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Quality standards

Consultation summary report: antenatal care

Quality Standards Advisory Committee post-consultation meeting: 19 October 2022

1. Introduction

The draft quality standard for antenatal care was made available on the NICE website for a 4-week public consultation period between 11 August and 15 September 2022. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 21 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the quality standards advisory committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards, editorial changes and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in appendix 1.

1. Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

3. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

Stakeholders were also invited to respond to the following statement-specific questions:

4. For statement 3. In light of the findings of the [Ockenden review (final report published March 2022)](https://www.gov.uk/government/publications/final-report-of-the-ockenden-review/ockenden-review-summary-of-findings-conclusions-and-essential-actions) do you have any additional comments on this statement?

5. Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please provide details.

1. General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

* Support for the quality standard from stakeholders.
* Some stakeholders queried whether there was evidence that the quality statements needed to be updated.
* The quality standard reflects current service provision in general practice and there is adequate signposting to services.
* Statements and supporting information should include fathers or partners in order to benefit maternal health and wellbeing and reflect family life. The definition of ‘partner’, ‘supporter’ and ‘parents’ should be amended to distinguish between the role and contribution of father, partner and supporter which sometimes overlap but are often distinct.
* Statements and supporting information should include risks associated with alcohol use in pregnancy and should align with the NICE quality standard in fetal alcohol spectrum disorder.

### Consultation comments on data collection

* Local systems and structures are in place to collect data for the proposed quality measures.
* Stakeholders highlighted lack of record keeping in relation to social factors and domestic abuse. They noted that information may not be easily extracted from data systems and may not be updated over time.

### Consultation comments on resource impact

* It is important to focus on appropriate resourcing and staffing needs. Stakeholders noted existing midwife shortages having a significant impact on workload and pressures.
* Stakeholders commented on the need for midwives with specialist knowledge and skills to successfully implement the quality standard.

### Consultation comments on equality and diversity considerations

* Stakeholders supported the focus on inequalities in outcomes for different groups.
* Stakeholders highlighted that there are persistently poorer maternal and perinatal mortality outcomes and poorer outcomes related to preterm birth relating to ethnicity and deprivation.
* Stakeholders suggested that equality and diversity considerations relating to women known to social services should be included in the quality standard.
* Equality and diversity considerations should include people with fetal alcohol spectrum disorder (FASD) and other neurodevelopmental conditions.
* High-quality interpretation should be provided in the specific context of maternity care. Healthcare professionals should receive training on how to work with interpreters and commissioners should allow services flexibility in number and length of antenatal appointments.
* Healthcare professionals should receive training on how to work with people with different levels of health literacy.
* Stakeholders highlighted NHS charging policies as a key issue in migrant women’s engagement with antenatal care.

1. Summary of consultation feedback by draft statement
   1. Draft statement 1

Pregnant women are supported to access antenatal care by 10 weeks of pregnancy. **[2012, updated 2022]**

### Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

* It should include a sentence about prioritising women who present late for their booking appointment and offering an appointment within 10 days of presenting in pregnancy.

Audience descriptors

* The wording around involvement of a partner should be less cautious as this may discourage some parents from including the other parent. There are benefits from including partners and baby’s fathers in pregnancy.
* Need to recognise that not all women will be accessing maternity care with a partner.

Definitions

* Support to access antenatal care should include languages and interpretative services.

Equality and diversity considerations

* The statement should consider the impact of new means of communication and care delivery on outcomes. For example, telephone and virtual appointments in the context of digital poverty and IT literacy. This could be a barrier for people from socially deprived backgrounds or Black, Asian and minority ethnic communities.
* Services should provide locally based, visible and accessible antenatal care within community settings with access to advocacy and interpretative services at every contact. There should be recognition that interpreted appointments will take longer.

### Issues for consideration

#### For discussion:

* Is it possible to include women who present late in this statement?
* Are amendments needed to the audience descriptors to be more directive about involving the women’s partner or baby’s father? Stakeholder comments also proposed recognition that not all women will want to involve their partner.
* Should the statement include additional equality and diversity considerations relating to advocacy, interpretive services and digital poverty? Are there any other considerations to be added?

#### For decision:

* Should this statement remain in the quality standard?
  1. Draft statement 2

Pregnant women have a risk assessment at routine antenatal appointments. **[2012, updated 2022]**

### Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

* There was support for this statement as early identification and treatment represent some of the key steps to improve outcomes for women with medical complexities. Timely referral is key to improve outcomes for high-risk women and is particularly relevant for Black, Asian and ethnic minority women.
* The pregnant woman’s partner or baby’s father should be present at risk assessments and the statement should include risk assessment for the father or partner.
* The statement and supporting information should include early identification of potential need, for example family history of genetic disorders, and recognition of recommended care pathways for women with a genetic risk.
* Statement should include evidence-based questions about maternal mental health.

Measures

* Risk assessments should be entered onto data systems to capture local, regional and national data showing women’s needs and experiences.
* Data collection is improving with the new version of Maternity Services Data Set (MSDS).
* It is unclear whether the recording of fetal growth restriction relates to previous history or risk factors for growth restriction.

Definitions

* Not all women at 42 weeks will accept induction so should not be excluded.
* The definition of risk assessment should include consanguinity and genetic risk.
* Risk assessments should be carried out in line with principles of trauma-informed care.
* The definition should include proactive enquiry about any previous births or pregnancies to determine presence of post-traumatic stress disorder.

Equality and diversity considerations

* Consideration should include consanguinity language barriers as this is a sensitive subject.
* An example using post-traumatic stress disorder would be welcomed. People may need more time at appointments.

### Issues for consideration

#### For discussion:

* Are there amendments to be made to the definition of a risk assessment, based on stakeholder comments?
* Should the risk assessment be extended to the woman’s partners or baby’s father?
* Are there additional equality and diversity considerations, based on stakeholder comments?

#### For decision:

* Should this statement remain in the quality standard?
  1. Draft statement 3

Pregnant women have access to a named midwife. **[2012, updated 2022]**

### Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

Statement

* Some stakeholders felt that continuity of carer is not feasible.
* The statement is midwife centred. It should focus on women’s ability to access care rather than whether the service knows the history of the woman.
* The rationale should make it clear that this statement will support achievement of the other statements in the quality standard.
* Midwives should have specialist knowledge of relevant health and social factors to ensure support of vulnerable women.

Measures

* The structure measure should say ‘continuity of care’ to align with the rest of the quality statement and to avoid confusion with the Midwifery Continuity of Care model outlined in the NHS Long Term Plan, the national target for which has been removed by NHS England following the publication of the Ockenden report.
* All women are allocated to a community midwife at booking and therefore compliance is likely to be 100%. Would it be possible to record the number of times the woman has contact or seen her named midwife?
* The process measure should include care in a continuity team with an annual case load of 1 to 36.
* The process measure should measure this at 29 weeks gestation.
* The outcome measure does not seem to relate to the quality statement.
* It would be impossible to achieve the outcome measure.
* Add an outcome measure on the proportion of women who reported having the same midwife and team throughout their pregnancy and birth episode.
* Some providers have digital immaturity but there are other means in place to collect the data.
* Services are being supported in roll out of plans to support continuity of care.

Audience descriptors

* The descriptor for providers should ensure that the building blocks have been clearly articulated in a plan to ensure the safe roll out of this model of care.

Equality and diversity considerations

* Consideration may be given to teams of midwives specialising in caring for specific cohorts of women, such as uncomplicated, medically complex, Black, Asian and minority ethnic women. This means care can be tailored to their needs.
* There are a number of interventions to improve equity and equality included in [NHS England’s equity and equality: guidance for local maternity systems](https://www.england.nhs.uk/wp-content/uploads/2021/09/C0734-equity-and-equality-guidance-for-local-maternity-systems.pdf) (2021).

### Consultation question 4

Stakeholders made the following comments in relation to consultation question 4:

In light of the findings of the Ockenden review (final report published March 2022) do you have any additional comments on this statement?

* The findings of the review should affect whether or not a woman has access to a named midwife.
* Does access mean a telephone number or a named contact? The Ockenden review focusses on safety as a priority over continuity of care when staffing levels are suboptimal. Women should access a telephone number that is answered 24 hours but doesn’t need to be a named person.
* Midwives should have specialist knowledge of relevant health and social factors to ensure support of vulnerable women.

### Issues for consideration

#### For discussion:

* Does the Ockenden review impact on this statement?
* Should the statement remain as access to a named midwife, or should it reflect access to a team or access to a midwife 24 hours?
* Are all pregnant women allocated to a community midwife at booking? Should the process measure be amended, based on stakeholder comments about potential for 100% achievement?
* Does the outcome measure reflect the aim of the statement?
* Are there additional equality and diversity considerations, based on stakeholder comments?

#### For decision:

* Should this quality statement remain in the quality standard?
  1. Draft statement 4

Pregnant women are offered vaccinations at routine antenatal appointments. **[new, 2022]**

### Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

Statement

* Need to clarify that not all vaccinations are recommended in pregnancy. Some vaccines are not indicated, and some are contraindicated.
* Maternity services must provide up to date and personalised information related to vaccinations and midwives must be given sufficient time to discuss.

Audience descriptors

* Vaccinations should be administered only by trained staff and align with guidance provided by Royal College of Midwives and Royal College of Obstetricians and Gynaecologists.

### Issues for consideration

#### For discussion:

* Can we improve clarity around vaccinations that are given in pregnancy and those that are contraindicated?
* Should we include training requirements in the audience descriptors?

