



Saving Babies' Lives 2026:

A report on progress

Northern Ireland
briefing

October 2026

**Sands &
Tommy's**
Policy Unit

Working together
to save babies' lives

Summary of progress

- Both the stillbirth and neonatal mortality rates in Northern Ireland increased in 2024, relative to 2023.
- Overall, the stillbirth rate has declined by a third in Northern Ireland between 2013 and 2024 (33%, from 4.33 per 1,000 total births to 2.9); however, comparing the three-year average rate (2022-24 to 2013-15) shows a smaller reduction of 21.4%.
- The neonatal mortality rate in Northern Ireland has consistently been higher than the other UK nations since 2013. While the rate declined by 27.5% between 2022 and 2023, (from 2.29 per 1,000 live births to 1.66), it rose again in 2024 (2.34), above the 2022 rate. Since 2013, the rate has only decreased by 4.1%, but the average of the past three years (2022-24) compared to 2013-15 shows a 27.6% decrease.
- Unlike stillbirths and neonatal deaths, the total number of miscarriages and miscarriage rates are not reported in Northern Ireland.

While there was an ambition in England to halves rates of stillbirth, neonatal death, preterm birth, maternal death and brain injury by 2025, relative to 2010, no equivalent for Northern Ireland has ever been set. The Northern Ireland Executive must commit to reduce pregnancy loss and baby deaths and eliminate inequalities. Proposed targets must have a clear baseline to monitor progress and should be the driving force for a programme of policy activity with allocated funding and resources. This should include:

- Developing the [Health Inequalities Statistics Northern Ireland data dashboard](#) to incorporate wider socio-economic factors (currently it only includes smoking during pregnancy), as well as the addition of environmental factors and ethnicity data.
- Collating key themes from individual service inspections on a regular basis, as well as creating a centralised hub to access this information.
- Improving collection of staff and patient experience on a consistent basis; the last national survey of pregnancy and birth experiences took place a decade ago in 2016. This should also include a process to capture insights from bereaved parents' experiences.
- Publishing a methodology to count miscarriages.
- Increasing the number of perinatal deaths for which a review is started and completed using the Perinatal Mortality Review Tool.
- Learning from reviews and assessments from across the UK and assessing the systemic issues found in the Northern Ireland context to advance improvements in maternity and neonatal care.

Acronyms

BR+	BirthRate Plus
FOI	Freedom of Information
FTE	Full-time equivalent
HSC	Health and Social Care
JPU	Sands and Tommy's Joint Policy Unit
MSW	Maternity Support Worker
NHS	National Health Service
NQM	Newly Qualified Midwife
PMRT	The Perinatal Mortality Review Tool
PHA	Public Health Agency

Introduction

The Saving Babies' Lives 2026 report raises systemic issues facing maternity and neonatal services across the UK. While each nation faces similar systemic 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 Northern Ireland.

About the Sands and Tommy's Joint Policy Unit

Sands and Tommy's Joint Policy Unit is focused 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 Northern Ireland

In 2024, stillbirth and neonatal mortality rates in Northern Ireland increased; however, compared with 2013, the rates remain 33% and 4.1% lower respectively (see Figure 1).

