UCLPartners
Health Innovation

NCMD
National Child Mortality Database
Knowledge, understanding and learning to improve young lives

Maternity Clinicians Communications Preference Survey Results 2025

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Background

The National Child Mortality Database (NCMD) national data collection and analysis system is the first of its kind anywhere in the world. It records comprehensive data, standardised across a whole country (England), on the circumstances of children's deaths. The purpose of collating information nationally is to ensure that deaths are learned from, that learning is widely shared and that actions are taken, locally and nationally, to reduce the number of children who die.

The programme was established and is delivered by the University of Bristol, in collaboration UCLPartners, who lead the Quality Improvement workstream of the programme. The programme includes representation from bereaved families through the NCMD charity partners, Child Bereavement UK, SANDS and The Lullaby Trust. The programme is funded by NHSE.

NCMD Reports and Recommendations

Each year the NCMD publishes a number of reports and scientific papers containing recommendations directed at various groups and organisations, from practising clinicians to government departments. There is a perception that these messages are often not filtering through to "front line" clinicians and, in particular, midwives, GPs and Health Visitors, who have a vital role in advising new parents on child health and safety issues.

The Safety Engagement and Training Programme

UCLPartners have set up the NCMD Safety Engagement and Training Programme (SE&TP), a dynamic working group whose purpose is to identify key messages in NCMD publications, and advise on how best to convey these messages to target audiences. The group membership reflects the topics of the most recent NCMD reports, and currently includes representation from The Royal Society for the Prevention of Accidents (ROSPA) and The Child Accident Prevention Trusts (CAPT).

The SE&TP Working Group understands that the amount of information contained in national reports and research outputs can seem overwhelming for clinicians and, in response, the group aims to develop communications that streamline the safety messaging to clinicians about actions to reduce child mortality.

Methodology

The SE&TP Working Group aimed to collect the views of clinicians working in maternity services to understand their preferences on receiving information on the outputs of healthcare report, and related research projects, focusing on safety messages relevant to their role.

An MS Form was created with the following questions:

1. Where do you currently get your news about health care?
2. How often do you read articles about healthcare reports and research relevant to your clinical role?
3. How would you prefer to learn about findings and recommendations of health research, healthcare reports and national audits relevant to your clinical role?
4. Which generation do you belong to?
5. What type of healthcare professional are you?

Respondents were also asked if they would be willing to be contacted by a researcher to participate in a short interview to gather more in-depth feedback.

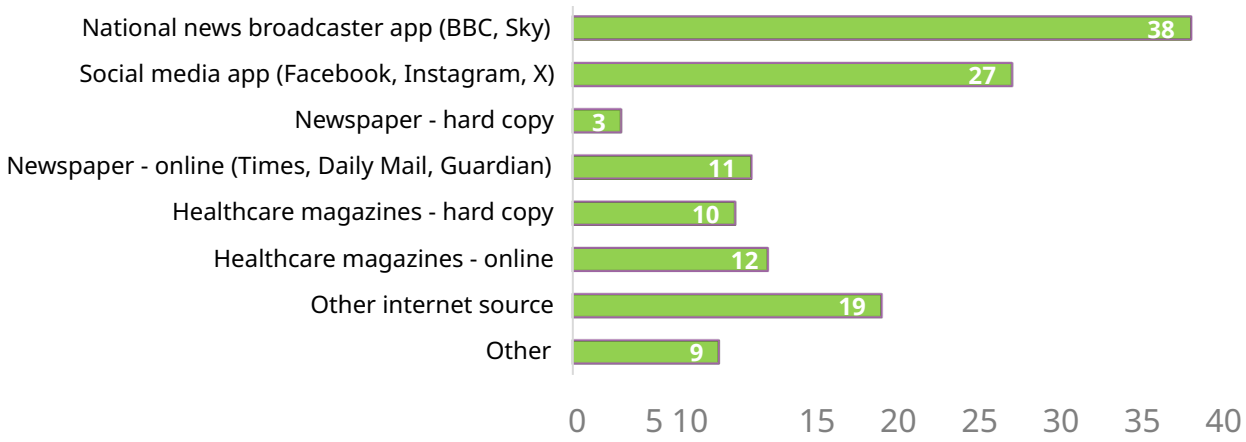
Posters with a QR code linking to the MS Form were printed and sent to the Practice Development midwives at each of the maternity units within the UCLPartners geography, and the main maternity unit in Bristol. An email link to the poster was sent to relevant maternity contacts in the UCLPartners contacts database.

The questions on the form were deliberately kept short to improve the response rate and survey ran for 50 days.

