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Baby Loss and Safe Staffing in Maternity Care

1	**Background**	2
2	**Press articles**	8
3	**Press releases**	9
4	**Parliamentary materials**	10

Summary
A debate on 'baby loss and safe staffing in maternity care' will take place in Westminster Hall on Tuesday 25 October. The subject for this debate was determined by the Backbench Business Committee. Jill Mortimer MP will open the debate.

1 Background

The term baby loss can describe different types of bereavement including miscarriage (when a baby dies before 24 weeks of pregnancy), ectopic pregnancy, molar pregnancy, stillbirth (the death of a baby at or after 24 weeks), neonatal and infant death, and termination of pregnancy. It is not possible to provide a comprehensive briefing on these in this debate pack. There are, however, several House of Commons Library, and Parliamentary Office of Science and Technology (POST), briefings which may provide useful information in preparation for the debate on baby loss:

- Progress towards the national ambition to reduce baby loss (July 2021)
- Black Maternal Health Week (September 2021)
- Bereavement Care after the Loss of a Baby in the UK (July 2016)

Detailed background information about Government policy and programmes in this area, including the National Maternity Review, government targets to reduce stillbirths, neonatal and maternal deaths can be found in the earlier Commons Library debate pack on Baby Loss Awareness Week 2019 (October 2019).

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

1.1 Maternity staffing

Earlier this year the All Party Parliamentary Groups (APPGs) on Baby Loss and Maternity launched a campaign for improved maternity staffing. The APPGs published a joint report on 13 October 2022, 'Safe staffing: The impact of staffing shortages in maternity and neonatal care' (PDF).

The report refers to a crisis in the workforce, and notes that both the Health and Social Care Committee[1], and Dame Ockenden's March 2022 report into

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

maternity service failings at Shrewsbury and Telford hospitals[2], have already recommended that the Government take action to tackle this.[3]

Having considered evidence submitted by staff, women and stakeholder organisations the APPGs recommend the following measures proposed by the Commons Health and Social Care Committee and the Ockenden Review, should be implemented as a matter of urgency:

- A multi-year, fully funded settlement for maternity and neonatal services.
- The ringfencing of a proportion of the funding settlement for the training and development of maternity and neonatal staff.
- The establishment of and adherence to nationally agreed minimum staffing levels for maternity and neonatal staff.[4]

The APPG's report also made some further recommendations of their own, including that workforce planning for maternity and neonatal services must be firmly based on the needs of women, babies and families. They also called for the Government and NHS to work with stakeholders to develop a national strategy for improving the retention of maternity and neonatal staff.[5]

1.2 Baby Loss Awareness Week

Baby Loss Awareness week has been held annually for the last 20 years. It is a time for those affected by baby loss to remember and commemorate their babies' lives and to raise awareness of this issue. This year it ran between 9 and 15 October and culminated in a global 'wave of light', with families lighting a candle "to remember all babies that have died too soon".[6] Baby Loss Awareness week is coordinated and supported by over 100 charities including the stillbirth and neonatal death charity, Sands, the Miscarriage Association and Antenatal Results and Choices (ARC).

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2 Final report of the Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust, 30 March 2022.

3 The All Party Parliamentary Groups (APPGs) on Baby Loss and Maternity joint report, 'Safe staffing: The impact of staffing shortages in maternity and neonatal care' (PDF),13 October 2022

4 See above.

5 See above.

6 Wave of Light – Baby Loss Awareness Week (babyloss-awareness.org), not dated [accessed 20 October 2022]

1.3 Recent reports on maternity safety

Reading the signals, report on maternity services in East Kent (19 October 2022)

The report of the independent investigation led by Dr Bill Kirkup on maternity and neonatal services in East Kent, entitled 'Reading the signals', was published on 19 October 2022. The report concludes that the NHS Trust running maternity services in East Kent failed to monitor safety and missed a number of opportunities to put things right.

The report focussed on a limited number of key themes and "four areas for action that we believe are essential to correct the underlying problems in East Kent and elsewhere, and to prevent recurrence."[7] It stated that the NHS could be much better at:

- identifying poorly performing units
- giving care with compassion and kindness
- teamworking with a common purpose
- responding to challenge with honesty[8]

The report noted that since the Morecambe Bay Investigation in 2015, maternity services have been the subject of more significant policy initiatives than any other service. It highlighted that since 2015, there had also been reports on major maternity service failures in Shrewsbury and Telford, and that an investigation was now underway into maternity services in Nottingham.[9]

In an oral statement in the House of Commons the Minister, Dr Caroline Johnson, set out steps the Government were already taking to improve the quality of maternity care in East Kent and across England, including the work of an independent working group, established following recommendation of the Ockenden review in March 2022. The Minister said the group, chaired by the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists, "is advising the maternity transformation programme in England on how it can take forward the findings of both the Ockenden [discussed below] and the Kirkup reports." She also recognised that there

7 The report of the independent investigation led by Dr Bill Kirkup on maternity and neonatal services in East Kent, 'Reading the signals', 19 October 2022, para 1.168

8 See above. These four key actions are considered further in Chapter 6 of the report.

9 See above.

was "still a long way to go and much more work to be done to put things right."[10]

The CQC State of Care report (21 October 2022)

The Care Quality Commission (CQC) has reported that it rated 39% of maternity units it inspected in the year to 31 July 2022 to "require improvement" or to be "inadequate". This was an increase from the 31% of services that received these ratings the previous year.

