# NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

## Health and social care directorate

## Quality standards and indicators

## Briefing paper

**Quality standard topic:** Intrapartum care

**Output:** Prioritised quality improvement areas for development.

**Date of Quality Standards Advisory Committee meeting:** 7 April 2015

## Contents

# 1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for intrapartum care. It provides the Committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

## *1.1 Structure*

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the Committee in considering potential statements and measures.

## *1.2 Development source*

The key development source referenced in this briefing paper is:

Intrapartum care: care of healthy women and their babies during childbirth. NICE guideline CG190 (2014).

Next review date: December 2016.

# 2 Overview

## *2.1 Focus of quality standard*

This quality standard will cover the care of women and their babies during labour and immediately after birth. It will cover both women who enter labour at low risk of intrapartum complications and women with more complicated pregnancies who are at higher risk of intrapartum complications.

## *2.2 Definition*

Intrapartum care is defined as the care of the women and their babies from the onset of labour and immediately after birth. Women are considered to be at low risk of complications if their pregnancy is straightforward, they are in good health and have no serious health conditions (pregnancy-related or otherwise). Factors that can increase the risk of complications during birth include:

- women being over the age of 35
- women who are overweight or obese

- recreational drug use
- bleeding after 24 weeks of gestation
- high blood pressure
- major gynaecological surgery
- fetal abnormality
- the baby lying in a breech position

Complications from a previous pregnancy can also increase the risk of complications during birth for pregnant women. These can include stillbirth, neonatal death, pre-eclampsia, a large baby (weighing more than 4.5kg), serious vaginal, cervical or perineal trauma, or neonatal jaundice requiring exchange transfusion.

Medical conditions that may place women at a higher risk of complications during birth include:

- cardiac disease
- anaemia
- asthma requiring an increase in treatment (or hospital treatment)
- sickle-cell
- infectious diseases such as hepatitis B and C and HIV
- hypertensive disorders
- risk factors for group B streptococcus
- spinal abnormalities
- diabetes
- epilepsy
- gastrointestinal problems like Crohn’s disease, ulcerative colitis and liver disease

## *2.3 Incidence and prevalence*

About 700,000 women give birth in England and Wales each year, of whom about 40% are having their first baby. Most of these women are healthy and have a straightforward pregnancy. Almost 90% of women will give birth to a single baby after 37 weeks of pregnancy, with the baby presenting head first.

See appendix 1 for the associated care pathway and algorithms from NICE clinical guideline190.

## *2.4 Management*

A range of healthcare professionals may be involved in a women's care, these will include midwives and may include doctors such as obstetricians, neonatologists and anaesthetists. The care team should explain the available options so that women can decide what's best for them. Women have a variety of options for choosing a location to give birth. These are normally explained by a midwife and include giving birth at home, in a midwife led unit or an obstetric unit

It is important that the woman is given information and advice about all available settings when she is deciding where to have her baby, so that she is able to make a fully informed decision. This includes information about outcomes for the different settings. It is also vital to recognise when transfer of care from midwifery-led care to obstetric-led care is indicated because of increased risk to the woman and/or her baby resulting from complications that have developed during labour.

Uncertainty and inconsistency of care has been identified in a number of areas, such as choosing place of birth, care during the latent first stage of labour, fetal assessment and monitoring during labour (particularly cardiotocography compared with intermittent auscultation) and management of the third stage of labour.

## *2.5 National Outcome Frameworks*

Tables 1–2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

**Table 1 NHS Outcomes Framework 2015–16**

| Domain | Overarching indicators and improvement areas |
|---|---|
| 1. Preventing people from dying prematurely | ***Overarching indicator***<br>1a Potential years of life lost (PYLL) from causes considered amenable to healthcare<br>i Adults ii Children and young people<br>1c Neonatal mortality and stillbirths<br>***Improvement areas***<br>Reducing deaths in babies and young children<br>1.6 i Infant mortality (PHOF 4.1*) |
| 4. Ensuring that people have a positive experience of care | ***Overarching indicators***<br>4b Patient experience of hospital care<br>***Improvement areas***<br>Improving hospitals' responsiveness to personal needs<br>4.2 Responsiveness to in-patients' personal needs<br>Improving women and their families' experience of maternity services<br>4.5 Women's experience of maternity services |
| 5. Treating and caring for people in a safe environment and protecting them from avoidable harm | ***Overarching indicators***<br>5a (previously 5c) Deaths attributable to problems in healthcare<br>5b Severe harm attributable to problems in healthcare<br>***Improvement areas***<br>Improving the safety of maternity services<br>5.5 Admission of full-term babies to neonatal care (definition and quality statement amended) |
| **Alignment across the health and social care system**<br>* Indicator is shared | |

**Table 2 Public health outcomes framework for England, 2013–2016**

| Domain | Objectives and indicators |
|---|---|
| 2 Health improvement | ***Objective***<br>People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities<br>***Indicators***<br>• Breastfeeding |
| 4 Healthcare public health and preventing premature mortality | ***Objective***<br>Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities.<br>***Indicators***<br>• Infant mortality |

# 3 Summary of suggestions

## *3.1 Responses*

In total 12 stakeholders responded to the 2-week engagement exercise 10/02/2015-24/02/2015.

One Stakeholder did not submit any data for this topic.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 3 for further consideration by the Committee.

Full details of all the suggestions provided are given in appendix 4 for information.

**Table 3 Summary of suggested quality improvement areas**

| Suggested area for improvement | Stakeholders |
|---|---|
| **4.1 Provision of care**<br>• Availability of all four places of delivery location<br>• Supporting informed choice | BR, NCT, RCM, RCN, RCOG, SCM |
| **4.2** Transfer of patients between birth locations | BR, NCT, SCM, RCM |
| **4.3 Staff support in labour**<br>• One to one care<br>• Consultant involvement | NCT, NHSE, SCM, RCM |
| **4.4 Fetal Monitoring**<br>• Cardiotocography (CTG) usage and monitoring<br>• Fetal blood sampling | BR, NCT, RCOG, SCM |
| **4.5 Delivery health**<br>• Prevention of Obstetric Anal Sphincter Injuries (OASIS) | RBH, RCOG |
| **4.6 Delayed Cord clamping** | RCOG, SCM, RCM |
| **4.7 Interventions during labour** | SCM, RCM |
| **Additional developmental areas** | NCT, RCOG, SCM, RCM |

BR, Birthrights
NCT, National Childbirth Trust
NHSE, NHS England
RBH, Royal Bournemouth Hospital
RCM, The Royal College of Midwives
RCN, Royal College of Nursing
RCOG, Royal College of Obstetricians and Gynaecologists
RCPCH, The Royal College of Paediatrics and Child Health
SCM, Specialist Committee Member
SU, Swansea University

# 4 Suggested improvement areas

## *4.1 Provision of Care*

### 4.1.1 Summary of suggestions

**Availability of all four places of delivery location**

Stakeholders highlighted the need for each trust and CCG to ensure all four birth locations (home, freestanding midwifery unit, alongside midwifery unit or obstetric unit) are made available for women.

Stakeholders comment that women with uncomplicated pregnancies have better outcomes in midwifery led settings and maternal and fetal outcomes are better when a multiparous (a woman who has given birth two or more times) woman deliver at home or in a midwifery led unit; this is due to reduced numbers of interventions.

**Supporting informed choice**

Stakeholders highlight that women with low risk of complications should be provided with clear and consistent information on the evidence for all birth settings to make informed delivery decisions.

A stakeholder further comments suggesting that information is currently location specific and providers may be biased to the services they currently provide.

### 4.1.2 Selected recommendations from development source

Table 4 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 4 to help inform the Committee's discussion.

**Table 4 Specific areas for quality improvement**

| Suggested quality improvement area | Suggested source guidance recommendations |
|---|---|
| **Availability of all four places of delivery location** | **Choosing planned place of birth**<br>NICE CG190 Recommendation 1.1.6 |
| **Supporting informed choice** | **Women at low risk of complications**<br>NICE Intrapartum Care CG190 Recommendation 1.1.2, 1.1.3. |

## Choosing planned place of birth

NICE CG190– Recommendation 1.1.6 (KPI)

Commissioners and providers should ensure that all 4 birth settings are available to all women (in the local area or in a neighbouring area).

## Women at low risk of complications

NICE CG190 Recommendation 1.1.2 (KPI)

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.

NICE CG190 Recommendation 1.1.3

Using tables (CG190 1.1.3 Table 1 and 2) explain to low-risk multiparous women that:

- planning birth at home or in a freestanding midwifery unit is associated with a higher rate of spontaneous vaginal birth than planning birth in an alongside midwifery unit, and these 3 settings are associated with higher rates of spontaneous vaginal birth than planning birth in an obstetric unit

- planning birth in an obstetric unit is associated with a higher rate of interventions, such as instrumental vaginal birth, caesarean section and episiotomy, compared with planning birth in other settings

- there are no differences in outcomes for the baby associated with planning birth in any setting.

### 4.1.3 Current UK practice

In England birth outside an obstetric unit is relatively uncommon with only around 8% giving birth outside an obstetric unit[1]:

- 2.8% giving birth at home

- 3% in alongside midwifery units

- under 2% in freestanding midwifery units.

A report found that over 95% of women are not given and therefore unable to make a choice between home birth, birth centre and an obstetric unit; with the main factor limiting choice is the low use of home birth in the UK. The report further states that the choice of where to give birth empowers women and improves satisfaction with the birth experience[2].

A survey[3] highlighting choice in childbirth found 50% of women agreed with the statement 'I had the birth I wanted'. Additionally, 66% of women who had vaginal births reported they had the birth they wanted compared to 14% of instrumental births and 36% of women who had a caesarean section. However, 21% of women reported that they were not given enough information to adequately make choices about their birth. The figures increased for women who had instrumental or caesarean section births, 26% and 25% respectively.

