# Consultation comments on the draft quality standard for antenatal care
## Comments grouped by statement and stakeholder

| ID | Stakeholder | Statement number | Comment on | Comments<br>Please insert each new comment in a new row. | Response |
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| 0013 | CSections.org | | Additional statement | There needs to be an additional quality statement clarifying that both modes of birth (vaginal and caesarean) should be presented with equal consideration and balance.<br><br>While natural, vaginal birth is the preference in many cases, many women do not achieve this and giving equal balance to the other possible outcomes should be mandatory. Caesarean section and instrumental birth should be given more time during preparation classes to ensure that women know not only the important facts about the procedures to reduce trauma at a later date, but more particularly so that they have the knowledge of how they can influence the procedure (in the case of a caesarean), and the experience in order to make this outcome more positive, even if it has not been their preference. Assuming that it will just frighten women takes away their ability to make informed decisions and removes their feeling of control both fundamental in birth perception. *J. Lally, M. Murtagh, S. Macphail et al, 'More in Hope Than Expectation: A Systematic Review of Women's Expectations and Experience of Pain Relief in Labour' BMC Medicine, (2008) 6:7doi:10.1186/1741-7015-6-7* | Thank you for your comments. The scope of the antenatal care quality standard does not include the additional care required for women with antenatal complications or intrapartum care including birthing choices.<br><br>There are separate NICE quality standards in development for intrapartum care and caesarean section. These have been referenced within the antenatal care quality standard as related NICE quality standards. Please refer to the NICE quality standard full topic library for further details of all related topics for maternity.<br>NICE would welcome feedback from CSections.org during the consultation for other maternity quality standards including the NICE quality standard for caesarean section. |
| 0013 | CSections.org | | Additional Statement | An additional quality statement required along the lines of: Pregnant women presenting with a fear of childbirth at the time of booking, or at subsequent appointments, are immediately referred to support | Thank you for your comments. The scope of the antenatal care quality standard does not include the additional care required for women with antenatal complications or intrapartum care including birthing choices. |

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| | | | | services aimed at addressing their fears and accommodating their birth mode request. The support should provide balanced information about both vaginal and caesarean birth but should not present one mode of birth as 'best'. Nor should the purpose of the support be to 'change the mind' of the woman. After the provision of balanced information, for some a planned caesarean will remain the preferred route whether fear remains a factor or not. | There are separate NICE quality standards in development for intrapartum care and caesarean section. These have been referenced within the antenatal care quality standard as related NICE quality standards. Please refer to the NICE quality standard full topic library for further details of all related topics for maternity.<br><br>NICE would welcome feedback from CSections.org during the consultation for other maternity quality standards including the NICE quality standard for caesarean section. |
| 0013 | CSections.org | | Additional Statement | An additional quality statement about respect for the women's 'perception of risk' to be accommodated. What is unacceptable to one woman may be entirely acceptable to another. Informed choice should be paramount, not the personal perspective of the practitioner or the policies of the place in which the woman is going to give birth. Therefore when the woman has received a complete set of balanced information her decision about how to attempt her birth should be honoured. For many this will continue to be a vaginal birth, however for some this will be a planned caesarean and this should be respected (as NICE guideline for Caesarean Section 2011 states). A measure of success of this quality statement will be the number of women perceiving their care as supportive. | Thank you for your comment. The topic expert group agree that informed decision making is an important consideration but the group felt this did not meet the specific criteria for a quality statement.<br><br>The topic expert group prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators.<br><br>The patient experience in adult NHS services quality standard includes a statement about informed decision making. This quality standard is referenced in section 8 of the quality standard for antenatal care. |
| 0013 | CSections.org | | Additional Statement | Smoking cessation during pregnancy should be included as a separate quality standard. | A statement on smoking cessation has now been included in the final quality standard. |
| 009 | Royal College of Midwives | | Additional statement | Pregnant women should be introduced to local universal children's services in pregnancy and | All suggestions for additional statements were discussed by the topic expert group who considered introduction to |

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| | | | | consent obtained to facilitate interagency sharing of each woman's contact details with these services. | local universal services was inappropriate for inclusion.<br><br>The topic expert group prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators.<br><br>The quality standard contains key markers of clinical and cost effective care across a care pathway. It remains important that other evidence-based guideline recommendations continue to be implemented. |
| 009 | Royal College of Midwives | | Additional statement | - Smoking cessation<br>- Information about safe sleeping<br>- Uptake of health start vitamins<br>- Use of customised growth charts | A statement on smoking cessation has now been included in the final quality standard.<br><br>All suggestions for additional statements were discussed by the topic expert group who considered information about safe sleeping, uptake of health start vitamins and use of customised growth charts did not meet the specific criteria for inclusion.<br><br>The topic expert group prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators.<br><br>The quality standard contains a small set of concise key markers of clinical and cost effective care across a care pathway with a specific focus on quality improvement and measurement. It remains important that other evidence-based guideline recommendations continue to be implemented and the quality standard should complement these. |

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| 007 | Royal College of Obstetricians and Gynaecologists | | Additional statement | Regarding questions 5 and 6, I would agree that there should be a separate statement about smoking cessation and for small group of healthcare professionals I'd suggest "named consultant and team of midwives". I agree with the suggested definition on page 9 of 44. | A statement on smoking cessation has now been included in the final quality standard.<br><br>In light of consultation comments the statement 'Services – continuity of care' has been reviewed by the topic expert group and refocused. |
| 001 | Walsall Healthcare NHS Trust | | Additional statement | Vitamin D supplementation is conspicuous by its absence. It should be offered to all mothers antenatally.<br><br>For the general population, the Department of Health has set dietary recommendations for people under the age of 4, those over the age of 64, and pregnant or lactating women. It also recommends that people at risk of low sun exposure should get 10 µg of vitamin D a day, mostly through supplements.<br><br>(1) The National Institute for Health and Clinical Excellence (NICE) also emphasises the importance of maintaining adequate vitamin D during pregnancy and breastfeeding, and suggests that women may choose to take up to 10 µg of vitamin D a day during these periods. (2) References<br>(1): SACN, Update on Vitamin D: Position Statement by the Scientific Advisory Committee on Nutrition, (2007)<br>(2) NICE, Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households 11, (2008). 10 Webb, et al., J Clin | All suggestions for additional statements were discussed by the topic expert group who considered vitamin D supplementation for potential inclusion but the group felt this did not meet the specific criteria for a quality statement.<br><br>The topic expert group prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators.<br><br>The quality standard contains key markers of clinical and cost effective care across a care pathway. It remains important that other evidence-based guideline recommendations continue to be implemented. |

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| 0014 | Department of Health (Children Family and Maternity branch) | | Additional statements | 1. Smoking<br>2. Early pregnancy care/miscarriage (bleeding and pain in early pregnancy) with indicator as the provision of minimum of a 5 day per week clinic with access available within 24- 48 hours<br>3. Provision of networks (including secondary and tertiary care) to ensure provision of expert and multidisciplinary care for all women with additional needs due to pre-existing conditions or complications that develop in pregnancy | 1. A statement on smoking cessation has now been included in the final quality standard.<br>2. A quality standard on pain and bleeding in early pregnancy will be developed as part of the library of topics. Please refer to the NICE quality standard full topic library for further details of all related topics for maternity<br>3. The scope of the antenatal care quality standard does not include the additional care required for the management of antenatal complications. The antenatal care quality standard is part of a suite of maternity-related standards which includes:<br>• Antenatal care<br>• Intrapartum care<br>• Postnatal care<br>• Induction of labour<br>• Hypertension in pregnancy<br>• Diabetes in pregnancy<br>• Caesarean section<br>• Pain and bleeding in early pregnancy<br>• Multiple pregnancy<br>• Premature labour<br>• Antenatal and postnatal mental health<br>The suite of maternity-related quality standards will cover core routine maternity care along with some additional areas of care. |
| 0020 | NHS Sickle Cell and Thalassaemia Screening | | Additional statements | The SCT programme is concerned that there is little regard played to linking with the birth of the baby. In the experience of the screening | Thank you for your comments.<br>All suggestions for additional statements were discussed |

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| | Programme | | | programme, users view the birth of a healthy baby as an important outcome of antenatal care. For sickle cell and thalassaemia screening this includes linking the antenatal and newborn screening results. This could be addressed by including the programme standard LO2 ”Alert systems should be in place to inform newborn laboratories of at risk couples” | by the topic expert group who recognised the importance of screening for sickle cell and thalassaemia and infectious diseases in pregnancy. The group made a consensus decision to focus the screening statement around fetal anomaly screening. However, NICE recognises that early booking is an important factor in delivering sickle cell and thalassaemia screening and quality statement 1 aims to support this.<br><br>In the final antenatal care quality standard:<br>-Statement 1 focuses on improving access to antenatal care (ideally by 10 weeks 0 days) which includes measures about the timeliness of access. One of the source clinical guideline references is to NICE clinical guideline 62, recommendation 1.6.3.3 which focuses on offering women screening for sickle cell and thalassaemia as early as possible within their pregnancy (ideally by 10 weeks).<br>-Statement 3 focuses on pregnant women having a complete record of the minimum set of antenatal test results in their hand-held maternity notes, including haemoglobinopathies screening and the outcome of screening for infectious diseases.<br><br>The quality standard in no way replaces the clinical guideline recommendations or National Screening Committee guidance and has been designed to serve quality improvement across antenatal care. It remains important that other evidence-based guideline recommendations continue to be implemented. |
| 0025 | electivecesarean.com | | Appendix 1 | Suggest important inclusion to this list of documents:<br>Caesarean Section. NICE clinical guideline 13 (2011). | Thank you for your comments. The scope of the antenatal care quality standard does not include the additional care required for women with antenatal complications or intrapartum care, including birthing choices. |

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| | | | | | There is a separate NICE quality standard on Caesarean section which is in development. This has now been referenced within the antenatal care quality standard as a related NICE quality standard. Please refer to the NICE quality standard full topic library for further details of all related topics for maternity.<br><br>NICE would welcome feedback from electivecesarean.com during the consultation for other maternity quality standards including the NICE quality standard for caesarean section. |
| 0023 | Bliss | | General | We were surprised that there is no mention of antenatal education anywhere in the document | All suggestions for additional statements were discussed by the topic expert group who considered antenatal education for potential inclusion but the group felt this did not meet the specific criteria for a quality statement.<br><br>The quality standard contains key markers of clinical and cost effective care across a care pathway. The topic expert group prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators.<br>Quality standards do not aim to cover the entirety of the topic area; they aim to provide a concise and selected set of precise statements designed to improve quality across a particular area. It remains important that other evidence-based guideline recommendations continue to be implemented and we recognise that antenatal education is central aspect of the underpinning clinical guidance. |
| 0013 | Csections.org | | General | I am very concerned to discover that the scoping document implies that antenatal education should omit aspects of birth. It states it will discuss *"the* | The scope of the antenatal care quality standard is available on the NICE website. |

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| | | | | *normal physiological processes taking place…"* but that *"The guideline will not address any aspect of intrapartum and postpartum care and therefore will exclude advice on birth*…" Having read the full Antenatal Care guideline (2008 update) I am not reassured that the guidance encourages practitioners to discuss the practicalities of birth (specifically those which do not follow the 'normal' path) to be covered sufficiently in antenatal classes. Csections.org knows from the experiences of our users that at present in many cases caesarean birth in particular is very poorly covered. Information is at best 'thin' and at worst 'biased'. Reference to the '*The pregnancy book'* (Department of Health 2007) as a tool for enhancing the information women have does not reassure us as the content of this book primarily vaginal birth as only 3 of the 196 pages cover the practicalities of instrumental and caesarean birth. There is no information about preparation for or recovery from these types of intervention specifically. Crucially there is no information about how to address such a birth in a birth plan.<br><br>The 2008 Antenatal Care guideline http://www.nice.org.uk/nicemedia/live/11947/40145/40145.pdf states that *"Informed decision making involves making reasoned choice based on relevant information about the advantages and disadvantages of all the possible courses of action (including taking no action).8 It requires that the individual has understood both the information provided and the full implications of all the alternative courses of action available. In providing information for women antenatally it is* | The standard addresses routine antenatal care and does not cover the additional care required to manage complications which occur in the antenatal period or any aspects of intrapartum care including birthing choices.<br><br>The antenatal care quality standard is part of a suite of maternity-related standards which includes intrapartum care and caesarean section. Full details of maternity-related topics are available on the NICE website. The suite of maternity-related quality standards will cover core routine maternity care along with some additional areas of care. |

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| | | | | *important that healthcare professionals are aware of what informed choice entails and that they provide information in order to facilitate this. The provision of clear information, and time for women to consider decisions and seek additional information, as well as the need for care to be provided in an individualised, woman-focused way are key components of Standard 11 Section 3 of the National Service Framework for Maternity Care (September 2004, www.dh.gov.uk/)."*<br><br>This goal can only be achieved if balanced information about caesarean birth is included in that education. Instrumental delivery and caesarean section are both a very real possibility in every birth. Antenatally most women do not know whether such interventions will be a part of their birth, that does not mean they should not be prepared for the possibility. Practitioners have a duty of care to prepare women realistically and fairly. To omit significant parts of the woman's experience from their education in the hope that it just wont happen to them does women a major disservice and leaves them open to greater degrees of emotional as well as physical trauma, Passing over interventions quickly means that all the preparation of mind, home and family will be omitted as will all the highly relevant recovery information pertinent to any difficult birth but particularly so after interventions. See *'Caesarean Birth: A positive approach to preparation and* recovery' published by Tiskimo (2011) to see the level of detail that ought to be included in preparation classes. Leaving the level of discussion that ought to be part of all antenatal | |

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| | | | | education until a woman is in labour are entirely inappropriate and in many cases impossible. It also means that interventions are seen as 'abnormal' and therefore become tied up with disappointment and trauma when in actual fact, whether we like it or not, they are a realistic and necessary part of many births. | |
| 0014 | Department of Health (Children Family and Maternity branch) | | General | We think it would be helpful to have the section "Description of what the quality statement means for each audience" immediately below the quality statement.<br>We had been under the impression that the Quality Standards were going to be used primarily for commissioning and service specifications, to support the clinical outcomes framework<br>There is considerable overlap with the CNST standards which measure process and in fact are more detailed than suggested here. We had hoped the NICE quality standards would measure more than process. | Thank-you for this suggestion which we have noted as part of ongoing review of the product.<br>The quality standards will be used to support a range of purposes both locally and nationally.<br>The aim of this quality standard is to provide a focused set of specific, concise statements that are intended to support improvements in the quality of care and services. |
| 0014 | Department of Health (Children, Family and Maternity branch) | | General | We have commented in detail on each section but have these general comments:<br>1. The measures are largely process measures and could result merely in tick box evidence<br>2. We had hoped for alignment with clinical outcomes to give objective, measurable outcome standards against which to commission and performance manage services on quality in the Outcome Frameworks domains<br>3. There is much overlap with CNST standards which are detailed on process | 1. NICE quality standards provide evidence-based statements of high quality care which aim to drive quality improvement. The focus of quality standards is on processes of care that are considered to be linked to better health outcomes, but outcomes in statements are desirable. We recognised that it may not always be possible to include outcome measures that can be used at local level to reliably assess the quality of care and allow comparisons between providers. The QS provides a balanced set of measures aimed at improving the structure, process and outcomes of healthcare.<br>2. Using rigorous development methods, NICE will develop indicators (from the published antenatal care |

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| | | | | for many aspects of antenatal service provision. Duplication is unhelpful.<br>4. The National Screening Committee requires many KPIs and these should be mentioned and possibly may provide data for inclusion without duplication<br>5. The measures largely suggest using data which are not collected and would only be available by individual audit of the notes. One solution might be to work up some detailed tools for carrying out local audit projects<br>6. Many of the measures would rely on women's surveys<br>7. The National Maternity Dataset will provide a data source which should be used for outcome measures<br>There is a general principle that needs to be clear that there must be an audit cycle so that failure to achieve a standard results in development of an action plan for improvement and learning | quality standard) drawn from the quality statements and measures for potential inclusion within the Commissioning Outcomes Framework. The prioritisation will include the extent to which proposed indicators (developed from the quality standards) relates to a healthcare process or outcome that is influenced, at least in part, by the actions of clinical commissioning groups.<br>3. Quality standards support a range of purposes. The topic expert group acknowledged that some duplication may exist where there is an overall need to focus improvements on a particular area. Where there is duplication, NICE statements are seen as being mutually supportive and complementary of the CNST standards to focus on aspirational care.<br>4. Thank-you for the comment, the QS will reference related measures in the system.<br>5. As a minimum, the measures should offer a starting point for local quality improvement. NICE quality standards will also inform national indicator development, for example the indicator development process for the Commissioning Outcomes Framework will examine whether data to support the indicator is likely to become available, or made available and whether changes to data collection need to be made. It is outside of the remit of this work to produce detailed tools for carrying out local audit projects, but this feedback has been noted as part of our ongoing review.<br>6. We agree that a small number of measures would require use of experience data and the topic expert group agreed these provide a useful addition to the outcomes set.<br>7. Noted. This will be referenced as an important development that will support implementation. |
| 0025 | electivecesarean.co | | General | Suggestion for future is that a similar list to those | Thank you for your comments. The scope of the antenatal |

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| | m | | | contained in quality statements 6, 7, 8 & 9 be drafted for “Risk assessment – emergency caesarean”. This is an important risk assessment to carry out because reducing emergency surgeries, which are associated with some of the greatest risks and costs, would be a good thing for women and hospitals. Often, in arbitrary efforts to reduce caesarean rates, ‘*all*’ c-sections are targeted, when in fact women at high risk of an emergency caesarean outcome were *offered* an elective caesarean, we might see a reduction in the current emergency CS rate of 15%. The emergency/elective caesarean rate split is 15% and 10%, but it’s possible that a quality statement that sets out to reduce emergency outcomes could result in a much better split of (*for example*) 10% emergency and 15% elective. | care quality standard does not include the additional care required for women with antenatal complications or intrapartum care, including birthing choices. There is a separate NICE quality standard on Caesarean section which is in development. This has now been referenced within the antenatal care quality standard as a related NICE quality standard. Please refer to the NICE quality standard full topic library for further details of all related topics for maternity. |
| 0030 | Epilepsy Action | | General | Epilepsy Action welcome the ante-natal quality standards, however we would like the draft standards to be extended to ensure that women with long-term medical conditions (including epilepsy) receive quality care too. We do not believe the needs of women with epilepsy are sufficiently covered by the drafted standards. In our response we have suggested opportunities to promote equality in the standards for women with epilepsy and other pre-existing medical conditions.<br><br>If this does not happen then inequality will exist in the antenatal care received by women with epilepsy. Specifically, the unacceptable risk of maternal death among women with epilepsy might increase or remain static. Women with epilepsy | The quality standard for antenatal care covers the antenatal care of all pregnant women, but the management of specific physical conditions and antenatal complications is outside of the scope. The full antenatal care scope, which was developed by the topic expert group is available from the NICE website.<br><br>The quality standard contains key markers of clinical and cost effective care across a care pathway. It remains important that other evidence-based guideline recommendations continue to be implemented. |

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| | | | | could be denied the opportunity to make informed choices and decisions about their care (due to receiving incorrect advice, or not receiving a timely foetal development scan). | |
| 0022 | Multiple Births Foundation | | General | The Multiple Births Foundation (MBF) welcomes the Antenatal Care Quality Standard and the aim of improving the effectiveness, safety and experience of care for pregnant women. Multiple births are continuing to rise in England and Wales with 11,228 multiple births in 2010, a rate of 15.7 multiple births per 1000 maternities, compared with 6,404 in 1980, a rate of 9.8 multiple births per 1000 maternities (Office for National Statistics). Multiple pregnancies are associated with higher maternal and fetal mortality and morbidity than singleton pregnancies (NICE Multiple Pregnancy Guideline 129) so each quality statement should be implemented taking into account the specific requirements for materno-fetal screening and medical and social interventions to optimise maternal and fetal health and improve the women's care and experience of pregnancy and birth set out in the NICE Multiple Pregnancy Guideline. The MBF suggests that this is referenced and integrated into the Quality Standard document as appropriate.<br>We are delighted to see that a quality standard for multiple pregnancy has been proposed and referred to NICE and anticipate that our comments on the Antenatal Care Quality Standard will be taken into account with this in mind. We would be pleased to contribute to the Multiple Pregnancy Quality Standard in due course. | The scope of the antenatal care quality standard does not cover the additional care required for women with multiple pregnancies. There is a separate NICE quality standard on multiple pregnancy which is in development. This has now been referenced within the antenatal care quality standard as a related NICE quality standard.<br><br>The forthcoming multiple pregnancy quality standard will be underpinned by NICE clinical guideline 129 (multiple pregnancy) and will set out markers of high quality care which are in addition or different to those for women with a singleton pregnancy. |

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| 0026 | NHS Direct | | General | NHS Direct welcome the quality standard and have no comments on its content. | Thank you. |
| 0031 | Perinatal Institute | | General | The document should include recommendations for outcome measures and clear definitions on data items required to fulfil the Quality Standard. For example, the ambiguity in booking definitions in quality standard 1 and additional data items needed (complex social factors in the MSDS). | The topic expert group has considered all the consultation comments and reviewed the quality standard including outcome measures and data sources. Outcome measures are stated where the topic expert group felt these were appropriate. |
| 009 | Royal College of Midwives | | General | The comments in this response have incorporated feedback from midwives who reviewed and responded to the RCM on the document. | Thank you. |
| 009 | Royal College of Midwives | | General | The quality standard is relevant and a valuable summation of useful information. Many units will already be implementing these recommendations. However many members have commented on the difficulties of measuring and collecting the relevant data at this time of austerity, where they do not envisage there will be the necessary investment in appropriate IT. They are also concerned about having good aspirational but possibly unachievable standards. | NICE has produced a support document to help commissioners and others consider the commissioning implications and potential resource impact of this quality standard and patient information to explain to patients and carers what the quality standard means to them, both available from www.nice.org.uk.<br><br>Examples of existing national data collection which may be relevant, in part at least, to the quality measure are referenced where appropriate. It is expected that local data sources and audits where appropriate will be considered in order to measure the quality statements in full. |
| 007 | Royal College of Obstetricians and Gynaecologists | | General | This includes a table of the draft quality statements.<br>1. I would suggest that number 1 does not need 'including those with complex social needs' (redundant).<br>2. Number 5 is about offering evidence based, balanced and consistent | The topic expert group has considered all the consultation comments and reviewed the quality standard.<br>1. Statement 1 no longer includes specific reference to ‘complex social needs’.<br>2. Draft statement 5 has been removed from the final quality standard as the topic expert group considered that generic information provision is |

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| | | | | information. Specifically information about what?<br>3. Number 9 - I would suggest that this should be that all pregnant women are risk assessed at each antenatal contact.<br>4. Number 13 – RCOG GTG 20a advises ECV in prims from 36 weeks and from 37 weeks in parous women. | covered within the quality standard for patient experience.<br>3. The topic expert group considered your feedback and decided to continue to focus this statement on the booking appointment.<br>4. Draft statement 13 reflects the source clinical guideline recommendations from NICE CG62. |
| 032 | Royal College of Paediatrics and Child Health (RCPCH) | | General | This is more relevant for antenatal care services generally, than for community paediatric services. It has been noted that there isn't much within the document about communication with relevant hospital or community paediatric services should there be issues either social or health with the mother e.g. positive antenatal screening findings, or safeguarding issues. It may be helpful to highlight this to the authors and ask if they would consider including some standards to this effect. | The topic expert group prioritised the areas of care they felt were most important for patients, based on the development sources listed.<br><br>The topic expert group prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators. Although acknowledged as an important area, the topic expert group did not prioritise communication between services for statement development.<br><br>The quality standard contains key markers of clinical and cost effective care across a care pathway. It remains important that other evidence-based guideline recommendations continue to be implemented. |
| 005 | British Maternal Fetal Medicine Society | | Introduction | Presumably it is standard NICE procedure to refer to 'people' rather than pregnant women but as this is an antenatal care document 'people' seems a rather odd choice of word | 'Pregnant women' is used throughout the document. |
| 0013 | CSections.org | | Introduction | Please insert words to the effect that antenatal care is also about the provision of realistic and balanced information to women about all birth options. It is more than just a duty of care to improve their experience, it should also be about | The scope of the antenatal care quality standard is available on the NICE website. The standard addresses routine antenatal care and does not cover aspects of intrapartum care including birthing choices. Provision of patient information is an important theme for all NHS care. |

