

Maternity Services Data Set User Guidance

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Information and technology
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Document Management

Revision History

Version	Date	Summary of Changes
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1.0	02/11/2018	Further updates prior to publication of initial version
1.1	14/03/2019	Updates based on provider/supplier feedback and FAQs
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Reviewers

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Contents

1	About this Document	5
1.1	Purpose of the Document	5
1.2	Scope of the Document	5
1.3	Schedule for Updating this Document	5
1.4	Background Information	5
1.5	MSDS v2.0 development drivers	6
1.6	Summary of Changes	7
2	Configuration of local systems	8
3	Integration of clinical terminologies within the MSDS	10
3.1	Why are we integrating clinical terminologies within the data set?	10
3.2	How have we integrated clinical terminologies within the Data Set?	10
3.3	How should clinical terminology data be captured and submitted?	11
3.4	What is SNOMED CT?	12
3.5	What are the benefits of using SNOMED CT?	12
3.6	Further Resources for SNOMED CT	12
3.7	ICD Codes	13
3.8	Read Version 2 and Clinical Terms Version 3	13
4	Constructing Submission Files	14
4.1	Key points relating to mandatory fields and validation	14
4.2	Inclusion Rules	16
5	Data Item Guidance	17
5.1	Linkage and Identifier Data Items	17
5.2	SNOMED CT data items	19
6	Breakdown of Data Items by Table	21
6.1	MSD000 Header	21
6.2	MSD001 Mother's Demographics	22
6.3	MSD002 GP Practice Registration	26
6.4	MSD003 Social and Personal Circumstances	28
6.5	MSD004 Overseas Visitor Charging Category	30
6.6	MSD101 Pregnancy and Booking Details	31
6.7	MSD102 Maternity Care Plan	42
6.8	MSD103 Dating Scan Procedure	46
6.9	MSD104 Coded Scored Assessment (Pregnancy)	48
6.10	MSD105 Provisional Diagnosis (Pregnancy)	50

6.11	MSD106 Diagnosis (Pregnancy)	52
6.12	MSD107 Medical History (Previous Diagnosis)	54
6.13	MSD108 Family History at Booking	55
6.14	MSD109 Finding and Observation (Mother)	56
6.15	MSD201 Care Contact (Pregnancy)	58
6.16	MSD202 Care Activity (Pregnancy)	62
6.17	MSD203 Coded Scored Assessment (Contact)	68
6.18	MSD301 Labour and Delivery	70
6.19	MSD302 Care Activity (Labour and Delivery)	78
6.20	MSD401 Baby's Demographics and Birth Details	83
6.21	MSD402 Neonatal Admission	92
6.22	MSD403 Provisional Diagnosis (Neonatal)	94
6.23	MSD404 Diagnosis (Neonatal)	95
6.24	MSD405 Care Activity (Baby)	97
6.25	MSD406 Coded Scored Assessment (Baby)	102
6.26	MSD501 Hospital Provider Spell	102
6.27	MSD502 Hospital Spell Commissioner	105
6.28	MSD503 Ward Stay	106
6.29	MSD504 Assigned Care Professional	107
6.30	MSD601 Anonymous Self-Assessment	108
6.31	MSD602 Anonymous Findings	109
6.32	MSD901 Staff Details	111

Appendix 1 – Abbreviations and Glossary	113
Appendix 2 – Care Activity table guidance	114
Appendix 3 – Example of a test requiring multiple care activities to be recorded in the MSD202 Care Activity (Pregnancy) table	115

1 About this Document

1.1 Purpose of the Document

The purpose of this document is to outline:

- The background to the development of Maternity Services Data Set (MSDS) v2.0 and the development approach.
- The manner by which MSDS v2.0 should be used and interpreted by users, system suppliers and other stakeholders, for example by providing additional information on data tables and data items, beyond that stated in the data set Technical Output Specification (TOS), to further explain their use and validation.

1.2 Scope of the Document

This document is aimed at:

- Managers and clinical leads for organisations providing NHS-funded Maternity Services which are within scope of the data set
- Information management departments within Maternity Data Provider organisations
- IT system suppliers supplying maternity systems

The following areas are out of scope of this document:

- Detailed justification for the development of the Information Standard.
- Data submission framework (i.e., how data is submitted by Maternity Data Providers to the Strategic Data Collection Service (SDCS) Cloud). Further information about this is available from the SDCS Cloud Submission Guide.
- Restating information already accessible from the MSDS v2.0 Technical Output Specification.

This document should be read in conjunction with the following documents:

- [MSDS v2.0 Requirements Specification](#)
- [MSDS v2.0 Change Specification](#)
- [MSDS v2.0 Technical Output Specification](#)
- [MSDS v2.0 Implementation Guidance](#)
- [SDCS Cloud User Guide and Intermediate Database Guidance](#)
- [NHS Data Model and Dictionary](#)

1.3 Schedule for Updating this Document

Please note this guidance document is considered a live document and NHS Digital reserves the right to review and update, when necessary, for example in response to stakeholder feedback. Changes to this document will not necessitate further acceptance from the [Data Alliance Partnership Board \(DAPB\)](#), on the understanding that the changes do not affect the scope of the Information Standard.

1.4 Background Information

The Maternity Services Data Set (MSDS) is a patient-level data set that captures key information at each stage of the maternity care pathway including mother's demographics, booking appointments, admissions and re-admissions, screening tests, labour, and delivery along with baby's demographics, admissions, diagnoses, and screening tests.

As a secondary uses data set it re-uses clinical and operational data for purposes other than direct patient care. It defines the data items, definitions and associated value sets extracted or derived from local information systems.

The MSDS Information Standard is the specification of a patient-level data-extraction (output) standard intended for Maternity Service providers in England. It has been approved by the [DAPB](#) and assigned standard number DCB1513. This mandates the patient-level MSDS as a national data standard.

The previous MSDS v1.5 was published in May 2014 (ref: ISB 1513). MSDS v2.0 replaced MSDS v1.5 on 1st April 2019. The MSDS v2.0 Information Standard amendment has been assigned Release Number Amd 10/2018 and retains standard number DCB1513. The Information Standard including latest amendments can be found on the [DCB 1513: MSDS webpage](#).

The standard mandates the central flow of administrative and clinical information for secondary uses purposes. The standard defines a 'data set specification' based on extracts from clinical systems. The scope includes all activity undertaken by Maternity Services funded, and/or provided, by the NHS. This could include NHS Foundation and non-Foundation Trusts, as well as independent organisations providing NHS-funded Maternity Services.

The scope of the data set includes all activity carried out by the Maternity Service relating to the mother and baby or babies, with the starting point for such activity being the 'Appointment Date (Formal Antenatal Booking)' in the MSD101 table. It is recognised that some activity related to a pregnancy, for example assessment by an Early Pregnancy Unit, may take place prior to the 'Appointment Date (Formal Antenatal Booking)' and this is currently outside the scope of MSDS v2.0 and does not need to be included in submissions.

The MSDS is designed to capture information about open pregnancies and mothers that were discharged from Maternity Services during the reporting period. A pregnancy becomes 'live' in the MSDS once the 'Appointment Date (Formal Antenatal Booking)' has taken place and the 'Estimated Date of Delivery (Agreed)' field is completed. It closes once the mother is discharged from Maternity Services, as recorded in the MSD101 table (this is usually about 10 days after discharge from hospital).

We expect providers to first submit the pregnancy in the reporting period where the 'Appointment Date (Formal Antenatal Booking)' took place and 'Estimated Date of Delivery (Agreed)' recorded. In order for a data submission to succeed, as a minimum the following mandatory tables need to be submitted:

- MSD001 Mother's Demographics
- MSD002 GP Practice Registration
- MSD101 Pregnancy and Booking Details.

For each subsequent month of the pregnancy, until the mother is discharged, you should (as a minimum) submit the three mandatory tables (MSD001, MSD003 and MSD101) even if no activity has occurred for that pregnancy. If activity has taken place in the pregnancy, this should be captured in the relevant table and submitted along with the three mandatory tables.

1.5 MSDS v2.0 development drivers

MSDS v2.0 is designed to meet requirements that resulted from the [National Maternity Review](#), which led to the publication of the [Better Births report](#) in February 2016. Better Births highlighted the need for Maternity Services in England to become safer, more personalised and provide better access to information for pregnant women. The publication of Better Births resulted in the establishment of the [Maternity Transformation Programme](#), and the updated version of the data set formed part of the 'Sharing Data and Information' workstream of the programme.

The Maternity Transformation Programme was originally established with the aim of transforming maternity services in five years in line with the vision for the future of maternity services outlined in Better Births. In addition, the Maternity Transformation Programme, provides the infrastructure for

delivering the maternity safety ambition and the Neonatal Critical Care Review (NCCR). These strategies were further reinforced by the NHS Long Term Plan (LTP) commitments.

As the Maternity Transformation Programme moves beyond its original five-year period it will continue to work across the health system and in collaboration with other organisations to lead and deliver these recommendations.

1.6 Summary of Changes

MSDS v2.0 introduced changes to the MSDS v1.5 Information Standard.

The release of the MSDS v2.0 represented a significant change to the structure of the MSDS v1.5, bringing MSDS into line with the core structures of other data sets maintained by NHS Digital, specifically the [Community Services Data Set \(CSDS\)](#) and the [Mental Health Services Data Set \(MHSDS\)](#).

MSDS v2.0 also mandated the submission of all maternity records in scope of the data set, including records that are held on paper which must be submitted in the required electronic format, and introduced a new structure and content, including clinical terminology.

Other changes included in MSDS v2.0 relate to new government policy initiatives, resolution of issues within the previous data collection, and inclusion of other key stakeholder requirements. A full summary is as follows:

- Structural changes to the data set
- Removal of paper-based records exemption
- Introduction of clinical classifications and terminology, including SNOMED CT
- Capture more detailed diagnoses (using clinical terminology)
- Updated payment requirements (using clinical terminology)
- Capture more detailed procedures, observations, and findings (using clinical terminology)
- Changes to the capture of smoking status
- Capture scored assessments during maternity care pathway (using clinical terminology)
- Capture data about continuity of carer
- Enable linkage to neonatal data
- Capture data about personalised care plans
- Capture intended and actual place of birth
- Capture data from existing data sets and collections, i.e., the CDS 'maternity tail' data set and other collections, to enable future retirement of overlapping collections
- Conformance with additional NICE guidelines and quality standards
- Additional data items, such as 'overseas visitor status'
- Minor updates to the data set to remove redundant tables/items.

Changes introduced into MSDS v2.0 are detailed in the MSDS v2.0 Change Specification and Technical Output Specification (TOS), available along with other supporting documents on the [DCB 1513: MSDS webpage](#) and [NHS Digital MSDS webpages](#) respectively.

2 Configuration of local systems

The TOS fully defines the data items within the MSDS. The TOS splits the data set into a number of tables, each containing related data items.

MSDS is an output data set. An output data set describes the set of data items that need to be extracted or derived from local systems and submitted to the central data warehouse. An output data set is distinctly different from a clinical data set, such as a Patient Administration System (PAS), in that it only defines the data that should be extracted, and so does not directly support patient care. In contrast, a clinical data set specifies data standards for clinical or operational purposes.

In many cases, the output data item will be identical to the operational input definition. However, the two may differ both in terms of the format of the data item and the range of values presented.

Care providers and system suppliers should familiarise themselves with the complementary DCB3066 [Digital Maternity Record Standard](#). The record standard is for primary use purposes and defines the data that should be captured for direct patient care, whereas the data set provides information for secondary uses and can be seen as a submitted subset of the full maternity record. The Digital Maternity Record Standard compliance date is currently on hold, but the standard will still be helpful to assist with system development, alignment, and interoperability.

The main alignment between the data set and record standard will be achieved through the local use in systems, and subsequent submission to the data set, of nationally agreed SNOMED CT codes. Providers can submit these SNOMED CT codes, or alternatively other types of clinical terminology or classifications, where used in local systems – please see Section 3.3 for further information regarding this. The use of SNOMED CT in both the maternity record standard and MSDS will ensure data captured clinically can be extracted and used for secondary purposes without the need for it to be transformed and submitted in a different way as part of the data set.

Nevertheless, the operational system may represent the data in a different manner or in more granularity than is required in the data set. This is particularly the case for administrative data items in MSDS which generally use national code lists rather than clinical terminology, or indicator items which require a yes/no response in the data set. However, providing the operational input data items can be mapped to the output data set, the operational system (input source) will not require any modification.

This concept is illustrated in the following table:

Maternity system (clinical system)		MSDS Technical Output Specification (TOS)	
Data item name	Format/Values	Data item name	Format/values
Reason for late booking	Pregnancy only recently confirmed Non-engagement with services Concealed pregnancy Booked elsewhere before Appointment not available Awaiting availability of interpreter DNA one or more appointments Unable to attend previous appointment	Late Antenatal Booking Appointment Reason	Mother unaware of pregnancy Maternal choice Concealed pregnancy Transferred in from other maternity provider Service capacity Awaiting availability of interpreter Did not attend one or more antenatal booking appointments Recently moved to area - no previous antenatal booking appointment

Maternity system (clinical system)		MSDS Technical Output Specification	
Data item name	Format/Values	Data item name	Format/values
	Recently moved to area – unbooked		Other (not listed)
Disability	- Sensory disability - Motor impairment - Intellectual disability - None	Disability Indicator (At Antenatal Booking)	Yes No

In each of the above scenarios, the input data items will map to the output data items.

It is possible that Maternity Data Providers may use the MSDS for local system implementation, and consequently only capture data as per the data set. However, this is imprudent and against the recommendations of NHS Digital and the Maternity Expert Reference Group. If the MSDS is implemented as a clinical data standard, there is a possibility that key clinical care data items will be omitted from local systems, and this may adversely impact clinical care. The Digital Maternity Record Standard should instead be used for this purpose.

3 Integration of clinical terminologies within the MSDS

MSDS v2.0 introduces the ability to capture and flow information in the form of clinical terminology, including SNOMED CT (Systematised Nomenclature of Medicine - Clinical Terms) codes (see Section 3.4). In addition to SNOMED CT, MSDS v2.0 allows the submission of other types of clinical terminology and classifications where, captured locally and where applicable, specifically ICD-10, OPCS-4, Read Code Version 2, and Read Code Clinical Terms Version 3 (CTV3) (though the latter two have been deprecated). The ability to flow data in the form of clinical terminology, including SNOMED CT, has already been successfully introduced into other national data sets such as the CSDS, IAPT and MHSDS.

3.1 Why are we integrating clinical terminologies within the data set?

The data set can benefit significantly from implementing clinical terminologies within the data model:

- Providers can choose between multiple schemes to submit clinical information. Specifically, providers can submit what they record over and above specific national information requirements. This enables commissioner information requirements to be better met through the data set.
- Using SNOMED CT to capture outcome measures reduces the need for individual tables for each measure. A single table can capture multiple measures using a common structure – for example, multiple different scored assessments can be submitted in the MSD104 Coded Scored Assessment (Pregnancy) and MSD203 Coded Scored Assessment (Contact) tables, rather than a separate table being needed for each type of scored assessment.
- The data set can respond more quickly to changes in clinical practice and information requirements. Terminology is updated at regular intervals and the data set can automatically capture the latest terms without the need to change the structure or content of the data set through the DAPB process.
- MSDS v2.0 conforms to the [Personalised Health and Care 2020 policy](#), which requires local systems to move to using SNOMED CT as the single standard for holding data locally for primary use. This is also set out in the [SCCI0034: SNOMED CT Information Standard](#), which states that service providers must “have detailed plans in place with an associated implementation schedule for SNOMED CT”.

3.2 How have we integrated clinical terminologies within the Data Set?

NHS Digital’s Data Set Development Service worked closely with the NHS Digital Terminology and Classifications team to restructure the data set to allow the recording of data using clinical terminology.

Within the MSDS v2.0:

- Diagnoses for the mother can be submitted using MSD105 Provisional Diagnosis (Pregnancy), MSD106 Diagnosis (Pregnancy) and MSD107 Medical History (Previous Diagnosis) tables.
- Diagnoses for the baby can be submitted using MSD403 Provisional Diagnosis (Neonatal) and MSD404 Diagnosis (Neonatal) tables

- Assessment Tools must be submitted using SNOMED CT. There are multiple ways to link this data within the data set such as against a specific booking (in the MSD104 Coded Scored Assessment (Pregnancy) table), Care Contact (in the MSD203 Coded Scored Assessment (Contact) or MSD406 Coded Scored Assessment (Baby) tables) or anonymously (in the MSD601 Anonymous Self-Assessment table).
- More detailed Care Activity information can be submitted, using a select choice of schemas. Procedures, observable entities, and findings are all recordable in the MSD202 Care Activity (Pregnancy), MSD302 Care Activity (Labour and Delivery), and MSD405 Care Activity (Baby) tables. Observations and findings can be submitted in the MSD109 Finding and Observation (Mother) table.
- Social and Personal Circumstances can be submitted using SNOMED CT, which will allow the flow of demographic data items and personal information in line with published SNOMED CT subsets.

3.3 How should clinical terminology data be captured and submitted?

Maternity data providers should flow activity as recorded in their systems for primary record purposes. This activity may consist of clinical terms that have been recorded in systems which have been used to record the treatment of the mother, baby, or babies during their care as part of the maternity service pathway in order to meet the extended scope and requirements of MSDS v2.0.

Please note that the MSDS v2.0 developers will not author or release specific subsets of SNOMED CT codes for secondary uses purposes. However, as part of the Digital Maternity Record Standard, NHS Digital worked with Royal Colleges and other clinical groups to review and update the available SNOMED CT terms so that they are appropriate for local data capture for clinical purposes. Clinically relevant subsets for specific areas, such as newborn screening, can be utilised where available. These same codes can then be submitted to MSDS v2.0 for national reporting purposes. NHS Digital will not prohibit the flow of specific SNOMED CT codes using validation, except where codes cannot be submitted in an identifiable form for patient confidentiality, governance, or legal reasons (e.g., IVF data).

NHS Digital has produced a [SNOMED CT mapping document](#) available on the NHS Digital website to assist maternity providers in mapping values that were submitted to MSDS v1.5 as a value list to MSDS v2.0 as a SNOMED CT code. The mapping document isn't designed to be exhaustive; if you already record other information relevant to the mother's maternity care then you should submit this to MSDS v2.0. Providers using maternity systems that already capture SNOMED CT codes (or other clinical terminology and classifications) for primary care purposes should flow these codes to MSDS v2.0 rather than trying to map to the codes contained within this document.

In addition, the majority of clinical terminology fields in MSDS v2.0 will also accept other forms of terminology and classifications, where these are used in local systems such as ICD-10 and OPCS-4 Read Code Version 2 and Read Code Clinical Terms 3 (CTV3) codes, (though the latter two have been deprecated). Providers may therefore wish to submit these codes in place of SNOMED CT codes if their system is not able to record or extract SNOMED CT.

It is also acceptable to submit a mixture of different classifications and terminologies within a single submission file, e.g., SNOMED CT codes and ICD-10 codes, provided you identify which type of code you are submitting using the relevant 'Scheme in Use' data item.

Section 6 of this document addresses guidance issues related to the above developments at a table and data item level.

3.4 What is SNOMED CT?

SNOMED CT is the standard clinical terminology for the NHS to support recording of clinical information, in a way that supports data management and analysis to support patient care, while enabling data extraction and data exchange.

SNOMED CT provides a comprehensive set of clinical phrases or terms; this is called a terminology. SNOMED CT is much more than just a set of clinical phrases, for example it also includes groups with relationships between terms. It is the most comprehensive international terminology currently available and can be used across all care settings and all clinical domains.

SNOMED CT is managed and maintained internationally by [SNOMED International](#) and in the UK by the [UK National Release Centre \(part of NHS Digital\)](#).

3.5 What are the benefits of using SNOMED CT?

As the NHS moves to paperless records and the exchange of data electronically across the NHS, it is critical that all systems share the same clinical vocabulary. If every system uses its own vocabulary, then interoperability is reduced to simply moving readable documents around the system and clinicians having to repeatedly transcribe data they need to be within their system, thus introducing errors.

The use of an international terminology enables system suppliers to design their system to a common terminology that can be implemented with less country specialisation across a number of countries. The last few years has seen a shift by suppliers from developing country specific solutions to global solutions with local configuration.

3.6 Further Resources for SNOMED CT

More information about SNOMED CT can be found on the [NHS Digital SNOMED CT pages](#), including information about:

- **Licensing**
The UK is a SNOMED International member country. Use of SNOMED CT in the UK is free; however, the use of SNOMED CT does require a licence. All SNOMED CT licensing enquiries can be sent to information.standards@nhs.net.
- **Training**
NHS Digital offer a range of ways for individuals to learn more about SNOMED CT and its uses. For those who feel they need more understanding of SNOMED CT, NHS Digital provide a number of [training and education resources](#). For an overview of SNOMED CT, the two live webinars provide a good introduction; you will also find case studies, brochures and technical guidance detailed on this web page. For system suppliers, you may also be interested in the more technical guidance provided through our [recorded webinar on the release files](#).
- **SNOMED CT browser**
The [NHS Digital SNOMED CT browser](#) enables users to search for SNOMED CT concepts and subsets.

See also Section 5.2 for guidance covering the submission of SNOMED CT data items.

3.7 ICD Codes

An ICD-10 code is the International Classification of Diseases (ICD) 10th Revision code.

ICD-10 diagnostic codes are at least four characters in length. The first character is always alphabetic. Where an undivided three-character code is used, the fourth character must be filled with 'X'. Further guidance regarding ICD-10 codes is available in the [NHS Data Model and Dictionary](#).

The Technology Reference date Update Distribution (TRUD) platform is the official source of NHS ICD-10 5th Edition data files for download for NHS IT system and software suppliers who build/update software to support NHS business functions.

Please note that MSDS does not currently allow the submission of ICD-11 codes, but this may be added to a future version.

3.8 Read Version 2 and Clinical Terms Version 3

Retirement of Read v2 and Clinical Terms version 3

Read v2 and v3 (CTV3) are now deprecated. Reference to them is made throughout this document for existing usage, however they should not be used for any new circumstances. Please refer to additional guidance on the [NHS Digital Read Codes webpage](#).

4 Constructing Submission Files

4.1 Key points relating to mandatory fields and validation

The MSDS v2.0 TOS fully defines the data items within the output data set and splits the data set into a number of tables, each containing related data items.

Mandatory data items and/or tables

The requirements for each data item are outlined in the original levels of mandation as described in the ISN(as outlined in the mandatory/required/optional column in the TOS):

Mandatory: These data items **MUST** be reported without exception. Failure to submit these items will result in the rejection of the record.

Required: These data items **MUST** be reported where they apply. It is a legal and contractual requirement to submit these data items where the service has been provided to a patient. Failure to submit these items will not result in the rejection of the record but may affect the derivation of national indicators or national analysis. Please note that the purpose of the data set is not to change clinical practice.

Optional: These data items **MAY** be submitted on an optional basis at the submitter's discretion.

Derived: These data items are derived during pre and/or post deadline processing for inclusion in the extracts made available for download. Please note that these are not for submission to the Submission Portal and are not included in the submission file. These items are also greyed out in the Technical Output Specification (TOS) and are not listed in this document.

The three phases of validation correspond to these mandation levels. So, for instance, if a data item is mandatory, it is likely to have data item level rejections for a null or invalid entry. The following default validation rules are applied across the MSDS:

Scenario	Error Code	Example message reported
Mandatory data item is blank	MSDDEF1	MSDDEF1 - Record rejected – M002901 LOCAL PATIENT IDENTIFIER (EXTENDED (MOTHER)) is blank.
Any data item has an incorrect data format	MSDDEF2	MSDDEF2 - Record rejected - M001010 ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (MOTHER)) has an incorrect data format. M001901 LOCAL PATIENT IDENTIFIER (EXTENDED (MOTHER))=<LPIDMother> M001010 ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (MOTHER))=<OrgIDLPID>
An invalid value is provided for a required data item	MSDDEF3	MSDDEF3 - Warning - M004010 OVERSEAS VISITOR CHARGING CATEGORY contains an invalid OVERSEAS VISITOR CHARGING CATEGORY. M001901 LOCAL PATIENT IDENTIFIER (EXTENDED (MOTHER))=<LPIDMother> M004010 OVERSEAS VISITOR CHARGING CATEGORY=<OvsVisChCat>
Required data item is blank (where applicable – see TOS)	MSDDEF4	MSDDEF4 - Warning - M001060 POSTCODE OF USUAL ADDRESS (MOTHER) is blank. M001901 LOCAL PATIENT IDENTIFIER (EXTENDED (MOTHER))=<LPIDMother>
An invalid value is provided for a mandatory data item	MSDDEF5	MSDDEF5 - Record rejected - M404010 DIAGNOSIS SCHEME IN USE contains an invalid DIAGNOSIS SCHEME IN USE. M404906 LOCAL PATIENT IDENTIFIER (EXTENDED (BABY))=<LPIDBaby> M404010 DIAGNOSIS SCHEME IN USE=<DiagScheme>

Whilst a particular table itself may not be mandatory, if a record is entered in this table, then all of the table's mandatory fields must be completed.

The following tables are mandatory, and MUST be submitted for all mothers with an 'open' pregnancy, i.e., mothers who have had a booking appointment, but have not yet been discharged from maternity services, otherwise all of the data connected to a mother's record will be rejected (including any babies):

- MSD001 Mothers Demographics
- MSD002 GP Practice Registration
- MSD101 Pregnancy and Booking Details

At a minimum, the mandatory items in these tables need to be included.

In addition, the following table MUST contain a single record for each submission:

- MSD000 Header

Other tables, such as MSD402 Neonatal Admission, only require a record to be present where applicable to the baby. For this example, not all records will include a baby's record, and not all babies will have a recorded Neonatal Admission - this whole table can be left blank in these cases. If a record is entered into this table, then data must be recorded against all mandatory fields.

Validation of records

Upon submission of the data to the central data warehouse, three phases of validation are undertaken:

1. File level

Leading to rejection or issuing of a warning message. A rejection would be of the entire submission against the selected reporting period, requiring identified issue(s) to be rectified and a resubmission made. Warning messages should be addressed and required actions undertaken.

Where these can be found File-Level Rejects tab

Example: MSDREJ002 - Failed Content Check. Mother's Demographics Table is empty.

2. Table level

These compare records within or across multiple tables, leading to rejection of multiple records or a warning message being displayed. For example, they could be used to check referential integrity between tables or for duplicated records within a table. Rejected records would not progress to post deadline processing. Records with warnings would progress, but data quality would not be as required.

Where these can be found: Individual table tab.

Example: The MSD001 group will be rejected if there is no valid MSD002 group transmitted for this LOCAL PATIENT IDENTIFIER (EXTENDED (MOTHER)).

3. Record level

These can be against a single data item or across multiple data items within a single record, leading to either the rejection of the record or a warning displayed. Rejected records would not progress to post deadline processing. Records with warnings would progress, but data quality would not be as required.

Where these can be found: Individual table tabs

Example: If PERSON DEATH DATE (MOTHER) is before the PERSON BIRTH DATE (MOTHER) the record will be rejected.

Each data item within the data set specification may have any of the above types of validation.

Please see the validations and warnings in the MSDS v2.0 TOS to understand the submission requirements for each table. The “Validation Rules” columns outline the date restrictions, and corresponding messages are shown in the “Error/Warning Messages” column. Please also see section 6 of this User Guidance which contains a description of each table.

4.2 Inclusion Rules

The MSDS v2.0 structure is based on the linkage of data to a specific pregnancy using a pregnancy identifier. The pregnancy can be thought of as effectively an ‘open referral’ for data linkage purposes. Each monthly submission should include all open/active pregnancies within that reporting period, which includes:

- Pregnancies that were opened in the reporting period
- Pregnancies that closed in the reporting period
- Pregnancies that were open throughout the reporting period, even if no activity took place.

Submissions for the MSDS should only occur in the reporting period in which the activity occurred. For example, data for August 2021 should be recorded in the appropriate reporting period (i.e., August 2021) and submitted in the corresponding submission window (i.e., 1st September 2021 – 31st October 2021).

If a large amount of data is submitted, outside of the required range, then numerous rejection messages will be generated back to the provider. This may hinder the provider’s ability to identify ‘real’ rejection messages that require corrections to be made to “included” data. Users are advised to check the date validation rules prior to submission to identify and submit data that is relevant to the reporting period only.

When making a submission it is good practice to access the pre-deadline extract, as this will show exactly what records have been accepted for each table.

5 Data Item Guidance

This section provides additional guidance with regard to data items included within the MSDS v2.0 TOS where this is deemed to be necessary. This includes fully explaining how tables may or may not repeat and extending descriptions and explanations of data items where space does not permit within the TOS. Frequently asked questions and areas that need further clarification are also addressed in this section.

5.1 Linkage and Identifier Data Items

The linkage data items are fully described within the MSDS v2.0 TOS.

Please note that linkage data items must be submitted in each table where they are included, however not all of the tables are required to be sent with each submission.

Linkage data items are included in all tables within the data set, apart from the 'MSD601 Anonymous Self-Assessment' and 'MSD602 Anonymous Findings' tables where identifiers MUST NOT be included for information governance reasons.

Local Patient Identifier – this will uniquely identify a mother or baby within the local system. This is a mandatory requirement to enable local linkage of the data.

Local Patient Identifiers will be accepted in the format max an20 (i.e., alphanumeric characters up to a maximum of 20) and do not need to be padded to 20 characters.

Pregnancy Identifier – this will uniquely identify a pregnancy within the local system. This is a mandatory requirement to enable local linkage of the data, as the submitted Pregnancy Identifier in the MSDS is used to associate data with a specific pregnancy within a submission file.

The Pregnancy Identifier should be locally unique (like the Local Patient Identifier), and providers should submit the same Pregnancy Identifier to represent a specific pregnancy in each monthly submission file

If the mother attends another maternity provider, we do not expect the same pregnancy identifier to be submitted. The separately submitted data relating to the single pregnancy will be reconciled by NHS Digital using a combination of other data items.

Relationship between Pregnancy Identifier and Labour and Delivery Identifier - There is a possible (albeit very infrequent) scenario where a multiple fetus pregnancy could result in more than one labour/delivery. As such, it is not recommended to use exactly the same ID for both the Pregnancy Identifier and the Labour and Delivery Identifier. Using separate identifiers for the Pregnancy Identifier and the Labour and Delivery Identifier will also assist in resolving errors/anomalies when you submit your data.

Where a separate unique Labour and Delivery Identifier is not generated automatically, providers could potentially add a prefix/suffix to the Pregnancy Identifier and make this the Labour and Delivery Identifier.

