Preterm labour and birth

NICE quality standard

Draft for consultation

April 2016

Introduction

This quality standard covers care for women who are considered to be at risk of preterm labour and birth, including diagnosing preterm labour. It does not cover women with a multiple pregnancy. For more information see the preterm labour and birth topic overview.

Why this quality standard is needed

Preterm birth is the single biggest cause of neonatal mortality and morbidity in the UK. Over 52,000 babies (around 7.3% of live births) in England and Wales in 2012 were born preterm – that is, before 37^{+0} weeks of pregnancy. There has been no decline in the preterm birth rate in the UK over the last 10 years.

Babies born preterm have high rates of early, late and post neonatal mortality, and the risk of mortality increases as gestational age at birth decreases. Babies who survive have increased rates of disability. Recent UK studies comparing cohorts born in 1995 and 2006 have shown improved rates of survival (from 40% to 53%) for extreme preterm births (born between 22 and 26 weeks). Rates of disability in survivors were largely unchanged over this time period.

The most important long−term consequence of prematurity is neurodevelopmental disability. Although the risk for the individual child is greatest for those born at the earliest gestational ages, the global burden of neurodevelopmental disabilities depends on the number of babies born at each of these gestations, and so is very significant for babies born between 32 and 36 weeks, less for those born between 28 and 31 weeks, and least for those born at less than 28 weeks gestation.

Around 75% of women delivering preterm do so after preterm labour, which may or may not be preceded by preterm prelabour rupture of membranes (P-PROM). The remaining women delivering preterm have an elective preterm birth when this is thought to be in the fetal or maternal interest (for example, because of extreme growth retardation in the baby or maternal conditions such as pre−eclampsia).

The quality standard is expected to contribute to improvements in the following outcomes:

- fetal and neonatal morbidity and mortality
- maternal morbidity
- safety of both fetus and the mother
- neonatal sepsis
- neurodevelopmental disability
- experience of childbirth.

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measurable improvements in the 3 dimensions of quality – patient safety, patient experience and clinical effectiveness – for a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 2 outcomes frameworks published by the Department of Health:

- NHS Outcomes Framework 2015–16
- Public Health Outcomes Framework 2013–16.

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

Table 1 NHS Outcomes Framework 2015–16

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	***Overarching indicators*** 1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare i Adults ii Children and young people 1c Neonatal mortality and stillbirths ***Improvement areas*** **Reducing mortality in children** 1.6 i Infant mortality* ii Neonatal mortality and stillbirths
4 Ensuring that people have a positive experience of care	***Overarching indicators*** 4c *Friends and family test* *4d Patient experience characterised as poor or worse* *i Primary care* *ii Hospital care* ***Improvement areas*** **Improving women and their families' experience of maternity services** 4.5 Women's experience of maternity services
5 Treating and caring for people in a safe environment and protecting them from avoidable harm	***Overarching indicators*** *5a Deaths attributable to problems in healthcare* *5b Severe harm attributable to problems in healthcare* ***Improvement areas*** **Improving the culture of safety reporting** 5.6 Patient safety incidents reported
Alignment with Public Health Outcomes Framework * Indicator is shared Indicators in italics in development	

Table 2 Public health outcomes framework for England, 2013–16

Domain	Objectives and indicators
4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities ***Indicators*** 4.1 Infant mortality* 4.3 Mortality rate from causes considered preventable**
Alignment with NHS Outcomes Framework * Indicator is shared ** Indicator is complementary	

Safety and people's experience of care

Ensuring that care is safe and that people have a positive experience of care is vital in a high-quality service. It is important to consider these factors when planning and delivering services relevant to women who are considered to be at risk of preterm labour and birth.

NICE has developed guidance and an associated quality standard on patient experience in adult NHS services (see the NICE pathway on patient experience in adult NHS services), which should be considered alongside this quality standard. This specifies that people receiving care should be treated with dignity, have opportunities to discuss their preferences, and be supported to understand their options and make fully informed decisions. It also covers the provision of information to patients and service users. Quality statements on these aspects of patient experience are not usually included in topic-specific quality standards. However, recommendations in the development sources for quality standards that affect people's experience of using services are specific to the topic are considered during quality statement development.

