HOUSE OF COMMONS LIBRARY

DEBATE PACK

Number CDP 2016/0118, 7 June 2016

Stillbirth

Dr Sarah Barber
Nikki Sutherland

This pack has been prepared ahead of the Westminster Hall debate on Thursday 9 June 2016 at 1.30pm on stillbirth. The Member in charge is Patricia Gibson.

Contents

The House of Commons Library prepares a briefing in hard copy and/or online for most non-legislative debates in the Chamber and Westminster Hall other than half-hour debates. Debate Packs are produced quickly after the announcement of parliamentary business. They are intended to provide a summary or overview of the issue being debated and identify relevant briefings and useful documents, including press and parliamentary material. More detailed briefing can be prepared for Members on request to the Library.

1. Press Articles

Guardian
Fifteen babies a day in UK are stillborn or die within month of birth
Sarah Boseley 17 May 2016
http://www.theguardian.com/lifeandstyle/2016/may/17/15-babies-a-day-uk-stillborn-or-die-within-month-of-birth

Sunday Times
NHS bid to prevent 1,500 stillbirths
Sarah-Kate Templeton, Health Editor 20 March 2016
http://www.thesundaytimes.co.uk/sto/news/uk_news/Health/SaferBirthsCampaign/article1680152.ece

Guardian
Rate of stillbirths in UK higher than Poland, Croatia and Estonia
Damien Gayle 7 February 2016
http://www.theguardian.com/lifeandstyle/2016/feb/07/rate-of-stillbirths-in-uk-higher-than-poland-croatia-and-estonia

Sunday Times
600 stillborn babies a year could be saved
Sarah-Kate Templeton, Health Editor 15 November 2015
http://www.thesundaytimes.co.uk/sto/news/uk_news/Health/article1633445.ece?CMP=OTH-gnws-standard-2015_11_14

Scotsman
Stillbirth rate drops following smoking ban
David O'Leary 12 August 2015
http://www.scotsman.com/news/education/stillbirth-rate-drops-following-smoking-ban-1-3856410

2. Press releases

SANDS Stillbirth and Neonatal Death Charity
June is Sands Awareness Month – raising awareness and understanding of baby death across the UK
6 June 2016

June is Sands Awareness Month, a time dedicated to increasing awareness of stillbirth and neonatal death and the everlasting impact experienced when a precious baby dies before, during or soon after birth.

The pain of baby loss has traditionally been a taboo subject and people have long been unaware of how common, and how devastating, it is to experience the death of a baby.

More recently a lot of progress has been made in breaking the silence, but there is still a long way to go. Sands Awareness Month is an opportunity to give a voice to anyone who has experienced the death of a baby; to highlight the fact that over 100 babies will die each week during the month of June (and throughout the year) and to raise vital funds so that Sands can continue to support families, work to improve bereavement care and fund, promote vital research and campaign for a world where fewer babies die.

Sands is also launching the Walk a Mile in My Shoes fundraising event. Walks can be done alone, with friends or family or work colleagues and are a chance to share and celebrate memories whilst raising vital funds. It can be serious or fun (the walks don't need to be done in hiking boots or trainers), high profile or lower key.

On 13 April 2003 life changed forever for Sean and Sian Casey when their baby girl Ciara was stillborn. During June they will be taking part in Sands' Walk a Mile in My Shoes.

Sean Casey said:
"As a family we were so fortunate that Sands supported us in the days, weeks and years that followed.
"For many years we have continued to strive to raise money for, and awareness of, all the great work that Sands does. In recent years we have even encouraged people to do one of Ciara's Miles, so it only seems right that as a family we will be taking part in Walk a Mile in My Shoes. More importantly we will be encouraging others to take part.
"Losing a child is unbearable and watching your loved ones in such pain can make you feel helpless. Getting active has made us feel like we are doing something to support and honour Ciara and she is the "fuel" that drives us on.
"We'll be doing our mile and raising a smile."

The charity is also asking people to help them spread the word by turning Orange this June!

Individuals and groups across the country will be embracing the colour orange by hosting orange dress down days, orange challenge events such as a baked beans bath or even an orange themed dinner party with carrots, pumpkins and orange sorbet on the menu.

Supporters will be sharing their Orange Selfie on their favourite social media networks to inspire others to do the same, and updating their profile picture and cover photo for the duration of June to raise awareness.

People are also encouraged to support Sands Awareness Month and commemorate babies taken too soon, by texting JUNE01 £5 to 70070. To find out more about Walk a Mile in My Shoes event please click here.
For further information please click here.

Royal College of Obstetricians and Gynaecologists
RCOG statement: MBRRACE-UK report on stillbirths and neonatal deaths
17 May 2016

Today, MBRRACE-UK publishes its annual perinatal mortality surveillance report which examines the deaths of babies from 24 weeks of pregnancy. There were 3,252 stillbirths and 1,381 neonatal deaths in 2014, which means almost 6 deaths per 1,000 births.
The report also found significant variation across the UK that is not solely explained by factors that influence the rate of death such as poverty, mother's age, multiple birth and ethnicity.

Other key findings from the report include:

- Two thirds of stillbirths and neonatal deaths were in preterm babies (between 24-37 weeks' gestation)
- The causes of 46% of stillbirths and 5% of neonatal deaths are unknown
- Geographical variation in mortality rates ranged from 4.7 to 7.1 per 1,000 births
- One area of unexplained variation is in the proportion of deaths coded as being due to major congenital anomalies
- Over 90% of parents whose baby died were offered a post-mortem, but only 40% consented

Dr David Richmond, President of the Royal College of Obstetricians and Gynaecologists (RCOG), said:
"Although the findings of the report show an overall improvement in the rates of stillbirth and neonatal deaths in the context of the increasing medical complexity of the maternal population, rates are still higher than many other high income countries. It is clear that we still face a challenge of further reducing these deaths, as well as addressing the existing variation of perinatal mortality rates across the UK.

"Sadly, much is still unknown about the causes of almost half of stillbirths and 5% of neonatal deaths. In addition, two thirds of all stillbirths and neonatal deaths were in preterm babies, so any future initiatives must also include a focus on reducing premature birth and the recently published NICE guideline provides healthcare professionals with clear guidance on reducing the risks of preterm birth and delaying early labour. As and when new evidence emerges, the RCOG's role is to translate this research into changes to practice in the UK.

"Our current focus is on the implementation of interventions which are already known to reduce stillbirths – particularly those that occur at full term, after 37 weeks' gestation. These include the diagnosis and management of gestational diabetes, measuring and recording of growth and fetal movements, improving multi-disciplinary training packages and promoting more effective team working to help doctors and midwives pick up potential complications.

"Promotion of messages which may help women reduce the risk of stillbirth – such as maintaining a healthy weight prior to conception, stopping smoking and attending antenatal appointments – are also essential components to help end preventable stillbirths.

"Although an extremely difficult time for grieving parents, post-mortems are vital in order to gain more of an understanding into why these deaths are occurring and families need skilled and highly trained professional support through this process."

"Along with the MBRRACE-UK team, we have also identified that local reviews following a stillbirth or early neonatal death remain an area in need of clear improvement. Standards of care can vary considerably across the country and frustratingly not all deaths are reviewed rigorously to ensure lessons are learned when mistakes do happen. Through the RCOG's Each Baby Counts initiative, we are undertaking a structured review to help identify common risk factors for perinatal deaths and enable us to learn from what went wrong and apply the lessons in maternity units across the country. It's time to ensure that every mother receives the best quality of care and avoidable deaths are prevented."

Royal College of Paediatrics and Child Health
Study finds 'significant variation' in stillbirths and neonatal mortality across the UK
17 May 2016
Research published today shows the wide regional variation in the incidence of stillbirth and neonatal deaths in the UK.

The MBRRACE-UK report focuses on rates of stillbirth and neonatal death across the UK. MBRRACE-UK focuses on babies born at 24 weeks of gestation or more. The report found that in 2014 there was a slight fall in both the stillbirth and neonatal death rates (4.16[1] and 1.77[2]) compared to 2013 (4.20[1] and 1.84[2]) although this pattern was not uniform across the UK.

One area of unexplained variation is in the proportion of deaths coded as being due to major congenital anomalies (such as serious heart defects). In some areas of the UK there were no deaths reported from this cause whereas in others over half of the deaths were linked to underlying congenital anomalies. This could be due to how the cause of death for these babies was interpreted and requires further investigation.

Responding to the new research Professor Neena Modi, President of the Royal College of Paediatrics and Child Health said:
"This research confirms the need for action to reduce stillbirths and neonatal deaths. However what is particularly concerning is the further evidence, already raised as a problem by other research groups, of the poor quality of much administrative data in the NHS and the lack of consistency across the UK in reporting the causes of stillbirths. Without high quality data it will continue to be very hard to build up a nationwide picture of the reasons for perinatal losses, or improve many other aspects of pregnancy and newborn care. We suggest that attention to identifying and utilising reliable sources of maternity and newborn clinical data, and improving NHS administrative data must be a priority."