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| | | | | the importance of realistic expectations and the ability for women to feel in control of the decisions they are making about their pregnancy and their birth. *"Even if the birth was not natural as planned, women were still pleased with the experience if they felt they had been in control of the decisions made." J. Lally, M. Murtagh, S. Macphail et al, 'More in Hope Than Expectation: A Systematic Review of Women's Expectations and Experience of Pain Relief in Labour' BMC Medicine, (2008) 6:7doi:10.1186/1741-7015-6-7 "The more rigid your views, the more likely you are to experience feelings ranging from disappointment or distress to full post-traumatic stress disorder, if you are unable to achieve your goals" J. Lally, M. Murtagh, S. Macphail et al, 'More in Hope Than Expectation: A Systematic Review of Women's Expectations and Experience of Pain Relief in Labour' BMC Medicine, (2008) 6:7doi:10.1186/1741-7015-6-7* Consider a fourth bullet point which, as the above point suggests, emphasises more than a *'positive experience of care'* rather that this specifically includes the provision of realistic and balanced information of all modes of birth such that there is an increased chance of experiencing the birth (not just the care) as positive too.<br>*Realistic expectations increase the likelihood of you viewing your birth in a positive light should it change direction." East L. 'Caesarean Birth: A positive approach to preparation and recovery' Tiskimo 2011.* | The topic expert group decided the NICE quality standard on 'patient experience in adult NHS services' which is cross-cutting and referenced in all quality standards (for adults) covers this in detail.<br><br>The antenatal care quality standard is part of a suite of maternity-related standards which includes intrapartum care and caesarean section.<br><br>Full details of maternity-related topics are available on the NICE website. The suite of maternity-related quality standards will cover core routine maternity care along with some additional areas of care. |
| 0014 | Department of Health (Children Family and Maternity | | Introduction | Bullets should be more specific but still consistent with the clinical outcomes framework :<br>• Preventing women from dying | Thank you for this suggestion.<br><br>While we recognise that this language is tailored, at |

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| | branch) | | | prematurely and reducing infant and perinatal mortality<br>• Ensuring women and their families have a positive experience of care<br>• Treating and caring for women in a safe environment and protecting them from avoidable harm<br>Treating and caring for babies in a safe environment and protecting them from avoidable harm, including reducing the admission rates of full-term babies to neonatal care. | present we have decided to retain the wording of the outcomes framework for consistency. |
| 0014 | Department of Health (Children, Family and Maternity branch) | | Introduction | Smoking should be added to the known risk factors<br><br>We do not think the term materno-fetal screening is common and would prefer separation to maternal and fetal screening<br><br>3rd para: should specify "… cost-effective care that, when commissioned and delivered…" | Smoking has been included as an additional risk factor in the final quality standard.<br><br>We agree with your feedback about the phrase 'materno-fetal' and have edited the final quality standard.<br><br>The opening paragraph of the overview section highlights that .the quality standard for antenatal care requires that services should be 'commissioned from and coordinated across all relevant agencies'. There is a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a duty to secure continuous improvement in quality. |
| 0025 | electivecesarean.com | | Introduction | Suggest adding "advanced maternal age" and "macrosomia" to the risk factors listed here (obesity, diabetes, hypertension, substance misuse or domestic abuse). | Thank you for your comments. The topic expert group has updated this list and decided that as these are example risks factors and it is not intended to be an exhaustive list that advanced maternal age and macrosomia do not need to be included. |
| 0022 | Multiple Births Foundation | | Introduction | The MBF suggests that there is a reference to multiple pregnancies being higher risk and | The scope of the antenatal care quality standard does not cover the additional care required for women with multiple |

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| | | | | requiring specific antenatal care in the introduction. | pregnancies. There is a separate NICE quality standard on multiple pregnancy which is in development. This has now been referenced within the antenatal care quality standard as a related NICE quality standard.<br><br>The forthcoming multiple pregnancy quality standard will be underpinned by NICE clinical guideline 129 (multiple pregnancy) and will set out markers of high quality care which are in addition or different to those for women with a singleton pregnancy. |
| 003 | Royal College of Nursing | | Introduction | The RCN suggests that it should be clarified in the introduction that multiple pregnancies are included and reference made to the different and additional information and care these women require and incorporate the NICE Multiple Pregnancy Guideline 129. | Thank you for your comments. The scope of the antenatal care quality standard does not cover the additional care required for women with multiple pregnancies. There is a separate NICE quality standard on multiple pregnancy which is in development. This has now been referenced within the antenatal care quality standard as a related NICE quality standard. |
| 008 | Tamba (Twins & Multiple Births Association) | | Introduction-paragraph 2 & Overview paragraph 1 | Although Tamba acknowledge that adverse outcomes can be unpredictable we feel this quality standard must aim to avoid complacency and encourage thorough risk assessment for the mother and baby/babies antenatally. Risks, which once assessed are communicated and promote 'an integrated approach to provision of services' for all women. A recent BMJ article (2012) reports the findings of a study of NHS specialist neonatal services in England and highlights a lack of coordination between maternity and neonatal services resulting in the 'continued separation of babies from multiple births' which perhaps could be avoided if in utero transfer was facilitated before delivery. | The scope of the antenatal care quality standard does not cover the additional care required for women with multiple pregnancies. There is a separate NICE quality standard on multiple pregnancy which is in development. This has now been referenced within the antenatal care quality standard as a related NICE quality standard.<br><br>The forthcoming multiple pregnancy quality standard will be underpinned by NICE clinical guideline 129 (multiple pregnancy) and will set out markers of high quality care which are in addition or different to those for women with a singleton pregnancy. |

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| 008 | Tamba (Twins & Multiple Births Association) | | Introduction-paragraph 1 | Tamba comment that the maternal mortality associated with multiple pregnancies is 2.5 times higher than for singleton births (NICE clinical guideline 129, 2011). | The scope of the antenatal care quality standard does not cover the additional care required for women with multiple pregnancies. There is a separate NICE quality standard on multiple pregnancy which is in development. This has now been referenced within the antenatal care quality standard as a related NICE quality standard.<br><br>The forthcoming multiple pregnancy quality standard will be underpinned by NICE clinical guideline 129 (multiple pregnancy) and will set out markers of high quality care which are in addition or different to those for women with a singleton pregnancy. |
| 0013 | CSections.org | | Overview | This update should specify the scope and content of antenatal education. The previous version simply states *'…preparation for labour and birth, including information about coping with pain in labour and the birth plan.'* (pg 65 2008 version) This means that at present providers can interpret this as they choose and women cannot be confident that the information they receive is unbiased or complete. (See General Comment above) It should not be assumed that women will ask the right questions as, for many, they do not even know what questions to ask-most will never have heard of terms like 'cascade of intervention'.<br><br>As an example: Csections.org users have found that the current approach to discussing interventions, in particular caesareans is typically unhelpful. If these issues are touched on at all in classes it is in the most 'light' and often negative terms. We have yet to come across a woman contacting us who has been told anything useful about how to help her own caesarean recovery | Thank you for your comment. The topic expert group agree that education and informed decision making is an important consideration but the group felt this did not meet the specific criteria for a quality statement.<br>The topic expert group prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators.<br><br>The patient experience in adult NHS services quality standard includes a statement about informed decision making. This quality standard is referenced in section 8 of the quality standard for antenatal care.<br><br>The quality standard contains key markers of clinical and cost effective care across a care pathway. It remains important that other evidence-based guideline recommendations continue to be implemented.<br><br>The quality standards are based on evidence-based recommendations from national accredited guidance, i.e. |

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| | | | | beyond 'rest as much as you can' and many more have been left with nothing but negative impressions and postnatal trauma. Caesareans are an important birth outcome and effective / appropriate preparation is key to a good recovery. There is so much more women can do to ensure their birth is positive regardless of the fact that their birth may not have gone according to plan. *"Antenatal education has a duty to help women understand that intervention, including pain relief, may be necessary and for some a caesarean will be the way their baby is delivered. Treadwell M Co-founder of Birth Trauma Association quoted in East L. 'Caesarean Birth: A positive approach to preparation and recovery' Tiskimo 2011.* A quarter of all UK births are via caesarean. At present antenatal education is woefully lacking in preparing women for this eventuality often being told 'don't worry, we'll try and help you avoid that', 'it's a last resort'. Last resort it may be for some but that does not mean that it needs to be negative or frightening, but by shielding women from this mode of birth most are totally unprepared and very traumatised as a result, some even arresting family planning or aborting much wanted babies because they cannot cope with birth. *K. Hofberg, M. R. Ward, 'Fear Of Pregnancy And Childbirth' Postgraduate Medical Journal 79 (2003) 505-510*<br><br>Research clearly shows that the preference of the practitioner can influence the decision making of the mother. '…*when patients perceived their providers as having a preference for ERCS* [repeat caesarean]*, very few chose TOLAC* | the NICE antenatal care clinical guideline. The quality standards do not seek to reassess or redefine the evidence base; this is the role of guideline updates and the appointed Guideline Development Groups.<br><br>Please refer to the source full clinical guidelines for detailed summary of the underpinning evidence base for the clinical recommendations on which the quality standard is based, as well as the guideline review schedule where such information can be given proper consideration. |

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| | | | | [VBAC] *whereas the majority chose TOLAC if this was their provider's preference." Bernstein S.N., Matalon-Grazi S., Rosenn B. 'Trial of Labor Versus Repeat Cesarean: Are Patients Making an Informed Decision? 2012 'Oral Concurrent Session 3 at the 32nd Annual SMFM Meeting in Dallas, Texas*<br><br>It is crucial therefore that the guideline includes the presentation of balanced information about caesarean birth as part of the Antenatal Care requirement. | |
| 0013 | CSections.org | | Overview | In the opinion of Csections.org it is impossible to identify any specific quality statements which are more important than others as there are none which can be removed or given less emphasis. Regarding the statement "small group of healthcare professionals" would it be better to clarify by role or appointment type? | Thank you for your comments.<br><br>In light of consultation comments draft statement 2 'Services – continuity of care' has been reviewed by the topic expert group and refocused. |
| 0014 | Department of Health (Children Family and Maternity branch) | | Overview | Para 1- "An integrated approach to provision of health and social care services is fundamental…"<br>Para 2 – "Women should have the opportunity to make informed decisions about their care and treatment based on their individual circumstances and needs using the current available evidence,…."<br>Para 3 – This quality standard covers the routine antenatal care of all…"<br>Para 4 – need a reference here to the fact that will also be used by Health and Well-being Boards<br>Para 5 – now out of date | Thank-you for these suggestions on wording and clarity which we have noted. The overview has been updated and we will consider your comments as part of the ongoing review of the quality standard product. |
| 0025 | electivecesarean.com | | Overview | Re: the quality standard "theme" that "pregnancy is a normal physiological process and that any interventions offered should have known benefits without doing harm and be acceptable to pregnant | Thank you for your comment. The topic expert group have reviewed and updated the text.<br><br>The scope of the antenatal care quality standard does not |

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| | | | | women." It is not possible to categorically ensure that any intervention, no matter what its benefits (e.g. forceps in order to deliver a baby urgently), be carried out "without doing harm". All interventions have risks and benefits, and this is why the next part of the Overview statement is so important – that women "should have the opportunity to make informed decisions about their care and treatment based on the current available evidence". From my organisation's perspective, as noted in subsequent comments below, the quality standard needs to include more information on the prophylactic intervention that is elective caesarean at 39+ weeks. This is not only applicable in cases of maternal request, but also in cases where there are medical and/or obstetric indications that warrant a thorough look at the possible outcomes of each possible birth plan choice (together with the woman), instead of setting the default to trial of labour in all cases. The current evidence no longer supports this default philosophy. | include the additional care required for women with antenatal complications or intrapartum care. The standard addresses routine antenatal care and does not cover the additional care required for caesarean section or any aspects of intrapartum care including birthing choices.<br><br>The antenatal care quality standard is part of a suite of maternity-related standards which includes intrapartum care and caesarean section. Full details of maternity-related topics are available on the NICE website. The suite of maternity-related quality standards will cover core routine maternity care along with some additional areas of care. |
| 0025 | electivecesarean.com | | Overview | We need to ensure that the "evidence-based, balanced and consistent information" offered to women includes the updated evidence on elective caesarean risks and benefits in comparison with planned vaginal delivery, included in the November 2011 NICE Caesarean Section (Update). Currently, antenatal information offered to women is not always balanced. | Thank you for your comments. The scope of the antenatal care quality standard does not include the additional care required for women with antenatal complications or intrapartum care. The antenatal care quality standard is part of a suite of maternity-related standards which includes intrapartum care and caesarean section. Full details of maternity-related topics are available on the NICE website. The suite of maternity-related quality standards will cover core routine maternity care along with some additional areas of care. |
| 0025 | electivecesarean.co | | Overview | This may be outside the Scope, but I would | Thank you for your comments. The scope of the antenatal |

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| | m | | | suggest that additional fetal screening (i.e. at circa 36 weeks' gestation) should be offered (at least) to (nulliparous and multiparous) women with suspected risk factors for adverse outcomes with a trial of labour. Screening results may indicate that an elective c-section should be offered. | care quality standard does not include the additional care required for women with antenatal complications or intrapartum care. The antenatal care quality standard is part of a suite of maternity-related standards which includes intrapartum care and caesarean section. Full details of maternity-related topics are available on the NICE website. The suite of maternity-related quality standards will cover core routine maternity care along with some additional areas of care. |
| 0022 | Multiple Births Foundation | | Overview | General: The MBF interprets the quality standard to include multiple pregnancies as it covers the antenatal care of all pregnant women.<br>An integrated approach to the care of women with a multiple pregnancy is particularly relevant as they are more likely to be referred to a tertiary fetal medicine centre and delivery planned to take account of the potential need for the babies to be require neonatal care as about 50% twins are born before 37 weeks gestation and about 10% before 32 weeks. The NICE Multiple Pregnancy Guideline recommends and defines how specialist care should be delivered and the need for continuity and consistency in different settings through care pathways so full implementation should meet all these requirements. | Thank you for your comments. The scope of the antenatal care quality standard does not cover the additional care required for women with multiple pregnancies. There is a separate NICE quality standard on multiple pregnancy which is in development. This has now been referenced within the antenatal care quality standard as a related NICE quality standard. |
| 007 | Royal College of Obstetricians and Gynaecologists | | Overview | Third paragraph of text says that the standard covers antenatal care up to 41 weeks - why not 42 or term + 10? | Thank you for your comments. The published scope refers to the antenatal care quality standard covering antenatal care up to 41 weeks of pregnancy. This has been extended to include antenatal care up to 42 weeks because 1 statement refers to the 41-week antenatal appointment, which can be carried out until 41 weeks and 6 days. The scope of the antenatal care quality standard is available on the NICE website. The antenatal care quality |

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| | | | | | standard is part of a suite of maternity quality standards, which includes a standard on induction of labour. The full list of maternity quality standards is available on the NICE website. |
| 008 | Tamba (Twins & Multiple Births Association) | | Overview | 'This quality standard covers the antenatal care of **all** pregnant women…' Tamba are concerned that the needs of multiple mothers are not included. There is an upward trend in multiple births (NICE, 2011) and in the UK numbers of triplets have trebled in the last decade (Multiple Birth Foundation, 2007) Tamba therefore feels the need to ask the question *is it the intention to label all women expecting multiples as having 'antenatal complications'?* Whilst Tamba acknowledge that multiple pregnancies can present a higher risk we strongly feel that for many multiple pregnancies, as with singleton pregnancies, services need to 'be commissioned from and coordinated across all relevant agencies encompassing the whole antenatal care pathway' and that until this is achieved there will still remain inequalities in service provision.<br>Our responses are intended to be helpful and to demonstrate the specific needs of mothers expecting multiples who have largely uneventful pregnancies. If the standard is not intended to cover these women we would recommend that this clear in the introduction. Tamba would support and be willing to contribute to the development of a multiple specific Quality Standard. | The scope of the antenatal care quality standard does not cover the additional care required for women with multiple pregnancies. There is a separate NICE quality standard on multiple pregnancy which is in development. This has now been referenced within the antenatal care quality standard as a related NICE quality standard.<br><br>The forthcoming multiple pregnancy quality standard will be underpinned by NICE clinical guideline 129 (multiple pregnancy) and will set out markers of high quality care which are in addition or different to those for women with a singleton pregnancy. |
| 0014 | Department of Health (Children | | Question 1 | Where possible we will suggest a healthcare outcome measure for each statement | Thank you. |

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| | Family and Maternity branch) | | | | |
| 0029 | National Childbirth Trust | | Question 1 | The outcomes are generally comprehensive and appropriate.<br><br>For draft quality standard 1, further specification might usefully be added to the denominator (number of pregnant women accessing antenatal care) to indicate when this would be collected and from what records, for example antenatal or intrapartum care records. If this is not specified, the resulting statistics may vary in accuracy.<br><br>Similar to this, for draft quality standard 3 (proportion of pregnant women accessing antenatal care who have a complete and accurate record of the minimum set of antenatal test results in their hand-held maternity notes, appropriate to their stage of pregnancy), it is not clear how many data collection points are envisaged. Unless this is specified and realistic, these data may not be collected at all or may be misleading and incomparable between trusts.<br><br>For draft quality standard 5, the term 'antenatal intervention' from process draft quality measure d) should be further defined to ensure that these data are meaningful.<br><br>For draft quality standard 10, under "Data sources" on page 29, the document refers to the Care Quality Commission Maternity Services Survey. It says that women were asked whether they had scans or screening tests, but only yes and no responses are mentioned. There was, however, also a "Don't know/Can't remember" option. Such responses should be analysed | Thank you.<br><br>Noted, and these measures are not necessarily intended as sophisticated measures, but a starting point for quality improvement and local measurement experts to refine and develop for local use. Where possible, we will link to relevant existing indicators and data collection but do not set out to offer detailed specification.<br><br>Draft quality statement 5 has been removed from the final quality standard as the topic expert group considered that generic information provision is covered within the quality standard for patient experience.<br><br>Draft quality statement 11 has been removed from the final quality standard.<br><br>The outcomes for draft statement 14 have been reviewed by the topic expert group and revised accordingly. |

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| | | | | separately or, because these women are not likely to have been "offered evidence-based, balanced and consistent information which they understand, have the opportunity to discuss, and which enables them to make informed decisions about their care" as set out in draft quality standard 5, added to responses where the woman states that she was not offered a test or scan.<br><br>For draft quality standard 11:<br><br>• One of the outcomes on page 31 is breastfeeding initiation rates. We think that this should go further to look at rates at selected points beyond birth. There is currently a sharp decline in the prevalence of breastfeeding during the early months: for example, only 63% of women who started breastfeeding were still doing so by 6 weeks [1]. As a result, it is important that the outcome for this quality standard is not simply whether breastfeeding is initiated.<br><br>• It would also be very useful to have small area (e.g. by postcode) data on breastfeeding rates so that those areas where this quality standard is not having an impact can be identified and any necessary action can be taken. This is particularly important because the initial incidence, prevalence at all ages up to 9 months, and duration of breastfeeding are all higher in affluent educated women [1]<br><br>For draft quality standard 14, the outcomes of interest are proportions of nulliparous women at 40 weeks and of nulliparous and parous women at 41 weeks who are offered a vaginal examination | |

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| | | | | for membrane sweeping and the rates of induction for prolonged pregnancy. Should the proportion of these women who actually have a membrane sweep be included as this is the link between these two outcomes?<br><br>Linked to draft quality standard 14, it would be very useful for the normal delivery rate by birth unit according to the Maternity Care Working Party definition to be routinely available [2]. Normal birth is defined by the Maternity Care Working Party for use throughout the UK as without induction, without the use of instruments, not by caesarean section, and without general, spinal or epidural anaesthetic before or during delivery. The consistent use of a standard definition for collection of data from birth units would facilitate comparisons within the UK to determine whether pregnancy and childbirth is a safe, positive and equitable experience for women.<br><br>[1] The NHS Information Centre. Infant Feeding Survey 2005. The NHS Information Centre, 2007.<br><br>[2] Maternity Care Working Party. Making normal birth a reality. Consensus statement from the Maternity Care Working Party. Our shared views about the need to recognise, facilitate and audit normal birth. NCT/RCT/RCOG November 2007. | |
| 0020 | NHS Sickle Cell and Thalassaemia Screening Programme | | Question 1 | *Can you suggest any appropriate healthcare outcomes for each individual quality statement*<br>As indicated above Draft quality statements1, 3, 5 and 10 should include an assessment of offer or testing by 10 weeks gestation or PND by 12 weeks 6 days | Thank you for your comment. The central quality improvement concept of Statement 1 of the published quality standard is importance of early access to antenatal care (ideally by 10 weeks 0 days).<br><br>All suggestions for additional statements were discussed |

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| | | | | | by the topic expert group who recognised the importance of screening for sickle cell and thalassaemia and infectious diseases in pregnancy. Quality standards do not aim to cover the entirety of the topic area; they aim to provide a concise and selected set of precise statements designed to improve quality across a particular area. The group made a consensus decision to focus the screening statement around fetal anomaly screening. However, NICE recognises that early booking is an important factor in delivering sickle cell and thalassaemia screening and quality statement 1 aims to support this.<br><br>In the final antenatal care quality standard:<br>-Statement 1 focuses on improving access to antenatal care (ideally by 10 weeks 0 days) which includes measures about the timeliness of access. One of the source clinical guideline references is to NICE clinical guideline 62, recommendation 1.6.3.3 which focuses on offering women screening for sickle cell and thalassaemia as early as possible within their pregnancy (ideally by 10 weeks).<br>-Statement 3 focuses on pregnant women having a complete record of the minimum set of antenatal test results in their hand-held maternity notes, including haemoglobinopathies screening and the outcome of screening for infectious diseases.<br><br>The quality standard in no way replaces the clinical guideline recommendations or National Screening Committee guidance and has been designed to serve quality improvement across antenatal care. It remains important that other evidence-based guideline recommendations continue to be implemented. |
| 003 | Royal College of | | Question 1 | As indicated above, the standards can be | Thank you for your comments. |

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| | Nursing | | | misleading and therefore commenting on measurable outcomes is difficult at this stage. | |
| 007 | Royal College of Obstetricians and Gynaecologists | | Question 1 | The suggested outcomes for the standards are appropriate. Additionally, please consider p33 outcome is incidence of stillbirths; this is the entire premise of reporting and acting upon RFM not solely providing re-assurance. | Thank you for your comments. Draft quality statement 12 has been removed from the final quality standard as the topic expert group feels that the evidence base linking reduced fetal movements to improved outcomes is limited. |
| 032 | Royal College of Paediatrics and Child Health (RCPCH) | | Question 1 | Healthcare outcomes – unbooked/late booked; maternal, fetal, neonatal mortality; referral for specialist care (mother and baby); preterm birth; admission to neonatal unit with encephalopathy; breast feeding commencement and continuing. | Thank you for these suggestions which have been considered by the topic expert group. The statement outcomes in the quality standard have been reviewed and updated.<br>The topic expert group prioritised measures they considered most important for measuring the quality statements. The quality measures aim to improve the structures and processes of care that are considered to be linked to outcomes, as well as specifying outcomes directly where the topic expert group felt able to define these. |
| 0025 | electivecesarean.com | | Question 2 | Suggested healthcare outcome:<br>Positive psychological and physical health outcomes *as assessed by the mother*. | Thank you for this suggestion which has been considered by the topic expert group. The statement outcomes in the quality standard have been reviewed and updated.<br>The topic expert group prioritised measures they considered most important for measuring the quality statements. The quality measures aim to improve the structures and processes of care that are considered to be linked to outcomes, as well as specifying outcomes directly where the topic expert group felt able to define these. |
| 0025 | electivecesarean.com | | Question 2 | Re: *Any important areas of care not covered?* My organisation's concern is that in its focus on *"pregnancy is a normal physiological process"*, there is a danger that it ignores the reality of many | Thank you for your comments. The scope of the antenatal care quality standard does not include the additional care required for women with antenatal complications or intrapartum care. There are a suite of maternity-related |

