Each Baby Counts: halving the incidence of stillbirth, neonatal death and severe brain injury by 2020

Ed Prosser-Snelling MRCOG Quality Improvement Lead — Each Baby Counts, eprosser-snelling@rcog.org.uk
On behalf of the Each Baby Counts project team, Royal College of Obstetricians and Gynaecologists

Each Baby Counts is the Royal College of Obstetricians and Gynaecologists' (RCOG) national quality improvement programme, which aims to reduce intrapartum stillbirth, early neonatal death and severe brain injury at term by 50% by 2020.

Stillbirth is a devastating experience for families, with a life-long impact and has always been one of the most feared outcomes for obstetricians. Rates in the 21st century have fallen to the point where it has thankfully become infrequent but consequently awareness of the condition has too. As many as one in 240 babies are stillborn, with one in 17 of these being an intrapartum death.[1] Advances in neonatal care have provided parents of children born in the NHS access to increasing levels of survival for sick, preterm and injured babies. Expectations of birth are now that it will be low risk, with minimal intervention and a good outcome for the majority.[2] However, this expectation by the general public can be distant from the experiences of health professionals, especially those working in high-risk hospital environments, and when things go wrong the emotions of parents, family members and staff run high. Maternity service staff have aimed for a just, learning culture[3] but maternity claims are at an all-time high[4] and the environment after a serious adverse event can be challenging for all concerned, with parents and staff suffering serious long-term consequences.[5] Reducing these tragic events is a priority, most recently highlighted by the *Lancet's* stillbirth series and MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK).[1,6]

As obstetricians, neonatologists, nursing and midwifery professionals, we have a clear and common goal in this area: to reduce the burden of suffering from incidents that happen during labour. The fourth Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) report[7] suggested that intrapartum stillbirths would be most amenable to reduction. We know that intrapartum stillbirth has a wide variety of causes. There are common aetiologies shared with neonatal encephalopathy and subsequent early neonatal death. The degree to which intrapartum hypoxia affects neonatal encephalopathy is disputed,[8,9] however we can be certain that the term fetus deprived of oxygen for long periods of time will suffer harm, damage and death.[10] The Each Baby Counts case definitions are designed to examine this group as a whole – a spectrum – with a presumed focus of injury that may include a common factor that is hypoxic, infective or traumatic but with scope to include any other relevant conditions.

A large volume of resources are invested in locally investigating adverse clinical incidents. Unlike randomised controlled trials, these investigations analyse the reality of attempting to practise evidence-based medicine in the NHS. Labour and birth are complex, multifactorial events, subject to large variations and human error. Identifying the clinical cause of an event does not necessarily lead to an understanding of why it actually happened, or a stratagem to prevent recurrence. All trusts in the UK have signed up to submit anonymised copies of their incident reports, which the RCOG will analyse. This analysis is qualitative in nature, subject to the quality of local incident reviews and must be carefully considered; it is not evidence from a randomised controlled trial but it is conducted by pairs of independent multidisciplinary reviewers. It will bring together the results of many hours of work completed by multidisciplinary review teams and share the learning that lies within the reports with the aim of driving improvement by seeing the results of these analyses translated into actions for frontline NHS staff.

The Each Baby Counts project team presented the first report into the quality of reviews at the RCOG in June 2016. Our investigations discovered that 48% of local reviews are conducted without use of a specific methodology, that few reviews featured an external panel member and, in the sample of reports we assessed for quality, just over a third of reviews contained inadequate clinical information for a judgement about care to be made.[11] A standardised approach to reviews will help to improve their quality and the information that our analysis can then aggregate. Good quality, transparent reviews will ultimately improve safety in all areas: stillbirth and beyond.

In addition to the qualitative analysis, we are conducting a systematic review of the literature pertaining to Each Baby Counts cases, examining the quality of local reviews, providing feedback to trusts and attempting to reach out to the wider community who are examining stillbirth reduction. Our principles are to be pragmatic at every step, to measure carefully but to work towards the target of a 50% reduction in intrapartum stillbirth, early neonatal death and severe brain injury by 2020.

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