House of Commons Library

Debate Pack

Number CDP 2021/0154
By Tom Powell,
Nikki Sutherland,
Sarah Barber,
Rachael Harker
22 September 2021

Baby Loss Awareness Week

1 Baby Loss awareness week

A debate on Baby Loss Awareness Week will take place in the Commons Chamber on 23 September 2021. The subject for this debate was determined by the Backbench Business Committee. Cherilyn Mackrory MP and Jeremy Hunt MP will lead the debate.

Baby Loss Awareness Week 2021 is on 9-15 October. It is an opportunity for those affected by baby loss to remember and commemorate their babies' lives and to raise awareness of this issue. The Baby Loss Awareness Week website provides more information about the aims of the week. This year the theme is wellbeing:

> Baby Loss Awareness Week is a wonderful opportunity to bring us together as a community and give anyone touched by pregnancy and baby loss a safe and supportive space to share their experiences and feel that they are not alone.
>
> This year our theme is Wellbeing and we will be exploring what this means to people from all walks of life who have been affected by pregnancy and baby loss.
>
> We recognise that health workers, who have been under immense pressure during the pandemic, can only look after bereaved families with empathy and kindness if they themselves are supported, and we are here for them too.
>
> Parents and families tell us how important it is that they each find a way to remember their baby in a way that suits them. Some join with others at special services organised by their local hospital or a local support organisation, some find solace in events organised by their faith community while others will remember alone in a way unique to them. It is important to remember there is no right or wrong way and it can change as the years pass too.
>
> During last year's #WaveOfLight messages of remembrance and hope brought many people together. Take care of yourselves and know that we are here for you now and throughout the year. You are not alone.[1]

Baby Loss Awareness week is coordinated and supported by over 60 UK charities including the stillbirth and neonatal death charity, Sands, the Miscarriage Association and Antenatal Results and Choices (ARC).

The Baby Loss Awareness week website encourages people to ask their MP to attend the debate on 23 September to debate what actions can be taken in this area, with a specific focus on the wellbeing of those who have been

[1] Baby Loss Awareness Week website, [accessed 22 September 2021]

affected by baby loss. It has published a debate briefing for MPs, Briefing from the Baby Loss Awareness Alliance for the general debate on Baby Loss Awareness Week - 23rd September 2021, Main Chamber, House of Commons

The term baby loss can describe a number of different types of bereavement 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.

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

- Baby Loss Awareness Week 2019 (October 2019)
- Progress towards the national ambition to reduce baby loss (July 2021)
- Black Maternal Health Week (10 September 2021).

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
- Commons Library briefing paper, Registration of stillbirth
- Commons Library briefing paper, Infant cremation
- POSTnote, Infant Mortality and Stillbirth in the UK
- POST Briefing, Bereavement Care after the Loss of a Baby in the UK

2 Statistics on stillbirths and neonatal deaths

2.1 Official statistics

The most recent official data from the Office for National Statistics (ONS) on stillbirths and neonatal deaths covers up to the end of 2019.[2]

The ONS publication uses the following definitions:

- Stillbirth - A baby born after 24 or more weeks completed gestation and which did not, at any time, breathe or show signs of life
- Neonatal death - The death of an infant aged under 28 days

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 that stillbirth and neonatal mortality rates in England will halve between 2015 and 2025.[3] The ambition is only for England since health policy is a devolved matter. ONS provides this assessment of the aims for England:

> 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.
>
> Comparable figures for the constituent countries of the UK show that Wales had the highest stillbirth rate in 2019 (4.6 stillbirths per 1,00 births) and Northern Ireland had the lowest rate (3.0).

[2] ONS, Child and infant mortality in England and Wales: 2019, published February 2021.
[3] Department for Health and Social Care, New maternity strategy to reduce the number of stillbirths

Stillbirths
United Kingdom 2019

	Number	Rate per 1,000 births
England	2,346	3.8
Wales	138	4.6
Scotland	174	3.5
Northern Ireland	67	3.0
United Kingdom	**2,763**	**3.9**

Source: ONS Child mortality data

Northern Ireland had the highest rate of neonatal deaths in 2019, (3.9 per 1,000 live births), while Scotland had the lowest rate (2.2).

