

# The impact on a DGH stillbirth rate of implementing from 2011 measures subsequently recommended in the 2015 MBRRACE-UK report on antepartum stillbirths

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## Aims/objectives

To bring about a reduction in our local stillbirth rate by improving care in areas identified by:

- local multidisciplinary case review
- local audit
- invited external review.

## Background

The stillbirth rate at BHFT almost doubled between 2007 and 2010. A proactive response to investigating potential causes for this identified several key themes

- absent or inadequate antenatal management plans
- failed detection of IUGR
- poor access to interpretation services
- failure to act on reduced fetal movements

## Methods

Since 2011 a review has been undertaken into the whole maternity care pathway of every woman whose baby is stillborn

- comprehensive, multidisciplinary
- standard template used to derive taxonomy
- parental involvement
  - specific questions for review group to address
  - findings shared at postnatal consultant visit
- lessons learned disseminated widely within trust and to other service providers (eg GP surgeries, CCGs)



Findings have led to improvements in several areas of care:

### Antenatal management plans:

- new referral form for antenatal booking devised, enabling
  - risk factors to be clearly identified at booking
  - timely consultant review to be arranged if required
  - women meeting any of the NICE criteria for gestational diabetes have 24-28 week GTT arranged at dating scan appt.

PATHWAY	INTERVIEW 1	INTERVIEW 2	INTERVIEW 3
Booking	1. Antenatal booking form completed	2. Antenatal booking form completed	3. Antenatal booking form completed
Diabetes	1. NICE criteria for gestational diabetes identified	2. NICE criteria for gestational diabetes identified	3. NICE criteria for gestational diabetes identified
Reduced fetal movements	1. Reduced fetal movements identified	2. Reduced fetal movements identified	3. Reduced fetal movements identified
SGA	1. SGA identified	2. SGA identified	3. SGA identified
Induction	1. Induction of labour at term	2. Induction of labour at term	3. Induction of labour at term
Delivery	1. Delivery at term	2. Delivery at term	3. Delivery at term
Stillbirth	1. Stillbirth identified	2. Stillbirth identified	3. Stillbirth identified

