National Institute for Health and Care Excellence

Multiple Pregnancy
Quality Standard Consultation Comments Table
5th April 2013 – 3rd May 2013

Notes for completion (NB this is for internal purposes – remove before posting on web)

ID – This is the stakeholder ID from the consultation response spreadsheet. Technical analysts will assign individual comment Ids at a later date.
Stakeholder – Please include the organisation name only.
Statement number – Any comment relating to multiple statements should be duplicated and assigned to each relevant statement. Comments can also be recorded as 'general' if they do not relate to a specific statement. If a stakeholder does not specify what the comment relates to then please leave this blank for the technical analyst to complete.
Comment on - Populate this only where stakeholder specifies what element of statement comment relates to, otherwise leave blank. Choose from statement, measure, audience, definitions, equality.

Comment ID	ID	Stakeholder	Statement No	Comment on	Comments Please insert each new comment in a new row.	Response Please respond to each comment
001	003	Royal College of General practitioners	General		There is no mention of "general practitioners" in this QS. Multiple pregnancy often results in preterm birth and infants/babies who have more medical needs than singletons. It would be good if this QS could encourage women with multiple pregnancies to develop a relationship with their primary care team during pregnancy (especially their GP, but also their HV), rather than being abandoned by specialist services after delivery and having to start developing relationships at times that may be fraught with anxiety about illness in their infants.	Thank you for your comment, please see the final wording of the statements and definitions for the role of GPs within the care or women with multiple pregnancies..
002	008	Royal College of Nursing	General		This draft quality standard seems good and appropriate. There are no further comments to add to this draft on behalf of the Royal College of Nursing.	Thank you for your comment.
003	009	Royal College Obstetricians and Gynaecologists	General		Please use "fetal growth restriction" not "intra uterine growth restriction". Also, fetal not foetal.	Thank you for your comment.
004	010	BMFMS	General		Quality measures for standards 1, 5 and 6 are the most important/valuable	Thank you for your comment.
005	010	BMFMS	General		Measuring adherence to standards 7 and 8 might be the most difficult.	Thank you for your comment.
006	010	BMFMS	General		Standard 3 is more difficult to define and therefore measure. What do we mean by the terms 'multidisciplinary core teams, named specialist obstetrician, specialist midwife'? What qualifications/experience are/is required to fulfil these roles? If we	Thank you for your comment. Within the final quality standard, abbreviations and key terms are defined within the definitions section

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					are not sure, how then can we measure compliance with this standard?	of each quality statement. Overarching definitions are provided within the introductory sections.
007	010	BMFMS	General		It is reassuring to read in the main NICE guideline the honesty of the authors who point out very clearly how many of the recommendations are not based on high quality evidence. This, in turn, is reflected in the quality document which does not set percentage values that should be reached. As a tool to help drive up quality, I think the document will do well. It will not be an appropriate tool for absolute comparisons between services because some of the standards are more clearly defined than others, and some are more open to interpretation.	Thank you for your comment.
008	004	TAMBA	General	Outcomes	1. Early identification of chorionicity and amnionicity pregnancies ensures appropriate care planning of women at increased risk of complications 2. Effective monitoring of each fetus ensures the early identification of any complications arising 3. i) Reduction in the risks for women associated with a multiple pregnancy by ensuring care is delivered by a core team with the appropriate skills and expertise ii) Enhances the experience for women with a multiple pregnancy and their families 4. Each women with a multiple pregnancy has a comprehensive, individual care plan to: i) Ensure early identification of any problems ii) Enhance her experience of maternity services iii) Improve communication and reduce duplication iv) Encourages her involvement at each stage hence enhancing patient experience 5. Early identification of any complications and appropriate referral to specialist consultant reducing risk of infant mortality 6. As in quality statement 5 7. Every women with a multiple pregnancy understands the risks/likelihood of preterm birth and knows how to identify signs and symptoms 8. All women with a multiple pregnancy are prepared physically and psychologically for birth and have a personalised birth plan in place	We have considered all suggestions for suitable outcome measures. The TEG prioritised measures they considered most important for measuring the quality statements. The quality measures aim to improve the structures and processes of care that are considered to be linked to outcomes, as well as specifying outcomes directly where the TEG felt able to define these.
009	009	Royal College Obstetricians and Gynaecologists	Introduction	Para 3	Feto-fetal transfusion syndrome occurs exclusively in monochorionic pregnancies rather than “twin pregnancies” in	Thank you for your comment.

