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| Specification for revisions to the Victorian Perinatal Data Collection (VPDC) for 1 July 2021December 2020 |
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# Executive summary

The Final revisions for the Victorian Perinatal Data Collection (VPDC) effective 1 July 2021 are summarised below:

* **Add three new data items**:
* Category of unplanned caesarean section urgency
* Date of decision for unplanned caesarean section
* Time of decision for unplanned caesarean section
* **Amend field size of one Header record data item**:
* Submission number
* **Amend reporting guide of three existing data items:**
* Indigenous status – baby
* Indigenous status – mother
* Method of birth
* **Amend codeset for one existing data item**:
* Version identifier
* **Amend one existing Concept and derived item definition**:
	+ - * + Hypertensive disorder during pregnancy
* **Add two new business rules**
* **Amend three existing business rules**
* **Amend Header record file structure specification**
* **Amend Episode record file structure specification**

These revisions are presented in this document in order of the section of the VPDC manual where they will appear.

# Introduction

Each year, the Department of Health and Human Services (DHHS) reviews the Victorian Perinatal Data Collection (VPDC) on behalf of the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM). This review seeks to ensure that the perinatal data collection supports the state and national reporting obligations of both the CCOPMM and the department, and DHHS planning and policy development, and incorporates appropriate feedback from data providers on improvements.

The annual review begins with circulation of an invitation to stakeholders for suggestions for changes. Responses are evaluated against criteria that consider the data collection’s scope, the collectability and intended use of the data, best practice, feasibility and consequential impact of implementation and data quality and cost and collection burden for health services.

Suggested changes that meet these criteria are compiled into a document – the Proposals for revisions to the VPDC – and distributed to health services and software vendors involved in reporting births to the VPDC, with feedback requested. Comments received are reviewed and where possible, accommodated, resulting in alteration to or withdrawal of some proposals, on advice from the CCOPMM.

One change adopted for this cycle is to move the implementation date of changes from calendar to financial year, hence the changes documented here will take effect for births on and from 1 July 2021.

These Final revisions are complete at the date of publication. Where further changes are required during the year, for example to reference files such as the postcode locality file, data validation rules or supporting documentation, these will be advised at the time.

An updated VPDC manual will be published in 2021, before these changes take effect. Until then, the current VPDC manual and this document form the data submission specifications on and from 1.7.2021.

Victorian health services must ensure their software can create a VPDC submission file in accordance with the revised specifications and ensure reporting capability is achieved to maintain compliance with reporting timeframes set out in the VPDC manual.

Submission of test files in 2021-22 file format is strongly recommended prior to submitting July 2021 data. Test files must include the filename extension ‘\_TEST’ as set out in section 5 of the VPDC manual. Please contact the HDSS HelpDesk (hdss.helpdesk@dhhs.vic.gov.au) to arrange for test file submission between 1.6.2021 and 24.6.2021.

## Orientation to symbols and highlighting in this document

New data items are marked as (new).

Changes to existing data items are highlighted in green.

Redundant values and definitions relating to existing items are ~~struck through~~.

Comments relating only to the proposal document appear in *[square brackets and italics].*

New validations are marked ###

Validations to be changed are marked \* when listed as part of a data item or below a validation table.

Changes are documented in relation to each specific proposal: the total impact of all changes will be reflected in the VPDC Manual for 1.7.2021, to be released later.

Entries in this document are sequenced in the order of the VPDC manual where the change will appear.

# Summary of changes

|  |  |  |
| --- | --- | --- |
| **New data element / Amend existing** | **Proposal title & summary of impact** | **VPDC Manual sections changed** |
| **2** | **3** | **4** | **5** |
| **Amend** | **Hypertensive disorder during pregnancy**:Amend definition/reporting guide | Checkmark |  |  |  |
| **New data element** | **Category of unplanned caesarean section urgency**:New data element, code set and validations |  | Checkmark | Checkmark | Checkmark |
| **New data element** | **Date of decision for unplanned caesarean section**: New data element, value range and validations |  | Checkmark | Checkmark | Checkmark |
| **Amend** | **Indigenous status – baby**:Amend reporting guide advice for asking questions about baby’s indigenous status |  | Checkmark |  |  |
| **Amend** | **Indigenous status – mother**:Amend reporting guide advice for asking questions about mother’s indigenous status |  | Checkmark |  |  |
| **Amend** | **Method of birth**:Amend reporting guide |  | Checkmark | Checkmark | Checkmark |
| **Amend** | **Submission number**:Increase field size to 4 digits (impacts Header record) |  | Checkmark |  | Checkmark |
| **New data element** | **Time of decision for unplanned caesarean section**:New data element, value range and validations |  | Checkmark | Checkmark | Checkmark |
| **Add new business rule** | **Transaction type flag**:Add new business rule |  | Checkmark | Checkmark | Checkmark |
| **Amend** | **Version identifier:**Amend code set |  | Checkmark |  | Checkmark |

## Proposals deferred

The call for proposals for changes to the VPDC circulated to health services and software vendors in January 2020 received a number of responses. However in March 2020, stakeholders were advised that, due to the health emergency, all proposals received would be held over for consideration in the next cycle of revisions to the VPDC, which will be from 1.7.2022. The only revisions considered for the current cycle are changes that are essential to enable Victoria to meet its reporting obligations to the Commonwealth or other statutory obligations. The three new data elements to be introduced from 1.7.2021 were proposed by the CCOPMM to facilitate outcome monitoring and reporting and improve safety for mothers and babies. Two changes are included for information, having already been implemented for submission processing.

It is anticipated that the next call for proposals will be circulated in late July 2021.

Please direct any questions about the deferred proposals to the HDSS HelpDesk at <hdss.helpdesk@dhhs.vic.gov.au>.

# End of calendar year reporting – 31.12.2020

No change to reporting specifications between 31.12.2020 and 1.1.2021, because no changes take effect from 1.1.2021.

Reporting specifications for births from 1 January 2021 to 30 June 2021 remain as set out in the VPDC manual, version 8.0, accessible at the [VPDC website](https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/consultative-councils/council-obstetric-paediatric-mortality/perinatal-data-collection) at < https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/consultative-councils/council-obstetric-paediatric-mortality/perinatal-data-collection>

# End of financial year reporting – 30.6.2021

Data submissions must include all relevant data elements and code sets valid as at the Date of birth – baby reported in the record:

* Date of birth – baby is prior to 1/7/2021 – report all data elements in 2020-21 format
* Date of birth – baby is on or after 1/7/2021 – report all data elements in 2021-22 format

This is described under File structure specifications in Section 5 of the VPDC manual, accessible at <https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/consultative-councils/council-obstetric-paediatric-mortality/perinatal-data-collection> : note that the three new data elements described in this Final revisions document will be added to the list of data elements on pages 11 to 15 inclusive.

