Each Baby Counts: the 2018 progress report

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The latest report from the Royal College of Obstetricians and Gynaecologists' (RCOG) Each Baby Counts initiative[1] shows there was an increase in the number of completed local investigations into stillbirths, early neonatal deaths and severe brain injuries that occurred from incidents during term labour in 2016 across the UK, when compared to 2015.

In 2016, 89% of completed local investigation reports contained sufficient information for review, which is necessary to drive clinical improvements to reduce the number of deaths and injuries.

Each Baby Counts is a quality improvement programme that aims to halve the number of stillbirths and babies who die or are left severely disabled due to incidents during term labour by 2020. Every year in the UK over 1,000 babies die or are left with a brain injury during term labour. These are investigated at a local level by a hospital or maternity unit and the Each Baby Counts team is bringing together the results of these local investigations to make recommendations to improve future care on a national level and ensure mothers and babies receive the safest possible care during labour.

The *Each Baby Counts 2018 Progress Report* presents key findings and recommendations based on the analysis of data from 2016 relating to the care given to mothers and babies throughout the UK (**FIGURE 1**).[1] Of the nearly 700,000 babies born in 2016, 1,123 babies fulfilled the Each Baby Counts criteria. There were 124 stillbirths, 145 babies who died within the first seven days of life and 854 babies who sustained severe brain injuries during labour at term (≥37 weeks' gestation).

FIGURE 1 The latest report from the RCOG Each Baby Counts.

Sadly the findings show that different care might have led to a different outcome in almost three-quarters (71%) of the stillbirths, neonatal deaths and severe brain injuries included in the review. This figure is too high and shows that much work is still needed to ensure healthcare professionals are supported to implement recommendations. There was an average of seven contributory factors identified per incident and this demonstrates the complex relationship between clinical and non-clinical factors (**FIGURE 2**).

In almost half (45%) of the completed local investigations that could be assessed, guidelines and best practice were not followed. Reasons for not following guidelines included gaps in training, lack of recognition of problems, communication issues, heavy workload, staffing levels and local guidelines not being based on best available evidence. The report makes a number of recommendations including addressing workload issues, an individualised management plan for women during antenatal, labour and postnatal care, and ensuring local guidelines are updated in line with national guidance.

FIGURE 2 An average of seven contributory factors were identified for each baby where different care might have made a difference to the outcome.

The main areas of care in which improvements might have led to a different outcome for the babies affected included: a failure of health professionals to identify or act upon relevant risk factors; issues related to monitoring of fetal wellbeing with cardiotocography (CTG) and blood sampling; and individual education or training issues.

The RCOG continues to call for improvements to local investigations to ensure they are of the highest possible quality to drive improvements in maternity care and that all parents are invited to take part in reviews. In 2016 there was an increase in the number of parents who were invited to take part in reviews – up to 41% from 34% in 2015. However, in almost a quarter of instances parents were not involved, or even made aware of reviews taking place.

Recommendations for future reviews

Improving the quality of local reviews will improve the lessons learned and, ultimately, improve care. The Each Baby Counts programme has improved its knowledge and understanding of

the issues that affect reporting of cases. Factors include a lack of resources, time and guidance. The key recommendations for future reviews include:

- Neonatal input: assess local processes for involving neonatal team members in the review of Each Baby Counts babies to see whether this needs to be improved to ensure a collaborative multidisciplinary approach. This could include identifying an Each Baby Counts neonatal lead for each unit.
- Local reviews: all trusts and health boards should inform the parents of any local review taking place and invite them to contribute in accordance with their wishes.
- All Each Baby Counts eligible babies who are stillborn or who die within the first seven days of life should be reviewed using the Perinatal Mortality Review Tool (PMRT).
- There is an urgent need for a PMRT-style tool that includes morbidity to be commissioned by the UK healthcare system.

Establishing a new programme – Each Baby Counts: Learn and Support

In a bid to take recommendations forward, RCOG, in partnership with the Royal College of Midwives and the Department of Health and Social Care, is establishing a new programme of work with a number of maternity teams. The aim is to support multi-professional learning and team working; the translation and delivery of services against national strategy; and to develop sustainable improvements in maternity services by disseminating best practice and learning locally and across the NHS.

Professor Lesley Regan, President of RCOG, says: "The stillbirth, death of a newborn baby or the birth of a baby with brain injuries are life-changing events that profoundly affect women and their families. It is absolutely vital that we sustain the momentum and progress to date to ensure we really make a difference to maternity care in the UK.

"Now is the time to establish a national centre dedicated to making sure that the UK is the safest place in the world for women and their babies. Bringing together the shared expertise and experience of women and families, frontline maternity teams, academics and policymakers would be a significant step forward in driving improvement across the country."

Case study

Nicky Lyon, a parent representative on the Each Baby Counts Advisory Group, co-founder of the Campaign for Safer Births, and mother of Harry says:

"My son Harry was born with profound brain damage due to lack of oxygen at birth after what should have been a 'normal' hospital labour. I was 'low risk', had no problems during pregnancy and did everything I could to be healthy and protect my baby. I went into labour at 10 days overdue, rang the hospital and went in when advised.

"When Harry was born, he was resuscitated and put on a ventilator. When Harry was four weeks old, we were told he had profound brain damage due to the lack of oxygen at birth and were given the devastating news that he would never walk, talk or be able to feed normally.

"An investigation concluded that the CTG had not been read correctly and National Institute for Health and Care Excellence guidelines for care in labour had not been followed.

"After a difficult life of tube feeding, constant sickness, fits and discomfort, our son died of a chest infection aged 18 months. As a family we have been left devastated at the loss of our beautiful boy.

"I'm so pleased that RCOG has decided to take action on this issue with the Each Baby Counts project. Success of this project will mean hundreds of babies' lives will be saved and families will not have to experience the terrible pain and heartache that we have suffered. The project has gained incredibly valuable insight and information, which is allowing us to understand the reasons why these tragedies occur and give recommendations for action."

Reference

1. **RCOG.** Each Baby Counts: 2018 Progress Report. Online at: www.rcog.org.uk/en/guidelines-research-services/audit-quality-improvement/each-baby-counts/reports-updates/each-baby-counts-2018-progress-report/

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