

NICE support for commissioning for caesarean section

June 2013

1 Introduction

Implementing the recommendations from NICE guidance and other NICE-accredited guidance is the best way to support improvements in the quality of care or services, in line with the statements and measures that comprise the NICE quality standards. This report:

- considers the resource impact of implementing the changes needed to achieve the quality standard at a local level
- identifies where potential cost savings can be made
- highlights the areas of care in the quality standard that have potential implications for commissioners
- directs commissioners and service providers to a package of support tools that can help them implement NICE guidance and redesign services.

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. The statements draw on existing guidance, which provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement. For more information see [NICE quality standards](#).

NHS England's [CCG outcomes indicator set](#) is part of a systematic approach to promoting quality improvement. The outcomes indicator set provides Clinical Commissioning Groups (CCGs) and health and wellbeing boards with comparative information on the quality of health services commissioned by CCGs and the associated health outcomes. The set includes indicators

derived from NICE quality standards. By commissioning services in line with the quality standards, commissioners can contribute to improvements in health outcomes.

Commissioners can use the quality standards to improve services by including quality statements and measures in the service specification of the standard contract and establishing key performance indicators as part of tendering. They can also encourage improvements in provider performance by using quality standard measures in association with incentive payments such as [Using the commissioning for quality and innovation \(CQUIN\) payment framework](#). NICE quality standards provide a baseline against which improvements can be measured and rewarded, enabling commissioners to address gaps in service provision, support best practice and encourage evidence-based care.

This report on the caesarean section quality standard should be read alongside:

- [Caesarean section](#) NICE quality standard 32 (2013).
- [Caesarean section](#) NICE clinical guideline 132 (2011).

Commissioners should also be aware that the quality standard for caesarean section forms part of a suite of maternity quality standards, of which antenatal care, intrapartum care and postnatal care will form the core pathway. The full set of quality standards, including all the maternity quality standards that should be considered when commissioning and providing high-quality maternity services are:

- [Antenatal care](#). NICE quality standard 22 (2012)
- [Patient experience in adult NHS services](#) NICE quality standard 15 (2012).
- [Specialist neonatal care](#). NICE quality standard 4 (2010)
- [VTE prevention](#). NICE quality standard 3 (2010).
- [Postnatal care](#) NICE quality standard 33. Publication expected July 2013.

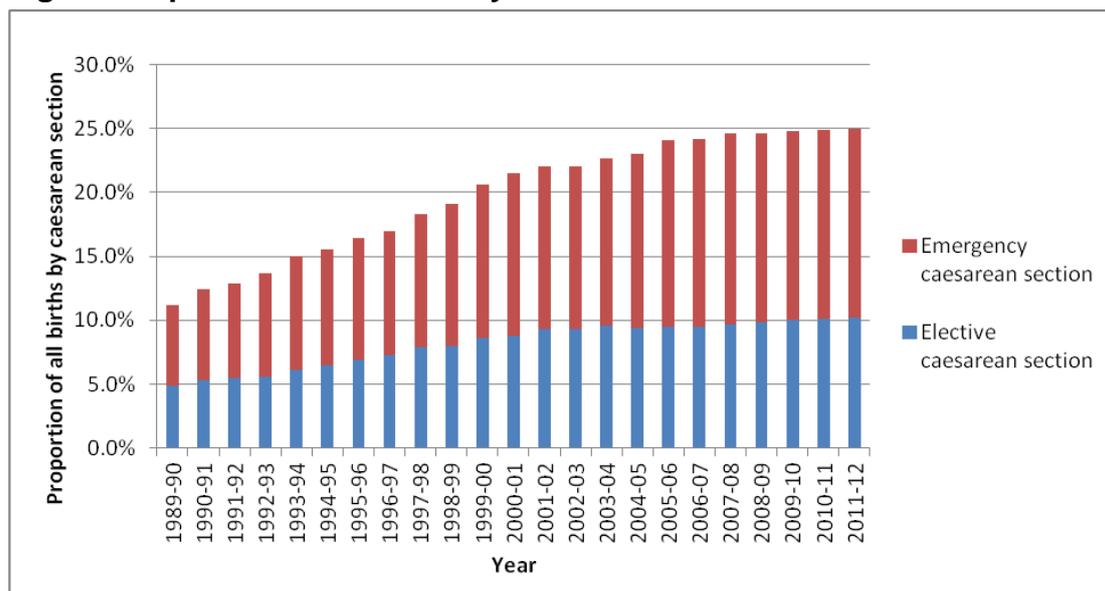
- [Hypertension in pregnancy](#). NICE quality standard 34. Publication expected July 2013
- [Multiple pregnancy](#). NICE quality standard 39. Publication expected September 2013

