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DEBATE PACK

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Baby Loss Awareness Week

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This pack has been produced ahead of the general debate to be held in the Commons Chamber on Tuesday 10 October 2017 on Baby Loss Awareness Week.

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 Awareness Week

Baby Loss Awareness Week 2017 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:
>
> 1. for bereaved parents, and their families and friends, to unite with others across the world to commemorate their babies' lives.
> 2. to raise awareness about the issues surrounding pregnancy and baby loss in the UK, and push for tangible improvements in services, support, research or policy around bereavement support.
> 3. to let the public and key stakeholders what charities and other supportive organisations are doing on bereavement support around pregnancy and baby loss.
>
> 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. We also want to identify how we can reduce preventable deaths and improve support for all those affected.

Baby Loss Awareness week is coordinated and supported by a number of charities including Sands, the Miscarriage Association and Antenatal Results and Choices (ARC).

The term baby loss can describe a number of different types of bereavements including, miscarriage, ectopic pregnancy, stillbirth, neonatal and infant death, and termination of pregnancy. It is not possible to provide a comprehensive briefing on these in this debate pack. However, this briefing will highlight key recent policy announcements and parliamentary activity in this area.

A number of Commons library and POST publications may provide useful information in preparation for the debate on baby loss awareness week:

- POSTnote, Infant Mortality and Stillbirth in the UK, May 2016
- Commons Library Debate pack, Bereavement leave for families that lose a child, 8 September 2017
- POST Briefing, Bereavement Care after the Loss of a Baby in the UK, July 2016
- Commons Library briefing paper, Registration of stillbirth, 4 October 2017
- Commons Library briefing paper, Infant cremation, 4 October 2017

2. Stillbirth and neonatal deaths in the UK

The most recent review of stillbirths and neonatal deaths in the UK reports that out of 782,720 births in 2015[1], 3,032 of these were stillbirth and 1,360 were neonatal deaths.[2] Whilst noting a reduction in stillbirths since 2013, the report highlighted that UK stillbirth rates still remain high compared with similar European countries.

An article in the Lancet journal (part of a series on stillbirth) in 2016, *Stillbirths: recall to action in high-income countries*, noted that inequality exists both between, and within, high income countries in stillbirth rates.[3] The authors state that "*if all high-income countries achieved stillbirth rates equal to the best performing countries, 19,439 late gestation (28 weeks or more) stillbirths could have been avoided in 2015.*" The UK was ranked 24th of 49 high income countries in the Lancet study.

Whilst perinatal mortality has decreased in the last few decades, there are concerns that the rate of this decrease has slowed over recent years. Another concern is that whilst numbers overall are improving, there remains a geographical and socio-economic inequality in rates. In 2016, NHS England reported that there was around a 25% variation in stillbirth rates just across England.[4]

Another 2016 Stillbirth series study reported that parents, family, health services, society and Government may all be affected by wide ranging and substantial impacts of stillbirth.[5] These include "*medical care and investigations at the time of stillbirth and in subsequent pregnancies; funeral costs; grief and negative psychological effects; reduced social functioning; family and relationship disruption and breakdown; and negative effects on employment.*" These impacts are often enduring and long lasting.

The UK Government have taken action to address maternity care and stillbirth rates. A number of programmes have stemmed from an announcement made by the Secretary of State for Health, Jeremy Hunt in November 2015- a national ambition to halve the rates of stillbirths, neonatal and maternal deaths in England by 2030.[6] Alongside this, the Better Births report from the National Maternity Review made a number of recommendations to improve maternity care.

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1 This includes babies delivered from 24 weeks of pregnancy, and does not include terminations of pregnancy.

2 MBRRACE-UK, Perinatal Mortality Surveillance Report – UK Perinatal Deaths for Births from January to December 2015, June 2017

3 Stillbirths: recall to action in high-income countries, Flenady, Vicki et al. The Lancet , Volume 387 , Issue 10019 , 691 - 702

4 NHS England, NHS England announces new action to cut stillbirths, March 2016

5 Stillbirths: economic and psychosocial consequences, Heazell, Alexander E P et al. The Lancet , Volume 387 , Issue 10018 , 604 - 616

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

Medical professional organisations, such as the Royal College of Obstetricians and Gynaecologists, and charities such as Sands also play an important role in developing programmes and reviewing and improving the care provided to both expectant and bereaved parents.

2.1 Surveillance and statistics

The MBRRACE- UK team at the National Perinatal Epidemiology Unit (NPEU) conducts UK wide surveillance of perinatal mortality, which includes all stillbirth and neonatal deaths, and maternal deaths.[7]

As part of this programme, MBRRACE-UK publishes an annual perinatal mortality surveillance report, which identifies risk factors, causes and trends, and makes recommendations on how stillbirth and neonatal mortality rates can be reduced.

The most recent report was published in June 2017 and provides information about rates of stillbirth and neonatal deaths in 2015, including comparing rates between different organisations delivering healthcare across the UK. The key findings of this report are provided in the infographic on the next page.

[7] For the purposes of the MBRRACE-UK report, extended perinatal death refers to all stillbirths and neonatal deaths.

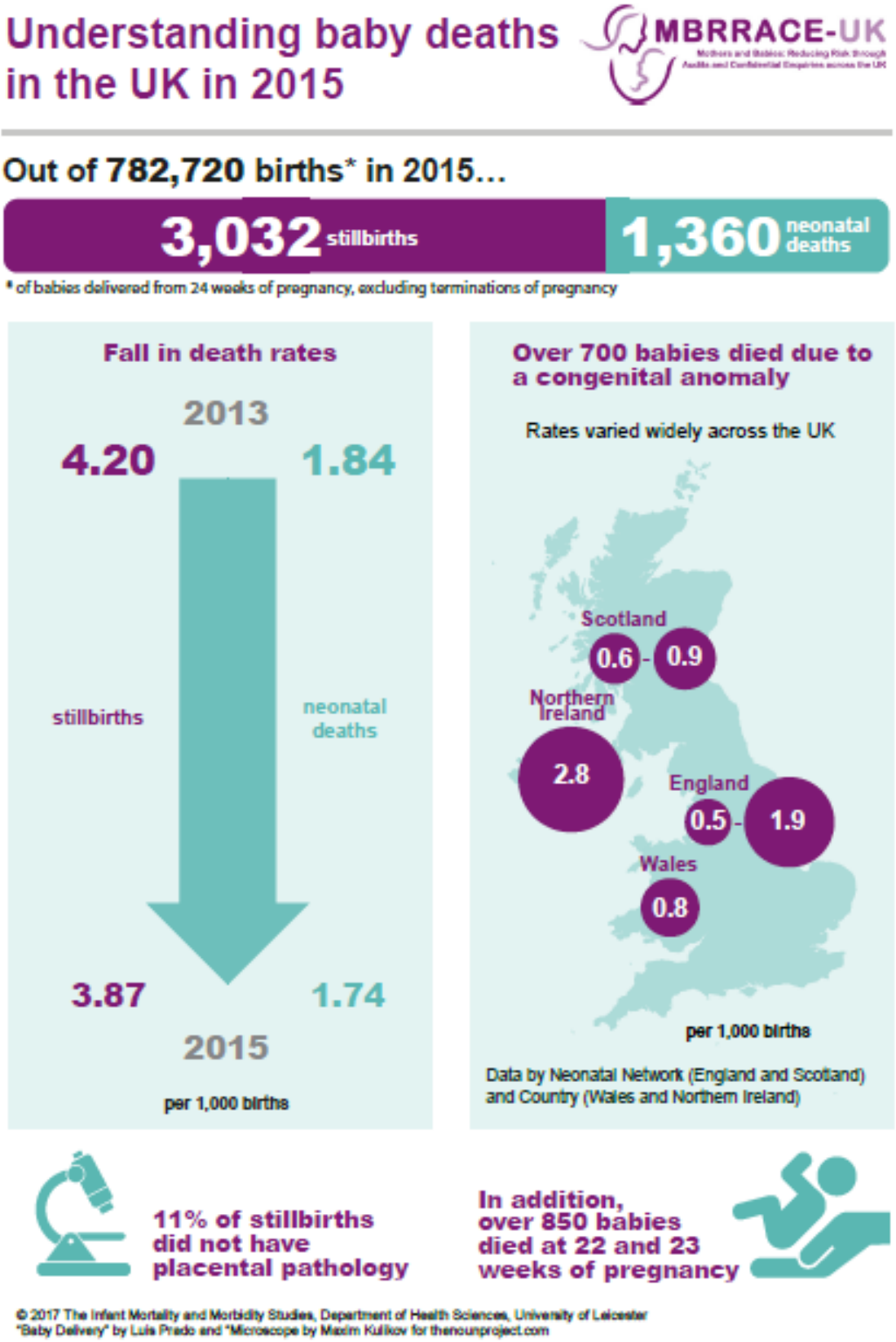

Figure 1: MBRRACE, Perinatal Mortality Surveillance Report – UK Perinatal Deaths for Births from January to December 2015, Infographic, June 2017

