



National Neonatal Audit Programme

A guide to the 2026 audit measures

October 2026

National Neonatal Audit Programme (NNAP): A guide to the 2026 audit measures

The NNAP is run by the Royal College of Paediatrics and Child Health (RCPCH) and commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). More information about the Programme can be found at: www.rcpch.ac.uk/nnap

This document sets out the details of the 2026 NNAP audit measures and describes the following details for each measure:

- NNAP audit measure
- Changes to the audit measure for 2025 data
- NNAP standard and source of standard
- Inclusion criteria
- Attributing results
- Deriving outcomes
- Where the required data should be entered on BadgerNet

Version control table

Version	Publication date	Comments
V1.0	February 2026	Version 1.0 published Additional guidance added on excluding transitional care cots for the "Nurse Staffing on Neonatal Units" measure.
V1.1	April 2026	Additions made to <i>Appendix 1: "Pathogens" in the NNAP</i> .
V1.2	August 2026	Addition made to the " <i>Parental inclusion in consultant lead ward rounds</i> " measure stating that digital presence on ward rounds is accepted and counts as "Parent Present" for this measure. Breastmilk feeding composite removed from measures guide as the NNAP no longer reports this.
V1.3	October 2026	Update to <i>Important note: Entering cranial ultrasound scans on BadgerNet</i> in sections 3.4, 3.5 and 3.6. Updates to measures subject to outlier identification and management. Updates to developmental standards for <i>Deferred cord clamping</i> and <i>Breastmilk feeding in the first 2 days of life</i> .

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About the NNAP dataset and methodology

The RCPCH receives the data contained in the NNAP dataset directly from System C, provider of the BadgerNet clinical system. The NNAP team processes data that is required solely for care quality and service improvement in relation to the aims and scope of the NNAP. Neonatal unit staff enter data onto the BadgerNet platform as part of routine care whilst a baby is present on the neonatal unit and this data is stored by System C. Data items contained within the NNAP dataset are synchronised to an NNAP database hosted by the RCPCH. Patient identifiable data is pseudonymised before analysis is conducted by the NNAP team. The RCPCH has approval to receive patient identifiable data without consent for England and Wales under Healthcare Research Authority (HRA) Confidentiality Advisory Group (CAG) Section 251 support (ref: 21/CAG/0007), for Scotland under the Health and Social Care Public Benefit and Privacy Panel (HSC-PBPP) support (ref: 2122-0254), and for the Isle of Man as approved by the Isle of Man Dept. of Health and Social Care and Information Commissioner.

NNAP data dictionary

The NNAP dataset is defined in the NNAP data dictionary, the most recent version is available at: <https://www.rcpch.ac.uk/work-we-do/clinical-audits/nap/measures#data-dictionary>

Inclusion criteria

The following inclusion criteria apply to all NNAP measures:

- Babies who were admitted to a neonatal unit for neonatal care (not including babies that only had transitional care, observational or postnatal ward care)
- Babies born at a gestational age of 22 weeks or more
- Babies who had care provided by an NNAP unit
- Babies whose parents or carers have not opted them out of secondary use of their data for the purpose of the NNAP*

Further criteria specific to each audit measure can be found in the measure descriptions.

** The [National Data Opt Out](https://www.rcpch.ac.uk/resources/national-neonatal-audit-programme-privacy-notice-your-babys-information) (which allows patients in England to opt out of their information being used for purposes beyond their direct care) does not apply to the National Neonatal Audit Programme. This is because applying the National Data Opt Out would introduce biases to the data and jeopardise patient safety. A patient can still be opted out from the NNAP via a project specific mechanism. For more information, please see: <https://www.rcpch.ac.uk/resources/national-neonatal-audit-programme-privacy-notice-your-babys-information>*

Case ascertainment

In usual practice, every baby admitted to a participating neonatal unit is entered on the BadgerNet patient record system and is eligible for inclusion in the NNAP; the audit therefore expects to achieve 100% case ascertainment in the participating organisations, excluding babies whose parents have chosen to opt them out of secondary use of their data for the purposes of the NNAP. Babies receiving special care in transitional care areas or postnatal wards can also be entered, but it is known that some units do not enter data for such babies and for this reason measures exclude babies who do not spend any time on a neonatal unit.

Data collection period

The cohort of babies included in the 2026 audit year are babies who are either born, experience their first neonatal admission, final neonatal discharge or turn 44 weeks' post menstrual age (PMA) in the calendar year 1 January 2026 to 31 December 2026, depending on the measure. The exception to this is the dataset used for two-year follow-up, the cohorts for which are set out in the measure description.

Describing gestational age

Gestation refers to "completed weeks" of gestation, based on the best available estimate recorded by clinical staff in BadgerNet. Gestation is typically described in bands – where we refer to all babies born at less than 32 weeks, we mean all babies with a gestation at birth of up to 31 weeks and six days inclusive. Where we refer to 23-33 weeks inclusive, we mean to include all babies with a gestation at birth of 23 weeks and 0 days to babies with a gestation at birth of 33 weeks and 6 days.

Two measures of age are used within the NNAP audit, corrected age and post-menstrual age. When describing post-menstrual age of babies, we mean the chronological age of the baby plus gestation at birth. Corrected age of babies is defined as chronological age minus prematurity at birth. For example, a baby born at 32⁺⁰ weeks' gestational age is 8 weeks premature, at 9 weeks of life, this baby would have a post-menstrual age of 41 weeks and a corrected age of 1 week post term.

1 Mortality to discharge in very preterm babies

Does a baby born between 24 weeks' and 31 weeks' gestational age inclusive die before discharge home, or 44 weeks' post-menstrual age (whichever occurs sooner)?

Change to the audit measure for 2026 data year: None.

NNAP standard

Developmental standard: None

Outlier identification: Yes, at network level.

Outlier management: No

Inclusion criteria

Number of babies admitted to a neonatal unit whose birth gestation was 24 to 31 weeks' inclusive (22 weeks and 23 weeks for additional reporting).

Denominator: Number of babies admitted to a neonatal unit whose birth gestation was 24 to 31 weeks' inclusive. Babies who are recorded as having died, but who do not have a recorded date of death, will not be included, and are recorded as missing.

Numerator: Deaths of babies 24 to 31 weeks' gestation inclusive, before discharge from hospital to home, or discharge for palliative care with agreed non-intervention plan in place followed by death prior to 44 weeks' post-menstrual age (e.g. ventilated baby discharged to a hospice). In hospital, deaths in units not submitting data to the NNAP will be included. Mortality at or after 44 weeks' postmenstrual age will be excluded.

Cohort: Babies who turned (or would have turned) 44 weeks' PMA in the calendar year of interest.

Attribution

The NNAP will report mortality on 1-year epochs. Attribution will be to network of birth. When the place of birth is listed as *Home* or *Transit*, place of birth will be assigned to the Network related to the unit of first admission.

Deriving outcomes

Raw national and network mortality rates will be published alongside network treatment effects. No data is published for individual units.

Case mix adjustment: For limited variables, including gestation, gender, multiplicity and ethnicity but neither antenatal steroid administration nor congenital anomalies.

BadgerNet data source

Use the *Final Neonatal Outcome* page to record deaths that occur at non-NNAP units, along with the date and time of death. Please ensure that you click save and close to ensure that any outcomes recorded by another unit using BadgerNet but not participating in the NNAP are recorded.

Should Figure 1: Final Neonatal Outcome page, BadgerNet.

Discharge details

Discharge letter details

Discharge Diagnoses (VON)

Research projects

Final Neonatal Outcome

Final Outcome

Used to record the final outcome of any baby who has been transferred out from this unit or is still hospitalised at 1 year of age.

Final Neonatal Unit Outcome

☐ Home ☐ Ward ☒ Died ☐ Unknown

Date/Time of Death at

Final outcome notes

The NNAP mortality analysis will only include babies admitted to neonatal units, in the first instance. However, we would like units to report liveborn but not admitted deaths using BadgerNet at gestations down to, and including, 22 weeks. Only the briefest of details are required to complete a “delivery room death” admission in place of a “neonatal unit admission”.

Figure 2: New Care Episode, BadgerNet

New Paediatric BadgerNet Care Episode

New Patient Care Episode

Select type of care episode and core baby details below...

New Care Episode

Episode location

Episodetype

- Ward admissions
- Neonatal admission
- Delivery room death
- Follow up
- Community follow-up

2 Optimal perinatal care composite metric

Does a baby born at less than 34 weeks' gestational age receive all reported perinatal optimisation measures (appropriate to their gestational age at birth)?

Change to the audit metric for the 2026 data year: None.

NNAP standard

Developmental standard: None.

Outlier identification: No

Outlier management: No

Inclusion criteria

Number of babies admitted to a neonatal unit whose birth gestation is between 22 and 33 weeks' inclusive. For multiple births, each baby will be included. Babies will be measured against each of the measures for which they are eligible, (based on e.g. gestational age) this means that some babies will not be measured against all six measures.

Denominator: Number of babies admitted to a neonatal unit whose birth gestation is between 22 and 33 weeks' inclusive and who have either:

- recorded outcomes for all the component measures for which they are eligible or;
- have at least one non-adherent outcome.

Numerator: Number of babies admitted to a neonatal unit whose birth gestation is between 22 and 33 weeks' inclusive and who are adherent for all the component measures for which they are eligible.

Cohort: Babies who experienced their first neonatal admission in the calendar year of analysis.

Attribution

Results will be reported for each hospital of birth and network of birth.

When the place of birth is listed as *Home* or *Transit* the hospital and network will be assigned as the provider of their earliest episode. When the place of birth is the site of a closed unit known to be within a network, the hospital will be assigned as *Other* and the network will be assigned as the network responsible for that location.

Deriving outcomes

As this is a composite metric, babies will be measured against each of the following 6 measures for which they are eligible:

- [Antenatal steroids](#)
- [Antenatal magnesium sulphate](#)
- [Birth in a centre with a neonatal intensive care unit \(NICU\)](#)
- [Deferred cord clamping](#)
- [Promoting normal temperature on admission](#)
- [Breastmilk feeding in the first 2 days of life](#)

As there is variation in the inclusion criteria for these measures, not all babies are eligible for all 6 of them. Babies will only be measured against measures for which they are eligible.

Babies will be counted as *complete* if they have a complete status for all the measures for which they are eligible.

Babies will be counted as *missing* if they have a *missing* status for any of the measures for which they are eligible and no *non-adherent* status for the measures for which they are eligible.

Babies will be counted as non-adherent if they have at least one *non-adherent* status for any of the measures for which they are eligible.

2.1 Antenatal steroids (component measure)

Does a mother who delivers a baby between 22 and 33 weeks' gestational age receive a full course of antenatal corticosteroids within 1 week prior to delivery?¹

Change to the audit measure for the 2026 data year: None. The future intention is to move to reporting the proportion receiving a full course with appropriate course duration.

NNAP standard

Developmental standard: None.

Outlier identification: No

Outlier management: No

Inclusion criteria

Mothers of babies between 22 and 33 weeks' gestational age. Only data from the first known episode of care will be considered for analysis. For multiple births, only one baby will be included so that each mother is only counted once per delivery.

Denominator: Number of mothers of babies between 22 and 33 weeks' gestational age with complete antenatal steroid data.

Numerator: Number of mothers of babies between 22 and 33 weeks' gestational age who received a full course of antenatal corticosteroids within 1 week prior to delivery.

Cohort: Babies who experienced their first admission in the calendar year of analysis.

Attribution

Results will be reported for each hospital of birth and network of birth.

When the place of birth is listed as *Home* or *Transit* the hospital and network will be assigned as the provider of their earliest episode. When the place of birth is the site of a closed unit, the hospital will be assigned as *Other* and the network will be assigned as the network responsible for that location.

Deriving outcomes

NNAP will use data from *Last dose of latest course, steroids given* and *steroid courses* to determine if the baby's mother received a full course of antenatal steroids within 1 week of birth. When multiple births present different data, data will be taken from the baby with "the most positive"* outcome.

**Most to least positive: timely completion, incomplete, missing data.*

When the steroids last dose timing indicates that the last dose of steroids was given after birth, this will be listed as incomplete.

When the steroids last dose timing has no data entered, Table 1 will be used to derive outcomes.

When the steroids last dose timing indicates that the last dose of steroids was given earlier than 7 days before birth, Table 2 will be used to derive outcomes.

When the steroids last dose timing is within 7 days of birth, Table 3 will be used to derive outcomes.

Table 1. Categorising data for antenatal steroids from BadgerNet fields steroids given and steroids courses when *Last dose of latest course* is not entered.

Last dose of latest course - Not entered			
Steroids given	Courses given		
	Complete within 7 days	Incomplete/no steroids within 7 days	Unknown/not entered
Yes	Missing	Incomplete	Missing
No	Missing	Incomplete	Incomplete
Unknown/Not entered	Missing	Incomplete	Missing

Table 2. Categorising data for antenatal steroids from BadgerNet fields steroids given and steroids courses when Last dose of latest course is not within 7 days of birth.

Last dose of latest course – Not within 7 days of birth			
Steroids given	Courses given		
	Complete within 7 days	Incomplete/no steroids within 7 days	Unknown/not entered
Yes	Missing	Incomplete	Incomplete
No	Missing	Incomplete	Incomplete
Unknown/Not entered	Missing	Incomplete	Incomplete

Table 3. Categorising data for antenatal steroids from BadgerNet fields steroids given and steroids courses when Last dose of latest course is within 7 days of birth.

Last dose of latest course - Within 7 days of birth			
Steroids given	Courses given		
	Complete within 7 days	Incomplete/no steroids within 7 days	Unknown/not entered
Yes	Timely completion	Incomplete	Missing
No	Timely completion	Incomplete	Missing
Unknown/Not entered	Timely completion	Incomplete	Missing

Note: Please use the time and data fields to enter only data about the most recent course of antenatal steroids.

Determining appropriate course duration

The NNAP has started reporting course durations for "Adherent" patients in the Antenatal Steroids measure. The rationale for this additional reporting is to ensure that adherence to the NNAP measure is not achieved through shortened dose courses, contrary to RCOG guidance.²

These are currently available only in the Details column of the Patient List in the Restricted Access Dashboard (RAD) but may also be presented in the 2026 Extended Analysis report.

The classifications are:

- Appropriate (Betamethasone: course duration is between 18 and 30 hours, Dexamethasone: course duration is between 18 and 42 hours)
- Unknown (dose interval cannot be calculated, or is illogical)
- Inappropriate (dose interval can be calculated but is not "Appropriate").

If the steroid name is missing it will be imputed as Betamethasone.

