



# Maternity Core Data Index

## Data Item, Basis, Explanation and Values

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**Data items: 242**

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## REFERENCE DATASETS

ANSAG	Antenatal Screening Advisory Group
BAPM	British Association of Perinatal Medicine
BNDS	Birth Notification Data Set
CAR	WM Congenital Anomalies Register
CDS	Commissioning Data Set
CEMACH	Confidential Enquiry into Maternal and Child Health
DOH	Department of Health
ENN	EuroNeoNet
GROW	Gestation Related Optimal Weight
HCC	Healthcare Commission
HES	Hospital Episode Statistics
HOI	Health Outcome Indicators – Normal Pregnancy and Childbirth
M-PAG	Maternity Professional Advisory Group – West Midlands
N-PAG	Neonatal Professional Advisory Group – West Midlands
NICE	National Institute for Clinical Excellence
NSC	National Screening Committee
ONS	Office for National Statistics
RCOG	Royal College of Obstetricians and Gynaecologists
RCPCH	Royal College of Paediatrics and Child Health
RCR	Royal College of Radiologists
RPM	Reducing Perinatal Mortality Project (Birmingham and the Black Country)
RUG	Regional Ultrasound Group
SS	SureStart

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## A1. MATERNAL DETAILS - Demographics

<b>DATA ITEM</b>	<b>NHS Number</b>
<b>BASIS</b>	Unique person identifier
<b>EXPLANATION</b>	Unique identifier for use at all levels and for record linkage with maternal data
<b>INPUT OPTIONS</b>	3-3-4 numerical format
<b>DATA ORIGIN</b>	BAPM, BNDS, CAR, CEMACH, CNST, HES, M-PAG, N-PAG, RPM

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<b>DATA ITEM</b>	<b>Surname</b>
<b>BASIS</b>	Aids identification in absence of the NHS number
<b>EXPLANATION</b>	Requirement for NN4B
<b>INPUT OPTIONS</b>	Free text to document details
<b>DATA ORIGIN</b>	BNDS, CAR, CEMACH, M-PAG

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<b>DATA ITEM</b>	<b>Forename</b>
<b>BASIS</b>	Aids identification in the absence of the NHS number
<b>EXPLANATION</b>	Requirement for NN4B
<b>INPUT OPTIONS</b>	Free text to document details
<b>DATA ORIGIN</b>	BNDS, CAR, CEMACH, M-PAG

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<b>DATA ITEM</b>	<b>Date of Birth</b>
<b>BASIS</b>	To ascertain age for screening tests and age at delivery
<b>EXPLANATION</b>	Requirement for NN4B
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	BNDS, CAR, CDS, CEMACH, HES, M-PAG, RPM, SS

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<b>DATA ITEM</b>	<b>Address</b>
<b>BASIS</b>	Aids identification in absence of the NHS number
<b>EXPLANATION</b>	Requirement for NN4B
<b>INPUT OPTIONS</b>	Free text to document details
<b>DATA ORIGIN</b>	BNDS, CAR, CEMACH, HES, M-PAG

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<b>DATA ITEM</b>	<b>Postcode of mother at time of delivery</b>
<b>BASIS</b>	Identification of residence at time of birth
<b>EXPLANATION</b>	To derive geographical distribution of babies Link to district code to compare with ONS data To derive deprivation score
<b>INPUT OPTIONS</b>	Alphanumerical format (Post Office Preferred Format)
<b>DATA ORIGIN</b>	BAPM, CAR, CDS, CEMACH, HES, M-PAG, RPM, SS

<b>DATA ITEM</b>	<b>Hospital number</b>
<b>BASIS</b>	Hospital record identifier
<b>EXPLANATION</b>	Facilitates tracking of patient notes/records within the hospital departments
<b>INPUT OPTONS</b>	Numerical format
<b>DATA ORIGIN</b>	CAR, CDS, CEMACH, HES, M-PAG

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<b>DATA ITEM</b>	<b>Geographical Ethnic Origin (GEO)</b>
<b>BASIS</b>	Classification by origin to support medical data
<b>EXPLANATION</b>	The current ONS/Census groupings do not meet requirements for medical data. In the perinatal field, this includes detailing maternal ethnic origin when assessing fetal growth (as recommended by RCOG guidelines) and identifying those at risk for haemoglobinopathy screening. The GEO classification is now used across the West Midlands. However, the options do map to ONS requirements for NN4B submissions.
<b>INPUT OPTIONS</b>	<p><i>Mutually exclusive</i></p> <p>Pick list within each group</p> <p><i>Africa</i></p> <ul style="list-style-type: none"> <li>- North Africa</li> <li>- SubSahara</li> <li>- Other</li> </ul> <p><i>Asia</i></p> <ul style="list-style-type: none"> <li>- India</li> <li>- Pakistan</li> <li>- Bangladesh</li> <li>- China</li> <li>- Far East Asia – Other</li> <li>- South East Asia</li> <li>- Other</li> </ul> <p><i>Caribbean</i></p> <p><i>Europe</i></p> <ul style="list-style-type: none"> <li>- Britain</li> <li>- Ireland</li> <li>- Northern Europe</li> <li>- Western Europe</li> <li>- Eastern Europe</li> <li>- Southern Europe</li> <li>- Other</li> </ul> <p><i>Middle East</i></p> <p><i>Other</i></p>
<b>DATA ORIGIN</b>	BNDS, CAR, CDS, CEMACH, GROW, HES, M-PAG, NSC, RPM

## A2. MATERNAL DETAILS – General Practitioner details

<b>DATA ITEM</b>	<b>GP Code</b>
<b>BASIS</b>	Unique GP identifier
<b>EXPLANATION</b>	Requirement for NN4B
<b>INPUT OPTIONS</b>	Linked to National GP database
<b>DATA ORIGIN</b>	BNDS, CDS, CEMACH, HES, M-PAG, N-PAG, RPM

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<b>DATA ITEM</b>	<b>GP Name</b>
<b>BASIS</b>	GP identifier
<b>EXPLANATION</b>	Conditional requirement for NN4B
<b>INPUT OPTIONS</b>	Linked to National GP database
<b>DATA ORIGIN</b>	BNDS, CEMACH, HES, M-PAG, N-PAG

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<b>DATA ITEM</b>	<b>Practice code</b>
<b>BASIS</b>	Practice location identifier
<b>EXPLANATION</b>	Requirement for NN4B
<b>INPUT OPTIONS</b>	Linked to National GP database
<b>DATA ORIGIN</b>	BNDS, CEMACH, M-PAG, N-PAG

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<b>DATA ITEM</b>	<b>Practice name</b>
<b>BASIS</b>	Practice location identifier
<b>EXPLANATION</b>	Conditional requirement for NN4B
<b>INPUT OPTIONS</b>	Linked to National GP database
<b>DATA ORIGIN</b>	BNDS, CEMACH, M-PAG, N-PAG

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<b>DATA ITEM</b>	<b>Practice address</b>
<b>BASIS</b>	Location of practice
<b>EXPLANATION</b>	Conditional requirement for NN4B
<b>INPUT OPTIONS</b>	Linked to National GP database
<b>DATA ORIGIN</b>	BNDS, CEMACH, M-PAG, N-PAG

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<b>DATA ITEM</b>	<b>Child Health Organisation Code</b>
<b>BASIS</b>	Link to Child Health system
<b>EXPLANATION</b>	Requirement for NN4B
<b>INPUT OPTIONS</b>	Alphanumerical format
<b>DATA ORIGIN</b>	BNDS, M-PAG

## B1. HISTORY & BOOKING – Past history

<b>DATA ITEM</b>	<b>Pre-pregnancy diabetes</b>
<b>BASIS</b>	To identify glucose intolerance existing outside of pregnancy that requires medication
<b>EXPLANATION</b>	Clinical factor relevant to pregnancy care and outcome
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Requires oral hypoglycaemics Requires insulin None
<b>DATA ORIGIN</b>	CEMACH, M-PAG

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<b>DATA ITEM</b>	<b>Epilepsy history</b>
<b>BASIS</b>	To identify seizures of any kind, petit mal or grand mal, and requiring neurological investigation
<b>EXPLANATION</b>	Clinical factor relevant to pregnancy care and outcome
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Requires medication Does not require medication None
<b>DATA ORIGIN</b>	CEMACH, M-PAG

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<b>DATA ITEM</b>	<b>Hypertension history</b>
<b>BASIS</b>	To identify raised blood pressure outside of pregnancy that requires the use of anti-hypertensive medication
<b>EXPLANATION</b>	Clinical factor relevant to pregnancy care and outcome
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Requires medication Does not require medication None
<b>DATA ORIGIN</b>	CEMACH, HOI, M-PAG

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<b>DATA ITEM</b>	<b>Mental health problems</b>
<b>BASIS</b>	Known risk factor identified in CEMD report 2000-2002
<b>EXPLANATION</b>	Clinical factor relevant to pregnancy care and outcome
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Psychiatric referral Psychiatric admission Medications (+ free text to document details) None
<b>DATA ORIGIN</b>	CDS, CEMACH, HOI

**DATA ITEM** **Thromboembolic disorder history**  
**BASIS** Known risk factor identified in CEMD report 2000-2002  
**EXPLANATION** Clinical factor relevant to pregnancy care and outcome  
**INPUT OPTIONS** *Mutually exclusive*  
Low molecular weight heparin  
Unfractionated heparin  
Warfarin  
Aspirin  
None  
**DATA ORIGIN** CEMACH, M-PAG

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**DATA ITEM** **Cardiac history**  
**BASIS** Known risk factor identified in CEMD report 2000-2002  
**EXPLANATION** Clinical factor relevant to pregnancy care and outcome  
**INPUT OPTIONS** *Mutually exclusive*  
Requires medication  
Does not require medication  
None  
**DATA ORIGIN** CEMACH, M-PAG

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**DATA ITEM** **Smoker in the 12 months prior to pregnancy**  
**BASIS** Risk factor for current pregnancy  
**EXPLANATION** Requirement for DSCN 50/2002  
**INPUT OPTIONS** *Mutually exclusive*  
Yes  
No  
**DATA ORIGIN** DSC Notice 50/2002, HOI, M-PAG, SS

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**DATA ITEM** **Smoker at time of booking**  
**BASIS** Risk factor for current pregnancy  
**EXPLANATION** Requirement for DSCN 50/2002  
**INPUT OPTIONS** *Mutually exclusive*  
Yes  
No  
**DATA ORIGIN** DSC Notice 50/2002, HOI, M-PAG, RPM, SS

## B2. HISTORY & BOOKING – Past obstetric history

<b>DATA ITEM</b>	<b>Number of previous pregnancies reaching 24 weeks gestation or more</b>
<b>BASIS</b>	Part of calculation to ascertain parity
<b>EXPLANATION</b>	Required to produce the GROW chart for the current pregnancy and calculate the Robson Groups as described in the National Sentinel Caesarean Section Audit Report (2001).
<b>INPUT OPTIONS</b>	Numerical format
<b>DATA ORIGIN</b>	CDS, CEMACH, GROW, HES, M-PAG, RPM

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<b>DATA ITEM</b>	<b>Number of previous pregnancies reaching less than 24 weeks gestation</b>
<b>BASIS</b>	To assist in analysis of pregnancy loss
<b>EXPLANATION</b>	Required to calculate total number of pregnancies when analysing outcome data
<b>INPUT OPTIONS</b>	Numerical format
<b>DATA ORIGIN</b>	CDS, CEMACH, M-PAG, RCOG, RPM

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<b>DATA ITEM</b>	<b>Number of previous live births</b>
<b>BASIS</b>	Part of calculation for GROW chart
<b>EXPLANATION</b>	Required to produce the GROW chart details for previous pregnancies
<b>INPUT OPTIONS</b>	Numerical format
<b>DATA ORIGIN</b>	CEMACH, GROW, HES, M-PAG, RPM

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<b>DATA ITEM</b>	<b>Number of previous stillbirths</b>
<b>BASIS</b>	Part of calculation for GROW chart and risk assessment
<b>EXPLANATION</b>	Required to produce the GROW chart details for the previous pregnancies
<b>INPUT OPTIONS</b>	Numerical format
<b>DATA ORIGIN</b>	CEMACH, GROW, HES, M-PAG, RPM