# Section 2 Concept and derived item definitions

|  |
| --- |
| Hypertensive disorder during pregnancy |
| **Definition/guide for use** | Hypertensive disorder during pregnancy includes pre-existing hypertensive disorders, hypertension arising in pregnancy and associated disorders such as eclampsia and preeclampsia.Hypertension in pregnancy is defined as:* Systolic blood pressure greater than or equal to 140 mmHg and/or
* Diastolic blood pressure greater than or equal to 90 mmHg.

Measurements should be confirmed by repeated readings over several hours. Elevations of both systolic and diastolic blood pressures have been associated with adverse fetal outcome and therefore both are important.Disorders associated with hypertension such as eclampsia and preeclampsia are further characterised by symptoms such as proteinuria, oedema or high body temperature.There are several reasons to support the blood pressure readings defined above as diagnostic of hypertension in pregnancy:* perinatal mortality rises with diastolic blood pressures above 90 mmHg
* readings above this level were beyond two standard deviations of mean blood pressure in a New Zealand cohort of normal pregnant women
* the chosen levels are consistent with international guidelines and correspond with the current diagnosis of hypertension outside of pregnancy.

This definition of hypertensive disorder in pregnancy from the Society of Obstetric Medicine in Australia and New Zealand (SOMANZ) aligns with the definition of the International Society for the Study of Hypertension in Pregnancy (ISSHP).(Source: METeOR #655620, Australian Institute of Health and Welfare) |
| **Related data items (Section 3):** | Events of labour and birth – free text; Events of labour and birth – ICD-10-AM code; Indication for induction (main reason) – ICD-10-AM code; Indications for induction (other) – free text; Indications for operative delivery – free text; Indications for operative delivery – ICD-10-AM code; Maternal medical conditions – free text; Maternal medical conditions – ICD-10-AM code; Obstetric complications – free text; Obstetric complications – ICD-10-AM code; Postpartum complications – free test; Postpartum complications – ICD-10-AM code |

# Section 3 Data definitions

## Category of unplanned caesarean section urgency (new)

#### Specification

|  |  |
| --- | --- |
| Definition | Category of unplanned caesarean section urgency |
| Representationclass | Code | Data type | Number |
| Format | N | Field size | 1 |
| Location | Episode record | Position | 148 |
| Permissible values | **Code** | **Descriptor** |
|  | 1 | Category 1 Urgent threat to the life or the health of a woman or fetus |
|  | 2 | Category 2 Maternal or fetal compromise but not immediately life-threatening |
|  | 3 | Category 3 Needing earlier than planned delivery but without currently evident maternal or fetal compromise |
|  | 4 | Category 4 At a time acceptable to both the woman and the caesarean section team, understanding that this can be affected by a number of factors |
|  | 9 | Urgency not stated/inadequately described |

|  |  |
| --- | --- |
| Reporting guide | Report the category of urgency of any unplanned caesarean section, whether this occurs before or during labour, **at the time the decision for caesarean section is made by the medical practitioner**. While the category may be subsequently downgraded or upgraded, it is to be reported as at the time the decision is made.The category of urgency code must be reported for all births with Method of birth code 5 Unplanned caesarean – labour or code 7 Unplanned caesarean – no labour.Where a decision is made for an urgent caesarean section, but vaginal birth occurs before the caesarean section can be performed, report the actual Method of birth.The Royal Australasian College of Obstetricians and Gynaecologists recommends and endorses the use of a 4-grade classification system for emergency caesarean section.1Some services use a Code Green classification system. A Code Green caesarean section should be reported as code 1 Category 1. These services should use the descriptors for codes 2-4 to report caesareans other than Code Green.1Statement on categorisation of urgency for caesarean section, RANZCOG, reviewed July 2019 [https://ranzcog.edu.au/RANZCOG\_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical-Obstetrics/Categorisation-of-urgency-for-caesarean-section-(C-Obs-14).pdf?ext=.pdf](https://ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical-Obstetrics/Categorisation-of-urgency-for-caesarean-section-%28C-Obs-14%29.pdf?ext=.pdf)  |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | Mandatory for all birth episodes with Method of birth code 5 Unplanned caesarean – labour or code 7 Unplanned caesarean – no labour. Leave blank for all other Method of birth codes. |
| Related concepts (Section 2): | Labour type |
| Related data items (this section): | Date of decision for unplanned caesarean section (new); Method of birth; Time of decision for unplanned caesarean section (new) |
| Related business rules (Section 4): | ### Category of unplanned caesarean section urgency, Date of decision for unplanned caesarean section and Time of decision for unplanned caesarean section; \*Date and time data item relationships; \*Labour type ‘Woman in labour’ and associated data items valid combinations; \*Labour type ‘Woman not in labour’ and associated data items valid combinations |

#### Administration

|  |  |
| --- | --- |
| Principal data users | Consultative Council on Obstetric Paediatric Mortality and Morbidity |
| Definition source | DHHS | Version | 1 July 2021 |
| Codeset source | RANZCOG | Collection start date | 1 July 2021 |

## Date of decision for unplanned caesarean section (new)

**Specification**

|  |  |
| --- | --- |
| Definition | The date of decision for unplanned caesarean section |
| Representation class | Date  | Data type | Date/time |
| Format | DDMMCCYY | Field size | 8 |
| Location | Episode record | Position | 149 |
| Permissible values | A valid calendar date**Code Descriptor**99999999 Not stated / inadequately described |
| Reporting guide | The date on which the medical practitioner decides to deliver by urgent caesarean section where that was not the previously planned method of birth, for example where the plan was for a vaginal birth or planned caesarean section, but circumstances change and the decision is made to proceed to an urgent caesarean section.In cases of transfer to theatre for trial of forceps, report the date on which the plan changed to delivery by caesarean section.Century (CC) can only be reported as 20.  |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | Mandatory for all birth episodes with Method of birth code 5 Unplanned caesarean – labour or code 7 Unplanned caesarean – no labour. Leave blank for all other Method of birth codes  |
| Related concepts (Section 2): | Labour type |
| Related data items (this section): | Category of unplanned caesarean section urgency (new); Method of birth; Time of decision for unplanned caesarean section (new) |
| Related business rules (Section 4): | ### Category of unplanned caesarean section urgency, Date of decision for unplanned caesarean section and Time of decision for unplanned caesarean section; \*Date and time data item relationships; \*Labour type ‘Woman in labour’ and associated data items valid combinations; \*Labour type ‘Woman not in labour’ and associated data items valid combinations |