#### For decision:

* Should this quality statement remain in the quality standard?
  1. Draft statement 5

Pregnant women and partners who smoke are referred for stop-smoking support at routine antenatal appointments. **[2012, updated 2022].**

### Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

* Stakeholders supported the inclusion of the statement as smoking is the main modifiable risk factor of poor pregnancy outcomes and there are significant geographical and demographics differences in prevalence.
* There may be cost savings to local systems by identifying women and partners who smoke and referring them for effective support to stop smoking.
* Stakeholders welcomed inclusion of partners in this statement and suggested that the rationale could be strengthened by referring to the impact of the partner or baby’s father smoking behaviour on the woman’s behaviours in addition to the risk associated with second-hand smoke.
* The statement should reference the opt-out referral in line with NICE recommendations. Other stakeholders felt that the statement should include ‘…offered referral...’ to reflect patient choice.
* The action should take place at all routine antenatal appointments due to reluctance to discuss and relapse rate.
* The statement rationale should refer to carbon monoxide measurement at all routine antenatal appointments, and subsequent referral for those with a reading of 4ppm or above. This should also be reflected in the audience descriptors.
* E-cigarettes have a role to play in helping pregnant women to stop smoking. Could the statement include this?
* The statement should include risk associated with alcohol exposure in pregnancy.

Measures

* Data on smoking at time of delivery is well-established with local systems set up to collect this.
* MSDS enables smoking status and carbon monoxide test results at antenatal appointments to be recorded but does not include whether a referral has been made. Providers should be encouraged to review data regularly to ensure pathways are operating effectively.
* Local systems will have to be set up to record smoking status or referral of partners. Treatment programmes for partners are generally external and may vary by area.

Audience descriptors

* Carbon monoxide testing should be offered at all routine antenatal appointments not just a booking or 36 weeks, in line with NICE recommendations.

Definitions

* Stop smoking support should include all interventions recommended by NICE, rather than ‘…may include…’ as written in the definition. Financial incentives need to be implemented in addition to behavioural support and nicotine replacement therapy.

Equality and diversity considerations

* [NHS England’s equity and equality: guidance for local maternity systems](https://www.england.nhs.uk/wp-content/uploads/2021/09/C0734-equity-and-equality-guidance-for-local-maternity-systems.pdf) (2021) includes interventions to implement a smoke-free pathway for mothers and their partners. Access to smoking cessation services must be available at all times.
* Rates of smoking in pregnancy varies by deprivation, ethnicity, religion, sexual orientation and country of birth.
* Specialist midwives are needed to support women.
* Considerations should be given to using less stigmatising language.

### Issues for consideration

#### For discussion:

* Are amendments needed to the statement wording around referral? Stakeholders suggest both ‘opt-out referral’ and ‘…offer of referral…’
* Are amendments needed to strengthen the rationale, audience descriptors and definitions?
* Is the lack of data collection on partner and carer smoking status a barrier?
* Are there additional equality and diversity considerations, based on stakeholder comments?

#### For decision:

* Should the quality statement remain in the quality standard?

1. Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

* GP notification of pregnancy and request for relevant past medical history.
* Lifestyle interventions such as exercise and diet and the risks around obesity and pregnancy.
* Common complications in pregnancies such as urinary incontinence and managing antenatal pain.
* Screening for pre-eclampsia.
* Risk of alcohol exposure in pregnancy.
* Women at risk of having a child with a genetic disorder should agree a birth plan with her named midwife and antenatal screening midwife, close relative midwife or local genomic service. There were specific comments on Down syndrome including training for screening midwives, longer appointments when Down syndrome is suspected or detected, availability of literature and up to date knowledge and information to be passed to the pregnant women, standardisation of care and awareness of antenatal pathways and guidelines for Down syndrome.
* Response to reduction in fetal movement beyond 24 weeks by all healthcare professionals.

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# Appendix 1: Quality standard consultation comments table – registered stakeholders

