Saving Babies' Lives 2024: A report on progress

Wales briefing

Sands & Tommy's Policy Unit

Working together to save babies' lives

Summary of progress

- The stillbirth rate has declined 17.0% in Wales since 2010; however, there has been little change since 2018. The stillbirth rate has also been higher than any other UK nation since 2014.
- There has been little progress to reduce neonatal mortality in Wales. Although the rate has declined 3.7% since 2010 overall, the rate in 2021 was higher than the rate in 2013, showing a lack of sustained progress.
- Unlike stillbirths and neonatal deaths, the total number of miscarriages and miscarriage rate are not reported in Wales.

What needs to change

Although there is an ambition in England to halve rates of stillbirth, neonatal death, preterm birth, maternal death and brain injury by 2025, relative to 2010, there is no equivalent ambition in Wales. The Welsh Government must commit to reducing pregnancy loss and baby deaths and eliminating inequalities. Any future targets must have a clear and agreed baseline to measure progress against.

These targets should be the driving force behind a programme of policy activity, with funding and resources to meet them. This should include:

- A nationally standardised data dashboard to monitor changes in outcomes over time and any variation across different Health Boards and population groups. This should include more comprehensive metrics on social risk factors and more complete data on ethnicity, to identify the groups at most risk of pregnancy and baby loss in Wales, understand what is driving inequalities, and inform potential solutions.
- More regular and robust reviews of the safety and quality of maternity and neonatal services, with key themes collated at national level. Any reviews of individual services should involve families from the outset, ensure a transparent process, and include independent oversight.
- More regular and consistent insight into staff and patient experience; the last national survey of pregnancy and birth experiences in Wales took place in 2017. This should also include consideration of how to capture insights from bereaved parents.
- Engaging with ongoing work in Scotland to develop a methodology to count miscarriages and consider the best methodology for the Welsh context.
- Consideration of mechanisms to ensure the timely completion of the Perinatal Mortality Review Tool for each perinatal death. In 2022-23, only a fifth of neonatal death reviews were completed in Wales – the lowest proportion across the UK.
- Learning from reviews and inquiries from across the UK which have consistently identified similar systemic issues with maternity and neonatal services. In the absence of evidence to the contrary, it should be assumed that these issues are as relevant in Wales as the rest of the UK, and the Welsh Government should consider how best to address these issues in their context.

Introduction

The Saving Babies' Lives 2024 Progress report brings together data on pregnancy and baby loss across the UK and assesses progress to save more babies' lives and reduce inequalities. Health is a devolved matter, with policies, funding and the healthcare system overseen by devolved governments in each of the four nations. While each nation faces similar systemic issues, much of the data are reported separately. To analyse the data and support devolved policy makers, the Sands and Tommy's Joint Policy Unit is publishing a series of tailored briefings with the most recent data for each of the four UK nations.

This briefing is focused on Wales. For additional analysis of trends across the UK, please see the Saving Babies' Lives 2024 report.

About the Sands and Tommy's Joint Policy Unit

Sands and Tommy's Joint Policy Unit is focussed on achieving policy change that will save more babies' lives during pregnancy and the neonatal period and on tackling inequalities in loss, so that everyone can benefit from the best possible outcomes.

Rates of pregnancy loss and baby deaths in Wales

Overall, stillbirth and neonatal mortality rates have declined in Wales since 2010, although progress has been uneven (see Figure 1). The stillbirth rate has declined 17.0% overall between 2010 and 2022, but there has been little change since 2018. Progress to reduce the neonatal mortality rate has been slower: a 3.7% reduction between 2010 and 2021[1]. The rate in 2021 was higher than the rate in 2013, showing a lack of sustained progress in reducing neonatal deaths.