**Administration**

|  |  |
| --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
| Definition source | DHHS | Version | 1. July 2021 |
| Codeset source | DHHS | Collection start date | 1 July 2021 |
|  |

## Indigenous status – baby

**Specification**

|  |  |
| --- | --- |
| Definition | ~~Indigenous status is a measure of whether~~ Whether a person ~~(baby)~~ identifies their baby as being of Aboriginal or Torres Strait Islander origin ~~and is accepted as such by the community in which they live.~~ |
| Representation class | Code | Data type | Number |
|  |
| Format | N | Field size | 1 |
|  |
| Location | Episode record | Position | 20 |
|  |
| Permissible values | **Code Descriptor**1 Aboriginal but not Torres Strait Islander origin2 Torres Strait Islander but not Aboriginal origin3 Both Aboriginal and Torres Strait Islander origin4 Neither Aboriginal nor Torres Strait Islander origin8 Question unable to be asked9 Not stated / inadequately described |
|  |
| Reporting guide | This information must be collected for every birth, regardless of the data collector’s perceptions based on appearance or other factors. Software must not be set up to input a default code.To collect Indigenous status – baby, it is suggested the parents are asked the following questions:Question 1: Is this baby’s mother of Aboriginal or Torres Strait Islander origin, or both?If the response is ‘no’, ask Question 2:Question 2: Is this baby’s father of Aboriginal or Torres Strait Islander origin, or both?If the response to Questions 1 and 2 are both ‘no’, record code 4 for this baby; no further questions.If the response to either Question 1 or Question 2 is ‘yes’, record the appropriate code (1, 2 or 3 respectively) to reflect those responses for the baby, and confirm this response with the parents.~~A person of Aboriginal descent is a person descended from the original inhabitants of Australia. The Torres Strait Islands are the islands directly to the north of Cape York, between Cape York and New Guinea. In Victoria, the community of Torres Strait Island people is small and the community of Aboriginal and Torres Strait Island people is smaller again, therefore the code 2 Torres Strait Islander but not Aboriginal origin and code 3 Both Aboriginal and Torres Strait Islander origin would not be widely used.~~ Code 8 Question unable to be asked should only be used under the following circumstances: * when the patient’s medical condition prevents the question of Indigenous status being asked
* in the case of an unaccompanied child who is too young to be asked their Indigenous status.

~~This information must be collected for every admitted patient episode and updated each time the patient presents to the hospital for admission. Software must not be set up to input a default code. Rather than asking every patient about his or her indigenous status, first ask the patient, ‘Were you born in Australia?’ Then, proceed as follows:~~* ~~If no, the patient should be asked, ‘What country were you born in?’~~
* ~~If yes, the patient should be asked, ‘Are you of Aboriginal or Torres Strait Islander origin?’~~

~~If the patient answers yes to being of Aboriginal or Torres Strait Islander origin, then ask further questions to correctly record the person’s Indigenous status.~~ ~~The parent or guardian should be asked about the indigenous status of the child. If the mother of a newborn baby has not identified as being of Aboriginal or Torres Strait Islander descent, hospital staff should not assume the baby is non-Aboriginal; the father may be of Aboriginal or Torres Strait Islander descent.~~  |
|  |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
|  |
| Reported for | All birth episodes |
|  |
| Related concepts (Section 2): | None specified |
|  |
| Related data items (this section): | Country of birth |
|  |
| Related business rules (Section 4): | Mandatory to report data items |

**Administration**

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| --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
|  |
| Definition source | NHDD | Version | 1. January 2009
2. July 2021
 |
|  |
| Codeset source | NHDD (DHHS modified) | Collection start date | 2009 |

## Indigenous status – mother

**Specification**

|  |  |
| --- | --- |
| Definition | ~~Indigenous status is a measure of whether~~ Whether a person (mother) identifies as being of Aboriginal or Torres Strait Islander origin ~~and is accepted as such by the community in which she lives.~~ |
|  |
| Representation class | Code | Data type | Number |
|  |
| Format | N | Field size | 1 |
|  |
| Location | Episode record | Position | 19 |
|  |
| Permissible values | **Code Descriptor**1 Aboriginal but not Torres Strait Islander origin2 Torres Strait Islander but not Aboriginal origin3 Both Aboriginal and Torres Strait Islander origin4 Neither Aboriginal nor Torres Strait Islander origin8 Question unable to be asked9 Not stated / inadequately described |
|  |
| Reporting guide | This information must be collected for every birth, regardless of the data collector’s perceptions based on appearance or other factors. Software must not be set up to input a default code.To collect Indigenous status – mother, it is suggested the questions are asked as follows:Question 1: Are you of Aboriginal or Torres Strait Islander origin?If the response is ‘no’, record code 4; no further questionsIf the response is ‘yes’, ask Question 2:Question 2: Are you of Aboriginal origin, Torres Strait Islander origin, or both?Record the appropriate code (1, 2 or 3 respectively) to reflect the response.~~A person of Aboriginal descent is a person descended from the original inhabitants of Australia. The Torres Strait Islands are the islands directly to the north of Cape York, between Cape York and New Guinea. In Victoria, the community of Torres Strait Island people is small and the community of Aboriginal and Torres Strait Island people is smaller again, therefore the code 2 Torres Strait Islander but not Aboriginal origin and code 3 Both Aboriginal and Torres Strait Islander origin would not be widely used.~~ Code 8 Question unable to be asked should only be used under the following circumstances:* when the patient’s medical condition prevents the question of Indigenous status being asked.