| ID | Stakeholder | Section | Comments |
| --- | --- | --- | --- |
| 01 | Birth Companions | General | We would urge the inclusion of clear references to expectations around trauma-informed care provision, in line with the principles developed for NHS maternity services, across all relevant sections of this standard.  We support the focus on the inequalities in outcomes for different groups highlighted by the MBRRACE reports. However, the standard currently focuses only on the ethnicity and deprivation inequalities, and fails to recognise the inequalities flagged by MBRRACE related to women known to social services. This group, which experiences acute and multiple health and social factors, should be specifically referenced in all MBRRACE links in the standard and the equality impact assessment, and included in references to the need for better data collection and record keeping.  The impact of NHS charging policies, including the fear of charging, should be recognised as a key issue in migrant women’s engagement with antenatal care. |
| 02 | Fatherhood Institute | General | We are struck, and disappointed by, the fact that this Quality Standard is FAR less inclusive of fathers/ partners than the Antenatal Guideline itself! This cannot be right. Accordingly, we draw the Committee’s attention below to places where more could be made of father/ partner inclusion in order to benefit maternal health and wellbeing – and to reflect the realities of family life in the UK across the transition to parenthood in 2022. |
| 03 | GPCPC | General | We think a GP should have been recruited as part of the Committee developing these QS |
| 04 | NHS England (Primary Care Team) | General | From a primary care perspective there are no fundamental changes that should impact on primary care as this is predominantly a secondary care/community midwifery update. Where GPs might be subject to a quality standard (referral to smoking cessation, vaccination uptake) this is already part of routine General Practice. There is sufficient sign posting to GP services in the document. |
| 05 | NHS England (Maternity Transformation Team) | General | Unclear why the previous standards have been removed. Is there evidence that quality has been improved in all those areas? |
| 06 | Royal College of Midwives | General | We support the quality standard for antenatal care |
| 07 | Royal College of Paediatrics and Child Health | General | One commenter noted that they are happy with this draft. |
| 08 | Royal College of Paediatrics and Child Health | General | Pages 5, 9, 14, 17, 23 – There are examples of how the statement can be measured, ‘adapted and used flexibly’ rather than ‘and can be adapted and used flexibly’. |
| 09 | Birth Companions | Question 1 | See above. In particular there is a need to include specific reference to care for women known to social services, in line with MBRRACE findings. |
| 10 | Fatherhood Institute | Question 1 | **Does this draft quality standard accurately reflect the key areas for quality improvement?**  (1) **The definition of ‘partner’ in this Quality Standard inherently casts doubt on and minimises the likely presence/ impact of the biological father - as if he is barely likely to be present when, in fact, he is almost certain to be present.** This drafting also confuses and confounds the often very different roles and significance of a biological parent (the father of the child) v. a ‘partner’ or a ‘chosen supporter’.  *The term ‘partner’ refers to the woman’s chosen supporter. This could be the baby’s father, the*  *woman’s partner, a family member or friend, or anyone who they feel supported by or wish to*  *involve.*  A Nuffield Foundation research review ([Burgess & Goldman, 2018](http://www.fatherhoodinstitute.org/wp-content/uploads/2017/12/Whos-the-Bloke-in-the-Room-Full-Report.pdf)) reveals that, currently in the UK, the biological father is almost always present at the time of the birth: 95% of *biological* parents are in a couple relationship at that time (85% cohabiting; a further 10% non-cohabiting; and, among the 5% who are said not to be in a relationship, frequent continuing engagement between father and infant. That the biological father is present in almost all families at this time is confirmed by other findings reported in this research review (and elsewhere): 95% of parents jointly register the baby’s birth; only 1:1000 births is registered to two women (with some of whom the biological father will be co-parenting); and it is now almost unheard-of for a woman to have a male partner at the time of the birth who is not her baby’s biological father.  In light of these indisputable facts, the wording in the Quality Standard should be amended to reflect the likelihood and importance of engagement with the *father,* whether or not he is the pregnant woman’s partner or ‘chosen supporter’ (he mostly is, of course). Confounding the three roles (father, partner, supporter) makes it very difficult for midwives. Some questions they have to ask are only relevant to the biological father (e.g. genetic bequests, family health history, prenatal testing, health conditions); while other questions, such as those relating to health behaviours (including smoking) will be relevant to both ‘fathers’ and ‘partners’ but not usually to ‘chosen supporters’. In some instances, midwives will need to engage with a pregnant woman’s partner or her chosen supporter’ AS WELL AS the biological father.  Neither ‘father’ or ‘partner’ needs defining but ‘supporter’ does. A draft could read:  *‘Supporter’’ refers to the woman’s chosen supporter, where this is not the father of her unborn child or a cohabiting or non-cohabiting partner. A supporter may be a family member or friend, or anyone who the pregnant woman feels supported by or wishes to involve.*  (2) **The definition of ‘parents’ in the Quality Standard also casts doubt on and minimises the likely presence/ impact of the biological father** – as follows:  *The term ‘parents’ refers to those with the main responsibility for the care of a baby. This will often be the mother and the father, but many other family arrangements exist, including single parents.*  The term ‘parents’ needs re-defining to acknowledge the reality of the situation – i.e., that the ‘parents’ will ALMOST ALWAYS be biological father and mother. A re-draft could read:  *The term 'parents' refers to those with the main responsibility for the care of a baby. These will*  *usually be the mother and the father, whether cohabiting or not, but other family arrangements exist,*  *including same-sex couples and mothers who have no co-parent either in their own or in another*  *household.*  **To sum up**  **the roles and contributions of father, partner or chosen supporter sometimes overlap but are often distinct – and this should be made clear in the Quality Standard i**n order for midwives to engage appropriately with the individuals concerned  **the term *father/ partner/ supporter* should be used throughout (instead of simply ‘partner):** neither father nor partner needs defining but ‘supporter’ does. A draft could read:  *‘Supporter’’ refers to the woman’s chosen supporter, where this is not the father of her unborn child or a cohabiting or non-cohabiting partner. A supporter may be a family member or friend, or anyone who the pregnant woman feels supported by or wishes to involve.*  **the term ‘parents’ also needs re-defining to acknowledge the reality of contemporary life** – i.e. that the ‘parents’ during the transition to parenthood will ALMOST ALWAYS be the biological father and mother |
| 11 | Maternal Mental Health Alliance | Question 1 | **Does this draft qual stand accurately reflect the key areas for qual improvement?** Quality Statement 2 (antenatal risk assessment) is not explicit enough regarding the need for healthcare professionals to ask specifically about mental health concerns at every maternity appointment, using evidence-based questions. |
| 12 | NHS England (Maternity Transformation Team) | Question 1 | No, see comment above and suggestions below in statement section. |
| 13 | Royal College of Midwives | Question 1 | Yes, it does.  Yes, the current quality standards reflect the key areas for quality improvement. Continuity of care is a priority and should be included, there is strong evidence to support midwifery continuity of care such models include continuity of care throughout pregnancy and postnatally.  RCM (2019) Midwifery Continuity of Carer (MCOC) Position Statement.    We recommend encouraging maternity systems to implement and support midwifery continuity of carer, given its well-known positive effect on breastfeeding initiation and continuation as well as on physical and mental wellbeing and pregnancy/post-partum outcomes |
| 14 | Birth Companions | Question 2 | The lack of record keeping relating to social factors and domestic abuse has been highlighted as an issue, and will need significant work if we are to be able to monitor need and assess improvement. There are many challenges relating to this – our recent work with one Local Maternity and Neonatal System found that referrals for other health and social factors are predominantly done on paper or in separate emails, with no easily extracted record of these on the central maternity data system, and little detailed record keeping on social factors beyond the initial assessments at booking. This means that where women’s needs develop and change over time, or are disclosed as trust builds during a woman’s antenatal care, these are not being captured in data sets. |
| 15 | Royal College of Midwives | Question 2 | Yes. |
| 16 | Birth Companions | Question 3 | There is a real lack of specialist midwifery roles available to support all the women who would benefit from more experienced and focused care based on specific needs, e.g. substance misuse, past removal of a child/ potential separation by social services at birth, contact with the criminal justice system, and insecure immigration status. Investment in these roles, along with the development of specialised pathways of care based on complex needs, would reduce trauma, improve engagement, and narrow healthcare inequalities. |
| 17 | GPCPC | Question 3 | Our answer to question 2 is relevant to this answer as well |
| 18 | Royal College of Midwives | Question 3 | Women and families are consistently less satisfied with postnatal care when compared with antenatal and intra-partum care. The same level of support available in pregnancy should be offered in the postnatal period, including personalised care provision centred on the needs of the woman, her baby and family. The current duration of antenatal appointments is not meeting basic women’s needs and not appropriate for the high complexity of our population.  It is important for NICE to focus on appropriate resourcing and staffing needs specific to the antenatal period.  CQC (2019) Maternity services survey.  In addition to the increases in complexity and acuity, demand for midwives is also being fuelled by national maternity policy commitments to improve the safety of maternity services, to provide women with more personalised care and greater continuity of carer as well as recognition of the increasing public health role that midwives play. Such initiatives, programmes and deliverables will increasingly require midwives with specialist knowledge and skills as well as making additional calls on the time of midwives and unfortunately, midwifery staffing numbers have not kept pace with these changes.  Existing staffing shortages – estimated by the RCM and Government ministers alike to be in the region of more than 2,000 full-time equivalent midwives in England – are having a significant impact on the workload and pressures experienced by midwives.  RCM (2022). Safer staffing Position Statement  [RCM (2022) position statement safer staffing](https://www.rcm.org.uk/media/5936/rcm_position-statement_safer_staffing.pdf) |
| 19 | DHSC, Office of Health Improvement & Disparities | Question 5 | Statement 5. Suggest the Greater Manchester smokefree pregnancy programme is considered as a case study here. A whole system approach to addressing smoking in pregnancy, which includes effective identification and referral of women and partners who smoke along with data collection/analysis. |
| 20 | Fatherhood Institute | Question 5 | Nothing added to comments form as, to our knowledge, there has not been any mapping of practice engaging fathers/ partners/ supporters in the NHS in the antenatal period. |
