NICE National Institute for Health and Care Excellence

NICE support for commissioning for multiple pregnancy

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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. They 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 Clinical Commissioning Group (CCG) outcomes indicator set is part of a systematic approach to promoting quality improvement. The outcomes indicator set provides 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 Commissioning for quality and innovation (CQUIN) 2013/14 guidance. 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 multiple pregnancy quality standard should be read alongside:

- Multiple pregnancy. NICE quality standard 46 (2013).
- Multiple pregnancy. NICE clinical guideline 129 (2011).
- Pregnancy and complex social factors. NICE clinical guideline 110 (2010).
- Antenatal care. NICE clinical guideline 62 (2008).

Commissioners should also be aware that the quality standard for multiple pregnancy is part of a suite of maternity quality standards, of which antenatal care, intrapartum care and postnatal care form the core pathway. The full set of quality standards that should be considered when commissioning and providing high-quality maternity services includes:

- Postnatal care. NICE quality standard 37 (2013)
- Hypertension in pregnancy. NICE quality standard 35 (2013)
- Caesarean section. NICE quality standard 32 (2013).
- 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).

2 Overview of multiple pregnancy

A multiple pregnancy is defined as a twin or triplet pregnancy and is associated with higher risks for the mother and babies. Women with multiple pregnancies have an increased risk of miscarriage, anaemia, hypertensive disorders, haemorrhage, operative delivery and postnatal illness. Maternal mortality associated with multiple births is 2.5 times that for singleton births. The overall stillbirth rate in multiple pregnancies is also higher than in singleton pregnancies: in 2009 the stillbirth rate was 12.3 per 1000 twin births and 31.1 per 1000 triplet and higher-order multiple births, compared with 5 per 1000 singleton births. The risk of preterm birth is also considerably higher in multiple pregnancies than in singleton pregnancies, occurring in 50% of twin pregnancies (10% of twin births take place before 32 weeks of gestation). In multiple pregnancies, 66% of unexplained stillbirths are associated with a birth weight of less than the tenth centile, compared with 39% for singleton births. The significantly higher preterm delivery rates in twin and triplet pregnancies result in increased demand for specialist neonatal resources. Major congenital abnormalities are 4.9% more common in multiple pregnancies than in singleton pregnancies.

Risks to fetuses depend partly on the chorionicity[1] and amnionicity[2] of the pregnancy. Feto-fetal transfusion syndrome[3], a condition associated with a shared placenta, can occur in monochorionic pregnancies and accounts for

[1] The number of chorionic (outer) membranes that surround fetuses in a multiple pregnancy. If there is only one membrane the pregnancy is described as monochorionic; if there are 2, the pregnancy is dichorionic; and if there are 3, the pregnancy is trichorionic. Monochorionic twin pregnancies and dichorionic triplet pregnancies carry higher risks because fetuses share a placenta.

[2] The number of amnions (inner membranes) that surround fetuses in a multiple pregnancy. Pregnancies with one amnion (so that all fetuses share an amniotic sac) are described as monoamniotic; pregnancies with 2 amnions are diamniotic; and pregnancies with 3 amnions are triamniotic.

[3] Feto-fetal transfusion syndrome is a complication of monochorionic multiple pregnancies in which shared blood vessels in the placenta cause an imbalance in the flow of blood from one fetus to another. The fetus with less blood is referred to as the donor, whereas the fetus with too much blood is called the recipient. There are significant risks to both babies. Feto-fetal transfusion syndrome is also referred to as twin-to-twin transfusion syndrome in twin pregnancies.

about 20% of stillbirths in multiple pregnancies. Additional risks to the fetuses include intrauterine growth restriction and congenital abnormalities.

This support for commissioning will help commissioners to ensure that the management of twin and triplet pregnancies in the antenatal period is aimed at monitoring and managing risks and complications to improve the health outcomes for mothers and their babies.

