NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

Draft quality standard for Caesarean section

1 Introduction

Caesarean section (CS) rates have increased significantly in recent years. In the UK 20–25% of births are by CS, up from 9% in 1980. The draft standard focuses on improving the information available to women who may request or need a CS. The draft standard also focuses on reducing potential risks or complications for the woman and the baby.

This draft quality standard covers the care of women who plan for or may need a CS. For more information see the scope for this quality standard.

The draft standard is made up of a set of measurable statements, which together with the guidance on which it is based, should contribute to the improvements outlined in the following outcome framework:

- The NHS Outcomes Framework 2012/13

The table below shows the indicators from the frameworks that the quality standard could contribute to:

NHS Outcomes Framework	Domain1: Preventing people from dying prematurely.	1a Potential years of life lost (PYLL) from causes considered amenable to healthcare 1.6.i Infant mortality* ii Neonatal mortality and stillbirths
	Domain 4: Ensuring that people have a positive experience of care	4b Patient experience of hospital care 4.5 Women's experience of maternity services

	Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm	5a Patient safety incidents reported 5b Safety incidents involving severe harm or death 5.5 Admission of full-term babies to neonatal care

2 Draft quality standard for caesarean section

Overview

The draft quality standard for CS requires that services should be commissioned from and coordinated across all relevant agencies encompassing the whole maternity care pathway. An integrated approach to provision of services is fundamental to the delivery of high-quality care to women who may need or have a CS and their families 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 should cross-refer across the library of NICE quality standards when designing high-quality services.

The quality standard should be read in the context of national and local guidelines on training and competencies. All professionals involved in the care of people who may request or require a CS should be sufficiently and appropriately trained to deliver the actions and interventions described in the quality standard.

No.	Draft quality statements
1	Pregnant women who request a CS (when there is no other indication) discuss this with members of the maternity team within a suitable time frame depending on the number of weeks left in their pregnancy
2	Pregnant women who request a CS because of anxiety about childbirth are offered a referral to a healthcare professional with relevant expertise
3	Pregnant women for whom CS is being considered have a consultant obstetrician involved in the decision-making process.
4	Pregnant women who have had a previous CS are given the option to attempt a vaginal birth
5	Pregnant women having a planned CS undergo the procedure at or after 39 weeks 0 days of gestation, unless an earlier delivery is necessary because of maternal or fetal complications

6	Pregnant women having a planned CS before 39 weeks of gestation due to maternal or fetal complications are offered a course of antenatal corticosteroids
7	Women in labour for whom a caesarean section is being considered for suspected fetal compromise are offered fetal blood sampling to inform decision making
8	Women who have had a CS are offered a discussion with a health professional about her CS and birth options for future pregnancies
9	Women who have had a CS are monitored for potential risks and complications until ready to be transferred to core postnatal care

This draft quality standard is part of a collection of maternity quality standards, of which antenatal care, intrapartum care and postnatal care will form the core pathway. The full set of quality standards, including all the maternity quality standards that should be considered when commissioning and providing high-quality maternity services are listed in in section 8.

General questions for consultation:

Question 1	Can you suggest any appropriate healthcare outcomes for each individual quality statement?
Question 2	What important areas of care, if any, are not covered by the quality standard?
Question 3	What, in your opinion, are the most important quality statements and why?
Question 4	Are any of the proposed quality measures inappropriate and, if so, can you identify suitable alternatives?
Please refer to Quality standards in development for additional general points for consideration (available from www.nice.org.uk).	

Draft quality statement 1: Maternal request for a caesarean section: maternity team involvement

Draft quality statement	Pregnant women who request a CS (when there is no other indication) discuss this with members of the maternity team within a suitable time frame depending on the number of weeks left in their pregnancy.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure that pregnant woman who request a CS (when there is no other indication) discuss this with members of the maternity team within a suitable time frame depending on the number of weeks left in their pregnancy **Process:** a) The proportion of pregnant women in the first or second trimester of their pregnancy who request a CS (when there is no other indication) who discuss this with members of the maternity team within 4 weeks of their request Numerator – the number of women in the denominator who discuss their request with members of the maternity team within 4 weeks of their request. Denominator – the number of pregnant women in the first of second trimester of their pregnancy who request a CS (when there is no other indication). b) The proportion of pregnant women in the third trimester of their pregnancy who request a CS (when there is no other indication) who discuss this with members of the maternity team within 2 weeks of their request Numerator – the number of women in the denominator who discuss their request with members of the maternity team within 2 weeks of their request Denominator – the number if pregnant women in the third trimester of their pregnancy who request a CS (when there is no other indication). **Outcome:** a) Patient satisfaction with involvement in decision-making. b) Rates of planned CS in women where there were no indications for a CS.
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place for pregnant women who request a CS (when there is no other indication) to discuss this with members of the maternity team within a suitable time frame depending on the number of weeks left in their pregnancy. **Healthcare professionals** ensure that pregnant women who request a CS (when there is no other indication) discuss this with

