NMPA

National Maternity & Perinatal Audit

State of the Nation

Based on births in NHS maternity services in England, Scotland and Wales during 2023

Published September 2025

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

Introduction

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 within their decision making.

Contents

How to use this report

This State of the Nation report presents the audit's key findings and recommendations. We also have a range of additional supporting documents available online:

- A **glossary** explaining all the terminology used in our reports.
- A **methods** document outlining how the analysis for this report was carried out.
- A **measures technical specifications** document describing how the measure were constructed.
- **Summary results tables** with results displayed by country.
- Interactive **data tables** and **funnel plots** at trust/board level.
- A **line-of-sight table** describing the evidence base for the recommendations in this report.
- **Quality Improvement** (QI) resources.

Results can be used to benchmark against national standards and recommendations where these exist, and to identify good practice among maternity care providers and specific clinical areas for quality improvement. 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.

Background

What has changed?

The datasets we use have changed since previous reports; for the first time, this State of the Nation report uses the English Maternity Services Data Set updated version 2.0 (MSDS v2.0).

Unforeseen delays in the supply of this data from NHS England led to a significant delay in the production of NMPA reports for births occurring between 2019 and 2023. Following publication of this State of the Nation report based on births occurring in 2023, results from the intervening years (2019–2022) will be reported on the NMPA website.

Since our previous annual clinical report, the NMPA has:

- Moved to calendar year reporting, to align reporting periods with other related projects such as the National Neonatal Audit Programme (NNAP) and Mothers and Babies: Reducing Risk through Audits and Confidential Enquires across the UK (MBRRACE-UK).
- Revised our suite of measures; details of the process can be found on our website.
- Amended our ethnic group categories to include 'Chinese' in the 'Asian' ethnic group, whereas in previous reports 'Chinese' women and birthing people were included in the 'Any Other' ethnic group category.
- Reintroduced Scottish data into our reports and outputs.

Full details about all the datasets used for England, Scotland and Wales are included in our methods document.

Case-mix adjustment

Variation in care processes and outcomes can be used to highlight differences between trusts/boards. Factors such as clinical and demographic characteristics of women and birthing people can affect both the demands placed on the maternity service and the outcomes of care.

In order to make meaningful and fair comparisons between trusts/boards with different patient populations, we carry out a statistical adjustment called 'case-mix adjustment'. This process aims to take into account any factors which may have an effect on the results and are outwith the control of the maternity service, for example maternal age or previous obstetric history.

More information about case-mix adjustment can be found in the methods and measures technical specification documents online.

Summary characteristics of women and birthing people by country

Included in the 2023 NMPA Results

GREAT BRITAIN
This report includes data for 592 594 women and birthing people who gave birth in 2023

ENGLAND
520 643 women and birthing people gave birth across 120 trusts

SCOTLAND
45 316 women and birthing people gave birth across 14 boards

WALES
26 635 women and birthing people gave birth across 7 health boards

A longstanding trend of declining fertility rates exists worldwide. This trend can be seen in England and Wales, where the number of births per year have been steadily falling since 2012, and 2023 saw the lowest number of births since 1977. Scotland is facing its lowest total fertility rate (TFR≠) on record and at 1.3 this is lower than other parts of the UK, where the TFR for England and Wales stands at 1.44.

Table 1 shows the age, ethnic group and IMD quintile for the 592 594 women and birthing people who gave birth in 2023. One quarter were aged 35 years or over, while around two thirds were aged between 25 and 34 years. Women and birthing people from ethnic minority groups and those from the most deprived quintiles were overrepresented in the maternity data when compared with 2021 national census data for England and Wales and 2022 national census data for Scotland.

Table 1: Characteristics of women and birthing people who gave birth in 2023, by country

