NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Draft quality standard for multiple pregnancy

1 Introduction

The incidence of multiple births has risen in the last 30 years. In 2011, 16 women per 1000 giving birth in England and Wales had multiple births compared with 10 per 1000 in 1980. This rising multiple birth rate is due mainly to increasing use of assisted reproduction techniques including in vitro fertilisation (IVF), as the average age at which women give birth increases. Multiple births currently account for 3% of live births.

Multiple pregnancy is associated with higher risks for the mother and babies. Maternal mortality associated with multiple births is 2.5 times that for singleton births. The risk of preterm birth is also considerably higher in multiple pregnancies than in singleton pregnancies, occurring in 50% of twin pregnancies .The significantly higher preterm delivery rates in twin and triplet pregnancies result in increased demand for specialist neonatal resources.

Risks to babies depend partly on the chorionicity and amnionicity of the pregnancy (whether the fetuses share the same chorionic membrane or amniotic sac). Feto-fetal transfusion syndrome, a condition associated with a shared placenta, most commonly occurs in twin pregnancies and accounts for about 20% of stillbirths in multiple pregnancies. Additional risks to the babies include intrauterine growth restriction and congenital abnormalities.

This quality standard covers the management of twin and triplet pregnancies in the antenatal period. For more information see the scope for 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. They draw on existing guidance, which provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement. The quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following frameworks:

- The NHS Outcomes Framework 2013/14
- A public health outcomes framework for England, 2013–2016

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

NHS outcomes framework 2013-14	
Domain 1: Preventing people from dying prematurely.	**Overarching indicators** 1a: Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare **Improvement areas** *Reducing deaths in babies and young children* 1.6i: Infant mortality 1.6ii: Neonatal mortality and stillbirths
Domain 4: Ensuring that people have a positive experience of care.	**Improvement areas** *Improving women and their families' experience of maternity services* 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.	**Overarching indicators** 5a: Patient safety incidents reported 5b: Safety incidents involving severe harm or death **Improvement areas** *Improving the safety of maternity services* 5.5: Admission of full-term babies to neonatal care.
Public health outcomes framework 2013-16	
Domain 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** 4. 1: Infant mortality

2 Draft quality standard for multiple pregnancy

Overview

The draft quality standard for multiple pregnancy requires that services should be commissioned from and coordinated across all relevant agencies encompassing the whole multiple pregnancy care pathway. An integrated approach to provision of services is fundamental to the delivery of high-quality care to women with a multiple pregnancy.

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 socail care 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 assessing, caring for and managing multiple pregnancy should be sufficiently and appropriately trained in recognising the condition, and competent to deliver the actions and interventions described in the quality standard.

No.	Draft quality statements
1	Women with a multiple pregnancy have the chorionicity and amnionicity of their pregnancy determined between 11 weeks and 0 days to 13 weeks 6 days using ultrasound .
2	Women with a multiple pregnancy have the position of the fetuses mapped and recorded between 11 weeks and 0 days to 13 weeks and 6 days using ultrasound.
3	Women with a multiple pregnancy are cared for by a multidisciplinary core team.
4	Women with a multiple pregnancy have a care plan which specifies the timing of appointments appropriate for the chorionicity and amnionicity of their pregnancy with the multidisciplinary core team.
5	Women with a multiple pregnancy are monitored for fetal complications according to the chorionicity and amnionicity of their pregnancy.

6	Women with a multiple pregnancy are referred for a consultant opinion from a tertiary level fetal medicine centre if the pregnancy is higher risk or if there are complicated.
7	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.
8	Women with a multiple pregnancy have a discussion with a member of the multidisciplinary core team by 32 weeks gestation about the timing of birth and possible modes of delivery in order to agree their birth plan.

In addition, quality standards that should also be considered when commissioning and providing high-quality multiple pregnancy services are listed in section 7.