These classifications are based on the [RCOG Green-top Guideline no. 74](#), allowing a buffer of 6 hours around the optimum dosing intervals.

These additions will not affect the headline measure classifications of Adherent, Missing and Not adherent.

BadgerNet data source

Data from the *Pregnancy Details* page, for *Steroids during pregnancy* will be used to determine if antenatal steroids were given.

Figure 3: Pregnancy Details page, BadgerNet

Steroids during pregnancy

Steroids given ☒ Yes ☐ No ☐ Unknown ★

Courses given ▼

Magnesium

Mother received Magnesium Sulphate loading dose in 24 hours prior to delivery ☒ N

Reason Magnesium Sulphate not given ☐ N ☐ Unknown

One complete course given within 7 days of birth

Incomplete course given within 7 days of birth with previous full course given

Incomplete course given within 7 days of birth, no previous full course given

No steroids given within 7 days of birth, previous full course given

Figure 4: Entering first and last dose date and time, BadgerNet

Steroids during pregnancy

Steroids given ☒ Yes ☐ No ☐ Unknown

Courses given ▼ Incomplete course given within 7 days of birth with previous full course given

First dose of latest course ▼ at

Last dose of latest course ▼ at

Which ☐ Betamethasone ☐ Dexamethasone

Definition

If using a two-dose course and a full course has not been given the 'Last dose of latest course' should be left blank

If using a four-dose course and a full course has not been given the 'Last dose of latest course' should be the date of the last dose administered

2.2 Antenatal magnesium sulphate (component measure)

*Does a mother who delivers a baby below 30 weeks' gestational age receive magnesium sulphate in the 24 hours prior to delivery?*¹

Change to the audit measure for 2026 data year: None.

NNAP standard

Developmental standard: Ninety percent (90%) of eligible mothers should receive antenatal magnesium sulphate.

Source of standard: NNAP Project Board

Outlier identification: Yes

Outlier management: No

Inclusion criteria

Mothers of babies between 22 and 29 weeks' gestational age. Only data from the first known episode of care will be considered for analysis. For multiple births, only one baby will be included so that each mother is only counted once per delivery.

Denominator: Number of mothers of babies between 22 and 29 weeks' gestational age with complete magnesium sulphate data.

Numerator: Number of mothers of babies between 22 and 29 weeks' gestational age who receive magnesium sulphate in the 24 hours prior to delivery.

Cohort: Babies who experienced their first admission in the calendar year of analysis.

Attribution

Results will be reported for each hospital of birth and network of birth.

When the place of birth is listed as *Home* or *Transit* the hospital and network will be assigned as the provider of their earliest episode. When the place of birth is the site of a closed unit, the hospital will be assigned as *Other* and the network will be assigned as the network responsible for that location.

Deriving outcomes

NNAP will use data from *Mother received magnesium sulphate in 24 hours prior to delivery* to categorise the administration of magnesium sulphate. When multiple births present different data, data will be taken from the baby with "the most positive"* for the audit.

Table 3: Categorising antenatal magnesium sulphate from BadgerNet field Mother received magnesium sulphate in 24 hours prior to delivery

Q1: Mother received MgSO ₄ loading dose in 24 hours prior to delivery?	Q2: Was a minimum of 4 hours of antenatal MgSO ₄ given after a loading dose and completed within 4 hours of the birth?		
	Yes	No	Unknown/Not recorded
Yes	Given	Given	Given
No	Given	Not given	Not given
Unknown / Not recorded	Given	Not given	Missing

*Most to least positive: magnesium sulphate given, magnesium sulphate not given, missing / unknown data.

BadgerNet data source

Data from the *Labour and Delivery* page for *Mother received magnesium sulphate in 24 hours prior to delivery* will be used to determine if magnesium sulphate was given.

Details at Birth and Admission - Test Hospital A

T:TEST9SCE69P5D1E NNAP, Baby
 Baby boy, singleton, born 21 Sep 22 at 07:00 at 30+0 weeks weighing 1000 grams.
 Admitted 21 Sep 22 at 08:00 from Test Hospital A. Now in unit - day 1 of stay.
 Today (21 Sep 22): Current age 5 hours Corrected gestational age is 30 weeks, 0 day Working weight 1000g

Baby Details

Syphilis ☐ Negative ☐ Positive ☐ Reactive ☐ Not tested ☐ Unknown

VDRL ☐ Negative ☐ Positive ☐ Not tested ☐ Unknown

TPHA ☐ Negative ☐ Positive ☐ Not tested ☐ Unknown

Hepatitis C virus antibody ☐ Negative ☐ Positive ☐ Not tested ☐ Unknown

Hepatitis C virus PCR ☐ Negative ☐ Positive ☐ Not tested ☐ Unknown

Other screening 1

Other screening 2

Other screening 3

Antenatal

Received Antenatal Care ☐ No ☐ Yes ☐ Unknown

Date of dating scan

Last menstrual period

EDD from LMP

Agreed EDD

Calculated gestation Weeks Days

Detailed Anomaly Scan

Anomaly Scan Comments

Doppler studies

Doppler Comments

Steroids during pregnancy

Steroids given ☐ Yes ☐ No ☐ Unknown

Last dose at

Courses given

Which ☐ Betamethasone ☐ Dexamethasone

Magnesium

Mother received Magnesium Sulphate loading dose in 24 hours prior to delivery ☐ No ☐ Yes ☐ Unknown

[Click to view guideline](#)

Was a minimum of a 4 hour infusion of antenatal magnesium sulphate given after the loading dose ☐ No ☐ Yes ☐ Unknown

[Audit trail...](#) [Previous Tab](#) [Next Tab](#) [Save & Close](#) [Cancel](#)

Figure 5: Labour and delivery page, BadgerNet

2.3 Birth in a centre with a neonatal intensive care unit (component measure)

Is a baby:

- *born at less than 27 weeks' gestational age, or*
 - *less than 800 grams at birth, or*
 - *born as a multiple at less than 28 week's gestational age*
- delivered in a maternity service on the same site as a designated neonatal intensive care unit (NICU)?*

Change to the audit measure for 2026 data year: None.

NNAP standard

Developmental standard: Eighty-five (85%) of babies born at less than 27 weeks' gestational age should be delivered in a maternity service on the same site as a NICU.

Source of standard: Neonatal Critical Care Clinical Reference Group, NHS England.

Outlier identification: No

Outlier management: No

Inclusion criteria

Mothers of babies between 22 and 26 weeks' gestational age or at less than 800 grams at birth, or a multiple at between 22 and 27 weeks' gestational age. Only data from the first known episode of care will be considered for analysis. For multiple births, only one baby will be included so that each mother is only counted once per delivery.

Denominator: Number of mothers of babies between 22 and 26 weeks' gestational age or at less than 800 grams at birth, or a multiple at between 22 and 27 weeks' gestational age.

Numerator: Number of mothers of babies between 22 and 26 weeks' gestational age or at less than 800 grams at birth, or a multiple at between 22 and 27 weeks' gestational age, who are delivered on a site with a NICU.

Cohort: Babies who experienced their first admission in the calendar year of analysis.

Attribution

Attribution will be to the neonatal network of birth. Outcomes will be reported by neonatal network of birth. Babies whose place of birth is listed as *Home or Transit* will have their network of birth updated to the provider network of their earliest episode.

Deriving outcomes

NNAP will use data from the place of birth to determine the level of neonatal unit within the hospital where babies were delivered (Table).

Table 4: Categorising birth in a centre with a NICU from BadgerNet field Place of birth

Place of birth	NNAP category
Hospital with a designated NICU	Delivered in appropriately designated location (NICU)
Hospital with a designated local neonatal unit (LNU) / special care unit (SCU)	Delivered in inappropriately designated location (LNU / SCU)
Hospital with no designated neonatal unit/ non-hospital location	Delivered in location without neonatal facilities

BadgerNet data source

Data on place of birth are captured on BadgerNet on the *Details at Birth and Admission* page. Values from the *Place of birth* field are used by NNAP for analysis.

The screenshot shows the 'Details at Birth and Admission' page for a baby. The page is divided into two main sections: 'Baby's Identification' and 'General information'.

Baby's Identification:

- NHS Number: T:TEST9SCE69P5D1E
- Additional National Identifier: [Empty]
- Baby's Local Hospital ID: [Empty]
- Badger ID: AAJHHP
- Surname: NNAP
- Forename: Baby
- Other/Previous Surnames: [Empty]
- Sex: ☐ Female ☒ Male ☐ Indeterminate
- Non NHS patient: ☐ Yes ☐ No (Overseas patients only. DO NOT use for UK residents)

General information:

- Birth Order: 1 of 1
- Date and Time of Birth: 21 Sep 22 at 07:00
- Place of birth: Test Hospital A (Code: X0888)
- Birth Location: [Empty]
- Agreed gestation at birth: 30 Weeks 0 Days
- Birth weight: 1000 grams (Between 2nd and 9th centiles)
- Head Circumference at Birth: [Empty] cm
- Length at Birth: [Empty] cm
- Ethnic Group: [Empty]
- Baby's blood group: [Empty]
- DAT: [Empty]
- Vitamin K given: [Empty] date: [Empty]
- Route of administration of vitamin K: [Empty]

A red arrow points to the 'Place of birth' field, which is set to 'Test Hospital A'.

Figure 5: Details at birth and admission page, BadgerNet

2.4 Deferred cord clamping (component measure)

Does a baby born at less than 34 weeks' gestational age have their cord clamped at or after one minute?¹

Change to the audit measure for 2026 data year: None.

NNAP standard

Developmental standard: Eighty-five percent (85%) of babies born at less than 34 weeks' gestational age should have their cord clamped at or after one minute.

Outlier identification: Yes

Outlier management: Yes

Inclusion criteria

Babies born between 22 and 33 weeks' gestational age. Only the first known episode of care will be considered for analysis.

Denominator: Number of babies born between 22 and 33 weeks' gestational age with complete cord clamping data.

Numerator: Number of babies born between 22 and 33 weeks' gestational age who had their cord clamped at or after 1 minute.

Cohort: Babies who experienced their first admission in the calendar year of analysis.

Attribution

Results will be reported for each hospital of birth and network of birth.

When the place of birth is listed as *Home* or *Transit* the hospital and network will be assigned as the provider of their earliest episode. When the place of birth is the site of a closed unit, the hospital will be assigned as *Other* and the network will be assigned as the network responsible for that location.

Deriving outcomes

NNAP will use data from the *Time of Cord Clamping* to determine whether cord clamping was deferred for 1 minute or more (Table).

Table 5: Categorising time of cord clamping in the NNAP

Time of cord clamping*			
Missing	< 0 minutes	Less than a minute after birth	Greater than or equal to one minute after birth
Time of cord clamping missing	Time of cord clamping missing	Less than 1 minute after birth	Deferred cord clamping (≥ 1 minute)

*Time of cord clamping is calculated by combining the *time of cord clamp minutes* and *time of cord clamp seconds* fields. If one of the two fields is not recorded, the not recorded field will be counted as 0, if both fields are not recorded, time of cord clamping will be counted as *missing*, unless immediate cord clamping is indicated on BadgerNet.

BadgerNet data source

Data on time of cord clamping are taken from the field *Time from birth to clamp* on the *Labour and Birth* page.

Maternal Medical / Antenatal History

Labour and Birth

Management at Birth

GP and Professionals

CRIB II

Duration of Membrane Rupture Hours Mins

Maternal pyrexia in labour more than 38C ☐ No ☐ Yes ☐ Unknown

Intravenous Intrapartum antibiotics given ☐ No ☐ Yes

Delivery

Presentation Immediately Before Delivery

Mode of Delivery ☐ Emergency caesarean - not in labour ☐ Emergency caesarean - in labour ☐ Elective section - not in labour ☐ Elective section - in labour ☐ Vaginal - forceps assisted ☐ Vaginal - spontaneous ☐ Vaginal - ventouse assisted ☐ Vaginal - kiwi assisted ☐ Breech birth, spontaneous, assisted or partial

Baby delivered in water ☐ Yes ☐ No

Condition at birth

Was cord clamping immediate ☐ Yes ☒ No ☐ Unknown

Time from birth to clamp mins secs

'Stripping' of blood from cord ☐ Yes ☐ No ☐ Unknown

Figure 6: Delivery section, Labour and birth page, BadgerNet

2.5 Promoting normal temperature on admission (component measure)

Does a baby born at less than 34 weeks' gestational age have a first temperature on admission which is both between 36.5–37.5°C and measured within one hour of birth?

Change to the audit measure for 2026 data year: None.

NNAP standard

Developmental standard: First temperature on admission should be taken within an hour of birth for all eligible babies.

The composite measure of timeliness and normal temperature should be met for at least ninety percent (90%) of babies.

Source of standard: NNAP Project Board

Outlier identification: Yes

Outlier management: No

Comparison standard for outlier analysis: National proportion.

Inclusion criteria

Babies born between 22 and 33 weeks' gestational age and admitted to a neonatal unit within 12 hours of birth. Only the first known episode of care will be considered for analysis.

Denominator: Number of babies born between 22 and 33 weeks' gestational age with complete temperature data and admitted to a neonatal unit within 12 hours of birth.

Numerator: Number of babies born between 22 and 33 weeks' gestational age who have a first temperature on admission which is both between 36.5–37.5°C and measured within one hour of birth.

Cohort: Babies who experienced their first admission in the calendar year of analysis.

Attribution

Results will be reported for each hospital of birth and network of birth.

When the place of birth is listed as *Home* or *Transit* the hospital and network will be assigned as the provider of their earliest episode. When the place of birth is the site of a closed unit, the hospital will be assigned as *Other* and the network will be assigned as the network responsible for that location.

Deriving outcomes

NNAP will use data from the first temperature taken after admission to categorise when babies had their temperature taken, and the value of temperature measurement (Table).

Table 6: Categorising temperature measurement from BadgerNet fields Temperature measured after admission, Temperature value and Temperature not recordable

Time of first temperature measurement (minutes from birth)	Value of first temperature measurement				
	Temp. not taken	< 35.9°C	36-36.4°C	36.5-37.5°C	>37.5°C
Temperature not taken after admission	Not taken	Not taken	Not taken	Not taken	Not taken
Within an hour (≤ 60 minutes from birth)	Not taken	Within an hour	Within an hour	Within an hour and between 36.5-37.5	Within an hour and >37.5
After an hour (> 60 minutes from birth)	Not taken	Late	Late	Late	Late

Categorising temperature values

Babies with a temperature measured *Within an hour* will be further categorised into the following groups based on their temperature values:

- Less than 32.0°C
- 32.0°C-35.9°C
- 36.0°C-36.4°C
- 36.5°C-37.5°C (normothermic)
- Greater than 37.5 °C

When the temperature value was not recordable, babies will be assigned to the 32.0°C-35.9°C group.

