WELSH INFORMATION STANDARDS BOARD

DSC Notice:	DSCN 2016 / 02
Date of Issue:	28th June 2016

Ministerial / Official Letter: WHC/2016/034	**Subject:** Maternity Indicators Data Set
Sponsor: Polly Ferguson Nursing Lead Maternity and Women's Reproductive Health, Welsh Government	
Implementation Date: 1st April 2016	

DATA STANDARDS CHANGE NOTICE

A Data Standards Change Notice (DSCN) is an information mandate for a new or revised information standard.

This DSCN was approved by the Welsh Information Standards Board (WISB) at its meeting on the 3rd March 2016.

WISB Reference: ISRN 2014 / 019

Summary:

To introduce the Maternity Indicators Data Set and associated definitions

Data sets / returns affected:

- Maternity Indicators Data Set

Please address enquiries about this Data Standards Change Notice to the Data Standards Team in NHS Wales Informatics Service

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The Welsh Information Standards Board is responsible for appraising information standards. Submission documents and WISB Outcomes relating to the approval of this standard can be found at:

http://howis.wales.nhs.uk/sites3/page.cfm?orgid=742&pid=24632

DATA STANDARDS CHANGE NOTICE

Introduction

As part of the development of *"A Strategic Vision for Maternity Services in Wales"* (published in 2011[1]) a set of outcome indicators and performance measures were established by the Welsh Government to measure the effectiveness and quality of Welsh maternity services. In addition to these Public Health Wales (PHW) developed a set of reproductive and early year's surveillance indicators, which included measures relevant to pregnancy and the neonatal period. In July 2012 David Sissling (then Chief Executive, NHS Wales) wrote to Welsh Health Boards (HBs) to set out requirements for them to demonstrate improvements in the care provided by their maternity services.

Existing data sets do not provide the information required to produce the various maternity indicators and measures. The two national data sets that relate to maternity services are:

1. The Admitted Patient Care data set (APCds) mother's record and "maternity tail":

    a. The requirements of the Maternity Indicator data set are not met by the data collected within the APCds – for example, the Maternity Indicators data set includes antenatal data and home births, as well as hospital delivery data.

    b. The APCds is predominantly populated from data captured in Health Board Patient Administration Systems (PAS), rather than the dedicated maternity IT systems used by Welsh HBs.

2. National Community Child Health Database (NCCHD):

    a. Records in the Health Board Child Health System databases (which are the source of NCCHD) are started at birth, whereas the requirements of the Maternity Indicator data set also relates to the antenatal period.

In light of the current lack of usable data on maternity services, a national programme of work was initiated to establish a baseline of the quality of data associated with NHS Wales maternity services, with a view to ensuring that LHBs could collect and store data of sufficiently high quality so as to enable the production of a consistent, reliable and valid set of performance reports in relation to the national indicators. A series of data quality reviews have been undertaken collaboratively by Public Health Wales (PHW) and the NHS Wales Informatics Service; summary reports for each Health Board were prepared by PHW and NWIS and have been used in Welsh Government performance meetings with Health Boards.

Having established the data quality baseline, Welsh Government now require the implementation of the Maternity Indicators data set (MI ds), which will be sourced from HB maternity IT systems.

This new data set will replace the existing flow of maternity data (the "maternity tail" found in the APCds). A separate DSCN will be issued to confirmed changes to the APCds.

Description of Change

To introduce the collection and submission of the new Maternity Indicators Data Set.

[1] http://wales.gov.uk/topics/health/publications/health/strategies/maternity/?lang=en

Data Dictionary Version

Where applicable, this DSCN reflects changes introduced by DSCN and/or DDCN since the release of version 4.8 of the NHS Wales Data Dictionary.

The changes introduced by such DSCNs will be published in version 4.9 of the NHS Wales Data Dictionary.

Actions Required

Actions for Local Health Boards:

- Ensure that their maternity systems and related local data warehouse infrastructure are set up to enable the national reporting of the Maternity Indicators data set.
    - NWIS monitoring of transition from manual to sql-2-sql view
- Work with the NHS Wales Informatics Service Data Warehouse team to enable the connection between national and local data warehouse infrastructure, resolving any firewall / security issues.
    - Betsi Cadwaladr and Cardiff & Vale University Health Boards do not currently store maternity activity data in their local data warehouses.
    - Both Health Boards are therefore required, temporarily, to provide monthly the relevant maternity 'events' via .csv files.
    - These files should be provided via the NWIS Secure File Sharing Portal – details will be confirmed by the NWIS Data Acquisitions team.
- Provide the NWIS Data Standards team with details of any local mappings of relevant maternity data items (and their associated values) to the national reporting requirements of the MI ds.
- Ensure data is available for NWIS Data Warehouse team to collect on a monthly basis, by Friday 15th July 2016 (i.e. reporting of June 2016 data).
    - Retrospective provision of 2015/16 data (i.e. all 2015/16 births and their related 'initial assessments') and 2016/17 data is also required. To facilitate this, Health Boards are required to provide:
        - All 'initial assessment' events from 1st April 2014 onwards; and
        - All labour / birth events from 1st April 2015 onwards.

Actions for the NHS Wales Informatics Service:

- Update the relevant infrastructure to enable the collection, storage, onward distribution and analysis of the Maternity Indicators data set in time for the receipt of June 2016 data.
- Ensure affected national applications managed by NWIS, namely the Welsh Patient Administration System (WPAS, formerly known as Myrddin), are updated to enable the reporting of the Maternity Indicators data set.

Appendix A: Table reflecting areas that are impacted as a result of this DSCN

The following table shows where there are changes to the scope and/or definitions of applicable data sets, data items, terms and other associated areas that are linked with the changes documented within this DSCN.

Each data definition type is listed in alphabetical order and is shown in the sequence in which it appears in this DSCN.