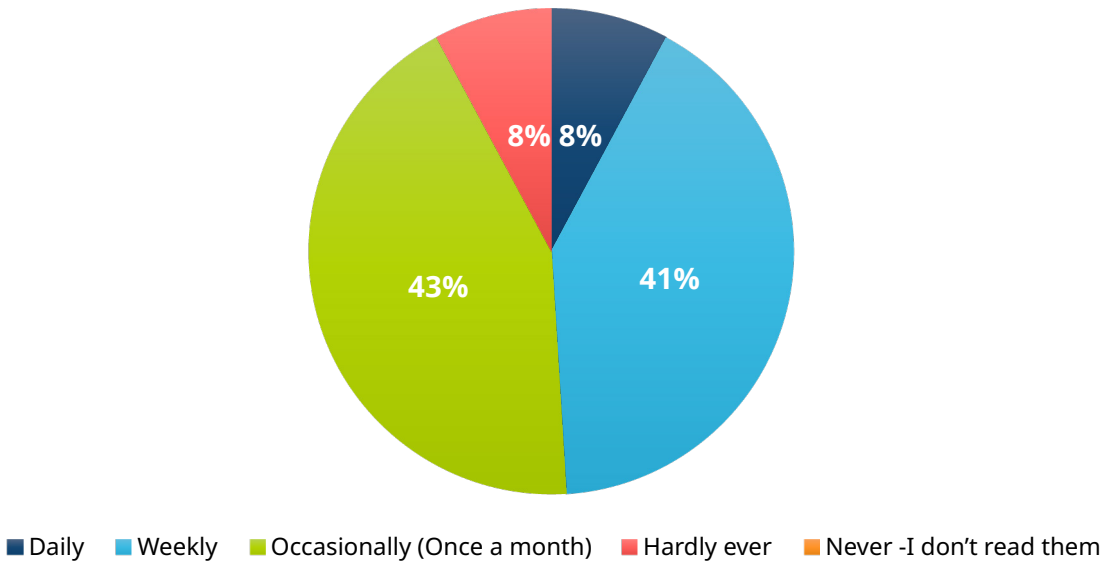
Results

- Over 50 days there were 51 respondents. All five questions were completed on every form.
- Four midwives agreed to take part in an interview with more in-depth questions averaging 20 minutes

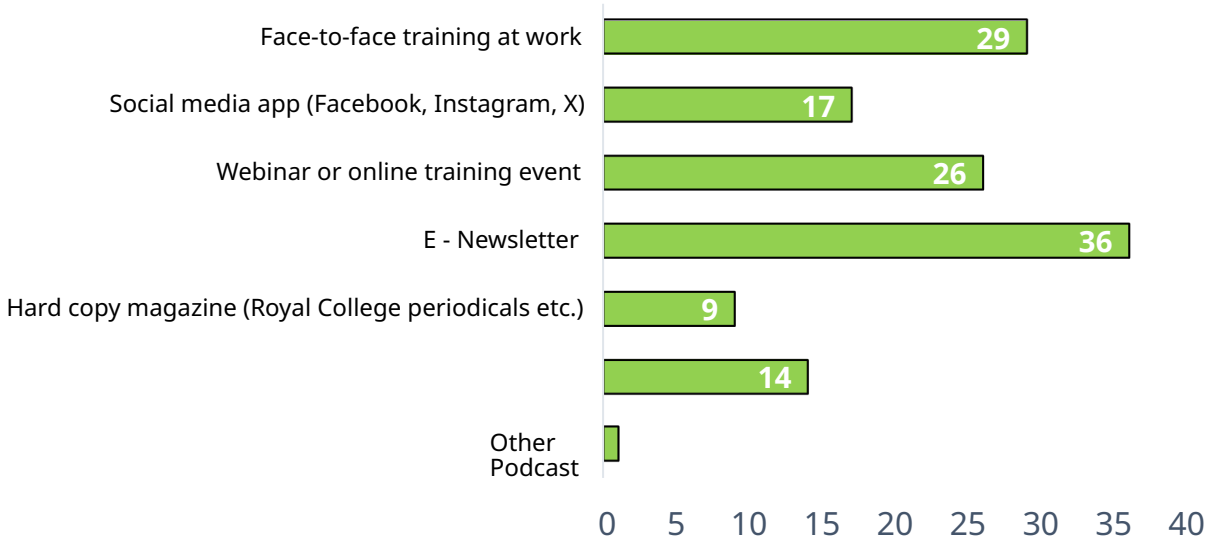
1. Where do you currently get your news about health care? (Check all that apply)



