NICE National Institute for Health and Care Excellence

NICE quality standard

Intrapartum care: existing medical conditions and obstetric complications

Quality standard

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This standard is based on NG121 and NG51.

This standard should be read in conjunction with QS135, QS129, QS115, QS109, QS105, QS75, QS60, QS46, QS37, QS35 and QS32.

Quality statements

Statement 1 Pregnant women with existing medical conditions or obstetric complications are involved in developing and reviewing their individualised intrapartum care plan.

Statement 2 Pregnant women with existing medical conditions are cared for by a multidisciplinary team that can access expertise in managing the medical conditions in pregnancy and is led by a named healthcare professional.

Statement 3 Pregnant women with heart disease have their cardiovascular risk regularly assessed during pregnancy and the intrapartum period.

Statement 4 Pregnant women in labour with suspected sepsis have an immediate assessment by a senior clinical decision maker and antibiotics given within 1 hour if indicated.

Statement 5 Pregnant women who present in labour with no antenatal care have an obstetric assessment and medical examination, and assessment of their medical, psychological, and social history.

Quality statement 1: Involving women in care planning

Quality statement

Pregnant women with existing medical conditions or obstetric complications are involved in developing and reviewing their individualised intrapartum care plan.

Rationale

Involving a woman in developing and reviewing her intrapartum care plan enables her to discuss and make choices about her care. It allows her to be given information and opportunities for discussion to support shared decision making. Involvement of the woman allows the care plan to be tailored to her conditions or obstetric complications, her experience of these, and her preferences for labour and birth. The woman should be involved in updating the plan during pregnancy and on admission for birth to reflect changes in her conditions or obstetric complications.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence of local processes to provide opportunities for pregnant women with existing medical conditions or obstetric complications to discuss and make decisions on the intrapartum management of their medical conditions or obstetric complications.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from documented procedures, service specifications and staff training on communication skills.

b) Evidence of local processes to ensure that pregnant women with existing medical conditions or obstetric complications are supported to develop an intrapartum care plan.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from service protocols and records for training in communication skills, multidisciplinary working and shared decision making.

c) Evidence of local arrangements to ensure that pregnant women with existing medical conditions or obstetric complications are supported to review their intrapartum care plan throughout pregnancy, including when their conditions change, and on admission for birth.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from service protocols and records for training in communication skills and shared decision making.

Process

a) Proportion of pregnant women with existing medical conditions or obstetric complications with an individualised intrapartum care plan who reported that they were involved as much as they wanted to be in discussing and making decisions about their care when developing the plan.

Numerator – the number in the denominator who reported that they were involved as much as they wanted to be in discussing and making decisions about their care when developing the plan.

Denominator – the number of pregnant women with existing medical conditions or obstetric complications with an individualised intrapartum care plan.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient surveys.

b) Proportion of pregnant women with existing medical conditions or obstetric complications with an individualised intrapartum care plan, who reported that they were involved as much as they wanted to be in discussing and making decisions about their care when reviewing the plan on admission for birth.

Numerator – the number in the denominator who reported that they were involved as

much as they wanted to be in discussing and making decisions about their care when reviewing the plan on admission for birth.

Denominator – the number of pregnant women with existing medical conditions or obstetric complications with an individualised intrapartum care plan.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient surveys.

c) Proportion of pregnant women with existing medical conditions or obstetric complications with an individualised intrapartum care plan, who reported that they were involved as much as they wanted to be in discussing and making decisions about their care when updating the plan when their medical condition changed.

Numerator – the number in the denominator who reported that they were involved as much as they wanted to be in discussing and making decisions about their care when updating the plan when their medical condition changed.

Denominator – the number of pregnant women with existing medical conditions or obstetric complications with an individualised intrapartum care plan.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient surveys.

Outcome

Proportion of pregnant women with existing medical conditions or obstetric complications who felt that they were involved in preparing and reviewing their intrapartum care plan.

Numerator – the number in the denominator who were satisfied with their involvement in preparing and reviewing their intrapartum care plan.

Denominator – the number of pregnant women with existing medical conditions or obstetric complications and an intrapartum care plan.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from a patient (maternity) experience survey.