Characteristic		England		Scotland		Wales		Total (GB)	
		n	%	n	%	n	%	n	%
Total number of women and birthing people		520 643		45 316		26 635		592 594	
Age (years)	<20	12 357	2.4	1 119	2.6	864	3.2	14 340	2.4
	20–24	60 897	11.7	5 104	11.6	3 730	14.0	69 731	11.8
	25–29	135 746	26.1	11 339	25.9	7 614	28.6	154 699	26.2
	30–34	180 550	34.7	15 422	35.2	8 931	33.5	204 903	34.7
	35–39	105 317	20.2	8 834	20.2	4 553	17.1	118 704	20.1
	40–44	23 665	4.5	1 882	4.3	885	3.3	26 432	4.5
	≥45	2 110	0.4	120	0.3	47	0.2	2 277	0.4
Missing (% of total)		<5	(<0.00)	1 496	(3.3)	11	(0.04)	1 508	(0.3)
Ethnic group	White	360 282	71.2	33 790	87.6	20 479	86.4	414 551	73.0
	Asian	79 843	15.8	2 328	6.0	1 117	4.7	83 288	14.7
	Black	32 946	6.5	1 128	2.9	531	2.2	34 605	6.1
	Mixed	15 432	3.1	601	1.6	1 364	5.8	17 397	3.1
	Other	17 299	3.4	729	1.9	210	0.9	18 238	3.2
Missing (% of total)		14 841	(2.9)	6 740	(14.9)	2 934	(11.0)	24 515	(4.1)
Index of Multiple Deprivation quintile (IMD)[a]	1 = least deprived	82 313	15.9	7 507	16.6	4 276	16.3	94 096	16.0
	2	91 233	17.6	9 252	20.5	4 476	17.0	104 961	17.8
	3	98 545	19.0	8 235	18.2	5 336	20.3	112 116	19.0
	4	114 678	22.1	9 230	20.5	5 583	21.2	129 491	22.0
	5 = most deprived	131 109	25.3	10 900	24.2	6 637	25.2	148 646	25.2
Missing (% of total)		2 765	(0.5)	192	(0.4)	327	(1.2)	3 284	(0.6)

[a] The IMD is derived from the recorded standardised socioeconomic quintile of the individual's local area based on postcode (LSOA) in England and Wales, and on postcode (data zone) in Scotland. As the areas used are of different granularity, these are not comparable between the three countries.

≠ Total fertility rate (TFR) represents the number of children that would be born to a woman if she were to live to the end of her childbearing years and bear children in accordance with age-specific fertility rates of the specified year.

Results at a glance

The National Maternity and Perinatal Audit (NMPA) uses information collected routinely as part of NHS maternity care, combined with information collected when women and birthing people and their babies are admitted to hospital, to report on a range of care process and outcome measures. Summarised here are results based on NMPA data relating NHS births in 2023.

The average rate for NHS maternity care providers across Great Britain appears in the blue spot. The blue arrows represent the middle half (interquartile range) of maternity care providers. A full description of the measures including results for each country can be found in the **summary results tables**.

Late booking

Women and birthing people who attended their first appointment with a midwife (booking) after 10^{+0} weeks of gestation.

16.7% ← **26.7%** → 30.2%

The **interquartile range** is the spread of the middle half of the results, it gives a sense of the data values around the median. Viewing the whole range of values from lowest to highest can be affected by a small number of providers with very low rates or very high rates

Small for gestational age

Babies born small for gestational age who were born at or after their estimated due date (40 weeks of gestation).

36.7% ← **42.6%** → 45.9%

Preterm birth

Women and birthing people whose baby was born preterm between 24^{+0} and 36^{+6} weeks.

5.48% ← **6.34%** → 6.90%

Of those, the proportion whose birth is recorded as:

Spontaneous

37.0% ← **43.9%** → 47.0%

Clinician Recommended (Iatrogenic)

53.2% ← **56.1%** → 62.8%

Induction of labour

Women and birthing people who had an induction of labour.

29.6% ← **33.9%** → 39.0%

Mode of birth

Vaginal birth without the use of instruments

47.4% ← **49.4%** → 52.6%

Vaginal birth with the use of instruments

9.6% ← **11.1%** → 12.0%

Vaginal birth with the use of instruments, by type

Vaginal birth with the use of **forceps.**

5.7% ← **7.0%** → 7.9%

Vaginal birth with the use of **ventouse.**

3.1% ← **4.1%** → 5.1%

Unplanned caesarean birth

Women and birthing people who had a caesarean birth that was unplanned (emergency).

20.9% ← **23.1%** → 25.0%

Planned caesarean birth

Women and birthing people who had a caesarean birth that was planned (elective).

15.1% ← **16.4%** → 17.9%

Vaginal Birth After Caesarean

Women and birthing people who had a vaginal birth for their second baby, after having had a caesarean birth for their first baby.

11.9% ← **14.2%** → 16.7%

Results at a glance

Caesarean birth by selected Robson Group Classification

Of the women and birthing people who meet the selected Robson Group Classification, the proportion who had a caesarean birth:

Robson Group 1: Nulliparous, single cephalic pregnancy, ≥37 weeks gestation, in spontaneous labour.

