

NICE Clinical Guideline:

Intrapartum care for high risk women:

Stakeholder scoping workshop notes

21st July 2015

Presentations
<p>The group was welcomed to the meeting and informed of the purpose of the day. The group was informed that the stakeholder scoping workshop is an opportunity for stakeholders to review the draft scope and give their input into whether it is clinically appropriate.</p> <p>The group received presentations about NICE's work, the work of the Patient and Involvement Programme (PIP) and the role of the National Collaborating Centre – Women's and Children's Health (NCC-WCH) in the development of guidelines. The Chair of the Guideline Committee also presented the key elements of the draft scope.</p>
Scope
Size of scope
<p>Group 1</p> <ul style="list-style-type: none">• The group considered the scope large but comprehensive. However they felt that the guideline should be split between medical and obstetric complications. They felt that obstetric conditions are covered well elsewhere and this guideline should focus on care for women with pre-existing medical conditions.• The group noted that mental health issues are not included in the scope. There was discussion around creating a guideline specifically for mental health. The group felt strongly that mental health should either be referred to or included in the guideline and that individual pathways needed to be created for the care of women with mental health issues during their intrapartum care. There was a similar discussion around substance misuse.• The group felt strongly that obesity and group B streptococcus (GBS) needed to be included in the medical conditions aspect of the scope (the group stated that when scoping for the intrapartum care guideline it was said that GBS was going to be covered in the high risk guideline but it is not and this was conflicting information). <p>Group 2</p> <ul style="list-style-type: none">• The group felt that the guideline should be split between medical and obstetric complications.• The group thought that the scope of the guideline was too large. It was suggested that obesity and/or social circumstances could be excluded and that individuals from these populations should only be included if they developed complications.• The group raised the point that women with known medical or obstetric complications were likely to be treated as individuals, whilst those who were considered as high risk due to personal or social circumstances were likely to be treated as a group or population, even though individuals from the latter category may be, and remain, low risk.

Group 3

- The group felt the topics covered were necessary however they felt that the areas would be more appropriately addressed in 3 separate guidelines due to size:
 - one guideline covering medical complex needs in intrapartum care
 - one guideline covering obstetric and baby-related complex needs in intrapartum care
 - social and personal complexities during intrapartum care (perhaps to be included in the guideline on pregnancy and complex social factors)
- The group proposed the extension of existing guidance on medical conditions to cover the whole care pathway – i.e. diabetes in pregnancy, hypertension in pregnancy and multiple pregnancy guidelines already cover antenatal care but should be extended to include intrapartum care. These would also need to be updated in the near future to ensure that there is not a long wait for guidance on intrapartum care for women with these conditions.
- The group felt that women with personal and social factors which makes them high risk have a different set of circumstances and management of care. The group felt that continuity of care would be very helpful and that the intrapartum care for those issues could be included in the guideline on pregnancy and complex social factors.

Group 4

- The group agreed that the scope of the guideline was too large and needed to be separated in two guidelines. They agreed that medical and obstetric conditions for high risk populations should be separated. The concept of planned versus unexpected issues arising during intrapartum care was deemed important. This group felt that social and personal circumstances and obesity could be categorised as medical issues.
- The group had queries over how comprehensively the scope should cover each medical condition considering the number of conditions there are to be covered overall.

Scope – general comments

Group 1

- The group stated that there are very specific approaches to many of the conditions listed in the draft scope, for example, cardiac disease. Some of these conditions have been covered elsewhere so the group felt that this guideline would not need to repeat the information, but should look at it.
- The group agreed that the level of training and competence in midwives/professionals caring for high risk women in intrapartum care can vary widely. It may not be common for midwives to be trained in individual medical conditions, and this could be covered in a separate guideline. There may also be some variation in practice but most hospitals will have taken on board guidance around the issue of high risk women (already guidance in place for example for women with diabetes or with a BMI of 40+, and the group felt that this did not need repeating in this guideline).
- The group felt that the following conditions should be included within this guideline: cardiac disease, asthma (but be specific), anti-coagulants, non-thrombophilic haematological disorders, obesity, and mental health issues (which would have to be dealt with sensitively).
- The group stated that breech presentation could be excluded, as this is well covered elsewhere.

