NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Intrapartum care

Date of Quality Standards Advisory Committee post-consultation meeting:
10th September 2015.

2 Introduction

The draft quality standard for Intrapartum care was made available on the NICE website for a 4-week public consultation period between 15th June and 13th July 2015. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 19 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the Quality Standards Advisory Committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the Committee as part of the final meeting where the Committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the Committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the Committee should read this summary alongside the full set of consultation comments, which are provided in appendix 1.

Additional statement suggestions are included at the end of this summary report. Some of the areas suggested are outside of the remit of this quality standard. A guideline is in development covering the intrapartum care of high risk women and is anticipated to publish in January 2017.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

3. For each quality statement what do you think could be done to support improvement and help overcome barriers?

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- Overall support for the quality standard and statements as key areas of improvement
- Support suggested that statements should be incorporated into contracts and pulled into CQUINs
- Support for including women's experiences of care as an outcome
- Stakeholders asked for clarity as to what constitutes a woman to be at low risk of complications
- Concerns were raised about the relevance of maternal morbidity and mortality as outcomes for various statements, stakeholders suggested a more proximal outcome of maternal satisfaction and experience
- Concerns for the lack of statements considering care of the baby after birth, particularly breastfeeding support
- Concerns about the steer and scope of the quality standard. In particular the assumption of the quality standard that making an informed choice for ***place of birth*** is of more importance than making an informed choice for ***mode of birth***.

Consultation comments on data collection

- Mixed comments were received for data collection
- Comments suggest that it should be possible to collect data on the quality statements
- Some stakeholder suggest it would be difficult to monitor, record and evaluate the quality statements
- Concerns that data may be difficult to collect with current systems and therefore would require specific audits that will have resource implications
- Stakeholders question what proportion of women would we need to collect data on to confirm compliance to the quality statements?

Summary of consultation feedback by draft statement

4.1 Draft statement 1

Women at low risk of complications are given the choice of all 4 birth settings, information about local birth outcomes and the likelihood of transfer.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- Patient choice is a key improvement area and it is important to offer women a choice of birth setting
- Support suggested that a CQUIN could be designed to encourage implementation of this quality statement as well encouraging the utilisation of the Decision Tree to facilitate discussions between the midwife and the woman
- Stakeholders suggested the outcome of neonatal morbidity and mortality needs careful definition and that women's satisfaction may be a more relevant outcome
- Stakeholders highlighted equality of access to all birth settings for disabled or marginalised women
- Information about analgesia options in each of the 4 birth settings should be available as well as rates of transfer to obstetric units for epidural analgesia
- Stakeholders commented that choice for mode of birth is of equal importance to choice of birth setting and women need information to make an informed choice about how they give birth
- Some stakeholders suggested that making informed decisions about birth settings as a key improvement area is better placed in an antenatal care quality standard.

4.2 Draft statement 2

Women in all 4 birth settings in established labour have one-to-one care and support from an assigned midwife.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- One-to-one care from a midwife can be very reassuring for women
- For measurement purposes, the numerator should be ‘the number of midwifery staff available to provide care to women in labour in the same time period’
- One-to-one care should be provided even when the labour ward is full. Furthermore, continuity of care should be provided where possible
- Comments suggest that this statement is too ambitious given the current shortage of midwives and current economic climate, and is therefore unlikely to be implemented
- Maternal satisfaction suggested as an additional outcome measure

4.3 Draft statement 3

Women at low risk of complications who are in suspected or established labour do not have Cardiotocography monitoring as part of the initial assessment in any birth setting.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- If Cardiotocography is not offered, the alternatives should be listed
- Concerns were raised over the outcome measures of maternal and neonatal morbidity/mortality
- Reword statement to ‘women at low risk of complications in suspected or established labour ***are not offered*** Cardiotocography monitoring as part of the initial assessment in any birth setting’.

4.4 Draft statement 4

Women at low risk of complications who have cardiotocography because of concern arising from intermittent auscultation have the cardiotocograph removed if the trace is normal for 20 minutes.

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- Overall support for this statement
- Reword statement to 'Women at low risk of complications who ***are offered'*** Cardiotocography because of a concern arising from intermittent auscultation have the cardiotocograph removed if the trace is normal for 20 minutes'. This will clarify that CTG monitoring is a woman's decision
- Concerns that women who are not classed as low risk may automatically have CTG and therefore increasing the risk for false positive results
- Concerns about the use of intermittent auscultation for the identification of variability, instead of monitoring the presence or absence of decelerations.

4.5 Draft statement 5

Women do not have the cord clamped earlier than 1 minute after the birth unless there is concern about cord integrity or the baby's heartbeat remains below 60 beats per minute.

Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

- Stakeholders supported this statement as an area for quality improvement
- Stakeholders concerned with the interpretation of this statement
- To ensure clarity, change the statement to '***women do not routinely have the cord clamped earlier than 1 minute'***
- Comments suggested recording the time between delivery and cord clamping as some babies will benefit from longer delays than 1 minute
- Stakeholders highlighted that meconium is not mentioned in the quality statement
- Concerns about scenarios not included in the statement in which prompt cord clamping should be performed
- Outcome of neonatal haemoglobin concentrations and neonatal anaemia is not appropriate as only a very small proportion of babies need to have a blood count; moreover, babies should not have their haemoglobin measured to satisfy the quality standard.

4.6 Draft statement 6

Women at low risk of complications are not offered amniotomy or oxytocin if labour is progressing normally.

Consultation comments

Stakeholders made the following comments in relation to draft statement 6:

- Stakeholder comments suggested that quality statement 6 should discuss the prescription of oxytocin as it is a more sensitive indicator than the documentation of offering oxytocin
- Reword the statement to 'Women at low risk of complications are not offered amniotomy or oxytocin if labour is progressing normally, ***even if labour progress is slower than the standard***'
- Comments highlighted that sometimes women are induced or prescribed oxytocin in the absence of any indications of a slow labour.

4.7 Draft statement 7

(Placeholder) Consultant obstetric supervision and involvement during labour and birth for women at high risk of complications.

Consultation comments

Stakeholders made the following comments in relation to draft statement 7:

- Definition to specify direct consultant obstetric supervision on the labour ward
- Definition of grade and involvement level
- Quality statement outcomes require clarity
- There is conflicting evidence on what consultant obstetric presence on labour wards will achieve
- Stakeholder comments suggested rewording rationale
- Stakeholders would like to see statistics relating to this statement published on trust websites
- Anaesthetist involvement should be included in the statement

4.8 Draft statement 8

(Placeholder) Handover of care information when women at high risk of complications are transferred from birth settings to an obstetric unit during labour.

Consultation comments

Stakeholders made the following comments in relation to draft statement 8:

- Stakeholders support the inclusion of this statement as an area for quality improvement
- Comments suggested widening the scope to include handover of care at all points of transfer and at any time during pregnancy, birth and postnatal period
- The wording of the statement requires clarification
- Stakeholders suggested outcome indicators could be the implementation of the SBAR tool and reduction in communication errors

5 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements

- Stakeholders suggested that offering extended breastfeeding support is needed for 1-2 weeks until the drugs administered during labour have cleared from the mother and the baby
- Stakeholders suggested uninterrupted skin to skin is important. It has been shown to have multiple benefits to both mother and baby
- Support during labour for women with severe mental illness
- Women need to be informed of group strep B carriage through pregnancy and the implications of strep B infection
- Stakeholders commented an area for quality improvement is ensuring midwife led units are equipped to offer intravenous antibiotics in labour to women who carry group strep B.