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: Determining chorionicity and amnionicity

Draft quality statement	Women with a multiple pregnancy have the chorionicity and amnionicity of their pregnancy determined between 11 weeks and 0 days to 13 weeks 6 days using ultrasound.
Rationale	If babies share a placenta there is a greater risk of complications. Determining chorionicity and amnionicity allows women to be assigned the correct plan of care for their pregnancy. Pregnancy risks, clinical management and subsequent outcomes are different for monochorionic and dichorionic twin pregnancies (and for monochorionic, dichorionic and trichorionic triplet pregnancies). Therefore accurate determinations of chorionicity is important.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure that women with a multiple pregnancy have an ultrasound scan between 11 weeks and 0 days to 13 weeks 6 days to determine the chorionicity and amnionicity of their pregnancy. **Process:** The proportion of women with a multiple pregnancy who have an ultrasound scan between 11 weeks and 0 days to 13 weeks and 6 days to determine the chorionicity and amnionicity of their pregnancy. Numerator – The number of women in the denominator having an ultrasound scan between 11 weeks and 0 days to 13 weeks and 6 days to determine the chorionicity and amnionicity of their pregnancy. Denominator – The number of women with a multiple pregnancy of greater than 14 weeks gestation. **Outcome:** Determination of chorionicity.
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place for women with a multiple pregnancy to have an ultrasound scanning between 11 weeks and 0 days to 13 weeks and 6 days to determine the chorionicity and amnionicity of their pregnancy. **Healthcare professionals** ensure women with a multiple pregnancy have an ultrasound scan between 11 weeks and 0 days to 13 weeks and 6 days to determine the chorionicity and amnionicity of their pregnancy. **Commissioners** ensure they commission specialist services that provide ultrasound scanning between 11 weeks and 0 days to 13 weeks and 6 days to women with a multiple pregnancy to determine the chorionicity and amnionicity of. **Women with a multiple pregnancy** have an ultrasound scan between 11 weeks and 0 days to 13 weeks and 6 days to see whether the foetuses share the same placenta and amniotic sac

	(called chorionicity and amnionicity).
Source clinical guideline references	NICE clinical guideline 129 recommendation 1.1.1.1 (key priority for implementation) and 1.1.2.1 (key priority for implementation).
Data source	**Structure:** Local data collection. **Process:** Local data collection. The Maternity Services Secondary Uses Data Set - Health & Social Care Information Centre once implemented will collect data on: Offer status – dating ultrasound scan (global number 17201960). Gestation – dating ultrasound scan (global number 17202010). Number of fetuses – dating ultrasound scan (global number 17202020). **Outcome:** Local data collection.
Definitions	**Multiple pregnancy** A multiple pregnancy is defined as a twin or triplet pregnancy. **Chorionicity** The number of chorionic membranes that surround the fetuses in a multiple pregnancy. If there is only one chorionic membrane the pregnancy is described as monochorionic; if there are two, the pregnancy is described as dichorionic; and if it is a triplet pregnancy with three membranes, the pregnancy is described as trichorionic. Monochorionic twin pregnancies and dichorionic and monochorionic triplet pregnancies carry higher risks because fetuses share a placenta. **Amnionicity** The number of amnions (inner membranes) that surround babies in a multiple pregnancy. Pregnancies with one amnion (so that all babies share an amniotic sac) are described as monoamniotic; pregnancies with two amnions are diamniotic; and pregnancies with three amnions are triamniotic. **Ultrasound scan** An ultrasound scan is used to determine chorionicity based on the number of placental masses, the lambda or T-sign and membrane thickness. Note: Antenatal care (NICE clinical guideline 62) recommends determination of gestational age from 10 weeks 0 days. However, the aim in Multiple pregnancy (NICE clinical guideline 129) was to keep to a minimum the number of scan appointments that women need to attend within a short time, especially if it is already known that a woman has a twin or triplet pregnancy.
Equality and diversity considerations	Pregnant women include women with complex social needs who may be less likely to access or maintain contact with antenatal care services. Examples of women with complex social needs include, but are not limited to, women who:

	• have a history of substance misuse (alcohol or drugs) • have recently arrived in the UK as a migrant, asylum seeker or refugee • have difficulty speaking or understanding English • are aged under 20 • have experienced domestic abuse • are living in poverty • are homeless. It is therefore appropriate that professionals give special consideration to women with complex social needs. Pregnancy and complex social factors (NICE clinical guideline 110) includes recommendations on how to make antenatal care accessible to pregnant women with complex social needs and how to encourage women to maintain ongoing contact with maternity services.