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					general.	
010	010	BMFMS	Other possible standards		Should we be attempting to measure what proportion of women are given contact details of TAMBA? The guideline focuses on the MDT as the provider of information. What role do other agencies have?	The topic expert group reviewed all measures in the draft quality standard and have prioritised and refined those they considered most important to measure the quality statements in the final standard.
011	010	BMFMS	Other possible standards		Proportion of women being offered low dose aspirin who have two or more risk factors for pre-eclampsia. All women with multiple pregnancies have one risk factor for PET, by definition.	The topic expert group prioritised the areas of care they felt were most important for patients, based on the development sources listed. The topic expert group prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators. All suggestions for additional statements were discussed by the topic expert group who considered they were inappropriate for inclusion (for example, outside the scope of the quality standard), or already covered by existing statements.
012	004	TAMBA	Quality statement 1		In relation to improving quality Tamba suggest the description of what the quality statement means for each audience should include the information given to the woman in an accessible and easy to understand format regarding the ultrasound scans. Tamba ask the TEG to consider what measures would be in place for late bookers? Tamba would support the inclusion of a statement on nomenclature.	NICE has produced a support document to help commissioners and others consider the commissioning implications and potential resource impact of this quality standard and patient information to explain to patients and carers what the quality standard means to them, both available from www.nice.org.uk The topic expert group prioritised the areas of care they felt were most important for patients, based on the development sources listed. The topic expert group prioritised areas of care where practice is

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						variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators.
013	007	Society and College of radiographers	Quality statement 1		The fact that a woman has a multiple pregnancy may often not be known until they attend for the first routine (Fetal Anomaly Screening Programme) 11w to 13w 6d scan. Some women will book later than 14w or towards the end of this time period and a short notice appointment cannot be arranged. A few women will decline all routine ultrasound examinations and multiple pregnancy may not be diagnosed until much later. Will the suggested statistical return take this into account?	We envisage that inclusion of these measures in the quality standard will ensure that they are measured at a local level, and may in time influence any national data collections.
014	009	Royal College Obstetricians and Gynaecologists	Quality statement 1		These are very similar to each other, collecting data which is obtained at the same time during a single scan. Why not combine the two standards? In contrast, there is no mention of a recommendation to offer trisomy screening to women with multiples at 11-13+6 weeks by way of nuchal translucency screening...this justifies a QS.	The topic expert group felt it was important to retain an individual statement on different aspects of ultrasound scanning to ensure each element is clearly addressed. The topic expert group considered trisomy screening when prioritising areas for improvement and felt that the Fetal Anomaly and Screening Programme standards in combination with NICE CG 129 provided sufficient guidance on this area.
015	010	BMFMS	Quality statement 1		Seem measurable and appropriate	Thank you for your comment.
016	010	BMFMS	Quality statement 1		Should there be a stipulation that there is a recorded USS image to demonstrate chorionicity? And to determine fetal localization?	The requirement to record the ultrasound image is now included within this statement.
017	006	Swansea University	Quality statement 1	Definition	Chorions should also be defined in brackets (as outer membranes)	Thank you for your comment.
018	006	Swansea University	Quality statement 1	Measure	The outcome should read Determination of chorionicity and amnionicity	Thank you for your comment.
019	006	Swansea University	Quality statement 2		The word ‘position’ relates to something quite specific in terms of describing the relationship of a denominator on the fetus	Thank you for your comment. Please see the final wording of this

