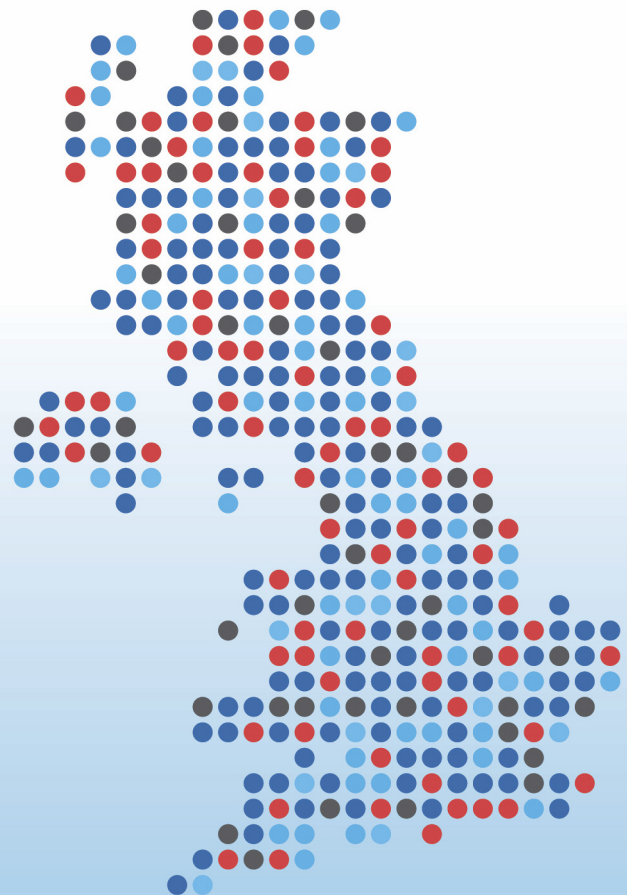




each baby COUNTS. ●

Key messages from 2015



June 2016

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each baby COUNTS.

Key messages from 2015

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We are indebted to the many healthcare professionals and other organisations who were involved in the notification of Each Baby Counts babies and the provision of other information. Without the generous contribution of their time and expertise it would not have been possible to produce this report.

We would particularly like to thank all of the Each Baby Counts Lead Reporters and Reviewers whose contribution has made it possible to carry out this surveillance and analysis. Due to the large number of individuals involved in these groups all contributors are listed on our website at: <https://www.rcog.org.uk/each-baby-counts-team>.

We would also like to express our gratitude to the members of our Independent Advisory Group, who provide supervision, strategic direction and governance of the activities of the programme, to our Independent Data Surveillance Panel, who are responsible for careful scrutiny of the national surveillance and Serious Incident (SI) data submitted to Each Baby Counts, and to the MBRRACE-UK team for providing data to check case ascertainment.

Finally, we are grateful to members of the RCOG committees, who have provided useful thoughts and valuable feedback on draft versions of this report, particularly the Lindsay Stewart Committee for Audit and Clinical Informatics and the Clinical Quality Board.

* denotes an equal contribution to this report

Foreword – Each Baby Counts origins and aspirations

Most women in the UK receive exemplary care during labour and the vast majority go home with a healthy baby. As professionals dealing with birth day, in and day out, we have always seen a small proportion of babies die or suffer a severe brain injury because of complications during labour. The small number of these tragedies does not betray their huge impact. There is a profound and long-lasting effect on the entire family – parents, siblings and extended family members. Often the root cause is difficult to ascertain and uncertainty leads to further pain. There is also an effect on staff involved, the financial costs to parents and the wider NHS, not to mention the years of uncertainty caused by possible litigation. We wanted to know if we could avoid this, or at least some of it.

Before we began Each Baby Counts, little evidence was available about the scale or causes of intrapartum harm to babies. The best available estimates suggested that, each year in the UK, between 500 and 800 babies died or suffered a severe brain injury at term as a result of incidents during labour. At the RCOG we felt the time had come to shine a light on the safety of intrapartum care in this country. We wanted to do everything possible to reduce this suffering and loss of life and set out to reduce this figure by 50% by 2020.

Since January 2015, the Each Baby Counts programme has been collecting and pooling the results of local risk management reviews to gain a national picture to better understand these tragedies. I have been heartened to see such a phenomenal level of professional engagement, with 100% of NHS maternity services signing up to participate in the programme within the first 3 months.

This report will be the first of many outputs from the Each Baby Counts team over the next few years. Our 2015 report peels back the curtain on the true scale of the challenge facing our professions and identifies the scale of the problem. It describes in detail the variation and lack of rigour in the present local review process within the NHS, the analysis of which forms the majority of this report.

Maternity care has always been at the forefront of reducing avoidable mortality, demonstrated by our track record with the Confidential Enquires over the last 65 years. Once an accepted risk of childbirth, the death of a mother in pregnancy is now a rare event and one we continue to strive to further reduce. As professionals, we endeavour to achieve the same results for all babies. Through our Each Baby Counts programme our focus is on reducing the number of term babies dying during labour, or shortly afterwards, and those born in such poor condition that long term harm and disability is a likely and tragic outcome.



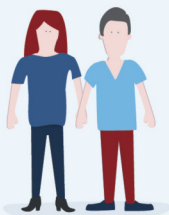
Dr David Richmond, RCOG President

This is an early brief report from the Each Baby Counts programme which we have decided to release at this stage as there are already clear messages for improvement identifiable from within these interim data.

Key messages from 2015

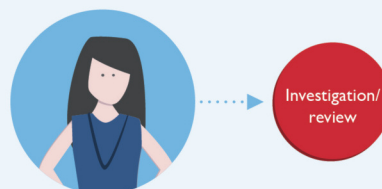


Ensure that the care of every baby eligible for Each Baby Counts gets a comprehensive and robust **review** by a **multidisciplinary team** that has **time set aside** for doing this work.



Make parents aware that a local review is taking place and **invite them to participate** in accordance with their wishes.

Recognise the additional perspective an **external panel member** will bring to local reviews



Focus on finding **systemic** rather than individual-level actions and recommendations to improve future care.

Engage with the new **standardised perinatal mortality review tool** once it is available.



Introduction

Why focus on term intrapartum care?

Whilst the stillbirth rate in the UK has fallen slightly in the past few years, we still lag behind the best in Europe (1). We know that stillbirth affects babies at all stages during pregnancy and that there are many important initiatives and research studies underway to tackle growth restriction, reduced fetal movements and to try to predict at-risk babies (2-5).

