

Saving Babies' Lives 2026: A report on progress

Scotland briefing

Summary of progress

- In recent years, there has been a general decline in stillbirth rates in Scotland, with a 20.1% reduction between 2013 and 2024.
- The decline in the neonatal mortality rate in Scotland has been smaller, 10.8% since 2013. After a sharp increase in 2021, the rate declined in 2022 and 2024.
- Unlike stillbirths and neonatal deaths, the total number of miscarriages and miscarriage rates are not reported in Scotland.

What needs to change

While there was an ambition in England to halve rates of stillbirth, neonatal death, preterm birth, maternal death and brain injury by 2025, relative to 2010, these have expired and no equivalent targets for Scotland has ever been set. Setting a target to reduce pregnancy loss and baby deaths is important to measure the impact of policy interventions and monitor variation between NHS Boards and population groups. Any future targets should have a clear, agreed baseline against which progress can be measured.

These targets should drive a coordinated programme of policy activity, supported by funding, resources and ongoing evaluation. This should include:

- Continued commitment to the Scottish Pregnancy, Births and Neonatal Data Dashboard, using these data to monitor outcomes over time and identify variation between NHS Boards and population groups. Public Health Scotland should continue improving the quality and completeness of ethnicity data and consider broader measures of social risk factors to better understand and address inequalities.
- Completion of work to develop a methodology for recording miscarriages in Scotland. Once reporting is established, the data should be used to track progress and inform policy priorities.
- More regular and consistent oversight of maternity and neonatal services, drawing on service performance, staff and patient experience, patient safety culture, and the findings of local and national reviews. Staff and patient experience should be measured regularly to enable trends to be monitored over time. The last [national survey](#) of pregnancy and birth experiences took place in 2025, following a seven-year gap since 2018. Findings should be published wherever possible to support transparency, accountability and improvement.
- Timely, consistent and high-quality reviews of perinatal deaths and adverse events to support learning and improvement.

- Resources to deliver the short-, medium- and long-term priorities of the Short Life Working Group on racialised inequalities, alongside robust evaluation to build the evidence base on what works to reduce inequalities.
- Action to improve workforce sustainability in maternity and neonatal services, including workforce planning, staffing capacity, retention, leadership and staff wellbeing, drawing on relevant recommendations from the Nursing and Midwifery Taskforce.

Introduction

The Saving Babies' Lives 2026 report considers the systemic issues facing maternity and neonatal services across the UK. While each nation faces many of the same issues, health is a devolved matter with policies and funding led by devolved governments in each of the four nations. Much of the data are also reported separately.

To analyse these data and support devolved policy makers, the Sands and Tommy's Joint Policy Unit is publishing a series of tailored briefings with the most recent insights for each of the four nations.

This briefing is focused on Scotland.

About the Sands and Tommy's Joint Policy Unit

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

Rates of pregnancy loss and baby deaths in Scotland

Overall, stillbirth and neonatal mortality rates have declined in Scotland since 2013, although progress has been variable (see Figure 1).

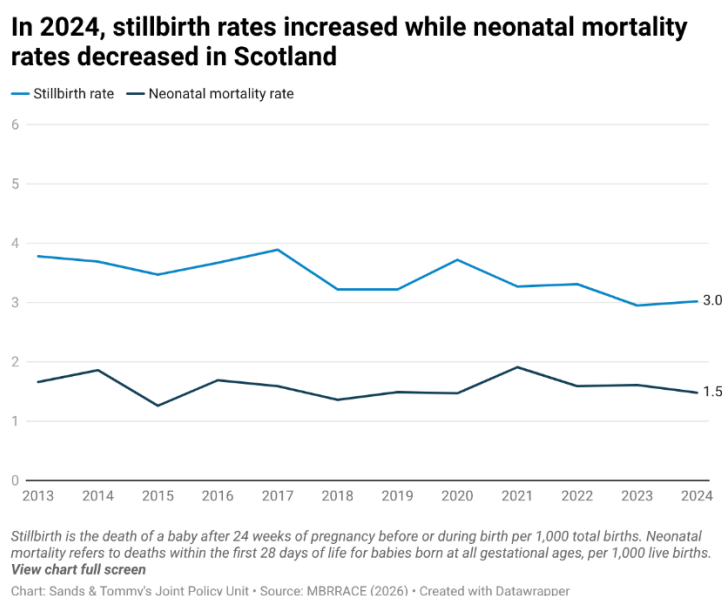


Figure 1. Stillbirth and neonatal mortality rate in Scotland, 2013-2024.