14.6% ← **18.0%** → 22.1%

Robson Group 2: Nulliparous, single cephalic pregnancy, ≥37 weeks gestation, with either induction of labour or pre-labour caesarean birth.

49.9% ← **56.0%** → 60.2%

Robson Group 5: Multiparous, single cephalic pregnancy, ≥37 weeks gestation, with at least one previous caesarean scar.

79.3% ← **81.8%** → 85.3%

Perineal tears

Women and birthing people who gave birth vaginally who experienced a 3rd or 4th degree perineal tear.

2.60% ← **3.29%** → 3.80%

Episiotomy

Women and birthing people who gave birth vaginally who had an episiotomy.

21.3% ← **24.4%** → 26.5%

PPH ≥1500 ml

Women and birthing people who had a postpartum haemorrhage of ≥1500 ml.

2.98% ← **3.41%** → 3.79%

Unplanned maternal readmission

Women and birthing people who had an unplanned overnight readmission to hospital within 42 days of birth.

2.14% ← **3.08%** → 3.68%

Measures of care for the newborn baby

Apgar score at 5 minutes

Babies who were assigned an Apgar score of less than 7 at 5 minutes of age.

1.03% ← **1.45%** → 1.85%

Breast milk

Babies who received any breast milk at first feed.

65.0% ← **71.7%** → 77.3%

Skin-to-skin contact

Babies who received skin-to-skin contact within one hour of birth.

68.3% ← **73.4%** → 84.1%

This is the first report published by the NMPA since the 2022 clinical report on births occurring between 1 April 2018 and 31 March 2019.

This State of the Nation report is the first time the NMPA have used the updated MSDS version 2.0. Information on the methods used and summary results tables can be found online.

Find out more at:
www.maternityaudit.org.uk
Or scan the QR code to visit the website on your smart-phone.

SCAN ME

National Key Findings and Recommendations

Timing of pregnancy booking

The NMPA recognises the importance of timely and accessible antenatal care, and so for the first time we explored the rate of late booking. In 2023, 1 in 4 (26.7%) women and birthing people attended their first (booking) appointment with a midwife after 10^{+0} weeks of gestation, with a wide distribution of rates between maternity care providers (IQR 16.7–30.2%).

