

Caesarean birth

Quality standard

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This standard is based on NG192.

This standard should be read in conjunction with QS22, QS15, QS37, QS35, QS46, QS60, QS105, QS115, QS135, QS192, QS193, QS109 and QS69.

Quality statements

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

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

Statement 3 Pregnant women or pregnant people who request a caesarean birth because of anxiety about childbirth are offered a referral to a healthcare professional with expertise in perinatal mental health support.

Statement 4 Pregnant women or pregnant people who may require a planned caesarean birth have consultant involvement in decision making.

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

Statement 6 Women or people in labour being considered for an unplanned caesarean birth have a consultant obstetrician involved in the decision.

Statement 7 This statement has been removed. For more details, see [update information](#).

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

Statement 9 Women and people who have had a caesarean birth are monitored for

postoperative complications.

Quality statement 1: Vaginal birth after a caesarean birth

Quality statement

Pregnant women or pregnant people who have had 1 or more previous caesarean births 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 birth and a planned vaginal birth in pregnant women or pregnant people who have had up to 4 previous caesarean births. If a pregnant woman or pregnant person chooses to plan a vaginal birth after they have previously had a caesarean birth, they should be fully supported in their choice.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

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

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

Process

The proportion of pregnant women or pregnant people who have had 1 or more previous

caesarean births who have a documented discussion of the option to plan a vaginal birth.

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

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

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

Outcome

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

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient surveys.

b) Rates of delivery modes for pregnant women or pregnant people who have had previous caesarean births.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. The [NHS Digital Maternity services secondary uses dataset](#) collects data on the percentage of women who have had a vaginal birth following a caesarean birth.

What the quality statement means for different audiences

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

Healthcare professionals ensure that they have a documented discussion with pregnant women or pregnant people who have had 1 or more previous caesarean births 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 or pregnant people who have had 1 or more previous caesarean births to have a documented discussion of the option to plan a vaginal birth.

Pregnant women or pregnant people who have had a caesarean birth 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

Caesarean birth. NICE guideline NG192 (2021, updated 2024), recommendations 1.8.1, 1.8.2 and 1.8.5

Definitions of terms used in this quality statement

Documented discussion

Pregnant women or pregnant people should be informed by members of the maternity team that in women or people who have had 4 or fewer previous caesarean births the risk of fever, bladder injuries and surgical injuries does not vary with planned mode of birth but that the risk of uterine rupture is higher for planned vaginal birth. This discussion should be documented in the pregnant woman or pregnant person's notes. [NICE's guideline on caesarean birth, recommendation 1.8.2]

Equality and diversity considerations

Good communication between healthcare professionals and pregnant women or pregnant people is essential. Treatment and care, and the information given about it, should be culturally appropriate. It should also be accessible to pregnant women or pregnant people with additional needs such as physical, sensory or learning disabilities, and to pregnant women or pregnant people who do not speak or read English. Pregnant women or pregnant people should have access to an interpreter or advocate if needed. For pregnant women or pregnant people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard or the equivalent standards for the devolved nations.

Quality statement 2: Request for a caesarean birth: maternity team involvement

Quality statement

Pregnant women or pregnant people who request a caesarean birth (when there is no medical indication) have a documented discussion with members of the maternity team about the overall benefits and risks of a caesarean birth 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 pregnant woman or pregnant person can talk to the most relevant member of the maternity team depending on what their question or concern is about their request for a caesarean birth. It is important that access to members of the maternity team is possible at any point during the pregnant woman or pregnant person's pregnancy and promptly arranged following a request.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

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

Data source: Data can be collected from information recorded locally by healthcare

professionals and provider organisations, for example from patient records.

Process

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

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

Denominator – the number of pregnant women or pregnant people who request a caesarean birth when there is no medical indication.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

Outcome

Women and people's satisfaction with the process of discussing options with the maternity team.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient surveys.

What the quality statement means for different audiences

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

Healthcare professionals ensure that pregnant women or pregnant people who request a caesarean birth (when there is no medical indication) have a documented discussion with

members of the maternity team about the overall benefits and risks of a caesarean birth compared with vaginal birth.

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

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

Source guidance

Caesarean birth. NICE guideline NG192 (2021, updated 2024), recommendations 1.2.26 and 1.2.27

Definitions of terms used in this quality statement

Documented discussion

The discussion should include the reasons for the request and ensure that the pregnant woman or pregnant person has accurate information (including written information) about the overall benefits and risks associated with different modes of birth, based on the section on planning mode of birth in NICE's guideline on caesarean birth. This discussion should be documented in the pregnant woman or pregnant person's antenatal notes.