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| | | | | women's actual birth experience. For example, almost 25% of women will have a caesarean, and 12% will have an instrumental delivery. These very important areas of care could be given greater coverage in the quality standards, especially in terms of identifying strategies to reduce negative physical and psychological outcomes. | quality standards in development, some of which will include additional areas of care. Full details of maternity-related topics are available on the NICE website. |
| 0030 | Epilepsy Action | | Question 2 | Epilepsy Action support the development of this standard, however the standard does not address the management of pregnancy in women with epilepsy or other pre-existing conditions. This is despite the total number of maternal deaths from pre-existing medical conditions (including cardiac disease, epilepsy, asthma) out numbering direct maternal deaths from pregnancy-related causes. [Centre for Maternal and Child Enquiries (CMACE). Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer: 2006–08. The Eighth Report on Confidential Enquiries into Maternal Deaths in the United Kingdom. BJOG 2011;118(Suppl. 1):1–203.].<br><br>Epilepsy Action would like to see these quality standards encourage best practice in pregnancy care for women with epilepsy and other pre-existing medical conditions (as promoted in CMACE). This could be one standard that measures the proportion of women with pre-exiting medical conditions who have:<br>• An ante-natal care plan developed by her specialist/medical professional and obstetrics professional.<br>• Received ongoing care for her medical condition and pregnancy. | Thank you for your comments. The quality standard for antenatal care covers the antenatal care of all pregnant women, but the management of specific physical conditions and antenatal complications is outside of the scope. The full antenatal care scope, which was developed by the topic expert group is available from the NICE website.<br><br>The quality standard contains key markers of clinical and cost effective care across a care pathway. It remains important that other evidence-based guideline recommendations continue to be implemented. |

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| | | | | • Laboured in an ante-natal setting equipped for their condition (for example women with epilepsy are advise to give birth in a hospital equipped for maternal and neonatal resuscitation).<br>• Received/offered an early high-resolution ultrasound scan to scan for foetal major malformations when their condition or treatment carries a higher risk of foetal malformation.<br>Been referred to her medical professional for a postnatal medical and treatment review. | |
| 0027 | Foundation Trust Network | | Question 2 | Members note the standard may also wish to address antenatal anaesthetic reviews for high risk women | Thank you for your comments. The scope of the antenatal care quality standard does not cover the additional care required for women with pregnancy complications. |
| 0029 | National Childbirth Trust | | Question 2 | Many areas are not specifically covered, for example care of women who are rhesus negative, but we presume that the choice of areas to be included was evidence-based. We do, however, have some suggestions.<br>• We propose a standard that states that "All pregnant women and their partners should be offered and have access to antenatal education that covers the Preparing for Birth and Beyond framework". This framework has been developed and is being implemented by a multi-disciplinary group of professional and voluntary sector agencies and Department of Health representatives [1].<br>• There is no standard about discussing a woman's options for place of birth by a given deadline. Although draft quality standard 5 | Thank you for these suggestions. All suggestions for additional statements were discussed by the topic expert group. The group considered antenatal education and vitamin D supplementation for potential inclusion and felt this did not meet the specific criteria for a quality statement. Place of birth was beyond the scope of the antenatal care quality standard.<br>The topic expert group prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators.<br>The quality standard contains key markers of clinical and cost effective care across a care pathway. It remains important that other evidence-based guideline recommendations continue to be implemented. |

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| | | | | generally describes facilitating informed decisions about care, given that the results of the Birthplace in England national prospective cohort study support a policy of offering healthy women with low risk pregnancies a choice of birth setting, we feel that this should be set out in a specific separate standard [2]. Similar to this, the recent "Refreshed Framework for Maternity Care in Scotland" included a service descriptor about the choice of where and how to give birth [3]. Ideally, women should be given information about the advantages and disadvantages of each option for themselves and their babies, including outcomes and transfer rates. The process draft quality measure could be the proportion of women at the start of care in labour (so that it is directly comparable with the Birthplace study) who have received information about the different options for place of birth.<br><br>• There is no standard about providing information about vitamin D supplementation. The NICE guidance on maternal and child nutrition (PH11) [4] states that every pregnant woman should be offered information about the benefits of vitamin D supplementation, such as to reduce the baby's risk of developing rickets, and that health professionals should particularly check that women at greatest risk of deficiency (e.g. women who are obese, have limited exposure to sunlight or who are of South Asian, African, Caribbean or Middle Eastern descent) are following the advice to take a vitamin D supplement during pregnancy and while | |

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| | | | | breastfeeding. Given this recommendation, it may be appropriate to highlight the provision of information about vitamin D supplementation, particularly to women at greatest risk of deficiency, in this document.<br><br>[1] Department of Health. Preparation for birth and beyond: a resource pack for leaders of community groups and activities. Department of health, London 2011.<br><br>[2] Birthplace in England Collaborative Group. Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. BMJ 2011; 343: d7400.<br><br>[3] The Maternity Services Action Group. A Refreshed Framework for Maternity Care in Scotland. The Scottish Government, Edinburgh 2011.<br><br>[4] National Institute for Health and Clinical Excellence. Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households. NICE public health guidance 11. National Institute for Clinical Excellence, March 2008. | |
| 0020 | NHS Sickle Cell and Thalassaemia Screening Programme | | Question 2 | *What important areas of care, if any, are not covered by the quality standard*<br>As indicated in our response – the issue of timeliness in pregnancy is not included in screening for sickle cell and thalassaemia and we see this as a major omission to quality antenatal care.<br>We also think that the standards would be improved if record keeping linked to newborn | All suggestions for additional statements were discussed by the topic expert group who recognised the importance of screening for sickle cell and thalassaemia and infectious diseases in pregnancy. The group made a consensus decision to focus the screening statement around fetal anomaly screening. However, NICE recognises that early booking is an important factor in delivering sickle cell and thalassaemia screening and quality statement 1 aims to support this. |

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| | | | | screening was included. | In the final antenatal care quality standard:<br>-Statement 1 focuses on improving access to antenatal care (ideally by 10 weeks 0 days) which includes measures about the timeliness of access. One of the source clinical guideline references is to NICE clinical guideline 62, recommendation 1.6.3.3 which focuses on offering women screening for sickle cell and thalassaemia as early as possible within their pregnancy (ideally by 10 weeks).<br>-Statement 3 focuses on pregnant women having a complete record of the minimum set of antenatal test results in their hand-held maternity notes, including haemoglobinopathies screening and the outcome of screening for infectious diseases.<br><br>The quality standard in no way replaces the clinical guideline recommendations or National Screening Committee guidance and has been designed to serve quality improvement across antenatal care. It remains important that other evidence-based guideline recommendations continue to be implemented. |
| 0031 | Perinatal Institute | | Question 2 | Women at high risk of fetal growth restriction (FGR) should be offered serial growth scans during pregnancy (target 100%).<br>All women should be offered parentcraft and parenting classes (target 100%).<br>Women with a previous caesarean section should be counselled on VBAC (target 100%). | All suggestions for additional statements were discussed by the topic expert group.<br><br>The topic expert group prioritised areas of care which were within the scope of the antenatal care quality standard and where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators.<br><br>The quality standard contains key markers of clinical and cost effective care across a care pathway. It remains |

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| | | | | | important that other evidence-based guideline recommendations continue to be implemented. |
| 0031 | Perinatal Institute | | Question 2 | Women should be seen alone at least once during their pregnancy to ask the routine enquiry questions (target 100%).<br>Women with substance misuse at booking should be referred to substance misuse advisor (target 100%).<br>All women who are new immigrants, asylum seekers or failed asylum seekers should be prioritised by maternity care providers and appropriate care pathways initiated by appropriately trained healthcare professionals (target<br>100%).<br>All women should have access to pre-conceptual advice (GP surgeries). | All suggestions for additional statements were discussed by the topic expert group.<br><br>The topic expert group prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators.<br><br>The quality standard contains key markers of clinical and cost effective care across a care pathway. It remains important that other evidence-based guideline recommendations continue to be implemented. |
| 003 | Royal College of Nursing | | Question 2 | There is no mention of choice of place of birth being offered in the standards, as there was with maternity matters. | The standard addresses routine antenatal care and does not cover aspects of intrapartum care including birthing choices.<br><br>The antenatal care quality standard is part of a suite of maternity-related standards which includes intrapartum care and which will be developed in due course.<br><br>Full details of maternity-related topics are available on the NICE website. The suite of maternity-related quality standards will cover core routine maternity care along with some additional areas of care. |
| 007 | Royal College of Obstetricians and Gynaecologists | | Question 2 | None | Thank you for your comment. |

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| 0014 | Department of Health (Children Family and Maternity branch) | | Question 3 | Most important are statements that can provide clinical outcome measures<br>1 Access and engagement in antenatal care gives the opportunity to provide care and improve outcomes (evidence CEMD that lack of AN care associated with poor outcomes)<br>2 If the emphasis is named midwife and continuity of care, this is high priority because continuity of care improves patient satisfaction and potentially quality of care<br>5 Quality of information and communication is very important. We agree with the statement but not necessarily with the suggested measures which are all associated with the antenatal screening offer – need to have some measure of how successful the information was e.g. uptake of screening or choice of place of birth rather than just the process measure which merely encourages tick-box compliance<br>12 This quality standard, as long as it includes the increasing women's awareness of the need to report reduced fetal movements has the potential to reduce SB and is a QS that will be welcomed by SANDS<br>6,7,8,9 are all important because they put emphasis on the importance of the initial risk assessment and what action should be taken. There is the possibility to measure compliance by clinical outcome | Thank you for these comments which have been considered by the topic expert group. |

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| 0030 | Epilepsy Action | | Question 3 | It is the view of Epilepsy Action that each drafted quality statement carries the same level of importance. However to deliver equality and safety in the antenatal care delivered to women with epilepsy, we have called for a number of small additions to the draft quality measures relating to quality standards 1,2,4,5,10 and 11. | Thank you for these comments which have been considered by the topic expert group. |
| 0029 | National Childbirth Trust | | Question 3 | Draft quality standards 1, 2 and 5 encompass the key elements of a quality service (namely access to antenatal care, continuity of care, and the provision of evidence-based, balanced and consistent information to facilitate informed decision-making) under which the other standards sit. | Thank you for these comments which have been considered by the topic expert group. |
| 0020 | NHS Sickle Cell and Thalassaemia Screening Programme | | Question 3 | *What in your opinion are the most important quality standards and why*<br>It is important that all aspects are covered, rather than one being more important than others. | Thank you for these comments which have been considered by the topic expert group. |
| 0031 | Perinatal Institute | | Question 3 | All women should be offered Healthy Start vitamins/ supplements pre-pregnancy. That women access services as early as possible to ensure early risk assessment and initiation of appropriate care pathways that are regularly assessed/reviewed throughout. New Quality Standard – Fetal Growth Restriction is the highest risk factor with stillbirth. Antenatal detection of FGR is vital in ensuring appropriate management and should be a KPI, as implemented in the West Midlands. | All suggestions for additional statements were discussed by the topic expert group.<br><br>The topic expert group prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators.<br><br>The quality standard contains key markers of clinical and cost effective care across a care pathway. It remains important that other evidence-based guideline recommendations continue to be implemented. |

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| 009 | Royal College of Midwives | | Question 3 | 5 - we know that good information giving is of paramount importance for women<br>1, 6, 11 - as there is considerable evidence that these women are not getting adequate care.<br>8 and 9 | Thank you for these comments which have been considered by the topic expert group. |
| 003 | Royal College of Nursing | | Question 3 | Number 13 and 14 are the most important standard, as any measures to reduce the need for obstetric intervention such as induction of labour, are likely to improve the quality of experience for women and their families. The advice to offer membrane sweep at 40 week visit is particularly helpful in this respect. | Thank you for these comments which have been considered by the topic expert group. |
| 007 | Royal College of Obstetricians and Gynaecologists | | Question 3 | 3, 5, 8, 10 because these likely to improve care for the largest number of women | Thank you for these comments which have been considered by the topic expert group. |
| 0014 | Department of Health (Children Family and Maternity branch) | | Question 4 | The measures are mostly process driven and will result in Tick-box compliance. We must identify measures that will monitor trends for health gain with improvement in quality, safety and patient satisfaction. | We have considered all suggestions for suitable outcome measures. The topic expert group prioritised measures they considered most important for measuring the quality statements. The quality measures aim to improve the structures and processes of care that are considered to be linked to outcomes, as well as specifying outcomes directly where the topic expert group felt able to define these. |
| 0029 | National Childbirth Trust | | Question 4 | We consider that all of the quality standards are appropriate. | Thank you for these comments. |
| 0020 | NHS Sickle Cell and Thalassaemia Screening Programme | | Question 4 | *Are any of the proposed quality measures inappropriate and, if so, can you identify suitable alternatives*<br>No comment | Thank you for your comment. |
| 0014 | Department of | | Question 5 | Yes, there should be a separate quality statement | Thank you for your comment. A statement on smoking |

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| | Health (Children Family and Maternity branch) | | | addressing smoking cessation for pregnant women. The Tobacco Control Plan 2011 for England includes a national ambition to reduce rates of pregnant women smoking at time of delivery to 11 per cent by the end of 2015. It will be useful to have a quality standard to ensure that health professionals can assist in helping to drive forward this national ambition. | cessation has been included in the final quality standard. |
| 0027 | Foundation Trust Network | | Question 5 | Members note that smoking should be included as a quality statement. One possible measure might be for providers to offer all smokers assistance with cessation; leaving providers to locally decide the nature of the assistance that would be most effective and clinically appropriate for their maternity patients. | Thank you for your comment. A statement on smoking cessation has been included in the final quality standard. |
| 0029 | National Childbirth Trust | | Question 5 | We feel that there should be a statement about improving health, but this would need to be carefully worded to take into account the complex causes of behaviours and that only providing information is not necessarily effective in promoting changes.<br><br>The statement could, for example, say that pregnant women should be offered evidence-based information about the impact on their baby of improving their health, including stopping smoking. The statement could then say that women will have the opportunity to discuss this information and any other information about the impact of improving their health or changing their behaviour when they feel it is appropriate and that this will be backed up by the provision of appropriate services should they choose to make | Thank you for your comment. A statement on smoking cessation has been included in the final quality standard. |

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| | | | | changes. The recent “Refreshed Framework for Maternity Care in Scotland” describes, for example, maternity care staff working in partnership with women in relation to their own and their baby’s health and well-being and smoking is one of the essential areas listed [1].<br><br>[1] The Maternity Services Action Group. A Refreshed Framework for Maternity Care in Scotland. The Scottish Government, Edinburgh 2011. | |
| 0024 | Northumbria Healthcare NHS Trust | | Question 5 | As a group we would say yes that there should be a separate quality statement addressing smoking cessation for pregnant women | Thank you for your comment. A statement on smoking cessation has been included in the final quality standard. |
| 0031 | Perinatal Institute | | Question 5 | A smoking cessation quality standard is needed within this document similar to other public health quality standards (Quality Standard 6 - BMI>30, new quality standard<br>– Substance misuse). General ‘Commissioners sections’ – should include a comprehensive needs assessment and trajectory of their populations to ensure effective planning and service capacity. | Thank you for your comment. A statement on smoking cessation has been included in the final quality standard.<br><br>The quality standard is not intended to provide detailed commissioning guidance, but a starting point for local quality improvement. This level of detail may be specified at a local level. |
| 003 | Royal College of Nursing | | Question 5 | Smoking cessation is best left as a public health indicator (as would be the preference for pregnant women with BMI over 30) as this will support the commissioning of appropriate interventions from providers other than maternity services. | Thank you for this feedback which has been considered by the topic expert group.<br><br>It is important that the quality standard, as part of a broad library of topics, is able to accommodate elements that have overlap (between the interface between clinical, public health and social care). |
| 007 | Royal College of Obstetricians and Gynaecologists | | Question 5 | Should there be a separate quality statement addressing smoking cessation for pregnant women? Yes. | Thank you for your comment. A statement on smoking cessation has been included in the final quality standard. |

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| 032 | Royal College of Paediatrics and Child Health (RCPCH) | | Question 5 | Yes | Thank you for your comment. A statement on smoking cessation has been included in the final quality standard. |
| 0028 | Unite the Union/CPHVA | | Question 5 | Yes, there should be a separate quality statement addressing smoking cessation for pregnant women | Thank you for your comment. A statement on smoking cessation has been included in the final quality standard. |
| 0014 | Department of Health (Children Family and Maternity branch) | | Question 6 | No – we think this is the wrong emphasis. What is needed is a named midwife giving the majority of care and good handover and cover when she is not available so that the emphasis is on continuity of care. (see more comments below) | Thank you for this comment. In the final quality standard the statement about continuity of care has been refocused to named midwife. |
| 0025 | electivecesarean.com | | Question 6 | In the definition for "a small group of healthcare professionals", suggest that this includes the word "or" in relation to care providers; i.e. midwives *or* obstetrician/consultant. My organisation is very concerned about the push towards "midwife-led care" for all 'low-risk' women*, and would like to see recognition that some women feel better suited to "obstetrician-led" care throughout their pregnancy (in a similar wording to that on pg.7, parag.4, which refers to "midwife or doctor").<br>*Midwife led care may not be appropriate or cost effective (BMJ2011;342:d2298)<br>http://www.bmj.com/content/342/bmj.d2298.full?keytype=ref&ijkey=j7RjVr3XVLG7F7G#aff-1 | Thank you for this comment. In the final quality standard the statement about continuity of care has been refocused to named midwife. |
| 0029 | National Childbirth Trust | | Question 6 | This states that "Pregnant women are cared for by a small group of healthcare professionals throughout their pregnancy".<br>We support that women are cared for by and have access to a named midwife or midwives in the | Thank you for this comment. In the final quality standard the statement about continuity of care has been refocused to named midwife. The supporting measures and definitions reflect this key quality concept. |

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| | | | | community and a named consultant obstetrician, which is in agreement with the example given in the definition of continuity of care set out on page 9 of the Draft quality standard for antenatal care. There should, however, also be access to a named professional who is able to discuss information and decisions around feeding and it would be useful to state a specific number of midwives because this would facilitate better assessment of such a standard. Any assessment of the standard should also exclude midwives contacted by telephone between appointments because this could discourage the provision of prompt and frequent telephone support for women who have questions or concerns. | |
| 003 | Royal College of Nursing | | Question 6 | It is not possible at present to suggest a prescriptive response for this question as the draft standard to which it relates seems to be impracticable. | Thank you for this comment. In the final quality standard the statement about continuity of care has been refocused to named midwife. |
| 0023 | Bliss | | Section 8 | We think it would be relevant to include reference to the NICE quality standards on specialist neonatal care in this section | Thank you for your comment. This has now been included. |
| 0014 | Department of Health (Children Family and Maternity branch) | | Using the Quality Standard | Although recognising that the quality standards are not “targets or mandatory indicators for performance management” we hoped for a clear steer and understanding that the quality standards should be integral to commissioning and service specification. They should be a major factor in reducing geographical variations in care by setting clear and unambiguous standards for service provision and clinical care.<br>Although we accept that it would not always be appropriate for “expected levels of achievement “ to be specified, there are some process measures | Thank you for your comments. The expectation is that quality statements and measures will be used and adapted at a local level and this level of detail would be decided locally. The principle is that all standards<br><br>While 100% is the aspirational achievement for all standards (or 0%), the feedback we have received is that it remains important to retain the principle that all standards should take account of patient safety, patient choice and clinical judgement.<br><br>As basis of national indicators to support the priorities of |

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| | | | | that should unequivocally be 100% e.g. recording BMI at booking (QS 6), recording risk factors for gestational diabetes at booking (QS 7), women presenting by 14 weeks offered screening (QS 10), women given information on infant feeding (QS 11). Could this be made clear? Then it should be clear that commissioners and providers should agree and specify expected local levels of achievement within the contracting and commissioning process to encourage driving up the quality of care. | relevant national Outcomes Frameworks, including indicators for the Commissioning Outcomes Framework, some of the measures will be further tested to ascertain appropriate levels of achievement to realise improvement. |
| 0029 | National Childbirth Trust | 1 | | This states that "Pregnant women, including those with complex social needs, are actively supported to access antenatal care".<br>We agree with this quality statement but would amend it slightly to highlight that "**All p**regnant women, including those with complex social needs, are actively supported to access antenatal care". | Thank you for your comments. The scope of the antenatal care quality standard covers the routine antenatal care of all pregnant women and as such statement one applies to all women. |
| 004 | NHS South Central | 1 | | Pregnant women should be encouraged to book early so that a timely offer of screening is made (75%) by 10+0 weeks of pregnancy – see Standard AP1 in the NHS Sickle Cell and Thalassaemia Screening Programme p.39. I think this standard will be misleading if this is not mentioned. | Thank you for these comments. This statement has now been revised and now reads:<br>'Pregnant women are supported to access antenatal care, ideally by 10 weeks 0 days'.<br>The measures have been revised accordingly. |
| 008 | Tamba (Twins & Multiple Births Association) | 1 | | **In response to question 1**- A potential measure could be that for late bookers (i.e. women who book after 12 weeks and 6 days) there is evidence locally of audits of women to establish the reasons for late booking in order to address local issues or cultural needs using questionnaires, telephone | Thank you for this suggestion. The quality measures have been reviewed and updated.<br>The scope of the antenatal care quality standard covers the routine antenatal care of all pregnant women and as such statement one applies to all women including women |

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| | | | | surveys etc.<br>**In response to question 2** -the standard does not cover or mention the needs of mothers of multiples. Tamba welcomed NICE clinical guidance 129 (2011) and consider the development of this quality standard to be an important opportunity to further include and emphasise the needs of **all** pregnant women. NICE clinical guideline 129 highlights, as a key priority, the need to 'Coordinate clinical care for women with twin and triplet pregnancies to; minimise the number of hospital visits, provide care as close to home as possible…'<br>**Source** –recommend NICE clinical guideline 129 to be added to references.<br>**Definitions** – suggest the inclusion of recommended number of antenatal appointments NICE clinical guideline 129 section 1.2.3.5-1.2.3.9<br>**In response to question 3** –Tamba believe this quality statement is one of the most important quality statements. All pregnant women must be actively supported to access antenatal care to enable them to be given the appropriate information and choices to ensure positive health outcomes for them and their baby/babies as early as possible. Service providers need to be innovative and flexible in their approach encouraging women to be able to book and access antenatal care in a variety of community and hospital settings. | with a multiple pregnancy.<br><br>The scope of the antenatal care quality standard does not cover the additional care required for women with multiple pregnancies. There is a separate NICE quality standard on multiple pregnancy which is in development. This has now been referenced within the antenatal care quality standard as a related NICE quality standard.<br><br>The forthcoming multiple pregnancy quality standard will be underpinned by NICE clinical guideline 129 (multiple pregnancy) and will set out markers of high quality care which are in addition or different to those for women with a singleton pregnancy. |
| 0014 | Department of Health (Children Family and Maternity branch) | 1 | Data Sources | The Maternity dataset will provide information to enable the measure to be a quality outcome of the elements of the AN risk and needs assessment, it will provide ethnicity, deprivation score by | Thank you for these suggested data sources. We have considered all suggestions for suitable data sources and updated the data sources sections. |

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| | | | | postcode, English as first language, substance use etc, all the elements needed for social needs assessment and employment status, as well as numbers of appointments for subsequent care. It is not clear whether the CQC survey will be repeated in any form so can at the moment only be relied upon for comparison using new data sources | |
| 0030 | Epilepsy Action | 1 | General | Epilepsy Action would like the draft quality measure: *Service should consider breaking down outcomes a-c by subgroups of women with complex social needs* -to include women with pre-existing medical conditions as a sub group. The CMACE 2011 report (and reports from its predecessor the Confidential Enquiry into Maternal and Child Health CEMACH) advocate that women with pre-existing medical conditions are referred for specialist opinion in early pregnancy. Measuring access to antenatal care for these women could indicate whether or not women are being seen in early pregnancy. | Thank you for your comments. Please note that the structure measures have been revised and updated. The expectation is that quality statements and measures will be used and adapted at a local level, alongside the evidence based guidance, to ensure services are sensitive to local needs. This level of detail would be decided locally. A definition of complex social needs is referenced within the quality standard, taken from the underpinning clinical guidance. |
| 0027 | Foundation Trust Network | 1 | General | Members note the standard may wish to include a measure of the proportion of women with complex social needs who have had regular content with a midwife. | The structure measures capture the importance of local services being readily and easily accessible for the local population, which includes women with complex social needs. The phrase 'complex social needs' is defined within the equality and diversity considerations section. |
| 0022 | Multiple Births Foundation | 1 | General | It would be helpful to clarify that this includes women with a multiple pregnancy so that the specific antenatal care set out in the NICE Multiple Pregnancy Guideline will be implemented. | Thank you for your comments. The scope of the antenatal care quality standard covers the routine antenatal care of all pregnant women and as such statement one applies to all women including women with a multiple pregnancy.<br><br>The scope of the antenatal care quality standard does not |

