NMPA

National Maternity & Perinatal Audit

Annual Clinical Report

Based on births in NHS maternity services in England, Scotland and Wales during 2024

Outlier Policy, Alarm-level Outliers and Trust/Board Responses

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LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE
RCPCH Royal College of Paediatrics and Child Health
Royal College of Midwives
Royal College of Obstetricians & Gynaecologists
HQIP Healthcare Quality Improvement Partnership

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Introduction

This document provides a summary of the outlier policy for the National Maternity and Perinatal Audit (NMPA), as well as a list of the alarm-level outlier trusts/boards, those for whom the outlier status has been removed following a review of their data quality, and the trusts/boards that were non-participatory in the outlier process because of data quality. These lists can be found in appendix 1; appendix 2 includes correspondence provided by a number of trusts/boards in response to their outlier status, including what they found when interrogating their own data and some opportunities for clinical and/or data quality improvement.

The outlier process aims to facilitate clinical improvement and reduce variation in practice by using audit data to identify areas where improvement is required.

The policy sets out:

- How data provided to the NMPA will be analysed to detect potential outliers (NHS maternity service providers that have a result for a specific indicator that falls outside a predefined range).
- How the NMPA team will engage with NHS maternity service providers that are identified as potential outliers.

This policy relates specifically to the analysis of singleton births in NHS Maternity Services in England, Scotland and Wales during 2024. It has been reviewed and updated in line with the NCAPOP Outlier Guidance which was updated in October 2025 and is published on the HQIP website.

Choice of indicators for outlier reporting

The NMPA indicators measure a range of processes and outcomes of maternity care. These indicators were selected on the basis of a number of criteria,1 including that they need to:

- be valid and accepted measures of a provider's quality of care
- meet feasibility and data quality standards – that available information can correctly identify the required women/birthing people and babies, and their associated features and outcomes
- be fair – it should be possible to accurately adjust for the differing case-mix of women and babies between participating data providers
- occur frequently enough to provide sufficient statistical power for analysis to identify outlying performance

1 Geary RS, Knight HE, Carroll FE, Gurol-Urganci I, Morris E, Cromwell DA, van der Meulen JH. A step-wise approach to developing indicators to compare the performance of maternity units using hospital administrative data. *BJOG*. 2018;125(7):857-865 [https//:doi.org/10.1111/1471-0528.15013]

The indicators selected for outlier reporting were chosen because they represent adverse outcomes for women/birthing people or babies with potential serious or long-term effects. The indicators included in the outlier reporting for the NMPA Annual Clinical Report for births in 2024 are:

1) Proportion of women and birthing people giving birth vaginally to a singleton baby between 37^{+0} and 42^{+6} weeks of gestation, who experience a third- or fourth-degree perineal tear
2) Proportion of women and birthing people giving birth to a singleton baby between 34^{+0} and 42^{+6} weeks of gestation, who have a postpartum haemorrhage of 1500 ml or more
3) Proportion of liveborn, singleton babies born between 34^{+0} and 42^{+6} weeks of gestation, with a 5-minute Apgar score less than 7

The level of reporting for the outlier indicators is NHS Trust in England, Board/Health Board in Scotland and Wales. This document uses the term 'Trusts and Boards' to include all Trusts, Boards and Health Boards across the three countries.

The results for each of the indicators are adjusted for case-mix. For more detail about how the indicators are defined and calculated, the data quality checks applied, and the case-mix factors used in the adjustment models, please see the NMPA measures technical specification.

How to use this document

This Outlier Policy document forms part of a suite of resources produced for the NMPA annual clinical report on singleton births occurring in 2024. The following additional supporting documents can be found on our website:

- Data flow diagrams
- NMPA online results at trust/board level
- A measures technical specification document describing how the audit measures were constructed
- A methods document outlining how the analysis for this report was carried out
- Data completeness by trust and board
- State of the Nation report on births occurring in 2024
- Country-level summary results tables
- A glossary explaining the terminology and abbreviations used in our reports
- Quality Improvement (QI) resources

Data sources

The NMPA annual clinical report uses English, Scottish and Welsh data from the following sources:

England: Maternity data from Maternity Services Data Set (MSDS) version 2, are linked to Hospital Episode Statistics (HES) Admitted Patient Care (APC) administrative data, as well as the Personal Demographics Service (PDS) Birth Notification data. All pseudonymised English datasets are controlled and supplied directly to the NMPA by NHS England (formerly NHS Digital).

Wales: Maternity data from the Maternity Indicators data set (MIds), including Initial Assessment (IA) data, and the National Community Child Health Database (NCCHD), are linked to administrative data from the Patient Episode Database for Wales (PEDW) Admitted Patient Care (APC). All pseudonymised Welsh datasets are controlled and supplied directly to the NMPA by The Digital Health & Care Wales (DHCW) (formerly NHS Wales Informatics Service (NWIS)).

Scotland: Maternity data from the Scottish Morbidity Record-02 (SMR-02) and the Scottish Birth Record (SBR) are linked to inpatient and daycase data from Scottish Morbidity Records-01 and data from the National Records of Scotland (NRS) registers for births, stillbirths, and death. All pseudonymised Scottish datasets are controlled and supplied directly to the NMPA by Public Health Scotland (PHS).

Potential outliers

Detection of a potential outlier

The target for the expected rate is based on the average rate of all maternity service providers, adjusted for case-mix. Statistically derived limits around this target are used to define whether a participating Trust or Board is a potential outlier.

Results that fall in the range between the upper 95% and 99.8% control limits (between 2 and 3 standard deviations above the mean) are considered to be 'alerts'. A relatively large number of Trusts and Boards will have results for performance indicators within this range. These Trusts or Boards will be notified, as specified in *Table 1* below, but they will not be required to follow the full outlier management process.

A result for an indicator that is **higher** than the upper 99.8% control limit (greater than 3 standard deviations above the mean) is considered to be an 'alarm'. The Trust or Board is

then deemed a potential outlier and will be required to follow all steps in the outlier management process shown in *Table 2* below.

A result for an indicator that is **below** the lower 99.8% control limit (more than 3 standard deviations below the mean) is considered to be a 'lower than expected alarm'. These Trusts or Boards will be notified, as specified in *Table 4* below.

Non-participation outliers

The NMPA makes use of centrally collected datasets, which should include all eligible trusts/boards. However, data quality is assessed for each indicator and only organisations that pass completeness and distribution checks are included in the analysis.

Given that NMPA make use of multiple datasets, the data quality issues may be due to a range of issues, some of which are out of the control of the trust/board. The types of non-participation and how they should be handled as part of the outlier process case be found in *Table 3*. Data quality outcomes will be published at organisation level for each indicator.

The following scenario will be followed up from step 5 of the outlier process, as outlined in *Table 2*, and in line with the NCAPOP outlier guidance.

- The trust/board failed data quality checks for one or more of the indicators selected for outlier reporting (as outlined in section 2) **and** the data quality issue is judged to be within the control of the trust/board.

Starting at Step 5 allows the organisation to review and improve their data quality going forwards, but acknowledges that given the NMPA makes use of routinely collected data via centralised sources, it is now too late in the process for them to be able to resubmit better quality data for inclusion in the current publication.

Management of a potential outlier

The following tables summarise the key steps that the NMPA will follow in managing potential outlier maternity service providers, including the action required, the people involved, and the maximum time scales. It is based on the NCAPOP Outlier Guidance which is published on the HQIP website.

Trusts and Boards need to invest the time and resources required to review the data when they are identified as a potential outlier. Those that are still considered to be potential outliers after completing all steps of the outlier management process will be reported to the CQC and NHS England (English Trusts), the Scottish Government (Scottish Boards) or the Welsh Government (Welsh Health Boards).

Table 1 Actions required for outliers at the alert level

Greater than 2 standard deviations above the mean			
Step	**England**	**Wales and Scotland**	**Owner**
1	For alert level outliers relating to mortality, NCAPOP providers should inform the CQC (clinicalaudits@cqc.org.uk), using the outlier template, and include a copy of the project specific outlier policy, NHSE (england.clinical-audit@nhs.net), HQIP associate director and project manager (www.hqip.org.uk/about-us/our-team/) and HQIP NCAPOP Director of Operations, Jill Stoddart (jill.stoddart@hqip.org.uk). The healthcare provider lead clinician should also be informed by the NCAPOP provider of any alert level outliers. However, unlike for alarm level outliers (see below) the CQC, NHSE, and HQIP are not mandating a formal notification and escalation process for alert level beyond notification of the relevant clinical team.	NCAPOP audit providers should inform the Welsh Government (wgclinicalaudit@gov.wales), HQIP associate director and project manager (http://www.hqip.org.uk/about-us/our-team/) and HQIP NCAPOP Director of Operations, Jill Stoddart (jill.stoddart@hqip.org.uk) of all outliers at the alert level. NCAPOP audit providers will need to ensure that in their regular local level Health Board performance reports, it is clear if a Health Board is an outlier at the alert level. The NMPA will also inform the Scottish Government Health Department (MaternalandInfantHealth@gov.scot) and HQIP of all outliers at the alert level.	NMPA
2	The expectation is that NHS Trusts should use 'alert' information as part of their internal quality monitoring process. They should review alerts in a proactive and timely manner, acting accordingly to mitigate the risk of care quality deteriorating to the point of becoming an alarm level outlier.	The expectation is that Health Boards should use 'alert' information (available within local Health Board reports) as part of their internal quality monitoring process. They should investigate alerts in a proactive and timely manner, acting accordingly to mitigate the risk of care quality deteriorating to the point of becoming an alarm level outlier.	England = Healthcare provider lead clinician Wales = Health Board Medical Directors Scotland = NHS Board Medical Directors

Table 2 Actions required for outliers at alarm level and for non-participation

Greater than 3 standard deviations from expected performance start from step 1 Non-participation outliers are included from step 5				
Step	**England**	**Wales and Scotland**	**Owner**	**Within working days**
1	Healthcare providers with a possible performance indicator at alarm level require scrutiny of the data handling and analyses performed (in some cases this may not be possible for the audit provider and details of this can be included in the individual NCAPOP provider Outlier Guidance, see section 8.3) to determine whether: 'Alarm' status not confirmed: • Data and results revised in national clinical audit (NCA) records • Details formally recorded, and process closed 'Alarm' status confirmed: • Potential 'alarm' status: > proceed to step 2		NCAPOP audit provider team	10
2	Healthcare provider lead clinician informed about potential 'alarm' status and asked to identify any data errors or justifiable explanation(s). All relevant data and analyses should be made available to the lead clinician.		NCAPOP audit provider clinical lead	5
3	Healthcare provider lead clinician to provide written response to NCAPOP audit provider team.		Healthcare provider lead clinician	25
4	Review of healthcare provider lead clinician's response to determine: 'Alarm' status not confirmed:		NCAPOP audit provider clinical lead	20

Greater than 3 standard deviations from expected performance start from step 1 Non-participation outliers are included from step 5				
Step	**England**	**Wales and Scotland**	**Owner**	**Within working days**
	• It is confirmed that the data originally supplied by the healthcare provider contained inaccuracies. Re-analysis of accurate data no longer indicates 'alarm' status • Data and results should be revised in NCAPOP audit provider records including details of the healthcare provider's response 'Alarm' status confirmed: • Although it is confirmed that the originally supplied data were inaccurate, analysis still indicates 'alarm' status, or • It is confirmed that the originally supplied data were accurate, thus confirming the initial designation of 'alarm' status > proceed to step 5			
5	Contact healthcare provider lead clinician, prior to sending written notification of confirmed 'alarm' 3SD outliers and/or non participation outliers to healthcare provider CEO and copied to healthcare provider lead clinician and medical director. The letter should include the following request (which can be adapted to be relevant to a project): "Please ensure this letter is circulated to the appropriate people in the trust/health board within 5 working days. This may include, but is not limited to, the trust or health board's director of nursing, the clinical audit department manager / lead, any relevant clinical directors, and the trust chair (for England only)." For 3SD outliers, all relevant data and statistical analyses, including previous response from the healthcare provider lead		NCAPOP audit provider clinical lead/ team	5

<table>
<tr><td colspan="5">Greater than 3 standard deviations from expected performance start from step 1

Non-participation outliers are included from step 5</td></tr>
<tr><th>Step</th><th>England</th><th>Wales and Scotland</th><th>Owner</th><th>Within working days</th></tr>
<tr><td></td><td colspan="2">clinician should be made available to healthcare provider medical director and CEO.

The relevant NCAPOP project specific outlier policy should also be provided to healthcare provider colleagues.

At the same time, the following country-specific actions should be taken:</td><td></td><td></td></tr>
<tr><td></td><td>For England, the outlier confirmation letter should also include the details in Step 7 below, and a request that the Trust engage with their CQC local team.

Notify the CQC (clinicalaudits@cqc.org.uk), using the outlier template, and include a copy of the project specific outlier policy, NHSE (england.clinical-audit@nhs.net), HQIP associate director and project manager (www.hqip.org.uk/about-us/our team/), and HQIP NCAPOP Director of Operations, Jill Stoddart (jill.stoddart@hqip.org.uk) of confirmed ‘alarm’ status. All three organisations should</td><td>For Welsh providers, notify wgclinicalaudit@gov.wales, HQIP associate director and project manager (www.hqip.org.uk/ab out-us/our-team/), and HQIP NCAPOP Director of Operations, Jill Stoddart (jill.stoddart@hqip.org.uk) of confirmed ‘alarm’ status. The Welsh Government will provide a monthly report of all alarm and alert level outliers to its Quality Delivery Board.

For Scottish providers, notify Scottish Government Health Department (MaternalandInfantHealth@gov.scot), HQIP associate director and project manager (www.hqip.org.uk/ab out-</td><td></td><td></td></tr>
</table>

Greater than 3 standard deviations from expected performance start from step 1 Non-participation outliers are included from step 5				
Step	**England**	**Wales and Scotland**	**Owner**	**Within working days**
	confirm receipt of the notification. The CQC will provide NHS England with a quarterly report of all alarm and alert level outliers that have been notified to CQC.	us/our-team/) and HQIP NCAPOP Director of Operations, Jill Stoddart (jill.stoddart@hqip.org.uk) of confirmed 'alarm' status.		
6	NCAPOP audit providers will proceed to public disclosure of comparative information that identifies healthcare providers as alarm level outliers or non participation outliers (e.g. NCAPOP provider annual report, data publication online). NCAPOP audit providers will publish any responses received from healthcare providers, including findings from investigations that they or others have carried out into the outlier alert, as an addendum or footnote. Publication will not be delayed whilst waiting for such investigation to be completed. This can be added, online, when and if it subsequently becomes available.	Acknowledge receipt of the written notification confirming that a local investigation will be undertaken with independent assurance of the investigation's validity for 'alarm' level outliers, copying in the Welsh Government.	England = NCAPOP audit provider team Wales = Healthcare provider CEO Scotland = Healthcare provider CEO	NCAPOP audit provider report publication date

Greater than 3 standard deviations from expected performance start from step 1 Non-participation outliers are included from step 5				
Step	**England**	**Wales and Scotland**	**Owner**	**Within working days**
	Conversely, if there has been no response from the healthcare provider concerning their alarm outlier status, that will be documented on the NCAPOP audit provider's website where this information is presented.			
7	The CQC advise that during their routine local engagement with the providers, their inspectors will: • Encourage Trusts to identify any learning from their performance and provide the CQC with assurance that the Trust has used the learning to drive quality improvement • Ask the Trust how they are monitoring or plan to monitor their performance • Monitor progress against any action plan if one is provided by the trust.	The Welsh Government monitors the actions of organisations responding to outliers and takes further action as and when required. The Healthcare Inspectorate Wales (HIW) does not act as regulator and cannot take regulatory action in relation to NHS providers. However, HIW can request information on the actions undertaken by organisations to ensure safe services are being delivered. The Welsh Government can share information with HIW where appropriate and advise on the robustness of plans in place to improve audit results and outcomes.	England = CQC Wales = Healthcare Inspectorate Wales in collaboration with Welsh Government Scotland = Healthcare Improvement Scotland and Scottish Government	Determined by the CQC and Welsh and Scottish Governments
	If an investigation has been conducted in the Trust into an alarm outlier status, it is required that the CQC and audit provider	N/A	Trust medical director	

Greater than 3 standard deviations from expected performance start from step 1 Non-participation outliers are included from step 5				
Step	**England**	**Wales and Scotland**	**Owner**	**Within working days**
	would be provided with the outcome and actions proposed.			
	This would be published by the audit provider alongside the annual results. Further if there were no response, the audit provider would publish this absence of a response. The CQC are not prescriptive concerning any such investigations but there needs to be a degree of independence so that the validity of the findings is acceptable.	N/A	NCAPOP audit provider team	
8	N/A	If no acknowledgement received, a reminder letter should be sent to the healthcare provider CEO, copied to Welsh Government and HQIP. If not received within 15 working days, Welsh Government notified of non-compliance in consultation with HQIP.	NCAPOP audit provider team	15
9	N/A	Public disclosure of comparative information that identifies healthcare providers (e.g. NCAPOP audit provider annual report, data publication online).	NCAPOP audit provider team	NCAPOP provider report publication date

Table 3 Types of non-participation and how they should be handled as part of the outlier process

Non-participation outliers				
	Issue	**Healthcare provider responsible for non participation?**	**Reporting of results by audit provider**	**Outlier process applied to metrics where provider is non participant?**
1	Healthcare provider is not eligible for any metrics in the audit. (Not eligible)	No	Nothing is published in relation to this healthcare provider for the specific audit. Healthcare provider is not included in the audit's published list of overall non participation.	No
2	Healthcare provider is eligible for at least one metric but has not participated in the audit at all. (Complete non participation)	Yes	Included in the audit's reporting, with results flagged with 'data not submitted by the healthcare provider'. Healthcare provider is included in the audit's published list of overall non participation.	Yes* Healthcare provider should be treated as an alarm level outlier and followed up via standard processes. All communications should make it clear that status is due to non participation.
3	Healthcare provider eligible for more than one metric (and had eligible cases in the cohort) but for one or some of these metrics has submitted no data.	Yes	Included in the audit's reporting, with specific metric results flagged with 'data not submitted by the healthcare provider'. Healthcare provider is	Yes* Healthcare provider should be treated as an alarm level outlier for all eligible metrics where they have not participated and followed up via standard

Non-participation outliers				
	Issue	**Healthcare provider responsible for non participation?**	**Reporting of results by audit provider**	**Outlier process applied to metrics where provider is non participant?**
	(Partial non participation)		not included in the audit's published list of overall non participation.	processes. All communications should make it clear that status is due to partial non participation.

*For non-participation, the outlier process (as outlined in *Table 2*) will start at step 5, with the healthcare provider lead clinician being notified that their non-participation is to be flagged up to the Trust/Health Board CEO and Medical Director, and the Outlier notification process continued with either:

- Notification of CQC, NHS England and HQIP (For English providers)
- Notification of the Welsh Government and HQIP (For Welsh providers)
- Notification of the Scottish Government and HQIP (For Scottish providers)

Table 4 Actions required for 'lower than expected' outliers at the alarm-level

Greater than 3 standard deviations **below** the mean			
Step	**England**	**Wales and Scotland**	**Owner**
1	The healthcare provider Clinical Director and Head of Midwifery will be informed by the NMPA team of any lower than expected alarm-level outliers. They will be encouraged to investigate whether under reporting could have been a contributing factor. However, the CQC, NHSE, and HQIP are not mandating a formal notification and escalation process for lower than expected alarm-level outliers beyond notification of the relevant clinical team.	The NMPA team will inform the Welsh Government (wgclinicalaudit@gov.wales) or Scottish Government (MaternalandInfantHealth@gov.scot) and HQIP of all lower than expected alarm level outliers.	NMPA Team

Appendix 1

List of outlier measures

Third- and fourth-degree perineal tears

What is measured: Proportion of women and birthing people giving birth vaginally to a singleton baby between 37+0 and 42+6 weeks of gestation, who experience a third- or fourth-degree perineal tear.

Postpartum haemorrhage of ≥1500 ml

What is measured: Proportion of women and birthing people giving birth to a singleton baby between 34^{+0} and 42^{+6} weeks of gestation, who have a postpartum haemorrhage of 1500 ml or more.

Apgar score <7 at 5 minutes

What is measured: Proportion of liveborn, singleton babies born between 34+0 and 42+6 weeks of gestation, with a 5-minute Apgar score less than 7.

List of confirmed outlier trusts/boards

The following trusts/boards were identified as alarm-level outliers, they were notified and, where provided, their response can be found in *appendix 2*.

Third- and fourth-degree perineal tears

English Trusts

East Lancashire Hospitals NHS Trust

Medway NHS Foundation Trust

Nottingham University Hospitals NHS Trust

Royal United Hospitals Bath NHS Foundation Trust

Somerset NHS Foundation Trust

Stockport NHS Foundation Trust

The Hillingdon Hospitals NHS Foundation Trust

University Hospitals of Derby and Burton NHS Foundation Trust

University Hospitals of Leicester NHS Trust

University Hospitals Southampton NHS Foundation Trust

University Hospitals Sussex NHS Foundation Trust

Scottish Boards

NHS Fife

NHS Greater Glasgow and Clyde

NHS Lothian

Postpartum haemorrhage of ≥1500 ml

English Trusts

Blackpool Teaching Hospitals NHS Foundation Trust

Ashford And St Peter's Hospitals NHS Foundation Trust

County Durham and Darlington NHS Foundation Trust

East Lancashire Hospitals NHS Trust

Nottingham University Hospitals NHS Trust

The Newcastle Upon Tyne Hospitals NHS Foundation Trust

University Hospitals of Morecambe Bay NHS Foundation Trust

University Hospitals Southampton NHS Foundation Trust

Whittington Health NHS Trust

Apgar score <7 at 5 minutes

English Trusts

Barnsley Hospital NHS Foundation Trust

Calderdale and Huddersfield NHS Foundation Trust

Chesterfield Royal Hospital NHS Foundation Trust

County Durham and Darlington NHS Foundation Trust

Hampshire Hospitals NHS Foundation Trust

North Cumbria Integrated Care NHS Foundation Trust

Northumbria Healthcare NHS Foundation Trust

Sheffield Teaching Hospitals NHS Foundation Trust

Somerset NHS Foundation Trust

South Tyneside and Sunderland NHS Foundation Trust

The Newcastle Upon Tyne Hospitals NHS Foundation Trust

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

University Hospitals Sussex NHS Foundation Trust

Warrington and Halton Hospitals NHS Foundation Trust

Scottish Boards

NHS Borders

NHS Fife

NHS Forth Valley

NHS Greater Glasgow and Clyde

NHS Lanarkshire

NHS Orkney

NHS Tayside

Non-participation trusts/boards

The following trusts/boards did not pass the NMPA data quality checks necessary to be included in the trust-level analysis for outlier measures.

