NMPA
National Maternity & Perinatal Audit

Maternity care in 2023 in Great Britain
Results from national audit data

Dr Amar Karia
NMPA Clinical Fellow - RCOG

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

NMPA
National Maternity & Perinatal Audit

What is the NMPA?

- Evaluate NHS maternity care and improve maternity standards
- Support and inform decision making
- Comparisons – between units, against national average
- Annual reports, snapshot audits, peer review publications - recommendations

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

NMPA
National Maternity & Perinatal Audit

NMPA measures of maternity care

Process Measures

Outcome Measures

NMPA
National Maternity & Perinatal Audit

NMPA measures of maternity care

Process Measures

Outcome Measures

1) Validity
Capture differences in quality of care?

2) Statistical power
Detect true outliers?

NMPA Measures

3) Technical specification
How good is the data?

4) Fairness
Variation between units?
Statistical adjustment

NMPA
National Maternity & Perinatal Audit

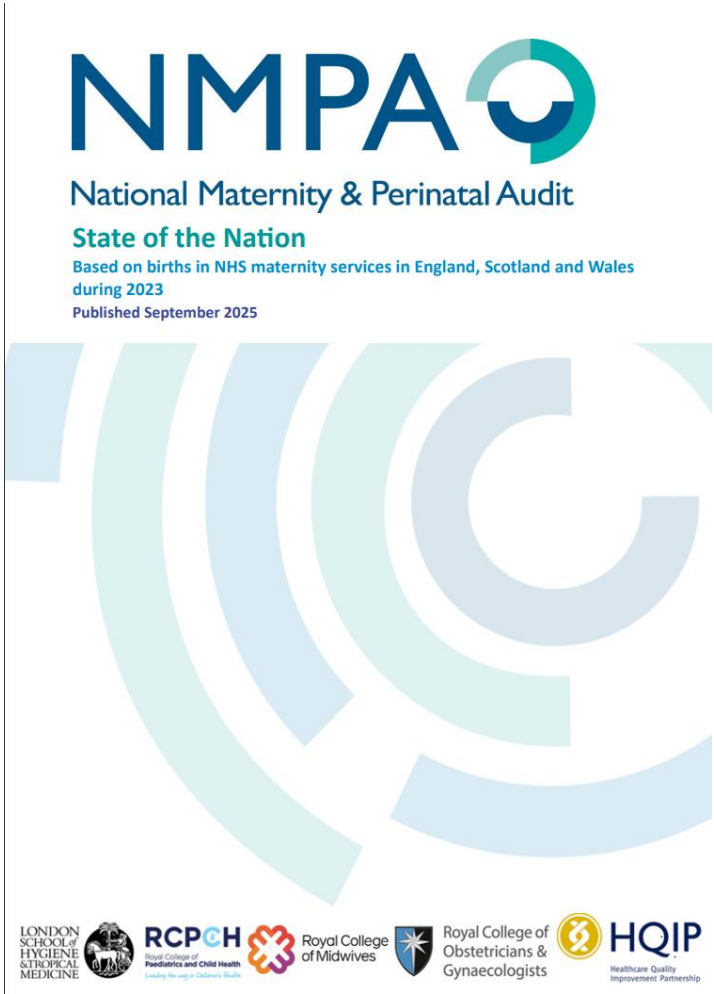
NMPA measures of maternity care

- Late antenatal booking
- Preterm birth
- Induction of labour
- Undetected Small for Gestational Age (SGA)
- Third and fourth degree perineal tears
- Episiotomy
- Vaginal birth with or without the use of instruments
- Caesarean birth
- Vaginal birth after caesarean birth (VBAC)
- Postpartum haemorrhage ≥1500
- Unplanned maternal readmission
- Skin-to-skin contact
- Breast milk at first feed
- Apgar score <7 at 5 minutes

NMPA
National Maternity & Perinatal Audit

State of the nation report 2025

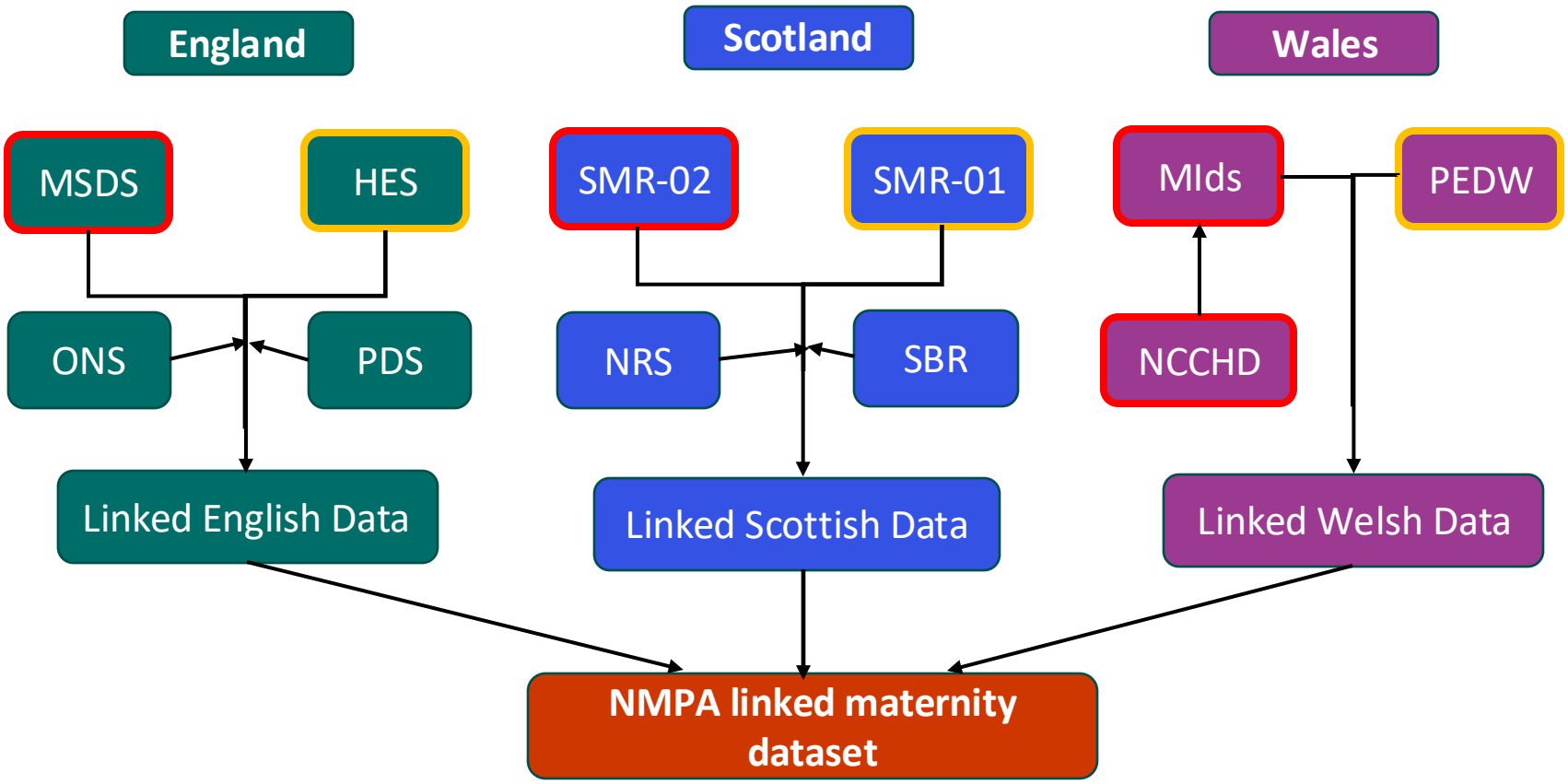
- Childbirth data for 2023 – England, Scotland & Wales
- Routinely collected data: maternity datasets + hospital administrative datasets
- Centralised, pseudonymised data
- Robust cleaning and processing
- Case-mix adjustment
- 592 549 GB births (520 643 - England, 45 316 - Scotland, 26 635 - Wales)
- 93% case ascertainment