Comparisons across the UK

The stillbirth rate in Scotland has consistently been one of the lowest rates in the UK, ranking second lowest in most years between 2013-2024. Smaller population sizes in Wales, Scotland, and Northern Ireland mean that slight changes can affect overall stillbirth and neonatal mortality rates, contributing to higher annual variability (see Figure 2). Comparing average stillbirth rates over three-year periods reduces the effect of this annual variability. Between 2013-15 and 2022-24 the stillbirth rate in Scotland declined by 13.9%, the smallest reduction of any nation. The largest reduction was in Northern Ireland (21%), while the rate declined 19.5% in England, and 16.7% in Wales.

Stillbirth rates across the four nations 2013-2024

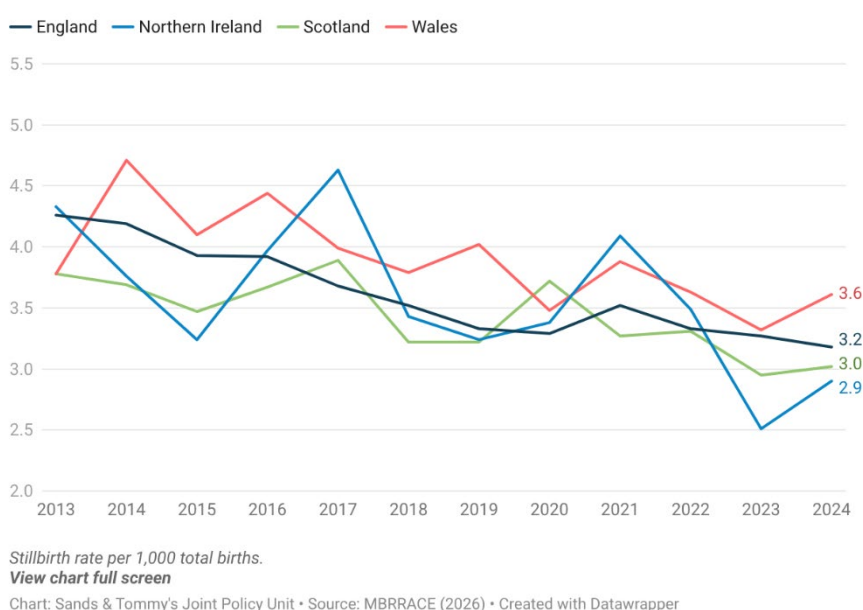


Figure 2. Stillbirth rate across the four nations between 2013 – 2024.

Scotland had the lowest neonatal mortality rate of the four UK nations in 2024 (see Figure 3). Looking at the three-year averages, Scotland had the smallest reduction in neonatal mortality rates between 2013-15 and 2022-24 (1.9%). Northern Ireland declined the most (27.1%), followed by Wales (8.5%), and England (7.4%).

Scotland's neonatal mortality rate increased between 2018 and 2021, rising from 1.4 to 1.9 deaths per 1,000 live births. MBRRACE-UK analysis suggests this increase was at least partly driven by a higher proportion of births with characteristics known to increase the risk of neonatal death, such as deprivation, prematurity and multiple births. In 2021, Scotland's crude neonatal mortality rate was more than 5% higher than the UK average, but after adjusting for these risk factors the rate was in line with the UK overall.

