

Antenatal care

Quality standard

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This standard is based on CG62.

This standard should be read in conjunction with QS3, QS4, QS15, QS65, QS83, QS82, QS92, QS98, QS69, QS60, QS46, QS37, QS35, QS32, QS43, QS67, QS73, QS75, QS94, QS105, QS109 and QS115.

Introduction and overview

Introduction

Most women who are pregnant in the UK will have an uncomplicated pregnancy, giving birth to a healthy baby at full term. However, problems during pregnancy (such as miscarriage, fetal growth restriction and preterm birth) remain common, and stillbirth rates have changed little in recent years. Maternal complications such as depression, thromboembolism, haemorrhage and sepsis are also still encountered, with the most extreme cases contributing to a UK maternal mortality rate of around 11 per 100,000 maternities (2006–2008 data)^[1].

Adverse outcomes of pregnancy are sometimes unpredictable events, but can also be associated with risk factors such as obesity, smoking, diabetes, hypertension, substance misuse or domestic abuse. The aims of antenatal care are to optimise maternal and fetal health, to offer women maternal and fetal screening, to make medical or social interventions available to women where indicated, to improve women's experience of pregnancy and birth and to prepare women for motherhood whatever their risk status.

This quality standard describes markers of high-quality, cost-effective care that, when delivered collectively, should contribute to improving the effectiveness, safety and experience of care for pregnant women in the following ways:

- Preventing people from dying prematurely.
- Ensuring that people have a positive experience of care.
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

These overarching outcomes are from [The NHS Outcomes Framework 2012–13](#).

The quality standard is also expected to contribute to the following overarching outcome(s) from the [Public Health Outcomes Framework 2013–16](#):

- Health improvement.
- Healthcare public health and preventing premature mortality.

Overview

The quality standard for antenatal care requires that services should be commissioned from and coordinated across all relevant agencies encompassing the antenatal care part of the maternity pathway. An integrated approach to provision of services is fundamental to the delivery of high quality care to pregnant women.

The theme of this quality standard is that pregnancy is a normal physiological process. Women should have the opportunity to make informed decisions about their care and treatment based on the current available evidence, in partnership with healthcare professionals.

This quality standard covers the antenatal care of all pregnant women up to 42 weeks of pregnancy, in all settings that provide routine antenatal care, including primary, community and hospital-based care. The quality standard addresses routine antenatal care, including screening tests for complications of pregnancy, but it does not address the additional care needed to manage these complications if they arise in pregnancy (for example, gestational diabetes, pre-eclampsia and venous thromboembolism).

This quality standard forms part of a suite of maternity quality standards, of which antenatal care, intrapartum care and postnatal care will form the core pathway. The full set of quality standards, including all the maternity quality standards, that should be considered when commissioning and providing high quality maternity services are listed in [related NICE quality standards](#).

^[1] Centre for Maternal and Child Enquiries (CMACE) (2011) Saving mothers' lives: reviewing maternal deaths to make motherhood safer: 2006–08. The eighth report on confidential enquiries into maternal deaths in the United Kingdom. *British Journal of Gynaecology* 118 (Suppl. 1): 1–203.

List of quality statements

July 2013: Quality statement 7: Risk assessment – pre-eclampsia has been removed and is replaced by [quality statement 2: Antenatal assessment of pre-eclampsia risk in hypertension in pregnancy \(NICE quality standard 35\)](#).

Statement 1. Pregnant women are supported to access antenatal care, ideally by 10 weeks 0 days.

Statement 2. Pregnant women are cared for by a named midwife throughout their pregnancy.

Statement 3. Pregnant women have a complete record of the minimum set of antenatal test results in their hand-held maternity notes.

Statement 4. Pregnant women with a body mass index of 30 kg/m² or more at the booking appointment are offered personalised advice from an appropriately trained person on healthy eating and physical activity.

Statement 5. Pregnant women who smoke are referred to an evidence-based stop smoking service at the booking appointment.

Statement 6. Pregnant women are offered testing for gestational diabetes if they are identified as at risk of gestational diabetes at the booking appointment.

Statement 7. Risk assessment – pre-eclampsia.

Statement 8. Pregnant women at intermediate risk of venous thromboembolism at the booking appointment have specialist advice provided about their care.

Statement 9. Pregnant women at high risk of venous thromboembolism at the booking appointment are referred to a specialist service.

Statement 10. Pregnant women are offered fetal anomaly screening in accordance with current UK National Screening Committee programmes.

Statement 11. Pregnant women with an uncomplicated singleton breech presentation at 36 weeks or later (until labour begins) are offered external cephalic version.

Statement 12. Nulliparous pregnant women are offered a vaginal examination for membrane

sweeping at their 40- and 41-week antenatal appointments, and parous pregnant women are offered this at their 41-week appointment.

Quality statement 1: Services – access to antenatal care

Quality statement

Pregnant women are supported to access antenatal care, ideally by 10 weeks 0 days.

Quality measure

Structure

- a) Evidence of local services that ensure antenatal care is readily and easily accessible.
- b) Evidence of local arrangements to encourage pregnant women to access and maintain contact with antenatal care services.

Data source: a) and b) Local data collection. The NICE guideline CG110 [baseline assessment tool](#) can be used to assess current activity related to recording information for women presenting to antenatal care with complex social needs to inform mapping of the local population and to guide service provision.

Process

Proportion of pregnant women missing a scheduled antenatal appointment who are followed up within locally defined timescales.

Numerator – the number of women in the denominator followed up within locally defined timescales.

Denominator – the number of pregnant women missing a scheduled antenatal appointment.

Data source: Local data collection.

Outcome

- a) Pregnant women accessing antenatal care who are seen for booking by 10 weeks 0 days.
- b) Pregnant women accessing antenatal care who are seen for booking by 12 weeks 6 days.
- c) Pregnant women accessing antenatal care who are seen for booking by 20 weeks 0 days.

d) Median gestation at booking.

e) Pregnant women accessing antenatal care attend at least the recommended number of antenatal appointments.

