Introduction to NICE Clinical Guideline
Intrapartum Care: Care of healthy women and their babies during childbirth (CG190)

What’s new?

The Intrapartum care (CG190) guideline published in December 2014\(^1\) is an update of the 2007 guidance (CG55).\(^2\) There are several different versions of the guidance, plus some resources to facilitate implementation. This is a summary of key resources:


- **The NICE version** which is made up of the priorities for implementation and the full list of recommendations (on the web starting at [https://www.nice.org.uk/guidance/cg190](https://www.nice.org.uk/guidance/cg190))

- **Information for the public** written in plain English ([https://www.nice.org.uk/guidance/cg190/informationforpublic](https://www.nice.org.uk/guidance/cg190/informationforpublic))


- **Baseline assessment tool** an Excel spreadsheet that can be used by organisations to identify if they are in line with practice recommended in NICE guidance and to help them plan activity that will help them meet the recommendations. An MSLC might find this a useful tool, to focus discussion. It encourages NHS trusts and CCGs to consider how many of the recommendations have been implemented and what percentage. [https://www.nice.org.uk/guidance/cg190/resources/cg190-intrapartum-care-baseline-assessment-tool](https://www.nice.org.uk/guidance/cg190/resources/cg190-intrapartum-care-baseline-assessment-tool)

- **The Appendices** which are listed A-R covering 18 different subjects from health economics to care pathway, including three appendices on place of birth [http://www.nice.org.uk/guidance/cg190/evidence/cg190-intrapartum-care-Appendices2](http://www.nice.org.uk/guidance/cg190/evidence/cg190-intrapartum-care-Appendices2) (PDF length 878 pages)
What’s unchanged?

Not all sections have been updated. A key example is the evidence on continuity models of midwifery-led care. NCT and RCM have written to NICE calling for an urgent review of the evidence on this subject as it has not been updated and the 2007 recommendation does not reflect the (positive) evidence.¹

Which UK countries is it for?

The guideline is for England and Wales and will be considered for use in Northern Ireland. In Scotland the NHS and SIGN use the full review of evidence and make their own recommendations for practice.

Whose care does it provide guidance on?

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 those experiencing preterm labour, pre-eclampsia, diabetes, multiple pregnancy.

What are the key priorities for implementation?

NCT says ‘NICE has identified 10 recommendations as priorities for implementation. Broadly, these are on quality of care and place of birth (opportunities to make informed choices, offering four settings for birth in all areas, developing respectful cultures and compassionate care, modelling of positive inter-personal behaviour by senior staff, one-to-one care for women in labour and active monitoring of under-staffing and any over-staffing, and robust protocols for transfer of care between settings), appropriate fetal heart-rate monitoring and next steps, and avoidance of intervention caused by offering procedures when labour is progressing normally. Many of these can be implemented with no additional cost to the NHS, some will require additional set-up or system-change investment but they will save money once they become established behaviours and services.’

The priorities NICE has set are:

### Place of birth

1) Explain to both multiparous and nulliparous women that they may choose any birth setting (home, freestanding midwifery unit, alongside midwifery unit or obstetric unit), and support them in their choice of setting wherever they choose to give birth:

- Advise low-risk multiparous women that planning to give birth at home or in a midwifery-led unit (freestanding or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit.

- Advise low-risk nulliparous women that planning to give birth in a midwifery-led unit (freestanding or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit. Explain that if they plan birth at home there is a small increase in the risk of an adverse outcome for the baby. [new 2014]
2) Commissioners and providers[^1] should ensure that all four birth settings are available to all women (in the local area or in a neighbouring area). [new 2014]

3) Providers, senior staff and all healthcare professionals should ensure that in all birth settings there is a culture of respect for each woman as an individual undergoing a significant and emotionally intense life experience, so that the woman is in control, is listened to and is cared for with compassion, and that appropriate informed consent is sought. [new 2014]

4) Senior staff should demonstrate, through their own words and behaviour, appropriate ways of relating to and talking about women and their birth companion(s), and of talking about birth and the choices to be made when giving birth. [new 2014]

5) Maternity services should
   - provide a model of care that supports one-to-one care in labour for all women and
   - benchmark services and identify overstaffing or understaffing by using workforce planning models and/or woman-to-midwife ratios. [new 2014]

6) Commissioners and providers[^1] should ensure that there are:
   - robust protocols in place for transfer of care between settings
   - clear local pathways for the continued care of women who are transferred from one setting to another, including:
     - when crossing provider boundaries
     - if the nearest obstetric or neonatal unit is closed to admissions or the local midwifery-led unit is full. [new 2014]

