Change NHS consultation

Sands & Tommy's Policy Unit

Working together to save babies' lives

Submission from Sands and Tommy's Joint Policy Unit

1. What does your organisation want to see included in the 10-Year Health Plan and why?

Saving more babies' lives needs to be a priority for the NHS

The 10-year plan is an opportunity for the NHS to focus on the fundamental changes needed to save more babies' lives and tackle persistent inequalities in pregnancy and baby loss. In September the Independent Investigation into the NHS in England identified maternity care as "an important area of concern," stating that "too many women, babies and families are being let down." It also highlighted the significant inequalities in maternity outcomes by ethnicity and deprivation. The plan must set the foundations for a comprehensive programme of improvement, focused on ensuring the NHS delivers safe, high-quality maternity and neonatal care for all.

Existing maternity safety ambitions are due to expire in 2025. To ensure focus on improvement the NHS must use the 10-year plan to establish new national maternity safety ambitions. This should include new ambitions to reduce baby loss which are focussed on matching the best performing countries in Europe. We have set out below (and in a separate briefing) the ambitions for reducing perinatal mortality and preterm birth that we believe should be included in the 10-year plan.

Sadly, not enough progress is being made. Recent data from the ONS show that the 2023 stillbirth rate in England remained at the same level as it was in 2022 and higher than it was in 2019 and 2020, and there have been recent increases in rates of neonatal mortality. In our annual 'Saving babies' lives progress report' we highlighted how too often babies are dying as a result of care not being delivered in line with nationally agreed standards. We also highlight how the lack of routine data continues to limit our understanding of the number of miscarriages happening each year. This is despite recommendations in the Independent Pregnancy Loss Review to introduce better ways of recording of miscarriage data in the NHS.

In our response we set out ways in which the NHS 10-year plan must support fundamental improvements in maternity and neonatal care and save more babies' lives.

New ambitions to reduce baby loss are needed

The NHS must make a clear commitment to save more babies' lives and establish a new set of maternity safety ambitions, including new ambitions to reduce perinatal mortality. The current ambitions expire in 2025, but there remains a significant gap between rates of perinatal mortality in England compared to the best-performing countries in Europe. To ensure a continued focus on reducing baby death we propose the following ambitions to be achieved by 2035 to align with the 10-year Plan:

- A stillbirth rate of 2.0 stillbirths per 1,000 total births.

- A neonatal mortality rate of 0.5 neonatal deaths per 1,000 live births for babies born at 24 weeks' gestation and over.
- A preterm birth rate of 6.0% by 2035, with disaggregated data for iatrogenic and spontaneous preterm births.
- Eliminate inequalities in these outcomes based on ethnicity and deprivation.
- Establishing routine data collection on miscarriages should be prioritised. Once established, an ambition to reduce the miscarriage rate should be added.

More background and rationale on these proposals is available here. We would expect these ambitions to be introduced alongside new ambitions to reduce maternal mortality and neonatal brain injury.

Achieving these ambitions requires comprehensive action from across government, of which NHS England must play a leading role. In our response, we have set out a range of areas where action is requited to achieve these ambitions.

To ensure progress on these ambitions, we propose action in the following areas:

The 10-year Plan should set a new national policy approach to improving the safety and quality of maternity and neonatal services

Reports and reviews into the safety of maternity and neonatal services across the UK consistently identify similar themes, which keep recurring. The Joint Policy Unit has undertaken a review of these themes, which can be read in more detail here. Briefly, these include the need for action in the following areas:

- Staffing levels and training
- Culture of safety within organisations
- Organisational leadership
- Personalisation of care and choice
- Reducing inequities
- Data collection and use
- Learning from reviews and investigations
- Engaging with service users
- Delivering care in line with nationally-agreed standards

Despite attempts to implement recommendations from previous reports, NHS England's current approach to supporting improvements in the safety of maternity services is falling short. The safety of two-thirds of maternity services have been rated as 'inadequate' or 'requires improvement' by the latest CQC reviews. it is clear that a different approach is needed.

To secure long-term improvements we need a process that provides clarity on what we are trying to achieve, focussed on addressing the structural or systemic changes that are needed to make meaningful progress. As part of this, the 10-year plan must recognise that providing support for individual 'failing' Trusts is, on its own, not sufficient. It must set out a comprehensive national approach that supports improvement across all services. This should include action in the following areas:

Implement and oversight of recommendations

We currently have too little focus on how recommendations should be implemented, and the resources needed to implement them effectively. With multiple recommendations for improving maternity and neonatal services from numerous different reports, which do not always neatly fit together, NHS

England needs to establish a process for prioritising and sequencing them and make a clear determination of who is responsible for delivering on them.