The data items listed below are marked as linkage items. The table name marked in **bold** denotes the table where the item is a primary key:

LOCAL PATIENT IDENTIFIER (EXTENDED (MOTHER)) - this is the unique local patient identifier of the mother as generated by the NHS Care Provider. This is not the same as the NHS number. This data item is included in the following tables:

MSD001 Mother's Demographics

MSD002 GP Practice Registration
MSD003 Social and Personal Circumstances
MSD004 Overseas Visitor Charging Category
MSD101 Pregnancy and Booking Details

PREGNANCY IDENTIFIER - this is the unique identifier allocated to each maternity episode. This data item is included in the following tables:

MSD101 Pregnancy and Booking Details

MSD102 Maternity Care Plan
MSD103 Dating Scan Procedure
MSD104 Coded Scored Assessment (Pregnancy)
MSD105 Provisional Diagnosis (Pregnancy)
MSD106 Diagnosis (Pregnancy)
MSD107 Medical History (Previous Diagnosis)
MSD108 Family History at Booking
MSD109 Finding and Observation (Mother)
MSD201 Care Contact (Pregnancy)
MSD301 Labour and Delivery
MSD501 Hospital Provider Spell

CARE CONTACT IDENTIFIER - this is used to uniquely identify the care contact within the Health Care Provider. This data item is included in the following tables:

MSD201 Care Contact (Pregnancy)

MSD202 Care Activity (Pregnancy)

CARE ACTIVITY IDENTIFIER (MOTHER) - the unique identifier for a care activity for the mother. This data item is included in the following tables:

MSD202 Care Activity (Pregnancy)

MSD203 Coded Scored Assessment (Contact)

LABOUR AND DELIVERY IDENTIFIER - this is the unique identifier for a specific labour/delivery. This data item is included in the following tables:

MSD301 Labour and Delivery

MSD302 Care Activity (Labour and Delivery)
MSD401 Baby's Demographics and Birth Details

LOCAL PATIENT IDENTIFIER (EXTENDED (BABY)) - this is the unique local patient identifier of the baby as generated by the NHS Care Provider. This is not the NHS number. This data item is included in the following tables:

MSD401 Baby's Demographics and Birth Details

MSD402 Neonatal Admission
MSD403 Provisional Diagnosis (Neonatal)
MSD404 Diagnosis (Neonatal)
MSD405 Care Activity (Baby)

CARE ACTIVITY IDENTIFIER (BABY) - this is the unique identifier for a care activity for a baby. This data item is included in the following tables:

MSD405 Care Activity (Baby)

MSD406 Coded Scored Assessment (Baby)

HOSPITAL PROVIDER SPELL NUMBER – this is a unique identifier for each Hospital Provider Spell for a Health Care Provider. This data item is included in the following tables:

MSD501 Hospital Provider Spell

MSD502 Hospital Spell Commissioner
MSD503 Ward Stay
MSD504 Assigned Care Professional

CARE PROFESSIONAL LOCAL IDENTIFIER – is a unique local care professional identifier within a Health Care Provider for each care professional. This data item is included in the following tables:

- MSD102 Maternity Care Plan
- MSD202 Care Activity (Pregnancy)
- MSD302 Care Activity (Labour and Delivery)
- MSD401 Baby's Demographics and Birth Details (N.B. named 'Care professional Local Identifier (Delivering Baby)')
- MSD405 Care Activity (Baby)
- MSD504 Assigned Care Professional
- MSD901 Staff Details**

NHS Number – Whilst the mother's, baby's, or babies' NHS number *should* be supplied wherever it is known, NHS Digital accepts that there may be occasions where the NHS number is not known.

The capture of the NHS number is vital as this is the only identifier that allows a patient to be tracked across different organisations or across a single organisation when multiple Local Patient Identifiers have been used for a mother and baby or babies.

In some cases, the NHS number can be used locally to link data across multiple systems where the Local Patient Identifier may differ. This could also support situations when a patient is referred to services using a number of different systems. In this case, the NHS number would act as a Local Patient Identifier data item locally but should not be submitted as is in the Local Patient Identifier field for information governance reasons.

Although the NHS number is not a mandated field, as not all mothers and babies have them, data quality reports will be produced to identify the completeness of this field and it is recommended that Maternity Data Providers use this as one of the primary data quality metrics for all patient level data sets.

In cases where a mother's NHS number is unavailable Maternity Data Providers must submit a null NHS number and [07] *Number not present and trace not required* in NHS NUMBER STATUS INDICATOR (MOTHER)/ NHS NUMBER STATUS INDICATOR (BABY) field.

5.2 SNOMED CT data items

During assurance activities for the similar MSDS, two potential issues have been identified with the handling of SNOMED CT data across various third-party systems, which could affect the accuracy of data outputs.

1. Loss of 16-Digit+ accuracy

SNOMED CT IDs can be up to 18 digits long and contain only numbers. Entering a 16-digit (or greater) code into any number-formatted field in a system using the IEEE 754 standard will result in all digits after the 15th being entered as a "0", irrespective of what is keyed.

For Assessment Tool data which will be restricted to specific codes, this will lead to most (but not all - some coincidentally end in a "0") of the 16 -18-digit SNOMED CT codes being rejected at the landing portal during validation.

For other SNOMED CT data, no reference data exists for validation therefore the incorrect SNOMED CT code would flow without warning and be available for future analysis.

2. SNOMED CT codes formatted in 'Scientific Notation'

When a large number (>11 digits) is entered in Excel and then formatted as text, Excel tries to be helpful and shows the number in scientific notation, e.g., 958051000000104 shows as 9.58051E+14.

If submitted in this form, these incorrectly formatted codes will be rejected by the landing portal.

The specific records affected may not be clearly identifiable from portal-generated summary reports. When importing the validations report into Excel, unless you specify that this field should be text, Excel will interpret it as a number and display it, accordingly, therefore leading to a mismatch between what has been submitted and what shows in the validation report.

Mitigating Guidance for above issues

The way round both these issues is to ensure that all SNOMED CT fields are formatted as text in all intermediary systems and import/export routines, and that identifiers are not copy/pasted or typed directly into a spreadsheet. However, this may not currently be the case for providers as SNOMED CT codes are defined in the NHS Data Model and Dictionary as numeric values.

SNOMED CT identifiers, whilst not human readable, are not random numbers and do contain patterns. Part of this pattern is a check-digit. You can use the check-digit to ensure a particular SNOMED CT ID is valid. For more information on SNOMED CT identifiers and how to use the check-digit please see the [SNOMED CT Technical Implementation Guide, Section 4.3.2 'Representing SNOMED CT Identifiers'](#).

Concept IDs and Description IDs

Please note that SNOMED CT code rejections may be received by submitters as a result of trying to submit 'description IDs' rather than 'concept IDs'. The description ID is designed to uniquely identify a SNOMED CT description, whereas the concept ID uniquely identifies the clinical idea represented by the SNOMED CT concept. Only concept IDs should be submitted to MSDS v2.0, and where necessary providers and their supplier should replace any description IDs with the relevant concept ID in their system and/or submissions. The last three digits of SNOMED CT codes enables identification of the type of ID used. '01x' at the end of the code denotes a description, while a concept is represented by '00x', or '10x'/'11x' for a realm or UK concept/description.

6 Breakdown of Data Items by Table

Data items are listed in the following tables using the NHS Data Model and Dictionary data element names.

Additional information on individual data items can also be found via the [NHS Data Model and Dictionary webpage](#). Within the Maternity Services Data Set section, individual data items can be found using the search bar.

6.1 MSD000 Header

MSD000 MSDS Header	
Description	
<p>The Header should include metadata relating to the submission, including which organisation, and reporting periods the data relates to and the date and time the submission was created.</p> <p>One occurrence of this table is required per submission.</p>	
Additional Notes on Data Items	
Data Item Name	Additional Notes
<p>DATA SET VERSION NUMBER</p> <p><i>No Change to Data Item</i></p>	<p>The version of the MSDS that this submission file is for. The current version of the data set is v2.0.</p> <p>'2.0' should be entered as the version number, otherwise your file may be rejected.</p>
<p>ORGANISATION IDENTIFIER (CODE OF PROVIDER)</p> <p><i>No Change to Data Item</i></p>	<p>This is the Organisation Identifier of the organisation acting as a Health Care Provider for the data contained within the submission file.</p>
<p>ORGANISATION IDENTIFIER (CODE OF SUBMITTING ORGANISATION)</p> <p><i>No Change to Data Item</i></p>	<p>This is the Organisation Identifier of the organisation acting as the physical sender of a data set submission.</p> <p>This Identifier provides an audit trail where a different organisation is undertaking the submission on behalf of the provider organisation.</p> <p>It will not be carried over into the national database.</p> <p>This field will normally contain the same Identifier as ORGANISATION IDENTIFIER (CODE OF PROVIDER). It may be appropriate for the codes to differ where a submission is carried out on behalf of another provider. In this instance, provider and submitter should ensure that appropriate governance is in place for the flow of patient identifiable data between the two organisations. For further details about Codes of Practice for handling information in health and care.</p>
<p>PRIMARY DATA COLLECTION SYSTEM IN USE</p> <p><i>New Data Item</i></p>	<p>The name of the Primary Data Collection System in use by the Health Care Provider.</p> <p>This is a free text field.</p> <p>Where multiple systems are in use, please indicate the primary system in use, i.e., the one from which the highest number of records is extracted, or which is used to record the main mandatory tables (MSD001 and MSD101).</p>

MSD000 MSDS Header	
REPORTING PERIOD START DATE <i>No Change to Data Item</i>	The reporting period start date to which this file refers This should be recorded in the eGIF Date format CCYY-MM-DD
REPORTING PERIOD END DATE <i>No Change to Data Item</i>	The reporting period end date to which this file refers This should be recorded in the eGIF Date format CCYY-MM-DD
DATA SET CREATED DATE <i>Amended data item previously - DATA SET CREATED DATE TIME</i>	The date this upload file was created This should be recorded in the eGIF Date format CCYY-MM-DD
DATA SET CREATED TIME <i>New Data Item to take account of Date/Time split, see above item.</i>	The time this upload file was created. The time should be recorded using the 24-hour clock format in eGIF format i.e., HH:MM:SS.

6.2 MSD001 Mother’s Demographics

MSD001 Mother’s Demographics	
Description	
<p>This table contains information on patient identifiers, demographic information, and organisational data. The collection of these data items can be used to analyse outcomes across different ethnic groups, age groups and geographic locations.</p> <p>Providers should supply MSD001 data as it was at the end of the reporting period.</p> <p>Providers must populate all known data items even if they are unchanged since the last submission. Do not just provide data for all "changed" data items.</p> <p>Please note that the MSD001 table is mandatory and must be included in every submission file, along with the MSD002 and MSD101 tables.</p>	
Additional Notes on Data Items	
Data Item Name	Additional Notes
LOCAL PATIENT IDENTIFIER (EXTENDED (MOTHER)) <i>Amended data item previously - LOCAL PATIENT IDENTIFIER (MOTHER)</i>	<p>This is the unique Local Patient Identifier of the mother as generated by the NHS Care Provider. This is not the NHS number.</p> <p>This is the primary key that enables tables of data to be joined together. As such this is a mandated item, and the record will be rejected if it is not included within this table.</p> <p>Ideally, mothers should have the same Local Patient Identifier across successive submission periods to make local reconciliation of data easier.</p>

MSD001 Mother's Demographics	
	<p>Where multiple systems are used it is acceptable to use a prefix to the Local Patient Identifier which relates to the system. The prefix enables each identifier to remain truly unique for all submissions from an organisation in the event that the same Local Patient Identifier is used to represent two different mothers in different systems. However, submitters should ensure that the same Local Patient Identifier is used to identify each distinct mother within a submission file, for example where a mother's records exist on two systems and therefore are potentially associated with different Local Patient Identifiers for the same mother.</p> <p>Duplicate Local Patient Identifiers within the same submission file will cause the entire file to be rejected.</p>
<p>ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (MOTHER))</p> <p><i>Amended data item previously - ORGANISATION CODE (LOCAL PATIENT IDENTIFIER (MOTHER))</i></p>	<p>This is the Organisation Identifier of the organisation that assigned the Local Patient Identifier.</p> <p>It is necessary where organisations have gone through a merger or split into a new or existing organisation.</p> <p>If Local Patient Identifiers are not modified during the merger or split of an organisation, then the issuing Organisation Identifier of the Local Patient Identifier (even if now discontinued) should be sent in this field. However, if the Local Patient Identifier has been modified since the organisation change i.e., by prefix etc, then the new Organisation Identifier should be used.</p>
<p>PERSON BIRTH DATE (MOTHER)</p> <p><i>No Change to Data Item</i></p>	<p>This captures the date on which a mother was born or is officially deemed to have been born. This is required to enable the positive identification of the mother.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p> <p>The data set does not capture whether the mother is a surrogate. In the case of a surrogate pregnancy, the date of birth will be of the mother carrying the baby.</p>
<p>ORGANISATION IDENTIFIER (RESIDENCE RESPONSIBILITY)</p> <p><i>Amended data item previously - ORGANISATION CODE (RESIDENCE RESPONSIBILITY)</i></p>	<p>This field can routinely be left blank, however if populated it should contain the Organisation Identifier (Residence Responsibility) of the commissioner with which the patient is resident (i.e., the CCG responsible for where the mother lives).</p> <p>The Organisation Identifier (Residence Responsibility) should be current at the end of the reporting period.</p> <p>This item is also derived by NHS Digital based on postcode of usual address, using a lookup file which assigns the patient to an organisation.</p> <p>This derivation only applies when the Organisation Identifier (Residence Responsibility) is blank upon submission. Providers can override this derivation (for instance, if they are aware that a particular CCG has residence responsibility for a patient) by manually entering an Organisation Identifier in this field.</p>

MSD001 Mother's Demographics	
<p>NHS NUMBER (MOTHER) <i>No Change to Data Item</i></p>	<p>This captures the NHS Number of the mother in this maternity episode. When the NHS number is provided this will be used instead of the Local Patient Identifier (Extended (Mother)) as the primary unique identifier for a mother.</p> <p>The capture of the NHS number is vital as this is the only identifier that allows the mother to be tracked across different organisations and submissions.</p> <p>Although this is not a mandated field, as not all mothers have NHS numbers, data quality reports will be produced to identify the completeness of this field. It is therefore recommended that Maternity Data Providers use this as one of the primary data quality metrics for all patient level data sets.</p> <p>Duplicate NHS Numbers within this table will cause the entire file to be rejected. Duplicate NHS Numbers across multiple submission files will cause both records to be rejected even if it is unique within each submission file.</p> <p>The data set does not capture whether the mother is a surrogate. In the case of a surrogate pregnancy, the NHS number must be of the mother carrying the baby.</p> <p>Further guidance about NHS Numbers can be found here: https://digital.nhs.uk/services/nhs-number</p>
<p>NHS NUMBER STATUS INDICATOR CODE (MOTHER) <i>No Change to Data Item</i></p>	<p>Whether the NHS number of the mother has been verified.</p> <p>This data item is 'Required' however it is recommended that this is always completed, irrespective of whether an NHS number is present.</p> <p>In cases where a mother's NHS number is unavailable (which may be because the mother does not possess one) Maternity Data Providers must submit a null NHS number and [07] <i>Number not present and trace not required</i> in NHS Number Status Indicator Code (Mother).</p> <p>In most cases, this data item will be flowed with value [01] - <i>Number present and verified</i>. The [01] will indicate that the Maternity Data Provider has validated the number against the central Personal Demographics Service (PDS), and therefore facilitates reliable data linkage.</p> <p>Maternity Data Providers may flow data for patients with an NHS Number Status Indicator Code (Mother) other than [01] and they will be accepted, however, reports that need reliable linkage may exclude these records (unless reliable linkage is available via Local Patient Identifier (Extended Mother) data items).</p>

MSD001 Mother's Demographics	
<p>POSTCODE OF USUAL ADDRESS (MOTHER)</p> <p><i>No Change to Data Item</i></p>	<p>The Postcode of Usual Address as stated by the mother.</p> <p>Where the mother has no fixed abode, this should be recorded as ZZ99 3VZ.</p> <p>If the postcode is unknown ZZ99 3WZ should be used.</p> <p>For overseas residents, the postcode will be recorded in the format ZZ99 xxZ, where xx denotes the country pseudo postcode.</p> <p>A full list of pseudo postcodes is available from the ONS web page for postcode related data to ODS, see: https://digital.nhs.uk/services/organisation-data-service/data-downloads/office-for-national-statistics-data</p> <hr/> <p>The link to download text files of bulk ODS data, available as self-extracting zip files is https://digital.nhs.uk/organisation-data-service/data-downloads</p> <p>For further details regarding acceptable postcode formats and validations applied at the submission portal see the 'Technical Glossary' tab within the MSDS v2.0 TOS.</p> <p>The postcode is one of the key data items that NHS Digital relies upon to assign individuals a nationally unique Master Person Service (MPS) ID. This allows NHS Digital to link a mother's record from one submission file with the same mother's record in another submission file, even if the submission files are from two different providers.</p> <p>Due to the importance of establishing a reliable MPS ID, providers should be aware that file-level validation checks are applied to postcodes in a submission file. If one (or more) mothers' postcodes within a submission file are invalid, this will result in the whole submission file being rejected.</p>
<p>ETHNIC CATEGORY (MOTHER)</p> <p><i>No Change to Data Item</i></p>	<p>Ethnicity, as specified by the mother.</p> <p>Codes [Z] – Not Stated, and [99] - Not Known should be applied as follows:</p> <p>The [Z] <i>Not Stated</i> national code should only be used where the patient has been asked and has declined to provide their ethnic category because of refusal or the inability to choose.</p> <p>The [99] <i>Not Known</i> national code should be used where the patient has not been asked or where the patient was not in a suitable condition to be asked.</p> <p>Please note that the Ethnic Category (Mother) data item is based on the 2001 Census code set.</p> <p>Locally, organisations can collect the newly introduced 2021 codes but for MSDS v2.0 submissions these should be mapped to the 2001 codes. The 2021 list includes the values 'Gypsy or Irish Traveller' and 'Arab', which should be mapped to 'S - Any other ethnic group' for submission. The Ethnic Category data item will be updated in a future release of MSDS.</p>

MSD001 Mother's Demographics	
<p>PERSON DEATH DATE (MOTHER)</p> <p><i>Amended data item previously - PERSON DEATH DATE TIME (MOTHER)</i></p> <p><i>Amended to separate death date time, see below data item.</i></p>	<p>This captures information on maternal deaths within the antenatal, intrapartum, and postpartum periods. The postpartum period will only cover deaths during the period the mother is in the care of Maternity Services (i.e., up to point of discharge from Maternity Services).</p> <p>This must be submitted for any known death not only where a death certificate is issued.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p> <p>Maternity Data Providers also report maternal deaths to MBRRACE-UK (Mothers and Babies - Reducing Risk through Audits and Confidential Enquiries across the UK) as part of the National Maternal, Newborn and Infant Clinical Outcomes Review Programme.</p> <p>Data submission to MBRRACE-UK must continue. Maternity Data Providers should ensure that the data submitted for a particular mother to the MSDS is consistent with the data submitted to MBRRACE-UK.</p> <p>N.B. Whilst both MSDS and MBRRACE-UK capture maternal death data, MSDS only captures death up to the point of discharge from Maternity Services, whereas MBRRACE-UK captures deaths up to 6 months after the end of pregnancy.</p>
<p>PERSON DEATH TIME (MOTHER)</p> <p><i>New Data Item Introduced to separate date time, see above data item.</i></p>	<p>Time of death within the antenatal, intrapartum, and postpartum periods. The postpartum period will only cover deaths during the period the woman is in the care of Maternity Services (i.e., up to point of discharge from Maternity Services).</p> <p>The time should be recorded using the 24-hour clock format in eGIF format i.e., HH:MM:SS.</p> <p>Also see the Person Death Date (Mother) data item guidance above.</p>

6.3 MSD002 GP Practice Registration

MSD002 GP Practice Registration (Prev MAT003)	
Description	
<p>This table contains information on the mother's current and previous registered GP Practice(s). The collection of these data items can be used to support the identification of the commissioner. The table includes start and end dates for when the mother was registered with the practice.</p> <p>Providers should supply MSD002 data as it was at the end of the reporting period.</p> <p>Please note that the MSD002 table is mandatory and must be included in every submission file, along with the MSD001 and MSD101 tables.</p>	
Additional Notes on Data Items	
Data Item Name	Additional Notes

MSD002 GP Practice Registration (Prev MAT003)	
<p>LOCAL PATIENT IDENTIFIER (EXTENDED (MOTHER))</p> <p><i>Amended data item previously - LOCAL PATIENT IDENTIFIER (MOTHER)</i></p>	<p>This is the unique Local Patient Identifier of the mother as generated by the NHS Care Provider. This is not the NHS number.</p> <p>This is the primary key that enables tables of data to be joined together. As such this is a mandated item, and the record will be rejected if it is not included within this table.</p> <p>Ideally, mothers should have the same Local Patient Identifier across successive submission periods to make local reconciliation of data easier.</p> <p>Where multiple systems are used it is acceptable to use a prefix to the Local Patient Identifier which relates to the system. The prefix enables each identifier to remain truly unique for all submissions from an organisation in the event that the same Local Patient Identifier is used to represent two different mothers in different systems. However, submitters should ensure that the same Local Patient Identifier is used to identify each distinct mother within a submission file, for example where a mother's records exist on two systems and therefore are potentially associated with different Local Patient Identifiers for the same mother.</p> <p>Duplicate Local Patient Identifiers within the same submission file will cause the entire file to be rejected.</p>
<p>GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION (MOTHER))</p> <p><i>No Change to Data Item</i></p>	<p>The General Medical Practice Code (Patient Registration Mother) is the Organisation Code of the GP Practice that the mother is registered with.</p> <p>The following default ODS codes apply:</p> <p>GP Practice Code is not applicable - V81998</p> <p>GP Practice Code not known - V81999</p> <p>No Registered GP Practice - V81997</p> <p>Please see General Medical Practice Code (Patient Registration) on Data Dictionary for information on the use of the above codes.</p> <p>For more general information on default codes, please visit Organisation Data Service Default Codes.</p> <p>We do not at this time recommend submitting branch surgery codes in this field. Please continue to submit the parent GP codes as these can be assigned to the correct CCG.</p>
<p>START DATE (GMP PATIENT REGISTRATION)</p> <p><i>No Change to Data Item</i></p>	<p>This is the start date on which the mother registered with the General Medical Practice. This field is primarily to track changes to the GP and their commissioner during the pregnancy episode.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p> <p>This field should only be populated if the actual start date is known. If this is not known, then it is acceptable to leave this field blank.</p> <p>If the mother changes General Medical Practice whilst under the care of Maternity Services, then a new GP Practice Registration record should be submitted, and the start date of the mother's new General Medical Practice registration populated.</p>

MSD002 GP Practice Registration (Prev MAT003)	
<p>END DATE (GMP PATIENT REGISTRATION)</p> <p><i>No Change to Data Item</i></p>	<p>This is the end date on which the mother ceased to be registered with a General Medical Practitioner Practice. This field is primarily to track changes to the GP and their commissioner during the pregnancy episode.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p> <p>If this field is left blank the General Medical Practice Code recorded in this table will be assumed to be current.</p> <p>If the mother changes General Medical Practice whilst under the care of Maternity Services, then it is expected that the end date of her previous General Medical Practice will be populated.</p>
<p>ORGANISATION IDENTIFIER (GP PRACTICE RESPONSIBILITY)</p> <p><i>Amended data item previously - ORGANISATION CODE (CODE OF COMMISSIONER)</i></p>	<p>This field is used to record the commissioner associated with a GP's registered population, which is derived from the General Medical Practice Code Patient Registration by NHS Digital.</p> <p>This field can routinely be left blank, however if populated it should contain the Organisation Identifier of the commissioner that is associated with the mothers current registered GP Practice (this is the organisation responsible for the GP practice where the mother is registered, irrespective of whether they reside within the boundary of the Clinical Commissioning table).</p>

6.4 MSD003 Social and Personal Circumstances

MSD003 Social and Personal Circumstances New Table
<p>Description</p>
<p>To carry details of the mothers social and personal circumstances, as recorded using SNOMED CT codes.</p> <p>Multiple occurrences of this table are permitted for each maternity episode, and separate instances of the MSD003 table can be submitted for each Social and Personal Circumstance relevant to a specific mother.</p> <p>Scope</p> <p>Providers are currently expected to collect the following information in these tables:</p> <ul style="list-style-type: none"> Required - RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE or RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION CODE Required - PERSON STATED SEXUAL ORIENTATION CODE <p>Please see the NHS Data Model and Dictionary links above for further information regarding the definitions and code lists for these data elements, as well as the specific data item guidance below.</p> <p>Please note that submission must be made using the specified SNOMED CT subsets for each data element, which can be found via the SNOMED CT Term Browser.</p> <p>The SNOMED CT subsets for both data elements are directly aligned with the NHS Data Model and Dictionary National Codes.</p> <p>Additional guidance regarding these data elements can be found below.</p>

MSD003 Social and Personal Circumstances		New Table
Additional Notes on Data Items		
Data Item Name	Additional Notes	
<p>LOCAL PATIENT IDENTIFIER (EXTENDED (MOTHER)) <i>New Data Item</i></p>	<p>This is the unique Local Patient Identifier of the mother as generated by the NHS Care Provider. This is not the NHS number.</p> <p>This is the primary key that enables tables of data to be joined together. As such this is a mandated item, and the record will be rejected if it is not included within this table.</p> <p>Ideally, mothers should have the same Local Patient Identifier across successive submission periods to make local reconciliation of data easier.</p> <p>Where multiple systems are used it is acceptable to use a prefix to the Local Patient Identifier which relates to the system. The prefix enables each identifier to remain truly unique for all submissions from an organisation in the event that the same Local Patient Identifier is used to represent two different mothers in different systems. However, submitters should ensure that the same Local Patient Identifier is used to identify each distinct mother within a submission file, for example where a mother’s records exist on two systems and therefore are potentially associated with different Local Patient Identifiers for the same mother.</p> <p>Duplicate Local Patient Identifiers within the same submission file will cause the entire file to be rejected.</p>	
<p>SOCIAL AND PERSONAL CIRCUMSTANCE (SNOMED CT) <i>New Data Item</i></p>	<p>RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE</p> <p>SNOMED CT Religious or other belief system affiliation group code subset: Religious or other belief system affiliation groups (Term Browser)</p> <p>This link provides the full list of Religious or other belief system affiliation group SNOMED codes.</p> <p>DD4C Subset Metadata: Religious or other belief system affiliation groups (DD4C)</p> <p>NHS Data Model and Dictionary Service mapping: RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION GROUP CODE</p> <p>Notes:</p> <p>Please note the following mapping between the National Codes and SNOMED CT Subset:</p> <p>“62458008 Has religious belief (finding)” aligns with “K – Other”</p> <p>“763896000 Religion not given – patient refused (finding)” aligns with “M – Declines to Disclose”</p> <p>“160552003 Not religious (finding)” aligns with “L – None”</p> <p>Please note the addition of “Agnostic (person)” within the SNOMED CT terms, which is currently not aligned with the NHS Data Model and Dictionary.</p> <p>RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION CODE</p> <p>NHS Data Model and Dictionary Service mapping to lower-level religious affiliation codes:</p>	

MSD003 Social and Personal Circumstances	
	<p>RELIGIOUS OR OTHER BELIEF SYSTEM AFFILIATION CODE</p> <p>PERSON STATED SEXUAL ORIENTATION CODE</p> <p>SNOMED CT Sexual orientation subset: Sexual orientation findings (Term Browser)</p> <p>This link provides the full list of Sexual orientation SNOMED codes</p> <p>DD4C Subset Metadata: Sexual orientation findings (DD4C)</p> <p>NHS Data Model and Dictionary Service mapping: PERSON STATED SEXUAL ORIENTATION</p> <p>Notes:</p> <p>Please see the DCB2094 Sexual Orientation Monitoring webpage for further details regarding this separate information Standard. In particular, Appendix A of the Implementation Guidance contains a mapping table for the national codes.</p>
<p>SOCIAL AND PERSONAL CIRCUMSTANCE RECORDED DATE</p> <p><i>New Data Item</i></p>	<p>This is the date that the social and personal circumstance was recorded.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p>

6.5 MSD004 Overseas Visitor Charging Category

MSD004 Overseas Visitor Charging Category	
Description	
<p>Details of the Overseas Visitor Charging Category of the mother using NHS Services.</p> <p>Multiple occurrences of this table are permitted for each maternity episode, one for each Overseas Visitor Charging Category recorded for the patient.</p> <p>Please see the Overseas Visitor Charging Category (OVCC) fundamental standard for more information on the recording of the Overseas Visitor Charging Category.</p>	
Additional Notes on Data Items	
Data Item Name	Additional Notes
<p>LOCAL PATIENT IDENTIFIER (EXTENDED (MOTHER))</p> <p><i>New Data Item</i></p>	<p>This is the unique Local Patient Identifier of the mother as generated by the NHS Care Provider. This is not the NHS number.</p> <p>This is the primary key that enables tables of data to be joined together. As such this is a mandated item, and the record will be rejected if it is not included within this table.</p> <p>Ideally, mothers should have the same Local Patient Identifier (Extended (Mother)) across successive submission periods to make local reconciliation of data easier.</p>

MSD004 Overseas Visitor Charging Category New Table	
	<p>Where multiple systems are used it is acceptable to include a prefix to the Local Patient Identifier (Extended (Mother)), which relates to the system. The prefix enables each identifier to remain truly unique for all submissions from an organisation.</p> <p>Duplicate Local Patient Identifiers within the same submission file will cause the entire file to be rejected.</p>
<p>OVERSEAS VISITOR CHARGING CATEGORY <i>New Data Item</i></p>	<p>The charging category relating to an Overseas Visitor Status.</p> <p>The value list includes:</p> <ul style="list-style-type: none"> A Standard NHS-funded PATIENT B Immigration Health Surcharge payee C Charge-exempt Overseas Visitor (European Economic Area) D Chargeable European Economic Area PATIENT E Charge-exempt Overseas Visitor (non-European Economic Area) F Chargeable non-European Economic Area PATIENT P Decision Pending 9 Not known (not recorded) <p>Where possible all patients included in an MSDS submission should have an entry in the MSD004 table even in cases where they are not an overseas visitor and have always been resident in the UK, by recording code 'A Standard NHS-funded PATIENT'.</p>
<p>OVERSEAS VISITOR CHARGING CATEGORY APPLICABLE DATE <i>New Data Item</i></p>	<p>The date when the Overseas Visitor Charging Category was applicable from.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p> <p>If the applicable date is not available, this should be the date that the Overseas Visitor Charging Category was recorded.</p>

6.6 MSD101 Pregnancy and Booking Details

MSD101 Pregnancy and Booking Details Amended Table	
Description	
<p>The scope of the data set includes all activity carried out by the Maternity Service relating to the mother and baby or babies, with the starting point for such activity being the 'Appointment Date (Formal Antenatal Booking)' in the MSD101 table. It is recognised that some activity related to a pregnancy, for example assessment by an Early Pregnancy Unit, may take place prior to the 'Appointment Date (Formal Antenatal Booking)' and this is currently outside the scope of MSDS v2.0 and does not need to be included in submissions.</p> <p>This table captures the personal, social, medical, and other details of the mother at the formal antenatal booking appointment, during the maternity episode and at discharge from Maternity Services.</p>	

MSD101 Pregnancy and Booking Details		Amended Table
<p>NICE CG62 states that the booking appointment should ideally occur within 10 weeks gestation¹, but, due to varying circumstances, it may occur later. Maternity Data Providers should submit this table irrespective of how early or late in pregnancy the booking appointment occurred.</p> <p>The Pregnancy and Booking table can be thought of as effectively a 'pregnancy episode' or 'referral' table for the duration of the pregnancy. The majority of the details included in the table will be captured locally at the booking appointment - in particular, those items which include 'AT ANTENATAL BOOKING' in the data item title - but some items will only be known at a later point (for example, the 'PRIMARY DISCHARGE REASON (MOTHER MATRNTY SERVICES)').</p> <p>As a mandatory table MSD101 must be included in every submission file, along with the MSD001 Mothers Demographics and MSD002 GP Practice Registration tables. The MSD101 table must include records for all pregnancies open within that reporting period, regardless of whether any activity has occurred within that reporting period.</p>		
Additional Notes on Data Items		
Data Item Name	Additional Notes	
<p>PREGNANCY IDENTIFIER</p> <p><i>New Data Item</i></p>	<p>This is the unique identifier allocated to each maternity episode.</p> <p>The Pregnancy Identifier uniquely identifies each pregnancy allowing the details of different pregnancies to be reconciled.</p> <p>In the event that a mother is no longer pregnant, and then becomes pregnant again, a different pregnancy identifier should be used for the new pregnancy.</p> <p>It would normally be automatically generated by the local system upon recording a new pregnancy (at booking appointment/ first contact), although could be manually assigned.</p> <p>This is a primary key that enables this table to be joined to several other tables. As such this is a mandated item, and the record will be rejected if it is not included within this group.</p>	
<p>LOCAL PATIENT IDENTIFIER (EXTENDED (MOTHER))</p> <p><i>Amended data item previously - LOCAL PATIENT IDENTIFIER (MOTHER)</i></p>	<p>This is the unique Local Patient Identifier of the mother as generated by the NHS Care Provider. This is not the NHS number.</p> <p>This is the primary key that enables tables of data to be joined together. As such this is a mandated item, and the record will be rejected if it is not included within this table.</p> <p>Ideally, mothers should have the same Local Patient Identifier across successive submission periods to make local reconciliation of data easier.</p> <p>Where multiple systems are used it is acceptable to use a prefix to the Local Patient Identifier which relates to the system. The prefix enables each identifier to remain truly unique for all submissions from an organisation in the event that the same Local Patient Identifier is used to represent two different mothers in different systems.</p>	

