Briefing from the Baby Loss Awareness Alliance for the General Debate on Baby Loss Awareness Week, Thursday 19 October 2023, House of Commons, Main Chamber

Introduction

Thousands of parents experience pregnancy or baby loss every year. The annual debate to mark Baby Loss Awareness Week which ended on Sunday, has become an important moment in the Parliamentary calendar to raise awareness about pregnancy and baby loss in the UK, helping to break the silence and holding the Government to account on their commitments to reduce pregnancy and baby loss and improve care. We welcome it's return to the main chamber of the House of Commons this year.

This briefing will focus on progress made since last year's debate on safe staffing in maternity and neonatal services, and recent reviews into these services, such as the Ockenden Review into Shrewsbury and Telford and the Kirkup Review into East Kent.

Safe staffing in maternity and neonatal services

While there are workforce pressures across the NHS, these are particularly acute in maternity services which are impacting on the ability to deliver safe and compassionate care. Staffing levels in neonatal care are also consistently below national recommendations.

Last year's debate highlighted evidence from the Baby Loss and Maternity APPGs on the impact of staff shortages on women and birthing people, their partners, babies and healthcare professionals.

"Staff are frightened to work in an understaffed under-resourced unit, for fear of mistakes or incidents occurring due to the high activity and understaffing. Fear of investigations as a consequence and fear for their mental health and wellbeing as a result" (Midwife)

"It's appalling. No follow up at all not even a call. Absolutely shocking and poor. Made a horrible experience worse by lack of care." (Bereaved Parent)

Since then, in his 2022 Autumn Statement, the Chancellor announced that the Government would follow Ockenden's recommendation for 2,000 extra midwives in England and promised a workforce plan soon. NHS England published the NHS Long Term Workforce Plan in June.

The Government has provided an initial financial commitment of £2.4 billion over the next 5 years to fund education and training. However, this is widely seen as inadequate, and long-term recurrent funding is needed as well as investment in retention. Without this we risk losing valuable experience and skills within the existing workforce. Beyond midwives, the Plan does not include detailed modelling for maternity and neonatal-related specialisms. For example, the current shortage of perinatal pathologists is affecting the ability of services to learn from deaths, and impacts the care provided to bereaved families. Similarly, the

Royal College of Obstetricians & Gynaecologists have said that staffing numbers need to increase by 20% to provide safe care for every family, equating to an extra 496 consultants.

Questions to raise:

- **Will the Government commit to providing adequate funding to realise the commitments in the Workforce Plan?**
- **What plans does the Government have to accelerate commitments to increase the wider maternity, neonatal and perinatal pathology workforce so that nobody is without the care and support they need during pregnancy and the neonatal period and if their baby dies?**
- **What plans does the Government have to address the retention crisis in the maternity and neonatal workforce?**

Maternity safety – the current situation

Across the UK, not enough progress is being made on reducing rates of pregnancy and baby loss, and there are stark and persistent inequalities by ethnicity and deprivation. Baby loss is not inevitable. It is possible to save more babies' lives.

Recent and ongoing reviews have highlighted significant issues with the safety of maternity and neonatal services. The Government have made various commitments to act because of these reviews but despite an increased policy focus on maternity safety, we have not seen the fundamental change required to ensure safe, equitable care for all. The current maternity safety ambitions in England are also due to come to an end in 2025.

Health services across the UK are under substantial pressure and struggling to recover following the COVID-19 pandemic. Despite the long-term impact on the health of women and children, pregnancy outcomes are often overlooked in discussions around recovery and reducing pressures on the NHS.

Not only is there a strong moral case to provide safe and equitable maternity and neonatal care, there is also a compelling financial case. The cost of harm from clinical negligence caused by NHS maternity services was £8.2 billion in 2021-22, 60% of the total cost of harm from clinical negligence in the NHS and more than double what the health service spends on maternity care. Shifting spend to maternity and neonatal care is key to prevention and addressing issues early on leading to more efficient use of the public purse by reducing costlier specialist interventions further down the line and reducing demand on the NHS, social services and education.

Clear commitment is needed to work towards a future where fewer babies die, and in equalities in baby loss are eliminated.

Recent data published by MBRRACE showed an overall increase in the rates of babies dying before or shortly after birth in 2021. It also highlighted marked increases in inequality by ethnicity and deprivation.

In 2021 babies of black ethnicity were over twice as likely to be stillborn compared to babies of white ethnicity, and in 2021 there was a substantial increase in the rates of stillbirth among babies born to mothers from the most deprived areas of the UK. The report also makes clear there is wide variation in rates of babies dying between different Trusts and Health Boards across the UK.

Questions to raise:

- **Will the Government commit to renewing maternity safety ambitions in England beyond 2025?**
- **What plans does the Government have to eliminate inequalities, so that everyone can benefit from the best possible pregnancy outcomes?**
- **How will progress be measured?**
- **What plans does the Government have to support improvement in maternity and neonatal services to prevent future tragedies?**

Listening to families

Listening to the voices and experiences of bereaved parents must be at the heart of all policies developed to save babies lives and improve future care.

The Ockenden and Kirkup and other reviews, including at Morecambe Bay and Cwm Taf in Wales consistently identify similar themes:

- Culture of safety within organisations
- Organisational leadership
- The need to improve staffing levels and training
- Providing personalised care and choice
- Better data collection and use of data
- Properly learning from reviews and investigations when things go wrong
- Meaningful engagement with service users
- Delivering care in line with nationally-agreed standards

The Government must focus on making progress in these areas. While there is a wide range of activity underway, there remains a long way to go to ensure lessons from previous reviews and reports are leading to improvements in the safety and equity of services. The Government must ensure that policy initiatives are properly evaluated to understand the impact they are having.

Questions to raise:

- **What plans does the Government have to ensure that policy initiatives aimed at improving care to prevent baby deaths are properly evaluated to understand the impact they are having?**
- **What plans does the Government have to ensure that voices and experiences of bereaved parents are at the heart of all policies developed to save babies lives and improve future care?**

About the Baby Loss Awareness Alliance

The Baby Loss Awareness Alliance is a group of well over 100 organisations committed to raising awareness of pregnancy and baby loss, providing support to anyone affected by pregnancy loss and the death of a baby, working with health professionals and services to improve bereavement care, and reducing preventable deaths.

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