Appendix 1: Quality standard consultation comments table – registered stakeholders

Stakeholder	Statement No	Comments Please insert each new comment in a new row.
NHS England	General	Fetal growth restriction should be included as a risk factor. Small fetuses are more vulnerable to hypoxia and poor outcomes.
Royal College of Paediatrics and Child Health	General	There are some grammar points to be corrected. Scope states about care of baby after birth but there is no relevant standard other than cord clamping.
Royal College of Paediatrics and Child Health	General	Consideration of which staff should be present for support of baby should there be complications should be added
Swansea University	General	We would support these statements. I think there could be difficulty in monitoring, recording and evaluating these statements. Electronic data collection is not robust in many organisations, and does not link to other key datasets, such as hospital admissions and primary care.
Royal College of Obstetricians & Gynaecologists	General	“Low risk of complications during labour “ to “low risk of complications during and after labour”
Royal College of Obstetricians & Gynaecologists	General	Suggest to change “CTG removed” to “CTG discontinued”
Royal College of Obstetricians & Gynaecologists	General	‘Complication’ should read ‘’complications’
The Royal College of Midwives	General	RCM welcomes this quality standard which covers several of the key areas that need quality improvement. The comments in this response are based on feedback from midwives who reviewed and responded to the Royal College of Midwives on this draft quality standard.
The Royal College of Midwives	General	These statements should be incorporated in contracts and possibly pulled into CQUINs. They definitely should feature in maternity dashboards.
Lactation Consultants of Great Britain	General	In table 2 on page 3 the standard mentions Breastfeeding as an indicator of public health outcomes. Babies who are not breastfed exclusively are at risk for several public health conditions such as obesity, diabetes, and many gastro-intestinal, respiratory, immunological and atopic conditions. I note that the standard does not mention any action or omission by the health care team to facilitate

Stakeholder	Statement No	Comments Please insert each new comment in a new row.
		breastfeeding at any point in this guideline, even though it is a key public health indicator. Practices that should be specifically mentioned that have a direct link to breastfeeding outcome are: **1) Pain relief in labour** (see: Jordan S, Emery S, Watkins A et al (2009) Associations of drugs routinely given in labour with breastfeeding at 48 hours: analysis of the Cardiff Births Survey. *BJOG*) **2) Intravenous fluids given in labour** (see: Kujawa-Myles-S, Noel-Weiss-J, Dunn-S, Peterson-W, and Cotterman K (2015) Maternal intravenous fluids and postpartum breast changes: a pilot observational study. *International Breastfeeding Journal* 2015,10:18) **3) Skin to skin contact immediately following delivery or as soon as mother and baby are stable** (see: Mikiel- Kostyra K, Mazur J, Boltruszko I (2002). Effect of early skin-to-skin contact after delivery on duration of breastfeeding: a prospective cohort study. *Acta Paediatr* 91(12):1301-6 **4) Delaying routine infant weighing and other procedures until after uninterrupted skin to skin and the baby's first feed** (see: Sobel H, Silvestre M, Mantaring J, Oliveros Y, Nyunt-U S (2011) Immediate newborn care practices delay thermoregulation and breastfeeding initiation. *Acta Paediatr*.100(8): 1127–1133. **5) Assistance with breastfeeding should the mother require it** (as specifically stated in NICE Postnatal Crae guideline 2006) **6) No artificial milk, teats or dummies given to the baby unless medically indicated** (see UNICEF Baby Friendly Standards, 2012)
Elective caesarean	General	Re: "*This quality standard covers the care of women **who go into labour at term** (37+0 weeks to 41+6 weeks) and their babies **during labour** and immediately after birth.*" QS110 suffers from the same issues as CG190, which is the assumption that place of birth is of greater importance than mode of birth, both in the context of women's choices and the health outcomes of women and their babies. As my organisation stated in response to the CG190 guidance consultation, "*the overall focus and steer of the research, recommendations and evidence selected for inclusion are very concerning – not just for the women my organisation represents (many of whom are healthy women with healthy pregnancies), but for the wider population of mothers who have no particular preference of birth mode or setting, and who may be influenced towards choosing a setting without all the available and relevant information to help them make a truly informed choice about **how** they give birth and not*

Stakeholder	Statement No	Comments Please insert each new comment in a new row.
		just where." My organisation would be interested to better understand why/how there is a change in terminology between the guideline and accompanying Quality Standard. Both CG55 (2007) and CG190 (2014) are titled, "*Intrapartum care: Care of healthy women and their babies* ***during childbirth***" but the QS focuses specifically on "*labour*" and the NICE Pathway included within it has "*information about labour*" instead of "*information about birth*". This excludes a sizeable proportion of women who may wish to consider planning a caesarean. There are now more women choosing a caesarean birth in the UK than there are women choosing a homebirth, despite the latter having the full force of government and maternity organisations' support and encouragement. However, there is an (often ideological) backlash against caesarean choice, not perceived by many as 'natural' or 'normal', and not to be included in a general guideline (or QS) on birth choices. This month, in a Sunday Times article, Gillian Smith, director of the Royal College of Midwives (RCM) Scotland, is quoted as saying (my emphasis), "*We need to know what is behind the rise in caesarean sections because there is a great deal of concern about it… It is a major abdominal operation and* ***it would be wrong if it's being given to women who regard it as a default option to avoid a painful labour***.*"* Mark Macaskill also reports that Smith said, "*a steady rise in women undergoing the* ***potentially dangerous operation*** *was a concern for her and the Scottish government. Smith wants health boards to justify the thousands of procedures carried out each year, adding "it would be wrong" if the rise was because women regarded a caesarean section as a default method of childbirth.*"(1) But any birth is "*potentially dangerous*", including a planned vaginal delivery and all *its* possible outcomes. And this view is similar to the RCM's comments in England when the NICE CG32 recommendations on maternal request were being drafted; it said the guidance "*seems to be simply encouraging CS. Many of our members have commented on this as* ***very unhelpful in their quest to reduce CS rate****".* The RCM also stated on its website: "*in cases where women ask for a caesarean section for* ***'purely social convenience'*** *the RCM does not think the procedure is appropriate.*" In more than a decade working with women who request caesareans, I have never encountered a woman for

Stakeholder	Statement No	Comments Please insert each new comment in a new row.
		whom "*purely social convenience*" was the reason proffered… While women are being provided with antenatal and intrapartum care information and advice within a framework of "*quests*" and "*targets*" (see below) to reduce caesarean rates, they will not be given the true facts about the many prophylactic benefits of planned surgery, and as my organisation has witnessed in the intervening years since 2011's CG32 was published, even women who actively make a request in the NHS are still being denied what is a perfectly legitimate birth plan. Finally, birth "*choice*", as advocated in this Quality Standard and others, is not a real choice if those who most powerfully and vocally advocate birth choices do so only for women who would choose from the exact same menu of choices they would. And aside from being disingenuous in the context of autonomy, it can lead to avoidable deaths and injuries as seen in the many litigation cases related to caesareans being refused or carried out too late.
Elective caesarean	General	Re: "*It is important that a woman is given information and advice about all available birth settings when she is deciding where to have her baby, so that she can make a fully informed decision. This includes information about outcomes for the different settings.*" Again, the focus on setting as opposed to mode of delivery within each setting means that women will not be receiving 'all' the information they need to make a truly 'fully informed decision' about **both how and where** to have their babies. One does not exist without the other, yet NICE guidance has been separated in such a way as to ensure that a very narrow and prescriptive view of what should matter to women is presented as all the tools they'll need to make an informed decision. The above should also read: '*It is important that a woman is given information about all available birth modes when she is deciding how to have her baby, so that she can make a fully informed decision."* For example, stillbirth risk and pelvic floor morbidity are just two outcomes that women are not properly informed about, and this is often because maternity health professionals have concerns that if women are told 'the whole truth/ all the facts' then they might be all too ready to opt for a planned caesarean. An example of this was criticised in a recent Supreme Court judgment for example(2):

Stakeholder	Statement No	Comments Please insert each new comment in a new row.
		The doctor had argued, "*if you were to mention shoulder dystocia to every [diabetic] patient, if you were to mention to any mother who faces labour that there is a very small risk of the baby dying in labour, then* ***everyone would ask for a caesarean section****, and* ***it's not in the maternal interests for women to have caesarean sections***". [Referring to Dr. McLellan's comments]: "***this does not look like a purely medical judgment. It looks like a judgment that vaginal delivery is in some way morally preferable to a caesarean section: so much so that it justifies depriving the pregnant woman of the information needed for her to make a free choice in the matter.***" The judgment continues: "*If Mrs Montgomery had had an elective caesarean section her son would have been born uninjured.*" And: "*the interest which the law of negligence protects is a person's interest in their own physical and psychiatric integrity, an important feature of which is their autonomy, their freedom to decide what shall and shall not be done with their body… "****The principal choice is between vaginal delivery and caesarean section****... For women requesting a CS, if after discussion and offer of support… a vaginal birth is still not an acceptable option, offer a planned CS."* "*A patient is entitled to take into account her own values, her own assessment of the comparative merits of giving birth in the "natural" and traditional way and of giving birth by caesarean section, whatever medical opinion may say, alongside the medical evaluation of the risks to herself and her baby…* *"****The medical profession must respect her choice****, unless she lacks the legal capacity to decide…* "*Gone are the days when it was thought that, on becoming pregnant, a woman lost, not only her capacity, but also her right to act as a genuinely autonomous human being.*" Note: *"****The principal choice is between vaginal delivery and caesarean section****...* Neither CG190 nor this Quality Standard address this principal choice, but rather focus on the choice of 'place of birth' alone... More than 92% of women already choose to give birth in hospital (page 10, section 4.1.3 of the Briefing Paper for this QS outlines '*Current UK practice… In England birth outside an obstetric unit is relatively uncommon with only around 8% giving birth outside an obstetric unit:*

