

1 RCOG Good Practice Paper No. XX

3 Local Adaptation and Implementation of RCOG Green-top Guidelines for UK and Global Practice

5 This is the first edition of this guidance.

7 This guidance is for healthcare professionals who care for women, non-binary and trans people in
8 maternity and gynaecology.

10 Within this document we use the terms woman and women’s health. However, it is important to
11 acknowledge that it is not only women for whom it is necessary to access women’s health and
12 reproductive services in order to maintain their gynaecological health and reproductive wellbeing.
13 Obstetric and gynaecological services and care must therefore be appropriate, inclusive and sensitive
14 to the needs of those individuals whose gender identity does not align with the sex they were
15 assigned at birth.

17 1. Purpose

19 The Royal College of Obstetricians and Gynaecologists (RCOG) produce a series of clinical Green-top
20 Guidelines (GTGs) that provide systematically developed recommendations to assist clinicians in
21 making evidence-based decisions for specific conditions. There is no formal process to be followed
22 when organisations wish to implement a GTG for local use.

24 The aim of this document is to support local adaptation and implementation of GTGs, both across
25 the UK and in global settings, by signposting to the available methodologies and issues in the
26 process, with an applied example included.

28 2. Introduction and background

30 Adapting clinical guidelines to local context is a critical step in guideline implementation. Knowing
31 the local requirements and assessing the value, usefulness and appropriateness of recommendations
32 is critical to guideline uptake and sustained use. Adapting GTGs to fit local circumstances (this may be
33 across the devolved nations or globally) serves not only to increase the relevance and applicability of
34 guidelines, but also gives end-users a sense of ownership. This improves and promotes
35 implementation as opposed to adoption of a guideline without any changes where implementation
36 may prove to be more challenging. However, adaptation of guidelines also runs the risk of deviating
37 from the original evidence base. Consequently, it is important that local adaptation follows a
38 structured, documented process, approved by governance teams and includes an implementation
39 plan developed collaboratively with an education team to ensure medicolegal protection and to
40 maintain alignment with professional standards. In order to address this, several systematic
41 approaches to guideline adaptation have been developed, including RAND/ADAPTE.^{1,2}

43 3. Challenges to implementation of guidelines

45 Nationally, unlike the National Institute for Health and Care Excellence (NICE) guidelines, NHS
46 organisations are not committed to implementing RCOG GTGs. This can lead to lack of intent and
47 support from stakeholders. However, GTGs are widely considered a robust review of evidence and
48 standard of practice. Therefore, while not mandated to do so, stakeholders, especially in the UK, are
49 supportive of implementing GTGs.

51 At the clinician level, it is important that the recommendations are applicable in the context of the
 52 population they serve. Variations in demographics of the population served by trusts/health
 53 boards/integrated care boards (ICBs) may mean that priority is given to different recommendations.
 54 In addition, healthcare provision is devolved for England, Scotland, Wales and Northern Ireland,
 55 which may also impact how recommendations are integrated into the system.

56
 57 Once there is stakeholder and clinician support, the next challenge is the lack of knowledge and
 58 understanding of structured adaption and implementation processes.

59
 60 Internationally, there can be a large variation in terms of the health system, staff and infrastructure
 61 availability, as well as the economic implications of care in different settings. Global burden of
 62 disease among women and children has steadily improved over the last three decades however
 63 there remain large variations in disease burden across the world. Greater burden is noted in low-
 64 income countries with slower pace of decline.³ Various social, cultural and economic factors are
 65 responsible for this inequality. While the GTG may be considered the standard, implementation may
 66 have to be modified to accommodate or circumvent these factors.

67 68 **4. Why should RCOG guidelines be recommended for clinical use?**

69
 70 The guidelines are developed following a rigorous scientific process resulting in a set of clear,
 71 unambiguous recommendations with clear rationales, and supporting evidence and context.

