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Introduction

The data presented here are mainly obtained from the Scottish Morbidity Record 02 (SMR02) submitted by maternity hospitals to ISD, who have collected this information since 1975.

A wide range of information is collected on the SMR02 - some of which are detailed below:

- mother - age, height, smoking history, previous obstetric history.
- baby - apgar score, sex, gestation, weight.

Although there is no legal requirement to submit these data to ISD, the level of submission falls only slightly short of the known total number of births occurring each year. Further details are shown on the first chart in the Results and Commentary section - this shows a comparison of births recorded on SMR02 compared to number of births registered with the National Records of Scotland (NRS). See also background information (Appendix 1).
Key points

- There were 58,095 births (including live and still births) recorded on SMR02 for the year ending March 2011. Although a slight decrease from last year’s figure of 58,275 births, the general trend over the last 10 years has been a gradual increase from 50,846 in 2002.

- Data from SMR02 represent approximately 98% of the births registered by the National Records Service. Some of this shortfall will be due to data on home births not being available from SMR02 data.

- Mothers are getting older: There was a steady increase in the proportion of births to mothers aged 30-34, from 13.5% in 1976 to a peak of 31.1% in 2002, but this has now declined slightly to 28.2% in 2011. The proportion of births to mothers in the 35-39 group climbed steadily to 17.1% in 2008 from 4.4% in the late 1970s and has now decreased to 16.1% in 2011. 3.6% of births are to mothers aged forty and over compared to 0.8% during the 1980s.

- Smoking in pregnancy: The overall percentage of women who reported smoking at the time of their first antenatal booking has decreased from 29.0% in 1995 to 19.3% in 2011. It should be noted that the percentage of 'unknowns' has fallen to 4.8% in 2011 from 10.6% in 2010 and that this may include a proportion of smokers. This is an improvement on 2009, when 'unknowns' accounted for 14.2% and below the 1995 figure of 5%. There is known to be considerable under-reporting of smoking by pregnant women themselves.

- Caesarean section: In singleton births, the emergency caesarean section rate increased from 3.9% in 1976 to a peak of 15.4% in 2006, The figure for 2011 is 15.3%  The rate of elective* or planned caesarean sections has continued to rise from 4.7% in 1976, to 11.2% in 2011. Together this has resulted in an overall increase in caesarean section rates from 8.6% in 1976 to 26.5% in 2011. [*An elective caesarean section refers to a caesarean section which has been planned in advance and in most cases will have been recommended for clinical reasons such as breech or multiple births or previous caesarean section. It may also be the case that the woman will have chosen this method of delivery for non-clinical reasons.]

- Forceps deliveries: After falling from 13.5% in 1980 to 6.8% in 2001 the use of forceps in delivery has risen over the last 10 years and is now at 10.0%.

- Premature babies: The percentage of pre-term (born before 37 completed weeks) singleton babies rose from 5.2% in 1976 to a peak of 6.7% in 2004 and has now fallen to 5.8% in 2011.

- Deprivation: The most common age for starting a family in the area of lowest deprivation is 30, which is 10 years later than the most common age in the area of highest deprivation.

- The percentage of babies with a healthy birthweight was 90.1% in year ending March 2011. This percentage has remained relatively stable over the last ten years.
• Miscarriage: There is a general downward trend in the number of recorded miscarriages, falling from 7,546 in 1998 to 5,634 in 2011. However, it is likely that some, particularly early, miscarriages are either managed solely by General Practitioners or may not be recognised by the women and so are never referred to hospital.
Results and Commentary

NRS birth registrations v SMR02 births

Since 1855 all births in Scotland have been registered with the National Records of Scotland (NRS) previously the General Register Office for Scotland. The chart below shows an initial rise to around 120,000 births per year in the early 1900s then a general downward trend to just over 50,000 in 2002. Since then there has been a steady year on year increase to a peak in 2008 of 60,041 live births. The 2011 provisional NRS figures show that the number of live births was 58,590, representing a decrease of 2.4% from 2008.

NRS birth registrations v SMR02 births; y/e 31 December 1855 to 2011\textsuperscript{P}

Sources: NRS birth registrations and SMR02.

\textsuperscript{P} Provisional.

The apparent SMR02 fall off in the period ending December 31\textsuperscript{st} 2011 is due to incomplete data.

For information on outcome of births see:
Table 1: Births by outcome and year; Scotland, NHS board, LCA and CHP
Maternal Age

It is well established that women are having fewer children, and postponing childbirth until they are older as shown in Table 2. Births to mothers aged 30-34 have risen steadily, accounting for 28% of all maternities. Since 1976 there has also been a steady rise in the proportion of mothers aged 35+ (from 6.0% to 19.6%). In 1976 there were 18,000 more births to mothers in the 20-24 group compared to those in the 35+ group; however, this gap has diminished steadily in the intervening years, such that in 2011 there were 820 more births to mothers aged 35+. This change has obstetric implications and has contributed to the rise in caesarean sections, since it is well documented that age is correlated with increased risk of emergency caesarean section.

Table 3 shows the number of first births by deprivation quintile, which are derived from the total population rather than just the childbearing population. Although 20% of the total population are classified into each quintile, there is an imbalance between the least and the most deprived quintiles of the childbearing population with a higher proportion of births in quintile 1 (most deprived) compared with quintile 5 (least deprived). When the data are examined by age, there are strong patterns as shown in the chart below.