The Royal College of Obstetricians and Gynaecologists', Each baby Counts initiative is a national quality improvement programme launched in October 2014. The investigation team undertakes a detailed analysis of all stillbirths, neonatal deaths and brain injuries that occurred during childbirth. The most recent report, published in June 2017, and based on 2015 data, concluded that three quarters of the babies reviewed might have had a different outcome with different care:

> The reviewers concluded that three quarters of these babies - 76% - might have had a different outcome with different care. This finding was based on 727 babies where the local investigation provided sufficient information to draw conclusions about the quality of care. A quarter of the local investigations were not thorough enough to allow full assessment.
>
> Co-principal investigator, Professor Zarko Alfirevic, consultant obstetrician at Liverpool Women's Hospital, said: "Problems with accurate assessment of fetal wellbeing during labour and consistent issues with staff understanding and processing of complex situations, including interpreting fetal heartrate patterns, have been cited as factors in many of the cases we have investigated.
>
> "This is the first time the Each Baby Counts team has been in a position to identify and share the lessons learned across the whole UK maternity service. However, until every incident is thoroughly investigated and important lessons identified locally, our understanding of the national picture will remain incomplete. The focus of a local investigation should be on finding system-wide solutions for improving the quality of care, rather than actions focusing only on individuals."[8]

2.2 Programmes and policies

There are a number of programmes to reduce rates of perinatal mortality and improve maternity services in all parts of the UK, with government, health services and stakeholders involved.

National Maternity Review '*Better Births*'

In March 2015, Simon Stevens, Chief Executive of NHS England, announced an independent review of maternity services as part of the NHS Five Year Forward View.

In February 2016, the report of the National Maternity Review, 'Better Births', was published. The review found that whilst there had been significant improvements in maternity care over the last decade, geographical variations remained and there were opportunities to improve services further. The report highlighted seven key improvements for maternity care. These included that women should be able to have care focused on their personal needs and choices, that women should have a named midwife, who is known to them and based in the community, and that there should be improvements in the provision of perinatal and postnatal mental healthcare.[9]

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8 RCOG, Teamwork in maternity units key to reducing baby deaths and brain injuries during childbirth, 21 June 2017

9 NHS England, National Maternity Review, (accessed 4 October 2017)

The Maternity Transformation Programme Board will lead the implementation of the Maternity Review, including work to reduce the rate of stillbirths, neonatal and maternal deaths in England.

A national ambition to halve the rates of stillbirths, neonatal and maternal deaths in England by 2030

In November 2015, the UK Government announced a national ambition to halve the rates of stillbirths, neonatal and maternal deaths in England by 2030. A press release at this time set out the actions that would be taken to realise this ambition:

> 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.[10]

In October 2016, the Department of Health published the Safer Maternity Care action plan. This document sets out the Government's vision "*for making NHS maternity services some of the safest in the world.*"

Prevention and guidance

In March 2016, NHS England launched the Saving Babies' Lives Care Bundle designed to support providers and commissioners of maternity care to take action to reduce stillbirths and early neonatal deaths. The clinical guidelines focus on four interventions to reduce the number of stillbirths:

- Reducing smoking in pregnancy

[10] Department of Health, New ambition to halve rate of stillbirths and infant deaths, November 2015

- Risk assessment and surveillance for fetal growth restriction
- Raising awareness of reduced fetal movement
- Effective fetal monitoring during labour

The important role of public health guidance and a focus on prevention was highlighted in a March 2017 Adjournment debate. In response to the debate, the Minister, Philip Dunne set out the risk factors for poor maternity outcomes, and some of the actions being taken to tackle these:

> When starting pregnancy, not all women will have the same risk of something going wrong, and women's health before and during pregnancy are some of the factors that most influence rates of stillbirth, neonatal death and maternal death. We know that a body mass index of over 40 doubles the risk of stillbirth. A quarter of stillbirths are associated with smoking, and alcohol consumption is associated with an estimated 40% increase to stillbirth risk. In addition, the MBRRACE-UK perinatal mortality surveillance report, published in June last year, showed that women living in poverty have a 57% higher risk of having a stillbirth. Women from black and minority ethnic groups have a 50% higher risk, and teenage mothers and mothers over 40 have a 39% higher risk of having a stillbirth.
>
> Those striking facts are why the Department of Health will continue to work closely with Public Health England and voluntary organisations to help women to have a healthy pregnancy and families to have the best start in life. Last year, NHS England published new guidance that aims to reduce the number of stillbirths in England. 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. The Saving Babies' Lives Care Bundle includes key elements intended to significantly impact on stillbirth rates through reducing smoking in pregnancy, detecting foetal growth restriction, raising awareness of reduced foetal movement and improving effective foetal monitoring during labour.

The 2016 Public Health England guidance document, Health matters: giving every child the best start in life provides more information about staying health and risk factors in pregnancy. The stillbirth and neonatal death charity, Sands has also launched a Safer Pregnancy website. This signposts women to evidence-based information around risks and keeping healthy in pregnancy.

2.3 Scotland

Review of maternity and neonatal services in Scotland was announced on 25 February 2015. The review looked at the quality and safety of maternity and neonatal services, and choice within those services. The report of the review, *The Best Start: A Five-Year Forward Plan for Maternity and Neonatal Care in Scotland*, was published in January 2017. The key recommendations were:

> Continuity of Carer: all women will have continuity of carer from a primary midwife, and midwives and obstetric teams will be aligned with a caseload of women and co-located for the provision of community and hospital based services.
>
> Mother and baby at the centre of care: Maternity and Neonatal care should be co-designed with women and families from the outset, and put mother and baby together at the centre of service planning and delivery as one entity.
>
> Multi-professional working: Improved and seamless multi-professional working.
>
> Safe, high quality, accessible care, including local delivery of services, availability of choice, high quality postnatal care, colocation of specialist maternity and neonatal care, services for vulnerable women and perinatal mental health services.
>
> Neonatal Services: proposes a move to a new model of neonatal intensive care services in Scotland in the short and long term.
>
> Supporting the service changes: recommendations about transport services, remote and rural care, telehealth and telemedicine, workforce, education and training, quality improvement and data and IT.[11]

In a statement to the Scottish Parliament, the Minister of Public health and Sport, Aileen Campbell, said that the Government were committed to implementing the recommendations, and that an implementation group was being established.

2.4 Wales

In Wales, a National Stillbirth Working Group was set up within the 1000 Lives Plus programme of work in April 2012, and included representation of important stakeholders in maternity care. The National Assembly for Wales published an Inquiry into stillbirths in Wales in 2013, which identified a number of actions to improve the stillbirth rate in Wales.

In March 2017, the Safer Pregnancy Wales campaign was launched. It is an initiative developed by the Wales Maternity Network in collaboration with 1000 Lives Improvement. The campaign highlights the important of keeping fit and healthy, and provides advice on lifestyle choices in pregnancy.

2.5 Northern Ireland

In December 2013 a new Northern Ireland Maternal and Infant Loss (NIMI) steering group was established to focus on policy to reduce the number of stillbirths and neonatal deaths. Chaired by Northern Ireland's Chief Medical Officer, Dr Michael McBride, the Northern Ireland group's remit covers all infant deaths in Northern Ireland, from miscarriage to one year. The group consists of healthcare professionals, officials and charities. Further information on this is available on the Sands website.

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[11] Scottish Government, The Best Start: A Five-Year Forward Plan for Maternity and Neonatal Care in Scotland, 2017

The Department of Health launched a Maternity strategy, A strategy for maternity care in Northern Ireland 2012 - 2018 in 2012.

