

Maternity - Towards Normal Birth in NSW

Document Number PD2010_045

Publication date 29-Jun-2010

Functional Sub group Clinical/ Patient Services - Maternity
Clinical/ Patient Services - Baby and child
Clinical/ Patient Services - Nursing and Midwifery
Personnel/Workforce - Learning and Development

Summary This policy provides direction to NSW maternity services regarding actions to increase the vaginal birth rate in NSW and decrease the caesarean section operation rate; to develop, implement and evaluate strategies to support women and to ensure that midwives and doctors have the knowledge and skills necessary to implement this policy.

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Applies to Area Health Services/Chief Executive Governed Statutory Health Corporation, Board Governed Statutory Health Corporations, Affiliated Health Organisations, Affiliated Health Organisations - Declared, Public Hospitals

Audience Maternity services, Aboriginal Maternity Infant Health Services, child & family health services

Distributed to Public Health System, Divisions of General Practice, Health Associations Unions, Ministry of Health, Private Hospitals and Day Procedure Centres, Tertiary Education Institutes

Review date 29-Jun-2015

Policy Manual Patient Matters

File No. 09/638-3

Status Active

Director-General

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is **mandatory** for NSW Health and is a condition of subsidy for public health organisations.

MATERNITY – TOWARDS NORMAL BIRTH IN NSW

PURPOSE

This policy provides direction to NSW maternity services regarding actions to increase the vaginal birth rate and decrease the caesarean section operation rate; to develop, implement and evaluate strategies to support women and to ensure that midwives and doctors have the knowledge and skills necessary to implement this policy.

The NSW Maternal and Perinatal Health Priority Taskforce have endorsed *Towards Normal Birth in NSW* and it is now issued as NSW Health policy.

MANDATORY REQUIREMENTS

All NSW Public Health organisations providing maternity services must implement the ten steps to providing woman centred labour and birth care.

IMPLEMENTATION

The Chief Executives or delegated officers of all NSW Public health organisations providing maternity services are ultimately responsible for the implementation of this policy directive and must ensure that it is implemented in accordance with this policy directive.

All maternity services staff must be made aware of the ten steps to providing woman centred labour and birth care and actively participate in its implementation.

REVISION HISTORY

Version	Approved by	Amendment notes
June 2010 PD2010_045	Deputy Director-General Strategic Development	New policy directive

ATTACHMENTS


1. Implementation checklist
2. Maternity –Towards Normal Birth in NSW

Attachment 1: Implementation checklist

Assessed by:		Date of Assessment:	
IMPLEMENTATION REQUIREMENTS	Not commenced	Partial compliance	Full compliance
1. All Area Health Services must establish the baseline performance of each maternity service against every measure by December 2010	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Notes:</u>		
2. All Area Health Services must identify year on year incremental targets to achieve the measures by June 2011	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Notes:</u>		
3. All Area Health Services must provide annual reports against every measure commencing June 2011.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Notes:</u>		
4. All Area Health Services must achieve the measures by December 2015	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Notes:</u>		



Maternity –
towards normal
birth in NSW



A WOMAN FRIENDLY BIRTH INITIATIVE:
PROTECTING, PROMOTING AND
SUPPORTING NORMAL BIRTH

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SHPN (PHCP) 100131
ISBN 978-1-74187-567-6

Produced by
Maternity and Child Health Unit
Primary Health and Community Partnerships Branch
Strategic Development Division
NSW Department of Health

Further copies of this document can be downloaded from the
NSW Health website: www.health.nsw.gov.au
June 2010

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Glossary

Antenatal

The period before giving birth i.e. pregnancy.

Artificial rupture of membranes

Also 'amniotomy'. Breaking the bag of waters which surrounds baby. It is done by the midwife or doctor during a vaginal examination with the aim of increasing natural labour hormones and contractions.

Augmentation

Medical treatment which helps labour to progress.

Breech birth

When the baby is born feet or bottom first.

Caesarean section operation

When the baby is delivered by a doctor cutting into the uterus through the abdomen.

Continuity of care

The practice of ensuring that a woman knows her maternity care providers/s and receives care from the same provider, or small group of providers, throughout pregnancy, labour, birth and the postnatal period.

Electronic fetal monitoring

Using an electronic monitor attached to a belt around the mother's abdomen to continuously record the baby's heartbeat and the mother's contractions on a paper print-out (also CTG: cardiotocography).

Epidural anaesthetic

A type of anaesthetic that makes you numb below the waist (also spinal anaesthetic).

Episiotomy

A surgical cut in the area between the vagina and the anus that may be done during birth.

External cephalic version

A doctor turns the baby from breech to head-first presentation in late pregnancy by placing hands on the mother's abdomen and gently coaxing the baby around.

Fetus

The baby is known as a fetus after about the 12th week of pregnancy.

Gestational age

The stage of the pregnancy, expressed in weeks.

Induction of labour

Using a medical treatment to start the labour rather than waiting for it to happen naturally.

Instrumental birth

Birth assisted by the use of forceps or vacuum.

Intervention

Using a medical treatment or instrument to help in labour or birth (e.g. forceps or an induction).

Midwife

Health professional who specialises in caring for women during pregnancy, labour, birthing and the postnatal period.

Obstetrician

Doctor who specialises in caring for women during pregnancy, labour and birthing.

Opioids

Narcotic drug (like morphine) given as an injection, for pain relief in labour.

Oxytocics

A hormone naturally produced by the mother's body in labour. Giving synthetic oxytocin (syntocinon) through an intravenous (IV) drip can help contractions start. Used to induce labour.

Postdates

A term for a pregnancy which is overdue – past 41 weeks.

Postnatal

After pregnancy and birthing – as in postnatal care or postnatal exercise.

Prostaglandins

A hormone produced in the mother's body which helps soften the cervix. Applying a synthetic hormone gel near the cervix can do the same. Used to induce labour.

Third stage of labour

The time period from the birth of the baby to the placenta being pushed out of the uterus.

Ventouse extraction

Also 'vacuum extraction' – often used instead of forceps. Uses an instrument like a pump. A cup is put into the vagina and onto the baby's head. The pump creates a vacuum effect which holds the cup to the baby's head so the doctor can gently pull the baby out.

Vertex

A term for the baby's head.