First birth\(^1,2\) by maternal age and deprivation quintile\(^3\); y/e 31 March 2011\(^p\)

![First birth by maternal age and deprivation quintile](chart.png)

Source: SMR02

1. Excludes home births and births at non NHS hospitals.
2. Where four or more babies are involved in a pregnancy, birth details are recorded only for the first three babies delivered.
3. Scottish Index of Multiple Deprivation (SIMD) 2009.

P Provisional.

The age distribution of first births by deprivation shows a difference of approximately 10 years between the most common age for starting a family in the most deprived quintile
compared to the least deprived. In the under 20s, there were ten times the proportion of births in the more deprived groups compared to the least deprived, and this pattern has remained fairly constant, despite a decrease of nearly 50% in the total number of births in this age group since 1976. In the 20-24 year olds the ratio of babies born in the least deprived quintile to those born in the most deprived quintile is 5 to 1. This starts to reverse at approximately 28 years, and for the combined age groups 30-34 and 35-39, the ratio is approximately 1 to 1.7. This is a slight decrease from the previous year. Much the same sort of pattern is seen when all births are examined rather than just first births. The data support the view that these changes in behaviour (delaying reproduction) are occurring in all sections of society.

For more information on births by maternal age see:
Table 2: Maternities by maternal age and year; Scotland, NHS board, LCA and CHP
Table 3: Maternities (first birth and all births), by maternal age and deprivation (SIMD); Scotland and by NHS board by year
**Mode of delivery**

**Singleton births**
In singleton births, spontaneous vertex (normal vaginal) deliveries have fallen steadily since 1976 from (75.8% to 60.4%). Forceps deliveries fell from 13.3% in 1976 to a low of 6.8% in 2002 before rising to 10.0% in 2011. The chart below illustrates the changes in mode of delivery since 1998.

**Live singleton births\(^1,2\)** by mode of delivery (excluding SVD); 1998-2011, y/e 31 March

![Graph showing mode of delivery changes](image-url)

Source: SMR02

1. Excludes home births and births at non NHS hospitals.
2. Where four or more babies are involved in a pregnancy, birth details are recorded only for the first three babies delivered.

Elective* and emergency caesarean section rates have both increased steadily since 1976 (from 4.7% to 11.2% and 3.9% to 15.3% respectively). The overall caesarean section rate has risen from 8.6% in 1976 to 26.5% in 2011. Possible explanations for this rise include demographic changes, differences in clinical practice, characteristics and views of the obstetrician, the organisation and availability of resources, one to one support in labour and womens' choices. The change in practice for delivery of breech presentation, repeat caesarean section, delivery of preterm infants and twins are contributing to the overall rise. In addition maternal age and weight are rising and this has been shown to correlate with a rise in caesarean section \(^1\).

Ventouse (vacuum extraction) was less than 1% until 1990 then rose to 5.6% in 2003. Since then there has been a steady decline to 2.9% in 2011. Vaginal breech delivery has fallen slowly but steadily from 1.7% in 1976 to 0.2% in 2011. In 1976 rates of induction of
labour were 47.6% and then fell steadily to reach a low of 20.3% in 1989. The rate was 22.7% in 2011. Population studies have shown a rise in perinatal and neonatal morbidity and mortality in prolonged pregnancies which has led to current recommendations for considering induction of labour after 41 completed weeks\(^2,3\).

**Multiple births**
Multiple births are less likely to be delivered vaginally, with 33.8% being delivered by elective caesarean section (compared to 6.1% in 1976) and 36.9% by emergency section (compared to 4.5% in 1976). The incidence of multiple births is rising partly because of an older maternal population (multiple births are more common with increasing maternal age) and the use of ovulation induction and IVF (In Vitro Fertilisation).

* An elective caesarean section refers to a caesarean section, which has been planned in advance and in most cases will have been recommended for clinical reasons such as breech or multiple births or previous caesarean section. It may also be the case that the woman will have chosen this method of delivery for non-clinical reasons.

For more information on mode of delivery see:
Table 4: Live births by mode of delivery (and induced) by year; Scotland, NHS board and hospital.

References:
Birthweight and gestation

Singleton births
Low birthweight (LBW) is a major determinant of infant mortality and morbidity. In addition, as it is associated with a variety of social and environmental factors, it is often used as a health status indicator. Low birthweight may result from being born too soon (i.e. a preterm birth), from poor intrauterine growth or from a combination of the two.

A number of factors have been shown to be associated with low birthweight and/or preterm births. These include maternal smoking, maternal age (older and younger mothers are more likely to have a low birthweight baby), deprivation, previous obstetric history, low pre-pregnancy maternal weight, drug/alcohol use, hypertension and multiple births. Information on some of these factors is also recorded and available on these web pages: maternal age; smoking at booking and maternal smoking recorded at public health nurse/health visitor’s First Visit.

The chart below shows trends in the proportions of babies born of low (1500-2499g) and very low (under 1500g) birthweight (VLBW) at full term (at or after 37 weeks gestation) and pre-term (before 37 weeks gestation) for singleton births.

Live singleton births 1, 2 by birthweight and gestation; 1998-2011, y/e 31 March

Source: SMR02
1. Excludes home births and births at non NHS hospitals.
2. Where four or more babies are involved in a pregnancy, birth details are recorded only for the first three babies delivered.
3. Includes births where the birthweight is unknown.
P Provisional.

