NICE National Institute for Health and Care Excellence

NICE quality standard

Caesarean section

Quality standard

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This standard is based on CG132.

This standard should be read in conjunction with QS22, QS4, QS15, QS37, QS35, QS46, QS60, QS75, QS105, QS115, QS135 and QS144.

Introduction and overview

Introduction

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

This quality standard covers the care of women who plan for or may need a caesarean section. 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:

- NHS Outcomes Framework 2013/14.

The table below shows the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving:

NHS Outcomes Framework 2013/14

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Domain 1: Preventing people from dying prematurely	**Overarching indicator** 1a Potential years of life lost (PYLL) from causes considered amenable to healthcare **Improvement area** **Reducing deaths in babies and young children** 1.6.i Infant mortality ii Neonatal mortality and stillbirths
Domain 4: Ensuring that people have a positive experience of care	**Overarching indicator** 4b Patient experience of hospital care **Improvement area** **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 indicator** 5a Patient safety incidents reported 5b Safety incidents involving severe harm or death **Improvement area** **Improving the safety of maternity services** 5.5 Admission of full-term babies to neonatal care

Overview

The quality standard for caesarean section states that services should be commissioned from and coordinated across all relevant agencies encompassing the whole maternity care pathway. A person-centred approach to provision of services is fundamental to the delivery of high-quality care to women who may need, request or have a caesarean section.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care

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should cross refer across the library of NICE quality standards when designing high-quality services.

Patients, service users and carers may use the quality standard to find out about the quality of care they should expect to receive; to support asking questions about the care they receive; and to make a choice between providers of social care services.

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

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List of quality statements

Statement 1. Pregnant women who have had 1 or more previous caesarean sections have a documented discussion of the option to plan a vaginal birth.

Statement 2. Pregnant women who request a caesarean section (when there is no clinical indication) have a documented discussion with members of the maternity team about the overall risks and benefits of a caesarean section compared with vaginal birth.

Statement 3. Pregnant women who request a caesarean section because of anxiety about childbirth are referred to a healthcare professional with expertise in perinatal mental health support.

Statement 4. Pregnant women who may require a planned caesarean section have consultant involvement in decision-making.

Statement 5. Pregnant women having a planned caesarean section have the procedure carried out at or after 39 weeks 0 days, unless an earlier delivery is necessary because of maternal or fetal indications.

Statement 6. Women being considered for an unplanned caesarean section have a consultant obstetrician involved in the decision.

Statement 7. Women in labour for whom a caesarean section is being considered for suspected fetal compromise are offered fetal blood sampling to inform decision-making.

Statement 8. Women who have had a caesarean section are offered a discussion and are given written information about the reasons for their caesarean section and birth options for future pregnancies.

Statement 9. Women who have had a caesarean section are monitored for postoperative complications.

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

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Quality statement 1: Vaginal birth after a caesarean section

Quality statement

Pregnant women who have had 1 or more previous caesarean sections have a documented discussion of the option to plan a vaginal birth.

Rationale

Clinically there is little or no difference in the risk associated with a planned caesarean section and a planned vaginal birth in women who have had up to 4 previous caesarean sections. If a woman chooses to plan a vaginal birth after she has previously given birth by caesarean section, she should be fully supported in her choice.

Quality measure

Structure: Evidence of local arrangements to ensure that pregnant women who have had 1 or more previous caesarean sections have a documented discussion of the option to plan a vaginal birth.

Process: The proportion of pregnant women who have had 1 or more previous caesarean sections who have a documented discussion of the option to plan a vaginal birth.

Numerator – the number of women in the denominator who have a documented discussion of the option to plan a vaginal birth.

Denominator – the number of pregnant women who have had 1 or more previous caesarean sections.

Outcomes:

a) Women's satisfaction that they were supported in their choice for planned birthing option.

b) Rates of delivery modes for women who have had previous caesarean sections.

What the quality statement means for each audience

Service providers ensure that systems are in place for pregnant women who have had 1 or more previous caesarean sections to have a documented discussion of the option to plan a vaginal birth.

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Healthcare professionals ensure that they have a documented discussion with women who have had 1 or more previous caesarean sections that they have the option to plan a vaginal birth and support them in their choice.

