NICE National Institute for Health and Care Excellence

NICE quality standard

Intrapartum care

Quality standard

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Contents

This standard is based on CG190, CG62 and NG4.

This standard should be read in conjunction with QS75, QS69, QS57, QS46, QS35, QS22, QS15, QS4, QS60 and QS32.

Introduction

This quality standard covers the care of women who go into labour at term (37^{+0} weeks to 41^{+6} weeks) and their babies during labour and immediately after the birth. It covers both women who go into labour at low risk of intrapartum complications and women who go on to develop complications.

A NICE guideline on the intrapartum care of women at high risk of complications is under development and is due to be published in 2017. When that guideline is published, this quality standard will be updated to include prioritised quality statements for the intrapartum care of women at high risk of complications.

For more information see the intrapartum care topic overview.

Why this quality standard is needed

Around 700,000 women give birth in England and Wales each year, of whom about 40% are having their first baby. Most of these women have a straightforward pregnancy and birth.

It is important that a woman is given information and advice about all available birth settings when she is deciding where to have her baby, so that she can make a fully informed decision. This includes information about outcomes for the different settings.

Uncertainty and inconsistency of care for women giving birth have been identified in a number of areas, such as choosing place of birth, care during the latent first stage of labour, fetal assessment and monitoring during labour (particularly cardiotocography compared with intermittent auscultation) and management of the third stage of labour.

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

- maternal mortality and morbidity

- neonatal mortality and morbidity
- breastfeeding uptake
- positive experience of and satisfaction with care
- treating and caring for people in a safe environment and protecting them from avoidable harm.

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measurable improvements in the 3 dimensions of quality – patient safety, patient experience and clinical effectiveness – for a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 2 outcomes frameworks published by the Department of Health:

- NHS Outcomes Framework 2015–16
- Public Health Outcomes Framework 2013–16.

Tables 1 and 2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 NHS Outcomes Framework 2015–16

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	*Overarching indicator* 1a Potential years of life lost (PYLL) from causes considered amenable to healthcare i Adults ii Children and young people 1c Neonatal mortality and stillbirths *Improvement areas* **Reducing deaths in babies and young children** 1.6i Infant mortality (Public Health Outcomes Framework 4.1*)

4 Ensuring that people have a positive experience of care	*Overarching indicators* 4b Patient experience of hospital care *Improvement areas* **Improving hospitals' responsiveness to personal needs** 4.2 Responsiveness to in-patients' personal needs **Improving women and their families' experience of maternity services** 4.5 Women's experience of maternity services
5 Treating and caring for people in a safe environment and protecting them from avoidable harm	*Overarching indicators* 5a (previously 5c) Deaths attributable to problems in healthcare 5b Severe harm attributable to problems in healthcare *Improvement areas* **Improving the safety of maternity services** 5.5 Admission of full-term babies to neonatal care (definition and quality statement amended)
Alignment across the health and social care system * Indicator is shared	

Table 2 Public health outcomes framework for England, 2013–16

Domain	Objectives and indicators
2 Health improvement	*Objective* People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities *Indicators* 2.2 Breastfeeding

4 Healthcare public health and preventing premature mortality	*Objective* Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities. *Indicators* 4.1 Infant mortality* 4.3 Mortality rate from causes considered preventable**
Alignment with NHS Outcomes Framework * Indicator is shared ** Indicator is complementary	

Patient experience and safety issues

Ensuring that care is safe and that people have a positive experience of care is vital in a high-quality service. It is important to consider these factors when planning and delivering services relevant to intrapartum care.

NICE has developed guidance and an associated quality standard on patient experience in adult NHS services (see the NICE pathway on patient experience in adult NHS services), which should be considered alongside this quality standard. They specify that people receiving care should be treated with dignity, have opportunities to discuss their preferences, and are supported to understand their options and make fully informed decisions. They also cover the provision of information to patients and service users. Quality statements on these aspects of patient experience are not usually included in topic-specific quality standards. However, recommendations in the development sources for quality standards that affect patient experience and are specific to the topic are considered during quality statement development.

Coordinated services

The quality standard for intrapartum care specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole maternity care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to women in labour.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to

secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality intrapartum care service are listed in related quality standards.

