

Sands and Tommy's Joint Policy Unit- Written evidence (PRT0045)

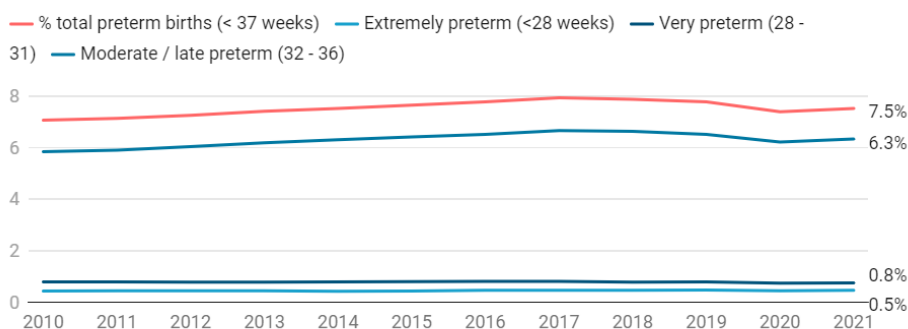
Submission from the Sands and Tommy's Joint Policy Unit

In 2022, Sands and Tommy's came together to form a Joint Policy Unit. Together we are 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. Through our collective voice we want to make sure that pregnancy loss and baby death stay high on the political agenda.

Background on preterm birth

Our Saving Babies' Lives [progress report](#) published in May 2023 brought together data from different sources for the first time to show the extent of pregnancy loss and baby death across the UK. In 2021, 7.5% of births were preterm in England (ONS, 2023). There has been little progress in reducing the preterm birth rate which has remained stable (between 7.0 - 8.0%) between 2016 and 2021. According to data from 'Euro-Peristat' preterm birth rates in England are higher than the average of 6.9% in Europe.

The proportion of babies born preterm between 2010 and 2021 in England



Preterm births as a proportion of live births in England

Chart: Sands & Tommy's Joint Policy Unit • Source: ONS (2023) • [Get the data](#) • Created with [Datawrapper](#)

Preterm births continue to have an important impact on mortality rates in the UK: three-quarters of neonatal deaths in 2021 were among babies

born before 37 weeks' gestational age. Lower gestational ages are associated with higher rates of neonatal mortality.

Beyond neonatal mortality, preterm birth is a major contributor to childhood mortality and morbidity.

- Reports from the National Child Mortality Database (NCMD) have highlighted the large contribution of preterm birth to overall child mortality, suggesting that preterm birth may be the leading cause of child mortality in England.
- Preterm birth is associated with an increased risk of developmental problems and disorders, including: physical, sensory, cognitive and learning disorders, and emotional and behavioural problems.
- The risk and prevalence of impairments that affect educational attainment rise sharply in children born before 28 weeks' gestation.
- Parents of preterm babies are more likely to experience stress and mental health problems than parents of full term babies.

Inequalities in preterm birth

Ethnicity

Data from the Office for National Statistics (ONS) shows that the proportion of babies born preterm varies between ethnic groups:

- In 2021, the proportion of preterm births out of total live births was highest among Black babies (8.7%) in England and Wales. This rate has remained consistently above all other ethnic groups since at least 2010 (the start of the time series for this data set).
- In the same year, preterm births were second highest among Asian babies (8.1%), while the rate among White (7.4%), Mixed

(7.0%) and Other (7.0%) ethnicities were below the overall population (7.6%).

- The proportion of babies born extremely or very preterm (under 32 weeks' gestation) was higher among babies from Black ethnic groups (over 2.0%) compared with the proportion overall (1.2%). This difference is important due to the substantially higher mortality rates at lower gestational ages.

Deprivation

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:

- A [cohort study by the NMPA](#) (National Maternity and Perinatal Audit) using NHS administrative hospital data found that the risk of preterm birth was 4.9% in the least deprived group and 7.2% in the most deprived group. The study found that 18.5% of preterm births could be attributed to socioeconomic inequality, although this estimate was reduced to 11.9% after adjusting for ethnic group, smoking and BMI.
- A [separate cohort study](#) of preterm birth in Scotland between 1980 – 2003 found that preterm births were more likely in lower deprivation quintiles, which was partly, but not entirely, explained by smoking status at first antenatal contact.
- A retrospective cohort study of routinely collected obstetric and neonatal data at the Liverpool Women's NHS Foundation Trust between 2002 to 2008, found deprivation of area of residence was associated with higher risk of preterm birth in a cohort of women with no identifiable risk factors, even after adjusting for

smoking and being underweight (both important independent risk factors).

It is clear from looking at the outcomes data and evidence from qualitative research that ethnic inequality exists in pregnancy and baby loss, and that current progress to reduce these inequalities is insufficient. However, it is less clear what exactly is driving these inequalities, a better understanding is needed to inform effective interventions.

