NHS
National Institute for Health and Clinical Excellence

Quick reference guide

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Intrapartum care

Care of healthy women and their babies during childbirth

NICE clinical guideline 55
Developed by the National Collaborating Centre for Women's and Children's Health

Key priorities for implementation

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.

Support in labour

- A woman in established labour should receive supportive one-to-one care.
- A woman in established labour should not be left on her own except for short periods or at the woman's request.

Normal labour

- Clinical intervention should not be offered or advised where labour is progressing normally and the woman and baby are well.

Planning place of birth

- 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 the woman and her 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 (see pages 21–23).
- Clinical governance structures should be implemented in all places of birth (see pages 24–25).

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.

Perineal care

- If genital trauma is identified following birth, further systematic assessment should be carried out, including a rectal examination.

Delay in the first stage

- 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 the mode of birth or other outcomes.

Instrumental birth

- Instrumental birth is an operative procedure that should be undertaken with tested effective anaesthesia.

Acute health care services

Report of a Working Party

September 2007

ACADEMY OF
MEDICAL ROYAL
COLLEGES

2.2 Obstetrics

2.2.1 Background

The National Service Framework (NSF) for Maternity Services[64] and Maternity Matters[65] set out a number of markers for good practice including managed maternity and neonatal care networks. Maternity care should be seen as a continuum with care pathways ranging from anticipated normal delivery up to complex tertiary care. Within this framework, the key issues of choice, safety and quality need to be addressed. There is concern that a number of NHS reforms and initiatives, not least payment by results, will inhibit or impair the implementation of the NSF. The major achievement of the NSF is that it has the full support and commitment of all stakeholders – the clinicians, the patients, the public and the politicians (manifesto commitment to deliver the NSF by 2009). Thus an approach that keeps the emphasis on the implementation at regional and local level of the key objectives of the NSF, rather than one which puts the emphasis on reconfiguration of services, may be more effective in the longer term.

2.2.2 Current level of provision and need

Most routine antenatal care can be delivered in the community by midwives. Access to consultant-led obstetric services is required for many obstetric and medical conditions and procedures such as detailed scanning, as well as the management of high-risk pregnancy.

Birth is a time of relatively high risk for both mother and child. Over 95% of births are managed with immediate access to a consultant-led obstetric unit with supporting anaesthetic and paediatric services. Even a pregnancy judged as low risk might develop sudden and unexpected complications that need immediate specialised management. A minority of births take place at home (2–3%) or in stand-alone midwife-led units (3%). There is increasing evidence that the management of risk is more difficult in these circumstances and that transfer to an obstetric unit as an emergency in labour is a poor experience for the mother. Currently 30% of primigravidae are transferred from home or from free-standing midwifery units to a consultant-led service. Women opting for such care should be made aware of the risks they are accepting in such choices.

2.2.3 Is change needed and why?

There is evidence that the continuous presence of trained obstetricians in delivery suites, particularly those dealing with high-risk pregnancies, improves maternal and neonatal outcomes. Intrapartum care, like other aspects of high-risk medicine, benefits from the presence of fully trained, experienced individuals. The implications for the specialty and the obstetric workforce have been published previously[66] and these will be confirmed in *Safer Childbirth: Minimum Standards for Service Provision and Care in Labour.* (www.rcog.org.uk/index.asp?PageID=498)

Table 2 illustrates the consultant sessions available in maternity units in England at present and demonstrates how far we are from achieving daytime consultant presence, even in the bigger units.

Table 2 Maternity units and consultant sessions in 2005.

Size of unit	Number (n=247)	Proportion with >10 consultant sessions (%)
<1,000	17	6
1–2,000	51	37
2–3,000	68	40
3–4,000	58	64
4–6,000	49	74
>6,000	4	100

2.2.4 Proposals to improve the quality of care

The gradual introduction of a consultant-based service in obstetrics was the key recommendation in *The Future Role* document,[66] and the new specialist training programme in obstetrics and gynaecology is to a great extent designed to meet this need. The evidence indicates that senior involvement leads to improved safety, less intervention and better outcomes, and is recommended by clinical negligence scheme for trusts.

