NMPA

National Maternity & Perinatal Audit

Multiple Births Outcomes of Maternity Care

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

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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

Introduction

Multiple births are pregnancies where there is more than one baby and can include twins, triplets or more. In the 20 years up to and including 2023, the rate of multiple births in England and Wales and Scotland was around 15 per 1000. This equates to around 1 in 65 pregnancies across Great Britain.

While most women and birthing people who are pregnant with twins, triplets or more will have a healthy pregnancy and give birth to healthy babies, there are conditions and complications that are more common for multiple births. For example in England, babies from multiple births are more likely to be born preterm with around 60% of twins and 75% of triplets born before 37 weeks of gestation. Women and birthing people are more likely to experience pelvic girdle pain, pregnancy induced high blood pressure, pre-eclampsia, anaemia, gestational diabetes, bleeding following birth (postpartum haemorrhage), and restricted growth of one or more of the babies.

There are also complications that can arise depending on the type of multiple birth and how many placentas (chorionicity) and amniotic sacs (amnionicity) there are. The number of tests, scans offered, and timing and mode of birth will depend on the number of babies, their position, and chorionicity and amnionicity. For a small number of babies that share a placenta, there can be an imbalance in blood flow meaning one baby has greater blood volume than the other (Twin Anaemia-Polycythaemia Syndrome (TAPS) affecting around 3–5% of monochorionic pregnancies), or where the imbalance also affects the amount of amniotic fluid around each baby (Twin-to-Twin Transfusion Syndrome (TTTS) affecting 10–15% of monochorionic pregnancies). Both these conditions can cause complications for both babies.

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The National Institute of Health and Care Excellence (NICE) guidance states that women and people who are pregnant with two or more babies should be supported by a multidisciplinary team (MDT) of specialist obstetricians, midwives and sonographers who have experience of multiple births, and have access to an enhanced team of specialists if needed. However, it is not known to what extent this guidance has been implemented, and MDT arrangements may differ between maternity services.

The charity Twins Trust, through their Maternity Engagement Programme, have supported and encouraged maternity units to engage with the NICE quality standard for twin and triplet pregnancies. Participating units in 2019 and 2023 demonstrated improved adherence to the guidance and an improvement in outcomes.

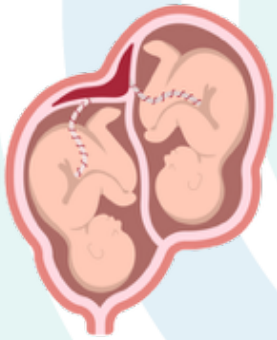
A confidential inquiry report published in 2021 by MBBRACE-UK identified improvements to the care provided during pregnancy, labour and after birth which may have made a difference to the outcome for over half (54%) of the baby cases reviewed, and for almost two thirds (64%) of the mother cases reviewed. The following MBRRACE perinatal mortality surveillance results showed an increase in stillbirth and neonatal death rates for twins between 2016–2020, and a widening of the gap between stillbirth and neonatal death rates between singleton babies and twins in 2020.

It is important that women and birthing people are provided with information about their individual circumstances that may affect their options for how, when and where to give birth.

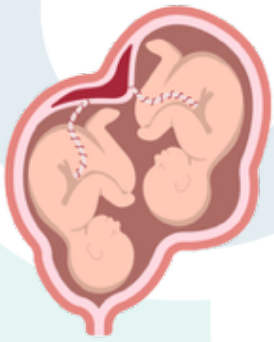
Chorionicity

The different arrangements of placentas (chorionicity) and amniotic sacs (amnionicity) are described here for twins, they apply to triplets or more as well but may be more complex than for twins:

Dichorionic diamniotic (DCDA): each baby has their own placenta and their own amniotic sac. This is the most common type of twin multiple birth, accounting for around three quarters of twins, and generally experiences fewer complications than other types of twin pregnancy.



Monochorionic diamniotic (MCDA): both babies share a placenta but each baby has their own amniotic sac.