Stakeholder	Statement No	Comments Please insert each new comment in a new row.
		• *2.8% giving birth at home* • *3% in alongside midwifery units* • *under 2% in freestanding midwifery units.* *Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study BMJ 2011; 343 :d7400'*) And these figures are despite massive national efforts to encourage and advise women to give birth away from obstetric units. Yet we have an entire Intrapartum Care guideline (and now QS) that deliberately chooses to focus on place of birth (currently affecting fewer than 8% of the birthing population) instead of 'mode of birth', which would be of greater relevance in 92% of births. My organisation is not confident that this issue will be addressed or resolved in 2015, but submits these comments in the hope that in subsequent years and guidelines, there will be enough professionals in the maternity services that might agree and help rectify the current situation.
Elective caesarean	General	Re: "*Uncertainty and inconsistency of care for women giving birth have been identified in a number of areas, such as choosing place of birth*" Again, the same is true for choosing mode of birth.
Elective caesarean	General	Re: "*The quality standard is expected to contribute to improvements in the following outcomes:* • ***neonatal mortality and morbidity*** • ***positive experience*** *of care* • *treating and caring for people in a safe environment and protecting them from* ***avoidable harm****.*" I understand that NICE will refer many of my comments back to CG32 and/or QS32, but it should not be the case in the year 2015 that only woman who 'request' a planned caesarean are privy to the information on prophylactic health outcomes for themselves and their babies that is now available. My organisation does not advocate 'encouraging' or 'advising' women to have caesareans, but rather that women are not denied genuine access to risk information just in case there is an increase in the number of requests overall. Pg.27 of the Quality Standard says "*It is important that the quality standard is considered alongside the*

Stakeholder	Statement No	Comments Please insert each new comment in a new row.
		documents listed in Development sources", and caesarean guidance is included in this, but given that many requests for caesareans are being denied, it seems very unlikely that this consideration is consistently taking place in practice. Also, in the context of the extract above, here is a comment from a medical resident in response to an online article(3) on the 2011 Birthplace study, on which so much of CG190 and this QS is based: "*I am a anesthesia resident and was shocked to see the sensationalist, media articles like "Low risk women urged to avoid hospital births" on my newsfeed today. It only takes reading the original homebirth studies to see how manipulative the media reporting is. As you mentioned, there is clearly a huge rate of transfer to obstetrical care for nulliparous women and significantly increased perinatal complications for the same group. However, beyond this, the Birthplace study does not even report maternal outcomes. I do not see any statistics for important outcomes like mortality, antenatal hemorrhage, infection rate etc. We are also missing long term outcomes for both mom and baby. It is so distressing to me that the NICE guidelines have been changed with incomplete evidence, and in fact, evidence that contradicts its message of equivalence in safety. Furthermore, I am outraged that the media has used this to further demonize medical care, without any understanding of the complex nature of labour and delivery, or any understanding of how to interpret the primary literature.* ***I am frightened that under this change, more women and/or babies will face complications, and they will accept this because they believe that they actually made the right choice.***"
Elective caesarean	General	**"***Re: Table 1 NHS Outcomes Framework 2015–16* *Preventing people from dying prematurely* • *1c Neonatal mortality and stillbirths*" As outlined in my BMJ letter published in 2011(4), "*the majority of stillbirths occur prior to labour, and indeed many full-term stillbirths occur in low risk pregnancies, yet* ***the Birthplace study excluded all stillbirths prior to the onset of labour***." Other letters raised similar concerns about information on neonatal mortality.(5) Also, as part of the CG190 and the NICE Pathway referred to in this QS, women won't be advised of studies like these, and therefore cannot make a "*fully informed decision*" when planning their births, especially when they reach full term and spontaneous labour has not yet occurred:

Stakeholder	Statement No	Comments Please insert each new comment in a new row.
		Hankins GDV et al. Cesarean section on request at 39 weeks: impact on shoulder dystocia, fetal trauma, neonatal encephalopathy, and intrauterine fetal demise. 2006 Semin Perinatol (**significant increase in the stillbirth rate after 39 weeks' gestation…** timely delivery could prevent two deaths in every 1000 living fetuses, the equivalent of 6,000 deaths annually… ***an impact that far exceeds any other strategy implemented for stillbirth reduction thus far.***" Ehrenthal DB et al. Neonatal outcomes after implementation of guidelines limiting elective delivery before 39 weeks of gestation. 2011 Obstet Gynecol ("*A policy **limiting elective delivery before 39 weeks** of gestation was followed by changes in the timing of term deliveries… This **was associated with a small reduction in NICU admissions; however, macrosomia and stillbirth increased.***") Dahlgren LS et al. Caesarean section on maternal request: risks and benefits in healthy nulliparous women and their infants. 2009 JOGC (***decrease in life-threatening injuries to babies in a breech cesarean group… fewer mothers died in the cesarean group too****)* Chongsuvivatwong V et al. Maternal and fetal mortality and complications associated with cesarean section deliveries in teaching hospitals in Asia. 2010 JSOG ("***the neonatal mortality rate was lowest with planned cesareans, as were rates of severe asphyxia and palsy****")*
Elective caesarean	General	Re: "*4. Ensuring that people have a positive experience of care* ***Overarching indicators*** *4b Patient experience of hospital care* ***Improvement areas*** *Improving hospitals' responsiveness to personal needs* *4.2 Responsiveness to in-patients' personal needs* *Improving women and their families' experience of maternity services* *4.5 Women's experience of maternity services*" Current maternity care is not achieving the above, as outlined on page 10 of this QS Briefing Paper: "*A survey [Dignity in Childbirth 2013] highlighting choice in childbirth found 50% of women agreed with the statement 'I had the birth I wanted'. Additionally, 66% of women who had vaginal births reported they had the birth they wanted compared to 14% of instrumental births and 36% of women who had a*

Stakeholder	Statement No	Comments Please insert each new comment in a new row.
		caesarean section. However, 21% of women reported that they were not given enough information to adequately make choices about their birth. The figures increased for women who had instrumental or caesarean section births, 26% and 25% respectively." Compare this to an Australian study of maternal request satisfaction, with a mean satisfaction rate of 9.25 out of 10.(6) And bear in mind that the Dignity in Childbirth Survey(7) was flawed in relation to measuring satisfaction with planned caesarean (and/or maternal request caesarean) because all caesareans (elective and emergency) were grouped together as one. Part of the problem is that women are not always told what to expect and/or the risks of a planned vaginal birth – in any setting – are not always communicated to women whereas the '*dangers*' of a caesarean birth are emphasised. One woman once told me how, during antenatal classes for her second pregnancy, she was being told about pelvic floor risks and she remarked, "*This would have been really useful information the first time around*". Her instructor promptly replied, "*Oh we don't cover all this in our classes with first-time moms. It would scare them too much.*" These examples of women's experiences are taken (with permission) from the *Birth Trauma Canada* website, but are just as applicable to the experiences of some women in the UK: "*I change my baby's diapers and then I change my own. I'm 23 years old."* *"My vaginal delivery was a surgical birth… My crotch looked like a horrible industrial accident."* *"When [my sister] needs to have a bowel movement now she has to insert her finger into her vagina to hold her rectum in place. She had to have another operation when her son was three years old so she can control when she urinates. Her husband left her for another woman when her son was a year and a half."* *"I looked at my genitals in a mirror when I got home from the hospital and immediately felt sick and faint. It did explain why ibuprofen and ice packs weren't doing anything for the pain. My prenatal course didn't prepare me for how much destruction happens."* *"I rarely leave my home anymore. Incontinence supplies cost about $20 every week. If I live to be 90, that will cost me $57,200."* *"I wanted a vaginal delivery to avoid surgery. That was a load of crap."*

