Intrapartum care

NICE quality standard

Draft for consultation

June 2015

Introduction

This quality standard covers the care of women who go into labour at term (37^{+0} weeks to 41^{+6} weeks) and their babies during labour and immediately after birth. It covers both women who go into labour at low risk of intrapartum complications and women who go on to develop complication. For more information see the intrapartum care topic overview.

Why this quality standard is needed

Around 700,000 women give birth in England and Wales each year, of whom about 40% are having their first baby. Most of these women have a straightforward pregnancy and birth.

It is important that a woman is given information and advice about all available birth settings when she is deciding where to have her baby, so that she can make a fully informed decision. This includes information about outcomes for the different settings.

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

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

- maternal mortality and morbidity
- neonatal mortality and morbidity
- positive experience of care
- health improvement
- treating and caring for people in a safe environment and protecting them from avoidable harm.

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 2013–2016.

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 indicator*** 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 deaths in babies and young children** 1.6i Infant mortality (Public Health Outcomes Framework 4.1*)

4 Ensuring that people have a positive experience of care	***Overarching indicators*** 4b Patient experience of hospital care ***Improvement areas*** **Improving hospitals' responsiveness to personal needs** 4.2 Responsiveness to in-patients' personal needs **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 (previously 5c) Deaths attributable to problems in healthcare 5b Severe harm attributable to problems in healthcare ***Improvement areas*** **Improving the safety of maternity services** 5.5 Admission of full-term babies to neonatal care (definition and quality statement amended)
Alignment across the health and social care system * Indicator is shared	

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

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

Patient experience and safety issues

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 intrapartum care.

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. They specify that people receiving care should be treated with dignity, have opportunities to discuss their preferences, and are supported to understand their options and make fully informed decisions. They also cover 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 impact on patient experience and are specific to the topic are considered during quality statement development.

Coordinated services

The quality standard for intrapartum care specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole intrapartum care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to women in labour.

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 intrapartum care service are listed in related quality standards. [Link to Related NICE quality standards section in web version]

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 during labour 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(s) 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 in labour. If appropriate, healthcare professionals should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care.

List of quality statements

Statement 1. Women at low risk of complications are given the choice of all 4 birth settings (at home, freestanding midwifery unit, alongside midwifery unit and obstetric unit), information about local birth outcomes and the likelihood of transfer.

Statement 2. Women in all birth settings in established labour has one-to-one care and support from an assigned midwife.

Statement 3. Women at low risk of complications who are in suspected or established labour do not have cardiotocography monitoring as part of the initial assessment in any birth setting.

Statement 4. Women at low risk of complications who have cardiotocography because of concern arising from intermittent auscultation have the cardiotocograph removed if the trace is normal for 20 minutes.

Statement 5. Women do not have the cord clamped earlier than 1 minute after the birth unless there is concern about cord integrity or the baby's heartbeat is below 60 beats per minute and is not getting faster.

Statement 6. Women at low risk of complications are not offered amniotomy or oxytocin if labour is progressing normally.

Statement 7. (Placeholder) Consultant obstetric supervision and involvement during labour and birth for women at high risk of complications.

Statement 8. (Placeholder) Handover of care information when women at high risk of complications are transferred from birth settings to an obstetric unit during labour.

Questions for consultation

Questions about the quality standard

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

Question 2 If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

Question 3 For each quality statement what do you think could be done to support improvement and help overcome barriers?

Quality statement 1: Choosing birth setting

Quality statement

Women at low risk of complications are given the choice of all 4 birth settings (at home, freestanding midwifery unit, alongside midwifery unit and obstetric unit), information about local birth outcomes and the likelihood of transfer.

Rationale

Women at low risk of complications during labour and birth need information that is specific to their local area about the safety and outcomes for women and babies in the different birth settings, and rates of transfer to obstetric units so that they can make an informed choice about where to have their baby.

Quality measures

Structure

a) Evidence of local arrangements to provide women at low risk of complications with a choice of all 4 birth settings, information about birth outcomes and the likelihood of transfer.

Data source: Local data collection.

Process

a) Proportion of women with a recorded discussion of; choice of birth setting, information about local birth outcomes and the likelihood of transfer.

Numerator – The number in the denominator with a recorded discussion at their antenatal booking appointment about choice of birth setting with information about local birth outcomes and likelihood of transfer

Denominator – The number of women who are pregnant and at low risk of complications.

Data source: Local data collection.