2 Overview of caesarean section

Caesarean section rates have increased significantly in recent years. In the UK between 20-25% of births are carried out by caesarean section, up from 9% in 1980. There are a number of different indications for the procedure, and there is local variation in caesarean section rates. The quality standard on [caesarean section](#) focuses on improving the decision-making process and the information available to women who may need, request or have had a caesarean section. It does not define acceptable caesarean section rates. The identified high-priority areas for quality improvement within the quality statements support the purpose of enabling healthcare professionals to offer appropriate research-based information about the risks and benefits to women and their families so that women are enabled to make properly informed decisions and potential risks or complications for the woman and the baby are reduced. The quality standard builds on NICE clinical guideline 132 on caesarean section that included recommendations that mean more women could avoid unnecessary surgery, could reduce post-operative infections and where mental health and physical conditions would be recognised as possible indications for caesarean section.

The figure below shows the annual proportion of all births carried out by caesarean section in NHS hospitals in England since 1989–90. From this graph, it is clear that there has been a large increase in the proportion of births by caesarean section in the last 20 years, and that this increase has 'tailed off' in the last 4 to 5 years.

Figure Proportion of all births by caesarean section



Data taken from NHS maternity statistics - England, 2011-12, The NHS Information Centre. Available at <http://www.hscic.gov.uk/article/2021/Website-Search?productid=10061&q=maternity+statistics&sort=Relevance&size=10&page=1&area=both#top>

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

3 Commissioning and resource implications

Table 1 below shows the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving:

Table 1 Outcomes, overarching indicators and improvement areas from the NHS Outcomes Framework

| | |
|---|--|
| NHS Outcomes Framework 2013/14 | |
| Domain 1: Preventing people from dying prematurely. | Overarching indicator 1a Potential years of life lost (PYLL) from causes considered amenable to healthcare |
| | Improvement area Reducing deaths in babies and young children 1.6.i Infant mortality ii Neonatal mortality and stillbirths |
| Domain 4: Ensuring that people have a positive experience of care | Overarching indicator 4b Patient experience of hospital care |
| | Improvement area Improving women and their families' experience of maternity services 4.5 Women's experience of maternity services |
| Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm | Overarching indicator 5a Patient safety incidents reported 5b Safety incidents involving severe harm or death |
| | Improvement area Improving the safety of maternity services 5.5 Admission of full-term babies to neonatal care |

The cost of meeting the quality standard for caesarean section depends on current local practice and the progress organisations have made in implementing NICE and NICE-accredited guidance.

Under the new [Maternity services pathway payment system](#) which came into effect in April 2013, the payment system is split into three modules, each of which is paid separately. These are: antenatal care; the delivery; and postnatal care.

The antenatal pathway commences when the pregnant woman has her first antenatal appointment or attendance with her maternity provider. The pathway payment is based on information collected at the antenatal assessment appointment (usually undertaken around 10 weeks' gestation)

when the health and social care risk assessment is carried out. The standard pathway price has been developed taking into account the proportion of women likely to develop complications during pregnancy that will require higher levels of care, or that some of the characteristics may develop or be disclosed later in pregnancy.

There are two delivery pathway prices, split by whether there were complications and co-morbidities (CC) or not. The price includes all postpartum care of the mother and well/healthy baby/babies until transfer to community postnatal care. The prices set take into account the higher-cost types of births.

Commissioners will only pay once per intrapartum episode, to the organisation that delivers the baby/babies. The postnatal pathway usually commences after the woman and baby/babies have been transferred to community postnatal care and concludes once the woman has been transferred to primary care.

When commissioning services to achieve the NICE quality standard for caesarean section, commissioners should therefore be aware of the potential impact of the pathway funding system.

Table 2 summarises the commissioning and resource implications for commissioners working towards achieving this quality standard. See section 4 for more detail on commissioning and resource implications.