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					(commonly the occiput) with one of six points on the maternal pelvis (this is in later pregnancy). Therefore it may be less confusing if one instead refers to **orientation** of the fetus at this early stage or pregnancy.	statement for the terminology used and its definition.
020	007	Society and College of radiographers	Quality statement 2		The fact that a woman has a multiple pregnancy may often not be known until they attend for the first routine (Fetal Anomaly Screening Programme) 11w to 13w 6d scan. Some women will book later than 14w or towards the end of this time period and a short notice appointment cannot be arranged. A few women will decline all routine ultrasound examinations and multiple pregnancy may not be diagnosed until much later. Will the suggested statistical return take this into account?	We envisage that inclusion of these measures in the quality standard will ensure that they are measured at a local level, and may in time influence any national data collections.
021	009	Royal College Obstetricians and Gynaecologists	Quality statement 2		These are very similar to each other, collecting data which is obtained at the same time during a single scan. Why not combine the two standards? In contrast, there is no mention of a recommendation to offer trisomy screening to women with multiples at 11-13+6 weeks by way of nuchal translucency screening...this justifies a QS.	The topic expert group felt it was important to retain an individual statement on different aspects of ultrasound scanning to ensure each element is clearly addressed.
022	010	BMFMS	Quality statement 2		Seem measurable and appropriate	Thank you for your comment.
023	010	BMFMS	Quality statement 2		Should there be a stipulation that there is a recorded USS image to demonstrate chorionicity? And to determine fetal localization?	The requirement to record the ultrasound image is now included within this statement.
024	006	Swansea University	Quality statement 2	Measure	I think that the outcome should be much clearer – what does 'identification of the fetuses' mean? – it should refer to orientation of the foetuses. The word orientation should then be defined in the definitions section.	Thank you for your suggestions. Outcome measures are stated where the topic expert group felt these were appropriate, measureable and specifically attributable to the action stated in the statement. In addition to this, each statement is now followed by a rationale section which provides a brief explanation for why the statement is important with some reference to the outcomes that the action referred to in the statement has a potential causal link to.
025	002	Royal College of Paediatrics and Child Health	Quality statement 3		Multidisciplinary core team description should include an acknowledgement of the role of the neonatologist in providing information on outcomes and newborn management.	Thank you for your comment. The definitions section for this statement defines the composition of the multidisciplinary core team. The role of the neonatal unit and

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						team has been included in the quality statements for 'Advice and preparation for preterm birth' and 'Preparation for birth'
026	004	TAMBA	Quality statement 3		Due to the high risks associated with multiple pregnancy Tamba would suggest the following additions to the information given by the core team ' *The core team should offer information and emotional support specific to twin and triplet pregnancies…including:* • Advice regarding smoking cessation • Post natal depression • Antenatal nutrition to include, if indicated by BMI over 30, discussion regarding increased risks posed by maternal obesity and referral as appropriate to include psychological support • Visit to the neonatal unit if possible/discussion • Other risks more prevalent with multiple pregnancies including pre-eclampsia and what signs/symptoms to look for • Parenting: to include a discussion regarding the role of the health visitor and referral to health visitor liaison to promote early identification of this group of women to support transition and relationship building along with timely distribution of the Person Child Health Records (Red books) to enhance communication.	The topic expert group prioritised the areas of care they felt were most important for patients, based on the development sources listed. The topic expert group prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators.
027	004	TAMBA	Quality statement 3		Regarding the inclusion of Fetal medicine specialist how available nationally are they? Would the TEG consider inclusion of health visitor to the core team?	NICE has produced a support document to help commissioners and others consider the commissioning implications and potential resource impact of this quality standard and patient information to explain to patients and carers what the quality standard means to them, both available from www.nice.org.uk
028	007	Society and College of radiographers	Quality statement 3		Definitions given for specialist obstetrician and midwives but not for ultrasonographers ('sonographer' is the term most often used).	A definition of ultrasonographer is now included within this statement.
029	004	TAMBA	Quality	Current	Tamba would agree with the concern on page 11 paragraph two of	NICE has produced a support