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| | | | | | cover the additional care required for women with multiple pregnancies. There is a separate NICE quality standard on multiple pregnancy which is in development. This has now been referenced within the antenatal care quality standard as a related NICE quality standard.<br><br>The forthcoming multiple pregnancy quality standard will be underpinned by NICE clinical guideline 129 (multiple pregnancy) and will set out markers of high quality care which are in addition or different to those for women with a singleton pregnancy. |
| 0024 | Northumbria Healthcare NHS Trust | 1 | General | As a group we feel this first statement to be extremely relevant and of great importance. Access must be considered and care tailored to meet the needs of the individual to allow attendance at appointments or support groups as necessary. Making the appointments around the client will ensure improved uptake of services in the more disadvantaged groups. | Thank you. |
| 0031 | Perinatal Institute | 1 | General | 'Description of the quality statement and its meaning for each audience – commissioners'<br>– How will commissioners understand their population needs without good quality primary source data?<br>– Complex social needs will require commissioned services from health, local authority and voluntary organisations and engagement from the multi-disciplinary team.<br>– Commissioners need to ensure that service providers have sufficient capacity to meet the additional needs of women and families with complex social needs.<br>– Commissioners will require evidence that | NICE has produced a support document to help commissioners and others consider the commissioning implications and potential resource impact of this quality standard. |

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| | | | | maternity care providers have the appropriate skills and care pathways to recognise and refer women with complex social needs to meet their requirements. | |
| 0031 | Perinatal Institute | 1 | General | The quality statement should also state '….and maintain appropriate contact' | The statement and associated measures refers to accessing antenatal care and therefore implies maintaining contact throughout the antenatal care period.<br><br>Statements are worded to be as concise and precise as possible, recognising that they complement more detailed evidence based guidelines and recommendations. |
| 0031 | Perinatal Institute | 1 | General | The outcomes are confusing for this quality statement as the measure definitions vary and therefore open to local interpretation i.e. the operating Framework describes 'booking completed', the MSDS uses the term 'booking' (may not be fully completed) and the Maternity Services Survey states 'giving the woman the pregnancy notes' (which may be before booking). | It is not anticipated that these quality statements and measures be used as targets. The expectation is that quality statements and measures will be used and adapted at a local level. Statements are worded to be as concise and precise as possible, recognising that they complement more detailed evidence based guidelines and recommendations.<br><br>Relevant measures from the operating framework, maternity services secondary uses dataset and maternity services survey are highlighted in the final quality standard to support services already working with these. |
| 009 | Royal College of Midwives | 1 | Measure | Following up on these women in a defined timescale is perceived as very difficult with the limitations of relevant IT | The timescales referred to in the measures are intended to be defined at a local level. |
| 0020 | NHS Sickle Cell and Thalassaemia Screening Programme | 1 | Measure, Source, Clinical Guideline Reference | "Draft Quality Statement: Pregnant women including those with complex social needs are actively supported to access antenatal care". "Draft Quality measure (c) Evidence of local audits of women, broken down by different populations, not booking for antenatal care by 12 weeks, 6 | Thank you for these comments. This statement has now been revised and now reads:<br><br>'Pregnant women are supported to access antenatal care, ideally by 10 weeks 0 days'. |

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| | | | | days”<br><br>The Sickle cell and thalassaemia screening programme is concerned because this target is outwit the NICE antenatal care guideline CG 62, Routine care for the antenatal woman, published June 2010. Section 1.6.3.3 states “Screening for sickle cell diseases and thalassaemias should be offered to all women as early as possible in pregnancy (ideally by 10 weeks).“<br><br>Antenatal screening policy is to offer sickle cell and thalassaemia screening to all pregnant women. If a woman is identified as a carrier, the baby’s father will also be offered screening. Practically this means offering screening early enough to allow time for screening the baby’s father, prenatal diagnosis, making a decision and taking action if wished – including vacuum suction termination – before the pregnancy is public knowledge.<br><br>There is a known association between gestation at screening offer and uptake of prenatal diagnosis (PND), with the early offer of screening being associated with greater uptake of PND [1 2 3]. One of the main objectives of antenatal screening for sickle cell and thalassaemia is to ensure that all eligible women are offered screening by 10+0 weeks, to allow time for fathers to be tested and for early prenatal diagnosis if wanted, reporting of results, and any subsequent action by the end of 13 weeks of pregnancy. This is consistent with NICE Guidelines [4] and preferred by women[5] . The majority of prenatal diagnostic testing | The measures have been revised accordingly. |

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| | | | | currently takes place after 11+6 weeks' gestation [6], which is too late to allow parents to make informed and timely reproductive choices, especially for some groups in the population and contrary to users wishes.<br><br>The highest prevalence of sickle cell disease is among black Africans and black Caribbean's. About 1 in 7 newborn babies of black African origin are carriers of sickle cell disease. The highest prevalence of thalasssaemia is among Cypriots, Italians, Greeks, Indians, Bangladeshis and other south East Asian groups.<br><br>Given the evidence on the association between gestation of screening offer and uptake of diagnostic testing for a condition predominantly affecting people from minority ethnic groups, a failure to include timeliness as a NICE antenatal quality standard has the potential to specifically disadvantage those from minority ethnic groups and therefore raises concerns around equality.<br><br>1 Modell, B., et al., *Informed Choice in Genetic Screening for Thalassaemia during Pregnancy: Audit from a National Confidential Inquiry.* BMJ: British Medical Journal, 2000. **320**(7231): p. 337-341.<br>2 Neuenschwander, H. and B. Modell, *Audit of process of antenatal screening for sickle cell disorders at a north London hospital.* BMJ, 1997. **315**(7111): p. 784.<br>3. Greengross, P., et al., *Outcomes of universal antenatal screening for haemoglobinopathies.* Journal of Medical | |

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| | | | | Screening, 1999. **6**(1): p. 3.<br>4. National Institute for Health and Clinical Excellence, *CG-62 Antenatal - NICE Guideline*. 2010.<br>5. Ahmed, S., J.M. Green, and J. Hewison, *Attitudes towards prenatal diagnosis and termination of pregnancy for thalassaemia in pregnant Pakistani women in the North of England.* Prenatal Diagnosis, 2006. **26**(3): p. 248-257.<br>6 NHS Sickle Cell and Thalassaemia Screening Programme, *Data Report: 2008/09 - Informing Policy and Improving Quality*. 2011.<br><br>Data on testing by 10 weeks is available from<br>• antenatal screening laboratories who submit the data annually to the NHS Sickle cell and thalassaemia screening programme<br>• through quarterly collection of screening Key performance indicators and the Maternity and Children's Data Set (MCDS) from April 2013. The MCDS has been approved by the Information Standards Board (ISB) and is awaiting approval for an Information Standards Notice (ISN). | |
| 0014 | Department of Health (Children Family and Maternity branch) | 1 | Outcome | **Outcome** (a) This is a process indicator which could just be a measure of contact but if the booking and completion of the risk and needs assessment was required then it would be an outcome measure. The implementation of the | We have considered all suggestions for suitable outcome measures. The topic expert group prioritised measures they considered most important for measuring the quality statements. The quality measures aim to improve the structures and processes of care that are considered to be |

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| | | | | maternity dataset will make this possible if a minimum number of completed fields are needed to demonstrate that the assessment and plan of care has been recorded<br>(c) should be broken down by nulliparous and multiparous to get a better assessment of whether the recommended number of bookings are being met. In the future (depending on the maternity dataset) it should be possible to link number of visits to clinical outcomes<br>Commissioners should require outcomes a)- c) to be broken down by ethnicity, deprivation scores, disadvantaged groups so that they can be reassured that they are commissioning services that are appropriate for the health needs of their population | linked to outcomes, as well as specifying outcomes directly where the topic expert group felt able to define these.<br>The quality standard is not intended to provide detailed commissioning guidance, but a starting point for local quality improvement. |
| 0014 | Department of Health (Children Family and Maternity branch) | 1 | Process | **Process :** This is covered in CNST Standard 4 criterion 1 and 2. If the statement relates to initial access to care then this measure is too wide suggesting DNAs for any stage of pregnancy. A more useful process measure would be the number of women accessing health care for pregnancy by gestation at access as a measure for commissioners.<br>If the statement is to include continued engagement with maternity services then DNA rates and follow-up data will be useful and a measure of the provider service and process. | We have considered all suggestions for suitable outcome measures. The topic expert group prioritised measures they considered most important for measuring the quality statements.<br><br>Outcome measure for DNA and follow-up were considered as these are implicit in the process measure, but the group decided that the key focus of the outcomes should be retained as access and attendance for appointment, i.e. as direct measurable outcomes of this statement. |
| 002 | UK Newborn Screening Programme Centre | 1 | Process | Nationally defined timescales for follow-up would be much more helpful than locally defined timescales | The topic expert group reviewed all measures in the draft quality standard and have prioritised and refined those they considered most important to measure the quality statements in the final standard. It is not anticipated that these quality statements and measures be used as |

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| | | | | | targets. The expectation is that quality statements and measures will be used and adapted at a local level. |
| 0014 | Department of Health (Children Family and Maternity branch) | 1 | Quality Measure | **structure** : It will be necessary to define who is accountable for this, and the role and responsibilities of the commissioner and provider. The commissioners will be responsible for ensuring that there are accessible services for all women for whom they commission care and this may span several providers. The providers need to make sure that the services they offer are appropriate, attractive and accessible for the local women.<br>(a) and (b) relate to the provider who should also demonstrate how they have made themselves accessible to women, but (c) must be measured by the commissioner to ensure they are commissioning services appropriate for all their women | Thank you for your comments. Please note that the structure measures have been revised and updated. We agree with your feedback and expect that accountability arrangements and roles and responsibilities will be decided at a local level. The quality standard is not intended to provide detailed commissioning guidance, but a starting point for local quality improvement. This level of detail may be specified at a local level.<br><br>Please also see the Support for commissioners using the antenatal care quality standard document which is available on the NICE website. |
| 0014 | Department of Health (Children Family and Maternity branch) | 1 | Statement | **Statement** – should be **" All** pregnant women…" There are definition problems here and it will be important to differentiate between "access" meaning women has contacted health services to report her pregnancy (which would be a process measure), and booking meaning that a useful assessment has been carried out (which could be an outcome measure if an informed plan of care had been recorded and this data will be available from the Maternity dataset). | Thank you for your comments. The scope of the antenatal care quality standard covers the routine antenatal care for all pregnant women and as such statement one applies to all women. The measures focus on the timeliness of booking appointments. |
| 0029 | National Childbirth Trust | 2 | | This states that "Pregnant women are cared for by a small group of healthcare professionals throughout their pregnancy". | In light of consultation feedback the focus of this statement has changed and the final statement has been revised to:<br>'Pregnant women are cared for by a named midwife |

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| | | | | We would amend the statement to highlight that it should apply to all pregnant women, although we would add that priority should be given to those women with particular clinical or social needs if availability is limited i.e. “All pregnant women are cared for by a small group of healthcare professionals throughout their pregnancy with priority for continuity of carer being given to those with complex clinical or social needs”. | throughout their antenatal care.’ |
| 0012 | NHS London | 2 | | The definition of continuity of care “…. as the provision of care by the same small team of healthcare professionals throughout pregnancy” is not what would be expected of the term by lay people. Why not define continuity of care as provision of care *by the same person (or small team)*? The Quality Standard starts with a model of ‘one obstetrician and four midwives’ (the ‘group’ standard that might be broken). It is not fully congruent with the evidence for low risk women, which is that midwifery-led models have better outcomes than obstetric led models (which is what is described). Thus, the quality standard is somewhat low in aspiration and thus less likely to raise standards of care for women. It would be better to state that the ideal is one midwife [with an identified link consultant if required or to cover responsibility for emergency care]. If a woman is low risk, an obstetrician is not required at all. It is possible to keep the number of midwives down to one, or close to one, particularly if a model of caseloading is supported. See http://summaries.cochrane.org/CD004667/midwife-led-versus-other-models-of-care-for-childbearing-women | In light of consultation feedback the focus of this statement has changed and the final statement has been revised to: ‘Pregnant women are cared for by a named midwife throughout their antenatal care.’ |

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| 009 | Royal College of Midwives | 2 | | The use of the definition of a small team of health professionals as ' a service consisting of four midwives and one obstetrician' is confusing here - as many women will not need to access an obstetrician. The RCM consider that the appropriate small team here for 'routine, scheduled antenatal care' would be 3 midwives. | In light of consultation feedback the focus of this statement has changed and the final statement has been revised to: 'Pregnant women are cared for by a named midwife throughout their antenatal care.' |
| 003 | Royal College of Nursing | 2 | | Suggest rewording this standard to read:<br><br>"Pregnant women with uncomplicated pregnancies are cared for by a small group of healthcare professionals (this may be physiotherapist, GP, midwife) throughout their pregnancy"<br><br>The draft statement is inappropriate for women with complex antenatal care who may be treated at a tertiary centre for fetal abnormality, by consultant specialists for endocrine disorders, heart problems, venous thrombosis, obesity, diabetes etc.<br>Prescribing a small group of health professionals in such circumstances is unrealistic and contradicts some of the other standards. | In light of consultation feedback the focus of this statement has changed and the final statement has been revised to: 'Pregnant women are cared for by a named midwife throughout their antenatal care.' |
| 008 | Tamba (Twins & Multiple Births Association) | 2 | | **In response to question 1**- the draft quality measures could include evidence of local audit to identify the implementation of agreed pathways for uncomplicated pregnancies and those for more complex or requiring specialist care e.g. for multiple mothers. NICE clinical guideline 129 encourages 'Networks to agree care pathways for managing all twin and triplet pregnancies to ensure that each woman has a care plan in place | The scope of the antenatal care quality standard does not cover the additional care required for women with multiple pregnancies. There is a separate NICE quality standard on multiple pregnancy which is in development. This has now been referenced within the antenatal care quality standard as a related NICE quality standard.<br><br>The forthcoming multiple pregnancy quality standard will be underpinned by NICE clinical guideline 129 (multiple |

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| | | | | that is appropriate for the chorionicity of her pregnancy.<br>**In response to question 2**- as before the standard is not inclusive to the needs of multiples mothers. NICE clinical guideline 129 recommends clinical care is coordinated to 'provide continuity of care within and between hospitals and the community'.<br>**Source** -Tamba recommend NICE clinical guideline 129 key priorities for implementation is added to references.<br>**In response to question 6**- a 'small group of healthcare professionals' is defined for mothers of multiples in Section 1.2.3-this could be adapted to define a recommended team for uncomplicated pregnancies and recommended enhanced team for complex pregnancies. | pregnancy) and will set out markers of high quality care which are in addition or different to those for women with a singleton pregnancy.<br><br>In light of consultation feedback the focus of this statement has changed and the final statement has been revised to: 'Pregnant women are cared for by a named midwife throughout their antenatal care.' |
| 0028 | Unite the Union/CPHVA | 2 | | A small group of healthcare professionals will include the lead midwife responsible for her case and his/her deputy, the GP responsible for her case and his/her deputy, practice nurses at the GP surgery, hospital staff in the ante-natal clinic and on the maternity unit, and any other relevant or significant healthcare professional or voluntary sector worker. Commissioners should require that provider hospital services ensure that pregnant women are always seen by the same hospital team, and that where that is a training hospital for medical students or nurses, that the woman (and her partner) is always asked for consent for them to attend, and that there is a requirement that each person formally introduces themselves and explains why they are there. | In light of consultation feedback the focus of this statement has changed and the final statement has been revised to: 'Pregnant women are cared for by a named midwife throughout their antenatal care.' |
| 0014 | Department of | 2 | Data | The CQC question does not provide good | In light of consultation feedback the focus of this statement |

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| | Health (Children Family and Maternity branch) | | Sources | evidence for continuity of care. Better ,if given the opportunity, to ask if the woman felt she had continuity of care and if she knew the name and contact details of her midwife. | has changed and the final statement has been revised to: 'Pregnant women are cared for by a named midwife throughout their antenatal care.'<br><br>We have considered all suggestions for suitable outcome measures. The topic expert group prioritised measures they considered most important for measuring the quality statements. The quality measures aim to improve the structures and processes of care that are considered to be linked to outcomes, as well as specifying outcomes directly where the topic expert group felt able to define these. |
| 0025 | electivecesarean.com | 2 | Data sources | The Care Quality Commission MSS2010 asks whether women saw the same midwife for every antenatal check-up. Suggest that the same question is asked whether women saw the same obstetrician/consultant every time too – because in the communication I receive from women, a recurrent compliant is that they see a different doctor each time and have to explain everything all over again, and are given different advice and answers from different doctors too. This introduces a great deal of uncertainty and unpredictability during their pregnancy while they are trying to arrange their preferred birth plan. | The expectation is that quality statements and measures will be used and adapted at a local level. The key quality improvement for this statement is named midwife and the outcome measure provided, while not providing a detailed menu of experience measures, could also encapsulate this question as part of future indicator development.<br><br>. |
| 0014 | Department of Health (Children Family and Maternity branch) | 2 | Definitions | Picking out one model of care could be misleading – better to stick to the principles from Maternity Matters. | In light of consultation feedback the focus of this statement has changed and the final statement has been revised to: 'Pregnant women are cared for by a named midwife throughout their antenatal care.' The underpinning source reference includes Maternity matters: choice, access and continuity of care in a safe service |
| 0014 | Department of | 2 | Description | In each statement, replace "to be cared for by a | In light of consultation feedback the focus of this statement |

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| | Health (Children Family and Maternity branch) | | | small group of healthcare professionals" with "**to have continuity of care…"** | has changed and the final statement has been revised to: 'Pregnant women are cared for by a named midwife throughout their antenatal care.' |
| 0014 | Department of Health (Children Family and Maternity branch) | 2 | General | We do not think this definition is necessary since the emphasis must be on the woman having perception of continuity of care | In light of consultation feedback the focus of this statement has changed and the final statement has been revised to: 'Pregnant women are cared for by a named midwife throughout their antenatal care.' |
| 0030 | Epilepsy Action | 2 | General | Epilepsy Action supports this proposed quality statement. To ensure that women with a co-existing medical condition receive quality antenatal care too, the methodology needs to ensure that partnership working with medical professionals is captured. This group should be a MDT consisting of named medical professionals to oversee the management of her medical condition and named professionals to oversee her pregnancy and delivery (NICE CG 137). Local protocols for care should also be developed and implemented in obstetric units that deliver babies of women with epilepsy (as per NICE CG 137). | In light of consultation feedback the focus of this statement has changed and the final statement has been revised to: 'Pregnant women are cared for by a named midwife throughout their pregnancy.'<br><br>The quality standard contains key markers of clinical and cost effective care across a care pathway. It remains important that other evidence-based guideline recommendations continue to be implemented. |
| 0022 | Multiple Births Foundation | 2 | General | As complex pregnancies may require a range of other specialist expertise it should be clarified whether this Statement is intended to apply to uncomplicated pregnancies only.<br>The NICE Multiple Pregnancy Guideline sets out a core multidisciplinary team for the clinical care of women with twins and triplet pregnancies and an enhanced team who should have experience and knowledge relevant to multiple pregnancies.<br>**Question 6**. While recognising that this Statement aims to reduce the number of professionals from the same discipline, such as midwives, seeing each women individually it is an opportunity to | In light of consultation feedback the focus of this statement has changed and the final statement has been revised to: 'Pregnant women are cared for by a named midwife throughout their antenatal care.'<br>In principle, this statement applies to all pregnant women who access antenatal care. As with all quality statements, the needs of clinical judgement, choice and safety would prevail.<br><br>The scope of the antenatal care quality standard does not cover the additional care required for women with multiple pregnancies. There is a separate NICE quality standard on multiple pregnancy which is in development. This has |

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| | | | | extend the definition of teams required to support women through pregnancy. A similar model as described for the core team for Multiple Pregnancy could be used to define the "small group of health care professionals". Enhanced teams could for example include Specialist Nurses for Diabetes already involved with the care of diabetic women to ensure professional communication and continuity of care during pregnancy and after birth to give appropriate advice and support about diet, lifestyle and infant feeding. With complex pregnancies, the role of midwives as co-ordinators of care as recommended in *Midwifery 2020: Delivering expectations* (Chief Nursing Officers 2010 Section 4.1) should also be taken into account. | now been referenced within the antenatal care quality standard as a related NICE quality standard.<br><br>The forthcoming multiple pregnancy quality standard will be underpinned by NICE clinical guideline 129 (multiple pregnancy) and will set out markers of high quality care which are in addition or different to those for women with a singleton pregnancy. |
| 0010 | Stockport Clinical Commissioning Pathfinder | 2 | General question 6 | I think that it is important that any definition of a small group includes the woman's general practitioner. If my memory is correct the evidence presented with NICE antenatal guidelines showed no outcome difference between antenatal GP, Midwife and Obstetrician led care (apart from possible higher pre-eclampsia detection with obstetrician care). Improved pre-conception care , care of women at risk of pre-eclampsia, care of women with hypertension will all benefit from more active GP involvement. There has been a trend towards GPs not being involved in ante-natal care which, especially with the pressures the NHS faces, should be reversed. I would be interested to know if NICE has considered the efficiency savings from an integrated pathway of antenatal care where initial counselling and screening is undertaken in general practice? | In light of consultation feedback the focus of this statement has changed and the final statement has been revised to: 'Pregnant women are cared for by a named midwife throughout their antenatal care.' |

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| 0027 | Foundation Trust Network | 2 | Measure | Members note that consideration should be given to balancing the convenience for women of attending popular "drop in" services, against a planned review with a woman's own midwife i.e. the convenience of seeing a midwife at a flexible time to suit the patient (including evenings and weekends) and having the ability to choose when they access antenatal care appointments may have a greater priority to some patients than continuity of care. | In light of consultation feedback the focus of this statement has changed and the final statement has been revised to: 'Pregnant women are cared for by a named midwife throughout their antenatal care.' |
| 0031 | Perinatal Institute | 2 | Question 1 | Possible outcome – Good continuity of care = 75% of antenatal appointments by a small team of healthcare professionals | In light of consultation feedback the focus of this statement has changed and the final statement has been revised to: 'Pregnant women are cared for by a named midwife throughout their antenatal care.' |
| 0031 | Perinatal Institute | 2 | Question 6 | For good continuity of care a 'small group of healthcare professionals' should be defined as 'the lead carer +1other' (midwives, obstetricians, GPs etc) (West Midlands KPI), for example if a low risk multiparous woman had the recommended number of antenatal visits of 7 and was seen by at least 4 healthcare professionals this could be seen as poor continuity of care | In light of consultation feedback the focus of this statement has changed and the final statement has been revised to: 'Pregnant women are cared for by a named midwife throughout their antenatal care.' |
| 0025 | electivecesarean.com | 2 | Source clinical guideline references | Suggest including NICE clinical guideline 13 recommendation 39, which relates to access to a different provider: "*An obstetrician unwilling to perform a CS should refer the woman to an obstetrician who will carry out the CS.*" | Thank you for your comments. The scope of the antenatal care quality standard does not include the additional care required for women with antenatal complications or intrapartum care. There is a separate NICE quality standard on Caesarean section which is in development. This has now been referenced within the antenatal care quality standard as a related NICE quality standard. Please refer to the NICE quality standard full topic library for further details of all related topics for maternity. |