NMPA
National Maternity & Perinatal Audit

Datasets and Linkage

Maternity datasets
Hospital administrative datasets



NMPA
National Maternity & Perinatal Audit

View my local results

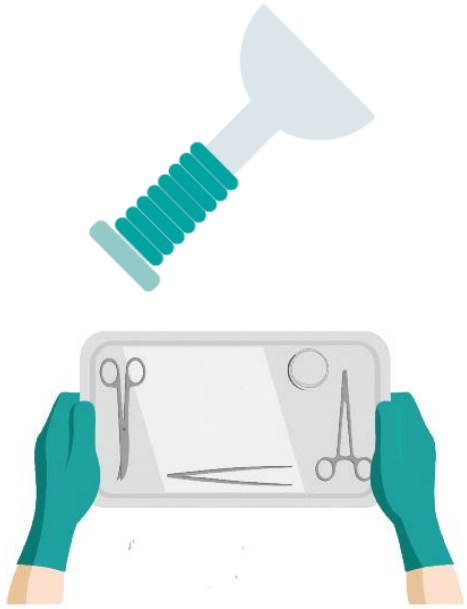
State of the Nation report – key findings and recommendations

NMPA
National Maternity & Perinatal Audit

View my local results

Intervention at birth

- 50.6% of all births were operative (instrumental/caesarean).
- 40% in 2018/2019

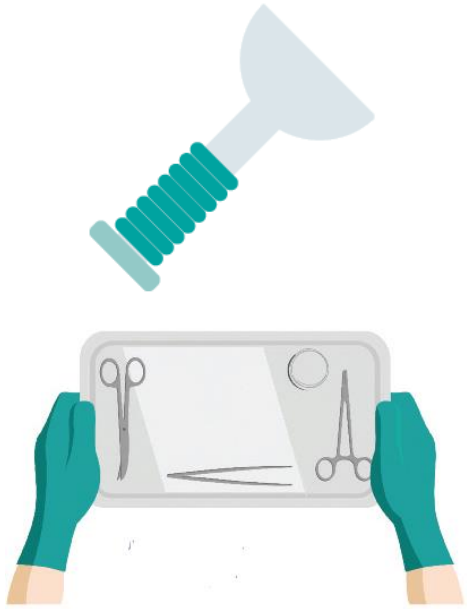


NMPA
National Maternity & Perinatal Audit

View my local results

Intervention at birth

- 50.6% of all births were operative (instrumental/caesarean).
- 40% in 2018/2019



Recommendation:

Government health departments should incorporate the impact of the changing trends in maternity care and outcomes when reviewing and planning maternity services. This information should be used to:

• Anticipate and respond with appropriate allocation of resources, such as workforce, bed/cot and obstetric theatre capacity, and finances, to optimise the options women and birthing people have for when and where they choose to give birth.