2.1 Epidemiology of multiple pregnancy

The incidence of multiple births has risen in the last 30 years. In 1980, 10 women per 1000 had multiple births in England and Wales compared to16 per 1000 births in 2011. This increase in multiple births is due mainly to the use of assisted reproduction techniques including in vitro fertilisation (IVF). Older women are more likely to have a multiple pregnancy and because the average age at which women give birth is rising this is also a contributory factor. Multiple births currently account for 3% of live births, which in England is equivalent to around 22,900 live births annually, or 41 live births per 100,000 population out of a total of 1240 live births per 100,000 population.

3 Summary commissioning and resource implications

Using the NICE quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the NHS Outcomes Framework 2013/14 and Improving outcomes and supporting transparency – Part 1A: public health outcomes framework for England, 2013–2016.

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

Under the maternity services pathway payment system that came into effect in April 2013, the payment system is split into 3 modules, each of which is paid separately. These are antenatal care, the delivery, and postnatal care.

The antenatal pathway payment system begins when the pregnant woman has her first antenatal appointment or attendance with her maternity care provider. The antenatal pathway payment (standard, intermediate or intensive) is based on the commissioner receiving information about the woman's health and social care needs reported at the antenatal assessment appointment, together with results from tests organised at this visit. The information will be used to assign each woman to the correct pathway. A multiple pregnancy is classified as one of the 'intensive resource' characteristics which would lead to the intensive level payment being made by the commissioning organisation.

Because of the increased risk of complications, women with multiple pregnancies need more monitoring and increased contact with healthcare professionals during their pregnancy than women with singleton pregnancies, and this will impact on NHS resources. An awareness of the increased risks may also have a significant psychosocial and economic impact on women and their families because this might increase anxiety in the women, resulting in an increased need for psychological support. Conversely, without additional monitoring, there may be an impact on NHS resources if complications arise for women and their babies that were not identified and monitored. Commissioners will therefore need to ensure effective arrangements are in place with their local tertiary centre to ensure that women and their babies are cared for in line with recommendations.

Table 1 summarises the commissioning and resource implications for commissioners working towards achieving the quality standard. Commissioners and providers may wish to work together to seek assurance that the quality statements are being achieved in line with the quality measures detailed in the quality standard. See section 4 for more detail on commissioning and resource implications.

The main focus of the quality standard for commissioners is to ensure that local services are organised effectively to enable achievement of the quality statements. No significant additional costs are anticipated as a result of working towards achieving the quality standard.

Table 1 Potential commissioning and resource implications of achieving the quality standard for multiple pregnancy

Quality statement	Commissioning implications	Estimated resource impact
Ultrasound scanning 1 - Determining chorionicity and amnionicity 2 - Labelling the fetuses	Specify and request evidence of practice by monitoring the proportion of women: - who have an ultrasound between 11 weeks 0 days to 13 weeks 6 days to determine the chorionicity and amnionicity of their pregnancy, and have this information recorded - who have their fetuses labelled using ultrasound and recorded between 11 weeks 0 days to 13 weeks 6 days. Measuring outcomes: Consistent identification of the foetuses and determination of chorionicity and amnionicity.	Cost impact not expected to be significant.
3 - Composition of the multidisciplinary core team	Specify and request evidence of practice by monitoring to ensure that women are cared for by a multidisciplinary core team.	If a multidisciplinary core team can be established using current resources then it is unlikely that there will be significant cost implications as a result of implementing this statement. Some training costs may be incurred.
Care planning 4 - Care planning 5 - Monitoring for fetal complications	Specify and request evidence of practice by monitoring the proportion of women: - who have a care plan that specifies the timing of antenatal care appointments appropriately - with a multiple pregnancy who are monitored appropriately. Specify local audit to monitor the completeness and accuracy of the antenatal care plan. Measuring outcomes: Women feel informed about their care and know which healthcare professionals they should see and when.	Cost impact not expected to be significant. Earlier identification of risks and complications is possible, with potentially improved outcomes for women and babies. This could result in savings for the NHS.
6 - Indications for seeking a consultant opinion from a tertiary level fetal medicine centre	Specify and request evidence of practice by monitoring the proportion of women with a higher-risk or complicated multiple pregnancy who have a consultant from a tertiary level fetal medicine centre involved in their care.	The number of referrals to specialist fetal medicine consultants may increase, but due to the relatively small numbers involved, the resource impact is not