Stakeholder	Statement No	Comments Please insert each new comment in a new row.
		"My genitals are grotesque. The labia are huge and floppy and parts of them fused together where they shouldn't… I have little flaps of flesh sticking out where the lacerations that weren't sutured healed asymmetrically. There are scar tissue ridges and the opening to my vagina gapes. I'm so ashamed of how hideous I look. Sex is always with the lights out now. Now I understand why women say 'not tonight dear, I have a headache'. The doctor just shrugged and called it 'normal sequelae' and pointed out that if I was that vain I could get cosmetic surgery. More surgery is the last thing I could deal with." *"This will be the third vaginal/anal surgery I've had since having my baby five years ago."* *"I was ripped apart stem to stern, shredded to pulp. Like hamburger… When I went for the 6-week postpartum check-up, [my doctor says] he wouldn't recommend doing anything to correct the maiming for six months. 'That is the time it takes to really finish the healing process from a vaginal birth', he says. 'Why wasn't I told that before you scarred me for life?' 'Oh', he says, 'then women wouldn't get pregnant, would they, if they knew?'"* *"**So many people know the truth but no one told me what to expect.**"*
Elective caesarean	General	Re: "*5 Treating and caring for people in a safe environment and protecting them from avoidable harm Overarching indicators* *5a (previously 5c) Deaths attributable to problems in healthcare* *5b Severe harm attributable to problems in healthcare*" In addition to pelvic floor risks (mentioned above but also referred to again below in relation to normal birth), there are other risks associated with current maternity healthcare that can cause death and severe harm – namely, the incessant drive to increase 'normal birth' and decreased caesarean rates. In August 2012, RCOG (in collaboration with the NCT and RCM) published advice for CCGs that included: A "clear *action plan*" to reduce caesarean rates to 20% and increase "*normal*" birth rates… *This "includes delivery by forceps and ventouse*" and delivery "*without epidurals*"… Midwifery-led birth units should be the "*default option*" for pregnant women… *Normal birt*h includes: "*antenatal, delivery or postnatal complications (including for example postpartum haemorrhage, perineal tear, repair of perineal trauma, admission to SCBU or NICU)*".(8) Eight organisations voiced their opposition to the publication (comments relevant to this Quality Standard and the CG190 it accompanies are cited below), but to no avail.(9)

Stakeholder	Statement No	Comments Please insert each new comment in a new row.
		Mr Charles Cox, Consultant obstetrician and Fellow Director of Baby Lifeline Training "*There is no mention of perineal trauma as a complication of vaginal birth. In our local audit, the rate of third and fourth degree tears is 3-4%, and the highest rate is among VBACs. In most areas of medicine, if you have a complication rate above 1% it is usual practice to consent the patient accordingly. No mention is made of need for revision of tears, bladder and bowel complication in the short, medium or long term. There is also no mention of long-term risk of prolapse.*" **Professor Philip Steer, Editor-in-chief of the British Journal of Obstetrics and Gynaecology** "*To try and achieve increased rates of uncomplicated births by reducing the availability of labour induction, epidural anaesthesia and caesarean section for informed women who request them, reduces choice without any guarantee of an improved outcome (and is likely to increase medicolegal costs substantially).*" **Deborah Morgan, Specialist Perinatal Psychotherapist, Perinatal Illness-UK** "*The physical and mental health of women and the lives of babies are now being compartmentalised to 'fit' a system which is not really in their interests, and instead, is all about saving money – bottom line. Under the guise of 'choice', women are being covertly pushed into accepting a (supposedly) cheap option. We are shocked at the RCOG for suggesting and supporting such a document. The safety and health of mothers and babies is paramount. If this document is implemented, the rate of perinatal mental health issues and litigation for trauma will no doubt increase.*" **WBenson Harer MD, Former president of the American College of Obstetricians and Gynecologists** "*The only meaningful data for either costs or outcomes must come from comparing the two different intentions to treat. One, let the pregnancy take its course hoping for a good birth or two, elective prophylactic cesarean delivery at 39 weeks.*" In the worst cases of a maternity care environment that fails to protect women and their babies from harm, Dr Bill Kirkup, Investigation Chairman outlined the consequences in March 2015: "*I've set out in the report the failures of care that resulted from poor clinical competence, fractured relationships between professional groups, and* ***the unacceptable pursuit of normal childbirth – itself a worthwhile aim – but not when it occurs at any cost****, as was described to the panel.*"
Elective caesarean	General	"*Healthcare professionals adapt and use NICE's intrapartum care: choosing place of birth resource for midwives tool as an aid to provide women at low risk of complications with local information about birth outcomes, rates of transfer to an obstetric unit for all birth settings, and support women to make*

Stakeholder	Statement No	Comments Please insert each new comment in a new row.
		informed decisions about where to have their baby." Some of the wording in this resource tool illustrates some of the emphasis problems outlined above. For example, under the general heading '*Planning where to give birth*' it says: "***Most women give birth in their chosen place***, ***but some*** *(particularly those having their first baby) are transferred to an obstetric unit if there are concerns about them or their baby, or if they decide they would like an epidural.*" Yet the chosen place of birth for the majority of women (around 92%) ***is*** an obstetric unit. Also, this statement on home birth: "*Home is a familiar environment where a woman can receive* ***all required standard care*** *during labour and after the birth.*" This emphasis is on how ***positive*** a home birth experience can be, and the information is provided in a very positive light, especially in the comparison tables beneath. In fact a planned caesarean birth at 39+ weeks' gestation is now comparatively very safe - hence the NICE CG32 recommendations – but my organisation is yet to see a resource for midwives in which planned surgery is presented in the same way home birth appears here.
Elective caesarean	general	Re: "*WHO definition of normal labour:* *"After birth woman and baby are in good condition*"" The question here must be, does the WHO include short- and long-term physical and psychological morbidity (e.g. pelvic floor damage and resultant mental health birth trauma requiring counselling) as part of its measure of "*good condition*"? This is important because: • "*Over 30% of women who deliver vaginally suffer trauma that is associated with future morbidity such as female pelvic organ prolapse, sexual dysfunction and anal incontinence…*"(10) • The "*reported rate of severe perineal tears in England tripled between 2000 and 2012 from 1.8% to 5.9%*"(11) [and over the same period, the forceps rate rose from 3.8% to 7%] • "*Pelvic floor and anal sphincter trauma should be key performance indicators of maternity services*".(12)

Stakeholder	Statement No	Comments Please insert each new comment in a new row.
Elective caesarean	general	Re: "*4.5.1 Summary of suggestions* ***Prevention of Obstetric Anal Sphincter Injuries*** *(OASIS)* *Stakeholders suggest the use of episiotomy to prevent obstetric anal sphincter injuries (OASIS). Sustaining tears have long term implications for repair and long term incontinence.*" The "*Intrapartum interventions to reduce perineal trauma [cited] in NICE CG190 Recommendation 1.13.20*", referred to here, describe how an episiotomy is best performed, but there is no mention of the protective benefits of a planned caesarean. This is because 'place of birth' and not 'mode of birth' is the focus, and of course the belief by many maternity care professionals that caesarean birth isn't simply an alternative to planned vaginal birth that should be held up for equal comparison. The study cited here (McPherson, Karl C., et al. "Can the risk of obstetric anal sphincter injuries (OASIs) be predicted using a risk-scoring system?." *BMC research notes* 7.1 (2014): 471.) found OASIs **occurred in 3.9%** of vaginal deliveries, and the Briefing Paper says, "*Obstetric Anal Sphincter Injuries (OASIs) are an important complication of vaginal delivery and* ***occurrence is rising***." And yet the latest June 2015 RCOG Green-top Guideline No. 29 (The Management of Third- and Fourth-Degree Perineal Tears) has no mention of elective caesarean as preventative for first-time mothers; it is referred to as a discussion point only for women who have already been damaged during a previous birth... Here is another example of one woman's experience *(reproduced here with permission)*: "*nobody ever tells you about this stuff. I had an episiotomy and then tore all the way through to my rectum. Took them just about as long to sew me up as it took to push out my son. My opening is very large too… My doctor will actually be repairing it after this one hopefully, and stitching it smaller… I keep reminding myself of how lucky I am to have my son and another one on the way, but it's still hard…*" And Gillian Smith (RCM director, Scotland)'s words again: "[*Maternal request caesarean*] *is a major abdominal operation and* ***it would be wrong if it's being given to women who regard it as a default option to avoid a painful labour***." Is it really so wrong for women to choose a mode of birth that will mean they avoid this risk altogether?