~~This information must be collected for every admitted patient episode and updated each time the patient represents to the hospital for admission. Software must not be set up to input a default code. Rather than asking every patient about his or her indigenous status, first ask the patient, ‘Were you born in Australia?’:~~* ~~If no, the patient should be asked, ‘What country were you born in?’~~
* ~~If yes, the patient should be asked, ‘Are you of Aboriginal or Torres Strait Islander origin?’~~

~~If the patient answers yes to being of Aboriginal or Torres Strait Islander origin, then ask further questions to correctly record the person’s indigenous status.~~ ~~The parent or guardian should be asked about the Indigenous status of the child. If the mother of a newborn baby has not identified as being of Aboriginal or Torres Strait Islander descent, hospital staff should not assume the baby is non-Aboriginal; the father may be of Aboriginal or Torres Strait Islander descent.~~  |
|  |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
|  |
| Reported for | All birth episodes |
|  |
| Related concepts (Section 2): | None specified |
|  |
| Related data items (this section): | Country of birth, Indigenous status – baby |
|  |
| Related business rules (Section 4): | Mandatory to report data items |

**Administration**

|  |  |
| --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
|  |
| Definition source | NHDD | Version | 1. January 19822. January 19993. January 20094. July 2021 |
|  |
| Codeset source | NHDD (DHHS modified) | Collection start date | 1982 |

## Method of birth

**Specification**

|  |  |
| --- | --- |
| Definition | The method of complete expulsion or extraction from the woman of a product of conception in a birth event |
|  |
| Representation class | Code | Data type | Number |
|  |
| Format | NN | Field size | 2 |
|  |
| Location | Episode record | Position | 74 |
|  |
| Permissible values | **Code Descriptor**1 Forceps3 Vaginal birth – non-instrumental4 Planned caesarean – no labour5 Unplanned caesarean – labour6 Planned caesarean – labour7 Unplanned caesarean – no labour8 Vacuum extraction9 Not stated / inadequately described10 Other operative birth |
|  |
| Reporting guide | In the case of multiple births, the method of birth is reported in each baby’s episode record. Where forceps/vacuum extraction are used to assist the extraction of the baby at caesarean section, code as caesarean section.Code 1 Forceps Includes any use of forceps in a vaginal birth – rotation, delivery and forceps to the head during breech presentations. Includes vaginal breech with forceps to the aftercoming headCode 3 Vaginal birth – non-instrumental Includes manual assistance for example, a vaginal breech that has been manually rotatedCode 4 Planned caesarean – no labour Caesarean takes place as a planned procedure before the onset of labour Code 5 Unplanned caesarean – labour Caesarean is undertaken for a complication after the onset of labour, whether that onset is spontaneous or induced.~~If a women is planning to have a caesarean for a non-urgent indication (for example, repeat caesarean, breech), then develops an urgent indication (for example, cord prolapse, antepartum haemorrhage) that becomes the immediate indication for the caesarean, code it as unplanned (code 5 or 7), either in labour or not in labour as appropriate.~~Code 6 Planned caesarean – labour Caesarean was a planned procedure, but occurs after spontaneous onset of labourCode 7 Unplanned caesarean – no labourProcedure is undertaken for an urgent indication before the onset of labour. Code 10 Other operative birthIncludes D&C, D&E, hysterotomy and laparotomy.Excludes operative methods of birth for which a specific code exists.Note: for Unplanned caesarean (codes 5 or 7): if a women is planning to have a caesarean for a non-urgent indication (for example, repeat caesarean, breech), then develops an urgent indication (for example, cord prolapse, antepartum haemorrhage) that becomes the immediate indication for the caesarean, code it as unplanned (code 5 or 7), either in labour or not in labour as appropriate. In this situation also report the Category of unplanned caesarean section urgency, the Date of decision for unplanned caesarean section and the Time of decision for unplanned caesarean section. |
|  |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
|  |
| Reported for | All birth episodes |
|  |
| Related concepts (Section 2): | None specified |
|  |
| Related data items (this section): | Anaesthesia for operative delivery – indicator; Anaesthesia for operative delivery – type; Analgesia for labour – indicator, Analgesia for labour – type; Date of decision for unplanned caesarean section; Time of decision for unplanned caesarean section |
|  |
| Related business rules (Section 4): | Anaesthesia for operative delivery – indicator and Method of birth valid combinations; Blood loss assessment – indicator, Episiotomy – indicator, Indications for operative delivery – free text, Indications for operative delivery – ICD-10-AM code, Method of birth, Perineal/genital laceration – degree/type and Perineal laceration – indicator conditional reporting; Episiotomy – indicator and Method of birth valid combinations; \*Labour type ‘Woman in labour’ and associated data items valid combinations; \*Labour type ‘Woman not in labour’ and associated data items valid combinations; Mandatory to report data items; Manual removal of placenta and Method of birth conditionally mandatory data items; Method of birth and Anaesthesia for operative delivery – indicator conditionally mandatory data item; Method of birth and Labour type valid combinations; Method of birth and Manual removal of placenta conditionally mandatory data item; Method of birth and Setting of birth – actual valid combinations; Method of birth, Indications for operative delivery – free text and Indications for operative delivery – ICD-10-AM code valid combinations; Perineal laceration – indicator and Method of birth valid combinations |

**Administration**

|  |  |
| --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
|  |
| Definition source | NHDD | Version | 1. January 19822. January 19993. January 20094. June 20155. July 2021 |
|  |
| Codeset source | NHDD (DHHS Modified) | Collection start date | 1982 |

## Submission number

**Specification**

|  |  |
| --- | --- |
| Definition | The number of times a particular piece of data is submitted or resubmitted |
|  |
| Representation class | Identifier | Data type | String |
|  |
| Format | NNNN | Field size | ~~2~~ 4 |
|  |
| Location | File name, Header record | Position | Not applicable |
|  |
| Permissible values | Range: one to 9999 (inclusive) |
|  |
| Reporting guide | Software-system generated. The incrementing submission number must cycle back to ‘01’ each time the Data submission identifier (submission end date) changes. |
|  |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | Each VPDC electronic submission file |
|  |
| Related concepts (Section 2): | None specified |
|  |
| Related data items (this section): | None specified  |
|  |
| Related business rules (Section 4): | None specified |

**Administration**

|  |  |
| --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
|  |
| Definition source | DHHS | Version | 1. January 2009
2. January 2020
 |
|  |
| Codeset source | DHHS | Collection start date | 2009 |

## Time of decision for unplanned caesarean section (new)

**Specification**

|  |  |
| --- | --- |
| Definition | The time of decision for unplanned caesarean section |
| Representation class | Time  | Data type | Date/time |
| Format | HHMM | Field size | 4 |
| Location | Episode record | Position | 150 |
| Permissible values | A valid time value using a 24-hour clock (not 0000 or 2400)**Code Descriptor**9999 Not stated / inadequately described |
| Reporting guide | The time at which the medical practitioner decides to deliver by urgent caesarean section where that was not the previously planned method of birth, for example where the plan was for a vaginal birth or planned caesarean section, but circumstances change and the decision is made to proceed to an urgent caesarean section.In cases of transfer to theatre for trial of forceps, report the time at which the plan changed to delivery by caesarean section. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | Mandatory for all birth episodes with Method of birth code 5 Unplanned caesarean – labour or code 7 Unplanned caesarean – no labour. Leave blank for all other Method of birth codes. |
| Related concepts (Section 2): | Labour type |
| Related data items (this section): | Category of unplanned caesarean section urgency (new); Date of decision for unplanned caesarean section (new); Method of birth |
| Related business rules (Section 4): | ### Category of unplanned caesarean section urgency, Date of decision for unplanned caesarean section and Time of decision for unplanned caesarean section; \*Date and time data item relationships; \*Labour type ‘Woman in labour’ and associated data items valid combinations; \*Labour type ‘Woman not in labour’ and associated data items valid combinations |

