@eachbabycounts

Royal College of Obstetricians & Gynaecologists

each baby COUNTS.

2015 Summary Report

June 2017

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Foreword

Although the UK remains one of the safest places to give birth, serious incidents do occur, some of which could be prevented if different care were given. This is a tragedy for the individuals and their families, and the litigation costs are a major diversion of NHS resources from the treatment of patients.

The Royal College of Obstetricians and Gynaecologists (RCOG) is determined to improve this situation and in 2014 launched a long-term quality improvement programme, Each Baby Counts, to halve the number of babies who die or are left severely disabled as a result of preventable incidents occurring during term labour by 2020.

We make no apologies for the size of our ambition. The Each Baby Counts programme was intended as a ground-breaking, long-term inquiry that will deliver improvements to maternity care over time, and we do not waver from this challenge.

We now have a complete set of baseline data relating to all stillbirths, neonatal deaths and brain injuries occurring during term labour in 2015, including each of the local investigations. For the first time, we are in a position to collect all of the results and analyse the local investigations at a national level, in order to be able to identify and share the lessons learned across the whole maternity service. The analysis needed to ensure the conclusions are accurate, and the recommendations we make are sound, has been an extremely time-consuming process. I would like to take this opportunity to formally thank all those colleagues who have contributed to this important work.

The Each Baby Counts investigation team has conducted more than 2,500 expert assessments of local reviews and we are beginning to understand the significant variation in the effort and time that different NHS institutions put into investigating incidents and learning from mistakes in their maternity services. One-quarter of local reports are still inadequate, and we have already made it clear that this must be improved as a matter of urgency. We must rapidly and robustly investigate the care provided, including contributions from parents and families, so we can understand the issues associated with these incidents, and operationalise and implement solutions nationally.

The variation in local investigations notwithstanding, we have identified a number of emerging themes that can be used to rapidly improve maternity care across the NHS. By persistently raising the profile of these incidents, we have helped to bring this aspect of maternity safety to the forefront of everybody's thinking. Our interim report, published in June 2016, made a number of recommendations about how to ensure future investigations are as consistent and effective as possible. This further report based on a more complete set of data focuses on key clinical actions that will improve the quality of clinical care.

The next step for the Each Baby Counts team is to seek feedback from the profession via our Clinical Engagement Meetings, which will include insights into how best to implement

change. To effect change, implementation tools are needed together with continuing support for trusts and health boards to embed them into their practice. This is outwith the original remit of Each Baby Counts and will require specific skills, dedicated time and significant funding to help us take this vital next step.

Each Baby Counts is a crucial element of improving care and the safety culture within the NHS, and we are committed to working in tandem with the other maternity safety initiatives to this end.

We urge individuals working in maternity units, trusts/health boards and policy makers to read and act on the findings in this report. The RCOG and its partners are serious about improving the safety of maternity services but to make this happen we need the full and total commitment from governments across the UK. One urgent priority is adequate resourcing for maternity units.

The Each Baby Counts programme has achieved 100% buy-in and engagement from trusts/health boards and the profession. While we are proud of the work we have achieved so far, we know that to secure the widest possible implementation of the recommendations and to drive sustained improvement in care, we now need to secure additional support to allow the programme to expand beyond its original objectives and achieve its full potential to improve maternity care and reduce preventable harm across the UK.

Professor Lesley Regan
President, Royal College of Obstetricians and Gynaecologists

Introduction

Each Baby Counts is the Royal College of Obstetricians and Gynaecologists' (RCOG) national quality improvement programme to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour. In individual maternity units, these events are rare and it is therefore difficult to see clear patterns or identify how best to avoid them. The Each Baby Counts programme brings together the results of local investigations into stillbirths, neonatal deaths and brain injuries occurring during labour to understand the bigger picture, share the lessons learned and prevent babies from dying or experiencing brain injuries in the future by ensuring each baby receives the safest possible care during labour.