- The group believed that a planned caesarean section should not mean an automatic exclusion from the guideline.
- The group discussed the possibility of editing the current title: 'Intrapartum care for women at high risk of adverse outcomes' was proposed.
- The group felt that the severity of conditions needed to be clarified before a pathway was laid out, i.e. not **all** women with asthma need specialist care in labour.
- The group raised the issue of informed consent, that women have the right to know what the increased risks are for individual outcomes (for example, outcome 'mode of birth') and that the guideline should guide clinical caregivers on how to provide this information. (It was noted that the Montgomery versus Lanarkshire case already set the boundaries of what information clinicians are required to disclose to patients.)
- The group stated the importance of cross-referring to other guidelines especially if information is omitted from this guideline because it is included elsewhere, such as in an RCOG 'Green-top Guideline'.
- The group felt that if conditions were excluded from the guideline then the reason should be stated.
- The group proposed the idea of a statement about what standard care should be for high risk women, as was done for low risk women in the existing intrapartum care guideline, staffing levels etc.
- The group noted that thyroid disease is not mentioned in the scope.

Group 2

- The group felt that the title should be changed so that the words 'high risk' are not used. The group suggested the alternative title 'Intrapartum care of women with obstetric and medical complications'.
- The group felt that it was important to estimate what percentage of pregnancies are considered high risk.

Group 3

- The group felt that obstetric complications was the area in which most clinicians would require guidance, closely followed by medical complications.
- The group felt that 'high risk' was a term which would be better replaced by the term 'complex needs'.
- The group felt that when another guideline covered antenatal and postnatal care it would be better from a user perspective to have high risk intrapartum care included in the same guideline. One example of this given was women with multiple pregnancy whose intrapartum care could be included in the multiple pregnancy guideline once it was updated. Another example was that where a medical condition often impacted on intrapartum care it should be included in the guideline for the condition when it is updated, one example of this being type 1 diabetes in adults.
- The group felt that general principles for care of women with medical conditions should be addressed, however, for the specific medical conditions this would need to be covered in the guideline for the medical condition in order to cover the whole pathway of care. General principles could be grouped according to the type of medical condition (for example, cardiac, respiratory, renal).
- The group proposed changing the title to 'Intrapartum care for women with complex needs' as they felt that complex needs did not necessarily determine whether a woman is 'high risk'.

Group 4

- The group stated that it is essential to have adequate risk assessments and subsequent plan(s) of care.
- The group discussed that the guideline should cover informed consent (guidance on which material risks women should be informed of) and that women should be guided with key points in order to grant them the ability to make informed choices (Montgomery versus Lanarkshire).
- The group discussed that intrapartum sepsis and prelabour rupture of membranes which were already included in the draft scope were high priority topics in obstetric emergency.
- The group discussed that intrapartum care for high risk women with multiple pregnancy could be added to the relevant guideline as a part of the update.
- The group discussed, for the ease of implementation, allowing some overlap; they felt a duplication of recommendations is okay as long as it aids implementation whereas lots of hyperlinks in the guideline would not be very helpful in a hospital environment when each labour room may not be equipped with a computer.

Section 2.1 Who is the focus?

Group 1

- The group agreed on the 4 suggested categories. They felt there were no other subgroups to add apart from mental health and substance misuse. The group expressed the concern that mental health and substance misuse are often not seen as medical conditions by some professionals at first glance and therefore these issues may be ignored unless specifically clarified within the guideline.
- The group discussed the importance of the following medical conditions and their coverage in this guideline.
 - Cardiac disease: the group discussed the high mortality rates however there should already be individualised plans agreed in advance for these women. There is geographical variation but some of these women will be inpatients. It was felt that this guideline did not need to explain how to deal with these cardiac problems but there was a need to ensure recognition and planning. The condition requires such individualised care that the guideline may need to cross-refer to other advice.
 - Asthma: the group discussed that there is a variation in monitoring, especially in teenagers where it can be difficult to achieve follow up. The group noted that 10% of women receive treatment for asthma.
 - Anticoagulants: the group discussed that this covers a large area of treatment and the definition used needs to be more specific. Not all women on this medication will be high risk during intrapartum care. Those receiving a treatment dose of anticoagulants could remain in the guideline but those receiving a prophylactic dose would not need to be included). There are more women taking these than before due to obesity but they may not all need high risk care.
 - Non-thrombophilic haematological disorders: the group agreed that these affect quite a small number of women; however this requires specialised referral.
 - Platelet disorders: the group agreed that this should also be included in this guideline as this can have an impact on localised anaesthetics.
 - Obesity: the group discussed that it is not possible with current resources to give consultant-led care to all obese women. Current guidance recommends women with a BMI of 30+ receive such care. In practice women with a BMI of 35+ receive specialist care, but this is

moving towards women with a BMI of 40+ due to lack of staffing resources. The group felt this was an area where more information and evidence was needed.

