HOUSE OF COMMONS LIBRARY

DEBATE PACK

Number CDP 2016/0175, 11 October 2016

Baby loss

Dr Sarah Barber
Alison Pratt
Nikki Sutherland

This pack has been prepared ahead of the debate on baby loss to be held in the Commons Chamber on Thursday 13 October 2016. The subject for the debate has been selected by the Backbench Business Committee and the Members in charge are Antoinette Sandbach and Will Quince.

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. Baby loss

Baby Loss Awareness Week 2016 is on 9-15 October. This is an opportunity for those affected by baby loss to remember and commemorate their babies' lives, and to raise awareness of this issue. The website provides more information about the aims of the week:

> Baby Loss Awareness Week is an opportunity:
>
> For bereaved parents, and their families and friends, across the world to unite and commemorate their babies' lives.
>
> - To raise awareness about the issues surrounding pregnancy and baby loss in the UK.
> - To let the public and key stakeholders know what the baby charities are doing to reduce the number of families affected and raise awareness about what support is available.
>
> The charities leading Baby Loss Awareness Week provide support to anyone affected by pregnancy loss and the death of a baby, and work with health professionals and services to improve care. Together we are committed to raising awareness of pregnancy and baby loss which affects up to one in five families in the UK.[1]

Baby Loss Awareness week is coordinated and supported by a number of charities including Sands, the Miscarriage Association and Antenatal Results and Choices (ARC). A number of events will be taking place across the UK to mark Baby Loss Awareness week, this includes a reception in Parliament on 12 October 2016.

A Backbench Business Committee debate on Baby Loss has been tabled on Thursday 13 October 2016. The debate has been tabled by Antoinette Sandbach and Will Quince, co-chairs of the new All Party Parliamentary Group on Baby loss. In their submission to the Committee, they explained that they wished to keep the scope of the debate wide, allowing Members to highlight the issues they wished on this subject.

Prior to the debate, there has been a Twitter digital debate with Antoinette Sandbach and Will Quince on Monday 10 October between 2-3pm, with the hashtag #babylossdebate. Contributions to the digital debate came from both individuals discussing their personal experiences of baby loss and charities working in this area. Issues discussed included support for families, geographical variation in services and raising awareness of baby loss. A Storify has been developed providing an overview of the digital debate:

https://storify.com/HouseOfCommons/baby-loss

This debate pack includes press and Parliamentary material and links to further reading. A number of briefings published by POST and the

---

1 Baby Loss awareness week, About us [accessed 10 October 2016]

Commons library may also provide useful background reading prior to the debate, links to these are included below:

- POSTnote, *Infant Mortality and stillbirth in the UK*, May 2016
- POSTbrief, *Bereavement Care after the Loss of a Baby in the UK,* July 2016
- Commons Library briefing paper, *Registration of Stillbirth*, June 2016

2. Press Articles

BBC online
Baby deaths: MPs tell of pain and trauma of their loss
Jennifer Scott 10 October 2016
http://www.bbc.co.uk/news/uk-37584827

Daily Telegraph
Twins should be born three weeks early to avoid early death, scientists say
Telegraph reporters 6 September 2016
http://www.telegraph.co.uk/news/2016/09/06/twins-should-be-born-three-weeks-early-to-avoid-early-death-scie/

The Guardian
Back to sleep: the doctor who helped stem a cot death epidemic
Anne Perkins 26 August 2016
https://www.theguardian.com/society/2016/aug/26/back-to-sleep-sudden-infant-death-syndrome-cot-death-peter-fleming

Daily Telegraph
Cot deaths at record low as winters get warmer and pregnant women stop smoking
Telegraph reporters 11 August 2016
http://www.telegraph.co.uk/news/2016/08/11/cot-deaths-at-record-low-as-winters-get-warmer-and-pregnant-wome/

The Independent
Parents given cardboard boxes to help prevent cot death among babies
Independent staff 30 June 2016
http://www.independent.co.uk/news/uk/home-news/cot-death-sids-nhs-baby-queen-charlotte-chelsea-hospital-london-a7110621.html