Data source: a), b) c) and d) The [Maternity Services Secondary Uses Dataset](#), once implemented, will collect data on booking appointment dates and estimated dates of delivery. The Care Quality Commission [Maternity Services Survey 2010](#) asks the question 'Roughly how many weeks pregnant were you when you had your 'booking' appointment (the appointment where you were given your pregnancy notes?)'. Possible responses are: before 8 weeks, 8 or 9 weeks, 10 or 11 weeks, 12 weeks and 13 or more weeks. The total number of respondents is also stated.

b) The [Integrated Performance Measure Access to Midwifery](#) is the collection of data to monitor women seen by a midwife or maternity health professional. This includes a national performance measure on the 'percentage of women who have seen a midwife or a maternity healthcare professional for health and social care assessment of needs, risks and choices by 12 weeks and 6 days'. This is monitored by the Department of Health on a quarterly basis.

e) The [Maternity Services Secondary Uses Dataset](#), once implemented, will collect data on the date of attendance at an antenatal appointment (excluding first contact and booking). The Care Quality Commission [Maternity Services Survey 2010](#) asks the question 'Roughly how many antenatal check-ups did you have in total?' Possible responses are: none, 1–6, 7–9, 10–14, 15 or more. The total number of respondents is also stated.

What the quality statement means for each audience

Service providers ensure that systems are in place to support pregnant women to access antenatal care, ideally by 10 weeks 0 days.

Health and social care professionals support pregnant women to access antenatal care, ideally by 10 weeks 0 days. This includes following up women who have missed a scheduled antenatal appointment.

Commissioners ensure they commission services that are readily and easily accessible and that support pregnant women to access antenatal care, ideally by 10 weeks 0 days.

Pregnant women are encouraged to see a healthcare professional about their pregnancy as early as possible and have regular check-ups from their midwife or doctor throughout their pregnancy

(antenatal care). This may include being contacted by their midwife or doctor if they miss a check-up.

Source guidance

- [Antenatal care](#) (2008) NICE guideline CG62, 1.1.1.1, 1.2.3.1, 1.2.5.1, 1.6.3.3 and appendix D (antenatal appointments).
- [Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors](#) (2010) NICE guideline CG110, recommendations 1.1.1, 1.1.2 (key priorities for implementation) and 1.2.8.

Definitions

[NICE full guideline CG62](#) acknowledges that the 'booking appointment' needs to be earlier in pregnancy (ideally by 10 weeks) than may have traditionally occurred.

[NICE guideline CG62](#) recommends that the schedule of antenatal appointments is determined by the woman's needs. For a woman who is nulliparous with an uncomplicated pregnancy, a schedule of 10 appointments should be adequate. For a woman who is parous with an uncomplicated pregnancy, a schedule of 7 appointments should be adequate.

Follow-up after a missed appointment may be undertaken by the maternity service or other community-based service the woman is in contact with, such as a children's centre, addiction service or GP. Follow-up should be via a method of contact that is appropriate to the woman, which may include:

- text message
- letter
- telephone
- community or home visit.

Equality and diversity considerations

Pregnant women include women with complex social needs who may be less likely to access or maintain contact with antenatal care services. Examples of women with complex social needs include, but are not limited to, women who:

- have a history of substance misuse (alcohol and/or drugs)
- have recently arrived as a migrant, asylum seeker or refugee
- have difficulty speaking or understanding English
- are aged under 20
- have experienced domestic abuse
- are living in poverty
- are homeless.

It is therefore appropriate that localities give special consideration to these groups of women within the measures. [NICE guideline CG110](#) has recommendations about how to make antenatal care accessible to pregnant women with complex social needs and how to encourage women to maintain ongoing contact with maternity services.

Quality statement 2: Services – continuity of care

Quality statement

Pregnant women are cared for by a named midwife throughout their pregnancy.

Quality measure

Structure

a) Evidence of local arrangements and audit to ensure that pregnant women are cared for by a named midwife throughout their pregnancy.

b) Evidence of local arrangements to ensure that systems are in place to coordinate a pregnant woman's care should her named midwife not be available.

Date source: a) and b) Local data collection.

Process

The proportion of pregnant women with a named midwife.

Numerator – the number of women in the denominator with a named midwife.

Denominator – the number of pregnant women accessing antenatal care.

Data source: Local data collection.

Outcome

Pregnant women's satisfaction with the continuity of their antenatal care.

Data source: Local data collection. The Care Quality Commission [Maternity Services Survey 2010](#) asks the question 'If you saw a midwife for your antenatal check-ups, did you see the same one every time?' Possible responses are: yes, every time; yes, most of the time; or no.

What the quality statement means for each audience

Service providers ensure that systems are in place to enable pregnant women to be cared for by a

named midwife throughout their pregnancy.

Healthcare professionals follow local systems and guidance to provide continuity of care to pregnant women through the provision of a named midwife.

Commissioners ensure they commission services that enable pregnant women to be cared for by a named midwife throughout their pregnancy.

Pregnant women are cared for by a named midwife throughout their pregnancy.

Source guidance

- [Antenatal care](#) (2008) NICE guideline CG62, recommendation 1.2.2.1.
- [Maternity matters: choice, access and continuity of care in a safe service](#) section 2.1.2–2.1.4
Continuity of midwifery care.

Definitions

A named midwife is a named registered midwife who is responsible for providing all or most of a woman's antenatal and postnatal care and coordinating care should they not be available (definition adapted from '[Maternity matters: choice, access and continuity of care in a safe service](#)').

Quality statement 3: Services – record keeping

Quality statement

Pregnant women have a complete record of the minimum set of antenatal test results in their hand-held maternity notes.

Quality measure

Structure

- a) Evidence of local arrangements to ensure that pregnant women have a complete record of the minimum set of antenatal test results in their hand-held maternity notes.
- b) Evidence of local audit to monitor the completeness and accuracy of antenatal test results in women's hand-held maternity notes.

Data source: a) and b) Local data collection.

Process

Proportion of pregnant women accessing antenatal care who have a complete record of the minimum set of antenatal test results in their hand-held maternity notes, appropriate to their stage of pregnancy.

Numerator – the number of women in the denominator with a complete record of the minimum set of antenatal test results in their hand-held maternity notes, appropriate to their stage of pregnancy.

Denominator – the number of pregnant women accessing antenatal care.

Data source: Local data collection. The NICE guideline CG110 [baseline assessment tool](#) and the NICE public health guidance 27 [audit support](#), criterion 3.

What the quality statement means for each audience

Service providers ensure that systems are in place to maintain a complete record of the minimum set of antenatal test results in women's hand-held maternity notes.

Healthcare professionals ensure that women have a complete record of the minimum set of antenatal test results in their hand-held maternity notes.

Commissioners ensure they commission services that maintain a complete record of the minimum set of antenatal test results in women's hand-held maternity notes.

Pregnant women are given a complete record of the minimum set of their antenatal test results in their hand-held maternity notes.