Outcome

Neonatal morbidity and mortality

Maternal morbidity and morality

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

Service providers (primary and secondary care services) ensure that systems and tools are in place to provide women at low risk of complications with local information about birth outcomes, rates of transfer to an obstetric unit for all birth settings, and to support women to make informed decisions about where to have their baby.

Healthcare professionals adapt and use NICE's intrapartum care: choosing place of birth resource for midwives tool as an aid to provide women at low risk of complications with local information about birth outcomes, rates of transfer to an obstetric unit for all birth settings, and support women to make informed decisions about where to have their baby.

Commissioners (clinical commissioning groups and NHS England) commission maternity services with care pathways that ensure that women at low risk of complications are given local information about birth outcomes, rates of transfer to an obstetric unit for all birth settings and to support women to make an informed choice about where to have their baby.

What the quality statement means for patients, service users and carers

Women at low risk of having complications during labour and birth are given a choice of 4 places where they can have their baby – at home, in a midwife-led unit that is either next to a hospital obstetric unit or in a different place, or in an obstetric unit (‘labour ward’). To help women make an informed choice, they are given information by their midwife about birth outcomes (such as the chance of having a 'normal' [vaginal] birth and the risk of serious medical problems for the baby), and about rates of transfer to an obstetric unit, in their local area.

Source guidance

- Intrapartum care (2014) NICE guideline CG190, recommendations 1.1.6 (key priority for implementation), 1.1.2 (key priority for implementation) and 1.1.3
- Antenatal Care (2008) NICE guideline CG62, recommendations 1.1.1.1

Definitions of terms used in this quality statement

4 birth locations

The 4 locations where a woman at low risk of complications may choose to have her baby are; at home, in a freestanding midwifery unit, in an alongside midwifery unit and in an obstetric unit.

Quality statement 2: One-to-one care

Quality statement

Women in all birth settings in established labour have one-to-one care and support from an assigned midwife.

Rationale

One-to-one care for a woman in labour from a midwife who is assigned to 1 woman at a time and is solely dedicated to her care will increase the likelihood of the woman having a 'normal' birth, and is also likely to reduce operative deliveries and length of labour. Care is not necessarily given by the same midwife for the whole labour. Improvement in this area will improve the woman's experience of care, maternal mortality and morbidity and neonatal birth outcomes.

Quality measures

Structure

Evidence of local arrangements to ensure that in all birth settings women in established labour are supported with one-to-one care and support provided by an assigned midwife.

Data source: Local data collection.

Process

Midwifery staffing levels as in Safe midwifery staffing for maternity settings (2015) NICE guideline

Numerator – The number of midwifery staff available in the same time period.

Denominator – The number of women in established labour in a time period.

Data source: Local data collection.

Outcome

a) Neonatal morbidity and mortality.

Data source: Local data collection.

b) Maternal morbidity and mortality.

Data source: Local data collection.

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

Service providers (secondary care services) ensure that systems are in place for midwifery staffing ratios to be maintained so that a woman in established labour has one-to-one care and support from an assigned midwife.

Healthcare professionals (Midwives) provide one-to-one care to a woman in established labour.

Commissioners (clinical commissioning groups and NHS England) commission services in which systems are in place for midwifery staffing ratios to be maintained so that a woman in established labour has one-to-one care and support from an assigned midwife.

What the quality statement means for patients, service users and carers

A woman in labour is cared for by a midwife who is just looking after her – this is called ‘one-to-one care’. She might not have the same midwife for the whole of labour. The one-to-one care of women during labour will contribute to reductions in neonatal morbidity and mortality, maternal morbidity and mortality and will positively impact the woman’s experience of care.

Source guidance

- Intrapartum care (2014) NICE guideline CG190, recommendation 1.7.1 (key priority for implementation)
- Safe midwifery staffing for maternity settings (2015) NICE guideline NG4, section 1.2

Definitions of terms used in this quality statement

Established labour

Labour is established when:

- there are regular painful contractions and
- there is progressive cervical dilatation from 4 cm.

Quality statement 3: Cardiotocography and the initial assessment of a woman in labour

Quality statement

Women at low risk of complications who are in suspected or established labour do not have cardiotocography monitoring as part of the initial assessment in any birth setting.

Rationale

It is important not to use cardiotocography for women at low risk of complications because this type of monitoring restricts the woman's movement during labour and can have adverse effects on birth outcomes.

