

Making normal birth a reality

Consensus statement from the Maternity Care Working Party
our shared views about the need to recognise, facilitate and audit normal birth



Foreword

This consensus statement has been developed by the members of the Maternity Care Working Party (MCWP) for:

- managers, commissioners and providers of maternity care,
- teachers and students in midwifery, medical and public health education, and
- maternity services user representatives.

The MCWP wants to encourage a positive focus on normal birth. The statement calls for a standard definition for normal labour and birth so that normal birth rates can be audited and compared with confidence. The Information Centre in England has adopted a measure for normal labour and birth, called 'normal delivery'. As health systems are separate for each of the four countries of the United Kingdom, we recognise that health communities in Scotland, Wales and Northern Ireland will need to consider whether this works for them.

Please let us know how useful you find the statement. Our contact details are on the back cover.

Gail Werkmeister,
NCT President and Chair of the Maternity Care Working Party

The Maternity Care Working Party

The Maternity Care Working Party is an independent, multi-disciplinary body that campaigns for improvements in maternity care. It was established to raise awareness of the public health implications of the rising caesarean rate. It highlights the health and social needs of women and their families, and the contribution that woman-centred maternity services can make to the promotion of public health, ensuring that babies have the best possible start in life.

Members supporting the consensus statement include:

The Royal College of Midwives	Wendy Savage, retired Consultant Obstetrician
The Royal College of Obstetricians and Gynaecologists	Centre for Research in Midwifery and Childbirth (CeMaC), Thames Valley University
NCT	Lesley Page, Visiting Professor in Midwifery, The Florence Nightingale School of Nursing and Midwifery, Kings College, London
Nursing and Midwifery Council	Dr Lindsay Smith, general practitioner
RCM Consultant Midwives Forum	Pauline Cooke, consultant midwife, St Mary's NHS Trust
The Association for Improvements in Maternity Services (AIMS)	BirthCentre Network UK
Independent Midwives Association	Jane Sandall, Professor of Midwifery and Women's Health, King's College, London
Association of Radical Midwives	Birth Crisis Network
BirthChoiceUK	Iolanthe Midwifery Trust
Susan Bewley, Consultant Obstetrician, Guys & St Thomas' Hospitals NHS Trust	
Soo Downe, Professor of Midwifery, University of Central Lancashire	

Normal Birth Consensus Statement

This consensus statement includes discussion about why normal birth matters, the Information Centre definition of 'normal delivery' with details of the inclusion and exclusion criteria, and recommendations for action to support normal birth. There is also further information on government policies, recent trends and factors that affect levels of intervention and normal birth rates.

Why normal birth matters

With appropriate care and support the majority of healthy women can give birth with a minimum of medical procedures and most women prefer to avoid interventions, provided that their baby is safe² and they feel they can cope.³

Members of the Maternity Care Working Party are concerned about rising intervention rates and wide variations between different services in terms of planned and unplanned caesarean sections, and operative births,^{4,2} as these procedures are known to be associated with both physical and psychological morbidity.³ We all want mothers and babies to come through birth healthy and well-prepared for the changes, demands and emotional growth that follows.

Procedures used during labour which are known to increase the likelihood of medical interventions should be avoided where possible. For example, continuous electronic fetal monitoring during labour in low-risk women is associated with an increase in emergency caesarean section but no long-term health gain,⁵ and use of epidural anaesthetic in labour increases the need for forceps or ventouse.⁶ However, it is important that women's needs and wishes are respected and they should be able to make informed decisions about their care.

“It is important to have a precise working definition for 'normal birth' to enable accurate comparisons to be made for similar women using different services and models of care.”

Normal labour and birth – the Information Centre definition

The Information Centre for the NHS in England has adopted a working definition for normal labour and birth which they call 'normal delivery'.¹ It is based on a specific set of routinely collected statistics. The definition is: “without induction, without the use of instruments, not by caesarean section and without general, spinal or epidural anaesthetic before or during delivery” (for full details see p3).

We want all NHS Trusts and Boards across the UK:

- to use this definition, and
- to collect and publish these statistics regularly.

