Classification: Official

NHS England

DAPB3066 Digital Maternity Record Standard release 2

Implementation Guidance

Publication reference:

Data Alliance Partnership Board

The Data Alliance Partnership Board (DAPB), which holds delegated authority from the Secretary of State for Health and Social Care, has approved a change to an existing information standard for publication under section 250 of the Health and Social Care Act 2012.

Assurance that this information standard meets the requirements of the Act and is appropriate for the use specified in the specification document has been provided by the Data Governance, Assurance and Testing (DGAT) team and endorsed by the Data Assurance Board (DAB).

This information standard comprises the following documents:

- Change Specification
- Implementation Guidance (this document)
- Requirements Specification
- Data Model

An Information Standards Notice (DAPB3066 Amd 01/2025) has been issued as a notification of use and implementation timescales. Please read this alongside the documents for the standard.

The controlled copies of these documents can be found on the Standards and collections - NHS England Digital. Any copies held outside of that area, in whatever format (e.g. paper, email attachment), are considered to have passed out of control and should be checked for currency and validity.

Date of publication: 31 March 2025

Document filename:	DAPB3066 Amd 01/2025 Implementation Guidance		
Project / Programme	Optimisation		
Document Reference	DAPB3066		
Project Manager	Terrence Daniel	**Status**	Final
Owner	Tim Ellis	**Version**	0.4
Author	Terrence Daniel	**Version issue date**	31/03/2025

Document management

Revision History

Version	Date	Summary of Changes
0.1	03/12/2024	Drafting.
0.2	09/12/2024	Updates to content.
0.3	25/02/2025	Updates and amendments from DSAS assurance.
0.4	28/02/2025	Further updates from assurance and template change.

Reviewers

This document must be reviewed by the following people:

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Glossary of Terms

Term / Abbreviation	What it stands for
AoMRC	Academy of Medical Royal Colleges
Better Births	The National Maternity Review undertaken by NHS England
EPR	Electronic patient record
DAPB	Data Alliance Partnership Board.
DAPB3066	The Digital Maternity Record Standard
HCRS	Healthy Child Record Standard
MTP	Maternity Transformation Programme
ICB	Integrated Care Board
ISN	Information Standards Notice
MTP	Maternity Transformation Programme
MSDS	Maternity Services Data Set
PRSB	Professional Record Standards Body
Refset	In the context of this Standard, a Refset is a group of SNOMED clinical terms that is represented by a single reference, rather than a list of all the terms contained therein
SNOMED CT	Structured clinical vocabulary for use in an electronic health record. SNOMED CT has been adopted as the standard clinical terminology for the NHS in England
TRUD	Technology Reference Data Update Distribution

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1. Purpose

The purpose of this document is to provide guidance for healthcare providers and their system providers on the implementation of the Digital Maternity Record Standard (DMRS Release 2), referred to hereafter as DAPB3066. This Implementation Guidance is to be read alongside the DAPB3066 Requirements Specification and the Digital Maternity Record Standard Data Model Specification.

2. Implementation Checklist

The following is a sequence of steps, set out to help implementers understand the implementation process, while enabling them to ask the right questions and engage with the right people within their respective organisations.

Step 1: Read the Information Standards Notice (ISN)

This is the official notification of the Information Standard, published by the Data Alliance Partnership Board (DAPB). It provides an outline of the approved Standard and timeframe for compliance.

NB: Compliance with Information Standards will normally be included in contracts between NHS Providers and their system providers; review your existing contracts with maternity system providers to confirm this is the case. If unsure, it is recommended that you liaise with your system provider to establish what their intentions are regarding implementation of the DAPB3066 and the timescales they are working to (as per Step 4, below).

Step 2: Read the Maternity Record Standard (Data Model Specifications)

Hosted on Standards and collections - NHS England Digital webpage, this document provides a more detailed description of the Information Standard including explanations about the data items, definitions, formats and values which can be recorded. These specifications are published and hosted alongside the ISN.

Step 3: Read the Healthy Child Record Standard (HCRS)

Healthcare providers should become compliant with the Healthy Child Record Standard when recording information which ultimately needs to be held within a baby's record.

Four specific Headings (known as Sections in the HCRS) and their respective data items in the HCRS have been identified for healthcare providers to consider recording about the baby at the point of birth (to support future interoperability with Healthy Child Programme providers):

1. Birth details
2. Newborn Blood Spot Screening
3. Feeding Status
4. Newborn and Infant Physical Examination (72 hours).