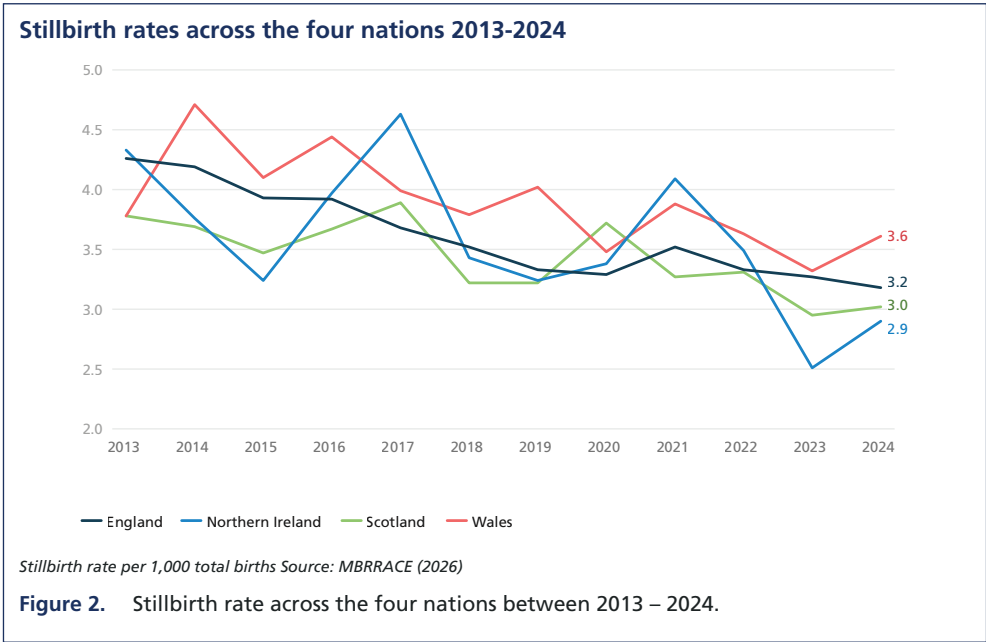


The relatively small population size in Northern Ireland means that slight changes in stillbirths and neonatal deaths can affect the overall rates, which may partially explain the variability over the years.

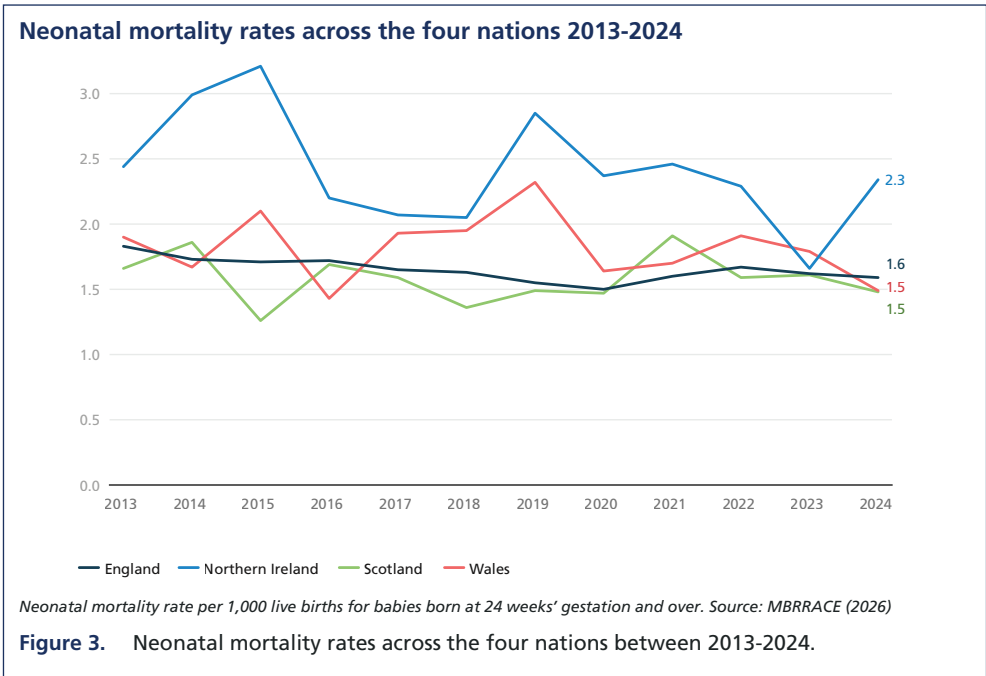
Unlike stillbirths and neonatal deaths, the total number of miscarriages are not reported in Northern Ireland. FOI responses obtained by the JPU from Northern Ireland Trusts indicate that miscarriage data are captured within obstetric records but are not reported centrally. The Southeastern Health and Social Care Trust response noted that miscarriage statistics can be requested, although a dedicated miscarriage report is still being developed and tested. Robust recording of miscarriage outcomes is essential for monitoring trends and informing efforts to reduce miscarriage prevalence.

Comparisons across the UK

On average, the stillbirth rate in Northern Ireland has mainly been lower than other UK nations since 2013 (see Figure 2). Comparing average stillbirth rates over three-year periods, reducing the effect of annual variation, shows that between 2013-15 and 2022-24 the rate in Northern Ireland declined the most (-21%). This was followed by England (-19.5%), Wales (-16.7%), and Scotland (-13.9%).