BadgerNet data source

Details on temperature measurement are captured on BadgerNet on the *Details at Birth and Admission* page. Values from the *Temperature measured after admission*, *Temperature value* and *Temperature not recordable* fields are used by NNAP for analysis (Indicated below).

Admission To Unit
Parent Details
Siblings / Guardian / Visitor
Previous Pregnancies
Maternal Medical / Antenatal History
Labour and Birth
Management at Birth
GP and Professionals
CRIB II

Admission to Unit

Date and Time Admitted: 21 Sep 22 at 08:00

Admitted to: Test Hospital A
Code: XX888

Admitted from: Test Hospital A Code: XX888
Admitted from this hospital

Admission type: Cannot Denive
Where admitted from:

Booking

Intended place of delivery: Code:

Booking hospital is this hospital

Admission Details

Principal category of admission: Neonatal intensive care
Principal clinical reason for admission: Prematurity
Admission area:

Admission weight: grams Use birth weight
Admission Head Circumference: cms Use birth head circ

Temperature measured after admission: Yes No Unknown recorded at
Temperature value: °C
Temperature not recordable: Yes (outside range of thermometer)
BP on admission: mmHg (Mean blood pressure)

Figure 7: Details at birth and admission page, BadgerNet

2.6 Breastmilk feeding in the first 2 days of life (component measure)

Does a baby born at less than 34 weeks' gestational age receive any of their own mother's milk in the first 2 days of life?

Change to the audit measure for 2026 data year: None.

NNAP standard

Developmental standard: Eighty percent (80%) of babies born at less than 34 weeks should receive any of their own mother's milk in the first 2 days of life.

Outlier identification: Yes

Outlier management: Yes

Comparison standard for outlier analysis: National proportion.

Inclusion criteria

Babies born between 22 and 33 weeks' gestational age who survive to 48 hours on a neonatal unit.

Denominator: Number of babies born between 22 and 33 weeks' gestational age who survive to 48 hours on a neonatal unit and have complete feeding data for either of their first two days of life.

Numerator: Number of babies born between 22 and 33 weeks' gestational age who receive any of their own mother's milk in the first two days of life.

**Note that for this measure the date of birth is counted as the first day of life e.g. if a baby is born at 2230 on a Tuesday, then Wednesday is their second day of life.*

Cohort: Babies who experienced their first admission in the calendar year of analysis.*

**Note that the cohort of babies included in this measure is different to measures 4.2 and 4.3, which consider babies discharged in the calendar year of analysis.*

Attribution

Babies will be attributed to their hospital and network of first admission.

Deriving outcomes

Babies will be classified as meeting the NNAP standard if they are noted to have received any of the following types of enteral feed or mouth care on the day of birth or day after birth.

- Suckling at the breast
- Mother's fresh expressed breastmilk
- Mother's frozen expressed breastmilk
- Breastmilk (mouth care)
- Colostrum (mouth care)

UNICEF Baby Friendly field

In addition, babies will also be classified as meeting the NNAP standard if the baby has both the following records in their UNICEF Baby Friendly section:

- Received breastmilk in the first 24 hours of life; *and*
- First human milk feed is “Mother’s milk”

BadgerNet data source

The primary source for information on feeding is daily summary data on enteral feeds and mouth care for the day of birth or day after birth on the BadgerNet system.

Figure 8: Daily summary data, BadgerNet.

In October 2025, the NNAP started supplementing this measure with the UNICEF Baby Friendly field. This form assesses if a baby received breastmilk within the first 24 hours of life. Through completing the highlighted fields below, a baby will be considered ‘adherent’ for this NNAP measure if they receive their own mother’s milk within the first 24 hours of life.

Figure 9: UNICEF Baby Friendly form, BadgerNet

3 Complications of prematurity composite metric

Proportion of babies born between 24 and 31 weeks' gestation inclusive who did not have a reported serious complication of prematurity (late onset infection, NEC, BPD, serious preterm brain injury or mortality).

Change to the audit measure for the 2026 data year: None.

NNAP standard

Developmental standard: None.

Outlier identification: No

Outlier management: No

Inclusion criteria

Babies admitted to a neonatal unit whose birth gestation is between 24 and 31 weeks inclusive. For multiple births, each baby will be included.

Denominator: Number of babies admitted to a neonatal unit whose birth gestation is between 24 and 31 weeks inclusive, and who are not classified as *missing*.

Numerator: Number of babies admitted to a neonatal unit whose birth gestation is between 24 and 31 weeks inclusive and who do not experience any of the adverse outcomes from the component measures for which they are eligible. Babies will be assessed against each of the measures for which they are eligible, this means that some babies will not be measured against all 6 measures.

Cohort: Babies who turned 44 weeks' PMA within the reporting period.

Attribution

Results will be reported for each hospital of birth and network of birth.

When the place of birth is listed as *Home* or *Transit* the hospital and network will be assigned as the provider of their earliest episode. When the place of birth is the site of a closed unit, the hospital will be assigned as *Other* and the network will be assigned as the network responsible for that location.

Deriving outcomes

As this is a composite measure, babies will be measured against each of the following 6 measures for which they are eligible*:

- [Bronchopulmonary dysplasia](#)
- [Necrotising enterocolitis](#)
- [Bloodstream infection](#)
- [Mortality](#)
- [Serious brain injury – IVH 3/4](#)
- [Serious brain injury – cPVL](#)
- [Serious brain injury – PHVD](#)

As there is variation in the inclusion criteria for these measures, not all babies are eligible for all 6 of them. Babies will only be measured against measures for which they are eligible.

Babies will be counted as having an *adverse outcome* if they have an adverse outcome for any of the measures for which they are eligible.

Babies will be counted as having *no adverse outcome* if they have no adverse outcome for all of the measures for which they are eligible.

Babies will be counted as *missing* if they have a *missing* status for any of the measures for which they are eligible and no adverse outcomes for the other measures for which they are eligible.

**Examples of ineligibility include babies first admitted to an NNAP NNU after 48 (NEC measure) or 72 (BSI measure) hours of life.*

3.1 Bloodstream infection (component measure)

Does an admitted baby born at less than 32 weeks' have one or more episodes of bloodstream infection, characterised by one or more positive blood cultures taken with a clearly pathogenic organism, after 72 hours of age?

Change to the audit measure for 2026 data year: None.

NNAP standard

Developmental standard: Benchmarking only.

Outlier identification: Yes

Outlier management: Yes

Comparison standard for outlier analysis: Average treatment effect.

Inclusion criteria

Babies between 22 and 31 weeks' gestational age who were present on a neonatal unit at 72 hours of age.

Denominator: Number of babies between 22 and 31 weeks' gestational age who were present on a neonatal unit at 72 hours of age.

Numerator: Number of babies between 22 and 31 weeks' gestational age who were present on a neonatal unit at 72 hours of age who had one or more positive blood cultures with a pure growth of a clearly pathogenic organism taken after 72 hours of age.

Cohort: Babies who experienced their final neonatal discharge in the calendar year of analysis.

Attribution

Blood cultures will be attributed to the neonatal unit of care when the culture was taken, or for units where there were two such units on a day of care, the unit completing the culture form. Babies will be counted as eligible once in each neonatal unit they were admitted to.

Deriving outcomes

Growths of bacteria, yeasts or fungi will be classified as per Table . A reference list of clearly pathogenic organisms will be used (see Appendix 1 of this measures guide).

Table 7: Classification of organisms grown in blood cultures - late onset bloodstream infection

Pathogens classification	Fungal and bacterial culture growths	Organisms of uncertain significance
Pure growths	Pathogenic	Not clearly pathogenic
Mixed growths	Not clearly pathogenic	Not clearly pathogenic

Data pertaining to late onset bloodstream infection will be subdivided by “any positive culture” and “clearly pathogenic organism”. Data viewing will be further enhanced by presentation of an indication that all positive blood cultures have been entered, for centres where this is the case.

BadgerNet data source

Details for blood cultures and their results will be captured via ad-hoc forms for cultures on BadgerNet.

The figure consists of two screenshots of the BadgerNet ad-hoc form for blood culture. Both screenshots are for a patient named T:6B5QBRYF5ZE FRIES, Chip, a baby boy, singleton, born 04 Jul 22 at 07:00 at 35+0 weeks weighing 4000 grams. The patient was admitted 25 Jul 22 at 18:36 from Test Hospital B. Now in unit - day 60 of stay. Note Entry Day 23 Sep 22: Day 82 of life. Corrected postnatal age 6 weeks past term. Working weight 4000g.

Top Screenshot: Culture Details

The 'Culture Details' form is shown. A red arrow points to the 'Sample Type(s)' field. The form includes the following fields:

- Date and Time Sample(s) Taken: 23 Sep 22 at 14:54
- Supervised By: [dropdown] Use current user...
- Performed By: [dropdown] Use current user...
- Sample Type(s):
 - ☒ Blood culture
 - ☐ CSF Culture
 - ☐ Urine
 - ☐ Secretions
 - ☐ Swab
 - ☐ Other
- Decision to treat: [dropdown] at
- Taken from: ☐ Central line ☐ Peripheral line ☐ Closed culture
- Paired sample: ☐ Yes ☐ No
- Reason for Culture: [dropdown]
- Signs Present When Culture(s) Obtained: [dropdown]
- Prep used: ☐ 2% Chlorhexidine ☐ 1% Chlorhexidine ☐ 0.05% Chlorhexidine ☐ 0.5% Chlorhexidine
- Hefu score (if done): [dropdown]
- Time of 1st antibiotics: [dropdown] at

Bottom Screenshot: Blood Result

The 'Blood Result' form is shown. A red arrow points to the 'Pathogens' field. The form includes the following fields:

- Pathogens: [dropdown] No growth
- Pathogens: [dropdown]
- Sensitivity List for Isolate: [dropdown]
- Notes: [text area]

Figure 10: Ad-hoc form for blood culture taken (top), and ad-hoc form for blood culture results (bottom)

3.2 Bronchopulmonary dysplasia (component measure)

Does an admitted baby born at less than 32 weeks' gestational age develop bronchopulmonary dysplasia (BPD) or die?

Change to the audit measure for 2026 data year: None.

NNAP standard

Developmental standard: None, bench marking only.

Outlier identification: Yes

Outlier management: No

Comparison standard for outlier analysis: Average treatment effect.

Inclusion criteria

Babies born between 22 and 31 weeks' gestational age who were first admitted to a neonatal unit before 36 weeks' PMA.

Denominator: Number of babies born between 22 and 31 weeks' gestational age first admitted to a neonatal unit before 36 weeks' PMA, and who have complete respiratory data at 36 weeks' of life.

Numerator: Number of babies born between 22 and 31 weeks' gestational age, who developed BPD or died before 36 weeks' PMA.

Cohort: Babies who turned 44 weeks' PMA in the calendar year of analysis.

Attribution

Attribution will be to the hospital of birth. Outcomes will also be reported by network of birth.

When the place of birth is *Home* or *Transit* the hospital will be assigned as *Other* and the network will be assigned as the network associated with the first episode. When the place of birth is the site of a closed unit, the hospital will be assigned as *Other* and the network will be assigned as the network responsible for that location.

In cases where a baby is transferred, categorisation of a patient is made using episodes that are not held by the unit that has been attributed the patient. The hospital that cares for the patient upon reaching 36 weeks' post-menstrual age time is responsible for updating episodic data, even if they have not been finally attributed the patient. We therefore ask all units to review the 'BPD Responsible' tab on the Restricted Access Dashboard (RAD) and ensure they are cleaned for other units' data.

Deriving outcomes

BPD will be defined by the level of respiratory support received at 36 weeks' post-menstrual age (Table 6).

When a baby was discharged from neonatal care before reaching 36 weeks' post-menstrual age, data from the time of discharge will be used instead.

Table 8: Categorising BPD or death in NNAP based on daily respiratory support data

Survival at 36 weeks CGA	Respiratory data from 36 weeks post-menstrual age / final discharge		
	Not receiving respiratory support	Receiving respiratory support*	Missing required respiratory data**
Died before 36 weeks PMA	Died	Died	Died
Survived to 36 weeks PMA	No BPD	BPD	BPD not determinable

*‘Respiratory Support’ is defined as receiving any of the following at the specified time:

- Ventilation
- CPAP
- Non-invasive ventilation (e.g. BiPAP)
- Hi flow nasal cannula therapy (i.e. ≥ 2 lpm gas flow)
- Oxygen treatment

** In instances where respiratory data is not available for the specified day, data from the subsequent day of care (or penultimate day of care for babies discharged at less than 36 weeks) will be sought instead. When respiratory data is also missing from this second source the baby will be classified as ‘Missing required data’ for that period.

Babies will be defined as having missing data if there is no data available to determine respiratory support.

BadgerNet data source

Details on respiratory support used to calculate levels of BPD are captured on BadgerNet in daily summary forms. A form is created for each baby for each calendar day where they are an inpatient on a neonatal unit, and the fields *Respiratory Support*, *Added oxygen*, *Mode of ventilation* and *Mode of non-invasive support* will be used by the NNAP.

Figure 11: Daily summary form, BadgerNet

3.3 Necrotising enterocolitis (component measure)

Does an admitted baby born at less than 32 weeks' gestational age meet the NNAP surveillance definition for necrotising enterocolitis (NEC) on one or more occasion?

Change to the audit measure for 2026 data year: None.

NNAP standard

Developmental standard: Benchmarking

Outlier identification: Yes

Outlier management: No

Comparison standard for outlier analysis: Average treatment effect.

Inclusion criteria

Babies born between 22 and 31 weeks' gestational age who survived to 48 hours after birth.

Denominator: Number of babies born between 22 and 31 weeks' gestational age who survived to 48 hours after birth and who have a complete NEC diagnosis field.

Numerator: Number of babies born between 22 and 31 weeks' gestational age who survived to 48 hours after birth and who meet the NNAP surveillance definition for necrotising enterocolitis on one or more occasion.

Cohort: Babies discharged in the calendar year of analysis.

Attribution

- Babies will be attributed to their location of care at 48 hours of life, which is intended as a proxy measure of the intention to provide ongoing care for a baby in a given neonatal unit.
- When a baby is in transit between units at 48 hours of life the baby will be assigned to the transferring hospital. When multiple admission locations exist at 48 hours of life, the baby will be attributed to the earliest associated admission time.
- NEC status is categorised using all episodes of each eligible patient. If a unit has episodes for patients who are not attributed to that unit (and those episodes contain missing data), they will be highlighted in the 'NEC Responsible' tab of the Restricted Access Dashboard.