Table 2 Potential commissioning and resource implications of achieving the quality standard for caesarean section

| Quality statement | Commissioning implications | Estimated resource impact |
|---|---|--|
| 1. Vaginal birth after a caesarean section | <p>Demonstrating evidence of practice and monitoring to ensure pregnant women who have had 1 or more previous caesarean section (CS) have a documented discussion about the option to plan a vaginal birth.</p> <p>Measuring women's satisfaction that they were supported in their choice.</p> <p>Monitoring the rates of different delivery modes for women who have had previous CS.</p> | No anticipated significant resource impact. |
| 2. Maternal request for a caesarean section: maternity team involvement | <p>Demonstrating evidence of practice and monitoring to ensure that pregnant women who request a CS (when there is no other indication) have a documented discussion with members of the maternity team about the overall risks and benefits of a CS compared with vaginal birth.</p> <p>Measuring women's experience of the process of discussing options.</p> | No anticipated significant resource impact. |
| 3. Maternal request for a caesarean section: maternal anxiety | <p>Demonstrating evidence of practice and monitoring to ensure pregnant women who request a CS because of anxiety about childbirth are offered a referral to a healthcare professional with expertise in perinatal mental health support.</p> <p>Measuring women's satisfaction with the support provided.</p> | No anticipated significant resource impact for commissioners. Potential local provider costs in ensuring availability of trained and experienced staff for referral. |
| 4. Consultant obstetrician involvement in decision-making for planned caesarean section | <p>Demonstrating evidence of practice and monitoring to ensure pregnant women who may need a planned CS have consultant involvement in decision-making.</p> <p>Monitoring of the rates of planned CS.</p> | No anticipated significant resource impact. |

| | | |
|---|---|---|
| 5. Timing of planned caesarean section | Demonstrating evidence of practice and monitoring to ensure pregnant women who are having a planned CS undergo the procedure at or after 39 weeks 0 days, unless an earlier delivery is necessary because of maternal or fetal indications. | By performing CS at a later gestation, the number of babies born with respiratory distress syndrome may decrease. There could be a resource saving in neonatal treatment costs for this condition. For providers there may be a local cost of ensuring staffing levels are maintained so that a dedicated maternity theatre list is possible. |
| 6. Consultant obstetrician involvement in decision-making for unplanned caesarean section | Demonstrating evidence of practice and monitoring to ensure women who are being considered for an unplanned CS have a consultant obstetrician involved in the decision. Monitoring unplanned CS rates and measuring women's satisfaction. | No anticipated significant resource impact. |
| 7. The use of fetal blood sampling | Demonstrating evidence of practice and monitoring to ensure women in labour who are being considered for a CS due to suspected fetal compromise are offered fetal blood sampling to inform decision-making. Assurance of maternity unit's access to functioning and serviced equipment. Monitoring the proportion of women where a fetal blood sample was attempted and a reading made. Monitoring unplanned CS rates. | No anticipated significant resource impact. |
| 8. Post caesarean section discussion | Demonstrating evidence of practice and monitoring to ensure women who have had a CS are offered a discussion and given written information about the reasons for their CS and birth options for future pregnancies. Measuring women's satisfaction with post-CS discussion and information. | No anticipated significant resource impact |
| 9. Maternal complications following caesarean section | Demonstrating evidence of practice and monitoring to ensure women who have had a CS are monitored for immediate postoperative complications. Monitoring the rates of complications in women who have had a CS. | No anticipated significant resource impact |

4 Commissioning implications and cost impact

This section considers the commissioning implications and potential resource impact of implementing the recommendations to achieve the NICE quality standard for caesarean section.

4.1 *Vaginal birth after a caesarean section*

Quality statement 1:

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

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

In line with [NICE clinical guideline 132](#) (recommendations [1.8.1](#), [1.8.2](#) [key priority for implementation] and [1.8.5](#)) commissioners should therefore assure themselves that there is evidence of local arrangements so that pregnant women with a preference for a vaginal birth who have had up to 4 previous caesarean sections are informed that there is little or no increased risk of complications. When healthcare professionals are advising about the mode of birth after a previous caesarean section, maternal preferences and priorities, the risks and benefits of a repeat caesarean section and a planned vaginal birth after a caesarean section, including the risk of unplanned caesarean section should be considered. The risk of fever, bladder injuries and surgical injuries does not vary with planned mode of birth and the risk of uterine rupture, although higher for planned vaginal birth, is rare. Pregnant women with both previous caesarean section and a previous vaginal birth should be informed that they have an increased likelihood of achieving a vaginal birth than women who have had a previous caesarean section but no previous

vaginal birth. Providers should ensure that the discussion is documented in the woman's maternity notes.