Having assessed the numerous important national and international quality improvement initiatives in maternity care, the decision to focus on intrapartum-related adverse outcomes in the Each Baby Counts programme was made in order to complement and not duplicate existing programmes of work in this area. Knowing that stillbirth may only represent the tip of the iceberg of intrapartum harm, we also decided to include babies who are starved of oxygen at birth but survive. Sadly, many of these babies will not live beyond infancy, or will suffer with a life-long disability. Little is known about how many babies in the UK are in this latter group, or what proportion of these injuries could have been averted.

Concentrating this programme on intrapartum care at term will allow us to focus our efforts on an area where we believe we can make the greatest impact in reducing the number of these devastating outcomes. Although intrapartum-related death and disability represents a relatively small proportion of overall perinatal mortality and morbidity, we are hopeful that by increasing the scrutiny on intrapartum care, units will look more closely at other areas of their maternity services, raising the bar across the service as a whole.

Each Baby Counts' Aims and Objectives

Our aim:

To achieve a 50% reduction by 2020 in incidents during term labour that lead to stillbirth, early neonatal death or severe brain injury.

Our objectives:

1. To establish on-going UK-wide surveillance of intrapartum stillbirth, early neonatal death or severe brain injury at term
2. To undertake on-going analysis of local governance and risk management reviews of these babies' care
3. To develop a rolling action plan based on these findings that is suitable for local implementation
4. To monitor the impact of the action plan by measuring the effects and side-effects of any interventions.

The Each Baby Counts eligibility criteria (Box 1) are designed to cast a wide net over adverse fetal and neonatal outcomes, whilst focussing on the most severe types of intrapartum harm. The definition of severe brain injury was selected in order to capture those babies with the worst brain injuries with a likely intrapartum cause, whilst recognising that this needs to be ascertainable within the first 7 days of life. Babies who meet these criteria may not necessarily go on to have a significant long-term disability, however it is generally not possible to confirm this until the child is of school age.

Box 1: Each Baby Counts eligibility criteria and definitions

Eligible babies include those born at term (≥ 37 completed weeks of gestation), following labour, that had one of the following outcomes:

- 1. Intrapartum stillbirth:** when the baby was thought to be alive* at the start of labour but was born with no signs of life†. This includes when:
 - Labour was diagnosed by a healthcare professional. This includes the latent phase of labour, i.e. less than 4cm dilatation
 - The mother called the unit to report any concerns of being in labour, for example (but not limited to) abdominal pains, contractions or suspected ruptured membranes
 - The baby was thought to be alive at induction of labour
 - The baby was thought to be alive following suspected or confirmed premature rupture of membranes (PROM).
- 2. Early neonatal death:** when the baby died within the first week of life (i.e. days 0–6) of any cause
- 3. Severe brain injury** diagnosed in the first seven days of life.** These are any babies that had one or more of the following:
 - Diagnosed with grade III hypoxic ischaemic encephalopathy (HIE)ⁱ
 - Actively therapeutically cooledⁱⁱ
 - Had all three of the following signs: decreased central tone,ⁱⁱⁱ comatose; seizures of any kind.

Notes:

* As assessed by any means, including but not limited to: Pinard stethoscope, handheld Doppler, CTG, bedside ultrasound, assessment of fetal movements, or assumed to be alive without confirmation.

† Excludes babies that clearly died before labour (macerated stillbirth) if confirmed by post mortem.

** Severe brain injury equates to neonatal encephalopathy, the clinical manifestation of disordered neonatal brain function.

ⁱ Hypoxic Ischemic Encephalopathy (HIE) is a condition associated with a reduction in oxygen supply to the baby from a variety of causes during the birthing process. The clinical syndrome of HIE is graded according to its severity with grade III being the most severe.

ⁱⁱ Active therapeutic cooling involves reducing a baby's body temperature to 33.5 C and maintaining it at this level for up to 72 hours before a gradual re-warming process is started.

ⁱⁱⁱ Decreased central tone is when the central muscles appear to be less firm than usual and the baby is floppy.

How are data collected?

From 1 January 2015, every NHS trust and health board in the UK was asked to nominate at least one Lead Reporter with responsibility for reporting all babies who meet the Each Baby Counts eligibility criteria (Box 1). Private maternity hospitals and independent midwives were also be notified about the project and invited to submit data.

Lead Reporters are asked to complete a brief online form for each baby born under their care who is eligible. Data collection is via a secure online platform, developed and hosted by MedSciNet UK (6). The form contains questions related to the adverse event and the results of the local review. No identifiable data are collected as part of the programme. Data from MBRRACE-UK and the National Neonatal Audit Programme are used to cross-check ascertainment. When a baby is identified through one of these sources which has not been reported to Each Baby Counts, the relevant reporter is contacted and asked to complete a notification form.

Once the local review is completed, Lead Reporters are asked to upload an anonymised copy of the report for further analysis. The Each Baby Counts project team carries out an initial assessment of the report and confirms that it has been fully anonymised, before sending it for further review by a multidisciplinary pair of trained Each Baby Counts reviewers (one midwife and one obstetrician). For each review undertaken, reviewers are required to complete a short online form identifying the key themes that emerged from the local report. The pair of reviewers can also indicate if they think that the report needs to be reviewed by a further specialist, for example a neonatologist or anaesthetist.

