



## National Maternity & Perinatal Audit

### State of the Nation

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

Published August 2026



# 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 in their decision-making.

## How to use this report

This State of the Nation report presents the audit's key findings and recommendations for singleton births in 2024. Previous reports and results, including the newly published annual clinical results for births that occurred between 2020–2022, can be found on our [website](#).

We also have a range of additional supporting resources available online:

- › [NMPA online](#) results at trust/board level.
- › [Methods](#) outlining the datasets used and how the analysis for this report was carried out.
- › A [measures technical specifications](#) document describing how the measures were constructed.
- › [Summary results tables](#) with results displayed by country.
- › A [glossary](#) explaining all the terminology and abbreviations used in our reports.
- › A [line-of-sight table](#) describing the evidence base for the recommendations in this report.
- › [Quality Improvement](#) (QI) resources.
- › [Data completeness](#) by trust and board.

The results can be used to benchmark against national standards and recommendations where these exist, and to identify good practice among maternity care providers 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.

Where 'NHS England' appears, this refers to NHS England or the succeeding responsible organisation in England.

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Further information about maternity and perinatal services is available from [Mothers and Babies: Reducing Risk through Audits and Confidential Enquires across the UK](#) (MBRRACE-UK); results of care processes and outcomes for babies who are admitted to neonatal services are available from the [National Neonatal Audit Programme](#) (NNAP).

The [Care Quality Commission](#) works to inspect, monitor and rate healthcare services and publish reports of national reviews of maternity services and individual provider inspections.

There is no routine linkage between maternity data and the mental health datasets. The [Maternal Mental Health Alliance](#) provide information and resources for perinatal mental health.

Evidence reviewed from 12 English NHS trusts as part of the [National Maternity and Neonatal Investigation](#) led to recommendations in the final report that are based on themes including women and birthing people not being listened to, reports of discrimination and issues with service provision, estates and staffing.

## What is 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.

The factors we include in the case-mix adjustment have changed from our previous report. More information about this change and the individual factors that are included in the case-mix adjustment can be found in the [methods](#) and [measures technical specification documents](#) online.

# Summary characteristics of women and birthing people by country



## GREAT BRITAIN

This report includes data for 593 475 women and birthing people who gave birth to a singleton baby in 2024



## ENGLAND

523 051 women and birthing people gave birth across 120 trusts



## SCOTLAND

44 651 women and birthing people gave birth across 14 boards



## WALES

25 773 women and birthing people gave birth across 7 health boards

Table 1 shows the characteristics of 593 475 women and birthing people who gave birth in 2024. More comprehensive results showing the characteristics of those who gave birth are presented in the [summary results tables](#).

Compared with 2023, there was a small decrease in the proportion of white women and birthing people who gave birth and a small increase in the proportion of those from Asian and Black ethnic groups.

Since the report on births in 2023, there have been improvements in the data completeness of smoking status and Body Mass Index (BMI) at booking. This has enabled the NMPA to use these data items for the first time in several years.

In 2024, BMI at booking was recorded for 82.2% of women and birthing people (compared with 71.6% in 2023). Of those who gave birth in 2024, just over one quarter (26.7%) had a BMI of 30kg/m<sup>2</sup> or more; this was similar to the 2023 rate of 26.5%. More information about the care and outcomes for women and birthing people with a BMI ≥30kg/m<sup>2</sup> can be found in the NMPA [sprint audit report](#).