Commissioners may wish to consider directing providers to examples of service changes. These include vaginal birth after caesarean section (VBAC) workshops, VBAC clinics and birth option clinics (see [Nursing Times: The high impact actions for nursing midwifery 7: promoting normal birth](#) for examples) and postnatal de-briefs.

It is anticipated that there will be no resource implications for commissioners as the discussion will be with existing members of the maternity team and no additional level of payment under the new maternity tariff will be triggered.

Commissioners may wish to refer to the NICE Implementation tools and resources for [NICE clinical guideline 132](#) on caesarean section.

Commissioners and providers may wish to work together to seek assurance that the statement is being achieved.

Commissioners can also use the [Maternity services secondary uses data set](#) which will collect data on 'the method for delivering baby' (global number 17206160) and on 'pregnancy previous caesarean sections' (global number 17200570) once implemented.

Commissioners may find it useful to refer to the [NICE 'do not do' recommendations database](#) to identify NHS clinical practices that should be discontinued completely or should not be used routinely in accordance with [NICE clinical guideline 132](#). 'Do not do' recommendations may be included if there is evidence that the practice is not on balance beneficial or there is a lack of evidence to support its continued use.

4.2 Maternal request for a caesarean section: maternity team involvement

Quality statement 2:

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

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

The Guideline Development Group found that a woman's request for a caesarean section should be the start of a continuing dialogue and process during which a negotiated plan of care can be developed. This enables women to continue to feel in control with the support of their healthcare providers. In line with [NICE clinical guideline 132](#) (recommendation [1.2.9.2](#)) commissioners should assure themselves that there is evidence of local arrangements to ensure that pregnant women who request a caesarean section (when there is no other indication) have a documented discussion with members of the maternity team about the overall risks and benefits of a caesarean section compared with a vaginal birth (see Box A in [NICE clinical guideline 132](#)). The discussion should include other members of the obstetric team (including the obstetrician, midwife and anaesthetist) if necessary to explore the reasons for the request, and ensure the woman has accurate information.

It is anticipated that there will be no resource implications for commissioners as the discussion will be with existing members of the maternity team and no

additional level of payment under the new maternity tariff will be triggered. Caesarean sections and vaginal births attract the same payment for commissioners and so there is no resource impact for commissioners of implementing this quality statement.

Commissioners may wish to refer to the NICE Implementation tools and resources for [NICE clinical guideline 132](#) on caesarean section.

Commissioners and providers may wish to work together to seek assurance that the statement is being achieved.

Commissioners and others can refer to the [NICE 'referral advice' recommendations database](#) in accordance with [NICE clinical guideline 132](#)¹.

The [NICE 'do not do' recommendations database](#) may also be useful for identifying NHS clinical practices that should be discontinued completely or should not be used routinely in accordance with [NICE clinical guideline 132](#). 'Do not do' recommendations may be included if there is evidence that the practice is not on balance beneficial or there is a lack of evidence to support its continued use.

4.3 Maternal request for a caesarean section: maternal anxiety

Quality statement 3:

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

¹ The [NICE referral advice recommendations database](#) states: If a woman requests a caesarean section when there is no other indication, discuss the overall risks and benefits of caesarean section compared with vaginal birth and record that this discussion has taken place. Include a discussion with other members of the obstetric team (including the obstetrician, midwife and anaesthetist) if necessary to explore the reasons for the request, and ensure the woman has accurate information.

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

In line with [NICE clinical guideline 132](#) (recommendation [1.2.9.3](#)) [key priority for implementation] commissioners should assure themselves that women who request a caesarean section because of anxiety about childbirth are offered a referral to a healthcare professional with expertise in providing perinatal mental health support. Commissioners should ensure that care pathways are in place to enable access to the relevant support. Referrals could be informal referrals within a maternity team or a more formal referral to another member of staff in a different team. It is not necessary for the person providing this psychological support to be a mental health expert unless clinically indicated, but rather that it could be provided by a member of the maternity team, such as a midwife or obstetrician. Commissioners may wish to direct providers to examples of service changes. Examples could include VBAC workshops, VBAC clinics and birth option clinics ([see Nursing Times: The high impact actions for nursing midwifery 7: promoting normal birth](#) for examples) and postnatal de-briefs.