Commissioners ensure that they commission services that have systems in place for pregnant women who have had 1 or more previous caesarean sections to have a documented discussion of the option to plan a vaginal birth.

Pregnant women who have had a caesarean section in the past have a discussion with a member of their maternity team (which is recorded in their notes) about the option to plan a vaginal birth.

Source guidance

NICE clinical guideline 132 recommendations 1.8.1, 1.8.2 (key priority for implementation) and 1.8.5.

Data source

Structure: Local data collection.

Process: Local data collection.

Outcomes:

a) Local data collection.

b) The Maternity services secondary uses dataset will collect data on 'the method for delivering baby' (global number 17206160) and on 'pregnancy previous caesarean sections' (global number 17200570), once implemented.

Definitions

Documented discussion

Pregnant women should be informed by members of the maternity team that in women who have had 4 or fewer previous caesarean sections the risk of fever, bladder injuries and surgical injuries does not vary with planned mode of birth and that the risk of uterine rupture, although higher for planned vaginal birth, is rare. This discussion should be documented in the woman's notes.

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Quality statement 2: Maternal request for a caesarean section: maternity team involvement

Quality statement

Pregnant women who request a caesarean section (when there is no clinical indication) have a documented discussion with members of the maternity team about the overall risks and benefits of a caesarean section compared with vaginal birth.

Rationale

The purpose of this statement is to inform decisions about the planned mode of birth. It is important that the woman can talk to the most relevant member of the maternity team depending on what her question or concern is about her request for a caesarean section. It is important that access to members of the maternity team is possible at any point during the woman's pregnancy and promptly arranged following a request.

Quality measure

Structure: Evidence of local arrangements to ensure that pregnant women who request a caesarean section (when there is no clinical indication) have a documented discussion with members of the maternity team about the overall risks and benefits of a caesarean section compared with vaginal birth.

Process: The proportion of pregnant women who request a caesarean section (when there is no clinical indication) who have a documented discussion with members of the maternity team about the overall risks and benefits of a caesarean section compared with vaginal birth.

Numerator – the number of women in the denominator who have a documented discussion with at least 1 member of the maternity team about the overall risks and benefits of a caesarean section compared with vaginal birth.

Denominator – the number of pregnant women who request a caesarean section when there is no clinical indication.

Outcome: Women's satisfaction with the process of discussing options with the maternity team.

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What the quality statement means for each audience

Service providers ensure that systems are in place for pregnant women who request a caesarean section (when there is no clinical indication) to have a documented discussion with members of the maternity team about the overall risks and benefits of a caesarean section compared with vaginal birth.

Healthcare professionals ensure that pregnant women who request a caesarean section (when there is no clinical indication) have a documented discussion with members of the maternity team about the overall risks and benefits of a caesarean section compared with vaginal birth.

Commissioners ensure that they commission services that have systems in place for all pregnant women who request a caesarean section (when there is no clinical indication) to have a documented discussion with members of the maternity team about the overall risks and benefits of a caesarean section compared with vaginal birth.

Pregnant women who ask for a caesarean section (when there is no medical reason) have a discussion with members of the maternity team (which is recorded in their notes) about the risks and benefits of a caesarean section compared with a vaginal birth.

Source guidance

NICE clinical guideline 132 recommendation 1.2.9.1 and 1.2.9.2.

Data source

Structure: Local data collection.

Process: Local data collection, included in NICE clinical guideline 132 Caesarean section: clinical audit tool – maternal request for caesarean section, criterion 2.

Outcome: Local data collection.

Definitions

Documented discussion

The discussion should include the reasons for the request and ensure that the woman has accurate

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information (including written information) about the relative risks and benefits associated with different modes of birth, based on box A in NICE clinical guideline 132. This discussion should be documented in the woman's antenatal notes.

Maternity team

The core membership of the maternity team should include a midwife, an obstetrician and an anaesthetist.

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Quality statement 3: Maternal request for a caesarean section: maternal anxiety

Quality statement

Pregnant women who request a caesarean section because of anxiety about childbirth are offered a referral to a healthcare professional with expertise in perinatal mental health support.