**Table 1:** Characteristics of women and birthing people who gave birth in 2024, by country

| Characteristic                                      |                    | England |        | Scotland |        | Wales  |        | Total (GB) |       |
|-----------------------------------------------------|--------------------|---------|--------|----------|--------|--------|--------|------------|-------|
|                                                     |                    | n       | %      | n        | %      | n      | %      | n          | %     |
| Total number of women and birthing people           |                    | 523 051 |        | 44 651   |        | 25 773 |        | 593 475    |       |
| Age (years)                                         | <20                | 11 780  | 2.3    | 1 062    | 2.5    | 795    | 3.1    | 13 637     | 2.3   |
|                                                     | 20–24              | 59 263  | 11.3   | 4 832    | 11.3   | 3 609  | 14.0   | 67 704     | 11.4  |
|                                                     | 25–29              | 134 663 | 25.7   | 10 872   | 25.4   | 7 165  | 27.8   | 152 700    | 25.8  |
|                                                     | 30–34              | 182 961 | 35.0   | 15 187   | 35.5   | 8 710  | 33.8   | 206 858    | 35.0  |
|                                                     | 35–39              | 108 337 | 20.7   | 8 695    | 20.4   | 4 531  | 17.6   | 121 563    | 20.6  |
|                                                     | 40–44              | 24 058  | 4.6    | 1 954    | 4.6    | 880    | 3.4    | 26 892     | 4.5   |
|                                                     | ≥45                | 1 988   | 0.4    | 119      | 0.3    | 75     | 0.3    | 2 182      | 0.4   |
| Missing (% of total)                                |                    | 1       | (<0.1) | 1 930    | (4.3)  | 8      | (<0.1) | 1 939      | (0.3) |
| Ethnic group                                        | White              | 348 862 | 68.0   | 32 953   | 85.7   | 20 046 | 83.9   | 401 861    | 69.9  |
|                                                     | Asian              | 93 342  | 18.2   | 2 701    | 7.0    | 1 454  | 6.1    | 97 497     | 17.0  |
|                                                     | Black              | 36 572  | 7.1    | 1 342    | 3.5    | 689    | 2.9    | 38 603     | 6.7   |
|                                                     | Mixed              | 16 600  | 3.2    | 601      | 1.6    | 1 436  | 6.0    | 18 637     | 3.2   |
|                                                     | Other              | 17 314  | 3.4    | 867      | 2.3    | 259    | 1.1    | 18 440     | 3.2   |
| Missing (% of total)                                |                    | 10 361  | (2.0)  | 6 187    | (13.9) | 1 889  | (7.3)  | 18 437     | (3.1) |
| Index of Multiple Deprivation quintile <sup>a</sup> | 1 = least deprived | 82 406  | 15.8   | 7 156    | 16.1   | 4 214  | 16.6   | 93 776     | 15.9  |
|                                                     | 2                  | 90 709  | 17.4   | 9 038    | 20.3   | 4 495  | 17.7   | 104 242    | 17.7  |
|                                                     | 3                  | 99 628  | 19.2   | 8 173    | 18.4   | 4 975  | 19.5   | 112 776    | 19.1  |
|                                                     | 4                  | 115 461 | 22.2   | 9 363    | 21.0   | 5 319  | 20.9   | 130 143    | 22.1  |
|                                                     | 5 = most deprived  | 131 757 | 25.3   | 10 752   | 24.2   | 6 449  | 25.3   | 148 958    | 25.3  |
| Missing (% of total)                                |                    | 3 090   | (0.6)  | 169      | (0.4)  | 321    | (1.2)  | 3 580      | (0.6) |

<sup>a</sup> The official measure of relative deprivation is based on an individual's Lower layer Super Output Area (LSOA) in England (Index of Multiple Deprivation (IMD)) and Wales (Welsh Index of Multiple Deprivation (WIMD)), and on Data Zone in Scotland (Scottish Index of Multiple Deprivation (SIMD)). However, the indices are different between the countries and they are not directly comparable.

# Results at a glance

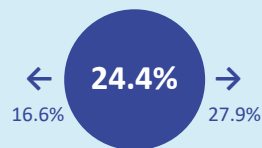
The National Maternity and Perinatal Audit (NMPA) uses information collected routinely as part of NHS maternity care, combined with information collected when women and birthing people and their babies are admitted to hospital, to report on a range of care process and outcome measures. Summarised here are results based on NMPA data relating to singleton births in the NHS in 2024.

The average rate for NHS maternity care providers across Great Britain appears in the blue circle, while the blue arrows present lower and upper rates for the middle half (interquartile range) of maternity care providers. A full description of the measures along with results for each country can be found in the [summary results tables](#).

More information about the NMPA and trust/board-level results can be found [online](#).

## Late booking

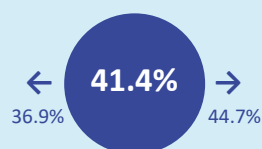
Women and birthing people who attended their first (booking) appointment with a midwife after 10<sup>th</sup> weeks of gestation.



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

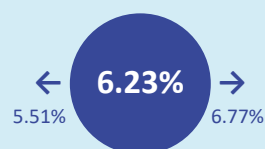
## Small for gestational age

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



## Preterm birth

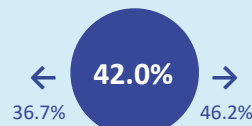
Women and birthing people whose baby was born preterm between 24<sup>th</sup> and 36<sup>th</sup> weeks.



Of those, the proportion whose birth is recorded as:

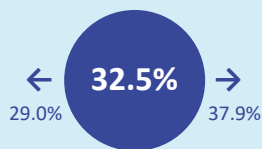
Spontaneous

Clinician Recommended (iatrogenic)



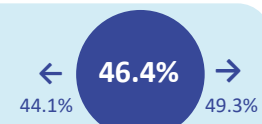
## Induction of labour

Women and birthing people who had an induction of labour.