Third- and fourth-degree perineal tears

Welsh Health Boards

Betsi Cadwaladr University Health Board

Scottish Boards

NHS Shetland

Postpartum haemorrhage of ≥1500 ml

English Trusts

Bedfordshire Hospitals NHS Foundation Trust

Calderdale and Huddersfield NHS Foundation Trust

Chelsea and Westminster Hospital NHS Foundation Trust

Chesterfield Royal Hospital NHS Foundation Trust

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

East and North Hertfordshire NHS Trust

East Cheshire NHS Trust

Frimley Health NHS Foundation Trust

Guy's and St Thomas' NHS Foundation Trust

James Paget University Hospitals NHS Foundation Trust

King's College Hospital NHS Foundation Trust

London North West University Healthcare NHS Trust

Maidstone and Tunbridge Wells NHS Trust

Manchester University NHS Foundation Trust

Medway NHS Foundation Trust

Mid and South Essex NHS Foundation Trust

Milton Keynes University Hospital NHS Foundation Trust

Norfolk and Norwich University Hospitals NHS Foundation Trust

North West Anglia NHS Foundation Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Northumbria Healthcare NHS Foundation Trust

Royal Berkshire NHS Foundation Trust

Royal Cornwall Hospitals NHS Trust

Salisbury NHS Foundation Trust

St George's University Hospitals NHS Foundation Trust

Stockport NHS Foundation Trust

The Hillingdon Hospitals NHS Foundation Trust

The Leeds Teaching Hospitals NHS Trust

The Princess Alexandra Hospital NHS Trust

The Rotherham NHS Foundation Trust

University Hospitals Coventry and Warwickshire NHS Trust

University Hospitals of Leicester NHS Trust

University Hospitals of North Midlands NHS Trust

University Hospitals Plymouth NHS Trust

Wirral University Teaching Hospital NHS Foundation Trust

Apgar score <7 at 5 minutes

English Trusts

Barking, Havering and Redbridge University Hospitals NHS Trust

London North West University Healthcare NHS Trust

Mid Cheshire Hospitals NHS Foundation Trust

The Hillingdon Hospitals NHS Foundation Trust

West Suffolk NHS Foundation Trust

Whittington Health NHS Trust

Scottish Boards

NHS Shetland

List of outlier trusts/boards who did not respond

All trusts/boards that triggered potential outlier status were contacted with the relevant outlier notification letter, confirmation of receipt along with a response was requested as per the outlier policy. However, the following trusts/boards did not respond:

Barking, Havering and Redbridge Hospitals NHS Trust

Betsi Cadwaladr University Health Board

Calderdale and Huddersfield NHS Foundation Trust

Chelsea and Westminster Hospital NHS Foundation Trust

East Cheshire NHS Trust

East Lancashire Hospitals NHS Trust

Manchester University NHS Foundation Trust

NHS Lanarkshire

North West Anglia NHS Foundation Trust

Northern Lincolnshire and Goole NHS Foundation Trust

South Tyneside and Sunderland NHS Foundation Trust

The Hillingdon Hospitals NHS Foundation Trust

The Leeds Teaching Hospitals NHS Trust

University Hospitals of Derby and Burton NHS Foundation Trust

University Hospitals Plymouth NHS Trust

Whittington Health NHS Trust

Trusts removed from outlier list

The following trusts have been removed from the outlier list following confirmation from each that their alarm-level outlier status was triggered by an issue with data quality and was not a true reflection of their clinical results.

Apgar score <7 at 5 minutes

English Trusts

North Tees and Hartlepool NHS Foundation Trust

South Tees Hospitals NHS Foundation Trust

Appendix 2

Trust/board outlier responses

This section contains trusts/board responses to their alarm-level clinical or non-participation outlier status, the responses include details such as a review of local data, data quality, recommendations for practice and/or quality improvements planned or implemented. Where the details provided may breach data sharing rules or individual confidentiality, such as where the results are less than five, information has been redacted.

Click on the trust/board name in the list below to read to their response.

Third- and fourth-degree perineal tears

Medway NHS Foundation Trust

Royal United Hospitals Bath NHS Foundation Trust

Somerset NHS Foundation Trust

Stockport NHS Foundation Trust

University Hospitals of Leicester NHS Trust

University Hospitals Southampton NHS Foundation Trust

University Hospitals Sussex NHS Foundation Trust

NHS Fife

Postpartum haemorrhage of ≥1500 ml

Ashford And St Peter's Hospitals NHS Foundation Trust

Chesterfield Royal Hospital NHS Foundation Trust

County Durham and Darlington NHS Foundation Trust

Frimley Health NHS Foundation Trust

King's College Hospital NHS Foundation Trust

London North West University Healthcare NHS Trust

Royal Berkshire NHS Foundation Trust

Royal Cornwall Hospitals NHS Trust

Salisbury NHS Foundation Trust

St George's University Hospitals NHS Foundation Trust

Stockport NHS Foundation Trust

The Newcastle Upon Tyne Hospitals NHS Foundation Trust

The Rotherham NHS Foundation Trust

University Hospitals Coventry and Warwickshire NHS Trust

University Hospitals of Leicester NHS Trust

University Hospitals of North Midlands NHS Trust

University Hospitals Southampton NHS Foundation Trust

Apgar score <7 at 5 minutes

Chesterfield Royal Hospital NHS Foundation Trust

County Durham and Darlington NHS Foundation Trust

Hampshire Hospitals NHS Foundation Trust

London North West University Healthcare NHS Trust

North Cumbria Integrated Care NHS Foundation Trust

North Tees and Hartlepool NHS Foundation Trust

Northumbria Healthcare NHS Foundation Trust

Somerset NHS Foundation Trust

South Tees Hospitals NHS Foundation Trust

The Newcastle Upon Tyne Hospitals NHS Foundation Trust

The Queen Elizabeth Hospitals King's Lynn NHS Foundation Trust

University Hospitals Sussex NHS Foundation Trust

North Cheshire and Mersey NHS Foundation Trust

NHS Fife

NHS Forth Valley

NHS Orkney

Medway NHS Foundation Trust

NHS
Medway
NHS Foundation Trust

Medway Maritime Hospital
Windmill Road
Gillingham
Kent
ME7 5NY

05 June 2026

National Maternity and Perinatal Audit (NMPA)
Royal College of Obstetricians and Gynaecologists,
10-18 Union Street
London SE1 1SZ

Email: nmpa@rcog.org.uk

Reference: Potential alarm-level outlier status for 3rd and 4th degree tears.

Dear NMPA senior clinical leads,

Thank you for your letter dated 30th April 2026 regarding a potential alarm outlier status with reference to our trust being identified as an outlier in the benchmark for 3rd and 4th degree tears and that an action is required to rectify this situation.

Your letter states that for the year 2024, our average rate for 3rd and 4th degree tears was 5.4% in comparison to the national average rate of 3.4% for the same year.

We agree our rate was higher than the national average for the year 2024 (Figure 1)

We noted this on our maternity dashboard that our rates for 3rd and 4th degree tears was on the rise compared to historical figures in our maternity unit.

This was discussed in our labour ward forum and departmental governance meetings on several occasions over the last several months and a robust action plan was made with a local Quality Improvement (QI) Project commenced to review the rates and the factors contributing to this.

This progress in this project is a matter of discussion in the Maternity and Neonatal Safety Assurance Group (MNSCAG) as well as the Trust Quality Assurance Committee (QAC).

One of our Urogynaecology Consultants has taken the lead for this project which has been ongoing for the last year.

I quote here directly her recent comment on this project:

"As part of our hospital's efforts to reduce obstetric anal sphincter injury (OASI) rates, the OASI Care Bundle has been successfully implemented in clinical practice. This has focused on standardising care and promoting evidence-based interventions during labour and delivery.

Best of care
Best of people

NHS
Medway
NHS Foundation Trust

Targeted teaching sessions have been delivered to junior doctors on the recognition and accurate diagnosis of OASI to ensure timely and appropriate management. In addition, hands-on practical training has been provided on the repair of fourth-degree tears using pig sphincter models, enhancing surgical skills and confidence in managing severe perineal trauma.
Training has also been delivered on manual perineal protection techniques to improve preventative practice during vaginal birth. Furthermore, Lisa is providing teaching to midwives as part of essential training sessions on the OASI Care Bundle, supporting a consistent multidisciplinary approach across the unit.
Future Plan
To build on this work, we plan to:

- *Continue regular multidisciplinary education sessions for both junior doctors and midwives.*
- *Conduct regular audits to monitor compliance with the OASI Care Bundle and track OASI rates.*
- *Provide structured feedback to clinical teams based on audit findings to support continuous improvement.*

These actions aim to sustain improvements in clinical practice, enhance staff competency, and further reduce the incidence of OASI within the hospital."

We are very proud of the results we achieved after implementing this training. Recent NHS England figures shows a very significant improvement with a clear drop in the rates for 3rd and 4th degree tear, such that currently, our trust figures match the national average and sometimes even lower (Figure 2).

The QI project is ongoing and we continue to monitor our 3rd and 4th degree tears and discuss in the Labour Ward forum, Maternity and Neonatal Quality Assurance Committee and Trust Quality Assurance Committee meetings. We also ensure all newly appointed Midwives and Resident doctors get this training soon after commencing their posts at our unit.

We are thankful to the RCOG for flagging this up and bringing it to our attention. We feel reassured that our own departmental and trust governance process also identified this in a timely fashion over a year ago and that we implemented an ongoing QI project to train obstetricians and midwives and monitor this, which has led to a reduction in 3rd and 4th degree rates.

Please let us know if any further information is required.

Yours sincerely,

Hany Wisa

Associate Specialist in Obstetrics and Gynaecology
Labour Ward and Obstetric Lead
Medway NHS Foundation Trust
Email: [redacted]

cc. Alison Herron, Director of midwifery
Email: [redacted]

Best of care
Best of people

NHS Medway NHS Foundation Trust

Figures

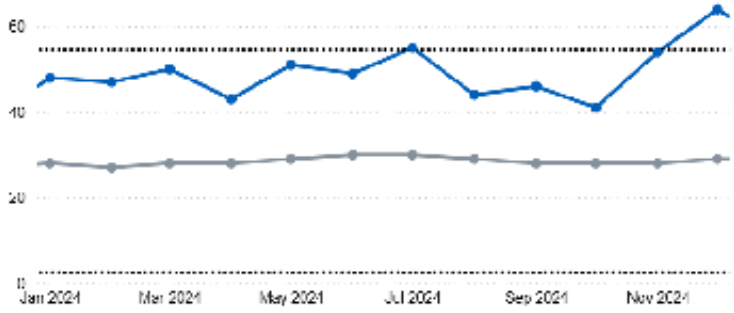

Figure 1: Women who had a 3rd or 4th degree tear at delivery values comparison over time for Medway NHS Foundation Trust (Rate per 1,000) (blue lines), compared to National rates (grey line) as reported on NHS Digital for the year 2024

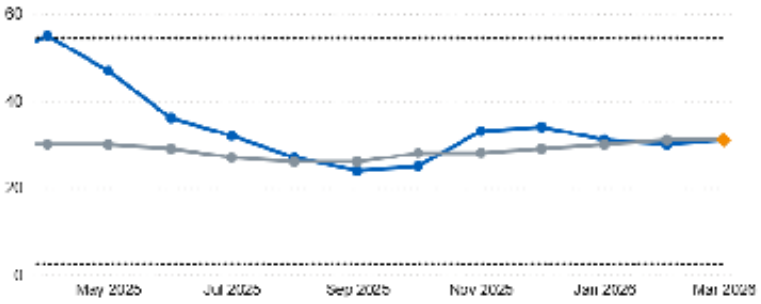

Figure 2: Women who had a 3rd or 4th degree tear at delivery values comparison over time for Medway NHS Foundation Trust (Rate per 1,000) (blue lines), compared to National rates (grey line) as reported on NHS Digital between April 2025 and March 2026

Royal United Hospitals Bath NHS Foundation Trust

Royal United Hospitals Bath
NHS Foundation Trust

Zita Martinez
Royal United Hospital
Combe Park
Bath
BA1 3NG
[redacted]
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2/6/2026

National Maternity and Perinatal Audit (NMPA)
Royal College of Obstetricians &
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10-18 Union Street
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Dear NMPA Senior Clinical Leads

Subject: Potential alarm-level outlier status – 3rd & 4th degree tears

Thank you for your letter dated 30th April 2026 regarding the potential alarm-level outlier status for 3rd and 4th degree perineal tears. We appreciate the opportunity to review our data and provide further context.

Following a detailed analysis of our 2024 data, we identified discrepancies related to data recording within our previous electronic patient record system. Preliminary review indicates that variation in coding and recording of perineal trauma severity within the previous system may have contributed to these discrepancies. Since transitioning to BadgerNet in July 2025, we have seen improvements in data accuracy, completeness, and reporting reliability, strengthening our ability to undertake robust surveillance and targeted quality improvement.

NMPA data is presented alongside triangulated local RUH data to support assurance and contextual interpretation.

NMPA data

Indicator	National Mean (%)	Trust/Board Numerator	Trust/Board Denominator	Trust/Board Unadjusted Result (%)	Trust/Board Adjusted Result (%)	Trust/Board 3SD upper limit
Third- or fourth-degree tears	3.494724	122	2144	5.690299	5.465811	4.66457

RUH local data

Indicator	National Mean (%)	Trust Numerator	Trust Denominator	Trust Unadjusted Result (%)	Trust/Board 3SD Upper Limit
Third or Fourth Degree Tears	3.494724	89	2449	3.64%	4.68457

Royal United Hospitals Bath
NHS Foundation Trust

Month	babies born	aLSCS %	EmLSCS %	LSCS babies born	Assisted Vaginal birth %	Assisted vaginal birth babies born	Spontaneous Vaginal Birth Rate	Spontaneous Vaginal birth Value	Cumulative Vaginal Birth Value
Jan-24	318	18.00%	19.20%	120	12.10%	38	50.20%	160	198
Feb-24	343	19.00%	20.70%	133	12.00%	45	47.50%	165	210
Mar-24	325	16.00%	20.60%	123	11.00%	36	49.40%	161	197
Apr-24	325	17.40%	18.60%	117	13.60%	44	50.50%	164	208
May-24	345	18.00%	21.00%	135	11.80%	41	48.10%	169	210
Jun-24	328	15.60%	21.10%	121	15.20%	50	47.80%	157	207
Jul-24	357	21.60%	21.20%	145	11.40%	38	45.50%	151	192
Aug-24	352	19.00%	22.60%	140	11.00%	40	43.80%	116	192
Sep-24	374	16.60%	21.50%	142	15.00%	57	46.60%	175	232
Oct-24	361	18.60%	17.20%	129	15.00%	54	49.20%	178	232
Nov-24	323	19.60%	18.00%	134	15.20%	49	47.20%	140	189
Dec-24	311	19.60%	21.90%	129	14.40%	45	44.10%	137	182
SJM	4027			1578		513		1936	2119
% of OASI 12 month Mean						1.37%		5.125%	
Number of OASI						24.00		69.00	89.00
% of OASI in all vaginal births									3.64%

There is a material discrepancy between the NMPA-reported numerator (122 cases) and locally validated data (89 cases), representing a substantial variance that suggests over-identification within the national dataset. While we recognise that the NMPA result is case-mix adjusted, we continue to monitor third and fourth degree perineal tear rates through established monthly governance processes, with oversight at Trust Board level. Data is triangulated with case level clinical review to validate findings, identify themes, and inform targeted quality improvement activity. The unadjusted third and fourth degree tear rate for 2024 was 3.64%, remaining within the Trust's 3SD upper limit, consistent with expected statistical variation.

Current national benchmarking for 2025 indicates a rate of 29.6 per 1,000 births when reviewed across the calendar year. Local data demonstrates some variation between months; however, this has not demonstrated a pattern consistent with an outlier position when validated against local data. Ongoing analysis is focused on understanding contributory factors and supporting continuous improvement in both clinical outcomes and care processes.

Quality Improvement Initiatives (2025 to 2026 Update)

Since our previous submission, we have further strengthened our quality improvement approach, with a continued focus on prevention, early recognition, accurate diagnosis, and reliable follow up of Obstetric Anal Sphincter Injury.

A focused audit of OASI has been completed and presented to the Urogynaecology team. This has provided detailed insight into clinical practice, documentation, and pathway adherence, enabling targeted actions to address identified gaps. Learning from this audit is being embedded within governance processes and clinical practice.

Royal United Hospitals Bath
NHS Foundation Trust

To enhance diagnostic capability, a grant application has been submitted to support the introduction of point of care MRI at the time of delivery. This aims to improve diagnostic accuracy and grading of OASI, supporting timely and appropriate management.

Administrative processes have been strengthened to improve the reliability and timeliness of follow up pathways. A dedicated administrator has been recruited and is due to commence in the coming weeks. This role will release specialist clinicians from administrative tasks, enabling greater clinical capacity for direct patient care while improving coordination, tracking, and oversight of follow up activity.

Summary

In summary, while acknowledging the national outlier flag, our triangulated local data, including an unadjusted rate of 3.64% for 2024 which remains within the Trust's 3SD upper limit, does not support classification as an outlier based on validated local data. We have a comprehensive and evolving programme of work in place focused on improving data quality, strengthening clinical practice, and ensuring reliable follow up care. These actions provide a robust framework for continued improvement. On this basis, we believe that data quality issues within the previous electronic patient record system have materially affected the accuracy of the NMPA result for this indicator. We remain committed to delivering demonstrable and sustained improvements in outcomes for women, supported by robust governance and continuous quality improvement.

We would welcome further dialogue to support validation of these findings if required. Please do not hesitate to contact me if you require any further information.

Yours sincerely

Zita Martinez
Director of Midwifery & Neonates

Somerset NHS Foundation Trust

NHS
Somerset
NHS Foundation Trust

Somerset NHS Foundation Trust
Maternity Quality & Safety Team
Musgrove Park Hospital
Taunton
Somerset
TA1 5DA

4th June 2026

Dear NMPA Senior Clinical Leads

Thank you for your letter dated 30 April 2026. In response, the Trust has reviewed the data provided in relation to third and fourth degree tears and Apgar score metrics.

For both 3rd and 4th degree tears and Apgar score metrics, the Trust has been unable to validate the externally provided numerators and denominators. Locally validated data for the reporting period have therefore been presented below.
Based on these figures, the unadjusted rates are 2.73% for 3rd and 4th degree tears and 2.08% for Apgar scores.

Assurance from the Trust's CQIM dashboard indicates that performance for both indicators is not identified as an outlier for this period.

Indicator	National Mean (%)	Trust/Board Numerator	Trust/Board Denominator	Trust/Board Unadjusted Result (%)	Trust/Board Adjusted Result (%)	Trust/Board 3SD upper limit
Third- or fourth-degree tears 37-42+6 weeks	3.494724	113 100	2173 3667	5.200184 2.73%	5.366001	4.676604
Apgar score 34-42+6 weeks	1.532615	68 82	3068 3949	2.216428 2.08%	2.304801	2.197974

We would welcome further clarification on the methodology used to derive the denominators, as there appears to be a significant discrepancy in these figures.

Yours sincerely

Sally Bryant
Director of Midwifery and Deputy Chief Nurse

Stockport NHS Foundation Trust

I am sure you are aware that OASI rates fluctuate so our position continues to change and I am keen to ensure that the information we provide you is relevant.

We discuss our maternity dashboard data monthly at Divisional level, and present to Trust Board which includes a robust action plan to align with a GM target of 2.6% for OASI. I am pleased to say that OASI rate at Stockport now averages between 2-3% and we expect this will improve since appointing a Perinatal Pelvic Health Lead Midwife in November 2025, procuring re-useable Episcissors and ensuring regular training sessions for Midwives and Doctors.

Kind regards, Lucy Tomlinson

Dr Lucy Tomlinson
MBChB MRCOG MSc
Consultant Obstetrician & Gynaecologist
Clinical Director Obstetrics & Gynaecology

Stockport NHS Foundation Trust
Women & Children Directorate Group
Room 58, Ground Floor, Treehouse
Stepping Hill Hospital
Stockport
SK2 7JE

University Hospitals of Leicester NHS Trust

Dear NMPA Senior Clinical Leaders,

Please accept our apologies for not meeting the 24 June response deadline. We would be grateful if our response could still be considered.

Response to Letter 1 – Data Quality / Completeness (PPH >1500ml)

Thank you for your letter regarding exclusion from the outlier analysis due to concerns relating to data quality and/or completeness for the following indicator:

- Proportion of women and birthing people giving birth to a singleton baby between 34+0 and 42+6 weeks of gestation who experience a postpartum haemorrhage of 1500 ml or more.

Having reviewed our local records, we are currently unclear as to where data quality or completeness concerns have arisen. Our data submissions for 2024 have been made consistently, with all identified queries and failed entries addressed and resubmitted in line with national requirements for MSDS.

We would welcome further clarification regarding the specific areas where data quality or completeness thresholds were not met, to support targeted review and any necessary improvement.

Please see supporting evidence of submissions below.

Date Submitted	ODS Code	Organisation Name	Collection	Reporting Period	Version	Status	Type	Action
2024-07-24 17:40	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	MSDS	June 2024	2.0	PROCESSED	Data	View
2024-06-25 16:10	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	MSDS	May 2024	2.0	PROCESSED	Data	View
2024-05-29 18:29	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	MSDS	April 2024	2.0	PROCESSED	Data	View
2024-04-25 17:51	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	MSDS	March 2024	2.0	PROCESSED	Data	View
2024-04-25 08:00	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	MSDS	March 2024	2.0	PROCESSED	Data	View
2024-03-27 10:00	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	MSDS	February 2024	2.0	PROCESSED	Data	View
2024-02-26 14:56	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	MSDS	January 2024	2.0	PROCESSED	Data	View
2024-02-27 08:17	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	MSDS	January 2024	2.0	PROCESSED	Data	View
2024-01-31 19:16	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	MSDS	December 2023	2.0	PROCESSED	Data	View
2024-01-31 18:57	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	MSDS	November 2023	2.0	PROCESSED	Data	View

Items per page: 10 Showing 1 - 10 of 141 results. « First Previous 1 2 3 4 5 Next Last »

Date Submitted	ODS Code	Organisation Name	Collection	Reporting Period	Version	Status	Type	Action
2025-02-05 09:29	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	IVSDS	January 2025	2.0	PROCESSED	Data	View
2025-01-31 11:19	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	IVSDS	December 2024	2.0	PROCESSED	Data	View
2024-12-31 16:23	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	IVSDS	November 2024	2.0	PROCESSED	Data	View
2024-12-05 09:53	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	IVSDS	November 2024	2.0	PROCESSED	Data	View
2024-11-25 10:52	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	IVSDS	October 2024	2.0	PROCESSED	Data	View
2024-10-28 15:59	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	IVSDS	September 2024	2.0	PROCESSED	Data	View
2024-10-10 10:38	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	IVSDS	August 2024	2.0	PROCESSED	Data	View
2024-09-23 11:13	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	IVSDS	July 2024	2.0	PROCESSED	Data	View
2024-09-22 18:43	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	IVSDS	August 2024	2.0	PROCESSED	Data	View
2024-09-22 10:47	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	IVSDS	July 2024	2.0	PROCESSED	Data	View

Response to Letter 2 – Potential Alarm-Level Outlier (3rd/4th Degree Tears)

Thank you for your letter advising that University Hospitals of Leicester NHS Trust has been identified as a potential alarm-level outlier for one or more indicators.

We acknowledge that this designation reflects a value above the upper 99.8% control limit (>3 standard deviations above the mean) and therefore requires further review, but does not in itself indicate poor performance.

We have undertaken a local review of our data for the relevant period and note the following:

- Our overall rate for 3rd and 4th degree tears is 4.1%

A breakdown of our local data is provided below:

Row Labels	Count	Percentage
3rd degree tear	185	3.74%
4th degree tear	18	0.36%
Other	4748	95.90%
Total	4951	100.00%

We are continuing to review this position in detail, including validation of coding, case mix, and any potential contributory clinical or organisational factors.

As part of this, we are strengthening our response through:

- Benchmarking against national and peer organisation data to better understand variation and contextualise our position.
- Case mix review, including consideration of clinical complexity, parity, mode of birth, and population characteristics that may influence risk.
- Focused quality improvement actions, including continued work on perineal protection techniques, training and competency in recognising and repairing obstetric anal sphincter injuries, and audit/feedback through governance structures.
- Ongoing data validation, to ensure coding accuracy and consistency in line with national definitions.

These actions are being overseen through established governance processes, with regular review to ensure learning is translated into sustained improvement.

Best wishes,

Karradene Aird
Head of Perinatal Governance & Quality Improvement
University Hospitals Leicester NHS Trust
Email | [redacted]
Mobile | [redacted]

University Hospital Southampton NHS Foundation Trust

University Hospital Southampton NHS
NHS Foundation Trust

Women & Newborn
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Private & Confidential
Sam Oddie, NMPA Senior Clinical Lead (Neonatology)
James Harris, NMPA Senior Clinical Lead (Midwifery)
Asma Khalil, NMPA Senior Clinical Lead (Obstetrics)
National Maternity and Perinatal Audit (NMPA)
Royal College of Obstetricians and Gynaecologists
10-18 Union Street
London
SE1 1SZ

2 June 2026

Dear NMPA Senior Clinical Leads

Thank you for your letter dated 30 April 2026 informing us of our potential alarm-level outlier status in relation to third and fourth-degree tears and postpartum haemorrhage (PPH) >1500 ml for births occurring in 2024.