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			statement 3	practice 3.1.5 outlined in briefing paper page 11	the briefing paper relating to the current availability of equipment and healthcare professionals responsible for care of twin and triplet pregnancies and the variability nationally. There has been a reduction in many areas in specialist roles held by midwives due to staff shortages including that of midwives supporting multiple births. Another important point to consider is in relation to staff training and refreshers to ensure this is considered by commissioners.	document to help commissioners and others consider the commissioning implications and potential resource impact of this quality standard and patient information to explain to patients and carers what the quality standard means to them, both available from www.nice.org.uk
030	009	Royal College Obstetricians and Gynaecologists	Quality statement 4		Care planning (p13 of 29) - The outcome for this draft quality measure is 'women feel informed about their care' – this will be very difficult to measure. Suggest change this outcome to 'women have a care plan that details which healthcare professionals they should see and when'.	Outcome measures are stated where the topic expert group felt these were appropriate.
031	004	TAMBA	Quality statement 4	Measure	Tamba strongly support the development of a care plan however feel there is an opportunity to extend the scope of the care plan to improve quality, ensure patient safety and a positive experience for all women. Tamba would suggest the draft quality measure 4 considers not only a care plan to specify the frequency and timing of appointments but also evidence of local arrangements for the development of care pathways to include for example: • Late bookers • Referral to consultant as necessary • Women with BMI greater than 30 to be referred to specialist • Identifying other risks with multiple pregnancy including pre-eclampsia • Screening for postnatal depression • Discussions relating to birth plans/timing of delivery/elective births • Breastfeeding	The topic expert group prioritised the areas of care they felt were most important for patients, based on the development sources listed. The topic expert group prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators. The quality standard contains key markers of clinical and cost effective care across a care pathway. It remains important that other evidence-based guideline recommendations continue to be implemented.
032	004	TAMBA	Quality statement 5		Tamba would support the inclusion of FFTs and IUGR fetal complications as referenced. Is there an opportunity to also include other risks more prevalent in multiple pregnancies to ensure women have the information and can identify symptom's early e.g. pre-eclampsia? As before there is scope for enhancing care plans to include pathways for FFTS and IUGR. Reducing the process measures is a challenge as there needs to be clarity for healthcare providers and commissioners.	The topic expert group prioritised the areas of care they felt were most important for patients, based on the development sources listed. The topic expert group prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes,

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						and where there is potential to generate measurable indicators. The quality standard contains key markers of clinical and cost effective care across a care pathway. It remains important that other evidence-based guideline recommendations continue to be implemented.
033	007	Society and College of radiographers	Quality statement 5		Fetal biometric parameters. There are no BMUS charts for BPD with HC being used instead Ref: http://www.bmus.org/policies-guides/23-17-3-161_ultBMUS.pdf Query any comments with respect to Doppler ultrasound and liquor volume assessment?	Thank you for your comment, please see the final wording of the definitions section for this statement.
034	009	Royal College Obstetricians and Gynaecologists	Quality statement 5		Monitoring for fetal complications (p16 of 29) - In the section 'Definitions', under the heading 'Fetal biometric parameters' the biparietal diameter measurement (BPD) is included. The BPD is not a useful parameter of fetal growth; the abdominal circumference is appropriate but if measurement of the head is required then the head circumference is appropriate. Rationale. '...is more likely to occur in monochorionic *than* dichorionic....'	Thank you for your comment, please see the final wording of the definitions section for this statement.
035	010	BMFMS	Quality statement 5		Adherence to the schedule of appointments for the different types of multiple pregnancies should be measurable and worthwhile. It seems to be more valuable to measure if these appointments are actually being offered, rather than whether the woman is informed of what this schedule will/should be (although I agree that this information is important for the woman to have (statement 4))	We have considered all suggestions for suitable outcome measures. The TEG prioritised measures they considered most important for measuring the quality statements. The quality measures aim to improve the structures and processes of care that are considered to be linked to outcomes, as well as specifying outcomes directly where the TEG felt able to define these.
036	011	Royal Berkshire Hospital NHS Foundation Trust	Quality statement 5		Measurement and documentation of BPD is of no value (providing the HC is measured) and should be excluded. I am not sure that FL measurements make any difference for growth monitoring other than (possibly) improving the sensitivity of EFW calculations for the diagnosis of IUGR/reduced growth velocity. If AC alone is used to diagnose growth abnormality (as recommended in Green Top Guideline) then FL is definitely not helpful.	Thank you for your comment, please see the final wording of the definitions section for this statement.