Deriving outcomes

The outcome is based on an analysis of all episodes for each eligible baby, using the following order of priority for the final outcome: Confirmed NEC > NEC status missing > No NEC.

NEC may be diagnosed at surgery, post-mortem or based on the following clinical and radiographic signs.

At least one clinical feature from:

- Bilious gastric aspirate or emesis
- Abdominal distension
- Occult or gross blood in stool (no fissure)

And at least one radiographic feature from:

- Pneumatosis
- Hepato-biliary gas
- Pneumoperitoneum

Infants clinically diagnosed as NEC using the clinical and radiographic criteria who are found at surgery or post-mortem to have “Focal Intestinal Perforation” should not be recorded as having NEC.

Table 9: Categorisation of NEC diagnosis

Survival to discharge home	Was NEC Diagnosed during this admission?					
	NEC diagnosis based on surgery	NEC diagnosis based on post-mortem	NEC diagnosis based on presence of clinical signs		NEC not diagnosed	NEC diagnosis data not recorded
			At least 1 radiographic and 1 clinical feature	Radiographic or clinical features missing		
Survived to discharge home	NEC	NEC	NEC	No NEC (NEC undiagnosed)	No NEC	Missing data
Died prior to discharge home	NEC	NEC	NEC	No NEC (NEC undiagnosed)	No NEC but died prior to discharge	Missing data

BadgerNet data source

For babies born at less than 32 weeks', the field *Was NEC diagnosed during this admission?* will appear on the *Discharge details* data from this field, and its follow on question (*Based on, Clinical feature(s), Radiographic Features*).

Discharge questions

Oxygen at Discharge ☐ Yes ☐ No

Apnoea/Cardiorespiratory/Saturation Monitoring at Discharge ☐ Yes ☐ No

Blood or csf culture done this admission ☐ Yes ☐ No

Blood products given during stay ☐ Yes ☐ No

Any ROP screening this stay ☐ Yes ☐ No

NEC diagnosed during this admission ☒ Yes ☐ No ★

Based on

☒ Clinical signs

☐ Surgical confirmation

☐ Post-mortem examination

Clinical feature(s)

☐ Bilious gastric aspirate or emesis

☐ Abdominal distension

☐ Occult or gross blood in stool (no fissure)

Radiographic feature(s)

☐ Pneumatosis intestinalis

☐ Hepato-biliary gas

☐ Pneumoperitoneum

Has this baby had a NIPE examination ☐ Yes ☐ No

Cranial ultrasound scans 0 recorded for this stay. Verify ☐ True ☐ False

Figure 12: Discharge details page, BadgerNet

3.4 Preterm brain injury – IVH 3 or 4 (component measure)

Does a baby born at less than 32 weeks' gestational age experience any intraventricular haemorrhage (IVH) grade 3 or 4?

Change to the audit measures for 2026 data year: The intention is to report a composite metric of any preterm brain injury from 2026 onwards. The measures guide will be updated in due course to reflect this change, following further consultation on the construction of the measure.

NNAP standard

Developmental standard: 95% completeness

Outlier identification: Yes, on proportion of missing data.

Outlier management: Yes, on proportion of missing data.

Comparison standard for outlier analysis: National percentiles of missing data.

Inclusion criteria

Babies born between 22 and 31 weeks' gestational age.

Denominator: Number of babies born between 22 and 31 weeks' gestational age with data for at least one scan completed within the first 28 days of life.

Numerator: Number of babies born between 22 and 31 weeks' gestational age with data for at least one scan completed within the first 28 days of life, and who experience IVH 3/4 or die before discharge.

Note: babies who died in the first week of life will be included in the numerator and denominator, even if they do not have complete scan results.

Cohort: Babies who turned 44 weeks' PMA in the calendar year of analysis.

Attribution

Outcomes will be attributed to the unit and network of birth.

When the place of birth is *Home* or *Transit* the hospital will be assigned as *Other* and the network will be assigned as the network associated with the first episode. When the place of birth is the site of a closed unit, the hospital will be assigned as *Other* and the network will be assigned as the network responsible for that location.

In cases where a baby is transferred, categorisation of a patient may be made using episodes that are not held by the unit that has been attributed the patient. All units that care for a baby that meets the inclusion criteria for this measure are responsible for updating scan data, even if they have not been finally attributed the patient. We therefore ask all units to review the 'IVH Responsible' tab on the RAD and ensure they are cleaned for other units' data.

Deriving outcomes

The analysis will be based on cranial ultrasound imaging data. Where no imaging is recorded for a baby, this will be reported as Missing Data.

Where babies have scans recorded within 28 days of life, but the data pertaining to IVH is missing, babies will be regarded as having missing data.

The outcomes will be reported according to the following definition, which are also visible in the Badger system:

Germinal Matrix/ Intraventricular Haemorrhage and Haemorrhagic Parenchymal Infarction

Recording the worst grade of GMH-IVH interpreted by any cranial ultrasound or MRI, performed on or before day 28 after birth; or clarify that no imaging was performed in the first 28 days.

Grading is based on an ultrasound classification system and is recorded separately per side (i.e. left and/or right):³

- No germinal matrix or intraventricular haemorrhage
- Grade 1: Germinal matrix haemorrhage with no or minimal intraventricular haemorrhage (<10% of ventricular area on parasagittal view)
- Grade 2: Intraventricular haemorrhage (10-50% of ventricular area on parasagittal view)
- Grade 3: Intraventricular haemorrhage (>50% of ventricular area on parasagittal view; usually distends lateral ventricle).
- Grade 4: Haemorrhagic infarction in periventricular white matter (with or without IVH)

BadgerNet Data Source

In the discharge details section of BadgerNet, professionals discharging a baby are asked to complete the following:

Discharge questions

Oxygen at Discharge ☐ Yes ☐ No

Apnoea/Cardiorespiratory/Saturation Monitoring at Discharge ☐ Yes ☐ No

Blood or csf culture done this admission ☐ Yes ☐ No

Blood products given during stay ☐ Yes ☐ No

Any ROP screening this stay ☐ Yes ☐ No

NEC diagnosed during this admission ☐ Yes ☐ No ★

Has this baby had a NIPE examination ☐ Yes ☐ No

Cranial ultrasound scans recorded for this stay. Verify ☐ True ☐ False

Figure 13: Discharge details, BadgerNet.

Clinical staff are asked to ensure the number of scans entered, and the scan data recorded adequately describes the full extent of scan findings, according to the classification system described above, for the IVH, cPVL and PHVD measures. The verification of the number of scans is designed to act as a prompt to clinical staff at discharge, to ensure this data entry is adequate.

The scan should be recorded using the cranial ultrasound section of the “Procedures/ events tab”. Findings from the examination should be recorded as below:

The screenshot displays the 'Procedures/ events tab' in the BadgerNet system. It is divided into several sections:

- Details:** Contains fields for 'Date and time of scan' (set to 00 Sep 22 at 15:58), 'Scan carried out by', 'Designation', 'Supervised By', and 'Normal scan' (Yes/No).
- Results - Right:** Includes 'IVH - right' (Normal, IVH - Grade 1, IVH - Grade 2, IVH - Grade 3, IVH - Grade 4), 'Ventricular dilatation - right' (Yes/No), and 'Porencephalic cyst(s) - right' (Yes/No).
- Results - Left:** Includes 'IVH - left' (Normal, IVH - Grade 1, IVH - Grade 2, IVH - Grade 3, IVH - Grade 4), 'Ventricular dilatation - left' (Yes/No), and 'Porencephalic cyst(s) - left' (Yes/No).
- Results:** Includes 'Cystic PVL' (Yes/No) and 'Post haemorrhagic ventricular dilatation' (Yes/No).
- Findings:** A large text area for 'Scan Comments'.

Red arrows point to the following elements:

- The 'Date and time of scan' field.
- The 'IVH - right' and 'IVH - left' grade selection buttons.
- The 'Cystic PVL' and 'Post haemorrhagic ventricular dilatation' Yes/No buttons.

Figure 14: Procedures/ events tab, BadgerNet.

Important note: Entering cranial ultrasound scans on BadgerNet

Within BadgerNet, it isn't possible to add a cranial ultrasound scan record via the Procedures/events tab in the BadgerNet client if a baby cared for in your unit went on to have a subsequent episode in another unit. Instead, you can use the "smart search" function and search for "cranial" to add a new note to the desired episode of care. If you have any questions about how to do this, please do get in touch with System C directly.

Please also note that details entered into BadgerNet EPR's Detailed Cranial Ultrasound form are not currently included in the analysis.

3.5 Preterm brain injury – cPVL (component measure)

Does a baby born at less than 32 weeks' gestational age experience cystic periventricular leukomalacia (cPVL)?

Change to the audit measures for 2026 data year: The intention is to report a composite metric of any preterm brain injury from 2026 onwards. The measures guide will be updated in due course to reflect this change, following further consultation on the construction of the measure.

NNAP standard

Developmental standard: None, benchmarking only.

Outlier identification: No

Outlier management: No

Inclusion criteria

Babies born between 22 and 31 weeks' gestational age.

Denominator: Number of babies born between 22 and 31 weeks' gestational age with a complete scan.

Numerator: Number of babies born between 22 and 31 weeks' gestational age with a complete scan, who experience cPVL or die before discharge.

Cohort: Babies who turned 44 weeks' PMA in the calendar year of analysis.

Note: All babies without a complete scan will be classified as "missing".

Attribution

Outcomes will be attributed to the unit and network of birth.

When the place of birth is *Home* or *Transit* the hospital will be assigned as *Other* and the network will be assigned as the network associated with the first episode. When the place of birth is the site of a closed unit the hospital will be assigned as *Other* and the network will be assigned as the network responsible for that location.

In cases where a baby is transferred, categorisation of a patient may be made using episodes that are not held by the unit that has been attributed the patient. All units that care for a baby that meets the inclusion criteria for this measure are responsible for updating episodic data, even if they have not been finally attributed the patient. We therefore ask all units to review the 'cPVL Responsible' tab on the RAD and ensure they are cleaned for other units' data.

Deriving outcomes

The analysis will be based on cranial ultrasound imaging data. Where no imaging is recorded for a baby, this will be reported as Missing Data.

Where babies have scans on the system, but the scan contains no relevant data, they will be listed as Missing Data.

The outcomes will be reported according to the following definition, which is also visible in the Badger system:

Cystic Periventricular Leukomalacia

At any time during the infant's stay:

- Evidence of cystic periventricular leukomalacia on a cranial ultrasound or MRI scan obtained at any time during admission or clarify that NO imaging was performed during the admission.
- To be considered cystic periventricular leukomalacia there must be multiple small periventricular cysts identified in the white matter.
- Connatal cysts should not be included. Connatal cysts are thin-walled cysts in the lateral aspect of frontal horn of lateral ventricle and anterior to the foramen of Monro.

BadgerNet data source

In the discharge details section of BadgerNet, professionals discharging a baby are asked to complete the following:

Discharge questions

Oxygen at Discharge ☐ Yes ☐ No

Apnoea/Cardiorespiratory/Saturation Monitoring at Discharge ☐ Yes ☐ No

Blood or csf culture done this admission ☐ Yes ☐ No

Blood products given during stay ☐ Yes ☐ No

Any ROP screening this stay ☐ Yes ☐ No

NEC diagnosed during this admission ☐ Yes ☐ No ★

Has this baby had a NIPE examination ☐ Yes ☐ No

Cranial ultrasound scans 1 recorded for this stay. Verify ☐ True ☐ False

Figure 15: Discharge details section of BadgerNet.

Clinical staff are asked to ensure the scan data recorded adequately describes the scan findings, according to the classification system described above, for eligible babies.

The scan should be recorded using the cranial ultrasound section of the "Procedures/ events tab". Findings from the examination should be recorded as below:

Details

Date and time of scan 30 Sep 22 at 15:58

Scan carried out by [User] Use current user...

Designation [User]

Supervised By [User] Use current user...

Designation [User]

Normal scan ☐ Yes ☐ No

Results - Right

IVH - right ☐ Normal ☐ IVH - Grade 1 ☐ IVH - Grade 2 ☐ IVH - Grade 3 ☐ IVH - Grade 4

Ventricular dilatation - right ☐ Yes ☐ No

Porencephalic cyst(s) - right ☐ Yes ☐ No

Results - Left

IVH - left ☐ Normal ☐ IVH - Grade 1 ☐ IVH - Grade 2 ☐ IVH - Grade 3 ☐ IVH - Grade 4

Ventricular dilatation - left ☐ Yes ☐ No

Porencephalic cyst(s) - left ☐ Yes ☐ No

Results

Cystic PVL ☐ Yes ☐ No

Post haemorrhagic ventricular dilatation ☐ Yes ☐ No

Findings

Scan Comments

Figure 16: Procedures/events tab, BadgerNet.

Important note: Entering cranial ultrasound scans on BadgerNet

Within BadgerNet, it isn't possible to add a cranial ultrasound scan record via the Procedures/events tab in the BadgerNet client if a baby cared for in your unit went on to have a subsequent episode in another unit. Instead, you can use the "smart search" function and search for "cranial" to add a new note to the desired episode of care. If you have any questions about how to do this, please do get in touch with System C directly.

Please also note that details entered into BadgerNet EPR's Detailed Cranial Ultrasound form are not currently included in the analysis.

3.6 Preterm brain injury – PHVD (component measure)

Does a baby born at less than 32 weeks' gestational age experience Post-haemorrhagic ventricular dilatation (PHVD)?

Change to the audit measures for 2026 data year: The intention is to report a composite metric of any preterm brain injury from 2026 onwards. The measures guide will be updated in due course to reflect this change, following further consultation on the construction of the measure.

NNAP standard

Developmental standard: None, benchmarking only.

Outlier identification: No

Outlier management: No

Inclusion criteria

Babies born between 22 and 31 weeks' gestational age.

Denominator: Number of babies born between 22 and 31 weeks' gestational age with a complete scan.

Numerator: Number of babies born between 22 and 31 weeks' gestational age with a complete scan, who experience PHVD or die before discharge.

Cohort: Babies who turned 44 weeks' PMA in the calendar year of analysis.

Note: All babies without a complete scan will be classified as "missing".

Attribution

Outcomes will be attributed to the unit and network of birth.

When the place of birth is *Home* or *Transit* the hospital will be assigned as *Other* and the network will be assigned as the network associated with the first episode. When the place of birth is the site of a closed unit the hospital will be assigned as *Other* and the network will be assigned as the network responsible for that location.