**Administration**

|  |  |
| --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
| Definition source | DHHS | Version | 1. July 2021 |
| Codeset source | DHHS | Collection start date | 1 July 2021 |

Transaction type flag

**Specification**

|  |  |
| --- | --- |
| Definition | An indicator that identifies the type of transaction to the VPDC |
|  |
| Representation class | Code | Data type | String |
|  |
| Format | A | Field size | 1 |
|  |
| Location | Episode record | Position | 3 |
|  |
| Permissible values | **Code Descriptor**C Confirmation of previously accepted recordN New recordU Updated/corrected recordX Record to be deactivatedR Reinstate record that was previously deactivated |
|  |
| Reporting guide | Software-system generated.Code X: Record to be deactivated:Report when a record that was previously submitted is found to be in error and is required to be removed from the VPDC: resubmitting the record with code X marks the record for ‘deactivation’ (removal) from the final VPDCCode R: Reinstate record that was previously deactivatedreport only for a record that was previously submitted (ie Code N), and then later deactivated (ie Code X), and now needs to be reinstated to the PVDC database |
|  |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
|  |
| Reported for | Each VPDC electronic episode records |
|  |
| Related concepts (Section 2): | None specified |
|  |
| Related data items (this section): | None specified  |
|  |
| Related business rules (Section 4): | Mandatory to report data items; Transaction Type Flag processing against prior data held, not held or deactivated (new) |

**Administration**

|  |  |
| --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
|  |
| Definition source | DHHS | Version | 1. January 20092. January 2020 |
|  |
| Codeset source | DHHS | Collection start date | 2009 |

## Version identifier

**Specification**

|  |  |
| --- | --- |
| Definition | Version of the data collection |
|  |
| Representation class | Identifier | Data type | Number |
|  |
| Format | NNNN | Field size | 4 |
|  |
| Location | Episode record, Header record | Position | 2 |
|  |
| Permissible values | **Code**2009201520172018201920202021 |
|  |
| Reporting guide | Software-system generated. A VPDC electronic submission file with a missing or invalid Version identifier will be rejected and the submission file will not be processed. |
| Reported by | All Victorian hospitals where a birth has occurred and homebirth practitioners |
| Reported for | Each VPDC electronic submission file (Header record); Each VPDC electronic birth record (Episode record) |
| Related concepts (Section 2): | None specified |
|  |
| Related data items (this section): | None specified  |
|  |
| Related business rules (Section 4): | Mandatory to report data items |

**Administration**

|  |  |
| --- | --- |
| Principal data users | Consultative Council on Obstetric and Paediatric Mortality and Morbidity |
|  |
| Definition source | DHHS | Version | 1. January 2009
2. July 2015
3. January 2017
4. January 2018
5. January 2019
6. January 2020
7. July 2021
 |
|  |
| Codeset source | DHHS | Collection start date | 2009 |

# Section 4 Business rules

## ###Category of unplanned caesarean section urgency, Date of decision for unplanned caesarean section and Time of decision for unplanned caesarean section

|  |  |  |
| --- | --- | --- |
| **If Category of unplanned caesarean section urgency is:** | **Date of decision for unplanned caesarean section must be:** | **Time of decision for unplanned caesarean section must be:** |
| 1 Category 1 **or** 2 Category 2 **or** 3 Category 3 **or** 4 Category 4 **or**9 Not stated/inadequately described | DDMMCCYY | HHMM |
| blank | blank | blank |

## Date and time data item relationships

Where a valid date and/or time is reported in the data elements listed in columns 1 and 3 below, validations check the data reflect logical sequence as indicated in the Relationship column:

|  |  |  |
| --- | --- | --- |
| **Data item 1:** | **Relation-ship:** | **Data item 2:** |
| Date and time of birth – baby  | ≥ | Date and time of onset of Labour |
| Date and time of birth – baby  | ≥ | Date and time of onset of second stage of labour |
| Date and time of birth – baby  | ≥ | Date and time of rupture of membranes |
| Date and time of birth – baby  | ≥ | Date and time of decision for unplanned caesarean section |
| Date and time of onset of labour  | < | Date and time of onset of second stage of labour |
| Date of admission – mother | > | Date of birth – mother |
| Date of birth – mother | < | Date and time of onset of labour |
| Date of birth – mother | < | Date and time of onset of second stage of labour |
| Date of birth – mother | < | Date and time of rupture of membranes |
| Date of birth – mother | < | Date of birth – baby |
| Date of birth – mother | < | Date and time of decision for unplanned caesarean section |
| Date of completion of last pregnancy | < | Date and time of onset of labour |
| Date of completion of last pregnancy | < | Date and time of onset of second stage of labour |
| Date of completion of last pregnancy | < | Date and time of rupture of membranes |
| Date of completion of last pregnancy | < | Date of admission – mother |
| Date of completion of last pregnancy | < | Date of birth – baby |
| Date of completion of last pregnancy | > | Date of birth – mother |
| Date of completion of last pregnancy | < | Date and time of decision for unplanned caesarean section |
| Estimated date of confinement | > | Date of birth – mother |
| Estimated date of confinement | > | Date of completion of last pregnancy |
| Separation date – baby | > | Date of birth – mother |
| Separation date – baby | > | Date of completion of last pregnancy |
| Separation date – baby | ≥ | Date and time of onset of labour |
| Separation date – baby | ≥ | Date and time of onset of second stage of labour |
| Separation date – baby | ≥ | Date and time of rupture of membranes |
| Separation date – baby | ≥ | Date of admission – mother |
| Separation date – baby | ≥ | Date of Birth – baby |
| Separation date – baby | ≥ | Date and time of decision for unplanned caesarean section |
| Separation date – mother | > | Date of Birth – mother |
| Separation date – mother | > | Date of completion of last pregnancy |
| Separation date – mother | ≥ | Date and time of onset of labour  |
| Separation date – mother | ≥ | Date and time of onset of second stage of labour |
| Separation date – mother | ≥ | Date and time of rupture of membranes |
| Separation date – mother | ≥ | Date of admission – mother |
| Separation date – mother | ≥ | Date of birth – baby |
| Separation date – mother | ≥ | Date and time of decision for unplanned caesarean section |