## Mode of birth

### Vaginal birth without the use of instruments

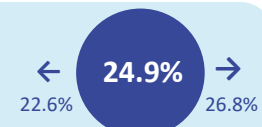


### Vaginal birth with the use of instruments



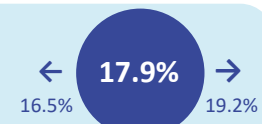
### Unplanned caesarean birth

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



### Planned caesarean birth

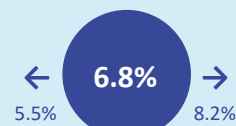
Women and birthing people who had a caesarean birth that was planned.



### Vaginal birth with the use of instruments, by type

Vaginal birth with the use of forceps

Vaginal birth with the use of ventouse



### 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.



\* Vaginal birth after a caesarean (VBAC) applies to the birth of any baby born vaginally after a mother has had a caesarean in any previous pregnancy. Due to availability of the data, the NMPA measure definition reports VBAC for women and birthing people giving birth to their second baby vaginally after having had a caesarean birth for their first baby.



# 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:

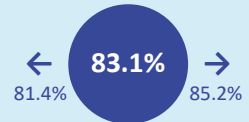
**Robson Group 1:** Nulliparous, single cephalic pregnancy,  $\geq 37$  weeks gestation, in spontaneous labour.



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



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



### Perineal tears

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



### Episiotomy

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



### PPH $\geq 1500$ ml

Women and birthing people who had a postpartum haemorrhage of  $\geq 1500$  ml.



### Unplanned maternal readmission

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



## Measures of care for the newborn baby

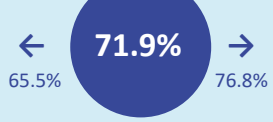
### Apgar score at 5 minutes

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



### Breast milk

Babies who received any breast milk at first feed.



### Skin-to-skin contact

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



Find out more at:

[www.maternityaudit.org.uk](http://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

Of 593 475 women and birthing people who gave birth across Great Britain (GB) to a singleton baby in 2024, just under a quarter (24.4%) had their first (booking) appointment with a midwife after 10 weeks of gestation. The rates of pregnancy booking after 10 weeks of gestation varied between countries (Figure 1); there was a decrease in England from 26.5% in 2023, while the rates increased from 32.8% in Scotland and 21.3% in Wales.

The observed variation between individual trusts and boards (interquartile range (IQR); 16.6–27.9%) may indicate differences in service provision and the local communities served by each trust/board. There may also be differences in the local information that is available to women and birthing people about when they should first be seen by a midwife.

The National Institute of Health and Care Excellence (NICE) [Antenatal Care](#) guideline recommends a booking appointment take place by 10 weeks of gestation to facilitate a timely dating scan between 11–14 weeks of gestation. A late dating scan reduces the accuracy of fetal anomaly screening and calculating an estimated due date, both of which may impact the care and options available during pregnancy, labour and birth. A number of factors may [contribute to late pregnancy booking](#), including access to midwifery care, the availability of clear and accessible information about the importance of timely booking, and individual factors such as maternal age, ethnicity, socioeconomic deprivation, language barriers and previous experience of maternity care.

NHS England has made it possible for pregnant women and people in England to [directly refer themselves for NHS maternity care](#) without having to go through their general practitioner (GP), and many trusts/boards across England, Scotland and Wales also offer an [option for self-referral](#). However, conflicting information remains available, with some publicly available resources indicating that booking can take place between 8–12 weeks.

## Maternal characteristics that may affect the timing of pregnancy booking

To explore the effect of maternal characteristics on booking after 10 weeks of gestation, we divided the results by ethnic group, Index of Multiple Deprivation (IMD) quintile and according to whether a woman or birthing person was giving birth for the first-time or had previously given birth (parity). The results presented in this section are crude, meaning they have not undergone case-mix adjustment (see [‘what is case-mix adjustment?’](#)).

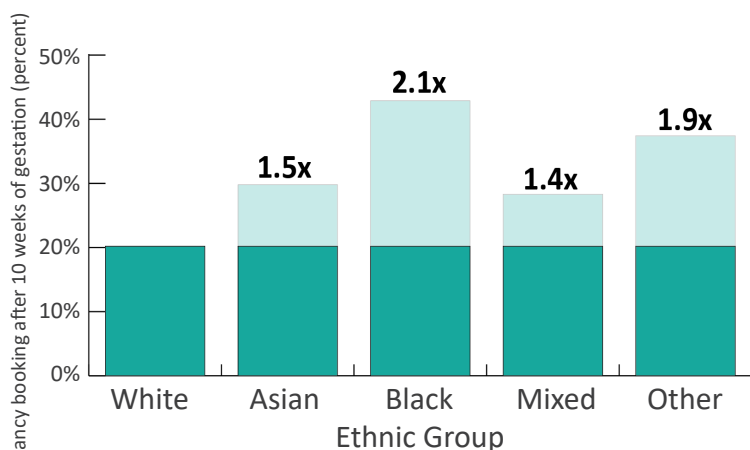


Figure 2: Difference between rates of pregnancy booking after 10 weeks of gestation by ethnic group across Great Britain