What the quality statement means for different audiences

Service providers (NHS hospital trusts) ensure that systems are in place for pregnant women with existing medical conditions or obstetric complications to take part in shared decision making and be involved in developing and reviewing individualised plans for their intrapartum care. They also ensure that staff are trained in how to involve pregnant women in developing the plan and shared decision making.

Healthcare professionals (such as obstetric physicians, clinicians with expertise in managing medical conditions during pregnancy and midwives) ensure that during pregnancy women with existing medical conditions or obstetric complications are involved in developing and reviewing their intrapartum care plan. To help support involvement, healthcare professionals should provide the woman with information about, and opportunities to discuss, her medical conditions or obstetric complications, and discuss how they might affect intrapartum care for her and her baby.

Commissioners ensure they commission services that involve pregnant women with existing medical conditions or obstetric complications in developing and reviewing their intrapartum care plan during pregnancy. Women should be provided with opportunities for discussion to support their involvement.

Pregnant women with medical conditions or complications during pregnancy or birth are cared for by staff who give them opportunities to discuss how their medical conditions or complications may affect their care and the care of their baby. Women can make choices about their care.

Source guidance

Intrapartum care for women with existing medical conditions or obstetric complications and their babies. NICE guideline NG121 (2019), recommendations 1.2.1 and 1.10.6

Definitions of terms used in this quality statement

Involved in developing and reviewing the individualised intrapartum care plan

This can include:

- providing tailored information in a way that can be understood
- discussion of different care options, including risks and benefits
- providing opportunities to ask questions
- discussing preferences and expectations for labour and birth
- discussing the woman's experience and knowledge of her existing condition
- taking into account previous discussions, planning, decisions and choices
- making decisions together about the woman's care.

[Adapted from NICE's guideline on intrapartum care for women with existing medical conditions or obstetric complications and their babies, recommendation 1.1.2, evidence reviews A and B, and NICE's information on shared decision making]

Existing medical conditions

Medical conditions within the scope of this quality standard include:

- heart disease
- asthma (dependent on severity)
- bleeding disorders
- neurological conditions
- obesity (BMI [kg/m^2] 30 or over)
- acute kidney injury or chronic kidney disease.

[NICE's guideline on intrapartum care for women with existing medical conditions or

obstetric complications and their babies, evidence review B and expert opinion]

Obstetric complications

A complication arising during pregnancy, including complications relating to a previous pregnancy. Obstetric complications within the scope of this quality standard include:

- pyrexia (high temperature or fever)
- sepsis
- intrapartum haemorrhage
- breech presentation
- suspected small-for-gestational-age baby
- suspected large-for-gestational-age baby
- previous caesarean section
- labour after 42 weeks of pregnancy.

[NICE's guideline on intrapartum care for women with existing medical conditions or obstetric complications and their babies, recommendation 1.11.1]

Equality and diversity considerations

Pregnant women with existing medical conditions or obstetric complications should be provided with information to support intrapartum care planning that they can easily read and understand themselves, or with support, so they can communicate effectively with healthcare professionals. The information should be accessible to women who do not speak or read English and it should be culturally appropriate. Women should have access to an interpreter, link worker or advocate if needed. The interpreter, link worker or advocate should not be a member of the woman's family, her legal guardian or her partner, and they should communicate with the woman in her preferred language.

For women with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard.

Quality statement 2: Composition of the multidisciplinary team

Quality statement

Pregnant women with existing medical conditions are cared for by a multidisciplinary team that can access expertise in managing the medical conditions in pregnancy and is led by a named healthcare professional.

Rationale

Specialist advice is important to ensure the best intrapartum care for a pregnant woman with existing medical conditions. Having a multidisciplinary team that can access expertise in managing the medical conditions during pregnancy means this advice is readily available when needed. More than 1 expert may be involved if a woman has more than 1 medical condition. Designating a named healthcare professional to lead the team supports coordination of expertise and continuity of care. This promotes planning of personalised, holistic care during labour and birth to help reduce the risk of adverse outcomes for the woman and her baby.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence that multidisciplinary teams caring for pregnant women with existing medical conditions can access expertise in managing the medical conditions in pregnancy.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from service protocols and local network agreements.

b) Evidence that a named healthcare professional is available to lead the multidisciplinary team caring for pregnant women with existing medical conditions.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from service protocols, local network agreements, maternity records and staff rotas.