Draft quality statement 2: Mapping the position of the fetuses

Draft quality statement	Women with a multiple pregnancy have the position of the fetuses mapped and recorded between 11 weeks and 0 days to 13 weeks and 6 days using ultrasound.
Rationale	Assigning the position of the fetuses and recording this within the notes at the dating scan (for example, using left and right, or upper and lower) allows the fetuses to be consistently identified throughout the pregnancy.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure that women with a multiple pregnancy have the position of the fetuses mapped and recorded between 11 weeks and 0 days to 13 weeks and 6 days using ultrasound. **Process:** The proportion of women with a multiple pregnancy who have the position of the fetuses mapped and recorded between 11 weeks and 0 days to 13 weeks and 6 days using ultrasound. Numerator – The number of women in the denominator who have the position of the fetuses mapped and recorded 11 weeks and 0 days to 13 weeks and 6 days using ultrasound. Denominator – The number of women with a multiple pregnancy of greater than 14 weeks gestation. **Outcome:** Consistent identification of fetuses within multiple pregnancies.
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place for women with a multiple pregnancy to have an ultrasound scan between 11 weeks and 0 days to 13 weeks and 6 days to map and record the position of the fetuses. **Healthcare professionals** ensure women with a multiple pregnancy have an ultrasound scan between 11 weeks and 0 days to 13 weeks and 6 days to map and record the position of the fetuses. **Commissioners** ensure they commission specialist services for women with a multiple pregnancy to have an ultrasound scan between 11 weeks and 0 days to 13 weeks and 6 days to map and record the position of the fetuses. **Women with a multiple pregnancy** have an ultrasound scan between 11 weeks and 0 days to 13 weeks and 6 days to record the position of the fetuses.
Source clinical guideline references	NICE clinical guideline 129 recommendation 1.1.2.2 (key priority for implementation).
Data source	**Structure:** Local data collection.

	Process: Local data collection. The Maternity Services Secondary Uses Dataset will once implemented collect data on fetal order – ultrasound fetal anomaly screening (global number 17210330). **Outcome:** Local data collection.
Definitions	**Ultrasound scan** An ultrasound scan is used to determine chorionicity based on the number of placental masses, the lambda or T-sign and membrane thickness. **Mapping the position of the fetus** The position of the fetuses can be recorded within the women's maternity notes as either upper and lower or left and right.
Equality and diversity considerations	Pregnant women include women with complex social needs who may be less likely to access or maintain contact with antenatal care services. Examples of women with complex social needs include, but are not limited to, women who: • have a history of substance misuse (alcohol or drugs) • have recently arrived as a migrant, asylum seeker or refugee • have difficulty speaking or understanding English • are aged under 20 • have experienced domestic abuse • are living in poverty • are homeless. It is therefore appropriate that professionals give special consideration to women with complex social needs. Pregnancy and complex social factors (NICE clinical guideline 110) includes recommendations on how to make antenatal care accessible to pregnant women with complex social needs and how to encourage women to maintain ongoing contact with maternity services.

Draft quality statement 3: Composition of multidisciplinary the core team

Draft quality statement	Women with a multiple pregnancy are cared for by a multidisciplinary core team.
Rationale	Women with a multiple pregnancy should have their clinical care provided by a multidisciplinary core team because of the increased risks and complications associated with multiple births. Members of the core team will have the expertise required to provide high-quality care for women with a multiple pregnancy. It may be appropriate for the core team to refer women to the community midwifery team for some of her additional antenatal appointments, such as for blood tests.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure that women are cared for by a multidisciplinary core team.
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place for women to be cared for by a multidisciplinary core team. **Healthcare professionals** ensure women are cared for by a multidisciplinary core team. **Commissioners** ensure they commission services for women to be cared for by a multidisciplinary core team. **Women with a multiple pregnancy** are cared for by a team of healthcare professionals from different disciplines (for example, specialist doctors, specialist midwives and ultrasound operators).
Source clinical guideline references	NICE clinical guideline 129 recommendation 1.2.3.1 (key priority for implementation), 1.2.3.3 (key priority for implementation) and 1.2.3.4 (key priority for implementation).
Data source	**Structure:** Local data collection.
Definitions	**Multidisciplinary core team** A multidisciplinary core team of named specialists includes named specialist obstetricians, specialist midwives and ultrasonographers, all of whom have experience and knowledge of managing twin and triplet pregnancies. A specialist obstetrician is an obstetrician with a special interest, experience and knowledge of managing multiple pregnancies, and who works regularly with women with multiple pregnancies. A specialist midwife is a midwife with a special interest, experience and knowledge of managing multiple pregnancies, and who works regularly with women with multiple pregnancies. The multidisciplinary team should coordinate clinical care for women with twin and triplet pregnancies to:

	• minimise the number of hospital visits • provide care as close to the woman's home as possible • provide continuity of care within and between hospitals and the community. The core team should offer information and emotional support specific to twin and triplet pregnancies at their first contact with the woman and provide ongoing opportunities for further discussion and advice including: • antenatal and postnatal mental health and wellbeing • antenatal nutrition • the risks, symptoms and signs of preterm labour and the potential need for corticosteroids for fetal lung maturation • likely timing and possible modes of delivery • breastfeeding • parenting.