Quality measures

Structure

a) Evidence of local arrangements to ensure that cardiotocography is not used in any birth setting in the initial assessment of women at low risk of complications who are in suspected or established labour.

Data source: Local data collection.

Process

a) Proportion of women at low risk of complications in suspected or established labour who do not have cardiotocography as part of the initial assessment.

Numerator – The number in the denominator who have cardiotocography monitoring as part of the initial assessment.

Denominator – The number of women at low risk of complications in suspected or established labour.

Data source: Local data collection.

Outcome

Neonatal and morbidity and mortality

Maternal morbidity and mortality

Data source: Local data collection.

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

Service providers (secondary care services) ensure that midwives and obstetricians do not perform cardiotocography as part of the initial assessment of women at low risk of complications who are in suspected or established labour.

Healthcare professionals (midwives and obstetricians) do not perform cardiotocography as part of the initial assessment of women at low risk of complications who are in suspected or established labour.

Commissioners (clinical commissioning groups and NHS England) commission services that ensure that midwives and obstetricians do not perform cardiotocography as part of the initial assessment of women at low risk of complications who are in suspected or established labour.

What the quality statement means for patients, service users and carers

Women who are at low risk of problems during labour do not have electronic monitoring of the baby's heartbeat (that is, being connected to a monitor) as part of the first checks when they go into labour.

Source guidance

- Intrapartum care (2014) NICE guideline CG190, recommendations 1.4.10 and 1.10.2

Definitions of terms used in this quality statement

Cardiotocography

Electronic recording of the fetal heart rate using either a Doppler ultrasound transducer strapped to the woman's abdomen, or an electrode attached to the fetal scalp, plus a second toco transducer strapped to the woman's abdomen to record uterine contractions.

Established labour

Labour is established when:

- there are regular painful contractions and
- there is progressive cervical dilatation from 4 cm.

Quality statement 4: Stopping cardiotocography

Quality statement

Women at low risk of complications who have cardiotocography because of concern arising from intermittent auscultation have the cardiotocograph removed if the trace is normal for 20 minutes.

Rationale

If cardiotocography is started because intermittent auscultation indicates possible fetal heart rate abnormalities, the cardiotocograph should be removed if the trace remains normal for 20 minutes. Cardiotocography restricts the woman's movement, and this can have adverse effects on birth outcomes. Removing the cardiotocograph enables the focus to return to the woman rather than the machine.

Quality measures

Structure

Evidence of local arrangements to ensure that women at low risk of complications having cardiotocography have the cardiotocograph removed if the trace remains normal for 20 minutes.

Data source: Local data collection.

Process

Proportion of women at low risk of complications who have cardiotocography have it removed if cardiotocograph trace readings remain normal for 20 minutes.

Numerator – The number in the denominator who have the cardiotocograph trace removed.

Denominator – The number of women in labour at low risk of complications who have cardiotocography due to a concern arising from intermittent auscultation and have normal trace readings for 20 minutes.

Data source: Local data collection.

Outcome

a) Neonatal morbidity and mortality.

b) Maternal experience.

c) Maternal outcomes.

Data source: Local data collection.

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

Service providers (secondary care services) ensure that protocols are in place for women in labour at low risk of complications who have cardiotocography because of concern arising from intermittent auscultation have the cardiotocograph removed if the trace remains normal for 20 minutes.

Healthcare professionals (midwives and obstetricians) ensure that women at low risk of complications who have cardiotocography because of concern arising from intermittent auscultation have the cardiotocograph removed if the trace remains normal for 20 minutes.

Commissioners (clinical commissioning groups and NHS England) commission services in which women at low risk of complications who have cardiotocography because of concern arising from intermittent auscultation have the cardiotocograph removed if the trace remains normal for 20 minutes.

What the quality statement means for patients, service users and carers

Women who are at low risk of complications during labour but who have electronic monitoring because of possible concerns about the baby's heartbeat are taken off the monitor if the baby’s heartbeat is normal for 20 minutes.

Source guidance

- Intrapartum care (2014) NICE guideline CG190, recommendation 1.4.7

Definitions of terms used in this quality statement

Intermittent auscultation

A systematic method of listening to fetal heart tones with an acoustical device (fetascope) or a hand held ultrasound (doptone), paying attention to rate, rhythm and variability.

Normal cardiotocograph trace

A normal trace has the following normal/reassuring features:

- baseline fetal heart rate of 100 to160 beats per minute **and**
- baseline variability of 5 beats/ minute or more **and**
- no or early decelerations.