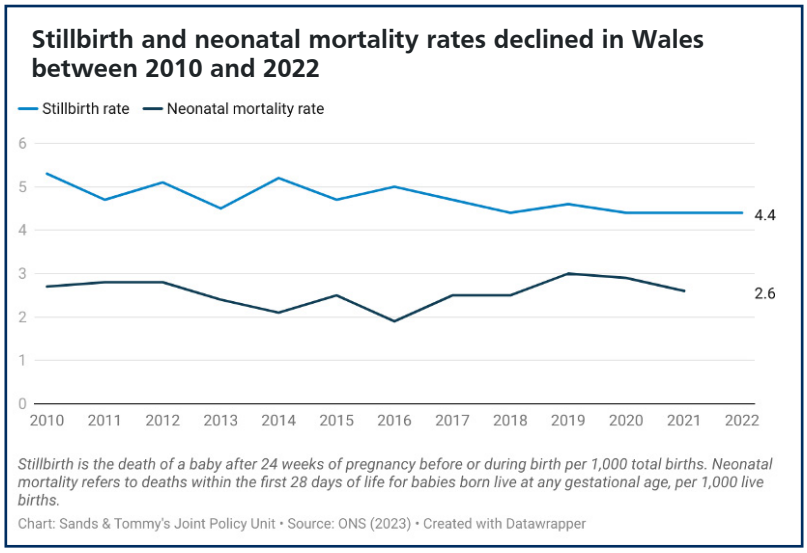

Figure 1. Stillbirth and neonatal mortality rates in Wales between 2010 - 2022

Unlike stillbirths and neonatal deaths, the total number of miscarriages and miscarriage rates are not reported in Wales, or by any UK nation. Without a robust mechanism to count the number of miscarriages, we cannot fully understand the impact on the Welsh and UK population or know whether the miscarriage rate is increasing or decreasing. It also means that meaningful reduction targets cannot be set, nor evaluations of preventative interventions completed.

1. Data are not yet available for 2022

Comparisons across the UK

The stillbirth rate in Wales has been higher than any other UK nation since 2014 (See Figure 2). The stillbirth rate in England declined steadily between 2010 and 2022 (a 24% reduction), although it increased again in 2021. Stillbirth rates also declined overall between 2010 and 2022 in Wales (-17%), Northern Ireland (-17%) and Scotland (-24%). However, the rates are more variable year-on-year compared to England, which may partly reflect the smaller populations.

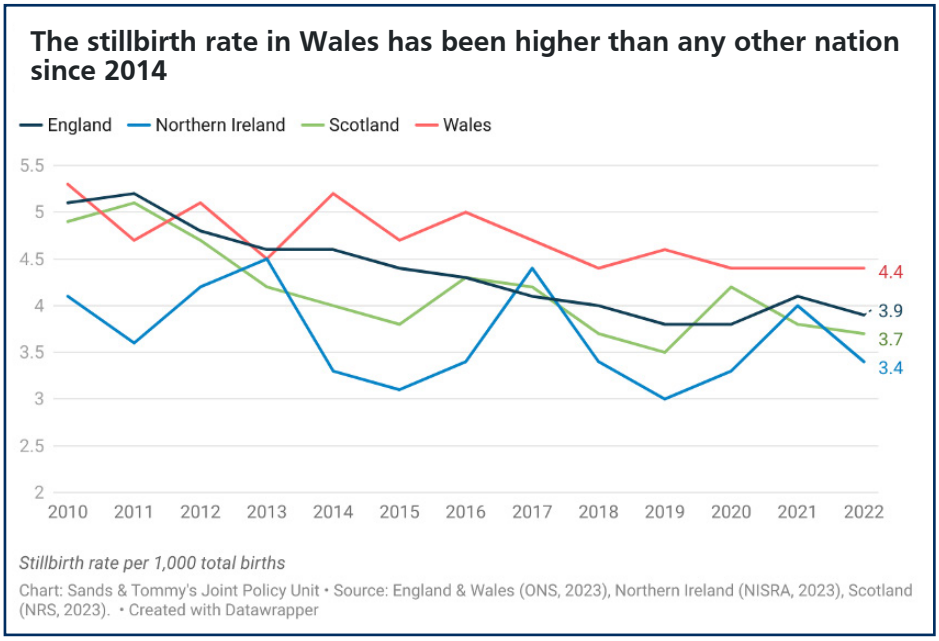

Figure 2. Stillbirth rate across the four nations between 2010 - 2022

In 2021, Wales had the lowest neonatal mortality rate; however, the increase in the rate between 2016 and 2019 was not reflected in other nations (see Figure 3). Like the stillbirth rate, there is high year-on-year volatility in the data for Wales, Northern Ireland, and Scotland due to the smaller population sizes. Using three-year average rates to reduce some of this variation shows that neonatal mortality rates increased slightly (+2.4%) in Wales between 2010-12 and 2019-21, while they declined in Scotland (-10.1%) and England (5.8%). The three-year average neonatal mortality rate for Wales was also the second highest out of the four nations in 2019-21 (2.8 per 1,000 live births), below Northern Ireland (3.7) but above England (2.7) and Scotland (2.4).