Monochorionic monoamniotic (MCMA): both babies share a placenta and share one amniotic sac. This is a much rarer type of twin multiple birth, occurring in around 5% of twins, and may experience more complications than other types of twin pregnancy.

What is the impact of assisted conception?

The national maternity datasets do not contain data fields for assisted conception. The Human Fertilisation and Embryology Authority (HFEA) produces reports of data submitted to them by licensed fertility clinics in the United Kingdom (UK). They reported high rates of multiple births from fertility treatment that peaked in the late 1990s/ early 2000s at almost 20 times higher than those from spontaneous conception. This was at a time when the rate of multiple embryo transfer was >90% and one quarter of pregnancies following assisted conception resulted in a multiple birth.

Because of the higher chance of complications for multiple births, the HFEA launched a campaign in 2007 called '*One at a Time*'. The campaign aimed to reduce the rate of multiple embryo transfer and while the numbers of babies born from assisted conception has continued to rise, the rate of multiple births from assisted conception has reduced from 25% to 3%. It is essential that women and people who are planning to become pregnant by assisted conception are appropriately counselled about their options for embryo transfer and the potential consequences, especially when more than one embryo is transferred.

What is the NMPA?

The National Maternity and Perinatal Audit (NMPA) is a large-scale audit of NHS maternity services across England, Scotland and Wales. The audit 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 outputs produced by the audit 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.

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 thorough data quality checks are included in these results. This means not every maternity service at every trust/board has results for every measure.

How to use this report

The NMPA published a report in 2021 on the feasibility of assessing NHS maternity care for women and birthing people with multiple births and their babies using routinely collected data for births that occurred between April 2015 and March 2017. That report, which used different datasets, made recommendations for future multiple births reporting, such as the recording of chorionicity and interventions during pregnancy in the maternity datasets, as well as intended place and mode of birth.

The aim of this report on 2023 births is to assess if the measures we report for singleton births in our annual clinical report can be presented for multiple births, and if they can provide information that is relevant and useful to commissioners, providers and users of NHS maternity care services when included in our annual clinical reporting in the future.

We 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.
- **Summary results tables** with results displayed by country.
- A **line-of-sight table** describing the evidence base for the recommendations in this report.

Summary characteristics of women and birthing people by country

Table 1 shows the characteristics of the women and birthing people who gave birth to twins, triplets or quadruplets (quads; four babies) in 2023. The rates were broadly similar to the characteristics of those reported in the NMPA State of the Nation report. The mothers of multiple births babies were slightly older, although the age range for the greatest number giving birth remained 30–34 years. The greatest proportion were from white ethnic groups, followed by Asian and Black ethnic groups; almost half were from the two most deprived quintiles. Families with babies born from multiple births face a greater burden on their resources with the additional financial, emotional, social and physical demands and challenges that come with having twins, triplets or more.

Table 1: Characteristics of women and birthing people who gave birth to twins, triplets or quads, by country

Characteristic		England		Scotland		Wales		Total (GB)	
		n	%	n	%	n	%	n	%
Total number of women and birthing people		7 299		645		357		8 301	
Age (years)	<20	89	1.2	56[#]	9.0[#]	38[#]	10.6[#]	103	1.3
	20-24	552	7.6					632	7.6
	25-29	1 622	22.2	143	23.1	87	24.4	1 852	22.4
	30-34	2 618	35.9	246	39.7	135	37.8	2 999	36.2
	35-39	1 784	24.4	138	22.3	81	22.7	2 003	24.2
	40-44	484	6.6	36[#]	5.8[#]	16[#]	4.5[#]	533	6.4
	≥45	150	2.1					153	1.8
	Missing (% of total)	0		26	(4.0)	0		26	(0.3)
Ethnic Group	White	5 012	70.6	480	89.2	273	85.3	5 765	69.5
	Asian	956	13.4	28	5.2	19	5.9	1 003	12.1
	Black	654	9.1	15	2.8	7	2.2	676	8.1
	Mixed	238	3.4	15[#]	2.8[#]	21[#]	6.6[#]	262	3.2
	Other	239	3.4					251	3.0
	Missing (% of total)	200	(2.7)	107	(16.6)	37	(10.3)	344	(4.1)
Index of multiple deprivation quintile (IMD)[a]	1 = least deprived	1 158	15.9	95	14.8	68	19.0	1 321	16.0
	2	1 359	18.6	143	22.2	57	16.0	1 559	18.9
	3	1 411	19.3	115	17.9	58	16.2	1 584	19.2
	4	1 594	21.9	143	22.2	89	25.0	1 826	22.1
	5 = most deprived	1 739	23.8	147	22.9	80	22.4	1 966	23.8
	Missing (% of total)	38	(0.5)	2	(0.3)	5	(1.4)	45	(0.5)