Across Great Britain, the rate of Black women and birthing people booking after 10 weeks of gestation was 2.1 times that of white women and birthing people, the rate for those from an Asian ethnic group was 1.5 times (Figure 2). Similar patterns were seen across country-level data for England, Scotland and Wales.

Barriers to pregnancy booking are often multiple, complex and overlapping. The challenges of inequalities, socioeconomic deprivation, ethnicity, language and communication barriers, social and partner support, and education, as well as fear of judgement from healthcare providers can all [contribute to reduced engagement](#) with healthcare and maternity services.

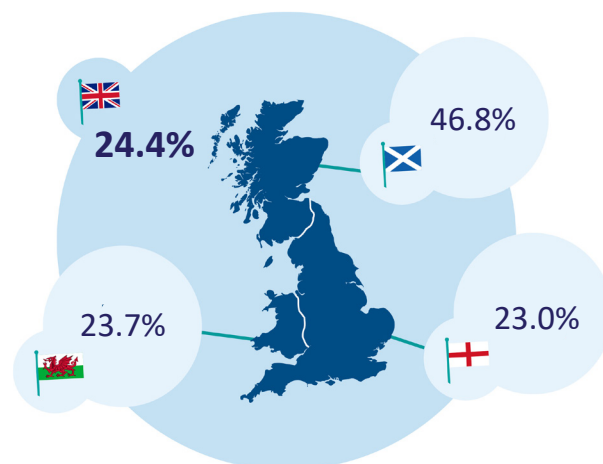


Figure 1: Rates of pregnancy booking after 10 weeks of gestation by country

Strategies for community engagement to understand and overcome barriers to accessing healthcare are included in NHS England’s [Neighbourhood health guidelines 2025/26](#) and [Core20PLUS5](#) approach to reducing healthcare inequalities, as well as in Public Health Wales’ [Improving Together for Wales](#), and [Scotland’s Population Health Framework 2025–2035](#) published by the Scottish Government.

The results in Figures 3 and 4 are presented as bar charts with a 95% confidence interval. A confidence interval is used to display the degree of accuracy of a result; the smaller the grey bar, the greater the level of certainty in the result.

Across England, Scotland and Wales, the rate of booking after 10 weeks of gestation was lower for white women and birthing people than for any other ethnic group (Figure 3). The highest rates were for Black women and birthing people across all three countries.

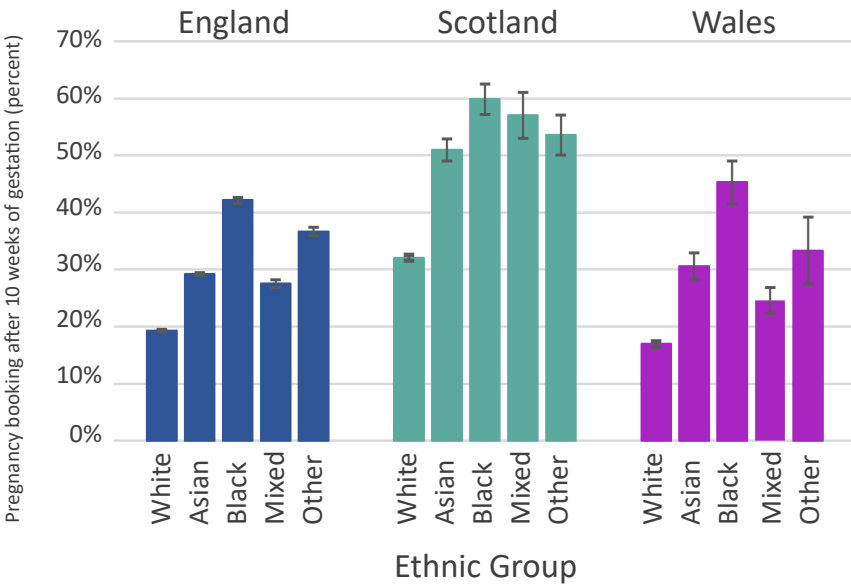
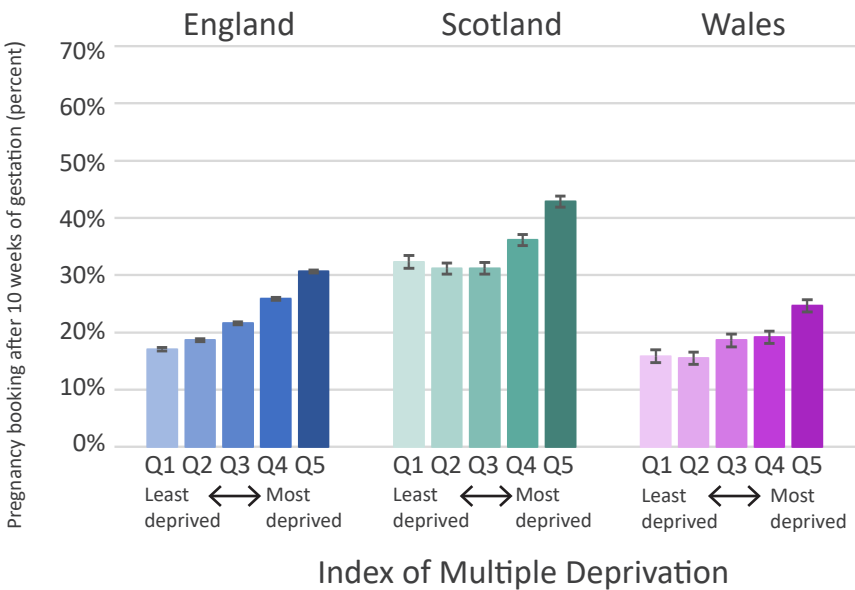