Recommendations for action

Attention should be paid to providing a comfortable and supportive environment to all women during labour to help them relax and feel secure. When it is possible to use fewer medical procedures in labour, with the woman's agreement and without jeopardising safety, this should be the objective. A straightforward birth makes it easier to establish breastfeeding, helps get family life off to a good start, and protects long-term health. We have developed the following practical recommendations for action.

Maternity commissioners, providers and NHS Boards

- Maternity services to set in place a strategy for supporting women to have a positive experience of pregnancy and birth and increasing normal birth rates, to be signed off by the clinical leads for midwifery and obstetrics.
- Active one-to-one midwifery support for all women during established labour, with midwifery staffing levels in line with the Royal Colleges' recommendation of 1.0 – 1.4 WTE midwives per woman in labour, depending on case-mix category.⁷
- Maternity services should aim to increase their normal birth rates towards a realistic objective of 60% by 2010, using the Information Centre definition.ⁱ
- Access to antenatal preparation courses with a positive focus on practical skills for coping with labour pain including, use of active positions, access to birth pools, relaxation, massage and aromatherapy.
- Evidence-based information for women about factors that make a normal birth with good outcomes for the mother and baby more or less likely, presented in a format which they understand, so that they can plan for the kind of birth they want and make informed decisions.
- Choice of place of birth including home birth, a midwife-led birth centre and a maternity unit with midwifery and medical facilities.
- The chance for women to get to know their midwife prior to labour.
- Consultant midwife and consultant obstetrician presence on the labour ward to lead and support staff.
- Comparative normal birth rates should be available for 'low risk' women planning and starting their care in different care settings (home, freestanding birth centre, alongside birth centre, hospital unit), using the principle of 'intention to treat'.
- Implementation of NICE evidence-based guidelines on Induction of Labour,⁹ Fetal Monitoring¹⁰, Caesarean Section¹¹ and Intrapartum Care¹² in England, Northern Ireland and Wales.

Government policy, funding support and action by other national agencies

- Revision of Payment by Results tariffs in England, as a matter of urgency, to remove the current perverse incentive to maintain high intervention rates.
- Active one-to-one midwifery support for all women during established labour, with midwifery staffing levels in line with the Royal Colleges' recommendation of 1.0 – 1.4 WTE midwives per woman in labour depending on case-mix category, backed up in England by a CNST requirement.⁷
- Education and training programmes and mentoring to build the confidence of midwives to support women who wish to give birth without technological interventions.

- All four countries of the UK to publish normal birth statistics annually using the same definition.
- Policy that services should increase their normal birth rates towards a realistic objective of 60% by 2010.
- Funding of research to establish how case-mix affects normal birth rates and the factors that facilitate normal birth, including inter-disciplinary working and referral arrangements, environments, size of unit, and organisation and qualities of care.

¹On the basis that some maternity units currently have a 59% normal birth rate.^{1,8} It is recognised that case-mix in a unit will affect normal birth rates and research is needed to establish confounding factors so that adjustments for case-mix can be made.

The Information Centre definition of '*normal delivery*'

The Information Centre definition '*normal delivery*' is a measurement of the process of labour and not outcomes.

Outcomes can be compared for '*normal delivery*' with other kinds of birth, such as '*spontaneous delivery*' or '*forceps delivery*' or '*caesarean section*'. Outcomes for a '*normal delivery*' will usually compare favourably with outcomes for other kinds of birth but they will not necessarily be benign.

The '*normal delivery*' group includes

- women whose labour starts spontaneously, progresses spontaneously without drugs, and who give birth spontaneously;
- and women who experience any of the following provided they do not meet the exclusion criteria (see below):
 - augmentation of labour,
 - artificial rupture of the membranes (ARM) if not part of medical induction of labour,
 - Entonox,
 - opioids,
 - electronic fetal monitoring,
 - managed third stage of labour,
 - antenatal, delivery or postnatal complications (including for example post partum haemorrhage, perineal tear, repair of perineal trauma, admission to SCBU or NICU).