¹ England. NICE (Corrected June 2008, last updated 4 February 2019) *CG62 Antenatal Care: Antenatal care for uncomplicated pregnancies*, London: RCOG Press, pp. 78 [<https://www.nice.org.uk/guidance/CG62>]

MSD101 Pregnancy and Booking Details	
<i>Amended Table</i>	
	<p>However, submitters should ensure that the same Local Patient Identifier is used to identify each distinct mother within a submission file, for example where a mother's records exist on two systems and therefore are potentially associated with different Local Patient Identifiers for the same mother.</p> <p>Duplicate Local Patient Identifiers within the same submission file will cause the entire file to be rejected.</p>
<p>ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)</p> <p><i>New Data Item</i></p>	<p>This is the Organisation Identifier of the organisation commissioning the provision of maternity care from the provider where the submitted booking appointment (and related activity) is taking place. The Organisation Identifier (Code of Commissioner) may be a specialist commissioner.</p> <p>The NHS England document 'Who Pays? (Aug 2020)' sets out a framework for establishing responsibility for commissioning an individual's care within the NHS and determining who pays for a patient's care.</p> <p>Updated guidance came into effect from 1 September 2020, replacing the 2013 version. The core rule remains that the commissioner responsible for payment will be the clinical commissioning group of which the patient's GP practice is a member, with some exceptions to this core rule which are described within the document.</p>
<p>APPOINTMENT DATE (FORMAL ANTENATAL BOOKING)</p> <p><i>No Change to Data Item</i></p>	<p>This is a mandated item, and the record will be rejected if it is not included within this table.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p> <p>Multiple visits</p> <p>Where the booking appointment is spread over two or more visits, this data item will capture the date of the last visit (i.e., the point at which the assessment was completed).</p> <p>The formal antenatal booking can also relate to the initial contact between the mother and a specific Care Provider whether this takes the form of a formal booking appointment or is simply the day when a mother presents herself to give birth (having booked elsewhere or not at all, such as in the event of a concealed pregnancy).</p> <p>Where a formal antenatal booking appointment has not taken place and will not take place prior to birth</p> <p>In this situation, the first appointment at the Maternity unit can be used in place of a formal antenatal booking date.</p> <p>If the first contact with the Maternity unit occurs when the mother is already in labour, the date that the mother arrived at the Maternity unit should be used in place of a formal antenatal booking date.</p> <p>Please note that the formal antenatal booking date does not need to be substituted by the above dates in your information system but should be included in place of the formal antenatal booking date in your data extract.</p>
<p>PREGNANCY FIRST CONTACT DATE</p> <p><i>No Change to Data Item</i></p>	<p>Date when mother was first in contact with the NHS for antenatal/pregnancy care, e.g., a GP appointment or direct access to maternity services, for this pregnancy.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p>

MSD101 Pregnancy and Booking Details	
<i>Amended Table</i>	
	<p>NICE CG62 Antenatal Care defines pregnancy first contact as:</p> <p><i>“The initial appointment where the mother first meets a healthcare professional with a confirmed pregnancy. This appointment includes referral into the maternity care pathway and an opportunity for information giving so that the mother is able to make informed decisions about her pregnancy care.”</i></p>
<p>ESTIMATED DATE OF DELIVERY (AGREED)</p> <p><i>No Change to Data Item</i></p>	<p>The estimated delivery date for the mother.</p> <p>The Estimated Date of Delivery (EDD) is normally calculated from the Last Menstrual Period Date, the dating ultrasound scan, or a clinical assessment (e.g., abdominal palpation). In cases where the date of conception is known precisely, such as with in vitro fertilization, the EDD can also be calculated using the date of conception or embryo transfer.</p> <p>For the purposes of MSDS v2.0, the EDD should be treated as a ‘working’ estimate. The EDD does not have to be formally ‘agreed’ with the mother or formally diagnosed by ultrasound scan in order for it to be submitted to MSDS v2.0.</p> <p>It is accepted that the EDD may change during the pregnancy, and this is accounted for within the data set through the use of the submitted Pregnancy Identifier and derived Unique Pregnancy Identifier. It is also acknowledged that, where a mother has different Care Providers though the course of a pregnancy, there is a possibility that a differing value for EDD may be submitted by these different providers.</p> <p>Where the data submitter does not know the EDD (e.g., the mother was not aware they were pregnant, or only accessed care at the point of labour and delivery), they should provide their best estimate. This will likely be based on the woman’s verbal history and a clinical assessment. Where the birth took place during the reporting period, data submitters should use the Baby’s Date of Birth as the EDD.</p> <p>Where a mother has a miscarriage before a dating ultrasound scan, or the dating ultrasound scan is yet to take place, the Last Menstrual Period (LMP) Date can be used to calculate the EDD.</p> <p>If no LMP date is available (e.g., where a woman becomes pregnant soon after a miscarriage and doesn’t have an LMP), then a clinical assessment would normally take place (along with an urgent referral for a scan).</p> <p>This item should be recorded in the eGIF Date format CCYY-MM-DD.</p>
<p>ORGANISATION SITE IDENTIFIER (OF ANTENATAL BOOKING)</p> <p><i>New Data Item</i></p>	<p>NHS organisation site identifier of place of booking. List of all NHS organisation sites (with their organisation site identifiers) are available from the NHS Digital website.</p> <p>In the event that a mother moves to a different maternity provider during their pregnancy (e.g., they move to a new house midway through their pregnancy), this item should be used to record the initial site where a booking appointment took place.</p>

MSD101 Pregnancy and Booking Details		<i>Amended Table</i>
	<p>The value list includes:</p> <ul style="list-style-type: none"> Alphanumeric site code ZZ201 Home ZZ888 Non-NHS organisation ZZ203 Not known (not recorded) ZZ999 Other 	
<p>METHOD OF ESTIMATED DATE OF DELIVERY (AGREED)</p> <p><i>Amended data item previously ESTIMATED DATE OF DELIVERY METHOD (AGREED)</i></p>	<p>The method by which the Agreed Estimated Date of Delivery was calculated.</p> <p>The Estimated Date of Delivery Method (Agreed) should be left blank where it is known to be due to IVF treatment.</p> <p>The value list includes:</p> <ul style="list-style-type: none"> 01 Last Menstrual Period (LMP) Date as stated by the mother 02 Last Menstrual Period Date (LMP) confirmed by Ultrasound Scan In Pregnancy 03 Ultrasound Scan in Pregnancy dating measurements 04 Clinical assessment 	
<p>SOURCE OF REFERRAL FOR MATERNITY</p> <p><i>New Data Item</i></p>	<p>The Source of the Referral of the mother to the maternity service for this maternity episode, i.e., the care setting or service that referred the mother to the maternity service.</p> <p>The value list includes:</p> <ul style="list-style-type: none"> 01 General Medical Practitioner Practice 02 Self-referral 03 Other maternity service 04 Early Pregnancy Unit (EPU) – note that this could be any Early Pregnancy Unit (i.e., belonging to a same or different provider). There is no requirement to know which unit at present, but if it has a unique organisation code, it could be submitted in the ORGANISATION IDENTIFIER (PROVIDER OF ORIGIN) item 05 Accident and Emergency Department (including Minor Injuries Units and Walk in Centres) 06 School 07 Prison 08 Social Services 09 Health Visiting Service 98 Other (not listed) 	

MSD101 Pregnancy and Booking Details		<i>Amended Table</i>
<p>ORGANISATION IDENTIFIER (PROVIDER OF ORIGIN)</p> <p><i>New Data Item</i></p>	<p>This is the Organisation Identifier of the originating organisation that referred the mother to the maternity service. This will be applicable only if the request has originated from another organisation. It will not be applicable for a self-referral.</p> <p>This item identifies mothers who have changed maternity service provider during their pregnancy. If applicable, this should identify the organisation that was previously providing maternity care for the mother during this pregnancy. If a mother has not changed maternity service provider during this pregnancy this data item should be left blank. This data item <u>should not</u> be populated with the same organisation as the ORGANISATION IDENTIFIER (CODE OF PROVIDER) in the MSD000 Header.</p> <p>This data item should be used to indicate a complete transfer of care, as opposed to shared care.</p>	
<p>ORGANISATION IDENTIFIER (RECEIVING)</p> <p><i>New Data Item</i></p>	<p>Organisation Identifier (Receiving) is the Organisation Identifier of the Organisation that is receiving the mother from another Health Care Provider.</p> <p>This item identifies the subsequent organisation of a mother who has changed maternity service provider during their pregnancy. If applicable, this should identify the organisation that subsequently provided maternity care for the mother during this pregnancy. If a mother has not changed maternity service provider during this pregnancy this data item should be left blank. This data item <u>should not</u> be populated with the same organisation as the ORGANISATION IDENTIFIER (CODE OF PROVIDER) in the MSD000 Header.</p> <p>This data item should be used to indicate a complete transfer of care, as opposed to shared care, i.e., the organisation preparing the submission file and populating the ORGANISATION IDENTIFIER (RECEIVING) would not be expecting to continue to provide maternity care for this mother in subsequent reporting periods. This could happen (and be recorded) at any point during the pregnancy. The data items DISCHARGE DATE (MOTHER MATERNITY SERVICES) and PRIMARY DISCHARGE REASON (MOTHER MATERNITY SERVICES) should also be populated to indicate that the mother's maternity care from this provider has ended.</p>	
<p>LATE ANTENATAL BOOKING APPOINTMENT REASON</p> <p><i>New Data Item</i></p>	<p>The reason why the mother did not have her booking appointment with the maternity service before she was 12 weeks and 6 days into her pregnancy.</p> <p>The value list includes:</p> <ul style="list-style-type: none"> 01 Mother unaware of pregnancy 02 Maternal choice 03 Concealed pregnancy 04 Transferred in from other maternity provider 05 Service capacity 06 Awaiting availability of interpreter 	

MSD101 Pregnancy and Booking Details		<i>Amended Table</i>
	<p>07 Did not attend one or more antenatal booking appointments</p> <p>08 Recently moved to area - no previous antenatal booking appointment</p> <p>98 Other (not listed)</p>	
<p>CARE PROFESSIONAL TYPE (PREGNANCY FIRST CONTACT)</p> <p><i>No Change to Data Item</i></p>	<p>The care professional with whom first contact was made for antenatal/pregnancy care.</p> <p>In the case of self-referrals (to Maternity Services), this data item will be null.</p>	
<p>LAST MENSTRUAL PERIOD DATE</p> <p><i>No Change to Data Item</i></p>	<p>This is the date of the first day of the last menstrual period (i.e., the date on which the last menstrual period began).</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p>	
<p>DISABILITY INDICATOR (AT ANTENATAL BOOKING)</p> <p><i>Amended data item previously - PHYSICAL DISABILITY STATUS INDICATOR (MOTHER AT BOOKING)</i></p>	<p>As identified at the Booking Appointment, an indication of whether a PERSON has been diagnosed as having a DISABILITY or perceives themselves to be disabled.</p> <p>This data item is set to [Y] Yes if the mother:</p> <ul style="list-style-type: none"> Has been diagnosed as having a disability Perceives herself to be disabled. <p>The Disability Discrimination Act 1995 has been replaced by the Equality Act 2010², (excluding Northern Ireland). The Disability Discrimination Act 1995 has been replaced by the Equality Act 2010³, (excluding Northern Ireland). The Equality Act 2010 defines 'disability' for the purposes of the Act:</p> <p><i>"If a person has a physical or mental impairment and the impairment has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities"</i></p> <p>This means that, in general:</p> <ul style="list-style-type: none"> the person must have an impairment that is either physical or mental (see paragraphs A3 to A8). the impairment must have adverse effects which are substantial (see Section B). the substantial adverse effects must be long-term (see Section C); and the long-term substantial adverse effects must be effects on normal day-to-day activities (see Section D). <p>This definition is subject to the provisions in Schedule 1 (Sch1)⁴.</p>	

² Equality Act 2010 [<http://www.legislation.gov.uk/ukpga/2010/15/contents>]

³ Equality Act 2010 [<http://www.legislation.gov.uk/ukpga/2010/15/contents>]

⁴ Definition of disability under the Equality Act 2010 [<https://www.gov.uk/definition-of-disability-under-equality-act-2010>]

MSD101 Pregnancy and Booking Details	
<i>Amended Table</i>	
	<p>Supplementary information related to specific elements of the definition are available in Schedule 1 of Equality Act 2010⁵.</p> <p>In addition, you could submit SNOMED CT codes in the diagnosis tables, e.g., MSD107 Medical History (Previous Diagnosis), to give further information about the diagnosed disability.</p> <p>The information recorded here should be a local clinical decision based on what disability the mother has been diagnosed with and the discussion with the mother at the booking appointment.</p> <p>Data providers could potentially default this to 'Y' if the mother has been diagnosed as disabled but retain the option for the local clinician to override this to 'N' if they think this is more appropriate based on the discussion with the mother.</p>
<p>LANGUAGE CODE (PREFERRED)</p> <p><i>New Data Item</i></p>	<p>This is the language the mother prefers to use for communication with a Health Care Provider.</p> <p>In order to populate this data item please select either: The two character code found in the ISO 639-1 Code column from the ISO 639.2 Codes for the Representation of Names of Languages (CRNL); code list; or one of the five communication method extensions detailed in NHS Data Model & Dictionary.</p> <p>Please note: the format for this data item is an2. Only the ISO 639-1 Code column should be referenced. Please do not attempt to submit codes that appear in the ISO 639-2 Code column by truncating to two characters. In some cases, a valid code would be derived, however the valid code may link to a language that is unconnected to the intended language for submission. On submission validations would not be able to detect this therefore any reporting would include incorrect calculations related to preferred language.</p>
<p>MENTAL HEALTH PREDICTION AND DETECTION INDICATOR (AT ANTENATAL BOOKING)</p> <p><i>Amended data item previously - MENTAL HEALTH PREDICTION AND DETECTION INDICATOR (MOTHER AT BOOKING)</i></p>	<p>As identified at the Booking Appointment, whether or not the recommended questions for prediction and detection of mental health issues were asked to identify mental health problems during the booking appointment. The purpose of this data item is not to capture mental health issues.</p> <p>NICE CG62 recommends that, at a mother's first contact with primary care, at her booking visit and postnatally (usually at 4 to 6 weeks and 3 to 4 months after the birth), healthcare professionals (including midwives 4 months after the birth), healthcare professionals (including midwives, obstetricians, health visitors and GPs) should ask two questions to identify possible depression (the Whooley questions):</p> <ol style="list-style-type: none"> 1. During the past month, have you often been bothered by feeling down, depressed, or hopeless? 2. During the past month, have you often been bothered by having little interest or pleasure in doing things? <p>A third question should be considered if the mother answers 'yes' to either of the initial questions.</p>

⁵ Equality Act 2010, Schedule 1, Disability: Supplementary Provision
[\[http://www.legislation.gov.uk/ukpga/2010/15/schedule/1/enacted\]](http://www.legislation.gov.uk/ukpga/2010/15/schedule/1/enacted)

MSD101 Pregnancy and Booking Details		<i>Amended Table</i>
	<p>3. Is this something you feel you need or want help with?</p> <p>Please note that SNOMED CT codes can also be used to denote that the Whooley questions have been asked, and the result of this.</p>	
<p>COMPLEX SOCIAL FACTORS INDICATOR (AT ANTENATAL BOOKING)</p> <p><i>Amended data item previously - COMPLEX SOCIAL FACTORS INDICATOR (MOTHER AT BOOKING) (OPTIONAL)</i></p>	<p>Indicates if the mother is deemed to be subject to complex social factors, as defined by NICE guidance (CG110⁶).</p> <p>Please note that SNOMED CT codes relating to the individual findings can also be submitted in the MSD202 Care Activity (Pregnancy) table.</p>	
<p>EMPLOYMENT STATUS (MOTHER AT ANTENATAL BOOKING)</p> <p><i>Amended data item previously - EMPLOYMENT STATUS (MOTHER AT BOOKING)</i></p>	<p>This captures whether or not the mother is in employment, as identified at the Booking Appointment.</p> <p>[01] Employed: Employed refers to mothers who are employed by a company and have their National Insurance paid for directly from their wages.</p> <p>It also includes mothers who are self-employed (i.e., those who work for themselves and generally pay their National Insurance themselves); mothers who are in supported employment; and mothers who are in permitted work (i.e., those who are in paid work and who are also receiving Incapacity Benefit). It should also include mothers who are unpaid family workers (i.e., those who do unpaid work for a business they own or work for a business a relative owns).</p> <p>[02] Unemployed and actively Seeking Work: Unemployed refers to mothers who are not in paid work but are actively seeking work and are available to start or are waiting to start a paid job they have already obtained.</p> <p>Other Employment Status codes (03, 04, 05, 06, 07, 08) represent mothers who are economically inactive, that is, those who are not in paid work and who are not actively seeking work, or they are not available to start.</p> <p>'ZZ – not stated' attribute should be used only in the event that the mother is asked but declines to provide a response.</p>	
<p>SUPPORT STATUS INDICATOR (AT ANTENATAL BOOKING)</p> <p><i>Amended data item previously - SUPPORT STATUS (MOTHER AT BOOKING)</i></p>	<p>As identified at the Booking Appointment. This item is set to 'Y - Yes' if the mother feels she is supported in pregnancy and when looking after a baby, from partner, family or friends. 'ZZ - not stated' should only be used in the event that the mother is asked but declines to provide a response.</p>	
<p>EMPLOYMENT STATUS (PARTNER)</p>	<p>Whether or not the partner of the mother (who may or may not be the father) is in employment, as identified at the Booking Appointment.</p>	

⁶ England. NICE (issued September 2010) *CG110 Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors* [<https://www.nice.org.uk/guidance/cg110>]

MSD101 Pregnancy and Booking Details		<i>Amended Table</i>
<p>AT ANTENATAL BOOKING)</p> <p><i>Amended data item previously - EMPLOYMENT STATUS (PARTNER AT BOOKING)</i></p>	<p>This data item should only be completed when the partner is known.</p> <p>[01] Employed: Employed refers to partners who are employed by a company and have their National Insurance paid for directly from their wages.</p> <p>It also includes partners who are self-employed (i.e., those who work for themselves and generally pay their National Insurance themselves); partners who are in supported employment; and partners who are in permitted work (i.e., those who are in paid work and who are also receiving Incapacity Benefit). It should also include partners who are unpaid family workers (i.e., those who do unpaid work for a business they own or work for a business a relative owns).</p> <p>[02] Unemployed and actively Seeking Work: Unemployed refers to partners who are not in paid work but are actively seeking work and are available to start or are waiting to start a paid job they have already obtained.</p> <p>Other Employment Status codes (03, 04, 05, 06, 07, 08) represent partners who are economically inactive, that is, those who are not in paid work and who are not actively seeking work, or they are not available to start.</p> <p>'UU - Unknown' should be used when a person asked but does not know or is unsure</p> <p>'ZZ - not stated' attribute should be used only in the event that the mother/partner is asked but declines to provide a response.</p>	
<p>PREGNANCY TOTAL PREVIOUS CAESAREAN SECTIONS</p> <p><i>Amended data item previously - PREGNANCY PREVIOUS CAESAREAN SECTIONS</i></p>	<p>The number of previous caesarean sections performed. This is not the same as number of babies previously delivered via caesarean.</p>	
<p>PREGNANCY TOTAL PREVIOUS LIVE BIRTHS</p> <p><i>No Change to Data Item</i></p>	<p>The number of previous registerable live births by the mother.</p>	
<p>PREGNANCY TOTAL PREVIOUS STILLBIRTHS</p> <p><i>No Change to Data Item</i></p>	<p>The number of registerable still births by the mother i.e., a birth after a gestation of 24 weeks (168 days), or more, where a baby shows no identifiable signs of life at delivery. Please note, up to and including 30/9/1992 the criteria was 28 weeks and not 24 weeks as above.</p>	

MSD101 Pregnancy and Booking Details		<i>Amended Table</i>
<p>PREGNANCY TOTAL PREVIOUS LOSSES LESS THAN 24 WEEKS</p> <p><i>No Change to Data Item</i></p>	<p>The recorded number of terminations and previous losses before 24 weeks of pregnancy (i.e., less than 23 weeks and 6 days) for a woman.</p>	
<p>FOLIC ACID SUPPLEMENT STATUS (AT ANTENATAL BOOKING)</p> <p><i>Amended data item previously - STATUS OF FOLIC ACID SUPPLEMENT (MOTHER AT BOOKING)</i></p>	<p>Whether a woman has been taking or intends to take folic acid supplements, as identified at First Contact or Booking Appointment.</p> <p>The value list includes:</p> <ul style="list-style-type: none"> 01 Has been taking prior to becoming pregnant 02 Started taking once pregnancy confirmed 03 Not taking folic acid supplement ZZ Not Stated (Person asked but declined to provide a response) 	
<p>DISCHARGE DATE (MOTHER MATERNITY SERVICES)</p> <p><i>New Data Item</i></p>	<p>Date on which mother ceased to be cared for in Maternity Services. This relates to the mother's final discharge from Maternity Services, for example following birth or a miscarriage. It does not relate to the mother's discharge from <u>hospital</u> following labour, which should be captured in the MSD301 Labour and Delivery table using the DISCHARGE DATE (MOTHER POST DELIVERYHOSPITAL PROVIDER SPELL) item.</p> <p>This item is associated with the PRIMARY DISCHARGE REASON (MOTHER MATERNITY SERVICES), below. Both items need to be submitted in the reporting month when the discharge occurred.</p> <p>These two items should also be submitted at any time when a Trust ceases to be responsible for the mother's maternity care for any of the reasons outlined below, e.g., in the case of a transfer to another health care provider.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p>	
<p>PRIMARY DISCHARGE REASON (MOTHER MATERNITY SERVICES)</p> <p><i>New Data Item</i></p>	<p>The primary reason that the mother was discharged from Maternity Services.</p> <p>This is the final discharge from Maternity Services (around 10 days after leaving hospital), as opposed to discharge from hospital following delivery.</p> <p>The permissible values are as follows:</p> <ul style="list-style-type: none"> 01 Discharge following delivery 02 Transfer to other Health Care Provider 03 Miscarriage 04 Termination of Pregnancy < 24weeks 	

MSD101 Pregnancy and Booking Details	
	<p>05 Termination of Pregnancy >= 24weeks</p> <p>06 No further contact from mother</p> <p>07 Maternal death</p> <p>Note: '06 – no further contact from mother' is to cover scenarios where a mother has no further contact with a maternity service. For example, this could occur where the mother moves address, but fails to notify the maternity provider where she made her initial booking. Ideally, in most scenarios, the maternity service should be able to make a follow up contact with the mother (e.g., by phone) to confirm for example that the mother has transferred to different maternity provider.</p>

6.7 MSD102 Maternity Care Plan

MSD102 Maternity Care Plan	
<i>Prev MAT301</i>	
Description	
<p>To carry details of Care Plans created during the current maternity episode.</p> <p>Multiple occurrences of this table are permitted. This data item indicates where a care plan is in place, including personalised care plans, in order to meet the requirements of the Better Births report.</p> <p>The data items in this table relate to antenatal, birth and postpartum care plans, and captures the initial plan and subsequent changes to each care plan.</p> <p>For the purpose of this data set, antenatal and postpartum care plans only capture the type of lead care professional, and changes in type of lead care professional. The birth plan captures additional information, specifically related to place of birth, and is usually completed before or at 36 weeks.</p> <p>The first antenatal plan should be produced at the booking appointment and reviewed at subsequent antenatal appointments. Any changes thereafter are largely dependent on the outcome of screening tests and antenatal complications.</p> <p>Changes to birth plans will be captured to the point of ONSET OF ESTABLISHED LABOUR DATE TIME. Any changes thereafter will be classed as transfers and indicated by differences in planned and actual place of delivery.</p>	
Additional Notes on Data Items	
Data Item Name	Additional Notes
<p>PREGNANCY IDENTIFIER</p> <p><i>New Data Item</i></p>	<p>This is the unique identifier allocated to each maternity episode.</p> <p>Use of the Pregnancy Identifier uniquely identifies each pregnancy allowing the details of different pregnancies to be reconciled.</p> <p>It would normally be automatically generated by the local system upon recording a new pregnancy (at booking appointment/ first contact), although could be manually assigned.</p> <p>This is a foreign key that enables this table to be joined to the Pregnancy and Booking Details table. As such this is a mandated item, and the record will be rejected if it is not included within this group.</p>

MSD102 Maternity Care Plan		<i>Prev MAT301</i>
<p>MATERNITY CARE PLAN DATE</p> <p><i>No Change to Data Item</i></p>	<p>The date on which a care plan was agreed with the mother. This covers antenatal, birth and postnatal care plans. If this date is not within the reporting period, the table will be rejected.</p>	
<p>MATERNITY CARE PLAN TYPE</p> <p><i>No Change to Data Item</i></p>	<p>The stage of maternity to which the care plan applies (antenatal, birth care, postpartum).</p>	
<p>MATERNITY PERSONALISED CARE PLAN INDICATOR</p> <p><i>New Data Item</i></p>	<p>An indication of whether the care plan is a personalised care plan, as defined by the Better Births recommendations.</p> <p>The Better Births report (page 8) states that:</p> <p>‘Every woman should develop a personalised care plan, with her midwife and other health professionals, which sets out her decisions about her care, reflects her wider health needs and is kept up to date as her pregnancy progresses.’</p> <p>The woman should have ownership and be actively involved in developing a Personalised Care and Support Plan (PCSP), that records her choices and provides a summary of choice conversations, which is reviewed in every contact.</p>	
<p>CONTINUITY OF CARER PATHWAY INDICATOR</p> <p><i>New Data Item</i></p>	<p>An indication of whether a mother has been booked onto a continuity of carer pathway, as defined by the Better Births recommendations – see Implementing Better Births: Continuity of Carer.</p>	
<p>CARE PROFESSIONAL LOCAL IDENTIFIER</p> <p><i>New Data Item</i></p>	<p>Care Professional Local Identifier is a unique local Care Professional Identifier within a Health Care Provider and may be assigned automatically by the computer system.</p> <p>This data item is intended to capture details of the named individual who will be responsible for the mother’s care during their pregnancy. This can then be compared to the details in the other relevant tables to establish whether the same care professional (or team, using the Care Professional Team Local Identifier in the same way) was involved in each aspect of the mother’s care.</p> <p>The Care Professional Local Identifier is captured in several tables (MSD102 Maternity Care Plan, MSD202 Care Activity (Pregnancy), MSD302 Care Activity (Labour and Delivery), MSD401 Baby's Demographics and Birth Details (N.B. named 'Care Professional Local Identifier (Delivering Baby)'), MSD405 Care Activity (Baby) and MSD504 Assigned Care Professional) to allow the recording and subsequent monitoring of continuity of carer information, where applicable.</p> <p>The identifier captured in this data item can be linked to the MSD901 Staff Details look up table to provide further details about the specific staff member.</p>	

MSD102 Maternity Care Plan		<i>Prev MAT301</i>
<p>CARE PROFESSIONAL TEAM LOCAL IDENTIFIER</p> <p>New Data Item</p>	<p>Care Professional Team Local Identifier is a unique Local Care Professional Team Identifier within a Health Care Provider and may be assigned automatically by the computer system.</p> <p>This data item is intended to capture details of the team who will be responsible for the mother's care during their pregnancy. This can then be compared to the details in the other relevant tables to find out whether the same care professional team (or named individual, using the Care Professional Local Identifier in the same way) was involved in each aspect of the mother's care.</p> <p>The Care Professional Team Local Identifier is captured in several tables (MSD102 Maternity Care Plan, MSD202 Care Activity (Pregnancy), MSD302 Care Activity (Labour and Delivery), MSD405 Care Activity (Baby) and MSD504 Assigned Care Professional) to allow the recording and subsequent monitoring of continuity of carer information, where applicable.</p> <p>For further guidance about the makeup of a local team, see the NHS England Implementing Better Births: Continuity of Carer guidance (specifically page 19).</p>	
<p>ORGANISATION SITE IDENTIFIER (OF PLANNED DELIVERY)</p> <p><i>Amended data item previously - SITE CODE (OF INTENDED PLACE OF DELIVERY)</i></p>	<p>The Organisation Site of the planned delivery of the baby as part of a Maternity Episode. This should be updated as recorded at the booking appointment, at the last antenatal appointment prior to labour start, and/or at the 36- or 38-week appointment.</p> <p>Home births</p> <p>In the case of a home birth, this data item will be not applicable and the code ZZ201 should be used in accordance with the <i>Maternity Data Set Technical Output Specification</i>.</p> <p>Site code link and format</p> <p>If provided, the SITE CODE should exist in national organisation tables.</p> <p><i>NHS Trust site codes consist of five characters and commence with the letter R (i.e., Rxxxx).</i></p> <p>Where the Maternity Data Providers system does not hold SITE CODE, locally held values should be mapped to the national code.</p>	
<p>MATERNITY CARE SETTING (OF PLANNED DELIVERY)</p> <p><i>Amended data item previously - DELIVERY PLACE TYPE (INTENDED MIDWIFERY UNIT TYPE)</i></p>	<p>This data item is designed to capture the intended place of birth, i.e., the planned delivery setting where the pregnant woman plans to have her baby as designated by the CARE PROFESSIONAL in consultation with the PATIENT. Where options are limited, the recorded location may not directly reflect a woman's wishes, but it is the planned place of birth in this situation.</p> <p>This should be updated as recorded at the booking appointment, at the last antenatal appointment prior to labour start, and/or at the 36- or 38-week appointment.</p> <p>In an obstetric unit (OU), care is provided by a team of midwives and doctors. Midwives provide care to all women in an obstetric unit, whether or not they are considered at high or low risk and take primary responsibility for women with straightforward pregnancies during labour and birth.</p>	

MSD102 Maternity Care Plan		Prev MAT301
	<p>Obstetricians have primary professional responsibility for women at high risk of complications during labour and birth and for women who develop complications during labour and birth. Obstetric units are always situated in hospitals where diagnostic and medical treatment services - including obstetric, neonatal, and anaesthetic care - are available on site. Obstetric units provide care to low and higher risk women. 'Higher risk' women– those who have health problems and/or less straightforward pregnancies - should normally be advised to give birth in an obstetric unit.</p> <p>In midwifery units, midwives take the primary professional responsibility for labour care. This is sometimes described as midwifery-led care. Midwifery units offer care to women with straightforward pregnancies.</p> <p>See also The Birthplace in England Research Programme.</p> <p>The value list includes:</p> <ul style="list-style-type: none"> 01 NHS Obstetric unit (including theatre) – see above 02 NHS Alongside midwifery unit (AMU) - situated in the same hospital or on the same site as an obstetric unit so have access to obstetric, neonatal, or anaesthetic care on site, although women may need to be physically transferred to the obstetric unit if they need obstetric care. 03 NHS Freestanding midwifery unit (FMU) - are not situated in a hospital or site with an obstetric unit or neonatal unit. This means that if the woman needs obstetric or anaesthetic care or the baby requires neonatal care they need to be transferred, typically by ambulance or car, to another hospital where these services are provided. 04 Home (NHS care) 05 Home (private care) 06 Private hospital 96 Undecided 97 Not discussed 98 Other (not listed) 99 Not known (not recorded) 	
<p>PLANNED DELIVERY SETTING CHANGE REASON (ANTENATAL)</p> <p><i>Amended data item previously – DELIVERY PLACE CHANGE REASON CODE</i></p>	<p>This captures the reason why the planned delivery setting has changed during the antenatal period, i.e., prior to the start of labour care.</p> <p>The value list includes:</p> <ul style="list-style-type: none"> 01 Change of address 02 Maternal preference 03 Clinical reason maternal 04 Clinical reason fetal 05 Unit closure 06 Service capacity 99 Not known (not recorded) 	