Data Definition Type	Name	New/Retired/ Changed	Page Number
Patient Level Data Set	Maternity Indicators Data Set	New	7
Data Item	Birth Date (Woman)	Changed	9
Data Item	Apgar Score	Changed	9
Data Item	Birth Date (Baby)	Changed	10
Data Item	Birth Order	Changed	11
Data Item	Birth Weight (g)	Changed	11
Data Item	Case Record Number	Changed	12
Data Item	Breast Feeding	Changed	12
Data Item	Ethnic Group	Changed	13
Data Item	NHS Number	Changed	16
Data Item	Organisation Code (Code of Provider)	Changed	19
Data Item	Organisation Code (LHB Area of Residence)	Changed	21
Data Item	Patients Name	Changed	22
Data Item	Patient Usual Address	Changed	22
Data Item	Postcode of Usual Address	Changed	23
Data Item	Site Code (of Treatment)	Changed	24
Data Item	Sex (of Baby)	Changed	24
Data Item	Time of Birth	Changed	25
Data Item	Data of Initial Assessment / Booking Visit	New	26
Data Item	Augmentation of Labour	New	26
Data Item	Epidural Status	New	26
Data Item	Estimated Blood Loss	New	27
Data Item	Episiotomy	New	27
Data Item	Existing Mental Health Conditions	New	28
Data Item	Foetal Lie at Onset of Labour	New	28
Data Item	Gestation at onset of labour	New	29
Data Item	Foetal Presentation at Onset of Labour	New	29
Data Item	Gestation Period at Initial Assessment / Booking Visit	New	30
Data Item	Gravida	New	31
Data Item	Maternal Weight at Initial Assessment / Booking	New	31
Data Item	Maternal Height at Initial Assessment / Booking	New	31
Data Item	Maternal Weight at 36-38 weeks or onset of labour	New	31
Data Item	Mental Health Care Plan	New	32
Data Item	Mode of onset of labour	New	33
Data Item	Mode of Birth	New	33
Data Item	Number of Foetus at Onset of Labour	New	34
Data Item	NHS Number (Baby)	New	34
Data Item	Parity	New	35
Data Item	Perineal Trauma	New	35
Data Item	Outcome of Birth	New	35
Data Item	Smoker at Initial Assessment / Booking	New	36

Data Item	Previous Caesarean Sections	New	36
Data Item	Smoker at 36-38 weeks or onset of labour	New	36

Appendix B: Highlighted changes to be made to the NHS Wales Data Dictionary

Changes to the NHS Wales Data Dictionary are detailed below, with new text being highlighted in **blue** and deletions are shown with a ~~**strikethrough**~~**.** The text shaded in **grey** shows existing text copied from the NHS Wales Data Dictionary.

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a) New Data Set to be added to 'Patient Level Data Sets'

Maternity Indicators Data Set (MI DS)

Return Submission Details

Data is to be extracted via a SQL-2-SQL view from the Local Health Boards data warehouse into the national (NWIS) data warehouse.

Full details of this implementation can be found here Maternity Dataset Technical Implementation.

The data will be extracted on a daily basis. However this does not mean that the data has to be up to date on a daily basis – the intention is simply to allow flexibility into when LHBs would like to make any new data available.

Any publications requiring the data to be updated by certain time point in time every month across all the health boards, for a consistent viewpoint of maternity information for the whole of Wales, will require a monthly deadline date to meet the reporting requirements – this will be confirmed in a subsequent DSCN.

Patient Security & Confidentiality

'Patient Name' and 'Patient Usual Address' (not 'Postcode of Usual Address') should not be populated in the Maternity Indicators Data Set where a valid NHS Number is present.

A valid NHS Number is one that has passed the check digit calculation on entry into the source system. If an NHS Number is not valid (i.e. does not conform with the check digit algorithm) then Patient Names and Patient Usual Addresses should not be removed, as the reliability of the NHS Number will not be known.

The NHS Number Status Indicator is a mandatory data item within the Maternity Indicators data set. 'Patients Name' and 'Patients Usual Address' should be removed when a valid NHS Number is present, even if the NHS Number Status Indicator does not have a value of 'nn - Number present and traced using Welsh NHS AR' or '01 – Number present and traced'.

Scope

The scope of the data is as follows:

- The Maternity Indicators Data Set captures data relating to the woman at initial assessment and to mother and baby (or babies) for all births. This relates to initial assessment and birth activity undertaken in Wales only. Each Health Board must make available data in relation to the initial assessments and/or birth events which they managed.

- For example, if they only carried out the initial assessment the Health Board would only be required to provide the initial assessment data. This is further detailed in the technical specification (see 'return submission details').
- Where the initial assessment and birth events take place in different Health Boards, data will be linked nationally by the NHS Wales Informatics Service.

- Velindre NHS Trust are excluded from this requirement, as they do not provide any maternity services.
- Monthly activity data must include only initial assessment and birth activity that took place in the previous month.

Data Set Structure

1) Data items relating to the Initial Assessment

Data Items Relating to Mother / Woman	**Format**
Patient Name	Unstructured alpha numeric 70 or structured with two alpha character elements
Patients Usual Address	175 character alpha numeric
NHS Number	10 digit numeric
NHS Number Status Indicator	2 digit numeric
Case Record Number	10 character alpha numeric
Postcode of usual address	8 character alpha numeric
Organisation Code (Code of Provider)	5 character alpha numeric
Organisation Code (LHB Area of Residence)	3 character alpha numeric
Birth Date (Woman)	8 digit numeric , CCYYMMDD
Ethnic Category (Woman)	1 alpha character
Date of Initial Assessment / Booking Visit	CCYYMMDD
Data Items Relating to the Pregnancy / Initial Assessment	**Format**
Site Code (of Treatment)	5 character alpha numeric
Gestation at Initial Assessment / Booking Visit	2 digit numeric
Parity	1 digit numeric
Gravida	1 digit numeric
Maternal Weight at Initial Assessment / Booking Visit	4 character alpha numeric, kg.g
Maternal Height at Initial Assessment / Booking Visit	3 digit numeric
Smoker at Initial Assessment / Booking Visit	1 digit numeric
Previous Caesarean Sections	2 digit numeric
Existing Mental Health Condition	1 digit numeric
Mental Health Care Plan	1 digit numeric