Figure 3: Rates of pregnancy booking after 10 weeks of gestation by ethnic group and by country



The rate of booking after 10 weeks of gestation across England, Scotland and Wales was higher for those from the most deprived IMD quintile (Q5), compared to the least deprived (Q1) (Figure 4).

The rate of pregnancy booking after 10 weeks of gestation was higher for those who had given birth before (26.3%) compared to those who were having a baby for the first time (22.0%). This pattern was repeated across England, Scotland and Wales.

Figure 4: Rates of pregnancy booking after 10 weeks of gestation by IMD quintile and by country

In our [SON report on 2023 data](#), where we published overall GB and country-level results, we targeted one of our recommendations at the Government health departments to work with stakeholders in developing national and local-level initiatives and campaigns to improve rates of timely pregnancy booking. In this report, we present the results by ethnic group and IMD. These maternal characteristics are different for the different populations served by individual trusts and boards.

### Recommendation 1

Commissioners of maternity care and local maternity networks should work with their constituent units and local community stakeholders to determine the barriers to booking before 10 weeks of gestation. Local level initiatives and campaigns targeted at improving rates of timely pregnancy booking should be co-designed with groups and communities most likely to receive care after 10 weeks to ensure their needs are met.

**ACTION:** Commissioners of maternity care in England, Scotland and Wales (e.g., Integrated Care Boards (ICBs), Scottish Government and Welsh Health Boards) and local maternity networks (ICBs, or English local maternity networks where these exist, the Scottish Perinatal Network, and the Wales Maternity and Neonatal Network)



## Mode of birth

In 2023, we reported that just under half (49.4%) of women and birthing people gave birth vaginally without the use of instruments (forceps or ventouse). The rate has steadily declined over the years from 62.3% in our first report on births occurring in 2015/16 to 46.4% in 2024. Rates of both planned and unplanned caesarean birth have risen across the same period (Figure 5).

Of the women and birthing people giving birth for the first time following a spontaneous labour (Robson Group 1), the rate who gave birth by caesarean was slightly higher in 2024 at 19.9% compared with the 2023 rate of 18.0%. Of those giving birth for the first time following an induction of labour or by caesarean before labour (Robson Group 2), the rate who gave birth by caesarean was 60.5% in 2024 compared with 56.0% in 2023. Of the women and birthing people who had previously given birth by caesarean (Robson Group 5), the rate of giving birth by caesarean again was 83.1% in 2024 compared with 81.8% in 2023.

Vaginal birth after a caesarean (VBAC) applies to the birth of any baby born vaginally after a mother has had a caesarean in any previous pregnancy. Due to availability of the data, the NMPA measure definition reports VBAC for women and birthing people giving birth to their second baby vaginally after having had a caesarean birth for their first baby; the rate of VBAC for these mothers decreased from 24.9% in 2015/16 to 13.7% in 2024.