Source guidance

- [Antenatal care](#) (2008) NICE guideline CG62, recommendation 1.2.4.2.
- [Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors](#) (2010) NICE guideline CG110, recommendation 1.1.10.

Definitions

The minimum set of tests for routine scheduled antenatal care has been developed from the appointment schedule in appendix D of [NICE guideline CG62](#).

Investigation	Timing
Blood pressure	All routine appointments
Urine test for proteinuria	All routine appointments
Blood group and rhesus D status	At booking
Haemoglobinopathies screen	At booking
Hepatitis B virus screen	At booking
HIV screen	At booking
Rubella susceptibility	At booking
Syphilis screen	At booking
MSU for asymptomatic bacteriuria	At booking
Height, weight and body mass index	At booking
Haemoglobin	At booking and 28 weeks

Red-cell alloantibodies	At booking and 28 weeks
Ultrasound scan to determine gestational age	Between 10 weeks 0 days and 13 weeks 6 days
Down's syndrome screen	Combined test: between 10 weeks 0 days and 14 weeks 1 day. Serum quadruple test: 14 weeks 2 days to 20 weeks 0 days.
Ultrasound screen for structural anomalies	Between 18 weeks 0 days and 20 weeks 6 days
Measure of symphysis–fundal height	All routine appointments from 25 weeks
Fetal presentation	36 weeks
Women should be able to make an informed choice about whether to accept or decline each test, and notes should include a record of any tests offered and declined as well as the results of tests accepted.	

Equality and diversity considerations

Hand-held maternity notes and the information within them should be accessible to all women, including women who do not speak or read English and those with additional needs such as physical, sensory or learning disabilities.

Women should be able to choose whether to have all the results of their antenatal tests documented in their hand-held maternity notes. This may be particularly important when information is sensitive (for example, positive screening results for HIV, hepatitis B virus and syphilis). Where a woman declines to have antenatal test results documented in her hand-held notes, the results should instead be recorded within other medical notes.

Quality statement 4: Risk assessment – body mass index

Quality statement

Pregnant women with a body mass index of 30 kg/m² or more at the booking appointment are offered personalised advice from an appropriately trained person on healthy eating and physical activity.

Quality measure

Structure

- a) Evidence of local arrangements to ensure that pregnant women have their body mass index calculated and recorded at the booking appointment.
- b) Evidence of local arrangements to ensure that pregnant women with a body mass index of 30 kg/m² or more at the booking appointment are offered personalised advice from an appropriately trained person on healthy eating and physical activity.

Data source: a) and b) Local data collection. The NICE guideline PH27 [self assessment tool](#).

Process

- a) Proportion of pregnant women accessing antenatal care whose body mass index is calculated and recorded at the booking appointment.

Numerator – the number of women in the denominator whose body mass index is recorded at the booking appointment.

Denominator – the number of pregnant women accessing antenatal care.

- b) Proportion of pregnant women with a body mass index of 30 kg/m² or more at the booking appointment who are offered personalised advice from an appropriately trained person on healthy eating and physical activity.

Numerator – the number of women in the denominator offered personalised advice from an appropriately trained person on healthy eating and physical activity.

Denominator – the number of pregnant women with a body mass index of 30 kg/m² or more at the

booking appointment.

Data source: a) The [Maternity Services Secondary Uses Dataset](#), once implemented, will collect data on the following risk factors at booking: maternal height (global number 17209970) and weight (global number 17209960). The booking appointment date will also be available (global number 17201190). The NICE guideline PH27 [audit support](#), criteria 1 and 3.

b) Local data collection.

Outcome

Women with a body mass index of 30 kg/m² or more feel confident to make decisions about healthy eating and physical activity during their pregnancy.

What the quality statement means for each audience

Service providers ensure that systems are in place to offer pregnant women with a body mass index of 30 kg/m² or more at the booking appointment personalised advice from an appropriately trained person on healthy eating and physical activity.

Healthcare professionals offer women with a body mass index of 30 kg/m² or more at the booking appointment personalised advice on healthy eating and physical activity or if they are not appropriately trained to do this, refer them to an appropriately trained person.

Commissioners ensure they commission services that offer pregnant women with a body mass index of 30 kg/m² or more at the booking appointment personalised advice from an appropriately trained person on healthy eating and physical activity.

Pregnant women with a body mass index of 30 kg/m² or more at the booking appointment are offered advice relevant to them from an appropriately trained person on healthy eating and physical activity.

Source guidance

- [Antenatal care](#) (2008) NICE guideline CG62, recommendation 1.2.2.2 and 1.5.1.1.
- [Maternal and child nutrition](#) (2008) NICE guideline PH11, recommendation 6.
- [Weight management before, during and after pregnancy](#) (2010) NICE guideline PH27,

- recommendation 2.

Definitions

An appropriately trained person can demonstrate expertise and competencies in weight management in pregnancy, including providing advice about nutrition and/or physical activity. This may include obstetricians, GPs, midwives, health visitors, nurses, dietitians, midwifery assistants, support workers and those working in weight management programmes (commercial or voluntary).

Equality and diversity considerations

The body mass index threshold may need adapting for different groups of pregnant women (for example, women from certain ethnic groups). NICE is developing public health guidance on [body mass index and waist circumference in black and minority ethnic groups](#). A body mass index measure is considered unsuitable for use with those under 18.

Quality statement 5: Risk assessment – smoking cessation

Quality statement

Pregnant women who smoke are referred to an evidence-based stop smoking service at the booking appointment.

Quality measure

Structure

- a) Evidence of local arrangements that pregnant women have their smoking status recorded at the booking appointment.
- b) Evidence of local arrangements to ensure that pregnant women who smoke are referred to an evidence-based stop smoking service.
- c) Evidence of local arrangements to ensure that pregnant women who smoke and decide not to attend an evidence-based stop smoking service receive follow-up.

Data source: a) Local data collection through [Maternity Services Secondary Uses Dataset](#) b) local data collection through [PHQ30](#) and c) local data collection.

Process

- a) Proportion of pregnant women accessing antenatal care whose smoking status is recorded at the booking appointment.

Numerator – the number of women in the denominator whose smoking status is recorded at the booking appointment.

Denominator – the number of pregnant women accessing antenatal care.

- b) Proportion of pregnant women who smoke who are offered a referral to an evidence-based stop smoking service.

Numerator – the number of women in the denominator who are offered a referral to an evidence-based stop smoking service.

