



Saving Babies' Lives 2024: A report on progress

**Sands &
Tommy's
Policy Unit**

Working together
to save babies' lives

May 2024

Foreword

The motivation for Sands and Tommy's to come together to form a Joint Policy Unit was to ensure that decision makers have access to up-to-date information and evidence, and that pregnancy loss and baby deaths stay high on the political agenda. Both charities are committed to ensuring fewer people suffer the heartbreak of losing a baby. Through our joint unit we wanted to help build consensus on the policy change needed to achieve that.

When we published the first version of this report last year, we warned that government inaction was costing lives. Sadly, despite increasing concerns about the safety of maternity services over the last year, and the unacceptably unequal outcomes experienced by some communities, saving babies lives is still not the political priority it needs to be. This report lays out the key issues that need to be addressed. But for this to lead to meaningful change then much more comprehensive action from government is needed in each of the areas it identifies.

These challenges are not unique to any part of the UK. This year's report includes a more in-depth look at progress in Wales, Scotland and Northern Ireland. Sands and Tommy's continue to be committed to working constructively with policymakers across the UK to secure change that will save more babies lives and tackle the stark inequalities in pregnancy and baby loss.



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Glossary of key terms

- **Ethnicity** - is a form of collective social identity which encompasses elements of physical features (such as skin colour and hair texture), language, culture, shared history, and common ancestry. It is socially constructed and dynamic; identities and meanings are shaped by ethnic groups' own members and wider society. Data on ethnicity is based on self-declaration for adults, and on guidance from parents, guardians or carers for children under the age of 12. This report refers to ethnicity, not race, in line with the official terminology used during data collection and reporting. However, the language used by individuals to describe their experience is personal and may vary. We do not use collective terms such as Black, Asian and minority ethnic (BAME) which emphasise certain groups and exclude others, while also masking differences between groups. Where it is necessary to refer to broad categories to describe inequalities, we refer to "minoritised ethnic groups" to recognise that individuals have been minoritised through social processes of power rather than existing in distinct statistical minorities.
- **Deliveries** - the total number of distinct pregnant women and birthing people, with one or more babies born in the period.
- **Deprivation** - the term commonly used by governments and the NHS to describe a lack of income and other resources, which can also be referred to as socioeconomic status. People may be considered to be living in poverty if they lack financial resources to meet their needs. Deprivation is a wider measure which goes beyond income to consider employment, health, education and skills, crime, housing and living environment. Deprivation is measured on a relative rather than absolute scale. Where we refer to people living in areas of high or low deprivation or within certain deprivation quintiles or deciles as deprivation, this is based on geographical area and not individual circumstances.
- **Late fetal loss** - see miscarriage.
- **Maternal mortality** - death while pregnant or within 42 days of the end of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. In this report, we present the maternal mortality rate per 100,000 maternities. Direct maternal mortality are deaths related to obstetric complications during pregnancy, labour or postnatally (up to 42 days). Indirect deaths are deaths resulting from existing disease of health conditions, or disease/health conditions which developed during pregnancy, the effect of which were aggravated by pregnancy.
- **Maternities** - pregnancies resulting in the birth of 1 or more children. Some Trusts record maternities as the number of women and birthing people with booking appointments for antenatal care. The precise definition is specified throughout this document to reflect the underlying data.
- **Miscarriage** - the legal definition of miscarriage is the spontaneous loss of a pregnancy before 24 weeks of pregnancy. Miscarriage can be described as either an early miscarriage if it occurs before 13 weeks of pregnancy or a late miscarriage if it occurs between 13 and 24 weeks of pregnancy. A late miscarriage can also be called a late fetal loss.
- **Neonatal mortality / neonatal death** - the death of a live born baby in the first 28 days of life. Usually expressed as the neonatal mortality rate per 1,000 live births. Early neonatal mortality refers to death before 7 days and late neonatal mortality refers to deaths between 7 and 28 days old. While neonatal mortality includes the death of a live born baby at any gestational age, some data are only reported for deaths at 24 weeks' gestation and above. Due to variation across sources please refer to the notes of each figure to confirm the scope of reporting.
- **Perinatal** - describes the period surrounding birth, usually from about 24 weeks of pregnancy up to either 7 or 28 days of life.
- **Perinatal mortality / perinatal death** - perinatal mortality includes both stillbirths and early neonatal deaths. The perinatal mortality rate is calculated per 1,000 total births. Extended perinatal mortality includes stillbirths and all neonatal deaths up to 28 days.
- **Preterm birth** - any birth before 37 weeks of pregnancy. Preterm births can be further broken down according to gestational age:
 - **Extremely preterm** (less than 28 weeks)
 - **Very preterm** (28 to 32 weeks)
 - **Moderate to late preterm (32 to 37 weeks).**
- **Rate** - an amount of something measured per unit of something else. Where its occurrence is relatively rare the rate may be expressed per 1,000 or even 100,000 of the denominator. For example, the stillbirth rate is the number of stillbirths divided by the total number of births (live births + stillbirths) during a given period (usually per year). In 2020, the stillbirth rate in the UK was 3.3 per 1,000 total births meaning that out of 1,000 births, 3.3 sadly resulted in a stillbirth.
- **Stillbirth** - the death of a baby after 24 weeks of pregnancy before or during birth. Usually expressed as the stillbirth rate per 1,000 total births (live births + stillbirths). Antepartum stillbirths are those which occur prior to labour, while intrapartum stillbirth is when a baby was thought to be alive at the start of labour but was born with no signs of life.
- **Women and birthing people** - The Sands & Tommy's Joint Policy Unit is committed to inclusivity and ensuring that everyone feels heard and seen. To recognise transgender and non-binary gestational parents, we refer to women and birthing people throughout this report. However, when referencing research, we will mirror the language used in the underlying study to avoid introducing inaccuracies.

Acronyms

- **CQC:** Care Quality Commission
- **DHSC:** Department of Health and Social Care
- **FTE:** Full-Time Equivalent
- **LMNS:** Local Maternity and Neonatal Systems
- **MBRRACE-UK:** Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
- **NHS:** National Health Service
- **NICE:** National Institute for Health and Care Excellence
- **NICU:** Neonatal Intensive Care Unit
- **NIHR:** National Institute for Health and Care Research
- **NISRA:** Northern Ireland Statistics and Research Agency
- **NMC:** Nursing and Midwifery Council
- **NNAP:** National Neonatal Audit Programme
- **NRS:** National Records of Scotland
- **OECD:** Organisation for Economic Cooperation and Development
- **ONS:** Office for National Statistics
- **PMRT:** Perinatal Mortality Review Tool
- **RCOG:** Royal College of Obstetricians and Gynaecologists



1. Introduction: With political will, progress is possible

This is the second ‘saving babies’ lives’ progress report from the Joint Policy Unit. When we published our first report in May 2023 we committed to reassessing progress each year. Through this process we aim to hold government and decision-makers to account, helping to ensure that saving babies’ lives and tackling inequalities in pregnancy and baby loss are the political priorities they deserve to be. Moving towards a general election this is more important ever. As this year’s report makes clear, we need a much more transformative approach from government that matches the scale and impact of the issue.

We are not on course to meet government ambitions to reduce rates of stillbirth, neonatal death, or preterm birth, and there continue to be stark and persistent inequalities in rates of pregnancy and baby loss by ethnicity and deprivation.

Alongside these headline statistics, the analysis presented in this report points to a range of key policy issues which need to be addressed. Action on these areas is vital to achieving our vision of a future where fewer babies die, and inequalities in baby loss are eliminated so that everyone can benefit from the best possible outcomes. New analysis presented in this report highlights that government investment in maternity and neonatal services is falling short of the amount needed to support comprehensive improvements. As well as investment, variations in care must be reduced: too often nationally agreed standards of care are not being followed, which is contributing to avoidable deaths. We must also continue to develop best practice; through a greater focus on research and innovation, more deaths can be avoided in the future.

We are committed to continuing to bring together evidence on the state of maternity and neonatal services and drawing attention to knowledge gaps. Outside of these regular progress reports the Joint Policy Unit is undertaking focussed work across a range of areas. This has included a review of [NHS Trust boards’ oversight of the safety and quality of maternity and neonatal services](#) which highlighted ongoing issues with governance processes. We are currently undertaking a call for evidence aimed at developing consensus on what is needed to make progress on key themes from previous reports and reviews into the safety of maternity and neonatal services.

Losing a baby during pregnancy or shortly after birth is not just ‘one of those things’ – not a sad inevitability that must be accepted. With firm commitment from government, progress is possible.

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.



2. Progress to reduce rates of stillbirth and neonatal death is stagnating

Chapter summary:

- Progress to reduce stillbirth and neonatal mortality rates are stagnating across the UK: the stillbirth rate in Wales has remained at around 4.4 per 1,000 total births since 2018 and there has been little change in the neonatal mortality rates in England and Northern Ireland over the past few years.
- Despite the decline in mortality rates in England since 2010, progress is not on track to meet government ambitions to halve mortality rates by 2025. Since 2018 around 1,000 lives a year¹ could have been saved if ambitions were met.
- Being born preterm is an important risk factor for neonatal mortality but there continues to be little progress on reducing the number of preterm births. In 2021, three-quarters of neonatal deaths in the UK were among babies born prematurely.
- Lack of data continues to limit our understanding of the number of miscarriages happening each year. Work is underway to improve miscarriage data recording in Scotland, but no similar initiatives are currently planned for the other UK nations.
- While this report is focused on outcomes for babies, there is a significant overlap with outcomes for women and birthing people. The latest data show the three-year maternal mortality rate for 2020-22 in the UK increased to the highest rate since 2003-05.



What needs to change:

- We are not on track to meet the national maternity safety ambitions in England by 2025. It is important that there are renewed commitments beyond 2025, and that these are expanded to cover each of the four nations of the UK and include an ambition to address inequalities (see section 3). Any future targets must have a clear and agreed baseline to measure progress against, with the funding and resources necessary to meet them.
- Health services in England, Wales and Northern Ireland should learn from efforts to count miscarriages in Scotland and commit to counting miscarriages in their national health system.

1. Using Office for National Statistics (ONS) data for England, we compared the actual rate of stillbirths and neonatal deaths between 2018 and 2021 with the target rates of 2.6 per 1,000 total births and 1.0 per 1,000 live births respectively. On average, we estimate 780 stillbirths and 220 neonatal deaths could have been prevented each year.

The latest data from the UK perinatal surveillance programme conducted by MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) show that progress to reduce stillbirth and neonatal mortality rates is stagnating. Stillbirth and neonatal mortality rates both increased in 2021 (see Figure 1), which may be partly linked to the direct and indirect impact of the Covid-19 pandemic.

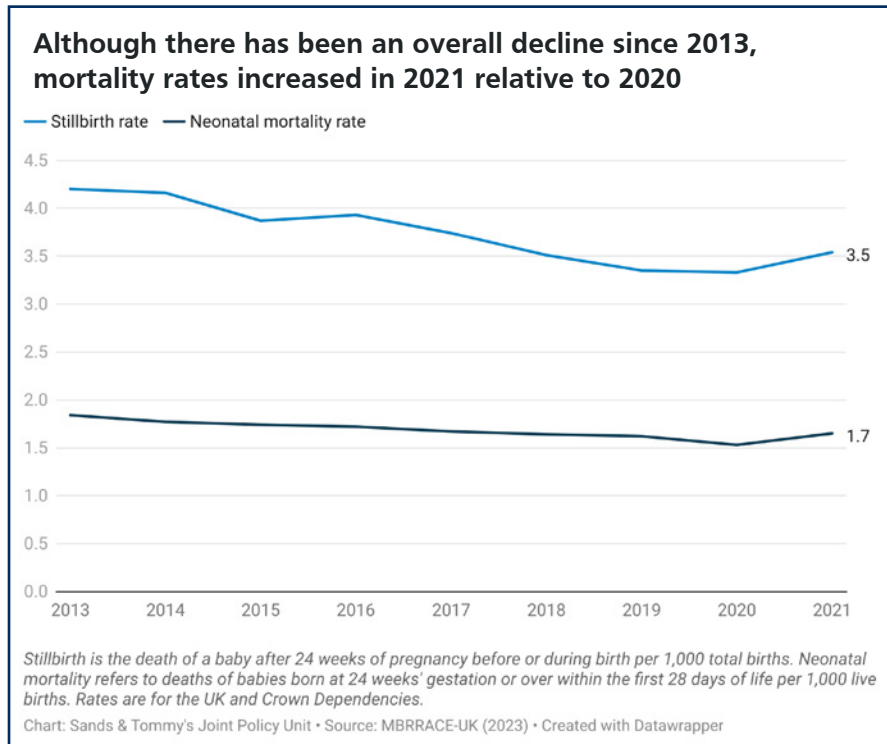


Figure 1. Stillbirth and neonatal mortality rates across the UK, between 2013 and 2021, MBRRACE-UK

Although more recent data from individual UK nations suggest a slight decline in 2022 (see Figures 3 and 4), progress is too slow. As outlined in our 2023 report (1), international comparisons show that it is possible for the UK to reduce perinatal mortality rates further. In 2019, four countries in Europe reported stillbirth rates which were below England's 2025 target of 2.6 per 1,000 total births: Denmark (2.2), Finland (2.4), Norway (2.5), and Slovenia (2.0) (2).

Preterm births continue to have an important impact on mortality rates in the UK: three-quarters of neonatal deaths in 2021 (73%) were among babies born before 37 weeks' gestational age (see Figure 2). Despite this impact, there has been little progress in reducing the preterm birth rate which has remained stable (between 7.5 - 8.0%) between 2016 and 2021.

Unlike preterm births, stillbirths and neonatal deaths, the number and rate of miscarriages are not reported across the UK or for any individual nation. Instead, we are reliant on estimates which are likely to underestimate the true number of miscarriages and do not show any changes over time. A systematic review of nine large cohort studies in Europe and North America found a pooled miscarriage risk of 15.3% (with a 95% confidence interval between 12.5%–18.7%) of all recognised pregnancies. However, this pooled risk is based on clinically recognised pregnancies but does not include pregnancies which were unknown at the time of miscarriage. Some of the studies also only included miscarriages which resulted in hospital treatment, which is likely to be an underestimate. For more detailed analysis of the gaps in the recording of miscarriage across the UK, please see the [Saving Babies' Lives 2023 report](#).

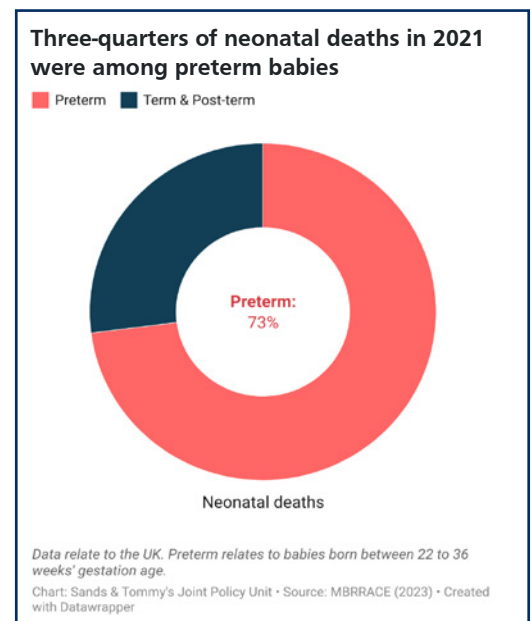


Figure 2. The proportion of neonatal deaths which were among babies born preterm

Counting miscarriages in Scotland:

The Scottish Government is currently working with Public Health Scotland to improve miscarriage data recording and build a more accurate picture of the number of miscarriages in Scotland. To inform their scoping study (3), Health Boards were surveyed to establish what miscarriage-related data are currently collected and where they are recorded, which highlighted variation across and within Health Boards. Public Health Scotland has created a draft dataset which is out for consultation and refinement before it is integrated into maternity data systems.

Mortality rates across the UK

In 2022, the stillbirth rate² across the four nations of the UK ranged between 3.4 and 4.4 per 1,000 births. Rates declined between 2010 and 2022 in England (-24%), Northern Ireland (-17%), Scotland (-24%) and Wales (-17%), although there has been greater volatility in year-on-year changes in stillbirth rates in Northern Ireland, Scotland and Wales partly due to their smaller population size which means that a slight change in the number of deaths has a greater effect on the overall rate.

Despite a reduction since 2010, the stillbirth rate in Wales has stagnated at around 4.4 per 1,000 total births since 2018 (see Figure 3). Stillbirth rates in Wales have also been the highest out of the four nations since 2014.

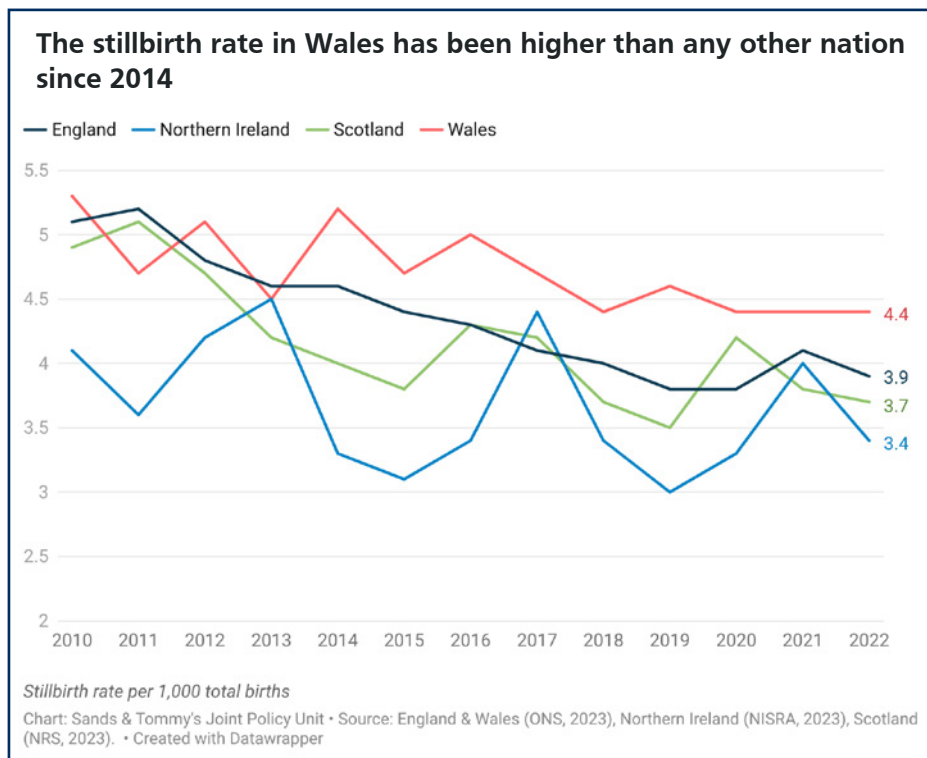


Figure 3. Stillbirth rates in England, Northern Ireland, Scotland, and Wales between 2010 and 2022.