For more information on birthweight and gestation see:
Table 5: Live births by birthweight, gestation and year; Scotland and NHS board
Table 6: Births by term, birthweight and year; Scotland and NHS board
Table 7: Live births by birthweight, deprivation and year; Scotland and NHS board
Healthy Birthweight

Birthweight is one of the important indicators used to assess the health of an infant at birth and there has been an overall rise in mean birthweight in recent years. However, it is important to be able to differentiate between babies who are light because they are preterm and those who are inappropriately light after adjustment for gestational age at birth. Such babies, known as “small for gestational age” may be growth restricted and have an increased risk of other complications. Some of the babies who are large for gestational age may be macrosomic, perhaps secondary to maternal diabetes.

Birthweight that is not within normal ranges has a strong association with poor health outcomes in infancy, childhood and across the whole life course, including long term conditions such as diabetes and coronary heart disease.

The data in the accompanying tables is presented for live births and has been produced by comparing the birthweights and gestations with a set of standard tables derived from Scottish data on all births from the years 1998-2003. The details of the way in which the standards were derived are available here: http://www.biomedcentral.com/1471-2393/8/5

For the year ending March 2011 the percentage of babies with a healthy birthweight was 90.1%. This percentage has remained relatively stable over the last ten years.

Percentage of Babies of Healthy Birthweight (Appropriate Weight for Gestational Age), Scotland, 2001-2011

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1 – Centiles for Birthweight Charts for Gestational Age for Scottish Singleton Births, Sandra Bonnellie et al, BMC Pregnancy and Child Birth 2008

In order to match to the birthweight standard charts cases with unknown gestation, birthweight and parity were excluded as were cases with estimated gestation outwith the range 24-43 weeks and undetermined gender

2 - Excludes home births and births at non-NHS hospitals.

3 - Scotland data includes births where NHS board of residence is unknown or outside Scotland.

Source: SMR02
Little variation is seen across the different NHS Boards in the percentage of babies with a healthy birthweight.

**Percentage of Babies of Healthy Birthweight (Appropriate Weight for Gestational Age), Year ending March 2011, by NHS Board, with Upper and Lower 95% Confidence Interval**

1 – Centiles for Birthweight Charts for Gestational Age for Scottish Singleton Births, Sandra Bonnellie et al, BMC Pregnancy and Child Birth 2008
In order to match to the birthweight standard charts cases with unknown gestation, birthweight and parity were excluded as were cases with estimated gestation outwith the range 24-43 weeks and undetermined gender

2 - Excludes home births and births at non-NHS hospitals.
3 - Scotland data includes births where NHS board of residence is unknown or outside Scotland.

Source: SMR02
ISD Scotland

For more information on healthy birthweight see

Table 10 [Appropriate weight for gestational age]
Early access to antenatal services

The Scottish Government has developed a new “Health Efficiency, Access and Treatment (HEAT) target for early access to antenatal services. Full details are available here. http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance/AntenatalAccess. The rationale for this target is that the advice and interventions available during antenatal care are likely to have the greatest effect if they are started early. In particular, there is evidence that those women at highest risk of poor pregnancy outcomes are less likely to access antenatal care early and/or have a poorer experience of that care.

The target specifies that: “At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation by March 2015 so as to ensure improvements in breast feeding rates and other important health behaviours.” The gestation at booking (in completed weeks) is calculated by subtracting the time between the delivery and booking dates from the gestation at delivery (in completed weeks).

It should be noted that for the purpose of the HEAT target, the SIMD quintiles are derived at individual NHS Board level (ie the population of each NHS Board divided into five SIMD quintiles). The figure for the whole of Scotland uses SIMD derived for the total population.

“The present publication is displaying data for the financial year 2010/2011 as an introduction to the target. The official data for the target will be produced on the “Scotland Performs” website http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance.”

At the present time, individual NHS Boards are working on improving the quality of their data (including missing booking dates) and their approach to antenatal care. For the period 2010/2011 there were some problems with data definition and completeness in some board areas, so the figures presented here should be considered to be illustrative only.

For more information on early access to antenatal services see:

Table 12: Early access to antenatal services
### Percentage of all maternities booked by 12 weeks gestation by NHS board of residence and deprivation quintile

<table>
<thead>
<tr>
<th>NHS Board</th>
<th>SIMD Quintile 1-Most deprived</th>
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<th>4</th>
<th>5-Least deprived</th>
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### Percentage of all maternities where there is no date of booking by NHS board of residence and deprivation quintile

<table>
<thead>
<tr>
<th>NHS Board</th>
<th>SIMD Quintile 1-Most deprived</th>
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<th>3</th>
<th>4</th>
<th>5-Least deprived</th>
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</tr>
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</table>

1. Excludes records where mother has delivered at home or at non-NHS hospital.
2. Scotland data includes delivery records where NHS board of residence is unknown or outside Scotland.
3. Deprivation in the boards is based on SIMD health board quintile, whereas deprivation in Scotland is based on SIMD Scotland quintiles.
Smoking and pregnancy

It is widely accepted that smoking during pregnancy is harmful to both mother and baby. As mentioned in the Birthweight and Gestation section, maternal smoking is associated with preterm and/or low birthweight babies. Smoking in pregnancy is also associated with increased risk of miscarriage, stillbirth and sudden unexpected death in infancy (SUDI). The Scottish Stillbirth Perinatal and Infant Mortality and Morbidity Report provides information on the incidence of stillbirth and SUDI.