[1] Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study BMJ 2011; 343 :d7400
[2] Location, location, location. Making choice of place of birth a reality. NCT 2009
[3] Dignity in Childbirth. The dignity survey 2013: Women's and midwives' experiences of UK maternity care .Birthrights Dignity in Childbirth Forum, 16 October 2013.

## *4.2 Transfer of patients between birth locations*

### 4.2.1 Summary of suggestions

Stakeholders identified the need for safe transfer of women between birth settings during established labour. A stakeholder suggested agreed lengths of transfer time may be an area for quality improvement.

### 4.2.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 5 to help inform the Committee's discussion.

**Table 5 Specific areas for quality improvement**

| Suggested quality improvement area | Selected source guidance recommendations |
|---|---|
| **Transfer of patients between birth locations** | **Service organisation and clinical governance**<br>NICE CG190 Recommendation 1.1.15. |

**Service organisation and clinical governance**

NICE CG190– Recommendation 1.1.15

Ensure that all women giving birth have timely access to an obstetric unit if they need transfer of care for medical reasons or because they request regional analgesia.

### 4.2.3 Current UK practice

Available data show a variation in the estimates of intrapartum transfer rates[4]. 21% of women planning births in a freestanding midwifery unit are transferred compared to alongside units where the transfer rate is 26%. A higher proportion of transfers take place during labour in alongside units when compared with freestanding midwifery units and the odds for transfer are twice as great for women with at least one complicating condition[5].

[4] Local guidelines for the transfer of women from midwifery unit to obstetric unit during labour in England: a systematic appraisal of their quality Rachel E Rowe Qual Saf Health Care 2010;19:2 90-94 doi:10.1136/qshc.2008.030239

[5] Rowe R, Fitzpatrick R, Hollowell J, Kurinczuk J. Transfers of women planning birth in midwifery units: data from the Birthplace prospective cohort study. BJOG 2012;119:1081–1090.

## *4.3 Staff support in labour*

### 4.3.1 Summary of suggestions

**One to one care**

Stakeholders highlight the need for midwife or consultant led one-to-one care of women in labour and identifying overstaffing and understaffing. A stakeholder comments that one-to-one care provision increases normal delivery rates and reduces operative deliveries and length of labour.

Stakeholders also comment on the support of continuity of carer as it remains a rare option for women despite the value derived from it.

**Consultant involvement**

A stakeholder suggests that consultant supervision is required at more complex births or with women with more complex needs. The aforementioned clinical situations represent more high risk medical interventions.

**Companions remaining with women after birth**

A stakeholder highlights that women need and want emotional support in hospital after birth, particularly if they are recovering from a difficult labour. Support from a trusted companion can support women's mental well-being and help establish breastfeeding. Moreover, postnatal wards where one midwife can frequently care for up to 16 women are sometimes unable to offer new mothers such basic help. Hospital policies enabling companions to remain overnight must be carefully constructed.

The development for policies or protocol for companions remaining with women is outside the remit for this quality standard.

### 4.3.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 6 to help inform the Committee's discussion.

**Table 6 Specific areas for quality improvement**

| Suggested quality improvement area | Selected source guidance recommendations |
|---|---|
| **One to one care** | **Support in labour**<br>NICE CG190 Recommendation 1.7.1, 1.7.2, 1.7.3 |
| **Consultant involvement** | No recommendations identified |
| **Companions remaining with women after birth** | No recommendations identified |

**Support in labour**

NICE CG190 Recommendation 1.7.1. (KPI)

Provide a woman in established labour with supportive one-to-one care.

NICE CG190 Recommendation 1.7.2.

Do not leave a woman in established labour on her own except for short periods or at the woman's request

NICE CG190 Recommendation 1.7.3.

Team midwifery (defined as a group of midwives providing care and taking shared responsibility for a group of women from the antenatal, through intrapartum to the postnatal period) is not recommended.

**Consultant involvement**

No recommendations identified. A NICE clinical guideline on intrapartum care for the high risk woman is in development.

**Companions remaining with women after birth**

No recommendations identified. A NICE clinical guideline on intrapartum care for the high risk woman is in development.

### 4.3.3 Current UK practice

The Royal College of Midwives' Audit of Midwifery Practice[6] reports the midwife was identified as the key one to one care provider in 92% of labours and the student

[6] Royal College Of Midwives (RCM) 2010 *The Royal College Of Midwives' Audit Of*

midwife in 8% of labours. The report also highlights that one to one care introduces the role of a doula as a provision of support for some women and that this model may become more prominent in the future. Normal practice in the UK is that the midwife would always be present providing care, and a doula would be present in addition to the midwife.

## *4.4 Fetal monitoring*

### 4.4.1 Summary of suggestions

**Cardiotocogprahy (CTG) usage and monitoring**

Stakeholders highlight that CTG monitoring – electronic monitoring of the baby's heartbeat – has not yet shown reduction in neonatal morbidity or mortality. A new approach that takes into account all aspects of treatment for mother and fetus is needed for interpretation.

Stakeholders highlight CTG monitoring should only be applied when concerns are raised about a baby's well-being and where labour is considered high-risk. Moreover, stakeholders suggest that CTG should be removed if the trace is normal for 20 minutes; this is due to the risks associated with CTG use in low-risk labours, restriction in mobility when applied, an increase in anxiety in women during labour and an associated increased epidural rate.

**Fetal blood sampling**

A stakeholder commented that fetal blood sampling is currently used routinely to quantify cardiotocography (CTG). The stakeholder comments that fetal lactate has a higher sensitivity and can be completed at the bedside and requires a smaller sample however acknowledges that current guidance doesn't favour using one over the other.

### 4.4.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 7 to help inform the Committee's discussion.

**Table 7 Specific areas for quality improvement**

| Suggested quality improvement area | Selected source guidance recommendations |
|---|---|
| **Cardiotocogprahy (CTG) usage and monitoring** | **Measuring fetal heart rate as part of initial assessment**<br>NICE CG190 Recommendation 1.4.10 (KPI)<br>**Measuring fetal heart rate**<br>NICE CG190 Recommendation 1.10.2, 1.10.7. |
| **Fetal blood sampling** | **Fetal blood sampling**<br>NICE CG190 Recommendation 1.10.44, |

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

NICE CG190 Recommendation 1.4.10 (KPI)

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**.**

**Measuring fetal heart rate**

NICE CG190 Recommendation 1.10.2

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

NICE CG190 Recommendation 1.10.7

If continuous cardiotocography has been used because of concerns arising from intermittent auscultation but there are no non-reassuring or abnormal features on the cardiotocograph trace after 20 minutes, remove the cardiotocograph and return to intermittent auscultation.

**Fetal blood sampling**

NICE CG190 Recommendation 1.10.44

Measure either lactate or pH when performing fetal blood sampling. Measure lactate if the necessary equipment and suitably trained staff are available; otherwise measure pH.

### 4.4.3 Current UK practice

Intrapartum electronic fetal monitoring is widely practised in the UK and is associated with the almost elimination of unexpected intrapartum fetal mortality[7]. Its use is associated with operative delivery of nonacidotic babies. This results from the focus on morphological appearances of fetal heart rate declarations instead of an understanding on how the fetus is able to defend itself for intrapartum hypoxic events

The Royal College of Midwives' (RCM) Audit of Midwifery Practice[8] found 18% of women reported having had continuous electronic fetal monitoring (CTG) during labour.

[7] Ugwumadu A. Are we (mis)guided by current guidelines on intrapartum fetal heart rate monitoring? Case for a more physiological approach to interpretation. BJOG 2014;121:1063–1070.
[8] Royal College Of Midwives (RCM) 2010 The Royal College Of Midwives' Audit Of Midwifery Practice London : RCM

## *4.5 Delivery health*

### 4.5.1 Summary of suggestions

**Prevention of Obstetric Anal Sphincter Injuries (OASIS)**

Stakeholders suggest the use of episiotomy to prevent obstetric anal sphincter injuries (OASIS). Sustaining tears have long term implications for repair and long term incontinence.

Cutting episiotomies at a 60 degree angle away from the midline crowning can consequently avoid harms such as anal incontinence, stoma and psychological trauma, which are caused by episiotomies that are acutely or laterally angled.

### 4.5.2 Selected recommendations from development source

Table 8 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 8 to help inform the Committee's discussion.

**Table 8 Specific areas for quality improvement**

| Suggested quality improvement area | Selected source guidance recommendations |
|---|---|
| **Prevention of Obstetric Anal Sphincter Injuries (OASIS)** | **Intrapartum interventions to reduce perineal trauma**<br>NICE CG190 Recommendation 1.13.20 |

**Intrapartum interventions to reduce perineal trauma**

NICE CG190 Recommendation 1.13.20

If an episiotomy is performed, the recommended technique is a mediolateral episiotomy originating at the vaginal fourchette and usually directed to the right side. The angle to the vertical axis should be between 45 and 60 degrees at the time of the episiotomy.

### 4.5.3 Current UK practice

Obstetric Anal Sphincter Injuries (OASIs) are an important complication of vaginal delivery and occurrence is rising. McPherson *et al*[9] found OASIs occurred in 3.9% of vaginal deliveries.

[9] McPherson, Karl C., et al. "Can the risk of obstetric anal sphincter injuries (OASIs) be predicted using a risk-scoring system?." *BMC research notes* 7.1 (2014): 471.

Episiotomy is advocated to reduce the risk of anal sphincter injury during delivery as well as regarded necessary in the prevention of perineal trauma during forceps delivery. Episiotomy can also contribute to postnatal morbidity including depression, abnormal sexual function after childbirth and higher rates of perineal pain.