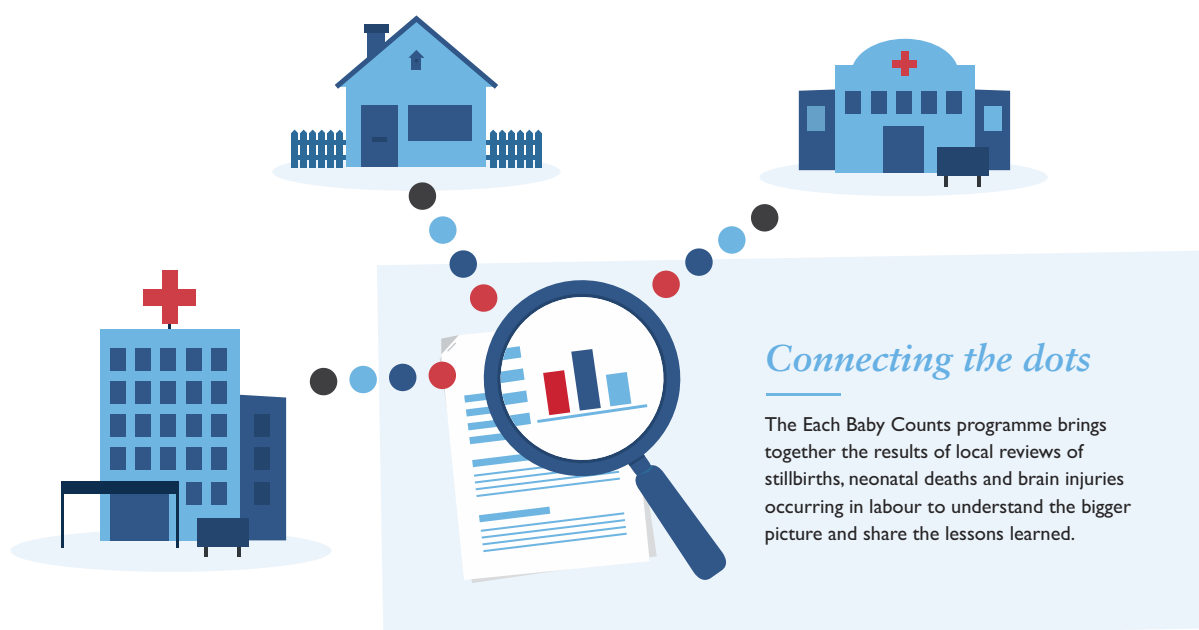


Figure 1

Box 2: 100% participation

“We have been delighted by the enthusiasm of Trusts and Health Boards to participate in this initiative, with 100% now signed up. The medical, midwifery and paediatric professions recognise that this is a timely opportunity for maternity services to share information with each other and we see this programme as leading the way in developing the open and honest NHS our patients deserve.”

Neil Marlow, Chair of the Each Baby Counts Independent Advisory Group

Risk management in the UK – in theory and in practice

The management of risk in maternity care relies on the identification, investigation, quantification and mitigation of threats to patient safety arising from our day to day work. The investigation of clinical incidents which lead to harm, or near-misses, is a process borne out of the deeply held desire that we should avoid making the same mistake twice.

Maternity care has a long history of championing the investigation of maternal deaths at a national level through Confidential Enquiry (7). Many statutory bodies are also involved in investigating clinical incidents, in various ways. Some of these bodies are familiar, such as Coroners, Parliamentary and Health Services Ombudsman, Child Death Overview Panels and Procurators Fiscal. Investigative journalists, solicitors and barristers will also champion legal routes for incidents falling outside the tight purview of statutory bodies.

Recent years have seen a radical re-organisation and redistribution of responsibilities for patient safety. Following devolution, the administrations in Scotland, Wales and Northern Ireland all developed models for incident reporting and investigations (8–10). Some functions previously carried out by the National Patient Safety Agency in England have been taken over by NHS England, some by the new NHS body ‘NHS Improvement’ and some by local bodies such as Clinical Commissioning Groups, Senates and Healthwatch. The most recent announcement is the opening of the Healthcare Safety Investigation Branch by the Department of Health, which will cover the English NHS (11).

Although NHS England has recently issued a revised framework for Serious Incidents (12) there is no UK-wide definition of what constitutes a Serious Incident. The RCOG offers a trigger list which includes all babies eligible for Each Baby Counts, which can be viewed as the “bare minimum” of incidents that should be examined locally to see if lessons can be learned (13).

Having identified an adverse outcome for local review, there are a plethora of methodologies and approaches to choose from ranging from Root Cause Analysis, tools such as the Standardised Clinical Outcome Review (SCOR) tool (14), the National Patient Safety Agency pro forma (15), frameworks such as the London Protocol (16), as well as many more locally or internationally derived tools.

There is a great desire to bring together all of these disparate groups, bodies, tools and methodologies into a standardised national approach which allows clear causes to be identified and lessons shared. The recent announcement of funding to develop a national standardised perinatal death review tool as a functioning online resource is a long-awaited and important development that is to be welcomed (17).

Box 3: What is it like to be a risk management midwife in the current NHS?

“The role of the risk management midwife is vital for a high quality, safe maternity service. The main aim is to promote and encourage safety awareness across the unit by learning from incidents, being proactive in developing practice and ensuring the highest standards of care are provided to our women.

“However, the time pressures on staff are significant and unfortunately completion of risk reporting is often not the highest priority and therefore important incidents may go unreported. The current shortage of midwives is very concerning.

“A further challenge is the reluctance to change; the balance between promoting confidence in the service and driving through change can be a fine line. However through providing support, professional leadership, using evidence-based principles and identifying champions, we forge ahead.