[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.
[#] Counts and percentages have been combined to retain anonymity due to small numbers.

Results at a glance

The National Maternity and Perinatal Audit (NMPA) use 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 for the women and birthing people who gave birth to twins, triplets or quadruplets (quads) in 2023. Outcomes for the mother are presented per woman/birthing person and outcomes for the babies are presented per baby.

For a number of the measures, we have adjusted the gestational age inclusion criteria from our singletons measures definitions to report results for multiple births from 32+0 weeks. A full description of the measures including results for each country can be found in the Summary Results Tables.

GREAT BRITAIN

This report includes results for 8 301 women and birthing people who gave birth to twin, triplet or quadruplet babies. Of these, 98.6% were twin births and 1.4% were triplet or quadruplet births.

For a few births, the number of baby records did not match with the number of babies born in the mother record.

Included in the 2023 NMPA Results

ENGLAND

7 299 women and birthing people gave birth to 14 572 babies

SCOTLAND

645 women and birthing people gave birth to 1 302 babies

WALES

357 women and birthing people gave birth to 723 babies

Late Booking

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

All multiples 26.8%

Singleton rate 26.7%

Preterm birth

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

All multiples 64.4%

Singleton rate 6.34%

	24^{+0}–31^{+6} weeks	32^{+0}–33^{+6} weeks	34^{+0}–36^{+6} weeks
Twins	8.88%	8.74%	46.2%
Triplets/Quads	34.1%	39.9%	25.5%

Birthweight discordance

Twin baby pairs with a difference of 25% or more between birthweights and who were born at/after 36 weeks of gestation.

Twins 46.5%

Labour onset and Mode of birth

Vaginal birth without the use of instruments

Twins 13.3%

Singleton rate 49.4%

Vaginal birth with the use of instruments

Twins 4.55%

Singleton rate 11.1%

Unplanned caesarean birth

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

Twins 36.5%

Triplets/Quads 50.6%

Singleton rate 23.1%

Planned caesarean birth

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

Twins 42.9%

Triplets/Quads 48.1%

Singleton rate 16.4%

Induction of labour

Women and birthing people who had an induction of labour.

Twins 15.8%

Singleton rate 33.9%

Sequential Vaginal and Caesarean birth

Women and birthing people who gave birth to baby 1 vaginally, who then gave birth to baby 2 by caesarean.

Twins 12.0%

Vaginal Birth After Caesarean

Women and birthing people who gave birth to one or more of their babies vaginally, after having had a caesarean birth in their first pregnancy.

Twins 4.65%

Singleton rate 14.2%

Results at a glance

Perineal tears

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

Twins 1.04%

Singleton rate 3.29%

PPH ≥1500 ml

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

Twins 11.6%

Triplets/Quads 33.3%

Singleton rate 3.41%

Unplanned maternal readmission

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

Twins 5.20%

Singleton rate 3.08%

Episiotomy

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

Twins 21.3%

Singleton rate 24.4%

Episiotomy in sequential birth

Women and birthing people who gave birth vaginally to baby 1 and had an episiotomy, who then gave birth to baby 2 by caesarean.

Twins 15.7%

Measures of care for the newborn babies

Apgar score at 5 minutes

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

Twins 2.98%

Triplets/Quads*

Singleton rate 1.45%

* Poor data quality means the rate of having a 5-minute Apgar score of less than 7 is not available for triplets/quads.

Breast milk

Babies who received any breast milk at first feed.