There is not anticipated to be any cost to the commissioner here because no additional level of payment under the new maternity tariff will be triggered as a result of the woman requiring further discussions. However there may be costs locally for the provider in ensuring that a healthcare professional with appropriate expertise in perinatal mental health support is available. There may be a need for extra staff or training requirements for existing staff. This should be quantified locally as there is expected to be variability in the type of staff member and the level of expertise needed to meet the quality statement.

The tariff payment made by the commissioner does not vary depending on the method of birth.

Commissioners may wish to refer to the NICE Implementation tools and resources for [NICE clinical guideline 132](#) on caesarean section.

Commissioners and providers may wish to work together to seek assurance that the statement is being achieved.

Commissioners can refer to the [NICE 'referral advice' recommendations database](#) in accordance with [NICE clinical guideline 132](#).² The [NICE 'do not do' recommendations database](#) may also be useful for identifying NHS clinical practices that should be discontinued completely or should not be used routinely in accordance with [NICE clinical guideline 132](#). 'Do not do' recommendations may be included if there is evidence that the practice is not on balance beneficial or there is a lack of evidence to support its continued use.

4.4 Consultant obstetrician involvement in decision-making for planned caesarean section

Quality statement 4:

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

Consultant obstetricians are best placed to advise a woman who may need or want to plan a caesarean section about the potential benefits and risks for each option based on their specific circumstances and needs. The

² The [NICE referral advice recommendations database](#) states: When a woman requests a caesarean section because she has anxiety about childbirth, offer referral to a healthcare professional with expertise in providing perinatal mental health support to help her address her anxiety in a supportive manner.

involvement of a consultant is intended to ensure that the best possible outcomes are achieved for the woman and the baby.

[NICE clinical guideline 132](#) (recommendation [1.3.2.4](#)) recommends that consultant obstetricians should be involved in decision-making for caesarean section, because this reduces the likelihood of caesarean section.

Commissioners should assure themselves that service providers have systems in place and are able to demonstrate evidence of local arrangements for women to have a consultant obstetrician involved in their decision-making process when a caesarean section is being considered.³ Commissioners should specify that consultant obstetricians are directly involved in the decision for a caesarean section to be carried out and that involvement and the mode in which they were involved (for example, by phone or in person) is documented in the woman's maternity notes.

It is anticipated that there will be no resource implications because there should already be a consultant obstetrician available in the maternity team who contributes to decisions made for caesarean sections. No additional level of payment under the new maternity tariff will be triggered. Caesarean sections and vaginal births attract the same payment for commissioners and so there is no resource impact for commissioners in implementing this quality statement.

Commissioners may wish to refer to the NICE Implementation tools and resources for [NICE clinical guideline 132](#) on caesarean section.

Commissioners and providers may wish to work together to seek assurance

³ Being considered refers to the considerations carried out at the different categories of urgency as described in the Royal College of Obstetricians and Gynaecologists' [Classification of urgency of caesarean section – a continuum of risk](#) (2010).

that the statement is being achieved.

Commissioners can also use the [Maternity services secondary uses data set](#)⁴ which will collect data on the 'the method for delivering baby' (global number 17206160) once implemented.

Commissioners may find it useful to refer to the [NICE 'do not do' recommendations database](#) which identifies NHS clinical practices that should be discontinued completely or should not be used routinely in accordance with [NICE clinical guideline 132](#). 'Do not do' recommendations may be included if there is evidence that the practice is not on balance beneficial or there is a lack of evidence to support its continued use.

4.5 *Timing of planned caesarean section*

Quality statement 5:

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

Babies born by planned caesarean section⁵ at term but before the due date are at a higher risk of respiratory complications than babies who are not born by caesarean section. The level of risk decreases with gestational age, particularly from 39 weeks onwards. Therefore planned caesarean section should not routinely be carried out before 39 weeks.

⁴ The Maternity and children's data set has been developed to help achieve better outcomes of care for mothers, babies and children. The data set will provide comparative, mother and child-centric data that will be used to improve clinical quality and service efficiency; and to commission services in a way that improves health and reduces inequalities. It incorporates a maternity services secondary uses data set available from: <http://www.ic.nhs.uk/maternityandchildren>

⁵ Planned caesarean section – this should have been agreed between the woman and the maternity team. The woman should have been given a specific day and time at which the caesarean section will be performed.