Rationale

When a woman who is requesting a caesarean section due to anxiety is given the opportunity to discuss this with someone who can answer their questions and understand their concerns in a supportive manner, the anxieties can often be reduced to the point where the woman is able to choose a planned vaginal birth. This discussion is an important part of the decision-making process and should happen before a decision on caesarean section is made with the maternity team. A referral can be to a member of the maternity team with interest and experience in this area of antenatal support.

Quality measure

Structure: Evidence of local arrangements to ensure that pregnant women who request a caesarean section because of anxiety about childbirth are offered a referral to a healthcare professional with expertise in perinatal mental health support.

Process: The proportion of pregnant women who request a caesarean section because of anxiety about childbirth who are referred to a healthcare professional with expertise in perinatal mental health support.

Numerator – the number of women in the denominator who are referred to a healthcare professional with expertise in perinatal mental health support.

Denominator – the number of pregnant women who request a caesarean section because of anxiety about childbirth.

Outcome: Women's satisfaction with the support provided for anxiety about childbirth.

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What the quality statement means for each audience

Service providers ensure that systems are in place for pregnant women who request a caesarean section because of anxiety about childbirth to be offered a referral to a healthcare professional with expertise in perinatal mental health support.

Healthcare professionals ensure that pregnant women who request a caesarean section because of anxiety about childbirth are offered a referral to a healthcare professional with expertise in perinatal mental health support.

Commissioners ensure that they commission services that offer women who request a caesarean section because of anxiety about childbirth a referral to a healthcare professional with expertise in perinatal mental health support.

Pregnant women who ask for a caesarean section because of anxiety about childbirth are offered a referral to a healthcare professional with expertise in mental health support for women approaching childbirth.

Source guidance

NICE clinical guideline 132 recommendation 1.2.9.3 (key priority for implementation).

Data source

Structure: Local data collection.

Process: Local data collection, included in NICE clinical guideline 132 Caesarean section: clinical audit tool – maternal request for caesarean section, criterion 3.

Outcomes: Local data collection.

Definitions

Healthcare professional with expertise in perinatal mental health support

Someone, usually from the maternity team, who has an interest and expertise in providing support to women with higher than normal anxiety levels, to the extent that they are requesting a caesarean section.

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Referral

The referral could be an informal referral within a maternity team or formal referral to another member of staff in a different team.

Anxiety

Anxiety that goes beyond the general anxiety that women have about childbirth. This refers to women whose anxiety is preventing them from wanting to attempt a vaginal birth.

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Quality statement 4: Consultant obstetrician involvement in decision-making for planned caesarean section

Quality statement

Pregnant women who may require a planned caesarean section have consultant involvement in decision-making.

Rationale

Consultant obstetricians are best placed to advise a woman who may need or want to plan a caesarean section about the potential benefits and risks for each option based on their specific circumstances and needs. The involvement of a consultant is intended to ensure that the best possible outcomes are achieved for the woman and the baby.

Quality measure

Structure: Evidence of local arrangements to ensure that pregnant women who may require a planned caesarean section have consultant involvement in decision-making.

Process: The proportion of pregnant women who may require a planned caesarean section who have consultant involvement in decision-making.

Numerator – the number of women in the denominator who have a consultant involved in decision-making.

Denominator – the number of pregnant women who may require a planned caesarean section.

Outcome: Women's satisfaction with the decision-making process.

What the quality statement means for each audience

Service providers ensure that systems are in place for pregnant women who may require a planned caesarean section to have consultant involvement in decision-making.

Healthcare professionals ensure that pregnant women who may require a planned caesarean section have consultant involvement in decision-making.

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Commissioners ensure that they commission services that have systems in place for pregnant women who may require a planned caesarean section to have consultant involvement in decision-making.

Pregnant women who may need a planned caesarean section have a consultant obstetrician involved in making the decision.

Source guidance

NICE clinical guideline 132 recommendation 1.3.2.4.

Data source

Structure: Local data collection.

Process: Local data collection.

Outcome: Local data collection.