Stakeholder	Statement No	Comments Please insert each new comment in a new row.
		Doctors who choose a caesarean birth for themselves don't think so, and the NICE guidance doesn't say this, yet some midwives still clearly disagree. Can we really trust that women are receiving unbiased information in order to help them make a "*fully informed decision*" as this Quality Standard sets out?
Elective caesarean	General	Re: "*A NICE pathway brings together all NICE guidance, quality standards and materials to support implementation on a specific topic area. The pathways are interactive and designed to be used online. This pdf version gives you a single pathway diagram and uses numbering to link the boxes in the diagram to the associated recommendations.* http://pathways.nice.org.uk/pathways/antenatal-care *June 22, 2015*" In this pathway, there is no mention of maternal request caesarean at all – and that's despite the fact that more than double the percentage of women would choose surgery than choose a home birth. Again, there is a section on "*planning place of birth*" but not planning ***type*** of birth. Even CG32 does not appear to be included in the Pathway, even though overall almost a quarter of women who receive antenatal care will have a caesarean birth. One of my organisation's main concerns as a Stakeholder during the development of CG190 was the focus on planned place versus planned mode of delivery and with many of my comments, NICE's response was '*this is covered in CG32*'. That is, caesarean delivery is 'separate' and 'distinct' from 'normal' antenatal care. How can we ensure satisfaction and respect for women who request a caesarean when their antenatal care doesn't even appear on the NICE Pathway? And when they make their request, they are considered to have a 'mental health problem' – except the NICE Quality Standard on Antenatal and Postnatal Mental Health does not (currently) include maternal request or tokophobia either. This apparently inconsistent and fragmented approach to delivering guidance and standards in antenatal and postnatal care does not help communicate NICE recommendations in the most effective way, and my organisation hopes that this will be remedied as new NICE guidance is produced.
Elective caesarean	General	**References**:

Stakeholder	Statement No	Comments Please insert each new comment in a new row.
		1. July 5, 2015 Top midwife calls for curb on caesareans. Sunday Times. Mark Macaskill http://www.thesundaytimes.co.uk/sto/news/uk_news/scotland/article1577381.ece 2. Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (Scotland) 2015 UKSC 11 3. December 3, 2014 New UK homebirth guidelines: midwives win, babies lose. The Skeptical OB http://www.skepticalob.com/2014/12/new-uk-homebirth-guidelines-midwives-win-babies-lose.html • 4. April 30, 2012 Re: Cost effectiveness of alternative planned places of birth in woman at low risk of complications: evidence from the Birthplace in England national prospective cohort study http://www.bmj.com/content/344/bmj.e2292/rr/581969 5. November 25, 2011 Re: Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study http://www.bmj.com/rapid-response/2011/11/25/re-perinatal-and-maternal-outcomes-planned-place-birth-healthy-women-low-0 6. Stephen Robson et al. Elective caesarean delivery at maternal request: a preliminary study of motivations influencing women's decision-making. 2008 Aust NZJ Obstet Gynaecol 7. Dignity in Childbirth. The dignity survey 2013: Women's and midwives' experiences of UK maternity care .Birthrights Dignity in Childbirth Forum, 16 October 2013. 8. Weston N. Making sense of commissioning maternity services in England - some issues for Clinical Commissioning Groups to consider. 2012 RCOG 9. electivecesarean.com New RCOG guidance urges CCGs to increase births without epidurals and reduce caesarean rates to 20% August 24, 2012 http://www.electivecesarean.com/images//12-aug-24%20rcog%20ccg%20press%20release%20final.pdf 10. Skinner EM, Dietz HP. Psychological and somatic sequelae of traumatic vaginal delivery: A literature review. 2014 ANZJOG

Stakeholder	Statement No	Comments Please insert each new comment in a new row.
		11. Edozien et al. Impact of third- and fourth-degree perineal tears at first birth on subsequent pregnancy outcomes: a cohort study. BJOG 2014 12. Dietz, Pardy J, Murray H Pelvic floor and anal sphincter trauma should be key performance indicators of maternity services. 2015 Int Urogynecol J
National Childbirth Trust	General	We feel it is important to include some measure of respectful and compassionate care for women and their babies in this Quality Standard as these are key parts of the patient experience. We appreciate these can be difficult to measure, and that there are generic guidelines in place, however the importance of the developing mother-baby relationship and formation of a new family merit a specific Quality Statement.
The Royal College of Anaesthetists	General	Most obstetric anaesthetic departments keep detailed data in electronic form, therefore data collection should not be too onerous for them.
The Royal College of Anaesthetists	General	Our respondents have offered the following comments: - Information about all aspects of obstetric anaesthesia services offered in hospital should be provided to help mothers make informed choices. This should include patient information leaflets produced by the Royal College of Anaesthetists and the Obstetric Anaesthetists Association. - NICE should consider the importance of the Royal Colleges' role in underpinning training and ensuring competencies across the various specialties (midwifery, anaesthesia, obstetrics etc.). - Most Medical Royal Colleges run accreditation schemes (Anaesthesia Clinical Services Accreditation – ACSA is the scheme run by the Royal College of Anaesthetists). The CQC uses accreditation standards to inform its inspections processes and NICE should encourage hospital departments to engage with relevant accreditation schemes to ensure obstetric units provide a high standard of care.
The Royal College of Anaesthetists	General	*Improvement areas: 'Improving responsiveness to in-patients' personal needs' and 'Improving women and their families' experience of maternity service*s' This needs to include not just the needs of the woman and her family during labour and birth, but also afterwards. Consideration needs to be given to facilities for a partner/friend/family member to allow them to stay with the woman after giving birth to support her and to allow for family time. (Lay comment)
Association for Improvements in the Maternity Services (AIMS)	General	"Ensuring that care is safe and that people have a positive experience of care is vital in a high-quality service."

Stakeholder	Statement No	Comments Please insert each new comment in a new row.
		"They specify that people receiving care should be treated with dignity, have opportunities to discuss their preferences, and are supported to understand their options and make fully informed decisions." We strongly agree with these statements.
Association for Improvements in the Maternity Services (AIMS)	General	Several statements include the importance of the woman's experience, which we are delighted to see. We would appreciate clarity on how this is to be evaluated.
Association for Improvements in the Maternity Services (AIMS)	General	Does this draft quality standard accurately reflect key areas for quality improvement? Postnatal depression and post traumatic stress are poorly measured and the quality of support for women with these conditions is patchy and unacceptable. Evaluating the levels of these conditions is difficult as so many women are reluctant to reveal that they have this problem because, justifiably, they fear that they will be reported to social services and their baby removed. We have many cases in our records where this has occurred.
Association for Improvements in the Maternity Services (AIMS)	General	For each quality statement what do you think could be done to support improvement and help overcome barriers? The research shows that where women receive individualised community based care from community midwives so many of these recommendations could be achieved were every Trust required to establish and support such a service.
Saint Marys Hospital Manchester	General	What proportion of women would we need to collect data on to confirm compliance?
Saint Marys Hospital Manchester	General	A lot of this data will be difficult to collect with our current systems, and would require specific audits and will have resource implications.
Saint Marys Hospital Manchester	General	What proportion will be set as an acceptable standard?
Department of Health		
Ferring Pharmaceuticals Ltd		
Royal College of Nursing		
The Royal College of Midwives	1	We consider that there should be more emphasis on information giving in this statement i.e. "Women at low risk of complications are given an ***informed*** choice of all 4 birth settings". Members report that informed choice including the evidence about risks and benefits as well as alternatives is still poorly evidenced in documentation audits and that they repeatedly hear women's concerns about the lack of good information.
Elective caesarean	1	"*Quality statement 1: Choosing birth setting*

Stakeholder	Statement No	Comments Please insert each new comment in a new row.
		Process *Proportion of women with a recorded discussion of; choice of birth setting, information about local birth outcomes and the likelihood of transfer.* - *Does this draft quality standard accurately reflect key areas for quality improvement?*" No, as per all comments above. My organisation maintains that the emphasis on information about birth setting, without including information about birth mode, is misleading for many women, particularly those with no prior knowledge of the NHS and/or different birth risks and benefits.
Royal College of Paediatrics and Child Health	1	The data will have to come from the booking proforma. Key to data accuracy will be an common understanding of what exactly constitutes a low risk pregnancy, or the question is meaningless. For instance, is 'being a primigravida' a reason for not recommending a home delivery? I suggest that 'low risk' should mean women with a singleton pregnancy between 18 and 40 years old at booking with a BMI below 30 kg/m^2, and without other identified obstetric or medical risk factors.
Royal College of Paediatrics and Child Health	1	'Neonatal morbidity and mortality' also needs careful definition. Is this to be measured by place of booking or place of delivery, and how are care pathways for transfer to be accounted (bearing in mind that risk status may change during pregnancy)? Which morbidities are to be counted? What is the minimum significant denominator? I suggest 1000 deliveries but others might argue for 2000. Maternal mortality is so very rare (1 in 10,000) that it is not a useful outcome measure. Which maternal morbidities are considered to be relevant outcomes? This needs to be thought through. The same issues pertain to other quality standards: 'maternal/neonatal morbidity and mortality' are easy to say, but much more difficult to define in a way that allows comparison between different services.
Royal College of Obstetricians & Gynaecologists	1	Question 1: Does this draft quality standard accurately reflect key areas for quality improvement? Yes – it is important that women are given choice
Royal College of Obstetricians & Gynaecologists	1	Question 2: If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures? Yes – it should be possible to collect the data
Royal College of Obstetricians & Gynaecologists	1	Question 3: For each quality statement what do you think could be done to support improvement and help overcome barriers? Resources would be required to support women's choices (eg if there was an increased uptake of home births)
Royal College of Obstetricians & Gynaecologists	1	Page 9 of 34 – we are not sure that 'Neonatal morbidity and mortality, and Maternal morbidity and mortality' are the correct outcomes for this statement. Shouldn't it be women's satisfaction with the