We acknowledge these findings and have completed a comprehensive review of the data, taking into account both organisational and clinical contributory factors. While we recognise that the reported figures fall within the potential alarm-level category, our internal validation has identified minor discrepancies between locally held data and that produced by NMPA. We are satisfied that these differences are attributable to variations in organisational coding, particularly in cases where women and birthing people receive care across multiple providers and activity may be attributed to more than one organisation. These discrepancies are minimal and do not materially change the overall interpretation of our position.

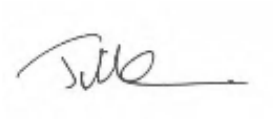
In relation to postpartum haemorrhage, we have already implemented a robust and structured improvement programme. This includes the introduction of a locally developed PPH dashboard, providing systematic oversight of performance, enabling early identification of variation and supporting targeted, data-led improvement actions. Furthermore, as a pilot site for the OBS UK study from January 2025, we have embedded a comprehensive care bundle focused on reducing red cell transfusion through strengthened risk assessment, accurate cumulative blood loss measurement and timely escalation of care. The integration of point-of-care testing (TEG) has further enhanced our ability to deliver precise, responsive clinical management. Early indicators demonstrate measurable improvement; however, we are continuing to drive consistency in application across all clinical areas to ensure sustained impact. In addition, we have strengthened governance through the routine multidisciplinary review of all PPH cases exceeding two litres, as well as those requiring fibrinogen or cryoprecipitate, in line with the updated Maternal Care Bundle. This approach is providing clear oversight, accelerating learning and enabling us to implement focused corrective actions where required.

With regard to third- and fourth-degree tears, decisive action has similarly been taken. We have established a dedicated OASI dashboard to ensure continuous surveillance, enabling us to identify trends promptly and intervene where necessary. The RCOG OASI Care Bundle was implemented in April 2025 in direct response to rising incidence and has been actively driven through strong clinical leadership supported by an LMNS-funded Pelvic Health Midwife. This has ensured the consistent embedding of best practice across the multidisciplinary team. Alongside this, targeted and mandatory training has been delivered to obstetric staff, with a clear focus on perineal protection techniques, particularly in the context of instrumental birth. This programme is designed to standardise practice, strengthen clinical decision-making and reduce avoidable harm.

These actions are part of a wider, coordinated programme aligned to national maternity safety priorities and the Maternal Care Bundle, with clear oversight through established governance structures. Both measures remain under close scrutiny via our maternity dashboard and are formally reported through the Maternity and Neonatal Safety Report to the Quality Committee on a quarterly basis, with escalation to Trust Board where indicated. This ensures continued executive visibility, accountability and pace of improvement.

We are confident that the actions implemented to date are appropriate, evidence-based and already demonstrating impact. We will continue to rigorously monitor progress and take further action as required to ensure sustained improvement in outcomes for women, birthing people and families.

Yours sincerely



Jillian Connor
Consultant Obstetrician and Care Group Clinical Lead

cc Emma Northover, Director of Midwifery

University Hospital Sussex NHS Foundation Trust

University Hospitals Sussex
NHS Foundation Trust

Maternity Services
WCCS Division
Trust Headquarters
Worthing Hospital
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Worthing
BN11 2DH

Tel: 01903 205111

Private & Confidential
Sam Oddie, James Harris, & Asma Khalil
NMPA Senior Clinical Leads

Sent via email as requested to: nmpa@rcog.org.uk

Dear colleagues,

I write in response to your letter to my colleague, Ms Bronwyn Middleton, Clinical Director for Gynaecology & Sexual Health, in my capacity as Medical Director for Women, Children, and Clinical Support Services Division at University Hospitals Sussex NHS Foundation Trust. I reviewed your letter in cooperation with Mr Seb Adamson, Clinical Director for Obstetrics as well as colleagues Frances Barnes and Gail Addison, Heads of Midwifery and our response has been reviewed and approved by Chief Medical Officer, Professor Catherine Urch.

You have rightly raised concern over our trust's alarm-level outlier status in the areas of Apgar Scores and Third or Fourth Degree Tears. I provide a response to your concerns as requested and I hope our review of the information helps to assure you of our attention to the issue.

Apgar Scores
In your letter, you gave the following as parameters:

Proportion of liveborn, singleton babies born between 34+0 and 42+6 weeks of gestation, with a 5-minute Apgar score less than 7.

Indicator	National Mean (%)	Trust/Board Numerator	Trust/Board Denominator	Trust/Board Unadjusted Result (%)	Trust/Board Adjusted Result (%)	Trust/Board 3SD upper limit
Apgar score	1.532615	155	7786	1.990753	2.048217	1.950278

Review of our local data set does not match your calculation. The data extracted from our Badgernet system shows the following figures for 2024, broken down by site:

Indicator	Site	Trust Numerator	Trust Denominator	Trust unadjusted %
	PRH	32	2140	1.4953%
	RSCH	42	2094	2.0057%
	SRH	50	2103	2.3776%
	WH	40	1854	2.1575%
Apgar Score 34+0-42+6	UHSx	164	8191	2.0022%

We have previously raised issues with the MSDS dataset, including underestimation of the number of births for the Trust. That said, this metric is causing us our own local concern as well. Our local tracking is shown in the SPC charts below which demonstrates the mean average for the site/Trust as the black line and the national mean average as the red line:

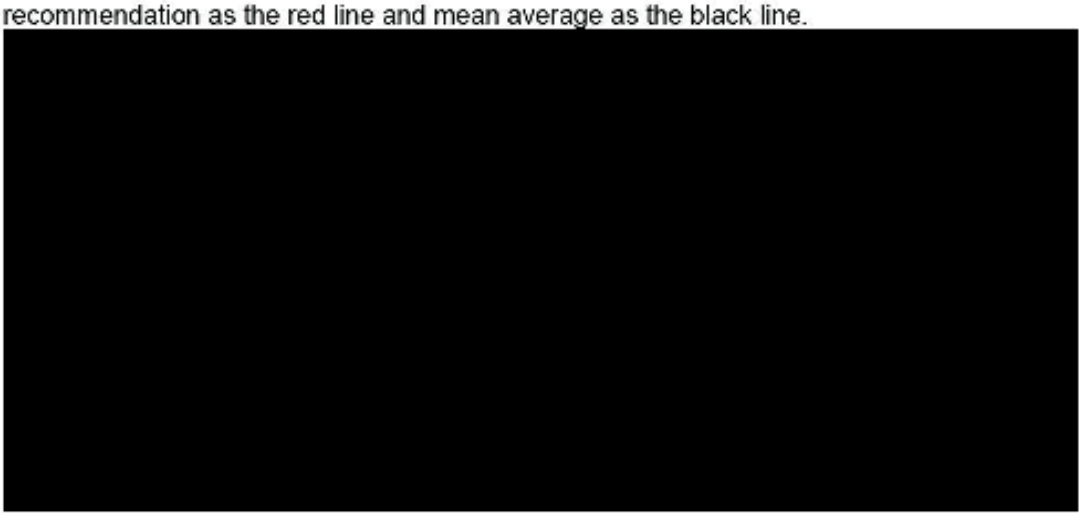
It is important to mention that our local data collection is for term births in line with the national maternity dashboard found under the CQIM+ tab, link here: Microsoft Power BI and regional recommendations via our Perinatal Quality Oversight Model dashboard. The 2024 data when broken down by preterm and term gestations shows significant differences in outcomes along with obvious site variations which we must explore.

Indicator	Site	Trust Numerator	Trust Denominator	Trust unadjusted %
	PRH	25	1865	1.3405%
	RSCH	24	1700	1.4118%
	SRH	34	1847	1.8408%
	WH	24	1573	1.5257%
Apgar Score 37+0 - 42+6	UHSx	107	6985	1.5319%

Indicator	Site	Trust Numerator	Trust Denominator	Trust unadjusted %
	PRH	7	275	2.5455%
	RSCH	18	394	4.5685%
	SRH	16	256	6.2500%
	WH	16	281	5.6940%
Apgar Score 34+0 – 36+6	UHSx	57	1206	4.7264%

Prior to receiving your letter, our fetal monitoring team had started an audit of 2025 cases with a view to doing a thematic review of term births with 5-minute Apgar of less than 7. In the light of your letter and the timescales required for response, the team redirected their efforts to comparing the first quarter of 2024 with the first quarter of 2026 (the most recent available). We have been reassured by our ATAIN data – see below, which did not flag any concerns for term admission to the neonatal unit on any site.

The charts below demonstrate the ATAIN rates from Apr 24 – Mar 26, national recommendation as the red line and mean average as the black line.



We have identified a potential contributing factor in relation to organisational coding. The Trust is not consistently listed within the 'Org_Name' field in publicly available datasets (e.g. NHS Digital Maternity Services Monthly Statistics), where multiple site-level identifiers appear, including:

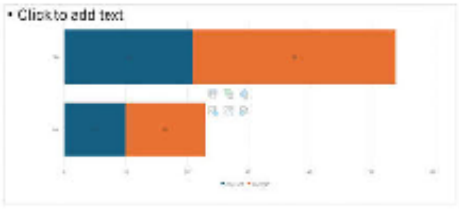
- CHICHESTER
- ST RICHARD'S HOSPITAL
- WORTHING HOSPITAL
- ROYAL SUSSEX COUNTY HOSPITAL
- THE PRINCESS ROYAL HOSPITAL (MATERNITY)

While the Trust's primary organisation code is **RYR**, additional codes (RYR16 and RYR18) are present, which may indicate that the NMPA dataset has aggregated across multiple identifiers.

The Fetal Wellbeing Team is assured by the data reviewed to date, which suggests that the vast majority of 5-minute Apgar scores of <7 were scored at 6 and did not require admission to the neonatal unit/special care baby unit or need on-going treatment or support.

5-minute Apgar

Admission to SCBU



We plan next to audit births >=34/40 so that we can compare directly to NMPA data and continue the audit for 2025 data. We will explore the themes of discrepancy between midwife and Paediatrician scores – where available, midwife scores appear to be lower. We will also be looking at smoking, mode-of-birth, maternal medication, cord gases and amount of support required to see if these provide an answer for the higher than expected, and increasing, number of low Apgar scores without evidence of harm.

Quality Improvement and Service Development

The Trust meets the requirements for Saving Babies' Lives Care Bundle with fetal monitoring lead midwives and obstetric lead posts, and the requirements for fetal wellbeing training and competency assessment in place. The fetal wellbeing leads split their time between teaching, clinical support on the wards, work on guidelines, and audit and data collection. Data is presented monthly at the maternity safety and quality meeting and quarterly through to Trust board.

Education and Workforce Development

The Fetal Wellbeing Team works alongside the practice development team to design and deliver the multidisciplinary annual study day on fetal monitoring and competency assessment for all staff involved in fetal monitoring. Successful completion is monitored, with scores meeting the threshold. The study days include scenarios and discussion on human factors and escalation.

Continuous Improvement and Future Focus

The Trust remains committed to continuous improvement through innovation, evaluation, and collaboration. Our teams are committed to maintaining professional relationships with regional partner trusts and will work collaboratively with the regional team and ICB –

integrated care board. Our teams have found the national fetal monitoring network to be a valuable resource for support, shared learning and benchmarking, and are all engaged in relevant continuous professional development to ensure that they maintain and improve their skills and expertise in all aspects of their role.

Third or Fourth Degree Tears
In your letter, you gave the following as parameters:

Proportion of women and birthing people giving birth vaginally to a singleton baby between 37+0 and 42+6 weeks of gestation who experience a third- or fourth-degree tear.

The NMPA dataset reports that, for 2024, 205 cases of obstetric anal sphincter injury (OASI) occurred among 4,109 vaginal births (4.99% unadjusted; 4.78% adjusted), against a national mean of 3.49%.

Indicator	National Mean (%)	Trust/Board Numerator	Trust/Board Denominator	Trust/Board Unadjusted Result (%)	Trust/Board Adjusted Result (%)	Trust/Board 3SD upper limit
Third- or fourth-degree tears	3.49	205	4,109	4.99	4.78	4.35

However, our locally validated data, reviewed and confirmed by the Trust Business Intelligence Team, identifies 4,442 eligible vaginal births during the same period, with 138 cases of OASI (3.11%), placing the Trust below the national mean.

Indicator	Year	Numerator	Denominator	%
Raw data from Badgernet Third- or fourth-degree tears	2024	138	4,442	3.11%
Numbers sent to NHSD after data validation Third-or fourth-degree tears	2024	120	3,820	3.14%

At present, we are unable to reconcile the discrepancy between the datasets and would welcome further clarification to support alignment.

Our Business Intelligence team welcomes the opportunity to understand the derivation of the NMPA dataset and has offered to undertake case-by-case validation should NHS numbers be available. Alternatively, we would be grateful if you could share the parameters and SNOMED codes used in compiling your dataset.

For transparency, the parameters used by the Trust to compile our comparison dataset are:

- All deliveries between 1 January 2024 and 31 December 2024 (inclusive)
- All births at ≥37 weeks' gestation
- Singleton births only
- Exclusion of caesarean births
- Identification of third- and fourth-degree tears using the following SNOMED codes: 449807005, 449808000, 449809008, 10217006, 199930000, 199931001, 6825008, 199934009, 34262005, 199935005

It is worthwhile noting my previous comments from the Apgar section regarding the organisational coding which we believe may be contributing to data differences.

To support review, we have provided our the data which informs our calculations in the attached file *3rd_4th_TEARS_NHSD_Monthly_CSV_DATA_2024_20260519.xlsx*, which includes:

- **'All' tab** – full dataset
- **'RYR RXWMT' tab** – records aligned to submitted Trust data (numerator = 120)
- **'RYR RYR16 RYR18' tab** – combined dataset (numerator = 205)

The latter corresponds to the numerator reported by NMPA, whereas the former reflects the validated data submitted by the Trust.

We are pleased to provide assurance regarding our ongoing programme of quality improvement and service development in relation to obstetric anal sphincter injuries (OASI) and perinatal pelvic health.

Quality Improvement and Service Development
The Trust has been an early implementer of the Perinatal Pelvic Health Service (PPHS), established in line with the NHS Long Term Plan and funded through the Local Maternity and Neonatal System (LMNS). This multidisciplinary service operates across all four maternity sites providing coordinated, end-to-end care throughout the perinatal pathway. Since 2022, Specialist Pelvic Health Midwives have led a comprehensive programme of transformation including the implementation of unified Trust-wide clinical guidelines, standard operating procedures, and multidisciplinary perineal clinics. Governance has been strengthened through robust case identification, reporting, and review processes, supported by monthly LMNS dashboard monitoring and formal review via the Trust Quality and Safety Forum.

Implementation of Evidence-Based Practice
The OASI Care Bundle (OASI2) was implemented across all sites from September 2023, supported by a structured rollout and comprehensive staff education. A reduction in OASI rates was observed within six months, with sustained improvement through 2024.

Education and Workforce Development
A structured programme of multidisciplinary education supports consistent practice, with >80% compliance in mandatory training. This is complemented by simulation training, study days, undergraduate teaching, and readily accessible digital learning resources. Workforce development continues, including plans to embed OASI training within PROMPT and expand clinical leadership through OASI Champions.

Prevention and Education for Women and Birthing People
Digital maternity systems enable early and ongoing access to pelvic health education. Women are supported with evidence-based information throughout pregnancy, including pelvic floor health, perineal massage, and informed decision-making regarding birth. Self-referral pathways to physiotherapy and accessible digital resources further support prevention and recovery.

Multidisciplinary Care and Follow-Up
Specialist perineal clinics provide integrated follow-up care, including assessment, treatment, and access to diagnostics such as endoanal ultrasound. Referral pathways have been streamlined to ensure timely and equitable access across sites.

Continuous Improvement and Future Focus
The Trust remains committed to continuous improvement through innovation, evaluation, and collaboration. Current work includes enhancing perineal wound care approaches, optimising clinical interventions, and strengthening patient information. Ongoing collaboration with national networks and internal groups supports shared learning and consistency of practice.

In summary
The Trust identified that the 5-minute Apgar scores <7 were higher than expected prior to receipt of the NMPA's letter and has taken steps to explore why this is the case. We are committed to implement further quality improvement and educational intervention to rectify the issue when the root cause and needs are fully understood through further investigative processes of audit and thematic review. In view of Third or Fourth Degree Tears, the Trust has implemented a comprehensive, evidence-based and multidisciplinary approach to reducing OASI rates and improving perinatal pelvic health outcomes. This work is underpinned by strong governance, robust clinical leadership, and a clear commitment to continuous learning and improvement.

We ask for assistance in addressing the data issues we raise as well as the multiple data sets which we believe may be contributing to the discrepancies highlighted in our response. With OASI specifically, we are unable to fully reconcile the difference; however, our data indicates an OASI rate below the national average. We would welcome further discussion to support alignment and enhance shared understanding.

We trust this response provides assurance regarding the actions taken and progress achieved and remain committed to delivering safe, high-quality care for all women and birthing people.

Please do not hesitate to contact us should further information be required.

Yours sincerely,

Dr Tim Taylor
Medical Director
Women, Children, and Clinical Support Services Division
University Hospitals Sussex NHS Foundation Trust

NHS Fife

NHS Fife

29th May 2025

Dear NMPA

Subject: Response regarding the outlier status in the forthcoming National Maternity and Perinatal Audit (NMPA) report for the births in 2024.

We are in receipt of the correspondence from the NMPA team dated 1st May 2026 identifying NHS Fife as an outlier for the following indicators:

1. Proportion of live born singleton babies (34+0 to 42+6 weeks) with a 5-minute Apgar score <7
2. Proportion of women and birthing people having a vaginal singleton birth (37+0 to 42+6 weeks) who experience a third- or fourth-degree tear (OASI)

We have reviewed our data and can confirm that we are outliers in the above named indices. A detailed review of our data is presented below. We thank the NMPA team for corresponding with us.

Apgar Score <7 at 5 Minutes

An internal review of Maternity BadgerNet data for the period 1 January 2024 to 31 December 2024 identified:

- Number of babies with Apgar <7 at 5 minutes: 89
- Total singleton births (34+0 to 42+6 weeks): 2,505
- Rate: 3.55%

In comparison, the national mean is 1.53%, with an upper limit of 2.31%, confirming NHS Fife's outlier status.

NHS Fife undertook a detailed "deep dive" review of cases; all 89 babies with Apgar <7 were included in the review. We identified the following:

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1. 67.4% (60/89) remained with parents.
2. 51 (46/89) required some type of resuscitation at birth.
3. 62% (56/89) had an Apgar of 6 at 5 minutes. 42% (25/56) of these babies required no resuscitation, 28% of them (16/56) required resuscitation and admission to the neonatal unit (NNU).

Neonatal admissions:

4. 32% (29/89) were admitted to the neonatal unit. None of these were ICU admissions)
5. Out of the 29 babies who were admitted to the neonatal unit 75% (22/29) were short-term admissions and related to transitional or respiratory issues. The length of the stay was between 6hrs to 3 days, after which they returned to their families.
6. The 7 other babies were admitted for varying reasons, but all returned to their parents.

Summary of Key Findings

- A significant proportion, 21% (19/89), of cases involved babies of mothers who had had a general anaesthetic, which is a recognised factor that can influence Apgar scores.
- 62% of babies had Apgar scores of 6. As Apgar scoring includes both subjective and objective components, the possibility of underestimation or inconsistent scoring should be considered.
- 27% of admitted babies (8/29) were delivered by planned Caesarean section. This is a significant proportion; on thorough review, appropriate care was provided during these births. There were specific risk factors associated with each delivery which contributed to the neonatal outcomes. Notably, NHS Fife reports to the SPSP Perinatal Collaborative on term admissions. An audit identified that 10% of planned Caesareans resulted in admissions due to transient tachypnoea of the newborn. A strengthened and more consistent approach is required to reduce term neonatal unit admissions, with targeted improvement actions focused on planned Caesarean births.
- While an Apgar score of <7 at 5 minutes has been used as a trigger for concern, the findings here appear to be largely explained by the factors outlined above. Reassuringly, the unit's rates of hypoxic-ischaemic encephalopathy (HIE) and term neonatal mortality remain in line with national averages.

Recommendations

1. Targeted Apgar training should emphasise **objective assessment rather than subjective interpretation**, particularly for tone, respiration and colour.
    a. Implement periodic case-note review comparing Apgar scores with clinical condition/resuscitation provided.
2. Promote the consideration of cord gases, need for resuscitation and admission indicators, as part of a holistic neonatal assessment rather than reliance on Apgar alone.
3. Review the indications for, and evaluate the incidence of, intrapartum general anaesthesia compared with regional anaesthesia in NHS Fife.
4. Continue to report on Datix and then review cases, where the Apgar score is less than 7 at five minutes and/or cord pH is below 7.1 (arterial and venous). This has been implemented from quarter three of 2025. This learning will be shared through the monthly risk management newsletter to strengthen awareness across the maternity team.

NHS Fife also contributes to national improvement programmes, including:

- Scottish Patient Safety Programme (SPSP) Perinatal Collaborative
- National Neonatal Audit Programme (NNAP)
- MBRRACE-UK surveillance

Proportion of women and birthing people having a vaginal singleton birth (37+0 to 42+6 weeks) who experience a third- or fourth-degree tear (OASI)

We acknowledge that NHS Fife is an outlier for the proportion of women sustaining 3rd or 4th degree tear at birth

Analysis of Maternity BadgerNet data for the same period identified:

- Number of third- and fourth-degree tears: 86
- Total vaginal singleton births (37+0 to 42+6 weeks): 1,530
- Rate: 5.62%

This exceeds the national mean of 3.49% and upper limit of 4.96%, confirming outlier status. NHS Fife routinely audit rates of OASI on an annual basis, and noted an increased rate of OASI in 2023 to 4.6%, and again in 2024 when there was a further increase to 5.6%.

In response to the increase in OASI rates, the RCOG OASI Care Bundle was implemented since June 2025. The bundle comprises of four elements:

1) Antenatal discussion about OASI tears and how to reduce them
2) During birth using manual perineal protection
3) If clinically indicated mediolateral episotomy at an angle of 60 degrees from the midline at crowning of the head
4) Systematic examination of the vaginal and ano-rectum after birth to ensure identification and treatment of any tears

The unit developed an OASI team, comprising of Senior Charge Midwife (for both delivery and antenatal care), Risk Management Midwife, Consultant Obstetrician, Education Midwife and Digital/Badgernet Midwife. The bundle was implemented in a phased approach starting with training of midwifery and medical staff (April 2025), and then antenatal discussion from June/July 2025, with official launch in June 2025.

Data was prospectively collected on compliance with the bundle and on OASI rates on a rolling monthly basis (previously just audited annually). In 2025, there were 1540 vaginal births between 37 and 42+6 weeks, with 50 incidences of OASI. This represents a rate of 3.24%.Data for the year to date for 2026 has shown 632 vaginal births, with 21 incidences of OASI, with a rate of 3.3%.

Recommendations

1. Continue with OASI care bundle training
2. Embedding OASI into unit culture
3. Minimising risk factors by identification of risk and planning in the antenatal period
4. Continued analysis of bundle compliance and cases.
5. We have applied to be considered as part of the GynZone national pilot being led by PSD Scotland

Summary

NHS Fife has confirmed its outlier status for both Apgar scores <7 at 5 minutes and higher OASI rates in the 2024 NMPA report.

Detailed local review indicates that:

- Many instances of low Apgar scores reflect expected clinical variation associated with identifiable contributing factors, with overall favourable neonatal outcome.
- Key areas for focused improvement to improve Apgars scores are within the planned Caesarean births cohort and the babies of mothers who have had a general anaesthetic
- Robust clinical governance and review processes are in place to identify Apgars <7 and babies born with cord pH of <7.1
- In relation to OASI, identification of increased rates had already occurred, and targeted improvement work undertaken. This has already shown evidence of impact in sustained reduction of rates over the last 12 months, and is back into line with national rates.