This report presents key findings and recommendations based on the analysis of complete data relating to term stillbirths, neonatal deaths and babies with brain injuries born during 2015, the first full year of the programme. This builds on the previous Each Baby Counts report, published in June 2016, which presented the methodology for the project and interim data for 2015 in order to share initial recommendations for improvement emerging from the early data analysis. The full first-year data will now be used as a benchmark against which the future work of the programme will be measured. A more detailed report based on the 2015 data, with practical guidance on how to implement the recommendations, will follow later in 2017.

A parent's perspective

"When something goes wrong during labour at the end of a healthy pregnancy, and a baby dies or experiences a serious brain injury, what should be one of life's happiest events turns to devastating tragedy. As parents, we have to go through something for which we had no preparation. We are in a blur of distress and shock. We cannot believe this could happen to our baby, carried with care and love for 9 months… But it has. And in 2015, it happened to 1136 babies.

The vast majority of parents want desperately to know what happened, even when the truth is difficult. After all we've already experienced the worst. But too many of us are left with poor explanations and unanswered questions. We want our babies' lives to matter and to see hospitals determined to learn from these grave mistakes that have changed our lives. The Each Baby Counts report shines a spotlight on how too many hospitals are failing to examine and admit, even to themselves, how things go wrong and where care might improve. We want to know that things will be better for the next parents whose labour and birth are like ours. To make this happen, there have to be thorough reviews of every baby's case that involve us, the parents… the only ones to be present at every stage. And there needs to be learning, and a commitment to change, at every level.

Each Baby Counts is starting to show the areas that need urgent attention. This must not be another report that sits on a shelf; it is vital that it is acted upon and these levels of avoidable harm are confronted."

Laura Price and Janet Scott from Sands and Michelle Hemmington and Nicky Lyon from Campaign for Safer Births

Methodology

The methodology and eligibility criteria for the Each Baby Counts programme are set out in detail in the previous Each Baby Counts report.[1]

Figure 1 shows the number of babies born in 2015 who were reported to Each Baby Counts.

723 251 term babies born in the UK in 2015[2]

Exclusions:

- Ineligible babies
- Centrally excluded (congenital or chromosomal abnormalities) (51)
- Potential unreported babies ascertained (MBRRACE-UK 170 and BadgerNet 112)

1136 eligible babies reported

Exclusions:

- Reports which have been started but not yet completed by the Lead Reporter (113)
- Babies whose care was not investigated locally (54)
- Completed reports with insufficient information for reviewers to make an assessment of the care provided (242).

727 babies fully reported and the reviews uploaded assessed as containing sufficient information for assessment by at least two reviewers

Figure 1

1 Royal College of Obstetricians and Gynaecologists. *Each Baby Counts: key messages from 2015*. London: RCOG, 2016 [www.rcog.org.uk/eachbabycounts].

2 Manktelow BN, Smith LK, Prunet C, Smith PW, Boby T, Hyman-Taylor P, Kurinczuk JJ, Field DJ, Draper ES, on behalf of the MBRRACE-UK Collaboration. *MBRRACE-UK Perinatal Mortality Surveillance Report, UK Perinatal Deaths for Births from January to December 2015*. Leicester: The Infant Mortality and Morbidity Studies, Department of Health Sciences, University of Leicester. 2017.