In cases where a baby is transferred, categorisation of a patient may be made using episodes that are not held by the unit that has been attributed the patient. All units that care for a baby that meets the inclusion criteria for this measure are responsible for updating episodic data, even if they have not been finally attributed the patient. We therefore ask all units to review the 'PHVD Responsible' tab on the RAD and ensure they are cleaned for other units' data.

Deriving outcomes

The analysis will be based on cranial ultrasound imaging data. Where no imaging is recorded for a baby, this will be reported as Missing Data.

Where babies have scans on the system, but the scan contains no relevant data, they will be listed as Missing Data.

The outcomes will be reported according to the following definition, which is also visible in the Badger system:

Post-haemorrhagic ventricular dilatation

At any time during the infant's stay:

- On any ultrasound or MR imaging, performed at any time during the stay, was the following diagnosed:
- Intraventricular haemorrhage (past or residual) with enlarged ventricles: VI >97th centile +4 mm.

BadgerNet data source

In the discharge details section of BadgerNet, professionals discharging a baby are asked to complete the following:

Discharge questions

Oxygen at Discharge	☐ Yes ☐ No
Apnoea/Cardiorespiratory/Saturation Monitoring at Discharge	☐ Yes ☐ No
Blood or csf culture done this admission	☐ Yes ☐ No
Blood products given during stay	☐ Yes ☐ No
Any ROP screening this stay	☐ Yes ☐ No
NEC diagnosed during this admission	☐ Yes ☐ No
Has this baby had a NIPE examination	☐ Yes ☐ No
Cranial ultrasound scans	1 recorded for this stay. Verify ☐ True ☐ False

Figure 16: Discharge details section of BadgerNet.

Clinical staff are asked to ensure the scan data recorded adequately describes the scan findings, according to the classification system described above, for eligible babies.

The scan should be recorded using the cranial ultrasound section of the “Procedures/ events tab”. Findings from the examination should be recorded as below:

Details

Date and time of scan: 30 Sep 22 at 15:58

Scan carried out by: [User] Use current user...

Designation: [Dropdown]

Supervised By: [User] Use current user...

Designation: [Dropdown]

Normal scan: ☐ Yes ☐ No

Results - Right

IVH - right: ☐ Normal ☐ IVH - Grade 1 ☐ IVH - Grade 2 ☐ IVH - Grade 3 ☐ IVH - Grade 4

Ventricular dilatation - right: ☐ Yes ☐ No

Porencephalic cyst(s) - right: ☐ Yes ☐ No

Results - Left

IVH - left: ☐ Normal ☐ IVH - Grade 1 ☐ IVH - Grade 2 ☐ IVH - Grade 3 ☐ IVH - Grade 4

Ventricular dilatation - left: ☐ Yes ☐ No

Porencephalic cyst(s) - left: ☐ Yes ☐ No

Results

Cystic PVL: ☐ Yes ☐ No

Post haemorrhagic ventricular dilatation: ☐ Yes ☐ No

Findings

Scan Comments: [Text Area]

Figure 17: Procedures/events tab, BadgerNet.

Important note: Entering cranial ultrasound scans on BadgerNet

Within BadgerNet, it isn't possible to add a cranial ultrasound scan record via the Procedures/events tab in the BadgerNet client if a baby cared for in your unit went on to have a subsequent episode in another unit. Instead, you can use the "smart search" function and search for "cranial" to add a new note to the desired episode of care. If you have any questions about how to do this, please do get in touch with System C directly.

Please also note that details entered into BadgerNet EPR's Detailed Cranial Ultrasound form are not currently included in the analysis.

4 Parental consultation within 24 hours of every admission

Is there a documented consultation with parents by a senior member of the neonatal team, within 24 hours of admission? ^{4,5,6}*

**By senior member of the neonatal team, NNAP means a consultant or middle grade doctor, or a nurse practitioner acting in such a role.*

Change to the audit measure for 2026 data year: None.

NNAP standard

Developmental standard: A consultation should take place within 24 hours of admission for every admission (100%).

Source of standard: NNAP Project Board

Outlier identification: Yes

Outlier management: No

Comparison standard for outlier analysis: National average

Inclusion criteria

Admissions to neonatal units lasting at least 12 hours and receiving special care or a higher order of neonatal care. Babies receiving neonatal care in non-neonatal unit locations (postnatal ward, transitional care etc.) will not be included. Babies admitted to a neonatal unit, or units, more than once will count as having had more than one admission.

Denominator: Number of admissions to neonatal units lasting at least 12 hours and receiving special care or a higher order of neonatal care, with complete consultation data.

Numerator: Number of admissions to neonatal units lasting at least 12 hours and receiving special care or a higher order of neonatal care with a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission. Presented as a proportion.

Cohort: Admissions in the calendar year of analysis.

Attribution

Results will be attributed to the neonatal unit and network of admission.

Deriving outcomes

The recorded time for first consultation with a senior member of staff is compared to the time of admission to determine when consultation takes place. The NNAP standard is aimed specifically at consultation at or after the time of admission, and so consultations prior to admission or birth cannot meet the NNAP standard (Table 10).

Table 10: Categorising consultation with parents from BadgerNet fields Parents seen by senior staff and Time first seen

Time of first consultation	NNAP category
Before admission	Before admission
Time of admission – 24 hours after admission	Within 24 hours (NNAP standard)
More than 24 hours after admission	After 24 hours
Confirmed “no consultation”	No consultation
Confirmed “unknown”	Missing
Consultation time not recorded	Missing

BadgerNet data source

Details on first consultation are captured on BadgerNet on the *Details at Birth and Admission* page. The answer to the question *Parents seen by senior staff* and the *Time first seen* are used by NNAP for analysis.

The screenshot displays the 'Admission Details' section of the BadgerNet interface. The left sidebar contains navigation links: Admission To Unit, Parent Details, Siblings / Guardian / Visitor, Previous Pregnancies, Maternal Medical / Antenatal History, Labour and Birth, Management at Birth, GP and Professionals, and CRIS II. The main form includes fields for 'Intended place of delivery' and 'Code'. Below this, the 'Admission Details' section contains numerous fields for clinical data, including 'Principal category of admission' (Neonatal intensive care), 'Principal clinical reason for admission' (Prematurity), 'Admission area', 'Admission weight', 'Admission Head Circumference', 'Temperature measured after admission', 'Temperature value', 'Temperature not recordable', 'BP on admission', 'HR on admission', 'Resp rate on admission', 'SaO2 on admission', 'Blood glucose on admission', 'Parents seen by senior staff' (set to Yes), 'Time first seen' (set to at), 'Name of senior staff member', 'Designation', 'Does mother intend to breastfeed', and 'Problems/diagnosis on admission'. Two red arrows highlight the 'Parents seen by senior staff' and 'Time first seen' fields.

Figure 18: Details at birth and admission page, BadgerNet

5 Parental inclusion in consultant ward rounds

What proportion of baby care days had a consultant-led ward round with at least one parent included?

**Consultant ward round refers to any ward round where a consultant is in attendance, at any time of the day.*

Change to the audit measure for 2026 data year: None.

NNAP standard

Developmental standard: Benchmarking only.

Outlier identification: No

Outlier management: No

Inclusion criteria

Care days from all admissions to neonatal units that are at least one full calendar day in length (midnight to midnight). All full calendar days from each eligible admission for a baby will be included. Ward days on non-neonatal unit locations (postnatal ward, transitional care etc.) will not be included.

Denominator: Number of care days from all admissions to neonatal units that are at least one full calendar day in length (midnight to midnight) and have complete consultation data.

Numerator: Number of care days from all admissions to neonatal units that are at least 24 hours in length with at least one parent present on the consultant ward round. Presented as a proportion.

Cohort: Babies who experienced their final neonatal discharge in the calendar year of analysis.

Attribution

Attribution will be to the neonatal unit providing care in each eligible admission.

Deriving outcomes

NNAP will use data captured as part of the daily summary of care to confirm parental presence on consultant led ward rounds (Table 11).

If a parent is included in a consultant-led ward round via a digital platform, including a phone or video call, this is considered an appropriate alternative if a parent/carer is unable to be at the ward round in person, and can be counted as parent present.

Table 11: Categorising parental presence at consultant ward rounds from BadgerNet field
Parent present on consultant ward round today?

Parent present on consultant ward round today?	NNAP category
Yes, parent was present for consultant ward round	Parent present
No, parent was not present for consultant ward round	Parent not present
No, no consultant ward round occurred today	Parent not present
Blank	Missing

BadgerNet data source

Details on daily parental presence on ward rounds are captured on BadgerNet in daily summary forms in the *Parent present on consultant ward round today?* field. A form can be created for each baby for each calendar day when they are an inpatient, and NNAP will consider all of the forms created.

Details on daily parental presence on ward rounds can also be captured in the BadgerNet EPR system under the clinical review section, where *Reason for Review* is listed as Ward Round and the *Consultant Ward Round* and *Parent Present at Review* fields are completed.

The screenshot shows the BadgerNet daily summary form for a patient on 28 Aug 22. The form is divided into two main sections: 'General details' and 'Clinical Summary'.

General details:

- Patient care date: 28 Aug 22
- Location of care today: ☐ ICU ☐ TransCare ☐ PICU ward ☐ Other obstetric area
- Ward location:
- Weight today: grams (complete only if baby actually weighed today)
- Working weight: grams
- Get latest weight:
- Most recent head circumference: cm
- Most recent length: cm
- Requiring 1:1 nursing today: ☐ Yes ☐ No (sick/unstable)
- Carer Status: ☐ Carer resident - Caring for baby ☐ Carer resident - Not caring for baby ☐ Carer not resident
- Nursing Status: ☐ Barrier nursed ☐ Isolation
- Observations/monitoring: ☐ None or 3-4 hourly intervals ☐ Continuous ☐ Special ☐ Obs at regular intervals
- Parent present on consultant WR today: ☐ Yes - Parent was present ☐ No - Parent was not present ☐ No - no consultant ward-round (highlighted with a red arrow)
- Any surgical review/contact today: ☐ Yes ☐ No (Other specialty reviews now recorded elsewhere)
- Transported today: ☐ Not transported ☐ With Nurse Only ☐ With Nurse and Doctor ☐ With Paramedic

Clinical Summary:

- Summary for Sunday 28 Aug 22
- At Test Hospital B
- On this date:
 - Day 56 of life
 - Corr. PN age 2wks past term
 - Last weighed on 30 Jul - 1420g
 - Working weight 4000g (31 Jul)
 - Cannot calculate BARN Care Level
 - Cannot calculate HRG value
 - HRG 2016: 9
- Management to this date:
 - 1 Intensive care day
 - 1 High dependency day
 - 3 Special care days
 - 1 day Ventilation
 - 1 day of TPM
- Screening summary in stay to this date:
 - No Cranial Ultrasound this stay
 - Not eligible for SOP Screening
 - No Blood Spot screens done
 - No Hearing Screen this stay
- Diagnosis to this date:
 - Sepsis Suspected (31/Jul)
 - Hyperglycaemia (31/Jul)
 - Jaundice (31/Jul)
- Drugs to this date:
 - Dopamine (31/Jul)
 - Dobutamine (31/Jul)
 - Total parenteral nutrition (31/Jul)
 - Rocuronium (01/Aug)
 - Benzylpenicillin (01/Aug)
 - Gentamicin (01/Aug)
- Operations and Procedures to this date:
 - No operations or procedures recorded

Figure 19: Daily summary, BadgerNet

6 Breastmilk feeding at day 14

Does a baby born at less than 34 weeks' gestational age receive any of their own mother's milk at day 14 of life?

Change to the audit measure for 2026 data year: None.

NNAP standard

Developmental standard: Benchmarking only.

Outlier identification: No

Outlier management: No

Inclusion criteria

Babies born between 22 and 33 weeks' gestational age who survive to their 14th day of life on a neonatal unit.

Denominator: Number of babies born between 22 and 33 weeks' gestational age who survive to their 14th day of life on a neonatal unit and have complete feeding data on the 13th, 14th, or 15th day of life.

Numerator: Number of babies born between 22 and 33 weeks' gestational age who receive any of their own mother's milk on day 14 of life.

**Note the date of birth is counted as day zero. Day one begins on the babies first full day of life.*

Cohort: Babies who experienced their final neonatal discharge in the calendar year of analysis.

Attribution

- Babies will be attributed to their location of care at 48 hours of life, which is intended as a proxy measure of the intention to provide ongoing care for a baby in a given neonatal unit.
- When a baby is in transit between units at 48 hours of life the baby will be assigned to the transferring hospital. When multiple admission locations exist at 48 hours of life, the baby will be attributed to the earliest associated admission time.
- In cases where a baby is transferred, categorisation of a patient is made using episodes that are not held by the unit that has been attributed the patient. The hospital that cares for the patient upon 48 hours of life is responsible for updating episodic data, even if they have not been finally attributed the patient. We therefore ask all units to review the 'BMD14 Responsible' tab on the RAD and ensure they are cleaned for other units' data.

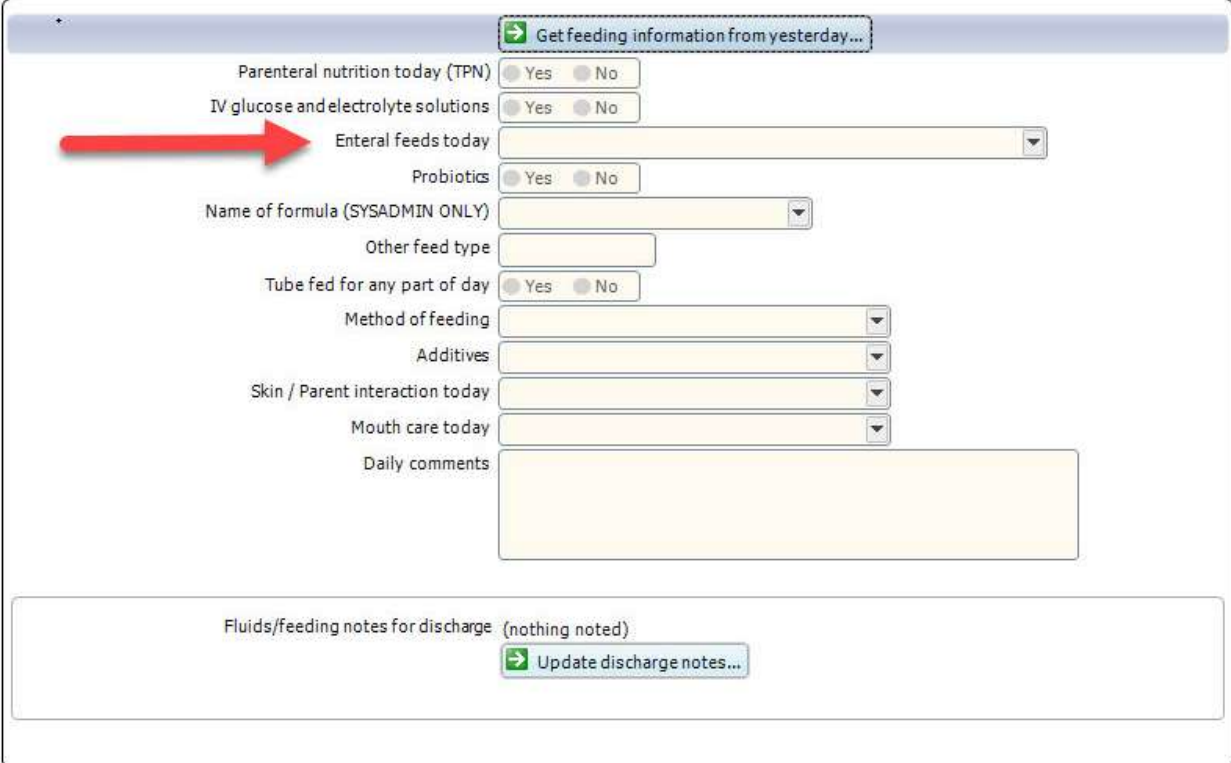
Deriving outcomes

Babies will be classified as meeting the NNAP standard if they are noted to have received any of the following types of enteral feed on their 14th day of life.