	members of the maternity team within a suitable time frame depending on the number of weeks left in their pregnancy **Commissioners** ensure they commission services that have systems in place for all pregnant woman who request a CS (when there is no other indication) to discuss this with members of the maternity team within a suitable time frame depending on the number of weeks left in their pregnancy **Pregnant women** who request a CS (when there is no other medical reason) are able to discuss their request with members of the maternity team within a suitable time frame depending on the number of weeks left in their pregnancy.
Source clinical guideline references	NICE clinical guideline 132 recommendation 1.2.9.2
Data source	**Structure:** Local data collection **Process:** a) and b) Local data collection **Outcome:** a) Local data collection b) The Maternity services secondary uses dataset will collect data on 'the method for delivering baby' (global number 17206160) once implemented.
Definitions	**Discuss** – the discussion should include the reasons for the request and ensure that the woman has accurate information about the relative risks and benefits associated with different modes of birth, based on Box A in NICE clinical guideline 132. **Maternity team** – the core membership of the maternity team should include a midwife, an obstetrician and an anaesthetist. **Suitable timeframe** for women who are in their first or second trimester this discussion should happen within 4 weeks of their request being made. For women in the final trimester this discussion should happen no later than 2 weeks after the request was made, but this should be sooner for women close to being full term.
Equality and diversity considerations	Communication and information giving between women (and their families) and members of the maternity team is a key aspect of this statement. Relevant adjustments will need to be in place for anyone who has communication difficulties, and for those who don't speak English.

Draft quality statement 2: Maternal request for a caesarean section: maternal anxiety

Draft quality statement	Pregnant women who request a CS because of anxiety about childbirth are offered a referral to a healthcare professional with relevant expertise.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure that pregnant women who request a CS because of anxiety about childbirth are offered a referral to a healthcare professional with relevant expertise. **Process:** The proportion of pregnant women who request a CS because of anxiety about childbirth who are offered a referral to a healthcare professional with relevant expertise. Numerator – the number of women in the denominator who are offered a referral to a healthcare professional with relevant expertise. Denominator – the number of pregnant women who request a CS because of anxiety about childbirth. **Outcomes:** Rates of planned sections in those with previous anxiety about childbirth
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place for pregnant women who request a CS because of anxiety about childbirth to be offered a referral to a healthcare professional with relevant expertise. **Healthcare professionals** ensure pregnant women who request a CS because of anxiety about childbirth are offered a referral to a healthcare professional with relevant expertise. **Commissioners** ensure they commission services that offer pregnant women who request a CS because of anxiety about childbirth a referral to a healthcare professional with relevant expertise. **Women** who request a CS because of anxiety about childbirth are offered a referral to a healthcare professional with relevant expertise.
Source clinical guideline references	NICE clinical guideline 132 recommendation 1.2.9.3 (KPI)
Data source	**Structure:** Local data collection **Process:** Local data collection **Outcomes:** The Maternity services secondary uses dataset will collect data on 'the method for delivering baby' (global number

	17206160) once implemented.
Definitions	**Healthcare professional with relevant expertise** – this includes but is not limited to a psychologist interested in perinatal mental health or a midwife with counselling skills and expertise. **Referral** – pregnant women who accept a referral should be seen within 4 weeks if in their first or second trimester or within 2 weeks in the third trimester.