Commissioners should therefore assure themselves that providers are acting in accordance with [NICE clinical guideline 132](#) (recommendation [1.4.1.1](#)) and check that there is evidence of local arrangements to ensure that pregnant women having a planned caesarean section, have the caesarean section carried out after 39 weeks' gestation, unless an earlier delivery is necessary for maternal or fetal indications.⁶

Costs associated with providing neonatal care are excluded from maternity pathway payments. There is a decrease in respiratory morbidity in babies born at 39 weeks' gestation onwards (from 40 per 1000 at 38 weeks to less than 20 per 1000 at 39 weeks) and therefore a decrease in the number of babies requiring care for respiratory distress syndrome, resulting in a resource saving. It is anticipated that numbers will be small and that there is no significant resource impact. Commissioners may wish to explore with providers the potential for dedicated maternity theatre lists for planned caesarean sections. The lists should have protected surgical and anaesthetic time and appropriate staffing levels to ensure that planned caesarean sections are not delayed because of surgical time being prioritised for emergency cases. There may be a resource impact for providers in ensuring that staffing is maintained to a level that makes a dedicated maternity theatre list possible.

Commissioners may wish to refer to the NICE Implementation tools and resources for [NICE clinical guideline 132](#) on caesarean section.

Commissioners and providers may wish to work together to seek assurance that the statement is being achieved.

Commissioners can use the [Maternity services secondary uses data set](#) which will collect data on 'the method for delivering baby' (global number 17206160) and on 'gestational age at birth' (global number 17206160) once

⁶ Maternal or fetal indications – this includes but is not limited to the following: significant conditions, hypertensive disease, diabetes or gestational diabetes, significant antepartum haemorrhage, intrauterine growth restriction, congenital abnormality, hydrops or compromise due to blood group incompatibility, acute fetal compromise, multiple pregnancy.

implemented.

Commissioners can also refer to the [NICE shared learning database](#) for examples of implementation of [NICE clinical guideline 132](#).

Commissioners may find it useful to refer to the [NICE 'do not do' recommendations database](#) which identifies NHS clinical practices that should be discontinued completely or should not be used routinely in accordance with [NICE clinical guideline 132](#). 'Do not do' recommendations may be included if there is evidence that the practice is not on balance beneficial or there is a lack of evidence to support its continued use.

4.6 Consultant obstetrician involvement in decision-making for unplanned caesarean section

Quality statement 6:

Women being considered for an unplanned⁷ caesarean section have a consultant obstetrician involved in the decision.

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

[NICE clinical guideline 132](#) (recommendation [1.3.2.4](#)) recommends that consultant obstetricians should be involved in the decision-making for caesarean section, because this reduces the likelihood of caesarean section.

Commissioners should assure themselves that service providers have systems in place and are able to demonstrate evidence of local arrangements for women to have a consultant obstetrician involved in the decision when an

⁷ Unplanned caesarean section refers to the categories described [NICE clinical guideline 132](#).

unplanned caesarean section is being considered.⁸ Commissioners should specify that consultant obstetricians are directly involved in the decision for a caesarean section to be carried out and that involvement and the mode in which they were involved (for example, by phone or in person) is documented in the woman's maternity notes.

It is anticipated that there will be no resource implications as there should already be a consultant obstetrician available in the maternity team who contributes to decisions made regarding caesarean sections. No additional level of payment under the new maternity tariff will be triggered. Caesarean sections and vaginal births attract the same payment for commissioners and so there is no resource impact for commissioners in implementing this quality statement.

Commissioners may wish to refer to the NICE Implementation tools and resources for [NICE clinical guideline 132](#) on caesarean section.

Commissioners and providers may wish to work together to seek assurance that the statement is being achieved.

Commissioners can also use the [Maternity services secondary uses data set](#)⁹ which will collect data on the 'the method for delivering baby' (global number 17206160) once implemented.

Commissioners may find it useful to refer to the [NICE 'do not do' recommendations database](#) which identifies NHS clinical practices that should be discontinued completely or should not be used routinely in accordance with [NICE clinical guideline 132](#). 'Do not do' recommendations

⁸ Being considered refers to the considerations carried out at the different categories of urgency as described in the Royal College of Obstetricians and Gynaecologists' [Classification of urgency of caesarean section – a continuum of risk](#) (2010).