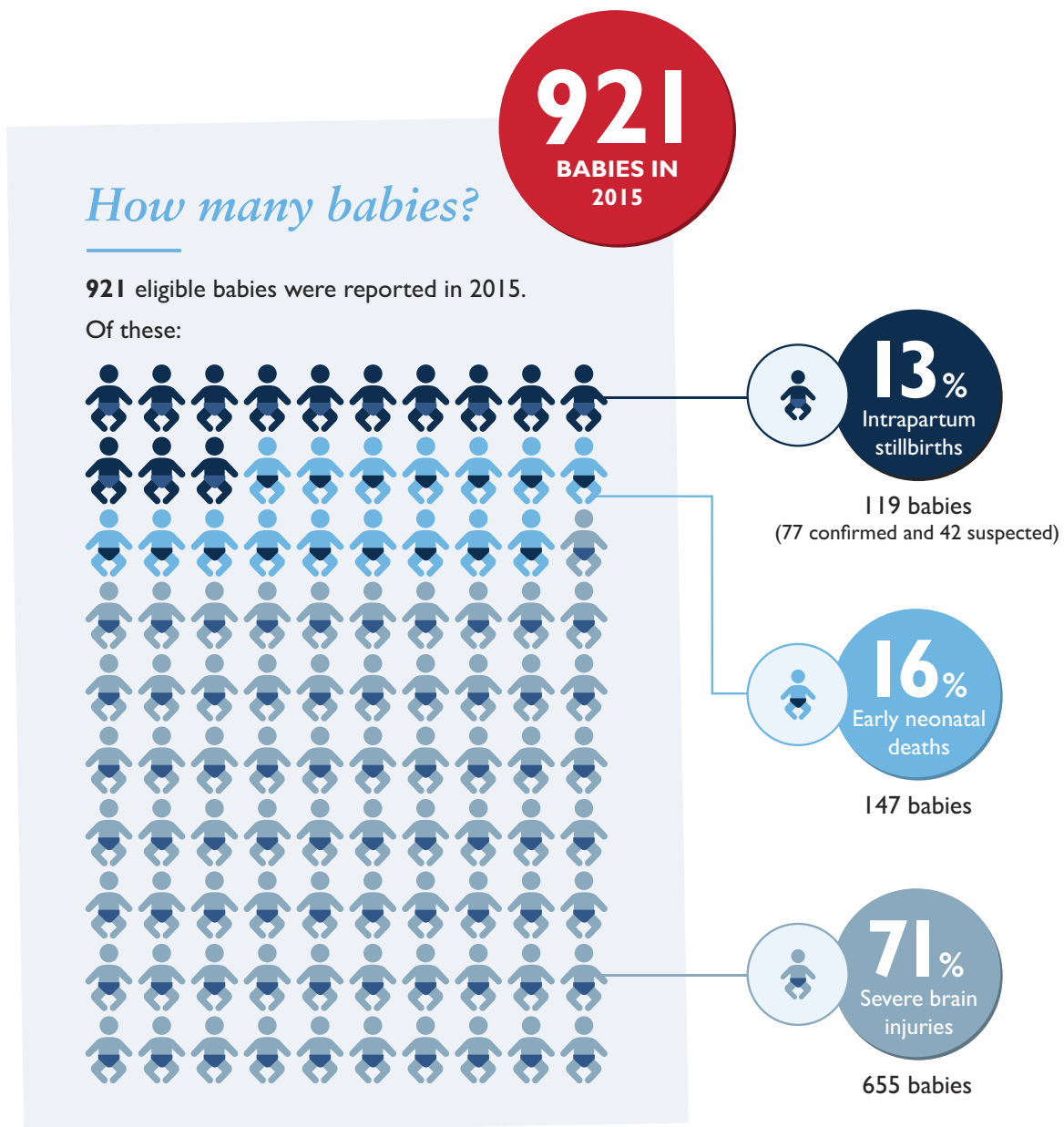
“Each Baby Counts is a national initiative which I jumped at the chance to be involved with. It is encouraging to know that units up and down the country are also striving to improve outcomes for mothers and babies.”

Katrina Mleczko, Risk Management Midwife at West Middlesex Hospital
and Each Baby Counts Lead Reporter and Reviewer

Each Baby Counts: how many do we know about?

Here we present the preliminary results for the babies born in 2015 that have been reported to Each Baby Counts to date. The reporting window for 2015 is not yet closed and case ascertainment based on other sources of national data is still underway. Although indicative figures suggest that the majority of eligible babies in 2015 have now been reported, the lag in case ascertainment means that final figures will not be available until summer 2017.

Out of almost 800,000 births in the UK in 2015:



Note: These categories are mutually exclusive. Babies with a severe brain injury who died within the first 7 days of life are classified as early neonatal deaths.

Figure 2

To date, 921 babies born in 2015 who met the eligibility criteria for Each Baby Counts have been reported (Figure 2). Despite not being the final data for 2015, these figures are higher than our original estimate of 500-800 eligible babies per year.

There were 119 intrapartum stillbirths, of which 77 were confirmed to be alive at the onset of labour by a health professional and 42 were thought to be alive but without confirmation by a health professional. A further 147 babies were born alive following labour but died within the first 7 days after birth.

Whilst the number of deaths is more or less in line with our original estimates, the number of babies meeting our definition of severe brain injury (655) is higher than projected and accounts for over 70% of the total number of babies reported. It is important to note that our definition of severe brain injury is based on information that is available within the first seven days after birth. We do not yet know how many of these babies will have a significant long-term disability as a result of the injuries sustained during birth, however the fact that the majority of these infants (96%) were actively therapeutically cooled – an intensive intervention requiring sedation and admission to the neonatal unit – reflects the serious clinical condition of these babies at birth. Data from the TOBY Children Study suggest that 45% of newborns with asphyxial encephalopathy who were therapeutically cooled survived to age 6 or 7 without neurologic abnormalities, and 21% were diagnosed with cerebral palsy (18).

Of the 921 babies, the information for 610 (66%) has been fully completed by a Lead Reporter on the Each Baby Counts online reporting system. The remainder are awaiting completion for various reasons, for example because the local review is still ongoing or because the Each Baby Counts project team has reviewed the data and sent it back to the Lead Reporter for further information. Units with incomplete reports receive reminders on a monthly basis, and an escalation policy is implemented if reports are not completed within 6 months.

Of the 610 babies with complete information, 599 (98%) have had a local review of some kind carried out. Below, we present further breakdown of information about these reviews.

How are local reviews carried out, and by whom?

Tools and methodologies

Of the 599 local reviews that were carried out, just over half (52%) made use of a specific tool or methodology to conduct the review. The remaining 48% of reviews were not carried out using any specific process (Figure 3).

