D	DOWNS SYNDROME SCREENING METHOD	The complete list of the techniques used to screen for Downs Syndrome in this pregnancy derived from the serum screening tests and observation of nuchal translucency (NT) between 11 to 13 weeks and 6 days gestation	Used to monitor screening process and uptake of routine screening	NT 1st trimester biochemistry NT plus 1st trimester biochemistry NT plus 1st and 2nd trimester biochemistry 1st plus 2nd trimester biochemistry 2nd trimester biochemistry
Downs Syndrome Serum tests: To carry details of the serum tests offered and undertaken for screening for Downs Syndrome One occurrence of this Group is required for each test offered This group will normally be collected at the appropriate times on the screening pathway. Tests may be discussed, consent given and samples for the various tests taken at the same time. Input of data should facilitate this, but also allow for them to be done at separate times. Testing at different times in the pregnancy may be undertaken according to individual unit policy or because of when the woman accesses maternity services. Markers for other chromosomal disorders, eg Edwards or Patau, may also be detected					
	I	SCREENING TEST TYPE (DOWNS SYNDROME)	Type of test for Downs Syndrome Screening	Used to monitor uptake of screening and identification of anomalies identified through screening	1st trimester biochemistry 2nd trimester biochemistry
	I	SCREENING BLOOD TEST SAMPLE DATE (DOWNS SYNDROME)	Date blood test sample taken for Downs Syndrome screening	Used to monitor screening process and uptake of routine screening	
	D	GESTATIONAL AGE AT (SCREENING DOWNS SYNDROME)	Gestational age derived from AGREED EDD when blood test taken. NB EDD must be agreed by dating scan before screening as per Working Standards for Down's Syndrome Screening.	Used to monitor screening process and uptake of routine screening	
	D	DATING SCAN PRIOR TO DOWNS SYNDROME SCREENING	A value derived from a check that the DATING SCAN had been carried out prior to this screening test for Downs Syndrome	Used to monitor screening process and uptake of routine screening	Yes No
	I	SCREENING INVESTIGATION RESULT (DOWNS SYNDROME)	Risk rating of screening test	Used to monitor screening process and uptake of routine screening	
	I	SCREENING INVESTIGATION RESULT DATE (DOWNS SYNDROME)	The date on which an investigation was concluded e.g. the date the result was authorised.		
		SCREENING INVESTIGATION RESULT TIME (DOWNS SYNDROME)	The time at which an investigation was concluded e.g. the time the result was authorised		
	I	SCREENING RESULT INFORMING DATE (DOWNS SYNDROME)	Date on which mother was informed of the result of screening for Downs Syndrome	Used to monitor screening process	
	I	SCREENING RESULT INFORMING METHOD (DOWNS SYNDROME)	The way in which the mother was informed of the result of screening for Downs Syndrome	Used to monitor screening process	Telephone Letter Personal visit Antenatal clinic
	I	SCREENING RESULT PROFESSIONAL INFORMING (DOWNS SYNDROME)	Professional status of person who informs mother of results of screening for Downs Syndrome	Used to monitor screening process	GP Midwife Consultant Sonographer Clerical Other

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Downs Syndrome Screening Follow Up: To carry details of options following high risk screening for Downs Syndrome One occurrence of this Group is required This group will normally be collected at the appropriate times on the screening pathway or derived from such items. It is also to be collected where factors such as maternal age may prompt diagnostic testing irrespective of other screening.					
	I	POST SCREENING FOLLOW UP APPOINTMENT (DOWNS SYNDROME)	Evidence of a follow up appointment with a Specialist Midwife or Consultant to discuss positive screening for Downs Syndrome	Used to monitor screening process	
	I	POST SCREENING FOLLOW UP DATE (DOWNS SYNDROME)	Date of a follow up appointment with a Specialist Midwife or Consultant to discuss positive screening for Downs Syndrome	Used to monitor screening process	
	I	POST SCREENING REFERRAL (CARDIAC SCAN FOR DOWNS SYNDROME)	Evidence of a referral for cardiac scan	Used to monitor screening process	
	I	OFFER REASON DIAGNOSTIC TESTING (DOWNS SYNDROME)	Reason for offering diagnostic testing	Used to monitor screening process	High risk Past history USS indication Other (inc Maternal age)
	I	OFFER DIAGNOSTIC TESTING (DOWNS SYNDROME)	Evidence of an appointment at which diagnostic testing was offered	Used to monitor screening process	
	I	OFFER DATE DIAGNOSTIC TESTING (DOWNS SYNDROME)	Date diagnostic testing was offered	Used to monitor screening process	
	I	OFFER STATUS (DOWNS SYNDROME DIAGNOSTIC TESTING)	Whether or not a mother was offered a diagnostic test and whether or not she declined or accepted. The final value should be reported, including where a woman changes her decision. The default value would be 'Not offered', once explained and discussed but without a decision 'Offered and considering' should be chosen, when a decision is arrived at 'Offered and declined' or 'Offered and accepted' should be chosen.	Used to monitor screening process	Not offered Offered and considering Offered and declined Offered and accepted

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Neural Tube Defect Screening: To carry details of screening for neural tube defects					
One occurrence of this Group is required					
This group will normally be collected at the appropriate times on the screening pathway or derived from such items					
			Maternal Serum Screening (AFP)		
	I	SCREENING OFFER STATUS (NEURAL TUBE DEFECT)	Whether or not maternal serum screening for neural tube defects was offered, accepted or declined	Used to monitor screening process and uptake of routine screening	Not offered Not eligible Offered and considering Offered and declined Offered and accepted
	I	SCREENING OFFER DATE (NEURAL TUBE DEFECT)	Date maternal serum screening for neural tube defects was offered	Used to monitor screening process and uptake of routine screening	ccyymmdd
	I	SCREENING BLOOD TEST SAMPLE DATE (NEURAL TUBE DEFECT)	Date blood test sample taken for neural tube defect screening	Used to monitor screening process and uptake of routine screening	ccyymmdd
	D	GESTATIONAL AGE AT (SCREENING NEURAL TUBE DEFECT)	Gestational age derived from AGREED EDD when blood test taken. NB EDD must be agreed by dating scan before screening as per Working Standards for Down's Syndrome Screening.	Used to monitor screening process and uptake of routine screening	ww +d
	I	SCREENING INVESTIGATION RESULT (NEURAL TUBE DEFECT)	Risk rating of screening test	Used to monitor screening process and uptake of routine screening	
	I	SCREENING INVESTIGATION RESULT DATE TIME (NEURAL TUBE DEFECT)	The date on which an investigation was concluded e.g. the date the result was authorised.		ccyymmdd hh:mm
	I	SCREENING RESULT INFORMING DATE (NEURAL TUBE DEFECT)	Date on which mother was informed of the result of screening for neural tube defects	Used to monitor screening process	ccyymmdd
	I	SCREENING RESULT INFORMING METHOD (NEURAL TUBE DEFECT)	The way in which the mother was informed of the result of screening for neural tube defects	Used to monitor screening process	Telephone Letter Personal visit Antenatal clinic
	I	SCREENING RESULT PROFESSIONAL INFORMING (NEURAL TUBE DEFECT)	Professional status of person who informs mother of results of screening for neural tube defects	Used to monitor screening process	GP Midwife Consultant Sonographer Clerical Other

Data Item Number	Data Item Name	Description	Purpose	Values/Format
Rhesus Antibodies: To carry details of 28 week check for Rhesus antibodies				
One occurrence of this Group is required				
This group will be collected at the appropriate time on the maternity pathway for non-sensitised Rhesus -ve mothers				
I	SCREENING OFFER STATUS (MOTHER RHESUS ANTIBODIES 28 WEEKS)	Whether or not a mother was offered a screening test and whether or not she declined or accepted. The final value should be reported, including where a woman changes her decision. The default value would be 'Not offered', once explained and discussed but without a decision 'Offered and considering' should be chosen, when a decision is arrived at 'Offered and declined' or 'Offered and accepted' should be chosen.	Used to monitor implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve and their babies	Not offered Already sensitised Father Rh-ve Baby Rh-ve Offered and considering Offered and declined Offered and accepted
I	SCREENING OFFER STATUS DATE (MOTHER RHESUS ANTIBODIES 28 WEEKS)	The date on which the test was explained and offered	Used to monitor implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve and their babies	ccyymmdd
I	SCREENING BLOOD TEST SAMPLE DATE (MOTHER RHESUS ANTIBODIES 28 WEEKS)	Date of test for RhD Antibodies	Used to monitor implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve and their babies	ccyymmdd
D	GESTATIONAL AGE AT (MOTHER RHESUS ANTIBODIES 28 WEEKS)	Gestational age derived from AGREED EDD if available or EDD(LMP) when blood test taken	Used to monitor implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve and their babies	ww +d
I	SCREENING INVESTIGATION RESULT (MOTHER RHESUS ANTIBODIES 28 WEEKS)	Result of test for RhD Antibodies	Used to monitor implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve and their babies	
	SCREENING INVESTIGATION RESULT DATE TIME (MOTHER RHESUS ANTIBODIES 28 WEEKS)	The date/time on which an investigation was concluded e.g. the date the result was authorised.	Used to monitor implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve and their babies	ccyymmdd hh:mm

Data Item Number	Data Item Name	Description	Purpose	Values/Format
Routine Antenatal Anti-D Prophylaxis: To carry details of Routine Antenatal Anti-D Prophylaxis (RAADP)				
One occurrence of this Group is required for each administration of Anti-D vaccination				
This group will be collected at the appropriate times on the maternity pathway for non-sensitised Rhesus -ve mothers. Vaccinations at 28 weeks and 34 weeks are recommended, however other regimes, eg a single vaccination at 30 weeks are also used. A further vaccination is recommended postnatally.				
I	DRUG TREATMENT (RAADP)	Administration of Anti-D Immunoglobulin as part of RAADP	Used to monitor implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve and their babies	
I	ANTI-D PROPHYLAXIS DOSAGE (RAADP)	The dosage of Anti-D Immunoglobulin given as part of RAADP Recommendation is for 500IU at 28 and 34 weeks, but other regimes may be used	Used to monitor implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve and their babies	
I	DRUG TREATMENT DATE TIME (RAADP)	Date/time of routine antenatal Anti-D Prophylaxis (RAADP) treatment	Used to monitor implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve and their babies	ccyymmdd hh:mm
D	GESTATIONAL AGE AT (RAADP)	Gestational age when routine antenatal Anti-D Prophylaxis (RAADP) was administered	Used to monitor implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve and their babies	ww +d
Routine Antenatal Anti-D Prophylaxis Monitoring: To carry details of routine antenatal Anti-D Prophylaxis regime				
One occurrence of this Group is required				
This group will be derived from items on the maternity pathway for non-sensitised Rhesus -ve mothers. Vaccinations 500 IU at 28 weeks and 34 weeks are recommended, however other regimes, eg a single vaccination at 30 weeks are also used. A further vaccination is recommended postnatally.				
I	DRUG TREATMENT OFFER STATUS (RAADP)	Status of whether or not woman has been offered routine antenatal Anti-D Prophylaxis (RAADP)	Used to identify reasons why a Rh-ve mother may not have had anti-D prophylaxis	Not offered Already sensitised Father Rh-ve Baby Rh-ve No further pregnancies planned Offered and considering Offered and declined Offered and accepted
I	DRUG TREATMENT OFFER STATUS DATE (RAADP)	The date routine antenatal Anti-D Prophylaxis (RAADP) was offered	Used to monitor implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve and their babies	ccyymmdd
I/D	ROUTINE ANTENATAL ANTI-D PROPHYLAXIS COMPLETE	Whether or not a non-sensitised Rh-ve woman received DRUG TREATMENT (RAADP) at 28 and 34 wks gestation, or a single dose at 30 weeks	Used to monitor implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve and their babies	RAADP at 28 & 34 weeks RAADP other regimen Not required Not complete
D	ROUTINE POSTNATAL ANTI-D PROPHYLAXIS COMPLETE	Whether or not a non-sensitised Rh-ve woman received DRUG TREATMENT (RAADP) postnatally	Used to monitor implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve and their babies	Yes No

Data Item Number	Data Item Name	Description	Purpose	Values/Format
Sensitising event: To carry details of Antenatal Anti-D Prophylaxis (AADP) after a sensitising event				
One occurrence of this Group is required for each event				
This group will be collected at the appropriate time on the maternity pathway for non-sensitised Rhesus -ve mothers				
I	RhD SENSITISING EVENT	An event which would or could potentially lead to the sensitisation of the woman to RhD antigen: PROCEDURE (AMNIOCENTESIS) PROCEDURE (CVS) EVENT (CLOSED ABDOMINAL INJURY) PROCEDURE (ECV) PROCEDURE (THERAPEUTIC TOP) DIAGNOSIS (MISCARRIAGE AFTER 12 WEEKS) PROCEDURE (INTERVENTION FOR INCOMPLETE ABORTION) DIAGNOSIS (THREATENED MISCARRIAGE)	Used to monitor implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve and their babies	
I	RhD SENSITISING EVENT DATE TIME	Date/time of the RhD SENSITISING EVENT	Used to calculate whether or not DRUG TREATMENT (AADP) was given within 72 hours of RhD SENSITISING EVENT	ccyymmdd hh:mm
I	DRUG TREATMENT OFFER STATUS (AADP)	Status of whether or not woman has been offered Antenatal Anti-D Prophylaxis	Used to identify reasons why a Rh-ve mother may not have had anti-D prophylaxis	Not offered Already sensitised Father Rh-ve Baby Rh-ve No further pregnancies planned Offered and considering Offered and declined Offered and accepted
I	DRUG TREATMENT OFFER STATUS DATE (AADP)	The date Antenatal Anti-D Prophylaxis was offered	Used to monitor implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve and their babies	ccyymmdd
I	DRUG TREATMENT (AADP)	Administration of Anti-D Immunoglobulin as part of AADP	Used to monitor implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve and their babies	
I	ANTI-D PROPHYLAXIS DOSAGE (AADP)	The dosage of Anti-D Immunoglobulin given as part of AADP A dose of 250iu is recommended for prophylaxis following sensitising events up to 20 weeks of pregnancy. For all events after 20 weeks, at least 500iu anti-D Ig should be given followed by a test to identify FMH greater than 4ml red cells; additional anti-D Ig should be given as required (RCOG Green Top Guideline 22)	Used to monitor implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve and their babies	
I	DRUG TREATMENT DATE TIME (AADP)	Date/time of treatment with Anti-D Immunoglobulin as part of AADP	Used to monitor implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve and their babies	ccyymmdd hh:mm
D	TIME TO ANTENATAL ANTI-D PROPHYLAXIS	The number of hours between a sensitising event and DRUG TREATMENT (AADP) - standard is within 72 hrs of sensitising event or potentially sensitising event	Used to monitor implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve and their babies	hrs

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Postnatal Anti-D Prophylaxis: To carry details of Postnatal Anti-D Prophylaxis (PADP)					
One occurrence of this Group is required					
This group will be collected at the appropriate time on the maternity pathway for non-sensitised Rhesus -ve mothers					
	I	DRUG TREATMENT OFFER STATUS (PADP)	Status of whether or not woman has been offered Postnatal Anti-D Prophylaxis	Used to identify reasons why a Rh-ve mother may not have had anti-D prophylaxis	Not offered Already sensitised Father Rh-ve Baby Rh-ve No further pregnancies planned Offered and considering Offered and declined Offered and accepted
	I	DRUG TREATMENT OFFER STATUS DATE (PADP)	The date Postnatal Anti-D Prophylaxis was offered	Used to monitor implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve and their babies	ccyymmdd
	I	DRUG TREATMENT (PADP)	Administration of Anti-D Immunoglobulin as part of Postnatal Anti-D Prophylaxis	Used to monitor implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve and their babies	
	I	ANTI-D PROPHYLAXIS DOSAGE (PADP)	The dosage of Anti-D Immunoglobulin given postnatally At least 500iu of anti-D Ig must be given to every non-sensitised RhD negative woman within 72 hours following the delivery of a RhD positive infant (RCOG Green Top Guideline 22)	Used to monitor implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve and their babies	
	I	DRUG TREATMENT DATE TIME (PADP)	Date/time of treatment with Anti-D Immunoglobulin as part of Postnatal Anti-D Prophylaxis	Used to monitor implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve and their babies	ccyymmdd hh:mm
	D	TIME TO POSTNATAL ANTI-D PROPHYLAXIS	The number of hours between delivery and DRUG TREATMENT (PADP) - standard is within 72 hrs following delivery	Used to monitor implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve and their babies	hrs

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Diagnostic Tests: To carry details of antenatal diagnostic tests One occurrence of this Group is required for each sample This group will normally be collected at the appropriate times on the testing pathway. Laboratory items may be sent to the electronic record electronically, or may be manually input. A test may need to be repeated, but only the details of a subsequent successful specimen are required. For multiple pregnancies with more than one chorion/amnion, a sample may be taken from each and the results should be attributable to the correct one. Tests may be required for diagnosis of Downs Syndrome or other chromosomal disorders and Sickle Cell and Thalassaemia disorders with or without prior screening.					
	I	DIAGNOSTIC TEST REASON	The condition for which diagnostic testing is undertaken	Used to monitor requirements for screening	Downs Syndrome Haemoglobinopathy Other Multiple
	I	DIAGNOSTIC TEST REASON (DOWNS SYNDROME)	The condition for which diagnostic testing is undertaken	Used to monitor requirements for screening	High risk Past history USS indication Other (inc Maternal age)
	I	DIAGNOSTIC TESTING INFORMATION GIVEN	Evidence that information was given to the mother about diagnostic testing	Used to monitor screening process	
	I	OFFER DIAGNOSTIC TESTING	Evidence of an appointment at which diagnostic testing was offered	Used to monitor screening process	
	I	OFFER DATE DIAGNOSTIC TESTING	Date diagnostic testing was offered	Used to monitor screening process	
	I	OFFER STATUS DIAGNOSTIC TESTING	Whether or not a mother was offered a diagnostic test and whether or not she declined or accepted. The final value should be reported, including where a woman changes her decision. The default value would be 'Not offered', once explained and discussed but without a decision 'Offered and considering' should be chosen, when a decision is arrived at 'Offered and declined' or 'Offered and accepted' should be chosen.	Used to monitor screening process	Not offered Offered and considering Offered and declined Offered and accepted
	I	DIAGNOSTIC TEST DATE	The date on which the diagnostic test took place	Used to monitor requirements for screening	
	D	GESTATIONAL AGE AT (DIAGNOSTIC TESTING)	Gestational age derived from AGREED EDD if available or EDD(LMP) when test taken	Used to monitor requirements for screening	
	I	PROCEDURE (DIAGNOSTIC TESTING)	Type of diagnostic procedure	Used to monitor screening process	Amniocentesis CVS
	I	PROCEDURE APPROACH (DIAGNOSTIC TESTING)	The approach method for amniocentesis	Used to monitor screening process	Transabdominal Transvaginal
	I	PRACTITIONER (DIAGNOSTIC TESTING)	Identifier of person carrying out diagnostic test	Used to monitor screening process	
	I	DIAGNOSTIC TEST LAB RECEIPT DATE	Date on which laboratory received the sample	Used to monitor requirements for screening	
	I	DIAGNOSTIC TESTING (TECHNIQUE)	Technique used for diagnostic testing	Used to monitor screening process	Karyotype QPCR FISH DNA Microarray Other
	I	DIAGNOSTIC TEST LAB REPORT ISSUED DATE	Date on which the laboratory issued the report giving the results of the diagnostic test	Used to monitor requirements for screening	
		INVESTIGATION RESULT TIME (DIAGNOSTIC TESTING)	The time at which an investigation was concluded e.g. the time the result was authorised	Used to monitor requirements for screening	
	D	TIME FROM DIAGNOSTIC TEST TO RECEIPT OF RESULTS	Working days between diagnostic test and date informed of results	Used to monitor screening process	
	I	INVESTIGATION RESULT INFORMING DATE (DIAGNOSTIC TESTING)	Date on which result of diagnostic testing was informed to parents	Used to monitor requirements for screening	

Data Item Number		Data Item Name	Description	Purpose	Values/Format
	I	INVESTIGATION RESULT INFORMING METHOD (DIAGNOSTIC TESTING)	How result of diagnostic testing was communicated to parents	Used to monitor requirements for screening	Telephone Letter Personal visit Antenatal clinic
	I	DIAGNOSTIC TEST RESULT SPECIALIST INFORMING	Specialist who informs parents of results of diagnostic testing	Used to monitor screening process	GP Midwife Consultant Other
	I	DATE OF REQUEST FOR TERMINATION	Date on which parents requested termination	Used to monitor screening process	
	D	TIME FROM RECEIPT OF RESULTS TO REQUEST FOR TERMINATION	Where a termination has been requested, the number of working days between being informed of results and requesting termination	Used to monitor screening process	
Diagnostic Test Result: To carry details of antenatal diagnostic tests One occurrence of this Group is required for each disorder identified This group will be provided by the laboratory. Laboratory items may be sent to the electronic record electronically, or may be manually input. See also Fetal Anomaly diagnosis					
	I	INVESTIGATION RESULT (DIAGNOSTIC TESTING)	Details of the Hb phenotype or chromosomal disorder detected or NAD. Also may indicate where a repeat sample is required	Used to monitor requirements for screening	