Smoking behaviour in pregnancy is collected at a woman's first antenatal booking appointment which usually takes place within the first three months of pregnancy. These booking appointments take place either at hospital or in the community and are recorded on the Scottish Woman Held Maternity Record, with data being subsequently transcribed onto the Scottish Morbidity Record (SMR02). Information on maternal smoking is also recorded at the public health nurse/health visitor's First Visit to the mother and baby which usually takes place about 10 days after the birth. Data from the First Visit is recorded on the Pre-school component of the Child Health Systems Programme (CHSP-PS). The CHSP-PS was introduced in 1991 and the number of participating boards has increased over the years. All NHS Boards in Scotland now use the CHSP-PS.

In recent years, there have been concerns about the completeness and quality of the SMR02 data, and to a lesser extent, the CHSP-PS data. In the following charts, we present the data so that the reader can see the level of recording of all responses including 'unknown', and they can also compare the two systems. It should be noted that the CHSP-PS data does not record whether the woman was a 'former' smoker. The label of 'missing' in the CHSP-PS data is assumed to be equivalent to the label of 'Not Known' in the SMR02 data.

There is considerable pressure on women not to smoke during pregnancy, and there is evidence of under-reporting by women of their smoking behaviour at the booking clinic\(^1\). The public health nurses/health visitors perform their First Visit at home, so it is less easy for the mother to hide evidence of smoking.

Charts showing overall smoking rates, deprivation categories, NHS board and mother's age for ‘Smoking history at Booking’ and ‘Smoking at public health nurse/health visitor’s first visit’ are shown on the following pages. Please refer to footnotes relevant to charts at end of Smoking and Pregnancy section.

Links to the tables are available here:
Table 8: Smoking history at booking; Scotland, NHS board, deprivation and maternal age
Table 9: Smoking at public health nurse/health visitor’s first visit; Scotland, NHS board, deprivation and maternal age

Reference:
The SMR02 data demonstrates a fall in the level of women who are smokers at booking from 29.0% in 1995 to 19.3% in 2011. The level of 'Not Known' has decreased slightly from 5.0% in 1995 to 4.8% in 2011, which is an improvement on 2010 (10.6%). It should be noted that the percentage of 'unknowns' may include a proportion of smokers. Nevertheless, the SMR02 data are supported by the CHSP-PS data and suggest a reduction in the level of smoking in recent years.
Smoking by deprivation category
For the following charts, the woman’s deprivation has been derived using the Scottish Index of Multiple Deprivation 2009 (SIMD). SIMD5 is the least deprived quintile and SIMD1 is the most deprived.

**Smoking at booking by SIMD; y/e 31 March 2011**

![Chart showing smoking rates by SIMD quintile]

Source: SMR02
Please refer to footnotes at end of section.

**Smoking at first visit by SIMD; y/e 31 March 2011**

![Chart showing smoking rates by SIMD quintile]

Source: CHSP-PS
Please refer to footnotes at end of section.

These charts demonstrate clearly the strong relationship between smoking and deprivation, with smoking at booking in 2011 ranging from 31.6% in SIMD1 to 6.0% in SIMD5.
Smoking by NHS Board
The following charts show the variation in smoking across NHS Boards. Please note the wide variation in the 'Not Known' category, especially in 'Smoking at Booking' data.

Smoking at booking by NHS Board of residence; y/e 31 March 2011

Source: SMR02
Please refer to footnotes at end of section.

Smoking at first visit by participating NHS Board of review; y/e 31 March 2011

Source: CHSP-PS
Please refer to footnotes at end of section.
Smoking by mother's age

### Smoking at booking by maternal age; y/e 31 March 2011

![Bar chart showing smoking rates by maternal age at booking.](chart_booking)

- **Never**
- **Former**
- **Not Known**
- **Current**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 20</td>
<td>Never 95%</td>
</tr>
<tr>
<td>20-24</td>
<td>Never 90%</td>
</tr>
<tr>
<td>25-29</td>
<td>Never 85%</td>
</tr>
<tr>
<td>30-34</td>
<td>Never 80%</td>
</tr>
<tr>
<td>35-39</td>
<td>Never 75%</td>
</tr>
<tr>
<td>40+</td>
<td>Never 70%</td>
</tr>
</tbody>
</table>

Source: SMR02
Please refer to footnotes at end of section.

### Smoking at first visit by maternal age; y/e 31 March 2011

![Bar chart showing smoking rates by maternal age at first visit.](chart_first_visit)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 20</td>
<td>Non-smoker 95%</td>
</tr>
<tr>
<td>20-24</td>
<td>Non-smoker 90%</td>
</tr>
<tr>
<td>25-29</td>
<td>Non-smoker 85%</td>
</tr>
<tr>
<td>30-34</td>
<td>Non-smoker 80%</td>
</tr>
<tr>
<td>35-39</td>
<td>Non-smoker 75%</td>
</tr>
<tr>
<td>40+</td>
<td>Non-smoker 70%</td>
</tr>
</tbody>
</table>

Source: CHSP-PS
Please refer to footnotes at end of section.

This chart shows that a mother's age is correlated to her smoking behaviour. With increasing age there is a decrease in smoking behaviour. The data in Table 9 illustrate that smoking behaviour has declined between 2002 and 2011.
Footnotes relevant to Smoking and Pregnancy section

Smoking at Booking

Excludes home births and births at non-NHS hospitals.

