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NCT policy briefing:

NICE Intrapartum Care Guideline
Care of healthy women and their babies during childbirth

Introduction

The *Intrapartum care* guideline[1] provides reviews of research evidence, concluding 'evidence statements' and recommendations on most aspects of the care of healthy women and their babies during labour and immediately after birth. The guideline is for England and Wales and will be considered for use in Northern Ireland. It is intended for use by all relevant NHS healthcare professionals, including those responsible for commissioning and planning healthcare services. There is also a version of the guideline for women, families and carers and the public. The guideline covers the care of healthy women in labour at term (37–42 weeks). It does not cover the care of women with more complex care needs, such as preterm labour, pre-eclampsia, diabetes, multiple pregnancy. Other related guidelines, include: Antenatal care,[2] Postnatal care,[3] Induction of labour,[4] and Caesarean section.[5]

The NCT welcomes many of the recommendations in the *Intrapartum care* guideline. It will encourage evidence-informed care and provision of more similar standards of care throughout England and Wales. Where we have comments about specific aspects of the guideline they are noted in the text. Importantly, the guideline recognises that; *'Birth is a life-changing event and the care given to women has the potential to affect them both physically and emotionally in the short and longer term'* (p.1).

Key priorities for implementation

NICE has identified eight recommendations as priorities for implementation:

1. **Communication:** *'All women in labour should be treated with respect and should be in control of and involved in what is happening to them, and the way in which care is given is key to this. To facilitate this, healthcare professionals and other caregivers should establish a rapport with the labouring woman, asking her about her wants and expectations for labour, being aware of the importance of tone and demeanour, and of the actual words they use. This information should be used to support and guide her through her labour'* (p.70).

2. **Support in labour:** *'A woman in established labour should receive supportive one-to-one care and should not be left on her own except for short periods or at the woman's request'* (p.75).

3. **Normal Labour:** *'Clinical intervention should not be offered or advised where labour is progressing normally and the woman and baby are well'* (p.138).

4. **Planning Place of birth:** *'Women should be offered the choice of planning birth at home, in a midwifery-led unit or a consultant-led unit.'* Before making their choice, women should be informed of the potential risks and benefits of each birth setting (p.62).

5. **Coping with pain:** *'The opportunity to labour in water is recommended for pain relief. Before choosing epidural analgesia, women should be informed about the risks and benefits, and the implications for their labour'* (p.96).

6. **Perineal care:** *'If genital trauma is identified following birth, further systematic assessment should be carried out, including a rectal examination'* (p.191).

7. **Delay in the first stage of labour:** *'When delay in the established first stage of labour is confirmed in nulliparous women, advice should be sought from an obstetrician and the use of oxytocin should be considered. The woman should be informed that the use of oxytocin following spontaneous or artificial rupture of the membranes will bring forward her time of birth but will not influence mode of birth or other outcomes'* (p.238).

8. **Instrumental birth:** *'Instrumental birth is an operative procedure that should be undertaken with tested effective anaesthesia'* (p.243).

In general, the NCT supports these recommendations as priorities for development of maternity care. We particularly welcome the positive emphasis on communication between women and their carers, and the recommendations on place of birth (set out in detail below), support during labour and the use of water for pain relief, which is not currently made available to all women during labour. One to one support is necessary for women to be given practical help and emotional encouragement during labour. We are very pleased to see an explicit recommendation that; *'Women should be encouraged to move and adopt whatever positions they find most comfortable throughout labour'* (p.73).

Communication between women and healthcare professionals

The NCT feels that the new guidance on communication underpins the fundamental principle of woman-centred care, and we warmly welcome it.

In addition to the key recommendations on communication in the full guideline, care has been taken to address the particular needs of vulnerable and disadvantaged groups, such as young mothers, women who do not read or speak English and disabled women. NICE advises:

'Women and their families should always be treated with kindness, respect and dignity. The views, beliefs and values of the woman, her partner and her family in relation to her care and that of her baby should be sought and respected at all times.

The woman should be fully involved in planning her birth setting so that care is flexible and tailored to meet her needs and those of her baby'.[6]

And that good communication '*should be supported by the provision of evidence-based written information tailored to the needs of the individual woman'.*[6]

The guideline sets out in detail the importance of a warm welcome, asking women how they are feeling, knocking before entering a woman's room, encouraging her to adapt the environment to suit her needs, focusing on the woman rather than the technology or the documentation, and reassuring the woman that she may ring for help whenever, and as often, as she wishes.