| 21 | GPCPC | Question 5 | No further information |
| 22 | NHS England (Maternity Transformation Team) | Question 5 | (Reference to statement 3) Example of good practice James Paget in EoE – 85% of women are cared for in this way Case Study:  Midwifery Continuity of Carer at the James Paget University Hospital NHS Trust  The James Paget University Hospital (JPUH) NHS Trust is situated in the East of England and have approximately 2000 births per year. Demographics include a high proportion of women living in the lowest decile of deprivation (IMD, 2019) with a high number who are non-English speaking. In February 2021, the JPUH launched 3 geographical, mixed risk teams based in the areas of highest deprivation. There are around 7 WTE midwives per team, each providing all 3 elements of care with a live caseload of 1:27. A Quality Improvement approach and PDSA cycles were utilised, continually gaining feedback and testing what works best, listening to women and staff to optimise the model locally. To model our teams and draw up our plan we used the NHSE/I Continuity workforce tool Home (continuityofcarer-tools.nhs.uk)  We now provide Maternity care to approx. 85% of women using the MCoC model. Recent data collected from staff and service user surveys have shown overall improvements in maternity outcomes, midwives job satisfaction and service user satisfaction. A snapshot of 3 months of maternity outcomes for women cared for under the MCoC model has shown marked improvement against those cared for under the traditional model:  - preterm birth rates were 4.2% lower  - miscarriage rates were 0.9% lower  - ELCS rates were 3.4% lower  - EMCS rates were 3.4% lower  - episiotomy rates were 1.1% lower  - 3/4th degree tear rates were 1.6% lower  - unassisted vaginal delivery rates were 6.7% higher  - breast feeding initiation rates were 11.6% higher  Through staff and service user surveys we have seen an overall increase in job satisfaction and service user satisfaction:  "It's so much nicer now, I have really enjoyed my pregnancy and birth experience from start to finish, I am gutted it's all over. The way it's all done now with the continuity model is so much nicer, I was fortunate enough to see my lovely midwife at every appointment and was able to build up a rapport. However, when at the appointments if another [team] Midwife was free [my midwife] would kindly introduce me to them and say that they may deliver your baby, which was nice, so I knew a few more names and faces, luckily enough for me my midwife was on call the night I went into labour so delivered my son for me”  MCoC service user, MVP survey  “My job satisfaction has massively improved. It makes so much sense to me to care for the whole family, educate over time and the family understand that you are there for them and they can come to you as a professional friend that has their interests at the forefront. Seeing families flourish or supporting them in times of need throughout the whole journey has been such a privilege. I am excited to go to work and see them and ensure they're doing well. I can also see that women are benefiting from us understanding their history/background/birth experience and feel heard which has made me feel that I am doing my job well.” MCoC midwife, staff survey  The JPUH are working towards ensuring all women are cared for under the MCoC model, with plans in place to achieve this by the end of November this year. |
| 23 | Royal College of Midwives | Question 5 | no |
| 24 | Fatherhood Institute | Statement 1 | **Pregnant women are supported to access antenatal care by 10 weeks of pregnancy.**  **The Quality Standard states:** *Healthcare professionals involve a pregnant woman’s partner, according to her wishes, and tell her that she is welcome to bring her partner to the booking appointment if she wishes.*  While it is welcome to see mention of including the woman’s partner in the booking appointment, the wording of this ‘offer’ is unhelpfully cautious and conditional. Research from [Bristol University](http://ethos.bl.uk/OrderDetails.do?uin=uk.bl.ethos.686417) has shown that this kind of cautious ‘framing’ of an invitation is likely to DISCOURAGE some parents from including the other parent, even when to do so would be beneficial and they are not opposed to the other parent’s inclusion. Further, social media posts [reveal](https://www.mumsnet.com/talk/pregnancy/4124770-Do-you-take-your-partner-to-midwife-appointments) that some pregnant women are not even sure whether they are permitted to bring their partner with them. Without putting pressure on the pregnant woman, would it be possible to change the wording of the above sentence to:  *Healthcare professionals involve a pregnant woman’s partner, according to her wishes, explaining*  *that she is welcome to bring her baby’s father or her partner or chosen support person to the*  *booking appointment and that they will be able to contribute.*  Questions relating to genetic risk, pre-natal testing, family risk, and own health and health behaviours are much better asked directly of the father than of the pregnant woman as his ‘proxy’. Also, research shows that it is important to meet the father early on so that he is there when pre-natal testing is explained: if he does need to be called in himself later (if the pregnant woman proves to be a carrier – e.g. cystic fibrosis) then his early understanding of pre-natal testing means he will be more likely to come in, and to come in quickly (Burgess & Goldman, 2018).  Furthermore pregnant women’s compliance with positive health behaviours is better when their partner (usually, as outlined above, the baby’s father) understands what is required and can both actively support her and adjust his own health behaviours. |
| 25 | GPCPC | Statement 1 | We are happy to support this statement |
| 26 | NHS England (Maternity Transformation Team) | Statement 1 | It would be helpful to include women who may have a genetic risk. There is no reference at all to this group of women throughout the quality standard.  From a genetic risk perspective and improving outcomes for women from Black, Asian and minority ethnic communities as well as socially deprived communities, whom we know have poorer birth outcomes/maternal etc (MBRRACE), in the section on access to antenatal care a sentence on late bookers consider:  e.g. Some women may present late for their booking appointment, these women are often at increased risk of poorer outcomes thus it is important to prioritise and offer them a booking appointment within ten days of presenting in pregnancy.  Equality and diversity considerations:  As there is a move to digital records and ‘online’ booking etc, consider a sentence around digital poverty, IT literacy, which may become a further barrier for people from socially deprived backgrounds or Black, Asian and minority ethnic communities. Consideration to be given for the provision of extra support if an appointment is online and the woman does not know how to access it. Consider how can these women be supported and not be disadvantaged. |
| 27 | Royal College of Midwives | Statement 1 | Only a third (31%) of women who received antenatal care, received the recommended level of care according to NICE antenatal care guidelines (booking at 10 weeks or less and no routine antenatal visits missed) according to the latest MBRRACE report. There are persistently poorer maternal and perinatal mortality outcomes for those from Black, Asian and Mixed ethnic groups and those living in the most deprived areas. There are also poorer outcomes relating to preterm birth by ethnicity and deprivation.  In recent years, Europe has experienced an unprecedented influx of refugees, asylum seekers and other migrants. The RCM has produced a guide to support midwives and maternity staff in the vital role that they play in providing immediate and responsive care to this group of women. In recognition of the fact that every woman’s circumstances are different, the contents of this guide are generically designed to serve as a practical resource, setting out principles of good care, examples of best practice and signposting for further support.  There is a need for maternity services to provide locally based visible and accessible antenatal care services within community settings, which has ready access to advocacy and interpretation services at every contact. Bespoke antenatal education, including written materials, that reflect the communities that maternity services serve.  Adequate time for antenatal appointments – recognition that interpreted appointments will take longer.  Consider what the impact of new means of communication and care delivery has on experience of maternity services and outcomes (ex. Telephone and virtual appointment for women with limited access to technology)  [RHO Rapid Review - NHS RHO](https://www.nhsrho.org/wp-content/uploads/2022/02/RHO-Rapid-Review-Final-Report_v.7.pdf)  [MBRRACE report 2021](https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2021/MBRRACE-UK_Maternal_Report_2021_-_FINAL_-_WEB_VERSION.pdf)  [RCM - Caring for vulnerable migrant women pocket guide](https://www.rcm.org.uk/media/5868/caring-for-vulnerable-migrant-women-pocket-guide.pdf)  <https://www.england.nhs.uk/wp-content/uploads/2021/09/C0734-equity-and-equality-guidance-for-local-maternity-systems.pdf> |
| 28 | Royal College of Obstetricians and Gynaecologists | Statement 1 | Healthcare professionals section: to recognise that not all women will be accessing maternity care with a partner, consider instead “Healthcare professionals involve a pregnant woman’s partner, according to her wishes, and tell her that she is welcome to bring her partner or other person supporting her to the booking appointment if she wishes.” |
| 29 | Royal College of Paediatrics and Child Health | Statement 1 | Page 5 rationale section - Supporting women to attend ‘their’ rather than ‘the’. |
| 30 | Royal College of Paediatrics and Child Health | Statement 1 | Page 6 commissioners - Services ‘which’ rather than ‘that’ pregnant women can access easily |
| 31 | Royal College of Paediatrics and Child Health | Statement 1 | Page 7 support to access antenatal care – Languages – Wessex paediatric services set up the Healthier Together app which uses a very useful SMS share function to send safety net advice leaflets in a wide range of languages directly to a parent’s mobile phone. Weblink: https://what0-18.nhs.uk/ |
| 32 | Birth Companions | Statement 2 | These risk assessments should be entered into data systems in ways that allow the capture of local, regional and national data showing women’s needs and experiences, including contact with the criminal justice system, housing need, immigration status, language needs, domestic violence, and involvement of children’s and adult social services teams.  These risk assessments must also be carried out in line with principles of trauma-informed care in order to build trust, support disclosure and minimise the risk of re-traumatisation.  Failure to attend scheduled antenatal appointments must be handled in line with trauma-informed principles of care. Women should be supported to discuss the reasons for not attending, and be given support to reschedule and to attend future appointments, without missing key aspects of antenatal provision.  See above comments in ‘general’ on the inclusion of MBRRACE statistics on social services involvement.  Women should also be supported to discuss any concerns about maternity charging policies, with information provided to pregnant women and the professionals working with them about the relevant exemptions. |
| 33 | British Maternal & Fetal Medicine Society | Statement 2 | Not all women at 42 weeks will accept induction so should not be excluded |
| 34 | Fatherhood Institute | Statement 2 | **Pregnant women have a risk assessment at routine antenatal appointments**.  A risk assessment will clearly be enhanced if service providers actually meet the baby’s father or the pregnant woman’s partner as these people have immense impact on the wellbeing of the pregnant woman and the unborn child. For example, a [wealth of research](http://www.fatherhoodinstitute.org/wp-content/uploads/2017/12/Whos-the-Bloke-in-the-Room-Full-Report.pdf) documents the impact of father’s depression in the antenatal period on the pregnant woman’s wellbeing AND on the child through to age seven, possibly through fetal programming. Around 3% of pregnant women’s partners will use violence towards them with a higher percentage misusing drugs or alcohol. No risk assessment will be reliable unless the father/ woman’s partner is actually *met* and, if necessary, *assessed.* For example, a quick screening questionnaire would identify mental health risks in a father or partner which would indicate need for further investigation. Assessing the mental health of a father or partner is significant not just to identify individuals who may prove problematic in their family context, but also to identify families where if the pregnant woman’s mental health is poor, she will – or will not - receive adequate support. |