Definitions

Pregnant women who may require a planned caesarean section

This includes both women who have clinical indications that would suggest that a planned caesarean section would be the safest way of delivering the baby, and women who request a caesarean section when there are no clinical indications.

Decision-making

The nature of the decision-making process and the extent to which the consultant will need to be involved in the process will vary between each woman and will depend on the complexity of their specific circumstances.

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Quality statement 5: Timing of planned caesarean section

Quality statement

Pregnant women having a planned caesarean section have the procedure carried out at or after 39 weeks 0 days, unless an earlier delivery is necessary because of maternal or fetal indications.

Rationale

Babies born by planned caesarean section at term but before the due date are at a higher risk of respiratory complications. The level of risk decreases with gestational age, particularly from 39 weeks onwards. Therefore planned caesarean section should not routinely be carried out before 39 weeks.

Quality measure

Structure: Evidence of local arrangements to ensure that pregnant women having a planned caesarean section have the procedure at or after 39 weeks 0 days, unless an earlier delivery is necessary because of maternal or fetal indications.

Process: The proportion of pregnant women having a planned caesarean section and not needing an earlier delivery because of maternal and fetal indications who have the procedure carried out at or after 39 weeks 0 days.

Numerator – the number of women in the denominator who have the caesarean section carried out at or after 39 weeks 0 days.

Denominator – the number of pregnant women having a planned caesarean section who do not need an earlier delivery because of maternal or fetal indications.

What the quality statement means for each audience

Service providers ensure that systems are in place for pregnant women having a planned caesarean section to have the procedure at or after 39 weeks 0 days, unless an earlier delivery is necessary because of maternal or fetal indications.

Healthcare professionals ensure that pregnant women having a planned caesarean section have the procedure at or after 39 weeks 0 days, unless an earlier delivery is necessary because of

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maternal or fetal indications.

Commissioners ensure that they commission services in which women having a planned caesarean section have the procedure at or after 39 weeks 0 days, unless an earlier delivery is necessary because of maternal or fetal indications.

Women having a planned caesarean section have the procedure at or after 39 weeks of pregnancy, unless an earlier delivery is needed because of problems with the baby or the mother.

Source guidance

NICE clinical guideline 132 recommendation 1.4.1.1.

Data source

Structure: local data collection.

Process: The Maternity services secondary uses data set will collect data on 'the method for delivering baby' (global number 17206160) and on 'gestational age at birth' (global number 17206160), once implemented.

Definitions

Planned caesarean section

Planned caesarean section should be agreed between the woman and the maternity team. The woman should be given a specific day and time at which the caesarean section will be performed. A model for delivering planned caesarean section is for services to have dedicated planned caesarean section lists. The lists should have protected surgical and anaesthetic time and appropriate staffing to ensure that planned caesarean section are not delayed because of surgical time being prioritised for emergency cases.

Maternal or fetal indications

Maternal or fetal indications include but are not limited to the following significant conditions: hypertensive disease, diabetes or gestational diabetes, significant antepartum haemorrhage, intrauterine/fetal growth restriction, congenital abnormality, hydrops or compromise resulting from blood group incompatibility, acute fetal compromise, and multiple pregnancy.

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Quality statement 6: Consultant obstetrician involvement in decision-making for unplanned caesarean section

Quality statement

Women being considered for an unplanned caesarean section have a consultant obstetrician involved in the decision.

Rationale

Involving a consultant obstetrician in urgent decisions about whether an unplanned caesarean section is necessary helps to ensure that all the relevant factors are taken into consideration. This should ensure the best possible outcome for the woman and the baby.

Quality measure

Structure: Evidence of local arrangements to ensure that women being considered for an unplanned caesarean section have a consultant obstetrician involved in the decision.

Process: The proportion of women being considered for an unplanned caesarean section who have a consultant obstetrician involved in the decision.

Numerator – the number of women in the denominator who have a consultant obstetrician involved in the decision.

Denominator – the number of women being considered for an unplanned caesarean section.

Outcome:
a) Unplanned caesarean section rates.

b) Women's satisfaction with the decision-making process.

What the quality statement means for each audience

Service providers ensure that systems are in place to ensure women being considered for an unplanned caesarean section have a consultant obstetrician involved in the decision.

