National Institute for Health and Clinical Excellence

Quality Standards C-section Scoping workshop

Minutes of the meeting held on Tuesday 10th July 2012 at the NICE offices in Manchester

Attendees	Malcolm Griffiths (Chair) (MG), Debbie Chippington Derrick (DCD), Olujimi Jibodu (OJ), Christine Johnson (CJ), Nina Khazaezadeh (NK), Andrew Loughney (AL), Nuala Lucas (NL), David James (DJ), Pippa Nightingale (PN) **DH Attendee** Heather Mellows (HM) **NICE Attendees** Brian Bennett (BB), Terence Lacey (TL), Andrew McAllister (AM), Jenny Harrisson (JH) **NICE Observers** Lynda Ayiku, Janette Boynton, Rita Parkinson, Elizabeth Flemming
Apologies	Tim Stokes (NICE)

Agenda item	Discussions and decisions	Actions
1.Introductions and apologies	MG welcomed the attendees and the group introduced themselves. MG then reviewed the agenda for the day.	
2.Business items • Declarations of interest	MG reminded Topic Expert Group (TEG) members that they represent themselves rather than a particular organisation. MG outlined the declarations of interest policy and the group confirmed they had no additional interests to declare	
3.Quality Standard Overview	AM presented the group with an overview of the current process for developing NICE quality standards. He highlighted that QS clarify what high quality care looks like, explained what QS are used for and highlighted the current work programme. AM reported that the NHS White Paper *Equity and Excellence: Liberating the NHS* and the Health and Social Care Act indicate that QS will be very important in the future. AM advised the group that once the QS has been published they will be invited to undertake further work on the quality standard measures in order to develop valid and clearly worded Commissioning Outcomes Framework (COF) and Quality and Outcomes Framework (QOF) indicators. AM then explained that there will be a new process for developing NICE quality standards (QS). He explained that quality standards will begin to be developed by Quality Standard Advisory Committees (QSAC) which will consist of both standing members and topic experts for each standard in order to develop 150 standards by 2015. However, for the time being the Topic Expert Group process will continue to be used alongside this new approach for some topics. AM gave an overview of the roles and responsibilities of relevant teams in NICE. AM described the stakeholder consultation process and the use of endorsing organisations to help disseminate the QS.	

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	The group queried whether stakeholders already registered for the guideline would automatically be registered for the QS. AM stated that this is the case. The group queried whether QS are legally applicable in individual places. AM explained that according to the 'Health and Social Care Act' health economies 'must have regard' to NICE quality standards when commissioning or providing services.	
4. Quality Standards Methodology	TL outlined the methods used to develop QS. TL highlighted that QS are aspirational but achievable and are not intended to reinforce current practice. TL advised the group that NICE quality standards are informed by evidence-based recommendations from published NICE guidance or other NICE accredited sources. They do not review or redefine the underlying evidence base. TL described quality statements as descriptive, clear and concise evidence-based qualitative statements. He informed the group that the statements identify the most important 'markers' or key requirements of high quality care where specific improvements are required and which, if achieved, imply high quality practice in all other areas. TL outlined the need to ensure that the quality statements are based on one concept to ensure clarity and measurement and that this is the direction for the quality standards. TL advised the group that there will be some 'cross cutting' standards and commissioners/providers will be expected to cross refer across the library of topics. TL asked the TEG to be mindful that when considering areas of care and statements some issues maybe/ could be covered elsewhere. TL also explained the drive to have around 8 statements per standard. TL stated for some topics this would be difficult but asked the TEG to be mindful that due to the vast number of QS being developed there would eventually be a library of a large number of statements which organisations would be encouraged to adhere to.	.

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	The group discussed the number of statements needed as some past QS included 12 statements. TL explained that different topics would require different numbers of statements but the more statements there are the more the statements can lose focus. TL stated the need for fewer, more precise statements. It would be unsustainable for 10+ statements per standard. The group queried whether the TEG could be advised which standards would be cross cutting as he believed this to be useful for the afternoon session. BB presented the maternity list of topics to the TEG and also mentioned the Patient experience QS which had previously been circulated. AM also explained that it is useful to have AL (Chair of the Antenatal care TEG) on the group as he could note any overlap with the antenatal care QS which is currently in development. The group queried whether evidence sources have to be NICE guidelines. BB explained that any NICE accredited source can be used to develop the standard.	
5.Example of a quality standard	BB showed the group an example of a QS on the NICE website. The QS shown was Ovarian Cancer. BB explained to the group that the statements are person centred and need to show that patients have choice.	
6. Clinical and policy issues	HM gave the TEG an overview of the current clinical and policy issues surrounding maternity. The TEG requested a copy of the slides.	JH to circulate HM slides after the meeting
7.Scoping session	The group considered the scope and agreed its content. The group questioned whether birth partner/life partner could be included in the population. BB to check if this is in the guideline. The group considered the areas of care diagram, adapted from the areas identified in CG132. BB led the group through a discussion of the key recommendations from the guideline and the group agreed that they will consider the following areas of care:	BB to check if birth/life partner is included in the guideline scope population.

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	• **Antenatal considerations** - Process for managing maternal anxiety / referral to Mental Health expert in perinatal counselling - Process for managing maternal preference / request for C-Section - VBAC- informed choice / not restricted to women with 1 C-Section - Timing for elective pre 39 weeks / use of steroids - Dedicated list for C-Section • **Indications for an unplanned C-Section** - Foetal blood sampling for foetal compromise • **Surgery** - Consultant obstetrician involved in any decision to perform a C-Section - A consultant obstetrician should attend all C-Sections when conducted at full dilation • **Post operative monitoring and care** - Debriefing following C-Section - Use of maternity early warning systems BB & TL emphasised the requirement that all statements will need an evidence base to be included. It was noted that some of the above areas were not covered in clinical guideline and there may be some difficulty in identifying suitably accredited to evidence to progress these areas. The group did not feel it was necessary to include specific statements on the following areas due to them being covered sufficiently elsewhere, having no recommendations or were not in need of a sufficient quality drive as they were common practice: - Antenatal medical or obstetric complications - Intrapartum complications - Time from decision to deliver to delivery - Use of prophylaxis - Anaesthetic care - Incision	BB to update the areas of care diagram.

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	- Delivery of foetus/ foetuses - Uterotonics - Cord clamping/ placenta removal - Wound closure These areas were suggested by the TEG. BB to check all have underpinning evidence sources. The TEG suggested the following sources for BB to explore: Guidance from the Royal college of midwives, the Birthplace study, the Neonatal survey for neonatal outcomes and UCOS Confidential enquires 'Saving mother lives'. It was suggested by the TEG to include staffing/training. TL highlighted that this is a generic issue in every QS and the patient experience QS includes a statement around this. Furthermore a sentence has now been included in the QS template to cover this issue and will be included in all future published QS. The group reviewed equality issues surrounding the areas of care. It was suggested that women with English not as their first language could be an issue, although the group agreed that the standard is for all those accessing care.	BB to check underpinning evidence sources
8.Next steps and AOB	The group discussed the composition of the topic expert group and felt it was sufficient to cover the areas of care identified for inclusion. JH outlined the next steps in the QS development process and highlighted important dates. JH advised the group that they will have chance to comment on the QS at various stages of development. MG thanked the TEG and NICE team and then closed the meeting.	