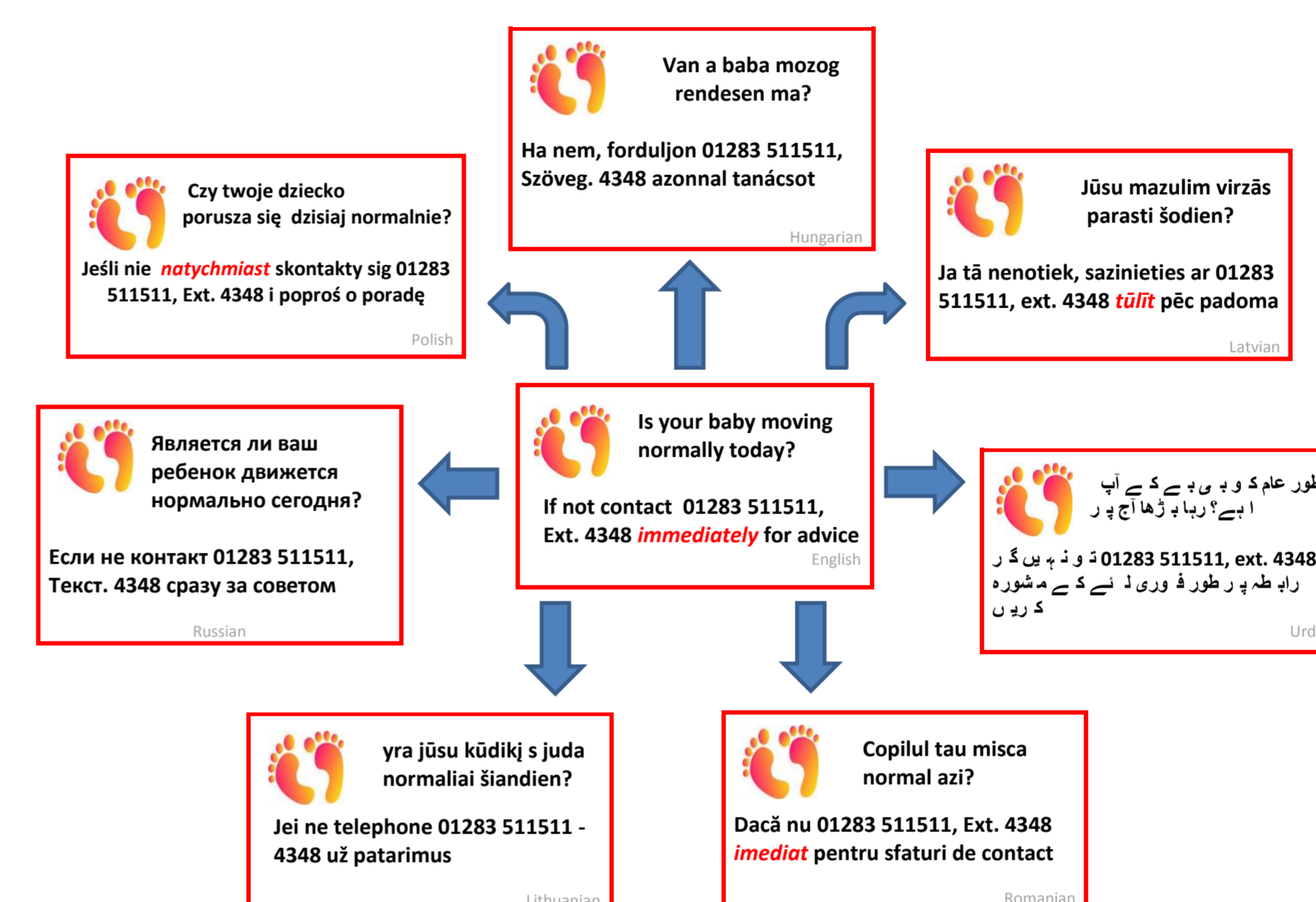
ASSESSMENT FOR GTT	YES	NO
1. Booking visit	YES	NO
2. Antenatal booking form completed	YES	NO
3. NICE criteria for gestational diabetes identified	YES	NO
4. Timely consultant review arranged if required	YES	NO
5. Women meeting any of the NICE criteria for gestational diabetes have 24-28 week GTT arranged at dating scan appt.	YES	NO

### Access to interpretation services:

- staff encouraged to book face to face interpreters in advance
- LanguageLine available as back up if required

### Reduced fetal movements (RFM): a

- comprehensive care pathway and checklist for women with RFM developed
  - strict criteria for medical review and escalation to consultant
  - low threshold for delivery at term
- women encouraged to report RFM
  - antenatal education
  - prominent sticker on handheld notes with RFM advice available in several different languages