The eventual target outlined in the *Safer Childbirth* document is to achieve 168-hour consultant presence in the biggest units and certainly by 2010 in those units delivering more than 5,000 babies. For units delivering 4,000–5,000 babies the aspiration is that 98-hour presence would be achieved by 2009, and for units delivering 2,500–4,000 babies by 2014 (see Table 3).

Table 3 Consultant presence on labour ward.

Size of unit	60-hour	98-hour	168-hour
<2,500	Local decision	Local decision	Local decision
2,500–4,000	2009	2014	
4,000–5,000	2008	2009	
5,000–6,000	2007	2008	2010
>6,000		2006	2008

It is anticipated that units delivering less than 2,500 babies per year will be regarded to a great extent as low-risk units and will have to make arrangements according to an assessment of the level of risk (at present only one-third of those units even have daytime consultant presence).

These aspirations to increase the trained presence in UK delivery suites would require an expansion in the number of trained specialists of the order of 60–70%, increasing the workforce in England from about 1,500 to approximately 2,500, which is probably unattainable. However, if there was to be a degree of reorganisation of the services, particularly smaller consultant-led

units — which seems inevitable with the additional pressures of the EWTD — an acceptable consultant presence throughout the delivery suites in the country could be delivered by 2,100 consultants; this figure could be achieved by a 5% expansion over five years (see Table 4).

Table 4 Anticipated workforce in 2011 (England and Wales).

Consultant expansion (%)	2005	2007	2009	2011
3	1,544	1,637	1,737	1,843
5	1,544	1,702	1,876	2,069
7	1,544	1,768	2,024	2,318

It should perhaps be emphasised that these calculations refer to reconfiguration of consultant-led services delivering more than 2,500 patients (or thereabout) and do not refer to the very small consultant-led units or indeed to midwifery-led units, particularly those that are free-standing. Thus fluctuations up or down in the number delivering in smaller and midwifery-led units do not affect these calculations and in no way undermine the need to reconfigure the other consultant-led units. Less than 6% of UK deliveries currently take place at home or in free-standing midwifery units. Similar issues occur in staffing neonatal and obstetric anaesthetic services.

Rural and isolated populations

In many parts of England, particularly in the North and South West, the provision of maternity services is greatly affected by the geography of the region and the necessity to meet the needs of dispersed, rural and remote populations. The provision of maternity and neonatal care in these circumstances requires consideration of a number of quality issues including safety and satisfaction (delivery closer to home). There will be particular resource issues, as well as personnel issues, including morale and the maintenance of skills. The closure of a unit in these circumstances rapidly becomes a political issue as the local communities rally round their small hospital or delivery unit.

A major neglected issue in these considerations is the quality of transfer and transport, in the event of emergency, to a suitable unit. Some work addressing the issues in the context of neonatal transfer has been carried out in Scotland. This particular issue (ie the transport and transfer of women and their babies) requires more serious consideration when issues of reconfiguring of services are discussed.

2.2.5 Are there problems with this model?

A number of policies are acting as barriers to change and to setting up meaningful networks of care.

Payment by results makes it difficult to set up pathways of care as it is individual episodes that receive funding, which may lead to perverse incentives. Also payment by results might lead some

providers to provide low-risk 'office hours' services but hand back the high-risk 24/7 service to the NHS.

The provision of obstetric services is a very emotional issue for health communities and a perceived loss of a service will generate a great deal of debate and anxiety. Local and at times national politicians inevitably become involved in these debates. This can be a major barrier to change.

