New NICE Quality Standard Reinforces Support for Maternal Request Caesareans and Mothers' Satisfaction with Maternity Care

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Following the National Institute for Health and Care Excellence (NICE)'s publication of its Caesarean Section Guideline (update) in November 2011, which recommended ultimate support for women who choose to plan a caesarean birth without any clinical indication, and highlighted a cost difference of just £84 with planned vaginal birth when the adverse outcome of urinary incontinence was considered,[1] **electivecesarean.com** welcomes NICE's Quality Standard for Caesarean Section, and hopes that it results in greater adherence by hospitals and health professionals to its 2011 caesarean recommendations.

It is this organisation's experience, through communication with parents, midwives, doctors and hospital trusts, that arbitrary refusal of maternal request planned (primary and repeat) caesareans continues to occur, and more widely, that women without a personal preference for any particular birth plan are being encouraged to focus on the benefits of planned vaginal delivery and the risks of planned caesarean – with the emphasis on reducing overall caesarean rates and increasing rates of 'normal birth' – rather than being provided with balanced information and an evidence-based assessment of their individual risk factors associated with a trial of labour.

WHAT IS MOST WELCOME FROM THE QUALITY STATEMENTS

· Overview: "*A person-centred approach to provision of services is fundamental…*"

· QS 2 Maternal request for a caesarean section: maternity team involvement: "*The purpose of this statement is to inform decisions about the planned mode of birth. It is important that the woman can talk to the most relevant member of the maternity team… 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.* Outcome measure: "*Women's satisfaction with the process of discussing options with the maternity team.*" Definitions: "*The core membership of the maternity team should include a midwife, an obstetrician and an anaesthetist.*"

· QS 1 VBAC: "*Pregnant women who have had 1 or more previous caesarean section have a documented discussion of the option to plan a vaginal birth.*" (i.e. it is **not compulsory**)

· Q 4 Definitions. Pregnant women who may require a planned caesarean section have consultant involvement in decision-making: This includes both women who have clinical indications… and women who request a caesarean section when there are no clinical indications.

· QS 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

· QS 5 Timing of planned caesarean section: The woman should be given a specific day and time at which the caesarean section will be performed. A model for delivering planned caesarean section is for services to have dedicated planned caesarean section lists. The lists should have protected surgical and anaesthetic time and appropriate staffing to ensure that planned caesarean section are not delayed because of surgical time being prioritised for emergency cases.

· NICE press release: She should also be able to talk to the most relevant member of the maternity team depending on her question or concern at any time during her pregnancy. A consultant should be involved in decisions surrounding caesarean sections because they are best placed to advise about the potential benefits and risks. Quote from Dr Malcolm Griffiths, Consultant Obstetrician and Gynaecologist, Luton and Dunstable Hospital and chair of this QS expert group: "*…Most women want to avoid the major surgery of a caesarean section. However, it is important that the NHS ensures all women can give birth in the most appropriate way for them, and for some women, this will mean having a caesarean section...*"

WHAT WOULD ALSO HAVE BEEN WELCOME IN THE QUALITY STANDARD

· NICE press release: While the number of caesareans "*has gone up dramatically*" in the last 30 years from 9% in 1980 to around 20-25% in 2013 – in 2011, NICE made clear that "*Many of the factors contributing to CS rates are often poorly understood. This guideline has not sought to define acceptable CS rates.*"[1]

Over the same period, rates of infant deaths have decreased significantly. The neonatal mortality rate fell by 62%, from 7.7 deaths per 1,000 live births in 1980 to 2.9 in 2010, and the perinatal mortality rate (which includes stillbirths) fell by 44% from 13.3 deaths per 1,000 total births in 1980 to 7.4 in 2010 (and in October 1992, the legal definition of a stillbirth was changed to include deaths after 24 completed weeks of gestation or more, instead of after 28 completed weeks of gestation or more; therefore improvements in perinatal mortality outcomes may be even greater.)

· QS 9 Outcome: "*Rates of complications in women who have had a caesarean section.*" For this information to be useful, it's essential that type of caesarean is recorded here.

· QS 2 Outcome: "*Women's satisfaction with the process of discussing options with the maternity team.*" Women's satisfaction with actual birth outcome is crucial to record here too (whether she has her maternal request CS or is persuaded to plan a vaginal birth), as is the actual number of maternal request births (so that we finally know this % rate).

[1] CG 132 - http://www.nice.org.uk/nicemedia/live/13620/57162/57162.pdf

"*For women requesting a CS, if after discussion and offer of support (including perinatal mental health support for women with anxiety about childbirth), a vaginal birth is still not an acceptable option, offer a planned CS."*
"*An obstetrician unwilling to perform a CS should refer the woman to an obstetrician who will carry out the CS.*"
"*On balance, this model does not provide strong evidence to refuse a woman's request for CS on cost effectiveness grounds.*" (Health Economics p.100-1 & see p.220 for £84 figure)

Contact for Further Information

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