72
 73 The GTG development process is rigorous and reflects aspects of similar guidance produced by NICE.
 74 Scottish Intercollegiate Guidelines Network (SIGN) methodology is used to appraise the evidence in
 75 order to formulate the guideline's recommendations. A new guideline or update of an existing
 76 guideline is commissioned based on the clinical need and the extent of good quality evidence
 77 available to develop recommendations. The developers for individual guidelines are clinicians with
 78 expertise in the field and are supported by the RCOG. The development process includes agreeing
 79 the scope of the guideline, performing a comprehensive literature search and developing successive
 80 drafts to be reviewed by the College's Guidelines Committee. Following comprehensive review by the
 81 Guidelines Committee, expert review and peer review are sought. The whole process is scheduled to
 82 take approximately 3 years (see Appendix I).

83
 84 This is a very resource intensive process involving a multidisciplinary group of clinicians, subject
 85 experts and service users. Adaptation of these guidelines can avoid duplication and reduce the work
 86 involved in developing local guidelines for clinical conditions where a GTG is already available.

87 88 **5. Adaptation or adoption of recommendations?**

89
 90 In the UK, most recommendations are likely to be adopted without change. If there are challenges to
 91 implementation owing to local service needs, the rationale for adaptation should be clearly
 92 documented in accordance with local governance processes. If there are difficulties in adopting
 93 recommendations with high grades of evidence, a framework of adaptation should be considered.

94
 95 Internationally, adaptation is more likely to be needed to complement local service needs. Similarly, a
 96 structured framework or process should be followed.

97
 98 Implementation plans should incorporate the audit of outcomes recommended in the GTG, to
 99 monitor whether adapted guidelines have achieved their intended benefits. The auditable standards
 100 recommended in the GTG are relevant to UK practice. Consequently, international healthcare
 101 facilities should select the outcomes/standards most suitable to their service.

102

103 **6. Adaptation of guidelines for local use**

104

105 While RCOG GTGs are developed with the UK NHS in mind, they are used globally. As they are not
 106 prescriptive protocols, healthcare providers can modify recommendations where necessary, which
 107 leads to increased feasibility and acceptability within their local context. Whether using unchanged
 108 or adapting RCOG GTGs for local use, developers must seek permission in advance to reproduce
 109 RCOG guidance and patient information as outlined fully on the [website](#).⁴ This permission extends to
 110 reproduction of text, algorithms, tables and figures from the guidelines.

111

112 **UK experience**

113

114 There is large variation between hospital trusts/health boards/ICBs in terms of resources,
 115 infrastructure, and organisational processes, which national guidelines are unable to account for.
 116 While many recommendations can be adopted without a change, some may need adaptation.
 117 Depending on the setting if a guideline is not adapted, there is a risk that its recommendations may
 118 be deemed unachievable. Involving local clinicians and service users in the adaptation of the
 119 guideline ensures it is relevant, while supporting clinical engagement and ownership. It is therefore
 120 critical that if local adaptation is undertaken, the guideline remains evidence-based and is practically
 121 acceptable and deliverable, with clear justification for the modifications which have gone through
 122 local governance processes.

123

124 There are a range of approaches employed by UK trusts/health boards/ICBs to adapt GTGs for local
 125 use. Some institutions use frameworks for adaptation, which ensure a consistent, systematic and
 126 replicable process. Others have more informal approaches to adapting guidelines based on
 127 consensus among local guideline developers, senior clinicians and governance teams.

128

129 When a formal approach is planned, there will often be multiprofessional working groups within the
 130 hospital or across regional networks as well as service users that will review national guidance and
 131 identify recommendations that need local modification. Where necessary, additional information
 132 may be added to clarify implementation details, such as local pathways for referral or named
 133 responsibilities for specific items.

134

135 Where an informal approach is taken, a clinician may review national guidance and develop a local
 136 protocol, which may be reviewed by senior clinicians or local governance teams for comments and
 137 modifications prior to approval and ratification. An informal approach is typically quicker and suitable
 138 when minor or no adaptations are required. However, when anticipating major adaptations to the
 139 national guideline, a formal approach is likely to add rigour to the process.

140

141 **International experience**

142

143 Internationally, some countries have comprehensive national guidelines, while many have good
 144 practice recommendations rather than detailed guidelines. Despite the presence of local guidelines,
 145 RCOG GTGs are often referenced and can sometimes be used as a base for local recommendations.
 146 While the GTG is referred to and guides clinical practice, there may be variations in resources that
 147 necessitate modification prior to implementation.