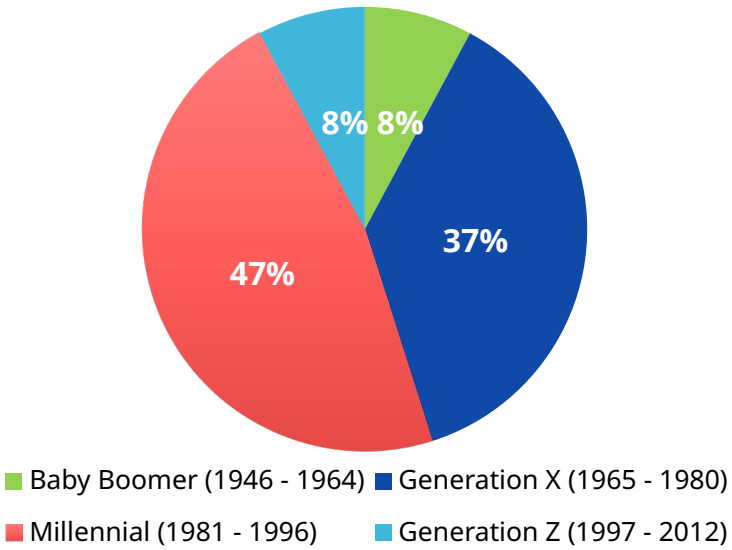
2. How often do you read articles about healthcare reports and healthcare research findings relevant to your clinical role?



3.How would you prefer to learn about findings and recommendations of health research, healthcare reports and national audits relevant to your clinical role? (Check all that apply)



4. Which generation do you belong to?



Number of respondents by occupation

Midwife	38
Doctor	9
Neonatal Nurse	2
Other	2

Themes from the in-depth interviews

All of the health care professionals who were interviewed were practicing midwives. One also held a post as a research midwife. Several themes emerged from the interviews:

1. Report fatigue

Midwives reported that there was a sense of report fatigue and that they often felt bombarded with information. Midwives also considered that the tone of reports, and the associated coverage in the press, was often negative and disparaging towards midwives.

"It can be quite frustrating and disheartening as well, I think having read a lot of these reports, when they come out, you're just like oh, I don't know if I can bear to go through this again because it's just quite disheartening, and especially with the current narratives in the media. I find that they can be quite negative about midwives."

2. Repeated messaging

Feelings of futility around repeated messages in successive reports were also mentioned. This discouraged the midwives from reading new reports.

"There's been so many different maternity enquiries in recent years and there's been a lot of research done on how staff felt about these enquiries and reports. Most of the times they find that it's the same things are being published and a lot of midwives feel the recommended changes are out of our control, things like culture and staffing numbers."

3. A lack of protected time for personal development activity

Midwives reported feelings of resentment about the expectation to complete professional development activities outside of their working hours.

"All of my mandatory training had to be done for this week and I just didn't have the time to actually do it because there was so much other stuff going on at work. My manager is like 'you need to do this' and I was like, yeah okay, but I just end up doing it outside of work time when there's other things that I want to do with my time off."

Midwives reported a sense of wanting to keep their work and home life separated to protect their mental wellbeing.

"I don't follow midwifery accounts on my Instagram and TikTok because I look at them on my way home to switch off and I don't want to keep reading lots of things about work. I just need some headspace".

4. Limited face to face time with patients

Midwives reported having very limited time to engage with parents on the wards to discuss the causes of child mortality. It was also suggested that parents were often too tired at the point of discharge from the postnatal ward to take on lots of new information, and it was suggested that antenatal classes might be a better place to discuss these issues.

"We are all rushing around so much to make sure that the mums go home and that they have all the right paperwork and meds, it feels like there's just no time for anything else at that point, and, maybe it would be better to talk to them before or after they are in hospital. Sometimes it's all very chaotic on the wards and that's not the right time to talk about this sort of thing."

5. Lack of knowledge about traumatic causes of infant death

The midwives were knowledgeable about infant sleep safety, but less so around the causes of traumatic deaths in infants such as the risk of infants drowning in the bath.

"In regards to accidental injury for child death, we don't counsel patients on that. I think the communicable and non-communicable diseases, we would talk to them about that more so, and (advise them to) escalate early if there are signs of deterioration in their health, or the baby's health."

"I definitely talk to mums about not bed sharing, or not bed sharing if like they're smokers, and also not letting the baby get too hot at night and things like that, but I don't think I've thought about the bath time safety issues".

Recommendations

1. Carefully consider the tone of reports and outputs, avoiding criticism of midwifery and medical staff, and instead focusing on positive actions for improved care and outcomes for infants.

2. Social media channels and news corporation apps are key sources of information for clinicians; however, staff may prefer to receive messaging from health reports and related research during workplace face-to-face training sessions and in e-newsletters, which are viewed as less intrusive in terms of maintain a good work life balance.

3. There is a lack of knowledge in the healthcare community around the causes of traumatic deaths in infants. An information campaign should be targeted at clinicians who have the most contact with parents, particularly during the antenatal period.