Background

The Mothers and Babies Report 2006¹ revealed that the rate of caesarean section operations (both elective and emergency) in NSW hospitals was 28.8%. This represented a rise of almost 10% above the rate in 1998. In NSW public hospitals, the caesarean section operation rate was 24.2% in 2006, a rise of 5.2% over the same period. In addition, there is growing evidence of increasing maternal mortality and morbidity associated with multiple caesarean operations, such as more difficult surgery, increased blood loss, abdominal organ injury, hysterectomy and longer hospital stay²⁻³⁻⁴.

Many reasons have been put forward to explain the rise in numbers of caesarean section operations (CS). For instance, reduced working hours of trainee obstetricians may mean that there are less opportunities to develop skills in the management of complex labour and/or instrumental birth. The move away from birth in the community to birth occurring predominately in a hospital setting and the increased use of technology may have reduced the confidence of health care providers in caring for women experiencing normal labour and birth. Fear of litigation is also often cited as a major driver for increased intervention rates in pregnancy and labour, and potentially more CS operations. Changes in clinical practice, for example, in the management of women with breech presentations or women who are HIV positive, may have led to an increase in the number of elective CS operations recommended. Consumer demand or women exercising choice and requesting CS operations in the absence of medical indication may also have played a part. Rates of CS operation also vary between maternity services and although no two maternity services are the same, the variations in CS operation rates cannot be readily explained by differences in the size of maternity services, complexity of caseload or demography alone⁵.

In response to the increasing CS operation rate and wider concerns about interventions in childbirth, the Maternal and Perinatal Health Priority Taskforce (HPT) and the NSW Department of Health hosted a statewide forum on caesarean section on 22 June 2007 at the Royal Hospital for Women, Randwick. The purpose of the multidisciplinary forum was to examine the rise in CS operations within the public health system and to inform the future policy direction for childbirth in NSW.

Detailed analysis of the forum identified themes for future discussion with the Maternal and Perinatal HPT which included:

- the promotion of birth as a natural event for most women
- the need to minimise fear, particularly women's fear, and improve support throughout labour and birth
- the importance of consistent and balanced information for women and health care providers regarding vaginal birth after caesarean section operation and the potential risks associated with elective caesarean operation
- the need to develop programs of care, both midwifery and medical, that focus on providing continuity of care.

These themes for reducing caesarean section operation rates were presented to members of the HPT in August 2007. It was proposed that an action plan for normal birth be developed. At the same time, it was recognised that for a variety of reasons, some women will be unable to attempt a 'normal birth'. These women should not necessarily be left feeling they are 'abnormal' and excluded from programs of care available to other women and their families. To acknowledge this, the document was subsequently titled *Towards normal birth in NSW*.

The directions and actions within this policy are designed to recognise that pregnancy and birth is a normal physiological event and emphasises that everything should be done to support and promote the woman's physiology to grow the baby well and to progress in labour and birth. It is recognised that some women will have, or develop, certain risk factors that require attention. However, unnecessary interference in the natural process may disturb the expected course and may lead to a cascade of intervention.

1 Centre for Epidemiology and Research, NSW Department of Health New South Wales Mothers and Babies. 2006, *NSW Public Health Bulletin* 2007;18(s-1)

2 Hager, RM, Daltveit, D, Hofoss, ST, Nilsen, T, Kolaas, P Øian et al. 2004, Complications of cesarean deliveries: rates and risk factors. *American Journal of Obstetric Gynecology*; 190: 428-34

3 National Collaborating Centre for Women's and Children's Health. 2004, *Caesarean Section*. Clinical Guideline. London: RCOG Press.

4 MacDorman MF, Menacker F, Declerq E 2008, Cesarean birth in the United States: epidemiology, trends and outcomes. *Clinical perinatal* 35: 293-307

5 NHS Institute for Innovation and Improvement 2007, Pathways to success: Focus on normal birth and reducing Caesarean section rates, www.institute.nhs.uk

Introduction

Woman centred care

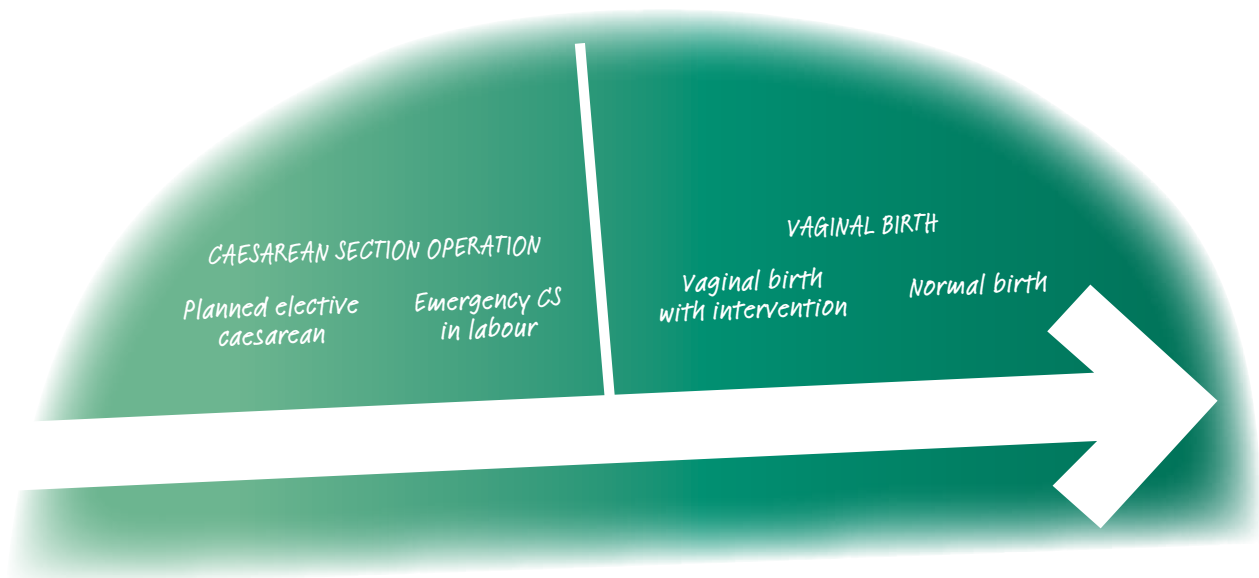
Woman centred care⁶ is a concept that implies that care:

- is focussed on the woman's individual unique needs, expectations and aspirations, rather than the needs of the institutions or professions involved
- recognises the woman's right to self determination in terms of choice, control, and continuity of care from a known or known caregivers
- encompasses the needs of the baby, the woman's family, her significant others and community, as identified and negotiated by the woman herself
- follows the woman across the interface between institutions and the community, through all phases of pregnancy, birth and the postnatal period. It therefore involves collaboration with other health professionals when necessary
- is holistic in terms of addressing the woman's social, emotional, physical, psychological, spiritual and cultural needs and expectations.