## Labour type ‘Woman in labour’ and associated data items valid combinations

|  |  |
| --- | --- |
| **If Labour type is:** | **and Method of birth is:** |
| 1 Spontaneous **or** 2 Induced medical **or** 3 Induced surgical **or** 1 Spontaneous **and** 4 Augmented **or** 2 Induced medical **and** 3 Induced surgical | 1 Forceps **or** 3 Vaginal birth – non-instrumental **or**8 Vacuum extraction |
| **the following data items:** | **must report:** |
| Category of unplanned caesarean section urgencyDate of decision for unplanned caesarean sectionDate of onset of labourDate of onset of second stage of labourDate of rupture of membranesFetal monitoring prior to birth – not in labourTime of decision for unplanned caesarean sectionTime of onset of labourTime of onset of second stage of labourTime of rupture of membranes | Blank Blank DDMMCCYYDDMMCCYYDDMMCCYY **or** 77777777BlankBlank HHMM or 7777HHMMHHMM **or** 7777 |

|  |  |
| --- | --- |
| **If labour type is:** | **and Method of birth is:** |
| 1 Spontaneous **or** 2 Induced medical **or** 3 Induced surgical **or** 1 Spontaneous **and** 4 Augmented **or** 2 Induced medical **and** 3 Induced surgical | ~~5 Unplanned caesarean – labour~~ **~~or~~**6 Planned caesarean – labour |
| **the following data items:** | **must report:** |
| Category of unplanned caesarean section urgencyDate of decision for unplanned caesarean sectionDate of onset of labourDate of onset of second stage of labourDate of rupture of membranesFetal monitoring prior to birth – not in labourTime of decision for unplanned caesarean sectionTime of onset of labourTime of onset of second stage of labourTime of rupture of membranes | blankblankDDMMCCYYDDMMCCYY **or** 88888888DDMMCCYY **or** 77777777 **or** 88888888blankblankHHMM or 7777HHMM **or** 8888HHMM **or** 7777 or 8888 |

|  |  |
| --- | --- |
| **If labour type is:** | **and Method of birth is:** |
| 1 Spontaneous **or** 2 Induced medical **or** 3 Induced surgical **or** 1 Spontaneous **and** 4 Augmented **or** 2 Induced medical **and** 3 Induced surgical | 5 Unplanned caesarean – labour  |
| **the following data items:** | **must report:** |
| Category of unplanned caesarean section urgencyDate of decision for unplanned caesarean sectionDate of onset of labourDate of onset of second stage of labourDate of rupture of membranesFetal monitoring prior to birth – not in labourTime of decision for unplanned caesarean sectionTime of onset of labourTime of onset of second stage of labourTime of rupture of membranes | 1 **or** 2 **or** 3 **or** 4 **or** 9DDMMCCYYDDMMCCYYDDMMCCYY **or** 88888888DDMMCCYY **or** 77777777 **or** 88888888BlankHHMMHHMM or 7777HHMM **or** 8888HHMM **or** 7777 or 8888 |

## Labour type ‘Woman not in labour’ and associated data items valid combinations

|  |  |
| --- | --- |
| **If Labour type is:** | **and Method of birth is:** |
| 5 No labour **or** 2 Induced medical **and** 5 No labour **or** 3 Induced surgical **and** 5 No labour **or** 2 Induced medical **and** 3 Induced surgical **and** 5 No labour | 4 Planned caesarean – no labour **or** ~~7 Unplanned caesarean – no labour~~ **~~or~~**10 Other operative birth |
| **the following data items:** | **must report:** |
| Category of unplanned caesarean section urgencyDate of decision for unplanned caesarean sectionDate of onset of labourDate of onset of second stage of labourDate of rupture of membranesFetal monitoring in labourTime of decision for unplanned caesarean sectionTime of onset of labourTime of onset of second stage of labourTime of rupture of membranes | blank blank 8888888888888888DDMMYYYY **or** 77777777 **or** 88888888blankblank 88888888HHMM **or** 7777 **or** 8888 |

|  |  |
| --- | --- |
| **If Labour type is:** | **and Method of birth is:** |
| 5 No labour **or** 2 Induced medical **and** 5 No labour **or** 3 Induced surgical **and** 5 No labour **or** 2 Induced medical **and** 3 Induced surgical **and** 5 No labour | 7 Unplanned caesarean – no labour |
| **the following data items:** | **must report:** |
| Category of unplanned caesarean section urgencyDate of decision for unplanned caesarean sectionDate of onset of labourDate of onset of second stage of labourDate of rupture of membranesFetal monitoring in labourTime of decision for unplanned caesarean sectionTime of onset of labourTime of onset of second stage of labourTime of rupture of membranes | 1 **or** 2 **or** 3 **or** 4 **or** 9DDMMCCYY8888888888888888DDMMYYYY **or** 77777777 **or** 88888888blankHHMM88888888HHMM **or** 7777 **or** 8888 |

## ###Transaction Type Flag processing against prior data held, not held or deactivated

|  |  |  |  |
| --- | --- | --- | --- |
| **TTF in this record** | **Prior record in VPDC?**  | **Prior record’s TTF & (current Status)** | **Will this record be rejected?** |
| C | No | Not applicable | No |
| C | Yes | C or N or U or R (Active) | No |
| C | Yes | X(Deactivated) | Yes |
| N | No | Not applicable | No |
| N | Yes | C or N or U or R(Active) | No |
| N | Yes | X(Deactivated) | Yes |
| U | No | Not applicable | No |
| U | Yes | C or N or U or R(Active) | No |
| U | Yes | X(Deactivated) | Yes |
| X | No | Not applicable | Yes |
| X | Yes | C or N or U or R(Active) | No |
| X | Yes | X(Deactivated) | No |
| R | No | Not applicable | Yes |
| R | Yes | C or N or U or R(Active) | No |
| R | Yes | X(Deactivated) | No |

# Section 5: Compilation and submission

## File naming convention

Each VPDC submission file is uniquely identified by its file name, which must be in the following format:

CCCC\_NNNN\_YYYYMMDDhhmm\_TTTT.txt

where:

CCCC = Collection identifier (always VPDC)

NNNN = Hospital code (agency identifier)

YYYYMMDDhhmm = Data submission identifier

TTTT = Submission number

txt = Submission file extension (always .txt)

Test files must include \_TEST at the end of the submission file name as follows:

CCCC\_NNNN\_YYYYMMDDhhmm\_TTTT\_TEST.txt

For example, a health service with Hospital code (agency identifier) ‘1234’ creates a new submission file at 9.45 am on 13 July 2020, using that date and time as the Data submission identifier:

* Data submission identifier = 202007130945
* Submission number = 0001.