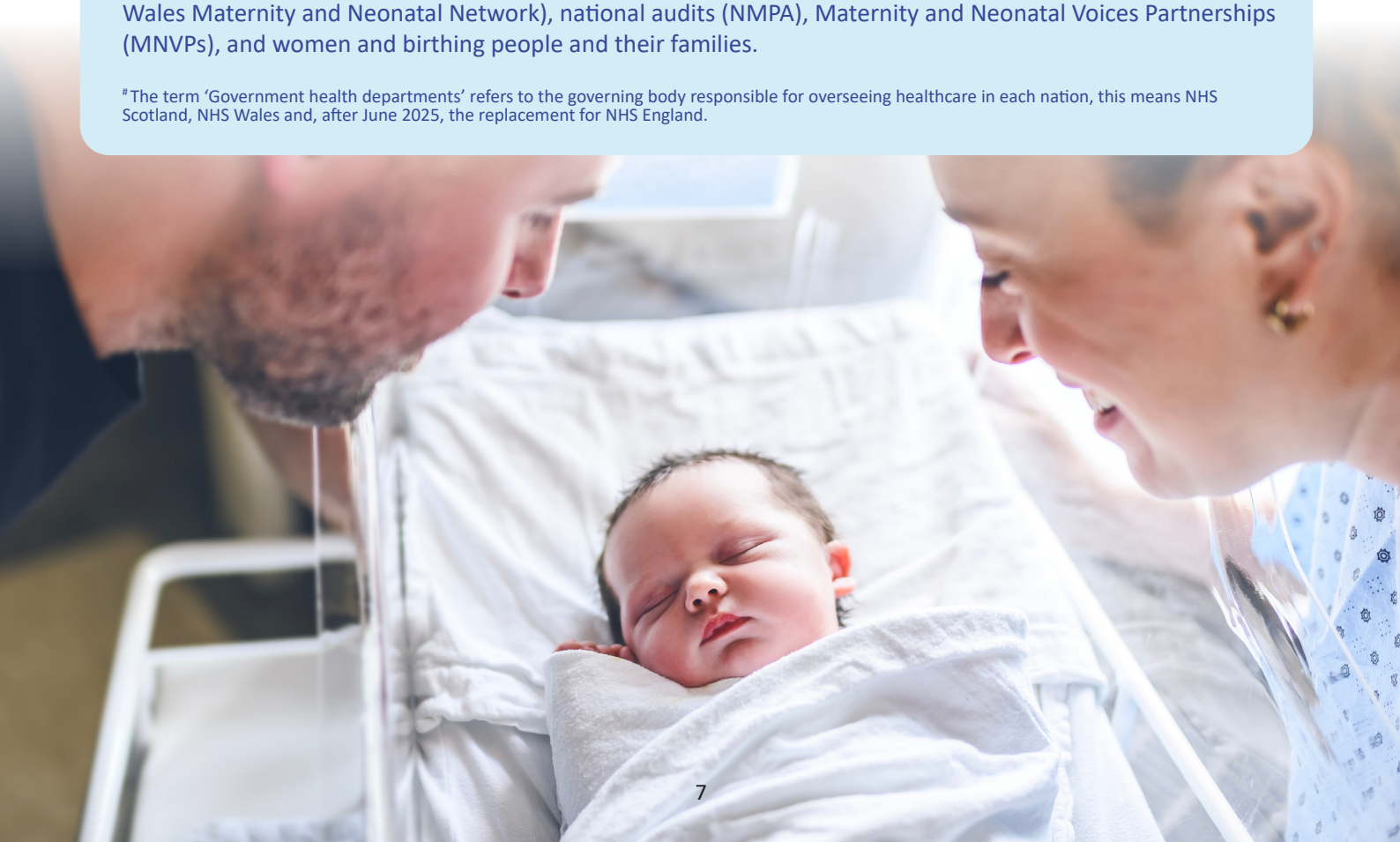
Late booking rates also varied between the devolved nations (1 in 5 in Wales to 1 in 3 in Scotland). The National Institute of Health and Care Excellence (NICE) Antenatal Care guideline recommends a booking appointment take place by 10^{+0} weeks of gestation to facilitate a timely dating scan between 11^{+2} and 14^{+1} weeks of gestation. A late dating scan reduces the accuracy of fetal anomaly screening and calculating an estimated due date, both of which may have implications for subsequent antenatal and intrapartum care. A number of factors may contribute to late pregnancy booking, including maternal age, ethnicity, deprivation, language barriers and previous experience of maternity care.

Recommendation 1 – Timely pregnancy booking

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.

Stakeholders should include maternity care commissioners, integrated care systems, the Royal Colleges (RCGP, RCOG, RCM), Office for Health Improvement and Disparities (OHID), NHS Inform, NHS 111 Wales, local networks (e.g. English local maternity and neonatal systems (LMNS), the Scottish Perinatal Network, and the Wales Maternity and Neonatal Network), national audits (NMPA), Maternity and Neonatal Voices Partnerships (MNVPs), and women and birthing people and their families.

[#] The term 'Government health departments' refers to the governing body responsible for overseeing healthcare in each nation, this means NHS Scotland, NHS Wales and, after June 2025, the replacement for NHS England.



Mode of birth

This State of the Nation report demonstrates a shift in the mode of births taking place in 2023 compared to previous years, with a decrease in vaginal births with and without the use of instruments and an increase in caesarean births.

- Just under half (49.4%) of all births were vaginal births without the use of instruments compared with 60.0% in 2018/19. The rate of vaginal birth with the use of instruments has fallen from 12.3% in 2018/19 to 11.1% in 2023. Caesarean birth rates have increased considerably since our previous report (Unplanned caesarean birth: 2018/19, 15.5%; 2023, 23.1%. Planned caesarean birth: 2018/19, 12.1%; 2023, 16.4%). There are risks and benefits to both vaginal and caesarean modes of birth, and the reasons for choosing a caesarean birth (planned or unplanned) can include physical or psychological benefits. While unnecessary interventions may lead to adverse outcomes, it is important to note that there is no 'ideal' rate for births by caesarean and that overall caesarean rates must not be used to assess the performance of a trust/board.

- There have been significant publications relating to maternity services since our last annual report on 2018/9 births, most notably the Ockenden and Kirkup Reports, and an update to the NICE Caesarean Birth guideline wording around caesarean birth for maternal choice.

- For the first time, improved data quality allows us to present caesarean births by selected Robson Group classification. There was greater variation in caesarean birth rates between providers for Robson Groups 1 and 2, both of which describe women and birthing people giving birth for the first time. Over 80% of women and birthing people who had a previous caesarean birth (Robson Group 5), had another caesarean birth and we have seen a reduction in the rates of vaginal birth after caesarean (VBAC).