- The group discussed that there is large variation in care of women with pyrexia due to variation in use of thresholds and knowing what is high risk. They felt it was important to look at this.
- The group felt that there was the possibility to remove malpresentation.
- The group felt that small- and large-for-dates babies belong in this guideline as there is variation between hospitals. There is an RCOG guideline on this subject, but they felt strongly that this should be included in the guideline on intrapartum care for high risk women.
- The group raised the importance of antenatal risk assessment in order to support women effectively with mental health issues or social disadvantage during their intrapartum care and prevent it from becoming high risk.

Group 2

- The group acknowledged that the scope was too ambitious and that the topics should be divided.

Group 3

- The group felt that a way to look at this guideline was to keep in one guideline:
 - the woman who is high risk before or during labour due to obstetric conditions
 - the woman with a high risk baby (not including congenital disorders).
- The group felt that the following topics should be covered in separate guidelines:
 - women with medical problems for whom intrapartum care will be high risk
 - an update to the caesarean section guideline to include women with medical issues such as cardiac disease
 - women whose intrapartum care is high risk due to social and personal complexities
 - intrapartum care for women with cardiac disease could take up a whole guideline on its own.

Group 4

- The group referenced this topic under other headings.

Equalities

Group 1

- The group felt that substance misuse was not an equality issue but a medical one and should be treated as such.
- The group felt that women who have been trafficked should to be referred to.
- The group felt that FGM needs to be mentioned and referenced to the recent RCOG guideline.
- The group questioned whether domestic abuse should be referenced.
- The group discussed that older women are at risk because of a greater risk of medical conditions associated with age (i.e. cardiac disorders) but this could be captured in the equality considerations.
- The group discussed that teenagers who are pregnant would not be at high risk because they tend to have quite safe pregnancies physically; however there are social factors related to teenage pregnancy which require different

antenatal care but the group was not sure if there would be different care during the intrapartum period.

- The group felt that learning disabilities needed to be included.
- The group felt that rural locations would have an impact on intrapartum care due to issues around transfer which needed to be considered.
- The group discussed assisted conception; this would potentially need to be covered in intrapartum care for high risk women as it is not midwifery care.
- There are additional complexities related to the psychological aspects of a fear of losing the child.
- The group discussed women who have had a previous miscarriage - they felt that the planning is different but they are not sure about the intrapartum care. .

Group 2

- The group highlighted the importance of access to specialist care, especially with regard to newly arrived immigrants or women who experience language barriers.
- The group thought that women with a disability and travelling communities should be considered under equalities.
- The group thought that substance misusers might already be covered by the pregnancy and complex social needs guideline.

Group 3

- The group stated that HIV in pregnancy is managed well but there is no guidance on women with HIV who are experiencing other obstetric complications.
- The group believed that women with physical disabilities, hearing difficulties, sight difficulties and learning disabilities should be considered under this heading.

Group 4

- The group discussed that care regarding socially disadvantaged women should not be only about the place of birth.
- The group felt that it may be helpful to distinguish between women who have an underlying medical condition and those who have no antenatal care at all or other social problems such as domestic abuse and substance misuse (with greater psychological effects).
- Other groups that should be considered in this section were:
 - women who cannot speak English
 - women with physical disabilities (including hearing, visual)
 - religious subgroups.
- The group felt that although FGM is covered in an RCOG Green-top Guideline, it is better to double up and cover it in this guideline as well because it is very important.

Section 2.2 Setting

Group 1

- Specific medical issues are generally covered within a hospital setting, especially in London. The group queried how far this differed outside London.

Group 2

- This was not discussed in detail, but members of the group did not raise any objections to the content of this section.

Group 3

- No comments were made on the setting of care.

Group 4

- The group agreed with the settings indicated in the scope.
- Transfer issues were discussed, including transfer time from a low risk environment to high risk environment, recognising the time to transfer, and managing the transfer. In terms of governance it was considered better to have a geographically close place for transfer. Guidance on this would be useful as currently it is more politically based on budget and finances. The group felt very strongly that this required challenging because politics and finance should not interfere with best practice.

Section 2.3 Activities, services or aspects of care

Key areas that will be covered

Group 1

- The group believed that pregnant women with a baby identified during antenatal care to be at risk of adverse outcomes due to a congenital disorder should be covered, as should pregnant women in suspected preterm labour.

Group 2

- The group felt that service delivery, and more specifically multi-disciplinary teams, should be covered by the guideline.
- The group felt that care plans involving women were important and should be included in the guideline.
- The group was concerned that terminology or categorisation associated with 'high risk' or 'complications' should not limit choices.
- The group felt that women with a previous caesarean section should be included in the guideline.
- The group agreed that they wanted to have guidance on transfer included.

