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Each Baby Counts: the recommendations

Hannah Knight and **Edward Prosser-Snelling MRCOG** take a close look at the recommendations of the first report focusing on the quality of reviews

"When there has been a serious incident, a good review of care can identify clear lessons to prevent adverse events in the future. We owe it to the families of these babies to identify these lessons."

Marian Knight
Professor of Maternal and Child Population Health

EACH BABY COUNTS has been making steady progress since data collection began in 2015, and we released our first report in June 2016.

The first report peels back the curtain on the true scale of the challenge facing our maternity services and identifies the scale of the problem. We now know that in 2015, at least 921 babies died or had a severe brain injury at term as a result of incidents during labour*. The report also describes in detail the variation in extent and quality of the current local review process within the NHS, the analysis of which forms the majority of the report. Although the report is based on interim data, there are already clear messages for improvement for everyone involved in delivering maternity care.

What improvements have been implemented as a result?

We asked some of our lead reporters and clinicians trying to take this work forward locally for their views on how the report is translating into action.

*Royal College of Obstetricians and Gynaecologists. Each Baby Counts: key messages from 2015. London: RCOG, 2016.

Recommendation 1:

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.

WE KNOW THAT NHS maternity teams are operating under intense pressure, with shortages of junior doctors and midwives piling pressure on staff who are all working at or over capacity. With these pressures, resource allocation becomes a major challenge, with pressures from trusts to adhere to ever shrinking budgetary targets.

"Risk management midwives are doing a great job under pressure, but undoubtedly need more resources. We have had to think outside the box to find suitable staff to contribute to conducting investigations. By using our (more senior) junior doctors and a system of close supervision we have been able to improve the understanding of obstetric risk management throughout our department, as well as improving efficiency of reviews. The next step is to meaningfully connect reviews with clinical quality improvement."

Martin Cameron
Consultant Obstetrician and Clinical Director of Obstetrics, Norfolk and Norwich University Hospital

"Risk management midwives are doing a great job under pressure, but need more resources."

Recommendation 2:

Make parents aware of the local review, and invite them to participate in accordance with their wishes.

PARENTS ARE THE only ones present throughout the whole of pregnancy and birth, and their story is important to understanding how care can be improved. However, we found that in 25% of instances, 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.

"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 under way. It's hard to describe how upset and confused we were – the poor communication made a terrible situation so much worse. It would have made such a difference if, in the first few hours, 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 much as possible'."

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

"The key challenge for all of us is to see the enthusiasm for reporting to Each Baby Counts translated into action to improve care and prevent these babies from dying or having a brain injury. We need you to take action on the five key Each Baby Counts messages [two of which are profiled here] 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."

Zarko Alfirevic and Alan Cameron
Co-Principal Investigators, Each Baby Counts

Each Baby Counts is the RCOG's 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. To find out more, visit: rcog.org.uk/eachbabycounts

Towards the future

Maternity care has always been at the forefront of reducing avoidable mortality and morbidity, demonstrated by our track record with the Confidential Enquires over the last 65 years. The death of a mother in pregnancy is now a rare event in the UK and one we continue to strive to further reduce. Through Each Baby Counts, we now endeavour to achieve the same results for all babies. We will publish our next report in 2017, with analysis of the causes of some of these tragedies and recommendations to improve care.