Thank you

Dr. Nithiya Palaniappan

Consultant Obstetrician and Gynaecologist

Clinical Lead in Obstetrics

NHS Fife

Ashford And St Peter's Hospitals NHS Foundation Trust

Ashford and St. Peter's Hospitals NHS Foundation Trust

NATIONAL MATERNITY AND PERINATAL AUDIT (NMPA)
Royal College of Obstetricians and Gynaecologists
10-18 Union Street, London SE1 1SZ
nmpa@rcog.org.uk

29th May 2026

Dear NMPA Senior Clinical Leads,

Re: Confirmation of NMPA alarm-level outlier status: postpartum haemorrhage ≥1500 ml, births in 2024

Thank you for your letter received 4 May 2026 notifying the Trust of alarm-level outlier status for the following NMPA indicator: **Proportion of women and birthing people giving birth to a singleton baby between 34+0 and 42+6 weeks of gestation who have a postpartum haemorrhage (PPH) of 1500 ml or more.**

Response to NMPA questions (a) and (b)

Your letter asked the Trust to confirm either:

a) that it accepts the results as they are, outlining any organisational or clinical factors which may have played a part, if applicable; or
b) that it has identified data errors which call into question the accuracy of the results.

The Trust confirms that it accepts the NMPA-reported alarm-level outlier status for PPH ≥1500 ml for births in 2024 under response option (a). Following review by the maternity clinical leadership team and information analysts, the Trust is satisfied that the submitted data are substantially accurate and that the result should remain within the NMPA outlier process. In relation to option (b), the Trust has not identified data errors that call into question the accuracy of the NMPA result. Local validation identified an unadjusted PPH ≥1500 ml rate of 5.3% for 2024, compared with 5.6% in the NMPA dataset. This difference is small and is attributable to known variation in MSDS coding, denominator reconciliation and routine data extraction. It does not invalidate the NMPA result and the Trust is not seeking removal from the outlier list on data-quality grounds. The organisational and clinical factors that may have contributed to, or contextualised, the reported rate are set out below, together with the Trust's improvement actions, current performance and assurance arrangements.

1. Clinical and organisational context

The Trust provides maternity care within a service that includes a Level 3 Neonatal Unit, receiving in-utero transfers from across, and occasionally beyond, the local maternity and neonatal system. These transfers may include pregnancies with fetal, neonatal, medical or obstetric complexity. As a result, the Trust's caseload may include a higher concentration of women and birthing people with recognised risk factors for PPH. Parts of the Trust's catchment area include communities with higher levels of socioeconomic deprivation and ethnic diversity. These population factors are relevant to the Trust's interpretation of maternity outcomes and to the design of targeted improvement work, particularly where deprivation, ethnicity, anaemia, access to antenatal optimisation and wider maternal morbidity may contribute to increased risk.

During 2024, the Trust also moved to more comprehensive cumulative weighing of blood loss as part of a deliberate patient-safety improvement programme. This improved the accuracy and consistency of blood-loss assessment, supported earlier recognition of PPH and enabled more timely escalation. The Trust recognises that improved ascertainment may have increased the reported incidence of PPH ≥1500 ml when compared with earlier periods in which visual estimation could have contributed to under-recognition. These contextual factors do not reduce the Trust's accountability for the outlier result. They have informed the Trust's risk assessment, targeted improvement work, and the strengthening of oversight of outcomes by ethnicity and deprivation.

The Trust previously received an NMPA outlier notification for the same indicator relating to births in 2023. Learning from that process, particularly in relation to blood-loss measurement, case ascertainment and timely escalation, has informed the improvement programme described in this response.

2. Local review and learning

The maternity clinical leadership team undertook a review of the 2024 signal. This included local validation of the numerator and denominator, review of PPH governance processes, and triangulation with maternity dashboard data. The review confirmed that the higher reported rate was not explained by a single data-quality issue.

The review identified the following learning themes:

- PPH risk was concentrated in a subset of women and birthing people with recognised antenatal or intrapartum risk factors, including complex obstetric and medical profiles and in-utero transfers associated with the Level 3 Neonatal Unit.
- Cumulative measurement of blood loss improved recognition and escalation but also increased the likelihood that PPH ≥1500 ml was captured consistently in the data.
- There was a need to strengthen standardisation of contemporaneous documentation, escalation triggers and multidisciplinary role clarity during evolving haemorrhage.
- Ongoing surveillance by ethnicity and deprivation was required to ensure that improvement work addressed avoidable variation and did not mask unequal outcomes for specific groups.

3. Quality improvement programme

In August 2024, the Trust launched a clinically led PPH Quality Improvement programme in direct response to the PPH signal. The Trust participated in and completed the national Obstetric Bleeding Study UK (OBS UK) Quality Improvement programme, using the OBS UK methodology with external support, benchmarking and challenge. The Trust is now embedding this methodology as part of its ongoing local improvement work. The programme is jointly led by a Consultant Anaesthetist, Consultant Obstetrician and Senior Midwife, with dedicated protected time.

Key components of the programme are:

- Introduction of a standardised PPH proforma and evidence-based PPH care bundle, incorporating cumulative weighing of blood loss to improve assessment accuracy and support timely escalation.
- Implementation of ROTEM point-of-care coagulation testing, supported by targeted multidisciplinary training to improve timely recognition and treatment of coagulopathy in major haemorrhage.
- Strengthened data capture, audit and reporting, with outcomes reviewed through the multidisciplinary PPH Working Group, Quality-of-Care Committee and Trust Board reporting routes.
- Monthly multidisciplinary PPH simulation drills, supplemented by in-situ clinical-area exercises to test escalation, communication, equipment readiness and team roles.
- A monthly PPH Newsletter and safety-huddle learning to disseminate themes from case reviews, simulation and audit.
- Targeted upskilling in cell salvage, resulting in improved awareness, use and reinfusion of autologous blood in eligible cases.
- Enhanced antenatal risk assessment and personalised care planning for women and birthing people at increased risk of anaemia or PPH, including targeted monitoring by ethnicity and deprivation.

Following completion of the OBS UK programme, the Trust is sustaining the methodology through its local PPH Working Group, maternity governance processes and Trust Board reporting routes. This ensures continued oversight of implementation, outcomes, learning and variation.

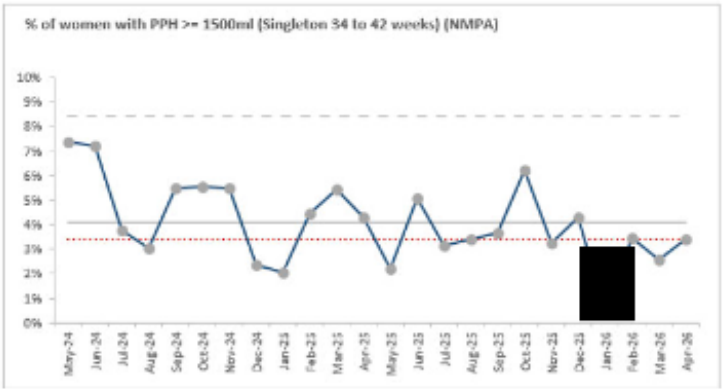
4. Current performance

For clarity, the Trust has used the NMPA-aligned percentage indicator throughout this response: PPH ≥1500 ml among singleton births from 34+0 to 42+6 weeks' gestation. Other operational dashboard formats, including rate-per-1,000 charts, have not been used in the main response because they may apply different denominators or reporting conventions and are therefore less directly comparable with the NMPA outlier indicator. Local performance data demonstrate improvement following implementation of the PPH improvement programme (figure1). The Trust's locally validated unadjusted PPH ≥1500 ml rate reduced from 5.3% for births in 2024 to 4.0% for births in 2025. The latest 12-month rolling average to March 2026 was 3.4% (table1), supporting a sustained improvement trajectory from the 2024 outlier position.

Table 1 PPH ≥1500 ml rates using the NMPA-aligned definition

Reporting period	PPH ≥1500 ml rate
2024 calendar year	5.3% locally validated / 5.6% NMPA dataset
2025 calendar year - local data	4.0%
Latest 12-month rolling average to March 2026	3.4%

Figure 1: Monthly PPH ≥1500 ml rate using the NMPA-aligned cohort definition, May 2024 to April 2026. The chart shows the monthly percentage of women and birthing people with PPH ≥1500 ml among singleton births from 34+0 to 42+6 weeks' gestation. Monthly performance is reviewed alongside rolling average data and the wider trend.



5. Reducing health inequalities

The Trust monitors PPH outcomes by ethnicity and deprivation and uses this information to support targeted improvement. This is particularly important where deprivation, ethnicity, anaemia risk, access to antenatal optimisation and wider maternal morbidity may contribute to increased risk.

Local review has identified women from Asian backgrounds as a group requiring continued focused monitoring and targeted support. Internal quarterly monitoring during full year 2025/26 showed an improving position for this group, with a reduction over the year in a rate of PPH ≥1500 ml. The Trust will continue to monitor ethnicity and deprivation data through the PPH Working Group and maternity governance routes, ensuring that improvement is sustained and that emerging variation is acted on promptly.

6. Ongoing and planned work

The Trust will continue to embed and sustain the PPH improvement programme during 2026, with a focus on clinical reliability, timely escalation and equitable outcomes. Ongoing priorities include continued multidisciplinary review of all PPH ≥1500 ml events, sustained use and audit of cumulative blood-loss

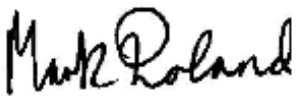
measurement, the PPH proforma and care bundle, and ongoing multidisciplinary simulation to test escalation, communication and team roles.

The Trust will also continue to strengthen access to key clinical interventions, including point-of-care coagulation testing and cell salvage where clinically indicated, alongside enhanced antenatal risk assessment and personalised care planning for women and birthing people at increased risk of anaemia or PPH. Progress will continue to be monitored through the PPH Working Group and maternity governance routes, with learning shared through safety huddles, handovers, simulation and staff communications.

7. Board assurance and senior accountability

The Trust Board is fully sighted on the NMPA alarm-level outlier status and on the improvement, programme described in this response. Performance against the PPH metric is reviewed through the Quality-of-Care Committee, with upward reporting to Trust Board. The Trust recognises the seriousness of PPH ≥1500 ml as a maternal safety outcome. The improvement seen to date is encouraging, but the Trust remains focused on sustaining the reduction, reducing avoidable harm and ensuring that improvements are equitable across all communities served by the maternity service. We remain committed to providing safe, equitable and high-quality maternity care and welcome the accountability and learning provided through the NMPA outlier process.

Yours sincerely,



Dr Mark Roland

Chief Medical Officer

Copy to: Chief Executive Officer

Chesterfield Royal Hospital NHS Foundation Trust

In response to Chesterfield Royal Hospital NHS Foundation Trust being a potential alarm-level outlier for the-

- Proportion of liveborn, singleton babies born between 34+0 and 42+6 weeks of gestation, with a 5-minute Apgar score less than 7

We are writing to you because **Chesterfield Royal Hospital NHS Foundation Trust** has been identified as a potential alarm-level outlier for one or more of these three indicators, as detailed in the table below. This means that the indicator lies outside the expected range of values for a trust/board of this size, with a result that is higher than the upper 99.8% control limit (greater than 3 standard deviations (SD) above the mean). This is not necessarily an indication of poor performance but it does require investigation.

Indicator	National Mean (%)	Trust/Board Numerator	Trust/Board Denominator	Trust/Board Unadjusted Result (%)	Trust/Board Adjusted Result (%)	Trust/Board 3SD upper limit
Apgar score	1.532615	59	2662	2.216379	2.279802	2.246913

Our local data review suggests-

- **CRH local reporting from K2 shows 60 babies born in 2024 between 34 and 42+6 weeks had an APGAR score less than 7, out of a total of 2681 total babies meeting the numerator of liveborn, singleton – a rate of 2.2379% unadjusted. There were [redacted] babies with no 5 minute APGAR documented, which may alter the figures [redacted] BBA, [redacted] unknown reason)**
- **In 2025, CRH had 50 babies meeting criteria, with an unadjusted rate of 1.895%, an improving picture.**

Whilst there is a slight discrepancy in the data, the unadjusted result holds firm and therefore we believe the data submitted, and therefore reality of the Trust's result, does align with the NMPA findings of the 2024 data.

- **In relation to the sources of data used to collate this information-**
  - **MSDS reports on singleton babies born between 37 and 45 weeks gestation, both relating to numerator and dominator, so this data cannot be compared – see screenshot below of MSDS metadata relating to the CQIM measure in question**
  - **The letter from NMPA states data is pulled via NHS England from the MSDS, we are unsure how given the data parameters are different. There is no suggestion the data pulled and highlighted by the NMPA team is incorrect as, a Trust, we are likely unaware how this data is filtered.**
  - **The NMPA also pulls data from birth notifications but APGARs are not a compulsory field in order to complete a birth notification so are not always present at the time the notification is sent.**

As a Trust we would be happy to engage in a meeting with the NMPA Team to further understanding of this data pull.

The second letter 'data completeness and quality' states that for PPH measurements of 1,500mls or more Chesterfield Royal Hospital NHS FT have not submitted complete/correct data sets. The technical specification document identifies the data sets that have been used and the specifications for data completeness. Having reviewed the data, we do not believe this to be the case.

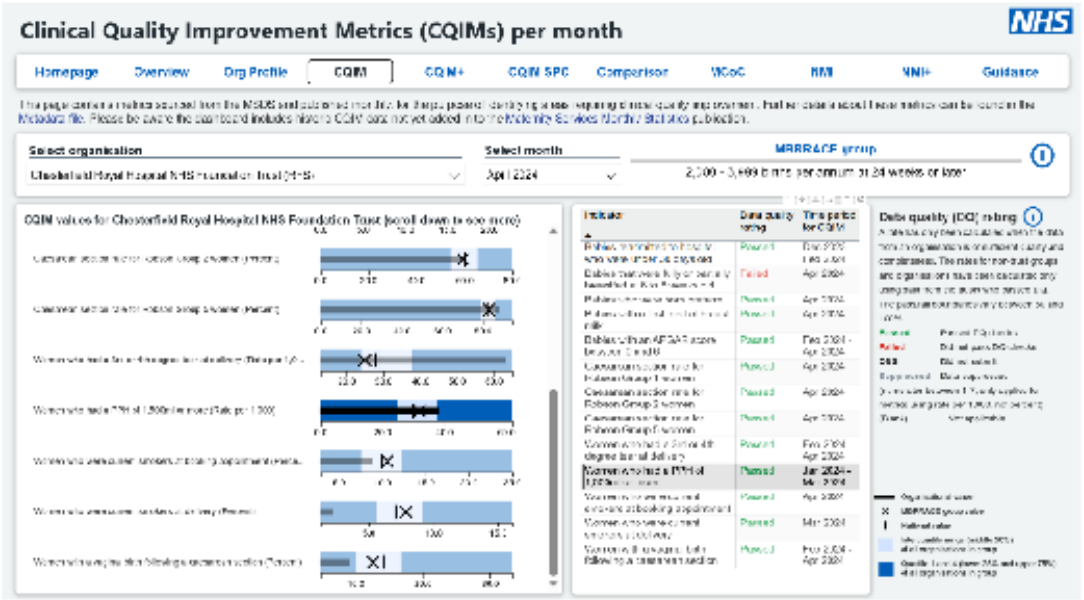
- NMPA state their data source includes the MSDS (see below for screenshot from the letter confirming this), and for the time period of 2024 MSDS data has been submitted and met DQ demands for PPH >1500mls, so we are unsure why NMPA feel this data has not been submitted and/met DQ demands.

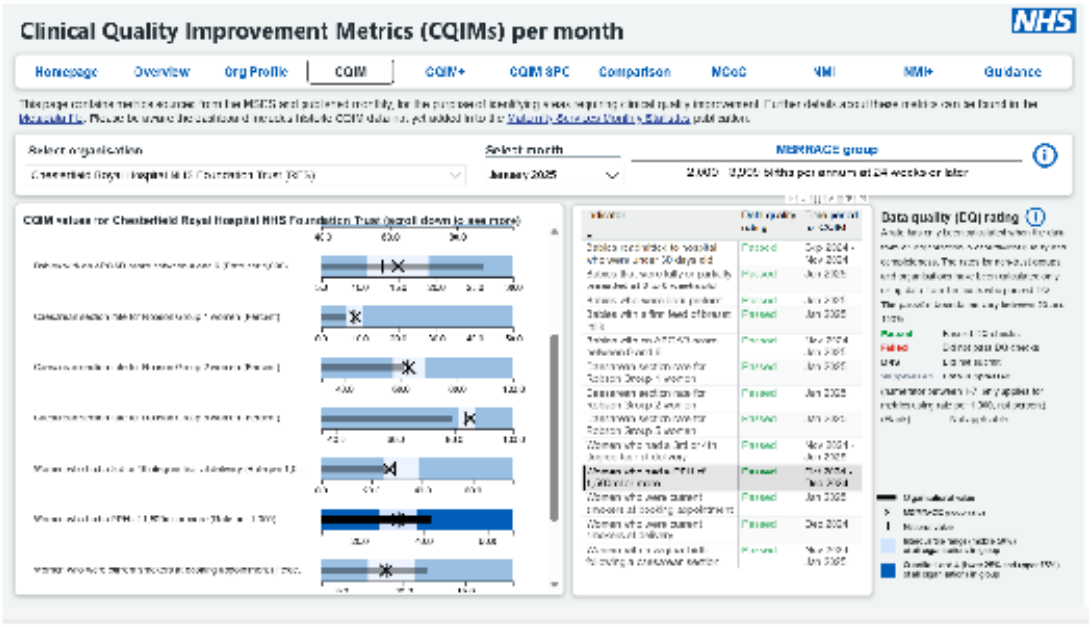
3. Data sources

The NMPA annual clinical report uses English, Scottish and Welsh data from the following sources:

England: Maternity data from Maternity Services Data Set (MSDS) version 2, are linked to Hospital Episode Statistics (HES) Admitted Patient Care (APC) administrative data, as well as the Personal Demographics Service (PDS) Birth Notification data. All pseudonymised English datasets are controlled and supplied directly to the NMPA by NHS England (formerly NHS Digital).

Below is evidence that CRH's MSDS is meeting DQ standards for the measure of CQIM PPH >1500mls




Clinical Quality Improvement Metrics (CQIMs) per month
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Comparison
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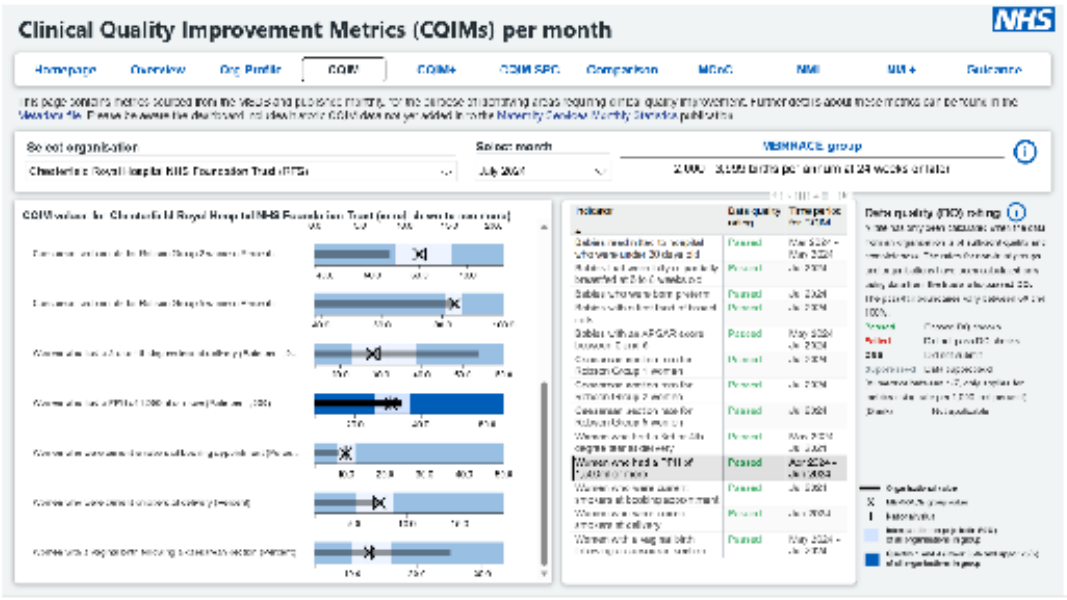
MBRRACE group
Data quality (DQ) rating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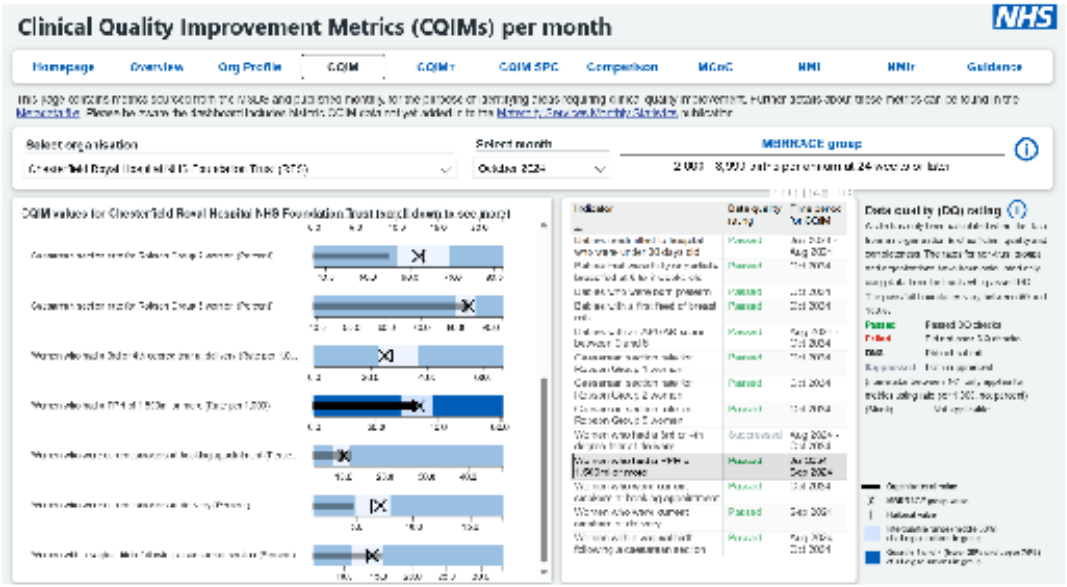
MBRRACE group
Data quality (DQ) rating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Select organisation
Select month
MBRRACE group
CQIM values for Chesterfield Royal Hospital NHS Foundation Trust (scroll down to see more)
Indicator
Data quality rating
Time period for CQIM
Data quality (DQ) rating

County Durham and Darlington NHS Foundation Trust

NHS
County Durham and Darlington
NHS Foundation Trust

Trust response to potential NMPA alarm-level outlier status

The National Maternity and Perinatal Audit (NMPA) is preparing to publish its report on outcomes for births that took place in the NHS during 2024 in England, Scotland, and Wales. Three measures have been selected as indicators which are subject to 'outlier reporting.' These indicators have been case-mix adjusted to consider the different maternal demographic and clinical characteristics at each trust/board, as far as is currently possible. The aim of the audit is to provide relevant and comprehensive information about maternity and neonatal services provided by the NHS in England, Scotland and Wales. This information will allow clinicians, NHS managers, commissioners and women to compare and evaluate services, and can be used to inform care quality improvements. Maternity service providers and commissioners can benchmark the care provided by their service against other, similar services, against regional and national averages, or against local or national standards. Together, these outputs from the audit will allow healthcare professionals, NHS managers, commissioners and policy makers to examine the extent to which current practice meets guidelines and standards and to identify areas for improvement.

The three indicators are:

Proportion of women and birthing people giving birth vaginally to a singleton baby between 37+0 and 42+6 weeks of gestation, who experience a third- or fourth degree tear.

Proportion of women and birthing people giving birth to a singleton baby between 34+0 and 42+6 weeks of gestation, who have a postpartum haemorrhage of 1500 ml or more.

Proportion of liveborn, singleton babies born between 34+0 and 42+6 weeks of gestation, with a 5-minute Apgar score less than 7

The Trust has been identified as a potential alarm level outlier for Apgar score <7 at 5 minutes and Postpartum Haemorrhage of 1500 ml or more. The Trust have explored this further, with a response to NMPA to confirm that the Trust accepts the results.

Postpartum Haemorrhage Outlier status

Introduction

The National Maternity and Perinatal Audit (NMPA) has identified Postpartum Haemorrhage (PPH) greater than 1500ml as an outlier indicator for maternity services at CDDFT. The NMPA outlier policy identifies this indicator as a significant

adverse maternal outcome requiring local investigation, triangulation of findings, and assurance regarding the quality and safety of care.