Royal College of Midwives
'UK must do more to address health inequalities and to reduce stillbirths say midwives'
10 April, 2016

Avoidable maternal and child deaths could be greatly reduced in a generation by rapid expansion of essential, highly-cost effective health interventions and services according new research published in The Lancet.

Improving pregnancy and delivery care is just one of the three integrated packages of proven interventions which the researchers say will focus on a range of health problems that, despite major progress, continue to kill millions of women, new-borns, and children every year. The authors have estimated that 90 percent of the global unmet need for contraception in the Reproductive Health package could avert 28 million births each year and consequently prevent around 67,000 maternal deaths from childbirth, around 91,0000 new-born and child deaths, and over 56,0000 stillbirths every year

Commenting Louise Silverton Director for Midwifery at The Royal College of Midwives (RCM) says; "The RCM welcomes this latest study, but it is important to remember that improvements in overall child health outcomes show that perinatal outcomes have not improved as much as those for older children, much more needs to be done to improve this."

"These findings must be looked at with the Lancet series on midwifery that showed that access to midwifery care in low and middle income countries could vastly reduce maternal and perinatal mortality."

"In the UK attention to preventing stillbirths in the approach to term must be improved, this has been recognised and government initiatives are in place. To do this there must be sufficient midwives employed in the NHS. In addition, the UK still needs to do more to address health inequalities and to reduce stillbirths in areas of social deprivation."

The Lancet preventable maternal and child deaths research:http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)00738-8/abstract
The Lancet Series on Midwifery:
http://www.thelancet.com/series/midwifery

Notes to editors
The RCM is the only trade union and professional association dedicated to serving midwifery and the whole midwifery team. We provide workplace advice and support, professional and clinical guidance and information, and learning opportunities with our broad range of events, conferences and online resources. For more information visit the RCM website at https://www.rcm.org.uk/.

Royal College of Midwives
NHS England publishes new guidance to reduce stillbirths
21 March, 2016

The new guidance is part of a drive to halve the rate of stillbirths in England by 2030.

Saving babies' lives – a care bundle for reducing stillbirth brings together four key elements of care and is the first time that guidance specifically for reducing stillbirths has been brought together in a coherent package.

It will support commissioners, providers and professionals in making care safer for women and babies.

Four of the key interventions included in the guidance include reducing smoking in pregnancy, enhancing detection of fetal growth restriction, improving the awareness of fetal movement, and improving fetal monitoring during labour.

As part of this, an information and advice leaflet on reduced fetal movement is being launched and will be provided to all women by week 24 of their pregnancy.

Saving babies' lives builds on existing clinical guidance and best practice, and was developed by NHS England working with organisations including the RCM, RCOG, British Maternal and Fetal Medicine Society and Sands, the stillbirth and neonatal death charity.

RCM chief executive Cathy Warwick said that while maternity services in England are among the safest in the world and the stillbirth rate is low, we still lag behind other western European countries, and this is not acceptable.

'The four key interventions outlined by NHS England are key to ensuring consistent care and in helping to reduce stillbirths,' said Cathy.

'We must all be striving to reduce stillbirths as much as is possible. All trusts should be working to the same standards of care and we would expect them to use this guidance to provide the best possible care to mothers, babies and their families.

'All of the interventions and their implementation will need investment in resources, particularly in staff. Midwives and other staff must have the time to spend with women and they must have the time to attend training. Having the right number of midwives will also contribute to continuity of care and carer; in women seeing the same midwife or small number of midwives. They will be able to get to know the women better and spot changes in their condition that could go unnoticed without that consistency.

'England remains 2600 full-time midwives short of the number it needs. So while this guidance is welcome and valuable, we must have the right numbers of staff to ensure it is implemented correctly.

'There are also much wider issues in society that contribute to stillbirths, including smoking and obesity. There are cuts to public health funding for local authorities, such as smoking cessation services, and we need to see these reversed, indeed increased.

'This guidance should make a difference and help to prevent families experiencing the tragedy of their baby being stillborn. However, to get the maximum benefit we must make sure the right resources are in place. The RCM looks forward to working to ensure the highest quality of care is provided for all mothers and their babies.'
Access the new guidance here.

Department of Health
Focus on maternity services drives safer care
7 March 2016

Hospitals in England have been asked to make a public commitment to improve maternity care today.

As part of the Government's campaign to halve the number of stillbirths, neo natal deaths, maternal deaths and brain injuries occurring during or soon after birth by 2030, new guidance has been prepared which will help hospitals commit to making practical changes in order to improve care for mums and babies.

More than 90 trusts (full list here) have also received additional funding - part of a £2million government fund - to spend on new equipment and devices, including new ultrasound machines and mother and baby monitoring equipment, so any problems can be detected and addressed earlier.

New guidance – 'Spotlight on Maternity'
The new 'Spotlight on Maternity' guidance will help hospitals to set out concrete actions that can be taken to improve the care offered to families at this important moment. Actions could include a board-level focus on maternity safety, rolling out training for all maternity staff on the risks and symptoms of perinatal mental health and ensuring staff focus on safety when handing over to colleagues at the end of a shift.

Welcoming the guidance, health minister Ben Gummer said:
Patients deserve a safer NHS seven days a week and this guidance is part of our plan to make our maternity services among the safest in the world.

Along with the introduction of new equipment and improved training programmes, this guidance will place a further spotlight on our ambition to reduce the number of stillbirths, neonatal deaths, maternal deaths and brain injuries occurring during or soon after birth.

Additional investment
As part of its campaign to improve maternity safety, the Government is also investing in the development of a new system that can be used consistently across the NHS so staff can review and learn from every stillbirth and neonatal death. More than £1million has also been invested to roll out training programmes so staff can develop the skills and confidence they need to deliver world-leading safe care.

Royal College of Obstetricians and Gynaecologists
RCOG response to The Lancet: Ending preventable stillbirths series
19 January 2016

The Lancet has published a five-paper series on ending preventable stillbirths. The series reports on the present state of stillbirths, highlights missed opportunities, and identifies actions for accelerated progress to end preventable stillbirths and reach 2030 maternal, neonatal, and child survival targets.

Dr David Richmond, President of the RCOG, said:
"This comprehensive series of papers presents a 'wake-up call' to governments worldwide to make faster progress in reducing the number of stillbirths, which wreak untold damage on families, care givers and communities. In low and middle income countries, most stillbirths could be prevented with straightforward improvements to antenatal care and the care of women and their babies during childbirth, and we support the call for recommendations on preventing stillbirths to be included in every country's Newborn Action Plan.

"In the UK, there is still much to be done to ensure our rate of progress is as good as the best in Europe. As leaders of the profession, we are committed to understanding more about stillbirths, improving multi-disciplinary training packages and promoting more effective team working to help doctors and midwives pick up potential complications and reduce the number of babies who are stillborn.

"We have also identified that local reviews following stillbirth remain an area in need of clear improvement. Through the RCOG's Each Baby Counts initiative, we are this year beginning to undertake a structured review of each and every stillbirth that occurs during labour in term pregnancies to help identify common risk factors, learn from what went wrong and apply the lessons in maternity units across the country.

"The series highlights that much is still unknown about the causes of stillbirth and it will be the role of the RCOG to translate any new research or emerging evidence into changes to practice in the UK. Promotion of messages which may help women reduce the risk of stillbirth – such as maintaining a healthy weight prior to conception, stopping smoking and attending antenatal appointments – are all essential components to help end preventable stillbirths worldwide. Additionally, the messages within the recent MBRRACE stillbirth review in the UK – which include recognising risk factors for gestational diabetes and implementation of recommendations for care, measuring and recording of growth as well as fetal movements – are just as relevant globally as they are here in the UK."

Notes to editors:
The Royal College of Obstetricians and Gynaecologistsis a medical charity that champions the provision of high quality women's healthcare in the UK and beyond. It is dedicated to encouraging the study and advancing the science and practice of obstetrics and gynaecology. It does this through postgraduate medical education and training and the publication of clinical guidelines and reports on aspects of the specialty and service provision.

The RCOG's Each Baby Counts national quality improvement programme was launched in October 2014 and is a major five-year project to reduce the number of stillbirths, neonatal deaths and brain injuries occurring as a result of incidents during term labour by 50% by 2020.

MBRRACE-UK confidential enquiry into perinatal mortality: term, singleton, normally-formed, antepartum stillbirths (published on 19 November, 2015).

Royal College of Paediatrics and Child Health
RCPCH responds to MBRRACE-UK report into still-births
19 November 2015

In response to the report published today by MBRRACE-UK into the care of pregnant mothers and babies, Professor Neena Modi, President of the Royal College of Paediatrics and Child Health, said:

"Giving birth to a still-born baby is heartbreaking. The report from MBRRACE-UK indicates that opportunities to prevent this may be being missed. The team identified a number of associations between stillbirths and sub-optimal care and suggests that improvements in the management of pregnant women may reduce the rate of this tragic outcome. We were glad to see that a high standard of bereavement care and well conducted post-mortem examinations were also found.