6.8 MSD103 Dating Scan Procedure

MSD103 Dating Scan Procedure		Prev MAT112
Description		
<p>To carry details of the first ultrasound (dating) scan the mother has during the current Maternity Episode. This is generally offered at the booking appointment and performed between 10 weeks + 0 days and 13 weeks + 6 days, although can be undertaken at any time during the pregnancy.</p> <p>(NB: This is not the 18-21 week 'mid-pregnancy' scan, or any additional scans carried out (e.g., additional scans for reassurance)).</p> <p>Multiple occurrences of this table are permitted.</p> <p>This table collects the information captured when a dating scan is performed.</p> <p>Whilst this scan is generally offered at the booking appointment and performed between 10 weeks + 0 days and 13 weeks + 6 days¹, it can be undertaken at any time during the pregnancy.</p> <p>The data set does not record the method by which gestational length was calculated. There are insufficient data items to assess the type of method.</p> <p>The matching values of procedure date/time across the two tables will indicate that a 'combined' dating-fetal anomaly scan was undertaken.</p> <p>The dating scan may be performed by the radiology department, Maternity Services or fetal medicine units. Therefore, the data relating to the scan may be captured from either radiology, maternity or fetal medicine systems.</p> <p>The Local Fetal Identifier and Fetal Order items are included to allow a Trust to return multiple records in the event that the dating scan identifies multiple fetuses and an anomaly is detected in one of them – the table can flow multiple times with a different Local Fetal Identifier and Fetal Order and a different Abnormality Detected Indicator</p>		
Additional Notes on Data Items		
Data Item Name	Additional Notes	
<p>PREGNANCY IDENTIFIER <i>New Data Item</i></p>	<p>This is the unique identifier allocated to each maternity episode.</p> <p>Use of the Pregnancy Identifier uniquely identifies each pregnancy allowing the details of different pregnancies to be reconciled.</p> <p>It would normally be automatically generated by the local system upon recording a new pregnancy (at booking appointment/ first contact), although could be manually assigned.</p> <p>This is a foreign key that enables this table to be joined to the Pregnancy and Booking Details table. As such this is a mandated item, and the record will be rejected if it is not included within this group.</p>	
<p>ACTIVITY OFFER DATE (DATING ULTRASOUND SCAN) <i>Amended data item previously - ACTIVITY OFFER DATE</i></p>	<p>The date that the dating scan activity was offered. If the ACTIVITY OFFER DATE (DATING ULTRASOUND SCAN) is after the PROCEDURE DATE (DATING ULTRASOUND SCAN) or before the APPOINTMENT DATE (FORMAL ANTENATAL BOOKING) in MSD101, then the table will be rejected.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p>	

MSD103 Dating Scan Procedure		<i>Prev MAT112</i>
<p>OFFER STATUS (DATING ULTRASOUND SCAN)</p> <p><i>No Change to Data Item</i></p>	<p>Whether or not the dating scan was offered, and the subsequent response to the offer.</p>	
<p>PROCEDURE DATE (DATING ULTRASOUND SCAN)</p> <p><i>No Change to Data Item</i></p>	<p>Date on which the ultrasound dating scan took place.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p>	
<p>GESTATION LENGTH (DATING ULTRASOUND SCAN)</p> <p><i>No Change to Data Item</i></p>	<p>The gestation length in days of the fetus(es) as measured by the dating ultrasound scan.</p>	
<p>NUMBER OF FETUSES (DATING ULTRASOUND SCAN)</p> <p><i>No Change to Data Item</i></p>	<p>The number of Fetuses counted during an Ultrasound Scan in Pregnancy within a particular Pregnancy Episode.</p>	
<p>LOCAL FETAL IDENTIFIER</p> <p><i>New Data Item</i></p>	<p>The unique identifier allocated to a fetus, which remains consistent throughout the pregnancy.</p> <p>It could be automatically generated by the local system at the point of the first ultrasound scan, where more than one fetus is identified.</p> <p>The code allows information from an early scan (where more than one fetus is present) to be associated with eventual birth outcomes.</p> <p>The Local Fetal Identifier is a 'required' data item and must be submitted by providers where used and recorded locally. The format is max an36.</p>	
<p>FETAL ORDER</p> <p><i>New Data Item</i></p>	<p>The order or sequence in which the Fetus was assessed. The Fetal Order is represented by a single numeric value, with 1 indicating the first or only Fetus assessed in the sequence, 2 indicating the second, and so on.</p> <p>This item is for use where a specific Local Fetal Identifier cannot be ascertained, as it is recognised that medically it isn't always possible to uniquely identify distinct fetuses (in a multi-fetus pregnancy) and could be particularly difficult as early as the 12-week scan (dating scan).</p>	

MSD103 Dating Scan Procedure		<i>Prev MAT112</i>
<p>ABNORMALITY DETECTED INDICATOR (DATING ULTRASOUND SCAN)</p> <p><i>Amended data item previously - ABNORMALITY DETECTED (DATING ULTRASOUND SCAN)</i></p>	<p>Whether any abnormality is detected at the dating scan</p> <p>If a Maternity Data Provider uses locally defined value codes, then these need to be mapped to the relevant national code in the data set.</p> <p>Multiple abnormalities</p> <p>This data item is only to be submitted once, even in the case of a fetus having multiple abnormalities or two or more fetuses (of a multi-fetus pregnancy) each having abnormalities.</p> <p>Combined dating-fetal anomaly scan</p> <p>Where dating scan assessments are undertaken for the first time in conjunction with a fetal anomaly scan, any observed abnormality will be captured using clinical terminology, e.g., in the MSD202 Care Activity table.</p> <p>NB. This data item is not related to Down's Syndrome Screening.</p>	
<p>ORGANISATION IDENTIFIER (OF DATING ULTRASOUND SCAN)</p> <p><i>New Data Item</i></p>	<p>The Organisation Identifier of the Organisation that performed the Dating Ultrasound Scan.</p>	

6.9 MSD104 Coded Scored Assessment (Pregnancy)

MSD104 Coded Scored Assessment (Pregnancy)		<i>New Table</i>
Description		
<p>To carry details of coded scored assessments that are issued and completed as part of a maternity episode outside of a contact. For example, this could include an assessment that is handed to a mother at an appointment or posted out, but then completed and returned by the mother by post. Scored assessments that are completed as part of a contact should be submitted in the MSD203 Coded Scored Assessment (Contact) table.</p> <p>The specific scored assessments and SNOMED CT codes that we expect providers to record in these tables are shown in the Technical Output Specification on the 'MSDS Assessment Scales' tab. The assessments are as follows:</p> <ul style="list-style-type: none"> Whooley questions Patient Health Questionnaire (PHQ-9) Generalised Anxiety Disorder Assessment (GAD-7) Edinburgh Postnatal Depression Scale (EPDS) London Measure of Unplanned Pregnancy (LMUP) <p>Only the scored assessments listed in the 'MSDS Assessment Scales' tab in the TOS should be submitted to MSDS v2.0. The majority of assessments in scope of MSDS are likely to be carried out at a face-to-face contact, so most will be submitted in the MSD203 Coded Scored Assessment (Contact) table.</p> <p>The MSD104 table can be left blank if there are no scored assessments that are carried out outside of a contact.</p> <p>One occurrence of this table is permitted for each coded scored observation question or dimension, as represented by a distinct SNOMED CT code.</p>		

MSD104 Coded Scored Assessment (Pregnancy)		<i>New Table</i>
<p>NHS Digital have investigated copyright permissions for the new content and they are now listed on NCCR tools and measures library website. The library includes instructions of how to request permission to use the content, as well as details of any translated versions that are available.</p> <p>Important Note: National Clinical Content Repository (Copyright Licensing Service)</p> <p>The National Clinical Content Repository (NCCR) is a service operated by the NHS Digital Copyright Licensing Service. Find out how to register and gain easy access to copyrighted clinical assessment tools and outcome measures.</p> <p>Some of the content that NHS Digital publish in our documents is protected by copyright law. This includes some of the clinical assessment tools and outcome measures used for collection in our national data sets.</p> <p>In order to use some of the scores, scales or assessments contained in NHS Digital's data sets, providers need to be sub-licensed by NHS Digital to have permission to use the content under UK law.</p> <p>Provider organisations should register with the NHS Digital Copyright Licensing Service and request the permission for the particular content from NHS Digital that they would like to use.</p> <p>Full instructions of how to register and request permissions can be found on the NCCR website. Any enquiries regarding copyright should be directed to clin.licences@nhs.net.</p>		
Additional Notes on Data Items		
Data Item Name	Additional Notes	
<p>PREGNANCY IDENTIFIER <i>New Data Item</i></p>	<p>This is the unique identifier allocated to each maternity episode.</p> <p>Use of the Pregnancy Identifier uniquely identifies each pregnancy allowing the details of different pregnancies to be reconciled.</p> <p>It would normally be automatically generated by the local system upon recording a new pregnancy (at booking appointment/ first contact), although could be manually assigned.</p> <p>This is a foreign key that enables this table to be joined to the Pregnancy and Booking Details table. As such this is a mandated item, and the record will be rejected if it is not included within this group.</p>	
<p>CODED ASSESSMENT TOOL TYPE (SNOMED CT) <i>New Data Item</i></p>	<p>The SNOMED CT concept ID which is used to identify an Assessment in SNOMED CT.</p> <p>Please note that validation will be applied to this data item using a list of approved, licensed SNOMED CT codes that are specified in the MSDS Assessment Scales tab in the Technical Output Specification. The submitted code must be one of the codes included in the list, otherwise the record will be rejected.</p>	
<p>PERSON SCORE <i>New Data Item</i></p>	<p>The observable value (score) resulting from an Assessment.</p>	
<p>ASSESSMENT TOOL COMPLETION DATE <i>New Data Item</i></p>	<p>The date on which an Assessment took place.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p>	

6.10 MSD105 Provisional Diagnosis (Pregnancy)

MSD105 Provisional Diagnosis (Pregnancy)		New Table								
Description										
<p>To carry details of a provisional diagnosis for a mother made by the maternity service, relating to a mother or unborn fetus, i.e., for a condition treated or investigated during the maternity episode.</p> <p>Provisional diagnosis could also be termed a 'working diagnosis'. The specific classification or clinical terminology submitted should be based on a trust's local decision and judgement about what's clinically relevant.</p> <p>Provisional diagnosis can be used by care professionals who might otherwise feel that they are not qualified, or it would be inappropriate for them, to record a definitive Primary Diagnosis; or where it is too early in the pregnancy to make a definitive diagnosis, but an indication of the likely diagnosis can be recorded.</p> <p>This table can also be used to capture provisional diagnoses relating to a fetus, for example as detected by a scan. In order to indicate this, the Local Fetal Identifier or Fetal Order item should be populated, along with a relevant SNOMED CT diagnosis code relating to the fetus.</p> <p>We're aware that a number of systems do not recognise the concept of 'provisional diagnosis' and in terms of MSD105 there are differing approaches to the recording of Provisional Diagnoses (e.g., as a 'working diagnosis'), which means in some cases there would not be any data to flow here.</p> <p>If no provisional or formal diagnosis is made, then trusts do not need to flow either table.</p>										
Additional Notes on Data Items										
Data Item Name	Additional Notes									
<p>PREGNANCY IDENTIFIER <i>New Data Item</i></p>	<p>This is the unique identifier allocated to each maternity episode.</p> <p>Use of the Pregnancy Identifier uniquely identifies each pregnancy allowing the details of different pregnancies to be reconciled.</p> <p>It would normally be automatically generated by the local system upon recording a new pregnancy (at booking appointment/ first contact), although could be manually assigned.</p> <p>This is a foreign key that enables this table to be joined to the Pregnancy and Booking Details table. As such this is a mandated item, and the record will be rejected if it is not included within this group.</p>									
<p>DIAGNOSIS SCHEME IN USE <i>New Data Item</i></p>	<p>The code scheme basis of a diagnosis.</p> <p>The value list includes:</p> <table border="0" style="width: 100%;"> <tr> <td style="padding-left: 20px;">02</td> <td>ICD-10</td> </tr> <tr> <td style="padding-left: 20px;">04</td> <td>Read Coded Clinical Terms Version 2</td> </tr> <tr> <td style="padding-left: 20px;">05</td> <td>Read Code Clinical Terms Version 3 (CTV3)</td> </tr> <tr> <td style="padding-left: 20px;">06</td> <td>SNOMED CT</td> </tr> </table>		02	ICD-10	04	Read Coded Clinical Terms Version 2	05	Read Code Clinical Terms Version 3 (CTV3)	06	SNOMED CT
02	ICD-10									
04	Read Coded Clinical Terms Version 2									
05	Read Code Clinical Terms Version 3 (CTV3)									
06	SNOMED CT									
<p>PROVISIONAL DIAGNOSIS (CODED CLINICAL ENTRY) <i>New Data Item</i></p>	<p>This is the Provisional Diagnosis of the person, from a specific classification or clinical terminology, for the main condition treated or investigated during the relevant episode of healthcare.</p>									

MSD105 Provisional Diagnosis (Pregnancy)		<i>New Table</i>
<p>PROVISIONAL DIAGNOSIS DATE</p> <p><i>New Data Item</i></p>	<p>The date of diagnosis.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p>	
<p>LOCAL FETAL IDENTIFIER</p> <p><i>New Data Item</i></p>	<p>The unique identifier allocated to a fetus, which remains consistent throughout the pregnancy.</p> <p>It could be automatically generated by the local system at the point of the first ultrasound scan, where more than one fetus is identified.</p> <p>The code allows information from an early scan (where more than one fetus is present) to be associated with eventual birth outcomes.</p> <p>This item (or the Fetal Order) should be populated where a provisional diagnosis relates to a fetus but can be left blank if the provisional diagnosis only relates to the mother.</p> <p>The Local Fetal Identifier is a 'required' data item and must be submitted by providers where used and recorded locally. The format is max an36.</p>	
<p>FETAL ORDER</p> <p><i>New Data Item</i></p>	<p>The order or sequence in which the Fetus was assessed. The Fetal Order is represented by a single numeric value, with 1 indicating the first or only Fetus assessed in the sequence, 2 indicating the second, and so on.</p> <p>This item is for use where a specific Local Fetal Identifier cannot be ascertained, as it is recognised that medically it isn't always possible to uniquely identify distinct fetuses (in a multi-fetus pregnancy) and could be particularly difficult earlier in the pregnancy.</p> <p>This item (or the Local Fetal Identifier) should be populated where a provisional diagnosis relates to a fetus but can be left blank if the provisional diagnosis only relates to the mother.</p>	

6.11 MSD106 Diagnosis (Pregnancy)

MSD106 Diagnosis (Pregnancy)		New Table
Description		
<p>To carry the details of diagnoses recorded for the person made by the service that the person was referred or admitted to. This can change during a reporting period.</p> <p>This table is designed to record details of any diagnoses carried out by the maternity service, i.e., for a condition treated or investigated during the maternity episode. Further guidance about relevant diagnoses or conditions (and potentially subsets of SNOMED CT codes) will be released as part of the maternity record standard: https://theprsb.org/standards/maternityrecord/</p> <p>This table can also be used to capture diagnoses relating to a fetus, for example as detected by a scan. In order to indicate this, the Local Fetal Identifier or Fetal Order item should be populated, along with a relevant SNOMED CT diagnosis code relating to the fetus.</p> <p>One occurrence of this Group is permitted for primary diagnosis.</p> <p>Providers may want to refer to the MSDS v2.0-v1.5 SNOMED CT mapping guidance for examples of the national code lists used previously in MSDS v1.5 for consideration in mapping to SNOMED CT codes for submission in the MSD106 Diagnosis (Coded Clinical Entry) data item, (see tabs MAT101-MAT112 & MAT303-MAT310).</p> <p>If trusts use other forms of clinical classification and terminology locally for diagnosis (most likely ICD-10 codes) then alternatively these can be submitted.</p> <p>N.B: Routine assessments, such as testing blood pressure or assessment of the growth of the unborn fetus, flow in MSD201 and MSD202 tables with interventions / care activities during labour recorded in the MSD302 table.</p>		
Table Level Validation and Repeating Rules		
<p>These rules are fully described in the appropriate section for this table within the document <i>MSDS v2.0 Technical Output Specification</i>.</p>		
Additional Notes on Data Items		
Data Item Name	Additional Notes	
<p>PREGNANCY IDENTIFIER <i>New Data Item</i></p>	<p>This is the unique identifier allocated to each maternity episode.</p> <p>Use of the Pregnancy Identifier uniquely identifies each pregnancy allowing the details of different pregnancies to be reconciled.</p> <p>It would normally be automatically generated by the local system upon recording a new pregnancy (at booking appointment/ first contact), although could be manually assigned.</p> <p>This is a foreign key that enables this table to be joined to the Pregnancy and Booking Details table. As such this is a mandated item, and the record will be rejected if it is not included within this group.</p>	
<p>DIAGNOSIS SCHEME IN USE <i>New Data Item</i></p>	<p>The code scheme basis of a diagnosis.</p> <p>The value list available:</p> <ul style="list-style-type: none"> 02 ICD-10 04 Read Coded Clinical Terms Version 2 05 Read Code Clinical Terms Version 3 (CTV3) 06 SNOMED CT 	

MSD106 Diagnosis (Pregnancy)		<i>New Table</i>
<p>DIAGNOSIS (CODED CLINICAL ENTRY)</p> <p><i>New Data Item</i></p>	<p>This is the Diagnosis of the person, from a specific classification or clinical terminology, for a condition treated or investigated during the maternity episode.</p>	
<p>MATERNITY COMPLICATING DIAGNOSIS INDICATOR</p> <p><i>New Data Item</i></p>	<p>To indicate where a diagnosis may lead to complications during the pregnancy pathway as determined by a clinician.</p>	
<p>DIAGNOSIS DATE</p> <p><i>New Data Item</i></p>	<p>The date of the Primary Diagnosis.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p>	
<p>LOCAL FETAL IDENTIFIER</p> <p><i>New Data Item</i></p>	<p>The unique identifier allocated to a fetus, which remains consistent throughout the pregnancy.</p> <p>It could be automatically generated by the local system at the point of the first ultrasound scan, where more than one fetus is identified.</p> <p>The code allows information from an early scan (where more than one fetus is present) to be associated with eventual birth outcomes.</p> <p>This item (or the Fetal Order) should be populated where a diagnosis relates to a fetus but can be left blank if the diagnosis only relates to the mother.</p> <p>The Local Fetal Identifier is a 'required' data item and must be submitted by providers where, used and recorded locally. The format is max an36.</p>	
<p>FETAL ORDER</p> <p><i>New Data Item</i></p>	<p>The order or sequence in which the Fetus was assessed. The Fetal Order is represented by a single numeric value, with 1 indicating the first or only Fetus assessed in the sequence, 2 indicating the second, and so on.</p> <p>This item is for use where a specific Local Fetal Identifier cannot be ascertained, as it is recognised that medically it isn't always possible to uniquely identify distinct fetuses (in a multi-fetus pregnancy) and could be particularly difficult earlier in the pregnancy.</p> <p>This item (or the Local Fetal Identifier) should be populated where a diagnosis relates to a fetus but can be left blank if the diagnosis only relates to the mother.</p>	

6.12 MSD107 Medical History (Previous Diagnosis)

MSD107 Medical History (Previous Diagnosis)		New Table
Description		
<p>This table collects information on obstetric conditions diagnosed in previous pregnancies, as captured, or made available during this pregnancy (e.g., at the booking appointment), or other relevant pre-existing diagnoses not made by the maternity service (e.g., the pregnant woman has pre-existing diabetes) which the maternity service would need to be aware of.</p> <p>The recording of previous diagnoses may rely on a discussion with the mother, in particular mothers who have pregnancy history with a different maternity provider from a previous pregnancy.</p> <p>In this scenario data providers may not be aware of those previous diagnoses from the mother's record alone, so have to rely on discussion with the mother (most likely at the booking appointment). However, diagnoses made or identified at other times outside of the maternity service can also be included in this table.</p> <p>The diagnoses do not need to be linked to specific pregnancies nor do they need to be repeated if the same diagnosis has occurred in several pregnancies.</p> <p>This table should include SNOMED CT codes and/or codes relating to other terminologies or classifications; it is acceptable to submit more than one type in separate instances of the MSD107 table, as long as data providers identify which type of code, they are submitting by populating the 'Diagnosis Scheme in Use' data item.</p>		
Additional Notes on Data Items		
Data Item Name	Additional Notes	
PREGNANCY IDENTIFIER <i>New Data Item</i>	<p>This is the unique identifier allocated to each maternity episode.</p> <p>Use of the Pregnancy Identifier uniquely identifies each pregnancy allowing the details of different pregnancies to be reconciled.</p> <p>It would normally be automatically generated by the local system upon recording a new pregnancy (at booking appointment/ first contact), although could be manually assigned.</p> <p>This is a foreign key that enables this table to be joined to the Pregnancy and Booking Details table. As such this is a mandated item, and the record will be rejected if it is not included within this group.</p>	
DIAGNOSIS SCHEME IN USE <i>New Data Item</i>	<p>The code scheme basis of the Diagnosis.</p> <p>The value list includes:</p> <ul style="list-style-type: none"> 02 ICD-10 04 Read Coded Clinical Terms Version 2 05 Read Code Clinical Terms Version 3 (CTV3) 06 SNOMED CT 	
PREVIOUS DIAGNOSIS (CODED CLINICAL ENTRY) <i>New Data Item</i>	<p>A unique identifier for a Clinical Diagnosis from a specific classification or clinical terminology, for a previous obstetric condition.</p>	

MSD107 Medical History (Previous Diagnosis) New Table	
DIAGNOSIS DATE <i>New Data Item</i>	Diagnosis Date is the Person Property Observed Date for the Patient Diagnosis . This should be recorded in the eGIF Date format CCYY-MM-DD

6.13 MSD108 Family History at Booking

MSD108 Family History at Booking New Table	
Description	
<p>This table collects information on the baby's maternal and paternal medical family history (but only where the relative is a blood relative), as captured or made available at the booking appointment.</p> <p>The diagnoses do not need to be linked to specific relatives nor do they need to be repeated if the same diagnosis has occurred in several relatives. Blood relatives included:</p> <ul style="list-style-type: none"> • Mother • Father • Sister • Brother • Half Sister • Half Brother • Paternal Grandparent • Maternal Grandparent • Paternal Great-Grandparent • Maternal Great-Grandparent • Aunt • Uncle • First Cousin • Nephew/Niece 	
Additional Notes on Data Items	
Data Item Name	Additional Notes
PREGNANCY IDENTIFIER <i>New Data Item</i>	<p>This is the unique identifier allocated to each maternity episode.</p> <p>Use of the Pregnancy Identifier uniquely identifies each pregnancy allowing the details of different pregnancies to be reconciled.</p> <p>It would normally be automatically generated by the local system upon recording a new pregnancy (at booking appointment/ first contact), although could be manually assigned.</p> <p>This is a foreign key that enables this table to be joined to the Pregnancy and Booking Details table. As such this is a mandated item, and the record will be rejected if it is not included within this group.</p>
SITUATION SCHEME IN USE <i>New Data Item</i>	The code scheme basis of a Situation .

MSD108 Family History at Booking New Table	
CODED SITUATION (CLINICAL TERMINOLOGY) <i>New Data Item</i>	This is the Situation of the person, from a specific classification or clinical terminology, for a relevant medical condition from a blood relative of the baby's mother or father that may affect the pregnancy. This item should include any such conditions that are recorded by the maternity service.
	<p>This could include, but is not limited to, the following conditions:</p> <ul style="list-style-type: none"> • Congenital disorders • Diabetes • Inherited disorders • Haematological disorders • Hypertensive disorders • Mental health disorders • Multi-fetal pregnancy • Pregnancy Induced Hypertension • Thrombosis • Tuberculosis (TB)

6.14 MSD109 Finding and Observation (Mother)

MSD109 Finding and Observation (Mother) New Table	
Description	
<p>To carry details of findings and observations of a mother which have taken place during a maternity episode. The intention is that this table will capture the details of findings and observations not apparent at a face-to-face contact, i.e., those tests where the result (finding) may only be available after the contact, (i.e., activity that occurs outside of a care contact). For example, if results of a blood test are received back, but there is no associated care contact to link this to (for example the mother is sent the results by post, or they are not shared with the mother at all), this result can flow in the MSD109 table.</p> <p>Multiple occurrences of this table are permitted when findings and observations are recorded.</p>	
Additional Notes on Data Items	
Data Item Name	Additional Notes
PREGNANCY IDENTIFIER <i>New Data Item</i>	<p>This is the unique identifier allocated to each maternity episode.</p> <p>Use of the Pregnancy Identifier uniquely identifies each pregnancy allowing the details of different pregnancies to be reconciled.</p> <p>It would normally be automatically generated by the local system upon recording a new pregnancy (at booking appointment/ first contact), although could be manually assigned.</p> <p>This is a foreign key that enables this table to be joined to the Pregnancy and Booking Details table. As such this is a mandated item, and the record will be rejected if it is not included within this group.</p>

MSD109 Finding and Observation (Mother)		<i>New Table</i>
LOCAL FETAL IDENTIFIER <i>New Data Item</i>	<p>The unique identifier allocated to a fetus, which remains consistent throughout the pregnancy. This should be recorded in the event that a specific finding affects a fetus.</p> <p>It could be automatically generated by the local system at the point of the first ultrasound scan, where more than one fetus is identified.</p>	
	<p>The code allows information from an early scan (where more than one fetus is present) to be associated with eventual birth outcomes.</p> <p>The Local Fetal Identifier is a 'required' data item and must be submitted by providers where used and recorded locally. The format is max an36.</p>	
FETAL ORDER <i>New Data Item</i>	<p>The order or sequence in which the Fetus was assessed, in the event that a specific finding affects a fetus. The Fetal Order is represented by a single numeric value, with 1 indicating the first or only Fetus assessed in the sequence, 2 indicating the second, and so on. This should be recorded in the event that a specific finding affects a fetus.</p> <p>This item is for use where a specific Local Fetal Identifier cannot be ascertained, as it is recognised that medically it isn't always possible to uniquely identify distinct fetuses (in a multi-fetus pregnancy).</p>	
FINDING DATE <i>New Data Item</i>	<p>The date that the finding was recorded.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p>	
FINDING SCHEME IN USE <i>New Data Item</i>	<p>The code scheme basis of a finding.</p>	
CODED FINDING (CODED CLINICAL ENTRY) <i>New Data Item</i>	<p>A unique identifier for a finding from a specific classification or clinical terminology.</p>	
OBSERVATION DATE <i>New Data Item</i>	<p>The date that an observation was made.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p>	
OBSERVATION SCHEME IN USE <i>New Data Item</i>	<p>The code scheme basis of an Observation.</p> <p>The value list includes:</p> <ul style="list-style-type: none"> 01 Read Coded Clinical Terms Version 2 02 Read Coded Clinical Terms Version 3 (CTV3) 03 SNOMED CT 	
CODED OBSERVATION (CLINICAL TERMINOLOGY) <i>New Data Item</i>	<p>A unique identifier for an observation from a specific clinical terminology.</p>	

MSD109 Finding and Observation (Mother) New Table	
OBSERVATION VALUE <i>New Data Item</i>	The numeric value resulting from a clinical observation . If OBSERVATION VALUE is populated and the UCUM UNIT OF MEASUREMENT is blank, a warning will be reported.
UCUM UNIT OF MEASUREMENT <i>New Data Item</i>	The unit of measurement used to measure the result of a clinical observation . See http://unitsofmeasure.org/trac .

