NICE National Institute for Health and Care Excellence

NICE quality standard

Intrapartum care

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This standard is based on NG4, NG201, NG229 and NG235.

This standard should be read in conjunction with QS75, QS46, QS35, QS22, QS15, QS60, QS32, QS109, QS115, QS135 and QS192.

Quality statements

Statement 1 Women at low risk of complications during labour are given the choice of all 4 birth settings and information about local birth outcomes.

Statement 2 Women in established labour have one-to-one care and support from an assigned midwife.

Statement 3 This statement has been removed. For more details, see update information.

Statement 4 Women at low risk of complications who have cardiotocography because of concern arising from intermittent auscultation have the cardiotocograph removed if the trace is normal for 20 minutes.

Statement 5 Women at low risk of complications are not offered amniotomy or oxytocin if labour is progressing normally.

Statement 6 Women do not have the cord clamped earlier than 1 minute after the birth unless there is concern about cord integrity or the baby's heartbeat.

Statement 7 Women have skin-to-skin contact with their babies after the birth.

Quality statement 1: Choosing birth setting

Quality statement

Women at low risk of complications during labour are given the choice of all 4 birth settings and information about local birth outcomes.

Rationale

Women at low risk of complications during labour and birth need information that is specific to their local or neighbouring area about safety and outcomes for women and babies in the different birth settings. This information will help women to make informed choices about where to have their baby.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence of local arrangements to provide women at low risk of complications with a choice of all 4 birth settings.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, such as from service specifications and protocols.

b) Evidence of local arrangements to provide women at low risk of complications with local information about birth outcomes.

Data source: Data can be collected from information recorded locally by healthcare

professionals and provider organisations, such as patient leaflets and information available on local NHS and service provider websites.

Process

a) Proportion of women at low risk of complications with a recorded discussion at their 16-week antenatal appointment of their preferred choice of birth setting.

Numerator – the number in the denominator with a recorded discussion at their 16-week antenatal appointment of their preferred choice of birth setting.

Denominator – the number of women at low risk of complications attending a 16-week antenatal appointment.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

b) Proportion of women at low risk of complications with a recorded discussion at their 16-week antenatal appointment about local birth outcomes.

Numerator – the number in the denominator with a recorded discussion at their 16-week antenatal appointment about local birth outcomes.

Denominator – the number of women at low risk of complications attending a 16-week antenatal appointment.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

Outcome

Maternal experience and satisfaction with place of birth.

Data source: National data is collected as part of the Care Quality Commission's Maternity Survey, question B3 ('Were you offered a choice about where to have your baby?'). Data can also be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient satisfaction surveys.

What the quality statement means for different audiences

Service providers (community, primary and secondary care services) raise awareness of maternity pathways and ensure that systems and tools are in place to offer women at low risk of complications a choice of all 4 birth settings and local information about birth outcomes to support them to make informed decisions about where to have their baby.

Healthcare professionals (such as midwives and obstetricians) provide women at low risk of complications with local information about birth outcomes and rates of transfer to an obstetric unit for all birth settings, and support them to make informed decisions about where to have their baby. Healthcare professionals can adapt and use NICE's resource for midwives on choosing place of birth to do this.

Commissioners (integrated care systems) commission maternity services to ensure that all 4 birth settings are available in the local or a neighbouring area to women at low risk of complications. Commissioners also ensure that services provide local information about outcomes for women and babies and rates of transfer to an obstetric unit for all birth settings to support women to make informed decisions about where to have their baby. Commissioners coordinate collection of outcome data in local and neighbouring areas to help service providers and healthcare professionals give information to women.

Women at low risk of having problems during labour and birth have a choice of 4 places where they can have their baby – at home, in a midwife-led unit that is either next to a hospital obstetric unit or in a different place, or in an obstetric unit ('labour ward'). To help women make an informed choice, they are given information by their midwife about birth outcomes and rates of transfer to an obstetric unit for their local or neighbouring area. Birth outcomes are things like the chances of needing a ventouse or forceps birth, caesarean birth or episiotomy, and the risk of serious medical problems for the baby.

Source guidance

- Antenatal care. NICE guideline NG201 (2021), recommendation 1.3.16 and schedule of appointments (16-week appointment)
- Intrapartum care. NICE guideline NG235 (2023), recommendations 1.2.1, 1.3.3 and 1.3.7

Definitions of terms used in this quality statement

4 birth settings

The 4 settings where a woman at low risk of complications may choose to have her baby are: at home, in a freestanding midwifery unit, in an alongside midwifery unit and in an obstetric unit. [NICE's guideline on intrapartum care, recommendation 1.3.3]

Local birth outcomes

Outcomes for women for each planned place of birth include rates of spontaneous vaginal birth, transfer to obstetric unit, obstetric intervention and delivering a baby with or without serious medical problems. [Adapted from NICE's guideline on intrapartum care, recommendation 1.3.7]

Quality statement 2: One-to-one care

Quality statement

Women in established labour have one-to-one care and support from an assigned midwife.

