House of Commons Library

Debate Pack

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Progress towards the national ambition to reduce baby loss

Summary

There will be a debate in Westminster Hall on policy to reduce baby loss. This debate will take place on the 20th of July at 9:25am. The subject for this debate was determined by the Backbench Business Committee.

1 Background

The term baby loss can describe several different types of bereavement including miscarriage, ectopic pregnancy, molar pregnancy, stillbirth, neonatal and infant death, and termination of pregnancy. Pregnancy and baby loss are defined differently around the world. In the UK, a miscarriage is the loss of a pregnancy during the first 23 weeks; a stillbirth is when a baby is born dead after 24 weeks of pregnancy. When a baby dies within the first 28 days of life it is called a 'neonatal death'.

An ectopic pregnancy occurs when a fertilised egg implants itself outside of the uterus, typically in one of the fallopian tubes, where it cannot develop. A molar pregnancy happens when something goes wrong during the initial fertilisation process which means the baby and a placenta do not develop as they should after conception.

Further information is provided on the NHS website, and from a number of organisations offering information and support, including The Lullaby Trust, Bliss, the Miscarriage Association, and Sands, the Stillbirth and Neonatal Death charity.

1.1 The ambition to reduce baby loss

The 2015 report of the Kirkup review uncovered "serious and shocking" problems with maternity care at the University Hospitals of Morecambe Bay NHS Foundation Trust.[1] As the Health and Social Care Committee has noted, since the Morecambe Bay scandal, major concerns have been raised, at Shrewsbury and Telford Hospital NHS Trust and East Kent Hospitals University NHS Foundation Trust. The Committee state that these "…emerging findings from investigations into those trusts are a stark reminder that lessons still need to be learned and there can be no complacency when it comes to improving the safety of maternity services."[2]

There have been a number of initiatives focused on improving the safety of maternity services in England, since the Kirkup review. These included, the National Maternity Safety Ambition, launched in November 2015 and updated in November 2017, to reduce the 2010 rates of stillbirths, neonatal

[1] Dr Bill Kirkup CBE led an independent review of maternity safety incidents between 2004 and 2013 at the University Hospitals of Morecambe Bay NHS Foundation Trust. The report of the Morecambe Bay investigation was published in March 2015.

[2] Health and Social Care Committee, The safety of maternity services in England, 6 July 2021, HC 19 2021-22

and maternal deaths and brain injuries in babies that occur during or soon after birth by 20 per cent by 2020 and 50 per cent by 2025.[3] The Government also launched a Safer Maternity Care action plan in October 2016 as part of this "national ambition".[4]

Other measures included:

- the introduction of new independent maternity safety investigations process, where every case of a stillbirth, neonatal death, suspected brain injury or maternal death that is notified to the Royal College of Obstetricians and Gynaecologists Each Baby Counts programme—about 1,000 incidents annually—will be investigated not by the trust at which the incident happened, but independently by the Healthcare Safety Investigation Branch.
- The Saving Babies' Lives Care Bundle (SBLCB) has been provided to maternity units in England since 2019. This guidance supports services in reducing still births and early neonatal deaths. This initially included four elements are care widely recognised as evidence-based and/or best practice including: reducing smoking in pregnancy, risk assessment and surveillance for fetal growth restriction, raising awareness of reduced fetal movement and effective fetal monitoring during labour. Version 2 of SBLCB was launched in March 2019, including an additional element to reduce preterm birth.
- The Maternity and Neonatal Safety Improvement Programme (formerly known as the National Maternal and Neonatal Health Safety Collaborative), which aims to support NHS Trusts with practical improvements to make care safer in maternity units.

in February 2016, the NHS England report, Better Births: Improving outcomes of maternity services in England, set out a vision for maternity services to become safer, more personalised, kinder, professional and more family friendly.[5] NHS England's Maternity Transformation Programme seeks to achieve the vision set out in Better Births by bringing together a wide range of organisations to lead and deliver across a number of work streams.