This review has therefore been undertaken by the current Matron for Community Services to review 2024 data in relation to:

- The incidence and management of PPH within CDDFT.
- To assess compliance with local and national guidance.
- To identify contributory themes and variation in practice.
- Provide assurance regarding clinical management and governance oversight.

Methodology

Inclusion criteria for the review of cases included, women sustaining a post-partum haemorrhage greater than 1500ml, singleton births between 34+0 and 42+6 weeks gestation in line with NMPA methodology, births occurring within the 2024 reporting period, 1st January 2024 to the 31st of December 2024 with care delivered across both maternity sites within CDDFT. Interestingly, there was a discrepancy with data, with NMPA reporting 3460 births against data provided by CDDFT which recorded 3712 births. This changed the recorded unadjusted rate from 4.52% to 4.0%. This is still greater than the nationally recorded mean.

Results

During the review of 2024 data, it was found that there was good compliance with core emergency interventions, appropriate use of first line uterotonics and strong evidence of graduated escalation of uterotonics. Increased BMI was found to be a significant risk factor regarding the incidence of PPH, which in an area of increased deprivation such as County Durham is an interesting finding. Areas for improvement identified were the consistent use of the PPH proforma, alongside the provision of a structured postnatal debrief following the trauma of an emergency birth.

In 2025, the Director of Midwifery identified from her review of the maternity dashboard, that CDDFT rate of PPH was elevated. Consequently, the classification of post-partum haemorrhage for reporting within the Ulysses incident reporting system within CDDFT maternity was amended to identify themes and trends. The incidence of PPH as described in the title 500mls (Vaginal Birth) and >1000mls (operative birth) up to 1500mls was requested to be recorded by clinicians for monitoring and review of cases. A report was presented following evaluation of Q3 incidence of PPH 500-1500mls by the Deputy Head of Midwifery. Obstetric consultants were required to review PPH greater than 1500mls for Q2/Q3 25-26 and present their findings in a thematic review. Both reports have been presented through internal governance process within CDDFT in Q4 25-26.

Both 2025 reports found that emergency caesarean section increased the risk of PPH, with BMI being a factor within the increased volumes. Again, care that was delivered well was the compliance with core emergency interventions, escalation of the incident and obstetric attendance at the emergency. For greater volumes, stepping up and subsequent step down of the major obstetric haemorrhage policy was found to be a strength.

Areas for improvement included the compliance with pharmacological management of the PPH and the electronic patient record (EPR). The offer of a postnatal debrief was an area of challenge along with the completion of the emergency proforma. Consequently, an action plan has been developed to address the areas for improvement identified with ongoing audit in place to confirm compliance.

The need to use the PPH proforma within an emergency setting has been incorporated into local learning for all members of the MDT attending management of obstetric emergency training. The importance of postnatal debrief is also highlighted within core training. Compliance for attendance at this training is monitored monthly as part of the perinatal surveillance minimum dataset. New whiteboards have been ordered for each obstetric theatre to facilitate data entry and transcription to a proforma.

Ward managers, obstetric consultants and CDDFT pharmacy have worked closely to develop a PPH prescription bundle within the EPR to facilitate timely and accurate pharmacology used to manage the PPH. Quarterly reports are now submitted by ward managers reviewing PPH 500-1500mls and mapping these against an action plan. Review of the wider determinants of health including increased BMI, deprivation indices and ethnicity are provided by the current Matron for Public Health and Inequalities via a quarterly report and review of maternity incidents. She works closely with the Local Authority to ensure a collaborative approach is taken strategically to the impact of public health within maternity care as a means of early intervention, addressing inequality and improving access to maternity services of our pregnant population.

Apgar Score Outlier status

Introduction

The National Maternity and Perinatal Audit has identified CDDFT as a potential alarm-level outlier for Apgar scores of less than 7 at 5 minutes of age, based on 2024 outcome data. This indicates that the Trust's reported rate lies outside the expected range for an organisation of this size, with results exceeding the upper 99.8% control limit (greater than three standard deviations above the national mean). In 2025, CDDFT received a similar outlier notification pertaining to 2023 cases and conducted a retrospective review with dissemination of learning into practice. Following the notification, the Director of Midwifery also requested quarterly ongoing audits of this metric to be completed with ongoing scrutiny, monitoring and reporting in process.

NHS
County Durham and Darlington
NHS Foundation Trust

Methodology

In response to the alert, the service took the approach to review the outcome data from 2024 and commenced a fully inclusive clinical audit of all babies who have an Apgar score of less than 7 at 5 minutes in 2024. The rationale was to review the intrapartum care delivered and to provide assurance that the neonatal resuscitation and stabilisation are in keeping with national guidance, whilst also supporting ongoing identification of themes, trends and opportunities for improvement.

The Head of Midwifery, reviewed the 98 cases from 2024 to identify themes, trends and learning opportunities.

The review aimed to:

- Identify the babies born with an Apgar less than 7 at 5 minutes.
- To assess standards of assessment at birth and resuscitation.
- To identify contributory themes and variation in practice.
- Provide assurance regarding clinical management and governance oversight.

Inclusion criteria for the review of cases included all singleton babies delivered between 34+0 and 42+6 weeks gestation in line with NMPA methodology, within the 2024 reporting period, 1st January 2024 to the 31st of December 2024 with care delivered across both maternity sites within CDDFT. Limitations to the audit include the inability to assign controls, the outcome is known and can provide an element of recall bias or documentation bias.

Results

The themes identified from the 2024 review reflected the same findings previously recognised during the 2023 audit process and subsequent ongoing quarterly audits, particularly in relation to the subjective nature and consistency of Apgar scoring practices. All components of the Apgar score remain inherently subjective and may be influenced by a range of factors including clinical experience, situational pressures, and the complexity of the clinical scenario at the time of delivery. When comparing the documented clinical narrative with the recorded Apgar scores, it was frequently difficult to reconcile the assigned score with the described clinical condition of the neonate. Limited documentation relating to colour and tone was identified as a significant limitation, as these elements can only be fully assessed in real time at the point of birth.

Local data identified that a significant proportion of babies with an Apgar score of less than 7 at 5 minutes were born by caesarean section. It is recognised that respiratory transition following caesarean birth differs from that of vaginal delivery, with evidence demonstrating an association with lower Apgar scores at 5 minutes and increased neonatal unit admissions. Local outcome data demonstrated that many babies delivered by caesarean section were assigned an Apgar score of 6 at 5

minutes despite establishing spontaneous respiration whilst requiring positive end-expiratory pressure (PEEP).

The review further suggested that conservative scoring practices may be associated with staff grade and level of clinical experience, reflecting the relative inexperience of some members of the workforce. Additional contributory factors identified by auditors included individual interpretation of scoring criteria, timeliness of scoring, team dynamics during neonatal assessment, and limitations within electronic documentation systems, which can restrict the level of clinical detail recorded contemporaneously.

The audit identified several notable findings relating to maternal demographics, clinical input, neonatal interventions and neonatal outcomes. These included higher rates of maternal smoking, low levels of active resuscitation interventions, low neonatal admission rates, a low incidence of significantly abnormal cord gases, and consistently high levels of neonatal team attendance and support at delivery.

The service continues to undertake detailed review of all cases in which an infant is recorded as having an Apgar score of less than 7 at five minutes of age. In addition, a clear action plan remains in place to support a more objective, consistent and standardised approach to neonatal assessment and Apgar scoring at delivery.

Quarterly reports continue to be submitted, with ongoing audit findings, learning points and improvement actions reported through both service-level and CDDFT governance structures. Learning is also shared through regional forums to support wider dissemination, assurance processes and continuous improvement in clinical practice.

Outcome of the Retrospective Review

- There were limitations to the studies due to the methodology (Retrospective).
- There were limitations due to the numbers included within the review.

Conclusion

The Trust was aware of the outlier status for postpartum haemorrhages from the Maternity Dashboard and from the alert status received in 2025 from the 2023 NMPA report pertaining to Apgar Scores of <7 at 5 minutes. As a result, have completed comprehensive deep dives and audits to identify and disseminate immediate learning. This learning has been disseminated widely to inform practice. CDDFT acknowledges the information shared as part of the NMPA review. Ongoing internal review of data, alongside the implementation of a targeted action plan, will support the identification of emerging trends and enable ongoing monitoring and learning to continue.

Kimberly Williams (Director of Midwifery)
Dr Remko Beukenholdt (Care Group Director – Family Health)
Joanne Stout (Associate Director of Nursing Family Health)

Frimley Health NHS Foundation Trust

We have reviewed the letter sent regarding non submission of data relating to Postpartum hemorrhages above 1500mls.

We have found the following information which informs our response. Following the go live of a trust wide new Elctronic Patient record system EPIC, there was an issue with the total volume of blood loss being recorded in multiple different location within the system which meant clinician could record in various different places and this had a knock-on effect on the background reporting figures which did not feed through effectively.

A workgroup was put together between November 2024 and July 2025 when this issue was identified. Following the implementation of this group recommendations were made to change the workflows and data collection points. Internally we have seen the reporting of PPH rates improve during 2025 and we expect this to feed through to the national data.

Our data analysts are currently reviewing the data that is being sent through the system externally to ensure there are no outstanding issues.

kind regards
Danielle Eghobamien
Frimley Health NHS Foundation Trust
Interim Director of Midwifery
[redacted]
Email [redacted]

King's College Hospital NHS Foundation Trust

King's College Hospital
NHS Foundation Trust
King's College Hospital NHS Foundation Trust
Denmark Hill
SE5 9RS
[redacted]
www.kch.nhs.uk

Attention of

NMPA Senior Clinical Leads

Sam Oddie, NMPA Senior Clinical Lead (Neonatology)

James Harris, NMPA Senior Clinical Lead (Midwifery)

Asma Khalil, NMPA Senior Clinical Lead (Obstetrics)

Dear Emma,

Re: NMPA Notification of Alarm-Level Outlier Status Due to Data Quality and Completeness Concerns issued to KCH on 4th June 2026

Thank you for your letter regarding King's College Hospital NHS Foundation Trust's exclusion from the outlier analysis for the indicator "Proportion of women and birthing people giving birth to a singleton baby between 34+0 and 42+6 weeks of gestation, who have a postpartum haemorrhage of 1500 ml or more."

We acknowledge the concerns regarding data quality and completeness. King's College Hospital NHS Foundation Trust was unable to submit complete Maternity Services Data Set (MSDS) data between January and March 2024 following the implementation of the EPIC electronic patient record system, which went live in October 2023. During this transition period, data submissions were limited to the minimum dataset while data collection, validation processes, and reporting mechanisms were being established within the new system. As the NMPA dataset is derived from MSDS submissions, the data quality issues identified within the 2024 NMPA dataset reflect this temporary disruption to MSDS reporting rather than concerns regarding clinical care or outcome performance.

Following stabilisation of the EPIC system and associated reporting processes, the Trust has restored data completeness and quality. Submission of postpartum haemorrhage (PPH) data to MSDS commenced in August 2024 and has continued consistently thereafter. Internal validation processes have been strengthened to ensure the accuracy and completeness of submitted data.

Current performance data available through the MSDS Maternity Dashboard demonstrates that the Trust's rate of severe postpartum haemorrhage is below the national average for England. In addition, maternity outcomes are routinely monitored through the Trust's governance framework, including regular review through clinical governance and quality assurance processes. These reviews provide

assurance regarding the quality and safety of maternity care provided to our families across the organisation.

It is also important to recognise the differing clinical case mix across the Trust's maternity sites. Denmark Hill Hospital functions as a tertiary referral centre managing a higher proportion of complex pregnancies and births, while Princess Royal University Hospital operates as a Level 2 district general hospital. These differences are reflected in the patient populations and risk profiles managed at each site and should be considered when interpreting outcome data.

Local audit data for the period May 2025 to March 2026 demonstrates stable postpartum haemorrhage rates across both sites and modes of birth, with no indication of performance concerns. These data continue to be reviewed through established governance processes and benchmarked against regional performance within the Southeast London Local Maternity and Neonatal System.

The Trust fully recognises the importance of high-quality national data submissions and has implemented measures to ensure sustained completeness and accuracy of MSDS reporting. We are confident that the issues affecting the 2024 dataset were temporary, related to the implementation of a new electronic patient record system, and have now been resolved.

We remain committed to supporting national audit programmes and to continuous improvement in both data quality and maternity outcomes.

Yours sincerely,

Dr Lisa Long

King's College Hospital NHS Foundation Trust

Email copied to:

Tracey Carter, Chief Nurse, Executive Director of Midwifery
Dr Carmel Curtis, Chief of Division
Rachel Keeley, Divisional Director of Operations
Debbie Hutchinson, Divisional Director of Nursing

London North West University Healthcare NHS Trust

Dear NMPA Team,

The review of these metrics, extracted from the locally validated Qlik dashboard, identified the following:

Data Quality – Calendar Year 2024			
Metric	Numerator	Denominator	Completeness
PPH recorded among eligible singleton births	3052	3199	95.4%
Apgar 5 recorded among eligible live singleton births	2966	3196	92.8%
Mapped EDD available across all 2024 birth records	3758	3798	98.9%

- High levels of completeness for the data items underpinning both NMPA indicators.
- Clinically plausible rates for both PPH ≥1500ml and Apgar <7 at 5 minutes.
- Consistent findings across multiple years of local data.
- Evidence that the relevant clinical information exists within the Trust's reporting environment.
- A materially different position to that currently reflected within the MSDS-derived outputs used for the NMPA review.

Whilst further investigation is required to ensure that the missing ("n/r") values are not clinically driven, these findings support the hypothesis that the issue may sit within the current MSDS extraction, transformation or submission pathway rather than the underlying clinical record itself. As a result, we have begun reviewing alternative submission methodologies, including direct XML generation using the official MSDS specification. We have already obtained the XML structure and are currently reviewing the minimum dataset requirements needed to support this approach.

Based on a review of the NMPA Outlier Policy, it appears unlikely that revised data submitted at this stage would be incorporated into the forthcoming publication cycle, given the advanced stage of the reporting process.

The immediate objective of the Trust's response should therefore be to demonstrate that:

- A detailed review of the issue has been undertaken.
- The underlying clinical data appears substantially more complete than currently reflected within the MSDS-derived outputs.
- A credible root-cause hypothesis has been identified.
- Appropriate governance arrangements are in place to oversee investigation and remediation.
- A clear corrective action plan is being developed to strengthen future submissions and minimise the risk of recurrence.

The analysis provides a strong evidence base to support this position and demonstrates that the discrepancy appears more likely to relate to the data submission pathway than to the completeness of the underlying clinical record. The primary objective of the response should therefore be to demonstrate appropriate investigation, governance and corrective action, whilst evidencing that the issue appears more likely to relate to the submission pathway than the underlying clinical record.

If you need further information please let us know.

yours sincerely,

Asra Saleem CD
and Caroline Macrae Director of Midwifery

Mrs Asra Saleem FRCOG FRCSEd

Clinical Director | Women's Services
Consultant Obstetrics and Gynaecology
London North West University Healthcare NHS Trust
Mob: [redacted]
Email Address: [redacted] | www.lnwh.nhs.uk
Office: Level 5, Maternity Block, Northwick Park Hospital

Royal Berkshire NHS Foundation Trust

Dear NMPA

I can confirm that after investigation we have located the problem and to why our haemorrhage data was not correct in the MSDS data sent to you. This problem will be rectified so future data will be accurate.

The problem identified was the PPH data is recorded on EPR; but not within a Maternity Critical Incident data which then prevented it from being sent to MSDS and so it does not arrive at NHSE for the Inequalities dashboard.

We are recording haemorrhage within our EPR PPH within the Trust Intelligence Portal, so we will utilise this data and be added to the MSDS data bypassing the need for the Maternity Critical Incident data to be recorded in the future so that data will come through to yourselves as required.

I hope this information is sufficient, if you see any discrepancies in our future data please let us know immediately.

Kind regards

Sarah Bailey
Interim Director of Midwifery
[redacted]

Royal Cornwall Hospitals NHS Trust

Dear NMPA Team,

Thank you for your letter regarding our Trust's potential alarm-level outlier status in the forthcoming National Maternity and Perinatal Audit (NMPA) report for births in 2024. I am writing to acknowledge receipt of your correspondence and to provide the requested assurance response.

Following your clarification, we understand that our Trust's Estimated Blood Loss (EBL) completeness is recorded at 67%, which falls below the required 70% threshold for inclusion in the PPH ≥1500 ml indicator. We appreciate the detailed explanation you provided regarding the methodology used to derive a continuous blood loss value for every birth, including 0 ml entries, and the reliance on SNOMED-CT coded total EBL values.

We recognise that our current maternity system records initial and further blood loss separately but does not automatically calculate or submit a total EBL. As a result, although our MSDS submissions passed validation checks, this configuration results in missing total EBL values from your perspective and therefore reduced completeness.

We acknowledge that this is a data-collection and system-configuration issue, not a reflection of clinical performance or safety. We continue to maintain robust internal oversight of all PPH ≥1500 ml cases through our maternity dashboard, case reviews, triangulation processes and Board reporting.

Actions taken

- We have identified the system gap and have formally requested a configuration change from Euroking to ensure that a total EBL is automatically calculated and submitted for every birth.
- This change is expected to significantly improve completeness for future reporting cycles.
- We will validate the improvement once the configuration is implemented.

Ongoing assurance

Until the system change is in place and verified, we recognise that there remains a possibility of recurrence in future cycles. We will continue to monitor this closely and ensure that improvements are embedded and sustained. We do not have a date for this change yet.

This has been signed off for approval by the Chief Medical Director Meredith Kane and Interim Chief Nursing Officer Bernadette George.

We appreciate the clarity you have provided and will keep you updated as our system changes progress. Please accept this email as our formal response to your request.

Kind regards,

Josie Director of Midwifery, Tom Smith-Walker, Clinical Director for Obstetrics.

Josie Dodgson|
Director of Midwifery
Royal Cornwall Hospitals NHS Trust |
Princess Alexandra Wing | Truro | TR1 3LJ
Email: [redacted]

Salisbury NHS Foundation Trust

Salisbury NHS Foundation Trust
Salisbury District Hospital
Salisbury
Wiltshire
SP2 8BJ

Telephone: 01722 336262
Email: [redacted]
9th June 20226

Dear National Maternity and Perinatal Audit team,

Potential alarm-level outlier status

Thank you for your letter on 15th May regarding our exclusion from the outlier analysis due to poor data quality and/or completeness for data in 2024 related to:

- Proportion of women and birthing people giving birth to a singleton baby between 34+0 and 42+6 weeks of gestation, who have a postpartum haemorrhage of 1500 ml or more.

Any omissions in data are due to the incomplete data in our legacy maternity database system, which ran as a hybrid system alongside paper documentation.

At SFT we launched our digital system (Badgernet) on 25/02/2025 and all data is now recorded digitally and we have since then consistently passed the data quality standards required for the Maternity Services Data Set (MSDS) data quality dashboard.

We anticipate that this action will preclude any further ongoing poor data quality for National Maternity and Perinatal Audit requirements.

Kind regards

Miss Abigail Kingston
Clinical Director – Maternity and Neonatal Services

Katherine Barrio

Head of Midwifery & Neonatal Services

St George's University Hospitals NHS Foundation Trust

St George's University Hospitals
NHS Foundation Trust

St George's University Hospitals
NHS Foundation Trust
Blackshaw Road
London
SW17 0QT

NMPA Senior Clinical Leads,
Sam Oddie, NMPA Senior Clinical Lead (Neonatology)
James Harris, NMPA Senior Clinical Lead (Midwifery)
Asma Khalil, NMPA Senior Clinical Lead (Obstetrics)

Royal College of Obstetricians and Gynaecologists
10-18 Union Stret
London
SE1 1SZ

12/08/2026

Dear NMPA Senior Clinical Leads,

Re: Email and letter dated 05 May 2026 – Potential outlier in National Maternity and Perinatal Audit (NMPA) – St George's University Hospitals NHS Foundation Trust: St George's response

Thank you for your email dated 05 May 2026, informing us that St George's has been excluded from this outlier analysis due to poor data quality and/or completeness for the following indicator/s:

- Proportion of women and birthing people giving birth to a singleton baby between 34+0 and 42+6 weeks of gestation, who have a postpartum haemorrhage of 1500 ml or more

We understand that in line with updated NCAPOP guidance, trusts that have been excluded from outlier analysis due to poor data quality and/or completeness will now constitute as an 'Alarm' level outlier.

We acknowledge that our results have been shared in strict confidence and remain under embargo until 00:01 on 13th August 2026. We appreciate the opportunity to review our data quality and completeness and respond to your request regarding:

a) Acceptance of the results, including any relevant organisational or clinical factors, or
b) Identification of data errors that may affect the accuracy of the results.

Review of data accuracy

On reviewing the relevant data from 2024 we are unable to identify why the local data did not meet the 70% threshold required to provide assurance of data quality. We have reviewed our MSDS data on the National Maternity Dashboard and it appears complete.

However, since our move to Cerner in 2025 we acknowledge the challenges we face with reporting data and are working towards aligning our maternity dashboard with Maternity Services data set (MSDS) metrics to ensure consistent reporting.
The concerns identified with data quality are a known significant risk which is on the maternity risk register at extreme with actions and mitigations in place. We are manually cross referencing and triangulating delivery and LFPSE data to track our PPH rate more accurately. These figures are reported monthly to the Trust Board and monitored via an SPC chart.

Review of relevant organisation or clinical factors

We recognise that our PPH rate for 2024 was above the national average of 3.5%, and above our Trust target of <4%. As a result, we have actively implemented measures to improve outcomes. We are pleased to report that in 2025 our PPH rate (manually calculated) for all births has reduced to 3.4%.

St George's has a level 3 neonatal unit, and we offer bariatric and invasive placentation services.
As the Placenta Accreta Spectrum disorder (PAS) centre we take referrals from London, Surrey and the Southwest of London. The only other London hospitals accepting similar referrals are Guy's and St Thomas's (GSST), Kings College London (RIH) and St Bartholomew's (RJZ).

We carried out a detailed audit which was used to drive local learning and improvement. This demonstrated that most PPH is associated with vaginal birth following induction of labour, and with forceps delivery. Our review of indications for, and management of, induction of labour was designed in part to identify further issues requiring intervention to improve PPH outcomes. In particular, we looked at our management of PPH following delivery by forceps, where the likely cause of bleeding is trauma, to identify if any change in clinical approach is needed.

<u>The following actions were introduced to address our 2024 PPH rate</u>

- New multidisciplinary governance process for PPH review, in line with other London tertiary referral centres, to ensure themes and learning are rapidly identified.
- Thromboelastogram (TEG) - guided use of fibrinogen concentrate.
- Updated our haemorrhage guideline in line with Obs Cymru recommendations.
- Updated our PPH guideline following our audit findings.
- Use of carbetocin for caesarean and instrumental deliveries in theatre.
- Use of tranexamic acid for deliveries with greater than 500ml blood loss.
- Bi-annual PPH staff awareness weeks.
- PPH station within our mandatory PROMPT training.
- In-situ simulation sessions.
- Hands on instrumental delivery teaching for trainees.

We appreciate the opportunity to review our data and provide this response, which we hope demonstrates our commitment to addressing and improving our PPH rate.

Please do not hesitate to contact us should you require any further information.

gesh

NHS
St George's University Hospitals
NHS Foundation Trust

Yours sincerely,

Mr Hugh Byrne BMedSc MB BCh BAO (hons.) FRCOG MSc
Consultant Obstetrician & Gynaecologist, and
Clinical Director – Women's Services
St George's University Hospitals NHS Foundation Trust
London SW17 0QT

[redacted]

Secretary:
[redacted]

The Newcastle Upon Tyne Hospitals NHS Foundation Trust

NHS
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Trust response to potential NMPA alarm-level outlier status

1. Introduction

The National Maternity and Perinatal Audit (NMPA) is preparing to publish its report on outcomes for births that took place in the NHS during 2024 in England, Scotland, and Wales. Three measures have been selected as indicators which are subject to 'outlier reporting.' These indicators have been case-mix adjusted to consider the different maternal demographic and clinical characteristics at each trust/board, as far as is currently possible.