Coordinated services

The quality standard for preterm labour and birth specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole preterm labour and birth care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to women who are considered to be at risk of preterm labour and birth.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality preterm labour and birth service are listed in Related quality standards.

Training and competencies

The quality standard should be read in the context of national and local guidelines on training and competencies. All healthcare professionals involved in assessing, caring for and treating women who are considered to be at risk of preterm labour and birth should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard. Quality statements on staff training and competency are not usually included in quality standards. However, recommendations in the development source on specific types of training for the topic that exceed standard professional training are considered during quality statement development.

Role of families and carers

Quality standards recognise the important role families and carers have in supporting women who are considered to be at risk of preterm labour and birth. If appropriate, healthcare professionals should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care.

Resource impact

Resource impact and affordability were considered during development, and achieving the quality statements is not expected to result in significant additional costs. There may be longer-term savings for health and social care from preventing preterm birth, and from reducing adverse outcomes by using maternal corticosteroids and magnesium sulfate.

List of quality statements

Statement 1. Women at increased risk of preterm labour are given information about the potential signs and symptoms.

Statement 2. Women who are having a planned preterm birth are given information about the risks and outcomes including the likelihood of the baby surviving.

Statement 3. Women in suspected preterm labour who are 29^{+6} weeks pregnant or less are offered tocolysis, maternal corticosteroids and magnesium sulfate.

Statement 4. Women between 30 and 33^{+6} weeks of pregnancy are offered maternal corticosteroids if they are in diagnosed preterm labour, are having a planned preterm birth, or have preterm prelabour rupture of membranes (P-PROM).

Questions for consultation

Questions about the quality standard

Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement?

Question 2 Are local systems and structures in place to collect the data for the proposed quality measures? If not, how feasible would it be for these systems and structures to be put in place?

Question 3 Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

Question 4: Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

Question about the individual quality statements

Question 5: When developing quality standards and prioritising key areas for quality improvement, current variation in practice is a key consideration. Section 1.2 in the NICE guideline on preterm labour and birth makes recommendations on prophylactic vaginal progesterone and prophylactic cervical cerclage for women who have had a transvaginal ultrasound between 16^{+0} and 24^{+0} weeks of pregnancy. Are transvaginal ultrasound scans routinely offered to all pregnant women between 16^{+0} and 24^{+0} weeks of pregnancy, or is there variation in practice? Please detail your answer.

Quality statement 1: Providing information about potential signs, symptoms and care

Quality statement

Women at increased risk of preterm labour are given information about the potential signs and symptoms.

Rationale

Not all women at increased risk of preterm labour know what symptoms and signs to look out for. At such a vulnerable time in their lives, families need to be given information and support to meet their needs, without causing unnecessary anxiety.

Quality measures

Structure

Evidence of local arrangements and written clinical protocols to ensure that women at increased risk of preterm labour are given information about the potential signs and symptoms.

Data source: Local data collection.

Process

Proportion of women at increased risk of preterm labour who are given information about the potential signs and symptoms.

Numerator – the number in the denominator who are given information about the potential signs and symptoms.

Denominator – the number of women at increased risk of preterm labour.

Data source: Local data collection.

Outcome

Patient satisfaction with the information provided.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (secondary care services) ensure that women at increased risk of preterm labour are given information about the potential signs and symptoms.

Healthcare professionals (such as midwives and obstetricians for women with high risk pregnancies) give information to women at increased risk of preterm labour about the potential signs and symptoms.

Commissioners (clinical commissioning groups) commission services that ensure that women at increased risk of preterm labour are given information about the potential signs and symptoms.

What the quality statement means for women and their companions

Women at increased risk of preterm labour (at risk of giving birth before the 37th week of pregnancy) are given information that explains the signs and symptoms they may have.