Process

a) Proportion of pregnant women with existing medical conditions cared for by a multidisciplinary team that can access expertise in managing the medical conditions in pregnancy.

Numerator – the number in the denominator with a multidisciplinary team that can access expertise in managing the medical conditions in pregnancy.

Denominator – the number of pregnant women with existing medical conditions.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from an audit of maternity records.

b) Proportion of pregnant women with existing medical conditions who were cared for by a multidisciplinary team that was led by a named healthcare professional.

Numerator – the number in the denominator who had a multidisciplinary team that was led by a named healthcare professional.

Denominator – the number of pregnant women with existing medical conditions who were cared for by a multidisciplinary team.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from an audit of maternity records.

Outcome

a) Incidence of maternal morbidity associated with an existing medical condition.

Data source: Data can be collected from information recorded locally by healthcare

professionals and provider organisations, for example from an audit of maternity records. The MBRRACE-UK Confidential Enquiries into Maternal Deaths and Morbidity and the National Maternity and Perinatal Audit (NMPA) report on maternal morbidity. Indicators from MBRRACE-UK and the NMPA are available via the Maternity Services Dashboard.

b) Incidence of maternal mortality associated with an existing medical condition.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from an audit of maternity records. The MBRRACE-UK Confidential Enquiries into Maternal Deaths and Morbidity reports on maternal mortality. NHS England's Maternity Services Data Set includes data on maternal mortality and the Maternity Services Dashboard can be used to monitor performance and compare services.

c) Incidence of neonatal mortality in babies of women with existing medical conditions.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from an audit of maternity records. The MBRRACE-UK National Perinatal Mortality Review Tool presents data on perinatal deaths of babies. NHS Digital's Maternity Services Data Set includes data on neonatal mortality and the Maternity Services Dashboard can be used to monitor performance and compare services.

What the quality statement means for different audiences

Service providers (NHS hospital trusts) ensure that protocols are in place for pregnant women with existing medical conditions to be cared for by a multidisciplinary team that can access expertise in managing the medical conditions in pregnancy. They ensure that there are rotas and systems in place for the staff with expertise to be available to give advice when needed, and for a named healthcare professional to be available to lead the team.

Healthcare professionals (such as midwives, obstetricians and obstetric anaesthetists) take part in multidisciplinary meetings to plan intrapartum care for pregnant women with existing medical conditions. They ask for input from an obstetric physician or clinician with expertise in caring for pregnant women with the medical condition by phone or email if

expertise is needed. A named healthcare professional takes responsibility for leading the multidisciplinary team.

Commissioners ensure that services have protocols in place for multidisciplinary teams planning intrapartum care for pregnant women with existing medical conditions to access input from obstetric physicians or clinicians with expertise in managing the medical conditions during pregnancy. They also ensure that services have arrangements so that the staff with expertise are available to give advice when needed, and for a named healthcare professional to lead the multidisciplinary team.

Pregnant women with medical conditions are cared for by a team that can get advice from healthcare professionals who are experts in the medical conditions during pregnancy. The team is led by a named healthcare professional.

Source guidance

Intrapartum care for women with existing medical conditions or obstetric complications and their babies. NICE guideline NG121 (2019), recommendations 1.2.1 and 1.2.2

Definitions of terms used in this quality statement

Existing medical conditions

Medical conditions within the scope of this quality standard include:

- heart disease
- asthma (dependent on severity)
- bleeding disorders
- neurological conditions
- obesity (BMI [kg/m^2] 30 or over)
- acute kidney injury or chronic kidney disease.

[NICE's guideline on intrapartum care for women with existing medical conditions or obstetric complications and their babies, evidence review B and expert opinion]

Multidisciplinary team

For pregnant women with existing medical conditions, the multidisciplinary team may include, as appropriate:

- a midwife
- an obstetrician
- an obstetric anaesthetist
- an obstetric physician or clinician with expertise in caring for pregnant women with the medical condition
- a clinician with expertise in the medical condition
- a specialty surgeon
- a neonatologist
- a critical care specialist
- the woman's GP
- allied health professionals.