In addition, there are commonalities across these two Standards (such as Investigation Results, and its respective data items). Thus, there may be additional benefit in healthcare providers recording information against these headings about the baby, as well as the mother, i.e. a consistent and standardised approach to data management which enables effective interoperability between Maternity and Child Health information systems.

Approaches to managing the record split between mother and baby may vary considerably. As such, the Healthy Child Record Standard headings that a provider considers becoming compliant with will need to be defined at a local level, by the provider themselves.

As with Step 2, detailed descriptions and specifications supporting implementation of the Healthy Child Record Standard are hosted on NHS England's Standards and Collections webpage.

Step 4: Discuss with current IT System Provider

If a commercial system is in use, discuss with the system provider to confirm the timescale for any necessary changes to the system. In most cases these changes will be part of your Service Level Agreement (SLA). Incidentally, it would be wise to make sure any future SLAs, via re-procurement or contract refreshes etc, cover adherence to ISNs impacting your service.

Healthcare organisations should discuss with their system providers to agree dates for roll-out of their systems and local updates. Discussions with system providers should help inform subsequent steps.

Where an in-house solution is in place, discussions need to start early to ensure all changes can be incorporated within the implementation timetable.

Step 5: Stakeholder Engagement

It is essential to engage with those who are involved in collecting, recording and subsequently using the data items detailed within DAPB3066.

For example, you may find it useful to share the contents of this Implementation Guidance, and other documents relating to DAPB3066, with all staff groups and organisations directly impacted, such as frontline staff or commissioners.

Step 6: Check current state of readiness IT Systems (Software)

- Many of the Elements in the Maternity Record Standard may already be recorded electronically
- Check what changes are required to meet the new Elements.

Processes

- Are there any changes to clinical/business processes required?
- Additional training needs.

Step 7: Plan implementation

Each provider's approach to implementation may vary to suit their individual circumstances. At a high level, the following factors should be considered when assessing and enacting any business change:

- Scope of change
- Finance
- Change governance
- Change manager requirements
- Change resource requirements
- Timescales
- Key milestones
- Benefits
- Training requirements/resource
- Key stakeholders (Information Governance, Communications, Users, System Providers, NHS England)
- Key risks/barriers to change
- Success measures.

3. Implementation Plan

Compliance with Release 2 of DAPB3066 must be achieved no later than 31 December 2025.

The email address support@theprsb.org can be used should you have any suggested enhancements or amendments to any aspect of this standard or require other implementation support. The management of such items is summarised in section 8 below.

4. Maternity Record Standard

It is important to understand the key terms used to describe the data hierarchy of the Record Standard. All documentation supporting this standard will refer to some or all of the following terms:

Term	Description
Data Item	This is a label for the unit of data contained in a record section which describes an attribute stored within an **Element**. This could be an option in a drop-down list for example. "General Surgery Service" and "Urology Service" are two such data items in the "Specialty" **Element** of the "Performing Professional" **Section**.

Value Sets	Value sets describe precisely how the information is recorded in the system and communicated between systems. This is required for interoperability (for information to flow between one IT system and another). The information can be text, multi-media or in a coded format. If coded it can be constrained to SNOMED CT and specific SNOMED CT reference sets, NHS Data Dictionary values or other code sets.
Element	This is a label for sub-sections (or sub-headings) in relation to a specific record entry. For example, the GP Practice **Section** may be composed of the following Elements: • GP Name • GP Practice Details • GP Practice Identifier
Record entry	A record entry within a section is used where a set of information is repeated for a particular item, and there can be multiple items. For example, for each formulation there is a set of information associated with that formulation. Other examples include personal and professional contacts.
Section	This is a label for a high-level section within the record. For example, 'Care and support plan' and 'Personal Contacts' are sections. This could also be referred to as a 'container' or 'heading'. A section will appear in a record only once.
Record	This is a label for the overarching record as a whole. In the instance of the DAPB3066 Digital Maternity Record Standard Release 2, this is the combination of all the sections listed within the Data Model.

The Maternity Record Standard Data Model Specification provides the detailed content, format, structure and rules needed for a system provider to implement the standard.

5. Maternity Record Standard Data Model Specification Content

This section is designed to be read alongside the Maternity Record Standard Data Model Specification and gives more context to the information that is contained therein to support implementing the Standard.