Draft quality statement 4: Care planning

Draft quality statement	Women with a multiple pregnancy have a care plan which specifies the timing of appointments appropriate for the chorionicity and amnionicity of their pregnancy with the multidisciplinary core team.
Rationale	Women with a multiple pregnancy should have the majority of their antenatal appointments with a member of the multidisciplinary core team. The number of appointments and ultrasound scans a woman should have depends on the chorionicity and amnionicity of her pregnancy and any associated risk factors or complications. Women should have a record of the expected number of antenatal appointments they should receive, who they should have them with and where they will take place.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure that women with a multiple pregnancy have a care plan which specifies the frequency and timing of antenatal care appointments appropriate for the chorionicity and amnionicity of their pregnancy. with the multidisciplinary core team **Process:** The proportion of women with a multiple pregnancy who have a care plan which specifies the frequency and timing of antenatal care appointments appropriate for the chorionicity and amnionicity of their pregnancy with the multidisciplinary core team. Numerator – The number of women in the denominator who have a care plan which specifies the frequency and timing of antenatal care appointments appropriate for the chorionicity and amnionicity of their pregnancy with the multidisciplinary core team. Denominator – The number of women with a multiple pregnancy. **Outcome:** Women feel informed about their care and know which healthcare professionals they should see and when.
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place for women with a multiple pregnancy to have a care plan which specifies the timing of antenatal care appointments appropriate for the chorionicity and amnionicity of their pregnancy with the multidisciplinary core team. **Healthcare professionals** ensure they provide women who have a multiple pregnancy with a care plan which specifies the timing of antenatal care appointments appropriate for the chorionicity and amnionicity of their pregnancy with the multidisciplinary core team. **Commissioners** ensure they commission services which provide women who have a multiple pregnancy with a care plan which specifies the timing of antenatal care appointments appropriate for the chorionicity and amnionicity of their pregnancy with the multidisciplinary core team.

	Women with a multiple pregnancy have a care plan which specifies the timing of their antenatal care appointments with the multidisciplinary core team.
Source clinical guideline references	NICE clinical guideline 129 recommendation 1.1.2.11 (key priority for implementation), 1.2.3.5, 1.2.3.6, 1.2.3.7 and 1.2.3.8.
Data source	**Structure:** Local data collection. **Process:** Local data collection. **Outcome:** Local data collection.
Definitions	**Care plan** A care plan should be provided at determination of chorionicity which specifies the frequency and timing of antenatal care appointments. Such a care plan should contain the recommended schedule of specialist antenatal appointments according to the chorionicity and amnionicity of a pregnancy, as detailed in NICE clinical guideline 129 appendix D (see supplementary information). Women may be seen for additional antenatal appointments within the community with healthcare professionals outside the multidisciplinary core team, such as community midwives and GPs. The scheduling of these appointments will be coordinated by the multidisciplinary core team.
Equality and diversity considerations	Specialist multidisciplinary teams should be available in all localities.