The Guardian
Investigations into baby deaths often inadequate, says study
Haroon Siddique 9 June 2016
https://www.theguardian.com/lifeandstyle/2016/jun/09/investigations-into-baby-deaths-often-inadequate-says-study

The Guardian
Wearables for babies: saving lives or instilling fear in parents?
Tim Smedley 31 May 2016
https://www.theguardian.com/sustainable-business/2016/may/30/wearables-for-babies-saving-lives-or-instilling-fear-in-parents

The Independent
Air pollution could increase risk of stillbirth, research suggests
Siobhan Fenton 25 May 2016
http://www.independent.co.uk/life-style/health-and-families/health-news/air-pollution-could-increase-risk-of-stillbirth-research-suggests-a7046201.html

The Guardian
Fifteen babies a day in UK are stillborn or die within month of birth
Sarah Boseley 17 May 2016
https://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

The Independent
UK's first miscarriage research centre 'to help 24,000 women' every year
Kayleigh Lewis 25 April 2016
http://www.independent.co.uk/news/uk/home-news/uk-s-first-miscarriage-research-centre-help-24000-women-every-year-tommys-a7000391.html

The Independent
Stillbirths: NHS England publishes advice for parents and healthcare professionals in bid to halve deaths
Kashmira Gander 21 March 2016
http://www.independent.co.uk/life-style/health-and-families/health-news/stillbirths-nhs-england-publishes-advice-for-parents-and-healthcare-professionals-in-bid-to-halve-a6943781.html

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

The Independent
Analysis of infant deaths finds UK could save the lives of up to 2,000 babies a year
Charlie Cooper 9 June 2015
http://www.independent.co.uk/life-style/health-and-families/health-news/analysis-of-infant-deaths-finds-uk-could-save-the-lives-of-up-to-2000-babies-a-year-10307871.html

3. Press releases

Miscarriage Association
10 October 2016
#heretolisten

The Babyloss Awareness Week animation that we launched yesterday ends with the message:

"It was such a hard time and we'll never forget our baby, but having people listen – really listen – has helped us through."

Here at the Miscarriage Association, we've supported thousands of people who have been affected by pregnancy loss, and one thing we've heard again and again is that it can often help to talk.

However we also know that talking can be difficult. People who want to support their friends tell us that they're worried they'll say the wrong thing and that they sometimes say nothing in case they make things worse.

Last year, we asked our supporters to share the helpful things that others had said to them after a pregnancy loss. There were hundreds of different answers. Everyone's experience of loss is different, of course. However, a common message that emerged is that sometimes it's not so much what we say, as what we do: being there for a friend, really listening to what they have to say, can make all the difference in helping them through.

That's why, this Babyloss Awareness Week, we're asking you to use the #heretolisten hashtag as you share one of the graphics below with your friends and family, on Facebook, on Twitter, on Instagram and across social media, to say – if you want to talk about pregnancy loss, I'm here to listen.

Two other people who will be here to listen later today are the chairs of the All Party Parliamentary Group on Baby loss.
From 2 to 3 p.m. today, the two group chairs, Will Quince MP and Antoinette Sandbach MP, will be on Twitter, asking questions to inform a special House of Commons debate about pregnancy and baby loss this Wednesday. The Miscarriage Association will be participating in this event via our twitter account (@MiscarriageA). If you would also like to get involved, please follow the hashtag #babylossdebate.
For more information about the events in Westminster this week, see our Babyloss Awareness Week events page.

Bliss
7 October 2016
Baby Loss Awareness Week 2016

Baby Loss Awareness Week (9 to 15 October 2016) gives bereaved parents, families and friends across the world an opportunity to unite

and commemorate their babies' lives, both in person at local events and online.

Bliss will be linking up with other charities this Baby Loss Awareness Week to raise awareness of baby loss and the work being done by organisations to prevent it and support those affected by it. Activities taking place during the week include:

Bereaved parents and families sharing kind actions or words that helped them after their baby died, on social media using the hashtag #babyloss. The stories captured as part of Baby Loss Awareness Week in 2015 can be read on the Baby Loss Awareness Week website.