Draft quality statement 3: Involvement of senior staff in decision-making for caesarean section

Draft quality statement	Pregnant women for whom CS is being considered have a consultant obstetrician involved in the decision-making process.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure that pregnant women for whom a CS is being considered have a consultant obstetrician involved in the decision-making process. **Process:** The proportion of pregnant women for whom a CS was being considered who have a consultant obstetrician involved in the decision-making process. Numerator – The number of women in the denominator who have a consultant obstetrician involved in the decision-making process. Denominator – The number of pregnant women for whom a CS is being considered. **Outcome:** CS rates.
Description of what the quality statement means for each audience	**Service providers** ensure that systems are in place to ensure pregnant women for whom CS is being considered have a consultant obstetrician involved in the decision-making process. **Healthcare professionals** ensure pregnant women for whom CS is being considered have a consultant obstetrician involved in the decision-making process. **Commissioners** ensure they commission services that involve a consultant obstetrician in the decision-making process in cases where CS is being considered. **Women** for whom CS is being considered have a consultant obstetrician involved in the decision-making process.
Source clinical guideline references	NICE clinical guideline 132 recommendation 1.3.2.4
Data source	**Structure:** Local data collection **Process:** Local data collection **Outcome:** Local data collection
Definitions	**Being considered** – this refers to the considerations carried out at the different categories of urgency (as described in NICE clinical guideline 132). **Decision-making process** – the local process used to decide whether a CS should be carried out or not. **Involved** – this should include direct involvement in the decision, and should be documented in the woman's maternity notes. This should include documentation of the mode of involvement, for example, by phone or in person.

Draft quality statement 4: Vaginal birth after a caesarean section

Draft quality statement	Pregnant women who have had a previous CS are given the option to attempt a vaginal birth
Draft quality measure	**Structure:** Local arrangements to ensure that pregnant women who have had a previous CS are given the option to attempt a vaginal birth **Process:** a) The proportion of pregnant women who have had 1 previous CS who were given the option to attempt a vaginal birth in their current pregnancy Numerator – the number of women in the denominator who were given the option to attempt a vaginal birth. Denominator – the number of pregnant women who have had 1 previous CS. b) The proportion of pregnant women who have had more than 1 previous CS who were given the option to attempt a vaginal birth in the current pregnancy. Numerator – the number of women in the denominator who were given the option to attempt a vaginal birth. Denominator – the number of pregnant women who have had more than 1 previous CS. **Outcomes:** a) The rate of women who have had previous CS who opt to attempt a vaginal birth. b) Mode of delivery rates for women who have had previous CS.
Description of what the quality statement means for each audience	**Service providers** ensure that systems are in place for pregnant women who have had a previous CS to be given the option to attempt a vaginal birth **Healthcare professionals** advise pregnant women who have had a previous CS are that they have the option to attempt a vaginal birth **Commissioners** ensure they commission services that have systems in place for pregnant women who have had a previous CS to be given the option to attempt a vaginal birth **Women** who have had a previous CS are given the option to attempt a vaginal birth
Source clinical guideline references	NICE clinical guideline 132 recommendation 1.8.2 (KPI)
Data source	**Structure:** Local data collection

	Process: a) and b) Local data collection **Outcomes:** a) Local data collection b) The Maternity services secondary uses dataset will collect data on 'the method for delivering baby' (global number 17206160) and on 'pregnancy previous caesarean sections' (global number 17200570), once implemented.
Definitions	**Given the option –** Pregnant women should be advised that if they wish they can attempt a vaginal birth and advised that in women who have had up to and including 4 CS the risk of fever, bladder injuries and surgical injuries does not vary with planned mode of birth and the risk of uterine rupture, although higher for planned vaginal birth, is rare. This offer should be documented in the women's notes.

Draft quality statement 5: Timing of planned caesarean section

Draft quality statement	Pregnant women having a planned CS undergo the procedure at or after 39 weeks 0 days of gestation, unless an earlier delivery is necessary because of maternal or fetal complications.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure that pregnant women having a planned CS undergo the procedure at or after 39 week 0 days of gestation, unless an earlier delivery is necessary because of maternal or fetal complications. **Process:** The proportion of pregnant women having a planned CS who undergo the procedure at or after 39 weeks 0 days of gestation. Numerator – The number of women in the denominator who undergo the CS at or after 39 weeks 0 days of gestation. Denominator – The number of pregnant women having a planned CS who do not need an earlier delivery because of maternal or fetal complications.
Description of what the quality statement means for each audience	**Service providers** ensure that systems are in place for pregnant women having a planned CS to undergo the procedure at or after 39 weeks 0 days of gestation, unless an earlier delivery is necessary because of maternal or fetal complications. **Healthcare professionals** ensure that pregnant women having a planned CS undergo the procedure at or after 39 weeks 0 days of gestation, unless an earlier delivery is necessary because of maternal or fetal complications. **Commissioners** ensure they commission services in which women having a planned CS undergo the procedure at or after 39 weeks 0 days of gestation, unless an earlier delivery is necessary because of maternal or fetal complications. **Women** having a planned CS undergo the procedure at or after 39 weeks 0 days of pregnancy, unless an earlier delivery is necessary because of complications.
Source clinical guideline references	NICE clinical guideline 132 recommendation 1.4.1.1
Data source	**Structure and process:** The Maternity services secondary uses dataset will collect data on 'the method for delivering baby' (global number 17206160) and on 'gestational age at birth' (global number 17206160), once implemented.
Definitions	**Maternal or fetal complications** – this includes but is not limited to the following: significant maternal medical disorder, hypertensive disease, diabetes or gestational diabetes, significant