Denominator – the number of pregnant women accessing antenatal care who smoke.

c) Proportion of pregnant women who smoke who are referred to an evidence-based stop smoking service.

Numerator – the number of women in the denominator who are referred to an evidence-based stop smoking service.

Denominator – the number of pregnant women accessing antenatal care who smoke.

d) Proportion of pregnant women who smoke and decide not to attend an evidence-based stop smoking service who receive follow-up.

Numerator – the number of women in the denominator who decide not to attend an evidence-based stop smoking service who receive follow-up.

Denominator – the number of pregnant women who smoke and decide not to attend an evidence-based stop smoking service.

Data source: a) Local data collection. The Maternity Services Secondary Uses Dataset, once implemented, will collect data on 'the mother's self-reported smoking status at the Booking Appointment' (global number 17201020). b), c) and d) Local data collection.

Outcome

a) Quit rates for pregnant women.

b) Smoking rates in pregnancy.

Data source: a) Local data collection.

b) The Smoking at Time of Delivery (SATOD) collection covers information on the number of women smoking and not smoking at time of delivery (childbirth). Each PCT (and a number of care trusts) is required to submit three figures each quarter:

- total number of maternities
- number of women known to smoke at the time of delivery

- number of women known not to smoke at the time of delivery.

From 2011–12 quarter 3 onwards, the Information Centre for Health and Social Care has taken over responsibility for publishing 'Statistics on women's smoking status at time of delivery: England' from the Department of Health. The reports from 2011–12 quarter 3 are available from the [Information Centre for Health and Social Care](#).

The [Maternity Services Secondary Uses Dataset](#), once implemented, will collect data on 'the mother's self-reported smoking status, specifically after the birth of the baby' (global number 17207150).

PHQ30: Smoking quitters – Number of users of NHS stop smoking services who report that they are not smoking 4 weeks after setting a quit date. Data are broken down into sub-categories, which include 'Pregnant women setting a quit date and outcome'. Monitoring frequency: quarterly.

What the quality statement means for each audience

Service providers ensure that systems are in place to ensure that all pregnant women who smoke are referred to an evidence-based stop smoking service at their booking appointment.

Healthcare professionals refer all pregnant women who smoke to an evidence-based stop smoking service at their booking appointment.

Commissioners ensure they commission services which refer all pregnant women who smoke to an evidence-based stop smoking service at their booking appointment.

Pregnant women who smoke are referred to an evidence-based stop smoking service at their booking appointment.

Source guidance

- [Quitting smoking in pregnancy and following childbirth](#) (2010) NICE guideline PH26, recommendation 1.

Definitions

Advice on smoking cessation should be first provided at the booking appointment and when appropriate throughout the period of antenatal care. The midwife may provide the pregnant woman with information (in a variety of formats, for example a leaflet) about the risks to the

unborn child of smoking when pregnant and the hazards of exposure to secondhand smoke for both mother and baby.

Women who smoke or have recently quit smoking should be referred to an evidence-based stop smoking service if:

- they say they smoke, or
- they have a carbon monoxide (CO) reading of 7 ppm or above, or
- they say they have quit smoking in the past 2 weeks, or
- they say they are a light or infrequent smoker but register a low CO reading (for example, 3 ppm).

[adapted from [Quitting smoking in pregnancy and following childbirth](#) (NICE guideline PH26)]

Evidence-based stop smoking services are local services providing accessible, evidence-based and cost-effective support to people who want to stop smoking. The professionals involved may include midwives who have been specially trained to help pregnant women who smoke to quit ([NICE pathways: Evidence-based stop smoking services and quitlines](#)).

At the time of referral the pregnant woman should be given the number of an evidence-based stop smoking service. This may include the number of the NHS Pregnancy Smoking Helpline (0800 1699 169), details of their [website](#) and a number for a local helpline if one is available.

Quality statement 6: Risk assessment – gestational diabetes

Quality statement

Pregnant women are offered testing for gestational diabetes if they are identified as at risk of gestational diabetes at the booking appointment.

Quality measure

Structure

- a) Evidence of local arrangements to ensure that pregnant women have their risk factors for gestational diabetes identified and recorded at the booking appointment.
- b) Evidence of local arrangements to ensure that pregnant women identified as at risk of gestational diabetes at the booking appointment are offered testing for gestational diabetes.

Source data: a) and b) Local data collection.

Process

- a) Proportion of pregnant women identified as at risk of gestational diabetes at the booking appointment who are offered testing for gestational diabetes.

Numerator – the number of women in the denominator offered testing for gestational diabetes.

Denominator – the number of pregnant women identified as at risk of gestational diabetes at the booking appointment.

- b) Proportion of pregnant women identified as at risk of gestational diabetes at the booking appointment who receive testing for gestational diabetes.

Numerator – the number of women in the denominator receiving testing for gestational diabetes.

Denominator – the number of pregnant women identified as at risk of gestational diabetes at the booking appointment.

Data source: a) and b) Local data collection. The NICE guideline CG62 [audit support](#), criterion 8 and 9. The [Maternity Services Secondary Uses Dataset](#), once implemented, will collect data on the

following risk factors at booking: maternal height (global number 17209970) and weight (global number 17209960), maternal family history of diabetes (global number 17200950) and ethnic group (global number 17200030), and obstetric diagnoses from previous pregnancies including gestational diabetes mellitus (global number 17200720). The date of the booking appointment will also be available (global number 17201190).

Outcome

Early identification of women with gestational diabetes.

What the quality statement means for each audience

Service providers ensure that systems are in place to offer pregnant women identified as at risk of gestational diabetes at the booking appointment testing for gestational diabetes.

Healthcare professionals offer pregnant women identified as at risk of gestational diabetes at the booking appointment testing for gestational diabetes.

Commissioners ensure they commission services that offer pregnant women identified as at risk of gestational diabetes at the booking appointment testing for gestational diabetes.

Pregnant women with a higher than normal chance of developing gestational diabetes (a type of diabetes that occurs during pregnancy) at the booking appointment are offered a test for gestational diabetes.

Source guidance

- [Antenatal care](#) (2008) NICE guideline CG62, recommendation 1.2.2.2
- [Diabetes in pregnancy](#) (2015) NICE guideline NG3, recommendations 1.2.1–1.2.7

Definitions

Risk factors are taken from [NICE guideline NG3](#):

- body mass index above 30 kg/m²
- previous macrosomic baby weighing 4.5 kg or above
- previous gestational diabetes

- family history of diabetes (first-degree relative with diabetes)
- minority ethnic family origin with a high prevalence of diabetes.

