Tommy's
Together, for every baby

27th April 2021
The Rt Hon Matt Hancock MP
Secretary of State for Health and Social Care
By email

Dear Health Secretary,

Call to address miscarriage treatment and care in England/the UK

In light of the publication of The Lancet series of papers on miscarriage, on 26th April 2021, which describe the prevalence, impact and evidence for best practice in miscarriage care, we are calling for an overhaul of miscarriage services in England, so that they are effective, fair and equitable to all.

The key findings of the three 'Miscarriage Matters' papers were as follows:

- The short-term national economic costs of miscarriage, associated with immediate costs to hospital and community health and social services, are estimated to be £471 million annually to the UK. Taking a wider view of miscarriage would undoubtedly raise this figure, once GP-associated costs and the costs of caring for couples with psychological conditions caused by a miscarriage are included. Other factors to consider would be longer-term employment and occupational status, income, and receipt of social welfare benefits.
- Black women are at a 40% increased relative risk of miscarriage than white women and female age is one of the most prominent risk factors for miscarriage, along with the number of previous losses. Women who have underlying health conditions have an increased risk of miscarriage.
- Smoking is an important modifiable risk factor for miscarriage. Women who smoke in the first trimester are 1.2 times more likely to have a miscarriage than non-smokers, and the risk of miscarriage increases with the amount smoked (1% increase in relative risk per cigarette smoked per day).
- A woman's BMI is associated with the risk of miscarriage. The BMI associated with the least risk of miscarriage is 18.5 – 24.9 kg/m2, considered to be the healthy weight range, whilst women with a BMI under 18.5 are 1.6 times more likely to miscarry and those with a BMI over 30 were 1.9 times more likely to miscarry.
- Miscarriage, particularly recurrent miscarriage, is a sentinel risk marker for obstetric complications in a future pregnancy. The risk of preterm birth increases stepwise with each previous miscarriage, demonstrating a biological gradient. Women after one miscarriage are 1.2 times more likely to have a preterm birth, after two 1.4 times more likely and after three 1.8 times more likely. Miscarriage is associated with an increased risk of placental dysfunction disorders in later pregnancies. Our review found that after three miscarriages women are 1.7 times more likely to experience placental abruption in a later pregnancy, and 1.6 times more likely to have a stillbirth.
- Recurrent miscarriage is associated with a significantly increased risk of cardiovascular disease and venous thromboembolism. After experiencing three miscarriages, women are

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1.4 times more likely to suffer from cardiovascular diseases, and 6.1 times more likely to suffer from venous thromboembolism.

- Anxiety, depression, post-traumatic stress and suicide are strongly associated with miscarriage. It is important to note that it is not only recurrent miscarriage that is associated with these psychological conditions, but also that one miscarriage can have a significant psychological impact. A recent study[1] from the Tommy's centre found that nine months after a pregnancy loss, 18% of women met the criteria for post-traumatic stress, 17% for moderate to severe anxiety, and 6% for moderate to severe depression. This demonstrates that distress remains at clinically important levels for some months after an early pregnancy loss. One miscarriage also increased the likelihood of suicide, with women who had experienced miscarriage being 3.8 times more likely to die by suicide.

We are calling for the Government to implement three key changes in response to this new evidence:

1. **Act to ensure that designated miscarriage services are available 24/7 to all, taking into account local conditions and resources.** Women must receive appropriate, standardised care during and after their first miscarriage, including the best management of miscarriage and pre-conceptual support to intervene on modifiable risk factors and underlying health conditions. Women and partners should have access to follow-up mental health support to help reduce mental illness post-miscarriage.
2. **Treatment and care must be standardised and equitable. Appropriate care must be given to everyone after 1, 2 and 3 miscarriages in line with a 'graded model' of care.** Health services should standardise and structure care using a graded model where women are offered nurse-led and online healthcare advice and support after one miscarriage, care in a nurse or midwife-led clinic after two miscarriages, and care in a medical consultant-led clinic after three miscarriages. This approach balances the need for evidence-based management and supportive care, whilst targeting health care resources appropriately. Where Early Pregnancy Units and recurrent miscarriage clinics already exist, these services are integrated to deliver care within this graded model.
   In addition:
   - Parity of esteem must be given to mental health
   - Specific, personalised care pathways must be established to those at highest risk – i.e. black women, women over 40 and those with underlying health conditions.
   - Centres of excellence for those experiencing recurrent (three or more) miscarriages must be available regionally; no one should have to travel for more than an hour to access specialist care.
3. **To acknowledge that miscarriage matters to parents and take steps to record every miscarriage in England.** Data on the number of miscarriages from Early Pregnancy Units, GPs and Accident and Emergency services must be calculated and published along with stillbirth and preterm birth rates. This will allow us to fully understand the scope of the problem and enable the setting of targets for reduction.

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We have been seeking public support for these changes, and have so far amassed over 127,000 signatures from members of the public who would welcome the government acting to improve miscarriage care. You can view the petition here: https://actions.tommys.org/a/miscarriage-petition

We share and applaud the Government's ambitions to improve maternity care and reduce the number of babies who die during pregnancy and birth and now is the right time to ensure that miscarriage care receives parity of focus and ambition in line with the efforts to reduce stillbirth and preterm birth.

We commend the Government's decision to open 26 dedicated mental health services for new, expectant and bereaved mothers. We hope that this new evidence can help ensure that the needs of those women who have experienced miscarriage are taken into consideration in these services. We also welcomed the announcement that the Government is embarking on the first women's health strategy for England this year. We want to ensure our recommendations are helpful in determining this strategy, and discuss how we might work towards achieving this.

I would like to request a meeting with you to discuss the evidence and the changes we have recommended and perhaps this might be held at the National Centre for Miscarriage Research in the clinical space where we see women who have experienced many miscarriages. It would give you the opportunity to talk to the authors of the papers and meet some parents whose experiences motivated us to do this work.

Yours sincerely,

Jane Brewin, Chief Executive Officer, Tommy's

Dr Edward Morris, President, Royal College of Obstetricians and Gynaecologists

Gill Walton, Chief Executive, Royal College of Midwives

Dr Clea Harmer, Chief Executive, Sands

The Miscarriage Association

Jane Plumb MBE, Chief Executive Group B Strep Support

Munira Oza, Director, The Ectopic Pregnancy Trust

Naomi Delap, Director, Birth Companions

Leanne Turner, Founder/CEO, Aching Arms

Justine Roberts, Founder and CEO, Mumsnet

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Marcus Green, Chief Executive, Action On Pre-Eclampsia

Dr Judy Shakespeare, Retired GP

Jenny Ward, Chief Executive, Lullaby Trust

Laura-Rose & Stacey Thorogood, Founders, The LGBT Mummies Tribe

Alison Morton, Acting Executive Director, The Institute of Health Visiting

Best Beginnings

CMV Action

Twins Trust

Pregnant Then Screwed

Petals

Baroness Estelle Morris, Chair, APS Support UK

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