The spectrum of birth

A reduction in caesarean section operation rates will be achieved by increasing the number of women who have vaginal births. This can only be achieved by increasing the number of women who commence labour. Whilst this may sound simplistic, often the focus is on the two extremes of the spectrum of birth, either elective CS operation or normal vaginal birth. The spectrum of birth also includes women who require a caesarean section operation after being in labour (also known as unplanned CS) and those women who require intervention to either initiate or accelerate labour or to facilitate the actual birth (birth with intervention).

The figure below demonstrates the spectrum and shows how birth is a continuum. The arrow indicates the change in direction required to ultimately increase the vaginal birth rate and decrease the CS operation rate.



6 Homer, C, Brodie, P, & Leap N 2008, Chapter 1. Getting started: what is midwifery continuity of care. in Homer C, Brodie P & Leap N (eds), *Midwifery Continuity of Care: A Practical Guide* Sydney: Elsevier, pp. 1-24

What is normal birth?

Birth with minimal intervention or no medical intervention is considered normal⁷. The World Health Organization (WHO) definition of normal birth is:

‘Spontaneous in onset, low-risk at the start of labour and remaining so throughout labour and delivery. The infant is born spontaneously in the vertex position between 37 and 42 completed weeks of pregnancy. After birth mother and infant are in good condition’⁸.

The UK normal birth consensus⁹ states that normal birth includes women who experience any of the following:

- augmentation of labour, artificial rupture of the membranes (ARM) if not part of medical induction of labour
- entonox (nitrous oxide)
- opioids
- electronic fetal monitoring
- managed third stage of labour.

The focus should be on increasing the proportion of women who have a vaginal birth rather than only aiming to convert births from one extreme to the other i.e. a CS operations into normal births. The number of women who embark on a labour and/or go into labour spontaneously needs to increase and the number of labour interventions needs to decrease. This will take NSW towards normal birth.

7 Duff E, 2002, Normal birth: ‘Commonplace’, ‘according to rule’ or ‘well adjusted’? *MIDIRS Midwifery Digest*, 12 (3), 313-314

8 World Health Organization. 1997, Care in normal birth: a practical guide. Report of a technical working group. Maternal and Newborn Health/Safe Motherhood Unit, www.who.int/making_pregnancy_safer/documents/who_frh_msm_9624/en/index.html

9 Making normal birth a reality: consensus statement from the Maternity Care Working Party, www.rcog.org.uk/files/rcog-corp/uploaded-files/JointStatmentNormalBirth2007.pdf

The normal birth group excludes women who experience any one or more of the following:

- induction of labour (with prostaglandins plus oxytocics or ARM)
- epidural or spinal anaesthesia
- general anaesthetic
- forceps delivery or ventouse extraction
- caesarean section operation
- episiotomy.

Normal birth, by this definition, covers only a small proportion of births in NSW. Within the group of women who achieve vaginal birth there are a number of variables, each with their own spectrum. These include onset of labour, gestational age, identified risk factors, interventions at birth, and plurality. The spectrum for each variable can be represented as shown in the following diagram.

Normal birth, by definition, sits at one end of this spectrum. However, viewing the spectrum of vaginal births in this way suggests that changes can be made through a multifaceted approach rather than focusing on normal birth alone.

The focus should be on increasing the proportion of women who have a vaginal birth rather than only aiming to convert women who are having a CS operation into having normal births. The number of women who embark on a labour and/or go into labour spontaneously needs to increase and the number of labour interventions needs to decrease. This will not only increase vaginal births but take NSW towards normal birth.



Aims

Towards normal birth in NSW aims to:

- increase the vaginal birth rate in NSW and decrease the CS operation rate¹⁰⁻¹¹
- develop, implement and evaluate strategies to support women to have a positive experience of pregnancy and birth
- ensure that midwives and doctors have the knowledge and skills to support women who choose to give birth without technological interventions unless necessary, use non-pharmacological interventions, use birthing pools and different positions for labour and birth.



10 Waldenstrom, U, et al. 2000, Does team midwife care increase satisfaction with antenatal, intrapartum and postpartum care? A randomised controlled trial'. *Birth*. Vol 27, no 3, pp156-67

11 Rowley, MJ, Hensley, MJ, Brinsmead, MW, Wlodarczyk, JH 1995, Continuity of care by a midwife team versus routine care during pregnancy and birth: a randomised trial. *Medical Journal of Australia*. 163 (6): 289-193

Purpose of the action plan

The purpose of the action plan, *Towards normal birth in NSW*, is to:

- increase the number of women starting labour spontaneously¹²
- increase the number of women receiving support at home in early labour
- reduce the use of interventions that women experience in labour, particularly augmentation of labour, analgesia and electronic fetal monitoring¹³
- enhance experiences and satisfaction with care during pregnancy and childbirth including social and emotional aspects of care¹⁴
- enable women to be better prepared for birth and early parenting¹⁵ with increased participation in decision-making
- increase women's sense of self confidence and self esteem in the early postnatal period¹⁶ which may have an important role in the prevention of postnatal distress or depression¹⁷
- reduce unnecessary interventions.

12 Hatem, M, Sandall, J, Devane, D, Soltani, H, & Gates S 2008, Midwife-led versus other models of care for childbearing women (Review). *Cochrane library*, 126

13 Hodnett, ED 2001, Continuity of caregivers for care during pregnancy and childbirth (Cochrane Review). *The Cochrane Library*, 4, 2003. Chichester, UK: John Wiley & Sons, Ltd

14 Homer CSE, Davis GK, Brodie PM, Sheehan A, Barclay LM, Wills J, Chapman MG 2001, Collaboration in maternity care: a randomised controlled trial comparing community-based continuity of care with standard care. *British Journal of obstetrics and Gynaecology*. 108 (1):16-22

15 Hodnett, ED 2001, Continuity of care givers for care during pregnancy and childbirth (Cochrane Review). *The Cochrane Library*. Issue 3, Update Software: Oxford

16 Ball, JA 1989, Postnatal care and adjustment to motherhood. *Midwives, Research and Childbirth*. Volume 1, S Robinson & AM Thomson (eds) Chapman and Hall, London, pp. 154-175

17 McCourt, C, Percival, P 1999, Social support in childbirth in *The New Midwifery*, LA Page (ed.) Churchill Livingstone, Edinburgh, pp. 245-266

Framing documents and indicators

The action plan is informed and shaped by the following core NSW Government documents:

- NSW State Plan¹⁸
- NSW State Health Plan¹⁹
- Caring Together²⁰
- Caring Together Building Sustainability²¹.