2) Data items relating to Labour/Birth

Data Items Relating to Mother / Woman	**Format**
Patient Name	Unstructured alpha numeric 70 or structured with two alpha character elements
Patients Usual Address	175 character alpha numeric

NHS Number	10 digit numeric
NHS Number Status Indicator	2 digit numeric
Case Record Number	10 character alpha numeric
Postcode of usual address	8 character alpha numeric
Organisation Code (Code of Provider)	5 character alpha numeric
Organisation Code (LHB Area of Residence)	3 character alpha numeric
Birth Date (Woman)	8 digit numeric , CCYYMMDD
Ethnic Category (Woman)	1 alpha character
Date of Initial Assessment / Booking Visit	CCYYMMDD
Data Items Relating to Woman at 36-38 weeks or onset of labour	**Format**
Maternal Weight at 36-38 weeks or onset of labour	4 character alpha numeric, kg.g
Smoker at 36-38 weeks or onset of labour	1 digit numeric
Data Items Relating to Labour and Birth	**Format**
Site Code (of Treatment)	5 character alpha numeric
Mode of onset of Labour	1 digit numeric
Augmentation of Labour	1 digit numeric
Gestation at onset of Labour	1 digit numeric
Number of Foetus at Onset of Labour	2 digit numeric
Estimated Blood Loss	4 digit numeric
Epidural Status	1 digit numeric
Perineal Trauma	1 digit numeric
Episiotomy	1 digit numeric
Foetal Lie at Onset of Labour	1 digit numeric
Foetal Presentation at Onset of Labour	1 digit numeric
Outcome of Birth	1 digit numeric
Data Items Relating to the Baby	**Format**
Sex (of Baby)	1 digit numeric
NHS Number (Baby)	10 digit numeric
NHS Number Status Indicator (Baby)	2 digit numeric
Case Record Number	10 character alpha numeric
Birth Date (Baby)	8 digit numeric, CCYYMMDD
Time of Birth	4 character alpha numeric, hhmm
Birth Order	1 digit numeric
Mode of Birth	1 digit numeric
Apgar Score	2 digit numeric
Birth Weight (g)	4 digit numeric
Breast Feeding	1 digit numeric

b) Changes to Existing Data Items

Apgar Score

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
NCCHD		
MI ds	1st April 2016	

The apgar score is a measure of the physical condition of a newborn baby. It is obtained by adding points (2, 1, or 0) for heart rate, respiratory effort, muscle tone, response to stimulation and skin coloration; a score of ten represents the best possible condition.

FOR NCCHD:

This is the total apgar score for a baby at 1 minute and 5 minutes after birth.

~~Format is a positive integer between 0 and 10.~~

FOR MI ds

This is the total Apgar score for a baby at 5 minutes after birth.

See Apgar Score

Format: 2 digit numeric

Value	Meaning
nn	Apgar score (0-10)

Birth Date

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
APC ds99	1st April 1999	
EAL ds	1st April 1999	21st November 2012
OP ds	1st April 1999	
CC ds	1st April 2007	
OPR ds	1st July 2008	
EDDS	1st April 2009	
SBH50-59a	-	2nd January 2013
Non – Medical Staffing	-	2nd January 2013
PAP ds	1st April 2013	
SM ds	1st April 2014	

RTDS	1st April 2014	
MI ds	1ST April 2016	

Date of birth of patient / client.

Format: 8 digit numeric, CCYYMMDD

For Radiotherapy Data Set;

Format: CCYY-MM-DD

If the Date of Birth is unknown; use the date '11/11/1811' (that is 18111111)

Where Birth Date Status is associated with this data item, it ~~and~~ should be used to indicate whether Birth Date is supplied or is not applicable.

Value	Meaning	Valid From	Valid To
00000000	*Date of Birth Unknown*	*1st March 2006*	*31st January 2007*
18111111	Date of Birth Unknown	1st February 2007	

(Psychiatric Census)

Date of birth of patient.

Format: 8 digit numeric, DDMMCCYY

Birth Date (Baby)

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
APC ds	1st April 1999	
NCCHD		
MI ds	1st April 2016	

Date of birth of baby. Note that **Date Status** is not associated with this date; the provider must record this date and should always be able to supply it.

If the Date of Birth is unknown; use the date '11/11/1811' (that is 18111111)

Format: 8 digit numeric, CCYYMMDD

Value	Meaning
18111111	Date of Birth Unknown

Birth Order

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
APC ds	1st April 1999	
NCCHD		
MI ds	1st April 2016	

~~This is in the case of a multiple birth, the position of this birth in the sequence.~~

The order of the birth where more than one birth resulted from pregnancy.

Format: 1 digit numeric

Value	Meaning	Valid From	Valid To
N	Sequence number of birth (1-6)	Pre 28th December 1995	
8	Not applicable	Pre 28th December 1995	
9	*Not known, a validation error*	*1st May 1998*	*20th January 2002*

~~See Birth Order~~

Birth Weight (g)

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
APC ds	1st April 1999	
NCCHD		
MI ds	1st April 2016	

The weight of the baby at birth, recorded in grams.

Format: 4 digit numeric

Value	Meaning	Valid From	Valid To
NNNN	0001 - 6999 grams	Pre 28th December 1995	
7000	*7000 grams or greater*	*Pre 28th December 1995*	*30th April 1998*
9999	*Not Known*	*Pre 28th December 1995*	*20th January 2002*

See Birth Weight, Terms (A-Z)

Breast Feeding

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
NCCHD		
MI ds	1st April 2016	

~~Breast feeding (either wholly or partially) intention recorded at birth. Include any breast feeding or giving of breast milk to infants.~~

Did the Mother intend to breastfeed the baby at birth?

~~See Breast Feeding~~

For NCCHD:

Values are Y or N.

FOR MI ds:

Format: 1 digit numeric

Value	Meaning
1	Yes – includes mothers who are expressing / intend to express breast milk for their baby
2	No
9	Not Known – for example, baby is immediately transferred to neonatal intensive care at another healthcare provider and breastfeeding intention was not established prior to birth

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Case Record Number

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
Psychiatric Census		
CC ds	1st April 2007	
MI ds	1st April 2016	

This is the patient's case record number which is unique to that patient within a hospital or health care provider.