Key findings

Clinical findings

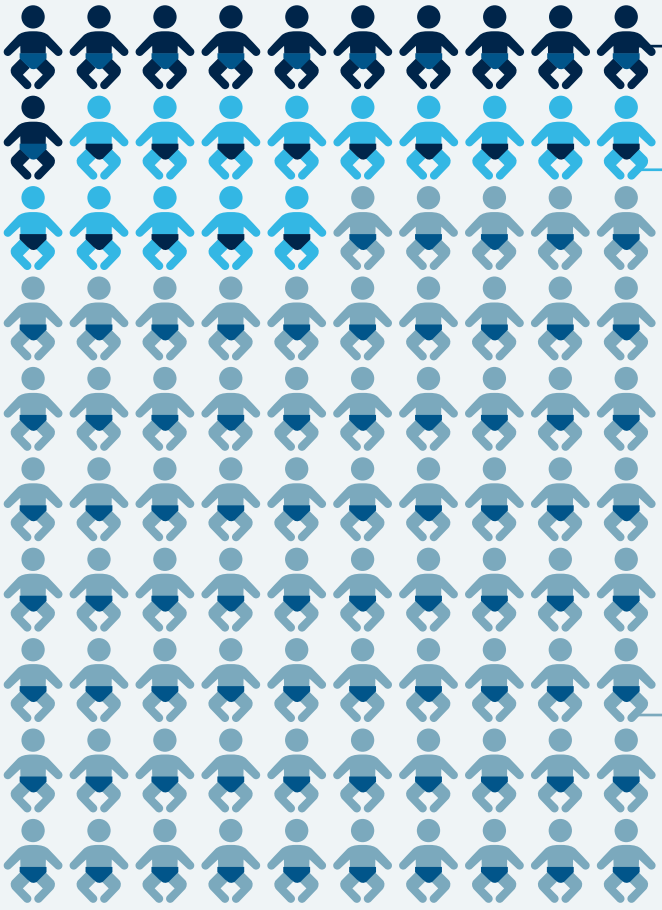
Out of over 720 000 term babies born in the UK in 2015:

How many babies?

1136
BABIES IN 2015

The total number of babies that fulfil the 'Each Baby Counts' criteria in 2015 was **1136**.

Of these:



11% Intrapartum stillbirths
126 babies

14% Early neonatal deaths
156 babies

75% Severe brain injuries
854 babies

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.

In total, 1136 babies born in 2015 who met the eligibility criteria for Each Baby Counts were reported. There were 126 intrapartum stillbirths, and a further 156 babies were born alive following labour but died within the first 7 days after birth. There were 854 babies who met the Each Baby Counts eligibility criteria for severe brain injury. As explained in the previous report,[3] the Each Baby Counts definition of severe brain injury is based on information available within the first 7 days after birth and it is not known how many of these babies will have a significant long-term disability as a result of the injuries sustained during birth.

In 76% of the 727 reports where there was sufficient information to draw conclusions about the quality of the care (Figure 1), at least one Each Baby Counts reviewer concluded that the baby might have had a different outcome with different care.

Findings related to reviews

As shown in Figure 1, 25% of the local reviews did not contain sufficient information to draw conclusions about the quality of care provided.

Of the 727 reviews the Each Baby Counts team analysed:

- parents were invited to be involved in only 34% of reviews
- external panel members were involved in only 9% of reviews
- neonatologists were involved in 68%[4] of local review panels of liveborn Each Baby Counts babies
- where clear actions or recommendations were made in local reviews, 23%[5] were aimed solely at individual members of staff.

3 Royal College of Obstetricians and Gynaecologists. *Each Baby Counts: key messages from 2015*. London: RCOG, 2016 [www.rcog.org.uk/eachbabycounts].
4 This percentage relates to the 628 liveborn Each Baby Counts babies.
5 This percentage relates to the 542 local reviews which contained a clear action or recommendation.

Recommendations for clinical care

The recommendations below have been identified through detailed thematic analysis of the 2015 reviews. They address critical factors in the care of many of the Each Baby Counts babies that may have prevented their death or brain injury. This report focuses on fetal monitoring, human factors and neonatal care.

Clinical issues

Fetal monitoring

Intermittent auscultation (IA)

Women who are apparently at low risk should have a formal fetal risk assessment on admission in labour irrespective of the place of birth to determine the most appropriate fetal monitoring method. The development of IT tools that bring together data from across a trust's systems to support accurate, easily accessible risk assessment should be prioritised.	
NICE guidance on when to switch from intermittent auscultation to continuous cardiotogography (CTG) monitoring should be followed. This requires regular reassessment of risk during labour.	