	antepartum haemorrhage, intrauterine growth restriction, congenital abnormality, hydrops or compromise due to blood group incompatibility, acute fetal compromise, multiple pregnancy.

Draft quality statement 6: Corticosteroid use in planned caesarean section before 39 weeks

Draft quality statement	Pregnant women having a planned CS before 39 weeks of gestation due to maternal or fetal complications are offered a course of antenatal corticosteroids
Draft quality measure	**Structure:** Evidence of local arrangements to ensure that pregnant women having a planned CS before 39 weeks of gestation due to maternal or fetal complications are offered a course of antenatal corticosteroids. **Process:** The proportion of pregnant women having a planned CS before 39 weeks of gestation due to maternal or fetal complications who were offered a course of antenatal corticosteroids. Numerator – The number of women in the denominator who were offered a course of antenatal corticosteroids. Denominator – The number of pregnant women having a planned CS before 39 weeks of gestation due to maternal or fetal complications. **Outcome:** Rates of respiratory morbidity in babies delivered by planned CS before 39 weeks of gestation.
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place for pregnant women having a planned CS before 39 weeks of gestation due to maternal or fetal complications to be offered a course of antenatal corticosteroids. **Healthcare professionals** ensure pregnant women having a planned CS before 39 weeks of gestation due to maternal or fetal complications are offered a course of antenatal corticosteroids. **Commissioners** ensure they commission services in which pregnant women having a planned CS before 39 weeks of gestation due to maternal or fetal complications are offered a course of antenatal corticosteroids. **Women** having a planned CS before 39 weeks of pregnancy due to maternal or fetal complications are offered a course of antenatal corticosteroids.
Source clinical guideline references	Royal College of Obstetricians and Gynaecologists (2010) Antenatal corticosteroids to reduce neonatal morbidity (Green-top 7).
Data source	**Structure:** Local data collection **Process:** Local data collection **Outcome:** Local data collection

Definitions	**Course of antenatal corticosteroids** – the chosen course of antenatal corticosteroids should be in adherence with agreed local protocols and relevant NICE and Royal College of Obstetricians and Gynaecologists guidance.

Draft quality statement 7: The use of fetal blood sampling

Draft quality statement	Women in labour for whom a caesarean section is being considered for suspected fetal compromise are offered fetal blood sampling to inform decision making
Draft quality measure	**Structure:** a) Evidence of local arrangements to ensure that women in labour for whom a CS is being considered for suspected fetal compromise are offered fetal blood sampling to inform decision making b) Evidence of local arrangements to ensure that maternity units have access to functioning and, serviced fetal blood sampling machines. **Process:** a) The proportion of women in labour for whom a CS is being considered for suspected fetal compromise that are offered fetal blood sampling to inform the decision Numerator – The number of women in the denominator that are offered fetal blood sampling Denominator – The number of women in labour for whom a CS is being considered for suspected fetal compromise without contraindications for fetal blood sampling b) The proportion of women in labour where a fetal blood sample was attempted and successfully obtained and a reading made. Numerator – the number of attempted fetal blood samples that were successfully obtained and a reading made Denominator – the number of pregnant women in whom a fetal blood sample was successfully obtained.
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place for women in labour for whom a CS is being considered for suspected fetal compromise to be offered fetal blood sampling to inform decision making **Healthcare professionals** ensure that women in labour for whom a CS is being considered for [suspected fetal compromise] are offered fetal blood sampling to inform decision making **Commissioners** ensure they commission services that have systems in place for women in labour for whom a CS is being considered for [suspected fetal compromise] to be offered fetal blood sampling to inform decision making **Women** in labour for whom a CS is being considered for suspected fetal complications during labour are offered a procedure called fetal blood sampling to help decide whether to have a CS.