For analyses using SIMD 2009 ISD have changed their labelling and now label the categories as 1=most deprived to 5=least deprived. Our policy of population-weighting the quintiles remains unchanged, so the datazones contained within each quintile will differ slightly to those presented in Scottish Government releases.

p - Provisional.
# Please refer to notes on Accuracy of Smoking Data available on Appendix A1- Background information.

Smoking at first visit

These statistics are derived from breastfeeding data recorded at the public health nurse/health visitor First Visit review (at around 10 days old) and the 6-8 week review, for NHS Boards in Scotland which participate in the Child Health Systems Programme Pre-School system (CHSP-PS). The number of NHS Boards participating in the CHSP-PS and included in these statistics has increased since 2001/02 from 10 to 14 Boards (all NHS Boards in Scotland now use the CHSP-PS). This has resulted in an increase in the proportion of the pre-school population covered by CHSP-PS from approximately 84% in 2001/02 to 100% in 2010/11. Therefore the trend for 'All participating NHS Boards' should be interpreted with a degree of caution. In particular, NHS Grampian and NHS Orkney implemented the CHSP-PS during 2010 and are included in these statistics for the first time (in the figures for 2010/11 only). These Boards account for approximately 8% of First Visits and have lower smoking at First Visit rates than the Scotland average. This should be borne in mind when comparing the 'All participating NHS Boards' smoking rates for 2010/11 with previous years.
Miscarriage

Accurate assessment of the number of miscarriages (previously referred to as “spontaneous abortions”) that occur is not possible as only miscarriages that require hospital inpatient or day-case treatment are recorded. Hospital based information is derived from two sources: the acute hospital inpatient and day-case record (SMR01) and the maternity inpatient and day case record (SMR02), with individual episodes being derived from only one of these sources. It is possible that some, particularly early, miscarriages are either managed solely by General Practitioners or may not be recognised by the women and so are never referred to hospital.

There is a general downward trend in the number of recorded miscarriages, falling from 7,546 in 1998 to 5,634 in 2011. The table in the link below shows the number of miscarriages by NHS board of residence and age group for year end 31st March 2011.