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<b>DATA ITEM</b>	<b>Number of previous pregnancies delivered by caesarean section</b>
<b>BASIS</b>	Used as clinical indicator for risk in current pregnancy
<b>EXPLANATION</b>	To assist in clinical care
<b>INPUT OPTIONS</b>	Numerical format
<b>DATA ORIGIN</b>	CDS, M-PAG, RCOG

### B3. HISTORY & BOOKING – Booking details

<b>DATA ITEM</b>	<b>Date of booking</b>
<b>BASIS</b>	Record of first antenatal contact
<b>EXPLANATION</b>	Required on documentation in the clinical area and enables calculation of maternal age at any point in the current pregnancy
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	CDS, HES, M-PAG, RPM

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<b>DATA ITEM</b>	<b>Partnership at booking</b>
<b>BASIS</b>	Social factor relevant to pregnancy
<b>EXPLANATION</b>	To assist in assessing support mechanisms at time of booking
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Single Partner Married Separated Divorced Widowed
<b>DATA ORIGIN</b>	CEMACH, M-PAG

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<b>DATA ITEM</b>	<b>Maternal height at booking</b>
<b>BASIS</b>	Part of calculation for Body Mass Index
<b>EXPLANATION</b>	Clinical indicator for risk
<b>INPUT OPTIONS</b>	Numerical format, expressed in centimetres
<b>DATA ORIGIN</b>	GROW, M-PAG, RCOG, RPM

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<b>DATA ITEM</b>	<b>Maternal weight at booking</b>
<b>BASIS</b>	Part of calculation for Body Mass Index
<b>EXPLANATION</b>	Clinical indicator for risk
<b>INPUT OPTIONS</b>	Numerical format, expressed in kilograms
<b>DATA ORIGIN</b>	GROW, M-PAG, RCOG, RPM

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<b>DATA ITEM</b>	<b>Body Mass Index (BMI)</b>
<b>BASIS</b>	Used as clinical indicator for health risk in current pregnancy
<b>EXPLANATION</b>	Automatically calculated using a formula that requires input of height and weight
<b>INPUT OPTIONS</b>	None - calculated field displayed as numerical format
<b>DATA ORIGIN</b>	CEMACH, M-PAG

<b>DATA ITEM</b>	<b>Alcohol consumption</b>
<b>BASIS</b>	To ascertain possible alcohol abuse prior to and during pregnancy
<b>EXPLANATION</b>	Clinical factor relevant to pregnancy care and outcome
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> None Less than 3 units per week Less than 7 units per week Less than 14 units per week Less than 21 units per week 21 or more units per week
<b>DATA ORIGIN</b>	DOH, HOI, M-PAG

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<b>DATA ITEM</b>	<b>Non-medicinal drug use</b>
<b>BASIS</b>	To ascertain any substance abuse prior to and during pregnancy
<b>EXPLANATION</b>	Clinical factor relevant to pregnancy care and outcome
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes (+ free text to document details) No
<b>DATA ORIGIN</b>	HOI, M-PAG

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<b>DATA ITEM</b>	<b>Last menstrual period</b>
<b>BASIS</b>	To calculate an estimated delivery date at 40 weeks gestation
<b>EXPLANATION</b>	Used in the absence of a dating scan derived estimated date of delivery
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	M-PAG, RPM

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<b>DATA ITEM</b>	<b>Estimated date of delivery (EDD)</b>
<b>BASIS</b>	Record of expected delivery date at 40 weeks gestation
<b>EXPLANATION</b>	The most accurate method of dating the pregnancy is by dating scan. The EDD is calculated according to the crown rump length (CRL) at 8-13 weeks gestation or biparietal diameter at 12-22 weeks gestation.
<b>INPUT OPTIONS</b>	Calculated value displayed as DD/MM/YYYY
<b>DATA ORIGIN</b>	CAR, CEMACH, HES, M-PAG, RPM

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<b>DATA ITEM</b>	<b>Booked place of delivery</b>
<b>BASIS</b>	Assist with monitoring changes during pregnancy, delivery or postpartum
<b>EXPLANATION</b>	Clinical decision related to risk factors at time of booking
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Hospital inside region (pick list provided) Hospital outside region (+ free text to document details) Home Private hospital Private birth centre Unbooked
<b>DATA ORIGIN</b>	BAPM, CDS, HES, M-PAG, RPM



<b>DATA ITEM</b>	<b>Initial antenatal care plan</b>
<b>BASIS</b>	Intended designated professionals to provide antenatal care
<b>EXPLANATION</b>	Clinical decision related to risk factors at time of booking
<b>INPUT OPTIONS</b>	<p><i>Mutually exclusive</i></p> <p>Midwife + GP shared care</p> <p>Midwife, Obstetrician + GP</p> <p>Midwife only</p> <p>Midwife + Obstetrician</p> <p>Obstetrician only</p>
<b>DATA ORIGIN</b>	CDS, HES, M-PAG

## C1. ANTENATAL SCREENING – Blood tests

<b>DATA ITEM</b>	<b>Blood group</b>
<b>BASIS</b>	Record of group required for pregnancy care
<b>EXPLANATION</b>	Information required on documentation – reference for checking cross matching
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> A B AB O
<b>DATA ORIGIN</b>	ANSAG

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<b>DATA ITEM</b>	<b>Rhesus group</b>
<b>BASIS</b>	Record of group required for pregnancy care
<b>EXPLANATION</b>	Information required on documentation as an indicator for Anti-D Prophylaxis NICE guidelines
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Positive Negative
<b>DATA ORIGIN</b>	ANSAG, HOI

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<b>DATA ITEM</b>	<b>Haemoglobin at booking</b>
<b>BASIS</b>	Record of first haemoglobin status
<b>EXPLANATION</b>	Clinical indicator for risk of anaemia during pregnancy
<b>INPUT OPTIONS</b>	Numerical format, expressed as g/dl
<b>DATA ORIGIN</b>	ANSAG

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<b>DATA ITEM</b>	<b>Haemoglobin pre-delivery</b>
<b>BASIS</b>	Record of current haemoglobin status
<b>EXPLANATION</b>	Clinical indicator for risk as a result of haemorrhage intrapartum/post-delivery
<b>INPUT OPTIONS</b>	Numerical format, expressed as g/dl
<b>DATA ORIGIN</b>	ANSAG

## C2. ANTENATAL SCREENING – Haemoglobinopathy screening

<b>DATA ITEM</b>	<b>Mother's family origin</b>
<b>BASIS</b>	NSC proposed standards
<b>EXPLANATION</b>	Monitoring and audit of screening provision for local, regional QA arrangements and commissioning purposes
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Requested Not Requested
<b>DATA ORIGIN</b>	NSC

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<b>DATA ITEM</b>	<b>Haemoglobinopathy screening offered to mother</b>
<b>BASIS</b>	NHS Plan (DoH 2002) advocates a linked antenatal and neonatal screening programme for haemoglobinopathies and sickle cell disease by 2004
<b>EXPLANATION</b>	Monitoring and audit of screening provision for local, regional QA arrangements and commissioning purposes
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Offer accepted Offer declined (+ free text to document details) Not offered
<b>DATA ORIGIN</b>	ANSAG, NSC

---

<b>DATA ITEM</b>	<b>Date of haemoglobinopathy screening offer</b>
<b>BASIS</b>	NHS Plan (DoH 2002) advocates a linked antenatal and neonatal screening programme for haemoglobinopathies and sickle cell disease by 2004
<b>EXPLANATION</b>	Monitoring and audit of screening provision for local, regional QA arrangements and commissioning purposes Required for calculation of pregnancy gestation when test offered
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	NSC

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<b>DATA ITEM</b>	<b>Haemoglobinopathy screen test date</b>
<b>BASIS</b>	NSC proposed standards
<b>EXPLANATION</b>	Monitoring and audit of screening provision for local, regional QA arrangements and commissioning purposes Required for calculation of gestation and maternal age when test performed
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	NSC

<b>DATA ITEM</b>	<b>Haemoglobinopathy screen test result</b>
<b>BASIS</b>	NHS Plan (DoH 2002) advocates a linked antenatal and neonatal screening programme for haemoglobinopathies and sickle cell disease by 2004
<b>EXPLANATION</b>	Indicator for risk of sickle cell disease and thalasaemia major in current pregnancy
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Normal Abnormal (pick list of abnormal haemoglobinopathies) Inconclusive
<b>DATA ORIGIN</b>	ANSAG, NSC

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<b>DATA ITEM</b>	<b>Action following abnormal result</b>
<b>BASIS</b>	NSC proposed standards
<b>EXPLANATION</b>	Monitoring and audit of screening provision for local, regional QA arrangements and commissioning purposes
<b>INPUT OPTIONS</b>	Non-mutually exclusive Closure of screening episode Specialist review / Risk assessment
<b>DATA ORIGIN</b>	NSC

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<b>DATA ITEM</b>	<b>Date of action</b>
<b>BASIS</b>	NSC proposed standards
<b>EXPLANATION</b>	Monitoring and audit of screening provision for local, regional QA arrangements and commissioning purposes Required for calculation of pregnancy gestation when action taken
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	NSC

---

<b>DATA ITEM</b>	<b>Father's family origin</b>
<b>BASIS</b>	NSC proposed standards
<b>EXPLANATION</b>	Monitoring and audit of screening provision for local, regional QA arrangements and commissioning purposes
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Requested Not Requested
<b>DATA ORIGIN</b>	NSC

<b>DATA ITEM</b>	<b>Geographical Ethnic Origin (GEO) of father of baby</b>
<b>BASIS</b>	Classification by origin to support medical data pertaining to haemoglobinopathies
<b>EXPLANATION</b>	The current ONS/Census groupings do not meet requirements for medical data. In the perinatal field, this includes detailing paternal ethnic origin when identifying those babies at risk for haemoglobinopathy screening. The GEO classification is now used across the West Midlands. However, the options do not map to ONS requirements for NN4B submissions.
<b>INPUT OPTIONS</b>	<p><i>Mutually exclusive</i></p> <p>Pick list within each group</p> <p><i>Africa</i></p> <ul style="list-style-type: none"> <li>- North Africa</li> <li>- SubSahara</li> <li>- Other</li> </ul> <p><i>Asia</i></p> <ul style="list-style-type: none"> <li>- India</li> <li>- Pakistan</li> <li>- Bangladesh</li> <li>- China</li> <li>- Far East Asia – Other</li> <li>- South East Asia</li> <li>- Other</li> </ul> <p><i>Caribbean</i></p> <p><i>Europe</i></p> <ul style="list-style-type: none"> <li>- Britain</li> <li>- Ireland</li> <li>- Northern Europe</li> <li>- Western Europe</li> <li>- Eastern Europe</li> <li>- Southern Europe</li> <li>- Other</li> </ul> <p><i>Middle East</i></p> <p><i>Other</i></p>
<b>DATA ORIGIN</b>	BNDS, CAR, CDS, CEMACH, GROW, HES, M-PAG, NSC

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<b>DATA ITEM</b>	<b>Haemoglobinopathy screening offered to father of baby</b>
<b>BASIS</b>	NHS Plan (DoH 2002) advocates a linked antenatal and neonatal screening programme for haemoglobinopathies and sickle cell disease by 2004
<b>EXPLANATION</b>	Monitoring and audit of screening provision for local, regional QA arrangements and commissioning purposes
<b>INPUT OPTIONS</b>	<p><i>Mutually exclusive</i></p> <p>Offer accepted</p> <p>Offer declined (+ free text to document details)</p> <p>Not offered – mother declined</p> <p>Not offered – father unavailable</p>
<b>DATA ORIGIN</b>	ANSAG, NSC

<b>DATA ITEM</b>	<b>Date of haemoglobinopathy screening offer to father of baby</b>
<b>BASIS</b>	NSC proposed standards
<b>EXPLANATION</b>	Monitoring and audit of screening provision for local, regional QA arrangements and commissioning purposes Required for calculation of pregnancy gestation when test offered
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	NSC

---

<b>DATA ITEM</b>	<b>Haemoglobinopathy screen test date for father of baby</b>
<b>BASIS</b>	NSC proposed standards
<b>EXPLANATION</b>	Monitoring and audit of screening provision for local, regional QA arrangements and commissioning purposes
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	NSC

---

<b>DATA ITEM</b>	<b>Haemoglobinopathy screen test result for father of baby</b>
<b>BASIS</b>	NHS Plan (DoH 2002) advocates a linked antenatal and neonatal screening programme for haemoglobinopathies and sickle cell disease by 2004
<b>EXPLANATION</b>	Indicator for risk of sickle cell disease and thalassaemia major in offspring
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Normal Abnormal (pick list of abnormal haemoglobinopathies) Inconclusive
<b>DATA ORIGIN</b>	ANSAG, NSC

