Addressing preventable stillbirth and brain injury

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Nearly three-quarters of stillbirths, neonatal deaths, and severe brain injuries in the UK that resulted from incidents occurring during term labour might have been averted with different care. These are the stark findings of the second Each Baby Counts report from the Royal College of Obstetricians and Gynaecologists, released on Nov 13.

Each Baby Counts is a UK-wide quality improvement programme set up to meet the Government target of halving the number of babies who die or are left severely disabled as a result of events in labour by 2025. The report is based on an independent review of local investigations into the 124 stillbirths, 145 neonatal deaths, and 854 cases of severe brain injury that occurred in 2016. A mean of seven critical factors were found to contribute to the poor outcomes, including failure to act on risk factors, errors interpreting cardiotocography results or not acting on abnormal results, and failure to follow guidelines. The findings echo those of the 2016 MBRRACE-UK confidential inquiry into intrapartum deaths, which painted a picture of an overstretched, under-resourced workforce struggling to keep up with demand. Deficiencies in fetal monitoring were a common theme and it is deeply concerning that only 16% of midwives and doctors at units implementing the Saving Babies' Lives care bundle reported having a competency assessment on fetal heart rate monitoring in the past 12 months.

Worryingly, the numbers of stillbirths, neonatal deaths, and brain injuries are almost identical to the previous year's report. This lack of progress is inexcusable and lessons can be learned internationally. The Netherlands, for example, had the highest rate of perinatal mortality in Europe in 2000. Yet, thanks in part to introduction of a robust perinatal audit system, the country saw a 6·8% annual reduction in stillbirth rates from 2000 to 2015.

Without urgent action to increase staffing levels, improve competency in fetal heart monitoring, and ensure appropriate guidelines are followed, the goal of halving stillbirths, neonatal deaths, and severe brain injuries occurring during labour by 2025 will not be achieved. ■ *The Lancet*

For the **Each Baby Counts report** see https://www.rcog.org.uk/en/guidelines-research-services/audit-quality-improvement/each-baby-counts

For the **2016 MBRRACE-UK confidential inquiry** see https://www.npeu.ox.ac.uk/mbrrace-uk/reports/perinatal-mortality-and-morbidity-confidential-enquiries

For the **data from the Netherlands** see **Series** *Lancet* 2016; **387:** 691–702

Health-care system staffing: a universal shortfall

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In a world where the population is growing and living longer, the health-care workforce is not keeping up with demand. Two reports—published by The King's Fund on Nov 15 and Wemos, an independent civil society organisation, and the Association of Malawian Midwives on Nov 11—show how two very different health systems are facing similar predicaments over staffing.

Despite the UK's National Health System, the fifth largest employer in the world, being substantially larger than Malawi's health system, there are similarities when it comes to health-care resourcing. Both systems are impacted negatively by migration. Probably because of the migration uncertainties brought by Brexit, more EU nurses and visiting health staff are leaving than entering the country. Similarly, according to the latest available data dating back to 2002, 59% of the doctors born and trained in Malawi were working abroad. In both countries, many skilled workers are driven away by poor working conditions. Understaffing means that the health-care workforce is overworked and, in both settings, staff are underpaid. Training of new staff is also not sufficient. In the UK, the percentage of health spending dedicated to training has gone down to 3% in 2017. In Malawi, more health workers are being trained than a decade ago—although too few to meet demands—but their recruitment into the system lags after graduation.

An understaffed health system cannot be resilient, struggles to provide adequate care, especially for populations such as children and older people, and cannot react adequately to imponderables, such as natural and man-made disasters. The issue of health-care staffing is, by all means, not a new one, but the case studies of these two countries show that progress is stagnating. Indeed, the Global Burden of Disease Study 2017 found that 47·2% of countries and territories have less than one physician per 1000 population and that health worker density would need to increase by 85·4% by 2030 to meet the sustainable development goals. It is now time to go beyond the discourse around health-care staff shortages and to implement action. Improving welfare of the workforce will be crucial to ensure that investment in human resources for health is sustainable. ■ *The Lancet*

For more on **health-care staffing in Malawi** see https://www.wemos.nl/wp-content/uploads/2018/11/Wemos_Country-report-Malawi-2018.pdf

For more on **health-care staffing in the UK** see https://www.kingsfund.org.uk/publications/health-care-workforce-england