Equity for Every Baby: Tackling inequalities in neonatal care linked to ethnicity and socioeconomic deprivation

Summary report: England 2026

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Bliss
for babies born premature or sick

Equity for Every Baby

Some babies born premature or sick face a double disadvantage: they are more likely to need neonatal care and more likely to have worse outcomes when on the unit

Financial barriers can limit parental presence and involvement

Inequity related to minoritised ethnicity and socioeconomic deprivation is present throughout every step of a baby's journey to, and through, neonatal care

Interpretation and translation services are poor, impacting FICare delivery

Babies born to families experiencing socioeconomic deprivation are less likely to receive developmental follow up, despite being more likely to have worse developmental outcomes

What needs to change

Embed FICare and ensure equal access to financial support

Improve collection of babies' demographic data

Invest in high-quality translation and interpreting services

Set national targets to reduce inequalities in rates of neonatal mortality, preterm birth and full-term admission

Increase representation in neonatal studies

Executive summary

Every day, over 1,500 babies are born in hospitals in England, with 1 in 7 of them needing specialist neonatal care[1]. These babies do not have an equal chance of survival and long-term health.

The report presents a comprehensive picture, showing the unacceptable and shameful truth that inequities related to socioeconomic disadvantage and minoritised ethnicity are present throughout every step of a baby's journey to, and through, neonatal care.

Our report provides stark insight into how a system under pressure can perpetuate existing health inequalities and lead to poor care and harm for babies and families. Yet this is not inevitable. Change is possible and is being embedded right now on some neonatal units and in initiatives to tackle health inequalities.

Achieving equity for every baby requires bold and decisive action from everyone involved in the commissioning and resourcing, direct delivery, and monitoring of neonatal services, including policymakers, care providers, researchers and healthcare professionals. This project also reaffirms the importance of Bliss continuing to identify how we can be more inclusive and better advocates for the needs of all babies and families.

What we did

We undertook a comprehensive literature review to understand existing evidence on outcomes for babies needing neonatal care who are born into socioeconomically deprived families and minoritised ethnic groups. We wanted to understand:

- how a baby's neonatal care experience and health outcomes are impacted by health inequalities
- what the most significant data and evidence gaps are
- how effective current policy has been at identifying the impact of health inequalities in neonatal settings, and at addressing these.

We worked with two community partner organisations who conducted in-depth one-to-one interviews with nine parents who face challenges relating to socioeconomic deprivation. Additionally, we analysed transcripts from previous Bliss listening events with 11 Black and South Asian parents to identify common themes.

What we found

Unequal risk before and after birth:

- some babies face a **double disadvantage**. They are more likely to need neonatal care and more likely to have poorer outcomes on the neonatal unit
- there is a clear **intersection** between ethnicity and socioeconomic deprivation. Both factors are independent drivers of disparities in care and outcomes but they also have a combined impact that increases the likelihood of poorer outcomes
- while there is growing evidence of where inequalities exist, and the extent to which they are present, there is **much less evidence on how to address them effectively**

[1]NHS England (2025) Maternity and neonatal infrastructure review findings [accessed online:] https://www.england.nhs.uk/long-read/maternity-and-neonatal-infrastructure-review-findings/

- data gaps are prevalent, and there are **significant issues with data collection**, preventing effective response to known issues
- policy intervention has focused on reducing inequity in neonatal outcomes through addressing maternal inequalities during pregnancy and around the time of birth. **There has been limited attention on how inequalities in care delivery within neonatal services may manifest.**

Inequalities in clinical care, and experiences of care:

- evidence shows clear disparities in treatment and care practices, including **lower likelihood of deferred cord clamping and inconsistencies in breastfeeding rates** for minoritised ethnic groups and babies born into deprivation
- Family Integrated Care (FICare) – which enables parents to be partners in delivering their baby's care and decision-making – is proven to improve outcomes for babies but it is experienced inequitably
- **parental presence does not equal participation.** Data shows that parents with minoritised ethnicity and parents experiencing deprivation are less likely to be involved in ward rounds, receive early updates from staff and are not always adequately supported to be involved in their baby's care. We heard that **individualised care** was essential to support increased involvement but was often lacking in practice
- **language and communication issues are a significant barrier to FICare delivery.** Neonatal services frequently lack access to good and reliable systems to support interpretation. We also heard from families that minimal efforts were made to support communication with families who did not speak English
- **when parents are unable to be partners in delivering care, this affects babies' outcomes.** Evidence shows that babies whose parents are more involved in their care have better outcomes. The barriers to parental partnership for parents facing deprivation, and parents from minoritised ethnic groups, have a direct impact on their baby's health and development.

Beyond neonatal care:

- inequalities in parental partnership on the unit mean some parents will be less confident navigating the transition from unit to home. **Some babies go home to conditions which do not facilitate recovery**, and some parents cannot afford to run essential medical equipment
- socioeconomic inequalities impact longer-term developmental outcomes, and there are **ethnic and socioeconomic inequalities in developmental follow-up**
- outreach and follow-up services are patchy, resulting in **inequitable access across England** that increases the risk of poorer health outcomes for these babies as they grow up.

What needs to happen

Making neonatal services more equitable and ensuring every baby has the best chance of survival and quality of life, regardless of their background or circumstances, is the responsibility of everyone working in or around these services: policymakers, care providers, researchers, healthcare professionals and organisations who support babies and families, including Bliss.