- Suckling at the breast
- Mother's fresh expressed breastmilk
- Mother's frozen expressed breastmilk

BadgerNet data source

The primary source for information on feeding at discharge is daily summary data on enteral feeds for the 14th day of neonatal care on the BadgerNet system. When enteral feeding data is missing for the 14th day, data from 13th or 15th day of care will be used instead (the most positive result will be used).



The screenshot shows a web-based form for entering daily summary data. At the top, there is a button labeled "Get feeding information from yesterday...". Below this, the form contains several fields and checkboxes:

- Parenteral nutrition today (TPN) ☐ Yes ☐ No
- IV glucose and electrolyte solutions ☐ Yes ☐ No
- Enteral feeds today (highlighted with a red arrow) [dropdown menu]
- Probiotics ☐ Yes ☐ No
- Name of formula (SYSADMIN ONLY) [dropdown menu]
- Other feed type [text input]
- Tube fed for any part of day ☐ Yes ☐ No
- Method of feeding [dropdown menu]
- Additives [dropdown menu]
- Skin / Parent interaction today [dropdown menu]
- Mouth care today [dropdown menu]
- Daily comments [text area]

At the bottom of the form, there is a section for "Fluids/feeding notes for discharge" with the text "(nothing noted)" and a button labeled "Update discharge notes...".

Figure 20: Daily summary data, BadgerNet.

7 Breastmilk feeding at discharge home

Does a baby born at less than 34 weeks' gestational age receive any of their own mother's milk at discharge to home from a neonatal unit?

Change to the audit measure for 2026 data year: None.

NNAP standard

Developmental standard: At least eighty percent (80%) of babies born at less than 34 weeks' gestational age should receive at least some of their mother's milk at discharge home from the neonatal unit.

Source of standard: By consensus, in consultation with BAPM.

Outlier identification: No

Outlier management: No

Inclusion criteria

Babies born between 22 and 33 weeks' gestational age who are discharged home alive.

Denominator: Number of babies born between 22 and 33 weeks' gestational age who are discharged home alive with complete feeding data on their last or penultimate day of care.

Numerator: Number of babies born between 22 and 33 weeks' gestational age who receive any of their own mother's milk at discharge.

Cohort: Babies who experienced their final neonatal discharge in the calendar year of analysis.

Attribution

Attribution will be to the neonatal unit of final discharge.

Deriving outcomes

Babies will be classified as meeting the NNAP standard if they are noted to have received any of the following types of enteral feed on their final day of care:

- Suckling at breast
- Mother's fresh expressed breast milk
- Mother's frozen expressed breast milk.

UNICEF Baby Friendly field

In addition, babies will also be classified as meeting the NNAP standard if the baby has either of the following records as "yes" in their UNICEF Baby Friendly section:

- "Baby being breastfed" at discharge from unit; *or*
- Both of "Receiving breastmilk" at discharge from unit and "Mother expressing breastmilk" at discharge from unit.

Data will be presented subdivided by rates of breastfeeding, and breastmilk feeding by bottle.

BadgerNet data source

The primary source for information on feeding at discharge is daily summary data on enteral feeds for the last day of neonatal care on the BadgerNet system. When enteral feeding data is missing for the final day, data from the penultimate day of care will be used instead.

The screenshot shows the 'Daily summary form' in BadgerNet. At the top, there is a button labeled 'Get feeding information from yesterday...'. Below this, the form contains several fields with radio buttons for 'Yes' or 'No': 'Parenteral nutrition today (TPN)', 'IV glucose and electrolyte solutions', 'Probiotics', and 'Tube fed for any part of day'. There are also dropdown menus for 'Enteral feeds today' (highlighted with a red arrow), 'Name of formula (SYSADMIN ONLY)', 'Method of feeding', 'Additives', 'Skin / Parent interaction today', and 'Mouth care today'. A text input field for 'Other feed type' and a larger text area for 'Daily comments' are also present. At the bottom, there is a section for 'Fluids/feeding notes for discharge (nothing noted)' with an 'Update discharge notes...' button.

Figure 21: Daily summary form, BadgerNet

In October 2025, the NNAP started supplementing this measure with the UNICEF Baby Friendly field. This form assesses if a baby received breastmilk on their final day of care. Through completing the highlighted fields below, a baby will be considered 'adherent' for this NNAP measure if they receive their own mother's milk on day of discharge.

The screenshot shows the 'UNICEF Baby Friendly - EPR Demo Unit' form. It displays patient information for 'T:WL9F4488S4F SALTY, Thursday', a baby girl born 11 Dec 25 at 06:00, weighing 2323 grams. The form is divided into two main sections: 'During this admission' and 'At discharge from unit'. The 'During this admission' section includes fields for 'Date mum first expressed' and 'Date baby first received human milk', both with dropdown menus and 'at' labels, and a radio button for 'First human milk feed' (Mother's milk or Human donor milk). The 'At discharge from unit' section contains three radio button fields: 'Receiving breastmilk', 'Mother expressing breastmilk', and 'Baby being breastfed', each with 'Yes' and 'No' options. Red arrows point to these three fields. At the bottom, there are buttons for 'Audit trail...', 'Save & Close', and 'Cancel'.

Figure 22: UNICEF Baby Friendly form, BadgerNet

8 Follow-up at two years metric

Does a baby born at less than 30 weeks' gestational age receive medical follow-up at two years gestationally corrected age (18-30 months' gestationally corrected acceptable age range)?⁷

Does a baby have complete results of a structured assessment recorded?⁷

Change to the audit measure for 2026 data year: None. Note that the NNAP is developing reporting of outcomes at 2 years of age for units with a high rate of follow-up completion.

NNAP standard

Developmental standard: At least ninety percent (90%) of babies with two-year follow-up data entered.

Outlier identification: Yes

Outlier management: Yes

Comparison standard for outlier analysis: National proportion.

Inclusion criteria

Babies admitted to a neonatal unit whose gestational age at birth is between 22 and 29 weeks' inclusive, and who are not recorded as having died in their episodic data.

Denominator: Number of babies admitted to a neonatal unit whose gestational age at birth is between 22 and 29 weeks' inclusive, and who are not recorded as having died in their episodic data.

Numerator: Number of babies admitted to a neonatal unit whose gestational age at birth is between 22 and 29 weeks' inclusive, and who are not recorded as having died prior to discharge in their episodic data, who received a medical follow up at two years gestationally corrected age or died post discharge. Presented as a proportion.

Cohort: The eligible cohort runs from July to June each year, for babies who would have reached two years corrected age since the last annual report. Current and projected denominator periods are shown in Table 11.

Table 12: Categorising eligible babies for follow-up at two years of age

NNAP data year	Two-year assessment cohort: Time of birth (inclusive)
2025	July 2022 to June 2023
2026	July 2023 to June 2024
2027	July 2024 to June 2025

Attribution

Attribution will be to the neonatal unit of final discharge. When the unit of final neonatal discharge home cannot be ascertained, two-year data is assigned to the last known episode of neonatal care.

Deriving outcomes

Assessment data will be considered for analysis if it took place between 18 and 30 months corrected age for the infant. This is calculated using assessment date, date of birth and gestational age at birth. If the assessment date is not recorded, the infant will be classified as *Outside of date range*.

Table 13: Categorising two-year follow-up data

Two-year follow-up outcome form	NNAP category
Any two-year follow-up health data entered	Health data entered
Lost to follow-up	No health data entered: Lost to follow-up
Died post discharge	Health data entered
Responsibility of another unit	No health data entered: Not assessed for other reason
Local decision not to follow-up	No health data entered: Not assessed for other reason
Empty follow-up form / No follow up form	No health data entered: No health data entered at all
Assessment occurred outside 18-30 months corrected gestational age	Assessment outside of range

BadgerNet data source

Data from the two-year follow-up form will be used to analyse assessment data. Which sections are used for each part of the analysis is indicated below by the coloured arrows:

The screenshot shows the 'Assessment' form in BadgerNet. On the left is a sidebar with a list of categories: Assessment, Neuromotor, Malformations, Social, Respiratory / CVS system, Gastro-intestinal Tract, Renal, Neurology, Growth, Development score, Bayley III, Griffiths, Schedule of growing, Auditory, Vision, Communication, Neurological diagnosis, and Other Notes. The main form area is titled 'Assessment' and contains the following fields: 'Was 2 year examination done' (radio buttons for No/Yes), 'Assessment late due to COVID restrictions with clinics' (radio buttons for No/Yes), 'Name of person completing form' (text input), 'Designation' (dropdown menu), and 'Date of death (if known)' (dropdown menu). Colored arrows point to specific sections: a red arrow points to the 'Assessment' title; a blue arrow points to the 'Respiratory / CVS system' category in the sidebar; a green arrow points to the 'Gastro-intestinal Tract' category in the sidebar; a red arrow points to the 'Neuromotor' category in the sidebar; a red arrow points to the 'Was 2 year examination done' field; a red arrow points to the 'Assessment late due to COVID restrictions with clinics' field; a red arrow points to the 'Name of person completing form' field; a red arrow points to the 'Designation' field; a red arrow points to the 'Date of death (if known)' field; a red arrow points to the 'Neurology' category in the sidebar; a red arrow points to the 'Growth' category in the sidebar; a red arrow points to the 'Development score' category in the sidebar; a yellow arrow points to the 'Bayley III' category in the sidebar; a yellow arrow points to the 'Griffiths' category in the sidebar; a yellow arrow points to the 'Schedule of growing' category in the sidebar; a red arrow points to the 'Auditory' category in the sidebar; a red arrow points to the 'Vision' category in the sidebar; a red arrow points to the 'Communication' category in the sidebar; and a red arrow points to the 'Neurological diagnosis' category in the sidebar. At the bottom of the form are buttons for 'Save & Close' and 'Cancel'.

Figure 23: Two-year follow-up form, BadgerNet

Red: Assessment data and neurodevelopmental outcomes

Blue: Respiratory outcomes

Green: Gastrointestinal outcomes

Yellow: Standardised assessment data

9 On-time screening for retinopathy of prematurity

Does a baby born at less than 31 weeks' gestational age, or weighing less than 1501g at birth undergo the first ROP screening according to the guideline? ⁸

Change to the audit measure for 2026 data year: None.

NNAP standard

Developmental standard: Ninety percent (90%) of eligible babies should receive ROP screening within the recommended time windows for first screening.

Note that the Guideline recommends that all (100%) of eligible babies should receive ROP screening within the recommended time windows for first screening.

Source of standard: NNAP Project Board consensus. National standard (RCPCH, *UK Screening of Retinopathy of Prematurity Guideline, 2022*).⁸

Outlier identification: Yes

Outlier management: No

Comparison standard for outlier analysis: National proportion.

Table 14: ROP screening window

Gestational age at birth (completed weeks)	National guideline ROP screening window ¹⁰
Less than 31 weeks' gestational age	31+0 and 31+6 weeks' postmenstrual age, or at 4 completed weeks' postnatal age (28-34 days), whichever is later.
At or after 31 weeks' gestational age, with birthweight less than 1501g	36 weeks' postmenstrual age or 4 completed weeks' postnatal age (28-34 days), whichever is sooner.

Inclusion criteria

Babies admitted to a neonatal unit whose birth gestation is between 22 and 30 weeks' inclusive, or whose birth weight was less than 1501g and alive at the beginning of the national guideline screening window.

Denominator: Number of babies admitted to a neonatal unit whose birth gestation is between 22 and 30 weeks' inclusive, or whose birth weight was less than 1501g and alive at the beginning of the national guideline screening window.

Numerator: Number of babies admitted to a neonatal unit whose birth gestation is between 22 and 30 weeks' inclusive, or whose birth weight was less than 1501g and alive at the beginning of the national guideline screening window, who were screened in line with national guidance. Presented as a proportion.

Cohort: Babies who experienced their final neonatal discharge in the calendar year of analysis.

Attribution

ROP screenings will be attributed to the unit completing the earliest screening within the screening window.

If a baby is not screened within the window, they are assigned to the neonatal unit of care at the time that the screening window closed, or the neonatal unit of final discharge when the infant was discharged before the closure of the screening window.

Babies who died before the end of screening window, and who do not have a record of being “Screened on time” will not be attributed to a unit.

Deriving outcomes

ROP status will be derived from the ad-hoc and daily summary of care sections of BadgerNet to confirm if a screening took place and whether it took place during the NNAP ROP screening window (Table).

Table 15: ROP screening categories

These categories are totalled to give ‘Any screen’:			No screening data
Within ROP screening window	Only before ROP screening window opened*	Only after ROP screening window	No ad-hoc ROP form or ROP screen data on daily care summary
Screened on time	Screened early	Screened late	No screening data

*Babies screened both before and after the window, but not within, are classified as “Screened early”.

BadgerNet data source

Details on ROP screenings are captured on BadgerNet via ad-hoc forms for ROP screening and from the daily summary form when *ROP screen today* is answered Yes. Where evidence of ROP screening is available from both sources for the same day ad-hoc screening data will be used preferentially.

Dates from both the ad-hoc and the daily summary forms are used to determine the date of the screening. The time of the screen is not taken into account when calculating ROP screening windows and screens.