In contrast, aside from 2023, the neonatal mortality rate in Northern Ireland has been the highest across all nations since 2013 (see Figure 3). Between 2013-15 and 2022-24, the neonatal mortality rate declined the most in Northern Ireland (-27.1%), followed by Wales (-8.5%), and England (-7.4%). The smallest reduction was Scotland (-1.9%).



Inequalities in pregnancy losses and baby deaths

Across the UK, inequalities in perinatal mortality [continue to persist](#). In Northern Ireland, the [Enabling Safe Quality Midwifery Services and Care in Northern Ireland review](#) ('the Review') was published in late 2024 and revealed:

- Northern Ireland has the highest proportion of the population living in the most deprived quintile of the UK, with a larger proportion of total births being to women and birthing people in the most deprived, compared to the least deprived, quintiles.
- Preterm birth is linked to levels of deprivation, with more preterm babies being born to women and birthing people living in deprived areas.
- The midwifery workforce described a lack of cultural awareness and generalisations made by colleagues based on ethnicity.

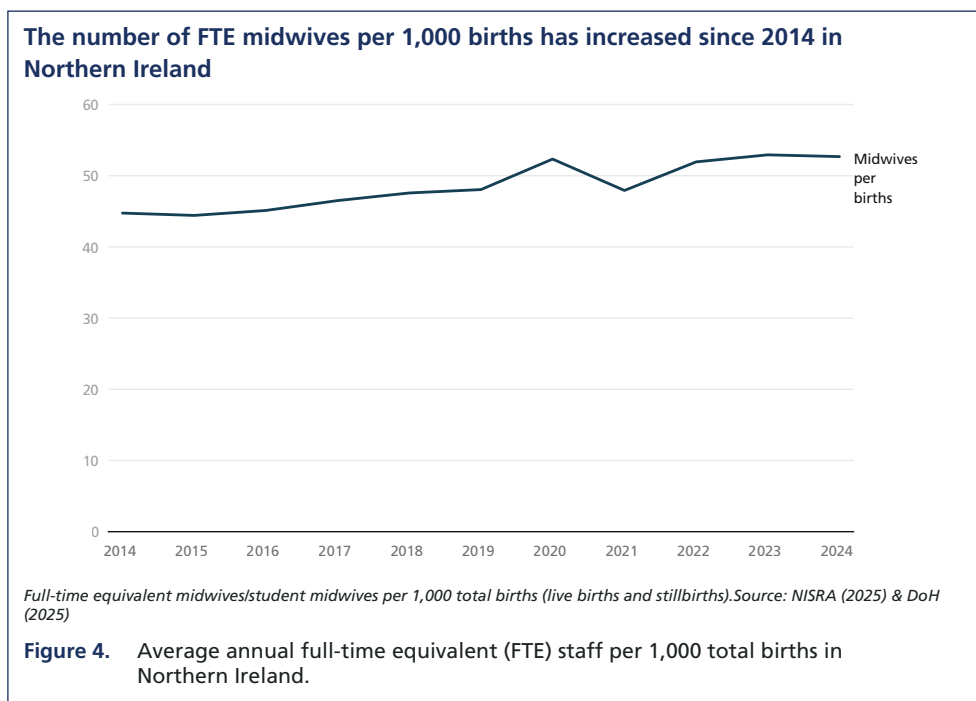
In Northern Ireland, better data are needed to identify the groups at most risk of pregnancy and baby loss, as well as understanding what is driving inequalities and identifying potential solutions. The Maternity and Neonatal Dashboard contains a range of demographic and clinical information of women, birthing people and their babies at booking and mode of onset labour and birth. However, the Review notes that this information is not reported by levels of deprivation or ethnicity. Improving data collection and analysis to understand the experiences of Black, Asian, and minority ethnic women and birthing people, as well as those living in deprived areas, are essential to address inequalities in maternity and neonatal care.

Systemic issues in maternity and neonatal services need to be addressed

The absence of regular, national reporting makes monitoring the quality of services across Northern Ireland challenging. Reports and assessments reviewed by the Sands and Tommy's Joint Policy Unit identified recurring issues affecting the safety of maternity and neonatal services. This section explores these issues in the context of Northern Ireland.

Workforce capacity and training

In Northern Ireland, the number of midwives/student midwives per 1,000 births has increased 16.1% since 2014 (see Figure 4). This is driven partly by falling birth rates in the same period (-20.4%).