The submission file name is then: VPDC\_1234\_202007130945\_0001.txt

Detailed specifications for the components of the file name are provided in Section 3: Data definitions.

## Header record

The header record must be included as the first record of all submission files reported to the VPDC.

Episode records within a data submission file must be reported as per the version of the data collection as specified in the header record. For example, to submit new records for births between ~~1 December 2019~~ 1 June 2021 and 31 ~~January 2020~~ July 2021, at least two data submission files are to be compiled:

* The first containing records for births from 1 ~~December 2019~~ June 2021 to ~~31 December 2019~~ 30 June 2021 (inclusive) as per the appropriate specifications with the version identifier reported as ~~‘2019’~~ ‘2020’ in the header and episode records
* The second containing records for births from 1 ~~January 2020~~ July 2021 to 31 ~~January 2020~~ July 2021 (inclusive) as per the appropriate specifications with the version identifier reported as ~~‘2020’~~ ‘2021’ in the header and episode records

The convention for naming is:

CCCC | VVVV | NNNN | YYYYMMDDhhmm | TTTT | NNNNN | AAA…AAA

where:

CCCC: = Collection identifier

VVVV: = Version identifier

NNNN: = Hospital code (agency identifier)

YYYYMMDDhhmm: = Data submission identifier

TTTT: = Submission number

NNNNN: = Number of records following

AAA…AAA: = Name of software

## Episode records

| Position number | Data item name | Data type | Format | Field size |
| --- | --- | --- | --- | --- |
| 1 | Collection identifier | String | AAAA | 4 |
| 2 | Version identifier | Number | NNNN | 4 |
| 3 | Transaction type flag | String | A | 1 |
| 4 | Hospital code (agency identifier) | Number | AAAA | 4 |
| 5 | Patient identifier – mother | String | A(10) | 10 |
| 6 | Patient identifier – baby | String | A(10) | 10 |
| 7 | Date of admission – mother | Date/time | DDMMCCYY | 8 |
| 8 | Surname / family name – mother | String | A(40) | 40 |
| 9 | First given name – mother | String | A(40) | 40 |
| 10 | Middle name – mother | String | A(40) | 40 |
| 11 | Residential locality | String | A(46) | 46 |
| 12 | Residential postcode | Number | NNNN | 4 |
| 13 | Residential road number – mother | String | A(12) | 12 |
| 14 | Residential road name – mother | String | A(45) | 45 |
| 15 | Residential road suffix code – mother | String | AA | 2 |
| 16 | Residential road type – mother | String | AAAA | 4 |
| 17 | Admitted patient election status – mother | Number | N | 1 |
| 18 | Country of birth | Number | NNNN | 4 |
| 19 | Indigenous status – mother | Number | N | 1 |
| 20 | Indigenous status – baby | Number | N | 1 |
| 21 | Marital status | Number | N | 1 |
| 22 | Date of birth – mother | Date/time | DDMMCCYY | 8 |
| 23 | Height – self-reported – mother | Number | NNN | 3 |
| 24 | Weight – self-reported – mother | Number | NN[N] | 3 |
| 25 | Setting of birth – intended | Number | NNNN | 4 |
| 26 | Setting of birth – intended – other specified description | String | A(20) | 20 |
| 27 | Setting of birth – actual  | Number | NNNN | 4 |
| 28 | Setting of birth – actual – other specified description | String | A(20) | 20 |
| 29 | Setting of birth – change of intent | Number | N | 1 |
| 30 | Setting of birth – change of intent – reason | Number | N | 1 |
| 31 | Maternal smoking < 20 weeks | Number | N | 1 |
| 32 | Maternal smoking ≥ 20 weeks | Number | NN | 2 |
| 33 | Gravidity | Number | N[N] | 2 |
| 34 | Total number of previous live births | Number | NN | 2 |
| 35 | Parity | Number | NN | 2 |
| 36 | Total number of previous stillbirths (fetal deaths) | Number | NN | 2 |
| 37 | Total number of previous neonatal deaths | Number | NN | 2 |
| 38 | Total number of previous abortions – spontaneous | Number | NN | 2 |
| 39 | Total number of previous abortions – induced | Number | NN | 2 |
| 40 | Total number of previous ectopic pregnancies | Number | NN | 2 |
| 41 | Total number of previous unknown outcomes of pregnancy | Number | NN | 2 |
| 42 | Date of completion of last pregnancy | Date/time | {DD}MMCCYY | 6 (8) |
| 43 | Outcome of last pregnancy | Number | N | 1 |
| 44 | Last birth – caesarean section indicator | Number | N | 1 |
| 45 | Total number of previous caesareans | Number | NN | 2 |
| 46 | Plan for VBAC | Number | N | 1 |
| 47 | Estimated date of confinement | Date/time | DDMMCCYY | 8 |
| 48 | Estimated gestational age | Number | NN | 2 |
| 49 | Maternal medical conditions – free text | String | A(300) | 300 |
| 50 | Maternal medical conditions – ICD-10-AM code | String | ANN[NN] | 5 (X12) |
| 51 | Obstetric complications – free text | String | A(300) | 300 |
| 52 | Obstetric complications – ICD-10-AM code | String | ANN[NN] | 5 (x15) |
| 53 | Gestational age at first antenatal visit | Number | N[N] | 2 |
| 54 | Discipline of antenatal care provider | Number | N | 1 |
| 55 | Procedure – free text | String | A(300) | 300 |
| 56 | Procedure – ACHI code | Number | NNNNNNN | 7 (x8) |
| 57 | Deleted field |  |  |  |
| 58 | Deleted field |  |  |  |
| 59 | Deleted field |  |  |  |
| 60 | Artificial reproductive technology – indicator | Number | N | 1 |
| 61 | Date of onset of labour | Date/time | DDMMCCYY | 8 |
| 62 | Time of onset of labour | Date/time | HHMM | 4 |
| 63 | Date of onset of second stage of labour | Date/time | DDMMCCYY | 8 |
| 64 | Time of onset of second stage of labour | Date/time | HHMM | 4 |