Quality statement 5: Delayed cord clamping

Quality statement

Women do not have the cord clamped earlier than 1 minute after the birth unless there is concern about cord integrity or the baby's heartbeat is below 60 beats per minute and is not getting faster.

Rationale

Women should not have the cord clamped for at least 1 minute after the birth of the baby. The benefits of delayed cord clamping include higher haemoglobin concentrations, reduction in iron deficiency and greater vascular stability in babies.

Quality measures

Structure

Evidence of local arrangements to ensure that midwives and obstetricians do not clamp the cord earlier than 1 minute after the birth unless there is a concern about cord integrity or the baby's heartbeat is below 60 beats per minute and is not getting faster.

Data source: Local data collection.

Process

Proportion of cords clamped earlier than 1 minute from birth where there was not concern about cord integrity or the heartbeat was below 60 beats per minute.

Numerator – The number in the denominator where the cord is clamped earlier than 1 minute and where there was not a concern about cord integrity or the baby's heartbeat.

Denominator – The number of babies born.

Data source: Local data collection.

Outcome

Neonatal haemoglobin concentrations and neonatal anaemia.

Data source: Local data collection.

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

Service providers (secondary care services) have protocols in place to ensure that midwives and obstetricians do not clamp the cord earlier than 1 minute after the birth unless there is concern about cord integrity or the heartbeat is below 60 beats per minute and is not getting faster.

Healthcare professionals (midwives and obstetricians) do not clamp the cord earlier than 1 minute after the birth unless there is concern about cord integrity or the heartbeat is below 60 beats per minute and is not getting faster.

Commissioners (clinical commissioning groups and NHS England) commission maternity care services with protocols in place to ensure that midwives and obstetricians do not clamp the cord earlier than 1 minute after the birth unless there is concern about cord integrity or the heartbeat is below 60 beats per minute and is not getting faster.

What the quality statement means for patients, service users and carers

Women do not have the cord clamped for at least 1 minute after the birth unless there are concerns about the baby. This allows more blood to reach the baby and may help to prevent iron deficiency and anaemia.

Source guidance

Intrapartum care (2014) NICE guideline CG190, recommendation 1.14.14 (key priority for implementation)

Quality statement 6: Interventions during labour

Quality statement

Women at low risk of complications are not offered amniotomy or oxytocin if labour is progressing normally.

Rationale

Interventions such as amniotomy and oxytocin are unnecessary for women at low risk of complications if labour is progressing normally. Such interventions often mean that the woman does not return to the normal intrapartum care pathway.

Quality measures

Structure

Evidence of local arrangements to ensure that amniotomy is not performed and oxytocin is not given to women at low risk of complications if labour is progressing normally.

Data source: Local data collection.

Process

Proportion of women at low risk of complications are not offered amniotomy or oxytocin if labour is progressing normally

Numerator – The number in the denominator who receive amniotomy or oxytocin.

Denominator – The number of women at low risk of complications who are in labour that is progressing normally.

Data source: Local data collection.

Outcome

Women at low risk of complications remain on the normal intrapartum care pathway.

Data source: Local data collection.

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

Service providers (secondary care services) have systems and protocols in place to ensure that women at low risk of complications are not offered amniotomy or oxytocin if labour is progressing normally.

Healthcare professionals (obstetricians and midwives) do not offer amniotomy or oxytocin to women at low risk of complications if labour is progressing normally.

Commissioners (clinical commissioning groups and NHS England) commission maternity care services with protocols in place to ensure that women at low risk of complications are not offered amniotomy or oxytocin if labour is progressing normally.

What the quality statement means for patients, service users and carers

Women who are at low risk of problems and whose labour is going well are not offered amniotomy (having their waters broken) or oxytocin (a medicine given through a drip that speeds up labour).

Source guidance

- Intrapartum care (2014) NICE guideline CG190, recommendations 1.12.11 and 1.12.12

Definitions of terms used in this quality statement

Normal intrapartum care pathway

The routine care pathway for pregnant women at low risk of complications who go into labour at term. The NICE guideline on intrapartum care includes recommendations on normal intrapartum care within this pathway.

Normal labour and normal progression of labour

The NICE guideline on intrapartum care adopts the World Health Organisation definition of a normal labour as ‘labour is normal when it is spontaneous in onset, low

risk at the start and remaining so throughout labour and birth. The baby is born spontaneously and in the vertex position between 37–42 completed weeks of pregnancy. After birth woman and baby are in good condition'.