Training and competencies

The quality standard should be read in the context of national and local guidelines on training and competencies. All healthcare professionals involved in assessing, caring for and treating women during labour should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard. Quality statements on staff training and competency are not usually included in quality standards. However, recommendations in the development source(s) on specific types of training for the topic that exceed standard professional training are considered during quality statement development.

Role of families and carers

Quality standards recognise the important role families and carers have in supporting women in labour. If appropriate, healthcare professionals should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care.

List of quality statements

Statement 1. Women at low risk of complications during labour are given the choice of all 4 birth settings and information about local birth outcomes.

Statement 2. Women in established labour have one-to-one care and support from an assigned midwife.

Statement 3. Women at low risk of complications do not have cardiotocography as part of the initial assessment of labour.

Statement 4. Women at low risk of complications who have cardiotocography because of concern arising from intermittent auscultation have the cardiotocograph removed if the trace is normal for 20 minutes.

Statement 5. Women at low risk of complications are not offered amniotomy or oxytocin if labour is progressing normally.

Statement 6. Women do not have the cord clamped earlier than 1 minute after the birth unless there is concern about cord integrity or the baby's heartbeat.

Statement 7. Women have skin-to-skin contact with their babies after the birth.

Quality statement 1: Choosing birth setting

Quality statement

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

Rationale

Women at low risk of complications during labour and birth need information that is specific to their local or neighbouring area about safety and outcomes for women and babies in the different birth settings. This information will help women to make informed choices about where to have their baby.

Quality measures

Structure

a) Evidence of local arrangements to provide women at low risk of complications with a choice of all 4 birth settings.

Data source: Local data collection.

b) Evidence of local arrangements to provide women at low risk of complications with local information about birth outcomes.

Data source: Local data collection.

Process

a) Proportion of women at low risk of complications with a recorded discussion at their antenatal booking appointment of their preferred choice of birth setting.

Numerator – The number in the denominator with a recorded discussion at their antenatal booking appointment of their preferred choice of birth setting.

Denominator – The number of women at low risk of complications attending an antenatal booking appointment.

Data source: Local data collection.

b) Proportion of women at low risk of complications with a recorded discussion at their antenatal booking appointment about local birth outcomes.

Numerator – The number in the denominator with a recorded discussion at their antenatal booking appointment about local birth outcomes.

Denominator – The number of women at low risk of complications attending an antenatal booking appointment.

Outcome

Maternal experience and satisfaction with place of birth.

*Data source:*Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (community, primary and secondary care services) raise awareness of maternity pathways and ensure that systems and tools are in place to offer women at low risk of complications a choice of all 4 birth settings and local information about birth outcomes to support them to make informed decisions about where to have their baby.

Healthcare professionals provide women at low risk of complications with local information about birth outcomes and rates of transfer to an obstetric unit for all birth settings, and support them to make informed decisions about where to have their baby. Healthcare professionals can adapt and use NICE's choosing place of birth resource for midwives to do this.

Commissioners (clinical commissioning groups) commission maternity services to ensure that all 4 birth settings are available in the local or a neighbouring area to women at low risk of complications. Commissioners also ensure that services provide local information about outcomes for women and babies and rates of transfer to an obstetric unit for all birth settings to support women to make informed decisions about where to have their baby. Commissioners coordinate collection of outcome data in local and neighbouring areas to help service providers and healthcare professionals giving information to women. Commissioners can refer to the costing statement for

the intrapartum care guideline for more information about the likely resource impact of this quality statement, which will depend on local circumstances.

What the quality statement means for women and their companions

Women at low risk of having problems during labour and birth have a choice of 4 places where they can have their baby – at home, in a midwife-led unit that is either next to a hospital obstetric unit or in a different place, or in an obstetric unit ('labour ward'). To help women make an informed choice, they are given information by their midwife about birth outcomes and rates of transfer to an obstetric unit for their local or neighbouring area. Birth outcomes are things like the chances of needing a ventouse or forceps birth, caesarean section or episiotomy, and the risk of serious medical problems for the baby.