'Care and information should be appropriate to the woman, and her cultural practices should be taken into account. All information given should also be accessible to women, their partners and families, taking into account any additional needs such as physical, cognitive or sensory disabilities and inability to speak or read English' (p.6).[6]

Throughout the guideline, clear guidance is given on the specific information that women should be given regarding care choices and procedures. This is backed up with a NICE booklet for women containing a lot of clearly written, evidence-based information. The information notes, for instance, that opioid drugs given as injections *'could make the baby drowsy for several days which may interfere with breastfeeding'* (p.5). There is also a weaker reference to this possibility after an epidural that has been in place for *'a long time'* (p.5). This guidance to health professionals and to parents should help women and their partners feel fully involved in decisions about care, promoting informed consent and decision-making. If these recommendations on communication are followed, many more women will feel respected and treated as an individual. This has the potential to improve their overall birth experience significantly.

Planning place of birth

The final version of the guidance now states that:

'Women should be offered the choice of planning birth at home, in a midwife-led unit or in an obstetric unit. Women should be informed:

- *That giving birth is generally very safe for both mother and baby.*
- *That the available information on planning place of birth is not of good quality, but suggests that among women who plan to give birth at home or in a midwife-led unit there is a higher likelihood of a normal birth, with less intervention. We do not have enough information about the possible risks to either the woman or her baby relating to planned place of birth.*
- *That the obstetric unit provides direct access to obstetricians, anaesthetists, neonatologists and other specialist care including epidural analgesia.*
- *Of locally available services, the likelihood of being transferred into the obstetric unit and the time this may take.*

- *That if something does go unexpectedly seriously wrong during labour at home or in a midwife-led unit, the outcome for the woman and baby could be worse than if they were in the obstetric unit with access to specialised care.*

- *That if she has a pre-existing medical condition or has had a previous complicated birth that makes her at higher risk of developing complications during her next birth, she should be advised to give birth in an obstetric unit.'*

(p.62)

The NCT has been actively involved in the development of the place of birth chapter in the guideline, submitting feedback, lobbying for a second consultation phase (which was granted) and finally making a complaint to NICE about the methodology used for the review of home birth, which has been 'partly upheld with regard to errors and ambiguities in the development process'. The non-executive directors of NICE who responded to the NCT complaint said, 'as the NCC-WCH CEMACH study was unable to control for confounders it appears, *prima facie* that this study should also have been excluded (from the review of evidence)'. The October 2007 issue of New Digest includes an NCT review on the safety of home birth[7] which is significantly different from the NICE review.

Despite the 'errors and ambiguities', there is broad general agreement that the available evidence comparing the safety of home birth with hospital birth for low-risk women is limited. However, it is clear that giving birth in out-of-hospital settings is generally very safe for both mother and baby and we endorse the NICE recommendations. In particular we welcome the recommendation that *'clinical governance structures should be implemented in all places of birth'* (p.62).

Other important recommendations

Continuity of carer

Unfortunately continuity of care gets rather a mixed report from NICE. Team midwifery (defined as a group of midwives providing care and taking shared responsibility for a group of women from the antenatal, through intrapartum to the postnatal period) is not recommended as it is considered to be more expensive, and to have an excess of perinatal mortality, compared with standard maternity care. *'There was no indication as to which component of care, or combination of components of care, might have contributed to this'* (p.83). In addition, studies were of teams varying in size from 4-10 or more midwives and it remains unclear how responsibility was shared between the midwives within the teams. There were fewer medical interventions, with more spontaneous births and fewer episiotomies. The review acknowledges that *'All the trials reported that team midwifery systems of care designed to provide intrapartum care by a midwife met antenatally increased women's satisfaction and resulted in more positive experiences of childbirth compared with standard maternity care'* (p.77). Three of the 10 trials had been conducted in the UK.

Caseload midwifery on the other hand, possibly fares a little better. There is strong evidence that women were significantly more satisfied with their maternity care at all stages. The conclusion is that *'Findings from two trials show that women cared for in a caseload midwifery system are less likely to receive interventions during labour and*

that women prefer this system of care compared with traditional shared care. No evidence of difference in other maternal or neonatal outcomes was found. There is no evidence about its cost effectiveness' (p.83).

We support the research recommendation that studies should be undertaken on the effects of caseload midwifery, particularly in the UK context, as continuity of carer is highly valued by women. We are concerned that PCTs may be deterred from implementing new ways of working aimed at providing continuity of carer. We fully back the *Maternity Matters* guidance that: '*every woman will be supported by a midwife she knows and trusts throughout her pregnancy'* (p.5).[8]

Eating and drinking during labour

The NCT welcomes recommendations around freedom to eat and drink to appetite during labour:

'Women may eat a light diet in established labour unless they have received opioids or they develop risk factors that make a general anaesthetic more likely' (p.86).