Source guidance

- Preterm labour and birth (2015) NICE guideline NG25, recommendation 1.1.1

Definitions of terms used in this quality statement

Women at increased risk of preterm labour

Women with a history of spontaneous preterm birth or mid-trimester loss between 16^{+0} and 34^{+0} weeks of pregnancy.

[Adapted from Preterm labour and birth (2015) NICE guideline NG25, recommendation 1.2.1]

Potential symptoms of preterm labour

The potential symptoms could include:-

- Watery, mucosal or bloody vaginal discharge
- increased amount of vaginal discharge
- pelvic or lower abdominal pressure

- constant low, dull backache
- mild abdominal cramps, with or without diarrhoea

[Expert opinion]

Potential signs of preterm labour

The potential signs could include:

- Regular or frequent (often painless) contractions or uterine tightening.
- P-PROM.

[Expert opinion]

Information

Women should be given oral and written information, and directed to organisations that can provide further support.

[Preterm labour and birth (2015) NICE guideline NG25, full guideline]

Equality and diversity considerations

Women at increased risk of preterm labour should have access to information that is understandable if they:

- have additional needs, such as physical, sensory or learning disabilities
- do not speak or read English
- have religious, ethnic or cultural needs.

Interpreters and advocates should be provided if needed.

Quality statement 2: Providing gestation-specific information and support

Quality statement

Women who are having a planned preterm birth are given information about the risks and outcomes including the likelihood of the baby surviving.

Rationale

Women who are having a planned preterm birth need information given as early as possible in the antenatal period on the level and nature of the risks. This can help them to understand what neonatal care their baby might need and to discuss this with their neonatologist or paediatrician, tour the neonatal unit, and to help them give their wishes for resuscitating the baby.

Quality measures

Structure

Evidence of local arrangements and written clinical protocols to ensure that women who are having a planned preterm birth are given information about the risks and outcomes including the likelihood of the baby surviving.

Data source: Local data collection.

Process

Proportion of women who are having a planned preterm birth and are given information about the risks and outcomes including the likelihood of the baby surviving.

Numerator – the number in the denominator who are given information about the risks and outcomes including the likelihood of the baby surviving.

Denominator – the number of women who are having a planned preterm birth.

Data source: Local data collection.

Outcome

Patient satisfaction with the information provided.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (secondary care services) ensure that women who are having a planned preterm birth are given information about the risks and outcomes including the likelihood of the baby surviving.

Healthcare professionals (such as obstetricians, neonatologists and paediatricians) give information to women who are having a planned preterm birth about the risks and outcomes including the likelihood of the baby surviving.

Commissioners (clinical commissioning groups) commission services that ensure that women who are having a planned preterm birth are given information about the risks and outcomes including the likelihood of the baby surviving.

What the quality statement means for women and their companions

Women who are having a planned preterm birth (planning to give birth before the 37th week of pregnancy) are told:

- how likely it is that their baby will survive
- other outcomes (including long-term outcomes) and risks for the baby about any risks to their baby, and how likely these are giving values as natural frequencies (for example, 1 in 100)
- explaining about the neonatal care of preterm babies, including where the baby will be cared for
- the immediate problems that can arise when a baby is born preterm
- the possible long-term consequences of prematurity for the baby (how premature babies grow and develop)
- where they will deliver their baby, and how much time their baby will need to stay in hospital afterwards.

Source guidance

- Preterm labour and birth (2015) NICE guideline NG25, recommendation 1.1.2

Definitions of terms used in this quality statement

Planned preterm birth

The planned birth of an infant before 37 weeks of pregnancy due to medical complications.

[Preterm labour and birth (2015) NICE guideline NG25, full guideline]

Outcomes

Including long-term infant neurodevelopmental outcomes.

[Preterm labour and birth (2015) NICE guideline NG25, full guideline]

Information

Women should be given oral and written information, and directed to organisations that can provide further support.