Rationale

One-to-one care will increase the likelihood of the woman having a 'normal' vaginal birth without interventions, and will contribute to reducing both the length of labour and the number of operative deliveries. Care will not necessarily be given by the same midwife for the whole labour.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of midwifery staff available to provide one-to-one care to women in established labour in each birth setting.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from staffing records.

Process

Proportion of women in established labour who receive one-to-one care from an assigned midwife.

Numerator – the number of women in the denominator who receive one-to-one care from an assigned midwife.

Denominator – the number of women in established labour.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records. This may also include monitoring midwifery staffing levels as described in the NICE guideline on safe midwifery staffing for maternity settings.

Outcome

a) Neonatal morbidity.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from antenatal care records on provider systems. Trusts report on neonatal mortality as part of reporting on perinatal mortality rates using the MBRRACE-UK National Perinatal Mortality Review Tool for ongoing audit. NHS Digital's Maternity Services Data Set includes data on neonatal mortality and the Maternity Services Dashboard can be used to monitor performance and compare services.

b) Maternal morbidity.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records. MBRRACE-UK Confidential Enquiries into Maternal Deaths and Morbidity and the National Maternity and Perinatal Audit (NMPA) report on maternal morbidity. Indicators from MBRRACE-UK and the NMPA are available via the Maternity Services Dashboard.

c) Maternal satisfaction and experience of care.

Data source: National data is collected as part of the Care Quality Commission's Maternity Survey, section C ('Your labour and the birth of your baby'). Data can also be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient satisfaction surveys.

What the quality statement means for different audiences

Service providers (for all 4 birth settings) ensure that recommended midwifery staffing ratios are maintained so that women in established labour have one-to-one care and support from an assigned midwife.

Healthcare professionals (assigned midwives) give one-to-one care to each woman in established labour and are solely dedicated to the care of that woman.

Commissioners (integrated care systems) commission services that have systems in place to maintain recommended midwifery staffing ratios, so that women in established labour have one-to-one care and support from an assigned midwife.

A woman in labour is cared for by a midwife who is looking after just her – this is called 'one-to-one care'. She might not have the same midwife for the whole of labour. One-to-one care aims to ensure that the woman has a good experience of care and reduces the likelihood of problems for her and her baby.

Source guidance

- Intrapartum care. NICE guideline NG235 (2023), recommendation 1.4.5
- Safe midwifery staffing for maternity settings. NICE guideline NG4 (2015), recommendation 1.2.2

Definitions of terms used in this quality statement

Established labour

Labour is established when:

- there are regular painful contractions **and**
- there is progressive cervical dilatation from 4 cm.

[Adapted from NICE's guideline on intrapartum care, recommendation 1.8.1]

Quality statement 3: Cardiotocography and initial assessment of a woman in labour

This statement has been removed. For more details, see update information.

Quality statement 4: Stopping cardiotocography

Quality statement

Women at low risk of complications who have cardiotocography because of concern arising from intermittent auscultation have the cardiotocograph removed if the trace is normal for 20 minutes.

Rationale

Cardiotocography is offered to women if intermittent auscultation indicates possible fetal heart rate abnormalities. However, cardiotocography that is started for this reason should be stopped if the trace is normal for 20 minutes, because it restricts the woman's movement and can cause labour to slow down. This can lead to a cascade of interventions that may result in adverse birth outcomes.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that women at low risk of complications having cardiotocography because of concern arising from intermittent auscultation have the cardiotocograph removed if the trace is normal for 20 minutes.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from local protocols on cardiotocography.

Process

Proportion of women at low risk of complications who receive cardiotocography because of concern arising from intermittent auscultation who have the cardiotocograph removed if the trace is normal for 20 minutes.

Numerator – the number in the denominator who have the cardiotocograph removed.

Denominator – the number of women in labour at low risk of complications who receive cardiotocography because of concern arising from intermittent auscultation who have a normal trace for 20 minutes.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

Outcome

Maternal satisfaction and experience of care.

Data source: National data is collected as part of the Care Quality Commission's Maternity Survey, section C ('Your labour and the birth of your baby'). Data can also be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient satisfaction surveys.

What the quality statement means for different audiences

Service providers (freestanding midwifery units, alongside midwifery units and obstetric units) have evidence of local arrangements to ensure that protocols are in place so that women in labour at low risk of complications who have cardiotocography because of concern arising from intermittent auscultation have the cardiotocograph removed if the trace is normal for 20 minutes.