⁹ The Maternity and children's data set has been developed to help achieve better outcomes of care for mothers, babies and children. The data set will provide comparative, mother and child-centric data that will be used to improve clinical quality and service efficiency; and to commission services in a way that improves health and reduces inequalities. It incorporates a maternity services secondary uses data set available from: <http://www.ic.nhs.uk/maternityandchildren>

may be included if there is evidence that the practice is not on balance beneficial or there is a lack of evidence to support its continued use.

4.7 *The use of fetal blood sampling*

Quality statement 7:

Women in labour for whom a caesarean section is being considered for suspected fetal compromise¹⁰ are offered fetal blood sampling to inform decision-making.

Fetal blood sampling¹¹ is recommended if delivery by caesarean section is contemplated because of an abnormal fetal heart rate pattern or in cases of suspected fetal acidosis. Fetal blood sampling helps the maternity team to make a more informed judgement about whether to recommend a caesarean section or to continue with a vaginal delivery.

Commissioners should therefore ensure that providers are adhering to [NICE clinical guideline 132](#) (recommendation [1.3.2.5](#)) and there is evidence of local arrangements to ensure that women in labour for whom an emergency or urgent caesarean section is considered, are offered fetal blood sampling to inform that decision. Commissioners may also wish to assess the levels of available equipment and request assurance that equipment is in working order and that staff are adequately trained to use it.

There are no anticipated costs to the commissioner as the use of fetal blood sampling during labour would not trigger an increased tariff payment. There is

¹⁰ Suspected fetal compromise – abnormal fetal heart rate pattern or suspected fetal acidosis.

¹¹ Fetal blood sampling should be undertaken when it is technically possible to do so and there are no contraindications. The National Sentinel Caesarean Section Audit defines 'technically possible' as cervical dilation of 4 cm or more. If there is clear evidence of acute fetal compromise (for example, prolonged deceleration greater than 3 minutes), fetal blood sampling should not be undertaken and urgent preparations to expedite birth should be made. If fetal blood sampling is not attempted because of contraindications, the contraindications should be documented in the woman's maternity notes.

not anticipated to be a resource impact for local providers for the purchase of equipment in order to provide fetal blood sampling which includes kits for obtaining the blood sample and a machine for analysing the pH level. It is anticipated that all units will already have the required equipment.

Commissioners may wish to refer to the NICE Implementation tools and resources for [NICE clinical guideline 132](#) on caesarean section.

Commissioners and providers may wish to work together to seek assurance that the statement is being achieved.

Commissioners may find it useful to refer to the [NICE 'do not do' recommendations database](#) which identifies NHS clinical practices that should be discontinued completely or should not be used routinely in accordance with [NICE clinical guideline 132](#). 'Do not do' recommendations may be included if there is evidence that the practice is not on balance beneficial or there is a lack of evidence to support its continued use.

4.8 Post caesarean section discussion

Quality statement 8:

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

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

Commissioners should therefore ensure that providers are acting in accordance with [NICE clinical guideline 132](#) (recommendation [1.7.1.9](#)) [key priority for implementation] and that women who have had a caesarean section, have the opportunity to discuss the reasons for the caesarean section with healthcare professionals while in hospital. In order to achieve the statement, women should also be offered both verbal and printed information about their caesarean section and birth options for any future pregnancies. This information should be available to them at a later date if they prefer.

Commissioners can also refer to the [NICE shared learning database](#) for an example of implementation of [NICE clinical guideline 132](#) called '[Explanatory letter to women who have had a caesarean section](#)'. The example letter provides women who have just had a caesarean section with a brief explanation of their caesarean section and emphasises that there are good prospects of vaginal birth in a future pregnancy. The letter is intended to be given before discharge from hospital.

It is anticipated that there will be no significant resource implications as the discussion will be with existing members of the maternity team and no additional level of payment under the new maternity tariff will be triggered.

Commissioners may wish to refer to the NICE Implementation tools and resources for [NICE clinical guideline 132](#) on caesarean section.

Commissioners and providers may wish to work together to seek assurance that the statement is being achieved.

