Each Baby Counts - Six Month Progress Report

Overview of rationale

While maternity care in the United Kingdom is generally safe, when things do go wrong the impact on families can be profound. The death of a baby during or shortly after birth is a life-changing event that affects women and their families for many years.

In addition to intrapartum stillbirths and neonatal deaths, Each Baby Counts includes babies who survive birth but are left with a severe brain injury, causing life-long disability. The time and financial costs, physical and emotional demands, and logistical complexities associated with raising a child with this type of severe disability also have far-reaching consequences.

Current estimates for the UK suggest that between 500 and 800 babies a year die or are left severely disabled, not because they are born too soon, too small, or with serious birth defect, but because something goes wrong during labour.

Zero harm is a challenging aspiration. The RCOG does not accept that all of these cases are unavoidable tragedies. The aim of Each Baby Counts is to achieve a 50% reduction by 2020 in incidents during term labour that lead to stillbirth, early neonatal death or severe brain injury in normally-formed infants. Although the cases that fall within the scope of the project are only a proportion of all perinatal deaths, we hope that by increasing the scrutiny on these cases, maternity care providers will look more closely at their other adverse outcomes, raising the bar across maternity services as a whole.

How will Each Baby Counts achieve its aims?

At present, when these tragic events occur, they are investigated locally. What has never been done before is to pool the results of these local investigations to identify common preventable factors and share the lessons learned.

Each Baby Counts has recruited a network of Lead Reporters in every maternity service throughout the UK who report notifiable cases when they occur. The project team then analyses the findings of the local investigations into these cases in order to identify lessons learned to improve future care.

By bringing this data together for the first time, we will be able to identify common themes across the country which relate to these events and recommend actions to improve practice. We will also be able to advocate for national change, where appropriate, as well as local service improvements.

We will provide central, thematic analysis of the content of these reports, making us the first national body to undertake such a project. These data, published in a report, will be accompanied by expert recommendations for practice, drawn from the wealth of high-quality, evidence-based guidance already published by the RCOG. We will also conduct a systematic review of literature pertaining to the events we are focussed on and use this to inform our reports. A key part of the project is to develop a network of enthused and engaged professionals, to drive local the local changes our national work identifies.

Progress to date

Project initiation and governance

The Each Baby Counts Project Team was recruited in August 2014 (Appendix 1). The team brings together the clinical and methodological expertise needed to deliver a project of this scale and national importance. The project is led by two senior academic clinicians acting as co-Principal Investigators (Professor Zarko Alfirevic and Professor Alan Cameron) and a Senior Project Advisor (Professor Marian Knight) who has many years of experience in carrying out national surveillance programmes and quality improvement initiatives in maternal and fetal medicine. They are supported by a dedicated project management team based at the RCOG comprising a Project Manager (Hannah Knight); Quality Improvement and Network Lead (Dr Ed Prosser-Snelling) and Project Coordinator (Emily Petch).

In September 2014 an Independent Advisory Group (IAG) was established to provide overall supervision, strategic direction and governance of the activities of the programme. The IAG will meet twice every year and comprises 20 members representing the obstetric, midwifery and neonatology professions, specific stakeholder organisations, the devolved administrations, academic institutions, as well as two patient representatives (Appendix 2). The current Chair of the IAG is Neil Marlow, Professor of Neonatology at University College London and former Director of the Institute for Women's Health and President of the European Society for Paediatric Research. The IAG's Terms of Reference can be seen here.

Stakeholder engagement and communication

Keeping clinical staff and other stakeholders informed of the programme's progress is a key priority and we use several approaches to ensure that this happens.

An official launch event was held at the RCOG on 23rd October 2014 to coincide with the launch of the Each Baby Counts website and video. Over 300 obstetricians, midwives and VIPs attended and heard from leading experts on the latest research in this area. At the launch the team presented an overview of the project, and the College made a commitment to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour by 50% by 2020. The project launch gained widespread media coverage, including from the BBC, and generated huge interest on social media, highlights of which are available on our storify page.