[Since 2021](#), the nursing, midwifery and health visiting staff groups have grown by 8%, which is the same rate as all staff groups. In the same period, the number of FTE midwives has increased by 0.5%, showing a much lower rate of growth.

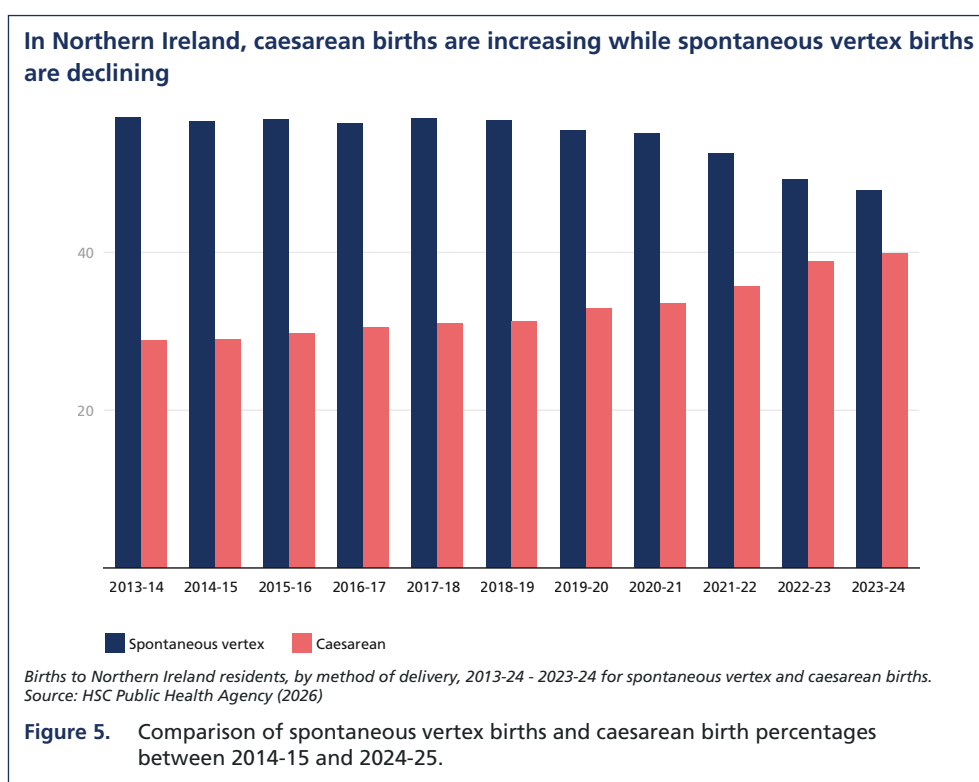
Despite the improvement in staff to birth ratios, staff report high levels of stress and burnout. The Review notes the impact of stress on midwives and the issues it causes for retention and recruitment.

There are also high rates of staff absence due to sickness. The Review noted that the sickness absence rates for both midwives and MSWs have increased between 2018/19 and 2022/23, from 7.52% to 9.08% (midwives) and from 11.12% to 16.33% (MSWs). The Review notes that the leading cause of sickness absence was mental health, including workplace stress (35.6%).

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

- The mean age of mothers and birthing people in Northern Ireland has slightly increased in the past decade (4%). Pregnancy at advanced maternal age¹, which has increased by [4.8% in the past decade](#), 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; almost a third (29%) of women and birthing people² [were classed as obese](#) in 2024-25, a 10% increase from a decade earlier (19%). 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 age³ in Northern Ireland have declined slightly in the past decade; 12.6% of females aged 16-54 had a high [GHQ12](#)⁴ score compared to 14.9% in 2014-15.
- Women and birthing people with long term physical (including obesity, diabetes) or mental health conditions (including anxiety, depression) or social complexities may require additional, and often specialist, staff time to provide the necessary support and referrals.

Mode of birth delivery is also changing, with an increase in caesarean sections and decline in vaginal births (see Figure 5).