Draft quality statement 5: Monitoring for fetal complications

Draft quality statement	Women with a multiple pregnancy are monitored for fetal complications according to the chorionicity and amnionicity of their pregnancy.
Rationale	Multiple pregnancies are associated with increased risk of fetal complications. There is greater risk of feto-fetal transfusion syndrome with monochorionic multiple pregnancies and intrauterine growth restriction is more likely to occur in monochorionic and dichorionic multiple pregnancies. Therefore it is important that monochorionic and dichorionic pregnancies are monitored closely for fetal complications in order to manage them effectively should they arise.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure that women with a multiple pregnancy are monitored for fetal complications according to the chorionicity and amnionicity of their pregnancy. **Process:** a) Women with a monochorionic pregnancy are monitored for feto-fetal transfusion syndrome using ultrasound from 16 weeks and repeat monitoring fortnightly until 24 weeks. Numerator – The number of women in the denominator who are monitored for feto-fetal transfusion syndrome using ultrasound from 16 weeks which is repeated fortnightly until 24 weeks. Denominator – The number of women with a monochorionic multiple pregnancy and a gestational age greater than 24 weeks. b) Women with a multiple pregnancy receive an estimate of fetal weight discordance using two or more biometric parameters at each ultrasound scan from 20 weeks. Numerator – The number of women in the denominator receiving an estimate of fetal weight discordance using two or more biometric parameters at each ultrasound scan from 20 weeks. Denominator – The number of women with a multiple pregnancy and a gestational age greater than 20 weeks. **Outcome:** Incidence of fetal complications. Incidence of low birth weight.
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place to ensure that enable women with a multiple pregnancy can be monitored for fetal complications according to the chorionicity and amnionicity of their pregnancy. **Healthcare professionals** ensure women with a multiple pregnancy are monitored for fetal complications according to the chorionicity and amnionicity of their pregnancy. **Commissioners** ensure they commission services that monitor

	women with a multiple pregnancy for fetal complications according to the chorionicity and amnionicity of their pregnancy. **Women with a multiple pregnancy** are monitored for fetal complications in a way that is appropriate for their pregnancy.
Source clinical guideline references	NICE clinical guideline 129 recommendation 1.3.4.2, 1.3.4.3 and 1.3.5.2.
Data source	**Structure:** Local data collection. **Process:** a) and b) Local data collection. **Outcome:** Local data collection. The Maternity Services Secondary Uses Dataset will once implemented collect data on birth weight (global number 1720680) and instance of a neonatal critical incident (global number 17210380).
Definitions	**Intrauterine growth restriction** A difference in size of 25% or more between twins or triplets is a clinically significant indicator of intrauterine growth restriction. In clinical practice any degree of fetal growth restriction or discordance below 25% would lead to increased fetal surveillance. **Feto-fetal transfusion syndrome (FFTS)** Feto-fetal transfusion syndrome is a complication of monochorionic multiple pregnancies in which shared blood vessels in the placenta cause an imbalance in the flow of blood from one fetus to another. The fetus with less blood is referred to as the donor, and may experience slowed growth and development, whereas the fetus with too much blood is called the recipient. Feto-fetal transfusion syndrome is also referred to as twin-to-twin transfusion syndrome in twin pregnancies. **Fetal biometric parameters** Standard antenatal ultrasound measure to assess the growth and wellbeing of the fetus include: • biparietal diameter • head circumference • abdominal circumference • femoral length.

Draft quality statement 6: Indications for seeking a consultant opinion

Draft quality statement	Women with a multiple pregnancy are referred for a consultant opinion from a tertiary level fetal medicine centre if the pregnancy is higher risk or if there are complications.
Rationale	Collaborative care between local and tertiary level fetal medicine centres facilitates access to tertiary level neonatal and paediatric services when needed, while maintaining the focus on delivery of care locally. Referral of women with triplet pregnancies to tertiary level fetal medicine centres may have significant resource implications, may be inconvenient for the woman and her partner, and may cause additional anxiety for the woman. Therefore it may be more suitable to seek the opinion of a specialist fetal medicine consultant at tertiary level centres rather than refer a woman directly.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure that women with a multiple pregnancy are referred for a consultant opinion from a tertiary level fetal medicine centre if the pregnancy is determined to be at higher risk or if complications arise during the pregnancy. **Process:** a) The proportion of women with a multiple pregnancy who are referred for a consultant opinion from a tertiary level fetal medicine centre if the pregnancy is determined to be at higher risk. Numerator – The number of women in the denominator referred for a consultant opinion from a tertiary level fetal medicine centre. Denominator – The number of women with a higher risk multiple pregnancy. b) The proportion of women with a multiple pregnancy who are referred for a consultant opinion from a tertiary level fetal medicine centre if complications arise during the pregnancy. Numerator – The number of women in the denominator referred for a consultant opinion from a tertiary level fetal medicine centre. Denominator – The number of women with a complicated pregnancy. **Outcome:** Infant and maternal mortality and morbidity.
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place for women with a multiple pregnancy to be referred for a consultant opinion from a tertiary level fetal medicine centre if the pregnancy is determined to higher risk or complicated. **Healthcare professionals** ensure women with a multiple pregnancy are referred for a consultant opinion from a tertiary