Current practice as evidenced in a study by Tincello *et al*[10] found no difference among midwives and doctors in the median distance of the start of the episiotomy from midline. However when comparing degree of angle when performing episiotomy; a midline start angled at least 40 degrees was performed by 46% of doctors and 33% of midwives. Moreover, 30% and 15% (respectively) drew an episiotomy with a midline start angled 45 degrees or more.

[10] Tincello, Douglas G., et al. "Differences in episiotomy technique between midwives and doctors." *BJOG: An International Journal of Obstetrics & Gynaecology* 110.12 (2003): 1041-1044.

## *4.6 Delayed cord clamping*

### 4.6.1 Summary of suggestions

Stakeholders suggest that delayed cord clamping of at least one minute should be ensured in low risk births if the baby's heart rate is above 60 beats per minute. Additionally, stakeholders highlight that current evidence shows that a 1 minute delay in cord clamping decreases neonatal anaemia, increases the early haemoglobin concentrations and iron stores in babies. It is suggested that early cord clamping has been established practice for many years and this is not in line with current guidance.

### 4.6.2 Selected recommendations from development source

Table 9 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 9 to help inform the Committee's discussion.

**Table 9 Specific areas for quality improvement**

| Suggested quality improvement area | Selected source guidance recommendations |
|---|---|
| **Delayed cord clamping** | **Active and physiological management of the third stage**<br>NICE CG190 Recommendation 1.14.14 (KPI) |

**Active and physiological management of the third stage**

NICE CG190 Recommendation 1.14.14 (KPI)

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.

### 4.6.3 Current UK practice

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

## *4.7 Interventions during labour*

### 4.7.1 Summary of suggestions

Stakeholders comment on the high level of intervention during labour and that the woman rarely returns to the normal care pathway once a complication has resolved. Stakeholders suggest not advising clinical intervention if the labour is progressing normally.

### 4.7.2 Selected recommendations from development source

Table 10 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 10 to help inform the Committee's discussion.

**Table 10 Specific areas for quality improvement**

| Suggested quality improvement area | Selected source guidance recommendations |
|---|---|
| **Interventions during labour** | **First stage of labour**<br>NICE CG190 Recommendation 1.12.1 (KPI) and 1.12.2 |

**First stage of labour**

NICE CG190 Recommendation 1.12.1 (KPI)

Do not offer or advise clinical intervention if labour is progressing normally and the woman and baby are well.

NICE CG190 Recommendation 1.12.2

In all stages of labour, women who have left the normal care pathway because of the development of complications can return to it if/when the complication is resolved.

### 4.7.3 Current UK practice

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

## *4.8 Additional developmental areas*

### 4.8.1 Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However these were felt either to be outside the remit of the quality standard referral and the development source (NICE guidance) or require further discussion by the Committee to establish potential for statement development.

**Development of a care bundle**

A stakeholder comments on the current development of a care bundle to reduce the incidence of third and fourth degree tears through intrapartum interventions in line with the guidance.

The care bundle concerns a method to change practice in line with the guidance. Quality standards should focus on the content of the guideline, not methods to implement it.

**Protocol development to maximise use of alongside maternity units**

A stakeholder highlights the current development of guidance and protocol to maximise the use of alongside maternity units among women at higher risk of complications. The protocol will cover women with healthy pregnancies with underlying risk factors to enable these women to give birth in alongside maternity units. The stakeholder comments that a national lead on this issue is needed in order to ensure guidance is based on good quality evidence and to prompt further rollout of this practice. The stakeholder comments that trusts across England are developing protocols to cover women with a healthy pregnancy and underlying risk factors, such as previous CS or straightforward breech presentation, in order to enable these women to give birth in an AMU.

Quality statements focus on specific measurable actions. Whilst the content of protocols may be suitable for development, the existence of a protocol itself would not be suitable.

**Breastfeeding**

A stakeholder comments on the promotion of breastfeeding immediately after birth in women at increased risk of breastfeeding failure due to administration of drugs during labour.

Breastfeeding is addressed by a separate quality standard on postnatal care

**Neonatal resuscitation**

A stakeholder comments that this is an important area within intrapartum care as current practice is varied and therefore contributes to quality of care, mortality and neurodevelopmental outcome.

Requires further discussion by the Committee to establish potential for statement development.

**Management of premature rupture of membranes and pre-term labour**

A stakeholder highlights the varied practice of the management of premature rupture of membranes (PROM) and its impact on quality of care, mortality and neurodevelopmental outcomes. Another stakeholder comments on the financial consequences of pre-term labour to the NHS as well as the associated high mortality and morbidity rates.

Requires further discussion by the Committee to establish potential for statement development.

**Development of a culture of respect for women**

A stakeholder comments on the development of a culture of respect for individual women and their wishes. Healthcare professionals should ensure there is a culture of respect for women undergoing a significant and emotionally intense life experience. Ensuring a culture where the woman is care for compassionately and appropriate informed consent is sought. The stakeholder further states they would like more guidance on how senior staff can model respect for the women in their care and consideration of their point of view.

The needs of different groups will be considered throughout development of the quality standard. Equality and diversity will be considered for each quality statement to ensure that the statement promotes equality.

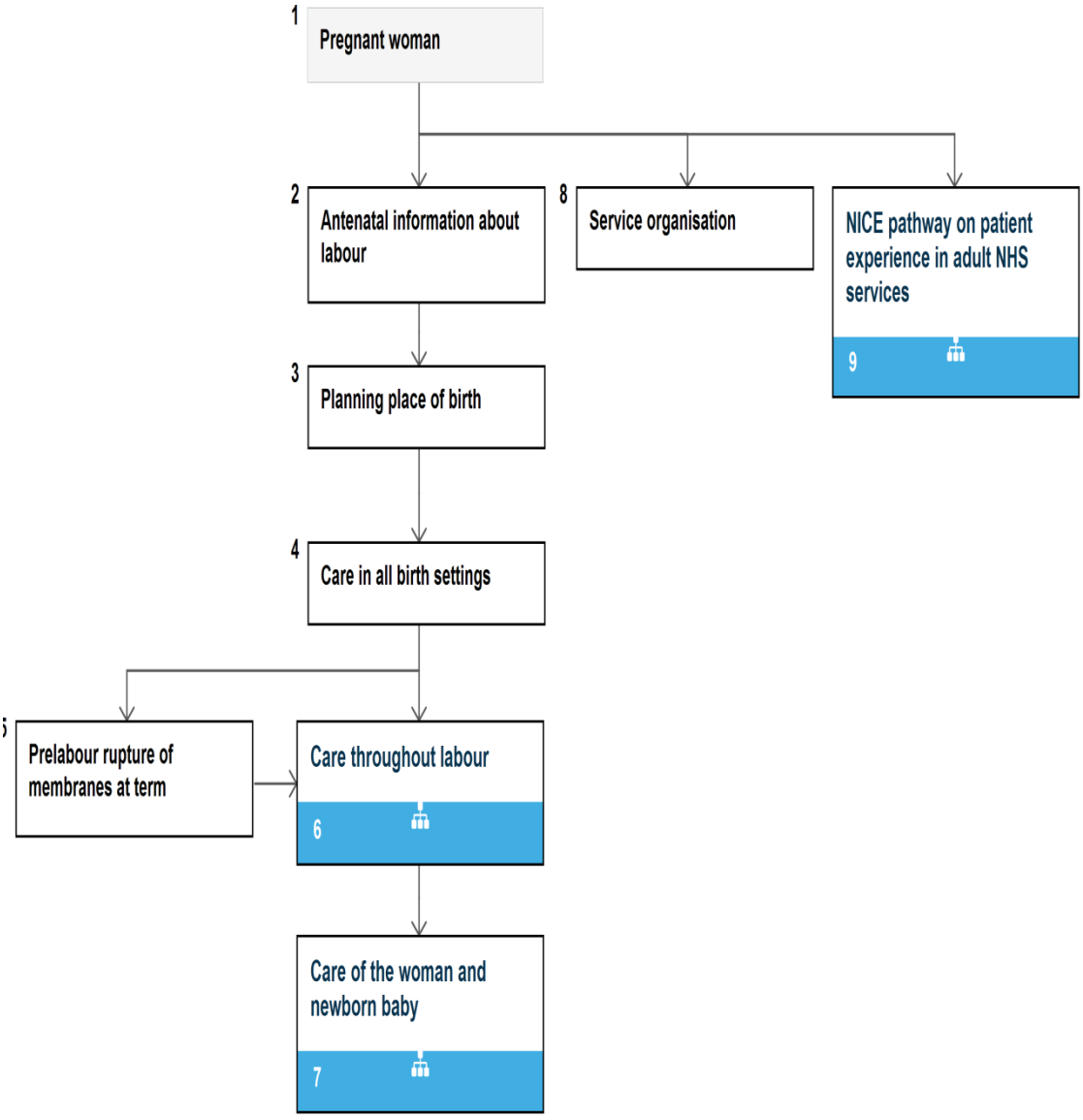
**Elective caesarean section**

A stakeholder comments that a woman's decision to choose a C-section should be respected whether or not the professionals involved in her care believe there is clinical justification for the procedure. It is a feature of maternity care that should respect women's choices and decisions they make about giving birth. Elective caesarean section is covered by the NICE Quality Standard (QS32);

- QSt1: Pregnant women who request a caesarean section (when there is no clinical indication) have a documented discussion with members of the maternity team about the overall risks and benefits of a caesarean section compared with vaginal birth.

- QSt2: Pregnant women who request a caesarean section because of anxiety about childbirth are offered a referral to a healthcare professional with expertise in perinatal mental health support.

# Appendix 1: Care Pathway for Intrapartum Care



## Appendix 2: Key priorities for implementation (CG190)

Recommendations that are key priorities for implementation in the source guideline and that have been referred to in the main body of this report are highlighted in grey.

### *Place of birth*

- 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]
- Commissioners and providers[1] should ensure that all 4 birth settings are available to all women (in the local area or in a neighbouring area). [new 2014]
- Maternity services should
    - provide a model of care that supports one-to-one care in labour for all women

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

- 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.