6.15 MSD201 Care Contact (Pregnancy)

MSD201 Care Contact (Pregnancy) New Table	
Description	
<p>To carry details of any contacts with a mother which have taken place as part of a maternity episode, up until their discharge from maternity services (so both antenatal and postnatal appointments are within scope). This would include the various appointments carried out throughout a pregnancy, including further details of the booking appointment that have not already been captured in the MSD101 Pregnancy and Booking Details table to allow specific activities that happen at the booking appointment to be submitted (i.e., in the linked MSD202 Care Activity (Pregnancy) table). For example, details of the mother's antenatal appointments could be submitted in this table. This includes the regular scheduled appointments as set out in NICE Guidance CG62, Appendix D.</p> <p>A care contact can involve seeing multiple care professionals as part of the same appointment.</p> <p>This table should include contacts connected to the pregnancy and carried out by the maternity service only, not general outpatient, inpatient and accident and emergency attendances whilst a mother is pregnant.</p> <p>However, this table can include individual contacts that took place during a mother's inpatient stay where these were carried out by the maternity service. This will allow the recording of associated activity that was carried out in the MSD202 Care Activity (Pregnancy) table, providing that the mother has been in contact with the maternity service.</p> <p>If the mother had a hospital provider spell where she did not have any contact with the maternity service at all, then this would not need submitting to either the MSD501 Hospital Provider Spell or MSD201 Care Contact (Pregnancy) / MSD202 Care Activity (Pregnancy) tables.</p> <p>Labour & Delivery hospital admission is covered by MSD301 Labour and Delivery table, with activity associated with the labour and delivery being submitted in MSD302 Care Activity (Labour and Delivery) table.</p> <p>Multiple occurrences of this table are permitted for each pregnancy identifier.</p>	

MSD201 Care Contact (Pregnancy)	
Additional Notes on Data Items	
Data Item Name	Additional Notes
<p>CARE CONTACT IDENTIFIER <i>New Data Item</i></p>	<p>The Care Contact Identifier is used to uniquely identify the Care Contact within the Health Care Provider.</p> <p>It would normally be automatically generated by the local system upon recording a new Care Contact, although could be manually assigned.</p> <p>This is the primary key that enables groups of data to be joined together. As such this is a mandated item, and the record will be rejected if it is not included within this group.</p> <p>Where multiple systems are used it is acceptable to include a prefix to the Care Contact Identifier, which relates to the system. The prefix enables each identifier to remain truly unique for all submissions from an organisation where different systems may generate the same Care Contact Identifier for different contacts.</p> <p>The Care Contact Identifier is truly a unique data item, both within the same submission file and across multiple submission files. The Care Contact Identifier is a primary key for its respective table and is based upon the Activity Identifier data attribute which is defined as “A unique number or set of characters that is applicable to only one Activity for a Patient within an Organisation”. This reiterates that these identifiers should be unique across submissions.</p>
<p>PREGNANCY IDENTIFIER <i>New Data Item</i></p>	<p>This is the unique identifier allocated to each maternity episode.</p> <p>Use of the Pregnancy Identifier uniquely identifies each pregnancy allowing the details of different pregnancies to be reconciled.</p> <p>It would normally be automatically generated by the local system upon recording a new pregnancy (at booking appointment/ first contact), although could be manually assigned.</p> <p>This is a foreign key that enables this table to be joined to the Pregnancy and Booking Details table. As such this is a mandated item, and the record will be rejected if it is not included within this group.</p>
<p>CARE CONTACT DATE <i>New Data Item</i></p>	<p>The date on which a Care Contact took place, or, if cancelled, was scheduled to take place.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p>
<p>CARE CONTACT TIME <i>New Data Item</i></p>	<p>The time at which a Care Contact took place.</p> <p>The time should be recorded using the 24-hour clock format in eGIF format i.e., HH:MM:SS.</p>
<p>ORGANISATION IDENTIFIER (CODE OF COMMISSIONER) <i>New Data Item</i></p>	<p>This is the Organisation Identifier of the Organisation that is commissioning health care provided as part of this care contact.</p>

MSD201 Care Contact (Pregnancy)		<i>New Table</i>
<p>ADMINISTRATIVE CATEGORY CODE</p> <p><i>New Data Item</i></p>	<p>The Administrative Category Code refers to a patient's status regarding payment for NHS services.</p> <p>This is recorded for Patient Activity. It is primarily for local use and identifies whether a contact is with an NHS patient or a non-NHS funded patient.</p> <p>A Patient, who is an Overseas Visitor, does not qualify for free NHS healthcare and can choose to pay for NHS treatment or for private treatment. If they pay for NHS treatment, then they should be recorded as NHS Patients.</p> <p>Activity for non-NHS funded patients is not for inclusion in the MSDS and should not be submitted.</p>	
<p>CLINICAL CONTACT DURATION OF CARE CONTACT</p> <p><i>New Data Item</i></p>	<p>The total duration of the direct clinical contact at care contact in minutes, excluding any administration time prior to or after the care contact and the care professional's travelling time to the care contact.</p> <p>Clinical Contact Duration of Care Contact includes the time spent on the different care activities that may be performed in a single care contact. The duration of each care activity is recorded in clinical contact duration of care activity.</p>	
<p>CONSULTATION TYPE</p> <p><i>New Data Item</i></p>	<p>This indicates the type of consultation for a service.</p> <p>The value list includes:</p> <ul style="list-style-type: none"> 01 Initial Consultation 02 Follow-up Consultation 	
<p>CARE CONTACT SUBJECT</p> <p><i>New Data Item</i></p>	<p>The person who was the subject of the Care Contact.</p> <p>The value list includes:</p> <ul style="list-style-type: none"> 01 Patient 02 Patient proxy (in lieu of a contact with the patient) 	
<p>CONSULTATION MEDIUM USED</p> <p><i>New Data Item</i></p>	<p>Identifies the communication mechanism used to relay information between the Care Professional and the person who is the subject of the consultation, during a care activity.</p> <p>The telephone or telemedicine consultation should directly support diagnosis and care planning and must replace a face to face out-patient attendance consultant, clinic attendance nurse or clinic attendance midwife, types of care activity. A record of the telephone or telemedicine consultation must be retained in the patient's records.</p> <p>Telephone contacts solely for informing patients of results are excluded.</p>	
<p>ACTIVITY LOCATION TYPE CODE</p> <p><i>New Data Item</i></p>	<p>The type of physical location where patients are seen or where services are provided or from which requests for services are sent.</p> <p>For a non-face-to-face contact (e.g., by telephone), this item should be left blank. If your system prevents this, the location of the clinician can be used instead.</p>	

MSD201 Care Contact (Pregnancy)		<i>New Table</i>
<p>ORGANISATION SITE IDENTIFIER (OF TREATMENT)</p> <p><i>New Data Item</i></p>	<p>Organisation Site Identifier (Of Treatment) is the Organisation Identifier of the Organisation Site where the mother was treated.</p> <p>This identifies the site within the organisation at which the mother was treated, since facilities may vary on different hospital sites. The code recorded should always be the national code; if the treatment is sub-commissioned to another provider, the site code used should be that of the provider actually carrying out the work.</p> <p>If the site code is not available and only the organisation code is available, then this field should contain the organisation code suffixed with '00' as the site code. If a patient is treated at home, the site code (of treatment) field should be left as null.</p>	
<p>GROUP THERAPY INDICATOR</p> <p><i>New Data Item</i></p>	<p>An indicator of whether a Care Activity was delivered as Group Therapy.</p> <p>Group Therapy is a Session where more than one Patient attends at the same time, to see one or more Care Professionals. Clinical notes are recorded in each individual Patient's case notes.</p> <p>The value list includes:</p> <ul style="list-style-type: none"> Y Yes - CARE ACTIVITY was delivered as Group Therapy N No - CARE ACTIVITY was delivered individually Z Not Known if the ACTIVITY was Group Therapy 	
<p>ATTENDED OR DID NOT ATTEND CODE</p> <p><i>New Data Item</i></p>	<p>Indicates whether an appointment for a care contact took place and if the appointment did not take place, it also indicates if advance warning was given.</p> <p>The value list includes:</p> <ul style="list-style-type: none"> 5 Attended on time or, if late, before the relevant Care Professional was ready to see the PATIENT 6 Arrived late, after the relevant CARE PROFESSIONAL was ready to see the PATIENT, but was seen 7 PATIENT arrived late and could not be seen 2 APPOINTMENT cancelled by, or on behalf of, the PATIENT: An appointment is classified as being 'cancelled by, on or behalf of the patient' where it is cancelled at any point in time prior to the start of the appointment. 3 Did not attend - no advance warning given: An appointment is classified as being a DNA if the patient does not attend for the entire duration of the appointment slot, or they do attend but there is insufficient time remaining to conduct the planned activity and therefore the appointment is not usable. <p>In the case of telephone contacts, duration should be recorded as 0 and marked as DNA only if the contact was a planned telephone contact and the patient did not answer the phone.</p> <ul style="list-style-type: none"> 4 APPOINTMENT cancelled or postponed by the Health Care Provider: An appointment is classified as being 'cancelled or postponed by the Healthcare Provider' where it is cancelled at any point in time prior to the start of the appointment. 	

MSD201 Care Contact (Pregnancy)	
	<p>When an appointment is cancelled (by, or on behalf of the patient, or by the Healthcare Provider) the appointment cancelled date should also be recorded. This will identify instances where the appointment was cancelled on the day it was intended to take place.</p> <p>When an appointment is re-arranged this is effectively classed as a cancelled appointment. When it is re-arranged the original appointment is cancelled and a new one is created. Dependant on who cancelled (re-arranged) the appointment, the national code [2] or [4] should be used.</p>
<p>CARE CONTACT CANCELLATION DATE</p> <p><i>New Data Item</i></p>	<p>The date that a Care Contact was cancelled by the Provider or Patient.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p> <p>If CARE CONTACT CANCELLATION DATE is populated and CARE CONTACT CANCELLATION REASON is blank, a warning will be reported.</p>
<p>CARE CONTACT CANCELLATION REASON</p> <p><i>New Data Item</i></p>	<p>The reason that a Care Contact was cancelled.</p> <p>Care contact cancellations do not need to be submitted to MSDS v2.0 unless they occur after the Appointment Date (Formal Antenatal Booking) has actually taken place.</p>
<p>REPLACEMENT APPOINTMENT DATE OFFERED</p> <p><i>New Data Item</i></p>	<p>The Replacement Appointment Date Offered by the provider to the patient following the cancellation of an appointment by the service.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p>
<p>REPLACEMENT APPOINTMENT BOOKED DATE</p> <p><i>New Data Item</i></p>	<p>The date that a replacement appointment was booked following the cancellation of an appointment with the patient by the service.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p>

6.16 MSD202 Care Activity (Pregnancy)

MSD202 Care Activity (Pregnancy)
<p>Description</p> <p>To carry details of any activities which have taken place as part of a contact with a mother during a maternity episode.</p> <p>For example, this could include immunisation and screening information for the mother where carried out by the maternity service, such as:</p> <ul style="list-style-type: none"> • Pertussis vaccination • Flu vaccination • Hepatitis B screening (to record whether screening was offered/done and outcome)

MSD202 Care Activity (Pregnancy)*New Table*

- Measles, Mumps and Rubella check
- Metabolic blood spot screening information
- Downs Syndrome screening details

A care activity is a clinical activity carried out at a care contact. This could include a test or measurement (e.g., blood pressure check), scan or other activity (e.g., giving healthy eating advice). We expect care providers and system suppliers to capture and submit each distinct clinical activity (e.g., procedure, observation, finding) that happens at a specific appointment (i.e., care contact) as a separate care activity linked to that care contact. The care activities should be identified based on the activities carried out, not the care professional that undertook them – a single care professional could carry out multiple care activities, and indeed more than one care professional could be involved in a single activity.

There may be instances where an individual test requires multiple care activities to be submitted in order to capture the procedure undertaken, the observation recorded (with associated value and unit of measurement, where applicable) and an associated finding. An example is shown in appendix 3 for a carbon monoxide test, which has a distinct procedure (describing the test being carried out), observation (the numeric score of the test) and finding (the mother is a smoker). Each is given a distinct Care Activity Identifier.

Procedures relating to scans carried out, and the findings of these scans (e.g., twins) can also be submitted in this table. The country of birth of the mother can also be captured as a SNOMED CT finding, where recorded locally.

Maternal BMI can also be submitted in this table using SNOMED CT procedure, observation and finding codes. The procedure code will indicate the procedure being carried out (e.g., measuring of height and/or weight), the observation code and associated observable value and unit will indicate the measurement value, and the finding code will indicate a related finding.

Vitamin D supplementation status at booking should also be submitted in this table in the form of clinical terminology, where this is captured locally.

One occurrence of this Group is permitted for each Care Activity.

This table should contain a record for each separate element of assessment, treatment or review that was undertaken within a Care Contact. However, there is no necessity to duplicate closely linked care activity. For example: if several Coded Scored Assessment (Contact) records are submitted, they can be linked to one appropriate care activity (as a result of local decision).

This table should reflect Care Activity from a patient perspective. For example, where multiple Care Professionals are involved in a single Care Activity, a single record should flow for the 'lead' or responsible Care Professional, rather than creating multiple records linked to each involved Care Professional.

Where the ATTENDED OR DID NOT ATTEND CODE submitted in the Care Contact table is **[7] Patient arrived late and could not be seen; [2] Appointment cancelled by, or on behalf of the patient; [3] Did not attend, no advance warning given; or [4] Appointment cancelled or postponed by the Healthcare Provider** a Care Activity record should not be submitted.

NHS Digital will not be restricting the input of Coded Procedures/Findings/Observations through validation. Providers can opt to flow any activities and related information that are naturally recorded against the Care Contact. However, NHS Digital suggest adherence to the maternity record standard and any code subsets created for use in the record.

Further information about the structure of care activity tables can be found in Appendix 2.

MSD202 Care Activity (Pregnancy)		New Table
Additional Notes on Data Items		
Data Item Name	Additional Notes	
<p>CARE ACTIVITY IDENTIFIER (MOTHER)</p> <p><i>New Data Item</i></p>	<p>The unique identifier for a care activity for the mother.</p> <p>It would normally be automatically generated by the local system upon recording a new activity, although could be manually assigned.</p> <p>Where multiple systems are used it is acceptable to include a prefix to the Care Activity Identifier, which relates to the system. The prefix enables each identifier to remain truly unique for all submissions from an organisation where different systems may generate the same Care Activity Identifier for different contacts.</p> <p>The Care Activity Identifier is truly a unique data item, both within the same submission file and across multiple submission files. The Care Activity Identifier (Mother) is a primary key for the MSD202 table and is based upon the Contact Identifier data attribute which is defined as “A unique number or set of characters that is applicable to only one Contact for a PATIENT within an Organisation”. This reiterates that these identifiers should be unique across submissions.</p>	
<p>CARE CONTACT IDENTIFIER</p> <p><i>New Data Item</i></p>	<p>The Care Contact Identifier is used to uniquely identify the Care Contact within the Health Care Provider.</p> <p>It would normally be automatically generated by the local system upon recording a new Care Contact, although could be manually assigned.</p> <p>This is the primary key that enables groups of data to be joined together. As such this is a mandated item, and the record will be rejected if it is not included within this group.</p> <p>Where multiple systems are used it is acceptable to include a prefix to the Care Contact Identifier, which relates to the system. The prefix enables each identifier to remain truly unique for all submissions from an organisation where different systems may generate the same Care Contact Identifier for different contacts.</p> <p>The Care Contact Identifier is truly a unique data item, both within the same submission file and across multiple submission files. The Care Contact Identifier is a primary key for its respective table and is based upon the Activity Identifier data attribute which is defined as “A unique number or set of characters that is applicable to only one Activity for a Patient within an Organisation”. This reiterates that these identifiers should be unique across submissions.</p>	
<p>CARE PROFESSIONAL LOCAL IDENTIFIER</p> <p><i>New Data Item</i></p>	<p>Care Professional Local Identifier is a unique local Care Professional Identifier within a Health Care Provider and may be assigned automatically by the computer system.</p> <p>Where multiple Care Professionals are involved in a single Care Activity, a ‘lead’ Care Professional should be allocated to the Care Activity. There is no requirement to duplicate records for a single Care Activity for each involved Care Professional.</p> <p>This data item is intended to capture details of the individual who delivered the care activity to the mother.</p>	

MSD202 Care Activity (Pregnancy)	
<i>New Table</i>	
	<p>The Care Professional Local Identifier is captured in several tables (MSD102 Maternity Care Plan, MSD202 Care Activity (Pregnancy), MSD302 Care Activity (Labour and Delivery), MSD401 Baby's Demographics and Birth Details (N.B. named 'Care Professional Local Identifier (Delivering Baby)'), MSD405 Care Activity (Baby) and MSD504 Assigned Care Professional) to allow the recording and subsequent monitoring of continuity of carer information, where applicable.</p> <p>The identifier captured in this data item can be linked to the MSD901 Staff Details look up table.</p>
<p>CARE PROFESSIONAL TEAM LOCAL IDENTIFIER</p> <p><i>New Data Item</i></p>	<p>Care Professional Team Local Identifier is a unique Local Care Professional Team Identifier within a Health Care Provider and may be assigned automatically by the computer system.</p> <p>This data item is intended to capture details of the team who delivered the care activity to the mother.</p> <p>The Care Professional Team Local Identifier is captured in several tables (MSD102 Maternity Care Plan, MSD202 Care Activity (Pregnancy), MSD302 Care Activity (Labour and Delivery), MSD405 Care Activity (Baby) and MSD504 Assigned Care Professional) to allow the recording and subsequent monitoring of continuity of carer information, where applicable.</p> <p>For further guidance about the makeup of a local team, see the NHS England Implementing Better Births: Continuity of Carer guidance (specifically page 19).</p>
<p>CLINICAL CONTACT DURATION OF CARE ACTIVITY</p> <p><i>New Data Item</i></p>	<p>The duration of a Care Activity in minutes, excluding any administration time prior to or after the Care Activity and the Care Professional's travelling time to the location where the Care Activity was provided.</p> <p>This is calculated from the Start Time and End Time of the Care Activity.</p> <p>The total summed duration of Care Activities linked to a Care Contact should not exceed the Clinical Contact Duration of the Care Contact, i.e., the duration should be reported from a patient perspective and not duplicated for reporting purposes, such as against multiple Care Professionals involved in a single Care Activity.</p>
<p>LOCAL FETAL IDENTIFIER</p> <p><i>New Data Item</i></p>	<p>The unique identifier allocated to a fetus, which remains consistent throughout the pregnancy.</p> <p>It could be automatically generated by the local system at the point of the first ultrasound scan, where more than one fetus is identified.</p> <p>The code allows information from an early scan (where more than one fetus is present) to be associated with eventual birth outcomes.</p> <p>The Local Fetal Identifier is a 'required' data item and must be submitted by providers where used and recorded locally. The format is max an36.</p>

MSD202 Care Activity (Pregnancy)		<i>New Table</i>
<p>FETAL ORDER <i>New Data Item</i></p>	<p>The order or sequence in which the Fetus was assessed. The Fetal Order is represented by a single numeric value, with 1 indicating the first or only Fetus assessed in the sequence, 2 indicating the second, and so on.</p> <p>This item is for use where a specific Local Fetal Identifier cannot be ascertained, as it is recognised that medically it isn't always possible to uniquely identify distinct fetuses (in a multi-fetus pregnancy) and could be particularly difficult earlier in the pregnancy.</p>	
<p>PROCEDURE SCHEME IN USE <i>New Data Item</i></p>	<p>The code scheme basis of a procedure, i.e., the type of clinical classification or terminology that the Coded Procedure relates to.</p> <p>The value list includes:</p> <ul style="list-style-type: none"> 02 OPCS-4 04 Read Coded Clinical Terms Version 2 05 Read Coded Clinical Terms Version 3 (CTV3) 06 SNOMED CT 	
<p>CODED PROCEDURE AND PROCEDURE STATUS (CODED CLINICAL ENTRY) <i>New Data Item</i></p>	<p>A unique identifier for a procedure from a specific classification or clinical terminology, plus the status of a procedure where SNOMED CT codes are used.</p> <p>This item can be used to record the specific activity that was undertaken within the Care Contact, through the submission of a clinical terminology or classification code(s).</p> <p>A SNOMED CT post-coordinated expression can be used to represent the status of a procedure, for example whether it was offered or declined.</p> <p>Procedure: "represents activities performed in the provision of health care. This includes not only invasive procedures but also administration of medicines, imaging, education, therapies and administrative procedures" – SNOMED CT Starter Guide - Section 6 (page 21 onwards).</p> <p>For example, for a blood pressure test this would represent the clinical procedure, e.g., a code for 'blood pressure taking'.</p> <p>For further information on SNOMED CT Expressions, see the SNOMED CT Glossary at: Expression.</p> <p><u>Examples of appropriate SNOMED CT codes</u></p> <p>Post-coordinated expression (procedure + qualifier)</p> <p>To flow a procedure and qualifier, three pieces of information are required:</p> <ul style="list-style-type: none"> • The procedure code (for example: 271549001 Asymptomatic bacteriuria screening (procedure)) • The qualifier code (for example: 410527000 Offered (qualifier value)) • A code that links the procedure and the qualifier (for example:408730004 Procedure context (attribute)) <p>The three codes are concatenated for submission as follows:</p> <p>271549001:408730004=410527000</p>	

MSD202 Care Activity (Pregnancy)	
<i>New Table</i>	
	<p>(Asymptomatic bacteriuria screening (procedure): Procedure context (attribute) = Offered (qualifier value) </p> <p>Precoordinated expression (procedure only)</p> <p>Procedure only flows as a single code:</p> <p>271549001</p> <p>Asymptomatic bacteriuria screening (procedure)</p> <p>For this example, in the absence of an additional qualifier, we will assume that the procedure has been 'delivered'. This also applies to OPCS-4, Read 2 and CTV3 codes submitted for this data item where post-coordination is not possible.</p>
<p>FINDING SCHEME IN USE</p> <p><i>New Data Item</i></p>	<p>The code scheme basis of a finding, i.e., the type of clinical classification or terminology that the Coded Finding relates to.</p> <p>The value list includes:</p> <p>01 ICD-10</p> <p>02 Read Coded Clinical Terms Version 2</p> <p>03 Read Coded Clinical Terms Version 3 (CTV3)</p> <p>04 SNOMED CT</p>
<p>CODED FINDING (CODED CLINICAL ENTRY)</p> <p><i>New Data Item</i></p>	<p>A unique identifier for a finding from a specific classification or clinical terminology.</p> <p>This data item should be used to report any Findings captured during the Care Activity.</p> <p>Finding: "represents the result of a clinical observation, assessment or judgment and includes normal and abnormal clinical states" – SNOMED CT Starter Guide - Section 6 (page 21 onwards).</p> <p>For example, for a blood pressure test this would represent the clinical finding, e.g., a code for 'high blood pressure'.</p> <p>This could also include the results of a test such as a blood test, where available at the contact (otherwise the results would flow in the MSD109 table).</p>
<p>OBSERVATION SCHEME IN USE</p> <p><i>New Data Item</i></p>	<p>The code scheme basis of an Observation.</p> <p>The value list includes:</p> <p>01 Read Coded Clinical Terms Version 2</p> <p>02 Read Coded Clinical Terms Version 3 (CTV3)</p> <p>03 SNOMED CT</p>
<p>CODED OBSERVATION (CLINICAL TERMINOLOGY)</p> <p><i>New Data Item</i></p>	<p>A unique identifier for an observation from a specific clinical terminology.</p> <p>This data item should be used to report any Observations captured during the Care Activity.</p> <p>Observation: "represents a question or assessment which can produce an answer or result" – SNOMED CT Starter Guide - Section 6 (page 21 onwards)</p>

MSD202 Care Activity (Pregnancy)		<i>New Table</i>
	<p>For example, for a blood pressure test this would represent the observation carried out, e.g., a code denoting that 'systolic blood pressure' is being observed.</p> <p>This could also include the results of a test such as a blood test, where available at the contact (otherwise the results would flow in the MSD109 table).</p>	
<p>OBSERVATION VALUE</p> <p><i>New Data Item</i></p>	<p>The Observation Value represents the numeric value resulting from a clinical Observation.</p> <p>For example, for a blood pressure test this would represent the measured value from the blood pressure test, e.g., '120'.</p> <p>The value entered must be accurate and not an approximation. If there isn't sufficient evidence to arrive at an accurate value, please refrain from entering a value that can be misinterpreted or is imprecise.</p> <p>NB: If OBSERVATION VALUE is populated and the UCUM UNIT OF MEASUREMENT is blank, a warning will be reported.</p>	
<p>UCUM UNIT OF MEASUREMENT</p> <p><i>New Data Item</i></p>	<p>The unit of measurement used to measure the result of a clinical Observation. See http://unitsofmeasure.org/trac/.</p> <p>For example, for a blood pressure test this would represent the unit of measurement for the blood pressure test, e.g., 'm Hg'.</p>	

6.17 MSD203 Coded Scored Assessment (Contact)

MSD203 Coded Scored Assessment (Contact)	<i>New Table</i>
Description	
<p>To carry details of coded scored assessments that are completed as part of a specific contact during a maternity episode. For example, this could include an assessment that is completed by a mother at an appointment with a midwife. Scored assessments that are not completed as part of a contact should be submitted in the MSD104 Coded Scored Assessment (Pregnancy) table.</p> <p>The specific scored assessments and SNOMED CT codes that we expect providers to record in these tables are shown in the Technical Output Specification on the 'MSDS Assessment Scales' tab. The assessments are as follows:</p> <ul style="list-style-type: none"> • Whooley questions • Patient Health Questionnaire (PHQ-9) • Generalised Anxiety Disorder Assessment (GAD-7) • Edinburgh Postnatal Depression Scale (EPDS) • London Measure of Unplanned Pregnancy (LMUP) <p>Only the scored assessments listed in the 'MSDS Assessment Scales' tab in the TOS should be submitted to MSDS v2.0.</p> <p>One occurrence of this table is permitted for each coded scored observation question or dimension, as represented by a distinct SNOMED CT code.</p>	

MSD203 Coded Scored Assessment (Contact)

New Table

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Additional Notes on Data Items

Data Item Name	Additional Notes
<p>CARE ACTIVITY IDENTIFIER (MOTHER) <i>New Data Item</i></p>	<p>The unique identifier for a Care Activity for the mother. It would normally be automatically generated by the local system upon recording a new activity, although could be manually assigned.</p>
<p>CODED ASSESSMENT TOOL TYPE (SNOMED CT) <i>New Data Item</i></p>	<p>The SNOMED CT concept ID which is used to identify an Assessment in SNOMED CT. Please note that validation will be applied to this data item using a list of approved, licensed SNOMED CT codes that are specified in the MSDS Assessment Scales tab in the Technical Output Specification. The submitted code must be one of the codes included in the list, otherwise the record will be rejected.</p>
<p>PERSON SCORE <i>New Data Item</i></p>	<p>The observable value (score) resulting from an Assessment.</p>

6.18 MSD301 Labour and Delivery

MSD301 Labour and Delivery		Prev MAT404
Description		
<p>To carry details of events in labour and delivery.</p> <p>Multiple occurrences of this table are permitted.</p> <p>This table captures information on the labour and delivery episode and is required for all pregnancies where labour occurs.</p> <p>Where some data items in the table become redundant, due to other interventions (e.g., caesarean section) or the exact times are unknown (e.g., due to a mother delivering without support from a healthcare professional), they may be submitted as null. An example of this would be the ONSET OF ESTABLISHED LABOUR TIME.</p> <p>This table acts as a linking table for the MSD302 and MSD401 tables.</p> <p>The definitions for the three stages of labour are available from NICE CG190 – Intrapartum care for healthy women and babies. See the following recommendations:</p> <p>Recommendation: 1.3.1 First stage of labour https://www.nice.org.uk/guidance/cg190/chapter/recommendations#definitions-of-the-latent-and-established-first-stages-of-labour</p> <p>Recommendation: 1.13.1 Second stage of labour https://www.nice.org.uk/guidance/cg190/chapter/Recommendations#second-stage-of-labour</p> <p>Recommendation: 1.14.2 Third stage of labour https://www.nice.org.uk/guidance/cg190/chapter/Recommendations#third-stage-of-labour</p>		
Additional Notes on Data Items		
Data Item Name	Additional Notes	
<p>LABOUR AND DELIVERY IDENTIFIER <i>New Data Item</i></p>	<p>The unique identifier for a specific labour/ delivery.</p> <p>It would normally be automatically generated by the local system upon recording a labour/ delivery, although could be manually assigned.</p>	
<p>PREGNANCY IDENTIFIER <i>New Data Item</i></p>	<p>This is the unique identifier allocated to each maternity episode.</p> <p>Use of the Pregnancy Identifier uniquely identifies each pregnancy allowing the details of different pregnancies to be reconciled.</p> <p>It would normally be automatically generated by the local system upon recording a new pregnancy (at booking appointment/ first contact), although could be manually assigned.</p> <p>This is a foreign key that enables this table to be joined to the Pregnancy and Booking Details table. As such this is a mandated item, and the record will be rejected if it is not included within this group.</p>	

MSD301 Labour and Delivery		<i>Prev MAT404</i>										
<p>ORGANISATION SITE IDENTIFIER (AT START OF INTRAPARTUM CARE)</p> <p><i>New Data Item</i></p>	<p>The NHS organisation site identifier where the mother started intrapartum care from Maternity Services (where applicable). This could be the point when the mother is admitted for an induction or an elective caesarean section.</p> <p>List of all NHS organisation sites (with their organisation identifiers) are available from the NHS Digital website.</p> <p>The value list includes:</p> <table style="margin-left: 40px; border: none;"> <tr> <td colspan="2" style="text-align: center;">Alphanumeric site codes</td> </tr> <tr> <td style="padding-right: 10px;">ZZ201</td> <td>Home</td> </tr> <tr> <td style="padding-right: 10px;">ZZ888</td> <td>Non-NHS organisation</td> </tr> <tr> <td style="padding-right: 10px;">ZZ203</td> <td>Not known (not recorded)</td> </tr> </table>		Alphanumeric site codes		ZZ201	Home	ZZ888	Non-NHS organisation	ZZ203	Not known (not recorded)		
Alphanumeric site codes												
ZZ201	Home											
ZZ888	Non-NHS organisation											
ZZ203	Not known (not recorded)											
<p>MATERNITY CARE SETTING (AT START OF INTRAPARTUM CARE)</p> <p><i>New Data Item</i></p>	<p>The mother's actual location (type) at the start of intrapartum care, i.e., at the point where the mother is actively starting to receive care from Maternity Services for this labour or delivery. This could be the point when the mother is admitted for an induction or an elective caesarean section.</p> <p>In an obstetric unit (OU), care is provided by a team of midwives and doctors. Midwives provide care to all women in an obstetric unit, whether or not they are considered at high or low risk and take primary responsibility for women with straightforward pregnancies during labour and birth. Obstetricians have primary professional responsibility for women at high risk of complications during labour and birth and for women who develop complications during labour and birth. Obstetric units are always situated in hospitals where diagnostic and medical treatment services - including obstetric, neonatal, and anaesthetic care - are available on site. Obstetric units provide care to low and higher risk women. 'Higher risk' women – those who have health problems and/or less straightforward pregnancies - should normally be advised to give birth in an obstetric unit.</p> <p>In midwifery units, midwives take the primary professional responsibility for labour care. This is sometimes described as midwifery-led care. Midwifery units offer care to women with straightforward pregnancies.</p> <p>See also The Birthplace in England Research Programme.</p> <p>This data item should be recorded regardless of whether this is the same as the MATERNITY CARE SETTING (OF PLANNED DELIVERY), to allow changes between these settings and the eventual birth setting of the baby/babies to be recorded and assessed.</p> <p>The value list includes:</p> <table style="margin-left: 40px; border: none;"> <tr> <td style="padding-right: 10px;">01</td> <td>NHS Obstetric unit (including theatre) – see above</td> </tr> <tr> <td style="padding-right: 10px;">02</td> <td>NHS Alongside midwifery unit - situated in the same hospital or on the same site as an obstetric unit so have access to obstetric, neonatal, or anaesthetic care on site, although women may need to be physically transferred to the obstetric unit if they need obstetric care.</td> </tr> <tr> <td style="padding-right: 10px;">03</td> <td>NHS Freestanding midwifery unit (FMU) - are not situated in a hospital or site with an obstetric unit or neonatal unit. This means that if the woman needs obstetric or anaesthetic care or the baby requires neonatal care they need to be transferred - typically by ambulance or car - to another hospital where these services are provided.</td> </tr> <tr> <td style="padding-right: 10px;">04</td> <td>Home (NHS care)</td> </tr> <tr> <td style="padding-right: 10px;">07</td> <td>Maternity assessment or triage unit/ area</td> </tr> </table>		01	NHS Obstetric unit (including theatre) – see above	02	NHS Alongside midwifery unit - situated in the same hospital or on the same site as an obstetric unit so have access to obstetric, neonatal, or anaesthetic care on site, although women may need to be physically transferred to the obstetric unit if they need obstetric care.	03	NHS Freestanding midwifery unit (FMU) - are not situated in a hospital or site with an obstetric unit or neonatal unit. This means that if the woman needs obstetric or anaesthetic care or the baby requires neonatal care they need to be transferred - typically by ambulance or car - to another hospital where these services are provided.	04	Home (NHS care)	07	Maternity assessment or triage unit/ area
01	NHS Obstetric unit (including theatre) – see above											
02	NHS Alongside midwifery unit - situated in the same hospital or on the same site as an obstetric unit so have access to obstetric, neonatal, or anaesthetic care on site, although women may need to be physically transferred to the obstetric unit if they need obstetric care.											
03	NHS Freestanding midwifery unit (FMU) - are not situated in a hospital or site with an obstetric unit or neonatal unit. This means that if the woman needs obstetric or anaesthetic care or the baby requires neonatal care they need to be transferred - typically by ambulance or car - to another hospital where these services are provided.											
04	Home (NHS care)											
07	Maternity assessment or triage unit/ area											

MSD301 Labour and Delivery		<i>Prev MAT404</i>
	<ul style="list-style-type: none"> 08 NHS ward/health care setting without delivery facilities 98 Other (not listed) 99 Not known (not recorded) 	
<p>PLANNED DELIVERY SETTING CHANGE REASON (LABOUR) <i>New Data Item</i></p>	<p>This data item is used to record changes between the MATERNITY CARE SETTING (AT START OF INTRAPARTUM CARE) and MATERNITY CARE SETTING (ACTUAL PLACE OF BIRTH), i.e., changes that occurred while the mother was in labour. Other changes can be captured using the PLANNED DELIVERY SETTING CHANGE REASON (ANTENATAL) in the MSD102 table.</p> <p>This data item is intended to capture the reason why the planned delivery setting has changed during labour care (as opposed to at the planning stage), i.e., recorded at start of labour care/on admission for induction of labour or elective caesarean section. This includes from the start of labour care up to, but not including routine postpartum transfer to postnatal ward/area or back home – i.e., including a change of intended place of birth due to lack of staff or rooms at the intended place of birth and including immediate postpartum transfer for maternal or neonatal clinical reasons.</p> <p>The value list includes:</p> <ul style="list-style-type: none"> 02 Maternal preference 03 Clinical reason maternal – the specific clinical reason could flow as clinical terminology as a finding in the MSD302 table 04 Clinical reason fetal – the specific clinical reason could flow as clinical terminology as a finding in the MSD302 table 05 Unit Closure 06 Service capacity 07 Unintentional change 98 Not applicable (no change to planned delivery setting) 99 Not known (not recorded) <p>It supports the capture of data relating to intended and actual place of birth, in order to replicate the Birthplace Study.</p>	
<p>LABOUR OR DELIVERY ONSET METHOD CODE <i>New Data Item</i></p>	<p>The method by which the process of labour began, or delivery by caesarean section occurred.</p> <p>The value list includes:</p> <ul style="list-style-type: none"> 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 administration of agents either orally, intravenously or intravaginally with the intention of initiating labour 5 Combination of surgical induction and medical induction 9 Not Known: a validation error <p>NB: In the case of ‘Mechanical induction of labour’ leave this data item blank and instead, flow a SNOMED CT procedure code in the CODED PROCEDURE AND PROCEDURE STATUS (CODED CLINICAL</p>	