	level fetal medicine centre if the pregnancy is determined to be higher risk or complicated. **Commissioners** ensure they commission services for women with a multiple pregnancy to be referred for a consultant opinion from a tertiary level fetal medicine centre if the pregnancy is determined to be higher risk or complicated. **Women with a multiple pregnancy** are referred for a consultant opinion from a specialist fetal medicine centre by a member of the multidisciplinary core team if there are complications.
Source clinical guideline references	NICE clinical guideline 129 recommendation 1.6.1.1 and 1.3.2.6.
Data source	**Structure:** Local data collection. **Process:** Local data collection. **Outcome:** Local data collection.The Maternity Services Secondary Uses Dataset, once implemented, will collect data on neonatal death (global number 17209680).
Definitions	**Tertiary level fetal medicine centre** A regionally commissioned centre with the experience and expertise for managing complicated twin and triplet pregnancies. **Consultant opinion** An opinion should be sought by a member of the multidisciplinary core team from consultant in a tertiary level fetal medicine centre, if the pregnancy is higher risk or complicated. NICE clinical guideline 129 recommendation 1.6.1.1 states seek a consultant opinion from a tertiary level fetal medicine centre for higher risk multiple pregnancies or complicated multiple pregnancies. **Higher risk** multiple pregnancies are defined as the following: • monochorionic monoamniotic twin pregnancies • monochorionic monoamniotic triplet pregnancies • monochorionic diamniotic triplet pregnancies • dichorionic diamniotic triplet pregnancies. **Complicated** multiple pregnancies are defined as those with: • discordant fetal growth • fetal anomaly • discordant fetal death • feto-fetal transfusion syndrome.

	In addition NICE clinical guideline 129 recommendation 1.3.2.6 states offer women with twin and triplet pregnancies who have a high risk of Down's syndrome referral to a fetal medicine specialist in a tertiary level fetal medicine centre.
Equality and diversity considerations	The woman's preferences should be taken into account when referring for a consultant opinion at a tertiary level fetal medicine centre. An opinion may be sought from a consultant at a tertiary level fetal medicine centre if the centre is a long distance from the woman's home and it is clinically appropriate to do so.

Draft quality statement 7: Preparation for preterm birth

Draft quality statement	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.
Rationale	The multidisciplinary core team have expert knowledge in managing multiple pregnancies. Women with a multiple pregnancy are at increased risk of maternal and fetal complications during pregnancy. It is important that they are given advice on the possible risks, signs and symptoms of preterm labour so that they know what to expect and can act quickly to contact their multidisciplinary core team if such symptoms arise.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure 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. **Process:** The proportion of women with a multiple pregnancy who have a discussion by 24 weeks.with a member of the multidisciplinary core team about the risks, signs and symptoms of preterm labour Numerator – The number of women in the denominator who have a discussion by 24 weeks with a member of the multidisciplinary core team about the risks, signs and symptoms of preterm labour. Denominator – The number of women with a multiple pregnancy that is greater than 24 weeks gestation. **Outcome:** Levels of satisfaction with support and confidence to recognise the signs and symptoms of preterm labour.
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place for women with a multiple pregnancy to have a discussion by 24 weeks with a member of multidisciplinary core team about the risks, signs and symptoms of preterm labour. **Healthcare professionals** ensure women with a multiple pregnancy have a discussion by 24 weeks with a member of multidisciplinary core team about the risks, signs and symptoms of preterm labour. **Commissioners** ensure they commission services in which women with a multiple pregnancy have a discussion by 24 weeks with a member of multidisciplinary core team about the risks, signs and symptoms of preterm labour. **Women with a multiple pregnancy** have a discussion by 24 weeks with a member of multidisciplinary core team about the risks and signs of preterm (early) labour.
Source clinical guideline references	NICE clinical guideline 129 recommendation 1.2.3.4 (key priority for implementation).