**Measuring fetal heart rate as part of initial assessment**

7) Do not perform cardiotocography on admission for low-risk women in suspected or established labour in any birth setting as part of the initial assessment. [new 2014]

**Interpretation of cardiotocograph traces**

8) Do not make any decision about a woman's care in labour on the basis of cardiotocography findings alone. [new 2014]

**First stage of labour**

9) Do not offer or advise clinical intervention if labour is progressing normally and the woman and baby are well. [2007]

**Third stage of labour**
After administering oxytocin, clamp and cut the cord.

- Do not clamp the cord earlier than 1 minute from the birth of the baby unless there is concern about the integrity of the cord or the baby has a heartbeat below 60 beats/minute that is not getting faster.
- Clamp the cord before 5 minutes in order to perform controlled cord traction as part of active management.
- If the woman requests that the cord is clamped and cut later than 5 minutes, support her in her choice. [new 2014]

The NCT welcomes the new recommendations in the *Intrapartum care* guideline, and the priorities for implementation. These will contribute to services that are woman-centred and family-focused and based on best available evidence, objectives which NCT promotes.4,5,6.

Importantly, building on the ethos of the 2007 guideline, the revised guideline recognises that; ‘Giving birth is a life-changing event. The care that a woman receives during labour has the potential to affect her – both physically and emotionally, in the short and longer term – and the health of her baby. Good communication, support and compassion from staff, and having her wishes respected, can help her feel in control of what is happening and contribute to making birth a positive experience for the woman and her birth companion(s). 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.19).1

**What are the key themes and messages to look out for?**

There are many important recommendations. Rather than reproduce them all here, this list provides some highlights that are likely to be especially relevant and interesting for NCT practitioners and parent/service user reps on maternity services liaison committees. They are intended to prompt further reading:

1. **Communication:** continues to be emphasised as a crucial aspect of care, essential for safety, quality and providing a respectful and personalised service. For example (unchanged recommendation) ‘…establish a rapport with the woman, ask her about her wants and expectations for labour, and be aware of the importance of tone and demeanour, and of the actual words used.’ (p.41).

2. **Support in labour:** continues to be emphasised as a crucial aspect of care ‘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. **Criteria for increased risk for the woman or baby during or shortly after labour, where care in an obstetric unit would be expected to reduce this risk:** in Tables (39-42) are have been revised somewhat, including the upper age (now ‘age over 35 at booking’) in ‘factors indicating individual assessment when planning place of birth’. (p41)

4. **Comparative safety and rates of intervention for women and babies with planned care in different settings for birth:** there is considerable new evidence included on this, clearly

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1 All page numbers are taken from the full version.
5. **Planning place of birth**: The tone of the recommendations has changed in line with the new evidence (see priorities for implementation above).

6. **Normal labour**: continues to be emphasised as important and there are many examples. (see priorities for implementation above).

7. **Immersion in water**: The 2007 recommendation is strengthened to: ‘The opportunity to labour in water is recommended for pain relief.’ (p332)

8. **Coping with pain**: there are new recommendations (p303), but the formal evidence was frequently limited and this is reflected in what is said: ‘Advise the woman and her birth companion(s) that breathing exercises, immersion in water and massage may reduce pain during the latent first stage of labour. [new 2014]

   Do not offer or advise aromatherapy, yoga or acupressure for pain relief during the latent first stage of labour. If a woman wants to use any of these techniques, respect her wishes. [new 2014]

   The 2007 recommendations is retained: ‘Offer all women with delay in the established first stage of labour support and effective pain relief.’

9. **Opioids (e.g. pethidine, diamorphine)**: Continuing what was said previously, the guideline says: ‘Inform the woman that these will provide limited pain relief during labour and may have significant side effects for both her (drowsiness, nausea and vomiting) and her baby (short-term respiratory depression and drowsiness which may last several days). [2007] and

   Inform the woman that pethidine, diamorphine or other opioids may interfere with breastfeeding. [2007] (p346)

10. **Epidural analgesia**: The guideline says: ‘Provide information about epidural analgesia, including the following:

    - It is available only in obstetric units.
    - It provides more effective pain relief than opioids.
    - It is not associated with long-term backache.
    - It is not associated with a longer first stage of labour or an increased chance of caesarean birth.
    - It is associated with a longer second stage of labour and an increased chance of vaginal instrumental birth.
    - It will be accompanied by a more intensive level of monitoring and intravenous access, and so mobility may be reduced.’ [2007, amended 2014] (p352)

11. **Risk of Infection**: The guideline is unchanged in terms of management when a woman’s membranes have ruptured prior to the onset of labour ‘Advise women presenting with prelabour rupture of the membranes at term that:

    - the risk of serious neonatal infection is 1%, rather than 0.5% for women with intact membranes
• 60% of women with prelabour rupture of the membranes will go into labour within 24 hours
• *induction is appropriate approximately 24 hours after rupture of the membranes.* [2007] (p323)

What does NCT think about the new recommendations?
NCT supports the new 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 and delayed cord clamping.