To coincide with the launch of data collection phase in January 2015, we disseminated a letter to all maternity professionals, co-signed by the Presidents of the RCOG, RCM and RCPCH. This letter emphasised that everyone involved in clinical incident investigations has a duty to ensure that the quality of the review undertaken reflects the serious emotional and financial cost these cases bring to families and to the NHS. We also published a statement and blog to communicate this message to key stakeholders and patient organisations.

As part of our ongoing communications strategy, we produce a quarterly e-newsletter containing updates about how the project is progressing. Over 500 people have signed up to receive these communications to date. We also have an active presence on Twitter (@EachBabyCounts) and send a minimum of two tweets per day to our growing number of followers.

Finally, between January and June 2015, the Project Team will be speaking to groups of obstetricians and midwives at a series of regional meetings held in each of the NHS Strategic Clinical Networks in England, as well as at meetings in Wales, Scotland and Northern Ireland.

Data collection

The Project Team developed the Each Baby Counts data collection protocol between October and December 2014. The data collection tool was then piloted in two obstetric units during November and approved at the IAG meeting on 4th December 2014.

Following the launch event, we wrote to the head of every maternity service in the UK asking them to nominate an Each Baby Counts Lead Reporter. We have been delighted with the response: as of February 20th 2015, 96% of services have nominated a Lead Reporter who has been trained on how to use the reporting system. Approximately half of the Lead Reporters are consultant obstetricians and half are risk management midwives.

The Lead Reporters are responsible for reporting events when they occur, and are also the main contact point for queries from the Project Team. Clinical Directors will ultimately be responsible for ensuring data is submitted for eligible cases in each Trust or Health Board.

MedSciNet, a company specialising in design and development of web applications and online database systems, was contracted to supply the online data collection system. This was built during December 2014, ready for the launch of data collection in January 2015.

At regular intervals, the data submitted to Each Baby Counts will be cross-checked against other national sources of data to ensure that all notifiable cases have been reported. Cases of intrapartum stillbirth and early neonatal death will be identified from MBRRACE-UK data, and cases of severe neonatal brain injury will be identified through the National Neonatal Research Database (NNRD). We now have a system in place for contacting Lead Reporters if we become aware of any notifiable cases that have not been reported, and in this way we will ensure complete case ascertainment.

Data analysis

We expect to begin thematic data analysis of the local reports once the incident investigations into the first 50 eligible cases have been completed (anticipated in May 2015). A data analysis protocol is currently in development and will be discussed at the second IAG meeting in June 2015. We envisage our first publication around the anniversary of data collection – i.e. Winter/Spring 2016.

Dissemination of findings and recommendations

The programme will produce various outputs aimed at different audiences. One of the first outputs will be a systematic review of the literature to identify effective interventions for reducing intrapartum stillbirth, early neonatal death and severe brain injury. We will also publish an annual report summarising the main themes emerging from the analysis of the clinical incident investigations into these cases. Shorter and more frequent safety bulletins will be included in our e-newsletter, which will be disseminated to local teams via Lead Reporters.

We also plan to hold an annual quality improvement conference at the RCOG to disseminate and share learning from the programme. We will hold a call for abstracts and invite local teams to submit examples of successful quality improvement projects in this area.

The project may also produce other research articles, conference papers and reports describing methodological developments.

Summary

We have been able to achieve rapid progress in setting up this project, due in no small part to the enthusiasm of Trusts and Health Boards to participate in this initiative. The profession recognises that this is a timely opportunity for maternity services to share information with each other and the RCOG is therefore well-placed to lead such an initiative. We see this project as Women's Health leading the way in developing the open and honest NHS our patients deserve.

Based on the high levels of engagement and commitment that have been demonstrated to date, we believe that this project has the potential to deliver the type of robust evidence needed to underpin and drive forward service improvements that will benefit women and their families throughout the United Kingdom.