Data Item Number	Data Item Name	Description	Purpose	Values/Format
Fetal Anomaly Screening: To carry details of the "20 week" Anomaly Scan One occurrence of this Group is required for each scan and each fetus This group will be collected at the routine scan for fetal anomalies. A scan may need to be repeated.				
	I	ACTIVITY (ULTRASOUND FETAL ANOMALY SCREENING)	List of items from RCOG July 2000 Supplement to Ultrasound Screening for Fetal Abnormalities Appendix 1	
	I	ACTIVITY DATE (ULTRASOUND FETAL ANOMALY SCREENING INFORMATION)	Date on which the leaflet explaining fetal anomaly screening was given	Used to monitor the correct information is given to all mothers regarding fetal anomaly screening	ccyymmdd
	I	ACTIVITY STATUS (ULTRASOUND FETAL ANOMALY SCREENING)	Whether or not fetal anomaly screening was offered, accepted or declined	Used to monitor the uptake and provision of fetal anomaly screening	
	I	ACTIVITY DATE (ULTRASOUND FETAL ANOMALY SCREENING)	Date on which fetal anomaly screening was undertaken	Used to monitor the uptake and provision of fetal anomaly screening	ccyymmdd
	I	PROFESSIONAL STATUS (ULTRASOUND FETAL ANOMALY SCREENING)	Profession of person conducting the ultrasound fetal anomaly screening	Used to monitor the uptake and provision of fetal anomaly screening	Obstetrician Radiologist Radiographer Sonographer Midwife sonographer
	D	GESTATIONAL AGE (ULTRASOUND FETAL ANOMALY SCREENING)	Gestational age when fetal anomaly screening was undertaken	Used to monitor the uptake and provision of fetal anomaly screening	ww +d
	I	ULTRASOUND FETAL ANOMALY SCREENING REPORT DATE ISSUED	Date on which report of results of Ultrasound fetal anomaly screening was issued	Used to monitor the timeliness of report being issued	ccyymmdd
Fetal Anomaly Screening Results: To carry details of the observations at the "20 week" Anomaly Scan One occurrence of this Group is required for each scan and each fetus This group will be collected at the routine scan for fetal anomalies. A scan may need to be repeated.				
	I	ULTRASOUND FETAL ANOMALY SCREENING (SKULL & VENTRICLES)	Whether or not the item was examined, problem suspected, ... values	Used to monitor success of identification of anomalies identified through screening	Normal Definite abnormality Suspicious abnormality Not examined
	I	ULTRASOUND FETAL ANOMALY SCREENING (CEREBELLUM)	Whether or not the item was examined, problem suspected, ... values	Used to monitor success of identification of anomalies identified through screening	Normal Definite abnormality Suspicious abnormality Not examined
	I	ULTRASOUND FETAL ANOMALY SCREENING (SPINE Tx)	Whether or not the item was examined, problem suspected, ... values	Used to monitor success of identification of anomalies identified through screening	Normal Definite abnormality Suspicious abnormality Not examined
	I	ULTRASOUND FETAL ANOMALY SCREENING (STOMACH/DIAPHRAGM)	Whether or not the item was examined, problem suspected, ... values	Used to monitor success of identification of anomalies identified through screening	Normal Definite abnormality Suspicious abnormality Not examined
	I	ULTRASOUND FETAL ANOMALY SCREENING (KIDNEYS & BLADDER)	Whether or not the item was examined, problem suspected, ... values	Used to monitor success of identification of anomalies identified through screening	Normal Definite abnormality Suspicious abnormality Not examined
	I	ULTRASOUND FETAL ANOMALY SCREENING (SPINE LONG)	Whether or not the item was examined, problem suspected, ... values	Used to monitor success of identification of anomalies identified through screening	Normal Definite abnormality Suspicious abnormality Not examined
	I	ULTRASOUND FETAL ANOMALY SCREENING (THORAX 4 CHAMBER CARDIAC VIEW)	Whether or not the item was examined, problem suspected, ... values	Used to monitor success of identification of anomalies identified through screening	Normal Definite abnormality Suspicious abnormality Not examined
	I	ULTRASOUND FETAL ANOMALY SCREENING (ARMS 3 BONES AND HAND LEFT)	Whether or not the item was examined, problem suspected, ... values	Used to monitor success of identification of anomalies identified through screening	Normal Definite abnormality Suspicious abnormality Not examined

Data Item Number		Data Item Name	Description	Purpose	Values/Format
	I	ULTRASOUND FETAL ANOMALY SCREENING (ARMS 3 BONES AND HAND RIGHT)	Whether or not the item was examined, problem suspected, ... values	Used to monitor success of identification of anomalies identified through screening	Normal Definite abnormality Suspicious abnormality Not examined
	I	ULTRASOUND FETAL ANOMALY SCREENING (LEGS 3 BONES AND FOOT LEFT)	Whether or not the item was examined, problem suspected, ... values	Used to monitor success of identification of anomalies identified through screening	Normal Definite abnormality Suspicious abnormality Not examined
	I	ULTRASOUND FETAL ANOMALY SCREENING (LEGS 3 BONES AND FOOT RIGHT)	Whether or not the item was examined, problem suspected, ... values	Used to monitor success of identification of anomalies identified through screening	Normal Definite abnormality Suspicious abnormality Not examined
	I	ULTRASOUND FETAL ANOMALY SCREENING (LVOT)	Whether or not the item was examined, problem suspected, ... values	Used to monitor success of identification of anomalies identified through screening	Normal Definite abnormality Suspicious abnormality Not examined
	I	ULTRASOUND FETAL ANOMALY SCREENING (RVOT)	Whether or not the item was examined, problem suspected, ... values	Used to monitor success of identification of anomalies identified through screening	Normal Definite abnormality Suspicious abnormality Not examined
	I	ULTRASOUND FETAL ANOMALY SCREENING (FACE)	Whether or not the item was examined, problem suspected, ... values	Used to monitor success of identification of anomalies identified through screening	Normal Definite abnormality Suspicious abnormality Not examined
	I	ULTRASOUND FETAL ANOMALY SCREENING (LIPS)	Whether or not the item was examined, problem suspected, ... values	Used to monitor success of identification of anomalies identified through screening	Normal Definite abnormality Suspicious abnormality Not examined
	I	ULTRASOUND FETAL ANOMALY SCREENING (AORTIC ARCH)	Whether or not the item was examined, problem suspected, ... values	Used to monitor success of identification of anomalies identified through screening	Normal Definite abnormality Suspicious abnormality Not examined
	I	ULTRASOUND FETAL ANOMALY SCREENING (CORD INSERTION)	Whether or not the item was examined, problem suspected, ... values	Used to monitor success of identification of anomalies identified through screening	Normal Definite abnormality Suspicious abnormality Not examined
	I	ULTRASOUND FETAL ANOMALY SCREENING (OTHER ANOMALY)	Whether or not the item was examined, problem suspected, ... values	Used to monitor success of identification of anomalies identified through screening	Normal Definite abnormality Suspicious abnormality Not examined
	I	ULTRASOUND FETAL ANOMALY SCREENING OUTCOME	Whether or not any follow up action from this scan is required	Used to monitor success of identification of anomalies identified through screening	NAD Repeat scan Fetal medicine referral Follow up by midwife/obstetrician ...
Fetal Diagnosis: To carry details of any diagnosis made antenatally One occurrence of this Group is required for each diagnosis and for each fetus This group will normally be collected at the appropriate time on the maternity pathway. A scan may need to be repeated.					
	I	INVESTIGATION RESULT (FETAL ANOMALY)	A diagnosis of a fetal anomaly made by the use of ultrasound scan	Used to monitor requirements for screening	

Data Item Number	Data Item Name	Description	Purpose	Values/Format
Termination of Pregnancy: To carry details of terminations following diagnosis of fetal anomaly, genetic or other condition				
One occurrence of this Group is required				
This group will normally be collected during care of the mother after a confirmed diagnosis				
				Not for TOP stats which are available from DH
	I	DATE REQUEST TERMINATION	Date termination was requested	Used to monitor screening process	ccyymmdd
	I	PROCEDURE DATE (TOP)	Date of Termination of Pregnancy	Used to monitor screening process	ccyymmdd
	D	GESTATIONAL AGE AT (TOP)	Gestational age at Termination of Pregnancy	Used to monitor screening process	ww +d

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Other Ultrasound Scans: To carry details of any other Ultrasound Scans					
One occurrence of this Group is required for each scan and each fetus					
This group will be collected at each ultrasound scan					
	I	ACTIVITY (ANTENATAL ULTRASOUND SCAN)			
	I	ACTIVITY DATE (ANTENATAL ULTRASOUND SCAN)	Date on which antenatal ultrasound scan was undertaken	Used to monitor the uptake and provision of fetal anomaly screening	ccyymmdd
	I	PROFESSIONAL STATUS (ANTENATAL ULTRASOUND SCAN)	Profession of person conducting the ultrasound fetal anomaly screening	Used to monitor the uptake and provision of fetal anomaly screening	Obstetrician Obstetrician - Fetal medicine Cardiologist Paediatrician Radiologist Radiographer Sonographer Midwife sonographer
	D	GESTATIONAL AGE (ANTENATAL ULTRASOUND SCAN)	Gestational age when fetal anomaly screening was undertaken	Used to monitor the uptake and provision of fetal anomaly screening	ww +d
	I	REPORT DATE (ANTENATAL ULTRASOUND SCAN)	Date on which report of results of Ultrasound fetal anomaly screening was issued	Used to monitor the timeliness of report being issued	ccyymmdd
	I	ANTENATAL ULTRASOUND SCAN PURPOSE	The reason for the antenatal ultrasound scan	Used to monitor success of identification of anomalies identified through screening	Follow up from anomaly scan Nuchal Translucency Cardiac following maternal serum Low lying placenta assessment Amniotic fluid assessment Umbilical artery Doppler Small or large for gestational age assessment Suspected fetal death Presentation Monitoring monochorionic twins Assisting diagnostic testing

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Routine Antenatal Contact: To carry details of a routine antenatal contact					
One occurrence of this Group is required for each contact					
This group will normally be collected at the antenatal contact or derived from those items					
	I	ACTIVITY (ANTENATAL APPOINTMENT)	Activity of Routine Antenatal Appointment	Used to identify antenatal appointments and to monitor attendance as per guidelines	
	I	ACTIVITY STATUS (ANTENATAL APPOINTMENT)	Whether or not a woman attended a scheduled Routine Antenatal Appointment	Used to identify antenatal appointments and to monitor attendance as per guidelines	
	D	GESTATION (ANTENATAL APPOINTMENT)	Gestational age at appointment	Used to identify antenatal appointments and to monitor attendance as per guidelines	ww +d
	D	ROUTINE ASSESSMENTS COMPLETED AT ANTENATAL APPOINTMENT	A Pass/Fail based on algorithm of evidence of measuring Blood Pressure, Symphysis-Fundal distance and testing of Urine at every* ACTIVITY (ANTENATAL APPOINTMENT). See Antenatal Observations tab	Used to check appropriate assessments are undertaken which may indicate complications requiring further investigation	Yes No
	I	CARE PROFESSIONAL STATUS (ANTENATAL APPOINTMENT)	Professional status of the practitioner leading the Routine Antenatal Appointment	Used to calculate the proportion of antenatal appointments undertaken by different practitioners	
	I	CARE PROFESSIONAL IDENTIFIER (ANTENATAL APPOINTMENT)	The unique identifier of the individual leading the Routine Antenatal Appointment	Used to calculate the proportion of antenatal appointments undertaken by different practitioners	
Antenatal Contacts: To carry derived details of routine antenatal contacts					
One occurrence of this Group is required					
This group will normally be derived from data collected at each antenatal contact					
	D	COUNT ANTENATAL APPOINTMENT (GP)	Number of routine antenatal appointments with General Practitioner	Used to calculate the extent to which maternity services are community led	n2
	D	COUNT ANTENATAL APPOINTMENT (MIDWIFE)	Number of routine antenatal appointments with Midwife	Used to calculate the extent to which maternity services are community led	n2
	D	COUNT ANTENATAL APPOINTMENT (CONSULTANT LED)	Number of routine antenatal appointments with Hospital Consultant team	Used to calculate the extent to which maternity services are community led	n2
	D	COUNT ANTENATAL APPOINTMENT (INDIVIDUALS)	Number of different individuals who led routine antenatal appointments	Used to calculate the extent to which maternity services are community led	n2
	D	COUNT ANTENATAL APPOINTMENT (LEAD CARER)	Number of routine appointments led by the individual who was identified as the lead carer	Used to monitor the continuity of care throughout a pregnancy	n2
	D	COUNT ANTENATAL APPOINTMENT (MAIN CARER)	Number of routine appointments led by the individual who led the most appointments	Used to monitor the continuity of care throughout a pregnancy	n2
	D	PROFESSIONAL STATUS (MAIN CARER)	The profession of the person who led the most routine antenatal appointments	Used to monitor the continuity of care throughout a pregnancy	
	D	COUNT ANTENATAL APPOINTMENT (ALL)	Number of routine Antenatal appointments attended	Used as denominator value for calculations on the extent to which maternity services are community led, and whether or not some groups are receiving additional care, possibly in the absence of specialist facilities	n2
	D	ANTENATAL APPOINTMENTS BEFORE 12 WEEKS	The number of antenatal contacts before 12 wks gestation	Used to monitor implementation of guidelines and outcomes for mothers and babies	n2
	D	ROUTINE ANTENATAL APPOINTMENTS PLANNED	A Pass/Fail based on algorithm of PARITY/ESTIMATED DATE OF DELIVERY for singletons and evidence of planned appointment at ACTIVITY ANTENATAL APPOINTMENT at <12, 16, 18-20, 25, 28, 31, 34, 36, 38, 40 wks for nulliparous women and <12, 16, 18-20, 28, 34, 36, 38 wks for parous women	Used to check for variance in provision or uptake of recommended routine antenatal care, for example by unit, geographical location, minority or demographic grouping	Yes No

Data Item Number		Data Item Name	Description	Purpose	Values/Format
	D	ROUTINE ANTENATAL APPOINTMENTS KEPT	A Pass/Fail based on algorithm of PARITY/ESTIMATED DATE OF DELIVERY for singletons and evidence of attendance at ACTIVITY ANTENATAL APPOINTMENT at <12, 16, 18-20, 25, 28, 31, 34, 36, 38, 40 wks for nulliparous women and <12, 16, 18-20, 28, 34, 36, 38 wks for parous women	Used to check for variance in provision or uptake of recommended routine antenatal care, for example by unit, geographical location, minority or demographic grouping	Yes No
	I	FIRST ANTENATAL ASSESSMENT DATE	The date on which the pregnant woman was assessed and arrangements made for antenatal care as part of the Pregnancy Episode. This is not necessarily the occasion on which arrangements were made for delivery.	Used to check for variance in provision or uptake of recommended routine antenatal care, for example by unit, geographical location, minority or demographic grouping	ccyymmdd
	D	ROUTINE ASSESSMENTS COMPLETED AT EVERY ANTENATAL APPOINTMENT	A Pass/Fail based on algorithm of evidence of measuring Blood Pressure, Symphysis-Fundal distance and testing of Urine at every * ACTIVITY (ANTENATAL APPOINTMENT)	Used to check appropriate assessments are undertaken which may indicate complications requiring further investigation	Yes No
Other Antenatal Contact: To carry details of other antenatal contacts One occurrence of this Group is required for each contact This group will normally be collected at the antenatal contact or derived from those items					
	I	ACTIVITY (ANTENATAL CONTACT)	Activity of Antenatal CARE CONTACT	Used to monitor contacts with and accessing services	
	I	ACTIVITY DATE (ANTENATAL CONTACT)	The date of the Antenatal Care Contact	Used to monitor contacts with and accessing services	
	I	CONTACT TYPE (ANTENATAL CONTACT)	A type of CARE ACTIVITY A contact made with a PATIENT for the delivery of care	Used to monitor contacts with and accessing services	First notification of pregnancy First Formal Antenatal Booking Appointment Routine antenatal assessment Routine screening Advice/information Unscheduled/urgent assessment Specialist opinion Post-term review
	I	CONTACT METHOD (ANTENATAL CONTACT)		Used to monitor contacts with and accessing services	Face to Face Telephone
	D	GESTATION (ANTENATAL CONTACT)	Gestational age at CARE CONTACT	Used to monitor contacts with and accessing services	ww +d
	I/D	CARE PROFESSIONAL STATUS (ANTENATAL CONTACT)	Professional status of the practitioner involved in the CARE CONTACT	Used to calculate the proportion of antenatal contacts undertaken by different practitioners	
	I/D	CARE PROFESSIONAL SPECIALTY (ANTENATAL CONTACT)	Speciality of the practitioner involved in the CARE CONTACT	Used to calculate the proportion of antenatal contacts undertaken by different practitioners	
	I	CARE PROFESSIONAL IDENTIFIER (ANTENATAL CONTACT)	The unique identifier of the practitioner involved in the CARE CONTACT	Used to calculate the proportion of antenatal contacts undertaken by different practitioners	
	I/D	ORGANISATION CODE (ANTENATAL CONTACT)	The unique identifier of the organisation involved in the CARE CONTACT	Used to monitor requirement, availability, uptake of specialist services for pregnant women with complicating factors	

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Specialist Antenatal Referrals: To carry details of referrals or requests for specialist or additional opinion					
One occurrence of this Group is required for each referral					
This group will be collected in the event of a referral					
	I	REFERRAL (ANTENATAL SPECIALIST)	A referral to another service or part of service for specialist or second opinion	Used to monitor requirement, availability, uptake of specialist services for pregnant women with complicating factors	
	I	REFERRAL DATE (ANTENATAL SPECIALIST)	Date of referral for specialist or second opinion	Used to monitor requirement, availability, uptake of specialist services for pregnant women with complicating factors	ccyymmdd
	D	GESTATION AT REFERRAL DATE (ANTENATAL SPECIALIST)	Gestation at date of referral for specialist or second option	Used to monitor requirement, availability, uptake of specialist services for pregnant women with complicating factors	ww +d
	I	REFERRAL REASON (ANTENATAL SPECIALIST)	Reason for antenatal referral to a specialist	Used to monitor requirement, availability, uptake of specialist services for pregnant women with complicating factors	*List of high risk factors for which they have specialist clinics:* Substance misuse Mental Health Haematology, inc options for Jehovah's Witnesses Neurology Sexual health Musculoskeletal Genetic disorders Multiple births Previous preterm or 2nd trimester loss Physical or learning disabilities Cardiac Liver Preconception Diabetes Endocrine Renal Placentation Eclampsia Elective delivery <37 wks Previous late loss or infant death Anti D Teenage pregnancies Anomalies Invasive procedures Other conditions *Also referral for hospital opinion:* BMI>=45 Previous CS or uterine surgery Previous difficult birth, eg large baby Age over 44 Previous miscarriage Low lying placenta Previous baby with Group B Strep *Not n'c list:* Second opinion for caesarean section High risk or family history of anaesthetic problems Allergies
	Post Term Monitoring: To carry details of monitoring for women beyond 42 weeks				
	One occurrence of this Group is required for each review				
	This group will be collected for women from 42 weeks who have declined induction				
	I	CONTACT TYPE (POST TERM REVIEW)	A CARE ACTIVITY for monitoring pregnancy after 42 weeks		
	I	ACTIVITY DATE (POST TERM REVIEW)	Date of Post Term Review		ccyymmdd
	D	GESTATIONAL AGE (POST TERM REVIEW)	Gestation at the Post term review		ww +d
	I	ANTENATAL OBSERVATION TYPE			
		Ultrasound for amniotic pool depth	Evidence that amniotic pool depth was measured by ultrasound	Used to monitor adherence to guidelines for the management of post term pregnancies and to commission and plan resources	
		Cardiotocography	Evidence that cardiotocography was undertaken	Used to monitor adherence to guidelines for the management of post term pregnancies and to commission and plan resources	

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Infectious Diseases: To carry details of diagnoses of infectious diseases occurring in this pregnancy One occurrence of this Group is required for each diagnosis This group will normally be collected at the antenatal contact or derived from those items					
	I	INFECTIOUS DISEASE DIAGNOSIS DATE	The date in this pregnancy when the infectious disease was diagnosed	To monitor outcomes for mothers and babies where complicating or risk factors are present	ccyymmdd
	I	INFECTIOUS DISEASE DIAGNOSIS TYPE	The infectious disease diagnosed in this pregnancy	To monitor outcomes for mothers and babies where complicating or risk factors are present	Rubella Varicella Group B streptococcus Asymptomatic bacteriuria
	D	GESTATIONAL AGE AT (INFECTIOUS DISEASE DIAGNOSIS)	Gestational age at diagnosis of infectious disease	To monitor outcomes for mothers and babies where complicating or risk factors are present	ww +d
Obstetric Complications: To carry details of obstetric complications occurring in this pregnancy One occurrence of this Group is required for each diagnosis This group will normally be collected at the antenatal contact or derived from those items					
	I	CURRENT MATERNITY OBSTETRIC DIAGNOSIS DATE	The date in this pregnancy when the obstetric condition was diagnosed	To monitor outcomes for mothers and babies where complicating or risk factors are present	ccyymmdd
	I	CURRENT MATERNITY OBSTETRIC DIAGNOSIS TYPE	The obstetric condition diagnosed in this pregnancy	To monitor outcomes for mothers and babies where complicating or risk factors are present	Severe pre-eclampsia HELLP Eclampsia ~~Puerperal psychosis~~ Liver cholestasis of pregnancy Gestational diabetes mellitus Gestational hypertension Gestational oedema Gestational proteinuria Antepartum haemorrhage ~~Postpartum haemorrhage~~ Feto-maternal haemorrhage Symphysis pubic dysfunction Placenta praevia
	D	GESTATIONAL AGE AT (CURRENT MATERNITY OBSTETRIC DIAGNOSIS)	Gestational age at diagnosis of obstetric condition	To monitor outcomes for mothers and babies where complicating or risk factors are present	ww +d
Diabetes - Antenatal: To carry details of checks for mothers with type 1 diabetes One occurrence of this Group is required This group will be collected during the antenatal period for women with type 1 diabetes					
	I	DIABETES CONTROL MEASUREMENT (IN FIRST TRIMESTER)	Whether or not a diabetes control measurement was recorded in the first trimester of pregnancy. See Antenatal Observations	Used to monitor outcomes for women with diabetes and their babies according to the level of control achieved	Measurement recorded No measurement recorded
	I	DIABETES CONTROL MEASUREMENT DATE (IN FIRST TRIMESTER)	Date of the diabetes control measurement in order to derive that it was taken in the first trimester of pregnancy	Used to monitor outcomes for women with diabetes and their babies according to the level of control achieved	ccyymmdd
	D	DIABETES CONTROL <7% (IN FIRST TRIMESTER)	Whether or not the woman had a DIABETES CONTROL MEASUREMENT (IN FIRST TRIMESTER) <7%	Used to monitor outcomes for women with diabetes and their babies according to the level of control achieved	
	I	DIABETES RETINAL ASSESSMENT	Evidence of having had a DIABETES RETINAL ASSESSMENT	Used to monitor implementation of guidelines and to monitor outcomes for mothers with diabetes	Procedure code
	I	DIABETES RETINAL ASSESSMENT DATE	Date of DIABETES RETINAL ASSESSMENT	Used to identify assessment in first trimester	ccyymmdd
	D	GESTATION AT (DIABETES RETINAL ASSESSMENT)	Gestational age at DIABETES RETINAL ASSESSMENT	Used to identify assessment in first trimester	ww +d
	D	DIABETES RETINAL ASSESSMENT (IN FIRST TRIMESTER)	Whether or not the woman had a DIABETES RETINAL ASSESSMENT in first trimester, or at booking	Used to monitor implementation of guidelines and to monitor outcomes for mothers with diabetes	None First Trimester Later