Source guidance

- Intrapartum care (2014) NICE guideline CG190, recommendations 1.1.2 (key priority for implementation), 1.1.3 and 1.1.6 (key priority for implementation)
- Antenatal care (2008) NICE guideline CG62, recommendation 1.1.1.1

Definitions of terms used in this quality statement

4 birth settings

The 4 settings where a woman at low risk of complications may choose to have her baby are: at home, in a freestanding midwifery unit, in an alongside midwifery unit and in an obstetric unit.

[Intrapartum care (NICE guideline CG190) recommendation 1.1.2]

Birth outcomes

Outcomes for women for each planned place of birth include rates of spontaneous vaginal birth, transfer to obstetric unit, obstetric intervention and delivering a baby with or without serious medical problems.

[Adapted from intrapartum care (NICE guideline CG190) recommendation 1.1.3]

Quality statement 2: One-to-one care

Quality statement

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

Rationale

One-to-one care will increase the likelihood of the woman having a 'normal' vaginal birth without interventions, and will contribute to reducing both the length of labour and the number of operative deliveries. Care will not necessarily be given by the same midwife for the whole labour.

Quality measures

Structure

Evidence of midwifery staff available to provide one-to-one care to women in established labour in each birth setting.

Data source: Local data collection.

Process

Midwifery staffing levels as in the NICE guideline on safe midwifery staffing for maternity settings.

Numerator – The number of women in the denominator who receive one-to-one care from an assigned midwife during established labour.

Denominator – The number of women in established labour in a time period.

Data source: Local data collection.

Outcome

a) Neonatal morbidity.

Data source:Local data collection.

b) Maternal morbidity.

Data source:Local data collection.

c) Maternal satisfaction and experience of care.

Data source:Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (for all 4 birth settings) ensure that recommended midwifery staffing ratios are maintained so that women in established labour have one-to-one care and support from an assigned midwife.

Healthcare professionals (assigned midwives) give one-to-one care to each woman in established labour and are solely dedicated to the care of that woman.

Commissioners (clinical commissioning groups) commission services that have systems in place to maintain recommended midwifery staffing ratios, so that women in established labour have one-to-one care and support from an assigned midwife. Commissioners can refer to the costing statement for the intrapartum care guideline for more information about the likely resource impact of this quality statement, which will depend on local circumstances.

What the quality statement means for women and their companions

A woman in labour is cared for by a midwife who is looking after just her – this is called 'one-to-one care'. She might not have the same midwife for the whole of labour. One-to-one care aims to ensure that the woman has a good experience of care and reduces the likelihood of problems for her and her baby.

Source guidance

- Intrapartum care (2014) NICE guideline CG190, recommendation 1.7.1 (key priority for implementation)
- Safe midwifery staffing for maternity settings (2015) NICE guideline NG4, recommendation 1.2.2

Definitions of terms used in this quality statement

Established labour

Labour is established when:

- there are regular painful contractions **and**
- there is progressive cervical dilatation from 4 cm.

[Intrapartum care (NICE guideline CG190) recommendation 1.3.1]

Quality statement 3: Cardiotocography and the initial assessment of a woman in labour

Quality statement

Women at low risk of complications do not have cardiotocography as part of the initial assessment of labour.

Rationale

Cardiotocography is not appropriate in the initial assessment of women at low risk of complications who are in labour. This is because it may lead to unnecessary interventions and does not provide any benefit to the baby.

Quality measures

Structure

Evidence of local arrangements to ensure that cardiotocography is not used in the initial assessment of women at low risk of complications who are in labour.

Data source: Local data collection.

Process

Proportion of women at low risk of complications in labour who have cardiotocography as part of the initial assessment.

Numerator – The number in the denominator who have cardiotocography as part of the initial assessment.

Denominator – The number of initial assessments of women at low risk of complications in labour.

Data source: Local data collection.

Outcome

Women having cardiotocography in the initial assessment of labour.

Data source:Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (for freestanding midwifery units, alongside midwifery units and obstetric units) have protocols in place to ensure that cardiotocography is not used in the initial assessment of women at low risk of complications who are in labour.

Healthcare professionals (midwives and obstetricians) do not use cardiotocography in the initial assessment of women at low risk of complications who are in labour.

