Critical gaps in antenatal care identified in cases of term stillbirths

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A new study launched today (Thursday 19 November) has revealed key steps for hospitals to improve care for pregnant mums and babies.

It follows an investigation by a team of experts into 133 cases of stillbirth in 2013 - and found that national guidance was not followed by hospitals in the majority of cases and identified 'missed opportunities' which could have potentially saved babies lives.

In the UK today, almost one in every 200 babies is stillborn and one third of these occur when the pregnancy has reached full term. A team of academics, clinicians and charity representatives, called MBRRACE-UK, has looked at how care for these mothers and term babies can be improved.

The report, commissioned by the Healthcare Quality Improvement Partnership as part of the Maternal, Newborn and Infant Clinical Outcome Review Programme, is led by a team from the University of Leicester. It is launched on 19 November at The Royal College of Obstetricians and Gynaecologists.

In its latest report, the group has examined stillbirths born at term who were singletons (sole births) and not affected by a congenital anomaly. These occur in over 1000 pregnancies a year in the UK.

A random representative sample of 133 of these babies who were stillborn in 2013 was selected. The pregnancy notes were assessed for all

133 and 85 were reviewed in detail against national care guidelines by a panel of clinicians, including midwives, obstetricians and pathologists who considered every aspect of the care.

The expert enquiry found:

- More than half of all term, singleton, normally formed, antepartum stillbirths had at least one element of care that required improvement which may have made a difference to the outcome.
- Two thirds of women with a risk factor for developing diabetes in pregnancy were not offered testing - a missed opportunity for closer monitoring.
- National guidance for screening and monitoring growth of the baby was not followed for two thirds of the cases reviewed.
- Almost half of the women had contacted their maternity units concerned that their baby's movements had slowed, changed or stopped. In half of these cases there were missed opportunities to potentially save the baby including a lack of investigation, misinterpretation of the baby's heart trace or a failure to respond appropriately to other factors.
- Documentation indicating that an internal review had taken place was only present in one quarter of cases and the quality of these reviews was highly variable.
- Only half of the stillbirths selected for confidential enquiry had a post mortem carried out. In the majority of cases post mortems were of satisfactory or good quality.
- A good standard of bereavement care was provided for parents immediately following birth including the offer of an opportunity to create memories of their baby.

The experts have identified key areas for action including:

- Implementation of national guidance regarding:
    - Screening and identification of women who should be offered testing to detect those at risk of developing diabetes in pregnancy.
    - Routine measurement of the baby's growth by symphysis fundal height measurement and detailed plotting of the growth at each antenatal appointment from 24 weeks of pregnancy.
    - Management of reduced fetal movements and identification of additional risk factors.
    - Standardised multidisciplinary review of ALL term stillbirths.
- Obstetric and midwifery care during labour for women following stillbirth should be of the same in quality and content to that of women having a healthy birth
- All parents of a stillborn baby should be offered a post-mortem. This offer should be clearly documented in the mother's notes.
- All parents should be offered a follow-up appointment with a consultant obstetrician to discuss their care, the actual or potential cause, chances of recurrence and plans for any future pregnancy.
- A summary of the follow-up appointment should be written in plain English and sent to the parents and their GP.

Professor Elizabeth Draper, Professor of Perinatal and Paediatric Epidemiology at University of Leicester, said:

"The panel has identified a number of areas where improvements of care are required which, if implemented, could lead to an overall reduction in this type of stillbirth, representing missed opportunities in the provision of antenatal care.

"However not all findings were negative. We found examples of

excellent bereavement care where midwives had provided long term support for families in a way that surpassed normal expectations, high quality interpreter services when these were needed as well as a high standard of post mortems."

Professor Jenny Kurinczuk, Director of the National Perinatal Epidemiology Unit and National Programme Lead for MBRRACE-UK, said:

"The findings from this enquiry are important because they provide clear pointers as to how care can be improved. The guidelines are clear and individual practitioners and maternity units need to ensure that the guidelines are implemented and every opportunity is taken to prevent a stillbirth occurring. There is no panacea in this situation; we have to prevent stillbirths one by one to ensure that as a nation we are able to reduce our stillbirth rate to those rates experienced by our European neighbours and avoid the terrible heartache experienced by three families every day across the UK."

Health Minister, Ben Gummer, said:

"This is further evidence of the urgent need for change - we need to do everything we can to reduce the number of families going through the heartache of stillbirth and ensure the NHS is one of the very best and safest places to have a baby across the world.

"Last week we launched our ambition to halve stillbirths, neonatal deaths, maternal deaths and neonatal brain injuries, through cutting-edge technology and multi-disciplinary training. The MBRRACE-UK recommendations will help the NHS to further improve and shape future, safer care.

"With greater transparency and more than 1,800 additional midwives

since 2010, as well as 6,600 currently in training, we will support local maternity services to make sure every baby receives consistently high quality care, 24 hours a day, seven days a week."

Cathy Warwick, Chief Executive of The Royal College of Midwives (RCM), said:

"The RCM welcomes this important report. It is imperative that it does not sit on the shelf but instead is translated into practice and service change. We owe it to women and their families to do everything we can to prevent avoidable antenatal stillbirths. The findings and recommendations from this report are critical in helping us to do just that. The RCM will work with others to do everything we can to ensure implementation."

Dr David Richmond, President of the Royal College of Obstetricians and Gynaecologists (RCOG), said:

"We welcome this comprehensive report by the MBRRACE team and the clear recommendations of key actions required at all levels of the health service to reduce the number of stillbirths and improve the care given to women and their babies.

"Although fewer babies in the UK are stillborn today, it's desperately disappointing that the four recommendations from this report remain exactly the same as when the last confidential enquiry into these stillbirths took place over 15 years ago. Today's report suggests six in 10 of these stillbirths are potentially avoidable. We can and should do better by the 1,000 families affected by stillbirths that occur before a woman goes into labour each year in the UK.

"The RCOG does not accept that stillbirths are unavoidable tragedies so last year we launched Each Baby Counts, a complementary programme

to MBRRACE which aims to reduce by 50% the number of babies who die or are left severely disabled as a result of incidents occurring during term labour."

More information: To read the full report, MBRRACE-UK Perinatal Confidential Enquiry: Term, singleton, normally formed, antepartum stillbirth, to read more about the involvement of patients and the public in decisions about services, and to find out about the Perinatal Surveillance programme and the topics for confidential enquiries that MBRRACE will cover, see www.npeu.ox.ac.uk/MBRRACE-UK

Provided by University of Leicester