Data Item Number		Data Item Name	Description	Purpose	Values/Format
FGM: To carry details of women with Female Genital Mutilation (FGM)					
One occurrence of this Group is required					
This group will be collected for women who are identified with female genital mutilation (FGM)					
	I	OBSERVATION (FGM)	Evidence that woman has undergone Female Genital Mutilation	Used to monitor extent of FGM and pathway for resolution (RCM PP21)	Type I Type II Type III Type IV
	I	OBSERVATION DATE (FGM)	Date when FGM was observed/known	Used to monitor extent of FGM and pathway for resolution (RCM PP21)	ccyymmdd
	D	GESTATION AT OBSERVATION (FGM)	Gestational age when carers are first aware of FGM	Used to monitor extent of FGM and pathway for resolution (RCM PP21)	ww +d
	I	PROCEDURE STATUS (DEINFIBULATION)	Whether or not resolution of FGM was required and offered, accepted or declined - antenatally or at delivery	Used to monitor extent of FGM and pathway for resolution (RCM PP21)	Not offered Offered and accepted Offered and considering Offered and declined
	I	PROCEDURE OFFER DATE (DEINFIBULATION)	Date when resolution of FGM was offered	Used to monitor extent of FGM and pathway for resolution (RCM PP21)	ccyymmdd
	D	GESTATION AT PROCEDURE OFFER DATE (DEINFIBULATION)	Week of pregnancy when deinfibulation was offered or during delivery	Used to monitor extent of FGM and pathway for resolution (RCM PP21)	ww +d
	I	PROCEDURE (DEINFIBULATION)	Evidence of procedure to resolve infibulation	Used to monitor extent of FGM and pathway for resolution (RCM PP21)	
	D	PROCEDURE TIMING (DEINFIBULATION)	Whether or not resolution of FGM was carried out antenatally or during delivery	Used to monitor extent of FGM and pathway for resolution (RCM PP21)	ANTEPARTUM INTRAPARTUM
	I	PROCEDURE DATE (DEINFIBULATION)	Date of procedure to resolve infibulation	Used to monitor extent of FGM and pathway for resolution (RCM PP21)	ccyymmdd
	D	GESTATION AT PROCEDURE (DEINFIBULATION)	Week of pregnancy when deinfibulation was undertaken antenatally	Used to monitor extent of FGM and pathway for resolution (RCM PP21)	ww +d

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Antenatal Admissions: To carry details of antenatal hospital admissions					
One occurrence of this Group is required for each admission					
This group will normally be collected during admission and discharge					
	I	ADMISSION DATE (ANTENATAL)	Date of antenatal inpatient admission	Used to monitor incidence of antenatal complications and morbidity	ccyymmdd
	I	DISCHARGE DATE (ANTENATAL)	Date of antenatal inpatient discharge	Used to monitor incidence of antenatal complications and morbidity	ccyymmdd
	D	LENGTH OF ANTENATAL STAY	No of nights of antenatal inpatient admission	Used to monitor incidence of antenatal complications and morbidity	
	I	REASON FOR ANTENATAL ADMISSION	Reason for antenatal inpatient admission	Used to monitor incidence of antenatal complications and morbidity	Management of major placenta praevia Management of pre-eclampsia ...
	D	GESTATIONAL AGE AT (ANTENATAL ADMISSION)		Used to monitor incidence of antenatal complications and morbidity	ww +d

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Tocolysis: To carry details of administration of tocolytic agents					
One occurrence of this Group is required for each administration					
This group will normally be collected during the normal care pathway for preterm labour					
	I	OFFER STATUS (TOCOLYSIS)	Whether or not tocolysis was considered and offered for treatment of preterm labour	Used to monitor the outcomes for mothers and their babies in situations where tocolysis might be used	Not considered Not appropriate Offered and declined Offered and accepted
	I	TOCOLYSIS DATE	Date on which tocolytic treatment was started	Used to monitor the outcomes for mothers and their babies in situations where tocolysis might be used	ccyymmdd
	I	TOCOLYSIS REASON	Reason for administration of tocolysis	Used to monitor the outcomes for mothers and their babies in situations where tocolysis might be used	prevention of preterm birth/treatment of preterm labour - time to complete course of corticosteroids - time to transfer in utero - bleeding with placenta praevia - other abnormal FHR patterns and uterine hypercontractility external cephalic version at term
	D	TOCOLYSIS TIMING	Whether or not tocolysis was started before or after the onset of labour	Used to monitor the outcomes for mothers and their babies in situations where tocolysis might be used	Before onset of labour After onset of labour
	I	TOCOLYSIS DRUG	The drug used for tocolysis	Used to monitor the outcomes for mothers and their babies in situations where tocolysis might be used	beta-agonists - ritodrine hydrochloride - atosiban - salbutamol - terbutaline - indomethacin - magnesium sulphate calcium channel blockers - nifedipine prostaglandin synthetase inhibitors nitric oxide donors - glyceryl trinitrate oxytocin receptor antagonists isoxsuprine
	D	GESTATIONAL AGE AT TOCOLYSIS	Gestational age at start of tocolytic treatment	Used to monitor the outcomes for mothers and their babies in situations where tocolysis might be used	ww +d
	D	DAYS FROM TOCOLYSIS TO DELIVERY	The number of completed days from start of tocolytic treatment to delivery	Used to monitor the outcomes for mothers and their babies in situations where tocolysis might be used	n2

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Corticosteroid Therapy: To carry details of administration of corticosteroids for indicated premature delivery					
One occurrence of this Group is required					
This group will be collected during the normal care pathway in women between 24 and 34 weeks of gestation where delivery is indicated before 34 weeks					
	I	CORTICOSTEROID THERAPY REASON	The condition leading to the consideration of corticosteroid therapy to prevent respiratory distress syndrome	Used to monitor implementation of guidelines and to assess where corticosteroid therapy for indicated premature delivery prevents neonatal respiratory distress syndrome	threatened preterm labour antepartum haemorrhage preterm rupture of membranes any condition requiring elective preterm delivery
	I	OFFER STATUS (CORTICOSTEROID THERAPY)	Whether or not corticosteroid therapy was considered and offered for delivery before 34 weeks	Used to monitor implementation of guidelines and to assess where corticosteroid therapy for indicated premature delivery prevents neonatal respiratory distress syndrome	Not offered Offered and declined Offered and accepted
	D	GESTATIONAL AGE AT (START OF CORTICOSTEROID THERAPY)	The gestational age at the start of corticosteroid therapy	Used to monitor implementation of guidelines and to assess where corticosteroid therapy for indicated premature delivery prevents neonatal respiratory distress syndrome	ww +d
	I	PROCEDURE STATUS (CORTICOSTEROID THERAPY)	For women where delivery before 34 week is indicated, the status of administration of corticosteroids	Used to monitor implementation of guidelines and to assess where corticosteroid therapy for indicated premature delivery prevents neonatal respiratory distress syndrome	Full course completed Delivery prior to completion of full course Concerned about effect of steroids on maternal glycaemic control Declined by patient Maternal infection No reason given
	D	NO OF COURSES (CORTICOSTEROIDS)	Total no of courses of corticosteroids commenced	Used to monitor implementation of guidelines and to assess where corticosteroid therapy for indicated premature delivery prevents neonatal respiratory distress syndrome	n2
Corticosteroid Course: To carry details of course of corticosteroid therapy for indicated premature delivery					
One occurrence of this Group is required for each course					
This group will be collected during the normal care pathway in women between 24 and 34 weeks of gestation where delivery is indicated before 34 weeks					
	D	COURSE OF CORTICOSTEROIDS	The appropriate course of corticosteroids to prevent neonatal respiratory distress syndrome	Used to monitor implementation of guidelines and to assess where corticosteroid therapy for indicated premature delivery prevents neonatal respiratory distress syndrome	two doses of betamethasone 12 mg, given intramuscularly 24 hours apart four doses of dexamethasone 6 mg, given intramuscularly 12 hours apart
	D	COURSE OF CORTICOSTEROIDS COMPLETE	The extent to which the course of corticosteroids was completed before delivery	Used to monitor implementation of guidelines and to assess where corticosteroid therapy for indicated premature delivery prevents neonatal respiratory distress syndrome	Course completed At least one dose given Course not started
	D	COURSE OF CORTICOSTEROIDS COMPLETE DATE	The date on which the course of corticosteroid therapy was complete	Used to monitor implementation of guidelines and to assess where corticosteroid therapy for indicated premature delivery prevents neonatal respiratory distress syndrome	ccyymmdd

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Corticosteroid Dose: To carry details of administration of doses of corticosteroids for indicated premature delivery					
One occurrence of this Group is required for each dose within the course					
This group will be collected during the normal care pathway in women between 24 and 34 weeks of gestation where delivery is indicated before 34 weeks					
	I	ADMINISTRATION (CORTICOSTEROIDS)	Evidence of administration of corticosteroids	Used to monitor implementation of guidelines and to assess where corticosteroid therapy for indicated premature delivery prevents neonatal respiratory distress syndrome	
	I	ADMINISTRATION DATE (CORTICOSTEROIDS)	Date of administration of corticosteroids	Used to monitor implementation of guidelines and to assess where corticosteroid therapy for indicated premature delivery prevents neonatal respiratory distress syndrome	ccyymmdd
	I	DRUG ADMINISTRATION (CORTICOSTEROIDS)	The drug used as corticosteroid therapy	Used to monitor implementation of guidelines and to assess where corticosteroid therapy for indicated premature delivery prevents neonatal respiratory distress syndrome	
	I	DRUG ADMINISTRATION ROUTE (CORTICOSTEROIDS)	The route by which the drug was administered	Used to monitor implementation of guidelines and to assess where corticosteroid therapy for indicated premature delivery prevents neonatal respiratory distress syndrome	
	I	DRUG ADMINISTRATION DOSE (CORTICOSTEROIDS)	The dose of drug administered	Used to monitor implementation of guidelines and to assess where corticosteroid therapy for indicated premature delivery prevents neonatal respiratory distress syndrome	

Data Item Number		Data Item Name	Description	Purpose	Values/Format
ECV: To carry details of External Cephalic Version (ECV)					
One occurrence of this Group is required for each procedure					
This group will be collected for women who have a breech presentation detected at 36 weeks					
				Guideline No. 20a	
	I	BREECH PRESENTATION DETECTION DATE	The date on which breech presentation was formally noted as a complicating factor in this pregnancy	Used to monitor management of breech presentation and outcomes for mother and baby	ccyymmdd
	D	GESTATIONAL AGE AT (BREECH PRESENTATION DETECTION)	Gestational age at formally noting breech presentation in this pregnancy	Used to monitor management of breech presentation and outcomes for mother and baby	ww +d
	I	EXTERNAL CEPHALIC VERSION STATUS	Whether or not the offer of PROCEDURE (ECV) was appropriate (Singleton only), made and accepted or declined	Used to monitor management of breech presentation and outcomes for mother and baby	Contraindication Not available Offered and declined Offered and accepted
	I	STATUS DATE (ECV)	Date on which offer of ECV was made	Used to monitor management of breech presentation and outcomes for mother and baby	ccyymmdd
	I	PROCEDURE (ECV)	Evidence of ECV	Used to monitor management of breech presentation and outcomes for mother and baby	
	I	PROCEDURE DATE (ECV)	Date of ECV	Used to monitor management of breech presentation and outcomes for mother and baby	ccyymmdd
	D	GESTATIONAL AGE AT (ECV)		Used to monitor management of breech presentation and outcomes for mother and baby	ww +d
	I	PROCEDURE (ECV - TOCOLYSIS)	Whether or not tocolytic drugs were administered when undertaking ECV	Used to monitor management of breech presentation and outcomes for mother and baby	Yes No
	I	PROCEDURE OUTCOME (ECV)	Whether or not ECV was successful in inverting a breech presenting baby	Used to monitor management of breech presentation and outcomes for mother and baby	Fetus successfully turned Fetus not successfully turned

Data Item Number	Data Item Name	Description	Purpose	Values/Format
Ectopic Pregnancy: To carry details of a diagnosis of ectopic pregnancy				
One occurrence of this Group is required				
This group will normally be collected at the urgent/emergency care contact				
I	DIAGNOSIS (ECTOPIC PREGNANCY)	Evidence of diagnosis ectopic pregnancy	Used to monitor timely diagnosis of ectopic pregnancies - a cause of maternal death	
I	DIAGNOSIS DATE (ECTOPIC PREGNANCY)	Date of diagnosis of ectopic pregnancy	Used to monitor timely diagnosis of ectopic pregnancies - a cause of maternal death	
I	CARE PROFESSIONAL (DIAGNOSIS ECTOPIC PREGNANCY)	Profession of the person diagnosing ectopic pregnancy	Used to monitor timely diagnosis of ectopic pregnancies - a cause of maternal death	
Miscarriage: To carry details of pregnancies				
One occurrence of this Group is required				
This group will be collected in the event of a miscarriage				
I	DIAGNOSIS (MISCARRIAGE)	Evidence of miscarriage in this pregnancy	Used to monitor incidence of miscarriage and implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve	
I	DIAGNOSIS DATE (MISCARRIAGE)	Date of miscarriage	Used to monitor incidence of miscarriage and implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve	
D	GESTATIONAL AGE AT (MISCARRIAGE)	Gestational age at miscarriage	Used to monitor incidence of miscarriage and implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve	
I	PROCEDURE (INTERVENTION FOR INCOMPLETE MISCARRIAGE)	Evidence of intervention for incomplete miscarriage	Used to monitor incidence of intervention required and implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve	Medical Surgical
I	PROCEDURE DATE (INTERVENTION FOR INCOMPLETE MISCARRIAGE)	Date of intervention for incomplete miscarriage	Used to monitor incidence of intervention required and implementation of Anti-D Prophylaxis guidance and outcomes for mothers who are Rhesus -ve	

Data Item Number	Data Item Name	Description	Purpose	Values/Format
Induction of Labour Offer: To carry details of offer of induction of labour				
One occurrence of this Group is required				
This group will normally be derived from the input data groups. Where induction is initially refused or deferred the first dates should be recorded				
I	FORMAL INDUCTION OF LABOUR REASON	Primary indication for offering induction NB not all reasons are necessarily recommendations for induction	Used to calculate incidence of formal induction of labour by reason	• prolonged pregnancy • diabetic pregnancy • breech presentation • multifetal pregnancy • high parity • prelabour rupture of membranes • macrosomia • the presence of fetal growth restriction • previous caesarean section • maternal request • history of precipitate labour
I	INDUCTION OFFERED STATUS	Whether or not induction (prostaglandin or other, preferred method) was accepted, declined, or not offered	Used to monitor involvement of mother in decisions	Offered and declined Offered and deferred Offered and accepted
I	INDUCTION OFFERED DATE	Date on which formal induction of labour was first offered	Used to calculate incidence of formal induction of labour	ccyymmdd
D	GESTATIONAL AGE AT (OFFER FORMAL INDUCTION)	Gestation of pregnancy when induction of labour was first offered	Used to calculate incidence of formal induction of labour	ww +d
I	INDUCTION ACCEPTED DATE	Date on which formal induction of labour was accepted	Used to calculate incidence of formal induction of labour	ccyymmdd
D	GESTATIONAL AGE AT (INDUCTION ACCEPTED)	Gestation of pregnancy when induction of labour was accepted	Used to calculate incidence of formal induction of labour	ww +d
I	INDUCTION PLANNED DATE	Date planned for formal induction of labour	Used to calculate incidence of formal induction of labour	ccyymmdd
D	GESTATIONAL AGE AT (INDUCTION PLANNED)	Gestation of pregnancy when induction of labour was planned	Used to calculate incidence of formal induction of labour	ww +d
Induction of Labour: To carry details of interventions for induction of labour				
One occurrence of this Group is required				
This group will normally be derived from the input data groups. Where induction is initially refused or deferred the first dates should be recorded				
D	MEDICAL INDUCTION PRECEDED BY MEMBRANE SWEEP	Whether or not any medical induction was preceded by a sweep of membranes	Used to compare outcomes according to methods employed to induce labour	Not offered Offered and declined Offered and accepted
D	FORMAL INDUCTION OF LABOUR METHOD (FIRST)	First method used for PROCEDURE (FORMAL INDUCTION OF LABOUR)	Used to calculate incidence of formal induction of labour by method first used	Intracervical prostaglandin Intravaginal prostaglandin Oxytocin ...
D	FORMAL INDUCTION OF LABOUR DATE TIME (FIRST)	Date/time on which formal induction of labour first attempted	Used to calculate incidence of formal induction of labour	ccyymmdd hh:mm
D	FORMAL INDUCTION OF LABOUR GESTATION (FIRST)	Gestation of pregnancy when first PROCEDURE (FORMAL INDUCTION OF LABOUR) administered	Used to identify post term inductions and the extent to which intervention is delayed	ww +d
D	FORMAL INDUCTION OF LABOUR (COUNT)	Number of times PROCEDURE (MEDICAL INDUCTION OF LABOUR) administered	Used to identify where repeat or subsequent formal induction of labour procedures were administered	n2
Membrane Sweep: To carry details of interventions for induction of labour				
One occurrence of this Group is required for each offer/procedure				
This group will be collected when a membrane sweep is indicated				
I	PROCEDURE (MEMBRANE SWEEP)			
I	OFFER STATUS (MEMBRANE SWEEP)	Whether or not offer of a membrane sweep was accepted or declined	Used to derive whether or not membrane sweep was offered prior to medical induction	Not offered Offered and declined Offered and accepted
I	PROCEDURE DATE TIME (MEMBRANE SWEEP)	Date/time of Membrane Sweep	Used to compare outcomes according to methods employed to induce labour	ccyymmdd hh:mm

Data Item Number	Data Item Name	Description	Purpose	Values/Format
Artificial Rupture of Membranes: To carry details of interventions for induction and augmentation of labour				
One occurrence of this Group is required				
This group will be collected when artificial rupture of the membranes is indicated				
	I PROCEDURE (ARM)			
	I OFFER STATUS (ARM)	Whether or not offer of artificial rupture of membranes (ARM) was accepted or declined	Used to derive whether or not ARM was offered, either prior to or to augment labour	Not offered Offered and declined Offered and accepted
	I PROCEDURE DATE TIME (ARM)	Date/time of artificial rupture of membranes (ARM)	Used to compare outcomes according to methods employed to induce labour	ccyymmdd hh:mm
	I REASON FOR AMNIOTOMY	Whether or not artificial rupture of membranes (ARM) was for induction or augmentation of labour	Used to compare outcomes according to methods employed to induce or augment labour	Induction Augmentation
Medical Induction of Labour: To carry details of medical interventions for induction of labour				
One occurrence of this Group is required for each occasion				
This group will be collected when medical induction is indicated				
	I PROCEDURE (MEDICAL INDUCTION OF LABOUR)			
	I OFFER STATUS (MEDICAL INDUCTION OF LABOUR)	Whether or not offer of medical induction of labour was accepted or declined	Used to derive whether or not membrane sweep was offered prior to medical induction	Not offered Offered and declined Offered and accepted
	I MEDICAL INDUCTION OF LABOUR METHOD	The agent and route used for medical induction of labour	Used to compare outcomes according to methods employed to induce labour	Intracervical prostaglandin Intravaginal prostaglandin Oxytocin ...
	I PROCEDURE DATE TIME (MEDICAL INDUCTION OF LABOUR)	Date/time of Membrane Sweep	Used to compare outcomes according to methods employed to induce labour	ccyymmdd hh:mm
Oxytocin: To carry details of medical interventions for induction and augmentation of labour				
One occurrence of this Group is required for each occasion				
This group will be collected when induction or augmentation of labour using oxytocin is indicated				
	I OXYTOCIN OFFERED STATUS	Whether or not induction/augmentation was accepted, declined, or not offered	Used to monitor involvement of mother in decisions	Not offered Offered and declined Offered and accepted
	I OXYTOCIN ADMINISTERED DATE TIME	Date/time on which oxytocin was administered	Used to monitor implementation of guidance and outcomes for mothers and babies	ccyymmdd hh:mm
	I/D REASON FOR OXYTOCIN	Whether for induction or augmentation of labour Could be derivable by comparing date/time of onset of labour with date/time of administration	Used to monitor implementation of guidance and outcomes for mothers and babies	Induction Augmentation

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Rupture of Membranes: To carry details of rupture of membranes					
One occurrence of this Group is required					
This group will be collected during the normal care pathway or derived from the values for artificial rupture of membranes (ARM)					
	I	RUPTURE OF MEMBRANES DATE TIME	Date/time on which membranes ruptured	Used to monitor implementation of guidance	ccyymmdd hh:mm
	I	RUPTURE OF MEMBRANES METHOD	The way in which membranes were ruptured	Used to monitor implementation of guidance	Spontaneous Amniotomy Ruptured during VE Intact at c-section
	D	MEMBRANES RUPTURED TIMING	Whether rupture of membranes occurred before onset of labour	Used to monitor delays in delivery and outcomes for mothers and babies	Before labour In labour
	D	GESTATIONAL AGE AT RUPTURE OF MEMBRANES	Gestational age when membranes ruptured	Used to identify those with preterm, prelabour rupture of membranes (PPROM)	ww +d
	D	TIME FROM ROM TO DECISION TO DELIVER	The length of time in hours between RUPTURE OF MEMBRANES DATE/TIME in an at term pregnancy and the DECISION TO DELIVER DATE/TIME	Used to monitor delays in delivery and outcomes for mothers and babies	hours part of hh:mm
	I	LIQUOR CONDITION (AT ROM)	Clinical observation of liquor	Used to monitor the incidence of complications of delivery	Clear/straw coloured Light meconium Grade 1, green-stained Grade II - moderate, particulate matter seen Thick meconium Grade III, thick, lumpy Blood stained No liquor seen Other discolouration Purulent Not known