The rate of those having an induction of labour has remained around 1 in 3. In 2025, we published a [snapshot audit on induction of labour](#) that showed variation in induction of labour rates between maternity care providers, as well as variation in the outcomes following an induction. In that report, we presented results on the maternal characteristics that may affect the mode of birth or a baby's 5-minute Apgar score following induction.

These changing trends in mode of birth place increased demands on the maternity services workforce (midwifery, obstetric, theatre and anaesthetic staffing groups) and resources, such as theatres and postnatal ward bed availability. The [Independent Investigation into Maternity and Neonatal Services in England - Final report and recommendations](#), [The path to safer beginnings in Wales: A national assurance assessment of Maternity and Neonatal care and services](#), and the planned [independent review of maternity services in Scotland](#) focus on the effect of the changing trends in maternity care and how these impact service capacity, the quality of estates and workforce. An increase in interventions may also [impact postpartum recovery](#) for women and birthing people.

In our [SON report on 2023 data](#) we targeted a recommendation at those who fund and commission maternity services to provide adequate resources.

*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.*

While this recommendation continues to be relevant, responding to the changing trends applies to all those who fund, commission, plan and provide maternity services.

## Recommendation 2

Maternity networks should work with their constituent units using local trends in maternal characteristics and mode of birth to target adequate allocation of resources, such as obstetric theatres and workforce.

**ACTION:** Local maternity networks (e.g., Integrated Care Boards (ICBs), English local maternity networks where these exist, the Scottish Perinatal Network, and the Wales Maternity and Neonatal Network)

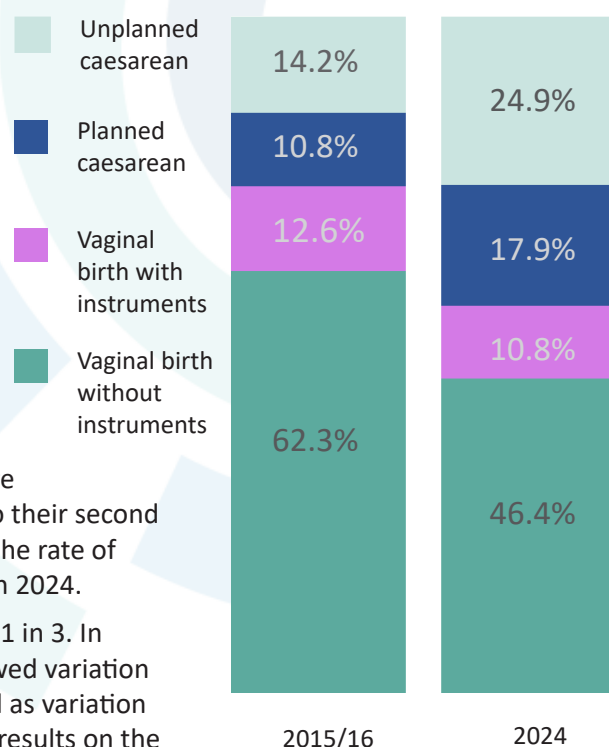


Figure 5: Change in rates of mode of birth between 2015/16 and 2024





## Variation in practice and outcomes

The changing trends in mode of birth may potentially be explained by changes in clinical practice, such as improvements in fetal monitoring and the way in which women and birthing people are supported in their choices for how, when and where to give birth. While we can report the rates of mode of birth and interventions, such as induction of labour, the reasons that underpin the decision-making are not currently recorded in the maternity datasets. We are unable to report the indication for an induction of labour nor the reasons for a caesarean birth or clinician recommended (iatrogenic) birth, as this information is not captured in the national maternity datasets, despite it often being recorded in the local hospital records.

In 2024, 6.23% of babies were born preterm (before 37 weeks of gestation). The rate was higher in Scotland (7.25%) than in England (6.15%) and Wales (6.24%). The results show an increase in the rate of preterm birth in Scotland compared with 2023 (6.87%) and a small decrease in the rates for England (6.28%) and Wales (6.52%). There were also differences in the rates of preterm birth following a spontaneous labour onset compared with clinician recommended (iatrogenic) preterm birth rates. In England and Wales, the rates of preterm birth following spontaneous labour were 40.2% and 44.2% respectively, and rates of preterm birth that were clinician recommended (iatrogenic) were 59.8% and 55.6% respectively. In Scotland, the rate of preterm birth following spontaneous labour was 59.6% and 40.2% were clinician recommended. The [method used to determine spontaneous versus clinician recommended labour onset](#) for preterm births is slightly different in Scotland compared with England and Wales, which may explain the difference in rates between the countries. Starting with 2024 births, the NMPA has amended the method used for Scottish data when reporting preterm birth rates.