3. Bereavement care

The stillbirth and neonatal death charity, Sands (which works to improve care for bereaved parents, and promote research in this area) published a report of an audit of bereavement care provision in the UK in 2016.[12] This updated a similar piece of work in 2010. The key findings of this audit are shown in the infographic below:

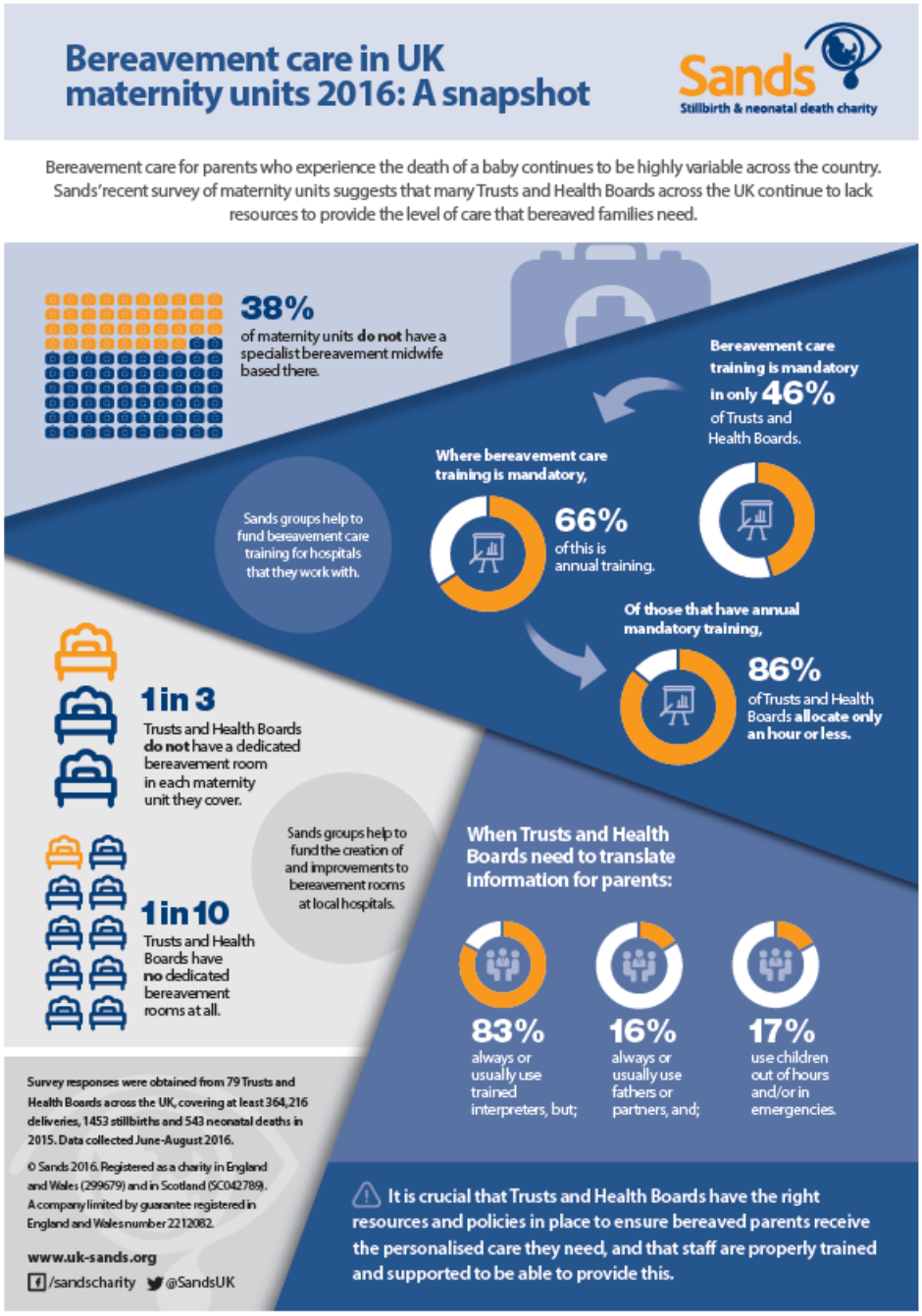

Figure 2: Sands, Bereavement care in UK maternity units 2016: A snapshot, January 2017

[12] Sands, Audit of bereavement care provision in UK maternity units 2016, January 2016

Bereavement care has been raised a number of times in parliamentary debates and questions. The most recent Government response on the provision of bereavement suites, from the Parliamentary under-Secretary of State for Health, Jackie Doyle-price outlined some action in this area:

> Since 2010, we have invested £35 million in the National Health Service to improve birthing environments and this included better bereavement rooms and quiet area spaces at nearly 40 hospitals to support bereaved families.
>
> We are also funding Sands, the Stillbirth and Neonatal Death charity to work with other baby loss charities, Royal Colleges and the All Party Parliamentary Group on Baby Loss to produce a National Bereavement Care Pathway to reduce the variation in the quality of bereavement care provided by the NHS. The pathway will cover all forms of baby loss to ensure that all bereaved parents are offered equal, high quality, individualised, safe and sensitive care.[13]

The All Party Parliamentary Group on Baby Loss, and the Department of Health are supporting Sands, and partner charities to produce a National Bereavement Care Pathway. This group have recently announced that 11 sites have been identified in England to pilot the new pathway.[14]

13 HC Written Question 900193, Perinatal Mortality: Counselling, 4 July 2017
14 Sands, National Bereavement Care Pathway to be piloted at 11 sites, August 2017

4. Press articles

The Guardian

A very private grief: the parents breaking the stillbirth taboo

Angela Neustatter 9 October 2017

https://www.theguardian.com/lifeandstyle/2017/oct/09/stillbirths-very-private-grief-parents-breaking-taboo

The Times

Parents call for NHS stillbirths to be investigated

Lucy Bannerman 7 October 2017

https://www.thetimes.co.uk/article/parents-jack-and-sarah-hawkins-call-for-stillbirths-to-be-investigated-after-nottingham-university-hospitals-nhs-trust-errors-ktvxfpt78

The Guardian

UK retailers halt sale of baby sleep positioners after US warning

Nadia Khomami 6 October 2017

https://www.theguardian.com/society/2017/oct/06/uk-retailers-halt-sale-of-baby-sleep-positioners-after-us-warning

BBC News

Baby heart images could help reduce miscarriage, Leeds research suggests

28 September 2017

http://www.bbc.co.uk/news/uk-england-leeds-41430947

Nursing Times

Yorkshire trust starts giving out 'wallets of vital pregnancy tips and information'

Steve Ford 15 September 2017

https://www.nursingtimes.net/news/hospital/trust-giving-out-wallets-full-of-vital-pregnancy-information/7021276.article

The Telegraph

After a miscarriage, it's not just women who feel the loss

Milli Hill 11 September 2017

http://www.telegraph.co.uk/women/family/miscarriage-not-just-women-feel-loss/

The Times

Stillbirth rates decline for the first time in a decade

Chris Smyth 22 June 2017

https://www.thetimes.co.uk/article/stillbirth-rates-decline-for-the-first-time-in-a-decade-c37c28xhs

BBC News

Scottish stillbirth rates lowest in UK

22 June 2017

http://www.bbc.co.uk/news/uk-scotland-40366637

The Guardian

The incidence of stillbirth hasn't changed in decades. We need to talk about why

Kristina Keneally 17 March 2017

5. Press Releases

Royal College of Paediatrics and Child Health

Research published in the Archives of Diseases in Childhood finds overall improvement in survival rates of preterm babies

8 September 2017

New research shows that overall survival rates for very preterm babies have shown steady improvement in England over the last two decades, particularly for infants of the lowest gestations. However, the findings reveal regional variation which is masked by overall improvements. Authors say further investigation is needed into the reasons for these inconsistencies.

Professor Neena Modi, Lead of the Medicines for Neonates Investigator Group, said:

> Preterm birth is the number one cause of neonatal death worldwide.
>
> Using a unique resource, the National Neonatal Research Database, we show that In the UK survival rates for very preterm babies, born more than two months early, have shown steady improvement over the last two decades. This is a tribute to the dedication of healthcare professionals around the country and the families with whom they work.
>
> However, unexpectedly our study found that the overall improvement in the survival of very preterm babies is hiding significant regional variation, with improvements seen in London and the South of England. This unexplained north-south divide requires further investigation in order to identify the reasons behind the variation and promote improvement more uniformly across the country.

The paper can be read in full in the Archives of Diseases in Childhood.

Miscarriage Association

Top ten priorities for miscarriage research

25 August 2017

This week's BMJ Open publishes the top ten priorities for miscarriage research, as identified by the Miscarriage Priority-Setting Partnership, a project of the James Lind Alliance.

Miscarriage Association Trustee Barbara Hepworth-Jones* represented the M.A. on the Priority-Setting Partnership steering group, and explains:

There are many unanswered questions about miscarriage – so a key question is "What should researchers (and their funders) be focusing on?"

That question tends to get answered by health professionals, researchers themselves and, sometimes, drug companies. But this time, the James Lind Alliance has worked with clinicians, researchers and people who've been through miscarriage, and they've worked together to come up with the top ten priorities for miscarriage research. In summary, these are:

1. Research into preventative treatment
2. Emotional aspects in general
3. Investigations
4. Relevance of pre-existing medical conditions
5. Emotional support as a treatment
6. Importance of lifestyle factors
7. Importance of genetic and chromosomal causes
8. Preconception tests
9. Investigation after different numbers of miscarriage and
10. Male causal factors.

You can read more about those priorities and the process of how they were reached here.

You can read the full published paper in the BMJ Open here.

Lullaby Trust

17 August 2017

Rates of SIDS reach new record low but The Lullaby Trust warns against complacency

Rates of Sudden Infant Death Syndrome (SIDS) have shown another decrease in England and Wales according to figures released today by the Office for National Statistics (ONS).

The new figures show that the number of deaths dropped from 217 (a rate of 0.31 deaths per 1,000 live births) in 2014 to 191 (a rate of 0.27 deaths per 1,000) in 2015. The 2015 figures show a decrease of 25% since 2013 and continue the trend of record low SIDS rates in England and Wales for the second year running.

ONS attribute the decrease to a reduction in maternal smoking and increased awareness of safer sleep advice, referencing the launch of The Lullaby Trust's annual Safer Sleep Week campaign in 2015. The campaign aimed to raise awareness of SIDS (commonly known as cot death) and safer sleep and involved health authorities across the UK. The Lullaby Trust also trains health professionals in how to educate new and expectant parents on safer sleep practices.

Although rates have declined by more than a third over the past 10 years, leading SIDS charity The Lullaby Trust cautions that it is important

not to become complacent and following safer sleep advice remains as vital as ever. If parents were to stop following safer sleep advice such as placing a baby on their back to sleep then the rate of SIDS would inevitably go up.

> Francine Bates, Chief Executive of The Lullaby Trust said:
>
> The further reduction in SIDS rates for 2015 is extremely positive and demonstrates the effectiveness of following safer sleep advice and the importance of making sure that advice reaches all parents and carers. The Lullaby Trust has been campaigning over the past 25 years to ensure that this happens. Although SIDS rates have decreased significantly over the past decade, 191 babies still died in 2015 and the risk has not gone away. We need to ensure that parents continue to recognise the vital importance of following safer sleep advice. Only by making all families aware of the steps they can take to help protect their babies, can we save more lives and drive the number down.

The ONS figures also show a significant decrease in unexplained infant deaths to mothers aged under 25 years in 2015, with a reduction of 40.6% being seen for those aged under 20. The rate of SIDS remains highest in Yorkshire and the Humber at 0.42 deaths per 1,000 live births, showing a decrease from 0.48 followed by the North West at 0.40, which has increased from a rate of 0.32 the in 2014.

Before 1991 around 2,000 babies died from SIDS each year in the UK and sleeping babies on their front was common practice. Following the high profile Back to Sleep campaign, which advised all parents to sleep their babies on their backs and subsequent work over 25 years by The Lullaby Trust, to raise awareness of SIDS and safer sleep advice, SIDS rates have reduced by 85%. The cause of SIDS remains unknown but the advice to parents on how they can reduce the risk is scientifically proven. The Lullaby Trust is determined to ensure this advice continues to reach all parents and people do not assume the danger has passed.

About Sudden Infant Death Syndrome (SIDS)

Sudden Infant Death Syndrome is the term used to describe the sudden and unexpected death of a baby where no cause is found even after post mortem. Though the cause of SIDS remains unknown there are steps parents can take to help reduce the chance of it occurring:

Things you can do to reduce the risk of SIDS

- Always place your baby on their back to sleep
- Keep your baby smoke free during pregnancy and after birth
- Place your baby to sleep in a separate cot or Moses basket in the same room as you for the first 6 months
- Breastfeed your baby
- Use a firm, flat, waterproof mattress in good condition

Things to avoid

- Never sleep on a sofa or in an armchair with your baby

- Don't sleep in the same bed as your baby if you smoke, drink or take drugs or are extremely tired, if your baby was born prematurely or was of low birth-weight
- Avoid letting your baby get too hot
- Don't cover your baby's face or head while sleeping or use loose bedding

Further advice on safer sleep can be found here.

ONS

To view the ONS statistical bulletin visit the ONS website here.

The ONS figures cover unexplained infant deaths, which include both sudden infant deaths and unascertained deaths.

Lullaby Trust

27 July 2017

Global research priorities for Sudden Unexpected Death in Infancy identified in landmark initiative led by The Lullaby Trust

Pediatrics, the journal of the American Academy of Pediatrics, today published a paper from The Lullaby Trust and partner international organisations, which sets out new global priorities for tackling Sudden Unexpected Death in Infancy (SUDI).

The paper, titled *Research Priorities in Sudden Unexpected Infant Death: An International Consensus*, highlights the charity's pioneering 'Global Action and Prioritisation of Sudden infant death (GAPS)' project, run in collaboration with the International Society for the Prevention of Perinatal and Infant Death (ISPID), Red Nose (formerly SIDS and Kids) in Australia and the American SIDS Institute.

The project is the first of its kind to bring together both professionals and bereaved family members from 25 different countries to achieve consensus on the top ten SUDI research priorities. These priorities aim to focus the efforts of the SUDI research community and ultimately put an end to sudden unexpected deaths worldwide, by identifying the cause, which still eludes researchers.

In the UK alone, some 230 babies die suddenly and unexpectedly each year at a rate of 0.30 deaths per 1,000 live births. Since the launch of the ground-breaking 'Back to Sleep' campaign in England and Wales in 1991, the number of sudden infant deaths has fallen by more than 80%, and in 2016 ONS reported that figures had reached their lowest ever.

Francine Bates, Chief Executive of The Lullaby Trust and co-author of the paper says:

> The death of any baby is a tragedy for a family. That tragedy is compounded when a baby dies suddenly and unexpectedly and no cause is found. While sudden unexpected deaths in infancy are

> less common than they were 30 years ago, we must not be complacent. The GAPS research priorities now provide a clear direction for researchers around the world to make significant gains in tackling SUDI. The Lullaby Trust is proud of its achievements in identifying these ten global research priorities. As a world leader in tackling sudden unexpected infant deaths, we are committed to halving these deaths in the UK by the year 2020 and finding and eliminating the cause.

The charity has developed a new research strategy in response to the GAPS findings, and as well as urging researchers to drive the priorities forward, is calling on donors and research funders to help them beat sudden infant death forever.

Ms Bates added:

> While we understand the risks associated with sudden infant death, we do not know why apparently healthy babies and young children fail to rouse from sleep. Greater resources targeted at the problem are urgently needed. Bereaved parents generously stepped forward to work with researchers all over the world to identify these priorities and we now call on public and private donors to help us eradicate the pain of losing a baby suddenly and unexpectedly.

The ten international research priorities for tackling SUDI are:

1. Studying mechanisms leading to death and how they interact with environmental risk factors.
2. Enabling best practice processes and systematic data collection for accurate classification of SUDI deaths to inform research and prevention.
3. Developing and evaluating new ways to make safe sleep campaigns more effective.
4. Understanding to what extent social and cultural factors affect parental choice in sleep practices and responses to risk reduction campaigns.
5. Identifying specific biomarkers to assist pathologists in determining the cause of death.
6. Understanding the role of genetic factors in SUDI risk.
7. Understanding what mechanisms underlie SUDI risk at different ages.
8. Conducting further research on the role of abnormal or immature brain anatomy and physiology.
9. Better understanding of the practice of sharing any sleep surface with an infant, notably how it interacts with other factors to make it more or less risky.
10. Identifying what factors are associated with SUDI where all aspects of recommended risk reduction have been followed.

Dr Alexis Willett one of the lead authors of the paper said:

> When we initiated the study we hoped to bring together like minds. The response from both SUDI researchers and bereaved

> parents around the world has been incredible and there is clearly a huge appetite for working together to make a difference. The Lullaby Trust and the entire SUDI community now have a critical role to play in maintaining this momentum but will need support if they are to make significant headway.

To learn more about the GAPS project, download our Target SUDI Together report.

