NICE National Institute for Health and Care Excellence

NICE quality standard

Caesarean birth

Quality standard

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Contents

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

For simplicity of language, this quality standard will use the term 'women' or 'mother' throughout, and this should be taken to include people who do not identify as women but who are pregnant or who have given birth.

Statement 1 Pregnant women 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 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 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 who may require a planned caesarean birth have consultant involvement in decision making.

Statement 5 Pregnant women 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 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 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 who have had a caesarean birth are monitored for postoperative complications.

NICE has developed guidance and a quality standard on people's experiences using adult NHS services (see the NICE Pathway on patient experience in adult NHS services).

Other quality standards that should be considered when commissioning or providing services for caesarean birth include:

- Specialist neonatal respiratory care for babies born preterm. NICE quality standard 193 (2020)
- Intrapartum care: existing medical conditions and obstetric complications. NICE quality standard 192 (2020)
- Preterm labour and birth. NICE quality standard 135 (2016, updated 2019)
- Antenatal and postnatal mental health. NICE quality standard 115 (2016)
- Diabetes in pregnancy. NICE quality standard 109 (2016)
- Intrapartum care. NICE quality standard 105 (2015, updated 2017)
- Ectopic pregnancy and miscarriage. NICE quality standard 69 (2014)
- Inducing labour. NICE quality standard 60 (2014)
- Multiple pregnancy: twin and triplet pregnancies. NICE quality standard 46 (2013, updated 2019)
- Postnatal care. NICE quality standard 37 (2013, updated 2015)
- Hypertension in pregnancy. NICE quality standard 35 (2013, updated 2019)
- Antenatal care. NICE quality standard 22 (2012, updated 2016)
- Patient experience in adult NHS services. NICE quality standard 15 (2012, updated 2019)

A full list of NICE quality standards is available from the quality standards topic library.

Quality statement 1: Vaginal birth after a caesarean birth

Quality statement

Pregnant women 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 women who have had up to 4 previous caesarean births. If a woman chooses to plan a vaginal birth after she has previously given birth by caesarean section, she should be fully supported in her choice.

Quality measures

Structure

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

Data source: Local data collection.

Process

The proportion of pregnant women 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 of women in the denominator who have a documented discussion of the option to plan a vaginal birth.

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

Data source: Local data collection.

Outcome

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

Data source: Local data collection.

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

Data source: The NHS Digital Maternity services secondary uses dataset collects data on delivery method and previous caesarean sections.

What the quality statement means for different audiences

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

Pregnant women 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), recommendations 1.8.1, 1.8.2 and 1.8.5

Definitions of terms used in this quality statement

Documented discussion

Pregnant women should be informed by members of the maternity team that in women 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 woman's notes. [NICE's guideline on caesarean birth, recommendation 1.8.2]

Equality and diversity considerations

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

Quality statement

Pregnant women 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 woman can talk to the most relevant member of the maternity team depending on what her question or concern is about her request for a caesarean birth. It is important that access to members of the maternity team is possible at any point during the woman's pregnancy and promptly arranged following a request.

Quality measures

Structure

Evidence of local arrangements to ensure that pregnant women 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: Local data collection.

Process

The proportion of pregnant women 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 of women 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 who request a caesarean birth when there is no medical indication.

Data source: Local data collection.

Outcome

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

Data source: Local data collection.

What the quality statement means for different audiences

Service providers ensure that systems are in place for pregnant women 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 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 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 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), recommendations 1.2.25, 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 woman 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 woman's antenatal notes. [Adapted from NICE's guideline on caesarean birth, recommendations 1.2.25 to 1.2.27]

Maternity team

The core membership of the maternity team should include a senior midwife, an obstetrician and an anaesthetist. [Adapted from NICE's guideline on caesarean birth, recommendation 1.2.27]

Equality and diversity considerations

Good communication between healthcare professionals and women 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 women with additional needs such as physical, sensory or learning disabilities, and to women who do not speak or read English. Women who request a caesarean birth should have access to an interpreter or advocate if needed. For women 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: Maternal request for a caesarean birth: maternal anxiety

Quality statement

Pregnant women 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 woman 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 the woman is able to choose a planned vaginal birth. This discussion is an important part of the decision-making process and should happen before a decision on caesarean 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

Structure

Evidence of local arrangements to ensure that pregnant women 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: Local data collection.