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| | | | | | NICE would welcome feedback from electivecesarean.com during the consultation for the NICE quality standard for caesarean section. |
| 0014 | Department of Health (Children Family and Maternity branch) | 2 | Statement | Currently this statement advocates one model of team based midwifery care. There are other models that need to be reflected. Even being seen by "a small group" will not ensure continuity. The important fact is to ensure continuity of care through communication, and that could be that every woman should have a named midwife and understand the cover arrangements when that midwife is not available, as well as having confidence in handover and continuity through the quality of communication in the handheld record.<br>We suggest:<br>Pregnant women receive continuity of care throughout their pregnancy | In light of consultation feedback the focus of this statement has changed and the final statement has been revised to: 'Pregnant women are cared for by a named midwife throughout their antenatal care.' |
| 0014 | Department of Health (Children Family and Maternity branch) | 2 | Structure | a) Evidence of local arrangements to ensure that pregnant **women receive continuity of care** throughout their pregnancy<br>b) Evidence of local audit of the number of healthcare …..for routine antenatal **care"** | In light of consultation feedback the focus of this statement has changed and the final statement has been revised to: 'Pregnant women are cared for by a named midwife throughout their antenatal care.' |
| 0013 | CSections.org | 3 | | The quality measure should include that all medical notes are either written in lay terms or are accompanied by a 'terms' sheet such that women can understand the content of their notes. The latter should be included either way as practitioners frequently revert to 'medical speak'. | Thank you for your comment. Quality statements are specific and concise and therefore cannot cover all aspects of record keeping. It remains important that other evidence-based guideline recommendations continue to be implemented. |
| 0029 | National Childbirth Trust | 3 | | This states that "Pregnant women have a complete and accurate record of the minimum set of antenatal test results in their hand-held | The equality and diversity section of this statement has been expanded to include the option for women to specify not to have sensitive results recorded in her hand-held |

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| | | | | maternity notes".<br><br>Women have the right to accept or decline tests though, as stated on page 12. We would, therefore, amend the statement to "**All p**regnant women have a complete and accurate record of the**ir** ~~minimum set of~~ antenatal test results in their hand-held maternity notes".<br><br>With regard to sensitive information, women may prefer that some results are not included explicitly in their maternity notes, for example results of screening for HIV or domestic abuse. There should, therefore, be a way of maintaining confidentiality (e.g. symbols or colour coding of notes) while alerting staff who need to know about important clinical conditions. | notes. |
| 0031 | Perinatal Institute | 3 | | The document needs to be clear that women should have complete access to their maternity records at all times (either handheld or in electronic format). To date there is no electronic system that gives access to women. Therefore, until this time, hand-held records should be available in all cases. | Thank you for this comment. This statement is about ensuring that all pregnant women have a complete record of the minimum set of antenatal test results in their hand-held maternity notes. |
| 009 | Royal College of Midwives | 3 | | It would be valuable to collect data on the discussion about the tests and the number of women who decline. | Noted, and these are not intended as sophisticated measures with technical specification, but simply a starting point for quality improvement and local measurement experts to refine and develop for local use. The quality standards now provide an important basis for national indicator development, including those for the commissioning outcomes framework. This in turn will create opportunities to further specify and improve data collection for the standards. The primary intent of this statement is to focus on the completeness and accuracy of test results recorded in women's hand-held maternity |

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| | | | | | records. This level of detail may be specified at a local level. |
| 009 | Royal College of Midwives | 3 | | Carbon monoxide screening should be included here. It has been in NICE recommendations since June 2010 | Carbon monoxide testing is referenced in the definitions section of statement 5, Risk assessment – smoking cessation. |
| 009 | Royal College of Midwives | 3 | | It is important to clarify who a maternity services provider is in this context. GPs will be a maternity services provider in that they will provide some of the maternity pathway and there may be the assumption that the woman's maternity record is the same as the GP electronic system. In the context of a quality statement the intention is for completeness of communication and for investigation, treatments and results to be in one place accessible to all potential care providers involved in the maternity pathway at any time of day or night. This is most likely to be the overarching Maternity PBR Pathway provider, usually through the provision of hand held maternity records for pregnant women, and with secure back ups detailing information that needs to be withheld from handheld records to preserve confidentiality / women's personal safety. E.g. HIV status, remaining in a domestic abuse environment. | Noted and we agree this is important. The equality and diversity section of this statement has been expanded to include the option for women to specify not to have sensitive results recorded in her hand-held notes. |
| 008 | Tamba (Twins & Multiple Births Association) | 3 | | **In response to question 1**- refer to NICE clinical guideline 129 Section 1.1.2.11–evidence of local audit to identify if there is an individualised care plan in the woman's records appropriate to the chorionicity of her pregnancy. This measure could also be used for women who are expecting singletons<br>Secondly NICE clinical guideline 129 key priorities | The scope of the antenatal care quality standard does not cover the additional care required for women with multiple pregnancies. There is a separate NICE quality standard on multiple pregnancy which is in development. This has now been referenced within the antenatal care quality standard as a related NICE quality standard.<br><br>The forthcoming multiple pregnancy quality standard will |

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| | | | | for implementation recommend nomenclature is assigned and documented clearly-this could be a further quality measure.<br>**Source**- NICE clinical guideline 129 to be included in references.<br>**Definitions-** to acknowledge high incidence of anaemia amongst women expecting multiples Tamba suggest the list include a full blood count at 20-24 weeks to identify those women who need early supplementation which is be repeated at 28 weeks as in routine antenatal care.<br>The ultrasound scan to determine gestational age should ideally also determine chorionicity and screen for Down's syndrome in the same scan (NICE clinical guideline 129, key priority).<br>**In response to question 2** –the specific needs of women who are expecting multiples is not included. | be underpinned by NICE clinical guideline 129 (multiple pregnancy) and will set out markers of high quality care which are in addition or different to those for women with a singleton pregnancy. |
| 002 | UK Newborn Screening Programme Centre | 3 | | Add 'declines' to the numerator | Noted, however these are not intended as sophisticated measures with technical specification, but simply a starting point for quality improvement and local measurement experts to refine and develop for local use. The expectation is that patient safety, clinical judgement and choice would always prevail. |
| 0014 | Department of Health (Children Family and Maternity branch) | 3 | Data Sources | It is local data collection but will be in maternity dataset as listed on page 12 | Thank you for your comment. This statement focuses on recording of antenatal test results in women's hand-held maternity notes. |
| 0019 | UK NSC | 3 | Data Sources | Data sources could include UKNSC KPI data collection | Thank you for your comment. The data sources have been reviewed and updated throughout the standard. |
| 0025 | electivecesarean.com | 3 | Definitions | This may be beyond the terms of the Scope, but would suggest: | Thank you for your comments. The minimum set of tests for routine scheduled antenatal care has been developed |

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| | | | | a) including the offer of an Ultrasound investigation at near-to-term gestation for (at least) women with suspected risk factors for adverse outcomes with a trial of labour.<br>b) including the offer of Group B Streptococcus investigation. | from the appointment schedule in Appendix D of NICE clinical guideline 62. These did not include the additional investigations suggested and it was beyond the remit of this group to expand these within this quality standard. However, this does not mean they are not important. |
| 0020 | NHS Sickle Cell and Thalassaemia Screening Programme | 3 | Definitions, Source Clinical guideline reference, Equality and diversity considerations | This standard refers to Haemoglobinopathy screen at booking.<br>As outlined above haemoglobinopathy screening should be offered by 10 weeks gestation (see section 1.6.3.3 NICE guidelines CG62).<br>Data on testing by 10 weeks is available from<br>• antenatal screening laboratories who submit the data annually to the NHS Sickle cell and thalassaemia screening programme,<br>• through quarterly collection of screening Key performance indicators and<br>• the Maternity and Children's Data Set (MCDS) from April 2013. The MCDS has been approved by the Information Standards Board (ISB) and is awaiting approval for an Information Standards Notice (ISN).<br><br>Given the evidence on the association between gestation of screening offer and uptake of diagnostic testing for a condition predominantly affecting people from minority ethnic groups, a failure to include timeliness as a NICE antenatal quality standard has the potential to specifically disadvantage those from minority ethnic groups | Thank you for your comments. Thank you for these comments. Statement 1 has now been revised and now reads:<br><br>'Pregnant women are supported to access antenatal care, ideally by 10 weeks 0 days'.<br><br>The measures have been revised accordingly. All suggestions for additional data sources were discussed by the topic expert group. The final standard does include a statement on improving access to antenatal care. This core quality concept of improved access for all pregnant women is also supported by high level measures about the timeliness of access. |

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| | | | | and therefore raises concerns around equality.<br><br>As evidenced by standards and nice guidelines, see comments on draft quality statement 1 | |
| 0014 | Department of Health (Children Family and Maternity branch) | 3 | Description | Healthcare providers and commissioners need to ensure that the offer and acceptance are recorded as well as results | Thank you for your comment. The topic expert group agreed to make the focus of this statement complete and accurate record keeping. However the definition section does state that:<br>'Women should be able to make an informed choice about whether to accept or decline each test, and notes should include a record of any tests offered and declined as well as the results of tests accepted.' |
| 0014 | Department of Health (Children Family and Maternity branch) | 3 | Equality and Diversity | We think it **is important that all women have hand-held records** and this should be a standard for communication and information sharing | Thank you for your comment. It is anticipated that this statement will support the use of hand-held maternity notes. |
| 0023 | Bliss | 3 | General | No mention is made of whether previous pregnancy history will be included in maternity notes. We think this would be beneficial, particularly in identification of potentially high risk mothers. | Thank you for your comment. All suggestions for additional statements were discussed by the topic expert group. The group considered previous pregnancy history for potential inclusion but felt this did not meet the specific criteria for a quality statement.<br><br>The topic expert group prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators.<br><br>The quality standard contains key markers of clinical and cost effective care across a care pathway. It remains important that other evidence-based guideline recommendations continue to be implemented. |
| 0022 | Multiple Births | 3 | General | The MBF suggests that the NICE Multiple | The scope of the antenatal care quality standard does not |

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| | Foundation | | | Pregnancy Guideline is specifically referenced in this Statement. | cover the additional care required for women with multiple pregnancies. There is a separate NICE quality standard on multiple pregnancy which is in development. This has now been referenced within the antenatal care quality standard as a related NICE quality standard.<br><br>The forthcoming multiple pregnancy quality standard will be underpinned by NICE clinical guideline 129 (multiple pregnancy) and will set out markers of high quality care which are in addition or different to those for women with a singleton pregnancy. |
| 0018 | The Royal College of Radiologists (Faculty of Clinical Radiology) | 3 | General | This standard applies to the records kept in the patient's hand held notes. However, we would also support the inclusion of a standard for the retention of images relating to any ultrasound scan the baby may have. With the advent of PACS, we feel this should be possible (the standard for retention of images at 20 week anomaly is now part of the National Screening Committee standard) and the inclusion of such a standard for retention of images would improve quality. However, we also appreciate that some units may have difficulty in retaining images of all obstetrics scans. | Thank you for your comment. This statement is supported by the minimum set of tests for routine scheduled antenatal care which has been developed from the appointment schedule in appendix D of NICE clinical guideline 62. The expert group agreed that their role was not to go beyond this. |
| 0019 | UK NSC | 3 | General | These statements should be combined to include antenatal screening as well as other tests that are carried out. The antenatal (fetal) screening referred to in 10 should be expanded to include all the current screening programmes offered to women as part of their antenatal care. (AN Sickle Cell & Thalassaemia, Infectious diseases in Pregnancy and Fetal Anomaly).<br>General Q.1 Appropriate healthcare outcomes for | Thank you for your comments.<br><br>All suggestions for additional statements were discussed by the topic expert group who recognised the importance of screening for sickle cell and thalassaemia and infectious diseases in pregnancy. The group made a consensus decision to focus the screening statement around fetal anomaly screening. However, NICE recognises that early booking is an important factor in |

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| | | | | the screening elements of the care would be the UKNSC Key Performance indicators. These are collected quarterly and give a measure of offer, acceptance and outcome by individual maternity units and/or current PCT's. It would make sense to use these rather than ask organisations to complete additional data sets. Also, the CNST maternity standards require organisations to monitor offer and uptake regarding AN screening. | delivering sickle cell and thalassaemia screening and quality statement 1 aims to support this.<br><br>In the final antenatal care quality standard:<br>-Statement 1 focuses on improving access to antenatal care (ideally by 10 weeks 0 days) which includes measures about the timeliness of access. One of the source clinical guideline references is to NICE clinical guideline 62, recommendation 1.6.3.3 which focuses on offering women screening for sickle cell and thalassaemia as early as possible within their pregnancy (ideally by 10 weeks).<br>-Statement 3 focuses on pregnant women having a complete record of the minimum set of antenatal test results in their hand-held maternity notes, including haemoglobinopathies screening and the outcome of screening for infectious diseases.<br><br>The quality standard in no way replaces the clinical guideline recommendations or National Screening Committee guidance and has been designed to serve quality improvement across antenatal care. It remains important that other evidence-based guideline recommendations continue to be implemented.<br><br>The data sources have been reviewed and updated throughout the standard. |
| 007 | Royal College of Obstetricians and Gynaecologists | 3 | Page 12 | Equality and diversity section says that "in this case, the minimum set of antenatal tests results should be recorded in the alternative system (such as an electronic database), which should be available to the woman and anyone caring for her". I am not clear how the woman can access the electronic database. | Thank you for your comment. The equality and diversity section has been revised and updated. |

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| 0031 | Perinatal Institute | 3 | Question 1 | Possible outcome – e.g. The proportion of women that had screening results documented in hand-held record or electronic system within 3 weeks of the test being taken, where the test was offered and accepted. All tests should have an explanation of the test, result and the ensuing care pathway (target 100%). | Thank you for your comment. The outcome has been reviewed and updated for this statement. |
| 0031 | Perinatal Institute | 3 | Question 1 | Possible outcome – Proportion of women who have access to translated maternity hand-held records (target 95% on non English speaking) | Thank you for your comment. The statement outcomes have been reviewed by the topic expert group and updated as appropriate. |
| 0014 | Department of Health (Children Family and Maternity branch) | 3 | Statement | We agree that there should be a Quality Standard on quality of record keeping but are not convinced that offer of screening is the best measure . This could be a tick box whereas recording uptake as well introduces some measure of quality<br>Important to differentiate between tests offered and taken up - therefore:<br>Pregnant women have a complete and accurate record in their hand-held notes of the offer of the minimum set of antenatal tests and results of those they accepted. | Thank you for your comment. The topic expert group agreed to make the focus of this statement complete and accurate record keeping. However the definition section does state that:<br>'Women should be able to make an informed choice about whether to accept or decline each test, and notes should include a record of any tests offered and declined as well as the results of tests accepted.' |
| 0014 | Department of Health (Children Family and Maternity branch) | 3 | Structure | a) Evidence of local arrangements….pregnant women have a complete and accurate record of the offer, acceptance and results of the minimum set of antenatal test in their hand-held notes<br>b) **Process:** need to add **"offer, acceptance and** results " | Thank you for your comment. The topic expert group agreed to make the focus of this statement complete and accurate record keeping. However the definition section does state that:<br>'Women should be able to make an informed choice about whether to accept or decline each test, and notes should include a record of any tests offered and declined as well as the results of tests accepted.' |
| 006 | Gloucestershire Hospitals NHS Foundation Trust | 4 | | Not a workable standard as pregnant women are the keepers of their maternity records / hand held notes and it would not be possible for the | This statement was not progressed to the final quality standard. |

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| | | | | organisation to enter these details into their hand held records – when, by definition they are at the other end of the telephone and, if they are low risk, will not / may not attend the hospital at all. What about women who are ringing for advice – but are planning to deliver elsewhere? How can we ensure that these conversations get to the right place. | |
| 0029 | National Childbirth Trust | 4 | | This states that “Pregnant women who call maternity services for advice about their pregnancy have the details of their call logged by the service and entered into their maternity record”.<br><br>This is agreed in principle, but we anticipate that systems will need to be in place to ensure that confidentiality is maintained, for example appropriate training for non-professional members of staff who have access to personal confidential information (e.g. about domestic abuse, HIV status, medical history, and antenatal screening results and decisions). As with the previous quality statement, there should also be a way of recording details of calls for women who do not want sensitive conditions recorded explicitly in their maternity notes. | This statement was not progressed to the final quality standard. |
| 0031 | Perinatal Institute | 4 | | This quality standard should be assessed to evaluate its impact upon care and outcome. This standard also requires an equity audit on access. | This statement was not progressed to the final quality standard. |
| 003 | Royal College of Nursing | 4 | | The logistics of recording telephone advice given to women in the hand held record, pose extreme challenges to maternity services. | This statement was not progressed to the final quality standard. |

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| | | | | Many women may telephone a central delivery suite out of hours for midwifery advice (or an Early Pregnancy Assessment Unit) which is geographically at some distance from the team of community midwives who would be able to access the hand held maternity records.<br><br>Some services cross healthcare trust boundaries, for example, a mother who telephones Lewisham Early Pregnancy Advice Unit for advice, may actually have hand held maternity records for a neighbouring trust's maternity service such as South London Health Trust.<br><br>Even with good integrated IT services, between Community and Hospital Based Services, the challenge of entering an episode into a hand held record within one service, may be cumbersome and have a lag time, which brings no immediate benefit to a mother who may have health problems in the antenatal period.<br><br>The only realistic way of achieving this standard is to specify 'women who call their 'community midwife' for telephone advice, rather than women who call their maternity service for advice. | |
| 007 | Royal College of Obstetricians and Gynaecologists | 4 | | I think you will need to come up with some very clear, directive and possibly imaginative solutions as to how the record of these calls will find its way into the medical records, especially if one considers the handheld record to be key. The Welsh maternity pathway may have some lessons for the NICE group as calls are recorded in a | This statement was not progressed to the final quality standard. |

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| | | | | standard way and promptly find their way into the hospital record (at least). | |
| 008 | Tamba (Twins & Multiple Births Association) | 4 | | **In response to question 1**- Draft quality measure consideration to be given to including c) Evidence, that if appropriate, women were referred for specialist advice from a midwife or consultant. Tamba (2009) found often mothers raised concerns about the lack of knowledge and expertise on multiple births and frequently received mixed messages from health professionals, particularly about twin to twin transfusion syndrome. Adding this measure would allow this to be monitored.<br>Evidence of local audit of women who rang maternity services to establish if they were happy with the advice given using telephone or text. | This statement was not progressed to the final quality standard. |
| 002 | UK Newborn Screening Programme Centre | 4 | | Getting a record of a telephone call into hand held notes is laudable but also a logistical nightmare to do and to accurately measure.<br>May work if there is a specific call line but in a small team of HCP/GP/HV/labour ward etc very difficult. | This statement was not progressed to the final quality standard. |
| 0028 | Unite the Union/CPHVA | 4 | | Ensure these are entered into the woman's maternity record IMMEDIATELY | This statement was not progressed to the final quality standard. |
| 0023 | Bliss | 4 | General | We suggest that this issue is included in Quality Statement 3 | This statement was not progressed to the final quality standard. |
| 0030 | Epilepsy Action | 4 | General | Epilepsy Action would like to see this quality marker broadened to include contact made with any professional in their care pathway. This would ensure that a woman's obstetrician is aware of | This statement was not progressed to the final quality standard. |

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| | | | | any issues a woman has reported to her GP or medical specialist (i.e. neurologist or epilepsy specialist) about her pre-existing medical condition, as it might have an effect on her pregnancy. | |
| 0022 | Multiple Births Foundation | 4 | General | Although it should be implicit in this Statement as all details of the calls should be recorded, the MBF suggests that it would be a useful for audit purposes to ensure that if women have a multiple pregnancy it is clearly documented. | This statement was not progressed to the final quality standard. |
| 009 | Royal College of Midwives | 4 | Measure | This statement needs clarity for the process in the community - as it cannot be assumed the community midwife has immediate access to facilities for logging their calls, or entering details in the maternity record. We know of at least one unit where midwives have access to a system via their Blackberries in which they can record all contacts that go into the woman's records, so it is possible with investment. | This statement was not progressed to the final quality standard. |
| 007 | Royal College of Obstetricians and Gynaecologists | 4 | Page 13 | Section 'draft quality measure' (b), I agree with this in principle but this will be very difficult to achieve. Is there a timeframe for the details of the call being passed to the booked maternity service? Logistics of transferring a telephone call to a hand held record are very considerable; this requires to be acknowledged. | The focus of draft statement 4 has been changed in the final quality standard. |
| 007 | Royal College of Obstetricians and Gynaecologists | 4 | Page 14 | E+D Access to an interpreter for telephone advice. Is this remotely realistic? | Following review of consultation results the topic expert group decided to not progress this statement. |
| 0031 | Perinatal Institute | 4 | Question 1 | Possible outcome - Unit has a telephone advice | This statement was not progressed to the final quality |

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| | | | | log in their MIS or in their in-hospital maternity record (target 100% of all providers). | standard. |
| 0014 | Department of Health (Children Family and Maternity branch) | 4 | Statement | This is a good idea and clearly a governance issue particularly in late pregnancy or labour when a woman calls the midwife or delivery suite but it could be an impossible standard to achieve throughout pregnancy when she may not attend the maternity unit for weeks after the phone call. It is important to specify that she should call the service where she is booked<br>What we are aiming for is:<br>• All women know a number to call for advice<br>• Better use of telephone advice to reduce inappropriate attendances, reassure women, ensure urgent admission where necessary<br>There should certainly be a record of action agreed and taken and messages and referrals made but it will only be possible to record this in the woman's maternity record when the woman calls the maternity service where she is booked for care, and when she next attends when it could be recorded in her handheld and hospital records.<br>How will it be possible to collect "the number of calls to maternity units from pregnant women for advice about their pregnancy"? Collecting the data is likely to be manual and probably only feasible through a local audit .<br>There is also the fact that she may call the GP or attend A & E and the information given and action taken will be equally important.<br>With increasing use of IT and alternative communication there will in the future be email | This statement was not progressed to the final quality standard. |

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| | | | | and text communications.<br>Overall , although appreciating the reason that this has been included as a standard , we do not think it is a good discriminator for quality care. | |
| 003 | CSections.org | 5 | | The 'balanced, evidence based information' should include as a minimum (in no particular order):<br>• Vaginal birth<br>• Caesarean birth<br>• All pain relief options<br>• Expectation management e.g. the development of 'open' birth plans, specifically the importance of being open to change<br>• Discussion of the 'cascade of intervention' and decision points in which they can impact their birth plan<br>• Discussion of options when induction is required and presentation of planned caesarean as a viable alternative to chemical intervention<br>• Breastfeeding support including alternatives after surgery<br>• Balanced risk/benefit of interventions e.g. including an analysis of switching to an caesarean sooner during a protracted labour versus risks to baby of vaginal instrumental delivery<br>• Detailed recovery support for both vaginal and caesarean birth<br>• Family planning including post caesarean considerations<br>• Detailed information (names, | This statement was not progressed in the final quality standard. Provision of patient information is an important theme for all NHS care. The topic expert group decided the NICE quality standard on 'patient experience in adult NHS services' which is cross-cutting and referenced in all quality standards (for adults) covered this in more detail. |

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| | | | | times, locations) of where to access: breastfeeding support, mental health support etc.<br>• Provision of tailored information sessions for women who have had a prior caesarean – both VBAC and repeat caesarean risk/benefit assessment<br><br>The quality measure could include: number of women seeking support service postnatally, a reduction in number of emotional trauma cases, formal satisfaction measures achieved during postnatal period etc. | |
| 0013 | CSections.org | 5 | | Quality statement 5 overview should include the word 'complete' as follows: "Pregnant women are offered [complete] evidence based, balanced and …" This is only a useful word to include if the other points raised in this feedback are taken on board and what constitutes 'complete' is described. | This statement was not progressed into the final quality standard. Provision of patient information is an important theme for all NHS care. The topic expert group decided the NICE quality standard on 'patient experience in adult NHS services' which is cross-cutting and referenced in all quality standards (for adults) covered this in more detail. |
| 0029 | National Childbirth Trust | 5 | | This states that "Pregnant women are offered evidence-based, balanced and consistent information, which they understand, have the opportunity to discuss, and which enables them to make informed decisions about their care".<br><br>We would amend the statement so that it is more explicit about ensuring that information is provided in an appropriate format that can be easily understood. The amended statement would read "**All p**regnant women are offered evidence-based, balanced and consistent information, which they understand **and which answers their questions and concerns, and which they~~,~~** have the opportunity to discuss, ~~and which enables~~ | This statement was not progressed in the final quality standard. Provision of patient information is an important theme for all NHS care. The topic expert group decided the NICE quality standard on 'patient experience in adult NHS services' which is cross-cutting and referenced in all quality standards (for adults) covered this in more detail. |