The All-Party Parliamentary Group on Baby Loss is driving activities in parliament, including a reception on Wednesday 12 October and a general debate in the House of Commons Chamber on Thursday 13 October.

Saturday 15 October sees the week finish in a global 'Wave of Light'. By simply lighting a candle at 7pm and burning it for at least one hour, you can join others in remembering all babies that have died too soon.

To be part of the digital Wave of Light as well, simply take a photo of your candle and post it to Facebook or Twitter using #WaveOfLight at 7pm.

If you would like a lasting and positive way to remember your loved one this Baby Loss Awareness Week, you can also create a Bliss Precious Star Fund. This is a personalised tribute fund which you can choose to donate however much you like, and will be there for as long as you want it.

If you already have a Precious Star Fund, why not light a candle on your memorial page and join the 'Wave of Light'.

For more information on how you can support the campaign, please visit babyloss-awareness.org or if you need someone to talk to concerning bereavement, call our confidential helpline on 0808 801 0322.

Royal College of Midwives
15 August 2016
SIDS at lowest level ever

Rates of sudden infant death syndrome (SIDS) in England and Wales are at the lowest level since records began, new figures show.

An Office for National Statistics (ONS) report shows there were 128 in 2014, compared with 165 in 2013. This follows the decreasing trend that has generally been seen over the last decade.

Rosie Amery, ONS health analysis and life events statistician, said: 'Unexplained infant deaths in 2014 were the lowest on record, driven by a decrease in sudden infant deaths.

'A number of factors may have contributed to the fall including warmer than average temperatures throughout the year, fewer women smoking at the time of delivery and greater awareness of safer sleeping practices.'

SIDS has reduced in England and Wales by over a third in the last 10 years, according to the figures.

Francine Bates, CEO of SIDS charity The Lullaby Trust, welcomed the news but said there is more work to do.

'While it is extremely good news that SIDS has gone down in England and Wales, evidence has shown that many more babies' lives could be saved if all families had access to and followed safer sleep advice,' she said.

'It is very important that we work together to ensure safer sleep messages consistently reach all families, particularly those at increased risk such as young parents and families living in areas with higher SIDS rates.'

To access the ONS report click here. For more information on the Lullaby Trust, click here.

Royal College of Obstetricians and Gynaecologists (RCOG)
9 June 2016
Over a quarter of local investigations into stillbirths, neonatal deaths and severe brain injuries are not good enough, says RCOG report

More robust and comprehensive local reviews are urgently needed to ensure lessons can be learnt and improvements made.

The quality of local investigations into cases of stillbirth, early neonatal death and severe brain injury occurring as a result of incidents during term[1] labour must improve, highlights the first annual report from the Royal College of Obstetricians and Gynaecologists' (RCOG) Each Baby Counts initiative.

Each Baby Counts is a national quality improvement programme, launched in October 2014, aiming to halve the number of these tragic events by 2020. This project will bring together the lessons learned from a review of all local investigations in order to improve the quality of care in labour across the UK.

The interim data from 2015 reveal that 921 babies were reported [2] to the Each Baby Counts programme. Of these, 654 (71%) were classified as having severe brain injuries, and there were 147 (16%) early neonatal deaths and 119 (13%) stillbirths that occurred during term labour.

Of the 610 reports which have been completed 599 (98%) have had a local investigation of some kind and 204 have been assessed by Each Baby Counts reviewers to date. However, 27% of these were classified poor quality as they did not contain sufficient information for the care to be classified. Of those that passed the initial quality checks, 39% contained no actions to improve care or only made recommendations which were solely focussed on individual actions.

Although 96% of reviews were made up of multidisciplinary teams, including midwives and obstetricians, only 62% included a neonatologist, 44% included a member of the senior management team and 10% an anaesthetist. Only 7% of local review panels included an external expert.