Data Item Number	Data Item Name	Description	Purpose	Values/Format
Intended Delivery Care Plan: To carry details of the plans for delivery as last recorded prior to labour/delivery				
One occurrence of this Group is required				
This group will normally be derived from that collected at the last antenatal contact and as part of the normal delivery care pathway				
	D	PLANNED PLACE OF DELIVERY (ONSET OF LABOUR)	Planned place of delivery at onset of labour	Used to monitor changes in intended plan of care	Midwife unit, co-located with Consultant obstetric unit Midwife unit, co-located with other Consultant unit (with theatre and anaesthetic services) Midwife unit, stand alone Home 2 In NHS hospital - delivery facilities associated with consultant ward 3 In NHS hospital - delivery facilities associated with GMP ward 4 In NHS hospital - delivery facilities associated with consultant/GMP/midwife ward inclusive of any combination of two of the professionals mentioned 5 In private hospital Private wing of NHS hospital 9 Not known Other
	D	PLANNED MODE OF DELIVERY (ONSET OF LABOUR)	The intended mode of delivery as agreed usually by 36 weeks	Used to monitor outcomes compared with planned mode of delivery, especially for VBAC (vaginal birth after caesarean)	Vaginal Elective Caesarean
	I/D	SECOND OPINION ELECTIVE CAESAREAN SECTION	Whether or not planned delivery by caesarean section was made after seeking second opinion	Used to monitor incidence and reasons for caesarean sections	Yes No
	D	GESTATIONAL AGE AT INTENDED DELIVERY CARE PLAN	The gestational age when the intended place and mode of delivery was agreed	Used to monitor changes in intended plan of care	ww +d
	I	PRESENTATION AT ONSET OF LABOUR	The presentation of the (first) fetus at onset of labour	Used to monitor changes in intended plan of care	Cephalic Breech Transverse/oblique Not known
					?planned or requested water birth -
Plans for Delivery: To carry details of plans for delivery made antenatally				
One occurrence of this Group is required for the first and subsequent changes in plans for delivery				
This group will normally be collected as part of the normal care pathway. A decision about delivery may not be made until later in pregnancy.				
	I	PLANNED PLACE OF DELIVERY	Planned place of delivery	Used to monitor changes in intended plan of care	Midwife unit, co-located with Consultant obstetric unit Midwife unit, co-located with other Consultant unit (with theatre and anaesthetic services) Midwife unit, stand alone Home 2 In NHS hospital - delivery facilities associated with consultant ward 3 In NHS hospital - delivery facilities associated with GMP ward 4 In NHS hospital - delivery facilities associated with consultant/GMP/midwife ward inclusive of any combination of two of the professionals mentioned 5 In private hospital Private wing of NHS hospital Other
	I	PLANNED MODE OF DELIVERY	The intended mode of delivery	Used to monitor outcomes compared with planned mode of delivery, especially for VBAC (vaginal birth after caesarean)	Vaginal Elective Caesarean

Data Item Number		Data Item Name	Description	Purpose	Values/Format
	I	DELIVERY CARE PLAN CHANGE REASON	Reason care plan was changed	Used to monitor changes in intended plan of care	1 Decision made during pregnancy because of change of address 2 Decision made during pregnancy for clinical reasons - mother 2 Decision made during pregnancy for clinical reasons - baby 2 Decision made during pregnancy for clinical reasons - mother and baby 3 Decision made during pregnancy for other reasons 4 Decision made during labour for clinical reasons - mother 4 Decision made during labour for clinical reasons - baby 4 Decision made during labour for clinical reasons - mother and baby 5 Decision made during labour for other reasons 6 Occurred unintentionally during labour clinical reasons - mother and/or baby
	D	GESTATIONAL AGE AT DELIVERY CARE PLAN	The gestational age at plan for place and mode of delivery	Used to monitor changes in intended plan of care	ww +d
Labour: To carry details of events in labour One occurrence of this Group is required This group will normally be collected during the normal care pathway for labour. Interventions at any point may make some items irrelevant					
	D	SPONTANEOUS ONSET OF LABOUR INDICATOR			
	I	NUMBER OF BABIES (ONSET OF LABOUR)	No of babies in pregnancy at onset of labour	Used to monitor outcomes comparing singleton and multiple pregnancies	n1
	I	ONSET OF ESTABLISHED LABOUR (DATE TIME)	Date/time when established labour is confirmed	Used to monitor chronology of labour and outcomes for women and babies according to length of labour	ccyymmdd hh:mm
	I	FIRST PUSHING URGE	Whether or not the mother experiences the first pushing urge	Used to check whether or not values for FIRST PUSHING URGE DATE/TIME are expected	Yes No - intervention prior to stage No - due to epidural
	I	FIRST PUSHING URGE DATE TIME	Date/time when mother experiences first pushing urge If on epidural, is it the contractions as observed by monitoring?	Used to monitor outcomes for mother and babies according to lengths of time in various stages of labour/delivery	ccyymmdd hh:mm
	I	DILATATION AT FIRST PUSHING URGE	Record of the dilatation at maternal first pushing urge	Used to monitor outcomes for mother and babies according to lengths of time in various stages of labour/delivery	in cm Fully dilated None, eg no pushing urge when fully dilated N/A, eg c-section before pushing urge
	I	FULL DILATATION ACHIEVED	Whether or not full dilatation of the cervix was achieved. Full dilatation might not be achieved before a decision to deliver is made, eg resulting in emergency caesarean section	Used to check whether or not values for FULL DILATATION DATE/TIME are expected	Yes No
	I	FULL DILATATION DATE TIME	Recording of the date and time full dilatation of the cervix achieved.	Used to monitor outcomes for mother and babies according to lengths of time in various stages of labour/delivery	ccyymmdd hh:mm
	I	ONSET OF SECOND STAGE DATE TIME	Date/time of onset of active second stage of labour	Used to monitor outcomes for mother and babies according to lengths of time in various stages of labour/delivery	ccyymmdd hh:mm
	D	ONSET OF THIRD STAGE DATE TIME	Date/time of onset of third stage of labour (= last delivery date/time)	Used to monitor outcomes for mother and babies according to lengths of time in various stages of labour/delivery	ccyymmdd hh:mm
	I	END OF THIRD STAGE DATE TIME	Date/time of end of third stage of labour	Used to monitor outcomes for mother and babies according to lengths of time in various stages of labour/delivery	ccyymmdd hh:mm
	D	LENGTH OF TIME OF FIRST STAGE	Length of time from onset of labour to second stage	Used to monitor outcomes for mother and babies according to lengths of time in various stages of labour/delivery	

Data Item Number		Data Item Name	Description	Purpose	Values/Format
	D	LENGTH OF TIME OF SECOND STAGE	Length of time from onset of second to third stage	Used to monitor outcomes for mother and babies according to lengths of time in various stages of labour/delivery	
	D	LENGTH OF TIME OF THIRD STAGE	Length of time of third stage	Used to monitor outcomes for mother and babies according to lengths of time in various stages of labour/delivery	
	I	FETAL HEART RATE MONITORING METHOD	The predominant way in which fetal heart rate was monitored during labour	To monitor guidelines for Electronic Fetal Monitoring and outcomes for mothers and babies	Intermittent auscultation Intermittent EFM Continuous EFM Continuous with scalp clip
	I	TRANSFER DESTINATION	Type of place destination immediately after delivery and any transfer required	Used to monitor destination after delivery	Postnatal ward - obstetric Postnatal ward - midwife Transitional care ward Home Mother & Baby unit - psychiatric Mother & Baby unit - prison Prison ITU HDU Died Other hospital Unknown
	D	BIRTH SUPPORTERS	Whether the mother had someone attending labour/delivery providing support	Used to compare outcomes for mothers and babies and common practices between units, etc.	Yes No
Pain relief: To carry details of pain relief in labour and delivery One occurrence of this Group is required for each method used This group will be collected during care in labour and delivery					
	I	PAIN RELIEF	Evidence of having used any of the following for pain relief	Used to monitor usage/availability of types of pain relief	TENS Inhalational analgesia Narcotics Regional - spinal Regional - epidural Regional - combined spinal/epidural Regional - pudendal Regional - spinal catheter Paracetamol Water Complementary therapies others …
Decision to accelerate delivery: To carry details of a decision to accelerate delivery One occurrence of this Group is required This group will be collected in the event of a reason to augment labour or carry out operational delivery. The reason is recorded with the method of intervention used.					
	I	DATE TIME OF DECISION TO DELIVER	The date and time on which the decision was made to deliver, eg following rupture of membranes or requiring emergency caesarean section or other assisted delivery	Used to derive time from ROM to decision to deliver and time from decision to delivery for other emergency situations	ccyymmdd hh:mm

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Delivery: To carry details of the delivery					
One occurrence of this Group is required					
This group will normally be collected during the normal care pathway. The Delivery for the mother is for all births in this pregnancy					
	I	LEAD CARER (DELIVERY)	Professional status of lead carer at delivery	Used to monitor continuity of care or reasons for changes in care plan	most senior person in room
	I	POSITION IN DELIVERY	The position of the mother at delivery of the (first) baby delivered vaginally	Used to compare outcomes for mothers and babies and common practices between units, etc.	All fours Birthing chair/stool Kneeling Left lateral Lithotomy -Lying on back -Lying on back with stirrups Right lateral Semi-recumbent Squatting Standing Lying on back Lying on back with stirrups Other in water NA - c-section
	I	REMOVAL OF PLACENTA METHOD	Whether placenta was removed through physiological, active or manual means. Where more than one method is used, the final method should be recorded.	Used to monitor the way third stage is managed	Physiological Active Manual Removal Remains in situ
	I	APPEARANCE OF PLACENTA	Appearance of placenta	Used to monitor risk of complications due to appearance of placenta	Apparently complete Incomplete Ragged/fragmented Retained in situ Not known
	I	APPEARANCE OF MEMBRANES	Appearance of membranes	Used to monitor risk of complications due to appearance of membranes	Apparently complete Incomplete Ragged/fragmented Not known
	D	NUMBER OF BABIES	Number of babies delivered	Used to monitor outcomes comparing singleton and multiple pregnancies	n1
	D	SPONTANEOUS ONSET AND DELIVERY INDICATOR	Whether or not women had an uncomplicated birth, but may have had an epidural	Used as a typical comparison for delivery	Yes No
	D	NORMAL DELIVERY INDICATOR	The Association of Improvements in Maternity Services (AIMS) definition excludes any births where labour has been altered by technological intervention. Thus their definition of normal birth does not include one where labour has been induced or accelerated by drugs, or has involved amniotomy, epidural anaesthesia or episiotomy. All babies in the pregnancy must be delivered without such intervention to qualify DIFFERENT ITEM TO INCLUDE arm	Used to compare statistics with earlier definitions	Yes No
	D	NORMAL DELIVERY INDICATOR (HES)	The method of delivery according to HES definitions. Normal delivery calculations: defined as those without surgical intervention, use of instruments, induction, epidural or general anaesthetic. Includes: spontaneous method of delivery, spontaneous method of onset, anaesthetic = other, N/A, not known, repair of laceration (R32), Op code R24 Normal delivery, R20 Other breech delivery, inc R20.2 assisted breech delivery, R23 Cephalic vaginal delivery with abnormal presentation of head at delivery without instrument Excludes: Spinal anaesthetic, artificial rupture of membranes (surgical induction), oxytocin, episiotomy, assisting delivery	Used to compare statistics with earlier definitions	Yes No

Data Item Number		Data Item Name	Description	Purpose	Values/Format
	D	DAY OF WEEK OF DELIVERY	The day of the week when the mother delivered	Used to compare outcomes for mothers and babies	Monday Tuesday Wednesday Thursday Friday Saturday Sunday
	D	BANK HOLIDAY WEEKEND DELIVERY	Whether or not the woman delivered at a bank holiday weekend	Used to compare outcomes for mothers and babies	Yes No
Birth supporters: To carry details of who was attending labour and delivery supporting the mother One occurrence of this Group is required for each individual This group will normally be collected during the normal care pathway					
	I	BIRTH SUPPORTER	Any individual attending labour/delivery supporting the mother	Used to compare outcomes for mothers and babies and common practices between units, etc.	Husband, partner Female friend or relative Doula or other professional supporter Independent midwife Complementary therapist Other friend or relative
Antibiotics in labour: To carry details of antibiotics given in labour One occurrence of this Group is required This group will be collected for women for women given antibiotics in labour, eg for syphilis, Group B Streptococcus					
	I/D	DRUG ADMINISTRATION (ANTIBIOTICS IN LABOUR)	Whether or not antibiotics were administered in labour	Used to monitor implementation of guidelines and outcomes for mothers with infectious diseases and their babies	Yes No Need input list of antibiotics
	I/D	DRUG ADMINISTRATION REASON (ANTIBIOTICS IN LABOUR)	The reason for administration of antibiotics in labour	Used to monitor implementation of guidelines and outcomes for mothers with infectious diseases and their babies	
Diabetes - Labour and Delivery: To carry details of checks for mothers with type 1 diabetes One occurrence of this Group is required This group will be collected during labour for women with type 1 diabetes					
	I	PROCEDURE (INTRAVENOUS ADMINISTRATION OF GLUCOSE)	Evidence that dextrose was administered during labour to women with diabetes need to compare this with 'opportunity' and usual method of control	Used to monitor implementation of guidelines and outcomes for mothers with diabetes and their babies	check gki - alberti
	I	PROCEDURE (INTRAVENOUS ADMINISTRATION OF INSULIN)	Evidence that insulin was administered during labour to women with diabetes need to compare this with 'opportunity' and usual method of control	Used to monitor implementation of guidelines and outcomes for mothers with diabetes and their babies	

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Transfers: To carry details of transfers between units, organisations or sites					
One occurrence of this Group is required for each transfer					
This group will be collected in the event of a transfer of the mother					
	I	DECIDED TO TRANSFER DATE TIME MOTHER	Date/time of decision to transfer mother to another unit	Used to monitor transfers	ccyymmdd hh:mm
	D	TRANSFER TIMING MOTHER	The timing of the decision to transfer mother from one unit, or type of unit, to another	Used to monitor transfers	Antepartum Intrapartum Postpartum
	I	REASON FOR TRANSFER MOTHER	Reason for transfer of mother to another unit.	Used to monitor transfers	neonatal capacity not available in unit neonatal facility not available in unit maternal medical condition maternal request obstetric complications return to local unit ...
	I	TRANSFER OUT DATE TIME MOTHER	Date/time on which mother is discharged from delivering unit	Used to monitor transfers	ccyymmdd hh:mm
	I	ORGANISATION SITE CODE (TRANSFER OUT)	The unique identifier of the unit from where a mother is transferred	Used to monitor transfers	Include a code for 'Home' where a decision is made intrapartum to transfer into 'hospital' unit where plan at onset of labour is for home birth
	I	ORGANISATION SITE CODE (RECEIVING UNIT)	The unique identifier of the unit to which a mother is transferred	Used to monitor transfers	
	I/D	CARER ORGANISATION CHANGED	Whether or not the carer organisation changed with the transfer	Used to monitor transfers	Yes No

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Caesarean Section: To carry details of caesarean sections					
One occurrence of this Group is required					
This group will be collected in the event of delivery by caesarean section					
	I	PROCEDURE CAESAREAN SECTION		Used to monitor implementation of Caesarean Section Guidelines	
	I	PROCEDURE DATE TIME (CAESAREAN SECTION)	The date/time of the caesarean section (? Knife to skin?)	Used to monitor implementation of Caesarean Section Guidelines	ccyymmdd hh:mm
	I	CAESAREAN SECTION (URGENCY)	Urgency for delivery by caesarean section	Used to monitor reasons for caesarean section	immediate threat to the life of the woman or fetus maternal or fetal compromise which is not immediately life-threatening no maternal or fetal compromise but needs early delivery delivery timed to suit woman and staff
	I	ADMINISTRATION ANTIEMETICS (CAESAREAN SECTION)	Evidence of antiemetics being offered/accepted/declined for Caesarean Section or opioid	Used to monitor implementation of Caesarean Section Guidelines	Not offered Offered and declined Offered and accepted
	I	ANAESTHESIA TYPE (CAESAREAN SECTION)	Type of regional anaesthesia used	Used to monitor and compare use of regional anaesthesia for pain relief or surgery	general conscious sedation epidural spinal combined continuous spinal cordal pudendal block local infiltration
	I	ADMINISTRATION ANTACIDS (CAESAREAN SECTION)	Evidence of antacids being offered/accepted/declined after Caesarean Section	Used to monitor implementation of Caesarean Section Guidelines	Not offered Offered and declined Offered and accepted
	I	CAESAREAN SECTION (CONSULTANT INVOLVED)	Evidence of a Consultant being involved in the decision to deliver by Caesarean Section	Used to monitor implementation of guidelines	Yes No
	I	ANTIBIOTICS (CAESAREAN SECTION)	Whether or not the woman had a course of antibiotics following Caesarean sections	Used to monitor implementation of guidelines	Yes No
	I	THROMBOPROPHYLAXIS (CAESAREAN SECTION)	Whether or not the woman had thromboprophylaxis following Caesarean sections	Used to monitor implementation of guidelines	Yes No

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Continuous Electronic Fetal Monitoring: To carry details of continuous electronic fetal monitoring					
One occurrence of this Group is required					
This group will be collected when continuous EFM is offered/undertaken					
				Clinical Guideline Number 8	check belt and scalp
	I	OFFER STATUS (CONTINUOUS EFM)	Whether or not a mother was offered and recommended continuous electronic fetal monitoring (EFM)	To monitor guidelines for Electronic Fetal Monitoring and outcomes for mothers and babies	Offered and declined Offered and accepted
	I	OFFER DATE TIME (CONTINUOUS EFM)	The date/time on which continuous EFM was offered	To monitor guidelines for Electronic Fetal Monitoring and outcomes for mothers and babies	ccyymmdd hh:mm
	I	PROCEDURE REASON (CONTINUOUS EFM)	Reason for continuous EFM	To monitor guidelines for Electronic Fetal Monitoring and outcomes for mothers and babies	Maternal problems Previous caesarean section Pre-eclampsia Post-term pregnancy (> 42 weeks) Prolonged membrane rupture (> 24 hours) Induced labour Diabetes Antepartum haemorrhage Other maternal medical disease Fetal problems Fetal growth restriction Prematurity Oligohydramnios Abnormal Doppler artery velocimetry Multiple pregnancies Meconium-stained liquor Breech presentation Intrapartum risk factors Oxytocin augmentation Epidural analgesia Vaginal bleeding in labour Maternal pyrexia Fresh meconium-stained liquor Abnormal FHR on auscultation
	I	PROCEDURE START DATE TIME (CONTINUOUS EFM)	Date/time of EFM	To monitor guidelines for Electronic Fetal Monitoring and outcomes for mothers and babies	ccyymmdd hh:mm
					Analysis of no of women who decline cEFM is the interesting. Also where less favourable outcomes are achieved where cefm might have improved, proof that it was offered
Fetal blood sampling: To carry details of fetal blood sampling					
One occurrence of this Group is required for each sample					
This group will be collected in the event of fetal blood sampling being indicated					
	I	OFFER STATUS (FETAL BLOOD SAMPLING)	Whether or not a mother was offered and recommended fetal blood sampling	Used to monitor the instance of and guidance on fetal monitoring	Offered and declined Offered and accepted
	I	PROCEDURE (FETAL BLOOD SAMPLING)	Whether or not baby was monitored during labour using fetal blood sampling	Used to monitor the instance of and guidance on fetal monitoring	
	I	PROCEDURE DATE TIME (FETAL BLOOD SAMPLING)	Date/time of fetal blood sampling	Used to monitor the instance of and guidance on fetal monitoring	ccyymmdd hh:mm
	I	FETAL BLOOD SAMPLE RESULT	pH value of blood sample	Used to monitor the instance of and guidance on fetal blood sampling. pH value ≤7.2 indicates intervention for early delivery	

Data Item Number	Data Item Name	Description	Purpose	Values/Format
Critical Incidents: To carry details of critical incidents One occurrence of this Group is required for each incident This group will be collected at occurrence				
			Clinical Governance Advice No. 2	
	I/D	OTHER CRITICAL INCIDENT (MCDD List)	Evidence that a critical incident occurred	Used to monitor outcomes for mothers and babies where a critical incident has occurred	Maternal incident Maternal death Undiagnosed breech Shoulder dystocia Blood loss > 500 ml Blood loss > 1000 ml Blood loss > 1500 ml Hypovolaemic shock Return to theatre Eclampsia Hysterectomy/laparotomy ITU admission Venous thromboembolism Pulmonary embolism Third/fourth degree tears Unsuccessful forceps or ventouse Uterine rupture Condition requiring readmission of mother *Anaesthetic complications:* Accidental dural puncture Administration of suxamethonium in presence of cholinesterase deficiency Anaphylaxis Aspiration of gastric contents Awareness or recall under ga Backache Excessively high regional block Failed intubation Failed regional anaesthesia Local anaesthetic toxicity Pain during regional anaesthesia caesarean section Post dural puncture headache Fetal/neonatal incident Stillbirth > 500 g Neonatal death Apgar score < 7 at 5 minutes Birth trauma Fetal laceration at caesarean section Cord pH < 7.05 arterial or < 7.1 venous Neonatal seizures Term baby admitted to neonatal unit Undiagnosed fetal anomaly European Congenital Anomalies and Twins (Eurocat)
	I	CRITICAL INCIDENT DATE TIME	Date/time of event considered as a critical incident	Used to monitor outcomes for mother and babies following critical incident	ccyymmdd hh:mm
	I	CRITICAL INCIDENT SEVERITY	Outcome of the critical incident for the individual	Used to monitor outcomes for mothers and babies where a critical incident has occurred	None (No harm occurred) Low (Minimal harm – patient(s) required extra observation or minor treatment) Moderate (Short term harm – patient(s) required further treatment, or procedure) Severe (Permanent or long term harm) Death (Caused by the Patient Safety Incident)