[Preterm labour and birth (2015) NICE guideline NG25, full guideline]

Equality and diversity considerations

Women who are having a planned preterm labour should have access to information that is understandable if they:

- have additional needs, such as physical, sensory or learning disabilities
- do not speak or read English
- have religious, ethnic or cultural needs.

Interpreters and advocates should be provided if needed.

Quality statement 3: Treatment for suspected preterm labour before 30 weeks of pregnancy

Quality statement

Women in suspected preterm labour who are 29^{+6} weeks pregnant or less are offered tocolysis, maternal corticosteroids and magnesium sulfate.

Rationale

Not all women in suspected preterm labour who are 29^{+6} weeks pregnant or less are offered treatment. Treatment at this stage can be the best option, as tocolysis, maternal corticosteroids and magnesium sulfate may delay birth and reduce the risk of problems such as cerebral palsy and of neonatal death. It is important that the potential benefits and risks of these treatments are discussed with these women.

Quality measures

Structure

Evidence of local arrangements and written clinical protocols to ensure that women in suspected preterm labour who are 29^{+6} weeks pregnant or less are offered tocolysis, maternal corticosteroids and magnesium sulfate.

Data source: Local data collection.

Process

a) Proportion of women who are 29^{+6} weeks pregnant or less and are in suspected preterm labour who are offered tocolysis.

Numerator – the number in the denominator who receive tocolysis.

Denominator – the number of women who are 29^{+6} weeks pregnant or less and are in suspected preterm labour.

Data source: Local data collection.

b) Proportion of women who are 29^{+6} weeks pregnant or less and are in suspected preterm labour who are offered maternal corticosteroids.

Numerator – the number in the denominator who receive maternal corticosteroids.

Denominator – the number of women who are 29^{+6} weeks pregnant or less and are in suspected preterm labour.

Data source: Local data collection.

c) Proportion of women who are 29^{+6} weeks pregnant or less and are in suspected preterm labour who are offered magnesium sulfate.

Numerator – the number in the denominator who receive magnesium sulfate.

Denominator – the number of women who are 29^{+6} weeks pregnant or less and are in suspected preterm labour.

Data source: Local data collection.

Outcome

a) Neonatal death.

Data source: Local data collection.

b) Risk of cerebral palsy.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (such as secondary or tertiary care services) ensure that women in suspected preterm labour who are 29^{+6} weeks pregnant or less are offered tocolysis, maternal corticosteroids and magnesium sulfate.

Healthcare professionals (such as midwives, obstetricians and neonatologists) offer tocolysis, maternal corticosteroids and magnesium sulfate to women in suspected preterm labour who are 29^{+6} weeks pregnant or less.

Commissioners (clinical commissioning groups) commission services that ensure that women in suspected preterm labour who are 29^{+6} weeks pregnant or less are offered tocolysis, maternal corticosteroids and magnesium sulfate.

What the quality statement means for women and their companions

Women in suspected preterm labour who are less than 30 weeks pregnant are offered tocolytics (medicines that slow down or stop labour), steroid injections and magnesium sulfate (medicine that helps protect a baby's brain).

'Suspected preterm labour' is when a woman who is less than 37 weeks pregnant thinks she may be in labour, and her care team have assessed her and think this is a possibility (the assessment is not 100% accurate).

Source guidance

- Preterm labour and birth (2015) NICE guideline NG25, recommendation 1.7.3 and sections 1.8, 1.9 and 1.10

Definitions of terms used in this quality statement

Suspected preterm labour

A woman is in suspected preterm labour if she has reported symptoms of preterm labour and has had a clinical assessment (including a speculum or digital vaginal examination) that confirms the possibility of preterm labour but rules out established labour.

[Preterm labour and birth (2015) NICE guideline NG25]

Equality and diversity considerations

Women who are in suspected preterm labour should have access to information that is understandable if they:

- have additional needs, such as physical, sensory or learning disabilities
- do not speak or read English
- have religious, ethnic or cultural needs.

Interpreters and advocates should be provided if needed.