Format: 10 character alpha-numeric. Do not leave blank spaces - lead with zeros if necessary

See Local Patient Identifier

Ethnic Group

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
APC ds99	1st April 1999	
NCCHD		
CC ds	1st April 2007	
OPR ds	1st September 2008	
EDDS	1st April 2009	
SM ds	1st April 2014	
Non – Medical Staffing	-	2nd January 2013
MI ds	1st April 2016	

This is the ethnic group of the patient, as selected by the patient. The patient is the arbiter of the information. Classifications are based on the 14+1 new ethnic group data categories used in the 2001 Census and the information recorded about ethnic group must be obtained by asking the patient / client.

Format: 2 character alpha-numeric

Value	Meaning	Valid From	Valid To
	WHITE		
A	Any White Background	1st April 2002	
	MIXED		
D	White and Black Caribbean	1st April 2002	
E	White and Black African	1st April 2002	
F	White and Asian	1st April 2002	
G	Any other mixed background	1st April 2002	
	ASIAN OR ASIAN BRITISH		
H	Indian	1st April 2002	

J	Pakistani	1st April 2002	
K	Bangladeshi	1st April 2002	
L	Any other Asian background	1st April 2002	
	BLACK OR BLACK BRITISH		
M	Caribbean	1st April 2002	
N	African	1st April 2002	
P	Any other Black background	1st April 2002	
	OTHER ETHNIC GROUPS		
R	Chinese	1st April 2002	
S	Any other ethnic group	1st April 2002	
	NOT STATED		
Z	Not stated	1st April 2002	

FOR MI ds:

This is the ethnic group of the patient, as selected by the patient. The patient is the arbiter of the information. Classifications are based on the 14+1 new ethnic group data categories used in the ~~2001~~ 2011 Census and the information recorded about ethnic group must be obtained by asking the patient / client.

Format: 2 character alpha-numeric

Value	Meaning	Valid From	Valid To
	WHITE		
A	Any White Background, including Welsh / English Scottish / Northern Irish / British	1st April 2002	
B	Gypsy or Irish Traveller	1st April 2016	
	MIXED/MULTIPLE ETHNIC GROUP		
D	White and Black Caribbean	1st April 2002	
E	White and Black African	1st April 2002	
F	White and Asian	1st April 2002	
G	Any other mixed background / multiple ethnic background	1st April 2002 *Amended 1st April 2016*	
	ASIAN OR ASIAN BRITISH		
H	Indian	1st April 2002	
J	Pakistani	1st April 2002	
K	Bangladeshi	1st April 2002	

R	Chinese	1st April 2002	
L	Any other Asian background	1st April 2002	
	BLACK OR BLACK BRITISH		
M	Caribbean	1st April 2002	
N	African	1st April 2002	
P	Any other Black / African / Caribbean / Black British background	1st April 2002 *Amended 1st April 2016*	
	OTHER ETHNIC GROUPS		
~~R~~	~~Chinese~~	~~1st April 2002~~	
T	Arab	1st April 2016	
S	Any other ethnic group	1st April 2002	
	NOT STATED		
Z	*Not stated*	*1st April 2002*	*1st April 2016*

The national code must be entered as the first character in the 2 character field. The second character is an optional field only required for use locally. It must, however, be able to be grouped consistently with the 14 main categories as above. If no further local breakdown is required, the second character must be filled with a 'Z'.

The codes below are for historical information only and were retired on the 1st April 2002.

~~Patient Details~~

Format: 2 character alpha-numeric

Value	Meaning	Valid From	Valid To
0	*White*	*1st July 1997*	*31st March 2002*
1	*Black – Caribbean*	*1st July 1997*	*31st March 2002*
2	*Black – African*	*1st July 1997*	*31st March 2002*
3	*Black – Other*	*1st July 1997*	*31st March 2002*
4	*Indian*	*1st July 1997*	*31st March 2002*
5	*Pakistani*	*1st July 1997*	*31st March 2002*
6	*Bangladeshi*	*1st July 1997*	*31st March 2002*
7	*Chinese*	*1st July 1997*	*31st March 2002*

8	*Any other ethnic group*	*1st July 1997*	*31st March 2002*
9	*Not given*	*1st July 1997*	*31st March 2002*

NHS Number

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
APC ds99	1st April 1999	
EAL ds	1st April 1999	21st November 2012
OP ds	1st April 1999	
CC ds	1st April 2007	
OPR ds	1st July 2008	
EDDS	1st April 2009	
PAP ds	1st April 2013	
SM ds	1st April 2014	
RTDS	1st April 2014	
MI ds	1st April 2016	

It is mandatory to record the NHS Number for each patient registered with a GP practice in England and Wales. The NHS number is allocated to an individual, to enable unique identification for NHS health care purposes.

This NHS Number format was mandated for use effective 1st November 1997. Prior to this, the NHS Number was an alphanumeric code which ranges in size from 10 – 17 characters.

If known, the patient's Health and Care Number should be used to populate this field for patients resident in Northern Ireland.

If known, the patient's Community Health Index (CHI) Number should be used to populate this field for patients resident in Scotland.

Format: 10 digit numeric

See Health and Care Number

See Community Health Index (CHI) Number

Check Digit Algorithm

(This algorithm applies to the Welsh and English NHS Number and the Northern Ireland Health & Care Number. The check digit algorithm for the Scottish CHI Number is available on request from the NHS Wales Informatics Service.)

Step 1 Multiply each of the first nine digits by a weighting factor as follows:

Digit Position (starting from the left)	Factor
1	10
2	9
3	8
4	7
5	6
6	5
7	4
8	3
9	2

Step 2 Add the results of each multiplication together

Step 3 Divide the total by 11 and establish the remainder

Step 4 Subtract the remainder from 11 to give the check digit

Step 5 Check the remainder matches the check digit. If it does not, the number is invalid.