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Perineum: To carry details of any trauma to the perineum in delivery One occurrence of this Group is required for each identified trauma This group will normally be collected during the normal care pathway for a vaginal birth					
	I	TRAUMATIC LESION OF PERINEUM	Whether or not there was a traumatic lesion of the perineum during delivery	Used to monitor incidence of trauma to the perineum in conjunction with any other intervention or outcome	Intact Labial tear Vaginal tear Perineal tear Episiotomy Cervical tear
	D	TRAUMATIC LESION REPAIR	Whether or not a traumatic lesion was sutured	Used to monitor incidence of trauma to the perineum in conjunction with any other intervention or outcome	Yes No
Spontaneous Perineal Tear: To carry details of any spontaneous perineal tear in delivery One occurrence of this Group is required This group will be collected for women having a vaginal delivery who have a tear					
				29 Management of 3rd and 4th degree tears	
	I	DEGREE OF TEAR	Severity of tear of perineum	Used to monitor incidence of trauma to the perineum in conjunction with any other intervention or outcome	First degree Injury to perineal skin only. Second degree Injury to perineum involving perineal muscles but not involving the anal sphincter. Third degree Injury to perineum involving the anal sphincter complex: 3a: Less than 50% of EAS thickness torn. 3b: More than 50% of EAS thickness torn. 3c: Both EAS and IAS torn. Fourth degree Injury to perineum involving the anal sphincter complex (EAS and IAS) and anal epithelium.
Episiotomy: To carry details of episiotomy One occurrence of this Group is required This group will be collected for women having an episiotomy for delivery					
	I	EPISIOTOMY		26 Operative vaginal delivery	
	I	INDICATION FOR EPISIOTOMY	Indication for episiotomy	Used to monitor reasons for episiotomy including due to female genital mutilation	instrumental birth suspected fetal compromise without instruments prevention of uncontrolled/serious tearing female genital mutilation not resolved antenatally
Perineal Repair: To carry details of repair of the perineum after tear or episiotomy One occurrence of this Group is required This group will be collected for women having an episiotomy or tear in delivery					
	I	PERINEAL REPAIR		23 Perineal repair	
	I	PERINEAL REPAIR (METHOD OF SKIN CLOSURE)	Method of skin closure used to repair perineum	Used to monitor outcomes for women who required perineal repair	Not sutured Two layered (skin open) Three layered (skin closed)
	I	SUTURE MATERIAL	Material used to repair perineum	Used to monitor outcomes for women who required perineal repair	
	I	REPAIRED BY (STATUS)	Professional status of the person suturing perineum	Used to monitor outcomes for women who required perineal repair	
	I	REPAIRED BY (INDIVIDUAL)	Individual ID of the person suturing perineum	Used to monitor outcomes for women who required perineal repair	

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Initiation of breastfeeding: To carry details of actions to initiate breastfeeding					
One occurrence of this Group is required					
This group will normally be collected during the normal care pathway					
	D	SKIN TO SKIN CONTACT	Whether or not baby had skin to skin contact with mother in the first hour of life	Used to monitor implementation of postnatal guidelines	Yes No
	I	DATE TIME SKIN TO SKIN CONTACT STARTED	Date and time when first skin to skin contact made	Used to monitor implementation of postnatal guidelines	ccyymmdd hh:mm
	I	DATE TIME SKIN TO SKIN CONTACT ENDED	Date and time when first skin to skin contact ended	Used to monitor implementation of postnatal guidelines	ccyymmdd hh:mm
	I	DATE TIME BABY PUT TO BREAST	Date and time when baby put to breast or given mother's breast milk	Used to derive initiation of breastfeeding as per DH definition	ccyymmdd hh:mm
	D	BREASTFEEDING INITIATED	Whether or not the baby was put to the breast or given any of the mother's breast milk within an hour of delivery	Used to monitor implementation of Baby Friendly guidance	Within first hour Within 48 hours After 48 hours Timing unknown Not put to breast
Breastfeeding difficulty: To carry details of difficulties in breastfeeding					
One occurrence of this Group is required					
This group will be collected for babies for whom there is concern over breastfeeding					
	I	BREASTFEEDING DIFFICULTY	Observation of breastfeeding difficulties, or none	Used to monitor implementation of Baby Friendly guidance	Poor attachment Tongue tie Candidiasis Other
	I	OBSERVATION DATE (BREASTFEEDING DIFFICULTY)	The date on which the breastfeeding difficulty was noted	Used to monitor implementation of Baby Friendly guidance	ccyymmdd
Tongue Tie: To carry details of difficulties in breastfeeding resulting from tongue tie (ankyloglossia)					
One occurrence of this Group is required					
This group will be collected for babies for whom there is concern over breastfeeding due to tongue tie (ankyloglossia)					
				IPG149 Division of ankyloglossia (tongue tie) for breastfeeding - guidance	
	I	EXAMINATION (ANKYLOGLOSSIA)	Whether or not examination for tongue tie was undertaken and observed	Used to monitor implementation of guidance	Not examined Satisfactory Problem
	I	EXAMINATION DATE (ANKYLOGLOSSIA)	Date of examination for tongue tie	Used to monitor implementation of guidance	ccyymmdd
	I	REFERRAL DATE (EVALUATION ANKYLOGLOSSIA)	Date referred for evaluation of ankyloglossia	Used to monitor implementation of guidance	ccyymmdd
	I	OFFER STATUS (DIVISION OF ANKYLOGLOSSIA)	Whether or not division of ankyloglossia was offered	Used to monitor implementation of guidance	Not offered Offered and accepted Offered and declined
	I	PROCEDURE (DIVISION OF ANKYLOGLOSSIA)	Record of procedure for division of tongue tie	Used to monitor implementation of guidance	
	I	PROCEDURE DATE (DIVISION OF ANKYLOGLOSSIA)	Date of procedure for division of tongue tie	Used to monitor implementation of guidance	ccyymmdd
	I	CLINICIAN IDENTIFIER (DIVISION OF ANKYLOGLOSSIA)	Unique identified of the person undertaking division of ankyloglossia	Used to monitor implementation of guidance	

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Congenital anomalies: To carry details of diagnosis of congenital anomalies					
One occurrence of this Group is required for each anomaly					
This group may be collected as diagnosed antenatally, neonatally, or sometimes later					
	I	DIAGNOSIS (CONGENITAL ANOMALY)	Diagnosis of a congenital anomaly	Used to monitor the prevalence of individual congenital anomalies, particularly in conjunction with other factors	
	I	DIAGNOSIS DATE (CONGENITAL ANOMALY)	Date diagnosis of a congenital anomaly was made	Used to monitor the prevalence of individual congenital anomalies, particularly in conjunction with other factors	ccyymmdd
	D	CONGENITAL ANOMALY DIAGNOSED ANTENATALLY	Whether or not the anomaly was diagnosed at a scan or diagnostic testing antenatally. Can be derived from results of Fetal Anomaly Scan and Diagnostic Test Results	Used to monitor the success of antenatal screening for anomalies	Yes No

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Outcome for fetus: To carry details of the pregnancy outcome for the fetus/baby One occurrence of this Group is required for each fetus identified at the dating scan This group will normally be collected during the normal care pathway					
	I/D	OUTCOME OF PREGNANCY (BABY)	Records the outcome of pregnancy	Used to monitor outcome of pregnancy compared to other factors, eg antenatal diagnosis of conditions	Live Antepartum stillbirth Intrapartum stillbirth Indeterminate stillbirth Spontaneous miscarriage Miscarriage after invasive procedure TOP - medical TOP - surgical Alive but died Other
Birth: To carry details of the baby's birth One occurrence of this Group is required for each baby delivered This group will normally be collected during the normal care pathway					
	I	UNIQUE ID (BABY)	Unique identifier of baby in pregnancy, NHS NUMBER given at birth	Used to link child(ren) with pregnancy and mother	
	I	NHS NUMBER (BABY)	Unique identifier of baby	Used to link child(ren) with pregnancy and mother	
	I/D	NUMBER OF BABIES	Number of babies delivered	Used to monitor outcomes comparing singleton and multiple pregnancies	
	I/D	BIRTH ORDER	Sequence in which the baby was born in a multiple pregnancy	Used to monitor outcomes comparing singleton and multiple pregnancies	
	I	DATE OF BIRTH (BABY)	Date of birth of baby	Used to monitor timeliness of tests	
	I	GENDER	Gender of the baby	Used to aggregate by gender	Female Male Not specified (for miscarriage or prematurity) Indeterminate (ambiguous) Not known
	I	TIME OF BIRTH	Time of birth of baby	Used to monitor timeliness of tests	
	I	BIRTH WEIGHT	Weight of baby in grammes at birth	Used to monitor outcomes according to birth weight	
	I	BIRTH LENGTH	Length of baby in cm at birth This may not be done routinely	Used to monitor outcomes according to birth length	
	I	BIRTH HEAD CIRCUMFERENCE	Circumference measurement of baby's head at birth	Used to monitor outcomes according to head circumference	
	I	ETHNICITY (BABY)	ONS classification of ethnicity	Used to compare outcomes according to ethnicity	
	D	GESTATIONAL AGE (AT BIRTH)	Derived from ESTIMATED DATE OF DELIVERY in weeks and days	Used to identify whether or not the baby was delivered preterm, at term, or postterm to compare outcomes and inform service provision	
	D	PRETERM DELIVERY	Identification of babies born before 37 weeks gestation, ie up to and including 36 +6	Used to compare outcomes of babies with those delivered at term	
	D	VERY PRETERM DELIVERY	Identification of babies born before 32 weeks gestation, up to and including 31 +6	Used to compare outcomes of babies with those delivered at term	
	I/D	ELECTIVE PRETERM DELIVERY REASON	Reason why a baby was electively born early	Used to compare outcomes with other groups	
	I/D	METHOD OF DELIVERY (BABY)	Whether the baby was born without or with intervention. Multiple interventions derived from Assisted delivery methods group	Used to compare outcomes and variance in practice	Spontaneous vaginal Manual Vacuum Forceps after failed vacuum Forceps (low cavity) Forceps (mid cavity or with rotation) Elective caesarean Emergency caesarean Emergency caesarean after failed instrumental delivery
	I	DELIVERED IN WATER	Whether or not the baby was delivered under water	Used to monitor the incidence of water births and outcomes for babies born under water	Yes No

Data Item Number		Data Item Name	Description	Purpose	Values/Format
	I	PRESENTATION PRIOR TO BIRTH	Presentation of the baby prior to birth	Used to monitor type of birth offered and outcomes	Cephalic Breech Transverse/oblique Not known
	I	PRESENTING PART PRIOR TO BIRTH	The presenting body part of the fetus before delivery	Used to monitor type of birth offered and outcomes	Cephalic: -vertex -face -brow -compound Breech -extended legs (frank) -flexed legs (complete) -footling -compound Transverse/oblique (inc shoulder) Not known
	D	MATERNAL DRUGS AT BIRTH (BABY)	Analgesia or anaesthesia used at birth of this baby	Used to monitor affects of analgesia on outcomes for mother and baby	Epidural Spinal Caudal Pudendal block Local anaesthetic infiltrate General anaesthetic Opiates Entonox
	I	TIME OF CLAMPING UMBILICAL CORD	The time of clamping the umbilical cord	Used to monitor outcomes and variance in practice	
	D	AGE AT CLAMPING OF UMBILICAL CORD	Age in minutes when umbilical cord was clamped, including negative value for clamping prior to delivery	Used to monitor outcomes and variance in practice	
	I	LIQUOR CONDITION (AT BIRTH)	Clinical observation of liquor	Used to monitor the incidence of complications of delivery	Clear/straw coloured Light meconium Grade 1, green-stained Grade II - moderate, particulate matter seen Thick meconium Grade III, thick, lumpy Blood stained No liquor seen Other discolouration Purulent Not known
	D	UMBILICAL ACID BASE EXCESS MEASURED	Whether or not the umbilical acid-base status was performed	Used to monitor implementation of guidelines	Yes No
	D	RESUSCITATION AT BIRTH	Whether or not the baby was resuscitated at birth	Used to monitor implementation of guidelines	None Basic Advanced
	D	NORMAL BIRTH INDICATOR (BABY)	The Association of Improvements in Maternity Services (AIMS) definition excludes any births where labour has been altered by technological intervention. Thus their definition of normal birth does not include one where labour has been induced or accelerated by drugs, or has involved amniotomy, epidural anaesthesia or episiotomy.	Used to monitor outcomes for mothers and babies	Yes No

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Place of birth: To carry details of the place of birth of the baby One occurrence of this Group is required for each baby This group will be collected as part of the normal care pathway					
	I	ACTUAL PLACE OF DELIVERY	Type of unit in which baby was delivered	Used to monitor and compare outcomes	
	I	ACTUAL PLACE OF DELIVERY (ORGANISATION CODE)	The organisation code of the place of delivery	Used to monitor and compare outcomes	
		ACTUAL PLACE OF DELIVERY (ORGANISATION SITE CODE)	The unique identifier of the unit where baby was delivered	Used to monitor transfers	Include a code for 'Home' where a decision is made intrapartum to transfer into 'hospital' unit where plan at onset of labour is for home birth
	D	ACTUAL PLACE OF BIRTH TYPE			0 In NHS hospital - delivery facilities associated with midwife ward Midwife unit, co-located with Consultant obstetric unit Midwife unit, co-located with other Consultant unit (theatre and anaesthetic services) Midwife unit, stand alone 1 At a domestic address 2 In NHS hospital - delivery facilities associated with consultant ward 3 In NHS hospital - delivery facilities associated with GMP ward 4 In NHS hospital - delivery facilities associated with consultant/GMP/midwife ward inclusive of any combination of two of the professionals mentioned 5 In private hospital Private wing of NHS hospital 6 In other hospital or institution 7 In NHS hospital - ward or unit without delivery facilities 8 None of the above 9 Not known
	D	PLACE OF DELIVERY WITH NNU (BABY)	Derived from organisational data to identify those babies born in units with or without Neonatal Unit facilities	Used to monitor need to transfer babies requiring Neonatal Unit facilities and to plan appropriate services	Yes No
	I	POST CODE (DELIVERING UNIT)	Post code of the unit at which the baby is delivered	Used to monitor appropriateness of distance in transfer to NICU/SCBU	
	D	PLACE OF DELIVERY DIFFERENT FROM INTENDED (BABY)	Evidence that the type of unit where delivery took place was different to that planned	Used to monitor the extent to which delivery plans are kept or changed	Yes No
	I	PLACE OF DELIVERY DIFFERENT FROM INTENDED REASON (BABY)	Reason why delivery took place in a different place to that planned	Used to monitor the extent to which delivery plans are kept or changed	Occurred unintentionally Maternal request Clinical reasons - mother Clinical reasons - fetus N/A
Assisted delivery methods: To carry details of the baby's birth One occurrence of this Group is required for each method used for each baby delivered This group will be collected when assistance in delivery is required					
				26 Operative Vaginal Delivery	
	I	METHOD OF ASSISTED DELIVERY (BABY)	Any method of assistance used in the delivery of a baby	Used to derive type of delivery	Manual with maternal effort Manual without maternal effort Vacuum (Ventouse) Forceps
	I	STATION POSITION FOR ASSISTED DELIVERY	The position of the baby for assisted delivery	Used to derive type of delivery	Outlet Low <45° rotation Low >45° rotation Mid <45° rotation Mid >45° rotation High

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Baby Birth Trauma: To carry details of any indications of trauma sustained at birth One occurrence of this Group is required for each trauma observed for each baby This group will be collected when a trauma at birth is observed					
	I	BABY BIRTH TRAUMA	Indication of a trauma sustained at birth	Used to monitor type of birth offered and outcomes	brachial plexus injury bone fracture ventouse/forceps injury with loss/necrosis of skin/scalp laceration
Cord bloods: To carry details of tests on umbilical cord blood acid-base status One occurrence of this group is required Umbilical artery acid-base status should be performed as a minimum after: • emergency caesarean section is performed • instrumental vaginal delivery is performed • a fetal blood sample has been performed in labour • birth, if the baby's condition at birth is poor					
	I	UMBILICAL ARTERY pH	The pH of the blood gases in umbilical artery	Umbilical artery pH below 7.00 is associated with an increase in both short and long-term complications in the neonate	
	I	UMBILICAL VEIN pH	The pH of the blood gases in umbilical vein	Paired blood samples required for analysis	
	I	UMBILICAL ACID BASE	Umbilical acid base excess/deficit assessed by collection of paired samples from the cord artery and vein	Used to identify neonates with risk of complications	
Apgar score: The Apgar score of the neonate One occurrence of this Group is required for each baby delivered This group will normally be collected during the normal care pathway. Apgar scores at 1, 10 and 20 minutes may also be required for care of the neonate. Scores for the individual aspects should also be recorded on the care record.					
	I	APGAR SCORE (5 MINUTES)	The Apgar score of the neonate 5 minutes after delivery	Used to compare babies in different scenarios and their outcomes	
Person delivering: To carry details of the person delivering the baby One occurrence of this Group is required for each baby delivered This group will normally be collected during the normal care pathway					
	I	CARER ORGANISATION (DELIVERY)	Organisation for which the person delivering the baby works	Used to aggregate the number of babies delivered in different organisations	
	I/D	PERSON DELIVERING BABY	The status or profession of the person delivering the baby		mother themselves father other non professional trained midwife trainee midwife trained doctor trainee doctor ambulance personnel
	I	PERSON DELIVERING BABY IDENTIFIER	The unique identifier of the professional delivering the baby	Used to derive status of person delivering	
	I	SENIOR PERSON PRESENT AT DELIVERY	The status or profession of the most senior person present at the delivery		no professional present no trained professional present ambulance personnel trained midwife trained doctor
	I	SURNAME OF PERSON NOTIFYING BIRTH	Surname of person notifying birth	Requirement for NN4B	
	I	FORENAME OF PERSON NOTIFYING BIRTH	Forename of person notifying birth	Requirement for NN4B	

Data Item Number	Data Item Name	Description	Purpose	Values/Format
Person present at delivery: To carry details of the individuals present at the delivery				
One occurrence of this Group is required for each individual present				
This group will normally be collected during the normal care pathway				
I	PERSON PRESENT AT DELIVERY IDENTIFIER	The unique identifier of any professional present at the delivery	Used to derive status of most senior person present at delivery	
I/D	PERSON PRESENT AT DELIVERY PROFESSION	The status or profession of the person delivering the baby		non professional trained midwife trainee midwife trained doctor trainee doctor ambulance personnel
Complications at delivery: To carry details of any complications at delivery				
One occurrence of this Group is required for each complication				
This group will be collected in the event of a complication				
I	COMPLICATION AT BIRTH			
	Shoulder dystocia			
	Cord prolapse			
	Suspected fetal compromise			
	Neonatal encephalopathy			Grade I Grade II Grade III
	Fetal acidaemia	Fetal blood sample pH ≤ 7.2, borderline 7.21-7.24		Fetal blood sample indicating early delivery Fetal blood sample borderline for early delivery
Reason for Caesarean: To carry details of the primary reason for delivery by caesarean section				
One occurrence of this Group is required				
This group will be collected in the event of delivery by caesarean section				
I	CAESAREAN SECTION REASON (BABY)	Reason why baby was delivered by caesarean section	Used to monitor reasons for caesarean section	Fetal - not cephalic Fetal - multiple pregnancy Fetal - baby size problem Fetal - compromise Fetal - cord prolapse Fetal - chorioamnionitis Fetal - indication for other baby in pregnancy Maternal - placenta praevia & vasa praevia Maternal - APH/Intrapartum Haemorrhage - unknown origin Maternal - Placental abruption Maternal - Preeclampsia/Eclampsia/HELLP Maternal - Medical disease Maternal - failure to progress, first stage Maternal - failure to progress, second stage Maternal - previous caesarean section Maternal - previous poor outcomes Maternal - previous emotional/physical traumatic vaginal delivery Maternal - previous infertility Maternal - uterine rupture Maternal - maternal request social or medical Maternal - trauma due to sexual abuse Maternal - FGM

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Resuscitation: To carry details of procedures undertaken in resuscitation of the neonate					
One occurrence of this Group is required					
This group will be collected where resuscitation is required					
	D	ARTERY/VEIN ACID BASE STATUS	Whether or not acid base status was investigated	Used to monitor implementation of guidance	Yes No
	I	SURFACTANT ADMINISTRATION	Evidence of surfactant being administered (for babies between 26-28 weeks gestation)	Used to monitor neonatal outcomes	
	I	DATE TIME OF SURFACTANT ADMINISTRATION	Date and time of surfactant administration to the neonate	Used to monitor neonatal outcomes	ccyymmdd hh:mm
	D	AGE AT SURFACTANT ADMINISTRATION	Age in minutes when surfactant administered to neonate	Used to monitor neonatal outcomes	
	I	DATE TIME SPONTANEOUS RESPIRATION	Date and time when spontaneous respiration achieved	Used to monitor neonatal outcomes	
	D	AGE WHEN NORMAL SPONTANEOUS RESPIRATION	Age in minutes when spontaneous respiration achieved	Used to monitor neonatal outcomes	
Resuscitation method: To carry details of methods used to resuscitate the neonate					
One occurrence of this Group is required for each method					
This group will be collected where resuscitation is required					
	I	DATE TIME OF RESUSCITATION	The date and time resuscitation was started	Used to monitor neonatal outcomes	ccyymmdd hh:mm
	I	TYPE OF RESUSCITATION	Method of resuscitation used to assist baby in establishing breathing	Used to monitor neonatal outcomes	oxygen control airway clearance IPPV mask IPPV tube cardiac massage
	D	TIMING OF START OF RESUSCITATION	Timing of the start of resuscitation	Used to monitor neonatal outcomes	Exit procedure After delivery
	I	RESUSCITATION LEADER	Unique Id of individual leading resuscitation	Used to derived grade/profession of individual leading resuscitation	
	I	PROFESSIONAL LEADING RESUSCITATION	The grade/profession of the individual leading resuscitation	Used to monitor neonatal outcomes	
Acid Base Status: To carry details of acid base status tests undertaken following resuscitation of the neonate					
One occurrence of this Group is required for each test					
This group will be collected where resuscitation is required					
	I	ARTERY/VEIN ACID BASE	The base excess/deficit in arterial and venous pH values	Used to monitor implementation of guidance	
	I	ARTERIAL pH	Value of Arterial acid base status	Used to monitor neonatal outcomes	
	I	VENOUS pH	Value of Venous acid base status	Used to monitor neonatal outcomes	
Resuscitation drugs: To carry details of drugs used in resuscitation of the neonate					
One occurrence of this Group is required for each drug					
This group will be collected where resuscitation is required					
	I	DRUGS GIVEN (RESUSCITATION)	Whether or not drugs were administered for resuscitation	Used to monitor neonatal outcomes	iv adrenaline sodium bicarbonate dextrose isotonic crystalloid saline to replace blood volume surfactant