	Measuring outcomes: Infant and maternal mortality and morbidity.	expected to be significant. Costs incurred by CCG commissioners should not be affected by this quality statement, because of the maternity services pathway payment system in place from April 2013.
Preparation for preterm birth 7 - Advice and preparation for preterm birth 8 - Preparation for birth	Specify and request evidence of practice by monitoring the proportion of women who: - have a discussion by 24 weeks with one or more members of the multidisciplinary core team about the risks, signs and symptoms of preterm labour and possible outcomes of preterm birth - have a discussion by 32 weeks about the timing of birth and possible modes of delivery so that a birth plan can be agreed. Measuring outcomes: Women feel well informed and able to make decisions that reflect what is important to them about the options for delivery.	Cost impact not expected to be significant.

4 Commissioning implications and resource cost impact

This section considers the commissioning implications and potential resource impact of implementing the recommendations to achieve the NICE quality standard for multiple pregnancy. Commissioners may find it helpful to refer to the NICE shared learning database which provides service model examples of implementation of the quality standard for multiple pregnancy and NICE clinical guideline 129 on multiple pregnancy[4].

[4] Examples are offered to share good practice and NICE makes no judgement on the compliance of these services with its guidance.

4.1 Ultrasound scanning

Quality statement 1: Determining chorionicity and amnionicity

Women with a multiple pregnancy have the chorionicity and amnionicity of their pregnancy determined using ultrasound[5] and recorded between 11 weeks 0 days to 13 weeks 6 days.

Quality statement 2: Labelling the fetuses

Women with a multiple pregnancy have their fetuses labelled using ultrasound and recorded between 11 weeks 0 days to 13 weeks 6 days.

If fetuses share a placenta there is a greater risk of complications. Pregnancy risks, clinical management and subsequent outcomes are different for monochorionic and dichorionic twin pregnancies (and for monochorionic, dichorionic and trichorionic triplet pregnancies).

Accurate determination of chorionicity and amnionicity allows women to be assigned the correct plan of care for their pregnancy. Labelling the fetuses and recording this in the notes at the dating scan, using either 'left and right' or 'upper and lower' orientation, allows the fetuses to be consistently identified throughout the pregnancy. It also takes into account that the ‘leading’ fetus may change as pregnancy progresses and labelling by number can cause confusion, particularly with left and right fetuses.

In line with this quality statement and NICE clinical guideline 129 recommendations 1.1.1.1, 1.1.2.1 and 1.1.2.2 (key priorities for implementation), commissioners need to ensure that antenatal care services are offering an ultrasound scan to women with a multiple pregnancy between 11 weeks 0 days to 13 weeks 6 days to:

[5] An ultrasound scan is used to determine chorionicity based on the number of placental masses, the lambda or T-sign and membrane thickness.

- accurately determine and record the chorionicity and amnionicity of the pregnancy
- labelling and recording the position of the fetuses

Commissioners need to ensure that the chorionicity and amnionicity and the labelling of the fetuses determined by the ultrasound scan are recorded in the women's notes. An electronic copy of the ultrasound report and an ultrasound image (of Lambda or T-sign) should be stored on the radiology reporting and picture archiving system. Hard copies of the report should be printed out and placed in the woman's hand-held maternity notes and their hospital notes.