### C3. ANTENATAL SCREENING – Infectious diseases screening

<b>DATA ITEM</b>	<b>Rubella screening offered</b>
<b>BASIS</b>	Record of rubella status in pregnancy Infectious Disease Standards DoH 2003
<b>EXPLANATION</b>	Monitoring and audit of screening provision for local, regional QA arrangements and commissioning purposes
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Offer accepted Offer declined (+ free text to document details) Not offered
<b>DATA ORIGIN</b>	ANSAG

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<b>DATA ITEM</b>	<b>Rubella screen test date</b>
<b>BASIS</b>	Infectious Disease Standards DoH 2003
<b>EXPLANATION</b>	Monitoring and audit of screening provision for local, regional QA arrangements and commissioning purposes Required for calculation of pregnancy gestation when test performed
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	NSC

---

<b>DATA ITEM</b>	<b>Rubella screen test result</b>
<b>BASIS</b>	Record of rubella status in pregnancy Infectious Disease Standards DoH 2003
<b>EXPLANATION</b>	Clinical indicator for risk of acquiring an infection which is potentially hazardous to the fetus and the need for postpartum immunisation strategy
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> $\leq 10$ iu/ml (IgG -ve therefore non-immune) $> 10$ iu/ml (IgG +ve therefore immune)
<b>DATA ORIGIN</b>	ANSAG

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<b>DATA ITEM</b>	<b>Action following IgG negative test</b>
<b>BASIS</b>	Infectious Disease Standards DoH 2003
<b>EXPLANATION</b>	Monitoring and audit of screening provision for local, regional QA arrangements and commissioning purposes
<b>INPUT OPTIONS</b>	<i>Non-mutually exclusive</i> Offered test in postnatal period Immunised in postnatal period
<b>DATA ORIGIN</b>	NSC

<b>DATA ITEM</b>	<b>Hepatitis B screening offered</b>
<b>BASIS</b>	Record of status in pregnancy Infectious Disease Standards DoH 2003
<b>EXPLANATION</b>	Monitoring and audit of screening provision for local, regional QA arrangements and commissioning purposes
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Offer accepted Offer declined (+ free text to document details) Not offered
<b>DATA ORIGIN</b>	ANSAG

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<b>DATA ITEM</b>	<b>Hepatitis B screen test date</b>
<b>BASIS</b>	Infectious Disease Standards DoH 2003
<b>EXPLANATION</b>	Monitoring and audit of screening provision for local, regional QA arrangements and commissioning purposes Required for calculation of pregnancy gestation when test performed
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	NSC

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<b>DATA ITEM</b>	<b>Hepatitis B screen test result</b>
<b>BASIS</b>	Record of status in pregnancy Infectious Disease Standards DoH 2003
<b>EXPLANATION</b>	Clinical indicator for intrapartum alert and neonatal immunisation strategy
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Positive Negative
<b>DATA ORIGIN</b>	ANSAG

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<b>DATA ITEM</b>	<b>Action following positive result</b>
<b>BASIS</b>	Infectious Disease Standards DoH 2003
<b>EXPLANATION</b>	Clinical indicator for intrapartum alert and neonatal immunisation strategy
<b>INPUT OPTIONS</b>	<i>Non-mutually exclusive</i> Family testing arranged Specialist review
<b>DATA ORIGIN</b>	ANSAG

---

<b>DATA ITEM</b>	<b>Syphilis screening offered</b>
<b>BASIS</b>	Record of status in pregnancy Infectious Disease Standards DoH 2003
<b>EXPLANATION</b>	Monitoring and audit of screening provision for local, regional QA arrangements and commissioning purposes
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Offer accepted Offer declined (+ free text to document details) Not offered
<b>DATA ORIGIN</b>	ANSAG



<b>DATA ITEM</b>	<b>Syphilis screen test date</b>
<b>BASIS</b>	Infectious Disease Standards DoH 2003
<b>EXPLANATION</b>	Monitoring and audit of screening provision for local, regional QA arrangements and commissioning purposes Required for calculation of pregnancy gestation when test performed
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	NSC

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<b>DATA ITEM</b>	<b>Syphilis screen - reactive</b>
<b>BASIS</b>	Record of status in pregnancy Infectious Disease Standards DoH 2003
<b>EXPLANATION</b>	Clinical indicator of risk for maternal treatment and neonatal and family care
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes No
<b>DATA ORIGIN</b>	ANSAG

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<b>DATA ITEM</b>	<b>Action following screen–reactive result</b>
<b>BASIS</b>	Record of status in pregnancy Infectious Disease Standards DoH 2003
<b>EXPLANATION</b>	Clinical indicator of risk for maternal treatment and neonatal and family care
<b>INPUT OPTIONS</b>	<i>Non-mutually exclusive</i> Confirmation test GU review
<b>DATA ORIGIN</b>	ANSAG

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<b>DATA ITEM</b>	<b>HIV screening offered</b>
<b>BASIS</b>	Record of status in pregnancy Infectious Disease Standards DoH 2003
<b>EXPLANATION</b>	Monitoring and audit of screening provision for local, regional QA arrangements and commissioning purposes
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Offer accepted Offer declined (no reason) Offer declined (not perceived as risk) Offer declined (specialist review) Not offered
<b>DATA ORIGIN</b>	ANSAG

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<b>DATA ITEM</b>	<b>HIV screen test date</b>
<b>BASIS</b>	Infectious Disease Standards DoH 2003
<b>EXPLANATION</b>	Monitoring and audit of screening provision for local, regional QA arrangements and commissioning purposes Required for calculation of pregnancy gestation when test performed
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	NSC

<b>DATA ITEM</b>	<b>HIV screen test result</b>
<b>BASIS</b>	Record of status in pregnancy Infectious Disease Standards DoH 2003
<b>EXPLANATION</b>	Clinical indicator of risk for maternal treatment and neonatal and family care
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Positive Negative
<b>DATA ORIGIN</b>	ANSAG

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<b>DATA ITEM</b>	<b>Action following positive test result</b>
<b>BASIS</b>	Infectious Disease Standard DoH 2003
<b>EXPLANATION</b>	Monitoring and audit of screening provision for local, regional QA arrangements and commissioning purposes
<b>INPUT OPTIONS</b>	<i>Non-mutually exclusive</i> Results explained person to person Specialist counselling Confirmatory test performed Referral to HIV specialist
<b>DATA ORIGIN</b>	ANSAG

#### C4. ANTENATAL SCREENING – Down's syndrome screening

<b>DATA ITEM</b>	<b>Down's screening offered</b>
<b>BASIS</b>	NSC Standards January 2003
<b>EXPLANATION</b>	Clinical indicator of risk of fetal anomalies
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Offer accepted Offer declined (+ free text to document details) Not offered – late booker Not offered (+ free text to document details)
<b>DATA ORIGIN</b>	CAR, NSC

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<b>DATA ITEM</b>	<b>Screening leaflet given</b>
<b>BASIS</b>	NSC Standards January 2003
<b>EXPLANATION</b>	Facilitates audit of informed choice
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes No
<b>DATA ORIGIN</b>	CAR, NSC

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<b>DATA ITEM</b>	<b>Type of test</b>
<b>BASIS</b>	NSC Standards January 2003
<b>EXPLANATION</b>	Monitoring and audit of screening provision for local, regional QA arrangements and commissioning purposes
<b>INPUT OPTIONS</b>	<i>Non-mutually exclusive</i> 1 <sup>st</sup> trimester serum Nuchal translucency 2 <sup>nd</sup> trimester serum
<b>DATA ORIGIN</b>	CAR, NSC

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<b>DATA ITEM</b>	<b>Date of test</b>
<b>BASIS</b>	NSC Standards January 2003
<b>EXPLANATION</b>	Monitoring and audit of screening provision for local, regional QA arrangements and commissioning purposes Required for calculation of gestation and maternal age when test performed
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	CAR, NSC

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<b>DATA ITEM</b>	<b>Test result risk</b>
<b>BASIS</b>	NSC Standards January 2003
<b>EXPLANATION</b>	Monitoring and audit of screening provision for local, regional QA arrangements and commissioning purposes
<b>INPUT OPTIONS</b>	Numerical format (Moms)
<b>DATA ORIGIN</b>	CAR, NSC

## C5. ANTENATAL SCREENING – Neural tube defect screening

<b>DATA ITEM</b>	<b>Neural tube defect test offer</b>
<b>BASIS</b>	NSC Standards January 2003
<b>EXPLANATION</b>	Monitoring and audit of screening provision for local, regional QA arrangements and commissioning purposes
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Offer accepted Offer declined (+ free text to document details) Not offered – late booker Not offered (+ free text to document details)
<b>DATA ORIGIN</b>	CAR, NSC

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<b>DATA ITEM</b>	<b>Screening leaflet given</b>
<b>BASIS</b>	NSC Standards January 2003
<b>EXPLANATION</b>	Facilitates audit of informed choice
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes No
<b>DATA ORIGIN</b>	NSC

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<b>DATA ITEM</b>	<b>Neural tube defect test date</b>
<b>BASIS</b>	NSC Standards January 2003
<b>EXPLANATION</b>	Monitoring and audit of screening provision for local, regional QA arrangements and commissioning purposes
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	CAR, NSC

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<b>DATA ITEM</b>	<b>Neural tube defect test result</b>
<b>BASIS</b>	NSC Standards January 2003
<b>EXPLANATION</b>	Monitoring and audit of screening provision for local, regional QA arrangements and commissioning purposes
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Low risk High risk
<b>DATA ORIGIN</b>	CAR, NSC

## C6. ANTENATAL SCREENING – Booking scan

<b>DATA ITEM</b>	<b>Date of scan</b>
<b>BASIS</b>	Record of date when scan performed
<b>EXPLANATION</b>	Used in calculation of EDD by scan and to calculate gestation for follow up
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	CAR, NSC, RCOG, RCR, RUG

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<b>DATA ITEM</b>	<b>Gestation</b>
<b>BASIS</b>	Record of gestation at time of booking scan
<b>EXPLANATION</b>	Derived from biometry details used to calculate EDD Establishes gestation of detection for any congenital anomalies – effectiveness of ultrasound screening Required for accurate calculation of Down's risk and nuchal translucency measurement or serum analytes Used in analysis of fetal loss
<b>INPUT OPTIONS</b>	Calculated field displayed as numerical format
<b>DATA ORIGIN</b>	CAR, NSC, RCOG, RCR, RUG

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<b>DATA ITEM</b>	<b>Fetal heart</b>
<b>BASIS</b>	Detection/screening of fetal anomalies during antenatal period
<b>EXPLANATION</b>	Facilitates assessment of pregnancy viability
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Present Not present
<b>DATA ORIGIN</b>	CAR, NSC, RCOG, RCR, RUG

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<b>DATA ITEM</b>	<b>Crown rump length (CRL)</b>
<b>BASIS</b>	Record of CRL measurement at booking scan
<b>EXPLANATION</b>	Parameter required for calculation of gestation at scan
<b>INPUT OPTIONS</b>	Numerical format, expressed in millimetres
<b>DATA ORIGIN</b>	CAR, NSC, RCOG, RCR, RUG

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<b>DATA ITEM</b>	<b>Biparietal diameter (BPD)</b>
<b>BASIS</b>	Record of BPD measurement at booking scan
<b>EXPLANATION</b>	Parameter required for calculation of gestation at scan
<b>INPUT OPTIONS</b>	Numerical format, expressed in millimetres
<b>DATA ORIGIN</b>	CAR, NSC, RCOG, RCR, RUG

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<b>DATA ITEM</b>	<b>Nuchal translucency (NT)</b>
<b>BASIS</b>	Record of NT measurement at booking scan (in multiple pregnancy)
<b>EXPLANATION</b>	Required to determine risk of Down's according to gestation Predictor for other congenital anomalies
<b>INPUT OPTIONS</b>	Numerical format, expressed in millimetres
<b>DATA ORIGIN</b>	CAR, NSC, RCOG, RCR, RUG