Within this government context, the action plan, *Towards normal birth in NSW*, is designed to meet the following NSW State Plan commitments:

- Clever State
 - make sure children have the skills for learning by school entry
- Healthy communities
 - improve and maintain access to quality healthcare in the face of increasing demand
 - promote healthy lifestyles
 - reduce preventable hospital admissions
- Stronger communities
 - improve child wellbeing, health and safety
 - strengthen Aboriginal communities
 - caring for children and young people
 - delivering opportunities for women.

And the following NSW State Health Plan commitments:

- SD1: Make prevention everybody's business
- SD2: Create better experiences for people using health services
- SD3: Strengthen primary health and continuing care in the community
- SD5: Make smart choices about the costs and benefits of health services.

And the following Caring Together commitment:

- expanding maternity options.

The action plan is also designed to build on the priorities and recommendations contained in the NSW Framework for Maternity Services²².

Target groups

The target groups for *Towards normal birth in NSW* are all women planning a pregnancy and all pregnant women and their partners as well as all maternity health care professionals.



18 NSW Department of Premier and Cabinet, Investing in a better future, NSW State Plan 2010, <http://www.nsw.gov.au.stateplan>

19 NSW Department of Health, 2007, A new direction for NSW, state health plan towards 2010, http://www.health.nsw.gov.au/pubs/2007/pdf/state_health_plan.pdf

20 NSW Department of Health, 2009, Caring Together: The Health Action Plan for NSW, <http://www.healthactionplan.nsw.gov.au>

21 NSW Department of Health, 2009, Caring Together, Building Sustainability, <http://healthactionplan.nsw.gov.au/progress-reports.php>

22 NSW Department of Health, 2000, *The NSW Framework for Maternity Services*, NSW Department of Health, Sydney

Implementation

The implementation of this policy will be in stages.

- All Area Health Services must undertake a baseline audit of all measures to establish the starting point by June 2011.
- All Area Health Services must implement 80% of strategies in this document by 2012.
- All Area Health Services must demonstrate at least a 50% improvement on the baseline audit by 2012.
- All Area Health Services must implement 100% of the strategies by 2015.
- All Area Health Services must be achieving the measures and targets by 2015.

The key measures and targets to be achieved are outlined in this document.

Area Health Services can also use the following characteristics of a successful organisation (in relation to caesarean section operations) identified by the NHS Institute for Innovation and Improvement Unit²³ as a guide to identify goals. These can be viewed from a number of perspectives as outlined below.

For the woman:

- regardless of risk status, a pregnant woman can access midwifery continuity of care/r across the childbirth continuum within an interdisciplinary framework
- information is presented in a way that supports, wherever possible, the normality of the childbirth process
- women feel empowered in making decisions with support from staff
- decisions about the use of interventions are made in partnership with care providers and are based on the woman's individual needs and preferences and the best evidence available
- labour will be seen as a positive experience
- a woman in labour receives one to one professional support
- a woman in labour has access to a private birthspace where the environment is conducive to facilitating/promoting normal birth.

For staff:

- staff express a high level of job satisfaction
- staff articulate a sense of pride in the achievements of the maternity unit
- staff work as a well functioning team that respect each other's area of expertise in the normal birth process
- communication patterns are open and transparent
- staff retention rates are high.

For the organisation:

- a mission statement, values and strategic plan that clearly reflects a recognition of the importance of birth in a woman's life and focuses on supporting normal birth at all levels of service provision
- the organisation ethos focuses on supporting the emotional wellbeing of staff
- leadership that is recognised to be inclusive, progressive and engaged with the consumers of the service, their staff, professional organisations and the community
- fiscal management that reflects the importance of primary health care and preventive initiatives
- governance processes that are recognised as world class and owned by consumers and staff
- reputation as a maternity unit that places the woman at the centre of care and engenders feeling of safety in a pregnant woman.

²³ NHS Institute for Innovation and Improvement 2007, Pathways to success: Focus on normal birth and reducing Caesarean section rates, www.institute.nhs.uk

Measures for improvement and reporting requirements

Key measures for improvement are provided under each of the ten principles beginning on page 8. These measures will assist facilities in achieving the strategies outlined in this document.