Commissioners may request that providers demonstrate that ultrasonographer staff are competent and that the necessary processes are in place to achieve these statements. Commissioners may also find it helpful to refer to NICE Referral advice recommendation for NICE clinical guideline 129 (recommendation 1.1.2.4), and may wish to check that this is reflective of current practice:

- If it is not possible to determine chorionicity by ultrasound at the time of detecting the twin or triplet pregnancy, seek a second opinion from a senior ultrasonographer or offer the woman referral to a healthcare professional who is competent in determining chorionicity by ultrasound scan as soon as possible[6].

Implementing these quality statements is unlikely to lead to a significant cost impact, since additional ultrasound scans are not expected to be needed for determination of amnionicity and chorionicity. Similarly, additional ultrasound scans are not expected to be needed for determining and recording the position of the fetuses, although there may be some costs for providers associated with any identified training needs.

The Maternity services secondary uses data set will collect data on 'offer status - dating ultrasound scan' (global number 17201960), 'gestation - dating

[6] The NICE 'referral advice' recommendations database contains referral advice from NICE clinical guidelines.

ultrasound scan' (global number 17202010), 'number of fetuses - dating ultrasound scan' (global number 17202020)[7].

Commissioners may find it helpful to refer to the Schedule of specialist antenatal appointments in NICE clinical guideline 129[8].

Commissioners may find it helpful to refer to the NICE 'Do not do' recommendation for NICE clinical guideline 129[9] (recommendation 1.1.2.10):

- Do not use 3-dimensional ultrasound scans to determine chorionicity.

Commissioners may also find it helpful to refer to the NICE Support for commissioning for antenatal care for further consideration of women who may be experiencing complex social factors and may not be accessing services at the recommended times. The NICE shared learning database also provides a service model example of implementation of NICE clinical guideline 110 on pregnancy and complex social factors[10].

4.2 Composition of the multidisciplinary core team

Quality statement 3: Composition of the multidisciplinary core team

[7] 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: www.ic.nhs.uk/maternityandchildren

[8] Antenatal care (NICE clinical guideline 62) recommends determination of gestational age from 10 weeks 0 days. However, the aim of recommendation 1.1.1.1 in NICE clinical guideline 129 is to keep the number of scan appointments that women need to attend within a short time to a minimum.

[9] The NICE 'do not do' recommendations database identifies NHS clinical practices that should be discontinued completely or should not be used routinely. This may be because of evidence that the practice is not on balance beneficial or because there is a lack of evidence to support its continued use.

[10] The NICE shared learning database offers examples on how commissioners and providers have used NICE guidance to create innovative and effective local implementation programmes for service improvement.

Women with a multiple pregnancy are cared for by a multidisciplinary core team.

Women with a multiple pregnancy should have their clinical care provided by a multidisciplinary core team because of the increased risks and complications associated with multiple births. Commissioners may wish to refer to NICE clinical guideline 129 (section 1.2.3, recommendations 1.2.3.1, 1.2.3.3 and 1.2.3.4 [key priorities for implementation]) to ensure that women with twin and triplet pregnancies receive the recommended specialist care from a multidisciplinary core team with the expertise needed to provide high-quality care for women with a multiple pregnancy.

The nominated multidisciplinary team needs to consist of a core team and an enhanced team for referrals. The core team should consist of named specialist obstetricians[11], specialist midwives[12] and ultrasonographers[13]. The core team should have experience and knowledge of managing twin and triplet pregnancies, and should offer information and emotional support specific to twin and triplet pregnancies at their first contact with women as well as ongoing opportunities for further discussion and advice.

The enhanced team should include a perinatal mental health professional, a women's health physiotherapist, an infant feeding specialist and a dietitian. Members of the enhanced team should also have experience and knowledge relevant to twin and triplet pregnancies.

[11] A specialist obstetrician is an obstetrician with a special interest, experience and knowledge of managing multiple pregnancies, and who works regularly with women with multiple pregnancies.

[12] A specialist midwife is a midwife with a special interest, experience and knowledge of managing multiple pregnancies, and who works regularly with women with multiple pregnancies.