The screenshot shows the 'ROP Screening Result - Test Hospital B' form. On the left, there's a sidebar with 'Key notes by topic' and a list of topics including 'ROP screening result...'. The main form area contains patient details for 'T:6B5QBRYF5ZE FRIES, Chip', a date and time field set to '23 Sep 22 at 14:37', a 'Performed By' dropdown, and a 'Parents informed of screen/treatment findings' section with 'Yes' and 'No' radio buttons. Below this is the 'Right Eye' section with various clinical options and a 'Notes' text area. A red arrow points to the 'Date and time' field.

Neonatal day summary - Test Hospital B

T:6B5QBRYF5ZE FRIES, Chip
 Baby boy, singleton, born 04 Jul 22 at 07:00 at 35+0 weeks weighing 4000 grams. Admitted 25 Jul 22 at 16:36 from Test Hospital B. Now in unit - day 60 of stay.
Note Entry Day - 4 Sep 22: Day 63 of life. Corrected postnatal age 3 weeks past term. Working weight 4000g

General details

Respiratory

Cardiovascular

Gastrointestinal

Neurology/NAS

Ophthalmology

Lines in situ/Sepsis

Metabolic/ Jaundice

Haem/transfusions

Renal/Genitourinary

Skin

Fluids and Feeding

Other Problems

Diagnosis, Procedures, and Drugs

Ophthalmology

ROP screen/treatment today ☒ Yes ☐ No

Daily comments

ROP notes for discharge (nothing noted)

[Update discharge notes...](#)

Clinical Summary

Summary for Sunday 04 Sep 22

At Test Hospital B

On this date:

- Day 63 of life.
- Corr. PN age 3wks past term
- Last weighed on 30 Jul - 1420g
- Working weight 4000g (31 Jul)
- Cannot calculate BAPM Care Level.
- Cannot calculate HRG value.
- HRG 2016: 9

Management to this date

- 1 Intensive care day
- 1 High dependency day
- 3 Special care days
- 1 day Ventilation
- 1 day of TPN

Screening summary in stay to this date

- No Cranial Ultrasound this stay
- Not eligible for ROP Screening.
- No Blood Spot screens done.
- No Hearing Screen this stay

Figure 24: Ad-hoc form for ROP screening (top) and daily summary form (bottom), BadgerNet

10 Nurse staffing on neonatal units

What proportion of nursing shifts are numerically staffed according to guidelines and service specification? ⁹

Change to the audit measure for 2026 data year: None.

NNAP standard

Developmental standard: 100% of shifts staffed according to guidelines and service specification.

Outlier identification: No

Outlier management: No

Comparison standard for outlier analysis: NA

Inclusion criteria

Number of shifts (data collection instrument and measure based on a two-shift model of each calendar day).

Denominator: Number of shifts with complete cot occupancy and nurse numbers from the "Registered Nurses, qualified in specialty" field.

Numerator: Number of shifts where nurse staffing met or exceeded service specification rules (1:1 intensive care; 1:2 high dependency care; 1:4 special care; additional shift coordinator)⁹.

Cohort: Shifts within calendar year of analysis.

Attribution

Attribution will be to the neonatal unit.

Deriving outcomes

A "nurse" is a member of non-medical staff with an allocated patient workload, or acting as a coordinator, with or without Nursing and Midwifery Council (NMC) registration, with or without a qualification in speciality. Staff members without allocated patients, such as housekeepers, research nurses, nurses in primarily educational roles are specifically excluded.

The BadgerNet nurse fields included in this analysis are: Shift leader, Registered Nurses QIS, Registered Nurses not QIS, Registered Nurses undertaking QIS training, Associate nurses, Non registered nurses.

Units with transitional care cots located within the neonatal unit should not include transitional care staff within the nursing numbers.

When entering data about partially worked day shifts, units should enter early or late shifts as follows: where a nurse is only present for an "early" or "late" part of a day shift, record as 0.5 shift.

Additionally, any units with less than or equal to 25% data completeness across all their entered shifts will be removed from the measure. This completeness is assessed based on completion of the "Registered Nurses, qualified in specialty" field.

Use the guidance [Safe, sustainable and productive staffing: An improvement resource for neonatal care](#) to support data completion.

BadgerNet data source

Data from the Nursing numbers update form in BadgerNet will be used for this measure. The Nursing numbers update form is found within the Unit report section.

Figure 25: Nursing numbers update form, BadgerNet

Data entered into the form is summarised in the Neonatal Unit Nursing Numbers report (below).

Period	Nurses caring for patients							Cot occupancy				Nurses required				QIS Required (IC & HD)			
	With qual.	Assoc.	Undertaking QIS	Without qual.	Not Reg.	Team Leader	Total	Bank Staff	IC	HD	SC	Admissions	Discharges	BAPM Recommends		Difference	Toolkit recommends	Difference	
01 Sep Day 22	8	1	1	1	1	1	13	3	0	0	0	0	0	1	12 ⁽⁰⁾ (1,200%)	0	0	0	
Night	8	1	1	1	1	1	13	3	0	0	0	0	0	1	12 ⁽⁰⁾ (1,200%)	0	0	9	
02 Sep Day 22	4	1	1	1	1	1	9	0	0	0	0	0	0	1	8 ⁽⁰⁾ (800%)	0	0	5	
Night Update...									0	0	0	0	0	1	-1 ⁽⁻¹⁾ (-100%)	0	0	0	
03 Sep Day 22	Update...								0	0	0	0	0	1	-1 ⁽⁻¹⁾ (-100%)	0	0	0	
Night Update...									0	0	0	0	0	1	-1 ⁽⁻¹⁾ (-100%)	0	0	0	

Figure 26: Neonatal unit nursing numbers, BadgerNet

11 Non-invasive breathing support

What proportion of babies born at less than 32 weeks' gestation only receive non-invasive breathing (or respiratory) support during the first week of life?*

**Invasive respiratory support is defined as that delivered through an endotracheal tube.*

Change to the audit measure for 2026 data year: None.

NNAP standard

Developmental standard: None

Outlier identification: Yes

Outlier management: No

Comparison standard for outlier analysis: Average treatment effect

Inclusion criteria

Babies admitted to a neonatal unit whose birth gestation is between 22 and 31 weeks' inclusive who survived to day 8 of life and did not have surgery in the first week of life. Episodes in the first week of life will be considered for analysis.

Denominator: Number of babies admitted to a neonatal unit whose birth gestation is between 22 and 31 weeks' inclusive, who survived to day 8 of life, who have complete respiratory support data each of their first 7 days, and who did not have surgery in the first week of life.

Numerator: Number of babies admitted to a neonatal unit whose birth gestation is between 22 and 31 weeks' inclusive who survived to day 8 of life and did not have surgery in the first week of life, who only received non-invasive respiratory support during the first week of life. Presented as a proportion.

Cohort: Babies who experienced their first admission in the calendar year of analysis.

Attribution

Results will be attributed to the hospital and network of birth.

When the place of birth is listed as *Home* or *Transit* the hospital and network will be assigned as the provider of their earliest episode. When the place of birth is the site of a closed unit, the hospital will be assigned as *Other* and the network will be assigned as the network responsible for that location.

Deriving outcomes

Outcomes will be derived from the "respiratory support" field of the day summary forms from the first seven days of a baby's care. The numerator is babies who only receive non-invasive respiratory support ("no ventilation/no CPAP" or "non-invasive support (inc. CPAP)") on all of the first seven days of life.

Babies born at or after 23:00 hours will have respiratory data from their first day of life imputed to match respiratory data from their second day of life, if data from their first day of life is missing. This is to account for babies born the day before their first admission to a neonatal unit.

Presenting the data

Type and duration of respiratory support unit and network results are balanced on gestational age. Balancing is a process that compares the babies at each unit to babies from the national population whose results are weighted to create the same gestational age mix as the unit of comparison.

The weighted national result (referred to as the “balanced proportion”) is then compared to the unit’s result (referred to the “observed proportion”), with the difference between their proportions referred to as the “treatment effect”. A positive treatment effect indicates that babies at the unit would have been more likely to receive only non-invasive respiratory support had they been treated elsewhere, and a negative treatment effect indicates that they would have been less likely to receive only non-invasive respiratory support elsewhere.

BadgerNet data source

Details on type of respiratory support are captured on BadgerNet on the Day summary form, indicating type of respiratory support provided on the day.

Glossary of terms and abbreviations

BAPM	The British Association for Perinatal Medicine improves standards of perinatal care by supporting all those involved in perinatal care to optimise their skills and knowledge, promote high quality, safe and innovative practice, encourage research, and speak out for the needs of babies and their families. https://www.bapm.org/
BPD	Bronchopulmonary dysplasia
Bliss	Bliss is a national charity for babies born premature or sick. It exists to give every baby born premature or sick in the UK the best chance of survival and quality of life. Bliss supports families, campaigns for change, supports professionals, and enables life-changing research. https://www.bliss.org.uk
DCC	Deferred cord clamping
GIRFT	Getting It Right First Time (GIRFT) is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change ¹⁰ .
HQIP	The Healthcare Quality Improvement Partnership (HQIP) aims to promote quality improvement in patient outcomes, and in particular, to increase the impact that clinical audit, outcome review programmes and registries have on healthcare quality in England and Wales. HQIP is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices. https://www.hqip.org.uk/
HRG	Healthcare resource group: Standard groupings of clinically similar treatments which use common levels of healthcare resource.
Hyperthermia	A body temperature more than 37.5°C
Hypothermia	A body temperature less than 36.5°C
LNU	Local neonatal units (LNUs) provide neonatal care for their own catchment population, except for the sickest babies. They provide all categories of neonatal care, but they transfer babies who require complex or longer-term intensive care to a NICU, as they are not staffed to provide longer-term intensive care. Most babies over 27 weeks' gestational age will usually receive their full care, including short periods of intensive care, within their LNU. Some networks have agreed variations on this policy, due to local requirements. Some LNUs provide high dependency care and short periods of intensive care for their network population. LNUs may receive transfers from other neonatal services in the network, if these fall within their agreed work pattern ¹¹ .
MatNeoSIP	The Maternity and Neonatal Safety Improvement Programme (MatNeoSIP), formerly known as the Maternal and Neonatal Health Safety Collaborative, is the programme supporting improvement in the quality and safety of maternity and neonatal units across England. https://www.england.nhs.uk/mat-transformation/maternal-and-neonatal-safety-collaborative/
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK. https://www.npeu.ox.ac.uk/mbrance-uk

NCAPOP	National Clinical Audit and Patient Outcomes Programme
NEC	Necrotising enterocolitis
NHSE	NHS England
NICE	National Institute for Health and Care Excellence
NICU	Neonatal intensive care units (NICUs) are sited alongside specialist obstetric and feto-maternal medicine services and provide the whole range of medical neonatal care for their local population, along with additional care for babies and their families referred from the neonatal network. Many NICUs are co-located with neonatal surgery services and other specialised services. Medical staff in a NICU should have no clinical responsibilities outside the neonatal and maternity services ¹¹ .
NMPA	The National Maternity and Perinatal Audit is a national clinical audit of NHS maternity services in England, Scotland and Wales. The audit, commissioned by HQIP, is led by the Royal College of Obstetricians and Gynaecologists in partnership with the Royal College of Midwives (RCM), the Royal College of Paediatrics and Child Health (RCPCH) and the London School of Hygiene and Tropical Medicine (LSHTM). www.maternityaudit.org.uk
NNAP	National Neonatal Audit Programme
Normothermia	A body temperature between 36.5°C and 37.5°C
ODN	Operational delivery network: In England, managed clinical networks for the coordination of neonatal critical care.
Outlier	A result that is statistically above or below expected performance. The NNAP defines outliers in four categories: • outstanding: three or more standard deviations above expected performance • excellent: between two and three standard deviations above expected performance • alert: between two and three standard deviations below expected performance • alarm: three or more standard deviations below expected performance.
PDSA	Plan, do, study, act
Perinatal	The period before and immediately after birth, here defined as the time from fetal viability up to 28 days after birth.
PERIPrem	Perinatal Excellence to Reduce Injury in Premature Birth https://www.weahsn.net/our-work/transforming-services-and-systems/periprem/
PreCePT	The Prevention of Cerebral Palsy in PreTerm Labour. https://www.weahsn.net/our-work/transforming-services-and-systems/precept/

Preterm	Preterm is defined by the World Health Organisation as a baby born alive before 37 weeks of pregnancy are completed. This definition is sub-categorised by gestational age: • extremely preterm (less than 28 weeks) • very preterm (28 to 32 weeks) • moderate to late preterm (32 to 37 weeks).
QI	Quality improvement
RCPCH	The Royal College of Paediatrics and Child Health (RCPCH) was founded in 1996 and now has over 17,000 members across the world. The RCPCH plays a major role in postgraduate medical education, professional standards, research and policy. https://www.rcpch.ac.uk
RCOphth	Royal College of Ophthalmologists
ROP	Retinopathy of prematurity
SCU	Special care units (SCUs) provide special care for their own local population. Depending on arrangements within their neonatal network, they may also provide some high dependency services. In addition, SCUs provide a stabilisation facility for babies who need to be transferred to a neonatal intensive care unit (NICU) for intensive or high dependency care, and they also receive transfers from other network units for continuing special care¹¹.

Appendix 1: “Pathogens” in the NNAP

Bacterial, fungal and yeast positive blood cultures reported to the NNAP in 2024 for the late onset bloodstream infection measure have been classified as shown below into organisms whose growth would be regarded as indicative of a bloodstream infection without further clinical evidence of infection (clearly pathogenic), and into a list of other organisms. This list of organisms included for NNAP reporting is available below. The NNAP are grateful to Dr Jim Gray, Consultant Microbiologist at Birmingham Women's and Children's NHS Foundation Trust, who kindly reviewed organisms reportedly cultured in blood, and helped classify them into 'clearly pathogenic' and 'other' organisms.