The team is led by a named healthcare professional who is responsible for facilitating communication and coordinating care.

[Adapted from NICE's guideline on intrapartum care for women with existing medical conditions or obstetric complications and their babies, recommendations 1.2.1 and 1.2.2, evidence reviews A and B]

Equality and diversity considerations

Pregnant women with existing medical conditions should be provided with information to support intrapartum care planning that they can easily read and understand themselves, or with support, so they can communicate effectively with the multidisciplinary team. The information should be accessible to women who do not speak or read English and it should be culturally appropriate. Women should have access to an interpreter, link worker or advocate if needed. The interpreter, link worker or advocate should not be a member of

the woman's family, her legal guardian or her partner, and they should communicate with the woman in her preferred language.

For women with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard.

Quality statement 3: Heart disease – risk assessment

Quality statement

Pregnant women with heart disease have their cardiovascular risk regularly assessed during pregnancy and the intrapartum period.

Rationale

Changes to the heart and circulation occur during pregnancy. Regular risk assessment allows planning for any additional management needed for women with heart disease who are at risk of adverse cardiovascular outcomes during labour and birth. Cardiovascular risk assessment is based on a combination of clinical, diagnostic and functional assessment. It is carried out by a multidisciplinary team that includes a cardiologist with expertise in managing the condition in pregnancy. The content and timing of risk assessment are tailored to the severity of the condition and the findings of previous assessment.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence of local arrangements for pregnant women with heart disease to have their cardiovascular risk regularly assessed during pregnancy and the intrapartum period by a multidisciplinary team that includes a cardiologist with expertise in managing heart disease in pregnant women.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from service protocols, local network agreements for referral and core multidisciplinary team membership records.

b) Evidence of local arrangements for pregnant women with heart disease to have their cardiovascular risk regularly assessed during pregnancy and the intrapartum period.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from service protocols and local network agreements for referral.

Process

Proportion of pregnant women with heart disease who have their cardiovascular risk regularly assessed during pregnancy and the intrapartum period.

Numerator – the number in the denominator who have their cardiovascular risk regularly assessed during pregnancy and the intrapartum period.

Denominator – the number of pregnant women with heart disease.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from an audit of maternity records. NHS England's maternity services dataset includes the number of women with cardiac disease.

Outcomes

Rates of mortality during labour, birth and the early postnatal period for women with heart disease.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from an audit of maternity records. The MBRRACE-UK Confidential Enquiries into Maternal Deaths and Morbidity reports on the number of maternal deaths attributed to heart disease.

What the quality statement means for different audiences

Service providers (NHS hospital trusts) ensure that local protocols and referral pathways are in place so that pregnant women with heart disease have their cardiovascular risk

regularly assessed during pregnancy and the intrapartum period by a multidisciplinary team that includes a cardiologist with expertise in managing heart disease in pregnancy. They ensure that staff have capacity to perform the assessments regularly and that there are rotas and systems in place for a cardiologist to be available to take part in team discussions.

Healthcare professionals (such as midwives, obstetricians, obstetric anaesthetists and cardiologists with experience of managing heart disease in pregnancy) regularly assess cardiovascular risk for pregnant women with heart disease during pregnancy and the intrapartum period through clinical, diagnostic and functional assessment. Cardiologists use their knowledge and experience to advise the multidisciplinary team on specialist aspects of intrapartum care for pregnant women with heart disease that is tailored to the woman's individual level of risk.

Commissioners ensure that they commission services that have local protocols and referral pathways in place, and the capacity for pregnant women with heart disease to have their cardiovascular risk regularly assessed during pregnancy and the intrapartum period by a multidisciplinary team that includes a cardiologist with expertise in managing heart disease in pregnancy. They ensure that services have rotas and systems in place for the cardiologist to be involved in team discussions.

Pregnant women with heart disease have regular tests to check their heart condition during pregnancy and up to 24 hours after birth by a team that includes a specialist in managing heart disease in pregnancy. This will help them and the team to plan the care needed during labour and birth.