The '*normal delivery*' group excludes

- women who experience any one or more of the following:
 - induction of labour (with prostaglandins, oxytocics or ARM),
 - epidural or spinal,
 - general anaesthetic,
 - forceps or ventouse,
 - caesarean section, or
 - episiotomyⁱⁱ

ⁱⁱ Some MCWP members would like the Information Centre definition tightened in future to also exclude procedures like augmentation of labour, use of opioids drugs, artificial rupture of the membranes or managed third stage. This would depend on the necessary statistics being routinely collected. Alternatively, a tighter definition could lead to the establishment of a separate definition of '*physiological*' or '*natural*' birth.

Further information

Policies for maternity care are different for the four countries of the UK. However, there is a shared emphasis on offering pregnant women more choice, with better access to community-based and midwife-led services. In England, Scotland and Wales there is also an explicit focus on facilitating normal birth and reducing interventions, partly in response to rising caesarean section rates (see figure 1).

“For the majority of women, pregnancy and childbirth are normal life events requiring minimal intervention. These women may choose to have midwifery-led care, including a home birth.”¹³

“Birth environments (should be) regularly audited to ensure they optimise normality, privacy and dignity during labour and birth for the mother and birth partner(s).”¹⁴

“Studies have shown that women who are supported during labour need to have fewer pain killers, experience fewer interventions and give birth to stronger babies. After their babies are born, supported women feel better about themselves, their labour and their babies.”¹⁵

In Northern Ireland there is a policy to develop midwife-led care:

“The development of midwife-led maternity units will be encouraged alongside consultant-led units, and two stand-alone midwife led units will also be piloted.”¹⁶

In England and Wales there is emphasis on increasing access to home birth, with a 10% home birth target in Wales,¹⁷ and to midwifery units or birth centres.¹⁸ The recent audit demonstrates that community maternity units make an enormous contribution to maternity care in Scotland.¹⁹

What affects levels of intervention?

Numerous factors make up the culture in maternity units and influence levels of intervention. Normal births seem to be higher where there is a shared positive attitude towards birth as a normal physiological process, positive leadership, timely access to support for junior staff, commitment to evidence-based practice, integration of different parts of the service, and an ability to manage change.²⁰ There is growing evidence that mutually respectful, interdisciplinary working and clear communication are especially important for delivering high quality care consistently and avoiding preventable morbidity and mortality.^{20,21,22,23}

What increases normal births?

It is also known that some factors help to facilitate straightforward birth without evidence of additional risks, including one-to-one support,²⁴ immersion in water,^{25,26} for low-risk women, planning for a home birth,¹¹ care from known midwives, more extensive training of junior doctors,²⁷ employment of consultant midwives focusing on normality, and support on the labour ward from consultant obstetricians.²⁸

Recent statistics

Statistics for 2005 show that in England around 48% of women having their baby in hospital have a normal birth, using the definition adopted by the Information Centre in England, and 39.4% in Scotland. Normal birth rates are not readily available for Northern Ireland or Wales. There are wide variations between services, with maternity units in England reporting a range of normal birth rates from 37% and 59%^{1,8} (see figure 2).

Figure 1

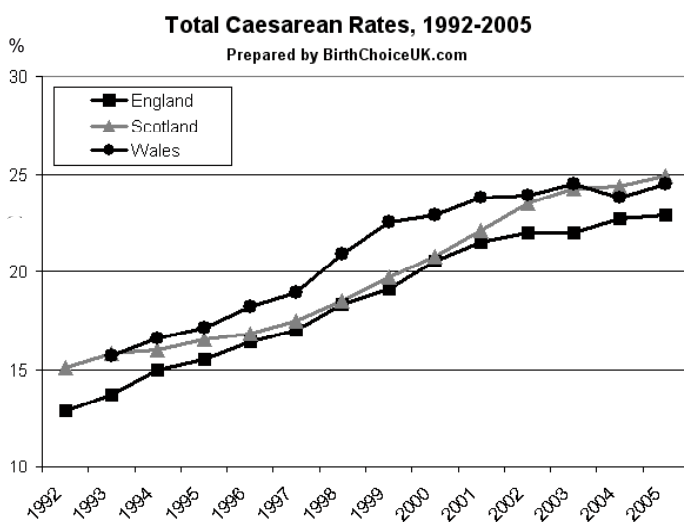
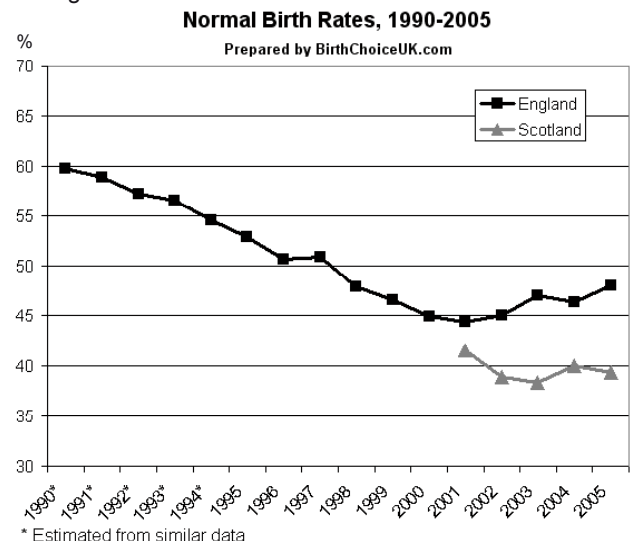


Figure 2



References

1. Department of Health. NHS Maternity Statistics, England: 2004-05. London: The Information Centre, Community Health Statistics; 2006. Available from: www.ic.nhs.uk/pubs/maternityeng2005/maternitystats06/file
2. Thomas J, Paranjothy S, and Royal College of Obstetricians and Gynaecologists Clinical Effectiveness Support Unit. National sentinel caesarean section audit report. London: RCOG Press; 2001.
3. Green JM, Baston H, Easton S et al. Greater expectations? Inter-relationships between women's expectations and experiences of decision making, continuity, choice and control in labour, and psychological outcomes: summary report. Leeds: Mother & Infant Research Unit; 2003. Available from: www.leeds.ac.uk/miru/
4. NHS Institute for Innovation and Improvement. Delivering quality and value. Focus on: caesarean section. Coventry: NHS Institute for Innovation and Improvement; 2006.
5. Alfirevic Z, Devane D, and Gyte GM. Continuous cardiotocography (CTG) as a form of electronic fetal monitoring (EFM) for fetal assessment during labour. Cochrane Database of Systematic Reviews 2006, Issue 3. Art. No.: CD006066. DOI: 10.1002/14651858.CD006066. Available from: www.nelh.nhs.uk/cochrane.asp
6. Anim-Somuah M, Smyth R, and Howell C. Epidural versus non-epidural or no analgesia in labour. Cochrane Database of Systematic Reviews Issue 4, 2005. Available from: www.nelh.nhs.uk/cochrane.asp
7. Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, Royal College of Anaesthetists et al. Safer childbirth: minimum standards for the organisation and delivery of care in labour. London: RCOG Press; 2007. Available from: www.rcog.org.uk/index.asp?PageID=1168
8. BirthChoiceUK. Normal Birth: welcome to the BirthChoiceUK normal birth pages. 2005. Available from: www.birthchoiceuk.com/Professionals/index.html
9. Royal College of Obstetricians and Gynaecologists Clinical Effectiveness Support Unit. Induction of labour: evidence-based clinical guideline number 9. 2001. Available from: www.rcog.org.uk/resources/pdf/rcog_induction_of_labour.pdf
10. Royal College of Obstetricians and Gynaecologists Clinical Effectiveness Support Unit. The use of electronic fetal monitoring: the use and interpretation of cardiotocography in intrapartum fetal surveillance. Evidence-based clinical guideline Number 8. London: RCOG; 2001. Available from: www.nelh.nhs.uk/guidelinesdb/html/efmguidelinerocg.pdf
11. National Collaborating Centre for Women's and Children's Health. Caesarean section: clinical guideline. London: RCOG Press; 2004. Available from: www.nice.org.uk/pdf/CG013NICEguideline.pdf; <http://www.nice.org.uk/pdf/CG013fullguideline.pdf>
12. National Collaborating Centre for Women's and Children's Health. Intrapartum care: care of healthy women and their babies during childbirth. Clinical Guideline. London: RCOG Press; 2007. Available from: <http://guidance.nice.org.uk/CG55/niceguidance/pdf/English>
13. Department of Health. National Service Framework for Children, Young People and Maternity Services. London: Department of Health; Department for Education and Skills; 2004.
14. Welsh Assembly Government. National Service Framework for Children, Young People and Maternity Services in Wales. Cardiff: Welsh Assembly Government; 2005.
15. NHS Quality Improvement Scotland. Clinical standards - maternity services. Edinburgh: NHS Quality Improvement Scotland; 2005. Available from: www.nhsqs.org.uk/nhsqs/2228.html
16. Northern Ireland Department of Health SSaPS. Developing better services: modernising hospitals and reforming structures. Belfast: Northern Ireland Department of Health, Social Services and Public Safety; 2002.