Neonatal deaths
United Kingdom 2019

	Number	Rate per 1,000 live births
England	1,674	2.7
Wales	89	3.0
Scotland	110	2.2
Northern Ireland	88	3.9
United Kingdom	**1,971**	**2.8**

Source: ONS Child mortality data

2.2 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 MBRRACE figures do not fully align with the ONS estimates due to methodological differences.[4]

The most recent report was published in December and provides information about rates of stillbirth and neonatal deaths in 2019, including comparing rates between different organisations delivering healthcare across the UK.

Key findings from the report include:

- Stillbirth rates have reduced by just over 16% from 4.20 per 1,000 total births in 2013 to 3.51 per 1,000 total births in 2018, representing approximately 500 fewer stillbirths in 2018.
- Neonatal mortality has reduced by 11% from 1.84 per 1,000 live births in 2013 to 1.64 deaths per 1,000 live births in 2018, representing approximately 170 fewer neonatal deaths in 2018.
- Despite rates of stillbirth and neonatal mortality reducing over time, women living in the most deprived areas remain at 80% excess risk of stillbirth and neonatal death compared to women living in the least deprived areas
- Mortality rates remain exceptionally high for babies of Black and Black British ethnicity: stillbirth rates are over twice those for babies of White ethnicity and neonatal mortality rates are 45% higher.
- Similarly, mortality rates remain high for babies of Asian and Asian British ethnicity: stillbirth and neonatal mortality rates are both around 60% higher than for babies of White ethnicity.[5]

Alongside the main report, **MBRRACE-UK** publish a useful summary and infographic of the 2018 findings

[4] See Section 10 of Childhood, infant and perinatal mortality in England and Wales 2019 for a description of the difference between ONS and MBBRACE-UK estimates.

[5] MBRRACE-UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2018, published December 2020.

3 The ambition to reduce baby loss

There have been a number of initiatives focused on improving the safety of maternity services in England in recent years. These included the National Maternity Safety Ambition, launched in November 2015 and updated in November 2017. Its aim is to reduce the 2010 rates of stillbirths, neonatal and maternal deaths and brain injuries in babies, that occur during or soon after birth, by 20% by 2020 and 50% by 2025.[6] The Government also launched a Safer Maternity Care action plan in October 2016 as part of this national ambition.[7]

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 of 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.[8] NHS England's Maternity Transformation Programme seeks to achieve the vision set out in Better Births by bringing together a wide range of

[6] 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

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

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

organisations to lead and deliver across a number of work streams. A review of progress report on Better Births was published by NHS England in March 2020. Better Births Four Years On: A review of progress considered where further action is needed, particularly in relation to the care of Black, Asian and minority ethnic mothers and babies.

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 (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.[9]

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.

3.1 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.[10] 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; and 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.[11]

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

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

[11] 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

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.[12]

The Committee recommended, 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 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.[13]

The Government responded to the Committee's report on 21 September.[14] It said that whilst the vast majority of NHS births in England are safe, and good progress had been made in meeting the National Maternity Safety Ambition, there was no room for complacency and "unacceptable variations in the quality of care and outcomes remain." It set out a number of measures it was taking to address concerns, including;

- Investing £95.6million to target workforce numbers, provide training and development programmes to support culture and leadership, and strengthen board assurance and surveillance;
- Funding the Royal College of Obstetricians and Gynaecologists to develop a tool to identify workforce requirements for safe maternity care;
- Establishing safety training targets; and
- Introducing a number of initiatives to improve patient safety.

[12] Ibid.

[13] Ibid.