MSD301 Labour and Delivery		<i>Prev MAT404</i>
	ENTRY) data item in the 'MSD302 Care Activity (Labour and Delivery)' table.	
<p>ONSET OF ESTABLISHED LABOUR DATE</p> <p><i>Amended data Item previously - ONSET OF ESTABLISHED LABOUR DATE TIME</i></p> <p><i>Amended to separate date time, see data item below.</i></p>	<p>Date when the commencement of established labour is confirmed by a clinician - regular painful contractions and progressive cervical dilatation. This may be confirmed retrospectively as it could occur before admission.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p> <p>If a mother has not had a caesarean section, this data item must be populated to allow the MSD301 record to flow.</p> <p>Where a mother goes into labour and then subsequently has a caesarean section, both this data item and the PROCEDURE DATE (CAESAREAN SECTION) should be populated.</p> <p>The intrapartum period may commence in the absence of a health care professional, often in the woman's own home. On meeting the mother, a detailed history will be obtained by the midwife to enable them to risk assess and plan subsequent care. During this interaction or after an internal examination the midwife will be able to determine the onset of established labour.</p> <p>This transition from latent phase of labour to established labour is not a definitive point and is based on the health care professional's clinical judgement using a variety of observations to confirm this. This applies to all labour environments and is considered with input from the mother where at all possible.</p>	
<p>ONSET OF ESTABLISHED LABOUR TIME</p> <p><i>New Data Item Introduced to separate date time, see data item above.</i></p>	<p>Time when established labour is confirmed - regular painful contractions and progressive cervical dilatation.</p> <p>The time should be recorded using the 24-hour clock format in eGIF format i.e., HH:MM:SS.</p>	
<p>PROCEDURE DATE (CAESAREAN SECTION)</p> <p><i>Amended data item previously - PROCEDURE DATE TIME (CAESAREAN SECTION)</i></p> <p><i>Amended to separate date time, see data item below.</i></p>	<p>The date of the caesarean section (i.e., date of Knife to skin)</p> <p>If the ONSET OF ESTABLISHED LABOUR DATE has not been completed, i.e., the mother has not gone into labour prior to a caesarean taking place, then this data item must be populated to allow the MSD301 record to flow.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p>	

MSD301 Labour and Delivery		Prev MAT404
<p>PROCEDURE TIME (CAESAREAN SECTION)</p> <p><i>New Data Item Introduced to separate date time, see data item above.</i></p>	<p>The time of the caesarean section (i.e., time of Knife to skin).</p> <p>The time should be recorded using the 24-hour clock format in eGIF format i.e., HH:MM:SS.</p> <p>.</p>	
<p>START DATE (MOTHER LABOUR AND DELIVERY HOSPITAL PROVIDER SPELL)</p> <p><i>Amended data item previously - START DATE TIME (MOTHER DELIVERY HOSPITAL PROVIDER SPELL)</i></p> <p><i>Amended to separate date time, see data item below.</i></p>	<p>Date of in-patient admission, to a hospital, as part of the onset of labour, or for a caesarean section procedure.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p>	
<p>START TIME (MOTHER LABOUR AND DELIVERY HOSPITAL PROVIDER SPELL)</p> <p><i>New Data Item Introduced to separate date time, see data item above.</i></p>	<p>Time of in-patient admission, to a hospital, as part of the onset of labour, or for a caesarean section procedure.</p> <p>The time should be recorded using the 24-hour clock format in eGIF format i.e., HH:MM:SS.</p>	
<p>DECISION TO DELIVER DATE</p> <p><i>Amended data item previously - DATE TIME OF DECISION TO DELIVER</i></p> <p><i>Amended to separate date time, see data item below.</i></p>	<p>The date on which the decision was made to deliver the baby (where an emergency caesarean or other assisted delivery is required).</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p> <p>If DECISION TO DELIVER DATE is more than 5 days before the START DATE (MOTHER LABOUR AND DELIVERY HOSPITAL PROVIDER SPELL), the record will be rejected.</p> <p>This data item is only relevant where the delivery is accelerated by caesarean section or instrumental birth (usually due to prolonged labour or complications during labour). N.B. For elective caesarean sections, the commencement of labour is not deemed as a method of accelerating labour, and so this data item is out of scope for such scenarios, and the Decision to Deliver Date can be left blank.</p> <p>Providers may wish to submit a SNOMED CT procedure code in the MSD302 Care Activity (Labour and Delivery) table for elective caesarean section where this is captured locally.</p>	

MSD301 Labour and Delivery		Prev MAT404
	<p>Multi-fetus pregnancy</p> <p>In a multi-fetus pregnancy this data item should refer to the final delivery. However, this table does not capture the specific fetus for whom this data item refers.</p> <p>Alignment with data item DELIVERY METHOD CODE in table MSD401</p> <p>Where DECISION TO DELIVER DATE is POPULATED, an appropriate value should be captured in data item DELIVERY METHOD CODE.</p>	
<p>DECISION TO DELIVER TIME</p> <p><i>New Data Item Introduced to separate date time, see data item above.</i></p>	<p>The time at which the decision was made to deliver the baby (where an emergency caesarean or other assisted delivery is required).</p> <p>The time should be recorded using the 24-hour clock format in eGIF format i.e., HH:MM:SS.</p>	
<p>ADMISSION METHOD CODE (MOTHER LABOUR AND DELIVERY HOSPITAL PROVIDER SPELL)</p> <p><i>New Data Item</i></p>	<p>The method of admission to a Hospital Provider Spell for a mother for Labour and Delivery.</p> <p>The value list includes:</p> <p>Elective Admission</p> <ul style="list-style-type: none"> 11 Waiting list 12 Booked 13 Planned <p>Emergency admission</p> <ul style="list-style-type: none"> 21 Accident and emergency or dental casualty department of the Health Care Provider 22 General Practitioner: after a request for immediate admission has been made direct to a Hospital Provider, i.e., not through a bed bureau, by a General Practitioner or deputy 23 Bed Bureau 24 Consultant clinic, of this or another Health Care Provider 25 Admission via Mental Health Crisis Resolution Team 2A Accident and Emergency Department of another provider where the PATIENT had not been admitted 2B Transfer of an admitted PATIENT from another Hospital Provider in an emergency 2C Baby born at home as intended 2D Other emergency admission <p>Maternity Admission</p> <ul style="list-style-type: none"> 31 Admitted ante-partum 32 Admitted post-partum <p>Other Admission</p> <ul style="list-style-type: none"> 82 The birth of a baby in this Health Care Provider 83 Baby born outside the Health Care Provider except when born at home as intended 81 Transfer of any admitted patient from other hospital provider other than in an emergency 98 Not applicable 99 Not Known: a validation error 	

MSD301 Labour and Delivery		<i>Prev MAT404</i>
<p>DISCHARGE DATE (MOTHER POST LABOUR AND DELIVERY HOSPITAL PROVIDER SPELL)</p> <p><i>Amended data item previously - DISCHARGE DATE TIME (MOTHER POST DELIVERY HOSPITAL PROVIDER SPELL)</i></p> <p><i>Amended to separate date time, see data item below.</i></p>	<p>The date when the mother was discharged from hospital, following delivery, to the community midwifery service.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p> <p>If DISCHARGE DATE (MOTHER POST LABOUR AND DELIVERY HOSPITAL PROVIDER SPELL) is populated and is before the start date of the reporting period, the table will be rejected.</p> <p>If DISCHARGE DATE (MOTHER POST LABOUR AND DELIVERY HOSPITAL PROVIDER SPELL) is before the ONSET OF ESTABLISHED LABOUR DATE, the table will be rejected.</p> <p>Please note that this data item relates to the mother's discharge from <u>hospital</u> following labour. It is not the final discharge from Maternity Services, for example following birth or a miscarriage, which should be captured in the MSD101 Pregnancy and Booking Details table using the DISCHARGE DATE (MOTHER MATERNITY SERVICES) item.</p>	
<p>DISCHARGE TIME (MOTHER POST LABOUR AND DELIVERY HOSPITAL PROVIDER SPELL)</p> <p><i>New Data Item Introduced to separate date time, see data item above.</i></p>	<p>The time at which the mother was discharged from hospital following completion of labour and delivery.</p> <p>The time should be recorded using the 24-hour clock format in eGIF format i.e., HH:MM:SS.</p>	
<p>DISCHARGE METHOD CODE (MOTHER POST DELIVERY HOSPITAL PROVIDER SPELL)</p> <p><i>New Data Item</i></p>	<p>The method of discharge from a Hospital Provider Spell for the mother following delivery.</p> <p>The Value List available:</p> <ol style="list-style-type: none"> 1 Patient discharged on clinical advice or with clinical consent 2 PATIENT discharged him/herself or was discharged by a relative or advocate 3 Patient discharged by mental health review tribunal, Home Secretary, or court 4 Patient died 5 Stillbirth 8 Not applicable - Hospital Provider Spell not finished at episode end (i.e., not discharged) or current episode unfinished 9 Not known: a validation error 	

MSD301 Labour and Delivery Prev MAT404	
<p>DISCHARGE DESTINATION CODE (MOTHER POST DELIVERY HOSPITAL PROVIDER SPELL)</p> <p><i>New Data Item</i></p>	<p>The method of discharge from a Hospital Provider Spell for the mother following delivery.</p> <p>The Value List available is as follows:</p> <ul style="list-style-type: none"> 19 Usual place of residence unless listed below, for example, a private dwelling whether owner occupied or owned by local authority, housing association or another landlord. This includes wardened accommodation but not residential accommodation where health care is provided. It also includes PATIENTS with no fixed abode. 29 Temporary place of residence when usually resident elsewhere (includes hotel, residential educational establishment) 30 Repatriation from high security psychiatric accommodation in an NHS Hospital Provider (NHS Trust or NHS Foundation Trust) 37 Court 38 Penal establishment or police station 48 High Security Psychiatric Hospital, Scotland 49 NHS other hospital provider - high security psychiatric accommodation 50 NHS other hospital provider - medium secure unit 51 NHS other hospital provider - ward for general PATIENTS or the younger physically disabled 52 NHS other hospital provider - ward for maternity PATIENTS or neonates 53 NHS other hospital provider - ward for PATIENTS who are mentally ill or have learning disabilities 54 NHS run Care Home 65 Local Authority residential accommodation i.e., where care is provided 66 Local Authority foster care 79 Not applicable - PATIENT died or still birth 84 Non-NHS run hospital - medium secure unit 85 Non-NHS (other than Local Authority) run Care Home 87 Non-NHS run hospital 88 Non-NHS (other than Local Authority) run Hospice 98 Not applicable 99 Not known
<p>ORGANISATION IDENTIFIER (POSTNATAL PATHWAY LEAD PROVIDER)</p> <p><i>Amended data item previously – ORGANISATION CODE (POSTNATAL PATHWAY LEAD PROVIDER)</i></p>	<p>NHS organisation identifier of postnatal lead provider organisation. List of all NHS organisations (with their organisation identifiers) are available from the NHS Digital website.</p>

6.19 MSD302 Care Activity (Labour and Delivery)

MSD302 Care Activity (Labour and Delivery)		<i>New Table</i>
Description		
<p>To carry details of any activities which have taken place during labour and delivery.</p> <p>Any clinical procedures, findings and observations that occurred during labour and delivery should be recorded here. This includes induction method (including medical and non-medical methods), pain relief in labour and delivery, anaesthesia type in labour and delivery, and genital tract traumas that occurred during labour and delivery.</p> <p>Multiple occurrences of this table are permitted. There would potentially be several MSD302 records for each 'MSD301 Labour and Delivery' record.</p> <p>Activity in the MSD302 table should be submitted in the reporting month in which it took place</p> <p>Further information about the structure of care activity tables can be found in Appendix 2.</p>		
Additional Notes on Data Items		
Data Item Name	Additional Notes	
LABOUR AND DELIVERY IDENTIFIER <i>New Data Item</i>	<p>The unique identifier for a specific labour/ delivery.</p> <p>It would normally be automatically generated by the local system upon recording a labour/ delivery, although could be manually assigned.</p>	
CLINICAL INTERVENTION DATE (MOTHER) <i>New Data Item</i>	<p>The date on which a Clinical Intervention took place for the mother.</p> <p>For the purposes of MSDS v2.0, clinical interventions are synonymous with care activities and the clinical intervention date can be considered the same as the care activity date. This item can therefore be used to represent the date that any submitted activity within scope of the data set took place.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD.</p>	
CLINICAL INTERVENTION TIME (MOTHER) <i>New Data Item</i>	<p>The time at which a Clinical Intervention took place for the mother.</p> <p>For the purposes of MSDS v2.0, clinical interventions are synonymous with care activities and the clinical intervention time can be considered the same as the care activity time. This item can therefore be used to represent the time that any submitted activity within scope of the data set took place.</p> <p>The time should be recorded using the 24-hour clock format in eGIF format i.e., HH:MM:SS.</p>	

MSD302 Care Activity (Labour and Delivery)		<i>New Table</i>
<p>CLINICAL CONTACT DURATION OF CARE ACTIVITY</p> <p><i>New Data Item</i></p>	<p>The duration of a distinct CARE ACTIVITY in minutes, excluding any administration time prior to or after the CARE ACTIVITY and the CARE PROFESSIONAL's travelling time to the LOCATION where the CARE ACTIVITY was provided.</p> <p>This is calculated from the Start Time and End Time of the CARE ACTIVITY.</p> <p>Some examples of activities from the SNOMED CT mapping document include:</p> <p>1105791000000108 Mifepristone induction of labour (procedure)</p> <p>408816000 Artificial rupture of membranes (procedure)</p> <p>177212000 Normal delivery of placenta (procedure)</p> <p>Each of the above procedures would take a specific amount of time and this data item should be populated with the amount of time taken, in minutes, for each activity.</p> <p>If providers do not record to this level of detail for individual activities this data item can be left blank.</p>	
<p>CARE PROFESSIONAL LOCAL IDENTIFIER</p> <p><i>New Data Item</i></p>	<p>Care Professional Local Identifier is a unique local Care Professional Identifier within a Health Care Provider and may be assigned automatically by the computer system.</p> <p>This data item is intended to capture details of the individual who delivered the care activity to the mother.</p> <p>Where multiple Care Professionals are involved in a single Care Activity, a 'lead' Care Professional should be allocated to the Care Activity. There is no requirement to duplicate records for a single Care Activity for each involved Care Professional.</p> <p>The Care Professional Local Identifier is captured in several tables (MSD102 Maternity Care Plan, MSD202 Care Activity (Pregnancy), MSD302 Care Activity (Labour and Delivery), MSD401 Baby's Demographics and Birth Details (N.B. named 'Care Professional Local Identifier (Delivering Baby)'), MSD405 Care Activity (Baby) and MSD504 Assigned Care Professional) to allow the recording and subsequent monitoring of continuity of carer information, where applicable.</p> <p>The identifier captured in this data item can be linked to the MSD901 Staff Details look up table.</p>	
<p>CARE PROFESSIONAL TEAM LOCAL IDENTIFIER</p> <p><i>New Data Item</i></p>	<p>Care Professional Team Local Identifier is a unique Local Care Professional Team Identifier within a Health Care Provider and may be assigned automatically by the computer system.</p> <p>This data item is intended to capture details of the team who delivered the care activity to the mother.</p> <p>The Care Professional Team Local Identifier is captured in several tables (MSD102 Maternity Care Plan, MSD202 Care Activity (Pregnancy), MSD302 Care Activity (Labour and Delivery), MSD405 Care Activity (Baby) and MSD504 Assigned Care Professional) to allow the recording and subsequent monitoring of continuity of carer information, where applicable.</p> <p>For further guidance about the makeup of a local team, see the NHS England Implementing Better Births: Continuity of Carer guidance (specifically page 19).</p>	

MSD302 Care Activity (Labour and Delivery)		<i>New Table</i>
<p>LOCAL FETAL IDENTIFIER</p> <p><i>New Data Item</i></p>	<p>The unique identifier allocated to a fetus, which remains consistent throughout the pregnancy.</p> <p>It could be automatically generated by the local system at the point of the first ultrasound scan, where more than one fetus is identified.</p> <p>The code allows information from an early scan (where more than one fetus is present) to be associated with eventual birth outcomes.</p> <p>The Local Fetal Identifier is a 'required' data item and must be submitted by providers where used and recorded locally. The format is max an36.</p>	
<p>FETAL ORDER</p> <p><i>New Data Item</i></p>	<p>The order or sequence in which the Fetus was assessed. The Fetal Order is represented by a single numeric value, with 1 indicating the first or only Fetus assessed in the sequence, 2 indicating the second, and so on.</p> <p>This item is for use where a specific Local Fetal Identifier cannot be ascertained, as it is recognised that medically it isn't always possible to uniquely identify distinct fetuses (in a multi-fetus pregnancy) and could be particularly difficult earlier in the pregnancy.</p>	
<p>MATERNAL CRITICAL INCIDENT INDICATOR</p> <p><i>New Data Item</i></p>	<p>To capture whether or not the mother experienced a critical incident during the labour and delivery episode (as part of activity that is relevant before, during or after birth). This can be used in conjunction with a clinical term to provide further details of what the critical incident was.</p> <p>Note:</p> <p>Use the 'critical incident indicator' to associate against the single specific activity that is deemed to be the 'critical incident'</p> <p>Only one 'critical incident indicator' is required.</p> <p>The 'critical incident indicator' may appear in MSD405 rather than MSD302.</p>	
<p>PROCEDURE SCHEME IN USE</p> <p><i>New Data Item</i></p>	<p>The code scheme basis of a procedure.</p> <p>The value list available is as follows:</p> <ul style="list-style-type: none"> 02 OPCS-4 04 Read Coded Clinical Terms Version 2 05 Read Coded Clinical Terms Version 3 (CTV3) 06 SNOMED CT 	

MSD302 Care Activity (Labour and Delivery)		<i>New Table</i>
<p>CODED PROCEDURE AND PROCEDURE STATUS (CODED CLINICAL ENTRY)</p> <p><i>New Data Item</i></p>	<p>A unique identifier for a procedure from a specific classification or clinical terminology, plus the status of a procedure where SNOMED CT codes are used.</p> <p>This item can be used to record the specific activity that was undertaken within the Care Contact, through the submission of a clinical terminology or classification code(s).</p> <p>A SNOMED CT post-coordinated expression can be used to represent the status of a procedure, for example whether it was offered or declined.</p> <p>Procedure: “represents activities performed in the provision of health care. This includes not only invasive procedures but also administration of medicines, imaging, education, therapies and administrative procedures” – SNOMED CT Starter Guide - Section 6 (page 21 onwards)</p> <p>For example, for a blood pressure test this would represent the clinical procedure, e.g., a code for ‘blood pressure taking’.</p> <p>For further information on SNOMED CT Expressions, see the SNOMED CT Glossary at: Expression.</p> <p><u>Examples of appropriate SNOMED CT codes</u></p> <p>Post-coordinated expression (procedure + qualifier)</p> <p>To flow a procedure and qualifier, three pieces of information are required:</p> <ul style="list-style-type: none"> • The procedure code • The qualifier code • A code that links the procedure and the qualifier <p>The three codes are concatenated for submission.</p> <p>Precoordinated expression (procedure only)</p> <p>Procedure only flows as a single code:</p> <p>408816000: Artificial rupture of membranes (procedure)</p> <p>For this example, in the absence of an additional qualifier, we will assume that the procedure has been ‘delivered’. This also applies to OPCS-4, Read 2 and CTV3 codes submitted for this data item where post-coordination is not possible.</p>	
<p>FINDING SCHEME IN USE</p> <p><i>New Data Item</i></p>	<p>The code scheme basis of a finding.</p> <p>The value list includes:</p> <ul style="list-style-type: none"> 01 ICD-10 02 Read Coded Clinical Terms Version 2 03 Read Coded Clinical Terms Version 3 (CTV3) 04 SNOMED CT 	

MSD302 Care Activity (Labour and Delivery)		<i>New Table</i>						
<p>CODED FINDING (CODED CLINICAL ENTRY)</p> <p><i>New Data Item</i></p>	<p>A unique identifier for a finding from a specific classification or clinical terminology.</p> <p>This data item should be used to report any Findings captured during the Care Activity.</p> <p>Finding: “represents the result of a clinical observation, assessment or judgment and includes normal and abnormal clinical states” – SNOMED CT Starter Guide - Section 6 (page 21 onwards)</p> <p>For example, for a blood pressure test this would represent the clinical finding, e.g., a code for ‘high blood pressure’.</p> <p>This could include findings relating to a maternity obstetric diagnosis, such as:</p> <ul style="list-style-type: none"> • Prolonged pre-labour rupture of membranes • Known or suspected intrauterine growth restriction • Reduced (decreased) fetal movements • Non-cephalic presentation/malpresentation • Known or suspected sepsis 							
<p>OBSERVATION SCHEME IN USE</p> <p><i>New Data Item</i></p>	<p>The code scheme basis of an Observation.</p> <p>The value list available:</p> <table style="margin-left: 20px;"> <tr> <td style="padding-right: 10px;">01</td> <td>Read Coded Clinical Terms Version 2</td> </tr> <tr> <td>02</td> <td>Read Coded Clinical Terms Version 3 (CTV3)</td> </tr> <tr> <td>03</td> <td>SNOMED CT</td> </tr> </table>		01	Read Coded Clinical Terms Version 2	02	Read Coded Clinical Terms Version 3 (CTV3)	03	SNOMED CT
01	Read Coded Clinical Terms Version 2							
02	Read Coded Clinical Terms Version 3 (CTV3)							
03	SNOMED CT							
<p>CODED OBSERVATION (CLINICAL TERMINOLOGY)</p> <p><i>New Data Item</i></p>	<p>A unique identifier for an observation from a specific clinical terminology.</p> <p>This data item should be used to report any Observations captured during the Care Activity.</p> <p>Observation: “represents a question or assessment which can produce an answer or result” – SNOMED CT Starter Guide - Section 6 (page 21 onwards)</p> <p>For example, for a blood pressure test this would represent the observation carried out, e.g., a code denoting that ‘systolic blood pressure’ is being observed.</p>							
<p>OBSERVATION VALUE</p> <p><i>New Data Item</i></p>	<p>The numeric value resulting from a clinical OBSERVATION.</p> <p>For example, for a blood pressure test this would represent the measured value from the blood pressure test, e.g., ‘120’.</p> <p>The value entered must be accurate and not an approximation. If there isn’t sufficient evidence to arrive at an accurate value, please refrain from entering a value that can be misinterpreted or is imprecise.</p> <p>NB: If OBSERVATION VALUE is populated and the UCUM UNIT OF MEASUREMENT is blank, a warning will be reported.</p>							
<p>UCUM UNIT OF MEASUREMENT</p> <p><i>New Data Item</i></p>	<p>The unit of measurement used to measure the result of a clinical OBSERVATION. See http://unitsofmeasure.org/trac/.</p> <p>For example, for a blood pressure test this would represent the unit of measurement for the blood pressure test, e.g., ‘m Hg’.</p>							

6.20 MSD401 Baby's Demographics and Birth Details

MSD401 Baby's Demographics and Birth Details		Prev MAT502
Description		
<p>To carry details of the baby's demographics and birth.</p> <p>Multiple occurrences of this table are permitted.</p> <p>This table will be rejected if there is no valid MSD301 group transmitted for this Labour and Delivery Identifier.</p> <p>This table captures data collected when the baby is born.</p> <p>The table must be submitted for all registerable births including both live births and stillbirths.</p> <p>A MSD401 table must be transmitted within the reporting period that includes the date of birth. It should also be retransmitted in subsequent reporting periods when flowing any other table containing activity or data related to the baby, i.e., prior to discharge of the baby from maternity services.</p>		
Additional Notes on Data Items		
Data Item Name	Additional Notes	
<p>LOCAL PATIENT IDENTIFIER (EXTENDED (BABY))</p> <p><i>Amended data item previously - Local Patient Identifier (Baby)</i></p>	<p>The unique local patient identifier of the baby as generated by the NHS Care Provider. This is not the NHS number.</p> <p>The data item will be captured for all live births and stillbirths.</p> <p>This is the unique system identifier that identifies the baby. This is the primary key that enables tables of data to be joined together. As such this is a mandated item, and the record will be rejected if it is not included within this table.</p> <p>Ideally, babies should have the same Local Patient Identifier (Extended (Baby)) across successive submission periods to make local reconciliation of data easier.</p> <p>Where multiple systems are used it is acceptable to include a prefix to the Local Patient Identifier (Extended (Baby)), which relates to the system. The prefix enables each identifier to remain truly unique for all submissions from an organisation in the event that the same Local Patient Identifier is used to represent two different babies in different systems. However, submitters should ensure that the same Local Patient Identifier is used to identify each distinct baby within a submission file, for example where a baby's records exist on two systems and therefore are potentially associated with different Local Patient Identifiers for the same baby.</p> <p>Duplicate Local Patient Identifiers within the same submission file will cause the entire file to be rejected.</p>	
<p>LABOUR AND DELIVERY IDENTIFIER</p> <p><i>New Data Item</i></p>	<p>The unique identifier for a specific labour/ delivery.</p> <p>It would normally be automatically generated by the local system upon recording a labour/ delivery, although could be manually assigned.</p>	

MSD401 Baby's Demographics and Birth Details Prev MAT502	
<p>ORGANISATION IDENTIFIER (LOCAL PATIENT IDENTIFIER (BABY))</p> <p><i>Amended data item previously - ORGANISATION CODE (LOCAL PATIENT IDENTIFIER (BABY))</i></p>	<p>The Organisation Identifier of the organisation that assigned the local patient identifier (Baby).</p> <p>This will identify the organisation where the Local Patient Identifier (Extended (Baby)) was issued. It is necessary where organisations have gone through a merger or split into a new or existing organisation.</p> <p>If Local Patient Identifiers are not modified during the merger or split of an organisation, then the issuing Organisation Code of the Local Patient Identifier (Extended (Baby)) (even if now discontinued) should be sent in this field. However, if the Local Patient Identifier (Extended (Baby)) has been modified since the organisation change i.e., by prefix etc, then the new organisation code should be used.</p> <p>If Organisation Identifier (Local Patient Identifier (Baby)) is not in national organisation tables as a "live" organisation at any point during the reporting period, a warning will be reported.</p>
<p>PERSON BIRTH DATE (BABY)</p> <p><i>Amended data item previously - DATE TIME OF BIRTH (BABY)</i></p> <p><i>Amended to take account of date time split, See data item below.</i></p>	<p>Date of Birth of baby.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p>
<p>PERSON BIRTH TIME (BABY)</p> <p><i>New Data Item Introduced to separate date time, see data item above.</i></p>	<p>Time of birth of baby.</p> <p>The time should be recorded using the 24-hour clock format in eGIF format i.e., HH:MM:SS.</p>
<p>PREGNANCY OUTCOME</p> <p><i>New Data Item</i></p>	<p>The pregnancy outcome of each baby.</p> <p>The value list includes:</p> <ul style="list-style-type: none"> 01 Live birth 02 Antepartum Stillbirth 03 Intrapartum Stillbirth 04 Stillbirth – timing unknown 05 Termination of Pregnancy equal to or greater than 24 weeks 98 Other (not listed) <p>This information can also be submitted as a clinical finding, using clinical terminology or classifications, in the MSD405 table.</p>

MSD401 Baby's Demographics and Birth Details		<i>Prev MAT502</i>
<p>PERSON PHENOTYPIC SEX</p> <p><i>No Change to Data Item</i></p>	<p>The Person Phenotypic Sex of the baby. This is as observed by a person (such as a Care Professional) and is not self-stated.</p> <p>The value list includes:</p> <ul style="list-style-type: none"> X Not Known (PERSON PHENOTYPIC SEX not recorded) 1 Male 2 Female 9 Indeterminate (unable to be classified as either male or female) 	
<p>ETHNIC CATEGORY (BABY)</p> <p><i>New Data Item</i></p>	<p>Based on the 2001 census values, the ethnicity of the baby in a maternity episode as specified by the mother.</p>	
<p>NHS NUMBER (BABY)</p> <p><i>No Change to Data Item</i></p>	<p>This captures the NHS Number of the baby in a maternity episode.</p> <p>The data item should be captured for all live births and stillbirths.</p> <p>Most maternity systems are linked to NN4B, so the NHS number should be readily available from maternity systems.</p> <p>The importance of the NHS Number</p> <p>When the NHS number is provided this will be used instead of the Local Patient Identifier as the primary unique identifier for a baby or babies.</p> <p>The capture of the NHS number is vital as this is the only identifier that allows the baby or babies to be tracked across different organisations or across a single organisation when multiple Local Patient Identifiers have been used for a mother, baby, or babies.</p> <p>Although this is not a mandated field, as not all babies have NHS numbers, data quality reports will be produced to identify the completeness of this field and it is recommended that local Care Providers use this as one of the primary data quality metrics for all patient level data sets.</p> <p>Duplicate NHS Numbers within this table will cause the entire file to be rejected.</p> <p>Further guidance about NHS Numbers can be found here: https://digital.nhs.uk/services/nhs-number</p>	
<p>NHS NUMBER STATUS INDICATOR CODE (BABY)</p> <p><i>No Change to Data Item</i></p>	<p>Whether the NHS number of the baby has been verified.</p> <p>This data item is 'Required' however it is recommended that this is always completed, irrespective of whether an NHS number is present.</p> <p>In cases where a baby's NHS number is unavailable, Maternity Data Providers must submit a null NHS number and [07] <i>Number not present and trace not required</i> in NHS Number Status Indicator Code (Baby).</p> <p>In most cases, this data item will be flowed with value [01] - <i>Number present and verified</i>. The [01] will indicate that the Maternity Data Provider has validated the number against the central Personal Demographics Service (PDS), and therefore facilitates reliable data linkage.</p> <p>Maternity Data Providers may flow data for patients with an NHS Number Status Indicator Code (Baby) other than [01] and they will be accepted, however, reports that need reliable linkage may exclude</p>	