Source clinical guideline references	NICE clinical guideline 132 recommendation 1.3.2.5
Data source	**Structure:** a) and b) Local data collection **Process:** a) and b) Local data collection
Definitions	**Suspected fetal compromise** – abnormal fetal heart rate pattern or suspected fetal acidosis. **Fetal blood sampling** should be undertaken when it is technically possible to do so and there are no contraindications. The National Sentinel Caesarean Section Audit defines 'technically possible' as cervical dilation of 4 cm or more. If there is clear evidence of acute fetal compromise (for example, prolonged deceleration greater than 3 minutes), fetal blood sampling should not be undertaken and urgent preparations to expedite birth should be made. If fetal blood sampling is not attempted because of contraindications, the contraindications should be documented in the women's maternity notes.

Draft quality statement 8: Debriefing

Draft quality statement	Women who have had a CS are offered a discussion with a health professional about her CS and birth options for future pregnancies
Draft quality measure	**Structure:** a) Evidence of local arrangements to ensure that women who have had a CS are offered a discussion with a health professional about her CS and birth options for future pregnancies. b) Evidence of local arrangements to ensure that health professionals involved in discussions about birth options for future pregnancies with women who have had a CS are suitably qualified and experienced. **Process**: The proportion of women who have had a CS who are offered a discussion with a health professional about her CS and birth options for future pregnancies. Numerator – The number of women in the denominator who have been offered a discussion with a health professional about her CS and birth options for future pregnancies. Denominator – The number of women who have had a CS **Outcome:** Patient satisfaction with postnatal debriefing and information.
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place for women who have had a CS to be offered a discussion with a health professional about her CS and birth options for future pregnancies. **Healthcare professionals** ensure women who have had a CS are offered a discussion with a health professional about her CS and birth options for future pregnancies. **Commissioners** ensure they commission services that offer a discussion with a health professional about the CS and birth options for future pregnancies to women who have had a CS. **Women** who have had a CS are offered a discussion with a health professional about her CS and the options for birth in future pregnancies.
Source clinical guideline references	NICE clinical guideline 132 recommendation 1.7.1.9 (KPI)
Data source	**Structure:** a) and b) Local data collection **Process:** Local data collection **Outcome:** Local data collection
Definitions	**Offered** – the offer should be made when the women is still in the postnatal ward, with the option to provide this at a later date, if the

	woman prefers. **Discussion** – an opportunity for women to discuss the reasons for the CS and how successful the procedure was with healthcare professionals and receive verbal and printed information about birth options for future pregnancies. **Health professional** – this should be an appropriately trained midwife, a consultant obstetrician or a trainee obstetrician who has completed at least 5 years of training.

Draft quality statement 9: Maternal complications following caesarean section

Draft quality statement	Women who have had a CS are monitored for potential risks and complications until ready to be transferred to core postnatal care
Draft quality measure	**Structure:** Evidence of local arrangements to ensure that women who have had a CS have potential risks and complications monitored until transferred to core post natal care **Process:** The proportion of women who have had a CS that had potential risks and complications monitored until transferred to core post natal care Numerator – The number of women in the denominator that had potential risks and complications following CS monitored until transferred to core post natal care Denominator – The number of women who had a CS **Outcomes:** Rates of complications in women who have had a CS.
Description of what the quality statement means for each audience	**Services providers** ensure that systems are in place for women who have had a CS to have potential risks and complications monitored until ready to be transferred to core post natal care **Healthcare professionals** ensure that women who have had a CS have potential risks and complications monitored until ready to be transferred to core post natal care **Commissioners** ensure they commission services where women who have had a CS have potential risks and complications monitored until ready to be transferred to core post natal care **Women** who have had a CS have potential risks and complications monitored until ready to be transferred to core post natal care
Source clinical guideline references	NICE clinical guideline 132 recommendations 1.6.1.1, 1.6.2.1 to 1.6.2.4, 1.7.1.3, 1.7.1.6
Data source	**Structure:** Local data collection **Process:** Local data collection **Outcome:** Local data collection
Definitions	**Monitoring of potential risks and complications** – NICE clinical guideline 132 recommends the following in women who have had a CS: • Women should be observed on a one-to-one basis by a properly trained member of staff until they have regained airway control and cardiorespiratory stability and are able to communicate.