Source guidance

Intrapartum care for women with existing medical conditions or obstetric complications and their babies. NICE guideline NG121 (2019), recommendations 1.3.1, 1.3.3, and 1.3.4

Definitions of terms used in this quality statement

Pregnant women with heart disease

Relevant populations and heart conditions within the scope of this quality standard include:

- women with mechanical heart valves
- disease of the aorta
- pulmonary arterial hypertension
- heart failure
- severe left-sided stenotic lesions (for example, aortic stenosis and mitral stenosis)
- hypertrophic cardiomyopathy
- cardiomyopathy with systolic ventricular dysfunction
- Fontan circulation and other univentricular circulations
- moderately severe and severe cardiovascular disease, as classified by New York Heart Association (NYHA) functional class.

[Adapted from NICE's guideline on intrapartum care for women with existing medical conditions or obstetric complications and their babies, section 1.3 and evidence review C]

Some women with heart disease are at low riskof complications and their care should be in line with NICE's guideline on intrapartum care, whereas others need individualised specialist care.

Cardiovascular risk regularly assessed

The timing of risk assessment is tailored to the severity of the condition and the findings of previous assessment. The following should be used for the initial and ongoing assessments:

- comprehensive clinical assessment, including history and physical examination
- the modified World Health Organization (WHO) classification of risk – defined according to the modified WHO classification of maternal cardiovascular risk (see European Society of Cardiology guidelines on managing cardiovascular diseases during pregnancy)
- NYHA functional class – see American Heart Association's information about classes of heart failure.

[Adapted from NICE's guideline on intrapartum care for women with existing medical conditions or obstetric complications and their babies, recommendation 1.3.4 and evidence review C]

Equality and diversity considerations

Pregnant women with heart disease should be able to communicate effectively with the multidisciplinary team as part of their risk assessments. Women should have access to an interpreter, link worker or advocate if needed. The interpreter, link worker or advocate should not be a member of the woman's family, her legal guardian or her partner, and they should communicate with the woman in her preferred language.

Quality statement 4: Assessment and antibiotic treatment for suspected sepsis

Quality statement

Pregnant women in labour with suspected sepsis have an immediate assessment by a senior clinical decision maker and antibiotics given within 1 hour if indicated.

Rationale

Physiological changes during labour may mask the early signs of sepsis. Sepsis is a medical emergency and needs immediate assessment from a senior clinical decision maker. The team determines whether antibiotics are needed as part of initial management, and they should be given within 1 hour of sepsis being suspected, if needed. Sepsis is associated with maternal and neonatal mortality. Unwarranted antibiotic treatment may, however, pose an unnecessary risk to the unborn baby, so senior assessment before prescribing is important.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence of local arrangements to support escalation protocols to ensure that pregnant women in labour with suspected sepsis are transferred from home birth and midwifery-led units to an acute setting for assessment and to start antibiotic treatment (if indicated) within 1 hour.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from local network agreements and transfer protocols.

b) Evidence of local arrangements to ensure availability of, or access to, a senior clinical decision maker for pregnant women in labour with suspected sepsis to have an immediate assessment.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from local network agreements, transfer protocols and staff rotas.

c) Evidence of local arrangements to start antibiotic treatment, if indicated, for pregnant women in labour with suspected sepsis within 1 hour.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from maternity records.

d) Evidence of local arrangements to document the decision to start antibiotic treatment for pregnant women in labour with suspected sepsis.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from maternity records.

Process

a) Proportion of pregnant women in labour with suspected sepsis who have an immediate assessment by a senior clinical decision maker.

Numerator – the number in the denominator who have an immediate assessment by a senior clinical decision maker.

Denominator – the number of pregnant women in labour with suspected sepsis.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from an audit of maternity records.

b) Proportion of pregnant women in labour with suspected sepsis who started antibiotics within 1 hour.

Numerator – the number in the denominator who started antibiotics within 1 hour.

Denominator – the number of pregnant women in labour with suspected sepsis who needed antibiotics.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from an audit of maternity records.

c) Proportion of pregnant women in labour with suspected sepsis who had the rationale for the decision to start antibiotics documented.

Numerator – the number in the denominator who had the rationale for the decision to start antibiotics documented.