NMPA
National Maternity & Perinatal Audit

View my local results

Patterns in caesarean births

Elective

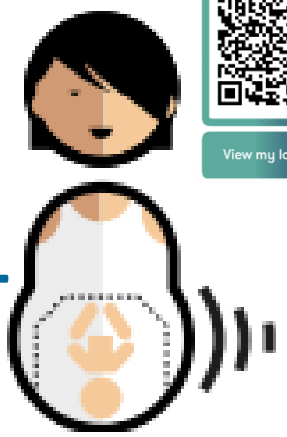
Vs

Robson groups classification

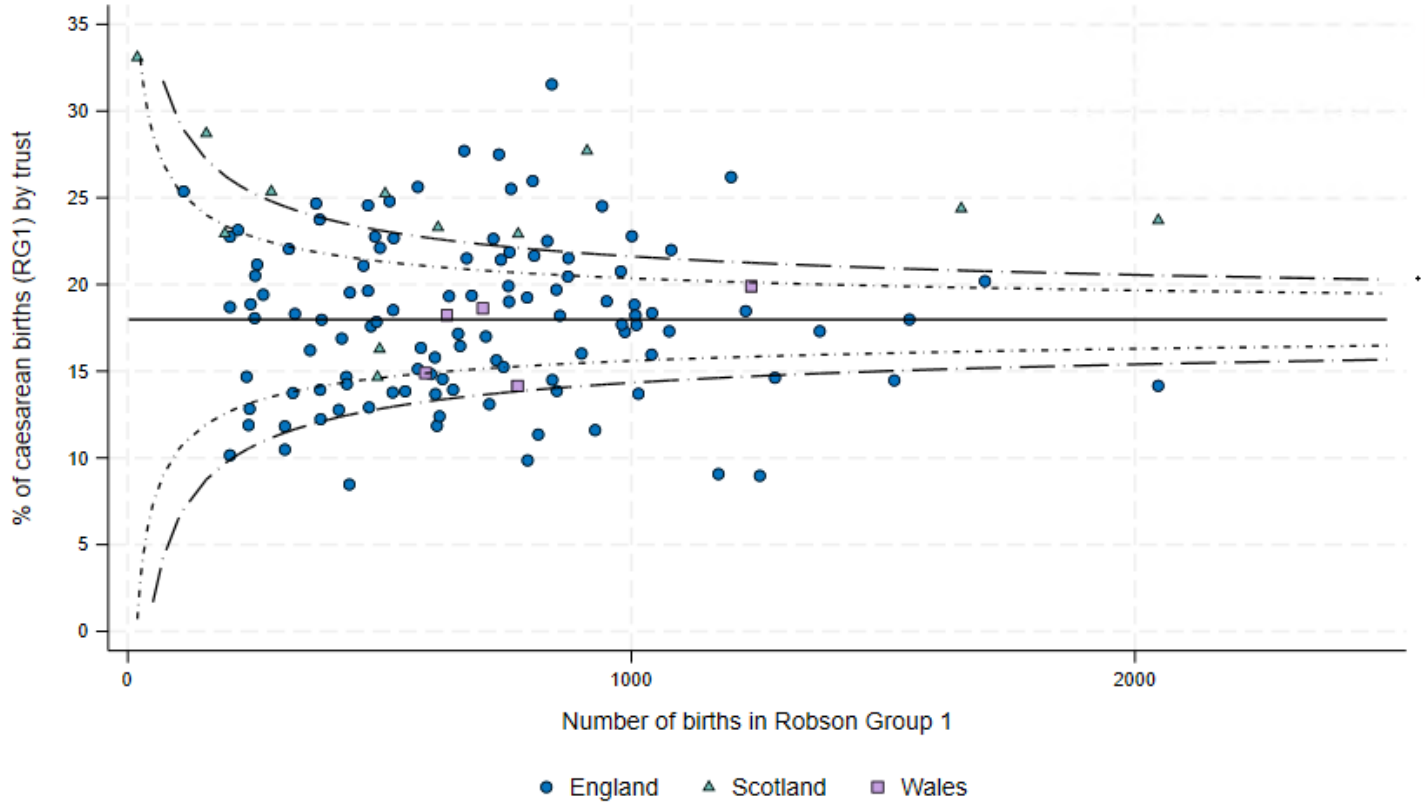
Emergency

NMPA
National Maternity & Perinatal Audit

View my local results



Caesarean birth patterns - Robson Group 1



Numerator: Number of caesarean births

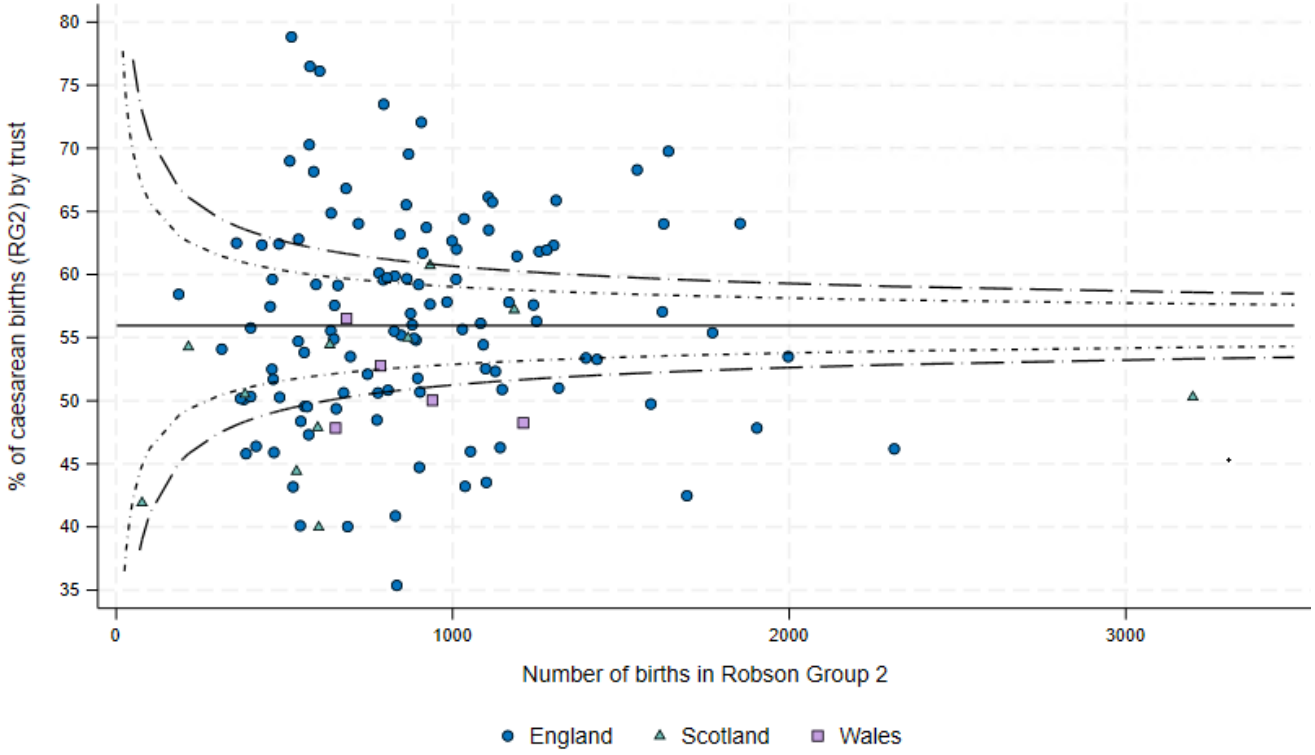
Denominator: Nulliparous women with a single cephalic pregnancy, ≥37 weeks gestation in spontaneous labour

GB rate: 18.0% caesarean births

NMPA
National Maternity & Perinatal Audit

View my local results

Robson Group 2



GB rate: 56.0% caesarean births

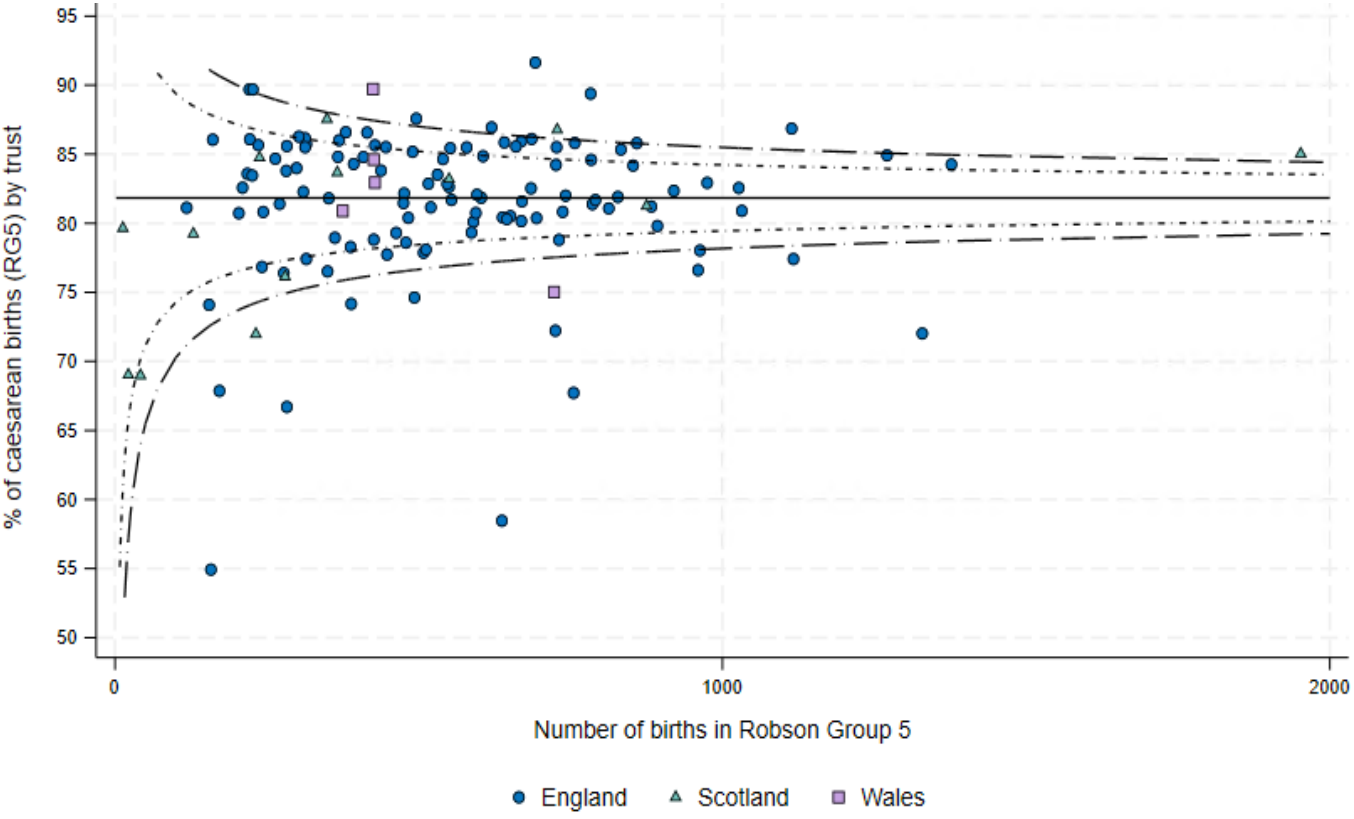
Numerator:
Number of caesarean births

Denominator:
Nulliparous women with a single cephalic pregnancy, ≥37 weeks gestation who either had labour induced or were delivered by caesarean section before labour