Changes in the birthing population and clinical approaches affect all staff working in maternity and neonatal services. However, the workforce planning tool used nationally in Northern Ireland, BirthRate+ (BR+), is limited to midwives and does [not adequately reflect](#) the clinical and administrative demands on staff time. The Review notes that a recent BR+ report shows a deficit of more than 80 WTE midwives across Northern Ireland, which is likely to be a significant underestimate due to the number of important midwifery responsibilities that are not accounted for in the tool. In addition, the Review notes that newly qualified midwives (NQMs) are struggling to gain experience in core skill areas partially due to the reduction in the number of spontaneous vaginal births. An updated, multidisciplinary workforce planning tool is needed to accurately assess how many staff, from all relevant staff groups, are needed in each role across the country.

1. Defined as a woman or birthing person who will be aged 40 years or over at the time of giving birth. While some sources define advanced maternal age as 35 years or over, this document uses 40 years and over as the threshold throughout.

2. Females between ages 16-44.

3. Females between ages 16-54.

4. 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.

Understanding of workforce skill mix remains limited due to a lack of benchmarking data and insufficient information linking workforce composition to the care needs of women, birthing people, and their babies. Improved data collection is needed to better understand workforce skill mix and ensure services are staffed with the right people in the right roles, with the right skills, at the right time to deliver safe care. The introduction of a multidisciplinary workforce planning tool would help to recognise the range of staff involved in care and factor in the time needed for training.

Culture of safety

The Review identified a culture of fear among staff in maternity and neonatal services. Participants reported that concerns about adverse outcomes, investigations, scrutiny and litigation influenced decision-making and discussions with women, contributing to a more risk-averse approach to care. The Review also found that this culture affected staff confidence, morale and wellbeing.

A culture that is overly focused on blame and risk management can hinder learning, collaboration and staff wellbeing. Strengthening safety therefore requires an environment that balances accountability with support, enabling staff to exercise professional judgement, learn from incidents and provide person-centred care with confidence.

To strengthen the culture of safety, the Review highlighted the importance of moving away from fear-based practice towards approaches that support learning, collaboration and person-centred care. It also emphasised the role of multidisciplinary education and training in promoting effective teamwork and the delivery of safe, high-quality care.

Leadership, governance and accountability

The Review highlighted the need for a more consistent approach to leadership across maternity and newborn services. Participants reported challenges with communication, transparency and opportunities for staff to share their views and experiences.

Findings also emphasised the importance of psychologically safe leadership, where staff feel respected, supported and able to speak up. It recommended leadership that promotes learning, collaboration and improvement, alongside investment in leadership development to strengthen teamwork and the delivery of safe, high-quality care.

Stronger governance and accountability arrangements across maternity services were also identified as a priority. It found that HSC Trust Boards did not always have a clear line of sight to service outcomes, operational pressures or the challenges being experienced by staff. Our review of Board papers highlighted the importance of effective monitoring, reporting and use of data to support oversight, accountability and quality improvement. Improved use of data and reporting is therefore required to provide greater visibility of service performance, support informed decision-making and strengthen accountability across the system.

Data, monitoring and assurance

High-quality data are essential for monitoring outcomes and improving maternity and neonatal care. The introduction of Epic in 2023 created a single electronic patient record, improving opportunities for data sharing and performance monitoring.

While some maternity-related data are reported through Public Health Agency (PHA) publications, challenges remain around data completeness and consistency. Midwives are responsible for recording much of the information entered into Epic throughout the maternity care pathway, creating a significant administrative responsibility alongside clinical care. The Review notes that midwives feel the 'considerable burden of responsibility' for accurate data collection.

More complete demographic data are also needed. The Review noted that approximately 95% of women giving birth in Northern Ireland in 2021-22⁵ were recorded as White, yet ethnicity and deprivation are not routinely reported across all maternity performance measures. This limits understanding of inequalities and opportunities to improve outcomes for different population groups.