[Adapted from NICE's guideline on caesarean birth, recommendations 1.2.26 and 1.2.27]

Maternity team

The maternity team should include a consultant midwife or senior midwife, a consultant or senior obstetrician and other members such as an anaesthetist. [Adapted from NICE's guideline on caesarean birth, recommendation 1.2.26]

Equality and diversity considerations

Good communication between healthcare professionals and pregnant women or pregnant people who request a caesarean birth is essential. Treatment and care, and the information given about it, should be culturally appropriate. It should also be accessible to pregnant women or pregnant people with additional needs such as physical, sensory or learning disabilities, and to pregnant women or pregnant people who do not speak or read English. Pregnant women or pregnant people who request a caesarean birth should have access to an interpreter or advocate if needed. For pregnant women or pregnant people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in [NHS England's Accessible Information Standard](#) or the equivalent standards for the devolved nations.

Quality statement 3: Request for a caesarean birth: anxiety

Quality statement

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

Rationale

When a pregnant woman or pregnant person who is requesting a caesarean birth 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 they are 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 birth 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 measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

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

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

Process

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

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

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

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

Outcome

Women and people's satisfaction with the support provided for anxiety about childbirth.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient surveys.

What the quality statement means for different audiences

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

Pregnant women or pregnant people who ask for a caesarean birth 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

Caesarean birth. NICE guideline NG192 (2021, updated 2024), recommendation 1.2.28

Definitions of terms used in this quality statement

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 pregnant women or pregnant people with higher-than-normal anxiety levels, to the extent that they are requesting a caesarean birth. [Expert opinion]

Referral

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

Anxiety

Tokophobia or other severe anxiety about childbirth (for example, following abuse or a previous traumatic event). [NICE's guideline on caesarean birth, recommendation 1.2.28]

Equality and diversity considerations

Good communication between healthcare professionals and pregnant women or pregnant people who request a caesarean birth is essential. Treatment and care, and the information given about it, should be culturally appropriate. It should also be accessible to pregnant women or pregnant people with additional needs such as physical, sensory or learning disabilities, and to pregnant women or pregnant people who do not speak or read English. Pregnant women or pregnant people who request a caesarean birth should have access to an interpreter or advocate if needed. For pregnant women or pregnant people

with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in [NHS England's Accessible Information Standard](#) or the equivalent standards for the devolved nations.

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

Quality statement

Pregnant women or pregnant people who may require a planned caesarean birth have consultant involvement in decision making.

Rationale

Consultant obstetricians are best placed to advise a pregnant woman or pregnant person who may need or want to plan a caesarean birth 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 pregnant woman or pregnant person and the baby.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that pregnant women or pregnant people who may require a planned caesarean birth have consultant involvement in decision making.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

Process

The proportion of pregnant women or pregnant people who may require a planned caesarean birth who have consultant involvement in decision making.

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

Denominator – the number of pregnant women or pregnant people who may require a planned caesarean birth.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

Outcome

Women and people's satisfaction with the decision-making process.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient surveys.

What the quality statement means for different audiences

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

Healthcare professionals ensure that pregnant women or pregnant people who may require a planned caesarean birth have consultant involvement in decision making.

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

Pregnant women or pregnant people who may need a planned caesarean birth have a consultant obstetrician involved in making the decision.

Source guidance

Caesarean birth. NICE guideline NG192 (2021, updated 2024), recommendation 1.3.3

Definitions of terms used in this quality statement

Pregnant women or pregnant people who may require a planned caesarean birth

This includes both pregnant women or pregnant people who have medical indications that would suggest that a planned caesarean birth would be the safest way of delivering the baby, and pregnant women or pregnant people who request a caesarean birth when there are no medical indications. [Adapted from NICE's guideline on caesarean birth, section 1.2, and expert opinion]

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 pregnant woman or pregnant person and will depend on the complexity of their specific circumstances. [Expert opinion]

Equality and diversity considerations

Good communication between healthcare professionals and pregnant women or pregnant people who may need a caesarean birth is essential. Treatment and care, and the information given about it, should be culturally appropriate. It should also be accessible to pregnant women or pregnant people with additional needs such as physical, sensory or learning disabilities, and to pregnant women or pregnant people who do not speak or read English. Pregnant women or pregnant people who may need a caesarean birth should have access to an interpreter or advocate if needed. For pregnant women or pregnant people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard or the equivalent standards for the devolved nations.

Quality statement 5: Timing of planned caesarean birth

Quality statement

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

Rationale

Babies born by planned caesarean birth 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 birth should not routinely be carried out before 39 weeks.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

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

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

Process

The proportion of pregnant women or pregnant people having a planned caesarean birth

and not needing an earlier delivery because of maternal and fetal indications who have the procedure carried out at or after 39 weeks.

