Department of Health & Social Care

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Cherilyn Mackrory MP and Jeremy Hunt MP

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Dear Cherilyn and Jeremy,

Thank you for your correspondence of 8 September about baby loss prevention and data reporting. I apologise for the long delay in replying, which has been caused by an unprecedented volume of correspondence in recent months.

It was a pleasure to attend the APPG on Baby Loss meeting on 27 January last year and to discuss the key areas relating to baby loss prevention and support for the families. I would like to congratulate you in taking over the role of co-chairs of the APPG.

The data shows that maternity safety outcomes have improved since 2015, at a time of increasing complexity and risk factors in the maternal population – for example, increasing maternal age, obesity and pre-existing co-morbidities. Women are also reporting improvements in their experiences of maternity care.

The outcomes data shows that maternity and neonatal services are making clear progress to achieve the Maternity Safety Ambition for a 20 per cent reduction in these outcomes by 2020 and a 50 per cent reduction by 2025.

The stillbirth rate has fallen from 5.1 per 1,000 births in 2010 to 3.8 per 1,000 births in 2019. This represents a 25 per cent reduction in the stillbirth rate and is ahead of target to meet the 2020 ambition and on track to meet the 2025 ambition.

The neonatal mortality rate for babies born at 24 or more weeks' gestation shows a 29 per cent reduction, from 2.0 deaths per 1,000 live births in 2010 to 1.4 deaths per 1,000 live births in 2019. This represents significant progress, ahead of the 2020 ambition and on track to meet the 2025 ambition.

Maternal mortality is a rare occurrence in the UK. Data from the annual MBRRACE-UK confidential enquiries in maternal death and morbidity reports are used to monitor this ambition. Because the numbers are small, maternal mortality rates are presented triennially rather than annually. For the purposes of monitoring progress with achieving the national ambition, data for the mid-point of the triennial is used, so the baseline for the maternal mortality rate is 2009-11[1].

[1] MBRRACE-UK cautions that the decrease in the rates from 2009-11 to 2011-2014 is not statistically significant and, for this reason, achieving the aspiration to halve the maternal mortality rate will be a challenge for UK health services.

The maternal mortality rate in 2016-18 is nine per cent lower than the 2009-2011 baseline, having increased between 2012-14 and 2014-16. The volatility of the trend is likely to be due to the small numbers of incidents. This is broadly on track to meet the 2020 ambition, but further concerted efforts, enhanced through existing and incoming initiatives, are critical to meet the 2025 ambition.

With regard to brain injury, the Government's national ambition is to halve the rate of intrapartum brain injuries from a 2010 baseline by 2025. The data used to monitor this ambition is commissioned by the department from the Neonatal Data Analysis Unit and derived from the National Neonatal Research Database according to a bespoke definition of 'brain injuries occurring during or soon after birth', which was developed in 2017[2]. The findings from the most recent report, published in January, shows that the brain injury rate has fallen to 4.2 per 1,000 live births in 2019, since rising from 4.2 to 4.7 per 1,000 live births between 2012 and 2014. In addition, although good care can reduce the risk of hypoxic ischaemic encephalopathy (HIE), the national brain injury definition also incorporates other causes, including preterm-related brain injury. The rate of infants with HIE has fallen by 15 per cent between 2014 and 2019.

The preterm birth-rate ambition, announced in *Safer Maternity Care* (2017)[3], is to achieve a 25 per cent reduction, from an eight per cent baseline in 2015 to six per cent in 2025. In 2019, there were 46,575 preterm live births and 1,699 preterm stillbirths (gestational age between 24+0 and 36+6 weeks) in England. The rate of preterm births rose from 7.3 per cent in 2010 to 8.1 per cent in 2017 and reduced to 7.9 per cent in 2019. A number of evidence-based initiatives to reduce preterm births, including the establishment of preterm birth clinics and continuity of carer, are currently being implemented.

We know that there are ethnic and socio-economic disparities in maternal and perinatal mortality outcomes and experience, including babies from black, Asian and other minority ethnicities.

For data from the MBRRACE-UK *Perinatal Mortality Surveillance Report* (2019) on stillbirth and neonatal rates broken down by characteristics, including the baby's ethnicity and the mother's socio-economic deprivation quintile, please visit www.npeu.ox.ac.uk and search for the title.

Reducing inequalities in maternal and neonatal mortality, morbidity and women's experiences of maternity care is a priority for me personally and for the Government. In September, I established the Maternity Inequalities Oversight Forum to bring together experts from key stakeholders to consider and address the inequalities for women and babies from different ethnic backgrounds and socio-economic groups. This Forum provides rapid and contemporary information about reduction in disparities, and reviews whether policies and strategies are being implemented as intended and whether expected results are being achieved.