148

149 **6.1 Frameworks**

150

151 There are many frameworks used for systematic adaptation.⁵ Two commonly referenced frameworks
 152 are the RAND consensus method and the ADAPTE framework.^{1,2} RAND is the more traditional

153 method, which uses modified Delphi method for building a consensus. The method relies on
 154 individual scoring of recommendations. The key stages are outlined below:

155

- 156 1. Key stakeholders are identified, and asked to undertake private decision-making on individual
 157 recommendations, often using a questionnaire with Likert scoring, rating their suitability for
 158 implementation in their own setting.
- 159 2. The participants complete these questionnaires prior to a group meeting where they discuss the
 160 scores.
- 161 3. Each point is discussed as a group to adjudicate on any differences, before implementing those
 162 that best fit the local setting.

163

164 More than one cycle of scoring may be needed to reach consensus.

165

166 Presently, the ADAPTE framework is favoured because it involves assessing the quality and
 167 publication date of the original guideline and determining the relevance of recommendations to local
 168 context.² All modifications made are then documented for a clear audit trail. The process consists of
 169 three key phases, outlined in Figure 1, and described as follows.

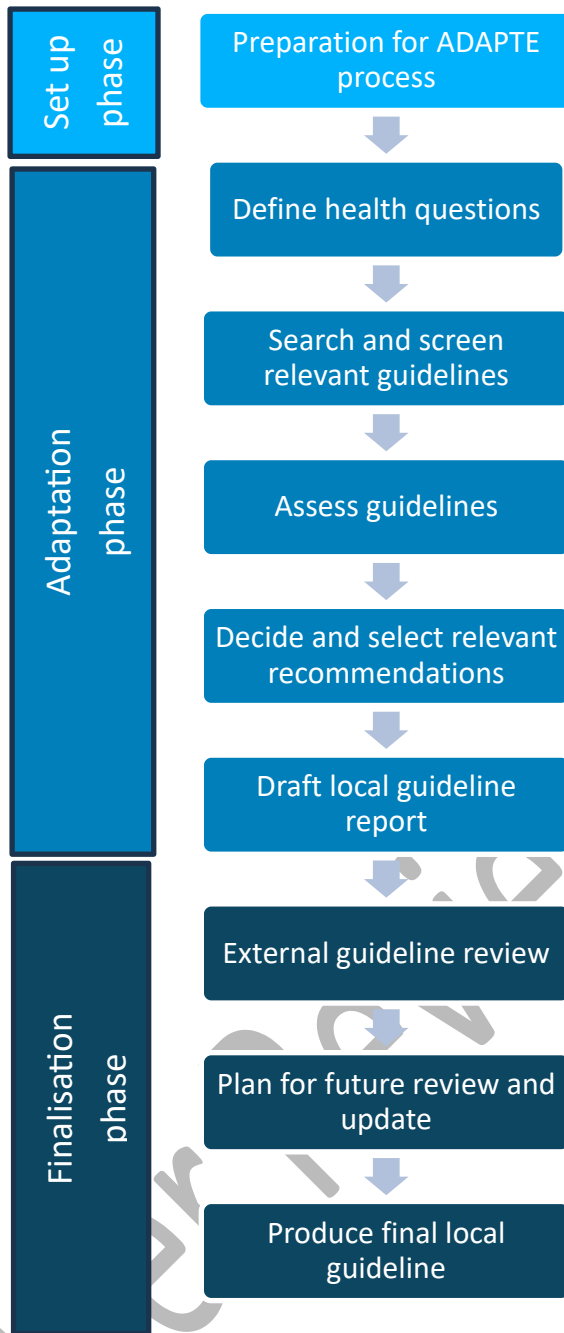
170

Set-up phase	Necessary tasks are outlined prior to beginning the process. This involves identifying necessary skills and resources for the guideline.
Adaptation phase	Authors will identify the specific health question, and search and retrieve all relevant guidelines on the topic. They will then assess the consistency of the evidence and guidelines, before drafting the adapted guideline.
Final phase	Authors obtain feedback on the guideline from multiprofessional stakeholders and occasionally consulting with authors of source. guidelines. They then review and update the guideline accordingly, leading to the creation of the final document.