Bliss will continue to champion equity in our policy and influencing work, including routinely monitoring the impact we have for babies facing socioeconomic deprivation and from minoritised ethnic groups.

Bliss will continue to review its information, support services and parent engagement approaches to ensure they are culturally responsive and shaped by families facing inequalities, including through targeted outreach and partnerships with community organisations.

Recommendations

1. The Government should set clear, national targets to reduce disparities in rates of neonatal mortality, preterm birth, and full-term neonatal admissions between ethnic and socioeconomic groups.

2. The Government should establish a financial support package for families to support with a range of unanticipated costs which occur when a baby is admitted to neonatal care, modelled on the support provided through the travel fund for families of children and young people who have cancer.

3. The Government should set out a plan for long-term investment in overnight accommodation for parents with a baby in neonatal care, supported by short-term actions such as updating the guidance in the Neonatal Health Building Note and developing a small grants programme for NHS Trusts to improve their existing facilities.

4. Integrated Care Boards and NHS Trusts should ensure adequate funding, provision and oversight of high-quality interpreting and translation services.

5. Neonatal units should ensure all staff are trained and supported to deliver culturally responsive care, utilising tools such as the Bliss Baby Charter and Bliss' Early Conversations Toolkit to improve practice.

6. Neonatal units should proactively review their existing financial and practical support, like meal provision, and Neonatal Operational Delivery Networks should ensure equity across the region.

7. Neonatal units should ensure all families are informed as early as possible about the support available to them and are reminded of this throughout admission, utilising tools such as the Bliss Baby Charter to audit and improve practice. Neonatal units should ensure that dedicated staff hold these responsibilities and that mechanisms are in place to ensure all families are receiving this information.

8. The Government must invest to ensure evidence-based staffing standards can be met across medical, nursing, Allied Health Professionals, Psychologists and Pharmacists.

9 NHS Trusts should ensure all neonatal staff receive training and ongoing support in culturally responsive care, equipping them to identify and respond to inequalities, understand families' diverse circumstances, and tailor care to individual needs in day-to-day practice.

10 NHS Trusts should make training in culturally responsive palliative and bereavement care mandatory for all neonatal staff, ensuring they can provide compassionate, individualised support that reflects the cultural, faith and practical needs of each family at end of life.

11 NHS Trusts should ensure that psychologists working on neonatal units have adequate time and resources to ensure their remit includes providing support to the neonatal staffing team, as well as families.

12 Local authorities and other relevant bodies should work with neonatal services to ensure that no baby's discharge from neonatal care is delayed due to unsafe or unsuitable home conditions, including lack of reliable energy supply or adequate housing.

13 The Government should ensure neonatal community outreach services are commissioned consistently to ensure more babies receive care at home, reducing separation, improving care experience and reducing pressure on acute hospital services. This should include ensuring Allied Health Professional, Pharmacy and Psychology input can continue to be facilitated at home. Priority for service development should be in areas with higher levels of deprivation and poorer access to follow-up support.

14 Neonatal units should comply with the Neonatal Critical Care Service Specification for discharge planning, ensuring that planning starts at admission for all babies and that unit staff are able to identify any support that families may need to care for their baby at home.

15 Neonatal units should share best practice to improve rates of 2-year follow-up, with a specific focus on improving access and attendance among babies from more deprived backgrounds and minority ethnic groups.

16 The National Neonatal Audit Programme should include measures to monitor uptake of 4-year follow-up, and compliance against best practice guidance.

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The Government should ensure that the forthcoming Single Patient Record can support greater uptake of eligible children receiving 4-year follow-up, by ensuring there are systems in place to proactively identify eligible children within community health care (e.g. GP services) and reach those at higher risk of being lost to follow-up.

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NHS Trusts should work with their Neonatal ODN to improve the rate of collection, accuracy and reporting of babies' demographic data, including ethnicity, and standardise the recording of deprivation, ensuring this information is used both to strengthen research and analysis and for units to identify and respond to families' needs from the earliest stage.

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Neonatal research, including clinical trials, should be designed, funded and conducted to ensure meaningful inclusion of babies and parents of minoritised ethnicities and those experiencing socioeconomic deprivation; including proactive approaches to patient and public involvement (PPI) to ensure these parents are adequately represented in PPI activities.

About Bliss

Our vision is that every baby born premature or sick in the UK has the best chance of survival and quality of life. Bliss champions the right of every baby born premature or sick to excellent neonatal care, experience and outcomes. We achieve this by improving care, giving voice to babies, and supporting parents to be partners in care.

Across our 2025-2029 strategy period, we will continue to prioritise equity for all neonatal babies and families:

Equity of care

every baby born premature or sick benefits from Family Integrated Care which builds a culture of partnership between their parents and the neonatal healthcare team

Equity of voice

every baby born premature or sick has their voice and interests represented by Bliss, to influence improvements in all aspects of their care at local, regional and national levels

Equity of support

every baby born premature or sick has well-supported parents who have the information they need, when they need it, to be partners in their baby's care.

Campaign with us

Campaigning is a great way to make a difference to babies born premature or sick and their families. Sign up to our campaign network at **bliss.org.uk**

Join the family, search Blisscharity on

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