Despite declining by the largest percentage overall, neonatal mortality rates³ have been highest in Northern Ireland between 2010 and 2022 (see Figure 4). Given historical differences in policy and practice related to terminations, women and birthing people's access to, and uptake of, terminations for medical reasons may vary compared to the rest of the UK.

The neonatal mortality rate in Scotland increased by a third to 2.8 per 1,000 live births in 2021, relative to 2020. A review into this increase was inconclusive; finding no new or unusual causes of death, or systemic failures of care which could explain the rise in deaths (4). The rate in Scotland declined again in 2022 to 2.2 per 1,000 live births; however, it remained higher than the rate in 2020 and provisional data for January to September 2023 suggest a return to a higher rate again in 2023.

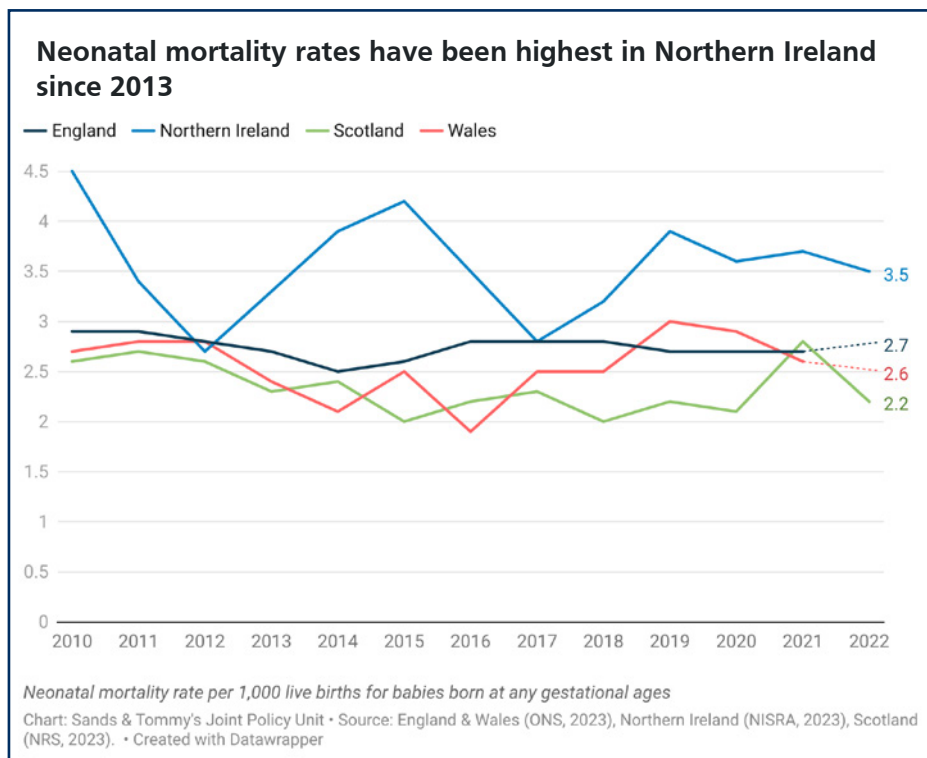


Figure 4. Neonatal mortality rates for all gestational ages in England, Northern Ireland, Scotland, and Wales between 2010 and 2022.

2. To analyse progress across the four nations of the UK, this report uses data from the Office of National Statistics (ONS) for England and Wales, the Northern Ireland Statistics and Research Agency (NISRA), and National Records of Scotland (NRS). These sources use birth and death registration data rather than hospital registration data used by MBRRACE-UK. Although this data offers less information about mother and baby, it is reported in a more timely manner which allows us to consider rates for 2022.

3. Although MBRRACE-UK reports neonatal mortality for babies born at 24 weeks gestation and over, neonatal mortality data according to gestational age are not available for Northern Ireland or Scotland. This is due to differences between data collected in death registrations and hospital-reported data.

National Maternity Safety Ambition in England

The National Maternity Safety Ambition, launched in November 2015, aims to halve the 2010 rates of stillbirths, neonatal and maternal deaths, and brain injuries occurring during or soon after birth in England by 2025.

The stillbirth rate in 2022 was 23.5% lower compared to 2010, while the neonatal mortality rate has declined 30.0% as of 2021 (See Figure 5)⁴. Despite the decline since 2010, more recently progress has stagnated and is not on track to meet government ambitions for England.

Compared to most recent data, around 1,000 lives a year⁵ could have been saved in England if ambitions were met.

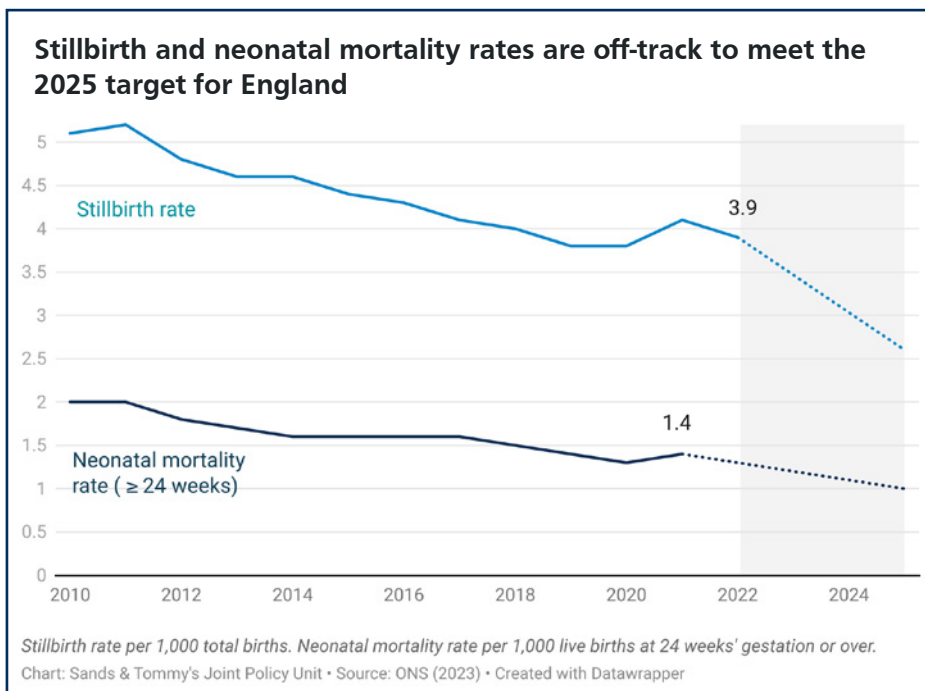


Figure 5. Stillbirth and neonatal mortality rates in England between 2010 and 2022 and trajectories required to meet 2025 targets

Maternal mortality

While this report is focused on saving babies' lives and reducing inequalities, there is a significant overlap with outcomes for women and birthing people. The latest data show the three-year maternal mortality rate for 2020-22 in the UK increased to the highest rate since 2003-2005 (see Figure 6). While deaths due to Covid-19 partly accounted for the sharp increase, the rate excluding these deaths (11.5 per 100,000) reached a 15-year high. This change underlines the need for maternity safety to become a more urgent priority for government.

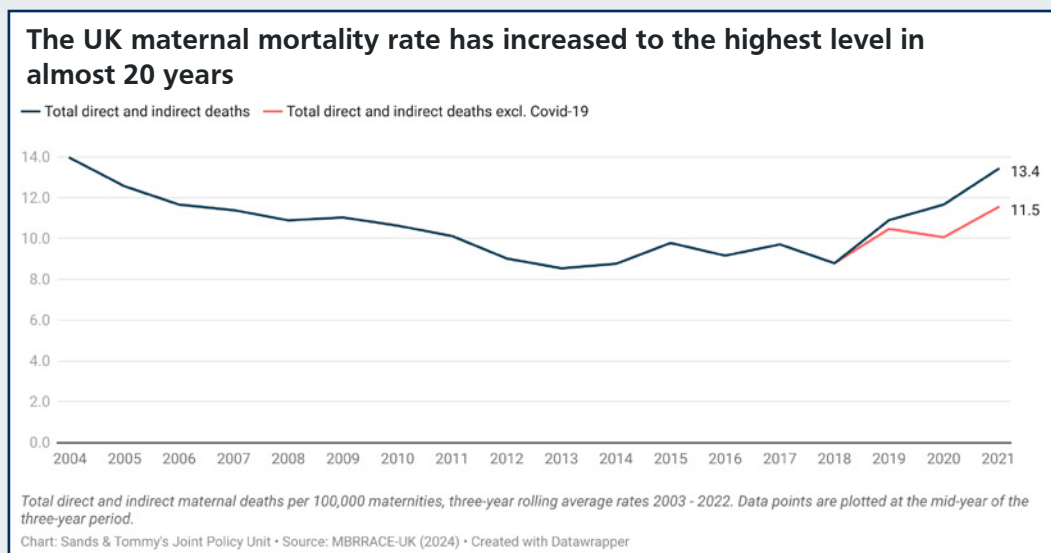


Figure 6. Three year rolling average of maternal deaths per 100,000 maternities

The latest rates also show continued inequalities across ethnic groups. Women and birthing people from Black ethnic groups had nearly four times higher risk of maternal death compared to women and birthing people from White ethnic groups. The risk for women and birthing people from Asian ethnic groups was nearly twice the risk for White women and birthing people.

4. Here the data presented are from the ONS as the first year of MBRRACE-UK data reporting was 2013. There are slight differences in the mortality rates reported by MBRRACE-UK and the ONS. MBRRACE-UK is based on hospital reported data while ONS uses death and birth registration data.
5. Using ONS data for England, we compared the actual rate of stillbirths and neonatal deaths between 2018 and 2021 with the target rates of 2.6 per 1,000 total births and 1.0 per 1,000 live births respectively. On average, we estimate 780 stillbirths and 220 neonatal deaths could have been prevented each year.



3. Meaningful action is needed to address stark and persistent inequalities by ethnicity and deprivation

Chapter Summary:

- There continue to be substantial differences in rates of pregnancy and baby loss by ethnicity and deprivation. The stillbirth rate in the most deprived areas of the UK is double that of the least deprived.
- In several areas inequalities have widened. Between 2013 and 2021 stillbirth and neonatal mortality rates increased for babies from Black ethnic groups, while the rates declined for babies from Asian and White ethnic groups.
- The proportion of babies born preterm varies between ethnic groups. This can have an important impact due to higher mortality rates among babies born preterm. There are no routine data on the proportion of preterm births according to area-level deprivation.
- Limitations in data and evidence on the varied factors that may be contributing to inequalities continues to hamper efforts to reduce inequalities. A more nuanced understanding of the drivers of inequalities is still needed; however, there is an urgent need to move beyond diagnosing the problem to taking meaningful action to reduce inequalities.



What needs to change:

- Our current approach to tackling inequalities is too limited in scope. Governments across the UK must make clear commitments to eliminating inequalities in pregnancy and baby loss. This must be underpinned by the latest research and a comprehensive programme of improvement initiatives, as well as clear metrics to measure progress against.
- Schemes intended to support improvements in maternity safety should consider how to integrate efforts to tackle inequalities.
- The National Institute for Health and Care Research (NIHR) Challenge fund focused on tackling maternity disparities is a significant step change in the amount of research funding available. To realise its potential, the NIHR Challenge must deliver its aim of bringing together diverse researchers from a broad range of disciplines and backgrounds as well as people with lived experience.
- Alongside long-term commitment from government, there are a range of immediate actions that could be taken to address potential drivers of inequality. This includes improving the collection of data on social risk factors and providing adequate and consistent support for the implementation of local plans to improve equity and equality.

Ethnicity

Stillbirth

There continued to be stark inequalities in outcomes for babies of different ethnicities across the UK in 2021 (see Figure 7). Babies from Black ethnic groups continued to be more than twice as likely to be stillborn compared to White babies.

The stillbirth rate among babies from Mixed and “Any Other” ethnic groups were both 5.4 per 1,000 total births. A study led by the NHS Race and Health Observatory on the quality and completeness of hospital data on ethnic groups found that hospital records over-represent “Other” categories while under-representing Mixed ethnic groups (5). This may affect the validity of any analysis of differences for these groups.

Stillbirth rates declined for babies from White (-13.6%) and Asian (-18.2%) ethnic groups between 2013 and 2021 (see Figure 8). The stillbirth rate increased among babies from Black ethnic groups (+7.1%), which remained the highest rate throughout the reporting period.

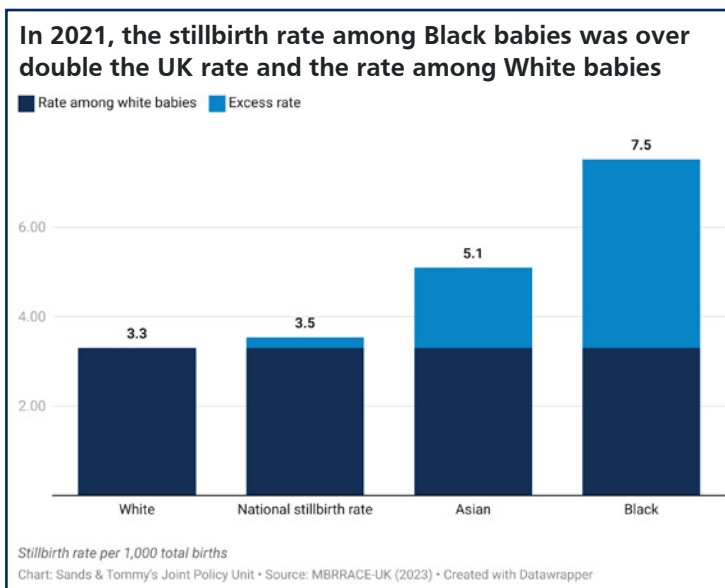


Figure 7. Comparison of stillbirth rates across ethnic groups in the UK in 2021

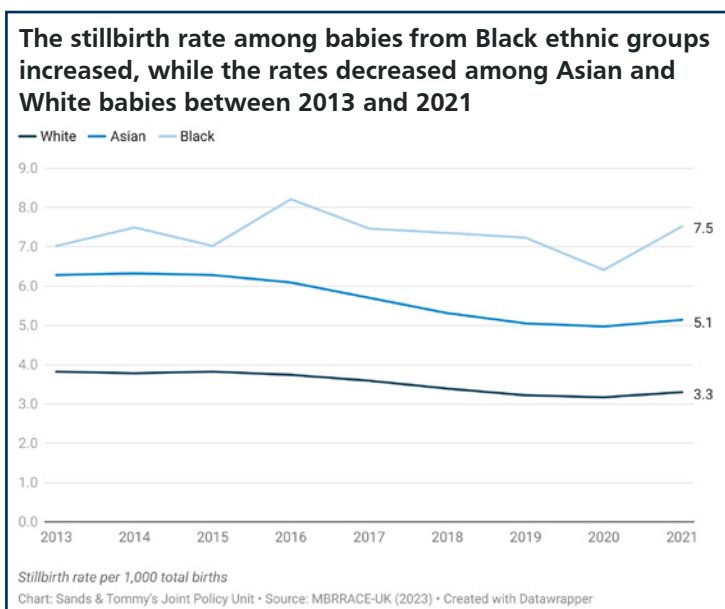


Figure 8. Changing UK stillbirth rate across Asian, Black, and White ethnic groups between 2013 and 2021

Neonatal death

There are also inequalities in neonatal deaths, although they are less stark than the inequalities in stillbirths. The risk of neonatal mortality is 75% higher among babies from Black ethnic groups, and 30% higher among babies from Asian ethnic groups, compared to White babies (see Figure 9). The neonatal mortality rate among babies from Mixed and “Any Other” ethnic groups were 1.8 and 2.2 per 1,000 live births respectively in 2021.

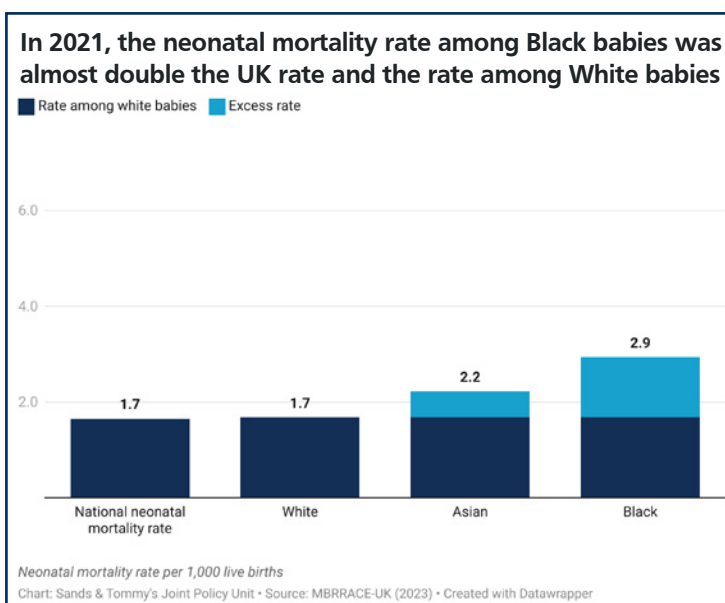


Figure 9. Comparison of neonatal mortality rates across ethnic groups in the UK in 2021

Between 2013 and 2021, neonatal mortality rates were similar between babies from Black and Asian ethnic groups (see Figure 10). However, a year-on-year decline in rates among Asian babies between 2017 and 2020, led to the largest overall decrease in neonatal mortality rates (-12.6%) of any ethnic group between 2013 and 2021. The rate also declined among White babies (-2.9%) but increased among Black babies (+5.0%). The rate increased for all ethnic groups between 2020 and 2021.