Stakeholder	Statement No	Comments Please insert each new comment in a new row.
		information and support they received about place of birth?
Royal College of Obstetricians & Gynaecologists	1	Small Trusts/health boards, and some larger ones, may not be in a position to offer all 4 options. This could be for reasons of geography, or scale, small numbers delivering. It would therefore be worth adding to the quality statement a 'relevant to local area'
The Royal College of Midwives	1	A CQUIN could be designed to improve this. A useful intervention has been the routine use of the Decision Tree to facilitate discussions between the midwife and woman on at least 2 points in the pregnancy. It is important that alongside this, there are efforts to ensure easy ways of women understanding their choices in order to enable disadvantaged and marginalised women to have equal access to all choices. In one locality, MSLC members have designed a poster visually representing birth choices which have been rolled out to all acute and community settings where pregnant women may be. This could also be accessed through the trust, CCG and local authority web-sites. This needs to be regularly tested. One MSLC successfully used a face-book questionnaire to support this.
Obstetric Anaesthetists Association	1	Women at low risk of complications must also be informed of the different analgesia options available at each of the 4 birth settings. Their choice of analgesia should be included in the recorded discussion described under Process. The rate of transfer to an obstetric unit for epidural analgesia from other birth settings should be recorded and this information should be available, together with information about delays in receiving epidural analgesia associated with transfer. Reference: Royal College of Anaesthetists Guidelines for the provision of anaesthetic services, Chapter 9 Obstetric Anaesthesia services 2015. http://www.rcoa.ac.uk/document-store/guidance-the-provision-of-obstetric-anaesthesia-services-2015 A recent Cochrane review has found that there is no benefit from a delay in the initiation of epidural analgesia. It is therefore imperative women who request epidural analgesia are able to receive this in a timely fashion. This is an important part of Women's experience of maternity services, Domain 4, Overarching indicator 4.5 Reference: Cochrane Database Syst Rev. 2014 Oct 9;10:CD007238. doi: 10.1002/14651858.CD007238.pub2. http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007238.pub2/epdf
British Maternal & Fetal Medicine	1	Should the outcomes also examine transfer rates according to parity?

Stakeholder	Statement No	Comments Please insert each new comment in a new row.
Society		
Newcastle upon Tyne NHS Foundation Trust	1	Provision of accurate local information is the most important quality indicator for low risk women. Unsure how documentation of further discussion is a good quality indicator in this group (in contrast to women with risk factors, when timely documentation of place of birth preferences and documentation of discussion if maternal preference is against local / national recommendations would be a reasonable quality indicator)
National Childbirth Trust	1	*Women at low risk of complications are given the choice of all 4 birth settings (at home, freestanding midwifery unit, alongside midwifery unit and obstetric unit), information about local birth outcomes and the likelihood of transfer.* We welcome this statement, and would like to see it expanded to include information about the transfer process. For example "…information about local birth outcomes, the likelihood of transfer and details of the transfer process." We feel this will lead to greater dialogue between women, midwives and, ultimately, commissioners about the factors which are important to women when they are choosing their place of birth such as average time taken for transfer, who will accompany the labouring woman in the ambulance and how birth partners are expected/ supported to transfer.
The Royal College of Anaesthetists	1	In discussions about choosing birth settings, information should be made available about anaesthetic services to aid informed decision making by patients.
The Royal College of General Practitioners	1	Place of birth seems more relevant to antenatal care and perhaps should not be included in this Intrapartum care quality standard. This QS is perhaps the only one that GPs are likely to need to know about, so they are aware that the choice should be offered.
Saint Marys Hospital Manchester	1	What will happen in some geographical areas where all 4 birth setting options are not available? Eg not having a standalone midwifery led unit. This standard is related to the commissioners willing to fund all 4 birth settings. Is there really a need for a standalone midwifery led unit if you have a co-located midwifery led unit?
Association for Improvements in the Maternity Services (AIMS)	1	We strongly support the statement that women who are at low risk of complications should be offered care in all four settings. We strongly feel that this must not be limited to women with low risk of complications. We are concerned that this statement implies that women who are not classed as low risk will have their place of birth options limited. All women have the legal right to birth at home and they should be

Stakeholder	Statement No	Comments Please insert each new comment in a new row.
		supported in this choice. Women who choose to birth in a midwife led unit (alongside or freestanding but who are not classed as low risk should be treated as individuals and not barred from access to the unit solely on the basis of not being "low risk". This is because many women classed as "high risk" have health considerations which are not relevant to their place of birth, and yet they can find themselves being automatically barred from midwife led units **or home births. Failure to support them in these choices results, as our records show, in some women feeling forced into birthing at home without a midwife.**.
Association for Improvements in the Maternity Services (AIMS)	1	Page 8 – Please note typographical error at the top of the page – we are not interested in a woman's morality!
Association for Improvements in the Maternity Services (AIMS)	1	"To help women make an informed choice, they are given information by their midwife about birth outcomes (such as the chance of having a 'normal' [vaginal] birth and the risk of serious medical problems for the baby)" We are concerned that this could be interpreted to focus on the very low increased statistical risk to the baby of a first time mother if she chooses to plan to birth at home, rather than the similarity in outcomes for the baby for second and subsequent births, and between birth planned at MLUs, home births and OB units. We feel that it would be worth mentioning the very many other statistical benefits to the mother of planning a birth outside of an obstetric unit.
Elective caesarean	2	Re: "*Quality statement 2: One-to-one care* *Women in all birth settings in established labour have one-to-one care and support from an assigned midwife.*" My organisation agrees with this statement in so far as women who have chosen a vaginal delivery should have one-to-one care. Consultant led care tends to be available mainly in private hospital settings, but as long as midwives request the presence of a doctor when a low risk labour shows signs of developing into a high risk situation, this is absolutely a valuable statement. The consistent presence of a one-to-one midwife can be very reassuring for women, though changes with working shift patterns are inevitable if the labour is long. One thing my organisation would like to emphasise here is that where a woman has requested a planned caesarean and goes into labour early, her agreed birth plan should still be respected and honoured, as I am aware of cases where women were forced to continue in labour when there was more than sufficient time to allow the planned caesarean birth. In cases like these, the lasting impact of mental health trauma can be lengthy and also costly, and that's before any physical morbidity associated with

Stakeholder	Statement No	Comments Please insert each new comment in a new row.
		the vaginal birth.
Royal College of Paediatrics and Child Health	2	One to one care is being measured at a system not an individual level. But surely the true measure is the woman's experience, not the hospital's staffing records?
Royal College of Obstetricians & Gynaecologists	2	Question 1: Does this draft quality standard accurately reflect key areas for quality improvement? *Yes – one-to-one care and support and labour is a key area for quality improvement* Question 2: If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures? *It should be possible to collect the data. Page 11 of 34 'Process' says the numerator is 'the number of midwifery staff available in the same time period'. Should this be 'The number of midwifery staff available to provide care to women in labour in the same time period' (since not all midwives on a particular shift will be assigned to provide care to women in labour')?* Question 3: For each quality statement what do you think could be done to support improvement and help overcome barriers? *I am led to believe from my midwifery colleagues that more midwives would be required*
Royal College of Obstetricians & Gynaecologists	2	Women in all birth settings in established labour <u>has</u> one-to-one care and support from an assigned midwife. Should read: Women in all birth settings in established labour <u>have</u> one-to-one care and support from an assigned midwife.
The Royal College of Midwives	2	1:1 care should be given wherever the woman is in labour even if labour ward is full, and wherever possible continuity should be provided (outwith shift changes). This has a staffing consideration for the majority of units. It would be helpful to have an additional statement addressing the needs of women having a protracted latent phase. They can be traumatised by lack of support.
British Maternal & Fetal Medicine Society	2	Whilst we of course support this statement, in reality in mnay units this is difficult to achieve. Should an additional outcome measure be maternal satisfaction with support in labour.co
National Childbirth Trust	2	*Women in all birth settings in established labour has one-to-one care and support from an assigned midwife.* We would like to see statistics such as these published in an accessible format and location on trust websites in order for women to be able to find the information they need in order to make an informed choice. We appreciate that some information is available through the BirthChoiceUK website, but this is not compulsory for trusts.