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[2] Imperial College London. *Brain injury occurring during or soon after birth: a report for the national maternity ambition commissioned by the Department of Health*, 2017. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/662974/Report_on_brain_injury_occurring_during_or_soon_after_birth.pdf

[3] https://www.gov.uk/government/publications/safer-maternity-care-progress-and-next-steps

In addition, the department launched a new £7.6million Health and Wellbeing Fund, based on the theme of 'Starting Well' that will support 19 projects to reduce health inequalities among new mothers and babies. The projects include a number of innovative schemes aimed at levelling up black, Asian and other ethnic minority groups and promoting healthy behaviours.

The Chief Midwifery Officer, with support from the department and other Government ministers, is leading work with maternity leaders and service users to address disparities in outcomes. Local understanding of underpinning cultural causes and solutions is required to improve outcomes and experiences of care for all service users. Maternity Voices Partnerships are improving involvement of local groups and individuals in service design and delivery. The new NHS Race and Health Observatory will also be working on this issue.

NHS England and NHS Improvement (NHSE&I) is working with a range of national partners, led by the Chief Midwifery Officer and the National Specialty Advisor for Obstetrics, to develop an equity strategy, which will focus on black, Asian and mixed-race women and their babies and those living in the most deprived areas.

The Maternity Safety Strategy comprises evidence-based initiatives to support the maternity system to strengthen leadership, implement best clinical practice and develop cultures of continuous learning for improvement. Most of the safety initiatives announced in 2016 and 2017 are in progress and have been supplemented by improvements to care identified through the ongoing development of the Maternity Transformation Programme (MTP) and included in the *NHS Long Term Plan*. The improvements in outcomes mentioned therefore cannot be unequivocally attributed to implementation of individual interventions. However, annual review reports and independent evaluations have been undertaken on some key interventions:

- *Evaluation of implementation of the Saving Babies Lives Care Bundle in the Early Adopter NHS Trusts in England* (July 2018) found that stillbirth rates declined by 20 per cent over the period during which version one of the care bundle was implemented, but this improvement could not be unambiguously attributed to the care bundle. The review findings led to the introduction of a second version of the care bundle, with revisions to the original four care bundle elements and the addition of a fifth on reducing preterm births;
- an independent evaluation of the Maternity Safety Training Fund (December 2018) found that, in total, 30,945 training places were delivered through the fund. The trusts had successfully incorporated their learning and training skills into their mandatory programmes, and the training had improved everyday practice through increasing confidence and empowering the maternity staff, enhancing skills, knowledge and awareness, improving multi-professional working and communication, improving patient safety, and encouraging cultural change. A new core curriculum for professionals working in maternity and neonatal services is being developed by the MTP in partnership with professional organisations, clinicians and service users to address variations in safety training and competency assurance across England and to enable the workforce to bring a consistent set of updated safety skills as it moves between services and trusts;

- the *Early Notification Scheme Progress Report* (September 2019) identified a number of clinical issues as likely contributors of substandard care and made recommendations. As a result, work with the Royal Colleges and academic partners is in progress nationally to understand impacted fetal head and difficult delivery of the fetal head at caesarean section and to develop evidence-based guidance on management protocols and skills drills for impacted fetal head;
- the first annual report of the Perinatal Mortality Review Tool (October 2019) provided data from the first 1,500 reviews conducted using the tool. The majority of factors contributing to the issues identified in perinatal deaths related to human factors, the clinical condition of the mother and/or baby, and organisational priorities; and
- the Healthcare Safety Investigation Branch summary of themes arising from its maternity programme (2020) identified eight prominent themes that have emerged through analysis of completed maternity investigations.

Following the publication of Donna Ockenden's first report, *Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust*, on 11 December, NHSE&I's letter of 14 December to NHS trust and foundation trust chief executives outlined the immediate response required by trusts and also the steps that were being taken nationally to implement seven immediate and essential actions. To support the system to address all seven actions consistently and to achieve sustained improvements in maternity services, NHSE&I announced at its public board meeting on 25 March that an additional £95million will be invested in 2021/22 to increase workforce numbers, training and development programmes to support culture and leadership, and to strengthen board assurance and surveillance to identify issues earlier, thereby enabling rapid intervention.

This includes £46.7million to fund the establishment of 1,000 more midwifery posts, £10.6million to fund an increase in consultant time, and £26.5million in workforce capacity to allow training that will improve the way multidisciplinary teams work together.

While it is difficult to attribute improvements in mortality and brain injury outcomes to individual Maternity Safety Strategy interventions, they have led to the development of a substantial body of new evidence and learning over the past five years, which we are using to refine and target support for improvements.

I look forward to attending a future meeting of the APPG.

I hope this reply is helpful.

NADINE DORRIES