MBRRACE-UK MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

MBRRACE-UK release "Perinatal Mortality Surveillance Report – UK Perinatal Deaths for Births from January to December 2015"

22 June 2017

The stillbirth rate in the UK has reduced by almost 8% over the period 2013 to 2015. The Government ambition is to halve the rates of stillbirth and neonatal death in England by 2030. These findings indicate that things are moving in the right direction.

The MBRRACE-UK report focuses on rates of stillbirth and neonatal death across the UK for babies born at 24 weeks of gestation or more. In 2015 the stillbirth rate was 3.87 per 1,000 total births, a fall from 4.20 in 2013. Nevertheless, despite this reduction UK stillbirth rates still remain high compared to many similar European countries and there remains significant variation across the UK that is not solely explained by some of the important factors that influence the rate of death such as poverty, mothers age, multiple birth and ethnicity.

Over the same period the neonatal death rate has remained fairly static with a fall between 2013 and 2015 from 1.84 to 1.74 deaths per 1,000 live births, indicating that more work is required to prevent these deaths in the future. Data for the Neonatal Networks shows that neonatal mortality rates vary between 1.15 and 3.21 deaths per 1,000 live births. Much of this variation is accounted for by differences in the proportion of babies dying from a major congenital anomaly.

Broadly similar NHS Trusts and Health Boards have been grouped together by their type of care or the number of mothers they provide maternity care for to provide an appropriate comparison of their mortality rates. MBRRACE-UK recommend that those Trusts and Health Boards identified with high rates of stillbirth or neonatal death rates (highlighted by a traffic light system) should review the quality of the care they provide. Work commissioned by the Healthcare Quality Improvement Programme is underway to develop a standardised Perinatal Mortality Review Tool (PMRT) to support and improve the quality of local reviews of all stillbirths and neonatal deaths carried out by Trusts and Health Boards in the future. The PMRT is in development as an integral part of the MBRRACE-UK programme of work.

Royal College of Obstetricians and Gynaecologists

Teamwork in maternity units key to reducing baby deaths and brain injuries during childbirth

21 June 2017

Adherence to best practice on fetal monitoring and neonatal care also identified as crucial to improving outcomes

Case studies included at the end of the release

A detailed analysis of all stillbirths, neonatal deaths and brain injuries that occurred during childbirth in 2015 has identified key clinical actions needed to improve the quality of care and prevent future cases, reveals a summary 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 babies who die or are left severely disabled as a result of preventable incidents occurring during term labour (after 37 weeks) by 2020.

The investigation team has now conducted 2,500 expert assessments of the local reviews into the care of 1,136 babies born in the UK in 2015 – 126 who were stillborn, 156 who died within the first seven days after birth and 854 babies who met the eligibility criteria for severe brain injury*.

The reviewers concluded that three quarters of these babies - 76% - might have had a different outcome with different care. This finding was based on 727 babies where the local investigation provided sufficient information to draw conclusions about the quality of care. A quarter of the local investigations were not thorough enough to allow full assessment.

Co-principal investigator, Professor Zarko Alfirevic, consultant obstetrician at Liverpool Women's Hospital, said: "Problems with accurate assessment of fetal wellbeing during labour and consistent issues with staff understanding and processing of complex situations, including interpreting fetal heartrate patterns, have been cited as factors in many of the cases we have investigated.

"This is the first time the Each Baby Counts team has been in a position to identify and share the lessons learned across the whole UK maternity service. However, until every incident is thoroughly investigated and important lessons identified locally, our understanding of the national picture will remain incomplete. The focus of a local investigation should be on finding system-wide solutions for improving the quality of care, rather than actions focusing only on individuals."

While last year's interim report made a number of recommendations about how to ensure future investigations are as consistent and effective as possible, this full report of 2015 data goes much further and includes recommendations highlighting critical factors in the care of many of the Each Baby Counts babies that may prevent these incidents in the future.

The recommendations are aimed at doctors and midwives working in maternity units across the UK and centre around:

- *Fetal monitoring* – formally assessing all low risk women on admission in labour to determine the most appropriate fetal monitoring method; following NICE guidance on when to switch between intermittent and continuous monitoring during labour; ensuring all staff have documented evidence of appropriate annual training
- *Neonatal care* – paediatric/neonatal teams informed of pertinent risk factors in a timely and consistent manner
- *Human factors*– understanding 'situational awareness' to ensure the safe management of complex clinical decisions; key members of staff maintaining appropriate clinical oversight; seeking a different perspective to support decision making, particularly when staff feel stressed or tired; ensuring everyone understands their roles and responsibilities when managing a complex or unusual situation

Professor Alfirevic continued: "We urge everyone working in maternity care to ensure the report's recommendations are followed at all times. Trusts and Health Boards have a role to play in supporting their staff to implement the recommendations, ensuring staff tasked with fetal monitoring interpretation receive annual training, promoting the development of non-clinical skills such as situational awareness and providing multi-disciplinary training to support good team working.

"Our next steps are to seek feedback and work with the maternity teams on implementation. To make a real difference, specific implementation tools are needed together with ongoing support for Trusts and Health Boards to embed them into practice. This requires specific skills, dedicated time and significant funding."

Professor Lesley Regan, President of the Royal College of Obstetricians and Gynaecologists, said: "The Each Baby Counts programme was intended as a ground-breaking, long term inquiry that will deliver improvements to maternity care over time, and we do not waver from this challenge.

"It is a profound tragedy whenever a death, disability or illness of a baby results from incidents during labour. The emotional cost to each family is incalculable and we owe it to them to properly investigate what happened and ensure the individuals and the healthcare Trusts involved take the steps needed to avoid making the same mistakes again.

"Through our detailed analysis of local reviews we are beginning to understand the vast variation in the effort and time that different NHS institutions put into investigating incidents and learning from mistakes in their maternity services. The fact that a quarter of reports are still of such poor quality that we are unable to draw conclusions about the quality of the care provided is unacceptable and must be improved as a matter of urgency.

"Each Baby Counts is a crucial element of the changing safety culture within the NHS. The RCOG and its partners are serious about improving the safety of maternity services but to make this happen we need the full and total commitment from governments across the UK. As an urgent priority, maternity units need to be adequately resourced – without this, Trusts, Health Boards and healthcare professionals will struggle to implement these recommendations."

ENDS

For media enquiries and copies of the summary report, please contact the RCOG press office on 020 7772 6773 or email pressoffice@rcog.org.uk

Case studies:

Mel Scott, Somerset

"After previously suffering a miscarriage, I was overjoyed to be pregnant in 2009. After a nervous 12 weeks, I settled into a beautiful, problem free pregnancy.

"At 41 weeks, I thought my waters had broken so my husband, Barry, and I went to hospital. I was admitted to the antenatal ward but a few hours later a CTG showed my baby's heart beat was dropping so I was rushed in for an emergency caesarean section.

"On August 2, Finley John Scott was born. Sadly he didn't wake up.

"Barry arrived at the hospital to discover that I'd had surgery, we had a son and that he hadn't been able to be resuscitated. Barry spent time with the midwife, bathing and dressing Finley, all of which was captured on video. We were fortunate to be able to stay for three days in the bereavement suite and make treasured memories with our son. We had prints of his hands and feet done, he was blessed, casts were made, we gave him gifts and friends and family visited.

"We later discovered that key opportunities to save Finley were missed. The first CTG was in fact suspicious and there were delays in a doctor seeing me due to the busy labour ward. There were queries over whether a different outcome may have occurred had I had one-to-one care on the labour ward.

"Each Baby Counts is so important. Whilst no one can say that Finley would have survived, having doubts about the path that my labour took is distressing to me. I wish everything that could have been done was done."

Kym Field, Cambridgeshire

"On 19 December 2015, I went into hospital to be induced as my waters had broken by active labour hadn't started. Leaving the house, my husband and I we were so full of excitement and anticipation to meet the baby we had waited nine months for.

"As soon as my baby, Alfie, was born, he was handed to paediatric doctors. He was then briefly shown to us before being whisked away. The next morning we were told there was nothing more they could do

for our perfect baby boy, who was the image of his father. Details were sparse but we were told he had no brain activity. We had to say goodbye before we even had chance to say hello. It was, to this day, the hardest thing we have ever had to do. Instead of organising a date for family to come and meet our perfect new bundle, we arranged his funeral.

"After three months of going round and round every eventuality in our head, we were told "the root cause of the incident was that Alfie's CTG trace was misinterpreted during labour". Our baby's death was down to a collection of errors and negligence. He was our perfectly healthy boy until a few hours before he was born when he was showing all the signs of struggling but this was simply not interpreted correctly. Many opportunities were missed. Hospital meetings and the inquest passed in a blur. All we wanted was our precious perfect baby in our arms.