In a quarter of local reviews, the parents were not made aware that an investigation was taking place. In 47% of the reviews, parents were made aware that an investigation was taking place and were informed of its outcomes, but in only 28% were parents invited to contribute to the investigation.

Professor Alan Cameron, RCOG Vice President for Clinical Quality and co-Principal Investigator for Each Baby Counts, said:
"This report shows that although some trusts are conducting reviews very well, it is clear that we need more robust and comprehensive reviews, which are led by multidisciplinary teams and include parental and external expert input. Additionally, we need to move to a more standardised national approach for carrying out these investigations to improve future care. The focus of a local investigation should also be on finding system-wide mechanisms for improving the quality of care, rather than individual actions.

"Stillbirth rates in the UK remain high and our current data indicate that nearly 1,000 babies a year die or are left severely disabled because of potentially avoidable harm in labour. The emotional cost of these events is immeasurable and each case of disability costs the NHS around £7million in compensation to pay for the complex, lifelong support these children need – this equates to nearly half of the NHS' litigation budget.

"Currently, there is a lack of consistency in the way local investigations are conducted. When the outcome for parents is the devastating loss of a baby, or a baby born with a severe brain injury, there can be little justification for poor quality reviews. Only by ensuring that local investigations are conducted thoroughly with parental and external input, can we identify where systems need to be improved. Once every baby affected has their care reviewed robustly we can begin to understand the causes of these tragedies."

Miss Kate Harding, Consultant Obstetrician and an external reviewer for maternal death investigations, said:

"Having an external expert as part of a local review process is a vital way of truly learning from mistakes that happen in healthcare. Every time a maternal death occurs in our region, an external expert will participate in a local investigation. This allows for an unbiased perspective and an ability to review events against national standards, focusing on system-wide approaches to improving services, rather than identifying an individual who may need further training. We now need to see this process expanded to include investigations into stillbirths, early neonatal deaths and brain injuries."

Ms Judith Abela, Acting Chief Executive at Sands, the stillbirth and neonatal death charity, said:
"The death of a baby has a lifelong impact on families and Sands supports hundreds of parents every year whose baby has died before, during or shortly after birth. Many believe their baby's death was not inevitable and opportunities were missed to save their child.

"We have been calling for a robust and effective review process for some time, including parental involvement in local investigations. Parents' perspective of what happened is critical to understanding how care can be improved and they must be given the opportunity to be involved, with open, respectful and sensitive support provided throughout."

Ms Nicky Lyon, parent representative on the Each Baby Counts Advisory Group and co-founder of the Campaign for Safer Births said:
"Our son Harry suffered profound brain damage during term labour. After a difficult life of tube feeding, constant sickness, fits and discomfort, our son died of a chest infection aged 18 months. As a family we have been left devastated at the loss of our beautiful boy.

"In the days following Harry's birth we asked what had gone wrong, but we were ignored. It was only after submitting a formal complaint that we learnt that an investigation was already underway. It's hard to describe how upset, confused and angry we were – the poor communication and secrecy made a terrible situation so much worse.

"Patients and their families should always be at the heart of a review, and being included in the process would have made such a difference to our family."

Ben Gummer, Health Minister, said:
"These findings are unacceptable. We expect the NHS to review and learn from every tragic case which is why we are investing in a new system to support staff to do this and help ensure far fewer families have to go through this heartache.

"Our ambition is to make the NHS one of the safest places in the world to have a baby and halve the number of stillbirths and neonatal deaths by 2030."

The next phase of the Each Baby Counts programme involves undertaking a structured review of each case that occurred in 2015, identifying the themes that emerged and developing an action plan on how lessons can be learned.

[1] 37+ weeks gestation
[2] The reporting window for 2015 is not yet closed and case ascertainment based on other sources of national data is still underway. Details of case eligibility are included in the report.

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/.

NHS England
NHS England announces new action to cut stillbirths
21 March 2016

NHS England publishes new guidance that aims to reduce stillbirths in England.