<b>DATA ITEM</b>	<b>Neural tube defect</b>
<b>BASIS</b>	Detection/screening of fetal anomalies during antenatal period
<b>EXPLANATION</b>	Presence of fetal anomaly, detectable on booking scan
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Anencephaly Spina bifida Encephalocele Not seen
<b>DATA ORIGIN</b>	CAR, NSC, RCOG, RCR, RUG

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<b>DATA ITEM</b>	<b>Abdominal wall defect</b>
<b>BASIS</b>	Detection/screening of fetal anomalies during antenatal period
<b>EXPLANATION</b>	Presence of fetal anomaly, detectable on booking scan
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes No
<b>DATA ORIGIN</b>	CAR, NSC, RCOG, RCR, RUG

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<b>DATA ITEM</b>	<b>Other structural anomaly</b>
<b>BASIS</b>	Detection/screening of fetal anomalies during antenatal period
<b>EXPLANATION</b>	To record any other congenital anomalies detected
<b>INPUT OPTIONS</b>	Free text to document details
<b>DATA ORIGIN</b>	CAR, NSC, RCOG, RCR, RUG

## C7. ANTENATAL SCREENING – Anti-D prophylaxis

<b>DATA ITEM</b>	<b>Antibody test at 28 weeks gestation</b>
<b>BASIS</b>	NICE Technology Appraisal Guidance – No. 41
<b>EXPLANATION</b>	Clinical indicator for risk of rhesus haemolytic disease of the newborn (HDN)
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes No
<b>DATA ORIGIN</b>	HOI, M-PAG, NICE

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<b>DATA ITEM</b>	<b>28 week vaccination</b>
<b>BASIS</b>	NICE Technology Appraisal Guidance – No. 41
<b>EXPLANATION</b>	Clinical indicator for risk of rhesus haemolytic disease of the newborn (HDN)
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes No
<b>DATA ORIGIN</b>	HOI, M-PAG, NICE

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<b>DATA ITEM</b>	<b>34 week vaccination</b>
<b>BASIS</b>	NICE Technology Appraisal Guidance – No. 41
<b>EXPLANATION</b>	Clinical indicator for risk of rhesus haemolytic disease of the newborn (HDN)
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes No
<b>DATA ORIGIN</b>	HOI, M-PAG, NICE

## D1. PRENATAL DIAGNOSIS – Diagnostic tests

<b>DATA ITEM</b>	<b>Offer of test</b>
<b>BASIS</b>	RCOG Guidance No. 8A 2004
<b>EXPLANATION</b>	Monitoring of service provision and indicator of risk
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Offer accepted Offer declined (+ free text to document details) Not offered (+ free text to document details)
<b>DATA ORIGIN</b>	NSC

---

<b>DATA ITEM</b>	<b>Type of test</b>
<b>BASIS</b>	RCOG Guidance No. 8A 2004
<b>EXPLANATION</b>	Monitoring of service provision and indicator of risk
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Chorionic Villus Sampling Amniocentesis Fetal blood sampling Test not done (+ free text to document details)
<b>DATA ORIGIN</b>	NSC

---

<b>DATA ITEM</b>	<b>Why offered</b>
<b>BASIS</b>	RCOG Guidance No. 8A 2004
<b>EXPLANATION</b>	Monitoring of service provision and indicator of risk
<b>INPUT OPTIONS</b>	<i>Non-mutually exclusive</i> Higher risk Maternal age Family history USS indication
<b>DATA ORIGIN</b>	NSC

---

<b>DATA ITEM</b>	<b>Laboratory techniques</b>
<b>BASIS</b>	RCOG Guidance No. 8A 2004
<b>EXPLANATION</b>	Monitoring of service provision
<b>INPUT OPTIONS</b>	<i>Non-mutually exclusive</i> Full karyotype PCR FISH DNA Analysis
<b>DATA ORIGIN</b>	NSC



<b>DATA ITEM</b>	<b>Test date</b>
<b>BASIS</b>	RCOG Guidance No. 8A 2004
<b>EXPLANATION</b>	Monitoring of service provision, and gestation of pregnancy and maternal age
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	NSC

---

<b>DATA ITEM</b>	<b>Test result</b>
<b>BASIS</b>	RCOG Guidance No. 8A 2004
<b>EXPLANATION</b>	Monitoring of service provision and congenital anomalies
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Normal karyotype Positive Down's Other (+ free text to document details)
<b>DATA ORIGIN</b>	NSC

## D2. PRENATAL DIAGNOSIS – Anomaly scan

<b>DATA ITEM</b>	<b>Date of scan</b>
<b>BASIS</b>	Record of date when scan performed
<b>EXPLANATION</b>	Used to calculate gestation at scan, and EDD
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	CAR, NSC, RCOG, RCR, RUG

---

<b>DATA ITEM</b>	<b>Gestation at scan</b>
<b>BASIS</b>	Record of gestation calculation when scan performed
<b>EXPLANATION</b>	Establishes gestation of detection for any congenital anomalies for effectiveness of ultrasound screening
<b>INPUT OPTIONS</b>	Calculated field displayed as numerical format
<b>DATA ORIGIN</b>	CAR, NSC, RCOG, RCR, RUG

---

<b>DATA ITEM</b>	<b>Markers for trisomy</b>
<b>BASIS</b>	Detection/screening of fetal anomalies during antenatal period
<b>EXPLANATION</b>	To screen for cases of trisomy
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Seen <i>Pick list for seen option – non-mutually exclusive</i> <ul style="list-style-type: none"><li>- Nuchal pad</li><li>- Echogenic bowel</li><li>- Choroid plexus cyst(s)</li><li>- Echogenic focus</li><li>- Dilated renal pelvis</li><li>- Short femur</li></ul> Not seen
<b>DATA ORIGIN</b>	CAR, NSC, RCOG, RCR, RUG

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<b>DATA ITEM</b>	<b>Other anomalies</b>
<b>BASIS</b>	Detection/screening of fetal anomalies during antenatal period
<b>EXPLANATION</b>	Identification of other anomalies
<b>INPUT OPTIONS</b>	Free text to document details
<b>DATA ORIGIN</b>	CAR, NSC, RCOG, RCR, RUG

## E1. ANTENATAL PERIOD – Antenatal Visits

<b>DATA ITEM</b>	<b>Number of antenatal visits with community midwifery service</b>
<b>BASIS</b>	Record number of documented antenatal contacts with midwifery service
<b>EXPLANATION</b>	Enable calculation of continuity of carer
<b>INPUT OPTIONS</b>	Numerical format Not Known Not Documented
<b>DATA ORIGIN</b>	RPM

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<b>DATA ITEM</b>	<b>Number of antenatal visits with named midwife</b>
<b>BASIS</b>	Record number of documented antenatal contacts with identified lead midwife
<b>EXPLANATION</b>	Enable calculation of continuity of carer
<b>INPUT OPTIONS</b>	Numerical format Not Known Not Documented
<b>DATA ORIGIN</b>	RPM

## E2. ANTENATAL PERIOD – Complications

<b>DATA ITEM</b>	<b>Threatened miscarriage</b>
<b>BASIS</b>	Any reported vaginal bleeding during the course of pregnancy prior to 24 weeks
<b>EXPLANATION</b>	Clinical factor relevant to pregnancy care and potential risk factors
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes No
<b>DATA ORIGIN</b>	M-PAG

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<b>DATA ITEM</b>	<b>Antepartum haemorrhage</b>
<b>BASIS</b>	Any reported vaginal bleeding from the 24 weeks until the birth
<b>EXPLANATION</b>	Clinical factor relevant to pregnancy care and potential risk factors
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Abruptio Placenta praevia Cervical Other (+ free text to document details)
<b>DATA ORIGIN</b>	CEMACH, M-PAG

<b>DATA ITEM</b>	<b>Maternal trauma</b>
<b>BASIS</b>	Any significant event or injury to the mother that could affect the course of the pregnancy e.g. seatbelt injury, road traffic accident, domestic violence
<b>EXPLANATION</b>	Clinical factor relevant to pregnancy care, potential risk factors and outcome
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes Yes, attributed to domestic violence No
<b>DATA ORIGIN</b>	CEMACH, HOI, M-PAG, RCOG

---

<b>DATA ITEM</b>	<b>Vaginal infection</b>
<b>BASIS</b>	Any microbiologically proven infection during pregnancy
<b>EXPLANATION</b>	Clinical factor relevant to pregnancy care, potential risk factors and outcome
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes No
<b>DATA ORIGIN</b>	M-PAG

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<b>DATA ITEM</b>	<b>Urinary tract infection</b>
<b>BASIS</b>	Any microbiologically proven infection during pregnancy
<b>EXPLANATION</b>	Clinical factor relevant to pregnancy care, potential risk factors and outcome
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes No
<b>DATA ORIGIN</b>	M-PAG

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<b>DATA ITEM</b>	<b>Threatened prematurity</b>
<b>BASIS</b>	Any episode of uterine activity before 37 weeks that requires the use of tocolysis
<b>EXPLANATION</b>	Clinical factor relevant to pregnancy care, potential risk factors and outcome
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes (+ free text to document details) No
<b>DATA ORIGIN</b>	CEMACH, M-PAG, RCOG

---

<b>DATA ITEM</b>	<b>Antenatal steroids</b>
<b>BASIS</b>	Steroids administered to the mother at any time during pregnancy where premature delivery is anticipated
<b>EXPLANATION</b>	Facilitates audit of best practice guidelines
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Incomplete course Complete course < 7 days before delivery Complete course $\geq$ 7 days before delivery Multiple courses None
<b>DATA ORIGIN</b>	BAPM, CEMACH, HOI, M-PAG, N-PAG, RCOG, RCPCH

**DATA ITEM** **Total number of doses of antenatal steroids**  
**BASIS** A record of the total number of doses given to a mother  
**EXPLANATION** Antenatal steroids enhance foetal surfactant production and reduce neonatal morbidity and mortality in preterm babies  
**INPUT OPTIONS** Numerical format  
**DATA ORIGIN** HCC, M-PAG, N-PAG

---

**DATA ITEM** **Gestational diabetes**  
**BASIS** Glucose intolerance that develops during pregnancy and requires intervention(s) to control blood sugar metabolism  
**EXPLANATION** Clinical factor relevant to pregnancy care, potential risk factors and outcome  
**INPUT OPTIONS** *Mutually exclusive*  
Yes  
Yes with treatment (+ free text to document details)  
No  
**DATA ORIGIN** CEMACH, M-PAG

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**DATA ITEM** **Thromboembolism**  
**BASIS** Any thrombus and/or embolism formation during pregnancy  
**EXPLANATION** Clinical factor relevant to pregnancy care, potential risk factors and outcome  
**INPUT OPTIONS** *Mutually exclusive*  
Yes  
Yes with treatment (+ free text to document details)  
No  
**DATA ORIGIN** CEMACH, M-PAG, RCOG

---

**DATA ITEM** **Referral for suspected intrauterine growth retardation (IUGR) antenatally**  
**BASIS** Sub optimal fetal growth suspected antenatally from clinical assessment  
**EXPLANATION** Clinical factor relevant to pregnancy care, potential risk factors and outcome  
**INPUT OPTIONS** *Mutually exclusive*  
Yes  
No  
**DATA ORIGIN** M-PAG, RPM

---

**DATA ITEM** **IUGR**  
**BASIS** Sub optimal fetal growth confirmed on ultrasound or doppler  
**EXPLANATION** Clinical factor related to potential risk factors and outcome  
**INPUT OPTIONS** *Mutually exclusive*  
Yes  
No  
**DATA ORIGIN** MPAG

<b>DATA ITEM</b>	<b>Pregnancy induced hypertension (PIH)</b>
<b>BASIS</b>	Raised blood pressure during the pregnancy requiring extra surveillance and/or medication
<b>EXPLANATION</b>	Clinical factor relevant to pregnancy care, potential risk factors and outcome
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes No
<b>DATA ORIGIN</b>	CEMACH, M-PAG

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<b>DATA ITEM</b>	<b>Proteinuria during pregnancy</b>
<b>BASIS</b>	The presence of two or more "+" of protein on urine testing at any time
<b>EXPLANATION</b>	Clinical factor relevant to pregnancy care, potential risk factors and outcome
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes No
<b>DATA ORIGIN</b>	M-PAG

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<b>DATA ITEM</b>	<b>Eclampsia</b>
<b>BASIS</b>	Convulsions associated with the preeclamptic group of conditions (excluding epilepsy)
<b>EXPLANATION</b>	Clinical factor relevant to pregnancy care, potential risk factors and outcome
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes No
<b>DATA ORIGIN</b>	HOI, M-PAG