Using data from individual ethnic groups can provide further insight into populations who require targeted support to reduce inequalities. For example, across Asian ethnic groups, stillbirth rates were highest among babies from the Pakistani ethnic group (see Figure 11). The rate among babies from the Pakistani ethnic group (6.2) was higher than the stillbirth rate among babies from Black Caribbean (6.1) and Other Black⁶ (5.0) ethnic groups.

Comparisons can also provide insights into areas of highest risk for different groups. For example, while stillbirth rates were similar for Bangladeshi and Indian ethnic groups (4.6 and 4.8 respectively), neonatal mortality rates were 90% higher among babies from the Bangladeshi ethnic group. Risk of stillbirth was 30% higher for babies from the Black African ethnic group compared to the Black Caribbean group, while neonatal mortality rates were 40% higher for Black Caribbean babies compared to Black African.

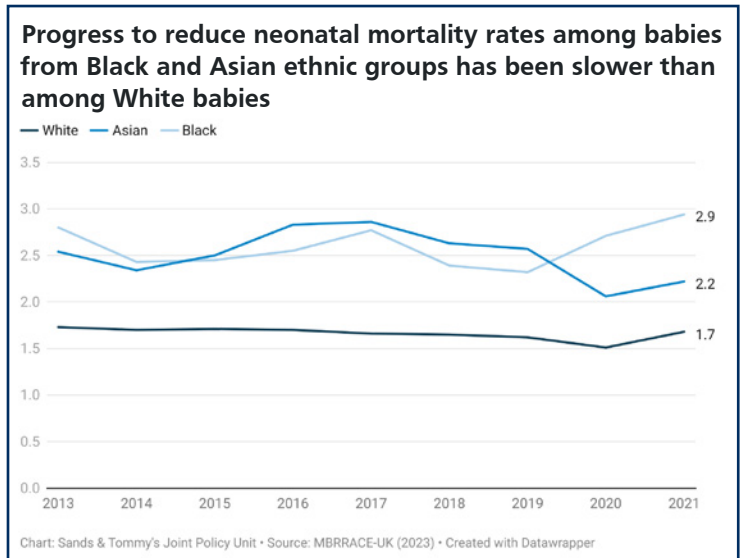


Figure 10. Changing UK neonatal mortality rate across Asian, Black, and White ethnic groups between 2013 and 2021

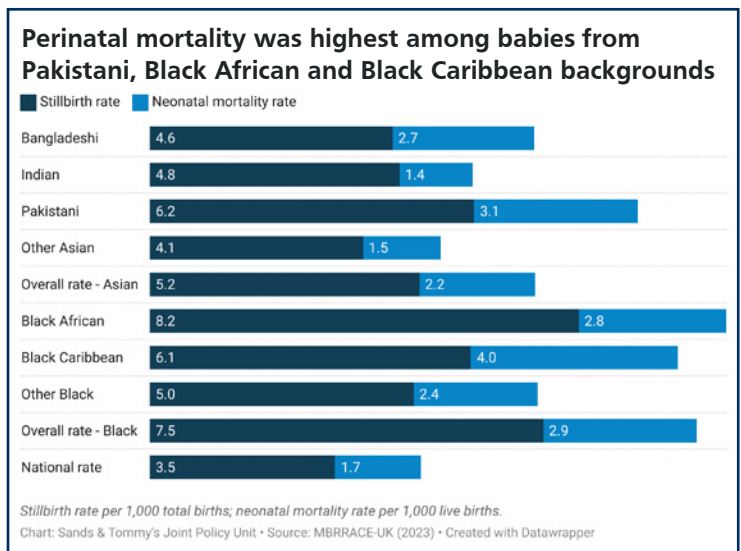


Figure 11. 2021 UK stillbirth and neonatal mortality rates across Asian and Black ethnic groups in comparison to national and aggregate rates

Preterm birth

The proportion of babies born preterm also varies between ethnic groups. In 2021, rates in England and Wales were highest among babies from Black Caribbean, Other Black and Bangladeshi ethnic groups (see Figure 12). The proportion of babies born extremely or very preterm (under 32 weeks' gestation) was higher among babies from Black ethnic groups (between 1.9 to 2.2%) compared with the proportion overall (1.2%). This difference is important due to the higher mortality rates at lower gestational ages. For example, the neonatal mortality rate in England and Wales in 2021 was 28.7 per 1,000 live births for babies born between 28 and 31 gestational weeks, compared to 4.4 per 1,000 live births for babies born between 32 – 36 gestational weeks.

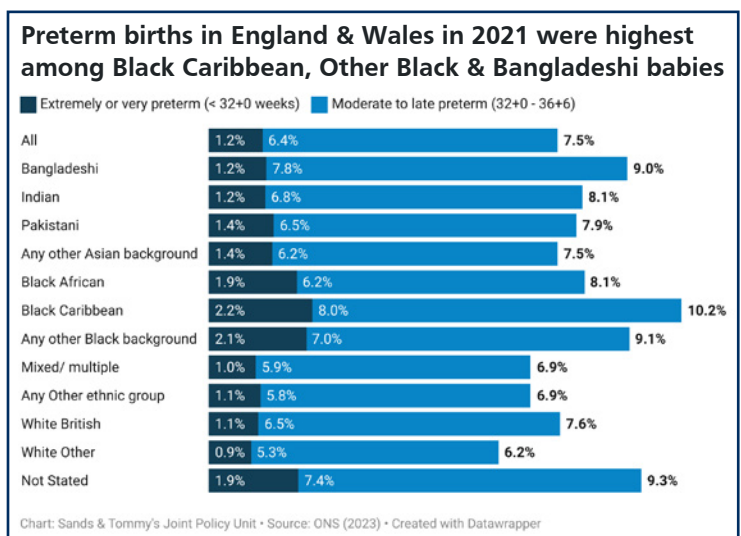


Figure 12. Proportion of babies born extremely or very preterm, and moderate to late preterm across ethnic groups in England & Wales in 2021 ethnic groups in comparison to national and aggregate rates

6. As outlined above, NHS Race & Health Observatory analysis suggests that comparisons with "Other" ethnic groups is likely to be affected by inconsistent coding and any conclusions should be treated with caution.

Deprivation

Deprivation is measured based on geographical areas, using the mother’s residential postcode at the time of birth, and not data related to individuals (unlike data relating to ethnicity). Area-level data shows ongoing inequalities in pregnancy and baby loss.

Stillbirth

The stillbirth rate among mothers living in the most deprived areas of the UK was double the rate among mothers living in the least deprived areas in 2021 (see Figure 13).

The difference in stillbirth rates between those living in the least and most deprived quintiles⁷ was the second highest in 2021 (the highest difference was in 2019) (see Figure 14). While rates followed a similar trajectory between 2015 and 2018, in 2021 the rate declined in the least deprived quintile and increased in the most deprived quintile.

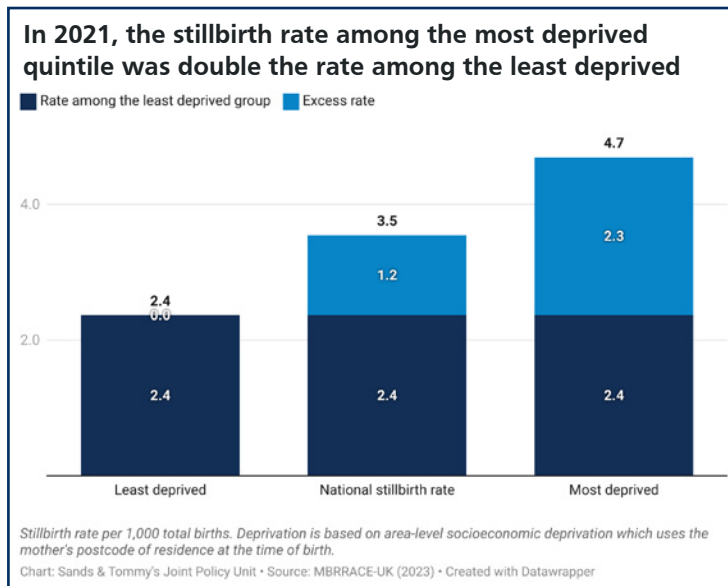


Figure 13. Comparison of stillbirth rates between the least and most deprived areas in the UK and the national rate in 2021

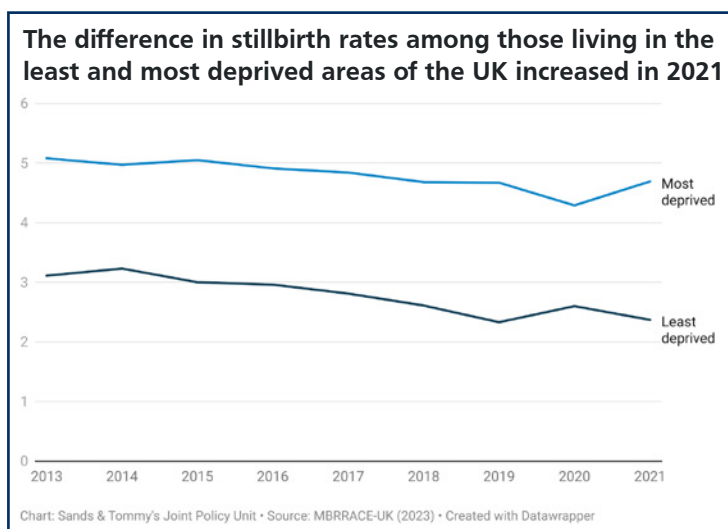


Figure 14. Changing UK stillbirth rate between the least and most deprived areas between 2013 and 2021

7. Quintile is a statistical value that represents 20% of a given population. The most deprived quintile refers to the 20% most deprived geographical areas and the least deprived quintile refers to the 20% least deprived geographical areas.

Neonatal death

Similar inequalities were also apparent for neonatal deaths in 2021, with rates two-thirds higher among the most deprived quintile compared to the least deprived (see Figure 15).

Unlike stillbirths, the difference in neonatal mortality rates in 2021 declined to the smallest level since 2018. This was driven by an increase in the rates among the least deprived rather than any reduction in the rates among the most deprived quintile (see Figure 16).

There are concerns that the current cost-of-living crisis will disproportionately affect low-income households, further increasing disparities in deaths. A 2023 survey of health visitors found that 93% reported an increase in poverty affecting families over the past year (6). The UK is also performing worse than many comparable countries on measures of child poverty. Rates of child poverty are the 13th highest out of the 39 Organisation for Economic Cooperation and Development (OECD) countries and the UK saw the largest increase (+19.6%) in child poverty levels between 2012-2014 and 2019-2021 (7).

Preterm birth

As outlined in our 2023 report, gestational age at birth and area-level deprivation are not reported by MBRRACE-UK or ONS. Although some studies suggest an association between deprivation and preterm birth, this relationship is not monitored through routine reporting.

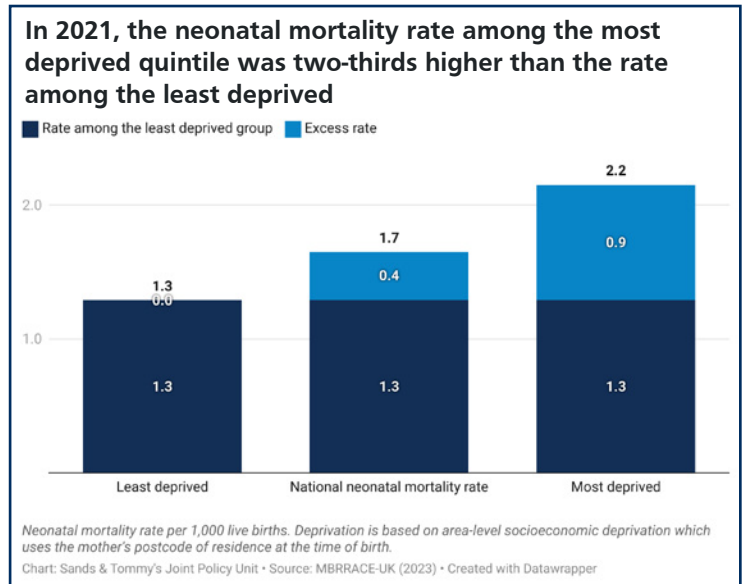


Figure 15. Comparison of neonatal mortality rates between the least and most deprived areas in the UK and the national rate in 2021

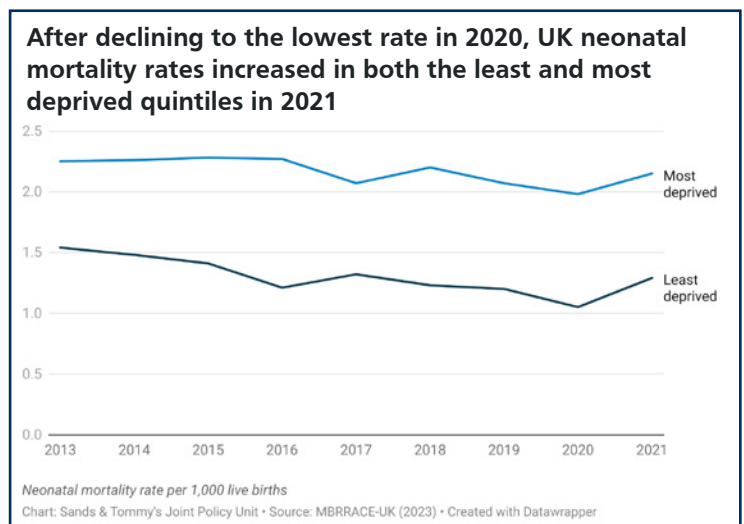


Figure 16. Changing UK neonatal mortality rate between the least and most deprived quintiles between 2013 and 2021

Understanding drivers of inequalities

The causes of disparities in pregnancy loss and baby deaths are multiple, complex, and still not fully understood. In the past year, further reports have been published which documented experiences of inequalities and considered their potential causes. MBRRACE-UK published confidential enquiries into the care provided to women and birthing people from Asian (8), Black (9) and White ethnic groups who experienced a stillbirth or neonatal loss. An expert panel used anonymised medical notes to review whether the quality of care may have made a difference for the baby and mother.

Although the confidential enquiries highlighted specific issues for attention, including vitamin D prescribing for darker skin tones, provision of interpreters and improvements in antenatal care, they did not identify what is driving inequalities in rates overall. In contrast, the reviews found a greater proportion of issues with care provided to White women and birthing people (49%) which could have prevented a stillbirth or neonatal death, compared to 42% of Black women and birthing people and 26% of Asian women and birthing people.

This may be partly explained by the limitations of solely using medical notes to investigate care without interviewing the relevant parents or healthcare professionals (a necessary limitation due to the use of anonymised notes during the enquiry). To complement the MBRRACE-UK confidential enquiries and capture parents' perspectives, the Sands Listening Project interviewed Asian and Black bereaved parents about their care (10). Over half of the parents participating in the Sands Listening Project believed that their ethnicity affected how they were treated by healthcare professionals, in some cases leading to unsafe care. This echoed the perspectives of midwives from minoritised ethnic groups who described how racial stereotypes and lack of cultural awareness among staff lead to negative experiences and potential safety issues.

Despite successive qualitative reports (11–13) which outline experiences of racism and discrimination within healthcare settings, it is challenging to quantify its contribution to inequalities in pregnancy and baby loss. Responses to the Care Quality Commission (CQC) maternity survey⁸ (14) from Asian or Asian British respondents were significantly better than average for 6 out of 31 question categories⁹, and 9 out of 31 categories for Black or Black British respondents. According to the CQC, none of the responses from Asian / Asian British and Black / Black British were statistically worse than average responses. In contrast, White respondents had worse than average responses for 5 out of 31 categories. These results are surprising given that Asian and Black women and birthing people are at higher risk of worse perinatal outcomes. However, the most marginalised groups may be less likely to respond to the survey which may create some response bias. Women and birthing people who do not speak English as their main language may be less likely to respond: only 2.0% of

responses were from non-English language forms which were completed online¹⁰ or forms filled using a telephone translator. Many of the questions in the survey are also influenced by individuals' expectations of the care they will and should receive which could differ between groups. Those who are unfamiliar with NHS systems may have different expectations, for example. Bereaved parents, who have experienced the worst outcomes, are also not included in the survey.

A recent study of maternal mortality in the UK between 2009 and 2019 found that known risk factors, including age, socioeconomic status, and medical comorbidities, do not fully explain disparities between ethnic groups (15). While this study focused on maternal rather than perinatal mortality, it suggests that ethnicity remains an independent risk factor and that policy and practice should not only aim to optimise pre-conception health but should also focus on improving equity in the provision of maternity care. In addition, cross-government issues such as housing, education and healthy environments need to be addressed.

Tackling inequalities will require a more culturally competent and equitable provision of maternity and neonatal services, as well as targeted support to improve the individual risk factors for pregnant women and birthing people. Healthcare professionals must be able to have personalised conversations with parents from minoritised ethnic background and other vulnerable groups about possible risks that might affect them or their baby (10), and direct them to additional support.

One of the limiting factors to understanding health inequalities is the availability of routine data on a range of social risk factors. Although some data quality challenges remain (5), ethnicity is routinely recorded individually while data on deprivation are based on broader measures related to residential postcode. 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 of causes of pregnancy loss and baby deaths.