NMPA
National Maternity & Perinatal Audit

View my local results

Robson Group 5



GB rate: 81.8% caesarean births

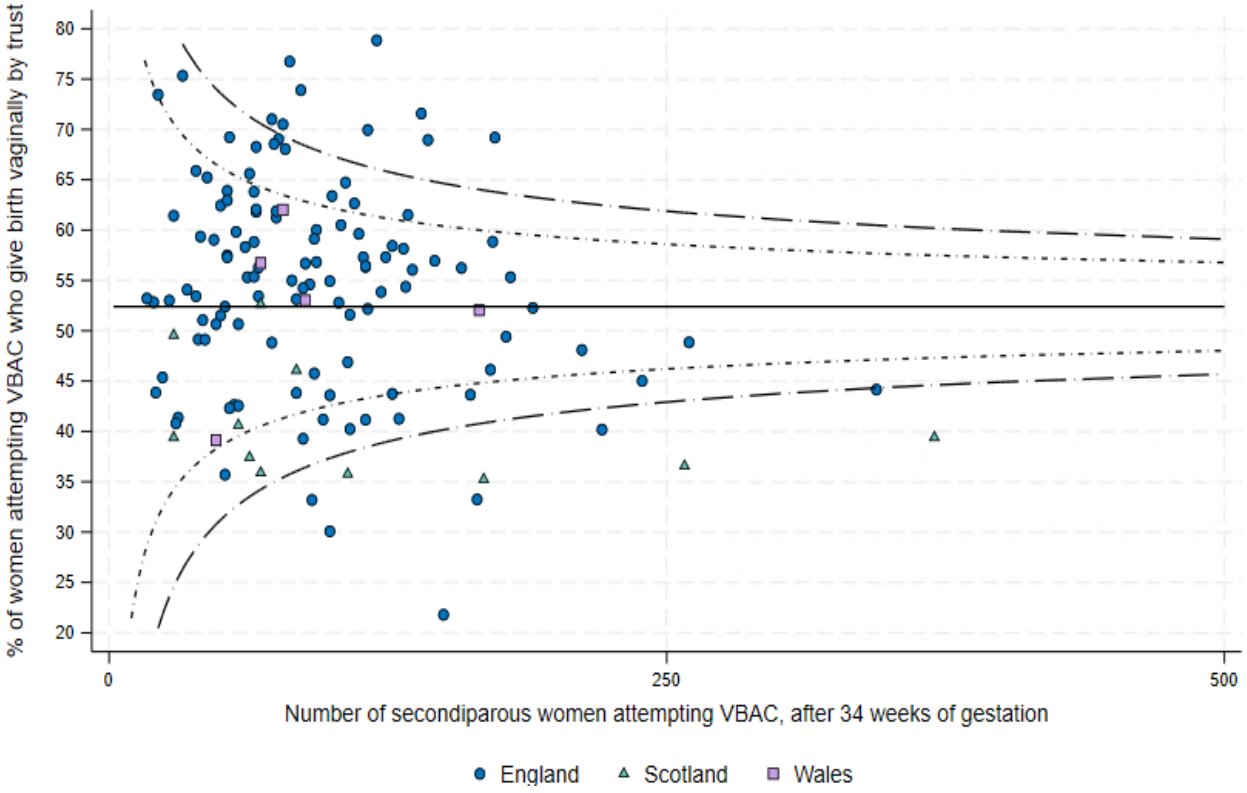
Numerator:
Number of caesarean births

Denominator:
All multiparous women with at least one previous uterine scar, with a single cephalic pregnancy, ≥37 weeks gestation

NMPA
National Maternity & Perinatal Audit

View my local results

Vaginal birth after caesarean (VBAC)



- 26% (40% in 2016/17) of secundiparous women and birthing people opted for a vaginal birth following previous caesarean birth
- 52.4% attempting VBAC experienced vaginal birth

NMPA
National Maternity & Perinatal Audit

View my local results

Late booking

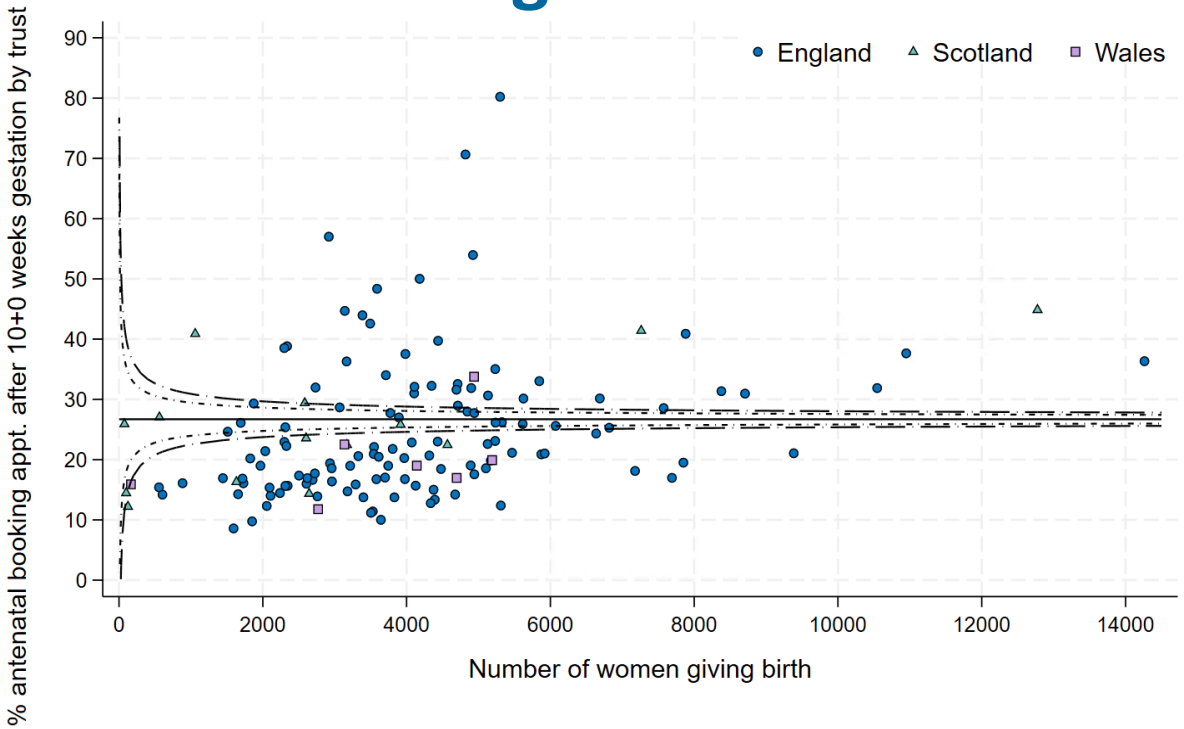
- 26.7% of women and birthing people booked their pregnancy after 10/40