If the result of Step 4 is 11 then a check digit of 0 is used

If the result of Step 4 is 10 then the number is invalid and not used

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NHS Number Status Indicator

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
APC ds99	1st April 1999	
EAL ds	1st April 1999	21st November 2012
OP ds	1st April 1999	
OPR ds	1st July 2008	
EDDS	1st April 2009	

MI ds	1st April 2016	

The status indicator provides information about the potential accuracy and reliability of the NHS number and hence the use to which the number can be put. The indicator can also be used to indicate the general standard of patient data quality within Trusts. This data item became mandatory in Wales in April 1999.

Format: 2 digit numeric

Value	Meaning	Interpretation	Valid From	Valid To
nn	Number present and traced using Welsh NHS AR	Welsh LHB's should look for high levels of NHS numbers which have an associated status indicator value of 'nn'.	1st April 1999	
01	Number present & traced	Providers should be striving to submit numbers that have been traced against an authoritative source (currently the Initial Tracing Service) and so are as reliable and accurate as possible. Therefore Local Health Boards should look for high levels of NHS numbers which have an associated status indicator value of "01".	1st April 1999	
02	Number present but not traced	This value reveals that although a number is present, it has not been traced against an authoritative source i.e. it has most likely been manually input but not sent to the Initial Tracing Service for checking. An exception to this could be that the NHS number has entered the provider system electronically from a reliable and safe source other than the authoritative tracing service. Users of NHS numbers with a status indicator value of "02" should be cautious.	1st April 1999	
03	Trace required	The provider should submit patient details for NHS number tracing before DS's are submitted. Therefore the proportion of missing numbers is indicated by the "03" value should be very small.	1st April 1999	
04	Trace attempted – no match or multiple match found	A significant proportion of "04s" could indicate data quality problems at the provider. However, the LHB should take account of whether the provider has a high level of difficulty to trace patient's e.g. ethnic names, mobile population.	1st April 1999	
05	Trace needs to be resolved (NHS number or patient detail conflict)	High levels of "05s" imply that the NHS numbers sent by the provider for check tracking are incorrect for the patient. This indicates poor quality of data which could either be due to a poor original source e.g.	1st April 1999	

		wrong number given on a GP referral letter, or poor data input by the provider.		
06	Trace in progress	This value indicates that the NHS number has been submitted for tracing but a response is awaited. Local Health Boards should expect to see a small proportion of these as the time of DS submission may be before the response from the tracing service is received.	1st April 1999	
07	Number not present and trace not required	Two circumstances are explained by this indicator:	1st April 1999	
	1.	NHS number is not required e.g. overseas visitor. This should be easy to identify from other DS data items		
	2.	There is insufficient patient data to enable a successful trace to be made. Local Health Boards need to be more cautious about this reason although they should take into account the type of population the provider serves e.g. itinerants and mental health patients who may not be willing or able to provide sufficient information.		
		Note: Local Health Boards should expect to see a small proportion of cases where there is no NHS number at all.		
08	Trace postponed (baby under six weeks old)	This indicator should only be used for babies under six weeks old and Local Health Boards should check the date of birth details on the DS.	1st April 1999	

Organisation Code (Code of Provider)

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
APC ds99	1st April 1999	
EAL ds	1st April 1999	21st November 2012
OP ds	1st April 1999	
CC ds	1st April 2007	
OPR ds	1st July 2008	
DATS		
RTT	1st April 2007	31st August 2011

RTT-PTR	1st September 2008	30th September 2009
PP01W		
EDDS	1st April 2009	
RTT (Combined)	1st September 2011	
PAP ds	1st April 2013	
RTDS	1st April 2014	
MI ds	1ST April 2016	

This is the organisation code of the health care provider. The provider code identifies the health care provider who is responsible for managing the treatment of the patient.

Notes:

1. Healthcare providers may also act as commissioners when sub-contracting patient care services to other providers of health care.
2. Although the healthcare provider identified in this data item is responsible for managing the patient's treatment, it may not necessarily be where the treatment is actually conducted. For example, where the treatment has been sub-contracted to another healthcare provider.
3. For OPR ds, the Organisation Code (Code of Provider) is that of the organisation receiving the referral. If the provider is a Local Health Board/Trust, use the 3 character Local Health Board/Trust code with 2 zeros placed in the 4th and 5th character position.
4. For Referral to Treatment Times (Combined), use the 3 character Local Health Board/Trust code.

Format:

For Patient Level Data Sets *(APC, OP, CC, OPR, PAP, RTDS)*:-

5 character alpha-numeric Local Health Board/Trust Code with 2 zeros placed in the 4th and 5th character position.

For Aggregate Data Collections *(DATS, RTT (Combined) and PP01W)*:-

3 character alpha numeric Local Health Board/Trust Code

Value	Meaning
XAABB	The organisation code for the provider

Default codes:

Value	Meaning	Valid From	Valid To
89997	Non-UK provider where no organisation code has been issued	1st April 2004	

89999	Non-NHS UK provider where no organisation code has been requested and issued	1st April 2002	

See ORGANISATION CODE

Organisation Code (LHB Area of Residence)

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
APC ds99	1st April 1999	
EAL ds	1st April 1999	21st November 2012
OP ds	1st April 1999	
RTT	1st April 2007	31st August 2011
PP01W		
OPR ds	1st July 2008	
EDDS	1st April 1999	
CRTT	1st June 2009	31st August 2011
Angiogram	1st December 2008	1st April 2010
RTT (Combined)	1st September 2011	
MI ds	1st April 2016	

The Local Health Board where the patient is a resident, identified via the NHS Postcode Directory. This ensures that the Local Health Board can receive information about the care given to its residents.

Format: 3 character alpha-numeric

Value	Meaning	Valid From	Valid To
NAN	The code of the LHB. Codes for Welsh LHBs can be accessed via the National Reference Data Service – http://nrds.cymru.nhs.uk**(NHS Wales Users Only)**	N/A	N/A
X98	Not applicable e.g. for overseas visitors	1st April 1996	

Note: For English Residents treated in Wales, use the Organisation Code of the Primary Care Trust (PCT) of Residence for all activity / waiting times data up to 31st March 2013.

From 1st April 2013 (inclusive) onwards, use the Organisation Code of the Clinical Commissioning Group (CCG).