Healthcare professionals (midwives and obstetricians) remove the cardiotocograph if the trace is normal for 20 minutes for women at low risk of complications who have cardiotocography because of concern arising from intermittent auscultation.

Commissioners (integrated care systems) specify and check that service providers have protocols in place to ensure that women in labour at low risk of complications who have cardiotocography because of concern arising from intermittent auscultation have the cardiotocograph removed if the trace is normal for 20 minutes.

Women who are at low risk of problems during labour, but who have electronic monitoring because of possible concerns about the baby's heartbeat, are taken off the monitor if the baby's heartbeat is normal for 20 minutes.

Source guidance

Fetal monitoring in labour. NICE guideline NG229 (2022), recommendations 1.2.12 to 1.2.14

Definitions of terms used in this quality statement

Normal cardiotocograph trace

A normal trace has the following normal/reassuring features:

- baseline fetal rate of 110 to 160 beats per minute **and**
- baseline variability of 5 to 25 beats per minute **and**
- no or early decelerations or variable decelerations that are not evolving to have concerning characteristics.

[NICE's guideline on fetal monitoring in labour, recommendations 1.4.15, 1.4.18 and 1.4.24]

Quality statement 5: Interventions during labour

Quality statement

Women at low risk of complications are not offered amniotomy or oxytocin if labour is progressing normally.

Rationale

For women at low risk of complications, amniotomy and oxytocin do not reduce the incidence of caesarean birth, increase the incidence of spontaneous vaginal births or contribute to improved neonatal outcomes. They are therefore unnecessary for women at low risk of complications if labour is progressing normally.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that women at low risk of complications who are in labour that is progressing normally do not have amniotomy or oxytocin.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from local protocols on the use of amniotomy and oxytocin.

Process

Proportion of women at low risk of complications whose labour is progressing normally who do not have amniotomy or oxytocin.

Numerator – the number in the denominator who do not have amniotomy or oxytocin.

Denominator – the number of women at low risk of complications whose labour is progressing normally.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

Outcome

a) The number of women whose labour progressed normally who had amniotomy or oxytocin.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

b) Maternal satisfaction and experience of care.

Data source: National data is collected as part of the Care Quality Commission's Maternity Survey, section C ('Your labour and the birth of your baby'). Data can also be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient satisfaction surveys.

What the quality statement means for different audiences

Service providers (all 4 birth settings) have protocols in place to ensure that women at low risk of complications whose labour is progressing normally are not offered amniotomy or oxytocin.

Healthcare professionals (midwives and obstetricians) do not offer amniotomy or oxytocin to women at low risk of complications whose labour is progressing normally.

Commissioners (integrated care systems) specify and check that service providers have protocols in place to ensure that women at low risk of complications whose labour is progressing normally are not offered amniotomy or oxytocin.

Women who are at low risk of having problems and whose labour is progressing normally are not offered amniotomy (having their waters broken) or oxytocin (a medicine given through a drip that speeds up labour).

Source guidance

Intrapartum care. NICE guideline NG235 (2023), recommendations 1.8.33 and 1.8.34

Definitions of terms used in this quality statement

Normal labour and normal progression of labour

The NICE full guideline on intrapartum care adopts the World Health Organization definition of a normal labour: 'labour is normal when it is spontaneous in onset, low risk at the start and remaining so throughout labour and birth. The baby is born spontaneously and in the vertex position between 37 to 42 completed weeks of pregnancy. After birth the woman and baby are in good condition'.

Quality statement 6: Delayed cord clamping

Quality statement

Women do not have the cord clamped earlier than 1 minute after the birth unless there is concern about cord integrity or the baby's heartbeat.

Rationale

The benefits of delayed cord clamping include higher haemoglobin concentrations, a decreased risk of iron deficiency and greater vascular stability in babies. If they wish, women can ask healthcare professionals to wait longer to clamp the cord.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that midwives and obstetricians do not clamp the cord earlier than 1 minute after the birth unless there is a concern about cord integrity or the baby's heartbeat.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, local protocols on cord clamping.

Process

a) Proportion of babies who had their cord clamped more than 1 minute after the birth where there was not a concern about cord integrity or the baby's heartbeat.

Numerator – the number in the denominator who had their cord clamped more than 1 minute after the birth.

Denominator – the number of babies born where there was not a concern about cord integrity or the baby's heartbeat.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

b) Proportion of babies who had their cord clamped earlier than 1 minute after the birth where there was a concern about cord integrity or the baby's heartbeat.

Numerator – the number in the denominator who had their cord clamped earlier than 1 minute after the birth.

Denominator – the number of babies born where there was a concern about cord integrity or the baby's heartbeat.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

Outcome

Maternal satisfaction and experience of care.