Healthcare professionals ensure that women being considered for an unplanned caesarean section

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have a consultant obstetrician involved in the decision.

Commissioners ensure that they commission services that have systems in place for women being considered for an unplanned caesarean section to have a consultant obstetrician involved in the decision.

Women who, during labour, are being considered for an unplanned caesarean section because of complications have a consultant obstetrician involved in the decision.

Source guidance

NICE clinical guideline 132 recommendation 1.3.2.4.

Data source

Structure: Local data collection.

Process: Local data collection.

Outcome:
a) The Maternity services secondary uses data set will collect data on 'the method for delivering baby' (global number 17206160) once implemented.

b) Local data collection.

Definitions

Unplanned caesarean section

This refers to the categories described in NICE clinical guideline 132 section 1.2.

Consultant obstetrician involvement

This should include direct involvement in the decision either in person or via telephone if consultant cover is through on-call arrangements. Their involvement and the way in which they were involved (that is, by phone or in person) should be documented in the woman's maternity notes.

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Quality statement 7: The use of fetal blood sampling

Quality statement

Women in labour for whom a caesarean section is being considered for suspected fetal compromise are offered fetal blood sampling to inform decision-making.

Rationale

Fetal blood sampling is recommended if delivery by caesarean section is contemplated because of an abnormal fetal heart rate pattern or in cases of suspected fetal acidosis. Fetal blood sampling helps the maternity team to make a more informed judgement about whether to recommend a caesarean section or to continue with a vaginal delivery.

Quality measure

Structure:
a) Evidence of local arrangements to ensure that women in labour for whom a caesarean section is being considered for suspected fetal compromise are offered fetal blood sampling to inform decision-making.

b) Evidence of local arrangements to ensure that maternity units have access to a functioning and serviced fetal blood gas analyser.

Process:
a) The proportion of women in labour for whom a caesarean section is being considered for suspected fetal compromise who are offered fetal blood sampling to inform the decision.

Numerator – The number of women in the denominator who are offered fetal blood sampling.

Denominator – The number of women in labour for whom a caesarean section is being considered for suspected fetal compromise without contraindications for fetal blood sampling.

b) The proportion of women in labour in whom a fetal blood sample was attempted and a fetal blood reading was made.

Numerator – the number of women in the denominator in whom the fetal blood sample was successfully obtained and a reading made.

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Denominator – the number of pregnant women in whom a fetal blood sample was attempted.

Outcome: Unplanned caesarean section rates.

What the quality statement means for each audience

Service providers ensure that systems are in place for women in labour for whom a caesarean section is being considered for suspected fetal compromise to be offered fetal blood sampling to inform decision-making.

Healthcare professionals ensure that women in labour for whom a caesarean section is being considered for suspected fetal compromise are offered fetal blood sampling to inform decision-making.

Commissioners ensure that they commission services that have systems in place for women in labour for whom a caesarean section is being considered for suspected fetal compromise to be offered fetal blood sampling to inform decision-making.

Women in labour for whom a caesarean section is being considered because of concerns about the baby are offered a blood test from the baby's scalp (called fetal blood sampling) to help decide whether a caesarean section is needed.

Source guidance

NICE clinical guideline 132 recommendation 1.3.2.5.

Data source

Structure: a) and b) Local data collection.

Process: a) and b) Local data collection.

Outcome: Local data collection.

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Definitions

Suspected fetal compromise

Abnormal fetal heart rate pattern or suspected fetal acidosis.

Fetal blood sampling

Sampling should be undertaken when it is technically possible to do so and there are no contraindications. The National Sentinel Caesarean Section Audit defines 'technically possible' as cervical dilation of 4 cm or more. If there is clear evidence of acute fetal compromise (for example, prolonged deceleration greater than 3 minutes), fetal blood sampling should not be undertaken and urgent preparations to expedite birth should be made. If fetal blood sampling is not attempted because of contraindications, the contraindications should be documented in the woman's maternity notes.

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Quality statement 8: Post caesarean section discussion

Quality statement

Women who have had a caesarean section are offered a discussion and are given written information about the reasons for their caesarean section and birth options for future pregnancies.