Data source	**Structure:** Local data collection. **Process:** Local data collection. The Health and Social Care Information Centre (2011) Maternity Statistics – 2010-2011 • Complications during non-delivery obstetric episodes, 2010-11 (Table 24). • Singleton, twin and higher order multiple deliveries by gestation and birth status, 2010-11 (Table 26). The Clinical Negligence Scheme for Trusts (CNST) Maternity Standards includes requirements for services to have discussion on timing and mode of birth. Standard 3: High risk conditions, Criterion 4, Multiple pregnancy and birth: For level 1, the maternity service has approved documentation for the management of multiple pregnancy and birth, which as a minimum must include the: a) requirement for providing information on the risks and benefits of different modes of delivery to support women in planning for birth. b) requirement to discuss the planned and agreed place and timing of birth. **Outcome:** Local data collection.
Definitions	**Preterm labour** The risk of preterm birth is higher in multiple pregnancies. About 60% of twins are delivered by 37 weeks and 10% before 32 weeks gestation, whereas 75% of triplets are delivered by 35 weeks. The benefits and risks of targeted corticosteroids for fetal lung maturation should also be discussed when providing information about preterm labour. The signs and symptoms of preterm labour include more frequent and regular contractions, ruptured membranes, unusual or severe back ache or other pain.
Equality and diversity considerations	Information on the risk, signs and symptoms of preterm labour should be understood by all women so they can feel fully informed. Information should be provided in an accessible format (particularly for women with physical, sensory or learning disabilities and women who do not speak or read English).

Draft quality statement 8: Preparation for birth

Draft quality statement	Women with a multiple pregnancy have a discussion with a member of the multidisciplinary core team by 32 weeks gestation about the timing of birth and possible modes of delivery in order to agree their birth plan.
Rationale	The majority of women with multiple pregnancies deliver by 37 weeks either spontaneously or electively. It is important that women are informed of the risks, signs and symptoms of preterm birth so they know what to expect and feel prepared. Women who are advised to have a vaginal delivery or caesarean section will need information to allow them to make an informed decision.
Draft quality measure	**Structure:** Evidence of local arrangements to ensure women with a multiple pregnancy have a discussion with the multidisciplinary core team by 32 weeks gestation about the timing of birth and possible modes of delivery in order to agree their birth plan. **Process:** a) The proportion of women with a multiple pregnancy who have a discussion with the multidisciplinary core team by 32 weeks gestation about the timing of birth and possible modes of delivery. Numerator – The number of women in the denominator who have a discussion with the multidisciplinary core team by 32 weeks gestation about the timing of birth and possible modes of delivery. Denominator – The number of women with a multiple pregnancy that is greater than 32 weeks gestation. b) The proportion of women who receive an offer of an elective birth by 32 weeks. Numerator – The number of women in the denominator who receive an offer for an elective birth by 32 weeks. Denominator – The number of women with a multiple pregnancy that is greater than 32 weeks gestation and a gestational age greater than 32 weeks. **Outcome:** Women feel well informed and able to make decisions that reflect what is important to them about the options for delivery. Rates of elective birth.
Description of what the quality statement means for each audience	**Service providers** ensure systems are in place for women with a multiple pregnancy to have a discussion with the multidisciplinary core team by 32 weeks gestation about the timing of birth and possible modes of delivery in order to agree their birth plan. **Healthcare professionals from the multidisciplinary core team** ensure the timing of birth and possible modes of delivery is discussed with women with a multiple pregnancy by 32 weeks gestation in order to agree the woman's birth plan. **Commissioners** ensure they commission services so that women

	with a multiple pregnancy have a discussion with the multidisciplinary core team by 32 weeks gestation about the timing of birth and possible modes of delivery by 32 weeks in order to agree the woman's birth plan. **Women with a multiple pregnancy** have a discussion with the multidisciplinary core team about the timing of birth and possible modes of delivery by 32 weeks gestation, and agree their birth plan.
Source clinical guideline references	NICE clinical guideline 129 recommendation 1.7.1.1, 1.7.1.2, 1.7.1.3, 1.7.1.4, 1.7.1.5, 1.7.1.6, and 1.7.1.7, 1.7.1.8 (key priority for implementation).
Data source	**Structure:** Local data collection. **Process:** Local data collection. The Clinical Negligence Scheme for Trusts (CNST) Maternity Standards includes requirements for services to have discussion on timing and mode of birth. Standard 3: High risk conditions, Criterion 4, Multiple pregnancy and birth: For level 1, the maternity service has approved documentation for the management of multiple pregnancy and birth, which as a minimum must include the: a) requirement for providing information on the risks and benefits of different modes of delivery to support women in planning for birth. b) requirement to discuss the planned and agreed place and timing of birth. **Outcome:** Local data collection. The Maternity Services Secondary Uses Dataset, once implemented, will collect data on delivery method (global number 2016160) and gestational age at birth (global number 17206120).
Definitions	NICE clinical guideline 129 recommendation 1.7.1.8 states offer women with uncomplicated: • monochorionic twin pregnancies elective birth from 36 weeks 0 days, after a course of antenatal corticosteroids has been offered • dichorionic twin pregnancies elective birth from 37 weeks 0 days • triplet pregnancies elective birth from 35 weeks 0 days, after a course of antenatal corticosteroids has been offered.
Equality and diversity considerations	Information on the timing of birth and possible modes of delivery should be understood by all women to enable them to make informed decisions. Information should be provided in an accessible format (particularly for women with physical, sensory or learning disabilities and women who do not speak or read