17. "Realising the potential" A strategic framework for nursing, midwifery and health visiting in Wales into the 21st century. Briefing paper 4. "Delivering the future in Wales" A framework for realising the potential of midwives in Wales. Cardiff: Welsh Assembly Government; 2002.
18. Department of Health. Maternity matters: choice, access and continuity of care in a safe service. London: Department of Health; 2007.
19. Hogg M, Penney G, and Carmichael J. Audit of care provided and outcomes achieved by community maternity units in Scotland 2005: final report. SP CERH Publication No. 29. Aberdeen: Scottish Programme for Clinical Effectiveness in Reproductive Health (SP CERH); 2007. Available from: www.abdn.ac.uk/spcerh
20. Biringer A, Davies B, Nimrod C et al. Attaining and maintaining best practice in the use of caesarean sections: an analysis of four Ontario hospitals. Report of the Caesarean Section working group of the Ontario Women's Health Council. Ontario: Ontario Women's Health Council; 2000. Available from: http://www.womenshealthcouncil.on.ca/userfiles/page_attachments/3842819_Caesarean_Section.pdf
21. Commission for Healthcare Audit and Inspections. State of healthcare 2005 [Kennedy report]. London: Healthcare Commission; 2005. Available from: www.healthcarecommission.org.uk
22. Lewis G, Drife J. Why mothers die 2000 - 2002: the sixth report of the Confidential Enquiries into Maternal Deaths in the United Kingdom. London: RCOG Press; 2004. Available from: www.cemach.org.uk/publications/WMD2000_2002/content.htm
23. Confidential Enquiry into Maternal and Child Health. Perinatal mortality surveillance report 2004: England, Wales and Northern Ireland. London: CEMACH; 2006. Available from: www.cemach.org.uk
24. Hodnett ED, Gates S, Hofmeyr GJ, and Sakala C. Continuous support for women during childbirth (Cochrane Review). In: The Cochrane Library, 3, 2003. Available from: <http://www.nelh.nhs.uk/cochrane.asp>
25. Alfirevic Z, Gould D. Immersion in water during labour and birth. Royal College of Obstetricians and Gynaecologists/Royal College of Midwives - Joint statement No.1. Available from: www.rcog.org.uk/index.asp?PageID=546
26. Cluett ER, Nikodem VC, McCandlish R, and Burns E. Immersion in water in pregnancy, labour and birth (Cochrane Review). In: The Cochrane Library, Issue 2, 2004. Available from: www.cochrane.org/cochrane/revabstr/AB000111.htm
27. Spencer C, Murphy DJ, Bewley S. Caesarean delivery in the second stage of labour: better training in instrumental delivery may reduce rates. BMJ 2006;333(7569):613-4.
28. NHS Institute for Innovation and Improvement. Delivering quality and value. Pathways to success: a self-improvement toolkit. Focus on normal birth and reducing Caesarean section rates. Coventry: NHS Institute; 2006.

RCM Campaign for Normal Birth

The RCM Campaign for Normal Birth provides an opportunity to share good practice to promote normal birth. The campaign aims to inspire and support normal birth practice. It is a reminder that good birth experiences can happen despite the challenges. Interventions and caesarean should not be the first choice - they should be the last.

www.rcmnormalbirth.org.uk

Cover photograph - We are most grateful to Jules, Matt and Clemmie for the use of their birth photograph. © Albany Midwifery Practice

To contact the Maternity Care Working Party (MCWP) write to mcwp@nct.org.uk
For further information on the MCWP, see www.mcwp.org.uk

© NCT/RCM/RCOG November 2007