Stakeholder	Statement No	Comments Please insert each new comment in a new row.
The Royal College of Anaesthetists	2	*'Women in all birth settings in established labour have one-to-one care and support from an assigned midwife'* Our clinical respondents find this statement to be too ambitious and with the current economic climate and shortage of midwives, this is unlikely to be implemented in practice.
Association for Improvements in the Maternity Services (AIMS)	2	"One-to-one care for a woman in labour from a midwife who is assigned to 1 woman at a time and is solely dedicated to her care will increase the likelihood of the woman having a 'normal' birth, and is also likely to reduce operative deliveries and length of labour." We are very pleased to see this statement, but would prefer a statement that says: Women in all birth settings should have one-to-one care and support from a midwife who supports her during pregnancy labour and post-natally. We are concerned that this will have the same effect as the guideline for a "named" midwife, where one named midwife was allocated to a woman, and then the care was provided by a range of midwives.
Royal College of Paediatrics and Child Health	3	The suggested outcome measures are completely unjustified by the guidance CG190. Maternal/neonatal morbidity and mortality are essentially unaffected by electronic fetal monitoring.
Royal College of Paediatrics and Child Health	3	If no CTG, the alternatives for monitoring should be listed
Royal College of Obstetricians & Gynaecologists	3	Statement 3: In the NICE guidance the evidence states there is no difference in outcome between intermittent auscultation and CTG, but it is the opinion of the authors that intermittent auscultation is to be preferred. Can you have a quality standard for an opinion. (Also applies to page 17)
Royal College of Obstetricians & Gynaecologists	3	Question 1: Does this draft quality standard accurately reflect key areas for quality improvement? We do not feel that this is a key area for improvement. Furthermore, I would be more comfortable if this quality standard read 'women are not offered' cardiotocography' or 'women are encouraged not to have cardiotocography as part of the initial assessment'. It is our role to provide information and allow women to make choices about their intrapartum care.
Association for Improvements in the Maternity Services (AIMS)	3	We support the statement that low risk women are not to be automatically given a CTG as part of their initial monitoring.
Royal College of Paediatrics and Child Health	4	Maternal experience is the only outcome that matters – see above.
Royal College of Obstetricians & Gynaecologists	4	In the NICE guidance there is no evidence for the use of 20 minutes of CTG. Most people would consider 40 minutes to be the minimum (also applies to page 20)
Royal College of Obstetricians &	4	Typo in fetoscope

Stakeholder	**Statement No**	**Comments** Please insert each new comment in a new row.
Gynaecologists		
British Maternal & Fetal Medicine Society	4	With regard to the use of IA – can variability be examined by IA as stated? Should IA not be paying attention to the presence or absence of decelerations?
Association for Improvements in the Maternity Services (AIMS)	4	We support this statement. We would prefer the wording to read, "Women at low risk of complications who ARE OFFERED cardiotocography" to make it clear that it is always the woman's decision whether or not to accept an intervention which is offered to her. We are concerned that women who are not classed as "low risk" may automatically put onto the CTG, despite their specific risk factors not making this relevant, and thereby unnecessarily increasing their risk of false positive results from the CTG We would like the statement to specify that women who are not classed as "low risk" are considered as individuals when deciding whether it is appropriate to offer CTG to the woman.
Royal College of Paediatrics and Child Health	5	Better to suggest recording the exact time (in seconds) between delivery and cord clamping because some babies will benefit from longer times than 1 minute and the minimum could get re-interpreted as being the maximum time. The standard could be something like '80% of babies have at least 1 minute delay before cord clamping'. Will this include mothers who end up with operative deliveries as well? It should.
Royal College of Paediatrics and Child Health	5	The outcome "Neonatal haemoglobin concentrations and neonatal anaemia" is crazy and should be abandoned. Babies should not have to have their Hb measured merely to satisfy the quality standard, as is implied. Hardly any babies need to have a blood count and to increase the number would be a real harm to babies and unnecessary work for midwives and doctors. We know the benefits of delayed cord clamping from research; we don't need to replicate this on every baby.
Royal College of Paediatrics and Child Health	5	Integrity is a strange word to use. Meconium stained liquor should be added as an exception.
Royal College of Obstetricians & Gynaecologists	5	Statement 5: does not mention Meconium
Royal College of Obstetricians & Gynaecologists	5	We think this statement is out of order and might be better placed after statement 6
Royal College of Obstetricians & Gynaecologists	5	Question 1: Does this draft quality standard accurately reflect key areas for quality improvement? *Yes – this represents a key area for quality improvement* Question 2: If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures? *Yes – it should be possible to collect the data*

Stakeholder	Statement No	Comments Please insert each new comment in a new row.
		Question 3: For each quality statement what do you think could be done to support improvement and help overcome barriers? *Better education of healthcare professionals of the benefits of delayed cord clamping* *We would suggest that in addition to 'concern about cord integrity or the baby's heartbeat below 60 beats per minute and not getting faster', the cord should be clamped and cut if there are concerns about maternal wellbeing (eg postpartum haemorrhage or maternal collapse)*
Royal College of Obstetricians & Gynaecologists	5	Process sentence – syntax error. Suggest ' proportion of cords……..where there was neither concern about cord integrity nor was the baby's heartbeat less than 60'
National Childbirth Trust	5	*Women do not have the cord clamped earlier than 1 minute after the birth unless there is concern about cord integrity or the baby's heartbeat is below 60 beats per minute and is not getting faster.* We would amend this to read: "The placental cord is not clamped for at least 1 minute after the birth, and in accordance with the mother's wishes, unless….". We appreciate that the 'at least' wording features in the rationale for this quality statement but this could easily be missed by busy staff.
Saint Marys Hospital Manchester	5	There are other scenarios where the cord should be clamped promptly eg if the mother is bleeding significantly.
Association for Improvements in the Maternity Services (AIMS)	5	We strongly support this statement but would like to see cord cutting at later than 1 minute as we are not aware of good quality evidence to support earlier intervention. The woman's request for a longer delay or no cutting at all should be included in this statement. In the case of the baby's heartbeat being persistently below 60 beats per minute, we would like to see methods by which the baby can be resuscitated while still being attached to their placenta, in order that the baby continues to receive oxygen via that source**.**
Newcastle upon Tyne NHS Foundation Trust	6	The standard should discuss prescription of oxytocin rather than documentation of offering oxytocin as the latter evidence will be only be able to be collected by review of partogram narrative .
Newcastle upon Tyne NHS Foundation Trust	6	It will be difficult to collect denominator data that is sensitive to other reasons for amniotomy (e.g. low risk woman who develops abnormal FH on auscultation, confirmed on CTG). Oxytocin prescription is a more sensitive indicator as the only indication for use is delayed progress.
Association for Improvements in the Maternity Services (AIMS)	6	We would suggest that this statement is amended as follows: Women at low risk of complications are not offered amniotomy or oxytocin if labour is progressing normally, even if the progress is slower than the standard. Note: we are concerned that many women report to us that their labour was induced or accelerated