"The RCPCH supports the recommendations set out by MBRRACE-UK, but we would also advocate that mechanisms are put in place to evaluate their effectiveness in reducing the rate of stillbirths. We would additionally urge greater support for mothers to reduce risky behaviours during pregnancy such as smoking, and help for young women who are contemplating pregnancy to maintain a normal weight.

"Smoking during pregnancy is a major concern as it causes higher rates of stillbirth, premature birth, low birth weight and sudden infant death in babies. Smoking among pregnant women in poor and disadvantaged groups and teenage mothers-to-be remains considerably more prevalent than in the general population. Teenagers are almost six times more likely to smoke throughout pregnancy than women who are over 35, and less likely to quit. Obesity is also more prevalent among poor and disadvantaged groups and also carries an increased risk of stillbirth and other poor pregnancy outcomes.

"Government only last week pledged to cut the number of stillbirths and neonatal deaths. We therefore urge Government to focus on improving the health of young women in order to safeguard the wellbeing of the next generation."

Department of Health
New ambition to halve rate of stillbirths and infant deaths
13 November 2015

Government announces new commitment to ensure England is one of the safest places in the world to have a baby.

The Health Secretary, Jeremy Hunt, has announced a new ambition to reduce the rate of stillbirths, neonatal and maternal deaths in England by 50% by 2030.

The number of brain injuries occurring during or soon after birth will also be targeted as part of a new commitment by the government, in partnership with consultants, midwives and other experts across the country to make England one of the safest places to have a baby. The government will work with national and international experts to ensure that best practice is applied consistently across the NHS and that staff can review and learn from every stillbirth and neonatal death. Maternity services will be asked to come up with initiatives that can be more widely adopted across the country as part of a national approach – such as appointing maternity safety champions to report to the board and ensuring all staff have the right training to enable them to identify the risks and symptoms of perinatal mental health.

Trusts will receive a share of over £4 million of government investment to buy high-tech digital equipment and to provide training for staff already working to improve outcomes for mums and babies. This includes a £2.24 million fund to help trusts to buy monitoring or training equipment to improve safety, such as cardiotocography (CTG) equipment to monitor babies' heartbeat and quickly detect problems, or training mannequins that staff can practise emergency procedures on.

A further £500,000 will be invested in developing a new system for staff to review and learn from every stillbirth and neonatal death. The new safety investigation unit will also be asked, once established, to consider a particular focus on maternity cases for its first year.

Over £1 million will be invested in rolling out training packages developed in agreement with the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists, to make sure staff have the skills and confidence they need to deliver world-leading safe care.

This builds on previous government commitments to invest £75 million in improving perinatal mental health services and ensuring all maternity care is considered as part of 'Ofsted style' ratings for commissioners. Over time this initiative will allow the money spent on caring for injured children or paid as compensation to be re-invested in improved front line services.

Health Secretary Jeremy Hunt said:
The NHS is already a safe place to give birth, but the death or injury of even one new baby or mum is a devastating tragedy which we must do all we can to prevent.

With more support and greater transparency in maternity services across England we will ensure every mother and baby receives the best and safest care, 24 hours a day, 7 days a week – this is at the heart of the NHS values we are backing with funding from a strong economy. Countries like Sweden are proof that focusing on these issues can really improve safety – with the help of staff on the frontline, we can improve standards here at home.

The ambition is part of a wider government aim to reduce all avoidable harm by 50% and save 6,000 lives by 2017, and it will form a key part of the work of the patient safety campaign Sign up to Safety. The government will align next steps with the Independent Review of Maternity Services' recommendations, which is already looking at ways to improve quality and safety.

Dr David Richmond, President of the Royal College of Obstetricians and Gynaecologists (RCOG), said:
We support this initiative and our important role in it as leaders of the profession. Good progress has been made but the fact is many of these incidents could be avoided with improvements to the care women and their babies receive.

The RCOG will continue to work closely with our clinical colleagues and the Royal College of Midwives to provide better multi-disciplinary training packages and promote more effective team working, so that this aspect of care can be improved. The challenges of reducing health problems and deaths in mothers and babies due to contributory factors such as smoking, obesity and alcohol also require similar commitment.

Bliss – for babies born premature or sick
Bliss baby report 2015
October 2015

Research by Bliss shows that hospital services for babies born premature or sick in England are hanging the balance, with dedicated, hardworking neonatal staff forced to cope with increasing demand with far too few resources. This means that units are unable to meet national standards for high quality and safe care, putting babies' safety and survival at risk.

What we've found
For the first time in five years, we have heard from neonatal units, transport services and parents across the country, to assess the state of neonatal care in England in 2015. What we have found is a service that is hanging in the balance and struggling to cope with increasing demand, and too few resources.

Our findings show:

- 2,140 more nurses are needed to care for babies in England. Three quarters of this shortage is because there is not enough funding from the Government.
- Two-thirds of units do not have enough specialist nurses
- More than 850 babies were transferred between hospitals last year because there was not enough space or staff at the unit they were currently in. Over 100 of these babies were ventilated
- 70 per cent of intensive care units are consistently caring for more babies than is considered safe
- Nearly a third of units can offer no psychological support to families.

Read our full report here

This is putting babies' safety and survival at risk, and is impacting on their long-term development. Despite five years passing since our last comprehensive report on the issues facing neonatal services, our new findings shows that little has changed. Nurse staffing levels and occupancy levels (the number of babies being cared for at one time on a unit) remain persistent challenges and we're deeply concerned to see such little progress.

You can help us address this problem though, by signing our letter to NHS boss Simon Stevens urging him to review of funding levels for neonatal care so that services can meet the government and NHS' own standards for safety and quality.

Find out more about the challenges facing vital neonatal transport services across the UK in our separate transport services report

Get involved
The issues raised in our report are deeply concerning and we need urgent action from government and NHS England. You can help us right

now by signing our open letter to Simon Stevens, NHS England Chief Executive, calling for a fundamental review of funding levels for neonatal care.

Show your support for safer, better care and sign our letter now

Make sure you never miss out on campaign updates or ways to get involved by joining our online campaign network

Campaign progress
Over 3800 supporters have signed our open letter to Simon Stevens so far, and our campaign has attracted support from a wide range of professional bodies and other charities.
You can make a difference too – by signing our letter today.

3. Parliamentary material

3.1 PQs

Maternity Services: Safety

Asked by: Morton, Wendy

To ask the Secretary of State for Health, what progress the Government has made on improving safety in maternity care.

Answering member: Ben Gummer | Department: Department of Health

In November, we announced a national ambition to halve the rates of stillbirths, neonatal and maternal deaths and brain injuries occurring during or soon after birth by 2030. Since then progress has included the launch of the 'Spotlight on Maternity' initiative and distribution of a £2.24 million capital fund for safety equipment.

HC Deb 10 May 2016 | PQ 904960

Maternity Services

Asked by: Quince, Will

To ask the Secretary of State for Health, pursuant to the Answer of 21 March 2016 to Question 32013, what sanctions will apply to NHS maternity units which do not reduce their rates of stillbirth and neo-natal death.

Answering member: Ben Gummer | Department: Department of Health

The mandate to NHS England includes a goal and deliverable for measurable progress towards reducing the rate of stillbirths, neonatal and maternal deaths and brain injuries that are caused during or soon after birth by 50% by 2030 with a measurable reduction by 2020.

The mandate also has a deliverable for in 2016/17 to implement agreed recommendations of the National Maternity Review in relation to safety, and support progress on delivering Sign up to Safety. On 7 March we launched 'Spotlight on Maternity' as part of 'Spotlight on Safety' and asked all trusts with maternity services to commit publically to placing a spotlight on maternity and to contributing towards achieving the Government's national ambition.

The Department holds NHS England to account for progress against the mandate, which will include progress against the deliverable and goal above. It would be for commissioners (NHS England or clinical commissioning groups) to design contracts to incentivise providers to reduce their rates of stillbirth and neonatal death, and NHS Improvement may look at these rates as part of regulating providers.

HC Deb 18 April 2016 | PQ 32850

Maternity Services

Asked by: Quince, Will

To ask the Secretary of State for Health, what plans he has to ensure that NHS maternity units improve their safety records.

Answering member: Ben Gummer | Department: Department of Health

In November 2015 the Government announced a national ambition to halve by 2030 the rates of stillbirths, neonatal and maternal deaths and brain injuries occurring during or soon after birth.

To support the National Health Service in achieving this ambition more than 90 trusts have received additional funding as part of a £2.24 million fund to spend on equipment to improve safety, over £1 million to roll out training programmes to make sure staff have the skills and confidence they need to deliver world-leading safe care, and £500,000 to develop, a new online system that can be used consistently across the NHS to enable staff to review and learn from every stillbirth and neonatal death.