There are currently around 665,000 babies born in England each year, but there are over 3,000 stillbirths. Despite falling to its lowest rate in 20 years, one in every 200 babies is stillborn in the UK, more than double the rate of nations with the lowest rates.

The new guidance – called Saving Babies' Lives Care Bundle – is part of a drive to halve the rate of stillbirths from 4.7 per thousand to 2.3 per thousand by 2030, potentially avoiding the tragedy of stillbirth for more than 1500 families every year.
While the majority of women receive high quality care, there is around a 25 per cent variation in stillbirth rates across England.

The guidance addresses this variation by bringing together four key elements of care based on best available evidence and practice in order to help reduce stillbirth rates.

This 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.

Care bundles bring together a small number of focused interventions in order to bring about improvement. They exemplify known best practice in areas where current practice is unacceptably variable. Evidence shows that greater benefits are achieved at a faster pace when implementing those interventions together.

Building on existing clinical guidance and best practice, the guidance was developed by NHS England working with organisations including the Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, British Maternal and Fetal Medicine Society and Sands, the stillbirth and neonatal death charity.

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. The leaflet will contain clear messaging consistent with national guidelines.

The move follows publication of the recent National Maternity Review report, which set out wide-ranging proposals designed to make care safer and give women more control.

The four key interventions outlined include:

- Reducing smoking in pregnancy – All women should be offered a test at their antenatal booking appointment to establish the level of carbon monoxide they are exposed to as well as referral to support to stop smoking. This will ensure that smokers and those exposed to smoke are fully aware of the risks to their unborn baby and are supported to make an informed decision about quitting or staying away from smoke.
  The latest figures show that just over one in 10 women smoke during their pregnancy, this is below the national target set for 2015, but it masks wide geographical variation – figures from NHS Central London reveal that around one in 100 women continue to smoke, but in NHS Blackpool it is one in four.
- Enhancing detection of fetal growth restriction – Growth of babies should be monitored and recorded on growth charts and an algorithm should be used to indicate the level of monitoring required. Of the one in 200 babies that are stillborn, growth restricted babies are the single largest preventable group.
- Improving awareness of the importance of fetal movement – Women and their partners should be better informed and more empowered to monitor their baby's movements by clear, consistent advice. An information and advice leaflet on reduced fetal movement will be provided to all pregnant women. Providers should also have protocols in place to manage care effectively for women who report reduced movement.
- Improving fetal monitoring during labour – there should be annual training and assessment for staff on cardiotocograph (CTG) interpretation and use of auscultation (monitoring of the baby's heartbeat) during labour. A buddy system for CTG

interpretation should also be implemented so that 'fresh eyes' can detect any potential problems during labour.

Simon Stevens, the Chief Executive of NHS England, said: "For over 650,000 families who'll have a baby in the NHS this year, it'll be one of their happiest and most moving experiences. NHS maternity care is now the safest it's ever been, and most mums say they're cared for brilliantly. But that makes it all the more tragic and heart wrenching when for a small number of families something goes terribly wrong. We could however cut the chances of this happening if all pregnant mums were encouraged to quit smoking, if proper monitoring takes place during pregnancy, and if maternity providers listen carefully when pregnant women report worries about their baby's movements. That's what this new NHS 'care bundle' – developed by obstetricians, midwives, and parents – now recommends as the best standard of care everywhere. It brings together evidence-based best practice to support midwives and doctors and is a key step in driving forward safer care as set out in the recently published national Maternity Review."

Professor Jacqueline Dunkley-Bent, Head of Maternity, Children & Young People for NHS England, said: "Having a baby in this country is now safer than ever before, but for some mums that's not the case, and the 'care bundle' and new National Maternity Review will help all families receive excellent maternity care."

Dr Matthew Jolly, National Clinical Director for Maternity and Women's Health at NHS England, said: "Saving babies' Lives' provides clinicians with the best available clinical approaches to tackling stillbirth across four key elements of care. Though many NHS maternity care providers already follow much of this best practice, this is the first time that guidance specifically for reducing the risk of stillbirth and early neonatal death has been brought together in a coherent package."