Over the past year, the Sands and Tommy's Joint Policy Unit has developed a Health Inequalities Framework which brings together varied factors which could directly or indirectly affect pregnancy outcomes (see Figure 17). This was adapted from an existing framework (16) - which considered social inequalities in adverse birth outcomes based on predominantly American studies¹¹ - through workshops with Sands and Tommy's staff and feedback from external stakeholders. We aim to use this framework to develop consensus on the range of policy interventions required to reduce inequalities. Focusing on any single cause risks oversimplifying the problem (17). Instead, the framework recognises the complexity and intersectionality of a wide range of factors and the impact they have on individuals' health outcomes.

8. The CQC maternity survey asks women and birthing people from all NHS trusts who gave birth in February 2023 to share their experience. In 2023, the maternity survey included a "booster sample" to include people using maternity services from minoritised ethnic groups in January and March 2023. This led to an increase in the proportion of minoritised ethnic groups in the sample. Despite this improvement, only a high-level summary of results disaggregated by ethnic group are provided which offers limited insights.

9. The CQC groups the 54 survey questions into 31 categories or themes, for example "Communication, Listening - antenatal care" and "Involvement - Labour & Birth."

10. The 2023 survey was available in 9 non-English languages.

11. The framework was developed based on 35 studies. 27 of the studies were from the USA, followed by six from Europe, one from Asia, and a final study covering USA, Canada, UK and Australia.

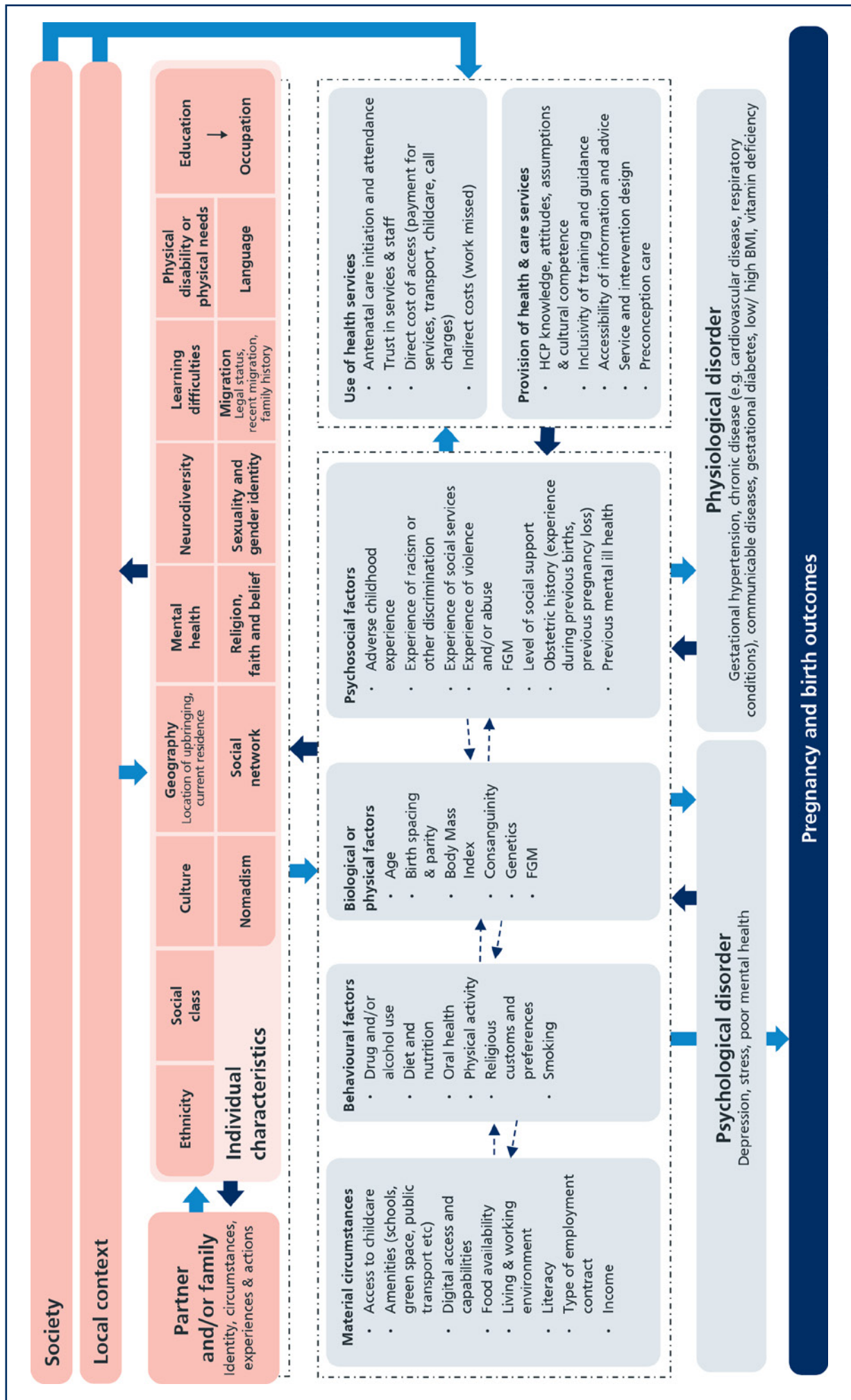


Figure 17. Health inequalities framework for pregnancy and birth outcomes

Improvements to routine data collection are needed to inform approaches to tackle health inequalities. The MBRRACE-UK confidential enquiries (8,9) recommended the development of UK-wide metrics 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.

Collecting these data points will require changes to digital databases and training for staff to understand the importance of collecting this data and methods to do so sensitively. The frequently inaccurate and inconsistent recording of citizenship and ethnicity within maternity records highlighted by the confidential enquiry suggests that services are not sufficiently prioritising the collection of this information currently (8,9).

Aligned datasets are critical to gather data on many of the factors included in the inequalities framework and enable national analysis of the drivers of inequalities, including regional or local differences. These data will also be valuable for research, which may increase following the welcome announcement of the NIHR Challenge, which is focused on research related to maternity inequalities (see Chapter 5).

While a more nuanced understanding of the drivers of inequalities is needed to inform a comprehensive, cross-government approach to reduce disparities in pregnancy and neonatal outcomes, the government does not need to wait for more data and research to act. Recent reports have already flagged issues which require immediate action and suitable solutions will need testing. This includes actions within maternity and neonatal services and from wider government, including housing and employment (18).

Equity and equality plans

In September 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. The plans also aim to address prejudice and discrimination against certain groups and individuals across the NHS workforce. Implementing these plans is an objective in NHS England's three year delivery plan for maternity and neonatal services (19).

In 2021-22, LMNSs received ring-fenced funding to co-produce their equity and equality action plans with families, voluntary organisations, and maternity and neonatal voice partnerships, and implement targeted and enhanced continuity of carer. Each LMNS should have received a minimum of £90,000. Since then, funding has not been ring-fenced, due to NHS England's new operating framework which places a greater responsibility on Integrated Care Systems to deliver for their local populations.

There has been concern over variation in funding across LMNSs, with some receiving this funding as part of the general maternity allocation, which risks this work being de-prioritised.

Sands and Tommy's Joint Policy Unit submitted a Freedom of Information request to each LMNS to determine levels of funding and variation. We received data from 27 LMNSs (64.3%) on their equity and equality plans' budget and from 23 (54.8%) on their spend.¹² 15 LMNSs were unable to provide this information, as they did not have access to the data or did not have equity and equality plans as a distinct stream of funding.

Ten LMNSs (39.1% of respondents) reported a decreased equity and equality budget in 2023-24, compared to 2022-23. Of the LMNSs who responded, half (52.25%) reported a decrease or no change in their equity and equality spend in 2023-24 compared to 2022-23 (see Figure 18).

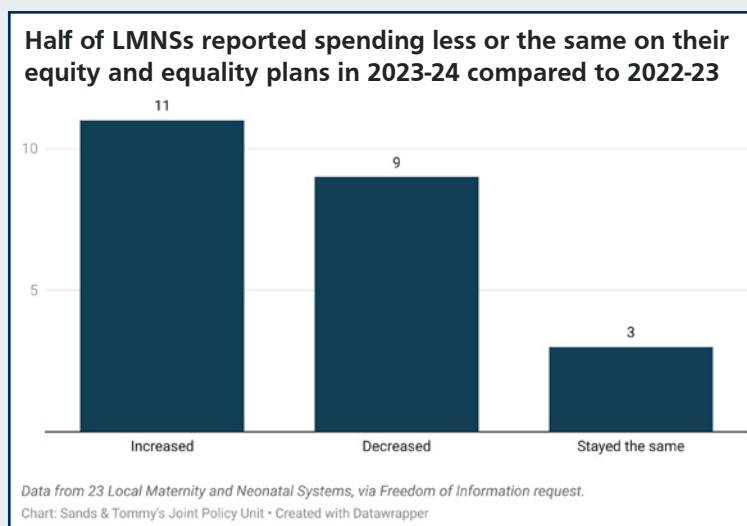


Figure 18. Change in reported spending by LMNSs on equity and equality plans between 2022-23 and 2023,24

As well as adequate funding and resourcing, there needs to be a focus on evaluating the impact of individual equity and equality initiatives and the scheme overall.

12. Data are available on request.



4. Systemic issues in maternity and neonatal services need to be addressed

Chapter Summary:

- The current scale of pregnancy loss and baby deaths in the UK is not inevitable. 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.
- Reports and reviews into the safety of maternity and neonatal services across the UK have consistently identified the same themes.
- Despite numerous policy initiatives mortality rates, safety and quality metrics, patient satisfaction and staff survey results all show that progress has been inadequate.
- While there are many instances of good care being delivered, there is too much variation. Too often, nationally agreed standards of care are not being followed which is contributing to avoidable deaths.
- Improving staffing levels across all roles engaged in maternity and neonatal services is necessary but not sufficient. 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.
- Recent commitments to increase funding for maternity and neonatal services remain significantly below the level needed to support the transformative improvements that are required.



What needs to change:

- The next government must move away from focusing on individual services which are deemed to be outliers, towards a comprehensive national approach which addresses the fundamental issues and puts the key elements of a safe system in place.
- Renewed approaches to improving the safety of services must ensure care is delivered in line with nationally agreed guidance.
- Work to develop an early warning surveillance tool to identify when the safety of services is declining is important but must be used to trigger action which improves the safety of services.
- There should be an increased focus on evaluating the impact of policy initiatives, with key performance indicators agreed from the outset which are monitored throughout delivery.
- Further funding is required which recognises the scale of the issues facing maternity and neonatal services and the transformative improvements that are required to save more babies' lives. This includes the recurrent funding required to deliver the NHS Long Term Workforce Plan in England.

Alongside the mortality data presented in Chapter 2 & 3, safety and quality metrics, patient satisfaction and staff survey results all suggest that despite the introduction of numerous policy initiatives, there continue to be systemic issues in maternity and neonatal services. 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. Most of the data in this report relate to England or the UK. For more detailed information on these systemic issues in Northern Ireland, Scotland and Northern Ireland please see the dedicated briefings.

In England, the CQC said that despite finding some good practice and reports of staff going “above and beyond” for those using maternity services, the overall picture was “one of a service and staff under huge pressure”, warning that many patients were still not receiving safe, high-quality care (20). The CQC has rated 10% of maternity services as “inadequate” overall, and a further 39% were rated as “requires improvement”.

The 2023 CQC survey of women and birthing people’s experience of care show that despite improvements since 2022, satisfaction with care has declined since pre-pandemic levels¹³ (14). Responses show that while most respondents have a positive experience (either “always” or “sometimes”) (see Figure 19), areas of concern remain. Particularly, listening to women and birthing people: 1 in 5 respondents felt their concerns during labour were not taken seriously.

Concerns regarding patient safety were also echoed in NHS England’s staff survey (see Figure 20). While over 75% of midwives agreed that their organisation would act on concerns raised by patients, only half were confident their organisation would act on their concerns. 2023 responses were more positive relative to 2022¹⁴, but further improvements are still required. For example, in 2022 58.6% of midwives would be happy with the standard of care provided by their organisation if their friend or relative needed treatment, which increased to 64.7% in 2023.

Although most respondents report a positive experience, there remain some areas of concern

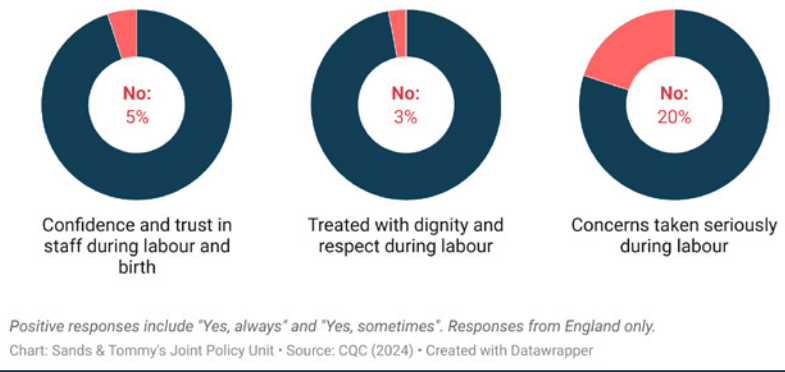


Figure 19. 2023 CQC maternity survey results for England

A greater proportion of midwives believed that their organisation would act on patients’ safety concerns compared to their own

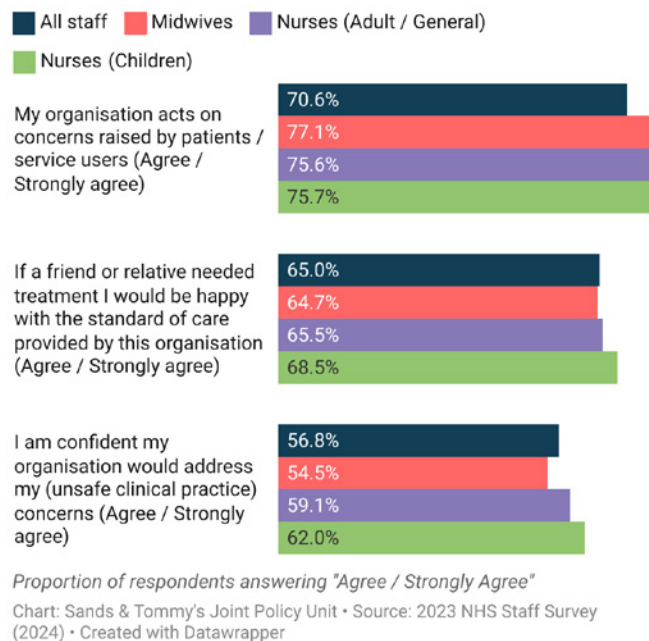


Figure 20. 2023 NHS England Staff survey results related to safety and quality of services

Calls for public inquiry into maternity services

Recently, there have been calls from bereaved parents for a public inquiry into maternity services. Concerns have been raised about the persistent safety and quality issues in maternity services, despite successive reviews and investigations into service failings.

This report makes it clear that systemic issues with maternity and neonatal services need to be addressed. More comprehensive and wide-ranging action is required from the government and the NHS than there has been to date. We need a response that matches the scale of the issue. We need to move from addressing issues in maternity services as if there are a few outliers that need support, towards a much more fundamental approach that puts in place the key elements of a safe system.

13. Of the 54 questions relating to satisfaction in the care provided (excluding operational questions related to place of birth, mode of birth or continuity of carer) with responses available for 2022 and 2023, the majority (74.1%) of questions showed a statistically significant improvement and only one question (1.9%) declined. Of the 42 comparable questions available for 2019 and 2023, 76.2% declined while 9.5% improved. Of the 23 comparable questions available for 2013 and 2023, 47.8% improved and 17.4% declined.

14. The response rate to the 2023 survey was 48%, up from 46% in 2022. Data in the report are weighted to adjust for differences in occupational group proportions between trusts and for differences in trusts. Registered Nurses and Midwives were the occupation group with the highest number of respondents (196,184 or 28.9 % of responses from staff at NHS trusts). Results are only weighted for occupational group and trust size. As with the CQC maternity survey, the NHS staff survey may be affected by bias, including response bias (where answers deviate from how the respondent actually feels) and non-response bias (where those who chose not to respond to the survey differ from those who do, for example having an English language barrier).

Staffing levels and training

Total staff in NHS England

By comparing average full-time equivalent (FTE) staff numbers for different health professional roles with the total deliveries in the same financial year, an increase in the staff to delivery ratio is visible across most groups in England (see Table 1).

2012-13	2022-23
1 midwife for every 33 deliveries	1 midwife for every 25 deliveries
1 maternity nurse for every 164 deliveries	1 maternity nurse for every 202 deliveries
1 obstetrician or gynaecologist for every 123 deliveries	1 obstetrician or gynaecologist for every 82 deliveries
1 neonatal nurse for every 187 deliveries	1 neonatal nurse for every 89 deliveries
1 nursing support staff (maternity) for every 105 deliveries	1 nursing support staff (maternity) for every 77 deliveries
1 health visitor for every 87 deliveries	1 health visitor for every 94 deliveries

Table 1. Comparison of FTE staff to delivery ratios in 2012-13 and 2022-13 in England, NHS Digital

In 2003, Birthrate Plus¹⁵ estimated that NHS England needs 1 clinical midwife for every 28 births. This ratio was updated in 2010 to 1:29 (21), suggesting fewer midwives are required due to changing patterns of care. More recent national estimates have not been provided by Birthrate Plus. A recent review highlighted the weak evidence base for Birthrate Plus and the need for more research to understand how the tool performs in the current context of midwifery practice (22). Anecdotal reports also suggest that improvement initiatives and reporting requirements have increased the time spent by frontline staff on administrative tasks which may affect their availability for patient care. This requires further exploration to substantiate but may have significant implications for staffing models.

Birthrate Plus is also limited to workforce planning for midwives. The Department of Health and Social Care (DHSC) commissioned the Royal College of Obstetricians and Gynaecologists (RCOG) to develop a planning tool to quantify the number of obstetricians required in maternity units in England. The RCOG has developed a prototype tool but the next phase of the project, including expanding it to Scotland and Wales, has not been confirmed by DHSC (23).