Crucially, there must be more effective oversight over the implementation of recommendations, to hold organisations responsible for delivering on change to account. To highlight a specific example, it is now over two years since the report into East Kent maternity services was published by Dr Bill Kirkup. This report recommended that:

'Relevant bodies, including Royal Colleges, professional regulators and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance.'

To date, it is not clear what actions Royal Colleges or professional regulators have taken to progress this recommendation. The new government must ensure proper oversight of implementing such recommendations, including of those organisations tasked with taking them forward.

Failure to act on the recommendations of inquiries or reviews is not unique to maternity. Too often the publication of such reports is seen as the end, rather than beginning. There have been calls for a national oversight mechanism to ensure independent oversight when it comes to following up on recommendations from inquests, reviews, and inquiries.

Proper evaluation of how effective our current policy approaches have been

To support progress NHS England must ensure initiatives intended to support improvement are rigorously evaluated, and that it builds up an evidence base of what works. The NHS must be able to identify where attempts at improvement are having unintended consequences and be able to stop doing things that are not effective.

For example, the Maternity Incentive Scheme was introduced to support the delivery of safer care and has been running for six years. Evaluation of the scheme to date has focussed on the extent to which Trusts self-report compliance with different elements of it, but not on the extent to which it is having an impact on maternity outcomes or improvements in safety. We have previously highlighted concerns that the scheme in its current form does not incentivise transparent reporting of performance issues, but instead on demonstrating compliance. This may contribute to a system that prioritises financial certainty and reputation management over a culture of learning and improvement.

A focus on delivering care in line with nationally agreed standards

Our saving babies' lives progress report highlighted how far too often babies are dying because of care that is not in line with recommendations in NICE (National Institute for Health and Care Excellence) guidance and other nationally agreed standards (such as the Saving Babies' Lives Care Bundle). Data from reviews suggest that at least 1 in 5 stillbirths and neonatal deaths may have been prevented with better care, equating to over 800 babies' lives in 2022-23. Failure to follow national guidance is a consistent finding in the Maternity and Newborn Safety Investigations programme.

Recent analysis of advice on contacting maternity triage by the Joint Policy Unit found concerning levels of variation, as well as language encouraging women to stay at home, without a clear evidence base. This is despite numerous reports identifying maternity triage as an area of concern, with delays in admitting women to hospital contributing to poor outcomes. This is an area where clear and consistent national standards are required.

The NHS must get better at addressing unwarranted variation. Clear, consistent national guidance is required in a number of areas, and where national standards or guidance currently exist, comprehensive data is required on the extent to which it is implemented.

More effective oversight of safety and quality

The safety and quality of maternity and neonatal services are the responsibility of the board in each NHS Trust. Inadequate board oversight has been highlighted as an issue in successive inquiries and reviews. Research from the Joint Policy Unit in 2023 found issues with the quality and consistency of information discussed at board level and raised concerns about boards' ability to have a full understanding of the performance of maternity and neonatal units. We highlighted the need for NHS England to review current governance arrangements and to ensure consistency in the data presented at board level. We are now over a year on, and no specific action has been taken in the areas identified.

Learning from reviews and investigations

When serious incidents occur, it is important to have an independent, standardised method of investigating. But this alone is not enough. As well as providing answers to parents and families, it is vital that the learnings from reviews and investigations are shared and acted upon, to prevent avoidable deaths in the future. Fewer than 1 in 6 action plans resulting from standardised reviews following the death of a baby (PMRT) were rated as "strong" in 2022-23.

Strong actions focus on system-level changes. The 10-year plan must ensure that systems are in place to support the sharing of learning locally, regionally, and nationally – with clear actions implemented to address concerns raised. There must be adequate resources for comprehensive reviews and investigations to take place, and follow-up of agreed actions monitored.

The 10-year plan should ensure maternity and neonatal services have the resources they need to deliver safe care to all

An adequate maternity and neonatal workforce

While there are workforce pressures across the NHS, there are particularly acute staffing issues in maternity services which are impacting the delivery of safe care. In 2023, 58% of midwives felt unwell in the last 12 months due to stress. Staffing levels in neonatal care are also consistently below national recommendations - 1 in 5 of Neonatal Intensive Care Unit (NICU) shifts were not sufficiently staffed in England and Wales in 2023.

The Joint Policy Unit has previously highlighted how NHS England's Long Term Workforce plan was not accompanied by adequate long-term recurrent funding or investment in retention, which is needed across the maternity and neonatal workforce. Without this we risk losing valuable skills and experience.