| 35 | GPCPC | Statement 2 | We think this statement needs to be reframed to include risk assessments. The wording in the definition (p11/12) does not match the wording in the guideline (p1.2.10). We think that last item should be identical and state “identify women who need additional care”. The draft states “review and reassess the plan of care for the pregnancy” and we do not think this conveys an adequate sense of risk assessment |
| 36 | NHS England (Maternity Transformation Team) | Statement 2 | Risk assessments for all women at antenatal appointments is supported – data collection is improving with the new version of MSDS but this work is ongoing. |
| 37 | NHS England (Maternity Transformation Team) | Statement 2 | Risk assessment  To ‘early identification of potential need’- add sentence e.g. family history of genetic disorders which means that the woman is at increased risk (own health if she is affected for example with MARFAN (example of a genetic condition) or at risk of an affected pregnancy). If the woman is in a close relative marriage, this should be recorded at booking; This may indicate that the woman is at increased risk and a detailed family history should be taken. If anything is identified in relation to close relative marriage, it would be advisable to discuss with the ante natal screening midwife/close relative midwife/ local genomic service. Early identifications can empower women to make improved reproductive choice.  Evidence: MBRRACE Data - Pakistan heritage overrepresented in mortality data with genetic congenital anomalies being leading cause of death.  In the risk assessment section (p.11), the list includes for example ‘ask woman about general heath.’  Consider adding a bullet point about consanguinity and genetic risk.  Equality and diversity considerations to include consanguinity language barriers as this is a sensitive subject |
| 38 | NHS England (Maternity Transformation Team) | Statement 2 | Consideration should be given to include reference to include recommended care pathways for women who may have a genetic risk, eg. Close relative marriage – suggestions in response to statements 1-3 included below) |
| 39 | National Patient Safety Team  NHS England | Statement 2  (Page 9) | Quality statement 2: Risk assessment – Quality measures  It is unclear if the recording of fetal growth restriction at booking appointment relates to a previous history or risk factors for growth restriction.  **Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from antenatal care records on provider systems. [NHS Digital’s Maternity Services Data Set](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set) includes recording of fetal growth restriction at the booking appointment in support of the NHS’s Saving babies’ lives care bundle version 2. |
| 40 | PTSD UK | Statement 2, Risk Assessment page 11/12 | We would welcome the inclusion here of a proactive query about ANY previous births or pregnancies. PTSD or C-PTSD from pregnancy and giving birth (including miscarriage, ectopic pregnancy or still birth) can be caused by a variety and complicated mix of objective (e.g. the type of delivery) and subjective (e.g. feelings of loss of control) factors, and so someone may not label their previous birth or pregnancy as a ‘traumatic birth’ but it may have caused them to develop Post Traumatic Stress Disorder, and so they may be having symptoms they may be unaware are connected (which could impact upon this current pregnancy). This is a vital opportunity to identify this, and support them in their current pregnancy and ensuring their health on an ongoing basis. |
| 41 | PTSD UK | Statement 2, Equality and diversity considerations page 12 (and repeated elsewhere) | Whilst we’re aware not every example can be included, we’d welcome the inclusion of another example here relating to PTSD. “It is important for providers to make reasonable adjustments to support pregnant women with a physical, sensory, cognitive or learning disability to participate effectively in risk assessments. For example, independent British Sign Language interpreting services may be needed, or someone who has developed PTSD or C-PTSD as a result of a previous traumatic birth or pregnancy (including miscarriage, ectopic pregnancy or still birth) may need additional support such as more flexibility with appointments, a ‘birth reflection’ opportunity to go over their previous pregnancy/birth medical notes to discuss worries etc, additional time and an awareness from the healthcare provider how their symptoms may impact upon their own care during pregnancy etc. |
| 42 | Royal College of Midwives | Statement 2 | Early identification and treatment represent some of the key steps to improve outcome for women with medical complexities.  Timely referrals to Multidisciplinary Clinics where midwife/obstetrician/medical specialists are all present. This is key to improve outcomes for high risk women (timely consultant appointment and treatment prescription, better connections with GP/community prescribers). This is particularly relevant for Black, Asian and ethnic minority women who are more likely to have negative outcomes if they develop or have medical complexities in pregnancy.  Cardiac disease remains the commonest cause of indirect maternal death and the commonest cause of maternal death overall. Several of the women who died from cardiac causes reviewed in the latest MBBRACE report had unplanned pregnancies and in many cases they had not received pre-pregnancy counselling. Cardiomyopathy is often not known/undiagnosed and manifests in pregnancy. Increasing deaths because of this and because women are not listened to when they talk about symptoms and these may be mistaken for indigestion, growing pregnancy, already existing asthma etc. Pre-pregnancy counselling should be available to women of child bearing age with known cardiac disease. This should include provision of appropriate contraceptive advice.  [MBBRACE final report 2021](https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2021/MBRRACE-UK_Maternal_Report_2021_-_FINAL_-_WEB_VERSION.pdf)  [RCM Informed decision making briefing](https://www.rcm.org.uk/media/5989/informed-decision-making_0604.pdf)  [RCM Care outside of guidance briefing](https://www.rcm.org.uk/media/5941/care_outside_guidance.pdf)  [RHO Rapid Review - NHS RHO](https://www.nhsrho.org/wp-content/uploads/2022/02/RHO-Rapid-Review-Final-Report_v.7.pdf)  [NPEU - Saving Lives , Improving Mothers care](https://www.npeu.ox.ac.uk/mbrrace-uk/presentations/saving-lives-improving-mothers-care#saving-lives-improving-mothers-care-lessons-learned-to-inform-maternity-care-from-the-uk-and-ireland-confidential-enquiries-into-maternal-deaths-and-morbidity-2015%E2%80%9317) |
| 43 | Royal College of Obstetricians and Gynaecologists | Statement 2 | Equality and diversity considerations section – access to interpreters.  Consider specifying that interpreters supporting maternity care should be able to provide high quality interpretation in the specific context of maternity care (recommendation in [RCOG Position Statement: Equitable access to maternity care for refugee, asylum seeking and undocumented migrant women](https://www.rcog.org.uk/about-us/campaigning-and-opinions/position-statements/position-statement-equitable-access-to-maternity-care-for-refugee-asylum-seeking-and-undocumented-migrant-women/))  The RCOG has also recommended that NHS Trusts and Health Boards ensure healthcare professionals receive training on the roles of different types of interpreters working in maternity care, how to work with them effectively, how to recognise poor interpretation and how to work with people with different levels of health literacy.  Consider also stressing that commissioners should ensure that antenatal services can offer flexibility in the number and length of antenatal appointments to allow for the use of interpreting services, over and above the appointments outlined in national guidance, as recommended by NICE complex care guideline. |
| 44 | Birth Companions | Statement 3 | The focus on a named midwife should be matched with a focus on access to care from a midwife with specialist knowledge of relevant complex health and social factors. This would ensure that the most vulnerable women are supported by professionals who have levels of experience and understanding appropriate to their needs. |
| 45 | British Maternal & Fetal Medicine Society | Statement 3 | Continuity of carer is just not feasible |
| 46 | Fatherhood Institute | Statement 3 | No comment – not our area of expertise |
| 47 | GPCPC | Statement 3 | We do not think that ”access to a named midwife” is clear or helpful; does this mean a name, has a telephone number or what? We consider that the final Ockenden review is correct in saying that focussing on safety is a priority over continuity of care, especially during intrapartum care when staffing levels are sub-optimal. Women need to have a telephone number that is answered 24/7, but it doesn’t necessarily need to be one named person.  All the quality measures seem to be about whether the service knows about the history of the woman, not about the woman knowing about the service. It is midwife-centred, not woman centred as written. Please consider making this about women’s ability to access care/help |
| 48 | GPCPC | Statement 3 | We think that in QS 3 it would be impossible to complete the proportion of women who report that midwives and doctors were aware of their medical history. In addition we do not see the relevance of this outcome to the content of the QS: how can this relate to women having access to a named midwife? |
| 49 | NHS England (Maternity Transformation Team) | Statement 3 | (Reference to Statement 3) With attached amendments within the statement it does. Amendments in red in QS draft (attached to email) |
| 50 | NHS England (Maternity Transformation Team) | Statement 3 | (Reference to Statement 3) Although there is digital immaturity in some provider services, there are other means in place to collect the data. |
| 51 | NHS England (Maternity Transformation Team) | Statement 3 | (reference to statement 3) In October 21 guidance was published B0961\_Delivering-midwifery-continuity-of-carer-at-full-scale.pdf (england.nhs.uk) setting out how to achieve this care. In June 2022 providers and LMS were asked to submit a plan describing how they would achieve full continuity for women. Services are being supported in roll out of these plans and development of building blocks to ensure that over time they will have the safe staffing to provide this care. |
| 52 | NHS England (Maternity Transformation Team) | Statement 3 – Statement | Suggestion to change statement wording to: Pregnant women have access to a named midwife, who is supported by the Continuity team for out of hours care |
| 53 | NHS England (Maternity Transformation Team) | Statement 3 – rationale | Add the following at the start of the rationale text: Continuity of Carer has been proven to deliver safer and more personalised maternity care (Cochrane 2016,18 and 20). It will not only improve clinical outcomes, but evidence suggests it will support the realisation of the other quality statements in this document. |
| 54 | NHS England (Maternity Transformation Team) | Statement 3 – process measure | Add ‘and cared for in a continuity team, with an annual case load of 1:36.’ |
| 55 | NHS England (Maternity Transformation Team) | Statement 3 – process measure (denominator) | Add ‘in the service at 29/40 gestation’ at the end |
| 56 | NHS England (Maternity Transformation Team) | Statement 3 process measure – data source | Add: Due to the digital immaturity of some services other methods may also be employed to capture and confirm this data at the end |