Commissioners (clinical commissioning groups) specify and check that providers do not use cardiotocography in the initial assessment of women at low risk of complications who are in labour.

What the quality statement means for women and their companions

Women who are at low risk of having problems during labour do not have electronic monitoring of the baby's heartbeat (that is, being connected to a monitor) as part of the first checks when they go into labour.

Source guidance

- Intrapartum care (2014) NICE guideline CG190, recommendation 1.4.10

Definitions of terms used in this quality statement

Established labour

Labour is established when:

- there are regular painful contractions **and**
- there is progressive cervical dilatation from 4 cm.

[Intrapartum care (NICE guideline CG190) recommendation 1.3.1]

Quality statement 4: Stopping cardiotocography

Quality statement

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

Rationale

Cardiotocography is offered to women if intermittent auscultation indicates possible fetal heart rate abnormalities. However, cardiotocography that is started for this reason should be stopped if the trace is normal for 20 minutes, because it restricts the woman's movement and can cause labour to slow down. This can lead to a cascade of interventions that may result in adverse birth outcomes.

Quality measures

Structure

Evidence of local arrangements to ensure that women at low risk of complications having cardiotocography because of concern arising from intermittent auscultation have the cardiotocograph removed if the trace is normal for 20 minutes.

Data source: Local data collection.

Process

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

Numerator – The number in the denominator who have the cardiotocograph removed.

Denominator – The number of women in labour at low risk of complications who have cardiotocography because of concern arising from intermittent auscultation and who have a normal trace for 20 minutes.

Data source: Local data collection.

Outcome

Maternal satisfaction and experience of care.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners.

Service providers (for freestanding midwifery units, alongside midwifery units and obstetric units) have evidence of local arrangements to ensure that protocols are in place so that women in labour at low risk of complications who have cardiotocography because of concern arising from intermittent auscultation have the cardiotocograph removed if the trace is normal for 20 minutes.

Healthcare professionals (midwives and obstetricians) remove the cardiotocograph if the trace is normal for 20 minutes for women at low risk of complications who have cardiotocography because of concern arising from intermittent auscultation.

Commissioners (clinical commissioning groups) specify and check that service providers have protocols in place to ensure that women in labour at low risk of complications who have cardiotocography because of concern arising from intermittent auscultation have the cardiotocograph removed if the trace is normal for 20 minutes.

What the quality statement means for women and their companions

Women who are at low risk of problems during labour, but who have electronic monitoring because of possible concerns about the baby's heartbeat, are taken off the monitor if the baby's heartbeat is normal for 20 minutes.

Source guidance

- Intrapartum care (2014) NICE guideline CG190, recommendations 1.4.12 and 1.10.7

Definitions of terms used in this quality statement

Normal cardiotocograph trace

A normal trace has the following normal/reassuring features:

- baseline fetal heart rate of 100 to 160 beats per minute **and**
- baseline variability of 5 beats per minute or more **and**
- no or early decelerations.

[Intrapartum care (NICE guideline CG190) table 10]

Quality statement 5: Interventions during labour

Quality statement

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

Rationale

For women at low risk of complications, amniotomy and oxytocin do not reduce the incidence of caesarean section, increase the incidence of spontaneous vaginal births or contribute to improved neonatal outcomes. They are therefore unnecessary for women at low risk of complications if labour is progressing normally.

Quality measures

Structure

Evidence of local arrangements to ensure that women at low risk of complications who are in labour that is progressing normally do not have amniotomy or oxytocin.

Data source: Local data collection.

Process

Proportion of women at low risk of complications whose labour is progressing normally who do not have amniotomy or oxytocin.

Numerator – The number in the denominator who do not have amniotomy or oxytocin.

Denominator – The number of women at low risk of complications whose labour is progressing normally.

Data source: Local data collection.

Outcome

a) The number of women in labour that is progressing normally having amniotomy or oxytocin.

Data source:Local data collection.

b) Maternal satisfaction and experience of care.

Data source:Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (for all 4 birth settings) have protocols in place to ensure that women at low risk of complications whose labour is progressing normally are not offered amniotomy or oxytocin.