Quality statement 4: Treatment for diagnosed preterm labour, planned preterm birth or P-PROM between 30 and 33^{+6} weeks of pregnancy

Quality statement

Women between 30 and 33^{+6} weeks of pregnancy are offered maternal corticosteroids if they are in diagnosed preterm labour, are having a planned preterm birth, or have preterm prelabour rupture of membranes (P-PROM).

Rationale

Antenatal administration of maternal corticosteroids to a mother prior to preterm birth has a number of positive outcomes including reducing the severity of lung disease of prematurity and of other associated complications for her baby.

Repeat courses of maternal corticosteroids should not routinely be offered, because they can be unsafe. The decision to offer a repeat course should be based on the time since the last course of corticosteroids ended, the gestational age of the baby and the likelihood of birth within 48 hours.

Quality measures

Structure

Evidence of local arrangements and written clinical protocols to ensure that women between 30 and 33^{+6} weeks of pregnancy are offered maternal corticosteroids if they are in diagnosed preterm labour, are having a planned preterm birth, or have preterm prelabour rupture of membranes (P-PROM).

Data source: Local data collection.

Process

a) Proportion of women who are between 30 and 33^{+6} weeks of pregnancy and are in diagnosed preterm labour who are offered maternal corticosteroids.

Numerator – the number in the denominator who receive maternal corticosteroids.

Denominator – the number of women who are between 30 and 33^{+6} weeks of pregnancy and are in diagnosed preterm labour.

Data source: Local data collection.

b) Proportion of women who are between 30 and 33^{+6} weeks of pregnancy and are in planned preterm labour who are offered maternal corticosteroids.

Numerator – the number in the denominator who receive maternal corticosteroids.

Denominator – the number of women who are between 30 and 33^{+6} weeks of pregnancy and are in planned preterm labour.

Data source: Local data collection.

c) Proportion of women who are between 30 and 33^{+6} weeks of pregnancy and have P-PROM who are offered maternal corticosteroids.

Numerator – the number in the denominator who receive maternal corticosteroids.

Denominator – the number of women who are between 30 and 33^{+6} weeks of pregnancy and have P-PROM.

Data source: Local data collection.

Outcome

Safety to both fetus and the mother

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (secondary care services) ensure that women between 30 and 33^{+6} weeks of pregnancy are offered maternal corticosteroids if they are in diagnosed preterm labour, are having a planned preterm birth, or have P-PROM.

Healthcare professionals (such as obstetricians and midwives) offer maternal corticosteroids to women between 30 and 33^{+6} weeks of pregnancy who are in diagnosed preterm labour, are having a planned preterm birth, or have P-PROM.

Commissioners (clinical commissioning groups) commission services that ensure that women between 30 and 33^{+6} weeks of pregnancy are offered maternal corticosteroids if they are in diagnosed preterm labour, are having a planned preterm birth, or have P-PROM.

What the quality statement means for women and their companions

Women who are over 29 weeks and under 34 weeks of pregnancy are offered steroid injections if:

- they are in diagnosed preterm labour (they have had a test that shows they are in labour before the 37th week of pregnancy)
- they are having a planned preterm birth (planning to give birth before the 37th week of pregnancy)
- they have preterm prelabour rupture of membranes (also called P-PROM, this is when a woman's waters break when she is less than 37 weeks pregnant but labour hasn't started).

Source guidance

- Preterm labour and birth (2015) NICE guideline NG25, recommendations 1.9.3 and 1.9.6

Definitions of terms used in this quality statement

Diagnosed preterm labour

A woman is in diagnosed preterm labour if she is in suspected preterm labour and has had a positive diagnostic test for preterm labour.

[Preterm labour and birth (2015) NICE guideline NG25]

Planned preterm labour

The planned birth of an infant before 37 weeks of pregnancy due to medical complications.

[Preterm labour and birth (2015) NICE guideline NG25]

Preterm prelabour rupture of membranes (P-PROM)

A woman is described as having P-PROM if she has ruptured membranes before 37^{+0} weeks of pregnancy but is not in established labour.