| 57 | NHS England (Maternity Transformation Team) | Statement 3 – outcome measure | Add the following outcome measure  The proportion of women to reported having the same midwife and team throughout their pregnancy and birth episode  The number of women who reported having the same midwife and team throughout their pregnancy and birth episode |
| 58 | NHS England (Maternity Transformation Team) | Statement 3 – outcome measure, data source | Add the following: Did you have the same midwife and team throughout your pregnancy, birth and postnatal period at the end |
| 59 | NHS England (Maternity Transformation Team) | Statement 3 – service provider audience descriptor | Add Providers ensure that the building blocks have been clearly articulated in a plan to ensure that safe roll out of this model of care is in place at the end |
| 60 | NHS England (Maternity Transformation Team) | Statement 3 – source guidance | Add B0961\_Delivering-midwifery-continuity-of-carer-at-full-scale.pdf (england.nhs.uk) |
| 61 | National Patient Safety Team  NHS England | Quality statement 3  (Page 14) | **Quality statement 3: Continuity of care - Pregnant women have access to a named midwife**  All women are allocated a community midwife at booking and therefore compliance is likely to be 100%. Would it be possible to record the number of times the woman has contact / is seen by her named midwife? |
| 62 | Royal College of Midwives | Statement 3 | Consideration may be given to teams of midwives specialising in caring for specific cohorts of women (e.g. uncomplicated pregnancy, medically complexity, Black Asian and ethnic minority women or socially complex care) The advantage of specialist teams is that women benefit from the expertise the midwives are able to provide, tailored to their needs.  Based on the five health inequalities priorities in the 2021/22 Planning Guidance, Equity and Equality: Guidance for Local Maternity Systems· The guidance includes 18 interventions to improve equity and equality, good practice case studies, resources, indicators and metrics, including planning for implementing enhanced continuity of carer for women in Black, Asian and Mixed ethnic groups and women living in deprived areas  It would be worth including and considering the growing evidence on the benefit of group antenatal care for continuity, empowerment, education and social support.  [Cochrane review on CoC - 2016](https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004667.pub5/full)  [RCM - Caring for vulnerable migrant women pocket guide](https://www.rcm.org.uk/media/5868/caring-for-vulnerable-migrant-women-pocket-guide.pdf)  [RHO Rapid Review - NHS RHO](https://www.nhsrho.org/wp-content/uploads/2022/02/RHO-Rapid-Review-Final-Report_v.7.pdf)  [Group antenatal care (Pregnancy Circles) for diverse and disadvantaged women: study protocol for a randomised controlled trial with integral process and economic evaluations - 2020](https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-020-05751-z)  [Impact of group antenatal care (G-ANC) versus individual antenatal care (ANC) on quality of care, ANC attendance and facility-based delivery: A pragmatic cluster-randomized controlled trial in Kenya and Nigeria - 2019](https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0222177)  [NHS England - Equity and Equality guidance for Local Maternity services 2021](https://www.england.nhs.uk/wp-content/uploads/2021/09/C0734-equity-and-equality-guidance-for-local-maternity-systems.pdf) |
| 63 | Royal College of Obstetricians and Gynaecologists | Statement 3 | Recommend under structure where it says ‘continuity of carer’ this should be changed to ‘continuity of care’ to align with the rest of the quality statement, and to avoid confusion with the Midwifery CoC model outlined in the NHS LTP, the national target for which has been removed by NHS England following the publication of the Ockenden report ([link here](https://www.england.nhs.uk/wp-content/uploads/2022/09/B2011-Midwifery-Continuity-of-Carer-letter-210922.pdf)) |
| 64 | Royal College of Paediatrics and Child Health | Statement 3 | Page 15 healthcare professionals – They communicate and share information with ‘both midwives in the team and other healthcare’ rather than with ‘both other midwives in the team and other healthcare’. |
| 65 | Birth Companions | Statement 3, question 4 | The focus on a named midwife should be matched with a focus on access to care from a midwife with specialist knowledge of relevant complex health and social factors. This would ensure that the most vulnerable women are supported by professionals who have levels of experience and understanding appropriate to their needs. |
| 66 | GPCPC | Statement 3, Question 4 | We think that the findings of the Ockenden review should affect whether or not a woman has access to a named midwife. We think QS3 needs reframing in any case (see below) |
| 67 | NHS England | Statement 3, Question 4 | (Reference to statement 3) This addressed in amendments attached and comments above. |
| 68 | NHS England (Maternity Transformation Team) | Statement 3, question 4 | Addressed as above. The building blocks included and describe safe staffing and other elements that need to be in place to deliver this model of care effectively. |
| 69 | Royal College of Midwives | Statement 3, Question 4 | See statement 3 comment box |
| 70 | Fatherhood Institute | Statement 4 | No comment – not our area of expertise |
| 71 | GPCPC | Statement 4 | We are delighted to see this standard included. In order to make it truly aspirational and improve rates of recommended vaccination (that are pitifully poor) we would like to see that the jabs are commissioned and delivered in antenatal clinics by midwives. |
| 72 | NHS England (Maternity Transformation Team) | Statement 4 | Are these vaccinations all recommended in pregnancy – to consider |
| 73 | NHS England (Maternity Transformation Team) | Statement 4 | Need to clarify that these are vaccinations which are recommended in pregnancy (not just any vaccination – some vaccines are not indicated and live vaccines are contraindicated) |
| 74 | Royal College of Midwives | Statement 4 | Maternity Services must provide up to date and personalised information in relation to recommended vaccinations in pregnancy, and midwives must be given sufficient time to discuss this with women.  Vaccinations could be administered at antenatal appointments, but only by specially trained staff. This is not typically part of a midwife’s role and therefore additional provision must be made to ensure that vaccinating women at routine antenatal appointments does not impact on other aspects of their care.  The information delivered should be aligned with joint guidance provided by the RCM and RCOG [2022-03-07-coronavirus-covid-19-infection-in-pregnancy-v15.pdf (rcog.org.uk)](https://www.rcog.org.uk/media/xsubnsma/2022-03-07-coronavirus-covid-19-infection-in-pregnancy-v15.pdf) |
| 75 | Royal College of Obstetricians and Gynaecologists | Statement 4 | Equality and diversity considerations section – access to interpreters.  Consider specifying that interpreters supporting maternity care should be able to provide high quality interpretation in the specific context of maternity care (recommendation in [RCOG Position Statement: Equitable access to maternity care for refugee, asylum seeking and undocumented migrant women](https://www.rcog.org.uk/about-us/campaigning-and-opinions/position-statements/position-statement-equitable-access-to-maternity-care-for-refugee-asylum-seeking-and-undocumented-migrant-women/))  The RCOG has also recommended that NHS Trusts and Health Boards ensure healthcare professionals receive training on the roles of different types of interpreters working in maternity care, how to work with them effectively, how to recognise poor interpretation and how to work with people with different levels of health literacy.  Consider also stressing that commissioners should ensure that antenatal services can offer flexibility in the number and length of antenatal appointments to allow for the use of interpreting services, over and above the appointments outlined in national guidance, as recommended by NICE complex care guideline. |
| 76 | Royal College of Paediatrics and Child Health | Statement 4 | Page 20 commissioners – ‘They take action to address identified inequalities and improve access’ rather than ‘They take action to address identified inequalities and take action to improve access’ |
| 77 | Fatherhood Institute | Statement 5 | Pregnant women and partners who smoke are referred for stop-smoking support at routine antenatal appointments  It is good to see partners included here, but the rationale given for their inclusion is weak and incomplete. It reads: Referring partners who smoke to stop-smoking support reflects the need to reduce or prevent the mother and baby’s exposure to second-hand tobacco smoke as part of their antenatal care.  A re-draft needs to acknowledge, in addition to ‘second hand smoke’ the impact of the father/ woman’s partner’s smoking behaviour on hers. A redraft could read:  Referring partners who smoke to stop-smoking support reflects the need to reduce or prevent the  exposure of the pregnant woman and her baby to second-hand tobacco smoke as part of antenatal  care; and because the partner’s smoking behaviour impacts on the pregnant woman’s - for example,  making it harder for her to quit or cut down when her partner continues to smoke. |
| 78 | GPCPC | Statement 5 | We are happy to support this statement |
| 79 | NHS England (Maternity Transformation Team) | Statement 5 | Whilst referral of partners who smoke is desirable and good practice, this is not required information in routine datasets. Treatment programmes for partners are generally external and may vary by area. |
| 80 | NHS England (Maternity Transformation Team) | Statement 5 | Referral and support for partners of pregnant women to stop smoking would be a challenge due to varying practice and resources |
| 81 | NHS England (Maternity Transformation Team) | Statement 5 | It would be helpful to reference ‘opt-out’ referral for the pregnant woman in line with NG209 which is referred to in the guidance |
| 82 | National Patient Safety Team  NHS England | Quality statement 5  (Page 23) | Quality statement 5: Referral for stop-smoking support  Pregnant women and partners who smoke are referred for stop-smoking support at routine antenatal appointments  Should this standard be rephrased as ‘offered referral’, as not possible to refer someone without their consent? Appreciate this statement links back to NG209. For example, Quality Standard 4 states ‘pregnant women are **offered** vaccinations at routine appointments’. |
| 83 | Office of Health Improvement & Disparities, DHSC | Statement 5, general | Our comments refer to Statement 5: Pregnant women and partners who smoke are referred for stop-smoking support at routine antenatal appointments. |
| 84 | Office of Health Improvement & Disparities, DHSC | Statement 5, question 1 | Smoking in the main modifiable risk factor for a range of poor pregnancy outcomes and there are significant geographical and demographic differences in smoking prevalence around the country, it is important this statement is included in the quality standard. |
| 85 | Office of Health Improvement & Disparities, DHSC | Statement 5, question 2 | Data on smoking at time of delivery is a well-established collection with local systems set up to routinely collect this information and submit data on a quarterly basis. The Maternity Services Dataset enables smoking status and Carbon Monoxide (CO) test results of pregnant women at antenatal appointments to be recorded, but this does not include referral whether a has been made. |
| 86 | Office of Health Improvement & Disparities, DHSC | Statement 5, question 2 | The recording of smoking status or referral related to partners is likely to be limited and local systems may not be set up to collect this. |
| 87 | Office of Health Improvement & Disparities, DHSC | Statement 5, question 2 | Local systems will need to be collecting this information already as it relates to both the Saving babies lives care bundle (Element 1) and implementation of the NHS Long Term Plan smokefree pregnancy pathway. They should be encouraged to review information on smoking status and referral rates, as well as uptake of support, regularly to ensure identification and referral pathways are operating effectively. |