171

172 **Figure 1.** ADAPTE process (adapted from ADAPTE Guideline adaptation: A Resource Toolkit)²

173



174
175
176
177
178
179
180
181
182
183

6.2 Adaptation framework in practice

When considering a framework suitable for GTG adaptation, the practical application of the framework is outlined below. The framework should be comprehensive in order to support local developers to develop the process. Once the local guideline development process is embedded, it can be replicated. Typically, the set-up phase is well defined in most UK obstetrics and gynaecology units and embedded within the governance framework.

- | |
|---|
| 1. Set up phase – practitioners leading on guideline adaptation are identified and supported. |
| 2. The scope of the local guideline is defined. |
| 3. National/regional guidelines that are applicable to the scope of the local guideline are selected. |

<p>In the UK, the most sourced guidelines are from NICE or RCOG. If more recent international guidance has been published, this may also be considered.</p> <p>Internationally, some countries have national guidelines, but others rely on other reputable sources for robust evidence-based guidelines.</p>
<p>4. Source guidelines are assessed.</p> <ul style="list-style-type: none"> • Is the guideline of high quality from a trustworthy source? • Is the guideline up-to-date?
<p>5. Recommendations relevant to the need of the local guideline are selected.</p> <ul style="list-style-type: none"> • Is the recommendation clear and consistent with the evidence presented? • Is the recommendation based on high grade evidence? Is the evidence graded correctly? • Has there been more recent high quality evidence published?
<p>6. Recommendations are reviewed to decide whether they can be adopted as stated or require adaptation. To make this decision, current local guidance and practices must be compared with the national guideline to identify areas of alignment, partial compliance and gaps, and document reasons for deviation.</p> <p>Factors to be considered when making this decision include:</p> <ul style="list-style-type: none"> • Local population demographics and health needs. • Local resources – in the UK this is often related to the size of the local unit and the staffing levels. Escalation to appropriate grade of clinical staff should be adapted to local staffing. Larger units may have more tiers of resident doctors, while smaller units may have only one tier of resident doctor. Internationally, the personnel in the maternity team may vary. For example, obstetric nurses and birth attendants instead of midwives in UK. • The influence of estates and geography on how a guideline will be adapted. For example, thresholds for escalation in an obstetric emergency in a midwife-led unit (MLU) are likely to be influenced by the distance from the nearest obstetric unit (standalone or co-located MLU). • Variability in terms of the technology and facilities available in different healthcare settings. This variation is likely to be greater in countries outside UK. An example is variation in availability of outpatient hysteroscopy services.
<p>7. Draft guideline is developed. The guideline development should ideally be carried out by a multidisciplinary group. The multidisciplinary group should include representatives from relevant healthcare professionals such as obstetricians, gynaecologists, anaesthetists, radiologists, neonatologists, nurses, midwives and operating theatre staff. Where feasible, it is also important to include the voice of service users, such as support group representatives for specific conditions and maternity and neonatal voices partnership (MNVP) representatives.</p>
<p>8. Draft guideline is reviewed by a multidisciplinary group to ensure that the instructions are unambiguous and can be implemented in clinical setting.</p>
<p>9. Guideline is finalised after considering the review findings.</p>
<p>10. The implementation phase, frequently led by the training and education teams, should commence with a clear plan for future reviews and updates. This will be carried out by local governance teams in the UK.</p>

184
185
186
187

6.3 Challenges of local adaptation

Challenges include:

- 188 • Divergence from the original guideline means that new recommendations may be far from the
189 evidence-based original articles, especially if local constraints lead to significant modifications.
- 190 • Risk of duplication of effort: if multiple hospitals are undertaking similar adaptation at the same
191 time, then economy of effort is wasted, where similar modifications may have been appropriate
192 for trusts/health boards/ICBs in similar positions.
- 193 • A lack of standardised national frameworks mean that local adaptation can be inconsistent in
194 quality and scope, meaning that questions arise over the robustness of the guideline
195 recommendations.
- 196 • A standardised framework is likely to need more time and resources at the beginning. Familiarity
197 with the framework and the national guidelines is likely to reduce the time needed for
198 adaptation. However, low-income countries may not be able to dedicate adequate resources to
199 adaptation and this may have an impact on the rigour of the adaptation process.