- One in seven (14.2%) births following a previous caesarean birth were vaginal (VBAC), this is lower than the rate in our previous reports (24.5% in 2016/17 and 22.5% in 2018/19). Across Great Britain, the rate of women and birthing people eligible for VBAC who try for a VBAC has fallen since our previous reports (25.8% in 2023 compared with 40.0% in 2016/17, and 38.0% in 2018/19); among those who did, the rate who gave birth vaginally has also fallen since our previous reports (52.4% in 2023 compared with 58.5% in 2016/17, and 60.7% in 2018/19). Whilst there is no 'ideal' rate for VBAC, the variation may be reflective of counselling, consideration of obstetric history and individual informed decision-making.

- Around 1 in 3 women and birthing people experienced an induction of labour and while the rates between England, Scotland and Wales were similar (33.7%, 36.1% and 33.6% respectively), there was wide variation between maternity care providers. While induction of labour rates have increased since the NMPA first annual report (28.5% in 2015/16), as the indication for induction is not available in the datasets, it is not possible to explore the reasons that may explain this increase. An NMPA snapshot audit taking a closer look at induction of labour care processes and outcomes is due to be published later in 2025.

- These changes in mode of birth lead to increased demands on the maternity services workforce (midwifery, obstetric, theatre and anaesthetic staffing groups) and resources, such as theatres and postnatal ward bed pressures due to increased length of stay. An increase in interventions may also impact postpartum recovery for women and birthing people.

Recommendation 2 – The impact of changing trends in maternity care and outcomes

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.

[#] The term 'Government health departments' refers to the governing body responsible for overseeing healthcare in each nation, this means NHS Scotland, NHS Wales and, after June 2025, the replacement for NHS England.

Variation in practice and outcomes

The results display variation between countries and maternity care providers across a range of outcome measures. For example:

- Episiotomy rates in England (24.7%) were higher than in Wales (18.3%). In our previous report, we identified that episiotomies were less likely to be performed during vaginal birth with the use of instruments in Wales than England. The lower rate of instrumental births in Wales in 2023 than in England may contribute to the differences in the rates of episiotomy. Interpretation of this measure is difficult without understanding the context in which episiotomy was performed and it is important to remember that for vaginal birth without the use of instruments, there is no ideal episiotomy rate. Data completeness and quality concerns prevented accurate reporting of episiotomy rates for Scotland.

- The rate of third- and fourth-degree perineal tears, also known as Obstetric Anal Sphincter Injury (OASI), was 3.29% and has remained similar to previous reports. Across the devolved nations, the rate was higher in Scotland (3.82%) and lower in Wales (3.04%) than England (3.26%) and there was variation between maternity care providers in each nation. Initiatives such as the OASI care bundle and warm perineal compress during the second stage of labour have been shown to reduce OASI rates in a research setting. Differences between OASI rates published in our report and those published on the NHS maternity dashboard can be explained by the added benefit of linked maternity and administrative hospital datasets that we use.

- Overall preterm birth rates were consistent between countries. However, the rate of preterm births that were recorded as following a spontaneous onset of labour in Scotland (73.0%) was considerably higher than England (40.9%) and Wales (46.3%). There was wide variation between maternity care providers across countries for both spontaneous onset and clinician recommended (iatrogenic) preterm birth; this may be partly attributable to the type of neonatal unit at a trust/board but it is unlikely this alone can explain the extent of between provider variation. The English National Maternity Safety Strategy ambition is to reduce preterm birth rates from 8% to 6% by 2025; however, the Preterm Birth Inquiry acknowledged this target will not be met due to an increase in preterm birth rates in 2022.

- The rate of babies born small for gestational age (SGA) at or after 40 weeks has reduced in recent years from 55.4% in our first report on births in 2015/16, to 42.6% in 2023. Despite this improvement, there remains considerable between-provider variation across Great Britain, and the rate is higher in Wales than in England and Scotland. The overall reduction may be the result of enhanced antenatal monitoring, diagnostic pathways and the impact of national initiatives such as the NHS England Saving Babies Lives Care Bundle; however, we are not aware of equivalent resources in Scotland or Wales.