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Neonatal admission: To carry details of admissions to neonatal units One occurrence of this Group is required for each admission This group will be collected when admitted to or transferred between neonatal units					
	I	ADMISSION (NNU)	Evidence that baby was admitted to Neonatal Unit	Used to monitor the requirement for Neonatal Unit facilities and outcomes for babies	
	I	ADMISSION DATE TIME (NNU)	Date/time on which baby was admitted/transferred to Neonatal Unit	Used to monitor timeliness of admission to Neonatal Unit, separation times and inform planning of appropriate services	ccyymmdd hh:mm
	I	NEONATAL CARE LEVEL ON ADMISSION	The level of care received by a neonate on admission	Used to monitor timeliness of admission to Neonatal Unit, separation times and inform planning of appropriate services	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 care 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 and education of the infant's parent(s). 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. Medical supervision is not so immediate as in Level 1 Intensive Care. Care includes support of the infant's parent(s). 3 Level 1 Intensive Care (Maximal Intensive Care): Care given in an intensive care nursery which provides continuous skilled supervision by qualified and specially trained nursing and medical staff. Such care includes support of the infant's parent(s).
	I	NEONATAL CARE HIGHEST LEVEL THIS ADMISSION	The highest level of care given to baby in this admission	Used to monitor the requirement for Neonatal Unit facilities and outcomes for babies	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 care 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 and education of the infant's parent(s). 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. Medical supervision is not so immediate as in Level 1 Intensive Care. Care includes support of the infant's parent(s). 3 Level 1 Intensive Care (Maximal Intensive Care): Care given in an intensive care nursery which provides continuous skilled supervision by qualified and specially trained nursing and medical staff. Such care includes support of the infant's parent(s).
	I	INTUBATED ON ADMISSION TO NNU	Whether or not baby was already intubated on admission/transfer to neonatal unit	Used to monitor neonatal outcomes	Yes No
	I	SOURCE OF ADMISSION	Source of admission to neonatal unit	Used to monitor appropriateness of distance in transfer to Neonatal Unit	from home delivery own delivery/postnatal wards allied peripheral birthing unit other neonatal unit picu other hospital unit in network other hospital unit outside network
	I	ORGANISATION CODE (ADMITTING UNIT)	Organisation and site code of the unit to which the baby was admitted or transferred (may be within the same hospital)	Used to monitor appropriateness of distance in transfer to Neonatal Unit	
	I	POST CODE (NNU)	Post code of the Neonatal Unit to which the baby is transferred	Used to monitor appropriateness of distance in transfer to Neonatal Unit	

Data Item Number		Data Item Name	Description	Purpose	Values/Format
	I	ORGANISATION CODE (ORIGINATING UNIT)	Organisation and site code of the unit from where the baby was transferred (may be within the same hospital)	Used to monitor appropriateness of distance in transfer to Neonatal Unit	
	I	POST CODE (ORIGINATING UNIT)	Post code of the Neonatal Unit to which the baby is transferred	Used to monitor appropriateness of distance in transfer to Neonatal Unit	
	I	DISCHARGE DATE TIME BABY (ORIGINATING UNIT)	Date/time on which baby is discharged from delivering unit	Used to monitor delays in transfer to Neonatal Unit	ccyymmdd hh:mm
	D	DISTANCE TRANSFERRED TO NNU	Distance in miles between originating unit and admitting unit	Used to monitor appropriateness of distance in transfer to Neonatal Unit	
	I	DISCHARGE DATE TIME (NNU)	Date/time on which baby was discharged/transferred from Neonatal Unit	Used to monitor timeliness of admission to Neonatal Unit, separation times and inform planning of appropriate services	ccyymmdd hh:mm
	I	DESTINATION ON DISCHARGE (NNU)	The destination of baby from Neonatal Unit	Used to monitor delays in transfer to Neonatal Unit	Home Postnatal ward Died Other hospital/unit - clinical reasons Other hospital/unit - return to local unit Other hospital/unit - organisational reasons
	I	SCREENING RETINOPATHY OF PREMATURITY	Evidence of screening for ROP (for babies <1250 g)	Used to monitor neonatal outcomes - neonatal audit item	
	I	OBSERVATION (FIRST NNU TEMPERATURE)	The result of the first temperature reading on admission to Neonatal Unit	Used to monitor neonatal outcomes - neonatal audit item	Result in °C
	I	OBSERVATION DATE TIME (FIRST NNU TEMPERATURE)	Date/time of measuring or attempting to measure baby's temperature	Used to monitor neonatal outcomes - neonatal audit item	ccyymmdd hh:mm
	I	OBSERVATION (FIRST NNU BLOOD PRESSURE)	The activity of measuring or attempting to measure baby's blood pressure	Used to monitor neonatal outcomes - neonatal audit item	
	I	OBSERVATION DATE TIME (FIRST NNU BLOOD PRESSURE)	Date/time of measuring or attempting to measure baby's blood pressure	Used to monitor neonatal outcomes - neonatal audit item	ccyymmdd hh:mm

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Mother's Demographics at Delivery: To carry the personal, social and other details of the Mother as they are observed at first postnatal assessment					
One occurrence of this Group is required					
This group will normally be collected at the first postnatal assessment. Many of these items are also collected at Booking					
	I	POST CODE (MOTHER AT DELIVERY)	The POSTCODE OF USUAL ADDRESS nominated by the mother at the first postnatal assessment	Used to derive PCT and other geographical areas, including Sure Start areas, for aggregation to compare outcomes and plan services	an8 (max)
	D	SURESTART AREA (MOTHER AT DELIVERY)	The SureStart area in which the mother lives. This is derived from the mother's POST CODE (MOTHER AT DELIVERY) and look up table from ???	Used to analyse outcomes and plan services at aggregated level	Look up table required
	D	PCT OF RESIDENCE (MOTHER AT DELIVERY)	The PCT in which the mother lives derived from POST CODE (MOTHER AT DELIVERY)	Used to aggregate by geographical area	an3
	I	GP CODE (MOTHER AT DELIVERY)	Unique identifier of GP	Required for NN4B and aggregation by GP/Area	
	I	PRACTICE CODE (MOTHER AT DELIVERY)	Unique identifier of GP Practice	Required for NN4B and aggregation by GP/Area	an6
	D	RESPONSIBLE PCT (MOTHER AT DELIVERY)	This is the ORGANISATION CODE of the responsible Primary Care Trust. The Primary Care Trust is responsible for a population which comprises: - those persons registered with GENERAL PRACTITIONERS whose practices are within the Primary Care Trust, irrespective of whether they reside within the boundary of the Primary Care Trust, plus - those persons who are not registered with any GENERAL PRACTITIONER but who reside in the Primary Care Trust's geographic area	Used to aggregate by geographical area	an3
	I	ACCOMMODATION TYPE (MOTHER AT DELIVERY)	The type of accommodation in which the mother lives at the time of delivery/postnatal assessment	Used as a factor in socio-economic analysis	Census 2001: *Whole House:* - Detached - Semi-detached - Terraced (including end terrace) *Flat:* - Purpose built - Converted or shared (including bed-sits) - In a commercial building (eg over shop) *Mobile or temporary building:* - Caravan or other mobile or temporary structure *Medical and Care establishments:* - General hospital - Psychiatric hospital or home - Other hospital - Nursing home - Residential care home - Children's home (including secure unit) - Other medical and care home *Other establishments:* - Defence establishment - Prison service establishment - Probation/bail hostel - Educational establishment (inc halls of residence) - Hotel, boarding house, guest house - Hostel - Civilian ship, boat, barge - Other
	I	HOMELESS INDICATOR (MOTHER AT DELIVERY)	An indicator to identify pregnant mothers who are homeless	Used to compare outcomes for specific vulnerable groups	Yes No

Data Item Number		Data Item Name	Description	Purpose	Values/Format
	I	HOUSING TENURE (MOTHER AT DELIVERY)	The tenure of accommodation in which the mother lives at delivery	Used as a factor in socio-economic analysis	Census 2001: Owns outright Owns with mortgage or loan Pays part rent and part mortgage (shared ownership) Rents Lives rent free Not applicable (for other values where inappropriate - not a census value)
	I	SUPPORT STATUS (MOTHER AT DELIVERY)	Whether or not the mother reports feeling supported in looking after a baby. The highest applicable value should be selected	Used to assess support and social factors relevant to pregnancy and outcomes	Full support of partner Full support of family Poor support of partner Poor support of family Support of friends Support of social services or other agency/organisation No support
Postnatal - Mother: To carry details of routine postnatal activities for the mother One occurrence of this Group is required This group will normally be collected during the normal care pathway					
	I	HOSPITAL DISCHARGE DATE TIME (POST DELIVERY)	The date and time when the mother was discharged home following delivery	Used to monitor lengths of stay in hospital and outcomes	ccyymmdd hh:mm
	D	LENGTH OF STAY (MOTHER)	Length of stay of mother in hospital after delivery	Used to monitor lengths of stay in hospital and outcomes	Less than 48 hours: No of hours 0-6 6-12 12-18 18-24 24-36 36-48 More than 48 hours: No of days
	I/D	DISCHARGED WITH BABY	Whether or not the mother was discharged together with the baby/babies	Used to monitor lengths of stay in hospital and outcomes	Yes No
	I	DISCHARGED DELAYED	Whether or not a mother's discharge was delayed because the baby was not fit for discharge	Used to monitor lengths of stay in hospital and outcomes	Yes No
	I	DATE POSTNATAL CARE PLAN	Evidence of a postnatal care plan agreed with mother	Used to monitor postnatal care	ccyymmdd
	I	POSTNATAL CARE NAMED INDIVIDUAL	Evidence of a named individual responsible during postnatal period	Used to monitor postnatal care	
	I	POSTNATAL CONTRACEPTION DISCUSSED	Whether or not contraception was discussed postnatally	Used to monitor postnatal care and guidelines	Yes No
	I	DATE POSTNATAL CONTRACEPTION DISCUSSED	Date of discussion about contraception	Used to monitor postnatal care and guidelines	ccyymmdd
	D	NO OF POSTNATAL CONTACTS WITH MIDWIFE	Count of the number of postnatal contacts with a midwife	Used to monitor the levels of postnatal care	
	I	DATE OF DISCHARGE MOTHER (MATERNITY SERVICES)	Date on which mother ceased to be cared for in maternity services. The date of last contact with a midwife where care continued by health visitor	Used to monitor length of time after delivery mother and baby remain cared for in maternity services	ccyymmdd
	D	POSTNATAL MATERNITY SERVICES (MOTHER)	Length of time mother was cared for in maternity services after delivery	Used to monitor length of time after delivery mother and baby remain cared for in maternity services	

Data Item Number	Data Item Name	Description	Purpose	Values/Format
Postnatal Observations: To carry the details of postnatal observations				
One occurrence of this Group is required for each Postnatal Observation Type				
These observations should be checked as part of the routine assessment/enquiry process				
I	POSTNATAL OBSERVATION TYPE			
I	POSTNATAL OBSERVATION DATE			ccyymmdd
D	NO OF WEEKS AFTER DELIVERY POSTNATAL OBSERVATION DATE	The number of completed weeks after delivery when observation measured		
	Mental health prediction and detection	Whether or not the recommended questions for prediction and detection of mental health issues were asked	Used to monitor implementation of antenatal and postnatal mental health guidelines	Not asked Asked, no issues Asked, issues identified
	Domestic abuse	A record of the fact that the woman was asked about whether they have experienced or are experiencing domestic abuse. This may not be asked at every appointment, but it is recommended (although not in NICE 6) that women should be asked at an opportune moment about their experiences of domestic abuse.	To check whether routine screening for common risk factors are undertaken and the effects this has on outcomes for women and their babies and to support commissioning of services for women who request support for coping with domestic violence	no yes - explanation entered not asked - and reason
Delivery Substance Observations: To carry the details of observations of smoking and alcohol use at the end of pregnancy				
One occurrence of this Group is required				
These observations should be checked as part of the routine assessment/enquiry process and may be collected retrospectively at first postnatal assessment				
I	SMOKING STATUS (MOTHER AT DELIVERY)	The mother's self-reported status of whether or not she smokes or has ever smoked. Specifically at the end of pregnancy.	Used to compare outcomes for babies of mothers who smoke	Current smoker ... Ex-smoker Non-smoker - history unknown Never smoked Unknown
I	CIGARETTES PER DAY (MOTHER AT DELIVERY)	The number of cigarettes smoked by the PATIENT where they are a current or ex-smoker	Used to compare outcomes for babies of mothers who smoke	
I	DATE STOPPED SMOKING	The date on which the PERSON stopped smoking where they are an ex-smoker. If the exact date is not known, then the year should be recorded	Used to derive the length of time prior to pregnancy mother stopped smoking	ccyymmdd
I	WEEKLY ALCOHOL UNITS (AT DELIVERY)	The typical number of units the mother reports she drank per week at the end of pregnancy	Use to identify possible alcohol misuse and compare outcomes for babies and mothers	
I	BINGE DRINKING (AT DELIVERY)	The frequency of consuming more than 6 units on one day during pregnancy as reported by the mother at first postnatal assessment	Use to identify possible alcohol misuse and compare outcomes for babies and mothers	Never Occasionally Monthly Weekly Daily
Postnatal Smoking Observations: To carry the details of observations of smoking postnatally				
One occurrence of this Group is required				
These observations should be checked as part of the routine assessment/enquiry process				
I	SMOKING STATUS (MOTHER POSTNATAL)	The mother's self-reported status of whether or not she smokes or has ever smoked. Specifically after the birth of the baby.	Used to compare outcomes for babies of mothers who smoke	Current smoker ... Ex-smoker Non-smoker - history unknown Never smoked Unknown
I	CIGARETTES PER DAY (MOTHER POSTNATAL)	The number of cigarettes smoked by the PATIENT where they are a current or ex-smoker	Used to compare outcomes for babies of mothers who smoke	
I	DATE STOPPED SMOKING	The date on which the PERSON stopped smoking where they are an ex-smoker. If the exact date is not known, then the year should be recorded	Used to derive the length of time prior to pregnancy mother stopped smoking	ccyymmdd
I	SMOKING CESSATION SUPPORT OFFERED STATUS	Whether or not referral to smoking cessation support was offered	Used to compare outcomes for babies of mothers who smoke	Offered and accepted Offered and declined Offered and undecided/considering Not offered Not applicable

Data Item Number	Data Item Name	Description	Purpose	Values/Format
Postnatal antibiotics: To carry details of antibiotic administration postnatally				
One occurrence of this Group is required				
This group will be collected when postnatal antibiotics are indicated, eg post caesarean section				
I	MEDICATION (ANTIBIOTICS)			
I	OFFER STATUS (POSTNATAL ANTIBIOTICS)	Whether or not a course of antibiotics was offered	Used to monitor implementation of guidelines	Not offered Offered and declined Offered and accepted
I	INDICATION (POSTNATAL ANTIBIOTICS)	The reason why postnatal antibiotics may be offered	Used to monitor implementation of guidelines	Caesarean section 3rd/4th degree tear other ...
Postnatal thromboprophylaxis: To carry details of postnatal thromboprophylaxis				
One occurrence of this Group is required				
This group will be collected when postnatal thromboprophylaxis is indicated, eg post caesarean section				
			37 Thromboprophylaxis during pregnancy, labour and after vaginal delivery	
I	OFFER STATUS (POSTNATAL THROMBOPROPHYLAXIS)	Whether or not postnatal thromboprophylaxis was offered	Used to monitor implementation of thromboprophylaxis guidelines	Not offered Continuation of existing treatment Offered and declined Offered and accepted
I	MECHANISM (POSTNATAL THROMBOPROPHYLAXIS)	The mechanical or chemical method used for postnatal prophylaxis	Used to monitor implementation of thromboprophylaxis guidelines	Chemical 01 Chemical - Aspirin 02 Chemical - Chloroquine 03 Chemical - Low Dose Heparin (LDH) 04 Chemical - Low Molecular Weight Heparin (LMWH) 05 Chemical - Pentasaccharide 06 Chemical - Warfarin 07 Chemical - Other (please specify) Mechanical 08 Mechanical - Foot Pump 09 Mechanical - Intermittent calf compression 10 Mechanical - TED Stockings 11 Mechanical - Other
I	INDICATION (POSTNATAL THROMBOPROPHYLAXIS)	The primary reason for offering postnatal prophylaxis	Used to monitor implementation of thromboprophylaxis guidelines	Prolonged labour Midcavity instrumental delivery Immobility before or after delivery, eg following caesarean section Pre-existing risk factors: Previous VTE Thrombophilia -congenital antithrombin deficiency -protein C deficiency -protein S deficiency Factor V Leiden -prothrombin gene variant -acquired (antiphospholipid syndrome) lupus anticoagulant -anticardiolipin antibodies Age over 35 years Obesity (BMI > 30 kg/m2) either pre-pregnancy or in early pregnancy Parity > 4 Gross varicose veins Paraplegia Sickle cell disease Inflammatory disorder e.g. inflammatory bowel disease Medical disorder, e.g. nephrotic syndrome, certain cardiac diseases Myeloproliferative disorder, e.g. essential thrombocythaemia, polycythaemia vera

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Postnatal theatre admission: To carry details of an admission to theatre post partum					
One occurrence of this Group is required for each admission to theatre					
This group will be collected when postnatal antibiotics are indicated, eg post caesarean section					
	I	POSTPARTUM THEATRE ADMISSION			
	I	POSTPARTUM THEATRE ADMISSION DATE TIME	Date/time of postpartum admission to theatre for procedure	Used to monitor outcomes of mothers	ccyymmdd hh:mm
	D	TIME FROM DELIVERY TO THEATRE PROCEDURE	Length of time in hours from delivery to POSTPARTUM THEATRE ADMISSION	Used to monitor outcomes of mothers	
	I	POSTPARTUM THEATRE PROCEDURE	Reason for theatre admission postpartum	Used to monitor outcomes of mothers	
					ERPC (evacuation of retained products of conception)
					Hysterectomy
	I	POSTNATAL ANAESTHETIC	Whether or not the mother underwent a procedure requiring anaesthetic after delivery	Used to monitor outcomes for mothers	
Postnatal rubella immunisation: To carry details of postnatal rubella immunisation					
One occurrence of this Group is required					
This group will be collected for women who were found not to have serum antibodies to rubella					
	I	IMMUNISATION OFFERED STATUS (RUBELLA)	Whether or not a mother with previous seronegative result for rubella antibody was offered, accepted or declined rubella vaccination	Used to monitor implementation of guidance and uptake of rubella immunisation	
	I	IMMUNISATION OFFER DATE (RUBELLA)	Date on which mother was offered rubella immunisation	Used to monitor screening programme	ccyymmdd
	I	IMMUNISATION (RUBELLA)	Evidence that mother receive rubella vaccination	Used to monitor implementation of guidance and uptake of rubella immunisation	MMR ?Other
	I	IMMUNISATION DATE (RUBELLA)	Date of rubella vaccination	Used to monitor implementation of guidance and uptake of rubella immunisation	ccyymmdd
Postnatal check up: To carry details of the mother's postnatal (6-8 week) check up					
One occurrence of this Group is required					
This group will normally be collected during the normal care pathway					
	D	ACTIVITY (POST NATAL CHECK)	Evidence that the mother had a post natal check up at 6-8 weeks	Used to monitor the delivery of postnatal checks	Yes No
	I	ACTIVITY DATE (POST NATAL CHECK)	Date of mother's post natal (6-8 week) check up	Used to monitor the delivery of postnatal checks	ccyymmdd
Postnatal contacts: To carry details of the postnatal contacts					
One occurrence of this Group is required for each contact					
This group will normally be collected during the normal care pathway					
	I	POSTNATAL CONTACT	Evidence of a postnatal contact	Used to monitor the levels of postnatal care	
	I	POSTNATAL CONTACT DATE	Date of postnatal contact	Used to monitor the levels of postnatal care	ccyymmdd
	I	POSTNATAL CONTACT (PROFESSION)	Professional status of person undertaking postnatal contact	Used to monitor the levels of postnatal care	

Data Item Number	Data Item Name	Description	Purpose	Values/Format
Postnatal complications and comorbidity: To carry details of any postnatal complicating or comorbid condition				
One occurrence of this Group is required for each condition				
This group will normally be collected during the normal care pathway				
I	POSTNATAL MORBIDITY	Evidence of a diagnosis of typical postnatal conditions	Used to monitor the prevalence of postnatal morbidity	
	Back Ache			
	Breast Problems			
	Clotting disorder			
	Constipation			
	Dyspareunia			
	Faecal Incontinence			
	Fatigue			
	Fits			
	Genital tract sepsis			
	Headache			
	Hypertension			
	Late PPH			
	Mental health			
	Perineal Pain			
	Pre-eclampsia and eclampsia			
	Stress Incontinence			
	Thrombosis			
	Urinary Retention			
I	DATE OF ONSET	Date on which condition was noted to have started	Used to monitor the prevalence of postnatal morbidity	ccyymmdd
I	DATE OF CONCLUSION	Date on which condition was noted to have ceased	Used to monitor the prevalence of postnatal morbidity	ccyymmdd
D	LENGTH OF TIME	Length of time for which the condition was experienced	Used to monitor the prevalence of postnatal morbidity	
Postnatal readmission: To carry details of any readmission to hospital postnatally				
One occurrence of this Group is required for each readmission				
This group will be collected in the event of a mother being readmitted to hospital postnatally				
I	POSTNATAL READMISSION	Evidence of a readmission postnatally	Used to monitor the incidence of postnatal readmissions	
I	POSTNATAL READMISSION DATE	Date of admission postnatally	Used to monitor the incidence of postnatal readmissions	ccyymmdd
I	POSTNATAL READMISSION DISCHARGE DATE	Date of discharge after postnatal readmission	Used to monitor the incidence of postnatal readmissions	ccyymmdd
I	POSTNATAL READMISSION WITH BABY	Whether or not the mother was readmitted with her baby(ies)	Used to monitor the incidence of postnatal readmissions and separation from baby	