| 88 | Office of Health Improvement & Disparities, DHSC | Statement 5, question 3 | Recording smoking status and referral for stop smoking support is achievable and most local areas will be doing this to some extent already. Adaptations may be needed to some local systems to include information on partners. |
| 89 | Office of Health Improvement & Disparities, DHSC | Statement 5, question 3 | Cost savings to local systems will be achieved by identifying women (and partners) who smoke and referring them for effective support to stop smoking. |
| 90 | Office of Health Improvement & Disparities, DHSC | Statement 5, question 3 | Due to reluctance of some women to disclose smoking and the relapse rate, it is important that this action takes place at all routine antenatal appointments |
| 91 | Office of Health Improvement & Disparities, DHSC | Statement 5, question 3 | Stop smoking support – the three interventions listed: intensive & ongoing behavioural support; NRT; voucher incentives are all recommended by NICE Guidance NG209 as part of effective and cost effective treatment support for pregnant women to stop smoking, which should be reflected in the Quality Standard by altering this line as follows:    Stop-smoking support  Interventions and support to stop smoking, regardless of how services are commissioned or set up.  The support ~~may~~ should include: |
| 92 | Office of Health Improvement & Disparities, DHSC | Statement 5, question 3 | To be effective and cost effectives financial incentives need to be implemented IN ADDITION to the provision of behavioural support and NRT, this should be made clear. |
| 93 | Office of Health Improvement & Disparities, DHSC | Statement 5, question 3 | Regarding e-cigarettes and the NG209 evidence review - Since NG209 was published the following paper on the use of e-cigarettes to support pregnant women to stop smoking has been published –<https://www.nature.com/articles/s41591-022-01808-0> - finding that e-cigarettes have a role to play in helping pregnant women to stop smoking, and that their safety for use in pregnancy is similar to that of nicotine patches. Could this statement be changed to reflect this? |
| 94 | Office of Health Improvement & Disparities, DHSC | Statement 5, question 3 | NICE guidance NG209 recommends that all women are offered a CO test at all routine antenatal appointments to help with identifying those who may smoke. Those with a CO reading of 4ppm or above should be referred for support to stop smoking. This should be reflected within the rationale of the statement. |
| 95 | Office of Health Improvement & Disparities, DHSC | Statement 5, question 3 | Service providers/Healthcare professionals/Commissioners: Currently the text indicates that CO testing should take place at the booking and 36 week appointment. This is not in line with current NICE guidance and should be updated to reflect NG209, with all women offered a CO test at all routine antenatal appointments. |
| 96 | Royal College of Midwives | Statement 5 | Based on the five health inequalities priorities in the 2021/22 Planning Guidance, Equity and Equality: Guidance for Local Maternity Systems· The guidance includes 18 interventions to improve equity and equality, good practice case studies, resources, indicators and metrics. Intervention 2 of this guidance is to implement a smoke-free pregnancy pathway for mothers and their partners. Access to smoking cessation services must be available at all times (in-house SCS) and support from organisation like Action on Smoking and Health must be sought.  Rates of smoking in pregnancy in the most deprived areas of England are nearly six times those in the least deprived areas. Smoking also varies by ethnicity, religion, sexual orientation and country of birth.  Organisations must have well resourced smoke-free clinics and consider the employment of specialist midwives to support women through those life-style changes. Consideration must be given to the use of less stigmatising language for those clinics, considering that not all high levels of Carbon Monoxide identified in pregnancy are due to smoking.  Diet and exercise are lifestyle interventions that should be discussed and supported antenatally. There is growing evidence around the benefits of moderate exercise (at least 150 minutes a week as recommended by the Chief medical officers) a balanced healthy diet, for the growing fetus and the pregnant woman and the risks around obesity and pregnancy.  [NICE 2021 - Tobacco: preventing uptake, promoting quitting and treating dependence](https://www.nice.org.uk/guidance/ng209)  [Sport UK and Chief medical officers resources on exercise in pregnancy/post-partum](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/832868/uk-chief-medical-officers-physical-activity-guidelines.pdf)  <https://ash.org.uk/home/>  [NHS England 2021 - Equity and Equality guidance for local maternity services](https://www.england.nhs.uk/wp-content/uploads/2021/09/C0734-equity-and-equality-guidance-for-local-maternity-systems.pdf)  [NICE - Maternal and Child Nutrition guidance](https://www.nice.org.uk/guidance/PH11/chapter/4-Recommendations#diet-in-pregnancy) |
| 97 | Royal College of Obstetricians and Gynaecologists | Statement 5 | “no evidence about the effectiveness or safety of using nicotine-containing e‑cigarettes to help women stop smoking in pregnancy.” – The RCOG is a signatory to Action on Smoking and Health resources [Using e-cigarettes before, during and after pregnancy](https://ash.org.uk/about/who-we-work-with/smoking-in-pregnancy-challenge-group/using-e-cigarettes-before-during-and-after-pregnancy) including the [guide for maternity and other healthcare professionals](https://ash.org.uk/uploads/2019-Challenge-Group-ecigs-briefing-FINAL.pdf?v=1656430825), which notes “While licensed Nicotine Replacement Therapy (NRT) products such as nicotine patches, gum and inhalers are the recommended option, if a pregnant woman chooses to use an e-cigarette and if that helps her to quit smoking and stay smokefree, she should be supported to do so”, as evidence from adult smokers in general suggests that they are likely to be significantly less harmful to a pregnant woman and her baby than continuing to smoke. |
| 98 | Royal College of Paediatrics and Child Health | Statement 5 | Page 17 rationale – ‘immunise themselves’ rather than ‘immunise them’ |
| 99 | Down Syndrome UK | Additional areas | It is essential that when Down syndrome is suspected or detected in a pregnancy the woman has a dedicated care pathway to positively impact her mental health. This includes adopting and following the Personalised Antenatal Care Guidelines for Pregnancies Suspected or Diagnosed with Down syndrome <https://www.stgeorges.nhs.uk/wp-content/uploads/2021/01/Personalised-antenatal-care-of-pregnancies-suspected-or-diagnosed-with-Down-syndrome.pdf#:~:text=All%20pregnant%20women%20whose%20babies%20are%20known%20to,specialist%20care%20pathways%20%28e.g.%20Diabetes%2C%20BMI%20and%20Hypertension%29> as well as continuity of care by recently Down syndrome trained midwives. |
| 100 | Down Syndrome UK | Additional areas | When Down syndrome is suspected or detected in a pregnancy do women have continuity of care from midwives who have had specific Down syndrome training highlighting the importance of positive language and attitude as well as an up to date understanding of what life is like with Down syndrome and have knowledge of where to signpost for support – reference <https://www.britishjournalofmidwifery.com/content/charity-spotlight/down-syndrome-training> |
| 101 | Down Syndrome UK | Additional areas | Do all hospitals have the Personalised Antenatal Care Guidelines for Pregnancies Suspected or Diagnosed with Down syndrome embedded in their Standard Operating Procedures (referenced above) |
| 102 | Down Syndrome UK | Additional areas | Do all screening midwives have specific Down syndrome training, it has been reported that negative language and attitudes are experienced by women throughout the UK which is unacceptable and easily remedied by screening midwives and other maternity professionals regularly attended The Lived Experience training by Positive about Down Syndrome – reference <https://www.aims.org.uk/journal/item/attitudes-language-down-syndrome#:~:text=Author%20bio%3A%20Nicola%20Enoch%20is,stakeholders%20to%20achieve%20this%20goal.> |
| 103 | Down Syndrome UK | Additional areas | When Down syndrome is suspected or detected in a pregnancy, do women get longer antenatal appointments to discuss any fears or worries about the birth of a child who may have known health complications? |
| 104 | Down Syndrome UK | Additional areas | Are all NHS Trust websites and all literature about Down syndrome available to expectant parents up to date [ for example life expectancy is now over 60, heart surgery is 98% successful] ref |
| 105 | Down Syndrome UK | Additional areas | Are all pregnant women who opt for screening given a balanced view of the outcomes and choices? |
| 106 | Down Syndrome UK | Additional areas | When Trusts report on late fetal losses, stillbirths and neonatal losses, is Down syndrome noted? |
| 107 | Down Syndrome UK | Additional areas | Where Down syndrome is suspected or detected every woman should have a high quality of care in every hospital within the UK. A standardisation of antenatal care from screening to birth must be put in place. Women should not be subjected to negative and disrespectful language and out of date attitudes especially if a decision to continue with the pregnancy has yet to be established. |
| 108 | Down Syndrome UK | Additional areas | It has been reported that when maternity professionals have a contemporary understanding of Down syndrome and know where expectant parents can get the best support, the mental health of the parents is significantly improved. The Lived Experience Down Syndrome Training from Positive about Down syndrome has had very good feedback from Maternity professionals. –referenced above |
| 109 | Down Syndrome UK | Additional areas | Service providers must be aware of the St George’s antenatal pathway and carry out its recommendations for the best outcomes for mother and baby – reference above. |
| 110 | Down Syndrome UK | Additional areas | It is essential that if Down syndrome is detected in any fetal losses it is recorded separately. knowing the statistics for late fetal losses in babies with Down syndrome could be used in research to improve outcomes. |
| 111 | Down Syndrome UK | Additional areas | The mental health of pregnant women where Down syndrome is suspected or detected can be vastly improved by a contemporary understanding of the condition which can be easily attained by regular Down syndrome training for staff involved in antenatal maternity care. |
| 112 | Down Syndrome UK | Additional areas | Antenatal Results and Choices (ARC) are specialists in termination and bereavement not the conditions screened for. All staff must have knowledge and access to contemporary information about Down syndrome to pass on to pregnant women so they are equipped with **all** the information about Down syndrome to make an informed choice about continuing the pregnancy. |
| 113 | GPCPC | Additional areas | No. We regret that you have not included a standard about notifying the GP that a woman is pregnant and requesting any relevant past medical history (in guideline 1.2.9). We know that this continues to be missed, as evidenced by repeated MBRRACE reports  In addition we had suggested that this statement should be included:  **All health professionals should inquire about and respond to mothers’ concerns about a reduction in fetal movement in a timely manner beyond 24+0 weeks**  We are aware that midwives and obstetricians will know this information as part of the SML care bundle, but this does not necessarily include other health professionals with whom a women may come into contact e.g. GP, practice nurse, paramedic, physiotherapist |
| 114 | NHS England (Maternity Transformation Team) | Additional areas | NICE antenatal guidance to mention consanguinity -ensure that consanguineous relationships are recorded on maternity information systems |
| 115 | NHS England (Maternity Transformation Team) | Additional areas | If the woman is at risk of having an affected child with genetic disorder, the named midwife (or midwifery team) is to liaise with the ante natal screening midwife/close relative midwife/ local genomic service to ensure a birth plan agreed with the woman is documented in her records to achieve best birth outcomes. |