Neonatal mortality rates across the four nations 2013-2024

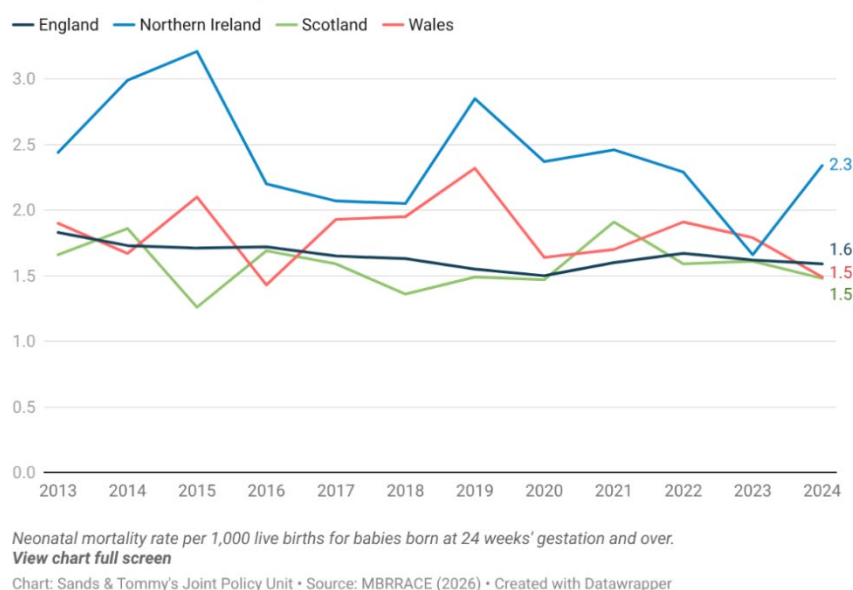


Figure 3. Neonatal mortality rates across the four nations between 2013-2024.

Inequalities in pregnancy losses and baby deaths

Across the UK, inequalities in perinatal mortality [continue to persist](#). In Scotland, [recent data](#) show:

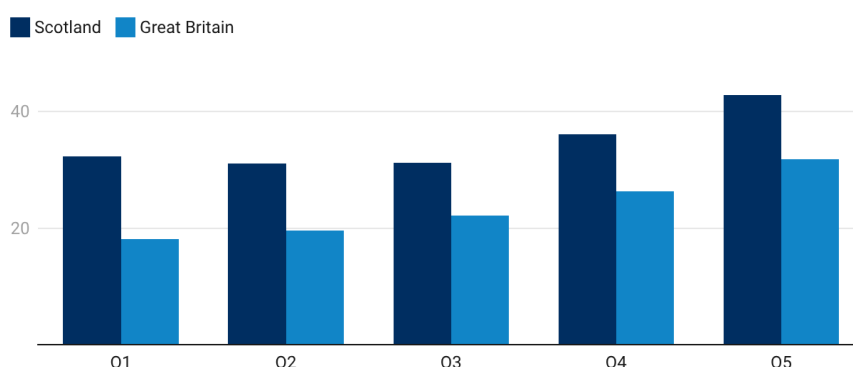
- Almost a quarter (24.6%) of total births were to women and birthing people living in the most deprived areas.
- Higher levels of deprivation were associated with preterm birth, higher induction rates, and risk of being born small for gestational age in comparison to less deprived areas.

One area where disparities in access to services are clear, and may impact outcomes, is when women and birthing people first engage with antenatal services, known as the booking appointment. The booking appointment involves an important assessment of needs and risks to identify whether additional care and support is required so late booking may impact pregnancy outcomes.

In 2024, Scotland had the [highest rates of pregnancy booking](#) after 10 weeks' gestation (46.8%) compared to Great Britain as a whole (24.4%). This difference may partly be influenced by NICE guidance for the booking appointment to take place by 10 weeks' which is followed in England and Wales, while guidance varies across NHS Boards in Scotland.

A higher proportion of women and birthing people living in the most deprived areas of Scotland attended their first antenatal appointment, or booking appointment, after 10 weeks of gestation (42.8%) compared to the least deprived (32.3%) (see Figure 4).

In 2024, booking appointment attendance after 10 weeks' gestation was higher in Scotland across all deprivation quintiles compared to Great Britain



Proportion of women and birthing people who gave birth to a singleton baby between 24+0 and 42+6 weeks who attended their first (booking) appointment with a midwife after 10+0 weeks gestation. The National Institute for Health and Care Excellence (NICE) guidelines recommend the first antenatal appointment takes place by week ten of the pregnancy, although initial contact and referral may have been earlier. Q1 is the least deprived quintile, and Q5 is the most deprived quintile.

Chart: Sands and Tommy's Joint Policy Unit • Source: National Maternity and Perinatal Audit (2026)

Figure 4. Proportion of women and birthing people in Scotland attending booking appointments after 10+0 weeks' gestation in 2024, by deprivation quintiles.

The percentage of late bookers was also highest among Black women and birthing people (59.9%) and lowest among White women and birthing people (32.1%).

Better data is needed to identify the groups at most risk of pregnancy and baby loss in Scotland, as well as understanding what is driving inequalities and identifying potential solutions. The [Neonatal Mortality Review](#) noted that recording of maternal ethnicity on the SMR02 dataset has historically been around 80% with the remaining 20% being 'not known / refused / not provided'. This meant it was not possible to draw any conclusion regarding the impact of ethnicity due to lack of data.

A key area of focus for the upcoming independent review of maternity services in Scotland will be care for women at risk of poorer outcomes, including Black and Asian women, women from Gypsy and Traveller communities, and women with complex social and clinical disadvantages.