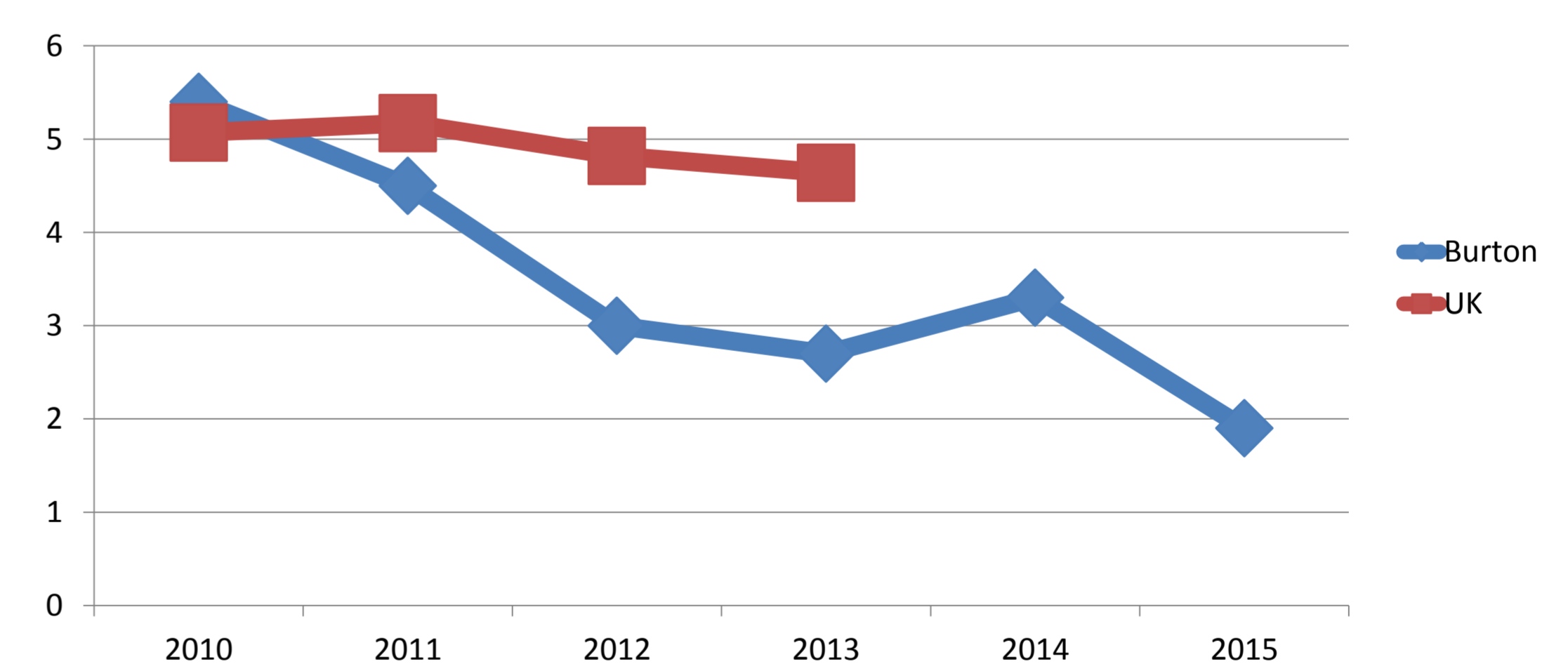


### Detection of SGA fetuses:

- customised growth charts/SFH measurements for low risk women in use at BHFT for many years
- audit demonstrated a relatively high rate of missed SGA at term
- serial scans for women with major risk factors (RCOG) for SGA continued until 39-40 weeks
- women with any biometry below 5<sup>th</sup> centile at anomaly scan have growth scans from 24 weeks.

## Results

Stillbirth Rate per 1000 births in Burton and UK 2010 - 2015



- BHFT stillbirth rate has fallen to level well below UK average
- maintained for the last 4 years
- 40% babies born weighing <10<sup>th</sup> centile identified prior to delivery
- low threshold for induction of labour at term with RFM
  - increase in induction rate
  - no significant increase in LSCS rate

## Conclusions

The 2015 MBRRACE report into antepartum stillbirths recommended that standardised local review of care should take place after every stillbirth, and identified missed opportunities for intervention in 3 key areas; developing diabetes in pregnancy, monitoring fetal growth and identifying and responding to reduced fetal movements. We believe that our results demonstrate clearly how improving care in these areas over the last 5 years, together with continuous learning from case reviews, can lead to a significant reduction in local stillbirth rate.

### Acknowledgements

Katharina Anwar, consultant O&G  
 Catherine Askey, clinical risk midwife  
 Claire Cookson, bereavement midwife  
 Sam Evans, bereavement midwife  
 Sue Harrison, labour ward manager

Helen Hurst, matron maternity  
 Jo Shillito, bereavement midwife  
 Jo Wallace, matron community midwifery  
 Sharon Wallis, head of midwifery