200
201 Best practice approaches aim to address these challenges by being transparent, involving
202 stakeholders and clearly documenting the process. Having multiprofessional teams working on
203 guidelines ensures that different perspectives are considered and that local solutions are practical.
204 Clearly documenting all changes promotes accountability and makes auditing easier. Finally, hospitals
205 should be encouraged to incorporate mechanisms for recording implementation and auditable
206 outcomes.

207 208 **7. Implementation of guidelines into practice after local adaptation**

209
210 The implementation of national guidelines requires a structured and collaborative approach,
211 underpinned by a strong governance strategy and involving staff across all disciplines and levels of
212 seniority. Through active staff engagement, systematic outcome monitoring, and a focus on
213 sustained improvement; services can ensure that national standards are adapted and implemented,
214 to ensure safe, high-quality, evidence-based effective care for women and families.

215
216 Although research in this area exists, the evidence base to date offers only limited guidance as to
217 which strategies for guideline dissemination and implementation are the most effective across
218 different organisational structures.^{6,7} However, common themes in the evidence base include the
219 importance of identifying local barriers to implementation, multiprofessional collaboration, piloting
220 initiatives where possible/practical, ensuring accessibility, securing support from all levels of the
221 organisation from management to clinical staff, and the use of multiple modes for dissemination.^{7,8}

222
223 It is also important to acknowledge that while guidelines may have been adapted to a local context,
224 they may need further tailored implementation approaches depending on the specific setting.^{9,10}

225 226 **7.1 Identification of barriers and facilitators to implementation**

227
228 If potential barriers to the implementation of GTG recommendations are identified, appropriate
229 facilitation strategies should be employed in the local context. Commonly cited implementation
230 barriers include:^{10,11}

- 231
- 232 • staffing,
- 233 • rotation of staff to new trusts/health boards and clinical areas,
- 234 • complexity and inaccessibility of the guideline,
- 235 • lack of resources,
- 236 • training,
- 237 • funding, and
- 238 • lack of awareness or perceived applicability of the guideline's content.

239
 240
 241
 242
 243
 244
 245
 246
 247
 248
 249
 250
 251
 252
 253
 254
 255
 256
 257
 258
 259
 260
 261
 262
 263
 264
 265
 266
 267
 268
 269
 270
 271
 272
 273
 274
 275
 276
 277
 278
 279
 280
 281
 282
 283
 284
 285
 286
 287
 288
 289

However, this list is not exhaustive, and additional barriers may be present, and all should be tackled at individual, organisational, and system levels to determine solutions.

7.2 Multiprofessional collaboration

Guideline implementation responsibilities may be assigned differently across trusts/health boards/ICBs and organisations, reflecting variations in staffing structures and the intended scope of use.¹² However, for successful implementation and local acceptance of new or revised guidelines, engagement should be multiprofessional and be comprised of all relevant stakeholders including, but not limited to, obstetricians, gynaecologists, midwives, nursing staff, anaesthetists, healthcare support workers, maternity support workers, neonatal/paediatric and theatre teams.^{13–15} The engagement of multiprofessional teams will also help to identify potential barriers at an early stage and with the development of effective strategies to support local implementation.

Involvement and support from senior leaders or the executive team can help overcome barriers in the clinical environment, while also fostering a sense of ownership of the implementation at leadership level.¹⁶

7.3 Piloting

Where feasible, piloting changes within selected areas of a trust/health board/ICB or department prior to full implementation can help to identify the most likely barriers and refine likely interventions before dissemination to a broader group of staff.¹⁷ The ability to undertake small scale implementation testing before rolling out the guideline more widely should take into consideration practical organisational and environmental challenges, as well as those at individual and team level.¹⁷ The involvement of staff groups in a piloting phase can also help to build staff confidence and acceptance by encouraging engagement and fostering a collaborative ownership of the new guideline.