| 65 | Date of rupture of membranes | Date/time | DDMMCCYY | 8 |
| 66 | Time of rupture of membranes | Date/time | HHMM | 4 |
| 67 | Labour type | Number | N | 1 (x3) |
| 68 | Labour induction/augmentation agent | Number | N | 1 (x4) |
| 69 | Labour induction/augmentation agent – other specified description | String | A(20) | 20 |
| 70 | Indications for induction (other) – free text | String | A(50) | 50 |
| 71 | Indication for induction (main reason) – ICD-10-AM code | String | ANN[NN] | 5 (X1) |
| 72 | Fetal monitoring in labour | String | NN | 2 (x7) |
| 73 | Birth presentation | Number | N | 1 |
| 74 | Method of birth | Number | NN | 2 |
| 75 | Indications for operative delivery – free text | String | A(300) | 300 |
| 76 | Indications for operative delivery – ICD-10-AM code | String | ANN[NN] | 5 (x4) |
| 77 | Analgesia for labour – indicator | Number | N | 1 |
| 78 | Analgesia for labour – type | Number | N | 1 (x4) |
| 79 | Anaesthesia for operative delivery – indicator | Number | N | 1 |
| 80 | Anaesthesia for operative delivery – type | Number | N | 1 (x4) |
| 81 | Events of labour and birth – free text | String | A(300) | 300 |
| 82 | Events of labour and birth – ICD-10-AM code | String | ANN[NN] | 5 (x9) |
| 83 | Prophylactic oxytocin in third stage | Number | N | 1 |
| 84 | Manual removal of placenta | Number | N | 1 |
| 85 | Perineal laceration – indicator | Number | N | 1 |
| 86 | Perineal / genital laceration – degree/type | Number | N | 1 (x2) |
| 87 | Perineal laceration – repair | Number | N | 1 |
| 88 | Episiotomy – indicator | Number | N | 1 |
| 89 | Blood loss (ml) | Number | N[NNNN] | 5 |
| 90 | Blood product transfusion – mother | Number | N | 1 |
| 91 | Postpartum complications – free text | String | A(300) | 300 |
| 92 | Postpartum complications – ICD-10-AM code | String | ANN[NN] | 5 (x6) |
| 93 | Discipline of lead intra-partum care provider | Number | N | 1 |
| 94 | Admission to high dependency unit (HDU) / intensive care unit (ICU) – mother | Number | N | 1 |
| 95 | Date of birth – baby | Date/time | DDMMCCYY | 8 |
| 96 | Time of birth | Date/time | HHMM | 4 |
| 97 | Sex – baby | Number | N | 1 |
| 98 | Birth plurality | Number | N | 1 |
| 99 | Birth order | Number | N | 1 |
| 100 | Birth status | Number | N | 1 |
| 101 | Birth weight | Number | NN[NN] | 4 |
| 102 | Apgar score at one minute | Number | N[N] | 2 |
| 103 | Apgar score at five minutes | Number | N[N] | 2 |
| 104 | Time to established respiration (TER) | Number | NN | 2 |
| 105 | Resuscitation method – mechanical | String | NN | 2 (x10) |
| 106 | Resuscitation method – drugs | Number | N | 1 (x5) |
| 107 | Congenital anomalies – indicator | Number | N | 1 |
| 108 | Deleted field |  |  |  |
| 109 | Deleted field |  |  |  |
| 110 | Deleted field |  |  |  |
| 111 | Neonatal morbidity – free text | String | A(300) | 300 |
| 112 | Neonatal morbidity – ICD-10-AM code | String | ANN[NN] | 5 (x10) |
| 113 | Admission to special care nursery (SCN) / neonatal intensive care unit (NICU) – baby | Number | N | 1 |
| 114 | Hepatitis B vaccine received | Number | N | 1 |
| 115 | Breastfeeding attempted | Number | N | 1 |
| 116 | Formula given in hospital | Number | N | 1 |
| 117 | Last feed before discharge taken exclusively from the breast | Number | N | 1 |
| 118 | Separation date – mother | Date/time | DDMMCCYY | 8 |
| 119 | Separation date – baby | Date/time | DDMMCCYY | 8 |
| 120 | Separation status – mother | Number | N | 1 |
| 121 | Separation status – baby | Number | N | 1 |
| 122 | Transfer destination – mother | Number | NNNN | 4 |
| 123 | Transfer destination – baby | Number | NNNN | 4 |
| 124 | Number of antenatal care visits | Number | NN | 2 |
| 125 | Influenza vaccination status | Number | N | 1 |
| 126 | Pertussis (whooping cough) vaccination status | Number | N | 1 |
| 127 | Spoken English Proficiency | Numeric | N | 1 |
| 128 | Year of arrival in Australia | Number | NNNN | 4 |
| 129 | Head circumference | Number | NN.N | 4 |
| 130 | Episode identifier | String | A(9) | 9 |
| 131 | Fetal monitoring prior to birth – not in labour | String | NN | 2 (x5) |
| 132 | Reason for transfer out – baby | Number | N | 1 |
| 133 | Reason for transfer out – mother | Number | N | 1 |
| 134 | Congenital anomalies – ICD-10-AM code | String | ANN[NN] | 5 (x9) |
| 135 | Maternal alcohol use at less than 20 weeks | Number | N | 1 |
| 136 | Maternal alcohol volume intake at less than 20 weeks | Number | N | 1 |
| 137 | Maternal alcohol use at 20 or more weeks | Number | N | 1 |
| 138 | Maternal alcohol volume intake at 20 or more weeks | Number | N | 1 |
| 139 | Antenatal corticosteroid exposure | Number | N | 1 |
| 140 | Chorionicity of multiples | Number | N | 1 |
| 141 | Cord complications | String | ANN[NN] | 5(x3) |
| 142 | Diabetes mellitus during pregnancy – type  | Number | N | 1 |
| 143 | Diabetes mellitus – gestational – diagnosis timing | Number | NN | 2 |
| 144 | Diabetes mellitus – pre-existing – diagnosis timing | Number | NNNN | 4 |
| 145 | Diabetes mellitus therapy during pregnancy | Number | N | 1(x3) |
| 146 | Main reason for excessive blood loss following childbirth  | Number | N | 1 |
| 147 | Blood loss assessment – indicator  | Number | N | 1 |
| 148 | Category of unplanned caesarean section urgency | Number | N | 1 |
| 149 | Date of decision for unplanned caesarean section | Date/time | DDMMCCYY | 8 |
| 150 | Time of decision for unplanned caesarean section | Date/time | HHMM | 4 |