Table 11: Miscarriage by NHS board
# Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>All births</td>
<td>When four or more babies are born, details about the babies are only recorded on the SMR02 for the first three babies delivered. However, the total number of births from the pregnancy are recorded.</td>
</tr>
<tr>
<td>Antenatal</td>
<td>Occurring before birth.</td>
</tr>
<tr>
<td>Delivery</td>
<td>A delivery is a pregnancy resulting in a live or still birth.</td>
</tr>
<tr>
<td>Deprivation Category</td>
<td>The deprivation analyses on these webpages are based on either Carstairs deprivation quintiles or the Social Index of Multiple Deprivation (SIMD) according to the recommendations on this page. See footnotes at bottom of individual tables for which deprivation measure was used.</td>
</tr>
<tr>
<td>Elective Caesarean</td>
<td>An elective caesarean section refers to a caesarean section, which has been planned in advance and in most cases will have been recommended for clinical reasons such as breech or multiple births or previous caesarean section. It may also be the case that the woman will have chosen this method of delivery for non-clinical reasons.</td>
</tr>
<tr>
<td>Full term</td>
<td>A birth is considered full-term if the delivery occurs during or after the 37th week of gestation.</td>
</tr>
<tr>
<td>Live Births</td>
<td>A live birth is defined as a birth where the baby was born breathing or showing other signs of life.</td>
</tr>
<tr>
<td>Low birthweight</td>
<td>Babies with a birthweight of less than 2,500 grams.</td>
</tr>
<tr>
<td>Macrosomic</td>
<td>Babies with an abnormally large body size.</td>
</tr>
<tr>
<td>Maternity</td>
<td>A pregnancy resulting in a live or stillbirth, with multiple births being counted only once.</td>
</tr>
<tr>
<td>Multiple birth</td>
<td>A baby from a pregnancy resulting in more than one live or stillbirth.</td>
</tr>
<tr>
<td>Parity</td>
<td>Refers to the number of previous pregnancies resulting in a live or stillbirth.</td>
</tr>
<tr>
<td>Postnatal</td>
<td>Occurring after birth.</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>The period during which a woman is pregnant.</td>
</tr>
<tr>
<td>Preterm</td>
<td>A birth is considered preterm if the delivery occurs before the 37th completed week of gestation.</td>
</tr>
<tr>
<td>Singleton birth</td>
<td>A baby from a pregnancy resulting in only one live or stillbirth.</td>
</tr>
<tr>
<td>Stillbirths</td>
<td>The Registration of Births, Deaths and Marriages (Scotland) Act 1965 defines a stillbirth as a child which was born after the 24th week of pregnancy and which did not breathe or show any other sign of life.</td>
</tr>
<tr>
<td>Very low birthweight</td>
<td>Babies with a birthweight of less than 1,500 grams.</td>
</tr>
<tr>
<td>Table No.</td>
<td>Name</td>
</tr>
<tr>
<td>----------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>1</td>
<td>Births by outcome;</td>
</tr>
<tr>
<td></td>
<td>• Scotland</td>
</tr>
<tr>
<td></td>
<td>• NHS board of residence</td>
</tr>
<tr>
<td></td>
<td>• Local Council Area</td>
</tr>
<tr>
<td></td>
<td>• Community Health Partnership</td>
</tr>
<tr>
<td>2</td>
<td>Maternities by maternal age;</td>
</tr>
<tr>
<td></td>
<td>• Scotland</td>
</tr>
<tr>
<td></td>
<td>• NHS board of residence</td>
</tr>
<tr>
<td></td>
<td>• Local Council Area</td>
</tr>
<tr>
<td></td>
<td>Community Health Partnership</td>
</tr>
<tr>
<td>3</td>
<td>Maternities (first birth and all births) by maternal age and deprivation</td>
</tr>
<tr>
<td></td>
<td>• Scotland</td>
</tr>
<tr>
<td></td>
<td>• NHS board of residence</td>
</tr>
<tr>
<td>4</td>
<td>Live births by mode of delivery and induction;</td>
</tr>
<tr>
<td></td>
<td>• Scotland</td>
</tr>
<tr>
<td></td>
<td>• hospital</td>
</tr>
<tr>
<td>5</td>
<td>Live births (all, singleton and multiple) by birthweight and gestation</td>
</tr>
<tr>
<td></td>
<td>• Scotland</td>
</tr>
<tr>
<td></td>
<td>• NHS board of residence</td>
</tr>
<tr>
<td>6</td>
<td>All births (live and still), pre-term and full term by birthweight</td>
</tr>
<tr>
<td></td>
<td>• Scotland</td>
</tr>
<tr>
<td></td>
<td>• NHS board of residence</td>
</tr>
<tr>
<td>7</td>
<td>Live births (all, singleton and multiple) by birthweight and deprivation</td>
</tr>
<tr>
<td></td>
<td>• Scotland</td>
</tr>
<tr>
<td></td>
<td>• NHS board of residence</td>
</tr>
<tr>
<td>8</td>
<td>Smoking history at booking;</td>
</tr>
<tr>
<td></td>
<td>• Scotland</td>
</tr>
<tr>
<td></td>
<td>• NHS board of residence</td>
</tr>
<tr>
<td></td>
<td>• deprivation</td>
</tr>
<tr>
<td></td>
<td>• maternal age</td>
</tr>
<tr>
<td>9</td>
<td>Smoking at public health nurse/health visitor’s first visit;</td>
</tr>
<tr>
<td></td>
<td>• Scotland</td>
</tr>
<tr>
<td></td>
<td>• NHS board of residence</td>
</tr>
<tr>
<td></td>
<td>• deprivation</td>
</tr>
<tr>
<td></td>
<td>• maternal age</td>
</tr>
<tr>
<td>10</td>
<td>Appropriate for gestational age</td>
</tr>
<tr>
<td></td>
<td>• Summary</td>
</tr>
<tr>
<td></td>
<td>• Small</td>
</tr>
<tr>
<td></td>
<td>• Appropriate</td>
</tr>
<tr>
<td>Chart No.</td>
<td>Name</td>
</tr>
<tr>
<td>----------</td>
<td>------------------------------------------------------------</td>
</tr>
<tr>
<td>1</td>
<td>NRS birth registrations v SMR02 births</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>First birth by maternal age and deprivation</td>
</tr>
<tr>
<td>3</td>
<td>Live singleton births by mode of delivery</td>
</tr>
<tr>
<td>4</td>
<td>Live singleton births by birthweight and gestation</td>
</tr>
<tr>
<td>5</td>
<td>Smoking at booking by deprivation</td>
</tr>
<tr>
<td>6</td>
<td>Healthy Birthweight, Scotland, 2001-2011</td>
</tr>
<tr>
<td>7</td>
<td>Healthy Birthweight, by NHS Board, 2011</td>
</tr>
</tbody>
</table>

List of Charts
Contact
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Further Information
Further information can be found on the ISD website

Rate this publication
Click here to provide feedback and rate this publication.
Appendix

A1 – Background Information

Maternity Data Source (inpatients and day cases)
Hospital based maternity and birth data are derived from the maternity inpatient and day case record (SMR02).

Births
In Scotland the most reliable number of births is based on the civil registration system administered by the National Records of Scotland (NRS). However, NRS numbers are based on the date of registration of the births rather than the date of birth, so that a child born in late December of one year may not be registered until the following year. The data presented on these web pages are derived from SMR02 (maternity hospital records) and are based on date of discharge from hospital. Unlike civil registrations, there is no legal requirement to complete the maternity return, with under-recording of home births being one area for particular concern.

Coverage and completeness
Since 1976 the SMR02 system has achieved national coverage of approximately 98 per cent of all births and pregnancies and includes a wide range of clinical data such as birthweight, gestational age, mode of delivery, induction and outcome of pregnancy. More recently, information on smoking during pregnancy (1993/94) and drug and alcohol misuse (2003/04) has been introduced. There are, however, concerns about the completeness and accuracy of the recording of these variables. See note below on issues regarding smoking data. Information on drug misuse in pregnancy and on babies discharged from neonatal care can also be found in the Drug Misuse Statistics Scotland report.

Delivery records account for approximately half of all SMR02 discharges each year with antenatal, postnatal and abortion episodes forming the remaining discharges (see also Teenage Pregnancy and Abortion Act Statistics).