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Maternal Death: To carry details of maternal deaths					
One occurrence of this Group is required					
This group will be collected in the event of a mother's death within 1 year of delivery					
	I	DATE TIME OF DEATH (MOTHER)	Date/time of death of mother	Used to monitor and audit maternal deaths	ccyymmdd hh:mm
	I	PLACE OF DEATH (MOTHER)	Location of place of death of mother	Used to monitor and audit maternal deaths	
	I	CAUSE OF DEATH (MOTHER)	Cause of death as recorded on death certificate	Used to monitor and audit maternal deaths	
	I	AUTOPSY	Evidence of an autopsy having been carried out	Used to monitor procedures after maternal or neonatal death	
	I	AUTOPSY DATE	Date of autopsy	Used to monitor procedures after maternal or neonatal death	ccyymmdd
	I	AUTOPSY PATHOLOGIST	Individual carrying out the autopsy	Used to link to special interest/expertise in maternal deaths	

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Postnatal - Baby: To carry details of routine postnatal activities for the baby					
One occurrence of this Group is required for each baby					
This group will normally be collected during the normal care pathway					
	I	DISCHARGE DATE TIME BABY (DELIVERING UNIT)	Date/time on which baby is discharged from delivering unit	Used to monitor lengths of stay in hospital and outcomes	ccyymmdd hh:mm
	D	LENGTH OF STAY (BABY)	Length of stay of baby in hospital after delivery	Used to monitor lengths of stay in hospital and outcomes	
	I	INTENDED METHOD OF FEEDING	The intended method of feeding the baby recorded at discharge from the delivering unit	Used to monitor the effectiveness of campaigns to increase incidence of breastfeeding	
	I	USUAL ADDRESS	Home address of baby	Requirement for NN4B	
	I	DISCHARGE ADDRESS	Address where baby is going on discharge	Requirement for NN4B	
	I	DISCHARGE DESTINATION	Type of place where baby is going on discharge	Used to monitor incidence of babies not returning immediately to their usual address and to inform planning of services	Usual address Family/other support address Local authority care Mother and baby unit Mother and baby unit - prison Other Unknown
	D	NO OF TIMES WEIGHED (FIRST WEEK)	Count of the number of times a baby is weighed in the first week	Used to monitor implementation of new postnatal care guidelines	
	D	NO OF TIMES WEIGHED (FIRST MONTH)	Count of the number of times a baby is weighed in the first month	Used to monitor implementation of new postnatal care guidelines	
	I	DATE OF DISCHARGE BABY (MATERNITY SERVICES)	Date on which baby ceased to be cared for in maternity services	Used to monitor length of time after delivery mother and baby remain cared for in maternity services	ccyymmdd
	D	POSTNATAL MATERNITY SERVICES (BABY)	Length of time baby was cared for in maternity services after delivery	Used to monitor length of time after delivery mother and baby remain cared for in maternity services	
	I	SMOKING STATUS (HOUSEHOLD)	Whether or not someone in the baby's household smokes	Used to compare outcomes for babies of mothers who smoke	
Vitamin K prophylaxis: To carry details of Vitamin K prophylaxis to prevent vitamin K deficiency bleeding					
One occurrence of this Group is required					
This group will normally be collected during the normal care pathway					
				RCM Position Paper 13b	
	I	DRUG TREATMENT (VITAMIN K)			
	I	DRUG TREATMENT STATUS (VITAMIN K)	Whether or not Vitamin K prophylaxis was offered, accepted or declined	Used to monitor the uptake of Vitamin K prophylaxis	Offered and accepted Offered and declined Not offered
	I	DRUG TREATMENT ROUTE (VITAMIN D)	Route by which Vitamin K was administered	Used to monitor the uptake of Vitamin K prophylaxis	IM Oral
	I	FIRST DRUG TREATMENT DATE (VITAMIN K)	Date on which Vitamin K was administered	Used to monitor the uptake of Vitamin K prophylaxis	ccyymmdd
Neonatal Diagnosis: To carry details of diagnoses made neonatally					
One occurrence of this Group is required for each diagnosis					
This group will normally be collected during the normal care pathway					
	I	DIAGNOSIS		Used to identify babies with neonatal complications	
	I	DIAGNOSIS DATE		Used to identify babies with neonatal complications	ccyymmdd
		Jaundice			
		Kernicterus			
		Hypernatraemia	Na >145 mmol/l		
		Erb Palsy			
		Surfactant deficiency lung disease			
		Hypoglycaemia	Evidence of baby being diagnosed with hypoglycaemia (less than 2.6)	Used to monitor prevalence of Diabetes in newborns	
		Neonatal abstinence syndrome			

Data Item Number	Data Item Name	Description	Purpose	Values/Format
Baby weight: To carry details of babies weight measurements One occurrence of this Group is required for each measurement This group will normally be collected during the normal care pathway				
	I	OBSERVATION DATE (BABY WEIGHT)		ccyymmdd
	I	OBSERVATION TYPE (BABY WEIGHT)		
Babies of Diabetic Mothers: To carry details of observations of the babies of diabetic mothers One occurrence of this Group is required for each baby This group will be collected for babies whose mother had diabetes				
	I	DIABETES CONTROL MEASUREMENT (BABY)	The first diabetes control measurement of a baby born to a mother with diabetes	Use to monitor outcomes for babies of mothers with diabetes	
	I	DIABETES CONTROL MEASUREMENT DATE TIME (BABY)	Date/time of the first diabetes control measurement of a baby born to a mother with diabetes	Use to monitor outcomes for babies of mothers with diabetes	ccyymmdd hh:mm
	I	FIRST FEED BABY DATE TIME	Date/time on which baby had first feed	Used to monitor feeding of babies and outcomes, particularly where mother has Diabetes	ccyymmdd hh:mm
	I	FIRST FEED BABY METHOD	Method of baby's first feed	Used to monitor feeding of babies and outcomes, particularly where mother has Diabetes	

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Newborn follow up for infectious disease in pregnancy: To carry details of tests, immunisations and treatment of the newborn					
One occurrence of this Group is required for each infectious disease					
This group will be collected for newborns where the mother was diagnosed with the condition antenatally or otherwise indicated					
Hepatitis B					
	I	IMMUNOGLOBULIN STATUS OFFERED STATUS (HEPATITIS B)	Whether or not test for Hepatitis B was offered, accepted or declined	Used to monitor implementation of screening guidelines and take up of services, and outcomes for babies	Offered and declined Offered and accepted Not offered
	I	NEWBORN INFECTION TEST (HEPATITIS B)	A test carried out on the newborn to ascertain whether or not they have been affected by mother-to-baby transmission of an infectious disease	Used to monitor outcomes for babies of women with infectious diseases	
	I	NEWBORN INFECTION TEST DATE (HEPATITIS B)		Used to monitor outcomes for babies of women with infectious diseases	ccyymmdd
	I	IMMUNISATION (HEPATITIS B)	Whether or not a baby of a mother with Hepatitis B was immunised	Used to monitor implementation of screening guidelines and take up of services, and outcomes for babies	
	I	IMMUNISATION OFFERED STATUS (HEPATITIS B)	Whether or not immunisation for Hepatitis B was offered, accepted or declined	Used to monitor implementation of screening guidelines and take up of services, and outcomes for babies	Offered and declined Offered and accepted Not offered
	I	IMMUNISATION DATE (FIRST HEPATITIS B)	Date on which baby received first dose for Hepatitis B immunisation	Used to monitor implementation of screening guidelines and take up of services, and outcomes for babies	ccyymmdd
BCG					
	I	BCG VACCINATION	Evidence of having BCG vaccination	Used to monitor implementation of new postnatal care guidelines	
	I	IMMUNISATION OFFERED STATUS (BCG)	Whether or not BCG immunisation was offered, accepted or declined	Used to monitor implementation of screening guidelines and take up of services, and outcomes for babies	Offered and declined Offered and accepted Not offered
	I	BCG VACCINATION DATE	Date of BCG vaccination	Used to monitor implementation of new postnatal care guidelines	ccyymmdd
Syphilis					
	I	NEWBORN INFECTION TEST (SYPHILIS)	A test carried out on the newborn to ascertain whether or not they have been affected by mother-to-baby transmission of an infectious disease	Used to monitor outcomes for babies of women with infectious diseases	
	I	NEWBORN INFECTION TEST DATE (SYPHILIS)		Used to monitor outcomes for babies of women with infectious diseases	ccyymmdd
	I	NEWBORN TREATMENT (SYPHILIS)	Whether or not the baby of a woman with syphilis was treated with penicillin	Used to monitor outcomes for babies of women with infectious diseases	
	I	NEWBORN TREATMENT START DATE (SYPHILIS)		Used to monitor outcomes for babies of women with infectious diseases	ccyymmdd

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Group B Streptococcus (http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD003667/frame.html)					
	I	NEWBORN INFECTION TEST (GROUP B STREPTOCOCCUS)	A test carried out on the newborn to ascertain whether or not they have been affected by mother-to-baby transmission of an infectious disease	Used to monitor outcomes for babies of women with infectious diseases	
	I	NEWBORN INFECTION TEST DATE (GROUP B STREPTOCOCCUS)		Used to monitor outcomes for babies of women with infectious diseases	ccyymmdd
	I	NEWBORN INFECTION TREATMENT START DATE (GROUP B STREPTOCOCCUS)		Used to monitor outcomes for babies of women with infectious diseases	ccyymmdd
HIV					
	I	NEWBORN INFECTION TEST (HIV)	A test carried out on the newborn to ascertain whether or not they have been affected by mother-to-baby transmission of an infectious disease	Used to monitor outcomes for babies of women with infectious diseases	
	I	NEWBORN INFECTION TEST DATE (HIV)		Used to monitor outcomes for babies of women with infectious diseases	ccyymmdd
	I	POSTPARTUM ANTIRETROVIRAL FOR INFANT		Used to monitor outcomes for babies of women with infectious diseases	Yes No Not known
	I	NEWBORN INFECTION TREATMENT START DATE (HIV)		Used to monitor outcomes for babies of women with infectious diseases	ccyymmdd
Other infection					
	I	NEWBORN INFECTION (OTHER DIAGNOSIS)	Diagnosis of other infectious disease observed in newborn	Used to monitor neonatal health outcomes related to antenatal screening programme and other antenatal care	e.coli other ...
	I	NEWBORN INFECTION TEST (OTHER DIAGNOSIS)	A test carried out on the newborn to ascertain whether or not they have an infectious disease	Used to monitor neonatal health outcomes related to antenatal screening programme and other antenatal care	
	I	NEWBORN INFECTION TEST DATE (OTHER DIAGNOSIS)		Used to monitor neonatal health outcomes related to antenatal screening programme and other antenatal care	ccyymmdd

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Newborn Physical Screening: To carry details of newborn screening					
One occurrence of this Group is required					
This group will normally be collected during the normal care pathway					
	I	SCREENING (NEWBORN PHYSICAL EXAMINATION)			
	I	SCREENING STATUS (NEWBORN PHYSICAL EXAMINATION)	Whether or not the NEWBORN PHYSICAL EXAMINATION was offered and accepted	Used to identify the uptake of screening	Offered and accepted Offered and declined Not offered Not applicable
	I	SCREENING DATE (NEWBORN PHYSICAL EXAMINATION)	Date of NEWBORN PHYSICAL EXAMINATION	Used to identify when the screening took place for aggregation by date period	ccyymmdd
	D	AGE AT NEWBORN PHYSICAL EXAMINATION	Age in days NEWBORN PHYSICAL EXAMINATION was undertaken	Used to identify whether or not the NEWBORN PHYSICAL EXAMINATION was undertaken at an appropriate age	n2
	D	GESTATIONAL AGE AT NEWBORN PHYSICAL EXAMINATION	Gestational Age in weeks when NEWBORN PHYSICAL EXAMINATION was undertaken	Used to identify whether or not the NEWBORN PHYSICAL EXAMINATION was undertaken at an appropriate age, for pre-term babies	ww
	I	SCREENING CLINICIAN (NEWBORN PHYSICAL EXAMINATION)	Unique identifier of the person carrying out the NEWBORN PHYSICAL EXAMINATION	Used to monitor screening processes	
	I	SCREENING CLINICIAN PROFESSION (NEWBORN PHYSICAL EXAMINATION)	Profession of the person carrying out the NEWBORN PHYSICAL EXAMINATION	Used to monitor screening processes	
	I	NEWBORN PHYSICAL EXAMINATION (HIPS)	Whether or not a problem was detected or suspected with hips	Used to monitor identification of conditions in screening	Satisfactory Problem Observation Treatment Referral Not examined
	I	NEWBORN PHYSICAL EXAMINATION (HEART)	Whether or not a problem was detected or suspected with the heart	Used to monitor identification of conditions in screening	Satisfactory Problem Observation Treatment Referral Not examined
	I	NEWBORN PHYSICAL EXAMINATION (EYES)	Whether or not a problem was detected or suspected with vision	Used to monitor identification of conditions in screening	Satisfactory Problem Observation Treatment Referral Not examined
	I	NEWBORN PHYSICAL EXAMINATION (TESTES)	Whether or not a problem was detected or suspected with the testes	Used to monitor identification of conditions in screening	Satisfactory Problem Observation Treatment Referral Not examined
	I	NEWBORN PHYSICAL EXAMINATION (GENERAL)	Whether or not any general problems were detected or suspected	Used to monitor identification of conditions in screening	Satisfactory Problem Observation Treatment Referral Not examined

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Newborn hearing Screening: To carry details of newborn hearing screening					
One occurrence of this Group is required					
This group will normally be collected during the normal care pathway					
	I	SCREENING (NEWBORN HEARING)	Evidence of screening for congenital hearing impairments	Used to monitor screening process	
	I	SCREENING DATE TIME (NEWBORN HEARING)	Date/time of screening for congenital hearing impairments. If repeat screening is indicated, this is the date of the first screen	Used to monitor screening process	ccyymmdd hh:mm
	I	SCREENING STATUS (NEWBORN HEARING)	Whether or not the NEWBORN HEARING SCREENING was offered and accepted	Used to identify the uptake of screening	Offered and accepted Offered and declined Not offered Not applicable
	D	AGE AT NEWBORN HEARING SCREENING	Age in days when NEWBORN HEARING SCREENING was undertaken. If repeat screening is indicated, this is the age at the first screen	Used to identify whether or not the NEWBORN HEARING SCREENING was undertaken at an appropriate age	
	D	GESTATIONAL AGE AT NEWBORN HEARING SCREENING	Gestational Age in weeks when NEWBORN HEARING SCREENING was undertaken. If repeat screening is indicated, this is the age at the first screen	Used to identify whether or not the NEWBORN HEARING SCREENING was undertaken at an appropriate age, for pre-term babies	ww
	I	SCREENING OUTCOME NEWBORN HEARING SCREENING	Outcome of NEWBORN HEARING SCREENING	Used to monitor screening process	Clear Response – No follow-up required Clear Response – Targeted follow-up required No Clear Response – Unilateral referral No Clear Response – Bilateral referral Incomplete – Declined screen Incomplete – Appointments missed Incomplete – Lost contact Incomplete – Deceased Incomplete – Out of screening coverage Incomplete – Withdrew consent Incomplete – Late entry Incomplete – Baby/equipment reason
	I	SCREENING OUTCOME DATE	Date at which Newborn Hearing Screening Outcome is set	Used to monitor screening process	ccyymmdd
Newborn Bloodspot Screening: To carry details of newborn bloodspot screening					
One occurrence of this Group is required for each card and each condition					
This group will normally be collected during the normal care pathway					
Bloodspot card					
	I	BLOODSPOT TEST SAMPLE DATE	Date on which bloodspot sample was taken or declined	Used to monitor screening process	ccyymmdd
	D	AGE (BLOODSPOT TEST SAMPLE)	Age in days of baby when bloodspot sample was taken. NB Date of birth is Day 0	Used to monitor screening process	n2
	D	GESTATIONAL AGE (BLOODSPOT TEST SAMPLE)	Gestational equivalent age in weeks of preterm baby when bloodspot test was taken	Used to monitor screening process	ww
	I	RESAMPLE REASON (BLOODSPOT TEST SAMPLE)	The reason for a repeat bloodspot card	Used to monitor screening process	N/A - First card Too young for reliable screening Too soon after transfusion Unsuitable sample Insufficient sample Unsatisfactory analysis Other, condition specific
	I	DATE BLOODSPOT RECEIVED AT LABORATORY	Date Bloodspot card received by laboratory. This generates code 01 for BLOODSPOT RESULT	Used to monitor screening process	ccyymmdd
	I	TIME FROM BLOODSPOT TEST TO RECEIPT AT LABORATORY	Working days between Bloodspot test and date received at laboratory	Used to monitor screening process	
	I	LABORATORY IDENTIFIER (BLOODSPOT)	The identifier of the laboratory undertaking bloodspot testing	Used to monitor screening process	

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Phenylketonuria (PKU)					
	I	BLOODSPOT CARD SCREEN CONDITION (PKU)	Whether or not screening for PKU was carried out on this sample	Used to monitor screening process	Yes No
	I	BLOODSPOT STATUS (PKU)	Whether or not screening for PKU was offered, accepted or declined. This generates code 02 for BLOODSPOT RESULT	Used to monitor screening process	Offered and accepted Offered and declined Not offered
	I	BLOODSPOT DECLINE REASON (PKU)	Reason screening for PKU was declined	Used to monitor screening process	
	I	BLOODSPOT RESULT (PKU)	Result of screening for PKU	Used to monitor screening process	01 Specimen received in laboratory 02 Screening declined 03 Further sample required 04 Condition not suspected 07 Condition not suspected, other disorders follow up 08 Condition suspected 09 Not screened/screening incomplete
	I	FURTHER SAMPLE REQUIRED REASON (PKU)	Reason for repeat testing required. Gives further information for BLOODSPOT RESULT code 03	Used to monitor screening process	Too young for reliable screening Too soon after transfusion Unsuitable sample Insufficient sample Unsatisfactory analysis Intermediate result Raised Tyrosine
	I	BLOODSPOT REASON FOR NO RESULT (PKU)	The reason why there is no result for screening for PKU. Gives further information for BLOODSPOT RESULT code 09		Child died Unreliable result No specimen collected
	I	DATE BLOODSPOT REPORT AVAILABLE (PKU)	Date on which Bloodspot Report is available	Used to monitor screening process	ccyymmdd
	I	AGE OF BABY AT BLOODSPOT REPORT AVAILABLE DATE (PKU)	Age in days of baby when Bloodspot Report is available	Used to monitor screening process	
	I	DATE BLOODSPOT RESULTS NOTIFIED TO PARENTS (PKU)	Date on which parents were notified of the result of Bloodspot screening		ccyymmdd

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Sickle Cell Disease (SCD)					
	I	BLOODSPOT CARD SCREEN CONDITION (SCD)	Whether or not screening for SCD was carried out on this sample	Used to monitor screening process	Yes No
	I	BLOODSPOT STATUS (SCD)	Whether or not screening for SCD was offered, accepted or declined. This generates code 02 for BLOODSPOT RESULT	Used to monitor screening process	Offered and accepted Offered and declined Not offered
	I	BLOODSPOT DECLINE REASON (SCD)	Reason screening for SCD was declined	Used to monitor screening process	
	I	BLOODSPOT RESULT (SCD)	Result of screening for SCD	Used to monitor screening process	01 Specimen received in laboratory 02 Screening declined 03 Further sample required 04 Condition not suspected 05 Carrier 06 Carrier of other haemoglobin 07 Condition not suspected, other disorders follow up 08 Condition suspected 09 Not screened/screening incomplete
	I	BLOODSPOT REPEAT REASON (SCD)	Reason for repeat testing required. Gives further information for BLOODSPOT RESULT code 03	Used to monitor screening process	Too young for reliable screening Too soon after transfusion Unsuitable sample Insufficient sample Unsatisfactory analysis Transfusion
	I	BLOODSPOT REASON FOR NO RESULT (SCD)	The reason why there is no result for screening for SCD Gives further information for BLOODSPOT RESULT code 09		Child died Unreliable result No specimen collected
	I	DATE BLOODSPOT REPORT AVAILABLE (SCD)	Date on which Bloodspot Report is available	Used to monitor screening process	ccyymmdd
	D	AGE OF BABY AT BLOODSPOT REPORT AVAILABLE DATE (SCD)	Age in days of baby when Bloodspot Report is available	Used to monitor screening process	
	I	DATE BLOODSPOT RESULTS NOTIFIED TO PARENTS (SCD)	Date on which parents were notified of the result of Bloodspot screening		ccyymmdd
Cystic Fibrosis (CF)					
	I	BLOODSPOT CARD SCREEN CONDITION (CF)	Whether or not screening for CF was carried out on this sample	Used to monitor screening process	Yes No
	I	BLOODSPOT STATUS (CF)	Whether or not screening for CF was offered, accepted or declined. This generates code 02 for BLOODSPOT RESULT	Used to monitor screening process	Offered and accepted Offered and declined Not offered
	I	BLOODSPOT DECLINE REASON (CF)	Reason screening for CF was declined	Used to monitor screening process	
	I	BLOODSPOT RESULT (CF)	Result of screening for CF	Used to monitor screening process	01 Specimen received in laboratory 02 Screening declined 03 Further sample required 04 Condition not suspected 07 Condition not suspected, other disorders follow up 08 Condition suspected 09 Not screened/screening incomplete
	I	BLOODSPOT REPEAT REASON (CF)	Reason for repeat testing required. Gives further information for BLOODSPOT RESULT code 03	Used to monitor screening process	High IRT
	I	BLOODSPOT REASON FOR NO RESULT (CF)	The reason why there is no result for screening for CF Gives further information for BLOODSPOT RESULT code 09		Child died Unreliable result No specimen collected Too old > 8 weeks
	I	DATE BLOODSPOT REPORT AVAILABLE (CF)	Date on which Bloodspot Report is available	Used to monitor screening process	ccyymmdd
	D	AGE OF BABY AT BLOODSPOT REPORT AVAILABLE DATE (CF)	Age in days of baby when Bloodspot Report is available	Used to monitor screening process	
	I	DATE BLOODSPOT RESULTS NOTIFIED TO PARENTS (CF)	Date on which parents were notified of the result of Bloodspot screening		ccyymmdd