Women with any 1 of these risk factors should be offered testing for gestational diabetes.

Testing for gestational diabetes should be carried out in accordance with [diabetes in pregnancy](#) NICE guideline NG3:

Use the 2-hour 75 g oral glucose tolerance test (OGTT) to test for gestational diabetes in women with risk factors.

Offer women who have had gestational diabetes in a previous pregnancy:

- early self-monitoring of blood glucose or
- a 75 g 2-hour OGTT as soon as possible after booking (whether in the first or second trimester), and a further 75 g 2-hour OGTT at 24–28 weeks if the results of the first OGTT are normal.

Offer women with any of the other risk factors for gestational diabetes a 75 g 2-hour OGTT at 24–28 weeks.

Equality and diversity considerations

Any risk assessment for gestational diabetes should be corrected for family origin. Some family origins are risk factors for diabetes (see [definitions](#)) and people from these groups should be offered testing in accordance with the guidance.

Quality statement 7: Risk assessment – pre-eclampsia

July 2013: Quality statement 7 has been removed and is replaced by [quality statement 2: Antenatal assessment of pre-eclampsia risk in Hypertension in pregnancy \(NICE quality standard 35\)](#).

Quality statement 8: Risk assessment – intermediate risk of venous thromboembolism

Quality statement

Pregnant women at intermediate risk of venous thromboembolism at the booking appointment have specialist advice provided about their care.

Quality measure

Structure

- a) Evidence of local arrangements to ensure that pregnant women have their risk of venous thromboembolism (VTE) assessed and recorded at the booking appointment.
- b) Evidence of local arrangements to ensure that pregnant women at intermediate risk of VTE at the booking appointment have specialist advice provided about their care.

Data source: a) and b) Local data collection.

Process

- a) Proportion of pregnant women accessing antenatal care who have their risk of VTE recorded at the booking appointment.

Numerator – the number of women in the denominator having their risk of VTE assessed and recorded at the booking appointment.

Denominator – the number of pregnant women accessing antenatal care.

- b) Proportion of pregnant women at intermediate risk of VTE at the booking appointment who have specialist advice provided about their care.

Numerator – the number of women in the denominator with specialist advice provided about their care.

Denominator – the number of pregnant women at intermediate risk of VTE at the booking appointment.

Data source: a) and b) Local data collection.

Outcome

Incidence of VTE in pregnant women.

Data source: The [Maternity Services Secondary Uses Dataset](#), once implemented, will collect data on VTE as a maternal critical incident (global number 17205700).

What the quality statement means for each audience

Service providers ensure that systems are in place to provide pregnant women who are at intermediate risk of VTE at the booking appointment with specialist advice.

Healthcare professionals seek or provide specialist advice for pregnant women at intermediate risk of VTE at the booking appointment.

Commissioners ensure they commission services which provide pregnant women at intermediate risk of VTE at the booking appointment with specialist advice.

Pregnant women who at the time of their booking appointment have a moderate risk of developing VTE (a blood clot) have specialist advice sought about their care.

Source guidance

- [Antenatal care](#) (2008) NICE guideline CG62, recommendation 1.2.2.2.
- [RCOG green-top guideline 37a](#) recommendations 1, 4 and 6 (executive summary of recommendations).

Definitions

Definitions are taken from [RCOG green-top guideline 37a](#).

Intermediate risk of VTE is defined as any of the following:

- single previous VTE with no family history or thrombophilia (inherited or acquired)
- thrombophilia (inherited or acquired) and no VTE

- medical comorbidities such as:
 - heart or lung disease
 - systemic lupus erythematosus
 - cancer
 - inflammatory conditions
 - nephrotic syndrome
 - sickle cell disease
 - intravenous drug use
- Surgical procedures such as appendicectomy

or 3 or more risk factors from the following list (or 2 or more risk factors from the following list if admitted to hospital):

- age above 35 years
- body mass index more than 30 kg/m²
- parity 3 or more
- smoker
- gross varicose veins (symptomatic, above the knee or associated with phlebitis/oedema/skin changes)
- current systemic infection
- immobility (for at least 3 days) such as:
 - paraplegia
 - symphysis pubis dysfunction with reduced mobility
- long-distance travel (greater than 4 hours)
- pre-eclampsia
- dehydration/hyperemesis/ovarian hyperstimulation syndrome

- multiple pregnancy or assisted reproductive therapy.

Women assessed as being at intermediate risk should have specialist advice provided about their care. This would involve the healthcare professional responsible for the pregnant woman's care discussing the woman's risk factors with a specialist service (for example, a trust-nominated thrombosis in pregnancy expert or team) and acting on this advice.

Quality statement 9: Risk assessment – high risk of venous thromboembolism

Quality statement

Pregnant women at high risk of venous thromboembolism at the booking appointment are referred to a specialist service.

Quality measure

Structure

- a) Evidence of local arrangements to ensure that pregnant women have their risk of venous thromboembolism (VTE) assessed and recorded at the booking appointment.
- b) Evidence of local arrangements to ensure that pregnant women at high risk of VTE at the booking appointment are referred to a specialist service.

Data source: a) and b) Local data collection.

Process

- a) Proportion of pregnant women accessing antenatal care who have their risk of VTE recorded at the booking appointment.

Numerator – the number of women in the denominator having their risk of VTE assessed and recorded at the booking appointment.

Denominator – the number of pregnant women accessing antenatal care.

- b) Proportion of pregnant women at high risk of VTE at the booking appointment who are referred to a specialist service.

Numerator – the number of women in the denominator referred to a specialist service.

Denominator – the number of pregnant women at high risk of VTE at the booking appointment.

Data source: a) and b) Local data collection.

Outcome

Incidence of VTE in pregnant women.

Data source: The [Maternity Services Secondary Uses Dataset](#), once implemented, will collect data on VTE as a maternal critical incident (global number 17205700).

What the quality statement means for each audience

Service providers ensure that systems are in place to provide pregnant women at high risk of VTE at the booking appointment with onward referral to a specialist service.

Healthcare professionals refer pregnant women at high risk of VTE at the booking appointment to a specialist service.

Commissioners ensure they commission services which provide pregnant women at high risk of VTE at the booking appointment with onward referral to a specialist service.

Pregnant women who at the time of their booking appointment have a high chance of developing VTE (a blood clot) are referred to a specialist service.