### *First stage of labour*

- Do not offer or advise clinical intervention if labour is progressing normally and the woman and baby are well.

### *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.

# Appendix 3: Suggestions from stakeholder engagement exercise

**National Institute for Health and Care Excellence**

**Antenatal and postnatal mental health**
**Quality Standard Topic Engagement Comments Table**

| | Name | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
|---|---|---|---|---|---|---|
| | Margaret Ojo | Royal College of Nursing | This is to inform you that the Royal College of Nursing has no comments to submit to inform on the above Quality Standards topic engagement at this time. | | | |
| 4.1 | Jane Munro | The Royal College of Midwives | 1.1.6 Providers and CCGs should ensure that all 4 places of birth should be available to women (Home, FMU, AMU, OU). | Women with uncomplicated pregnancies have better outcomes in midwifery led settings with the same outcomes for their babies as an OU, except for babies of nulligravid women at home. | Current lack of equity across the UK | www.which.co.uk/birthchoice |
| 4.1 | Louise Robertson | SCM | Place of birth | There is evidence that the maternal and foetal outcomes are better when a multiparous woman delivers at home or in a midwifery led unit, either stand alone or alongside and obstetric unit. This is due to reduced numbers of interventions. There is also a potential cost saving associated with | Reduction in neonatal and maternal morbidity and mortality in multiparous women and reduction in cost. Potential for improved satisfaction for mothers through achieving more normal births. Could this possibly increase breastfeeding rates? And potentially reduce patients adverse experiences which has | NICE intrapartum care guidelines 2014<br><br>Schroeder. E, Et al. Cost effectiveness of alternative planned places of birth in woman at low risk of complications: evidence from the Birthplace in England national prospective cohort study. *BMJ* 212; 344: e2292 |

| | Name | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| | | | | such practice that would outweigh the initial start up funding | been shown to increase PND | Birthplace in England Collaborative Group. Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *BMJ* 2011; 343:d4700<br><br>Hodnett E, Et al. Cochrane Pregnancy and Childbirth Group Alternative versus conventional institutional settings for birth Aug 2012 |
| 4.1 | Dr Manish Gupta & Dr Andrew Thomson | Royal College of Obstetricians and Gynaecologists | The proportion of multiparous women delivering at home | The majority of women who have delivered without complications are safe to deliver at home | Birthing at home is associated with better birth experience and lower intervention | NICE guideline – Intrapartum care<br>Dutch birth data |
| 4.1 | Dr Manish Gupta & Dr Andrew Thomson | Royal College of Obstetricians and Gynaecologists | The proportion of nulliparous women delivering in a midwifery led unit | The majority of nulliparous women who have no risk factors complications are safe to deliver at in this location | • There is a reduction in intervention | NICE guideline – Intrapartum care |
| 4.1 | Tracey Cooper | SCM | Key area for quality improvement 1 | Providers and CCGs should ensure that all 4 places of birth should be available to women (Home, FMU, AMU, OU). | Recommendation 1.1.6 in IPC guideline.<br>Women with uncomplicated | Currently all 4 places of birth are not offered across the UK.<br>See www.which.co.uk/birthchoice |

| | Name | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| | | | | | pregnancies have better outcomes in midwifery led settings than an OU, with the same outcomes for their babies as an OU, except for babies of nulligravid women at home. | |
| 4.1 | Sarah Fishburn | SCM | All women should have a choice of all four settings when choosing where to give birth (home, freestanding birth centre, alongside birth centre or obstetric unit) | Women have lower risk of intervention outside obstetric units, and risks to babies are the same or lower out of obstetric units for multiparous woman although slightly higher at home for primiparous women. Not all areas offer all settings for birth, and this therefore presents inequity of provision, and places women who do not have choices at risk of intervention. It is therefore important to set this as a standard so that women can choose where they wish to give birth. | Not all areas currently offer all four choices of place of birth. Some areas could offer these choices if they worked across trust/area boundaries, and this is recommended in the guideline. This will improve quality of care and outcomes and women's choices if implemented. | • NICE intrapartum care guideline |
| 4.1 | Jane Munro | The Royal College of Midwives | 1.1.7 Giving clear information to women and their families about the | Consistency and clarity of information is necessary to restrict the impact of subjective professional opinion. | Information is currently location specific and providers may be biased to the services they currently provide<br><br>There are multiple sources of | CQC maternity survey 2013<br><br>Houghton G et al (2008) Factors influencing choice in birth place–an exploration of the views of women, their partners and professionals. |

| | Name | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| | | | evidence to support their decision making | | evidence documenting women's lack of familiarity and therefore confidence in non-medicalised settings<br><br>Professionals need to improve the presentation of unbiased up-to-date information on birth place and actively promote the full range of options, to overcome these barriers. | *Evidence based midwifery* 10: 59.<br><br>Cooper T and Lavender T (2013). Women's perceptions of a midwife's role: An initial investigation. *British Journal of Midwifery*, *21*(4), 264-273.<br><br>Schroeder, E et al (2012) Cost effectiveness of alternative planned places of birth in woman at low risk of complications: evidence from the Birthplace in England national prospective cohort study *BMJ: British Medical Journal* 344 (2012). |
| 4.1 | Tracey Cooper | SCM | Key area for quality improvement 2 | All women with uncomplicated pregnancies should be given information about place of birth and be informed that:<br>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.<br>Advise low-risk nulliparous women that planning to give | Recommendation 1.1.2 in IPC guideline.<br>Evidence shows multigravida women planning birth at home or in a freestanding midwifery unit is associated with a higher rate of spontaneous vaginal birth than planning birth in an alongside midwifery unit, and these 3 settings are associated with higher rates of spontaneous vaginal birth than planning birth in an obstetric unit. Planning birth in an obstetric unit is associated with a higher rate of interventions, such as instrumental vaginal birth, caesarean section and | Currently women are generally less likely to be aware of the advantages of giving birth for them in a midwifery led setting.<br>Evidence shows that women are more likely to associate places where there is technology and medical staff as a safer option for birth.<br>Refs:<br>CQC maternity survey 2013.<br>Houghton G et al (2008) Factors influencing choice in birth place–an exploration of the views of women, their partners and professionals. *Evidence based midwifery* 10: 59.<br>Cooper T and Lavender T (2013). Women's perceptions of a midwife's |

| | Name | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| | | | | 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. | episiotomy, compared with planning birth in other settings there are no differences in outcomes for the baby associated with planning birth in any setting. In low risk nulligravid women planning birth at home or in a freestanding midwifery unit is associated with a higher rate of spontaneous vaginal birth than planning birth in an alongside midwifery unit, and these 3 settings are associated with higher rates of spontaneous vaginal birth than planning birth in an obstetric unit. Planning birth in an obstetric unit is associated with a higher rate of interventions, such as instrumental vaginal birth, caesarean section and episiotomy, compared with planning birth in other settings. There are no differences in outcomes for the baby associated with planning birth in an alongside midwifery unit, a freestanding midwifery unit or an obstetric unit. Planning birth at home is associated with an overall small increase (about 4 | role: An initial investigation. *British Journal of Midwifery*, *21*(4), 264-273.<br><br>Even though the evidence on outcomes for low risk women shows midwifery led settings are safer for them.<br>Refs:<br>NICE IPC 2014<br>Birthplace in England Collaborative Group, Brocklehurst P, Hardy P, Hollowell J, Linsell L, Macfarlane A, Mccourt C, Marlow N, Miller A, Newburn M, Petrou S, Puddicombe D, Redshaw M, Rowe R, Sandall J, Silverton L, Stewart M. Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. British Medical Journal. 2011;343 |

| | Name | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| | | | | | more per 1000 births) in the risk of a baby having a serious medical problem compared with planning birth in other settings. | |
| 4.1 | Sarah Fishburn | SCM | Women should be offered information about options for place of birth and statistics to support their choice. | Women are often guided to make a choice based on the health professional's personal view rather than evidence. The evidence is now available to show that outcomes are better for all low risk women out of hospital settings, and for babies all settings are equally safe, except home for first time mothers. Women and babies have better outcomes if they give birth out of the obstetric unit setting if they have already had a baby, and the same risks for the woman, and for the baby except if she chooses to birth at home with her first baby. Women may choose to give birth at home for their first baby and their choice should be supported, as the risk, although increased, is still small. | By offering women information they can make an informed choice. | NICE intrapartum care guideline. There are other tools now available to women, eg Which/birth choices tool, but none uses the full range of information which has been used to develop the NICE guideline. |

| | Name | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| 4.1 | Rachel Plachcinski | National Childbirth Trust | Implementing the recommendations on planning place of birth | Where women plan to give birth is a key factor in both the immediate and long term health of mothers, plus the immediate health of the babies of multiparous women, as evidenced in CG190. Supporting informed choice of place of birth for women and their partners has the potential to reduce rates of intervention, improve outcomes for mothers and babies, and improve experiences of maternity services. Avoidance of unnecessary interventions, such as non-clinically-indicated caesarean birth, may also have implications for the future wellbeing of babies. | We know from both formal evidence, and from the conversations NCT practitioners and MSLC reps have with women, that there is a huge variation in how health professionals discuss place of birth with pregnant women and also the choices they present to them.<br><br>The Maternity Services survey (2013) states: "Information needed to make choices was not consistently provided and the choices themselves were not universally offered to women."<br>This applies to all pregnant women, regardless of whether they are classed as at high or low risk of complications.<br><br>We would like to see:<br>- More good quality decision aids made routinely available to women, eg Coxon (2015): Birth place decisions<br>- The development of audit tools that record a | Coxon (2015). Birth place decisions: https://kclpure.kcl.ac.uk/portal/files/33242518/Birth_place_decision_support_Generic_2_.pdf<br><br>NCT (2009). Location, location, location – Making choice of place of birth a reality. P25-26.<br><br>NICE (2014). Intrapartum Care: Care for healthy women and their babies during childbirth.<br><br>Maternity Services Survey 2013: http://www.cqc.org.uk/content/maternity-services-survey-2013 |