The 2019 NHS Long Term Plan included a commitment to work with midwives, mothers and their families to implement continuity of carer so that, by March 2021, most women receive continuity of the person caring for them during pregnancy, during birth and postnatally. It also committed to an enhanced and targeted continuity of carer model for Black, Asian and minority ethnic

[3] The original 2015 ambition was to halve rates of stillbirths, neonatal deaths, maternal deaths and brain injuries that occur during or shortly after birth, by 2030, with the target subsequently brought forward to 2025

[4] Department of Health, Safer Maternity Care action plan, October 2016, Executive summary

[5] NHS England, Better Births: Improving outcomes of maternity services in England – A Five Year Forward View for maternity care, February 2016

(BAME) women, as well as for women from the most deprived areas. This included a commitment for 75% of women from BAME background to receive continuity of care by 2024.[6]

The Maternity Workforce Transformation Strategy was published in March 2019 by Health Education England and set out plans to retain experienced and skilled maternity staff, as well as supporting employers to upskill and develop their workforces through new roles and new ways of working. This includes rolling out the 'Maternity Support Worker' role with a national competency, education and career framework; and new routes to becoming a registered midwife, including via apprenticeships.

1.2 The Health and Social Care Committee's reports on maternity safety

On 6 July 2021 the Health and Social Care Committee published the report of its inquiry into the safety of maternity services in England.[7] Alongside the Health and Social Care Committee's inquiry, the Committee's Expert Panel analysed the Government's progress in achieving four of its maternity safety goals. This included the commitment to halve the rate of stillbirths; neonatal deaths; maternal deaths; brain injuries that occur during or soon after birth in England by 2025. The Panel found there was good progress towards halving the rate of stillbirths and neonatal deaths, with a 25% and 30% reduction since 2010 respectively. However, using Care Quality Commission style ratings, the Panel gave an overall rating across all four commitments as 'Requires Improvement', with 'Inadequate' ratings for aspects of continuity of carer, personalised care, and safe staffing.[8]

The Committee's inquiry considered a range of issues related to the safety of maternity services in England, and their report addressed the following areas:

- Supporting maternity services and staff to deliver safe maternity care
- Learning from patient safety incidents
- Providing safe and personalised care for all mothers and babies[9]

The Committee recommend, as a matter of urgency, that the Government commits to funding the maternity workforce at the level required to deliver safe care to all mothers and their babies. The Committee also urged the Government to reform the clinical negligence system in a way that better

[6] NHS Long Term Plan, January 2019, para 3.13

[7] Health and Social Care Committee, The safety of maternity services in England, 6 July 2021, HC 19 2021-22

[8] The Health and Social Care Committee's Expert Panel, Evaluation of the Government's progress against its policy commitments in the area of maternity services in England, 5 July 2021, HC 18 2021-22

[9] Ibid.

meets the needs of families and establishes a less adversarial process which instead promotes learning. The Committee urged NHS England and Improvement to ensure every woman is fully informed about the risks of all their birthing options as well as the pain relief options that are available to them during labour. The Committee asked the Government to introduce a target, with a clear timeframe, to address the inequalities in maternal and neonatal outcomes. The Committee also noted evidence of insufficient training at hospital trusts in the Saving Babies Lives Care Bundle.[10]

Other parliamentary briefings

Detailed background information about Government policy and programmes in this area, including the National Maternity Review, targets to reduce stillbirths, neonatal and maternal deaths, and the National Care Bereavement Care Pathway, can be found in two Commons Library debate packs:

- Baby Loss Awareness Week 2019 (October 2019)
- E-petition debate relating to Black maternal healthcare and mortality (April 2020).

Further background on the impacts of the Covid-19 pandemic can be found in the Commons Library debate pack on the effect of the Covid-19 outbreak on people experiencing baby loss (November 2020).

There are several Commons Library and POST briefings which provide relevant information:

- Commons Library briefing paper, The investigation of stillbirth, March 2019
- Commons Library briefing paper, Registration of stillbirth, August 2019
- Commons Library briefing paper, Infant cremation, February 2020
- POSTnote, Infant Mortality and Stillbirth in the UK, May 2016
- POST Briefing, Bereavement Care after the Loss of a Baby in the UK, July 2016

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2 Surveillance and official statistics on infant mortality

The most recent official data on child and infant mortality in England, including stillbirths, covers up to the end of 2019.[11] In 2019, stillbirths in England reached their lowest level since current records began in 1980, with 3.8 stillbirths per 1,000 births. This has decreased from 5.1 in 2010. Meanwhile the neonatal mortality rate was 2.7 per 1,000 live births, compared with 2.9 in 2010.