- Massive variation in rates of late booking between trusts and boards

NMPA
National Maternity & Perinatal Audit

View my local results

Late booking

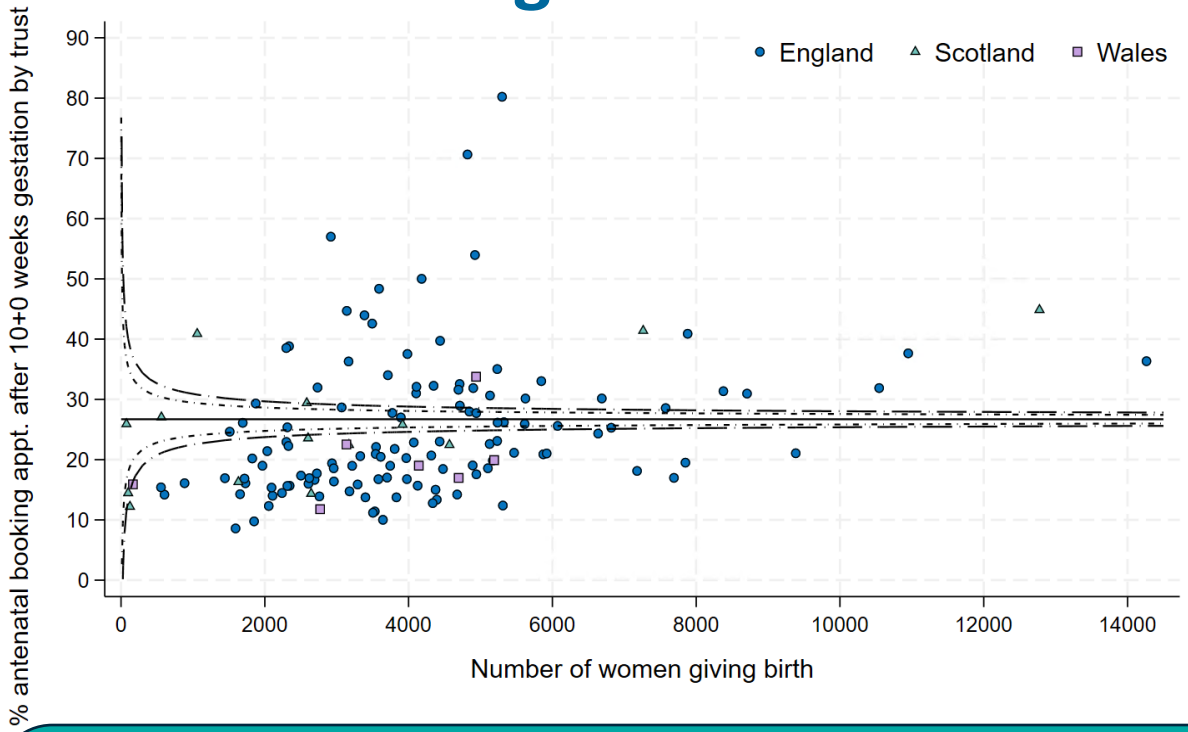


- Differences between GB nations:
- Wales: 1 in 5 pregnancies booked late
- Scotland: 1 in 3 pregnancies booked late
- Implications for subsequent pregnancy management

NMPA
National Maternity & Perinatal Audit

View my local results

Late booking



- Differences between GB nations:
- Wales: 1 in 5 pregnancies booked late
- Scotland: 1 in 3 pregnancies booked late
- Implications for subsequent pregnancy management

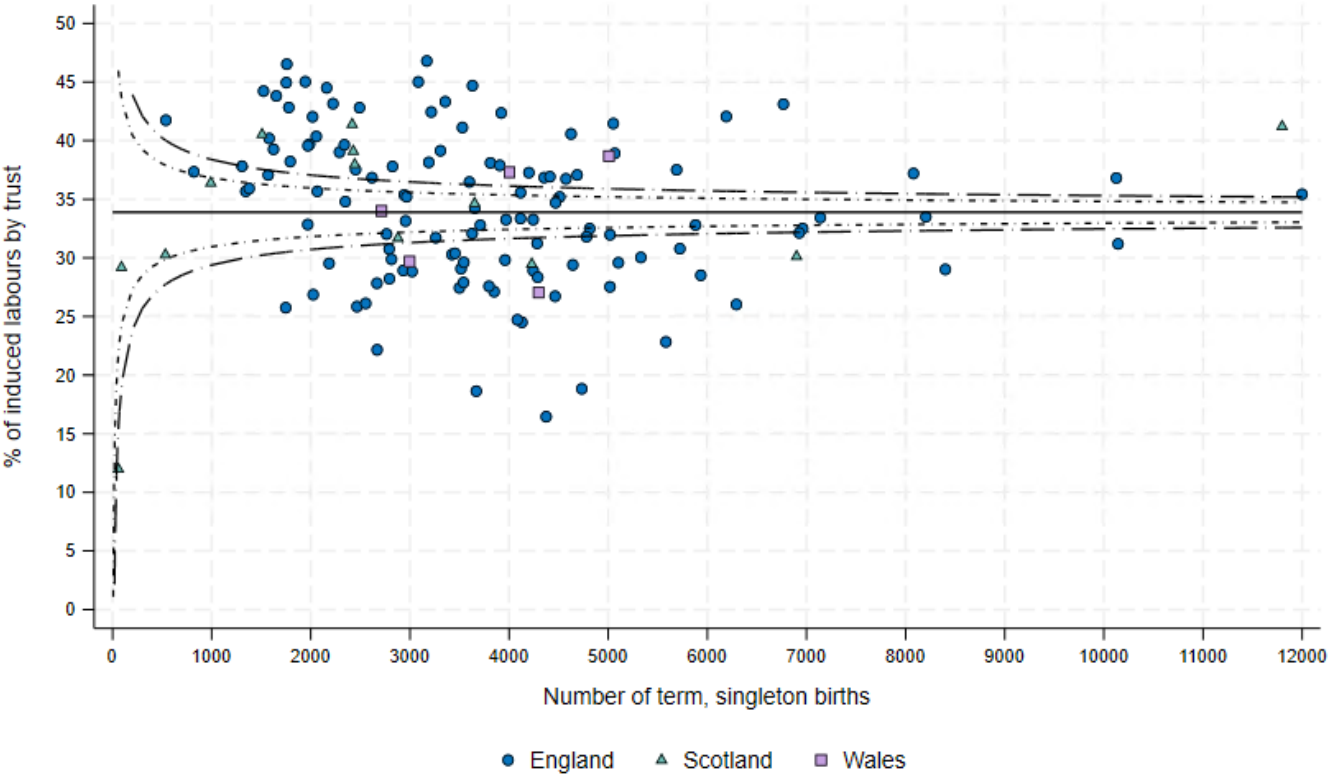
Recommendation:

Government health departments should work with stakeholders to develop national and local level initiatives and campaigns targeted at improving rates of timely pregnancy booking. Initiatives should be co-designed with stakeholders to overcome existing barriers to booking and ensure information and access to services are appropriate.

NMPA
National Maternity & Perinatal Audit

View my local results

Induction of Labour (IOL)