Numerator – the number in the denominator who have the caesarean birth carried out at or after 39 weeks.

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

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

What the quality statement means for different audiences

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

Healthcare professionals ensure that pregnant women or pregnant people having a planned caesarean birth have the procedure at or after 39 weeks, unless an earlier delivery is necessary because of maternal or fetal indications.

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

Pregnant women or pregnant people having a planned caesarean birth have the procedure at or after 39 weeks of pregnancy, unless an earlier delivery is needed because of problems with the baby or the person who is pregnant.

Source guidance

Caesarean birth. NICE guideline NG192 (2021, updated 2024), recommendation 1.4.1

Definitions of terms used in this quality statement

Planned caesarean birth

A planned caesarean birth that is scheduled before the onset of labour. Planned caesarean birth should be agreed between the pregnant woman or pregnant person and the maternity team. The pregnant woman or pregnant person should be given a specific day and time at which the caesarean birth will be performed. A model for delivering planned caesarean birth is for services to have dedicated planned caesarean birth lists. The lists should have protected surgical and anaesthetic time and appropriate staffing to ensure that planned caesarean births are not delayed because of surgical time being prioritised for emergency cases. [[NICE's 2011 full guideline on caesarean section](#), glossary, and expert opinion]

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. [Expert opinion]

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

Quality statement

Women or people in labour being considered for an unplanned caesarean birth have a consultant obstetrician involved in the decision.

Rationale

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

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that women or people in labour being considered for an unplanned caesarean birth have a consultant obstetrician involved in the decision.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

Process

The proportion of women or people in labour being considered for an unplanned caesarean birth who have a consultant obstetrician involved in the decision.

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

Denominator – the number of women or people in labour being considered for an unplanned caesarean birth.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

Outcomes

a) Unplanned caesarean birth rates.

Data source: The [NHS Digital Maternity services secondary uses data set](#) collects data on delivery method, which includes the number of emergency caesarean births.

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

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient audits.

What the quality statement means for different audiences

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

Healthcare professionals ensure that women or people in labour being considered for an unplanned caesarean birth have a consultant obstetrician involved in the decision.

Commissioners ensure that they commission services that have systems in place for

women or people in labour being considered for an unplanned caesarean birth to have a consultant obstetrician involved in the decision.

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

Source guidance

Caesarean birth. NICE guideline NG192 (2021, updated 2024), recommendation 1.3.3

Definitions of terms used in this quality statement

Unplanned caesarean birth

This refers to the classification of urgency for caesarean birth described in NICE's guideline on caesarean birth, recommendation 1.4.2.

- Category 1. Immediate threat to the life of the pregnant woman or pregnant person or fetus.
- Category 2. Maternal or fetal compromise which is not immediately life-threatening.
- Category 3. No maternal or fetal compromise but needs early birth.
- Category 4. Birth timed to suit pregnant women or pregnant person or healthcare provider.

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 pregnant woman or pregnant person's maternity notes. [Expert opinion]

Equality and diversity considerations

Good communication between healthcare professionals and women or people in labour

who may need a caesarean birth is essential. Treatment and care, and the information given about it, should be culturally appropriate. It should also be accessible to pregnant women or pregnant people with additional needs such as physical, sensory or learning disabilities, and to pregnant women or pregnant people who do not speak or read English. Pregnant women or pregnant people who may need a caesarean birth should have access to an interpreter or advocate if needed. For pregnant women or pregnant people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in [NHS England's Accessible Information Standard](#) or the equivalent standards for the devolved nations.

Quality statement 7: The use of fetal blood sampling

This statement has been removed. For more details, see [update information](#).

Quality statement 8: Post caesarean birth discussion

Quality statement

Women or people who have had an emergency or unplanned caesarean birth are offered a discussion and are given written information about the reasons for their caesarean birth and birth options for future pregnancies.

Rationale

While women or people are in hospital after having an emergency or unplanned caesarean birth, it is important to discuss the reasons for the caesarean birth 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 or people 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 measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that women or people who have had an emergency or unplanned caesarean birth are offered a discussion and are given written information about the reasons for their caesarean birth and birth options for future pregnancies.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

Process

The proportion of women or people who have had an emergency or unplanned caesarean birth who have had a discussion and were given written information about the reasons for their caesarean birth and birth options for future pregnancies.

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

Denominator – The number of women or people who have had an emergency or unplanned caesarean birth.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

Outcome

Women or people's satisfaction with post-caesarean birth discussion and information.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient surveys.