MSD401 Baby's Demographics and Birth Details		<i>Prev MAT502</i>
	these records (unless reliable linkage is available via Local Patient Identifier (Extended/Baby) data items).	
LOCAL FETAL IDENTIFIER <i>New Data Item</i>	<p>The unique identifier allocated to a fetus, which remains consistent throughout the pregnancy.</p> <p>It could be automatically generated by the local system at the point of the first ultrasound scan, where more than one fetus is identified.</p> <p>The code allows information from an early scan (where more than one fetus is present) to be associated with eventual birth outcomes.</p>	
	The Local Fetal Identifier is a 'required' data item and must be submitted by providers where used and recorded locally. The format is max an36.	
BIRTH ORDER (MATERNITY SERVICES) <i>No Change to Data Item</i>	<p>Sequence in which the baby was born.</p> <p>Singleton and multi-fetus pregnancies</p> <p>The data item captures the sequence in which the baby or babies were born, with [1] indicating the first or only birth in the sequence (i.e., singleton), [2] indicating the second birth in the sequence, [3] indicating the third, and so on. This does not need to match the value recorded in the Fetal Order data item in other tables.</p> <p>Unknown birth order</p> <p>The Maternity Data Provider should submit [UU] <i>Unknown</i>.</p>	
PERSON DEATH DATE (BABY) <i>Amended data item previously - PERSON DEATH DATE TIME (BABY)</i> <i>Amended to separate death date time, see data item below.</i>	<p>Date of death of baby, before 28 completed days of birth</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p> <p>This item captures information on babies dying before 28 completed days of birth (i.e., within 27 days and 23 hours + 59 minutes). i.e., the data set captures information on early and late neonatal deaths.</p> <p>A table must be submitted for any known death not only where a death certificate is issued. However, please note that, due to data set validation rules, providers should not submit dates of death for the baby that are over 28 days after the date of birth, as these are out of scope for MSDS, and the table will be rejected.</p> <p>In the event of an intrapartum stillbirth the PERSON DEATH DATE (BABY) should be submitted as the same date as the birth date.</p> <p>Maternity Data Providers also report neonatal deaths to MBRRACE-UK (Mothers and Babies - Reducing Risk through Audits and Confidential Enquiries across the UK) as part of the national Maternal, Newborn and Infant Clinical Outcomes Review Programme.</p> <p>Data submission to MBRRACE-UK must continue and Maternity Data Providers must ensure that data submitted to the MSDS central data warehouse is consistent with the data submitted to MBRRACE-UK.</p> <p>NB. Whilst both MSDS and MBRRACE-UK capture maternal death data, MSDS only captures death up to the point of discharge from Maternity Services, whereas MBRRACE-UK captures deaths up to 6 months after the end of pregnancy.</p>	

MSD401 Baby's Demographics and Birth Details		<i>Prev MAT502</i>				
<p>PERSON DEATH TIME (BABY)</p> <p><i>New Data Item Introduced to separate date time, see data item above.</i></p>	<p>Time of death of baby, before 28 completed days of birth.</p> <p>The time should be recorded using the 24-hour clock format in eGIF format i.e., HH:MM:SS.</p> <p>See also the Person Death Date (Baby) data item guidance above.</p>					
<p>PRESENTATION OF FETUS AT ONSET OF LABOUR OR DELIVERY</p> <p><i>Amended data item previously – PRESENTATION AT ONSET OF LABOUR (in MAT404 – Labour and Delivery in MSDS V1.5)</i></p>	<p>The presentation of the fetus at onset of labour or delivery. This should be captured for all types of birth, including caesarean section births.</p> <p>Where there are multiple fetuses presentation can differ, and all babies should have a presentation type recorded.</p> <p>If Person Death Time (Baby), where Person Birth Date (Baby) is the same as Person Death Date (Baby), the record will be rejected.</p> <p>The value list includes:</p> <ul style="list-style-type: none"> 01 Cephalic 02 Breech 03 Transverse/oblique 04 Presentation not known XX Other 					
<p>GESTATION LENGTH (AT BIRTH)</p> <p><i>No Change to Data Item</i></p>	<p>The number of days that the baby was in gestation prior to birth. This is calculated based on the difference between the date 280 days prior to the Estimated Date of Delivery (Agreed) in MSD101 and the Person Birth Date (Baby). For babies born prior to the Estimated Date of Delivery (Agreed) in MSD101 the Gestation Length (At Birth) should be lower than 280; for babies born after the Estimated Date of Delivery (Agreed) in MSD101 the Gestation Length (At Birth) should be higher than 280.</p> <p>Maternity Data Providers may be able to derive this value by comparing the Person Birth Date (Baby) with the mother's Estimated Date of Delivery (Agreed).</p>					
<p>DELIVERY METHOD CODE</p> <p><i>Amended data item previously - DELIVERY METHOD (CURRENT BABY)</i></p>	<p>The method by which a baby is delivered, which is a Registrable Birth.</p> <p>Delivery Method Code allows the method of delivery to be associated with the fetus rather than the mother, and different methods to be submitted for different babies where this applies i.e., a twin pregnancy might be delivered both vaginally and by caesarean section.</p> <p>Further information about the delivery method can also be submitted using clinical terminology in the 'MSD405 Care Activity (Baby)' table.</p> <p>Where Maternity Data Providers capture delivery methods in a different way or at a lower level then they should be mapped to an appropriate value stated in the national code list.</p> <p>The national code list includes:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;">0 Spontaneous Vertex</td> <td style="width: 50%; padding: 5px;">Normal vaginal delivery, occipitoanterior</td> </tr> <tr> <td style="padding: 5px;">1 Spontaneous Other Cephalic</td> <td style="padding: 5px;">Cephalic vaginal delivery with abnormal presentation of head at delivery, without instruments, with or without manipulation</td> </tr> </table>		0 Spontaneous Vertex	Normal vaginal delivery, occipitoanterior	1 Spontaneous Other Cephalic	Cephalic vaginal delivery with abnormal presentation of head at delivery, without instruments, with or without manipulation
0 Spontaneous Vertex	Normal vaginal delivery, occipitoanterior					
1 Spontaneous Other Cephalic	Cephalic vaginal delivery with abnormal presentation of head at delivery, without instruments, with or without manipulation					

MSD401 Baby's Demographics and Birth Details		<i>Prev MAT502</i>										
	2 Low forceps not breech	<p>E.g., forceps, low application, without manipulation. Includes forceps delivery not otherwise specified.</p> <p>Where an NHS Trust only captures 'forceps', the method of delivery will map to 'Low forceps, not breech'.</p>										
	3 Other Forceps not breech	E.g., forceps with manipulation. Includes high forceps and mid forceps)										
	4 Ventouse, Vacuum extraction											
	5 Breech	Spontaneous delivery assisted or unspecified. Includes partial breech extraction)										
	6 Breech Extraction	Not otherwise specified. Includes total breech extraction and version with breech extraction										
	7 Elective caesarean section	<p>Caesarean section before, or at onset of, labour.</p> <p>Where a mother, scheduled for a caesarean section (i.e., elective caesarean section), is admitted to an NHS Trust due to early onset of labour (and without maternal or fetal compromise) and subsequently has a caesarean section, she will still be classed as having an 'elective caesarean section'.</p>										
	8 Emergency caesarean section	Where a caesarean section is planned but is performed urgently, due a complication, the method of delivery will be classed as 'emergency caesarean section'.										
	9 Other	E.g., application of weight to leg in breech delivery. Includes destructive operation to facilitate delivery and other surgical or instrumental delivery.										
<p>DELIVERED IN WATER INDICATOR</p> <p><i>No Change to Data Item</i></p>	<p>An indicator of whether or not the baby was delivered in a birthing pool.</p> <p>The data item refers to babies delivered in a birthing pool. This is irrespective of whether the baby's head is above or under the water at the point of delivery.</p>											
<p>ORGANISATION SITE IDENTIFIER (OF ACTUAL PLACE OF DELIVERY)</p> <p><i>Amended data item previously - SITE CODE (OF ACTUAL PLACE OF DELIVERY)</i></p>	<p>The unique identifier of the organisation site where the baby was delivered. List of all NHS organisation sites is available from the NHS Digital website.</p> <p>The value list includes:</p> <table style="margin-left: 20px; border: none;"> <tr> <td style="padding-right: 10px;">ZZ201</td> <td>Alphanumeric site code</td> </tr> <tr> <td>ZZ201</td> <td>Home</td> </tr> <tr> <td>ZZ888</td> <td>Non-NHS organisation</td> </tr> <tr> <td>ZZ203</td> <td>Not known (not recorded)</td> </tr> <tr> <td>ZZ777</td> <td>In transit</td> </tr> </table>		ZZ201	Alphanumeric site code	ZZ201	Home	ZZ888	Non-NHS organisation	ZZ203	Not known (not recorded)	ZZ777	In transit
ZZ201	Alphanumeric site code											
ZZ201	Home											
ZZ888	Non-NHS organisation											
ZZ203	Not known (not recorded)											
ZZ777	In transit											

MSD401 Baby's Demographics and Birth Details		<i>Prev MAT502</i>
	<p>Codes provided will be validated against the NHS Organisation Data Service (ODS).</p> <p>Where Maternity Data Providers capture site of delivery in a different format or at a lower level than the ODS codes, then they should be mapped to an appropriate value stated in the national code list.</p>	
<p>CARE PROFESSIONAL LOCAL IDENTIFIER (DELIVERING BABY)</p> <p><i>New Data Item</i></p>	<p>A unique local Care Professional Identifier within a Health Care Provider and may be assigned automatically by the computer system.</p> <p>This data item captures details of the Care Professional who delivered the baby, or the supervising professional in the case of a student (when the delivery is carried out by a student, the individual supervising the delivery should be the one recorded as conducting it).</p> <p>The identifier captured in this data item can be linked to the MSD901 Staff Details look up table.</p>	
<p>MATERNITY CARE SETTING (ACTUAL PLACE OF BIRTH)</p> <p><i>Amended data item previously - DELIVERY PLACE TYPE CODE (ACTUAL)</i></p>	<p>The type of location or unit in which a baby or babies was/were delivered.</p> <p>In an obstetric unit (OU), care is provided by a team of midwives and doctors. Midwives provide care to all women in an obstetric unit, whether or not they are considered at high or low risk and take primary responsibility for women with straightforward pregnancies during labour and birth. Obstetricians have primary professional responsibility for women at high risk of complications during labour and birth and for women who develop complications during labour and birth. Obstetric units are always situated in hospitals where diagnostic and medical treatment services - including obstetric, neonatal, and anaesthetic care - are available on site. Obstetric units provide care to low and higher risk women. 'Higher risk' women – those who have health problems and/or less straightforward pregnancies - should normally be advised to give birth in an obstetric unit.</p> <p>In midwifery units, midwives take the primary professional responsibility for labour care. This is sometimes described as midwifery-led care. Midwifery units offer care to women with straightforward pregnancies.</p> <p>See also The Birthplace in England Research Programme.</p> <p>The value list includes:</p> <ul style="list-style-type: none"> 01 NHS Obstetric unit (including theatre) – see above 02 NHS Alongside midwifery unit (AMU) - situated in the same hospital or on the same site as an obstetric unit so have access to obstetric, neonatal, or anaesthetic care on site, although women may need to be physically transferred to the obstetric unit if they need obstetric care. 03 NHS Freestanding midwifery unit (FMU) - are not situated in a hospital or site with an obstetric unit or neonatal unit. This means that if the woman needs obstetric or anaesthetic care or the baby requires neonatal care they need to be transferred - typically by ambulance or car - to another hospital where these services are provided. 04 Home (NHS care) 05 Home (private care) 06 Private hospital 07 Maternity assessment or triage unit/ area 08 NHS ward/health care setting without delivery facilities 09 In transit (with NHS ambulance services) 10 In transit (with private ambulance services) 11 In transit (without healthcare services present) 	

MSD401 Baby's Demographics and Birth Details		Prev MAT502
	12 Non-domestic and non-health care setting 98 Other (not listed) 99 Not known (not recorded)	
BABY FIRST FEED DATE <i>Amended data item previously - BABY FIRST FEED DATE TIME</i> <i>Amended to separate date time, see data item below.</i>	Date on which baby or babies had first feed. This should be recorded in the eGIF Date format CCYY-MM-DD. If Baby First Feed Date is before the Person Birth Date (Baby), the record will be rejected. If Baby First Feed Date is more than 2 days after the Person Birth Date (Baby) , the record will be rejected.	
BABY FIRST FEED TIME <i>New Data Item Introduced to separate date time, see data item below</i>	Time at which baby or babies had first feed. The time should be recorded using the 24-hour clock format in eGIF format i.e., HH:MM:SS.	
BABY FIRST FEED BREAST MILK INDICATION CODE <i>Amended data item previously - BABY FIRST FEED BREAST MILK STATUS</i>	An indicator of whether the Baby's First Feed was breast milk, and if so the type of breast milk. NICE NG194 defines the routine postnatal care that a mother, and the baby or babies, should receive in the first 8 weeks after birth ⁷ . It includes the organisation and delivery of postnatal care, identifying and managing common and serious health problems in women and their babies, how to help parents form strong relationships with their babies, and baby feeding. The recommendations on emotional attachment and baby feeding also cover the antenatal period. This table provides full conformance towards the skin-to-skin contact standard, but not so to the breastfeeding standard. The feeding data items in this table only capture data on the first feed whereas the Standard wishes to identify breastfeeding status within the first hour. MSDS in combination with the CSDS captures breast milk feeding information at 3 further stages: <ul style="list-style-type: none"> • Neonatal discharge from hospital (captured in MSDS) • Part of the primary course of immunisation (8, 12, 16 weeks) (captured in CSDS) • As part of the new baby review (normally between 10 and 14 days) plus the 6-to-8-week review (captured in CSDS) Where Maternity Data Providers capture the status in a different way or at a lower level then they should be mapped to an appropriate value stated in the national code list. Further explanation of the national code list is below:	

⁷ England. NICE (2021) NG194 *Postnatal Care* – This guideline was commissioned by NICE and developed in partnership with the Royal College of Obstetricians and Gynaecologists (RCOG). <https://www.nice.org.uk/guidance/ng194> pp: 25

This guideline updates and replaces NICE guideline CG37 (published July 2006).

MSD401 Baby's Demographics and Birth Details		<i>Prev MAT502</i>
	01 Yes - Maternal Breast Milk	For the purpose of this data set, 'maternal breast milk' will refer to any type of human breast milk, from the initial 'Colostrum' through to the richer established breast milk.
	02 Yes - Donor Breast Milk	Where a baby is given breast milk from a wet nurse, the Maternity Data Provider will capture 'donor breast milk'
	03 No - Not Breast Milk	Where a baby is given a form of feed other than breast milk, the Maternity Data Provider will capture 'Not breast milk'. The data set does not have the capacity to record whether the baby initially declined breast milk.
SKIN TO SKIN CONTACT INDICATOR (WITHIN ONE HOUR) <i>Amended data item previously - SKIN TO SKIN CONTACT WITHIN ONE HOUR</i>	<p>An indicator of whether or not baby or babies had skin to skin contact with mother in the first hour of life.</p> <p>This data item is not relevant for stillbirths (this will not be checked by the central system).</p>	
DISCHARGE DATE (BABY POST DELIVERY HOSPITAL PROVIDER SPELL) <i>New Data Item</i>	<p>Date on which the baby was discharged from hospital following delivery, where this is different from the mother's discharge date.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p>	
DISCHARGE TIME (BABY POST DELIVERY HOSPITAL PROVIDER SPELL) <i>New Data Item</i>	<p>Time at which the baby was discharged from hospital following delivery, where this is different from the mother's discharge time.</p> <p>The time should be recorded using the 24-hour clock format in eGIF format i.e., HH:MM:SS.</p>	

6.21 MSD402 Neonatal Admission

MSD402 Neonatal Admission	Amended Table
Description	
<p>This table captures information on each admission to a Neonatal Unit (NNU), and is only designed to capture limited details, such as the fact that a baby was transferred to a neonatal unit and when. This includes babies admitted to all types/levels of neonatal unit, see examples below.</p> <p>Providers only need to include babies in the MSD402 table where they were born at the Trust and then transferred to neonatal units, either within Trust or elsewhere.</p> <p>Multiple occurrences of this table are permitted.</p> <p>However, from the point of view of MSDS v2.0 any baby admitted to an NNU is no longer in scope of the data set. As such, any further NNU activity does not need to be submitted, including any further referrals to a different NNU. This information is captured in the National Neonatal Data Set and the Neonatal Critical Care Minimum Dataset.</p> <p>A 'Neonatal Unit' is defined as:</p> <p><i>A unit which provides additional care for babies over and above the essential core postnatal care that all babies should receive.</i></p> <p>There are different levels of complexity of additional care, defined by British Association of Perinatal Medicine (BAPM) categories, which can be offered by an individual neonatal unit. This table should be used for any admission to a neonatal unit. This could include critical care units, but could also include admissions to Special Care Baby Units (level 1 neonatal units) and Local Neonatal Units (level 2) as defined below:</p> <ul style="list-style-type: none"> • Level 1 - Special Care Baby Units (SCBU): Provide special care for their own local population for babies who do not need intensive care - often, this will be for babies born after 32 weeks' gestation. Also provide, by agreement with their neonatal network, some high dependency services. • Level 2 - Local Neonatal Units (LNU): Provide special care and high dependency care and a restricted volume of intensive care (as agreed locally). Babies who need a higher level of medical and nursing support are cared for here – often, this will be babies between 28- and 32-weeks' gestation. Would expect to transfer babies who require complex or longer-term intensive care to a Neonatal Intensive Care Unit. • Level 3 - Neonatal Intensive Care Unit (NICU): Larger intensive care units that provide the whole range of medical (and sometimes surgical) neonatal care for their local population and additional care for babies and their families referred from the neonatal network in which they are based, and from other networks when necessary to deal with peaks of demand or requests for specialist care not available elsewhere. Many will be sited within perinatal centres that are able to offer similarly complex obstetric care. These units will also require close working arrangements with all the relevant paediatric sub-specialties. 	

MSD402 Neonatal Admission	
Additional Notes on Data Items	
Data Item Name	Additional Notes
<p>LOCAL PATIENT IDENTIFIER (EXTENDED (BABY))</p> <p><i>Amended data item name previously - LOCAL PATIENT IDENTIFIER (BABY)</i></p>	<p>The unique local patient identifier of the baby as generated by the NHS Care Provider. This is not the NHS number.</p> <p>The data item will be captured for all live births and stillbirths.</p> <p>This is the unique system identifier that identifies the baby. This is the primary key that enables tables of data to be joined together. As such this is a mandated item, and the record will be rejected if it is not included within this table.</p> <p>Ideally, babies should have the same Local Patient Identifier (Extended (Baby)) across successive submission periods to make local reconciliation of data easier.</p> <p>Where multiple systems are used it is acceptable to include a prefix to the Local Patient Identifier (Extended (Baby)), which relates to the system. The prefix enables each identifier to remain truly unique for all submissions from an organisation in the event that the same Local Patient Identifier is used to represent two different babies in different systems. However, submitters should ensure that the same Local Patient Identifier is used to identify each distinct baby within a submission file, for example where a baby's records exist on two systems and therefore are potentially associated with different Local Patient Identifiers for the same baby.</p> <p>Duplicate Local Patient Identifiers within the same submission file will cause the entire file to be rejected.</p>
<p>TRANSFER START DATE (NEONATAL UNIT)</p> <p><i>Amended data item previously - TRANSFER START DATE TIME (NEONATAL UNIT)</i></p> <p><i>Amended to separate date time, see data item below.</i></p>	<p>Date on which baby was admitted to Neonatal Unit (NNU).</p> <p>The Transfer Start Date (Neonatal Unit) is equivalent to the Critical Care Start Date when the Critical Care Period for a Neonate begins within the same Healthcare Provider.</p> <p>If Transfer Start Date is not within the reporting period, the table will be rejected.</p> <p>If Transfer Start Date (Neonatal Unit) is before the Person Birth Date (Baby), the record will be rejected.</p> <p>This data item is not relevant for stillbirths (this will not be checked by the central system).</p>
<p>TRANSFER START TIME (NEONATAL UNIT)</p>	<p>Time at which baby was admitted to Neonatal Unit (NNU).</p> <p>Transfer Start Time (Neonatal Unit) is equivalent to the Critical Care Start Time when the Critical Care Period for a Neonate begins within the same Health Care Provider.</p>
<p><i>New Data Item Introduced to separate date time, see data item above</i></p>	<p>The time should be recorded using the 24-hour clock format in eGIF format i.e., HH:MM:SS.</p>

MSD402 Neonatal Admission		<i>Amended Table</i>
<p>ORGANISATION SITE IDENTIFIER (OF ADMITTING NEONATAL UNIT)</p> <p><i>Amended data item previously - SITE CODE (OF ADMITTING NEONATAL UNIT)</i></p>	<p>Organisation Identifier of the Neonatal Unit where the Neonate was transferred to as part of a Maternity Episode.</p> <p>Codes provided will be validated against the NHS Organisation Data Service (ODS).</p> <p>Where Maternity Data Providers capture site information in a different format or at a lower level than the ODS codes, then they should be mapped to an appropriate value stated in the national code list.</p>	
<p>NEONATAL CRITICAL CARE ADMISSION INDICATOR</p> <p><i>New Data Item</i></p>	<p>An indicator of whether or not the baby has been admitted to a Neonatal Critical Care Unit, also known as a Neonatal Intensive Care Unit (NICU). A Neonatal Critical Care Unit delivers high-dependency or intensive (level 3) care to the smallest, most premature, and most unwell babies.</p>	

6.22 MSD403 Provisional Diagnosis (Neonatal)

MSD403 Provisional Diagnosis (Neonatal)		<i>New Table</i>
Description		
<p>To carry details of provisional diagnoses made for the baby by the maternity service.</p> <p>Provisional diagnosis could also be termed a 'working diagnoses.</p> <p>Provisional diagnosis can be used by care professionals who might otherwise feel that they are not qualified, or it would be inappropriate for them, to record a definitive Primary Diagnosis; or where it is too soon after birth to make a definitive diagnosis, but an indication of the likely diagnosis can be recorded.</p> <p>Neonatal unit activity is not expected to be submitted in this table. The table is designed to capture provisional diagnoses carried out by the maternity service for the baby.</p>		
Additional Notes on Data Items		
Data Item Name	Additional Notes	
<p>LOCAL PATIENT IDENTIFIER (EXTENDED (BABY))</p> <p><i>New Data Item</i></p>	<p>The unique local patient identifier of the baby as generated by the NHS Care Provider. This is not the NHS number.</p> <p>The data item will be captured for all live births and stillbirths.</p> <p>This is the unique system identifier that identifies the baby. This is the primary key that enables tables of data to be joined together. As such this is a mandated item, and the record will be rejected if it is not included within this table.</p>	

MSD403 Provisional Diagnosis (Neonatal)	
	<p>Ideally, babies should have the same Local Patient Identifier (Extended (Baby)) across successive submission periods to make local reconciliation of data easier.</p> <p>Where multiple systems are used it is acceptable to include a prefix to the Local Patient Identifier (Extended (Baby)), which relates to the system. The prefix enables each identifier to remain truly unique for all submissions from an organisation in the event that the same Local Patient Identifier is used to represent two different babies in different systems. However, submitters should ensure that the same Local Patient Identifier is used to identify each distinct baby within a submission file, for example where a baby's records exist on two systems and therefore are potentially associated with different Local Patient Identifiers for the same baby.</p> <p>Duplicate Local Patient Identifiers within the same submission file will cause the entire file to be rejected.</p>
<p>DIAGNOSIS SCHEME IN USE <i>New Data Item</i></p>	<p>The code scheme basis of a diagnosis.</p> <p>The value list includes:</p> <ul style="list-style-type: none"> 02 ICD-10 04 Read Coded Clinical Terms Version 2 05 Read Code Clinical Terms Version 3 (CTV3) 06 SNOMED CT
<p>PROVISIONAL DIAGNOSIS (CODED CLINICAL ENTRY) <i>New Data Item</i></p>	<p>This is the Provisional Diagnosis of the person, from a specific classification or clinical terminology, for the main condition treated or investigated during the relevant episode of healthcare.</p> <p>If Provisional Diagnosis (Coded Clinical Entry) format does not match expected format for Diagnosis Scheme In Use, the record will be rejected.</p>
<p>PROVISIONAL DIAGNOSIS DATE <i>New Data Item</i></p>	<p>The date of diagnosis.</p> <p>If Provisional Diagnosis Date is after the Reporting Period End Date, the record will be rejected.</p>

6.23 MSD404 Diagnosis (Neonatal)

MSD404 Diagnosis (Neonatal)	
<i>New Table</i>	
Description	
<p>To carry details of diagnoses made for the baby.</p> <p>Multiple occurrences of this table are permitted.</p> <p>This table will be rejected if there is no valid MSD401 table transmitted for this Local Patient Identifier (Extended (Baby)).</p> <p>If there are more than one MSD404 tables transmitted for a Local Patient Identifier (Extended (Baby)) + Diagnoses (Coded Clinical Entry) + Diagnosis Date combination, then all duplicated tables will be rejected.</p> <p>Neonatal unit activity is not expected to be submitted in this table. The table is designed to capture diagnoses carried out by the maternity service for the baby.</p>	

MSD404 Diagnosis (Neonatal) New Table	
Additional Notes on Data Items	
Data Item Name	Additional Notes
<p>LOCAL PATIENT IDENTIFIER (EXTENDED BABY)</p> <p><i>New Data Item</i></p>	<p>The unique local patient identifier of the baby as generated by the NHS Care Provider. This is not the NHS number.</p> <p>The data item will be captured for all live births and stillbirths.</p> <p>The data set development process has highlighted that the Local Patient Identifier (LPI) is captured for all registerable births.</p> <p>This is the unique system identifier that identifies the baby. This is the primary key that enables tables of data to be joined together. As such this is a mandated item, and the record will be rejected if it is not included within this table.</p> <p>Ideally, babies should have the same Local Patient Identifier (Extended Baby) across successive submission periods to make local reconciliation of data easier.</p> <p>Where multiple systems are used it is acceptable to include a prefix to the Local Patient Identifier (Extended Baby), which relates to the system. The prefix enables each identifier to remain truly unique for all submissions from an organisation.</p> <p>Duplicate Local Patient Identifiers within the same submission file will cause the entire file to be rejected.</p>
<p>DIAGNOSIS SCHEME IN USE</p> <p><i>New Data Item</i></p>	<p>The code scheme basis of a diagnosis.</p> <p>The value list includes:</p> <ul style="list-style-type: none"> 02 ICD-10 04 Read Coded Clinical Terms Version 2 05 Read Code Clinical Terms Version 3 (CTV3) 06 SNOMED CT
<p>DIAGNOSIS (CODED CLINICAL ENTRY)</p> <p><i>New Data Item</i></p>	<p>This is the Diagnosis of the person from a specific classification or clinical terminology, for the main condition treated or investigated during the relevant episode of healthcare.</p> <p>If Diagnosis (Coded Clinical Entry) format does not match expected format for Diagnosis Scheme In Use, the record will be rejected.</p>
<p>DIAGNOSIS DATE</p> <p><i>New Data Item</i></p>	<p>The date of Diagnosis.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p>

6.24 MSD405 Care Activity (Baby)

MSD405 Care Activity (Baby)		New Table
Description		
<p>To carry details of any activities for the baby which have taken place prior to discharge from Maternity Services.</p> <p>For example, this could include immunisation and screening information for the baby where carried out by the maternity service, such as:</p> <ul style="list-style-type: none"> • Bacillus Calmette–Guérin (BCG) vaccination (for eligible babies) • Neonatal hepatitis B dose (for eligible babies) • Newborn physical examination results <p>The birthweight of the baby and Apgar scores can also be captured in this table as clinical procedures, observations, and findings.</p> <p>Multiple occurrences of this table are permitted.</p> <p>This table will be rejected if there is no valid MSD401 table transmitted for this Local Patient Identifier (Extended (Baby)).</p> <p>If there are more than one MSD405 tables transmitted for a Care Activity Identifier (Baby), then all duplicated tables will be rejected.</p> <p>Further information about the structure of care activity tables can be found in Appendix 2.</p>		
Additional Notes on Data Items		
Data Item Name	Additional Notes	
CARE ACTIVITY IDENTIFIER (BABY) <i>New Data Item</i>	<p>The unique identifier for a Care Activity for a baby.</p> <p>It would normally be automatically generated by the local system upon recording a new activity, although could be manually assigned.</p>	
LOCAL PATIENT IDENTIFIER (EXTENDED (BABY)) <i>New Data Item</i>	<p>The unique local patient identifier of the baby as generated by the NHS Care Provider. This is not the NHS number.</p> <p>The data item will be captured for all live births and stillbirths.</p> <p>This is the unique system identifier that identifies the baby. This is the primary key that enables tables of data to be joined together. As such this is a mandated item, and the record will be rejected if it is not included within this table.</p> <p>Ideally, babies should have the same Local Patient Identifier (Extended (Baby)) across successive submission periods to make local reconciliation of data easier.</p> <p>Where multiple systems are used it is acceptable to include a prefix to the Local Patient Identifier (Extended (Baby)), which relates to the system. The prefix enables each identifier to remain truly unique for all submissions from an organisation in the event that the same Local Patient Identifier is used to represent two different babies in different systems.</p> <p>However, submitters should ensure that the same Local Patient Identifier is used to identify each distinct baby within a submission file, for example where a baby’s records exist on two systems and</p>	

MSD405 Care Activity (Baby)	
<i>New Table</i>	
	<p>therefore are potentially associated with different Local Patient Identifiers for the same baby.</p> <p>Duplicate Local Patient Identifiers within the same submission file will cause the entire file to be rejected.</p>
<p>CLINICAL INTERVENTION DATE (BABY)</p> <p><i>New Data Item</i></p>	<p>The date on which a Clinical Intervention took place for the baby.</p> <p>For the purposes of MSDS v2.0, clinical interventions are synonymous with care activities and the clinical intervention date can be considered the same as the care activity date. This item can therefore be used to represent the date that any submitted activity within scope of the data set took place.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD.</p>
<p>CLINICAL INTERVENTION TIME (BABY)</p> <p><i>New Data Item</i></p>	<p>The time at which a Clinical Intervention took place for the baby.</p> <p>For the purposes of MSDS v2.0, clinical interventions are synonymous with care activities and the clinical intervention date can be considered the same as the care activity time. This item can therefore be used to represent the time that any submitted activity within scope of the data set took place.</p> <p>The time should be recorded using the 24-hour clock format in eGIF format i.e., HH:MM:SS.</p>
<p>CLINICAL CONTACT DURATION OF CARE ACTIVITY</p> <p><i>New Data Item</i></p>	<p>The duration of a Care Activity in minutes, excluding any administration time prior to or after the Care Activity and the Care Professional's travelling time to the Location where the Care Activity was provided.</p> <p>This is calculated from the Start Time and End Time of the Care Activity.</p>
<p>CARE PROFESSIONAL LOCAL IDENTIFIER</p> <p><i>New Data Item</i></p>	<p>Care Professional Local Identifier is a unique local Care Professional Identifier within a Health Care Provider and may be assigned automatically by the computer system.</p> <p>This data item is intended to capture details of the individual who delivered the care activity to the mother.</p> <p>Where multiple Care Professionals are involved in a single Care Activity, a 'lead' Care Professional should be allocated to the Care Activity. There is no requirement to duplicate records for a single Care Activity for each involved Care Professional.</p> <p>The Care Professional Local Identifier is captured in several tables (MSD102 Maternity Care Plan, MSD202 Care Activity (Pregnancy), MSD302 Care Activity (Labour and Delivery), MSD401 Baby's Demographics and Birth Details (N.B. named 'Care Professional Local Identifier (Delivering Baby)'), MSD405 Care Activity (Baby) and MSD504 Assigned Care Professional) to allow the recording and subsequent monitoring of continuity of carer information, where applicable.</p> <p>The identifier captured in this data item can be linked to the MSD901 Staff Details look up table.</p>