The announcement also committed to publishing an annual report to update the public, health professionals, providers and commissioners on the progress we are making towards achieving the ambition. We also welcome the publication of the NHS England Independent Review of Maternity Services. The recommendations will have an important role in shaping the system to drive ambitious improvements in quality and safety.

On 7 March we launched Sign up to Safety - 'Spotlight on Maternity,' a guidance document that asks all trusts with maternity services to commit publically to placing a spotlight on maternity and to contributing towards achieving the Government's national ambition.

HC Deb 24 March 2016 | PQ 32013

Perinatal Mortality

Asked by: Shannon, Jim

To ask the Secretary of State for Health, what steps the Government is taking to reduce the time taken on investigations into still births.

Answering member: Ben Gummer | Department: Department of Health

The Royal College of Obstetricians and Gynaecologists' Green-top Guideline 55 on *Later Intrauterine Fetal Death and Stillbirth* (2010) *guidance for obstetricians and midwives* states that all stillbirths should be reviewed in a multi-professional meeting using a standardised approach to analysis. This will enable the identification of substandard care and establish whether any future preventative measures are required. Results of the review should be discussed with the parents.

The Government is investing £500,000 to develop and roll out by March 2017 a new web-based system to be used consistently across the National Health Service so staff can review and learn from every stillbirth and neonatal death.

All stillbirths should also be reported to the MBRRACE-UK collaboration (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) which undertakes national surveillance of late fetal losses, stillbirths and infant deaths.

HC Deb 24 March 2016 | PQ 31296

Perinatal Mortality

Asked by: Hanson, Mr David

To ask the Secretary of State for Health, what steps his Department has taken to review the definition of stillbirth since January 2014; and whether he has had discussions with his ministerial colleagues on changing the procedure on the registration of stillbirths to allow for the registration of deaths before 24 weeks.

Answering member: Ben Gummer | Department: Department of Health

The Births and Deaths Registration Act 1953, as amended, provides for the registration of babies born without signs of life after 24 weeks' gestation, which is the legal age of viability. Parents of babies who are stillborn after 24 weeks' gestation receive a medical certificate certifying the stillbirth and, upon registration, can register the baby's name and receive a certificate of registration of stillbirth.

Parliament supported a change to the stillbirth definition from "after 28 weeks" to "after 24 weeks" in 1992, following a clear consensus from the medical profession at that time that the age at which a foetus should be considered viable should be changed from 28 to 24 weeks. Medical opinion does not currently support reducing the age of viability below 24 weeks of gestation. Therefore, there are no plans to amend the stillbirth definition.

We are aware that some parents find it very distressing that they may not register the birth of a baby born before 24 weeks. However, it is important to recognise there would also be parents distressed at the possibility of having to do so. When a baby is born without signs of life before 24 weeks' gestation, hospitals may issue a local certificate to commemorate the baby's birth.

In November 2015, the Government announced a national ambition to halve by 2030 the rates of stillbirths, neonatal and maternal deaths and brain injuries occurring during or soon after birth. The announcement also committed to publishing an annual report to update the public, health professionals, providers and commissioners on the progress we are making towards achieving the ambition.

To support the system in achieving this ambition we also announced:

A £2.24 million capital fund for equipment to improve safety.

Over £1 million to roll out training programmes to make sure staff have the skills and confidence they need to deliver world-leading safe care.

£500,000 to develop a new system that can be used consistently across the National Health Service to enable staff to review and learn from every stillbirth and neonatal death.

HC Deb 11 March 2016 | PQ 29604

Perinatal Mortality

Asked by: Shannon, Jim

To ask the Secretary of State for Health, what recent steps he has taken to reduce stillbirths.

Answering member: Ben Gummer | Department: Department of Health

We are committed making sure every baby receives consistently high quality care, 24 hours a day, seven days a week.

In November 2015, the Government announced a national ambition to halve by 2030 the rates of stillbirths, neonatal and maternal deaths and brain injuries occurring during or soon after birth.

To support the National Health Service in achieving this ambition we also announced:

a £2.24 million capital fund for equipment to improve safety;

over £1 million to roll out training programmes to make sure staff have the skills and confidence they need to deliver world-leading safe care; and

£500,000 to develop a new system that can be used consistently across the NHS to enable staff to review and learn from every stillbirth and neonatal death.

The announcement also committed to publishing an annual report to update the public, health professionals, providers and commissioners on the progress we are making towards achieving the ambition.

The National Maternity Review, chaired by Baroness Cumberlege, will include proposals for the future shape of modern, high quality and sustainable maternity services across England. We anticipate that its report will have an important role in shaping the system to achieve our ambition.

For those babies who are born sick or premature, NHS England commissions Neonatal Care from 165 neonatal units. These units are organised and supported by 13 Operational Delivery Networks. The organisation of networks has brought tangible benefits in the delivery of babies in the right place to receive specialist care when it is needed.

NHS England's Neonatal Critical Care Service Specification states that providers should ensure that expert and experienced staff treat

sufficient numbers of cases to maintain a safe high quality service and move towards national standards.

It is for local hospital trusts and specialised commissioners to decide how best to use the guidance and the National Institute for Health and Care Excellence quality standard for specialist neonatal care to improve babies' chances of survival and minimise mortality associated with being born either premature or unwell. We know that that there is still more to do to ensure these services are consistent across the country and that is why the Neonatal Clinical Reference Group at NHS England has committed to review the findings of the Bliss report, (published in October 2015 which can be found here http://www.bliss.org.uk/babyreport), and will work with all of its key partners to make recommendations for further improvement.

Unless we invest in research we cannot understand how to best improve services for mothers and their babies. Significant sums have been invested over recent years in support of research looking at important questions regarding premature birth. The National Institute for Health Research (NIHR) funds a range of research relating to causes, risk factors and prevention of stillbirth and neonatal death. The NIHR Health Technology Assessment is funding a £6.0 million trial of an intelligent system to support decision making in the management of labour using the cardiotocogram - due to report in 2017. The NIHR is also funding a £1.2 million study on preventing adverse pregnancy outcome in women at increased risk of stillbirth by detecting placental dysfunction– due to report in 2019.

To help achieve the best outcomes, women are also offered a comprehensive programme of scans, screening tests and development examinations during pregnancy and following birth babies will receive the checks in the NHS newborn and infant physical examination screening programme and the NHS newborn blood spot screening programme .

HC Deb 12 February 2016 | 26392

Antenatal Care

Asked by: Baroness Taylor of Bolton

To ask Her Majesty's Government what changes have taken place in the last two years to improve the measurement of babies in the final stages of pregnancy.

Answering member: Lord Prior of Brampton | Department: Department of Health

Fetal growth restriction is widely recognised as a major determinant of stillbirth. Knowledge to inform the effective identification and management of these babies continues to grow, particularly around what constitutes 'normal' growth for each baby.

We are advised by NHS England that it is developing the *Saving Babies' Lives* "care bundle". This is a package of measures which includes a

recommendation to improve the detection of growth restricted babies. This includes use of a growth chart to plot fundal height (the distance from the maternal pelvis to the top of the growing womb) and estimated fetal weight, both measures to estimate a baby's growth. The recommendation is also designed to tackle variable practice amongst clinicians in carrying out measurements. We understand this will be published as a guidance document later in 2016 and will be followed by an implementation toolkit.

The care bundle is now being voluntarily implemented by maternity care providers while its recommendations are tested, formally evaluated in practice and refined over time and in the light of new evidence.

HL Deb 09 February 2016 | PQ HL5610

3.2 Debate

Adjournment Debate - Maternity Units: Bereavement Care

HC Deb 02 November 2015 | Vol 601 cc848-852

http://www.publications.parliament.uk/pa/cm201516/cmhansrd/cm151102/debtext/151102-0004.htm#1511036000001

3.3 Early Day Motions

EDM 137

SANDS Awareness Month Campaign

Primary Sponsor: Patricia Gibson

That this House is aware that June 2016 is SANDS Awareness Month; appreciates that during this month the charity will work hard to increase awareness of stillbirth and neonatal death; understands that the impact of losing a baby during pregnancy, at birth or shortly afterwards is devastating for all those affected; applauds SANDS for the excellent work it does to promote awareness of this issue and breaking the silence around what is often a taboo subject; is deeply concerned that over 100 babies in the UK will die each week during the month of June 2016; wishes the charity well in the inaugural year of its Walk a Mile in My Shoes event as well as continuing with its orange-themed events including Orange Fridays and Orange Challenge Events; supports the launch of SANDS' Research Fund to spearhead vital projects as well as other new initiatives that will help the charity speak out and call for improvements that will save more babies' lives in the future .