"One thing was for sure, we had to do everything we could to ensure no one else found themselves in our situation, or those who did had support in place. After raising £10,000 for charity, we later discovered Each Baby Counts. Finally, someone who acknowledges that mistakes happen and wants to work together to ensure they are learnt from. No family should ever have to go through what we have."

The Royal College of Obstetricians and Gynaecologists (RCOG) is 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.

Department of Health

Improving the safety of maternity care in the NHS

17 October 2016

New measures to make giving birth safer, including maternity safety funding and publishing maternity ratings, have been announced.

The safer maternity care action plan, designed to dramatically improve the safety of maternity care in the NHS, was announced by the Health Secretary today (17 October 2016).

The new measures will provide resources for trusts to improve their approach to maternity safety, including an £8 million fund for maternity safety training, with at least £40,000 available to each NHS trust in England. They also will make sure lessons are learned from mistakes and shared openly and transparently across the NHS. We will also consult on how to change the litigation culture, which can prevent openness and transparency, by taking views on a new voluntary compensation scheme as an alternative to costly legal processes.

The safer maternity care action plan also includes:

- a £250,000 maternity safety innovation fund to help create and pilot new ideas for improving maternity care, like the successful PROMPT scheme pioneered by Professor Tim Draycott, a consultant obstetrician, and Cathy Winter, a midwife, at Southmead Hospital in Bristol, where they have seen a 50% reduction in babies born with a low oxygen and a 70% reduction in babies born with a paralysed arm
- publishing new maternity ratings for every clinical commissioning group (CCG) across the NHS to improve transparency, raise standards and give families better information about the quality of local maternity services
- a new national Maternal and Neonatal Health Quality Improvement Programme for all trusts to exchange ideas and best practice – a similar scheme in Scotland was linked to a 19% decrease in stillbirths over a 3 year period
- a consultation to develop a 'safe space' to allow clinicians to speak openly about things that go wrong without fear that information they disclose may be used against them in court or professional misconduct hearings
- the Healthcare Safety Investigation Branch, modelled on the highly successful Air Accident Investigation Branch, which will be up and running from April 2017

There will also be a consultation on a new rapid resolution and redress (RRR) scheme. The RRR scheme could investigate and learn lessons from more than 500 incidents a year. In cases where harm was avoidable this would offer timely access to financial support without the current obligation on families to launch a formal legal process. At present, the average time families have to wait for resolution of a case is 11.5 years.

Eligible families would be given the option to join an alternative system of compensation that offers support and regular payments without the need to bring a claim through the courts and the scheme would ensure families receive personalised support including counselling, case management and legal advice. A similar scheme operating in Sweden has reduced serious avoidable birth injuries by around 50% in the last 6 to 7 years.

Health Secretary Jeremy Hunt said:

> Our NHS maternity staff do a fantastic job under huge pressure. But even though we have made much progress, our stillbirth rates are still amongst the highest in Western Europe and many on the frontline say there is still too much of a blame culture when things go wrong - often caused by fear of litigation or worry about damage to reputation and careers.
>
> These comprehensive measures will give practical support to help trusts improve their approach to safety – and help to foster an open and transparent culture so that the courts become a last resort not an automatic first step. By learning from proven methods in countries like Sweden we hope to achieve a dramatic reduction in the number of tragedies where babies are lost or injured for life.

As part of the ambition to halve the rates of stillbirths, neonatal deaths, brain injuries that occur during or soon after birth and maternal deaths by 2030, we've launched "Our Chance", a new public health campaign in partnership with Sands and Best Beginnings. It aims to raise awareness of key issues that can lead to stillbirth, such as reduced foetal movement, itching and smoking, and highlight lifestyle changes women can take to improve their likelihood of having better pregnancy outcomes.

Department of Health

Safer pregnancy awareness campaign

17 October 2016

The "Our Chance" campaign aims to maximise women's chances of having safer pregnancies.

Our Chance has been developed with charities Best Beginnings and Sands to give parents the knowledge and confidence to maximise their chances of healthy outcomes for themselves and their babies.

With timely diagnosis, most conditions can be well-managed to reduce the risks of stillbirth, neonatal death and maternal death.

Women and their families will be able to learn about how to look after themselves and their baby through support available at ourchance.org.uk and through the Best Beginnings Baby Buddy app.

Health Secretary Jeremy Hunt said:

> The loss of any baby or new mum is a tragedy. We want any NHS hospital to be one of the safest places in the world to have a baby. By making sure women are aware of the small changes they can make or the signs to look out for, they can increase their chances of a healthy pregnancy.
>
> The new campaign is a game-changing moment and will help us halve the rates of stillbirths, neonatal deaths, maternal deaths and brain injuries occurring during or soon after birth by 2030

Alison Baum, CEO at Best Beginnings said:

> We are so proud to be jointly leading the ground-breaking Our Chance initiative with Sands and thanks to support from the Department of Health, NHS England and Public Health England. We'd like to thank all the parents, charities and health professionals who helped create the Our Chance films and are now supporting the campaign.
>
> I set up Best Beginnings to reduce child health inequalities across the UK. Best Beginnings created our free Department of Health-endorsed Baby Buddy app to enable parents of all ages and backgrounds to look after their own mental and physical health and to maximise the chances of their children having a healthy and happy start.

The campaign includes 25 short films, featuring real-life stories from parents, healthcare professionals and Our Chance supporter Abbey

Clancy. The films were developed in collaboration with royal colleges, other health charities and parents.

They films cover a range of maternity issues, including:

- attending antenatal appointments
- the importance of mental health and seeking help early
- not smoking or drinking alcohol during pregnancy
- being aware of symptoms such as itching or swelling which might point to potentially harmful conditions such as pre-eclampsia or intrahepatic cholestasis of pregnancy
- being aware of reduced foetal movement

Clea Harmer, Chief Executive at Sands said:

> We are delighted to be jointly leading this ground-breaking project, which is the culmination of many years of work with the Department of Health. We're particularly excited about reaching younger people, to help them have a safer pregnancy whether they are planning on having a family now or in the future.

Find out more by visiting ourchance.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.

6. Parliamentary material

Debates

Parental Bereavement (Leave and Pay) Bill 2017-19

Private Members' Bill (Ballot Bill) sponsored by Kevin Hollinrake MP

This Bill is expected to have its second reading debate on Friday 20 October 2017

Westminster Hall debate: Bereavement Leave: Loss of a Child

HC Deb 12 September 2017 | Volume 628 c270-

Commons adjournment debate: Baby Loss (Public Health Guidelines)

HC Deb 21 March 2017 | Vol 623 c829-

Ten-minute Rule Bill: Maternity and Paternity Leave (Premature Birth)

HC Deb 26 October 2016 | Volume 616 c283-

Commons debate: Baby loss

HC Deb 13 October 2016 | Volume 615 c467-

PQs

Maternity Services

Asked by: Davies, Mims

To ask the Secretary of State for Health, what plans the Government has to act upon the recommendations made by the Royal College of Obstetricians and Gynaecologists' report, Each Baby Counts, published in June 2017, to improve maternity care.

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

The Government and NHS England are supporting National Health Service maternity services to implement important changes that address the key recommendations in the Each Baby Counts report.

We published Safer Maternity Care: next steps towards the national maternity ambition in October last year to achieve the National Maternity Ambition to halve the rates of stillbirths, neonatal and maternal deaths and brain injuries by 2030. This action plan, which feeds into the NHS England-led Maternity Transformation Programme, includes:

- an £8 million Maternity Safety Training Fund, which has been shared out to every NHS maternity unit to enable multidisciplinary teams to undertake training on CGT fetal monitoring, obstetric emergency skills and drills, leadership, human factors and team working;

- the Saving Babies Lives Care Bundle which supports maternity teams by bringing together four key elements of care based on best available evidence and practice in order to help reduce stillbirth rates – these are reducing smoking in pregnancy, risk assessment and surveillance for fetal growth restriction, raising awareness of reduced fetal movement and effective fetal monitoring during labour;

- the development of a National Standardised Perinatal Mortality Review Tool that will be available later this year to support maternity and neonatal units to undertake and share learning from standardised, high quality case reviews of every stillbirth and neonatal death; and

- consultation on a Rapid Resolution and Redress scheme, which would contribute to reducing severe avoidable birth injuries through improved investigations and learning.