The rate of third- and fourth-degree perineal tears, also known as Obstetric Anal Sphincter Injury (OASI), was higher in Scotland (4.29%) and lower in Wales (2.89%) than in England (3.45%). The first phase of the [OASI care bundle 'OASI1'](#) was implemented in 16 maternity units across England, Scotland and Wales; [OASI2](#) took place in 10 of the original 16 plus an additional 19 maternity units. The [bundle](#) aims to reduce the chance of a third- or fourth-degree perineal tear by providing pregnant women and people with information about perineal tears, performing an episiotomy when indicated, performing manual perineal protection and performing appropriate examinations following birth to assess the degree of tear. Experiencing a third- or fourth-degree perineal tear can have [significant and long-lasting](#) effects for women and birthing people. Both the NMPA and the [NHS England maternity dashboard](#) use the Maternity Services Data Set version 2.0 (MSDS v2.0). However, differences between third- and fourth-degree perineal tear rates for England published in our report and those published on the dashboard may be because we use linked maternity (MSDS v2.0) and administrative hospital ([Hospital Episode Statistics Admitted Patient Care](#)) datasets, details of which can be found in our [measures technical specification](#).

Rates of an Apgar score of less than 7 at 5 minutes were similar in 2024 (1.53%) to those that we reported for 2023 (1.45%). The rate remained slightly higher in Scotland (2.22%) compared to England (1.48%) and Wales (1.43%). 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) outlined the challenges in Apgar scoring for ethnic minority babies. The report describes the difficulties in determining if a baby is getting enough oxygen based on assessing their 'appearance', because current guidance does not take ethnicity and race into consideration. The report sets out clear recommendations for policy updates, areas for targeted research and improved education and training, that includes the use of a pulse oximeter to measure oxygen levels. 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, such as timing and mode of birth.

## Recommendation 3

Update the digital maternity standards\* in England, Scotland and Wales to include mandatory data capture on the indication for interventions, and where applicable, the method and timing for induction of labour.

ACTION: Digital teams in NHS England, Public Health Scotland, and Digital Health and Care Wales

\*Digital Maternity Record Standard in England, the Maternity Data Record Standard in Wales and SMR Input Record in Scotland



## Small for Gestational Age Babies

Across Great Britain, the rate of babies born small for gestational age (SGA), defined as a birthweight less than the [10th centile](#), who were born at or after their estimated due date (40 weeks of gestation) has decreased since our first report on 2015/16 data; when more than half (55.4%) were born at/after 40 weeks. In 2024, the GB rate was 41.4%.

While the rates of SGA babies born at/after 40 weeks decreased across all three countries between 2015/16 and 2023, they remained higher in Wales than in England and Scotland. The rates decreased further in England and Wales between 2023 (England 42.2%; Wales 51.7%) and 2024 (England 40.8%; Wales 49.7%), however there was an increase in the rate in Scotland from 41.7% in 2023, to 45.7% in 2024.

The overall reduction may be the result of enhanced antenatal monitoring, diagnostic pathways and the impact of national initiatives such as the first NHS England [Saving Babies Lives Care Bundle](#) published in 2016 and more [recent versions](#). Although we are not aware of equivalent resources available in Scotland or Wales.

When there is concern about the growth of a fetus, the [International Society of Ultrasound in Obstetrics and Gynecology](#) (ISUOG), [Royal College of Obstetricians and Gynaecologists](#) (RCOG), and [Wales Maternity and Neonatal Network](#) provide guidance on additional monitoring during pregnancy and planning for labour and birth. These include recommendations for when a growth restricted baby should be born before their estimated due date to reduce the chance of stillbirth, as well as short- and long-term adverse outcomes following birth. The guidance also takes into consideration maternal characteristics, pre-pregnancy conditions, current pregnancy conditions and the type of growth restriction.

### Recommendation 4

Commissioners of maternity care and local maternity networks should work with their constituent units to use their local rate of small for gestational age births to:

- Review their policies and protocols that support detection, monitoring and intervention when there are concerns about fetal growth.
- Promote shared learning between units, networks and countries to continue the improvement in rates.

**ACTION:** Commissioners of maternity care in England, Scotland and Wales (e.g., Integrated Care Boards (ICBs), Scottish Government, and Welsh Health Boards) and local maternity networks (ICBs, or English local maternity networks where these exist, the Scottish Perinatal Network, and the Wales Maternity and Neonatal Network)



To determine if appropriate care was offered, we divided the results of babies born SGA into those born at/after their due date (40 weeks) and those born early term before their due date (37–39 weeks), and whether their birth was following a spontaneous labour onset or was clinician recommended (iatrogenic).

Across Great Britain, the rate of babies born SGA at/after 40 weeks following a spontaneous labour onset was 50.0%, and 50.0% were born following a birth that was clinician recommended. The rates were very similar across all three countries.