EDM 1175

Safer Births Campaign

Primary Sponson: Patricia Gibson

That this House is shocked that more than 3,500 babies are stillborn in the UK every year, one of the worst rates in the developed world so that the UK currently ranks 21st out of 49 similar high income countries; is aware that more babies die in the womb or first week of life than they do from cot death, road deaths and meningitis combined; recognises that one in three of these babies - around 1,200 each year - are stillborn when the pregnancy has reached full term; notes that if delivered on time, before the babies got into difficulty, they are likely to have survived and been healthy; understands that more research is needed to help answer the questions that surround stillbirth and neonatal death; believes that more than half of stillbirths in the UK could be prevented if the NHS implemented additional scans; pays tribute to organisations like Sands, Kicks Count and others who seek to raise awareness of this issue; appreciates the devastating, heartbreaking and long-term impact on couples who face the stillbirth of their child; and congratulates the Sunday Times Safer Births Campaign which is seeking to shine a light on this issue and improve outcomes for all mothers-to-be and their babies.

4. Useful links and further reading

NHS England *Saving Babies' Lives A care bundle for reducing stillbirth* 21 March 2016
https://www.england.nhs.uk/wp-content/uploads/2016/03/saving-babies-lives-car-bundl.pdf

NHS Choices : Stillbirth
http://www.nhs.uk/conditions/Stillbirth/Pages/Definition.aspx
Causes of stillbirth
http://www.nhs.uk/Conditions/Stillbirth/Pages/Causes.aspx

MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
https://www.npeu.ox.ac.uk/mbrrace-uk

Parliamentary Office of Science and Technology *Infant Mortality and Stillbirth in the UK* 27 May 2016
http://researchbriefings.parliament.uk/ResearchBriefing/Summary/POST-PN-0527#fullreport

NHS England *Spotlight on Maternity*: Contributing to the Government's national ambition to halve the rates of stillbirths, neonatal and maternal deaths and intrapartum brain injuries by 2030 March 2016
https://www.england.nhs.uk/signuptosafety/wp-content/uploads/sites/16/2015/11/spotlight-on-maternity-guide.pdf

BLISS Baby Report 2015 *Hanging in the Balance* October 2015
http://www.bliss.org.uk/Handlers/Download.ashx?IDMF=74c6e3e7-40af-462c-8cf0-86d4fca5430c

SANDS: Stillbirth and Neonatal Death Charity
https://www.uk-sands.org/

Royal College of Paediatrics and Child Health
http://www.rcpch.ac.uk/

Royal College of Midwives
https://www.rcm.org.uk/

Royal College of Obstetricians and Child Health guideline *Late Intrauterine Fetal Death and Stillbirth*
https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg55/

The Lancet series of papers: *Ending preventable stillbirths* 19 January 2016
http://www.thelancet.com/series/ending-preventable-stillbirths

HOUSES OF PARLIAMENT
PARLIAMENTARY OFFICE OF SCIENCE & TECHNOLOGY

POSTNOTE

Number 527 May 2016

Infant Mortality and Stillbirth in the UK

Stillbirth and infant mortality rates are higher in the UK than several European countries, including Germany and Sweden. This POSTnote reviews recent UK data and examines the factors contributing to increased risk. It then looks at the policy options that may help to improve health outcomes for infants and their families.

Overview

- Stillbirth and infant mortality rates have fallen in the UK since the early 1900s, but in the last two decades progress has slowed.
- Stillbirths and infant deaths are linked to a number of complex and interacting risk factors, many of which can be addressed. These include obesity, smoking, maternal age and inequalities across different socioeconomic and ethnic groups.
- Improvements in care received during pregnancy, labour and early infancy could also improve mortality rates.
- Studies show that many existing guidelines to improve care in the UK are not being followed, such as those relating to testing and monitoring of women with an increased risk of complications during pregnancy.

Background

Data on stillbirth and infant mortality is reported in national statistics.[1] In the UK the following definitions apply:[2]

- **Stillbirth** applies to babies born after 24 weeks of pregnancy, who did not breathe or show signs of life.
- **Miscarriage** is a pregnancy lost before 24 weeks.
- **Infant mortality** is the death of a child in the first year of life, including babies born at any stage of pregnancy who show signs of life after birth.
- Infant mortality is further defined as either **neonatal** (in the first 28 days) or **post-neonatal** (28 days to 1 year).
- **Perinatal mortality** includes stillbirths and deaths in the first 28 days of life.

Absolute numbers are collected, but data are often expressed as a rate: the number of deaths per 1,000 births a year for stillbirths, and per 1,000 *live* births for infant mortality. This allows comparisons to be made between populations and over time. Figure 1 shows how stillbirth and infant mortality rates have declined, largely due to improved healthcare.

The impact on a family of losing a baby is profound. Many parents report symptoms of anxiety and depression which can last for years after their baby's death.[3] The care of bereaved families is discussed in detail in a forthcoming POSTbrief on Bereavement Care.

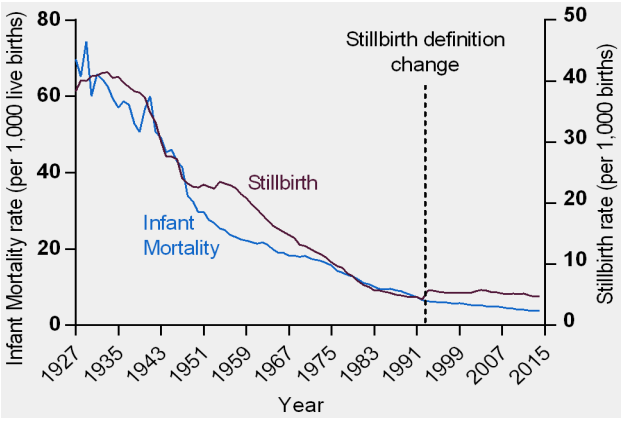

Figure 1. Stillbirth and infant mortality rates in England and Wales 1927-2014 (Office for National Statistics).[1,2]

Infant Mortality in the UK

In 2014, 3,014 babies died before 1 year of age, 2,103 of them (around 70%) in the first 28 days of life (the neonatal period).[6] Infant mortality has more than halved since 1990, as has neonatal mortality.[7] The main causes of infant mortality in England and Wales are:[8]

- complications from being born prematurely (44%)
- congenital anomalies (see Box 3) (28%)
- lack of oxygen or trauma just before/during birth (7%)
- sudden infant deaths (6%)
- infections (4%)

All infant mortality can be affected by the care that mothers and infants receive. Post-neonatal mortality is more closely associated with conditions at home, due to risk factors (for example, smoking) that are discussed later.

Stillbirth in the UK

Stillbirth rates have not decreased significantly since the 1980s. There were 3,245 stillbirths in England and Wales (4.7 per 1,000 births).[9] In 1992, the definition of stillbirth was changed from a death after 28 weeks to the current definition of after 24 weeks of pregnancy. The lowest rate since the 24 week definition was introduced in 1992 was 4.4 per 1,000 in the same year, rising to 5.7 per 1,000 in 2003 (England and Wales). Since 2003 the rate has been largely stable, although rates have declined since 2012;[11] it is not yet clear whether this will continue. Around nine in ten stillbirths occur before the onset of labour. One in three stillbirths occur in babies who have reached term and seem to be completely healthy. In England and Wales, half (52%) of stillbirths are unexplained, with the remainder resulting from lack of oxygen or trauma just before or during birth (25%), congenital anomalies (15%) or infections (<10%).[12] Data are also available for Scotland[4] and Northern Ireland.[5] International comparisons are described in Box 1.

Risk Factors

An increased risk of infant mortality and stillbirth is in turn linked to several complex and interacting factors ('risk factors') many of which could be addressed. Risk factors for stillbirth include: social inequality; maternal obesity, age and ethnicity; smoking in pregnancy; having experienced a previous stillbirth; and contracting infections during pregnancy.[13] In the first year of life risk factors for mortality include low birth weight[14] and prematurity[15] (which are closely linked), which are also risk factors for stillbirth. Tackling the risk factors for stillbirth could thus reduce both the stillbirth and infant mortality rate (discussed below).