Reference data files containing details of the Organisation Codes for English organisations, including the NHS postcode file, can be accessed via the NHS postcode file, which is available via the Technology Reference data Update Distribution (TRUD).

The TRUD website can be accessed via the following link:

https://isd.hscic.gov.uk

See Organisation Code

Patients Name

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
APC ds99	1st April 1999	
EAL ds	1st April 1999	21st November 2012
OP ds	1st April 1999	
CC ds	1st April 2007	
OPR ds	1st July 2008	
EDDS	1st April 2009	
RTDS	1st April 2014	
MI ds	1ST April 2016	

This will be the patients preferred name. The patient is the arbiter of his/her name.

Format: either structured with two 35 alpha character elements (forename followed by surname) or an unstructured string of 70 characters. Use block capitals, ignore apostrophes and insert space for hyphen. Enter surname first then as many letters of the first name as possible, leaving a blank box between each part of the name. Double-barrelled surnames should be coded in the same order as in the hospital records. Name Format Code indicates which format is being used.

Patients Usual Address

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
APC ds99	1st April 1999	
EAL ds	1st April 1999	21st November 2012
OP ds	1st April 1999	
CC ds	1st April 2007	

OPR ds	1st July 2008	
EDDS	1st April 2009	
RTDS	1st April 2014	
MI ds	1st April 2016	

This is the usual address nominated by the patient at the time of admission or attendance. If patients usually reside elsewhere are staying in hotels, hostels or other residential establishments for a short term, say a week, they should be recorded as staying at their usual place of residence. However if long term, such as at boarding school, the school address must be recorded. University students may nominate either their home address or the address of their university accommodation. Where patients are not capable of supplying this information, because of age or mental illness, for example, then the person responsible for the patient, such as a parent or guardian, should nominate the usual address. Patients not able to provide an address should be asked for their most recent address. If this cannot be established then you should record the address as `No fixed abode' or `Address unknown'. These patients are regarded as resident in the local geographical district for contracting purposes. For birth episodes this should refer to the mother's usual place of residence.

Format: 175 character alpha-numeric. This is based on 5 lines of 35 characters. This relates to the physical layout of the address, not the logical layout and does not require intelligent intervention when splitting the text string into lines.

Prior to April 1999 the PEDW Format: 100 character alpha-numeric. This is based on 4 lines of 25 characters. This relates to the physical layout of the address, not the logical layout.

Postcode of Usual Address

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
APC ds99	1st April 1999	
EAL ds	1st April 1999	21st November 2012
OP ds	1st April 1999	
CC ds	1st April 2007	
OPR ds	1st July 2008	
EDDS	1st April 2009	
RTDS	1st April 2014	
MI ds	1st April 2016	

The postcode applied to the usual address nominated by the patient at the time of admission or attendance.

Format: 8 character alpha-numeric. This allows a space to be inserted to differentiate between the inward and outward segments of the code, enabling full use to be made of the Royal Mail postcode functionality.

Organisation Data Service rules apply.

If a patient has no fixed abode, this should be recorded with the appropriate code (ZZ99 3VZ).

For overseas visitors, the postcode field must show the relevant country pseudo postcode commencing ZZ99, plus spaces followed by a numeric, then an alpha character, then a Z. For example, ZZ99 6CZ is the pseudo-postcode for India. Pseudo-postcodes can be found in the NHS Postcode Directory.

See Postcode

(PEDW (Prior to April 1999), Psychiatric Census)

The postcode applied to the usual address nominated by the patient at the time of admission or attendance, using rules supplied above and those in the NHS Postcode User Directory.

Format: 8 character alpha-numeric. The 5th position is always blank (Δ) and possibly the 3rd and 4th characters may be blank also.

See Postcode

Sex of Baby

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
NCCHD		
MI ds	1st April 2016	

This is the sex of a baby who is born or who is registered with the Local Health Board.

Allowable values are:-

Male

Female

Not Known

FOR MI ds:

See Sex

Site Code (of Treatment)

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
APC ds99	1st April 1999	
OP ds	1st April 1999	
CC ds	1st April 2007	
EDDS	1st April 2009	
PAP ds	1st April 2013	
MI ds	1st April 2016	

The organisation code for the site where the patient will be or is treated.

Format: 5 character alpha-numeric

See ORGANISATION CODE

For outpatients and MI ds:-

Activity may take place outside the hospital, such as in the patient's home; in such cases, raising a site code is impractical. The following default codes should be used in the Outpatient ds when required:

Value	Meaning	Valid From	Valid To
R9998	Not a hospital site	21st January 2002	
89999	Not applicable: Non-NHS providers where no site code has been requested and issued	1st April 2002	
89997	Not applicable: Non-UK provider	21st January 2002	

Where treatment for an NHS patient is sub-commissioned to an overseas provider the default code 89997 is applicable.

Time of Birth

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
NCCHD		
MI ds	1st April 2016	

This is the time of birth of the child.

Format: HHMM

~~Infants born during the night are thought to have a greater risk of infant & early neonatal mortality and related to asphyxia.~~

c) New data items

Augmentation in Labour

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
MI ds	1st April 2016	

Whether medical or surgical augmentation of labour was undertaken in order to accelerate labour.

The augmentation of labour is an intervention that is intended to increase the intensity of labour, usually when the caregiver feels the labour is not 'progressing', or is progressing too slowly.

Augmentation of labour differs from induction, in that the labour has already started in some way, but is not progressing, has slowed or stopped. This can also include interventions to stimulate contractions after the waters have broken on their own (although some caregivers will refer to this as an induction).

Augmenting the labour involves artificial stimulation of the contractions. This may be needed if the contractions have become weak, not coordinated (or irregular), far apart, not lasting long enough or have ceased for a period. If the labour needs augmenting, it means the contractions are not efficient enough to dilate the cervix.

Format: 1 digit numeric

Value	Meaning
1	Medical or surgical augmentation was undertaken
2	No medical or surgical augmentation was undertaken
9	Not Known

Date of Initial Assessment / Booking Visit

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
MI ds	1st April 2016	

The date of the initial maternity assessment / booking visit where a full Health & Social Care Needs Assessment is undertaken and the antenatal sections of the maternity hand held record are completed.