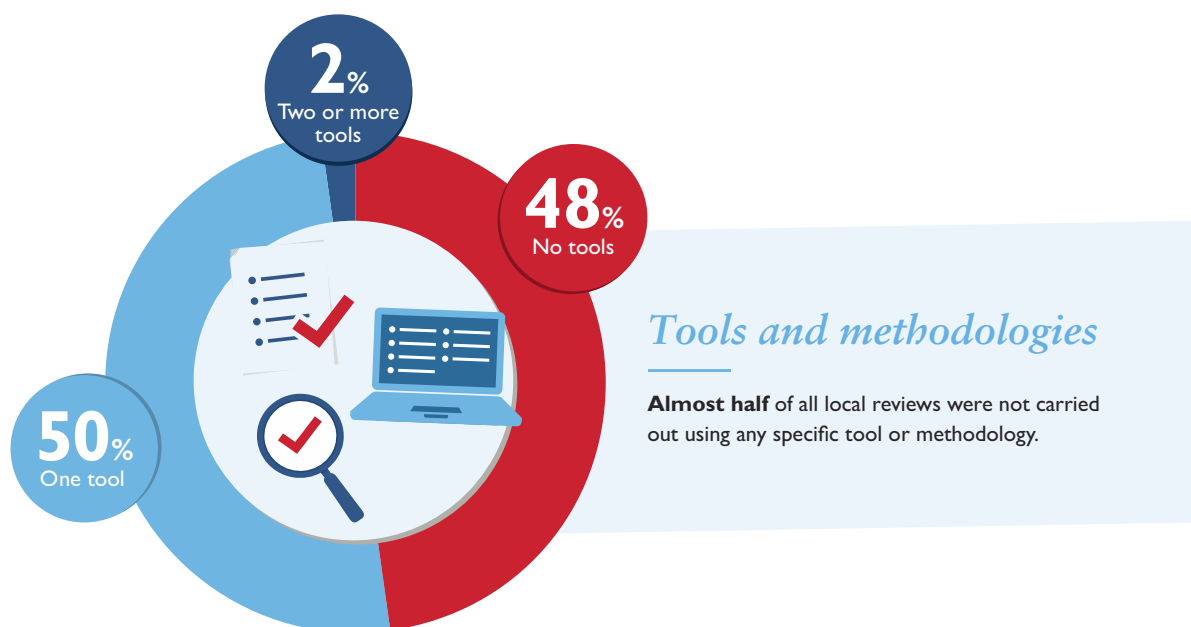


Figure 3

As shown in Figure 4, of the 300 local reviews that made use of a specific tool or methodology, the most commonly used process was Root Cause Analysis, used in 128 individual reviews. Other common methods included locally developed tools (58 reviews) and the National Patient Safety Agency [review of intrapartum-related perinatal death review pro forma](#) (15) (45 reviews). Less common methodologies included multidisciplinary team meetings (19 reviews), the [London protocol](#) (16) (11 reviews), the Local Supervising Authority [investigation tool](#) (19) (4 reviews) and [SCOR](#) (14) (1 review). 57 local reviews made use of a tool which did not fall under any of these categories.

Tools and methodologies used

Where a tool or methodology is used, there is little consistency in local practices.

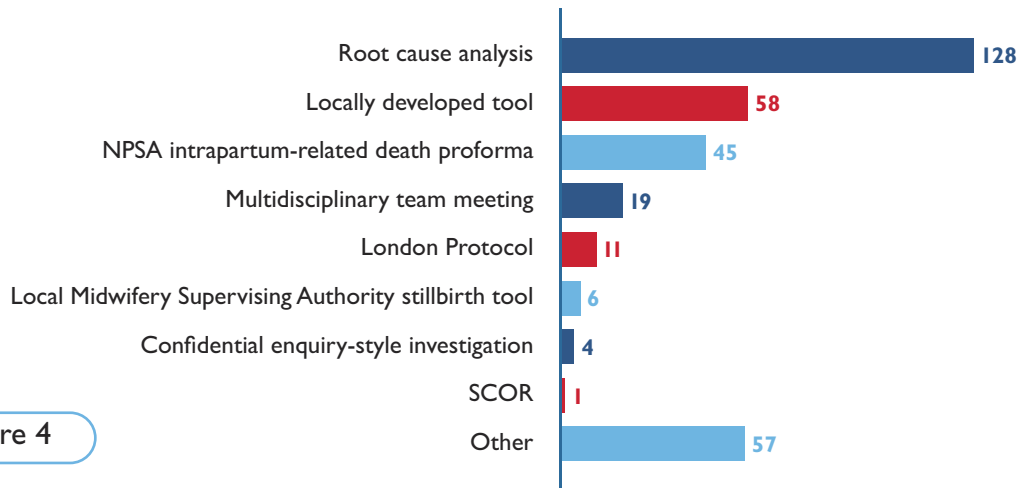


Figure 4

Make-up of local review panels

96% of local reviews are carried out by a multidisciplinary team (Figure 5). Whilst this is encouraging to see, efforts must now be focused on increasing this to 100% and on ensuring on a case-by-case basis that the composition of the panel is appropriate given the circumstances of the incident. Whilst 96% of panels included a midwife and 94% an obstetrician, only 62% included a neonatologist. It was even less common to have a member of the senior management team (44%) or an anaesthetist (10%) represented on the panel.

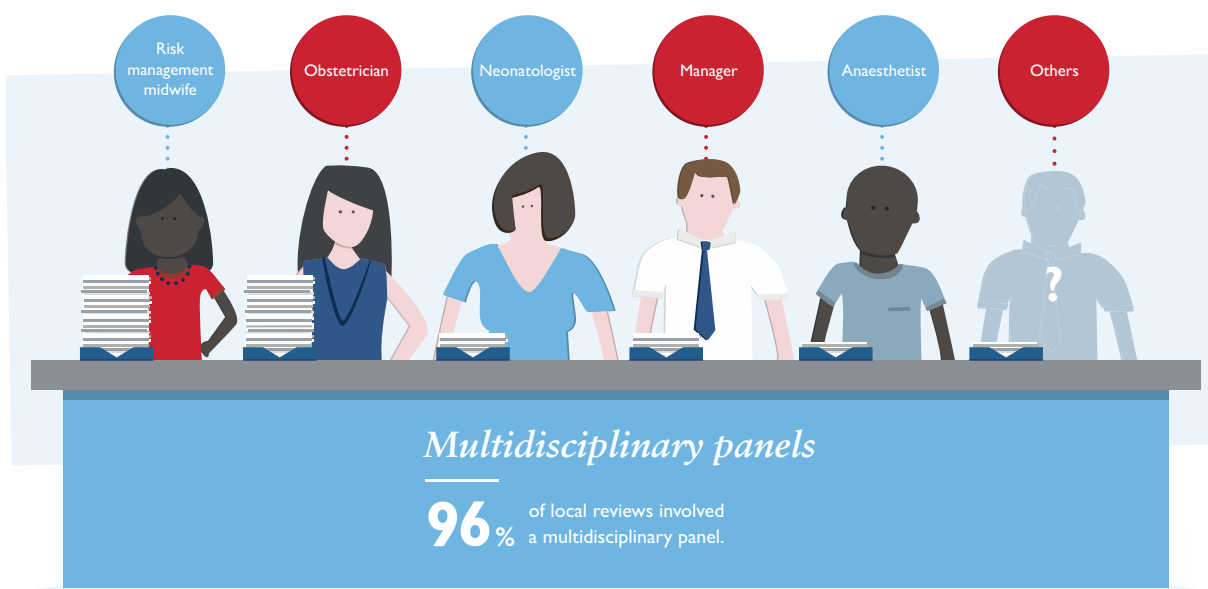


Figure 5

External involvement

Box 4: A view from the outside

“It has been recognised for several years that an unbiased expert might assist in real learning from individual maternal deaths. There has therefore been an increase in the use of external experts on local maternal death review groups. In London we now have a system by which we can provide external support for all maternal death reviews. When I sit on an investigation panel as an external expert I am unaware of local politics, allocation of resources and the structure of the local services. This allows me the opportunity to review the events against national standards rather than considering local issues (or personalities). As such, one is more likely to identify system changes rather than identifying an individual who needs additional training. Learning may be applicable to units additional to the one in which the death has occurred and I have been able to bring learning back to my own unit and (I hope) improve care for women in my part of London. I also think that the family benefits from having an independent clinician involved in the investigation and may help them get closure on a tragic event. I would like to see these principles applied to local reviews of the care of all Each Baby Counts babies.”