[13] An ultrasonographer is a healthcare professional with a postgraduate certificate in the performance and interpretation of obstetric ultrasound examinations.

Commissioners should specify that the multidisciplinary team coordinate clinical care for women with twin and triplet pregnancies to minimise the number of hospital visits, provide care as close to the woman's home as possible and provide continuity of care within and between hospitals and the community. The community includes GPs within primary care and community midwives and health visitors. It may be appropriate, for example, for the core team to refer women to the community midwifery team for some of her additional antenatal appointments.

If a multidisciplinary core team can be established using current resources then it is unlikely that there will be significant cost implications as a result of implementing this quality statement. However, because there are relatively few multiple pregnancies each year, staff at some hospitals may have little experience of multiple pregnancies. Therefore training may be needed, which could have some resource implications.

Commissioners may find it helpful to refer to the NICE 'Do not Do' recommendation for NICE clinical guideline 129 (recommendation1.2.3.2):

- Referrals to the enhanced team should not be made routinely for women with twin and triplet pregnancies but should be based on each woman's needs.

4.3 Care planning

Quality statement 4: Care planning

Women with a multiple pregnancy have a care plan that specifies the timing of appointments with the multidisciplinary core team appropriate for the chorionicity and amnionicity of their pregnancy.

Quality statement 5: Monitoring for fetal complications

Women with a multiple pregnancy are monitored for fetal complications according to the chorionicity and amnionicity of their pregnancy.

Multiple pregnancies are associated with an increased risk of fetal complications. For example, there is greater risk of feto-fetal transfusion syndrome with monochorionic multiple pregnancies, and intrauterine growth restriction is more likely to occur in monochorionic and dichorionic multiple pregnancies[14]. Commissioners need to ensure that service providers develop care plans for women with a multiple pregnancy and that care plans specify the timing of appointments with the multidisciplinary core team appropriate for the chorionicity and amnionicity of their pregnancy and any associated risk factors or complications. Care pathways for managing multiple pregnancies need to be in place to enable the development of care plans which are appropriate for the chorionicity of women's pregnancies (NICE clinical guideline 129 recommendation 1.1.2.11 [key priority for implementation]).

Women with a multiple pregnancy should have most of their antenatal appointments with a member of the multidisciplinary core team[15] and they should have a record of the expected number of antenatal appointments they should receive, who they should have them with and where they will take place. Commissioners may want to seek assurance that providers are adhering to recommendations for the specialist care of women with a multiple pregnancy as defined in NICE clinical guideline 129, section 1.2.3 (recommendations 1.2.3.5, 1.2.3.6, 1.2.3.7 and 1.2.3.8). Commissioners may also find it helpful to refer to the Schedule of specialist antenatal appointments in NICE clinical guideline 129[16].

Commissioners need to ensure that the multidisciplinary team are monitoring monochorionic and dichorionic pregnancies closely for fetal complications in

[14] A difference in size of 25% or more between twins or triplets is a clinically significant indicator of fetal growth restriction.

[15] Women may be seen for additional antenatal appointments in the community with healthcare professionals outside of the multidisciplinary core team, such as neonatal unit staff, community midwives and GPs. The scheduling of these appointments will be coordinated by the multidisciplinary core team.

[16] Table 5.8 in the full guideline on multiple pregnancy shows a comparison of the schedule of appointments for women with singleton pregnancies and women with multiple pregnancies.

line with NICE clinical guideline 129 (recommendations 1.3.4.2, 1.3.4.3 and 1.3.5.2), in order to manage them effectively should they arise.