[14] DHSC, Safety of maternity services in England: government response, 21 September 2021

3.2 Intrapartum stillbirth: learning from maternity safety investigations that occurred during the Covid-19 pandemic

The Health Safety Investigation Branch (HSIB) national review of intrapartum stillbirths during the Covid-19 pandemic was published on 15 September 2021.The review was prompted by an increase in referrals of intrapartum stillbirths HSIB received, that fitted specific criteria between April and June 2020 (45 compared to 24 in the same period in 2019). The report describes how the pressures and changes as a result of the pandemic may have impacted on the care received. Findings in the report suggest that many safety risks that were identified in the review were already known to maternity services and these were further exacerbated by the pandemic, for example, the sustainability of staffing levels in maternity units. It also highlighted that Covid-19 created specific safety risks including the impact of limiting face to face interactions and increasing remote consultations.[15]

[15] HSIB, Report concludes review into intrapartum stillbirths during first wave of Covid-19, 15 September 2021

4 Parliamentary material

4.1 Debates

Westminster Hall debate - Reducing Baby Loss

HC Deb 20 July 2021 | Vol 699 c287WH-

Commons adjournment debate - Miscarriage Research: The Lancet

HC Deb 17 June 2021 | Vol 697 c560-

Westminster Hall debate - Black Maternal Healthcare and Mortality

HC Deb 19 April 2021 | Vol 692 c149WH-

Westminster Hall debate - Maternal Mental Health

HC Deb 10 March 2021 | Vol 690 c150WH-

Westminster Hall debate - Baby Loss: Covid-19

HC Deb 5 November 2020 | Vol 683 c201WH-

4.2 Commons statement

Ockenden Review

Volume 685: debated on Thursday 10 December 2020 | Vol 685 c1025-

4.3 Committee report

House of Commons Health and Social Care Committee report: The safety of maternity services in England HC19, 6 July 2021

Government response CP513, September 2021

The Government's response to the Health and Social Care Committee's Expert Panel Evaluation - The Government's progress against its policy commitments in the area of maternity services in England CP514, September 2021

4.4 PQs

Infant Mortality

Asked by: Sturdy, Julian

To ask the Secretary of State for Health and Social Care, what steps he has taken to help ensure that hospitals are updating their (a) practices and (b) procedures on an ongoing basis and in line with the latest evidence to reduce baby loss.

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

National Health Service (NHS) trusts in England providing maternity services have partnered with service users and commissioners to form local maternity systems (LMS), aligned to integrated care partnerships.

LMS' share information and learning in a structured and systematic way, working with partners to turn learning into service improvement; co-designing and implementing a vision for local maternity and neonatal services with local women through Maternity Voices Partnerships; and implementing shared solutions wherever possible through shared clinical and operational governance.

The Government expects all NHS trusts to operate in line with the latest evidence and guidelines on all aspects of maternity care and baby loss.

HC Deb 07 September 2021 | PQ 40892

Miscarriage

Asked by: Sultana, Zarah

To ask the Secretary of State for Health and Social Care, what steps he is taking to improve the care for women who experience a miscarriage.

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: Department of Health and Social Care

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.

HC Deb 30 June 2021 | PQ 22210; PQ 22211

Miscarriage: Mental Health Services

Asked by: Cameron, Dr Lisa

To ask the Secretary of State for Health and Social Care, what steps he is taking to ensure that the mental health needs of bereaved families who have experienced a miscarriage are supported within NHS mental health provision.

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

Every part of the country has perinatal mental health services in place and we remain committed to improving and expanding these services. By 2023/24, at least 66,000 women in total with moderate to severe perinatal mental health difficulties will have access to specialist perinatal mental health services. The new services will integrate maternity, reproductive health and psychological therapy for women experiencing moderate-severe or complex mental health difficulties directly arising from, or related to, the maternity experience, including perinatal loss.

The national bereavement care pathway brings together information, tools and resources to support the provision of high quality care for women and their families who experience pregnancy or baby loss, as well as linking to online learning for all healthcare professionals and staff who are involved in the care of a woman who experiences perinatal loss. This is available at the following link:

https://nbcpathway.org.uk/

HC Deb 25 November 2020 | PQ 116529

Bereavement Counselling and Maternity Services: Standards

Asked by: Hunt, Jeremy

To ask the Secretary of State for Health and Social Care, what steps his Department is taking to reduce the variation in quality of maternity and bereavement services throughout the NHS.

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

The Maternity and Neonatal Safety Improvement Programme covers all maternity and neonatal services across England. The programme has been working with trusts to support frontline staff to create the conditions for continuous improvement, a safety culture and a national maternal and neonatal learning system to reduce unwarranted variation in outcomes and care experiences, and provide a high quality healthcare experience for all women, babies and families across maternity and neonatal care settings in England.

The Government also funded Sands, the Stillbirth and Neonatal Death charity to work with other baby loss charities and Royal Colleges to produce and support the roll-out of a National Bereavement Care Pathway to reduce the variation in the quality of bereavement care provided by the National Health Service.

HC Deb 24 November 2020 | PQ 116432

Perinatal Mortality: Registration

Asked by: Loughton, Tim

To ask the Secretary of State for Health and Social Care, what progress he has made on publishing the report on registration of pre-24 week stillbirths as legislated for in the Civil Partnerships, Marriages and Deaths (Registration etc) Act 2019.

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

'The Independent Pregnancy Loss Review: Care and support when baby loss occurs before 24 weeks gestation' was commissioned by the Department. The purpose of the review is to consider the impact on families of the current threshold of 24 weeks gestation before being able to formally register a miscarriage if they so wish, and whether it would be beneficial to look at legislative options to amend existing primary legislation to allow parents to register a miscarriage if they wish to do so.

Good progress has been made on the review, but work was delayed during the COVID-19 pandemic. Work has resumed and the review now plans to report to the Secretary of State for Health in the new year.

HC Deb 24 November 2020 | PQ 114746

Perinatal Mortality: Health Services

Asked by: Stevenson, Jane

To ask the Secretary of State for Health and Social Care, what support is available to mothers who suffer baby loss; and if he will make a statement.

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

Support is available for parents who suffer baby loss through the 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.

HC Deb 22 October 2020 | PQ 104770

Perinatal Mortality: Health Services

Asked by: Fletcher, Colleen

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: Department of Health and Social Care

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.

HC Deb 22 October 2020 | PQ 104743

Bereavement Counselling: Parents

Asked by: Foxcroft, Vicky

To ask the Secretary of State for Health and Social Care, what guidance his Department provides to support local services to assist with the effective assessment of the psychological support needs of bereaved parents.

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

The Government has funded Sands, the Stillbirth and Neonatal Death charity to work with other baby loss charities and Royal Colleges to produce and support the roll-out of a National Bereavement Care Pathway to reduce the variation in the quality of bereavement care provided by the National Health Service. 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.

HC Deb 20 October 2020 | PQ 100489

Bereavement Counselling: Parents

Asked by: Foxcroft, Vicky

To ask the Secretary of State for Health and Social Care, whether his Department has taken steps to develop quality standards and national guidance to support people planning, funding and delivering specialist psychological support services for bereaved parents.

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

The national bereavement care pathway for pregnancy and baby loss was launched in 2017 and seeks to increase the quality of, and reduce the inequity in, the bereavement care provided by healthcare professionals after the loss of a baby or pregnancy at any gestation based on nine bereavement care standards which can be accessed at the following link:

https://nbcpathway.org.uk/sites/default/files/2019-05/Bereavement%20Care%20Standards.pdf

A key element of this is the requirement for a key worker who acts as a single point of contact for the bereaved family, who they can turn to for information on the child death review process, and who can signpost them to sources of support such as specialist psychological support.

In December 2018, NHS England published 'When a child dies - a guide for parents and carers to support parents through the child death review process' and help them understand the support that is available.

HC Deb 20 October 2020 |PQ 100487

Bereavement Counselling: Parents

Asked by: Foxcroft, Vicky

To ask the Secretary of State for Health and Social Care, what steps his Department is taking to ensure that relevant professionals across health services receive training in the identification of psychiatric illness in parents who have experienced pregnancy and baby loss.

Answering member: Helen Whately | Department: Department of Health and Social Care

Training programmes for healthcare professionals must meet the standards set by the regulatory body for their profession.

Whilst not all curricula may necessarily highlight a specific condition, they all nevertheless emphasize the skills and approaches a healthcare practitioner must develop in order to ensure accurate and timely diagnoses and treatment plans for their patients.

Curricula for specialities and roles that regularly treat pregnant and post-partum patients will contain competencies relating to understanding and identifying the psychological and mental health impacts of pregnancy, birth and baby loss, and assessing the health of women.

An example is outlined in the Nursing and Midwifery Council's 'Standards for competence for registered midwives' requirement: providing care for women who have suffered pregnancy loss which is available at the following link:

https://www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-standards-for-competence-for-registered-midwives.pdf

Employers in the health system are responsible for ensuring that their staff are trained to the required standards to deliver appropriate treatment for patients.

HC Deb 19 October 2020 | PQ 100488

Bereavement Counselling: Parents

Asked by: Foxcroft, Vicky

To ask the Secretary of State for Health and Social Care, what assessment his Department has made of the value of providing clear referral pathways to high quality, effective and evidence-based specialist psychological support for those experiencing pregnancy and baby loss.

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

Every part of the country has perinatal mental health services in place and we remain committed to improving and expanding these services. By 2023/24, at least 66,000 women in total with moderate to severe perinatal mental health difficulties will have access to specialist perinatal mental health services. The new services will integrate maternity, reproductive health and psychological therapy for women experiencing moderate-severe or complex mental health difficulties directly arising from, or related to, the maternity experience, including perinatal loss.

The national bereavement care pathway brings together information, tools and resources to support the provision of high quality care for women and their families who experience pregnancy or baby loss, as well as linking to online learning for all healthcare professionals and staff who are involved in the care of a woman who experiences perinatal loss. This can be accessed at the following link:

https://nbcpathway.org.uk/

HC Deb 16 October 2020 | PQ 100490

5 News and useful links

Baby Loss Awareness Week

Miscarriage Association

Baby Loss Awareness Week 2021

Miscarriage Association press release

Employers urged to take our Pregnancy Loss Pledge

6 September 2021

Ectopic Pregnancy Trust

Baby Loss Awareness Week 2021

Tommy's

Baby Loss Awareness Week 2021

Tommy's press release

Premature birth could be predicted as early as 10 weeks pregnant

23 August 2021

Tommy's press release

Health and Social Care Committee report says maternity care in England requires improvement

9 July 2021

Independent

Pandemic changes affected maternity care for women who had stillbirths

16 September 2021

House of Commons Health and Social Care Committee press release

'Blame culture' in maternity safety failures prevents lessons being learnt, says Committee

6 July 2021

BMJ

Maternity services are not improving fast enough, say MPs

6 July 2021, cite as BMJ 2021;374:n1712

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

Nuffield Trust blog

Stillbirths and other adverse outcomes for babies in Britain during the pandemic

4 May 2021

Royal College of Obstetricians and Gynaecologists

Each Baby Counts reports and updates

Nursing and Midwifery Council

SANDS – Stilbirth and neonatal death charity

The Lullaby Trust

Disclaimer

The Commons Library does not intend the information in our research publications and briefings to address the specific circumstances of any particular individual. We have published it to support the work of MPs. You should not rely upon it as legal or professional advice, or as a substitute for it. We do not accept any liability whatsoever for any errors, omissions or misstatements contained herein. You should consult a suitably qualified professional if you require specific advice or information. Read our briefing 'Legal help: where to go and how to pay' for further information about sources of legal advice and help. This information is provided subject to the conditions of the Open Parliament Licence.

Feedback

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

If you have any comments on our briefings please email papers@parliament.uk. Please note that authors are not always able to engage in discussions with members of the public who express opinions about the content of our research, although we will carefully consider and correct any factual errors.

You can read our feedback and complaints policy and our editorial policy at commonslibrary.parliament.uk. If you have general questions about the work of the House of Commons email hcenquiries@parliament.uk.