

CASE STUDY SUPPORTING CONTINUITY OF CARE MODELS FOR BREECH PRESENTATION AT OR NEAR TERM

With the publication of *Better births* (NHS England 2016) there has been a national movement to develop continuity of care teams to provide gold standard midwifery care. Research has supported this approach to caring for mothers, by showing improved outcomes for both mothers and their babies (Sandall et al 2016). However, the focus has always been around generalised groups of mothers where continuity can not only improve outcomes, but be easy to implement.

One group of mothers who would benefit from continuity is those who have a baby in the breech (bottom down) presentation. Small teams of breech specialists can work with the mother's continuity team to provide specialist care to support mothers wishing to have a vaginal breech birth in the safest way. This case study shows how a continuity of care model would be beneficial to this cohort of mothers.



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CONTINUITY OF CARE

Continuity of care has been deemed the 'gold standard' model of care for mothers globally (Sandall et al 2016). The benefits of continuity of care are well known, and the release of a Government backed report, *Better births* (NHS England 2016), has seen maternity services across the UK being re-shaped and transformed to support this model of working. The benefits of continuity of care include reductions in stillbirth, pre-term birth and late miscarriage; improved maternal and neonatal outcomes; and a more positive birth experience for mothers (Sandall et al 2016). It is hypothesised that these benefits are possibly due to having a known midwife who is trusted by the families in their care, to whom they will disclose information that they may otherwise feel uncomfortable discussing. It is also thought to be because the midwife knows the mother, and is therefore quickly able to identify when there is a concern or deviation from the norm for that individual. Continuity of

care teams are often implemented to support mothers with socially complex lives, but they can also be used to support obstetrically complex cases.

This article describes a case study of a mother in her second pregnancy with a breech presentation and the effect continuity of care had on her labour and birth. A pseudonym has been used throughout to preserve anonymity in accordance with the Nursing and Midwifery Council (NMC) guidelines (2018).

CASE STUDY

Chloe was referred to me as the midwife leading on a breech-birth service within the hospital where I work. The referral was made by Chloe's doctor, following an ultrasound scan at 36 weeks' gestation, to confirm the presentation of Chloe's baby. The ultrasound scan found the baby to be in the frank breech presentation, with both hips flexed and the legs extended at the knees (See Figure 1). This is a suitable position if a mother is considering a vaginal breech birth. On the initial consultation with Chloe, I explained the position of the baby and discussed options of: moxibustion – a complementary therapy used to turn breech babies to a cephalic (head down) position (Coyle et al 2012); external cephalic version (ECV) – a procedure performed by a trained healthcare professional to manually turn the baby to a cephalic presentation (Impey et al 2017a); planned caesarean section; or a planned vaginal breech birth (Impey et al 2017b).



Figure 1*

Counselling

Chloe was counselled according to the Royal College of Obstetricians and Gynaecologists (RCOG) breech presentation guidelines (Impey et al 2017b), regarding the benefits and limitations of planned caesarean section, emergency caesarean section and planned vaginal breech birth. The risks of perinatal mortality for each option were given: 0.5 per 1,000 births for planned caesarean section at 39 weeks' gestation and two per 1,000 births for planned vaginal breech birth (See Figure 2) (Impey et al 2017b). This compares to one per 1,000 births for vaginal cephalic birth (Impey et al 2017b). Chloe was informed of the effects of caesarean section on future pregnancies: vaginal birth after caesarean section (VBAC) and increased risk of stillbirth (Impey et al 2017b). The complications associated with vaginal breech birth such as compound arm, nuchal arm and deflexed head were discussed, along with the manoeuvres required to resolve the complications and restore the mechanism of physiological breech birth (Walker 2019). Following the consultation, Chloe decided to have an ECV; however, this was unsuccessful, as happens in 50 per cent of cases (Impey et al 2017a). Following the ECV, I met with Chloe and her partner as the breech specialist midwife. We had another discussion about Chloe's options, and I gave them a copy of the RCOG guidelines (Impey et al 2017b) to read, along with my contact details, so I could be contacted for further advice and information. Chloe and her partner went away to think about the information they were given. They were to contact me to inform me of their choice of mode of birth so that a plan could be put in place to facilitate their wishes.

Continuity and the birth

Over the course of the next week, there was further communication between Chloe and me, and they arranged another consultation. During this appointment Chloe and her partner decided they would like to try a vaginal breech birth with the knowledge there was a 60 per cent chance of a successful vaginal breech birth and a 40 per cent chance of needing a caesarean section if the pregnancy went past 42 weeks' gestation, or there was fetal distress

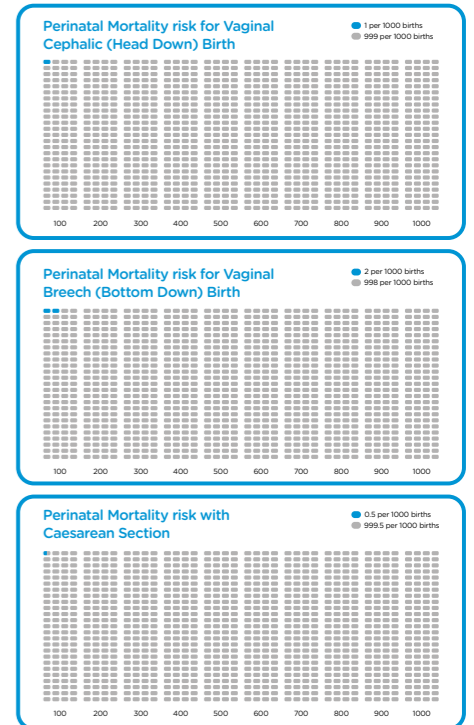


Figure 2

“The complications associated with vaginal breech birth such as compound arm, nuchal arm and deflexed head were discussed”



“ I was not enabled by the Trust to be on call for breech births, despite being the specialist in this area within the Trust ”

or a prolonged first or second stage of labour. I wrote a birth preference plan supporting Chloe's wishes, and referred her to a consultant obstetrician for further discussion. I attended this appointment with Chloe, promoting a joined up multidisciplinary team approach to care, which is important to ensure excellent and safe care for women with more complex pregnancies (National Institute for Health and Care Excellence [NICE] 2019).