For those born between 37–39 weeks of gestation, the rates of SGA babies born following a spontaneous labour onset compared with a clinician recommended labour onset were different between the countries (Figure 6).



## Rates of babies born SGA between 37–39 weeks of gestation

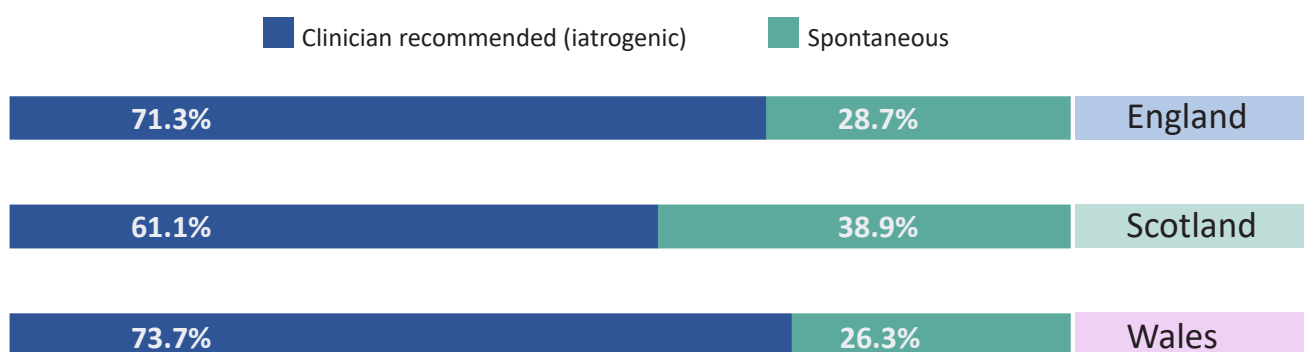


Figure 6: Rates of babies born SGA between 37–39 weeks by spontaneous or iatrogenic birth and by country

The rates for clinician recommended (iatrogenic) birth for babies born 37–39 weeks whose birthweight was less than 10th centile were similar for England and Wales, and lower for Scotland (Figure 6). However, without information on the indication for iatrogenic birth, we are unable to report if birth was recommended due to concerns about fetal growth or for some other reason. The rates of birth following a spontaneous labour onset for SGA babies born 37–39 weeks were similar for England and Wales, for Scotland the rate was higher.

A baby born SGA at/after 40 weeks may suggest that growth restriction during pregnancy was not identified or that decision-making for the timing of birth was not in line with recommendations in the national guidelines.

### Data quality and capture

A postpartum haemorrhage (PPH) of 1500 ml or more was experienced by 3.50% of women and birthing people. We previously reported that a number of units appeared to report only high-volume blood loss; without the lower volumes also being recorded, we are unable to accurately calculate results of PPH  $\geq 1500$  ml for these units. PPH results are reported for all but one Welsh health board and for 85/120 English trusts.

The NHS England [Maternity Care Bundle](#) published in January 2026 outlines techniques to accurately measure blood loss volumes and guidance for when to involve more experienced colleagues. [Guidance on the management of PPH](#) provided by Healthcare Improvement Scotland includes measuring and recording of blood loss volumes as part of the [Scottish Patient Safety Programme](#). While this information is available to individual NHS boards in Scotland, PPH data is not currently captured in the Scottish maternity dataset and therefore, not available to the NMPA. Public Health Scotland have plans to [expand the data that is available for mothers, births and babies](#) which we understand will include blood loss volumes.



In our [SON report on 2023 data](#) we targeted a recommendation at the digital teams within the Government health departments to review the data definitions and descriptions within the digital maternity record standards for each country, with the purpose of improving data quality and capture for blood loss volumes, skin-to-skin following birth and breast milk feeding. Since then, the [Maternity Care Bundle](#) has been published but applies only to NHS trusts in England. Therefore, our new recommendation aims to improve the quality and availability of blood loss volumes to allow the NMPA to report PPH  $\geq 1500$  ml across all three countries.

## Recommendation 5

Commissioners of maternity care and local maternity networks should work with their constituent units to objectively measure and record all volumes of blood loss during labour and birth.

**ACTION:** Commissioners of maternity care in England, Scotland and Wales (e.g., Integrated Care Boards (ICBs), Scottish Government, and Welsh Health Boards) and local maternity networks (ICBs, or English local maternity networks where these exist, the Scottish Perinatal Network, and the Wales Maternity and Neonatal Network)



## Acknowledgements

This report was prepared by the NMPA Project Team:

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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](http://www.maternityaudit.org.uk)

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