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 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 3rd 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.

Study design Parents were contacted to explain the objectives of the survey and to obtain their consent. Two copies were then sent to each home, one for each partner.
Results In total 36 completed questionnaires were returned: 21/29 mothers, 15/28 fathers. Only 38% of respondents strongly agreed that on diagnosis they received written information or contact support. While most felt that they were facilitated in spending high quality precious time with their baby, not all felt this need was met on the labour ward. The majority, 90%, of parents felt post-mortem was explained sensitively but not always clearly. Only 47% of parents met their consultant during their inpatient care, and half felt they did not have a timely postnatal visit to meet a consultant. All parents said that "kindness and sensitivity of staff" was a vital aspect of their care.
Discussion These findings identify routes for modifying the care we provide. Prioritising our bereaved parents' views supports and expands an open culture, in which we empower our parents in their continuing grieving process.

PP.71 ACTIVE DRUG USE VS REPLACEMENT THERAPY OR ABSTINENCE DURING PREGNANCY: IMPACT ON THE OUTCOMES FOR MOTHERS AND BABIES

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Aims To evaluate demographic characteristics of women with history of substance misuse, analyse the differences in the birth weights (term baby) amongst continuous drug users and the abstinent (or on replacement treatment) mothers, and to identify key factors associated with placement of neonate under social services care.
Methodology Data was collected retrospectively from a database set up by the Bristol Specialist Drugs and Alcohol Service for all pregnant women with illicit drug use between April 2010 and March 2011.
Results Sixty-two women attended the specialist substance misuse antenatal clinic. Only 50% of the women without replacement therapy were first seen within 12 weeks of gestation. Term babies born to mothers who were on replacement therapy or showed abstinence were 350 grammes heavier (3.1 kg vs. 2.75 kg) than the babies born to ongoing illicit drug using group. 73% of neonates whose mothers were still misusing drugs at the time of delivery were taken into care. Postpartum average length of stay for mothers abusing illicit drug during pregnancy was 8.4 days vs. 5.5 days in the abstinent or replacement therapy group. Babies born to mothers using illicit drugs stayed in hospital for an average of 12.3 days compared to 5.5 days for the other group.
Conclusions This study provides some initial data, which can be used for patient education and awareness training for a variety of professionals regarding importance of early booking, and evidence based advice to remain abstinent or on replacement therapy, to improve the outcomes of the pregnancy.

PP.72 REDUCED FETAL MOVEMENTS - HAS RCOG GUIDANCE BEEN TRANSLATED INTO PRACTISE?

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Background NHS clinical effectiveness initiatives aim to promote uniform standards of high-quality evidence based care. Clinical practise guidelines produced by the RCOG are a principle component of such care. We aimed to determine if the publication of the RCOG guideline on 'Reduced Fetal Movements' (RFM), (Feb 2011) had translated into the development of evidence-based policies in maternity units in the UK.
Methods UK maternity units were asked to provide a copy of their guideline for the management of reduced fetal movements (May-July 2012). 12 audit criteria were agreed by committee, based on the strongest evidence in the RCOG RFM guideline. Guidelines were then audited to assess concurrence with these criteria.
Results Responses were obtained from 50% of units. 12 units had no guideline. The 101 remaining guidelines were of variable length (1–27 pages). 8 were out-of-date and 12 had no review date. Zero unit policies contained all 12 criteria taken from the RCOG guideline. The median number of audit criteria included in any guideline was 7 (26.7%) (range 3–11). The only criterion included in all the guidelines was 'After fetal viability has been confirmed…..the woman should have a CTG'. 11 units (10.9%) continue to recommend the use of kick charts.
Conclusion The translation of RCOG guidance into effective clinical practise is variable. Research is needed to determine how improvements can be made in this transition.

PP.73 HEALTH PROMOTION OF THE PREGNANT: ANALYSIS OF SOME INTERVENING VARIABLES

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Background The deficit in preparing women for motherhood is responsible for a higher incidence of complications in pregnancy, childbirth and postpartum, as well as lower prevalence of breastfeeding until 6 months of baby's life.
Objective To analyse the relationship of education/information made during pregnancy and preparing women for motherhood.
Method This is a non-experimental, quantitative, cross-sectional, descriptive and correlational study with a non-probability convenience sample (n = 195). Data collection was made through a questionnaire comprising a sociodemographic component and obstetric history (previous and current) and a pregnant women's empowerment scale (KAMEDA; SHIMADA, 2008). This data collection instrument was administrated to pregnant women in the third pregnancy trimester.
Results 70.8% have breastfeeding information and of these, 40.6% were informed by the nurse. 89.2% of pregnant women surveyed received information about the discomforts of pregnancy and of these, 27.6% were informed by the doctor. 94.4% received information on nutrition and weight gain during pregnancy, and 39.1% said it was the doctor. Information on harmful habits in pregnancy was performed to 80.5% and in 34.4% it was the doctor who transmitted the information. Obstetric variables and the transmitter of information are predictors of the health promotion of the pregnant.
Conclusions In order to make choices in a conscious and healthy way pregnant woman should have adequate information at every step of the pregnancy and childbirth. Health professionals (doctors and nurses) should play a facilitating role in acquiring skills of self-care during pregnancy and postpartum.

PP.74 AUDIT ON THE MANAGEMENT OF MULTIPLE PREGNANCIES AND REVIEW OF OUTCOMES

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Aim and methodology Retrospective audit on the antenatal care and intrapartum outcomes for the women with multiple pregnancies booked at City Hospital over a year. The total number of cases included in the audit were 81 excluding the 4 IUT's from other hospitals and the standards were obtained from the Trust guidelines on management of multiple pregnancy.