Data source: National data is collected as part of the Care Quality Commission's Maternity Survey, section C ('Your labour and the birth of your baby'). Data can also be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient satisfaction surveys.

What the quality statement means for different audiences

Service providers (all 4 birth settings) have protocols in place to ensure that the cord is not clamped earlier than 1 minute after the birth unless there is concern about cord integrity or the baby's heartbeat.

Healthcare professionals (midwives and obstetricians) do not clamp the cord earlier than 1 minute after the birth unless there is concern about cord integrity or the baby's heartbeat.

Commissioners (integrated care systems) specify and check that service providers have protocols in place to ensure that the cord is not clamped earlier than 1 minute after the birth unless there is a concern about cord integrity or the baby's heartbeat.

Women who have just given birth do not have their baby's cord clamped for at least 1 minute after the birth unless there are concerns about the baby. This is to allow more blood to reach the baby and may help to prevent anaemia.

Source guidance

Intrapartum care. NICE guideline NG235 (2023), recommendation 1.10.14

Definitions of terms used in this quality statement

Cord integrity

Concerns would arise over cord integrity if the cord was damaged in any way, if it had snapped during delivery or if there was bleeding to the cord. Definitions of cord integrity are not limited to those stated here. [Expert opinion]

Concern about the baby's heartbeat

Concern would arise if, after delivery, the baby has a heartbeat below 60 beats per minute that is not getting faster. [Adapted from NICE's guideline on intrapartum care, recommendation 1.10.14]

Quality statement 7: Skin-to-skin contact

Quality statement

Women have skin-to-skin contact with their babies after the birth.

Rationale

Skin-to-skin contact with babies soon after birth has been shown to promote the initiation of breastfeeding and protect against the negative effects of mother–baby separation.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that midwives and obstetricians encourage women to have skin-to-skin contact with their babies after the birth.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from local protocols on skin-to-skin contact.

Process

Proportion of women with a record of having skin-to-skin contact with their baby after the birth.

Numerator – the number in the denominator where there is a record of them having skin-to-skin contact with their baby after the birth.

Denominator – the number of women who had a live birth.

Data source: The Maternity Services Data Set collects data on whether a mother had skin-to-skin contact with their baby within 1 hour of birth. Data can also be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

Outcome

Women's satisfaction with the support received to have skin-to-skin contact with their baby after the birth.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient satisfaction surveys.

What the quality statement means for different audiences

Service providers (all 4 birth settings) have protocols in place for midwives and obstetricians to encourage women to have skin-to-skin contact with their baby as soon as possible after the birth.

Healthcare professionals (midwives and obstetricians) encourage women to have skin-to-skin contact with their baby as soon as possible after the birth. If the woman is not well enough, healthcare professionals encourage her birth companion to have skin-to-skin contact instead.

Commissioners (integrated care systems) specify and check that service providers have protocols in place to ensure that women are encouraged to have skin-to-skin contact with their baby as soon as possible after the birth.

Women are encouraged to have skin-to-skin contact with their baby as soon as possible after the birth. If she is not well enough, her birth companion is encouraged to have skin-to-skin contact instead.

Source guidance

Intrapartum care. NICE guideline NG235 (2023), recommendation 1.11.7

Update information

February 2017: Statement 3 on cardiotocography and the initial assessment of a woman in labour has been removed. This change has been made because the source guidance for this statement (NICE's guideline on intrapartum care for healthy women and babies) has been updated and the advice on cardiotocography for low-risk women has changed.

Minor changes since publication

September 2023: Recommendation numbers and references have been updated throughout the quality standard in line with the updated NICE guideline on intrapartum care.

December 2022: Changes have been made to align statement 4 of this quality standard with NICE's guideline on fetal monitoring in labour, which has updated the section on monitoring labour in NICE's guideline on intrapartum care for healthy women and babies. The source guidance, recommendation numbers and definition of normal cardiotocograph trace have been updated. Data sources and references have also been updated throughout.

August 2021: Changes have been made to align statement 1 of this quality standard with NICE's guideline on antenatal care. The process measures, recommendation numbers, references and links to the source guidance have been updated. Data sources and references have also been updated throughout.

November 2017: Changes were made to the definition of normal cardiotocograph trace in statement 4 to ensure alignment with NICE's guideline on intrapartum care for healthy women and babies.

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See our webpage on quality standard advisory committees for details of standing committee 2 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available from the webpage for this quality standard.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Diversity, equality and language

Equality issues were considered during development and equality assessments for this

quality standard are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- National Childbirth Trust
- Royal College of General Practitioners (RCGP)
- Royal College of Midwives
- Royal College of Obstetricians and Gynaecologists