Tobacco Smoking

If no women smoked during pregnancy, an estimated 7.1% of stillbirths could be avoided.[18] Smoking and passive smoking in pregnancy (see Box 2) increase the risk of infant mortality by an estimated 40%.[19] Smoking in pregnancy increases the risk of low birth weight and premature birth, which in turn increase the risk of infant mortality.[20,21] Smoking and passive smoking in pregnancy increase the risk of Sudden Infant Death Syndrome (SIDS), the unexplained death of an apparently healthy baby. A baby living in a household in which one or more people smoke has more than double the risk of SIDS.[22] National clinical guidelines from NICE (the National Institute of Health and Care Excellence) advise that women who smoke during pregnancy should be referred to NHS stop smoking services, and that partners and other household members who smoke should also be advised to quit.[23] While there is no data on how NICE guidelines are used[24] only 15% of pregnant women who smoke use stop smoking services, and of these just under half succeed in quitting.[25]

Box 1. International Comparisons

International comparisons are complicated by the fact that countries have different definitions of stillbirth. For instance, some do not register deaths as stillbirths until later in pregnancy. By including only babies stillborn from 28 weeks, researchers found that the UK has a higher stillbirth rate (2.9 per 1,000 births) than Germany (2.4), Poland (2.3), Sweden (1.9), the Netherlands (1.8) and Denmark (1.7). The stillbirth rate in the UK is falling more slowly than elsewhere in Europe. Stillbirth rates declined by 1.4% per year between 2000 and 2015 in the UK, compared with the Netherlands (6.8%), Denmark (4.4%) and Poland (4.5%).[16] The World Health Organisation reported that the UK has a higher infant mortality rate (3.5 per 1,000 live births) than several countries including Germany (3.1), Croatia (2.6), Sweden (1.6) and Finland (1.3).[17] Lower rates in other European countries suggest that further improvements are possible in the UK. However, international comparisons do not account for factors such as the prevalence of obesity, ethnic demographics and smoking, all of which affect rates. Data collection and recording standards also vary between countries, further complicating international comparisons.

Overweight and Obesity in Pregnancy

Statistics on obesity in pregnancy are not routinely reported in England. However, obesity data are available for women aged 16-44, which is broadly representative of child-bearing age. Between 1994 and 2014, the proportion of this group who were overweight (Body Mass Index or BMI 25-29) rose from 19.5% to 21.2% and the proportion who were obese (BMI >30) from 7.8% to 12.9%.[36] Being overweight or obese in pregnancy increases the risk of both stillbirth and death in infancy, although the biological mechanism is unknown.[26] One study estimated that 12.2% of UK stillbirths could be prevented if no mothers were overweight or obese.[13]

Obesity increases the risk of conditions such as gestational diabetes (diabetes in pregnancy) and pre-eclampsia (high blood pressure in pregnancy). Both conditions increase the risk of stillbirth. Diabetes also increases the risk of congenital anomalies,[27] a major cause of infant mortality in the UK.[28-30] Obese women are more likely to have complications that require early delivery, and to have babies of lower birth weights,[31,32] which are both risk factors for infant mortality.[20,21] Obese women are also more likely to be older and live in areas of higher deprivation than non- obese women. Both of these are risk factors for infant mortality.[40]

Box 2. Smoking in Pregnancy

Smoking in pregnancy exposes the fetus to chemicals such as nicotine and carbon monoxide, and narrows blood vessels in the placenta. This reduces nutrient and oxygen availability[33] and interferes with fetal development. Smoking rates in pregnancy, recorded at the time of delivery, fell from 15.1% in 2006/7[34] to 11.4% of women by 2014/2015 (England). This varies across the country: from 19.9% in Durham, Darlington and Tees to 4.9% in London (2015).[35] Women aged under 20 have significantly higher smoking rates in pregnancy (57%) than the national average, as do women in routine and manual occupations (40%).[36] Smoking in pregnancy is likely to be higher than the recorded rate,[37] because :

- self-reported data is used, so smoking is often under-reported.[38]
- these rates do not include women who had a miscarriage or a stillborn baby, both of which are more likely to occur in women who smoke during pregnancy.[39]

NICE guidelines advise that obese women are helped to lose weight before becoming pregnant, as dieting in pregnancy may harm the baby. During pregnancy, NICE advises that obese women should exercise, eat healthily, and be assessed for conditions such as gestational diabetes and pre-eclampsia[41] Some health care workers say they have difficulties discussing obesity in pregnancy with women, and women report being distressed by the critical approach of some health workers when discussing their weight.[42,43] To help improve diet, women receiving benefits or under 18 are eligible for vouchers to spend on items such as fruit, vegetables and milk from early pregnancy.[44]

Social Inequality

Stillbirth rates in the most socio-economically deprived areas of the UK are twice as high as those in the least deprived.[40] Infant mortality is also higher in deprived areas. One analysis divided parents into 5 groups based on level of deprivation, and found that babies born to parents in the most deprived group were 1.6 times more likely to die during the first year of life than those in the least deprived group.[45] Infants in the lowest socio-economic groups are also twice as likely to die in the neonatal period due to a congenital anomaly (see Box 3) than infants in higher socio-economic groups.[46] It is not fully understood why babies from deprived families are at higher risk of death. One explanation could be that women from lower socioeconomic groups have higher rates of other risk factors such as smoking,[47] obesity,[48] teenage pregnancy,[49] are less likely to quit smoking during pregnancy[37] and are more likely to have stillbirths or an infant death caused by infection.[50]

Ethnicity

South Asian women are 60% more likely, and black women twice as likely to have a stillbirth than white women, in England and Wales. Infant mortality is twice as common for babies born to Caribbean and Pakistani women than to white women.[51] Some of this increased risk is due to higher rates of obesity, diabetes and deprivation in minority ethnic groups, but these do not explain the full extent of the increased risk. Other possible factors include biological variation in birthweights and lengths of gestation, and the ability to access maternity and postnatal care. The risk of stillbirth and infant mortality is higher in communities where marriages occur between couples with at least one shared ancestor (great grandparent or closer), such as some UK born Pakistani communities. One study shows that babies born to such couples are at increased risk of genetic diseases, increasing the risk of stillbirth by over 80%.[52]

Box 3. Congenital Anomalies

Congenital anomalies describe numerous development disorders (such as spina bifida and heart defects); the causes of most are unknown. The most effective preventative measures are those which are implemented before conception. These include managing diabetes, providing genetic counselling services for those at risk (those with a family history), and promoting the taking of folate supplements to prevent problems with the development of the spinal cord. However, 45% of pregnancies in the UK are unplanned,[53] so these interventions are not always possible. Improved prenatal screening and diagnosis of anomalies in early pregnancy can reduce infant deaths, since parents may opt to terminate a pregnancy.[46]

Maternal Age

Being an older mother (over 35) or younger mother (under 20) increases the risk of both stillbirth and infant mortality. In the UK, births to mothers over 35 increased from 8% to 20% between 1985-2013.[13] Older women are at the highest risk of stillbirth at the end of pregnancy (earlier in pregnancy the risk is similar to that for a women in her mid-20s). However, the Royal College of Obstetrics and Gynaecologists (RCOG) does not recommend inducing all older mothers early, as it is unclear how induction affects the risk of death for babies during labour or just after birth.[54] Babies born to women over 40 are 1.3 times more likely to die in the neonatal period than those born to younger women. The risk of neonatal death is higher for babies from multiple pregnancies, which are becoming more common, particularly in older women (Box 4). Older women are more likely to have pre-existing conditions such as obesity and diabetes, and complications such as gestational diabetes and pre-eclampsia.[55] Women under 20 are more likely to have babies of low birthweight, and the risk is higher the younger the mother is. This is thought to be linked to poor diet; it could also be because the baby has to compete for nutrients with the growth requirements of the mother.[56] Teenage mothers are also more likely to be from a lower socio-economic background and to smoke during pregnancy.[57] Teenage pregnancy has fallen from a high of 55 to 22.9 conceptions per 1,000 (1971-2014).[58] Some campaigns target pregnant teenagers to stop smoking, such as Tommy's Baby Be SmokeFree campaign.[59]

Previous Stillbirth

Compared to women who have had a previous healthy pregnancy, women who have had a stillbirth are almost twice as likely to have another in a future pregnancy.[60] Researchers recommend that these women benefit from increased monitoring in subsequent pregnancies. Analysis by the charity Sands found that 1 in 10 maternity units do not offer extra monitoring or support in subsequent pregnancies for women who have had a stillbirth.[61]

Infection

An estimated 10-25% of stillbirths in developed countries are caused by infection, through compromising a baby's major organs, damaging the placenta or by making the mother seriously ill. However, it can be difficult to tell if an infection was the cause of death, or if a baby with an

Box 4. Multiple Pregnancy

Babies from multiple pregnancies (e.g. twins or triplets) are 3.5 times more likely to die in pregnancy or in the first month of life than babies from single pregnancies, largely due to prematurity and low birth weight. Multiple pregnancies increased from 9.6 to 15.6 per 1000 births from 1980-2012. This is due to increased use of assisted reproductive technology and increased maternal age, both of which are more likely to result in multiple pregnancies.[62] NICE recommends that one embryo is transferred in IVF, to reduce multiple births.[63,64]

infection died of another cause [65,66] Infections are often bacterial (*E. coli,* Group B Streptococcus (GBS), *H. influenza* and chlamydia) and travel from the vagina into the uterus. Non-bacterial infections can also cause stillbirth, such as rubella, influenza, herpes simplex and *T. gondii*.[67] Infections cause 11% of post-neonatal infant deaths in England and Wales, although this may be an underestimate because such deaths cannot always be identified and recorded.[12,68] Premature babies with under-developed immune systems are the most susceptible to infections. One of the most common infections in newborns is GBS, which infects 14% of women in the UK harmlessly. However the bacteria can be passed to the baby during labour and can cause life-threatening illness.[69] Routine screening for GBS is not available on the NHS as it is not cost-effective.[70,71] Immunisation is the most effective public health intervention to reduce infections. Women are offered a range of immunisations to protect them and their babies, but vaccines are not available for all of these infections. [72,-75]