Process

The proportion of pregnant women 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 of women in the denominator who are referred to a healthcare professional with expertise in perinatal mental health support.

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

Data source: Local data collection.

Outcome

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

Data source: Local data collection.

What the quality statement means for different audiences

Service providers ensure that systems are in place for pregnant women 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 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 women 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 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), 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 women 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 women 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 women with additional needs such as physical, sensory or learning disabilities, and to women who do not speak or read English. Women who request a caesarean birth should have access to an interpreter or advocate if needed. For women 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 who may require a planned caesarean birth have consultant involvement in decision making.

Rationale

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

Quality measures

Structure

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

Data source: Local data collection.

Process

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

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

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

Data source: Local data collection.

Outcome

Women's satisfaction with the decision-making process.

Data source: Local data collection.

What the quality statement means for different audiences

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

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

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

Source guidance

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

Definitions of terms used in this quality statement

Pregnant women who may require a planned caesarean birth

This includes both women who have medical indications that would suggest that a planned caesarean birth would be the safest way of delivering the baby, and women 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 woman and will depend on the complexity of their specific circumstances. [Expert opinion]

Equality and diversity considerations

Good communication between healthcare professionals and women 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 women with additional needs such as physical, sensory or learning disabilities, and to women who do not speak or read English. Women who may need a caesarean birth should have access to an interpreter or advocate if needed. For women 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 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

Structure

Evidence of local arrangements to ensure that pregnant women 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: Local data collection.

Process

The proportion of pregnant women 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 of women in the denominator who have the caesarean birth carried out at or after 39 weeks.

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

Data source: The NHS Digital Maternity services secondary uses data set collects data on delivery method and gestational length at birth.

What the quality statement means for different audiences

Service providers ensure that systems are in place for pregnant women 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 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 women 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.

Women 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 mother.

Source guidance

Caesarean birth. NICE guideline NG192 (2021), 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 woman and the maternity team. The woman should be given a specific day and time at which the caesarean section will be performed. A model for delivering planned caesarean 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 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 and the baby.

Quality measures

Structure

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

Data source: Local data collection.

Process

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

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

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

Data source: Local data collection.

Outcomes

a) Unplanned caesarean birth rates.

Data source: The NHS Digital Maternity services secondary uses data set collects data on delivery method.

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

Data source: Local data collection.

What the quality statement means for different audiences

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

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

Women 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), 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 woman 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 women 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 woman's maternity notes. [Expert opinion]

Equality and diversity considerations

Good communication between healthcare professionals and women 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 women with additional needs such as physical, sensory or learning disabilities, and to women who do not speak or read English. Women who may need a caesarean birth should have access to an interpreter or advocate if needed. For women 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 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 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 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

Structure

Evidence of local arrangements to ensure that women 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: Local data collection.

Process

The proportion of women 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 of women 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 who have had an emergency or unplanned caesarean birth.

Data source: Local data collection.

Outcome

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

Data source: Local data collection.

What the quality statement means for different audiences

Service providers ensure that systems are in place for women 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 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 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 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), recommendation 1.7.10

Definitions of terms used in this quality statement

Offered

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

Discussion

An opportunity for women 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 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 with additional needs such as physical, sensory or learning disabilities, and to women who do not speak or read English. Women who have had a caesarean birth should have access to an interpreter or advocate if needed. For women 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 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 receive in hospital immediately after giving birth.

Quality measures

Structure

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

Data source: Local data collection.

Process

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

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

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

Data source: Local data collection.

Outcome

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

Data source: Local data collection.

What the quality statement means for different audiences

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

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

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

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

Source guidance

Caesarean birth. NICE guideline NG192 (2021), recommendations 1.6.1 to 1.6.8, 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.

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.

Information about the topic experts is available from the webpage for this quality standard.

This quality standard has been included in the NICE Pathway on caesarean birth, which brings together everything we have said on a topic in an interactive flowchart.

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.

Improving outcomes

This quality standard is expected to contribute to improvements in the following outcomes:

- Women's satisfaction with planning and discussion.
- Women's satisfaction with support provided.

- Rates of delivery modes.
- Women's satisfaction with post-caesarean birth discussion.
- Rates of postoperative complications after caesarean birth.

It is also expected to support delivery of the NHS outcomes framework. Equivalent frameworks may be used in the devolved nations.

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)