Group 3

- The group felt that facilities, place of birth and transfer were issues of importance. The group discussed the difference in care and transfers nationally.
- The group felt that breech and face presentation should be included in the guideline as these were common obstetric complications.
- The group felt that not including induction of labour was an omission as labour may be induced due to medical or obstetric complexities and in some cases there is resistance to induction due to social and cultural factors in women for whom intrapartum care will be high risk.
- The group felt that women with neuromuscular problems should be included.
- The group felt that there was no need to include epilepsy as there is an RCOG Green-top Guideline currently in progress.
- The group felt that as a topic cardiac disease was so large that an entire guideline could be commissioned on this.
- The group felt that morbidity and mortality weighting needed to be considered when choosing the focus.
- The group felt that amniotic fluid embolism could be removed as there is already an RCOG Green-top Guideline on this topic.
- The group felt that thromboprophylaxis should be removed from the guideline as there are two RCOG Green-top Guidelines covering this topic.

Group 4

- The group felt that there should be a very clear subsection on multidisciplinary approaches to managing the condition with a focus on obstetrics rather than the medical conditions.
- The group felt that the selection of medical conditions in the draft scope excluded other important medical conditions.

Areas that will not be covered

Group 1

- The group felt that women with mental health issues should be covered.
- The group discussed sickle cell anaemia and because there is an RCOG Green-top Guideline on this their view was that it should not be covered.
- The group felt strongly that obesity should be covered.
- The group felt that the following areas would be better updated in the intrapartum care guideline:
 - care of women with delay in the first stage of labour
 - care of women with delay in the second stage of labour (as they are not particularly high risk).
- The group felt that covering care of women with delay in the third stage of labour (retained placenta) would be useful as this was not covered sufficiently in the existing guideline on intrapartum care.
- The group felt that subarachnoid haemorrhage and/or arterio-venous malformations of the brain were important areas to cover despite representing small populations. As these conditions cannot be identified without an MRI scan they cannot be diagnosed at the point of presentation and, therefore, this point should be renamed 'women in labour presenting with a severe headache' in the scope.
- The group felt that breech presentation and delivery after 42 weeks were well covered elsewhere.
- The group discussed that care of women with suspected amniotic fluid embolism is covered in the RCOG Green-top Guideline 56.
- The group agreed on not repeating specific topics covered by other guidelines (hypertension in pregnancy, diabetes in pregnancy and multiple pregnancy). The group agreed that updates could be made to the relevant guidelines rather than including the topics in this guideline.
- The group discussed that pregnant women who have a caesarean section planned as part of antenatal care should not be omitted as this does not mean that the birth will be complication free and a preplanned caesarean section should not automatically exclude them from the guideline. An example of this which was discussed by the group was cardiac issues: women who have planned caesarean section could experience complications that are covered by this guideline, as they are at high risk anyway even if they already have intrapartum care planning.
- The group questioned where guidance is given for those have a caesarean section planned but then go into labour spontaneously.

Group 2

- The group mentioned that an RCOG thyroid Green-top Guideline will be published shortly so this topic could be excluded.
- The group wanted to cover the following areas that are currently not covered: pelvic girdle pain, subarachnoid haemorrhage, women with hepatitis B, hepatitis C or HIV.
- The group agreed that respiratory conditions in general should be covered but asthma specifically should not be covered.

- The group wanted to exclude obesity and social complexities.
- The group thought that women with mental health problems were probably too large and diverse a group to include in the guideline.
- The group agreed that delay in the first or second stage of labour should remain in the existing intrapartum care guideline.

Group 3

- The group felt strongly that exclusion of planned caesarean section was an omission, as this would result in women who have a medical condition and a planned caesarean section not receiving guidance in relation to the high risk nature of their condition.
- The group felt that respiratory diseases should be included, i.e. restrictive lung disease. The group felt that women with renal medical conditions should be included and especially those who had received a transplant, however they acknowledged that there was a lack of evidence on this.
- The group felt that it would be helpful to cover women currently taking stress-dose steroids as these are prescribed for a number of medical conditions which could create high risk situations during intrapartum care.
- The group felt that despite there being a guideline on sepsis this should be covered as the RCOG Green-top Guideline needs updating.
- The group felt that vaginal birth following caesarean section needed to be covered in this guideline if obstetric complications during intrapartum care were being covered by the guideline.
- The group felt that women currently taking anticoagulants should be removed as there is an RCOG Green-top Guideline already published on this topic.

Group 4

- The group was happy with the 'groups not to be covered' listed in the scope.
- The group discussed that intrapartum care after 42 weeks could be covered in the induction of labour guideline.
- The care of women with meconium stained liquor should stay in the existing intrapartum care guideline.
- Delay in the first and second stages of labour should also stay in the existing intrapartum care guideline.