Appendix 1. Each Baby Counts Project Team

Name	Organisation	Position	Project Team Role
Professor Zarko Alfirevic	University of Liverpool; Liverpool Women's Hospital	Professor of Fetal and Maternal Medicine; Consultant Obstetrician	Co-Principal Investigator
Professor Alan Cameron	RCOG; Southern General Hospital, Glasgow	RCOG Vice President, Clinical Quality; Consultant Obstetrician	Co-Principal Investigator
Miss Hannah Knight	RCOG	Manager, Lindsay Stewart Centre for Audit and Clinical Informatics	Project Manager
Professor Marian Knight	NPEU	Professor of Maternal and Child Population Health	Senior Project Advisor
Dr Ed Prosser-Snelling	RCOG; National Trainee – East of England	National Medical Director's Clinical Fellow; Senior Speciality Registrar	Quality Improvement and Network Lead
Miss Emily Petch	RCOG	Coordinator, Lindsay Stewart Centre for Audit and Clinical Informatics	Coordinator/Data Manager

Appendix 2. Each Baby Counts Independent Advisory Group

Chair: Professor Neil Marlow, University College London, Elizabeth Garrett Anderson Wing

Name	Organisation	Position
Dr Catherine Calderwood	NHS England; Scottish Government	National Clinical Director for Maternity and Women's Health; Senior *Medical* Officer Women and Children's Health
Ms Anita Dougall	Royal College of Obstetricians and Gynaecologists (RCOG)	Director, Clinical Quality
Professor Elizabeth Draper	University of Leicester; MBBRACE	Professor of Perinatal Epidemiology
Dr Joanna Gillham	Saint Mary's Hospital, Manchester	Consultant Obstetrician; Sub-specialist in Maternal and Fetal Medicine
Professor Anne Greenough	Kings College London, Department of Paediatrics	Professor of Neonatalology; Head of Department; Head of School of Medicine
Ms Michelle Hemmington	RCOG Women's Voices Involvement Panel; Campaign for Safer Births	Lay Representative
Ms Gail Johnson	The Royal College of Midwives (RCM)	Education and Professional Development Advisor
Dr Sara Kenyon	University of Birmingham	Reader in Evidence Based Maternity Care
Professor Jenny Kurinczuk	National Perinatal Epidemiology Unit (NPEU); MBBRACE	Professor of Perinatal Epidemiology; NPEU Director
Mr Bertie Leigh	Hempsons Solicitors; NCEPOD	Senior Partner of Hempsons Solicitors; Chair of NCEPOD
Ms Nicky Lyon	NHS England Women's Health Patient Safety Expert Group; Campaign for Safer Births	Lay Representative
Professor Jan van der Meulen	London School of Hygiene and Tropical Medicine (LSHTM)	Professor of Clinical Epidemiology, Department of Health Services Research and Policy
Dr Amanda Ogilvy-Stuart	British Association for Perinatal Medicine (BAPM)	Consultant Neonatologist; BAPM Treasurer
Dr Heather Payne	Welsh Government	Senior Medical Officer for Maternal and Child Health
Ms Madeleine Percival / Ms Catherine Pearson	Department of Health	Deputy Director, Children, Families & Maternity
Ms Heather Reid	Northern Ireland Maternal and Child Health (NIMACH)	Regional Manager
Ms Janet Scott	Stillbirth and Neonatal Death Charity (Sands)	Head of Research and Prevention
Professor Steve Thornton	University of Exeter Medical School	Dean; Chair of RCOG Lindsay Stewart Committee for Audit and Clinical Informatics
Ms Michele Upton	NHS England	Patient Safety Lead - Maternity and Newborn
Professor Gerry Visser	Universitair Medisch Centrum (UMC), Utrecht	Head of Obstetrics, UMC, Utrecht