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| | | | | enabling them to make informed decisions about their care". | |
| 004 | NHS South central | 5 | | This standard refers to the Pregnancy Book – are you sure this is still going to be printed as I had heard that it was no longer funded.<br>The NSC booklet, 'Screening tests for you and your baby' should also be mentioned here. This should be given to all pregnant women when they book | This statement was not progressed in the final quality standard. Provision of patient information is an important theme for all NHS care. The topic expert group decided the NICE quality standard on 'patient experience in adult NHS services' which is cross-cutting and referenced in all quality standards (for adults) covered this in more detail. |
| 0031 | Perinatal Institute | 5 | | The outcome described does not demonstrate an effective assessment of this quality standard. The Maternity services<br>Survey will not all women's perspectives particularly "the seldom seen and seldom heard". There is a need for local audit of population needs (e.g. literacy levels, ethnicity) and a more comprehensive evaluation of informed decision-making care provision. For example, appropriate methodologies to ensure engagement of all women (i.e. focus groups, interviews, advocacy support) | This statement was not progressed in the final quality standard. Provision of patient information is an important theme for all NHS care. The topic expert group decided the NICE quality standard on 'patient experience in adult NHS services' which is cross-cutting and referenced in all quality standards (for adults) covered this in more detail. |
| 008 | Tamba (Twins & Multiple Births Association) | 5 | | **In response to question 2**- research conducted by the National Perinatal Epidemiology Unit (NPEU, 2011) amongst women who were expecting multiples found a mixed picture of experiences in relation to information and choice e.g. a higher proportion of women with a multiple pregnancy were not offered Down's Syndrome screening (15%, compared with 4% for singleton pregnancies) and women having a multiple birth had less choice in some aspects of their labour and birth, being less able to move and to adopt alternative positions.<br>The information needs of parents, when they are | This statement was not progressed in the final quality standard. Provision of patient information is an important theme for all NHS care. The topic expert group decided the NICE quality standard on 'patient experience in adult NHS services' which is cross-cutting and referenced in all quality standards (for adults) covered this in more detail. |

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| | | | | being cared for by a range of healthcare professionals, needs to be coordinated. This is supported by NICE clinical guideline 129 1.2.3.4. Many of the concerns raised by Tamba clients are around lack of continuity and about the way information is communicated (2009). Whilst some of this may be explained by widespread issues of low staffing levels it is important that service providers ensure their staff are trained and have the necessary skills to meet the needs of women who are expecting multiples.<br>**Source**- NICE clinical guideline 129 to be included in references<br>**In response to question 3**- This is one of the most important quality measures. Women need to be confident that any information they receive is based upon best available evidence and communicated in such a way that the information is clear, consistent and can be understood. | |
| 002 | UK Newborn Screening Programme Centre | 5 | | Numerator – the number of pregnant women in the denominator who received the NSC booklet screening tests for you and your baby in an appropriate language<br>Denominator – the number of pregnant women accessing antenatal care. | This statement was not progressed in the final quality standard. Provision of patient information is an important theme for all NHS care. The topic expert group decided the NICE quality standard on 'patient experience in adult NHS services' which is cross-cutting and referenced in all quality standards (for adults) covered this in more detail. |
| 0028 | Unite the Union/CPHVA | 5 | | We are concerned that especially here, but also in general throughout the document, the term 'healthcare professionals' must signify qualified midwives, nurses, radiotherapists, and obstetricians. It is qualified professional staff, who have accountability to ensure that informed consent has been given. | This statement was not progressed in the final quality standard. Informed consent and delivery of care by trained and competent staff is an important theme for all NHS care and not specific to antenatal care. The topic expert group decided the NICE quality standard on 'patient experience in adult NHS services' which is cross-cutting and referenced in all quality standards (for adults) covered the principles of informed decision making and patient |

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| | | | | | experience in more detail. |
| 0014 | Department of Health (Children Family and Maternity branch) | 5 | Data Sources | Need to add the NHS Screening KPIs which are already collected and data that will be available from the Maternity dataset | This statement was not progressed in the final quality standard. Provision of patient information is an important theme for all NHS care. The topic expert group decided the NICE quality standard on 'patient experience in adult NHS services' which is cross-cutting and referenced in all quality standards (for adults) covered this in more detail. |
| 0023 | Bliss | 5 | General | We suggest adding 'proportion of high risk pregnant women given info/advice on potential complications' under 'Process'. | This statement was not progressed in the final quality standard. Provision of patient information is an important theme for all NHS care. The topic expert group decided the NICE quality standard on 'patient experience in adult NHS services' which is cross-cutting and referenced in all quality standards (for adults) covered this in more detail. |
| 0030 | Epilepsy Action | 5 | General | Quality antenatal care for women with a pre-existing medical condition requires the delivery of antenatal advice and information that is tailored to their pre-existing medical condition and its treatment (NICE CG 137). For this reason Epilepsy Action would welcome a change in the methodology to indicate the proportion of women who have accessed antenatal advice provided by their medical specialist, under appropriate service referrals. Advice should be taken from appropriate services at:<br>• Booking in clinic<br>• When discussing ante-natal tests and scans for foetal malformation<br>• If seizures return<br>• Around labour | This statement was not progressed in the final quality standard. Provision of patient information is an important theme for all NHS care. The topic expert group decided the NICE quality standard on 'patient experience in adult NHS services' which is cross-cutting and referenced in all quality standards (for adults) covered this in more detail.<br><br>The quality standard for antenatal care covers the antenatal care of all pregnant women, but the management of specific physical conditions is outside of the scope. The full antenatal care scope, which was developed by the topic expert group is available from www.nice.org.uk.<br><br>The quality standard contains key markers of clinical and cost effective care across a care pathway. It remains important that other evidence-based guideline recommendations continue to be implemented. |
| 0022 | Multiple Births | 5 | General | The MBF suggests that the NICE Multiple | This statement was not progressed in the final quality |

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| | Foundation | | | Pregnancy Guideline is referenced in this Statement to take account of the need for specific information about care, management and decisions overall with particular reference to chorionicity, screening processes and management of maternal and fetal complications which require information, specialist counselling and support for the women when faced with complex decisions. | standard. Provision of patient information is an important theme for all NHS care. The topic expert group decided the NICE quality standard on 'patient experience in adult NHS services' which is cross-cutting and referenced in all quality standards (for adults) covered this in more detail. |
| 0020 | NHS Sickle Cell and Thalassaemia Screening Programme | 5 | information informed decision making Draft quality measure Source Clinical guideline reference Data sources Equality and Diversity Considerations | "Pregnant women are offered evidence –based balanced and consistent information which they understand, have the opportunity to discuss and which enables them to make informed decisions about their care.<br><br>The sickle cell and thalassaemia screening programme is concerned because this metric does include the need to provide information in a timely manner. As outlined in point 1 this screening test needs to be offered early in pregnancy to allow women the opportunity to make a choice about subsequent options. Given the fact that data sources are available to collect information on testing by 10 weeks gestation we remain concerned that failure to include offer and/or testing by 10 weeks raises concerns around equality. | This statement was not progressed in the final quality standard. Provision of patient information is an important theme for all NHS care. The topic expert group decided the NICE quality standard on 'patient experience in adult NHS services' which is cross-cutting and referenced in all quality standards (for adults) covered this in more detail. |
| 007 | Royal College of Obstetricians and Gynaecologists | 5 | Page 15 | Can this be achieved by giving the woman written information (e.g. in Scotland the 'ready steady baby' book)? | This statement was not progressed to the final quality standard. |
| 0014 | Department of Health (Children Family and Maternity | 5 | Quality Measure | The **structure** statement suggests all types of information but the measures all relate to screening which are covered in CNST Standard 4 | This statement was not progressed in the final quality standard. Provision of patient information is an important theme for all NHS care. The topic expert group decided |

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| | branch) | | | criterion 5<br>Availability of other information is very important and would be a good measure of equitable services e.g. information on pregnancy (to replace the pregnancy book), information about local service provision including choices for place of birth, access to NHS choices,<br>The **process** measures could include comparative data on antenatal services and data on place of birth choices<br>Outcome measure could be number (rate) of women accessing care by 12 weeks who took folic acid | the NICE quality standard on 'patient experience in adult NHS services' which is cross-cutting and referenced in all quality standards (for adults) covered this in more detail. |
| 0031 | Perinatal Institute | 5 | Question 1 | Possible Outcome – Information should be provided and reinforced in a number of different formats to meet different population requirements (e.g. interpreting services, Braille, pictorial, DVDs, CDs etc). | This statement was not progressed in the final quality standard. Provision of patient information is an important theme for all NHS care. The topic expert group decided the NICE quality standard on 'patient experience in adult NHS services' which is cross-cutting and referenced in all quality standards (for adults) covered this in more detail. |
| 0025 | electivecesarean.com | 5 | Source clinical guideline references | Suggest including NICE clinical guideline 13 recommendations 34, 35, 36, 37, 38 and 39 in the list of references here. A number of hospitals and individual medical professionals have decided not to follow some of the November 2011 updated recommendations in this guideline, so it would be useful for it to be added as a specific source in this Quality Standard. Thank you. | This statement was not progressed in the final quality standard. Provision of patient information is an important theme for all NHS care. The topic expert group decided the NICE quality standard on 'patient experience in adult NHS services' which is cross-cutting and referenced in all quality standards (for adults) covered this in more detail. |
| 0014 | Department of Health (Children Family and Maternity branch) | 5 | Statement | The statement is good but the measures suggested overlap with the screening statement/standard and misses the opportunity to include broader information such as nutrition and supplements, life-style advice, smoking, alcohol, weight (obesity) and substance use as well as personalised info on specific risks and choices. | This statement was not progressed in the final quality standard. Provision of patient information is an important theme for all NHS care. The topic expert group decided the NICE quality standard on 'patient experience in adult NHS services' which is cross-cutting and referenced in all quality standards (for adults) covered this in more detail. |

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| | | | | Informed decision making requires good communication and a standard that would cover information in a form and language appropriate for the women (including interpreters) would have been helpful | |
| 0013 | CSections.org | 6 | | This quality statement needs to include words to the effect that all women in this category be offered “evidence based, balanced and consistent information” about the increased risk of caesarean birth. This guidance should specifically include detailed, balanced and consistent information about how to prepare for such a birth and how to cope with and recover from it.<br><br>The detail and quality of this information needs to be far greater than that typically provided in antenatal care at present as there is a greater likelihood of women in this category requiring a caesarean. Indeed evidence based information should be provided reflecting the risk comparison between a planned vaginal birth (which may include an emergency caesarean) versus a planned caesarean so that the woman can make an informed choice in favour of a prophylactic caesarean if that turns out to be their preference. | Thank you for your comments. The scope of the antenatal care quality standard does not include the additional care required for women with antenatal complications or intrapartum care, including birthing choices.<br><br>There is a separate NICE quality standard on Caesarean section which is in development. This has been referenced within the antenatal care quality standard as a related NICE quality standard. Please refer to the NICE quality standard full topic library for further details of all related maternity topics.<br><br>NICE would welcome feedback from electivecesarean.com during the consultation for the NICE quality standard for caesarean section. |
| 006 | Gloucestershire Hospitals NHS Foundation Trust | 6 | | This is an issue for the providers of care – i.e. the PCT/GP commissioning groups and they would need to commission us to provide the service with appropriate funding identified. | NICE has produced a support document to help commissioners and others consider the commissioning implications and potential resource impact of this quality standard and patient information to explain to patients and carers what the quality standard means to them, both available from www.nice.org.uk. |
| 0029 | National Childbirth Trust | 6 | | We agree with the statement that “Pregnant women with a body mass index of 30 kg/$m^2$ or more at the booking appointment are offered | Thank you for your comment. |

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| | | | | personalised advice from an appropriately trained professional on healthy eating and how to be physically active". | |
| 0012 | NHS London | 6 | | What is the evidence that personalised advice to pregnant women with a BMI over a certain amount regarding eating and activity is of value? Why not offer group or peer support (such as free attendance at weightwatchers)? If there is poor evidence in the literature, picking on individual pregnant women may make them feel worse and potentially drive them away from antenatal care as they are vulnerable to 'fattist' health professionals. There is evidence that long-term weight loss can be achieved by a multicomponent intervention http://summaries.cochrane.org/CD005270/long-term-non-pharmacological-weight-loss-interventions-for-adults-with-prediabetes Thus, it might be much better to turn the outcome measure on its head: i.e. BMI at onset of pregnancy should be as a quality standard of the effectiveness of school health services, family planning, abortion clinics, departments of transport and the environment etc to effect primary prevention. Would this not put pressure on the Secretary of State and others to do something about the causes of obesity (i.e. control of fast-food outlets, school meal services, food labelling transport systems, safer roads, and consumer choices made before pregnancy etc.) which will help all people, not merely pregnant women?<br>Otherwise the quality standard risks being an exercise in measuring the nagging of obese pregnant women. Surely it is more important to measure the efficacy of the advice, not just its | Thank you for your comment. The 'source clinical guideline reference' section provides details of the underpinning evidence-based NICE recommendations for this statement.<br><br>The process guide for developing quality standards does not include a review of primary evidence sources. |

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| | | | | provision? Efficacy might be measured in terms of the outcome to the mother (her BMI at end of pregnancy) or the baby (its weight). It would be more ambitious to report the interpregnancy change in BMI from one pregnancy to another? | |
| 0031 | Perinatal Institute | 6 | | 'Appropriately trained professional' needs to be clearly defined and include an endorsed training package to ensure equity of care provision. This service should be offered to all women regardless of BMI. | The statement now includes an expanded definition of appropriately trained person. |
| 009 | Royal College of Midwives | 6 | | All women should receive this advice on healthy eating. Having a normal BMI is not clear evidence of having a healthy diet. | Your comment has been reviewed by the topic expert group who decided to continue to focus this statement around pregnant women with a raised BMI.<br><br>The quality standard contains key markers of clinical and cost effective care across a care pathway. It remains important that other evidence-based guideline recommendations continue to be implemented. |
| 003 | Royal College of Nursing | 6 | | Suggest rewording of this statement as many health advisers who advise on diet and exercise are not considered trained professionals (e.g. Slimming World)<br><br>Suggest rewording to **personalised advice from an appropriately trained person on healthy eating and physical activity**. This will enable maternity support workers to be trained by external providers, to deliver this service locally for maternity services as well as for commissioners to commission separately from organisations with locations near to women's homes (e.g. Slimming World, Weightwatchers, | Thank you for your comment. The wording of the statement and definition has been reviewed by the topic expert group and has been updated. |

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| | | | | Active Living Centres) | |
| 008 | Tamba (Twins & Multiple Births Association) | 6 | | **In response to question 1**- **Structure**- Evidence of local arrangements to ensure that pregnant women with a BMI of 30kg/m2 are offered psychological advice and support alongside nutritional information.<br>**Process**-There is a concern with this measure that it could become a tick box exercise and advice could be given in a 'one off' without any follow up which would be ineffective for most women. It needs to be measured by demonstration of the implementation of a locally agreed pathway.<br>**Description of what the quality statement means for each audience**-who would the 'appropriately trained professional be? As well as appropriate training will healthcare professionals have received adequate training around 'raising the issue'? Very often a barrier to discussions on sensitive subjects like this.<br>**In response to question 2**- refer to NICE clinical guideline 129 1.1.2.9 regarding recommendation to use transvaginal ultrasound scan to determine chorionicity if the BMI is high.<br>**In response to question 3**-this is one of the most important quality statements as it is an increasing problem and one that can impact negatively on the outcome for mother and baby/babies.<br>**Definitions**- There is the concern here that for women with a BMI of between 3- and 40 kg/m2, midwifery or obstetric staff *'may'* be able to provide advice-with such a risk to outcomes that a high BMI brings women deserve to be confident that any advice is accurate/consistent/evidence | Thank you for your comment. The wording of the statement, measures and definition have been reviewed by the topic expert group. The statement and definition have been updated. |

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| | | | | based. The definition also needs to consider covering how long would they be supported for? Would it continue postnatally? What training as a minimum would healthcare professional/obstetric staff need? | |
| 005 | British Maternal Fetal Medicine Society | 6 | | What does specialist advice mean specifically? | Thank you for your comment. The wording of the statement and definition has been reviewed by the topic expert group and has been updated. |
| 0028 | Unite the Union/CPHVA | 6 | Description | Healthcare professionals need to discuss with the pregnant woman what risks are associated with overweight in pregnancy in a tactful and non-judgemental manner, as well as advice about healthy eating. | Thank you for your comment. |
| 0014 | Department of Health (Children Family and Maternity branch) | 6 | Equality and Diversity | Geographical variation in service is unacceptable and is the reason for having quality standards embedded in commissioning to ensure equity in service provision | Thank you for your comment. We agree that one of the purposes of quality standards is to reduce geographical variation in practice. The equality and diversity section has been reviewed by the topic expert group and updated. |
| 0023 | Bliss | 6 | General | There is no explicit mention of potential risks to pregnancy among pregnant women with a high BMI, which we think would make this statement stronger. | The quality standard does not review and present the evidence base which underpins antenatal care. The source clinical guidelines are referenced should the reader want to understand more about the potential risks which obesity poses in pregnancy. |
| 0014 | Department of Health (Children Family and Maternity branch) | 6 | Measure | It would be helpful to have a clinical quality outcome measure. The **process** measure b) should be 100% and will give no indication of the quality of the advice or how many women take it seriously. An additional measure which may be worth including is one on the incidence of maternal obesity in second or subsequent pregnancies as a means of identifying if local | Thank you for your comment. An outcome measure for this statement has been developed by the topic expert group.<br><br>On the point of incidence of maternal obesity in subsequent pregnancy, the group felt while important, this outcome would not be sufficiently direct enough to link as a measurable outcome within this statement. |

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| | | | | arrangements on personalised advice from trained professionals on healthy eating and how to be physically active are working. | |
| 009 | Royal College of Midwives | 6 | Measure | Evidence about the accuracy of scales should be included here. | Thank you for your comment. This is important it is not unique to antenatal care and the expectation is that the quality standard would be considered in relation to other national and local guidance. |
| 0014 | Department of Health (Children Family and Maternity branch) | 6 | Statement | Obesity is extensively covered in CNST Standard 3 criterion 10. This Quality Standard is adding a further requirement and process measure – would it be better to add it to the CNST standards?. Need to define "appropriately trained professional…" because given the numbers if all women BMI >30, it is likely that the midwives will be the professional. In fact, shouldn't all pregnant women be given this life-style advice? So that it should be 100% for all? | Your comment has been reviewed by the topic expert group who decided to continue to focus this statement around pregnant women with a raised BMI.<br><br>Thank you for your comment. The wording of the statement and definition has been reviewed by the topic expert group and has been updated.<br><br>The quality standard contains key markers of clinical and cost effective care across a care pathway. It remains important that other evidence-based guideline recommendations continue to be implemented. |
| 0028 | Unite the Union/CPHVA | 6 | Structure | Structure a) It will not always be possible to calculate body mass index at the booking appointment as some women who book late will be advanced in their pregnancy. b) It needs to be added here that a suitably qualified professional (e.g. midwife) should discuss with the pregnant woman what risks are associated with being overweight in pregnancy, as well as being offered advice about healthy eating and exercise. | The statement now considers calculating body mass index of pregnant women who book late in their pregnancy and includes an expanded definition of appropriately trained person. |
| 0029 | National Childbirth Trust | 7 | | We agree with the statement that "Pregnant women with one or more risk factors for gestational diabetes at the time of booking are | Thank you for your comments. |

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| | | | | offered testing for gestational diabetes". | |
| 0028 | Unite the Union/CPHVA | 7 | | 'are offered testing for gestational diabetes' and this is explained to her by a qualified health professional (e.g. midwife) | Thank you for your comment. The overview section states 'Women should have the opportunity to make informed decisions about their care and treatment based on the current available evidence, in partnership with healthcare professionals' and this principle should apply throughout antenatal care. |
| 0025 | electivecesarean.com | 7 | Definitions | Suggest including here (or elsewhere) a risk factor for primiparous women too, such as suspected macrosomic baby. | Thank you for your comment. The risk factors are taken from the underlying clinical guideline which are referenced in the 'source clinical guideline references' section. |
| 0031 | Perinatal Institute | 7 | Definitions | Definitions – Middle Eastern – List should include Palestine | Thank you for your comment. The risk factors are taken from the underlying clinical guideline which are referenced in the 'source clinical guideline references' section. |
| 0028 | Unite the Union/CPHVA | 7 | Description | Where healthcare professionals assess that the woman is at risk of gestational diabetes, then that must be properly explained to her to ensure that she understands, and then she can be offered testing | Thank you for your comment. The overview section states 'Women should have the opportunity to make informed decisions about their care and treatment based on the current available evidence, in partnership with healthcare professionals' and this principle should apply throughout antenatal care. |
| 0014 | Department of Health (Children Family and Maternity branch) | 7 | Equality and Diversity | The geographical variation in provision of care is unacceptable and we rely on the quality standards to be robust to inform commissioning and service specification and ensure equitable service provision | Thank you for your comment. We agree that one of the purposes of quality standards is to reduce geographical variation in practice. The equality and diversity section has been reviewed by the topic expert group and updated. |
| 0028 | Unite the Union/CPHVA | 7 | Equality and Diversity | All risk assessments must be properly explained and informed consent obtained | Thank you for your comment. The overview section states 'Women should have the opportunity to make informed decisions about their care and treatment based on the current available evidence, in partnership with healthcare professionals' and this principle should apply throughout antenatal care. |

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| 009 | Royal College of Midwives | 7 | Measure | It would be useful to collect data on the number of women who decline this test. | Thank you for your comment. This level of detail may be specified at a local level and we are keen not to overload the quality standards with requirements for measurement and data collection. In the final quality standard two process measures are suggested which capture the number of women offered the test and the number of women who receive the test. The difference between these two groups will include women who declined or failed to attend for the test. |
| 0014 | Department of Health (Children Family and Maternity branch) | 7 | Risk Assessment | Would it be possible to develop a clinical outcome measure of quality rather than just use process e.g. incidence of shoulder dystocia, caesarean section, distribution of birth weights by diabetic/non-diabetic mothers | Thank you for your comments. The topic expert group have reviewed the outcomes for this statement and feel it inappropriate to specify outcomes of shoulder dystocia rates, caesarean section rates and birth weights when the statement is about early diagnosis. A NICE quality standard on Diabetes in pregnancy is in development and further outcomes will be developed within that standard. |
| 005 | British Maternal Fetal Medicine Society | 8 | | What about aspirin for BMI >40? | Thank you for your comment. The topic expert group have reviewed your comment and have decided to continue focusing the statement on pregnant women at high risk of pre-eclampsia. The recommendation, which includes the associated risk factors, is detailed in the 'source clinical guideline references'.<br><br>The quality standard contains key markers of clinical and cost effective care across a care pathway. It remains important that other evidence-based guideline recommendations continue to be implemented, including recommendations about women with moderate risk factors for pre-eclampsia. |
| 006 | Gloucestershire Hospitals NHS Foundation Trust | 8 | | Aspirin reduces the incidence of early onset pre-eclampsia (that which occurs at less than 28 weeks gestation). What is the rationale for | The source clinical guideline reference (NICE clinical guideline 107, recommendation 1.1.2.1) recommends that aspirin is continued until birth of the baby. It was the |