	• After recovery from anaesthesia, observations (respiratory rate, heart rate, blood pressure, pain and sedation) should be continued every half hour for 2 hours, and hourly thereafter provided that the observations are stable or satisfactory. If these observations are not stable, more frequent observations and medical review are recommended. • For women who have had intrathecal opioids, there should be a minimum hourly observation of respiratory rate, sedation and pain scores for at least 12 hours for diamorphine and 24 hours for morphine. • For women who have had epidural opioids or patient-controlled analgesia with opioids, there should be routine hourly monitoring of respiratory rate, sedation and pain scores throughout treatment and for at least 2 hours after discontinuation of treatment. The Centre for maternal and child enquiries provides an example tool called the modified early obstetric warning score (MEOWS) to support monitoring after CS.

3 Status of this quality standard

This is the draft quality standard released for consultation from 21 December 2012 to 24 January 2013. This document is not NICE's final quality standard on CS. 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 5 pm on 24 January 2013. All eligible comments received during consultation will be reviewed by the Topic Expert Group and the quality statements and measures will be refined in line with the Topic Expert Group considerations. The final quality standard will then be available on the NICE website from May 2013.

4 Using the quality standard

It is important that the quality standard is considered alongside current policy and guidance documents listed in the evidence sources section.

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

Expected levels of achievement for quality measures are not specified. As quality standards are intended to drive up the quality of care, achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, we recognise that this may not always be appropriate in practice when taking account of patient safety, patient choice and clinical judgement and therefore desired levels of achievement should be defined locally.

We have indicated where national indicators currently exist and measure the quality statement. National indicators include those developed by the Health and Social Care Information Centre through their Indicators for Quality Improvement Programme. For statements for which national quality indicators do not exist, the quality measures should form the basis for audit criteria developed and used locally to improve the quality of care.

For further information, including guidance on using quality measures, please see What makes up a NICE quality standard.

5 Diversity, equality and language

During the development of this quality standard, equality issues have been considered and equality assessments will be published on the NICE website with the final version of the quality standard.

Good communication between health care professionals and women who request or need a CS is essential. Treatment and care, 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 request or need a CS should have access to an interpreter or advocate if needed.

6 How this quality standard was developed

The evidence sources used to develop this quality standard are listed in appendix 1, along with relevant policy context, definitions and data sources. Further explanation of the methodology used can be found in the Quality Standards Programme interim process guide.

7 Related NICE quality standards

- Patient experience in adult NHS services. NICE quality standard (2012).
- Antenatal care. NICE quality standard (2012).
- Specialist neonatal care. NICE quality standard (2010).
- Postnatal care. NICE quality standard. Publication expected July 2013.
- Hypertension in pregnancy. NICE quality standard. Publication expected July 2013.
- Multiple pregnancy. NICE quality standard. Publication expected September 2013

The following maternity quality standard topics have been referred to the core library and are not yet in development:

- Intrapartum care.
- Induction of labour.

- Diabetes in pregnancy.
- Pain and bleeding in early pregnancy
- Premature labour.
- Antenatal and postnatal mental health.

Appendix 1: Development sources

Evidence sources

The documents below contain clinical guideline recommendations or other recommendations that were used by the TEG to develop the quality standard:

- Caesarean section. NICE clinical guideline 132 (2011).
- Royal College of Obstetricians and Gynaecologists (2010) Antenatal corticosteroids to reduce neonatal morbidity (Green-top 7).

Current practice and policy context

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

- Department of Health (2011) The 'never events' list 2011/12 (see number 25: Maternal death due to post partum haemorrhage after elective Caesarean section).
- Hospital Episode Statistics (2010-11) Maternity data (2010-11).
- Centre for Maternal and Child Enquiries (2011) Saving mothers' lives: reviewing maternal deaths to make motherhood safer: 2006–08.
- National Perinatal Epidemiology Unit (2010) Delivered with care: a national survey of women's experience of maternity care 2010.
- Care Quality Commission (2010) Maternity services survey 2010.
- Department of Health (2007) Maternity matters: choice, access and continuity of care in a safe service.
- Department of Health (2007) Delivering quality and value: focus on fractured neck of femur; primary hip and knee replacement; acute stroke; caesarean section; short stay emergency care.
- Royal College of Obstetricians and Gynaecologists (2001) The national sentinel caesarean section audit report.

Data sources for the quality measures

References included in in the definitions and data sources sections:

The Maternity services secondary uses dataset