There are also wider programmes underway in Scotland to address inequalities in maternity care. In 2023, The Scottish Government's Short-Life Working Group on Racialised Health Inequalities in Maternity Care brought together professionals and people with lived experience to identify actions to reduce inequalities in maternity outcomes and experiences. The group developed a Racialised Health Inequalities Action Plan, an Interpretation Toolkit to support equitable communication with women and families, and an Evidence and Data Resource to strengthen identification, monitoring and understanding. The programme has now moved into the implementation phase; NHS Boards are expected to embed these resources into local planning, service delivery and anti-racism activity.

Systemic issues in maternity and neonatal services need to be addressed

An upcoming independent review of maternity services in Scotland, due to commence in Autumn 2026, provides opportunity to assess what systemic changes are required to improve outcomes for women and birthing people. This section will explore many of the recurring issues facing maternity and neonatal services which have been raised by reviews across the UK.

Workforce capacity and training

In Scotland, the number of maternity and neonatal staff per 1,000 births has increased in the past decade (see Figure 5). The number of midwives relative to births increased 38.1% between 2015 and 2025, partly driven by falling birth rates in the same period (-18.2%).

In Scotland, WTE per 1000 deliveries has increased among midwives in the past decade, while other maternity and neonatal staff groups have remained stable

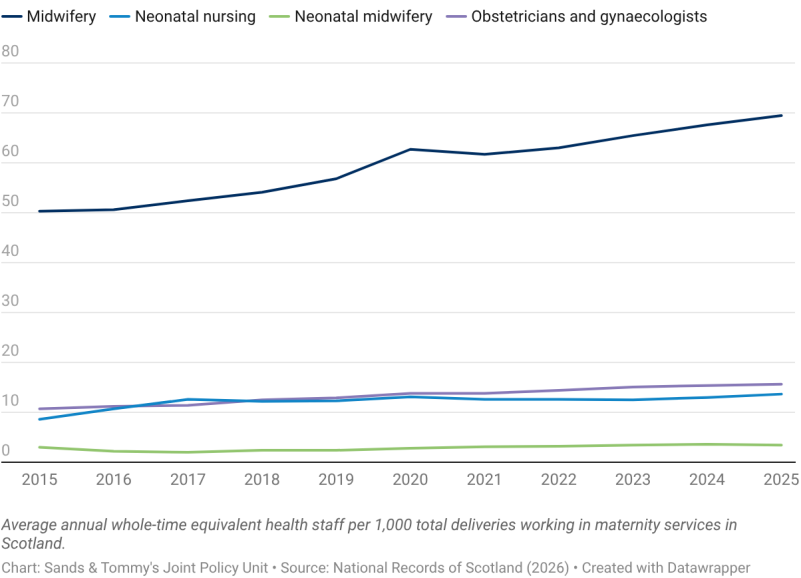
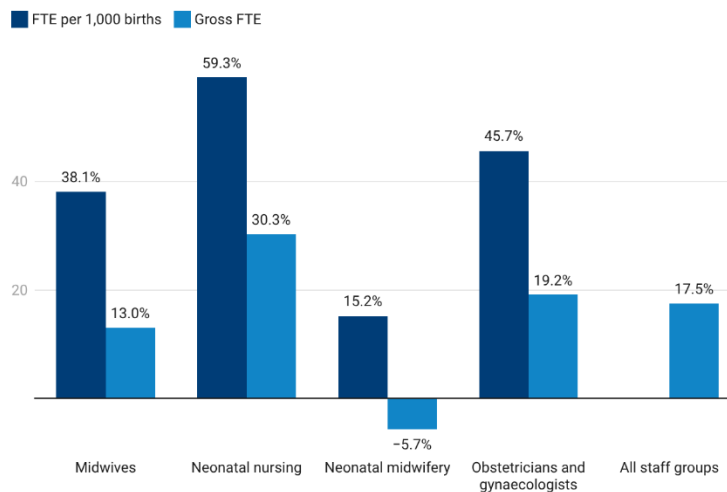


Figure 5. Average annual full-time equivalent (FTE) staff per 1,000 total births.

In the past decade, the maternity and neonatal workforce FTE per 1,000 births has increased more than gross FTE (see Figure 6).

In Scotland, the total change in gross FTE staff working in maternity services over the past decade has been lower than calculations per 1,000 births



Full-time equivalent staff working in maternity services in Scotland hospitals, showing total change between 2015 and 2025.