Furthermore, piloting the implementation of a guideline can support the development and identification of the resources required for larger-scale dissemination and training based on local resources.¹⁷

7.4 Dissemination

Irrespective of whether a piloting phase is undertaken, the dissemination of information remains essential to implementation, with effective embedding of guidelines often being conditional to employing a range of dissemination methods.¹⁸ Methods to consider include:

- Education and training – changes or updates to guidelines to be introduced during multiprofessional training/skills and drills days.
- In-person introduction to the guideline via team handovers, education forums, team meetings and ‘tea trolley teaching’.
- Notification systems such as email, e-learning, flowchart/ infographic displays, and social media platforms utilising closed/secure groups.

When considering implementation of guidelines, appropriate accessibility should be ensured, for example, via a trust/health board/ICB intranet and/or via QR codes displayed in the clinical area. Staff should be able to access guidelines easily and they should be presented in accessible formats.¹⁸

290 To support implementation, any changes to clinical guidelines should be applied to all relevant
 291 available resources, for example, care bundles, toolkits, patient information and routine
 292 documentation tools such as handover tools for postoperative care.

293

294 **7.5. Sustainability and continuous improvement**

295

296 To support implementation of guidelines and monitor adherence locally, clinical champions or
 297 governance leads should be assigned to provide refresher updates and regular communication, in
 298 addition to audit and monitoring.

299

300 If undertaking audits, benchmarking against national standards, in addition to using dashboards,
 301 safety metrics and feedback from staff and service users should be considered to determine if
 302 guidelines have been successfully implemented and are being used as intended.

303

304 Where it is agreed that the guidance is applicable but is not, or cannot, be adhered to, the associated
 305 risks should be formally recorded within the organisation's risk register, with appropriate mitigation
 306 actions identified.