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<b>DATA ITEM</b>	<b>Anti-hypertensives</b>
<b>BASIS</b>	Any oral or parenteral medication administered during pregnancy
<b>EXPLANATION</b>	Clinical factor relevant to pregnancy care, potential risk factors and outcome
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes No
<b>DATA ORIGIN</b>	CEMACH, M-PAG, RCOG

## F1. BIRTH EVENT - MOTHER – Initial details

<b>DATA ITEM</b>	<b>Care plan at the start of labour</b>
<b>BASIS</b>	To identify lead professional responsible for care at start of labour
<b>EXPLANATION</b>	To facilitate audit of standards of care in labour
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Midwife & GP shared care Midwife, obstetrician & GP shared care Midwife only Midwife & obstetrician only Obstetrician only
<b>DATA ORIGIN</b>	CDS, HES, M-PAG

---

<b>DATA ITEM</b>	<b>Reason for change of care</b>
<b>BASIS</b>	Record of reason for change of intended plan of care at any time during pregnancy and/or labour
<b>EXPLANATION</b>	Facilitates tracking of care and audit of best practice
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Clinical reasons during pregnancy Other reasons during pregnancy Clinical reasons during labour Other reasons during labour
<b>DATA ORIGIN</b>	CDS, CEMACH, HES, M-PAG

---

<b>DATA ITEM</b>	<b>Labour onset</b>
<b>BASIS</b>	To ascertain if labour was spontaneous
<b>EXPLANATION</b>	To record any intervention in process of labour
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Spontaneous Induction/ripening Caesarean before labour TOP – Medical / surgical
<b>DATA ORIGIN</b>	CDS, HES, M-PAG

---

<b>DATA ITEM</b>	<b>Method of induction</b>
<b>BASIS</b>	To record any intervention in process of labour
<b>EXPLANATION</b>	To facilitate audit of standards of care in labour
<b>INPUT OPTIONS</b>	<i>Non-mutually exclusive</i> Membrane sweep Prostaglandin E2 Gemprost ARM Oxytocin
<b>DATA ORIGIN</b>	HES, M-PAG

<b>DATA ITEM</b>	<b>Reason for induction</b>
<b>BASIS</b>	To record decision for intervention
<b>EXPLANATION</b>	To facilitate audit of standards of care in labour
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Postdates PET IUGR SROM Past obstetric history Maternal pain / distress
<b>DATA ORIGIN</b>	M-PAG

---

<b>DATA ITEM</b>	<b>Membranes ruptured before labour</b>
<b>BASIS</b>	Relevant to possible infection of baby
<b>EXPLANATION</b>	Clinical factor relevant to pregnancy care, risk factors and outcome
<b>INPUT OPTIONS</b>	Calculated field
<b>DATA ORIGIN</b>	M-PAG

---

<b>DATA ITEM</b>	<b>Date of rupture of membranes (ROM)</b>
<b>BASIS</b>	Date of ROM
<b>EXPLANATION</b>	Needed to ascertain length of time elapsed between ROM and birth
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	M-PAG

---

<b>DATA ITEM</b>	<b>Time of rupture of membranes (ROM)</b>
<b>BASIS</b>	Time of ROM
<b>EXPLANATION</b>	Needed to ascertain length of time elapsed between ROM and birth
<b>INPUT OPTIONS</b>	HH:MM (24 hour clock)
<b>DATA ORIGIN</b>	M-PAG



## F2. BIRTH EVENT – MOTHER - Labour

<b>DATA ITEM</b>	<b>Lead professional</b>
<b>BASIS</b>	To identify most senior professional responsible for care during labour
<b>EXPLANATION</b>	To facilitate audit of standards of care in labour and change of lead professional
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Consultant obstetrician Midwife GP
<b>DATA ORIGIN</b>	HES, M-PAG

---

<b>DATA ITEM</b>	<b>Augmentation of labour</b>
<b>BASIS</b>	To record any intervention in process of labour
<b>EXPLANATION</b>	To facilitate audit of standards of care in labour
<b>INPUT OPTIONS</b>	<i>Non-mutually exclusive</i> ARM Syntocinon
<b>DATA ORIGIN</b>	CDS, M-PAG

---

<b>DATA ITEM</b>	<b>Pain relief</b>
<b>BASIS</b>	To identify method of pain relief during labour
<b>EXPLANATION</b>	To facilitate audit of standards of care in labour
<b>INPUT OPTIONS</b>	<i>Non-mutually exclusive</i> TNS Inhalational analgesia Narcotics Regional – spinal Regional – epidural Regional – combined spinal/epidural Regional – pudendal
<b>DATA ORIGIN</b>	HOI, M-PAG

---

<b>DATA ITEM</b>	<b>Monitoring during established labour</b>
<b>BASIS</b>	Minimum standards of care in labour (NICE)
<b>EXPLANATION</b>	To facilitate audit of best practice
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Intermittent Continuous Intermittent and continuous None
<b>DATA ORIGIN</b>	M-PAG, RCOG

<b>DATA ITEM</b>	<b>Intrapartum haemorrhage</b>
<b>BASIS</b>	Vaginal bleeding after onset of labour
<b>EXPLANATION</b>	To identify risk factor and facilitate audit of best practice
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Abruptio None
<b>DATA ORIGIN</b>	M-PAG

---

<b>DATA ITEM</b>	<b>Date of onset of established labour</b>
<b>BASIS</b>	To record basic chronology of labour
<b>EXPLANATION</b>	To facilitate audit of standards of care in labour
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	HES, M-PAG

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<b>DATA ITEM</b>	<b>Time of onset of established labour</b>
<b>BASIS</b>	To record basic chronology of labour
<b>EXPLANATION</b>	To facilitate audit of standards of care in labour
<b>INPUT OPTIONS</b>	HH:MM (24 hour clock)
<b>DATA ORIGIN</b>	HES, M-PAG

---

<b>DATA ITEM</b>	<b>Date of onset of second stage</b>
<b>BASIS</b>	To record basic chronology of labour
<b>EXPLANATION</b>	To facilitate audit of standards of care in labour
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	M-PAG

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<b>DATA ITEM</b>	<b>Time of onset of second stage</b>
<b>BASIS</b>	To record basic chronology of labour
<b>EXPLANATION</b>	To facilitate audit of standards of care in labour
<b>INPUT OPTIONS</b>	HH:MM (24 hour clock)
<b>DATA ORIGIN</b>	M-PAG

---

<b>DATA ITEM</b>	<b>Date of onset of third stage</b>
<b>BASIS</b>	To record basic chronology of labour
<b>EXPLANATION</b>	To facilitate audit of standards of care in labour
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	M-PAG

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<b>DATA ITEM</b>	<b>Time of onset of third stage</b>
<b>BASIS</b>	To record basic chronology of labour
<b>EXPLANATION</b>	To facilitate audit of standards of care in labour
<b>INPUT OPTIONS</b>	HH:MM (24 hour clock)
<b>DATA ORIGIN</b>	M-PAG



<b>DATA ITEM</b>	<b>Number of babies this confinement</b>
<b>BASIS</b>	To differentiate types of pregnancy
<b>EXPLANATION</b>	Requirement for NN4B To facilitate audit of risk factors and outcome in different types of pregnancy
<b>INPUT OPTIONS</b>	Numerical format
<b>DATA ORIGIN</b>	BAPM, BNDS, CDS, HES, M-PAG, N-PAG

---

<b>DATA ITEM</b>	<b>Third stage management</b>
<b>BASIS</b>	To record any intervention in process of labour/birth
<b>EXPLANATION</b>	Identifies risk factor and facilitates audit of practice
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Physiological Active Manual removal
<b>DATA ORIGIN</b>	M-PAG

---

<b>DATA ITEM</b>	<b>Placenta</b>
<b>BASIS</b>	To record appearance of placenta
<b>EXPLANATION</b>	Relevant to risks of maternal complications
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Apparently complete Incomplete Ragged/fragmented Not known
<b>DATA ORIGIN</b>	M-PAG

---

<b>DATA ITEM</b>	<b>Membranes</b>
<b>BASIS</b>	To record appearance of membranes
<b>EXPLANATION</b>	Relevant to risks of maternal complications
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Apparently complete Incomplete Ragged/fragmented Not known
<b>DATA ORIGIN</b>	M-PAG

### F3. BIRTH EVENT – MOTHER - Perineum

<b>DATA ITEM</b>	<b>Perineum</b>
<b>BASIS</b>	To record any intervention in process of labour/birth
<b>EXPLANATION</b>	Identifies risk factor and facilitates audit of practice
<b>INPUT OPTIONS</b>	<i>Non-mutually exclusive</i> Intact Labial tear Vaginal tear Perineal tear Episiotomy Cervical tear
<b>DATA ORIGIN</b>	HOI, M-PAG

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<b>DATA ITEM</b>	<b>Degree of tear</b>
<b>BASIS</b>	To record presence/severity of tear
<b>EXPLANATION</b>	Identifies risk factor and facilitates audit of practice
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> None 1 <sup>st</sup> degree 2 <sup>nd</sup> degree 3 <sup>rd</sup> degree 4 <sup>th</sup> degree
<b>DATA ORIGIN</b>	HOI, M-PAG

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<b>DATA ITEM</b>	<b>Perineal repair</b>
<b>BASIS</b>	To record method of repair
<b>EXPLANATION</b>	Facilitates audit of practice
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Two-layered (skin open) Three-layered (skin closed) Not sutured
<b>DATA ORIGIN</b>	M-PAG, RCOG

---

<b>DATA ITEM</b>	<b>Suture material</b>
<b>BASIS</b>	Identification of suture material
<b>EXPLANATION</b>	Facilitates audit of practice
<b>INPUT OPTIONS</b>	Free text to document details
<b>DATA ORIGIN</b>	M-PAG

<b>DATA ITEM</b>	<b>Repaired by (status)</b>
<b>BASIS</b>	Identification of grade of professional
<b>EXPLANATION</b>	Facilitates audit of practice
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Midwife Student midwife Consultant Registrar SHO
<b>DATA ORIGIN</b>	M-PAG

## F4. BIRTH EVENT – MOTHER – Immediate postpartum

<b>DATA ITEM</b>	<b>Significant early postpartum haemorrhage (PPH)</b>
<b>BASIS</b>	Any estimated blood loss >500mls or that which results in hypovolaemic shock within 2 hours of delivery
<b>EXPLANATION</b>	Identifies risk factor and facilitates audit of practice
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes No
<b>DATA ORIGIN</b>	CEMACH, HOI, M-PAG, RCOG

---

<b>DATA ITEM</b>	<b>Blood loss in labour, delivery &amp; early PPH</b>
<b>BASIS</b>	Records total amount of blood loss
<b>EXPLANATION</b>	Relevant to risks of maternal complications
<b>INPUT OPTIONS</b>	Numerical format, expressed in millimetres
<b>DATA ORIGIN</b>	CEMACH, M-PAG

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<b>DATA ITEM</b>	<b>Skin to skin contact</b>
<b>BASIS</b>	Record of opportunity for bonding
<b>EXPLANATION</b>	Possible effects on maternal/child relationship and likelihood of breastfeeding
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes No (+ free text to document details)
<b>DATA ORIGIN</b>	M-PAG, SS

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<b>DATA ITEM</b>	<b>Length of contact</b>
<b>BASIS</b>	Length of time taken when offer accepted
<b>EXPLANATION</b>	Possible effects on maternal/child relationship and likelihood of breastfeeding
<b>INPUT OPTIONS</b>	Numerical format, expressed in minutes
<b>DATA ORIGIN</b>	M-PAG

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<b>DATA ITEM</b>	<b>Initiated breast feeding at delivery</b>
<b>BASIS</b>	Record of opportunity to breastfeed as soon as possible following delivery
<b>EXPLANATION</b>	Possible effects on maternal/child relationship and likelihood to succeed with breastfeeding Required for monitoring Public Health and PSA targets
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes No (+ free text to document details)
<b>DATA ORIGIN</b>	HOI, M-PAG, RPM, SS

<b>DATA ITEM</b>	<b>Transfer date</b>
<b>BASIS</b>	Date of transfer/end of labour care episode
<b>EXPLANATION</b>	Facilitates tracking and calculation on care episodes
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	HES, M-PAG