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037	006	Swansea University	Quality statement 5	Measure	I think that the outcomes should read Incidence of feto-fetal transfusion. Incidence of low birth weight	Thank you for your suggestions. Outcome measures are stated where the topic expert group felt these were appropriate, measureable and specifically attributable to the action stated in the statement
038	010	BMFMS	Quality statement 5	Measure 5b	Calculation of discordance at each scan from 20 weeks. I do favour this, although it is part of the guideline which I have not seen in practice. There should be an example to illustrate the point and demonstrate how the discordancy is calculated, as I suspect that size discordancy in twins is a relatively poorly appreciated marker of risk in the wider obstetric community.	The quality standards are based on evidence-based recommendations from national accredited guidance, i.e. the NICE Multiple pregnancy clinical guideline. The quality standards do not seek to reassess or redefine the evidence base.
039	002	Royal College of Paediatrics and Child Health	Quality statement 6		This statement should include referral back to the most appropriate local unit. The birth should take place at the most appropriate local unit, unless complications mandate care remaining at specialist unit.	Thank you for your comment. Please see the rationale and definitions sections for this statement for additional detail.
040	003	Royal College of General practitioners	Quality statement 6		Title should be “Indications for seeking a tertiary level fetal medicine opinion” rather than a consultant opinion, because they should all be seeing a “consultant” already.	Thank you for your comment. Please see the final wording for the title of this statement.
041	003	Royal College of General practitioners	Quality statement 6		Slightly confused – is an “opinion” different from a referral? Do you mean that the tertiary centre does not necessarily need to take over the woman’s care? It would be helpful to have more information about what “complications” actually means – seems a bit vague at present	Thank you for your comment. Please see the rationale and definitions sections for this statement for additional detail.
042	009	Royal College Obstetricians and Gynaecologists	Quality statement 6		The outcome in this section is infant and maternal mortality and morbidity. Is there good evidence that referral for a consultant opinion in a fetal medicine centre actually improves infant and maternal mortality and morbidity (especially maternal)?	Thank you for your suggestions. Outcome measures are stated where the topic expert group felt these were appropriate, measureable and specifically attributable to the action stated in the statement
043	010	BMFMS	Quality statement 6		The title is woolly, but the definitions tighten it up. a) Discordant growth (?use 25%), and also SGA with EFW <10th centile b) Liquor volume discordancy, but short of TTTS. I assume that the omission of ‘the next step’ in complicated multiple pregnancy, is because it falls outside of the remit. Eg discussion of MFPR, laser for management of TTTS, occlusive techniques for TRAP	Thank you for your comment. The scope of the quality standard is the management of twin and triplet pregnancies in the antenatal period and excludes any interventions including those required as a result of monitoring.
044	011	Royal Berkshire Hospital	Quality		Statutory referral (or even discussion about) of all these ‘higher	Thank you for your comment. Please