| | Name | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| | | | | | woman's choice at booking, at onset of labour, and denial of choice (with reason) at onset of labour | |
| 4.1 | Elizabeth Prochaska | Birthrights | Choice of place of birth | There is good evidence that giving women a choice about where they give birth, including in obstetric units, birth centres and at home, improves both clinical outcomes and women's satisfaction with childbirth. The NICE Intrapartum Care Guideline recommends that all low risk women are given this choice | Despite long-standing Department of Health policy and NICE guidance, many NHS Trusts do not provide women with a choice about where they give birth. Birth centre provision is patchy. Home birth services are often suspended or cancelled. As the evidence in the NICE Guideline makes clear, there is the potential dramatically to improve birth outcomes if women are able to give birth outside obstetric-led units. | NICE Intrapartum Care Guideline (2014).<br><br>Care Quality Commission. National Maternity Survey 2013. www.cqc.org.uk/ public/publications/surveys/2013--national--maternity--survey<br><br>National Federation of Women's Institutes and NCT (May 2013). Support Overdue: Women's Experiences of Maternity Services. www.thewi.org.uk/__data/assets/pdf_Xile/0006/49857/support--overdue--Xinal-15--may--2013.pdf<br><br>Birthrights (2013). Dignity Survey: Women's and Midwives' Experiences of UK Maternity Care. http://www.birthrights.org.uk/wordpress/wp-content/uploads/2013/10/Birthrights-Dignity-Survey.pdf |

| | Name | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| 4.2 | Louise Robertson | SCM | Robust protocols for transfer of care between settings | With the development of Midwifery led units and the potential increase in home births there needs to be and agreed safe way to transfer patients to an obstetric unit should the need arise. There needs to be agreed instances where transfer is advised and length of time taken to transfer should be take into account | 115/1000 women for multiparous women and 450/1000 women for nulliparous women required transfer of care to an obstetric unit. This is a significant figure. Not only are there safety implications for our women but also there may be an effect upon the woman's perception of her labour. | NICE intrapartum guideline 2014<br><br>Birthplace in England Collaborative Group. Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *BMJ* 2011; 343:d4700 |
| 4.2 | Rachel Plachcinski | National Childbirth Trust | Each trust to ensure provision of all four birth settings outlined in CG190, plus transfer protocols and governance arrangements to support the maternity care system and regular audit of availability of all four settings. | As noted above, place of birth is a key factor in the health of mothers and their babies. However, in many areas women struggle to access their choices, particularly birth at home.<br><br>Moving women in established labour from one birth setting to another has the potential to cause significant trauma and, where transfer arrangements are poorly planned and co-ordinated, may also lead to increased morbidity and mortality for both mother and baby. | There is a current lack of integration in many areas, for example obstetric and delivery suite teams may not see home birth as part of the regular 'local offer', and this may in turn affect the confidence of both mothers and home birth midwives, and the safety of the service. Home birth and community midwifery teams are regularly shut down in order to ease staffing issues at obstetric units.<br><br>NCT practitioners report that many women are put off considering either home birth or birth in a freestanding MLU due to uncertainty about or lack of confidence in transfer | Dodwell and Gibson (2009). An Investigation into Choice of Place of Birth. NCT<br><br>NCT (2009). Location, location, location – Making choice of place of birth a reality.<br><br>Rowe RE. Local guidelines for the transfer of women from midwifery unit to obstetric unit during labour in England: a systematic appraisal of their quality. Quality and Safety in Health Care 2010; 19:90-94.<br><br>Rowe RE, Fitzpatrick R, Hollowell J, Kurinczuk JJ. Transfers of women planning birth in midwifery units: data from the Birthplace prospective cohort study. BJOG 2012;119:1081– |

| | Name | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| | | | | | arrangements Women's confidence in choosing out of hospital settings depends on knowing that an integrated system will support transfer if needed and how this will work. | 1090<br><br>Rowe RE, Kurinczuk JJ, Locock L, Fitzpatrick R. Women's experience of transfer from midwifery unit to hospital obstetric unit during labour: a qualitative interview study. BMC Pregnancy and Childbirth 2012 12:129<br><br>McCourt C, Rayment J, Rance, Sandall J (2012). Organisational strategies and midwives' readiness to provide care for out of hospital births: An analysis from the Birthplace organisational case studies. Midwifery, 28 (5), p636–645. |
| 4.3 | Jane Munro | The Royal College of Midwives | 1.7 Maternity services should provide a model care that supports one to one care in labour for all women and benchmark services and identifying overstaffing and understaffing | The value of one to one care is well documented. This entails providing continued and holistic support throughout labour regardless of whether the woman is under midwifery led care or obstetric led care. | Surveys continue to document that the provision of one to one care throughout labour is very variable. | CQC Survey 2013<br><br>http://www.safetythermometer.nhs.uk/index.php?option=com_dashboards&view=maternity&Itemid=400 |

| | Name | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| 4.3 | Louise Robertson | SCM | One to one care in all birth settings | One to one care in labour has been shown to reduce LSCS rates, operative deliveries, analgesic requirements, and length of labour and increase normal delivery rates. | Current reduction in midwifery staffing levels lead to less one-one care in labour, which may be accounting for the increased use of epidurals and operative births. If we could increase midwifery staffing we may be able to provide better outcomes for patients and increase satisfaction levels | NICE intrapartum care guideline 2014<br><br>Hodnett ED, Gates S, Hofmeyr GJ, et al. (2011) Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews* Issue 2. Chichester: John Wiley and Sons Ltd<br><br>Evidence Based Guidelines for Midwifery-Led Care in Labour ©The Royal College of Midwives 2012 |
| 4.3 | Tracey Cooper | SCM | Key area for quality improvement 3 | One to one care should be given by a midwife during established labour. | NICE IPC Recommendation 1.1.14 and Safe Staffing for Maternity Care guideline: 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. | Due to staffing problems in NHS Trusts, one to one care in labour can not always be provided and this should be viewed as a priority to safe care.<br>CQC Survey 2013<br>http://www.safetythermometer.nhs.uk/index.php?option=com_dashboards&view=maternity&Itemid=400 |
| 4.3 | Rachel Plachcinski | National Childbirth Trust | The organisation of maternity services in each trust should provide a model of care that supports | CG190 details the evidence on the benefits of one-to-one care for mothers and babies. | The 2013 Maternity Services Survey details the number of women who did not receive one-to-one care throughout labour:<br>□ 13% of women felt that they were left alone at a time that worried them during early labour, | Maternity Services Survey 2013:<br>http://www.cqc.org.uk/content/maternity-services-survey-2013 |

| | Name | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| | | | one-to-one care in labour for all women, through use of appropriate workforce planning | | □ 9% during the later stage of labour,<br>□ 2% during the birth, and<br>□ 9% shortly after the birth. | |
| 4.3 | Dr Sturgiss and Dr Simpson on behalf of the North East and Cumbria SCN and Matthew Jolly | NHS England | Consultant attendance / supervision at more complex births – eg trials, CS at full dilatation, praevia etc | These clinical situations represent some of the most high risk medical interventions in maternity care provision | | |
| 4.3 | Dr Sturgiss and Dr Simpson on behalf of the North East and Cumbria SCN and Matthew Jolly | NHS England | Consultant involvement with women who have complex care needs, as stated in the NICE IP guidance | Informing a Consultant Obstetrician if any FBS result is abnormal<br><br>Discussion with a Consultant if an FBS cannot be obtained or a third FBS is thought to be needed | | NICE IP guidance 190 |
| 4.4 | Elizabeth | Birthrights | Electronic fetal | The utility of EFM as a | Routine use of EFM does not | NICE Intrapartum Care Guideline |

| | Name | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| | Prochaska | | monitoring (EFM) | predictive tool in maternity care has recently been called into question in the NICE Intrapartum Care Guideline. Its deleterious effect on women's labour and birth outcomes is well-established. The selective use of EFM in high-risk labours may be justified, but the risks of its use in low risk labours significantly outweigh any benefits.<br><br>Women who receive EFM are rarely informed of the paucity of evidence supporting its use or the risks that it poses. It continued use in these circumstances is a widespread violation of the principle of informed consent. | confer any clinical benefit and is likely to cause significant harm. The failure to give women adequate information about EFM violates basic principles of medic ethics and consent. Guidance on use of EFM, including guidance on the information that should be shared with women, is critical to ensure that it is properly used. | (2014).<br><br>Ugwumadu A (2014). Are we (mis)guided by current guidelines on intrapartum fetal heart rate monitoring? Case for a more physiological approach to interpretation. BJOG: An International Journal of Obstetrics and Gynaecology, 121(9):1063-70. http://onlinelibrary.wiley.com/doi/10.1111/1471-0528.12900/abstract<br><br>Sartwelle TP, Johnston JC (2014). Cerebral Palsy Litigation: Change Course of Abandon Ship. *J Child Neurol* September 2, 2014. http://jcn.sagepub.com/content/early/2014/09/01/0883073814543306.full.pdf+html<br><br>Sartwelle, TP, Electronic Fetal Monitoring: A Defense Lawyer's View, Rev Obstet Gynecol. 2012; 5(3-4): e121–e125. |
| 4.4 | Louise Robertson | SCM | Foetal Lactate vs. Foetal Blood Sampling | FBS is used to quantify interpretation of the CTG. It takes on average 20mins to perform, has a significant failure rate and is not particularly sensitive. | Cost analysis shows minimal difference (slightly less for lactate) however; increased success rate with lactate may be more acceptable to the women and lead to less intervention. | NICE intrapartum guideline appendix A Pages 38-42<br><br>RGOG Scientific impact paper 47 Jan 2014 – Is it time for UK Obstetricians to accept foetal scalp |