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<b>DATA ITEM</b>	<b>Transfer destination</b>
<b>BASIS</b>	Denotes place of care following delivery
<b>EXPLANATION</b>	Facilitates analysis of good practice guidelines and tracking of care episodes
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Postnatal Ward Transitional care ward Home Mother & baby Unit ITU HDU Died Other hospital (+ free text to document details) Other (+ free text to document details)
<b>DATA ORIGIN</b>	HES, HOI

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<b>DATA ITEM</b>	<b>Smoker at time of delivery</b>
<b>BASIS</b>	Risk factor for current pregnancy
<b>EXPLANATION</b>	Requirement for DSCN 50/2002
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes No
<b>DATA ORIGIN</b>	DSC Notice 50/2002, HOI, M-PAG, RPM, SS



## G1. BIRTH DETAILS – BABY - Delivery

<b>DATA ITEM</b>	<b>Outcome of pregnancy</b>
<b>BASIS</b>	Records outcome of pregnancy
<b>EXPLANATION</b>	Requirement for NN4B Facilitates audit on outcome
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Live Antepartum stillbirth Intrapartum stillbirth Indeterminate stillbirth Spontaneous miscarriage Miscarriage after invasive procedure TOP – medical TOP - surgical Alive but died Other (+ free text to document details)
<b>DATA ORIGIN</b>	BAPM, BNDS, CAR, CDS, CEMACH, HES, HOI, M-PAG, RCOG, RPM, SS

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<b>DATA ITEM</b>	<b>Date of birth</b>
<b>BASIS</b>	Date of birth of the baby
<b>EXPLANATION</b>	Requirement for NN4B Required to derive patient age for analysis by age at admission or discharge, for screening, to assist clinical care
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	BAPM, BNDS, CDS, CEMACH, HES, M-PAG, N-PAG, RPM

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<b>DATA ITEM</b>	<b>Time of birth</b>
<b>BASIS</b>	Time of birth of the baby
<b>EXPLANATION</b>	Requirement for NN4B Required to derive patient age for analysis by age at admission or discharge, for screening, to assist clinical care
<b>INPUT OPTIONS</b>	HH:MM (24 hour clock)
<b>DATA ORIGIN</b>	BAPM, BNDS, CDS, CEMACH, HES, M-PAG, N-PAG

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<b>DATA ITEM</b>	<b>Gender</b>
<b>BASIS</b>	Phenotypic classification of appearance of sex of baby at delivery
<b>EXPLANATION</b>	Required for NN4B Facilitates analysis of outcome by sex
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Male Female Not specified Not known
<b>DATA ORIGIN</b>	BAPM, BNDS, CDS, CEMACH, HES, M-PAG, N-PAG, RPM

<b>DATA ITEM</b>	<b>Birth weight</b>
<b>BASIS</b>	The first weight of the baby obtained after birth recorded in grams, ideally within an hour of delivery
<b>EXPLANATION</b>	Requirement for NN4B Indicator of pregnancy outcome Major risk factor for neonatal mortality and morbidity Required to plan perinatal services for high risk babies
<b>INPUT OPTIONS</b>	Numerical format, expressed in grams
<b>DATA ORIGIN</b>	BAPM, BNDS, CDS, CEMACH, HES, HOI, M-PAG, N-PAG, RPM, SS

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<b>DATA ITEM</b>	<b>Gestation at delivery</b>
<b>BASIS</b>	Number of weeks of age of baby at time of delivery calculated by first trimester dating ultrasound scan or menstrual date
<b>EXPLANATION</b>	Requirement for NN4B A determinant of outcome
<b>INPUT OPTIONS</b>	Calculated field
<b>DATA ORIGIN</b>	BAPM, BNDS, CDS, CEMACH, HES, HOI, M-PAG, N-PAG

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<b>DATA ITEM</b>	<b>Birth order</b>
<b>BASIS</b>	The sequence in which the baby was born in a multiple birth
<b>EXPLANATION</b>	Requirement for NN4B To analyse pregnancy outcome according to birth order and to identify the individual baby resulting from a multiple birth pregnancy
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Singleton First of twins Second of twins First of triplets, etc.
<b>DATA ORIGIN</b>	BAPM, BNDS, CDS, CEMACH, HES, M-PAG

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<b>DATA ITEM</b>	<b>Customised centile</b>
<b>BASIS</b>	Customised birth Centile for baby
<b>EXPLANATION</b>	Determines potential risk factors for baby and facilitates audit of outcome
<b>INPUT OPTIONS</b>	Calculated field
<b>DATA ORIGIN</b>	GROW, M-PAG, RCOG

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<b>DATA ITEM</b>	<b>NHS Baby Number</b>
<b>BASIS</b>	Unique identifier for baby
<b>EXPLANATION</b>	Produced on submission of NN4B data - facilitates record linkage
<b>INPUT OPTIONS</b>	Numerical – generated from NN4B notification
<b>DATA ORIGIN</b>	BAPM, BNDS, CDS, CEMACH, HES, M-PAG, N-PAG, RPM

<b>DATA ITEM</b>	<b>Place of delivery</b>
<b>BASIS</b>	Location of place of delivery of baby
<b>EXPLANATION</b>	Requirement for NN4B
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Hospital inside region (pick list) Hospital outside region (+ free text to document details) Home Other (+ free text to document details)
<b>DATA ORIGIN</b>	BAPM, BNDS, CDS, CEMACH, HES, M-PAG, N-PAG, RPM, SS

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<b>DATA ITEM</b>	<b>Hospital code</b>
<b>BASIS</b>	Unique identifier denoting the hospital
<b>EXPLANATION</b>	Requirement for NN4B Facilitates audit and tracking of patient care
<b>INPUT OPTIONS</b>	Linked to National Hospital database
<b>DATA ORIGIN</b>	BNDS, CDS, CEMACH, HES, M-PAG, N-PAG, RPM

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<b>DATA ITEM</b>	<b>Lie/presentation before birth</b>
<b>BASIS</b>	Position of baby prior to birth
<b>EXPLANATION</b>	Relevant to type of birth offered and facilitates audit of best practice
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Cephalic Breech Transverse/oblique Not known
<b>DATA ORIGIN</b>	BAPM, BNDS, HES, M-PAG

---

<b>DATA ITEM</b>	<b>Delivery mode</b>
<b>BASIS</b>	Mode of delivery for baby
<b>EXPLANATION</b>	Facilitates audit of practice
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Spontaneous vaginal Breech vaginal Ventouse Ventouse (after failed forceps) Forceps (low cavity) Forceps (mid cavity/rotational) Forceps (after failed ventouse) Elective caesarean Scheduled caesarean Urgent caesarean Urgent caesarean (after failed ventouse) Urgent caesarean (after failed forceps) Urgent caesarean (after failed forceps and ventouse) Emergency caesarean
<b>DATA ORIGIN</b>	BNDS, HES, HOI, M-PAG, N-PAG

<b>DATA ITEM</b>	<b>Caesarean primary reason</b>
<b>BASIS</b>	Records reason for decision
<b>EXPLANATION</b>	Facilitates audit of best practice and trends in care
<b>INPUT OPTIONS</b>	<p><i>Mutually exclusive</i></p> <p><i>Fetal</i></p> <ul style="list-style-type: none"> <li>- Not cephalic</li> <li>- Multiple pregnancy</li> <li>- Baby size problem</li> <li>- Compromise, presumed</li> <li>- Cord prolapse</li> <li>- Chorioamnionitis</li> </ul> <p><i>Maternal</i></p> <ul style="list-style-type: none"> <li>- Placenta praevia</li> <li>- APH / Intrapartum haemorrhage</li> <li>- Placental abruption</li> <li>- Preeclampsia / Eclampsia / HELLP</li> <li>- Medical disease</li> <li>- Failure to progress</li> <li>- Previous caesarean section</li> <li>- Previous poor outcome</li> <li>- Previous emotional/physical traumatic vaginal delivery</li> <li>- Previous infertility</li> <li>- Uterine rupture</li> <li>- Maternal request</li> </ul>
<b>DATA ORIGIN</b>	HES, M-PAG

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<b>DATA ITEM</b>	<b>Analgesia / Anaesthesia for birth</b>
<b>BASIS</b>	Identifies analgesia/anaesthesia used for birth
<b>EXPLANATION</b>	Facilitates audit of practice, may be relevant to complications and effect on mother/infant bonding
<b>INPUT OPTIONS</b>	<p><i>Non-mutually exclusive</i></p> <p>Epidural</p> <p>Spinal</p> <p>Caudal</p> <p>Pudendal Block</p> <p>Local Anaesthetic Infiltrate</p> <p>General anaesthetic</p>
<b>DATA ORIGIN</b>	CDS, HES, M-PAG

<b>DATA ITEM</b>	<b>Ethnic Origin</b>
<b>BASIS</b>	Classification by origin to support medical data
<b>EXPLANATION</b>	The current ONS/Census groupings do not meet requirements for medical data. In the perinatal field, this includes detailing baby's ethnic origin when assessing birth centile and identifying those at risk for haemoglobinopathy screening. The GEO classification is now used across the West Midlands. However, the options do map to ONS requirements for NN4B submissions.
<b>INPUT OPTIONS</b>	<p><i>Mutually exclusive</i></p> <p>Pick list within each group</p> <p><i>Africa</i></p> <ul style="list-style-type: none"> <li>- North Africa</li> <li>- Sub Sahara</li> <li>- Other</li> </ul> <p><i>Asia</i></p> <ul style="list-style-type: none"> <li>- India</li> <li>- Pakistan</li> <li>- Bangladesh</li> <li>- China</li> <li>- Far East Asia – Other</li> <li>- South East Asia</li> <li>- Other</li> </ul> <p><i>Caribbean</i></p> <p><i>Europe</i></p> <ul style="list-style-type: none"> <li>- Britain</li> <li>- Ireland</li> <li>- Northern Europe</li> <li>- Western Europe</li> <li>- Eastern Europe</li> <li>- Southern Europe</li> <li>- Other</li> </ul> <p><i>Middle East</i></p> <p><i>Other</i></p>
<b>DATA ORIGIN</b>	BNDS, CDS, HES, M-PAG, N-PAG

## G2. BIRTH DETAILS – BABY – Professionals for delivery

<b>DATA ITEM</b>	<b>Grade</b>
<b>BASIS</b>	Record of professional responsible for delivery
<b>EXPLANATION</b>	Facilitates audit of practice
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Midwife Student midwife Consultant Registrar GP Other
<b>DATA ORIGIN</b>	CDS, HES, M-PAG

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<b>DATA ITEM</b>	<b>Surname of person notifying birth</b>
<b>BASIS</b>	Personal identifier
<b>EXPLANATION</b>	Requirement for NN4B
<b>INPUT OPTIONS</b>	Free text to document details
<b>DATA ORIGIN</b>	BNDS, M-PAG

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<b>DATA ITEM</b>	<b>Forename of person notifying birth</b>
<b>BASIS</b>	Personal identifier
<b>EXPLANATION</b>	Requirement for NN4B
<b>INPUT OPTIONS</b>	Free text to document details
<b>DATA ORIGIN</b>	BNDS, M-PAG

### G3. BIRTH DETAILS – BABY – Congenital anomalies (at birth)

<b>DATA ITEM</b>	<b>Congenital anomaly</b>
<b>BASIS</b>	Presence of a congenital anomaly excluding those detailed in EUROCAT
<b>EXPLANATION</b>	To measure incidence of congenital anomaly in babies born
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes No Suspected
<b>DATA ORIGIN</b>	BAPM, CAR, M-PAG, N-PAG

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<b>DATA ITEM</b>	<b>Date of notification</b>
<b>BASIS</b>	Record of notification
<b>EXPLANATION</b>	Facilitates audit of process and dissemination of information to parents
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	CAR, M-PAG, N-PAG

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<b>DATA ITEM</b>	<b>Details of anomaly</b>
<b>BASIS</b>	Clinical factor relevant to clinical care
<b>EXPLANATION</b>	Determines potential risk factors and outcome for baby
<b>INPUT OPTIONS</b>	<i>Non-mutually exclusive</i> Abnormal karyotype Central nervous type Cardiac / CVS Renal & urogenital Skeletal / limb Head & neck Chest & abdominal Syndrome Other (+ free text to document details)
<b>DATA ORIGIN</b>	CAR, M-PAG, N-PAG