This care bundle will be analysed and evaluated so that it can be developed and refined to ensure that it continues to reflect best practice.

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.

4. Parliamentary material

Bills

Parental Bereavement Leave (Statutory Entitlement) Bill 2016-17

First reading on 6 September 2016

Second reading on 28 October 2016

PQs

Streptococcus

Asked by: Simpson, David

To ask the Secretary of State for Health, what steps the Government is taking to prevent and tackle Group B Strep infection among pregnant women and unborn children.

To ask the Secretary of State for Health, how much funding has been provided to prevent and tackle Group B Strep infection among pregnant women in the last five years.

Answering member: Mr Philip Dunne | Department: Department of Health

Information on how much funding has been provided to prevent and tackle Group B Strep infection among pregnant women over the last five years is not collected centrally.

The Government has made clear that maternity care is a priority and on 13 November 2015 announced an ambition to reduce by 50% stillbirths, neonatal deaths, maternal deaths and neonatal brain injuries by 2030. This includes harm and death caused by Group B Streptococcus (GBS).

A range of work addressing GBS is being taken forward by the Department of Health and Public Health England with a range of partner organisations. This includes:

- Monitoring developments on GBS vaccines and undertaking a grant-funded study to assess the potential impact of a maternal immunisation programme.
- An audit in partnership with the London School of Hygiene and Tropical Medicine and supported by the Royal College of Midwives, recently carried out by the Royal College of Obstetricians and Gynaecologists (RCOG). This examined current practice in preventing early onset neonatal GBS disease by investigating the implementation of the RCOG Green-top guideline on preventing the disease. The last of two reports was published on 29 January 2016 and has made recommendations for improvements in care in the prevention of early-onset GBS disease.
- The National Institute of Health Research has approved funding for a study on accuracy of a rapid intrapartum test for maternal group B streptococcal colonisation and its potential to reduce antibiotic usage in mothers with risk factors (GBS2). The study commenced in May 2016.

The Department is also convening two half day workshops with leading experts from a wide range of organisations, including the RCPG and

Gynaecologists, the Royal College of Paediatrics and Child Health and the charity Group B Strep Support to discuss research evidence gaps in relation to GBS.
HC Deb 13 September 2016 | PQ 44994; PQ 44993

Childbirth
Asked by: Baroness Hodgson of Abinger
To ask Her Majesty's Government whether they will include information on twins and multiple births in any formal updates on progress towards their aim of halving the rates in England of stillbirths, neonatal deaths and brain injuries occurring during or soon after birth by 2030.
To ask Her Majesty's Government when, where and how often they plan to publish a formal update on progress made towards achieving their aim of halving the rates in England of stillbirths, neonatal deaths and brain injuries occurring during or soon after birth by 2030.
To ask Her Majesty's Government what reductions they aim to achieve in rates of (1) stillbirths, (2) neonatal deaths, and (3) brain injuries, in (a) single pregnancies, and (b) multiple pregnancies, by 2030.

Answering member: Lord Prior of Brampton | Department: Department of Health
In November 2015, the Secretary of State 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. This ambition applies to both single and multiple pregnancies.
The Department will publish an annual report on the progress towards achieving this aim and will include information on twins and multiple births. The first report will be published later this year.
HL Deb 07 July 2016 | PQ HL786; PQ HL785; PQ HL784

Perinatal Mortality
Asked by: Sandbach, Antoinette
To ask the Secretary of State for Health, what assessment he has made of differences between bereavement support services for families who have suffered a stillbirth or neonatal death commissioned by clinical commissioning groups and such services provided by hospital trusts; and if he will make a statement.
To ask the Secretary of State for Health, if he will review the (a) commissioning framework and (b) tariff payment for bereavement care for families who have suffered a stillbirth or neonatal death.