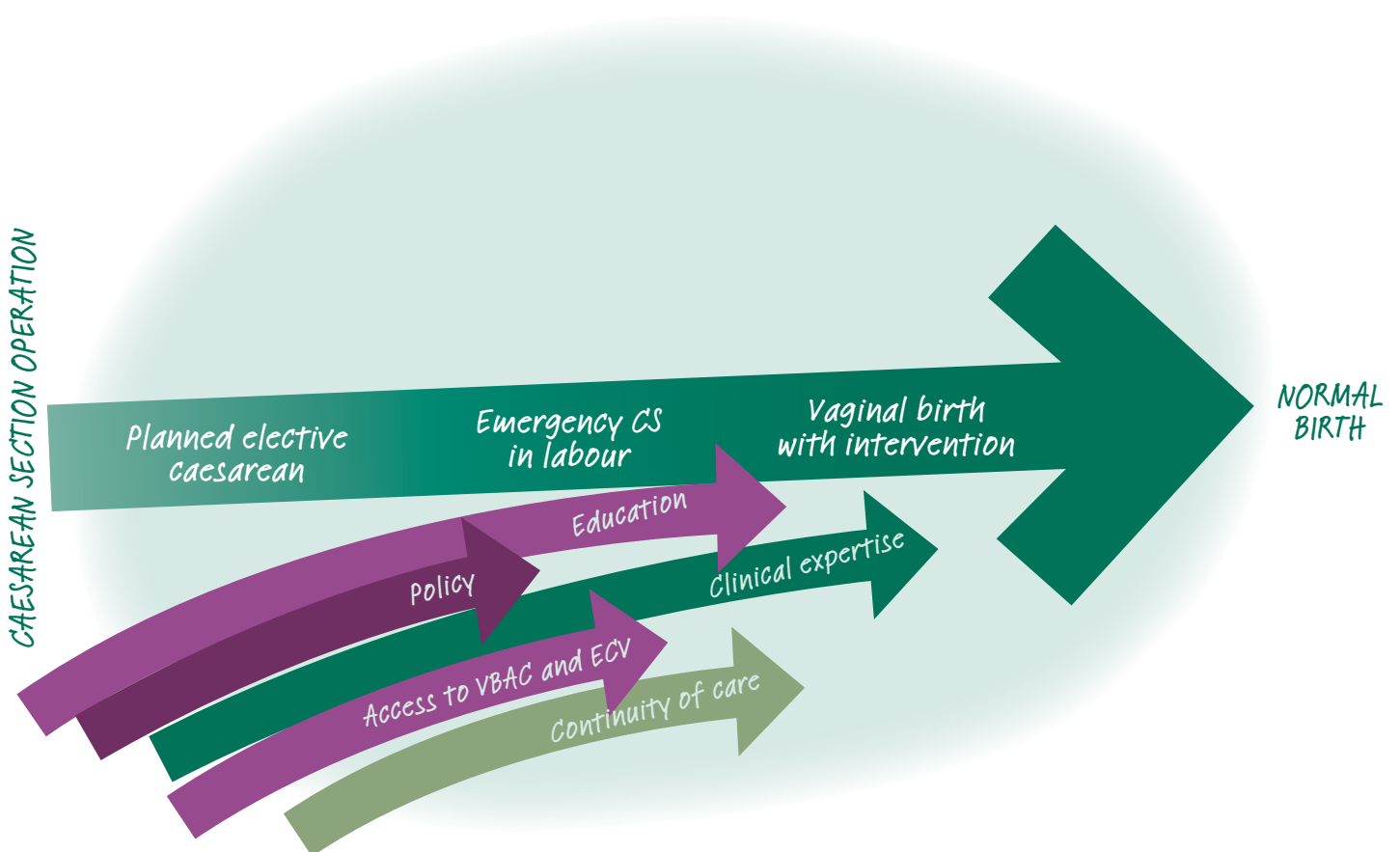
Area Health Services are required to report against these measures annually.

As facilities implement changes in maternity service delivery, it will be important to know if these changes have resulted in real improvements.

Area Health Services are encouraged to link these Key Performance Indicators (KPIs) and Clinical Indicators to existing data from their own sources, such as Midwives Data Collection (MDC) and ObstetriX.

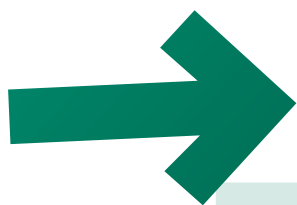
The measurement plan template at Appendix A may also assist facilities with obtaining key measures and reporting requirements.

Priorities for action



10 steps to providing woman centred labour and birth care

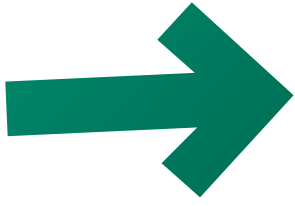
– a woman friendly birth initiative: protecting, promoting and supporting normal birth in NSW



1. **Have a written normal birth policy/guidelines, along with other relevant policies, that are routinely communicated to all health care staff.**
2. **Train all health care staff in skills necessary to implement this policy.**
3. **Provide or facilitate access to midwifery continuity of carer programs in collaboration with GPs and obstetricians for all women with appropriate consultation, referral and transfer guidelines in place.**
4. **Inform all pregnant women about the benefits of normal birth and factors that promote normal birth.**
5. **Have a written policy on pain relief in labour that includes the use of water immersion in labour and birth.**
6. **Have a written postdates policy/guideline that is routinely communicated to all health care staff.**
7. **Provide or facilitate access to vaginal birth after caesarean section operation (VBAC) that is supported by a written vaginal birth after caesarean section operation policy/guideline and health care staff with the skills necessary to implement this policy/guideline.**
8. **Provide or facilitate access to external cephalic version.**
9. **Provide one to one care to all women experiencing their first labour or undertaking a vaginal birth after caesarean section operation, vaginal breech or vaginal twin birth.**
10. **Provide formal debriefing in the immediate postpartum period for all women requiring primary caesarean section operation or instrumental birth with the opportunity for further discussion and information transfer.**



NSW Health must adopt the following principles and implement the associated actions.



1. Have a written normal birth policy/guidelines, along with other relevant policies, that are routinely communicated to all health care staff

NSW Department of Health (DOH) will:

- develop the strategic policy – *Towards normal birth in NSW*
- include guidelines for the development and alteration of birthing rooms to support normal physiology
- recommend documentation of specific cultural requirements as well as women's specific wishes and needs in the antenatal period
- issue the Fetal Monitoring Policy Directive to provide guidance for fetal heart rate monitoring interpretation and appropriate use of electronic fetal heart rate monitoring and management of non-reassuring findings
- issue a policy directive, describing the approved clinical activity/interventions by role delineation of maternity services including vaginal birth after caesarean section operations (VBAC), induction of labour (IOL) and instrumental birth
- issue Induction of Labour Policy Directive and provide standardised approaches and guidance for appropriate selection and management of women for IOL to achieve vaginal birth
- explore mechanisms for women's right to refuse care while enabling clinicians to continue to provide care
- issue a framework for tiered maternity networks for both critical and planned consultation and referral.

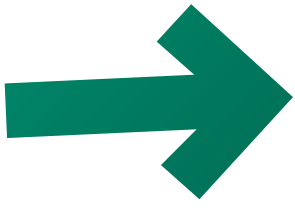
The Area Health Service (AHS) will:

- communicate all NSW Department of Health maternity policy and guidelines to all maternity care clinicians
- implement all maternity care policy into AHS maternity service provision
- develop local guidelines for elective caesarean operation for less than 39 completed weeks gestation only where there is a medical indication, as per NSW policy directive (PD 2007_024)
- nominate senior staff to coordinate and report on audits of PD 2007_024 in all the maternity services across the AHS
- develop and alter the birthing environment to support normal physiology of labour
- undertake annual audits of documentation standards
- consider consumer involvement in the development and implementation of all *Towards normal birth* directions and actions.