| | Name | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| | | | | Foetal lactate requires a smaller sample, is proposed to take a shorter time, allows diagnosis at the bedside and has a higher sensitivity. Current NICE guidance recommends their usage in labour and does not favour one over the other but suggests more research in the area. | There is some evidence that lactate is a better predictor of foetal outcomes which I believe needs further investigation as this could be an important consideration | lactate as an alternative to scalp pH? |
| 4.4 | Louise Robertson | SCM | CTG interpretation | CTG monitoring has not yet been shown to reduce neonatal morbidity/mortality and has been shown to increase operative delivery. A new approach to CTG interpretation is needed, as we are not getting it right. A whole patient approach – treating the patient and not the CTG is required. | CTG usage is increasing as more women are becoming high risk (rising obesity levels, gestation diabetes, heart disease etc) and so is the caesarean section rate. | Alfirevic Z, Devane D, Gyte GM. Pregnancy and Childbirth Group Chocrane review Comparing continuous electronic fetal monitoring in labour (cardiotocography, CTG) with intermittent listening (intermittent auscultation, IA) 2013<br><br>NICE intrapartum care guideline 2014 |
| 4.4 | Sarah Fishburn | SCM | If a woman has had a CTG monitor applied because of concerns about fetal wellbeing, the midwife should remain in the room with the woman | Women often report having CTG applied and then being left alone. This means that although the baby has been considered to be at risk, there is nobody supporting and monitoring the woman directly, which is recommended in the guideline based on | Monitoring the woman and her baby by being present in the room with her will improve her experience, and also may pick up deterioration more effectively than if the midwife is not present in the room. | NICE intrapartum care guideline |

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| | | | throughout monitoring, and this should be audited. | evidence. | | |
| 4.4 | Rachel Plachcinski | National Childbirth Trust | That all trusts have rigorous protocols for CTG use which are routinely audited for staff compliance | CG190 contains several new recommendations with regard to use of CTG:<br>* Measuring fetal heart rate as part of initial assessment - 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]<br>* Interpretation of cardiotocograph traces - Do not make any decision about a woman's care in labour on the basis of cardiotocography findings alone. [new 2014]<br>* If continuous cardiotocography has been used because of concerns arising from intermittent auscultation but there are no non reassuring or abnormal features (see table 10) on the | Poor practice persists in many units despite the strong body of evidence on the appropriate use of CTG to monitor the fetal heart.<br><br>CG190 highlights a modified approach to using CTG in which the trace alone is not to be used as a basis for decisions about care, and a robust approach needs to be taken to ensure that a prevailing culture is challenged and this new, evidence-based approach is adopted. | Chapter 10 of CG190: Intrapartum Care: Care for healthy women and their babies during childbirth.<br><br>Mead, Kornbrot (2004). The influence of maternity units' intrapartum intervention rates and midwives' risk perception for women suitable for midwifery-led care. Midwifery, 20 (1), p61-71. |

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| | | | | cardiotocograph trace after 20 minutes, remove the cardiotocograph and return to intermittent auscultation. [new 2014]<br>The full guideline (Ch 10) concludes that too much confidence is placed on EFM using CTG, and that poor practice (such as admission CTG for women at low risk of complications) persists. This may result in iatrogenic harm through unnecessary intervention. | | |
| 4.4 | Sarah Fishburn | SCM | CTG monitoring should only be applied where there is a concern about the baby's wellbeing, and should be removed if the trace is normal for 20 minutes. | CTG monitoring restricts women's mobility, increases anxiety, and is often used as a "treatment" which it is not as it only shows when an adverse event has occurred and does not predict when one might occur. | Unnecessary monitoring affects women's experience of labour and birth adversely and increases anxiety. | |
| 4.4 | Dr Manish Gupta & Dr Andrew Thomson | Royal College of Obstetricians and Gynaecologis | The proportion of women who require EFM | There are a number of indications which have changed for EFM in particular a reduction in indication. | EFM is associated with unnecessary intervention particularly caesarean section | NICE guideline – Intrapartum Care |

| | Name | Stakeholder | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| 4.4 | Louise Robertson | SCM | Telemetry for continuous monitoring | Continuous monitoring is required in an increasing number of women and is associated with an increased intervention rate. This has been partly attributed to a reduction of mobilisation in labour. | Many women who are advised continuous monitoring in my experience express a concern about the restriction it places upon their movement.<br>It has been suggested that lack of mobilisation increases operative birth, pain and reduces patient satisfaction in labour. There is an increase in epidural rate associated with CTG monitoring.<br>Cost effectiveness analysis shows that changing to a telemetry system for CTG | NICE intrapartum guideline 2014 appendix a page 33-38<br><br>Lawrence A, Lewis L, Hofmeyr GJ, Dowswell T, Styles C Chocrane Review group Maternal positions and mobility during first stage labour (Review) 2009 |
| 4.5 | Dr Manish Gupta & Dr Andrew Thomson | Royal College of Obstetricians and Gynaecologists | The use of episiotomy to prevent obstetric anal sphincter injuries (OASIS).<br><br>The proportion of women who experience third or fourth degree tears | Sustaining these tears has implication for repair and long term continence<br><br>*Episiotomy to prevent OASIS.* The HES data showed that the use of episiotomy was associated with the lowest rate of OASIS. In addition they state that the 'the reluctance to use episiotomy' might have contributed to the increased incidence of OASIS seen | Sustaining these tears has implication for repair and long term continence.<br><br>As part of a package of preventative measures e.g. as used in Norway, an episiotomy performed at 45-60 degrees to the midline should be considered in women at risk of trauma and OASIS. Such risk groups have been defined (Power et al 2006).<br>As mentioned data suggest that episiotomy can be preventative | NICE guideline – Intrapartum Care RCOG GTG – Third and Fourth Degree Tears<br><br>Current NICE guidance states that if episiotomy is to be performed, the recommended technique is a mediolateral episiotomy originating at the vaginal fourchette and usually directed to the right side. The angle to the vertical axis should be between 45 and 60 degrees at the time of the episiotomy. However, this is not always being carried out in current practice (Eogan et al 2006, |

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| | | | | over a 10 year period (Gurol-Urganci et al 2013). Data suggest that episiotomy rates have fallen in recent years and that many midwives have not been taught the technique. | for OASIS. However in recent years the numbers performed have dropped and many midwives and obstetricians have not been taught the correct technique of 45-60 degree episiotomy (Trochez et al 2011). This has the potential along with manual perineal protection to reduce OASIS rates further. | Kalis et al 2008). |
| 4.5 | Dharmesh Kapoor | Royal Bournemouth Hospital | Ensuring episiotomies are cut at 60 degrees away from the midline at crowning. | To prevent avoidable harm (Obstetric Anal Sphincter Injuries (OASIS)) caused by episiotomies that are angled very acutely, or angled too laterally.<br><br>Consequent avoidable harms:<br>-anal incontinence<br>- dyspareunia<br>- psychological trauma<br>- anorectal-vaginal fistula<br>- Caesarean section is subsequent pregnancy<br>- need for secondary repair<br>- Cosmetic reconstruction especially after cloacal like defect<br>- SNS (sacral nerve stimulation)<br>- stoma | Obstetric Anal Sphincter Injuries (OASIS) are a moderate-to-severe harm injury in the NHS Patient Safety classification. They occur in 6% of first vaginal births. Upto 40% of women with OASIS develop Anal Incontinence (AI).<br><br>Obstetric anal sphincter injuries (OASIS) are caused by episiotomies resulting too close to the midline ($<30^0$), which can mechanically disrupt the anal sphincter. The average angle in OASIS cases was 26 degrees [Andrews 2006] and 30 degrees [Eogan 2006] respectively, while in controls, the angle was 38 degrees in both studies.<br><br>The incidence of OASIS was | Please see the Royal College of Obstetricians and Gynaecologists (RCOG) GTG 29 revision (peer-reviewed draft-Oct 2014). It states “Where episiotomy is indicated, the mediolateral technique is recommended, with careful attention to ensure that the angle is 60 degrees away from the midline when the perineum is distended. [D]”<br><br>Tincello DG, Williams A, Fowler GE, Adams EJ, Richmond DH, Alfirevic Z. Differences in episiotomy technique between midwives and doctors.BJOG2003;110:1041-4<br><br>Freeman RM et al. Cutting a Mediolateral Episiotomy at the Correct Angle: Evaluation of a new device: The Episcissors-60. Med |

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| | | | | | 10% if the post-delivery sutured episiotomy angle was < $25^{o}$ and 0.5% if the angle was ≥ $45^{o}$. The authors also found that the incidence of OASIS reduces by 50% for every $6^{o}$ the episiotomy is away from the midline [Eogan 2006].<br><br>OASIS are also caused by episiotomies too far from the midline (>$60^{0}$), as these fail to relieve the pressure on the perineum [Stedenfeldt 2012]. To reduce OASIS, episiotomies need to be within the post-delivery *SAFETY ZONE* of 40-$60^{0}$.<br><br>Current practice of performing episiotomies is by 'eyeballing' the angle.<br><br>It appears that the majority of episiotomies are not truly mediolateral but closer to the midline'. Andrews et al (BJOG 2005) found 'No midwife and only 22% of doctors performed truly mediolateral episiotomies. Only 13% of the episiotomies were found to be more than 40 | Devices (Auckl). 2014 Feb 21;7:23-8. doi: 10.2147/MDER.S60056. eCollection 2014<br><br>Patel R et al. Evaluation of the angled EPISCISSORS-60® episiotomy scissors in spontaneous vaginal deliveries: A case series. Med Devices (Auckl). 2014: In press<br><br>Eogan M, Daly L, O'Connell PR and O'Herlihy C. Does the angle of episiotomy affect the incidence of anal sphincter injury? BJOG 2006; 113: 190-4.<br><br>Stedenfeldt 2012) (Stedenfeldt M, Pirhonen J, Blix E, Wilsqaard T, Vonen B, Qian P. Episiotomy characteristics and risks for obstetric anal sphincter injury: a case-control study. BJOG 2012; 119:724-30<br><br>Revicky V, Nirmal D, Mukhopadhyay S, Morris EP and Nieto JJ. Could a mediolateral episiotomy prevent obstetric anal sphincter injury? European J Obstet Gynecol Reproductive Biol 2010; 150: 142-6. 2 |