Kate Harding, Consultant Obstetrician, Guys and St Thomas’ Hospital

Only 7% of panels included an external expert (Figure 6). Where external panel members were present, these were mostly midwives and obstetricians but also included CQC representatives, senior management and neonatologists.

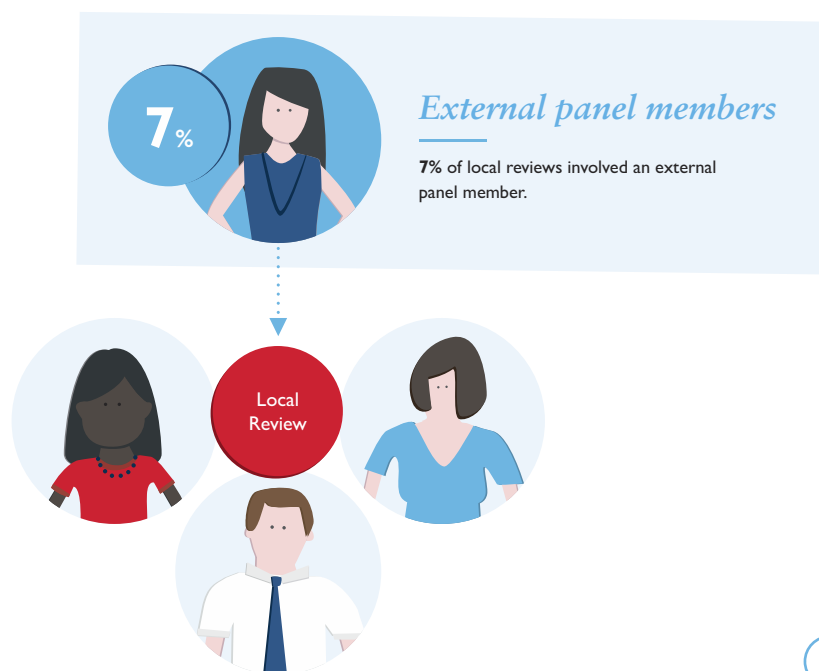


Figure 6

Parental involvement in local reviews

Box 5: A personal experience

“As one of the parent representatives on the Each Baby Counts Advisory Group I was shocked and saddened to learn that a quarter of parents were unaware that an investigation was taking place into their baby’s birth.

My son Harry suffered profound brain damage during term labour. In the days following his birth we asked what had gone wrong and asked to see an obstetric consultant, but we were ignored and told to forget the birth. In frustration we submitted a formal complaint. It was then that we found out that it had already been reported as a Serious Incident and that an investigation was underway. It’s hard to describe how upset, confused and angry we were – the poor communication and secrecy made a terrible situation so much worse.

It would have made such a difference if, in the first few hours/days, someone had said ‘It is rare for a term baby to be born in such a poor condition, therefore we are going to conduct a review. We would like to involve you, as Harry’s parents, as much as possible.’

We eventually received a copy of the investigation, which appeared to blame individuals, rather than examine why mistakes had been made or look for wider issues.

I’m pleased that the new NHS England Serious Incident Framework puts patients and their families at the heart of the process. I hope that as the Each Baby Counts initiative progresses we will see increasing communications with parents and involvement in investigations.”

Nicky Lyon, Co-founder: Campaign for Safer Births
www.campaignforsaferbirths.co.uk

Each Baby Counts is promoting the voices of families whose births have been touched by tragedy. You can find more stories from affected families on our website at <https://www.rcog.org.uk/why-each-baby-counts-matters/>

As shown in Figure 7, in a quarter of instances (25%), parents were not made aware that a local review was taking place. Just under half the time (47%), parents were made aware that the review was happening and informed of the outcome but were not invited to contribute. In just over a quarter of local reviews (28%) the parents were invited to contribute evidence if they wished to.