There needs to be a much stronger commitment, and long-term funding, from government to eliminating inequalities in pregnancy loss and baby deaths. While the problem is well known, understanding of the drivers of inequalities and solutions to overcome them is more limited. Mixed-method and qualitative research is needed to:

- Test theories about what drives inequalities and how these factors intersect.
- Identify solutions which recognise, and are adapted to, the complexity of people's lives, particularly groups who are most affected by pregnancy loss and baby deaths.
- Understand how racism, bias and discrimination operates in the health system and identify ways to change NHS cultures, processes and systems. The quality and consistency of routine data collection should be improved, and clear metrics agreed against which progress to reduce inequalities can be measured.

Variation in neonatal care

Data from the National Neonatal Audit Programme (NNAP) show overall improvement in the proportion of babies receiving optimal care across key measures. However, comparing the proportion of babies receiving optimal care across neonatal networks shows unacceptable variation. **For example:**

- **Delayed cord clamping** - [NICE guidelines](#) recommend delaying cord clamping until at least 60 seconds, unless there are specific maternal or neonatal conditions that require earlier clamping. In 2022, the rate of delayed cord clamping was a third higher among the neonatal network with the highest rate, compared to the lowest.
- **Thermal management** - British Association of Perinatal Medicine (BAPM) recommend regular monitoring of babies' temperature after birth, and the temperature at admission to neonatal care should be recorded as a prognostic and quality indicator. According to the Perinatal Mortality Review Tool (PMRT) [fifth annual report](#), thermal management is the issue most commonly identified as relevant to baby deaths. The NNAP found that 73.2% of very preterm babies in England and Wales were admitted with a temperature within the recommended range of 26.5 - 37.50 C, although this ranged from 63.8% to 82.9% across neonatal networks. No network met the NNAP developmental standard of 90% of babies with a temperature taken within an hour of birth measuring within the normal range. Keeping babies at the right temperature after birth is also a modifiable factor for reducing neonatal admissions for respiratory symptoms for babies born at full-term.
- **Transfer to neonatal intensive care unit (NICU)** - According to [guidance from BAPM](#), women and birthing people who are at risk of preterm labour before 27+0 weeks' gestation in a singleton pregnancy or under 28 weeks' gestation for multiple pregnancies should be transferred antenatally to maternity units with a co-located NICU and/or neonatal surgical centre. Staff in NICUs are more likely to have specialist training and experience of managing preterm babies, which gives extremely preterm babies the best chance of good outcomes. However, data from NNAP shows that in England and Wales, 21% of preterm babies were born in a hospital

without a NICU, ranging from 13.2% to 32.4% across neonatal networks

The [APPG report on staffing shortages](#) presented evidence that neonatal resuscitation is not always being led by appropriately skilled staff and delays in neonatal team attendance can occur when simultaneous or complex deliveries occur. NNAP also highlighted differences in chest infection rates or death rates between neonatal networks, which remain after adjusting for case mix suggesting that there may be opportunities to reduce avoidable deaths with better care in some networks.

Meeting national maternity safety ambitions

There has been little progress in reducing rates of preterm birth over recent years and the government is not on track to meet the ambition of a 6% preterm birth rate. In 2021, 7.5% of births were preterm in England. This rate has remained stable (between 7.0 - 8.0%) between 2016 and 2021.

Reducing rates of preterm birth is important for meeting the government's other ambitions for improving maternity safety, which include achieving 50% reduction in neonatal mortality and stillbirth by 2025 relative to 2010 levels. While there has been some progress in these areas, they are also not on track to be met:

- In 2022, the stillbirth rate in England was 3.9 per 1,000 total births (stillbirths and live births). This rate will need to decline by a third (34.6%) over the next three years to meet the target of 2.6 per 1,000 total births.
- The neonatal mortality target is limited to births at 24 gestational weeks and over. In 2021 (the latest data available), the neonatal mortality rate at for ≥ 24 gestational weeks was 1.4 per 1,000 live births. To meet the target of 1.0 per 1,000 live births in 2025, the rate will have to decline 10%.

Trust board oversight of maternity and neonatal services

The safety and quality of individual maternity and neonatal services are ultimately the responsibility of the board in each NHS Trust in England. We recently published a [report](#) highlighting issues with the oversight that NHS Trust boards have over the safety and quality of the maternity and neonatal services they provide. The aim of this research was to review whether the information presented to boards - and subsequent review and discussion - enabled boards to deliver on their responsibility of ensuring the safety and quality of services. Some of the key findings in our report were:

- Boards are not consistently being presented with the key metrics which NHS England has suggested to provide an overview of maternity and neonatal service performance. This, along with data being spread over multiple reports with little to no additional analysis to draw attention to declining metrics or trends, limits their capability to have full oversight over their service.
- Board members may not have full understanding of the data being shared. Clinical service leaders have the knowledge to contextualise data and help board members to understand the implications. However, from the reports we reviewed it appeared that this knowledge was not currently translating into the submissions to the board.
- Trust boards review information from across the Trust which makes focusing on particular services challenging. Agendas only allocated between 5–30 minutes to discuss maternity services. Discussion notes showed variable scrutiny from board members, suggesting limited capacity for boards to comprehend and explore insights fully.

- Inconsistencies with metrics being reported on, a lack of contextualised intelligence and limited discussions and scrutiny of data suggests that the current board reporting process may not be leading to the effective insights needed for board members to maintain full oversight of their services.

27 March 2024