

All had live births with no NNU admissions. There were no infants <2.5 kg.

**Conclusion** 82% (14) of women were not scanned who met criteria for referral. 35% (8) of women had no form of follow up arranged.

Currently our unit is failing to meet the RCOG recommendations of Greentop Guideline 57. We have developed a local guideline to improve management of women with RFM and re-audit is underway.

## REFERENCE

RCOG Greentop Guideline 57; Reduced Fetal Movements. February 2011.

### PP.67 SURVEY OF CURRENT MANAGEMENT OF REDUCED FETAL MOVEMENTS IN SCOTLAND

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Maternal perception of fetal movements is the oldest and most commonly used method to evaluate fetal wellbeing. The investigation and management of reduced fetal movements (RFM) is complicated by a wide variation in the amount perceived by individual mothers and the paucity of good evidence to guide clinicians.

This survey was designed in line with the RCOG Green-top Guideline on Reduced Fetal Movements (February 2011) using [www.surveymonkey.com](http://www.surveymonkey.com) and was distributed to all trainee and consultant obstetricians and all midwifery staff across Scotland.

200 responses were collected; 68% from midwives and 32% from obstetric trainees or consultants. 63% of responders were aware of the RCOG guideline on RFM; of these, 79% had read this guideline. Despite this, only 69% work in a unit which has a policy detailing investigations and management of women presenting with RFM. 80% of responders accepted "maternal perception of decreased fetal movements" as a definition of RFM and an indication to seek advice. Over 90% of responders routinely perform CTG (if greater than 28 weeks), blood pressure and urinalysis on women presenting with RFM. Less than 5% would routinely refer women with RFM for ultrasound examination without additional risk factors and only 67% of responders have access to this within 24 hrs or during the next working day. Surprisingly, 23% would never offer induction for RFM.

The results reveal the huge variation across Scotland when investigating and managing women presenting with RFM, highlighting the importance of further research into the issue and the development of nationally agreed policy.

### PP.68 'TAKE CARE OF THE POUNDS AND THE PENNIES WILL TAKE CARE OF THEMSELVES' – THE COST OF OBESITY IN OBSTETRICS

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**Objectives** The literature contains little information on the economic effect of obesity on maternity services. We aimed to assess the cost impact of obesity on antenatal, intrapartum and postpartum care.

**Methods** Retrospective cohort study. Study group: BMI > 30 (n = 72). Control group: BMI 18.5 – 25 (n = 68). Exclusion criteria: breech, pre-existing hypertension/diabetes, multiple pregnancy, late bookers. Costing information from NI Database of Healthcare Resource Group Costs. Outcomes recorded and statistical analysis performed.

**Results** Overall cost of maternity care in the obese group (£11699) was significantly higher than the normal BMI group (£10643)

(p = 0.026, power 73%). Further analysis revealed the greatest cost difference was with antenatal care (p = 0.005, power 89%) from increased appointments and admissions due to increased rates of PIH, PET and GDM. There was no significant difference in the cost of intrapartum care (Normal BMI £2424, Obese £2355, p = 0.669) or postpartum care (Normal BMI £1097, Obese £1052, p = 0.627). The obese group had a higher rate of NVD (61% versus 47%), and Caesarean delivery (18% versus 13%) and lower rate of instrumental delivery (21% versus 40%). The incidences of PPH were similar, with a higher rate of 3<sup>rd</sup> degree tears in the normal BMI group. Birthweights and SCBU admissions were similar with a higher rate of breastfeeding in the normal BMI group (60% versus 53%).

**Conclusion** Obesity significantly increases the cost of maternity care by over £1000 per patient. This study highlights the importance of investment in maternity services and weight management programmes to cope with the evolving obesity epidemic.

### PP.69 FACTORS THAT INFLUENCE CLINICIANS IN THEIR CARE OF FAMILIES WHO EXPERIENCE STILLBIRTH

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**Objective** Surveys of clinicians are important in Health Service research. Previous surveys have noticed a strong reluctance of doctors to know, notice or remember anything about patients who have experienced a stillbirth. Are attitudes of clinicians to stillbirth created by lack of training, education, personal experience or clinical experience? We wanted to find out what influences clinicians in their care of women and their families at the time of stillbirth.

**Study design** Clinicians, including junior and senior trainees, consultants and specialists were surveyed. We asked questions to elicit in-depth information on their knowledge of factual details of stillbirth cases and bereavement services available. We also questioned their personal experiences and feelings when dealing with bereaved families. Finally, we examined the impact caring for this patient group had on clinicians. Anonymised data was analysed.

**Results** Clinicians (90%), whether senior or junior, agreed that caring for women who experience stillbirth takes an emotional toll personally. Talking to senior colleagues or friends/family was used to cope with the impact. Only 71% could remember details of a patient who experienced stillbirth in the last year, and many were unclear on details of routine hospital bereavement care. Of the group surveyed, 14% strongly agreed that they had received adequate training to cope with stillbirth. Half had personal experience of perinatal death, while a third were parents themselves.

**Conclusion** Clinicians feel this patient group are challenging and should have support in this area of work. There is a continual need for staff education and training.

### PP.70 PROVISION OF CARE AT THE TIME OF STILLBIRTH

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**Objective** The multi-disciplinary bereavement team focuses on all aspects of care including emotional, medical and spiritual, in accordance with international evidence-based practise. While there are universal commonalities in the pain of grief involved in stillbirth, we wished to refine our practise based on the needs of our specific patient group. We surveyed bereaved parents from 2011 to discover how they felt about the care they received and to look for their views on the bereavement team.