Key Measures

- 1.1 All clinical staff are aware and familiar with maternity services policy directives (target 100% by 2015)
- 1.2 All maternity services staff have a clear understanding of the role delineation of their maternity service (target 100% by 2015)
- 1.3 All maternity services staff are aware of networking arrangements for consultation and referral when higher levels of care are required (target 100% by 2015)
- 1.4 All maternity services have a written normal birth policy (target 100% by 2015)





2. Train all health care staff in skills necessary to implement this policy

NSW Department of Health will:

- develop an interdisciplinary workshop for all health professionals involved in childbirth that helps build confidence in supporting women positively during pregnancy, labour and birth, without technological interventions and working with pain in uncomplicated labour. The workshop needs to be centrally developed and resourced followed by a program in all AHS across the state. Continuing professional development points must be applicable for all the disciplines. All health professionals involved in care of childbearing women should undertake the workshop, including midwives, obstetric staff (junior and senior) and GPs. Attendance at such a workshop could be built into AHS performance plans
- focus all education on evidence based care around precursors to caesarean section operations, such as external cephalic version to reduce breech presentations, judicious use of continuous electronic fetal monitoring, care in the second stage of labour, instrumental birth, breech, VBAC, Induction of Labour
- conduct Master Class in Vacuum Extraction workshops and explore opportunities to conduct further workshops for rural clinicians.

Area Health Services will:

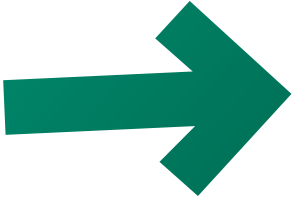
- support attendance of all staff (including GP obstetricians in rural areas) at the interdisciplinary workshop
- Develop work patterns that embed cultural change in the workplace to ensure that all midwives work to their full scope of practice
- Develop work patterns that embed cultural change in the work place to ensure that appropriate escalation to attract medical review and/or attendance occurs when risk factors arise
- provide opportunities for interdisciplinary and interactive learning²⁴⁻²⁵
- provide opportunities to midwives, GPs and obstetricians for networking and education/upskilling of staff
- implement care provision by the most appropriate clinician e.g. midwives caring for normal pregnancies and birth whilst consulting and referring when complications arise, as per NSW policy directive (PD2010_ ACM Consultation and Referral Guidelines)
- include appropriate training and supervision of medical and midwifery trainees.

Key Measures

- 2.1 All maternity clinicians report that training increased their confidence in terms of mutual trust and respect between professions (target 100% by 2015)**
- 2.2 All maternity clinicians report that training increased their confidence in communication and use of information to enhance decision making (target 100% by 2015)**
- 2.3 All maternity clinicians attend interdisciplinary training days (target 100% by 2015)**

24 O'Brien, M, Freemantle, N, Oxman, A, Wolf, F, Davis, D, & Herrin J 2001, Continuing education meetings and workshops: effects on professional practice and health care outcomes. *Cochrane Database of Systematic Reviews* (Issue 2. Art.No: CD003030. DOI: 10.1002/14651858.CD003030)

25 Barr, H, Koppel, I, Reeves, S, Hammick, M & Freeth, D 2005, *Effective Interprofessional Education: Argument, Assumption & Evidence*. Oxford: Blackwell Publishing



3. Provide or facilitate access to midwifery continuity of carer programs in collaboration with GPs and obstetricians for all women with appropriate consultation, referral and transfer guidelines in place

NSW Department of Health will:

- issue policy directives, describing approved clinical activity/interventions by role delineation (see step 1)
- examine the feasibility of the introduction of acuity assessment methodology for day to day management of birthing units.

Key Measures

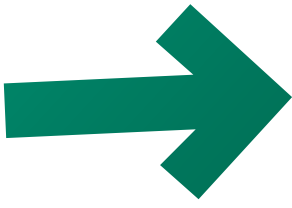
- 3.1 **Percentage of women accessing midwifery continuity of carer programs (target at least 35% by 2015)**
- 3.2 **All women accessing midwifery continuity of carer programs receive postnatal care at home for at least 2 weeks after the baby is born (target 100% by 2015)**
- 3.3 **All women receive midwifery support at home for at least 2 weeks after the baby is born (target 100% by 2015 for metropolitan/regional services; target 80% by 2015 for rural/remote services)**



Area Health Services will:

- plan and implement strategies to enable women the option of a program of care so that the woman has known midwives providing her individualised care. Collaborative midwifery/medical programs of care, with obstetric/GP obstetric and midwifery support and leadership should be available in labour wards appropriate for the role level of the maternity service
- plan and implement strategies to allow women to access comprehensive public antenatal care close to their home
- reconfigure staff deployment in order to provide one to one midwifery care in labour – resources may need to be reprioritised
- provide information to NSW DOH about the risks and impediments to implementing midwifery continuity of carer and collaborative programs by December 2010
- develop, implement and evaluate Midwifery Group Practices in collaboration with GPs and obstetricians in a range of settings in NSW
- ensure midwives have opportunities to work in continuity of carer programs and provide access to professional development and skill development where needed
- reform maternity services so that at least 35% of women in each Area Health Service access continuity of care programs before 2012
- reconfigure service delivery to increase access to obstetricians who support midwifery continuity of carer programs beginning in early pregnancy and continuing through pregnancy, labour, birth and through the postnatal period to 6 weeks after the baby is born
- ensure obstetric anaesthetic availability on site at Level 5 & 6 maternity services
- ensure that all maternity services delineated lower than level 5 that provide caesarean section operation have a dedicated anaesthetic service on standby/on call.

N.B. Further information on continuity of carer programs can be found in the document *Primary Maternity Services in Australia – A framework for implementation*. This is located at the following link: <http://www.ahmac.gov.au/site/home.aspx>



4. Inform all pregnant women about the benefits of normal birth and factors that promote normal birth

NSW Department of Health will:

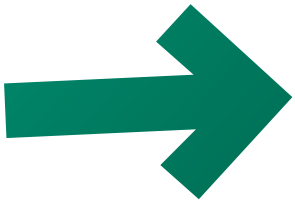
- consult with the Department of Education (DET) regarding awareness of and access to school education campaigns to promote normal birth. This will increase awareness of programs of care that facilitate normal birth including assisting with the promotion and development of an education package for schools if agreed. Education may include: addressing fear of normal birth; the role of midwives, general practitioners and obstetricians in maternity services; the implementation of evidence based programs of care; and strategies to keep birth normal
- develop promotion of a normal birth package for the wider community in plain English and other languages. All women should have access to evidence based information and practical skills for keeping their first pregnancy and birth normal including programs of care that facilitate normal birth for all pregnant women. The promotional package will include: addressing fear of normal birth; role of midwives, general practitioners and obstetricians in maternity services; providing descriptions of evidence based programs of care; strategies to keep birth normal; and a standardised method to reach an agreed estimated date of birth (EDB)
- involve consumers in development of information packages
- use positive language to normalise the process of labour and birth
- develop a website to include facts and figures (Q&A or FAQs) about labour and birth, VBAC and keeping birth normal. A link to information on *Towards Normal Birth in NSW* will be provided
- explore opportunities for promoting labour and vaginal birth in the NSW Health publication *Having a Baby*
- educate media liaison personnel at DOH and in Area Health Services about the value of moving towards normal birth by developing and disseminating resources for purposes of consistency and commonality.