Source guidance

- [Antenatal care](#) (2008) NICE guideline CG62, recommendation 1.2.2.2.
- [RCOG green-top guideline 37a](#) recommendations 1, 2, 4 and 8 (executive summary of recommendations).

Definitions

Definitions are taken from [RCOG green-top guideline 37a](#).

High risk of VTE is defined as any of the following:

- single previous VTE and thrombophilia (inherited or acquired) or family history
- single previous unprovoked/oestrogen-related VTE
- previous recurrent VTE (more than 1).

Women assessed as being at high risk should be referred to a specialist service, for example a trust-nominated thrombosis in pregnancy expert or team.

Quality statement 10: Screening – national fetal anomaly screening programmes

Quality statement

Pregnant women are offered fetal screening in accordance with current UK National Screening Committee programmes.

Quality measure

Structure

Evidence of local NHS-commissioned services to ensure that all pregnant women are offered fetal screening in accordance with current UK National Screening Committee programmes.

Data source: a) and b) Local data collection.

Process

Note a pregnant woman would be offered either process a) or b) and always process c).

a) Proportion of pregnant women booking before 14 weeks 2 days who are offered the combined screening test to take place between 10 weeks 0 days and 14 weeks 1 day.

Numerator – the number of women in the denominator offered the combined screening test to take place between 10 weeks 0 days and 14 weeks 1 day.

Denominator – the number of pregnant women booking before 14 weeks 2 days.

b) Proportion of pregnant women booking between 14 weeks 2 days and 20 weeks 0 days who are offered the quadruple screening test for Down's syndrome to take place between 14 weeks 2 days and 20 weeks 0 days.

Numerator – the number of women in the denominator offered the quadruple screening test for Down's syndrome to take place between 14 weeks 2 days and 20 weeks 0 days.

Denominator – the number of pregnant women booking between 14 weeks 2 days and 20 weeks 0 days.

c) Proportion of pregnant women booking before 21 weeks who are offered ultrasound screening for fetal anomalies to take place between 18 weeks 0 days and 20 weeks 6 days.

Numerator – the number of women in the denominator offered ultrasound screening for fetal anomalies to take place between 18 weeks 0 days and 20 weeks 6 days.

Denominator – the number of pregnant women booking before 21 weeks.

Data source: a), b) and c) Local data collection.

a) The Care Quality Commission [Maternity Services Survey 2010](#) asks the following questions: 'Did you have a dating scan? This takes place between 8–14 weeks of pregnancy' and 'Did you have any screening tests (a blood test or nuchal scan) to check whether your baby might have Down's syndrome?' Possible responses to the latter are: 'yes, a blood test only'; 'yes, a nuchal scan only'; 'yes, a nuchal scan and blood test'; and 'no, I wasn't offered any screening tests for Down's syndrome'. The total number of respondents is also stated.

a), b) and c) The [Maternity Services Secondary Uses Dataset](#), once implemented, will collect data on 'whether or not screening for Down's Syndrome was offered, accepted or declined' (global number 17202360), 'date blood test sample taken for Down's Syndrome screening' (global number 17202410), 'whether or not fetal anomaly screening was offered, accepted or declined' (global number 17203180) and 'date and time on which fetal anomaly screening was undertaken' (global number 17203190).

a), b) and c) QOF indicator [MAT1](#) – Antenatal care and screening are offered according to current local guidelines (Additional services domain).

c) The Care Quality Commission [Maternity Services Survey 2010](#) asks the question 'Did you have a scan at around 20 weeks of pregnancy?' The total number of respondents is also stated.

Outcome

a) Pregnant women feel they have made an informed decision about whether to undergo fetal anomaly screening.

b) Screening uptake rates.

What the quality statement means for each audience

Service providers ensure that systems are in place to offer fetal screening to pregnant women in accordance with current UK National Screening Committee programmes.

Healthcare professionals offer fetal screening to pregnant women in accordance with current UK National Screening Committee programmes.

Commissioners ensure they commission services that offer fetal screening to pregnant women as part of NHS care, in accordance with current UK National Screening Committee programmes.

Pregnant women who access antenatal care before 21 weeks are offered an ultrasound scan to screen for various conditions in their unborn baby.

In addition, pregnant women who access antenatal care before 20 weeks are offered screening for Down's syndrome in their unborn baby. The type of test carried out (for example, an ultrasound scan and a blood test or just a blood test) will depend on how far advanced the pregnancy is.

Source guidance

- [Antenatal care](#) (2008) NICE guideline CG62, recommendations 1.7.1.1 and 1.7.2.1.
- UK National Screening Committee [Screening for Down's syndrome: UK NSC Policy recommendations 2011-2014 Model of best practice policy recommendations and supporting information](#).
- UK National Screening Committee [Fetal anomaly screening programme 18+0 to 20+6 weeks fetal anomaly scan national standards and guidance for England standard 1](#).

Definitions

Current UK National Screening Committee programmes for fetal screening are defined here as the National Screening Committee policy on fetal anomaly screening in pregnancy, which includes both fetal anomaly ultrasound, and Down's syndrome screening.

[UK National Screening Committee recommendations](#) (Screening for Down's syndrome: UK NSC Policy recommendations 2011–2014 Model of best practice) state that the gestational age window for the combined test runs from 10 weeks 0 days to 14 weeks 1 day. The combined test is made up of linear fetal measurement of the crown–rump length to estimate fetal gestational age (dating

scan), measurement of the nuchal translucency space at the back of the fetal neck, and maternal blood to measure the serum markers of pregnancy associated plasma protein A and human chorionic gonadotrophin hormone. In striking a balance between the benefits of all the markers, trusts should consider screening women around 11 weeks 2 days.

For women presenting beyond 14 weeks 1 day, the quadruple test (maternal serum) window runs from 14 weeks 2 days to 20 weeks 0 days.

The fetal anomaly ultrasound scan should be offered at first contact visit or booking visit, to take place between 18 weeks 0 days and 20 weeks 6 days.

Equality and diversity considerations

The offer and implications of screening should be understood by all women to enable them to make informed decisions. This will necessitate provision of information in an accessible format (particularly for women with physical, sensory or learning disabilities and women who do not speak or read English).

Quality statement 11: Fetal wellbeing – external cephalic version

Quality statement

Pregnant women with an uncomplicated singleton breech presentation at 36 weeks or later (until labour begins) are offered external cephalic version.