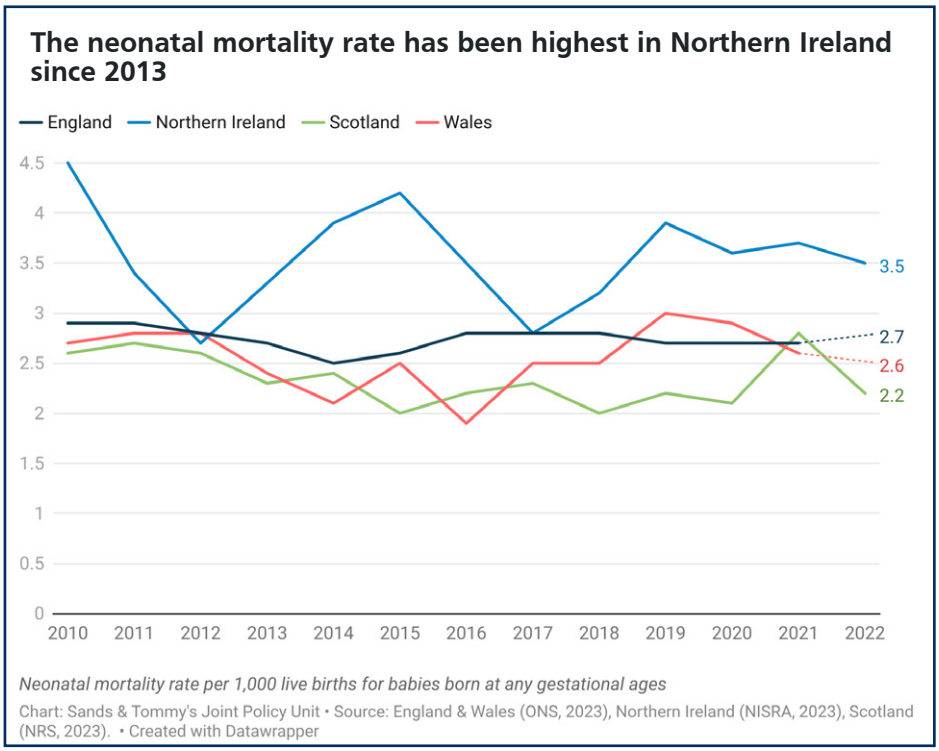

Figure 3 Neonatal mortality rates[2] across the four nations between 2010 and 2022

Inequalities in pregnancy losses and baby deaths

Across the UK, there are stark and persistent inequalities in pregnancy loss and baby deaths, with higher mortality rates among minoritised ethnic groups and people living in more deprived areas (1). Better data are needed to identify the groups at most risk of pregnancy and baby loss in Wales as well as understanding what is driving inequalities and identifying potential solutions.

Some explanations include differences in access to, and treatment by, maternity services, health behaviours, and personal and social contexts. Multiple reports have highlighted the impact of racism and discrimination which some individuals experience when engaging with health services. Drivers of inequalities are explored in more detail in the Joint Policy Unit's 2024 Progress Report.

The Welsh Government has launched an Anti-Racist action plan (2) and a midwife focused on equity, diversity and inclusion has been recruited to the Chief Midwifery officer's team. Ongoing workstreams include strengthening of cultural competency training across health boards, improving access to interpreting services and collaborating with Welsh universities to decolonise the midwifery curriculum.

2. To aid comparison between the four nations, all neonatal mortality rates are for births at 24 weeks gestation and over.

Systemic issues in maternity and neonatal services need to be addressed

Maternity services are inspected by the Healthcare Inspectorate Wales (HIW) to check the service meets the quality standards and any other relevant professional standards and guidance. Reports include areas where the inspected service could improve and what the service is doing well. However, unlike the Care Quality Commission inspections in England, ratings of services are not provided and HIW does not regularly report on the quality of services across Wales. Women and birthing people's experience of care is also not consistently sought across Wales: the last national survey of pregnancy and birth experiences took place in 2017 (3).

The last national review of maternity services took place between June 2019 and January 2020 (prior to the Covid-19 pandemic) and found that the quality of care is good and that maternity services in general are delivered in a safe and effective way (4). However, individual inspections since 2020 have identified patient safety concerns including at Wales's biggest hospital the University Hospital of Wales in Cardiff where the maternity department needs urgent improvement (5). In December 2023, two health boards in Wales were subject to enhanced monitoring of their maternity and neonatal services (6).

The absence of regular, national reporting makes monitoring the quality of services across Wales challenging. The Sands and Tommy's Joint Policy Unit has reviewed a range of reports and inquiries into the safety of maternity and neonatal services across the UK, which identify recurring issues. In this section, we will briefly explore each of these systemic issues in the context of Wales.

Staffing levels and training

The number of full-time equivalent (FTE) staff per 1,000 births increased over the past decade across most, although not all, staff groups working in maternity and neonatal services (see Figure 4). The exception was the number of FTE maternity nurses, which decreased slightly (-2.3%).

The growth in the number of FTE staff per 1,000 total births shown in Figure 4 was partly due to the falling number of births during this period. The total change in FTE staff has been lower (see Figure 5). Growth in staff groups working in maternity and neonatal services is also lower than growth in the number of FTE staff in Wales overall. While total FTE has increased by nearly a third over the past decade, total change in maternity and neonatal staff has lagged behind.

Despite the increase in the number of FTE staff, there are still concerns about the workforce in Wales. Although birth rates are falling, the profile of the birthing population is changing and now has more complex needs. The proportion of women and birthing people in Wales reporting a mental health condition at their initial assessment has increased (from 23.2% in 2017 to 29.4% in 2021) alongside a slight rise in those recorded as overweight (an increase from 28.3% to 29.6%) or obese (an increase from 27.3% to 29.7%) (7).

Headline FTE numbers also do not reflect the mix of professional experience within staff groups. The Royal College of Midwives highlights a decline in midwives in their late forties or early fifties between 2016 and 2022 in Wales (204 left the workforce) (7). The age profile of the workforce can be used a proxy for professional experience, assuming older midwives have more years of professional experience compared to younger midwives. Although the decline in older midwives was largely compensated by increases in midwives aged below 40 years (an increase of 167) and over 56 years (an increase of 40), this change has implications for the skill mix and experience of the workforce. According to the Nursing and Midwifery Council, the proportion of nurses and midwives aged 21 - 40 years old working across the NHS in Wales is 38.5% in 2023, an increase from 33.6% in 2018 (8).

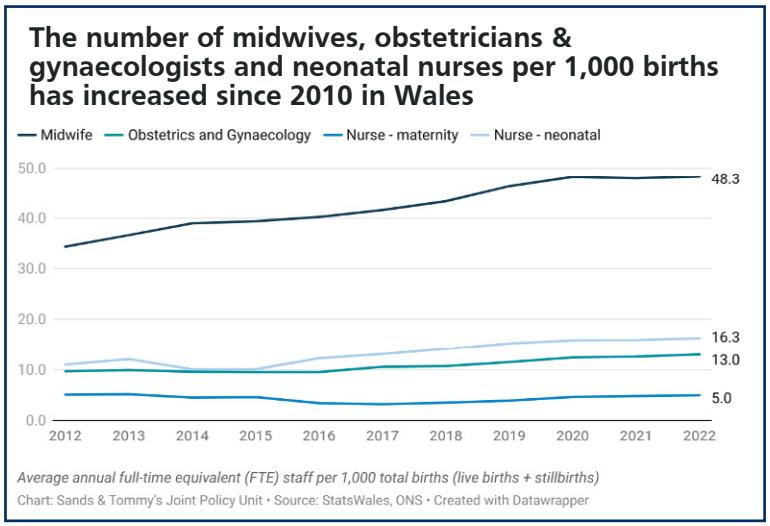

Figure 4. Average annual full-time equivalent (FTE) staff per 1,000 total births

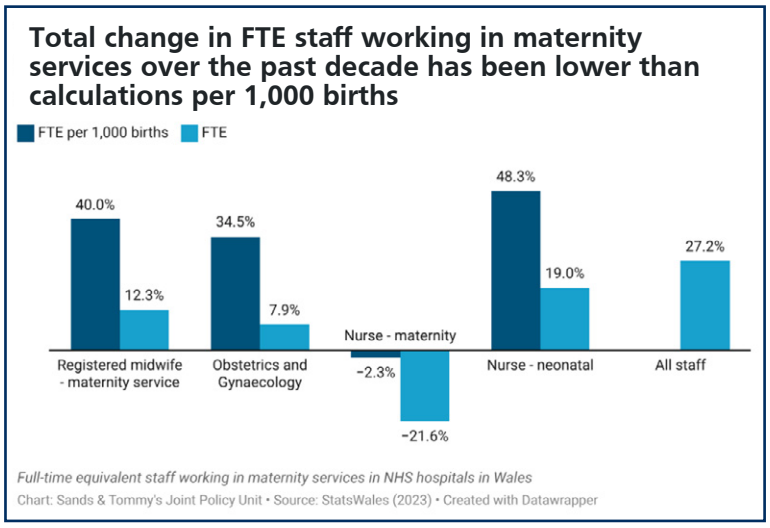

Figure 5. Percentage change in FTE staff per 1,000 births and gross percentage change in FTE staff between 2012 and 2022 in Wales