Over the past decade, the number of FTE midwives has increased per 10,000 deliveries in England (see Figure 21). After a 4.0% decline in FTE midwives per 10,000 deliveries in 2021-22, relative to 2020-21, there was a similar increase (4.5%) in 2022-23.

The number of FTE staff working across the NHS in England also increased among neonatal nurses, obstetricians and gynaecologists and nursing support staff in maternity services (see Figure 22). Although not all professional roles are disaggregated according to maternity or neonatal services, such as sonographers, managerial and operational staff, anaesthetists and pathologists, these data allow for some analysis of maternity and neonatal staffing levels.

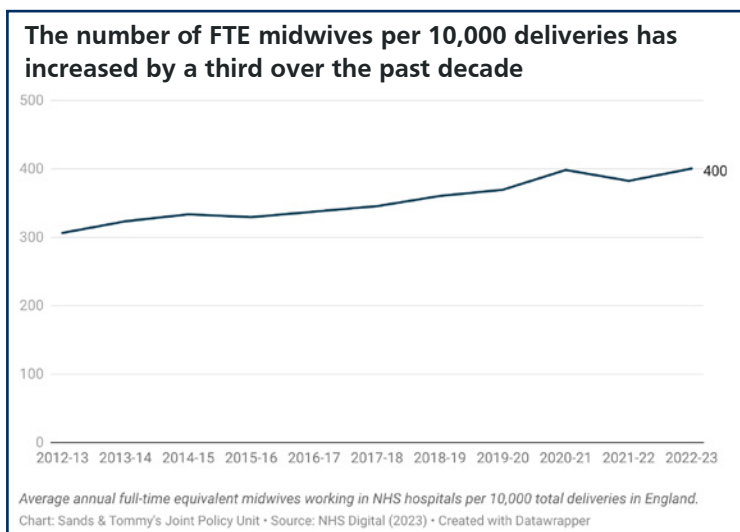


Figure 21. Average FTE midwives per 10,000 deliveries in NHS hospitals in England between 2012-13 and 2022-23.

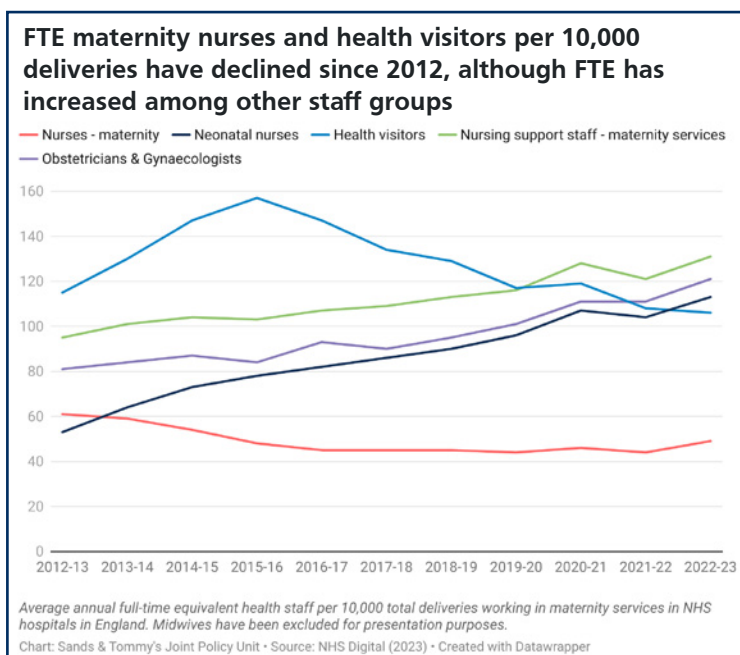


Figure 22. Average FTE across professional roles per 10,000 deliveries in NHS hospitals in England between 2012-13 and 2022-23.

15. Birthrate Plus is a workforce planning and decision-making system which assesses the needs of women for midwifery care throughout pregnancy, labour and the postnatal period, in hospital and community settings. The methodology calculates the number of midwives required based on defined standards and models of care, and incorporating local population needs. Birthrate Plus is used by individual maternity units for workforce planning and publishes a limited amount of national data. Responses to the survey differ from those who do, for example having an English language barrier).

Shortage of perinatal pathologists

One example of a specialism which is acutely affected by staffing shortages is perinatal pathology. The shortage has been building for many years and is leading to lengthy delays for post-mortem reports. 1 in 5 recently bereaved parents who were surveyed by Sands in 2023 reported waiting six months or longer for their babies' post-mortem results (24).

Providing timely post-mortems is critical to understand the cause of baby deaths. Delays can have a significant impact on parents' mental health and grief journey, as well as health professionals' and health services' ability to learn from deaths and take actions to prevent similar deaths in the future.

While these figures show a broadly positive trend in the maternity and neonatal workforce, progress is less positive when considering the total change in FTE staff, rather than staff relative to the number of deliveries, which has declined nearly 20% since 2012-13. Over the past decade, the overall FTE of professionally qualified clinical staff working in NHS hospitals in England has grown 23.1%, while the number of FTE midwives has only grown 6.6% and the number of FTE nurses in maternity has declined 34.0% (see Figure 23).

While the falling number of deliveries provides important context, it does not recognise the increasing complexity of deliveries and the staff time that they require. Data suggest that a greater proportion of women and birthing people are older, overweight, and more likely to have underlying health conditions and complex social needs than in the past (25). Total numbers also do not reflect changes in scope of practice for midwives over this period.

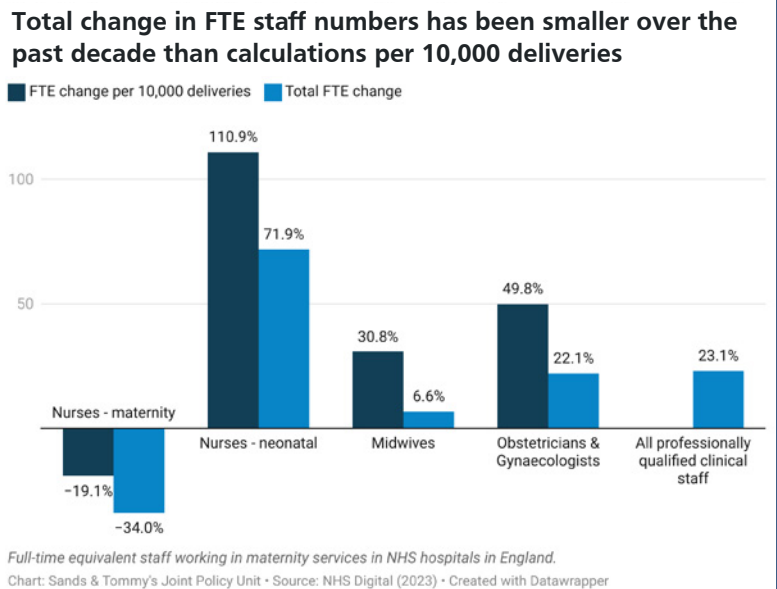


Figure 23. Percentage change in FTE staff per 10,000 deliveries and total FTE change between 2012-13 and 2022-23 in England

As outlined in our 2023 report, national statistics do not always reflect the reality on the ground for maternity and neonatal services. Staffing levels vary across regions and periods throughout the year. There is typically a surge in FTE staff in the autumn as students graduate from academic courses followed by a decline from December to August. This annual pattern may also reflect issues with the workforce skills mix, as more experienced staff leaving throughout the year are replaced by newly qualified midwives. Anecdotal evidence suggests that the profession has lost many experienced midwives but there are not good data on the experience levels of staff to guide policy and practice.

It is intuitive that understaffing could lead to worse patient outcomes, although evidence on this association in maternity is limited. A cross-sectional analysis of clinical incidents in maternity inpatient areas matched with inpatient staffing levels for three maternity services in England between April 2015 and February 2020 did find an association between the number of harmful incidents which are reported and the understaffing of registered midwives (26). Staffing was measured by Hours Per Patient Day and understaffing was determined based on average (mean) staffing levels for that service.

NHS England: Long Term Workforce Plan

NHS England published its Long Term Workforce Plan in June 2023 (27). This includes plans to grow the midwifery workforce by 31,000 – 33,000 midwives by 2036-37, an increase of 35% to 43% from the 2021-22 baseline.

Much of the detail and investment in the Plan relates to growing the workforce through training. However, comparing the target for new midwifery students with 2036-37 workforce projections indicates low rates of student retention, high rates of leavers from elsewhere in the midwifery workforce, or both. This raises questions about increasing student numbers before improving retention, and concerns about the skill and experience mix of the midwifery workforce. Poor staff retention may also affect the health system's ability to provide clinical placements and training for student midwives. Already, midwives joining the Nursing and Midwifery Council register are particularly likely to describe feeling pressured to undertake tasks they felt unprepared or inadequately supervised for because of staffing shortage (28).

Beyond midwives, the Plan does not include detailed modelling for maternity- and neonatal-related specialisms, such as obstetricians, neonatal nurses, or perinatal pathologists. And, while it recognises the importance of complementary professional groups such as health visitors and maternity support workers and nurses, limited details are provided. Further analysis is also required to identify which specialisms and geographies are facing the biggest shortages and to inform tailored strategies.

While the Plan offered a welcome commitment to growing the NHS workforce, more detail on implementation and long-term funding is required.

Recruitment

The NHS England Long Term Workforce Plan aims to increase the number of midwives in training by 13% in 2024-25 compared to 2021-22. However, the number of applicants to university midwifery courses has been in decline since 2021 (see Figure 24). Applications for the academic year 2023-24 were 26.1% lower for universities in England relative to 2021-22.

The current conversion rate of application to those accepting an offer to study midwifery, 38.6% over the past five years, suggests that NHS England may struggle to meet its midwifery training placement target of 4,269 places per year. In 2023, out of 8,090 applicants 43% (3,475 students) accepted their offer. If applicant numbers continue to decline, there is a risk that the selection criteria may be weakened to meet recruitment targets.

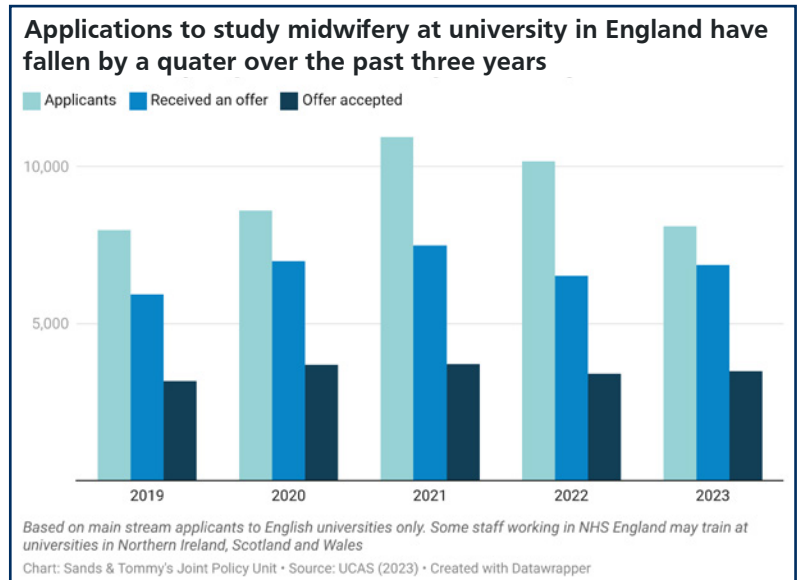


Figure 24. Number of applicants, offers received and offers accepted for midwifery courses at English universities, 2019-2023

The National Education and Training Survey by Health Education England found that most midwives in England (70.0%) in 2023 would recommend their placement for training (29). Despite this positive response, the survey also revealed that half of respondents (52.0%) were considering leaving their course in 2023, although this declined from 58.3% in 2022. Rota and staffing issues were the most given reason for student midwives in England to not recommend their placement (66.3%) followed by the impact on their health and wellbeing (50.4%) (29). Qualitative research with newly registered professionals across the UK found the majority felt adequately prepared upon qualification (28). However, some participants identified the following issues or gaps in their education:

- **Health inequalities:** while professionals were made aware of disparities, many felt they were not given adequate guidance on the implications for clinical practice and how they could better support these groups.
- **Practice placements:** experiences were varied, and some professionals struggled to find sufficient and diverse placements due to the pressure health and social care services were under. As a result, some midwives felt underprepared and overwhelmed when facing certain situations in their practice (e.g. emergencies).
- **Oversight of practice placements:** some examples of poor oversight, and in some instances cases of students being deployed inappropriately as substitutes for qualified professionals.
- **Support within placements:** some spoke about the lack of support from employers, other professionals or universities, which created a hostile or unwelcoming working environment. 71.0% of midwifery students responding to the National Education and Training Survey in 2023 said that staffing levels had negatively impacted their experience of clinical supervision (30).

Midwifery Degree Apprenticeships

The NHS England Long Term Workforce Plan aims for 5% of the annual intake for midwifery training to come through apprenticeship routes by 2028. An evaluation (31) of the Midwifery Degree Apprenticeship was positive and suggested that apprentices will help to boost workforce supply due to the extremely low drop-out rates, the ready transition of apprentices into work after qualification, and apprentices' continued contribution to service delivery while on the programme. The evaluation found no academic differences between apprentices and fee-paying students and suggests that apprenticeships may help to diversify the workforce, particularly by helping existing NHS maternity support workforce to become registered professionals.

Retention

The NHS staff survey¹⁶ for England highlights several key issues for retention, including stress and burnout, lack of work-life balance and dissatisfaction with pay. The 2023 results show an improvement across staff groups between 2022 and 2023, but midwives' responses continue to be worse than staff overall (see Figure 25). The survey showed that nearly two-thirds of midwives felt unwell over the past 12 months because of stress and only a quarter were satisfied with their level of pay.

These pressures are also reflected in data from staff leaving professional registers. Physical or mental health and burnout or exhaustion were the second and third most selected reasons for nurses and midwives who left the Nursing and Midwifery Council (NMC) register in 2022 (32).

The average sickness rates declined across NHS England in 2023 (4.8% until September 2023), compared to an average rate of 5.6% in 2022 (see Figure 26). Sickness absence rates among midwives remain second highest out of all professionally qualified staff, although the gap between midwives' absence rates and absence rates overall has declined. The sickness absence rate for midwives peaked in 2022 at an annual average of 7.0%, compared to 5.0% in 2019 and an estimated 5.5% in 2023¹⁷.

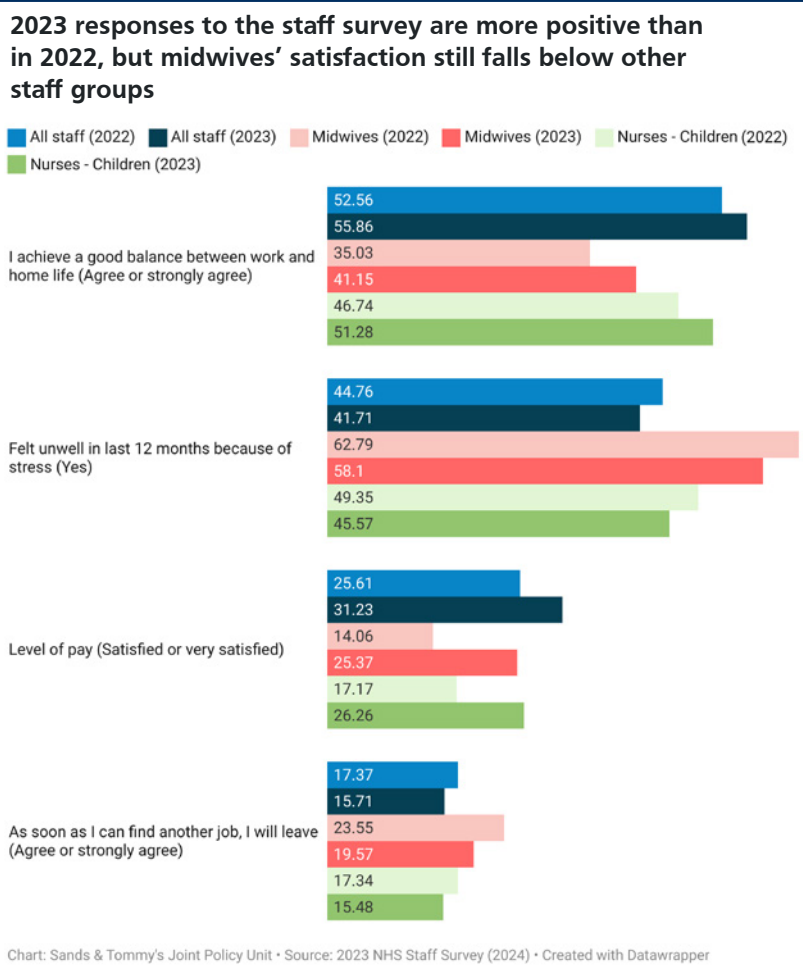


Figure 25. 2023 and 2022 NHS Staff survey responses based on wellbeing, satisfaction and plans to leave across select staff groups

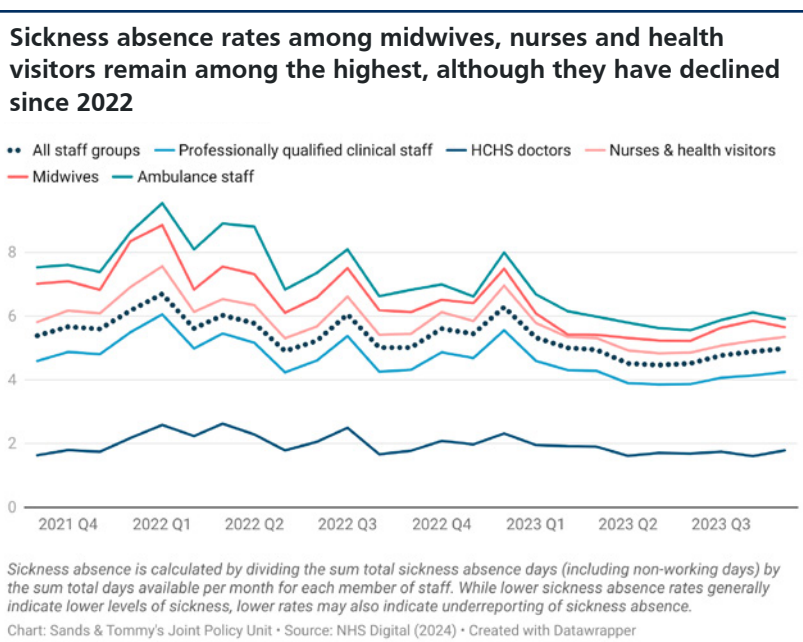


Figure 26. NHS England sickness absence rates among key staff groups, 2021 to 2023

16. For survey limitations please see p.20

17. Based on January – September 2023 data

Culture of safety within organisations

Safety culture has been consistently identified as an issue in reviews and investigations. Having a good safety culture enables staff to escalate concerns about clinical care whenever necessary, with clear protocols in place to support this. The Institute for Healthcare Improvement Framework outlines four cultural requirements for safe, reliable, and effective care: psychological safety, accountability, teamwork, and communication (33). In 2022-23, 15% of maternity services in England were rated as inadequate by the CQC for their safety (20).