| 116 | POGP | Additional areas | Common complications in normal uncomplicated pregnancies seem to be missing; identifying Urinary Incontinence antenatally or managing antenatal pain – whether from PGP or other MSK in terms of identifying and signposting to appropriate help  Considering the NHS is launching the Perinatal Pelvic health programme for exactly this for early intervention in pregnancy it should get included on the QS-in  <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8295103/>    <https://www.england.nhs.uk/2021/06/nhs-pelvic-health-clinics-to-help-tens-of-thousands-women-across-the-country/>    <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7203602/> |
| 117 | Royal College of Obstetricians and Gynaecologists | Additional areas | As I read the briefing paper and the comments that have already been included, I cannot find any new issues to raise. The only thing I would emphasise from an RCOG perspective is the screening for pre-eclampsia which is commented on, and the potential for the Tommy’s research to have an impact - but this is in a very early stage at present and needs large numbers to justify the change of approach.  I concur with assertions and time is indeed short. I’ve read the quality standards document and don’t have anything else to add. |
| 118 | The National Organisation for FASD | Additional areas | **It is critical that this draft quality standard is amended to align with and to reflect the NICE Quality Standard 204 on FASD (2022) as well as PHE Maternity High Impact Area: reducing incidence of harms caused by alcohol use in pregnancy (2020) and the DHSC FASD Health Needs Assessment (2021).**  Failure to do so puts various elements of public health at conflict with each other and ignores the fact that DHSC has previously pointed out the failure for joined up thinking and policy in this area.   The DHSC FASD Health Needs Assessment states: ‘FASD is a lifelong condition caused by alcohol exposure to the developing fetus. It can have a significant impact on early-years development and life chances…. FASD can only occur if alcohol is consumed during pregnancy, offering an opportunity for prevention where alcohol can be avoided. An important component of any policy response to FASD should therefore include efforts to reduce the number of women drinking alcohol during pregnancy or while planning to be pregnant…. **The importance of consistent messaging has been identified as a policy priority** with advocacy groups raising concerns around the length of time the CMO advice did not align with that from NICE. The UK was slower than other countries in recommending no alcohol during pregnancy. The US Surgeon General has advised against consuming alcohol during pregnancy since 1981.  PHE’s maternity high impact area document states, ‘Reducing the incidences of harms caused by alcohol before, during and after pregnancy is a **public health priority**, and is vital to ensuring that all children are given the best possible start in life.’   NICE QS 204, statement 1, states: ‘Midwives and other healthcare professionals should give women clear and consistent advice on avoiding alcohol throughout pregnancy, and explain the benefits of this, including preventing fetal alcohol spectrum disorder (FASD) and reducing the risks of low birth weight, preterm birth and the baby being small for gestational age.’ It lists measurable indicators.   NICE QS 204, statement 2, states: ‘ Pregnant women are asked about their alcohol use throughout their pregnancy and this is recorded.’  The NICE Quality Standard 204 in addition calls for evidence of recording the ‘ Proportion of antenatal appointments in which pregnant women are advised not to drink alcohol during pregnancy, ‘the ‘Proportion of antenatal booking appointments where drinking of alcohol is reported’ and ‘Proportion of routine antenatal appointments attended in which alcohol consumption is recorded.’ It states ‘Service providers (maternity services) ensure that antenatal appointments include discussion and recording of alcohol consumption in pregnancy. They ensure that midwives providing antenatal care are aware of the risks to the fetus of drinking alcohol in pregnancy, and have training on FASD awareness and alcohol brief interventions.’   Someone reading the antenatal quality standard would not know of the important strides made by public health bodies, including NICE, to draw attention to the priority given now to the importance of preventing and addressing alcohol exposed pregnancies to prevent Fetal Alcohol Spectrum Disorder, lifelong  It is inconceivable and dangerous to the health and wellbeing of the fetus and pregnant person alike that these 3 key recent documents are not even referenced in the draft quality standard on antenatal care despite this having been raised in an earlier consultation period about this quality standards and being noted in the background materials  There is an entire statement on smoking in pregnancy and there should be a similar statement 6 in which pregnant women are advised not to drink alcohol in pregnancy drawing upon these key documents that were the result of intensive scrutiny and work by leading public health bodies and after quite extensive consultation.   At the very least all three of these documents must be highlighted and referenced or this new antenatal quality standard will be incomplete and sorely and dangerously out of step with current government policy on FASD prevention, recognition and support.  In the box at the beginning of the quality standard where it lists relevant quality standards, should not the quality standard on FASD be mentioned there as it gives more detail on FASD than can be provided in this quality standard  National FASD also believes that the antenatal quality standard should include people with FASD and other neurodevelopmental conditions in its equality and diversity considerations. **Pregnant mothers with FASD (or other neurodevelopmental conditions) should be given support during their care that recognises potential areas of difficulty including: comprehension of written and spoken language, memory difficulties, difficulties with sequencing, understanding cause and effect.**  [**NICE QS 204 – Fetal Alcohol Spectrum Disorder**](https://www.nice.org.uk/guidance/qs204) **(2022)**  [**DHSC FASD Health Needs Assessment for England**](https://www.gov.uk/government/publications/fetal-alcohol-spectrum-disorder-health-needs-assessment/fetal-alcohol-spectrum-disorder-health-needs-assessment) **(2021)**  [**PHE PHE Maternity High Impact Area: reducing incidence of harms caused by alcohol use in pregnancy**](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942477/Maternity_high_impact_area_4_Reducing_the_incidence_of_harms_caused_by_alcohol_in_pregnancy.pdf) **(2020)**  **Other:**  BMA (2007) [fetal-alcohol-spectrum-disorders-report-feb2016.pdf (bma.org.uk)](https://www.bma.org.uk/media/2082/fetal-alcohol-spectrum-disorders-report-feb2016.pdf)  [Antenatal care. NICE guideline NG201](https://www.nice.org.uk/guidance/ng201) (2021), recommendations 1.2.11 and 1.3.10  [Children and young people exposed prenatally to alcohol. Scottish Intercollegiate Guidelines Network guideline SIGN 156](https://www.sign.ac.uk/sign-156-children-and-young-people-exposed-prenatally-to-alcohol) (2019), recommendations 2.1 (page 11) and 2.1.2 (page 12)  [**Alcohol-use disorders: prevention. NICE guideline PH24**](https://www.nice.org.uk/guidance/ph24)**(2010), recommendation 9** |
| 119 | AIMS | N/A | No comments |
| 120 | British Medical Ultrasound Society | N/A | No comments. |
| 121 | Royal College of General Practitioners | N/A | No comments. |
| 122 | Royal College of Nursing | N/A | No comments. |
| 123 | The Society and College of Radiographers | N/A | No comments. |
| 124 | UK Health Security Agency | N/A | No comments. |
| 125 | Hertfordshire FASD Support Network | Additional areas | **It is critical that this draft quality standard is amended to align with and to reflect the NICE Quality Standard 204 on FASD (2022) as well as PHE Maternity High Impact Area: reducing incidence of harms caused by alcohol use in pregnancy (2020) and the DHSC FASD Health Needs Assessment (2021).**  Failure to do so puts various elements of public health at conflict with each other and ignores the fact that DHSC has previously pointed out the failure for joined up thinking and policy in this areas.  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They ensure that midwives providing antenatal care are aware of the risks to the fetus of drinking alcohol in pregnancy, and have training on FASD awareness and alcohol brief interventions.’   Someone reading the antenatal quality standard would not know of the important strides made by public healh bodies, including NICE, to draw attention to the priority given now to the importance of preventing and addressing alcohol exposed pregnancies to prevent Fetal Alcohol Spectrum Disorder, lifelong  It is inconceivable and dangerous to the health and wellbeing of the fetus and pregnant person alike that these 3 key recent documents are not even referenced in the draft quality standard on antenatal care despite this having been raised in an earlier consultation period about this quality standards and being noted in the background materials  We are surprised, and indeed appalled, that despite the existence Statement 5 on smoking as a risk, alcohol exposure is not considered. Either a new Statement should be added on FASD, or Statement 5 should be about risk more generally with alcohol risks as outlined in QS 204 given prominence, since the risks of alcohol exposure for the fetus are far greater than those of exposure to smoking.  The Hertfordshire FASD Support Network also believes that the antenatal quality standard should include people with FASD and other neurodevelopmental conditions in its equality and diversity considerations. **Pregnant mothers with FASD (or other neurodevelopmental conditions) should be given support during their care that recognises potential areas of difficulty including: comprehension of written and spoken language, memory difficulties, difficulties with sequencing, understanding cause and effect.**  [**NICE QS 204 – Fetal Alcohol Spectrum Disorder**](https://www.nice.org.uk/guidance/qs204) **(2022)**  [**DHSC FASD Health Needs Assessment for England**](https://www.gov.uk/government/publications/fetal-alcohol-spectrum-disorder-health-needs-assessment/fetal-alcohol-spectrum-disorder-health-needs-assessment) **(2021)**  [**PHE Maternity High Impact Area: reducing incidence of harms caused by alcohol use in pregnancy**](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942477/Maternity_high_impact_area_4_Reducing_the_incidence_of_harms_caused_by_alcohol_in_pregnancy.pdf) **(2020)**  **Other:**  BMA (2007) [fetal-alcohol-spectrum-disorders-report-feb2016.pdf (bma.org.uk)](https://www.bma.org.uk/media/2082/fetal-alcohol-spectrum-disorders-report-feb2016.pdf)  [Antenatal care. NICE guideline NG201](https://www.nice.org.uk/guidance/ng201) (2021), recommendations 1.2.11 and 1.3.10  [Children and young people exposed prenatally to alcohol. Scottish Intercollegiate Guidelines Network guideline SIGN 156](https://www.sign.ac.uk/sign-156-children-and-young-people-exposed-prenatally-to-alcohol) (2019), recommendations 2.1 (page 11) and 2.1.2 (page 12)  [**Alcohol-use disorders: prevention. NICE guideline PH24**](https://www.nice.org.uk/guidance/ph24)**(2010), recommendation 9**  As it stands this QS is absolutely inadequate for its function. Amending it to include reference to FASD as outlined is imperative. As parents and carers supporting people with FASD we are shocked that any mention of the condition should have been omitted from this draft, particularly since we know representations on this topic have been made previously. |

Note: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

## Registered stakeholders who submitted comments at consultation

* Birth Companions
* British Maternal and Fetal Medicine Society
* Down Syndrome UK
* Fatherhood Institute
* GPs Championing Perinatal Care (GPCPC)
* Maternal Mental Health Alliance
* National Patient Safety team, NHS England
* NHS England (Maternity Transformation Team)
* NHS England (Primary Care Team)
* Office of Health Improvement and Disparities, DHSC
* Pelvic Obstetric and Gynaecology Physiotherapy (POGP)
* PTSD UK
* Royal College of Midwives
* Royal College of Obstetricians and Gynaecologists
* Royal College of Paediatrics and Child Health
* The National Organisation for FASD