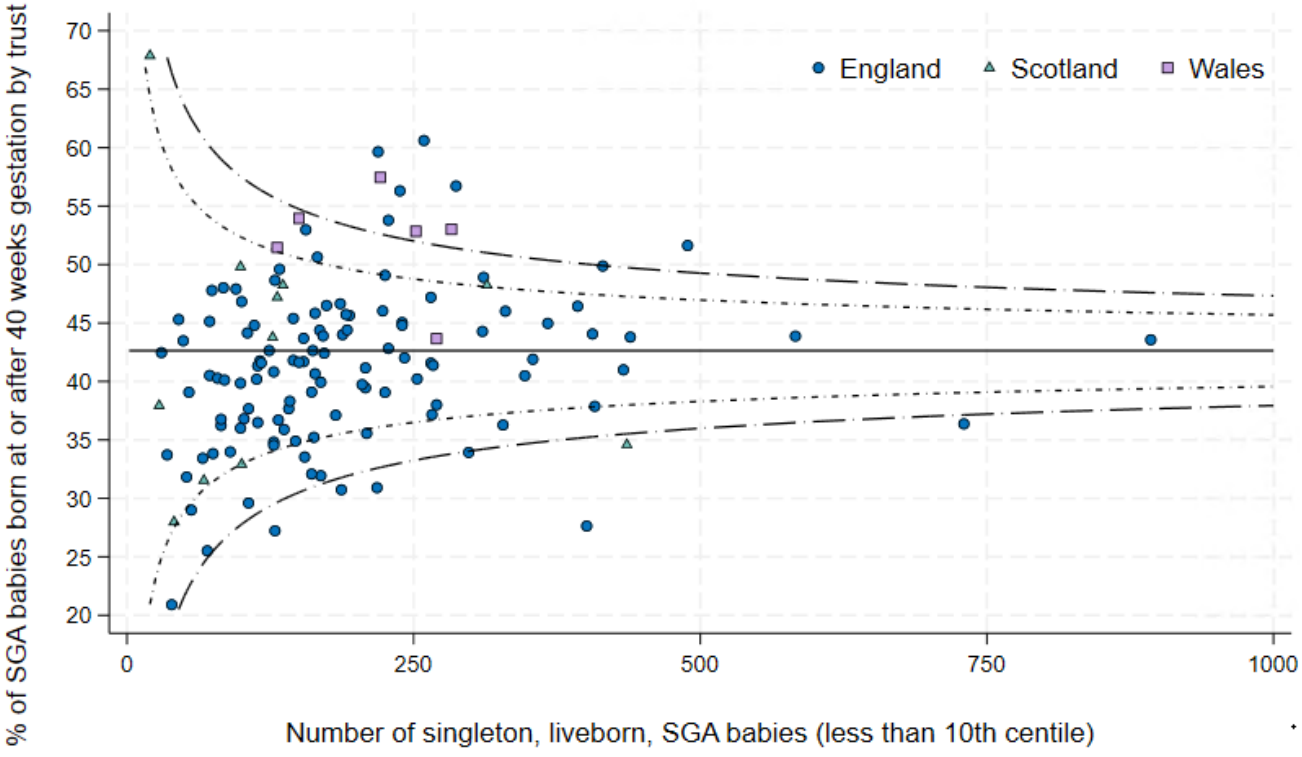


- 33.9% of women and birthing people had IOL
- IOL rates continue to increase (25% in 2015-2016)
- Mean IOL rates similar between England, Scotland and Wales

NMPA
National Maternity & Perinatal Audit

View my local results

Small for gestational age (SGA) born at/after EDD



- 42.6% of SGA babies born at or after their due date
- Overall consistency in trust/board rates across GB
- 48.9% in 2018-19 - important for improvements to be recognised

NMPA
National Maternity & Perinatal Audit

View my local results

Key Findings:

- Consistent preterm birth rates in England Scotland and Wales.
- However spontaneous preterm birth 73.0% (Scotland), 40.9% (England) & 46.3% (Wales)

- % Apgar score <7 @ 5 minutes – 50% higher in Scotland than England and Wales
- PPH rates– inadequate data quality in 21% of English trusts, not reported in Scottish data.

NMPA
National Maternity & Perinatal Audit

Data Quality and Completeness:

- Inconsistent data completeness patterns between trusts and across nations
- Unable to include important case-mix factors: BMI, smoking
- Data completeness table
- Data completeness ≠ good quality data

5 Key areas to improve data
• Smoking at delivery
• Blood loss
• BMI
• Breast milk at discharge
• Skin-to-Skin

data completeness

NMPA
National Maternity & Perinatal Audit

Data capture recommendations:

Recommendation:

Digital teams in the Government health departments should review data definitions and descriptions of care processes and outcomes in the Digital Maternity Record Standard (DMRS) (and Scottish and Welsh equivalents), and their application to clinical practice in order to:

- Objectively measure and record all volumes of blood loss during labour and birth.
- Develop meaningful and consistent measures of:
- skin-to-skin contact following birth in line with the UNICEF definition and to include reasons for non-occurrence.
- establishing and supporting breast milk feeding beyond the first feed

NMPA
National Maternity & Perinatal Audit

Data quality recommendations:

Recommendation:

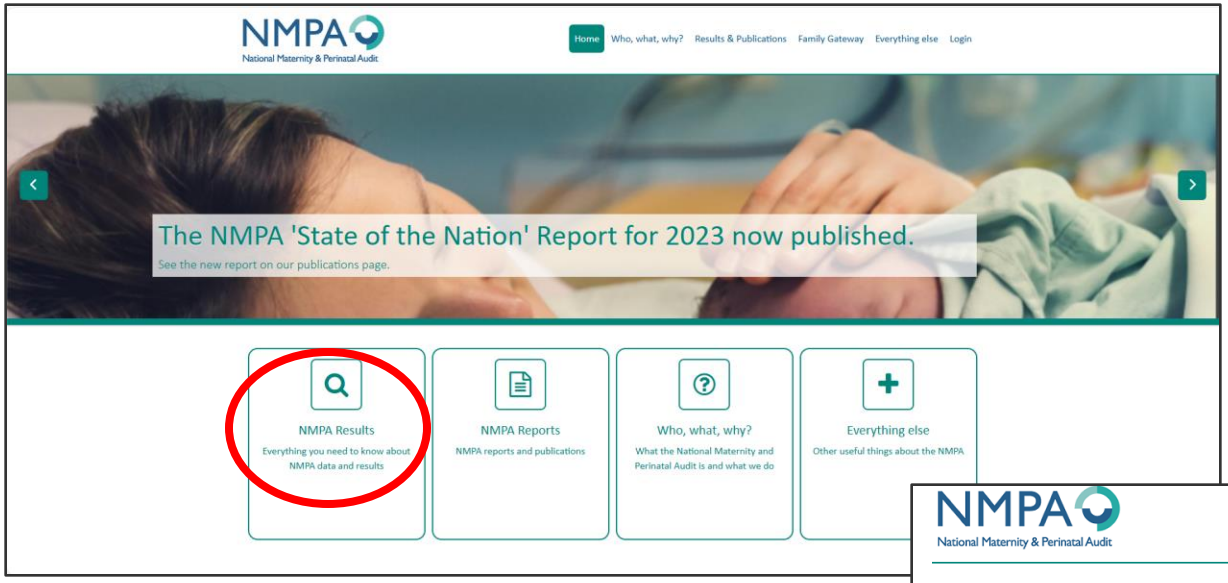
Digital teams in the Government health departments should work with maternity data controllers and software developers to incorporate processes and systems into the next version update of each dataset that support maternity care providers to optimise data quality. This should include stakeholder engagement to:

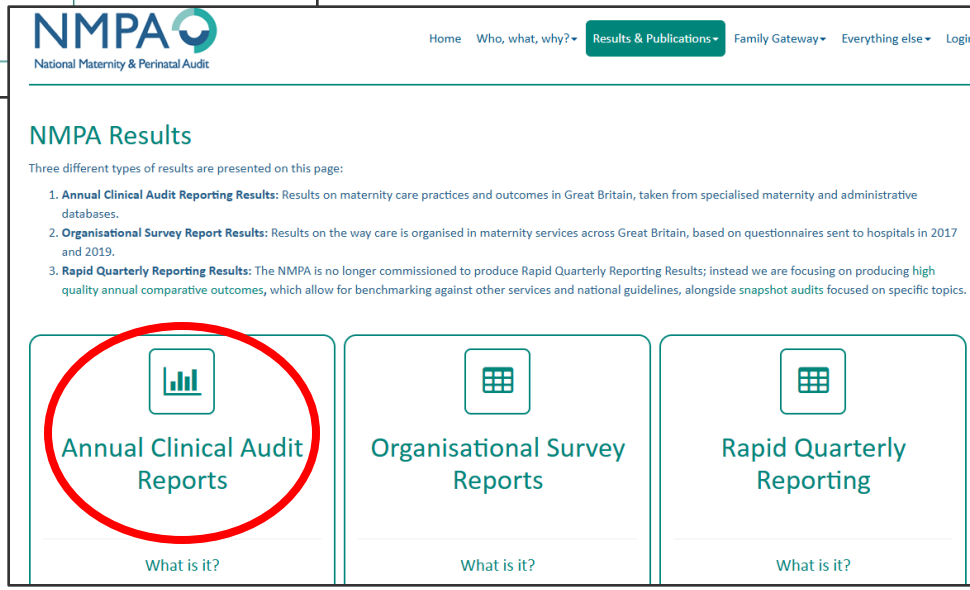
- Minimise data entry burden while supporting trusts/boards to reduce areas of missing or incomplete data.
- Standardise data definitions and data fields to support consistency, comparability and interoperability.
- Ensure updates to the dataset technical specifications meet the needs of data users including frontline clinicians, analysts, researchers, and policymakers.
- Align maternity data standards with SNOMED CT and the Digital Maternity Record Standard (DMRS), to support future interoperability and integration with other clinical systems.