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| | | | | | degrees.<br><br>An earlier study found doctors and midwives are unable to correctly estimate the angles even on paper. Only one-third of episiotomies were> $40^0$ [Tincello 2003].<br><br>There is a significant difference between the incision angle and suture angle of the episiotomy. Perineal distension/stretching at crowning necessitates that the incision angle should be greater than the suture angle to the extent of 15-30 degrees [Kalis 2008, Kalis 2011, Zemncik 2012, Eliashiv 2013, El-Din 2014].<br><br>NICE's recommendation for the episiotomy angle in 2007 was 45-60 degrees at the time of giving the episiotomy. If accoucheurs follow the NICE guidance, then they could be performing episiotomies that result in being too close to the midline, and be more likely to cause OASIS. | Kalis V, Karbanova J, Horak M, Lobovsky L, Kralickova M and Rokyta Z. The incision angle of mediolateral episiotomy before delivery and after repair. International J Gynecol Obstet. 2008; 103: 5-8.<br><br>Kalis V, Landsmanova J, Bednarova B, Karbanova J, Laine K and Rokyta Z. Evaluation of the incision angle of mediolateral episiotomy at 60 degrees. Int J Gynecol Obstet 2011; 112: 220-4<br><br>Fodstad K et al. Int Urogynecol J 2013;24:865-72<br><br>Deering SH. Perineal body length and lacerations at delivery. J Reprod Med 2004;49: 306-10<br><br>Geller EJ. Perineal body length as a risk factor for ultrasound-diagnosed anal sphincter tear at first delivery. Int Urogynecol J 2014;25:631-6<br><br>Gurol-Urganci I, Cromwell D, Edozien L, Mahmood T, Adams E, Richmond D, Templeton A, van der Meulen J. Third- and fourth-degree perineal tears among primiparous |

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| | | | | | NICE needs to review this recommendation in light of the above evidence. | women in England between 2000 and 2012: time trends and risk factors. BJOG Nov 2013;<br><br>Andrews V, Sultan AH, Thakar R and Jones PW. Occult anal sphincter injuries-myth or reality? BJOG 2006; 113: 195-200.<br><br>Andrews V, Thakar R, Sultan AH and Jones PW. Are mediolateral episiotomies actually mediolateral? BJOG 2005; 112: 1156-8.<br><br>Zemnick R, Karbanova R, Kalis V, Lobovsky L. Stereophotogrammetry of the perineum during vaginal delivery. Int J Gynecol Obstet 2012; 119:76-80 |
| 4.6 | Jane Munro | The Royal College of Midwives | 1.14<br>Delayed cord clamping of at least 1 minute should be ensured at low risk births, if heart rate above 60 beats per min. | Current evidence demonstrates benefits to the newborn following delayed cord clamping which<br>increases early haemoglobin concentrations and iron stores in infants. | Early cord clamping has been established practice for decades in the majority of units, this is likely to make it hard to change. | Royal College Of Midwives *(*RCM) 2010 *The Royal College Of Midwives' Audit Of Midwifery Practice* London RCM<br><br>McDonald, S et al. "Effect of timing of umbilical cord clamping of term infants on maternal and neonatal outcomes." *Evidence-Based Child Health: A Cochrane Review Journal* 9.2 (2014): 303-397. |

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| 4.6 | Dr Manish Gupta & Dr Andrew Thomson | Royal College of Obstetricians and Gynaecologists | The proportion of women who have delayed cord clamping and a modified active 3rd stage of labour | 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.<br><br>Delayed cord clamping reduces neonatal anaemia | Delayed cord clamping reduces neonatal anaemia.<br><br>Evidence of harm from early cord clamping. | NICE guideline – Intrapartum Care<br><br>RCOG Scientific Impact Paper February 2015 – Delayed Cord Clamping |
| 4.6 | Tracey Cooper | SCM | Key area for quality improvement 4 | Delayed cord clamping of at least 1 minute should be ensured at low risk births, if heart rate above 60 beats per min. | NICE IPC guideline recommendation 1.14.14<br>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. | This is not generally part of current practice across the UK.<br>Refs:<br>Royal College Of Midwives *(*RCM) 2010 *The Royal College Of Midwives' Audit Of Midwifery Practice* London RCM<br>McDonald, S et al. "Effect of timing of umbilical cord clamping of term infants on maternal and neonatal outcomes." *Evidence-Based Child Health: A Cochrane Review Journal* 9.2 (2014): 303-397. |
| 4.6 | Sarah Fishburn | SCM | Cord clamping should be carried out after one minute after birth | This improves outcomes for babies. | There is currently variable delay prior to cord clamping, which is not based on evidence. | NICE intrapartum care guideline |
| 4.7 | Jane Munro | The Royal College of | 1.12<br>Do not offer or | There is a high level of intervention in labour and it | This is despite the growing evidence base that associates | Souza J et al (2010) Caesarean section without medical indications is |

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| | | Midwives | advise clinical intervention if labour is progressing normally<br><br>..women who have left the normal care pathway because of the development of complications can return to it if/when the complication is resolved. | is rare that women return to the normal care pathway when a complication has resolved | interventions in labour and birth, including mode of birth, use of oxytocin, and use of antibiotics to increased risk of longer-term non-communicable autoimmune disorders, such as type one diabetes, multiple sclerosis, asthma, eczema, and even some cancers, and to so-called 'lifestyle' disorders, such as obesity. | associated with an increased risk of adverse short-term maternal outcomes: the 2004-2008 WHO Global Survey on Maternal and Perinatal Health. *BMC Med* 8:71.<br><br>Dahlen H (2013) The EPIIC hypothesis: intrapartum effects on the neonatal epigenome and consequent health outcomes. *Med Hypotheses* 2013; 80:656-62.<br><br>Conrad P, Mackie T, Mehrotra A. (2010) Estimating the costs of medicalization. *Soc Sci Med* 70: 1943-7. |
| 4.7 | Tracey Cooper | SCM | Key area for quality improvement 5 | There is a high level of intervention in labour and it is rare that women return to the normal care pathway when a complication has resolved | NICE IPC guideline Recommendation 1.12.1<br>Do not offer or advise clinical intervention if labour is progressing normally<br>Recommendation 1.12.2<br>..women who have left the normal care pathway because of the development of complications can return to it if/when the complication is resolved | There is growing evidence that intervention is creating more harm. There are associations of interventions in labour and birth, including mode of birth, use of oxytocin, and use of antibiotics which is leading to increased risk of longer-term non-communicable autoimmune disorders, such as type one diabetes, multiple sclerosis, asthma, eczema, and even some cancers, and to so-called 'lifestyle' disorders, such as obesity |

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| | | | | | | Refs:<br>Souza J et al (2010) Caesarean section without medical indications is associated with an increased risk of adverse short-term maternal outcomes: the 2004-2008 WHO Global Survey on Maternal and Perinatal Health. *BMC Med* 8:71.<br>Dahlen H (2013) The EPIIC hypothesis: intrapartum effects on the neonatal epigenome and consequent health outcomes. *Med Hypotheses* 2013; 80:656-62.<br>Conrad P, Mackie T, Mehrotra A. (2010) Estimating the costs of medicalization. *Soc Sci Med* 70: 1943-7. |
| 4.8 | Dr Manish Gupta & Dr Andrew Thomson | Royal College of Obstetricians and Gynaecologists | Additional developmental areas of emergent practice | | The RCOG and the RCM are currently in the process of developing a care bundle to prevent the occurrence of third and fourth degree tears through intrapartum interventions. Though this is not being introduced as a formal training program, there will be an element of training, inspired by the work in Norway. The ultimate goal is to reduce the incidence of the incidence of third and fourth degree tears | |

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| | | | | | through interventions which are already supported by current evidence. | |
| 4.8 | Rachel Plachcinski | National Childbirth Trust | Additional developmental areas of emergent practice<br><br>Development of guidance / protocols to maximise use of alongside maternity units by women at higher risk of complications | Place of birth also appears to have significant impact in reducing intervention rates, and improving outcomes, in women and babies at higher risk of complications. (Li et al, 2015). | Trusts across England are developing protocols to cover women with a healthy pregnancy and underlying risk factors, such as previous CS or straightforward breech presentation, in order to enable these women to give birth in an AMU. It has also been suggested that the majority of women who plan to freebirth do so because of the lack of options and support available to them through the NHS (Edwards & Kirkham, 2012).<br><br>A national lead on this issue is needed in order to ensure guidance is based on good quality evidence and to prompt further rollout of this practice. | Li, Townend, Rowe et al (2015). Perinatal and maternal outcomes in planned home and obstetric unit births in women at 'higher risk' of complications: secondary analysis of the Birthplace national prospective cohort study. BJOG, DOI: 10.1111/1471-0528.13283.<br><br>Edwards & Kirkham (2012). Why women might not use NHS maternity services. Essentially Midirs, 3(9). |
| 4.8 | Jane Munro | The Royal College of Midwives | Additional developmental areas of emergent practice | There is a real need to highlight the importance of continuity of carer | Despite the known value of continuity of carer it remains a rare option for women. | CQC maternity survey 2013<br><br>National Federation of Women's Institute and National Childbirth Trust (NFWI) (2013) *Support overdue: Women's experiences of maternity Services* London: NFW |