Denominator – the number of pregnant women in labour with suspected sepsis who had antibiotics.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from an audit of maternity records.

What the quality statement means for different audiences

Service providers (NHS hospital trusts) ensure that protocols, systems and pathways are in place for pregnant women in labour with suspected sepsis to have an immediate assessment by a senior clinical decision maker and receive the first dose of antibiotics, if indicated, within a 1-hour timeframe. They also ensure that protocols are in place to document the rationale for the decision to start antibiotics.

Healthcare professionals (clinicians grade ST3 or above or equivalent) assess pregnant women in labour with suspected sepsis immediately. They decide whether to give antibiotics based on this assessment, and administer the first dose of antibiotics, if indicated, within the 1-hour timeframe. They also document the rationale for the decision to start antibiotics.

Commissioners ensure that they commission services that have protocols, systems and pathways for pregnant women in labour with suspected sepsis to have an immediate assessment by a senior clinical decision maker and antibiotics given within 1 hour, if indicated. They also ensure that services have capacity to perform the assessment and

have protocols in place to document the rationale for the decision to start antibiotics.

Pregnant women with suspected sepsis are assessed by a senior healthcare professional as soon as sepsis is suspected. As part of this assessment, a decision is made about whether antibiotics are needed, and if they are, they are started within an hour.

Source guidance

- Intrapartum care for women with existing medical conditions or obstetric complications and their babies. NICE guideline NG121 (2019), recommendations 1.13.1, 1.13.3 and 1.13.22
- Suspected sepsis: recognition, diagnosis and early management. NICE guideline NG51 (2016, updated 2024), recommendation 1.10.2

Definitions of terms used in this quality statement

Senior clinical decision maker

A 'senior clinical decision maker' for people aged 18 years or over is a clinician of grade ST3 or above or equivalent. The senior decision-maker for people under 18 is a clinician of grade ST4 or above or equivalent. [Adapted from NICE's guideline on suspected sepsis, terms used in this guideline]

Quality statement 5: Women with no antenatal care

Quality statement

Pregnant women who present in labour with no antenatal care have an obstetric assessment and medical examination, and assessment of their medical, psychological, and social history.

Rationale

Women in labour with no antenatal care are at increased risk of serious obstetric and medical complications for themselves and their babies because there is no baseline information and no birth plan. Assessment of the woman's medical, psychological and social history, as far as possible, as well obstetric assessment and medical examination, is likely to establish the reason she has not accessed antenatal care. It also indicates the likelihood of complications during labour and birth and identifies the woman's preferences and needs. A complete assessment helps reduce the risk of adverse outcomes during labour and birth, recognise potential vulnerability and safeguarding concerns, and allows planning of further support, such as postnatal care and continuity of midwifery care.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence of local processes to ensure that pregnant women who present in labour with no antenatal care have an obstetric assessment and medical examination by an obstetrician.

Data source: Data can be collected from information recorded locally by healthcare

professionals and provider organisations, for example from written protocols, service specifications, and staff rotas.

b) Evidence of local processes to ensure that pregnant women who present in labour with no antenatal care have an assessment of their medical, psychological and social history.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from written protocols, service specifications, staff training records.

c) Evidence of training for healthcare professionals on understanding multiple disadvantage, supporting women with complex social factors and trauma-informed care.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from staff training records.

Process

a) Proportion of pregnant women who present in labour with no antenatal care who have an obstetric assessment and medical examination.

Numerator – the number in the denominator who had an obstetric assessment and medical examination.

Denominator – the number of pregnant women who present in labour with no antenatal care.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from an audit of maternity records.

b) Proportion of pregnant women who present in labour with no antenatal care who have an assessment of their medical, psychological and social history.

Numerator – the number in the denominator who have an assessment of their medical, psychological and social history.

Denominator – the number of pregnant women who present in labour with no antenatal care.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from an audit of maternity records.

Outcomes

a) Incidence of maternal mortality associated with no antenatal care on presentation in labour.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from an audit of maternity records. The MBRRACE-UK Confidential Enquiries into Maternal Deaths and Morbidity reports on the number of women who died and had received no antenatal care.

b) Incidence of neonatal mortality associated with no antenatal care for the mother on presentation in labour.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from an audit of maternity records. The MBRRACE-UK Confidential Enquiries into Maternal Deaths and Morbidity reports on the number of neonatal deaths for women who received no antenatal care.