5.1. Name (Section and Element)

This column details the name of each Section and the name of each Element under a Section.

5.2. Conformance

The Data Model Specification states where Elements are mandatory, required or optional. Within the context of DAPB3066 Release 2, these terms can be defined as follows:

- **Mandatory**: Must be recorded. Where there is nothing to record then the entry must contain appropriate coded text to identify this; e.g. “not specified” / “refused to answer”
- **Required**: Should be recorded, if available
- **Optional**: May be recorded.

It is essential that any mandatory items can be validated at the point of data entry to prevent a user from not completing an associated field.

If an Element is denoted as Optional, a healthcare professional must still have the option of recording it, but when this information is available to be shared via national or local infrastructure a local provider can elect to share it.

Where an Element is denoted as Mandatory or Required, this only applies where recording of this information makes logical sense. For example, in Allergies and Adverse Reactions, Causative Agent is shown as mandatory, but it is only mandatory if an allergy or reaction is being recorded. A Causative Agent will always have an associated allergy or adverse reaction.

Where Elements are Mandatory in the Maternity Services Data Set (MSDS), these have been replicated in this standard. Additional Elements have been marked as Mandatory beyond those replicated from MSDS as a result of Clinical SME input; the Element “Causative Agent”, under the Allergies and Adverse Reactions Heading is one such example

5.3. Cardinality

All Elements defined in the Maternity Record Standard Data Model Specification have cardinality as defined by the Unified Modelling Language as part of their definition – a minimum number of required appearances and a maximum number. These numbers specify the number of times the attribute may appear against the individual Element being recorded. This specification only defines the following cardinalities:

0..1

0..*

1..1

1..*

In the example of Admission Details:

Element Name	Cardinality	Description

Specialty admitted to	1..1	This means that only 1 type of Specialty as a minimum, and as a maximum should be recorded by a healthcare professional
Person accompanying patient	0..*	This implies that there could have been zero people accompanying the patient, but the * (many) allows a healthcare professional to record as many people as they believe are necessary

5.4. Description

This column details a definition of what should be recorded against each element.

5.5. Value Sets

Value sets describe precisely how the information is recorded in the system and communicated between systems. This is required for interoperability (for information to flow between one IT system and another). The information can be text, multi-media or in a coded format. If coded it can be constrained to SNOMED CT and specific SNOMED CT reference sets, NHS Data Dictionary values or other code sets.

5.6. Type

This column details whether the element is comprised of multiple elements (group) or is a single element (item).

5.7. Context

This column details applicable context and guidance relevant to the recording of a particular item.

5.8. Information type

This column details where a record entry or other information component has context or provenance information that needs to be recorded with that entry. There are two possible values for information type: “Record” and “Event Record”.

For “Record” information types, the provenance data includes the person (or device) recording the data, and the date and time it was recorded. For “Event.Record” information types, details of the performer (professional, person or device) of the event, the location, and the time the event happened are included in the provenance data. Full details at Provenance data – PRSB (theprsb.org) .

6. Free Text Fields

Free text will be available where there is a clear clinical requirement. Free text field size will be appropriate to support the clinical requirement. All free text documentation should be completed in accordance with professional record keeping standards, being clear and accurate.

7. Clinical Safety and Information Governance

The standard has been assured for all potential privacy, data quality and standards alignment concerns highlighted by the Information Standards Assurance process.

A Hazard Log and Clinical Safety Case have been developed to ensure that clinical risk management and appropriately governed hazard assessment have been undertaken. It is recommended that all healthcare providers implementing the record standard still follow their local clinical safety, information governance and security review processes to assess the local impact.

8. Future Changes

The Maternity Record Standard Data Model Specification will be updated as necessary. Updates to the record standard could be based on further clinical requirements, clinical safety feedback, technical SME feedback or system provider implementation findings for example. Throughout the implementation process, any lessons learned will be documented and used to influence future releases.

Where there are suggested changes to either the DMRS Data Model, or the DMRS implementation guidance document, feedback should be directed to the PRSB support and maintenance service (support@theprsb.org).

9. URL details

URL name	Link
NHS England DAPB Standards and Collections	https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/
Healthy Child Record Standard	http://www.digital.nhs.uk/isce/publication/dcb3009
Unified Modelling Language	https://www.uml-diagrams.org/multiplicity.html