Applications for midwifery courses in Wales have declined 35.4% since 2021, a steeper decline than the UK overall (27.0%) and second steepest behind Scotland (40.3%). Only 13.9% of applicants for mainstream midwifery courses at universities go on to accept an offer on average over the past five years (see Figure 6). This is mainly driven by a low proportion of applicants receiving an offer: 18.9% over the past five years in Wales compared to 74.6% in England.

The national review of maternity and neonatal services, led by the Maternity Neonatal Safety Support Programme Cymru (MatNeoSSP), found significant challenges among the workforce, with vacancies impacting on wellbeing, education, training, research, and other services (9). The 9.7% vacancy rate for nursing, midwifery and health visiting roles recorded in June 2023 (10), an increase from 8.4% in March 2023, suggests further progress is required. High rates of staff absence due to sickness also impact on staffing levels. Sickness rates among midwives, nurses and health visitors were the third highest of any staff group in Wales between 2019 and 2023 and above the overall staff average (see Figure 7). After a peak in 2022, absence rates in the first half of 2023 have declined across staff groups, suggesting a slight easing of pressure due to staff sickness absence.

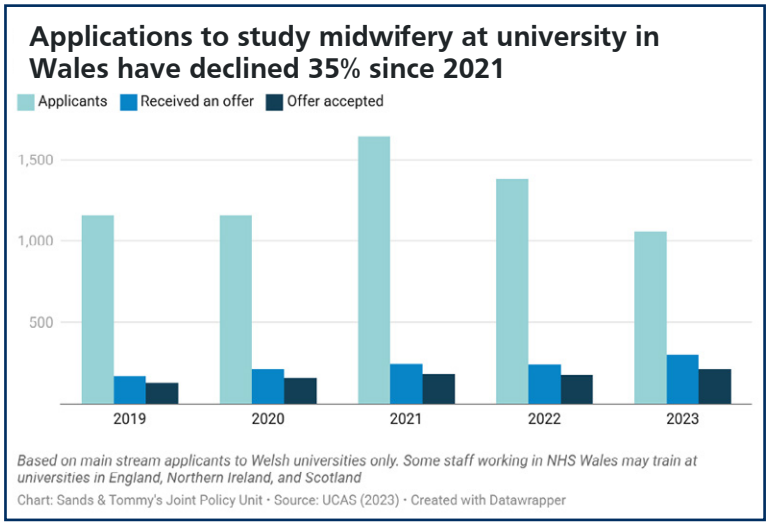

Figure 6. Number of applicants, offers received and offers accepted for midwifery courses at Welsh universities, 2019- 2023

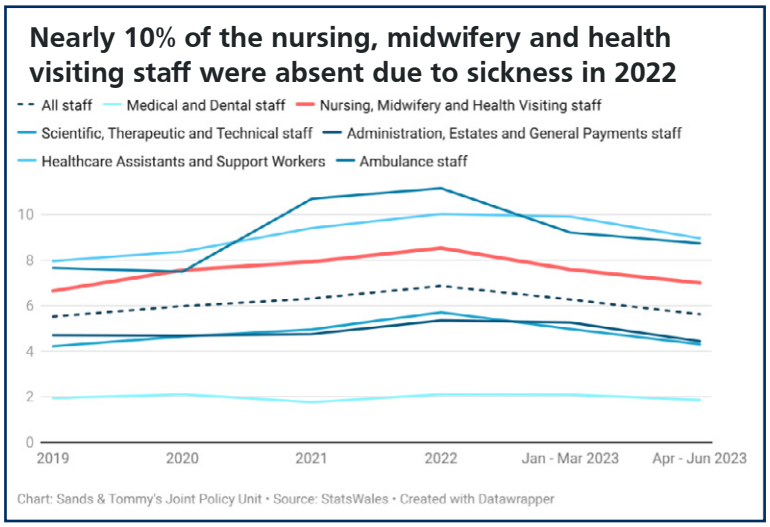

Figure 7. Sickness absence rate by staff group 2019 – 2023 (Jan - Jun)

Culture of safety

According to the MatNeoSSP team, maternity and neonatal services across Wales are "making progress" across the four cultural components of the Institute for Healthcare Improvement Framework for Safe, Reliable, and Effective Care: psychological safety, accountability, teamwork and communication, and negotiation (9). This means that services have made initial progress to integrate these ideas and processes, but they are not yet embedded in all processes as standard. Some staff described a blame culture, lack of teamwork, and communication problems, and the MatNeoSSP team found that team culture was not typically monitored in a standardised way across Wales (9). This lack of monitoring, alongside a lack of regular and comparable staff and patient surveys makes it challenging to confirm the MatNeoSSP view that progress is being made.

NMC runs qualitative research with early career professionals across the UK and categorises them according to whether they are i) happy and confident; ii) happy but in need of support; and iii) unhappy and underconfident (11). While still a minority, being unhappy and underconfident is more common among midwives and internationally educated professionals. Some midwives reported feeling prepared upon qualifying but became disillusioned by high levels of pressure or negative working cultures. This lack of confidence is exacerbated by perceived lack of support from senior staff, feelings of being unwelcome, unappreciated, and unable to ask for help. This has led them to doubt their ability to carry out their responsibilities, reporting burnout and dissatisfaction.

Organisational leadership

The Independent Review of Maternity Services at Cwm Taf Health Board highlighted serious issues with the governance processes in place to respond to concerns raised by families in 2019 (12). The review found that the data supplied under the governance processes did not give a true picture of the service and had not undergone any clinical scrutiny or validation. A programme of inspections by the Health Inspectorate Wales between June 2019 and January 2020 highlighted some concerns about the management and governance arrangements in some maternity units (4). While clinical incidents were reported to boards, the report found a need for significant improvements in identifying and learning from the trends and themes arising from these incidents an ensuring that this is effectively shared with staff to improve the quality of care.

More recently, leadership was highlighted as a priority action by the MatNeoSSP team, which recommended that key maternity and neonatal leaders attended board Quality and Safety Committee meetings to improve (9).

Personalisation of care and choice

Providing personalised care to women and birthing people, and their babies, is one of the key priorities for action outlined by the MatNeoSSP report (9). A public survey run by HIW in 2019 found that 68% of respondents said their birth plan had been listened to (4). However, it is not clear from the report how satisfied respondents were with the information they received and whether there was any variation across stages of care. Parents need clear, unbiased information to help them make decisions throughout their pregnancy and birth, and during the neonatal period. While in England, women and birthing people are surveyed annually to monitor how involved they felt during each stage of care, comparable data are not available for Wales.

Data collection

Maternity dashboards are actively used across all units in Wales, but data are not comparable between health boards which prevents any benchmarking of services (4). The MatNeoSSP report recommended that NHS Wales agrees a nationally standardised data dashboard to enable benchmarking within Wales and with the NHS England Maternity Services and National Maternity and Perinatal Audit datasets (9). A recent update to the All-Wales Maternity Records will also support the recording of ethnicity, nationality and citizenship of women and birthing people to inform national analysis on health inequalities. However, these do not currently include metrics on social risk factors, as recommended by MBRRACE-UK (13,14) and discussed in the full report. More complete data are required to inform a more nuanced understanding of the drivers of health inequalities and efforts to reduce disparities in maternal and neonatal outcomes.

Learning from reviews and investigations

When serious incidents do occur, it is important to have an independent, standardised method of investigating. As well as providing answers to families it is vital that learnings from reviews and investigations are shared and acted upon to prevent avoidable deaths in the future. The Perinatal Mortality Review Tool (PMRT) has been developed to standardise the review of perinatal deaths and create action plans for improvement. A timely review of care is important for parents and the NHS. Since the launch of PMRT in 2018-19, the proportion of perinatal deaths with a review which has started within the same year has increased in Wales (see Figure 8).

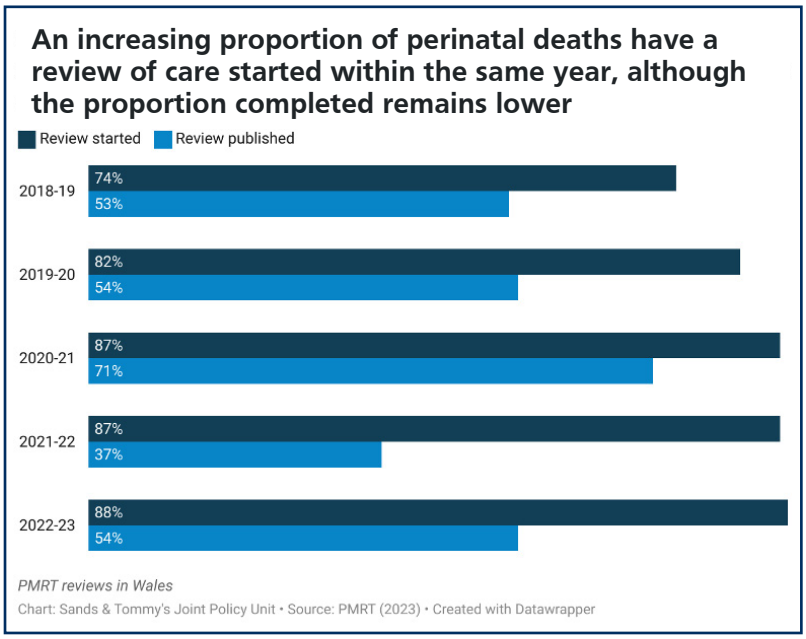

Figure 8. Proportion of perinatal deaths with a PMRT review started and a review completed by year in Wales

Since 2020-21, 100% of neonatal deaths have had a review started; however, the rate of completion has been much lower (15). In 2022-23, 22% of reviews of neonatal deaths were completed within the same year. Conversely, the proportion of stillbirths and late miscarriages with a review of care started is lower (82% in 2022-23), but a greater proportion are completed (69% in 2022-23). Wales had the lowest completion rate across the UK in 2022-23 (54%), lagging far behind England (86%) and slightly behind Northern Ireland (64%) and Scotland (57%). Incomplete reviews mean that any learning for health services and staff are not captured or acted upon, this could mean any mistakes being repeated in the future.

Since the PMRT was launched, some measures of review quality have improved across the UK, such as the composition of review teams which include more external members and are more multi-disciplinary than they were in the past. Involving parents is another critical component of reviews; ensuring that parents are given the opportunity to ask questions or share concerns. In Wales in 2022-23, 83% of reviews noted that parents' perspectives had been sought, but only 45% of reviews included parents' comments.

Parents need support to understand the review and should be given multiple opportunities to ask questions. One in five of the UK based parents' surveyed by Sands did not understand what the review entailed which limited their ability to engage with the process (16). Some parents may need additional support: the MBRRACE-UK Confidential Enquiries found that those parents with an identified language barrier never raised any questions or concerns as part of reviews (13,14).

For more information on PMRT trends across the UK, please see the main report.

Engagement with service users

Listening and learning from the experience of women and birthing people using maternity and neonatal services is vital to improving care. Although all individual services engage with parents in some form, methods vary across the country which prevents overall analysis of parents' satisfaction with the safety and quality of services (9). There are also some concerns about the extent to which patient experience is translated into action plans (12).

When parents have raised concerns about service provision, they have not always been taken seriously (17). Some parents who raised concerns about Swansea Bay Health Board were told that a review had taken place, although it has since emerged that no such review took place (18). Any reviews into services should involve families from the outset, ensure a transparent process, and include independent oversight.

Delivering care in line with nationally agreed standards

Nearly all (97%) of the PMRT reviews completed in Wales during 2022-23 found at least one issue with the care that was provided (15). Across the UK, 1 in 5 reviews identified at least one issue with the care which may have prevented a late miscarriage, stillbirth or neonatal death. Too often, avoidable deaths occur because of care that is not in line with nationally agreed standards, including recommendations in the National Institute for Health and Care Excellence (NICE) Guidance, the All Wales Maternity and Neonatal Guidelines or others[3].

The first antenatal care appointment, or booking appointment, involves an important assessment of needs and risks to identify whether additional care and support is required. NICE guidelines recommend the first antenatal appointment takes place by week 10 of the pregnancy, although initial contact and referral may have been earlier (19). In Wales, 77% of women and birthing people meet this recommendation, although compliance varies between health boards (see Figure 9).

Although this proportion declined slightly since 2021 (80.8%), it has broadly improved since pre-pandemic levels (approximately 70% of women and birthing people on average).

The National Neonatal Audit Programme (NNAP)[4] assesses the care provided to preterm babies in neonatal networks across Great Britain. Care is assessed across key measures which are aligned to professionally agreed guidelines and standards. Wales is currently below target for four out of the five metrics with a standard (see Figure 10).

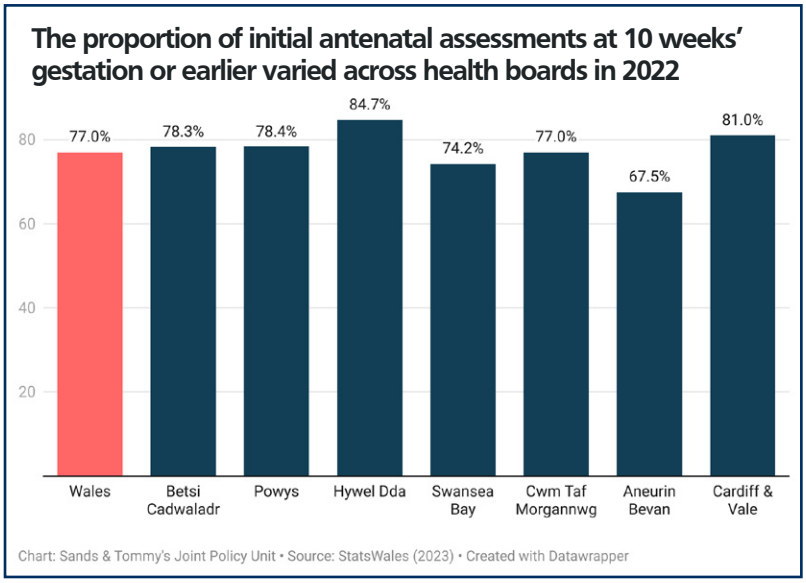

Figure 9. Percentage of women and birthing people who had an initial assessment carried out by 10 completed weeks of pregnancy, by health board providing the service, 2022

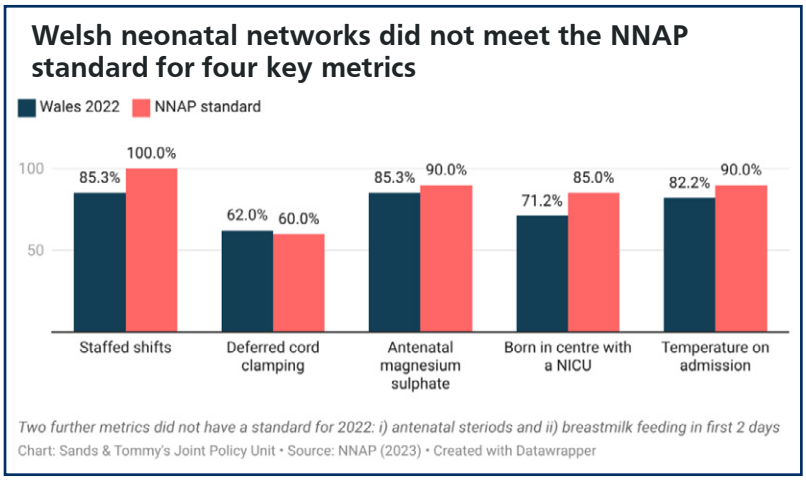

Figure 10. Proportion of babies provided with optimal perinatal care in Wales compared to the NNAP standard

3. Some examples of good practice from across the UK influence Welsh maternity and neonatal services, even if they are not mandated by NHS Wales. For example, the Saving Babies' Lives care bundle Version 3 synthesises six key areas to reduce perinatal mortality, based on existing guidance and inputs from the Royal Colleges, frontline clinicians, service users, and other national organisations. The MatNeoSSP report found that although the bundle is not mandated, several units have worked to align their care with the previous version of the bundle
4. Many of the NNAP criteria are included in the Perinatal Excellence to Reduce Injury from Preterm Birth (PERIPrem) Cymru programme including place of birth, antenatal steroids and deferred cord clamping among others.

Acronyms

- **FTE:** Full-time equivalent
- **HIW:** Health Inspectorate Wales
- **ONS:** Office for National Statistics
- **MatNeoSSP:** Maternity Neonatal Safety Support Programme Cymru
- **NICE:** National Institute for Health and Care Excellence
- **NNAP:** National Neonatal Audit Programme
- **PMRT:** The Perinatal Mortality Review Tool
- **PHS:** Public Health Scotland

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