The three indicators are:

- Proportion of women and birthing people giving birth vaginally to a singleton baby between 37+0 and 42+6 weeks of gestation, who experience a third- or fourth degree tear.
- Proportion of women and birthing people giving birth to a singleton baby between 34+0 and 42+6 weeks of gestation, who have a postpartum haemorrhage of 1500 ml or more.
- Proportion of liveborn, singleton babies born between 34+0 and 42+6 weeks of gestation, with a 5-minute Apgar score less than 7

The Trust has been identified as a potential alarm level outlier for Apgar score <7 and postpartum haemorrhage >1500mls, this warrants further exploration and investigation with a response to NMPA to confirm that the Trust either accepts the results or has identified data errors.

2. The North East North Cumbria Clinical Indicator Dashboard

The North East NHSE Analytics team, in conjunction with the North East North Cumbria Integrated Care Board (NENC ICB) and Local Maternity and Neonatal System (LMNS), have developed a Clinical Indicator Dashboard and safety signal process. The Trust has been influential in developing the dashboard and the safety signal process to alert to any potential trends and outliers. Analysis of this dashboard by clinical experts and the LMNS Head of Quality and Safety occurs quarterly, with further analytics supported by the NHSE team if indicated.

This may include:

- Benchmarking against the rest of the country (for instance, via funnel plots) to robustly identify outliers.
- Understanding variation for any given metric by patient cohorts. This may include factors specific to a pregnancy (for instance, gestational age or delivery method), as well as health inequalities (for instance, socio-economic deprivation or ethnicity)

- Produce analysis which highlights variation in MSDS data quality and can be used to drive improvements.

The broader analytical objectives of the clinical indicator dashboard and maternity analytics programme is to.

- Encourage and embed insight driven analysis.
- Continuous improvement of data processing to ensure outputs are designed efficiently and automated.
- Rigorous quality assurance to be at the heart of all outputs to ensure accuracy of information.
- Ensure all dashboards, routine reports and ad hoc analysis use high quality visualisations that enable insight to be drawn from the analysis.
- Work in collaboration with analytical teams across NHSE to further enhance our analytical capability.
- Promote matrix working as a mechanism for reducing duplication, ensuring dashboards are fit for purpose, enhancing subject matter expertise knowledge and utilising wider skillsets that sit outside of our team.
- Stakeholders receive a consistent high quality analytical service, which includes fit for purpose self-serve dashboards, resource to meet ad hoc requests and consultancy to drive forward insight driven analysis.

Newcastle Hospitals having been working collaboratively with the North East Local Maternity and Neonatal System to improve data quality. The Data User Group brings clinicians and analysts together to devise, test and implement consistent extraction scripts, with a focus on MSDS data.

"The Maternity Services Data Set (MSDS) is a patient-level data set that captures information about activity carried out by Maternity Services relating to a mother and baby(s), from the point of the first booking appointment until mother and baby(s) are discharged from maternity services. As a secondary use data set, MSDS re-uses clinical and operational data for purposes other than direct patient care. It defines the data items, definitions and associated value sets extracted or derived from local information systems and sent to NHS Digital for analysis purposes."

The LMNS identified discrepancies in the MSDS data and have been working as a system to resolve.

- MSDS duplicated data being recorded when women are receiving care across providers.
- The BadgerNet single pregnancy record means some women are counted against both providers in the published statistics, this has a significant impact on Newcastle as the Trust provide both the fetal medicine and maternal medicine services for the NENC, resulting in a high number of consultations with patients from the other 7 Trusts in the ICB.

As a system we have;

- Identified how to remove duplicates utilising the site code in MSDS.

- LMNS and NEY Analytics have highlighted the duplicates issue with MSDS to NHSE Statisticians. NHSE have looked to improve site completeness across the country. Site code recording at birth is being reported on now in our CNST Scorecard (as a non-CNST DQ priority).
- NEY are updating the local metrics to exclude duplicates. This is occurring on a metric by metric basis, which demonstrates the Trust is not an outlier for preterm birth.
- Highlighted this issue to NHSE Statisticians and NEY Analytics.

As a Trust with Maternal and Fetal Medicine services and a Level 3 neonatal intensive care unit we care for some of the most complex and high risk pregnancies and have previously been disproportionately impacted by the duplicates issues as the Trust receive referrals and reviews many women referred from Trusts with the NENC ICB.

3. **Postpartum haemorrhage safety signal generated by NENC Clinical Indicator Dashboard**

The Trust triggered a safety signal from the NENC Clinical Indicator Dashboard in Q3 & Q4 2022/23 and so a review was instigated in November 2023 to understand the data and any safety implications.

Further analysis of the data by the NHSE analytics team revealed that the higher rate of PPH was for women delivered by caesarean section, both emergency and elective, which allowed the deep dive to focus on these cases.

Following this safety signal the Trust has been closely monitoring the data to ensure the learning from this has been embedded, and the data reported on the NENC Clinical Indicator Dashboard is accurate, with duplications removed by the NEY analytics team prior to publication.

The Trust is assured that the MSDS data with duplications removed demonstrates that the Trust is not an outlier with PPH rates reported as:

Q1 2024/25 31 per 1000

Q2 2024/25 36 per 1000

Q3 2024/25 26 per 1000


North East _ North Cumbria_ Key Matern


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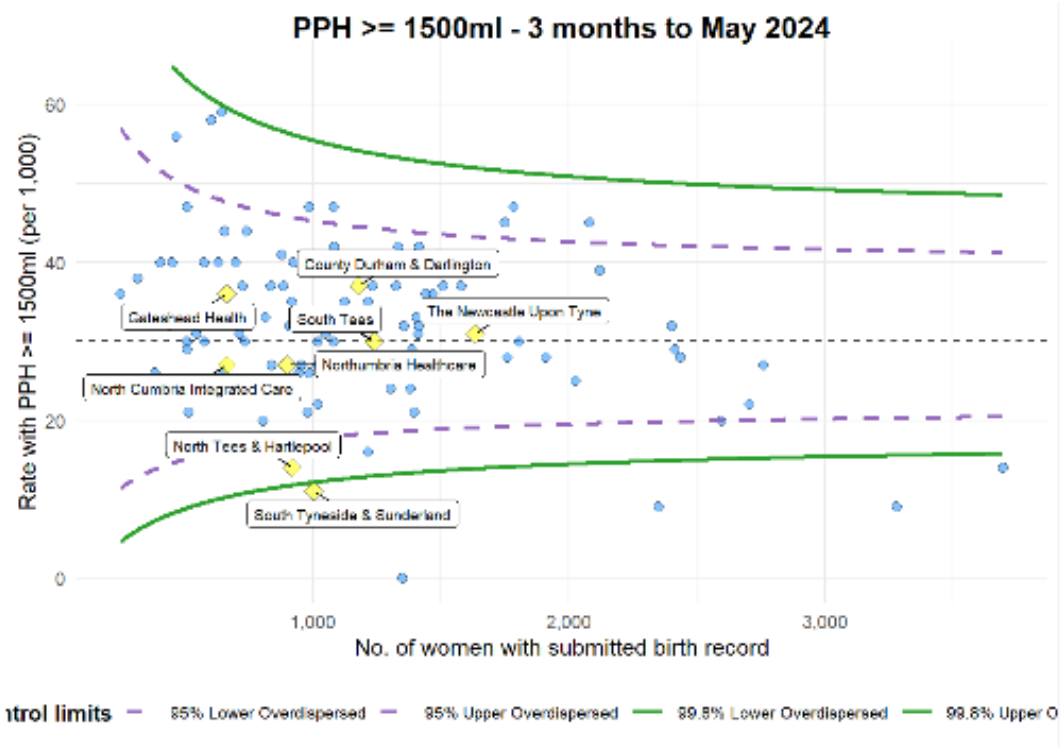
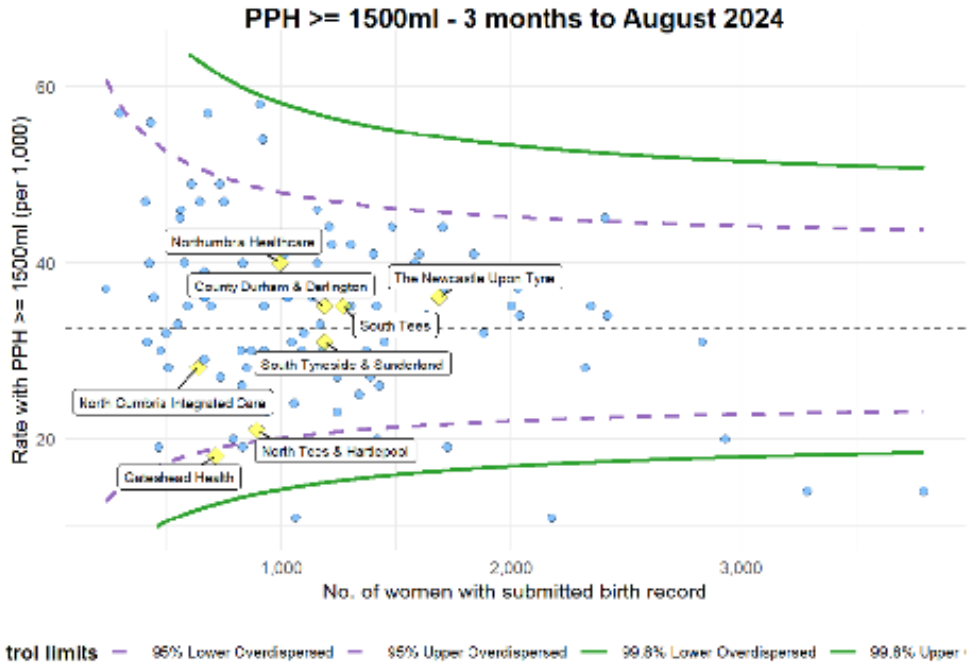
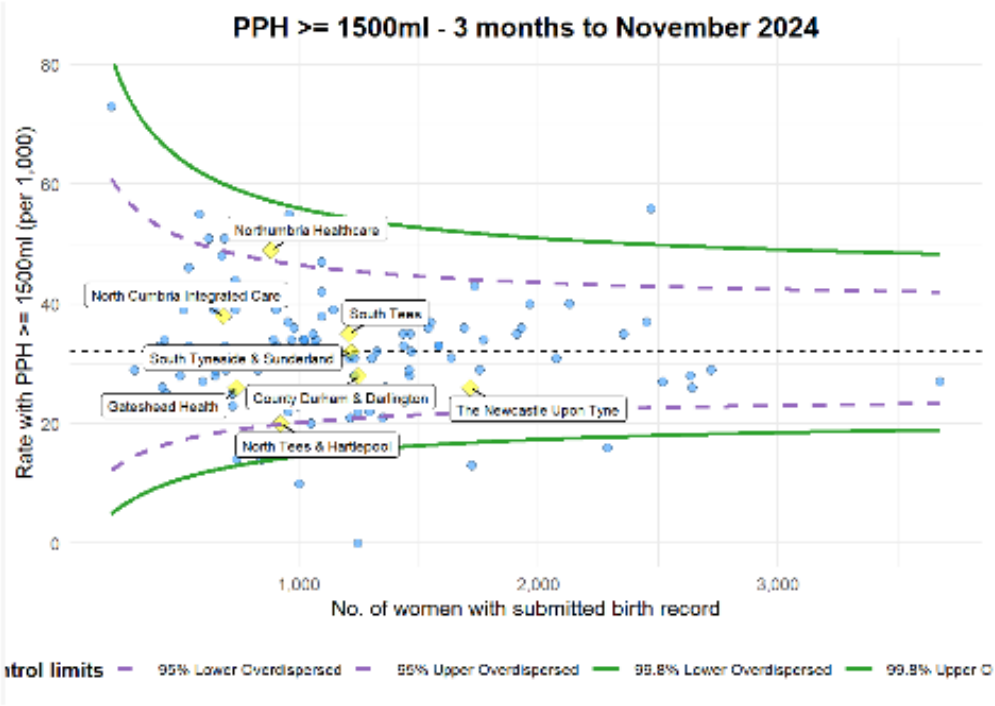

PPH >= 1500ml - 3 months to May 2024
Rate with PPH >= 1500ml (per 1,000)
60
40
20
0
County Durham & Darlington
Gateshead Health
South Tees
The Newcastle Upon Tyne
Northumbria Healthcare
North Cumbria Integrated Care
North Tees & Hartlepool
South Tyneside & Sunderland
1,000
2,000
3,000
No. of women with submitted birth record
ıtrol limits
95% Lower Overdispersed
95% Upper Overdispersed
99.8% Lower Overdispersed
99.8% Upper O


PPH >= 1500ml - 3 months to August 2024
Rate with PPH >= 1500ml (per 1,000)
60
40
20
Northumbria Healthcare
County Durham & Darlington
The Newcastle Upon Tyne
South Tees
South Tyneside & Sunderland
North Cumbria Integrated Care
North Tees & Hartlepool
Gateshead Health
1,000
2,000
3,000
No. of women with submitted birth record
trol limits
95% Lower Overdispersed
95% Upper Overdispersed
99.8% Lower Overdispersed
99.8% Upper



4. **<u>APGAR <7 at 5 minutes safety signal generated by NENC Clinical Indicators Dashboard.</u>**

The Trust was one of many within the ICB who triggered a safety signal in regard to APGAR score <7 at 5 minutes of age. This signal was monitored for 3 quarters before a deep dive was commenced in 2024/25.

The rates were reported on the NENC Clinical Indicators Dashboard as:

Q1 2024/25 30 per 1000

Q2 2024/25 30 per 1000

Q3 2024/25 24 per 1000

Four key areas were identified by NENC LMNS to be explored:

1. Data Accuracy
2. Evidence of potential harm
    a. number of babies with cord gases pH ≤7.0 or Base Deficit (BD) ≥12
    b. number of babies who received Therapeutic Hypothermia (TH) or had diagnosis of Hypoxic Ischaemic Encephalopathy (HIE)
3. Evidence of other harm
    a. Number of babies admitted for Neonatal Care
    b. ventilation/hypoglycaemia/other significant neonatal morbidity
4. Evidence that guidelines were followed:
    a. Maternity (CTG/Infection/Other guidelines)
    b. Neonatal (resuscitation/admission/subsequent care)

Using data collected from BadgerNet Unit Reports, all babies who were delivered at term (≥37 weeks gestation) were identified. Cross checks of data were undertaken against neonatal mortality data; ATAIN (Avoiding Term Infants Into Neonatal Units) database and babies who received therapeutic hypothermia.

Validation of data

In Q1 there were 36 cases initially identified with an APGAR score <7 at 5 minutes of age. There were 6 'missing APGAR score'. When these were reviewed [redacted] women delivered unattended, [redacted] APGAR score of 7/1 and [redacted] score of 6/1 but no score for 5 minutes had been recorded for [redacted] The neonatal expert reviewing the cases felt that 14 babies were inaccurately scored at 5mins of age.

In Q2, 35 cases were initially identified with an APGAR score <7 at 5 minutes of age. There were 19 cases with 'missing APGAR score'. The neonatal expert reviewing the cases felt 12 babies were inaccurately scored at 5mins of age.

The majority of inaccurate scores were due to a respiratory score of 1 being incorrectly assigned to babies receiving facial PEEP with regular respiratory effort.

Evidence of harm/adherence to guidance

In Q1, there were 5 babies who had low cord gases (or neonatal gas within first hour/ pH ≤ 7.0 and/or BD≥12). One Infant was treated with therapeutic hypothermia. No infants had confirmed injury on MRI. There were no deaths.

In Q2, 5 babies had low cord gases (or neonatal gas within first hour/ pH ≤ 7.0 and/or BD≥12). In Q2, [redacted] received therapeutic hypothermia. [redacted] There were no deaths.

In Q1 & Q2 there were no cases where NLS algorithm or neonatal guidance was not followed.

CTG guidance compliance during Q1 and Q2 with prompt recognition of a suspicious or pathological CTG.

Learning and action points

- Incorrect calculation of Apgar score when babies are receiving facial positive end expiratory pressure (PEEP) and have regular respiratory effort. A score of 1 is often assigned when this should be 2.
- In Q1 & 2 there were only 2 cases where care issues were identified which were not felt to have impacted on the outcome.
- No significant long term morbidity or mortality associated with an APGAR<7 at 5 mins in Q1 and Q2.
- BadgerNet generated report for Apgar score <7 at 5 minutes of age does not capture all data.
- There were APGAR scores missing from some records.

5. Conclusion

The Trust was alerted to safety signals from the NENC Clinical Indicator Dashboard and has completed comprehensive deep dives and audits to understand if there were any safety implications and learning. This learning was shared with the LMNS and ICB at the time of the reviews to inform practice, and the clinical teams and analysts who support the LMNS and Trusts. The LMNS identified discrepancies in the MSDS data and have been working as a system to resolve. As a system we have identified how to remove duplicates utilising the site code in MSDS.

The Trust is assured the PPH rates reported within the NENC Clinical Indicators Dashboard are accurate and demonstrate the Trust is not an outlier following the previous review, however, the MSDS data reported nationally continues to include duplications.

The review team completing the APGAR <7 at 5 minutes review found missing data in records and the incorrect classification of APGAR score when babies are receiving PEEP with regular respiratory activity.

On this basis the Trust has identified data entry errors and clinical factors which have influenced the potential alarm.

Report of Michelle Russell & Jenna Wall
Clinical Director & Director of Midwifery
5 June 2026

The Rotherham NHS Foundation Trust

Good Afternoon,

Rotherham NHS Foundation Trust received correspondence from the yourselves on 4th May 2025 informing the Trust that it **was excluded from this outlier analysis due to poor data quality and / or completeness** of the following indicator:

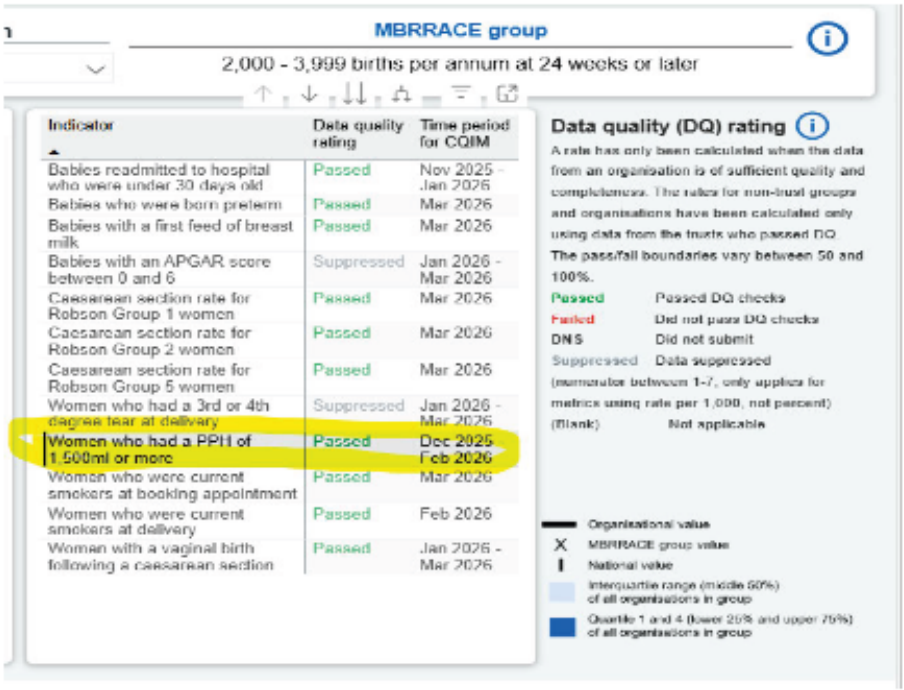
Proportion of women and birthing people giving birth to a singleton baby between 34+0 and 42+6 weeks of gestation, who have a postpartum haemorrhage of 1600 ml or more.

As requested, we acknowledged the email and you confirmed TRFT were excluded from the audit as we **failed completeness checks** for 'Estimated blood loss (EBL) (ml)'.

In response to this our Digital Midwife has reviewed the data with the Trust Data Analyst teams who informed the reason why TRFT fell short of the required standard was due to the wrong code being used for the MSDS submission

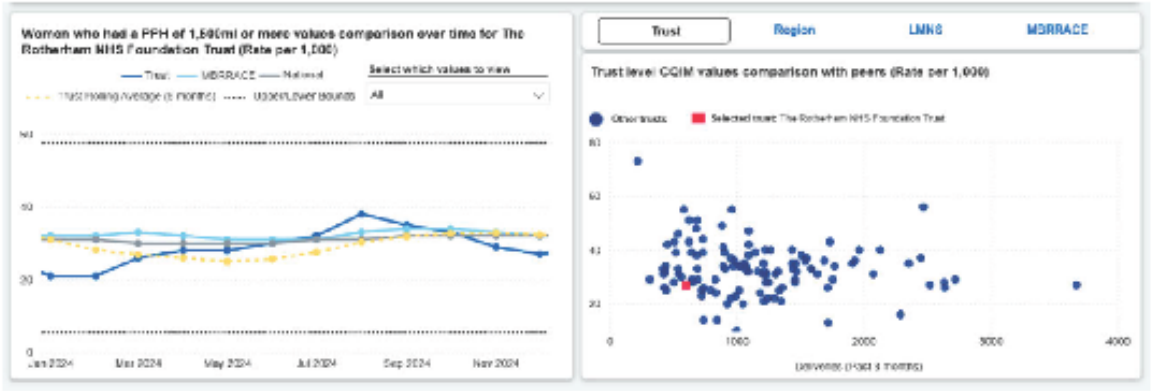
Historically, TRFT have submitted Postpartum Haemorrhage of 500ml or more as part of our MSDS submissions. This passes MSDS data quality validation when looking at the Post partum Haemorrhage of 1500ml indicator (see screen shot below). The National Maternity and Perinatal Audit take a cut of the MSDS data submission and looks at Estimated blood loss in all patients requiring a 70% completion check. This check does not appear in the validation of our MSDS submissions . We have not historically submitted estimated blood loss for all patients. This has now been changed from May 2025 whereby the estimated blood loss will be submitted for all patients, and this will also allow Postpartum Haemorrhage of 1500ml to still be calculated. Going forward this should then meet the data quality checks for the National Maternity and Perinatal Audit

RFT - MSDS data quality index last 12 months:



We contacted yourselves to inform you of the identified reporting error and to enquire if our 2024 data could be submitted manually, and thus not be an outlier. You acknowledged the efforts we have made to rectify the error, but unfortunately you could not accept data into the audit that is submitted manually as it needed to be secure, through MSDS. You also advised that our 2025 data may be impacted by this error and so TRFT are likely to be identified as a potential outlier next year as well on this element.

For assurance, we reviewed our 2024 data for postpartum haemorrhage >1500ml and had our data been included in the NMPA audit, TRFT would not be an outlier for incidence rates



Please do not hesitate to contact us if you wish to discuss anything further

Bw

Sarah Petty
Director Midwifery
Barnsley/ Rotherham NHS Foundation Trusts
Email [redacted]

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@barnshospital barnsleyhospital

Barnsley Hospital NHS Foundation Trust

Ambitious Caring Together

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TheRotherhamNHSFoundationTrust
@TRFTNHS

The Rotherham NHS Foundation Trust

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02 June 2026

National Maternity and Perinatal Audit (NMPA)
Royal College of Obstetricians and Gynaecologists
10-18 Union Street
London
SE1 1SZ

Dear NMPA Team,

Re: National Maternity and Perinatal Audit – Potential alarm-level outlier status

Thank you for your letter received on 4th May 2026 regarding the exclusion of our organisation from the outlier analysis for the indicator relating to postpartum haemorrhage ≥1500ml, due to concerns around data quality and completeness.

We have undertaken an initial review of this finding and would like to provide the following response.

During the reporting period in question, the Trust underwent a transition to the Cerner electronic patient record system. We believe this system change has had a significant impact on the completeness and quality of data submissions to the Maternity Services Data Set (MSDS), particularly in relation to this indicator. As such, we are working on the assumption that this is the primary contributory factor to the issue identified.

Importantly, we have evidence that clinical teams have continued to collect and document the relevant data as part of routine care throughout this period. This indicates that the issue is unlikely to reflect a lack of clinical recording, but rather a challenge in the extraction, mapping, or submission of this data to national datasets. We are able to provide supporting evidence of local data collection processes as part of this response.