Answering member: Ben Gummer | Department: Department of Health
A report in 2015 on *Term, singleton, normally-formed, antepartum stillbirth from Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK* found that 60% of parents currently receive a good standard of bereavement care but this is not the case for everyone and we are continuing to consider the actions that should be taken to improve bereavement care across England.
NHS England has established a Maternity Transformation Programme Board, this will bring key partners together to oversee the implementation of a broad range of policies to deliver significant improvements to maternity care in England, including implementation

of the recommendations of *Better Births, Improving outcomes of maternity services in England* (2016). The Transformation Programme includes work on supporting local transformation of maternity services, promoting best practice for safer care, increasing choice and reforming the payment system.
In *Delivering the Forward View: NHS planning guidance 2016/17-2020/21* localities have been asked to produce "Sustainability and Transformation Plans" to show how local services should transform and ensure they are sustainable over the next five years. As part of this, local health economies have been asked to plan how they will transform their maternity services in line with the vision outlined in *Better Births, Improving outcomes of maternity services in England*. NHS England will be reviewing how well commissioners are planning for delivery of this vision in signing-off plans; and how well those plans are being put into action and on an ongoing basis through its Clinical Commissioning Group (CCG) Assessment Framework, and annual Ofsted-style rating of each CCG on its commissioning of maternity services.
HC Deb 09 Jun 2016 | PQ 38494; PQ 38493

Miscarriage: Counselling
Asked by: Cameron, Dr Lisa
To ask the Secretary of State for Health, what steps he has taken to ensure that affected women and their partners have access to bereavement counselling after early miscarriage.

Answering member: Ben Gummer | Department: Department of Health
The mandate to NHS England makes it clear they should ensure the National Health Service meets the needs of each individual with a service where people's experience of their care is seen as an integral part of overall quality.
It is for the NHS locally to ensure appropriate facilities and services are in place to support parents following pregnancy loss. To assist NHS commissioners and providers, the Royal College of Obstetricians and Gynaecologists' Standards for Gynaecology and Standards for Maternity (2008) sets out clear standards for the level of care provided to help women and their partners experiencing pregnancy loss, including the availability of skilled staff to support parents following a stillbirth or miscarriage. In addition, the Department has supported the publication of Health Building note 09-02, which sets out guidance on the planning and design of maternity care facilities, including the facilities available for women and families who suffer bereavement at any stage of pregnancy.
HC Deb 04 May 2016 | PQ 35733

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: 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.
To ask the Secretary of State for Health, what steps he is taking to reduce deaths of premature babies.

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 | PQ 26392; PQ 26384

Debate

Westminster Hall debate: Stillbirth
HC Deb 09 June 2016 | Vol 611 cc201-225WH
https://hansard.parliament.uk/Commons/2016-06-09/debates/16060930000001/Stillbirth

EDMs

EDM 137 2016-17
6 June 2016
Patricia Gibson
SANDS AWARENESS MONTH CAMPAIGN

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 2015-16
1 March 2016
Patricia Gibson
SAFER BIRTHS CAMPAIGN

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.

5. Useful links and further reading

All-Party Parliamentary Group on Baby Loss
http://www.lullabytrust.org.uk/all-party-parliamentary-group-on-baby-loss

Baby Loss Awareness Week
http://babyloss-awareness.org/

Bliss for babies born premature or sick
https://www.bliss.org.uk/

Kicks Count
http://www.kickscount.org.uk/support/stillbirth-support/

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

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

Miscarriage Association
http://www.miscarriageassociation.org.uk/support/how-we-can-help/?gclid=CP_Vzsz_w88CFcQV0wodbiYF4A

NHS England *BETTER BIRTHS: Improving outcomes of maternity services in England A Five Year Forward View for maternity care* February 2016
https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

NHS England Maternity Transformation Programme
https://www.england.nhs.uk/ourwork/futurenhs/mat-transformation/

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*
https://www.england.nhs.uk/signuptosafety/wp-content/uploads/sites/16/2015/11/spotlight-on-maternity-guide.pdf

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

Royal College of Obstetricians and Gynaecologists
https://www.rcog.org.uk/

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

Tommy's
https://www.tommys.org/

DEBATE PACK
Number CDP 2016/0175
11 October 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