307

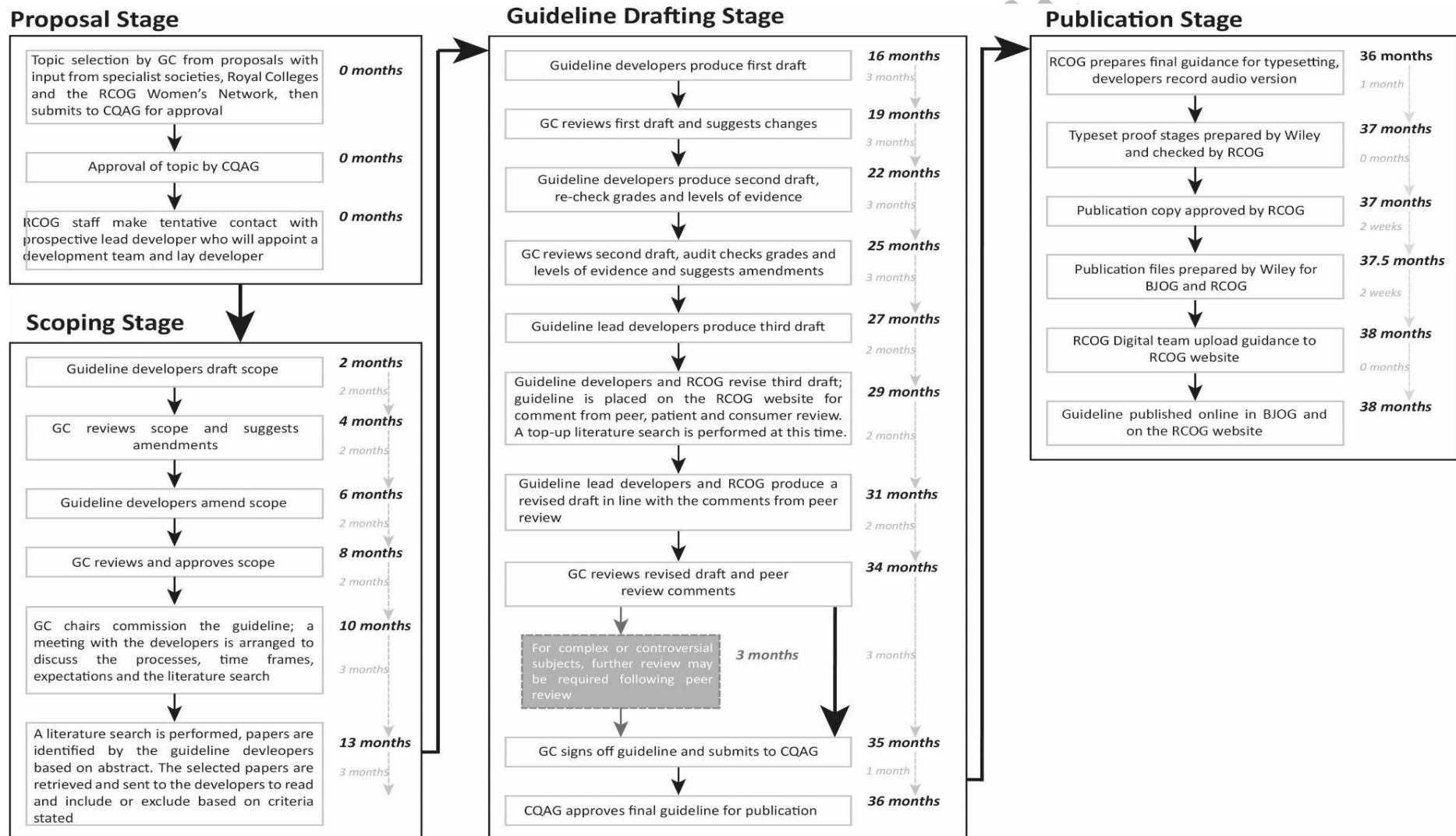
308 **References**

309

- 310 1. Fitch K, Bernstein SJ, Aguilar MD, Burnand B, LaCalle JR, Lazaro P, et al. The RAND/UCLA
 311 Appropriateness Method User's Manual. Santa Monica, CA: RAND Corporation, 2001
 312 [www.rand.org/pubs/monograph_reports/MR1269.html]. Accessed 11 Feb 2026
- 313 2. The ADAPTE Collaboration (2009). The ADAPTE Process: Resource Toolkit for Guideline
 314 Adaptation. Version 2.0. March 2010 [[g-i-n.net/wp-content/uploads/2021/05/ADAPTE-
 315 Resource-toolkit-V2.1-March-2010-updated-disclaimer.pdf](http://g-i-n.net/wp-content/uploads/2021/05/ADAPTE-Resource-toolkit-V2.1-March-2010-updated-disclaimer.pdf)]. Accessed 11 Feb 2026.
- 316 3. Vos T, Lim SS, Abbafati C, Abbas KM, Abbasi M, Abbasifard M, Abbasi-Kangevari M, Abbastabar
 317 H, Abd-Allah F, Abdelalim A, Abdollahi M. Global burden of 369 diseases and injuries in 204
 318 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease
 319 Study 2019. *The lancet*. 2020 Oct 17;396(10258):1204–22.
- 320 4. Royal College of Obstetricians and Gynaecologists. Reproducing RCOG guidance and patient
 321 information [www.rcog.org.uk/guidance/reproducing-rcog-guidance-and-patient-information].
 322 Accessed 10 Apr 2026.
- 323 5. Glasier A, Brechin S, Raine R, Penney G. A consensus process to adapt the World Health
 324 Organization selected practice recommendations for UK use. *Contraception*. 2003
 325 Nov;68(5):327–33.
- 326 6. Grimshaw J, Thomas R, MacLennan G, Fraser C, Ramsay C, Vale L, et al. Effectiveness and
 327 efficiency of guideline dissemination and implementation strategies. *Health Technol Assess*
 328 (Rockv). 2004 Feb;8(6).
- 329 7. Francke AL, Smit MC, de Veer AJ, Mistiaen P. Factors influencing the implementation of clinical
 330 guidelines for health care professionals: A systematic meta-review. *BMC Med Inform Decis Mak*.
 331 2008 Dec 12;8(1):38.
- 332 8. Thoonsen AC, Merten H, Broeders TT, Gans A, van Beusekom I, Delnoij DMJ, et al. The role of
 333 guideline organizations in nationwide guideline implementation: a qualitative study. *Health Res*
 334 *Policy Syst*. 2024 Dec 23;22(1):174.
- 335 9. Wang Z, Norris SL, Bero L. The advantages and limitations of guideline adaptation frameworks.
 336 *Implementation Science*. 2018 Dec 29;13(1):72.
- 337 10. Zhou P, Chen L, Wu Z, Wang E, Yan Y, Guan X, et al. The barriers and facilitators for the
 338 implementation of clinical practice guidelines in healthcare: an umbrella review of qualitative
 339 and quantitative literature. *J Clin Epidemiol*. 2023 Oct;162:169–81.