NMPA
National Maternity & Perinatal Audit

View my local results

NMPA results page:





NMPA
National Maternity & Perinatal Audit

View my local results

NMPA
National Maternity & Perinatal Audit

Clinical results

The NMPA clinical audit measures cover various aspects of maternity care for mothers and babies provided by NHS maternity services in England, Scotland and Wales. The NMPA aims to support improvements in maternity and newborn care by providing national statistics and enabling comparison between NHS maternity services providers. This information is intended for use by healthcare professionals, managers, commissioners, collaborative networks and national organisations, and by women and birthing people and families using the services. The results are available at the level of site, trust/board, region and country; the level available differs by reporting year. For 2023, reporting is available at trust/board level, but is not currently available at site level.

View by site or trust/health board

View summary information about individual maternity services

View by measure

View details and compare maternity services

Results tables

View all results in one table

Maternity care outcomes posters

Latest Report

Download the latest annual clinical audit report

Resources

FAQs

Latest key findings

NMPA
National Maternity & Perinatal Audit

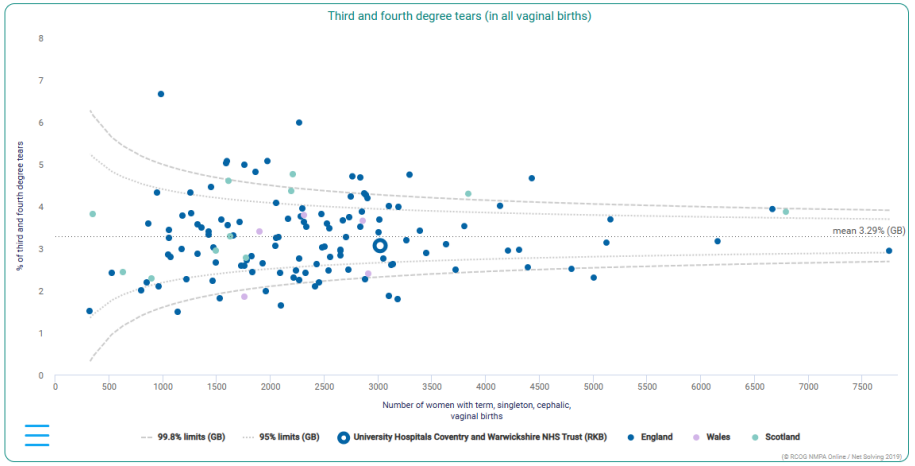
View my local results

NMPA results page:

St George's University Hospitals NHS Foundation Trust				All Trusts/Health boards included		
Measure	Counts	Trust/Health board adjusted mean	Range	Mean	Lowest	Highest
Unplanned maternal readmission within 42 days	68 / 3777	1.8%		3.1%	0.1%	9.1%
Induction of labour	1456 / 3812	38.1%		33.9%	12.0%	48.3%
Episiotomy (Overall)	635 / 2638	21.2%		24.4%	7.0%	38.4%
Caesarean birth (overall)	1280 / 4029	30.8%		39.6%		
Vaginal birth after primary caesarean section	78 / 364	19.3%		14.2%	3.3%	70.9%
3rd and 4th degree tears (Overall)	109 / 2673	3.7%		3.3%	1.2%	6.7%
Postpartum haemorrhage of 1500ml or more	189 / 3985	4.5%		3.4%	0.7%	6.6%
Preterm birth rate (Overall)	275 / 4145	6.6%		6.3%	3.5%	10.1%
Small-for-gestational-age babies born at or after 40 weeks	110 / 240	45.0%		42.6%	20.9%	82.1%
Term babies with a 5-minute Apgar score of less than 7	33 / 3637	1.0%		1.5%	0.4%	4.3%
Skin to skin contact (Overall (34+0 to 42+6 weeks))	3342 / 3681	90.5%		73.4%	9.4%	96.2%
Caesarean birth (In Robson Group 1, overall)	82 / 794	9.9%		18.0%	8.5%	33.1%
Caesarean birth (In Robson Group 2, overall)	464 / 1037	43.2%		56.0%	35.4%	78.8%
Caesarean birth (In Robson Group 5, overall)	356 / 493	74.6%		81.8%	54.9%	91.6%
Skin to skin contact (Overall (24+0 to 33+6 weeks))	12 / 99	12.5%		10.8%	4.0%	66.2%
Vaginal birth, with or without the use of instruments (Overall)	2749 / 4029	69.6%		60.4%	50.4%	69.6%
Late antenatal booking (Overall)	1262 / 4105	31.0%		26.7%	8.6%	80.2%

Trust level spine chart

Customisable funnel plot



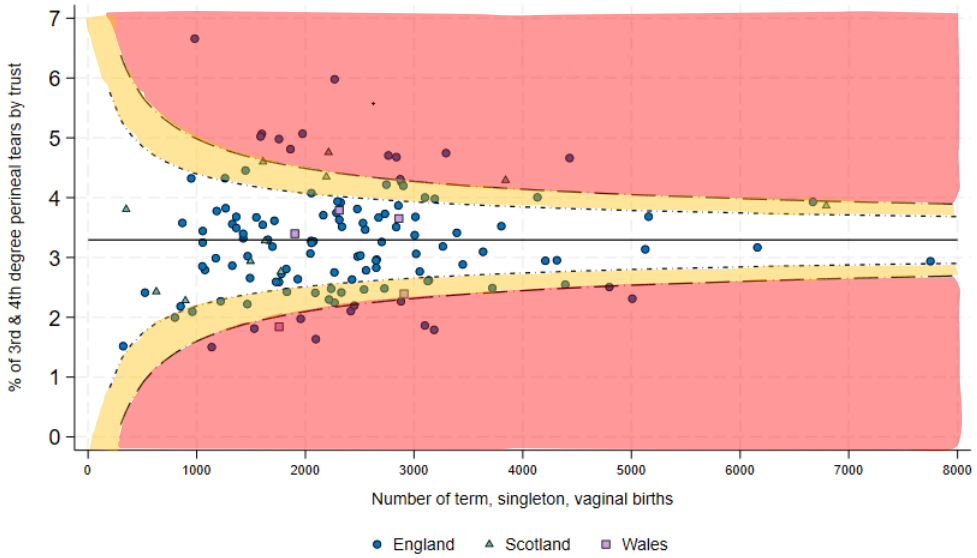
NMPA
National Maternity & Perinatal Audit

NMPA Outlier measures & policy:

Outlier measures:

- Postpartum Haemorrhage (≥1.5L)
- Third and fourth degree tears
- Apgar score <7 at 5 minutes