In addition, NHS Improvement launched a new Maternal and Neonatal Health Safety Collaborative – a three-year programme to improve clinical practices and reduce variations in outcomes involving every trust, making it one of the largest maternity quality improvement programmes.

HC Deb 11 September 2017 | PQ 7417

Antenatal Care

Asked by: Shannon, Jim

To ask the Secretary of State for Health, what steps he is taking to reduce the occurrence of post-natal illness.

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

The Department is committed to improving maternity outcomes and experience of care for women and babies.

In November 2015, my Rt. hon. Friend the Secretary of State announced a national ambition to halve the rates of stillbirths, neonatal and maternal deaths and brain injuries that occur during or soon after birth by 2030. Action includes tackling issues of culture, leadership and learning, to improve safety in maternity units as well as the outcomes and experience of care for mothers and babies.

The Our Chance campaign promotes advice about healthy pregnancy, highlighting the crucial risk factors during pregnancy and the postnatal period which may lead to adverse outcomes for mother and baby. In addition, the Avoiding Term Admission in Neonatal Units programme seeks to prevent the separation of mother and baby (except in cases with a compelling medical reason) and avoid admissions of full-term babies to neonatal units.

The Department has invested £365 million from 2015/16 to 2020/21 in perinatal mental health services, and NHS England is leading a transformation programme to ensure that by 2020/21 at least 30,000 more women each year are able to access evidence-based specialist mental health care during the perinatal period.

HC Deb 12 July 2017 | PQ 2710

Perinatal Mortality

Asked by: Shannon, Jim

To ask the Secretary of State for Health, what steps he is taking to further reduce the incidence of still births.

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

My Rt. hon. Friend the Secretary of State is committed to reducing the rates of stillbirth in England and improving maternity outcomes for women and babies. In November 2015, he announced a national ambition to halve the rates of stillbirths, neonatal and maternal deaths and brain injuries that occur during or soon after birth by 2030. The Safer Maternity Care: next steps towards the national maternity ambition, published in October 2016, then set out a suite of initiatives, including actions to tackle issues of culture, leadership, and learning, in order to improve safety in maternity units and the outcomes and experience of care for mothers and babies.

The action plan included the Saving Babies' Lives Care Bundle which is designed to support midwives and other clinicians to identify risks and implement care to prevent stillbirths and neonatal deaths in a focused way. The four interventions included in the Care Bundle are:

- Reducing Smoking In Pregnancy;

- Detecting Fetal Growth Restriction;

- Raising Awareness Of Reduced Fetal Movement; and

- Improving Effective Fetal Monitoring During Labour.

The Care Bundle is being tested and piloted by volunteer maternity care providers. NHS England will then consider how to support implementation nationwide, as part of the Maternity Transformation Programme.

The Department has also funded the National Perinatal Epidemiology Unit at the University of Oxford to develop a national standardised

Perinatal Mortality Review Tool to support local perinatal death reviews. This is an important contribution to the efforts to reduce stillbirths as the tool will ensure systematic, multidisciplinary, high quality reviews are carried out on the circumstances and care leading up to and surrounding each stillbirth and neonatal death. It will then enable maternity and neonatal staff to identify emerging themes across a number of deaths to support learning and changes in the delivery and commissioning of care, to improve future care and prevent future deaths which are avoidable.

HC Deb 12 July 2017 | PQ 2681

Perinatal Mortality: Counselling

Asked by: Quince, Will

To ask the Secretary of State for Health, what plans the Government has to ensure that every hospital has a bereavement suite.

Answering member: Jackie Doyle-Price | Department: Department of Health

Since 2010, we have invested £35 million in the National Health Service to improve birthing environments and this included better bereavement rooms and quiet area spaces at nearly 40 hospitals to support bereaved families.

We are also funding Sands, the Stillbirth and Neonatal Death charity to work with other baby loss charities, Royal Colleges and the All Party Parliamentary Group on Baby Loss to produce a National Bereavement Care Pathway to reduce the variation in the quality of bereavement care provided by the NHS. The pathway will cover all forms of baby loss to ensure that all bereaved parents are offered equal, high quality, individualised, safe and sensitive care.

HC Deb 04 July 2017 | PQ 900193

Topical Questions

Asked by: Will Quince

I know that Ministers share my passion for ensuring that a bereavement suite is attached to every maternity unit in the country. What steps can the Government take to make that a reality?

Answering member: Jackie Doyle-Price | Department: Health

I congratulate my hon. Friend on his dedicated work. The Government understand the importance of bereaved parents having a dedicated place where they can be cared for and not hear other babies crying. We have funded better bereavement spaces in nearly 40 hospitals and continue to work with Sands—the stillbirth and neonatal death charity—to see what more we can do to improve provision.

HC Deb 04 July 2017 | Vol 626 c1063

Pregnancy: Smoking

Asked by: Hodgson, Mrs Sharon

To ask the Secretary of State for Health, what steps his Department is taking to reduce smoking amongst pregnant women.

Answering member: Steve Brine | Department: Department of Health

The Government is committed to reducing smoking prevalence in pregnant women and will be publishing its new Tobacco Control Plan for England shortly. This will aim to reduce smoking prevalence generally and includes actions to reduce smoking during pregnancy.

Public Health England continues to work closely with NHS England to increase the number of women having a smoke-free pregnancy through a variety of initiatives. This is a key priority within NHS England's Maternity Transformation Programme and a key action to reduce stillbirths and meet the Secretary of State's ambition to halve the number of stillbirths by 2030, and to reduce stillbirths by 20% by 2020.

HC Deb 27 June 2017 | PQ 284

Baby Care Units

Asked by: Turley, Anna

To ask the Secretary of State for Health, what assessment he has made of the implications for his policies of the report by Bliss, entitled Neonatal care and admissions variation in the provisions for the parents of babies receiving neonatal care; and if he will take steps to reduce those variations.

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

This Government is committed to improving maternity and neonatal care. In November 2015 my Rt. hon. Friend the Secretary of State announced a national ambition to halve the number of neonatal deaths, stillbirths, maternal deaths and brain injuries occurring during or soon after birth by 2030. The Department is working closely with NHS England to make progress on the ambition and implement the NHS England led Maternity Transformation Programme, a programme set up to deliver the National Maternity Review's recommendations, outlined in the report Better Births.

The Better Births publication set out the vision for maternity services across England. It also outlined that a dedicated review of neonatal services should be taken forward in light of the overall maternity review findings. Within that context, and linked to NHS England's Maternity Transformation Programme, the Neonatal Critical Care Clinical Reference Group, chaired by Professor Neil Marlow, is carrying out a review of neonatal services. That review is ongoing and will report in

September 2017 but it has acknowledged that adequate support and facilities for parents are integral to the provision of centred care.

The review has completed its data gathering stage and will be working with Bliss and other stakeholders to develop recommendations for service improvement, including the support and facilities for parents.

HC Deb 05 April 2017 | PQ 69577

Maternity Services

Asked by: Quince, Will

To ask the Secretary of State for Health, what recent assessment he has made of the (a) number and (b) availability of dedicated maternity bereavement rooms and facilities across the NHS.

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

Decisions about the provision of bereavement services are best taken locally. It is for local National Health Service organisations to ensure that appropriate facilities and services are in place to support bereaved parents following the death of a baby.

The Department has published *Health Building Note 09-02: Maternity Care Facilities* a guideline on the design and planning of maternity care facilities in new healthcare buildings and on the adaptation/extension of existing facilities. In line with the guidance, we would expect new build or redesigned maternity units to have facilities available for women and families who suffer bereavement at any stage of pregnancy.

Since 2010, we have invested £35 million in the NHS to improve birthing environments and this included better bereavement rooms and quiet area spaces at nearly 40 hospitals to support bereaved families.

In 2016, the Stillbirth and Neonatal Death Charity, Sands, published Audit of bereavement care provision in United Kingdom maternity. The audit found that of the 62 trusts and health boards that responded:

- 63% has a bereavement room in each maternity unit in the trust or health board;

- 26% has a bereavement room in at least one maternity unit but not all in the trust or health board; and

- 11% had no dedicated bereavement room in the trust or health board.

HC Deb 13 March 2017 | PQ 67079

Maternity Services

Asked by: Quince, Will

To ask the Secretary of State for Health, what assessment he has made of the level of cold cot availability in maternity units across the NHS.

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

All bereaved parents should be offered the same high standard of care and support in an appropriate environment.