Care in Pregnancy and Early Infancy

Improving care before, during and after pregnancy is seen as an important step in reducing stillbirths and infant mortality. Care of babies who make it to term but die before labour are an important target for care improvements, as babies identified at risk at this point can be safely delivered. Research from a 2015 enquiry for NHS England indicates which aspects of clinical practice could improve (Box 5).[76,61] Health care in the post-natal period and in the first year of life is provided by midwives, health visitors and GPs through regular child health and development reviews. These staff check and offer advice on feeding, weight gain and general health in a variety of settings. Parents are also offered a range of immunisations for their children during infancy.[75,77] Government advice is that women should aim to breastfeed exclusively for 6 months. This is linked to a lower risk of infant mortality as it reduces the likelihood of infection and SIDs. In the UK, 81% of mothers report trying breastfeeding, but only 34% are still breastfeeding at 6 months. Mothers who are young or from a lower socio-economic background are less likely to breastfeed than others.[36] Charities also advise parents, such as how to reduce the risk of SIDs.

Reviewing Clinical Care and Research

Some professional bodies and charities, including the Royal College of Midwives, are concerned about the impact of staffing levels on health services.[61] The premature baby charity Bliss estimates 2,140 more nurses are needed to care for babies in England.[78] According to Sands an estimated 500 babies a year in the UK die or are left severely disabled because of an event during birth that was either not anticipated or not well managed.[61] After a baby dies due to incidents during labour, a review of care should be carried out locally but the results are not always shared between maternity units. A 2015 enquiry for NHS England found that for three quarters of stillbirths occurring at term, patients' notes contained no evidence of a local review having taken place. When reviews took place, few followed national guidance or involved parents' views.[76]

Box 5. Improving Clinical Care

Monitoring Growth - Fetal growth restriction is when growth slows or stops. A baby with restricted growth is more likely to be stillborn or die shortly after birth. An estimated 60% of stillborn babies show signs of restricted growth. Fetal growth is monitored with ultrasound scans and tape measurement of the size of the uterus. However, in a third of cases where babies died at term but before labour, national guidance for screening and monitoring fetal growth was not followed. When reduced growth was detected, it was often not acted upon.[76]

Acting on Reduced Fetal Movements - From 20 weeks gestation fetal movements have a regular pattern, increasing in frequency until 32 weeks. Reduced or changed movements can indicate fetal distress. Over half of women who have a stillbirth at term report reduced fetal movements.[79] However, movements differ between women and between pregnancies, so defining reduced movements is difficult. A mother's own perceptions are the best measure available. If a woman feels her baby is moving less, it is more likely her baby will be stillborn.[80] It is unclear which investigations should be carried out when a woman perceives reduced movement. The RCOG's guidelines advise that women should be told that the frequency of fetal movements should not reduce. If they then perceive a reduction, tests on fetal heart rate and growth should be conducted.[81] However the implementation of this guidance has been poor. Local guidelines vary and are frequently of low quality.[82] A study is underway to examine the effectiveness of encouraging women to report concerns about fetal movements and the effectiveness of their subsequent monitoring.[83]

Diagnosing Gestational Diabetes - Any type of diabetes increases the risk of stillbirth, and increases risk factors for infant mortality (such as congenital anomalies). Gestational diabetes can develop in pregnancy and resolves after birth. However, it may not cause symptoms, so screening is used to identify cases. The main risk factors are obesity and ethnicity (South Asian, Black Caribbean and Middle Eastern are at higher risk). According to NICE guidelines women meeting these criteria should be screened,[84] with those diagnosed offered increased monitoring in pregnancy, and induction of birth at 38 weeks. Screening and monitoring could reduce stillbirths, but one study found that two thirds of women at risk were not tested.[76]

The RCOG has launched a five year Each Baby Counts programme that aims to halve the number of deaths and injuries due to problems in labour by 2020.[85] This will be achieved by collecting more comprehensive data on stillbirth and mortality and to identify which aspects of care to improve nationally. Post-mortems can often determine why a baby died which can inform decisions on care during future pregnancies, and improve understanding of the underlying causes.[76] However, the shortage of specialist pathologists and current low take up of post-mortems, are issues of concern. It is estimated that the number of specialist pathologists needs to increase by 20% just to meet current demand.[86] The Department of Health ambition is to halve the number of stillbirths and neonatal deaths in England by 2030.[87] In response, NHS England has released new guidelines in the 'Saving Babies' Lives' Care Bundle. This includes advice aimed at improving: smoking cessation rates in pregnancy; detection of fetal growth restriction; awareness of the importance of fetal movements and monitoring of the baby during labour.[88] There will also be an additional £4 million for equipment and training.[87] Similar policy initatives exist in the devolved administrations.[89,90] Governments across the UK have no targets for overall infant mortality rates.

POST is an office of both Houses of Parliament, charged with providing independent and balanced analysis of policy issues that have a basis in science and technology. POST is grateful to Rebecca Montacute for researching this briefing, to the Medical Research Council for funding her parliamentary fellowship, and to all contributors and reviewers. For further information on this subject, please contact the co-author, Dr Sarah Bunn.