Twins 58.5%

Triplets/Quads 50.0%

Singleton rate 71.7%

Skin-to-skin contact

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

Twins 42.4%

Triplets/Quads 20.0%

Singleton rate 73.4%

Find out more at:

www.maternityaudit.org.uk

Or scan the QR code to visit the website.

SCAN ME

Key messages and Recommendations

This report found it was possible to report the majority of the NMPA annual clinical report measures for multiple births. Although for many, the small number of triplet/quad births meant we could not report separate rates for twins and triplets/quads. This report includes results for one year of data however, in the future, combining data years to report a greater number of births may strengthen the meaning of the results, enhance interpretation and more accurately describe variation between countries. This could also allow publication of trust/board-level results for measures where the numbers are very small.

Timing of pregnancy booking

Just over one quarter of women and birthing people had their first appointment with a midwife (booking appointment) after 10 weeks of gestation. This rate was the same for those having a multiple birth as those having a singleton birth. While this is not unexpected because many women and birthing people will not be aware they are pregnant with more than one baby until their dating scan, some may know in advance due to contact with assisted reproduction care or early pregnancy services.

A late booking appointment may have ongoing consequences for the timing of the first scan, for the planning of care during pregnancy, and for labour and birth. Guidelines from NICE and the Royal College of Obstetricians and Gynaecologists (RCOG) state that chorionicity be determined must at the time of detecting a multiple birth on ultrasound scan.

Mode of birth

Mode of birth options differ for individual women and birthing people based on the number of babies and the arrangement of placentas and amniotic sacs, as well as if any other complications have occurred and their obstetric history. NICE and RCOG offer guidance on when and what type of birth should be offered based on these details. For example, NICE state that for uncomplicated DCDA and MCDA twins, vaginal birth and caesarean birth are safe options.

We found the rates for vaginal modes of birth for twins differed from singleton rates. Vaginal birth without the use of instruments was 13.3% for twins compared with 49.4% for singletons and vaginal birth with the use of instruments (forceps or ventouse suction cup) was 4.55% for twins, compared with 11.1% for singletons.

Caesarean birth rates also differed for multiples. For twins, the rate of planned (elective) caesarean birth was 42.9%, compared with 16.4% for singletons and the rate of unplanned (emergency) caesarean birth for twins was 36.5% compared to 23.1% for singletons. NICE guidance recommends offering a caesarean birth to women and birthing people who are pregnant with MCMA twins or with triplets. For triplets/quads, the planned (elective) caesarean rate was 48.1% and the rate of unplanned (emergency) caesarean birth was 50.6%. Despite the NMPA making a recommendation for including planned mode of birth as a mandatory data item, this is not recorded in the maternity datasets.

Of the women and birthing people who gave birth to baby 1 of twins, triplets or quads vaginally, 12.0% went on to give birth to baby 2 or more by caesarean. Of these, 1 in 6 (15%) had an episiotomy with their vaginal birth for baby 1 and went on to give birth to baby 2 or more by caesarean.

Postpartum haemorrhage

Rates of postpartum haemorrhage (PPH) ≥1500 ml were higher for mothers of twins (11.6%) and triplets/quads (33.3%) compared to singletons (3.4%). The chance of experiencing a postpartum haemorrhage may be increased for many reasons, including preeclampsia, giving birth by caesarean, induction of labour, long labour (> 12 hours), and having had a PPH in a previous pregnancy. Multiple births have a higher chance of bleeding following birth for reasons that include the extra stretching of the uterus (overdistension), a larger area of placenta within the uterus, and higher rates of preeclampsia and caesarean birth compared with singleton births.

NICE guidance recommends an assessment for potential postpartum blood loss be carried out antenatally, during labour and following birth, and that women and birthing people be offered active management of the third stage (the period between the birth of a baby/babies and delivery of the placenta). RCOG's guideline includes interventions to reduce the chance of bleeding following birth and where a bleed occurs, interventions to reduce the chance of blood loss volumes becoming a major PPH.