[View chart full screen](#)

Chart: Sands & Tommy's Joint Policy Unit • Source: National Records of Scotland (2026) • Created with Datawrapper

Figure 6. Percentage change in FTE staff per 1,000 births and gross percentage change in FTE staff between 2015 and 2025 in Scotland.

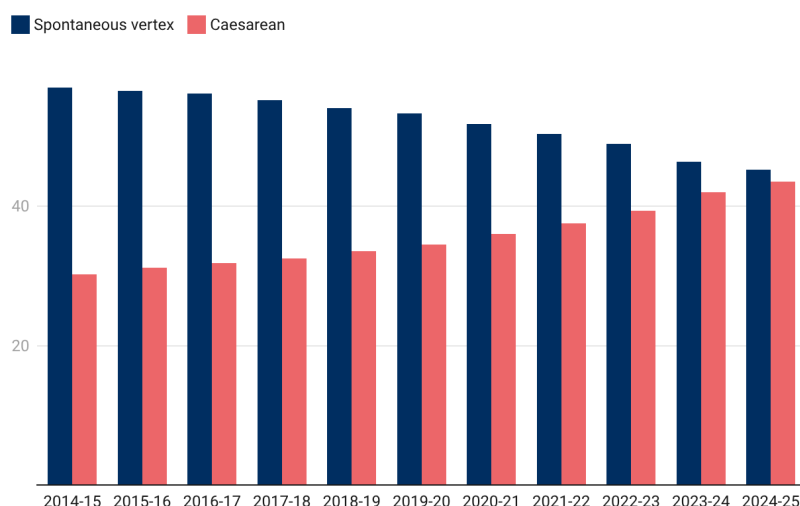
While birth rates are falling, the needs of the birthing population are changing in Scotland, impacting the care required:

- The mean age of mothers and birthing people in Scotland has slightly increased in the past [decade](#) by 4%. Pregnancy at advanced maternal age, which has [increased](#) by 4.5% between 2015-25, increases the likelihood of [multiple pregnancies](#), [co-morbidities and pregnancy complications](#), which require more monitoring during pregnancy and increase the demand on staff time.
- Obesity rates are increasing; over a [quarter](#) (28.5%) and nearly a tenth (9.8%) of maternities were affected by obesity and diabetes respectively in 2024-25. In the past decade, maternal BMI category obese at [antenatal booking](#) has increased by 7%. Women and birthing people living with obesity are at [higher risk](#) of gestational diabetes, pre-eclampsia, caesarean delivery and neonatal complications.
- Mental health needs of women and birthing people of childbearing age in Scotland have risen 8% in the past decade; 27% of females aged 16-54 had a high GHQ12¹ in [2024](#) compared to 19% in [2014](#).
- Women and birthing people increasingly have long term physical (including obesity and diabetes), mental health conditions or social complexities which may require additional, and often specialist, staff time to provide the necessary support and referrals.

¹ The General Health Questionnaire contains 12 questions (GHQ12), and is a screening tool designed to detect the possibility of psychiatric morbidity in the general population.

Mode of delivery is also changing, with an increase in caesarean sections and decline in spontaneous vertex births (see Figure 7). In 2025, caesarean sections accounted for over [two in five births](#) (43.5%), the highest rate ever recorded in Scotland.

In Scotland, caesarean births are increasing while spontaneous vertex births are declining



Live singleton births by method of birth and year in Scotland, percentage of live singleton births with a known method of birth, 2014-15 - 2024-25 for spontaneous vertex and caesarean births. See PHS Table 6.1 for further information.

Chart: Sands and Tommy's Joint Policy Unit • Source: Public Health Scotland (2025)

Figure 7. Comparison of spontaneous vertex births and caesarean birth percentages between 2014-15 and 2024-25.