We have initiated internal discussions with our Trust's Informatics team to understand how this data is captured within Cerner, and subsequently extracted for submission to MSDS. However, we have identified ongoing uncertainty regarding how the data fields used for this indicator are derived within the national dataset.

To address this, we have made multiple attempts to seek clarification from the NMPA regarding the specific methodology used to extract and construct this indicator from MSDS submissions. We have also requested a meeting with the NMPA statistician to support this understanding, but have not yet been able to arrange this.

Despite these challenges, we are taking the following steps:

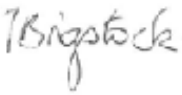
- Continuing to work with Informatics colleagues to validate data capture and submission processes within Cerner.
- Reviewing local data against submitted MSDS data to identify any discrepancies
- Strengthening internal assurance processes around maternity data quality
- Seeking further clarification from NMPA to ensure alignment with national definitions and extraction methodologies.

We are confident that, following the stabilisation of the Cerner system and improvements to data extraction processes, this issue will not persist in future reporting periods. We will continue to monitor this indicator through our own internal reporting mechanisms to maintain oversight and internal assurance.

We welcome any further guidance the NMPA team can provide and remain keen to engage in discussion to ensure accurate and complete data submission going forward.

Yours sincerely

Jonathan Young, Chief Medical Officer



Tracey Brigstock, Chief Nursing Officer

Cc.
Professor Andy Hardy, Chief Executive Officer
Karen McLachlan, Group Clinical Director
Mara Tonks, Director of Midwifery
Suzanne Wilson, Deputy Director of Midwifery

University Hospitals of North Midlands NHS Trust

Executive Summary

NMPA Outlier Response
University Hospitals of North Midlands

NHS
University Hospitals of North Midlands
NHS Trust

Purpose:	Information	✓	Approval	✓	Assurance	✓	**Agenda Item:**	
Author:	Catherine Hegarty Quality & Risk Manager Lucy Boot Digital lead Midwife							
Executive Lead:	Ann-Marie Riley Chief Nurse							

Alignment with our Strategic Priorities		
	Our People We will create an inclusive environment where everyone learns, thrives and makes a positive difference	✓
	Our Patients We will provide timely, innovative and effective services to our patients	✓
	Our Population We will tackle inequality and improve the health of our population	✓

Risk Register Mapping		

Executive Summary

Situation

UHNM have been highlighted as an outlier in the 2026 National Maternity and Perinatal Audit based on births during 2024 for the following dataset.

1. Proportion of women and birthing people giving birth to a singleton baby between 34+0 and 42+6 weeks of gestation, who have a postpartum haemorrhage of 1500 ml or more – Non - participation (due to poor Data Quality)

Background

The National Maternity and Perinatal Audit (NMPA) is a large-scale audit of NHS maternity services across England, Scotland and Wales. The NMPA uses information routinely collected as part of maternity care, combined with information collected when women and birthing people and their babies are admitted to hospital. The audit produces outputs that can be used by commissioners and providers of maternity services, as well as to support women and birthing people and their families to use the data to make informed decisions. Only records and maternity services which passed detailed data quality checks are included in these results. This means not every maternity service at every trust/board has results for every measure.

Assessment

PPH Data:

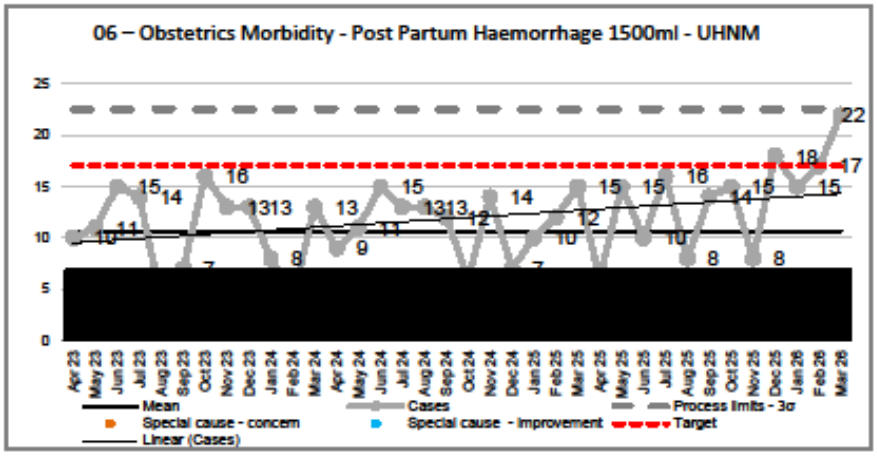
NMPA data excludes records if they were missing information on estimated blood loss, gestational age, or number of babies (multiplicity).
For each trust / board, specific months were excluded if:
• counts were less than 70% of the expected monthly average
• completeness for estimated blood loss was less than 70%

The outlier status is in relation to data quality resulting in the PPH data being excluded from the NMPA audit.

Following an investigation with the EPR supplier, K2MS, it was identified that a change is required to the *MDS302_SessionData_View* table. Specifically, the WHERE clause (EBL_Post_Partum_Haemorrhage) needs to be removed, as it is currently restricting results to blood loss values greater than 1499ml. This amendment will ensure that all blood loss values are reported, rather than only those above this threshold. The fix is scheduled to be implemented in the live system on Tuesday 23 June 2026.

Local data extracted for PPH dataset for UHNM is currently above the national average based on the NMPA dataset criteria. National average for PPH of 1500mls and above is currently 3.4% and UHNM is currently 3.95%

Rates between Trusts will vary depending on local thresholds for escalation. There are lots of issues around establishing accurate and comparable incidences of PPH, which should be acknowledged as a limitation of the NMPA data.



Assurance Assessment		
Significant	High level of confidence in delivery of existing mechanisms / objectives	
Acceptable	General confidence in delivery of existing mechanisms / objectives	x
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	
No Assurance	No confidence in delivery	

Rationale

The paper provides assurance to Trust Board of PPH rates and oversight.

Key Recommendations

- Action plan developed to provide assurance of ongoing monitoring and improvements PPH rates and data quality.
- Service to ensure all PPH above 1500mls are incident reported and reviewed by the multidisciplinary teams
- Monitor themes of PPH incidents

- Implementation of the Maternity Care bundle
- Benchmark UHNM data against national data for PPH rates
- Provide a robust training programme for the management of PPH
- Improve data quality for MSDS data submission
- Explore upgrades within K2 to ensure data is captured within national reports
- Governance oversight of data quality issues within the service

Hampshire Hospitals NHS Foundation Trust

NHS
Hampshire Hospitals
NHS Foundation Trust

Basingstoke and North Hampshire Hospital
Aldermaston Road
Basingstoke
Hampshire
RG24 9NA

03 June 2026

Response sent in writing to nmpa@rcog.org.uk

Re: Hampshire Hospitals Foundation Trust Potential alarm-level outlier status

FAO: The National Maternity and Perinatal Audit (NMPA)

We are writing to acknowledge receipt of the NMPA notification indicating that Hampshire Hospitals Foundation Trust (HHFT) is being considered for potential alarm-level outlier status. In response to the notification, we have reviewed the results and found some discrepancies. However, a review has been conducted of the 2024 birth outcome data concerning the NMPA metric: *Proportion of liveborn, singleton babies born between 34+0 and 42+6 weeks of gestation, with a 5-minute Apgar score of less than 7.*

Please find a summary of the internal quality review below:

- The NMPA Potential alarm level notification letter received by HHFT on 01 May 2026
- The NMPA potential alarm-level outlier status was presented at the Quality and Workforce Group (subcommittee of Trust Board) on 02 June 2026 for Trust Board oversight and Safety Champion awareness. (Appendix 1)
- The NMPA potential alarm-level outlier data was reviewed for the proportion of liveborn, singleton babies born between 34+0 and 42+6 weeks of gestation, with a 5-minute Apgar score of less than 7, against HHFT data set from Badgernet.

Indicator	National Mean (%)	Trust/Board Numerator	Trust/Board Denominator	Trust/Board Unadjusted Result (%)	Trust/Board Adjusted Result (%)	Trust/Board 3SD upper limit
Apgar score	1.532615	90	4388	2.051048	2.210013	2.088968

HHFT Review

The NMPA's rate for the Trust is **2.2%** which is calculated from their numbers of 90 cases from 4388 births.

To assess the accuracy of the NMPA figures as requested we have reviewed our Birth Register data recorded on the electronic patient record (BadgerNet) against the most recent NMPA metrics for Apgar Score <7 at 5 minutes:

> *Numerator: Number of liveborn singleton babies born between 34+0 and 42+6 weeks of gestation with an Apgar score of less than 7 at 5 minutes of age*
>
> *Denominator: Number of liveborn singleton babies born between 34+0 and 42+6 weeks of gestation*

Total births at HHFT between Jan-Dec 2024	4662
Number of liveborn singleton babies born between 34+0 and 42+6 weeks of gestation *(excluding babies born < 34 weeks, multiple births, all stillbirths)*	4447[1]
Number of liveborn singleton babies born between 34+0 and 42+6 weeks of gestation with an Apgar score of < 7 at 5 minutes of age	91[1]
Percentage of babies born with an Apgar of <7 at 5 minutes	2.05%

We are unable to determine how a denominator of 4388 was achieved and so our overall reported Apgar <7 at 5 minutes rate is lower than the rates provided for accuracy checking by just 1.5%.

[1] For 36 babies, a 5-minute Apgar score was not recorded, primarily because these births occurred as Born Before Arrival of midwife (BBAs) - no healthcare professional was present to perform the assessment. Recalculating the denominator to 4411 births (excluding these cases) results in only a minimal change to the overall rate of Apgar <7 at 5 minutes, which becomes 2.06%.

The 2024 maternity dashboard metric data was reviewed, showing that HHFT reported an average 6 babies a month across both sites of ***term*** (37-42 weeks) babies with a 5-minute Apgar score of less than 7.

In October 2024, there was a move from reviewing babies with Apgar <7 at 5minutes to all babies born with low cord gases as it was felt this was a more objective parameter for assessing the outcomes for babies. Our decision was made on the basis that the Apgar score is subjective and is used to assist in the decision around any resuscitation a newborn may require, however it is not reliable for predicting long-term health or developmental outcomes. It is also more controversial now as the resuscitation council have moved away from focus on colour of the baby. The criterion we use for our reviews is babies born with cord pH <7.10. These babies are monitored via our maternity dashboard, reviewed monthly by the fetal monitoring leads and reported at maternity governance meetings. The reviews adopt a PSIRF approach to learning with support to colleagues where required. Learning from these reviews is shared with wider maternity teams via Theme of Week and Safety Bulletins which are shared at the daily Huddles. This change was shared with the CQC during their inspection in July 2025.

As a result of this alert from the NMPA, the maternity services have instigated a thematic review of the 91 cases in 2024 and 97 babies who met the same criteria in 2025. The outcome, learning and actions of the review will be shared with maternity teams and reported to the maternity safety champions and submitted and reviewed by the Trust Board.

In addition to the above, HHFT would value the NMPA's guidance on whether the indicator: *Proportion of liveborn, singleton babies born between 34+0 and 42+6 weeks of gestation, with a 5-minute Apgar score of less than 7* should be reported on our local maternity dashboard? This would be in addition to our on-going monitoring of babies born with a cord pH <7.10 but is more a subjective measure rather than what we are currently doing.

A copy of the thematic review can be shared on completion

If you have any questions or require any further information, please don't hesitate to contact us.

Your Sincerely

Wendy Randall, Director of Midwifery

Renee Behrens, Clinical Director Obstetrics and Gynaecology

North Cumbria Integrated Care NHS Foundation Trust

NHS
North Cumbria
Integrated Care
NHS Foundation Trust

4th June 2026

North Cumbria Integrated Care NHS Foundation Trust
Cumberland Infirmary
Newtown Road
Carlisle
Cumbria
CA2 7HY

Dear Sir/Madam

Please accept this letter as a response to the letter received on the 30th April 2026 asking for action in response to the potential alarm level outlier status for our Trust. The indicator identified was Apgar score. We have looked at the data supplied by the NMPA and have found that there are discrepancies compared to our data that was assessed by the Trust data analyst team. We have the same numerator as the NMPA data but our denominator is higher at 2342 (excluding Apgar score not recorded).

This data has been taken from our digital Badgernet system.

Excluding Apgar Score at 5 Mins Not Recorded:

Apgar 5 mins	Number	Percentage
0-6	70	*3.0%*
7-10	2272	97.0%
Total	**2342**	**100.0%**

The Apgar score data for 2024 was known to the Trust at the time through dashboard monitoring, the regional dashboard and our own incident reporting. The data was examined through a deep dive of all the cases within a reporting period and learning and actions around accurate assessment and recording of Apgar scoring by clinicians, application of PEEP and timing of Morphine analgesia in labour was undertaken.

We would be grateful if you could review this data in light of the figures supplied.

Yours sincerely

Amanda Kennett
Director of Midwifery, Neonates and Gynaecology

PP - Mr Ajibade Consultant Obstetrician and Gynaecologist

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01228 523444 www.ncic.nhs.uk

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28/05/2026

NMPA Leads
Sam Oddie, NMPA Senior clinical Lead (Neonatology)
James Harris, Senior Clinical Lead (Midwifery)
Asma Khalil, NMPA Senior Clinical Lead (Obstetrics)

Dear NMPA Leads,

Re. Potential alarm-level outlier status

Thank you for your letter dated the 1st May 2026 notifying the trust of the outlier status for the following measure.

Proportion of liveborn, singleton babies born between 34+0 and 42+6 weeks of gestation, with a 5-minute Apgar score less than 7.

The maternity service within the University Hospital of North Tees and Hartlepool identified locally, that the Trust was outlier for Apgar scores below 7 at 5 minutes in Q2/Q3 2024. A system-wide review provided shared learning, which informed the development of a consistent definition and agreed audit dataset.

The trust developed the following actions

- Work with the system to agree an APGAR scoring definition
- Undertake a retrospective audit
- Learning to inform an improvement plan

Work with the system to agree APGAR scoring definition

Shared learning from the system highlighted two key aspects. Firstly, there had been incorrect APGAR scoring for newborns who were breathing spontaneously but required PEEP. Following discussion with neonatal leads, it was agreed that these infants should receive a respiration score of 2, not 1, as the score reflects the baby's respiratory effort rather than the level of support provided. The second learning point was the need to review documentation practices following the transition from paper notes to the electronic BadgerNet system, as several units reported an increase in recorded APGAR scores after moving to digital documentation.

Undertake a retrospective audit

A retrospective audit of low APGAR score at 5 min of age (<7) was undertaken for cases in 2024 with a sample of 82 cases. 66 of those cases were breathing on their own but required

Professor Derek Bell, OBE
Group Chair

Stacey Hunter
Group Chief Executive

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PEEP, with [redacted] of these scored as a 2 for respiratory, the remaining [redacted] scored as a 1. Following an agreed APGAR scoring system, the adjusted and corrected scores demonstrated a reduced average rate from 7.85 (chart 1) to 4.23 (chart 2). By adjusting the score and mapping against the rate per 1000 births it was identified that had the patients been correctly classified then the organisations rate would be in line with previous data trends (chart 3).

Chart 1. Pre audit average

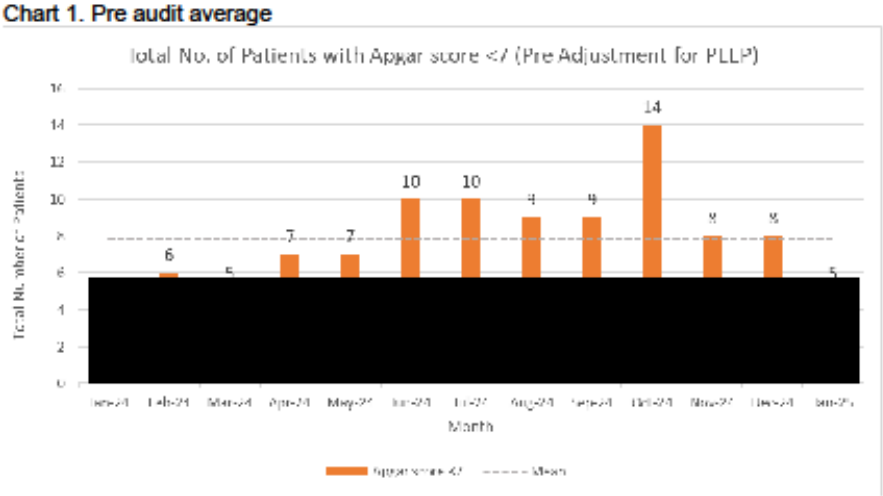
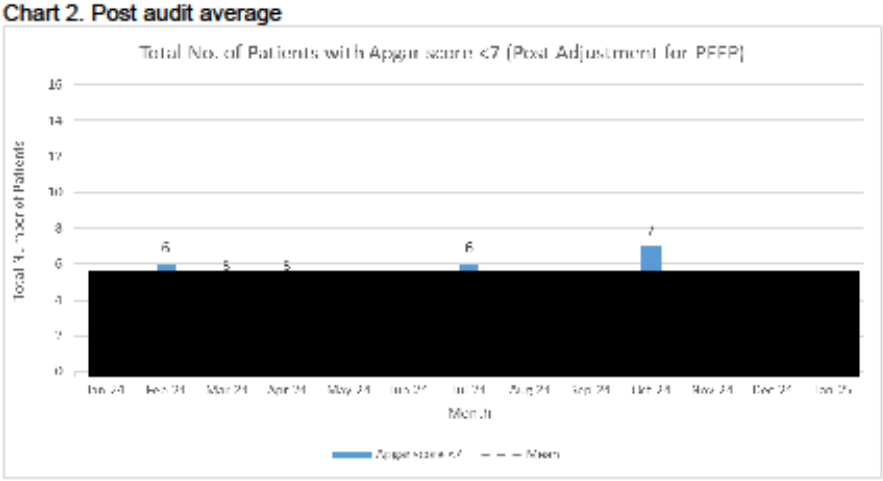


Chart 2. Post audit average



Professor Derek Bell, OBE
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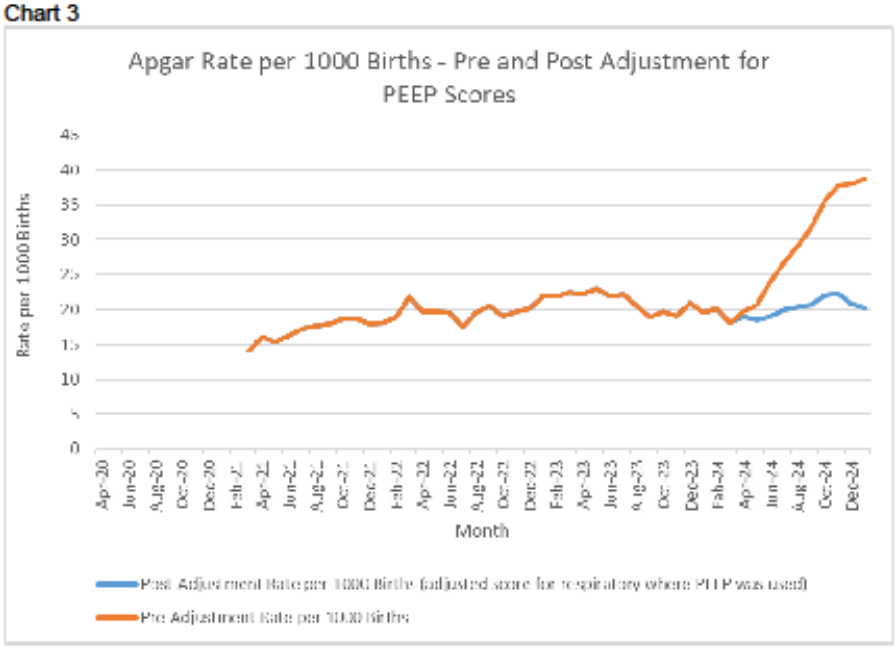
Chart 3



Learning to inform an improvement plan

Through the retrospective and prospective audit, a number of actions and quality improvement initiatives were actioned by the service including:

- **Immediate training and education to staff regarding the correct scoring of APGARs when a baby requires PEEP.**
- **An urgent action was implemented through staff communication, education and simulation to ensure all staff issue an emergency call out when neonatal resuscitation is initiated.**
- **Process to ensure paired cord gas results are available for any baby who has a low APGAR score at 5min or an ATAIN baby must be reviewed and improvements made**
- **No direct correlation due to apparent higher low APGAR rates and admission to SCBU**

Professor Derek Bell, OBE
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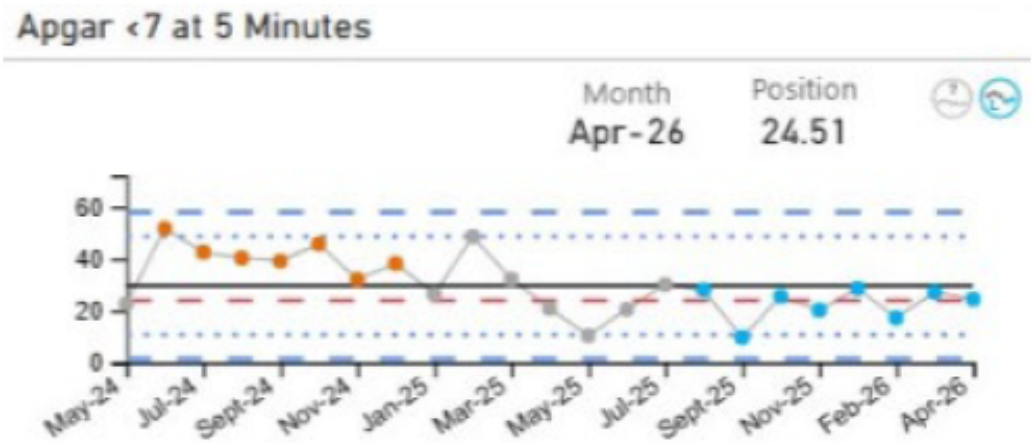
Ongoing Monitoring

The service continues to report rates of Apgar scores below 7 at 5 minutes through our monthly PQOM reporting, supported by an ongoing audit to ensure that the improvements achieved following the outlier status in Q3/Q4 2024 are sustained.

The SPC chart below demonstrates a period of sustained improvement, reflecting the impact of the initial actions implemented in response to the outlier findings.



Yours sincerely,

Hannah Matthews, Head of Midwifery, University Hospital of North Tees and Hartlepool.
Shilpa Mahadasu, Clinical Director for Obstetrics, University Hospital Tees.
Vrinda Nair, Clinical Director for Neonates, University Hospital Tees.

Northumbria Healthcare NHS Foundation Trust

NHS
Northumbria Healthcare
NHS Foundation Trust

Northumbria House
Unit 7/8 Silver Fox Way
Cobalt Business Park
Newcastle upon Tyne
NE27 0QJ

05 June 2026

To: National Maternity & Perinatal Audit

RE: Potential alarm-level outlier status

Thank you for the letter received on 04 May 2026, notifying that Northumbria Healthcare NHS Foundation Trust had been identified as a potential alarm-level outlier for the below indicator:

Proportion of liveborn, singleton babies born between 34+0 and 42+6 weeks of gestation, with a 5-minute Apgar score less than 7

Indicator	National Mean (%)	Trust/Board Numerator	Trust/Board Denominator	Trust/Board Unadjusted Result (%)	Trust/Board Adjusted Result (%)	Trust/Board 3SD upper limit
Apgar score	1.60	77	3378	2.28	2.37	2.17

We at Northumbria Healthcare NHS Foundation Trust accept outlier status, when compared to the national mean for 5-minute Apgar score less than 7.

We are aware that Northumbria Healthcare NHS Foundation Trust were an outlier in the previous NMPA report released last year based on 2023 data for this indicator. Due to the timeframe of the first Trust notification in 2025, there are no further changes in our response this year regarding the 2024 data for this clinical indicator.