Stakeholder	Statement No	Comments Please insert each new comment in a new row.
		because it was 'too slow' despite the fact that neither the woman nor the baby showed any indication of problems.
British Maternal & Fetal Medicine Society	7	In the paragraph titled 'rationale' – all units have 24/4 'consultant cover' – this needs to be more specific to define direct consultant supervision or consultant presence on the labour ward. Multiple concerns have been expressed about these outcomes as there is conflicting evidence as to what increased consultant presence may achieve – ie may increase CS rates, may not increase normal vaginal deliveries, may not reduce operative vaginal deliveries. Therefore we have concerns about using such outcome indicators – hopefully they should decrease the number of unexpected admission to NICU, decrease the numbers of apgars <7, decrease sequential instrumentals use etc
Royal College of Obstetricians & Gynaecologists	7	(Placeholder) Consultant obstetric supervision and involvement during labour and birth for women at high risk of obstetric complications has been identified as a priority by the Royal College of Obstetricians and Gynaecologists (Labour Ward Solutions – Good Practice No. 10. RCOG January 2010)
Royal College of Obstetricians & Gynaecologists	7	It would be helpful is this section was clearer about what 'obstetric supervision' means. We assume it is 'obstetric led' rather than suggesting that a consultant needs to be specifically present at all 'high risk' deliveries (which are also undefined).
Royal College of Obstetricians & Gynaecologists	7	Safer Childbirth report is jointly by RCOG,RCM, RCOA, RCPCH. Hence incorrect to attribute
Royal College of Obstetricians & Gynaecologists	7	The phrase "events involving fetal compromise are more likely to happen outside the hours when units have consultant obstetric cover" might be interpreted as 'fetal compromise is more likely to happen when units have consultant cover'. Suggest stating explicitly as in ' fetal compromise more likely to happen outside the hours of consultant obstetric cover'. Delete 'when units have'.
The Royal College of Midwives	7	This should be written in the same way as the other standards ie women at high risk of complications should have ….. Also should this would be clearer if it specified medical or obstetric complications (as opposed to social complications) A definition of grade/experience and level of involvement would be also helpful
National Childbirth Trust	7	*Consultant obstetric supervision and involvement during labour and birth for women at high risk of complications.* We welcome the inclusion of this statement. NCT has had some feedback from maternity services user reps that not all trusts are achieving 24/7 obstetric consultant cover despite this being cited as an important justification for the reconfiguration of maternity services, ie concentration of obstetric services

Stakeholder	Statement No	Comments Please insert each new comment in a new row.
		and creation of freestanding MLUs. We would like to see statistics such as these published in an accessible format and location on trust websites, along with data on one-to-one midwifery care in labour.
The Royal College of Anaesthetists	7	*'Consultant obstetric supervision and involvement during labour and birth for women at high risk of complications'* A high risk woman in labour is highly likely to receive some aspect of care by an anaesthetist. To this effect an anaesthetist is an integral and essential part of the labour ward team and must be involved at an early stage following admission to hospital. This should be in addition to consultant obstetrician involvement.
Association for Improvements in the Maternity Services (AIMS)	7	We support this statement other than this, "Consultant obstetric supervision and consultant obstetric-led care is needed to increase rates of 'normal' (vaginal) births, reduce operative deliveries". We are not aware of evidence that this is the case. We would also prefer that the statement is written as, "Consultant obstetric supervision and involvement IS OFFERED during labour and birth for women at high risk of complications" to ensure that it is clear that is the woman's choice to accept or decline the offer of all services, including an obstetrician.
Royal College of Obstetricians & Gynaecologists	8	(Placeholder) Handover of care information when women at high risk of complications are transferred from birth settings to an obstetric unit during labour is crucially important. This has been highlighted by the Royal College of Obstetricians and Gynaecologists (Standards for Maternity Care – standards database. RCOG June 2008)
Royal College of Obstetricians & Gynaecologists	8	Clear communication and efficient handover of care information between healthcare professionals is needed for women considered to be low risk encounter unforeseen complications during labour and are consequently considered to be at a high risk of complications, are transferred to an obstetric-led unit (from home, a freestanding midwifery units or an alongside midwifery unit). Change to: Clear communication and efficient handover of care information between healthcare professionals is needed for women considered to be low risk who encounter unforeseen complications during labour and are consequently considered to be at a high risk of complications and are transferred to an obstetric-led unit (from home, a freestanding midwifery units or an alongside midwifery unit).
The Royal College of Midwives	8	The sentiment appears to be good but this is strangely worded. Isn't an obstetric unit a birth setting and transfer isn't just in labour? We suggest something like "When women are transferred from one

Stakeholder	Statement No	Comments Please insert each new comment in a new row.
		birth setting to another at any point during pregnancy, birth or the postnatal period there should be a process in place for the handover of information about their care from one maternity professional to another."
British Maternal & Fetal Medicine Society	8	It has been queried whether the standard should stress more at all points of labour handover should be improved "Handover of care information should be undertaken at all points of transfer between staff during labour using the SBAR tool. This is particularly important when women at high risk of complications are transferred from low risk birth settings to an obstetric unit during labour." An outcome could then be 1. Implementation of SBAR 2.reduction in communication errors in clinical incident reports
National Childbirth Trust	8	*Handover of care information when women at high risk of complications are transferred from birth settings to an obstetric unit during labour.* We welcome this placeholder statement and look forward to seeing more evidence accumulate as a result of NICE's lead on this issue. It may need clarification, for example to read "transferred from other birth settings to an obstetric unit" or "transferred from out-of-hospital birth settings to an obstetric unit."
Swansea University	9	I should like to see a statement indicating that women who have received high doses and multiple medications in labour being offered extended support to breastfeed, for the 1-2 weeks until the drugs have been cleared from both mother and infant and normal physiology has had time to adjust.
The Royal College of Midwives	9	A missing statement in the context of the Kirkup report is one addressing risk assessment. We would suggest "All women should have their needs assessed at the beginning of pregnancy, throughout the antenatal period and labour and after birth. This assessment should be based on agreed multi professional guidelines and should form the basis of discussions about the best care setting for an individual woman"
Lactation Consultants of Great Britain	9	LCGB questions why uninterrupted skin to skin has not been included as a quality standard in this document. It is known to improve infant respiratory and cardiovascular stability, regulates body temperature, improves bonding, facilitates calming of both mother and baby through the release of oxytocin, and provides the best start for breastfeeding. It has also been shown to decrease the risk of post partum haemorrhage.

Stakeholder	Statement No	Comments Please insert each new comment in a new row.
		(See: Saxton A, Fahy K, Skinner V, Hastie C (2013) Effects of immediate skin to skin contact and breastfeeding after birth on postpartum haemorrage (PPH) rates: A cohort study. *Women and Birth.* 26 (Supplement 1): S16-S17
Royal College of Psychiatrists	9	We were disappointed that there were no quality standards around the management of women with severe mental illness in labour. It is vital that maternity services address both the physical and mental health needs of women in pregnancy, labour and delivery, and the postpartum period. The importance of the management of these women has been emphasised over the last decade by the confidential enquires into maternal deaths. It would be good to see a quality standard in this area, for example around the management of psychiatric emergencies or the availability and continuation of psychotropic medication on labour wards for women with severe mental illness.
Group B Strep Support	9	Group B Strep Support is disappointed that none of the quality standards address the issue of group B Strep carriage during pregnancy. A statement such as “Women should be routinely informed of group B Strep and steps they can take to minimize the risk of infection to their baby” could have significant implications for the burden of avoidable early-onset group B Strep infection.
Group B Strep Support	9	A potential key area for quality improvement would be in ensuring that all midwife led units are equipped to offer women known to carry GBS intravenous antibiotics in labour. This is already happening in a number of alongside MLUs and a QS covering this point would help in consistency, as well as in ensuring low-risk pregnant women who have been found to carry GBS are also offered choice in place of birth.
Saint Marys Hospital Manchester	3 & 7	These are not routinely done – and therefore are quite negative factors to assess.
Royal College of Paediatrics and Child Health	7 & 8	These are placeholders and not statements.
Newcastle upon Tyne NHS Foundation Trust	7 & 8	Both these would seem to sit better in the proposed High Risk Intrapartum Care guideline / QS
Royal College of Paediatrics and Child Health	6, 7 & 8	No comments

Registered stakeholders who submitted comments at consultation

[Please include an alphabetical list of the registered stakeholders who submitted comments at consultation.]

- Association for Improvements in the Maternity Services (AIMS)
- British Maternal & Fetal Medicine Society
- Department of Health
- Elective caesarean
- Ferring Pharmaceuticals Ltd
- Group B Strep Support
- Lactation Consultants of Great Britain
- National Childbirth Trust
- Newcastle upon Tyne NHS Foundation Trust
- NHS England
- Obstetric Anaesthetists Association
- Royal College of Nursing
- Royal College of Obstetricians & Gynaecologists
- Royal College of Paediatrics and Child Health
- Royal College of Psychiatrists
- Saint Marys Hospital Manchester
- Swansea University
- The Royal College of Anaesthetists
- The Royal College of General Practitioners

- The Royal College of Midwives

Appendix 2: Quality standard internal checks table

Comment number	Page number Or **'general'** for comments on the whole document	Statement number Or **'general'** for comments on the whole document	Comments
QS team			
1	20	5	Reword statement to: 'Women do not routinely have the cord clamped earlier than 1 minute'