Bullying and harassment undermines psychological safety for NHS employees and affects teamwork and communication. The 2022 NHS England staff survey results¹⁸ suggested that midwives experienced more bullying, harassment or abuse from managers and colleagues compared to staff overall. Bullying and harassment from other staff and members of the public are also more commonly experienced by staff from minoritised ethnic groups compared to White staff across the NHS (34).

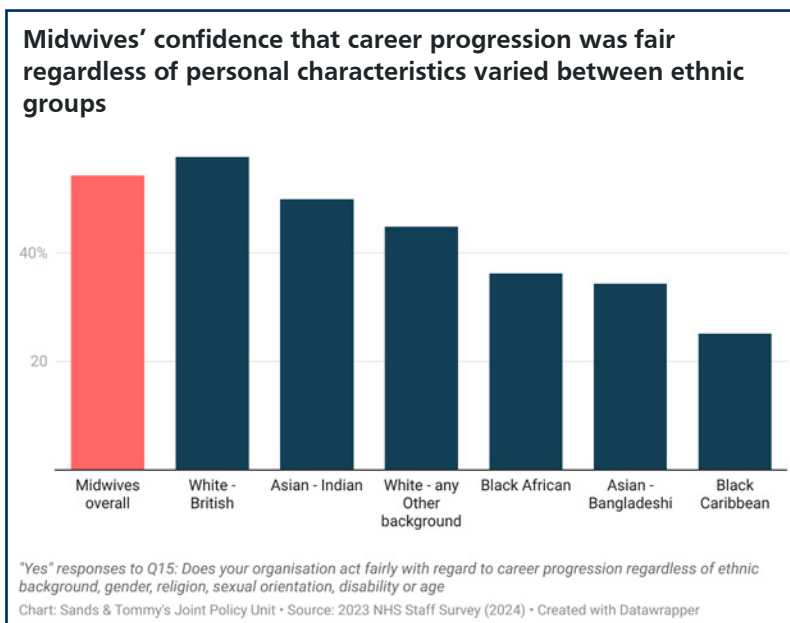


Figure 27. 2023 NHS staff survey results on career progression, disaggregated by selected ethnic groups

Staff survey results show that midwives from minoritised ethnic groups are less likely to believe that career progression is fair compared to White British midwives and midwives overall (see Figure 27).

In 2023, 76.0% of student midwives in England would recommend their training post location to friends and family if they needed treatment, an increase since 2022 (71.9%) but a longer-term decline since 87.6% in 2019 (30). Issues of bullying were also raised in the survey: a quarter of students experienced bullying or harassment by other staff while training, a decline from 29.0% in 2022 (see Figure 27). Of those who experienced bullying or harassment, only 14.7% reported it.

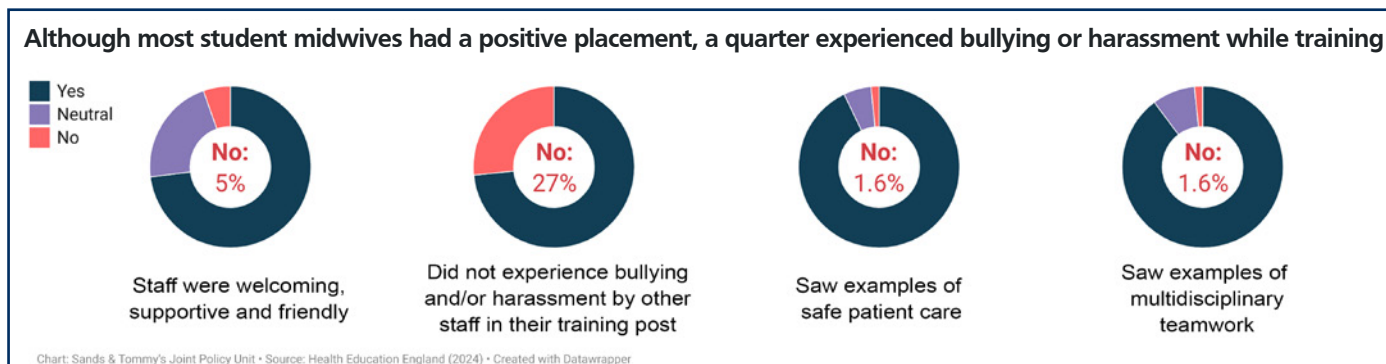


Figure 28. Health Education England survey of student midwives in England, 2023

Responses relating to examples of safe patient care and multidisciplinary work were more positive with nearly all respondents reporting seeing some examples. However, there is a limit to what this question can tell us: seeing examples is not the same as systematically embedding safe care and multidisciplinary teamwork.

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 (28). 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 elevated 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.

18. Due to data collection issues, 2023 NHS staff survey responses related to experience of bullying, harassment or abuse are not available.

Listening to parents and responding to their concerns is also a critical component of having a safe culture. NMC’s review of maternity cases across the UK between 2017 and 2020 found that professionals’ lack of empathy and compassion when communicating with members of the public was a recurring theme (28).

The 2023 CQC maternity survey for England found that most women and birthing people¹⁹ “always” felt listened to through their perinatal care, although the proportion was lowest for postnatal care (see Figure 29). Although the proportion of respondents who “always” felt listened to increased in 2023, it has declined across all areas of care since 2019.

Responses were more positive for being spoken to in a way they could understand, with 88% reporting “always” being spoken to in a way they could understand during antenatal care and 87% during labour and birth.

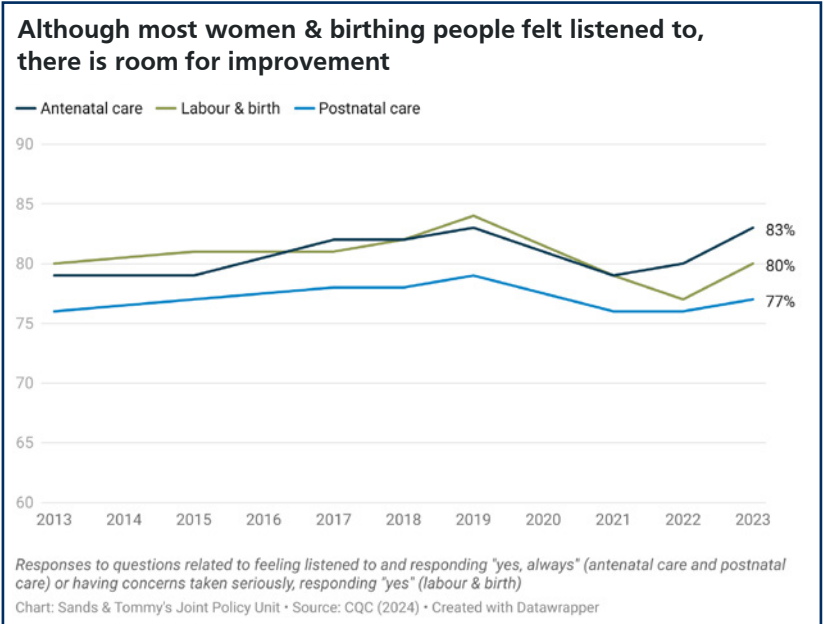


Figure 29. Proportion of 2023 CQC maternity survey respondents who felt listened to.

Organisational leadership

An open learning culture should run from board-to-ward level and requires curious leaders who are problem-sensing rather than comfort seeking (35). However, the CQC rated 12% of maternity services in England as inadequate for being well-led in 2022-23 (20). Although the programme of inspections highlighted some good practice, including at board level, leadership remains an area of concern, with the quality of leadership varying between trusts.

Effective leadership and governance require three components (see Figure 30). Data and intelligence are intricately linked to other systemic issues outlined in this section, including availability and analysis of data, listening to parents and families, and creating a culture which enables staff to escalate safety concerns whenever necessary.

Data & intelligence	Robust & candid review process	Early action to address concerns
Relevance & coverage of metrics	Scrutiny of data and intelligence	Request for further information
Quality and accuracy of data	Problem-sensing	Mitigation actions agreed
Breadth of intelligence	Interest in safety & quality of care, workplace culture and staffing	Action plans monitored
Presentation & analysis	Safety champions at board level	

Figure 30. Building blocks for board oversight of quality and safety of maternity and neonatal services

The CQC also identified challenging working relationships between service level managers, neonatal, midwifery and obstetric leaders. The three year delivery plan for maternity and neonatal services in England includes a commitment that all neonatal, obstetric, midwifery and operational leads will be offered a place on the perinatal culture and leadership programme. As of October 2023, 98 perinatal leadership teams (out of 152 maternity and neonatal sites in England) had started the programme (36). NHS England aims for all trusts to be enrolled by November 2023, with all 152 sites completing the programme by September 2024. An evaluation of the leadership programme has been commissioned, which should focus on the impact that the programme has had on leadership, culture, and behaviours, as well as evaluating its implementation.

19. With the exception of bereaved women and birthing people who are not currently included in the CQC maternity survey.

The 2023 NHS England staff survey showed midwives often had a more positive view of reporting safety concerns and the subsequent actions that are taken by their organisation compared to NHS staff overall (see Figure 31). While this shows some positive findings, it is concerning that 25% of midwives do not feel secure raising concerns about unsafe clinical practice.

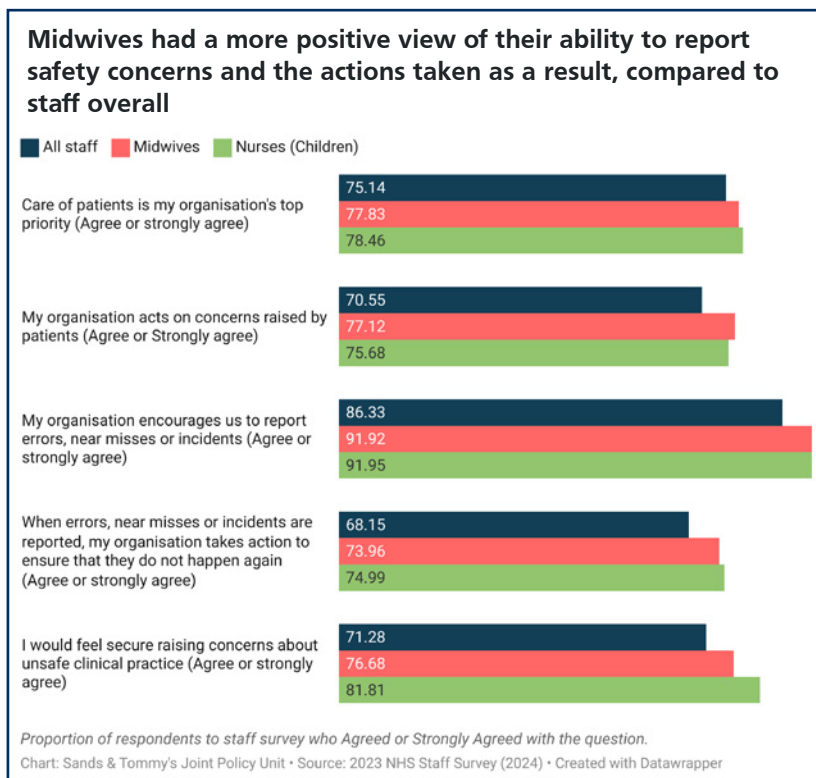


Figure 31. 2023 NHS England staff survey responses related to reporting safety concerns

Board oversight of the quality and safety of maternity and neonatal services

Trust boards' regular oversight of the quality and safety of maternity and neonatal services has been the subject of successive inquiries and reviews. The Sands & Tommy's Joint Policy Unit reviewed publicly available board papers and minutes for seven NHS Trusts in England to analyse whether the information presented to boards, the process for review and actions taken enabled boards to deliver on this responsibility. In November 2023, we published [a briefing](#) with our findings alongside a [blog in the Health Service Journal](#).

Our findings raised questions about boards' ability to have a full understanding of the performance of maternity and neonatal units under their direction under the current system.

Our review has highlighted the need for:

- Further guidance on the minimum metrics to be submitted to boards, including any new measures identified by the Maternity and Neonatal Outcomes Group to provide an early warning of service quality and safety declining;
- Better ward-to-board communication to contextualise data, including more analysis from Clinical Service Leaders to interpret metrics and more board member engagement with wards and staff;
- Reports which reflect on and contextualise metrics and trends over a longer period in addition to regular service monitoring dashboards;
- A review of current systems and processes in each Trust and whether they allow boards to have meaningful oversight over the quality and safety of services;
- Transparent reporting of issues discussed outside of public board meetings, such as at sub-committee-level;
- A review of whether the Maternity Incentive Scheme prioritises financial certainty and reputation management over a culture of learning and improvement;
- Clarity over the role of Local Maternity and Neonatal Systems in oversight of quality and safety and the implications for Trust boards' responsibilities.

While our findings relate to Trusts in England, other reports suggest that there is an opportunity for all the devolved health services to review and improve board oversight processes.

Personalisation of care and choice

Personalisation of care and choice is based on the principle that all women and birthing people should be able to make choices about their perinatal care based on full, impartial information about the different options. This requires developing an understanding of the individual's needs and circumstances, involving them in decisions about their care, and having the operational capacity to deliver a range of choices.

The CQC maternity survey in England found that 1 in 10 respondents felt that staff did not know their medical history during antenatal care, labour, and birth (see Figure 32). This proportion was higher for postnatal care, although this may be partially explained by the binary "Yes/No" response options for this question.

While few women and birthing people never felt involved in decisions related to their care, around a quarter only sometimes felt involved (see Figure 33). Having enough information to decide where to have their baby was a particular issue highlighted by the CQC maternity survey.

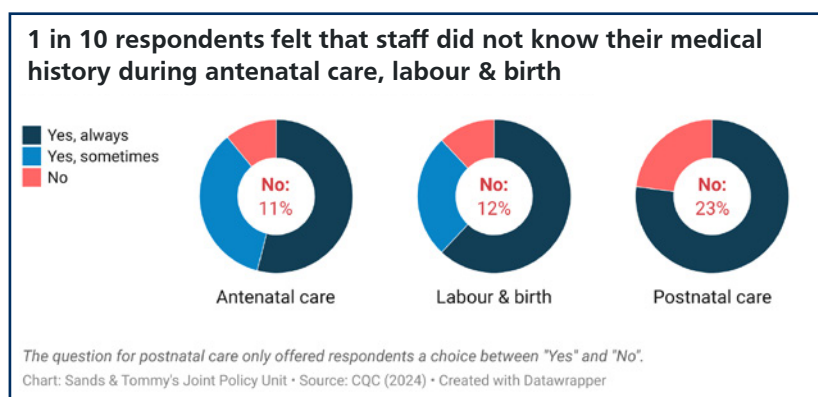


Figure 32. 2023 CQC maternity survey responses related to doctors and midwives' knowledge of medical history

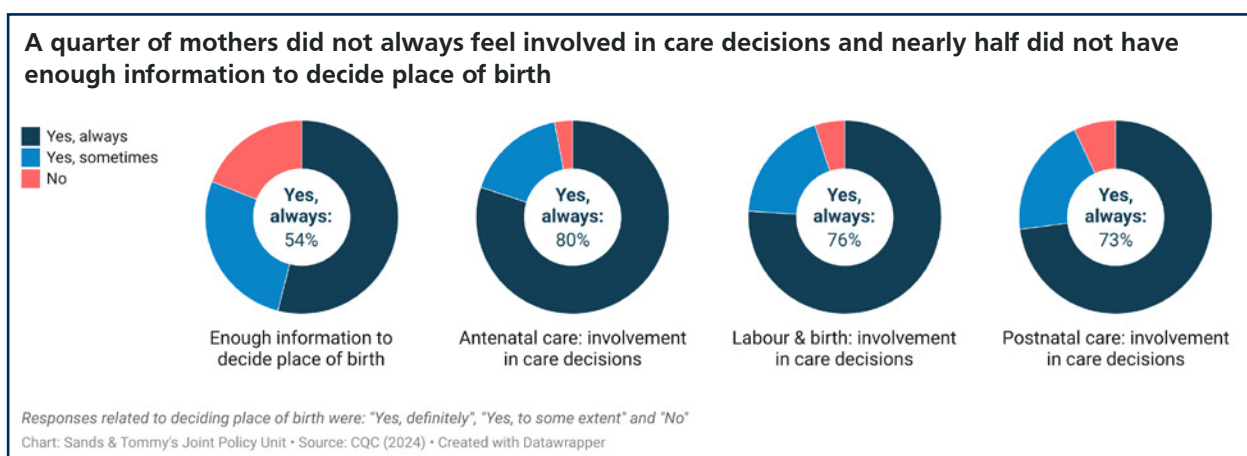


Figure 33. 2023 CQC maternity survey responses related to involvement in care decisions

NIHR has tendered a programme of work to develop a patient-reported experience measure to help trusts and LMNSs monitor and improve personalised care (36). NHS England is also developing a new neonatal service users survey to listen to and work with families whose babies have spent time in neonatal units.