In 2016, the Stillbirth and Neonatal Death Charity, Sands, published *Audit of bereavement care provision in UK maternity.* The audit found that of the 69 trusts and health boards responding to the survey 91% reported that each of the maternity units they covered have access to at least one cold or cuddle cot.

HC Deb 13 March 2017 | PQ 66830

Maternity Services: Bereavement Counselling

Asked by: Quince, Will

To ask the Secretary of State for Health, what assessment he has made of the level of bereavement support midwife availability in maternity units across the NHS.

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

All bereaved parents should be offered the same high standard of care and support in an appropriate environment.

In 2016, the Stillbirth and Neonatal Death Charity, Sands, published *Audit of bereavement care provision in UK maternity.* The audit found that of the 66 trusts and health boards which responded, 62% of the maternity units they cover have at least one bereavement support midwife that is based there.

NHS England has commissioned Sands to undertake a project on the role of the bereavement midwife. The project will make recommendations for the remit of the role of the bereavement midwife and also give some guidance on the support structures required around the role. Sands are due to report their finds to NHS England later this year.

HC Deb 13 March 2017 | PQ 66829

Childbirth

Asked by: Caulfield, Maria

To ask the Secretary of State for Health, whether his Department plans to allow registered birth certificates for children born from 20 weeks gestation.

Answering member: Mr Philip Dunne | 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 able to survive should be changed from 28 to 24 weeks. Medical opinion does not currently support reducing this 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.

HC Deb 10 February 2017 | PQ 62995

Miscarriage

Asked by: Godsiff, Mr Roger

To ask the Secretary of State for Health, whether (a) NHS England, (b) his Department and (c) other bodies for which his Department is responsible has issued guidance to hospitals on whether they must seek consent from women who have experienced a miscarriage before tissue from the miscarriage is sent for analysis.

Answering member: David Mowat | Department: Department of Health

The Human Tissue Act 2004 introduced a regulatory framework for the removal, storage and use of human tissue. Fetal tissue is regarded as the mother's tissue and is consequently subject to the same consent requirements for analysis under the Act, as would apply to all other tissue taken for diagnostic or treatment purposes. The Human Tissue Authority (HTA) publishes codes of practice that provide guidance to professionals carrying out activities lying within the HTA's remit, including 'Code of Practice 1, Consent[1] '. This recommends that 'whenever possible, the consent process for the examination of stillbirths and neonatal deaths involves the mother…'.

Neither NHS England nor the Department has issued relevant guidance additional to that provided by through the HTA's Codes of Practice.

Note:

[1] Code of Practice 1, Consent, published by the Human Tissue Authority (as updated) July 2014, available at:

https://www.hta.gov.uk/guidance-professionals/codes-practice/code-practice-1-consent

HC Deb 07 February 2017 | PQ 62324

Perinatal Mortality

Asked by: Loughton, Tim

To ask the Secretary of State for Health, how many babies have been stillborn in each of the last six years.

Answering member: Mr Philip Dunne | Department of Health

The information is shown in the following table.

England and Wales

Year	Number of live births	Number of stillbirths	Stillbirth rate per 1,000 total births
2015	697,852	3,147	4.5
2014	695,233	3,254	4.7
2013	698,512	3,284	4.7
2012	729,674	3,558	4.9
2011	723,913	3,811	5.2
2010	723,165	3,714	5.1

Source: Office of National Statistics:

https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/datasets/birthsummarytables

HC Deb 03 February 2017 | PQ 62438

Bereavement Counselling: Perinatal Mortality

Asked by: Perkins, Toby

To ask the Secretary of State for Health, what plans his Department has to improve the aftercare and bereavement counselling services for women and their families who have experienced miscarriage, stillbirth or infant death.

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

It is important that women and families who have experienced loss and bereavement are offered the right care and services to support them. NHS England is developing a 'toolkit/resource pack' to assist local services in capturing the experiences of loss and bereavement in a sensitive and evidence based manner. This will be used by Local Maternity Systems as they develop and implement action plans to transform maternity services in their locality.

In Our Commitment to you for end of life care: The Government Response to the Review of Choice in End of Life Care (2016), the Government committed the Department to 'work with system and

voluntary sector partners to identify bereavement care pathway exemplar models to be shared widely across the National Health Service so that for instance, a hospital in the East of England can learn from and implement the good bereavement practice of a service in the West'. This will help to ensure that all parents receive the appropriate level of bereavement care they need.

HC Deb 16 January 2017 | PQ 59067

Midwives: Training

Asked by: Hodgson, Mrs Sharon

To ask the Secretary of State for Health, pursuant to the Answer of 20 December 2016 to Question 57868, when Health Education England plans to publish the new competency framework for all midwifery staff on basic bereavement training that is being developed with NHS England and the Royal College of Midwives.

Answering member: David Mowat | Department: Department of Health

Health Education England's (HEE) End of Life Care Core Skills Education and Training Framework is in the final stages of comment and amendment by the steering group following a consultation period. HEE are hoping to publish the framework in early 2017.

The Royal College of Midwives (RCM), the Royal College of Obstetricians and Gynaecologists, the Stillbirth & Neonatal Death Charity (SANDS) and other charities have agreed to design a new bereavement care pathway, rather than a new competency framework specifically for midwives, to improve the bereavement care provided by all professions.

Additionally, the Nursing Medical Council is undertaking a review of midwifery standards and competencies, due to be completed in 2018. SANDS are also running bereavement training days, accredited by the RCM, for both student midwives and fully trained midwives.

HC Deb 16 January 2017 | PQ 58817

Infant Mortality

Asked by: Madders, Justin

To ask the Secretary of State for Health, what discussions Ministers of his Department have had with Ministers of the Department for Justice on the investigation of stillbirths and neonatal deaths.

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

No recent meetings have been held with colleagues at the Ministry of Justice to discuss this subject.

By law coroners can only investigate deaths of a baby when they have lived independently of their mother. Coroners have no role in investigating stillbirths, and there are no plans to change this. If there is doubt as to whether a baby was stillborn or lived independently of their mother the loss should be reported to the coroner to consider whether an investigation should be carried out.

We are providing £500,000 of funding, via the Healthcare Quality Improvement Partnership, for the development of a new system - the Standardised Perinatal Mortality Review Tool – which once complete will be used across the National Health Service to enable maternity services to review and learn from every stillbirth and neonatal death. We have also asked the new independent Healthcare Safety Investigation Branch, established in April 2016, to consider a particular focus on maternity services in its first year.

On 17 October my Rt. hon. Friend the Secretary of State for Health announced a comprehensive package of measures designed dramatically to improve the safety of maternity care in the NHS, with a particular focus on learning and supporting the NHS to become the world's largest learning organisation. The announcement introduced the commitment to consult on a new voluntary alternative to litigation for families affected by severe birth injury (Rapid Resolution and Redress (RRR)).

RRR will provide an independent and thorough investigation of all instances of severe avoidable birth injury (around 500 cases per year), and for eligible cases the option to join an alternative system of compensation that offers support and regular payments without the need to bring a claim through the courts. We will be consulting to ensure the policy design best meets the needs of families.

HC Deb 24 October 2016 | PQ 48766

7. Useful links and further reading

Baby Loss Awareness Week website

https://babyloss-awareness.org/

All-Party Parliamentary Group on Baby Loss *Beyond Awareness to Action: Tackling Baby Loss in the UK* vision paper October 2016

https://www.lullabytrust.org.uk/wp-content/uploads/APPG-on-baby-loss-Beyond-Awareness-to-Action-Tackling-baby-loss-in-the-UK-1.pdf

NHS England *Saving Babies' Lives: A care bundle for reducing stillbirth* March 2016

https://www.england.nhs.uk/wp-content/uploads/2016/03/saving-babies-lives-car-bundl.pdf

SANDS Stillbirth and Neonatal Death Charity *Three year strategy* August 2017

https://www.uk-sands.org/about-sands/media-centre/news/2017/08/new-three-year-strategy

Royal College of Paediatrics and Child Health *National Neonatal Audit Programme 2017 Annual Report* on 2016 data Published September 2017

https://www.rcpch.ac.uk/system/files/protected/page/NNAP%20National%20Annual%20report%202017_0.pdf

Department of Health *Safer Maternity Care Action Plan* October 2016
https://www.gov.uk/government/publications/safer-maternity-care

Bliss: for babies born premature or sick

https://www.bliss.org.uk/

Child Bereavement UK

https://childbereavementuk.org/

Tommy's

https://www.tommys.org/

MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

https://www.npeu.ox.ac.uk/mbrrace-uk

DEBATE PACK
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