Workforce planning for maternity and neonatal care requires coordination across multidisciplinary teams. While the workforce plan models the future number of midwives required, it does not include other groups in the wider maternity and neonatal workforce, many of which are facing significant staffing issues. For example, the shortage of perinatal pathologists and mortuary technicians is severely affecting the ability of services to learn from deaths, and impacts the care provided to bereaved families.

The 10-year plan is an opportunity to ensure the commitments already made in the Workforce Plan are backed by adequate funding, and to focus on expanding the wider maternity and neonatal workforce so that nobody is without the care they need during pregnancy and the neonatal period. Improving staffing levels across all roles engaged in maternity and neonatal services is necessary but not sufficient. As highlighted above, a culture of safety is needed in which multidisciplinary staff work together effectively, services listen to concerns from staff and families, and lessons are learned from any serious incidents.

Funding for maternity and neonatal services

Much more comprehensive investment is needed to support government ambitions to reduce rates of stillbirth and neonatal death, tackle inequalities and support improvements in the safety and quality of services. The Joint Policy Unit has previously assessed government commitments to increase funding for maternity and neonatal services in England, highlighting how these remain significantly below the level needed to support transformative improvements in these services.

Based on a spend of £5 billion on maternity and neonatal services in 2021/22, annual spending on maternity services should have risen by over £450 million in 2022/23 and almost £1 billion by 2023/24, just to keep track with inflation. Over the same time-period the government made additional spending commitments of only £165m.

Ensuring equitable access to maternity and neonatal care

Tackling persistent inequalities in baby loss requires more equitable provision of maternity and neonatal services. In 2021, NHS England published guidance for Local Maternity and Neonatal Systems (LMNSs) to develop equity and equality action plans. The plans aim to reduce inequalities for women and birthing people and babies from Black, Asian, and Mixed ethnic groups and for those living in the most deprived areas. Initially LMNSs received ring-fenced funding to produce their equity and equality action plans. Each LMNS should have received a minimum of £90,000. Since then, funding has not been ring-fenced, and there has been concern over the variable implementation of plans across different LMNSs. Analysis of FOI data obtained by the Joint Policy Unit shows that half of LMNSs reported spending less or the same on their plans in 2023-24 compared to 2022-23. Alongside adequate funding and resourcing, the impact of individual equity and equality initiatives and the scheme overall needs to be evaluated. NHS England have committed to doing this, which must focus on understanding the extent to which plans on paper are leading to tangible improvements in the equity of services.

Monitoring progress will require much more consistent collection of data, both on ethnicity as well as on a wider range of social factors that may contribute to inequalities. In England, the only nationally reported data are the number of individuals recorded as having one or more complex social factors, or none, which offers limited insight for secondary analysis into the drivers of pregnancy and baby loss. The MBRRACE-UK confidential enquiries recommended that UK-wide metrics should be developed to record the number and nature of social risk factors. The key metrics that can feasibly be collected by services must be urgently agreed upon and integrated into NHS systems – in line with recommendations made in NICE guidelines.

Reports and reviews have highlighted issues with the use and quality of interpreting and translation services in maternity care, contributing to poor outcomes and avoidable harm. Existing guidance states that professional interpreting services must always be available when needed. However, where interpreting and translation services are available, they are not used consistently. Barriers to this include limited appointment time and poor quality of services. The 10-year plan is an opportunity for the

NHS to review translation and interpreting services in maternity and neonatal care, with a view to ensuring consistent national provision.

The 10-year plan must support research, which is vital to saving more babies' lives and tackling inequalities in pregnancy and baby loss

The NHS 10-year plan must clearly set out how it will support improvements in the research environment. Embedding research in the NHS is vital to achieving new national ambitions for reducing baby loss. Our saving babies' lives progress report highlighted how relatively little is invested in pregnancy-related research. Although the amount of funding for reproductive health and childbirth increased nearly 25% between 2018 and 2022, its share of public and charity health-related research has remained at around 2% over the past 20 years.

Beyond funding, the strength of the research environment is determined by research expertise, specialist facilities, and the workforce. The number of clinical staff involved in research remains low and, in some cases, is declining. Less than 2% of the nursing and midwifery workforce were engaged in research in the UK in 2022 and the number of obstetricians and gynaecologists working as clinical academics has declined over the past decade.

The NHS 10-year plan is an opportunity to set strong foundations for research. This requires a broad range of research topics and specialisms, the involvement of bereaved parents and communities at risk of the worst maternal and neonatal outcomes, and strong connection with policy and practice.