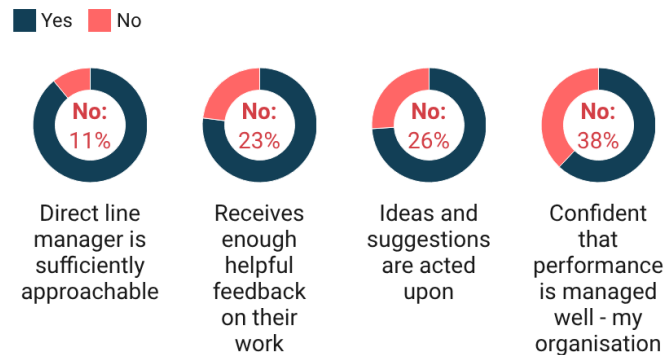
Changes in the birthing population and clinical approaches affect all staff working in maternity and neonatal services. However, Scotland currently has limited evidence available to assess whether staffing levels are sufficient to meet these changing demands. A new workforce planning tool, the [Maternity Services Staffing Level Tool Version 1](#), was implemented in early 2026 to replace the Maternity Staffing Level Tool Version 3, which had been reviewed and found to require redevelopment to reflect current maternity services and the staff needed to deliver safe care. As the updated tool has not yet been evaluated, and workforce data are not yet available, its effectiveness in estimating workforce requirements remains to be seen.

Culture of safety

Promoting leadership at all levels to support a culture of safety is one of the [Scottish Patient Safety Programme](#) (SPSP)'s essential drivers of safe care. Leadership must [create the right conditions](#) for a culture of safety within an organisation. Compassionate and inclusive leadership can support staff wellbeing and encourage openness and collaboration. Results from the staff survey suggest that most nurses and midwives² feel they receive enough helpful feedback on their work, (77%), but fewer find that this leads to change (74%) (see Figure 8).

² Responses include nurses who are not engaged in maternity or neonatal services, due to disaggregated data not being available.

Although most nurses & midwives find line managers approachable, fewer find their suggestions are acted upon



Responses from Nurses & Midwives to Health and Social Care Staff Experience survey. Responses include nurses who are not engaged in maternity or neonatal services.

Chart: Sands & Tommy's Joint Policy Unit • Source: Scottish Government (2025)

Figure 8. Nurse and midwife responses to Health and Social Care Staff Survey 2025.

Unlike the NHS England Staff Survey, the Scottish Staff Survey does not include any questions relating to patient safety. Additional questions should be included to ensure that all aspects of staff experience, including perceptions of patient safety, are adequately captured.

Leadership, governance and accountability

Good "ward-to-board" communication is important to connect frontline staff with leaders. Although confidence and trust in direct line managers was high, the [Health and Social Care Staff Experience survey](#) results highlight concerns regarding the visibility of, and trust in, board members (see Figure 9). This may suggest a lack of engagement from board members which can affect their ability to understand and act on the information that is provided to them.

Our [review](#) of board reports in England showed how effective leadership and governance require good quality data and intelligence being shared with leaders, a robust and candid review of the evidence and early action to address concerns. These survey results raise questions as to whether board members can contextualise the information that they receive, which may affect their ability to identify safety risks in maternity and neonatal services in their Health Board.

Staff have more confidence and trust in line managers than board members



Responses from Nurses & Midwives to Health and Social Care Staff Experience survey. Responses include nurses who are not engaged in maternity or neonatal services.

Chart: Sands & Tommy's Joint Policy Unit • Source: Scottish Government (2025) • Created with Datawrapper

Figure 9. Nurse and midwife responses on leadership to Health and Social Care Staff Survey 2025.

Data, monitoring and assurance

The [MatNeo Data Hub](#) was established in 2019 as a collaboration between Public Health Scotland (PHS), the Scottish Strategic Perinatal Network, Healthcare Improvement Scotland, the Scottish Government and the National Records of Scotland to improve the quality, consistency and accessibility of maternity and neonatal data across Scotland. Key workstreams include:

- **Scottish Pregnancy, Births and Neonatal Data Dashboard ([SPBAND](#)):** launched in October 2023 and continues to be updated quarterly, providing national maternity and neonatal indicators to support benchmarking and comparison across NHS Boards.
- **Maternity and Neonatal Data Access Liaison Group for Scotland (MaNDALS):** established to align and standardise maternity and neonatal data collection across Scotland. As of April 2025, a mechanism has been developed to transfer data from BadgerNet to PHS, to make these data available for analysis on the MatNeo Data Platform.
- **Development of new national maternity datasets:** to improve the breadth and quality of routinely collected maternity information. There is focus on expanding antenatal and birth data collections with the aim of strengthening national reporting.
- **NeoCareIn+ data collection through BadgerNet:** introduced to support routine collection of specialist neonatal care data. These data are now included on the SPBAND and updated regularly.
- **Core Maternity Measures:** developed to support benchmarking, quality improvement and reduction of unwarranted variation in care, and now reported through the SPBAND.