The Government has expressed an ambition to halve stillbirth and neonatal mortality rates by 2025.[12] The Office for National Statistics (ONS) provides this assessment of the ambitions:

> Achieving the ambition would mean reducing the stillbirth rate to 2.6 stillbirths per 1,000 births by 2025. If the total number of births were to remain constant until 2025, this would require the number of stillbirths to fall from 2,346 in 2019 to 1,594 in 2025, a decrease of 752.
>
> Achieving the ambition would mean reducing the neonatal mortality rate to 1.5 deaths per 1,000 live births by 2025. If the number of live births were to remain constant until 2025, this would require the number of neonatal deaths to fall from 1,674 in 2019 to 916 in 2025, a decrease of 758.[13]

MBRRACE-UK annual perinatal mortality surveillance report

The MBRRACE-UK (*Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the 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.

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 October 2019 and provides information about rates of stillbirth and neonatal deaths in 2017, including

[11] ONS, Child and infant mortality in England and Wales: 2019,published February 2021.

[12] Department for Health and Social Care, New maternity strategy to reduce the number of stillbirths, November 2017

[13] ONS, Child and infant mortality in England and Wales: 2019,published February 2021.

comparing rates between different organisations delivering healthcare across the UK. Key findings from the report include:

- There has been a reduction in the rate of extended perinatal mortality in the UK in 2017: 5.40 per 1,000 total births for babies born at 24+0 weeks gestational age or later compared with 5.64 in 2016. This represents a 12% reduction in extended perinatal mortality since 2013, equivalent to nearly 500 fewer deaths in 2017.
- The stillbirth rate for the UK in 2017 has reduced to 3.74 per 1,000 total births from 4.20 in 2013, which represents 350 fewer stillbirths.
- The rate of neonatal mortality for babies born at 24 weeks gestational age or later in the UK continues to show a steady decline over the period 2013 to 2017 from 1.84 to 1.67 deaths per 1,000 live births. This represents a 10% reduction in neonatal mortality over the last five years.[14]

[14] MBRRACE-UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2017, published October 2019.

3 Parliamentary Material

3.1 Parliamentary Questions

Maternity Services

09 Jul 2021 | 19644

Asked by: Dr Rupa Huq

To ask the Secretary of State for Health and Social Care, what steps he is taking to ensure that (a) the transition to a midwifery-led Continuity of Carer model is properly resourced and supported and (b) women who are pregnant again after the death of a baby are able to access it as a priority.

Answering member: Ms Nadine Dorries | Department: Department of Health and Social Care (DHSC)

NHS England and NHS Improvement have committed to midwifery-led continuity of carer, so that it becomes the default model of care for women using maternity services across England by March 2023. NHS England and NHS Improvement have provided local maternity systems with £90.05 million in service development funding from 2018 to 2021 to fulfil transformational objectives, including implementing continuity of carer models. An additional £96 million was announced earlier this year in response to the emerging findings from the Ockenden Report, the majority of which will be invested in additional midwives and obstetric capacity.

Upcoming NHS England and NHS Improvement guidance will include advice on the implementation of maternal medicine-focused continuity of carer teams, which could be used to accommodate women deemed higher risk due to previous loss, whilst still offering continuity of the midwife caring for them.

Miscarriage

30 Jun 2021 | 22211

Asked by: Zarah Sultana

To ask the Secretary of State for Health and Social Care, what steps he is taking to record the national rate of miscarriages.

Answering member: Ms Nadine Dorries | Department: DHSC

We have funded SANDs, the Stillbirth and Neonatal Death charity, to work with other baby loss charities and Royal Colleges to produce and support a National Bereavement Care Pathway to reduce the variation in National

Health Service bereavement care. The pathway covers a range of circumstances of a baby loss including miscarriage.

The Women's Health Strategy call for evidence sought to examine women's experiences of the whole health and care system, including issues such as fertility, pregnancy and baby loss. We are analysing responses on miscarriage to ensure that the strategy reflects what women identify as priorities. We will consider recording all miscarriages as part of this work.

Brain Injuries and Death: Babies

25 Nov 2020 | 116434

Asked by: Jeremy Hunt,

To ask the Secretary of State for Health and Social Care, how many neonatal brain (a) injuries and (b) deaths were reported in the NHS in each year from 2010 to 2020.