Format: ccyymmdd

Epidural Status

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
MI ds	1st April 2016	

Epidural administered for pain relief.

An Epidural is an injection of a local anaesthetic into the space outside the *dura mater* of the spinal cord in the lower back region to produce a loss of sensation especially in the abdomen or pelvic region.

Format: 1 digit numeric

Value	Meaning
1	Epidural administered
2	Epidural not administered
9	Not Known

Episiotomy

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
MI ds	1st April 2016	

Did the woman have an episiotomy during childbirth?

Episiotomy is a surgical cut made at the opening of the vagina during childbirth, to aid a difficult delivery and prevent rupture of tissues.

Format: 1 digit numeric

Value	Meaning
1	Yes
2	No
8	Not Applicable – e.g. caesarean section
9	Not Known

Estimated Blood Loss

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
MI ds	1st April 2016	

The estimated post-partum blood loss (measured in millilitres – ml)

Format: 4 digit numeric

Value	Meaning
nnnn	Estimated blood loss (ml)

Existing Mental Health Condition

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
MI ds	1st April 2016	

The woman reports that she has one of the following mental health conditions:

- Puerperal psychosis (severe postnatal depression)
- Bi-polar effective disorder/manic depression
- Psychosis
- Psychotic depression
- Schizophrenia
- Other

Format: 1 digit numeric

Value	Meaning
1	Woman reports that she has existing mental health condition
2	Woman reports that she does not have an existing mental health condition
9	Not Known / Not Asked / Declined to answer

Foetal Lie at Onset of Labour

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
MI ds	1st April 2016	

The lie of the foetus at onset of labour.

A foetal lie of 'Transverse' is compatible with a foetal presentation of '08 – Other' or '09 –Not Known' only. It must not be used if the presentation is cephalic or breech.

Conversely, a foetal lie of 'Oblique' or 'Longitudinal' may only be used where the foetal presentation is '01 – Cephalic', '02 – Breech' or '08 – Other'.

Format: 1 digit numeric

Value	Meaning
1	Transverse
2	Oblique
3	Longitudinal
9	Not known

Foetal Presentation at Onset of Labour

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
MI ds	1st April 2016	

The presentation of the foetus at onset of labour.

The reported presentation may be different for each baby born in a multiple birth.

Format: 1 digit numeric

Value	Meaning
1	Cephalic
2	Breech
8	Other – i.e. a transverse / other lie
9	Not known

Gestation at Onset of Labour

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
MI ds	1st April 2016	

The gestation period at onset of labour, in completed weeks (rounded down).

Gestation is the carrying of an embryo or foetus inside a woman. The time interval of a gestation is known as the gestation period. This should be estimated based on the findings of ultrasound scan at the initial assessment / booking visit, which is regarded as the most reliable means of calculating the gestation period.

When an ultrasound scan is not undertaken, the gestation period should be measured from the first day of the last menstrual period (LMP), where this is thought to be reliable. Where the LMP is unknown and an ultrasound scan is not undertaken, this should be a best estimate based on likely LMP.

Please use the example below to calculate and report the gestation period at onset of labour in completed weeks:

- 9 + 6 = 9 completed weeks.
- 10 + 0 = 10 completed weeks
- 10 + 1 = 10 completed weeks etc.

Format: 1 digit numeric

Value	Meaning
nn	Gestation Period (completed weeks)

Gestation Period at Initial Assessment / Booking Visit

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
MI ds	1st April 2016	

The gestation period at initial assessment / booking visit, in completed weeks (rounded down).

Gestation is the carrying of an embryo or foetus inside a woman. The time interval of a gestation is known as the gestation period.

An ultrasound scan is regarded as the most reliable means of calculating the gestation period.

When an ultrasound scan is not undertaken, the gestation period should be measured from the first day of the last menstrual period (LMP), where this is thought to be reliable. Where the LMP is unknown and an ultrasound scan is not undertaken, this should be a best estimate based on likely LMP.

Please use the example below to calculate and report the gestation period at initial assessment / booking visit in completed weeks:

- 9 + 6 = 9 completed weeks.
- 10 + 0 = 10 completed weeks

- 10 + 1 = 10 completed weeks etc.

Format: 2 digit numeric

Value	Meaning
nn	Gestation Period (completed weeks)

Gravida

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
MI ds	1st April 2016	

Gravida indicates the number of times the woman has been pregnant, regardless of whether these pregnancies were carried to term. A current pregnancy, if any, is included in this count.

Format: 1 digit numeric

Value	Meaning
nn	Gravida (Number of pregnancies)

Maternal Height at Initial Assessment / Booking Visit

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
MI ds	1st April 2016	

The height of the woman (in cm)as measured at the Initial Assessment (Booking Visit), or within the 10-12 week gestation period (when not undertaken at Initial Assessment).

Format: 3 digit numeric

Value	Meaning
nnn	Maternal Height at Initial Assessment (cm)

Maternal Weight at 36-38 weeks or onset of labour

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
MI ds	1st April 2016	

The weight of the woman (in kg, to the nearest 100g), as measured at 36-38 weeks, or at onset of labour. The aim is that the information relates to a point as late in the pregnancy as is practically possible.

Format: 4 character alphanumeric – kg.g

Value	Meaning
nn.n (e.g. 82.5)	Maternal Weight at 36-38 weeks or onset of labour

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Maternal Weight at Initial Assessment / Booking Visit

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
MI ds	1st April 2016	

The weight of the woman (in kg, to the nearest 100g), as measured at the Initial Assessment (Booking Visit), or within the 10-12 week gestation period (when not undertaken at Initial Assessment).

Format: 4 character alphanumeric – kg.g

Value	Meaning
nn.n (e.g. 82.5)	Maternal Weight at Initial Assessment

Mental Health Care Plan

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
MI ds	1st April 2016	

To establish whether the woman has had a Mental Health Care Plan put in place within 4 weeks following the initial assessment.