## G4. BIRTH DETAILS – BABY – Complications of labour & birth

<b>DATA ITEM</b>	<b>Suspected fetal compromise (distress)</b>
<b>BASIS</b>	Records possible clinical complication
<b>EXPLANATION</b>	Aids in determination of potential risk factors for baby and facilitates audit of practice
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes No
<b>DATA ORIGIN</b>	M-PAG

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<b>DATA ITEM</b>	<b>Liquor condition</b>
<b>BASIS</b>	Records clinical observation of liquor
<b>EXPLANATION</b>	Aids in determination of potential risk factors for baby and facilitates audit of practice
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Clear Light meconium Thick meconium Blood stained No liquor seen Not known
<b>DATA ORIGIN</b>	M-PAG, NICE, RCOG

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<b>DATA ITEM</b>	<b>Cord prolapse</b>
<b>BASIS</b>	Records possible clinical complication
<b>EXPLANATION</b>	Aids in determination of potential risk factors for baby and facilitates audit of practice
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes No Not known
<b>DATA ORIGIN</b>	M-PAG

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<b>DATA ITEM</b>	<b>Shoulder dystocia</b>
<b>BASIS</b>	Records possible clinical complication
<b>EXPLANATION</b>	Aids in determination of potential risk factors for baby and facilitates audit of practice
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes No
<b>DATA ORIGIN</b>	M-PAG



## G5. BIRTH DETAILS – BABY – Resuscitation details

<b>DATA ITEM</b>	<b>Professionals leading resuscitation</b>
<b>BASIS</b>	A measure of competency and seniority of personnel present at resuscitation
<b>EXPLANATION</b>	Staff trained in neonatal resuscitation favourably influence the management and outcome of an ill or preterm baby requiring resuscitation
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Midwife Neonatal Nurse ANNP SHO Specialist Registrar Consultant
<b>DATA ORIGIN</b>	CEMACH, M-PAG, N-PAG

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<b>DATA ITEM</b>	<b>Type of resuscitation</b>
<b>BASIS</b>	Identifies the method used to assist baby in establishing effective breathing
<b>EXPLANATION</b>	An indirect measure of the baby's physical condition at birth and response of professional present at birth to infants condition
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Basic Advanced None
<b>DATA ORIGIN</b>	CDS, HES, M-PAG, N-PAG

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<b>DATA ITEM</b>	<b>Intermittent Positive Pressure Ventilation (IPPV)</b>
<b>BASIS</b>	Identifies method of delivering respiratory support
<b>EXPLANATION</b>	The need for endotracheal IPPV is an indicator of continuing need for airway support
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Face mask Endotracheal tube Both None
<b>DATA ORIGIN</b>	HES, M-PAG, N-PAG

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<b>DATA ITEM</b>	<b>Age at intubation</b>
<b>BASIS</b>	Records age at which baby was intubated
<b>EXPLANATION</b>	A measure of the time taken to secure baby's airway during resuscitation and a means of recording compliance with RCPCH RDS guideline and surfactant administration in appropriate cohort
<b>INPUT OPTIONS</b>	MM (to nearest minute)
<b>DATA ORIGIN</b>	HES, M-PAG, N-PAG

<b>DATA ITEM</b>	<b>Intubated transfer to neonatal unit</b>
<b>BASIS</b>	Identifies whether baby was transferred intubated to neonatal unit
<b>EXPLANATION</b>	Required in analysing the level of dependency on admission to the NNU
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes No
<b>DATA ORIGIN</b>	M-PAG, N-PAG

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<b>DATA ITEM</b>	<b>External cardiac massage given</b>
<b>BASIS</b>	Record of use of this procedure
<b>EXPLANATION</b>	Facilitates audit of resuscitation practice and best practice guidelines
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes No
<b>DATA ORIGIN</b>	M-PAG, N-PAG

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<b>DATA ITEM</b>	<b>Drugs given</b>
<b>BASIS</b>	Record of use of any drugs for resuscitation
<b>EXPLANATION</b>	Facilitates audit of resuscitation practice and best practice guidelines
<b>INPUT OPTIONS</b>	<i>Non-mutually exclusive</i> Adrenaline Bicarbonate Volume Glucose
<b>DATA ORIGIN</b>	HES, M-PAG, N-PAG

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<b>DATA ITEM</b>	<b>Apgar score at 1 minute of age of baby</b>
<b>BASIS</b>	An assessment of the baby's physical condition at birth
<b>EXPLANATION</b>	Low apgar score indicates need for resuscitation and is related to outcome
<b>INPUT OPTIONS</b>	Numerical format
<b>DATA ORIGIN</b>	HES, M-PAG, N-PAG

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<b>DATA ITEM</b>	<b>Apgar score at 5 minutes of age of baby</b>
<b>BASIS</b>	An assessment of the baby's physical condition at birth
<b>EXPLANATION</b>	Low apgar score indicates need for resuscitation and is related to outcome
<b>INPUT OPTIONS</b>	Numerical format
<b>DATA ORIGIN</b>	HES, M-PAG, N-PAG

## G6. BIRTH DETAILS – BABY – Transfer details

<b>DATA ITEM</b>	<b>Transfer date</b>
<b>BASIS</b>	Date of transfer/end of care episode
<b>EXPLANATION</b>	Facilitates tracking and calculation on care episodes
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	HES, M-PAG

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<b>DATA ITEM</b>	<b>Vitamin K</b>
<b>BASIS</b>	Prevention of Vitamin K deficient bleeding of the newborn (VKDB)
<b>EXPLANATION</b>	Vitamin K administration prevents VKDB
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Given IV Given IM Given orally – no further doses needed Given orally – further doses needed Not given
<b>DATA ORIGIN</b>	DOH PL/CMO/98/3; DOH PL/CMO/98/4; DOH/HMSO 2000, M-PAG, N-PAG

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<b>DATA ITEM</b>	<b>Intended method of feeding</b>
<b>BASIS</b>	Method of choice at the time of birth
<b>EXPLANATION</b>	Possible effects on maternal/child relationship and facilitates calculation of breast feeding rates
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Breast Artificial Breast and artificial Other (+ free text to document details)
<b>DATA ORIGIN</b>	M-PAG, N-PAG, SS

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<b>DATA ITEM</b>	<b>SCBU / NICU admission</b>
<b>BASIS</b>	Records necessity for transfer of care
<b>EXPLANATION</b>	Assists with audit of babies requiring admission to SCBU/NICU
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes No
<b>DATA ORIGIN</b>	BAPM, HES, HOI, M-PAG

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<b>DATA ITEM</b>	<b>Usual address</b>
<b>BASIS</b>	To provide follow up address for continuance of clinical care
<b>EXPLANATION</b>	Requirement for NN4B
<b>INPUT OPTIONS</b>	Free text to document details
<b>DATA ORIGIN</b>	BNDS, M-PAG, N-PAG

## H. POSTNATAL DATA - MOTHER

<b>DATA ITEM</b>	<b>Antibiotic administration</b>
<b>BASIS</b>	Records administration of antibiotics following caesarean section
<b>EXPLANATION</b>	Facilitates audit of best practice guidelines
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes No
<b>DATA ORIGIN</b>	CEMACH

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<b>DATA ITEM</b>	<b>Thromboprophylaxis given</b>
<b>BASIS</b>	Records administration of thrombolytic agents
<b>EXPLANATION</b>	Facilitates audit of best practice guidelines
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Increased risk factors (e.g. previous history, high BMI) Following caesarean section On-going administration (due to episode during this pregnancy) None
<b>DATA ORIGIN</b>	CEMACH

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<b>DATA ITEM</b>	<b>Medical complications</b>
<b>BASIS</b>	Records medical complications relevant to outcome
<b>EXPLANATION</b>	Facilitates audit of best practice guidelines
<b>INPUT OPTIONS</b>	<i>Non-mutually exclusive</i> Hypertension Fits Clotting disorder Late PPH
<b>DATA ORIGIN</b>	CEMACH, HOI

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<b>DATA ITEM</b>	<b>Surgical complications</b>
<b>BASIS</b>	Records surgical complications relevant to outcome
<b>EXPLANATION</b>	Facilitates audit of best practice guidelines
<b>INPUT OPTIONS</b>	<i>Non-mutually exclusive</i> Anaesthetic after delivery ERPC Hysterectomy
<b>DATA ORIGIN</b>	CDS, CEMACH

<b>DATA ITEM</b>	<b>Severe postnatal depression / Psychotic complications</b>
<b>BASIS</b>	Records episodes relevant to mental health and outcome
<b>EXPLANATION</b>	Facilitates audit of best practice guidelines
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Psychiatric referral Psychiatric admission Medications (+ free text to document details) None
<b>DATA ORIGIN</b>	CEMACH, HOI

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<b>DATA ITEM</b>	<b>Date of discharge to Health Visitor</b>
<b>BASIS</b>	Date denoting change of care episode
<b>EXPLANATION</b>	Facilitates tracking of care episodes and calculation of duration
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	CDS, HES, M-PAG, RPM

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<b>DATA ITEM</b>	<b>Transfer details</b>
<b>BASIS</b>	Record of next episode of care
<b>EXPLANATION</b>	Facilitates tracking of care episodes and auditing of practice
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Home Mother & baby Unit ITU HDU Died Other hospital (+ free text to document details) Other (+ free text to document details)
<b>DATA ORIGIN</b>	CDS, HES, HOI

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<b>DATA ITEM</b>	<b>Number of postnatal visits with midwifery service</b>
<b>BASIS</b>	Record number of documented postnatal contacts with midwifery service
<b>EXPLANATION</b>	Enable calculation of continuity of carer
<b>INPUT OPTIONS</b>	Numerical format Not Known Not Documented
<b>DATA ORIGIN</b>	RPM

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<b>DATA ITEM</b>	<b>Number of postnatal visits with lead midwife</b>
<b>BASIS</b>	Record number of documented postnatal contacts with identified lead midwife
<b>EXPLANATION</b>	Enable calculation of continuity of carer
<b>INPUT OPTIONS</b>	Numerical format Not Known Not Documented
<b>DATA ORIGIN</b>	RPM

## I. MATERNAL DEATH DATA

<b>DATA ITEM</b>	<b>Date of death</b>
<b>BASIS</b>	Record of the date of death of the mother
<b>EXPLANATION</b>	Used in audit of maternal mortality
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	CEMACH, HOI

---

<b>DATA ITEM</b>	<b>Time of death</b>
<b>BASIS</b>	Record of the time of death of the mother
<b>EXPLANATION</b>	Used in audit of maternal mortality
<b>INPUT OPTIONS</b>	HH:MM (24 hour clock)
<b>DATA ORIGIN</b>	CEMACH, HOI

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<b>DATA ITEM</b>	<b>Place of death</b>
<b>BASIS</b>	Location of place of death of mother
<b>EXPLANATION</b>	Facilitates audit of maternal mortality
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Hospital (pick list provided) Other (+ free text to document details)
<b>DATA ORIGIN</b>	CEMACH

---

<b>DATA ITEM</b>	<b>Cause of death</b>
<b>BASIS</b>	A description of cause of death of a mother
<b>EXPLANATION</b>	An important outcome indicator
<b>INPUT OPTIONS</b>	As per Medical certificate of cause of death ONS
<b>DATA ORIGIN</b>	CEMACH, HOI, M-PAG, ONS

## J. POSTNATAL DATA - BABY

<b>DATA ITEM</b>	<b>Date of discharge</b>
<b>BASIS</b>	Date denoting end of care episode
<b>EXPLANATION</b>	Required to derive length of stay
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	BAPM, CDS, HES, M-PAG, N-PAG

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<b>DATA ITEM</b>	<b>Discharge weight</b>
<b>BASIS</b>	Weight of baby at time of discharge
<b>EXPLANATION</b>	An important outcome measure of neonatal care. Has resource implications.
<b>INPUT OPTIONS</b>	Numerical format, expressed in grams
<b>DATA ORIGIN</b>	BAPM, ENN, M-PAG, N-PAG, SS

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<b>DATA ITEM</b>	<b>Feeding method</b>
<b>BASIS</b>	Method of choice at time of discharge
<b>EXPLANATION</b>	Facilitates calculation of breastfeeding rates and audit of practice
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Breast Artificial Breast and artificial Other (+ free text to document details)
<b>DATA ORIGIN</b>	HOI, M-PAG, N-PAG, RPM, SS

---

<b>DATA ITEM</b>	<b>Date of first feed</b>
<b>BASIS</b>	Record of first feed
<b>EXPLANATION</b>	Enables calculation for timing of bloodspot test
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	M-PAG, SS