[Preterm labour and birth (2015) NICE guideline NG25, full guideline]

Status of this quality standard

This is the draft quality standard released for consultation from 26 April to 24 May 2016. It is not NICE's final quality standard on preterm labour and birth. The statements and measures presented in this document are provisional and may change after consultation with stakeholders.

Comments on the content of the draft standard must be submitted by 5pm on 24 May 2016. All eligible comments received during consultation will be reviewed by the Quality Standards Advisory Committee and the quality statements and measures will be refined in line with the Quality Standards Advisory Committee's considerations. The final quality standard will be available on the NICE website from October 2016.

Using the quality standard

Quality measures

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

We have indicated if current national indicators exist that could be used to measure the quality statements. These include indicators developed by the Health and Social Care Information Centre through its Indicators for Quality Improvement Programme. If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

See NICE's What makes up a NICE quality standard? for further information, including advice on using quality measures.

Levels of achievement

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something

should not be done). However, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

NICE's quality standard service improvement template helps providers to make an initial assessment of their service compared with a selection of quality statements. It includes assessing current practice, recording an action plan and monitoring quality improvement.

Using other national guidance and policy documents

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered alongside the documents listed in Development sources.

Diversity, equality and language

During the development of this quality standard, equality issues have been considered and equality assessments are available.

Good communication between healthcare professionals and women who are considered to be at risk of preterm labour and birth is essential. Treatment, care and support, and the information given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. Women who are considered to be at risk of preterm labour and birth should have access to an interpreter or advocate if needed.

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

Development sources

Further explanation of the methodology used can be found in the quality standards Process guide.

Evidence sources

The documents below contain recommendations from NICE guidance or other NICE-accredited recommendations that were used by the Quality Standards Advisory Committee to develop the quality standard statements and measures.

- Preterm labour and birth (2015) NICE guideline NG25

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

- Department of Health (2013) Maternity care facilities: planning and design (HBN 09-02)
- NHS England (2013) The National Friends and Family Test (FFT): guidance for maternity services
- Scottish Government (2012) Getting our priorities right
- Department of Health (2011) Preparation for birth and beyond: a resource pack for leaders of community groups and activities
- Royal College of Obstetricians and Gynaecologists (2011) Preterm labour, tocolytic drugs (green-top guideline no. 1B)
- Scottish Government (2011) A refreshed framework for maternity care
- Royal College of Obstetricians and Gynaecologists (2010) Preterm prelabour rupture of membranes (green-top guideline no. 44)
- King's Fund (2008) Safe births: everybody's business
- Care Quality Commission (2008) Towards better births: a review of maternity services in England
- Department of Health (2004) National service framework: children, young people and maternity services

Related NICE quality standards

Published

- Diabetes in pregnancy (2016) NICE quality standard 109
- Intrapartum care (2015) NICE quality standard 105

- Antibiotics for neonatal infection (2014) NICE quality standard 75
- Induction of labour (2014) NICE quality standard 60
- Multiple pregnancy: twin and triplet pregnancies (2013) NICE quality standard 46
- Hypertension in pregnancy (2013) NICE quality standard 35
- Caesarean section (2013) NICE quality standard 32
- Patient experience in adult NHS services (2012) NICE quality standard 15
- Neonatal specialist care (2010) NICE quality standard 4

In development

- Antimicrobial stewardship. Publication expected April 2016.

Future quality standards

This quality standard has been developed in the context of all quality standards referred to NICE, including the following topics scheduled for future development:

- Cerebral palsy
- Developmental follow-up of preterm babies

The full list of quality standard topics referred to NICE is available from the quality standards topic library on the NICE website.

Quality Standards Advisory Committee and NICE project team

Quality Standards Advisory Committee

This quality standard has been developed by Quality Standards Advisory Committee 1. Membership of this committee is as follows:

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Clinical Director, Central Manchester Clinical Commissioning Group

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About this quality standard

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

The methods and processes for developing NICE quality standards are described in the quality standards process guide.

This quality standard has been incorporated into the NICE pathway on preterm labour and birth.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

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