The continued detailed review and audit into each case with Apgar <7 at 5 mins found a significant proportion of cases with either:

- Documentation inaccuracies - disparities between Apgar score with described and documented neonatal condition
- Incorrect calculation of Apgar score when babies are receiving facial positive end expiratory pressure (PEEP) with regular respiratory activity - a score of 1 is often assigned when this should be scored 2

In summary, the Trust has identified data entry errors and clinical factors (incorrect classification) which have influenced the alarm level status.

We continue to audit and monitor performance in relation to this clinical metric, measuring progress with the related quality improvement initiatives. In particular, the impact of training regarding the assessment of neonatal clinical condition, PEEP and Apgar score guidance that has been taught on Neonatal Life Support multi-disciplinary mandatary training syllabus since 2025.

Yours sincerely

Kate Carney
Clinical Director
Obstetrics & Gynaecology

Katy Lissaman
Head of Midwifery

South Tees Hospitals NHS Foundation Trust

NHS
South Tees Hospitals
NHS Foundation Trust

05th June 2026

Trust response to potential NMPA alarm-level outlier status

Introduction

The National Maternity and Perinatal Audit (NMPA) is preparing to publish its report on outcomes for births that took place in the NHS during 2024 in England, Scotland and Wales. The report will describe various aspects of maternity and perinatal care.

The NMPA is part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). It has been commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England, the Welsh Government and the Health Department of the Scottish Government.

Three measures have been selected as indicators which are subject to 'outlier reporting'. These indicators have been case-mix adjusted to take into account the different maternal demographic and clinical characteristics at each trust/board, as far as is currently possible. The three indicators are:

• Proportion of women and birthing people giving birth vaginally to a singleton baby between 37+0 and 42+6 weeks of gestation, who experience a third- or fourth-degree tear

• Proportion of women and birthing people giving birth to a singleton baby between 34+0 and 42+6 weeks of gestation, who have a postpartum haemorrhage of 1500 ml or more

• Proportion of liveborn, singleton babies born between 34+0 and 42+6 weeks of gestation, with a 5-minute Apgar score less than 7

South Tees Hospitals NHS Foundation Trust has been identified as a potential alarm level outlier for APGAR <7 at 5 minutes. This warranted further exploration and investigation with a response to NMPA to confirm that the Trust either accepts the results or has identified data errors.

A retrospective audit was undertaken, using data collected from Badgernet Unit Reports, of all babies who were delivered at term (≥37 weeks gestation) with an APGAR <7 at 5 minutes of age, in 2024.

Four key areas were identified for exploration:

1. Data accuracy
2. Evidence of potential harm & Evidence of other harm
3. Evidence that guidelines were followed

Validation of data

All cases above 37 weeks gestation were reviewed, this gave us 92 cases.

Of the 92 cases reviewed:

1. **Data Accuracy**
   18 were scored incorrectly. Inaccurate scores were due to a respiratory score of 1 being incorrectly assigned to babies receiving facial PEEP with regular respiratory effort. According to recent LMNS guidance which stipulated if PEEP was given and respirations regular a score of 2 should be given.
2. **Evidence of Potential harm & Evidence of other Harm**
   74 babies were correctly scored on review.
   12 babies were scored correctly and transferred to Neonatal Unit and have been reviewed under ATAIN
3. [redacted]

Learning and action points

The audit has highlighted areas for improvement:

- A further 'deep dive' into a small number of cases of APGARS < 7 at 5 minutes to determine if there are any clinical factors which are affecting scoring and outcomes

- Further education is required relating to scoring when administering PEEP only in the presence of regular respirations
- Improvements are required in neonatal resuscitation documentation

Conclusion

The APGAR <7 at 5 minutes review team found missing data in records and inaccuracies in classification of APGAR scores when babies are receiving PEEP with regular respiratory activity. Therefore, after correction for data errors the trust is not an outlier.

Apgar Review team

Shilpa Mahadasu- Clinical Director Obstetrics

Jyothyi Lakshmi- Consultant Obstetrician

Lynne Staite- Head of Midwifery

Tracey Gray- Quality assurance, Governance and Compliance Midwife

Vrinda Nair- Clinical Director Neonates

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

Response to NMPA Outlier Status for Apgar Score <7 at 5 Minutes

S - Situation

The Queen Elizabeth Hospital King's Lynn (QEH) has been identified as an outlier for babies born with an Apgar score of less than 7 at 5 minutes. During the audit period, 55 of 1,670 births met this criterion, equating to a rate of approximately 33 per 1,000 births. This compares with a national average of approximately 13 per 1,000 births and an MBRRACE comparator rate of approximately 21 per 1,000 births.

A retrospective clinical audit was undertaken to understand the contributing factors associated with this performance indicator and to identify opportunities for improvement in neonatal outcomes, intrapartum care, clinical documentation and newborn resuscitation practices.

B - Background

The audit reviewed all babies born between 34+0 and 42+6 weeks' gestation during 2025 with a 5-minute Apgar score below 7. Fifty-five complete records were analysed using data obtained from the maternity electronic record system (BadgerNet).

The audit explored maternal, fetal and intrapartum factors, mode of birth, neonatal resuscitation requirements, cord blood gas analysis, documentation standards and neonatal outcomes.

Whilst QEH's reported rate places the organisation above national and comparator benchmarks, the audit sought to determine whether this reflected poorer neonatal condition at birth or whether other contributory factors existed, including clinical practice, documentation and recording processes.

A - Assessment

The audit demonstrated several reassuring findings.

Neonatal Recovery

- 76% (42/55) of babies recovered to an Apgar score of 7 or greater by 10 minutes.
- Only 5 babies remained below 7 at 10 minutes.

- Eight cases (15%) had no documented 10-minute Apgar score.

These findings suggest that the majority of babies responded appropriately to initial stabilisation and neonatal resuscitation measures.

Cord Gas Findings

Cord gas analysis showed generally reassuring physiological outcomes:

- Median arterial pH was 7.20.
- [redacted]29 recorded arterial samples demonstrated a pH below 7.10.
- [redacted]babies had a pH below 7.05.
- Venous gases were largely within expected ranges.

These findings indicate that severe intrapartum hypoxia was uncommon within the cohort and that many babies categorised within the metric were not experiencing significant metabolic compromise.

Resuscitation Requirements

- 85% (46/55) of babies required inflation or ventilation breaths.
- 40% (22/55) were admitted to NICU, although [redacted]admissions were due to clinical concerns and [redacted]were related to prematurity.

This indicates that a substantial proportion of babies required active neonatal support immediately after birth.

Emerging Themes

Several recurring themes were identified:

Caesarean Births

- 60% (33/55) of babies were born by caesarean section.
- 44% (24/55) were born by emergency caesarean section.
- 44% of babies experienced deterioration in Apgar score between 1 and 5 minutes.
- Of these deteriorating cases, 63% were delivered by caesarean section.

This finding suggests a potential relationship between operative birth and delayed neonatal respiratory transition, although causation cannot be confirmed from this audit alone.

Intrapartum Risk Escalation

- 44% of women were initially classified as low risk at booking.

- Seventy-one percent of these women subsequently required escalation to high-risk care during labour.
- Intrapartum risk assessments were completed before birth in only 56% of cases.
- Forty percent were completed retrospectively after delivery.

This raises concerns regarding timely recognition, documentation and communication of intrapartum risk factors that may influence neonatal condition at birth.

Fetal Monitoring Concerns

- 38% of pregnancies had documented suspicious or pathological fetal monitoring before birth.
- Abnormal CTG findings were the most frequently identified fetal risk factor.

This highlights the importance of continued strengthening of fetal surveillance and escalation processes.

Documentation and Data Quality

Significant documentation issues were identified:

- Approximately half of arterial cord gas samples were unavailable.
- Paired arterial and venous gases were frequently incomplete.
- 15% of babies had no recorded 10-minute Apgar score.
- Some records lacked complete documentation of neonatal resuscitation and personnel present.

These gaps may impact the ability to accurately interpret outcomes and benchmark performance.

R - Recommendation

The audit concludes that QEH's outlier status cannot be attributed solely to poor neonatal outcomes or widespread evidence of intrapartum hypoxia. The majority of babies demonstrated rapid recovery, and cord gas results were largely reassuring.

However, the audit has identified several areas requiring improvement:

1. **Strengthen neonatal resuscitation education**
    - Reinforce early recognition of neonatal deterioration.
    - Focus on management of respiratory transition, particularly following caesarean birth.
    - Continue regular Neonatal Life Support training and simulation.
2. **Enhance fetal monitoring and escalation**

- Ensure all babies with Apgar scores below 7 at 5 minutes undergo structured review through the fetal monitoring improvement pathway.
- Strengthen escalation and decision-making processes when CTG concerns arise.

3. **Improve intrapartum risk assessment compliance**
   - Ensure risk assessments are completed contemporaneously during labour and not retrospectively.
   - Improve multidisciplinary communication regarding changing maternal and fetal risk status.
4. **Increase compliance with cord gas sampling**
   - Standardise paired arterial and venous cord gas collection for all cases with a low Apgar score.
   - Introduce mandatory recording of reasons when samples cannot be obtained.
5. **Improve documentation quality**
   - Improve recording of Apgar scores, particularly at 10 minutes.
   - Improve documentation of neonatal interventions and staff attendance at resuscitations.
   - Continue support through the Trust documentation improvement programme.
6. **Review management of meconium-stained liquor**
   - Undertake further review of local guidance and response pathways, noting that meconium was present in a significant proportion of NICU admissions.
   - Consider targeted escalation and attendance criteria for these births.

Summary

Although QEH remains an outlier for Apgar scores <7 at 5 minutes, this audit demonstrates that most affected babies recovered rapidly and showed reassuring cord gas results. The findings suggest that improvements in neonatal transition following caesarean birth, intrapartum risk recognition, fetal monitoring escalation, cord gas compliance and documentation standards are likely to have the greatest impact on reducing the reported rate and achieving alignment with national benchmarks. The audit has been shared with the whole team and measures put in place to support the learning; the more recent MSDS data shows an improvement for 2026. All cases of low Apgar scoring undergo an MDT review alongside our CTG meetings and reported on our local dashboard for continued oversight and learning.

North Cheshire and Mersey NHS Foundation Trust

NHS
North Cheshire and Mersey
NHS Foundation Trust

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Email: [redacted]

To: NMPA Senior Clinical Leads
Date: 5 June 2026

Dear Colleagues,

Thank you for your letter dated 30 April 2026 regarding the potential alarm-level outlier status for Warrington and Halton Hospitals NHS Foundation Trust in relation to the indicator measuring the proportion of liveborn, singleton babies born between 34+0 and 42+6 weeks with a 5-minute Apgar score less than 7. We have reviewed the data in detail with our maternity and information teams, as requested.

Following this review, we have identified data accuracy issues which call into question the validity of the results presented. Your letter states that the Trust's denominator for this indicator is 2311 births and the numerator is 55 babies with a 5-minute Apgar score less than 7. Our internal validated records show that the correct denominator is 2421 live singleton births between 34+0 and 42+6 weeks, and the correct numerator is 57 babies meeting the Apgar <7 criterion.

Using the corrected figures, our unadjusted result is 2.354399%, which is slightly lower than the unadjusted result of 2.379922% reported in your letter. While this remains above the national mean of 1.532615%, the discrepancy indicates that the published values do not accurately reflect our Trust's activity. We therefore request that the numerator and denominator be amended to 57 and 2421 respectively, and that the adjusted and unadjusted results be recalculated accordingly.

We remain committed to transparent reporting and continuous improvement, and we will continue to review our internal processes, including data validation and clinical governance, to ensure accuracy and support the wider aims of the NMPA audit programme.

Please let us know if any further information or clarification is required to support the recalculation of this indicator.

Yours sincerely,

Dr Rita Arya
Clinical Lead Obstetrics and Gynaceology and Labour Ward Lead
Tina Moors
Interim Director of Nursling

West Suffolk NHS Foundation Trust

Following notification that West Suffolk Hospital was an outlier and did not pass the quality check criteria for fetus outcome distribution, our data quality was checked and verified and our response is below.

The Trust was excluded from this outlier analysis due to poor data quality and/or completeness for the following indicator/s:

• Proportion of liveborn, singleton babies born between 34+0 and 42+6 weeks of gestation, with a 5-minute Apgar score less than 7

This was due to concerns regarding data quality, specifically in relation to fetal outcome distribution. Following a review by the Information Team of our data for 2024, we have [redacted] recorded during the 2024 reporting period. [redacted]

While we acknowledge that this figure is unusual for a Trust our size, we can confirm that it is accu[redacted].

[redacted] and have identified this as a data entry error. Staff have been reminded of the correct recording process, and additional checks will be undertaken prior to future data submissions to ensure accuracy.

NHS Forth Valley

NHS Forth Valley Response to NMPA Low Apgar Outlier status (2024 births)

Assurance summary: NHS Forth Valley has completed all actions agreed in response to the NMPA low Apgar outlier status. Local review confirmed data discrepancies with the NMPA dataset, no associated rise in neonatal admissions was identified, staff training and documentation processes have been strengthened, and real-time KPI monitoring is now in place through Pentana to support ongoing oversight.

NHS Forth Valley was identified by the NMPA as an alarm level outlier in the 2023 and 2024 reports for the proportion of eligible babies with a 5-minute Apgar score below 7.

2023 Data supplied by NMPA

Indicator	National Mean (%)	Trust/Board Numerator	Trust/Board Denominator	Trust/Board Unadjusted Result (%)	Trust/Board Adjusted Result (%)	Trust/Board 3SD upper limit
Apgar score	1.45	87	2598	3.35	3.19	3.15

2024 Data supplied by NMPA

Indicator	National Mean (%)	Trust/Board Numerator	Trust/Board Denominator	Trust/Board Unadjusted Result (%)	Trust/Board Adjusted Result (%)	Trust/Board 3SD upper limit
Apgar score	1.53	87	2808	3.57	3.53	3.25

Local review of 2024 BadgerNet data identified 71 babies from 2,691 eligible births, highlighting potential discrepancies with the NMPA dataset, however this is thought to be attributed to normal variation with respect to Board of Treatment versus Board of Residence discrepancy (*see Appendix 3).*

NHS Forth Valley provided assurance to the NMPA in August 2025 that a programme of review, validation, education and system improvement would be completed.

All agreed actions are now complete, providing assurance that governance, education, reporting and oversight arrangements are established.

Agreed action from 2025 report of 2023 data	Status	Notes
Communicate outlier findings to all obstetric, neonatal and midwifery staff	Complete	
Interrogate any link between Apgars <7 at 5 minutes and neonatal unit admission	Complete	No increase in admissions identified
Test of change in Labour Ward to ensure that Apgar's are being recorded accurately at 5 minutes	Complete	Completed August 2025 – see *Appendix 1*. Process in place where every Apgar <7 at 5 minutes is reported using the Safeguard IR1 reporting system to trigger full review
Any Apgars <7 recorded at 5 minutes during this test of change to have full review undertaken	Complete	
New medical staff due to commence in August 2025 to have formal training in neonatal resuscitation as part of induction	Complete	Completed for intake in August 2025 and now business as usual
Establish SLWG to interrogate 2023 data and consider implementation of ABC programme	Complete	SLWG led by Clinical Director O&G with midwifery and Obstetric representation, no significant themes identified – see Appendix 1. ABC programme implementation considered but not adopted at present
Midwifery Practice Educator to ensure focus on Apgar assessment and documentation in scenario-based drills as part of the local MDT Training.	Complete	BAU in 'Strobe' and MDT Obstetric Emergency skills training for all clinical staff.
Maternity Practice Education Facilitator to ensure focus on Apgar assessment and documentation in midwifery undergraduate practice placements	Complete	
NMPA KPIs to be built into the NHS Forth Valley's Performance Review System to flag in real time any deviations. This will support real time analysis of local performance, and any actions required.	Complete	Real time reporting of Apgars <7 at 5 minutes now interfaces directly from Badgernet Maternity notes into Pentana system – see *Appendix 2*.

Ongoing data surveillance and analysis

Ongoing assurance is supported through bimonthly reporting to the WCSH Clinical Governance and Risk Manager Meeting and real-time Pentana monitoring. This has already enabled early identification of increased cases and prompt correction of an IR1 reporting issue.

Next steps

- Maintain governance oversight through the next WCSH Clinical Governance meeting on 10 June 2026.
- Include Apgars <7 at 5 minutes within routine WCSH dashboard reporting.
- Link Pentana and IR1 data to strengthen oversight and reporting assurance with side by side comparison of IR1 reports and actual incidences of low Apgars.

Appendix 1

Test of change in Labour Ward August 2026

August 2025 Apgar Audit

Summary of the 6 babies identified in August 2025 as having Apgar scores <7 at 5 minutes when additional intervention in place to set timer on resus at time of delivery to accurately identify 5 minute timing for Apgar assessment

Area	Result
Records reviewed	6
Resuscitation recorded	5 of 6
NNU admissions	[redacted]
Induced labours	[redacted]
Caesarean births	[redacted]
Low 5 min Apgar (<7)	6 of 6
Missing BMI entries	[redacted]
Missing Apgar 10 entries	[redacted]
Missing arterial pH entries	[redacted]

Key messages

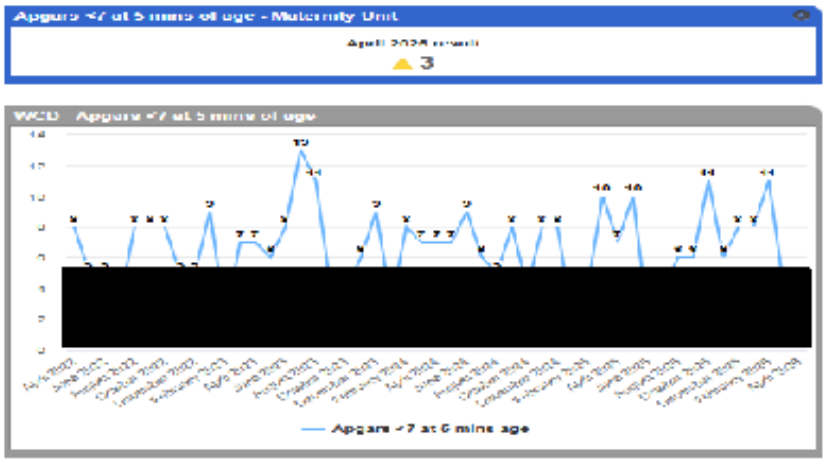
The dataset gives a usable view across 6 maternity/neonatal records, with risk factors documented in every case. The review highlights 5 of 6 babies requiring resuscitation, [redacted] 6 admitted to NNU (both diagnosed RDS) [redacted] 6 labours induced.

Risk factors

Risk factors for each women and baby were assessed and all were identified as having abnormal or pathological CTGs, but no other additional risk factors linked the 6 cases. Additional risk factors/potential contributors to low Apgar included reduced fetal movements and meconium stained liquor.

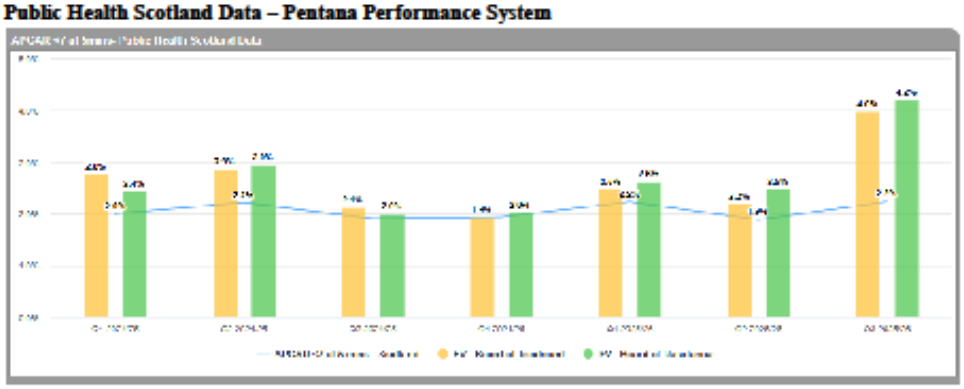
Appendix 2: Low Apgar KPI views within Pentana

Local Data – Pentana Performance System



Appendix 3: PHS Data on Apgars <7 at 5 minutes

Public Health Scotland Data – Pentana Performance System



NHS Orkney

Interim Deputy Director of Nursing & Lead Midwife
NHS Orkney
Foreland Road
Kirkwall
Orkney
KW15 1NZ
Telephone 07774640602

NHS Orkney

Date: 07 June 2026

Dear NMPA Team

Thank you for notifying NHS Orkney of a potential outlier finding in relation to the proportion of liveborn singleton babies with a 5-minute APGAR score of less than 7.

In line with Step 2 of the NMPA Outlier Policy, we have reviewed the relevant data to identify whether there are any data errors, organisational factors, or clinical factors that may have contributed to the potential outlier status.

We can confirm that there were five relevant cases in 2024. The numbers have been checked locally and confirmed as accurate. All five cases have been reviewed.

Local validation did not identify any data entry, coding, or case ascertainment issues in relation to the five cases reviewed. No consistent organisational factor was identified across the cases. [redacted] and was managed and resolved promptly at the time.

The review was undertaken by:

- Michelle Mackie, Interim Deputy Director of Nursing & Lead Midwife
- Jordan Towers, Integrated Midwife
- Lauren Flett, Senior Charge Midwife
- Brian Magowan, Obstetrician (external reviewer)

Overall, the review found appropriate clinical management in the cases reviewed, including timely neonatal assessment, resuscitation, escalation, observation, and transfer where clinically indicated. No single recurring clinical theme or systematic issue was identified.

Given the small number of births in NHS Orkney, a small absolute number of cases may contribute to a disproportionate impact on reported rates and the potential outlier position.

Learning points identified from the case review were:

- To consider whether artificial rupture of membranes may have been beneficial in one case, as part of reflection on intrapartum management.

NHS Orkney

- To review scan images [redacted] where fetal growth concerns were present, to support reflection on antenatal assessment and interpretation.
- To consider whether cord gases should be obtained for all births involving low APGAR scores, to support fuller clinical assessment and review.
- To consider earlier airway insertion where there is limited chest wall movement during inflation breaths, as part of neonatal resuscitation learning.
- To note that equipment failure was identified [redacted] was managed and resolved promptly [redacted] no recurring equipment concern identified.
- To note that consultant availability on the ward was supportive in the cases reviewed.

In summary, NHS Orkney confirms that the relevant 2024 cases have been reviewed, the numbers are accurate, and no evidence of a single recurring theme or systematic care concern was identified. The learning points outlined above are considered case-specific opportunities for reflection and improvement. These will be discussed through the local Maternity Clinical Governance Group, with any agreed actions progressed through local governance and quality improvement processes and monitored through existing maternity governance arrangements.

Yours sincerely

M Mackie

Michelle Mackie
Interim Deputy Director of Nursing & Lead Midwife

Acknowledgements

This report was prepared by the NMPA project team:

Dr Amar Karia, Clinical Fellow (Obstetrics); **Kirstin Webster**, Clinical Fellow (Neonatology); **Alissa Frémeaux**, Statistician; **Buthaina Ibrahim**, Statistician; **George Dunn**, Audit Lead; **Emma Heighway**, Project Coordinator; **Dr Fran Carroll**, Head of Research Partnerships; **Dr Ipek Gurol-Urganci**, Senior Methodological Advisor; **Professor Asma Khalil**, Senior Clinical Lead (Obstetrics); **Professor Sam Oddie**, Senior Clinical Lead (Neonatology); **Dr James Harris**, Senior Clinical Lead (Midwifery); **Professor Jan van der Meulen**, Senior Methodologist and Audit Chair.

We would like to thank both the NMPA **Clinical Reference Group (CRG)** and our **Women and Families Involvement Group (WFIG)** for their valuable expert input to this report.

The NMPA is supported by the **RCOG Clinical Quality team**, and the **NMPA Project Board** chaired by **Dr Jenny Barber**, Consultant Obstetrician and RCOG Vice President for Clinical Quality.

Funding Status

The National Maternity and Perinatal Audit is commissioned by the Healthcare Quality Improvement Partnership (HQIP) and funded by NHS England and the Governments of Wales and Scotland as part of the National Clinical Audit and Patient Outcomes Programme.

For further information and resources, please visit the NMPA website where you can also subscribe to the email newsletter for regular audit updates: https://maternityaudit.org.uk

Alternatively, you can contact us at: nmpa@rcog.org.uk

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