Continuous cardiotocography (CTG)

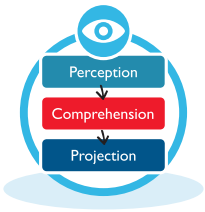
Staff tasked with CTG interpretation must have documented evidence of annual training.	
Key management decisions should not be based on CTG interpretation alone. Healthcare professionals must take into account the full picture, including the mother's history, stage and progress in labour, any antenatal risk factors and any other signs the baby may not be coping with labour.	

Neonatal care

If therapeutic hypothermia is being considered, continuous monitoring of core temperature must be undertaken. Early efforts to passively cool the baby should also be considered (turn off the heater, take off the hat).	
The paediatric/neonatal team must be informed of pertinent risk factors for a compromised baby in a timely and consistent manner.	

Human factors

'Human factors' are the ways in which people interact with each other and their surroundings. One element of this is 'situational awareness', which involves understanding all the things that are happening around you and anticipating their potential consequences. Other elements are staff stress and fatigue, including how they influence decision making.

All members of the clinical team working on the delivery suite need to understand the key principles of maintaining situational awareness to ensure the safe management of complex clinical situations.	
A senior member of staff must maintain oversight of the activity on the delivery suite, especially when others are engaged in complex technical tasks. Ensuring someone takes this 'helicopter view' will prevent important details or new information from being overlooked and allow problems to be anticipated earlier.	
Decision making is more difficult when staff feel stressed and/or tired. A different perspective improves the chances of making a safe decision. Clinical staff should be empowered to seek out advice from a colleague not involved in the situation who can give an unbiased perspective (either in person or over the phone).	
When managing a complex or unusual situation involving the transfer of care or multiple specialties, conduct a 'safety huddle' – a structured briefing for the leaders of key clinical teams. This will ensure everyone understands their roles and responsibilities and shares key clinical information relevant to patient safety.	

Recommendations for future reviews

This full analysis of the 2015 data underlines the recommendations for reviews highlighted previously. Improving the quality of local reviews will improve the lessons learned and, ultimately, improve care.

All eligible babies should be reported to Each Baby Counts within 5 working days.	
All local reviews of Each Baby Counts babies should contain sufficient information to determine the quality of the care provided.	
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 local reviews must have the involvement of an external panel member.	
All reviews of liveborn Each Baby Counts babies must involve neonatologists/neonatal nurses.	

Next steps

This report sets out a number of recommendations about what is needed to drive quality improvement within UK maternity services. To make the recommendations a reality, engagement and support is needed from all stakeholders.

Healthcare professionals

Doctors, midwives and other healthcare professionals should ensure this report's recommendations for clinical practice are followed at all times.

Healthcare professionals involved in local reviews should ensure good practice is followed, based on this report's recommendations for the conduct of future reviews.

All healthcare professionals should support the dissemination of learning and, where it is needed, culture change within their unit.

Trusts and health boards

We ask all trusts and health boards for their continued commitment to Each Baby Counts, which is vital for the programme's continuing success and impact.

Trusts and health boards should support their staff to implement the recommendations set out in this report, ensuring staff tasked with CTG interpretation receive annual training, promoting the development of non-clinical skills such as situational awareness and providing multidisciplinary training to support good teamworking.

Trusts and health boards should ensure the necessary protocols are in place to ensure all local reviews are of high quality, incorporating the key points highlighted in this report.

Policy makers and governments

As an urgent priority, maternity units need to be adequately resourced. Without this, trusts, health boards and healthcare professionals will struggle to implement the recommendations from the Each Baby Counts team.

Each Baby Counts should be supported to fulfil its maximum potential as part of the continuing commitment to maternity safety.

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