Engagement with service users

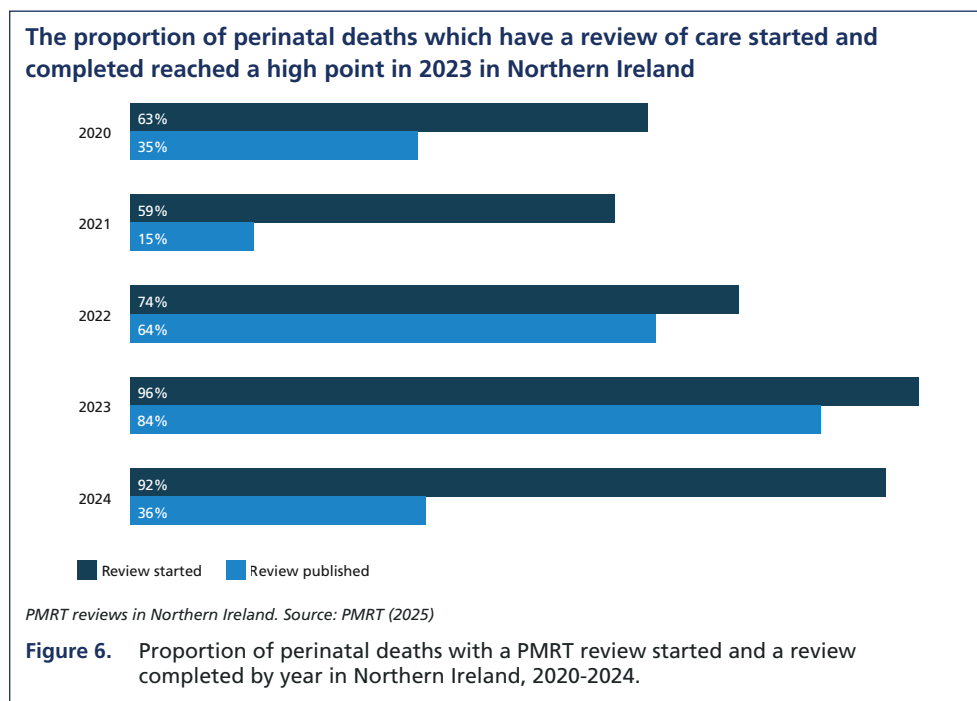
The Review highlighted the need to transform the relationship between women and birthing people and healthcare professionals to offer equitable, personalised care and ensure they feel listened to and supported. However, there is a lack of consistent recording of women and birthing people's opinions across Northern Ireland.

In August 2020, [Care Opinion](#) was launched in Northern Ireland, enabling service users to share their experiences of health and social care. Since its introduction, more than 10,000 maternity-related stories and 800 neonatal stories have been shared through the platform. Care Opinion shows how many staff members have read each story, whether positive or negative, and requires a response from a member of staff outlining any actions taken as a result. While the platform provides an important opportunity for service users to share their experiences and encourages organisational learning, participation is voluntary. As a result, the feedback may not be fully representative of all service users, as those with particularly positive or particularly negative experiences may be more likely to share their views.

5. These are the most recent data published regarding ethnicity.

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. [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 ensure understanding and reducing future avoidable harm. Since the Perinatal Mortality Review Tool (PMRT) was introduced in Northern Ireland in 2020⁶, the proportion of perinatal deaths reviewed within the same year and completed has been variable. A high point for reviews started and completed peaked in 2023, with 2024 showing a 50% decrease in completed reviews (see Figure 6).



In 2024, a review was started for 93% of stillbirths and late miscarriages occurring in Northern Ireland Health Boards, with a 51% completion rate. For neonatal deaths, a review was started for 90% of deaths in 2024, but with a much lower completion rate (16%). The proportion of completed perinatal reviews in Northern Ireland is the lowest of the four nations; compared to Scotland (43%), Wales (79%), and England (89%). Incomplete reviews mean that any learning for health services and staff is not captured or acted upon, which could lead to repeat of avoidable harm in the future.

Delivering care in line with nationally agreed standards

Nearly all (98%) of the PMRT reviews completed in Northern Ireland 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.

In July 2025, the Department of Health set out a Reset and Recovery aimed to reduce unwarranted clinical variation across the Health and Social Care system. However, as it did not include specific actions for individual services, its impact on reducing unwarranted variation for maternity and neonatal services remains to be seen.

Variation may also exist in access to and experiences of miscarriage and recurrent pregnancy loss services. The Review highlighted the limited availability of data on miscarriage outcomes and identified opportunities to improve consistency in care pathways. In response, a regional Recurrent Pregnancy Loss Task and Finish Group [has been established](#) to review existing pathways, identify variation in access and quality of care, and develop recommendations for more standardised and timely care across HSC Trusts.

6. Trusts in Northern Ireland adopted the PMRT for the conduct of reviews during autumn 2019. Therefore, the reviews carried out in Northern Ireland in 2019 and 2020 were during the implementation phase of the use of the PMRT and few reviews were completed or published in 2019. This table therefore only includes information about reviews carried out from January 2020.