Recommendation 1

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 seek assurance that maternity providers' local policies, procedures and care planning for multiple births are aligned with relevant national guidance, including NICE guidance on twin and triplet pregnancy and RCOG guidance on the prevention and management of postpartum haemorrhage.

This assurance should confirm that multiple pregnancy is explicitly recognised as increasing the chance of experiencing a major postpartum haemorrhage and that local guidance supports appropriate care planning, preparedness and escalation to reduce the likelihood of anticipated blood loss progressing to major postpartum haemorrhage.

Preterm birth and care of the newborn babies

The majority of multiple births babies (64.4%) were born preterm before 37 weeks of gestation, this compares with 6.34% of singleton births. NICE offers guidance on timing of when to offer a planned birth based on the number of babies, chorionicity/amnionicity and any complications.

We divided preterm birth into gestational age categories for reporting and found that while almost half of twins (46.2%) were born late preterm between 34^{+0}–36^{+6} weeks of gestation, only a quarter of triplets/quads were born late preterm.

The majority of triplets/quads (39.9%) were born between 32^{+0}–33^{+6} weeks of gestation, with just over a third (34.2%) born earlier between 24^{+0}–31^{+6} weeks of gestation.

These higher rates of preterm birth may have contributed to a higher rate of twins having an Apgar score of less than 7 at 5 minutes (2.98%) compared with singletons (1.45%).

The Apgar score is a tool widely used to assess the condition of a baby at time intervals following birth, typically at 1, 5 and 10 minutes. A score of less than 7 at 5 minutes may be suggestive of a baby requiring additional support. Babies born preterm (before 37 completed weeks of gestation) may be assessed as having a 5-minute Apgar score of less than 7 due to their gestation at birth.

The number of triplets/more with an Apgar score <7 at 5 minutes was too small to report and in general, the data for 5-minute Apgar score for these babies appeared to be of poor quality.

While we were unable to report neonatal unit admission rates and therefore the potential impact of early family separation following birth, the rates of multiples receiving skin-to-skin were lower than singletons. Just under half (42.4%) of twin babies received skin-to-skin within one hour of birth, and only 1 in 5 (20.0%) triplets/quads, these compare with almost three quarters of singleton babies.

The rate of breast milk at first feed was also lower for twins (58.5%) and triplets/quads (50.5%) than singletons (71.7%). We have previously commented on the meaningfulness and accuracy of recording skin-to-skin and breast milk at first feed as measures of early postnatal care in our 2022 Clinical Report and 2023 State of the Nation reports and included recommendations in each of those reports.

Optimal fetal growth

A measure we report for singleton births is the proportion of babies with a birthweight below the 10th centile* who were born at or after their estimated due date (40 weeks of gestation). This measure of accurately identifying growth restricted babies and whether or not they received appropriate and timely care is not one we can report for babies of multiple births. This is because there is an absence of validated estimated fetal weight (EFW) centile charts and birthweight centile charts customised for multiple births babies, and there is research to suggest growth of twins differs by chorionicity, which is not sufficiently recorded in the maternity dataset.

There is invariably a difference in birthweight between each baby born from a multiple birth. For many this difference is small and may demonstrate normal patterns of fetal growth. However, an increase in the discordance between birthweights may increase the chance of adverse outcomes for babies of multiple births. RCOG and NICE guidance both recommend increased monitoring when there is a discordance of >20% between the EFW of twins, and referral to a specialist fetal medicine centre when there is a discordance of 25% or more. We found that almost half (46.5%) of twin baby pairs, where both twins were liveborn, had a difference between their birthweights of ≥25% and were born at or after 36 weeks of gestation. When there is growth restriction of one baby in a multiple birth, it is important to consider the impact on that baby of continuing the pregnancy with the effect an earlier birth may have on the other baby/babies.

There remains uncertainty about appropriate patterns of antenatal growth for multiple births, with the Global Twins and Multiples Priority Setting Partnership including 'optimal fetal growth' as one of their top 10 research priorities set in 2019. Published research suggests that singleton EFW centile charts, which are currently used by the majority of providers, over-estimate fetal growth restriction in twins by as much as 30%. While studies have been published that aim to produce EFW centiles customised for twins, either by chorionicity or by maternal characteristics, they are yet to be validated for use in clinical practice.