Healthcare professionals (midwives and obstetricians) do not offer amniotomy or oxytocin to women at low risk of complications whose labour is progressing normally.

Commissioners (clinical commissioning groups) specify and check that service providers have protocols in place to ensure that women at low risk of complications whose labour is progressing normally are not offered amniotomy or oxytocin.

What the quality statement means for women and their companions

Women who are at low risk of having problems and whose labour is progressing normally are not offered amniotomy (having their waters broken) or oxytocin (a medicine given through a drip that speeds up labour).

Source guidance

- Intrapartum care (2014) NICE guideline CG190, recommendations 1.12.11 and 1.12.12

Definitions of terms used in this quality statement

Normal labour and normal progression of labour

The NICE full guideline on intrapartum care adopts the World Health Organization definition of a normal labour: 'labour is normal when it is spontaneous in onset, low risk at the start and remaining so throughout labour and birth. The baby is born spontaneously and in the vertex position between 37–42 completed weeks of pregnancy. After birth woman and baby are in good condition'.

Quality statement 6: Delayed cord clamping

Quality statement

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

Rationale

The benefits of delayed cord clamping include higher haemoglobin concentrations, a decreased risk of iron deficiency and greater vascular stability in babies. If they wish, women can ask healthcare professionals to wait longer to clamp the cord.

Quality measures

Structure

Evidence of local arrangements to ensure that midwives and obstetricians do not clamp the cord earlier than 1 minute after the birth unless there is a concern about cord integrity or the baby's heartbeat.

Data source: Local data collection.

Process

a) Proportion of cords clamped earlier than 1 minute after the birth where there is not a concern about cord integrity or the baby's heartbeat.

Numerator – The number in the denominator where the cord is clamped after 1 minute after the birth.

Denominator – The number of babies born where there is no concern about cord integrity or the baby's heartbeat.

b) Proportion of cords clamped earlier than 1 minute where there is a concern about cord integrity or the baby's heartbeat.

Numerator – The number in the denominator where the cord is clamped earlier than 1 minute after the birth.

Denominator – the number of babies born where there is a concern about cord integrity or the baby's heartbeat.

Data source: Local data collection.

Outcome

Maternal satisfaction and experience of care.

*Data source:*Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (for all 4 birth settings) have protocols in place to ensure that the cord is not clamped earlier than 1 minute after the birth unless there is concern about cord integrity or the baby's heartbeat.

Healthcare professionals (midwives and obstetricians) do not clamp the cord earlier than 1 minute after the birth unless there is concern about cord integrity or the baby's heartbeat.

Commissioners (clinical commissioning groups) specify and check that service providers have protocols in place to ensure that the cord is not clamped earlier than 1 minute after the birth unless there is a concern about cord integrity or the baby's heartbeat.

What the quality statement means for women and their companions

Women who have just given birth do not have the cord clamped for at least 1 minute after the birth unless there are concerns about the baby. This is to allow more blood to reach the baby and may help to prevent anaemia.

Source guidance

- Intrapartum care (2014) NICE guideline CG190, recommendation 1.14.14 (key priority for implementation)

Definitions of terms used in this quality statement

Cord integrity

Concerns would arise over cord integrity if the cord was damaged in any way, if it had snapped during delivery or if there was bleeding to the cord. Definitions of cord integrity are not limited to those stated here.

[Expert opinion]

Concern about the baby's heartbeat

Concern would arise if, after delivery, the baby has a heartbeat below 60 beats/minute that is not getting faster.

[Adapted from intrapartum care (NICE guideline CG190), recommendation 1.14.14]

Quality statement 7: Skin-to-skin contact

Quality statement

Women have skin-to-skin contact with their babies after the birth.

Rationale

Skin-to-skin contact with babies soon after birth has been shown to promote the initiation of breastfeeding and protect against the negative effects of mother–baby separation.

Quality measures

Structure

Evidence of local arrangements to ensure that midwives and obstetricians encourage women to have skin-to-skin contact with their babies after the birth.

Data source: Local data collection.

Process

Proportion of women with a record of having skin-to-skin contact with their babies after the birth[1].