Answering member: Ms Nadine Dorries | Department: DHSC

The numbers of neonatal brain injuries and neonatal deaths in England in years from 2010 is shown in the following table:

Year	Neonatal brain injuries[1]	Neonatal deaths[2]
2010	3,390[3]	2,015
2011	3,532[3]	2,023
2012	3,404	1,933
2013	3,393	1,774
2014	3,558	1,679
2015	3,445	1,745
2016	3,446	1,832
2017	3,270	1,810
2018	Not yet available	1,742
2019	Not yet available	
2020	Not yet available	

Notes:

[1]Source: Imperial College, London, 2017 and 2019. The 2017 report is available at https://www.gov.uk/government/publications/safer-maternity-care-progress-and-next-steps

[2]Source: Office for National Statistics: Child mortality (death cohort) tables in England and Wales, available at https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/childmortalitystatisticschildhoodinfantandperinatalchildhoodinfantandperinatalmortalityinenglandandwales

[3]The original report presents a range for the years 2010 (3,160 to 3,619) and 2011 (3,434 to 3,630) as the available data did not cover all births in England. The table presents the midpoints of these ranges.

Perinatal Mortality: Health Services

22 Oct 2020 | 104743

Asked by: Colleen Fletcher

To ask the Secretary of State for Health and Social Care, what support is available for (a) women and (b) partners who have experienced pregnancy loss or baby loss; what steps his Department is taking to improve (i) funding for, (ii) provision of and (iii) access to support services for those who have experienced such losses; and what assessment he has made of the effect of the covid-19 outbreak on access to support services for pregnancy loss and baby loss for (A) women and (B) their partners.

Answering member: Ms Nadine Dorries | Department: DHSC

The Government has funded the Stillbirths and Neonatal Death charity (Sands) to work with other baby loss charities and Royal Colleges to produce and support the roll-out of a National Bereavement Care Pathway. The pathway covers a range of circumstances of a baby loss including miscarriage, stillbirth, termination of pregnancy for medical reasons, neonatal death and Sudden Infant Death Syndrome.

The Government announced £4.2 million of additional funding to mental health charities and charities providing bereavement support during the COVID-19 pandemic and is taking a cross-Government approach to assess what is needed to help ensure that families and friends of those deceased get the support they need.

Infant Mortality

20 Oct 2020 | HL7970

Asked by: Lord Hunt of Kings Heath

To ask Her Majesty's Government what progress they have made towards halving rates of stillbirths, neonatal and maternal deaths, and brain injuries occurring during or soon after birth from 2010 levels by 2025 as announced as part of their maternity strategy in November 2017.

Answering member: Lord Bethell | Department: DHSC

Overall, the outcome data shows that maternity and neonatal services are making clear progress to achieve the Maternity Safety Ambition for a 20% reduction in these outcomes by 2020 and a 50% reduction by 2025. Since 2010, there has been a 25% reduction in the stillbirth rate, a 26% reduction in the neonatal mortality rate for babies born over the 24-week gestational age of viability and a 14% reduction in the maternal mortality rate.

According to a definition developed to monitor the ambition, the brain injury rate fell to 5.1 per 1,000 births in 2017, after rising from 4.9 to 5.4 per 1,000 births between 2012 and 2014. The rate of term infants with hypoxic ischaemic encephalopathy fell by 11.8% between 2014 and 2017.

3.2 Debates

Baby Loss: Covid-19

Motion that this House has considered the effect of the covid-19 outbreak on people experiencing baby loss.

05 Nov 2020 | House of Commons | Westminster Hall | 683 cc242-738WH

4 Press Articles

The following is a selection of news and media articles relevant to this debate.

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4.1 News Articles

Maternity services in England need urgent improvement and at least £200m more to reduce unnecessary deaths, says MPs' report

Sky News

6 July 2021

Induce pregnant women earlier to reduce stillbirths, says new health advice

The Telegraph [Subscription required]

25 May 2021

Covid: Stillbirth and prematurity risks may be higher in pregnancy

BBC

21 May 2021

Miscarriage costs UK society £471m a year

Imperial College London

26 April 2021

Twin pregnancy deaths study highlights fears over NHS maternity care

The Guardian

14 January 2021

Stillbirths and neonatal deaths fell 15% in five years, but inequalities remain, UK report finds

BMJ

11 December 2020

Shrewsbury maternity scandal: Inquiry demands NHS overhaul to prevent baby deaths

The Independent

10 December 2020

'I had no idea stillbirth still happened': 5 things you may not know about baby loss

The Independent

25 November 2020

Stillbirth rate rises dramatically during pandemic

Nature

15 September 2020

No reduction in stillbirths, deaths, and injuries in babies for three years, finds review

BMJ

19 March 2020

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