---

<b>DATA ITEM</b>	<b>Time of first feed</b>
<b>BASIS</b>	Record of first feed
<b>EXPLANATION</b>	Enables calculation for timing of bloodspot test
<b>INPUT OPTIONS</b>	HH:MM (24 hour clock)
<b>DATA ORIGIN</b>	M-PAG, SS

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<b>DATA ITEM</b>	<b>Jaundiced</b>
<b>BASIS</b>	Records presence of jaundice before discharge from place of birth
<b>EXPLANATION</b>	Assists in identifying potential risk factors for baby
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes No
<b>DATA ORIGIN</b>	HES, M-PAG

<b>DATA ITEM</b>	<b>Highest plasma bilirubin</b>
<b>BASIS</b>	Record of highest plasma bilirubin reading
<b>EXPLANATION</b>	Assists in identifying potential risk factors for baby
<b>INPUT OPTIONS</b>	Numerical format, expressed in micromol/l
<b>DATA ORIGIN</b>	HES, M-PAG

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<b>DATA ITEM</b>	<b>Date of highest plasma bilirubin</b>
<b>BASIS</b>	Record of date of the test
<b>EXPLANATION</b>	Enables calculation of age at which test was taken and assists in identifying potential risk factors for baby
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	M-PAG

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<b>DATA ITEM</b>	<b>Time of highest plasma bilirubin</b>
<b>BASIS</b>	Record of time of the test
<b>EXPLANATION</b>	Enables calculation of age at which test was taken and assists in identifying potential risk factors for baby
<b>INPUT OPTIONS</b>	HH:MM (24 hour clock)
<b>DATA ORIGIN</b>	M-PAG

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<b>DATA ITEM</b>	<b>Neonatal Bloodspot Test</b>
<b>BASIS</b>	Record that test has been performed
<b>EXPLANATION</b>	Facilitates audit of practice and adherence to guidelines
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes No
<b>DATA ORIGIN</b>	M-PAG, N-PAG, NSC

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<b>DATA ITEM</b>	<b>Date of neonatal bloodspot test</b>
<b>BASIS</b>	Record of when the test was performed
<b>EXPLANATION</b>	Enables calculation of age at test and audit of practice
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	M-PAG, N-PAG, NSC

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<b>DATA ITEM</b>	<b>Universal Neonatal Hearing screen</b>
<b>BASIS</b>	Records that test has been performed
<b>EXPLANATION</b>	Facilitates audit of practice and adherence to guidelines
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes No
<b>DATA ORIGIN</b>	BAPM, M-PAG, N-PAG, NSC



<b>DATA ITEM</b>	<b>Hepatitis B immunisation given</b>
<b>BASIS</b>	Infectious Disease Standards DoH 2003
<b>EXPLANATION</b>	To audit neonatal immunisation strategy following positive maternal hepatitis B screening result
<b>INPUT OPTIONS</b>	Mutually exclusive Yes No
<b>DATA ORIGIN</b>	ANSAG

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<b>DATA ITEM</b>	<b>Date of discharge examination</b>
<b>BASIS</b>	Record of when examination took place
<b>EXPLANATION</b>	Enables calculation of age at examination and audit of practice
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	M-PAG, NSC

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<b>DATA ITEM</b>	<b>Time of discharge examination</b>
<b>BASIS</b>	Record of when examination took place
<b>EXPLANATION</b>	Enables calculation of age at examination and audit of practice
<b>INPUT OPTIONS</b>	HH:MM (24 hour clock)
<b>DATA ORIGIN</b>	M-PAG, NSC

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<b>DATA ITEM</b>	<b>Result</b>
<b>BASIS</b>	Records outcome of examination
<b>EXPLANATION</b>	Determines potential risk factors for baby and monitor quality of service provision
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Normal Abnormal (+ free text to document details)
<b>DATA ORIGIN</b>	M-PAG, NSC

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<b>DATA ITEM</b>	<b>Hip examination</b>
<b>BASIS</b>	Records that examination has taken place
<b>EXPLANATION</b>	Determines potential risk factors for baby and audit of service provision for those at risk
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Normal Abnormal (+ free text to document details)
<b>DATA ORIGIN</b>	HES, M-PAG, NSC

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<b>DATA ITEM</b>	<b>Undescended testes</b>
<b>BASIS</b>	Records that examination has taken place
<b>EXPLANATION</b>	Determines potential risk factors for baby and audit of service provision for those at risk
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Yes No
<b>DATA ORIGIN</b>	M-PAG, NSC

## K. NEONATAL DEATH DATA

<b>DATA ITEM</b>	<b>Date of death</b>
<b>BASIS</b>	Record of the date and time of death of the baby
<b>EXPLANATION</b>	Used to calculate duration of survival. An important outcome indicator, which has resource implications
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	BAPM, CEMACH, HOI, N-PAG

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<b>DATA ITEM</b>	<b>Time of death</b>
<b>BASIS</b>	Record of the time of death of the baby
<b>EXPLANATION</b>	Used to calculate duration of survival. An important outcome indicator, which has resource implication
<b>INPUT OPTIONS</b>	HH:MM (24 hour clock)
<b>DATA ORIGIN</b>	BAPM, CEMACH, HOI, N-PAG

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<b>DATA ITEM</b>	<b>Place of death</b>
<b>BASIS</b>	Location of place of death of baby
<b>EXPLANATION</b>	Facilitates audit of infant mortality
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Hospital (+ free text to document details) Other (+ free text to document details)
<b>DATA ORIGIN</b>	CEMACH

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<b>DATA ITEM</b>	<b>Post Mortem examination</b>
<b>BASIS</b>	Record of whether post mortem performed and whether efforts made to obtain consent for same
<b>EXPLANATION</b>	Used to determine post mortem rate and refusal rate
<b>INPUT OPTIONS</b>	<i>Mutually exclusive</i> Held / being arranged Requested but consent not given Parental consent but no autopsy performed Not requested Coroner's postmortem
<b>DATA ORIGIN</b>	BAPM, CEMACH, N-PAG

---

<b>DATA ITEM</b>	<b>Cause of death</b>
<b>BASIS</b>	A description of cause of death of a baby
<b>EXPLANATION</b>	An important outcome indicator
<b>INPUT OPTIONS</b>	As per Medical certificate of cause of death ONS
<b>DATA ORIGIN</b>	CEMACH, N-PAG, ONS

## L. SPECIALIST REFERRALS

<b>DATA ITEM</b>	<b>Specialist referral</b>
<b>BASIS</b>	Record of whether mother was referred to a specialist during pregnancy
<b>EXPLANATION</b>	To establish whether mother was referred and for what purpose
<b>INPUT OPTIONS</b>	Not referred Referred (+ free text to document details)
<b>DATA ORIGIN</b>	RPM

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<b>DATA ITEM</b>	<b>Date of specialist referral</b>
<b>BASIS</b>	Record of when mother was referred during pregnancy
<b>EXPLANATION</b>	Date required to establish gestation at which mother was referred
<b>INPUT OPTIONS</b>	DD/MM/YYYY
<b>DATA ORIGIN</b>	RPM

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<b>DATA ITEM</b>	<b>Follow-up arranged</b>
<b>BASIS</b>	Record of whether follow-up arranged following specialist referral
<b>EXPLANATION</b>	To establish whether a follow-up appointment was required
<b>INPUT OPTIONS</b>	Yes No
<b>DATA ORIGIN</b>	RPM

## APPENDIX 1 – ETHNICITY MAPPING: GEO -> ONS

### [RULE 1]

If no selection is made from the GEO options, the transformation selects the ONS “Not Known” option

### [RULE 2]

If one selection is made from the GEO options, the transformation to ONS looks like the following:

Africa – North	maps to	Black African
Africa – Sub-sahara	maps to	Black African
Africa – Other	maps to	Black African
Asia – India	maps to	Indian
Asia – Pakistan	maps to	Pakistani
Asia – Bangladesh	maps to	Bangladeshi
Asia – China	maps to	Chinese
Asia – Far East	maps to	Other
Asia - South East	maps to	Other
Asia – Other	maps to	Other
Caribbean	maps to	Black Caribbean
Europe – Britain	maps to	White
Europe – Ireland	maps to	White
Europe – Northern	maps to	White
Europe – Western	maps to	White
Europe – Eastern	maps to	White
Europe – Southern	maps to	White
Europe – Other	maps to	White
Middle East	maps to	Other
Other	maps to	Other

Example: GEO: African – North -> ONS: Black African

Example: GEO: African – Other -> ONS: Black African

Example: GEO: Asia – India -> ONS: Indian

Example: GEO: Asia – Other -> ONS: Other

Example: GEO: Middle East -> ONS: Other

### [RULE 3]

If multiple selections are made from the GEO options, the transformation to ONS follows the process outlined below:

- I. For each single selection made, perform the transformation as if that was the only selection
- II. Compare all the resulting ONS values together. If they are all the same, use that ONS value, but if they are different, transform to “ONS: Mixed”

Example: GEO: African – North + GEO: African – Other -> ONS: Black African + ONS: Black African -> ONS: Black African

Example: GEO: African – North + GEO: Asia – India -> ONS: Black African + ONS: Indian -> ONS: Mixed

Example: GEO: Asia – Other + GEO: Middle East -> ONS: Other + ONS: Other -> ONS: Other

## APPENDIX 2 – REFERENCE MATERIAL

BNDS	<a href="http://www.nhs.uk/nhsia/nhsia/nn4b/pages/bndatasetv4.0.doc">http://www.nhs.uk/nhsia/nhsia/nn4b/pages/bndatasetv4.0.doc</a>
CDS	<a href="http://www.nhs.uk/datastandards/pages/cds_manual.asp">http://www.nhs.uk/datastandards/pages/cds_manual.asp</a>
CEMACH	<a href="http://www.cemach.org.uk/publications.htm">http://www.cemach.org.uk/publications.htm</a>
ENN	<a href="http://www.euroneonet.com/">http://www.euroneonet.com/</a>
GROW	<a href="http://www.gestation.net/main.htm">http://www.gestation.net/main.htm</a>
HES	<a href="http://www.dh.gov.uk/PublicationsAndStatistics/Statistics/HospitalEpisodeStatistics/fs/en">http://www.dh.gov.uk/PublicationsAndStatistics/Statistics/HospitalEpisodeStatistics/fs/en</a>
M-PAG/NPAG	<a href="http://www.perinatal.nhs.uk/manners/advisory.htm">http://www.perinatal.nhs.uk/manners/advisory.htm</a>
NICE	<a href="http://www.nice.org.uk/cat.asp?c=61439">http://www.nice.org.uk/cat.asp?c=61439</a>
NSC	<a href="http://www.nelh.nhs.uk/screening/dssp/standards.htm">http://www.nelh.nhs.uk/screening/dssp/standards.htm</a>
RCOG	<a href="http://www.rcog.org.uk/guidelines.asp?PageID=108">http://www.rcog.org.uk/guidelines.asp?PageID=108</a>
RCPCH	<a href="http://www.rcpch.ac.uk/publications/clinical_docs.html">http://www.rcpch.ac.uk/publications/clinical_docs.html</a>
RCR	<a href="http://www.rcr.ac.uk">http://www.rcr.ac.uk</a>
RPM	<a href="http://www.perinatal.nhs.uk/rpnm">http://www.perinatal.nhs.uk/rpnm</a>
RUG	<a href="http://www.perinatal.nhs.uk/ultrasound/RUG.htm">http://www.perinatal.nhs.uk/ultrasound/RUG.htm</a>
SureStart	<a href="http://www.surestart.gov.uk/">http://www.surestart.gov.uk/</a>

British Association of Perinatal Medicine (1997) **The BAPM Neonatal Dataset - for the annual reporting of data by neonatal intensive care units** BAPM: London

Tackling Health Inequalities:

<http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/HealthInequalities/fs/en>

Troop P, Goldacre M, Mason A, Cleary R (eds) **Health Outcome Indicators: Normal Pregnancy and Childbirth. Report of a working group to the Department of Health.** Oxford: National Centre for Health Outcomes Development, 1999.

Unicef UK Baby Friendly Initiative <http://www.babyfriendly.org.uk>

**Why Mothers Die 2000-2002.** The sixth report of the Confidential Enquiries into Maternal Deaths in the United Kingdom. RCOG Press November 2004.