AIMS For a better birth...

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

Beverley Beech

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When I received a copy of this new NICE Guideline I resisted the urge to cartwheel around the room. Two paragraphs jump out of this new Guideline: *'Explain to both multiparous and nulliparous women who are at low risk of complications that giving birth is generally very safe for both the woman and her baby'* and *'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'*.

NICE's decision to update the 2007 Intrapartum Guideline was based on developments in the NHS and new evidence that has become available since then (such as the Birthplace Study https://www.npeu.ox.ac.uk/birthplace).

The Guideline is particularly strong on women's right to choose the place of birth. It says:

'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'.

Furthermore, it states that: Commissioners and providers should ensure that all four birth settings are available to all women (in the local area or in a neighbouring area).

The Guideline also addresses the uncertainty and inconsistency of care not only in relation to place of birth but also during the latent (early) first stage of labour, fetal assessment and particularly cardiotocography (continuous electronic monitoring of the baby's heartbeat) compared with intermittent auscultation (listening in to the baby's heartbeat at regular intervals) and third stage management. It recommends:

'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.'

'Do not perform cardiotocography for low-risk women in established labour.'

But the Guideline does highlight the circumstances when continuous cardiotography should be 'advised'.

The recommendations for management of the Third Stage of Labour are also welcome, particularly, this statement:

'Physiological management of the third stage involves a package of care that includes the following components: no routine use of uterotonic drugs no clamping of the cord until pulsation has stopped delivery of the placenta by maternal effort.'

It is worth stressing that the above recommendations apply to fit and healthy women, but there are instances where the Guideline covers all women:

'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.'

Needless to say, the press focused on the 'small' increased risk of an adverse outcome for first babies born at home, which became the focus of public debate. So it is worth mentioning the findings of the Birthplace study of over 64,000 healthy women. This showed that for first babies there was a slightly higher risk when born at home of 9.3/1,000 compared to 5.3/1,000 born in a consultant unit (though the outcomes for freestanding midwifery units and alongside midwifery units for first babies were 4.5/1,000 and 4.7/1,000 respectively). These figures represent 91 adverse outcomes out of 15,000 births (52 adverse outcomes in the 10,541 first babies born in an obstetric unit and 39 adverse outcomes in the 4483 first babies born at home), but the figures only reached statistical significance because they combined, mortality with specific morbidities – such as a fractured humerus or clavical, meconium aspiration syndrome and brachial plexus injury. These are not necessarily life threatening events and if one looked only at mortality there was little difference in the comparison between home and hospital, and those differences did not reach statistical significance. In other words, the very small numbers of mortalities could have occurred by chance.

Importantly, the research also shows that healthy women birthing in obstetric units have a greater risk of having caesarean sections, episiotomies, forceps or ventouse and are less likely to breastfeed successfully – statistics that the press conveniently ignored.

The Guideline makes recommendations for action and it will be interesting to see how seriously the Trusts take these recommendations, and how soon change will occur. It has been 30 years since Marjorie Tew's statistical analysis revealed the safety of birth outside obstetric units. I hope we do not have to wait another 30 years before action is taken on these recommendations to improve care for all women.

If the NICE recommendations are acted upon, the majority of fit and healthy women will have, at last, care appropriate to their needs, and those high-risk women who need the specialised attention of obstetricians will stand a greater chance of getting it; but we should also be aware that there are many midwives who have practised, and trained, in obstetric units and have lost the understanding and skills required when attending normal births, so the Trusts will have to ensure that when they implement the NICE Guideline they also re-educate their midwives.

References

- NICE (2014) Clinical Guideline 190 December 2014.www.nice.org.uk/guidance/cg190
- Tew, M (1985) Place of Birth and Perinatal Mortality. J R Coll. Gen. Pract. 1985;35(277):390-4.