Table 1 Rates of spontaneous vaginal birth, transfer to an obstetric unit and obstetric interventions for each planned place of birth: women who have had a baby before who are at low risk of complications (sources: Birthplace 2011; Blix et al. 2012)

<table>
<thead>
<tr>
<th></th>
<th>Number of incidences per 1000 multiparous women giving birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Home</td>
</tr>
<tr>
<td>Spontaneous vaginal birth</td>
<td>984*</td>
</tr>
<tr>
<td>Transfer to obstetric unit</td>
<td>115*</td>
</tr>
<tr>
<td>Regional analgesia (epidural and/or spinal)***</td>
<td>28*</td>
</tr>
<tr>
<td>Episiotomy</td>
<td>15*</td>
</tr>
<tr>
<td>Caesarean birth</td>
<td>7*</td>
</tr>
<tr>
<td>Instrumental birth (forceps or ventouse)</td>
<td>9*</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>4</td>
</tr>
</tbody>
</table>

* Figures from Birthplace 2011 and Blix et al. 2012 (all other figures from Birthplace 2011).
** Estimated transfer rate from an obstetric unit to a different obstetric unit owing to lack of capacity or expertise.
*** Blix reported epidural analgesia and Birthplace reported spinal or epidural analgesia.
Table 2 Outcomes for the baby for each planned place of birth: women who have had a baby before who are at low risk of complications (source: Birthplace 2011)

<table>
<thead>
<tr>
<th>Number of babies per 1000 births</th>
<th>Home</th>
<th>Freestanding midwifery unit</th>
<th>Alongside midwifery unit</th>
<th>Obstetric unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babies without serious medical problems</td>
<td>997</td>
<td>997</td>
<td>998</td>
<td>997</td>
</tr>
<tr>
<td>Babies with serious medical problems*</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

* See Intrapartum care: choosing place of birth resource for midwives table 5 for more information.

Table 3 Rates of spontaneous vaginal birth, transfer to an obstetric unit and obstetric interventions for each planned place of birth: women having their first baby who are at low risk of complications (sources: Birthplace 2011; Blix et al. 2012)

<table>
<thead>
<tr>
<th>Number of incidences per 1000 nulliparous women giving birth</th>
<th>Home</th>
<th>Freestanding midwifery unit</th>
<th>Alongside midwifery unit</th>
<th>Obstetric unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spontaneous vaginal birth</td>
<td>794*</td>
<td>813</td>
<td>765</td>
<td>688*</td>
</tr>
<tr>
<td>Transfer to an obstetric unit</td>
<td>450*</td>
<td>363</td>
<td>402</td>
<td>10**</td>
</tr>
<tr>
<td>Regional analgesia (epidural and/or spinal) ***</td>
<td>218*</td>
<td>200</td>
<td>240</td>
<td>349*</td>
</tr>
<tr>
<td>Episiotomy</td>
<td>165*</td>
<td>165</td>
<td>216</td>
<td>242</td>
</tr>
<tr>
<td>Caesarean birth</td>
<td>80*</td>
<td>69</td>
<td>76</td>
<td>121*</td>
</tr>
<tr>
<td>Instrumental birth (forceps or ventouse)</td>
<td>126*</td>
<td>118</td>
<td>159</td>
<td>191*</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>12</td>
<td>8</td>
<td>11</td>
<td>16</td>
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</table>

* Figures from Birthplace 2011 and Blix et al. 2012 (all other figures from Birthplace 2011).
** Estimated transfer rate from an obstetric unit to a different obstetric unit owing to lack of capacity or expertise.
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Table 4 Outcomes for the baby for each planned place of birth: women having their first baby who are at low risk of complications (source: Birthplace 2011)

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<th>Obstetric unit</th>
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</thead>
<tbody>
<tr>
<td>Babies without serious medical problems</td>
<td>991</td>
<td>995</td>
<td>995</td>
<td>995</td>
</tr>
<tr>
<td>Babies with serious medical problems*</td>
<td>9</td>
<td>5</td>
<td>5</td>
<td>5</td>
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</table>

* See Intrapartum care: choosing place of birth resource for midwives table 5 for more information.

References:


