AIMS For a better birth...

Birth Activist Briefing - The new NICE guideline on Intrapartum Care: what has changed?

AIMS Journal, 2023, Vol 35, No 4

By the AIMS Campaigns Team

The updated guideline was published on 29 September 2023 and you can read ithere.

The guideline covers care recommendations for "Women in labour who are pregnant with a single baby, who go into labour at term (37 to 42 weeks of pregnancy) and who do not have any preexisting medical conditions or antenatal conditions that predispose to a higher risk birth" and "whose baby has not been identified before labour to be at high risk of adverse outcomes." This was only a partial update, with many sections remaining unchanged from the 2014 version.

AIMS submitted 32 stakeholder comments and we are pleased to see that the majority of our suggestions were accepted in whole or in part by the Guideline Development Group. You can read our comments and those of other stakeholders, and the responses to themhere.

Here we review some of the key changes made to this guideline, as well as some remaining points of concern to AIMS. There are also many minor additions or changes of wording - too many to cover in this short article - so you may like to check the new wording of any sections that are of interest to you.

1.1 Antenatal education about labour

A new section has been added recommending discussion and recording of preferences and choices for care as early as possible in their pregnancy. AIMS was concerned that this might lead to women and birthing people being pressured into making decisions before they felt ready to do so. We are pleased that the draft wording was amended to make clear that "they are free to make their decisions and change their mind at any time, including during labour or while giving birth."

1.3 Planning place of birth

Although most of the recommendations in this section were not reviewed some of the wording has been altered. For example, the recommendation that women be advised of settings that are 'particularly suitable for them' has been replaced by the less directive wording that they should be told that a midwife-led unit (or home, for multiparous women)

> "is associated with a lower rate of interventions and the outcome for the baby is no

different compared with an obstetric unit."

There have been some useful additions to the list of information that should be given about all local birth settings, such as the availability of birth pools and different medical forms of pain relief.

1.3.6 Impact of BMI on choice of place of birth

The previous guideline simply listed a BMI at booking of 30 to 35 kg/m^2 as a factor "indicating individual assessment when planning place of birth." This has now been replaced by a separate section that puts the emphasis on the woman's decision-making:

> "Advise women that, in general, the higher their body mass index (BMI) at booking (and particularly with a BMI above 35 kg/m^2), the greater the likelihood of complications, so this may be something they wish to think about when planning their place of birth."

In response to AIMS suggestion they have added the clarification that "in general the risks of complications are higher for nulliparous women with an increased BMI compared with multiparous women with an increased BMI." They also amended the summary tables in Appendix B to include evidence that for those planning birth in an alongside midwifery unit it is only nulliparous woman that a BMI above 35 kg/m^2 who have an increased chances of an unplanned caesarean or a post-partum haemorrhage compared with those with a BMI of 35 kg/m^2. or less. For multiparous women their BMI made no difference.

However, we are disappointed that they failed to include the main point of our comment - that evidence suggests that the chances of a poor outcome for otherwise healthy multiparous women with a BMI over 35 kg/m^2 appear to be **lower** than for nulliparous women with a BMI in what is considered the 'healthy' rage of 18.5 to 24.9 35 kg/m^2 .{Ref Hollowell J. et al BJOG 2014 Feb;121(3):343-55} and that birth in a midwife-led unit is therefore an equally reasonable option for them.

The evidence tables in Appendix B are worth reading in detail.

1.4 Care throughout labour in all birth settings

We are pleased that in response to our comment "the committee added an additional overarching recommendation to emphasise that women should be given all the information they need to make a supported decision and consent should always be obtained." This is recommendation 1.4.2 which says:

> "When providing information on the benefits and risks of care options or suggested interventions:
>
> - encourage the woman to ask questions
> - if possible, give her time to think about the options and
> - help her make a supported decision.

> Obtain consent before carrying out the chosen care option or intervention."

We regret that NICE continues to use the misleading term "supported decision" rather than "informed decision" but otherwise welcome this addition.[1]

They have also made a couple of helpful changes to the wording of recommendation 1.4.3:

> "**All staff and organisations** should ensure that all birth settings have 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, **her choices are supported**, and she is cared for with compassion."

Communication

1.4.8 This new section covers how a woman (and her birth companions) should be given information about care during labour. Points include providing information in clear, plain language; tailoring the content and delivery of information to the needs and preferences of the woman; providing reliable interpreting services that are independent of the woman; using culturally sensitive language and adapting communications as necessary for people with learning disabilities or autism.

We are particularly pleased to see the strengthening of the language around autonomy and consent in recommendation 1.4.10:

> "Ensure that the woman is **empowered, informed and central to making decisions about her care**, and recognise that the way in which care is given is key to this. **Support the woman so she:**
>
> - **can continue to make decisions about her care**
> - **feels confident that her care team is there to assist her**
> - **understands that she can accept or decline care that is offered, can change her mind, and that decisions she makes will not affect how care is provided to her.**"

1.6 Pain Relief

One important addition to this section is a reminder "that every woman's experience of pain is unique and may be expressed in different ways."

New sections have been added on the use of sterile water injections (1.6.13 - 1.6.15) and intravenous remifentanil patient-controlled analgesia (1.6.20 - 1.6.23).

> "Consider intracutaneous or subcutaneous sterile water injections as a pain relief option for women in labour with back pain."

The quality of the evidence was insufficient for the committee to make a strong recommendation about

the use of this method for back pain, or to recommend it for general labour pain. (Note that NICE guidelines use the word 'consider' rather than 'recommend' to indicate a lower quality of evidence.)