Data collection

Good quality, routine data are needed to identify variations between maternity and neonatal units and among different patient groups, and to inform improvements. One of the key areas for NHS action following the independent investigation of services in East Kent Trust was the need for more effective monitoring of maternity service performance to identify poorly performing units (37). A Maternity and Neonatal Outcomes Group was established to develop an early warning surveillance tool using more timely outcome data to identify potential issues earlier for trust boards to act on, as well as identify services needed support. The group was due to present recommendations in the autumn of 2023, with the aim of having an operational tool by the end of 2024 (36). At the time of publication, no further updates were available.

To achieve their intended impact, any metrics must be linked to an effective system of support so that early warning signs are used to trigger effective action to improve the safety of services.

Improving the quality of routine data collection will also be essential to underpin national analysis. As outlined in Chapter 3, this must include increasing completeness and accuracy of ethnicity data and improved data on social risk factors. The Professional Record Standards Body ran a consultation on the standard for maternity care records in England in early 2024. The standards are focused on supporting frontline, personalised care for women and birthing people but an agreed national standard also enables national and local analysis of health trends. Although not yet confirmed, the draft updated standards include more detailed data collection on social risk factors.

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, reviews and investigations can inform service delivery to prevent avoidable deaths in the future. The Perinatal Mortality Review Tool (PMRT) has been developed to standardise the review of perinatal deaths across the UK and create action plans for improvement.

Action plans are rated by PMRT as “weak”, “intermediate”, or “strong”. “Strong” action plans focus on system level changes rather than relying on individuals to choose the correct action. While the proportion of “weak” action plans has declined over time across the UK, this has led to an increase in “intermediate” action plans rather than “strong” (see Figure 34).

The reviews consider whether issues with the provision of care may have contributed to late miscarriage, stillbirth, or neonatal death (summarised as “the outcome” by PMRT). Across the UK in 2022-23, 1 in 5 reviews identified at least one issue with care which may have made a difference to the outcome for the baby. This equates to over 800 babies’ lives that could have been saved with better care.

Since the PMRT was established in 2018-19, reviews have identified an increasing proportion of issues with care which could have contributed to the outcome (see Figure 35).

However, it is not clear whether this increase is due to worsening care or improvement in the quality of PMRT reviews. Since PMRT’s launch, some metrics of review quality have improved, including the composition of review teams which are now more multi-disciplinary than ever (see Figure 36). There have also been improvements in ensuring that relevant members of staff are available for reviews, such as neonatologists and neonatal nurses for reviews of neonatal deaths. Despite national improvements, targeted inspections (4) have found significant variation in the quality of local reviews suggesting ongoing work is required to ensure PMRT reviews are carried out at a consistent quality.

Two-thirds of PMRT panels included an external member in 2022-23 which is essential to provide “fresh eyes” and ensure a robust review. 22% of reviews with an external panellist found issues with care which may have or were likely to have affected the outcome (Grades C and D), compared to 19% of reviews without an external panellist.

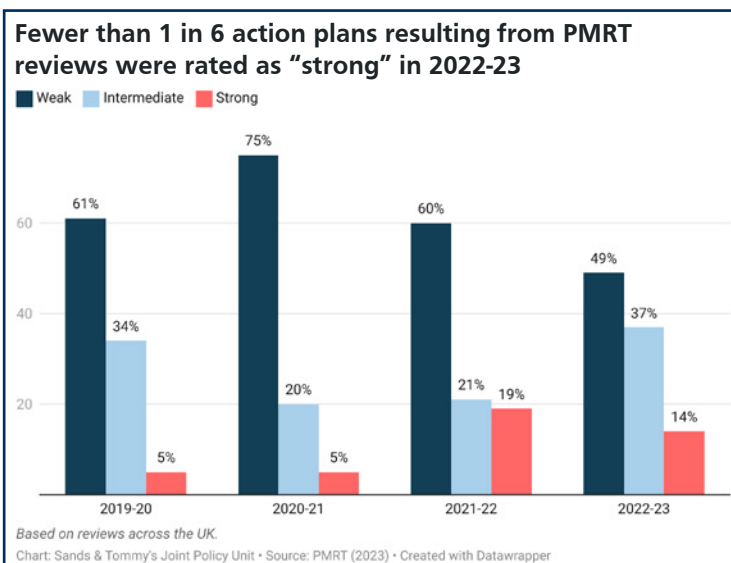


Figure 34. Proportion of action plans rated “weak”, “intermediate” and “strong” between 2019-20 and 2022-23 across the UK

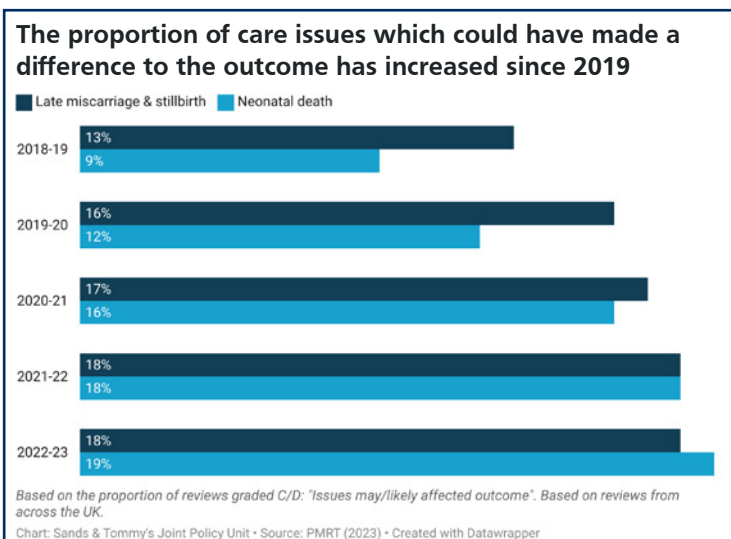


Figure 35. The proportion of PMRT reviews across the UK where better care may have prevented late miscarriage & stillbirth or neonatal death between 2018-19 and 2022-23

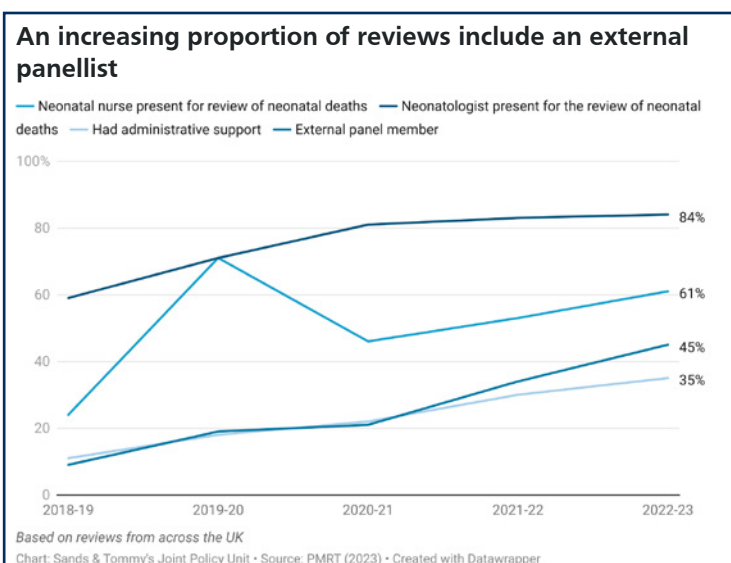


Figure 36. Changing metrics of review quality between 2018-19 and 2022-23 across the UK.

Listening to parents' perspectives and questions is an essential part of a good quality review. Despite ongoing progress to increase the proportion of reviews where parents' perspectives are sought, there has been a decline in the proportion of reviews with comments from parents (see Figure 37). Sands' research from 2021 found that some parents experienced poor communication, delays, and explanations about their baby's death which still lacked clarity and compassion (38).

To be able to ask questions, parents need support to understand the review and should be given multiple opportunities to ask questions. One in five of the parents surveyed by Sands did not understand what the review entailed, which limited their ability to engage with the process. 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 (8,9).

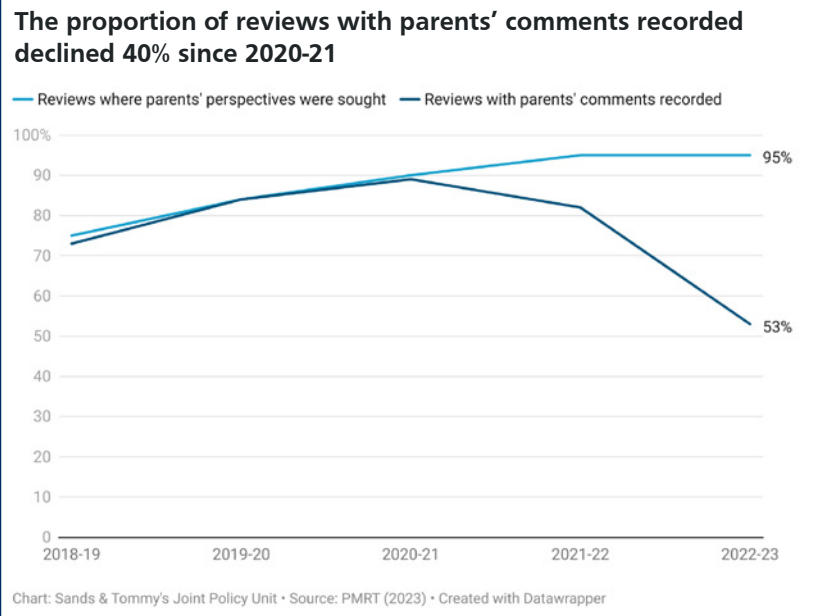


Figure 37. Proportion of reviews where parents' perspectives were sought, and comments recorded, between 2018-29 and 2022-23

Delivering care in line with nationally agreed standards

Too often avoidable losses continue to occur because of care that is not in line with recommendations in NICE (National Institute for Health and Care Excellence) and other nationally agreed standards (such as the Saving Babies' Lives Care Bundle). There is also a lack of comprehensive data on the implementation of national standards and guidance.

This section explores some variations in standards of care across the perinatal period.

Antenatal care

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 (39). Approximately two-thirds of deliveries meet this recommendation in England; however, in the most recent data the proportion of first antenatal appointments taking place at 10 weeks' gestation or earlier declined to 61.6% (see figure 38).

Late booking or not having booked at all was the most identified issue with pre-conception and antenatal care across the UK, identified in 27% of PMRT reviews (40).

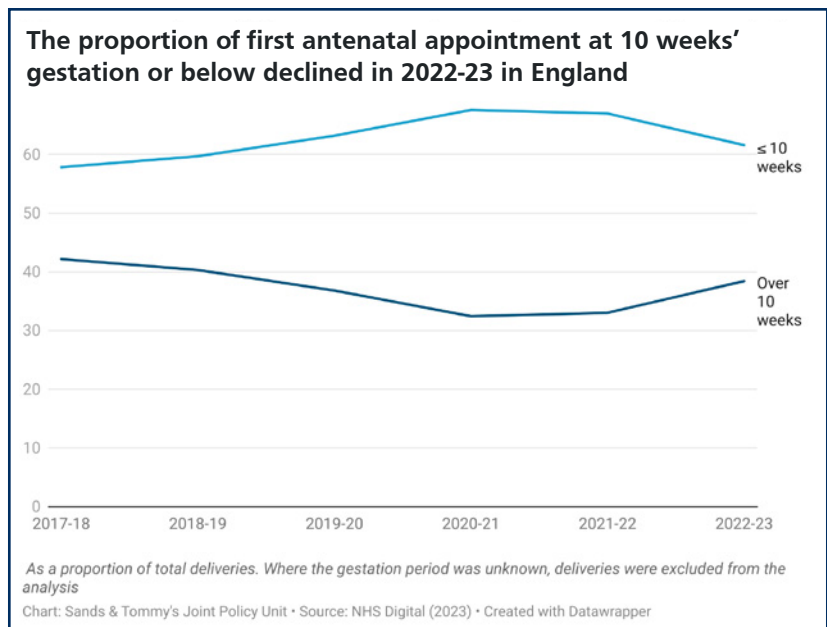


Figure 38. First antenatal appointments at 10 weeks' gestation or under and at over 10 weeks, as a proportion of total deliveries in England between 2017-18 and 2022-23

Results from the 2023 CQC maternity survey in England show that while most reported broadly positive perceptions of antenatal care, this was not always the case (see Figure 39).

Women and birthing people at risk of preterm birth should be identified in a timely manner through antenatal care in order to provide the recommended intervention prior to birth, including: a full course of antenatal steroids in the week prior to birth, antenatal magnesium sulphate within 24 hours before birth, and ensuring that singleton infants less than 27 weeks' gestation are born in a maternity service on the same site as a neonatal intensive care unit (NICU) (41). However, 1 in 5 eligible preterm babies were not born in a centre with a NICU in Great Britain and half of mothers did not receive a full course of antenatal steroids (see Figure 40). There was also unacceptable variation in the level of compliance with these recommendations between neonatal networks (see Figure 42).

Labour and birth

The five most common issues during labour and birth identified by PMRT reviews across the UK which were relevant to the pregnancy outcome²⁰ were: fetal monitoring in labour (3%), inappropriate setting / location of birth (3%), staffing issues (2%), assessment of maternal risk status (2%) and maternal monitoring in labour (2%). Some of the issues highlighted by PMRT reviews echo concerns with antenatal care raised by the CQC maternity survey in England. For example, although inappropriate setting or location of birth was one of the five most common issues during labour and birth, only 54% of respondents had enough information to decide the place of birth.

While the survey found that most respondents had a broadly positive experience during labour and birth, 1 in 5 did not always feel listened to or have confidence in staff (see Figure 41).

Challenges with triage processes have been identified as a key issue by the CQC following their national programme of inspections of maternity units in England (42). This means that the right care is not always being given in a timely and appropriate way. Experience of triage and the advice provided to patients is an area the Joint Policy Unit is currently exploring in more detail.

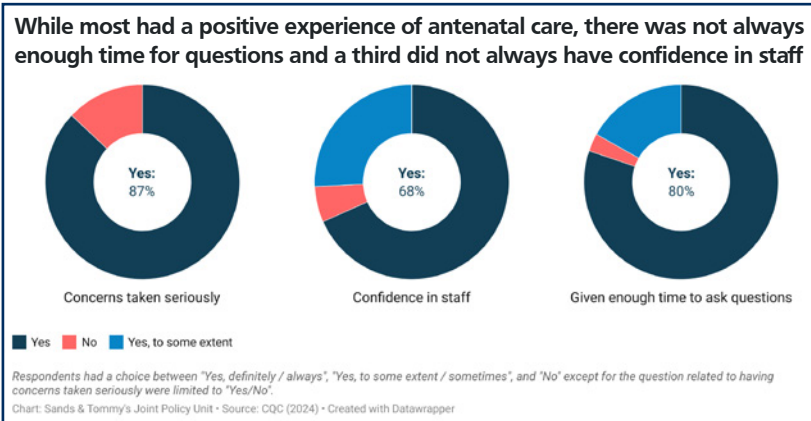


Figure 39. 2023 CQC maternity survey responses related to antenatal care in England

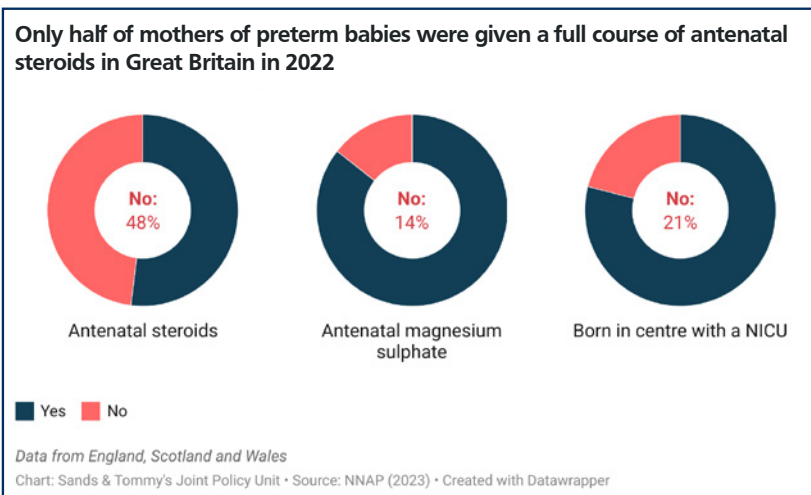


Figure 40. Proportion of mothers of preterm babies receiving optimal perinatal care in the Great Britain

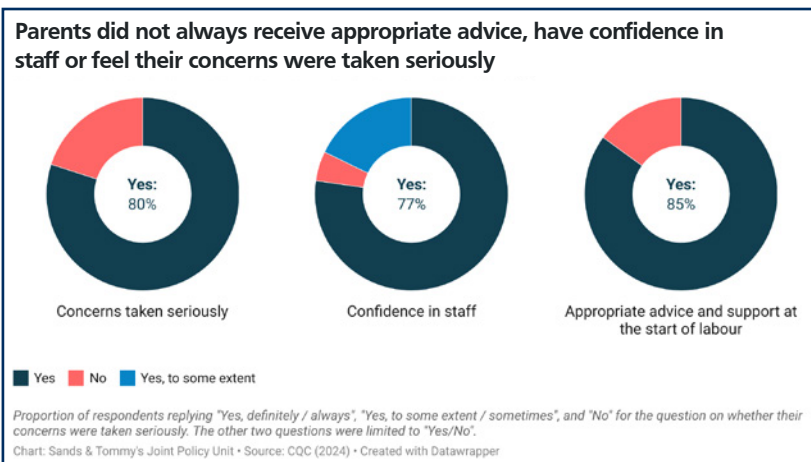


Figure 41. 2023 CQC Maternity survey results in England related to interactions with health care professionals

20. Late miscarriage, stillbirth or neonatal death

Neonatal care

Data from the National Neonatal Audit Programme (NNAP) show overall improvement in the proportion of babies receiving optimal care in England, Scotland, and Wales, across six key measures. However, comparing the proportion of eligible²¹ babies receiving optimal care across neonatal networks shows unacceptable variation (see Figure 42). NICE guidelines recommend delaying cord clamping until at least 60 seconds, unless there are specific maternal or neonatal conditions that require earlier clamping (43). In 2022, the rate of delayed cord clamping was a third higher among the neonatal network with the highest rate, compared to the lowest.