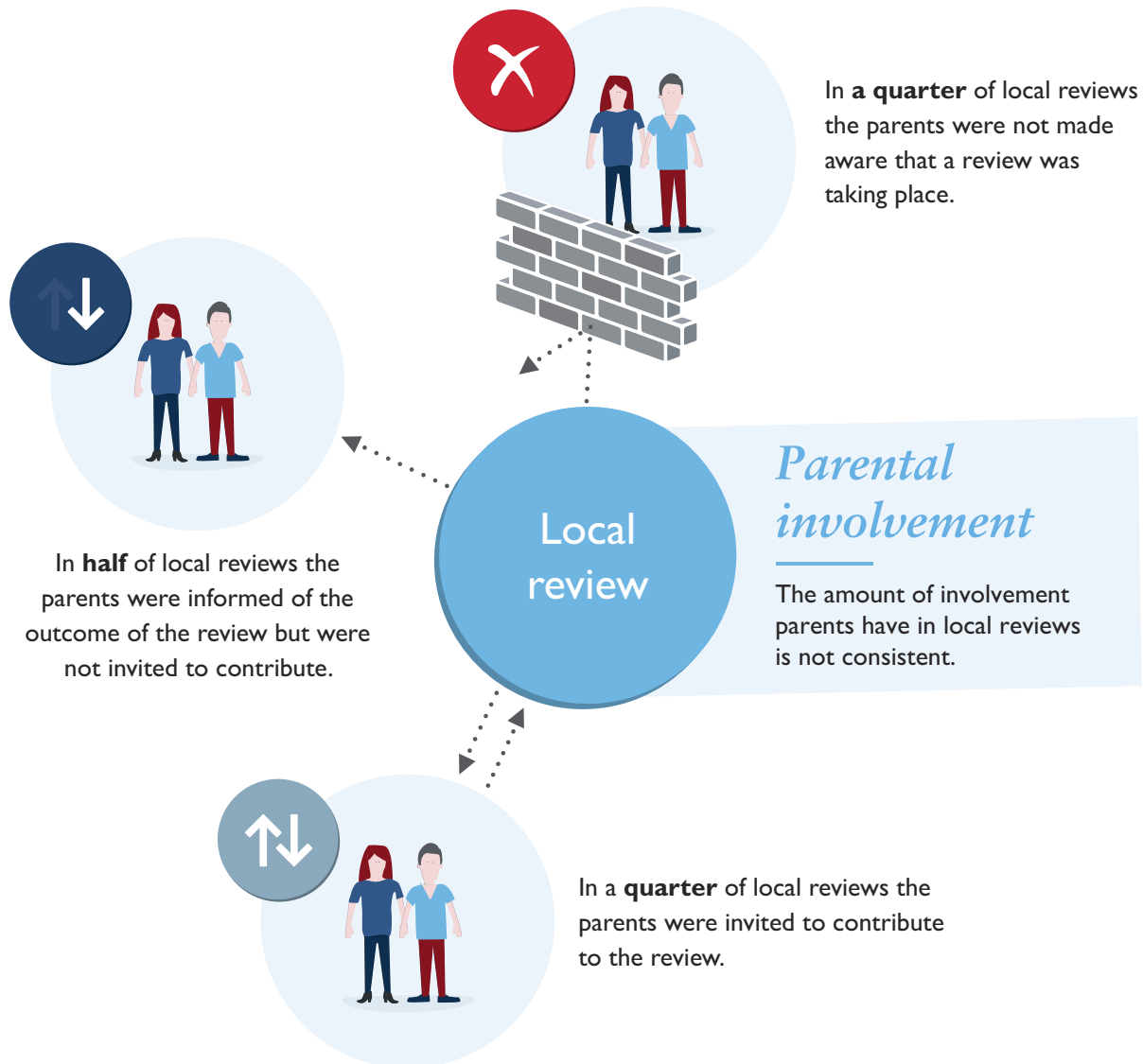


Figure 7

Box 6: A Sands perspective on parental involvement in local reviews

Sands has long called for effective and robust local reviews when a baby dies, and for the parent's perspective of what happened to be part of the review process. Parents are the only ones present the entire time, and their story is important to understanding how care can be improved.

Our recent snapshot survey of bereaved parents combined with outcomes from a qualitative study by the University of Bristol and the International Stillbirth Alliance (the PARENTS1 study)¹ showed that:

- *Most parents are not aware that the care around their baby's death was or should have been reviewed*
- *Parents want reviews to find out what happened when their baby died and to show where improvements might reduce the risk of more deaths*
- *Parents want a review to look at the entire pathway of care including after their baby died, and to include their emotional care alongside the clinical care*
- *Parents want to feedback on their experiences of both good and poor care*
- *Parents differ – most want the opportunity to contribute their perspective the review process, but a minority would choose not to participate, feeling it would be too upsetting or they wouldn't know what to say*
- *Flexibility is essential, with choice about whether, how and at what stage parents contribute to a review and how the outcomes are communicated back*
- *All parents need respectful and sensitive support throughout the process.*

The NHS constitution (20) sets out the right to an open and transparent relationship with an organisation providing care. The duty of candour (21) rests on openness. Parents whose baby has died deserve nothing less.

Laura Price and Janet Scott, Sands

1 Parents' Active Role & ENgagement in Their Stillbirth/Perinatal death review (PARENTS1) – Siassakos, Storey, Burden, Bakhbakhi, Jones and Yoward.

Quality of local reviews: the good, the bad and the absent

As of February 2016, 50 Each Baby Counts reviewers have been trained to carry out a structured evaluation of local reviews. Of the 599 completed reviews submitted to Each Baby Counts, 204 local reviews have now each been assessed by a multidisciplinary pair of reviewers.

The structured review process includes an assessment of the quality of the local review, which is shared with the local Lead Reporter once the review is complete. One aspect of this assessment is whether the report contained sufficient information to allow the care to be classified. Local reviews were classified as poor quality if the reviewers determined that the document/s submitted did not contain sufficient information for them to answer the question: “Would different care have made a difference to the outcome?” Where the pair of reviewers differed in their assessment, the discrepancy was reconciled by a member of the Each Baby Counts project team. Hallmarks of a good quality review were felt to include a detailed history, a timeline of events, and use of a structured tool.

Of the 204 local reviews that have been assessed in this way, 27% did not contain sufficient information to allow the care to be classified (Figure 8). A further 10% are awaiting further assessment by the project team because the pair of reviewers differed in their assessment.



Review quality: an initial assessment

27% of local reviews did not contain sufficient information to allow the care to be classified. In a further 10% one of the pair of reviewers judged the information insufficient to allow for the care to be classified – these are awaiting reconciliation by a third reviewer.

Figure 8

Box 7: There is always something to learn

“It has been a recurring observation in Confidential Enquiry reports concerning both maternal and perinatal deaths that local reviews of care are not always undertaken and that the quality of local reviews that are done is extremely variable. These emerging findings from Each Baby Counts show that this is also true for babies who die or have severe brain injury following term labour. This is something we can change now. We know that a good review of care when there has been a serious incident can identify clear lessons to prevent adverse events in the future. There is always something to learn. We owe it to the families of these babies to identify these lessons.”

Marian Knight, Professor of Maternal and Child Population Health

Connecting reviews with improvement

Of the 150 local reviews in which at least one reviewer has indicated that the report contains sufficient information for a full evaluation, 32 (21%) contained no actions or recommendations at all, 27 (18%) had actions or recommendations which were solely focussed on individual members of staff (for example, a requirement to attend further training). In 11 (7%) reviews it was unclear whether the recommendations were targeted at individuals or systems. The remaining 80 (53%) reviews contained actions or recommendations which took a systemic approach (Figure 9).