Where labour is progressing normally and both woman and baby are well the midwife's role is to offer support (physical and psychological) and to observe the woman and baby. Should it be necessary to offer an intervention it should one that is known, as far as is possible, to be of benefit.

Quality statement 7 (placeholder): Consultant obstetric supervision and involvement during labour and birth for women at high risk of complications

What is a placeholder statement?

A placeholder statement is an area of care that has been prioritised by the Quality Standards Advisory Committee but for which no source guidance is currently available. A placeholder statement indicates the need for evidence-based guidance to be developed in this area.

Rationale

Complex and life-threatening emergency births represent situations at a higher risk of medical interventions during birth. The 2007 report Safer Childbirth: Minimum standards for the Organisation and Delivery of Care in Labour by the Royal College of Midwives highlighted that events involving fetal compromise are more likely to happen outside the hours when units have consultant obstetric cover. Consultant obstetric supervision and consultant obstetric-led care is needed to increase rates of 'normal' (vaginal) births, reduce operative deliveries and reduce neonatal mortality.

Guideline in development

Intrapartum care for women at high risk of complications NICE guideline is under development and the anticipated publication date is January 2017.

Quality statement 8 (placeholder): Handover of care information when women at high risk of complications are transferred from birth settings to an obstetric unit during labour

What is a placeholder statement?

A placeholder statement is an area of care that has been prioritised by the Quality Standards Advisory Committee but for which no source guidance is currently available. A placeholder statement indicates the need for evidence-based guidance to be developed in this area.

Rationale

Clear communication and efficient handover of care information between healthcare professionals is needed for women considered to be low risk encounter unforeseen complications during labour and are consequently considered to be at a high risk of complications, are transferred to an obstetric-led unit (from home, a freestanding midwifery units or an alongside midwifery unit). Communication of vital information is needed for appropriate and safe care during labour and birth. Communication is also important in obstetric units, where there may be several handovers and transfers of emergency cases. Failure to communicate clearly and to ensure that information has been received and understood has been highlighted as a cause of unsafe care.

Guideline in development

Intrapartum care for women at high risk of complications NICE guideline is under development and the anticipated publication date is January 2017.

Status of this quality standard

This is the draft quality standard released for consultation from 15 June to 13 July 2015. It is not NICE's final quality standard on intrapartum care. 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 13 July 2015. 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 December 2015.

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.

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 [Link to section in web version]

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 in labour 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 in labour 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.

- Safe midwifery staffing for maternity settings (2015) NICE guideline NG4
- Intrapartum care (2014) NICE guideline CG190
- Antenatal Care (2008) NICE guideline CG62

Policy context

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

- Royal College of Paediatrics and Child Health (2014) National neonatal audit programme annual report 2013
- National Audit Office (2013) Maternity services in England
- Royal College of Anaesthetists (2012) Raising the standard: a compendium of audit recipes (section 8: obstetrics)
- Healthcare Commission (2008) Towards better births: a review of maternity services in England
- National Audit Office (2007) Caring for vulnerable babies: the reorganisation of neonatal services in England
- Centre for Maternal and Child Enquiries (2006–2012) Child death review, maternal deaths and perinatal mortality

Definitions and data sources for the quality measures

- Health and Social Care Information Centre (2013) Maternal mortality indicator portal
- Health and Social Care Information Centre (2013) Perinatal mortality indicator portal

Related NICE quality standards

Published

- Antibiotics for neonatal infection (2014) NICE quality standard 75
- Ectopic pregnancy and miscarriage (2014) NICE quality standard 69
- Induction of labour (2014) NICE quality standard 60
- Neonatal jaundice (2014) NICE quality standard 57
- Multiple pregnancy (2013) NICE quality standard 46
- Hypertension in pregnancy (2013) NICE quality standard 35
- Caesarean section (2013) NICE quality standard 32
- Antenatal care (2012) NICE quality standard 22
- Patient experience in adult NHS services (2012) NICE quality standard 15
- Specialist neonatal care (2010) NICE quality standard 4

In development

- Antenatal and postnatal mental health. Publication expected October 2015
- Diabetes in pregnancy. Publication expected January 2016

Future quality standards

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

- Premature labour

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 2. Membership of this committee is as follows:

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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 intrapartum care.

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