'Women may drink during established labour and be informed that isotonic drinks may be more beneficial than water' (p.86).

In our view there is no need for commercial isotonic drinks to be bought by women or provided by the NHS as there are other acceptable and cheaper ways of obtaining light nutrients.

Monitoring of babies in labour

Following the earlier guideline on Fetal Monitoring, this guideline confirms that *'Intermittent auscultation of the FHR is recommended for low-risk women in established labour in any birth setting'* (p.155).

Details are provided of when a change to continuous EFM might be 'advised' or 'considered'. Importantly it also advises *that 'Women should be informed that continuous EFM will restrict their mobility'* (p.218).

Coping with pain in labour

The guideline covers a wide range of methods for coping with pain in labour, emphasising that women should be supported in their choice if they wish to use breathing and relaxing methods, massage, acupuncture, hypnosis and the playing of music.

The NCT particularly welcomes the recommendations on use of water for pain relief, and its identification as a priority for implementation.

We support the importance of informing women in advance of the possible side effects of opioids and epidural. The guideline says that before choosing epidural analgesia, women should be informed amongst other things that it provides the most effective pain relief, that it requires more intensive monitoring, is associated with a

longer second stage and increased chance of an instrumental birth, though no increase in the length of the first stage of labour.

'Women should be informed that (opioid drugs) will provide limited pain relief during labour and may have significant side effects for both the woman (drowsiness, nausea and vomiting) and her baby (short-term respiratory depression and drowsiness which may last several days). Women should be informed that pethidine, diamorphine or other opioids may interfere with breastfeeding' (p.108).

Interventions in labour

The NCT welcomes the guidance on active management of labour, which has been controversial in terms of definition, application and outcomes:

'The package known as active management of labour (one-to-one continuous support; strict definition of established labour; early routine amniotomy; routine 2-hourly vaginal examination; oxytocin if labour becomes slow) should not be offered routinely' (p.152).

We also welcome the guidance that: *'In normally progressing labour, amniotomy should not be performed routinely'* (p.153).

Immediate care of the newborn

Reiterating the recommendations made in the NICE Postnatal Care guideline published in July 2006, the guideline emphasises the importance of skin-to-skin contact between mother and child immediately after the birth, the need to avoid separation of a women and her baby within the first hour of birth, and early initiation of breastfeeding '*ideally within 1 hour'* (p.188). These are highly important aspects of care that are often overlooked. The NCT hopes that these recommendations will help to improve practice in busy obstetric units, where, sadly, basic physiological and emotional needs of newborn babies are too often overlooked.

Third stage of labour

The guideline *recommends 'active management of the third stage of labour'* (p.183) but says that:

'Women at low risk of postpartum haemorrhage who request physiological management should be supported in their choice' (p.183).

This is an important recognition that there are alternatives and that women's preferences should be respected.

Definitions

The guideline provides a definition for each stage of labour and indicates what time period is within the normal range for each. This is likely to promote shared understandings and more consistent care between different maternity units. The guideline suggests that:

'Women should be informed that, while the length of established first stage of labour varies between women, first labours last on average 8 hours and are unlikely to last over 18 hours. Second and subsequent labours last on average 5 hours and are unlikely to last over 12 hours' (p.141).

The guideline makes a distinction between the 'latent first stage of labour' and the 'established first stage of labour':

'Latent first stage of labour – a period of time, not necessarily continuous, when:

- *there are painful contractions, and*
- *there is some cervical change, including cervical effacement and dilation up to 4cm.*

Established first stage of labour- when:

- *there are regular painful contractions, and*
- *there is progressive cervical dilatation from 4cm'* (p.139).

The second stage of labour is also divided into a 'passive' and an 'active stage'.

'Passive second stage of labour:

- *the finding of full dilatation of the cervix prior to or in the absence of involuntary expulsive contractions.*

Onset of the established second stage of labour:

- *the baby is visible*
  expulsive contractions, with a finding of full dilatation of the cervix
- *active maternal effort following confirmation of full dilatation of the cervix in the absence of expulsive contractions'* (p.156).

Discussion about the third stage of labour acknowledges that the length of time for physiological management is different from that for active management.

'The third stage of labour is diagnosed as prolonged if not completed within 30 minutes of the birth of the baby with active management and 60 minutes with physiological management' (p.175).

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