Section 2.6 Main outcomes

Group 1

- The group felt that the most important outcomes to consider were:
 - mortality (woman and baby) – as a given
 - major morbidity for the baby
 - major morbidity for the woman
 - women's experience of labour and birth (also to be looked at in the long term).
- The group also felt that the following should be considered:
 - long-term developmental outcomes for the baby
 - re-admission to hospital within 7-14 days for the mother (and possibly the baby)
 - longer term outcomes of distress, psychologically difficult situations (difficult birth)
 - breastfeeding – the group suggested that this needed to be referred to but they do not see it as a main outcome.

Group 2

- The group felt that accuracy of diagnosis was an important outcome that should be included.
- The group mentioned that 'use of analgesia' was the odd one out in the list of outcomes.
- The group thought that admission and readmission were important outcomes.
- The group discussed the importance of a psychological de-brief post-birth and its link to future pregnancies.
- The group thought that breastfeeding should be a main outcome.
- The group thought that an outcome could look at transfer and ask whether it was justified.

Group 3

- The group discussed the outcomes and considered them all to be important but the 3 most important outcomes for the woman and the baby would be as follows.

Woman

- Woman's experience of labour and birth
- Mortality
- Morbidity

Baby

- ICU admission
- Mortality
- Morbidity

Group 4

- The Group was happy with the outcomes indicated in the scope.

Section 2.5 Key issues and questions**Group 1**

- The group viewed diagnosis and intervention to be the most important question.

Group 2

- These were not discussed in detail because the group agreed that this would depend on the final decision about the content and configuration of the scope.

Group 3

- The group expressed the following views.
 - The appropriate planned place of birth is very important and should be reflected in the guideline.
 - The order of questions should be amended to put what observations should be done before when they should be done.
 - It would be relevant to cover what influence de-briefing has on women's experience of labour and birth. The group acknowledged that this was contentious and that perhaps what would be more important to cover would be discussion and informed choice in the third stage of labour.
 - It is important to consider what the most appropriate facilities are in place in order to provide women with a positive experience of labour and birth. The group felt that guidance on the optimal frequency of immediate postpartum care should be provided for women with complex needs following complications in labour.

Group 4

- The group felt that the following issues needed to be addressed:
 - Intrapartum care in women with sepsis and pyrexia.
 - Risk factors for sepsis.
 - Timing of birth in the presence of sepsis.
 - Effect of epidural analgesia in sepsis (regional analgesia and increased risk of sepsis).
 - Sepsis and neonatal hypoxia (delivery should be expedited).

Section 2.4 Economic Aspects

Group 1

- The group raised the point that there is currently not adequate funding for pregnant women who have a BMI of 30+/40+.

Group 2

- The group did not raise any points about the economic aspects of care.

Group 3

- The group did not raise any points about the economic aspects of care.

Group 4

- The group did not raise any points about the economic aspects of care.

Guideline Committee composition

Proposed members

Group 1

- The group did not suggest removing any of the proposed Guideline Committee members.

Group 2

- The group suggested that a consultant midwife could replace a community midwife and that another midwife or obstetrician could replace a GP.

Group 3

- The group discussed the proposed membership and made the following comments.
 - An obstetric physician would only be needed if the guideline were covering sepsis. The group felt this position could be broadened to be filled by any physician.
 - A neurologist would only be needed if the guideline were covering disabilities.
- The group felt that lay members needed to be specific to the guideline topic, i.e. having had experience of medical or obstetric complexities during intrapartum care.

Group 4

- The group discussed the roles and made the following comments.
 - A community midwife should be added.
 - Under expert witnesses, there was no need for a neurologist but a psychiatrist would be needed to support the consideration of social complications (NHS England).
 - One commissioner should be included.
 - One specialised commissioner (clinical reference group), to be

- representative of obstetrics complex issues, should be included.
- One GP should be included.

Members that should be included

Group 1

- The group suggested that the following Committee members or expert witness could or should be included:
 - A perinatal psychiatrist as an expert witness.
 - A psychologist with perinatal expertise as an expert witness.
 - A community mental health nurse (although there are very few) or a midwife with a special interest in mental health – someone who could cover community aspects.
 - An obstetrician with a special interest on obesity.
 - Another lay member.
 - A bariatric anaesthesiologist.

Group 2

- The group felt that an ambulance crew member should be on the Committee, perhaps instead of a GP. The GP could be a specialist instead. It was suggested that a junior doctor should be on the Committee.

Group 3

- There were no suggestions for further members to be added to the proposed constituency.

Group 4

- There were no comments raised by the group under this heading.