- 340 11. Hanley SJ, Jones AB, Oberman J, Baxter E, Sharkey D, Gray J, et al. Implementation of Public
341 Health England infection prevention and control guidance in maternity units in response to the
342 COVID-19 pandemic. *Journal of Hospital Infection*. 2022 Nov;129:219–26.
- 343 12. Gagliardi AR, Brouwers MC, Palda VA, Lemieux-Charles L, Grimshaw JM. How can we improve
344 guideline use? A conceptual framework of implementability. *Implementation Science*. 2011 Dec
345 22;6(1):26.
- 346 13. National Institute for Health and Care Excellence. Developing NICE guidelines: the manual. NICE
347 process and methods [PMG20]. NICE; Oct 2014 (updated Oct 2025)
348 [www.nice.org.uk/process/pmg20/]. Accessed 15 Apr 2026.
- 349 14. Sachs M. Erfolgreiche Strategien und Methoden der Implementierung von Pflegestandards. Eine
350 systematische Übersichtsarbeit. *Pflege*. 2006 Feb 1;19(1):33–44.
- 351 15. Fretheim A, Schünemann HJ, Oxman AD. Improving the use of research evidence in guideline
352 development: 3. Group composition and consultation process. *Health Res Policy Syst*. 2006 Dec
353 29;4(1):15.
- 354 16. Green SA, Bell D, Mays N. Identification of factors that support successful implementation of
355 care bundles in the acute medical setting: a qualitative study. *BMC Health Serv Res*. 2017 Dec
356 7;17(1):120.
- 357 17. Resnick B, McPherson R, Galik E. Pilot testing implementation of the pain management clinical
358 practice guideline in nursing homes. *Geriatric Nursing*. 2024 Mar 1;56:18-24.
- 359 18. South A, Bailey J V., Parmar MKB, Vale CL. The effectiveness of interventions to disseminate the
360 results of non-commercial randomised clinical trials to healthcare professionals: a systematic
361 review. *Implementation Science*. 2024 Feb 1;19(1):8.
- 362

363 **Appendix I: Green-top Guideline development pathway**
 364



365
366

This guideline was produced on behalf of the Royal College of Obstetricians and Gynaecologists by: **Dr R Bahl FRCOG, Bristol; Dr A Demitri, Honorary Reserch Fellow, Academic Centre for Women's Health, North Bristol NHS Trust, Department of Women's Health, Southmead Hospital; Dr N Hameed FRCOG, Lahore, Punjab, Pakistan; Siân Harrington, Senior Midwife, PROMPT Maternity Foundation; and Dr U Ram FRCOG, Chennai, Tamil Nadu, India.**

The following organisations and individuals submitted comments at peer review:
[to be completed by Guidance Editorial Manager]

The Committee lead reviewers were: Dr J Elson FRCOG, Nottingham; and Dr N Potdar FRCOG, Leicester.

The Chair of the RCOG Patient Safety Committee was: Dr CJ Calderwood FRCOG, Clydebank; and the Vice Chair was Dr J Elson FRCOG, Nottingham.

The final version is the responsibility of the Patient Safety Committee of the RCOG.

The review process will commence in 20XX, unless otherwise indicated.

DISCLAIMER

The Royal College of Obstetricians and Gynaecologists produces Good Practice Papers as an educational aid to good practice. They are based on evidence and data available at the time of publication, for consideration by obstetricians and gynaecologists and other relevant healthcare professionals. The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the doctor or other attendant in light of the evidence, local clinical data and the diagnostic and treatment options available.

RCOG guidance is unlike protocols or guidelines issued by employers, as it is not intended to provide prescriptive directions defining a single course of management. Departure from the local prescriptive protocols or guidelines should be fully documented in the patient's case notes at the time the relevant decision is taken.