Rationale

While women are in hospital after having a caesarean section, it is important to discuss the reasons for the caesarean section with them and their partners so that they know what this means for them when planning their family, including birth options for any future pregnancies. Because women and their partners receive a large amount of information during the immediate postnatal period, this information should be provided both verbally and in written formats.

Quality measure

Structure:
Evidence of local arrangements to ensure that women who have had a caesarean section are offered a discussion and are given written information about the reasons for their caesarean section and birth options for future pregnancies.

Process:
The proportion of women who have had a caesarean section who have had a discussion and were given written information about the reasons for their caesarean section and birth options for future pregnancies.

Numerator – The number of women in the denominator who have had a discussion and were given written information about the reasons for their caesarean section and birth options for future pregnancies.

Denominator – The number of women who have had a caesarean section.

Outcome: Women's satisfaction with post-caesarean section discussion and information.

What the quality statement means for each audience

Service providers ensure that systems are in place for women who have had a caesarean section to

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be offered a discussion and be given written information about the reasons for their caesarean section and birth options for future pregnancies.

Healthcare professionals ensure that women who have had a caesarean section are offered a discussion and are given written information about the reasons for their caesarean section and birth options for future pregnancies.

Commissioners ensure that they commission services that offer women who have had a caesarean section a discussion and written information about the reasons for their caesarean section and birth options for future pregnancies.

Women who have had a caesarean section are offered a discussion and given written information about the reasons for their caesarean section and birth options for future pregnancies.

Source guidance

NICE clinical guideline 132 recommendation 1.7.1.9 (key priority for implementation).

Data source

Structure: Local data collection.

Process: Local data collection.

Outcome: Local data collection.

Definitions

Offered

The offer of a discussion should be made when the woman is still in the postnatal ward, with the option to provide this at a later date, if the woman prefers.

Discussion

An opportunity for women to discuss the reasons for the caesarean section and how successful the procedure was with healthcare professionals and receive verbal and printed information about birth options for future pregnancies. The healthcare professional should be appropriately trained and experienced to provide accurate information. The level of experience needed will depend on

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the complexity of the case.

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Quality statement 9: Monitoring for postoperative complications following caesarean section

Quality statement

Women who have had a caesarean section are monitored for postoperative complications.

Rationale

Postoperative monitoring with regular observations in the immediate post-surgical period by someone with expertise in postoperative care is a key part of managing potential complications associated with surgery, including caesarean section. This needs to happen alongside the core postnatal care all women receive in hospital immediately after giving birth.

Quality measure

Structure: Evidence of local arrangements to ensure that women who have had a caesarean section are monitored for immediate postoperative complications.

Process: The proportion of women who have had a caesarean section who were monitored for immediate postoperative complications.

Numerator – the number of women in the denominator who are monitored for immediate postoperative complications.

Denominator – the number of women who have a caesarean section.

Outcomes: Rates of complications in women who have had a caesarean section.

What the quality statement means for each audience

Services providers ensure that systems are in place for women who have had a caesarean section to be monitored for postoperative complications.

Healthcare professionals ensure that women who have had a caesarean section are monitored for postoperative complications.

Commissioners ensure that they commission services in which women who have had a caesarean

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section are monitored for postoperative complications.

Women who have had a caesarean section are monitored for complications following the operation.

Source guidance

NICE clinical guideline 132 recommendations 1.6.1.1, 1.6.2.1 to 1.6.2.4, 1.7.1.3 and 1.7.1.6.

Data source

Structure: Local data collection.

Process: Local data collection.

Outcome: Local data collection.

Definitions

Monitoring complications

NICE clinical guideline 132 section 1.6.2 recommends the following in women who have had a caesarean section:

- After caesarean section by general anaesthetic, women should be observed on a one-to-one basis by a properly trained member of staff until they have regained airway control and cardiorespiratory stability and are able to communicate.
- After recovery from all forms of anaesthesia, observations (respiratory rate, heart rate, blood pressure, pain and sedation) should be continued every half hour for 2 hours, and hourly thereafter provided that the observations are stable or satisfactory. If these observations are not stable, more frequent observations and medical review are recommended.