Commissioners may find it useful to refer to the [NICE 'do not do' recommendations database](#) which identifies NHS clinical practices that should be discontinued completely or should not be used routinely in accordance with [NICE clinical guideline 132](#). 'Do not do' recommendations may be included if there is evidence that the practice is not on balance beneficial or there is a lack of evidence to support its continued use.

4.9 *Monitoring for postoperative complications following caesarean section*

Quality statement 9:

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

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

The national confidential enquiry into maternal death report produced by the Centre for Maternal and Child Enquiries, [Saving mothers lives](#) (2011) highlights an urgent need for routine use of a national modified early obstetric warning score (MEOWS) chart in all pregnant or postpartum women who become unwell and need either obstetric or gynaecology services.

Commissioners should assure themselves that there is evidence of local arrangements to ensure that women who have had a caesarean section are monitored for postoperative complications alongside core postnatal care and that providers are acting in accordance with [NICE clinical guideline 132](#) (recommendations [1.6.1.1](#), [1.6.2.1](#), [1.7.1.3](#) and [1.7.1.6](#)) in relation to necessary observations following anaesthesia, after recovery from anaesthesia, wound care, and the increased risk of thromboembolic disease.

It is anticipated that there will be no resource implications to the commissioner as no additional level of payment under the new maternity tariff will be triggered. Monitoring should align with [NICE clinical guideline 132](#) and be provided by staff with post-surgical monitoring expertise. It is anticipated that providers should be able to give the appropriate monitoring by staff from within the existing maternity team and so there is not expected to be a resource impact.

Commissioners may wish to refer to the NICE Implementation tools and resources for [NICE clinical guideline 132](#) on caesarean section.

Commissioners and providers may wish to work together to seek assurance that the statement is being achieved.

Commissioners may find it useful to refer to the support for commissioners using the [postnatal care quality standard](#) when available.

Commissioners may find it useful to refer to the [NICE 'do not do' recommendations database](#) which identifies NHS clinical practices that should be discontinued completely or should not be used routinely in accordance with [NICE clinical guideline 132](#). 'Do not do' recommendations may be included if there is evidence that the practice is not on balance beneficial or there is a lack of evidence to support its continued use.

Commissioners can also refer to the [NICE shared learning database](#) for an example of implementation of NICE clinical guideline 13 (updated and replaced by [NICE clinical guideline 132](#)) called [Integrated care pathway for elective caesarean section](#) which aims to enable rapid implementation of NICE guidance whilst encouraging accurate multi-professional documentation.

5 Other useful resources while in hospital

5.1 Policy documents

- Department of Health (2011) [The 'never events' list 2011/12](#) (see number 25: Maternal death due to post partum haemorrhage after elective Caesarean section).
- Hospital Episode Statistics (2010–11) [Maternity data \(2010–11\)](#).
- Centre for Maternal and Child Enquiries (2011) [Saving mothers' lives: reviewing maternal deaths to make motherhood safer: 2006–08](#).
- National Perinatal Epidemiology Unit (2010) [Delivered with care: a national survey of women's experience of maternity care 2010](#).

- Care Quality Commission (2010) [Maternity services survey 2010](#).
- Department of Health (2007) [Maternity matters: choice, access and continuity of care in a safe service](#).
- Department of Health (2007) [Delivering quality and value: focus on fractured neck of femur; primary hip and knee replacement; acute stroke; caesarean section; short stay emergency care](#).
- Royal College of Obstetricians and Gynaecologists (2007) [Birth after previous caesarean section](#). Green top guideline 45.
- Royal College of Obstetricians and Gynaecologists (2001) [The national sentinel caesarean section audit report](#).

5.2 Useful resources

- NHS England (2012) [Commissioning maternity services. A resource pack to support clinical commissioning groups](#).

5.3 NICE implementation support

- [Caesarean section](#) NICE baseline assessment tool (2011).
- [Caesarean section](#) NICE clinical audit tool – maternal request for caesarean section (2011).
- [Caesarean section](#) NICE electronic audit tool (2011).
- [Caesarean section](#) NICE clinical case scenarios (2011).
- [Caesarean section](#) NICE costing report (2011).
- [Caesarean section](#) NICE costing template (2011).
- [Caesarean section](#) NICE slide set (2011).
- [Caesarean section](#) NICE podcast (2011).

5.4 NICE pathways

- [Caesarean section](#) (2011).

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