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| | | | | | | Healthcare Commission (2008). *Towards better births: a review of maternity services in England.* The commission for healthcare Audit and Inspection<br><br>Royal College Of Midwives (RCM) (2015) *Audit of practice in postnatal care*<br>London: RCM<br><br>Sandall J et al (2013) Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Database Syst Rev* 8: CD004667. |
| 4.8 | Tracey Cooper | SCM | Additional developmental areas of emergent practice | Supporting continuity of care | Despite the known value of continuity of carer it remains a rare option for women | Refs:<br>CQC maternity survey 2013<br>National Federation of Women's Institute and National Childbirth Trust (NFWI) (2013) *Support overdue: Women's experiences of maternity Services* London: NFW<br>Healthcare Commission (2008). *Towards better births: a review of maternity services in England.* The commission for healthcare Audit and Inspection<br>Royal College Of Midwives (RCM) (2015) *Audit of practice in postnatal* |

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| | | | | | | *care*<br>London: RCM<br>Sandall J et al (2013) Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Database Syst Rev* 8: CD004667 |
| 5 | Sue Jordan and Susanne Darra | Swansea University | 14.7 Care immediately after birth: promotion of breastfeeding: offering additional support to women at increased risk of breastfeeding failure due to administration of multiple drugs in labour. | The benefits of breastfeeding for both infants and mothers underlie World Health Organisation (2003) and UK (UNICEF UK 2009) policies, recommending exclusive breastfeeding for the first six months. However, the UK's low breastfeeding rates, particularly outside England (McAndrew et al 2012), are an intransigent problem. | Identifying women at risk of failing to breastfeed, despite their intentions, might reduce the disruption to the physiological processes underlying breastfeeding induced by opioids and uterotonics.<br>The more medicines a woman has received in labour, the less likely she is to breastfeed (Jordan et al 2009). Such women can be easily identified and offered expert and practical help and reassurance. | The dose-response relationship between epidural fentanyl and breastfeeding at discharge is acknowledged (Jordan et al 2005, Beilin et al.) Women exposed to active management of third stage of labour (Brown & Jordan 2014) or complications of labour (Brown & Jordan 2013) are less likely to sustain breastfeeding.<br><br>Our (Jordan et al 2009) research recommendations for a large trial of active vs. physiological management of third stage are adopted on p.671 of the 2014 Intrapartum care guideline.<br>References<br><br>Brown AE., Jordan S. 2013 Impact of Birth Complications on Breastfeeding duration: an internet survey. Journal of Advanced Nursing. 69(4):828-39 DOI: 10.1111/j.1365-2648. |

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| | | | | | | Brown A, Jordan S. (2014) Active Management of the Third Stage of Labor May Reduce Breastfeeding Duration Due to Pain and Physical Complications. Breastfeed Med.2014 Volume 9, Number 10, 2014 Oct 27. [Epub ahead of print]<br>Jordan S, Emery S, Watkins A, Evans J, Storey M, Morgan G. Associations of drugs routinely given in labour with breastfeeding at 48 hours: analysis of the Cardiff Births Survey. BJOG 2009; 116(12) 1622-30<br>Jordan S., Emery S., Bradshaw C., Watkins A., Friswell W. 2005 The Impact of Intrapartum Analgesia on Infant Feeding. BJOG: An International Journal of Obstetrics and Gynecology. 112, 927-34.<br>McAndrew F., Thompson J., Fellows L., Large A., Speed M. and Renfrew MJ (2012) The Infant Feeding Survey 2010. NHS Information Centre for Health and Social Care, Office of National Statistics available: http://data.gov.uk/dataset/infant-feeding-survey-2010 accessed 22.6.13<br>UNICEF UK 2009 Baby Friendly |

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| | | | | | | Initiative: Developing a Breastfeeding Strategy. UNICEF UK, London. Available: http://www.unicef.org.uk/Documents/Baby_Friendly/Guidance/4/Strategy_Appendix.pdf accessed 10.7.13<br>World Health Organisation (2003). Global strategy for infant and young child feeding. 55th World Health Assembly. Geneva, Switzerland. |
| 6 | Aung Soe | The Royal College of Paediatrics and Child Health | Neonatal resuscitation | This is an important area within Intrapartum care | Variable Practices; important factor for quality of care, mortality and neurodevelopmental outcome | UK Resuscitation Council: NLS |
| 7 | Aung Soe | The Royal College of Paediatrics and Child Health | Observation on babies in the presence of Meconium and born to women with PROM at term | Linked to Intrapartum care | Variable Practices; important factor for quality of care, mortality and neurodevelopmental outcome | UK Resuscitation Council: NLS<br><br>NICE guidelines: Antibiotics for early-onset neonatal infection: Antibiotics for the prevention and treatment of early-onset neonatal infection 2012 (CG149)<br><br>NICE quality standard Antibiotics for neonatal infection 2014 (QS 75) |
| 8 | Dr Sturgiss and Dr | NHS England | Intrapartum management of pre-term labour | Pre-term birth associated with high morbidity and mortality | Significant financial consequences to the NHS | http://www.nice.org.uk/guidance/indevelopment/gid-cgwave0660 |

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| | Simpson on behalf of the North East and Cumbria SCN and Matthew Jolly | | | | | |
| 9 | Rachel Plachcinski | National Childbirth Trust | To ensure the development of a culture of respect for individual women, their needs and wishes | "Giving birth is a life-changing event." (NICE, CG190)<br>The updated guideline provides two new recommendations:<br>• 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]<br>• Senior staff should demonstrate, through their | 34% of respondents to the 2013 Maternity Services Survey reported that they were not always treated with kindness and understanding, and this was more likely among primiparous women.<br><br>We would like to see more guidance on how senior staff can model respect for the women in their care and consideration of their point of view, for example through joint working at groups such as Maternity Services Liaison Committees (MSLCs). A joint statement from RCM, RCOG and NCT notes: "For nearly 30 years, Maternity Services Liaison Committees (MSLCs) have been the means by which service users have been able to | Maternity Services Survey 2013: http://www.cqc.org.uk/content/maternity-services-survey-2013<br><br>Maternity services liaison committees (MSLCs): a consensus statement from NCT, RCM and RCOG<br>Our shared views on the importance of engaging with women and their partners in the planning and monitoring of maternity services and the role played by MSLCs. Available online at: https://www.nct.org.uk/sites/default/files/related_documents/MSLC%20document%202013%20web.pdf |

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| | | | | 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] | make those contributions. They have an excellent track record: maternity services have changed to meet the expressed needs of women, and their partners and babies, more than any other service. This is due, at least in part, to the unique approach of MSLCs, and their consensual, multidisciplinary ethos."<br><br>Changes to the NHS commissioning structure have led to MSLCs in some areas being marginalised or dismissed in favour of user groups such as Healthwatch, however this leads to the loss of a multi-disciplinary approach where women and maternity services professionals are brought together to debate local and national issues, with the resulting consensus to be fully integrated into decision-making in an effective, timely and appropriate way. | |
| 10 | Elizabeth Prochaska | Birthrights | Companions remaining with woman after birth | Many women need and want emotional and practical support in hospital after birth when they are | Support for women in the critical period after giving birth has a significant effect on women's recovery, relationship with their | Hayward J, Chalmers B. Obstetricians' and mothers' perceptions of obstetric events. J.Pyschosom.Obstet.Gynaecol. |

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| | | | | learning to care for their baby, particularly if they are recovering from a difficult labour. Support from a trusted companion (partner, family member or friend) can support women's emotional and mental well-being and help establish breast-feeding.<br><br>Postnatal wards, where one midwife frequently cares for up to 16 women, are often unable to offer new mothers basic help, such as providing water, supporting feeding, or lifting babies from their cots for mothers recovering from c-sections.<br><br>Hospital policies enabling companions to remain overnight must be carefully constructed so that they do not disturb other women or intrude on their privacy. | baby and ability to breastfeed. Department of Health best practice guidance states that maternity units should have facilities that enable fathers to remain overnight. While some NHS Trusts have introduced policies permitting women's companions to remain overnight, many hospitals continue to refuse to allow companions to remain with women.<br><br>The care and support that women receive after birth remains one of the most neglected and most criticised elements of UK maternity care. This simple measure has the potential to dramatically improve health and psychological well-being of mothers and babies. | 1990;11:57-71.<br><br>NCT, Involving Fathers in Maternity Care, March 2009. http://www.nct.org.uk/sites/default/files/related_documents/1MS11InvolvingFathersinMaternityCare.pdf<br><br>Lamb ME (2004). The role of the father in child development. 4th edition New Jersey: John Wiley.<br><br>Fatherhood Institute (2008). The dad deficit: the missing piece in the maternity jigsaw.<br><br>Department of Health (2008). E&FD, Health Building note 09-02: maternity care facilities. London: TSO. |
| 11 | Elizabeth Prochaska | Birthrights | Elective caesarean section | A woman's decision to choose a c-section should be respected whether or not | Despite NICE guidance on offering elective c-section published in 2011, many NHS | NICE Caesarean Section Guideline (2011). |

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| | | | | the professionals involved in her care believe that there is clinical justification for the procedure. Her decision may be inspired by tokophobia or a previous traumatic birth experience; whatever the motivation, it reflects her autonomous perspective of a good birth.<br><br>It is a feature of respectful maternity care that it should respect the full spectrum of choices that women can make about how they give birth. | Trusts continue to refuse to respect women's choice as a matter of policy. When an obstetrician refuses to offer a c-section, NICE recommends that the woman should be referred to an obstetrician who will perform the procedure. This often does not happen. Birthrights has been approached for advice by many women who have struggled to find support for their choice and who have felt ostracised by the maternity system. | NICE Quality Standard for Caesarean Section (2013). |