A Mental Health Care and Treatment plan will:

a) Be developed by a care coordinator in consultation with the service users and mental health providers (although the plan may be developed without the input of the patient where the outcomes cannot be agreed between all parties);
b) Record the outcomes that the provision of mental health services for the relevant patient are designed to achieve;
c) List these outcomes, record the services and/or actions that are to be provided to achieve each outcome, including when they will be provided, and state who is responsible for providing the service as well as where it will take place;

d) Be kept under review and updated to reflect any changes in the type of care and treatment which may be required by the service user over time.

Format: 1 digit numeric

Value	Meaning
1	Woman has Mental Health Care Plan
2	Woman does not have Mental Health Care Plan
9	Not Known / Not Asked

Mode of Birth

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
MI ds	1st April 2016	

The mode of birth of a baby. Note that this may be different for different foetuses in the same delivery.

Format: 1 digit numeric

Value	Meaning
1	Spontaneous Vaginal Birth
2	Ventouse
3	Forceps
4	Elective caesarean section - caesarean section before, or at onset of labour.
5	Emergency caesarean section.

Mode of Onset of Labour

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
MI ds	1st April 2016	

This is the method by which the process of labour began or delivery by a caesarean section occurred. Only those methods that are used to induce labour, such as surgical induction, medical induction or a combination of the two, should be recorded. Methods that are used to accelerate labour should not be recorded.

Format: 1 digit numeric

Value	Meaning
1	Spontaneous; the onset of regular contractions whether or not preceded by spontaneous rupture of the membranes.
2	Any caesarean section carried out before the onset of labour; or a planned elective caesarean section carried out immediately following the onset of labour, when the decision was made before labour.
3	Surgical induction; by amniotomy
4	Medical induction; including the administration of agents either orally, intravenously or intra vaginally with the intention of initiating labour.
5	Combination of surgical induction and medical induction.

NHS Number (Baby)

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
MI ds	1st April 2016	

See NHS Number

NHS Number Status Indicator (Baby)

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
MI ds	1st April 2016	

See NHS Number Status Indicator

Number of Foetus at Onset of Labour

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
MI ds	1st April 2016	

The number of foetus at onset of labour.

Format: 2 digit numeric

Value	Meaning
nn	Number of foetuses

Outcome of Birth

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
MI ds	1st April 2016	

An indicator of whether the birth was a live or a stillbirth (a birth on or after a gestation of 24 weeks (168 days) where the baby shows no identifiable signs of life at delivery).

Format: 1 digit numeric

Value	Meaning
1	Live birth
2	Still birth

Parity

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
MI ds	1st April 2016	

The parity group of the mother. Parity is the number of times a woman has given birth to a live neonate (any gestation) or at 24 weeks or more, regardless of whether the child was viable or non-viable (i.e. stillbirths).

Format: 1 digit numeric

Value	Meaning
1	Nulliparous – the mother has never previously given birth
2	Primiparous – the mother has previously given birth once only
3	Multiparous – the mother has previously given birth more than once

---

Perineal Trauma

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
MI ds	1st April 2016	

Did the woman experience a 3rd or 4th degree tear during childbirth?

Format: 1 digit numeric

Value	Meaning
1	Yes
2	No
8	Not Applicable – e.g. caesarean section
9	Not Known

Previous Caesarean Sections

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
MI ds	1st April 2016	

The number of previous caesarean sections performed on the woman.

A caesarean section is an operation to deliver a baby. It involves making a cut in the front wall of a woman's abdomen and womb. The operation can be a planned (elective) procedure – when a medical need for the operation becomes apparent during pregnancy or if it's requested by the mother in advance.

Format: 2 digit numeric

Value	Meaning
nn	Number of previous caesarean sections
99	n/a - no previous caesarean sections

Smoker at 36-38 weeks or onset of labour

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
MI ds	1st April 2016	

The smoking status of the woman at 36-38 weeks, or onset of labour – i.e. is the woman a smoker?

Wherever possible, this should be validated via Carbon Monoxide testing (i.e. CO-validated). Where not CO-validated, this should be the self-reported smoking status of the mother. The aim is that the information relates to a point as late in the pregnancy as is practically possible.

Format: 1 digit numeric

Value	Meaning
1	Smoker - CO validated
2	Smoker – Self Reported
3	Non Smoker – CO validated
4	Non Smoker – Self Reported
9	Not Known / Not Asked / Declined to answer

Smoker at Initial Assessment / Booking Visit

This data item is / was included in the following data sets / collections between the dates shown:

Data Set / Collection	Valid From	Valid To
MI ds	1st April 2016	

The smoking status of the woman at the time of the Initial Assessment / Booking Visit – i.e. is the woman a smoker?

Wherever possible, this should be validated via Carbon Monoxide testing (i.e. CO-validated). Where not CO-validated, this should be the self-reported smoking status of the mother.

Format: 1 digit numeric

Value	Meaning
1	Smoker - CO validated
2	Smoker – Self Reported
3	Non Smoker – CO validated
4	Non Smoker – Self Reported
9	Not Known / Not Asked / Declined to answer

d) New Terms

Initial Assessment

This is the date on which a pregnant woman was first assessed by hospital staff and arrangements were made for antenatal care. This is not necessarily the occasion on which arrangements were made for delivery.

e) Changes to Existing Terms (Deleted Terms)

~~**Apgar Score**~~

~~Apgar scoring is an assessment for newborn babies.~~

~~Heart rate, breathing, muscle tone, responsiveness, and colour are scored from 0 to 2 at one minute and five minutes after birth.~~

~~**Birth Order**~~

~~Birth Order denotes the order of the birth where more than one birth resulted from pregnancy.~~

~~Multiple pregnancy increases the risk of prenatal/neonatal morbidity and mortality.~~

~~**Breast Feeding**~~

~~This is a Health Promotion Indicator.~~

~~Breast-feeding is acknowledged as optimal nutrition for children. Better health outcomes later in life, particularly with regard to the prevention of heart disease and strokes have been reported. The DH has consistently sought to promote to breast-feeding. Will enable the monitoring of coverage and the outcome of interventions designed to increase coverage.~~

~~Breast-feeding at six-eight weeks is recorded at the six-eight week check. Breast feeding at four months is recorded with Immunisation.~~