Labour

One cold evening in March, Chloe went into labour. She attended the delivery suite for assessment; she was contracting every five minutes for one minute's duration and, on internal examination, her cervix was three centimetres dilated, fully effaced. The midwife in triage contacted me, as the breech specialist midwife, and informed me of Chloe's admission. The advice given was for Chloe to have one-to-one care on delivery suite in view of this being her second pregnancy and breech births being notoriously quick. At about three in the morning I contacted the hospital for an update, believing Chloe would have given birth, but was surprised to hear that she was sleeping on and off, and her contractions had spaced out somewhat and were less intense than previously felt. At five o'clock in the morning Chloe was taken to the antenatal ward to wait for her labour to establish.

At half past seven in the morning I attended for work and went straight to see Chloe who was contracting every 10 minutes, but she was able to talk through them at this time. I had been unable to see Chloe before this because I was not enabled by the Trust to be on call for breech births, despite being the specialist in this area within the Trust, and research supporting specialists to attend breech births – which has been shown to improve outcomes (Impey et al 2017a; Walker et al 2018; Walker 2017; Hannah et al 2000). I sat with Chloe for about 40 minutes discussing her options and finding out how Chloe was feeling about the labour and birth ahead. During this time Chloe's contractions became stronger and longer and she was unable to talk through them by the end of the conversation.



Figure 3

Continuity of carer

An hour later Chloe requested an examination; her cervix was five centimetres dilated, the presenting part being in left sacral transverse (LST) position at the level of the ischial spines. The normal mechanism for physiological breech birth is the buttocks descending in the pelvis in the transverse diameter (shown in Figure 3). Chloe was taken to delivery suite and cared for by me, with whom she had developed a rapport and had received continuity of care throughout the last few weeks of her pregnancy. Chloe's labour progressed quickly. As she started bearing down in the second stage of labour, an obstetrician and a neonatal doctor were called to attend to promote safety in case any intervention or resuscitation were required. My role as the breech specialist, at this point, was to support the obstetrician to facilitate a physiological (upright) breech birth to gain experience in facilitating breech births in this position. The birth proceeded without complication, and the baby was passed to Chloe for immediate skin-to-skin contact and initiation of breastfeeding.

PHYSIOLOGICAL BRECH BIRTH

Research by Louwen et al (2016), Bogner et al (2015) and Walker (2017) has shown improved outcomes for mothers and babies in physiological breech birth. In an upright (usually a forward-leaning kneeling) position, there is a reduction in the need for manoeuvres to resolve complications and a reduction in caesarean sections required (Louwen et al 2016). The breech birth guideline within the Trust was re-written by myself, with the support of the consultant midwife for normal birth and the consultant obstetrician leading on the breech service with me, to reflect this evidence and support mothers' choices. Therefore, it is imperative that all staff receive support to facilitate births in upright positions to improve outcomes and support parents' choices to birth in upright positions.

BENEFITS OF CONTINUITY

The following day I went to see Chloe to debrief, following the birth, and discuss future pregnancies. During the

conversation Chloe asked why she had had a prolonged latent phase of labour, as this had not happened with her first labour. I asked about Chloe's feelings when she was admitted and when her labour progressed. Chloe reported that she felt anxious and worried when she was admitted, because she did not know the staff and was unsure of the confidence and competence among the team, with regards to vaginal breech birth. Chloe reported feeling calmer, relaxed and more confident when I came to see her, and this was when her labour started to progress. The hormone needed

for contractions to become established and strong in labour – oxytocin – is inhibited by the release of adrenalin (Buckley 2015). The adrenal glands release adrenalin when we are scared and stressed, to prepare the body for 'fight or flight'. This can be seen in wild animals when they come under threat in labour: they produce adrenalin and their labour stops completely until it is safe again to birth their young; then their labour will restart. When Chloe became relaxed, her adrenalin levels subsided, which enabled an increase in oxytocin levels, thus progressing her labour.

“ There was a 60 per cent chance of a successful vaginal breech birth ”

CONCLUSION

This case study highlights the power of continuity of care and being cared for by a healthcare professional who is known and trusted, particularly so in cases that are more complex, such as breech birth. In these instances, being caseloaded by a midwife who has expert knowledge and experience in the field can enhance safety and improve physiological outcomes for mothers and neonates, but also improve emotional and psychological wellbeing. This leads to better long-term neonatal and maternal health. Having a practitioner competent in the particular complexity allows for transfer of knowledge and skills to others, as in this case, enhancing and increasing learning opportunities safely.

Whilst continuity of care is important for all women and should be a model of care used within maternity, it is particularly important in more complex cases, such as women choosing to have a physiological breech birth. It is also central to improving outcomes, because the presence of a skilled and experienced practitioner reduces the risks associated with vaginal breech birth as much as having a caesarean section does (Walker et al 2018; Louwen et al 2016; Hannah et al 2000). Therefore continuity of care supports an on-call system for specialist breech teams to attend such births. **TPM**

* Figure 1 – with thanks to Kate Evans for the use of this image.

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