The recent House of Lords committee report on preterm birth concluded that:

"*A greater focus on pregnancy and neonatal research is needed, alongside increased funding, to make progress in understanding the fundamental mechanisms of preterm labour, developing more effective interventions, and ensuring clinical guidance is implemented effectively*."

This approach is required across all aspects of care relevant to saving babies' lives and tackling inequalities in pregnancy and baby loss.

2. What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

While we recognise that a stated aim of the new 10-year plan is to move care from hospitals to communities, it is vital that the NHS considers the specific context of maternity and neonatal care. Service design must be based on clear evidence as to how it meets the needs of women and babies – rather than fit into a general policy ambition for the NHS to move care into the community. It is clear that for some aspects of maternity and neonatal care, access to specialist high-quality care in a hospital environment is vital.

The most common issues during labour and birth identified by standardised reviews (PMRT) following the death of a baby are:

- fetal monitoring in labour
- inappropriate setting / location of birth
- staffing issues

- assessment of maternal risk status
- maternal monitoring in labour

Similar issues have been consistently identified by the Maternity and Newborn Safety Investigations programme. Any changes to service delivery must clearly set out how they will support improvements in these areas.

Our saving babies' lives progress report also highlighted how there remains significant variation in the proportion of babies receiving optimal neonatal care across different parts of England. For example, national guidance is for babies less than 27 weeks' gestation to be born in a maternity service on the same site as a NICU, but 1 in 5 eligible preterm babies were not born in a centre with a NICU in 2023, with little change since 2020.

There is an opportunity to improve the quality and accessibility of antenatal care. NICE guidelines recommend the first antenatal appointment takes place by week 10 of pregnancy. Currently only two-thirds of deliveries meet this recommendation in England and in the most recent data the proportion of first antenatal appointments taking place at 10 weeks' gestation or earlier declined to 61.6%. High-quality antenatal care must provide people with clear, unbiased, evidence-based information of the range of options available to them during labour and birth.

3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

Strengthening the research environment

As highlighted above, the 10-year plan must clearly set out how it will support improvements in the research environment. Embedding research in the NHS is vital to achieving new national ambitions for reducing baby loss. Alongside funding, the strength of the research environment is determined by research expertise, specialist facilities, and the workforce. The number of clinical staff involved in research remains low and, in some cases, is declining. Less than 2% of the nursing and midwifery workforce were engaged in research in the UK in 2022 and the number of obstetricians and gynaecologists working as clinical academics has declined over the past decade.

High quality data collection

Supporting the development and introduction of new technology requires the collection of high-quality data. In our annual progress report, we highlight where better data collection in maternity and neonatal settings is needed. This includes the following:

Comprehensive data on miscarriages

The Sands and Tommy's Joint Policy unit has recently published a briefing on the steps required to collect better data on miscarriages across the UK. Unlike stillbirths and neonatal deaths, the number of miscarriages which occur each year in the UK are not measured or reported. While there are no UK-wide data on miscarriage, some miscarriage-related data are collected across the four nations. In England The Pregnancy Loss Review, published in July 2023, recommended that NHS England or the National Institute for Health and Care Research (NIHR) should undertake research into the feasibility of pre-12 week data collection and the Department for Health and Social Care (DHSC) should commission NHS England to collate and publish monthly data on all mid-trimester loss (12+0 to 23+6 weeks

gestation). As part of the 10-year plan NHS England should commit to the collation and publication of mid-trimester losses from digital maternity records.

Data on inequalities

As well as improving the consistency of the recording of data on ethnicity across maternity records, NHS must commit to collecting data on a range of other factors that may be driving inequalities. In England, the only nationally reported data are the number of individuals recorded as having one or more complex social factors, or none, which offers limited insight for secondary analysis into the drivers of pregnancy and baby loss. The MBRRACE-UK confidential enquiries recommended that UK-wide metrics should be developed to record the number and nature of social risk factors – in line with recommendations in NICE guidance on pregnancy and complex social factors.

4. What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

A number of medical conditions are associated with higher risk of pregnancy and baby loss. For example, being overweight or obese is associated with an increased risk of stillbirth and preterm birth. Other conditions such as gestational diabetes, Type 2 diabetes and hypertension are associated with poorer pregnancy outcomes. Improving preconception health is therefore an essential component of improving maternity outcomes and reducing pregnancy and baby loss. For the NHS to enable improvements in preconception health, there needs to be a focus on health care professionals providing tailored information on preconception and pregnancy care, in line with NICE guidance on preconception care. Alongside this, there must be a focus on ensuring timely access to appropriate antenatal care, so that needs during pregnancy can be identified early. Data from standardised reviews (PMRT) following the death of a baby, consistently highlights inappropriate management of medical problems during pregnancy as a key contributor to baby deaths.