What the quality statement means for different audiences

Service providers ensure that systems are in place for women or people who have had an emergency or unplanned caesarean birth to be offered a discussion and be given written information about the reasons for their caesarean birth and birth options for future pregnancies.

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

Commissioners ensure that they commission services that offer women or people who have had an emergency or unplanned caesarean birth a discussion and written information

about the reasons for their caesarean birth and birth options for future pregnancies.

Women or people who have had an emergency or unplanned caesarean birth are offered a discussion and given written information about the reasons for their caesarean birth and birth options for future pregnancies.

Source guidance

Caesarean birth. NICE guideline NG192 (2021, updated 2024), recommendation 1.7.10

Definitions of terms used in this quality statement

Offered

The offer of a discussion should be made when the woman or person is still in the postnatal ward, with the option to provide this at a later date, if the woman or person prefers. [Adapted from NICE's guideline on caesarean birth, recommendation 1.7.10]

Discussion

An opportunity for women or people to discuss the reasons for the caesarean birth 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 the complexity of the case. [Adapted from NICE's guideline on caesarean birth, recommendation 1.7.10, and expert opinion]

Equality and diversity considerations

Good communication between healthcare professionals and women or people who have had an emergency or unplanned caesarean birth is essential. Treatment and care, and the information given about it, should be culturally appropriate. It should also be accessible to women or people with additional needs such as physical, sensory or learning disabilities, and to women or people who do not speak or read English. Women or people who have had a caesarean birth should have access to an interpreter or advocate if needed. For women or people with additional needs related to a disability, impairment or sensory loss,

information should be provided as set out in NHS England's Accessible Information Standard or the equivalent standards for the devolved nations.

Quality statement 9: Monitoring for postoperative complications following caesarean birth

Quality statement

Women or people who have had a caesarean birth 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 birth. This needs to happen alongside the core postnatal care all women or people receive in hospital immediately after giving birth.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that women or people who have had a caesarean birth are monitored for immediate postoperative complications.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

Process

The proportion of women or people who have had a caesarean birth who were monitored for immediate postoperative complications.

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

Denominator – the number of women or people who have a caesarean birth.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

Outcome

Rates of complications in women or people who have had a caesarean birth.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

What the quality statement means for different audiences

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

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

Commissioners ensure that they commission services in which women or people who have had a caesarean birth are monitored for postoperative complications.

Women or people who have had a caesarean birth are monitored for complications following the operation.

Source guidance

Caesarean birth. NICE guideline NG192 (2021, updated 2024), recommendations 1.6.2 to 1.6.7, 1.6.17, 1.7.4 and 1.7.7

Definitions of terms used in this quality statement

Monitoring complications

See the section on monitoring after caesarean birth in NICE's guideline on caesarean birth.

MMBRACE-UK's report Saving lives, improving mothers care (2020) states that NHS England and NHS Improvement are rapidly developing a chart for an early warning score for pregnant and postpartum women, and a clear response pathway. The report provides an example tool called the modified early obstetric warning score (MEOWS) to support monitoring.

Update information

March 2021: Changes have been made to align this quality standard with the updated [NICE guideline on caesarean birth](#). The term 'caesarean section' has been replaced with 'caesarean birth' where appropriate. Quality statements 2 and 8 have had their wording updated for clarity and consistency with the updated guideline. Source guidance references and definitions have also been updated throughout. Quality statement 7 on the use of fetal blood sampling has been removed because the underpinning recommendation was removed from the NICE guideline.

Minor changes since publication

January 2024: Changes have been made to align this quality standard with the updated [NICE guideline on caesarean birth](#). Source guidance recommendation numbers have been updated in statements 2 and 9 and in the definitions section of statements 2 and 3.

June 2023: Changes have been made to align this quality standard with the updated [NICE guideline on caesarean birth](#). Pregnant people have been added to the quality standard to ensure equality. Source guidance recommendation numbers have been updated in statement 2 and in the definitions sections of statements 2 and 3.

About 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. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

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

Information about [how NICE quality standards are developed](#) is available from the NICE website.

See our [webpage on quality standards advisory committees](#) for details about our standing committees. Information about the topic experts invited to join the standing members is available from the [webpage for this quality standard](#).

NICE has produced a [quality standard service improvement template](#) to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource

impact work for the source guidance. Organisations are encouraged to use the [resource impact statement for the NICE guideline on caesarean birth](#) to help estimate local costs.

Diversity, equality and language

Equality issues were considered during development and [equality assessments for this quality standard](#) are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

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

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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 \(RCN\)](#)