	English).

3 Status of this quality standard

This is the draft quality standard released for consultation from 5 April 2013 until 3 May 2013. This document is not NICE's final quality standard on multiple pregnancy. 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 3 May 2013. All eligible comments received during consultation will be reviewed by the Topic Expert Group (TEG) and the quality statements and measures will be refined in line with the TEG considerations. The final quality standard will then be available on the NICE website in September 2013.

4 Using the quality standard

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 by commissioners, providers, health and social care professionals, patients, service users and carers 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 healthcare. 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 healthcare.

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 professionals and women with multiple pregnancies 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 with a multiple pregnancy 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 section 8, 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

Antenatal care. NICE quality standard (2012).

Patient experience in adult NHS services. NICE quality standard (2012).

Specialist neonatal care. NICE quality standard (2010).

8 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 statements and measures.

Multiple pregnancy: the management of twin and triplet pregnancies in the antenatal period. NICE clinical guideline 129 (2011).

Antenatal care. NICE clinical guideline 62 (2008).

Policy context

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

Centre for Maternal and Child Enquiries (2011). Perinatal mortality 2009.

Centre for Maternal and Child Enquiries (2011). Saving mothers' lives. Reviewing maternal deaths to make motherhood safer: 2006–2008.

Department of Health (2011). Parents' views on the maternity journey and early parenthood.

Centre for Maternal and Child Enquiries (2010). Maternal obesity in the UK: findings from a national project.

Care Quality Commission (2010). Maternity services survey 2010.

Twins and Multiple Births Association (2009). Multiple failings. Parents of twins and triplets experience of pre and postnatal NHS care (TAMBA Health and Lifestyle Survey 2008).

Definitions and data sources for the quality measures

References included in in the definitions and data sources sections:

Health & Social Care Information Centre Maternity Services Secondary Uses Data Set.

The Health and Social Care Information Centre Maternity Statistics – 2010-2011.

NHS Litigation Authority The Clinical Negligence Scheme for Trusts (CNST) Maternity Standards.

Supplementary information: Schedule of antentatal specialist appointments

NICE clinical guideline 129, appendix D

The schedule of specialist antental appointments shown in NICE clinical guideline 129, appendix D is recommended (see table below).

Table. NICE clincal guideline 129, appendix D: schedule of specialist appointments

Type of pregnancy (uncomplicated)	Minimum contacts with core multidisciplinary team	Timing of appointments PLUS scans	Additional appointments WITHOUT scans
Monochorionic diamniotic twins	9 (including 2 with specialist obstetrician)	Approximately 11 weeks 0 days to 13 weeks 6 days* and 16, 18, 20, 22, 24, 28, 32 and 34 weeks	–
Dichorionic twins	8 (including 2 with specialist obstetrician)	Approximately 11 weeks 0 days to 13 weeks 6 days* and 20, 24, 28, 32 and 36 weeks	16 and 34 weeks
Monochorionic triamniotic triplets and dichorionic triamniotic triplets	11 (including 2 with specialist obstetrician)	Approximately 11 weeks 0 days to 13 weeks 6 days* and 16, 18, 20, 22, 24, 26, 28, 30, 32 and 34 weeks	–
Trichorionic triamniotic triplets	7 (including 2 with specialist obstetrician)	Approximately 11 weeks 0 days to 13 weeks 6 days* and 20, 24, 28, 32 and 34 weeks	16 weeks
* When crown–rump length measures from 45 mm to 84 mm			