Depending on current local practice, an increase in the number of women who have a care plan which specifies the timing of appointments appropriate for the chorionicity and amnionicity of their pregnancy, may lead to an increased number of antenatal appointments and specialist care. This may also be the case when aiming to monitor women with a multiple pregnancy for fetal complications according to the chorionicity and amnionicity of their pregnancy. However, careful and individual care planning in line with recommendations could result in women having fewer appointments and still receiving effective and high quality of care. Under the maternity services pathway payment system (in place from April 2013) multiple births will be classed as 'intensive resource' and commissioners will be required to pay the associated single intensive tariff to providers, who will be reimbursed at the appropriate level (£2865 for the antenatal phase for 2013/14). These statements are not therefore anticipated to lead to a significant change in the use of NHS resources.

By offering appointments which are appropriate for the chorionicity and amnionicity of the pregnancy and therefore improving the monitoring of women with a multiple pregnancy, earlier identification of risks and complications is possible. This could lead to improved outcomes for women and babies and savings for the NHS.

Relevant data will be collected against NHS outcomes framework 2013/14 indicator 1.6i 'Infant mortality', indicator 1.6ii 'Neonatal mortality and stillbirths and indicator 4.5 'Women's experience of maternity services'. Data will also be collected against the Public health outcomes framework 2013–16 indicator 4.1 'Infant mortality'.

The Care Quality Commission Maternity Services Survey 2010 collected data on singleton and multiple births and included questions related to the number of antenatal appointments and the number of ultrasound scans.

4.4 Indications for seeking a consultant opinion from a tertiary level fetal medicine centre

Quality statement 6:

Women with a higher-risk or complicated multiple pregnancy have a consultant from a tertiary level fetal medicine centre involved in their care.

Commissioners need to commission collaborative care between local services and tertiary level fetal medicine centres[17] to allow access to appropriate knowledge and expertise and tertiary level neonatal and paediatric services when needed. Commissioners may also wish to check that multidisciplinary core teams caring for women with a multiple pregnancy are involving consultants from tertiary level fetal medicine centres for higher risk[18] pregnancies or if there are complications[19], in line with NICE clinical guideline 129 recommendations 1.6.1.1 and 1.3.2.6, and referral advice recommendation (recommendation 1.6.1.1).

Commissioners need to ensure that care pathways are in place that enable care to be delivered locally where possible in collaboration with tertiary level fetal medicine centres to minimise inconvenience and anxiety for women and their partners. But anxiety caused by travelling further for an appointment needs to be weighed against the anxiety of an unclear diagnosis or prognosis. Commissioners should note that a consultant can be involved either by giving an opinion on planning and managing women's care, and that discussion being recorded in the woman's notes, or by referring women with a higher-risk or complicated multiple pregnancy to a tertiary level fetal medicine centre. The

[17] A regionally commissioned centre with the experience and expertise for managing complicated twin and triplet pregnancies.

[18] Higher risk multiple pregnancies are defined as monochorionic monoamniotic twin pregnancies, monochorionic monoamniotic triplet pregnancies, monochorionic diamniotic triplet pregnancies and dichorionic diamniotic triplet pregnancies.

[19] Complicated multiple pregnancies are defined as those with discordant fetal growth, fetal anomaly, discordant fetal death and feto-fetal transfusion syndrome.

latter could have a resource impact for providers because the number of referrals to specialist fetal medicine consultants may increase. However, due to the relatively small numbers involved, the impact is not expected to be significant. Specialist fetal medicine services are commissioned by NHS England. Conversely, there may be an impact on NHS resources if appropriate referrals are not made and complications arise for women and their babies.

Costs incurred by CCG commissioners should not be affected by this quality statement, because of the maternity services pathway payment system in place from April 2013.

Commissioners can use the Maternity services secondary uses data set, which will collect data on 'neonatal death' (global number 17209680) once implemented[20].

Mothers and Babies: Reducing risk through audits and confidential enquiries across the UK (MBRRACE-UK) collects data on 'all deaths of pregnant women and women up to one year following the end of the pregnancy' and, 'neonatal deaths'.

Commissioners may also find it helpful to refer to NICE Referral advice recommendations for NICE clinical guideline 129 (recommendations 1.3.2.6 and 1.3.5.2) [21].