- An unplanned maternal readmission occurred for 3.08% of women and birthing people across England and Wales, with the rate higher in Wales (4.14%) than England (3.05%), and rates varied by provider (IQR: 2.57–5.02% in Wales; 2.14–3.59% in England). A difference in the way readmissions are recorded in the Scottish data means we are unable to report unplanned maternal readmission for Scotland.

Recommendation 3 – Unwarranted variation

Maternity care commissioners and maternity networks (e.g. English local maternity and neonatal systems (LMNS), the Scottish Perinatal Network, and the Wales Maternity and Neonatal Network) should use the evidence of variation in care processes and outcomes identified in this report, and the results for their local populations, when working with their constituent units to identify opportunities for improvements in service provision and clinical practice.

Data quality and capture

The NMPA uses a broad range of measures that enable maternity care providers, commissioners and other stakeholders to reflect on service provision. In order for the potential to understand current maternity care, the definitions and descriptions within some of these measures and their application to clinical practice requires improvement. For example:

- Data quality (completeness and/or distribution) for postpartum haemorrhage (PPH) ≥1500 ml was insufficient for nearly one quarter (27/120) of English trusts. Some trusts appear to mainly report high-volume blood loss only, which renders the calculation of this indicator impossible for those trusts. Although there is a blood loss variable in the Scottish dataset, this was only available for a minute number of records. The practice of a visual estimation of blood loss volumes has been reported as highly inaccurate, yet it appears that in some cases estimated volumes may be being recorded in place of objectively measured volumes. While a rapid visual assessment of high volumes of blood loss may lead to timely intervention to control PPH, more accurate objective measurement of all blood loss volumes is important to report rates of PPH across all maternity care providers.

- Rates of an Apgar score of less than 7 at 5 minutes in Scotland were 50% higher compared to England and Wales. The Apgar score, developed in the 1950s, remains subjective especially when assessing babies born to women and birthing people from ethnic minority groups and babies born preterm. A 2023 report by the NHS Race Health Observatory (RHO) outlines the challenges in neonatal care for ethnic minority babies and sets out clear recommendations for improved education and training, policy updates and areas for targeted research. The between country and between provider variation appearing in our results may in part be due to local demographics, especially for trusts/boards where there are fewer preterm births or women and birthing people from ethnic minority groups giving birth, but there may be other contributory factors.

- Skin-to-skin contact is not available as a variable in the Scottish or Welsh datasets, and there was striking variation in the rates between English trusts. We have previously commented on the discrepancy between the UNICEF Baby Friendly definition of skin-to-skin contact as “the practice where a baby is dried and laid directly on the mother’s bare chest after birth, and left for at least an hour or until after the first feed”; in contrast to the Maternity Services Data Set (MSDS) definition, which lists the data item name as “skin-to-skin contact indicator (within one hour)” and the description “Whether or not baby had skin-to-skin contact with mother in the first hour of life.”. The vast variation between maternity care provider rates (IQR: 68.3–84.1%) may reflect uncertainty around what constitutes meaningful skin-to-skin contact in the context of these two definitions. No information is available on reasons for non-occurrence or if skin-to-skin occurred with someone other than the mother. NICE Intrapartum Care guideline has recommended encouraging skin-to-skin contact as soon as possible after birth since 2007, this was updated in 2023 to encourage skin-to-skin with a “birth companion” if the mother is not well enough. Optimal positioning to prevent airway obstruction has also been included for the first time.

- Rates of babies receiving breast milk at first feed vary between provider and country, rates were higher in England (72.6%) than in Scotland (63.1%) or Wales (65.8%). A national infant feeding survey conducted every 5 years between 1975 and 2010, most recently reported breast milk given at first feed for 81% of babies across the United Kingdom (UK) (83% in England, 74% in Scotland and 71% in Wales). It is reported that the UK has some of the lowest breastfeeding rates in the world. Without longer-term breast milk feeding rates, it is difficult to interpret how meaningful breast milk at first feed is as a measure for influencing longer-term breast milk feeding rates. In October 2023 the Government commissioned Ipsos to carry out a new infant feeding survey, the results of which are not yet available.

Recommendation 4 – Data definitions and data capture

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.

[§]Digital teams include those who design, develop and operate national IT and data services, such as the former NHS Digital in England and the Scottish and Welsh equivalents.

Recommendation 5 – Optimise data quality

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.

[§]Digital teams include those who design, develop and operate national IT and data services, such as the former NHS Digital in England and the Scottish and Welsh equivalents.

Acknowledgements

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www.maternityaudit.org.uk

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

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