Tackling the causes of ill health requires action outside of the NHS. While we acknowledge that this consultation is focussed on the health service, the 10-year plan must recognise the need of a comprehensive cross-government approach to addressing the social determinants of health. In our annual progress report, we published a Health Inequalities Framework which brings together the varied factors that can contribute to maternal and perinatal health outcomes. There must be a cross-government commitment to build consensus on the key policy changes needed inside and outside of the healthcare system to tackle inequalities in pregnancy and baby loss.

5. Please use this box to share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in, for example:

- **Quick to do, that is in the next year or so**
- **In the middle, that is in the next 2 to 5 years**
- **Long term change, that will take more than 5 years**

Throughout this submission we have highlighted various specific changes in policy that are needed to make progress and save more babies' lives.

One key thing that the NHS can do immediately is to use the 10-year plan to establish new national maternity safety ambitions. These should include new ambitions to reduce baby loss which are focussed on matching the best performing countries in Europe. We have set out above and in a separate briefing what those ambitions should be. To support progress on new ambitions requires action across a wider range of areas, as highlighted in our annual Saving Babies' Lives progress report. We have suggested some specific ideas for change below.

Quick to do

- NHS England should use the 10-year plan to set new maternity safety ambitions.
- NHS England should commit to introducing a new strategy for maternity and neonatal care – focussed on ensuring safe high-quality care is delivered in line with national standards. This should be underpinned by a robust evaluation of our current policy initiatives and the effectiveness of different organisations that have statutory responsibility for the safety of maternity services.
- NHS England should establish a central oversight function - to ensure it has clear oversight and accountability for the implementation of the various maternity safety recommendations from recent reports and inquiries.
- Currently bereaved parents, who have experienced the worst outcomes, are excluded from the CQC's annual maternity survey. NHS England should immediately commit to capturing the experience of care received by parents that have lost a baby.
- NHS England should provide clear guidance to Trust board members on the data and insight available to them, so that they can effectively scrutinise the performance of their maternity and neonatal services.
- NHS England should provide a template for reporting maternity/neonatal service performance to board level. This should include a set of minimum metrics that must be reported to board level in every Trust, to ensure performance on key areas is reported consistently.
- NHS England should ensure comprehensive data collection in maternity records. This should include consistent recording of complex social factors in line with NICE guidance CG110. as well as a commitment to report miscarriage data in the National Maternity Services Data Set.
- So that it is the national NHS priority it deserves to be, a member of the NHS England executive team should have explicit responsibility for maternity and neonatal care, in the same way that there are currently executive directors for urgent and emergency care, and for primary and community services.
- In line with recommendations from the Care Quality Commission, NHS England should immediately commit to introducing a national standard and reporting tool for maternity triage, similar to that used in emergency medicine.
- Inadequate translation and interpreting services are frequently identified in reviews and reports as contributing to poor outcomes and avoidable harm. NHS England should immediately commit to a comprehensive review of translation and interpreting services in maternity and neonatal care, with a view to ensuring consistent national provision.

Medium/Long term change

- Over the medium/longer term NHS England must ensure that maternity and neonatal services have the resources they need to deliver safe care. This includes adequate funding and workforce, to ensure all aspects of maternity and neonatal care can be delivered in line with nationally agreed standards.

- There remains relatively little investment in pregnancy-related research. This needs to change if we are to achieve new ambitions to reduce pregnancy and baby loss. Over the medium/longer term the NHS must make commitments to put in place the funding, infrastructure, and workforce to embed research in this area.
- As part of a commitment to a new strategy for maternity and neonatal care (see above), NHS England should commit to publishing evaluations of all new policy initiatives, with clear outcome measures established when new programmes and initiatives are introduced. This requires investment over the medium/longer term and the capacity to undertake evaluation. Over the longer-term this could be cost saving if it ensured a focus on those programmes/initiatives that had a demonstrably positive impact.
- Once immediate steps have been taken to consistently record miscarriages in maternity and other secondary care settings, this should be expanded to cover all healthcare settings (including primary care). Long-term routine collection of data will allow trends over time to be measured, and the impact of interventions better evaluated.
- NHS England's plans to tackle inequalities in pregnancy and baby loss must form part of a comprehensive cross-government approach. In our annual progress report we published a Health Inequalities Framework which brings together the varied factors that can contribute to maternal and perinatal health outcomes. We need a long-term commitment from across government to build consensus on the key policy changes needed to make progress.