MSD405 Care Activity (Baby)		<i>New Table</i>
<p>CARE PROFESSIONAL TEAM LOCAL IDENTIFIER</p> <p><i>New Data Item</i></p>	<p>Care Professional Team Local Identifier is a unique Local Care Professional Team Identifier within a Health Care Provider and may be assigned automatically by the computer system.</p> <p>This data item is intended to capture details of the team who delivered the care activity to the mother.</p> <p>The Care Professional Team Local Identifier is captured in several tables (MSD102 Maternity Care Plan, MSD202 Care Activity (Pregnancy), MSD302 Care Activity (Labour and Delivery), MSD405 Care Activity (Baby) and MSD504 Assigned Care Professional) to allow the recording and subsequent monitoring of continuity of carer information, where applicable.</p> <p>For further guidance about the makeup of a local team, see the NHS England Implementing Better Births: Continuity of Carer guidance (specifically page 19).</p>	
<p>NEONATAL CRITICAL INCIDENT INDICATOR</p> <p><i>New Data Item</i></p>	<p>Whether or not a neonatal critical incident occurred.</p> <p>To capture where a baby suffered a critical incident during or immediately after birth.</p> <p>Note:</p> <p>Use the 'critical incident indicator' to associate against the single specific activity that is deemed to be the 'critical incident'</p> <p>Only one 'critical incident indicator' is required.</p> <p>The 'critical incident indicator' may appear in the MSD302 rather than MSD405.</p>	
<p>PROCEDURE SCHEME IN USE</p> <p><i>New Data Item</i></p>	<p>The code scheme basis of a procedure.</p> <p>If Coded Procedure and Procedure Status (Coded Clinical Entry) is populated, Procedure Scheme in Use must contain a valid value, or the record will be rejected.</p> <p>Value list includes:</p> <ul style="list-style-type: none"> 02 OPCS-4 04 Read Coded Clinical Terms Version 2 05 Read Coded Clinical Terms Version 3 (CTV3) 06 SNOMED CT 	
<p>CODED PROCEDURE AND PROCEDURE STATUS (CODED CLINICAL ENTRY)</p> <p><i>New Data Item</i></p>	<p>A unique identifier for a procedure from a specific classification or clinical terminology, plus the status of a procedure where SNOMED CT codes are used.</p> <p>This item can be used to record the specific activity that was undertaken within the Care Contact, through the submission of a clinical terminology or classification code(s).</p> <p>A SNOMED CT post-coordinated expression can be used to represent the status of a procedure, for example whether it was offered or declined.</p> <p>Procedure: "represents activities performed in the provision of health care. This includes not only invasive procedures but also administration of medicines, imaging, education, therapies and administrative procedures" – SNOMED CT Starter Guide - Section 6 (page 21 onwards)</p>	

MSD405 Care Activity (Baby)		<i>New Table</i>
	<p>For example, for a blood pressure test this would represent the clinical procedure, e.g., a code for 'blood pressure taking'.</p> <p>For further information on SNOMED CT Expressions, see the SNOMED CT Glossary at: Expression.</p> <p><u>Examples of appropriate SNOMED CT codes</u></p> <p>Post-coordinated expression (procedure + qualifier)</p> <p>To flow a procedure and qualifier, three pieces of information are required:</p> <ul style="list-style-type: none"> • The procedure code • The qualifier code • A code that links the procedure and the qualifier <p>The three codes are concatenated for submission.</p> <p>Precoordinated expression (procedure only)</p> <p>Procedure only flows as a single code:</p> <p>116859006: Transfusion of blood product (procedure)</p> <p>For this example, in the absence of an additional qualifier, we will assume that the procedure has been 'delivered'. This also applies to OPCS-4, Read 2 and CTV3 codes submitted for this data item where post-coordination is not possible.</p>	
<p>FINDING SCHEME IN USE</p> <p><i>New Data Item</i></p>	<p>The code scheme basis of a finding.</p> <p>If Coded Finding (Coded Clinical Entry) is populated, Finding Scheme in Use must contain a valid value, or the record will be rejected.</p>	
<p>CODED FINDING (CODED CLINICAL ENTRY)</p> <p><i>New Data Item</i></p>	<p>A unique identifier for a finding from a specific classification or clinical terminology.</p> <p>This data item should be used to report any Findings captured during the Care Activity.</p> <p>Finding: "represents the result of a clinical observation, assessment or judgment and includes normal and abnormal clinical states" – SNOMED CT Starter Guide - Section 6 (page 21 onwards)</p> <p>For example, for a blood pressure test this would represent the clinical finding, e.g., a code for 'high blood pressure'.</p>	
<p>OBSERVATION SCHEME IN USE</p> <p><i>New Data Item</i></p>	<p>The code scheme basis of an Observation.</p> <p>If Coded Observation (Clinical Terminology) is populated, Observation Scheme In Use must contain a valid value, or the record will be rejected.</p> <p>The value list includes:</p> <ul style="list-style-type: none"> 01 Read Coded Clinical Terms Version 2 02 Read Coded Clinical Terms Version 3 (CTV3) 03 SNOMED CT 	

MSD405 Care Activity (Baby)		<i>New Table</i>
<p>CODED OBSERVATION (CLINICAL TERMINOLOGY)</p> <p><i>New Data Item</i></p>	<p>A unique identifier for an observation from a specific clinical terminology.</p> <p>This data item should be used to report any Observations captured during the Care Activity.</p> <p>Observation: “represents a question or assessment which can produce an answer or result” – SNOMED CT Starter Guide - Section 6 (page 21 onwards)</p> <p>For example, for a blood pressure test this would represent the observation carried out, e.g., a code denoting that ‘systolic blood pressure’ is being observed.</p>	
<p>OBSERVATION VALUE</p> <p><i>New Data Item</i></p>	<p>The numeric value resulting from a clinical Observation.</p> <p>For example, for a blood pressure test this would represent the measured value from the blood pressure test, e.g., ‘120’.</p> <p>The value entered must be accurate and not an approximation. If there isn’t sufficient evidence to arrive at an accurate value, please refrain from entering a value that can be misinterpreted or is imprecise.</p> <p>NB: If OBSERVATION VALUE is populated and the UCUM UNIT OF MEASUREMENT is blank, a warning will be reported.</p>	
<p>UCUM UNIT OF MEASUREMENT</p> <p><i>New Data Item</i></p>	<p>The unit of measurement used to measure the result of a clinical OBSERVATION. See http://unitsofmeasure.org/trac/.</p> <p>For example, for a blood pressure test this would represent the unit of measurement for the blood pressure test, e.g., ‘m Hg’.</p>	
<p>ORGANISATION IDENTIFIER (NEWBORN BLOOD SPOT SCREENING LABORATORY)</p> <p><i>Amended data item previously – LABORATORY IDENTIFIER (NEWBORN BLOOD SPOT SCREENING)</i></p>	<p>This identifies the Laboratory undertaking the Clinical Investigation for Newborn Blood Spot Test within a Maternity Episode.</p>	

6.25 MSD406 Coded Scored Assessment (Baby)

MSD406 Coded Scored Assessment (Baby)		<i>New Table</i>
Description		
<p>To carry details of coded scored assessments that are completed for the baby prior to discharge from Maternity Services.</p> <p>Currently, no specific scored assessments for babies have yet been identified. Once appropriate scored assessments have been identified and licenses obtained, details will be added to the 'MSDS Assessment Scales' tab in the Technical Output Specification.</p> <p>One occurrence of this table is permitted for each coded scored observation question or dimension, as represented by a distinct SNOMED CT code.</p>		
Additional Notes on Data Items		
Data Item Name	Additional Notes	
<p>CARE ACTIVITY IDENTIFIER (BABY) <i>New Data Item</i></p>	<p>The unique identifier for a CARE ACTIVITY for a baby.</p> <p>It would normally be automatically generated by the local system upon recording a new activity, although could be manually assigned.</p>	
<p>CODED ASSESSMENT TOOL TYPE (SNOMED CT) <i>New Data Item</i></p>	<p>The SNOMED CT concept ID which is used to identify an Assessment in SNOMED CT.</p>	
<p>PERSON SCORE <i>New Data Item</i></p>	<p>The observable value (score) resulting from an Assessment.</p>	

6.26 MSD501 Hospital Provider Spell

MSD501 Hospital Provider Spell		<i>Amended Table</i>
Description		
<p>To carry details of each Hospital Provider Spell for the mother, where they were in contact with the maternity service. This is a continuous period of inpatient care under a single Hospital Provider starting with a hospital admission and ending with a discharge from hospital. This includes any hospital admissions for the mother during the maternity episode (i.e., both antenatal and postnatal admissions) but does not include admission for labour and delivery.</p> <p>If the mother had a hospital provider spell where she did not have any contact with the maternity service at all, then this would not need submitting to either the MSD501 Hospital Provider Spell or MSD201 Care Contact (Pregnancy) / MSD202 Care Activity (Pregnancy) tables.</p> <p>In the MSD501 Hospital Provider Spell table and associated tables, we only expect providers to capture spells that relate to care delivered by their maternity service; in practice this will relate to the 3 treatment functions identified in the MSD504 Assigned Care Professional table.</p> <p>One occurrence of this group is permitted for each Hospital Provider Spell.</p>		

MSD501 Hospital Provider Spell		<i>Amended Table</i>
Additional Notes on Data Items		
Data Item Name	Additional Notes	
HOSPITAL PROVIDER SPELL NUMBER <i>New Data Item</i>	A unique identifier for each Hospital Provider Spell for a Health Care Provider.	
PREGNANCY IDENTIFIER <i>New Data Item</i>	This is the unique identifier allocated to each maternity episode. Use of the Pregnancy Identifier uniquely identifies each pregnancy allowing the details of different pregnancies to be reconciled. It would normally be automatically generated by the local system upon recording a new pregnancy (at booking appointment/ first contact), although could be manually assigned. This is a foreign key that enables this table to be joined to the Pregnancy and Booking Details table. As such this is a mandated item, and the record will be rejected if it is not included within this group.	
START DATE (HOSPITAL PROVIDER SPELL) <i>Amended data item previously - START DATE TIME (HOSPITAL PROVIDER SPELL ANTENATAL)</i> <i>Amended to take account of date time split.</i>	The start date of a Hospital Provider Spell. This should be recorded in the eGIF Date format CCYY-MM-DD	
START TIME (HOSPITAL PROVIDER SPELL) <i>New Data Item</i> <i>Introduced to separate date time, see data item above.</i>	The start time of a Hospital Provider Spell.	
SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL) <i>New Data Item</i>	The source of admission to a Hospital Provider Spell or a Nursing Episode when the mother is in a Hospital Site or a Care Home. National Code 51 'NHS other hospital provider - WARD for general PATIENTS or the younger physically disabled or A & E department' should not be used if the patient arrives at an Accident and Emergency Department and is admitted to the same Hospital Provider.	
PATIENT CLASSIFICATION CODE <i>New Data Item</i>	A coded classification of patients who have been admitted to a Hospital Provider Spell.	

MSD501 Hospital Provider Spell		<i>Amended Table</i>
<p>ADMISSION METHOD CODE (HOSPITAL PROVIDER SPELL)</p> <p><i>New Data Item</i></p>	<p>The method of admission to a Hospital Provider Spell.</p>	
<p>DISCHARGE DATE (HOSPITAL PROVIDER SPELL)</p> <p><i>Amended data item previously - DISCHARGE DATE TIME (HOSPITAL PROVIDER SPELL POSTPARTUM)</i></p> <p><i>Amended to take account of date time split.</i></p>	<p>The discharge date from a Hospital Provider Spell.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p> <p>Date of in-patient discharge from hospital, after readmission in the postpartum period. Validations if Discharge Date (Hospital Provider Spell) is populated:</p> <p>If it is not within the reporting period, the table will be rejected.</p> <p>If it is before the Start Date (Hospital Provider Spell), the table will be rejected.</p>	
<p>DISCHARGE TIME (HOSPITAL PROVIDER SPELL)</p> <p><i>New Data Item Introduced to separate date time, see data item above.</i></p>	<p>The discharge time from a Hospital Provider Spell.</p> <p>The time should be recorded using the 24-hour clock format in eGIF format i.e., HH:MM:SS.</p>	
<p>DISCHARGE METHOD CODE (HOSPITAL PROVIDER SPELL)</p> <p><i>New Data Item</i></p>	<p>The method of discharge from a Hospital Provider Spell.</p>	
<p>DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL)</p> <p><i>New Data Item</i></p>	<p>The destination of a PATIENT on completion of a Hospital Provider Spell, or a note that the PATIENT died.</p>	

6.27 MSD502 Hospital Spell Commissioner

MSD502 Hospital Spell		<i>New Table</i>
Description		
<p>To carry details of each commissioner assignment for the hospital provider spell.</p> <p>Please note that the commissioner recorded in these tables is the commissioner of the maternity service, not the commissioner of the woman's GP practice (captured in the MSD002 table) or their resident commissioner, i.e., their commissioner based on their home address, which is captured in the MSD001 table.</p> <p>One occurrence of this Group is permitted for each Commissioner Assignment Period.</p>		
Additional Notes on Data Items		
Data Item Name	Additional Notes	
<p>HOSPITAL PROVIDER SPELL NUMBER</p> <p><i>New Data Item</i></p>	<p>A unique identifier for each Hospital Provider Spell for a Health Care Provider.</p>	
<p>ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)</p> <p><i>New Data Item</i></p>	<p>This is the Organisation Identifier of the Organisation commissioning health care.</p> <p>This is the commissioner of the service or trust they are admitted to. This is not necessarily the same as the commissioner of the GP practice, captured in the MSD002 table.</p> <p>In practice the Organisation Identifier (Code of Commissioner) in MSD502 will be the commissioner for your maternity service as you wouldn't be expected to record Hospital Provider Spells that originated with a different provider.</p> <p>This item is being captured to allow replication of functionality in CDS Maternity Tails (to allow the eventual retirement of this element of CDS).</p>	
<p>START DATE (COMMISSIONER ASSIGNMENT PERIOD)</p> <p><i>New Data Item</i></p>	<p>The Start Date of the Commissioner Assignment Period.</p> <p>Assignment period is the period of time when a specific commissioner was commissioning a particular service.</p> <p>The start and end dates are designed to account for any changes in the commissioner of the service during the period that a patient is admitted. In practice these start, and end dates may well correspond with the Start Date (Hospital Provider Spell) and Discharge Date (Hospital Provider Spell) in the MSD501 table.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p>	
<p>END DATE (COMMISSIONER ASSIGNMENT PERIOD)</p> <p><i>New Data Item</i></p>	<p>The End Date of the Commissioner Assignment Period.</p> <p>Assignment period is the period of time when a specific commissioner was commissioning a particular service.</p> <p>The start and end dates are designed to account for any changes in the commissioner of the service during the period that a patient is admitted. In practice these start, and end dates may well correspond with the Start Date (Hospital Provider Spell) and Discharge Date (Hospital Provider Spell) in the MSD501 table.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p>	

6.28 MSD503 Ward Stay

MSD503 Ward Stay		<i>New Table</i>
Description		
<p>To carry details of Ward Stays which occurred during a Hospital Provider Spell for the mother.</p> <p>This table should contain a record for each stay of a patient on a ward during an inpatient stay. A separate record should be created if the patient moves to a different ward.</p> <p>One occurrence of this table is permitted for each ward stay.</p>		
Additional Notes on Data Items		
Data Item Name	Additional Notes	
HOSPITAL PROVIDER SPELL NUMBER <i>New Data Item</i>	A unique identifier for each Hospital Provider Spell for a Healthcare Provider.	
START DATE (WARD STAY) <i>New Data Item</i>	The start date of a ward stay. This should be recorded in the eGIF Date format CCYY-MM-DD.	
START TIME (WARD STAY) <i>New Data Item</i>	The start time of a ward stay. The time should be recorded using the 24-hour clock format in eGIF format i.e., HH:MM:SS.	
END DATE (WARD STAY) <i>New Data Item</i>	The end date of a ward stay. This should be recorded in the eGIF Date format CCYY-MM-DD.	
END TIME (WARD STAY) <i>New Data Item</i>	The end time of a ward stay. The time should be recorded using the 24-hour clock format in eGIF format i.e., HH:MM:SS.	
ORGANISATION SITE IDENTIFIER (OF TREATMENT) <i>New Data Item</i>	Organisation Site Identifier (Of Treatment) is the Organisation Identifier of the Organisation Site where the Patient was treated.	
WARD CODE <i>New Data Item</i>	A unique identification of a ward within a Healthcare Provider. WARD CODE is an optional item for local reporting purposes only, such as with local commissioners. It must NOT contain any text which may identify the patient diagnosis of the patients using the ward (for example, it must not include the acronym 'HIV') or the Patient Procedure being undertaken (for example using the acronym 'TOP' for terminations of pregnancy). Use of such identifiers contravenes the legal requirements for withholding identifiable information about patients with identified conditions.	

6.29 MSD504 Assigned Care Professional

MSD504 Assigned Care Professional		New Table
Description		
<p>To carry details of the Care Professional Admitted Care Episodes during a Hospital Provider Spell for the mother.</p> <p>One occurrence of this table is permitted for each Care Professional Admitted Care Episode.</p> <p>This is defined as a continuous period of care for a patient under the responsibility of a consultant, nurse, or other healthcare professional.</p> <p>Please note that a separate record should be included for each change in responsible consultant, nurse, or other healthcare professional.</p> <p>Note: This table looks to capture the care professionals that have been responsible for the mother's maternity care, rather than track the exact date and time that each professional was involved in the mother's care. As such it would be acceptable to submit a single record for the care professional who starts caring for the mother at two separate times on the same day.</p>		
Additional Notes on Data Items		
Data Item Name	Additional Notes	
<p>HOSPITAL PROVIDER SPELL NUMBER</p> <p><i>New Data Item</i></p>	<p>A unique identifier for each Hospital Provider Spell for a Health Care Provider.</p>	
<p>CARE PROFESSIONAL LOCAL IDENTIFIER</p> <p><i>New Data Item</i></p>	<p>Care Professional Local Identifier is a unique local Care Professional Identifier within a Health Care Provider and may be assigned automatically by the computer system.</p> <p>This data item is intended to capture details of the lead care professional who is responsible for the care given to the mother during this hospital spell.</p> <p>Where multiple Care Professionals are involved in a single Care Activity, a 'lead' Care Professional should be allocated to the Care Activity. There is no requirement to duplicate records for a single Care Activity for each involved Care Professional.</p> <p>The Care Professional Local Identifier is captured in several tables (MSD102 Maternity Care Plan, MSD202 Care Activity (Pregnancy), MSD302 Care Activity (Labour and Delivery), MSD401 Baby's Demographics and Birth Details (N.B. named 'Care Professional Local Identifier (Delivering Baby)'), MSD405 Care Activity (Baby) and MSD504 Assigned Care Professional) to allow the recording and subsequent monitoring of continuity of carer information, where applicable.</p> <p>The identifier captured in this data item can be linked to the MSD901 Staff Details look up table.</p>	

MSD504 Assigned Care Professional	
<p>CARE PROFESSIONAL TEAM LOCAL IDENTIFIER</p> <p><i>New Data Item</i></p>	<p>Care Professional Team Local Identifier is a unique Local Care Professional Team Identifier within a Health Care Provider and may be assigned automatically by the computer system.</p> <p>This data item is intended to capture details of the team who are responsible for the care given to the mother during this hospital spell.</p> <p>The Care Professional Team Local Identifier is captured in several tables (MSD102 Maternity Care Plan, MSD202 Care Activity (Pregnancy), MSD302 Care Activity (Labour and Delivery), MSD405 Care Activity (Baby) and MSD504 Assigned Care Professional) to allow the recording and subsequent monitoring of continuity of carer information, where applicable.</p> <p>For further guidance about the makeup of a local team, see the NHS England Implementing Better Births: Continuity of Carer guidance (specifically page 19).</p>
<p>START DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)</p> <p><i>New Data Item</i></p>	<p>The start date of an assignment of a Care Professional responsible for the care of the patient.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p> <p>If START DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE) is after the DISCHARGE DATE (HOSPITAL PROVIDER SPELL), the record will be rejected.</p>
<p>END DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE)</p> <p><i>New Data Item</i></p>	<p>The end date of an assignment of a Care Professional responsible for the care of the patient.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p> <p>If END DATE (CARE PROFESSIONAL ADMITTED CARE EPISODE) is not within the reporting period, the record will be rejected.</p>
<p>TREATMENT FUNCTION CODE (MATERNITY)</p> <p><i>New Data Item</i></p>	<p>The TREATMENT FUNCTION CODE for the PATIENT treated by a Maternity Service.</p> <p>Value list includes:</p> <ul style="list-style-type: none"> 501 Obstetrics 502 Gynaecology 560 Midwifery Service

6.30 MSD601 Anonymous Self-Assessment

MSD601 Anonymous Self-Assessment
<p>Description</p>
<p>To carry details of anonymous self-assessments that are issued by Maternity Services.</p> <p>One occurrence of this table is permitted when an anonymous self-assessment is received from a mother.</p> <p>This table is not linked to the rest of MSDS at patient level.</p> <p>There are currently no assessment tools in scope for MSD601 Anonymous Self-Assessment. Any records submitted in this table will be rejected.</p>

MSD601 Anonymous Self-Assessment		<i>New Table</i>
<p>The table was added to MSDS v2.0 in an attempt to futureproof the data set should any anonymous assessments (e.g., patient reported outcome measures or surveys) be required to flow in the future. This table will allow such measures to flow in future, once identified as a requirement for submission at which point, a list of accepted assessments (and accompanying SNOMED CT codes) will be added within the Technical Output Specification. Therefore, you do not need to support the flow of information into this table at present.</p>		
Additional Notes on Data Items		
Data Item Name	Additional Notes	
<p>ASSESSMENT TOOL COMPLETION DATE <i>New Data Item</i></p>	<p>SELF ASSESSMENT COMPLETION DATE is the DATE the completed ASSESSMENT was received.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p>	
<p>CODED ASSESSMENT TOOL TYPE (SNOMED CT) <i>New Data Item</i></p>	<p>The SNOMED CT concept ID which is used to identify an ASSESSMENT in SNOMED CT.</p> <p>If CODED ASSESSMENT TOOL TYPE (SNOMED CT) is not in MSDS Assessment Tools reference table, the record will be rejected.</p>	
<p>PERSON SCORE <i>New Data Item</i></p>	<p>The observable value (score) resulting from an ASSESSMENT.</p> <p>If PERSON SCORE is not within the expected range for the CODED ASSESSMENT TOOL TYPE (SNOMED CT) submitted, a warning will be reported.</p>	
<p>ACTIVITY LOCATION TYPE CODE <i>New Data Item</i></p>	<p>The type of physical LOCATION where PATIENTS complete the self-assessment.</p> <p>This data item should be completed where available.</p> <p>Where contact is not face to face the Activity Location Type Code of the patient should be used; not the location of the clinician.</p>	
<p>ORGANISATION IDENTIFIER (CODE OF COMMISSIONER) <i>New Data Item</i></p>	<p>This is the ORGANISATION IDENTIFIER of the ORGANISATION commissioning health care.</p> <p>If ORGANISATION IDENTIFIER (CODE OF COMMISSIONER) is not in national organisation tables as a "live" organisation at any point during the reporting period, a warning will be reported.</p>	

6.31 MSD602 Anonymous Findings

MSD602 Anonymous Findings	<i>New Table</i>
Description	
<p>To carry details of anonymous findings that are recorded by Maternity Services.</p> <p>One occurrence of this table is permitted for each anonymous finding recorded for a mother.</p> <p>This table is not linked to the rest of MSDS at patient level.</p>	

MSD602 Anonymous Findings		<i>New Table</i>
<p>This table can be used to flow (anonymously) findings that are contained within a restricted list/refset that would otherwise be rejected if flowed elsewhere in the data set.</p> <p>NHS Digital continues to investigate the legal and regulatory implications of submitting certain data (e.g., IVF information) to the MSDS. This document will be updated to specify information that cannot be submitted in an identifiable form and therefore needs to be submitted using this table.</p> <p>However, providers may wish to flow information that would have previously been submitted in the MAT901-906 tables in MSDS v1.5 in the MSD602 table in MSDS v2.0 – the appropriate SNOMED CT codes are set out in the MSDS SNOMED CT mapping document on the NHS Digital website (see 'MAT901-MAT906' tab).</p>		
Additional Notes on Data Items		
Data Item Name	Additional Notes	
<p>CLINICAL INTERVENTION DATE</p> <p><i>New Data Item</i></p>	<p>The date on which a Clinical Intervention took place.</p> <p>This should be recorded in the eGIF Date format CCYY-MM-DD</p> <p>For the purposes of MSDS v2.0, clinical interventions are synonymous with care activities and the clinical intervention date can be considered the same as the care activity date. This item can therefore be used to represent the date that any submitted activity within scope of the data set took place. In the MSD602 table, this is likely to include the date that the diagnosis of a specific condition was made.</p> <p>If CLINICAL INTERVENTION DATE is not within the reporting period, the record will be rejected.</p>	
<p>FINDING SCHEME IN USE</p> <p><i>New Data Item</i></p>	<p>The code scheme basis of a finding.</p> <p>The value list includes:</p> <ul style="list-style-type: none"> 01 ICD-10 02 Read Coded Clinical Terms Version 2 03 Read Coded Clinical Terms Version 3 (CTV3) 04 SNOMED CT 	
<p>CODED FINDING (CODED CLINICAL ENTRY)</p> <p><i>New Data Item</i></p>	<p>A unique identifier for a finding from a specific classification or clinical terminology.</p> <p>If FINDING SCHEME IN USE is populated and CODED FINDING (CODED CLINICAL ENTRY) is blank, then a warning will be generated.</p> <p>If CODED FINDING (CODED CLINICAL ENTRY) format does not match expected format for the specific FINDING SCHEME IN USE (see Technical Glossary), the record will be rejected.</p>	
<p>ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)</p> <p><i>New Data Item</i></p>	<p>This is the ORGANISATION IDENTIFIER of the ORGANISATION commissioning health care.</p> <p>If ORGANISATION IDENTIFIER (CODE OF COMMISSIONER) is not in national organisation tables as a "live" organisation at any point during the reporting period, a warning will be reported.</p>	

6.32 MSD901 Staff Details

MSD901 Staff Details		<i>New Table</i>
Description		
<p>To carry details of the staff involved in the treatment of a mother or baby.</p> <p>This table should include one record for every Health Professional (responsible for providing care to the mother or baby), including lead care professionals, key workers, care coordinators, supervised clinicians and any other staff member who has clinical contact with a patient.</p> <p>Where a member of staff has multiple roles, a separate record with different Care Professional Local Identifier should be created to enable appropriate linkage to activity.</p> <p>One occurrence of this table is permitted for each staff member.</p>		
Additional Notes on Data Items		
Data Item Name	Additional Notes	
<p>CARE PROFESSIONAL LOCAL IDENTIFIER</p> <p><i>New Data Item</i></p>	<p>Care Professional Local Identifier is a unique local Care Professional Identifier within a Health Care Provider and may be assigned automatically by the computer system.</p> <p>The Care Professional Local Identifier is captured in several tables (MSD102 Maternity Care Plan, MSD202 Care Activity (Pregnancy), MSD302 Care Activity (Labour and Delivery), MSD401 Baby's Demographics and Birth Details (N.B. named 'Care Professional Local Identifier (Delivering Baby)'), MSD405 Care Activity (Baby) and MSD504 Assigned Care Professional) to allow the recording and subsequent monitoring of continuity of carer information, where applicable. This information can then be linked to the MSD901 table to provide further details about the staff member delivering specific activity.</p>	
<p>PROFESSIONAL REGISTRATION BODY CODE</p> <p><i>New Data Item</i></p>	<p>A code which identifies the Professional Registration Body or Representative Body.</p>	
<p>PROFESSIONAL REGISTRATION ENTRY IDENTIFIER</p> <p><i>New Data Item</i></p>	<p>The registration identifier allocated by the Professional Registration Body or Representative Body.</p>	
<p>CARE PROFESSIONAL STAFF GROUP (MATERNITY)</p> <p><i>New Data Item</i></p>	<p>The staff group of a Care Professional working in a Maternity Service.</p> <p>The value list includes:</p> <ul style="list-style-type: none"> 01 NHS Consultant Obstetrician 02 NHS Obstetrician - non-consultant grade 03 Private Consultant Obstetrician 04 Private Obstetrician - non-consultant grade 05 NHS employed Midwife 06 Midwife employed by private company contracted to the NHS 	

MSD901 Staff Details		<i>New Table</i>
	<p>07 Independent Midwife 08 Student Midwife 09 Midwifery support staff 10 Gynaecologist 11 General Medical Practitioner 12 Nurse 13 Health Visitor 14 Sonographer 15 Anaesthetist 16 Physiotherapist 98 Other care professional</p>	
<p>OCCUPATION CODE <i>New Data Item</i></p>	<p>An NHS Occupation Code for an Employee filling a Position.</p> <p>The NHS Occupation Codes are maintained by NHS Digital, on behalf of the Department of Health and Social Care (DHSC) and can be viewed in the NHS Occupation Code Manual.</p> <p>Occupation codes are the traditional way of identifying numbers of staff in particular work sectors of the NHS in a consistent way. Occupation codes cover all staff in the Maternity Service, both medical and non-medical.</p> <p>The manual covers NHS staff by their main functional groupings and is arranged in the following sections:</p> <ul style="list-style-type: none"> A - Ambulance staff G - Administration and Estates staff H - Health care assistants and other support staff M - Medical and dental staff N - Nursing, midwifery and health visiting staff P - Nursing, midwifery and health visiting learners S - Scientific, therapeutic, and technical staff T - Healthcare Scientists Z - General payments <p>Note: The occupation codes are based on staff roles and make no direct reference to pay scale information.</p>	
<p>CARE PROFESSIONAL (JOB ROLE CODE) <i>New Data Item</i></p>	<p>A National Code for a Position applicable to an employee.</p> <p>Student or agency work should be recorded under the relevant professional group.</p> <p>The values that should be used in this field can be found on the NHS Data Dictionary website.</p> <p>This information would normally be held in the Electronic Staff Record (ESR) system, so linkage with this system may be required in order to supply this information within MSDS.</p>	

Appendix 1 – Abbreviations and Glossary

Please refer to the glossary of terms found in the MSDS v2.0 Requirements Specification:

<https://digital.nhs.uk/binaries/content/assets/website-assets/isce/dcb1513/1513102018reqspec.pdf>

Appendix 2 – Care Activity table guidance

As clarified in Section 3.3, NHS Digital are not placing any restrictions on the activities that service providers can submit using clinical terminology.

The following table provides a high-level illustration and basic example of the purpose and relationship between each data item within the Care Activity tables within MSDS:

Hierarchy	Description	Example term	Example code
Procedure	Represents activities performed in the provision of health care. This includes not only invasive procedures but also administration of medicines, imaging, education, therapies, and administrative procedures. For example, taking blood pressure	'Measurement of blood pressure in left arm (procedure)'	990141000000106
Finding	Represents the result of a clinical observation, assessment or judgment and includes normal and abnormal clinical states	'Normal blood pressure (finding)'	2004005
Observation	Represents a question or assessment which can produce an answer or result	'Blood pressure (observable entity)'	75367002
Observation Value	Represents the value of the observation	120/80	N/A
Unit of Measure	Represents the unit of measure of the observation value	m Hg	N/A
Scheme in use	Represents the type of clinical classification or terminology submitted	SNOMED CT	04

Further information with regard to the concept model of SNOMED CT can be found within the [SNOMED CT Starter Guide](#), in particular please see section 6.

Appendix 3 – Example of a test requiring multiple care activities to be recorded in the MSD202 Care Activity (Pregnancy) table

There may be instances where an individual test requires multiple care activities to be submitted in order to capture the procedure undertaken, the observation recorded (with associated value and unit of measurement, where applicable) and an associated finding.

The illustrative example below shows how a carbon monoxide test is recorded, which has a distinct procedure (describing the test being carried out), observation (the numeric score of the test) and finding (the mother is a smoker). Each is given a distinct Care Activity Identifier.

CareActIDMother	ProcedureScheme	ProcedureCode	FindingScheme	FindingCode	ObsScheme	ObsCode	ObsValue	UCUMUnit	Comment
A123450001	06	226571000000100							SNOMED code for CO measurement
A123450002					03	251900003	3	Ppm	CO concentration result of 3 ppm
A123450003			04	77176002					SNOMED code for finding of 'smoker'