Endnotes

1 ONS, (2016) Health and life events guidance and metadata.
2 *Still-Birth (Definition) Act 1992.* (1992).
3 Heazell, A. E. P. et al. Stillbirths: economic and psychosocial consequences. Lancet (2016). doi:10.1016/S0140-6736(15)00836-3
4 Healthcare Improvement Scotland (2012). Scottish Perinatal and Infant Mortality and Morbidity Report (SPIMMR)
5 Northern Ireland Statistics and Research Agency, (2014). Stillbirths, 1974 to 2014.
6 Office for National Statistics, (2014). Mortality Statistics: Deaths Registered in UK by Area of Usual Residence, 2014.
7 I. Wolfe, A. Macfarlane, A. Donkin, M. Mormot, R. V (2014). Why children die: deaths in infants, children and young people in the UK Part A.
8 Office for National Statistics, (2015). Childhood, Infant and Perinatal Mortality in England and Wales - Office for National Statistics.
9 Office of National Statistics, (2015). Birth Characteristics in England and Wales, 2014
10 National Records of Scotland, (2014). Births, deaths and other vital events.
11 European Health for All Database (2015)
12 Public Health England & National Child and Maternal Health Intelligence Network, (2014). Facts and figures on infant mortality and stillbirths.
13 Flenady, V. et al. (2011), Major risk factors for stillbirth in high-income countries: a systematic review and meta-analysis. Lancet (London, England) 377, 1331–40
14 Office for National Statistics, (2011). Infant Mortality Rate in England and Wales Hits Record Low.
15 Callaghan, W. M., MacDorman, M. F., Rasmussen, S. A., Qin, C. & Lackritz, E. M, (2006). The contribution of preterm birth to infant mortality rates in the United States. Pediatrics 118, 1566–73
16 Flenady, V. et al, (2016). Stillbirths: recall to action in high-income countries. Lancet. doi:10.1016/S0140-6736(15)01020-X
17 World Health Organisation, Probability of dying per 1 000 live births - Data by country.
18 Flenady, V. et al. (2011) Major risk factors for stillbirth in high-income countries: a systematic review and meta-analysis. Lancet (London, England) 377, 1331–40.
19 The National Institute of Health and Care Excellence, (2010) and Smoking: stopping in pregnancy and after childbirth.
20 Nilsen, S. T., Sagen, N., Kim, H. C. & Bergsjø, P. (1984) Smoking, hemoglobin levels, and birth weights in normal pregnancies. Am. J. Obstet. Gynecol. 148, 752–8.
21 Savitz, D. A. & Murnane, P. (2010) Behavioral influences on preterm birth: a review. Epidemiology 21, 291–9.
22 Tobacco Advisory Group -Royal College of Physicians, (2010). Passive smoking and children.
23 The National Institute of Health and Care Excellence (2010), Smoking: stopping in pregnancy and after childbirth.
24 Smoking in Pregnancy Challenge Group, (2015). Smoking cessation in pregnancy - a review of the challenge.
25 Health and Social Care Information Centre, (2014). Statistics on NHS Stop Smoking Services in England 1 April 2013 to 31 March 2014.
26 Meehan, S., Beck, C. R., Mair-Jenkins, J., Leonardi-Bee, J. & Puleston, R. (2014). Maternal obesity and infant mortality: a meta-analysis. *Pediatrics* **133,** 863–71.
27 Correa, A. et al, (2008). Diabetes mellitus and birth defects. Am. J. Obstet. Gynecol. 199, 237.e1–9.
28 Jennifer, K., Jennifer, H., Peter, B. & Ron, G, (2009). Infant mortality: overview and context.
29 Fretts, R. C, (2005). Etiology and prevention of stillbirth. Am. J. Obstet. Gynecol. 193, 1923–1935.
30 Goldenberg, R. L., Kirby, R. & Culhane, J. F, (2004). Stillbirth: a review. J. Matern. Fetal. Neonatal Med. 16, 79–94
31 Steegers, E. A. P., von Dadelszen, P., Duvekot, J. J. & Pijnenborg, R, (2010). Pre-eclampsia. Lancet 376, 631–44.
32 Johansson, S. et al, (2014). Maternal overweight and obesity in early pregnancy and risk of infant mortality: a population based cohort study in Sweden. BMJ 349, g6572.
33 Wickström, R, (2007). Effects of nicotine during pregnancy: human and experimental evidence. Curr. Neuropharmacol. 5, 213–22.
34 Health and Social Care Information Centre, (2015). Statistics on Women's Smoking Status at Time of Delivery, England - Quarter 4, 2014-2015.
35 Health and Social Care Information Centre, (2016). Statistics on Women's Smoking Status at Time of Delivery, England - Quarter 2, 2015-2016.
36 Health and Social Care Information Centre, (2010). Infant Feeding Survey - UK, 2010 [NS].
37 Action on Smoking and Health, (2013). Smoking Cessation in Pregnancy - A Call to Action.
38 Shipton, D. et al, (2009). Reliability of self reported smoking status by pregnant women for estimating smoking prevalence: a retrospective, cross sectional study. BMJ 339, b4347.
39 Pineles, B. L., Park, E. & Samet, J. M, (2014). Systematic review and meta-analysis of miscarriage and maternal exposure to tobacco smoke during pregnancy. Am. J. Epidemiol. 179, 807–23.
40 Seaton, S. E. et al, (2012). Socioeconomic inequalities in the rate of stillbirths by cause: a population-based study. BMJ Open 2, e001100.
41 National Institute of Health and Care Excellence, (2010). Weight management before, during and after pregnancy.
42 Furness, P. J. et al, (2011). Maternal obesity support services: a qualitative study of the perspectives of women and midwives. BMC Pregnancy Childbirth 11, 69.
43 Poorman, E., Gazmararian, J., Parker, R. M., Yang, B. & Elon, L, (2015). Use of text messaging for maternal and infant health: a systematic review of the literature. Matern. Child Health J. 19, 969–89.
44 GOV.UK, (2015). Healthy Start.
45 Weightman, A. L. et al, (2012). Social inequality and infant health in the UK: systematic review and meta-analyses. BMJ Open 2.
46 Kurinczuk, J. et al, (2010). The contribution of congenital anomalies to infant mortality.
47 Hiscock, R., Bauld, L., Amos, A., Fidler, J. A. & Munafò, M, (2012). Socioeconomic status and smoking: a review. Ann. N. Y. Acad. Sci. 1248, 107–23.
48 National Obesity Observatory (2012). Adult Obesity and Socioeconomic Status.
49 Allen, E. et al, (2007). Does the UK government's teenage pregnancy strategy deal with the correct risk factors? Findings from a secondary analysis of data from a randomised trial of sex education and their implications for policy. J. Epidemiol. Community Health 61, 20–7.
50 Smith, L. K., Manktelow, B. N., Draper, E. S., Springett, A. & Field, D. J. (2010). Nature of socioeconomic inequalities in neonatal mortality: population based study. BMJ 341, c6654.
51 National Perinatal Epidemiology Unit, (2009). Towards an understanding of variations in infant mortality rates between different ethnic groups in England and Wales.
52 Shawky, R. M., Elsayed, S. M., Zaki, M. E., Nour El-Din, S. M. & Kamal, F. M, (2013). Consanguinity and its relevance to clinical genetics. Egypt. J. Med. Hum. Genet. 14, 157–164.
53 Annual Report of the Chief Medical Officer, (2014). The health of the 51%: Women.
54 Royal College of Obstetricians and Gynocologists, (2013). Induction of Labour at Term in Older Mothers.
55 Carolan, M. (2013). Maternal age ≥45 years and maternal and perinatal outcomes: a review of the evidence. Midwifery 29, 479–89.
56 Baker, P. N. et al, (2009). A prospective study of micronutrient status in adolescent pregnancy. Am. J. Clin. Nutr. 89, 1114–24.
57 Action on Smoking and Health, (2013). Smoking Cessation in Pregnancy - A Call to Action.
58 Office for National Statistics, (2014). Conceptions in England and Wales - Office for National Statistics.
59 Tommy's, Baby be smokefree.
60 Herring, A. H. & Reddy, U, (2010). Recurrence risk of stillbirth in the second pregnancy. BJOG 117, 1173–4.
61 Sands, (2012). Preventing Babies' Deaths - what needs to be done.
62 Glinianaia, S. V et al, (2013). The North of England Survey of Twin and Multiple Pregnancy. Twin Res. Hum. Genet. 16, 112–6.
63 National Institute of Health and Care Excellence, (2013). Fertility problems: assessment and treatment.
64 Human Fertilisation and Embryology Authority, Multiple births after IVF.
65 McClure, E. M., Dudley, D. J., Reddy, U. M. & Goldenberg, R. L, (2010). Infectious causes of stillbirth: a clinical perspective. Clin. Obstet. Gynecol. 53, 635–45.
66 McClure, E. M. & Goldenberg, R. L, (2009). Infection and stillbirth. Semin. Fetal Neonatal Med. 14, 182–9.
67 McClure, E. M. & Goldenberg, R. L, (2009). Infection and stillbirth. Semin. Fetal Neonatal Med. 14, 182–9.
68 Depani, S. J. et al, (2011). The contribution of infections to neonatal deaths in England and Wales. Pediatr. Infect. Dis. J. 30, 345–7.

69 British Medical Journal, (2014). Overview - Neonatal infections: group B streptococcus.
70 Royal College of Obstetricians and Gyncologists, (2012). The prevention of early-onset neonatal group B streptococcal disease.
71 UK NSC recommendations, (2012). The UK NSC recommendation on Group B Streptococcus screening in pregnancy.
72 Bunn, S, (2015). Childhood Immunisation Programme.
73 GOV.UK, The UK immunisation schedule.
74 NHS Choices, Whooping cough vaccination in pregnancy.
75 NHS Choices, Vaccination schedule.
76 MBRRACE-UK, (2015). Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK. Perinatal Confidential Enquiry 2015.
77 NHS Choices, Your baby's health and development reviews - Pregnancy and baby guide.
78 Bliss, (2015). Bliss baby report.
79 Royal College of Obstetricians and Gynaecologists, (2011). Reduced Fetal Movements.
80 O'Sullivan, O., Stephen, G., Martindale, E. & Heazell, A. E. P, (2009). Predicting poor perinatal outcome in women who present with decreased fetal movements. J. Obstet. Gynaecol. 29, 705–10.
81 Royal College of Obstetricians and Gynaecologists, (2011). Reduced Fetal Movements (Green-top Guideline No.57).
82 Jokhan, S., Whitworth, M. K., Jones, F., Saunders, A. & Heazell, A. E. P, (2015). Evaluation of the quality of guidelines for the management of reduced fetal movements in UK maternity units. BMC Pregnancy Childbirth 15, 54.
83 AFFIRM, Sands, Can promoting awareness of baby's movements in pregnancy help reduce stillbirths?
84 National Institute for Health and Care Excellence, (2015). Diabetes in pregnancy: management from preconception to the postnatal period.
85 Royal College of Obstetricians and Gynaecologists, (2015). Each Baby Counts.
86 Sands, (2012). Preventing Babies' Deaths - what needs to be done.
87 GOV.UK, New ambition to halve rate of stillbirths and infant deaths.
88 NHS England, Saving babies' lives care bundle.
89 NHS Wales, 1000 Lives Improvement - Transforming Maternity Services-Welsh Initiative for Stillbirth Reduction.
90. Scottish Government. Scottish Government, (2014). Stillbirth and infant death rates at record low.

DEBATE PACK
CDP 2016/0118
7 June 2016

About the Library

The House of Commons Library research service provides MPs and their staff with the impartial briefing and evidence base they need to do their work in scrutinising Government, proposing legislation, and supporting constituents.

As well as providing MPs with a confidential service we publish open briefing papers, which are available on the Parliament website.

Every effort is made to ensure that the information contained in these publically available research briefings is correct at the time of publication. Readers should be aware however that briefings are not necessarily updated or otherwise amended to reflect subsequent changes.

If you have any comments on our briefings please email papers@parliament.uk. Authors are available to discuss the content of this briefing only with Members and their staff.

If you have any general questions about the work of the House of Commons you can email hcinfo@parliament.uk.

Disclaimer