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		NHS Foundation Trust	statement 6		risk groups' to a tertiary centre is not appropriate. I am un -aware of any evidence that this improves outcome and it would serve to deskill the non-tertiary unit staff (as well as making them feel like second rate obstetric units). It may even be harmful for the reasons given in the draft document (travel, anxiety, social dislocation, unfamiliarity etc).	see the rationale and definitions sections for this statement for additional detail on referral to a tertiary fetal medicine centre.
045	006	Swansea University	Quality statement 6	Equality and diversity	I would say that the woman's preferences MUST be taken into account.	Thank you for your comment.
046	006	Swansea University	Quality statement 6	Introductio n	The statement should end with the word complications not complicated.	Thank you for your comment.
047	004	TAMBA	Quality statement 6	Measure	Structure: this could be reflected in the care plan and associated care pathways	Thank you for your comment.
048	006	Swansea University	Quality Statement 6	Measure	Perhaps the outcome should read perinatal, infant and maternal mortality and morbidity.	Outcome measures are stated where the topic expert group felt these were appropriate, measureable and specifically attributable to the action stated in the statement
049	009	Royal College Obstetricians and Gynaecologists	Quality statement 6	Section 2	"if there are complications"	Thank you for your comment.
050	002	Royal College of Paediatrics and Child Health	Quality statement 7		The benefits of corticosteroids have got lost in the definition box, it does not belong there.	Thank you for your comment.
051	002	Royal College of Paediatrics and Child Health	Quality statement 7		A crucial part of the conversation with women regarding preterm birth is discussions about neonatal management, including role of neonatal networks, place of delivery and possibility of the babies being cared for in more than one NNU.	Thank you for your comment. Please see the final wording of the rationale and definitions sections for this statement.
052	002	Royal College of Paediatrics and Child Health	Quality statement 7		The standard statement should be 'Women with a multiple pregnancy have a discussion by 24 weeks with a member of the multidisciplinary core team about the risks, signs and symptoms of preterm labour *and possible outcomes of preterm birth'*.	Thank you for your comment. Please see the final wording of this statement.
053	003	Royal College of General practitioners	Quality statement 7		Should title be "Advice about preterm birth", it's not really about preparation for preterm birth	Thank you for your comment. Please see the final wording of the title for this statement.
054	009	Royal College Obstetricians and Gynaecologists	Quality statement 7		Preparation for preterm birth - The outcome (Levels of satisfaction with support and confidence to recognise the signs and symptoms of preterm labour) is pretty woolly and will be difficult to assess. I would suggest that the outcome is documentation in the maternity case records by a member of the multidisciplinary core team that a discussion has taken place by 24 weeks about the risks, signs and symptoms of preterm labour. This is assuming that there is actually an evidence base which demonstrates that such a	We have considered all suggestions for suitable outcome measures. The TEG prioritised measures they considered most important for measuring the quality statements. The quality measures aim to improve the structures and processes of care that are considered to be linked to

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					discussion generates a material improvement in neonatal outcome (which is not easy to be confident of, but of course the QS are based upon recommendations from the relevant guideline).	outcomes, as well as specifying outcomes directly where the TEG felt able to define these.
055	005	Bliss	Quality statement 7	General	a) Given that most multiple pregnancies will be identified by the scan performed at 10-14 weeks, we would suggest an earlier deadline for the discussion with a member of the multidisciplinary team. 24 weeks seems too late. In addition to giving information about risks, signs and symptoms of preterm labour, it would also be helpful to give information about support available - a survey conducted by TAMBA of around 1300 mothers of multiples - http://www.tamba.org.uk/document.doc?id=73 – indicated that a high proportion of mothers feel ill-informed and unprepared. Signposting to sources of support (both national and local) could help address this and ensure parents have ongoing support.	The topic expert group prioritised the areas of care they felt were most important for patients, based on the development sources listed. The topic expert group prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators.
056	004	TAMBA	Quality statement 8		Tamba would agree to specify that at 28 weeks to discuss the timing and mode of delivery and that the discussion should include offer of an elective birth according to their chorionicity. This discussion could be led by specialist consultant with follow up discussions supported by midwife/multidisciplinary core team. Tamba would recommend the above points are included in the care plan/pathway to ensure clarity and improve standards by identifying whose responsibility this is.	Thank you for your comment. Please see the final wording of the rational and definitions sections for this statement.
057	002	Royal College of Paediatrics and Child Health	Quality statement 8		The statement should include that this should be reviewed if circumstances subsequently change.	Thank you for your comment.
058	003	Royal College of General practitioners	Quality statement 8		Rationale: duplicates some of information in QS 7 – e.g. pre-term birth.	Thank you for your comment.
059	004	TAMBA	Quality statement 8		In relation to when an elective birth should be offered Tamba would support the statement agreeing the earlier the better for both the core healthcare team and the woman and her family i.e. 32 weeks to allow for sufficient planning time in relation to the birth, liaison with specialist units as necessary and hence identify necessary resources and ensure patient safety. And for the woman in relation to psychological and emotional preparation, birth planning and on a practical note if she has other children and /or lives at some distance from the unit. Tamba would again suggest this is incorporated in to the care plan/pathway.	Thank you for your comment. Please see the final wording of the rational and definitions sections for this statement.
060	005	Bliss	Quality statement 8		Given that a significant number of twins will be born before 32 weeks, and the average gestation at delivery of triplets is 33 weeks, discussion at 32 weeks will be too late for many mothers.	The topic expert group prioritised the areas of care they felt were most important for patients, based on the