For more information, see *Fraser C, Muller-Pebody B, Blackburn R, Gray J, Oddie SJ, Gilbert RE, Harron K. Linking surveillance and clinical data for evaluating trends in bloodstream infection rates in neonatal units in England. PLoS One. 2019 Dec 12;14(12):e0226040. doi: 10.1371/journal.pone.0226040.eCollection 2019.*

Clearly Pathogenic Organisms		
Acinetobacter Baumannii	Acinetobacter Baumannii	Aeromonas Caviae
Aeromonas Hydrophila	Aeromonas Salmonicida	Aeromonas Sobria
Aeromonas Sp	Anaerococcus Prevotii	Aspergillus
Aspergillus Fumigatus	Aspergillus Niger	Aspergillus Sp
B Haemolytic Streptococci	Bacteroides Capillosus	Bacteroides Distasonis
Bacteroides Fragilis	Bacteroides Ovatus	Bacteroides Sp
Bacteroides Uniformis	Bacteroides Vulgatus	C. Koseri
Campylobacter Fetus	Campylobacter Jejuni	Campylobacter Sp
Campylobacter Ureolyticus	Candida	Candida Albicans
Candida Ciferrii	Candida Dubliniensis	Candida Fabianii
Candida Famata	Candida Glabrata	Candida Guilliermondii
Candida Haemulonis	Candida Krusei	Candida Lusitaniae
Candida Parapsilosis	Candida Sp	Candida Sp.
Candida Tropicalis	Cedecea Lapagei	Citrobacter
Citrobacter Amalonaticus	Citrobacter Braakii	Citrobacter Diversus
Citrobacter Farmeri	Citrobacter Freundii	Citrobacter Koseri
Citrobacter Sp	Citrobacter Sp.	Clostridium Beijerinckii
Clostridium Bifermentans	Clostridium Butyricum	Clostridium Paraputrificum
Clostridium Perfringens	Clostridium Septicum	Clostridium Sordelli
Clostridium Sp	Clostridium Sp.	Clostridium Sporogenes
Clostridium Tertium	Coccidioides Sp	Coliform
Cryptococcus Albidus	Cryptococcus Sp	E.Coli
Enterobacter	Enterobacter Aerogenes	Enterobacter Agglomerans
Enterobacter Agglomerans	Enterobacter Amnigenus	Enterobacter Asburiae
Enterobacter Cloacae	Enterobacter Cloacae Complex	Enterobacter Gergoviae
Enterobacter Gergoviae	Enterobacter Hormaechei	Enterobacter Intermedium
Enterobacter Intermedius	Enterobacter Kobei	Enterobacter Sakazakii
Enterobacter Sp	Enterobacter Sp.	Enterococcus Avium
Enterococcus Casseliflavus	Enterococcus Durans	Enterococcus Faecalis
Enterococcus Faecalis	Enterococcus Faecium	Enterococcus Gallinarum
Enterococcus Hirae	Enterococcus Raffinosus	Enterococcus Sp
Enterococcus Sp.	Escherichia	Escherichia Coli

Escherichia Hermannii	Escherichia Sp	Escherichia Vulneris
Extended Spectrum Beta-Lactamase	Fusobacterium Necrophorum	Fusobacterium Nucleatum
Fusobacterium Sp	Gardnerella	Gardnerella Vaginalis
Gbs	Group B Streptococcus	Group G Streptococcus
Haemophilus Influenzae	Hafnia Alvei	Hansenula Sp
Klebsiella	Klebsiella Aerogenes	Klebsiella Ornitholytica
Klebsiella Oxytoca	Klebsiella Planticola	Klebsiella Pneumoniae
Klebsiella Pneumoniae Subsp Ozenae	Klebsiella Sp	Klebsiella Sp.
Kluyvera Sp	Leclercia Adecarboxylata	Listeria Monocytogenes
Listeria Sp	Malassezia Furfur	Malassezia Pachydermatis
Malassezia Sp	Morganella Morganii	Mrsa
Neisseria Meningitidis	Pantoea Agglomerans	Pantoea Septica
Pantoea Sp	Pasteurella	Pasteurella Haemolytica
Pasteurella Multocida	Pasteurella Pneumotropica	Pasteurella Sp
Pasteurella Sp.	Peptostreptococcus	Peptostreptococcus Asaccharolyticus
Peptostreptococcus Magnus	Prevotella Bivia	Prevotella Buccalis
Prevotella Oralis	Proteus Mirabilis	Proteus Penneri
Proteus Sp	Proteus Sp.	Proteus Vulgaris
Providencia Alcalifaciens	Providencia Stuartii	Pseudomonas Aeruginosa
Raoultella Planticola	Raoultella Planticola	Raoultella Sp
Raoultella Terrigena	Rhodotorula	Rhodotorula Rubra
Rhodotorula Sp	S. Aureus	Salmonella Aba
Salmonella Agama	Salmonella Ajiobo	Salmonella Apapa
Salmonella Arizonae	Salmonella Brandenburg	Salmonella Colindale
Salmonella Cotham	Salmonella Cubana	Salmonella Djugu
Salmonella Dublin	Salmonella Enteritidis	Salmonella Gold-Coast
Salmonella Hadar	Salmonella Heidelberg	Salmonella Hofit
Salmonella Hull	Salmonella Infantis	Salmonella Kedougou
Salmonella Kiambu	Salmonella Kibusi	Salmonella Kintambo
Salmonella Kisarawe	Salmonella Matopeni	Salmonella Mississippi
Salmonella Monschaui	Salmonella Montevideo	Salmonella Muenchen
Salmonella Muenster	Salmonella Newport	Salmonella Oranienburg
Salmonella Poona	Salmonella Reading	Salmonella Saphra
Salmonella Senftenberg	Salmonella Sinstorf	Salmonella Sp
Salmonella Sp.	Salmonella Stanley	Salmonella Tel-El-Kebir
Salmonella Typhi And Paratyphi	Salmonella Typhimurium	Salmonella Unnamed
Salmonella Virchow	Salmonella Vitkin	Salmonella Wichita
Serratia Liquefaciens	Serratia Marcescens	Serratia Odorifera
Serratia Plymuthica	Serratia Proteamaculas	Serratia Rubidaea
Serratia Sp	Serratia Sp.	Shigella Flexneri
Shigella Sonnei	Staphylococcus Aureus	Stellatoidea
Streptococcus Agalactiae	Streptococcus Anaerobic	Streptococcus Anginosus
Streptococcus Bovis	Streptococcus Constellatus	Streptococcus Faecalis
Streptococcus Group A Stem	Streptococcus Group B Stem	Streptococcus Group C Stem
Streptococcus Group D Stem	Streptococcus Group G Stem	Streptococcus Milleri
Streptococcus Milleri Group	Streptococcus Pneumoniae	Streptococcus Pyogenes
Veillonella Atypica	Veillonella Named	Yeasts
Yeasts (Other)	Yersinia Enterocolitica	Yersinia Sp.

Other organisms		
Abiotrophia	Corynebacterium Striatum	Paecilomyces Lilacinus
Abiotrophia Adiacens	Corynebacterium Xerosis	Paenibacillus Amylolyticus
Abiotrophia Adjacens	Coryneform Bacilli	Paenibacillus Glucanolyticus
Abiotrophia Defectiva	Delftia Acidovorans	Paenibacillus Pabuli
Achromobacter Sp	Dermabacter Hominis	Paenibacillus Sp
Achromobacter Xylosoxidans	Dermacoccus Sp	Pantoea
Acidovorax Temperans	Diphtheroids	Parabacteroides Distasonis
Acinetobacter Anitratus	Eggerthella Lenta	Paracoccus Sp
Acinetobacter Calcoaceticus	Eikenella Corrodens	Paracoccus Yeeii
Acinetobacter Haemolyticus	Elizabethkingia Miricola	Pediococcus Acidilactici
Acinetobacter Johnsonii	Elizabethkingia Sp	Penicillium Sp
Acinetobacter Junii	Enterovirus	Peptococcus Sp
Acinetobacter Lwoffii	Eubacterium Lentum	Phialophora
Acinetobacter Parvus	Exophiala Sp.	Positiveâ Gram Cocci
Acinetobacter Radioresistens	Flavimonas Oryzihabitans	Propionibacterium Acnes
Acinetobacter Sp	Flavobacterium Sp.	Propionibacterium Freudenreichii
Acinetobacter Sp.	Gemella Haemolysans	Propionibacterium Sp
Acinetobacter Ursingii	Gemella Morbilarum	Propriobacterium Acnes
Actinomyces	Gemella Morbillorum	Providencia Rettgeri
Actinomyces Bovis	Geotrichum Sp	Pseudoclavibacter Sp
Actinomyces Cardiffensis	Globicatella Sanguis	Pseudomonas Alcaligenes
Actinomyces Naeslundii	Gordonia Bronchialis	Pseudomonas Fluorescens
Actinomyces Neuii	Gordonia Sp	Pseudomonas Luteola
Actinomyces Odontolyticus	Gram Negative Bacilli	Pseudomonas Oleovorans
Actinomyces Oris	Granulicatella Adiacens	Pseudomonas Oryzihabitans
Actinomyces Sp	Granulicatella Elegans	Pseudomonas Paucimobilis
Actinomyces Sp.	Haematobacter Sp	Pseudomonas Putida
Actinomyces Viscosus	Haemophilus	Pseudomonas Sp
Aerococcus Sp	Haemophilus Aphrophilus	Pseudomonas Sp.
Aerococcus Urinae	Haemophilus Haemolyticus	Pseudomonas Stutzeri
Aerococcus Viridans	Haemophilus Parahaemolyticus	Pseudoxanthomonas Kaohsiungensis
Agrobacterium Tumefaciens	Haemophilus Parainfluenzae	Psychrobacter Phenylpyruvicus
Alcaligenes Faecalis	Haemophilus Paraphrohaemolyticus	Rahnella Named
Alcaligenes Sp	Haemophilus Sp	Rahnella Sp
Alpha Haemolytic Streptococcus	Haemophilus Sp.	Ralstonia Pickettii

Alternaria Sp.	Kingella Denitrificans	Ralstonia Sp.
Anaerobes (Not Specified)	Kingella Kingae	Rhinovirus
Anitratius	Kingella Sp	Rhizobium Radiobacter
Arcanobacterium Haemolyticum	Kocuria Kristinae	Rhodococcus
Arthrobacter Sp	Kocuria Rhizophila	Rhodococcus Bronchialis
Aurantimonas Altamirensis	Kocuria Rosea	Rhodococcus Sp
Bacillus	Kocuria Sp	Roseomonas Gilardii
Bacillus Cereus	Kocuria Species	Roseomonas Mucosa
Bacillus Circulans	Kocuria Varians	Roseomonas Sp
Bacillus Licheniformis	Kytococcus Schroeteri	Rothia Aeria
Bacillus Pumilus	Lactobacillus	Rothia Dentocariosia
Bacillus Silvestris	Lactobacillus Crispatus	Rothia Sp
Bacillus Sp	Lactobacillus Fermentum	Rothia Spp
Bacillus Sp.	Lactobacillus Gasseri	Ruminococcus Gnavus
Bacillus Subtilis	Lactobacillus Jensenii	Scopulariopsis Brevicaulis
Bifidobacter Species	Lactobacillus Lactis	Sphingobacterium Multivorum
Bifidobacterium	Lactobacillus Paracasei	Sphingomonas
Bifidobacterium Adolescentis	Lactobacillus Rhamnosus	Sphingomonas Paucimobilis
Bifidobacterium Breve	Lactobacillus Sp	Sphingomonas Sp
Bifidobacterium Catenulatum	Lactobacillus Sp.	Staph Saprophyticus
Bifidobacterium Longum	Lactococcus Cremoris	Staphylococcus Capitis
Bifidobacterium Sp	Lactococcus Garvieae	Staphylococcus Coagulase Negative
Brevibacillus Parabrevis	Lactococcus Lactis	Staphylococcus Epidermidis
Brevibacterium	Lactococcus Sp	Staphylococcus Haemolyticus
Brevibacterium Casei	Lactococcus Sp.	Staphylococcus Hominis
Brevibacterium Sp	Leuconostoc Sp	Staphylococcus Lugdunensis
Brevundimonas Diminuta	Lysinibacillus Sp	Staphylococcus Pettenkoferi
Brevundimonas Sp	Mallassezia Furfur	Staphylococcus Simulans
Brevundimonas Vesicularis	Massilia Timonae	Staphylococcus Sp
Burkholderia Capecia	Methylobacterium Sp	Staphylococcus Sp.
Burkholderia Cepacia	Microbacterium Aurum	Staphylococcus Vitulinus
Burkholderia Gladioli	Microbacterium Paraoxydans	Staphylococcus Warneri
Burkholderia Sp.	Microbacterium Sp	Stenotrophomonas Acidaminiphila
Capnocytophaga	Micrococcus	Stenotrophomonas Maltophilia
Chryseobacterium Indologenes	Micrococcus Luteus	Stenotrophomonas Sp

Chryseobacterium Meningosepticum	Micrococcus Lylae	Stephanoascus Ciferrii
Chryseobacterium Sp	Micrococcus Sp	Streptococcus Mutans
Chryseobacterium Sp.	Micrococcus Sp.	Stomatococcus Mucilaginosus
Chryseomonas Indologenes	Micrococcus Varians	Stomatococcus Sp
Cladosporium Sp.	Microsporum Sp	Streptococcus Alactolyticus
Collinsella Aerofaciens	Mixed Growth	Streptococcus Alpha And Non-Haemolytic
Comamonas Acidovorans	Moraxella Catarrhalis	Streptococcus Cristatus
Comamonas Testosteroni	Moraxella Lacunata	Streptococcus Gordonii
Cons	Moraxella Nonliquefaciens	Streptococcus Infantarius Subsp Nov
Cons (Mixed)	Moraxella Osloensis	Streptococcus Infantis
Corynebacterium	Moraxella Sp	Streptococcus Intermedius Group
Corynebacterium Afermentans	Moraxella Sp.	Streptococcus Lutetiensis
Corynebacterium Amycolatum	Mycobacterium Sp.	Streptococcus Mitis
Corynebacterium Aurimucosum	Neisseria Cinerea	Streptococcus Oralis
Corynebacterium Auris	Neisseria Flavescens	Streptococcus Other Group
Corynebacterium Coyleae	Neisseria Lactamica	Streptococcus Parasinguinis
Corynebacterium Diphtheriae	Neisseria Mucosa	Streptococcus Peroris
Corynebacterium Imitans	Neisseria Perflava	Streptococcus Pseudoporcinus
Corynebacterium Jeikeium	Neisseria Polysacchareae	Streptococcus Salivarius
Corynebacterium Minutissimum	Neisseria Sicca	Streptococcus Sanguis
Corynebacterium Mucifaciens	Neisseria Sp	Streptococcus Sobrinus
Corynebacterium Propinquum	Neisseria Subflava	Streptococcus Sp
Corynebacterium Pseudodiphtheriticum	Nhs	Streptococcus Sp.
Corynebacterium Simulans	Oceanobacillus Profundus	Streptococcus Thermophilus
Corynebacterium Sp	Ochrobactrum Anthropi	Streptococcus Vestibularis
Corynebacterium Sp.	Ochrobactrum Sp	Streptococcus Viridans

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