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Congenital Hypothyroidism (CHT)					
	I	BLOODSPOT CARD SCREEN CONDITION (CHT)	Whether or not screening for CHT was carried out on this sample	Used to monitor screening process	Yes No
	I	BLOODSPOT STATUS (CHT)	Whether or not screening for CHT was offered, accepted or declined. This generates code 02 for BLOODSPOT RESULT	Used to monitor screening process	Offered and accepted Offered and declined Not offered
	I	BLOODSPOT DECLINE REASON (CHT)	Reason screening for CHT was declined	Used to monitor screening process	
	I	BLOODSPOT RESULT (CHT)	Result of screening for CHT	Used to monitor screening process	01 Specimen received in laboratory 02 Screening declined 03 Further sample required 04 Condition not suspected 05 Carrier 07 Condition not suspected, other disorders follow up 08 Condition suspected 09 Not screened/screening incomplete
	I	BLOODSPOT REPEAT REASON (CHT)	Reason for repeat testing required. Gives further information for BLOODSPOT RESULT code 03	Used to monitor screening process	Pre-term Equivocal biochemical finding
	I	BLOODSPOT REASON FOR NO RESULT (CHT)	The reason why there is no result for screening for CHT Gives further information for BLOODSPOT RESULT code 09		Child died Unreliable result No specimen collected
	I	DATE BLOODSPOT REPORT AVAILABLE (CHT)	Date on which Bloodspot Report is available	Used to monitor screening process	ccyymmdd
	D	AGE OF BABY AT BLOODSPOT REPORT AVAILABLE DATE (CHT)	Age in days of baby when Bloodspot Report is available	Used to monitor screening process	
	I	DATE BLOODSPOT RESULTS NOTIFIED TO PARENTS (CHT)	Date on which parents were notified of the result of Bloodspot screening		ccyymmdd
Medium Chain Acyl-CoA Dehydrogenase Deficiency (MCADD)					
	I	BLOODSPOT CARD SCREEN CONDITION (MCADD)	Whether or not screening for MCADD was carried out on this sample	Used to monitor screening process	Yes No
	I	BLOODSPOT STATUS (MCADD)	Whether or not screening for MCADD was offered, accepted or declined. This generates code 02 for BLOODSPOT RESULT	Used to monitor screening process	Offered and accepted Offered and declined Not offered
	I	BLOODSPOT DECLINE REASON (MCADD)	Reason screening for MCADD was declined	Used to monitor screening process	
	I	BLOODSPOT RESULT (MCADD)	Result of screening for MCADD	Used to monitor screening process	01 Specimen received in laboratory 02 Screening declined 03 Further sample required 04 Condition not suspected 05 Carrier 07 Condition not suspected, other disorders follow up 08 Condition suspected 09 Not screened/screening incomplete
	I	BLOODSPOT REASON FOR NO RESULT (MCADD)	The reason why there is no result for screening for MCADD Gives further information for BLOODSPOT RESULT code 09		Child died Unreliable result No specimen collected
	I	DATE BLOODSPOT REPORT AVAILABLE (MCADD)	Date on which Bloodspot Report is available	Used to monitor screening process	ccyymmdd
	D	AGE OF BABY AT BLOODSPOT REPORT AVAILABLE DATE (MCADD)	Age in days of baby when Bloodspot Report is available	Used to monitor screening process	
	I	DATE BLOODSPOT RESULTS NOTIFIED TO PARENTS (MCADD)	Date on which parents were notified of the result of Bloodspot screening		ccyymmdd

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Newborn Bloodspot Screening Follow up: To carry details of follow up actions from bloodspot screening					
One occurrence of this Group is required for each condition					
This group will normally be collected during the normal care pathway					
Phenylketonuria (PKU)					
	I	REFERRAL DATE (PKU)	Date on which a referral was made to the PKU team	Used to monitor screening policies and standards	ccyymmdd
	I	REFERRAL REQUEST (PKU)	Evidence of a referral to the PKU team	Used to monitor screening policies and standards	
	D	TIME FROM BLOODSPOT RECEIPT TO CLINICAL REFERRAL (PKU)	Working days between sample receipt and clinical referral initiated	Used to monitor screening policies and standards	
	I	SPECIALIST APPOINTMENT (PKU)	Evidence of an appointment with a PKU specialist	Used to monitor screening policies and standards	
	I	SPECIALIST APPOINTMENT DATE (PKU)	Date of appointment with a PKU specialist	Used to monitor screening policies and standards	ccyymmdd
	D	TIME FROM BLOODSPOT REPORT TO SPECIALIST APPOINTMENT (PKU)	Working days between sample receipt and clinical referral initiated	Used to monitor screening policies and standards	
	I	DIAGNOSTIC TEST (PKU)	Evidence of a test to diagnose PKU	Used to monitor screening policies and standards	
	I	DIAGNOSTIC TEST DATE TIME (PKU)	Date/time of test to diagnose PKU	Used to monitor screening policies and standards	ccyymmdd hh:mm
	I	DIAGNOSTIC TEST RESULT DATE TIME (PKU)	Date/time of availability of result of diagnostic test for PKU	Used to monitor screening policies and standards	ccyymmdd hh:mm
	D	TIME FROM DIAGNOSTIC TEST TO RESULT (PKU)	Length of time in hours from diagnostic test to the result being available (target 24 hrs, ideally same visit)	Used to monitor screening policies and standards	
	I	DIAGNOSIS (PKU)	Confirmed diagnosis of phenylketonuria	Used to monitor screening policies and standards	
	I	DIAGNOSIS DATE (PKU)	Date of diagnosis of phenylketonuria	Used to monitor screening policies and standards	ccyymmdd
	I	TREATMENT START DATE (PKU)	Date of commencement of treatment/diet	Used to monitor screening policies and standards	ccyymmdd
	D	TIME TO START TREATMENT (PKU)	No of days from diagnosis of PKU to commencement of treatment	Used to monitor screening policies and standards	
	I	DRUG PRESCRIPTION (PENICILLIN)	Evidence of prescription for prophylactic penicillin for babies with SCD	Used to monitor screening policies and standards	
	I	DRUG PRESCRIPTION DATE (PENICILLIN)	Date of prescription of prophylactic penicillin	Used to monitor screening policies and standards	
Sickle Cell Disease (SCD)					
	I	REFERRAL DATE (SCD)	Date on which a referral was made to the SCD team	Used to monitor screening policies and standards	ccyymmdd
	I	REFERRAL REQUEST (SCD)	Evidence of a referral to the SCD team	Used to monitor screening policies and standards	
	D	TIME FROM BLOODSPOT RECEIPT TO CLINICAL REFERRAL (SCD)	Working days between sample receipt and clinical referral initiated	Used to monitor screening policies and standards	
	I	SPECIALIST APPOINTMENT (SCD)	Evidence of an appointment with a SCD specialist	Used to monitor screening policies and standards	
	I	SPECIALIST APPOINTMENT DATE (SCD)	Date of appointment with a SCD specialist	Used to monitor screening policies and standards	ccyymmdd
	D	TIME FROM BLOODSPOT REPORT TO SPECIALIST APPOINTMENT (SCD)	Working days between bloodspot report and specialist appointment	Used to monitor screening policies and standards	
	I	DIAGNOSIS (SCD)	Confirmed diagnosis of SCD	Used to monitor screening policies and standards	
	I	DIAGNOSIS DATE (SCD)	Date of diagnosis of SCD	Used to monitor screening policies and standards	ccyymmdd
	I	TREATMENT START DATE (SCD)	Date of commencement of treatment	Used to monitor screening policies and standards	ccyymmdd

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Cystic Fibrosis (CF)					
	I	REFERRAL DATE (CF)	Date on which a referral was made to the CF team	Used to monitor screening policies and standards	ccyymmdd
	I	REFERRAL REQUEST (CF)	Evidence of a referral to the CF team	Used to monitor screening policies and standards	
	D	TIME FROM BLOODSPOT RECEIPT TO CLINICAL REFERRAL (CF)	Working days between sample receipt and clinical referral initiated	Used to monitor screening policies and standards	
	I	SPECIALIST APPOINTMENT (CF)	Evidence of an appointment with a CF specialist	Used to monitor screening policies and standards	
	I	SPECIALIST APPOINTMENT DATE (CF)	Date of appointment with a CF specialist	Used to monitor screening policies and standards	ccyymmdd
	D	TIME FROM BLOODSPOT REPORT TO SPECIALIST APPOINTMENT (CF)	Working days between bloodspot report and specialist appointment	Used to monitor screening policies and standards	
	I	DIAGNOSIS (CF)	Confirmed diagnosis of cystic fibrosis	Used to monitor screening policies and standards	
	I	DIAGNOSIS DATE (CF)	Date of diagnosis of cystic fibrosis	Used to monitor screening policies and standards	ccyymmdd
	I	TREATMENT START DATE (CF)	Date of commencement of treatment	Used to monitor screening policies and standards	ccyymmdd
Congenital Hypothyroidism (CHT)					
	I	REFERRAL DATE (CHT)	Date on which a referral was made to the CHT team	Used to monitor screening policies and standards	ccyymmdd
	I	REFERRAL REQUEST (CHT)	Evidence of a referral to the CHT team	Used to monitor screening policies and standards	
	D	TIME FROM BLOODSPOT RECEIPT TO CLINICAL REFERRAL (CHT)	Working days between sample receipt and clinical referral initiated	Used to monitor screening policies and standards	
	I	SPECIALIST APPOINTMENT (CHT)	Evidence of an appointment with a CHT specialist	Used to monitor screening policies and standards	
	I	SPECIALIST APPOINTMENT DATE (CHT)	Date of appointment with a CHT specialist	Used to monitor screening policies and standards	ccyymmdd
	D	TIME FROM BLOODSPOT REPORT TO SPECIALIST APPOINTMENT (CHT)	Working days between bloodspot report and specialist appointment	Used to monitor screening policies and standards	
	I	DIAGNOSTIC TEST (CHT)	Evidence of a test to diagnose CHT	Used to monitor screening policies and standards	
	I	DIAGNOSTIC TEST DATE TIME (CHT)	Date/time of test to diagnose CHT	Used to monitor screening policies and standards	ccyymmdd hh:mm
	I	DIAGNOSTIC TEST RESULT DATE TIME (CHT)	Date/time of availability of result of diagnostic test for CHT	Used to monitor screening policies and standards	ccyymmdd hh:mm
	D	TIME FROM DIAGNOSTIC TEST TO RESULT (CHT)	Length of time in hours from diagnostic test to the result being available (target 24 hrs, ideally same visit)	Used to monitor screening policies and standards	
	I	DIAGNOSIS (CHT)	Confirmed diagnosis of CHT	Used to monitor screening policies and standards	
	I	DIAGNOSIS DATE (CHT)	Date of diagnosis of CHT	Used to monitor screening policies and standards	ccyymmdd
	I	TREATMENT START DATE (CHT)	Date of commencement of treatment	Used to monitor screening policies and standards	ccyymmdd
	D	TIME TO START TREATMENT (CHT)	No of days from diagnosis of CHT to commencement of treatment	Used to monitor screening policies and standards	

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Medium Chain Acyl-CoA Dehydrogenase Deficiency (MCADD)					
	I	REFERRAL DATE (MCADD)	Date on which a referral was made to the MCADD team	Used to monitor screening policies and standards	ccyymmdd
	I	REFERRAL REQUEST (MCADD)	Evidence of a referral to the MCADD team	Used to monitor screening policies and standards	
	D	TIME FROM BLOODSPOT RECEIPT TO CLINICAL REFERRAL (MCADD)	Working days between sample receipt and clinical referral initiated	Used to monitor screening policies and standards	
	I	SPECIALIST APPOINTMENT (MCADD)	Evidence of an appointment with a MCADD specialist	Used to monitor screening policies and standards	
	I	SPECIALIST APPOINTMENT DATE (MCADD)	Date of appointment with a MCADD specialist	Used to monitor screening policies and standards	ccyymmdd
	D	TIME FROM BLOODSPOT REPORT TO SPECIALIST APPOINTMENT (MCADD)	Working days between bloodspot report and specialist appointment	Used to monitor screening policies and standards	
	I	DIAGNOSIS (MCADD)	Confirmed diagnosis of MCADD	Used to monitor screening policies and standards	
	I	DIAGNOSIS DATE (MCADD)	Date of diagnosis of MCADD	Used to monitor screening policies and standards	ccyymmdd
	I	TREATMENT START DATE (MCADD)	Date of commencement of treatment	Used to monitor screening policies and standards	ccyymmdd
6-8 Week Physical Screening: To carry details of 6-8 week physical screening One occurrence of this Group is required This group will normally be collected during the normal care pathway. For children entering the UK this physical screen may be completed up to the age of 12 months					
	I	SCREENING (6-8 WK PHYSICAL EXAMINATION)	Evidence of 6-8 WK PHYSICAL EXAMINATION being undertaken	Used to identify the uptake of screening	
	I	SCREENING DATE (6-8 WK PHYSICAL EXAMINATION)	Date of 6-8 WK PHYSICAL EXAMINATION	Used to identify when the screening took place for aggregation by date period	ccyymmdd
	I	SCREENING STATUS (6-8 WK PHYSICAL EXAMINATION)	Whether or not the 6-8 WK PHYSICAL EXAMINATION was offered and accepted	Used to identify the uptake of screening	Offered and accepted Offered and declined Not offered Not applicable
	I	SCREENING CLINICIAN (6-8 WK PHYSICAL EXAMINATION)	Unique identifier of the person carrying out the NEWBORN PHYSICAL EXAMINATION	Used to monitor screening processes	
	I	SCREENING CLINICIAN PROFESSION (6-8 WK PHYSICAL EXAMINATION)	Profession of the person carrying out the NEWBORN PHYSICAL EXAMINATION	Used to monitor screening processes	
	D	AGE AT 6-8 WEEK PHYSICAL EXAMINATION	Age in weeks and days when 6-8 WK PHYSICAL EXAMINATION was undertaken	Used to identify whether or not the 6-8 WK PHYSICAL EXAMINATION was undertaken at an appropriate age	ww +d
	D	GESTATIONAL AGE AT 6-8 WEEK PHYSICAL EXAMINATION	Gestational Age in weeks and days when 6-8 WK PHYSICAL EXAMINATION was undertaken (ie should be 46-48 wks)	Used to identify whether or not the 6-8 WK PHYSICAL EXAMINATION was undertaken at an appropriate age, for pre-term babies	ww +d
	I	6-8 WEEK PHYSICAL EXAMINATION (DDH)	Whether or not a problem was detected or suspected with hips	Used to monitor identification of conditions in screening	Satisfactory Problem Observation Treatment Referral Not examined
	I	6-8 WEEK PHYSICAL EXAMINATION (CARDIAC)	Whether or not a problem was detected or suspected with the heart	Used to monitor identification of conditions in screening	Satisfactory Problem Observation Treatment Referral Not examined

Data Item Number		Data Item Name	Description	Purpose	Values/Format
	I	6-8 WEEK PHYSICAL EXAMINATION (VISION)	Whether or not a problem was detected or suspected with vision	Used to monitor identification of conditions in screening	Satisfactory Problem Observation Treatment Referral Not examined
	I	6-8 WEEK PHYSICAL EXAMINATION (CRYPTORCHIDISM)	Whether or not a problem was detected or suspected with the testes	Used to monitor identification of conditions in screening	Satisfactory Problem Observation Treatment Referral Not examined
	I	6-8 WEEK PHYSICAL EXAMINATION (GENERAL)	Whether or not any general problems were detected or suspected	Used to monitor identification of conditions in screening	Satisfactory Problem Observation Treatment Referral Not examined

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Neonatal Death: To carry details of a neonatal death					
One occurrence of this Group is required					
This group will be collected in the event of a neonatal death					
	I	DATE OF DEATH	Date of death of baby	Used to monitor neonatal deaths	ccyymmdd
	I	TIME OF DEATH	Time of death of baby	Used to monitor neonatal deaths	hh:mm
	D	AGE AT DEATH	Age in days at death	Used to monitor neonatal deaths	n3
	D	GESTATIONAL AGE AT DEATH	Equivalent gestational age at death in weeks for preterm babies	Used to monitor neonatal deaths	ww
	D	DEATH TYPE	Calculated to distinguish Stillbirth, Early neonatal (<7 completed days), Late neonatal (7-<28 days), Post-neonatal (28-<365 days) deaths	Used to be able to aggregated deaths according to age band of baby	Stillbirth Early neonatal (<7 completed days) Late neonatal (7-<28 days) Post-neonatal (28-<365 days)
	I	CAUSE OF DEATH	Wigglesworth replacement classification of cause of death	Used to aggregated deaths by cause groups	
	I	AUTOPSY	Evidence of an autopsy having been carried out	Used to monitor procedures after maternal or neonatal death	
	I	AUTOPSY DATE	Date of autopsy	Used to monitor procedures after maternal or neonatal death	ccyymmdd
	I	AUTOPSY STATUS	Whether or not an autopsy was offered, accepted or declined	Used to monitor procedures after maternal or neonatal death	

Data Item Number	Data Item Name	Description	Purpose	Values/Format
Maternity Mental Health: To carry details of mother's mental health antenatally and postnatally				
One occurrence of this Group is required				
This group will normally be collected during the normal care pathway				
D	MENTAL HEALTH PREDICTION AND DETECTION (AT BOOKING)	Whether or not the recommended questions for prediction and detection of mental health issues were asked	Used to monitor implementation of antenatal and postnatal mental health guidelines	Not asked Asked, no issues Asked, issues identified
D	MENTAL HEALTH PREDICTION AND DETECTION (POSTNATAL)	Whether or not the recommended questions for prediction and detection of mental health issues were asked	Used to monitor implementation of antenatal and postnatal mental health guidelines	Not asked Asked, no issues Asked, issues identified
Maternity Mental Health Referral: To carry details of any referral for mental health assessment				
One occurrence of this Group is required for each referral				
This group will be collected for women who are referred for or who are undergoing assessment in pregnancy or postnatal period				
I	REFERRAL DATE (PSYCHIATRIC ASSESSMENT)	Date at which mother is referred for psychiatric assessment in this pregnancy	Used to monitor implementation of antenatal and postnatal mental health guidelines	ccyymmdd
I	REFERRAL REQUEST (PSYCHIATRIC ASSESSMENT)	Evidence that the mother was referred for psychiatric assessment in this pregnancy	Used to monitor implementation of antenatal and postnatal mental health guidelines	
I	REFERRAL SERVICE (PSYCHIATRIC ASSESSMENT)	The type of service to which the woman is referred for psychiatric assessment	Used to monitor implementation of antenatal and postnatal mental health guidelines	GP Specialist mental health service Specialist perinatal mental health service
D	TIMING OF REFERRAL (PSYCHIATRIC ASSESSMENT)	The gestation or weeks postpartum when referral was made	Used to monitor implementation of antenatal and postnatal mental health guidelines	ww
D	TIMING STAGE OF REFERRAL (PSYCHIATRIC ASSESSMENT)	Whether or not referral was made antenatally or postnatally	Used to monitor implementation of antenatal and postnatal mental health guidelines	Prenatal Antenatal Postnatal
Maternity Mental Health Admission: To carry details of any mental health admission in pregnancy or postnatal period				
One occurrence of this Group is required				
This group will be collected for women who are admitted to a mental health ward in pregnancy or postnatal period				
I	ADMISSION (MENTAL HEALTH)	Evidence of admission to a psychiatric ward in this pregnancy	Used to monitor implementation of antenatal and postnatal mental health guidelines	
I	ADMISSION DATE (MENTAL HEALTH)	Date of admission to psychiatric ward	Used to monitor implementation of antenatal and postnatal mental health guidelines	ccyymmdd
I	DISCHARGE DATE (MENTAL HEALTH)	Date of discharge from psychiatric ward	Used to monitor implementation of antenatal and postnatal mental health guidelines	ccyymmdd
D	ADMISSION TIMING (MENTAL HEALTH)	The gestation or weeks postpartum when admitted to a psychiatric ward	Used to monitor implementation of antenatal and postnatal mental health guidelines	ww
D	ADMISSION TIMING STAGE (MENTAL HEALTH)	Whether or not admission was antenatal or postnatal	Used to monitor implementation of antenatal and postnatal mental health guidelines	Prenatal Antenatal Postnatal

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Maternity Mental Health Care Plan: To carry details of a maternity and mental health care plan					
One occurrence of this Group is required for each care plan or change					
This group will be collected for any woman with a current or past history of severe mental health problems					
	I	CARE PLAN DATE (MATERNITY MENTAL HEALTH)	Date of care plan for mental health and maternity	Used to monitor implementation of antenatal and postnatal mental health guidelines	ccyymmdd
	I	CARE PLAN COMMUNICATED DATE (MATERNITY MENTAL HEALTH)	Date care plan for mental health and maternity communicated to lead maternity carer	Used to monitor implementation of antenatal and postnatal mental health guidelines	ccyymmdd
	I	CARE PLAN IMPLEMENTATION DATE (MATERNITY MENTAL HEALTH)	Date of implementation of care plan for mental health and maternity	Used to monitor implementation of antenatal and postnatal mental health guidelines	ccyymmdd

Data Item Number		Data Item Name	Description	Purpose	Values/Format
Other referrals: To carry details of referrals to other services or agencies					
One occurrence of this Group is required for each referral					
This group will be collected in the event of a referral to another service or agency					
	I	REFERRAL REQUEST (OTHER AGENCY)	Evidence of a referral to other services, eg smoking cessation	Used to monitor incidence of referral to other services	
	I	REFERRAL DATE (OTHER AGENCY)	Date on which a referral was made to other services	Used to monitor incidence of referral to other services	ccyymmdd
	I	REFERRAL REASON (OTHER AGENCY)	Reason for referral to other agencies	Used to monitor incidence of referral to other services	Child in Need Child at Risk Housing Smoking cessation ...
	I	REFERRAL REQUEST AGENCY	The unique identifier of the organisation, eg local authority, to which the referral is being made	Used to monitor incidence of referral to other services	