[20] 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

[21] The NICE 'referral advice' recommendations database contains current referral advice from NICE clinical guidelines.

4.5 Preparation for preterm birth

Quality statement 7: Advice and preparation for preterm birth

Women with a multiple pregnancy have a discussion by 24 weeks with one or more members of the multidisciplinary core team about the risks, signs and symptoms of preterm labour and possible outcomes of preterm birth.

Quality statement 8: Preparation for birth

Women with a multiple pregnancy have a discussion by 32 weeks with one or more members of the multidisciplinary core team about the timing of birth and possible modes of delivery so that a birth plan can be agreed.

The multidisciplinary core team have expert knowledge in managing multiple pregnancies. Women with a multiple pregnancy are at increased risk of maternal and fetal complications in pregnancy, and the risk of preterm birth is higher in multiple pregnancies (most women with multiple pregnancies deliver by 37 weeks either spontaneously or electively). About 60% of twins are delivered by 37 weeks and 10% before 32 weeks gestation. 75% of triplets are delivered by 35 weeks.

So that women with a multiple pregnancy feel prepared, and know what to expect and who to contact quickly if symptoms of preterm labour arise[22], commissioners need to ensure that the multidisciplinary team responsible for the specialist care of women:

- have a discussion by 24 weeks with women about risks, signs and symptoms of preterm labour and possible outcomes of pre-term birth in line with NICE clinical guideline 129 (recommendations 1.2.3.4 [key priority for implementation] and 1.7.1.4).

[22] The signs and symptoms of preterm labour include more frequent and regular contractions, ruptured membranes, unusual or severe back ache or other pain.

- have a discussion by 32 weeks with women about the timing of birth and possible modes of delivery in order to agree their birth plan in line with NICE clinical guideline 129 (recommendations 1.7.1.1–1.7.1.8).

Commissioners need to ensure that multidisciplinary teams are providing information to women who are advised to have a vaginal delivery or a caesarean section, to allow them to make an informed decision. They should also be informing women that a preterm birth is associated with an increased risk of admission to a neonatal unit, providing appropriate information about neonatal services, and if possible involving staff from the neonatal unit in the discussion.

Significant additional costs are not anticipated as a result of these quality statements since discussions are expected to take place in existing antenatal appointments.

Commissioners can refer to The Health and Social Care Information Centre (2011) Maternity Statistics – 2010-2011 for complications during non-delivery obstetric episodes, 2010-11 (table 24) and singleton, twin and higher order multiple deliveries by gestation and birth status, 2010-11 (table 26).

The Maternity Services Secondary Uses Dataset, once implemented, will also collect data on 'delivery method' (global number 2016160) and 'gestational age at birth' (global number 17206120).

Commissioners may also find it helpful to refer to The Clinical Negligence Scheme for Trusts (CNST) Maternity Standards, which includes requirements for services to have discussions on timing and mode of birth. The Care Quality Commission Maternity Services Survey 2010 also collected data on singleton and multiple births.

Commissioners may find it helpful to refer to Referral advice recommendation for NICE clinical guideline 129 (recommendation 1.7.1.9)[23].

[23] The NICE 'referral advice' recommendations database contains referral advice from NICE clinical guidelines.

5 Other useful resources

5.1 Useful resources

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

5.2 NICE implementation support

- Multiple pregnancy. NICE electronic audit tools (2011).
- Multiple pregnancy. NICE costing report (2011).
- Multiple pregnancy. NICE costing template (2011).
- Multiple pregnancy. NICE implementation advice (2011).
- Multiple pregnancy. NICE slide set (2011).
- Pregnancy and complex social factors. NICE clinical guideline 110 implementation tools and resources (2010).
- Antenatal care. NICE clinical guideline 62 implementation tools and resources (2008).

5.3 NICE pathways

- Patient experience in adult NHS Services (2012).
- Pregnancy and complex social factors (2012).
- Antenatal care (2011).