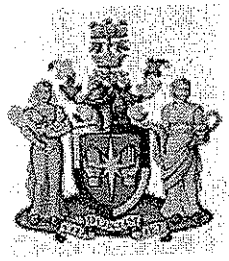
2.2.6 Recommendations

- The NSF for Children, Young People and Maternity Services[64] and Maternity Matters[65] should be implemented with particular respect to the issues of choice, equity, accessibility and continuity of care. There is a need to reach the vulnerable sections of our community more effectively. However there is also a need to improve the provision and quality of care for the 95% of the population who deliver in consultant-led delivery units. Recent experience with failing maternity services has indicated the importance of clinical leadership, consultant presence and multidisciplinary working. Safety remains a significant issue in the organisation of services.
- The key steps are to derive an agreed set of national maternity standards which encompass the whole of maternity care, including antenatal, intrapartum and postnatal care. In addition, there is a need for the appointment of local maternity leaders, probably in England at StHA level.
- A more detailed piece of work on the reorganisation and reconfiguration of maternity services should now be carried out.

SAFER CHILDBIRTH

Minimum Standards for the Organisation and Delivery of Care in Labour

Royal College *of* OBSTETRICIANS *and* GYNAECOLOGISTS



Royal College *of* MIDWIVES

Royal College *of* ANAESTHETISTS

Royal College *of* PAEDIATRICS *and* CHILD HEALTH

October 2007

Executive summary

1 Concerns from the Confidential Enquiry into Maternal and Child Health (CEMACH)[3] and its predecessor organisations the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI)[4-6] and the Confidential Enquiry into Maternal Deaths (CEMD),[7] have indicated the need for a fresh look at the organisation of care in labour. The requirements of Standards for Better Health[8] and the recommendations arising from investigations conducted by the Healthcare Commission[9-12] have added to the breadth of this report, which also incorporates the aspirations of UK maternity service policies.[8,13-16]

2 This report acknowledges:
- the central role of midwives as autonomous practitioners of normal labour and birth, together with their role as partners with obstetricians, anaesthetists and paediatricians, in the care of women with complex and complicated labours
- the importance of team working, as well the respective roles of midwives, obstetricians, anaesthetists, paediatricians, support staff and managers, as part of the local maternity care team
- the increased involvement of consultant obstetricians on the labour ward in the care of women with complex or complicated pregnancies and in the supervision and education of medical staff.

3 This document considers a number of factors influencing staffing levels which have serious implications for the service. These include:
- greater focus on woman-centred care
- an extension to the midwife's teaching role with multidisciplinary staff
- recruitment and retention crises in midwifery staffing
- changes in the experience of medical staffing at junior level
- demand for increasing consultant involvement in the labour ward.

4 It is important to match resources and facilities with workload. This document outlines minimum staffing and training requirements for midwives and doctors. Additional staff over and above this will be needed in specific situations.

5 A maternity network, which includes births at home, in midwifery units and in obstetric units, should have a common governance structure, including robust systems and clear guidelines for monitoring the safety, quality and performance of the maternity services and transfer arrangements within the network should problems arise.

6 A central theme is the need to improve communications between healthcare professionals and between professionals and women. Units should foster a team approach, based on mutual respect, a shared philosophy of care and a clear organisational structure for both midwives and medical staff, with explicit and transparent lines of communication.

7 This report provides healthcare planners, unit managers and clinical directors with guidelines on which to base realistic costing of the maternity service. Certain quality and clinical effectiveness issues have been identified, which include clinical supervision and statutory supervision of midwives, as well as basic and continuing training of all staff. Each provider will need to adapt the model suggested to achieve the standards in their own circumstances.

8 The organisation of care in labour in all settings should be reviewed and, if necessary, changes implemented to reflect the recommendations in this report. The adoption and implementation of the staffing standards, facilities and governance structures outlined below should help to ensure the best outcome for women and their babies regardless of the birth setting.

9 The outcome measures and standards described in this document should be audited and published as an annual report in line with best practice. The report should include an evaluation of women's views of their care and should inform the regular review of service provision and risk management policy. The annual report should be available to the public. Additionally, the Royal Colleges intend to audit the implementation of these standards in December 2009.