The CQC's State of Care report, published on 21 October 2022, echoed the concerns of the recent reviews of services in East Kent and Shrewsbury and Telford, which had shown "…the same concerns emerging again and again" over the quality of staff training, poor working relationships between obstetric and midwifery teams and a lack of robust risk assessments. The CQC noted that these issues "…all continue to affect the safety of maternity services…" and "…pose a barrier to good care."[11]

The Ockenden report on maternity services at Shrewsbury and Telford Hospital NHS Trust (30 March 2022)

The final report of the Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust was published on 30 March 2022. The report found significant and repeated failings in care over two decades. The then Secretary of State for Health and Social Care, Sajid Javid, made a statement to the House of Commons on 30 March 2022, accepting all 84 recommendations on behalf of the local trust, NHS England, and the Department of Health and Social Care.[12] He set out the Department's response to the three recommendations specifically aimed at the Government:

- to take forward measures to expand the maternity workforce
- to create a working group independent of the Maternity Transformation Programme
- to create a special health authority to continue the Maternity Investigation Programme that is currently run by the Healthcare Safety Investigation Branch.[13]

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[10] HC Deb 20 October 2022, c852

[11] CQC, State of Care 2021/22, Areas of specific concern: Maternity care, 21 October 2022

[12] Gov.uk, Ockenden report: statement by the Secretary of State for Health and Social Care, 30 March 2022

[13] The Secretary of State had announced plans for the special health authority in January 2022, and it is due to start its work from April 2023. See Written Ministerial Statement HCWS560, Special Health Authority for Independent Maternity Investigations, 26 January 2022.

In particular, he noted the NHS was committing an additional £127 million for maternity services across England, to "…bolster the maternity workforce even further and it will also fund programmes to strengthen leadership, retention and capital for neonatal maternity care."[14]

1.4 The National Bereavement Care Pathway

Initially funded by the Department of Health and Social Care, and with the backing of the All Party Parliamentary Group on Baby Loss, the National Bereavement Care Pathway (NBCP) has been led by pregnancy and baby loss charity Sands, working with other such charities and professional organisations. The pathway aims to reduce the variation in the quality of bereavement care provided by the NHS, and sets out 9 bereavement care standards, which include:

- bereavement care training for staff
- bereavement leads in every healthcare setting where a pregnancy or baby loss may occur
- bereavement rooms available and accessible in hospitals[15]

As of 1 August 2022, 79% of NHS trusts in England have committed to adopting the nine NBCP standards.[16]

The evidence gathered as part of the APPGs' report on safe staffing found that "…in too many maternity services, there are not currently enough staff to ensure good quality bereavement care, with bereavement specialists regularly called away from this role to cover staffing shortages in other parts of the service."[17]

1.5 The Women's Health Strategy

The Women's Health Strategy for England, published in July 2022, included pregnancy loss a priority area. As part of its 10-year ambition the strategy included the following on pregnancy loss support services:

[14] Gov.uk, Ockenden report: statement by the Secretary of State for Health and Social Care, 30 March 2022; see also NHS England, **NHS announces £127 million maternity boost for patients and families, 24 March 2022.**

[15] The All Party Parliamentary Groups (APPGs) on Baby Loss and Maternity joint report, 'Safe staffing: The impact of staffing shortages in maternity and neonatal care' (PDF), 13 October 2022

[16] NBCP website

[17] The All Party Parliamentary Groups (APPGs) on Baby Loss and Maternity joint report, 'Safe staffing: The impact of staffing shortages in maternity and neonatal care' (PDF), 13 October 2022, para 6.19

> there are improvements in care pathways for women and their partners who experience pregnancy loss – to support them through bereavement and through future pregnancies, especially if they have experienced multiple early pregnancy losses. Every woman and their partner who needs it should have access to bereavement support and it is our ambition that every maternity service should have a bereavement specialist midwife[18]

The strategy also noted that the independent Pregnancy Loss Review Group had recommended the Government introduce a pregnancy loss certificate in England. This would allow a non-statutory, voluntary scheme to enable parents who have experienced a loss before 24 weeks of pregnancy to record and receive a certificate to provide recognition of their loss.[19]

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18 Gov.uk, Women's Health Strategy for England, 20 July 2022

19 See above, and PQ52016, 26 September 2022.

2 Press articles

Care substandard at 39% of maternity units in England, NHS watchdog finds
The Guardian
21 October 2022

Many English maternity units not meeting safety standards
BBC
21 September 2022

'More than half' of English maternity units not meeting CQC standards
Nursing in practice
21 September 2022

Maternity failings account for the majority of the NHS's £13bn spend on negligence
The Independent
25 July 2022

Almost half of NHS maternity services in England are unsafe
The Times
04 April 2022

Baby deaths inquiry points to issues across England's maternity services
Guardian
30 March 2022

3 Press releases

NHS England, **NHS announces £127 million maternity boost for patients and families, 24 March 2022**

Department of Health and Social Care New taskforce to level-up maternity care and tackle disparities 23 February 2022

Tommy's Health and Social Care Committee report says maternity care in England requires improvement 09 July 2021

House of Commons Health and Social Care Committee press release 'Blame culture' in maternity safety failures prevents lessons being learnt, says Committee 06 July 2021

4 Parliamentary materials

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

4.2 Select committees

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

4.3 PQs

Maternity Services: Standards
22 Jul 2022 | Written questions | Answered | House of Commons | 37619

Asked by: Feryal Clark
To ask the Secretary of State for Health and Social Care, what assessment he has made of the potential merits of community-based models for delivering maternity care in respect of improving maternal outcomes.

Answering member: James Morris | Department: Department of Health and Social Care

NHS England are implementing the outcomes of 'Better Births: Improving outcomes of maternity services in England. A Five Year Forward View for maternity care', which called for safer, more personalised and family-centred

care which offers women choice across organisational boundaries. This is supported by midwifery continuity of carer provided by teams based within communities.

Miscarriage

25 Jul 2022 | Written questions | Answered | House of Commons | 33938

Asked by: Daisy Cooper
To ask the Secretary of State for Health and Social Care, if his Department will make it its policy to record and include miscarriages in official statistics for the purposes of (a) setting targets for reducing baby loss and (b) informing the forthcoming Women's Health Strategy.

Answering member: Maria Caulfield | **Department:** Department of Health and Social Care

There are no official statistics reported for miscarriages. The accurate reporting of miscarriages in England is challenging due to the significant number of miscarriages not reported to a healthcare provider, particularly those that take place at an early gestation.

Pregnancy loss is a priority area within the recently published Women's Health Strategy for England, which is available at the following link:

https://www.gov.uk/government/publications/womens-health-strategy-for-england

Mental Health Services: Mothers

20 Jul 2022 | Written questions | Answered | House of Commons | 35079

Asked by: Clark, Feryal To ask the Secretary of State for Health and Social Care, if he will make an assessment of the potential merits of mother and baby respite homes in helping to prevent escalation of (a) maternal and (b) perinatal mental health conditions.

Answering member: Gillian Keegan | **Department:** Department of Health and Social Care

We have no current plans to make a specific assessment. However, specialist community perinatal mental health services are now operational in England. The NHS Long Term Plan committed to implementing new measures to improve safety, quality and continuity of care which will allow an additional 24,000 women to access specialist perinatal mental health care by 2023/24. This will also be available from preconception to 24 months after birth.

Within specialist perinatal mental health services, 33 new maternal mental health services will provide psychological therapy, maternity services and reproductive health for women with mental health needs following trauma or loss related to their maternity experience. These will be available across England by March 2024. We are also investing £100 million in perinatal

mental health and parent-infant relationship support by 2024/25, as part of the Start for Life and Family Hub programme for 75 upper tier local authorities in England.

Pregnancy Loss Review
06 Jun 2022 | Written questions | Answered | House of Commons | 8234

Asked by: Olivia Blake
To ask the Secretary of State for Health and Social Care, what the scope of the Pregnancy Loss Review is; and how that review will relate to the Women's Health Strategy.

Answering member: Maria Caulfield | Department: Department of Health and Social Care
The Pregnancy Loss Review was commissioned to consider the registration and certification of pregnancy loss occurring before 24 weeks gestation and on the quality of National Health Service care. The Review will make recommendations on improving the care and support women and families receive when experiencing a pre-24 week gestation baby loss. The Review's terms of reference are available at the following link:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/693820/Pregnancy_Loss_Review_ToR_gov.uk.pdf(opens in a new tab)

The Pregnancy Loss Review will be published in due course. The forthcoming Women's Health Strategy will also consider pregnancy loss.

Infant Mortality
HC Deb 07 September 2021 | PQ 40892

Asking member: Julian Sturdy
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: Health and Social Care
Department of 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; codesigning 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.

Miscarriages

HC Deb 30 June 2021 | PQ 22210; PQ 22211

Asked by: Zarah Sultana
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: 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.

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