As part of the [Scottish Government's Miscarriage Framework and Progesterone Pathway](#), PHS has developed a national miscarriage data collection programme. Following development, piloting and testing, routine miscarriage data collection is now established and forms part of business-as-usual data collection. Miscarriages are identified using a range of fields within maternity records, including pregnancy outcomes, diagnoses recorded in maternity and early pregnancy services, and bereavement classifications.

The dataset captures key demographic and clinical information, including age, postcode, parity and previous miscarriages. Data are intended to support reporting on miscarriage numbers, incidence rates, inequalities by age and deprivation, and previous miscarriage history. An inclusive approach has been taken to identifying miscarriages within routine records. Subject to funding and analytical capacity, publication of national miscarriage statistics is anticipated from 2026.

Engagement with service users

Women and birthing people's views and experiences are not consistently captured across Scotland. The most recent [Maternity Care Survey](#) was conducted in 2025, but its findings have not yet been published. The previous survey took place in 2018, and only four surveys have been undertaken since 2013.

More frequent surveys, based on representative samples, are needed to ensure meaningful engagement with service users. This would provide more timely insights into people's experiences and support improvements in the quality and safety of maternity care.

Learning from reviews and investigations

When serious incidents or deaths do occur, reviews and investigations are essential to understand what went wrong, provide answers for families and prevent avoidable deaths in the future. In Scotland, there are Significant Adverse Event Reviews (SAERs) and Perinatal Mortality Review Tool (PMRT) reviews.

SAERs

SAERs are structured reviews of serious incidents, including maternal and neonatal deaths, undertaken to identify learning and improve patient safety. They are intended to support openness and learning following serious incidents, identify opportunities to improve care and clinical practice, engage families in the review process, and facilitate the sharing of learning and best practice across NHS Boards.

In May 2025, concerns raised in the [Scottish Parliament](#) highlighted ongoing challenges in ensuring that SAERs relating to maternal and neonatal deaths are conducted consistently, transparently, and in a way that enables learning to be shared effectively across NHS Scotland. The Scottish Government acknowledged these issues and outlined work to strengthen adverse event review processes through the updated Healthcare Improvement Scotland framework.

PMRT Reviews

The [Perinatal Mortality Review Tool](#) (PMRT) has been developed to standardise the review of perinatal deaths and create action plans for improvement. A timely review of care is important for parents and the NHS, to understand why a baby died and reduce future avoidable harm. Since the Perinatal Mortality Review Tool (PMRT) was introduced in 2018, the proportion of perinatal deaths reviewed within the same year has generally increased in Scotland and has been around 80% since 2019. (see Figure 10).

In Scotland, an increasing proportion of perinatal deaths have a review of care started within the same year since 2020, although the proportion of reviews which are published has declined

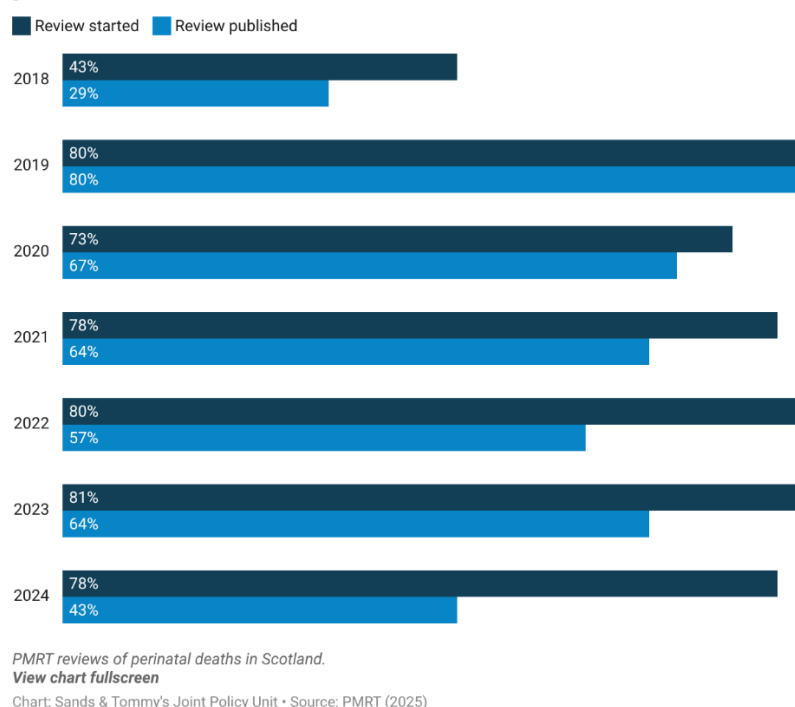


Figure 10. Proportion of perinatal deaths with a PMRT review started and a review completed by year. 2018 – 2024.