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| | | | | continuing it until 36 weeks? Aspirin should be stopped by 34 weeks as there is no benefit to taking it thereafter. | consensus of the topic expert group to state until at least 36weeks in the statement. |
| 0029 | National Childbirth Trust | 8 | | We agree with the statement that “Pregnant women at high risk of pre-eclampsia at the time of booking are offered a prescription of 75 mg of aspirin (unless contraindicated) to take daily from 12 weeks until at least 36 weeks”. | Thank you for your comment. |
| 0012 | NHS London | 8 | | Exactly what is a ‘high risk’ of preeclampsia that would justify taking aspirin. If this isn’t defined (in absolute terms) then how will measuring a number of ‘soft’ risks help assess a quality service? | Thank you for your comment. This is defined in the definitions section. |
| 0023 | Bliss | 8 | General | The statement does not mention the potential complications of pre-eclampsia (e.g. preterm birth). We think this statement would benefit from including reference to giving info/advice about these potential complications | Thank you for your comment. Quality statements are specific, concise statements and as such are focused. Hence the statement cannot cover all the aspects of pre-eclampsia management. It remains important that other evidence-based guideline recommendations continue to be implemented. |
| 0014 | Department of Health (Children Family and Maternity branch) | 8 | General | Good | Thank you for your comment. |
| 0024 | Northumbria Healthcare NHS Trust | 8 | General | As a group this was discussed and trusts must ensure that they are working towards embedding this principle across disciplines to ensure women (who are often yet unbooked) obtain Aspirin < 12 weeks. This means increased awareness by GP’s and community midwifery colleagues of the need for this group of women to be prescribed Aspirin as soon as they are registered pregnant, not only when they book at the consultant clinics which may be 12 weeks. | Thank you for your comment. The statement is underpinned by NICE clinical guideline 107, recommendation 1.1.2.1 which states ‘Advise women at high risk of pre-eclampsia to take 75mg aspirin from 12 weeks until the birth of the baby’. This is reflected in the statement. |

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| 007 | Royal College of Obstetricians and Gynaecologists | 8 | P24 | E+D Why does this not include women with two or more moderate risk factors who are also recommended to receive prophylaxis with LDA? | Quality standards do not aim to cover the entirety of the topic area; they aim to provide a concise and selected set of precise statements designed to improve quality across a particular area. This requires focus on specific areas and does not mean other areas are not important.<br><br>The topic expert group prioritised the areas of care based on the development sources listed. The inclusion of pregnant women with two or more moderate risk factors was discussed by the topic expert group and the group acknowledged that the NICE recommendation for pregnant women at high risk of pre-eclampsia (NICE CG107 recommendation 1.1.2.1) is a Key Priority for Implementation. The topic expert group felt that the greatest area for improvement was for women at high risk of pre-eclampsia and decided to focus the statement on this group of women. The quality standard should always be read with the supporting clinical guideline recommendations. |
| 0014 | Department of Health (Children Family and Maternity branch) | 9 | | Good. In the measure – outcome, - given as “incidence of VTE in pregnant women”, could this be strengthened to include the requirement for case review to assess whether appropriate advice and prophylaxis had been given? | Thank you for this comment. This level of detailed measurement would be expected to be decided at a local level. |
| 0029 | National Childbirth Trust | 9 | | We agree with the statement that “Pregnant women at intermediate or high risk of venous thromboembolism at the time of booking have specialist advice provided about their care appropriate to the level of risk”. | Thank you for your comment. |

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| 0012 | NHS London | 9 | | No cut off for the difference (in absolute risk) between high and moderate risk for VTE is specified, but it is good that some guidance is given for this. The difference between getting 'specialist advice' and 'a specialist referral' is not clear.<br>As there is little to no research whatsoever on adherence to thromoboprophylaxis, this seems an area where research might be commissioned as to the barriers and facilitators of taking the (expensive) medication. | Thank you for your comment.<br><br>The definitions section has been reviewed by the topic expert group and the difference between 'specialist advice' and 'specialist referral' clarified. |
| 0028 | Unite the Union/CPHVA | 9 | | Yes, this is excellent, as it states that 'specialist advice should be provided about their care appropriate to the level of risk'. Please can this form of statement be used for the other standards | Thank you for your comment. |
| 0031 | Perinatal Institute | 9 | Additional reference | Additional reference 'National CQUIN for VTE assessment | Thank you for your suggestions. This CQUIN relates to hospital-acquired VTE. Hospital settings are not in the scope of the antenatal care quality standard and so this is not referenced. |
| 0030 | Epilepsy Action | 10 | | We propose that consideration is given to adding another point to the draft quality measure in relation to ante-natal screening. The proportion of women (carrying a baby judged to be at a higher risk of malformation due to their family history, the teratogenicity of their medication, or pre-existing medical condition) offered a high-resolution ultra-sound scan to screen for structural abnormalities early than 18 weeks, This is because earlier scanning may allow major malformations to be detected sooner (NICE CG 137). | Thank you for your comment. The scope of the antenatal care quality standard does not cover the additional care required for women with pre-existing medical conditions. There is suite of maternity-related quality standards in development, some of which will include additional care. These are now referenced within the antenatal care quality standard as related NICE quality standards.<br><br>It remains important that other evidence-based guideline recommendations continue to be implemented including NHS National Screening Committee guidance. |
| 0027 | Foundation Trust | 10 | | Members note the standard may wish to include a | Thank you for your comment. Quality statements are |

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| | Network | | | measure of the proportion of women with positive screening results who were given an appropriate management plan. | specific, concise statements and as such are focused. Hence the statement cannot cover all the aspects of screening. It remains important that other evidence-based guideline recommendations continue to be implemented including NHS National Screening Committee guidance. |
| 0029 | National Childbirth Trust | 10 | | This states that "Pregnant women are offered fetal screening in accordance with current UK National Screening Committee programmes".<br>We would amend it slightly to highlight that "**All p**regnant women are offered fetal screening in accordance with current UK National Screening Committee programmes". | Thank you for your comment. The antenatal care quality standard covers the antenatal care of all pregnant women and this statement applies to all pregnant women. |
| 004 | NHS South central | 10 | | The title should read National Fetal Anomal Screening. | Thank you for your comment. The heading has been changed to reflect the programme title of 'NHS Fetal Anomaly Screening Programme'. |
| 0031 | Perinatal Institute | 10 | | This measure aims to estimate the coverage of the offer of gestation-appropriate screening to the eligible population, determined by booking date. The responses from the data source (Maternity services survey 2010) will not represent the whole population particularly the more vulnerable women. The trisomy 21 question and response will record the proportion not offered, however the responses to the fetal anomaly scan will only determine the uptake, not the offer of screening. The gold standard would be to record EDD and date of booking plus the offer (Y/N) of the 3 screening tests. | Thank you for your comment. The measures and data sources have been reviewed. It will be for local providers and commissioners to decide how best to collect and analyse the data for the measures. |
| 008 | Tamba (Twins & Multiple Births Association) | 10 | | **In response to question 2**- Refer to NICE clinical guideline 129 1.3.1. The quality statement is general and Tamba would encourage it to include | Thank you for your comment. Quality statements are specific, concise statements and as such are focused. Hence the statement cannot cover all the aspects of |

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| | | | | the complex decisions a woman expecting twins or triplets would potentially have to make depending on the results of screening she consented to. The need for counselling before and after screening tests which would be pertinent to other high risks groups not only to those women expecting multiples. Tamba clients have mixed experiences in relation to screening. As previously highlighted NPEU (2011) found a higher proportion of women with a multiple pregnancy were not offered Down's Syndrome screening (15%, compared with 4% for singleton pregnancies). Tamba would therefore recommend that the quality standard is not purely about the process but to also account for the training, skills and knowledge of the midwives and obstetric staff.<br>**References** –to include NICE clinical guideline 129 | screening. It remains important that other evidence-based guideline recommendations continue to be implemented including NHS National Screening Committee guidance.<br><br>The scope of the antenatal care quality standard does not cover the additional care required for women with multiple pregnancies. There is a separate NICE quality standard on multiple pregnancy which is in development. This has now been referenced within the antenatal care quality standard as a related NICE quality standard.<br><br>The forthcoming multiple pregnancy quality standard will be underpinned by NICE clinical guideline 129 (multiple pregnancy) and will set out markers of high quality care which are in addition or different to those for women with a singleton pregnancy. |
| 0014 | Department of Health (Children Family and Maternity branch) | 10 | Data Sources | Add Maternity dataset because it records offer and acceptance as well as results. | Thank you for this comment. This has been included in the final quality standard. |
| 0019 | UK NSC | 10 | Data Sources | Data sources could include UKNSC KPI data collection | Thank you for your comment. The data sources have been reviewed and updated throughout the standard. |
| 0023 | Bliss | 10 | General | There is no mention of multiple births (and other high risk pregnancies) and the potentially higher needs of these mothers in terms of screening. | The scope of the antenatal care quality standard covers the routine antenatal care of all pregnant women and as such statement ten applies to all women including women with a multiple pregnancy.<br><br>The scope of the antenatal care quality standard does not cover the additional care required for women with multiple pregnancies, complications of pregnancy or pre-existing |

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| | | | | | medical conditions. There is suite of maternity-related quality standards in development, some of which will include additional care. These are now referenced within the antenatal care quality standard as related NICE quality standards.<br><br>The forthcoming multiple pregnancy quality standard will be underpinned by NICE clinical guideline 129 (multiple pregnancy) and will set out markers of high quality care which are in addition or different to those for women with a singleton pregnancy. |
| 0014 | Department of Health (Children Family and Maternity branch) | 10 | General | Good to have this as a standard. We presume the National Screening Committee will comment | Thank you for your comment. |
| 0022 | Multiple Births Foundation | 10 | General | The MBF suggests that the NICE Multiple Pregnancy Guideline and recommendations from the NHS Fetal Anomaly Screening Programme for multiple pregnancies are incorporated into the Statement. | Thank you for your comments. The scope of the antenatal care quality standard does not cover the additional care required for women with multiple pregnancies. There is a separate NICE quality standard on multiple pregnancy which is in development. This has now been referenced within the antenatal care quality standard as a related NICE quality standard.<br><br>The forthcoming multiple pregnancy quality standard will be underpinned by NICE clinical guideline 129 (multiple pregnancy) and will set out markers of high quality care which are in addition or different to those for women with a singleton pregnancy.<br><br>The statement focuses on National Screening Committee guidance, stating 'Pregnant women are offered fetal screening in accordance with current UK National Screening Committee programmes.' |
| 0018 | The Royal College of | 10 | General | We note that this is a generic statement and | Thank you for your comment. |

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| | Radiologists (Faculty of Clinical Radiology) | | | appropriately refers to existing accepted guidelines. | |
| 0019 | UK NSC | 10 | General | These statements should be combined to include antenatal screening as well as other tests that are carried out. The antenatal (fetal) screening referred to in 10 should be expanded to include all the current screening programmes offered to women as part of their antenatal care. (AN Sickle Cell & Thalassaemia, Infectious diseases in Pregnancy and Fetal Anomaly).<br>General Q.1 Appropriate healthcare outcomes for the screening elements of the care would be the UKNSC Key Performance indicators. These are collected quarterly and give a measure of offer, acceptance and outcome by individual maternity units and/or current PCT's. It would make sense to use these rather than ask organisations to complete additional data sets. Also, the CNST maternity standards require organisations to monitor offer and uptake regarding AN screening. | Thank you for your comments.<br><br>All suggestions for additional statements were discussed by the topic expert group who recognised the importance of screening for sickle cell and thalassaemia and infectious diseases in pregnancy. The group made a consensus decision to focus the screening statement around fetal anomaly screening. However, NICE recognises that early booking is an important factor in delivering sickle cell and thalassaemia screening and quality statement 1 aims to support this.<br><br>In the final antenatal care quality standard:<br>-Statement 1 focuses on improving access to antenatal care (ideally by 10 weeks 0 days) which includes measures about the timeliness of access. One of the source clinical guideline references is to NICE clinical guideline 62, recommendation 1.6.3.3 which focuses on offering women screening for sickle cell and thalassaemia as early as possible within their pregnancy (ideally by 10 weeks).<br>-Statement 3 focuses on pregnant women having a complete record of the minimum set of antenatal test results in their hand-held maternity notes, including haemoglobinopathies screening and the outcome of screening for infectious diseases.<br><br>The quality standard in no way replaces the clinical guideline recommendations or National Screening Committee guidance and has been designed to serve quality improvement across antenatal care. It remains important that other evidence-based guideline |

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| | | | | | recommendations continue to be implemented.<br><br>The data sources have been reviewed and updated throughout the standard. |
| 0014 | Department of Health (Children Family and Maternity branch) | 10 | Measure | **Process:** Should it be clear that women would be offered a) or b)?<br>Recording of screening results has been used to measure record keeping in Standard 3. Would it be better measure of quality of the fetal screening to identify the proportion of pregnant women who were offered screening that accepted and actually had their screening within the recommended gestational period? Uptake of screening could be a measure of the quality of counselling and/or communication.<br>Other aspects of record keeping could then be used in standard 3 e.g. up-to-date management plan.<br>Could a clinical outcome measure be the number of unexpected fetal abnormalities or false positives or false negatives.<br>There is a risk of unhelpful duplication here with the KPIs required by the National Screening Committee. There should be alignment | Thank you for your comment. This statement has been reviewed and updated to make it clear that women should be offered a or b. This statement is aligned with national screening committee guidance.<br><br>It remains important that other evidence-based guideline recommendations continue to be implemented including NHS National Screening Committee guidance. |
| 0020 | NHS Sickle Cell and Thalassaemia Screening Programme | 10 | National fetal screening programmes<br><br>Draft quality measure<br><br>Source | The draft quality statement reads “Pregnant women are offered fetal screening in accordance with current UK National Screening committee programmes”<br>The SCT programme is concerned that this draft quality statement only includes metrics associated with the Fetal Anomaly Screening programme.<br><br>To be fair and equitable it should include | Thank you for your comments.<br><br>All suggestions for additional statements were discussed by the topic expert group who recognised the importance of screening for sickle cell and thalassaemia and infectious diseases in pregnancy screening. The group made a consensus decision to focus the screening statement around fetal anomaly screening. However, NICE recognises that early booking is an important factor |

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| | | | References<br><br>Data sources<br><br>Equality and Diversity Considerations | reference to the sickle cell and thalassaemia screening programme – for example the standard that screening should be offered by 10 weeks or that Prenatal diagnostic testing should be performed by 12 weeks 6 days gestation. There are two other antenatal screening programme standards that should be included – the infectious diseases in pregnancy programme and the sickle cell and thalassaemia screening programme. Definitions have been developed for both these programmes through the Key performance Indicator data<br><br>Given the Equality and diversity standards for this quality standard state" Screening should be offered in a sensitive way to all pregnant women. Staff should not discriminate based on age or assumptions about particular cultural or religious beliefs" it is of concern that a programme screening for conditions associated with minority ethnic groups is not included in the metrics<br>Include SCT screening – presently only Down's syndrome screening<br>Source reference – add SCT standards, otherwise as above<br>Definitions – add SCT screening (either KPI or standards)<br>Equality and diversity – screening is more than the Fetal Anomaly Screening Programme | in delivering sickle cell and thalassaemia screening and quality statement 1 aims to support this.<br><br>In the final antenatal care quality standard:<br>-Statement 1 focuses on improving access to antenatal care (ideally by 10 weeks 0 days) which includes measures about the timeliness of access. One of the source clinical guideline references is to NICE clinical guideline 62, recommendation 1.6.3.3 which focuses on offering women screening for sickle cell and thalassaemia as early as possible within their pregnancy (ideally by 10 weeks).<br>-Statement 3 focuses on pregnant women having a complete record of the minimum set of antenatal test results in their hand-held maternity notes, including haemoglobinopathies screening and infectious disease screening.<br><br>The quality standard in no way replaces the clinical guideline recommendations and has been designed to serve quality improvement across antenatal care. It remains important that other evidence-based guideline recommendations continue to be implemented. |
| 007 | Royal College of Obstetricians and Gynaecologists | 10 | Page 29 | The data sources rely on what women recall and not what was actually offered and done - better to see what has been documented and recorded in the case records. | Thank you for your comment. The data source now references local data collection through the Maternity Services Secondary Uses Dataset. |
| 0013 | CSections.org | 11 | | This quality statement needs to include the | Thank you for your comment. Draft statement 11 did not |

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| | | | | recommendation that this support should include alternative feeding positions post surgery. | progress to the final quality standard. |
| 0030 | Epilepsy Action | 11 | | We would like to refer you to NICE CG 137 "The decision regarding anti-epileptic drug (AED) therapy and breastfeeding should be made between the woman and her prescriber and be based upon the risks and benefits of breastfeeding against the potential risks of the drug affecting the child".<br><br>Epilepsy Action propose that the draft quality statement should measure the proportion of women with epilepsy/a pre-existing medical condition who received information/ discussed breastfeeding with their medications prescriber. | Thank you for your comment. Draft statement 11 did not progress to the final quality standard. |
| 0029 | National Childbirth Trust | 11 | | This states that "Pregnant women are offered balanced and consistent information about breastfeeding which they understand and have the opportunity to discuss". We are not sure that this standard would, as it stands, improve the quality of care because how awareness is raised, what information is offered and how a woman can access further support are all also important. Including all this in the standard itself would make it very long though so we suggest amending the statement but adding further detail in the description of what the standard means for healthcare professionals on page 31.<br><br>We suggest amending the statement to "Pregnant women are offered evidence-based ~~balanced~~ and consistent information about breastfeeding as part of an informal participative group ~~which they understand~~ and they then have the opportunity to | Thank you for your comment. Draft statement 11 did not progress to the final quality standard. |

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| | | | | discuss this or any other information about feeding when they feel it is appropriate with a named professional".<br>• We feel that the term "balanced" could be misinterpreted and that the term "evidence-based" more accurately defines how information offered to women should be selected.<br>• In terms of what information is offered, we suggest amending the description on page 31 of what the quality statement means for healthcare professionals so that it explicitly lists the information that should be covered. We suggest that this includes benefits for women and babies, what helps breastfeeding to go well (notably skin-to-skin and support from family and friends) and how to avoid common problems or minimise their impact (notably seeking early support). The importance of relationships and informal support from family and friends that enable women to focus on establishing a feeding relationship were highlighted by a recent research study by members of the Research and Information Team at NCT. This involved the use of focus groups and workshops with NCT's trustees, staff, breastfeeding counsellors, antenatal teachers, postnatal leaders, members and volunteers to highlight and then explore infant feeding problems [1].<br>• In terms of how awareness is raised, the evidence into practice briefing on breastfeeding and the NICE guidance on maternal and child nutrition (PH11) both | |

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| | | | | highlight the importance of informal practical breastfeeding education delivered in small groups [2, 3].<br><br>• The amended statement then set outs the need for continuing support to discuss any information about feeding that the woman herself has identified as important. Recent research by Hoddinott et al, involving serial interviews with women and their partners, identified clashes between idealism about breastfeeding and the practical realities within and between families and the health service at multiple points with the only solution often felt to be stopping or supplementing breastfeeding [4]. This shift away from the idea of mothers making one-off rational choices is also supported by the recent research study by members of the Research and Information Team at NCT [1]. Women should be supported by a care standard that reflects the need for individual on-going mother-centred support with the aim of enabling flexible incremental decisions about feeding, rather than seeking to influence one-off initial decisions and then categorising mothers according to initial feeding intentions.<br><br>• Finally, the amended statement highlights that a named professional should be available for discussing information because there is evidence, notably from a recent metasynthesis of 31 qualitative studies and surveys of peer and professional support for breastfeeding [5], that continuity of relationship with the same caregiver is | |

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| | | | | important in supporting a women to breastfeed.<br><br>On page 32, the equality and diversity considerations related to this standard state that "Some women may be advised not to breastfeed their baby on medical grounds, for example women with HIV. In these cases, individualised support and information on preparing for infant feeding should be provided". We feel that this statement may be misleading as such women still need to make decisions around feeding and we suggest changing it to "Some women may decide after discussion with a health professional not to breastfeed their baby on medical grounds. In these cases, individualised support and information on preparing for infant feeding should be provided".<br><br>[1] Trickey H, Newburn M. Goals, dilemmas and assumptions in infant feeding education and support. Applying theory of constraints thinking tools to develop new priorities for action. Submitted for publication and draft attached with this feedback.<br><br>[2] Dyson L et al. Promotion of breastfeeding initiation and duration. Evidence into practice briefing. National Institute for Clinical Excellence, July 2006.<br><br>[3] National Institute for Health and Clinical Excellence. Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households. NICE public health guidance 11. National Institute for Clinical Excellence, March 2008. | |

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| | | | | [4] Hoddinott P et al. A serial qualitative interview study of infant feeding experiences: idealism meets realism. BMJ Open2012;2:e000504 doi:10.1136/bmjopen-2011-000504.<br><br>[5] Schmied V et al. Women's Perceptions and Experiences of Breastfeeding Support: A Metasynthesis. Birth 2011; 38 (1): 49-60. | |
| 0012 | NHS London | 11 | | The measurement of breast feeding initiation is not an outcome measure. Whilst it is necessary to start breast feeding in order to continue breast feeding, this is an unambitious proxy measure for the full benefit of breast feeding to the infant. It would be better to measure breast feeding rates at 6 or 12 months as the desired outcome. This also links up with the public health agenda as community interventions may be required that act both before and after pregnancy. | Thank you for your comment. Draft statement 11 did not progress to the final quality standard. |
| 009 | Royal College of Midwives | 11 | | This should be worded as 'information about infant feeding' rather than 'breast feeding' to incorporate the negative implications of formula feeding. | Thank you for your comment. Draft statement 11 did not progress to the final quality standard. |
| 003 | Royal College of Nursing | 11 | | What is meant by balanced? Surely midwives have a responsibility to offer directive advice on breastfeeding. This statement may be misunderstood to mean balanced between breast feeding and artificial feeding.<br>Suggest rewording to 'consistent and evidence based information' | Thank you for your comment. Draft statement 11 did not progress to the final quality standard. |
| 032 | Royal College of Paediatrics and Child Health (RCPCH) | 11 | | Standard should be headed – maternal and neonatal wellbeing (not information) and should read….. information about the benefits to them and their babies of breastfeeding….. As written it | Thank you for your comment. Draft statement 11 did not progress to the final quality standard. |

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| | | | | does not make breast feeding sound very attractive | |
| 008 | Tamba (Twins & Multiple Births Association) | 11 | | **In response to question 1- Structure** - to consider including that information is given in line with UNICEF Baby Friendly standards and that locally infant feeding specialists are available to provide support. In relation to Outcomes Tamba would be keen to include breastfeeding initiation rates amongst multiples are used as an additional measure.<br>**In response to question 2**- In the knowledge that multiple births are increasing, currently representing 3% of live births (NICE,2011), and that they represent a vulnerable group of babies, with risks of preterm birth occurring in 50% of twin pregnancies (NICE,2011), who would undoubtedly benefit from being breastfed Tamba would strongly encourage the needs of multiples be included in this quality standard.<br>Tamba would also support the need for a clear definition of what 'initiation of breastfeeding' means as currently there is lack of clarity about what this constitutes. Tamba suspect figures may include when a baby latches on to the breast but may not complete a feed, presenting skewed statistics and hence inaccurate high drop off rates. Of all the issues that Tamba have feedback to them from their clients concerns around feeding and the lack of specialised support available is consistently a problem. In Tamba's most recent survey (2012) a third of parents (31%) thought feeding advice was poor or very poor. Previous studies highlight that unfortunately little has changed e.g. NPEU (2011) found fewer mothers with more than one baby exclusively breastfed | Thank you for your comment. Draft statement 11 did not progress to the final quality standard.<br><br>The scope of the antenatal care quality standard does not cover the additional care required for women with multiple pregnancies. There is a separate NICE quality standard on multiple pregnancy which is in development. This has now been referenced within the antenatal care quality standard as a related NICE quality standard.<br><br>The forthcoming multiple pregnancy quality standard will be underpinned by NICE clinical guideline 129 (multiple pregnancy) and will set out markers of high quality care which are in addition or different to those for women with a singleton pregnancy. |

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| | | | | their babies in the first few days (32% compared with 58%).<br>Several mothers said their babies were fed formula milk without their permission while in special care.<br>For example, one mother *said "I was told my initial breastmilk was not good enough for them and they were fed formula without my permission"* (Health & Lifestyle Survey, Tamba, 2011).<br>The problem may lie in the lack of antenatal classes for parents who are expecting multiples as often decisions about feeding choice are made early in pregnancy. Only a third of women being offered multiple specific parent education sessions ('*Multiple Failings'*, 2009) and a higher proportion were less likely to be offered antenatal classes at all (NPEU, 2011).<br>**Description of what the quality statement means for each audience**- **Service providers** have a responsibility to ensure that there is appropriate training in place in relation to breastfeeding multiples, **Healthcare Professionals** to understand the specific needs of women expecting multiples and how they can support them to breastfeed, **Commissioners** need to be aware of the needs of this group of vulnerable babies in their community and ensure they commission services to meet their needs, **Pregnant women** needs to include those expecting multiples.<br>**References** –to include NICE clinical guideline 129<br>**Definitions-** suggest edit to say 'successfully breastfeed one or more babies' | |