Area Health Services will:

- provide information for women and families on *Towards normal birth in NSW* for use in antenatal education
- provide antenatal groups to address normal fears of labour and birth, including practical skills for keeping the first pregnancy and birth normal including: coping with labour; an emphasis on the normality of pain in labour; normal length of pregnancy; implications of interventions in labour such as epidural anaesthesia; cardiotocography (CTG); IOL – all preparation for parenting education should have this incorporated into their curriculum
- provide antenatal groups/classes free of charge at the point of access for women who are potentially vulnerable due to recognised socioeconomic and lifestyle factors
- develop, implement and evaluate innovative ways to bring women together for information sharing and support, particularly women who are at risk of social isolation and those who may not normally access such services
- develop information about the value of labour and the implications of interventions in labour to be provided to women as part of routine antenatal care
- provide women desiring a vaginal breech birth access to clinicians that will support this choice.

Key Measures

- 4.1 All women receive information advising them of their options for place of birth and continuity of carer programs (target 100% by 2015)
- 4.2 All women from vulnerable groups have access to targeted antenatal education and support (100% by 2015)
- 4.3 Percentage of spontaneous vaginal births (target >70% by 2015)
- 4.4 Percentage of vaginal births (target >80% by 2015)
- 4.5 All maternity services undertake an annual audit of skin to skin contact within 1 hour of birth (target 90% by 2015)



5. Have a written policy on pain relief in labour that includes the use of water immersion in labour and birth

NSW Department of Health will:

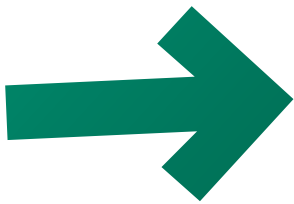
- develop a leaflet for women talking positively about the use of water for pain relief and citing the evidence.

Area Health Services will:

- develop written policy on pain relief in labour that includes: providing a leaflet for women talking positively about the use of water for pain relief and citing the evidence; encouraging women to move around and adopt positions of choice; the use of water immersion in labour and birth.

Key Measures

- 5.1 All Area Health Services have a written policy on pain relief in labour (target 100% by 2012)
- 5.2 All women receive information about the use of water immersion in labour and birth (target 100% by 2015)
- 5.3 All maternity services offer access to water immersion in labour (target 100% by 2015)
- 5.4 All clinicians report confidence in promoting and supporting the use of water for pain relief (target 100% by 2015)



6. Have a written postdates policy/guideline that is routinely communicated to all health care staff

NSW Department of Health will:

- develop statewide guidelines based on the national antenatal care guidelines to enable accurate dating of women's pregnancies. These guidelines will provide a clear process for reaching an agreed due date.

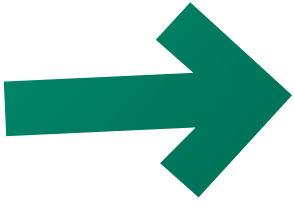
Area Health Services will:

- implement statewide policy to standardise reaching an agreed due date.

Key Measures

- 6.1 All women have an agreed due date of birth documented in their health record (target 100%)
- 6.2 All Area Health Services have an area wide induction of labour policy regarding the management of postdates pregnancies (target 100%)





7. Provide or facilitate access to vaginal birth after caesarean section operation (VBAC) that is supported by a written vaginal birth after caesarean section operation policy/guideline

NSW Department of Health will:

- review the evidence regarding clinical practice and recommendations for VBAC to inform the development of guidance for clinical practice
- issue a policy directive describing the approved clinical activity/interventions by role delineation of maternity services including care of women planning VBAC (see step 1)
- develop statewide workshop of GPs, midwives and obstetricians to exchange views and skills regarding VBAC (see step 2)
- identify and promote NSW centres of excellence re VBAC outcomes.

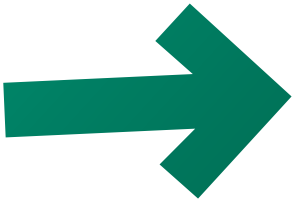
Area Health Services will:

- develop a VBAC policy informed by current evidence for each maternity service able to provide VBAC
- establish interdisciplinary VBAC clinics at Level 4 and above maternity services
- implement tiered maternity networks for lower level services
- showcase centres of excellence, particularly in rural areas and use them as resources to replicate results in other facilities
- conduct an annual audit/report card of VBAC outcomes
- provide access to specialist obstetric anaesthetic services where necessary.

N.B. Some Area Health Services have expanded their scope to include Next Birth After Caesarean Section operation (NBAC) where all women who experienced a caesarean section operation attain support for their next birth.

Key Measures

- 7.1 Percentage of women receiving VBAC advice before the 16th week of pregnancy (target >75% by 2015)**
- 7.2 Percentage of women who have a vaginal birth after one previous pregnancy delivered by caesarean section operation, i.e. primary caesarean section operation (targets >30% by 2012 and >60% by 2015)**
- 7.3 All maternity services undertake an annual audit of compliance with VBAC policy (target 100% by 2015)**
- 7.4 All maternity clinicians are informed of statistics relating to VBAC outcomes (target 100% by 2015)**



8. Provide or facilitate access to external cephalic version

Area Health Services will:

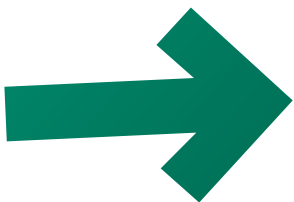
- ensure all clinicians have access to expertise in External Cephalic Version (ECV) and identify where ECV is available
- ensure the provision of training packages and networked support for obstetric registrars
- provide access to opportunities for observation and clinical training
- provide access to ECV expertise at Level 4 and above maternity services only.