> "Consider intravenous remifentanil patient-controlled analgesia (PCA), at 40 micrograms per bolus with a 2□minute lockout period, as an option for women who want ongoing pain relief during labour and birth."

The guideline points out that this is an off-label use of the drug, and cautions that it should only be used in obstetric units because of the risk of it causing respiratory depression.

1.7 Prelabour rupture of membranes at term

AIMS was concerned to see in the draft guideline a recommendation (1.7.2) that all women with suspected rupture of membranes after 37+0 weeks but no risk factors should be seen in person within 6 hours, despite the fact that the evidence review stated that there is no evidence to support the need for review at this stage.

We recognise that some people may find it reassuring to be seen in person and were happy with the recommendation to "see the woman in person as soon as possible if she has any concerns or wishes to be induced immediately." However, we felt that pressure to attend within a certain time limit when someone did not want this could be disruptive to the progress of labour and their emotional wellbeing. Also, we did not agree with the committee's belief that a 6-hour limit would be "sufficient to allow a woman to spend the night at home."

We suggested that this non-evidence-based recommendation be replaced with "offer the woman a review within 6 hours if she wishes." Unfortunately, the recommendation remains in the final version, but has at least been amended to say "within 12 hours" and with a recommendation to offer the woman a choice of where this review takes place.

1.8 First stage of labour

A small but important addition (1.8.41) under the heading of delay in the first stage is:

> "Do not advise transfer to obstetric-led care for amniotomy alone" because "Based on their knowledge and experience, the committee were aware that amniotomy could be safely carried out in midwife-led settings."

There are also some important additions concerning the use of oxytocin (1.8.45 - 1.8.53). We are pleased that they have accepted our suggestion to replace the words "she can be involved in decisions to start, stop or restart the oxytocin" with "her choice to start, stop or restart the oxytocin will be supported", to better reflect that this should be the woman's decision.

Also at our suggestion to explain why oxytocin might be stopped they have added the clarification that "oxytocin can cause hyperstimulation, which may increase the chance of transient fetal hypoxia, and if

hyperstimulation occurs the dose will be reduced or stopped."

Another new recommendation is "that the time between increments of the dose is no more frequent than every 30 minutes" which should hopefully reduce the chances of the dose being ramped up excessively.

We are pleased to see the words: "Use oxytocin in labour with caution", and the recommendations to reduce or stop it if a woman is having **more than four contractions in ten minutes**, and to discontinue it immediately and seek an urgent review "if the cardiotocography is pathological."

Given the role that appears to have been played by excessive oxytocin use in some of the cases in the Ockenden and East Kent maternity service reviews, AIMS hope that these recommendations will be taken to heart.

1.9 Second stage of labour

There are some new recommendations on positions and pushing for women with or without an epidural in place (1.9.5 - 1.9.10.)

A section on **Intrapartum interventions to reduce perineal trauma** includes the reminder to "Discuss the woman's preferences for techniques to reduce perineal trauma during birth and support her choices." Other recommendations are to offer a warm compress once the presenting part distends the perineum and to consider perineal massage if preferred to a compress. Because the evidence for 'hands on' and 'hands poised' was mixed and there was "no evidence for a technique called 'the Finnish grip'"[2] they decided not to include a recommendation about these approaches. However they did include a 'Research recommendation' to explore the effectiveness of these different approaches.

Research recommendations

There is quite an extensive list of recommendations for research to fill in gaps in the evidence:

- Effectiveness of hands on, hands poised or Finnish grip in the second stage of labour for reducing perineal trauma
- Effective dose for restarting oxytocin if it's been stopped because of abnormal CTG
- Position of the baby during cord clamping
- Impact of pharmacological interventions for the management of postpartum haemorrhage on breastfeeding and women's and their birth companions' experience and satisfaction in the postnatal period
- How does the provision of accurate, evidence-based information affect women's decision-making processes and choice of place of birth?
- What are the long-term consequences for women and babies of planning birth in different settings?
- What is the effectiveness of altering the dose of intravenous oxytocin to reduce excessive frequency of uterine contractions?
- What is the most effective treatment for primary postpartum haemorrhage?

AIMS is pleased that so many of our suggestions were accepted, although some areas of concern remain. It is particularly encouraging to see the clearer emphasis throughout on autonomy, the importance of providing full information in an appropriate and accessible way, and of supporting the woman's decisions. We hope that all maternity services staff will reflect on what they can do to:

"ensure that all birth settings have 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, her choices are supported, and she is cared for with compassion."

Actions for Birth Activists

- Read the full guideline and familiarise yourself with what has changed.
- If you are an MNVP or MSLC user representative, ask how your Trust/Board is updating their guidelines in the light of the changes to the NICE Guideline, if not then ask a local representative to check for you.
- Ask your local Trust/Board what actions they are taking to "ensure that all birth settings have 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, her choices are supported, and she is cared for with compassion."

---

[1] **Editor's note:** Legally, as with all health care, any care decision in labour is the mother's and hers alone. If she so wishes, it can be a fully informed decision, and all options must be on offer. The term 'supported decision' suggests that the mother needs a medical person's support before her decision can be accepted, when according to the Montgomery ruling, she absolutely does not. However, when she does make her decision, it must be supported by the midwives and doctors involved in her care, even if

they do not agree.

[2] **Editor's note:** The Finnish grip (not to be confused with the Javelin throwing hold of the same name) is a proposed method of 'guarding' the perineum by using the index finger and thumb to apply pressure as the head is being born. www.youtube.com/watch?v=YWx0_wP4yGk