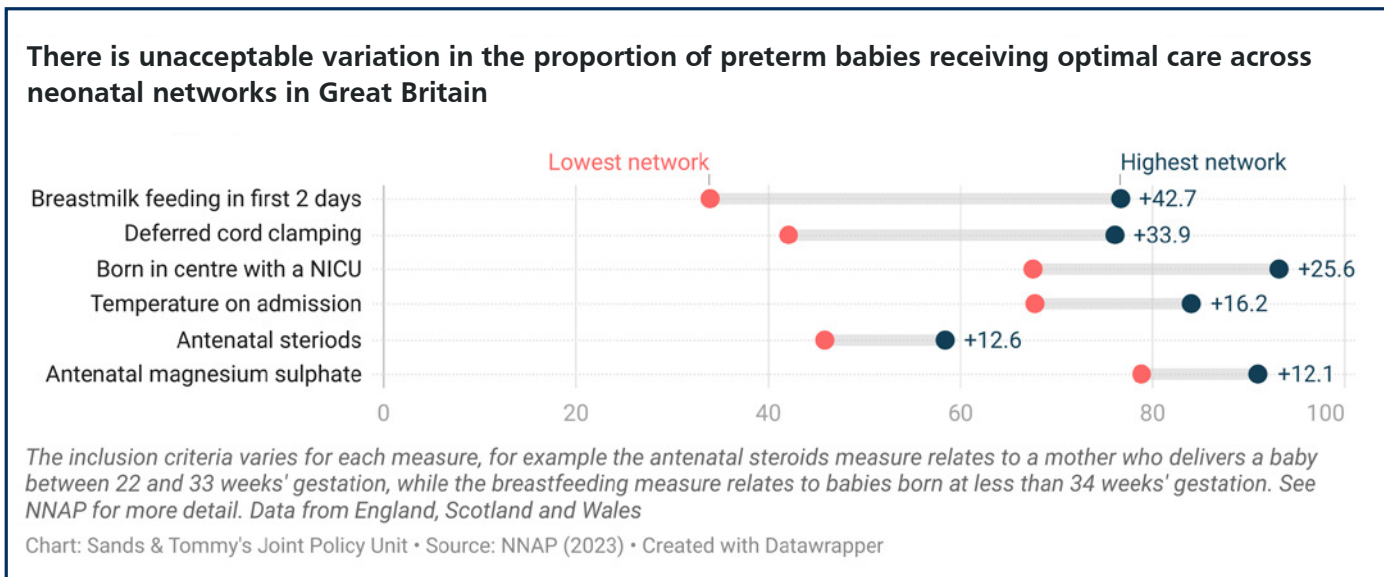


Figure 42. Variation in optimal perinatal care across neonatal networks in Great Britain, 2022

21. Eligibility based on gestation age varies for each NNAP measure. Please see [NNAP website](#) for more information.

Funding for maternity and neonatal services in England

The DHSC and NHS England have repeatedly highlighted the additional investment of £165 million per year to improve maternity and neonatal care in England²² since 2021. This investment will rise to an additional £186m per year from 2024-25. This investment consists of:

- £108 million to support increases in the frontline maternity and neonatal workforce.
- £21 million allocated to LMNSs to support further workforce commitments including: bereavement care, midwifery retention leads, preceptorship support, maternity support workers, and time for obstetric leadership.
- £36 million to LMNSs to support a range of projects including independent senior advocates, a culture and leadership programme, and improving staff retention.

In the 2024 Spring Budget, the government announced a further investment of £35 million over three years to improve maternity safety across England. There is a lack of detail and transparency about how these amounts relate to changes in overall spending on maternity and neonatal services.

Our analysis suggests that these amounts are insufficient to keep track with inflation and far below the scale required to achieve the transformative improvements that are required in maternity and neonatal services. Following a freedom of information request, NHS England provided the data which showed that in 2021-22 approximately £5 billion was spent on maternity and neonatal services (see Table 2).

Services	2021-22
	£m
Obstetric Services	3,372
Midwifery Services	679
Neonatal Critical Care	926
TOTAL	4,977

Source: NHS England, via Freedom of Information request. Based on trust submissions to the reference costs collection under the maternity, midwifery, and neonatal critical care specialty codes.

Table 2. NHS England spending on maternity and neonatal services, 2018-19 to 2021-22

Based on a spend of £5 billion on maternity and neonatal services in 2021-22, annual spending on maternity and neonatal services in England should have risen by over £450m in 2022-23 and almost £1 billion in 2023-24, just to keep track with inflation (see Figure 43). Without this, services face real terms budget cuts to keep delivering the same level of service, let alone making the improvements that are required.

In 2021 the Health and Social Care Committee recommended an additional increase in annual funding for maternity services by £250-£300 million – highlighting at the time that this was the minimum increase needed to ensure safe care (44). These figures suggest that, given the high rate of inflation since then, even this is now likely to be inadequate to achieve the transformative change that is required in these services.

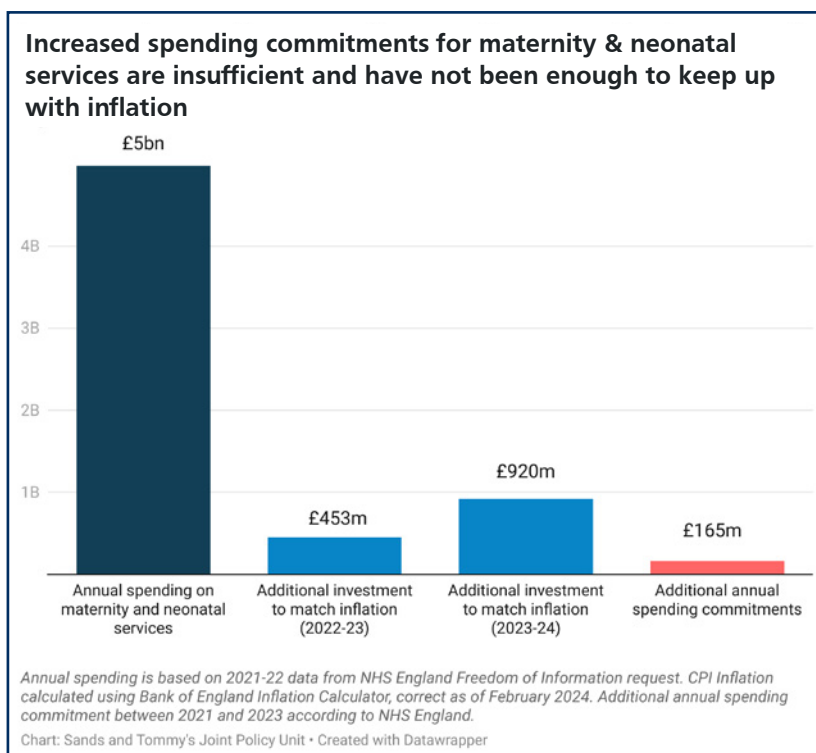


Figure 43. Additional investment required to match inflation, compared to annual spending increase

22. We are in the process of evaluating funding for these services across all the devolved nations, but currently data are only available for England.



5. Research and evaluation are vital for improving outcomes in the future

Chapter summary

- To achieve the national ambitions and improve the safety of services more research is needed.
- The proportion of public and charity funding for health-related research which is spent on reproductive health and childbirth has stagnated at around 2%, although the latest data show an increase in funding overall.
- Joint Policy Unit analysis suggests that research related to saving babies' lives accounts for over half of research spending on the reproductive health and childbirth health category.
- The government has recently announced a £50 million NIHR Challenge for research into maternity inequalities, which is a significant uplift from the amount that has been spent on this area of research over the past decade.



What needs to change

- While total funding appears to be increasing for research related to saving babies' lives, it remains a small portion of health research funding overall. There is still a lot we do not know, and more research is still required to meet ambitions to tackle pregnancy loss and baby deaths.
- The targeted NIHR Challenge Fund, focused on reducing maternity disparities, is a welcome investment in a previously under-funded area of research. Alongside this, additional funding for fundamental research is still needed to better understand the causes of pregnancy and baby loss.
- As well as funding, improvements to the research environment are needed to increase under-served groups and health professionals' participation in research, and bridge the gap between research, practice, and policy.
- NIHR Challenge must deliver on its objectives to bring together stakeholders from diverse specialisms as well as supporting early- and mid-career researchers. This could offer a step change in the development of the wider research environment related to saving babies' lives.
- The NIHR Challenge must form part of a wider programme of work to tackle inequalities, including funding to deliver existing research recommendations, improving routine data, and cross-government initiatives to tackle wider health inequalities.

Research is key to improving outcomes and saving more babies' lives in the future, yet 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 (see Figure 44).

Joint Policy Unit analysis of the UK Clinical Research Collaboration dataset has found that research related to saving babies' lives²³ accounted for over half (55.7%) of reproductive health and childbirth research funding, an increase from 46.2% in 2018 (See Figure 45).

Beyond funding, the strength of the research environment is determined by research expertise, specialist facilities, and the workforce; including the culture and behaviours which they demonstrate (45). A strong environment for research related to pregnancy loss and baby deaths 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 connection with policy and practice.

Clinical Academics and Clinical Research Midwives and Nurses play a vital role in embedding research while continuing to provide care. There is evidence to suggest that research active organisations have lower mortality rates and improved Care Quality Commission ratings (46,47). Possible reasons for improvements include increased collaboration between organisations, teams, and individuals; changes to institutional structures and organisational culture; and increased staff knowledge and skills. This suggests that research-active hospitals implement research findings more quickly and easily, and clinicians are more likely to adopt evidence-based practice (46).

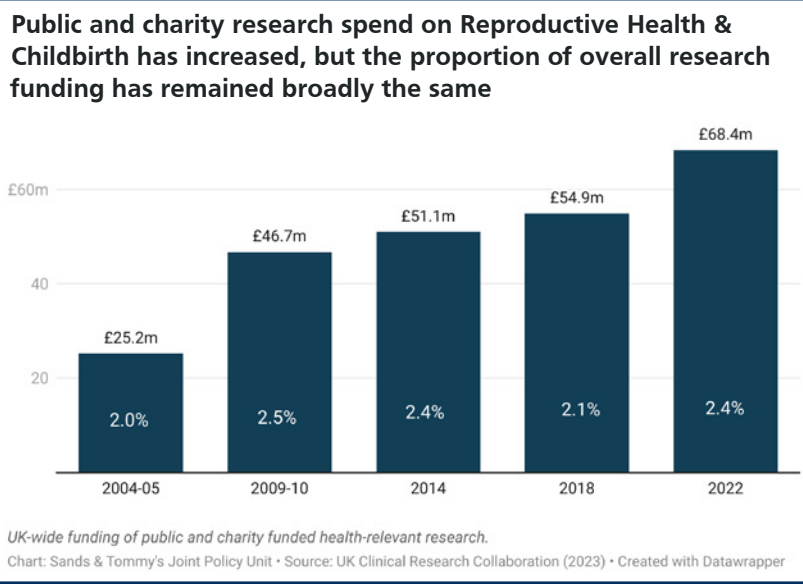


Figure 44. Public and charity research funding for Reproductive Health and Childbirth between 2004 and 2022, total and as a percentage of overall research funding

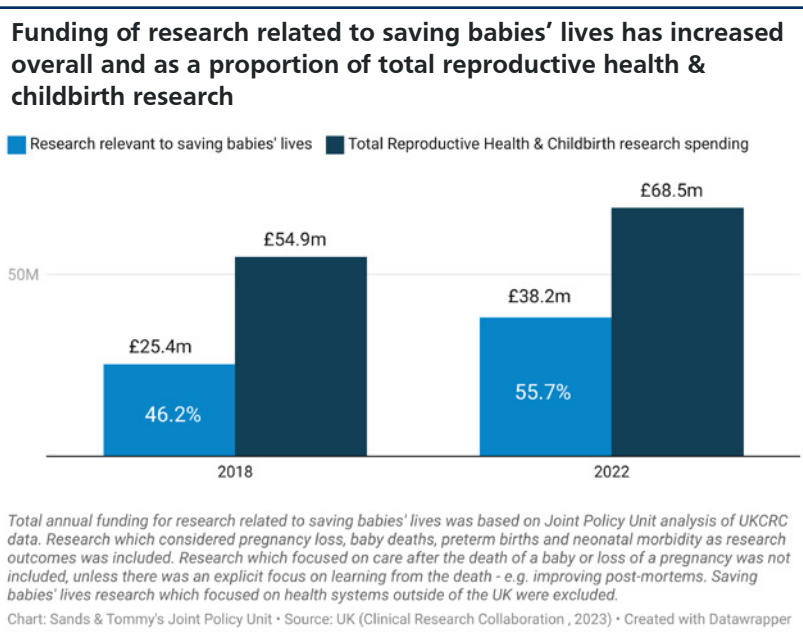


Figure 45. 2018 and 2022 public and charity research funding for research related to saving babies' lives and reproductive health and childbirth

23. Research which considered pregnancy loss, baby deaths, preterm births and neonatal morbidity as research outcomes was included. Research which focused on care after the death of a baby or loss of a pregnancy was not included, unless there was an explicit focus on learning from the death - e.g. improving post-mortems. Studies related to saving babies' lives which focused on health systems outside of the UK were excluded.

However, available data suggests that 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 (48) and the number of FTE obstetricians and gynaecologists working as clinical academics has declined over the past decade (see Figure 46). Although not the only specialism to decline during this period (40% of 16 specialisms also declined), a declining workforce of clinical academics may impact future research capacity in this field.

In 2023, the Sands and Tommy’s Joint Policy Unit surveyed researchers in the UK who considered pregnancy loss and baby deaths as part of their work, either directly or indirectly. We found that, although most researchers had a broadly positive view of the research environment, 1 in 5 thought it was “somewhat unsupportive” or “unsupportive”.

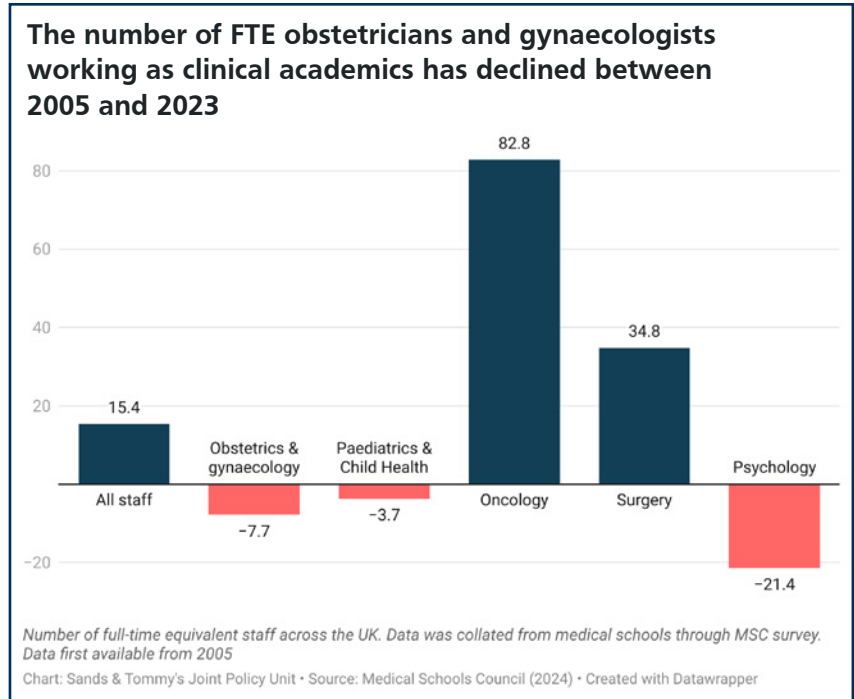


Figure 46. Change in the number of FTE clinical academics across specialisms in the UK, between 2005 and 2023

Despite this broadly positive view, our research did highlight key priorities to improve the research environment:

- More funding for diverse research projects (including a range of research topics, academic disciplines, and sizes);
- Improving working conditions and job security for all researchers;
- Ensuring that health care professionals have the capacity and capability to incorporate research into their role;
- Increasing under-served groups’ participation in research design, delivery, and interpretation;
- Improving the diversity of the research workforce; and
- Bridging the gap between research and policy.

The Joint Policy Unit will continue to explore ways in which to support the development of an improved research environment.

Funding research into health inequalities

In January 2024, the government announced a new £50 million Fund, NIHR Challenge, for research into maternity inequalities. Joint Policy Unit analysis of UK Clinical Research collaboration data found that £1.9 million was spent on research which included an explicit focus on inequalities in the UK in 2018 (8.0% of research funding related to saving babies’ lives in the UK), which increased to £4.1 million in 2022 (10.1% of funding) (49). Previous analysis showed that inequalities received £2 million between 2013 and 2017 (50). In this context, the £50 million NIHR Challenge is a significant uplift in the amount of funding available for research into maternity inequalities.

While welcome, this funding must form part of a comprehensive strategy to tackle inequalities, including funding to deliver existing research recommendations, improving routine data, and cross-government initiatives to tackle wider health inequalities.

The NIHR Challenge (51) aims to:

- Bring together a diverse consortium membership to increase the evidence base and develop the next generation of researchers;
- Determine priority topics within maternity inequalities;
- Undertake large scale transformative projects which drive measurable improvements;
- Provide strategic leadership for the development of maternity inequalities in research;
- Ensure research with the greatest impact is prioritised;
- Increase the representation of currently under-represented disciplines in maternity research; and
- Build research capacity.

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