Alert status (2SD — 3SD) **Alarm status (>3SD)**



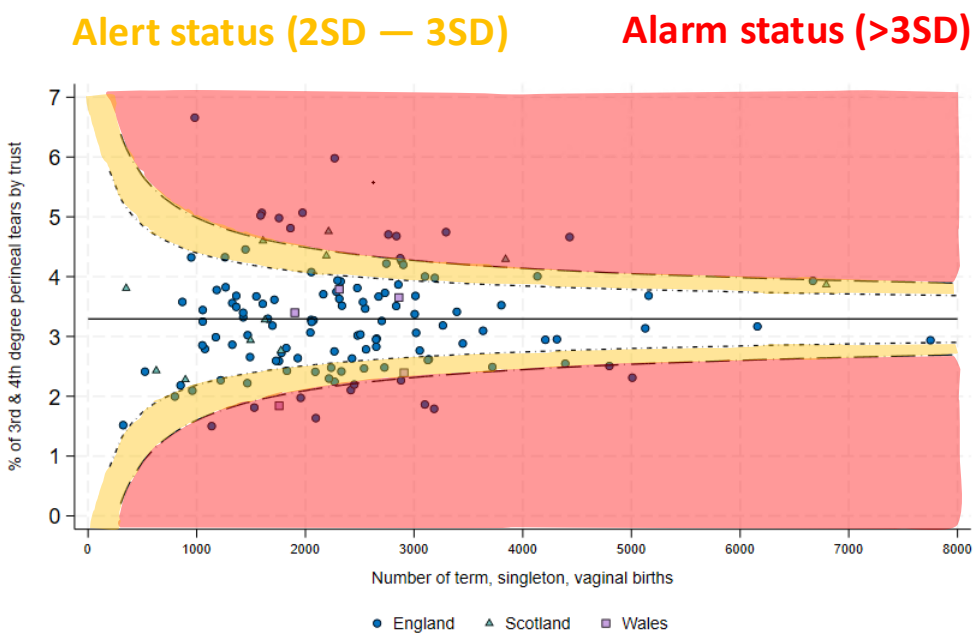
Support trusts/boards to : Identify learning, monitor performance, meet action plans, demonstrate accountability

NMPA
National Maternity & Perinatal Audit

NMPA Outlier measures & policy:

Outlier measures:

- Postpartum Haemorrhage (≥1.5L)
- Third and fourth degree tears
- Apgar score <7 at 5 minutes



Alert status / Lower alarm status:

- Leads informed - Encourage internal assessment

Upper Alarm status:

- Leads informed - Data / clinical review + formal response
- Confirmed -> escalated to commissioners & regulators, published on NMPA website

Non-participation secondary to poor quality data:

- Leads informed

Support trusts/boards to : Identify learning, monitor performance, meet action plans, demonstrate accountability

NMPA
National Maternity & Perinatal Audit

2023 Outlier process summary:

- 9 Trusts / boards removed from Alarm status – data quality issue identified – removed
- 43 instances data quality insufficient to assess against Outlier policy
- 30 confirmed Alarm level triggers
- “Thematic reviews” -> demonstrable / planned improvement secondary to QI initiative

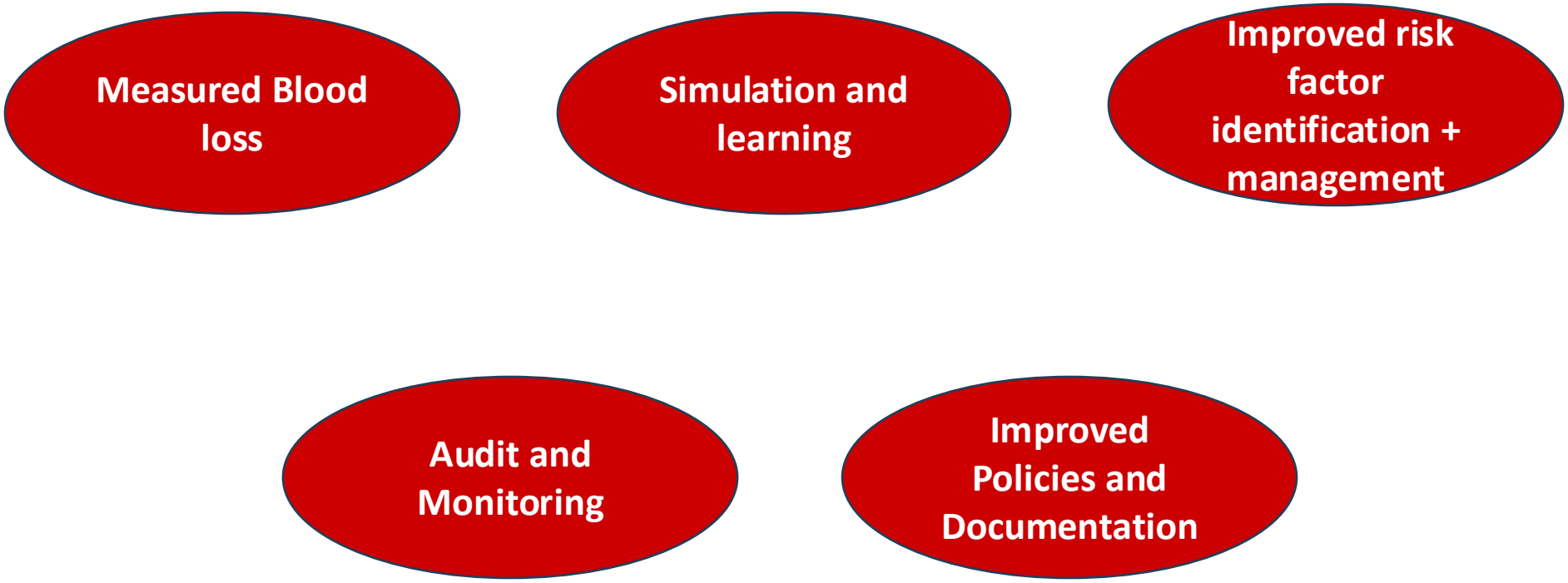
NMPA
National Maternity & Perinatal Audit

3rd/4th degree tears outliers: QI actions

- OASI care bundle implementation
- Focused training and Education
- Pelvic health services improvement
- Audit and Monitoring
- Improved Policies and Documentation

NMPA
National Maternity & Perinatal Audit

Postpartum Haemorrhage outliers: QI actions



NMPA
National Maternity & Perinatal Audit

Apgar <7 at 5 minutes outliers: Findings and QI actions

Findings

- Identification of incorrect Apgar scoring
- Incomplete documentation

Actions

- Simulation and learning
- Improvements to policies and documentation
- Audit and monitoring

NMPA
National Maternity & Perinatal Audit

Acknowledgements

- NMPA Project Board
- NMPA Clinical Reference Group
- NMPA Women and Families Group
- RCOG Clinical Quality department

NMPA
National Maternity & Perinatal Audit

NMPA team

- Professor Jan van der Meulen
- Professor Asma Khalil
- Dr Sam Oddie
- Dr James Harris
- Dr Ipek Gurol-Urganci
- Mr George Dunn
- Ms Kirstin Webster
- Ms Alissa Frémeaux
- Ms Buthaina Ibrahim
- Ms Amy Lloyd
- Ms Emma Heighway

NMPA
National Maternity & Perinatal Audit

View my local results

Other reports and 2026 plans:

- Induction of labour snapshot audit – published November 2025
- Multiple births snapshot audit – publication March 2026
- Collaborative proposal with the National Neonatal Audit Programme – linkage of maternity and neonatal data
- 2026 State of the Nation report (2024 data). Target: Q3 2026
- Webinars
- Enhanced engagement with maternity care providers
- Contact us: nmpa@rcog.org.uk

www.maternityaudit.org.uk

NMPA newsletter registration