Tables in this website which are based on SMR02 information exclude home births. Detailed birth information about the fourth or subsequent babies (third prior to 1997) in a multiple delivery is also not available from this source, as the SMR02 can only facilitate the recording of information on three babies (two prior to 1997).

The data for year ending 31 March 2011 should be regarded as provisional and will be revised at the update next year. Throughout this publication, figures shown for each year relate to live births, still births, maternities, or pregnancies which occurred in the year ending 31 March. The one exception to this is the section on NRS birth registrations v’s SMR02 births, which is based on year ending 31 December.

Data issues
In previous publications, a very small number of births in a delivery were recorded as 9 (not known) and these were recoded and counted as singleton births. This has now been revised and they are no longer counted as a singleton birth. A number of tables have been affected by this and will now more accurately reflect the number of births as recorded on an SMR02 record.

Population data used for calculating age specific rates are provided by the National Records of Scotland (NRS).
**Healthy Birthweight**
The data in the accompanying tables have been produced by comparing the birthweights and gestations of singleton and multiple live births with a set of standard tables derived from Scottish data on all births from the years 1998-2003. The details of the way in which the standards were derived are available here: [http://www.biomedcentral.com/1471-2393/8/5](http://www.biomedcentral.com/1471-2393/8/5).

The birthweights of both live and stillborn babies were included during the production of the standard tables. Only babies with lethal congenital anomalies and obvious outliers, such as those with recorded birthweights less than 250 grams, were excluded. As the analysis provided in this report includes only live births, this means there are some issues with comparability to the standard tables. Stillborn babies on average have lower birthweight than live born babies of comparable gestation. This means that the proportion of babies who are small for gestational age (under the 5th centile) will be slightly lower than 5% when only live born babies are considered. As the proportion of births that are stillborn is highest at the lowest gestations, this effect will be most pronounced for severely or extremely preterm babies (specifically gestational age 24-31 weeks in this report). However, because such a small proportion of babies are so preterm (less than 1%), there is very little effect on the overall healthy birthweight figure and comparison of trends in the data over time is not affected.

**Scottish Index of Multiple Deprivation 2009 (SIMD 2009)**
In a change to the previous SIMD analyses, the 2009 version have been reversed to match the English version. Deprivation quintile 1 is now the most deprived and deprivation quintile 5, the least deprived.

**Accuracy of Smoking at Booking Data**
Data on smoking behaviour is based on self-reported information obtained from mothers at their ante-natal booking visit in the community or at hospital. The 'smoking at booking' data item was introduced in 1993/94 and it should be noted that, particularly in the earlier years and again more recently, this information is not always recorded and therefore can affect the results. Because of concerns about the quality of 'smoking at booking' data, care should be taken in interpreting the results.

**Smoking at First Visit**
The CHSP PS system, from which these statistics are derived, facilitates the call/recall of children for reviews from shortly after birth until school entry and records results. The system is dynamic, with ongoing updating of records. For this reason there can be very minor changes to previously published data for previous years, however any changes are negligible.
### Metadata Indicator Description

<table>
<thead>
<tr>
<th>Metadata Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Publication title</td>
<td>Births in Scottish Hospitals</td>
</tr>
<tr>
<td>Description</td>
<td>Annual update to information on births in Scottish NHS hospitals. This includes information on the mother, the delivery and the baby, available at various geographies including NHS Board, Local Council Area, Community Health Partnership and hospital level.</td>
</tr>
<tr>
<td>Theme</td>
<td>Health and Social Care.</td>
</tr>
<tr>
<td>Topic</td>
<td>Maternity and pregnancy services.</td>
</tr>
<tr>
<td>Format</td>
<td>Excel workbooks.</td>
</tr>
<tr>
<td>Data source(s)</td>
<td>SMR02 (maternity hospital discharge summary) and SMR01 (acute hospital discharge summary) in miscarriage data.</td>
</tr>
<tr>
<td>Date that data are acquired</td>
<td>1st September 2012 (two months prior to release).</td>
</tr>
<tr>
<td>Release date</td>
<td>27 November 2012</td>
</tr>
<tr>
<td>Frequency</td>
<td>Annual</td>
</tr>
<tr>
<td>Timeframe of data and timeliness</td>
<td>Data for financial year ending 31 March 2011. The delay between data timeframe and date of publication timeliness is mainly due to delays in data submission from some NHS boards. Publication of data is generally delayed until SMR02 submission is estimated to be around 97-98% complete.</td>
</tr>
<tr>
<td>Continuity of data</td>
<td>Reports data from 1975/76.</td>
</tr>
<tr>
<td>Revisions statement</td>
<td>Data are generally noted as provisional (due to a small shortfall in completeness of data) at time of publication. The data are then revised at next year's update. Concepts and definitions</td>
</tr>
<tr>
<td>Revisions relevant to this publication</td>
<td>Maternal Smoking at First Visit figures for all years revised. See Appendix A1 Smoking at First Visit section.</td>
</tr>
<tr>
<td>Relevance and key uses of the statistics</td>
<td>Making information publicly available for planning, epidemiology, provision of services and the statistics provides comparative information.</td>
</tr>
<tr>
<td>Accuracy</td>
<td>SMR02 data are subjected to validation on submission. The figures are compared to previous years’ figures and to expected trends. The SMR02 data are also occasionally assessed for accuracy by ISD's Data Quality Assurance -- see latest report 'Data Quality Assurance (Assessment of Maternity Data) 2008-09' Report at <a href="http://www.isdscotland.org/Products-and-Services/Data-Quality">http://www.isdscotland.org/Products-and-Services/Data-Quality</a></td>
</tr>
<tr>
<td>Completeness</td>
<td>There is generally around a 2 - 3% shortfall in the number of births when compared to the National Records of Scotland (NRS) birth registrations,</td>
</tr>
</tbody>
</table>
Information Services Division