Quality measure

Structure

a) Evidence of local arrangements to ensure that pregnant women with a suspected breech presentation at 36 weeks or later (until labour begins) are referred for confirmatory ultrasound assessment.

b) Evidence of local arrangements to ensure that pregnant women with a confirmed uncomplicated singleton breech presentation at 36 weeks or later (until labour begins) are offered external cephalic version.

Data source: a) and b) local data collection.

Process

a) Proportion of pregnant women with a suspected breech presentation at 36 weeks or later (until labour begins) who are referred for confirmatory ultrasound assessment.

Numerator – the number of women in the denominator referred for confirmatory ultrasound assessment.

Denominator – the number of pregnant women with a suspected breech presentation at 36 weeks or later (until labour begins).

b) Proportion of pregnant women with a confirmed uncomplicated singleton breech presentation at 36 weeks or later (until labour begins) who are offered external cephalic version.

Numerator – the number of women in the denominator offered external cephalic version.

Denominator – the number of pregnant women with a confirmed uncomplicated singleton breech presentation at 36 weeks or later (until labour begins).

Data source: a) and b) local data collection.

Outcome

a) External cephalic version rates.

b) Mode of delivery including:

- rates of vaginal birth, emergency and elective caesarean section after successful external cephalic version.
- rates of vaginal birth, emergency and elective caesarean section after unsuccessful external cephalic version.
- rates of vaginal birth and emergency caesarean section after diagnosis of breech presentation in labour.

Data source: a) and b) local data collection.

b) The [Maternity Services Secondary Uses Dataset](#), once implemented, will collect data on 'the presentation of the (first) fetus at onset of labour (including option of breech)' (global number 17204960), 'instance of a critical incident occurring (including option of undiagnosed breech)' (global number 17205700), 'the method for delivering baby' (global number 17206160).

What the quality statement means for each audience

Service providers ensure that systems are in place to offer pregnant women with an uncomplicated singleton breech presentation at 36 weeks or later (until labour begins) external cephalic version.

Healthcare professionals offer pregnant women with an uncomplicated singleton breech presentation at 36 weeks or later (until labour begins) external cephalic version.

Commissioners ensure they commission services that offer pregnant women with an uncomplicated singleton breech presentation at 36 weeks or later (until labour begins) external cephalic version.

Pregnant women with a single baby in the breech position (bottom first with knees either flexed or extended) but with no other problems at 36 weeks or later in their pregnancy are offered external cephalic version (a procedure to move the baby round to the head first position), which includes

first having an ultrasound scan to confirm the baby's position.

Source guidance

- [Antenatal care](#) (2008) NICE guideline CG62, recommendations 1.10.5 and 1.11.2.1.

Definitions

As detailed in [NICE guideline CG62](#) recommendation 1.11.2.1 women in labour or those with 1 or more of the following obstetric complications should not be offered external cephalic version:

- a uterine scar or abnormality
- fetal compromise
- ruptured membranes
- vaginal bleeding
- medical conditions.

When obtaining informed consent for this procedure the woman should be provided with balanced information about the benefits and risks of external cephalic version (for example, the Royal College of Obstetricians and Gynaecologists patient information leaflet '[Turning a baby in the womb \(external cephalic version\)-information for you](#)').

Equality and diversity considerations

There may be some women whose breech presentation is not identified and who are not offered an external cephalic version.

Quality statement 12: Fetal wellbeing – membrane sweeping for prolonged pregnancy

Quality statement

Nulliparous pregnant women are offered a vaginal examination for membrane sweeping at their 40- and 41-week antenatal appointments, and parous pregnant women are offered this at their 41-week appointment.

Quality measure

Structure

Evidence of local arrangements to ensure that nulliparous pregnant women are offered a vaginal examination for membrane sweeping at their 40- and 41-week antenatal visits, and parous pregnant women are offered this at their 41-week appointment.

Data source: Local data collection.

Process

a) Proportion of nulliparous pregnant women attending a 40-week antenatal appointment who are offered a vaginal examination for membrane sweeping.

Numerator – the number of women in the denominator offered a vaginal examination for membrane sweeping.

Denominator – the number of nulliparous pregnant women attending a 40-week antenatal appointment.

b) Proportion of nulliparous pregnant women attending a 41-week antenatal appointment who are offered a vaginal examination for membrane sweeping.

Numerator – the number of women in the denominator offered a vaginal examination for membrane sweeping.

Denominator – the number of nulliparous pregnant women attending a 41-week antenatal appointment.

c) Proportion of parous pregnant women attending a 41-week antenatal appointment who are offered a vaginal examination for membrane sweeping.

Numerator – the number of women in the denominator offered a vaginal examination for membrane sweeping.

Denominator – the number of parous pregnant women attending a 41-week antenatal appointment.

Data source: a), b) and c) Local data collection.

Outcome

a) Rates of induction of labour for women with prolonged pregnancy.

b) Mode of delivery for women with prolonged pregnancy including:

- spontaneous vaginal birth
- instrumental vaginal birth
- elective or emergency caesarean section.

c) Rates of stillbirth beyond 40 weeks gestation (where there is no underlying medical cause).

Data source: a), b) and c) Local data collection.

a), b) and c) The [Maternity Services Secondary Uses Dataset](#), once implemented, will collect data on 'the medical induction of labour' (global number 17204740), 'the method for delivering baby' (global number 17206160) and neonatal death (global number 17209680).

What the quality statement means for each audience

Service providers ensure that systems are in place to offer nulliparous pregnant women a vaginal examination for membrane sweeping at their 40- and 41-week antenatal appointments, and parous pregnant women the same at their 41-week appointment.

Healthcare professionals offer nulliparous pregnant women a vaginal examination for membrane sweeping at their 40- and 41-week antenatal visits, and parous pregnant women the same at their

41-week appointment.

Commissioners ensure they commission services that offer nulliparous pregnant women a vaginal examination for membrane sweeping at their 40- and 41-week antenatal appointments, and parous pregnant women the same at their 41-week appointment.

Pregnant women having their first baby are offered a vaginal examination at their 40- and 41-week antenatal appointments to carry out a membrane sweep, in which a healthcare professional moves a finger around the cervix or massages the cervix, to help start labour.

Pregnant women having their second or later baby are offered a vaginal examination at their 41-week appointment to carry out membrane sweep, in which a healthcare professional moves a finger around the cervix or massages the cervix, to help start labour.

Source guidance

- [Antenatal care](#) (2008) NICE guideline CG62, recommendation 1.11.1.1.
- [Induction of labour](#) (2008) NICE guideline CG70, recommendations 1.3.1.2 and 1.3.1.3.