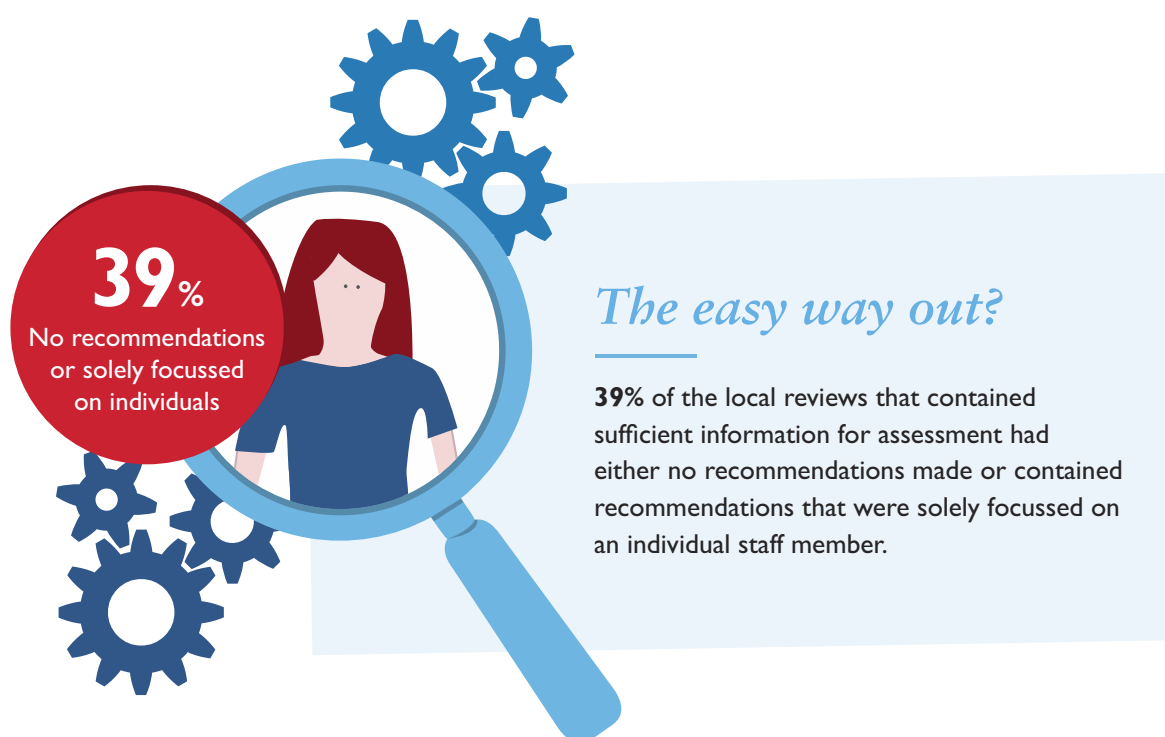


Figure 9

Box 8: Why every local review must link to quality improvement activity

“The many adverse incident reviews submitted to Each Baby Counts in 2015 are a testament to the enormous amount of effort which goes into risk management in UK maternity services. These reviews are the organisational memory (22) of a maternity service, the events which are serious enough for us never to want to forget them, or their consequences.”

“Many national reports have highlighted the fact that the same mistakes are made repeatedly, which suggests that our risk management processes may not be mitigating risk as we hope. One of the key findings in reviewing these reports has been that 18% of reviews targeted their recommendations solely for individual-level action, utilising the so-called ‘bad apple’ approach. What is missing in these cases is a systems-based approach to improving services, viewing individual failings as important and recognising the need for accountability, but balancing this with a need to establish processes to prevent reoccurrence. This has been described as a ‘just culture’, not ‘blame free’ but with fairness and accountability as the key principles (23, 24). There is an increasing recognition that guidelines are not the only answer to this problem, largely because they are not always followed (25). One increasingly widely adopted approach is quality improvement, which organisations such as NHS Improvement (26) and Healthcare Improvement Scotland are devoted to, as a way of improving systems.

“The concept of ‘quality’ encompasses patient safety, patient experience and efficacy (20). Quality improvement science is a way of using a variety of tools and methodologies to work to make small or large changes within a service, whilst monitoring the results and balancing any unexpected consequences. It involves, but goes beyond audit and is focussed on achieving sustainable, balanced and safe systems in healthcare. It starts with an adverse outcome and works to create a workable solution, with data to show improvement on a local scale. This change of approach will take time, investment and training, but there is already movement on a national level, with the Academy of Medical Royal Colleges recommending widespread adoption of training in quality improvement for all medical professionals, which will surely spread to midwifery and other colleagues (27).”

Ed Prosser-Snelling, Each Baby Counts Network and Quality Improvement Lead

Next steps

For NHS maternity services:

As well as continuing to ensure that data are reported to Each Baby Counts in a timely manner for each eligible baby born under their care, every UK maternity service should focus on implementing the key messages that have emerged from this interim report:

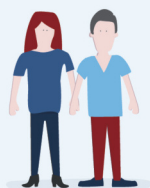
Key messages from 2015



Ensure that the care of every baby eligible for Each Baby Counts gets a comprehensive and robust **review** by a **multidisciplinary team** that has **time set aside** for doing this work.

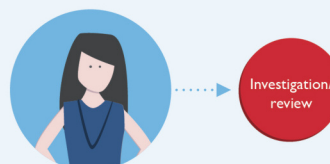


Multidisciplinary team



Make parents aware that a local review is taking place and **invite them to participate** in accordance with their wishes.

Recognise the additional perspective an **external panel member** will bring to local reviews



Focus on finding **systemic** rather than individual-level actions and recommendations to improve future care.

Engage with the new **standardised perinatal mortality review tool** once it is available.



For Each Baby Counts:

This is an early brief report from the Each Baby Counts programme which we have released at this stage as there are already clear messages for improvement identifiable from within these interim data. The next phase of the programme is to complete our ascertainment and analysis for babies born in 2015. A multidisciplinary team of 50 reviewers has been recruited who are now busy undertaking structured assessments of each local review. We will produce a final report on the themes that emerge and the lessons that can be learned from the care of these babies born in 2015 in summer 2017. The 2017 report will also contain provisional data for babies born in 2016. In the meantime we plan to publish our evidence synthesis on interventions to reduce intrapartum stillbirth, neonatal death and severe brain injury, as well as an interim qualitative analysis of our data.

Box 9: A message from the Each Baby Counts co-Principal Investigators:

Our first Each Baby Counts report has already identified clear messages for improvement from these early data. It has taken a huge amount of effort to get to this point, where we can see more clearly the landscape of maternity risk management practice in the UK. We will now turn to the in depth analysis of the data to find the reasons why these events are happening.

As well as our own team undertaking qualitative analysis, a multidisciplinary team of 50 national reviewers are now busy formulating structured assessments of each local review. We will be producing a series of thematic reports on the lessons that we all must learn from the care of all Each Baby Counts babies born in 2015. The 2017 report will also contain provisional data for babies born in 2016.

The key challenge for all of us is to see the enthusiasm for reporting Each Baby Counts babies translated into action. We need you to take action on the five key Each Baby Counts messages and improve the quality of reviews so that intrapartum care be made safer locally and nationally. We are only too aware of how challenging this is, but the reality is, if we don't do it, no-one else will.

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