formerly General Register Office Scotland (GROS). Some of this shortfall is due to data on home births not being available from SMR02 data source. For comparison of SMR02 births v NRS registrations see: [http://www.isdscotland.org/Health-Topics/Maternity-and-Births/Publications/2012-11-27/mat_bb_chart1.xls](http://www.isdscotland.org/Health-Topics/Maternity-and-Births/Publications/2012-11-27/mat_bb_chart1.xls)

| Comparability | Maternity data for England are published by NHS information Centre at HES Online ([http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=1009](http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=1009)) - some of this will be directly comparable with Scottish published data e.g. birthweight, gestation. Where directly comparable, Scottish maternity data are regularly provided to ONS, Department of Health for contribution to both UK and International reports/databases e.g. UK Health Statistics, Social Trends, European Health for All database. In these comparisons, data are provided only at national (Scotland) level or may be aggregated to UK. |
| Accessibility | It is the policy of ISD Scotland to make its web sites and products accessible according to published guidelines. |
| Coherence and clarity | Births in Scottish Hospital tables are accessible via the ISD website at [http://www.isdscotland.org/Health-Topics/Maternity-and-Births/Births](http://www.isdscotland.org/Health-Topics/Maternity-and-Births/Births) Drop down menus are presented where appropriate e.g. for selection of geography i.e. NHS board/local council area/community health partnership or for selection of singleton/multiple/all births or live/stillbirths/total births. |
| Value type and unit of measurement | Numbers and crude rates are presented. |
| Last published | 30 August 2011 |
| Next published | 26 November 2013 |
| Date of first publication | 1975 |
| Help email | Nss.isdmaternity@nhs.net |
| Date form completed | 8 August 2012 |
A3 – Early Access details (including Pre-Release Access)

Pre-Release Access

Under terms of the "Pre-Release Access to Official Statistics (Scotland) Order 2008", ISD are obliged to publish information on those receiving Pre-Release Access ("Pre-Release Access" refers to statistics in their final form prior to publication). The standard maximum Pre-Release Access is five working days. Shown below are details of those receiving standard Pre-Release Access and, separately, those receiving extended Pre-Release Access.

Standard Pre-Release Access:

Scottish Government Health Department
NHS Board Chief Executives
NHS Board Communication leads

Extended Pre-Release Access

Extended Pre-Release Access of 8 working days is given to a small number of named individuals in the Scottish Government Health Department (Analytical Services Division). This Pre-Release Access is for the sole purpose of enabling that department to gain an understanding of the statistics prior to briefing others in Scottish Government (during the period of standard Pre-Release Access).

Scottish Government Health Department (Analytical Services Division)

Pre-Release Access for Other Publications

Pre-Release Access is granted for the purpose of ensuring that related publications or other material being prepared for release at the same time as (or shortly after) the statistics concerned are properly informed by the correct figures, for example provision of data for the SG 'Scotland Performs' website.

Healthcare Improvement Scotland (HIS)
A4 – ISD and Official Statistics

About ISD

Scotland has some of the best health service data in the world combining high quality, consistency, national coverage and the ability to link data to allow patient based analysis and follow up.

Information Services Division (ISD) is a business operating unit of NHS National Services Scotland and has been in existence for over 40 years. We are an essential support service to NHSScotland and the Scottish Government and others, responsive to the needs of NHSScotland as the delivery of health and social care evolves.

Purpose: To deliver effective national and specialist intelligence services to improve the health and wellbeing of people in Scotland.
Mission: Better Information, Better Decisions, Better Health
Vision: To be a valued partner in improving health and wellbeing in Scotland by providing a world class intelligence service.

Official Statistics

Information Services Division (ISD) is the principal and authoritative source of statistics on health and care services in Scotland. ISD is designated by legislation as a producer of ‘Official Statistics’. Our official statistics publications are produced to a high professional standard and comply with the Code of Practice for Official Statistics. The Code of Practice is produced and monitored by the UK Statistics Authority which is independent of Government. Under the Code of Practice, the format, content and timing of statistics publications are the responsibility of professional staff working within ISD.

ISD’s statistical publications are currently classified as one of the following:

- National Statistics (ie assessed by the UK Statistics Authority as complying with the Code of Practice)
- National Statistics (ie legacy, still to be assessed by the UK Statistics Authority)
- Official Statistics (ie still to be assessed by the UK Statistics Authority)
- other (not Official Statistics)

Further information on ISD’s statistics, including compliance with the Code of Practice for Official Statistics, and on the UK Statistics Authority, is available on the ISD website.

The United Kingdom Statistics Authority has designated these statistics as National Statistics, in accordance with the Statistics and Registration Service Act 2007 and signifying compliance with the Code of Practice for Official Statistics. Designation can be broadly interpreted to mean that the statistics:

- meet identified user needs;
- are well explained and readily accessible;
- are produced according to sound methods, and
- are managed impartially and objectively in the public interest.

Once statistics have been designated as National Statistics it is a statutory requirement that the Code of Practice shall continue to be observed.