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					We recommend that discussion with the MDT takes place earlier. Around 50% of mothers of twins will see at least one of their babies admitted to neonatal care, and 90% of triplets require neonatal care. Therefore is it important that the possibility of hospitalisation immediately after birth (and what this might entail) is discussed with mothers at an appropriate point during their pregnancy.	development sources listed. The topic expert group prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators.
061	010	BMFMS	Quality statement 8		Statement regarding steroids to DC twins having an elective CS at 37-38 weeks (I know this is not mentioned in the full guideline)	The topic expert group identified the development sources they felt were most relevant to developing the standard, within the framework of the quality standards development process. The quality standards are based on evidence-based recommendations from national accredited guidance, i.e. the NICE multiple pregnancy clinical guideline. The quality standards do not seek to reassess or redefine the evidence base. Please refer to the full clinical guideline for detailed summary of the underpinning evidence base for the clinical recommendations on which the quality standard is based.
062	006	Swansea University	Quality statement 8	Measure	I am not clear about what 'Rates of elective birth' means.	Thank you for your comment.
063	010	BMFMS	Quality statement 8	Measure 8b	Ambiguous wording; 'The proportion of women who receive an offer of an elective birth by 32 weeks'. I think this would be better worded as 'The proportion of women who, by 32 weeks gestation, have documented plans for the timing of elective delivery, if spontaneous labour doesn't occur'.	Thank you for your comment. Please see the final wording of the measures for this statement.
064	004	TAMBA	Question 2	Areas not covered by the quality standard	2. The quality standard, whilst very comprehensive and acknowledges issues in relation to equality and diversity, does not, in my opinion, link with public health outcomes sufficiently. As outlined in Public Health Framework for England 2013-2016 in relation to planning of services *'the NHS, social care, the voluntary sector and communities will work together…'* specifically to achieve the high level outcomes of *'increasing life expectancy'* and *'reducing the difference in life expectancy and healthy life*	Thank you for your suggestions. Outcome measures are stated where the topic expert group felt these were appropriate, measureable and specifically attributable to the action stated in the statement. In addition to this, each statement is now followed by a rationale section which provides

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Comment ID	ID	Stakeholder	Statement No	Comment on	Comments Please insert each new comment in a new row.	Response Please respond to each comment
					expectancy between communities' (DH, 2012). Clearly health outcomes are often determined by complex social factors and it is therefore my concern that there may be a missed opportunity to integrate and include for example smoking cessation, maternal obesity, and postnatal depression within this quality standard. Similarly it does not make sufficient reference or links to primary care and the role of the GP and health visitor teams. This could be done via the care plan/pathway. Early identification and intervention antenatally is vital as well as plans made for the transition to primary care post-delivery to ensure a holistic, seamless approach to the care of this group of women. In relation to measures there would be value in gathering evidence, both quantitatively and qualitatively, from women with multiple pregnancies regarding their experiences and how this can be used to inform commissioning cycles	a brief explanation for why the statement is important with some reference to the outcomes that the action referred to in the statement has a potential causal link to. Please see the final wording of the defintions and data sources sections for this statement. Any outcomes which relate to pregnancy in general are covered by NICE clinical guideline 62 on Antenatal Care and the associated quality standard.
065	004	TAMBA	Question 3	Most important quality statements	3. The most important quality statements, in my opinion, are statements 3&4. This is because, I believe, they underpin the other statements. If there is a comprehensive, individualised care plan in place and care is delivered by members of a core team with the skills and expertise health outcomes of this vulnerable group will be improved. Whereas the remaining statements, whilst also important are driven by measures and can all be included in the care plan	Thank you for your comment.
066	004	TAMBA	Question 4	Any inappropriate quality measures	b) No it is my view that the quality measures are appropriate	Thank you for your comment.

These organisations were approached but did not respond:

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