Numerator – The number in the denominator where there is a record of the woman having skin-to-skin contact with the baby.

Denominator – The number of babies born.

Data source: Local data collection.

Outcome

Women's satisfaction with the support received to have skin-to-skin contact with their babies after the birth.

Data source:Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (for all 4 birth settings) have protocols in place for midwives and obstetricians to encourage women to have skin-to-skin contact with their babies as soon as possible after the birth.

Healthcare professionals (midwives and obstetricians) encourage women to have skin-to-skin contact with their babies as soon as possible after the birth.

Commissioners (clinical commissioning groups) specify and check that service providers have protocols in place to ensure that women are encouraged to have skin-to-skin contact with their babies as soon as possible after the birth.

What the quality statement means for women and their companions

Women are encouraged to have skin-to-skin contact with their babies as soon as possible after the birth.

Source guidance

- Intrapartum care (2014) NICE guideline CG190, recommendation 1.15.6

[1] It is important that this happens as soon as possible, but timescales should be determined locally, depending on the setting and whether the baby and mother are stable.

Using the quality standard

Quality measures

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

We have indicated if current national indicators exist that could be used to measure the quality statements. These include indicators developed by the Health and Social Care Information Centre through its Indicators for Quality Improvement Programme. If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

See NICE's what makes up a NICE quality standard? for further information, including advice on using quality measures.

Levels of achievement

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, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

Using other national guidance and policy documents

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered alongside the documents listed in development sources.

Diversity, equality and language

During the development of this quality standard, equality issues have been considered and equality assessments are available.

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

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.

Development sources

Further explanation of the methodology used can be found in the quality standards process guide.

Evidence sources

The documents below contain recommendations from NICE guidance or other NICE-accredited recommendations that were used by the Quality Standards Advisory Committee to develop the quality standard statements and measures.

- Safe midwifery staffing for maternity settings (2015) NICE guideline NG4
- Intrapartum care (2014) NICE guideline CG190
- Antenatal care (2008) NICE guideline CG62

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

- Royal College of Paediatrics and Child Health (2014) National neonatal audit programme annual report 2013
- National Audit Office (2013) Maternity services in England
- Royal College of Anaesthetists (2012) Raising the standard: a compendium of audit recipes (section 8: obstetrics)
- Healthcare Commission (2008) Towards better births: a review of maternity services in England
- National Audit Office (2007) Caring for vulnerable babies: the reorganisation of neonatal services in England
- Centre for Maternal and Child Enquiries (2006–2012) Child death review, maternal deaths and perinatal mortality

Definitions and data sources for the quality measures

- Health and Social Care Information Centre (2013) Maternal mortality indicator portal

- Health and Social Care Information Centre (2013) Perinatal mortality indicator portal

Related NICE quality standards

Published

- Neonatal infection (2014) NICE quality standard 75
- Ectopic pregnancy and miscarriage (2014) NICE quality standard 69
- Inducing labour (2014) NICE quality standard 60
- Jaundice in newborn babies under 28 days (2014) NICE quality standard 57
- Multiple pregnancy: twin and triplet pregnancies (2013) NICE quality standard 46
- Hypertension in pregnancy (2013) NICE quality standard 35
- Caesarean section (2013) NICE quality standard 32
- Antenatal care (2012) NICE quality standard 22
- Patient experience in adult NHS services (2012) NICE quality standard 15
- Neonatal specialist care (2010) NICE quality standard 4

In development

- Diabetes in pregnancy. Publication expected January 2016
- Preterm labour and birth. Publication expected October 2016
- Antenatal and postnatal mental health. Publication date to be confirmed

The full list of quality standard topics referred to NICE is available from the quality standards topic library on the NICE website.

Quality Standards Advisory Committee and NICE project team

Quality Standards Advisory Committee

This quality standard has been developed by Quality Standards Advisory Committee 2. Membership of this committee is as follows:

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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.

The methods and processes for developing NICE quality standards are described in the quality standards process guide.

This quality standard has been incorporated into the NICE pathway on intrapartum care.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

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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.

- Royal College of General Practitioners
- Royal College of Midwives
- Royal College of Obstetricians and Gynaecologists