In 2024, a review was started for 83% of stillbirths and late miscarriages occurring in Scottish NHS Boards, with a 56% completion rate. For neonatal deaths, a review was started for 61% of deaths in 2024, but with a much lower completion rate (20%). The proportion of completed perinatal reviews is lower in Scotland compared to England (89%) and Wales (79%), but higher than Northern Ireland (36%). Incomplete reviews mean that any learning for health services and staff is not captured or acted upon, which could lead to a repeat of avoidable harm in the future.

Involving parents is a critical component of reviews; ensuring that they are given the opportunity to ask questions or share concerns. [In 2024](#), 90% of Scottish reviews noted that parents' perspectives had been sought, but only 48% of reviews included parents' comments. [A rapid engagement exercise](#) with recent users of maternity services found that participants want ongoing engagement to influence how maternity services are delivered, rather than one-off consultations. They recommended introducing continuous feedback mechanisms, co-design approaches and shared decision-making. Further work is required to support parents to engage where they wish to do so.

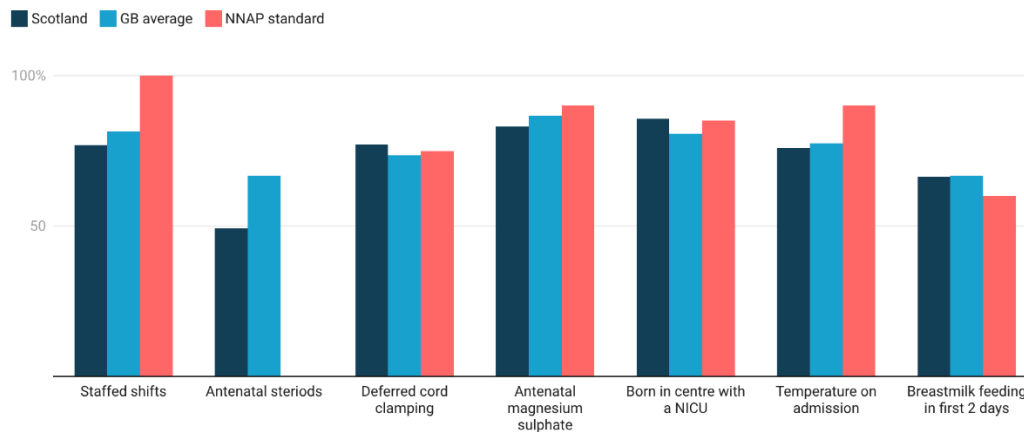
Delivering care in line with nationally agreed standards

Nearly all (94%) of the PMRT reviews completed in Scotland during 2024 found at least [one issue with the care](#) that was provided. Across the UK, 1 in 5 reviews identified at least one issue with the care which may have prevented a late miscarriage, stillbirth or neonatal death. Too often, avoidable deaths occur because of care that is not in line with nationally agreed standards.

One example of variation is the care provided to preterm babies. The National Neonatal Audit Programme (NNAP) assesses the care provided to preterm babies in neonatal networks across Great Britain. Care is assessed across key measures which are aligned to professionally agreed

guidelines and standards. Scotland is currently below target for four out of seven key NNAP metrics (see Figure 11).

The Scottish neonatal network met the NNAP standard for three out of seven key metrics in 2024



One metric did not have a standard for 2024: i) antenatal steroids. The National Neonatal Audit Programme (NNAP) collates data from Great Britain only.
View chart full screen

Chart: Sands & Tommy's Joint Policy Unit • Source: NNAP (2025)

Figure 11. Proportion of babies provided with optimal perinatal care in Scotland compared to the NNAP standard in 2024.

Reducing unwarranted variation is essential to save more babies' lives who are born preterm and are at higher risk of neonatal death. Our [briefing](#) looks in more detail at six of the NNAP optimal perinatal care measures; analysing level of adherence to understand why variation exists, and how to save more babies' lives.

Acronyms

FTE: Full-time equivalent

JPU: Sands and Tommy's Joint Policy Unit

NHS: National Health Service

NNAP: National Neonatal Audit Programme

PMRT: Perinatal Mortality Review Tool

PHS: Public Health Scotland

SPSP: Scottish Patient Safety Programme

SPBAND: Scottish Pregnancy, Births and Neonatal Data Dashboard