Area Health Services will consider the following for Level 5 and 6 maternity services:

- provide access to vaginal breech and vaginal twin birth services
- identify clinical expertise in vaginal breech birth and vaginal birth for twins
- identify centres of excellence for vaginal breech birth and vaginal birth for women having twins
- provision of training packages and networked support for obstetricians, obstetric registrars and midwives
- provide access to opportunities for observation and clinical training in these two areas
- provide access to expertise in services for twin vaginal birth in each AHS at Level 4 and above only.

Key Measures

- 8.1 All maternity services have guidelines for the provision of, or access to, ECV (target 100% by 2015)
- 8.2 All maternity services undertake an annual audit of provision and access to ECV (target 100% by 2015)
- 8.3 All staff are aware of the statistics relating to ECV uptake and outcomes (target 100% by 2015)



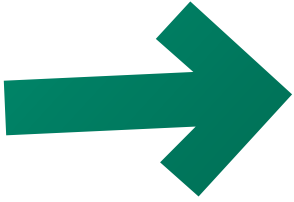
9. Provide one to one care in labour for all women experiencing their first labour or undertaking a vaginal birth after caesarean section operation, vaginal breech or vaginal twin birth

Area Health Services will:

- change maternity unit physical environments to facilitate electronic point of care documentation – this can reduce the time that midwives spend away from women and permit accurate, timely information to be recorded
- keep a woman's medical record with her throughout her intrapartum care
- implement local guidelines/protocols that discourage activities that separate midwives from the woman in labour. This includes the use of centralised monitoring systems as they discourage midwives from being with the woman in the labour room (the use of use of CTG /EFM should be in accordance with Safety Notice 004/07)

Key Measures

- 9.1 All women experiencing their first labour or undergoing induction of labour using oxytocics or undertaking a vaginal birth after caesarean section, vaginal breech or vaginal twin birth receive one to one care from a midwife in labour (target 100% by 2015)
- 9.2 All maternity services provide an environment designed to keep the midwife and the mother together (target 100% by 2015)



10. Provide formal debriefing in the immediate postpartum period for all women requiring primary caesarean section operation or instrumental birth with the opportunity for further discussion and information transfer

Area Health Services will:

- ensure women are offered the opportunity to talk about their birth experience with a midwife and/ or doctor. This discussion should be recorded in the medical record
- provide services for ongoing counselling or support and referral as required in the postnatal period
- provide midwifery home visiting for at least 2 weeks after the baby is born which may extend to 6 weeks postnatal²⁶.

Key Measures

10.1 All women undergoing primary caesarean section operation or instrumental birth receive postnatal debriefing/counselling by a senior clinician (target 100% by 2015)



²⁶ World Health Organization, 1997, Care in normal birth: a practical guide. Report of a technical working group. Maternal and Newborn Health/Safe Motherhood Unit, www.who.int/making_pregnancy_safer/documents/who_frh_msm_9624/en/index.html

Other policy directives and guidelines

PD2005_608

NSW Patient Safety and Clinical Quality Program

http://www.health.nsw.gov.au/policies/pd/2005/PD2005_608.html

PD2006_012

Breastfeeding in NSW: Promotion, Protection and Support

http://www.health.nsw.gov.au/policies/pd/2006/PD2006_012.html

PD2007_024

Maternity – Timing of Elective or Pre-Labour Caesarean Section

http://www.health.nsw.gov.au/policies/pd/2007/PD2007_024.html

PD2009_003

Maternity – Clinical Risk Management Program

http://www.health.nsw.gov.au/policies/pd/2009/PD2009_003.html

PD2010_017

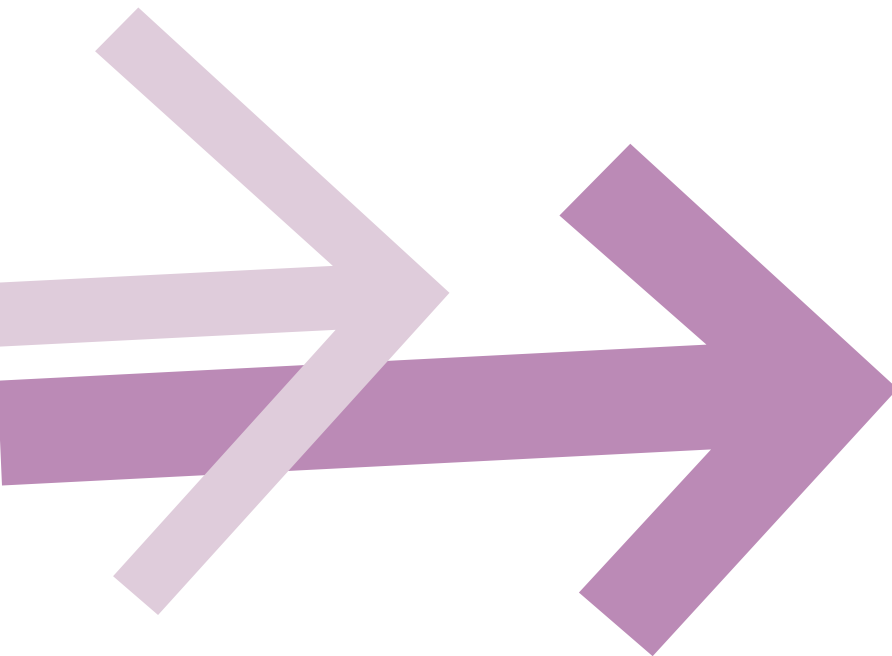
Maternal and Child Health Primary Health Care Policy

http://www.health.nsw.gov.au/policies/pd/2010/PD2010_017.html

PD2010_022

Maternity – National Midwifery Guidelines for Consultation and Referral

http://www.health.nsw.gov.au/policies/pd/2010/PD2010_022.html



Appendix A

Measurement plan template²⁷

Principle	
What is our aim?	
Measure	
Definition	
Baseline	
Target	
Over what period will we collect the data?	
How will we collect the data?	
How often will we collect the data?	
Who will collect the data?	
How will we present the data?	

²⁷ Adapted from NHS Institute for Innovation and Improvement 2007, Pathways to Success: a self-improvement toolkit -focus on normal birth and reducing Caesarean section rates NHS, available at www.institute.nhs.uk