Using the quality standard

It is important that the quality standard is considered alongside current policy and guidance documents listed in [development sources](#).

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of healthcare. They are not a new set of targets or mandatory indicators for performance management.

Expected levels of achievement for quality measures are not specified. As quality standards are intended to drive up the quality of care, achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, we recognise that this may not always be appropriate in practice when taking account of patient safety, patient choice and clinical judgement and therefore desired levels of achievement should be defined locally.

We have indicated where national indicators currently exist and measure the quality statement. National indicators include those developed by the Health and Social Care Information Centre through their [Indicators for Quality Improvement Programme](#). For statements where national quality indicators do not exist, the quality measures should form the basis for audit criteria developed and used locally to improve the quality of healthcare.

For further information, including guidance on using quality measures, please see [what makes up a NICE quality standard](#).

Diversity, equality and language

During the development of this quality standard, equality issues have been considered and equality assessments are published on the NICE website.

Good communication between healthcare professionals and pregnant women is essential. Treatment and care, and the information given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. Pregnant women should have access to an interpreter or advocate if needed.

Development sources

Evidence sources

The documents below contain clinical guideline recommendations or other recommendations that were used by the Topic Expert Group (TEG) to develop the quality standard statements and measures.

UK National Screening Committee (2011; NHS Evidence accredited) [Screening for Down's syndrome: UK NSC Policy recommendations 2011–2014 Model of best practice.](#)

[Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors](#) (2010; NHS Evidence accredited) NICE guideline CG110.

[Hypertension in pregnancy: the management of hypertensive disorders during pregnancy](#) (2010; NHS Evidence accredited) NICE guideline CG107.

[Weight management before, during and after pregnancy](#) (2010; NHS Evidence accredited) NICE guideline PH27.

[Quitting smoking in pregnancy and following childbirth](#) (2010; NHS Evidence accredited) NICE guideline PH26.

Royal College of Obstetricians and Gynaecologists (2009; NHS Evidence accredited) [Reducing the risk of thrombosis and embolism during pregnancy and the puerperium.](#) Green-top guideline 37a.

[Maternal and child nutrition](#) (2008; NHS Evidence accredited) NICE guideline PH11.

[Induction of labour](#) (2008; NHS Evidence accredited) NICE guideline CG70.

[Diabetes in pregnancy: management of diabetes and its complications from preconception to the postnatal period](#) (2015; NHS Evidence accredited) NICE guideline NG3.

[Antenatal care](#) (2008; NHS Evidence accredited) NICE guideline CG62.

Policy context

It is important that the quality standard is considered alongside current policy documents,

including:

Department of Health (2010) [Maternity and early years: making a good start to family life.](#)

Department of Health (2009) [Healthy Child Programme: pregnancy and the first five years of life \(Update of Standard One \(incorporating Standard Two\) of the National Service Framework for Children, Young People and Maternity Services \[2004\]\).](#)

Department of Health (2009) [Delivering high quality midwifery care: the priorities, opportunities and challenges for midwives.](#)

Department of Health (2007) [Maternity matters: choice, access and continuity of care in a safe service.](#)

UK National Screening Committee (2006) [The UK NSC policy on fetal anomaly screening in pregnancy.](#)

UK National Screening Committee (2006) [The UK NSC policy on Down's syndrome screening in pregnancy.](#)

Definitions, and data sources for the quality measures

References included in the definitions and data sources sections can be found below:

Department of Health (2012) [Public Health Outcomes Framework for England 2013–16.](#)

[Quality and Outcomes Framework \(QOF\) indicators.](#)

Department of Health (2010) [The operating framework for the NHS in England 2011–12.](#)

Care Quality Commission (2010) [Maternity Services Survey 2010.](#)

Department of Health (2007) [Maternity matters: choice, access and continuity of care in a safe service.](#)

[BMI and waist circumference – black and minority ethnic groups NICE public health guidance \(publication date to be confirmed\).](#)

Maternity Services Secondary Uses Dataset.

Related NICE quality standards

Published

- [Antenatal and postnatal mental health](#) (2016) NICE quality standard 115
- [Diabetes in pregnancy](#) (2016) NICE quality standard 109
- [Intrapartum care](#) (2015) NICE quality standard 105
- [Ectopic pregnancy and miscarriage](#) (2014) NICE quality standard 69
- [Induction of labour](#) (2014) NICE quality standard 60
- [Multiple pregnancy](#) (2013) NICE quality standard 46
- [Postnatal care](#) (2013) NICE quality standard 37
- [Hypertension in pregnancy](#) (2013) NICE quality standard 35
- [Caesarean section](#) (2013) NICE quality standard 32
- [Patient experience in adult NHS services](#) (2012) NICE quality standard 15
- [Specialist neonatal care quality standard](#) (2010) NICE quality standard 4
- [VTE prevention quality standard](#) (2010) NICE quality standard 3

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Update information

April 2016: The source recommendations and definitions for statement 6 on risk assessment – gestational diabetes have been updated to reflect changes to the NICE guideline on [antenatal care](#) in March 2016.

June 2015: This quality standard has been updated to ensure alignment with the NICE guideline on [diabetes in pregnancy](#) (NICE guideline NG3), which is a development source for this quality standard. The guideline on diabetes in pregnancy was updated in February 2015.

In particular, information in the definitions section of statement 6 on testing for gestational diabetes has been updated.

For more information about the changes to the diabetes in pregnancy guideline, see the [update information](#) section in the guideline on diabetes in pregnancy.

July 2013: Quality statement 7: Risk assessment – pre-eclampsia has been removed and is replaced by [quality statement 2: Antenatal assessment of pre-eclampsia risk in Hypertension in pregnancy](#) (NICE quality standard 35).

About this quality standard

NICE quality standards are a set of specific, concise statements and associated measures. They set out aspirational, but achievable, markers of high-quality, cost-effective patient care, covering the treatment and prevention of different diseases and conditions. Derived from the best available evidence such as NICE guidance and other evidence sources accredited by NHS Evidence, they are developed independently by NICE, in collaboration with NHS and social care professionals, their partners and service users, and address three dimensions of quality: clinical effectiveness, patient safety and patient experience.

The methods and processes for developing NICE quality standards are described in the [healthcare quality standards process guide](#).

We have produced a [summary for patients and carers](#).

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Supporting organisations

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

- [Royal College of Midwives](#)
- [Royal College of Nursing](#)
- [Royal College of Obstetricians and Gynaecologists](#)