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| 0028 | Unite the Union/CPHVA | 11 | | Should include initiating AND ESTABLISHING breast feeding | Thank you for your comment. Draft statement 11 did not progress to the final quality standard. |
| 0028 | Unite the Union/CPHVA | 11 | | We like the way this statement is written, but the title 'preparing for infant feeding ' needs to change to 'preparing to breast feed' | Thank you for your comment. Draft statement 11 did not progress to the final quality standard. |
| 0015 | La Leche League | 11 | Definitions | The definition for this Quality Statement reads "Information about breastfeeding should include technique and good management practices that will help a woman to successfully initiate breastfeeding."<br><br>We suggest that information for pregnant women should also include details of local and national breastfeeding support, such as local NHS or voluntary-run breastfeeding support groups and national breastfeeding support helpline numbers (La Leche League, National Childbirth Trust, Breastfeeding Network, Association of Breastfeeding Mothers, and the National Breastfeeding Helpline). | Thank you for your comment. Draft statement 11 did not progress to the final quality standard. |
| 0014 | Department of Health (Children Family and Maternity branch) | 11 | Equality and Diversity | It is important that there is not seen to be any discrimination against women who decide not to breast feed. | Thank you for your comment. Draft statement 11 did not progress to the final quality standard. |
| 0015 | La Leche League | 11 | General | This statement reads: "Pregnant women are offered balanced and consistent information about breastfeeding which they understand and have the opportunity to discuss."<br><br>In the context of infant feeding, '**balanced'** can sometimes be taken to mean presenting | Thank you for your comment. Draft statement 11 did not progress to the final quality standard. |

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| | | | | breastfeeding and bottle-feeding as equivalent choices, and although this statement refers specifically to breastfeeding, and is presumably intended to ensure women receive realistic information, we are concerned that in practice its meaning may be misconstrued. Also, information may be 'balanced and consistent' without being accurate or evidence-based. 'Consistent' may also be taken to mean a standard, 'one size fits all' approach, which would not provide appropriate support for all women.<br><br>Therefore we suggest that this statement reads "Pregnant women are offered accurate and comprehensive information about breastfeeding which they understand and have the opportunity to discuss." | |
| 0022 | Multiple Births Foundation | 11 | General | The MBF suggests that reference is made in each section of this Statement as appropriate to include multiple birth babies as a greater number are more vulnerable through preterm birth and low birth weight. Our experience at the MBF corroborates the findings of a recent survey by the parent organisation, *Tamba (2012)* and the National Perinatal Epidemiology Unit (NPEU) report *Maternity Care for Women with a Multiple Birth (2011)* that women with twins and triplets often don't have specific antenatal information and advice or post natal support from professionals with specialist knowledge about breast feeding twins and triplets. The MBF and NPEU reviewed the evidence as part of a research project and produced evidence based guidance for professionals and parent information on feeding | Thank you for your comment. Draft statement 11 did not progress to the final quality standard.<br><br>The scope of the antenatal care quality standard does not cover the additional care required for women with multiple pregnancies. There is a separate NICE quality standard on multiple pregnancy which is in development. This has now been referenced within the antenatal care quality standard as a related NICE quality standard.<br><br>The forthcoming multiple pregnancy quality standard will be underpinned by NICE clinical guideline 129 (multiple pregnancy) and will set out markers of high quality care which are in addition or different to those for women with a singleton pregnancy. |

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| | | | | twins triplets and more *(Guidelines for Health Professionals on Feeding Twins, Triplets and Higher Order Multiples MBF 2011).* As recommended in the MBF publication, auditable standards for the monitoring of breast feeding of twins and triplets should be developed. Local data collection and other surveys such as those conducted by the CQC should include multiples and details for each baby individually. | |
| 0016 | UNICEF UK | 11 | General | The Baby Friendly Initiative welcomes the inclusion of the need for on an opportunity for a discussion about feeding during the antenatal period and agrees that the provision of consistent information is crucial. However, there is concern that the term 'balanced' may lead to confusion if not properly clarified.<br><br>The Baby Friendly Initiative has always acknowledged the importance of mother centred discussions which may include both breast and bottle feeding. However, it is recognised that practice has not always reflected this ideal, with sometimes over-zealous promotion of breastfeeding replacing the previous position of indifference as to whether a woman breastfed or not. The choice between breast and bottle feeding is not an equal one, with the evidence supporting breastfeeding as being very important for the mother and baby's health and wellbeing. There is concern that use of the word 'balanced' may encourage some health professionals to return to a position where breast and bottle feeding are viewed as equal, without the understanding that best practice is to approach this topic sensitively, acknowledging and valuing women's real life | Thank you for your comment. Draft statement 11 did not progress to the final quality standard. |

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| | | | | situations, but not colluding with the view that infant feeding choices make no difference.<br><br>Evidence from recent studies of women's views indicate a preference for information that is realistic and acknowledges the challenges that can be part of breastfeeding1. Whilst accurate, evidenced based information is important, mothers also express a need for other softer and more relational aspects to be included, such as what breastfeeding will feel like and how it will fit into family life[2]. Mothers who have current or recent personal breastfeeding experience (peers) are particularly valued for experiential learning and support in group settings, both in the antenatal and postnatal period [3].<br><br>In addition, antenatal discussions about how a baby will be fed are an opportunity to talk to women and their partners about post birth skin to skin contact and the importance of responsive parenting, including baby led feeding and keeping the baby close, regardless of feeding method.<br><br>It may be of interest to the topic expert group that over the last year a review of the Baby Friendly Initiative standards in the UK has been carried out with support from experts in this field and in the light of new evidence. The results indicate that, whilst it is clear that breastfeeding has a profound impact on health, it also supports a close and loving relationship between mother and baby 4, 5. Therefore, when a baby is not breastfed, protecting this relationship is even more important 6, 7. The new draft standards will enter the public | |

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| | | | | consultation phase in June 2012.<br><br>The draft standard for antenatal information has been amended as follows:<br><br>All pregnant women are prepared for feeding and caring for their new baby, including the importance of early relationships on health and wellbeing.<br><br>Guidance to accompany the standards will emphasise the importance of a discussion which includes evidence based information, but also encourages a mother centred approach including the development of a personalised feeding plan.<br><br>Hoddinott P, Craig LCA, Britten J, et al.(2012) *A serial qualitative interview study of infant feeding experiences: idealism meets realism.* BMJ Open 2012;2:e000504. doi:10.1136/ bmjopen-2011-000504<br>[2] Trickney H and Newburn M (in press) *Goals, dilemmas and assumptions in infant feeding education and support. Applying theory of constraints thinking tools to develop new priorities for action.* Maternal and Child Nutrition<br>3 Hoddinott P, Craig LCA, Britten J, et al (2010) A prospective study exploring the early infant feeding experiences of parents and their significant others during the first 6 months of life: what would make a difference? NHS Health Scotland [online ] accessed 23.4.2012 http://www.healthscotland.com/documents/4720.aspx<br>4 Britton JR, Britton H, Gronwaldt V. (2011) | |

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| | | | | Breastfeeding – sensitivity and attachment. www.pediatrics.aapublications.org<br>5. Heikkilä, K. Sacker, A. Kelly, Y. Renfrew, M. Quigley, M. Breast feeding and child behaviour in the Millennium Cohort Study. Arch Dis Child 2011; doi:10.1136/adc.2010.201970<br>6. Schore AN (2002) Effects of a secure attachment relationship on right brain development, affect regulation and infant mental health. Infant Mental Health Journal, Vol.22 (1-2), 7-66<br>7. Gerhart S (2004) Why love matters – How affection shapes a baby's brain. Routledge. | |
| 0014 | Department of Health (Children Family and Maternity branch) | 11 | Measure | **Process –** this should be a wasted measure since it must be 100% and does not measure quality<br>**Outcome -** Breast feeding initiation rates is a reasonable measure of the quality of counselling. | Thank you for your comment. Draft statement 11 did not progress to the final quality standard. |
| 0025 | electivecesarean.com | 11 | Measure | This may be outside the Scope, but my organisation believes that it is important to make a distinction in the "Outcome" measure for infant feeding between whether or not the mother *wanted* to breastfeed. Breastfeeding initiation rates are often presented as a measure of 'success or failure', both of the mother and the healthcare provider, and they are also presented as an outcome measure of a particular mode of birth. However, with the knowledge of whether the initiation was wanted or not by the mother, this would make the data even more useful. | Thank you for your comment. Draft statement 11 did not progress to the final quality standard. |
| 0015 | La Leche League | 11 | Outcome | Currently, the outcome measures for Quality Statement 11 (on breastfeeding) are a) Pregnant women's sense of being sufficiently informed and | Thank you for your comment. Draft statement 11 did not progress to the final quality standard. |

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| | | | | supported to prepare for infant feeding; and b) Breastfeeding initiation rates. We suggest that breastfeeding rates at 6–8 weeks are also included as an outcome measure. Breastfeeding rates fall sharply within the first two weeks postnatally, and while effective postnatal support is paramount for breastfeeding continuation, accurate antenatal information is also likely to influence breastfeeding continuation within the early postnatal period. | |
| 0031 | Perinatal Institute | 11 | Outcome | Breastfeeding initiation rates should also be broken down into specific groups (e.g. ethnic groups, age ranges etc) so initiation rates are not just based on population characteristics. | Thank you for your comment. Draft statement 11 did not progress to the final quality standard. |
| 0028 | Unite the Union/CPHVA | 11 | Quality Measure | Under 'outcome' should be 'to prepare for breast feeding' | Thank you for your comment. Draft statement 11 did not progress to the final quality standard. |
| 0031 | Perinatal Institute | 11 | Reference | Additional reference UNICEF Baby Friendly (details information requirements ) will inform the outcomes for this quality standard. | Thank you for your comment. Draft statement 11 did not progress to the final quality standard. |
| 0014 | Department of Health (Children Family and Maternity branch) | 11 | Statement | The title is "Infant feeding" but the statement is about breast feeding. Although breastfeeding should be encouraged we think that the statement should be balanced to include both breast and bottle feeding and include benefits and disadvantages of both so that women can make an informed choice. | Thank you for your comment. Draft statement 11 did not progress to the final quality standard. |
| 005 | British Maternal Fetal Medicine Society | 12 | | How is this to be monitored? What advice will the woman be given about what reduced fetal movements is? The NICE antenatal care CG 62, section 12.6.2 states that the positive predictive | Thank you for your comment. Draft statement 12 did not progress to the final quality standard. |

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| | | | | value of the maternal perception of reduced fetal movements for fetal compromise is low, 2% to 7% but recommends that following a reduction in fetal movements women should be advised to contact their midwife or hospital for further assessment. It is unclear as to what exactly reduced fetal movements is defined as. The evidence does not support the routine use of formal fetal movement counting to prevent late fetal death so some advice should be given as to what to consider as a reduction in fetal movements if this standard is to be robust | |
| 0029 | National Childbirth Trust | 12 | | We agree with the statement that “Pregnant women reporting a perceived reduction in fetal movements are offered an immediate assessment of fetal wellbeing”. | Thank you for your comment. Draft statement 12 did not progress to the final quality standard. |
| 0012 | NHS London | 12 | | It is unclear what the purpose of this standard is. Is it to get a prompt diagnosis of fetal death (the auscultation followed by ultrasound)? Or is it to get a prompt diagnosis of fetal death or fetal distress (about which something might be done). If the latter, then auscultation of the fetal heart is not an adequate test of reassurance (especially near term when a CTG might demonstrate more subtle signs of fetal distress). As fetal movements are the best measure of fetal wellbeing, it seems strange to have a service standard that would not help living and distressed fetuses. Auscultation alone is an inadequate response to a concern about diminished fetal movements, and is not a diagnostic test of fetal wellbeing. | Thank you for your comment. Draft statement 12 did not progress to the final quality standard. |
| 0031 | Perinatal Institute | 12 | | What assessment of fetal wellbeing is recommended by NICE (e.g. CTG, growth scan?). | Thank you for your comment. Draft statement 12 did not progress to the final quality standard. |

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| | | | | This needs to be clearly defined to prevent inequities in service provision. | |
| 003 | Royal College of Nursing | 12 | | This is not a measurable standard unless adopting the previous position of many years ago (less than ten kicks).<br><br>Advice also needs to accompany this standard regarding a measurable assessment of fetal wellbeing. For example, a CTG is not a particularly helpful assessment of fetal wellbeing in the second trimester, and if it is suggested that an immediate assessment is required, this may put undue pressure on busy labour wards out of hours, which poses a risk to women with urgent medical or obstetric needs. | Thank you for your comment. Draft statement 12 did not progress to the final quality standard. |
| 032 | Royal College of Paediatrics and Child Health (RCPCH) | 12 | | Women need to be advised in definition and how to detect reduced fetal movements before they report it | Thank you for your comment. Draft statement 12 did not progress to the final quality standard. |
| 005 | British Maternal Fetal Medicine Society | 12, draft quality measure, structure | | What does 'assessment of fetal wellbeing' mean specifically? Needs to be more specific if it means auscultating fetal heart, computerised CTG or CTG + Ultrasound. The RCOG guideline is quite specific about the use of customised fundal height charts | Thank you for your comment. Draft statement 12 did not progress to the final quality standard. |
| 0025 | electivecesarean.com | 12 | Definitions | Re: "If an ultrasound scan assessment is deemed necessary, it should be performed when the service is next available – preferably within 24 hours." Just an expression of concern/surprise that in relation to something as serious as reduced fetal movements requiring "necessary" assessment, the quality statement (*and RCOG* | Thank you for your comment. Draft statement 12 did not progress to the final quality standard. |

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| | | | | *green-top guideline 57*) only suggests “preferably within 24 hours”. | |
| 009 | Royal College of Midwives | 12 | Definitions | In the requirement for same day auscultation for a woman with reduced fetal movements presenting in the community - it should also say that if not presenting in her local area, she should be referred to nearest appropriate maternity facility for same day auscultation. | Thank you for your comment. Draft statement 12 did not progress to the final quality standard. |
| 0028 | Unite the Union/CPHVA | 12 | Definitions | Surely if service providers have to ensure that systems are in place to offer an immediate assessment of well being then they must also be required to provide the equipment to do so. | Thank you for your comment. Draft statement 12 did not progress to the final quality standard. |
| 0014 | Department of Health (Children Family and Maternity branch) | 12 | Description | Should include that Healthcare Professionals should encourage women to report reduced movements and that pregnant women must understand that they should report reduced fetal movements. | Thank you for your comment. Draft statement 12 did not progress to the final quality standard. |
| 0018 | The Royal College of Radiologists (Faculty of Clinical Radiology) | 12 | General | We note that the standard of having an ultrasound scan within 24 hours, if clinically indicated, should be very achievable. | Thank you for your comment. Draft statement 12 did not progress to the final quality standard. |
| 0014 | Department of Health (Children Family and Maternity branch) | 12 | Measure | **Structure:** will it be necessary to define “immediate”? This would be helpful for commissioners and providers so that there is no room for doubt or misunderstanding (which could be a risk management issue). | Thank you for your comment. Draft statement 12 did not progress to the final quality standard. |
| 0014 | Department of Health (Children Family and Maternity branch) | 12 | Measure | Another potential outcome of an immediate assessment of fetal wellbeing is that it will identify high-risk pregnancies, identify compromised fetuses at risk of stillbirth, and encourage | Thank you for your comment. Draft statement 12 did not progress to the final quality standard. |

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| | | | | appropriate use of interventions to minimise adverse maternal and neonatal outcomes. | |
| 003 | Royal College of Nursing | 12 | Measure | This standard is too vague to be measurable, suggest instead - local guidelines are developed to ensure women understand who to contact, if there is a perceived reduction in fetal movements (after 24 weeks gestation?) | Thank you for your comment. Draft statement 12 did not progress to the final quality standard. |
| 0014 | Department of Health (Children Family and Maternity branch) | 12 | Statement | The statement misses the need “to encourage women to report reduced fetal movements” | Thank you for your comment. Draft statement 12 did not progress to the final quality standard. |
| 005 | British Maternal Fetal Medicine Society | 13 | | Is the ‘not in labour’ added because this document only deals with antenatal care, therefore no recommendation is given for the standard of care in labour. Or is it because it is unsafe – unclear from NICE guidelines 62 and the intrapartum guideline. | Thank you for your comment. This statement is underpinned by NICE clinical guideline 62, recommendations 1.10.5 and 1.11.2.1. Recommendation 1.11.2.1 states that exception to external cephalic version include ‘women in labour and women with a uterine scar or abnormality, fetal compromise, ruptured membranes, vaginal bleeding and medical conditions.’ |
| 0013 | CSections.org | 13 | | This quality statement should clarify that a planned caesarean at 39+ weeks is a viable alternative to ECV if the woman prefers this. The risks and benefits of both modes should be presented, irrespective of the preference of the practitioner, this is particularly important where the experience of the provider is low. | Thank you for your comments.<br><br>The scope of the antenatal care quality standard does not cover the additional care required for women requiring a caesarean section. There is a separate NICE quality standard on caesarean section which is in development. This has been referenced within the antenatal care quality standard as a related NICE quality standard.<br><br>NICE would welcome feedback from CSections.org during the consultation for the NICE quality standard for caesarean section. |
| 0029 | National Childbirth | 13 | | We agree with the statement that “Pregnant | Thank you for your comment. |

| ID | Stakeholder | Statement number | Comment on | Comments<br>Please insert each new comment in a new row. | Response |
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| | Trust | | | women with an uncomplicated singleton breech presentation at 36 weeks or later (until labour begins) are offered external cephalic version". | |
| 0012 | NHS London | 13 | | The standard could be more evidence based. At present it would not capture those units with a poor 'pickup' rate of breech (undiagnosed until labour). We would commend using the Term Breech Index (TBI) as a much simpler means of assessing the totality of a streamlined service. There is very little data burden; the only extra information that needs to be captured is the number of successful ECVs. The TBI is *"number of successful ECVs/ total of (no. of successful ECVs + vaginal term breech deliveries + CS term breech deliveries)".* The index will capture efficacy of diagnosis in the community, prompt confirmation by scan, provision of advice, uptake rate and success in turning all in one index that is meaningful. A high index indicates a unit with good systems and provision of evidence based care, and a low index can be addressed by attention to the local factors and systems of care. The exclusion criteria given in the NICE standard are not evidence based: There is no contraindication to offering ECV to women with a previous CS; Women with medical conditions (unspecified) are precisely the group in whom an unnecessary caesarean will be more dangerous to the mother; Women in early labour with undiagnosed breech and intact membranes can be offered tocolysis and an ECV attempt. This standard looks as though it has been written by non-enthusiasts for ECV. | Thank you for your comment. The topic expert group have reviewed the measures and outcomes and have updated them to include the outcome:<br>'rates of vaginal birth and emergency caesarean section following diagnosis of breech presentation in labour'.<br><br>The topic expert group identified the development sources they felt were most relevant to developing the standard, within the framework of the quality standards development process. The quality standards are based on evidence-based recommendations from national accredited guidance, i.e. the NICE clinical guideline 62. The quality standards do not seek to reassess or redefine the evidence base. Please refer to the full clinical guideline for detailed summary of the underpinning evidence base for the clinical recommendations on which the quality standard is based. |
| 032 | Royal College of | 13 | | We can see the advantages for ECV, but do not | Thank you for this comment. This heading was reviewed |

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| | Paediatrics and Child Health (RCPCH) | | | think it impacts directly on fetal wellbeing during pregnancy. | by the topic expert group. The group consider this heading to be appropriate because a breech pregnancy is more likely to result in an instrumental vaginal delivery or caesarean section, therefore impacting on fetal wellbeing. |
| 0014 | Department of Health (Children Family and Maternity branch) | 13 | Data Sources | The maternity dataset will give presentation (breech or cephalic) at the onset of labour and undiagnosed breech in labour as a maternal critical incident. | Thank you for your comment, the maternity dataset has been referenced in the final quality standard. |
| 0014 | Department of Health (Children Family and Maternity branch) | 13 | Measure | A clinical quality outcome would be undiagnosed breech presentation at onset of labour (so that woman had therefore not been offered ECV) Quality measure should also include how many suitable women accept ECV and the proportion where it was successful. | Thank you for your comment. The topic expert group have reviewed the outcome measures and updated the outcomes to include mode of delivery. |
| 0025 | electivecesarean.com | 13 | Measure | Suggest adding text to “Structure, b)”: “are offered external cephalic version and elective caesarean (at 39+ weeks)”. Concern is that it may otherwise be insufficiently clear that ECV is not the *only* option that should be offered to women. | Thank you for your comments. The scope of the antenatal care quality standard does not include the additional care required for women with antenatal complications or intrapartum care. There is a separate NICE quality standard on Caesarean section which is in development. This has now been referenced within the antenatal care quality standard as a related NICE quality standard. Please refer to the NICE quality standard full topic library for further details of all related topics for maternity. NICE would welcome feedback from electivecesarean.com during the consultation for the NICE quality standard for caesarean section. |
| 007 | Royal College of Obstetricians and Gynaecologists | 13 | Page 36 | Please cite the relevant RCOG GTG (20a) in the section source clinical guideline references. Also note earlier comments re gestational ages at which ECV is recommended. Also, exclusion | Thank you for your comment. The quality standard is based on evidence-based recommendations from national accredited guidance. This statement is underpinned by NICE clinical guideline 62 recommendations 1.10.5 and |

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| | | | | criterion is women with some medical conditions (many medical conditions are not CI to ECV). | 1.11.2.1 and reflects the content of this guidance. |
| 0013 | CSections.org | 14 | | It should be made clear as part of this quality statement that a planned caesarean is a viable alternative to a vaginal birth attempt with the benefits/risks of both modes presented in a balanced, research based manner. *NICE, Guideline for Caesarean Section, (National Institute for Clinical Excellence, 2004)* As part of this it should also be made clear that induction after a previous caesarean is associated with higher rupture rates. *NICE, Guideline for Caesarean Section, (National Institute for Clinical Excellence, 2004)* | Thank you for your comments.<br><br>The scope of the antenatal care quality standard does not cover the additional care required for women requiring a caesarean section. There is a separate NICE quality standard on caesarean section which is in development. This has been referenced within the antenatal care quality standard as a related NICE quality standard.<br><br>NICE would welcome feedback from CSections.org during the consultation for the NICE quality standard for caesarean section. |
| 0029 | National Childbirth Trust | 14 | | We agree with the statement that "Nulliparous pregnant women are offered a vaginal examination for membrane sweeping at their 40- and 41-week antenatal appointments, and parous pregnant women are offered this at their 41-week appointment". | Thank you for your comment. |
| 007 | Royal College of Obstetricians and Gynaecologists | 14 | | Seems irrational. Why differentiate between Nullips and parous women at all? If you do, why not the other way round. Stretch and sweep is so often not possible in nullips at 40 weeks, but is likely to be possible in parous women. Don't NICE currently advise an offer of IOL anyway in the 41st week (although I realise many people read this as the end of the 42nd week!)? Stretch & sweep reduces the number of women undelivered and therefore still requiring IOL 96 hours later. Aren't they therefore offering the intervention too late to benefit? | Thank you for your comment. The quality standard is based on evidence-based recommendations from national accredited guidance. The specific timings referred to in this statement are underpinned by NICE clinical guideline 70, recommendations 1.3.1.2 and 1.3.1.3. |

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| 0014 | Department of Health (Children Family and Maternity branch) | 14 | Data Sources | The maternity dataset will include information on induction and outcome that could be linked. | Thank you, this has been reviewed and updated. |
| 0014 | Department of Health (Children Family and Maternity branch) | 14 | Measure | **Outcome** - the outcome measure should include not only rates of induction for prolonged pregnancy but modes of delivery.<br>Is it enough to ask how many women are offered sweeps of should it include numbers of those who accepted and then link it to mode of delivery? | Thank you for your comment. An outcome on mode of delivery has now been included. |
| 007 | Royal College of Obstetricians and Gynaecologists | 14 | Page 37 | Middle section, the outcome is rates of induction of labour for prolonged pregnancy. Would proportion of women presenting in spontaneous labour after membrane sweeping not be more relevant? | Thank you for your comment. The outcomes have been reviewed and updated by the topic expert group. |