* using Cole et al, British 1990 growth reference centiles for weight, height, body mass index and head circumference fitted by maximum penalized likelihood. 1998. PMID: 9496720

Recommendation 2

NICE should review, and update where appropriate, the current methods used in clinical practice for monitoring adequate fetal growth in multiple births and the use of singleton estimated fetal weight centile charts.

Recommendation 3

The National Institute for Health and Care Research (NIHR) should review existing and emerging evidence for estimated fetal weight charts customised for multiple births and plan research to assess optimal fetal growth in multiple births and develop birthweight centile charts for multiple births babies.

Data quality and capture

Chorionicity

Determining chorionicity (the number of placentas and/or if any of the babies share a placenta) is essential to the planning of antenatal care and for decision-making around labour and birth.

NICE and the RCOG guidelines recommend that chorionicity is determined in the first trimester or before 14 weeks of gestation. Our previous multiple births report found chorionicity recording was not available in the national maternity datasets. While chorionicity is still not available as a standalone data field in maternity datasets for England, Scotland or Wales, the English national Digital Maternity Record Standard (DMRS) enables the recording of chorionicity, and the ability to record chorionicity using SNOMED CT concepts is in place. However, the DMRS does not mandate collection and in the 2023 maternity data, these codes were highly incomplete. We found fewer than 500 of 7 299 (6.8%) mother records in the English maternity dataset had a SNOMED CT code for chorionicity.

Recommendation 4

Improve the recording of chorionicity in the maternity datasets. This should include:

- NHS England# and the health departments in Devolved Governments must ensure the digital maternity record standards in England, Scotland and Wales are updated to include chorionicity as a mandatory item for multiple births.
- NHS England# should consider updating the Maternity Services Data Set (MSDS) to include chorionicity as a mandatory data item. NHS England# should include relevant SNOMED CT codes in the MSDS SNOMED CT Mapping.
- Maternity commissioners and regional maternity networks should encourage their constituent units to routinely record chorionicity for all multiple births, including through local data quality expectations, audit, and feedback mechanisms.
- Maternity commissioners and regional maternity networks should work with their constituent units to review local EPR configurations and clinical workflows to ensure chorionicity recording is clear and embedded into routine care.

NHS England or succeeding responsible organisation in England.

Assisted conception

Information on assisted conception is not available in the national maternity datasets. With the aim of minimising multiples births following assisted conception, a NICE quality standard offers guidance on the number of embryos transferred based on the age of the woman or person intending to become pregnant (or the egg donor if applicable), the stage of assisted conception (cycle number) and the quality of the embryos. The standard advises no more than 2 embryos be transferred under any circumstances.

Despite a drop in the rate of multiple births following assisted conception from 22% to 3% between 2003 and 2023, the rate of all multiple births across Great Britain remained largely unchanged (1.35–1.64%). As the UK regulator the HFEA oversee treatment by licensed fertility clinics in the UK, and while so-called "fertility tourism" is not unique to the UK, the NHS may provide care for women and birthing people who have become pregnant in regions where legislation and quality assurance differ.

Recommendation 5

NHS England# and the health departments in Devolved Governments should ensure the digital maternity record standards in England, Scotland and Wales are updated to include assisted conception as a mandatory item.

NHS England or succeeding responsible organisation in England.

Births that occur as a result of assisted conception may have a higher rate of complications, such as pregnancy induced high blood pressure, preeclampsia, and gestational diabetes. These rates may be higher for multiple births that occur from assisted conception, and can also include preterm prelabour rupture of membranes (PPROM), infection including chorioamnionitis, postpartum haemorrhage, and requiring a blood transfusion, as well as an increase in fetal complications and babies requiring neonatal care. The recording of method of conception, especially for multiple births, would assist in care planning and decision-making for pregnancy, labour and birth.

Acknowledgements

This report was prepared by the NMPA Project Team:

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

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

www.maternityaudit.org.uk

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

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