What the quality statement means for different audiences

Service providers (NHS hospital trusts) ensure that they have written protocols and service specifications in place so that pregnant women presenting in labour with no antenatal care have an obstetric assessment and medical examination by an obstetrician. They also ensure that staff are trained in understanding multiple disadvantage, supporting women with complex social factors and trauma-informed care.

Obstetricians lead an obstetric assessment and medical examination of pregnant women who present in labour with no antenatal care so that they can plan further testing and management. **Midwives or obstetricians** sensitively and respectfully assess the woman's medical, psychological and social history. This enables care for labour and birth to be planned, in line with the risk of adverse outcomes and the woman's preferences. **Midwives and obstetricians** also look for signs of potential vulnerability and safeguarding concerns, identify the need for further support, such as postnatal care, and offer referral to other

services as needed.

Commissioners ensure that they commission services that provide an obstetric assessment and medical examination by an obstetrician for pregnant women who present in labour with no antenatal care. They also ensure that services train staff in understanding multiple disadvantage, supporting women with complex social factors and trauma-informed care.

Pregnant women in labour who have not had care during pregnancy have a range of assessments, led by healthcare professionals specialising in childbirth, so that they can discuss their preferences and be supported to plan their care during labour and birth. Any potential concerns about the woman's welfare and her baby's can be identified and further support after birth planned.

Source guidance

Intrapartum care for women with existing medical conditions or obstetric complications and their babies. NICE guideline NG121 (2019), recommendations 1.18.4 and 1.18.5

Definitions of terms used in this quality statement

Obstetric assessment and medical examination

Assessments in line with those described in NICE's guideline on intrapartum care, section 1.8, and assessment of the unborn baby as described in NICE's guideline on intrapartum care for women with existing medical conditions and obstetric complications and their babies, recommendation 1.18.6. This includes listening to the woman's story and supporting her preferences and emotional and psychological needs when performing an initial assessment. [NICE's guideline on intrapartum care, recommendation 1.8.7]

Assessment of medical, psychological and social history

This should be undertaken as fully as possible to establish the woman's life situation and, if possible, to find out why she has not accessed antenatal care. This, in combination with medical and obstetric assessments, indicates her risk of complications during labour and birth. She should also be asked who (if anyone) she would like to support her as her birth companion(s) during labour.

Potential vulnerability and safeguarding concerns should be sensitively explored. [Adapted from NICE's guideline on intrapartum care for women with existing medical conditions or obstetric complications and their babies, recommendation 1.18.4 and evidence review R, and NICE's guideline on pregnancy and complex social factors]

Equality and diversity considerations

A woman's language needs should be established and women with difficulty understanding, speaking and reading English should have access to an interpreter, link worker or advocate. The interpreter, link worker or advocate should not be a member of the woman's family, her legal guardian or her partner, and they should communicate with the woman in her preferred language. This enables women who have difficulty speaking and reading English to give their own account of their situation.

Women with no antenatal care should also be provided with information that they can easily read and understand themselves, or with support, so they can communicate effectively with healthcare professionals during assessments. Information should be accessible to women who do not speak or read English and it should be culturally appropriate.

For women with no antenatal care who have additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard.

Update information

Minor changes since publication

February 2024: Changes have been made to align this quality standard with the updated NICE guideline on suspected sepsis. Statement 4 has been updated to reflect changes to related guideline recommendations. Links, definitions and source guidance sections have also been updated throughout.

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See our webpage on quality standard advisory committees for details of standing committee 3 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available on the webpage for the quality standard.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Resource impact

NICE quality standards should be achievable by local services. The potential resource

impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the resource impact statement and baseline assessment tool for the NICE guideline on intrapartum care for women with existing medical conditions or obstetric complications and their babies to help estimate local costs.

Diversity, equality and language

Equality issues were considered during development and equality assessments for this quality standard are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- Resuscitation Council (UK)
- Royal College of Paediatrics and Child Health
- Royal College of Nursing (RCN)