The Centre for Maternal and Child Enquiries provided an example tool called the modified early obstetric warning score (MEOWS) to support monitoring after caesarean section.

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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 the documents listed in Development sources.

NICE has produced a commissioning support document that considers the commissioning implications and potential resource impact of this quality standard. This is available on the NICE website. Information for patients about using the quality standard is also available on the NICE website.

The quality measures accompanying the quality statements aim to improve the structure, processes and outcomes of healthcare in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

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

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

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

Diversity, equality and language

During the development of this quality standard, equality issues have been considered. Equality assessments are available.

Good communication between healthcare professionals and women who need or request a caesarean section is essential. Treatment and care, and the information given about it, should be

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culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. Women who need or request a caesarean section should have access to an interpreter or advocate if needed.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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Development sources

Evidence source

The document below contains recommendations from NICE guidance used by the Topic Expert Group to develop the quality standard statements and measures.

- Caesarean section. NICE clinical guideline 132 (2011).

Current practice and policy context

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

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

Data source for the quality measures

Reference included in the data sources sections:

The Maternity services secondary uses data set.

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Related NICE quality standards

Published

- Antenatal care. NICE quality standard 22 (2012).
- Patient experience in adult NHS services. NICE quality standard 15 (2012).
- Specialist neonatal care. NICE quality standard 4 (2010).

In development

- Postnatal care. Publication expected July 2013.
- Hypertension in pregnancy. Publication expected July 2013.
- Multiple pregnancy. Publication expected September 2013.

Future quality standards

These quality standards will be developed in the context of the full list of quality standards referred to NICE including the following maternity topics scheduled for future development:

- Intrapartum care.
- Induction of labour.
- Diabetes in pregnancy.
- Pain and bleeding in early pregnancy.
- Premature labour.
- Antenatal and postnatal mental health.

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The Topic Expert Group and NICE project team

Topic Expert Group

Ms Debbie Chippington Derrick
Lay member

Dr Malcolm Griffiths (chair)
Consultant Obstetrician and Gynaecologist, Luton and Dunstable Hospital

Prof David James
Clinical Co-Director, National Collaborating Centre for Women's and Children's Health

Mr Olujimi (Jimi) Jibodu
Consultant Obstetrician and Gynaecologist, York Hospital NHS Foundation Trust

Ms Christine Johnson
Lay member

Ms Nina Khazaezadeh
Consultant Midwife, St Thomas' Hospital, London

Dr Andrew Loughney
Consultant Obstetrician, Women's Services, Royal Victoria Infirmary, Newcastle

Nuala Lucas
Consultant Anaesthetist, Northwick Park Hospital, London

Ms Pippa Nightingale
Head of Midwifery, Imperial NHS Trust

NICE project team

Dylan Jones
Associate Director

Tim Stokes
Consultant Clinical Adviser

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Rachel Neary
Programme Manager

Brian Bennett
Lead Technical Analyst

Esther Clifford
Project Manager

Jenny Harrisson
Coordinator

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About this quality standard

NICE quality standards are a set of specific, concise statements and associated measures. They set out aspirational, but achievable, markers of high-quality, cost-effective patient care, covering the treatment and prevention of different diseases and conditions. Derived from the best available evidence such as NICE guidance and other evidence sources accredited by NHS Evidence, they are developed independently by NICE, in collaboration with NHS and social care professionals, their partners and service users, and address three dimensions of quality: clinical effectiveness, patient safety and patient experience.

The methods and processes for developing NICE quality standards are described in the healthcare quality standards process guide.

This quality standard has been incorporated into the NICE pathway for caesarean section.

We have produced a summary for patients and carers.

Changes after publication

May 2015: Minor maintenance.

April 2015: Minor maintenance.

June 2013: List of Topic Expert Group and NICE project team members added.

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Contact NICE

National Institute for Health and Care Excellence
Level 1A, City Tower, Piccadilly Plaza, Manchester M1 4BT

www.nice.org.uk

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nice@nice.org.uk

0845 003 7780

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Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- Birth Trauma Association
- Obstetric Anaesthetists' Association
- Royal College of Midwives
- Royal College of Nursing

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